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Field Report

Making Services Work for the Poor in Indonesia: A Report on Health Financing Mechanisms in Kabupaten Tabanan, Bali

A Case Study

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ABSTRACT

Based on the notion that good health is one of the basic right of all citizens, the Government of Indonesia (GoI) has promoted programs on health care financing for the poor. One of these programs is the Jaminan Pemeliharaan Kesehatan (JPK). In 2003, the pilot project on JPK for the poor (JPK-Gakin) started in 15 districts and two provinces, and was expanded to additional regions the following year. Since April 1 2004, PT Askes, a profit oriented private insurance company, was assigned as the insurer of the non-profit health insurance scheme for the poor (the JPK-Gakin) in district Tabanan. With respect to PT Askes it is important to see in what ways does the prominent role of PT Askes influence the dynamics of health service delivery and how different is PT Askes from other insurers (the non-profit - public institutions) in managing the JPK-Gakin scheme.

The Tabanan case demonstrated that the supervision and monitoring by the Dinas Kesehatan (DinKes) of an insurer like Askes runs the risks of being less effective because PT Askes is a relatively well-established institution that is totally independent of the DinKes. Moreover, there is a difference in the level of expertise and experience between PT Askes and the Dinkes regarding the management of insurance schemes. Therefore, the supervision and monitoring of PT Askes by the DinKes tends to be "formal" instead of "actual." This difference in the level of expertise and experience can also be a barrier for the DinKes to negotiate the cost and coverage of the scheme with PT Askes. PT Askes – as the insurer – is also barely involved in the promotion and socialization of the program and the identification of the poor as their potential clients.

Obviously, the JPK-Gakin scheme can secure primary health care for the poor (the gakin) at the puskesmas, but this does not necessarily mean that the poor will receive good quality care. In general, the health care at the puskesmas is quite limited both in term of quality and variety. The implementation of the JPK-Gakin scheme –including adequate capitation for the puskesmas from this scheme– would certainly not change this condition easily as it relates to more complex factors such as the availability of good medical staffs, instruments and facilities. The most positive effect of the JPK-Gakin scheme on the provision of health care for the poor is the possibility to get secondary and tertiary health care that is usually unaffordable for the poor. Nevertheless, for a range of different reasons, the majority of Gakin patients are not referred to the hospital. There are cases where the poor refused to be referred to the hospital although it was necessary because they were insecure about the additional costs that were not covered by PT Askes. Thus, although the JPK-Gakin scheme does secure the right of the poor to get medical treatment at the hospital, it cannot secure the actualization of it.

Keywords: health care program; financing mechanism; insurance scheme; stakeholders; health services.

I. INTRODUCTION

Based on the notion that good health is one of the basic rights of all citizens, the Government of Indonesia (GoI) has promoted programs on health care financing for the poor. In 1998, the GoI introduced JPS-BK[1] program to provide healthcare for the poor through community healthcare centers (*puskemas*) and village midwives (*bidan desa*). In 2001, the GoI introduced the PDPSE-BK[2] program. This program, inter alia, consisted of the provision of medicines and Hepatitis-B vaccine for the primary health care. In 2002, the program was renamed into PKPS-BBM[3] Health Sector.

Nevertheless, a more effective, efficient and sustainable financing mechanism is needed as the costs of health provision for the poor increase and become a greater burden on the budget of the local government (APBD). For this reason, the GoI has developed a health-financing scheme, namely the *Jaminan Pemeliharaan Kesehatan* (JPK). In 2003, the pilot project on JPK for the poor (*JPK untuk keluarga miskin/JPK-Gakin*) started in 15 districts and two provinces in Indonesia, and was expanded to additional regions the following year.

In general referred to as JPK-Gakin, the individual schemes do contain many significant differences in the characteristics of the scheme provided and who has initiated or been assigned as the health insurance provider. Three of the main differences include the insurer, the benefit package and the reimbursement system. In most cases, the Management Unit, *Badan Pengelola (Bapel)*, consisting of members of the district Health Department and hospital doctors is the health insurance provider, whereas in two cases (Musi Banyuasin, Sumatra and Tabanan, Bali), PT Askes is the insurer. PT Askes is an organization that has a long history and experience of insurance provision and is a for-profit organization. The districts are not tied to the provision of certain benefit packages and thus differences in benefit packages have also arisen. Some districts cover all available healthcare services that extend to providers outside the region, other districts have a more limited benefit package.

Various evaluation studies (e.g. by ILO in 2003) have concluded that the JPK-Gakin scheme has not been successful in facilitating an accessible, affordable and sustainable health service for the poor. Problems such as low benefits, lack of institutional framework and poor management were mentioned as the reasons for the failure. In this case study however, we aim to look at the effects of these different characteristics of the health financing mechanism on healthcare service provision, quality of health care provision and how insurance characteristics can influence the relationships between stakeholders. Some districts have managed to implement and continue the scheme relatively well. This study examines a number of pertinent questions. These include:

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

[2] PDPSE-BK: *Penanggulangan Dampak Pengurangan Subsidi Energi – Bidang Kesehatan* (Reduced Energy Subsidies Impact Reduction – Health Sector).

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

- Why have some districts been more successful in implementing the JPK-Gakin program than other districts?
- What are the barriers to better service delivery for the poor?
- What factors influence significant improvements of these services?

Three districts were selected for the case studies; Purbalingga (Central Java), Tabanan (Bali) and East Sumba (Nusa Tenggara Timur).[4] Each of these districts was selected for a specific reason. Purbalingga was the first district to provide health insurance for the poor; a scheme that was its own initiative. As it now has a number of years of experience, an assessment on the sustainability of the scheme can also be undertaken. In addition, Purbalingga provides a benefit package for different premiums depending on people's income; thereby increasing the outreach of the program.

The second visit was to the district of Tabanan,[5] where a scheme is provided through PT Askes, a profit-oriented private company. The intention of the Department of Health (DepKes) "to provide JPK-Gakin in all districts by PT Askes in 2005" is another reason to include a scheme run by PT Askes. Until the end of 2004 there were only two districts where JPK-Gakin was provided by PT Askes; Musi Banyuasin (Sumatra) and Tabanan (Bali).[6] With respect to PT Askes it is important to see how an external body can interact with health provision and health management stakeholders and how their experience with providing insurance contributes to the provision of health insurance to the poor. Tabanan is a "second-generation JPK-Gakin" that was introduced in 2004. Including Tabanan in this case study provides an opportunity to examine its initial experiences with the provision of health insurance to the poor.

The third case study area, East Sumba, is one district that has a very high poverty rate and thus the provision of health insurance can have a major influence in increasing access to health care for the poor. East Sumba is also a district that experiences many problems with distance as the population is spread over a wide area. Based on the three case studies an executive summary will be constructed that gives more information about the effects of the different characteristics of the health insurance programs.

In Tabanan, PT Askes was assigned as the insurer or the *Badan Pengelola* (*Bapel*) of the non-profit health insurance scheme for the poor. The majority of the 25 districts, which were assigned as pilot project areas (*daerah uji coba*) of JPK-Gakin, have implemented different management systems by using a *Badan Pengelola*/Bapel JPKM.[7] This is a management unit consisting of at least four fulltime staff, including a unit head (the main coordinator) and three other staff who will manage the membership, finance and health service. In what ways does the prominent role of PT Askes influence the dynamics of health service delivery? How different is PT Askes from Bapel in managing the JPK-Gakin scheme and why? This report attempts to answer these questions.

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[4] For the pilot case study, we went to Cilegon, West Java.

[5] Tabanan district is an area of 839.33 km^2. This district (*kabupaten*) has 10 sub-districts (*kecamatan*) and 116 villages. In 2004, the district was inhabited by 394,004 people (94,544 households) with a density rate of 532 persons/km^2. The average number of household members is four people.

[6] Our initial plan was to visit Musi Banyuasin as this district was the first to initiate a PT Askes run JPK-Gakin, however, due to circumstances we have not been able to visit this location. Therefore, we have replaced Musi Banyuasin with Tabanan a second-generation JPK-Gakin.

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

II. THE HEALTH INSURANCE SCHEME

A. THE COMMENCEMENT

Unlike most other pilot areas, the health insurance scheme for the poor (JPK-Gakin) in Tabanan district is managed by PT Askes. Consequently, the scheme is also commonly known as Askes–Gakin. The scheme started in April 1st 2004 when the Tabanan district was awarded the status of "Area of Development" (*Daerah Pengembangan*).[8]

According to the Dinas Kesehatan[9] (*DinKes*) Tabanan district, they purposely assigned PT Askes as the insurer of JPK-Gakin for two reasons:

1. *DinKes* Tabanan wanted to avoid the risk of failure that can cause serious financial problems. They learned from the mismanagement of *Dana Sehat* (the previous health financing mechanism for the poor) by inexperienced institutions in other regions.
2. PT Askes is seen as a professional institution that has the required length of experience in managing insurance schemes and has a wide coverage area. It therefore has the ability to service the whole Bali province, thus allowing for a possible expansion of the scheme and thus increasing the risk pool. Another organization other than PT Askes with the ability to cover the whole region is not available.

Each stakeholder involved in the JPK-Gakin scheme claimed to be the initiator of the scheme. The *DinKes* suggested that they took the first step, by contacting and proposing PT Askes to manage the JPK-Gakin in Tabanan. On the other hand, PT Askes and even the public hospital (*Badan Rumah Sakit Umum*/BRSU) of Tabanan also suggested that they were the initiators of a health financing mechanism for the poor in Tabanan.

Referring to the fact that Bali does not have large industries with many employees (who would be potential members of Askes) and that most hotel employees are already insured by the Jamsostek, I Wayan Sumarta from PT Askes Tabanan said that PT Askes has implemented a more assertive policy of recruitment in Bali. PT Askes needs to look for potential members in various groups or institutions. According to the Denpasar branch of PT Askes, one of these recruitment efforts involves sending proposals on the health insurance scheme to many institutions as well as every district in Bali. Nevertheless, only Tabanan and Buleleng districts were interested in the proposal.

The management of the public hospital (BRSU Tabanan) also saw themselves as the initiator of the health financing mechanism. According to them, they were concerned about the provision of an affordable health care system for the poor and, therefore, made a proposal to the *DinKes* on this issue.

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[8] Singaraja and Klungkung Districts received the status of pilot district ('*Daerah uji coba*') in 2003, earlier than the Tabanan district, but in those regions health insurance was started only in August 2004. In Klungkung the Dinas Kesehatan decided against having PT Askes as the insurer and instead chose a 'Koperasi Kesehatan' to be the insurer.

[9] Dinas Kesehatan (*DinKes*) is the regional government health administration at the provincial or district (*kabupaten/kota*) level.

It will remain unclear who really took the first step to initiate the financing mechanism for the poor in Tabanan since all of the main stakeholders claim to be the initiator and they were (and still are) interconnected in their actions. It is likely that all of them did react to a central government program from their own position and perspective, and all have influenced the start of the JPK-Gakin (or the Askes-Gakin) in Tabanan.

As was mentioned earlier, the Musi Banyuasin district (Palembang) also has assigned PT Askes as the insurer of JPK-Gakin. As Tabanan is included in the second wave of districts that implemented JPK-Gakin, it expected to be informed by the central administrations of the Department of Health and/or PT Askes. On the question of whether they were able to learn from the experiences in the first district, Musi Banyuasin (Muba), the Dinas Kesehatan claimed that they only knew about Musi Banyuasin from the meeting in Cisarua, Puncak in December 2004. The Ministry of Health did not inform *DinKes* Tabanan about the similar mechanism used by Musi Banyuasin district on the health financing mechanism for the poor.[10]

B. THE INSURER AND THE FINANCING MECHANISM

The PT (Persero) Asuransi Kesehatan Indonesia/PT Askes (Denpasar branch) covers four districts: Tabanan, Buleleng, Badung and Jembrana. The Denpasar office is assisted by an office in Tabanan that is located at the public hospital (BRSU "Rumah Kita"). In Tabanan, apart from civil servants and retirees (about 33,000 insured), PT Askes also manages other health insurance schemes that are funded by the provincial government (*Pemerintah Daerah Tingkat I*) namely:

1. Health insurance for village officials started in 1997 (1,500 – 2,000 insured, premium: Rp.5,000/person/month, covers health care services provided according to the 3rd class in-patient standard at the BRSU).

2. Health insurance for the *Sulinggih* and *Bende seadat* (religious leaders) started in 2000 (500 insured, premium: Rp.25,000/person/month, covers health care services provided according to 1st class in-patient standard at the RSUD).

3. Health insurance for the *Pemangku Satu Kayangan* (other category of religious leaders), that started in 2002 and has a similar premium and coverage as the health insurance scheme for *Sulinggih* and *Bende seadat*.

In general, the membership of Askes can be categorized into:
1. Askes Social (*Kepesertaan Sosial*): civil servants and retirees;
2. Askes Commercial (*Kepesertaan Sukarela*): private companies, BUMN with a premium of Rp.15,000/month;
3. Askes-Gakin (starting Jan 1st, 2005, based on the Minister of Health's (Republic of Indonesia) Decree number 1241/MENKES/SK/XI/2004,[11] premium Rp.5,000/ person/month).

[10] In December 2004 a meeting between all the main stakeholders of JPK-Gakin of all 25 districts and four provinces currently providing JPK-Gakin was held in Cisarua (West-Java).

[11] Concerning the responsibilities of PT (Persero) Askes in the management of the healthcare program for poor communities.

Cooperation between *DinKes* Tabanan and ASKES Bali is formally regulated based on a one-year contract with PT Askes, which can be extended annually.[12] This contract covers the period April 1st, 2004 - March 31st, 2005 and regulates various aspects of JPK-Gakin Management, for instance the reimbursement system, the premium, rights and responsibilities of stakeholders, the provision of health services, the benefit package, arbitration of conflict, force majeure, etc. The contract does not, however, regulate how unspent health funds would be used. When, in 2004, there was indeed money left from the health funds, PT Askes considered it to be available for their disposal. Nevertheless, the *DinKes* Tabanan demanded and negotiated an outcome that resulted in PT Askes retaining 20% of the unspent funds with a part of the remaining funds (in the form of durable assets such as computers, cars etc.) being returned to *DinKes*. For 2005, the contract will be revised and unspent funds will be rolled over into the funds for the new term.

According to the evaluation on the implementation of JPK-Gakin scheme in 2004 carried out by the *DinKes* Tabanan, the unspent funds totalled Rp.33,026,000. This amount is based on a financial report made by PT Askes for the period of January – November 2004. Interestingly, the reported period is not consistent with the term of the JPK-Gakin contract. The contract was issued, and the formal cooperation period was started, three months later than the date of commencement of actual cooperation. The three months gap between the date of commencement of actual and formal cooperation between the main stakeholders of the JPK-Gakin scheme in Tabanan could be the result of different causes; from simple administration delay, strategic calculation, a tough negotiation process up to a flexible relationship between main stakeholders which is based on trust. On the basis of the investigation undertaken for this report, it appears that the *DinKes* Tabanan and PT Askes have had a cooperative relationship since the inception of the agreement. This is different to other districts (for example in Purbalingga and East Sumba) where PT Askes involvement in JPK-Gakin management is accepted only reluctantly by the district government.

DinKes Tabanan was also questioned about their decision to cooperate with a private and profit oriented company like PT Askes in managing a non-profit health financing mechanism for the poor and, specifically, whether *DinKes* negotiates with PT Askes about the limitations they set on the benefit package as a result of commercial calculations. *DinKes* admitted that they are gradually becoming aware of, and learning to deal with, the commercial side of PT Askes as the JPK-Gakin insurer. PT Askes, for instance, does not reimburse a number of more costly treatments, medication and referrals to Sanglah Hospital. As the contract with PT Askes is an annual contract, *DinKes* intends to revise the next contract. *DinKes* plans to demand that several treatments such as CT Scans be put in the benefit package and that the insured have a right of referral to Sanglah Hospital which has more facilities. Furthermore, *DinKes* also proposes that if there are unspent JPK-Gakin funds at the end of the contract period, *DinKes* will be partially reimbursed by PT Askes in the form of assets (computers, cars etc.). Nevertheless, Dr. Arisuta from the *DinKes* admitted that *DinKes*' actual bargaining position is not powerful enough to achieve these outcomes since the APBD funds (the portion of JPK-Gakin funds that should be subsidized by the district government) have not

[12] *Perjanjian Kerjasama Antara Pemerintah Kabupaten Tabanan dengan PT (Persero) Asuransi Kesehatan Indonesia Cabang Denpasar tentang Penyelenggaraan Jaminan Pemeliharaan Kesehatan*: The Cooperative Agreement between the Government of Kabupaten Tabanan and PT (Persero) Asuransi Kesehatan Indonesia, Denpasar Branch, concerning the Implementation of Health Care Support.

been given to PT Askes. Until now PT Askes only operates with funds provided by the central government.

C. THE INSURED

Poor families (the *keluarga miskin* or *gakin*) are automatically enrolled into Askes-Gakin. In 2004, there were 10,710 *gakin* households or 37,791 persons in Tabanan district. This is about 9% of the district population.[13] According to the *DinKes*, the criteria for the *gakin* in Tabanan are not clear, consequently there are poor people who were not identified and therefore were not entitled to the free health services. Nevertheless, some of them were able to assert their rights by approaching the village head, who appears to be the key to identifying the *gakin*, or went straight to *DinKes* to complain if they were not enrolled in the Askes-Gakin scheme. The enrolment takes place once a year and the new term commences each April.

D. THE HEALTH CARE PROVIDERS

The providers of primary health care (*Penyedia Pelayanan Kesehatan/PPK I*) are in the 19 *puskesmas* in Tabanan, including their secondary health centers or *puskesmas pembantu* (*pustu)* and village maternity polyclinics or *poliklinik bersalin desa* (*polindes)*. None of these *puskesmas* have in-patient facilities. People are not obliged to attend the *puskesmas* closest to their house to receive free health services. Patients are thus able to choose what *pukesmas* they want to attend and that will be recorded on their card. In practice, some people did go to different *puskesmas* than what is written on their card. This is usually tolerated for only a few times as it puts an administrative burden on the *puskesmas* because they get capitation only for the number of *gakin* in their working area.

Different maternity care services from different health care providers are included in the benefit package. Patients can go to the hospital to see a doctor or a nurse, but they can also receive services from the village midwife at the *puskesmas*, *pustu*, or *polindes*. Almost every village midwife runs a small private clinic outside her working hours at the *puskesmas*, *pustu* or *polindes* although the cost of childbirth in this private clinic ranges between Rp500,000 and Rp.700,000 (this is quite similar to the cost of childbirth in a public hospital). The reimbursement that the midwife receives from Askes for delivery is a maximum of Rp.100,000 and, as a consequence, the midwife provides a service under the asking price. As the income from *gakin* patients is so little, there is no incentive for the midwife to provide their services to the poor and so they are referred to the hospital. This policy was made to ensure that the poor will go to the hospital to give birth. This can prevent a higher cost in the situation where the patient has to be sent to the hospital anyway because there are complications during the childbirth which cannot be handled by the midwife. If the insured uses the services of Tabanan public hospital (BRSU), all costs will be covered by PT Askes. The utilization rate of maternity care services in the hospital has not altered since the implementation of the health insurance scheme. It may well be that patients are being referred to the hospital, but are actually not going there for other reasons. It could be that a change in doctors at a late stage of pregnancy is not a preferred option or, alternatively, that the distance from the patient's home to the hospital is too great.

[13] The number of *gakin* in Indonesia is about 38 million people.

The provider of secondary health care (PPK II) is the public hospital (BRSU 'Rumah Kita', Tabanan). As there is no private hospital, this is the only hospital in the district. The hospital manages its own resources and is independent of other financing.[14] It only receives funding from the local government for the salaries of civil servant staff (who constitute approximately 50% of total staff numbers).

In theory, *gakin* patients can only be treated at the hospital after obtaining a referral letter from a *puskesmas*. Exceptions to this rule are, however, made for chronic cases and emergency treatment. Nevertheless, *gakin* patients regularly attend the hospital without having the required referral letter. In the case of emergency care, the patient's family are usually asked to obtain a referral letter from the *puskesmas* within three days. We have identified several chronic illnesses for which a referral letter is, officially, not necessary, but a referral letter was still demanded by the hospital.

Tertiary care can be received at the provincial hospital in Denpasar (the Rumah Sakit Sanglah) when necessary specialized care cannot be provided in the hospital in Tabanan. There have been only a few cases where a referral to Sanglah hospital has been made. In these cases, the costs were not always fully reimbursed by PT Askes and so the patient was required to make a co-payment to cover the cost of their treatment.

E. THE PREMIUM

The premium of the Askes-Gakin scheme is Rp.5,000/person/month. Of this amount, Rp.1,000 is allocated for the PPK I (the *puskesmas*) and Rp.4,000 is allocated for the PPK II and III (the hospitals). The premium was calculated by the *DinKes*, PT Askes and the hospital. According to the *DinKes*, they tried to negotiate with PT Askes to get a lower premium but they (PT Askes) did not agree.

According to PT Askes Denpasar, the premium has been calculated based on:

1. hospital tariffs; and
2. PT Askes' experience in managing the health insurance scheme for village officials (since 1997). The Askes–Gakin scheme is, indeed, very similar to this scheme in many aspects, including the premium and benefit package.

F. THE REIMBURSEMENT SYSTEM

The reimbursement system for primary care is a monthly capitation based on the number of poor people who are served by primary care centers (*puskesmas*). For the Askes–Gakin scheme, the *puskesmas* in Tabanan had already received four months capitation. The hospital is reimbursed on a fee-for-service system. This is similar to the reimbursement system of other types of health insurance scheme managed by PT Askes. Because there is an Askes office in the hospital, the reimbursement procedure – both for Askes-Gakin as well as for other Askes members - is relatively efficient and quick, with reimbursement usually in about two weeks. On average, the amount claimed by the hospital is about Rp90 million/month. It is planned that the reimbursement system for the hospital will be changed into a capitation system.

[14] This is different in the sense that, in general, public facilities are highly subsidized.

Although it does not happen often, there are instances where PT Askes refused the claims from the hospital in cases with:

1. administrative errors;
2. mistakes in the benefit package provided, especially if the treatment standard is higher (and thus more costly); and
3. incomplete formalities.

G. THE HEALTH CARD

PT Askes has the responsibility for producing and providing the health insurance card also known as the Askes-Gakin card. In the Askes system each member receives one card. This reduces the chance of misusing the card, however, the experience of the health care providers is that people sometimes bring the health insurance cards of other family members. The card is white and similar to the Askes card of the village officials.[15] No photograph is required for this card. The Askes-Gakin card contains information on the identity of the insured (name, membership number and sex), the office code (*kode badan usaha*), benefit package code, the code of treatment standard and the term of the card.

PT Askes is the producer of the cards and it should take approximately seven days for the cards to reach the insured. According to PT Askes, Tabanan, the distribution process can take up to a maximum of one month and evidence gained through our interviews with *puskesmas*, *pustu* and village officials supports this conclusion. We also found that a number of cards were not ready yet. Even those cards that have been distributed sometimes cannot be immediately used. In Tua village, for example, some cards that had just arrived contained errors requiring correction. When the cards were ready, PT Askes gives them to the *DinKes*. The *DinKes* distributed the cards to each *puskesmas*. The village midwife took the cards from the *puskesmas* and gave them to the neighborhood heads (*Kepala-Kepala Dusun*) who know the recipients and are able to deliver the cards in their neighborhood.

[15] The village officials (*aparat desa*) in Bali have been insured at the PT Askes since 1997. The premium is paid by the provincial government.

III. THE FUNCTIONING OF THE HEALTH INSURANCE SCHEME

A. IDENTIFICATION AND VERIFICATION OF THE POOR (GAKIN)

The *DinKes* Tabanan is very proud of the fact that in 2004 they carried out the identification of the poor independently. This data, which is called the "List of Members of Poor Families in Kabupaten Tabanan – For Health Services in the Year 2003" (*Daftar Anggota Keluarga Miskin di Kabupaten Tabanan – Tahun 2003 untuk Pelayanan Kesehatan*) is different to the data of BPS and Bappeda. According to the *DinKes*, unlike BPS' and Bappeda's data, their data on the poor is free from political influences. The identification only aimed to locate, count and list the *gakin* of Tabanan district. In other words, the survey was primarily aimed at identifying the poor for the health insurance membership. The data is compiled in the form of a thick red book that is also available at the PT Askes office in Tabanan and to each *puskesmas* in the district. The book functions as the main source of information on the identity of the poor (name, age, family relationship, residential address/village etc.). It seems useful also for the verification of the poor by providers. For the survey in 2003, there was no financial contribution from PT Askes.

The identification of the poor who are eligible for health insurance was performed within a period of three months by *DinKes* staff, the village head, the *dusun* head and members of the *puskesmas*. After the initial year they realized that this process was not very effective and has a number of weaknesses. For next year the plan is to involve the health officials, the village midwife and volunteers from each village (*kader*). These people are closer to the people in society and have greater access to the information necessary to identify those in need of health support.

A second step in the process is the verification of those identified as poor and also those people who have been identified as falling outside the category of poor. In Tabanan the *puskesmas* performs an auditing function to correct initial identification errors. The *puskesmas* can notify suspected cases of misidentification to the *DinKes* that can undertake a verification. If those who were not initially identified as *gakin* are really *gakin*, they will get the Askes-Gakin card for the new health insurance term.[16]

[16] The verification and mutation of the data on *gakin* is planned to be carried out at the end of January 2005.

Based on the experiences of the *puskesmas* and staff associated with this function, it seems that the criteria used to identify the poor[17] are not very relevant or helpful in the field. These criteria were established by BKKBN on "Pra Keluarga Sejahtera"[18] (pre-prosperous family) and 'Keluarga Sejahtera Tahap I'[19] (prosperous family at the first stage) and were used in the identification of the poor as the Tabanan district does not have a formal guideline such as a decree (*surat keputusan/SK*) on the criteria of the poor (*gakin*).

The *DinKes* admitted that the absence of a guideline is one of the obstacles in identifying the poor since this means the identification is open to different interpretations and heavily dependent on direct observation. Dr. Era from Tabanan hospital also said that the identification of *gakin* in Tabanan is still problematic ("*tidak tepat sasaran*"). There are many known problems regarding those identified as poor and also those who remain unidentified. In several cases not all family members were registered for the health insurance card, in other instances personal information was wrongly administered. She suggested identifying *gakin* based on income, the number of dependent household members and local living standards.

B. SOCIALIZATION OF THE HEALTH INSURANCE

The socialization of the Askes-Gakin scheme is undertaken as a cooperative arrangement between *DinKes*, PT Askes and the village officials (especially the *Kepala Dusun* or *Kelian Dinas*).[20] Unlike the case of Purbalingga, the village midwife and *kader* play no role in the socialization of HI for the poor in Tabanan. In this district the socialization is mainly through the K*epala Dusun* (*Kelian Dinas*) who should explain the scheme to the poor in their neighborhood. In Tabanan, the socialization of the Askes–Gakin scheme appears to be rather minimal. In one case, a relatively new *Kepala Dusun* who received health insurance cards to be distributed to the people did not know what they were for. In addition, feedback from people in the neighborhoods indicates that there are many people, in fact the majority, who had not heard about the scheme.

[17] The Prosperous Family indicators that represent the characteristics of a poor family are: 1. Unable to eat twice a day; 2. Unable to provide meat/fish/eggs as a side dish at least once per week; 3. Don't possess a different set of clothes for each activity; 4. Unable to obtain at least one new set of clothing once per year 5. The largest part of the floor of the house is made of earth; 6. There is less than 8 square metres of floor space per occupant of the house; 7. There is no member of the family aged 15 years or over with a regular income; 8. Unable to access health facilities if a child is sick or to access family planning programs, and 9. Children aged between 7 and 15 years are not in school.

[18] The definition of a Pre-prosperous family is "a family that cannot yet fulfill basic needs to a minimal standard, namely the need to practice their religion, food, clothing, shelter and health, or a family that cannot yet fulfill one or more of the indicators for a Level 1 Prosperous Family."

[19] The definition of a Level 1 Prosperous Family is "a family that can fulfill basic needs to a minimal standard, but cannot yet fulfill their entire socio-psychological needs, namely education, family planning, family interactions, interactions with their residential environment and transport."

[20] Every village in Bali is divided into one or more *banjar*, a traditional form of neighborhood association led by the head of a *banjar* (*Kelian Banjar*). The *banjar*'s primary function is to organize various religious ceremonies. The main responsibility of the *Kelian Banjar* is to lead the community and to maintain the well-being of all community members in their daily lives according to the traditional laws that govern that particular village. There are two types of *Kelian Banjar*, the *Kelian Dinas*, who is in charge of the administrative aspects of the *banjar* life, and the *Kelian Adat*, who looks after the customary aspects.

The *DinKes* also recognizes that the socialization did not have optimal results. The *DinKes* therefore plans to involve, among others, the *Kelian Adat* in the socialization of the Askes-Gakin in its new term. The *Kelian Adat* is another category of prominent community member who knows more about local rules and customs (the *awig-awig*). It can be said that the *Kelian Adat* has more spiritual/charismatic authority while the *Kelian Dinas* has more political authority. The involvement of the *Kelian Adat* is expected to provide an alternative way to encourage people to enrol in health insurance or to cooperate in a program. One of the major factors contributing to successful socialization is good information distribution to those who will be in charge of the socialization program. If this is not properly addressed, the addition of a new element in the socialization process (in this case the involvement of the *Kelian Adat*) will not improve the result.

C. FINANCE

It is calculated that the cost of Askes–Gakin in Tabanan in 2004 is about Rp.2.2 billion (Rp.2,267,820,000)[21] per year. This consists of Rp453,492,000 (20%) for *puskesmas* capitation and Rp1,814,328,000 (80%) for the hospital claims. Although the allocations seem to be unbalanced and *puskesmas* (PPK I) receive a much smaller portion than the hospital (PPK II/III) we did not find any complaints from *puskesmas* that the JPK-Gakin subsidy is insufficient.

The costs at the *puskesmas* are so much lower because the services provided at the *puskesmas* are first of all much cheaper than those provided at the hospital, but a second more important reason is that the *puskesmas* services are already highly subsidized. The *puskesmas* in Tabanan receives subsidies from central, provincial and district governments for the expenditures of the *puskesmas*.

Looking at the financing of the *puskesmas* it becomes obvious that the funds from JPK-Gakin are more than enough to finance the health services of the poor. In fact, they have unspent monies that cannot be used for other than health service provision for the poor as they are tied funds. Sometimes the *puskesmas* have ideas on how to use the money to improve the quality of the *puskesmas* services. For example, the head of Puskesmas Tegal Ratu in Cilegon district told us that they badly needed to dig a better well since they regularly experienced lack of clean water. She even once had to close the *puskesmas* because they did not have clean water for a couple of days. She wanted to use the unspent portion of the subsidy to finance the well but it would be against the regulation.

Puskesmas have different financial resources:

1. APBD II;
2. *puskesmas* income (For example: the patient contribution is Rp2,500/visit both in *Puskesmas* Penebel I and *Puskemas* Marga I);
3. capitation Askes-Gakin (Askes gives Rp1,000 x number of *Gakin*. From this amount, 20% for the *puskesmas* head, 70% for the *puskesmas* staff and 10% for the *puskesmas* administration); and
4. claims on Askes for non-*Gakin* patients.

[21] Number of *Gakin* 37,791 times the premium Rp.5,000 for 12 months.

During the Tabanan fieldwork, SMERU researchers visited two *puskesmas* namely, Puskesmas Penebel I and Puskesmas Marga I. The head of both *puskesmas* complained about the decreasing income from the local government budget during the last couple of years. According to the head of Puskesmas Marga I, in 2002 – 2003 they received about Rp30 million and in 2004 Rp21 million. The optimal operational costs of the *puskesmas* are Rp50 million but the amount available is only between Rp10 – 20 million.

On the other hand, the hospitals we visited have to struggle to cover the health costs. A few of them have a large deficit. The Tabanan hospital has a deficit of Rp.780 million. They have temporarily solved this problem by delaying payment for procurements (for instance on the purchase of medicines). According to BRSU, the deficit is also caused by the health costs of patients who are no longer identified as poor (and no longer entitled to the Askes-Gakin) but do not have the financial resources to pay the hospital bills. They referred to these kinds of patients as "*pasien terlantar*" or "*pasien di luar system*" ("patients outside the system"). BRSU Tabanan will not, and cannot, refuse patients even though they do have money to pay the services. As a result, the hospital has to cover the costs from their own financial resources.
Regarding the total cost of JPK-Gakin scheme in Tabanan District (Rp2.2 billion), it was agreed that the central government would pay Rp1.3 billion (already provided) and the district government would cover the rest of the funds needed (Rp0.9 billion) but until now, the funds promised by the district government have not been provided.

D. BENEFIT PACKAGE AND SERVICES

The benefit package includes all services available from the primary care provider (*puskesmas*). In case additional or more specialized care is needed, a patient will be referred to the hospital where an insured is entitled to the third class treatment standard (*standar pelayanan kelas III*). In Tabanan, the *DinKes* and Askes have agreed that people who are willing and thus able to pay for a higher class of treatment are not poor and should not receive health insurance for the poor. An additional reason for this decision is that by making this regulation there should be a minimum quality standard for the *puskesmas* that the *DinKes* would like to uphold. Without regulations, real standards, and someone who bears the responsibility to accomplish this minimum quality standard, it is very difficult to achieve this.
The agreement between *DinKes* Tabanan and PT Askes, Denpasar regulates the services that should be provided for *Gakin* members. These include:

<u>For outpatient treatment at the *puskesmas* level</u>:

a. Promotive programs;
b. Preventive programs;
c. Curative programs (treatment and medication); and
d. Issuance of referral letter (for the hospital).

<u>For outpatient treatment at the hospital level</u>:

a. Consultation, treatment and medication by specialized doctors;
b. Laboratory tests, radio and electromedic diagnoses;
c. Medical treatments (including the specialized ones); and
d. Medication (within the range of the official list of medicines and their prices or the DPHO).[22]

[22] DPHO (Daftar Plafon Harga Obat): A list of medications covered by health insurance providers and their ceiling prices.

For in-patient treatment at the hospital level:

a. in-patient facilities (the 3rd class standard);
b. consultation, treatment and medication by specialized doctors;
c. laboratory tests, radio and electromedic diagnoses;
d. various sorts of medical treatments (including major surgery);
e. intensive care treatment (at the ICU);
f. medication (within the range of the official list of medicines and their prices or the DPHO); and
g. medical rehabilitation.

E. UTILIZATION AND REFERRAL

In Tabanan district, the utilization of Askes–Gakin is seen as still low:

- 31.7% for outpatients at the PPK I/*puskesmas*[23] (while the national standard is 40%);
- 2% for outpatients at the PPK II/hospital;[24] and
- 0.3% for inpatients at the PPK II/hospital.[25]

According to two *puskesmas* that were visited during the fieldwork, they only refer special cases to the hospital (for example, the cases of high risk childbirth, cardio-vascular disease and serious injuries). Until now, no referrals have been refused by the hospital. Sometimes patients insist on being referred to the hospital although the *puskesmas* can treat the disease or, on the contrary, refuse to be referred although the *puskesmas* cannot treat the disease. The poor are often reluctant to be referred because they are afraid of the additional costs that are not covered by PT Askes. Moreover, for some patients, the transportation costs to reach the hospital are also too high. The patients who are referred to the hospital have to bring their Askes-Gakin card and the referral letter from the *puskesmas* together with one photocopy of each document.

The head of Puskesmas Marga I complained about the Askes referral forms. According to him, the form is exactly the same as the referral form for the Askes non-*Gakin* patient and only available in limited numbers. Furthermore, in his opinion, PT Askes is too bureaucratic regarding the referral letter from the *puskesmas*. There have been emergency cases where the patients were brought directly to the RSUD (such as accidents). It should not be necessary to "formally" refer such patients from a *puskesmas* as it is very obvious that a *puskesmas* cannot treat such serious illnesses/injuries. In practice, the hospital still asked for the referral letter from the *puskesmas* so that the patient's relatives had to return to the *puskesmas* for the sole purpose of obtaining that letter. In his view, this is unnecessary and inefficient. When a response was sought from the *DinKes* Tabanan on this problem, they agreed that emergency cases indeed do not need to be referred by *puskesmas*. Chronic cases only need to be referred once in six months. The *DinKes* seems to be aware of the problem and have communicated their concerns to several staff members and doctors of the hospital. They worry however, that the hospital staff do not communicate the complaints with each other. The hospital staff –

[23] The utilization rate of health services: % = the number of visits at a given health center/total number of *gakin* in Tabanan x 100. According to an evaluation of the JPK-Gakin scheme in 2004 by *DinKes* Tabanan, the utilization rate at *puskesmas* is 11,980/37,791x100= 31.7.

[24] The number of *Gakin* outpatient visits to the Tabanan hospital is 756.

[25] The number of *Gakin* in-patient visits to the Tabanan hospital is 113.

especially those who are at the front desk and in charge of checking the formalities – tend to be more rigid as they seek to avoid administration mistakes.

Medicine for the poor

All health care providers (PPK I and II) mentioned that the medicines that are meant for the poor differ from the medicines for the non-poor. *Puskesmas* do not have to apply for medicines for the Askes-Gakin patients. The medicines are provided to *puskesmas* as one package from the *DinKes*. The sorts and amount of medicines received by a *puskesmas* are decided by the *DinKes* and is (theoretically) based on the specific need of each *puskesmas* (the main health problems of the poor in the given *puskesmas*). In Puskesmas Penebel I, for instance, the medicines for Askes-Gakin were provided in May-June 2004. The health care providers also have to report the usage of these medicines separately from the medicines used by the non-*Gakin*. The medicines that are available for the poor are even more limited than the "normal" spectrum of medicines available at the *puskesmas*. This can have serious consequences and is a major limit on the quality of care that the poor can receive.

Monitoring Mechanisms and Coordination among the Stakeholders

Monitoring mechanisms between *DinKes* and the different health care providers exist but are limited to monthly financial expenditure and utilization of health care services reports. The PPK I/*puskesmas* is obliged to provide monthly (financial) reports to the *DinKes*, but on the other hand the PPK II/RSUD does not have this obligation and can provide its financial report directly to PT Askes. This different monitoring system undermines the function of *DinKes* as "the supervisor and coordinator" of the health insurance system for the poor. For the *DinKes* it is very difficult to get the information regarding health care services at the hospital after the initiation of the Askes-Gakin. According to the *DinKes*, this is a "political matter" (although they did not explain exactly what this means) and because the BRSU considers itself at the same level with the *DinKes*.

The report of the hospital to PT Askes includes:

1. the number of in-patients (*Rawat Inap*);
2. the number of outpatients (*Rawat Jalan*);
3. the costs of special treatment (*Tindakan Khusus*); and
4. the total expenditures.

It can be said that the existing monitoring mechanisms are only financial monitoring ones. As is the case with other studies (Cilegon and Purbalingga), the *DinKes* of Tabanan also referred to a "Community Complaints Unit"' ("*Unit Pengaduan Masyarakat*") whose role is to record complaints on the health services. In Tabanan, this UPM, which is located at the *DinKes*, supposedly consists of five people from *DinKes* and the local government. Nevertheless, this cannot be seen as a sufficient mechanism to control the quality of services because the UPM does not have a clear policy and authority.

According to PT Askes, there is coordination among *DinKes*, PT Askes and the providers of health services. Each "case" (of complaint) would be handled separately by this coordinating team but they do not meet regularly. Furthermore, PT Askes also has a 24-hour "hotline service" for complaints and enquiries. This kind of vague monitoring mechanism and coordination are similar to other cases (Purbalingga and Cilegon).

DinKes Tabanan also admitted that they still need to develop a more effective control mechanism for the Askes–Gakin scheme. Until now *DinKes*, as the supervisor of the scheme, only received reports (e.g. on implementation problems) from the health providers and PT Askes. In the near future, *DinKes* plans to carry out a study on the implementation of Askes-Gakin, but they are not sure whether they have enough staff to carry out this task.

IV. EXPERIENCES FROM DIFFERENT PERSPECTIVES

A. THE PUSKESMAS

In general, the heads of both *puskemas* (as well as the *puskesmas* visited by the research team in Cilegon and Purbalingga districts) mentioned that from the *puskesmas*' point of view, the JPK-Gakin system is better than the previous health financing mechanism. There are two main arguments for this observation. First of all, the new system relieves the *puskesmas* of the burden of being responsible for the identification of the poor and issuance of the *gakin* card. In the health card system, the head of the *puskesmas* had to sign the cards and was therefore seen as the main person in the selection of *gakin*. People complained or were even angry with the *puskesmas* staff if they were not assessed as eligible to receive free health services. In the new system if there are protests from those who are not entitled to the card, the *puskesmas* head can suggest to them that they look for information at the *DinKes* or PT Askes office (or the *Bapel*, in other districts). Secondly, the *Bapel* is responsible for the administration that comes with the processing of the members eligible for health insurance. This saves the *puskesmas* from a large burden of administrative work. This investigation also found that the *puskesmas* are content with the current system because, in general, the capitation is more than enough for the *puskesmas* to cover the health cost of the poor and thus no additional burden is put on the *puskesmas*' work load.

Penebel I

Puskesmas Penebel I is located at Pitra village, Kecamatan Penebel, which has 27,572 inhabitants. This *puskesmas* has two doctors, one dentist, 12 midwives (*bidan*) and seven *pustu*. The Penebel I serves inhabitants of nine surrounding villages. There are 4,307 people eligible for the Askes-Gakin health insurance scheme, this makes up 15.6 % of Tabanan's population. According to the midwife at *Pustu* Senganan, which belongs to Puskesmas Penebel I, all *gakin* in her *pustu* have received the Askes-Gakin card. Nevertheless, Penebel I also provides services to patients who have other types of health insurance (Askes scheme).

Table 1. The Number of Insured Patients in Penebel I

Type of Askes scheme	Number of insured
Askes wajib	2,824
Askes sukarela – umum	41
Askes wajib – Sulinggih	4
Askes-Gakin	4,307
Total insured patients in Penebel I	7,176 (About 26% of the total population in the sub-district/Kecamatan Penebel)

The JPK-Gakin capitation is based on the number of poor in the region served by the *puskesmas* and will be allocated according to the decree issued by the head of *DinKes* Tabanan.[26] Based on the decree, the distribution of the Rp51.7 million allocation is:

Table 2. Allocation of Total Capitation for Puskesmas Penebel I (Rp.)

30% for the *kabupaten* (district)	15.6 million [A]
70% for the *puskesmas*	36.1 million [B]
Total capitation	51.7 million

Table 3. Allocation of the District Portion (A) in Rupiah

Management fee	5%	2.6 million
Supervision of JPK-Gakin Tabanan District	5%	2.6 million
Coordination Team at the district level (TKK)	5%	2.6 million
Operational cost of JPK-Gakin scheme at the *DinKes*	15%	7.8 million
Total	30%	15.6 million

Table 4. Allocation of the *Puskesmas* Portion (B) in *Rupiah*

Fee for the head of *puskesmas*	14%	7.2 million
Reserve for operational cost of JPK-Gakin scheme at the *puskemas*	7%	3.6 million
Fee of other *puskesmas* staffs	49%	25.3 million
Total	70%	36.1 million

As the tables show, most of the capitation is allocated for costs related to the functions of different stakeholders (fee for management, supervision, coordination, provision of health care). From the interviews, it seems that some of these functions – such as supervision and coordination – are quite unclear. If the fees are considered as an incentive for stakeholders to improve their performance and services, the effectiveness of this incentive is questionable.

In 2004, the poor visited the *puskesmas* approximately 1,656 times.[27] Based on this, we can calculate that the health care cost of Penebel I for the *gakin* patients would be Rp4,140,000.[28] As Penebel I is entitled to a Rp51.7 million[29] subsidy per year, the health care cost in 2004 was only 8.0% of the subsidy.

Apart from the capitation of Askes-Gakin, Penebel I receives income from other sources namely: reimbursement from other Askes schemes, the operational and regular funds from APBD and income from patient contributions (Rp2,500/visit). The *puskesmas* head complained that the income from other sources has declined, therefore the capitation of Askes-Gakin is very helpful in preventing a more disadvantageous financial condition.

[26] The Decree number: 050/1457/DIKES/2004 issued by the Head of the Dinas Kesehatan, Kabupaten Tabanan concerning the determination of allocations and utilization of guaranteed capitation funds for the health care of poor families (JPK-Gakin).

[27] Based on data, the number of *Gakin* visits to Puskesmas Penebel I from January – October 2004 is 1,380. From that number we can extrapolate that in 2004 approximately 1,656 visits to the *puskesmas* were made.

[28] 1,656 x *puskesmas* patient contributions Rp.2,500.

[29] 4,307 *Gakin* x Rp.1,000 x 12 months.

From the data on new visits at the Puskesmas Penebel I in 2003 and 2004, it can be concluded that the utilization of *puskesmas* services (not including *pustu* and *polindes*) by the non-*gakin* patients is higher than the *gakin* patients. According to the *puskesmas* head, the barrier for many *gakin* to get the free health services they are entitled to is the transportation cost to reach the *puskesmas*. This is especially the case for those who live relatively far from the health center. The *puskesmas pembantu* (*pustu*), which is located in almost each village, is therefore more accessible for the *gakin* patients. In 2004 the utilization of *puskesmas* services by the *gakin* was slightly lower than in 2003.

Table 5. Utilization in Penebel I, 2003 (Only Visits at the *Puskesmas*)

Month	*Gakin*	Non *Gakin*	Total	% *Gakin*
January	53	351	404	13.3
February	34	296	330	10.3
March	24	312	336	7.1
April	3	291	326	10.7
May	23	228	251	9.2
June	35	164	199	17.6
July	30	213	243	12.3
August	29	170	199	14.6
September	30	193	223	13.5
October	38	188	226	16.8
November	47	154	201	23.4
December	21	240	261	8.0
Total one year	399	2,800	3,199	**12.5**

Table 6. Utilization Penebel I, 2004 (Only Visits at the *Puskesmas*)

Month	*Gakin*	Non-*Gakin*	Total	% *Gakin*
January	19	193	212	9.0
February	19	186	205	9.3
March	32	249	281	11.4
April	26	302	328	7.9
May	32	197	229	14.0
June	35	231	266	13.2
July	33	212	245	13.5
August	36	195	231	15.6
September	36	196	232	15.5
October	32	240	272	11.8
November	32	199	231	13.9
December	36	325	361	10.0
Total one year	368	2,725	3,093	**11.9**

The *puskesmas* head said that the hospital never rejected the referral from Penebel I. The *puskesmas* only sent patients to the hospital if they cannot be treated in the *puskesmas*, for example in cases of childbirth with complications and cardio-vascular diseases. In 2004 Penebel I referred fewer patients to the Tabanan hospital than in 2003. Furthermore, the number of *Gakin* patients referred both in 2003 as well as in 2004 was much lower than for the non-*Gakin* patients.

Table 7. Number of Referrals from Puskesmas Penebel I to Tabanan Hospital

Type of patients	2003	2004
Gakin	165 (29%)	53 (10%)
Non-*Gakin*	406 (71%)	460 (90%)
Total	571	510

Marga I

Puskesmas Marga I is located in Kuwum village, *Kecamatan* Marga which had 22,544 inhabitants in 2003 and 22,569 in 2004. This *puskesmas* has six *pustu*. The Marga I serves inhabitants of six surrounding villages. The number of *gakin*, who are entitled to free health services in this *puskesmas*, is 3,308; all of them are insured by the JPK-Gakin Scheme. Like Penebel I, Puskesmas Marga I also provides services to patients who have other types of health insurance (Askes scheme).

Table 8. The Number of Insured Patients in Marga I

Type of Askes scheme	Number of insured
Askes wajib -	3,145
Askes sukarela – umum	43
Askes wajib – Sulinggih	5
Askes-Gakin	3,308
Total insured patients in Penebel I	6,501 (About 29 % of the total population in the sub-district/*Kecamatan* Marga)

Utilization at the Marga I in 2004 was 1,482.[30] Based on this, we can calculate that the health care cost of Marga I was Rp3,705,000.[31] As Marga I is entitled to Rp39,696,000[32] million subsidy per year, the health care cost in 2003 was only 9.3 % of the subsidy. Furthermore, the JPK-Gakin capitation, to which each *puskesmas* is entitled, will be allocated according to the decree issued by the head of *DinKes* Tabanan. Based on the decree, the distribution of the allocation of Rp39.7 million is:

Table 9. Allocation of Total Capitation for Puskesmas Marga I (Rp.)

30% for the *kabupaten* (district)	12 million [A]
70% for the *puskesmas*	27.9 million [B]
Total capitation	39.9 million

Table 10. Allocation of the District Portion (A) in *Rupiah*

Management fee	5%	2 million
Supervision of JPK-Gakin Tabanan District	5%	2 million
Coordination Team at the district level (TKK)	5%	2 million
Operational cost of JPK-Gakin scheme at the *DinKes*	15%	6 million

[30] Utilization between January – October 2004 is 1,235.

[31] 1,482 x *puskesmas* patient contributions Rp.2,500.

[32] 3,308 *Gakin* x Rp.1,000 x 12 months.

Total	30%	12 million

Table 11. Allocation of the *Puskesmas* Portion(B) in *Rupiah*

Fee for the head of *puskesmas*	14%	5.6 million
Reserve for operational cost of JPK-Gakin scheme at the *puskemas*	7%	2.8 million
Fee of other *puskesmas* staff	49%	19.5 million
Total	70%	27.9 million

Marga I receives income from similar sources to Penebel I, namely: Askes-*Gakin* capitation, reimbursement of other Askes schemes, the operational and regular funds from APBD and income from patient contributions (Rp.2,500/visit). The head of Marga I also complained about the reduction in *puskesmas* income, especially the operational and regular funds from the *DinKes* Tabanan.

From the data on new visits at the Puskesmas Marga I and the *pustu* in 2003 and 2004, this investigation also found a similar trend to Penebel I; namely the utilization of *puskesmas* services by the non-*Gakin* patients is much higher than the *Gakin* patients. Nevertheless, because the visits at the *pustu* were also included, the utilization of *gakin* patients is obviously higher than in Penebel I. As was mentioned above, those who live far from the *puskesmas* usually prefer to go to the *pustu* that is located in almost every village. Unlike the case with Puskesmas Penebel I, the utilization of *puskesmas* services by the *gakin* in Puskesmas Marga I was slightly higher in 2004 than in 2003.

Table 12. Utilization in Marga I, 2003 (Visits at the *Puskemas* and *Pustu*)

Month	*Gakin*	Non-*Gakin*	Total	% *Gakin*
January	182	613	795	22.9
February	136	331	467	29.9
March	154	535	689	22.4
April	86	379	465	18.5
May	96	419	515	18.6
June	151	492	642	23.5
July	123	387	510	24.1
August	99	428	527	18.8
September	146	566	712	20.5
October	71	351	422	16.8
November	90	372	462	19.5
December	87	292	379	23.0
Total one year	1,421	5,165	6,586	21.6

Table 13. Utilization in Marga I, 2004 (Visits at the *Puskesmas* and *Pustu*)

Month	*Gakin*	Non-*Gakin*	Total	% *Gakin*
January	143	596	739	19.4
February	157	557	714	22.0
March	112	437	549	20.4
April	174	584	758	22.9
May	107	480	587	18.2
June	149	367	516	28.9
July	98	299	397	24.7
August	113	335	448	25.2
September	91	333	424	21.5
October	129	481	610	21.1
November	60	303	370	16.2

December	208	259	467	44.5
Total one year	1548	5031	6579	23.5

Also in Marga I, only selected cases were referred to Tabanan hospital. These included major injuries, childbirth with complications and health problems that need more specialized treatments (mostly ophthalmological problems). As is the case with Puskesmas Penebel I, the referral rate for *Gakin* patients is much lower than for non-*Gakin* patients.

Table 14. Number of Referrals from Puskesmas Marga I to Tabanan Hospital

Type of patients	2004
Gakin	18 (4%)
Non-*Gakin*	449 (96%)
Total	467

According to the head of Puskesmas Marga I, the reason for the low referral rate is mostly because *Gakin* patients are afraid that they will probably have to pay additional costs for treatment at the hospital. He also said that it is unfair for the poor patients who are not utilizing their rights only because they are not well informed by PT Askes about the treatments and medicines they are entitled to. When we asked him what information the *puskesmas* provided the *Gakin* patients about their rights, he admitted that he also did not know what exactly was included in the benefit package of PT Askes.

Information on the benefit package (the services the poor are entitled to receive at the *puskesmas* and hospitals), treatments that are not covered by PT Askes and the procedure to get the health services is actually in the formal agreement between PT Askes and *DinKes* Tabanan.[33] PT Askes also has booklets – available at the Denpasar office - and from their website that provide information on their products. These are, however, not an accessible medium of communication for the *Gakin* clients.

B. THE HOSPITAL

Badan Rumah Sakit Umum (BRSU) "Rumah Kita" Tabanan

The BRSU "Rumah Kita" Tabanan is a public hospital and the only hospital in the district. This hospital has a total of 578 staff; including 52 doctors (24 specialized doctors). The hospital manages its own financial resources and only receives a limited subsidy from the APBD. This subsidy is allocated for the salary of hospital staff who are civil servants (287 people or almost 50% of the staff). The hospital building is a facility also provided by the local government. The purchase of medicines and medical instruments and the salaries of non-civil servant staff are independently financed. According to the management, most of the hospital tariffs are still provided at below their real cost and therefore they still struggle with a deficit.[34] The hospital is also able to borrow money from individuals in case of

[33] Cooperative Agreement between the Government of Kabupaten Tabanan and PT (Persero) Asuransi Kesehatan Indonesia, Denpasar Branch, concerning the Implementation of Health Care Support ("Perjanjian Kerja sama antara Pemerintah Kabupaten Tabanan dengan PT (Persero) Asuransi Kesehatan Indonesia Cabang Denpasar tentang Penyelenggaraan Jaminan Pemeliharaan Kesehatan"). Effective from 1 April 2004 to 31 March 2005. Code BU: 2202 8407.

[34] According to the hospital management, only the VIP class operates on a full cost-recovery basis, which allows the hospital to make a profit from it.

necessity but have not been able to identify the individuals in order to obtain a better idea of the incentive structure behind this lending process.

About Rp1.8 billion (80%) of the JPK-Gakin funds in 2004 were allocated for the health care expenditures made by the hospital. This is one of the income sources of the hospital, but the amount is a relatively small share (8.3%) in comparison to the total income of the hospital from other sources. The hospital receives reimbursements of Askes–Gakin claims monthly.

Table 15. The Total Income of Tabanan Hospital 2001 – 2004, not including JPK-Gakin Funds (in millions of Rp.)

Year	Income
2001	6,658
2002	10,408
2003	16,000
2004	21,550

Source: BRSU Kabupaten Tabanan, "Hospital Performance Data from 2001 to 2004".

One disadvantage of a capitation system is that there is a possibility of a diminished quality of service as the provider is limited in its income. With a fee-for-service (FFS) system such an impact is not expected to occur, but an increase in the quality of services is not expected to occur with a FFS either. By implementing a financing scheme for the poor one does expect a decrease in pressure on the service provider to contain costs and thus, in comparison to a system where poor patients pay for services, this may avoid a decrease in quality. As to the effect of the financing scheme, the management of BRSU Tabanan argued that the previous health financing mechanism (Subsidi BBM – 2001) is better than the Askes–Gakin scheme (2004). The previous mechanism totally covered the health costs while the Askes-Gakin scheme only covered services that are on the Askes list. This caused dissatisfaction among the insured.

Between January – October 2004, the visit rate – both outpatients as well as in-patients - of the *Gakin* patients in Tabanan hospital is much lower than the non-*Gakin* patients. This is consistent with the very small number of *Gakin* patients referred by *puskesmas*.

Table 16. The Number of Outpatient and In-patient Visits at Tabanan Hospital (Jan – Oct 2004)

Sort of visit	*Gakin*	Non-*Gakin*	Total	% *Gakin*
Outpatient	763	45,153	45,916	1.7
In-patient	359	7,643	8,002	4.5

Source: BRSU Tabanan, "Hospital Performance Data from 2001 to 2004" and "Results of the Evaluation of Health Care Support for Poor Families (JPK-Gakin) in Kabupaten Tabanan for the year 2004."

V. CONCLUDING REMARKS

A. THE RELATIONSHIP BETWEEN STAKEHOLDERS

The major involvement of PT Askes in the management of health financing for the poor in Indonesia has been legalized since January 1st, 2005. Whilst many other districts are still in the early phases of a transition period from the *Bapel* system to the Askes system, Tabanan district has fully implemented a cooperative agreement with PT Askes. It was mentioned in the previous section that this choice is based on two reasons; namely, the district wanted to avoid mismanagement by an inexperienced insurer and PT Askes is considered to be a professional insurance company with extended experience (more than three decades) and a wide working area. In other districts like Purbalingga and East Sumba, the local government and the *DinKes* have developed a management unit (the *Badan Pengelola* or *Bapel*) as the insurer. This management unit has a closer relationship with the *DinKes* in many respects because it is run by staff of *DinKes* or the district public hospital. Moreover, the office of Bapel is often located at the *DinKes* office (for instance in Cilegon and in East Sumba). Consequently, in this system, *DinKes* - as the key supervisor of the JPK-Gakin scheme - has a stronger grip on the insurer.

In the light of this, the choice to collaborate with an experienced private company like PT Askes has some consequences. The supervision and monitoring by *DinKes* of an insurer like PT Askes runs the risk of being less effective because PT Askes is a relatively well-established institution that is totally independent of the *DinKes*. Moreover, there is a difference in the level of expertise and experience between PT Askes and the *DinKes* regarding the management of insurance schemes. Therefore the supervision and monitoring by *DinKes* of PT Askes tends to be "formal" instead of "actual". This difference in the level of expertise and experience can also be a barrier for the *DinKes* to negotiate the cost and coverage of the scheme with PT Askes. For example, the *DinKes* Tabanan admitted that they have been unsuccessful in bargaining a lower premium with PT Askes. For the new contract they also intend to negotiate a better benefit package to be provided by PT Askes.

PT Askes – as the insurer – is also barely involved in the promotion and socialization of the JPK-Gakin program in Tabanan. They also did not engage in the identification of the *gakin* – thus, their potential clients - and only use the data compiled by *DinKes* Tabanan. In other words, in Tabanan, the insurer did not participate in the marketing of the scheme or in providing good information to the potential clients. In Purbalingga district, the *Bapel* (as the insurer) worked closely with *DinKes*, *puskesmas*, the village midwives and volunteers to identify and recruit clients. The *Bapel* allocated special funds and assigned staff to promote the scheme. Using *DinKes*' extensive network (especially the *puskesmas*, village midwives and volunteers) the *Bapel* in Purbalingga reached their clients down to the neighbourhood level. As a result, it appears that clients in Purbalingga are better informed and have a closer relationship with the insurer than is the case in Tabanan.

B. THE EFFECTS ON THE PROVISION OF HEALTH CARE SERVICES

The poor (as the clients) of the JPK-Gakin scheme – both in Bapel as well as the Askes system - have the strongest interest in the provision of good quality health care services. They cannot, however, utilize their purchasing power to affect the quality of services as the scheme is fully funded by the central and local government. In this paradigm, the *DinKes* is responsible for articulating and protecting the interest of the poor. With regard to the barriers mentioned before however, *DinKes* is not the most effective institution to carry out these tasks.

The capitation for the primary health care provider (the *puskesmas*) can be a suitable system to contain cost although in this system there is the possibility that the quality of services will be reduced in the pursuit of lower costs. Nevertheless, containing costs is an important issue for *puskesmas* as the capitation they received is more than adequate. The question will be whether adequate capitation fees will stimulate a better service. Obviously, the JPK-Gakin scheme can secure primary health care for the poor, but this does not necessarily mean that the poor will receive good quality of care. In general, the health care at the *puskesmas* is quite limited both in terms of quality and variety. The implementation of the JPK-Gakin scheme – including adequate capitation for *puskesmas* from this scheme - would certainly not change this condition easily as the condition relates to more complex factors such as the availability of good medical staff, instruments and facilities. Regarding the fact that the capitation is quite strictly allocated for certain costs (e.g. various fees for the stakeholders) so that the *puskesmas* cannot easily use the unspent funds for other purposes (e.g. to improve clean water system, the building etc.), it can be said that adequate capitation fees do not really empower *puskesmas* to solve the problems they have. The fee-for-service system for the secondary and tertiary health care providers does not provide the motivation to contain the costs either. Furthermore, it does not necessarily increase the quality of services.

The most positive effect of the JPK-Gakin scheme on the provision of health care for the poor is the possibility to get secondary and tertiary health care that is usually unaffordable for the poor. Nevertheless, for a range of different reasons, the majority of *Gakin* patients are not referred to the hospital. There are cases where the *Gakin* patients refused to be referred to the hospital although it was necessary because they were insecure about the additional costs that were not covered by PT Askes. They were also not well informed about the benefit package. At this point we can conclude that although the JPK-Gakin scheme does secure the *right* of the poor to get medical treatment at the hospital, it cannot secure the *actualization* of it. To push the actualization, the poor should at least be better informed about what treatments they are entitled to so that they do not forego the required treatment only because they are insecure about the financial consequences. Most importantly, the benefit package needs to be improved in order to reduce the co-payment required by the *Gakin* patients.