In 2004, the Indonesian government committed to provide health insurance coverage to its entire population through a mandatory health insurance program. As of 2008, its public budget provided coverage for 76.4 million poor and near poor, but more than half of the population still lacked health insurance. The authors of *Health Financing in Indonesia* develop a baseline of current health policies, highlighting their strengths and weaknesses in light of current epidemiological and socioeconomic trends, and provide a comprehensive framework for reform in the key financing functions involved in providing universal coverage (UC): revenue collection, risk pooling, and purchasing.

The book also provides an analytical framework based on global good practices, as well as rudimentary cost options for the transition to UC. *Health Financing in Indonesia* will be of interest to readers working in the areas of health care and public health, social protection, and social analysis and policy, in Indonesia and in other countries aiming for universal coverage.
In 2004 the Indonesian government made a commitment to provide its entire population with health insurance coverage through a mandatory public health insurance scheme. It has moved boldly and has already provided coverage to an estimated 76.4 million poor and near poor, funded through the public budget. Nevertheless, over half the population still lacks health insurance coverage, and the full fiscal impacts of the government’s program for the poor have not been fully assessed or felt. In addition, significant deficiencies in the efficiency and equity of the current health system, unless addressed will exacerbate cost pressures and could preclude the effective implementation of universal coverage (UC) and the desired result of improvements in population health outcomes and financial protection.

For Indonesia to achieve UC, systems’ performance must be improved and key policy choices with respect to the configuration of the health financing system must be made. Indonesia’s health system performs well with respect to some health outcomes and financial protection, but there is potential for significant improvement. High-level political decisions are necessary on key elements of the health financing reform package. The key transitional questions to get there include:

- the benefits that can be afforded and their impacts on health outcomes and financial protection;
- how the more than 50 percent of those currently without coverage will be insured;
- how to pay medical care providers to assure access, efficiency, and quality;
- developing a streamlined and efficient administrative structure;
- how to address the current supply constraints to assure availability of promised services; and,
Executive Summary

- how to raise revenues to finance the system, including the program for the poor as well as currently uninsured groups that may require government subsidization such as the more than 60 million informal sector workers, the 85 percent of workers in firms of less than five employees, the 70 percent of the population living in rural areas.

While Indonesia is modernizing and further developing its health system with major reforms such as decentralization and the implementation of UC, the demographic, nutritional and epidemiological transitions will have major implications for the design and costs of these reforms. An aging population will create additional demand for infrastructure (more hospitals), health workers (more specialists and care-givers) and old age social security. At the same time, a diminishing employment base, characterized by stagnant movement into the formal sector, will exacerbate cost-pressures. There are large emerging differences in the progress of these transitions across Indonesia with Eastern Indonesian provinces remaining at the initial stages of the transition with continuing high levels of communicable disease and child mortality, while provinces in Java and Bali have higher levels of noncommunicable diseases (NCDs).

On the positive side, Indonesia’s economic growth has been robust since the financial crisis in 1997/8, and the country appears well positioned to weather the current financial crisis, although the effects on future economic growth remain uncertain. However, poverty rates remain high for a lower-middle-income country, despite significant improvements since 1997/8 and with a looming potential crisis, poverty rates are a major concern. Moreover, some 50 percent of the population remains classified as poor or near poor, leaving a very large part of the population at risk to both economic and health shocks which can be catastrophic and push households into poverty.
In addition, labor market dynamics are important when developing a roadmap to universal coverage health insurance—for example, the large proportion of informality in the labor market complicates the use of worker-based contributions to finance the system.

The rationale for this health financing study is to provide real time evidence-based inputs to the Government of Indonesia’s (GoI) comprehensive Health Sector Review and assist the government in the development and implementation of its universal health insurance program. The intention is to assist the GoI by assembling both the Indonesia-specific and global evidence bases, with a specific focus on the development and implementation of policy options to achieve universal health insurance coverage in order to improve the health outcomes and financial protection of the Indonesian people.

This study focuses on the key health financing functions of revenue collection, risk pooling and purchasing and their respective objectives of: (i) equitably and efficiently raising sustainable revenues to support UC; (ii) pooling risks in an efficient and equitable manner to ensure financial protection for the Indonesian population; and, (iii) purchasing services in an allocatively and technically efficient manner. The study develops the current Indonesian health policy baseline predicated on the strengths and weaknesses of the current system and future epidemiological and socioeconomic trends, and provides a comprehensive framework which enumerates the key reform issues requiring resolution. It provides an analytical policy framework based on the global ‘good practices’ evidence base as well as some rudimentary costed options for the transition to universal coverage. Finally, it discusses the necessary future delivery system, public health, and demand-side reforms.

Health financing since decentralization has become more complicated, and health service delivery appears to be worsening,
Executive Summary

in large part due to governance issues. The national health system has not adapted to decentralized realities, nor has the decision to go to mandatory universal health insurance led to additional restructuring. The system remains publicly focused and continues to be based on the principles and features of Alma Ata (universal access to public primary care), although half of all health spending is private, largely out-of-pocket (OOP), and almost half of all those who are ill actually seek health services from private providers.

Governments’ ability at all levels to make direct payments in the form of salary payments and capital costs as well as provide additional coverage is contingent on their fiscal capacity. Such fiscal capacity depends heavily on both local revenue-raising capacities as well as the flow of funds through the intergovernmental fiscal systems in which some funds are earmarked by central level government, while others are not, and formulas used for redistributing funds from central to local governments often do not reflect local need and fiscal capacity.

Physical access to health services in Indonesia is considered adequate, although there are shortages in the number and distribution of health professionals. With more than 8,000 public health centers (1 per 23,000 head of population), a wide outreach system as well as more than 1,250 public and private hospitals, access to services is good in all but remoter areas. However, the quality of infrastructure, functionality of equipment, and the availability of supplies are often key problems. There are too few doctors, especially specialists, and this will be a major issue with future NCD needs expanding rapidly. Not only are there too few doctors and specialists, they are also very inequitably distributed across Indonesia. There are significantly more midwives and nurses, and they are better distributed with at least one midwife for every village. However, as with infrastructure, while absolute numbers are not the main issue, deployment and quality are.
Improvements in health service infrastructure have been one product of the overall increase in health expenditure which has risen from 1.9 percent of GDP in 1996 to 2.2 percent in 2006. At the same time, the public share has increased significantly from 42 percent in 1996 to 50 percent in 2006. Government health expenditures as a share of the budget increased from 4.3 percent to 5.3 percent, while household OOP spending decreased only slightly from 36 percent of all spending (62 percent of 58 percent of overall private spending) in 1996 to 33 percent (66 percent of 50 percent) in 2006. In exchange rate-based U.S. dollars, health spending has increased from US$20 in 1996 to US$34 in 2006 and in international dollars from US$55 to US$87.

Private health expenditure has, historically, played a more important role than public health spending in terms of overall health financing in Indonesia. However, this trend started to change in the period 2005/6, and it is expected that public health expenditure will have an increasingly important role to play in subsequent years as the government extends UC to the entire Indonesian population. The establishment of Jamkesmas/Askeskin in 2004 has had an impact on both total health spending and the public share of spending. OOP payments still comprise a sizeable share of health spending however, and the challenge for the government is to channel these expenditures into risk-pooling mechanisms in order to effectively provide protection against catastrophic health spending.

Nevertheless, despite this historical dependence on private health spending, Private Voluntary Health Insurance (PVHI) is not well developed in Indonesia. Each of the three major existing health financing programs is publicly owned. Civil servants and their dependents are covered under the ASKES program, which is administered by a for-profit state enterprise, PT Askes. Jamkesmas was originally designed to cover the poor but was expanded to also cover
the near poor. It was originally administered by ASKES but in 2008 the Ministry of Health (MoH) took over most of the major administrative functions, including provider payment. Jamsostek is similar to a classic social insurance program for private sector employees in firms with 10 or more employees and is also administered by a for-profit state enterprise. Employers have the option to opt out, either by self-insuring or by purchasing private insurance for their employees. Both P.T. Askes and Jamsostek also sell private commercial policies.

Three possible approaches, based on Indonesia’s existing health financing programs, the current policy debate, and the 2004 Social Security Law have been identified as viable UC options. The three options would all result in universal coverage, and all have sufficiently large numbers of enrollees for effective risk pooling. Irrespective of the approach chosen, however, crucial decisions regarding the benefit package, cost-sharing, payment/contracting arrangements and modalities to address supply-side constraints need to be made. The three approaches are:

- The first approach approximates a National Health Service like that in Sri Lanka and Malaysia, and involves expanding the general revenue financed Jamkesmas program for the poor and near poor to cover the entire population.
- The second approach approximates the ‘new’ national Social Health Insurance (SHI) model (now called Mandatory Health Insurance (MHI)), where the MHI system is funded through both wage-based contributions for public and private sector workers (and retirees) and government general revenue contributions for the poor and other disadvantaged groups.
- The third approach, which could be considered a variant of Option 2 or a combination of Options 1 and 2, provides coverage for the poor and other disadvantaged groups through a government financed system, with others covered through multiple MHI funds, each financed on a contributory basis.
Clearly, whichever option is chosen, the movement to universal coverage will have a sizeable impact on Indonesia’s health spending. Micro-analyses of current program costs and utilization patterns after the introduction of Askeskin/Jamkesmas allow crude projections of future costs. For example, crude estimates of future Jamkesmas costs range from 20 percent of current Jamkesmas spending to sixfold increases, depending on the coverage expansion scenario and health inflation assumptions chosen.

If the expansion is financed through government spending, there will also be significant new ‘demands’ for available fiscal space in the budget to be allocated to health. The cost analysis included in this report, albeit crude, does show the importance for Indonesia to start addressing the above mentioned weaknesses in the system, develop the information needed to conduct more sophisticated projections in the future, and the need for the reform process to address broader health systems issues in addition to the financing changes. If, as a result of UC, Indonesia's health spending increases to the levels of comparable income countries, while it implements policies to assure efficiency and control costs that follow its historical trends, then health spending in 2040 could be on the order of 6 percent of GDP compared to just over 2 percent currently. If it doesn't and faces the past cost pressures of the industrialized countries, health spending could be on the order of 10 percent of GDP.

One way of assessing the availability of fiscal space for health is to examine the different options by which the sources of government financing for health could be increased (and/or increased de facto through efficiency gains in existing health and/or other public spending). These include:

- conducive macroeconomic conditions such as economic growth and increases in overall government revenue that, in turn, lead to
increases in government spending for health;

- a **re prioritization** of health within the government budget;
- an increase in **health-specific foreign aid and grants**;
- an increase in **other health-specific resources**, for example through earmarked taxation or the introduction of premiums for mandatory health insurance; and
- an increase in the **efficiency** of government health outlays.

Of the above-mentioned options, the first two are largely outside the domain of the health sector *per se*. The remaining three options are more in the direct domain of the health sector and merit particular attention given that they provide the potential for resources that are sector specific.

**Indonesia has established the broad legislative base for moving forward to UC, and the Social Security Council has been focusing on specific implementation issues.** There have also been a number of studies by the GoI, donors and other stakeholders that provide relevant contributions for decision making as the GoI proceeds with the development and implementation of the reform. While all these efforts are useful in terms of planting individual trees in the complex forest of health care reform, what has not been evident to date is the final configuration for populating the forest and the roadmap to eventually get there. In short, the GoI needs to decide on the final UC system that it has in mind and then carefully lay out the transition steps to get there.

**In developing such major policies, Indonesia like most other countries lacks critical information, both policies and data, needed for informed decision making.** In addition, big picture policy choices on the ultimate UC system and transition steps can only be made in tandem with specific policy choices on more micro issues such as the groups eligible for coverage by program, targeting mechanisms, contribution requirements (individuals, firms, and governments), provider payment
mechanisms and levels and the future macroeconomic environment. Rational policy choices need to be based on both the quantitative and qualitative impacts of such policies on, inter alia, health outcomes, financial protection, consumer responsiveness, access, equity, efficiency, costs (public and private) and macroeconomic sustainability.

Based on global experiences the following critical policy issues should form the framework for the implementation of universal coverage:

1. Further development is needed on such DDM as National Health Accounts updates, claims data from the existing programs, and cost, equity and benefit incidence analyses to analyze policy options. It is crucial to give high priority to developing the actuarial baselines of the current and proposed future health insurance programs and getting better estimates of the behavioral responses of both consumers and suppliers to changes in insurance coverage. Included in these analyses should be assessments of the current Basic Benefit Packages (BBPs) in terms of both cost-effectiveness and financial protection against excessive OOP spending to enable rational choices of the BBP(s) under the UC reform;

2. The initial assessments regarding supply-side constraints with respect to both human and physical infrastructure highlighted a number of important areas where inefficiencies need to be addressed as well as areas which will come under more pressure given the underlying demographic, nutritional and epidemiological realities;

3. Building on the pharmaceutical sector assessment and the initial identification of potential opportunities in expending MHI, the GoI is encouraged to further evaluate pharmaceutical sector policies and needed changes to aid implementation of the UC reform;

4. The ongoing decentralization and UC reforms necessitate clarifying the future role of the MoH with respect to public health and its
Executive Summary

remaining stewardship and financing functions vis a vis the public insurance system. Within its broader stewardship role, assessing the effects of policies in other sectors impacting health such as water and education must also be a high priority as is assessing the need for additional demand-side policies such as Conditional Cash Transfers (CCT);

5. Once decisions have been made regarding the financing options under the roadmap to UC, it is essential to develop, experiment with, and evaluate the impact of alternative provider payment mechanisms on costs, quality, and access;

6. The range of necessary administrative structures to implement the reform need to be determined, including assessing administrative costs and developing systems to assure quality, assess efficiency and evaluate the reform's impacts;

7. The rich local experiences in providing health insurance coverage should be carefully assessed as these ‘natural experiments' are an important source of information for the national-level UC reform effort; and

8. Attaining UC is highly likely to require large increases in government expenditures, no matter which option is decided. In that context, continuing attention to evaluating Indonesia’s future macro situation, including competing priorities in light of the current global financial and economic crises is important, as is assessing the need for changes in the current intergovernmental fiscal structure.

Successful implementation of the UC reform will require carefully sequenced implementation of targeted, effective, and fiscally sound policies. The Social Security Council and MoH have taken important first steps, but more is needed. The Medium-term Development Plan (RPJM), the Ministry of Health's own internal planning efforts in developing the next Renstra, and the potentially large and possibly unaffordable (in the short-run due to the current global economic crisis) expenditure
implications of expanding health insurance to some 76 million poor and near poor, make this an ideal time to refocus efforts on the comprehensive set of policies needed to effectively implement the UC reform.