

Indonesia's Path to Universal Health Coverage: Key Lessons from the Implementation of Jamkesmas



Background **P. 1**

Jamkesmas: Indonesia's Health Insurance Program for the Poor and Near-Poor **P. 2**

The Three Dimensions of UHC: Lesson from Implementation of Jamkesmas **P. 3**

Some Policy Implications for the UHC Agenda **P. 5**

Background

Indonesia has made steady and significant progress on several key population health outcomes over the past few decades. Life expectancy has steadily increased to almost 70 years in 2011, up from about 45 years in 1960. The under-five mortality rate has declined steadily from 216 per 1,000 live births in 1960 to 82 in 1990 and 32 in 2010. At current trends, Indonesia is projected to meet the child-health related Millennium Development Goal (MDG) which calls for a two-thirds reduction in under-five mortality between 1990 and 2015.

Despite notable progress on some fronts, the Indonesian health sector faces considerable challenges. First and foremost is the fact that Indonesia is in the midst of a rapid epidemiological transition. Non-communicable diseases (NCDs) now account for the largest share of the overall burden of disease in the country: whereas in 1990 only about 37% of morbidity and mortality in the country was due to NCDs, by 2010 this number had risen to 58%. In conjunction with the growing burden of NCDs, Indonesia faces relatively poor levels of maternal health, a double burden from both over- and under-

nutrition, a growing HIV/AIDS epidemic, persistent geographic and income-related inequalities in health outcomes, as well as high levels of out-of-pocket (OOP) spending for health despite high and increasing coverage rates.

Indonesia's maternal mortality ratio (MMR) remains high compared to other countries with similar income levels, and projections are that Indonesia will not be able to reach the maternal mortality MDG target by 2015. Although Indonesia is projected to achieve the MDG target on the prevalence of (severely) underweight among under-5 children, reduction in stunting has been stagnating and in some parts of the country stunting rates are comparable to those observed in far poorer countries. Despite robust economic growth over the last decade, there remain large income and geographic inequalities in health outcomes; access to quality health care remains a huge problem, particularly in the remote provinces and districts of the archipelago.

From a health systems and service delivery perspective, Indonesia is characterized

This policy brief assesses Indonesia's progress towards attaining universal health coverage (UHC) across the three different dimensions of breadth, depth, and height by studying the implementation of *Jamkesmas*, the government-financed health insurance program for the poor and near-poor and currently the largest social health insurance program in the country.

As Indonesia transitions towards a merger of most of its existing social health insurance programs under a single-payer administrative umbrella in 2014, the policy brief highlights key lessons from the implementation of *Jamkesmas* that could help inform reforms aimed at attaining UHC in the country by 2019.



by low levels of spending, as well as generally low and variable levels and distribution of human resources and health facilities. Indonesia has a mixed model of public-private provision of health care services, with the public sector generally taking a more dominant role, especially in rural areas and for secondary levels of care. Public sector provision is decentralized to the district level. The central government remains the dominant source of overall financing of the health sector, but district governments have discretion over how budgets are allocated and how much gets spent on health. With regard to health financing, in addition to the continued high dependence on OOP payments, Indonesia is characterized by relatively low levels of total and government health spending per capita (US\$77 and US\$38 per capita, respectively). In fact, in global comparisons, Indonesia has one of the lowest levels of total and government health spending as share of GDP.¹

One immediate key policy challenge facing the country is implementation of health system reforms aimed at attaining universal health coverage (UHC) by 2019. The universal right to health care was included as an amendment to Indonesia's constitution in 1999. However, the impetus for UHC came a few years later, in a 2004 landmark legislation -- the *Sistem Jaminan Sosial Nasional* or the SJSN Law -- which formed the legal basis for attaining several social protection objectives in the country. In 2011, the government passed a ground-breaking follow-up law that defined the administrative and implementation arrangements -- the *Badan Penyelenggara Jaminan Sosial* or BPJS Law -- which stipulated that existing contributory and non-contributory social health insurance schemes be merged to provide streamlined, uniform benefits under a single-payer umbrella beginning in 2014. Following institutionalization of the single-payer insurance administrator (BPJS) in 2014, the government plans to phase in expanding coverage to the entire population by 2019.

As Indonesia transitions towards a merger of all its existing social health insurance programs under a single-payer administrative umbrella in 2014, this policy brief highlights key lessons from *Jamkesmas* -- the government-financed health insurance coverage program for the poor and near-poor and currently the largest social health insurance program in the country. The brief can help inform reforms aimed at attaining UHC in the country by 2019. More specifically, this brief assesses Indonesia's progress towards attaining the three dimensions of UHC -- depth, breadth, and height -- using the experience of *Jamkesmas*.

Jamkesmas: Indonesia's Health Insurance Program for the Poor and Near-Poor

The Jamkesmas program began in 2005 as the Askeskin program for the poor² and currently targets a third of Indonesia's population. In 2007, it was renamed as Jamkesmas and was expanded to also cover the near-poor. Jamkesmas currently targets almost a third of Indonesia's population (official estimates now indicate that there are 76.4 million poor and near-poor beneficiaries)³. The program is fully financed out of central government revenues and is administered by the Ministry of Health (MoH). Jamkesmas has an annual operating budget based on an estimated "premium" rate of Rp 6,500 per person per month (about US\$8⁴ per person per year), amounting to about a quarter of the central government's annual health budget (between 2006 to 2010).⁵

The Jamkesmas provider network comprises mainly public facilities with some participation from private hospitals. At the primary level of care, the program includes only Puskesmas (health centers); for referral services both public and listed private hospitals are included. The participation of private hospitals in the network has been increasing; currently, 30 percent of Jamkesmas network hospitals are private. Private and public hospitals are reimbursed at the same rate under the program. The reasons private hospitals have joined the network are likely driven by the assurance of volume of patient inflows; some private providers (which have large fixed costs and excess capacity) accept Jamkesmas since, at the margin, benefits from partial-cost reimbursements can outweigh average costs. Some private religious hospitals are not-for-profit and will also accept Jamkesmas patients. In some cases, private hospital participation is mandated by local governments.

To date, *Jamkesmas* has seen some degree of success with increased outpatient and inpatient utilization rates among program cardholders. In addition, there is evidence that levels of catastrophic health payments have declined, and there is generally a positive perception about the program among those who are enrolled. However, there is evidence of high levels of mis-targeting and leakages to the non-poor, low levels of socialization, lack of awareness of benefits, regional inconsistencies in the availability of the benefits package, relatively shallow levels of financial protection, as well as poor accountability and feedback mechanisms.

¹ Public spending on health is only 1.3% of GDP in Indonesia; by contrast, Thailand's ratio is 2.9%, China's 2.7%, Vietnam's 2.6%, Malaysia's 2.4%, and Cambodia's is 2.1% (WHO - NHA 2011).

² However, the origins of health-insurance for the poor date to 2001, when the Fuel Tax Compensation Scheme (PKPS-BBM) was established as a response to the end of the pro-rich government fuel subsidies, which were partly redirected into programs to compensate the poor.

³ The poor and near-poor equal roughly the bottom three economic deciles of the population. There are ongoing discussions to increase the number of targeted Jamkesmas beneficiaries to 86.4 million in 2013.

⁴ Based on the average 2011 exchange rate.

⁵ Jamkesmas Health Service Fee Waiver, Social Assistance Program and Public Expenditure Review 4, The World Bank 2012.

The Three Dimensions of UHC: Lessons from Implementation of Jamkesmas

In its 2008 World Health Report, the World Health Organization (WHO) outlined three dimensions of UHC coverage: breadth, depth, and height.⁶ The breadth of coverage addresses who is insured. The depth of coverage refers to the range of services to be covered (i.e., the extent of benefits package). Finally, the height of coverage captures the financial protection aspect: the degree to which those covered pay OOP in accessing health services. In order to help inform Indonesia's reform efforts, we assess the experience of *Jamkesmas* in terms of these three dimensions of UHC.

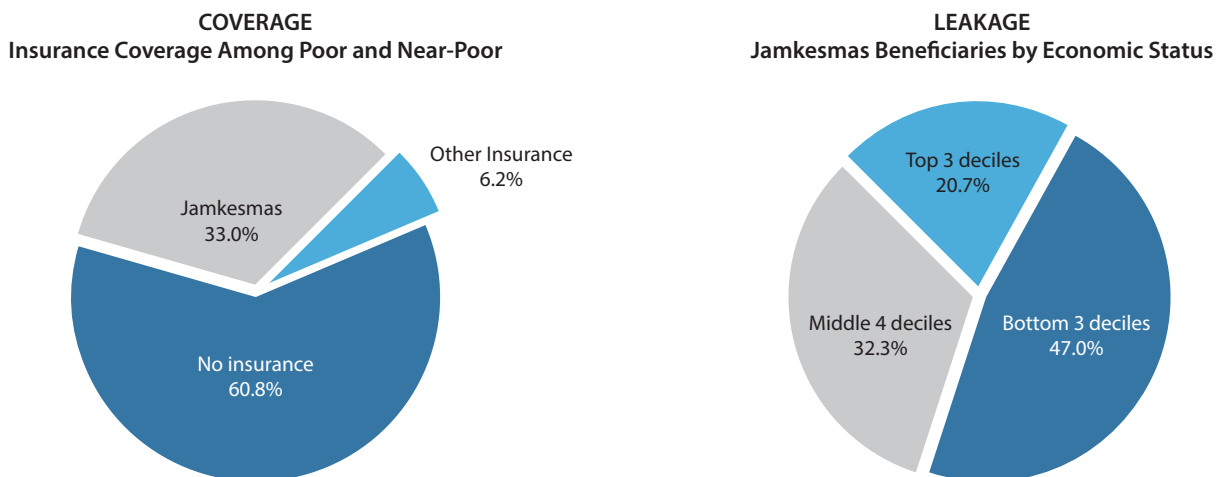
Breadth of Coverage

Officially, Jamkesmas now targets all poor and near-poor households: a total of 76.4 million individuals, which is nearly a third of the country's population. Targeting is based on a government-wide identification system used for all social assistance programs in Indonesia and has been used for *Jamkesmas* starting in 2013. Estimates from the national socioeconomic survey in 2011 suggest that only about 33 percent of all poor and near-poor households had *Jamkesmas* coverage. On the flip side, among *Jamkesmas* cardholders, survey data indicate that 47 percent of households were poor or near-poor, indicating a leakage rate of about 53 percent (Figure 1). Although some of the mis-match between official government numbers and those from survey data is likely a result of variations in the definition of the government's target population versus survey estimates, the relatively large magnitude of coverage under-estimation is indicative of substantial mis-targeting and leakages under the program.

The suboptimal performance of Jamkesmas in terms of targeting is likely due to variation in the proxy-means-testing criteria used across districts, and to poor program knowledge among the targeted beneficiaries. The criteria used to identify household characteristics vary across districts; in some districts, village midwives and subdistrict health center officials often distribute health cards according to their own criteria, regardless of economic status (World Bank 2012).⁷ There are no specific incentives in the system to either maximize enrolment or minimize mis-targeting. There is some anecdotal evidence and allegations of fraud and political clientelism, but only a few cases have been reported. Since enrolment of the poor and near-poor is not mandatory, there is some evidence that the target beneficiaries enroll only when they need to use health services (that is, there is adverse selection). Additionally, the list of eligible beneficiaries compiled by district officials is not subject to validation from the central government, resulting in mis-matching, poor coverage, and leakage of health insurance benefits to the non-poor. Furthermore, poor and near-poor households that were denied the card despite being eligible do not have a clear recourse.

The issue of low coverage rates and high levels of leakage are key considerations as the government moves to implement UHC in the country, wherein a large share of those currently uncovered are non-poor and employed in the informal sector. By law, this latter group is expected to contribute a partially-subsidized fixed premium amount (the exact contributory premium amount is yet to be decided). International experience has shown the collection of premiums from the informal sector to be a key challenge in attaining UHC, and this will likely be compounded given the extent of mis-targeting and leakage currently extant under

Figure 1: Estimates of Coverage and Leakage Rates for Jamkesmas, 2011



Source: SUSENAS 2011

⁶ The World Health Report 2008: Primary Health Care – Now More Than Ever. Chapter 2.

⁷ World Bank. 2012. "Targeting Poor and Vulnerable Households in Indonesia." PREM Indonesia, World Bank, Washington, DC

Jamkesmas implementation, resulting in capture of benefits of full subsidization to ineligible households and undermining the principle of solidarity and cross-subsidization.

Depth of Coverage

On paper, Jamkesmas offers a comprehensive benefits package that is more generous and inclusive than that of other social insurance schemes in the country, including the contributory civil servants health insurance program (*Askes*) and that of the program covering formal sector employees (*Jamsostek*). *Jamkesmas* benefits are set and updated by MoH and the National Social Security Council; there is no copayment, coinsurance, or extra-billing or balance-billing allowed under the program. As described, the *Jamkesmas* provider network comprises mainly public facilities; however, an increasing number of private hospitals have begun to participate in the program.

In reality, the access to the benefits package is limited by poor supply-side availability and readiness, especially in remote, rural locations of the country. Supply-side constraints comprise all the factors that limit health care delivery at the point of service, including the number of doctors, nurses, and midwives; the number of beds; medical equipment and technology; medicine supplies; and other basic amenities. Given Indonesia's geography, supply-side constraints reflect not only shortages in overall numbers, but also in distribution. Rural and remote areas are disadvantaged in that they not only have fewer health facilities but also face the difficulties associated with the retention of health personnel, especially doctors. The ratio of doctors in Indonesia is 0.2 per 1,000, one of the lowest in the region. The PODES 2011 survey (the village facilities survey) reported that 92 percent of Puskesmas had at least one doctor, which is similar to administrative data. However, more realistic estimates suggest that as many as 2,250 Puskesmas (around 25 percent of the total number) are without doctors, most of these being in the more remote areas of the country⁸. The distribution of doctors is highly concentrated in the Java-Bali region (which accounts for around 65 percent of all doctors); fewer than 6 percent of doctors practice in the eastern part of the country.

Analysis of the 2011 PODES survey indicates that 96.7 percent of Puskesmas had electricity, 88.1 percent had a water source, 87.5 percent had a cold-chain facility for the storage of vaccines, but only 36.4 percent had

an incubator. The availability of medical equipment and diagnostic tools is also highly variable across urban and rural areas; preliminary 2011 RIFASKES⁹ data estimates indicate that few Puskesmas had equipment close to stipulated national standards, and only 5.9 percent of urban Puskesmas and 6.4 percent of rural Puskesmas had more than 80 percent of the 56 ambulatory clinical devices available, respectively; around 10 percent of Puskesmas had less than 20 percent. In terms of essential drugs, only around 60 percent of Puskesmas both in rural and urban areas fulfilled 60 to 79 percent availability of 83 types of essential drugs, and only around 15 percent had 80 percent of the required drugs.

There are also clear shortages of qualified doctors and specialist doctors at the secondary level of service. Preliminary RIFASKES estimates from 10 provinces show that only 25 percent of type D, 50 percent of type C, and 70 percent of type B public hospitals have trained doctors on staff for emergency care.¹⁰ For specialist care, the facility census shows that 20 to 30 percent of public hospitals were without one of four basic specialties (ob-gyn, pediatrician, internist, surgeon). It is almost impossible for those living in remote and rural areas of the country to receive appropriate first management of care at emergency units and to access basic specialized services at hospitals.

The availability of hospital beds is also low in the country. In terms of inpatient capacity, Indonesia faced an estimated shortage of 13,875 beds. Some regions face particularly severe shortages and meet less than 50 percent of actual bed needs. Furthermore, hospitals—especially district hospitals—face shortages of both human resources and medical devices/facilities. RIFASKES estimates from 142 hospitals in 10 provinces indicate that 32 had no pediatric specialist, 27 had no internist or surgeon, and 20 had no obstetrician.

These supply-side constraints conceal the real costs of the Jamkesmas program and act as an implicit cost-management strategy. Although *Jamkesmas* offers a comprehensive benefits package of services, in practice, utilization and the associated claims reimbursements do not reflect the actual cost of health coverage due to the limited supply of services. If the utilization rates were higher, the actual costs of the *Jamkesmas* program would likely be much higher. Furthermore, Puskesmas and public hospitals continue to receive government subsidies for salaries and capital, which are also not included in the overall cost of *Jamkesmas* and therefore skew the perceived cost of the program.

⁸ "Distribution of Doctors is Unequal" Kompas (Indonesia), November 12, 2011.

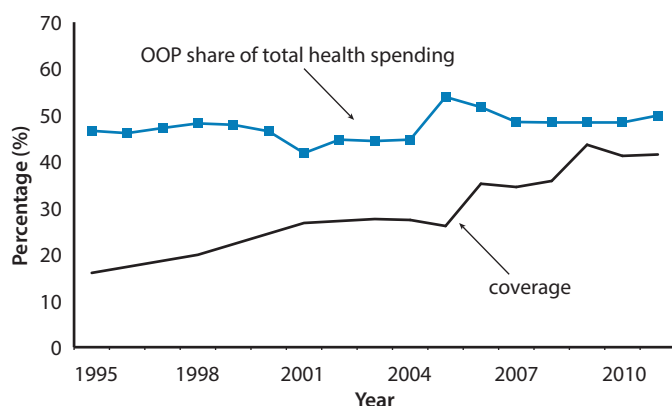
⁹ RIFASKES Riset Fasilitas Kesehatan, a census of health facilities conducted by the National Institute for Health Research and Development, Ministry of Health in 2011

¹⁰ Ministerial Regulations 986/1992 classifies five types of public hospitals; Type A is the top referral hospital; Type B is a provincial-level hospital that provides specialist and subspecialist services; Type C is district/regency hospitals that provide at least four basic specialties (surgeon, internist, ob-gyn, and pediatrician); and Type D provides, at a minimum, a general physician and dentist, but also has a transient status before it is upgraded to a Type C hospital. Type E hospitals are special hospitals, such as mental hospitals, maternal and child hospitals, lung hospitals, or heart/cardiac hospitals.

Height of Coverage

One measure of UHC is the extent to which coverage provides financial protection in terms of lowering or eliminating OOP payments at the point of care. Despite rising coverage rates, the OOP share of health spending in Indonesia has remained stubbornly high (Figure 2). From a health financing perspective, high levels of OOP spending pose significant financial barriers to accessing health care and result in a lack of financial protection for those who do utilize health care. High OOP payments are a prominent “risk factor” for impoverishment, especially given that a large proportion of Indonesia’s population is vulnerable and lives just above the poverty line. Although household health insurance population coverage rates have increased in the last decade or so -- from 15 percent in 1995 to more than 40 percent in 2011 – the OOP spending share of total health spending has remained in the 40-50% range in Indonesia (Figure 2).

Figure 2 : Coverage vs OOP share of total health spending, 1995-2011



Source: WHO

The current configuration of public financing for Jamkesmas does not lend itself to a system that can be easily or adequately scaled up in order to expand financial protection and ensure the program’s sustainability. As mentioned earlier, the *Jamkesmas* budget is based on a premium of RP 6,500 per person per month (or approximately US\$8 per person per year). *Jamkesmas* reimbursements do not cover the full cost of care: more than two-thirds of the estimated cost of care at public facilities still comes from supply-side subsidies. Salaries, capital, and some of the operating costs at public facilities continue to be paid for

via government budgetary transfers (central, provincial, or district, depending on the type of public facility). Low levels of reimbursement from demand-side financing programs such as *Jamkesmas* combined with low levels of public spending on health, supply-side deficiencies, and poor accountability mechanisms are key factors underlying the relatively high OOP spending in Indonesia, even among those with coverage.

Some Policy Implications for the UHC Agenda

As Indonesia moves towards implementing UHC under a single-payer umbrella, some key policy implications are evident as highlighted by the experience of *Jamkesmas*:

Improve targeting of non-contributory population sub-groups. The *Jamkesmas* experience highlights the need to significantly improve targeting of the poor and near-poor in Indonesia. Increased socialization among targeted beneficiaries will be needed to raise awareness and to encourage active enrollment among vulnerable population sub-groups. In this regard, incentive programs for local governments to enroll targeted beneficiaries could also be considered. For example, some proportion of resource transfers to local governments could be based on verified numbers of those in the target population group that actually enroll in the program, as opposed to being based solely on capitation and utilization as is currently the case under *Jamkesmas*.

Reduce mis-targeting and leakages. *Jamkesmas* targeting of the poor and near-poor needs significant improvements. More than half of *Jamkesmas* beneficiaries are not from the bottom three deciles. As mentioned, the country is in the process of improving beneficiary identification methods to improve coverage and reduce leakages. To achieve universal coverage, one of the most debated issues is expansion to cover the non-poor informal sector. According to global experience, other countries, such as Brazil, China, Mexico, South Korea and Thailand have had difficulties covering this particular group. The debate involves discussions around the level of premium contributions and collection mechanisms, both of which are expected to be extremely challenging.

Ensure supply-side availability and readiness. Ensuring the availability of quality health services remains one of the biggest challenges facing UHC in Indonesia. The experience of *Jamkesmas* highlights the significant disconnect between

About this brief

This policy brief is a summary of the World Bank UNICO Case Study (2013) The Nuts and Bolts of Jamkesmas: Indonesia's Government-Financed Health Converge Program, UNICO Studies Series No. 8 prepared by Pandu Harimurti, Eko Setyo Pambudi, Anna Lorenza Pigazzini and Ajay Tandon.

The findings, interpretations and conclusions expressed in this publication do not necessarily reflect the views of the Government of Indonesia, the World Bank, its Executive Directors or the governments they represent.

For more information, please contact Megha Kapoor (hdIndonesia@worldbank.org)

Human Development Sector World Bank Office Jakarta

Indonesia Stock Exchange
Building
Tower 2, 12th Floor
Jl. Jenderal Sudirman
Kav. 52-53
Phone: (021) 5299 3000
Fax: (021) 5299 3111

www.worldbank.org/id/health



@BankDunia



World Bank Indonesia

what the benefits package entitlements are on paper versus what the system is actually able and ready to deliver. As the system gears towards increasing demand-side financing via expansion of social health insurance, it will be key to clarify and enhance the accountability of the health system and of local governments to ensure provision of benefit entitlements, especially in terms of adapting to the evolving burden of disease that Indonesia faces.¹²

Ensure sustainability through improvements in efficiency and effectiveness of implementation of UHC. Jamkesmas is entirely financed through central government taxes. Premiums are not based on sound actuarial calculations. Supply-side constraints and supply-side subsidies have given the false impression that financing of Jamkesmas is sufficient. The program does not reimburse the full cost of services and relies heavily on supply-side subsidies. Consequently, the program does not provide strong incentives to the providers to deliver high-quality services. In addition, fund flows from the central levels to public health centers have proven to be problematic in a decentralized setting, given conflicting and confusing financial arrangements between central and local governments that have hampered health centers' use of funds. These pressures will continue to mount as the health system faces new burdens such as rising NCDs. In the face of these challenges, health system economic and fiscal sustainability, including improvements in efficiency and effectiveness, will be required to help ensure the financial, political and social sustainability of universal health coverage.¹¹

Make provider payment mechanisms more results-focused. Under Jamkesmas, payments to providers are basically fee-for-service (including diagnosis-related groups (DRGs) for hospital-based care). At present, there are no additional incentives to improve quality and provider performance. More fundamentally, there are no mechanisms to incentivize providers to attain population-level targets, for example,

at the district or catchment-area level.¹² Whereas the incentives on the demand side (for beneficiaries) under the program are relatively clear, supply-side incentives need to be better aligned and adjusted to ensure the program is attaining its objectives.

Establish a robust and reliable information system to support monitoring and evaluation. The information on service utilization and reimbursement claims serves as key input to monitor program performance, and to continuously update the calculation of the program's costs. Also, the information collected will describe changes in attitudes of both members and providers' behavior toward how services are delivered and financed. Improved information and reporting systems present opportunities to implement innovative community accountability mechanisms and beneficiary satisfaction surveys to improve health service delivery.

Learning lessons from selected provinces/districts that have attained UHC. Some provinces/districts in Indonesia have already attained UHC (including Bali, Aceh, and Jakarta). In looking at issues related to public financing, it is imperative that the government examines these experiences, estimates costs of UHC from these provinces/districts and identifies lessons learned.

¹¹ Thomson, S, T Foubister, and E Mossialos. 2009. Financing Health Care in the European Union. Edited by European Observatory on Health Systems and Policies Studies Series N. 17. World Health Organization.

¹² Langenbrunner, J. C., and A. Somanathan. 2011. Financing Health Care in East Asia and the Pacific: Best Practices and Remaining Challenges. Washington, DC: World Bank.

