Health Care Financing Arrangements: Experiences through Prepayment Mechanisms in Indonesia

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1. Scope and Definitions

This paper limits the scope and discussion of prepayment as a formal pool of health risk and share financing for health services through collection of contributions or premia specifically to cover some or all costs of health services in public or private health care facilities. By the above definition, financing health services through general taxation, social security and private health insurance are prepayment or health insurance mechanism (WHR, 2000), is excluded from the discussion of prepayment experiences in this paper. The contribution on general tax revenues does not separate the contribution and utilization of health services. In addition, only very small number of population (estimated at less than 2%) who formally contribute through general income tax. The health care financing in Indonesia is mixed between tax-funded financing, prepayment mechanisms, and out of pocket payments. Because the tax-funded financing does not guarantee access to, especially catastrophic care, this paper does not consider tax-funded health services in public health care services as prepayment. All people must pay user charges to receive care from public health centers or public hospitals. The charges are set at relatively low prices on fee for service basis. The levels of subsidies for each type of service vary from 70-80% of the total costs. Some officials considered the user charges as co-payments, but this argument does not eliminate financial risks because the so-called co-payments can consume more than 300% of household income to obtain health services in public hospitals (Thabrany, et al. 2002)

The term of prepayment, as it is used currently by WHO, is not appropriate here since this term does not explain the nature of risk sharing. In the prepayment, as it is used widely for phone cards, there is no risk transfer. The US Model HMOs often called prepaid health plan, the health insurance schemes sold by non-insurance companies. But the term of prepaid is no longer absolute (Fox, 1996). Some argued that prepayment is not insurance. If it is not insurance, then the separation of contribution and utilization, as emphasized in the WHR 2000 to ensure fairness in health care financing, will never happen because of no sharing of risk. The term insurance which facilitates risk sharing and risk transfer, and most frequently used in text books, is more appropriate for the topic discussed. The insurance mechanism inherently explain the aleatory risk transfer, with which a party can recover much higher than his/her contribution if there is high risk of ill-health that requires expensive medical procedures or treatments (HIAA, 2000). The key mechanism of insurance is risk
transfer and risk pool (Rejda, 1988; Dionne, 2000; Colaizzo, 2001; Willis and Hart, 2001; Doherty, 2000). But, one should keep in mind that insurance mechanism does not necessarily be undertaken by insurance companies. We should not afraid of using the term of health insurance to avoid confusion with commercial insurance. The term social health insurance is widely accepted and the social health insurance is normally administered by social security organizations throughout the world (Rejda, 1988; Butler, 1999; Dionne, 2000). For the above reason, I used the term health insurance more in this paper to describe prepayment.

2. Brief History of Health Insurance Development in Indonesia

Health care financing in Indonesia comes from the Ministry of Health budget, the Provincial health care budget, the District health budget, military health services budget, and other sector spending on health, social health insurance corporations, and private health insurance, out of pockets, and foreign aid and loans. The private sector financing comes from mainly out of pocket payments by individuals or households in public and private health care facilities, employer coverage, and private insurance. The amount of money the private sector contributes to health care is not known since Indonesia does not have a reliable a national health account system. However, recent studies indicate that the private sector contribute almost 80% of the health expenditures. According to the best estimates during the last ten years, public financing accounted only 23.7% of total health expenditure in 2000, down from about 30% five years earlier. In such heavy dependence on private—mainly out of pocket—health expenditures, health insurance mechanisms become viable alternatives.

In 1968, the health insurance scheme for civil servants was first implemented in Indonesia. Before the establishment of the health insurance scheme, civil servants received reimbursements for their health care. Several pilot projects were undertaken within the Ministry of Health, before the establishment of formal (by Presidential or Government Decree) of the health insurance fund. The scheme has evolved slowly but has been continued to evolve and to improve significantly, despite some problems and complaints by some members. Currently the scheme cover comprehensive health benefits for civil servants, civil servants families, civil servants and military pensioners and their families and the veterans. This is the oldest and the largest formal health insurance scheme in Indonesia. The scheme applies a social health insurance mechanism and is currently administered by a state own company, a for profit company known as PT Asuransi Kesehatan Indonesia (Health
Insurance Company of Indonesia). The ‘for profit’ objective of the company is not consistent with the concept and the philosophy of social health insurance.

Various community and voluntary initiatives of health care financing in small scales, community health funds (dana sehat), had been formally introduced and promoted by the Ministry of Health since the early 1970s through the promotion of Village Community Health Development (Pembangunan Kesehatan Masyarakat Desa). Since Indonesia had never provided free health care for the population, voluntary initiatives by the community to share resources to finance health care had been evolved since the 1950s using various names such as sickness funds, health funds, cooperative health funds, etc (MOH, 1994a). One model was introduced by the assistance of a private foundation in Banjarnegara, Central Java. Other similar schemes followed in East Nusa Tenggara and in Bali and then in many other regions of the country. Until 1994, there had been developed in 11,506 villages or 18.5% of the total villages. Most of the funds collected vary small contributions in the forms of cash contribution and in kind contributions. In addition, the community managed health care (Jaminan Pemeliharaan Kesehatan Masyarakat, JPKM), a copy of the health maintenance organization (HMO) concepts of the US model was also intensively encouraged by the Ministry of Health. The JPKM has been actively debated since the inception of the concept in the Health Act of 1992. The latter scheme is formal, in a way that the MOH made regulations on the benefits, premiums, and formal licensing mechanisms. The Ministry of Health (MOH) in 1999 set a vision of Healthy Indonesia 2010 by prioritizing JPKM as one of the four main elements for health sector development: healthy paradigm, professionalism, decentralization, and development of managed health care (JPKM) (MOH, 1999). Both community schemes and the JPKM, so far, have no significant effects in fairness in health care financing and on health status of the members due to insignificant benefits and contributions resulting from poor (no) actuarial calculations.

In 1992, for the first time a comprehensive Social Security programs were introduced through the passage of the Social Security Act. The social security Act mandates private employers and employees to contribute portions of their wages to finance four basic benefits: old age, occupational injury, death, and health benefits. The health benefits differ from other benefits in which the mandatory membership is conditional upon the provision of health benefits by employers through other channels. Employers who already offer better benefits from those offered by the SS schemes are exempted from mandatory joining the social security scheme. The scheme is administered by PT Jamsostek, a for profit state enterprise.
The profit objective of the enterprise is also peculiar in the implementation of social health insurance or social security system which creates high dissatisfaction and complaints. This scheme has not attracted many participants from the private sector.

3. Evidence of Current Health Insurance Coverage

Of the 212 million of Indonesian population, roughly 20.6% of the population is covered with some kind of health insurance. Data from the socio-economic survey (Susenas) of 2001 indicates that about seven percent of the population is covered by Askes, the most comprehensive scheme. The second largest health insurance coverage is the health card scheme, the social safety net (SSN) program introduced by the government in response to the economic crisis in 1999. The health card program was distributed through pre JPKM agencies. The relatively low proportion, 5.4%, of the population is covered under traditional health insurance schemes or under the employees’ benefit programs offered by employers. The benefits of those insurance schemes are not comparable one to another and therefore one should not assume that those 20.6% of the population is completely free from financial risks once they are suffer from a severe or catastrophic illness. Detail discussion of each types of health insurance is provided later.

Table 1.
Health Insurance Coverage in Indonesia, Susenas 2001

<table>
<thead>
<tr>
<th>Type of health insurance</th>
<th>% population</th>
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<tbody>
<tr>
<td>Askes</td>
<td>7.12%</td>
</tr>
<tr>
<td>Jamsostek</td>
<td>1.50%</td>
</tr>
<tr>
<td>Health Card, including JPKM</td>
<td>6.50%</td>
</tr>
<tr>
<td>Others</td>
<td>5.40%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>79.40%</td>
</tr>
</tbody>
</table>

The data of health insurance coverage in Indonesia is not easily available because there is no regulation mandating insurance agencies to report memberships or policies to a single entity. Each institution has their annual report but annual reports published by private insurers or HMOs are difficult to compare since the format and the contents of the reports are not standard. At this time, the only source of information to assess the prevalence of insurance coverage is from the Susenas survey. The Susenas survey collect health insurance information every three years, starting 1998. There are seven types of health insurance available: Askes for government employees, social security (SS) or Jamsostek for some
private employees, employer covered benefits (EC), health funds (HF), health card (HC) of the SSN program, JPKM, and other insurance (OI) including private insurance companies. However, because the design of the survey depends heavily on the respondents answer, the results are subject to recall and information bias. As can be seen on table 1, the prevalence of social security and JPKM coverage were higher than it should be due to information bias. Many respondents did not aware, for example, that they actually had no health coverage from Jamsostek but they did have coverage for other program in Jamsostek. As a result, when they were asked weather they have health insurance from Jamsostek they mistakenly reported that they do. The same bias occurred when they were asked about JPKM. Because the distribution of health card in the social safety net program was channeled through a newly established JPKM organization, the respondents reported that they have JPKM coverage, where it was actually health card coverage. The confusion between JPKM and health card was rampant during the pilot project of JPKM using the SSN fund. Because of this reason, health card and JPKM were grouped into one in the table 1.

How do we know that some respondents mistakenly reported their health coverage? The Susenas provides additional information about the types of employments or source of main income for the households. By examining the pattern of health insurance coverage and the sector to which the household received main income, one could safely conclude the coverage. For example, the majority of farmers would not purchase health insurance from insurance companies or received insurance coverage from Jamsostek, unless they were employees of a large company doing business in agriculture. However, such company is very rare in Indonesia. The table 2 below indicates that those who work in agriculture and reported having health insurance actually had health card, which was the SSN program distributed through a JPKM institution. More than 15% of those working in agriculture reported having JPKM. From the assessment of licensed institutions to sell JPKM, none of them sold their managed care products to people works in agriculture. From this assessment it can be concluded that those who reported having JPKM were actually having health card scheme. The number of people having health insurance coverage through social security scheme could be obtained precisely from PT Jamsostek. By 2001, PT Jamsostek reported having active members for health insurance coverage were 1.3 million employees (2.9 million members) (Jamsostek, 2003).
Table 2.
Distribution of Health Insurance Coverage by Employment Sector, Susenas 2001

<table>
<thead>
<tr>
<th>Sector</th>
<th>Distribution of Insurance Types as Reported by Respondents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Askes</td>
</tr>
<tr>
<td>Agriculture</td>
<td>7.8</td>
</tr>
<tr>
<td>Mining</td>
<td>4.9</td>
</tr>
<tr>
<td>Industrial</td>
<td>4.6</td>
</tr>
<tr>
<td>Utilities</td>
<td>29.5</td>
</tr>
<tr>
<td>Construction</td>
<td>8.4</td>
</tr>
<tr>
<td>Automotive</td>
<td>14.3</td>
</tr>
<tr>
<td>Retail</td>
<td>25.9</td>
</tr>
<tr>
<td>Wholesale</td>
<td>11.8</td>
</tr>
<tr>
<td>Import-Export</td>
<td>10.3</td>
</tr>
<tr>
<td>Transportation</td>
<td>12.7</td>
</tr>
<tr>
<td>Financial services</td>
<td>24.7</td>
</tr>
<tr>
<td>Health and Education</td>
<td>84.3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>28.1</td>
</tr>
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</table>

3.1. Civil Servant Social Health Insurance Scheme (Askes)

The legal bases for this scheme are Government Regulation No 69/1991, No 6/1992, No 28/2003. The scheme covers about 13.8 million members (almost 7% of the population). 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 status. Starting 2004, the government is mandated to match the contribution 0.25%, to be increased annually to reach the matching of 2% by 2007. All members entitle to comprehensive benefits considered medically necessary regardless of their wage levels. The benefits however differentiated into three non-medical levels of services. The highest rank of civil servants are entitled to first class room and boards, the middle one are entitled in the second class room, and the lowest rank are entitled to be hospitalized in the third class room. All other medical benefits, deemed medically necessary are not discriminated by the ranks. The benefits are provided in provider network; consist of mainly public health centers and public hospitals. Askes pay the providers using prospective payment systems: capitation, 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.

In addition to administering the compulsory scheme, PT Askes is permitted to sell commercial products to the private sector. Currently PT Askes has maintain contracts to over
2,500 companies covering about 1.5 million members; increased from 131,635 members in 1994. The commercial members are entitled to various levels of health benefits, arranged on managed care principles, provided by public and private health care facilities. There are five different products differ one to another on the basis of comprehensiveness of the benefits and the non-medical benefit levels such as VIP room if a member is hospitalized, or even hospital benefits in Singapore and Australia. Payments to the health care providers are negotiated on prospective bases. For each level of benefits, premium is set and negotiated based on underwriting assessment of the prospective groups. Premia are adjusted to ensure that the benefits will be adequately financed.

The growths of premiums for compulsory members, on average, have been lower than the growths of health care expenses because the government normally determines the wages not on a regular basis. On the other hand, health care prices, especially drug prices increase annually to compensate inflation and exchange rates. To ensure that PT Askes remain solvent, the government determines payment rates to public hospitals, which are normally below the publish rates (of hospital services) determined by local governments. The differences between the publish rates, applied to all citizens not covered by Askes, may vary from 0-50% depending on the size and location of hospitals. The price differentials often become the hot debates between the hospital directors and PT Askes. Often the hospitals charge the differences to the members creating dissatisfactions on both hospitals staff and the members. The status of PT Askes as a state enterprise seeking profits creates more tension between the stakeholders. The implementation of social health insurance in other part of the world normally on not for profit basis so that even if public hospitals are reimbursed under the costs, the complaint is minimal since the insurance carriers do not take any profit to be paid as dividends. This legal status of the carrier is being considered to be a not for profit state enterprise under the National Social Security Reform Bill under debate in the Parliament.

Although, in theory, all members have the right to receive comprehensive health services, many Askes beneficiaries—especially the upper income—have not used their entitlements due to perceived low quality of services and hassle ness to obtain the benefits. Susenas data showed roughly that one third of the members who demand health services claimed their benefits. Others simply pay out of their pocket. However, for catastrophic medical care, such as haemo-dialysis and open-heart surgery, almost all members used their entitlements. About 75% of patients in the centers for haemo-dialysis are Askes members as
contrast to the 7% proportion of Askes members to population (Thabrany, 1999). Despite some complaints and hesitant to use benefits provided by Askes, 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.

The Askes is facing several problems in line with the trend in the country to transform public hospitals into autonomous or state enterprise hospitals. The transformation is followed by price increases as the perception spreads that autonomous hospitals will no longer received the government subsidies. The second significant problem is the perceived poor quality of health services provided in public hospitals. The third problem is that the third child and beyond and related pregnancy treatments are not covered. The fourth problem is the relative adverse selection of the scheme that covers military pensioners (when health risks are higher) who were not covered during their active duties. The last problem is the demand for decentralized management in line with the Law of local autonomy being implemented in the country.

3.2. Private Employee Social Security Scheme (Jamsostek)

The legal basis for this Jamsostek is the Social Security law. All employers having 10 or more employees are obliged to join Jamsostek. The Law prescribes that (1) the participation of health insurance program is conditional; (2) only employers are mandated to pay premium of 3% (for singles) and 6% (for married) of wages (non-contributory scheme); (3) the wage ceiling has remained at one million Rupiah (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 provided to the employees but and the family members—up to the third child (Jamsostek, 1999).

The membership has grown very slowly from 199 thousand members in 1991 to 2.9 million people (1.3 million employees) in the year 2002. Only small employers are enrolling their employees to Jamsostek while 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 enrolled in the other three Jamsostek programs (Jamsostek, 2003). A national labor survey estimated that there were 56.2 million workers fully employed in the year 2000 (ILO, 2000). Data from commercial insurance companies show that total
membership of the private health insurance coverage in the 1999 was about 4 million people (Djaelani, 2000). In addition, currently there are 1.5 million members of PT Askes, from the private sector. The membership profile clearly indicates that many employers are reluctant to enroll their employees to the Jamsostek. This feature indicates some inherent operational problems within Jamsostek.

The first problem is that Jamsostek has lack of management capacity to organize health program, especially in dealing with health care providers. The second problem related with the ceiling of salary for premium determination that has never been updated since ten years ago. As a result the average contribution received by Jamsostek per member has been very low (in 2000 it was only Rp 5,224) (Jamsostek, 2002). A commercial product sold by Askes cost Rp 20,500 per person per month for less liberal benefits (Askes, 2002). With low average contribution, Jamsostek could not negotiate with high quality of providers and therefore ruining the trust from the employers. 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. Haemo-dialysis, cancer treatment, cardiac surgery, congenital diseases, and organ transplant are not covered (Supriyono, 1998). This will further discourage employers to join Jamsostek.

3.3. Commercial Health Insurance

3.3.1. JPKM

The JPKM (HMO) product is classified as commercial health insurance providing in kind benefits managed by various managed care organizations. The Ministry of Health (MOH) had been promoting JPKM to expand memberships which culminated by the stimulating the growth of JPKM bapels. Using the SSN funds, the MOH provided incentives to set up a pre bapel, a private corporation or foundation, to be developed as licensed JPKM organizations. A simple explanation of bapels is that the bapels are non insurance companies selling health insurance in the form of managed care product. The managed care product is insurance product because it is involved risk-transfer with aleatory contract. The promotion of JPKM was based on the Health Act of 1992 which prescribes the government to encourage the development of JPKM. Ministerial decrees regulate requirements to be licensed to sell these types of health insurance. As HMO in the US, the capital and other requirements for a bapel (HMOs) are different from the requirements for an insurance
company. The difference is that in the US, the supervision of the HMOs, mostly attach to state insurance departments while in Indonesia it is fully under the MOH.

However, in theory a bapel must offer comprehensive benefits but in practices—so far, none of the 24 licensed bapels provide true comprehensive benefits because of small capital and small operations. The majority of licensed bapels sold combination of managed care and traditional insurance products because the market demands such products. Actually the largest JPKM bapel is PT Askes that administered health insurance for civil servants. But, it is rarely acknowledged since PT Askes is not licensed by the MOH, instead it is licensed by a government decree which has higher legal status. Of the 24 licensed bapels only two were not for profit because the MOH decrees require for profit status. In the US at the beginning of HMO introduction, 96% of HMOs were not-for profit organizations (HIAA, 1997).

The largest pilot project in Klaten district, funded by USAID, was failed due to incompatible market and the concept of JPKM. The premiums were set too low, without actuarial calculation and the benefits are inferior. Efforts to encourage businesses and insurance companies to sell JPKM have not been fruitful due to the conflicting concept of JPKM as a commercial insurance with the requirement to accommodate social functions. In addition, the Ministry of Health has no adequate capacity to regulate, supervise, and understand the business of health insurance. Currently, the expansion of JPKM is being hold.

3.3.2. Traditional Health Insurance
Before 1992, many big companies provided health benefits to their employees on voluntary basis. An Insurance Act was passed in February 1992 permitting insurance companies to sell health insurance products at the same time, the social security laws prescribes conditional mandatory health coverage. It seems that the ‘opt out’ clause in Jamsostek law was aimed to provide opportunity to insurance companies to sell health insurance to employers. However, this Act does not regulate health insurance contract. It regulates practices of insurance business therefore insurance companies may sell any health insurance product: traditional indemnity or managed care (similar to JPKM).

Both life and general insurance companies started to offer health insurance as riders or as separate line of businesses. They have market advantage because they have long relationships with employers in selling life or general insurance products. By 2000, insurance companies earned premium for health insurance of more than 360 billion Rupiah (Djaelani, 2002), more than double the amount collected by Jamsostek. Their market
performance in term of the number of people covered and the amount of premium earned much better than JPKM bapels that did not have experience and small capital. However, only large employers purchase health insurance from insurance companies. Medium and small employers do not buy insurance and did not join Jamsostek. This bias selection undermines the effort to provide health insurance for all employees. Therefore, many experts demand that the opt out option in the SS law must be taken out to ensure that all employers provide health insurance for their employees (Mochtar, 2002)

3.4. Micro and Community Health Care Financing Schemes

Dana Sehat and other community health care financing was thought to be a vehicle after the recommendations to increase user charges of public health facilities by Gani et al. (1997) and YPKMI (1994). Higher user charges might pose a threat on access to health services by low-income groups and mobilization of private funds was perceived to be able to offset the recommendation. The same initiatives have been also introduced in many developing countries such as reported by Musau (1999), Atim et al (1998), and Edmond (1999). Experiences shows that Dana Sehat failed to address the access problems due to very low benefits and vary small population coverage. The Dana Sehat schemes were introduced mainly to the poor and low-income households by setting the contributions based on consensus among the households. There was no incentive for households to contribute to dana sehat when the household could pay health center services for the same prices as they contribute as premium.

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 Susenas 2001 shows that only 0.43% of the population joined a dana sehat. Studies by Silitupen, Iriani, and Asnah 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 dana sehat were between 60-90% annually. In addition, there was no significant improvement in the access to inpatient care for the members, because most dana sehat did not cover or only provide insignificant amount of lump sum when a member is hospitalized. These low levels of benefits discourage long-term membership. It is not surprising that since the introduction of the schemes, there had been very little progress. After the SSN program for about 18 million poor families was introduced during the crisis dana sehat schemes across the country halted (Azwar, 2001).
3.5. The Social Safety Net Scheme

The social safety net program was to provide financial assistance to assure that the poor have access to 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 (about US$ 1.2 in 2004 exchange rate) per poor household per year 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. This program increased access to hospital services for severe cases such as bleeding and complicated delivery (Hasan, 2000). (2) The second program was the promotion of JPKM by providing fund of Rp 10,000 per poor family per year to pre bapels. The pre bapel retained 8% of the funds for administration and marketing JPKM products to non-poor households. It was expected that after two years the pre bapels would be able to sell JPKM products and then self-sustained. Throughout the country, 354 pre bapels were created—the majority of those pre bapels were established by civil servants or pensioners of civil servants within district health offices of each district. They had no experience on doing business of health insurance. After one year, under heavy criticism, this program was terminated. Evaluation of pre bapels revealed that the pre bapels had no prospect to develop (Ekowati, 2000; Azwar, 2001); (3) the third program was the block grant of Rp 10,000 per poor family for health centers. The health center could use the money to buy drugs to supplement shortage of essential drugs; (4) in addition; public hospitals received some block grants for operational costs to compensate care for the poor.

This program had improved access to the poor. However, those in the near poor (not qualified for the assistance but unable to pay for expensive medical care) still have financial barriers to meet their medical needs. The SSN program was funded from a program loan from the Asian Development Bank. The loan was terminated in 2001 and then the government continued the program by directly distributed funds, taken from transferring some subsidies for gasoline or petrol, to hospitals and district health offices.

4. Strategic Purchasing

Strategic purchasing is an essential element of health insurance schemes because once a person is insured, the demand for health services increases. A liberal benefit would stimulate moral hazard and higher unnecessary utilization. The trade off between insurance and moral hazard must be managed by prudent purchasing of health services, including preventive measures. The Indonesian health insurance schemes, from the *dana sehat* to
Askes and Jamsostek that is managed in large scales, are designed to implement some managed care techniques to control costs and to reduce moral hazards. For example, the Jamsostek and JPKM law specifically prescribes capitation payment. The Askes scheme also uses the term ‘efficient purchasing’ to allow more flexible prospective payment systems. Except the traditional indemnity insurance sold by insurance companies, all other schemes use managed care techniques such as: limiting benefits in pre contracted providers (close system) and use prospective payment such as capitation, per diem, per case, or negotiated fee for services.

Although prospective payments and drug formularies have been used in the strategic purchasing, costs of drugs remain the largest expenditures among the insurance schemes. Sulastomo (2002), for example, reported that until 2001 the Askes scheme spent 52.85% of the total expenditure on drugs. Askes has been using drug formulary system (comprise of generic, brand names, and me too drugs) where pharmaceutical industries competitively bid for lower prices. Still, the proportion of drug expenditures to total expenditure remains high. This was due to low reimbursement levels for medical and hospital services.

5. Current Reform

In January 2004, the President of Indonesia has submitted a National Social Security Bill aimed at reforming social security system in Indonesia. The President has been very committed to provide social security for all citizens. The Bill lays the foundation for universal coverage by mandating all employers to cover health benefits through a new status of social security organizations, including Askes and Jamsostek. The Bill proposes reforming the SSO into not for profit special state enterprise. In addition, the bill paves a way for the informal sector to join the social security systems. The bill also mandates the government to pay contribution for the poor. The Bill prescribes comprehensive benefits and sets guidelines for controlling costs and quality of services. It is expected that the Bill will be passed before the end of 2004. If it is passed, Indonesia will follow the Philippines in establishing a national health insurance scheme.

6. Conclusions

Indonesia has been implementing pre payment (health insurance) schemes since 1950s, starting with community health funds. The more formal health insurance scheme has been implemented for civil servant since 1968. The year of 1992 changed the way the Indonesia providing health insurance by the passage of three laws: the Health Act (JPKM),
the social security (Jamsostek) and the insurance law. The three laws promote the growth of commercial health insurance. The Ministry of Health had been very keen to promote JPKM as the dominant form of health insurance, offered as managed care products. Massive efforts to stimulate the growth of JPKM were not successful because of the incompatibility of the market and the form of health insurance being promoted. The micro financing schemes have not shown any successful evidence to improve access and quality of health services. Learning from previous experiences, a national social security bill covering social health insurance will pave the foundation for the national health insurance in Indonesia. In term of strategic purchasing, Indonesia has long been committed to adopt cost control mechanism to prevent moral hazard and to improve efficiency by adopting managed care techniques.

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