POLICY BRIEF

SOCIAL HEALTH INSURANCE AND FINANCIAL PROTECTION FOR THE POOR IN INDONESIA

A first step towards meeting Indonesia's ambition for Universal Health Coverage (UHC) by 2019 was made in 2005, with the introduction of subsidised social health insurance for the poor. With the planned transition to UHC in mind, HEFPA has examined lessons that can be drawn from the experience of extending subsidised coverage to the poor.

Q HOW IS INDONESIA SETTING OUT ON THE ROAD TO UNIVERSAL COVERAGE?

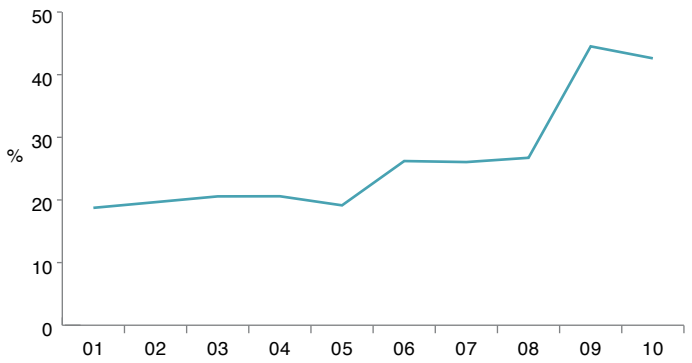
The subsidised social health insurance for the poor in Indonesia was first introduced in 2005, initially referred to as Askeskin and subsequently, from 2008 onwards, as Jamkesmas.

At the time, health coverage for civil servants and formal private sector employees had been in place for several decades. However, with roughly 60 per cent of the labour force employed in the informal sector, a large part of the population was thereby left without cover. Askeskin-Jamkesmas was a first attempt to bridge this gap by extending coverage to poor and near-poor households. Unlike formal sector social health insurance schemes, premiums for the poor and near-poor are fully subsidised from a tax-financed health fund. Enrolled households are entitled to comprehensive coverage for public healthcare, including inpatient and outpatient services.

The subsidised programme currently has a target population of about 76 million people (about a third of the population) and a further 25 million are covered by the formal sector schemes. That said, this still leaves more than half the population without any form of health insurance.

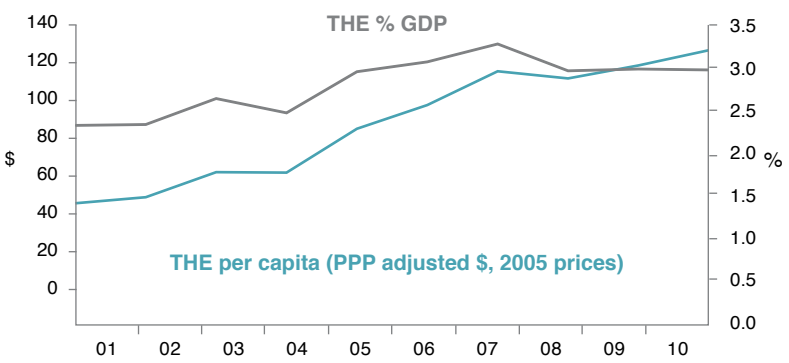
Since 2006, in response to this persistent coverage gap, there has been a proliferation of local healthcare financing schemes. Collectively known as Jamkesda, these schemes are implemented and operated by district governments, and are often motivated by the local political context. Since Indonesia's decentralisation in 2001, districts have been afforded a large degree of autonomy in setting local public health policy. Together with regional variation in financial and human resources, this process has led to substantial differences in the design of local schemes between districts, spanning factors such as coverage, benefit packages and provider contracting.

INSURED, 2001-2010



Source: *Susenas* household surveys 2001-2010

TOTAL HEALTH EXPENDITURE (THE), 2001-2010



Source: WHO Global Health Expenditure Database

Q WHAT WAS THE IMPACT OF COVERING THE POOR ON THEIR ACCESS TO CARE AND FINANCIAL PROTECTION?

ACCESS TO CARE

The experience of the Askeskin programme has shown that subsidised social health insurance can be effective in increasing healthcare utilisation, especially in the poorest households.[1] The bulk of the impact is on the use of public health centres in rural areas, and more expensive public hospitals and contracted private providers in urban areas. A factor that may have inhibited a broader impact among the poorest population has been the programme's targeting performance. While the poor and near-poor were the main beneficiaries of Askeskin coverage, there was also considerable leakage to the non-poor.

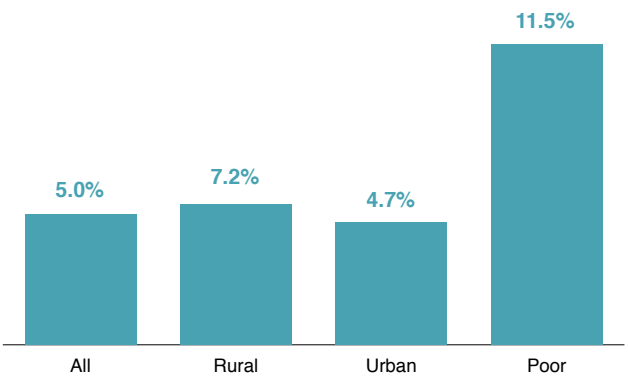
Although the local government Jamkesda schemes have had little overall impact, they do seem to have contributed to closing the coverage gap, by increasing healthcare utilisation of the near-poor falling just outside the Askeskin-Jamkesmas target population.[2] A 25 per cent increase in outpatient visits among the second poorest fifth of households can be attributed to Jamkesda schemes. However, there is no evidence of any effect for other income groups, and nor is there an impact on hospitalisations. Moreover, there is large variation in efficacy across districts, reflecting differences in design. The Jamkesda schemes that tend to increase healthcare utilisation typically rely on external management; they contract both public and private providers and prioritise basic services.

FINANCIAL PROTECTION

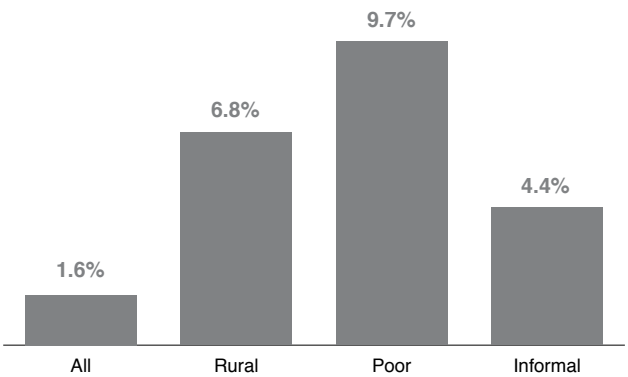
While Askeskin's subsidised coverage for the poor has improved access, it has had a more ambiguous impact on financial protection. Out-of-pocket healthcare spending was actually increased by the programme, in particular for urban households. This indicates that households may be bearing part of the cost of their increased utilisation of subsidised, but not fully insured, services. Nevertheless, the effect on utilisation is much larger than that on spending, suggesting a strong response of demand to the greater affordability of healthcare. Out-of-pocket spending on healthcare by Indonesian households has remained relatively low, accounting for approximately 2 per cent of household budgets, and the HEFPA study finds no conclusive evidence that Askeskin has led to an increased incidence of potentially financially deleterious healthcare spending. As with Askeskin, HEFPA found no evidence for a reduction in out-of-pocket spending among beneficiaries of Jamkesda schemes.

The financial protection from the risk of ill health offered by subsidised health insurance coverage of medical expenses is inevitably limited because it does not cover the other main source of economic risk from illness – income loss. Informal sector workers lack not only health insurance, but also go without sickness and disability insurance. The HEFPA study finds that an illness-induced income loss forces poor households to reduced consumption (especially for non-food items).[3] Although the poor tend to resort to borrowing and the sale of assets and savings as strategies for coping with the economic risk from ill health, these financial buffers are not sufficient to fully protect consumption levels in the short term. In addition, high interest rate borrowing, dissaving and productive asset depletion may negatively affect household consumption in the mid- and long terms.

INCREASE IN OUTPATIENT CARE VISITS DUE TO ASKESKIN



REDUCTION IN NON-FOOD CONSUMPTION DUE TO ILL HEALTH



HOW THE FINDINGS WERE OBTAINED

The impact analysis of Askeskin was based on a nationally representative dataset of households that were surveyed in both 2005 and 2006 (Susenas). The 2005 survey was conducted just prior to the introduction of Askeskin, providing a national baseline for the analysis. The impact of the Askeskin insurance on healthcare utilisation and out-of-pocket spending was then estimated by comparing differences between the Askeskin insured and non-insured, both before and after the programme was introduced. This comparison enabled the construction of a counterfactual scenario of how the Askeskin insured would have fared in the event they had not been targeted by the scheme.

The analysis of the economic risk from illness is drawn from a similar panel of households, but for the period 2002 to 2004. Besides detailed income and expenditure data, this survey also recorded information on ill health events and the coping strategies that households resorted to in response. This data allows us to estimate the effects of ill health on food- and non-food consumption, as well as exploring the role of out-of-pocket health spending and income loss as channels for economic risk.

The Jamkesda study is based on a district survey of local health financing schemes. Using a combination of a survey by mail and interviews by telephone, detailed information on local health financing schemes was collected from District Health Offices in 262 districts. This information was combined with the annual Susenas cross section surveys for 2004 to 2010, which are representative at the district level. This allowed us to track average healthcare utilisation and OOP spending in districts over time, and assess how these were affected by the Jamkesda schemes.

Q WHAT OBSTACLES STAND IN THE WAY OF INDONESIA ACHIEVING UHC?

The next phase of the reforms leading to UHC is to commence in 2014. Existing schemes are to be consolidated and scaled up in one nationwide social health insurance with mandatory contributions for formal sector workers and subsidised premiums targeted to the poor and near-poor.

Based on the experience with the Askeskin and Jamkesda schemes, one may expect that extending social health insurance coverage will improve both access and affordability of healthcare, but that gaps in financial protection may persist. The risk of illness-related income loss falls beyond the reach of social health insurance. Combined with the long-term economic consequences of exercising coping strategies such as borrowing and selling assets, uninsured income risk remains a source of potential impoverishment.

Most income risk is borne by the informal sector that harbours the bulk of the labour force from the poorest half of the population. An additional problem is that the roadmap for achieving UHC by 2019 is currently unclear on how the large share of Indonesians that neither qualify for subsidised premiums nor receive coverage through formal sector employment will be covered. This group comprises a third of the population, largely overlapping with the currently uninsured.

The provision of full financial protection for ill health would therefore require a further expansion of insurance to the informal sector, as well as considering broader social security policies that go beyond the UHC agenda, and comprehensively addressing the multiple sources of economic risk from ill health.

REFERENCES

[1] Sparrow R, Suryahadi A, Widyanti W (2013), 'Social Health Insurance for the Poor: Targeting and Impact of Indonesia's Askeskin Program', *Social Science and Medicine* 96: 264-271.

[2] Budiyati S, Yumna A, Warda N, Sparrow R, Suryahadi A, Bedi A, 'Sub-national Health Care Financing Reforms in Indonesia', *HEFPA Working Paper 15*, Erasmus University Rotterdam.

[3] Sparrow R, Van de Poel E, Hadiwidjaja G, Suryahadi A, Warda N, Yumna A, 'Coping with the Economic Consequences of Ill Health in Indonesia', *Health Economics* (first published online: 8 July 2013, *DOI*: 10.1002/hec.2945).

PROJECT IDENTITY

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- **World Bank Development Research Group** http://econ.worldbank.org/

FURTHER INFORMATION

Duration: June 2009 – December 2013

Funding: EU Seventh Framework Programme (FP7) – contract no 223166

Project website: HEFPA working papers and publications are available at www.hefpa.nl