International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Indonesia

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Extending Social Health Protection in Indonesia: Accelerating progress towards Universal Health Coverage

1. Introduction

With the enactment of the 2004 Law on the National Social Security System and Law No. 24 of 2011 on the Social Security Administrative Body, the Government of Indonesia has made a strong commitment to achieving universal health coverage (UHC). In 2012, the National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN) and the Ministry of Health (MOH) laid out a road map towards an integrated social health protection (SHP) system and the establishment of a Social Security Administrative Body for Health, known as BPJS Kesehatan. Prior to 2014, a range of fragmented health protection schemes existed, which were eventually merged into a single-payer system, known as Jaminan Kesehatan Nasional (JKN), managed by BPJS Kesehatan. Currently, the JKN national health insurance scheme is one of the largest single payer systems in the world, with around 223 million members as of 2020. Since its implementation, it extended social health insurance coverage to more than 82 per cent of the total population in Indonesia. However, the last mile towards universality is proving to be a significant challenge, particularly with regard to ensuring coverage for workers in the informal economy and their families. Due to inequitable access to health care, increased health care utilization has not yet translated into significant improvements of health outcomes. For example, the maternal mortality ratio remains high, decreasing from 199 deaths per 100,000 live births in 2014 to 177 deaths per 100,000 live births in 2017 (WHO 2018). Furthermore, the under-five mortality ratio increased from 19.1 in 2014 to 25 in 2017.

2. Context

The social health protection system in Indonesia has evolved over time and seen significant reforms. The oldest social health insurance scheme, Askes, was established in 1968 to provide coverage for civil servants, military and police personnel, retired government workers, and veterans and their families. In 1992, the social insurance scheme, Jamsostek (covering health, old-age and work injury), was set up for employees of private companies with more than ten employees and paying salaries

greater than 1 million Indonesian Rupiah (IDR) (approximately US$71) per month per employee. However, coverage of these two schemes was continuously low covering just 7 per cent and 5 per cent of the population in 2013, respectively (Director General for Poverty Alleviation 2019).

In 2005, a scheme called Jamkesmas was established to provide coverage for the poor and near-poor, which covered more than 76 million people in 2013 (32.2 per cent of the total population). Beneficiaries could access health services at public primary health care facilities and selected public hospitals with no co-payments. While the scheme was successful in increasing utilization and reducing catastrophic expenditures, significant supply-side constraints and inequities in the availability of services persisted (Harimurti et al. 2013).

In 2014, the establishment of Indonesia's national social health insurance scheme (JKN) consolidated all previously fragmented social health insurance schemes and assistance programmes at national and provincial levels. This resulted from citizens taking legal action to hold the Government accountable to implement the 2004 law on the National Social Security System. The merger of Indonesia's social health protection schemes and transition to a single-payer system has allowed for significant coverage extension.

3. Design of the social health protection system

- Financing

The JKN scheme is financed by central and local government revenues to provide subsidies for the poorest 40 per cent of the population. It is also funded by social security contributions from workers and employers. For salaried workers, 4 per cent of their monthly payroll is paid by the employer and 1 per cent by themselves, while non-salaried workers (informal sector) and non-workers pay a fixed contribution based on their choice of inpatient ward class (BPJS 2020). [1]

Domestic public health expenditure has steadily increased since the introduction of JKN, standing at 48 per cent of current health expenditure (CHE) in 2017. Within domestic public expenditure, general government revenues and social health insurance contributions represented 36 per cent and 13 per cent of CHE respectively in 2017 (PPJK 2018). The remaining proportion of health expenditure is comprised of private health expenditure (16 per cent of CHE) and out-of-pocket (OOP) expenditures (34 per cent of CHE).

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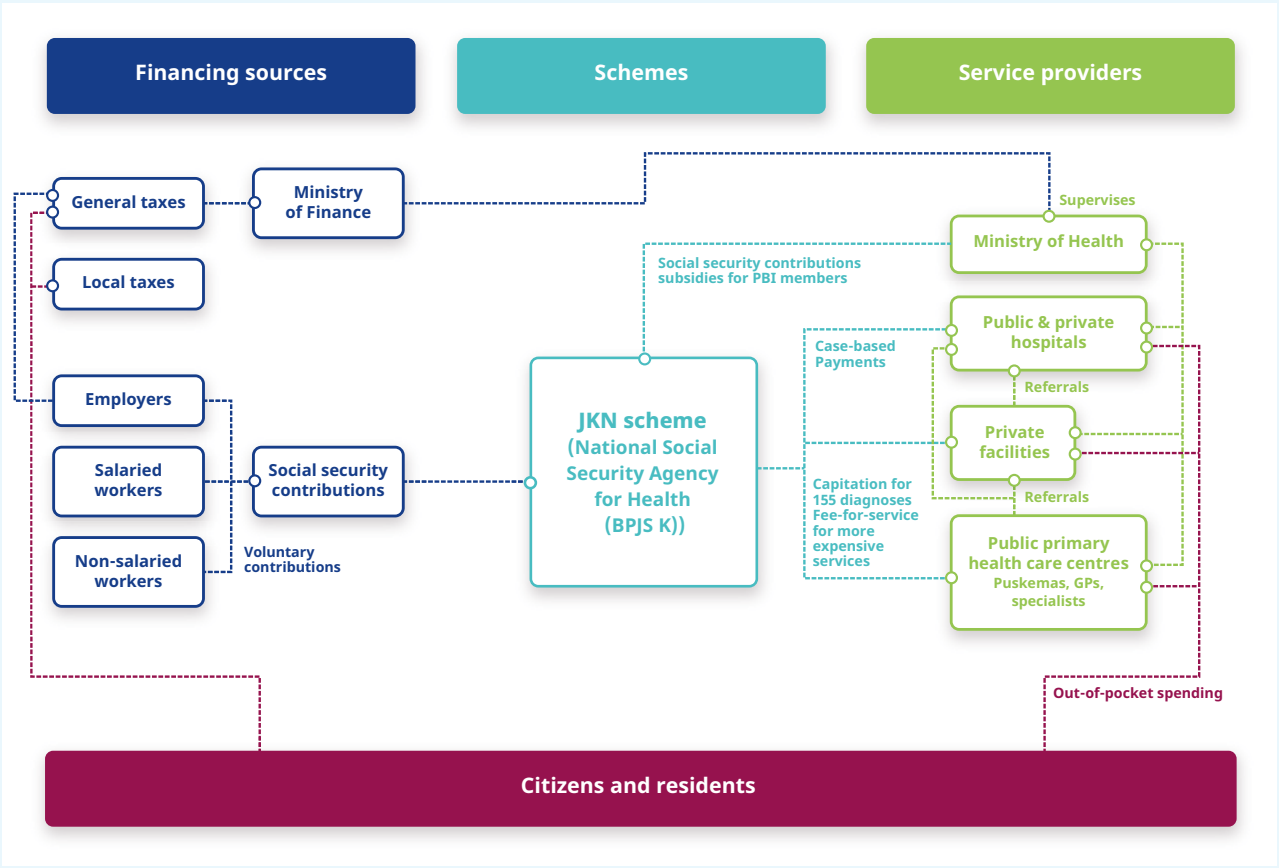
[1] According to the Presidential Regulation 82/2019, there are different monthly contributions for workers in the informal economy based on ward level: I – IDR42,000; II – IDR110,000; and III – IDR160,000.

▶ **Figure 1. Overview of main financial flows of the social health protection system in Indonesia**



Note:
PBI APBN: Subsidized segment (national level, based on unified database)
PPU BU: Formal private sector
PBI APBD: Subsidized segment (local level, transferred from Jamkesda)
PPU P: Public sector workers
PBPU: Informal sector workers
Source: Authors.

- Governance

The JKN scheme is implemented and managed by the BPJS Kesehatan – a not-for-profit trust fund, and legally independent entity directly controlled by the President of Indonesia. Under the supervision of the MOH, BPJS Kesehatan is responsible for the enrolment of beneficiaries, the collection of contributions, claims management, processing of payments to health care providers, and administering of contracts with providers. The National Social Security Board, Dewan Jaminan Sosial Nasional (DJSN), was established by the President of Indonesia as an autonomous and tripartite board with 15 members. It formulates social and health protection policies and oversees and monitors the performance of BPJS Kesehatan. As an independent body, it reports to the President of Indonesia. However, in terms of administration and budget, it is located under the Coordinating Ministry for Human Development and Cultural Affairs (Prabhakaran et al. 2019).

- Legal coverage and eligibility

Registration to the JKN scheme is compulsory for all residents, including foreigners who have been working in the country for a minimum of six months. The main categories of beneficiaries

covered by the scheme include: (i) salaried workers whose contributions are shared with employers; (ii) non-salaried workers and non-workers who pay a flat contribution; and (iii) poor and vulnerable population groups (the poorest 40 per cent of the population) whose contributions are fully subsidized. Coverage for dependents is possible for all member categories. As differentiated deadlines were set for implementing mandatory coverage, for some population groups (such as informal economy workers), registration remains voluntarily in practice.

- Benefits

The JKN scheme provides a unique, broad benefit package to all members. Some differences in the benefit package exist, depending on the type of ward where members access services or depending on different membership groups, but there are no differences in the services covered. Salaried workers are entitled to Class 1 or 2 wards, subsidized members can only access Class 3 wards, and informal economy members can access services in all wards depending on the contribution paid. All JKN members benefit from comprehensive coverage of health promotion; preventive, curative, and rehabilitative medicine services; medically indicated laboratory tests, drugs and supplies; and ambulance services for referrals (Prabhakaran et al. 2019). The establishment of the JKN was used as an opportunity to include both HIV and tuberculosis diagnostic and treatment services in the benefit package, which were previously managed vertically outside the social health insurance system (Prabhakaran et al. 2018). The only exclusions include services in health facilities that are not empaneled or contingencies already covered by other programmes, such as employment injury and traffic accidents.

- Provision of benefits and services

As of 2020, the BPJS registered network of facilities includes 27,075 public and accredited private facilities. In 2017, 60 per cent out of all BPJS Kesehatan contracted facilities were private, with the private health sector growing faster than the public sector (Gani and Budiharsana 2019). Primary health care (PHC) facilities typically provide outpatient services only, including consultations, the provision of medications and some diagnostic testing and screening (Gani and Budiharsana 2019). More complex services and most inpatient services are only available at the hospital level (Agustina et al. 2019). Patients are only covered for specialist care after a primary care provider has referred them (Agustina et al. 2019).

JKN members are initially registered at the PHC facility of their choice, which is usually a facility that is close to where they live, based on the address on their electronic ID card. For some beneficiaries with subsidized membership, the choice of PHC facility may have been decided based on the district, as their enrolment is linked with their identification through the social assistance programme, National Social Welfare Integrated Data.

Under the JKN scheme, there are three types of provider payment methods: capitation for primary health care for 155 diagnoses; fee-for-service for high-cost services not paid by capitation for more onerous interventions; and case-based payment rates (INA-CBG) for hospital services that vary by hospital level and region (Prabhakaran et al. 2019).

▶ 4. Results

- Coverage

JKN has achieved legal coverage of the entire resident population, and since its introduction, effective coverage has also continuously improved, particularly among the poor. As of 2020, the population at the lower end of the income stream, whose contributions are fully subsidized, made up around 60 per cent of all JKN members. [2] As of 2020, JKN covered 223 million members (equivalent to 82 per cent of the total population), which rose from 133,420,000 persons covered in 2014 (BPJS 2020).

However, there remain challenges to the extension of effective coverage, particularly for those working in the informal economy, otherwise known as the “missing middle”. Only 13.6 per cent of all members are registered under the non-salaried worker segment, although around 60 per cent of the labour force in Indonesia is self-employed (Badan Pusat

[2] The PBI is intended to cover approximately the bottom 40 per cent of the Indonesian population, which is much higher than the 9.7 per cent of the population who are below the official poverty line (TNP2K 2018).

Statistik 2019). Many of these workers may not be poor enough to qualify for subsidies, but they may also not be able to pay regular contributions independently. Even when informal workers are enrolled, irregular collection of contributions results in coverage gaps.

- Adequacy of benefits/financial protection

Although some progress has been made with regard to financial protection since the introduction of JKN, OOP spending remains relatively high at 32 per cent of CHE in 2018, with an estimated 2.71 per cent of Indonesian households facing catastrophic health care expenditures during the same year. This could be partly attributed to the existence of informal payments directly paid by patients to health providers in order to avoid long waiting times or to buy medicines that are not listed on the medicine list of the JKN (GIZ 2018; OECD 2019). The high share of OOP payments is also believed to result from limited geographical accessibility of health care facilities, particularly in rural and remote areas, which forces many people to visit facilities not contracted by BPJS and pay directly for their medical care (Health Policy Plus 2018). Additional, transportation costs increase when patients need to access facilities further away from their homes, resulting in additional non-medical costs of accessing care.

- Responsiveness to population needs

  o Accessibility and availability

The introduction of JKN, a single-payer system with a unified benefit package, has increased access to both outpatient and inpatient care, leading to a rise in utilization rates (Health Policy Plus 2018). Notably, JKN steadily increased the number of service providers contracted, resulting in an increase of 23 per cent between 2015 and 2018. However, the geographical distribution of facilities remains uneven (Gani and Budiharsana 2019). Inequalities in utilization rates between urban and rural areas, as well as across socio-economic quintiles persist, with the number of available health care facilities varying between regions, and a lack of available health infrastructure and health workers in rural and underprivileged areas. As noted above, this means that high transportation costs can be incurred through seeking medical care (Agustina et al. 2019).

Moreover, the distances between people's homes and BPJS Kesehatan offices are often considerable, which makes it difficult for people to access offices to receive information on the scheme and enrol. Opportunity costs (in terms of working time loss) can also be an additional barrier, particularly for self-employed workers. A particularly noteworthy initiative in this context is the Kader JKN partnership programme which aims to facilitate access to social health insurance for informal economy workers and other individuals through selected members from the closest communities. Kader JKN agents perform four functions: outreach and communication; enrolment of new members; collection of contributions and their transfer to the scheme; and handling of complaints. Candidates must fulfil certain criteria (such as domicile near area of target group or registration for online banking) to qualify as a Kader JKN agent. While BPJS acknowledges that there are potential risks in ensuring appropriate accountability and control mechanisms in such a programme, the initiative increased the contribution collection rate by around 14 per cent from 2017 to 2018, thanks to a total of 2,000 active agents who managed two million members (Nguyen and De Cunha 2019).

  o Quality and acceptability

A key challenge for the Indonesian system is to ensure access to quality health services in an equitable manner. Currently, the lack of health care facilities and the inequitable quality of services across provinces limits access to the broad benefit package offered by JKN (Gani and Budiharsana 2019). Limited quality of health care services is strongly linked to under-staffed and poorly equipped health care facilities in Indonesia. With regard to investments in infrastructure, in 2019, 233 districts had a minimum of one accredited public general hospital, compared with the target of 477 set by the MOH; and 350 sub-districts had at least one accredited PHC facility, compared with the MOH target of 5,600. Notably, fewer than 70 per cent of these centres were deemed to be in good condition and had access to tap water (Fauzia and Dita 2018). Furthermore, the number of doctors per 1000 people has remained stagnant

since the introduction of JKN, standing at a very low ratio of 0.378 doctors per 1,000 people (WHO n.d.).

In 2018, only about half of the community based health posts were properly staffed, which remains an important challenge to meet the needs of the population (Gani and Budiharsana 2019). Similarly, health sector assessments have highlighted a bias towards the greater financing of individual health interventions (financed by JKN) rather than whole population interventions (financed by the general budget), the latter of which are key to the eradication or systemic prevention of diseases such as tuberculosis, HIV and water-borne diseases (Gani and Budiharsana 2019). While the JKN benefit package does include essential preventative care, the changing burden of diseases in Indonesia, with non-communicable diseases on the rise, suggests the need for a stronger focus in this area. In this context, care provided in the community is of the utmost importance (Gani and Budiharsana 2019).

▶ 5. Way forward

According to the DJSN and MOH road map, Indonesia should have achieved UHC by 2019. While much progress has been achieved since the introduction of JKN, significant remaining challenges include ensuring effective access to quality care and reaching out to the "missing middle". The implementation of Mobile JKN — a mobile application that allows members to register, pay monthly contributions, submit complaints and access information — is among measures to address these challenges. Plans are also in place to introduce an auto-payment mechanism using e-wallet accounts which facilitate payments and ensure regular payment for members without bank accounts. Based on the national ID system, BPJS Kesehatan also plans to strengthen its collaboration with the Ministry of Interior to better identify informal economy workers whose participation could be supported with government subsidies.

In terms of fostering harmonization, the integration of social health protection schemes at administrative and policy levels has fostered linkages with the broader social protection system. Indonesia has made progress towards developing an information system underpinning the social protection system, creating a single targeting mechanism for all social assistance programmes, namely National Social Welfare Integrated Data. An integrated social protection information system of this nature has the potential to ensure a more equitable, responsive and inclusive distribution of resources while increasing efficiency and effectiveness to better serve the population.

▶ 6. Main lessons learned

- The integration of various health insurance schemes into JKN was key to accelerating the extension of coverage in Indonesia. The creation of JKN helped to reduce fragmentation within the social health protection system by introducing a unique benefits package and a single risk pool. Through the integration of several social health protection schemes and the provision of subsidies for vulnerable population groups, the Government managed to scale up the new solidarity-based scheme in a short period of time and extend coverage to 82 per cent of the total population.
- A rights-based approach is essential for the operationalization of the scheme and ensuring effective access. Progress in social health protection coverage was achieved through political commitment generated through pressure from civil society. The merger of Indonesia's SHP system was initiated after citizens took legal action to hold the Government accountable to implement the 2004 law on the National Social Security System. The law stipulates that benefits should be uniform for all members (Global Financing Facility and World Bank 2019).
- Institutional integration is necessary, but insufficient to guarantee equity. Considerable inequities between geographical regions and socioeconomic groups remain with regard to utilization of health services. The entitlement to a broad benefit package needs to be accompanied by its implementation in practice, especially with regard to increased investments in health care infrastructure

and equipment. Increasing the number of qualified health workers across regions is equally important to ensure a more equitable, responsive and inclusive distribution of human resources. It is also key to facilitating active outreach efforts to ensure equal information across all socioeconomic groups and geographical locations about rights to social health protection and how to access the scheme.

- More efforts are needed to effectively guarantee financial protection. Despite the rapid extension of JKN, as well as its comprehensive benefits package, OOP payments remain high in Indonesia, at 32 per cent of CHE in 2018. This can be explained by limitations of the network of contracted health care providers. Lack of accessibility to health care facilities, particularly in rural and remote areas, forces many people to visit non-contracted BPJS facilities and pay directly for their medical care. Additionally, a high level of informal payments can be requested by medical facilities or professionals. Moreover, the growth in the private health sector contributed to an increase in overall expenditure and the relatively high level of OOP.
- Based on Law No. 40/2004, JKN is mandatory for all. However, the Social Health Insurance Roadmap (2012–2019) foresaw mandatory affiliation increasing gradually, based on the size of participating enterprises. The remaining challenges for JKN is to extend health coverage to workers in the informal economy, demonstrating that voluntary affiliation did not lead to significant increases in coverage, which confirms other international experiences. Particularly when awareness of social health protection is low and contributory capacities are limited, voluntary affiliation seldom yields successful results. Including workers in the informal economy in the mandatory scheme, adapted to their contributory capacities, would not only ensure better protection, it would also contribute to sustainable and equitable financing through a larger risk pool.

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