Universal Health Coverage Assessment

Indonesia

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Universal Health Coverage Assessment:

Indonesia

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Introduction

This document provides a preliminary assessment of the Indonesian health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Indonesia.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Indonesia and identifies the main sources of health financing prior to the initiation of a universal health coverage policy in early 2014 (Table 1).[2]

In 2012, total health expenditure accounted for 3.0% of the country's Gross Domestic Product (GDP), an amount that was lower than the average of 4.5% for other lower-middle-income countries and a third of the global average of 9.2%.

Public allocations to fund the health sector (including a variety of social health insurance schemes)[3] stood at about 7% of total government expenditure. This was

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Indonesia, 2012

Indicators of the level of health care expenditure	
1. Total expenditure on health as % of GDP	3.0%
2. General government expenditure on health as % of GDP	1.2%
3. General government expenditure on health as % of total government expenditure	6.9%
4a. Per capita government expenditure on health at average exchange rate (US$)	42.7
4b. Per capita government expenditure on health (PPP $)	59.5
Indicators of the source of funds for health care	
5. General government expenditure on health as % of total expenditure on health*	39.6%
6. Private expenditure on health as % of total expenditure on health**	60.4%
7. External resources for health as % of total expenditure on health#	1.1%
8. Out-of-pocket expenditure on health as % of total expenditure on health	45.3%
9. Out-of-pocket expenditure on health as % of GDP	1.4%
10. Private prepaid plans on health as % of total expenditure on health	1.8%

* This includes tax-funded health spending, payroll tax-funded mandatory health insurance, and external revenues (loans and grants) flowing through government accounts in the category of general government expenditure on health.
**This includes external resources that flow through non-governmental organisations (NGOs).
#Some external resources flow through government and some through NGOs. Indicators 5 and 6 therefore add up to 100% whereas indicator 7 in this Table is a separate indicator altogether. This is different from Figure 1 where donor funds are distinguished from tax-based financing.
Source: Data drawn from World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en)

[2] The data quoted in this section all derive from the latest (2012) data in the World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Home/Index/en). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country's income category is determined from the World Bank's classification for the same year (http://data.worldbank.org/about/country-and-lending-groups).
[3] Different countries use the terms 'national health insurance,' 'social health insurance' and 'social security' differently to describe different types of mandatory health insurance. In each country assessment in this series, the term applied is the one commonly in use in the country in question. Until early 2014, Indonesia had a variety of mandatory social health insurance schemes covering different segments of the population but excluding a relatively large proportion of the population. In early 2014 a new national health insurance scheme was introduced that aims to eventually cover the entire population.

lower than the average of 8.4% for other lower-middle-income countries and under half the 15% target set by the Organisation for African Unity's 2001 Abuja Declaration (which, coincidentally, was the same as the global average for 2012).

In fact, government health expenditure translated into only 1.2% of GDP in 2012, which is low for the mandatory pre-paid component of a health financing system. The lower-middle-income country average for that year was 1.7% while the global average was 5.3%.

Per capita government expenditure on health was around $59 (in terms of purchasing power parity), also lower than the lower-middle-income country average of $67 and more than ten times less than the global average of $652. Despite lower levels of expenditure, this situation was a considerable improvement over earlier years (Soewondo et al. 2011).

As would have been expected from the relatively low levels of government expenditure, out-of-pocket payments played a significant role in Indonesia (at about 45% of total financing in 2012). This was high in global terms (where the average was 21%). It was also above the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010).

Both donor financing and private health insurance accounted for a very small percentage of total health sector expenditure in 2012, at around 1% and 2% respectively, with donor financing having declined considerably over the last decade.

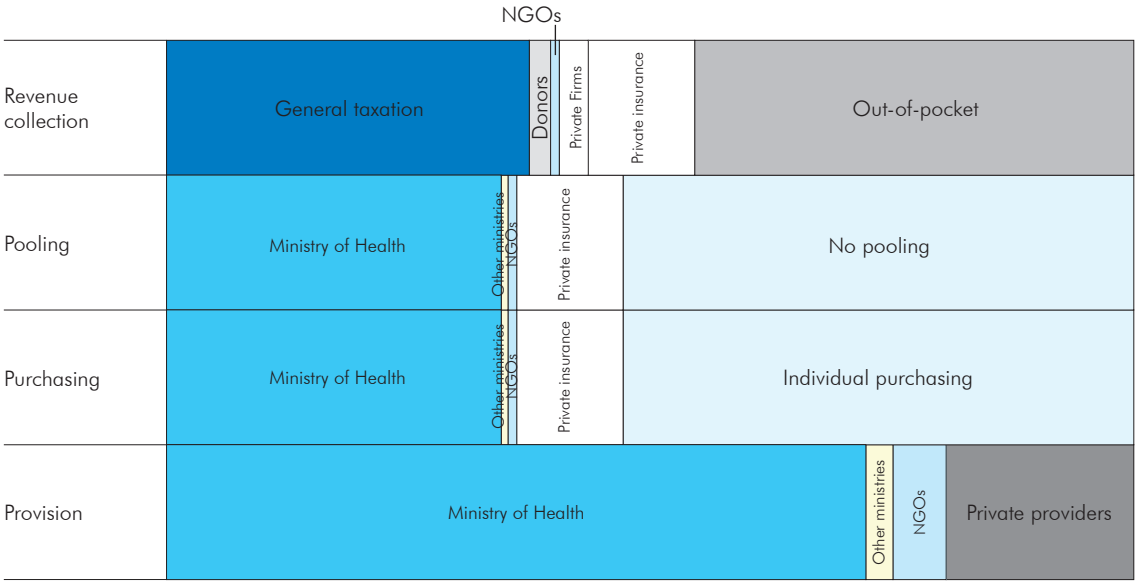
Structure of the health system according to health financing functions

Figure 1 provides a summary of the structure of the Indonesian health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.[4]

Revenue collection

Out-of-pocket payments are the dominant source of financing, accounting for more than three-quarters of total private expenditure, as shown in Table 1. Both public and private health care facilities charge fees, the latter being

Figure 1: A function summary chart for Indonesia, 2012



Source: Indonesia National Health Accounts, updated February 2014

[4] The data quoted in this section are slightly different from the previous section because they are based on more detailed disaggregation by the authors of Indonesia's National Health Accounts, updated in February 2014.

more expensive and potentially leading to catastrophic expenditure by some patients. Uninsured Indonesians pay close to 100% of the cost of their health care, including at public hospitals. According to a study by The World Bank (2007), even those covered by the government-run insurance schemes for government employees - Jamsostek and Askes – had to pay out-of-pocket for 40% of the cost of their care. For commercial insurance, out-of-pocket payments cover the dominant proportion of costs, generally for personal curative care and pharmaceuticals.

However, basic immunization is provided free of charge to anyone accessing public health facilities. Similarly, the Indonesian Family Planning Bureau provides family planning services free at both public and private health facilities. In addition, primary health care services in some areas are free of charge for holders of health insurance cards.

The next largest financing source after out-of-pocket payments is government revenue (at 40% in 2012 as shown in Table 1). Table 5 found that, in 2007, just over a third of government revenue (38%) was from social health insurance, 16% from indirect taxes and around a quarter each from direct taxes (22%) and other revenue (24%), including multilateral loans and grants. Ministry of Finance (2013) confirms that these proportions have remained much the same.

The Indonesian government has demonstrated an increased commitment to funding the public health sector over recent years. In 2012/2013, the total budget of the Ministry of Health was 30% higher than in 2009/2010 (Ministry of Finance 2014). The increase was partly due to additional funding specifically provided to finance public health programs at the district level. This funding is channelled directly from the Ministry of Health to over 9,000 primary health centres across Indonesia with the aim of improving the implementation of health promotion and prevention programmes.

In 2011, 60% of the Indonesian population had some sort of health insurance. Those covered were mainly civil servants and formal sector employees. This left approximately 88 million people uninsured (Harimurti 2013). These were mostly people working in the informal sector who could not afford private health insurance and did not meet the criteria for subsidized government social health insurance. Harimurti (2013) estimated that only 35% of the poor and near-poor population was insured in 2010.

In 2011, commercial insurance accounted for only 2% of the insured population, while a further 10% fell under in-house insurance schemes organised by some parastatal and private companies (Soewondo et al. 2014). The remaining insurance coverage was provided by a number of government-run insurance schemes (Table 2). Initially these had focused on mandatory insurance schemes for government officials and state-owned company employees, funded through payroll contributions, government subsidies and user fees. However, from 2009 government began to focus on extending voluntary coverage to the poorest, especially through Jamkesmas (formerly known as Askeskin), which managed to cover one third of the total population (or half the insured population) by 2011 (Ministry of Health 2011). The Jampersal scheme was enacted in 2011 and was designed to speed up progress towards meeting the Millennium Development Goals by reducing maternal and infant mortality rates. This scheme ensured free delivery services for all and removed administrative barriers associated with acquiring an insurance card.

Most of the government schemes in Table 2 are run by the central government but Jamkesda is a set of local government-run schemes with the design of each scheme adjusted to the particular fiscal capacity of each local government. Jamkesda schemes are generally used to finance health care for people who are not covered by the central government-run Jamkesmas. Overall Jamkesda currently covers almost 32 million people (Ministry of Health 2013). Some provinces have already achieved universal coverage, including Bali and Aceh province. Other provinces, including the capital city of Jakarta, West Sumatra, East Java and South Sumatra, are expected to reach universal coverage by around 2015. With their official identity cards, Jamkesda members are able to access certain health services for free. However, as Jamkesda depends on the local government budget, in many places there are limits on free services and cost sharing is allowed.

Unfortunately there is lack of qualified human resources to manage the Jamkesda schemes in a professional way, including routine administration, accounting and financial management, claims administration, information systems, and analysis of utilization patterns at each level of service. Consequently there is little information with which to judge how all the various health care initiatives that have been implemented at district and provincial levels have improved the health status of Jamkesda beneficiaries.

The intention of the Indonesian government is eventually to extend comprehensive coverage to everyone and, to this effect, a new universal health coverage scheme was initiated in 2014: this is discussed in more detail in the concluding section of this assessment.

Table 2: Summary of key features of current health insurance schemes in Indonesia[5]

Health insurance	Nature of scheme and target beneficiaries	Financing mechanism	Benefit package	Providers	Reimbursement mechanism
Government-controlled schemes					
PT Askes	mandatory insurance for civil servants, covering 11% of insured population in 2011	general taxes employee payroll contributions	comprehensive package across all levels of care	all health care providers (public and private)	capitation
PT Asabri	mandatory insurance for military staff and their families, covering 1% of insured population in 2011	general taxes user fees	primary, secondary and tertiary care	military primary level clinics and hospitals, and public hospitals	centrally allocated budgets
Jamsostek	voluntary component of social insurance for formal workers[6]	employee payroll contribution	comprehensive secondary and tertiary care	public and private clinics and hospitals	fee-for-service
Askeskin (Health Insurance for the Poor), renamed Jamkesmas (Social Security for Health) in 2009	pro-poor voluntary public insurance, covering 50% of insured population in 2011	general taxes (no user fees)	comprehensive package across all levels of care	public clinics and hospitals	Indonesian Diagnosis-related Groups
Jampersal	voluntary insurance for universally free reproductive, maternal and child health care, for all pregnant women	general tax (no user fees)	delivery care, including prenatal and postnatal care	public clinics as well as general and maternity hospitals	reimbursement according to Jampersal tariffs
Jamkesda	local government mandatory insurance	local government revenue through the district government budget	complementary with Jamkesmas benefits	public clinics and general hospitals	allocated budgets
Private schemes					
Commercial insurance schemes	voluntary health insurance	member premiums	comprehensive health care at secondary and tertiary hospitals	public and private hospitals	negotiated contract with registered providers, with reimbursement on a fee-for-service basis

Source: Tim (2004), Soewondo et al. (2014)

[5] This does not include the new universal health coverage scheme that was implemented in 2014: this is discussed in the concluding section.

[6] Jamsostek has four components: work safety insurance; death insurance; retirement insurance; and health insurance. The only mandatory component of Jamsostek is work safety insurance. Participating in Jamsostek's health insurance is voluntary with employees enrolling in this health insurance if they do not have any other health insurance. In other words, a formal sector employee must be enrolled in a health insurance programme, but not necessarily Jamsostek.

Pooling

Almost half of health financing is in the form of out-of-pocket payments and therefore not pooled.

Of total government revenue, a large share (84%) is pooled at the level of central government (Government of Indonesia 2014). The rest (16%) is pooled at the district level. The budgets for Jamkesmas, Jamkesda and Jampersal come from central government in the form of social assistance (and are not based on premiums).

Rapid decentralisation in the early years of this century has created several challenges for the Indonesian health system with respect to the disbursement of government funds. The Indonesian health system is complex, including central, provincial and district governments that represent over 500 different authorities in total.

These authorities receive government financing through two sources at the central level: the Ministry of Health and the Ministry of Finance. The former finances provincial hospitals, and the provincial and district health offices, through different financing schemes. The Ministry of Finance also provides funding to provincial and districts health offices. The dual funding streams apply even for routine expenditures, fragmenting funding pools and complicating financial decision-making and management.

Added to this, the Ministry of Health has no direct authority over provincial head offices, local governments, district health offices, public primary health centres or private providers: these report to the Ministry of Finance and the Ministry of Home Affairs. The Ministry of Health only has regulatory authority over provincial and district hospitals, which at least allows it to regulate the accreditation of hospitals and require hospitals to submit certain data.

A positive feature, though, is that, since 2003, budget allocations to districts (including funding for the health sector) are determined through a resource allocation formula that assesses districts' needs. This weights allocations according to a geographical indicator, population size and the proportion of the population that is poor.

As described earlier, there are numerous Jamkesda schemes run by different local governments. A 2011 qualitative study of 57 Jamkesda schemes indicated that the vast majority (79%) had been in operation for less than five years, while half had a membership of less than 100,000 individuals (TNP2K 2011). The risk sharing in these relatively small risk pools is limited, as shown by the fact that 20% of Jamkesda schemes experienced claims ratios[7] above 90% (while 40% had no data on their claims ratios at all). Where there are premium contributions,[8] these are limited and not based on actuarial calculations, which also limits financial risk protection.

The premiums for Asabri, Askes and Jamsostek come from the salaries of employees as premiums and form separate risk pools. Finally, commercial health insurance and in-house insurance schemes represent a number of additional risk pools. There are approximately 91 commercial insurance companies operating in Indonesia.

Purchasing

Direct purchasing of services through out-of-pocket payment by the uninsured population is still common, as the new universal health coverage programme was only launched in 2014.

With respect to the different health insurance plans in Indonesia, benefit packages vary considerably, despite legislation stating that uniform and comprehensive packages should cover all illness caused by natural diseases. Jamkesmas (the scheme for the poor) is notable in offering a more comprehensive package than other insurance plans, including primary health care (in government-run Puskesmas) and secondary and tertiary health care in public hospitals. Catastrophic illnesses are covered including, for example, open-heart surgery, cancer treatment, thalassemia, haemophilia and chronic kidney disease. Jamkesmas beneficiaries also receive medicines listed in the Ministry of Health's drug formulary. However, Jamkesmas does not cover cosmetic surgery, annual medical check-ups, traditional medicine, dental prosthetics, and treatment for reproductive infertility. All Jamkesmas patients are entitled to use third class hospital wards.[9]

The comprehensive nature of the Jamkesmas benefit package creates sustainability and quality challenges for the fund. Both utilization and costs have been escalating, while the increasing need for non-communicable disease interventions poses a challenge for the future. To overcome this problem, the Ministry of Health has developed a cost-containment policy. This includes the national drug formulary to guide prescribing, implementing Diagnosis -related Groups as a provider payment method, and recruiting verifiers to assess claims.

[7] This is claims payable as a percentage of a scheme's revenue.
[8] There are a few districts that introduced premium payments for Jamkesda, but these are very few and tend to be in the form of charity contributions by the richer population. Most Jamkesda schemes are budget-based, with government setting the budget for Jamkesda according to the availability of funds.
[9] These are the most basic wards that are shared by 10 patients or more.

Beneficiaries of the Jamsostek scheme (the health insurance scheme for formal sector workers and their families) experience more limitations on the benefit package. Although beneficiaries receive comprehensive medical services ranging from primary care to tertiary care, certain high-cost treatment such as haemodialysis and heart surgery was not covered until recently, while there are limits on the number of hospital days covered. There are some differences in drug benefits because Jamsostek utilises different drug formularies.

Benefit packages for local governments' Jamkesda schemes vary widely across districts, ranging from the more common basic outpatient care package at local Puskesmas to the less common comprehensive care packages for resource-rich areas that include tertiary care at top referral hospitals in Jakarta. Most schemes limit services to local health care providers in their own districts or provinces and many struggle to provide referral services (TNP2K 2011). In some districts, the benefit package is adjusted almost every year without considering contribution rates.

Apart from inequities created by variations in benefit packages, the different insurance schemes result in a number of funding sources for public services, each with their own guidelines. From the perspective of health care providers (especially hospitals), the contract administration duties created by this system are complex and time-consuming. Hospitals may deal with many insurance agencies through several individual contracts, since Jamkesmas, Jamsostek and Askes apply different benefit packages and administrative systems to their respective beneficiaries. Hospitals may require different personnel for different insurance agencies in order to be able to comply with different protocol guidelines.

Jamkesmas (the insurance scheme for the poor) reimburses providers using Indonesian case-based tariffs. Services under Jampersal (the insurance scheme for formal sector workers) are reimbursed based on claims using tariffs set by the Jampersal technical guidelines, while Askes uses a list of tariffs that it sets itself. With respect to funds channelled through insurance schemes, the district and provincial health offices do not have any regulatory authority for the use of these funds, and are limited only to a supervisory role through claim verification.

District and provincial health offices, as well as primary health centres and district hospitals, have limited room to manoeuvre as to how they choose to spend these insurance funds. For example, the general allocation fund could be used for any health spending, including wages, infrastructure and operational costs. However, it is mostly spent on salaries. The special allocation fund can only be used for infrastructure and physical medical equipment. On the other hand, the special operational supporting fund can only be used by the primary health centre for operational costs, but not for procuring medical equipment or maintenance. Given the complexity of these arrangements, and the lack of capacity at the sub-national level, the efficient utilization of these funds if often limited.

Public health care programmes – such as immunisation, the family planning programme and integrated mother-and-child care are also funded through tax funding which is channelled through the Ministry of Health. Primary health care is therefore funded through two sources, one through the government budget (for preventive care) and the other through social insurance schemes (for basic health care).

Provision

The Indonesian health system is complex, involving various public and private providers. The government's role is to provide health infrastructure such as personnel, hospitals and community health centres that are accessible to all: this service delivery network is jointly managed by the Ministry of Health and the Ministry of Home Affairs. The diverse services organized through the country's public health centres are delivered mainly by salaried public service workers.

Sixty per cent of public sector health spending goes on curative care, and the rest is for prevention, promotion and rehabilitative care. A decrease in hospital utilization has been noted: this may be due to the successful 'gatekeeper' role of the primary care Puskesmas and the success of the family planning programme.

As already described, one of the drawbacks of the decentralized Indonesian health system is the difficulty in coordinating sub-national health providers. For example, the district health office is separated from the district hospital, and there is no direct line of authority between the two. Without strong coordination, it is difficult to integrate the health promotion and curative aspects of health services.

Furthermore, the Jamkesmas and Jamkesda initiatives seem to have prompted health workers at district health offices and health facilities to focus on providing individual health care benefits, leading to a curative care bias. Funding that was previously allocated to support public health and disease surveillance has been shifted to support Jamkesda. This has seriously undermined the quality of disease surveillance and public health programmes.

The 1990s saw rapid growth in the private health sector due to economic growth, which led to changes in the population's preferences (Trisnantoro 2004). Investment in private hospitals and clinics expanded rapidly and probably outstripped spending on government facilities. Between 1989 and 1998, the number of private hospitals increased from 325 to 510 and the number of private hospital beds rose by 4% yearly (Soewondo et al. 2014). As capacity rose, utilization increased as well: the number of patient days in private hospitals grew by 5% a year between 1989 and 1997. Private hospitals accounted for 42% of total patient bed days in general hospitals, and the majority of beds in Jakarta and several other major cities. Currently this increase in private sector provision continues.

Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Indonesia and then moves on to assess the overall equity of the health financing system.

Catastrophic payment indicators

Using the 40% threshold of non-food household expenditure for assessing catastrophic payments, Table 3 shows that less than two per cent of the population incurred catastrophic spending in Indonesia in 2003 as a result of accessing health care. However, it is agreed in the literature that this method could understate the actual problem because it does not capture the reality that there may be people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

As Table 3 shows, too, catastrophic payments in Indonesia mainly affected richer households as revealed by a lower proportion for the weighted headcount compared to the un-weighted headcount. This may have been because existing government financing, including prepayment schemes, was effective in reducing the risk of catastrophic health payments among the poor population. On the other hand, the heavy reliance on out-of-pocket financing in Indonesia, and the relatively low level of expenditure on health care, suggests that poverty may preclude the poorest from seeking care. Unfortunately these data are over a decade old and it is not known how this situation may have changed over the intervening years.

Impoverishment indicators

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Indonesia, about 58% of the population lived below $2.15 per day in 2001 (see Table 4). An extra 1.7% dropped into poverty as a result of paying out of pocket when accessing health services. This translated into about 3.4 million people falling into poverty during 2001 because of out-of-pocket expenditure on health care although admittedly this was before the dramatic growth in government expenditure on health care that was seen more recently.

Table 3: Catastrophic payment indicators for Indonesia in 2003*

Catastrophic payment headcount index (the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold)	1.95%
Weighted headcount index**	1.25%
Catastrophic payment gap index (the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold)	0.32%
Weighted catastrophic gap index**	0.15%

* Financial catastrophe is defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food household expenditure.
** The weighted headcount and gap indicates whether it is the rich or poor households who mostly bear the burden of catastrophic payments. If the weighted index exceeds the un-weighted index, the burden of catastrophic payments falls more on poorer households.
Source: van Doorslaer et al. (2007)

The normalised poverty gap (also shown in Table 4) measures the percentage of the poverty line necessary to raise an individual who is below the poverty line to that line. The difference between the prepayment and the post-payment poverty gaps was relatively low at 0.8% in 2001. This proportion might be very low due to the fact that the methodology only captures those who access health care services, excluding those already very poor individuals who cannot afford to pay for health care.

Table 4: Impoverishment indicators for Indonesia in 2001 using $2.15 poverty line (in terms of 2003 purchasing power parity (PPP))

Pre-payment poverty headcount	58.2%
Post-payment poverty headcount	59.9%
Percentage point change in poverty headcount (pre- to post-payment)	1.7%
Pre-payment normalised poverty gap	17.3%
Post-payment normalised poverty gap	18.1%
Percentage change in poverty gap (pre- to post-payment)	0.8%

Source: van Doorslaer et al. (2006)

Table 5: Incidence of different domestic financing mechanisms in Indonesia (2007)

Financing mechanism	Percentage share	Kakwani index
Direct taxes		0.03
Personal income tax	10.5	
Corporate tax	1.4	
Property tax	0.7	
Total direct taxes	**12.5**	
Indirect taxes		0.01
VAT	5.9	
Excise tax	1.9	
Import duties	1.1	
Total indirect taxes	**9.0**	
Non-tax revenue	13.2	
Mandatory health insurance contributions (social health insurance)	21.3	0.07
Total public financing sources	**56.0**	
Commercial voluntary health insurance	6.0	
Out-of-pocket payments	38.0	0.04
Total private financing sources	**44.0**	
Total Financing Sources	**100.00**	

Note: Kakwani estimates are based on per adult equivalent expenditures; missing estimates reflect insufficient data to perform calculations.
Source: Tae-Jin et al. (2014 in press)

Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A 'progressive' health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity is measured by the Kakwani index: a positive value for the index means that the mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive. Table 5[10] provides an overview of the distribution of the burden of financing the Indonesian health system across different socio-economic groups (i.e. the financing incidence) as well as the Kakwani index for each financing mechanism.

As Table 5 shows, the main sources of finance in Indonesia had positive Kakwani indices which means that the financing system overall is progressive, with rich people paying relatively more. However, the Kakwani indices were close to zero, which means that the difference in the relative financing burden carried by richer and poorer people is not that large.

Social health insurance was progressive because in 2007 a huge proportion of the beneficiaries were civil servants who are better off financially. The influence of the Kakwani index for social insurance on overall progressivity was quite large as social health insurance accounted for a significant share of total health spending (21%).

Unlike in many other countries, Indonesia had slightly progressive out-of-pocket payments, meaning that the better-off population made higher payments compared to the poorer population. However, it should be noted that

Table 6: Distribution of utilization by women (aged 15-49) of health care across different socioeconomic groups (2007)

Background characteristics	Modern family planning methods (%)	Antenatal care service (%)	Skilled birth attendance (%)	Caesarean section (%)
Residence				
rural	58	90	76	4
urban	57	98	84	11
Education				
no education	40	63	50	3
some primary	51	82	69	2
completed primary	61	92	80	3
some secondary	66	96	83	7
secondary +	64	99	84	13
Wealth quintile				
lowest	50	82	65	2
second	60	92	79	5
middle	62	96	83	5
fourth	64	99	87	7
highest	64	99	86	17
Total	57	93	80	7

Source: Indonesia Demographic & Health Survey 2007

[10] This Table (based on 2007 data) estimates that private financing sources made up 44% of total financing sources, whereas Table 1 (based on 2012 data) sets the percentage at 60%. This discrepancy partly reflects real changes over time (for example, the economy grew at 8% per year between 2010 and 2012 which led to changes in private sector expenditure, including increased membership of commercial insurance). It also reflects the fact that, until recently, government statistics did not routinely capture private expenditure. Data for 2012 were supplemented by a once-off survey of private expenditure.

overall health care utilization among the poor is low (see later) and might have influenced the apparent progressivity of out-of-pocket expenditure.

Equitable use of health services and access to needed care

This section considers how benefits from using different types of health services are distributed across socio-economic groups. Table 6 shows the different utilization of reproductive health services across different socio-economic groups in Indonesia in 2007. Overall, richer groups had higher utilization of health services. The same was true of urban and more educated individuals.

Antenatal care, which is the basic health service for pregnant women, was accessed more equitably across different wealth quintiles. However, skilled birth attendance and facility-based delivery, which requires better access, showed inequitable use across different wealth quintiles. Caesarean sections were particularly high among the richest wealth quintile, suggesting possible over-use. In terms of general health service utilization, the pro-rich bias was greatest for inpatient care and smallest for non-hospital care (van Doorslaer et al. 2007).

It is generally agreed that individuals' use of health services should be in line with their need for care. The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. The distribution of utilization discussed above does not allow one to draw a categorical conclusion about whether the distribution is equitable or not: the distribution of utilization first needs to be compared to the distribution of need for health care.

Table 7 looks at mortality rates for different population groups in Indonesia in 2007, showing that there was significantly higher mortality among the residents of rural areas and those with less education. Similarly, the poorest wealth quintile had the highest rates for neonatal, infant and maternal mortality. It appears, therefore, that these populations were underserved by the health system, sometimes forgoing treatment.

Conclusion

The analyses above indicate that the distribution of the burden of health financing in Indonesia is mildly progressive.

Table 7: Early childhood mortality among different socioeconomic groups (2007)

Background characteristics	Neonatal mortality	Post-neonatal mortality	Infant mortality	Child mortality	Under-five mortality
Residence					
rural	24	21	45	16	60
urban	18	12	31	7	38
Education*					
no education	39	34	73	22	94
some primary	26	25	51	19	69
completed primary	23	21	44	23	56
some secondary	22	13	35	10	45
secondary +	14	10	24	8	32
Wealth quintile					
lowest	27	28	56	23	77
second	25	22	47	12	59
middle	19	13	33	12	44
fourth	17	12	29	8	36
highest	17	9	26	6	32

Note:
*Mother's education.
Source: Indonesia Demographic & Health Survey 2007

Indonesia's out-of-pocket payments are still at a very high rate because of user fees across the system and the large proportion of the population that remains uninsured, despite government-run social health insurance schemes. Catastrophic payments probably still burden many of the poor while utilization by the poor is low relative to their need for health care.

Furthermore, the complexity of the financial protection system has introduced distortions into the health system, both in terms of funding flows as well as the provision of care. Risk pools have also been fragmented.

To address these problems, in 2014 the Indonesian government initiated the implementation of its first universal health coverage programme, National Health Insurance or BPJS. PT Askes, which previously had administered the health insurance scheme for civil servants, has been transformed into BPJS Health, which now manages all members of the previous government-run schemes (PT Askes, PT Asabri, Jamsostek, Jamkesmas and that part of Jamkesda that was managed by Askes, representing 44% of members (Government of Indonesia 2011)). BPJS Health is a non-profit public entity that is directly responsible to the President of Indonesia.

BPJS Health is tasked with unifying these health schemes, creating one large risk pool. The current coverage of the new scheme is almost 122 million people (Ministry of Health 2012). The intention is to insure all 258 million Indonesians by 2019, including foreigners who work in the country for more than six months.

The new scheme is now funded through a mixture of government subsidies (or 'contributions') and premiums (Table 8). Government contributions are for what are known as 'contribution beneficiaries' (Penerima Bantuan Iuran or PBIs), namely those who are too poor to fund themselves. Premiums for non-contribution members (or non-PBIs) are set in proportion to the income of individual beneficiaries: for those who are not well paid, premiums will be nominal amounts. These members include salaried and non-salaried workers as well as the self-employed, and their families. These premiums are to be paid jointly by employers and their employees. It is anticipated that the scheme will become cheaper as more members join the system and that government contributions will be reduced over time as the scheme becomes more sustainable (Tim 2004).

BPJS Health is responsible for implementing a nation-wide, single benefit package that is comprehensive, except for some limits and exclusions. The comprehensive benefit package will include outpatient and inpatient care at primary level up to tertiary hospital settings. Implementation will be in several phases.

Table 8: Contributions and premiums for NHI members

Insured category	Contributors to premium	Contribution level
• government civil servants and pensioners	members	5% of salary or wages per month (3% paid by employer and 2% paid by members)
• non-civil servant government employees (i.e. contract employees)	central government for national level, and local government for local level, civil servants	
• Indonesian National Armed Forces/Indonesian National Police (including family members)	non-civil servant government employees	
• contribution beneficiaries (PBIs)	central government	USD1.50 per member per month
• salaried workers in the private sector	members employers	In 2014, 4.5% of salary or wages per month (4% paid by employer and 0.5% paid by member) After 2015, 5% of salary or wages per month (4.5% paid by employer and 0.5% paid by member)
• non-salaried workers and non-employees (including the self-employed, business-owners and investors)	members	varying monthly amounts qualifying members for different classes of room[11]

[11] All classes of room receive the same level of medical treatment. However, Class I is a private, air-conditioned room with a bathroom. Class II is a room shared with one or two other patients. Class III is a room without air conditioning and shared with 10 other patients.

As a single payer, BPHS Health will be in a good position to bargain with health care providers around charges and implement stricter cost controls. As a single fund, services for all sick people will be reimbursed without having to take cognisance of how much each member contributed.

Health facilities will be selected on the basis of criteria set by the Ministry of Health and BPJS Health, and individual contracts will be established between providers and BPJS Health. Regulations also address important issues such as the availability of services and performance of health facilities (Soewondo et al. 2014).

BPJS Health pays health care providers through various mechanisms. Both public and private primary care providers are reimbursed on a monthly capitation basis according to the number of registered participants. Participants have to register with one primary care provider but are allowed to re-register with another if they are dissatisfied. Other than in an emergency, participants are required to visit their primary care provider first: primary care providers therefore have an important role to play as gatekeepers. BPJS Health expects that this system will encourage gatekeepers to improve the quality of their care as well as the well-being of their registered members in order to reduce the frequency of visits. Implicitly, this also requires the gatekeeper to strengthen promotion and preventive measures.

BPJS Health pays hospitals using a prospective payment system based on Indonesian Diagnosis-related Groups (known as INA-CBGs), with health care costs varying according to region and hospital class but identical for public and private providers. Top-up payment is available only in special cases and using a cost-to-charge ratio.[12] The INA-CBG payment system was adopted to encourage a more patient-focused, efficient and high-quality service, as well as to avoid over-treatment, under-treatment, moral hazard and adverse selection.

A number of important policy details still need to be worked out, including the premium subsidy level, the benefit package and mechanisms to include informal sector workers. Co-payment is not allowed under the current national health insurance, but BPJS Health could in future establish an arrangement with a private insurance company for patients wishing to upgrade their ward to a higher class. The national health insurance policy also needs to decide whether the ward class will differ between those whose premiums are subsidized by the government and those paying the full premium through employer benefits.

Finally, financial protection should be regarded as one aspect of universal health coverage and not the sole agenda for Indonesia. Intensive investment is required to ensure supply-side readiness, so that equitable health care utilization and health attainment can be achieved even in the currently under-developed regions of Indonesia.

[12] This is the ratio of the actual hospital costs to the gross charges of the hospital.

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GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

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