36 Years Experiences of Social Health Insurance in Indonesia

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1. Introduction

Health status of the Indonesian people has improved significantly but slowly over the last two decades. Many factors affected the slow improvement of health status in Indonesia such as: low education, low income, difficult geographical access, cultural barriers, and low health expenditures. The World Health Report 2000, albeit of criticisms over the methodology and the data used, clearly assumes that health care financing is the most important element in the achievement of health improvement. The level of health care expenditures affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important process of health care delivery. Therefore, many studies uncover a strong relationship between health status of a population and health care financing. Data from the WHO 2000 Report shows clearly that health care expenditures, both in terms of nominal amount and in term of percentage of gross domestic product, are lower in developing countries than those in developed countries.

As a developing country recently hit by a severe financial crisis, Indonesia is struggling to finance health care, especially for the poor. At the same time, Indonesia is undertaking a massive government reform by decentralizing almost all authorities to regional governments—except fiscal, national security, foreign policy, and religious affairs. The crisis and the decentralization of authority have raised awareness and concerns over a sustainable health care financing in Indonesia. It is critical to review how current health care system affects the infant mortality rate or access to health services. Additionally, health care financing through health insurance schemes will be reviewed to identify problems and potentials for reforms. Finally, this paper will present current initiatives for the National Health Insurance program in Indonesia.

\(^1\) The section 1 and 2 of this paper are modified from two papers previously presented in the Health Policy Conference Workshop National University of Singapore, Singapore 6-8 September 2004 and in Islamabad, Pakistan, December 6, 2004
2. Current Health Care System

Indonesian health care system had been identified as an entrepreneurial system by Roemer (1993) and it is partially financed and delivered through public health care facilities consisting of health centers and public hospitals. Health centers provide various public health and primary health care to a defined community, usually a sub-district level. Health centers are the front lines for providing various public health programs ranging from health promotion, immunization, sanitation, etc and primary health care services to the community. A health center is normally headed by a newly graduate medical doctor (general practitioner) mandating to serve 1-3 years to the community before s/he could become a specialist.

The availability of public health centers (stationary, mobile, and sub health center) and low user fees make access to primary health services is quite good for all income levels of the community (Thabrany 2001). Although it is a public facility, people must pay user charges in the health center. In some provinces or districts, the user charges for certain services sometimes quite high, relative to the income of the community. Otherwise, the user charges are considered very low that everybody could afford. The better off who demand better services may visit private services of the same doctor in the afternoon and pay higher fees. One important factor for equitable access to primary health services is the proximity of those services to the population. The Indonesian health policy mandates local government to build one health center for every 30,000 inhabitants and one sub-health center for every 10,000 inhabitants. A public health center has staff of at least one physician (general practitioner), several nurses and midwives, other health related personnel and administrative staff. A sub health center has at least one nurse or a midwife plus few administrative staff to provide a very basic health services to the community. There are currently more than 7,000 health centers and more than 21,000 sub health centers through out Indonesia.

Public hospitals, providing secondary and tertiary care, consist of four types: (1) type D hospitals (less than 50 beds with four specialists: an internist, an ob-gyn, a surgeon, and a pediatrician) provide basic secondary care at district level, (2) type C hospitals (50-100 beds with more than four types of specialists) serve secondary and tertiary care for a larger district, (3) type B hospital (between 100-400 beds with variety of specialists) providing referral care of more advances at provincial level, and (4) type A hospital (up to 1,500 beds) designed to provide top (national) referral care. Users of public health care facilities are
charged based on the number of services they received (subsidized fees for services system). The user charges at health centers and at third class room of public hospitals are heavily subsidized (about 50-80% of the user fees are subsidized indirectly through publicly set fees). Since subsidies are given to the supply side, the target population receiving subsidies have been normally inappropriate.

The poorest populations have not received subsidies as much as the subsidies received by the middle income because naturally the poor often did not go to have health services fearing of unaffordable fees. As a result, there is great inequity in access – especially to public hospital services, not to mention to private hospitals. Additional barriers such as geographical (distance) and cultural (education and beliefs) remain significant factors for hospital services. Figure-4 shows large gaps in access to inpatient care in public hospitals between the poor and the wealthy (Thabrany, 2001). The richest 10% of the population had more than 400 hospital days per 1,000 people and members of Askes and Jamsostek (insured) had more than 500 hospital days per 1,000 people, higher than those of non-insured. On the other hand, the poorest 10% of the population and uninsured had less than 100 bed days per 1,000 people. The gaps between the poor and the rich among Askes members remain high because the benefits are inadequate that pushed members to pay uncovered charges and the distant factors where low-income insured live far from public hospitals. Many studies uncovered that insured civil servants before the year 2000 ought to pay up to 80% of the hospital costs and drugs (Trisnantoro et al. 2000; Thabrany 2001). However, currently Askes (the insurance carrier for civil servants and their families) pay much more reasonable prices to the public hospitals as Askes receiving higher revenues from 2% contribution of higher basic salary of civil servants. In several public hospitals, civil servants are currently exempted from cost sharing except for few expensive procedures.

Doctors working at health centers and public hospitals are public servants receiving low basic salary. To supplement the doctors’ income, they are allowed to have private practice in the evening. Nurses and midwives are officially not given such privileges. However, in practice, they (especially in small cities or districts) also have private practice. In addition to public hospitals and health centers, about 40% of hospital beds are provided by private hospitals. The charges in private practice of the same doctors can range from 3 to 10 times higher than in public health care facilities. In private practice, doctors, nurses or midwives often provide brand name drugs (perceived as much better quality by the community than the drugs provided in the public facilities) and charge the patients a single
price. Frequently the doctors tell the patients that the drugs provided in health centers are not good, generating higher demand for services in the private practice.

The dichotomous of public and private facilities has been generally accepted as an appropriate way to accommodate the freedom of choice of providers. The government had been (for long time) believed that the system work well to ensure equitable health care. However, a closer look of health seeking behavior revealed that the system is too regressive and inefficient. Public hospitals received more government subsidies that health centers but the public hospital services are consumed more by the better off than by the poor. The poor normally lived in remote areas or far from the public facilities and where transportation often not available or costly. Figure-1 illustrates how the current health care system in Indonesia is regressive. The figure indicates that inpatient days per 1,000-population of the poorest were much lower compared to those of the richest. On the other hand, the poorest have much higher burden to pay hospital charges as measured by a ration of hospital charges to monthly household expenditure. The poorest (decile-1) ought to pay hospital charge for a single hospital care episode more than one month normal household expenditure (as proxy of income). The figure indicates that once there is a need for inpatient care, an Indonesian household could go bankrupt because of the very high burden of health care. This condition had been prevalent during the beginning of financial crisis in 1999-2000.

Figure 1

Inpatient days and ratios of inpatient costs to household income by income groups and insurance status, analyzed from 1998 National Survey Data
The After the crisis, there have been strong initiatives to reform health care system in Indonesia. One of the significant reforms is the introduction of Healthy Paradigm introduced by the Minister of Health, Professor Moeloek, and signed by President Habibie in 1999. The Ministry of Health set four pillars to achieve Healthy Indonesia 2010, a goal to move toward healthy environment and universal coverage. The four pillars are: moving to Healthy Paradigm, professionalism, development of health insurance, and decentralization of health services.6

The law of regional autonomy, including health sector, has been implemented nationwide since January 2001. While decentralization provides faster response and more appropriate policy, there are some disadvantages of decentralization of health services. Under the law of regional autonomy, local governments are responsible for providing health services in districts. Many local governments perceive that hospital services could be utilized to generate income. On the other hand some rich districts are planning to provide health services for free. Decentralization could end up with regional inequities in health care. There are transformations of public hospitals into state owned companies (BUMN Perjan) or local government owned companies (BUMD) or even a transfer of shares from public hospital to employees of the public hospitals in Jakarta. The perception among directors of the transformed hospitals has been that they have to be financially independent from the
government leading to raise charges. Clearly this transformation paved the way to increasing inequity in health care financing in Indonesia.

The transformation of hospitals and health centers in several provinces into state or local government companies is, to certain degree, as a response of the recommendation made many national and international consultants to government to spend less for health care. The recommendation has been too much emphasis on the burden of government subsidies, without adequate consideration of the equity. On the other hand, many developed and developing countries are working hard to establish universal coverage to ensure equity in health care. South Korea, Mexico, Thailand, and the Philippines for example are moving toward expansion of insurance through the establishment of national health insurance.

The government health expenditure has been stagnant for the past two decades and now is moving away from equity. The government health expenditures have been stagnant at the level below S$ 4 per capita per year. The central government budgets normally cover about 80% of the total public spending on health in provinces and districts. This data suggest that compared to the increasing risks of the more expensive and chronic illnesses, funding for health from the government has been diminishing. In addition, out of pocket health expenditures by households have been also stable at the rate of below 3% of the total household expenditures. Health expenditure data show that health care financing in Indonesia is severely under funded, far below health care financing in the neighboring countries. Even if it is compared with county of similar or lower per capita gross domestic product such as Vietnam and India, Indonesia spent much less, as presented in Table 1.7

### Table 1: Health care financing in selected countries in Asia, 2000

<table>
<thead>
<tr>
<th>Countries</th>
<th>PCHE at exchange rate (US$)</th>
<th>PCHE in international dollars (US$)</th>
<th>THE as % of GDP (%)</th>
<th>Public share of THE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>19</td>
<td>84</td>
<td>2.7</td>
<td>23.7</td>
</tr>
<tr>
<td>Vietnam</td>
<td>21</td>
<td>129</td>
<td>5.2</td>
<td>25.8</td>
</tr>
<tr>
<td>India</td>
<td>23</td>
<td>71</td>
<td>4.9</td>
<td>17.8</td>
</tr>
<tr>
<td>Philippines</td>
<td>33</td>
<td>167</td>
<td>3.4</td>
<td>45.7</td>
</tr>
</tbody>
</table>

NHI Indonesia

H Thabrany.
Financing for the poor, and the vulnerable groups such as pregnant mothers, children under five years of age, and the elderly is severely inadequate. After the crisis and the social safety net programs terminated, there is no sustainable system currently in place. Many policy makers are worry about the impact of severe reduction in access to health services in the year 2004 and beyond. The government is introducing a temporary solution by switching small portion of money for oil subsidy to subsidize health care for the poor. But this subsidy in temporary in nature and the amount is relatively small, about S $ 20 per family per year.
Table 2:

Central Government Per Capita Health Spending Fiscal Year 1979/1980 to FY 2002

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Per Capita (Rupiah)</th>
<th>% Increase</th>
<th>Per Capita (US $)</th>
<th>% Increased in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979/1980</td>
<td>368</td>
<td>-</td>
<td>0.58</td>
<td>-</td>
</tr>
<tr>
<td>1980/1981</td>
<td>822</td>
<td>123.4</td>
<td>1.30</td>
<td>124.1</td>
</tr>
<tr>
<td>1981/1982</td>
<td>901</td>
<td>9.6</td>
<td>1.41</td>
<td>8.5</td>
</tr>
<tr>
<td>1982/1983</td>
<td>909</td>
<td>0.9</td>
<td>1.36</td>
<td>-3.5</td>
</tr>
<tr>
<td>1983/1984</td>
<td>916</td>
<td>-8.5</td>
<td>1.02</td>
<td>-25.0</td>
</tr>
<tr>
<td>1984/1985</td>
<td>1,210</td>
<td>32.1</td>
<td>1.17</td>
<td>14.7</td>
</tr>
<tr>
<td>1985/1986</td>
<td>1,492</td>
<td>23.3</td>
<td>1.34</td>
<td>14.5</td>
</tr>
<tr>
<td>1986/1987</td>
<td>850</td>
<td>-43.0</td>
<td>0.66</td>
<td>-50.7</td>
</tr>
<tr>
<td>1987/1988</td>
<td>767</td>
<td>-9.8</td>
<td>0.46</td>
<td>-30.3</td>
</tr>
<tr>
<td>1988/1989</td>
<td>1,055</td>
<td>37.5</td>
<td>0.62</td>
<td>34.8</td>
</tr>
<tr>
<td>1989/1990</td>
<td>1,311</td>
<td>24.3</td>
<td>0.74</td>
<td>19.4</td>
</tr>
<tr>
<td>1990/1991</td>
<td>2,275</td>
<td>73.5</td>
<td>1.23</td>
<td>66.2</td>
</tr>
<tr>
<td>1991/1992</td>
<td>3,048</td>
<td>34.0</td>
<td>1.56</td>
<td>26.8</td>
</tr>
<tr>
<td>1992/1993</td>
<td>3,946</td>
<td>29.5</td>
<td>1.94</td>
<td>24.4</td>
</tr>
<tr>
<td>1993/1994</td>
<td>4,296</td>
<td>8.8</td>
<td>2.05</td>
<td>5.7</td>
</tr>
<tr>
<td>1994/1995</td>
<td>4,680</td>
<td>8.9</td>
<td>2.12</td>
<td>3.4</td>
</tr>
<tr>
<td>1995/1996</td>
<td>5,277</td>
<td>12.8</td>
<td>2.29</td>
<td>8.0</td>
</tr>
<tr>
<td>1996/1997</td>
<td>5,845</td>
<td>10.8</td>
<td>2.45</td>
<td>7.0</td>
</tr>
<tr>
<td>1997/1998</td>
<td>6,343</td>
<td>8.5</td>
<td>1.11</td>
<td>-54.7</td>
</tr>
<tr>
<td>1998/1999</td>
<td>11,575</td>
<td>82.5</td>
<td>1.43</td>
<td>28.8</td>
</tr>
<tr>
<td>1999/2000</td>
<td>17,832</td>
<td>54.1</td>
<td>2.49</td>
<td>74.1</td>
</tr>
<tr>
<td>2000</td>
<td>13,776</td>
<td>-22.7</td>
<td>1.47</td>
<td>-41.0</td>
</tr>
<tr>
<td>2001</td>
<td>13,513</td>
<td>-1.9</td>
<td>1.29</td>
<td>-12.2</td>
</tr>
<tr>
<td>Average</td>
<td>4,479</td>
<td>22.6</td>
<td>1.40</td>
<td>11.0</td>
</tr>
<tr>
<td>Minimum</td>
<td>368</td>
<td>-43.0</td>
<td>0.46</td>
<td>-54.7</td>
</tr>
<tr>
<td>Maximum</td>
<td>17,832</td>
<td>123.4</td>
<td>2.49</td>
<td>124.1</td>
</tr>
</tbody>
</table>

a) At average exchange rates of the same year
b) Source. Thabrany, et al. 2002

3. The Civil Servant Social Health Insurance Scheme (Askes)

3.1. Overall Health Insurance Systems

Health insurances for Indonesian are available from various sources. The oldest and the largest health insurance scheme is the civil servant health insurance (Askes) established in 1968. This social health insurance covers all civil servants, retired civil servants, retired military personnel, veterans, and their families. The premium is currently share by employee and the government as the employer. The contribution level of employee is two percent of monthly basic salary or pension income, deducted automatically by the payroll offices. Starting 2003, the government started to contribute half percent of the employee salary,
intended to increase half percent annually until it match employee contribution of two percent. The benefit is comprehensive in the form of services provided in public health facilities, but cost sharing applies in various degrees. The second largest health insurance scheme is the social security scheme for private employees (called as Jamsostek). In theory, this scheme should cover all private employees, but the regulation was diverted to allow opt-out by large private employers. The Jamsostek scheme started in 1992 after the law of Social Security was passed. The opt out provision of Jamsostek allows private insurance companies to sell various types of health insurance products such as indemnity insurance, service benefits, and managed products and other hospital benefit plans. In addition, since 1992 the Ministry of Health has been promoting JPKM bapels (*Jaminan Pemeliharaan Kesehatan Masyarakat*, the Indonesian version of health maintenance organizations) as non-insurance companies selling HMO products. At present there are 67 insurance companies and 22 licensed JPKM bapels (HMOs) selling health insurance in Indonesia.

Regardless of various options, health insurance coverage has been very low in Indonesia. A reliable source of health insurance coverage is from the National Social and Economic Survey (Susenas) conducted annually by the Bureau of Census in Indonesia. The Susenas data of 1998 showed that only 14% of the population had health insurance of any types. The Susenas 2001 showed that 20% of the population had health insurance, but 6% of the population had health insurance from the government social safety net program for the poor. About eight percent of those insured are covered by Askes. Jamsostek covers less than 1.5% of the population (the potential number of people to be covered by this scheme is about 40-50% of the population). The low health insurance coverage by Jamsostek is mainly attributed to the “opt out” provision of the Government regulation number 14/1993. Other private insurance companies and JPKM (HMOs) bapels cover about one percent of the population. Efforts to expand JPKM to mobilize health care financing from the private sector were totally failed due to incompatibility of the Indonesian health care market with the US health care market. In 1990 data published by the World Bank provide estimate of the population with health insurance at about 13% (World Bank, 1993), a very slow growth until 2004. However, the absolute number of population covered has increased by almost ten million in the last decade due to the population increase. Most of the growth of health insurance coverage occurred in the last two years. After the economic crisis, the growth of private health insurance coverage increased sharply due to increasing health care costs in the private sector. The commercial HMO sold by PT Askes currently covered 1.5 million people.
while the number of people insured by other insurance companies in 2003 reached almost five million. An employer survey found that 82% of employers having 20 or more employees in Indonesia provided various kinds of health benefits, including purchasing private health insurance for their employees.

This paper focuses on the evaluation of the 36 years experiences of Civil Servant Social Health Insurance scheme (Askes), especially on its financial aspects. Initially, the scheme was administered by an agency within the Ministry of Health (called BPDPK, Badan Penyelenggara Dana Pemeliharaan Kesahatan). However, under the bureaucratic organization within the Ministry, the management of the scheme was not flexible to respond the changing needs and demands for better services. In 1984, the agency was transformed into a Public Company (Perum Husada Bhakti), a state own company in which the employees of the company remain civil servant but the company had financial flexibility to be operated as a corporate. This form of corporatization of social insurance administration had not provided satisfied performance. Incentives to be very efficient, as a goal of corporate management, did not work well because the employee maintained civil servant status and no drive to make profit since surpluses were not the primary goal. In 1992, the status of the company was again transformed into PT Persero called PT Asuransi Kesehatan Indonesia (in short it is more popular with PT Askes), a higher level of autonomous management of state owned company where the employees of the insurance carrier were no longer civil servants. The law of state enterprise require that this type of company, which is 100% of the share owned by the government, will be evaluated based on its financial performances. Certain level of profit must be made, as agreed by the shareholders. In part, this type of for profit status is not common for administering mandatory and monopoly social insurance scheme. To encourage the management to work harder to produce a reasonable profit, PT Askes has been allowed to sell commercial health insurance products. Currently PT Askes is selling commercial insurance (HMO products), to more than 2,500 companies covering about 1.5 million members, increased from 131,635 members ten years ago. The analysis of this commercial venture is beyond the scope of this paper.

3.2. Membership of Social Health Insurance Scheme

The membership growth of the compulsory scheme increased with the increasing number of civil servants and military pensioners. However, data indicated that the number of members declined sharply in 1998 after the management conducted an audit of members. Computerization of membership resulted in reduction of subscribers (families) due to some
duplication existed before computerization was made. In addition, the number of dependents fell sharply because Askes conducted consistent membership implementation that covers only the first two children under age 21 years (or 25 years if the child is a full time student). As the result the memberships of compulsory scheme in 1998 decreased from 15.8 million members in 1997 to only about 13.5 million. In the year 2004, the number of members was 13.8 million.

The growth of membership remain relatively constant due to no significant reform occurred since the beginning of the implementation of this social health insurance scheme. Even if the social security law of 1992 (Jamsostek) requires employers of 10 or more employees to insure their employees, the government appointed another state owned company to administer the social health insurance scheme for private employees. The opting out provision made the growth of membership of the Jamsostek also stagnant. In contrast, the growth of membership in the commercial health insurance schemes gain significantly. Policy makers and legislators did not perceived that social health insurance in Indonesia need some reform to protect employees from health risks. During the 1990s, no significant policy initiative to expand membership to the private sector was made. The public at large remained uninsured. Only after a severe financial crisis hit Indonesia in 1997 and the impact of this crisis to access of health care was realized in 1998, the government took action by providing financial assistance to the poor population in the from of distributing health card in which the card holders wereentitle to free health care (often did cov cover prescribed medicines) in public health care facilities.

Because the crisis had gone far with the complication of political and employment crises, thoughts to reform the Indonesian social security system, especially in expansion of social health insurance, were emerged. The Agency of National Planning (Bappenas) requested the School of Public Health, University of Indonesia to conduct comprehensive review on health insurance in Indonesia (Thabrany, 2000). The review suggested reform to expand social health insurance and recommends several options. Because of the complication of the crisis into political and government reforms, attentions by the public and the policy makers to political, economical, and government reforms overlooked the problem of uninsured. Many policy makers were happy with the social safety net program in health sector by distributing health card to the poor. Some others have more concerns in stimulating the growth of JPKM without knowing that the JPKM concept was actually a commercial health insurance concept that was not fit with the health care market of the low income
Indonesian. After the crisis, per capita income of Indonesia fell from about US$ 1,200 in the early 1997 to only about US$ 400 in 2000. Several international agencies, such as GTZ (the German international aids agency), World Health Organization, European Union, and International Labor Organization expressed their concerns over the growing difficulties of the public to meet their health care needs. Not until 2001 that the efforts to expand social health insurance coverage gained public interest. However, oppositions on expansion of compulsory health insurance were also sprout, fearing that the country would be unable to bear the financial consequences.

3.3. Financial Performances of Askes

The government determines the salary levels of civil servants periodically (about every two-three years) resulting in changing premium (contribution) income of Askes. Some times the basic salary is not adjusted; instead the government provides additional lump sum money to supplement income of civil servants and military personnel. In this case, as occurred in 1999, because the basic salary was unchanged, the premium income of Askes did not increase during that year. On the other hand, health care prices must be adjusted to offset higher inflation rate of more than 80% at the same year. This trend threatens the liquidity and solvency of Askes, especially during the decentralization and transformation of public hospitals into state own companies (called Perjan) resulting in setting higher user charges to the public. Negotiation and solution ought to be found during the difficult time like that. Fortunately, the government (a joint agreement between the Ministry of Health and the Ministry of Internal Affairs) determines the reimbursement rates to public health care providers so that Askes were protected from severe financial insolvencies. This type of balancing revenues and expenses over a period of time is common in the compulsory health insurance systems.

Figure 2 indicates that premium income of Askes grew from around 95 billion in 1986 Rupiah (Indonesian currency, Rp. US$1 in July 2005 is equivalent to Rp 9,800) to Rp 1,912 billion in 2003. This increase of about 20 times (2,000 percent) over 17 years. Significant increase occurred in 2001 when the government consolidated the salary system of the government employees to include additional benefits as the basic salary. This consolidation of employment benefits, which was not considered as the basic salary and therefore were excluded from the calculation of contribution level for the scheme, yield soaring premium income of Askes. However, since the government establishes reimbursement levels by Askes to public health care providers, which were also adjusted
after the salary of civil servants increased, Askes had to pay higher expenses to health care providers. As the result, the increase of premium income was followed by the increase of medical expenses. Accordingly, Askes also managed to control other expenses such as management so that total expenses (medical and management expenses) were lower than premium incomes. It should be noted that in addition to premium income, Askes received investment income of reserve funds.

Figure 2:

Askes Financial Performance, 1986-2003

Source: Askes Annual Reports

Evaluating financial performances of a company in Indonesia across a period of time can be misleading because of high inflation rates, ranging from 9-12% in a normal year and extraordinary high (up to 80%) during the Indonesian financial crises. Therefore, Figure 3 illustrates a better look of Askes financial development across 17 years of available data. Ideally, this analysis can be done from the beginning of Askes scheme in 1968. However, data for such analysis are not available. Instead, this paper presents portion (about half) of 36 years experiences of Askes. The figure indicates that during financial crisis in Indonesia, 1997-2001, PT Askes managed to control expenses and maintained relatively low deficit.
since there was no decrease in reimbursement levels to health care providers. In 2002 and 2003, Askes made significant profits even though it raised prices reimbursable to public hospitals. The figure also shows that on real term, Askes had lower premium incomes due to high inflation rates during financial crises of 1998 until 2000. During those three years, premium incomes were actually close to premium incomes in the mid 80s. on the other hand, health care costs had grown up in real term. Fortunately, the government also fixed user charges at low levels during the financial crisis. It may indicate that public hospitals suffered the most during the financial crisis in Indonesia.

Figure 3

Since the birth, Askes have undertaken various cost-containment measures applying various managed care techniques to overcome increasing health care costs. Critics have suggested that the managed care techniques applied by Askes have not shown significant impacts due to a shadow market in which, Askes have paid public health care facilities using the government decrees. In addition, the concept of managed care introduced in the US was actually a concept of cost control mechanism in a market oriented health care system. In public health care providers, where the owner is the government, thus there is lack of incentives to the management to respond adequately since they are not receiving economic gain by complying to the cost-control mechanisms. If we take a look on the macro, nation
wide financial performances of Askes, it reveals that those managed care techniques actually work to maintain claim ratios (ratio of health care costs over premiums received) as shown in Figure 4. In seventeen years, Askes actually managed to limit health care costs below the premium incomes. Although the total expenses of Askes surpassed the premium incomes in two periods, during 1990-1993 and during financial crisis of 1998-2000. The cycle can be shown in the ration of total expenses over premium incomes of the Figure 4. This cycle of loss and gain in social health insurance schemes is common elsewhere in the world. The differences are in the length of period of gain and losses. In term of management or administrative expenses, Askes has not experienced significant improvement since the proportion of administrative expenses over premium incomes has been relative stable between 10 to 20%, which is considered high in many social health insurance schemes. These high administrative expenses can be explained by a relatively small number of members spread across the country which cover almost two million square kilometer area. In constant prices, the ratios remain stable as shown in Figure 5, indicating that the inflation of health care costs and general inflation rates have been relatively comparable.

Figure 4 Selected Financial Ratios of Askes, 1986-2003

\[ HC/P = \text{health care costs/premium}, \ TE/P = \text{total expenses/premium}, \ A/P=\text{administrative cost/premium} \]

Figure 5. Selected Financial Ratios of Askes with Constant 1993 Prices, 1991-2003
The Figure 6 indicates cyclical natures of growth in premium and total revenues of Askes. This figure demonstrates income changes from the previous year in the current prices. It is easily observed that Askes is experiencing high increase in premium incomes in every 4-5 years, followed by high changes in investment incomes as the funds were not spent right after the money was received. If we compare the Figure 6 and Figure 7 that demonstrates annual changing in expenses, Askes has been in good condition. The changes in health care costs were relatively constant over a period of 16 years. It is not clear why changes health care expenses (claim) did not shown high variation across time. One theory is that Askes managed to control both claim (by structural measures such requiring rigid referral procedures and reimbursing only prescribed drugs from the formularies) and health care prices (which were set by the government). Other theory is that not all members utilized their rights of coverage due to perceived poor services. Instead, some members opted to pay out of their pockets all medical expenses incurred. Or, many of high income civil servants have their spouse working in the private sector or have their own business that enable them to buy health insurance from the private sector and then used the private insurance coverage they perceived of a better one.

**Figure 6 Changes in Premium Incomes from the Proceeding Year of Askes, 1987-2003**
Figure 7 Changes in Selected Expenses of Askes from the Proceeding Year, 1987-2003

3.4. Delivery of Health Benefits

All members have the right to receive comprehensive health services in health care provider network consist almost exclusively of public health facilities. Many Askes beneficiaries (especially upper income) did not use services they deserve to. The only difference is that the higher rank of civil servants are entitled to first class room and boards when they are admitted in public hospitals, while the lower rank entitle second and third class room and board when they are hospitalized. In mid 2005, the inpatient care provided for Askes members was increased to at least in the second class ward. Data from Susenas 1998 showed that of 28.2% members who complained had at least one
illness symptom, 16.3% sought treatment and only 7.3% sought treatment in Askes provider network. The data suggested that only about half of those who seek health care utilize their health insurance benefits. Many upper income members did not use outpatient services provided by Askes providers and simply pay out of pocket for services outside the network or have other insurance coverage. There is no harmful for the members because the charges for outpatient care have been affordable for many. However, for catastrophic medical care, such as hemodialysis and open-heart surgery, almost all members used the services provided by Askes. On average, in 1998, each household member of Askes paid Rp 19,200 out of their pocket for outpatient care and Rp 698,000 for inpatient care (Thabrany, 1999). The out-of-pocket expenses for inpatient care, reached about average monthly income of the members. Upper income members often file complaints that they receive poor quality of services in the provider network, because they have been charged for several hospital extras (ancillary care) by the public providers to offset the low reimbursement rates set by the Ministry of Health.

Figure 8 and 9 demonstrate trends on health care utilization by Askes members. Trend data for longer period, since the beginning of Askes, are unfortunately unavailable. From the last five years trend, it is clear that the utilization rates measured by visits per 1,000 members per year have been relatively stable for primary and secondary care. During that period, members have to go to public health center to get referral to public hospital it is needed. This structural delivery reduces moral hazards as the system rigorously requires referral or the care is not financed by Askes. In 2004, Askes is starting to utilize private primary physicians as the gatekeepers instead of public health centers. Because private primary care physicians are considered providing better services, the demand for the primary care has grown up. As compared to the demand for primary care visits by the commercial HMO members of Askes, the demand for primary care visits of this compulsory health insurance has been only about 40% of the demand for the same visits when private primary physicians are in the network. This experience will be very important in designing and calculating appropriate contribution levels for the proposed reform of social health insurance in Indonesia. The proposed reform will utilize primary care physicians for the paying members and utilize public health centers for non-paying members (the poor to whom the contribution will be paid by the government).

**Figure 8 the Growth of Outpatient Utilization Rates of Askes, 2000-2004**

*NHI Indonesia* 18  
*H Thabrany.*
In 2004, Askes started to offer primary care services in private practice to switch from services provided by public health center that considered poor services by many members. Accordingly, when the government could fully match the contribution, expected in 2008, all paying members will be hospitalized in the second and first class hospital beds. This policy will increase admission rates from around three admissions per 1,000 members per year which is considered very low to be double by 2008. In mid 2005, when the government started to provide subsidized premium for the poor to cover inpatient care at third class ward in public hospitals, Askes started to switch inpatient services for paying members to second class beds in public hospitals. This switch is expected to increase admission rates to close the gaps between admission rates by social health insurance members and commercial health insurance members. This data suggests that when benefits are provided in a better or perceived better services, the utilization rates will go up and consequently the claim ratios will also increase. In contrast, the admission rates for commercial HMOs of the same Askes have been about 6 admissions per 1,000 members per year.

*Figure 9 The Growth of Admission Rates of Askes Members, 2000-2004*
Admission rates

The data suggest that the utilization rates for primary care have been about 40% of those utilization rates of the commercial health insurance (HMOs), while utilization rates for secondary care have been about the same as for commercial HMO members, and the admission rates have been about half of those commercial products (Askes, 2005)\textsuperscript{12} This is one of the big challenges for Askes to improve utilization rates by improving the quality or perceived quality of services provided by the public health care facilities. In most cases, ensuring quality of medical and non medical services at public health providers is beyond the jurisdiction of Askes. But one thing for sure, when Askes could reimburse health centers and hospitals at a reasonable prices, the probability that services to be provided by the providers will improve.

Askes pay the providers using prospective payments, mostly on per case and per diem basis to public hospitals. The Ministry of Health and the Ministry of Internal Affairs determine the level of payment to public providers to ensure that Askes could maintain its solvency. The claim ratio data shown in the previous figures indicate that Askes could maintain its solvency. In fact, data from Askes reports indicated that in the last five years, Askes has maintained its solvency ratios at 1,600 percent. Despite the healthy financial performances, many accused Askes of providing poor services to the members in order to maintain high profits. To evaluate whether this accusation is true, in the last five years, Askes has requested independent consultant to conduct annual members’ satisfaction survey. Recent surveys indicated that 80% of the members satisfied with the services provided in the network (Soetadji, 2002)\textsuperscript{13} as shown in Figure 10. It is conceivable that those 20% members who did not satisfy were mainly those who were in the upper income levels.
Regardless of some member dissatisfaction, Askes has benefited civil servants, pensioners of civil servants and arm forces, their families, and their survivors for more than 36 years. For higher rank beneficiaries, the scheme has helped beneficiaries to access expensive medical care and drugs. The scheme has been very helpful for retirees and for non retirees in meeting the needs for major medical expenses (expensive medical care such as inpatient care, haemodialysis, surgical procedures, and cancer therapy). Practically, all beneficiaries utilize their benefits when they have kidney failure and when they need haemodialysis procedure regularly. About 75% of patients in haemodialysis centers in the country are Askes beneficiaries. Susenas data showed consistently that more than two-third of beneficiaries used their insurance for inpatient care. In contrast, slightly less then half of beneficiaries used their insurance for outpatient care (Thabrany et.al. 1999).14

3.5. Problems to be Solved

The Askes scheme is currently facing several problems. Before 2002, Askes members had to pay cost sharing that might vary from 0-60% of the total health care costs depending on the provider location and the medical procedures undertaken. The high cost sharing was the result of low reimbursement levels by Askes as set by the Ministry of Health. Many autonomous public hospitals, especially in large cities, charge the remaining

Figure 10

The Growth of Satisfaction Levels of Askes Members of Selected Services, 1999-2003

Satisfaction trends across services

Source: Askes in Statistics, 2004
balance between the reimbursement levels and the hospital charges (published user charges) to the members. In 2002, the Ministry has set new payment levels, in which Askes pays higher than published user charges in 60% of public hospitals, but remain below published charges for the rest of public hospitals, especially the large one in big cities. The second significant problem is the perceived poor quality of health services provided in public hospitals. As described before, higher income or higher rank civil servants often do not use their benefits for out patient care due to this perceived poor quality. The third problem is related to the goal of universal coverage in which the third child and beyond and related pregnancy treatments are not covered. The fourth problem is the relative adverse selection of the scheme from military pensioners. During their active duties, military personnel are covered by the military health care system. After retirement, when they are in higher risks and receive much lower pension—as compared to their salary and other incomes, the military personnel and their family members are covered by Askes. The fifth problem is the transformation of public hospitals into autonomous hospitals followed by increase user charges (prices). Many transformed hospitals express their unwillingness to serve Askes members unless Askes pay published prices. The last problem faced by Askes is the demand by several local mayors or bupatis (head of local government) to manage their employees insurance locally. This is a misunderstanding of decentralization of power and authority of regional autonomy law (just implemented in 2001).

4. Health Insurance Reform

The above conditions create high pressures to the government to establish equitable health care financing system(s). The President has established a Task Force to design and to develop a Law on National Social Security Scheme covering health insurance, workers’ compensation, provident fund, pension scheme, and death benefit. The Bill is currently in a final stage at the Parliament. It is scheduled to be enacted on September 14th, 2004. To meet the goal of universal coverage and to ensure fairness in health care financing, the opt-out provision of current health benefit program of current Social Security law will not be provided. By abolishing opt-out provision the number of insured in five years will soon cover about 100 million or almost 50% of the population. In addition, to be consistent with the goal of maximizing benefits to members, the legal status of for-profit oriented of PT Askes will be transformed into a not-for-profit Public Corporation. A National Health Insurance will be established using the existing assets of PT Askes and PT Jamsostek. The
government will pay contribution for the poor. Until all employees are covered, those who work in informal sector may join the scheme on a voluntary basis.

The National Health Insurance (NHI) design has taken consideration of the fact that Indonesia is a very large country with 210 million people scattered in about 7,000 islands. The labor force is estimated at about 101 million people in 2004. The labor force distribution is 36.2% are salaried workers, 51.9% are self-employed, 3.4% employers, and 8.5% family workers. The self-employed are farmers, individual retailers, and very few self-employed professionals. With only one-third of labor force is in formal sector (salaried workers) it is not easy to mobilize financial resources to finance health care for the entire population in a short period of time. In addition, income per capita of Indonesians is relatively low (at US$ 1,000 at official exchange rates or about $ 2,800 in international dollars). The low per capita income significantly affects household expenditures in Indonesia. The National Socio-Economic Surveys showed that between 50-70% of household expenditures in 1995 to 2000 were for foods, meaning that there is little extra money to pay for contribution.

The NHI relies heavily on contribution from employees, employers and the government. The NHI must start from formal sectors without “opting-out” provision, to allow higher income share the risk with low-income workers. There are problems in determining and collecting contributions from those who work temporarily, self-employed, or seasonal workers. Many of temporary and seasonal workers work without contract binding and they are paid daily or weekly by employers. Employers often did not count them as employees. Therefore, for efficient and effective administration these groups will first be covered through traditional supply-side subsidies. The universal coverage through NHI must be implemented gradually in accordance with the administrative capacity of the NHI and the social and economic conditions of the country. In addition, the scope of health services covered may be limited in accordance with the level of income and the feasibility in collecting contributions from employees and employers.

For those people in low income but in salaried jobs, they will join the system with relatively low effect on their daily consumption. Even if the employees of low wages must contribute half of the contribution for health insurance, it may not affect their normal consumption significantly, if the contribution is set at a low level such as 5%. However, if the total employee contributions for various social security programs reach above 15% of wages, the low salaried employees’ may confront significant cash problems in meeting their daily life.
The scenario of the grand design of the National Social Security System can be described as follows:

1. All salaried workers, and pensioners in the public and the private sector, up to certain salary cap, are mandated to join the NHI. There will the same level of contribution for singles and married employees to simplify administration and to strengthen the social solidarity principle. Within the first five years, the compulsory scheme must be imposed to those employers with ten or more employees, regardless of the legal status of employers. A for profit corporation, a private hospital, a government unit, a non-government organization, a university etc. are mandated to join the NHI. Expansion of membership will be enforced gradually to include employers with one or more employees by the tenth year of the implementation. Non formal sector that have adequate disposable income may join the scheme on voluntary basis during the first ten years of the implementation. The level of contribution for the non formal sector will be calculated and will be determined on a nominal amount varies according to estimated average income of various non-formal sectors’ economy.

2. Those who are not satisfied with the benefits provided by the NHI may purchase supplemental health insurance from private insurance companies or pay directly to providers for price differences in hospital. But they are not allowed to completely opt out from the NHI. Their entitlement of benefits from the compulsory scheme can be coordinated with a private health insurance scheme they purchase.

3. Self-employed professionals such as physicians, lawyers, insurance brokers, insurance agents, etc. are mandated to join the NHI. The contributions level will be calculated by the Board of the NSS and paid directly by the professionals on monthly basis.

4. It is expected that the members of the compulsory scheme are automatically expanding as formal employment picks up more people. This process is expected to take 20-30 years.

5. The poor and marginally poor (low-income) in the non-salaried workers will be provided with subsidized premiums from the government and subject to means test. This group can be divided into two sub groups:
   a. The very poor will receive financial assistance by receiving membership
in the NHI for free (100% subsidy for contribution). The local governments are responsible for identification of the poor by a means test developed nationally and adjusted locally. These people could be covered right a way as the continuation of the existing social safety net programs that has been in place for five years.

b. The low-income non-salaried (self employed) but do not pass the means test (marginally poor) will still cannot afford to pay expensive medical care. This group has not been systematically planned to join the NHI. This group must be provided with financial assistance for inpatient care and surgical procedures but this group could afford to pay out patient care. The government should ensure the access to expensive health care by providing subsidized health care in public hospitals or in third class private hospitals. However, they are free to join in the early stage on voluntary basis.

- During the first five year of NHI implementation, those who are not in the low-income group of non-salaried workers may pay health care out-of-pocket in public or private providers depending on their income or they may voluntarily join the compulsory scheme or purchase individual health insurance from private health insurance companies.

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