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Making Services Work for the Poor in Indonesia: A Report on Health Financing Mechanisms (JPK-Gakin) Scheme in Kabupaten Purbalingga, East Sumba, and Tabanan

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ABSTRACT

The government of Indonesia has started the implementation of locally based health-financing schemes based on health insurance principles. This scheme is commonly known as JPK-GAKIN, which is a health-financing scheme through which the poor can access health care in public facilities, including primary and secondary health care. Due to the perceived success of JPK-GAKIN pilots, the government has decided to provide JPK-GAKIN in all districts in Indonesia from January 1, 2005.

This study looks at the effects of different characteristics of JPK-GAKIN program on healthcare service provision, utilization of health care services, quality of healthcare provision, and how insurance characteristics can influence the relationships between stakeholders. Three districts were selected for the case studies: Purbalingga (Central Java), Tabanan (Bali) and East Sumba (Nusa Tenggara Timur).

We found that compared with previous health financing schemes, JPK-GAKIN scheme has achieved better results in providing access to adequate health care coverage to members of the population, especially the poor. However, we found several problems associated with the scheme, such as: there is a need to improve its targeting and efficiency, it needs stricter financial monitoring and auditing, and it needs to increase stakeholders' involvement in the governance of the scheme. We will elaborate on these concerns and recommend possible policy options to resolve them in this paper.

Keywords: local health financing; JPK-GAKIN; public health; poverty; Indonesia.

EXECUTIVE SUMMARY

The Government of Indonesia (GoI) has designated a number of districts as pilot areas to implement locally based health-financing schemes based on health insurance principles (*Jaminan Pemeliharaan Kesehatan (JPK)*). This scheme is commonly known as JPK-Gakin (*JPK untuk Keluarga Miskin*). JPK-Gakin is a health-financing scheme through which the poor can access public health care through primary and secondary health care facilities. The pilot JPK-Gakin project started in 15 districts and two provinces in Indonesia, and was later expanded to additional regions in the following year.

Originally, JPK-Gakin was managed by *Bapel* (*Badan Pengelola*: Management Unit), an independent body separate from the Regional Health Agency (*DinKes: Dinas Kesehatan)* that often consists partially of officials who were working for the *DinKes* prior to the establishment of the *Bapel*. Due to the perceived success of JPK-Gakin, however, the GoI has decided to provide JPK-Gakin in all districts in Indonesia from 1 January 2005. This time, JPK-Gakin has to be provided by PT Askes, which will run it as a government monopoly, in compliance with the newly passed Law No. 40 of 2004 on the National Social Security System. This has been done despite the concerns of some regional officials that PT Askes has not been successful in delivering good quality health benefits for its primary clientele, the Indonesian civil service.

This study aims to investigate the effects of different characteristics of the JPK-Gakin program on healthcare service provision, utilization of health care services, quality of healthcare provision, and how insurance characteristics can influence the relationships between stakeholders. Three districts were selected for the case studies: Purbalingga (Central Java), Tabanan (Bali) and East Sumba (Nusa Tenggara Timur). We selected each of these districts for a specific reason. Purbalingga was the very first district to initiate health insurance coverage for the poor in 2001. Purbalingga's scheme aims to extend the coverage of insured people in the region not just to the poor, but eventually to its entire population, although non-poor participants will pay a premium depending on their income. Tabanan provides a scheme through PT Askes and is also a "second-generation JPK-Gakin" pilot area, thus this its program can also highlight initial experiences with the provision of health insurance for the poor. East Sumba is one district that has a very high poverty rate and thus the provision of health insurance can have a major influence on increasing access to health care for the poor. It is also a district that experiences many problems with distance as the population is spread over a wide area.

Compared with previous health financing schemes promoted in Indonesia such as the JPS-BK scheme, the JPK-Gakin scheme has achieved better results in providing access to adequate health care coverage to members of the population, especially the poor. One of the reasons why it has achieved better results than previous schemes is the fact that JPK-Gakin is fully administered by local governments (the funding is shared between central and local government budgets). Because it is locally administered, it is easier for the government to develop innovations within the scheme, dealing with

problems and members' complaints, and taking into account local conditions that might affect health care delivery in a particular region.

The JPK-Gakin scheme needs to be improved in several ways, however, in order to enhance its effectiveness, improve its efficiency, and increase the quality of services received by its beneficiaries/clients. There are several problems that need to be immediately addressed by the *DinKes*, *Bapel* and health providers so they do not hinder the effectiveness of JPK-Gakin in delivering its service to its members/clients. These include the following:

- There seems to be a lack of efficiency in the management of JPK-Gakin funds by health providers (especially at RSUD). Claims were approved with little verification and inspection to ensure that they were accurate and there are indications that most of the funds were used to subsidize the care of non-poor patients rather than the poor ones who were supposed to benefit.

- There appear to be a number of formal and informal barriers whose effect is to discourage some *Gakin* members from using the services to which they are entitled. These barriers include high transportation costs, the delay in the distribution of their membership card, etc. Such barriers might discourage the poor from using JPK-Gakin services and could make many JPK-Gakin members reluctant to seek treatment in public facilities.

- The low utilization rate of JPK-Gakin members using the services they are entitled to results in the misallocation of *Gakin* subsidies to the supposedly better-off members, who can actually afford to pay some of their own health care costs. It is likely that most of these funds were used instead to upgrade the buildings and medical equipment of the hospital and to subsidize other hospital patients, especially those from the upper income brackets. For instance, in Purbalingga it is estimated that 79% of the JPK-Gakin funds subsidize the health care services of non-poor patients at *puskesmas* and at the local public hospital (RSUD) with 87.63% of overall JPK-Gakin funds going to non-poor patients.

- It was also found that the unit cost per patient for each JPK-Gakin member treated at hospital in these districts is quite high, ranging from Rp480,505 in East Sumba to Rp7,122,559 in Purbalingga. It is inconceivable that the patient's costs reflected in this calculation were all expended on the treatment of JPK-Gakin members and it is quite possible that a significant proportion of funds were "leaked" and resulted in the treatment of non-poor patients in these hospitals. In order for the JPK-Gakin scheme to become truly pro-poor, this misallocation needs to be addressed.

- There is little involvement by non-government stakeholders, in particular, JPK-Gakin members/clients, in the design, implementation and monitoring of the scheme. JPK-Gakin members are just passive clients. Because they do not participate in the scheme's decision-making processes, the management of the program is less transparent and accountable to its stakeholders, especially its members.

- With the exception of East Sumba, there is no involvement by private health providers in the provision of health services for JPK-Gakin members. They are

only able to seek health services in publicly managed health facilities (*puskesmas* and RSUD). The fact that most private providers do not participate in the scheme results in a more limited choice of health providers available for its members, and, therefore, in restricted access to better quality services.

- The choice of insurance manager/carrier is also becoming more limited, with the creation of the PT Askes monopoly to manage the JPK-Gakin scheme. The decision was made by the Ministry of Health (MoH) without advanced consultation with local governments, *Bapels* and other stakeholders, creating tension between the MoH, PT Askes and these stakeholders that could potentially create disincentives between them to cooperate and coordinate JPK-Gakin operations.

- JPK-Gakin funding largely depends on subsidies from the fuel subsidy compensation (PKPS-BBM/*Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak*) scheme and from the general block grant (*Dana Alokasi Umum* – DAU) given by the central government to district/local governments that largely funds the local government budget (APBD). Funding from other sources (e.g. member's premiums) only forms a small part of the program's overall funds. In the long run, this might make the scheme unsustainable as PKPS-BBM and DAU grants are reduced, creating potential disruptions in the delivery of services.

- Other than the required quarterly financial reports, there is little monitoring done by the *Bapel* and *DinKes* on the use of JPK-Gakin funds by providers. Thus, it is not known whether all the reimbursement claims made by the providers are made for services actually provided. This could provide the opportunity to misuse the funds through the submission of fraudulent claims.

- Coordination between related government agencies (*DinKes*, *Bapel* and health providers) could be improved further. While in these three districts there are efforts to coordinate the operation of the JPK-Gakin scheme, the outcome has not yet been optimized and turf-battles and finger-pointing between these agencies are still common when problems arise.

To address these problems and to make the JPK-Gakin scheme work better, the following steps are recommended for implementation by the government, *Bapel*, health providers and other stakeholders. We target these recommendations at the local governments that manage and implement the JPK-Gakin scheme, along with the central government (Ministry of Health) that will supervise and provide policy advice to the local implementers. We have divided these recommendations into short, medium and long-term recommendations, based on our assessment of how long it would take to implement them. Most of these recommendations should be implemented by local governments, after consultation with the central government, the private sector, NGOs, and most importantly, their citizens, who are the beneficiaries of the JPK-Gakin scheme.

Short-term recommendations (implemented within the next one to two years):

- Increase coordination between different government agencies, especially between *DinKes* and PT Askes in managing JPK-Gakin delivery at the local level.

- Create clear guidelines on the functions, duties and responsibilities of each government agency in administering the JPK-Gakin scheme at the local level. With such guidelines, the functions of each agency would be clarified and turf-battles between them could be avoided.

- Eliminate formal and informal barriers for G*akin* families to use the services to which they are entitled. The government also needs to eliminate the misallocation of G*akin* subsidies to higher income groups, to ensure that the JPK-Gakin scheme truly meets its intended purpose of providing health financing for poor families.

- Improve the efficiency of health services delivery by health providers (*puskesmas* and RSUD). Health services given to JPK-Gakin members should be appropriate to their needs and should be medically necessary. Stricter monitoring procedures should be introduced to ensure that G*akin* funds are used as efficiently as possible and that all expended funds are actually accounted for.

- Improve the quality of services provided by *puskesmas*. Many citizens perceive *puskesmas* as providing poor quality services, and thus, they are not willing to seek primary health care treatment there. Incentives to improve the quality of health service delivery at *puskesmas* should be introduced. At the same time, however, *puskesmas* should not use such incentives to increase their salaries or to pay out cash bonuses to *puskesmas* staff.

- Improve socialization/marketing techniques to recruit new JPK-Gakin members, using low-cost mass-marketing tools that would have wide credibility among prospective clients. *Kaders* (health cadres) might be a potential tool for such socialization purposes. Incentives could be created to make *kaders* more productive in recruiting new members. This could include regular honorariums for *kaders* that are higher than the current financial incentives available to them.

Medium-term recommendations (implemented within one to two years):

- Reactivate *puskesmas*' activities at village level (especially in remote districts), for instance, through reintroducing mobile health clinics (*puskesmas keliling*) or by training village level health providers (such as alternative healers or *dukun*) so that they can provide first-aid medical assistance to villagers, help doctors and other health practitioners at *puskesmas* who are travelling on *puskesmas keliling*, and to give referrals to *puskesmas* in cases where they are unable to treat the patients due to the seriousness of the patient's medical condition. By undertaking these tasks, it is hoped that access to health facilities at the village level can be improved and that citizens do not have to seek treatment at *puskesmas* unless their conditions cannot be treated at the village level.

- Provide stricter monitoring (both internal and external) to ensure that the JPK-Gakin 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*/The District Auditing Board) and also by an independent monitoring unit that could be set up by an NGO/CSO, by the community or by a JPK-Gakin members' association.

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

- Consider including private providers (e.g. private doctors, private hospitals and health clinics) in the list of providers of the JPK-Gakin 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 reimbursement payments set close to the market rate might be necessary so that the payment is in line with the rate charged by private providers. This might however, require premium increases that might force some JPK-Gakin members to drop out of the scheme because they could no longer afford the premium.

- Consider ending the PT Askes monopoly as the insurance carrier for the JPK-Gakin scheme and open the selection of insurance carrier to a competitive bidding process done by each local government. These companies would run the financial management, claims and reimbursement of the G*akin* funds in each region, while local governments (*DinKes*) would continue to issue appropriate regulations and monitor how the program is operated. All insurance companies (both state and privately owned) should be allowed to participate in this bidding process and given a chance to manage the JPK-Gakin scheme based on their previous achievements and their ability to serve its clients efficiently.

<u>Long-term recommendations (implemented in three or more years):</u>

- Efforts need to be taken to reduce or eliminate the dependency of the JPK-Gakin scheme on the PKPS-BBM and APBD-DAU grants to make it self-financing through premiums or other contributions from members/clients, either through increasing premiums for better-off *non-Gakin* members or by introducing new taxes to fund the scheme (e.g. introducing local cigarette and liquor taxes). Of course, efforts need to be taken to ensure that this measure does not reduce members' access to essential health services they need and would not be disruptive of local economic activity nor affect the local labor market.

- Consider charging a minimum premium rate (or co-insurance) for JPK-Gakin members, since it seems that paying G*akin* 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. Of course, the charges imposed on G*akin* members should be set at an appropriate minimal

level so that they do not drop out of the JPK-Gakin scheme altogether due to affordability issues. This has been done in the Rembang District where *Gakin* members are required to pay a premium of Rp5,000/person/year to receive their program benefits. It was quite successful; since the poor pay a small portion of their premium, they are more inclined to monitor the service quality of their health services and to complain if they think they receive unsatisfactory treatment.

- Carefully study the possibility of introducing a health voucher scheme, in which poor citizens would directly control the health subsidies given to them. This is done to minimize possible leakages of the subsidy to higher income patients and to promote accountability and improved service quality, since voucher holders could choose any health providers they feel would provide the best services available to them (both public and private providers would be allowed to treat voucher holders), so there would be competition between providers to attract the most voucher holders to their facilities. Of course, leakages could also occur in a voucher scheme if poor voucher holders sold their vouchers to those on higher incomes. Therefore steps should be taken to minimize this possibility (such as recording the names of voucher holders and assigning them a unique identification number).

I. INTRODUCTION

The Government of Indonesia (GoI) has promoted programs on health care financing for the poor based on the notion that good health is one of the basic rights of all citizens. There is limited access to health care by the poor who, for a number of reasons, have much lower rates of utilization of health care services than the rich. The GoI has introduced a number of policies to increase access to, and utilization of, health care services. In 1998, the GoI introduced the Social Safety Net for the Health Sector Program (JPS-BK[1]) to increase access to health care services for the poor through community healthcare centers (*puskesmas*) and village midwives (*bidan desa*). Under this program, poor citizens received a card with which they were eligible for free health care services from public primary health service providers. In 2001, the GoI introduced additional subsidies aimed at health care services for the poor through the energy subsidies program (*Penanggulangan Dampak Pengurangan Subsidi Energi – Bidang Kesehatan*). In 2002, this program was renamed the oil subsidies program (*Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak*) but the nature of the program stayed the same.

The health card program was implemented to increase access to health care services for the poor but it experienced many problems with identification of the poor, the distribution of the health card, additional administration burdens on health care providers, and, in particular, the financial governance of the government. Thus, access to health care services, especially for the poor, is still very limited. Due to the limitations of the health card program the GoI looked for a more effective, efficient and sustainable financing mechanism.

After the 2001 program of administrative decentralization, the central government designated a number of districts as pilot areas to implement locally based health-financing schemes based on health insurance principles (*Jaminan Pemeliharaan Kesehatan (JPK)*). This scheme is commonly known as JPK-Gakin (*JPK untuk Keluarga Miskin*). JPK-Gakin is a health-financing scheme through which the poor can access health care in public facilities, including primary and secondary health care. Through the use of insurance principles, the problem of administration overload of the *puskesmas* would be solved and cost-containment made possible. The pilot JPK-Gakin project started in 15 districts and two provinces in Indonesia, and was expanded to additional regions the following year.[2]

These locally based schemes do contain many significant differences. For example, the provision of JPK-Gakin was, until the end of 2004, not limited to one specific health insurance provider and as a result health insurers with different backgrounds provide health insurance in different districts. Three of the main differences include the benefit package, the insurer and the reimbursement system.

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[1] *Jaringan Pengaman Sosial Bidang Kesehatan*.

[2] Currently, Indonesia consists of over 400 districts. Thus, initially this was a small number of pilot projects. In 2004 the program expanded to a total of 25 districts and four provinces providing the health insurance scheme.

In most districts, JPK-Gakin is managed by *Bapel* (*Badan Pengelola*: Management Unit), an independent body separate from the Regional Health Agency (*DinKes: Dinas Kesehatan)* that often consists partially of officials who were working for the *DinKes* prior to the establishment of the *Bapel*. In some other cases JPK-Gakin is provided by PT Askes, which is a state-owned health insurance enterprise established by the Ministry of Health in 1968, which has an independent board of directors but is under the supervision of the Health Ministry. PT Askes is a for-profit state-owned company that provides a number of different benefit packages in Indonesia. Benefit packages (including those for the poor) provided by PT Askes are nationally set, so districts do not have the authority to make changes to accommodate local needs.

Due to the success of JPK-Gakin, the GoI decided in November 2004 to provide JPK-Gakin in all districts in Indonesia, however, a number of adaptations were made with the pilot projects. The main change is that from 1 January 2005, through a decree of the Minister of Health (Decree No. 1241/MENKES/SK/XI/2004), JPK-Gakin has to be provided by PT Askes, which will run it as a government monopoly, in compliance with the newly passed Law No. 40/2004 of the National Social Security System. This policy change was made without consultation with local governments implementing the JPK-Gakin scheme and other related stakeholders, who were only informed about it after the decision was finalized. Of course, local governments were not happy about this new policy, as they felt that PT Askes had not been successful in delivering good quality health benefits to its primary clientele, the Indonesian civil service, and they claimed that the JPK-Gakin scheme managed by local governments provided better benefit packages than PT Askes. Since the decision has become final, however, they could not do anything to reverse it. Currently, several districts in East Nusa Tenggara, East Indonesia, have started to implement the law and other regions in Indonesia will soon follow suit.

In this study we aim to look at the effects of these different characteristics of the program on healthcare service provision, utilization of health care services, quality of healthcare provision, and how insurance characteristics can influence the relationships between stakeholders. Some districts have managed to implement and continue the scheme relatively well. 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 in these services? What are some possible policy alternatives to make the JPK-Gakin scheme work better for its members?

II. DISTRICTS' INFORMATION

Three districts were selected for the case studies; Purbalingga (Central Java), Tabanan (Bali) and East Sumba (Nusa Tenggara Timur). Each of these districts was selected for a specific reason. Purbalingga was the very first district to initiate health insurance coverage for the poor in 2001. The Purbalingga government has aimed to extend the coverage of insured people in the region not just to the poor, but eventually to its entire population, although non-poor participants will pay a premium depending on their income. Tabanan provides its scheme through PT Askes. Tabanan is also a "second-generation JPK-Gakin" pilot area that was introduced in 2004. Its program can also highlight initial experiences with the provision of health insurance for the poor. The third case study, East Sumba, is one district that has a very high poverty rate and thus the provision of health insurance can have a major influence 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.

The table below shows differences between the benefit package and provision of the health insurance schemes.

Table 1. Comparison between Insurance Schemes Adopted by the Three Districts Surveyed

	Purbalingga	East Sumba	Tabanan
Insurer	Bapel	Bapel	PT Askes
Reimbursement	Capitation	Capitation and FFS	Capitation and FFS
Benefit package	Complete, everything covered	Flexible	
Start	2002	2003	April 2004
Insurance term	Once a year; August - July	Once a year	Once a year; April - March
Poverty rate	28%	66.5%	9%

Source: data received from *DinKes* and *Bapel* of each district.

III. METHODOLOGY

Information for this study was obtained from in-depth semi-structured interviews conducted with related informants in the three districts mentioned above. Informants included officials of the district Health Agency (*Dinas Kesehatan-DinKes*), the district scheme managers (*Badan Penyelenggara-Bapel*), *puskesmas* staff (*puskesmas* head, doctors and other support staff), district hospital (*Rumah Sakit Umum Daerah-RSUD*) staff (head, doctors and other support staff), village officials, village midwives (*bidan desa*), village volunteers (*kaders*), and patients/clients who enrolled in the JPK-Gakin scheme in these districts. The interviews were conducted in fieldwork conducted throughout the months of December 2004 and January 2005.

In addition to these interviews, we also collected relevant documents regarding the JPK-Gakin schemes operating in these districts, such as: any relevant district-level laws and regulations, financial reports, patient visitation reports at the RSUD and *puskesmas*, and so forth. We were able to obtain all of these documents in Purbalingga and East Sumba districts. In Tabanan district, however, we were only able to obtain some of the regulations and patient visitation reports and no financial reports.

IV. FINDINGS

A. OVERVIEW

Based on our study in the three JPK-Gakin pilot districts (Purbalingga, Tabanan and East Sumba), we found that, in comparison with previous health financing schemes such as the JPS-BK scheme, the JPK-Gakin scheme has achieved better results in providing access to adequate health care coverage to district residents, especially the poor.

One of the reasons for this is the fact that JPK-Gakin is fully administered by local governments (the funding is shared between the central and local government budgets). Because it is locally administered, it is easier for the government to develop innovations within the scheme, deal with problems and members' complaints as well as take into account local conditions that might affect health care delivery in a particular region. Each of the three districts we visited has a different financing mechanism and administration:

- Purbalingga chose to have an insurance scheme in which members are divided into three groups: Strata I for the poor, Strata II for the formerly or near poor, and Strata III are for the well-off citizens of the district. The premium for Strata I is fully paid by the government, while the premium for Strata II and III are paid by the members, either partially (Strata II) or fully (Strata III). It is expected that within the next decade the Purbalingga scheme could be self-financing, with Strata II and III premiums subsidizing Strata I. However, at this time it is the other way around, with *Gakin* (Strata I) members subsidizing the other two groups that are better-off (Stratas II and III), see section d for further details.

- Tabanan, a second-generation JPK-Gakin district, decided to contract out the management of its JPK-Gakin scheme to PT Askes, a state-owned company specializing in providing health insurance for Indonesian civil servants. Tabanan assigned responsibility to PT Askes as the insurer of JPK-Gakin because it wants to avoid the risk of failure that can cause serious financial problems and because PT Askes is seen as a professional institution that has the required length of experience in managing insurance schemes as well as a wide coverage area. The benefit package offered for the JPK-Gakin participants is similar to the one provided to civil servants.

- East Sumba in the East Nusa Tenggara province, was able to provide a JPK-Gakin scheme even though it is one of the poorest districts in Indonesia with about three quarters of its population living below the poverty line. From 1 January 2005, the insurance management was split between PT Askes, who will manage the health care financing for the urban population, and the East Sumba Health Agency (*Dinas Kesehatan-DinKes*), which continues to manage health care financing for the rural population.

Since JPK-Gakin schemes are fully managed by the districts themselves, they can be flexible in administering the program and dealing with local situations that might inhibit health care delivery in their respective regions. For instance, East Sumba has provided a transportation allowance for JPK-Gakin members living in remote areas, since they often have to travel a great distance to seek health treatment. The allowance helps them to offset the transportation cost to and from health facilities so that the cost of transportation does not discourage them from seeking health care.

There are also indications that *Gakin* members are more likely to express their complaints or dissatisfaction about how the program is being administered to the local government's *DinKes* or *Bapel* offices than was the case when the health scheme was still managed by the central government. Since local governments are perceived to be "closer" to their citizens, people have more confidence that they will get a response to their complaints from local governments, compared with lodging a complaint with a central authority in Jakarta. Thus, *Gakin* members are more likely to file a complaint with the local government, increasing their voice in how the JPK-Gakin scheme is administered. As described later in this section, however, this does not mean that local citizens were more involved in the design and implementation of JPK-Gakin compared with previous schemes, since it was also found that they continue to be excluded from the policy deliberation process.

B. THE INSURED

After a process of identification, all the poor are automatically enrolled into the JPK-Gakin program. The districts have different poverty levels, the poverty rate at the national level is around 16%. East Sumba has high levels of poverty, whereas Tabanan has only a very small proportion of poor people.

In Purbalingga 57,362 people have been identified as eligible for free health insurance, this equates to about 28% of the total population. In addition, there are 42,533 Strata II and 23,408 Strata III members, who pay premiums to access the health services, either in part (Strata II) or in full (Strata III). As a result, almost 60% of the population in Purbalingga in total is insured via the benefit package of the *Bapel*. Of this number, however, only about 28% were classified as poor.

In East Sumba as many as 129,074 people were classified as being poor. This varies widely from the number identified by the central government (81,200). After the first round of identification and verification, the second identification round in 2004 identified a total of 159,037 people who had income levels below the poverty line. This does not mean that people's income over that period decreased dramatically, but is the result of a different and (according to the *Bapel* and other stakeholders) improved identification process. As the central government only officially funds the 81,200 people it recognizes as poor, PT Askes will provide health insurance for that number of people, whereas *Bapel* will manage the JPK-Gakin program for those other poor recognized by the second identification round. Based upon 2003 data from Statistics Indonesia, the total population in the region was 198,940 people, thus around 66.5% of the population in *Kabupaten* Sumba Timur is identified as being poor.

Kabupaten Tabanan in Bali is a relatively wealthy district with a lower poverty rate than the national average. In 2004, only 10,710 *gakin* households or 37,791 persons were identified. This is about 9% of the district population.

The benefit packages differ between districts and the size of the package has a large influence on the usability of the package for the poor. The packages provided to the poor participants (*Gakin*) in Purbalingga and East Sumba are very complete without limitations, ceilings or co-payments but exclude some very expensive, but infrequent treatments. The PT Askes provided packages in Tabanan are, however, more limited due to the introduction of ceilings and co-payments. The premium in Purbalingga is relatively low; set at Rp50,000/family per year, thus equaling approximately Rp12,500/person per year, whereas the premiums in East Sumba and Tabanan are set at Rp60,000/person/year.

Table 2 shows the number of poor citizens (*Gakin*) who are members of the insurance scheme, along with the percentage of the district population that is considered to be poor.

Table 2: Number of JPK-Gakin Members in the Three Districts Surveyed

Name of District	*Gakin* members (persons)	Total Population	Percentage of the population
East Sumba	129,074	193,940	66.55%
Purbalingga	229,448	822,020	27.91%
Tabanan	37,791	419,900	9.00%

Source: authors' calculation based on district data received.

C. FINANCING AND REIMBURSEMENT SYSTEM

It should be noted that the JPK-Gakin scheme, while claiming to be a health insurance scheme, is not a scheme based on real insurance principles.[3] Instead, it is a financial transfer scheme that is supposed to channel funds from wealthier citizens to the poorer ones through the intermediary of the government, however, as will be detailed later, even this transfer scheme does not work as it was intended.

All three districts use a capitation system for primary health care providers. In both Tabanan and East Sumba, hospitals are reimbursed through a fee-for-service system, but the *Dinas Kesehatan* in Purbalingga has decided to make a capitation payment to the hospital to improve cost-containment. Over the past few years, however, the capitation payment for the RSUD has doubled as the capitation set in previous years proved to be insufficient. Hospital management are reluctant to predict whether this years' capitation will be enough. They expect that this year's expenditure will be closer to the capitation payment, but this will not reduce the deficit they

[3] A real insurance scheme would have the characteristics of insurance, such as: the premium would be calculated based on actuarial analyses, there would be cost control mechanisms such as co-insurance, deductibles, and exclusions and prospective customers would have the right to freely select the insurance scheme they want based on their own preferences and needs. By and large, these characteristics were not present in JPK-Gakin schemes and even when they exist on paper (such as cost-control mechanisms), they were not always enforced in practice.

accumulated over previous years. Typically, the *DinKes* and the *Bapel* set the capitation level once a year, when the terms of the JPK-Gakin scheme are reviewed.

These two reimbursement methods can largely influence the incentives of health care providers to perform their duties diligently. A capitation payment can have a large influence on cost-containment, the risk lies with the health care provider who has to give good quality care for a defined budget. This can have a negative impact on quality of services. On the other hand, fee-for-service does not have this limitation and thus does not give an incentive for the provider to contain costs and/or services. As a result health care expenditures can increase significantly, which results in increased pressure on (in this case) the government budget.

One observation we can make of the schemes in these districts is that there seems to be a lack of efficiency in the use of JPK-Gakin funds by health providers (especially at RSUD).[4] While the payment system is supposed to be largely operating on a capitation basis, in practice, health providers (both *puskesmas* and hospitals) charge for their services on a FFS (fee-for-service) basis. *Bapel* paid virtually all of the providers' claims and it is not clear whether they have verified the claims carefully before approving them.[5] As long as the payment system is operating de-facto as a FFS, cost control would not be achieved and the use of appropriate health services/treatments might be discouraged in favor of more expensive ones that might not be absolutely necessary for patients (e.g., using patented rather than generic drugs).

Another concern for us is that JPK-Gakin funding in the districts that have piloted it (including in the three districts used for this study) largely depends on subsidies from the fuel subsidy compensation (PKPS-BBM) scheme and from the general block grant (*Dana Alokasi Umum* – DAU) given by central government to district/local governments, which largely funds the local government budget (APBD). On average, over 80% of JPK-Gakin funding comes from these two sources.[6] Funding from member's premiums and other local tax revenues (*Pendapatan Asli Daerah – PAD*) only form a small part of the program's total funding.

If this funding pattern continues, it is feared that in the long run, funding for JPK-Gakin could be cut as the amount of PKPS-BBM and DAU grants to these districts is reduced. As these grants are reduced, service delivery for JPK-Gakin patients could be compromised as well. It is suggested that local governments should start planning alternative financing means to make the JPK-Gakin scheme self-financed and less dependent on the above two grants, either by requiring *Gakin* participants to make a financial contribution into the scheme, or through other local taxes that would not

[4] In the three districts surveyed, more than 80% of JPK-GAKIN expenditures were spent at RSUD, while the number of RSUD users is less than 1% of *Gakin* members.

[5] In Purbalingga, the head of *Bapel* is also a physician at the public hospital, where *Gakin* patients are referred. While he defends this practice as useful since he could "verified the hospital claims directly," to other observers this practice violates conflict-of-interest rules.

[6] Except in Purbalingga, where, thanks to the premiums paid by better off members of its insurance scheme, only about 70% of the scheme's funding comes from central and local government subsidies.

cause disruptions to the welfare of citizens and businesses alike (for instance, by taxing alcoholic beverages and cigarettes).

In all the three districts surveyed, primary care providers (*puskesmas*) are reimbursed through capitation payments. *Puskesmas* capitation funds are used to pay for the treatment of poor outpatients. Expenses for in-patient care and small operations are reimbursed on a FFS basis instead of being covered by capitation funds.

The costs at the *puskesmas* are so much lower than private doctors and hospitals 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 all districts already receive subsidies from central, provincial and district governments for the expenditures of the *puskesmas*. *Puskesmas* have different financial resources, the major ones are the following:

1. District government budget (APBD II); most of these funds (more than 80%) come from the central government's general block grant (Dana Alokasi Umum-DAU);
2. *puskesmas* income from user's fees;
3. JPK-Gakin capitation payments; and
4. claims on PT Askes for the treatment of Askes members (normally civil servants).

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 these are tied funds. Sometimes the *puskesmas* have ideas on how to use the money to improve the quality of the *puskesmas* services, but they could not use the unspent portion of the JPK-Gakin subsidy to finance such improvements, since it would be in breach of the scheme's regulations.

On the other hand, the hospitals we visited have to struggle to cover their costs. A few of them have a large deficit. For instance, the Tabanan hospital has a deficit of Rp780 million. This is despite the fact that in fiscal year 2003, only 0.3% of *Gakin* citizens eligible to receive free treatment at the hospital actually visited it (113 people out of 37,791 eligible *Gakins*). In the same fiscal year, the hospital received Rp1.8 billion to treat *Gakin* patients. Since the hospital is still running deficits, it is most likely that this subsidy was not used efficiently to treat those targeted for the subsidy. It is likely that it was used to upgrade the buildings and medical equipment of the hospital[7] and to subsidize other hospital patients, especially those coming from upper income brackets. The hospital was not audited by the local government (either *DinKes* or other entities), since it was an "independent" (but quasi-public) entity. Its financial reports were sent directly to PT Askes and PT Askes declined to make them public.[8]

[7] The hospital recently moved to a brand new building and the equipment is considered to be state-of-the-art for a district hospital.

[8] Unlike in Purbalingga and East Sumba, our research team failed to receive detailed financial data about Tabanan's JPK-Gakin scheme, either from the *Dinas Kesehatan*, PT Askes or the hospital.

These observations show that there is evidence that the JPK-Gakin funds were not used efficiently, were often leaked to non-poor patients, and were not carefully monitored and audited by appropriate authorities. We will elaborate on these in the next section.

D. *GAKIN* UTILIZATION: IS THE FUND DISTRIBUTION PRO-POOR?

Utilization data shows how many members of a health-financing scheme actually use the services it provides. It gives us a clue on whether or not the financing scheme was used mostly to fund the health care of its members. It also tells us how confident are members of the health financing scheme in the quality of services it provides and, hence, their willingness to use it.

A high utilization rate shows that the scheme is mostly used by its members and that they have a high level of confidence in it and are therefore willing to use it. On the other hand, a low utilization rate means that the scheme's members do not have much confidence in it and decline to use it. In this case, it is more likely that the funds allocated by the scheme are used to benefit non-members.

Our study indicates that the actual utilization rate of JPK-Gakin members who actually obtain health services from the selected health providers is still quite low (especially at hospitals), as illustrated in Table 3 below:

Table 3: Average Annual Utilization Rate of *Gakin* Members in the Three Districts Surveyed

	Purbalingga	Tabanan	East Sumba
Puskesmas	38.28%	31.70%	16.02%
Hospital	0.12%	0.30%	0.22%

Source: authors' calculation based on district data received.

This low utilization rate shows that members of the JPK-Gakin scheme were reluctant to use it, even though local officials have told them that they will get free treatment at the selected health facilities. Based on our analyses, the low utilization rate of JPK-Gakin members could be attributed to the following:

- The cost of transportation for poor citizens (*gakin*) from their homes to the *puskesmas*. Even when they receive free treatment at the *puskesmas*, they have to pay for their transportation costs themselves, since it could not be reimbursed by JPK-Gakin. The transportation cost is much higher than the *puskesmas*' user charges (and with JPK-Gakin, these charges were waived). A one-way trip to a *puskesmas* could cost Rp10,000, while the treatment itself costs nothing for the *Gakin*. Thus, there is an additional cost in attending the *puskesmas* that discourages some *Gakin* members from seeking treatment at *puskesmas*.

- Some *Gakin* members have not received their JPK-Gakin membership card, discouraging them from seeking treatment at *puskesmas* since they were afraid that they would be denied treatment if they do not have the new card. In fact, in Purbalingga we observed that premium paying members of the insurance scheme

tend to obtain their membership card more quickly than the non-paying *Gakin* members, indicating that services are better if one actually pays for it rather than if it is freely available.

- There is a common perception within the community that the quality of health services in *puskesmas* and public hospitals (RSUD) is poor and that the staff of these facilities do not treat patients courteously. As a result, some *Gakin* members interviewed stated that they prefer to use private providers, such as traditional healers, private doctors etc. Such services are, however, not reimbursable under the JPK-Gakin scheme, which only covers services provided by government-owned facilities such as *puskesmas* and RSUD. Thus, if one wants to get the best health care from the providers they trust the most, their choice would be very limited under JPK-Gakin. Many *Gakin* members choose not to use the scheme altogether and continue to use the service of private providers even when they charge high consultation fees, since they have more confidence in these private providers that they will get the best health services available to them.

The low utilization rate of *Gakin* members also indicates that most of the JPK-Gakin funds allocated to *puskesmas* and RSUD were actually not used to fund the health services of poor families, but instead were used to subsidize the health care of other customers of these facilities who are financially better-off. One example of this could be seen in Purbalingga. In Table 4 below, we can see that the monthly utilization rate of the *Gakin* members of the district's insurance scheme (JPKM) were the following:

Table 4: Average Monthly Utilization Rate of *Gakin* Members in Purbalingga District, Fiscal Year 2002/2003

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

Source: authors' calculation based on districts data.

Table 5 shows that while *Gakin* members received more than 57% of the JPKM funds allocated by the district government, they only use about 21% of the *puskesmas* health services and 12.37% of the services offered by the local public hospital (RSUD). This indicates that most of the JPK-Gakin funds allocated in the Purbalingga district were not used to fund health services of poor persons living in the district, but instead were used to subsidize other operational costs of the *puskesmas* and RSUD, specifically subsidizing other users of these facilities who are better-off financially than *Gakin* members (i.e. the premium-paying members of the JPKM insurance scheme).[9]

[9] The *Bapel* head in Purbalingga admitted that at this time, better-off members of the JPKM insurance scheme (Strata II and III) were subsidized by the *Gakin* members (Strata I) rather than the reverse, although he hopes that this situation can be turned around "sometime in the near future."

Table 5: Distribution of JPKM Funds in Purbalingga District

Percentage of JPKM funds allocated to *Gakin*.	**57.02%**
Percentage of JPKM funds allocated to non- *Gakin*.	**42.98%**
Percentage of *puskesmas* funds allocated to *Gakin* patients.	**20.92%**
Percentage of *puskesmas* funds allocated to non- *Gakin* patients.	**79.08%**
Percentage of RSUD funds allocated to *Gakin* patients	**12.37%**
Percentage of RSUD funds allocated to non-*Gakin* patients	**87.63%**

Source: authors' calculation.

Finally, when we calculated the unit cost per JPK-Gakin user in the two districts for which we have financial data (East Sumba and Purbalingga), we found that the average cost of treatment for each JPK-Gakin patient in these districts is quite high, especially at hospital level. As we can see from Table 6 below, it costs Rp7,122,559 to treat each *Gakin* patient in RSUD Purbalingga and Rp480,505 to treat each *Gakin* patient in the East Sumba hospitals (RSUD East Sumba and the Lindimara hospitals). It is inconceivable that the patient's costs reflected in this calculation all went to treat JPK-Gakin members, thus, it is possible that a significant portion of funds were "leaked" for the treatment of non-poor patients in these hospitals. Indeed, the hospitals said that the *Gakin* subsidies allocated by the *Bapel* were fully absorbed by them and yet, both of them are almost running financial deficits. It could be assumed, therefore, that most *Gakin* funds were used to subsidize other hospital operations rather than the servicing of *Gakin* patients.

Table 6a: JPK-Gakin Unit Cost/User Ratio in East Sumba District

Type of Services	Annual Utilization (in %)	# of Users per Year	JPK-Gakin Allocation (in Rp)	Unit Cost/User
Puskesmas services	16.02%	252,779	1,663,000,500	6,579
Hospital services	0.22%	3,408	1,637,560,000	480,505

Table 6b: JPK-Gakin Unit Cost/User Ratio in Purbalingga District

Type of Services	Annual Utilization (in %)	# of Users per Year	JPK-Gakin Allocation (in Rp)	Unit Cost/User
Puskesmas services	38.28%	76,844	804,144,000	10,465
Hospital services	0.12%	145	1,033,206,000	7,125,559

In other words, despite the goal of JPK-Gakin to help poor Indonesians receive the health care they need, the distribution of the JPK-Gakin subsidy is *pro-rich* rather than *pro-poor*. This might not be the most efficient way to provide health coverage for poor citizens, since most of its intended targets never use these services and those that actually use them might actually be able to fund most, if not all of their own health expenditures.

If the JPK-Gakin scheme were to be called truly pro-poor, the trend of subsidizing the health care of the non-poor at the expense of the poor has to be reversed, but doing so would require a major change in the way the JPK-Gakin scheme is organized and operated. This issue will be addressed in our policy recommendation section.

E. MEMBERS' IDENTIFICATION AND SOCIALIZATION

In a "normal" insurance situation people will acquire insurance by themselves if they are interested. In the case of JPK-Gakin, however, the premium for members is automatically paid by a third party (the government) so health insurance is, effectively, a free service for them. This does not necessarily mean that those people eligible to the service will instantly present themselves to the insurance provider. There is a need to identify people eligible for the program and make them aware of the benefits of the program so that they comply and avail themselves of their rights. Since the insurance package has been pre-paid by a third party, there is no financial incentive for the insurer to perform this function or to do it well. At the same time, members do not have an adequate incentive to find out more about their rights under the insurance scheme.

Because the JPK-Gakin scheme is fully administered by local governments, each district has the task of identifying the poor. In the three districts visited the *DinKes* has assumed this responsibility. In general, all three districts make use of the vertical structure of the *DinKes* (*puskesmas* staff, village head and *bidan desa*). From our field observations, however, we concluded that without additional help at the village level an accurate identification of the poor is very difficult. Each *Dinas Kesehatan* should, therefore, make use of village informants for this purpose.

There are several factors that determine the number of community members participating in JPK-Gakin:

1. The influence of marketing methods and the ability of local activists in promoting the scheme at community level (*kaders*, midwives and village officials). The marketing methods, skills and motivation of *kaders* largely influences whether or not people will enroll in the scheme. In areas 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 areas where the *kaders* play a more subdued role. This might be the most effective way to socialize the scheme, and this will be elaborated upon further in the next section.
2. The ability of the community to receive and understand information given to them, whether orally or in writing. This might relate to their education level.
3. Community perception of *puskesmas* services (cost/fees, facilities available, service quality, effectiveness of medication/drugs, etc).
4. The influence of conventional promotion and marketing efforts conducted by *Bapels* (flyers, leaflets, radio and newspaper ads, etc.). This method is, however, quite expensive and often is not effective.

Identification using village-level informants has been used in the Purbalingga District since the JPK-Gakin scheme started there in 2002. This is done by the so-called "village volunteers" (*kaders*) who play a major role in the identification, verification and socialization processes. Typical *kaders* are the wives of the local Household

Association (*Rukun Tetangga-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 at the grassroots of the community and at least one *kader* has been identified in each RT.[10]

Using *kaders* reduces the barriers of communication with the community and also the costs of performing the identification. This is because *kaders* live within the community and thus know many of the community members. Secondly, *kaders* have ready access to information needed to identify the poor, and finally, community members are more likely to consider information received from *kaders* more seriously than those that were 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*. Since *kaders* have closer relations with prospective members living in their community and tend to be well respected by the community, this might have contributed to the high level of membership in Purbalingga's JPK-Gakin scheme (nearly two-thirds of Purbalingga citizens by the end of 2004).

Kaders also have extensive powers in determining which prospective members should be classified as poor and which ones as non-poor. While they receive a prospective member's list made by the *Bapel*, they have the authority to verify and adapt it if necessary. When *kaders* make modifications to the prospective members' list, neither the *Bapel* nor the *puskesmas* usually challenge them. This indicates the influence of *kaders*' judgement in determining members of the insurance scheme.

On the other hand, the *DinKes* in both East Sumba and Tabanan has not used the *kader* system as extensively as Purbalingga. In East Sumba, the identification is carried out by the *puskesmas* staff, *bidan desa* (village midwives), and the village head and his/her assistants. During the first period (2003), there were many complaints and requests from people eligible for JPK-Gakin who had not received their insurance cards. Changes were subsequently made in 2004 to include additional village level helpers which resulted in a better outcome (and higher level of poverty) and higher level of satisfaction in the second phase of the pilot. Still the *DinKes* and members of the *Bapel* acknowledge that there are problems with the identification process, and that the criteria that are currently used are not very useful. In Tabanan, the identification of the poor 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 had a number of weaknesses. For next year the plan is to involve the health officials, the village midwife and volunteers from each village (*kaders*) to make identification of the poor easier.

The lack of a clear division of roles in the socialization process of the Askes-Gakin scheme in Tabanan seems to have limited the success of the program. Unlike the case of Purbalingga, the village midwife and *kaders* play no role in the socialization of health insurance for the poor in Tabanan. In this district the socialization is mainly through the *Kepala Dusun* (*Kelian Dinas*) who would explain the scheme to the poor in their neighborhood. To conclude, the socialization of the Askes–Gakin scheme in

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

Tabanan appears to be rather minimal. Many village heads 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 the majority of citizens have not heard about the scheme.

We can conclude that for both the identification and socialization of prospective JPK-Gakin members, the related stakeholders need to be identified and the existence of a clear process increases its accuracy. Looking at the identification process, it seems that to maximize accuracy in identifying prospective members at grassroots level, it is necessary to have enumerators who live with the prospective members and are well informed about their economic and social conditions. This has been done by Purbalingga. By using well-respected community members as *kaders* in the identification and socialization process, they were able to socialize the JPK-Gakin program in the district very well. Since nearly two-thirds of Purbalingga citizens are current members of the insurance scheme, this seems to indicate that the *kader's* efforts contributed greatly to the high rate of enrollment.

F. MONITORING AND COORDINATION OF STAKEHOLDERS

Financial monitoring of the JPK-Gakin program is supposed to be done by the District Auditing Board (*Badan Pengawas Daerah-Bawasda*), while monitoring the quality of the health services of the *puskesmas* and RSUD is done by the *Bapel* from the reports on financial and expenditure data submitted by the *puskesmas* and RSUDs.

Formally, *DinKes* as part of the Advisory Board of JPKM, is responsible for monitoring the work of the *Bapel* as well as the effect of JPK-Gakin on utilization rates and service quality. Health care providers (*puskesmas*, *pustu* and hospital) all provide monthly reports on utilization rates and expenditures to the *DinKes*. This kind of monitoring is, however, rather limited and does not provide information concerning why people do or do not make use of health care services if they need it. In addition, quality assessments of health care services in the facilities offering JPK-Gakin services are not done.

It can be said that the existing monitoring mechanisms were mainly focused on financial monitoring alone. All districts studied (East Sumba, Purbalingga and Tabanan) also referred to a "Community Complaints Unit" or UPM ("*Unit Pengaduan Masyarakat*") whose role is to record complaints on JPK-Gakin health services. 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. In addition, there is no independent monitoring of the JPK-Gakin scheme done by the clients or community groups/NGOs and such monitoring is not encouraged by the local governments. Thus, the opportunity for stakeholders to monitor the accountability and transparency of JPK-Gakin expenditures is very limited.

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*). We

found that each "case" (of complaint) would be handled separately by the above coordinating team but they do not meet regularly. This kind of "vague" monitoring mechanism and coordination could be found in all of the districts studies (East Sumba, Purbalingga and Tabanan).

Without careful and continuous monitoring of JPK-Gakin finances, the possibility of misallocation and misuse of JPK-Gakin funds for the benefit of those who are not *Gakin* could not be ruled out completely. One should be cautious of the fact that virtually all claims for JPK-Gakin services were approved. This might indicate that there has been a lack of verification to ensure that the services that were claimed were actually delivered. Without such verification, there is a strong possibility that some of these claims have been falsified.

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.

G. THIRD PARTIES' PARTICIPATION (PRIVATE SECTOR, INSURANCE CARRIER, CLIENTS, ETC.)

Private providers

With the exception of a private hospital in East Sumba that is allowed to accept JPK-Gakin patients, private providers are not included as participants in the JPK-Gakin scheme. This reduces the access and choice of JPKM members in their health care, since they are only able to use their entitlement at public facilities (*puskesmas* and RSUD), while a large number of citizens, even the poor ones, still prefer to be serviced by private providers rather than public ones. This might contribute to the perception of some JPK-Gakin members that the health services offered by the public providers are inadequate or lacking in quality.

Part of the reason why private providers are reluctant to join the scheme is because of the large discrepancy between the cost of health services performed at private and public facilities. Since public facilities (especially *puskesmas*) are heavily subsidized by the government, prices are kept much lower than the market prices. For instance, the user fee at *puskesmas* in East Sumba is just Rp2,000/person/visit (and is waived for *Gakin* scheme members), while private doctors would charge at least Rp20,000/person/visit for general consultations.

In addition, under JPK-Gakin, providers are reimbursed on a capitation basis, while virtually every private provider prefers to use a *fee-for-service (FFS)* arrangement. As long as the reimbursement arrangement is still via capitation, it would be very difficult to attract private providers to join the JPK-Gakin scheme. On the other hand, the FFS arrangement in the long run would not be financially sustainable, since providers have an incentive to prescribe expensive treatments and medications to their patients, knowing that they would be fully reimbursed by the insurance program, resulting in the collapse of the program over the long run.

A balanced approach would be to find a way to reimburse private providers either at the market price they charge, while containing the cost so that the program would be sustainable over the long run. This will be elaborated upon in the policy recommendation section.

Insurance Manager/Carrier

The choice of insurance manager/carrier is also becoming more limited, with the creation of the PT Askes monopoly to manage the JPK-Gakin scheme, starting on 1 January 2005. The decision was made by the Health Ministry without advance consultation with local governments, *Bapels* and other stakeholders, creating tensions between the Health Ministry, PT Askes and local governments that could potentially create disincentives between them to cooperate and coordinate JPK-Gakin operations. As a result, in some districts, there might be two JPK-Gakin carriers operating simultaneously: PT Askes (funded through the PKPS-BBM grant) and the local JPK-Gakin scheme (funded through the APBD-DAU grant). This has been the case in East Sumba and this could potentially occur in other districts as well. If these two schemes continue to exist with little cooperation and consultation between them, the result will be confusion among JPK-Gakin members and the possibility that service quality could be compromised.

Since the PT Askes benefit package will be uniform in all Indonesian districts, it will not take into account local conditions that might necessitate changes in the benefit package (for instance, providing health care in a remote rural district). In addition, under PT Askes, the beneficiaries would not be able to choose the best insurance carrier for themselves, since, under the new government policy, PT Askes would run JPK-Gakin as a public monopoly.

Our analysis above shows that local JPK-Gakin schemes tend to offer a better benefit package than PT Askes does, and are often better socialized to prospective clients. There are also indications that clients are more likely to approach local *DinKes* or *Bapel* when they have complaints about JPK-Gakin services, but less likely to approach PT Askes, which is perceived to be a central government institution which is more bureaucratic and distant from them. Thus, it might be necessary for the government to rethink its plan to entrust the management of JPK-Gakin to PT Askes, and instead create a plan where PT Askes and district governments work more closely in providing JPK-Gakin services in which the district will have more authority to change the benefit package of JPK-Gakin to make it more accommodative to local conditions.

Members/clients

There is little involvement of JPK-Gakin members/clients in the design, implementation and monitoring of the scheme. JPKM members are just passive clients who were registered, paid the premium, received a membership card and obtained health services from JPK-Gakin providers. They do not participate in the decision-making of the scheme itself.

Of course, some members did file complaints to the *DinKes* and *Bapel* when they received unsatisfactory services, however, one has to be a very assertive person in doing so, taking the initiative to file the complaint, following them up and so forth. Without doing this, it is unlikely that the complaint will receive a positive response from the scheme managers. Finally, JPK-Gakin members' participation is limited to filing complaints when receiving unsatisfactory services from the health providers. They are/were not involved in the design, implementation or monitoring of the program. This makes the management of the program less transparent and accountable to its stakeholders, especially its members.

V. CONCLUSIONS

Based on our research findings, we can conclude that the JPK-Gakin scheme has been more successful in providing access to adequate health care coverage for members of the population, especially the poor in comparison to previous health financing schemes promoted in Indonesia. This is because JPK-Gakin is administered and managed by local governments (the funding is shared between central and local government budgets). Thus, it is easier for the government to develop innovations within the scheme, dealing with problems and members' complaints, and taking into account local conditions that might affect health care delivery in a particular region (for example, very remote regions or regions that are vulnerable to periodic epidemics such as malaria).

The scheme needs to be improved in several ways, however, in order to enhance its effectiveness, improve its efficiency and improve the quality of services received by its beneficiaries/clients. There are several problems that need to be addressed immediately by the *DinKes*, the *Bapel* and health providers.

If these problems are not rectified, they could hinder the effectiveness of JPK-Gakin in delivering its service to its members/clients:

- There seems to be a lack of efficiency in the management of JPK-Gakin funds by health providers (especially at RSUD). Claims were approved with little verification and inspection to ensure that they were accurate and there are indications that most of the funds were used to subsidize the care of non-poor patients rather than the poor ones who were supposed to benefit (see below). Making the scheme better targeted towards the poor should become the government's priority if the goal of the program to make health services more accessible to the poor is to be realized.

- There appear to be a number of formal and informal barriers that have the effect of discouraging some *Gakin* members from using the services to which they are entitled. These include high transportation costs, the delay in the distribution of their membership card, etc. Such barriers might discourage the poor from using JPK-Gakin services, and combined with the existing perception about the quality of government-provided health facilities, could make many JPK-Gakin members reluctant to seek treatment in these facilities.

- The low utilization rate of JPK-Gakin members using the services they are entitled to results in the misallocation of *Gakin* subsidies to the supposedly better-off members, who could actually afford to pay some of their own health care costs. It is likely that most of these funds were used instead to upgrade the buildings and medical equipment of the hospital and to subsidize other hospital patients, especially those coming from upper income brackets. For instance, in Purbalingga it is estimated that 79% of the JPK-Gakin funds subsidize the health care services of non-poor at *puskesmas* and at the local public hospital (RSUD) with 87.63% of overall JPK-Gakin funds being expended on non-poor

patients. In order for the JPK-Gakin scheme to become truly pro-poor, this misallocation needs to be addressed.

- There is little involvement of non-government stakeholders, and JPK-Gakin members/clients in particular in the design, implementation and monitoring of the scheme. JPK-Gakin members are passive clients who 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.

- With the exception of East Sumba, there is no involvement of private health providers in the provision of health services for JPK-Gakin members. They are only able to seek health services in publicly managed health facilities (*puskesmas* and RSUD). The fact that most 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.

- The choice of insurance manager/carrier is also becoming more limited, with the creation of the PT Askes monopoly to manage the JPK-Gakin scheme. The decision was made by MoH without advance consultation with local governments, *Bapels* and other stakeholders, creating tensions between MoH, PT Askes, and these stakeholders that could potentially create disincentives between them to cooperate and coordinate JPK-Gakin operations.

- JPK-Gakin funding largely depends on subsidies from the fuel subsidy compensation (PKPS-BBM) scheme and from the general block grant (*Dana Alokasi Umum* – DAU) given by central government to district/local governments that largely funds the local government budget (APBD). Funding from other sources (e.g. member's premiums) only forms a small part of the program's overall funding. In the long run, this might make the scheme unsustainable as PKPS-BBM and DAU grants are reduced, creating potential disruptions in the delivery of services.

- Other than the required quarterly financial reports, there is little monitoring done by the *Bapel* and *DinKes* on the use of JPK-Gakin funds by providers. Thus, it is not known whether all the reimbursement claims made by the providers are made for services actually provided. This could provide the opportunity to misuse the funds through the submission of fraudulent claims.

- Coordination between related government agencies (*DinKes, Bapel*, and health providers) could be improved further. While in these three districts there are efforts to coordinate the operation of the JPK-Gakin scheme, the outcome has not yet been optimized and turf-battles and finger-pointing between these agencies when problems arise are still common.

Table 7 below summarizes the main findings of this study.

Table 7: Summary of the Characteristics of JPK-Gakin Programs in the Three Districts Surveyed

	East Sumba	Purbalingga	Tabanan
Program background	District-run program starting in 2003. Only available for poor citizens.	District-run program starting in 2002. Available for both *Gakin* and higher income citizens, the latter pays a premium.	District-run program starting in April 2004. Run by PT Askes. Only available for poor citizens.
Scheme manager/ carrier	Local health maintenance agency (*Bapel*). Since 1 January 2005, PT Askes manages the scheme, although the *Bapel* still run the scheme for the rural areas.	Local health maintenance agency (*Bapel*). Since 1 January 2005, PT Askes manages the scheme.	PT Askes since the scheme was introduced in April 2004.
Health providers available for scheme members	*Puskesmas*, village midwives (*bidan desa)*, district government-owned hospital (RSUD), and a private-religious hospital (there are only 2 hospitals in the district). No private doctors.	*Puskesmas*, village midwives (*bidan desa)*, and RSUD. No private doctors/hospitals.	*Puskesmas*, village midwives (*bidan desa)*, and RSUD. No private doctors/hospitals.
Role of private health providers (private doctors, hospitals, clinics, etc).	Limited. Private hospital could participate in the scheme and accept *Gakin* patients, but private doctors could not.	Non-existent. Scheme only opens for government-run *puskesmas* and hospital (RSUD).	Non-existent. Scheme only opens for government-run *puskesmas* and hospital (RSUD).
Funding sources	58.5% from central government (PKPS-BBM (oil subsidy compensation) grant), 41.5% from district's APBD (DAU block grant)	56% from district's APBD (DAU grant), 13% from the central government (PKPS-BBM grant), 28.5% from non-*Gakin* premium contributions, 2.5% from other sources (interest income, etc).	No relevant financial data were obtained.
Number of members of the JPK-Gakin scheme	129,074 poor citizens (66.55% of the district's population).	229,448 poor citizens (27.91% of the district's population), plus 263,746 non-poor citizens who joined the scheme by paying premiums.	37,791 poor citizens (9% of the district's population).
Average annual utilization rate	16.02% for *puskesmas*, 0.22% for hospitals.	38.28% for *puskesmas*, 0.12% for the RSUD.	21.75% for *puskesmas*, 0.3% for the RSUD.

	East Sumba	Purbalingga	Tabanan
Is the scheme pro-poor?	No, the RSUD receives Rp1.6 billion to treat *Gakin* patients. However, only 0.22% of eligible poor citizens that could receive free treatment at the hospital actually visited it (284 people out of 129,074 eligible *Gakins*).	No, it is estimated that 79% of the JPK-Gakin funds goes to subsidize the health care services of non-poor at *puskesmas*. At RSUD, 87.63% of the JPK-Gakin funds go to non-poor patients.	No, the RSUD receives Rp1.8 billion to treat *Gakin* patients. However, only 0.3% of eligible poor citizens that could receive free treatment at the hospital actually visited it (113 people out of 37,791 eligible *Gakins*).
Marketing and socialization	Socialization is done by the *puskesmas* staff, *bidan desa* (village midwives), and the village head and his/her assistants.	Socialization is done by the *puskesmas* staff, village midwives, and village volunteers (*kaders*) who live among the targeted community. Considered to be a more active and successful socialization campaign than the ones held by the other two districts.	Socialization is mainly through the *Kepala Dusun* (*Kelian Dinas*) The village midwife and *kader* play no role in the socialization of health insurance for the poor in Tabanan. As a result, the socialization of the Askes–*Gakin* scheme in this district appears to be rather minimal.
Members'/clients' role and involvement in the scheme's governance	Minimal, limited to lodging complaints whenever they receive unsatisfactory services. Not involved or consulted during the planning, implementation, and monitoring stages.	Minimal, limited to lodging complaints whenever they receive unsatisfactory services (and for non-poor customers, paying the premium). Not involved or consulted during the planning, implementation, and monitoring stages.	Minimal, limited to lodging complaints whenever they receive unsatisfactory services. Not involved or consulted during the planning, implementation, and monitoring stages.
Monitoring and auditing	Officially, done by the District Auditing Board (*Badan Pengawas Daerah-Bawasda*) and by *Bapel*, which in turn are supervised by Dinas Kesehatan (*DinKes*). However, in practice, extensive monitoring was not done. *Bapel* and *DinKes* just accept whatever financial reports and claims are submitted by health providers.	Officially, done by the District Auditing Board (*Badan Pengawas Daerah-Bawasda*) and by *Bapel*, which in turn are supervised by Dinas Kesehatan (*DinKes*). However, in practice, extensive monitoring was not done. *Bapel* and *DinKes* just accept whatever financial reports and claims are submitted by health providers.	Officially, done by the District Auditing Board (*Badan Pengawas Daerah-Bawasda*) and by *Bapel*, which in turn are supervised by Dinas Kesehatan (*DinKes*). However, in practice, extensive monitoring was not done. *Bapel* and *DinKes* just accept whatever financial reports and claims are submitted by health providers.

VI. POLICY RECOMMENDATIONS

To address these problems and to make the JPK-Gakin scheme work better, the following recommendations should be implemented by the government, *Bapel*, health providers and other stakeholders. We have targeted these recommendations at the local government that manages and implements the JPK-Gakin scheme, as well as the central government (Ministry of Health) that would supervise and provide policy advice to the local implementers. We have divided these recommendations into short, medium and long-term recommendations, based on our assessments of how long it would take to implement them. Most of these recommendations would be implemented by local governments, after consultation with the central government, the private sector, NGOs and, most importantly, their citizens who are the beneficiaries of the JPK-Gakin scheme.

Short-term recommendations (implemented within the next 1 year):

- Increase coordination between different government agencies, especially between *DinKes* and PT Askes in managing JPK-Gakin delivery at the local level. Coordination should be done continuously and not just be limited to formal monthly meetings and quarterly financial reports. PT Askes officials and *DinKes* officials should work closely together (perhaps in the same office) to resolve a situation or problem within the scheme immediately after it has been identified.

- Create clear guidelines on the functions, duties and responsibilities of each government agency in administering the JPK-Gakin scheme at the local level. *DinKes* (with the help of *puskesmas*, village heads and *kaders*) could be tasked with collecting updated information regularly about *Gakin* members, distributing the membership cards, and monitoring the financial management of the scheme. PT Askes would be tasked with paying out reimbursement claims of health providers; and health providers (*puskesmas* and RSUD) would provide health services to Gakin members. With such guidelines, the functions of each agencies would be clarified and turf-battles between them could be avoided.

- Eliminate formal and informal barriers for *Gakin* families to use the services to which they are entitled. This could be achieved for instance 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 groups, to ensure that the JPK-Gakin 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 JPK-Gakin members should be appropriate to their needs and should be medically necessary. For instance, the use of more expensive but not medically necessary services/treatments (such as patented drugs) should be limited by the imposition of efficiency-controlling mechanisms. Stricter monitoring procedures should be introduced to ensure that *Gakin* funds are used as efficiently as possible and that all the expended funds are actually accounted for.

- Improve the quality of services provided by *puskesmas*. Many citizens perceive *puskesmas* to have poor quality services, and thus, they are not willing to seek primary health care treatment there. Incentives to improve the quality of health service delivery at *puskesmas* should be introduced. At the same time, however, *puskesmas* should not use such incentives to increase the salaries or to pay out cash bonuses to *puskesmas* staff.

- Improve socialization/marketing techniques to recruit new JPK-Gakin members, using low-cost mass-marketing tools that would have wide credibility among prospective clients. *Kaders* might be a potential tool for such socialization purposes. Incentives could be created to make *kaders* more productive in recruiting new members. This could include a regular honorarium for *kaders* that is higher than the current financial incentives available to them.

Medium-term recommendations (implemented within one to two years):

- Reactivate *puskesmas*' activities at the village level (especially in remote districts), for instance, through reintroducing mobile health clinics (*puskesmas keliling*) or by training village level health providers (such as alternative healers (*dukun*) so that they are able to provide first-aid medical assistance to villagers in cases of more serious medical emergency when doctors and other health practitioners are absent from the *puskesmas* travelling in the *puskesmas keliling* (mobile clinic). These village providers would also be able to provide referrals to the *puskesmas* in cases where they could not treat the patients due to the seriousness of the patient's medical condition. By doing this, it is hoped that access to health facilities at the village level can be improved and that citizens do not have to seek treatment at *puskesmas* unless their conditions cannot be treated at the village level.

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

- Provide stricter monitoring (both internal and external) to ensure that the JPK-Gakin 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 an NGO/CSO, by the community or by a JPK-Gakin members' association.

- Consider including private providers (e.g. private doctors, private hospitals and health clinics) in the list of providers of the JPK-Gakin 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 reimbursement payments set close to the market rate might be necessary so that the payment would be in line with the rate charged by private providers. This might, however, require premium increases that might force some JPK-Gakin members to drop out of the scheme because they could no longer afford the premium.

- Consider ending the monopoly of PT Askes as the insurance carrier for the JPK-Gakin scheme and open the selection of insurance carrier to a competitive bidding process done by each local government. These companies would run the financial management, claims and reimbursement of the *Gakin* funds in each region, while local governments (*DinKes*) would continue to issue appropriate regulations and monitor how the program is operated. All insurance companies (both state and privately owned) should be allowed to participate in this bidding process and given a chance to manage the JPK-Gakin scheme based on their previous achievements and their ability to service their clients efficiently.

Long-term recommendations (implemented in three or more years):

- Efforts need to be taken to reduce or eliminate the dependency of the JPK-Gakin scheme on the PKPS-BBM and APBD-DAU grants to make it self-financing through premiums or other contributions from members/clients, either through increasing premiums for better-off *non-Gakin* members or by introducing new taxes to fund the scheme (e.g. by introducing local cigarette and liquor taxes). Of course, efforts need to be taken to ensure that this measure does not reduce members' access to health services they need and would not disrupt local economic activity or affect the local labor market.

- Consider charging a minimum premium rate (or co-insurance) for JPK-Gakin members, since it seems that paying *Gakin* 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. Of course, the charges imposed on *Gakin* members should be set at an appropriate minimum level so that they would not drop out from the JPK-Gakin scheme altogether due to affordability issues. This has been done in the Rembang District where *Gakin* members are required to pay a premium of Rp5,000/person/year to receive their program benefits. It has been quite successful, because the poor pay a small portion of their premium they are more inclined to monitor the service quality of their health services and to complain if they think they are receiving unsatisfactory treatment.

- Carefully study the possibility of introducing a health voucher scheme, in which poor citizens would directly control the health subsidies given to them (instead of the current scheme where the subsidies were given to health providers). This is done to minimize possible leakage of the subsidy to higher income patients and to promote accountability and improved service quality. Voucher holders could choose any health providers they feel would provide the best services available to them (both public and private providers would be allowed to treat voucher holders), so there would be competition between providers to attract the most voucher holders to their facilities and this could only be accomplished if their services are improved and more accountable. Of course, leakage could also occur in a voucher scheme if the poor voucher holders are able to sell their vouchers to those who have higher income, so steps should be taken to minimize this possibility (such as recording the names of voucher holders and assigning them a unique identification number).

APPENDICES

Appendix 1: Revenues and Expenditures of JPKM Scheme in Purbalingga District: Fiscal Year 2002-2003 (in Indonesian Rupiah)

Revenue			
Local Government Subsidies for:			
Gakin	996,902,016		
Non-*Gakin*	271,080,000		
Total Local Government Subsidies		1,267,982,016	
Central Government Subsidy (PKPS BBM)		291,417,984	
Premiums Collected from non-*Gakin* Members		645,420,000	
FY 2001/2002 Surplus		9,715,952	
Interest Income		44,715,978	
Total Revenue			**2,259,251,930**
Expenditures			
Capitation Payment to RSUD		1,033,206,000	
Capitation Payment to *Puskesmas* Outpatients		731,040,000	
Capitation Payment to *Puskesmas* In-patients		73,104,000	
Incentives for *kaders*, program coordinators, etc.		102,697,600	
Bapel Salaries and Admin Expenses		317,026,121	
Total Expenditures			**2,257,073,721**
Surplus (Revenue-Expenditures)			**2,178,209**

Appendix 2: Analysis of JPKM Funds' Benefit Distribution in Purbalingga District: Fiscal Year 2002-2003 (in Indonesian Rupiah)

Total funds available		2,259,251,930	
Funds allocated to *Gakin* members			
Local government subsidies	996,902,016		
Central government subsidies	291,417,984		
Total funds allocated to *Gakin* members		1,288,320,000	
Percentage of funds allocated to *Gakin*			**57.02%**
Funds allocated to non-*Gakin* members			
Local government subsidies	271,080,000		
Premiums paid by non-*Gakin* members	645,420,000		
Other sources of funds (interest, etc.)	54,431,930		
Total revenue funds to non-*Gakin* members		970,931,930	
Percentage of funds allocated to Non-*Gakin*			**42.98%**
Allocation of funds at *puskesmas*			
JPKM funds allocated to *puskesmas*		804,144,000	
Average monthly allocations to *puskesmas*		67,012,000	
Average number of *puskesmas* visitors/month	30,614		
Average number of *Gakin puskesmas* visitors/month	6,404		
Average number of non-*Gakin puskesmas* visitors/month	24,210		
Average funds allocated to *Gakin* patients/month		14,017,928	
Percentage of *puskesmas* funds allocated to *Gakin* patients			**20.92%**
Average funds allocated to non-*Gakin* patients/month		52,994,072	
Percentage of *puskesmas* funds allocated to Non-*Gakin* patients			**79.08%**
Allocation of funds at RSUD			
JPKM funds allocated to RSUD		1,033,206,000	
Average monthly allocations to RSUD		86,100,500	
Average number of RSUD visitors/month	97		
Average number of *Gakin* RSUD visitors/month	12		
Average number of non-*Gakin* RSUD visitors/month	85		
Average funds allocated to *Gakin* patients/month		10,651,608	
Percentage of RSUD funds allocated to *Gakin* patients			**12.37%**
Average funds allocated to non-*Gakin* patients/month		75,448,892	
Percentage of RSUD funds allocated to Non-*Gakin* patients			**87.63%**

Appendix 3: Revenues and Expenditures of the JPK-Gakin in East Sumba District: Fiscal Year 2003-2004 (in Indonesian Rupiah)

Fiscal Year 2003 Revenue				
Central government subsidies				
Basic health care delivery	2,163,000,000			
Referral to hospital	450,000,000			
Medicine distribution	27,470,000			
Other expenditures	25,000,000			
Total central government subsidies		2,665,470,000		
Local government subsidies				
Purchase of medicine	1,500,000,000			
Premium payment for *Gakin*	392,000,000			
Total local government subsidies		1,892,000,000		
Total revenue for Fiscal Year 2003			**4,557,470,000**	
Fiscal Year 2004 Revenue (until August 2004)				
Central government subsidies				
Basic health care delivery	1,071,583,000			
Referral to hospital	688,777,000			
Total central government subsidies		1,760,360,000		
Local government subsidies				
Medicine purchase and premium	2,000,000,000			
Other subsidies	81,520,000			
Total local government subsidies		2,081,520,000		
Total revenue for Fiscal Year 2004 (until August 2004)			**3,841,880,000**	
Interest income (until June 2004)			60,143,049	
Total combined revenue Fiscal Years 2003 and 2004				**8,459,493,049**
Expenditures (Fiscal Years 2003 and 2004)				
Outpatient treatment at *puskesmas*		1,548,888,000		
In-patient treatment at *puskesmas*		114,112,500		
In-patient treatment at hospitals		1,634,327,560		
Bapel management fee (5%)		218,668,000		
Medicine purchase		1,778,017,430		
Medicine distribution		4,120,500		
Claim validation and verification		81,520,000		
Other expenditures		25,000,000		
Total Expenditures				**5,404,653,990**
Surplus (Revenue-Expenditure)				**3,054,839,059**