Social Health Insurance in Indonesia:
Current Status and the Proposed National Health Insurance

By Hasbullah Thabrany
Center for Health Economic Studies, University of Indonesia

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2. Executive Summary

Indonesian health status has improved very slowly over the last two decades. Many factors affect the low improvement of health status in Indonesia such as: low education, low income, geographical access, cultures, and health care financing. Lessons learned from World Health Report 2000, albeit there are criticisms over the methodology, clearly suggested that health care financing is the most important element in the achievement of health improvement. The level of health care financing affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important processes. The same conditions apply to Indonesia. This paper emphasizes that health care financing in Indonesia is the key component to sustainable and significant health improvement.

This paper aims at evaluating health care financing and social health insurance implementation in Indonesia in the last two decades and to describe the proposed National Health Insurance Scheme.

Health care financing in Indonesia has been stagnant for the past two decades and now has been moving away from equity principles. Although many speeches addressed by executive governments and legislatives voiced the important of equity, there is currently no written law or policies that ensure the equity in health care financing in Indonesia. Current transformations of public hospitals into state own companies (BUMN Perjan) or local government own companies (BUMD) clearly paved the way to increasing the gap of inequity in health care financing in Indonesia. After the transformation, almost hospitals increase price of hospital services. The new health care policy taken by the MoH and many local governments will not benefit the low income, unless a reform in health care financing is implemented. Without adequate channeling of subsidies to demand side, clearly the transformation of health care facilities into autonomous bodies, not to mentioned companies, will jeopardize access and equity in health care financing of all citizens. Out of pocket payment for health care, the most regressive health care financing, will increase as shown in the latest data.

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 that the government must spend less for health
care, especially for those who can afford. The recommendation been made has too much emphasis on the burden of government subsidies, without adequate consideration of the nature of health care and the equity aspects. 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 for their people through the establishment of national health insurance, before the transformation of public hospitals. Indonesia seems has followed the trend of transformation but with no balance in improving access to essential health care by increasing public spending or developing social health insurance scheme. Access to, especially hospital services, has been very low for the middle and low-income brackets and the gaps are widening.

Data from Susenas 1992 to Susenas 2001 (ten year annual survey) reveal that accesses to hospital care have been very poor for the bottom 60% of the population. On average, each household must spend more than 100% of the household income for one admission, regardless of public or private hospitals. This amount of health care costs is definitely a catastrophic spending and can impoverish a household. However, there have been very few written policies to fill this access problem. Although during the crisis the government launched social safety net programs, to protect the poor from being impoverished for health care, hospital data show that the proportion of poor and nearly poor patients to the total patients served by public and private hospitals were far below the proportion of the poor to the population. Many public hospitals the proportions of the poor patients admitted were less than one percent of the total patients. In contract, the proportion of the poor the community is far above 20% of the total population. The gaps in access to hospital services between the poor and the reach continue to be very high. The gaps for outpatient care in health centers, in which the costs are relatively small, have been narrow and most low-income households could afford fix payments for outpatient care. The social safety net program launched during the crisis, funded by a loan from the Asian Development Bank, has improved access to the poor. However, the program has no sustainable substitute been installed by mid 2003.

Health care financing scheme for catastrophic illnesses in a more sustainable scheme for non-civil servants is not available at this time. Apparently the health care financing policy in Indonesia does not follow an analytical framework recommended in World Health Report 2000. The report clearly recommends public funding for catastrophic illness to ensure
equity, even though the care is purely private goods. In Indonesian health care policy, there is misunderstanding of public-private goods and the related financing of the goods. Many executives often mention that the government should only finance public goods, while financing of private goods of health services will be the responsibility of individual. The statement may be misleading if there is no explanation the financing of private goods, such as hospitalization and expensive surgical procedures will be the individual responsibility. It the individual responsibility is limited to paying contribution for social health insurance scheme that insure the catastrophic care will be covered, then the statement is acceptable. In addition, there are also philosophical problems in the definition and the policy regarding affordable health care. Many government executives think that by setting low prices for third class hospital services, all people could afford the services. This is not true, because the amount of health care needed and the costs of related services are uncertain. So setting low prices for room and board or a procedure will not guarantee that a member of low-income household could afford services he/she needs. Even if someone pays, often he/she is forced to pay rather than he/she is able or can afford to pay. The other misunderstanding is in the concept of subsidy to supply side or public hospital. The term of subsidy to public hospitals is somewhat misleading, since the concept of subsidy is usually used for financial assistance by the government to non-government agencies. Most policy makers think that by providing subsidy to hospitals, for example by purchasing expensive equipments and paying doctors salary, the poor could receive the services. In reality, most poor people could not get access to hospital services, as data suggested.

The government financing for health, from central government budget, over the last two decades have been stagnant at the level below US$ 2 per capita per year at related exchange rates. The central government budgets normally cover about 80% of the total public spending on health in provinces and districts. As percentage of the total central government expenditures, health expenditures during the last twenty years have been stagnant at below two percent. 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.

In all developed countries, except in the US, more than 50% of financing for hospital services is from the public fund, either directly from general revenues, social security scheme, social health insurance, or national health insurance funds. Very small portion of
hospital services come from out of pocket payment, because of regressive and inequity concern of the government. However, the Indonesian health insurance systems are far from the equity due to distorted implementations. For example, in social health insurance for civil servants (Askes), payments to hospitals by the insurers are set much below the public rates by the Ministry of Health and or by Join decree between MOH and the Ministry of Internal Affairs. As several public hospitals are transformed into state owned companies, the hospital managements perceived (and this is justified by the standard public hospital accounting developed by MoH) the hospitals are subsidizing PT Askes. This accounting standard creates conflict between Askes and public hospitals, all of them are public entities that supposed to ensure that the patients receive services according to his/her medical needs. Because of payment differences, in many occasion the insured now must pay the difference. While for outpatient care in health centers, the insured do not have to pay the difference or they may choose to opt out by receiving and paying services from private providers out of pocket. Since the costs of out of pocket for outpatient care are relatively small, this payment will not impoverish the insured. The paradox is that when the insured are facing catastrophic costs they have to pay on average more than 100% of their monthly income, up to 1,000%, as a “cost sharing”. This scheme covers 13.8 million civil servants and their families.

The social security scheme (Jamsostek) also faces inequity problems because the regulation allows larger companies to opt out, resulting in pooling of low income and small employers in Jamsostek. Those who enroll in Jamsostek are those in lower income groups. Only 1.3 million workers enroll in the scheme since the law was introduced ten years ago. In addition, the Jamsostek only covers workers and their families during their active duties. Once the employees retire and their income reduces significantly, there is no coverage at all. Again, this scheme creates bias selection so that social solidarity between workers in high-income industries to low-income industries does not occur. In addition, subsidy between the young to the old also does not happen in the Jamsostek scheme.

The JPKM schemes (the Indonesian HMOs) is more regressive than the ones in the US and since the schemes are commercial health insurance sold by for profit companies, the schemes will not ensure fairness in health care financing. Under current Ministry of Health decree, only for profit companies are eligible for a license to sell JPKM products. The JPKM products were sold to private employees on risk-based premium that does not provide social solidarity or equity among employees or members. The JPKM products sold by JPKM bapels (HMOs) are health insurance products sold by non-insurance companies but the MoH
so far had denied that JPKM products are health insurance products. There are imminent risks of solvency if JKPM products are not recognized as insurance products. Lately, there is significant progress within the MoH about controversies of JPKM versus health insurance; the MoH is now going along with other sector to support the development of a national health insurance scheme. In addition, various health insurance products sold by insurance companies also do not facilitate equity since the products are also sold on risk-based premiums. The health insurance schemes sold by insurance companies cover more than four million people presently.

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. The money saved from the reduction of oil subsidy goes more to pay the country debts rather than going to finance health care for vulnerable groups. Options to finance these groups adequately to avoid lost generations and to reduce severe social consequences must be developed as soon as possible. At present, there are some propositions to establish a more sustainable social protection scheme that will be funded from ADB loan.

The above conditions create high pressures to the government to establish equitable health care financing system(s). Currently the President has established a Task Force to design and to develop a Law on National Social Security Scheme, including social health insurance scheme. A lot of issues need to be resolved since currently there are many players who already enjoy the cream of commercial health insurance. This paper presents a design for the National Health Insurance, within the framework of the National Social Security. A strong leadership with a good vision and without individual or group interest is absolutely needed to make a national health insurance system works.

To meet the goal of universal coverage and to ensure fairness in health care financing, the opt-out provision of current health benefit program 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. The expansion of social health insurance is integrated, in law, with the other social security programs such as pension, provident fund,
and unemployment benefits. In addition, to be consistent with the goal of maximizing benefits to members the legal status of PT Persero--for-profit oriented, of PT Askes and PT Jamsostek will be transformed into a Trust Fund or a not-for profit Public Corporation. A National Health Insurance (NHI or in Indonesian called BPJKN) Agency will be established using the existing assets and employees of PT Askes and PT Jamsostek. It will be a single payer system, with some form of regional autonomy in negotiating prices and payment systems with local providers. The single payer system is taken to ensure a wide range of social solidarity and to ensure inter-regional cross subsidies. All employers, starting with employers having 10 or more employees, and gradually to employers employing one or more employees, will be mandated to enroll their employees to the NHI. The local district health offices must enroll the poor and the central government must share to contribute fund to cover the poor. Until all employees are covered, those who work in informal sector may join the scheme without any law enforcement. A contribution for the NHI is 6% of monthly salary. Employers and employees must share the contribution half-half.

To optimize social solidarity scheme and to fulfill the right of workers, the benefits of the compulsory health insurance scheme must be in reasonable and acceptable quality. Otherwise, higher income workers will somewhat resist to enroll happily. The benefits will be provided in the private health care providers and at least at second class hospital bed in public hospitals. This level of care will be acceptable by the majority of workers and will encourage employers and employees to join the scheme. The payment will be negotiated at regional basis between the Fund and association of providers facilitated by Regional Health Officers. Outpatient care will be delivered through family physician system while inpatient care will be provided by private and public hospitals paid on prospective payment system. By pooling a large number of workers, the scheme is expected to have a strong bargaining power to negotiate certain standards of care and certain level of prices from health care providers. Therefore, the compulsory health insurance scheme will have a strong power to provide cost-effective health care financing and delivery system in Indonesia. The administrative cost of the NHI is limited to 5% when the system enrolls all formal sector employees.
3. Introduction

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

As a developing country currently hit severe financial crisis leading to fall of national per capita income, Indonesia is struggling to finance health care for the poor known as social safety net program. At the same time, Indonesia is undertaking a massive government reform by decentralizing almost all authority, except fiscal, national security, foreign policy, and religious affairs to regional government. The crisis and the decentralization of authority have raised awareness and concern over a sustainable health care financing in Indonesia. It is critical to review how current health care financing affect the outcome of health development, as measured by traditional public health indicators such as infant mortality rate or outcome indicator such as access to health services. Additionally, health care financing through health insurance scheme will be reviewed to identify problems and potentials for development. In developed countries, health insurance especially social health insurance becomes one of the most viable solutions to improve health status of the population. However, health insurance alone will not be sufficient to overcome many health problems. This study reviews various health care financing scheme in Indonesia and recommend resource mobilization through expansion of social health insurance scheme.

More than thirty years ago, health insurance scheme for civil servants was first implemented in Indonesia. The scheme has evolved slowly but continue to evolve, despite
many problems and unsatisfactory services complained by members. The scheme is based on social health insurance concept and is now administered by a state own company, a for profit company, that is not consistent with the concept and philosophy of social health insurance. For more than two decades, other than civil servants have been not protected by any health insurance scheme. Various initiatives of health care financing in small scales such as community health insurance (dana sehat) has been introduced and promoted by the Ministry of Health without any significant effect on access to health services and on health status.

Ten years ago, for the first time a comprehensive Social Security Act of Indonesia was passed by the Parliament (Dewan Perwakilan Rakyat). The social security includes four basic benefits: provident fund, occupational injury, death benefits, and health benefits. The health benefits differ from other benefits in which participation is conditional mandatory upon availability of other health benefits provided by employers. Employers who may offer better benefits from those offered by PT Jamsostek may not join the social security scheme. The opt out option has resulted in low enrollments of health benefits and low coverage of health insurance for private employees. On the other hand, private health insurance scheme has grown faster that the public one. At the same time, the Ministry of Health introduced and promoted private insurance schemes based on managed care principles of Health Maintenance Organization in the United States called Jaminan pemeliharaan Kesehatan Masyarakat (JPKM). The confusion of and misunderstanding of managed care roles in assuring equitable health care financing among officials of the MoH and other health professionals have led intense debates over the continuation of JPKM in health care financing in Indonesia. Despite strong evidences that the development of JPKM was unsatisfactory and has been inconsistent with the goal of equity in health financing, the MoH continues to promote the development of JPKM. A thorough and objective review of managed care and JPKM will help health professional to understand why Indonesia need health care financing reform.

The review covers overview of current health policy and financing, access to modern health care by the Indonesian population and health care financing problems, especially from the public source. In addition, this review examines in details conception and managerial aspects of various health insurance schemes including Askes, Jamsostek, JPKM, and other private health insurance forms. At the end of the review we suggest various options for expansion of health insurance and recommend further steps to expand and to achieve a universal coverage.
4. Existing Health Care Policy and Financing

Indonesia is currently at the crossroads between centralized and decentralized governments and between strong state controls to market driven health care. In the health sector, reforms are being undertaken in various levels of governments to accommodate global changes and to respond to the local demand. The Ministry of Health (MOH) has set a vision of Healthy Indonesia 2010 by prioritizing four main elements of health sector development namely: healthy paradigm, professionalism, decentralization, and development of managed health insurance. This vision sets healthy life for all Indonesians in the year 2010. Many public hospitals are transformed into state or local government companies, legally for profit companies. In depth analysis, from the central government officials viewpoints, reveals that the transformation of vertical public hospitals into Perjan (state own companies) is to avoid inadequate capacity of local governments to manage the hospitals. While regional government officials accused that the transformation is a form of hesitation of central government to decentralize health services. State own pharmaceutical companies, previously appointed to ensure equitable distribution of essential drugs are being privatized to stimulate quicker response to market changes. The privatization of government pharmaceutical companies and transformation of public hospitals into a state own companies will likely to increase health care prices in improving quality of health services. However, this rise of health care costs may reduce access to necessary health services for the poor and nearly poor residents.

Infectious diseases continue to be a major problem for health services in Indonesia. However, expensive cured chronic diseases and HIV/AIDS are on the rise. Hospitals and other health care facilities must be equipped with resources to cure infectious diseases and the chronic and expensive diseases. Cardiovascular diseases have been the number one cause of death since 1992, yet tuberculosis and upper respiratory tract infections (URI) remain one of the fifth leading causes of death. The tuberculosis is combined with URI, the two cases have become the leading cause of death. Very few hospitals provide adequate cardiovascular services in the country. Public hospitals at district levels must focus their services to fight prevalent infectious diseases while public and private hospitals in urban areas must also provide expensive services for the growing chronic diseases’ patients. The market mechanism has shaped skewed distribution of specialists and other health care facilities in urban and big cities in Java. The pressure to provide more expensive equipment...
to accompany specialists in urban public hospitals has absorbed large amount of the
government budget for urban residents. It is estimated that more than 50% of specialists are
serving population in five big cities in Java. In contract, the cities have only about 15% of
the Indonesian population.

Significant policy changes accesses to essential health services in Indonesia come
from the devolution of health services and health care financing scheme from the public
sector. Under the regional autonomy law, financing of public health services is the
responsibility of city or district governments, the smallest local government units. The local
governments received block grant funds (dana alokasi umum) from the central government.
In addition to block grant funds, local governments receive additional income from local
taxes, portions of natural resources, and some earmarked central government budget in
health sector. Due to varying degree of awareness and local capacities, some districts
allocated significant portion of local government budget for health some others spend very
little for health. For example, a city of Depok in south of Jakarta spent only one percent of
the local government expenditure for health, while Jambi city spent 13% of government
budget for health. In term of per capita government expenditure, there have been also wide
variations. For example, in 2001 Solok district in West Sumatra spent Rp 1,141 (US 13 cent)
per capita while city of Padang Panjang in the same province spent Rp 80,045 (about US$ 9)
per capita. Before the devolution, the central government allocates health expenditure in
more equitable ways, depending on the per capita budget. The changes in local government
responsibility in financing and delivering public health services threaten equity in access to
essential health services across districts.

The pressure for policy changes in health care is reinforced by the recent currency
crisis in Indonesia. Among other Asian countries hit by the crisis, Indonesia suffered and
continues to suffer the worst. The Indonesian currency (Rupiahs) to US$ plunged from Rp.
2,500 in June 1997 to Rp. 13,500 per US$ 1 in January 1998 (the lowest). During 2002 the
Rupiah is floating around Rp 9,000 per US$ 1, still about less than one third of its value
before July 1997. As the crisis began to affect industries and individuals in early 1998, the
government realized that the burden of debts both in the public and the private sector was so
high (totaling around US $ 150 billion), a little less than the gross domestic product in the
year 2002 (estimated at US$ 170 billion). To pay the public debts, the government has been
selling state owned companies.

Following the financial crisis of 1997, while the Indonesian currency continued to
plunge, there have been many political, social, and economical changes through out the country. After July 97, the cost of living suddenly became four times more expensive for Indonesians compared to the beginning of 1997, while their real per capita income in US dollar fell to only one third of their income in the preceding year. The income per capita that had been around US $ 1,200 at current spending (it was estimated about US$ 3,200 using purchasing power parity) and then declined to around US $ 618 in 1998, is now about US$ 700.\(^5\) This condition has driven much social unrest in Jakarta and other parts of Indonesia. At the same time, devolution of political powers from the central government to local governments was unavoidable in all parts of the country, accelerating social and economical changes in Indonesia.

5. Stagnant Health Care Financing

Traditionally, health care financing for the public sector comes from the Ministry of Health, the Provincial health care budget, the District health budget, military health services, other sector spending on health, social health insurance corporations, and foreign aid and loans. The proportion of district health allocation becomes the largest health care financing source after the decentralization. Private sector health care financing comes from out of pocket payments by individuals and households, employers, and private insurance companies. The amount of money the private sector contributes on health care each year is not known since Indonesia does not have a reliable health account system. However, recent studies indicate that the private sector contribute much more than the public sector. According to the best estimates during the last ten years, health care financing from the public sector accounted only 23.7% of total health expenditure in 2000, down from about 30% five years earlier while the private sector contributed more than three quarter. Data on health expenditure show that health care financing in Indonesia is severely under funded, far below health care financing in Indonesia’s 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.\(^6\)
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>
<tr>
<td>Thailand</td>
<td>71</td>
<td>237</td>
<td>3.7</td>
<td>57.4</td>
</tr>
</tbody>
</table>

Source: Than Sein, Policy Brief, 2003

PCHE = Per Capita Health Expenditure; THE = Total Health Expenditure. GDP = Gross Domestic Product.

Table 1 shows data summarized from World Health Organization (WHO) in 2000 indicating that Indonesia spent only US$ 18 per capita on health in 1997, it increased only to US$ 19 in 2000, while the Philippines spent much more than Indonesia. In international dollars, Indonesia spent even much less than Vietnam with much lower GDP per capita. After the crisis when the GDP per capita of Indonesia plunged to about US$ above 700, much less than its per capita GDP in 1997, the health spending was much lower than Vietnam with the GDP per capita was US$ 382. Indonesia only spent 2.7% of its GDP for health while India and Thailand spent 4.9% and 3.7% of GDP respectively. For more than two decade, the central government of Indonesia has been spending less than 2% of the total government budget for health (see Figure 1) (Thabrany et al., 2002). This finding is consistent with study by Malik (1997) who found that public health care financing from central and local government expenditures had been never above four percent to total government expenditures. Separate analysis shows that since 1998 there has been significant increase in development budget for health. However, further in-depth analysis uncovers that the increase has been the results of foreign aids and loans for social safety net to alleviate the impact of severe financial crisis hitting Indonesia in 1997.
Figure 1:

Central Government Spending on Health as Percent of the Total Government Expenditures

In most European and developed Asian countries, the public sector contributes more than 50% of the total health expenditures because of strong social security or social health insurance systems. In ASEAN countries, the Philippine and Thailand are following developed countries moving toward more public financing for health. The public share on health expenditure in Thailand and the Philippines have been greater than the private sector. Among developed countries in the world, the United States (US) public spending on health less than 50% of total health care expenditure. Health care financing in Indonesia is dominated by the private sector, about 77% of the total health expenditure—mainly from out of pocket financing. This large portion of private health expenditure tends to increase since the early 80s when Roemer (1993) classify Indonesian health care system and the US health care system as entrepreneurial health care systems due to larger private roles than the Public. The large portion of private health expenditure in Indonesia leads to regressive and
unfair burden of health care financing to the population. The impact is clear. Large portion of Indonesian people could not afford to pay, even, essential health services, especially inpatient care and expensive outpatient treatments. The high infant mortality and maternal mortality rate of Indonesia may be strongly attributed to this regressive system. Although a World Bank report of 1993 entitle “Investing on Health” 13 had reached many decision makers in Indonesian Ministry of Health, apparently there has been very little impact of the report on health care financing policy in Indonesia. The government had not been convinced to prioritize and to invest more on health. The lack of political will by the government of Indonesia can be shown by the imbalance between health care allocation and the government revenues from tobacco excise. In 2002 the government received taxes from tobacco sales more than US$ 14 per capita but at the same time the government spent less than US$ 2 per capita on health.

The Indonesian government spending on health (in US$) at exchange rates during the last two decades have been varied from US$ 0.46 to US$ 2.49 per capita per year. The highest spending occurred in fiscal year of 1999/2000 because at that time, there was more money coming from foreign grants and loans for social safety net program in respond to the financial crisis. Although in local currency (Rupiah) the government spending on health increased constantly and significantly from Rp 368 per capita per year in FY 1979/1980 to Rp 13,513 in FY 2001, but in US $ the government spending remains stable on the average US$ 1.40 at exchange rates. This means that the central government has not pay significant attention to health in the last two decade. Despite the relatively low spending, the health risks increased significantly due to epidemiological and demographic changes.
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>916</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>1,210</td>
<td>32.1</td>
<td>1.17</td>
<td>14.7</td>
</tr>
<tr>
<td>1984/1985</td>
<td>1,492</td>
<td>23.3</td>
<td>1.34</td>
<td>14.5</td>
</tr>
<tr>
<td>1985/1986</td>
<td>850</td>
<td>-43.0</td>
<td>0.66</td>
<td>-50.7</td>
</tr>
<tr>
<td>1986/1987</td>
<td>767</td>
<td>-9.8</td>
<td>0.46</td>
<td>-30.3</td>
</tr>
<tr>
<td>1987/1988</td>
<td>1,055</td>
<td>37.5</td>
<td>0.62</td>
<td>34.8</td>
</tr>
<tr>
<td>1988/1989</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>8.9</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><strong>Average</strong></td>
<td><strong>4,479</strong></td>
<td><strong>22.6</strong></td>
<td><strong>1.40</strong></td>
<td><strong>11.0</strong></td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td>368</td>
<td>-43.0</td>
<td>0.46</td>
<td>-54.7</td>
</tr>
<tr>
<td><strong>Maximum</strong></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
The local government spending has not offset the low central government spending on health. Table 2 shows that the total government health expenditures, including central government, provincial government, and city/district government expenditures since fiscal year 1994 in US$ have been decreased. The conversion to US$ is very important since Indonesia imported more than 90% of medical supplies and raw materials for drugs. The high dependency on foreign supplies affects the purchasing power of government development expenditures. In US$, the total government expenditure on health during fiscal year 1994 to FY 2000 on average only less than US$ 3. The government expenditure on health in US$ for fiscal year 1997/1998 decreased 54.8% due to exchange rate crisis hitting Indonesia in mid 1997.
Table 3:
Government Development Spending by Local and Central Government per Capita

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Central (Rp)</th>
<th>Province (Rp)</th>
<th>District (Rp)</th>
<th>Total (Rp)</th>
<th>% Increase (Rp)</th>
<th>USD(^{3})</th>
<th>% Increase (US $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994/1995</td>
<td>4,680</td>
<td>573</td>
<td>1,148</td>
<td>6,401</td>
<td>-</td>
<td>2.90</td>
<td>-</td>
</tr>
<tr>
<td>1995/1996</td>
<td>5,277</td>
<td>717</td>
<td>1,242</td>
<td>7,236</td>
<td>13.0</td>
<td>3.14</td>
<td>8.3</td>
</tr>
<tr>
<td>1996/1997</td>
<td>5,845</td>
<td>896</td>
<td>1,443</td>
<td>8,184</td>
<td>13.1</td>
<td>3.43</td>
<td>9.2</td>
</tr>
<tr>
<td>1997/1998</td>
<td>6,343</td>
<td>755</td>
<td>1,761</td>
<td>8,859</td>
<td>8.2</td>
<td>1.55</td>
<td>-54.8</td>
</tr>
<tr>
<td>1998/1999</td>
<td>11,575</td>
<td>531</td>
<td>1,778</td>
<td>13,884</td>
<td>56.7</td>
<td>1.71</td>
<td>10.3</td>
</tr>
<tr>
<td>1999/2000(^{c})</td>
<td>17,832 (^{b})</td>
<td>2,676</td>
<td>20,508</td>
<td>47.7</td>
<td>2.86</td>
<td>67.3</td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>13,776</td>
<td>3,385</td>
<td>1,995</td>
<td>19,156</td>
<td>-6.6</td>
<td>2.04</td>
<td>-28.7</td>
</tr>
</tbody>
</table>

a) At average exchange rates at the same year.
b) Some local provincial expenditure is not available, not included
\(^{c}\) Total does not include provincial expenditure on health

6. Conceptual Problems in Health Care Financing

Since the beginning of the New Order government, the health care financing policy has aimed to provide affordable health care for all. The government constructed public health centers, sub health centers, and public hospitals in almost all districts. To ensure affordable health care, local governments set user charges (now it is often called prices) at ‘conceptually affordable by all”. The charges in health centers and sub health centers have been affordable for all because the majority charges have been all inclusive medicines for three days with uniform charges. The public hospital charges have been based on fee for services. The concept of affordable health care was understood by setting low room and boards, low charges of medical procedures and examinations, and other ancillary services. This is a “misconception” of affordable health care, since the true charges have been not determined in advance. The users have never been able, and will not be able to estimate how much they have to pay for health care. The uncertain nature of health care will not be met by fee for services charges, even though the unit of charges for each item is set affordable. It is affordable if the government fixed user charges per admission or per all-inclusive visit (including medicines).

The second problem in public health care financing in Indonesia has been supply side financing. The government provides facilities, health work forces, and all related equipments to public health facilities. To conceptually provide “affordable health care”, the government
set low user charges for each unit without appropriate costing. The cost recovery rates were low for all levels of services, especially in public hospitals. Since the public hospitals are located in the city or in the capital of districts while the poor normally reside distance from public hospitals, the middle class people receive disproportional public financing. The poor could not get access to the services because of relative unaffordable total costs (uncertain), higher transportation costs and other cultural barriers. More public financing goes to the better off than to the poor.

Efforts to establish a more appropriate public financing have been conducted since more than a decade but a significant change has not been conceived. Currently there are discussions to reformulate public-private financing for health care. The concept being discussed is that the government will only finance the public goods aspect of health services, while the private goods aspects will be financed by the private sector, except for the poor. This thought is derived from the concept of public and private goods. While the concept of public and private goods is clear, there is no direct relationship that the public goods must be financed by the government while the private goods must be financed by individual or private. The WHO report of 1999\textsuperscript{14} clearly recommends that certain private goods are justified to receive public finance, regardless of the income status of the population. There are two essential factors to be considered for public financing: externality and catastrophic financing. Current understanding of simplified division of public and private mixed in health care financing must be refined to appropriately establish fairness in health care financing. Without adequate understanding of the nature of health care, the appropriate health care financing schemes, and clear division of public and private roles in financing, Indonesia may be trapped into inefficient and ineffective health care system leading to more health care financing problems in the future.

In the delivery of health services, the trend is that the government will transform public health services into autonomous entities. It could be in the form of for-profit state or local government enterprises (BUMN or BUMD) or in other form. Health centers are also being transformed into autonomous health care facilities known as swadana. Much of this transformation aims at making financial management and the responsiveness of management to local demands more flexible. However, general trends of this transformation, the new facilities increased user fees while social protection (insurance) for those who cannot afford to pay health services is not yet established. One serious concern over this transformation is that higher user fees decrease access for the poor or nearly poor.
7. Direction of Health Care Reform

After the crisis, there have been strong initiatives to reform health care system in Indonesia. One of the more significant reforms is the Healthy Paradigm approach introduced by the Minister Moeloek and signed by President Habibie in 1999. Under this revival of public health paradigm, the Ministry of Health was taking a lead to the healthy public policy, healthy overall development, and healthy environment. 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 managed care schemes (JPKM), and decentralization of health services. However, this reform has not been systematically and widely implemented under the new Minister.

The requirement to sell only unleaded gasoline to reduce pollution of lead residues to provide blue sky is one example of healthy paradigm. A private, not-for-profit coalition has been set up to promote healthy paradigm. By promoting healthy lifestyle, the government expects to reduce the incidence of illnesses in the country and therefore there will be more productive days.

To improve professionalisms, nurse basic education that has been at high school level is now being upgraded to three years university education after high school (Diploma III). Many universities are now developing bachelor level (four year after high school) nurse education. Medical specialist training is now being transferred from university education into competency base training run by specialty societies. This transformation is expected to speed up the production of specialists in Indonesia. Currently there are only about one-fifth of 50,000 doctors in Indonesia are specialists. The shortage and misdistribution of specialists creates inequity in access to modern health care across the country.

The law of regional autonomy, including health sector, has been implemented nationwide since January 2001. While decentralization provides faster response and more appropriate policy in many aspects, 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 for local governments. On the other hand some rich districts, such as Musi Banyuasin, are planning to provide health services for free. So decentralization could end up with regional inequities in health care.
Efforts to expand JPKM had been done through promotion of JPKM Bapels (equivalent to for profit Health Maintenance Organizations in the US) and the creation of pre bapels using Social Safety Net money borrowed from the Asian Development Bank. However, more than 99% those pre bapels were not able to become a sustainable and promising bapels. A study by Ilyas (2003)\textsuperscript{16} indicated that all district health officials surveyed in Sumatra reported that no pre bapel survived. This massive failure of JPKM has given some impetus to reform the concept of JPKM. Several attempts by the MoH to establish a JPKM Law by mandating all citizens to chose a bapel aborted. The bapels—at least by the proposed law are for profit entities that will maximize profits to the stockholders.\textsuperscript{17} The original concept of JPKM and the proposed mandatory choices of bapels are not consistent with the concept of social health insurance that suppose to maximizes benefits to the members. A similar concept implemented in Chile\textsuperscript{18} have proved that running social health insurance by for profit entities lead to severe bias selection and to benefit investors more than the people. In addition, small capital of bapels could lead to serious solvency problems.

8. Existing Health Insurance Schemes

8.1. Civil Servant Social Health Insurance Scheme (Askes)

The legal basis of this scheme is based on Government Regulation No 69/1991 and Government Regulation No 6/1992. The number of insured in the civil servant compulsory health insurance (social insurance) scheme this year is a little more than 13,8 million members. The scheme is managed by PT Askes, a state own company. All civil servants and pensioners of civil servants and military personnel are mandated to contribute 2% of their basic monthly salary, regardless of their marital or family status. The government, central and local, had not contributed to the scheme. However, this year the central government is starting to contribute equivalent to half percent of the basic salary. All members entitle to comprehensive benefits considered medically necessary regardless of their rank or income. The benefits are provided in provider network; consist of mainly public health centers and public hospitals. Askes pay the providers using prospective payments, mostly on per case and per diem. The Ministry of Health and the Ministry of Internal Affairs determine the level of payment to providers to ensure that Askes could maintain its solvency. The only difference is that higher rank of civil servants are entitled to first class room and boards.
when they are admitted in public hospital, while the lower rank entitle second and third class room and board when they are hospitalized.

Initially, the scheme was administered by an agency within the Ministry of Health (BPDPK, Badan Penyelenggara Dana Pemeliharaan Kesahatan). However, under the Ministry the management of the scheme was tied to bureaucratic fiscal system that was not flexible to respond the changing needs and demand. In 1984, the agency was transformed into a Public Company (Perum Husada Bhakti), a state own company in which the employees of the company maintained to hold civil servant status. 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 autonomous status of state own company where the employees of the insurance carrier were no longer civil servants. After the transformation from Perum Husada Bhakti into PT Asuransi Kesehatan Indonesia, PT Askes is allowed to sell commercial products in accordance with the law. Currently by PT Askes is selling commercial insurance in the form of HMO products, on commercial basis, to more than 2,500 companies covering about 1.5 million members, increased from 131,635 members in 1994.

The membership growth of the compulsory scheme increased with the increasing number of civil servants and military pensioners. However, the number of members declined sharply in 1998 after the management conducted an audit of membership. Computerization of member services 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 by 2,173,448 from the number of members in the preceding year. In the year 2002, the compulsory members remain at about 13.8 million.

The growths of premiums for compulsory members, on average, have been lower than the growths of health care expenses. The government normally determines the salary levels of civil servants every two-three years. 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, such the case of 1999. Because the basic salary was unchanged, the premiums received by PT Askes did not increase during that year. On the other hand, health care prices must be adjusted to offset the high inflation rate of more than
80% at the same year. This trend threatens the sustainability of the social health insurance scheme for civil servants, especially during the coming decentralization and transformation of public hospitals into state own companies (called Perjan). Fortunately, the government determine reimbursement rates to public health providers so that Askes has been remained solvents.

**Figure 3:**

Askes Financial Performance, 1994-1999

![Askes financial performances](image)

*Source: Askes Annual Report, 2001*

Although, in theory, all members have the right to receive comprehensive health services in the provider network, mostly public health facilities, many Askes beneficiaries (especially upper income) did not use services they deserve to. 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. Many upper income members did not use outpatient services provided by Askes providers and simply pay out of pocket for services outside the network. There is no harmful for the members because the charges for outpatient care have been affordable. However, for catastrophic medical care, such as hemodialysis and open-heart surgery, almost all members used the services provided. 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). Upper income members often file complaints that they receive poor quality of services in the provider network, because they have been charged for several extras by the public providers to offset the low reimbursement rates set by the Ministry of Health. Recent surveys indicated that 80% of the members satisfied with the services provided in the network (Soetadji, 2002). It is conceivable that those 20% members who did not satisfy were mainly those who were in the upper income levels.

Regardless of member satisfaction, the implementation of Askes has benefited civil servants, pensioners of civil servants and army forces, their families, and their survivors for more than 30 years. For higher rank beneficiaries, the scheme has helped beneficiaries in access to expensive medical care and drugs. The scheme has been very helpful for retirees and 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 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 than half of beneficiaries used their insurance for outpatient care (Thabrany et al., 1999).

The Askes scheme is currently facing several problems. Before 2002, Askes members had to pay cost sharing that was very high, ranging from 30-60% 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 balance between the set prices and the hospital prices (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. 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 outpatient 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 state own companies followed by increase 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).

8.2. Private Employee Social Health Insurance Scheme (Jamsostek)

The legal basis for this social health insurance program (Jamsostek) is the Law No. 3/92 (Social Security law), the government decree (Peraturan Pemerintah) No.14/93 and the Ministry of Labor decree No. 05/93. The law also covers other three programs namely provident funds, death benefits, and occupational injury. However, the SHI program differs from other programs in several ways:

1. The participation of SHI is conditional. Employers who could provide health benefits (self insured) or could purchase more generous health insurance scheme are exempted. Because of this provision, the majorities of employers choose to opt out from Jamsostek and buy health insurance from insurance companies, JPKM bapels, Askes, or simply pay lump sum money to the employees.
2. Only employers are mandated to pay premium of 3% (singles) and 6% (married) of employees’ salaries while the employees pay nothing (non-contributory scheme).
3. The wage ceiling has remained Rp 1,000,000 (equivalent of US$ 120) per month since 1993, freezing revenues for SHI contributions while costs of medical care continue to rise.
4. The benefits are in kind, provided through various health care providers contracted, directly or indirectly, by Jamsostek. Other Jamsostek programs pay cash benefits to the beneficiaries.
5. The benefits are provided to the employees but and the family members—up to the third child.

8.2.1. Operational Problems

The regulation mandates all employers, regardless of the legal status of the entities, who employ 10 or more employees, to pay health insurance premiums for their employees
except the employers who choose and eligible to opt out. Employers having less than 10 employees but pay salary, in total, more than Rp 1 million a month are also mandated to enroll their employees into Jamsostek. If this law were enforced and no opt out option is possible, health insurance coverage would have increased to more than 100 million people or 50% of the population. But, the membership is increasing very slow from 199 thousand members in 1991 to 2.9 million people in the year 2002. The average growth of employers enrolling their employees to Jamsostek in the last ten years was 53% a year, but the number of employees enrolled grew only by 40% a year. The number of insured (members, including family members) grew even less at only 38% a year. This means that only small employers are enrolling their employees to Jamsostek. Larger employers opted out of Jamsostek. By 2002 Jamsostek covers less than 5% of eligible employees. On the other hand, in 2002, there were 18.8 million employees\textsuperscript{22} enrolled in the other three Jamsostek programs. Even the total number of employees enrolled does not cover the total number of employees as the law prescribes. A national labor survey estimated that there were 56.2 million workers fully employed in the year 2000.\textsuperscript{23}

Data from commercial insurance companies show that total membership of health insurance coverage in the 1999 was about 4 million people.\textsuperscript{24} Health insurance premiums (excluding personal accident insurance) received by commercial health insurance companies in 1999 was Rp 379 billion (including Askes); in contrast, in the year 2000, Jamsostek collected only Rp 155 billion of SHI contribution, much less than the total health insurance premiums received by the private insurers. The opt-out option benefited commercial health insurance schemes more than the Jamsostek and employees.
Table 4: Memberships Growth of Social Health Insurance of Jamsostek, 1991-2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Firm</th>
<th>Employees</th>
<th>Insured</th>
<th>Premium (Rp000)</th>
<th>Claim ratios (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>723</td>
<td>85,926</td>
<td>199,695</td>
<td>4,553,000</td>
<td>63.9</td>
</tr>
<tr>
<td>1992</td>
<td>958</td>
<td>110,345</td>
<td>238,022</td>
<td>8,280,000</td>
<td>62.2</td>
</tr>
<tr>
<td>1993</td>
<td>3,419</td>
<td>256,402</td>
<td>537,173</td>
<td>13,657,000</td>
<td>59.1</td>
</tr>
<tr>
<td>1994</td>
<td>5,624</td>
<td>458,257</td>
<td>963,619</td>
<td>28,263,000</td>
<td>67.5</td>
</tr>
<tr>
<td>1995</td>
<td>8,034</td>
<td>698,052</td>
<td>1,414,175</td>
<td>44,365,000</td>
<td>80.7</td>
</tr>
<tr>
<td>1996</td>
<td>9,452</td>
<td>961,594</td>
<td>1,725,618</td>
<td>64,314,563</td>
<td>79.7</td>
</tr>
<tr>
<td>1997</td>
<td>10,892</td>
<td>989,094</td>
<td>1,949,011</td>
<td>86,233,060</td>
<td>76.1</td>
</tr>
<tr>
<td>1998</td>
<td>14,225</td>
<td>1,110,478</td>
<td>2,338,075</td>
<td>100,220,435</td>
<td>88.5</td>
</tr>
<tr>
<td>1999</td>
<td>15,628</td>
<td>1,235,818</td>
<td>2,567,576</td>
<td>136,103,858</td>
<td>74.6</td>
</tr>
<tr>
<td>2000</td>
<td>16,707</td>
<td>1,321,844</td>
<td>2,699,977</td>
<td>155,360,770</td>
<td>65.4</td>
</tr>
<tr>
<td>Average annual growth 91-2000 (%)</td>
<td>53%</td>
<td>40%</td>
<td>38%</td>
<td>51%</td>
<td>71.77</td>
</tr>
</tbody>
</table>

Source: PT Jamsostek, Account Division 2001

The management of Jamsostek needs strengthening SHI to provide evidences that social health insurance scheme could be provided in an acceptable quality of services. Only through such high quality of services, memberships could be expanded. However, current administration of Jamsostek is not ready to take responsibility to manage larger membership. Current relative high claim ratio of an average of 71.8% (compare to the other three programs) and low revenues from SHI play a role to the lack of impetus to expand the SHI program. In addition, the benefits in kind have also complicated the management of SHI in which most of Jamsostek staff has lack of management capacity.

Due to lack of management capacity, in the past Jamsostek contracting the management of health care providers and health services to other parties called main providers (MP). The main MPs are JPKM bapels. Jamsostek paid capitation to MPs and then MPs paid other capitation or fee for services to providers –a reflection of poor capability of Jamsostek to manage direct contracts with health care providers. Certainly this subcontracting system leads to inefficient and higher operational costs since the main providers will also take some profits. Taking into account 20% administrative costs spent by PT Jamsostek and additional 20% administrative costs taken by MPs, the amount of money goes to health care providers becomes about 60% of the total contribution received. This high administrative cost in the end leads to low quality of health care benefits. The majority of
social health insurance schemes in other countries spent as low as 3% (Taiwan) up to 5% (in Germany) of the total contribution for administrative cost. The economy of scale of pooling one agency responsible for the administration of health insurance, such as the case in Taiwan, Canada, or even Medicare in the US can drive efficiency, up to 4% of contributions for administrative cost.

A lot of complaints from providers and dissatisfaction of contracting MPs led to discontinuation of most of the MP system. At present, Jamsostek is managing directly to contract providers with few exceptions. Several regions contract out patient services only with private providers, while others use mixed public and private providers. Several regions use public health centers as primary care providers (gate keeper) resulting in perception of poor quality by members. Members demand service differentiation from public health services provided by health centers.

Payment system to all health care providers cannot be made on capitation basis, as prescribed by the government regulation. The capitation payment system is required to assure that health services are delivered in a cost-effective way. However, in practice this payment system is not always possible. Doctors and hospitals are not ready for risk-contracting because they are not trained to accept risks and the market for fee-for-services is still dominant. The Ministry of Health regulation requires hospitals to set charges on fee for service basis. The environment is simply not supportive for capitation payment system, except for relatively small number of primary care physicians. Capitation payments to primary care providers are easier to make since the required number of members for primary care capitation is low and the variance of prices is also small. Capitation payment to hospitals is performed only in those branches with sufficient number of members (Purwoko and Mahmud, 1998).

8.2.2. Other Problems

The ceiling of salary for premium determination (one million rupiah) set ten years ago without adjustment is detrimental to Jamsostek financial condition. Under this ceiling, employers contribute only Rp. 60,000 (if married) or Rp. 30,000 (singles) per month for employees earning more than five million rupiah a month. If the ratio between employee and total members is 3 (on average two dependents for each employee) then the contribution is only Rp 10,000 – 20,000 per person per month. A commercial product sold by Askes cost Rp 20,500 per person per month for less liberal benefits. On the other hand, the private sector
continues to skim the cream by reporting lower salary levels and by reporting larger portion of single employees. Data show that the average contribution received by Jamsostek per member in 2000 was only Rp 5,224. Companies paying high salary have more incentive to opt out to obtain health insurance from private insurance companies (that perceived serving better services) rather than enrolling to Jamsostek. The low revenues from this social health insurance then put Jamsostek in difficulties in improving quality of services.

Another structural problem of Jamsostek is the limited benefit structures. For example, inpatient care is limited to 60 days, including maximum of 20 days intensive care unit. The level of inpatient care is limited to second-class rooms in designated public hospitals or third class room in designated private hospitals. Considering more limited choice of hospitals compared to a traditional health insurance product from the private sector, employers and employees will prefer the private insurance. Haemodialysis, cancer treatment, cardiac surgery, congenital diseases, and organ transplant, and all services provided by non-contracted providers are not covered (Supriyono, 1998). Because some expensive medical cares are not covered, many employees and employers consider that the benefits provided by Jamsostek are not sufficient and it is not worth to join.

8.3. Commercial Health Insurance

8.3.1. JPKM (HMOs)

JPKM stands for Jaminan Pemeliharaan Kesehatan Masyarakat is exactly the same as Health Maintenance Organization (HMO) products in the US. It is classified as commercial health insurance providing in kind benefits managed by various managed care organizations that are not insurance companies. The JPKM bapels (the HMOs) are actually non insurance companies selling health insurance. The JPKM concept was introduced by Health Act of 1992 as indication of strong US influence of the Indonesian health care system. More significant actions to promote the development of JPKM have been done since 1995. Since then, the Ministry of Health has been actively promoting JPKM to various actors such as local governments, private businesses, private insurance companies, and communities at large. The promotion of JPKM as managed care products aimed primarily at encouraging private sectors, mainly businesses, to develop bapels. A Ministerial decrees regulates requirements to be bapels. Bapels must meet capital requirements that are much less than the capital requirements for insurance companies under the Insurance Act (it can be less than 0.1% of the required capital for an insurance company). In addition, bapels must
provide comprehensive health services, quality assurance, utilization review, grievance procedures, and other cost and quality controls (but it is just in theory). Businesses that are willing to comply with and meet requirements will be granted a license by the Ministry of Health to sell JPKM. However, those requirements are good only in theory; in practices—so far, no bapels provide comprehensive health services, conduct quality assurance or utilization review and paying capitation to providers. Presently, the majority of licensed bapels are actually selling combination of managed care and traditional insurance products.

There are 22 licensed bapels (they are actually commercial HMOs because only two of them are not for profit entities) covering less than 500 thousands individuals in total. Compared to the regulation of HMOs in America where at the beginning of HMO introduction, 96% of HMO were not-for profit organizations, the JPKM regulation is much more liberal. The regulation requires that a bapel must be a legal business entity, while in Indonesia a legal business entity is understood as a for profit entity.

Although the Ministry of Health had worked hard to promote and to develop bapels, the result was not promising. All licensed bapels could not expand membership to larger population, no to mention to poor families as expected, since the majority of bapels are for profit entities. Several pilot projects funded by the USAID and the World Bank had been done in Klaten district and five other districts under the Health Project IV. Unfortunately, those pilot projects promoted business of managed care in small and relatively low-income districts. The premiums were set too low, without actuarial calculation, and the benefits are considered of inferior products. Definitely people, even the poor one, would not buy those inferior products. The results were obviously very disappointing and no success story is proven.

Efforts to encourage businesses and insurance companies to sell JPKM and expand memberships have not been fruitful. The conflicting concept of JPKM, which would combine business and social interests at the same time, and low capacity of the Ministry of Health to regulate, supervise, and understand the business of health insurance did not convince business people. Many insurance companies and even health officials within the Ministry of Health felt skeptical about JPKM. Currently, under heavy criticisms, the expansion of JPKM is being hold.

8.3.2. Traditional Health Insurance

Before 1992, many big companies provided health benefits to their employees on voluntary basis. The scope of health benefits vary significantly from cash benefits,
reimbursements, in kind benefits, or self provision of clinics or hospitals by the companies, depending on the size and location of the companies. There were no regulation mandating health benefits or regulating health benefit provisions. Many smaller companies often did not (some still do not) provide health benefits at all. The bargaining power of labor unions has been very weak (because of the over supplies of cheap labor) so that they rarely demanded health insurance coverage.

An Insurance Act was passed in February 1992 permitting insurance companies to sell health insurance products. The Ministry of Finance was the sponsoring agency to regulate insurance companies. However, this Act does not regulate health insurance contract. It regulates practices of insurance business in Indonesia such as life insurance, general insurance, reinsurance, and other supporting insurance businesses. Based on this Act, insurance companies may sell any health insurance products such as traditional indemnity health insurance, managed care (similar to JPKM), personal accidents, and other forms of health insurance. The Directorate of Insurance under the Ministry of Finance is in charge on the supervision, regulation, and controlling—mainly financial aspects such as solvency of all insurance companies.

After the introduction of opt out Employee Social Security Act (Jamsostek) in the same year, both life and general insurance companies, started to sell health insurance as riders or as separate line of businesses. Many insurance companies that had have long relationships with businesses for life or general insurance could easily convince the business to sell health insurance to employers. Several foreign insurance companies such as Cigna, Aetna, and Allianz that have experiences abroad could easily transfer the knowledge and expertise in selling health insurance in Indonesia. Although there relatively small number of companies that can afford to buy private health insurance at this time, the market for health insurance is promising. By 2001, 64 insurance companies sold various health insurance products (including personal accidents) covering more than 4 million people. The total premiums earned for health insurance products in 2000 was more than three times the amount of health insurance contribution received by Jamsostek. These traditional health insurance products are the fastest growing business of health insurance in the country.

8.4. Micro and Community Health Care Financing Schemes

The Ministry of Health introduced a concept of micro financing scheme called Dana Sehat or health fund in the 70s. At that time, it was conceived that the government fund for
health would be diminished because of the government financing would not be sufficient. Under this assumption, the traditional very low user charges in public health facilities would result in government financing for those who really did not need the government subsidies. The government financing for public health facilities had not been reaching the right population groups who deserved government subsidies while those who could afford to pay higher fees should do it and therefore there had been suggestions to increase user charges. Recommendations to increase user charges in public health facilities had been recommended by Gani et al (1997)\textsuperscript{31} and YPKMI (1994)\textsuperscript{32}. However, higher user charges might pose a threat on access to health services by low-income groups. Therefore, mobilization of private funds ought to be done to finance health care for their own. The Dana Sehat initiatives were introduced to respond to such recommendations. The same initiatives have been also introduced in many developing countries such as reported by Musau (1999)\textsuperscript{33}, Atim et al (1998)\textsuperscript{34}, and Edmond (1999)\textsuperscript{35}

However, Dana Sehat schemes in Indonesia have not address the access problems due to very low benefits and limited coverage. Households have been spending very low percentage of their total expenditure on health ranging, ranging from 2-4\% of the total household expenditures. This low health expenditure from household sources represents low ability to pay for health services. Data from Susenas show that many households in low and lower middle income must spend up to 80\% of the household income on foods. Therefore there is little money left to purchase other services and goods such as health care and education. The Dana Sehat schemes were introduced mainly to the poor and low-income households by setting the contributions based on consensus among those households. This targeting was a big mistake, since the low-income households suppose to receive financial assistance and those in higher income level that actually ought to contribute to the health funds. As a result, the contribution was set at very low, ranging from Rp 100 – Rp 1,000 (between US 10-20 cent at the current exchanges) per household and the benefits were mostly outpatient care at health centers. On the other hand, in the majority of the districts/municipalities, people could get access to health centers for Rp 1,000 (US$ 0.10) per visit. This is one reason why efforts to mobilize resources through Dana Sehat have been fruitless and not sustainable. There was no incentive for households to contribute to health funds when the household could pay health center services for the same prices.

A study by Thabrany and Pujianto using the National Socio-economic survey in 1998 found that only 1.87\% of the populations were holding health card or member of health
funds. The 2001 Susenas indicated that 0.43% of the population were holding this card. There was no significant improvement in the access to inpatient care among the health fund members, but there was about 47% higher utilization of health center services among the members compared to those who were uninsured or non-members. Studies by Silitupen\textsuperscript{36}, Iriani\textsuperscript{37}, and Asnah\textsuperscript{38} indicated that very few household paid contribution for more than two consecutive years. The studies found that drop out rates from the first year to the second year of health funds were between 60-90%. It is not surprising that since the introduction of this scheme in the 70s, there had been very little progress on this health fund schemes. After the social safety net program for about 18 million poor families was introduced during the crisis dana sehat schemes across the country halted\textsuperscript{39}.

### 8.5. The Social Safety Net Schemes

The social safety net program at the first concept consists of three different financial assistances to assure that the poor getting access to necessary health services. There were three different programs in health sector: (1) The first program targeted high risk pregnant women by providing block grant of Rp 10,000 per poor household directly to a village midwife. The midwife then could use the fund to refer high-risk pregnant mothers to a health center or hospital for further treatment such as drugs, services, or transportation costs. This program increased access to hospital services for quite severe cases such as bleeding and complicated delivery.\textsuperscript{40} (2) The second program was the promotion of JPKM (a model copied from health maintenance organizations in the U.S.). This program promoted the development of pre JPKM bapels (pre HMOs) by providing fund of Rp 10,000 per poor family to companies, cooperatives, or foundations seeking to establish an HMO in each district. The pre bapel retained 8% of the funds for administration and marketing HMO products to non-poor household. The objective was that after two years the pre bapels could expand membership to non-poor by selling the HMO products. Immediately, 354 pre bapels were created–the majority of those pre bapels were established by civil servants, pensioners or cooperatives of civil servants within district health offices. They had no experience of developing and selling HMO products ever. After one year, under heavy criticism, this program was terminated and the funds for the second year were not distributed. Evaluation of pre bapels in East Java and in South Jakarta revealed that the pre bapels had no prospect to become full HMOs (Ekowati\textsuperscript{41} 2000; Azwar 2001\textsuperscript{42}). (3) The third program was the assistance for health center services by providing block grant of Rp 10,000 per poor family...
to all health centers. The health center could use the money to buy drugs for the poor to supplement essential drugs supplied by the government. (4) In addition, public hospitals received some block grants for operational costs to care the poor. The program had improved access to the poor significantly. However, those in the marginally poor (not qualified for the assistance such as self-employed, part-time workers, seasonal workers, and farmers, but unable to pay for expensive medical care) still have financial problems to meet their medical needs. (Khumaedi, 2000) reported that more than 90% of the beneficiaries were actually the poor, met the means test, and about five percent of the beneficiaries actually could afford to pay part of the care.43

9. Other Problems in Access to Health Care

Health insurance for Indonesian is available from various sources. The oldest and largest health insurance scheme is the civil servant health insurance (Askes) established in 1968. The civil servant health insurance is a social health insurance covering all civil servants, retired civil servants, retired military personnel, veterans, and their families. The premium is two percent of monthly basic salary or pension that is deducted automatically by the Ministry of Finance. The benefit is comprehensive and provided in kind in public health facilities, but high cost sharing applies. The second largest health insurance scheme is the social security scheme for private employees (Jamsostek). In theory, this scheme should cover all private employees, but the regulation was diverted to have opt out provision. Unlike the Askes, Jamsostek 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 such as indemnity insurance, service benefits, and managed products. In addition, since 1992 the Ministry of Health has been promoting JPKM bapels (Indonesian version of controversial health maintenance organizations) as non-insurance companies selling HMO products. At present there are 67 insurance companies and 22 licensed JPKM bapels selling health insurance in Indonesia.

Health insurance coverage has been very low in Indonesia. A reliable source of health insurance coverage is the National Social and Economic Survey (Susenas) conducted annually by the Bureau of Census in Indonesia. Every three year, the survey includes a module of health survey specifically collecting health insurance coverage by types. The Susenas data of 1998 showed that only 14% of the population had health insurance of any types.44 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; a state owned company that administers compulsory health insurance. Jamsostek, another state own company that administer social security schemes, covers less than 1.5% of the population (the potential of this scheme is about 40-50% of the population). The low health insurance coverage by Jamsostek is mainly attributed to the “opt out” provision in the Government regulation number 14/1993. Other private insurance companies and JPKM bapels cover the remainder of the insured. For more than a decade the proportion of Indonesians who have health insurance remained relatively stable. In 1990 data published by the World Bank gave the proportion of the population with health insurance as 13% (World Bank, 1993). However, the absolute number of population covered has increased by almost ten million in the last decade due to the population increase. So the growth of health insurance coverage is about the growth of the population. 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 HMO products sold by PT Askes currently covered 1.3 million people while the number of people insured by other insurance companies in 2001 reached almost five million.\textsuperscript{45} An employer survey found that 82% of employers having 20 or more employees in Indonesia provide various kinds of health benefits, including purchasing private health insurance for their employees.\textsuperscript{46}

\textbf{9.1. Access to Health Centers}

Primary health care in Indonesia is delivered through public health centers and private clinics or doctors in solo practices. For 85% of the population who do not have health insurance, access to primary health care varies according to their economic status, individual preference, and availability of transportation to health facilities. Local governments normally set user fees in health centers at a very low level so that all people can afford. After the Regional Autonomy Law has been implemented, local governments will tend to raise user fees in order to recover the costs of providing basic health services that were funded by central government. User fees vary from Rp 500 to Rp 5,000 per visit including three days of medications across districts and provinces. The quality of services at public health centers, and sub health centers, are considered very poor such that the majority of the better off do not use health centers’ services. Instead, they go to private practices in the evening, often the same doctors who provide services in health centers in the morning. Private practices in the
evening aim to supplement their low income from government. Some policy makers are considering increasing user fees so that the health centers will have adequate funds to maintain certain level of quality. The trade off is that the poor or marginally poor may be excluded from services unless other scheme is in place.

Because user fees in health centers have been very low (less than the price of a bottle of drinking water) almost all people can afford to pay for the services. Often the problem is not in the price of services, but in the transportation costs. In rural areas, only one health center or sub health center is available for several villages or even for one sub-district. The travel costs to health centers can be the same or ten times more than the user fees set by local governments. Numerous studies have reported that access to health centers is good only for those living within one to two kilometers from the health center. Beyond that, many people have geographical barriers to health centers. Formal workers who normally live in relatively urban areas may not have geographical barriers to the services. To overcome geographical barriers, the government provides mobile health centers coming to remote villages at certain days. 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 levels of the communities. The better off who demand better services may visit private doctor in the afternoon. The chart below (Figure-2) depicts the relatively equitable access to primary health care for all group of the population (Thabrany 2001)47.

Figure-2 shows that the number of primary care visits per a thousand people by income deciles, from the poorest ten percent to the richest ten percent of the population, did not differ significantly. In other world, there has been equitable access to primary health care in Indonesia. There are some differences; however, 15 visit per thousand people between the poorest ten percent and the richest ten percent of the population (Figure 3). The poorest ten percent on average had 358 visits per thousand people per month while the richest ten percent had 373 visits per 1000 people. There were minor differences in primary health care visits between the insured and the uninsured. These minor differences were due to low health center fees, adequate distribution of health centers, sub health centers, nurses, general practitioners, and mobile health centers. If we examine visit rates to private doctor’s services, the differences between the poor and the rich were quite high. However, those who had low access to private doctor’s services had options to visit public health services with almost no barriers. This equitable access may diminish if local governments transform public health centers into swadana facilities and raise user 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, and administrative staff; while a sub health center has at least one nurse or a midwife plus administrative staff. There are currently more than 7,000 health centers and more than 21,000 sub health centers throughout Indonesia.48

9.2. Access to Hospital Services

Hospital services are available only in the capital of a city or district. Although the government has built one small hospital for every district with at least fifty beds and four types of specialists (internist, pediatrician, surgeon, and obstetrician), the hospital is quite distant from the rural residential areas. A district can cover area as wide as ten of thousands of square kilometers. In several large districts or municipalities there may be a private hospital. The majority of districts have only one public hospital. Geographical access to public hospital is more difficult than access to a health center.
Drugs and other medical supplies are not free of charge or inclusive in user fees in public hospitals. Patients must pay extra for medicines and medical supplies they need. In addition, a public hospital charges the patient for each item of all other services. This kind of charges, the financial barriers to meet the patient medical needs are very high.

Although, local governments normally set low user charges for hospital confinements, the true costs of a hospitalization may increase 3-10 times of the low cost of room and board. As an illustration in one public hospital in Jakarta the room charge for the third class services is only Rp 15,000 per day. A patient needing a surgical procedure and hospitalized for three days may end up receiving a bill upon discharge of Rp 900,000 covering the cost of operation, drugs, and medical supplies. A blue-collar worker earning Rp 650,000 (minimum wage) in Jakarta and having no insurance must spend more than one month of her/his salary.

Hospital services are designed to provide secondary or even tertiary care by specialists. However, in many occasions the specialists are not always available in public hospitals because they often spend more of their time in private hospitals or in private wards in the same public hospitals. This is especially true in big cities. The low-income patients must satisfy if one or two specialists visiting them regularly. Such conditions place public hospitals in perceived poor quality. Many patients are pushed to utilize second class ward or above to receive better quality of services, but then they have to pay more and there is almost no chance to have exempt or reduce charges.

Many low-income families simply did not go to hospitals because of they fear that the costs of hospitalization is not affordable. As a result, there is great inequity in access to hospital services, even at public hospitals. The barriers can be geographical, cultural, and financial. Financial barriers remain the largest factor. Figure-4 shows the 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 of inpatient days between the poor and the rich among Askes members remain high because the benefits are inadequate. According to many studies, insured civil servants before the year 2000 ought to pay up to 80% of the hospital costs and drugs (Trisnantoro et al. 2000^49; Thabrany 2001^50). However, currently Askes pay much more reasonable level after the government
increased basic salary of civil servants and contribute some funds to Askes. In several hospitals now, civil servants are exempted from cost sharing except for few expensive procedures.

A study by Thabrany et al (2000) found that the poorest 10% of the population had to spend 230% (2.3 times) of monthly total household expenditure for one inpatient care (Figure-5). Even the upper income class households on average ought to pay more than one month of their salary to pay an inpatient care of their family members. Despite low cost recovery rate of public hospitals, most low-income households could not get access to inpatient care because of costs of medical procedures and expensive but not subsidized drugs. Figure-4 and Figure-5 indicate high correlation between low inpatient days, household income, and high financial burden for inpatient care. This financial burden will continue or even heavier for households in the future because of transformation of public hospital and lack of insurance coverage.
Figure 5:
Hospital Inpatient Days Per 1000 People By Income Groups And Insurance Status, 1998.

Source: Thabrany, 2000
**9.3. Quality of Health Services**

Quality of health services, especially in hospitals, is difficult to measure because there is no standard, both in clinical and administrative services. The clinical standard developed by the Indonesian Medical Association provides only about 200 medical conditions/procedures and it is not widely accepted by specialists. Physical appearances of public hospitals and health centers generally are not attractive for middle and upper class. Upper class households generally perceive hospital services, even private hospitals, providing poor quality of services. Therefore, high class people and government officials often prefer to have medical procedures abroad, leading to large trade deficit in health sector in Indonesia.

One of important quality measures is the user satisfaction. However, there is no
national user satisfaction survey conducted in public or private hospitals. In general policy makers admit that the quality of services in Indonesia, especially in public providers, is poor. Evidences showing many patients went to Singapore, Malaysia or Australia for treatments are indicators of poor quality of health services in Indonesia. The poor quality of public health providers may also be judged by the fact that middle and high-income people tend to use private providers than public providers. Few facility surveys showed that 80-90% of patients were satisfied with services in public providers (Warnida, 200152 and Neneng, 200053). Some doubt the validity and reliability of such surveys. Accreditation of hospitals is not an indication of quality, since the accreditation process emphasis only on structural measures.

One of the more objective measures of quality is to examine how people choose medical care when they have options. The Susenas 1998 and 1999 data showed that even those who were covered by health insurance under Askes chose private health care facilities not covered by Askes. This means that those people prefer to utilize health care from the providers they believe providing better quality, even though they have to pay out of their own pocket. The proportion of insured civil servants who utilized outpatient care from private providers paid the full costs accounted for about half of the total visits.54 In general, people perceived that services in public providers, both out patient and inpatient services, are poor quality. The Jamsostek scheme that uses public health centers as gate keepers attracts only those in lower income.
10. Grand Design of Future Social Health Insurance in Indonesia

Currently there are three designs of Social Health Insurance Systems identified. The first one is the design proposed by the Task Force for National Social Security that integrates National Health Insurance with other social security programs. The Task Force was established by a Presidential Decree to meet the Constitution Obligation (article 34 item 2) to establish a social security for all citizens. This design will be further described in this paper. The second design is a proposal of compulsory health insurance with multiple HMOs proposed by the Ministry of Health. Under this scheme, all people are mandated to contribute to a selected bapel. The bapel must have a license by the MoH after meeting certain capital requirement. This concept is actually promoting the business of managed care (known as JPKM). The third design is a National Social Health Insurance Scheme proposed and agreed by the Parliament to be processed as the Parliament Rights to initiate a law. The content of the Parliament Bill on National Social Health Insurance is no difference with the concept of the Task Force, to be described later, except that the Parliament initiative allows the Single Health Insurance Carrier to offer integrated supplemental benefits.

The National Health Insurance (NHI), under the National Social Security Law is proposed by the Task Force. The NHI design has taken consideration of the fact that Indonesia is a very large country with 203 million people scattered in about 7,000 islands. The labor force is estimated at about 98 million people in 2003. The labor force is distributed at only 36.2% in wage and salaried workers, 51.9% in 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$ 800 at official exchange rates or about $ 2,600 in international dollars) with little disposable income for health insurance contributions. 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. The disposable income becomes very small for the majority of the population.

A social health insurance system, as the basis design for the NHI, relies on contribution from employees and employers (with some government subsidies for the self-
employed). 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 of 6% salary for health insurance, it may not affect their normal consumption significantly. However, if the total employee contributions for various social security programs are above 15% of their wages, the low salaried employees’ may confront with significant problems in their daily life. The National Social Security Bill design to take contribution about 10% of employees’ wages plus additional 10% contributed by the employers to cover health benefits, death benefit, work injury, provident fund, and the pension fund.

To be fair, the low-income people of non-salaried workers who have not joined the NHI scheme should entitle to subsidized medical care funded from the general tax revenues. These kinds of medical care have been available in public health centers and to certain degree in some public hospitals. Although the quality of services in public health centers or third class public hospitals in term of patient satisfaction is not good for middle class standard, it is accepted by the low-income. It is easier and more efficient for the government to provide subsidized health care in public health care facilities rather than asking the non-formal sector to pay regular contribution for a SHI scheme. The poor could be provided with membership of NHI scheme to whom the government pays the contributions.

Figure-7 depicts how the National Health Insurance system will work in the future. The NHI will be under of the National Social Security System. The grand design 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. The employers are mandated to deduct 3% of their employees’ salaries and employers add another 3% of employees’ salaries for contribution to the NHI. Pensioners must contribute 6% of their monthly pension income. 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. Employers must pay the contribution to Social Security Trust Fund (Badan Administrasi Jaminan Sosial Nasional, BAJSN) account along with contributions for other social security programs. Non formal sector who 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 by Actuarial Committee of the Board of Trustees of the National Social Security System every two years.

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 of higher quality of services. 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 and paid directly by the professionals on monthly basis along with the payment of monthly income tax. All people in this group must be covered by 2015. The Actuarial Committee of the NHI will calculate the levels of contributions annually for each region.

4. On Figure-6, the income curve line of salaried and self-employed professionals (solid line) moves to the right (there will be more people belong to this group) as time goes by and the economy of the country is improving. This means that the
members of the compulsory scheme are automatically expanding as formal employment picks up more people.

5. On the other hand, the incomes curve line for non-salaried workers (dotted line) will not move because this line also represents total population. As economy is progressing and more people are expected to enter into salaried or professional services, the number of non-salaried group will reduce. This process is expected to take 20-30 years.

6. The poor and marginally poor (low-income) in the non-salaried workers (under the solid horizontal line in the right) will be provided with subsidized premiums from the government budget and or other charitable organizations. To receive financial assistance from the government is subject to means test. The money for this assistance will be taken from general tax revenues or from the reduction of direct financing for health care providers or other subsidized services. 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 number of people of this group varies across regions. 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 away 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 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 receiving the government subsidies. By subsidizing health care at the point of services needs, there is no need to enroll to the NHI. The NHI will enforce this people to join the NHI in a later stage. However, they are free to join in the early stage on voluntary basis.

7. 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. The NHI will enforce membership to this group when all-salaried workers, the elderly, and poor are already covered. Once this group enter formal sector by becoming employees, then they automatically are mandated to join the NHI.

8. If the country tax system improves significantly, allowing income of the later group to be identified and collection of contributions either monthly or annually could be regularly collected, then they will be mandated to join the compulsory scheme. They may still purchase supplemental health insurance from the market if they perceive that the quality of services provided by the NHI is not adequate.
The NHI will focus (first) on those who are not currently covered either by Jamsostek, private health insurance, or enterprise provided health benefits. Gradually, after five years of the passage of the law, those who are not in the system but who are currently covered under the private schemes must join the NHI. This expansion stages will be accomplished by consistently provided quality of health services with less cost to employers and employees. It is expected that those who are currently covered under various health insurance systems will join the NHI because they will realize that they could get adequate benefits with less cost. The stages will be implemented in the following agenda (Table 5):
### Table 5: Agenda to Cover All Population in the National Health Insurance

<table>
<thead>
<tr>
<th>Year</th>
<th>Stage</th>
<th>People covered</th>
<th>Scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2009</td>
<td>I</td>
<td>Formal (waged) employers of $\geq 10$ employees, self employed professional, and pensioners in the private sector are mandated to enroll the NHI</td>
<td>Social health insurance is enforced during this period</td>
</tr>
<tr>
<td>2004-2009</td>
<td>I</td>
<td>Small employers ($&lt; 10$ employees) and self-employed can enroll the compulsory scheme at this stage. Those who are currently covered under private insurance scheme may transformed to the NHI without law enforcement</td>
<td>Social health insurance will not be enforced during this period</td>
</tr>
<tr>
<td>2004-2009</td>
<td>I</td>
<td>The poor and the marginal poor of informal sector (non-waged) are covered gradually starting from the very poor. Self-employed in upper income levels may join the NHI or purchase private health insurance</td>
<td>The contribution for the poor is paid by the government</td>
</tr>
<tr>
<td>2009-2014</td>
<td>II</td>
<td>Small employers ($&lt; 10$ employees) and self-employed in low income are enforced to enroll in the NHI All employers who are currently purchase private health insurance must join the NHI, but may still continue to purchase supplemental health insurance from the private sector</td>
<td>Social health insurance is enforced for all employers during this period</td>
</tr>
<tr>
<td>2015-2030</td>
<td>III</td>
<td>All people must be covered by the NHI during this period. The universal coverage is expected to be achieved during this period</td>
<td>Social health insurance and social assistance for the poor will be the NHI main business</td>
</tr>
</tbody>
</table>

### 10.1. The Benefits to Be Covered

The implementation of NHI cannot be separated with the existing health care delivery system. Generally, public health care delivery system is considered providing poor health services in term of patient satisfaction and physical appearance of the facilities. Currently the public providers are heavily subsidized, ranging from 70-80% of the total
investment and operational costs. In practice, middle class and high-income people do not use health services in public providers except services offered in the private wings offered by the public providers. On the other hand, private health care providers must provide (perceived) better quality of services to be able to attract significant number of users. In general, user charges in private providers are higher than the charges for the same services in public providers.

One of the important elements of the NHI scheme, to be sustainable and attractable, the benefits must be acceptable by those in middle and upper income brackets. Therefore, in the design of NHI, services must be delivered through private providers or equivalent quality of services offered in the private wings of public providers. The lower income brackets definitely will be happy to receive better quality of services than they normally get from the public providers. To be efficient and in order to prevent moral hazards, the benefits must be provided in kind, not in form cash payments. The scheme should not provide benefits from public health centers or third class public hospitals, except in the areas where a private provider is not available or for temporary natures. Inpatient care must be provided at least at the second class of public hospitals and of private providers. This will eventually increase the overall health care quality and expenditures. But this is necessary for successful NHI implementation. The providers (both public and private) must meet certain standards of services to be eligible to contract with the NHI.

The benefits will be comprehensive but some cost sharing will apply. Members must pay a portion of health care costs as cost control mechanism to prevent moral hazards. Cost sharing for out-patient care must be higher, proposed at 30% of the scheduled charges, set by a negotiation of NHI branch and association of health care providers in a region facilitated by Provincial and District Health Offices. The cost sharing for inpatient care and expensive medical procedures in outpatient basis is proposed at 10% of the charges, subject to maximum of one-month minimum salary. Drugs will be covered based on a special formulary developed by a Committee in the NHI. The NHI will conduct utilization review to evaluate appropriateness of medical procedures and treatments given by contracting providers. If there is no adequate provider in a region where the number of members is relatively large, the NHI is responsible for establishing or contracting providers from out of the region, even from foreign doctors if necessary, to ensure that those paying members will receive necessary health benefits.

Several services will not be covered by NHI. The services not covered include out of
the network health care, health care provided by hospital abroad except the hospitals are contracted by NHI approved to cost less for the same or better quality of services, drugs outside the formulary list, self-inflicted injuries, services covered by compulsory traffic accident insurance, alcoholisms and drug addicted care, and cosmetics.

10.2. Allocation of Health Insurance Revenues

The NHI is design to be financed by two main sources of revenues, the contributions from those who have regular income and the contributions from government for the poor. A nationwide employer survey found that in 2001 on average employer spent 5.2% of employee salaries for health benefits (Chusnun, et al, 2002). The proposed contribution of 6% salary paid by employer and employee will not be a significant additional burden for both employers and employees. Additional revenue will come from investment of idle funds and reserves.

Because of the nature of SHI is to maximize benefits for all, the NHI is designed to be very efficient. The Task Force decided to have a single payer system organized by a National Body (Badan Penyelenggara Jaminan Kesehatan Nasional, BPJKN) to ensure efficiency and portability of the benefits across the nation. At the first five years, when the number of contributors has not achieved an optimum level, the administrative expenses may not exceed 15% of revenues from contributions. As number of members is growing, the administrative expenses will be reduced to a maximum of 5% of the total contributions received by the 11th year of implementation. Currently Askes scheme spend between 10-15% of total premium revenues for administrative expenses. Any surplus from the operation will be deposited as reserve funds. The five percent administrative costs will be shared for national and regional expenses. Employees of the NHI will be hired on the basis of their competence in administrating social security or social health insurance.

Payment to health care providers will be made on prospective basis, but it is not the same for the whole nation as currently being implemented in the Askes scheme. Regional offices of the NHI will negotiate with association of health care providers in the region on the payment mechanism and the level of prospective payment. Both public and private providers meeting certain standard facility and health professionals are eligible for being the NHI network of provider. It is estimated that 80% of the revenues in a region will be used to pay providers in the region. About 10% of revenues in a region will be pooled into a national pool for cross-region expenses such as the case of referral care and to ensure portability. The
remaining 5% should be reserved for catastrophic expenses. The Actuarial Committee of the Board of Trustees will periodically examine the appropriateness of expenses across regions and to prescribe prudent spending for health care.

10.3. Health Insurance Law

Currently a Bill of National Social Security, including chapters of National Health Insurance, has been drafted. The Task Force and Commission VII of the Parliament already set up dates to discuss intensively the Bill. Both Task Force and the Commission VII have agreed that the National Social Security Law must be passed before the end of the Parliament term ended in June 2004. The law will mandate employers to enroll and pay contribution for NHI. In addition, the law will establish Social Security Trust Funds consist of one Administrative and Investment Trust Fund and two carriers (BPJHT and BPJKN) to deliver benefits to the members. The first one (BPJHT) is the carrier specializing in paying cash benefit covering lump sum payment at the pension age, monthly pension, death benefit, and temporary unemployment benefits. The second carrier (BPJKN) or the NHI will administer in kind benefits related to health and occupational injury. A National Board of Trustees consisting of 21 elected persons representing tri partite (employers, employees, and the government) will supervise the Trust Funds. The Board is a policy making body responsible for developing operational guidelines for investment and delivering benefits. The Minister of Health, Labor, Finance, Social Affairs, National Defense, Industry, and Cooperatives will appoint the Ministry representative for the Board.

10.4. The NHI

Because of the differences from other cash benefits the in kind benefits of health insurance will be managed separately from other social security programs (see Organization chart in the Appendix). The NHI (in Indonesian word called BP JKN) combines programs for civil servants, private employee programs, and the poor into a single pool. PT Askes, currently administered health insurance 14 million members of civil servants will be transformed into the NHI, changing the legal status of State Owned Company (PT Persero) into an independent not for profit Public Corporation. This combination permits maximum cross subsidy and portability of benefits in decentralized governments. At each region, a branch NHI will manage membership administration, payment with providers, delivery of health services, and providers’ claims. An oversight committee, representing tri partite, will

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1 This commission is in charge of social affairs, including health, labor, women, and population.
ensure that the program will run accountably and prudently.

10.4.1. Efficiency and Effectiveness

Combining compulsory health insurance scheme for civil servants, private employees, and non-salaried workers will improve overall efficiency in financing and delivery of health care to all citizens (universal coverage). Overall efficiency can be achieved through:

1. Collection of contribution will be integrated with other social security programs. This collection system is much more efficient than collection by each insuring agency and in pluralistic bapel system.

2. Information system as well as social security number (SSN) will be unified with all other social security programs using a unique and portable SSN for each member/beneficiary. This integrated information system will reduce duplication of coverage and memberships leading to higher efficiency and will ease portability of benefits in the dynamic labor market.

3. This system will provide large number of insured to be contracted with health care providers leading to higher possibility to pay providers on a uniform capitation or other prospective payment systems. These prospective payment systems will increase efficiency.

4. If non-capitation payment will be made, this system will allow free choice of providers.

5. A large number of members permit the system to utilize a gatekeeper system and promote the development of family physicians as gatekeepers. Thus this system will improve overall efficiency in delivering health care in Indonesia.

10.4.2. Advantages

As discussed above, there are advantages to workers and their families as well as to employers if all salaried workers are pooled into one NHI scheme. Additional advantages are:

1. Uniform benefit package for civil servant and private employees creates greater equity, simplicity and better understanding by members and providers of the uniform benefits (meeting medical needs).

2. Pooling all people into one pool creates maximum redistribution of income/financial burden for health services allowing effective cross subsidies from the rich to the
poor, from the young to the old, from the healthy to the sick, and from richer districts to poorer districts of the country.

3. Big pool will improve economy of scales that will maximize benefits to members. Similar schemes in Taiwan, Medicare in the US, Medicare in Australia, and National Health Insurance in South Korea and the Philippine spend administrative costs below 5% and can be as low as 3% of the total contribution revenues.

4. The big pool or single payer will create buying power to health care providers that in the end will have more power to control health care cost.

5. Pooling all Funds allows redistribution of health care providers in all regions in more equitable way. Under this pool, the money will follow patients. At present, about 25% of all doctors in Indonesia are residing and working in greater Jakarta, Jabotabek (to serve about 8% of the population).

6. Employers do not need to bargain health insurance premiums and benefits annually with private insurers. Bargaining with health insurers needs special skills and understanding of various benefits and health care costs. Thus, this system will permits employers to concentrate with their core businesses while their employees do not have to worry about changing benefits and insurers overtime.

7. This system will build stronger solidarity among employers and employees from various employments and regions. Thus this system will improve the Nation Building.

8. The not for profit status of NHI will no need to pay income tax and dividends for the government/stockholders. Any surplus will be returned to members in the form of services or accumulative reserves for improvement of benefits to maximize benefits to members.

10.4.3. Disadvantages

There are, however, disadvantages to employees and employers of this national pool as follow:

1. There is no choice of insurance carrier leading to potential dissatisfaction of some members, especially in the upper income. However, one should realize that choices of providers are much more important and much more meaningful than the choice of insurance carriers. Insurance carriers are just payers with little effect on the treatment process and outcomes. In this single payer system, free choice
of providers will be more likely compare to pluralistic HMO models formerly promoted by the MoH.

2. Combining PT Askes and PT Jamsostek into a newly carrier (BPJKN) could be affected by previous performances and perception of low quality of services created by inadequate premium level and misconstruction of the existing Jamsostek and Askes.

3. Current use of public health centers and public hospitals for Askes and Jamsostek members may generate distrust among those who are currently under private health insurance schemes. The private employees may perceive that the NHI will provide poor quality of health care as currently provided for Askes and Jamsostek members. To overcome this problem, for the first five years the new scheme must concentrate on those who are not covered by any scheme. Gradually the compulsory health insurance scheme must improve quality of services while proving that the scheme could provide quality of services with much less contribution compared to purchasing health insurance from the private sector.

4. The NHI will manage huge number of members in very diverse conditions and scattered population. Bureaucratic and uniform detail policy nation wide may create mismanagements. Some autonomous and flexible management styles, but within a framework of a national policy must be accommodated. For example, decision on methods and the level of payments to provider must be decentralized.

5. A national pool of the NHI will need a strong leadership by national decision makers and a very strong concept to obtain supports from various political parties and the private sectors. The Task Force must identify clearly and precisely all risks and supports needed by various stakeholders.

10.4.4. Potential Risks

Given the existing performance and perception of services provided by Askes and Jamsostek, the risk of failure to administer the proposed scheme is very high. Therefore, a very careful design and preparation to implement the scheme must be organized. The following issues need serious attention.

1. Currently there are five social insurance managed by state own companies covering traffic accident insurance (Jasa Raharja), Askes, Jamsostek, and the military social insurance (ASABRI). The association of social insurance in the
Insurance Council (Dewan Asuransi Indonesia) may perceive that they will be liquidated and therefore oppose the NHI idea.

2. The Ministry of Health already promoted JPKM for about a decade and efforts to establish bapels in each district have been done intensively. The NHI clearly will destabilize previous efforts done by the MoH, Provincial and District Health Offices (Dinas Kesehatan). They must be convinced that the NHI will benefit the people more than the current JPKM system. In addition, they must be well informed the market oriented JPKM will finally lead to skyrocketing health care costs and hurt the country the people. They must be convinced that the free choice-multi payer system will not lead to efficiency and equity.

3. Transformation of Askes and Jamsostek into NHI will require transfer of assets, liabilities, and employees. Identification of assets and liabilities and merging the two is a difficult and complicated job. This work may take years to finish with some risks of loosing some assets and increasing liabilities.

4. Political interests of so many parties currently working in Indonesian Parliament may hinder the NHI. Some parties may view that the establishment of NHI and the National Social Security Trust Fund will benefit only the ruling party. They may oppose the notion based on the political interests rather than the national gain.

5. The open and global market forces, especially those in insurance industries, will see the NHI as lowering the probability of making business in the health insurance field. They will be more likely to oppose the NHI.

6. The availability and the quality of health care providers may not suitable with the expansion of insurance scheme resulting in under serving populations who have contributed to the NHI. Current shortages of specialists, because of monopolistic behavior of medical specialty societies, provide high risks of undeliverable products to the contributors. In this case, the NHI must proactive to establish new providers or hire specialists from other countries.

7. The requirement of government, as employer to pay 3% contribution in contrast with 0.5% presently, will require addition expenses of about Rp 1.3 trillion annually. In addition, mandating central and local governments to pay contribution for the poor will need additional Rp 5- 8 trillion form central and local governments budget. Current fiscal problems of the government may delay
the coverage for the poor.

8. Employers in the private sector may object joining the NHI in the basis of increasing burden for contributions. Although in the long-run the NHI will be more likely to benefit the employers and the employees, current very competitive markets may push the employers to reduce labor expenses, thus opposing any mandatory contributions.

10.5. **Strategic Issues**

To be successful, before the NHI will start operating expansion and merging Askes and Jamsostek, several strategic issues must be carefully prepared.

1. At least two-year preparation is needed to set up management, information system, and human resources who are fully understand and skillful to run the system.

2. The government must develop easy and marketable name, vision, mission, goals, and strategic planning of the new Trust Fund.

3. Detailed standard procedures and forms must be developed in the very early, right after the NHI is passed by the parliament. It is estimated the at least two years preparation, by experts on full time basis, is needed.

4. Members of the Board of Trustees and Directors must be recruited professionally and from highly reputable, clean, and dedicated persons. Any doubtful persons will result in big failure.

5. The management should implement merit system to optimize benefits to the members and reduce potential corruption in managing large amount of money.

6. In the second year after the law is passed intensive training must provided for Board of Trustees, Board of Directors, managers of current Askes and Jamsostek, all operators of Askes and Jamsostek, and all providers interested in contracting with the NHI. Training can take several days for BOT to several weeks for operators.

7. Socialization or social marketing efforts must be executed to all stakeholders intensively through various media (TV, seminars, newspapers, magazines, local networks, web, etc.) at national and regional levels so that all stakeholders will be fully aware of the benefits of the NHI to them. They must understand that mandatory membership without exception will benefit them
instead of more burdens. The employers must understand that by pooling all resources into the NHI will give them competitive advantages in the global market by easily predict labor costs and therefore costing their products competitively.

8. In addition to socialization, the Trust Fund must always maintain a website providing current information on contributions, financial status, administrative expenses, medical expenses (claimed), surpluses, and development plans. This website will provide transparency in the management and must be accessible by any member at any time.

9. In addition to website conventional communication systems such as through newspaper, televisions, and radios must always be provided to members to encourage to support with any idea, concerns, critics, etc. to improve management of the Trust Fund.

11. Further Actions

* Subsidized study tours to neighboring countries (such as Australia, Taiwan, South Korea, Thailand, and the Philippines) for Parliament members, decision makers, employers and employees associations may help to pass the law smoothly. The aim of these tours is to desensitize employers and employees in resisting the NHI. They must see what other countries are doing with social health insurance/national health insurance system. Legal and policy makers and other stakeholders need to be convinced that the proposed NHI will provide more advantages than harmful to the stakeholders. Part of the travel costs must be borne by employers.

* Publication of various aspects of the NHI in Indonesia and in other countries through professional media (such as journals, text books, etc.) and public media (newspapers, televisions, magazines, and radios). The new scheme must provide at least 0.5% of the revenues in the first five years for these activities. Academicians, professionals, journalists, and independent writers must be given financial incentives to spread good news of the NHI in this country and in other countries. The main objective of this program is to make employers and employees who are currently under the opt-out option realize the benefits of joining the NHI.

* Incorporating social health insurance and social security topics in curriculum of medical, economics, nurse, and public health programs at various universities.
Special workshops must be undertaken for medical, nursing, and hospital communities including the students.

**Figure 8:**

Organization of the Social Security and the National Health Insurance Proposed by the Task Force

![Diagram of Social Security Trust Funds and National Health Insurance]

- **President**
- **Board of Trustee**
- **BAJSN (NSS Administration)**
- **BPJHT (other SS programs)**
- **NHI (BPJKN)**
- **Branches**

The Social Security Trust Funds

National level

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