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Policy and Discussion Notes

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Indonesia Health Sector Review

Does *JAMKESMAS* Protect the Population from Health Expenditure Shocks ?[1]

Introduction

Indonesia has embarked upon major reforms of its social security and health systems. One of them is the transformation to universal health insurance coverage (UHIC) for all Indonesians. Very few middle income countries have successfully achieved this and those that have face significant cost escalation pressures. Indonesia took a very bold significant first step in its ambition to UHIC with providing coverage to an estimated 76 million poor and near poor, a third of the population, through the government funded program Jamkesmas. After five years of implementation, it is opportune to review the program and document what we can learn from the implementation and what are areas for strengthening. This note is a first in a series which documents the findings of the reviews of the Jamkesmas program undertaken in collaboration with the GoI Ministry of Health and Vice Presidency Commission on Poverty Reduction. This first note focuses on the quantitative review, how health insurance coverage changes utilization of health services by the poor and provides financial protection to households. Subsequent notes focus on qualitative aspects from a beneficiary and providers perspective.

Providing financial protection from shocks to consumption due to health expenditures is one of the health development goals in Indonesia as stated in the National Strategic Plan for Health. The Government made a commitment in 2004 to achieve Universal Coverage of health insurance, with the passage of the National Social Security System Act. However, to achieve this, the Government is facing an enormous challenge as currently more than half the population has no form of health insurance. The Askeskin program (now known as *Jamkesmas*), a tax-financed program to provide health insurance to the poor, was introduced as one of the social assistance programs to mitigate the consequences of the reduction in fuel subsidies announced on the 1st of March, 2005 (see Box 1 for details). According to 2009 Ministry of Health data, the program covers 76.4 million people including the near poor population. Of those with formal health insurance coverage in Indonesia, *Jamkesmas* accounts for two-thirds.

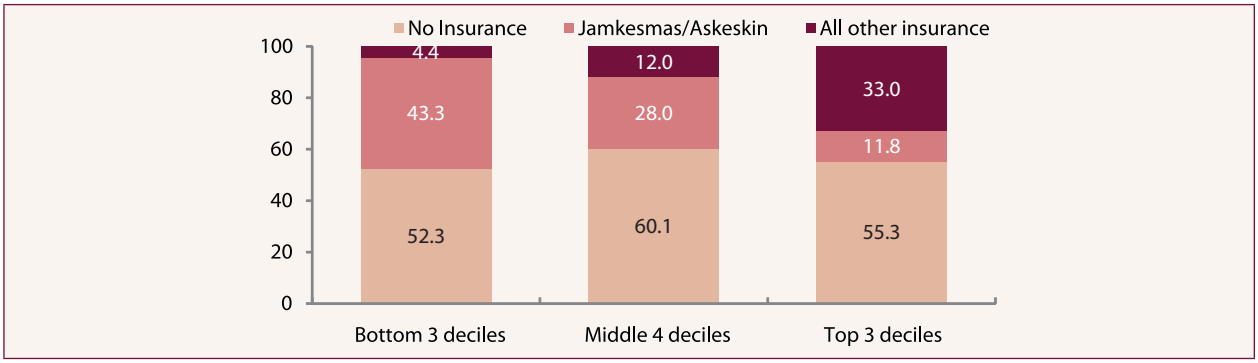
Despite evidence of some mis-targeting and program leakage, the *Jamkesmas* program appears to have helped to equalize the overall distribution of access to health insurance across the population. Before the *Jamkesmas* program started in 2005, health insurance

coverage among the poor was 16.5 percent in 2004, based on coverage from previous health insurance for the poor. Since then coverage among the poor has almost tripled to more than 43 percent in 2009. Considering that the coverage of other health insurance schemes is relatively stable, *Jamkesmas* is the main driver behind the rise in health insurance coverage to almost half of the population.

Figure 1 highlights how inequitable the distribution of other types of insurance is. Coverage by other[2] types of insurance (including Askes, Jamsostek and the smaller programs) is concentrated in the top three deciles, with 33 percent of individuals living in households that hold other forms of insurance, compared to only 4.4 percent of households in the bottom three deciles. Including the *Jamkesmas* program, total insurance coverage in the poorest three deciles rises to 48 percent, higher than coverage for both the richest three deciles (45 percent) and the middle four deciles (40 percent).

Individuals who have access to *Jamkesmas* are more likely to access health care. Based on the Susenas 2009 household survey data, individuals with *Jamkesmas* membership are more likely to use outpatient services than those without any health insurance, especially in the lowest three deciles (Figure 2). Access to *Jamkesmas* is also correlated with an increase in the likelihood of inpatient service utilization, as well as with a slightly longer length of stay. *Jamkesmas* members overwhelmingly choose to use public rather than private facilities, most likely reflecting the benefit

Figure 1: *Jamkesmas* health insurance covers almost half the poor population
(percentage of individuals living in households with access to health insurance, by expenditure decile, 2009)



Source: Susenas 2009

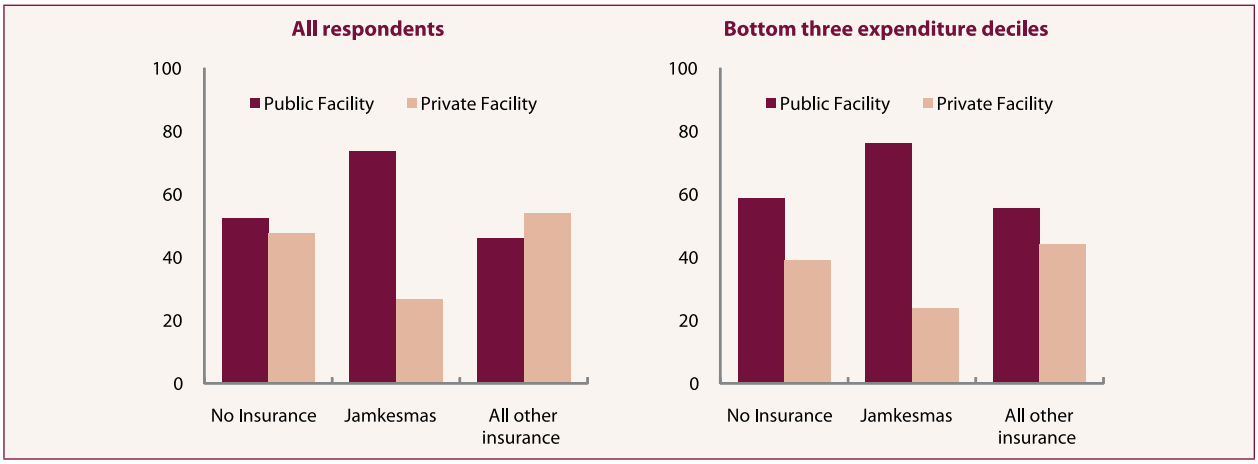
Box 1: A brief introduction to the *Jamkesmas* program

The *Jamkesmas* program provides health insurance for the poor and the near-poor (equivalent to approximately the lowest three expenditure deciles of the population) who are targeted through the application of a means test, with a comprehensive package of health benefits. The program is tax-financed by the central government and does not require any insurance contributions or cost-sharing on the part of beneficiaries or local governments. The budget cost per individual covered was initially IDR 5,000 per month, and now increased to IDR 6,500 giving a total budget for the current Jamkesmas program roughly equivalent to 20 percent of the central government health budget. The program is similar in spirit to several other initiatives that have recently been introduced by countries in the region such as in India (the Rashtriya Swastha Bima Yojna), Thailand Universal Coverage scheme and the health insurance program for the poor in Vietnam.

The benefit package is quite generous and requires no copayments (although this does not imply that out-of-pocket spending is zero), but the provider network is mostly limited to public facilities. In fact, Jamkesmas' benefit package is more generous than that of the other social insurance schemes, including the contributory civil servants health insurance program, Askes, and the program for formal sector employees, Jamsostek. For example, Askes beneficiaries often face high copayments (especially for inpatient care), have very limited access to private providers, and benefits are limited to the member, the spouse and up to two non-working, non-married children.

The providers included in the Jamkesmas program network are mainly government-owned facilities and are paid using a combination of capitation, fee-for-service, or Diagnostic Related Groups (DRGs), depending on the type of provider. The program pays for primary care services by capitation, reimburses inpatient services at primary health care facilities on a fee-for-service basis and has just recently started to use a DRG type provider payment mechanism for hospital inpatient care. The DRG was piloted in 15 vertical hospitals in 2008 and expanded to all hospitals in the network in 2009. In addition to the DRG payment, public providers receive subsidies in the form of the salaries of workers and some capital costs. Only a limited number and type of private providers are contracted, and mostly in the urban areas of Java (in 2009, private hospital accounted for more than 30 % of total hospitals in the network, but a far smaller share of the total number of beds).

Figure 2: Individuals with *Jamkesmas* coverage are more likely to use inpatient services
(percentage of individuals using public and private facilities for inpatient care, among those who used inpatient services, by insurance type, 2009)



Source: Susenas 2009

structure of the program in which its benefit package offers limited availability of private providers in its provider network.

Susenas 2009 data also suggest that *Jamkesmas* beneficiaries are, on average, better protected from the adverse financial effects of health shocks. Compared to households without insurance, and also compared to households with other types of insurance, *Jamkesmas* households have systematically lower Out of Pocket (OOP) spending, conditional on utilization. This is probably because the *Jamkesmas* benefit package is more generous than many other types of insurance, covering almost all types of care with no copayments and few service limitations. Importantly, this protective effect was more pronounced among households of lower economic status. *Jamkesmas* beneficiaries also have a lower incidence of catastrophic expenditure than those with no insurance and even those with other types of insurance. Moreover, the impoverishing effect of uninsured health expenditures, whether measured in terms of the increase in the incidence of poverty or the increase in the poverty gap, is smaller.

Nevertheless, it is important to note health service utilization among *Jamkesmas* beneficiaries remains low compared to those covered by other types of insurance despite a relatively generous benefit package. This indicates that other barriers for the poor to access health services persist. These barriers may include other out-of-pocket expenses, opportunity costs, distance to facilities, perceived low quality of care of the network providers, and availability of services.

Also, it is important to note that OOP health expenditures – although lower than among those without coverage -- remain relatively significant among *Jamkesmas* beneficiaries. This may suggest that those with no health insurance coverage use less health services thus have lower out of pocket spending. This finding suggests that although *Jamkesmas* has shown protective effect as mentioned above, it indicates that the program has not yet provided adequate protection to health shocks. This will require further investigation, e.g., via the use of focus group discussions among beneficiaries: Are transportation costs a factor? Do users face informal or other "hidden" payments?

The program performs relatively well in terms of increasing utilization and enhancing financial protection, but as mentioned above this remains inadequate. One of the issues is that a large share of the population which, according to their socioeconomic status, should be eligible for participation in *Jamkesmas*, but does not currently participate in the program. Not all of the poor are reached by the program, and there is considerable leakage to the non-poor. Part of this may be weaknesses in the program's targeting mechanism, but part of this might be the design and the implementation of the membership management of the *Jamkesmas* program itself. This is serious program weakness that needs to be addressed. Nevertheless, *Jamkesmas* participants are, on average, of poorer socioeconomic status than those who are not covered by *Jamkesmas*, confirming that the program is indeed pro-poor.

In relation to the Government's intention to achieve Universal Coverage (UC), the question is the role that the *Jamkesmas* program, which currently accounts for two-thirds of the currently insured, will play. There are several options, including expanding the program's

coverage to all uninsured, or to vulnerable population groups only, such as women and children. Each option has its own challenges for implementation and also each has significant fiscal implications.

For the option of expanding the program to the currently uninsured, the cost for a UC program, scaled up to full UC by 2020, is projected to be between 1.04 percent of GDP (low cost scenario) and 1.46 percent of GDP (high cost scenario; both scenarios include only health insurance costs but exclude all other public spending on health)[3]. To put this in context, in 2008 total health spending is 2.2 percent of GDP (WHO 2010) which is almost equally divided between public and private. Although the total cost projection includes general subsidies to public personnel salary and public health facilities, the magnitude of these figures still raises concerns about the option's long-term sustainability. Moreover, 1.46 percent does not include substantial spending needs for public health and primary and preventive care, which now make up an estimated 1 percent of GDP.

To remain affordable any program expansion will need to be accompanied by efficiency improvements. The introduction of Diagnostic Related Groups (DRGs)[4] in hospitals as a cost containment effort has been a good start. However, the implementation of DRGs needs to be improved, and so do other cost containment measures including utilization review, provider profiling, other provider payment methods, and the gatekeeper function of primary level providers as a key part of referral system needs to be strengthened.

Based on existing health financing programs, the Government of Indonesia still has to decide on the approach to achieving universal health insurance as the end goal. These approaches include the National Health System (NHS)-like program or Social Health Insurance (SHI), or variant or combination of both. The Social Security Law mandated the SHI model using contributions from its beneficiaries. Regardless of the option chosen important decisions on the basic benefit package, provider payment mechanism and contracting arrangements and strategies to respond to supply-side constraints need to be made.

More immediately, while the debate on future program expansion continues, there is the short-term challenge of improving the targeting and the management of the existing *Jamkesmas* program. Efforts to improve targeting are ongoing, including efforts to establish a unified database for potential beneficiaries, but over and above those efforts, there are additional specific problems related to the targeting of the *Jamkesmas* program. These include discrepancies between data at the central and sub-national levels and also the use of different targeting criteria in different districts.

Improving the program management is very important to enhance *Jamkesmas*' performance. The absence of a reliable information system, for instance, prevents the Government, as well as other stakeholders, from evaluating the effectiveness of the program in achieving its objectives. Records on utilization of both inpatient and outpatient of primary level of care, referral services, and drugs, and hospital claims, can be a start for a data warehouse that provides basic information to monitor and evaluate which can be used to further develop *Jamkesmas* program, especially if it is considered as the stepping stone to achieve Universal Coverage.

1 This policy brief is based on the forthcoming working paper "Enhancing Health Equity and Financial Protection in Indonesia: How Well Does *Jamkesmas* Do? prepared by Caryn Bredenkamp, Ajay Tandon, Pandu Harimurti, Eko Pambudi, and Claudia Rokx.

2 Other schemes together account for coverage of less than 10 percent of the population. They include all the categories of health security/ insurance mentioned in the SUSENAS survey other than Jamkesmas, i.e. (i) JPK (Health Insurance) for civil servants/veterans/pensioners, (ii) allowance/reimbursement from company or Self Insured, (iii) JPK Jamsostek for formal employees, (iv) private health insurance, (v) community-based health funds and (vi) JPKM (health maintenance organization, HMO-like health insurance).

3 Yves Guerard, "Actuarial Costing of UC Coverage Options: Model and Summary Results", Consultant Report, World Bank Indonesia, Jakarta 2010. The basis for the Government to set the premium of the Jamkesmas program, IDR 5,000 or now IDR 6,500, per member per month (PMPM) is not based on an actuarial calculation. The World Bank conducted an actuarial study as a part of the Health Sector Review activities. The actuarial study uses data from the civil servants social health insurance (ASKES) program and once adjusted to the whole population the study calculated that the baseline cost per member per month in 2010 ranges from IDR 18,704 (low baseline) to IDR 25,662 (high baseline).

4 Diagnostic Related Groups (DRGs) is a provider payment mechanism based on defined groups of diagnoses that are both cohesive and similar in the intensity of resources

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