ESS Extension of Social Security

Sharpening the Focus on the Poor:

Policy Options for Advancing Social Health Protection in Indonesia

Xenia Scheil-Adlung

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Global Campaign on Social Security and Coverage for All

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Only one in five people in the world has adequate social security; half of the world's population is without any social security protection. Social security is a universal need and a basic human right. Based on the consensus reached by governments, employers and workers during the International Labour Conference in 2001, the ILO launched the "Global Campaign on Social Security and Coverage for All" in June 2003. The Campaign is a concrete ILO contribution to the achievement of the Millennium Development Goals and to a fair and inclusive globalization.

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The Global Campaign on Social Security and Coverage for All
INTERNATIONAL LABOUR OFFICE
4, Route des Morillons * CH-1211 Geneva-22 * Switzerland
Tel.: (41-22) 799.66.35 * Fax: (41-22) 799.79.62
E-mail: socpol@ilo.org. * Internet: www.ilo.org/coverage4all

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Summary

Currently some 60 per cent of the Indonesian population is excluded from social health protection and a large part of total health care costs is financed by out-of-pocket payments.

Existing schemes are generally under-funded and weakened by opt-out-possibilities. In addition, a high amount of public health expenditure is spent on supply side financing, which often is not responding to the needs of the poor.

This situation led to strong links between ill health and poverty: within Indonesia considerable variations of health indicators are observed between people living in rich and poor provinces and in urban and rural areas.

The Indonesian Government decided to challenge the negative effects of lacking social health protection by introducing a national social health insurance scheme. The new scheme intends to achieve universal coverage within a timeframe of 20 to 30 years.

The study recommends that the extension of social health protection to the poor be advanced through various policy options. They include privileged implementation of related features of the new social health insurance scheme, strengthening consensus building on pro-poor policies among key stakeholders in social health protection and setting priorities on implementing these policies.

In addition, the implementation of innovative social health protection schemes suitable to informal sector workers, such as flexible community-based schemes, should be taken into consideration.

Innovative schemes should offset financial barriers to access health services. They should be based on solidarity between the healthy and the sick and apply main principles of social health insurance.

Furthermore, it is suggested to develop links and bridges between the national social health insurance scheme and the innovative schemes in order to reach coherent and comprehensive social health protection overcoming the current exclusion of the poor.

Abbreviations

ASEAN	Association of South Asian Nations
GDP	Gross Domestic Product
HMO	Health Maintenance Organization
JPKM	Jaminan Pemeliharaan Kesehatan Masyarakat
MDG	Millenium Development Goals
NHI	National Health Insurance
PRSP	Poverty Reduction Strategy Paper
SSN	Social Safety Net
UNSFIR	United Nations Support Facilities for Indonesian Recovery

1. Social health protection: the current situation

In 2002, the Indonesian Government introduced a new approach to equity, social justice and social security in its political agenda: The House of Representatives voted on an amendment of the Constitution regarding the extension of social security to the whole population and established the principle of equitable health care.

In addition, a Poverty Reduction Strategy Paper (PRSP) is being formulated. It focuses on four main areas of action including social protection for the poor. The government has also subscribed to achieving the Millennium Development Goals (MDGs) addressing various aspects of poverty reduction and health.

In January 2004, the government submitted a comprehensive social security bill to Parliament and declared the introduction of social health insurance a high priority. The new policy is essential for improving the low health status of the population and reducing poverty related to ill health. It also addresses the impact of ill health on the economy such as low productivity due to high absenteeism, care for family members, reduced life expectancy, and consuming large parts of income and savings for health care.

The re-orientation of health policy is crucial: currently in Indonesia, a large majority of the more than 200 million inhabitants is excluded from social health protection. A large part of total health care cost is financed through out-of pocket payments affecting particularly the high number of people living in poverty.

The situation has aggravated over the last years, since even a modest level of public health spending could not be maintained in real terms. As a result, health indicators range significantly behind the neighboring ASEAN countries and have been stagnating over the past decades.

The reform was announced three years after the Ministry of Health provided the framework for a national health insurance scheme and only a few months before the first direct presidential election.

Against this background, this paper (UNSFIR, 2003) attempts to evaluate some of the salient issues, highlight the challenges lying ahead and outline policy options for advancing social health protection schemes for the poor in Indonesia.

The improvement of the existing social health protection is of major concern to Indonesian politicians and the international community. This chapter provides a brief overview of the overall performance, the financial situation and the design of current social health protection schemes.

1.1 Core issues: equity, poverty and health

Despite impressive improvements during the last decade Indonesia's health indicators lag significantly behind those in neighboring countries. Whereas life expectancy at birth stands in Malaysia at 73 years and in Thailand at 69, it reaches only 67 years in Indonesia; infant mortality is 33 per 1000 births in Indonesia while it is only 8 in Malaysia and 24 in Thailand (World Bank, 1998).

Besides Indonesia's internationally low ranking overall health status, the provincial health status patterns indicate more profound problems in the rural areas and in some provinces (see Table 1.): In West Java infant mortality is 75 per 1000 births, in rural Central Sulawesi 84, in Kalimantan 93, and in West Nusa Tenggara the rate is over 100 (OECD, 2002, pp. 31 ff.). In addition, health service utilization patterns point to significant differences between rural and urban areas (OECD, 2002, P.56).

Table 1. Health indicators in Indonesia and neighboring countries, 1996-2002

Countries	Life expectancy at birth	Infant mortality per 1000 births	
Indonesia	67	West Java	75
		Rural Central Sulawesi	84
		Kalimantan	93
		West Nusa Tenggara	100 +
		Country average	33
Malaysia	73		8
Thailand	69		24

Source: World Bank, Country Data, 2003, www.worldbank.org/data/countrydata; OECD, Education and Health Expenditure, and Development: The cases of Indonesia and Peru, 2002.

There is considerable evidence that the variations in health outcomes among provinces are closely linked to poverty and a related lack of access to health services.

According to the draft Indonesia MDG Report (Government of Indonesia, 2004), 17.4 per cent (2003) of the population live below the National Poverty Line. However, ca. 54 per cent of the population live below $2 per day, i.e. a large proportion of the population is extremely vulnerable to falling below the poverty line with changes in situation. Moreover, there exists great poverty disparities between regions, provinces, districts and cities, as well as between urban and rural areas.

In districts such as Kalimantan and Nusa Tenggara, where infant mortality is extremely high, income poverty seems to be the main barrier for access to health care. Surveys carried out in these districts provide evidence that user fees lead to a complete exclusion of the poor from any formal medical care (World Bank, 1995) and constitute a problem of equity.

Particularly, exclusion from inpatient care is due to high financial barriers. The poorest 10 per cent of the population spend 2.3 times their total monthly household expenditure on standard inpatient care; the upper income class (Thabrany, 2003, P.39) spends about the equivalent of one month's household expenditure on standard inpatient care.

Furthermore, high costs of transportation to health facilities – in rural areas often more than ten times the user fees (Thabrany, 2003, P.36) – aggravate access problems to health services and contribute to the equity gap between the rich and poor, sick and healthy and people living in urban and rural areas of Indonesia.

In addition to high infant mortality and low life expectancy, Indonesia's health policy is challenged by the rapid escalation of chronic lifestyle diseases such as cardiovascular diseases and diabetes. Diseases of the cardiovascular system are among the leading causes of mortality. An increase in the prevalence of diabetes is expected in the near future (World Health Organization, 1999). Unlike in developed countries, where the majority of persons with diabetes is aged 65 years and above, most diabetics in the South-East Asia region belong to the younger and economically active age groups (45-64 years).

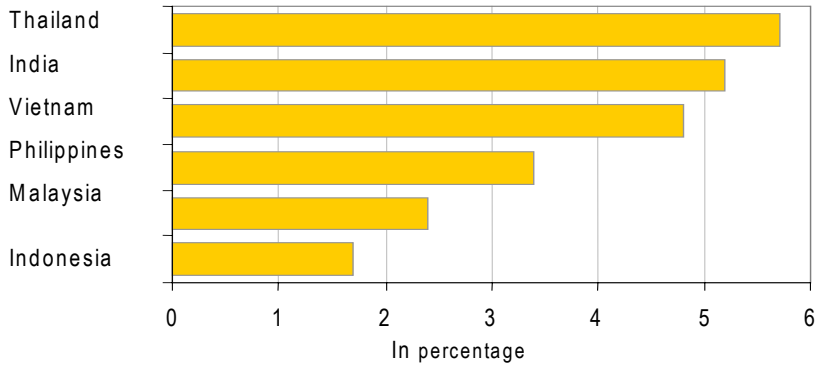
If these developments cannot be reversed over the next decade, this would lead to serious health related impact on Indonesia's labour force and a significant slow-down of economic growth. Main factors contributing to such negative effects will be:

- reduced life expectancy;
- high absenteeism;
- reduced employability;
- lower productivity;
- lower per capita income.

1.2 Health expenditure and economic development

Indonesia's expenditure on health care ranges with 1.7 per cent of GDP very low compared to other countries in the region such as Thailand (5.7), India (5.2), Vietnam (4.8), the Philippines (3.4) and Malaysia (2.4) (see Figure 1.). (WHO, 2000).

Figure 1. Total health expenditure as percentage of GDP



Source: WHO (2000).

In real terms total expenditure on health declined over the past years, e.g. by 7 per cent in 1997/98 and 12 per cent in 1998/99. Currently, it does not reach the share in GDP spent in the pre-crisis period (Ministry of Health, Indonesia, 2003).

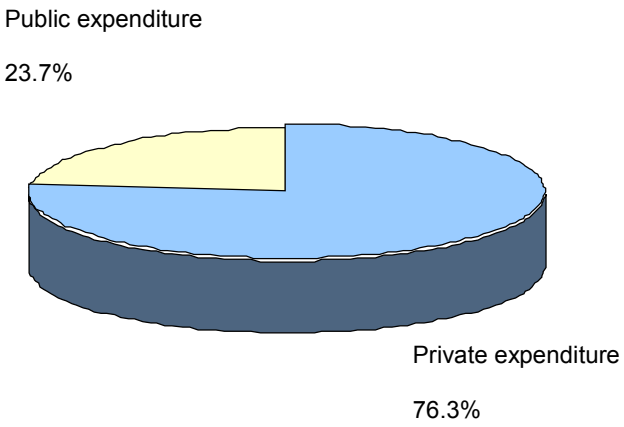
Public health expenditure is decreasing (Ministry of Health, Indonesia, 2003) while income rates are improving and inflation remains at a relatively high level. In 2003 wage increases in the formal sector were around 9 per cent and 0.6 per cent in the informal economy consisting of more than half of the work force; in September 2003 the inflation rate stood at 6.2 per cent (World Bank, 2003) and is expected to remain at around 5 per cent in 2004 (IMF, 2004).

Despite a 3.7 per cent growth rate of GDP in 2002, open unemployment remains high at 8.5 per cent in 2003 and is rising.

These economic developments indicate that financing of social health protection will pose a serious problem in the future; even macroeconomic stability and moderate growth might not be enough for increasing public spending in the field of health protection.

The share of private expenditure in total health care spending increased significantly over the last years from 54 per cent in 1995 to 76.3 per cent in 2000 (Ministry of Health, Indonesia, 2003) (see Figure 2.). It consists mostly of out-of-pocket spending; pre-paid and risk pooling plans amounting to less than 4 per cent of private expenditures.

Figure 2. Total health expenditure by source, 2000



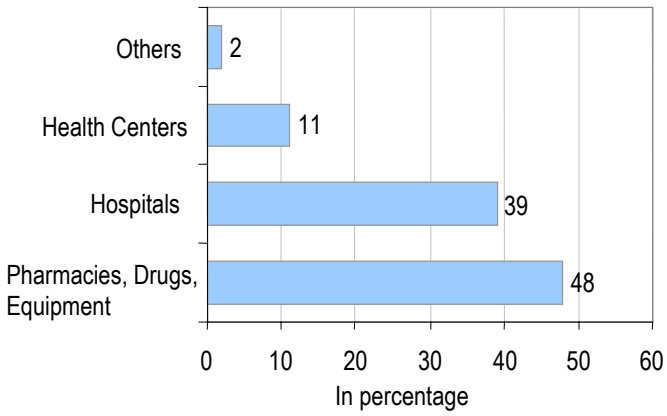
Source: Ministry of Health (2003)

The share of public health expenditure in total health expenditure is only 23.7 per cent (Ministry of Health, Indonesia, 2003). It is mostly funded by the central government (71.5 per cent) and loans of international donors (28.5 per cent). Social security funded health expenditure amounts to 7.5 per cent of the central government expenditure.

In 2000, about 50 per cent of public health expenditure was allocated to pharmacies, drugs and medical equipment; 39 per cent to hospitals and 11 per cent to health centers and sub-centers (see Figure 3.).

The high amount of public health expenditure (see Figure 3.) spent on supply side financing points to a pro-rich distribution (Thabrany, 2003, p.19) since the majority of public hospitals are located in cities or district capitals while the poor mostly live in the rural areas and cannot afford user fees and transportation costs.

Figure 3. Health budget allocation in percentage of public expenditure, 2000



Source: Ministry of Health, Indonesia (2003).

Despite emphasizing on supply side financing Indonesia experiences immense problems regarding a lack of equipment and a low number of hospital beds (0.7 per 1,000 persons), which ranges far below the average of other developing countries (2.7) (Consultative Group on Indonesia, 2003).

Weak financial management has aggravated this situation: Over the last years up to one third of the budget allocated to the Ministry of Health (Consultative Group on Indonesia, 2003) and nearly 60 per cent of funds allocated directly to health centers and midwives were not spent.

This clearly indicates that a simple increase in funds would not be sufficient to balance inequities and improve outcomes of the health care system. In addition, recent studies found that further investment in the supply side might lead to problems of sustainability (Consultative Group on Indonesia, 2003) given the follow up costs, e.g. for maintenance and operation.

Indispensable budget increases aiming at cutting the strong links between poverty and health need to be complemented by a reallocation of funds. This concerns the allocation of funds to the health care delivery system, across urban and rural regions and among the provinces.

1.3 Challenges in social health protection schemes

Indonesia's social health protection system is characterized by a combination of centralized and decentralized schemes, which are both market driven and state controlled. It consists of:

- the social health insurance schemes for civil servants, PT Askes and Jamsostek for private workers in companies with more than 10 employees managed by for-profit public companies;
- the state-run health care scheme called JPKM, a for-profit community health maintenance scheme based on the model of the United States Health Maintenance Organizations (HMO) providing benefits through 24 licensed JPKM "bapels" (private health insurance carriers);

- the community-based risk sharing scheme Dana Sehat operating on a micro-finance scheme basis, and various local initiatives, such as community funds;

- the social safety net program SSN that provides subsidies for health care focusing on the poor;

- a range of private commercial health insurance companies that are operating in Indonesia covering the better off.

As a general rule, schemes are under-funded and suffering from a lack of sustainability and quality. The overall reputation of the schemes is low and people opt-out wherever possible. In addition, contributory schemes are suffering from evasion.

In the past years, financial sustainability of PT Askes was threatened by a gap between the low increase of contributions and rapid growth of expenditure. This problem has been addressed by introducing a subsidy of 0.5 per cent of base salaries in 2003.

The contribution rate for PT Askes is about 2 percent of the monthly base salary and co-funded with 0.5 per cent of the base salary by the central government. Cost sharing for the insured is between 30 per cent and 60 per cent of the health care costs.

PT Askes members receive benefits from public facilities. Because of the perceived poor quality of these facilities, only 7.3 per cent of the insured sought treatment in the Askes provider network (Thabrany, 2003, p.23). The majority of the insured pays for treatment in private facilities in the case of sickness in addition to contributing to PT Askes.

PT Askes and Jamsostek are compulsory social health insurance schemes and cover the formal sector including spouses and up to two children of the insured civil servants and employees. PT Askes insures 14 million civil servants and their families, whereas Jamsostek covers around 3 million employees and their families.

The low number of insured in Jamsostek – it is estimated that more than 90 per cent of the population are excluded from formal health insurance schemes – is due to the opt-out clause for self-insured persons and those purchasing more generous health packages than that provided by Jamsostek. Jamsostek is fully funded by premiums from employers (3 per cent to 6 per cent of base salaries).

Members of the Jamsostek scheme have access to contracted providers. Given the limitation of benefits regarding hospital stays and specific treatment, and the restricted choice of providers, many employers believe that it is not worthwhile to join the scheme. Administrative costs of Jamsostek are rather high (20 per cent of total costs) compared to social insurance schemes in other countries (3-4 per cent) (Scheil-Adlung, 2001).

Table 2. Overview of main features of the Indonesian health protection scheme

Health Protection Scheme	Carrier	Coverage	Financing / Funding	Benefits	Comments and Issues
ASKES	State-owned for-profit insurance company	Compulsory coverage of 14 million civil servants and their spouses and up to two children	Contributions of 2% of base salary paid by insured persons; Cost sharing of 30-60% of health care costs; Government subsidy of 0.5% of base salaries.	Benefits provided by public health centers and hospitals	Payment method: Fee-per case; Sustainability: Growth of contributions lower than growth of expenses; Reputation: Due to poor quality many insured do not use services provided.
JAMSOSTEK	State-owned for-profit insurance company	Coverage of 3 million employees, their spouses and up to three children	Contributions of 3-6% of base salary up to a wage ceiling paid by employers	Limited benefits e.g. regarding inpatient care and hospital rooms, provided by selected providers contracted	Payment method: capitation; Opt-out possibility for employers providing more generous health schemes resulting in a coverage of small enterprises only; Restricted management capacity Administrative costs: 20% (compared to 3-5 in other schemes); Sustainability: Growth of premiums due to ceiling lower than growth of expenses; Reputation: Many employers consider that benefits are not sufficient.
JPKM	State-owned for-profit health maintenance organization	Voluntary coverage; Less than 500.000 persons	Funding through individual premiums	Benefits provided by 24 “bapels” (HMOs)	Payment method: capitation Sustainability: The further development of the small scheme is currently being hold. Reputation: Perceived low quality of benefits and too limited choice of providers
DANA SEHAT	State-owned micro-financing scheme	Voluntary coverage of poor households	Contributions: 2-4% of household expenditure; Government subsidies	Very low quality benefits mostly limited to outpatient care	Sustainability: High dropout rates, significant under funding, poor benefits, and access problems led to a halt of the scheme
SSN	Nationwide social assistance programs	12 million poor families and pregnant or birth giving women	Government subsidies to the poor, midwives, and community health services	Basic health and re-productive health care provided by community health services (Puskemas)	Miss targeting due to administrative problems, transportation problems are ranging among the main issues of the program. Sustainability: Based on ongoing Government subsidies

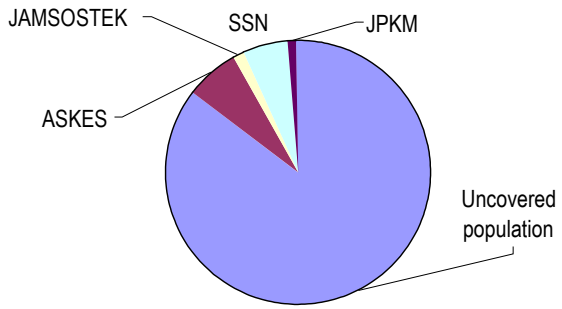
Sources: ILO (2002a); Thabrany (2003).

The concept of JPKM is trying to combine the conflicting commercial and social goals: on the one hand it is based on the HMO model of commercial health insurance, on the other hand it is trying to reach out to the poor setting low premiums.

Despite many efforts undertaken by the Ministry of Health and funding of pilot projects, e.g. by the World Bank, JPKM was not successful. The scheme is highly under-funded, mostly due to a lack of actuarial calculations for premiums, and benefits are considered

to be of poor quality. This led to a very low membership and finally to a hold of the further expansion.

Figure 4. Social health protection coverage by scheme



Source: ILO (2002a).

Askes, Jamsostek and JPKM are predominantly using fee-per-case and capitation as payment methods in order to control costs. A related, but undesired effect is the low service quality.

The Dana Sehat scheme aims at protecting the poor on a micro-finance basis. The further expansion of the scheme has been stopped. The reasons for the termination of the scheme are mainly to be found in (Thabrany, 2003):

- high dropout rates of the insured: on average, contributions are paid for a two-year-period;
- high utilization rates: on average, utilization was 47 per cent higher than among the non-insured;
- significant under-funding;
- low quality benefits mostly limited to outpatient care;
- access problems of the poor;
- cheaper health care provided by the majority of districts and provinces.

The Dana Sehat scheme has been widely replaced by the social assistance scheme SSN. SSN provides basic health and reproductive health services through community health services (Puskemas) to the poor and pregnant or birth-giving women. The poor can have access to health services through a health card. Recent data shows that currently around 12 million people are supported by SSN for their health needs (WHO, 1999).

Financing is ensured through subsidies from the government, which are directed to:

- the poor;
- community midwives; and

- health services.

Main challenges of the SSN scheme are mis-targeting of the poor due to administrative problems and lacking reimbursement of transportation costs.

2. Options for the future: anticipating problems in extending social health protection to the poor

2.1 Draft legislation: fostering a shared vision, specifying vague concepts

The Indonesian Government holds the view that social health protection requires immediate improvement. Related legislation has been drafted and sent to Parliament in January 2004.

The reform initiative focuses on developing a unified national social health insurance (NHI) (see Table 3.). NHI should be part of a newly created national social security system and operate under an umbrella organization for all social security branches.

Table 3. National social health insurance – draft legislation 2004

Carrier	Coverage	Financing	Benefits
Integration of existing schemes into one trust fund	Compulsory coverage of all employees and self employed in the formal sector Opting-out-possibility for self-employed in upper income classes Voluntary coverage of the uninsured until 2030 Coverage of informal sector workers until 2030	Premiums based on 6% of salaries from employees (contributed by employers and employees, 3% each) Subsidies of central and local governments, covering e.g. premiums for the poor Cost sharing: 10% of charges	Inpatient and outpatient care Graduated benefits for the poor

Sources: The Indonesian Social Security Reform Bill – SJSN, Part One, National Health Insurance, and discussions with representatives of the Ministry of Health, Indonesia

Main features of the proposed NHI are:

- integration of existing health protection schemes into a compulsory social health insurance scheme. Short-term adjustments envisaged for the next 3 to 5 years include changing the legal status of existing carriers from profit to non-profit, introducing portability of acquired rights and creating a unified Trust Fund governed by a tripartite board.

- NHI aims at universal coverage including informal sector workers within 25 to 30 years. In the meantime, voluntary coverage will be possible for those who are not covered. The self-employed in upper income levels may opt out.

- financing will be ensured through premiums of employers and employees (each 3 per cent of salaries).

- premiums for workers in the informal economy will be based on minimum wages and provide for reduced benefits.

- government subsidies deriving from central and local governments are expected to cover premiums of some 40 million people considered as poor (The Jakarta Post, 2004).

- cost sharing is proposed to be 10 per cent of charges up to a maximum of one-month minimum wage.

- benefits cover inpatient and outpatient care; a reduced benefit package might be developed for the poor.

The draft legislation aims at addressing main concerns in existing schemes. It intends to improve equity through extending risk pooling, subsidization of the poor and lowering cost sharing. Thereby, the high out-of-pocket rate should decrease. In addition, an integrated scheme might lead to improved governance and administration.

However, it is unclear to what extent the poor might benefit from the reform initiative in the near future. Given the long-term schedule for inclusion of informal sector workers into social health insurance and the current funding situation in health care it seems likely that the strong link between poverty and ill health and negative impacts on the labour force will remain for some time.

This issue is also of major concern in the context of poverty reduction efforts linked to the PRSP and MDGs. Questions raised, for instance, by the Consultative Group include potential pitfalls of the new social security scheme from a perspective of poverty alleviation (Consultative Group on Indonesia, 2003).

Furthermore, important elements of the reform remain vague and cause concern for various key players:

- the reform requires additional resources from the central government of Rp. 1.3 trillion per year, and in addition Rp. 5-8 trillion for coverage of the poor from budgets of provincial and local governments (Thabrany, 2003, p.56). Furthermore, it seems that the rate of premiums set at 6 per cent of salaries has not been determined by actuarial analysis and might not be sufficient to cover the future expenditure. It is not clear what impact these fiscal issues will have on the implementation.

- important features of the scheme have not been specified yet. These include a definition of benefit packages, contracting of providers, qualifying conditions, identification of the poor, the premium collection system, payment methods and the improvement of service quality. These elements are of prime concern for the expenditure and overall performance of the new scheme.

- the government has not announced any plans and schedules for implementing the reform, e.g. regarding the institutional integration of the various health care schemes. Deciding these issues at a later stage might cause high political and financial costs and delay the implementation.

- providing health protection to persons living in diverse economic conditions scattered over the country requires close cooperation among the various ministries, district and sub-district administrations, municipalities, employers' and employees' organizations and social security institutions. The role of these institutions and their financial contributions remain undefined in the bill. In addition, lacking traditions of cooperation and decision-making among these institutions may contribute to potential areas of conflict and difficulties.

The President is committed to the reform. However, not all government departments support the social security bill. Employers and workers who fear an increase in contribution liability without adequate improvements in benefits have also expressed adverse reactions (Jakarta Post, 2004).

The population is largely not informed about the reform, and acceptance remains questionable given the low reputation of the existing social health protection schemes and the planned slow extension of coverage to the majority of the population.

Against this background, it is likely that reaching political consensus with key actors will be a time consuming, disruptive and costly process that might involve issues such as the autonomy of districts (UNSFIR, 2000), and negotiation of revenue sharing arrangements. This process might significantly delay the implementation and enforcement of the law.

Therefore, it is important to foster the shared vision of social health protection among the key actors in central and local governments, economy and society, and to clarify details of the reform and its implementation.

2.2 Strategic approaches: supporting consensus building

It is essential to build up strategic approaches supporting and complementing efforts to implement NHI and develop health care as a key social benefit (see Table 4.).

The fact that the bill does not enjoy universal support of key actors points out the need to further consensus building and social dialogue.

In the few socialization activities carried out so far (Consultative Group on Indonesia, 2003) the text of the bill was not revealed. The same applies to detailed functions of various institutions and budget implications. The process was perceived as a "monologue" rather than a dialogue or a consultation and led to distrust which might hinder the future cooperation where funding of health care will rely on the support of district governments.

Table 4. Suggested strategies for consensus building among key stakeholders in health policy

Strategy	Target Group	Role of central government	Method
Social dialogue and consultations	District governments, communities, employers, employees, stakeholders in NHI	Facilitator	Participatory approach
Financial incentives to districts and communities	Districts and communities	Co-provider of funds	Re-allocation of national health budget through grants and risk-sharing funds
Increased effectiveness of funding	All stakeholders in social health protection	Legislator and supervisor	Revision of governance, benefit packages and quality, as well as training

It will be helpful to transform the top-down approach of the central government into a participatory approach of consultations and social dialogue and place the concerns of districts, communities, workers and employers, and the poor at the core of the debate, while the central government acts as a facilitator.

In addition, full transparency and information on all aspects of the new bill is required in order to reach binding outcomes and support from social dialogue and socialization activities.

These consultations should lead to decisions on responsibilities of the central and local governments, and consistent approaches to allocation and targeting of public spending, efficiency of benefit provision and quality of services.

The provision of incentives, e.g. to district governments, will improve the acceptance of newly defined roles and help assuming responsibilities. Such incentives could include grants from the central government or risk sharing. Refining mechanisms of re-allocation of revenues across the richer and poorer provinces (Consultative Group on Indonesia, 2003) in order to allocate funds for pro-poor programmes could support the implementation of the bill. However, such mechanisms could not compensate for general under-funding of core activities.

Increased effectiveness of funding for health will convince employers, workers and the poor of advantages from the new law. This will need to address:

- effective governance of NHI based on an enabling institutional framework, efficient contribution collection, needs-based allocation of funds and optimized service delivery.
- adequate benefit packages responding to health status and demographic patterns defined in relation to the available resources.
- improved service quality meeting defined standards of diagnostic and curative procedures provided through a minimum level of infrastructure in all regions.

Substantial work on the draft legislation, related regulations, guidelines, and standard setting will be necessary to improve effectiveness of health funding. In addition, capacity building on social health insurance will be a priority.

2.3 Policy-oriented action: prioritizing the protection of the poor

During the long-lasting transition to NHI and universal coverage it will be crucial to prioritize policy interventions cushioning the devastating effects of insufficient access to health services, particularly regarding the poor.

In Indonesia, lacking access to health services is mainly caused by high out-of-pocket payments, inequities in budget allocation, and significant under-funding. Particularly concerned are the poor in the informal economy.

Therefore, priority policy interventions that aim at reducing the impact of ill health should focus on extending social health protection to the workers in the informal economy through:

- accelerated implementation of NHI for the poor;
- pro-poor budget allocation;
- provision of adequate and sustainable funds;
- efficient use of resources;
- development of suitable social health protection schemes for informal sector workers.

Accelerated implementation of NHI for the poor will be important for addressing poverty in health. It is necessary to advance the subsidization of premiums for the poor in the

informal sector, design adequate benefit packages and reduce co-payments. This will require improved targeting of the poor involving local institutions and a decentralized scheme management.

Key activities to be carried out in this context include the development of a clear concept of the cooperation between the central level, regional service delivery and pro-poor schemes in the field of health such as SSN.

Problems in the current budget allocation are associated with the strong focus on supply side financing that support public health facilities, which are often geographically or financially inaccessible to the poor. Besides, there are significant disparities in health service provision and quality among rural and urban areas and provinces.

New responsibilities of districts and communities should be accompanied by an adequate resource transfer and central level response to patterns of regional service delivery. A shift to demand side financing could be based on:

- focusing budget allocation on primary health care rather than secondary and tertiary care;
- re-allocating funds to subsidize NHI premiums for poor households;
- balancing user fees and subsidized care in a way that the poorest pay less than those with higher resources;
- integration and balancing of central and local planning regarding budget allocation based priority health needs.

A priority in extension of social health protection to the poor includes scaling up the low level of funding on health care thereby ensuring long-term financing of core activities of the new bill, such as access, adequate benefits and improved service quality for the poor. This will involve significant increases of funds from both the central and district governments.

The total amount of funding required to meet basic needs will depend on the scope and quality of services. Furthermore, governance and administration of the health system will significantly determine it.

Local health councils or committees could advocate for increased health funding. They could work on a participatory approach and consist of a broad "coalition of all stakeholders in health care" from various levels including social partners, local authorities and representatives of the poor. These councils might also provide a feedback to central and local governments, e.g. on quality monitoring, planning and health care needs and thereby support priority setting and adjustments in budget allocation.

The most sustainable resources derive from premiums to social health insurance from the insured of the formal sector. It is therefore necessary to apply an effective registration and premium collection system minimizing evasion. It is recommended to use all available information, e.g. from authorities in districts and communities in order to identify employers.

Subsidies from various government resources will be necessary to cover the costs of the poor currently excluded from NHI. Possible sources might include income taxes and earmarked taxes.

In Indonesia, a fuel tax compensation system (Consultative Group on Indonesia, 2003), providing financial support to health costs of poor households is currently piloted in 13 districts and municipalities. The system's targeting approach is similar to SSN. Some 20 per cent of compensation funds amounting to Rp. 4.43 trillion in 2003 are used to cover pre-payments of

health costs for the poor. It might be considered to increase this percentage and hence extend health care coverage and service quality.

A more efficient and effective use of public funds could be achieved through improving governance and administration of NHI, defining adequate benefit packages and setting quality standards.

Furthermore, linking the extension of social health protection with activities focusing on poverty alleviation in the informal sector seems to be the key for effective use of public funds. This refers particularly to the current PRSP process and efforts striving for the achievement of health-related MDGs. MDGs targeting health include reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

Recognizing the overall objectives of these approaches could be the basis for a common framework of activities cutting the links between poverty and ill health.

The steps to be taken into account include the analysis of poverty, the identification of health care needs, the evaluation of the effectiveness of various social protection schemes, the selection of an adequate scheme mix, and the development of an implementation strategy (World Bank, 2000).

Table 5. Suggested priority policies in social health protection for the poor in Indonesia

Objective	Key action	Complementary policies	Enabling technical support
Accelerated implementation of NHI for the poor	Advancing Government subsidization of premiums to NHI for poor households and designing benefit packages Developing a clear concept of cooperation between central-level, regional service delivery and pro-poor schemes	Development of approaches for targeting the poor Establishing a decentralized scheme management	Actuarial studies Technical assistance on planning, management, monitoring, and service provision
Pro-poor budget allocation	Shifting to demand side financing Equalizing disparities of budget allocation among districts and communities	Focusing funding on primary health care Re-allocating funds to subsidize NHI premiums for poor households Balancing user fees and subsidized care Integration of central and local planning	Quality monitoring, planning and priority setting Community involvement in user fee management
Provision of adequate and sustainable funds	Scaling up funding of central and district governments deriving from premiums and taxes Increasing resources from the *Fuel tax compensation system*	Developing an efficient system of registration and contribution collection	Advocacy e.g. through health councils and committees
Efficient use of resources	Developing a common framework for efforts related to PRSP, MDGs, and social health protection Improving governance and administration Introducing adequate benefit packages	Introducing quality standards Enhancing service quality Improving budget formulation and financial management	Analysis of poverty and health care needs, evaluating cost-effectiveness of schemes, development of implementation plans Capacity building on central, district and local level
Development of suitable social health protection schemes for informal sector workers	Lowering barriers to formality Expanding *SSN* program Supporting development of localized schemes	Introducing voluntary and rural insurance schemes Extension of prepayment systems Facilitating portability of subsidies	Regulatory assistance Training on management of community –based schemes

To follow these steps will contribute to overcoming administrative difficulties, (ILO Office Jakarta, 2003) and streamlining diverse objectives and programs of the many government departments involved in the informal sector. In addition to the Ministry of Health, main government stakeholders in the informal sector include:

- coordinating Ministry for People's Welfare and Poverty Alleviation, running programs to empower the poor;
- Ministry of Agriculture, supporting agricultural workers and infrastructure;
- Ministry of Cooperatives and Small and Medium Sized Enterprises, promoting development of cooperatives and industry;

- State Ministry of Women's Empowerment Affairs, supporting unemployed women;
- Ministry of Finance, regulating micro finance schemes;
- Ministry of Manpower and Transmigration, improving labour standards and supporting job creation in the informal economy;
- Ministry of Industry and Trade, impacting on quality and output of the informal sector;
- Ministry of Regional Infrastructure, supporting local communities;
- Ministry of Social Affairs, assisting the poor;
- BAPPENAS, coordinating and improving opportunities of the informal economy.

Further, capacity building could improve the governance and administration of programs carried out by these institutions. In addition, a capacity building plan should be developed for the district and local levels.

Budget formulation and financial management also impacts significantly on the efficient use of resources. The further development of related administrative tools could improve funding problems, e.g. linked to the low take up of funds allocated to the Ministry of Health.

Suitable social health protection for informal sector workers needs to be flexible and based on tailored designs taking into account the diversity of workers and work in both the rural and urban parts of the informal economy.

While a large proportion of Indonesia's work force in the informal economy is supposed to be poor it cannot be assumed that income is necessarily lower than in the formal economy. Recent studies found that 17 per cent of the workers in the informal economy earn about twice the average national salary (ILO, 2002), whereas the incomes of the majority falls below the National Poverty Line.

Against this background it is important to identify the group of informal sector workers able to contribute to NHI, e.g. the self-employed in small-scale or family enterprises, sometimes even registered with local authorities, who pay taxes and other duties but are not enjoying a legal status of their business. Government actions should strive at legalizing these workers through lowering barriers to formality.

Further action might include the implementation of voluntary rural social insurance schemes that adhere to NHI and specifically designed to meet the needs and financial possibilities of this group.

Appropriate mechanisms to extend social health protection to the poor could be developed through a combination of regulations from central and local governments such as expanding the existing SSN program and advancing the subsidization of premiums to NHI.

Anticipated shortcomings of SSN and NHI include insufficient targeting of the poor. These issues need to be addressed by developing and supporting more localized schemes, such as community-based health financing schemes.

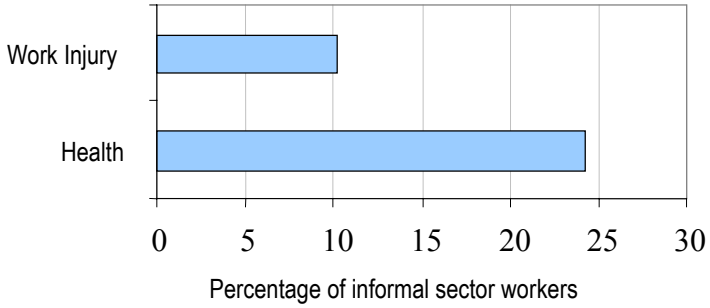
Particularly relevant for the poor in the informal sector are schemes that go beyond "banking functions", e.g. savings and credit societies (UNSFIR, 2003). Schemes based on solidarity between the healthy and the sick and striving towards equity, such as micro

insurance, community health funds, and mutual health organizations provide specific advantages to the covered poor and could be integrated into the national social health insurance scheme at a later stage.

The concept (World Bank/ILO, 2002), of these schemes contains flexible approaches regarding particularities of informal sector workers leading to low entry barriers. The targeting of the poor is facilitated through high localization. Main principles of social health insurance are applied, such as the pooling of risks and resources and providing defined benefits. Participatory management usually supports the solidarity created through risk and resource pooling. The voluntary membership is usually based on low contributions.

First surveys on the rural and urban informal economy in Indonesia (ILO Office Jakarta, 2003), identified a strong interest of informal sector workers in social health protection coverage. Some 25 per cent of informal sector workers indicated health and about 10 per cent work injury as the field of most desired social protection coverage (see Figure 5).

Figure 5. Desired social security coverage



Source: ILO, Office Jakarta (2003)

More than 50 per cent of the respondents declared that they could contribute a limited monthly amount of about Rp 10.000 to a social security scheme. About 30 per cent indicated that they would be prepared to pay voluntary contributions.

This confirms the acceptance and high priority attached to social health protection in Indonesia's informal sector. Community-based schemes seem to have the potential to extend social health protection. The implementation of innovative schemes is urgent and should range among the priority actions of the government.

When (re-) introducing these schemes frequent mistakes known from past experience and experience in neighboring countries should be avoided (ILO/STEP, 2001). Lessons from past experience in Indonesia, e.g. concerning Dana Sehat, suggest a scheme design on a "learning by doing" basis rather than on "best practices" observed elsewhere. This allows flexible adjustments to local particularities, e.g. related to:

- specific health protection needs of the poor;
- difficulties to identify and register workers;
- irregularity of income and ability to contribute to social health protection schemes;
- demographic patterns;
- migration patterns;

- availability of community and family safety nets.

In many cases failures (ILO, 2002a), of community-based schemes followed a short-term success and were linked to poor implementation, e.g. setting contributions that are not based on actuarial studies, inefficient collection of contributions, low benefits and insufficient numbers of contributors. Therefore, it will be necessary to enhance concepts of (previously existing) schemes with a view to overcoming technical and organizational weaknesses. Potential approaches , (ILO/STEP, 2000) include:

- diversifying and enlarging small risk pools;
- stabilizing membership, e.g. through subsidized premiums for the poor;
- limiting moral hazard, e.g. through the introduction of small co-payments;
- ensuring financial back-up and monitoring expenses;
- creating commitment and professionalism in management through active participation of stakeholders in health care;
- providing technical support, e.g. on planning, management, monitoring, and service provision through enabling policies from the central and the local governments.

Strategies specifically addressing funding problems include the provision of subsidies to the schemes and/or the covered population, facilitating the portability of subsidies (ILO, 2002b) and creating links to supporting social health protection in existing poverty alleviation programs in the informal sector in Indonesia. Such measures will significantly improve the financial sustainability of the schemes.

Recently, the Government of Indonesia has (re-) established some community-based schemes such as Dana Sehat and the Small Farmers Productivity Improvement Project run by the Ministries of Health and Agriculture, which provides loans to the poor for agricultural purposes. Contributions to community-based health schemes are automatically deducted from the loans.

In addition, the feasibility of newly designed community-based schemes is currently being tested in the Sickness Cash Benefit Pilot Project. The central government and 20 province governments are funding the project. It aims at providing lump-sum sickness cash benefits depending on contribution payments. Benefits can be claimed twice in a three-year period. Registered NGOs are collecting monthly contributions, while governments are partly funding benefits.

3. Conclusions

60 per cent of Indonesia's population is working in the informal sector; most of them are poor and lack social health protection. Extending coverage to the informal sector will make the poor more productive and employable. Thereby, advancing social health protection for the poor can reduce poverty and increase wealth.

Challenging the damaging effects of lacking health protection requires pro-poor government commitment.

In the past, government efforts to maintain health expenditure in real terms have not been successful. Currently, the central government is pushing for the implementation of compulsory social health insurance and – in the longer-term – universal coverage. The implementation of NHI will offer legal, financial and physical security to the sick in the formal economy.

The government has demonstrated strong commitment to extending social health protection to the poor working in the informal sector. However, it is questionable whether this will be feasible in view of the low economic performance, lacking support of key actors in health policy, significant under-funding and vague plans regarding the implementation.

It is therefore essential to set priorities and advance coherent pro-poor policy action aiming at meeting the needs of the majority of the labour force working in the informal sector:

- key policy action in the immediate future should include accelerated implementation of NHI for the poor and mobilization of adequate and sustainable funding.

- furthermore, a strong commitment of civil society and communities will be required to develop and implement effective social health protection schemes for the informal sector. These schemes should be implemented with a view to integrating them at a later stage into a unified social health protection scheme.

- in addition, it will be necessary to establish synergies with existing programs that aim at poverty alleviation, e.g. in the context of the PRSP process and efforts to achieve the MDGs.

Advancing social health protection for the poor requires new strategic approaches with a view to improving cooperation among all stakeholders in social health protection. Social dialogue should play a key role in this process.

Overcoming exclusion of the poor from social health protection and cutting links between poverty and health is a pre-requisite for social and economic development. It will contribute to achieving human dignity and social justice. The framework of policy options set out in this paper aims at contributing to these objectives.

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