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*Field Report*

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# Making Services Work for the Poor in Indonesia: A Report on Health Financing Mechanisms in Kabupaten Purbalingga, Central Java

## *A Case Study*

September 2005

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## *ABSTRACT*

*Purbalingga is the first kabupaten in Indonesia to start implementing its health insurance scheme for the poor, as a replacement for the JPS-BK scheme (Social Safety Net Program – Health Sector). Poor families (Gakin) receive a range of health insurance services that are subsidized by the government free-of-charge, while better-off families pay a premium of only 50% or 100%. They are categorized as participants in Gakin Levels I, II and III. The aim is to achieve universal coverage for all citizens in Kabupaten Purbalingga, those who are poor as well as those who are not.*

*Kabupaten Purbalingga is considered unique in the scope of its health services, because it not only includes poor families in its scheme, but also non-poor families. The local government of Kabupaten Purbalingga considers the health insurance scheme to be one of the main pillars of the poverty reduction effort in the region. They want the management of this scheme to become more independent and less dependent on DinKes (the local government health agency) so the program can be managed more efficiently and with more accountability. What is rather interesting is that DinKes plans to arrange a health insurance scheme that will be autonomous and sustainable for all better-off members in the future. They intend to slowly increase the premium until it reaches the real cost of the assistance package. According to DinKes, the cost should be approximately Rp92,000 per family per month. From the perspective of Bapel, an autonomous scheme with that level of premium definitely has potential, however they will always depend on the premiums to be paid by the government.*

*It needs to be noted that the Community Health Insurance Scheme (JPKM) initiative in Kabupaten Purbalingga is almost entirely the initiative of the government as its moving force. The main protagonists are government (Regent, DinKes and Bapel), public service providers (public hospitals and puskesmas), the local parliament (DPRD) and other government agencies.*

*Key words: JPK- Gakin; Purbalingga; health; poverty program.*

# I. OVERVIEW

## A. THE JPK-GAKIN SCHEME IN PURBALINGGA

The JPKM[1] Scheme in Purbalingga is managed by a Management Agency (*Bapel*), named PT Sadar Sehat Mandiri. The *Bapel* was established by the Bupati Decree No. 40/63 in 2003, effective April 7, 2003. The scheme has, however, been operational since the 2001/2002 fiscal year, since the Purbalingga government considered it important to firstly establish a scheme and worry about its implementing regulations later. Purbalingga chooses to have a separate *Bapel* managing its JPKM scheme because it wants the scheme's management to be independent of the government health office (*Dinas Kesehatan or DinKes*), so that the program can be managed more efficiently and accountably.

Purbalingga is considered to be unique in its health care coverage, because it not includes poor *(gakin)* families in its scheme, but also includes non-*gakin* families as well. *Gakin* clients receive their insurance coverage free of charge (subsidized by the government), while non-poor families pay a premium of either 50% or 100% of the full rate (see below for details). The aim of the program is to achieve universal coverage for the entire population of the Purbalingga District, both those who are poor (who formerly received the JPS-BK[2] subsidies) and those who are non-poor.

The *Bapel* in Purbalingga provides three benefit packages that are very similar, if people want to join they are eligible for a benefit package with a corresponding premium based on their income. Participants of the JPKM scheme were divided into three categories based on their income:

- Strata I: poor families (*keluarga miskin-Gakin*): free of charge. Usually Gakin/Strata I members work as casual laborers or landless farmers.
- Strata II: families that used to be poor (*keluarga pasca-Gakin*): income levels and living situation just above *miskin*: pay 50% of the full premium (currently Rp25,000). These are generally the informal workers such as *ojek* and *becak* drivers.
- Strata III: non-poor/rich families (*keluarga non-Gakin*): the "wealthy"/those who can pay the full amount of the premium (currently Rp50,000). *Kaders*, (local volunteers) only pay 50% of the premium but receive the Strata III benefit package. The *kaders* play a central role in the provisioning and functioning of the scheme in Purbalingga, their role will be expanded upon later in this report. In general, Strata III members are mid-size or large retail merchants.

Health providers in Purbalingga that accept JPKM members as patients are categorized as the following:

- Provider Class I (PPK I): public health center (*puskesmas*), and village midwife (*bidan desa*). All JPKM members are expected to seek their health care from the *puskesmas* first.
- Provider Class II (PPK II): District Public Hospital (*Rumah Sakit Umum Daerah-RSUD*). It receives JPKM patients that were referred by the *Puskesmas*.

[1] JPKM: *Jaminan Pemeliharaan Kesehatan Masyarakat* (Community Health Insurance Scheme).

[2] JPS-BK: *Jaringan Pengaman Sosial Bidang Kesehatan* (Social Safety Net Program in the Health Sector).

- Provider Class III (PPK III): Provincial Public Hospital (*Rumah Sakit Umum Provinsi-RSUP*). (This only applies for Gakin/Strata I clients Strata II and III could not be referred outside of Purbalingga). There are two RSUP in the Central Java Province: RSUP Karyadi in Semarang and RSUP Margono in Purwokerto, only 30 kilometers from the Purbalingga District.

It should be noted that these providers are public/state owned providers only. Private providers are unable (or unwilling) to become JPKM providers, due to the perceived inadequacy of reimbursements under the scheme.

# II. SCHEME: FUNCTIONAL

## A. POLITICAL ECONOMY: WHO INITIATED?

The health insurance scheme in Purbalingga had its roots in the 1998 economic crisis, as part of the Indonesian Government's Social Safety Net Scheme for the Health Sector (JPS-BK). Even though this program was discontinued by the central government in 2000, the local government realized that many of its beneficiaries continue to need support to access health care services. Therefore, the Purbalingga District Government decided to continue an adapted version of the program in 2000, and renamed it as the Health Insurance Scheme for Poor Families (JPK-Gakin). The program then was expanded into a Community Health Insurance Scheme (JPKM), that is open to all citizens in fiscal year 2001/2002. Purbalingga was the first district in Indonesia to install its own health insurance program for the poor as a replacement for the JPS-BK scheme within its district and the stakeholders involved seem to be highly motivated to make this scheme work. According to the Head of the *Bapel*, the initiative to create this health insurance is based on the view that during the previous JPS-BK scheme, the subsidies were spent with little accountability and little regard for the program's future sustainability, and with a health insurance scheme these problems could be addressed.

The reason for providing three benefit packages for people of different incomes is to increase access to health care and utilization of health care services for all people in Purbalingga's society. The Purbalingga government considers the health insurance scheme as one of the major pillars of the government's poverty reduction efforts in the district.[3] The scheme allows access not only for the poorest of their society, but also provides an option for people with other income levels in need of health insurance. These targets have been written down in the "Healthy Indonesia 2010" program formulated by the Ministry of Health. The idea that was adopted by the Purbalingga government was for it to develop a health insurance scheme with the aim of achieving universal coverage for the entire population of the Purbalingga District. Therefore, the Purbalingga government decided to provide three different packages depending on people's income, both those who are poor (who formerly received the JPS-BK subsidies) and those who are non-poor.

Interestingly enough, the *DinKes* plans to make the health insurance scheme self-sustainable for the non-*gakin* members in the future. They intend to slowly increase the premium until it reaches the real price of the benefit package. According to the *DinKes* that price should be around Rp92,000 per family per month. From *Bapel*'s perspective a self-sustaining scheme at that premium level is possible, but they will always depend on the premium paid for the poor by the government. As the head of the *Bapel* in Purbalingga puts it: "It is the task for the government to provide health care for the poor so they will continue to provide funds to do so." If they had to rely on a cross-subsidy from the Strata III insured for both the Strata II and the Strata I insured they will be over-reliant on the premium of Strata III insured and the burden on their contribution would be too high.

[3] Other pillars are: food security program, housing reparation program for poor households, provision of clothing, education and special credit for small businesses.

It should be noted that the JPKM insurance initiative in Purbalingga is almost entirely a government-driven initiative, with the main actors being the government (the *Bupati*, *DinKes*, *Bapel*), public providers (RSUD and *puskesmas*), local Parliament (DPRD), and other governmental agencies. Other stakeholders (the community, private sector, NGOs, etc.) do not have much role in shaping this policy initiative. Their role thus far is only as members/clients of the scheme, paying its premiums and receiving its benefits, if they are willing to do so.

## B. JPKM FINANCING IN PURBALINGGA

The premium for the health insurance scheme is set by the *Bapel* with feedback from the health care providers. When the program was set up in 2001, the premium for Strata II and III was set at Rp30,000 per family per year with full payment for the third strata and half payment for the second strata. The premium was raised to its current level (Rp25,000 per family per year for Strata II and Rp50,000 for Strata III) in 2003. Since the 2004 financial year, the insurance premium has been set at Rp50,000/household/year.

Apart from private contributions, the main portion of revenue comes from the subsidies of both central as well as local government. In Fiscal Year 2002/2003, over 70% of the revenues originated from government subsidies. These subsidies almost tripled in the following year as shown in Table 1 below.

**Table 1: Financing Sources of JPKM Scheme in Purbalingga**

| Funding Source | FY 2002/03 (millions of Rp) | FY 2003/04 (millions of Rp) |
|---|---|---|
| Oil subsidy compensation (PKPS-BBM) | 291 | 2,583 |
| Local government budget (APBD) | 1,270 | 2,080 |
| JPKM Premium (Strata II & III) | 645 | n/a |

Theoretically, each strata has different revenue sources:

- Strata I: all funding comes from the general block grant (*Dana Alokasi Umum*-DAU) and fuel compensation subsidies for poor families (PKPS-BBM[4]).
- Strata II: half of the funding comes from members' premiums and the other half is from subsidies coming from similar sources as Strata I.
- Strata III: all funding comes from members' own premiums (self-funded).

Both *Bapel* and the health provider (RSUD) stated that at this time however, the amount of funds allocated to subsidize Gakin/Strata I members far exceeded the funds collected from Strata II and III members and that the premium is not sufficient to fully cover the cost of health services for these members.[5] This allows members and society to get used to the principles of (health) insurance and increases their willingness to pay for a health scheme. The *Bapel* head said that this premium is only an "introductory premium." It is planned that this introductory premium will be increased gradually until it reaches the real premium rate around the year 2012. By that time, the scheme is supposed to become self-sufficient, without the need for government subsidies to cover its financial shortfalls.

[4] PKPS BBM: *Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak* (Compensation Program for Reduced Subsidies on Refined Fuel Oil).

[5] The real premium cost is estimated to be Rp96,000/household/year.

Both first line treatment and specialized care (*puskesmas* and hospital) are reimbursed through a capitation payment. Communication between the different stakeholders regarding the payment is regular, but there is more correspondence between hospital and *Bapel* than *puskesmas* and *Bapel*. This may be because the ties between the hospital and the *Bapel* are stronger as doctors in the hospital are also employed in the *Bapel*.

The capitation payment for outpatients receiving highly subsidized *puskesmas* care is, by definition, the smallest subsidy received. The *puskesmas* receives Rp20,000 per family per year.[6] Interestingly enough *puskesmas* and the hospital almost receive the same capitation payment although the reimbursement for in-patient treatment at the *puskesmas* is higher than the hospital.

**Table 2: Capitation Payment to RSUD (per Household/KK)**

| Services Type | Amount (in Rupiahs) | Note |
|---|---|---|
| RSUD Capitation for in-patients | 21,500 | |
| Outpatient Treatment at *puskesmas* | 20,000 | |
| In-patient Treatment at *puskesmas* | 22,000 | (Rp20,000 OP + Rp2,000) |
| *Bapel*'s Management Fee | 6,000 | |

Source: *Bapel*.

Over the past three years the capitation payment for the RSUD has doubled as the capitation set in previous years proved to be insufficient (see Table 3 below). After consultations between the different stakeholders the capitation rate has been significantly increased. The staff of the RSUD find it difficult to predict whether this years' capitation will be enough. They expect this years' expenditures to be closer to the capitation payment, but this will not reduce the deficit they accrued over previous years.

**Table3: Capitation Payments to RSUD (2001-2002 to 2004-2005)**

| | | |
|---|---|---|
| Year 1 | 2001-2002 | Rp11,000/yr |
| Year 2 | 2002-2003 | Rp14,000/yr |
| Year 3 | 2003-2004 | Rp20,750/yr |
| Year 4 | 2004-2005 | Rp21,500/yr |

Source: RSUD.

[6] One *puskesmas* visit costs Rp5,500 thus each family could make at least three visits to the doctor.

## C. BENEFIT PACKAGE

In principle, insurance members receive their primary health care first. They are entitled to receive *all necessary* medical services that are *available* at a *puskesmas*. It should be noted however, that the types of service and medication actually available at *puskesmas* are relatively limited,[7] although both *puskesmas* and *DinKes* staff (and also several patients/clients interviewed, especially those who are also *kaders*) stated that, since the JPKM commenced operations, the quality of services of *puskesmas* have increased. As a result, many JPKM members require referral to the RSUD.

For *Gakin*/Strata I members, there are no restrictions on the types of treatment they can receive at the RSUD. For Strata II and Strata III members however, there are some limitations, including:

- in-patient treatments are limited to a maximum of 10 days;
- the type of medication being used;[8]
- laboratory expenditures are limited to a maximum of Rp15,000; and
- X-ray expenditures are limited to a maximum of Rp25,000.

If Strata II and III health expenditures exceed these limits, the patient has to pay the entire cost above these limits (a co-payment). If insurance members cannot pay the entire amount at once, they can pay them by installment.

In addition, officially there is a rule stating that some health services will not be covered for insurance members,[9] however, it is unclear whether this rule is actually being enforced by health providers. Health providers seem to make exceptions to this rule in the case of Gakin/Strata I members. An RSUD staff stated that "all *Gakin* members will receive all necessary treatments required for their health care, regardless of costs." The rights of JPKM members to receive health services in *puskesmas* and RSUD are specified in Appendix 1.

## D. THE ROLE OF KADERS IN MARKETING AND IDENTIFYING JPKM MEMBERS

The identification and verification of the poor is an important and difficult step in providing health care for the poor. During the period of the health card (JPS-BK), identification of the poor was a major problem. If the poor are not aware of their rights they cannot make use of the health insurance and therefore publicizing the program is of crucial importance. For the identification and verification of the poor, and the socialization (or marketing) of the program, the Purbalingga District makes use of a *Tim Desa*. This team consists of the *puskesmas*, *bidan* and the village head (*kepala desa*).

[7] Examples of health services that are supposed to be available at *puskesmas* are: 1) outpatient and in-patient services for both JPKM and non-JPKM members, 2) prevention of infectious diseases, 3) identification of infectious diseases, and 4) malnutrition prevention and treatment.

[8] The use of generic medicine is strongly encouraged. Patented drugs can only be used after receiving an approval from a peer review commission established within the RSUD.

[9] See Appendix 1 for details.

A large role in the marketing and socialization of JPKM is played by members of the Family Welfare Program (PKK) who are commonly called *kaders*. Typical *kaders* are the wives of the local Household Association (RT) Head or the wives of an important member of the community, such as a teacher, a religious leader (*ulama*) or a civil servant. *Kaders* operate among the grassroots of the community and there is at least one *kader* in each RT.[10] They are involved in the socialization efforts of various other government programs, ranging from child immunization (*posyandu*) to farm planting methods.

Since *kaders* live among the community, they know many of the community members living near them quite well. Thus, it is easy for them to approach community members and publicize a given government program. At the same time, community members are more likely to consider information received from *kaders* more seriously than that communicated by government officials, who often do not live in the community and have more distant and impersonal relationships with community members compared with *kaders*.

*Kaders* are probably the most effective tools used by the district government to market the JPKM scheme, given that they know the surrounding community closely and are perceived to be a more reliable information source than formal government bureaucracy. As a result, the success of JPKM largely depends on the marketing methods of *kaders* and their skills in promoting and marketing it. Even when these efforts were also conducted by *Bapel* through other means,[11] it is through the *kader* system that most of the marketing and socialization efforts to recruit new JPKM members are centered. They are the ones who explain to the community what the JPKM scheme is all about and why citizens should join it as well as recruit JPKM members in their living/working area. These activities are done both through formal community members and informal communications with fellow community members when conducting routine daily activities.

*Kaders* normally do this work on a voluntary basis. They only receive a small amount of incentive payment (around Rp1,000 per member signed up) in return for their marketing and socialization efforts. Thus, the financial cost of using the *kader* system in marketing the program was minimal.

The recruitment and validation of JPKM members is done once per year, between the months of June and July. It is especially targeted to identify those families who have increased their wealth and are moving from Strata I to Strata II. *Kaders* are supposed to follow a list of predetermined names of community members given to them by the *Bapel* and *puskesmas*.[12] However, even when they claimed that they follow this list in identifying prospective members, in practice they have great influence and discretion in categorizing prospective members living in their community, especially in determining who is Gakin (Strata I) and who is post-Gakin (Strata II).

According to *kaders* who were interviewed, in determining those who move from *Gakin* to post-*Gakin* status, they normally used the condition of the family's house as a primary criteria (for instance, whether the house had a dirt or marble floor) or enquired about

[10] Each RT consists of 20 to 30 households.

[11] For instance, the distribution of leaflets and flyers and radio advertisements.

[12] See Appendix 2 for details.

whether members of the household have managed to improve their earnings (e.g. those who were unemployed are now working). When *kaders* made these modifications in the prospective members' list, they were usually not challenged by the *Bapel* and the *puskesmas*. Thus, the influence of *kaders* in determining JPKM's membership status is quite substantial.

At the same time, there is considerable pressure from *Bapel* to increase the number of premium paying members (especially at Strata II level) and reduce the number of non-paying Gakin/Strata I members in the JPKM membership roll. Thus, *kaders* are pressured to "upgrade" the Gakin members in their community to Strata II status, even when these members are still technically a *Gakin*.[13] Consequently, these former *Gakin* members are no longer eligible to receive health services without paying a premium of Rp25,000/KK/year to continue receiving these services.

Even though the *kaders* can more easily identify the category of wealth a household belongs to, they are also subject to complaints. Sometimes family members do not accept their assigned "status" and complain. In this case *kaders* have to convince the families that they can no longer be identified as *Gakin*. As the *kader* is close they can put social pressure on them, which can be a risk in correct identification of the real poor.

Another means by which community members were enticed to join the JPKM scheme was by increasing *puskesmas*' user fees from Rp2,000/person/visit before the 2003/2004 financial year to about Rp5,500/person/visit today. The fee is waived for JPKM members, but is charged for non-members. *Bapel* and *puskesmas* officials stated that this would serve as an incentive for citizens to enroll in the JPKM scheme, since they do not have to pay the *puskesmas* user fee if they are enrolled in it.

Lastly, Purbalingga District's civil servants and *kaders* were pressured to enroll in the JPKM scheme at Strata III level, in order to, according to a DinKes staff, "assure the success of this government program." The civil servants have to pay the full cost of Strata III themselves, while the *kaders* receive a 50% discount (Rp25,000/KK) if they enroll in the scheme.

There are several factors that determine the number of community members participating in JPKM:

1. Members joining Strata I and II are influenced by the marketing methods and ability of local activists to promote the scheme at community level (*kaders*, midwives, and RT head). The marketing methods, skills, and motivation of *kaders* largely influences whether or not people will enroll in the scheme. In RTs where the *kaders* are highly motivated and active, people are more likely to be enrolled in the scheme, whereas this is not the case in RTs where the *kader* play a more subdued role.
2. Members joining Strata III are influenced by conventional promotion and marketing efforts conducted by *Bapels* (by putting up flyers, radio and newspaper ads, distributing leaflets) and other methods such as using "social pressure" to persuade civil servants and *kaders* to enroll at Strata III level.
3. The ability of the community to receive and understand information given to them. This may be related to the level of their education.

[13] This is confirmed from one of the *kaders* we interviewed.

4. Community perception of *puskesmas* services (facilities available, service quality, effectiveness of medication/drugs, etc.).

Compared with the JPK-Gakin in other districts/cities (e.g. in Tabanan and East Sumba), there seems to be more awareness from members/citizens about the JPKM scheme and their rights as members of the scheme (e.g. in general they know that with Gakin card, they could obtain free health services at *puskesmas*/RSUD). This should be attributed to the aggressive socialization campaign by *kaders* at the RT level, the training by the *puskesmas* and knowledge of the *kaders* about the program itself.

This awareness does not necessarily mean however, that more citizens would become members of the scheme. Many are still refusing to join the scheme. In some RTs, up to 50% of residents are not JPKM members. Reasons given for not joining the program included: 1) they do not have the money to pay the JPKM premium (for Strata II and III members), 2) they are skeptical about whether they would actually receive the services promised by JPKM (without additional "payments/tips" to doctors/paramedics, 3) they believe that the quality of health care services provided by *puskesmas*/RSUD are inferior to those of private providers, even while they are not reimbursed by the JPKM scheme, and 4) they already have another health insurance package that is more attractive.

## E. UTILIZATION AND REFERRAL

A comparison of utilization rates of health care services between insured and non-insured and between the different strata indicates a difference in behavior regarding accessing health care services. The average monthly utilization rate of JPKM members in Purbalingga during fiscal year 2003/2004 is described in Tabel 4 below.

**Table 4: Average Monthly Utilization Rate of JPKM Members in Purbalingga District in the 2003/2004 Financial Year**

| Type of Services | Number of Visits per month | Utilization Rate (in %) |
|---|---|---|
| Outpatient Service (*Puskesmas* and RSUD Outpatient) | 30,614 | 7.64 |
| In-patient Service (RSUD) | 97 | 0.02 |
| Maternity | 278 | 0.07 |
| Emergency | 538 | 0.13 |
| Referral to RSUD | 1,909 | 0.48 |

Assumptions: There are 100,188 families signed up for JPKM.
Each KK consists of four members (father, mother, and two children).
It is therefore assumed that there are 400,752 citizens enrolled in JPKM
Source: *Bapel* in Purbalingga

For *Gakin*/Strata I members, the average monthly utilization statistics are as follows:

**Table 5: Average Monthly Utilization Rate of Gakin/Strata I Members in Purbalingga District in the 2003/2004 Financial Year**

| Type of Services | Number of Visits per month | Utilization Rate (in %) |
|---|---|---|
| Outpatient Service (*Puskesmas* and RSUD Outpatient) | 6,404 | 3.19 |
| In-patient Service (RSUD) | 12 | 0.01 |
| Maternity | 60 | 0.03 |
| Emergency | 98 | 0.05 |
| Referral to RSUD | 278 | 0.14 |

Assumptions: There are 50,217 poor families signed up for JPKM.
Each families consists of four members (father, mother, and two children).
It is therefore assumed that there are 200,868 citizens enrolled in JPKM
Source: JPKM *Bapel* in Purbalingga

While Strata I members contribute more than 50% of the total insured, they only use slightly over 20% of the *puskesmas* health services (see Tabel 6). Assuming that the health of people of different income groups is the same they will have a similar pattern of need. This need does not however, seem to be satisfied by the *puskesmas* health care services. For hospital services this discrepancy is even larger. Only 12.37% of JPKM members using hospital care were *Gakin*. This indicates that there are other barriers than financing of the health care services that limit access to health care services by *Gakin*.

**Table 6: Utilization by *Gakin* as a Percentage of Total JPKM Utilization**

| Type of Services | *Gakin* Visits per Month | Total Visits per Month | % of Visits by *Gakin* |
|---|---|---|---|
| Outpatient Service (*Puskesmas* and RSUD Outpatient) | 6,404 | 30,614 | 20.92% |
| In-patient Service (RSUD) | 12 | 97 | 12.37% |
| Maternity | 60 | 278 | 21.58% |
| Emergency | 98 | 538 | 18.22% |
| Referral to RSUD | 278 | 1,909 | 14.56% |

One possible barrier, identified by the Head of Puskesmas Kutasari, is the cost of transportation for poor citizens (*Gakin*) from their homes to the *puskesmas*. Even when they receive free treatment at the *puskesmas*, they often have to use public transportation or a relatively expensive motorbike taxi (*ojek*). The transportation cost is often much higher than the *puskesmas*' user fee.[14] There is also the opportunity cost in attending the *puskesmas* that puts additional pressure on someone's budget. This problem was raised by the *puskesmas* head we interviewed in Cilegon.

Another problem contributing to the low utilization rate of *puskesmas* by *Gakin*/Strata I members is a community perception that the quality of health services in *puskesmas* is poor or people's unwillingness to use conventional health treatment for their health care. Some

[14] The transportation cost is estimated to be Rp10,000 per trip taken using ojek, while currently, the *puskesmas* user fee is set at Rp5,500/person/visit, and the fee is waived for JPKM members.

members/clients we interviewed stated that they prefer to use private providers, such as the one provided by paramedics (*mantri*), traditional healers, etc.

These providers are often *puskesmas* staff who happen to live in the community where the clients live. They have often consulted these providers for their health care needs for many years, even decades. Thus, they feel a more personal relationship with these providers compared with other providers at a *puskesmas*. This is why they continue to use the service of these providers even when they charge much higher fees (sometimes the cost is up to 20 times more) compared with the *puskesmas* fees. Finally, some *puskesmas* staff said that some patients (especially G*akin*) are not willing to go to *puskesmas*/RSUD until their illness has become more serious. They attributed this to "cultural" issues (afraid of seeing formal health providers, etc).

In addition, many Strata I members have not received their JPKM membership card. The card they have is still the old health social safety net (JPS-BK) card. Many G*akin* members without the new card were reluctant to seek treatment at *puskesmas*, fearing that they would be refused treatment if they do not have the new card. In comparison, most Strata II and III members have already received their JPKM card. Thus, there is an indication that *Bapel* and the *puskesmas* prioritize the distribution of the card for premium-paying members instead of those who are G*akin*. This might discourage G*akin* members from using the health services available at *puskesmas* and RSUD. Thus, delaying the distribution of membership cards to G*akin* serves as an informal rationing mechanism for reducing G*akin*'s utilization of health services.

There is also a large difference in referral of *gakin* and non-*gakin* members; fewer than 15% of the total referrals are for *gakin* patients. We have to observe this outcome from different perspectives to understand what has caused this outcome. From the patients' perspective, it seems that not everybody is willing to go to hospital due to the long distance, length of time and costs that it would take to get there. From the hospital's perspective: there have been complaints from the hospital that the *puskesmas* initially referred too many cases that could actually be treated by *puskesmas*.

The policy that referrals should be signed by *puskesmas*' doctors was made because the RSUD complains that earlier, *puskesmas* referred too many patients to RSUD, often for cases which could have been treated by *puskesmas*. This resulted in the RSUD having to cope with a high number of new patients that also incurred higher health care expenditures. According to RSUD, most of these improper referrals were given by paramedics (*mantri*), so the diagnosis behind the referrals was also unclear. RSUD's complaints have resulted in a lower level of referrals from *puskesmas* since 2004.[15]

Thus, the reasons why G*akin*/Strata I utilizations were lower than other JPKM members could be attributed to the formal and informal rationing mechanism mentioned above. Since most of the health service users at *puskesmas* and RSUD were Strata II and III members, but most of the funding for JPKM (from BBM subsidies and DAU grants) were supposed to subsidize the health coverage for G*akin* members, this means that a large portion of these funds were actually used for subsidizing the health services for better-off

[15] We noted that in one case (Puskesmas Kutasari), before 2004, referrals by *puskesmas* were approximately 20-30 cases per month, whereas in 2004, referrals decreased to 5-10 cases.

JPKM members. This might not be the most efficient way to provide health coverage for Purbalingga citizens, since most of its intended target never utilize the service and those that actually use it might actually be able to fund most if not all of their own health expenditures.

## F. MONITORING AND COORDINATION OF STAKEHOLDERS

The JPKM Advisory Board consists of government officials from different district government's departments/agencies and also from different sub-departments within the *DinKes*. There are 16 different agencies that are members of this Board, one of whom is *DinKes*. The Board has three functions:

1. Monitoring and guidance: visiting *Bapel* (although there are no permanent and routine scheduled visits), receiving complaints from the community/JPKM members;
2. Development: especially developing regulations for the JPKM scheme; and
3. Advisory: directed towards the three JPKM stakeholders: *Bapel*, health providers, and members (through *kaders*).

In financial matters, monitoring is supposed to be done by the District Auditing Board (*Badan Pengawas Daerah-Bawasda*). The monitoring by *Bapel* of the quality of health services of the *puskesmas* and RSUD is done by the reporting of *puskesmas* and RSUD's financial and expenditure data to *Bapel*.

Formally, *DinKes* as part of the Advisory Board of JPKM, is responsible for monitoring the work of the *Bapel*, the effect of JPK-*Gakin* on utilization and quality (based on the *DepKes* book). Monitoring of the *Bapel* is performed by measuring the utilization of health care services and the health expenditure costs. Health care providers (*puskesmas*, *pustu*, and hospital) all provide monthly reports on utilization rates and expenditures to the *DinKes*. However, this kind of monitoring is rather limited and does not provide information concerning why people do or do not make use of health care services if they need it. Also, quality assessments of health care services are not done.

There also appears to be little coordination between involved parties (*DinKes*, *Bapel*, and providers) in monitoring the use and the finances of JPKM. Specifically, it is unclear whether the financial and utilization reports submitted by health providers were checked and verified by other government agencies (*DinKes* and *Bapel*). Within these two agencies, there is no agreement on which one should verify these reports—*Bapel* said the *DinKes* should do it, while *DinKes* said *Bapel* should do so.

Strata II and III members are more likely to complain about services they received at *puskesmas*/RSUD. On the other hand, there are very few complaints being lodged by *Gakin*/Strata I members. *Bapel* and health service providers attributed this to the lack of education of *Gakin* compared with the other two strata as well as a tendency to "just accept fate" (*nrimo*/*pasrah*) that made them unwilling to complain to healthcare providers/*Bapel* about the services they received.

It is also likely that the fact Strata II and III members are paying for their JPKM membership, while *Gakin*/Strata I members do not pay anything, also contributes to more complaints being filed by the former groups than the latter. Strata II and III members demand better services from the healthcare providers because they have paid the JPKM

premium (so they feel "entitled" to receive services commensurate with the amount of premiums they have paid), while *Gakin* members do not care much about the quality of services of JPKM providers since they do not pay the premium.

Measuring the level of satisfaction with health care services, especially when they are provided for free, is very difficult. When services are provided for free there is less likelihood that the clients will complain about those services. In addition, the assessment capabilities of a society with a low knowledge of health and health care is not a good benchmark. One option to filter complaints is at the community level through the *kader*, but such a system does not seem to have developed here.

# III. THE IMPACT OF JPKM ON HEALTH CARE DELIVERY IN PURBALINGGA DISTRICT

## A. OBSERVATIONS

Although health insurance takes away the risk of having to pay for health care and thus increases the affordability of health care, there are several characteristics of this health insurance scheme that may limit access to health services by the poor. We cannot compare the utilization rate before the implementation of JPKM with the rate after implementation, but from a comparison of utilization rates with *puskesmas* services in other regions it is obvious that the utilization rate is much higher in Purbalingga than in other regions evaluated. Attention also needs to be paid to the following:

1) The distribution of the JPKM card to members of different strata takes longer for Strata I members than for the paying members. This seems to be a general problem that also occurred in previous years. G*akin*/Strata I members interviewed for this study are still using their old JPKM card because their new card has not been distributed. On the other hand the cards for Strata II and III members have been distributed. The lack of a new card could serve as a barrier for members (especially G*akin*) that would make them reluctant to seek treatment at the health facilities.[16]

2) The transportation cost, especially if it is costly, which discourages the poor from going to the *puskesmas* and/or RSUD, even if they are JPK-G*akin* members, since they could not afford the transport cost.

3) Perception/stereotype of *puskesmas*: there is a common perception among community members that health services in *puskesmas* are of low quality (e.g. services offered by doctors/paramedics, quality of medicine, supplementary services such as laboratory, etc.). As long as this perception exists, many people would be reluctant to seek their treatments at *puskesmas*, and prefer to seek treatments with private providers, even when they charge much more than *puskesmas*.

Private providers are not included in (or refused) to join the JPKM scheme. This reduces the access and choice of JPKM members in their health care, since they could only use their entitlement at public facilities (*puskesmas* and RSUD). This might contribute to the perception of some JPKM members that the health services offered by the public providers are inadequate or lacking in quality. Inclusion of private providers should be (encouraged by offering an appropriate level of compensation/reimbursement to them. This would increase access to, and choice of, health services for JPKM members. Inclusion could also increase competition and quality standards.

[16] This is despite the reassurance from *Bapel* and *puskesmas* officials that G*akin* members could still come to health facilities and receive treatment there, even when they do not have the newest membership card.

It is difficult to determine whether healthcare providers are operating efficiently, since even with JPKM/JPK-*Gakin*, most of their expenditures are reimbursed by the *Bapel*. Thus, JPKM is in practice not an insurance scheme, but just a health financing mechanism, in which the government fully subsidizes the health spending of the poor, and also partially subsidizes regular, paid JPKM members.

RSUD officials believe that the quality of health services at the RSUD has improved since the enactment of the JPKM scheme, because RSUD management has increased "incentive payments" for its staff. In addition, the RSUD has purchased new hospital beds (although we observed that many of the new beds are in the Class I and VIP category, which is assumed to be for patients who can afford to pay the entire cost of their health care themselves and are not JPKM members).

## B. SUSTAINABILITY

This health insurance scheme is not sustainable as it is highly dependent on large sums of subsidies. First of all, the premium for the poor is fully paid by BBM subsidies and in addition DAU is used for partial contributions to all three strata. Secondly, the health care services are also subsidized through other funds, such as regular appropriations by the local government to subsidize the operational expenses of *puskesmas*. *Puskesmas* also receive government subsidies to purchase medicines and medical equipment. We have been unable to determine however, whether the capitation payments set for the different health care providers have had an effect on containing costs.

During the first and second year, the expenditures of the RSUD exceeded the budget (i.e. incurred a deficit). This deficit has since decreased, due to increasing capitation funding for the RSUD. Whether or not there will be a deficit is still in question and the RSUD is not answering it. RSUD officials also do not think that the deficit could turn into a serious financing problem in the future. Their attitude seems to be that as long as the district government continues to channel money to them, there won't be any problems. Thus, there is no incentive for *puskesmas* to try to control costs and reduce expenditures in order to avoid deficit spending.

This, combined with lack of monitoring of RSUD financing by *Bapel* (see above), casts some doubt over the long-term sustainability of the JPKM program, since financial sustainability requires a good financial plan that is enforceable and also accountability measures to prevent abuse/misuse of program funds. There seems to be little financial planning and control done by both *Bapel* and providers to maintain the efficiency of the scheme and to eliminate unnecessary expenditures. There are also no clear measures to ensure financial accountability of health providers in using the funds received from the *Bapel*. Without these, the scheme will be vulnerable to possible abuse and fraud, which could endanger its long-term sustainability.

The planned increase in JPKM insurance premiums to reflect its real market value in the next few years (to about Rp96,000/person/year) could potentially reduce the number of members participating in the scheme. This could also endanger the program's sustainability, especially if the number of members dropping out of the scheme is significant.

# IV. CONCLUDING REMARKS

The JPKM scheme in Purbalingga has been more successful in providing access to adequate health care coverage to members of the population, especially the poor. The number of people enrolled as JPKM members is quite substantial in comparison to similar schemes in other districts, thanks largely to extensive marketing and socialization efforts undertaken by *kaders*. The largely successful use of *kaders* in socializing the JPKM scheme in Purbalingga is of special attention and may provide the model for similar schemes in other Indonesian districts/regions.

The Purbalingga scheme needs to be improved in several ways however, in order to enhance its effectiveness and increase the number of people willing to join it. In addition, there are a few problems that need to be addressed by the *Bapel* and the health providers that could hinder the effectiveness of JPKM in delivering its service to its members, such as the following:

- There appears to be significant pressure to enroll more paying JPKM members into the scheme, for instance, by increasing the *puskesmas*' user fees and by upgrading many *Gakin*/Strata I members into Strata II/post *Gakin* status. These steps might be premature, considering the fact that there might be some *Gakin* families that in reality are still *Gakin*, but are forced to move up to Strata II status as a result of these pressures. This might force them to drop their JPKM membership altogether, since they are not able to afford the premium. The pressure to include more paying members into the JPKM scheme should be balanced by a concern to provide fair treatment to its members based on their ability to pay.

- There appear to be formal and informal barriers made to discourage some *Gakin* members from using the services they are entitled to, such as: the high transportation cost, the delay in the distribution of their membership card, etc. Such barriers might negate the function of JPKM as a health assistance scheme for the poor and could result in the misallocation of *Gakin* subsidies to the supposedly better-off members at Strata II and III level, who can theoretically afford to pay some of their own health care costs.

- There seems to be a lack of efficiency in the use of JPKM funds by health providers (especially RSUD). As long as the payment system is operating de facto as a FFS,[17] cost control would not be achieved and the use of more expensive health services/treatments that might not be necessary for patients would be encouraged.

- There is little monitoring done by the *Bapel* and *DinKes* on the use of JPKM funds by health providers. It is not known whether all the reimbursement claims made by the providers are claims for services actually provided. This could provide the opportunity to misuse the funds through the submission of fraudulent claims.

[17] This is especially true for *Gakin* patients. Some cost limitations were imposed to premium paying Strata II and III members.

- There is little involvement of non-government stakeholders (especially JPKM members) in the design, implementation and monitoring of the scheme. JPKM members are just passive clients who pay the premium, receive the membership card, and receive health services from JPKM providers. They do not participate in the decision-making of the scheme itself. This makes the management of the program less transparent and accountable to its stakeholders, especially its members.

- There is no involvement of private health providers in the provision of health services for JPKM members. They are only able to seek health services in publicly managed health facilities (*puskesmas* and RSUD). Part of the reason for private providers not participating in JPKM is its low reimbursement rate for health services performed, which is set at a rate much lower than the market price. In any case, the fact that private providers do not participate in the scheme results in a more limited choice of health providers available for its members, which could deny them access to better quality services.

To address these problems and to make the JPKM scheme in Purbalingga work better, the following steps are recommended to be implemented by the Purbalingga government:

- Improve the quality of services provided by *puskesmas*. Many citizens perceive *puskesmas* to have a low service quality, and thus, they are not willing to seek health care treatment there. If *puskesmas* services are improved, it is hoped that its image among community members would be improved as well, and thus, more citizens and JPKM members would seek their health treatment there.

- Reduce or eliminate the formal and informal barriers for *Gakin* families to use the services to which they are entitled. This could be achieved by speeding up the distribution of *Gakin* membership cards and by providing some transportation subsidies for *Gakin* patients. The government also needs to eliminate the misallocation of *Gakin* subsidies to higher income/Strata groups, to ensure that the JPKM scheme truly meets its intended purpose to provide health financing for poor families.

- Improve the efficiency of health services delivery by health providers (*puskesmas* and RSUD). Health services given to JPKM members should be appropriate to their needs and should be medically necessary. The use of more expensive but not medically necessary services/treatments should be discouraged by the imposition of efficiency-controlling mechanisms.

- Provide more strict monitoring (both internal and external) to ensure that the JPKM funds allocated to provide health services at RSUD and *puskesmas* are spent effectively and efficiently. The monitoring should be done both by *Bapel* (or *Bawasda*) and also by an independent monitoring unit that could be set up by the community or by a JPKM members' association.

- Implement measures to increase JPKM members' participation in the planning, implementation and monitoring of the JPKM scheme. The members should be allowed a voice in the decision-making process affecting their welfare and their membership in the JPKM scheme. The creation of a JPKM members' association would be the first step to achieving this goal.

- Incentives should be created to make the *kaders* more productive in recruiting new members. This could include regular honorariums for *kaders* that would be higher than the current incentive payments available to them (Rp1,000 per new member signed up).

- Consider including private providers (e.g. private doctors, private hospitals and health clinics) in the list of providers of the JPKM scheme. This would increase the choice of providers for members of the scheme and would improve their access to needed health services. In order to attract private providers into the scheme, higher capitation payments might be necessary so that the payment would be in line with the market rate charged by private providers. This might however, require a premium increase, that might force some JPKM members to drop out of the scheme because they could no longer afford the premium. Thus, the costs and benefits of expanding the choice of providers needs to be carefully weighed.

- Consider charging a minimum premium rate or co-insurance for G*akin*/Strata I members, since it seems that paying JPKM members are more likely to demand better services from the providers than non-paying ones and are more likely to complain when these services are not delivered to their satisfaction. This would motivate G*akin* members to demand better services from providers as well. Of course, the charges imposed on G*akin* members should be set at an appropriate minimal level so that they would not drop out from the JPKM scheme altogether due to affordability issues.

# APPENDICES

# APPENDIX 1: RIGHTS OF JPKM MEMBERS

**1. Receive outpatient and in-patient services in *puskesmas*, such as:**

Outpatient Services
- Village polyclinic.
- Sub health center (*pustu*).
- *Puskesmas* (I. General check-up, II. Emergency treatment such as: a. Dental treatment, III. Minor surgery as stipulated by the local government (Perda) legislation, IV. Maternity: for Strata I clients all costs are covered if members attend a public hospital/clinic, such as a *puskesmas*, *pustu*, *polindes*, Panti Nugroho maternity clinic and RSUD. For Strata II there is a maximum limit of Rp80,000 and for Strata III there is a limit of Rp90,000, V. Laboratory check-up with a maximum limit of Rp10,000.

In-patient Services (*puskesmas*)

a. Receives reimbursement for up to Rp125,000 for Strata II members and Rp150,000 for Strata III members, with a maximum stay of three days.

**2. Receive outpatient and in-patient services in RSUD, such as:**

a. Outpatient consultations both with general and specialist doctors at RSUD clinic.
b. Medications (JPKM standard).
c. Supplemental outpatient services, such as: laboratory (reimbursed for up to Rp15,000), X-ray (reimbursed for up to Rp25,000), USG (reimbursed for up to Rp30,000), EKG (fully reimbursed by JPKM).
d. Minor emergency measures.
e. Physical therapy.
f. Nutrition consultation.
g. In-patient service at Class III ward, if JPKM members want to get treatment at higher-class ward, they can do so, but they have to pay the difference between fees for higher-class ward and Class III ward (co-insurance).
h. For emergency surgery/operation, expenses are reimbursed to a maximum Rp500,000.

**3. Services Not Covered By JPKM**

1. Kidney dialysis.
2. Eye glasses and contact lenses.
3. Major dental treatment (e.g. prosthesis and orthodontal).
4. Patients with HIV/AIDS, permanent disability, mental illnesses.
5. Ambulatory care, funeral service and autopsy (except for *Gakin*/Strata I, who are fully covered).
6. Wheelchair, walking stick, corset, and other supporting aid.
7. Blood transfusion.
8. Infertility/impotency treatment and medication.
9. Cosmetic treatment/surgery.
10. General check-up.
11. Medical treatment outside the Purbalingga District (Note: *Gakin* could be referred outside the district (RSUP and RSCM Jakarta).

# APPENDIX 2: THE CRITERIA TO BE CONSIDERED A POOR FAMILY (*GAKIN*) IN THE PURBALINGGA DISTRICT

In order to be considered as a poor family in Purbalingga, a family has to meet two or more of the indicators set up by the *Bupati* of Purbalingga Decree No. 29/2003, effective July 31, 2003:

1. The family's earnings are not sufficient to pay for food consumption of the family in the amount of 2,100 calorie per day (or Rp85,000/person/month).
2. The family is not able to eat more than twice per day.
3. Member(s) of the family is/are suffering from malnutrition.
4. The family does not have an appropriate housing (e.g. house has a dirt floor).
5. The family cannot afford health care and family planning services.
6. The family is unable to send their children (between the age of 7 to 15 years) to school.
7. The family does not have more than three pieces of good clothing.