91217

Japan–World Bank Partnership
Program for Universal Health Coverage

Universal Health Coverage for Inclusive and Sustainable Development

Country Summary Report for Indonesia

Puti Marzoeki, Ajay Tandon, Xiaolu Bi, and Eko Setyo Pambudi

Health, Nutrition and Population Global Practice
World Bank Group
August 2014

Acronyms

Askes	Social health insurance for civil servants
Bappenas	Ministry of National Development Planning
BPJS	Social Security Administration (Badan Penyelenggara Jaminan Sosial)
DALY	Disability Adjusted Life Years
DHO	District Health Office
DRG	Diagnostic Related Group
GDP	Gross Domestic Product
GNI	Gross National Income
GOI	Government of Indonesia
HRH	Human Resources for Health
Jamkesmas	Government administered health program for the poor (Jaminan Kesehatan Masyarakat)
Jampersal	Maternal health universal coverage program
Jamsostek	Social health insurance for formal sector workers
JKN	National Health Insurance Program, 2012–2019 (Jaminan Kesehatan Nasional)
MDG	Millennium Development Goals
MOH	Ministry of Health
NGO	Non-governmental organization
OOP	Out of pocket health spending
PBI	Health insurance subsidies paid by the government for the poor and near-poor
PPP	Purchasing power parity
PTT	Pegawai Tidak Tetap
Susenas	National Socioeconomic Survey
THE	Total Health Expenditure
UHC	Universal Health Coverage
WHO	World Health Organization

Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Indonesia is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Brazil, Ethiopia, France, Ghana, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication "Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies," available at:

http://www.worldbank.org/en/topic/health/brief/uhc-japan.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

Acknowledgments

This study was supported through the PHRD Grant (Japan) as a joint Partnership Program between the government of Japan and the World Bank. The Program was steered by the Program Coordination Committee, co-chaired by Keizo Takemi, Member of the House of Councilors of the National Diet of Japan, and Timothy Grant Evans, Director of Health, Nutrition and Population Network of the World Bank.

The Program was led by a team comprising Akiko Maeda, Lead Health Specialist and Task Team Leader for the World Bank, and co-Team Leaders, Professor Naoki Ikegami, Department of Health Policy and Management, Keio University School of Medicine and Professor Michael Reich, Taro Takemi Professor of International Health Policy, Harvard School of Public Health.

This Country Summary Report was prepared by a World Bank team comprising Puti Marzoeki, Senior Health Specialist; Ajay Tandon, Senior Health Economist, Xiaolu Bi, Junior Professional Associate, and Eko Setyo Pambudi, Research Analyst. The report was prepared in consultation with the Ministry of Health, Indonesia, especially the Vice Minister of Health, Professor Ali Ghufron Mukti and the Chairman of the Human Resources for Health Board, Dr. Untung Suseno.

The report incorporates information from a background study on Human Resources for Health conducted by the Center for Health Services Management, Gadjah Mada University under the leadership of Dr. Andreasta Meliala; and a Jampersal (maternal health universal coverage) study conducted by the Center for Family Welfare, University of Indonesia. Dana de Ruiter and Ian Anderson prepared the early drafts. The authors would also like to acknowledge the guidance and comments received from Darren Dorkin and Pandu Harimurti, World Bank Group.

The report was edited by Jonathan Aspin.

Country Summary Report for Indonesia

Overview

Indonesia, a low-middle income country of around 242 million people, has made impressive gains in health over the past few decades, notably in increased life expectancy and reduced infant and child mortality rates. There has been less progress in improving maternal mortality and malnutrition. Inequities among geographic areas and income levels are large, presenting a major challenge to the health care system. Demographic and epidemiological transitions have affected the disease burden: disability-adjusted life-years (DALYs) due to cerebrovascular disease, cardiovascular diseases, diabetes, and lung cancer have increased by 80 percent or more during 1990–2010. The central government has committed to achieving universal health coverage (UHC) by 2019 as projected in the Road Map of the Jaminan Kesehatan Nasional (JKN), or National Health Insurance Program, 2012–2019.

Table 1. Data overview

Indicators	Figure	Year	Source
Population (millions)	242	2011	CBS
Life expectancy at birth (years)	69	2011	WDI
GDP per capita (PPP$)	4,573	2012	IMF-WEO
Total health expenditure per capita (PPP $)	126	2011	WHO
Total health expenditure per capita ($)	95	2011	WHO
Government % of total health expenditure	38	2011	NHA
Out-of-pocket (OOP) % of total health expenditure	47	2011	NHA
# physicians per 1,000 population	0.46	2013	MOH
# nurses per 1,000 population	1.2	2013	MOH
# hospital beds per 1,000 population	1.1	2013	RS Online, MOH

Sources: CBS: Indonesia Central Bureau of Statistics; Ministry of Health (MOH), Indonesia; RS Online (web-based hospital information managed by the MOH).

PART I. Universal Coverage—Status and Sequencing

A. Overview of current status

1. Legal and statutory basis

The 2004 National Social Security Law (Law No. 40/2004) envisages coverage of the entire population through JKN, a mandatory program evolving from existing insurance programs. Until the end of 2013, Indonesia was supported by three major social health insurance programs: Jamkesmas (Jaminan Kesehatan Masyarakat/the government-financed health coverage program for the poor and near-poor); Jamsostek Health (the social health insurance program for formal sector workers); and Askes (the social health insurance program for civil servants). The 2011 BPJS (Badan Penyelenggara Jaminan Sosial/Social Security Administration) Law (Law 24/2011) declared the transformation of PT Askes into Health BPJS.

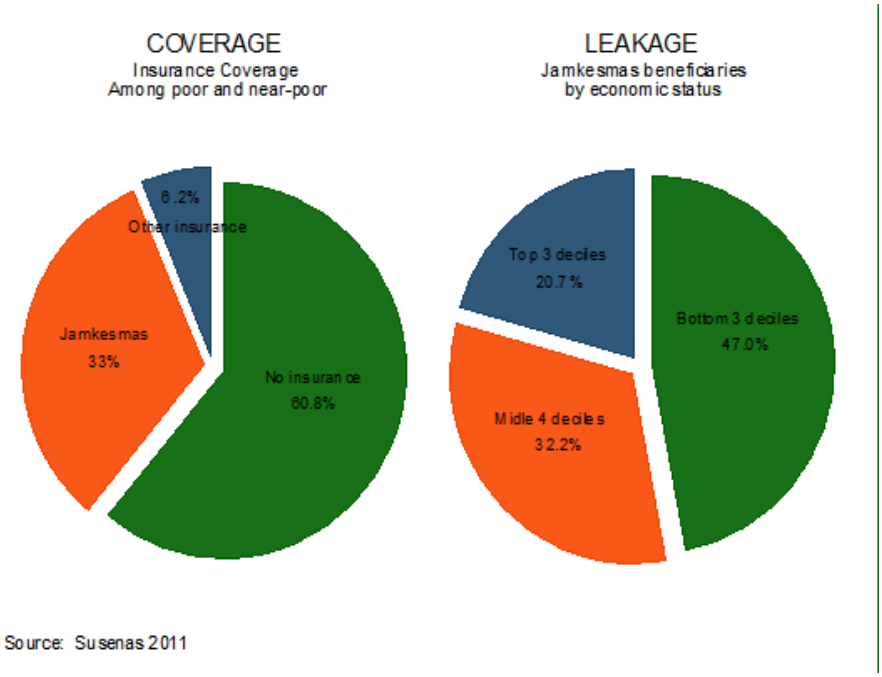
The Health BPJS began implementation of the JKN officially on January 1, 2014 with 121.6 million participants, 96.4 million of whom are participants (poor and near poor) whose premium is paid by the government (PBI), and the remainder are ex-participants of Askes and Jamsostek Health.

2. Current status of coverage along the key dimensions of UHC

a. Population

All Indonesians are entitled to health services, including through enrollment in one of the major health insurance programs. The share of households covered by insurance was around 40 percent in 2010. The largest program, Jamkesmas, targets 76.4 million poor and near-poor, or around one-third of Indonesia's population, while Askes and Jamsostek covered around 6 percent and 2.4 percent, respectively.

Figure 1. Estimated coverage and leakage rates, Jamkesmas, 2011



Analysis of the National Socioeconomic Survey (Susenas) 2011 finds Jamkesmas coverage is only around 33 percent from target and the leakage to non-eligible beneficiaries is around 53 percent (Figure 1).[1] Jamsostek only covers around 15 percent of formal workers, as a result of firm size limitation (only firms with 10 or more employees have to participate) and opt-out provisions for firms providing private voluntary health insurance. Indonesia faces a problem

[1] This is measured using the household consumption sections in Susenas. Consumption is adjusted for household size and district differences in the cost of living, and households are classified into deciles of per capita consumption. For the purposes of this analysis, the lowest three deciles of individuals in the survey are considered equivalent to the "poor and near-poor," that is, the population targeted by Jamkesmas.

common to many other countries in covering its informal workers—more than 60 million of them. The 2012–2019 road map of JKN acknowledged the difficulty of collecting contribution from this sector, and indicated the possibility of government subsidies.

b. Services

Jamkesmas has a benefit package that is more generous and inclusive than the other social insurance programs. It includes, for example, cancer treatment, cardiac surgery, hemodyalisis, and congenital diseases, all of which Jamsostek excludes. Table 2 provides a snapshot of the benefits available under the three main programs. Jamkesmas' target population can, in principle, use primary care services at all primary health centers (*puskesmas*) as well as inpatient services (in third-class beds) at secondary and tertiary public hospitals and selected private hospitals.

Yet challenges remain. Availability of services to deliver the Jamkesmas benefits package is limited, especially in remote and rural areas. OOP payments, even among those with coverage, are high.

Table 2. Comparing the three main social insurance programs

	Jamkesmas[2] (established 2005)	**Askes (established 1960)**	**Jamsostek (established 1992)**
Groups mandated	Poor and the near-poor	Civil servants; retired civil servants; retired military personnel and veterans	Private employers with >10 employees or pay salary >Rp 1 million a month
Number enrolled	76.4 million	16.6 million	5.0 million
Premium[3]	Rp 6,500 ($ 0.67) per capita per month	2% of basic + 1% government; No ceiling	3% of salary for bachelors; 6% of salary for married employees; Ceiling Rp 1 million per month (not changed since 1993)
Contributor	Government 100%	Employees 66%; employer 34%	Employers 100%
Carrier	Ministry of Health	PT Askes (for profit)	PT Jamsostek (for profit)

[2] Health insurance for the poor was introduced as Askeskin in 2005 which was expanded and renamed as Jamkesmas in 2007

[3] Under JKN, the contribution for PBI (poor and near poor paid by the government) is Rp 19,225 per person/per month; and for ex-Askes participants is 5 percent of salary (3 percent from employer and 2 percent from employee). For other formal sector workers, the contribution is 4.5 percent of salary (4 percent from employer and 0.5 percent from employee) until June 30, 2015, after which the contribution will be 5 percent of salary (4 percent from employer and 1 percent from employee). For the informal sector, the contribution varied according to the choice of service; Rp 25,500 (class 3), Rp 42,500 (class II), and Rp 59,500 (class 1)

	Jamkesmas[2] (established 2005)	Askes (established 1960)	Jamsostek (established 1992)
Benefits	Comprehensive; Drugs are covered if prescribed within formulary; No cost-sharing	Comprehensive, no specific exclusion; Drugs are covered if prescribed within formulary; Cost-sharing available when services fall outside basic benefit package	Comprehensive; cancer treatment, cardiac surgery, hemodialysis, and congenital diseases are excluded;[4] drugs are covered if prescribed within formulary; no cost-sharing
Dependents	All family members	Spouse + 2 children under 21 years who are not working and not married	Spouse + 3 children under 21 years who are not working and not married
Providers	All *puskesmas* and public hospitals and selected empanelled private hospitals	Mostly contracted public health centers and public hospitals	Mixed: public and private providers
Provider payment mechanisms	Fee for service at *puskesmas*; DRG for hospitals	Special fee schedules for civil servants; extra billing depending on negotiated fees	Fees are negotiated; extra billing depending on negotiated fees

c. Financial protection

In 2011, public spending accounted for around 38 percent of total health spending, and almost half public spending was at district level, where district governments are responsible for service delivery and therefore account for the greatest share of government health spending. Public health spending tends to be inequitably distributed across provinces and income quintiles. OOP spending, even among those with insurance coverage, remains high at around 47 percent of total health spending. Much of the OOP spending is borne by the rich, as the top three deciles accounted for more than 50 percent of all OOP—the bottom three deciles less than 15 percent. However, although OOP health spending per capita among Jamkesmas beneficiaries was lower than that among Askes, Jamsostek, or those without insurance, OOP health spending as a share of total household consumption in Jamkesmas households was no different from those without insurance. There is some evidence that the incidence of catastrophic expenditure is lower among Jamkesmas users than among other groups (Bredenkamp et al. 2011). Indonesia has a relatively low level of catastrophic spending for the region. There is no copayment, coinsurance, extra billing, or balance billing allowed under Jamkesmas, which is different from the benefits afforded to Askes or Jamsostek beneficiaries (see Table 2).

[4] Starting in 2012, Jamsostek expanded the benefit package to cover catastrophic cases as well.

3. Governance structure

a. Goal setting

The objectives of Jamkesmas are to increase access to and quality of health services for the poor and near-poor. The program is fully financed out of central government revenues and is administered by the MOH. Every year, the MOH releases a ministerial regulation to guide program implementation. It also reviews utilization and claims reports, although the review only focuses on analyzing information related to budgetary allocations and aggregate utilization rates, and does not explicitly monitor or target health or financial protection outcomes among beneficiaries. Information on utilization rates has been used to increase premiums and improve provider payment mechanisms, but not to improve health care delivery mechanisms or ensure improvement in health outcomes.

b. Governance structure

Five main actors are involved in the overall implementation of Jamkesmas: the National Task Force for Acceleration of Poverty Alleviation (TNP2K); national government ministries, including the Ministry of Finance, MOH, and the Ministry of National Development Planning (Bappenas); provincial and district governments; public and enlisted private health care providers; and the insurer/third-party administrator (Table 3). One additional actor (not in the table) is the Vice President's Office, which has the mandate to improve implementation of various social assistance programs, including Jamkesmas.

Table 3. Roles and responsibilities under Jamkesmas

	TNP2K	MOF/MOH/ Bappenas	Provincial/ district governments	Public and empanelled private providers	Insurer/third-party admin-istrator
Oversight scheme	X	X			
Financing of scheme		X			
Benefits package determination		X			
Accreditation/empanelment of providers		X	X		
Enrollment		X	X		X
Financial management/ planning		X			
Actuarial analysis	X				
Setting reimbursement rates		X			
Claims processing/ payment		X	X		
Outreach/social marketing			X		
Service delivery				X	
Clinical information system		X			

	TNP2K	MOF/MOH/ Bappenas	Provincial/ district governments	Public and empanelled private providers	Insurer/third-party admin-istrator
Monitoring local utilization		X	X		
Monitoring national utilization		X			
Customer service		X	X	X	

Source: Modified from JLN 2012.

c. Service delivery

Indonesia's system is characterized by a mix of public–private provision of services, with the public sector taking the dominant role, especially in rural areas and for secondary levels of care. However, private provision is increasing. Health service utilization rates are generally low nationally. About 14 percent of the population used outpatient care in the month before the 2010 Susenas survey. Around 60 percent of outpatient visits occurred at private facilities (typically clinics/midwives and nurses) and the rest at public facilities, mostly at primary care level. Susenas data also show that the better-off used private facilities for ambulatory services: 69.5 percent compared to 51.6 percent among the bottom three deciles. Public facilities continue to dominate inpatient care, except for the top three deciles, a larger proportion of which use private facilities for inpatient care.

Basic primary health care is provided by the public sector via the *puskesmas*, each serving a catchment area at the subdistrict level of about 25,000–30,000 individuals. Indonesia has over 9,500 *puskesmas*, and each is required to have at least one medical doctor on staff. About a third of all *puskesmas* also provide inpatient services. Primary care is also provided by private doctors, including by 70 percent of doctors working at *puskesmas* who practice privately after hours. In principle, *puskesmas* are meant to provide referrals to secondary and tertiary public hospitals, although in practice the gate-keeping and referral functions of *puskesmas* are not strong. There are no penalties for self-referring to higher facility levels: patients can go directly to secondary/tertiary hospitals and obtain services without *puskesmas* referrals (or simply obtain a referral letter from the *puskesmas* without first seeking care at the *puskesmas*).

Indonesia has around 2,200 hospitals, of which around 62 percent are private.[5] There are an estimated 270,000 hospital beds, implying about 1.1 beds per 1,000 population, much lower than the global benchmark of 3. About 45 percent of beds are at private hospitals. The ownership of tertiary hospitals is mainly public. The nation has about 376 tertiary hospitals, some of which are centers of excellence (about 300 of the 376 total tertiary hospitals are public). Jamkesmas cardholders can, in principle, use primary care services at all *puskesmas* and inpatient services (for third-class beds) at secondary and tertiary public hospitals and empanelled private hospitals.

One of the key supply challenges in Indonesia is the provision of health services in rural and remote areas in a dispersed archipelago of over 17,000 islands. The government is upgrading *puskesmas* with inpatient facilities, especially in secondary towns and rural locations. The government has allocated funds to expand inpatient facilities specifically for maternal emergency-ready facilities. The MOH contracts doctors and midwives under the Pegawai Tidak

[5] MOH Rumah Sakit (hospital) Online, 2013.

Tetap (PTT) policy for distribution throughout the country. The program offers shorter contracts and higher remuneration for rural and remote postings.

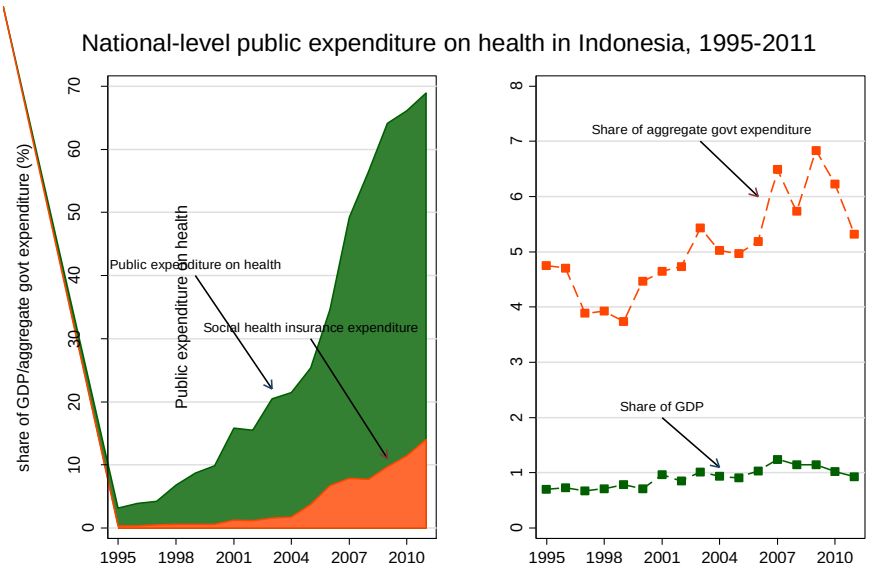
B. Current status of health financing

1. Sustainability of current coverage

a. Fiscal space

Has fiscal space been adequate to achieve UHC or at least enable an expansion of the breadth and depth of coverage over time?

Figure 2. National-level public expenditure on health in Indonesia, 1995-2011



Source: WHO (various years)

Indonesia's National Health Accounts data estimates indicate that national-level government expenditure on health was almost Rp 70 trillion in 2011, about 1 percent of GDP and over 5 percent of aggregate government expenditure.[6] Government health expenditure has more than tripled in nominal terms since 2005. A large part of the increase in government health expenditure is due to the rise in social health insurance expenditures following the introduction of Askeskin in 2005 (expanded and renamed Jamkesmas in 2007) (Figure 2 left panel). There has generally been an upward trend in health's share of aggregate government expenditure and an increase in government health spending's share of GDP over 1995–2011 (Figure 2 right panel).

About half of all government health expenditures are made at district level, about 15 percent at provincial level and about 35 percent at central level. Jamkesmas is entirely financed by the central government: with allocations currently determined based on a "premium" rate of

[6] National-level government expenditure on health includes central, provincial, and district health expenditures.

Rp 6,500 per person per month (about $8 per person per year) the program accounts for about a quarter of the central government's health budget. Jamkesmas premiums and expenditures do not reflect the full cost of provision of care, from both a unit cost as well as from an aggregate utilization perspective (inpatient utilization rates remain relatively low for Jamkesmas members). An estimated two-thirds of the cost of care for Jamkesmas continues to be subsidized by supply-side government health spending on salaries and infrastructure. Actuarial studies estimate the true cost to be at least three to four times higher than current premium rates, even with existing levels of supply-side constraints (Guerard et al. 2011).

Are the revenues and expenditures balanced? What mechanisms are in place to ensure fiscal sustainability?

In 2006–11, allocations and expenditures were largely in balance, with incremental adjustments made to the estimated premium over the years (Table 4). The 2006 budget for Jamkesmas was based on a cost per person per month of Rp 5,000, derived from preliminary actuarial estimates and the experience of the civil servant insurance scheme, Askes. In the following years, allocation adjustments were made based on expenditures of previous years.

Table 4. Jamkesmas target membership, premiums, allocations, and expenditures, 2005–12

Year	2005	2006	2007	2008	2009	2010	2011	2012
Target membership (million)	60	60	76.4	76.4	76.4	76.4	76.4	76.4
Premium per member per month (Rp)	5,000	5,000	5,000	5,000	6,250	6,500	6,500	6,500
Total allocations (Rp trillion)	2.3	3.6	3.5	4.6	4.6	5.3	6.3	7.2
Total expenditures (Rp trillion)[a]	1.3	3.5	3.4	4.2	4.5	4.6	6.3	7.1
Expenditures per member per month	1,806	4,861	3,709	4,581	4,908	5,017	6,872	7,744

a. The Askes and P2JK reports data may not capture all Jamkesmas spending, as additional funding could be mobilized from other sources during mid-year budget revision, and some Jamkesmas supporting activities could be funded by units outside of P2JK.

Source: 2005–07: Askes annual reports 2005, 2006, and 2007; 2008–10: P2JK report 2010; 2011–12: P2JK reports 2011, 2012.

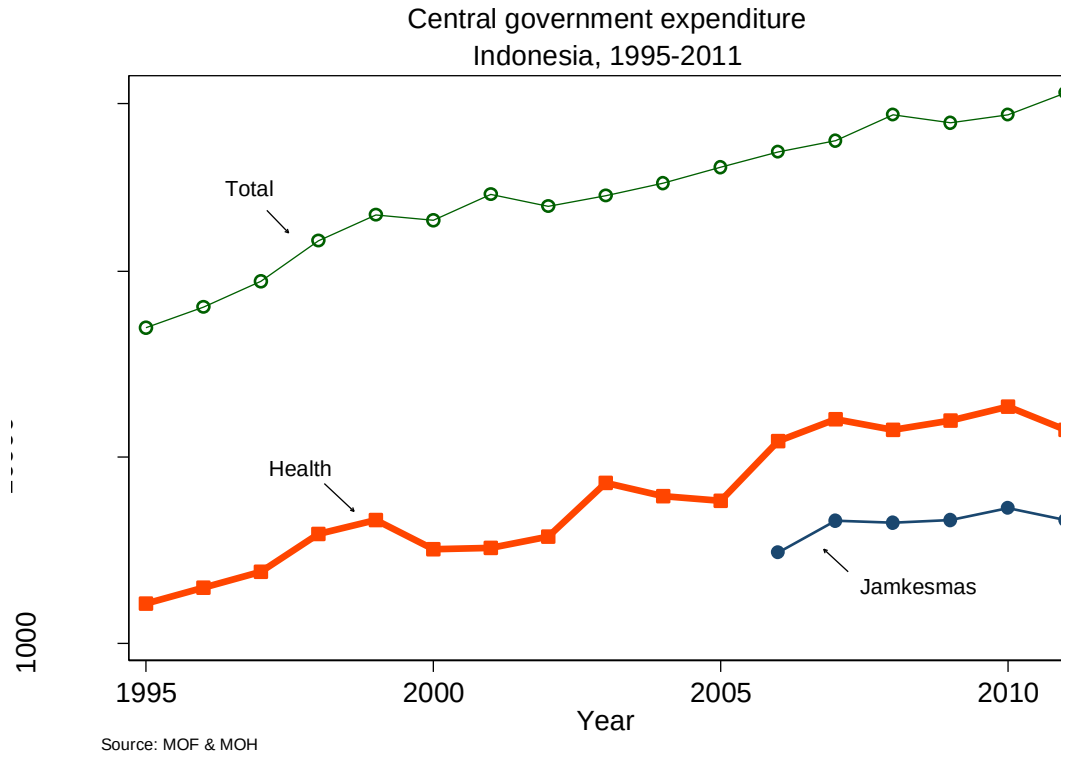
Fiscal sustainability is a key concern for Jamkesmas. Supply-side constraints and subsidies with demand-side financing give the impression that financing of Jamkesmas is sufficient. However, if the utilization rates were higher and supply-side constraints removed, actual costs would likely be much higher. There are no expenditure caps or other mechanisms to ensure fiscal

sustainability. Jamkesmas premiums have been adjusted over time to account for rising expenditures. In 2007, the use of services by Jamkesmas beneficiaries increased significantly, especially inpatient services, while the program was budgeted historically based on the use of funds from the previous year.[7] This caused a budget shortage, and the MOH had to reallocate the budget to pay hospital claims, which led to delays in paying hospital reimbursements. This received wide media attention and led to some changes (including the transfer of administration from PT Askes to the MOH) and some additional cost-containment measures such as the introduction of a drug formulary and diagnostic-related group (DRG) payments.

What factors have enabled sufficient fiscal space to expand coverage and ensure fiscal sustainability?

Jamkesmas is financed out of central government revenues. The expansion of this government-financed health insurance program since 2005 occurred over a period of generally good macroeconomic conditions (see Figure 3).

Figure 3. Central government expenditures in Indonesia, 1995-2011

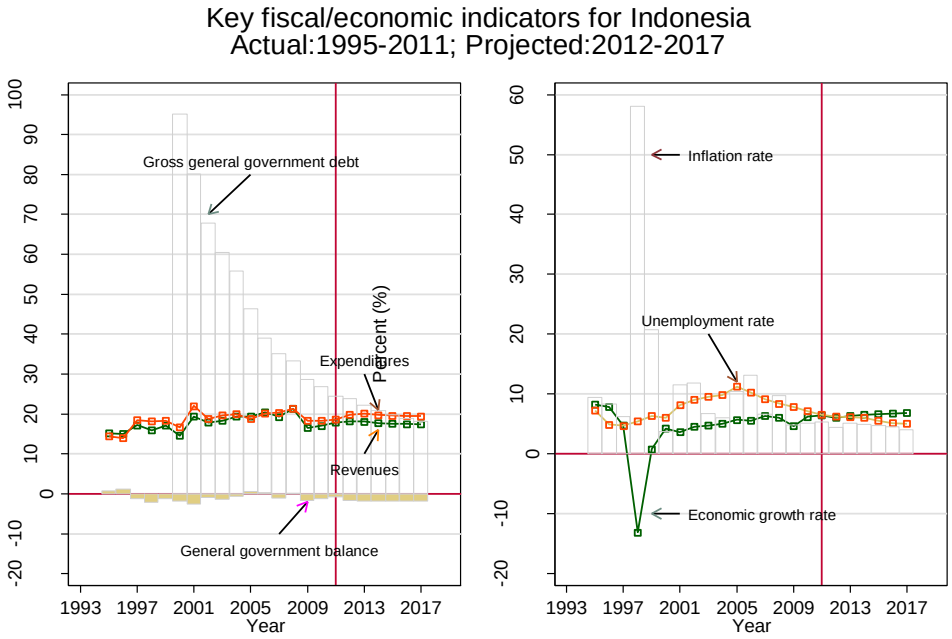


The overall economic and fiscal prospectives for Indonesia are positive (see Figure 4). Government expenditures have been fairly stable at around 20 percent of GDP, gross debt

[7] The spike in inpatient service utilization was mainly due to program maturation (more became aware of the program's benefit) and the absence of cost-containment measures (drug formulary, member verification, and so forth).

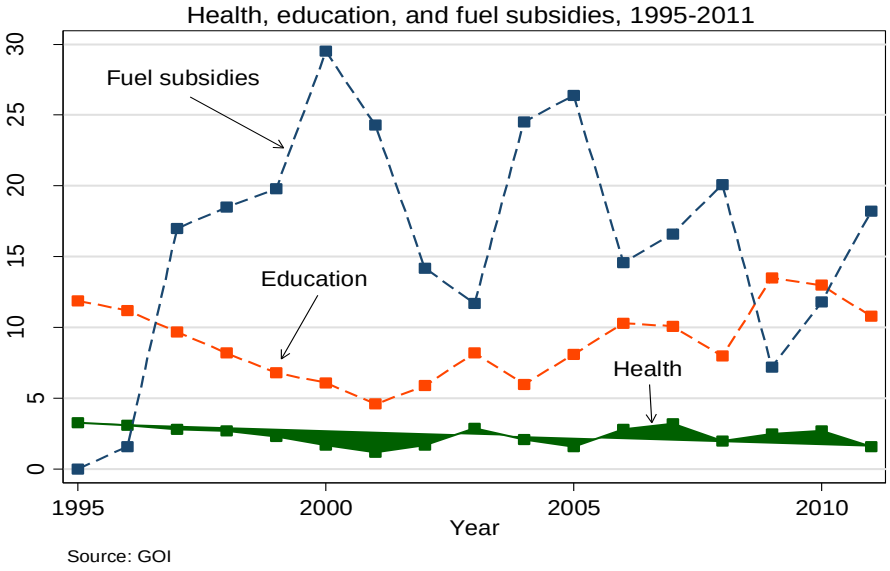
levels have declined sharply, government deficit levels have been in the manageable 1–2 percent of GDP range, and inflation and unemployment have been stable and low. Economic growth has been robust, averaging almost 6 percent over 2005–11 in real terms.

Figure 4. Key fiscal/economic indicators for Indonesia, 1995-2017



Source: World Bank and IMF (various years)

Figure 5. Share of central government budget in Indonesia, 1995-2010



Source: GOI

Analysis of central government allocation data suggests that the rise in central government health spending over 2005–11 occurred largely as a result of rising GDP and was not due to an increase in either overall government spending's share of GDP or in health's share of central government expenditures. Comparing 2011 with 2005, the central government expenditure's share of GDP decreased by 2.3 percentage points, and health's share of central government expenditure remained the same.

What factors have posed challenges to achieving adequate fiscal space to expand coverage and ensuring fiscal sustainability?

One of the challenges is the lack of priority given to health. Indonesia is a comparatively low spender on health, which to some extent is due to the perception of health as a non-productive sector by the Ministry of Finance. The share of health expenditure is low compared with that in other sectors. In 2011, health accounted for 1.6 percent of the central government budget, much lower than fuel subsidies (18.2 percent) and education (10.8 percent). (The fuel subsidies benefited mainly the top rather than the bottom income quintile.) The heavy burden placed by fuel subsidies is a key constraint on government health spending.

b. Cost management and value for money

Jamkesmas has an estimated premium rate of Rp 6,500 per person per month (about $8 per person per year), totaling about a quarter of the annual central government health budget. Actuarial studies estimate the true cost being at least three to four times the estimated premium rate, even with existing levels of supply-side constraints (Guerard et al. 2011). The magnitude of these numbers is consistent with the current estimated public and private expenditure on curative and rehabilitative care of about $40 per capita per year, about five times the Jamkesmas premium (Soewondo et al. 2011).

Supply-side constraints conceal the real costs of the Jamkesmas program and act as an implicit cost-management strategy. Although Jamkesmas offers a comprehensive benefits package of services, in practice, utilization and the associated claims reimbursements do not reflect actual costs due to the limited supply of services. If utilization rates were higher, the program's costs would likely be much higher. Furthermore, *puskesmas* and public hospitals continue to receive government subsidies for salaries, capital and some operational costs, which are also not included in the overall cost of Jamkesmas and therefore skew the apparent cost of the program. The subsidies are estimated at two-thirds of the average cost of care under Jamkesmas.

The MOH reimburses hospitals for Jamkesmas coverage based on DRGs. The system is called INA-CBG, generated from Askes utilization data. Reimbursement rates are the same for public and private hospitals in the network, although rates vary by the degree of specialization of the hospital. There is no information whether DRGs have helped contain costs and improve efficiency. Payments to *puskesmas* were initially based on capitation, but since 2011, *puskesmas* have been reimbursed based on fee for service. District health offices (DHOs) receive funds from the central government via the MOH based on a capitation payment of Rp 1,000 per poor and near-poor person per month and subject to the availability of funding at the time. DHOs are reimbursed for *puskesmas* utilization based on fee for service from these funds. Any surplus or deficit of Jamkesmas-related financing at the DHO-*puskesmas* level is adjusted by transfers to or from the local government treasury.

Of total program costs, about 75 percent are for reimbursement of hospital-based care, 20 percent for *puskesmas*-based care, and the rest for administrative costs. In 2011, it was

estimated that 50 percent of Jamkesmas funds at *puskesmas* level was undisbursed, primarily due to the absence of *puskesmas* autonomy in using Jamkesmas funds.

2. How equitable is coverage?

a. Solidarity and redistribution

Jamkesmas is entirely financed through central government revenues but provides benefits only for the poor/near-poor.

b. Targeting for priority population groups

The central government has prioritized better targeting of the poor and near-poor to improve the effectiveness of all social assistance programs. In 2011, a new list of the poor and near-poor was collected, and is being used as the basis for a unified registry for all social assistance programs from 2012. As a result for Jamkesmas, the poor and the near-poor are now being targeted on the basis of household per capita consumption, using a combination of geographic and proxy means-testing methods. A challenge with Jamkesmas is that while it uses the new list, actual targeting depends on local decisions, while identification and enrollment are done differently in different places (World Bank 2012). This likely also contributes to leakage problems. Continued efforts to improve overall social assistance targeting will help improve Jamkesmas targeting, particularly if the lists stay current and are well managed.

C. Human resources for health (HRH) policies

1. Current status of HRH

HRH category	Per 1,000 (2013)	Entry			Exit	
		Qualifications	Government policy on # of entrants	Number of entrants per year	Number of years of education	Production per year
Physicians	0.46	High school	Accreditation standards include lecturer to student ratio to control admission	No data	3.5 yr undergrad + 2 yr professional training	Around 10,000
Nurses	1.2	High school	Accreditation standards include lecturer to student ratio to control admission	No data	Vocational nurse: 3 yr training. Registered nurse: 4 yr undergrad + 1 yr professional training	Total around 33,700
Midwives	0.56	High school	Accreditation standards include lecturer to student ratio to control admission	No data	Vocational midwife: 3 yr training	Total around 21,200

HRH category	Per 1,000 (2013)	Entry			Exit	
		Qualifications	Government policy on # of entrants	Number of entrants per year	Number of years of education	Production per year
Community health workers	No data	Minimum elementary school	Recommend 5 cadres per Posyandu	No data	No standard	N/A

Source: MOH.
Note: Posyandu—integrated health services post run once a month by the community, providing maternal and child health services including growth monitoring, immunization, antenatal care, vitamin A, and counseling.

2. Labor market dynamics

The key feature of labor market dynamics is that supply of health workers has been rapidly increasing, but still not enough to meet demand. The government plans to achieve 1 physician per 1,000 nationally by 2019, the year when Indonesia is supposed to reach UHC. If production remains at the current level of around 10,000 doctors per year the MOH will be able to meet the 2014 target of 0.5 physician per 1,000. But to meet the 2019 target, Indonesia will need 130,000 doctors between 2014 and 2019. The MOH estimates that an additional 118,788 health workers were needed at hospitals in 2012. The largest shortfall was nurses: 87,874 additional nurses, or 74 percent of the total shortfall, were needed at hospital level. The second-largest cohort gap to be filled at hospitals was midwives. There is some evidence that the dramatic increase in provision in the private sector has relieved some access pressures in the public sector.

3. Flexibility of the HRH workforce

The public–private dual practice system in Indonesia provides flexibility and constraints on the HRH workforce. On the one hand, there is a good deal of flexibility because dual practice deliberately allows medical staff to practice in the public and private sectors. Health workers are allowed—even encouraged—to work simultaneously in the public sector as well as private practice of their choice. On the other, the need to generate private sector income and maintain clinical skills pushes health workers to urban settings and hospitals, reducing the overall flexibility of the health workforce in terms of geographic distribution.

D. Sequencing of reforms

The pressure and impetus for health policy reform in Indonesia arose in part from the Asian financial crisis in the late 1990s, which resulted in higher costs of living and declines in real per capita income. The government worked to help the poor in coping with some of the impacts of the crisis, among other things by using a portion of oil-subsidy savings to subsidize health care for the poor. This created pressure for the government to establish a more sustainable solution for equitable care.

The political process to reforming the system began in 2001, when the government established a team to review and reform the social security system. This was followed by issuance of a presidential decree to establish a task force to design a National Social Security System that

was later embodied in the 2004 National Social Security System Law, a landmark legislative commitment that called specifically for the attainment of UHC.

From creation of the task force to passage of the law was a rocky road. Various groups expressed opposition to the proposed new system centered largely on the following issues:

- The mandatory nature of the proposed system: employment associations, business chambers, and even several government officials believed this to be in violation of human rights;
- The integration of social security systems: resistance from two existing insurance carriers slowed the submission of the law, until a compromise was reached that a council would be established to harmonize the diverse systems;
- Too much government control: some bilateral aid organizations as well as the private sector agreed with the mandatory nature of the law but opposed the administration of the system, in which the government had a monopolistic role;
- Shared contribution: private sector employees strongly opposed the proposal to share contributions between employers and employees;
- Levels of contribution: employers feared the law would cause them financial problems by increasing their contributions.

Despite such opposition, the law prevailed and the National Social Security Law (Law No. 40/2004) was signed by the president in 2004. Although most stakeholders considered the law a positive development, some local governments challenged the law in the Constitutional Court, decrying the monopolistic nature and claiming it went against the decentralization legislation. Six months later, the Court decided the law was in line with the Constitution.

The year 2005 saw the birth of Askeskin (now Jamkesmas) providing free health care for the poor. The program was appropriately couched as part of the new law. Askeskin was declared an insurance program for the poor, initially administered by PT Askes, the carrier of the civil servants' insurance program. In 2007, a significant increase in beneficiaries led to a budget shortfall resulting in delayed payment of hospital claims. In 2008, the government decided to assign overall management of Jamkesmas to the MOH, while PT Askes continued to manage membership of the program, including issuance of membership cards.

All in all, despite the intense political debate and the early growing pains of the program, Jamkesmas is largely seen as an important part of Indonesia's efforts to improve health care for the poor.

PART II. Lessons for Other Countries

A. Current policy priorities, challenges, and opportunities

1. Current policy priorities

The central policy priority is to achieve UHC under a single-payer umbrella covering all citizens by 2014 and achieve full UHC coverage by 2019. Health insurance coverage has increased sharply, from 15 percent in 1995 to 40 percent in 2011, particularly targeted at the poor. A key priority is to further expand coverage in ways that deliver good health outcomes and financial protection to the rest of the population—many of whom are in the informal sector—in a manner

that is financially sustainable for the government. Other priorities as part of the national scale-up to UHC include the need to integrate the current health insurance program for the poor and near-poor—Jamkesmas—with all other social insurance programs.

2. Challenges

The overarching challenge is to achieve rapid scale-up of services, improved health outcomes, and increased financial protection in ways that are effective, efficient, equitable, and sustainable in a country as large and diverse as Indonesia. Like other middle-income countries, the country is facing the challenge of rapidly rising incidence of often preventable, chronic, and expensive to treat noncommunicable diseases while it still has an unfinished agenda of communicable diseases, especially tuberculosis, and undernutrition. Like others, Indonesia also has many development needs: increasing government expenditure on health therefore needs to achieve value for money and be sustainable financially.

Expanding the *number and availability* of qualified health workers. Despite rapid increases in the supply of health workers, there are still substantial staffing gaps. The number of doctors has increased annually but has barely kept up with population growth: the ratio of doctors to 1,000 population has increased only marginally from 0.43 in 2010 to 0.46 in 2013. Greater progress has been made with respect to increasing the relative targets for nurses and midwives. The MOH estimates that an additional 118,788 health workers were needed at hospitals in 2012. There are also significant gaps in key health worker positions at the primary care (*puskesmas* level). The shortage of nurses—despite large numbers of graduates—at hospitals and *puskesmas* is particularly notable.

Improving the *distribution* of health workers. The government uses several programs to increase the availability of medical staff in rural and remote areas. These programs include higher financial incentives and shorter contract periods for rural and remote postings; recruitment based on ethnicity and location; and internship programs. Distribution of health workers to remote and rural areas has been improving. However, efforts need to be maintained: at this stage 30 of 33 provinces in Indonesia still do not have the WHO-recommended ratio of one doctor per 1,000 population. The location of hospitals—many of which are concentrated in densely populated Jakarta, East, West, and Central Java—acts as a "pull" factor attracting health workers especially specialist doctors—who need the medical infrastructure that hospitals offer to practice their skills. For example, 100 percent of public hospitals in Jakarta had an anesthesia specialist, but in four provinces of Indonesia less than 20 percent of public hospitals did (Rifaskes[8] 2011). The geographic location of medical schools can also reinforce the urban bias and maldistribution of health workers. Only a few schools had special programs for recruiting students from rural or underserved areas.

Improving the *regulatory environment, overall quality* of health workers, and responsiveness of the health system to changing needs. The government in collaboration with the professional associations is reforming the accreditation system of health professional schools and standardizing the certification process of graduates. In 2012, 30 percent of medical schools, 60 percent of nursing schools, and 62 percent of midwifery schools are accredited. The dual practice (public–private) system provides flexibility for health workers and a source of income that government does not have to budget for. However, there is an ongoing need to strengthen the regulatory system: many specialists in provincial capital cities spend more time in

[8] *Rifaskes: Riset fasilitas kesehatan* (Health Facility Research) conducted by the National Institute for Health Research and Development, MOH.

private practice and less time in public hospitals than envisaged under the scheme. Medical schools do provide some initial training on UHC to prepare graduating health workers, but more intensive and nationally standardized training will be required in future as the country expands UHC. There is also a need to continually adjust the standards of competencies and the curriculum in response to the changes in disease burden.

Improving the financing of health systems. Government expenditure on health has been expanding in absolute and relative terms. However current total, and public, health expenditures are still low relative to comparable countries. Financing streams will need to be consolidated and made more coherent to make UHC effective. Sources of income for doctors and other health providers are fragmented: there were recently 10 separate sources of income for specialist doctors. Importantly in the context of the movement toward UHC, income from insurance organizations was always the smallest contribution to overall income, providing less than 5 percent of total income.

3. Opportunities

A key opportunity is that there is clear government leadership and commitment, and that many of the key building blocks for UHC are already in place. Since the 1970s, the government has constructed more than 9,500 health centers, 22,000 auxiliary health centers, and 800 public hospitals. There is an opportunity to expand the supply of health care for UHC further by harnessing the participation of the large number of private health providers. Most local governments have responded positively to Jamkesmas by expanding coverage; three provinces have already declared UHC.

The growing number of medical, nursing, midwifery and other health professional schools provides an opportunity to increase HRH production to meet demands for health care with universal coverage. The number of medical schools, for example, has increased from 40 schools in 2003 to 72 schools in 2013: an increase of 80 per cent during the last 10 years. Of those 72 schools, about 60 per cent are private medical schools. As a result, private medical schools have been providing more than 60 percent of the graduating physicians in the last three years. The increase of the number of midwifery and nursing schools is even larger. By investing in reform of the accreditation system of health professional education the government has an opportunity to improve the quality of HRH entering the market. Indonesia's internship program requiring a 12-month supervised practice for graduating physicians opens an opportunity to improve the quality of newly trained physicians while at the same time address some of the maldistribution problem.

B. Lessons to be shared

Indonesia's experiences to date are numerous, but the following points highlight some of the more recent lessons that may be pertinent for other countries at similar levels of development:

- The private sector can be a major contributor to the supply of health workers, but this requires good accreditation and quality control.
- Financial incentives are an important part of attracting health workers to remote areas, but other factors, including non-monetary incentives such as opportunities for professional development, are important.
- The wealth and fiscal capacity of a province that suggest potential capacity to pay for health worker incentive, is not a good predictor of availability of doctors and other health workers.

References

Anderson, I., P. Marzoeki, A. Meliala, E. Pambudi, K. Hariadi, and T. Marthias. 2013. “The Production, Disbursement, and Performance of Physicians, Nurses, and Midwives in Indonesia: An Update.” Working Paper, Jakarta, World Bank.

Bi, X., P. Harimurti, J. Langenbrunner, E. Pambudi, and A. Tandon. 2013. “Fiscal Space for Universal Health Coverage in Indonesia, Lessons from Jamkesmas Financing.” Working Paper, Jakarta, World Bank.

Bredenkamp, C., A. Tandon, P. Harimurti, E. Pambudi, and C. Rokx. 2011. “Enhancing Health Equity and Financial Protection in Indonesia: How Well Does Jamkesmas Do?” Working Paper, Washington, DC, World Bank.

Guerard, Y., M. Wiener, C. Rokx, G. Schieber, P. Harimurti, E. Pambudi, and A. Tandon. 2011. “Actuarial Costing of Universal Health Insurance Coverage in Indonesia.” HNP Discussion Paper, World Bank, Washington, DC.

JLN (Joint Learning Network). 2012. “Roles and responsibilities for Universal Coverage in The Nuts & Bolts of Jamkesmas, Indonesia’s Government Financed Health Coverage Program.” http//www.jointlearningnetwork.org/content/Jamkesmas.

MOH. Riset Fasilitas Kesehatan (Rifaskes). 2011.

———. RS Online. 2013. http://202.70.136.52/rsonline.

Pandu, H., E. Pambudi, A. Pigazzini, and A. Tandon. 2013. The Nuts and Bolts of Jamkesmas: Indonesia’s Government Financed Health Coverage Program, Jakarta: World Bank.

Rokx, C., G. Schieber, P. Harimurti, A. Tandon, and A. Somanathan. 2009. Health Financing in Indonesia: A Reform Roadmap, Jakarta: World Bank.

Soewondo, P., M. Nadjib, K. Sari, Y. Afdhila, and N. Afdhila. 2011. “SHA-Based Health Accounts in the Asia-Pacific Region: Indonesia 2005-2009.” SHA Technical Paper No. 15, OECD-Korea Policy Center, Seoul, Republic of Korea.

Thabrany, H. 2008. “Politics of National Health Insurance of Indonesia: A New Era of Universal Coverage”, Center for Health Economic and Policy Studies, University of Indonesia, Jakarta.

WHO (World Health Organization). 2013. Global Health Expenditure Database. http://apps.who.int/nha/database/DataExplorerRegime.aspx.

World Bank. 2012. “Targeting Poor and Vulnerable Households in Indonesia.” World Bank, Jakarta

World Bank, Center for Family Welfare, Faculty of Public Health, University of Indonesia. 2013. “A Study on the Implementation of Jampersal Policy in Indonesia.” Working Paper, Jakarta, World Bank.