THE DEVELOPMENT OF PREPAID HEALTH CARE IN INDONESIA\(^1\)

By

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Recently, the development of health care services in Indonesia has lagged behind that of many developing countries. If we compare it with neighboring countries in Southeast Asia, Indonesia is left behind. Several health indicators among ASEAN (the Association of the South East Asian Nations) show that Indonesia’s health status is the worst (Table 1).

Table 1
Comparisons of health status indicators among ASEAN countries, 1990

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<tbody>
<tr>
<td>Indonesia</td>
<td>570</td>
<td>61</td>
<td>62</td>
<td>7,120</td>
<td>2,840</td>
</tr>
<tr>
<td>Philippines</td>
<td>730</td>
<td>41</td>
<td>64</td>
<td>6,570</td>
<td>2,680</td>
</tr>
<tr>
<td>Thailand</td>
<td>1,420</td>
<td>27</td>
<td>66</td>
<td>6,290</td>
<td>710</td>
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<tr>
<td>Malaysia</td>
<td>2,320</td>
<td>16</td>
<td>70</td>
<td>1,930</td>
<td>-</td>
</tr>
<tr>
<td>Singapore</td>
<td>11,160</td>
<td>7</td>
<td>74</td>
<td>1,410</td>
<td>-</td>
</tr>
<tr>
<td>China</td>
<td>370</td>
<td>29</td>
<td>70</td>
<td>1,010</td>
<td>1,610</td>
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\(^1\) Presented in Health Care Reform in Asia, Taipei, March 1997
From Table 1 we can see that the infant mortality rate (IMR) in Indonesia in 1990 was twice as high as the IMR in China, although the GNP per capita of Indonesia was 54% higher than China, life expectancy in Indonesia was the lowest of the comparison countries. The two indicators showed that until 1990 the health status of Indonesia was very low. In addition, the availability of doctors and nurses was the worst among ASEAN and even worse than the availability of health practitioners in China. With 184 million people in 1990, Indonesia was facing tremendous problems in health care provision. The developments and problems of the health care delivery system in Indonesia can be divided into two eras.

Prior to 1965

During the first 20 years of its independence, the government of Indonesia had been struggling with political problems to control the new independent country. No major improvement in health care had been pursued. Political instability, limited skilled manpower, a shortage of government revenues, and poor economic developments were blamed as the major hindrance to health sector development during this era.

In 1950, there were only, 1,200 doctors, 150 dentists, 3,500 nurses, and 80 pharmacists in the nation of about 72 million people (Ministry of Health – MOH. 1980). The population-to-doctor ratio was about 60,000 to 1. The infant mortality rate was above 200 per thousand live births, and life expectancy at birth was only 48 years then. The number of hospital beds of all kinds was only 60,000 in the entire country. This meant that there was one bed per 1,166 persons. In terms of bed-population ratios, actually at that time Indonesia was better than it is today, however, since there were very few doctors, health services were badly lacking. Doctors were concentrated in hospitals and big cities, while ambulatory care services were generally available in limited urban areas (MOH, 1980).

Health centers were unknown. However, maternal and child clinics, as well as general clinics—headed mostly by a nurse or a midwife—were built by the government and by communities. The ministry of Health reported that by 1959 there were about 3,800 general clinics and 3,000 maternal clinics that provided curative care across the country. That meant that there was one clinic (without a doctor) for 23,000 people. Hospital and Clinics were available in urban areas only. By 1969, there was only one doctor per 100,000 population in rural areas (MOH. 1980; MOH,1990). Cities with less than 200,000 residents might not have any doctor at all. Hospital services were particularly poor due to the lack of personnel and supplies. Most people used traditional
medicines or herbs to cure their diseases.

Due to the political instability of the new country, it was not possible to build good health infrastructures during that period. Economic developments were slow, especially in the early 1960s when the old order government was much closed to communist countries, e.g., the Soviet Union and China. Malnutrition, along with malaria, cholera, and other infectious diseases, were rampant. For instance, about 40% of the population during the 1950s suffered from malaria (MOH, 1980), but by the 1980’s malaria was endemic only in several remote areas, and the annual parasite incidence in Java and Bali in 1990 was only 0.18 per 1000 population (MOH, 1991).

**After 1965**

The next two decades after Indonesia’s independence in 1945 showed the building of infrastructures and physical developments of health care facilities. The new Government (called the New Order, a government strongly oriented to the market economy and to the Western model) was started after the Communist Party failed to overthrow the former Government in 1965. Realizing that welfare services such as health care were very important for capturing community commitment in building the country, the Government built many health infrastructures. The health center concept as a part of integrated health services policy was discussed intensively in 1967 (MOH, 1990a; MOH, 1990b). The objectives of health sector developments during this period had been mainly the building of facilities, distributing health personnel, eradicating infectious diseases, sanitizing the environment, and performing health education. The goal was to build health care facilities within an accessible geographic area with sufficient personnel and supplies. One medium public hospital was built in each district and at least one health center and a doctor was supplied to each sub-district (MOH, 1990b).

During those first 20 years of the New Order government, the economy grew very rapidly as a result of the open policy on foreign investments and of the improvement of infrastructure throughout the country. Market in which Indonesia products could be exported had expanded across five continents. The Government revenues from oil and other export goods had grown more than 10% annually for several years. A strategic 25-years long-term plan was set up in 5-five year plan increments called Pelita.

Among 1968 and 1987 Indonesia had undergone four terms of five-year plans that focused on economic developments. A plan to establish comprehensive public health programs was approved in November, 1967
Prepaid Health Care in Indonesia (MOH, 1980; MOH.1990a). Since then, access to modern health care has received significant attention from the central and provincial governments. Health care facilities such as hospitals and health centers were constructed in urban and rural areas. In 1968, a National Health Conference adopted the health center concept called “puskesmas,” an acronym for *Pusat Kesehatan Masyarakat*, meaning “community health center.” In the puskesmas concept, a health center was built to provide comprehensive outpatient services within a defined geographical area (a sub district). At the beginning, a *puskesmas* had to provide seven basic services. Later, the seven were upgraded to twelve: medical care, maternal and child health, family planning, communicable disease control, environmental health and sanitation, nutrition, health education, dental health, school health, simple laboratory services, mental health, and community health nursing. In addition, two managerial functions—recording and reporting—were required for each *puskesmas*. UNICEF had been a very important contributor to the initial development of health centers (MOH, 1990a). Later, the Government built a “sub-health center” for every 10,000 people in addition to a *puskesmas*.

### Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>No of public health Centers</th>
<th>No of public sub-Health centers</th>
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<tbody>
<tr>
<td>1961</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1971</td>
<td>2,343</td>
<td>0</td>
</tr>
<tr>
<td>1975</td>
<td>3,443</td>
<td>0</td>
</tr>
<tr>
<td>1980</td>
<td>4,753</td>
<td>7,342</td>
</tr>
<tr>
<td>1985</td>
<td>5,453</td>
<td>15,134</td>
</tr>
<tr>
<td>1989/90</td>
<td>6,642</td>
<td>16,000</td>
</tr>
</tbody>
</table>

*Source: Series of statistical yearbooks of Indonesia, 1972-1992*

By the end of 1987, people in each sub-district (*Kecamatan*) and village (*Desa or Kelurahan*) had already had geographical access to at least one health center or a sub-health center. The formula for this development was initially one *puskesmas* per sub-district. Later, it was changed to the requirement that for every 30,000 people there must be at...
least one health center, regardless of administrative or sub-district. Boundaries. A newly graduated physician managed the health center under the mandatory service imposed by the Government (known as Inpres’s program of 1974). A new doctor had to serve for two five years in a health center or a district hospital before she or he could pursue a specialty training. In addition, the Government later built a sub-health center also provided primary health care but it was not headed by a physician; instead, the Government appointed a nurse or a midwife to staff it (MOH, 1990a: MOH. 1990b).

The local government, in cooperation with the central Government built at least one public hospital for every district as the first referral level. The size of the district determined the size of hospitals. In general, the Government built a 100-bed hospital for every district. Prior to 1980, many district hospitals did not have specialists, but by the end of 1980, each one had already had at least four principal specialists: an internist, a surgeon, an obstetrician, and a pediatrician. In addition, many general practitioners who had finished serving in health centers were placed in district hospitals to strengthen them (MOH. 1990b).

Prices in health centers and public hospitals were heavily subsidized, aimed at reducing the financial barrier for poor residents. Because of the growing number of health centers, sub-health centers, and hospitals, the government encountered difficulties in financing those services, especially when oil prices in the world plummeted in the early 1980s. A study of health care financing in 1987 estimated that the Government subsidized 83.8% of treatment costs in health centers (MOH. 1987). Many health policy makers were shocked, feeling that the subsidy was so big that a sudden drop of Government revenues could terminate all health services. This became a big issue in the provision of health care and ways to finance public facilities became the main objectives in reforming Indonesia’s health care.

### Table 3
**Changes in health status as measured by IMR, LE, and CDR in Indonesia, 1971 – 1990**

<table>
<thead>
<tr>
<th>Year</th>
<th>1971 (Census)</th>
<th>1975 (Mid-census)</th>
<th>1980 (Census)</th>
<th>1985 (Mid-census)</th>
<th>1990 (Census)</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate</td>
<td>142</td>
<td>137</td>
<td>112</td>
<td>71</td>
<td>61</td>
<td>48</td>
</tr>
</tbody>
</table>
As a result of the dissemination of health care facilities and personnel to all sub-districts, there was significant health improvement. Table 3 shows that the infant mortality rate (IMR), life expectancy (LE), and crude death rate (CDR) improved gradually. The infant mortality rate had decreased from 142 (per thousand live births) in 1971 to 48 in 1995. Life expectancy increased by 30% during those 15 years, meaning more productive days were available. Crude death rate dropped from 18.7 in 1971 to 7.5 in 1995 a decrease of more than 60%.

Even though the health status of the Indonesians has risen significantly; many policy makers have not been satisfied with the achievements. One can argue that the improvement of the health status was not as a result of health services development per se, but rather the product of economic development. The truth is that both economic developments and health care developments contributed to the improved conditions in Indonesia. How much each sector contributed to better health has not been analyzed yet. Data show that there was association between economic development health services developments, economic growth, and health status in Indonesia is shown in Table 3 and Figure 1.

**Figure 1**

*Increasing health status in relation with increasing income per capita*
Despite significant improvement in the provision of health care provision in Indonesia, problems have been growing, especially on the issue of equity and subsidy. It became evident that Government subsidies were skewed to the wealthier people. The subsidy aimed at improving the care of the poor and rural residents was not hitting the target. Griffin (1992) uncovered the fact that in 1985/86 the subsidies for curative care were mostly consumed by the middle and upper 30% of income groups, while the lowest 40% of income group received only small portions. Her reported that the 30% upper income group received almost 150 billion rupiahs (rupiah is the Indonesian currency) of Government subsidy in hospital care, while the lowest 40% income bracket received only about 40 billion rupiah—about one-fourth of the subsidy received by the richest 30%. About 50 billion rupiahs were consumed by the middle 30% income group.

The construction of health centers and the provision of primary care in health centers, especially in rural areas, also benefited middle and high income groups more than it did low income groups. The total subsidies received by the lowest 40% income group for care in health centers was only about 25 billion rupiahs, while the middle 30% received more than 50 billion rupiahs and the upper 30% swallowed about 45
billion rupiahs. Again, even for less sophisticated primary care, the subsidy gap between the rich and the poor was much too big, with the poorest 40% receiving only half of the subsidy going to the middle and high-income groups.

Those facts generated concerns about quality of management in health services provisions. How to provide subsidies to the right groups? One of the viable alternatives was to raise user charges to those who are able to pay full costs. Another alternative was to implement a risk sharing or a cross-subsidy mechanism. The World Bank (1991) suggested that financing for curative care could be delegated to private sectors while the Government concentrated its financial resources on preventative care and communicable disease control (the public goods aspect of health care).

As health care facilities have been constructed throughout the country, demands for modern medical care have increased significantly. The quality and equity if services need to be strengthened. Operational costs became more expensive as more public facilities built all over the country. The development of sophisticated medical technology and the epidemiologic and demographic changes have resulted in more costly medical care. Hospitals were treating more chronic diseases than ever before. By 1986, cardiovascular disease had become the third leading cause of death (Budiarso et. al.,1986). When oil prices declined sharply in the early 1980s, the Government was facing financial troubles. Direct Government spending in the health sector fell by 45% in real terms among 1982 and 1987. This level of financing by the Government was the same as the financing in the late 1970s (World Bank, 1991).

In the meantime the development of manufacturing, financial institutions had grown rapidly, shifting many non-wage earners to wage earners. Both education and the standard of living, especially of those in the labor force, had also increased significantly. Not surprisingly, the demands for modern health care increased as well. Many employers provided health benefits through a variety of methods. Large employers provided their clinics or hospitals; many others paid a lump sum of money or reimbursed their employees, while others arranged direct contracting with private doctors or hospitals to serve them. Nonetheless, many companies did not provide health benefits at all. Small companies could not afford to pay private doctors or hospitals to serve them. Nonetheless many companies did not provide health benefits at all. Small companies could not afford to pay private health care, which was much more expensive than public health care, for their employees, while others arranged direct contracting with private health care, for their employees (Sulastomo, 1988). Many medium size companies did not pay any health benefit, even when they could afford it. At this time, health care provisions for private workers varied from full reimbursement (often
without limit) to no coverage at all. The low-level workers did not have health benefits and could not afford private health care utilized public providers when they needed.

There were cases where a large percentage of wage earners, used public health services. Fasli Djalal, chief of the Health and Nutrition Bureau of the National Planning Board, clearly stated that the Government does not want this to happen, because Government subsidies meant for the poor were consumed by the economically better-off, the private employees. As a result, the Government had to spend more money to finance those heavily subsidized public health care facilities. Health care financing mechanisms needed to be changed, and health care financing became a subject for policy discussion during the last half of the 1980s.

The World Bank has been very active in advocating policies to reshape health care financing. A World Bank team identified four major problems in the health sector policy: first, resource mobilization, resulting from the heavy fiscal dependence on central government; second, the equity problem, reflected in the inequalities in per capita spending among regions; third, internal efficiency, shown by the decline of overall recurrent expenditure and the imbalance between personnel and non-personnel expenditures; and fourth allocation problem, manifested in a misallocation in spending priorities in favor of curative services (World Bank, 1991). The findings of this World Bank study shifted attention to health care financing issues in the mid-1980s.

Attention to financing and controlling the costs of health care increased after 1985 due to limited health care budget from the government—especially after oil prices went down in the early 80’s. Many were aware that health care financing for the 170 million people at that time was crucial, especially when the health care costs were increasing significantly beyond the Government’s ability to finance the care. The ministry of Health established a committee in health care financing reform in a comprehensive and systematic approach (Gani, 1994). Efforts to shift the financial burden from Government to private shoulders had been done since 1988, when Indonesia was entering the fifth five-year plan (*Pelita V*). Many health policy makers believed that health care financing mechanisms by private sectors and communities should be established right away. With these mechanisms. Cost recovery of public health care facilities, which was only 15% in 1987, could be increase significantly (Gani, 1990). The World Bank reported 10% cost recovery in health centers and 20% in hospitals in the mid 1980s (World Bank, 1991).
The development of health insurance

The discrepancy in health services, limited government resources, misallocation of preventive and curative care, and the trend of increasing operational costs in public hospitals raised a question about how to direct Government subsidies to the right population. The World Bank has been very active in advocating higher user charges for the rich while providing discounts for the poor (World Bank, 1991). Special studies to mobilize private financing for health centers were conducted in East Kalimantan and West Nusa Tenggara (Gertler et al., 1993). The Government also began to study the principles of health insurance to allow cross-subsidy or risk sharing among the poor and the rich. To start this plan, the Ministry of Health and the Ministry of Labor established a team to study health insurance starting for wage earners (ADB, 1987). Such a financing mechanism had been experimented in seven provinces during 1987-1992. Several evaluation studies reported that the experiment was worth expanding (Gani, 1989).

The willingness to develop insurance mechanisms was officially started in the early days of Indonesia’s independence. In 1947, two years after its independence, the Government mandated all industrial and construction companies to pay worker’s compensation for work-related illness, and tried to establish a fund with which employers could pay premiums. The basic Health Act of 1960 stated that the government should establish an “illness fund” to ensure that all citizens received equitable access to health care (MOH, 1985). In 1967, the Minister of Labor issued a decree to establish such a fund to manage an insurance plan similar to Health Maintenance Organization (HMO) concept. The premium was set at 5% of the employee’s monthly salary paid by employers, and 1% of the salary paid by employees (Djumialdji, 1993). The membership was voluntary, however, and the plan was never fully implemented. The reason, perhaps, was that there was little demand for health insurance and that enrollment was not mandatory. At this time Indonesia suffered from a severe shortage of health care facilities and health practitioners. According to Ron, Abel-Smith, and Tamburi (1990), with this condition no health insurance is feasible, therefore efforts to establish an insurance plan failed.

Until 1968, no significant health insurance mechanism had emerged even for the Government employees. Civil servants had the right to make claims to the Government for their health care. In the meantime, there was no corresponding systematic structure of health benefits for private employees. The provision of health benefits among private employees depended largely on the employers. Self employed workers such as farmers received little attention from the Government. All health care was very limited for urban areas, and people paid mostly
out of pocket on a fee-for-service basis (MOH. 1985).

In 1968, the central government mandated that all civil-servants be covered by a health plan which was then organized by an agency called BPDPK (Badan Penyelenggara dana Pemeliharaan Kesehatan), a Health Care financing Administration, under the Ministry of Health. The premiums (dues) were taken salary set aside for the agency by the Ministry of Finance. It is not clear how the 2% premium was set from monthly basic salary and it had never changed since then. The benefits (health care services) were delivered mainly through health centers and public hospitals (Askes, 1992; Djumialdji, 1993).

In 1984, this agency became an independent State enterprise named Perum Husada Bakti (PHB). The primary function of PHB was to manage the plan without Government subsidy, functioning as a not-for-profit health insurance company. This enterprise, under Government regulation, had a monopoly health plan for about 13 million civil-servants, retired persons, retired military personnel, and their families. It had no authority to expand its membership to other employees (PHB, 1991; Djumialdji, 1993). On September 29, 1992, this company became a quasi-private company (it changed the name to PT Asuransi Kesehatan Indonesia—PT Askes) owned by the Government. With the new status, the company was given two main functions by the central Government. First, it was to continue the above mentioned members and second, it was permitted to expand its membership to State enterprise employees, private employees, and other institutions with the possibility of making profits (Askes, 1992; Djumialdji, 1993). By the end of 1997, PT Askes covers 16 millions compulsory members and about a half million voluntary members.

While civil servants had coverage for any loss cause by an illness, the majority of private employees received no such benefits until the late 1980s, when a JPKTK (Jaminan Pemeliharaan Kesehatan Tenaga Kerja—similar concept of HMO) pilot project was introduced. The idea of introducing such a plan for non-civil-servants was actually not new in Indonesia. This idea had been launched long before the government began facing financial problems in dealing with health care when a seminar held in 1976 by the Center for Research and Development, Ministry of Health, concluded that health insurance was the only solution to the development of the Indonesia’s health care delivery system. Two years after the seminar, Sulastomo (1988)—a physician who had been working for the PT Askes since it was BPDPK and the leading insurance expert in Indonesia, proposed to expand health insurance mechanism to all private employees. He suggested adopting Kaiser system sponsored by big State-owned companies. He emphasized that health insurance in Indonesia is selected for five objectives: 1) to avoid economic barrier, (2) to distribute equitable health care, (3) to
finance costly medical care by private sector, (4) to encourage efficiency in health care services, and (5) to standardize health care delivery. Gertler and Melnick (1992), researchers at RAND, also emphasize that health insurance in Indonesia had potential benefits to overcome inappropriate government subsidies and to mobilize resources.

However, Sulastomo’s proposal was not incorporated because of several reasons: (1) there was no health care use analysis done on a comprehensive and large-scale basis, and (2) there was no agreement between the premium and the projected of health care costs due to lack of information (Sulastomo, 1988). In addition, tax structures were not conducive to the development of health insurance at that time. The new tax laws implemented in the mid 1980s considers the health insurance expenses of employers as a pre-tax expense item (ADB, 1987). This tax legislation may provide incentive to the health insurance development. In addition, Gertler and Melnick (1991) stressed that currently Indonesia has no database for actuarial forecasting, information absolutely needed to administer a viable insurance plan. Until 1991, the Government regulations were also not conducive to the development of health insurance mechanism. Consequently, no significant insurance plan was implemented until the first Insurance Act was passed in February 1992 and the employee Social Security Act was passed a week later.

Clearly, Indonesia’s health insurance systems is not as advance as those in Indonesia’s neighboring countries, not to mention in the developed or Western countries. South Korea had developed the first health insurance system in the early 1960s and now has a national health insurance system. The Philippines adopted health insurance in 1954, and even countries in which per Capita Gross National Products were less than that of Indonesia—e.g., Burma (Myanmar) and India—officially had inaugurated such a system in 1956 and 1952 respectively. Japan has been using insurance mechanism on employment based since 1923 which is still in effect and is more advance today (Roemer, 1991; ADB, 1987).

The conditions above, and the growth in the number of wage-earners, forced policy makers to establish a law requiring employers to provide health insurance for their employees. Serious efforts to expand health insurance for private employees was begun in 1987 (Brotowasisto, 1988). In 1988 the Ministry of Health established a committee on policy analysis, called Analisa Kebijakan Ekonomi Kesehatan (AKEK)—literally, the Committee for Policy Analysis on Health Economics—to study health care services and financing for future development (Gani, 1994). An HMO-like product, called Jaminan Pemeliharaan Tenaga Kerja (JPCKTK), designed for private employees was experimented in 14 cities with a premium of 7% of gross monthly wages. This plan covered families with a maximum of four dependents. By 1990 there were 70,000 members of
this plan. An evaluation of the project conclude that the pilot projects successfully increased access and equity in health care (Gani A and Rivvany R, 1992; Hasfarm, 1992).

So far, there was no national regulation which allows public or private sectors to produce health insurance products. Attention to implement nationwide health insurance was there, however, at that time this implementation was lack of political support from the government. The lack of insurance created inequity to access public and private health care providers. Thabrany (1995) found that the insured (civil servants) had 35% better access to outpatient care with public providers (health centers and hospitals). The insured had 56% more chance to receive care from public hospitals compared to private employees and non-wage earners who were not insured. The insured consumed about 2.5 times more inpatient care at public hospital than non-insured. Serrato and Melnick (1996) found that health insurance in Indonesia narrowed the gap of access among income groups.

On February 17, 1992, the House of Representatives (Dewan Perwakilan Rakyat, DPR) of Indonesia, passed a Social Security Act of 1992 that requires all employers to pay Social Security for their employees which includes health benefits, life insurance, pension funds, and worker’s compensation insurance. The Act, called Jamsostek Act (Jamsostek stance for Jaminan Sosial Tenaga Kerja, which literally means employee Social Security Act. The health plan part of this Act must cover comprehensive (preventive and curative) health services operating on the capitation payment system, and is called JPK Jamsostek. The Social Security Act requires an employer to provide health coverage with a premium of 6% of the employees’ monthly wages for married and 3% for single ones (Sekneg, 1992). PT Jamsostek, a State enterprise that run the worker’s compensation insurance plan before the Act was passed, was appointed to manage the Jamsotek (Sekneg, 1993). A similar Health Insurance Act, passed a week earlier permits private insurance companies to offer health insurance, but it appeared that the two Acts related to health insurance for private employees were not carefully coordinated. Basuki, a director of the largest mutual life insurance company—Bumiputera, assumed that the private companies may offer plans (supplemental insurance) above the basic package for private employees.

The Development of Prepaid Health Care

Prepaid health care (capitation payment system) in Indonesia was first implemented by health plan for civil servants (now PT Askes) in the early 80’s. During that time traditional HMO was discussed intensively in the United States as Rand Health Insurance Experiment proved that
capitation system save 30% of health care costs. The implementation of capitation system in this era was limited to health center services, provided by the government, by health plan which was also administered by the government. Payment for hospital services was remained fee-for-service and or package (case rate system). Implementation of this system in private sector was unthinkable at the time. Sulastomo evaluated the capitation system as fruitfully and saved a lot of money. Expansion of this system was evaluated. However, only recently this health plan administers full capitation system in several provinces in Indonesia. PT Askes may be considered as the first health plan implementing capitation (prepaid health care) in Indonesia.

The coverage of this plan is limited to civil servants and their families. Efforts to expand prepaid health care began in 1982 when in Jakarta the first *Daya Upaya Kesehatan Masyarakat (DUKM)*—a community financing scheme, the forerunner of HMO product, was pilot projected. The providers were health centers with the services provided in the evening. In line with the shortage of health care funding from the government and increasing attention to health care finance, the Ministry of Labor and the Ministry of Health implemented a pilot project HMO system for private employee for five years. Evaluation of this project revealed that the project was worth to expand. To expand this system nationwide, two drafts of legislation were prepared: Health Act and Employee Social Security.

In 1992, the two Acts were passed by the legislator along with Insurance Act which also allows commercial insurance companies to sell health insurance products. This year was the hallmark of the expansion of health insurance, both traditional and managed care, in Indonesia. The Employee Social Security mandated all employers with 10 employees or more to insure their employees to PT Jamsostek, so it is monopoly, unless the employers have better health care for their employees. The premium is set at 3% of monthly salary for single and 5% of monthly salary for married employees. The legislation explicitly mentioned that the health plan must pay provider on capitation basis, instead of fee-for-service. To day, about two million people are covered through this plan, roughly only 5% of eligible persons. Many employers have not trust the health plan due to lack of experience in administering this HMO product. In addition, some provinces use public health centers that considered providing poor services by employers. As the results, many employers opt out by purchasing commercial health insurance products where they can choose to buy traditional or managed care plans.

The Health Act which consists of several paragraph promoting HMO plan (JPKM) to unstated population was also passed in 1992. Basically, this Act encourage the development of HMO plan as the main model for health care financing and health care delivery in Indonesia on
voluntary basis. Both the JPK Jamsostek and health plan for civil servants are actually HMO products. The Ministry of Health holds the authority to license and monitor the HMOs throughout the country. Until now, 14 institutions are granted license to sell the HMO product, including one Australian company. After more than five years of the enactment of JPKM, very few people are covered under the voluntary scheme. To speed up the development of HMOs in Indonesia, the Ministry of Health is piloting projecting seven health plans in seven districts. This pilot project is funded by the loan from the World Bank. The World Bank views the HMO model in Indonesia is not feasible, therefore the Bank would like to see whether the model works and has significant impact to the health status of the people, through funding this pilot project.

Currently, each province has a section devoted to promote and develop HMOs. This section assumes the responsibility to monitor, recommend, and control health plans in the province. Almost all officials in the five provinces lack knowledge and experience about managed care or HMO operation. All officials are familiar with health fund (dana sehat) program, a grass roots movement to finance health care in public providers. The health fund run by volunteers collects small amount of money (US $ 2 cents) to cover maximum two visits to health center. No inpatient care is covered, however, the fund may donate up to US$ 5 for each admission. In many districts, membership of this fund is mandatory with premium set at a nominal, small fee, based on judgement about the ability to pay of the people. Certainly this fund has no impact (not significant) to raise health status. Because of this health fund program, almost all health officials are thinking that the HMO plan is equivalent to health fund, which is not true.

As this mindset remains in each official head, all officials want to implement the HMO in poor districts or sub-districts with premium set at the perceived ability to pay to all citizens. Covering all citizens (often more than 500,000 people) certainly is not possible within two years period (the duration of the pilot project), not to mention in rural areas where transportation and low income are problems. The HMO concept, on the other hand, requires benefit development and sets premium according to the benefit provided. In addition, they have possessive behavior as the HMO plan must be provided by the government or an institution to which they have control. Because of this behavior, they don’t invite and explain business entity to produce and sell this plan. They are afraid that the business will sacrifice services and concentrate to obtain as much profit as possible. Moreover, the focus to poor district or sub-district will worsen inequity of the government subsidy. Because the plan they are going to administer will use public providers, which is still heavily subsidized, the poor will end up paying the full costs while
the better of will enjoy more subsidy. The central government delineates that the plan must pay full costs if they want to use public providers.

In the last four months, major efforts to set up HMO plan have been to improve understanding of the JPKM, which has been introduced almost six years ago. It is peculiar that within the Ministry of Health which prepared and introduced HMO model, many officials still do not understand the full concept of HMO. Some people criticize that the slow progress of prepaid health care in Indonesia is due to lack of attention among the founders (officials in MOH). Others blame that the regulation is not conducive to invite private sectors and is not fully feasible due to some requirements that threat to adverse selection. For instance, the regulation stated that enrollment is open to group and individual and can be made any time. The Klaten experience, a JPKM project sponsored by USAID, showed that this adverse selection is true. Certainly, prudent insurers would not gamble to offer this HMO product. Instead, they offer variety of health insurance products without license from the MOH, which is possible under the Insurance Act.

Outside the MOH project of JPKM, the development of health insurance in Indonesia is relatively slow. Small profit from health insurance operation is considered as one reason for not entering this line of business among commercial insurers. In addition, very few managers and personnel in commercial insurers, health providers, and government officials know technical aspects of health insurance operation. It is only in 1996, when the School of Public Health University of Indonesia began to offer formal health insurance program and administer examination of traditional health insurance and managed health care courses (from the Health Insurance Association of America), formal health insurance education available. The legislation that insurers rely on were not available before 1992. Therefore, the development of health insurance had been very slow until recently.

The development of prepaid health care in private sectors is facing tremendous problem due to unfamiliarity of health care providers with this capitation system. For very long time, the providers have been using tradition fee-for-service system and they have been very satisfy with non risk-based payment system. Public sectors have been exposed to the capitation system without much resistant. This low resistance is due to small risk bore by individual providers. Much of the financial risk is on the government shoulder. So the promotion of HMO system, so far, is focus on non provider while the majority of private providers remain untouched.

Consumers in Indonesia face small risk when they have health problems, because the user fees in public providers are very low. In addition, extended family system plays as collateral to the high financial risk when they are sick. Families and relatives will contribute to pay
medical costs, in case the patient is unable to pay. Many people have risk taking behavior in respect to health care. This behavior may be affected by low income and low education that put health care in the low priority over food, clothing, housing, and even luxurious goods. Other alternative health care, such as herbal medicine and traditional healers, is available at lower costs than modern medical care. Finally, many consumers demand easy access and unlimited services at low costs from health insurance resist them from buying HMO products.

Because of many problems mentioned above, health insurance coverage remain low in Indonesia. It is estimated that 27.7 million (about 13% of the population) people are covered by any type of health insurance in Indonesia. However, more than 90% of insured are covered under prepaid system. Only about 6.6 million people (3%) are covered under voluntary health insurance scheme. The estimated number of people insured in 1997 can be seen in table 4.

**Table 4**

| Estimated number of people covered by health insurance in Indonesia |

<table>
<thead>
<tr>
<th>Group of insurer</th>
<th>Number of members</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPKM/HMO voluntary</td>
<td>700,000</td>
<td>500,000 of which belongs to PT Askes</td>
</tr>
<tr>
<td>Employee social security</td>
<td>2,000,000</td>
<td>HMO type</td>
</tr>
<tr>
<td>Civil servants</td>
<td>16,000,000</td>
<td>HMO type</td>
</tr>
<tr>
<td>Military personnel and families</td>
<td>2,500,000</td>
<td></td>
</tr>
<tr>
<td>Commercial insurers</td>
<td>1,500,000</td>
<td>Mix of traditional health insurance and managed care</td>
</tr>
<tr>
<td>Employers provided</td>
<td>5,000,000</td>
<td>Payment systems vary</td>
</tr>
<tr>
<td>TOTAL</td>
<td>27,700,000</td>
<td></td>
</tr>
</tbody>
</table>
Conclusion

Health insurance has been introduced in Indonesia for very long time, as old as the country, yet the coverage remain low at about 13% of the population. Effort to expand health insurance coverage through legal basis resulted in the enactment of three Acts (Insurance, Employee Social Security, and Health Act) is expected to boost the membership. However, due to unrealistic expectation, small profit, lack of skilled personnel, low costs public services, extended family, and other consumer factors resulted in only 6.5 million people (3% of the population) are covered through voluntary health insurance scheme. More than 90% of insured are covered by HMO type plan.

References
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