

Indonesia

Restructuring of the social security system (Part 7)

ILO PROJECT INS/00/M04/NET

The Jamsostek health care programme



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Glossary

Bapel JPKM insurance carrier.

BUMN(Badan Usaha Milik Negara) - is a legal status of state-own companies. The structure of this type of company is that of an ordinary public corporation in which there is a board of directors and commissioners. Normally, the boards are drawn from civil servants or government employees (including military personnel). There are three tiers of BUMN:—

Perjan (Perusahaan Jawatan) is the lowest level of companies, attached to certain ministries for the purpose of technical oversight. They are under the supervision of the Ministry of Finance for financial matters. In the health sector for instance, currently 13 central hospitals are being transformed into Perjans. Under this status, the company is not subject to the government accounting system. The mission of this type of company is to provide services or goods to the public. In terms of financial goals, the company may pursue profits but must take into consideration its social objectives. Perjans may receive subsidies from the government.

Perum (Perusahaan Umum) is the second stage of PRIVATISATION. This type of company must be financially independent and may not receive subsidies from the government. A ministry still holds the authority to oversee technical aspects while the Ministry of Finance will oversee financial aspects. Any profit generated from the operation must be shared with the General Treasurer.

PT. Persero (Perseroan Terbatas) is the third stage of PRIVATISATION of government institutions. In this form, all shares are owned by the government but the company is managed as a fully private corporation with its goal — to maximize profit. The Indonesian social security system (comprised of: PT Jamsostek, PT Askes, PT Taspen and PT Asabri) is managed by Perseros but it is now considered to be inappropriate for administration of social security.

BUMD Badan Usaha Milik Daerah, - is a form of company owned by local a government, either fully (100 per cent shares) or partially. Unlike

BUMN, these local companies are not sub-divided into several stages/forms. The objective of BUMD is also profit.

Dana alokasi khusus special allocation funds.

Dana Sehat Health fund — a form of community health care financing or a micro financing scheme that was introduced by the Ministry of Health and or a community initiative to share the burden of health care among the members of the community. Membership is voluntary, contribution level is based on consensus, and the benefits are normally limited to health services in public health centre.

Depkes (Departemen Kesehatan) Department of Health.

Depnakertrans (Departemen Tenaga Kerja dan Transmigrasi) Department of Manpower and Transmigration.

Dinas Kesehatan District or Provincial Health Office.

Jaminan Pemeliharaan Kesehatan Masyarakat (or Jaring Pengaman Kesehatan Masyarakat) (JPKM) – translated as ‘Community Health Maintenance Protection’ currently administered as a Directorate of the Ministry of Health.

Kartu Sehat Health card — issued to poor families to provide them with free care in public health centre or public hospitals. It was introduced when the government launched a social safety net program during the financial crisis in 1998.

Peraturan Pemerintah Government Regulation.

PT Askes (PT Asuransi Kesehatan Indonesia), the State-owned, autonomous, for-profit insurance company administering the Public Service health insurance scheme.

PT Jamsostek (Jaminan Sosial Tenaga Kerja (Persero) the State-owned company administering the private sector social security scheme (including health insurance).

Swadana Autonomous hospital

1. Executive summary

1.1 In practice, Indonesia has a three-tier system, which is additionally fragmented by the size and geographical fragmentation of the country, resulting in at least the following sub-systems:

- the Department of Health and the Provincial Authorities (after the decentralization law) running the health care system for the uninsured, mainly the poor;
- the social security organizations (ASKES and Jamsostek) for the formal sector, civil servants and private workers respectively; and
- private health insurance organizations (pure private health insurance and general private insurance that also provide health insurance) and JPKM. Also Community funds.

1.2 The public health protection programme has developed in a fragmented and piecemeal way over many years, each stage of development having arisen as a result of individual attempts to address particular problems rather than as any coherent attempt at a coordinated plan. The result is a system that lacks transparency, is administratively expensive and generally held in low esteem by the people who use it. At one end of the system, people requiring treatment feel that the quality is poor and the service providers at the other end feel the victims of late or insufficient payment for their services.

1.3 Accurate population statistics about the degree of health insurance cover provided by each of the sub-systems is not readily available. Unconfirmed reports suggest that about 15 percent of the population is covered by the combined social security organizations and private health insurers. However, preliminary discussions and literature review suggest a much lower level, possibly as low as 7 per cent.

1.4 Coverage for formal sector workers is provided under a dual system that includes traditional social health insurance organizations (Jamsostek and ASKES) and private insurance organizations (JPKM and traditional private health insurance) in competition with each other.

1.5 Jamsostek covers four programs: health benefits, occupational injury, death benefit, and provident funds. The health program is very different from the others in that the benefits are provided in kind (instead of cash) using managed care techniques; dependants are covered and membership is optional.

1.6 Although health insurance is part of the Jamsostek benefit package, this has only been partially implemented and exclusion (via the so-called 'opt-out' clause of Article 2 (4) of Government Regulation No.14 of 1993 made under the social security law: Law No.3 of 1992) has been permitted for those insured elsewhere such as with ASKES or where the employer has provided alternative arrangements. The number of people covered by the Jamsostek health care program is only 2.7 million (including 1.3 million workers) out of about 100 million potential people who could be covered by the programme.

1.7 The opt-out provision has resulted in adverse selection to Jamsostek. Higher salaried workers obtain health coverage from private health insurance while those who are on low salaries choose to join Jamsostek. The average per capita contribution in 2000 was only Rp. 5,224 per month while the closest comparable product from the private market cost an employer Rp. 20,500 per month. The total contributions received by PT Jamsostek for health care in 2000 was only Rp. 155 billion - much less than total premiums received by private insurance companies. Thus, the Jamsostek law is considered to benefit private insurance companies more than PT Jamsostek and its members.

1.8 The current organization of the system produces the following effects:-

- segmentation and fragmentation of the health insurance system. Potentially exacerbated, if not done well, by recent decentralization to the provinces (24) but mainly to the districts (320);

- fragmented government policy in social security, health and in social security reform;
- equity problems, including different contribution rates and benefit packages;
- leakage of public subsidies to the non poor;
- inefficiency issues within each sub-sector; and
- weak and fragmented regulation.

1.9 Given the geographic, cultural and political complexity of Indonesia and the weak institutional capacity present in the health sector, reforming the health sector will be particularly difficult. Indonesia has at least 3 possible main scenarios for such reform that are understood to be currently under consideration by the Presidential Task Force:

- reforming each sub-sector separately - addressing the main efficiency and equity issues within each sub-sector separately while maintaining system segmentation;
- the integration of social health insurance - maintaining system segmentation between the poor and informal population and the formal population but developing a single, unified system for the formal sector with either:
- an actual single integrated system with a single payer or insurance carrier; or Virtual single integration through 'same rules of the game' for all insurers (premium setting, package, etc.) but with competition permitted between insurers, possibly with some mechanisms in place to compensate for the eventuality of market failure;
- total system integration - with the formal sector subsidizing the premium for the poor and the informal sector, so that they can join any insurer of choice (within the above scenarios). It would mean total separation of purchasing and provision and a radical shift from historic supply-side financing to "portability" of the public subsidy.

1.10 The scenarios identified above are very complex politically as well as technically and will require very significant technical assistance at the policy level. It is considered that such technical assistance needs to be injected at the highest level with multiple actors - including, but not restricted to, the Department of Health, Depnaker and Jamsostek.

Probably the most logical way forward would be to plan a phased restructuring of the total system, starting with the scenario of reforming each sub-sector separately. When each sector has been strengthened and some harmonization has been achieved, then the possibility of institutional reform or rationalization could be considered.

1.11 Given the national commitment to develop a comprehensive social security scheme (JAMSOSNAS), it follows that there is a strong probability that a new network will be required. Once the system has been designed embodying the specific national answers to a number of policy issues, then will come the time for the structure appropriate for its implementation to be considered. This may call either for new (or different) institutional arrangements, or for some kind of integration or rationalization of the existing ones. It is the design of the system that should determine the institutional arrangements - not the other way round.

1.12 From the system design point of view it will be important to take account of advice and recommendations arising from the technical assistance projects being funded by the European Union.

1.13 International labour standards in relation to medical care

Two up-to date ILO Conventions cover medical care benefits: The Social Security (Minimum Standards) Convention No. 102, 1952 and the Medical Care and Sickness Benefit Convention No. 130, 1969. Convention No. 102 fixes worldwide agreed minimum standards of social security whereas Convention No. 130 sets higher standards. Indonesia has not yet ratified either Convention No. 102 or Convention No. 130. However, Convention No. 102 contains basic requirements and general principles and serves therefore as a guideline which should be applied for all social security systems throughout the world. A short description of the requirements of the Convention with regard to medical care benefits is set out below.

Convention No. 102 covers the contingency of medical care in respect of medical care necessitated by any morbid condition, whatever its cause, and pregnancy and confinement and their related consequences. In addition, a State which has ratified this Convention must secure for the persons protected medical care of a preventive nature. Generally speaking medical care has to be provided as to maintain, restore or improve the health of the persons protected and also must assist in their capacity to return to work.

The Convention prescribes that, in case of a contributory medical care scheme, at least 50 per cent of all employees in the country and also their wives and children shall be protected, or classes of the economically active population, which shall not be less than 20 per cent of all residents and also their wives and children. In case of a universal medical care scheme, at least 50 per cent of all residents shall be protected.

The Convention requires that in case of a morbid condition amongst others at least general practitioner care, specialist care at hospitals, the essential pharmaceutical supplies and hospitalisation are provided. In case of pregnancy and confinement and their consequences, at least pre-natal, confinement and post-natal care as well as hospitalisation shall be provided.

Furthermore, the Convention allows that the beneficiary or his breadwinner may share in the cost of medical care in case of a morbid condition. The Convention, however, does not allow cost-sharing in case of pregnancy and confinement and their consequences.

The Convention also allows to fix a qualifying period, however, only as long as the State regards it as necessary to preclude abuse.

According to the Convention, the medical care benefit shall be granted throughout the contingency, except that in case of a morbid condition its duration may be limited to 26 weeks in each case.

2. Introduction

2.1 The Government of Indonesia (GOI) regards the provision of health protection as a priority and was one of the first countries to embrace the 'Health for All' concept. Due largely to the economic crisis of the 1990s, the target date of the year 2000 has now moved to 'Healthy Indonesia 2010'. Wisely the country has concentrated on developing the primary, promotive and preventive health sectors and has established a comprehensive network of hospitals, clinics, family doctor services, village facilities, midwives, etc. However, this network is not evenly spread across the country and many of the facilities are falling into disrepair — many are lacking essential equipment. Most government facilities are operating at less than full capacity. Generally the system is under-funded and poorly managed.

2.2 Some elements of a three-tier health protection system that are in place are:

- a social safety net providing a basic level of health protection (particularly primary health care) via a system of certification by the community — giving access, in principle, to free medical treatment for the poor — financed by the State. The safety net has been supported by international aid, originally until April 2000, but it is understood that the period has been extended for a further period.
- insurance systems financed by contributions — for public servants by compulsory contributions deducted at source from employees' basic pay and administered by a State-owned company, PT Askes — and, for private sector workers, by compulsory contributions payable by employers, administered by PT Jamsostek (also a State-owned company). This central tier operates on similar lines to the Health Maintenance Organization (HMO) model, though on rather more commercial lines than most.
- supplementary (voluntary) private provision by individuals, from employers or occupational schemes — for health insurance promoted by the Ministry of Health's JPKM directorate. Insurance carriers (Bapels) are licensed by JPKM.

2.3 The provision of health care for the private sector is administered by PT Jamsostek, which has the legal status of a Persero, a public limited liability company required to make profits and pay taxes. This is considered to be inappropriate for a system based on State responsibility and constitutional rights. The overall strategy of the project: "Restructuring of the Social Security System in Indonesia" was to reconstitute Jamsostek as a public social security institution that will hold its members' contributions in trust against future benefit entitlement under the supervision of a tripartite Board. Within this strategy the project was to focus on the reform of the institution to ensure that it will be able to undertake the role envisaged as a core of the social security system in Indonesia. This will entail review of the organizational and administrative system aiming at improved accountability and efficiency and improved service to the public. The activities towards these institutional improvements are summarized in the main project Report - Part 1 of the series of reports on the project.

2.4 On the basis that whatever improvements are made in governance and operating efficiency would still leave the programme weaknesses, the project has also studied options for improvements in the benefit programme including the following:

- pensions to replace lump sums based on savings: Replacement or partial repayment of the existing provident fund scheme (JHT) by a social insurance pension scheme;
- employment Injury pensions: Introducing pensions more fully into employment injury insurance for long-term contingencies of serious disablement and death within the present financial system;
- maternity benefit as a social insurance benefit: Converting maternity benefit into a social insurance benefit by utilizing the same resources as are now expended by employers;

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- feasibility of unemployment insurance: Compensating those with recent formal sector employment through insurance financed by the payment of contributions;
 - social assistance: A feasibility study into the establishment of a social assistance system under which the most vulnerable among the poor would be identified and paid a monthly subsistence payment;
 - health care: The role of Jamsostek in relation to the provision and financing of access to health care and its relationship with other health care providers and insurers will be reviewed;
 - social budget: Analysing and projecting total social expenditure against anticipated income - this to include an actuarial analysis and an assessment of the administrative implications and recommendations for policy decisions; and
 - extension of coverage: Formulating policy options for the extension of coverage to those presently excluded - i.e. those who work for small employers, the informal sector and the self-employed.

2.5 The Director-General of the International Labour Office appointed Dr Hasbullah Thabrany, a national expert on public health, to undertake the study and to support the Chief Technical Adviser, Mr Michael Smith, who was in Indonesia throughout the period of the project. The Director-General also appointed Dr Cristian Baeza, an international expert on health insurance and Dr James R. Marzolf and international health economist both of whom contributed to this report. This present Report is Part 7 of the series of reports prepared for the project: Restructuring of the Social Security System. Further Reports will be issued separately on the other studies.

3. Current health care policy and delivery

3.1 Indonesia is currently at the crossover between centralized and decentralized government and between strong state controls to market driven businesses. In the health sector, reforms are being undertaken to accommodate global changes and to respond to the local demand in various levels of government. The Ministry of Health (MOH) has a vision of 'Healthy Indonesia 2010' by prioritising four main elements of health sector development: healthy paradigm, professionalism, decentralization, and development of managed health insurance.¹ This vision sets healthy life for all Indonesians by the year 2010. In line with the concept of improving professionalism and decentralization, privatisation of health care financing and services is being undertaken. 35 per cent of shares of a state owned company dealing with pharmaceutical production and distribution (PT Kimia Farma) were recently sold in the stock market to increase the company equity and to stimulate quicker response to market changes. Several public hospitals are to be privatised to form Perjan. The pros and cons of this privatisation process of public hospitals continue to be hot issues in health sector reform as, while improving quality of health services, privatisation of pharmaceutical companies and public hospitals is likely to increase health care costs. However, this rise of health care costs may affect access to necessary health services by the poor and nearly poor population.

3.2 As in many other developing countries Indonesia is experiencing the double burden of the continuing problem of infectious disease while social and economic development during the last 30 years has changed people's health behaviour and eating habits giving rise to increasing incidence of chronic disease. Cardiovascular diseases have been the number one cause of death since 1992 (see Table 1)². But many public and private general hospitals are not yet ready to respond to the increasing chronic diseases. There are few hospitals that can provide adequate cardiovascular services in the country. According to one cardiac surgeon, every year Indonesia spends about US\$ 120 million for cardiac treatment overseas. Many public hospitals in districts must concentrate their services to fight prevalent infectious diseases while public and private hospitals in urban areas must also provide expensive equipment to provide services for the growing chronic diseases as the population is ageing rapidly. To respond to the epidemiological changes, health insurers and health care providers must change the way they do business to anticipate higher costs of medical care.

Table 1. Five leading causes of death from series of household health survey

Rank	1980	1986	1992	1995
1	Respiratory infection	Diarrhoea	Cardiovascular	Cardiovascular
2	Diarrhoea	Tuberculosis	Tuberculosis	Respiratory infection
3	Cardiovascular	Diphtheria, measles	Respiratory infection	Tuberculosis
4	Tuberculosis	Tetanus	Diarrhoea	Other infection
5	Tetanus	Malaria	Other infection	Others

3.3 The impetus for changes also comes from the recent currency crisis that was followed by economic crisis in Indonesia. Among other Asian countries, Indonesia suffered and continues to suffer the worst. The Indonesian currency (Rupiah) plunged from about US\$1:Rp. 2,500 in June 1997 to \$1:Rp. 13,500 in January 1998 (at the lowest point). In the past year in response to current political change, the currency has been relatively stable, floating at around \$1:Rp. 9,000 - still less than one third of its pre-July 1997 value. In early 1998, the government reacted to the growing burden of debt - both in the public and private sector, totalling around US \$ 150 billion, a little less than the gross domestic product in the

¹ Healthy Indonesia 2010. MOH, Jakarta, Oktober 1999.

² MOH. Health Profile 2000. MOH, Jakarta 2000.

year 2001 estimated at US\$ 153 billion³ - by selling state owned companies to domestic and international investors.

3.4 Outside the health sector, privatisation of state owned companies is proceeding much faster than privatisation of the health sector. Following the financial crisis of 1997, while the Indonesian currency continued to plunge, there have been many political, social, and economical changes throughout the country. After July 1997, the cost of living suddenly rose four times compared to the beginning of 1997, while Indonesian income per capita fell to only one third of the income in the preceding year. 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 change. Despite the recent political instability, flow of foreign capital is increasing. The public confidence in the market in Indonesia is stabilizing slowly. The country's economic growth has been rising steadily from -15 per cent in 1998 to about 4 per cent in the year 2001⁴. The annual income per capita that had been around US \$ 1,200 at current values (it was estimated at about US\$ 3,200 using purchasing power parity) then declined to around US \$ 618 in 1998. It is now about US\$ 692⁵.

³ Asiaweek, August 31, 2001:13.

⁴ Ibid.

⁵ Asiaweek, August 24, 2001:55.

4. Health care financing

4.1 Health care financing for the public sector comes through the Department of Health (Depkes), the Provincial health care budget, the District health budget, other sector allocations, military health services, public health insurance corporations, and foreign aid and loans. Private sector health care financing comes from out-of-pocket payments from individuals and households, reimbursement by corporations/employers, third party payments through private insurance companies, and direct health services provision by large firms. It is difficult to determine how much the private sector spends on health care each year, since there is no regular survey on this issue. However, recent studies indicate that the private sector role in health care financing is much greater than the public sector. During the last ten years, public sector financing accounted for about 30-40 per cent of total health expenditure while private sector contributed about 60-70 percent, according to most cited sources⁶.

Table 2. Health care financing in selected countries in Asia, 1997⁷

Countries	Per capita health expenditure at exchange rate (US\$)	Per capita expenditure on health in international \$	Total expenditure on health as % of GDP	Public expenditure as % of total health expenditure
India	23	84	5.2	13.0
Indonesia	18	56	1.7	36.8
Malaysia	110	202	2.4	57.6
Philippines	40	100	3.4	48.5
Thailand	133	327	5.7	33.0
Vietnam	17	65	4.8	20.0

4.2 World Health Organization (WHO) 2000 report (see above) shows that Indonesia spent only US\$ 18 per capita on health in 1997 while countries such as India and the Philippines spent more. In US dollars, Indonesia spent even less for health (US\$ 56) than Vietnam (US\$ 65) which has a much lower GDP per capita than Indonesia⁸. Even after the 1997 economic crisis the GNP per capita of Indonesia is currently about US\$ 692 while the GNP per capita of Vietnam is US\$ 382⁹. Indonesia only spent 1.7 per cent of its GDP for health while India and Thailand spent 5.2 per cent and 5.7 per cent of GDP respectively¹⁰. As can be seen on Table 2 above, Indonesia lags behind its neighbours in health care financing. This low health care financing reflects lack of serious attention by the government, the private sector, and the community at large. Low coverage of social security or social health insurance schemes may be a factor in low health care financing.

4.3 In most European countries, the public sector spends much more on health than the private sector because of strong social security or social health insurance systems. Among developed countries in the world, only in the United States (US) does the public sector contribute less than 50 per cent of total health care expenditure. Health care financing in Indonesia is dominated by the private sector, including household contributions of between 60-70 per cent of the total expenditure on health. Using the public share of total health expenditure, Roemer (1993)¹¹ classified Indonesian health care system and the US health care system as entrepreneurial health care systems. These entrepreneurial systems are very regressive in terms of the burden of health care financing to the population. The high infant mortality and maternal mortality rate in Indonesia may be attributed to this regressive system. Thailand and the

⁶ WHO Report 2000, Geneva 2000.

⁷ Source: WHO Report 2000

⁸ Source: WHO Report 2000

⁹ Asia Week, 2001.

¹⁰ World Health Report 2000. WHO, Geneva, 2000.

¹¹ Roemer. Health System of the World, Oxford University Press, New York, 1993.

Philippines have been in the other quadrant where public share on health expenditure is greater than the private sector¹²

4.4 The possible reasons for low public health financing in Indonesia include:

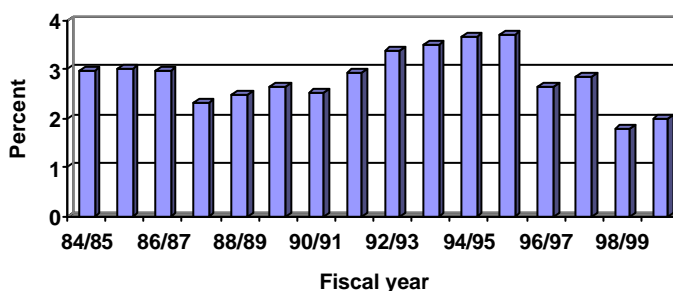
- the Indonesian Government does not have sufficient resources to invest adequately in health care. In 1998, the Indonesian Government invested less than US\$ 4 per capita per year through Central, Provincial, and District health care budgets for wide ranges of health programs and services. A significant proportion of these funds came from foreign assistance or loans. Foreign assistance is needed because the Government is unable to finance, from domestic sources, its total health care budget, including the budget for health programs and services;
- the Indonesian government places low priority in investing on health. While the government spent only US\$ 4 per capita in 1998, it received taxes from tobacco sales of about US\$ 5 per capita. If the government placed a high priority in investing on health, it would return all money received from tobacco taxes in recognition of the fact that tobacco destroys people's health. In the year 2001, the government set a target of Rp. 20 trillion-revenue from tobacco taxes, about four times greater than the government spent for health. If the revenue from tobacco taxes were be used to finance health programs and services, there will be more money for health.

4.5 The second reason seems more realistic than the first.

4.6 The government allocation for health is believed to be one of the lowest in the world. In the last fifteen years, it has never been above four percent of the total budget (see Figure-1)¹³. Although private sector contributions for health services have been and continue to be about twice as much as the government's share, the roles of the government in the provision of health services remain large. This is due to the central government tightly controlling the price of health services in health centres and public hospitals - aimed at assuring affordable health services to patients with low-income. For example, at public health centres people get treatment for as low as US\$ 0.10, including three-day supplies of medicines.

4.7 However, from 2001 the low cost of treatment at public hospitals and health centres changed. Many health centres and public hospitals now under full control of local governments will be transformed into swadana (autonomous) facilities and it will be more likely that the local government will approve higher prices. If prices of health services in public hospitals and public health centres rise, then the financial risks to the low and middle-income group will increase. Without significant health insurance coverage or financial assistance for the poor, the access to health services will be jeopardized.

Figure 1. Government allocation of health services as percentage of total government expenditures



¹² WHO Report, 1999.

4.8 Currently about 84-85 per cent of the population does not have health insurance¹⁴. About seven percent of those insured are covered through Askes; a state owned company that administers compulsory health insurance for civil servants, retired civil servants and the military, and their dependents. Jamsostek covers about 1.3 per cent of the population (instead of the potential 40-50 per cent of the population if the Jamsostek law were to be implemented consistently). The remainder are covered by other private health insurance schemes, including coverage by JPKM bapels (the Indonesian version of health maintenance organizations). In the ten years to 1998, the health insurance coverage as a proportion of total population remained relatively stable. In 1990 data published by the World Bank gave the proportion of the population with health insurance as 13 per cent¹⁵. The proportion of the population with health insurance now is only about 15-16 per cent. The number of people with health insurance has increased by 9 million in the last decade, excluding military personnel and their families. Most of the growth of health insurance coverage occurred in the last two years. After 1998 when economic crisis was at its worst in Indonesia, the growth of health insurance coverage increased sharply. The HMO products sold by PT Askes have reached one million people at present while the number of people insured by other insurance companies in 1999 was 3.98 million.¹⁶

4.9 It is estimated that private health insurance companies now cover more than five million people, twice the number of people covered by the Jamsostek health insurance programme. Private health insurance includes schemes for profit and non-profit. The lack of information about this sector is striking. There are at least three types of private health insurance schemes, all extremely weakly regulated by different government entities, so much so that there are problems in consumer protection (one large international JPKM went broke recently). The types of schemes are:

- the traditional indemnity health insurance being provided mostly by international insurance companies. The law only allows the life insurance companies to provide health insurance coverage but, in practice, even other companies are providing it. The companies providing health insurance are doing so under the Life Insurance business and they are regulated as such by the Ministry of Finance, mostly with no separation between the life insurance part of the business and the health insurance one;
- the JPKM, HMO type of private insurance, mostly offered by national companies, for profit or non-for-profit, created on an ad-hoc for this purpose and licensed and theoretically regulated by Depkes. The regulatory framework is also extremely weak; and
- community and cooperative arrangements to provide limited health benefits.

4.10 JPKM and community schemes are allowed to do risk rating, in practice to match the package to the contribution and to have short-term contracts which vary yearly. Most private health insurance companies focus on offering group insurance within which community rating or risk rating (for different sub-groups) is used for setting the premiums. However, although in principle it might look like community rating, they are increasingly doing individual risk rating as they differentiate the benefit package even within a group. This practice (resulting from the lack of regulation) might potentially result in very negative practices and abuse by insurers and employers' toward the low-income workers within a group. Regulation is almost absent and the existing one is weak and not enforced. Private Health Insurance is operating under two different frameworks. One, law 23, for JPKM, which is regulated by the corresponding unit of the Department of Health, including a financial guarantee which is in practice small (indexed to the reported membership), no solvency margin or technical reserves regulation, no effective

¹³ Malik, R et. Al. *Evaluasi Pembiayaan Kesehatan*, and Bureau of Planning Data., Jakarta 1997.

¹⁴ Thabrany, H and Pujiyanto. *Asuransi Kesehatan dan Akses Pelayanan Kesehatan*. *Majalah Kedokteran Indonesia*, 50(6), Juni 2000. 282-289.

¹⁵ *World Development Report 1993: Investing in Health*. Oxford University Press, New York, 1993.

¹⁶ Djaelani F. *Perkembangan dan Peluang Asuransi Kesehatan*. Seminar Nasional Asuransi Kesehatan, Jakarta 23-24 Oktober 2000.

benefit package or consumer-scheme contract regulation. In turn, other private health insurance (mainly international companies or large national insurance groups) is operating under law 3, which allows the provision of “health programs” under the Life Insurance section of such law. Therefore, all financial guarantees and solvency margins and technical reserves regulations are referred generically to the life insurance product and within it, implicitly for health insurance. No specific regulation for health insurance exists.

4.11 The Indonesian policy on health services allows public-private partnership both in financing and delivery of health services. However, it is not clear what portion the public sector must be responsible for and what portion the private sector could be responsible for. Currently this issue is being debated within the health sector, especially after the implementation of decentralization of health services. In general, there are discussions that money from the government budget should be used to pay for the provision “public goods” such as environmental sanitation and immunization. However, the detailed services to be the responsibility of the government and local governments are not yet listed. There is a general consensus that financing of curative care and other individual care that are considered “private goods” will be the responsibility of the community, except for the poor that will be financed by the government. It is still not clear who will bear the cost of personal health care for the marginal people who cannot afford to meet their health care needs but who are not qualified for assistance. It is also not clear to what extent; the government will provide assistance to the poor in meeting their health needs. In the past, the assistance covered only basic health care; whereas secondary and tertiary care (for which the poor and the marginally non poor cannot afford to pay) was not covered. The need for health insurance will, therefore, increase in the near future.

4.12 In the delivery of health services, the trend is that the government will place more reliance on the private sector. Currently, public hospitals are being privatised or transformed into autonomous entities. This could be in the form of for-profit state or local government enterprises (BUMN or BUMD). Many health centres are also being transformed from the local government facilities into autonomous health care facilities, known as *swadana*. Much of this transformation is aimed at making financial management and the responsiveness of management to local demands more flexible. As a general trend, user fees may increase significantly while social protection for those who may not be able to afford the services is not yet established. One serious concern over this transformation is that the financial access by the poor or nearly poor people might be jeopardized. Some public health programs currently installed, such as immunization, family planning, and eradication of communicable diseases, may fail to achieve significant coverage. As a consequence, there may be raising prevalence of communicable diseases.

5. Micro financing schemes

5.1 As discussed in the previous sections, the government contributes about 2 to 3.6 per cent of the total government expenditure for health annually, the lowest among ASEAN countries. To supplement this low public spending on health, the Ministry of Health introduced a concept of micro financing scheme called *dana sehat* or village health fund in the 1970's. At that time, it was predicted that the government funding for health would diminish because of a significant reduction in oil revenues. Many health care financing advocates suggested that the government domination of funding for health care was not good for the future of the health system in Indonesia. Therefore, money from households was to be mobilized to meet growing needs of health services of the community.

5.2 Households have been also spending a relatively low percentage of their total expenditure on health - ranging from 2 to 4 per cent of total household expenditure. This low health expenditure from household sources represents low ability to pay for health services where nationally 50 per cent of households spend 80 per cent of household income on food. In such households there is, therefore, little money left to purchase other services and goods such as health care and education. This low household health expenditure may be related to low prices charged by health centres and hospitals. The utilization data shows that visits to health centres account for about half of the total health care visits in most regions in the country. In the majority of the districts/municipalities, people get access to health centres for only about Rp. 1,000 (US\$ 0.10) per visit. This is one reason why efforts to mobilize resources from the community through micro financing schemes, such as health card or health fund (*dana sehat*) have been unsuccessful - there being no incentive to households to contribute to health funds when the cost of health centre services is so low.

5.3 Studies by Thabrany and Pujiyanto from the National Socio-economic survey in 1998 found that only 1.87 per cent of the population were holding health cards or were members of health funds. There was no significant improvement in the access to inpatient care among the health cardholders or health fund members, but there was about 47 per cent better access to health centre services among the members compared to those who were uninsured. This was due to most micro financing schemes covering only outpatient care in health centres. This coverage of health-centre only services was useless because the cost of health centres visits was affordable by all layers of the population. Therefore, the benefits of health funds were not considered meaningful. Studies by Silitupen¹⁷, Iriani¹⁸, and Asnah¹⁹ indicated that very few households paid contributions for more than two consecutive years. Drop out rates from the first to the second year of health fund membership were between 60-90 per cent. It is not surprising that since the introduction of this scheme in the 1970's, there was very little progress. During the beginning of the financial crisis in 1998, when the government introduced a social safety net program in the health sector by providing financial assistance to about 18 million poor families (at a cost of Rp. 180 billion in 1998); the *dana sehat* schemes halted²⁰. During the crisis the social safety net program that was fully funded by the government covered poor families. Having financial assistance, the poor families did not feel the need to contribute to *dana sehat*. The target of *dana sehat* scheme was mostly poor families from whom the fund collected contributions. This targeting was in contradiction to the general principle of contributions by those who could afford to pay to provide social assistance for the poor.

5.4 The failure of *dana sehat* to expand and to develop into more sustainable schemes was considered to be due to:

¹⁷ Silitupen, valens. *Evaluasi Perkembangan Dana Sehat di NTT*. Tesis, FKMUI, 1998.

¹⁸ Iriani, R. *Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Kabupaten Bogor*. Tesis, FKMUI, 1999.

¹⁹ Asnah. *Faktor-faktor yang berhubungan dengan kesinambungan Dana Sehat di Lampung Barat*, Tesis, FKMUI, 2001.

²⁰ Azwar, R. *Evaluasi program JPKM-JPSBK di Jakarta Selatan*, Tesis, FKMUI, 2001

- benefits provided were far from the members' needs. Most dana sehat provide health benefits in health centres and some small financial assistance where a member is hospitalized. Even a large scale dana sehat sponsored by the provincial government of West Java could not develop into a reasonable and sustainable scheme;
- contributions are set based on community consensus and normally very low. Normally dana sehat collect contributions door-to-door at a predetermined amount ranging from Rp. 100 – Rp. 1.000 per household per month. The amount of contribution is normally determined by general consensus. There is no actuarial calculation;
- the target memberships were the poor communities. While the membership was voluntary, like commercial health insurance schemes, the main target groups for membership were the poor who deserve free care. The poor rarely have money available to contribute regularly. The amount of finance available was, therefore, too small to be able to negotiate an acceptable level of health care; and
- Those people or heads of neighbourhoods or villages who had no knowledge about health insurance schemes manages all dana sehat on a volunteer basis. In some cases, the money was the subject of corruption by the management.²¹

5.5 The social safety net program at inception consisted of three different programs of financial assistances to ensure access to necessary health services for the poor:

- the first program targeted high-risk pregnant women by channelling money (Rp. 10,000 per poor household) directly to a village midwife. The midwife to refer high-risk pregnant mothers to a health centre or hospital could use this money. The money could also be used to pay for drugs, services, or transportation costs. This program increased access to hospital services for quite severe cases such as bleeding and complicated delivery²²;
- the second program was the promotion of JPKM (community health maintenance scheme adopted from the concept of HMO in the U.S.). Rp. 10,000 per poor family was given to companies, cooperatives, or foundations to establish a sustainable 'pre-bapel' (provisional bapel) in a district. The pre-bapel could retain 8 per cent of the money for administration and preparations for full (licensed) bapel status. The program provided the objective that, after two years; the pre-bapel could expand its membership by selling JPKM/HMO product to non-poor families. Immediately, 354 pre-bapels were created - the majority by civil servants, pensioners or cooperatives of civil servants within district health offices with no prior experience of managing such schemes. After one year, under heavy criticism, this program was terminated. Evaluation of the pre-bapel program in East Java and in South Jakarta revealed that there was no real prospect of pre-bapels achieving full HMO status (Ekowati 2000²³; Azwar 2001²⁴);
- the third program was the assistance for health centre services through special block grants of Rp. 10,000 per poor family to all health centres. The health centre could use the money to buy drugs, to supplement essential drugs supplied by the government;
- in addition, hospitals got some help through the disbursement of financial assistance for the operational costs of providing inpatient care for the poor. The latest programs had mixed results

²¹ Hasan, F. Evaluasi Program JPSBK terhadap Kehamilan Risiko Tinggi., Thesis December 2000.

²² Hasan, F. Evaluasi Program JPSBK terhadap Kehamilan Risiko Tinggi., Thesis December 2000.

²³ Ekowati. Faktor-faktor yang berhubungan dengan kemandirian pra bapel JPKM-JPSBK di Jawa Timur., Tesis, FKMUI, 2000.

²⁴ Azwar. Faktor-faktor yang mempengaruhi utilisasi JPKM JPSBK di Jakarta Selatan. Tesis, FKMUI, Depok 2001.

in improving access by the poor. However, those in the marginally poor group (who did not qualify for the assistance, but were unable to pay for expensive medical care in hospitals - such as self employed, part-time workers, seasonal workers, and farmers) remained in a difficult situation in meeting their medical needs. Evaluation of this program showed that more than 90 per cent of the beneficiaries who were eligible, satisfied the means test. While the remainder of the program was received by those who actually could afford to pay part of the care (Khumaedi, 2000)²⁵; and

- further evaluation of the safety-net program is given in the report entitled 'Klaten Re-visited' sponsored by the ILO under this project.

²⁵ Khumaedi. Evaluasi program JPSBK di RSU Tangerang, Thesis, FKMUI, Depok 2000.

6. Access to primary care

6.1 Primary health care in Indonesia is delivered through public health centres and private clinics or doctors in solo practices. For 85 per cent 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 the facilities. Local governments normally set user fees at very low levels that all people can afford. After the Regional Autonomy Law has been implemented, local governments will tend to raise user fees in order to recover the costs of providing basic health services that were traditionally funded by the central government. User fees have been between Rp. 500 and Rp. 2,000 per visit, including three days of medication. The quality of services at public health centres, and sub-health centres is considered very poor resulting in the majority of people who are the better off declining to use health centre services. Instead, they go to private doctors. These are the same doctors who provide services in the morning at health centres, having private practice in the evening to supplement their low income from government. This is one reason why policy makers are considering increasing user fees so that the facilities will have adequate funds to maintain certain level of quality. The trade-off is that the poor or marginally poor may be excluded.

6.2 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. Often the problem is not in the price of service, 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 centres 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 kilometres from the centre. While for hospitals, access is good for those living within ten kilometres from the hospital. Beyond that, many people have geographical barriers to health centre and hospital access. Formal workers who normally live in urban areas may not have geographical barriers to the services. To overcome geographical barriers, the government provides mobile health centres visiting remote villages at least once a week. The availability of public health centres (stationary, mobile, and sub-health centres) and low user fees make access to primary health services quite good for all levels of the community. The better off, who demand better services, may visit a 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)²⁶.

6.3 Figure-2 shows that the number of primary care visits per thousand of the population by ten income deciles, from the poorest ten percent to the richest ten percent of the population, did 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 percent and the richest ten percent of the population (Figure 3). The poorest ten percent on average had 358 visits per 1,000 people per month while the richest ten percent had 373 visits per 1,000 people. There were minor differences in primary health care visits between the insured and the uninsured. These minor differences were due to low health centre fees, good distribution of health centres, sub health centres, nurses, general practitioners, and mobile health centres. If we examine visit rates to private doctors services, the differences were quite high. However, those who had low access to private doctors 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.

²⁶ Khumaedi. Evaluasi program JPSBK di RSU Tangerang. Thesis, FKMUI, Depok 2000.

Figure 2. Visit rates for any outpatient care by income deciles, 1998

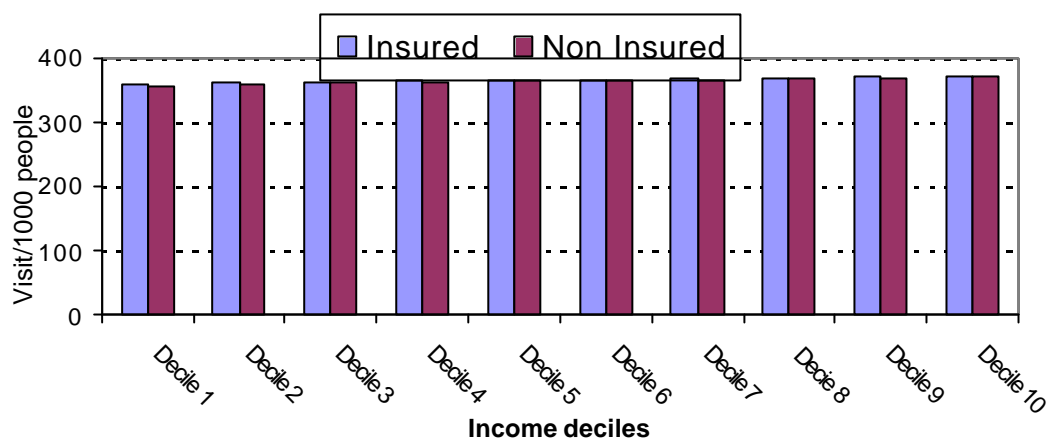
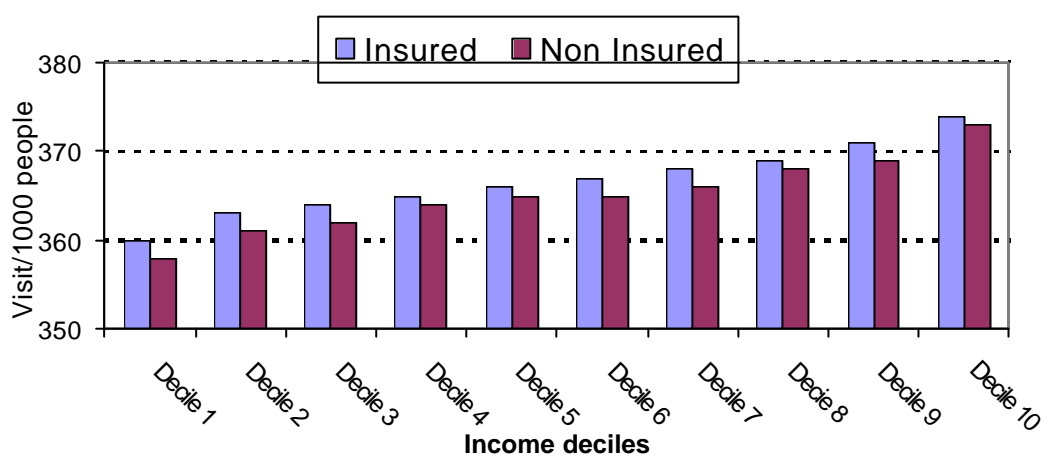


Figure 3. Differences in visit rates for primary health care utilization by income 1998



6.4 One important factor about 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 is staffed by at least one physician (general practitioner), several nurses and midwives, and administrative staff; while a sub-health centre is staffed by at least one nurse or a midwife plus administrative staff. There are currently more than 7,000 health centres and 21,000 sub-health centres throughout Indonesia²⁷. In addition, in the past (although the position may change) essential drugs are provided free in health centres through the Inpres program.

²⁷ Health Profile 2000. Pusdakes MOH, Jakarta, 2001.

7. Access to hospital services

7.1 Hospital services differ from health centre services for several reasons:

- hospital services are available only in the capital city of a district or municipality. Although the government has built one type D (the smallest) hospital for every district, the distance from the rural residential areas is much further than to - health centres. A district can cover an area as much as tens of thousands of square kilometres. While there are more than 50 health centres and sub-health centres in a district, there is only one public hospital. In several large districts or municipalities there may be a private hospital owned by doctors who work for the government in the districts/municipalities;
- drugs and other medical supplies are not free in public hospitals. Patients must pay out of their own - resources for medicines and medical supplies;
- although local governments normally set low user charges for hospital confinements, the true costs of a hospitalisation may be 310 times the low cost of room and board set by the local governments. As an illustration, in one public hospital in Jakarta the room charge for the third class services is only Rp. 15,000 per day. A patient needing an appendectomy and hospitalisation for three days may end up receiving a bill upon discharge from hospital of Rp. 800,000 covering the cost of operation, drugs, and medical supplies. A blue collar worker with a minimum wage of Rp. 426,000 in Jakarta and having no insurance, must spend about two months salary for such an appendectomy at a public hospital. The cost of intensive care or going to a private hospital would be devastating to a blue-collar worker's resources. They may even have to pay a deposit prior to admission; and
- the quality of services varies widely. Hospital services are designed to provide special/secondary or even tertiary care. In theory, type D hospitals provide four specialists; a surgeon, a gynaecologist, a paediatrician, and an internist. In reality, those services may not be available to communities at all times. At a type B hospital in Jakarta, third class patients do not get treatment from specialists. Many specialists in that hospital are unwilling to visit the patients because there is no additional fee beside the specialists' monthly income. Specialists who visit patients admitted in second class or first class, however, get financial incentives for each visit.

7.2 As a result of these problems, 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. Figures 4 and 5 suggest that there were, and continue to be, large gaps between the poor and the wealthy in access to hospital inpatient care, even at public hospitals (Thabrany, 2001). The richest 10 per cent of the population had more than 400 hospital days per 1,000 people. Members of Askes and Jamsostek (insured group) had 500 hospital days - higher than those of non-insured group. On the other hand, the poorest 10 per cent of the population had only about one-fifth of the hospital occupation of richest 10 per cent, both for the insured and non-insured. The gap between inpatient days for the insured poor and the rich - remain high because the benefits are inadequate. According to many studies, insured civil servants ought to pay up to 80 per cent of the hospital costs and drugs (Trisnantoro et al. 2000²⁸; Thabrany 2001²⁹).

7.3 Additional analysis can be conducted by examining the household financial burden to pay for hospitalisation. In this analysis, researchers examined how much a household had to pay for an admission of a household member to any hospital. Researchers calculated average amounts of money for such

²⁸ Trisnantoro, et al. Evaluasi RS Pasar Rebo dalam era desentralisasi, PPEK UGM, Yogyakarta, 2000.

²⁹ Thabrany, H. Perbaikan Askes Pegawai Pemda DKI. Unpublished. Jakarta 2001.

hospitalisation and average total household expenditure in one month for each income decile. The study found (Figure-5) that the poorest 10 per cent of the population had to spend 230 per cent (2.3 times) of monthly total household expenditure for one inpatient care. Despite high subsidies given by the government to public hospitals, most low income individuals could not get access to inpatient care because of the costs of medical procedures and expensive, unsubsidised drugs³⁰. Figures 4 and 5 indicate the correlation of low inpatient days by those in lower income levels and the high price a household had to pay to a hospital. This financial burden will continue or even worsen while there are no significant policy changes to solve the problems.

Figure 4. Hospital inpatient days per 1000 people by income groups and insurance status, 1998.

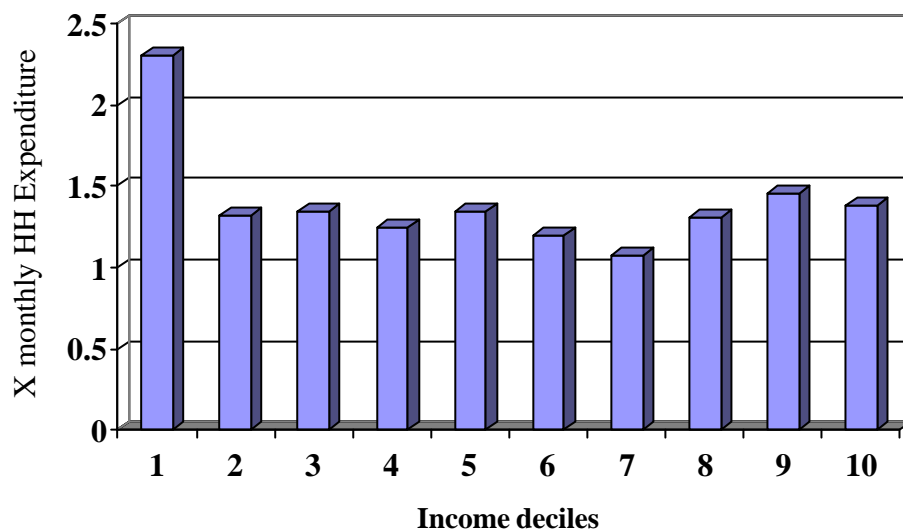
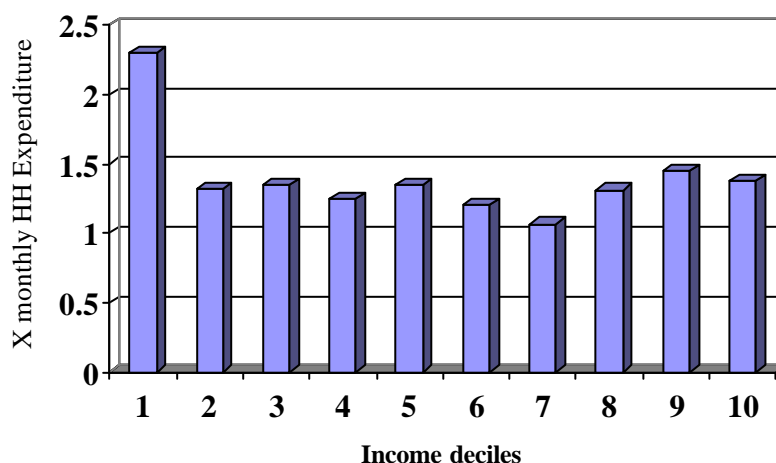


Figure 5. Average financial burden of households (times household monthly expenditure) for one admission by income deciles



³⁰ Thabrany, et.al. Comprehensive Review of JPK in Indonesia. Yayasan Pengembangan Kesehatan Masyarakat Indonesia, Jakarta 2000.

8. Quality of health services

8.1 The quality of health services in Indonesia is difficult to measure because of lack of set standards, for both clinical and administrative services. Although there are clinical standard guidelines developed by the Indonesian Medical Association, these guidelines provide standards for only about 200 medical conditions/procedures and these are not widely accepted, especially by specialists. Administration of health services in health centres and hospitals varies between institutions. Very few hospitals use computerized systems for medical records or appointments, even in Jakarta. The physical appearances of public hospitals and health centres are generally not attractive to patients from middle and upper classes, although it is argued that public health centres and public hospitals are provided for the people in the lower income bracket. Private clinics and private hospitals are competing to attract patients from middle and high incomes resulting in better physical appearance and amenity services being offered.

8.2 The market for health services remains quite small, except for large cities like Jakarta, with little incentive or need for competition for providers to improve services. One measure of service quality is user satisfaction. But there is no user satisfaction survey conducted in public health or public hospital services at national level. There is also an absence of a national survey on consumer satisfaction of private providers. In general policy makers admit that the quality of services in Indonesia, especially by public providers, is not good enough. The fact that many patients from middle and high-income groups use private providers rather than public, or go to Singapore or Australia for treatment is an indication of the poor quality of health services in Indonesia. Despite facility-wide surveys (Warnida³¹ and Neneng³²) showing that public providers satisfied 80 to 90 per cent of patients with services, many health analysts are sceptical of these results which differ from their own observations. Accreditation of hospitals is not yet considered a reliable measurement of quality of services, since the emphasis in the accreditation process is on structural measures like whether or not there are guidelines for emergency care or medical records.

8.3 The measurement of user satisfaction also lacks credibility because the majority of users are people from low educated and low-income groups. The measurement of user/customer satisfaction itself is problematical due to the subjectivity of the measurement. This measurement is considered reliable only for high-income or highly educated users in large cities where there is the availability of choice and where users are able to compare the services of other providers. In villages and districts where most people often have no choice of health centre or district hospital, no knowledge of how the services should be provided and no opportunity of comparison, measurement of user satisfaction is unreliable.

8.4 One of the more objective measures is to examine how people choose medical care when they have options. The assumption is that those who have a better option that they can afford would choose their perception of the best quality of service. On the basis of this assumption, an examination of utilization data from the Susenas of 1998 and 1999 shows that, even for those who were covered by health insurance under Askes, there were people who chose health care facilities outside the network of public providers that their entitlement covered. This means that many people prefer to utilize health care on the basis of service quality rather than cost. The proportion of insured civil servants who utilized outpatient care from private providers for which they had to pay the full cost accounted for about half of the total visits³³. This implies that those people perceived that the services provided in public health care facilities were not acceptable, preferring to pay for better services out of their own resources. In general, people perceived that both outpatient and inpatient services in public facilities do not meet their expectations. Therefore, any attempt to expand social health insurance using predominantly public health care providers will face significant resistance from prospective members. The JPK Jamsostek scheme, which often uses public health centres as gatekeepers, attracts only those in lower income groups - thus inhibiting optimal cross subsidy from the better off to the worse off..

³¹ Warnida, Faktor-faktor yang mempengaruhi kepuasan pasien di Paviliun Kartika, RSPAD, Skripsi FKMUI, 2001.

³² Neneng. Kepuasan pasien Askes dan Non Askes terhadap rawat jalan di RSU Bekasi, Tesis, FKMUI, 2000.

³³ Thabrany, H and Pujiyanto. Analisis utilisasi peserta Askes dari Susenas 98. Pusat Ekonomi Kesehatan, FKMUI, 1999.

9. Efficiency

9.1 Efficiency in health services in Indonesia can be evaluated from two different perspectives. The first perspective is from the allocation standpoint. Until recently, government policy focused on assuring that health services must be accessible by all citizens. Thus government subsidized health services in public health centres and hospitals across the country required doctors to provide mandatory services, constructing buildings, procuring medical and non medical equipment, and by paying medical staff (including doctors, nurses, and midwives) working for the public providers. Local governments normally set very low prices that low-income earners can afford, without taking into account the actual cost of each service. Often these low user fees become political issues. The assumption is that by lowering prices (user charges are subsidized up to 80 per cent of the true cost) those who are poor can afford to access health care. Because the subsidy goes to the supply side (public providers), the fees for the poor and the better off are the same. This is a regressive payment system, meaning that the poor must pay a higher percentage of their income than the rich in order to receive services from the public health care providers. The supply side subsidies lead to inefficiencies in usage of public money, especially for hospital services, because those who utilize health services are not necessarily those who need subsidies. In fact, data from ten years of the national socio-economic surveys indicate that those who are richer are more likely to utilize hospital services than those who are poor. In other words, the subsidies have been going to the better off and access to health care for the poor remains unsatisfactory. From this point of view, the low spending on the current health care system in Indonesia is biased against the poor.

9.2 The second perspective is from the technical aspects of health services delivery. The majority of services are delivered through a fee-for-service system leading to costly medical care. As cited in most health economics literature, this payment system leads to higher probability of supply-induced demand. The probability of the provider prescribing unnecessary care becomes higher than if the providers are paid on global budget or capitation payment system. In a private hospital in Jakarta for example, the proportion of deliveries by Caesarean section is as high as 80 per cent of the total birth deliveries. In order to prevent this kind of moral hazard, the Directorate General of Medical Care of the Ministry of Health issued a maximum standard for C-sections of 15 per cent in private hospitals. - This level is high by international standards³⁴. For other medical services, including prescription drugs, laboratory examinations, and other medical procedures, this payment system also contributes to high inefficiencies. Since about 85 per cent of the population is uninsured and pay medical care out of their own resources, this payment system will continue with minimal control over wastage, outcomes and inefficiencies. Therefore, efforts to strengthen social health insurance schemes leading to stronger purchasing power for health services may stimulate system efficiency, although health care providers may resist supporting these efforts.

³⁴ Berita IDI, February 2001.

10. Direction of health care reform

10.1 Since the crisis, there have been strong initiatives to reform the health care system in Indonesia. One of the more significant reforms is the Healthy Paradigm approach signed by President Habibie in 1999. Under this revival of the public health paradigm, the Ministry of Health will take the lead in the healthy public policy, healthy overall development, healthy environment, and shifting the paradigm from mainly curative approach towards a balance between promotive and preventive health care and curative approaches. The Ministry of Health set four pillars to achieve Healthy Indonesia 2010, a goal to move toward a healthy environment, and universal coverage. The four pillars are: shifting from sick paradigm to health paradigm; preserving health rather than curing diseases, professionalism in development of insurance schemes (called Jaminan Pemeliharaan Kesehatan Masyarakat, JPKM), and decentralization of health services.³⁵

10.1. Healthy paradigm

10.1.1 Under this paradigm, Depkes assumes responsibility of guiding the country in a healthy development policy in which all aspects of development must consider the effects on people's health. Depkes is responsible for making policy on healthy environment, healthy behaviour, and for shifting the orientation of health programs from curing the sick to maintaining people's health. In international public health jargon, this paradigm is actually not a novel idea. However, from the perspective of the Indonesian health care system that has been too much oriented toward reactive approaches to curing diseases, this paradigm realigns the vision and mission of Depkes toward a national goal of healthy Indonesia. One of the significant policies introduced recently in Jakarta is the requirement to sell only unleaded gasoline to reduce pollution by lead residues. By eliminating leaded gasoline, the government expects to improve the quality of life by reducing risks associated with lead pollution. To accelerate the goal of 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 consequently increase the number of productive days.

10.2. Professionalism

10.2.1 Under the professionalism principle, Depkes promotes and encourages the development and improvement in the quality of service by health professionals such as doctors, nurses, and midwives. Basic nurse education that has been at the level of high school is now being upgraded to the minimum level of three years education after high school. Many universities are now developing bachelor level (four years education after high school) to improve the knowledge and skills to the level equivalent with nurses in other countries. Medical specialist training that for more than three decades has been conducted from a university base is now being transferred to a hospital base managed by medical associations. The Indonesian Medical Association and other Specialty Organizations are now preparing for hospital-base specialist training. This transformation is expected to speed up the production of specialists in Indonesia. Currently about one-fifth of the 45,000 doctors in Indonesia are specialists. The shortage and uneven distribution of specialists across the country creates inequity in access to modern health care. Without significant efforts to improve skills of health professionals, Indonesia may face serious problems in the provision of modern health care because the demand for specialists has been growing much faster than the supply.

10.2.2 In administration, the government also requires that managers and directors must have certain job-relevant professional training. In several provinces, the head of Dinas Kesehatan (District or

³⁵ MOH. Healthy Indonesia 2010, Jakarta 1999.

Provincial Health Office) must be a doctor who has a Masters Degree in Public Health. A doctor who holds a Masters Degree in Hospital Administration now heads many hospitals. Health centre management is also being scrutinized to improve professionalism in service provision. For example, in the past public health centres had to be managed by a physician, now a public health graduate who may not be a medical doctor may become the head of a public health centre. The public health graduate will conduct all managerial and administrative tasks as well as community health programs. These kinds of tasks are currently the responsibility of a doctor as head of health centre which results in a doctor not being able to treat all health centre patients and performance of managerial and administrative tasks being below standard. Under this experimental new leadership the doctor(s) in health centres can concentrate on caring for and treating patients.

11. Privatisation/ autonomous hospitals and health centres

11.1 In line with the professionalism principle, many regions promoted by the MOH will transform public health centres and public hospitals into autonomous bodies. The main goal of this transformation is to give the management more flexibility to manage resources such as revenues and human resources in order to respond quickly to local demands. The transformation to autonomous bodies can be in the form of swadana or state owned companies. The swadana form is basically gives the management flexibility to use revenue from user fees according to the facility needs. The status of personnel remains that of civil servants. Under this form, the facilities are exempted from the government accounting system in which all revenues must be deposited in the government treasury the same day the fees are received. The facilities receive an annual budget for investment and operational costs, determined by the local government. Under the current system, the facilities often have chronic supply problems that affect quality of services because of rigid government budgeting and accounting systems. By transforming into swadana facilities the government expects that the quality of services can be improved and the scope of services can be adjusted to community needs.

11.2 The second form of privatisation is to transform public hospitals into BUMN or BUMD. Depending on the level of privatisation, a facility can be transform into Perjan, Perum, PT Persero, or BUMD. All of these forms, however, are for-profit organizations that are not consistent with the mission of public hospitals. The Presidential Decree No. 40/2001 allows a local public hospital to be transformed into a BUMD, a for-profit entity aimed at improving the local government revenues. Actually, what many health policy makers want is the flexibility of public health care facilities to manage revenues and to respond to local needs. However, they were not successful in finding a new legal entity that is in harmony with visions and missions of public health care facilities.

11.3 The swadana, BUMN, or BUMD forms have one common effect on user fees or prices. All of these forms normally increase user fees to satisfy financial requirements in managing the facilities. By increasing user fees, the management expects to provide better quality of services. However, higher user fees may jeopardize access to necessary care for the poor or near poor, especially as a formal mechanism to switch subsidies from the supply side to demand side of the cost equation .- such as kartu sehat which has not been developed adequately. Management argues that if a patient attends a swadana facility without adequate money, she/he may be exempted from user fees by showing a village certificate stating that she/he is poor. However, the certificate is not automatically issued to every poor family. The poor or near poor often decide not to come to a hospital (after knowing the level of fees from neighbours or friends) realizing that they cannot afford the fees. So the problems of access remain unsolved. There is also evidence that health cards have been issued to non-poor families.

12. Decentralization

12.1 Decentralization of power and authority has a national consensus. The law of regional autonomy, including the health sector, was implemented nationwide in January 2001. While decentralization provides faster response and more appropriate policy in many aspects of life, there are some disadvantages to decentralization of health services. Under this law, local governments are responsible for providing and financing health services in districts/municipalities. One immediate problem that arises from this decentralization is that many local governments perceive that health services are mainly consumed with intangible results without political leverage for them, therefore financing of health services is likely to be accorded low priority. Many local governments perceive that hospital services could be utilized to generate income. Yet other local governments set quite high income from hospital services while spending much less on health in the region. On the other hand some rich districts, such as the oil rich provinces of Riau and East Kalimantan, are planning to provide health services free of charge. Thus decentralization may result in regional inequities in health care.

12.2 Mechanisms to cross subsidize poor districts/municipalities have been proposed such as special allocation funds (*dana alokasi khusus*); however, this notion has not been politically acceptable. Problems of access to essential health care, especially for the poor, in decentralized governments have been the concern of many international and donor agencies such as the WHO, UNICEF, and the Asian Development Bank (ADB). The National Planning Bureau (Bappenas) is trying to establish a social safety net by providing special assistance funds for the poor to facilitate access to essential health services. Until the year 2002, the ADB has been providing loans for this social safety net. In addition, in 2001, some Rp. 540 billion was allocated to finance hospital services, immunization, and essential drugs from the government budget generated from increasing oil prices. Considering the very high number of poor households, this amount of money is very far from adequate.

13. JPKM

13.1 Initially, the concept of JPKM was taken from the concept of HMO in the United States. The common features of HMO such as voluntary membership, comprehensive benefits, capitation payment system, community rating premiums, and closed system delivery are also found in the concept of JPKM. The USAID had been very active in promoting the development of JPKM in Indonesia, starting from the development of the concept in the 1980s up to financing the pilot project in Klaten, Central Java. However, after almost 15 years of the promotion of the concept and more than seven years after the enactment of the Health Law in 1992 (providing for government promotion and development of JPKM) membership has barely reached 100,000 members. Millions of dollars and billions of Rupiah have been spent on promoting the growth of JPKM but currently there are only 21 licensed JPKM bapels (HMOs). During the economic crisis, the MoH spent Rp. 180 billion to promote the development of JPKM using social safety net money in order to establish 354 new pre-bapels across the nation. As explained earlier in this Report, none of those pre-bapels was able to become sustainable or able to cover a significant number of people. This has given some impetus to reform the concept of JPKM as a means of pooling financial resources using health insurance principles.

13.2 Depkes has considered promotion of the JPKM concept by drafting a law (JPKM Law) aimed at expansion of JPKM through mandatory membership of a bapel. By changing membership from voluntary to compulsory, JPKM is moving to a social health insurance concept. The draft also envisages contributions of 3 per cent of monthly income for singles and 6 per cent of income for married people.

13.3 The concept continues the existence of bapels and pre-bapels, the majority of which by law are for-profit entities that will maximize profits to the stockholders. All people mandated to contribute must choose from a number of available for-profit bapels as their health insurance carrier.³⁶ This is inconsistent with the principle of social health insurance of maximizing benefits to members. The current performance of JPK Jamsostek and similar schemes implemented in Chile³⁷ shows that social health insurance by for-profit entities leads to adverse selection that benefits investors, rather than the people it is designed to protect. It has also been suggested that should the bill be passed some investors, or even government officials, may try to use the proposed JPKM Law to their own business advantage within the health insurance industry.

13.4 In addition, the proposed JPKM law may require each of the existing social health insurance schemes (JPK Jamsostek and Askes) and all private insurance companies to obtain a licence from the MOH to operate as a bapel. The bill will create a huge regulatory responsibility for the MOH to license, control, and supervise bapels - complex tasks that may be beyond their current capacity. It is understood that at least two bapels have gone bankrupt, partially due to inadequate regulatory control. The two bapels left more than Rp. 7 billion in hospital debts while their paid up capital was only Rp. 150 million.³⁸ It is also understood that none of the remaining bapels has capital of more than Rp. 500 million, a very low level of financial solvency to run high-risk health insurance schemes³⁹.

³⁶ MOH. Draft RUU JPKM, Jakarta, April 2001.

³⁷ WHO. WHO Report 2000, Geneva, 2000.

³⁸ Personal communication with secretary of the Indonesian Hospital Association.

³⁹ Thabrany, H; Pujianto; and Mundiharno. Subsidi Silang Antar Bapel dan Antar Kabupaten dalam Pelaksanaan JPKM. PT MJM. Jakarta, 2001.

13.5 Some parliamentarians have suggested improving and strengthening the existing social health insurance organizations (Askes and Jamsostek) and expanding membership - rather than developing new private entities. At the time of writing this Report, it is understood that there is no parliamentary agenda for discussion of the proposed JPKM law.⁴⁰ On the other hand the recommendations of the present project on 'Restructuring the Social Security System' for Jamsostek to be strengthened and for its membership base to be expanded to cover all formal sector workers and progressively to the informal sector, if accepted and implemented, would actually meet the objectives of Depkes in a much more efficient and realistic manner, achieving greater social solidarity and equity than would be achieved by creating a new law.

⁴⁰ Personal communication with vice chairmen of Commission VII of DPR (House of Representative) responsible for health and social welfare issues.

14. Analysis of the organization of health care

14.1 The current organization of the health care system produces, inter alia, the following effects:-

- segmentation and fragmentation of the health insurance system. Potentially exacerbated, if the significant decentralization to the provincial (24) and the district (320) levels are not well managed;
- fragmented government policy in social security in health and in social security reform;
- equity problems:

formal workers with different contribution rates and benefit packages based exclusively on what sector they work for (e.g.: Askes has 2 per cent contribution for public sector workers while private sector workers contribute 3 to 6 per cent for Jamsostek.);

significant differences in the per-capita public expenditures even within the public sector (among the regions and districts), resulting from the historical allocations of budget. Extremely difficult to correct in the short term given the rigidity of public providers cost structures.

- public subsidies leaking to the non-poor:

users fees and differential utilization of services by rich and poor in the public sector;

indirect public subsidies to social security organizations: to both, Jamsostek and Askes through subsidized public sector facility prices;

direct public subsidies to JPKMs in the preliminary implementation process and indirect subsidies via subsidized public sector facility prices to all private health insurance including JPKM.

- inefficiency issues within each sub-sector:

low purchasing capacity. There is almost non existent in Jamsostek which subcontracts with “primary providers”, low capacity indemnity insurance that uses “fee-for-service” and also for JPKMs. Askes seems to be the most developed among all of the different insurance schemes;

public sector provider financing still under historical supply side financing (through line item budgets) - with no separation of purchasing and provision.

- weak and fragmented regulation and consumer protection capacity as well as weak enforcement capacity: Jamsostek has no right to enforce compliance, either by employers (this is the role of labour inspectors from Depnaker/Dinas) or by providers (it pays “primary providers” on the basis of capitation which in turn sub-contract with specific local providers). Multiple regulators for private insurance with scarce regulation available and weak enforcement capacity. There is no information on utilization and no monitoring systems. A capitation system widely used and implemented in such a way is potentially susceptible to risk selection behaviour by providers, denial of services and corruption.

15. The alternative scenarios for reform

15.1 Given the geographic, cultural and political complexity of Indonesia and the weak institutional capacity present in the health sector, reforming the health sector will be particularly difficult. Indonesia has at least 3 possible main scenarios for such reform that are understood to be currently under consideration by the Presidential Task Force:

- reforming each sub-sector separately - addressing the main efficiency and equity issues within each sub-sector separately while maintaining system segmentation;
- the integration of social health insurance - maintaining system segmentation between the poor and informal population and the formal population but developing a single, unified system for the formal sector within either:

An actual single integrated system with a single payer or insurance carrier; or

Virtual single integration through ‘same rules of the game’ for all insurers (premium setting, package, etc.) but with competition permitted between insurers, possibly with some mechanisms in place to compensate for the eventuality of market failure;

- total system integration - with the formal sector subsidizing the premium for the poor and the informal sector, so that they can join any insurer they choose (within the two scenarios shown in the last paragraph i.e. actual single integration or virtual single integration). This would mean total separation of purchasing and provision and a radical shift from the historical supply-side financing to “portability” of the public subsidy;
- reforming each sub-sector separately. This scenario assumes that Indonesia might wish for some reason (political and technical feasibility and/or policy decision), to retain a three-tier system (with its equity implications) but improving the functionality within each of the three. Some of the key aspects are: -

For the National Health Service (run by the Department of Health and district authorities after decentralization):

Shifting from historical supply side financing towards demand side financing or at least “money to follow the patient” within the public sector. Among other effects, it has the potential to empower users when alternative providers are available. It most probably requires increasing the level of separation of purchasing from provision. The decentralization process provides a good opportunity to do this;

Improving the costing and pricing systems in public facilities, improving the patient identification system (similar to the Health Card Process) and the management (public provider autonomy?) of public facilities, all in order to reduce leaking of public subsidies to non-poor and to increase efficiency;

Encourage community organization and participation in overseeing public facilities, not as self-contained pooling schemes but as entry points to the public system and as a means to improve accountability and responsiveness.

For traditional social security

It is not clear why there is a need for two separate public social health insurance agencies using different rules. The possibility of merging Askes and Jamsostek health insurance components is a possibility;

There are differential contribution rates for civil servants and private workers - this constitutes an unfair discrimination to non-government workers;

Separate the health insurance component of both, Askes (but particularly Jamsostek) from their other programs and establish them as independent social health insurance schemes;

Transformations in Askes and Jamsostek governance (to be really autonomous from any particular vested interested except its beneficiaries) and in taxation and government financial control to ensure autonomy, independence and focus on their user interest only; and

Significantly improve the strategic purchasing capacity, currently almost non-existent.

For private health insurance.

Amend law No. 3 to allow the private sector to provide health insurance coverage separately from life insurance;

Create a single independent regulator, responsible for licensing, regulating, solving controversies and regulating, under 'same rules' any form of private health insurance including JPKM, private health insurance, community health insurance and any other private health insurance;

The single autonomous regulator should enact clear regulations, mandatory for any form of private health insurance, including minimum required coverage, group insurance, consumer-insurer contracts (pre-existence, exclusions, controversy resolution, contract comparability), product marketing, solvency margins, technical reserves, minimum provider availability, etc.

15.2 This scenario does not include the elimination of the opt-out provision from Jamsostek. However, it would not be an opt-out provision from Jamsostek but a similar provision for the new organization created from the merger of Jamsostek-Astek. It also does not include any specific recommendation regarding the amount of the contribution or the maximum salary limit for contributions as decisions regarding them are a function of the size and quality of the package that is desired for Jamsostek-Astek to cover. However, the minimum coverage to be regulated for the private sector would probably have to be to indexed to the Jamsostek-Askes benefit package.

15.3 This scenario, particularly in that it does not change the opt-out provision, does not aim for equalizing all formal workers, much less for equalizing all workers in general. However, it achieves some equalization among civil servants and formal workers remaining in the new Jamsostek-Astek organization.

15.4 Integration of Social Security. This scenario would reform separately the National Health Service (for informal poor workers) and would integrate social security through a single system. Under this scenario all formal workers would be covered under the same rules. This could be accomplished under the following two sub-scenarios:

- single insurer for all formal workers with additional voluntary supplementary health insurance; or
- single rules of coverage but multiple agents (insurers) to provide coverage under those rules.

15.5 For Single Insurers, all formal workers would be mandated to contribute to a single insurer (most likely public). The single insurer could be the newly merged Jamsostek-Astek or a completely new public entity. In any case, all recommendations for single rules of cover shown above would apply.

15.6 For supplementary insurance, to be provided by private insurance (JPKM, private health insurance companies and others), all recommendations for Private Health Insurance (shown above) would apply.

15.7 The scenario for Single Insurer shown above de facto eliminates the opt-out provision and leaves private health insurance exclusively as voluntary supplementary health insurance. It also achieves, at least in theory (see comments previous section), equality if the single insurer provides a single package of benefits regardless of the contribution of the worker.

15.8 Under the Single rules of Cover scenario, all formal workers, regardless of their income, would be covered by health insurance under equal conditions and they would be allowed to choose the insurer among a multiplicity of insurers, including a public insurer. To avoid traditional health insurance competition failures (due to adverse selection, risk selection, income cream skimming, etc) resulting in risk and income segmentation, most probably a basic benefit package regulation would need to be included in the model as well as some kind of risk/income equalization fund, similar to the ones existing or being implemented in the Dutch, German, Chilean and Colombian systems. All recommendations for Private Health Insurance (shown above) would apply.

15.9 Total System Integration This scenario is an expansion of scenario described in the previous paragraph in which not only formal sector workers would be covered under a single system and same rules but also informal sector workers and the poor - with public funds being used to subsidize the premium for the informal sector and the poor to join either: the single insurer sub-scenario, or the choice among all insurers under the single rules of cover sub-scenario. All comments for that scenario would apply. If 'single package' is defined as one of the rules, it probably would be a very shallow one as it has to be affordable to the state through public financing, unless total cross-subsidization from formal to informal workers is decided which would have very significant incentives for under-contribution and evasion.

15.10 The policy debate within government is between those two scenarios (i.e. single insurer or single rules of cover). Both are very complex technically and politically and will require very significant Technical Assistance at policy decision level within the government, which are beyond the current capabilities of Depnaker and Jamsostek.

15.11 Given the current situation in the public health sector, it is very unlikely that any scenario that extends the Jamsostek scheme could be considered feasible in the medium term.

15.12 Although the single insurer and single rules of cover scenarios are the ones concentrating the discussion within the government (as they are rightfully the most rational alternatives for a country with the cultural, historical and geographic diversity of Indonesia), both scenarios are fundamentally different and it would not be surprising if the decision between either of them takes a long time so that the scenario Reforming each sub-sector separately becomes the "de-facto" choice. Therefore, future technical assistance should be designed in a way that would be useful for any of the 3 scenarios described above, focused on the key stakeholders, but not restricted only to Depnaker, Depkes and Jamsostek.

15.13 A detailed analysis of JPK Jamsostek follows in order to expand on the above scenarios.

16. JPK Jamsostek (health insurance component of Jamsostek)

16.1. Current conditions and problems of JPK Jamsostek

16.1.1. Legal Structure

16.1.1.1 The legal basis for the social health insurance program (JPK Jamsostek) is Law No. 3 of 1992; Government Regulation (Peraturan Pemerintah) No.14 of 1993, and the Minister of Manpower Regulation (Peraturan Menteri Tenaga Kerja) No. 05/MEN/1993. This legislation also applies to the other three Jamsostek programs. However, JPK Jamsostek differs from other Jamsostek programs in several ways:⁴¹

- the participation in JPK Jamsostek is effectively optional. Where superior health benefits are provided by an employer (self insured) or through health insurance companies, under Article 2 (4) of Regulation No.14, there is no liability to participate in the scheme. Because of this provision, the majority of employers choose to opt out of the Jamsostek scheme and buy health insurance from insurance companies or HMO's;
- employers are mandated to pay a premium of 3 per cent (for single employees) and 6 per cent (married) with no employee counterpart contribution;
- the contribution ceiling for this health insurance since 1993 has been Rp. 1,000,000 resulting in freezing low revenues for the medical benefit programme;
- the benefits are provided in the form of health services through various health care providers contracted directly or indirectly by Jamsostek, except for limited emergency out of zone care that is reimbursable. Other Jamsostek programs pay cash benefits to the beneficiaries; and
- the benefits are provided not only to the employees but also to family members up to the third child.

16.1.2. Operational Problems

16.1.2.1. Membership - The Jamsostek health insurance program covers employees and their dependents including up to three children under the age of 21 years. All employers who are not exempted under Article 2(4) of Regulation 14/93, regardless of the legal status of the entities and who employ 10 or more employees must pay health insurance premiums for their employees. Employers with fewer than 10 employees but with a total payroll of more than Rp. 1 million per month are also required to enrol their employees into JPK Jamsostek. Given the level of the minimum wage, most employers with two or more employees, including those with domestic workers (e.g. a driver and a housemaid), should be covered. If this law were fully enforced, health insurance coverage could increase to more than 100 million people. But, the membership growth of Jamsostek is progressing very slowly (see table-3), from 199,000 in 1991 to 2.7 million people in 2000. The average growth of employers enrolling their employees to Jamsostek in the last ten years was 53 per cent per year, but the number of employees enrolled grew only by 40 per cent per year and the number of insured (members, including family members) grew even less at 38 per cent per year. This means that only small employers (average size of 79 employees per employer) are enrolling in JPK Jamsostek while larger employers have been exempted from mandatory membership of JPK Jamsostek. As a result there is only about 2.5 per cent of the potential coverage by JPK Jamsostek - while the vast majority of the eligible workers are still not covered. Currently, there are about 18.8

⁴¹ Jamsostek. Kompilasi Peraturan Jamsostek. PT Jamsostek, 1999.

million employees enrolled in the other three Jamsostek programs (of those only 9.3 million are active members⁴²), but only 1.3 million people enrolled in JPK Jamsostek. The total number of people (including family members) covered by this social health insurance in 2000 was only 2.7 million people. The national labour force survey estimated that 56.2 million workers were fully employed in the year 2000.⁴³ If these workers have an average of only two dependents and only about two-thirds are eligible for Jamsostek, the total number of people covered by Jamsostek should be about 100 million. So there are more than 97 million people that should be covered by JPK Jamsostek who are outside the present coverage.

16.1.2.2. Data from commercial insurance companies show that total membership of health insurance schemes in the 1999 was about 4 million people.⁴⁴ Health insurance premiums (excluding personal accident insurance) received by commercial health insurance companies in 1999 was Rp. 279 billion is estimated to reach Rp. 1 trillion in the current year. At the same period, Jamsostek collected only Rp. 155 billion in 2000, much less than the total health insurance premiums received by the private insurance companies. Thus it could be inferred that the Jamsostek law - with the opt-out provision in place - has benefited commercial health insurance companies more than the JPK Jamsostek scheme.

16.1.2.3. The above comparison clearly indicates that the existing Jamsostek law is not consistent with the social health insurance principles of shared risk and protection of employees on an equitable basis. Employees with higher incomes get their health benefits from the private sector while employees with lower incomes receive their health benefits from an under-funded JPK Jamsostek. This creates an adverse selection situation.

Table 3. Membership growth of Jamsostek health insurance component (JPK), 1991-2000

Year	Firm	Employees	Insured	Premium (Rp. 000)	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 91-2000	53%	40%	38%	51%	Av. claim rate 71.77%

Source: PT Jamsostek, Account Division 2001.

16.1.2.4. Another main problem in the implementation of JPK Jamsostek is law enforcement. Jamsostek does not have the authority to enforce compliance. The Department of Manpower and Transmigration (Depnakertrans) has the authority but has failed to exercise it effectively. There is little direct incentive to enforce compliance and many areas are under-resourced. The level of enforcement is unlikely to improve with decentralization of the control of labour inspectors to Dinas (provincial manpower offices). Recommendations to improve the level of compliance by bringing it under direct

⁴² Jamsostek web data, 2001.

⁴³ ILO. National labor force survey, 2000.

⁴⁴ Djaelani, F. Perkembangan Asuransi Kesehatan di Indonesia. Makalah disajikan pada Seminar Nasional Asuransi Kesehatan, Jakarta, Oktober 2000.

control of Jamsostek have been made in the main project report. But if the trend of low compliance is allowed to continue, Indonesia will suffer severe health care financing problems. Chile and Argentina have experienced severe adverse selection of their social health insurance systems because of liberalization. The US experience is a very clear example of serious problems in financing health care because of too much dependence on market mechanisms. There is, therefore an urgent need to revise the provisions of JPK Jamsostek to meet the social security goals.

16.1.2.5. However, the management of JPK needs to be strengthened if it is to provide an acceptable quality of service. The current administration of JPK Jamsostek, and PT Jamsostek itself, does not have the capacity to manage a considerably large membership. Current high claim ratios of an average of 71.8 per cent and low revenues for JPK Jamsostek contribute to under-resourcing in the administration of JPK Jamsostek compared to other Jamsostek programs. Within PT Jamsostek, many employees even at managerial levels appear to have insufficient commitment to the JPK programme. This may be partially due to overall profit motive of the institution to which JPK contributes little. There is some way to go before the medical services provided meet members' expectations. One way of narrowing the gap would be to repeal the opt-out clause to prevent adverse selection; another is to ensure that the level of compliance and membership is increased.

16.1.3. Delivery of Services

16.1.3.1. PT Jamsostek sub-contracts the management of health care and health services to other parties called main providers (MP). Many of these parties are JPKM bapels that are insurance carriers, not health care providers. Capitation payment to providers are not made directly by Jamsostek, instead Jamsostek contracts on a capitation payment basis to JPKM bapels (HMO) or the MP - a reflection of poor capability of Jamsostek to directly manage contracting with health care providers. Certainly this contracting system leads to inefficiencies and higher costs since the main providers will also take profits. The contracted health care providers vary from region to region.

16.1.3.2. Several Jamsostek regions contract outpatient services only to private providers, while others use a mix of public and private providers. Several regions use public health centres as primary care providers resulting in poor quality perception by members. As discussed in the previous sections, services provided at public health centres are considered to be of poor quality. Members demand service differentiation from those services usually provided for the poor in public health centres. By contracting with public health centres, main providers can save some money in the short term. But in the long term, this system will discourage employers and employees from enrolling with JPK Jamsostek.

16.1.3.3. Some main providers do not provide good quality services and sometimes appear to be unaware of the mission of JPK Jamsostek to provide equitable health care to employees. As the majority of MPs operate on a for profit basis, they are generally more concerned with profit margins than maximizing quantity and quality of services - which should be the main goals of health care in a social security scheme. At present, there is no standard procedure for the selection of MP by Regional Offices of Jamsostek. Many MP's do not have their own service providers. Instead they sub-contract services to other providers leading to higher administrative expenses. Taking into account 20 per cent administrative costs by PT Jamsostek and additional administrative costs by MP's, the amount of funding going to health care providers is less than 60 per cent of the total contribution received. This high administrative costs lead to low quality of health care benefits and dissatisfaction of the system by service providers and members alike.

16.1.3.4. This long contracting chain is inefficient and can also lead to corruption. Indeed there were allegations that certain officials in Jamsostek asked for "kick back" money for placing contracts, resulting in less money reaching health care providers.

16.1.3.5. In most social health insurance schemes in other countries, the administrative costs can be as low as 3 per cent (Taiwan) and 5 per cent (Germany). The economy of scale by pooling in one agency that is responsible for the administration of health insurance, such as the case in Taiwan, Canada, or even

Medicare in the US, can achieve administrative costs efficiency levels of up to 4 per cent of premiums . If the number of members is very large, contracting out health services management through intermediaries (main providers) may lead to higher efficiency. For Indonesia where the amount of premiums is relatively small, the overall maximum of 10 per cent administrative costs would be acceptable if membership was high. If this low administrative cost can be achieved, then the benefits received by beneficiaries will be optimal.

16.1.3.6. The capitation payment system prescribed by Regulation 14/93 is required to ensure that health services are delivered in a cost-effective way. In theory, all providers must be paid on capitation payment system; however, in practice this is not always possible. Doctors and hospitals are not ready to accept risk contracting by capitation payment because they are not trained to accept risk and the market for fee-for-services is still dominant. The environment is simply not supportive for a capitation payment system, except for relatively small number of primary care physicians. Partial capitation payment to primary health services is, however, undertaken in many Jamsostek branches. Capitation payment to primary care providers is easier to manage since the required number of members for primary care capitation is low.⁴⁵

16.1.3.7. Capitation payment to hospitals is used only in those branches that have sufficient members (Purwoko and Mahmud, 1998).⁴⁶ Furthermore, the MOH Decree on hospital prices still provides guidelines for user charges based on a fee-for-service system. In addition, all local regulations on health centre and hospital prices are on a fee-for-service system. Capitation payment to hospitals is much more difficult to manage, even for private hospitals in which prices are not regulated. Many hospitals will not accept capitation payment since there is a lack of information on which to base an adequate level of capitation payment. Moreover, capitation payments to hospitals require much larger memberships due to large variations in costs per admission. Finally, hospital managers are not trained to assume risks for services provided.

16.1.3.8. This review of Jamsostek should, therefore, consider options for revising the payment systems that are applicable and accepted by various health care providers. The proposed revision of Jamsostek should accommodate more flexible payment systems (rather than only capitation) that facilitate efficiency in health care financing and delivery systems. Prospective payment systems other than capitation can stimulate efficiency.

16.1.3.9. Prospective payment systems must be accompanied by explicit standards of service. Most providers contracted by MPs or contracted directly by a Jamsostek branch do not have adequate quality standards. The MOH and the Indonesian Medical Association do not have the capacity to control standards of medical care, simply because acceptable standards are yet to be developed and implemented. If PT Jamsostek had a larger purchasing power, the absence of standards developed by the MOH or professional associations could be taken over by the purchaser. However, the number of members is very small. In addition, many MPs contracted by PT Jamsostek do not have adequate training or skill in managing social security or providing services to health insurers. The proposed revision must take into account the need to manage these quality standards in order to attract significant number of members.

16.1.4. Information Systems

16.1.4.1. The current information systems in Jamsostek do not support changes of membership data (marital status, family size, change of employers, etc.), while the capitation payment system to providers (MPs) requires exact numbers of employees and their dependents on a monthly basis. As a result, many members are not on the list for capitation payment but nevertheless demand health care services. Providers refuse to provide services, which creates conflict between members, providers, and Jamsostek.

⁴⁵ Thabrany H. Racional Pembayaran Kapitasi. Yayasan Penerbit IDI, Jakarta 2000.

⁴⁶ Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998.

This kind of conflict reduces the trust of members and employers in Jamsostek. The main cause of this information lag has been the difficulty in updating records due to employers' neglect, employees' poor awareness, and Jamsostek poor information management. Lack of adequate human resources in Jamsostek information division generates more information problems. The Report on Jamsostek Operations and IT Systems provides more detail about the shortcomings of the systems and makes recommendations for improvement.

16.1.4.2. It was reported that hospitals sometimes billed Jamsostek/MPs for services rendered for Jamsostek members using higher than pre-negotiated prices. There are several reasons for these inappropriate claims. Firstly staff at hospitals may be confused about various prices applicable to different insurance carriers. Currently there are more than 70 companies offering health insurance and contracting services to hospitals using unique prices negotiated in advance. Staff at hospitals may mistakenly quote prices negotiated with other insurance carriers and bill the prices to Jamsostek. The second possible reason is that hospital staffs deliberately charge higher than negotiated prices to increase income, especially when prices of medical supplies and drugs are not stable. This practice may enable providers to balance overall costs where there would otherwise be a loss. 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 provide these warnings.

16.1.5. Other operational problems

16.1.5.1. Many employers complained that Jamsostek was not responsive enough to their concerns about notices of payment received; issuing ID cards, poor services, and handling of other complaints about the JPK program. This is partially due to the low level of resources within the program. Clearly the human resource deployment, including provision for training in managed care techniques, would need to match increases in membership. Failure to address this problem will inevitably result in further dissatisfaction with the service and resistance to compliance.

16.2. Other problems in the implementation of JPK Jamsostek

16.2.1 The contribution ceiling (Rp. 1 million) set almost eight years ago without adjustment is detrimental to JPK Jamsostek's financial viability and is in urgent need of review. Under this ceiling, employers contribute a maximum of only Rp. 60,000 (married employees) or Rp. 30,000 (single) per 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 health insurance product sold by PT AJ Central Asia Raya costs Rp. 125,000 per person per month for inpatient coverage only⁴⁷, much higher than contributions for JPK Jamsostek despite its comprehensive coverage. Many employers allocate money for health benefits above Rp. 60,000 per employee. As a result, companies that, on average pay high salary have more incentive to opt out of the PT Jamsostek scheme in order to obtain health insurance from private insurance companies (that provide better service).

16.2.2 The average premium received by Jamsostek per member in 2000 was only Rp. 5,224⁴⁸. In contrast one of the cheapest premiums sold by a national insurance company was Rp. 50,000 per member per month. PT Askes markets the comparable products for Rp. 20,500 per month or four times the JPK Jamsostek average contribution. Of course, the commercial insurance companies must provide better services (or perceived to be better) as required by the Ministerial Decree No. 01/1998. The claim ratios of commercial insurance companies have been about 60 per cent and below current delivery of JPK services, the amount of money going to health care providers from Jamsostek may also reach 60 per cent of the

⁴⁷ A CAR advertisement on Kompas, Saturday 22, 2001.

⁴⁸ Source. Accounting Department, PT Jamsostek.

total contribution received. This comparison indicates that an employer may be in a better position to buy health insurance from the private sector in order to receive better services.

16.2.3 The minimum benefits dictated by the law cover limited comprehensive health services. Access to outpatient care and specialist services, including hospitalisation requires referral by gatekeepers, health centres or private doctors. However, inpatient services are limited to 60 days, including a maximum of 20 days in an 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 more limited choice of hospitals compared with a traditional health insurance product from the private sector, employers and employees will prefer the product from the private sector.

16.2.4 Haemodialysis, cancer treatment, cardiac surgery, congenital diseases, alcoholism, drug abuses, organ transplants and all services provided by non-contracted providers are not covered (Supriyono, 1998).⁴⁹ Drugs are covered if doctors prescribe them from a special formula developed by PT Jamsostek. Because some expensive medical care is not covered, many employees and employers consider that the benefits provided by JPK Jamsostek are not sufficient or meaningful. The proposed revision of Jamsostek must take into account to change the benefit levels.

16.3. Relevance

16.3.1 The Declaration of Human Rights, the ILO Convention and the Indonesian Constitution clearly acknowledge that employees and their dependents are entitled to health care under social security. The WHO emphasizes that health care is a fundamental human right that enables people to work, study, and improve the quality of life. Countries all over the world are striving to provide universal coverage of health insurance to be able to produce goods and services without worrying about unaffordable health care. The basic principle of equitable health care adopted by all developed and newly developed countries is that every-body should get health services according to his/her medical needs and independent of his/her ability to pay.⁵⁰ It is under this principle that social security covers medical care and maternity benefits, either integrated with other social security programs or managed independently as social health insurance programs for workers.

16.3.2 In Indonesia, the financial burden of ordinary households in obtaining necessary health services is very high. A family may go bankrupt if a member of the family needs inpatient care. Data from Susenas consistently shows that families may have to spend at least the total of all monthly family income in order to pay for a single inpatient care of one household member. This means that if a family with no insurance or other financial support will be in financial deficit if required to pay for inpatient care for one family member. Therefore, risk-pooling and sharing among all other workers, employers, and the government is necessary to ensure that no one should suffer from severe sickness and financial distress at the same time. If a group of workers is allowed to choose not to share by purchasing health insurance to meet their unique demands, then other groups may demand the same privilege. Eventually no group will wish to share with others and therefore many families will continue to bear high financial burden and suffer from an unexpected illness.

16.3.3 In neighbouring countries such as in Thailand, the Philippines, Taiwan, and South Korea all employers and employees must join the social health insurance scheme without exception. In the Askes program, all civil servants become members of Askes thus avoiding adverse selection. The JPK Jamsostek opt-out provision is inconsistent with the goal of social security and it does not facilitate the achievement of the objectives of the Declaration of Human Rights. The right of choice of insurers is not applicable for the social security system because it raises costs and loses the benefits of economy of scale.

⁴⁹ Paper presented at the First National Conference on Health Insurance, Jakarta, November 9-11, 1998.

⁵⁰ Equity.

Arguments that PT Jamsostek should not monopolize the social security system are also not appropriate because in the absence of profit there is no need for competition and Anti-Trust laws should not apply to the government or for social programs. The antitrust law is applicable for businesses based on voluntary contractual relationships.

16.4. Effectiveness

16.4.1 The current JPK Jamsostek scheme uses managed care techniques as the means of controlling utilization and costs through the 'gatekeeper' system, referral requirements, and limiting availability of drugs to essential drug lists. These kinds of procedures certainly keep costs of health services relatively low. However, the number of members in JPK Jamsostek has been too small to have significant leverage at the regional or national level. On the other hand, private health insurance companies offering traditional indemnity or reimbursement systems may stimulate inefficiencies. When health care providers are reimbursed on a fee-for-service basis, the incentive to prescribe more medical procedures and unnecessary drugs becomes greater. The provision of unnecessary medical technologies and procedures is growing because of this payment system. Often sophisticated medical technologies require more diagnostic techniques without offering more effective treatment - with very small marginal benefits to the patient⁵¹. The more people covered by this commercial insurance system, the more likely overall health care costs will increase. In the end, all members must bear the costs. Because in the near future it is unlikely that all people will be covered by health insurance, the uninsured will suffer the most due to the domino effects of ineffective and inefficient systems. Costs to non-insured will be affected if providers charge the same rates for insured and non-insured individuals.

16.4.2 The biggest obstacle to the development and implementation of standard procedures for medical care is lack of financial incentive to providers to follow the standards. Fragmented and small groups working and negotiating independently certainly do not have leverage to implement standard procedures. Therefore, liberalization of JPK Jamsostek by allowing members to choose and change insurer over time will create further disincentives for effective health care. If JPK Jamsostek and Askes were combined into one large pool, then there would be market power to push medical providers to follow higher standards. To be effective, however, the level of payment to providers must be reasonable. Moreover, contributions the pool must cover the real cost of providing both medical and administrative services. It follows that there must be vigorous enforcement to ensure that the level of wages declared by employers cannot be artificially low in order to reduce contributions. Such practices will adversely affect the financial viability of the scheme.

16.4.3 However, despite the case for a merger of institutions, such decisions can only be taken when the overall design of the future social security scheme has been agreed. It is the design of the system that should determine the institutional structure and not the other way around.

16.5. Financial performance

16.5.1 Before the current JPK Jamsostek was conditionally mandated, between 1985 and 1991, there was a pilot project on health insurance for private employees. Since then, PT Jamsostek (originally PT Astek) has been consistently managing health insurance using managed care techniques to control costs. The membership of JPK, however, is not fully mandatory resulting in a very low enrolment rates during the last 10 years compared with the enrolment of the other three programs. Since 1991, the growth of firms joining Jamsostek has steadily increased at the rate on average at 38 per cent annually. The number of insured employees and their dependants has also increased on average 24 per cent annually (see Table 3).

⁵¹ HIAA. Fundamental of Health Insurance, part A. HIAA, Washington, D.C., 1997.

16.5.2 The premium increase in the last ten years has been slightly faster (36 per cent) than the increase of the number of insured (24 per cent). The premium for JPK in 1991 was Rp. 4.5 billion for 199,000 insured giving the average of Rp. 22,800 per capita per year; while total premium for the year 2000 was Rp. 155 billion for almost 2.7 million members (insured) resulting in Rp. 57,542 per capita per year. However, compared with the price index, the growth of premiums has not matched the increase in health care costs. The price index in 1993 was 100, adjusting the index for the year 2000 to 311, thus in order to maintain sufficient financing for health benefits, the premiums should have increased from Rp. 4.4 billion in 1991 to Rp. 213 billion in the year 2000. This calculation results in shortfall of Rp. 58 billion needed to maintain quality of services at the 1993 level; assuming that the distribution of health risk in 2000 remains the same as in 1993. This analysis suggests that the quality of services provided by JPK Jamsostek has not been improving.

16.5.3 In practice, PT Jamsostek has not been losing money because until recently it was unable to separate administrative costs for running JPK Jamsostek from other programs. In addition, the management of JPK Jamsostek is pushing for more control over utilization to ensure that the revenue of JPK Jamsostek is adequate to purchase the required health benefits.

16.6. Utilization of health services

16.6.1 It could be argued that the imbalance in growth of per capita premiums in the last ten years may be offset by lower utilization of health services. Data from JPK Division show that utilization rates of outpatient and inpatient services have been relatively stable. The table below shows the stability of outpatient and admission rates per 1,000 members from 1992-2000. The use of managed care techniques such as gatekeeper and referral system to control utilization and costs shows significant success. One could then question whether the quality of services could have been maintained at the 1993 level (when JPK was introduced) if the real per capita contribution decreased over time. The admission rates have been quite low (average 2.2 admissions per 1000 members) compared to the admission rates of insured civil servants and privately insured individuals that are about 6 - 6.5 per thousand members.

16.6.2 Unfortunately no quality data are available at this time. JPK Jamsostek has been working with the Indonesian College of Family Physicians to improve the quality of services provided by primary care physicians serving Jamsostek members. However, the relatively small number of members does not provide adequate leverage to assure that the quality of services for members of JPK Jamsostek was acceptable by higher income employees. The relatively low wage index (the average per employee contribution compared with minimum wages) indicates that higher income employees are not joining JPK Jamsostek.

Table 4. Utilization rates per 1,000 members of JPK Jamsostek 1992-2000

Year	Outpatient visit rate (per 1000)	Outpatient referral rate (000)	Admission rate (000)
1992	163.8	6.8	2.1
1993	156.1	5.8	2.1
1994	117.5	7.2	1.8
1995	146.1	7.4	3.5
1996	142.9	11.8	2.7
1997	146.9	9.57	2.1
1998	133.3	7.3	2.4
1999	125.0	20.47	0.77
2000	147.5	8.9	2.2
Average 92-2000	142.1	9.5	2.2

16.7. Summary of JPK Jamsostek problems

16.7.1 The following paragraphs summarize the current problems of JPK Jamsostek.

16.7.2 The contribution ceiling of Rp. 1 million discourages employers paying higher salaries than Rp. 1 million per month from enrolling in PT Jamsostek. Employers paying a lower salary enrol their employees but often report lower levels of salary than they actually pay resulting in only lower-paid employees enrolling in Jamsostek. Consequently, Jamsostek cannot afford to pay higher capitation or per diem rates to providers. These low reimbursement levels produce low quality of services that in the end will discourage employers from joining Jamsostek.

16.7.3 Only employers are liable to pay premiums while employees have no obligation to pay premiums. The absence of a counterpart contribution (from employees) limits the sense of ownership of the scheme so essential to social security schemes.

16.7.4 The scope of benefits is much lower than benefits provided for civil servants who have lower premium rates. The lower economic status of employees enrolled in Jamsostek may result in their having severe financial problems in meeting their families' medical needs. For example, no coverage is provided for an employee having a child with a congenital disease and the employee cannot afford to pay medical bills from his/her low salary. A civil servant with a child having a similar medical condition is covered by PT Askes.

16.7.5 The Jamsostek law does not provide health care coverage to retirees (when employees' medical needs are likely to be increasing while their income is decreasing). The Jamsostek scheme creates a double financial burden that is not in line with the concept of social security and is in contrast with the protection previously provided (when they were active employees). Their civil servants counterparts, on the other hand, continue to receive health coverage until they die. Even the survivors of civil service retirees continue to receive health insurance benefits.

16.7.6 Although PT Jamsostek is a state owned company; it seeks profit instead of maximizing services. Transformation into a Trust Fund is under active consideration but has yet to be achieved despite the inputs from the present project.

16.7.7 The optional nature of the program places PT Jamsostek in a difficult situation to enforce membership. The income from low participation of JPK is relatively small. The claim ratios of this social health insurance programme are much higher than the other three programs. It is, therefore unable to compete with the other programmes on the basis of profit.

16.7.8 The staff of PT Jamsostek generally has less experience and training to equip them to undertake the system of managed social health insurance compared to managers and employees of PT Askes. PT Askes specializes in health insurance using managed care techniques supported by an adequate number of managers who have educational and relevant technical backgrounds in health insurance.

16.7.9 The nature of employment in the private sector is very different from employments in the public sector (civil servants). The turn over rate and change of employers is higher in the private sector; as a result membership management in JPK Jamsostek is very dynamic and more complex. Portability of coverage in JPK Jamsostek is currently not guaranteed. This becomes very hard for employees and their dependents when they are temporarily out of work and may not immediately qualify for benefit on re-employment.

16.7.10 Setting premiums proportional to salary has many advantages for inter-income level subsidies; however the low ceiling (Rp. 1 million) and low level of compliance create serious problems to the viability of the scheme. The growth of premium levels is lower than the growth of health services costs and PT Jamsostek will not keep up with increasing costs for long period of time. This imbalance of premiums and costs pose very significant threats to JPK Jamsostek.

16.7.11 JPK Jamsostek does not cover maternity care for the delivery of the fourth or subsequent child, regardless of the medical condition. For those who have pathologic deliveries, the costs of treatment may be prohibitive to most workers. Certainly this limitation is not consistent with the right for health care security of workers.

16.7.12 Lack of continuity of coverage for those who are undergoing treatment for chronic or serious diseases and have to leave employment, those who are temporarily out of work and those retiring is a weakness in the system. The absence of unemployment benefit and retirement pensions creates an added problem that needs to be addressed urgently.

The penalty for a company (Rp. 50 million, set in 1993) for non-compliance now seems very low and represents no real deterrence to violating the Jamsostek law.

17. Possible design of health insurance for Indonesia

17.1 Indonesia is a very large country with 210 million people scattered over about 7,000 islands. The labour force is estimated to be about 98 million people comprised of 36.2 per cent in wage and salaried employment, 51.9 per cent self-employed, 3.4 per cent employers, and 8.5 per cent family workers⁵². The self-employed people are farmers, individual retailers, and self-employed professionals. With only one-third of labour force in formal sector employment 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\$ 692 at official exchange rates) resulting in very low disposable income for health insurance contributions. The Indonesian per capita income adjusted for purchasing power parity, is estimated at about US\$ 2,600, far below Thailand and Malaysia. The low per capita income significantly affects household expenditure in Indonesia. The National Socio-Economic Surveys indicated that between 50-70 per cent of household expenditure between 1995 and 2000 was on food. The minimum wage (in Jakarta) is currently Rp. 426,000 or about US\$ 47.34 per month leaving the worker little residual money after buying food.

17.2 A social security system relies on contributions from employees and employers (or an individual contribution from self-employed persons). It is clear that social security systems must start from formal sectors without diluting the risk pool by allowing opt-out provisions. This allows all workers to share the risk of ill health - that tends to be higher among low-income workers. Outside the formal sector, there are problems in determining and collecting social security contributions from those who work temporarily, are self-employed, or seasonal workers. These people work without employment contracts and are paid daily or weekly by 'employers'. The problems of extension of coverage to these (and other excluded groups) are discussed in the main project Report (Part 1).

17.3 People with low income may be entitled to free or very low cost medical care provided by the government in public health centres or public hospitals on production of a health card. Although the quality of services in public health centres or third class public hospitals is not high, quality may be of less concern to low-income groups.

17.4 For those with low incomes but receiving more than a basic level of income there might still be capacity for them to pay an earnings-related contribution. Even pensioners might be required to contribute in a future health care system.

17.5 The implementation of this system may be decentralized to respond to local demands and Expansion of membership into non-salaried workers can be done in later stages.

17.6 The proposed new health care programme must take into account the general framework or the design of a new social security system. Figure-6 depicts how the national social health insurance system might work in the future.

17.7 The main features of the design are as follows:

- formal or salaried workers can be classified into low to high-income levels. For all salaried workers, and pensioners in the private sector regardless of their income level, it will be mandatory to join the social security system. The premium of 3 per cent (which will need further actuarial study and calculation) can be deducted from employees' salaries and the employers will pay additional 3 per cent. There should be no different levels of contribution for singles and married employees to simplify administration and to strengthen the social solidarity principle. Within the next ten years the compulsory scheme needs to be extended to all employers, regardless of the legal status or number of employees. The contributions will be collected by the

⁵² Irawan, PB; Ahmed, I; and Islam, I. Labour Market Dynamics in Indonesia. ILO Jakarta, 2000.

social security organization that administers long-term and cash benefit programs along with contribution for other programs. The social security organization then will transfer a sum equivalent to the total health component contributions to the compulsory health insurance scheme;

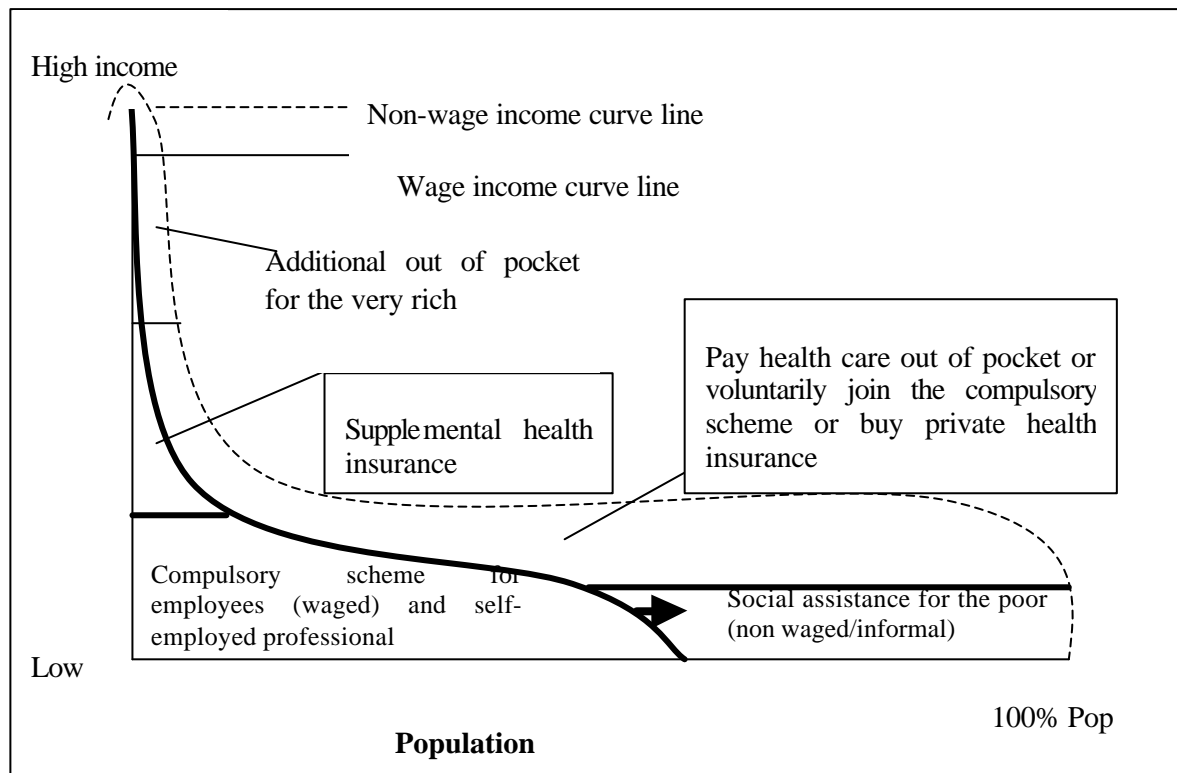
- those who are not satisfied with the compulsory scheme may purchase supplementary health insurance from private insurance companies. But they should not be allowed to opt out of the compulsory health insurance scheme. These people may have better services covered by their private health insurance schemes or pay out the difference themselves. Their entitlement to benefits from the compulsory scheme can be coordinated with a private health insurance scheme;
- self-employed professionals such as physicians, lawyers, brokers, agents, etc. should also be required 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 a monthly basis along with the payment of income tax. A deadline for inclusion of this group can be considered as a separate phase of implementation. The levels of contributions need further actuarial calculation;
- in Figure-6, the income curve of salaried and self-employed professionals (solid line) moves to the right (there will be more people belong to this group) as time goes by and the economy of the country is improves. This means that the membership of the compulsory scheme automatically expands as formal employment increases;
- on the other hand, the income curve for non-salaried workers (dotted line) will not move because this line also represents total population, reducing the number of people in this group;
- the low-income group (the poor and marginally poor) in the non-salaried workers (under the solid horizontal line at the right) might be provided with financial assistance from the government and or other charitable organizations. The financial assistance from the government would need to be subject to a means test. The money for this assistance could be allocated from oil subsidies. This group can be divided into two sub groups:

the very poor could receive financial assistance for outpatient and inpatient care from public providers. These people could be covered immediately as a continuation of the existing social safety net programs that will terminate in 2002; and

the low-income group who are not classified as 'poor' by the means test (i.e. the marginally poor) who still cannot afford to pay expensive medical care should be provided with financial assistance for inpatient care and surgical procedures. This group should be able to afford to pay for outpatient care, at least by public providers. This group could be covered next and should be covered completely by 2012.

- those who are not in the low-income group of non-salaried workers may pay health care out-of-pocket to 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. Once this group enters formal sector employment they should be obliged automatically to join the compulsory scheme; and
- if the national tax system improves significantly allowing income of the later group to be identified and either monthly or annual contributions to be regularly collected, then they will be required to join the compulsory scheme. They may still purchase supplementary health insurance from the market if they perceive that the quality of services provided by the compulsory scheme is not meeting their demands;

Figure 6. Possible design of social health insurance scheme in Indonesia



17.8 The above design could be implemented in stages since the current system covers only relatively few eligible workers for several reasons discussed in the previous sections.

17.9 The revised compulsory health insurance scheme should focus (firstly) on those who are not currently covered either by Jamsostek, private health insurance, or health benefits provided by enterprises. Gradually, over the next five to ten years those who are not in the system but who are currently covered under various schemes will be included in the system. This will enable private schemes to make the adjustments required to shift the emphasis to supplementary insurance coverage. Consistent, quality health cover with less cost to employers and employees will accomplish this expansion. It is expected that those who are currently under various health insurance systems will voluntarily join the scheme because they would realize that they could get adequate benefits for lower contributions. The stages could be implemented according to the following agenda (Table 5), although this will need to be flexible to take account of progress and experience:

Table 5. Agenda to cover all of the population in the proposed health insurance scheme

Year	Stage	People covered	Scheme
2003-2010	I	Formal (waged) employers of ≥ 10 employees, self employed professional, and pensioners in the private sector are mandated to enrol in the compulsory health insurance schemes	Social health insurance
2003-2012	II	Small employers (< 10 employees) and self-employed can unroll the compulsory scheme <u>voluntarily</u> .	Semi social health insurance
2003-2012	Ia	The poor and the marginal poor of informal (non-waged) are covered gradually starting from the very poor one. Self-employed in upper income levels may join the compulsory scheme voluntarily or purchase private health insurance	Social assistance Free health care by public providers or from charitable organizations or from private health insurance
2007-2013	III	Small employers (< 10 employees) and self employed in low income are mandated to enrol in the compulsory system	Social health insurance
2012-2020	IV	All groups must be covered by the compulsory health insurance scheme	Social health insurance and social assistance for the very poor

NB. The dates are for illustration only.

18. Health benefits coverage and contributions

18.1 The compulsory health insurance scheme cannot be separated from the existing health care delivery system. In general, health care delivery can be divided into two groups; the public and private providers. Public health care delivery is considered to provide poor health services in terms of amenities and the physical appearance of the facilities. The public providers are heavily subsidized, ranging from 70 – 80 per cent of the total investment and operation costs⁵³. The provision of health services by public providers aims at keeping essential health services affordable for all people. In practice, most high-income people do not use health services from public providers except those services offered in the private wings offered by some public providers. Public hospitals may offer private outpatient services in the afternoon and offer first class or VIP class inpatient services for those who demand better services in separate rooms of the hospitals.

18.2 On the other hand, private health care providers must provide a (real or perceived) better quality of services to be able to attract significant number of users. Under current Regulations, private hospitals are required to provide 25 per cent of beds for the poor to supplement inadequate public facilities. Although in practice, many private hospitals do not comply with this regulation. In exchange, private hospitals may receive assistance from the government in the form of building construction, medical equipment, or cash money. But in general, the services for the poor are still relatively more costly than the cost of services in third class public hospitals. Because of the asymmetric information of health services, people tend to judge that the more expensive the health service the better the quality. Therefore, higher income groups who demand better quality of services tend to use private providers or private wings of public hospitals when they have the option to do so.

18.3 One of the important elements of a compulsory health insurance scheme for it to be sustainable and attractive to all groups is the acceptability and meaningfulness of the benefits. Since optimal cross subsidy - from the rich to the poor - can be made possible by the compulsory health insurance scheme, the benefits of the compulsory health insurance scheme must be acceptable by those in upper income bracket. The lower income brackets would normally be happy to receive better quality of services than they normally get from the public providers. Therefore, the benefits of the compulsory health insurance scheme must be offered from private providers or private services in the facilities of public providers. To be efficient and in order to prevent moral hazards, the benefits must be provided in kind, not in cash. The compulsory scheme should not provide benefits from public health centres or third class public hospitals, except in the areas where a private provider is not available. Inpatient care must be provided at least at second-class public hospitals or the equivalent level from private providers.

18.4 The actuarial calculation of contributions to sustain necessary revenue must be based on the costs of providing the above levels of care. It is better to set contributions at the same level for singles and married workers for simplicity of administration and for optimum cross subsidy. Employers will not then discriminate in the selection of their employees based on marital status. Updating members' data for the collection of contributions and in providing services due to change in marital status will become unnecessary, saving time and cost of administration. Employers and employees ought to share contributions on a 50:50 basis for the system to be more equitable. The contributions must also take into account the financial requirements to provide services for pensioners. The actuarial calculation should be conducted at an early date and the level of contributions must be adjusted periodically to reflect increasing costs of health care.

18.5 The level of contributions should be a matter for secondary Regulation, not primary legislation and made on the recommendation of the Board of Trustees according to actuarial advice. The possibility of regional variations may be considered.

⁵³ Gani, A. et.al.. Laporan Mobilisasi Sumber Dana Proyek Kesehatan IV. FKMUI-LDUI, Depok 1998.

19. Options for non-salaried workers

19.1 Non-salaried workers currently represent the majority of the labour force in Indonesia. Together with their dependents, they represent more than half of the population. Their income varies from very low (below minimum wage) to very high that is equivalent to that of top executive levels. Seasonal workers, such as carpenters, part time drivers, and the unemployed may be completely without disposable income to pay for health services or even to buy clothes or pay to educate their children. Street vendors who sell cigarettes, light foods, newspapers, etc. may have income equivalent or below minimum wages and they may be considered poor or nearly poor people. Some merchants who may be helped by family members such as small restaurant owners, used-car sellers, or self-employed professionals may have income of Rp. 10 million or more per month, above the average salaries of middle managers in national companies. The latter types of non-salaried workers have the ability to pay sizeable contributions, but because they are unorganized, collecting contributions from them is difficult. The following options (not mutually exclusive) are possible: -

19.1. Public assistance programs

19.1.1 The non-salaried poor or the unemployed poor have almost nothing to contribute to the scheme. However, they may suffer from an illness or an accident without warning - the same as people in other groups. These poor people should be entitled to free health care from the government or from a charitable organization. The government (not a charitable organization) must be the last resort for them. Therefore, public health centres and public hospitals must continue to provide health services with very low user charges by providing subsidized facilities. This type of subsidy often does not reach the right target as is seen currently in service delivery in public hospitals. But this method of subsidy is the easiest to organize. Central and local governments must share in the provision of such subsidies. Third class care in public hospitals must be provided uniquely for such poor people, while second-class hospital inpatient care should be provided for members of the compulsory health insurance schemes.

19.1.2 One of difficulties of reaching the poor is that they often do not seek medical care in a public hospital fearing unavoidably high cost of medical services. Therefore, other alternative options must be developed. As a temporary solution, before the poor can be covered by the compulsory health insurance scheme, central and local government might share costs, channelled through a third party organization, to cover health care for the poor. This could be done in a decentralized system in which a district or provincial government contracts with a third party in the area such as a *bapel*, to identify the poor and provide them with Health Cards. By holding a Health Card the poor would be entitled to free health care at public health centres and or public hospitals, depending on the type of eligibility. The government needs to develop a means test to determine the eligibility criteria for those who will receive Health Cards in order to minimize the abuse of scarce resources. There might be two different cards. The very poor could receive a card giving entitlement to free health services at both public health centres and public hospitals. The marginally poor could receive another type of card entitling them to inpatient care, including medicines, in public hospitals with a small co-payment for each hospital admission.

19.1.3 The services provided for these beneficiaries should not be limited to low cost health services. However, the government may limit the use of medicines to essential drugs and or generic drugs only. In addition, the services may be limited to third class inpatient services in public hospitals and in private hospitals that are willing to join the programs at predetermined fees. The local government would set fees to health centres or hospitals that would be reimbursed by the contracted third party. Public hospitals must accept the fees without charging the cardholders additional costs while private hospitals may voluntarily join the program for the same fees.

19.1.4 The cost of this public assistance program could be taken from transferring money for gasoline subsidies to health and education subsidies, by gradually increasing gasoline prices. In the year 2000 the government spent Rp. 55 trillions to subsidize gasoline, more than ten times the government expenditure on health nationwide. Those better off with cars and other motorized vehicles than by the poor consumed more of the gasoline subsidies. In the year 2002, the government plans to spend Rp. 53 trillions for the same subsidy, while the estimated cost of providing free health care for all is about Rp. 30 trillions. The cost of public assistance to health care for the poor is estimated at about Rp. 4 - 6 trillion a year.

19.1.5 By 2004, the government should totally transfer all gasoline subsidies to subsidies for health care and education. By that time, the coverage for the poor and near poor people may be expanded as the capacity of local governments and third parties to manage such scheme will improve. From early 2002 until late 2003, the compulsory health insurance scheme and central and local governments can prepare human resources, administrative, and logistical standard procedures to implement this public assistance programs. Advocating and convincing policy makers to establish such public assistance programs must be done intensively during this period and they must be convinced that such public assistance programs will reduce potential social unrest and will reduce social and economic uncertainties that hinder the economic development of the country.

19.2. Charity care

19.2.1 There are always people willing to provide charity care for the poor or near poor for their religious practice or for their personal satisfaction. Currently thousand of religious and social organizations are providing some kind of charity care at various levels. It must be remembered that there is no guarantee that this charity care will be sustainable and adequate to cover the health needs of the poor and near poor. The number of poor people may reach more than 50 million depending on the level of income used in the means test. Although there is no guarantee for sustainability we should continue to encourage these grass roots movements to fill gaps in the public assistance programmes.

19.2.2 Religious hospitals and public hospitals are currently providing this kind of care, even though their capacity is limited. Data published by the MOH shows that between one and three percent of the total number of patients hospitalised was exempted from user fees⁵⁴. Of course private hospitals may provide charity care up to the level that the care does not harm the cash flow of the hospitals. Organizations such as Rotary Club, Muhammadiyah, Catholic societies etc., often sponsor free health services for the poor and free surgical services for certain illnesses. Special clubs such as Heart Club and Diabetic Club also provide some help for those who suffer from these diseases but cannot afford to pay for the necessary medical care. Before all people are covered and the health needs of the poor adequately catered for, charity care will be an essential for those who need medical care but are unable to pay.

19.3. Micro financing schemes

19.3.1 Micro financing schemes have been implemented since the 1970's all over the country. Normally the schemes were very small (covering tens to hundreds of households) and do not have adequate leverage to reduce financial burden of the households enrolled in the schemes. The schemes generally cover one or several villages and are organized by volunteers. Often the schemes worked well during a particular leadership of Camat (head of a Sub District) or Bupati (mayor) but when the leader left, the schemes also halted. Benefits provided are normally out patient care in public health centres or small financial assistance for inpatient care such as Rp. 50,000 per admission. Contributions are determined by consensus (usually very small amounts of money), not by actuarial calculation. Therefore, no micro

⁵⁴ MOH. Health Profile, Jakarta, Pusdakes Depkes, 2000.

financing scheme has been able to grow into a large scale-financing scheme that is sustainable, efficient, and beneficial to the members.

19.3.2 However, before the compulsory health insurance scheme covers the whole population, well-managed micro financing schemes should be encouraged to serve the community. These kinds of schemes are providing some lessons in risk sharing among the members. Religious organizations and local governments often help or sponsor communities to establish such micro-financing schemes. Their sponsorship should not, in any way, be discouraged. But all stakeholders must be informed that in the future they will join a much larger health insurance scheme that is much better more efficient. They must prepare to join the compulsory health insurance schemes when there is the mechanism to collect sufficient contributions in an efficient and sustainable way. Any effort to transform those micro-financing schemes into a large size and sustainable scheme before the compulsory health insurance scheme performs satisfactorily will meet resistance from members. In the meantime the compulsory health insurance scheme must focus on the formal sector until non-salaried workers see that it is beneficial for them.

19.3.3 As discussed in the Health Care Financing section, there is no evidence that micro financing schemes can grow significantly. Investing time and money into the development of micro financing schemes to become larger schemes is too expensive. Experience in the US in the early 20th century also shows that similar schemes were unable to grow because of lack of capital and data on which to base premium calculations⁵⁵. It is much more efficient and effective to concentrate efforts into developing large reliable compulsory health insurance schemes.

19.4. Cooperative or trade associations

19.4.1 In addition to micro financing schemes, cooperatives and trade associations often organize health funds for their members. The scope and effectiveness of these funds has not been systematically evaluated. In theory these funds may help members to cover some health care costs for their family members.

19.4.2 Members of these groups could potentially join the compulsory health insurance scheme sooner than members of micro financing schemes. Many farmers, fishermen, and small industries receive their income from cooperatives or trade associations through which they sell their products. Contributions can be deducted from payments made periodically by the cooperatives to members. The number of people belonging to this group could be as many as 50 million. However, there are many cases where members of cooperatives or trade associations are also members of salaried workers' unions. Many civil servants establish cooperatives in their offices to raise money to supplement their income. Many civil servants and private employees may have spouses working as farmers, entrepreneurs or have small businesses and establish cooperatives or trade associations. Therefore, establishing several schemes based on the source of household income groups may end up with duplication of membership and produce more administrative problems. This complication is especially more complex when the contribution levels and the benefits are different from one scheme to another. It would be helpful to study the informal sector schemes and to develop guidelines for the establishment of micro schemes.

19.4.3 For simplicity and equity, a compulsory health insurance scheme at least for one region, is much more efficient and simple to administer. Members of cooperatives or trade associations, whose household members are not employees, may join the compulsory scheme voluntarily. As with micro financing schemes, members of these groups must be informed that ultimately they will join the compulsory health insurance scheme. Members of cooperatives that deal with selling products or crops on a routine basis may be encouraged to join the compulsory scheme as soon as the scheme is in operation. An actuarial

⁵⁵ HIAA. Group Life and Health Insurance, part A. HIAA Education Program, Washington DC, 1994.

study needs to be conducted to calculate levels of contributions and the method of collection from these groups. The health benefits must be provided at the same level and scope as for salaried workers.

19.5. Purchase private health insurance

19.5.1 Another options for individual non-salaried workers is to purchase health insurance from private health insurance companies. Currently more than 60 private insurance companies offer health insurance, mostly for hospital and surgical coverage on indemnity or reimbursement basis⁵⁶. Looking at the high premium rates offered by private insurance companies, these types of cover might only be available to those in high-income groups. Salaried workers may purchase private health insurance as a supplement for their compulsory health insurance coverage. Non-salaried workers, who do not join the compulsory health insurance scheme, may rely on private health insurance as the only cover available to them. When the government tax collection system is reliable non-salaried workers will be required to join the compulsory scheme in their region.

19.5.2 In the long term, there will be very few people who will rely only on private health insurance. Those in the top five percent of the population may depend more on private health insurance coverage than on the compulsory health insurance scheme. However, for the optimum social solidarity it is better that those who are very rich should also contribute to the compulsory health insurance scheme whether or not they choose to use their entitlements to the benefits provided by the scheme or to rely solely on a private health insurance scheme.

⁵⁶ Thabrany. Asuransi Kesehatan Indonesia. Pusat Ekonomi Kesehatan FKMUI, Depok 2001.

20. Recommendation for the revision of JPK Jamsostek

20.1. General recommendation for the revision of Jamsostek law

20.1.1 After careful examination of the existing JPK Jamsostek and its performance within PT Jamsostek, several changes are recommended:

1. repeal the opt-out clause from Regulation No. 14 of 1993 to assure a larger pool and to reduce adverse selection. Employers/employees who wish to receive better quality benefits may purchase voluntary, supplementary health insurance from the private sector. Coordination of benefit should be undertaken by both administrator and the private insurer so that the beneficiaries should not deal with two separate entities and encounter administrative constraints when receiving benefits from two sources (the social security scheme and the private insurers). For example, the compulsory scheme pays the hospital bill for inpatient care in a second-class room of Rp. 2 million. An employee who purchased supplemental health insurance is hospitalised in first class room in a private hospital, which costs Rp. 3 million. Then the supplementary health insurance scheme pays the hospital only the difference (Rp. 1 million). The phasing out of the opt-out clause should be done gradually by allowing existing private options to continue for five years. Employers should be able to enter into the compulsory scheme anytime they want to. However, employers that are not in contract with any private scheme at present must join the compulsory scheme. Thus the revised Jamsostek law should allow entry (opt-in) but not exit (opt-out). This gradual transition should permit the compulsory scheme to improve services to the level that is acceptable by current employers/employees and for the private market to continue to grow. Removal of the opt-out provision will allow a large pool to develop (as many as 100 million people nationwide within the next five years) and the accumulation of at least Rp. 15 trillions (2001 value) per year for health care. This amount of money would provide purchasing power for the compulsory health insurance scheme to negotiate prices and quality of health services with health care providers. Thus the compulsory scheme could push the health care delivery system into a more efficient and more effective system than the current financing and delivery system.
2. for the next five years, the social security system should continue to expand with phased extension of coverage to smaller employers (with less than 10 employees). Consideration should also be given to covering pensioners. Self-employed in prescribed occupations should be brought into the scheme in line with their membership of the proposed retirement pension scheme. Voluntary membership should be considered for others. But the capacity of Jamsostek to manage a larger membership needs to progress ahead of the expansion of the membership base otherwise extending compulsory membership to all employers within the next five years will not be feasible due to the low capacity of the current system. Initially, emphasis could be focused on all employers of 10 or more employees with aggressive enforcement procedures to ensure that the law is complied with. The expansion of compulsory insurance to non-salaried workers may be introduced based on a proper study of the sector, perhaps in five to ten years' time, when the performance and the capacity of the enhanced compulsory health insurance scheme is widely accepted.
3. coverage for dependants should be expanded without limit on the number of children. But the plan should provide incentive to employees to take advantage of family planning services or require cost sharing for the third child and beyond.
4. the revised social security system should cover health benefits for retired employees and their dependents on a contribution basis. Premiums for retired employees should be collected from wages during employment or contributions taken from pension payments. In case of those with no pension payments at the beginning of the compulsory system, a community rate may be

applied. A special actuarial study must be conducted for this retired population. Benefits provided might commence with hospital services that become a large financial burden and may create economic hardship to the retired people. Later when the financial condition of the compulsory scheme permits, the expansion of benefits to out patient care can be introduced.

5. the premium level must be recalculated by actuarial study to meet the real cost of health services and development of the compulsory scheme. The level of contributions is estimated at 6 per cent of monthly salaries shared fifty-fifty by employers and employees. The higher contributions are justifiable because the scheme will provide for a larger scope of health services and better quality of services. The contributions for singles and married will be the same. Local or central governments pay 50 per cent contributions for civil servants at the rate that will be calculated later, perhaps about 3 per cent for both singles and married employees, the same arrangements as for private employees. Civil servants, civil service pensioners and military personnel would also contribute 3 per cent of their salaries or pensions.
6. the new scheme should utilize private health care providers for out patient and mixed public/private providers for inpatient care. To maintain costs at an acceptable level, the new scheme must utilize second-class inpatient care and only use the government subsidized third class inpatient care only for the uninsured. By differentiating services, members would feel different from ordinary poor citizens who use third class and subsidized care. Without this arrangement, there will be difficulty in attracting higher income employees to the scheme so that even if the law is enforced, the low level of satisfaction of the members could make the scheme unpopular.

20.2. Separation of health insurance coverage from other social security programs and establishing a new trust fund (Jaminan Kesehatan, Jamkes)

20.2.1 This scenario from Section 15 is further examined here.

20.2.2 Because of the differences in managing health benefits from social security cash benefits; consideration needs to be given in the longer term as to whether the health insurance component of the social security system should be managed separately. Such separation must ensure: that there are economies of scale, a sufficiently large risk pool, and maintenance of solidarity principles.

20.2.3 There are a number of options that would facilitate more equitable and stronger bargaining powers between the social security scheme and health care providers. One option is to combine the program for civil servants (currently administered by PT Askes) with the private employee program (currently JPK Jamsostek). This would create a combined pool of members from both present schemes and facilitate the administration of health benefits in a decentralized system at regional level - at the level of one province, several provinces, or several districts. However, the size of the pool should take account of the need to cover high cost medical care. Small pools will not be sustainable. Actuarial studies to calculate the optimal membership size and the contribution level must be performed later. The new organization should be a tripartite Trust Fund (not PT Persero) without profit motive (on the lines envisaged for 'Jamsostek Baru'). The possibility of separate Trust Funds for each region might be considered provided consistency across the country could be assured.

20.2.4 At regional level, a new Trust Fund might be established by combining branches of PT Askes and PT Jamsostek in each region. Current assets and human resources from both programmes must be transferred into the new entities. The new Trust Funds might be called Jamkes (Jaminan Kesehatan) Jakarta, Jamkes Jabar (for West Java), Jamkes Sulsel (South Sulawesi), etc. Each regional Jamkes might operate independently from others or the National Jamkes. At the national level, there should be a national pool managed by a Trust Fund responsible for coverage of catastrophic illnesses or inter-region referrals. This national pool will be discussed the following section.

20.3. Justification

20.3.1 Managing social health insurance and delivery of services at the same time, requires special skills and expertise that are very different from managing cash benefits in provident or pension funds. Managing such financial and health service delivery requires extensive information systems and processes to ensure that there is sufficient funding to pay benefits as the prices of health services, drugs, medical supplies, and other related health services increase. Special regulations that are flexible and adaptable to regional differences in provider availability, income level, health needs, and others factors pertinent to delivery of health services are required.

20.3.2 Decentralization of management and risk pooling provides flexibility to reflect differences in prices, service availability, and utilization of services by different characteristics of members in various regions. One national pool can create inequality in utilization between those who live in metropolitan areas and those who live in small towns in distant areas. Therefore, if all employees (public and private) were in large pools, then decentralized management and risk-pools in regions (such as for every 10 million population) are feasible. This decentralized management would be more responsive to the local demands while maintaining adequate risk sharing (social solidarity) across income groups. There might be 10-15 regional Trust Funds for social health insurance scheme throughout the country. A national Trust Fund (Jaminan Kesehatan Nasional, Jamkesmas) would need to be established to take responsibility for catastrophic illnesses funded by, for example 10 per cent of premium.

20.3.3 The main goal of the implementation of social security is redistribution of income/financial burden among the members/population. Combining both civil servants and private employees into not for profit organizations (Trust Funds) would optimise the benefits to the members and distribute financial burden for health care among members in more equitable way, unifying medical benefit between the public and private sectors. Such a system would create stronger solidarity among employers and employees from different employment fields and regions, improving Nation Building.

20.4. Disadvantages

20.4.1 There are, however, disadvantages to employees and employers of this pooling of contributions from civil servants, private employees and non-salaried workers. The disadvantages are:

- the absence of choice of insurance carrier may lead to dissatisfaction of members. However, it should be realized that choice of providers is more important than choice of insurance carriers. Insurance carriers are just payers with little effect on the treatment outcomes;
- combining PT Askes and PT Jamsostek into a new Trust Fund could be affected by previous performance and perception of low quality of services of the existing JPK Jamsostek and Askes; and
- 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. To overcome these problems, 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 quality of services while proving that the scheme could provide quality services.