Politics of National Health Insurance of Indonesia: A New Era of Universal Coverage

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1. Introduction

Health status of the Indonesian people has improved significantly but slowly over the last two decades. Many factors affected the slow improvement of health status in Indonesia such as: low education, low income, difficult geographical access, cultural barriers, and low health expenditures. The World Health Report 2000, albeit of criticisms over the methodology and the data used, clearly assumes that health care financing is the most important element in the achievement of health improvement. The level of health care expenditures affects the availability of human resources, medical supplies, distribution of health care facilities, quality of health services, and other important process of health care delivery. Therefore, many studies uncover a strong relationship between health status of a population and health care financing. Data from the WHO 2000 Report shows clearly that health care expenditures, both in terms of nominal amount and in term of percentage of gross domestic product, are lower in developing countries than those in developed countries.

As a developing country recently hit by a severe financial crisis, Indonesia is struggling to finance health care, especially for the poor. At the same time, Indonesia is undertaking a massive government reform by decentralizing almost all authorities to regional governments—except fiscal, national security, foreign policy, and religious affairs. The crisis and the decentralization of authority have raised awareness and concerns over a sustainable health care financing in Indonesia. It is critical to review how current health care system affects the infant mortality rate or access to health services. Additionally, health care financing through health insurance schemes will be reviewed to identify problems and potentials for reforms. Finally, this paper will present current initiatives for the National Health Insurance program in Indonesia.

2. Current Health Care System

Indonesian health care system had been identified as an entrepreneurial system by Roemer (1993)[1] and it is partially financed and delivered through public health care facilities consisting of health centers and public hospitals. Health centers provide various public health

and primary health care to a defined community, usually a sub-district level. Health centers are the front lines for providing various public health programs ranging from health promotion, immunization, sanitation, etc and primary health care services to the community. A health center is normally headed by a newly graduate medical doctor (general practitioner) mandating to serve 1-3 years to the community before s/he could become a specialist.

The availability of public health centers (stationary, mobile, and sub health center) and low user fees make access to primary health services is quite good for all income levels of the community (Thabrany 2001)[2]. Although it is a public facility, people must pay user charges in the health center. In some provinces or districts, the user charges for certain services sometimes quite high, relative to the income of the community. Otherwise, the user charges are considered very low that everybody could afford. The better off who demand better services may visit private services of the same doctor in the afternoon and pay higher fees. One important factor for equitable access to primary health services is the proximity of those services to the population. The Indonesian health policy mandates local government to build one health center for every 30,000 inhabitants and one sub-health center for every 10,000 inhabitants. A public health center has staff of at least one physician (general practitioner), several nurses and midwives, other health related personnel and administrative staff. A sub health center has at least one nurse or a midwife plus few administrative staff to provide a very basic health services to the community. There are currently more than 7,000 health centers and more than 21,000 sub health centers throughout Indonesia.[3]

Public hospitals, providing secondary and tertiary care, consist of four types: (1) type D hospitals (less than 50 beds with four specialists: an internist, an ob-gyn, a surgeon, and a pediatrician) provide basic secondary care at district level, (2) type C hospitals (50-100 beds with more than four types of specialists) serve secondary and tertiary care for a larger district, (3) type B hospital (between 100-400 beds with variety of specialists) providing referral care of more advances at provincial level, and (4) type A hospital (up to 1,500 beds) designed to provide top (national) referral care. Users of public health care facilities are charged based on the number of services they received (subsidized fees for services system). The user charges at health centers and at third class room of public hospitals are heavily subsidized (about 50-80% of the user fees are subsidized indirectly through publicly set fees). Since subsidies are given to the supply side, the target population receiving subsidies have been normally inappropriate.

The poorest populations have not received subsidies as much as the subsidies

received by the middle income because naturally the poor often did not go to have health services fearing of unaffordable fees. As a result, there is great inequity in access – especially to public hospital services, not to mention to private hospitals. Additional barriers such as geographical (distance) and cultural (education and beliefs) remain significant factors for hospital services. Figure-4 shows large gaps in access to inpatient care in public hospitals between the poor and the wealthy (Thabrany, 2001). The richest 10% of the population had more than 400 hospital days per 1,000 people and members of Askes and Jamsostek (insured) had more than 500 hospital days per 1,000 people, higher than those of non-insured. On the other hand, the poorest 10% of the population and uninsured had less than 100 bed days per 1,000 people. The gaps between the poor and the rich among Askes members remain high because the benefits are inadequate that pushed members to pay uncovered charges and the distant factors where low-income insured live far from public hospitals. Many studies uncovered that insured civil servants before the year 2000 ought to pay up to 80% of the hospital costs and drugs (Trisnantoro et al. 2000[4]; Thabrany 2001[5]). However, currently Askes (the insurance carrier for civil servants and their families) pay much more reasonable prices to the public hospitals as Askes receiving higher revenues from 2% contribution of higher basic salary of civil servants. In several public hospitals, civil servants are currently exempted from cost sharing except for few expensive procedures.

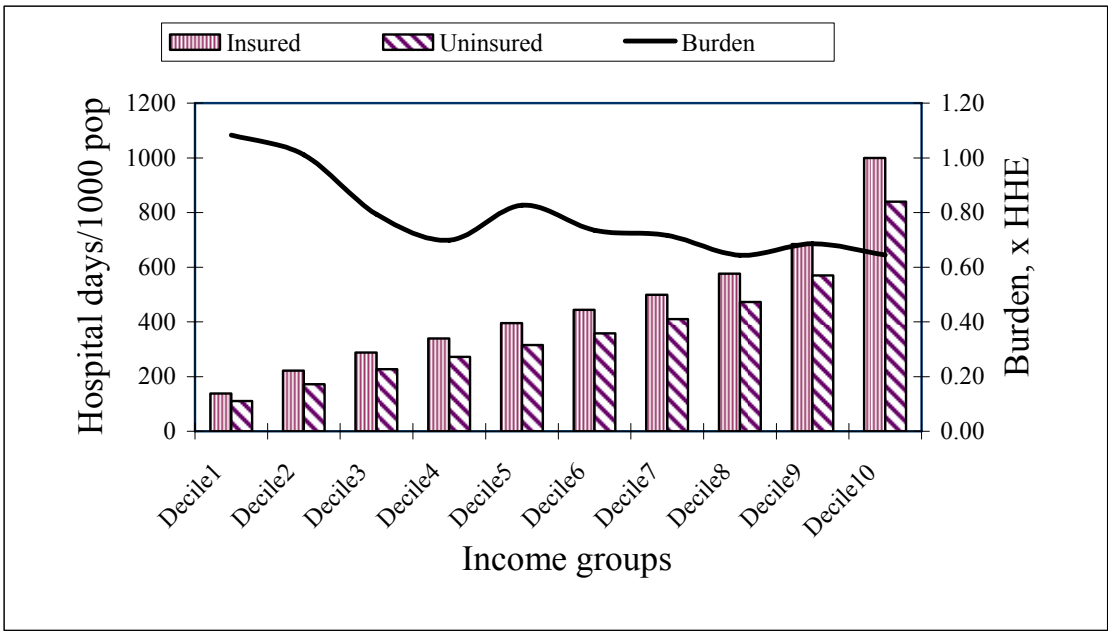
Doctors working at health centers and public hospitals are public servants receiving low basic salary. To supplement the doctors' income, they are allowed to have private practice in the evening. Nurses and midwives are officially not given such privileges. However, in practice, they (especially in small cities or districts) also have private practice. In addition to public hospitals and health centers, about 40% of hospital beds are provided by private hospitals. The charges in private practice of the same doctors can range from 3 to 10 times higher than in public health care facilities. In private practice, doctors, nurses or midwives often provide brand name drugs (perceived as much better quality by the community than the drugs provided in the public facilities) and charge the patients a single price. Frequently the doctors tell the patients that the drugs provided in health centers are not good, generating higher demand for services in the private practice.

The dichotomous of public and private facilities has been generally accepted as an appropriate way to accommodate the freedom of choice of providers. The government had been (for long time) believed that the system work well to ensure equitable health care. However, a closer look of health seeking behavior revealed that the system is too regressive

and inefficient. Public hospitals received more government subsidies that health centers but the public hospital services are consumed more by the better off than by the poor. The poor normally lived in remote areas or far from the public facilities and where transportation often not available or costly. Figure-1 illustrates how the current health care system in Indonesia is regressive. The figure indicates that inpatient days per 1.000-population of the poorest were much lower compared to those of the richest. On the other hand, the poorest have much higher burden to pay hospital charges as measured by a ration of hospital charges to monthly household expenditure. The poorest (decile-1) ought to pay hospital charge for a single hospital care episode more than one month normal household expenditure (as proxy of income). The figure indicates that once there is a need for inpatient care, an Indonesian household could go bankrupt because of the very high burden of health care. This condition had been prevalent during the beginning of financial crisis in 1999-2000.

Figure 1.

Inpatient days and ratios of inpatient costs to household income by income groups and insurance status, analyzed from 1998 National Survey Data



The After the crisis, there have been strong initiatives to reform health care system in Indonesia. One of the significant reforms is the introduction of Healthy Paradigm introduced by the Minister of Health, Professor Moeloek, and signed by President Habibie in 1999. The

Ministry of Health set four pillars to achieve Healthy Indonesia 2010, a goal to move toward healthy environment and universal coverage. The four pillars are: moving to Healthy Paradigm, professionalism, development of health insurance, and decentralization of health services.[6]

The law of regional autonomy, including health sector, has been implemented nationwide since January 2001. While decentralization provides faster response and more appropriate policy, there are some disadvantages of decentralization of health services. Under the law of regional autonomy, local governments are responsible for providing health services in districts. Many local governments perceive that hospital services could be utilized to generate income. On the other hand some rich districts are planning to provide health services for free. Decentralization could end up with regional inequities in health care. There are transformations of public hospitals into state owned companies (BUMN Perjan) or local government owned companies (BUMD) or even a transfer of shares from public hospital to employees of the public hospitals in Jakarta. The perception among directors of the transformed hospitals has been that they have to be financially independent from the government leading to raise charges. Clearly this transformation paved the way to increasing inequity in health care financing in Indonesia.

The transformation of hospitals and health centers in several provinces into state or local government companies is, to certain degree, as a response of the recommendation made many national and international consultants to government to spend less for health care. The recommendation has been too much emphasis on the burden of government subsidies, without adequate consideration of the equity. On the other hand, many developed and developing countries are working hard to establish universal coverage to ensure equity in health care. South Korea, Mexico, Thailand, and the Philippines for example are moving toward expansion of insurance through the establishment of national health insurance.

The government health expenditure has been stagnant for the past two decades and now is moving away from equity. The government health expenditures have been stagnant at the level below S$ 4 per capita per year. The central government budgets normally cover about 80% of the total public spending on health in provinces and districts. This data suggest that compared to the increasing risks of the more expensive and chronic illnesses, funding for health from the government has been diminishing. In addition, out of pocket health expenditures by households have been also stable at the rate of below 3% of the total household expenditures. Health expenditure data show that health care financing in

Indonesia is severely underfunded, far below health care financing in the neighboring countries. Even if it is compared with county of similar or lower per capita gross domestic product such as Vietnam and India, Indonesia spent much less, as presented in Table 1.[7]

Table 1: Health Care Financing in Selected Countries in Asia, 2005

Countries	PCHE at exchange rate (US$)	PCHE in international dollars (US$)	THE as % of GDP (%)	Public share of THE (%)
Indonesia				
Vietnam				
India				
Philippines				
Thailand				

Source: WHO/WHOSIS
PCHE= Per Capita Health Expenditure; THE = Total Health Expenditure. GDP = Gross Domestic Product.

Financing for the poor, and the vulnerable groups such as pregnant mothers, children under five years of age, and the elderly is severely inadequate. After the crisis and the social safety net programs terminated, there is no sustainable system currently in place. Many policy makers are worry about the impact of severe reduction in access to health services in the year 2004 and beyond. The government is introducing a temporary solution by switching small portion of money for oil subsidy to subsidize health care for the poor. But this subsidy in temporary in nature and the amount is relatively small, about S $ 20 per family per year.

Table 2:

Central Government Per Capita Health Spending Fiscal Year 1979/1980 to FY 2002

Fiscal Year	Per Capita (Rupiah)	% Increase	Per Capita (US $)[a)]	% Increased in $
1979/1980	368	-	0.58	-
1980/1981	822	123.4	1.30	124.1
1981/1982	h901	9.6	1.41	8.5
1982/1983	909	0.9	1.36	-3.5
1983/1984	916	0.8	1.02	-25.0
1984/1985	1,210	32.1	1.17	14.7
1985/1986	1,492	23.3	1.34	14.5
1986/1987	850	-43.0	0.66	-50.7
1987/1988	767	-9.8	0.46	-30.3
1988/1989	1,055	37.5	0.62	34.8
1989/1990	1,311	24.3	0.74	19.4
1990/1991	2,275	73.5	1.23	66.2
1991/1992	3,048	34.0	1.56	26.8
1992/1993	3,946	29.5	1.94	24.4
1993/1994	4,296	8.9	2.05	5.7
1994/1995	4,680	8.9	2.12	3.4
1995/1996	5,277	12.8	2.29	8.0
1996/1997	5,845	10.8	2.45	7.0
1997/1998	6,343	8.5	1.11	-54.7
1998/1999	11,575	82.5	1.43	28.8
1999/2000	17,832	54.1	2.49	74.1
2000	13,776	-22.7	1.47	-41.0
2001	13,513	-1.9	1.29	-12.2
Average	**4,479**	**22.6**	**1.40**	**11.0**
Minimum	368	-43.0	0.46	-54.7
Maximum	17,832	123.4	2.49	124.1

a) At average exchange rates of the same year
b) Source. Thabrany, et al. 2002

Health insurance for Indonesian is available from various sources. The oldest and largest health insurance scheme is the civil servant health insurance (Askes) established in 1968. This social health insurance covers all civil servants, retired civil servants, retired military personnel, veterans, and their families. The premium is two percent of monthly basic salary or pension that is deducted automatically by the payroll offices. The benefit is comprehensive and in kind provided in public health facilities, but high cost sharing applies. The second largest health insurance scheme is the social security scheme for private employees (Jamsostek). In theory, this scheme should cover all private employees, but the regulation was diverted to allow opt-out provision. Unlike the Askes, Jamsostek started in 1992 after the law of Social Security was passed. The opt out provision of Jamsostek allows

private insurance companies to sell various types of health insurance products such as indemnity insurance, service benefits, and managed products. In addition, since 1992 the Ministry of Health has been promoting JPKM bapels (Indonesian version of health maintenance organizations) as non-insurance companies selling HMO products. At present there are 67 insurance companies and 22 licensed JPKM bapels selling health insurance in Indonesia.

Health insurance coverage has been very low in Indonesia. A reliable source of health insurance coverage is the National Social and Economic Survey (Susenas) conducted annually by the Bureau of Census in Indonesia. The Susenas data of 1998 showed that only 14% of the population had health insurance of any types.[8] The Susenas 2001 showed that 20% of the population had health insurance, but 6% of the population had health insurance from the government social safety net program for the poor. About eight percent of those insured are covered by Askes; a state owned company that administers compulsory health insurance for civil servants and their families. Jamsostek, another state owned company that administer social security schemes, covers less than 1.5% of the population (the potential of this scheme is about 40-50% of the population). The low health insurance coverage by Jamsostek is mainly attributed to the "opt out" provision in the Government regulation number 14/1993. Other private insurance companies and JPKM (*Jaminan Pemeliharaan Kesehatan Masyarakat,* HMO-type managed care) bapels cover the remainder of the insured. Efforts to expand JPKM to mobilize health care financing from the private sector were totally failed due to incompatibility of the market with the US health care market. For more than a decade the proportion of Indonesians who have health insurance remained relatively stable. In 1990 data published by the World Bank gave the proportion of the population with health insurance as 13% (World Bank, 1993). However, the absolute number of population covered has increased by almost ten million in the last decade due to the population increase. So the growth of health insurance coverage is about the growth of the population. Most of the growth of health insurance coverage occurred in the last two years. After the economic crisis, the growth of private health insurance coverage increased sharply due to increasing health care costs in the private sector. The commercial HMO sold by PT Askes currently covered 1.3 million people while the number of people insured by other insurance companies in 2003 reached almost five million.[9] An employer survey found that 82% of employers having 20 or more employees in Indonesia provide various kinds of health benefits, including purchasing private health insurance for their employees.[10]

3. Health Insurance Reform

The above conditions create high pressures to the government to establish equitable health care financing system(s). The President has established a Task Force to design and to develop a Law on National Social Security Scheme covering health insurance, workers' compensation, provident fund, pension scheme, and death benefit. The Bill is currently in a final stage at the Parliament. It is scheduled to be enacted on September 14th, 2004. To meet the goal of universal coverage and to ensure fairness in health care financing, the opt-out provision of current health benefit program of current Social Security law will not be provided. By abolishing opt-out provision the number of insured in five years will soon cover about 100 million or almost 50% of the population. In addition, to be consistent with the goal of maximizing benefits to members the legal status of PT Persero--for-profit oriented, of PT Askes and PT Jamsostek will be transformed into a not-for profit Public Corporation. A National Health Insurance will be established using the existing assets of PT Askes and PT Jamsostek. The government will pay contribution for the poor. Until all employees are covered, those who work in informal sector may join the scheme on a voluntary basis.

Three designs of Social Health Insurance Systems have been proposed. The first one is proposed by the Task Force for National Social Security that integrates National Health Insurance with other social security programs. The Task Force was established by a Presidential Decree to meet the Constitution Obligation (article 34 item 2) to establish a social security for all citizens. The second design was a proposal of compulsory health insurance with multiple HMOs proposed by the Ministry of Health. Under this scheme, all people are mandated to contribute to a selected bapel. The bapel must have a license by the MoH after meeting certain capital requirement.[11] This concept is actually promoting the business of managed care (known as JPKM). The third design is a National Social Health Insurance Scheme proposed by the Parliament. The content of the Parliament Bill on National Social Health Insurance is very similar with the concept of the Task Force except that the Parliament initiative allows the Single Health Insurance Carrier to offer integrated supplemental benefits.

The National Health Insurance (NHI) design has taken consideration of the fact that Indonesia is a very large country with 210 million people scattered in about 7,000 islands. The labor force is estimated at about 101 million people in 2004. The labor force distribution is 36.2% are salaried workers, 51.9% are self-employed, 3.4% employers, and 8.5% family workers.[12] The self-employed are farmers, individual retailers, and very few self-employed professionals. With only one-third of labor force is in formal sector (salaried workers) it is not easy to mobilize financial resources to finance health care for the entire population in a short period of time. In addition, income per capita of Indonesians is relatively low (at US$ 1,000 at official exchange rates or about $ 2.800 in international dollars). The low per capita income significantly affects household expenditures in Indonesia. The National Socio-Economic Surveys showed that between 50-70% of household expenditures in 1995 to 2000 were for foods.

The NHI relies heavily on contribution from employees, employers and the government. The NHI must start from formal sectors without "opting-out" provision, to allow higher income share the risk with low-income workers. There are problems in determining and collecting contributions from those who work temporarily, self-employed, or seasonal workers. Many of temporary and seasonal workers work without contract binding and they are paid daily or weekly by employers. Employers often did not count them as employees. Therefore, for efficient and effective administration these groups will first be covered through traditional supply-side subsidies. The universal coverage through NHI must be implemented gradually in accordance with the administrative capacity of the NHI and the social and economic conditions of the country. In addition, the scope of health services covered may be limited in accordance with the level of income and the feasibility in collecting contributions from employees and employers.

For those people in low income but in salaried jobs, they will join the system with relatively low effect on their daily consumption. Even if the employees of low wages must contribute half of the contribution of 6% salary for health insurance, it may not affect their normal consumption significantly. However, if the total employee contributions for various social security programs are above 15% of their wages, the low salaried employees' may confront with significant problems in their daily life.

The grand design of the National Social Security System can be described as follows:

1. All salaried workers, and pensioners in the public and the private sector, up to certain salary cap, are mandated to join the NHI. There will the same level of

contribution for singles and married employees to simplify administration and to strengthen the social solidarity principle. Within the first five years, the compulsory scheme must be imposed to those employers with ten or more employees, regardless of the legal status of employers. A for profit corporation, a private hospital, a government unit, a non-government organization, a university etc. are mandated to join the NHI. Expansion of membership will be enforced gradually to include employers with one or more employees by the tenth year of the implementation. Non formal sector who have adequate disposable income may join the scheme on voluntary basis during the first ten years of the implementation. The level of contribution for the non formal sector will be calculated and will be determined on a nominal amount varies according to estimated average income of various non-formal sectors' economy.

2. Those who are not satisfied with the benefits provided by the NHI may purchase supplemental health insurance from private insurance companies or pay directly to providers for price differences in hospital. But they are not allowed to completely opt out from the NHI. Their entitlement of benefits from the compulsory scheme can be coordinated with a private health insurance scheme they purchase.
3. Self-employed professionals such as physicians, lawyers, insurance brokers, insurance agents, etc. are mandated to join the NHI. The contributions level will be calculated by the Board of the NSS and paid directly by the professionals on monthly basis.
4. It is expected that the members of the compulsory scheme are automatically expanding as formal employment picks up more people. This process is expected to take 20-30 years.
5. The poor and marginally poor (low-income) in the non-salaried workers will be provided with subsidized premiums from the government and subject to means test. This group can be divided into two sub groups:
    a. The very poor will receive financial assistance by receiving membership in the NHI for free (100% subsidy for contribution). The local governments are responsible for identification of the poor by a means test developed nationally and adjusted locally. These people could be covered right away as the continuation of the existing social safety net programs

that has been in place for five years.

b. The low-income non-salaried (self employed) but do not pass the means test (marginally poor) will still cannot afford to pay expensive medical care. This group has not been systematically planned to join the NHI. This group must be provided with financial assistance for inpatient care and surgical procedures but this group could afford to pay out patient care. The government should ensure the access to expensive health care by providing subsidized health care in public hospitals or in third class private hospitals. However, they are free to join in the early stage on voluntary basis.

6. During the first five year of NHI implementation, those who are not in the low-income group of non-salaried workers may pay health care out-of-pocket in public or private providers depending on their income or they may voluntarily join the compulsory scheme or purchase individual health insurance from private health insurance companies.

3.1. The Political Process

In 2000, I chaired a team at the University of Indonesia to review Indonesian health insurance systems and the social security systems under research grants from the National Planning Board (Bappenas) and the Office of Coordinating Ministry of Economic Affairs). The review basically indicated several flaws of the Indonesian social security/insurance systems and the threats of future social problems unless a reform is made. At the same time, several international agencies warned the Indonesian Government that social reforms and social protections system ought to be undertaken to prevent future social unrests. In 2001, the Vice President, at that time was Mrs. Megawati order her secretary to establish a team to review and to reform social security system. When she became the fifth President of Indonesia, then in 2002 she issued a Presidential Decree establish a Task Force to reform and design a National Social Security System. In August 2002, the House of Representative (MPR) passed the Fourth Amendment of the Constitution inserting Article 34 item 2 stating "The state shall establish a national social security system for all citizens.." The Task Force consists of about 60 members representing various Ministries, existing social security/social insurance corporations, and other relevant organizations. Despite of the expectation that an assurance that various views and concepts can be incorporated, the large number of the Task Force faced difficulties in making a uniform concept. The Task Force was expected to

finalize an Academic Paper and a Bill of National Social Security by early 2003 to allow about one to one and half year process in the Parliament. However, during the Task Force tenure, four key members passed away resulting in the delay of the concept. After a lengthy debates and the time became more limited, finally in December 2003 the Task Force was revised to be consisted of only 19 members. The Task Force made the final Bill early 2004 and the President submitted the Bill on January 26, 2004.

In Indonesian legislation system, a Bill can also be proposed by the Parliament (the Initiative rights). When the Parliament initiate a Bill, a plenary session of the Parliament must pass the Bill. Then the Chairperson of the Parliament sends the Bill to the President to have a partner from the Government site (usually a relevant Minister) to discuss and to finalize the Bill.

During the policy and concept development of a Bill (both the Government and the Parliament initiative) stakeholders (represented by labor organizations, employers associations, business associations, local governments, and other stakeholders) were invited to contribute to the Academic Paper and the draft Bill. Several international agencies such as German Technical Assistance (GTZ), European Unions, the Asian Development Bank, the International Labour Organization, and the World Health Organization Representative Office in Indonesia provided with experts and grants.

During the solicitation of the concept, the Task Force conducted regional workshops to ensure appropriate inputs from stakeholders could be accommodated. In each regional workshop, local governments, local parliament members, employee associations, employer associations, non-government organizations, and other stakeholders were invited. The workshops were organized in a two-day presentation and discussion of the concept. The regional workshops did not attract extreme oppositions or supports, since the workshops were aimed at soliciting ideas, concepts, and concerns. However, during the National Workshops with special employer and employee associations, resistances came out. Event during the process in the Parliament, demos to reject the Bill have been made by Employer and Employee Associations. In addition to formal workshops, that are costly, socializations and solicitations of the concepts and ideas were also made through media.

The International Business Chamber of Commerce, claiming of having representatives from various major investor countries such as the United Kingdom, the USA, the Australia, etc, frequently voiced their oppositions to the Bill. A USAID consultant sent his analysis of the impact of his perception of the Bill to the Indonesian economy,

threatening the Government that a massive lay off (equivalent to one percent decrease in GDP) will be experienced by Indonesia if such Bill be passed and implemented. In addition, USAID sponsored workshops were organized in Jakarta to show that the Bill would discourage investments in Indonesia.

In addition, fearing that the Bill will change the status and the operation of existing social insurance carriers, two (of four) existing carriers silently and openly opposed the Bill. Even the Minister of Labor initially opposed the Bill, perceiving that the Bill would put higher burden to workers and fearing that he could lose control over the existing social security carrier administering social security system for private employees. During the discussion process, many breaks were imposed to lobby parties to solve oppositions. The oppositions stem from the following aspects.

- **Mandatory system.** It is surprising that employer associations, business chambers, and even several government officials rejected the mandatory element of the social security. Many of them understood that a mandatory system would violate human rights and would result in a poor management system. Rejection of this aspect represent poor understanding of social security or social insurance concepts, as alternatives to the market failures in areas of health insurance and social protection. The market (based on voluntary transaction) fails to protect every body in a country because all people are short-sighted to their future risks. As a result, they will never voluntarily prepare adequate funds to meet their basic living needs, including basic incomes, health care, and survivors' income. Therefore, in all developed countries such mandatory systems have been implemented as also mandatory taxes for incomes of a country.
- **Integration of the social security systems**. The current SS systems are organized based on combination of the employment and the programs. The SS for private employees and for military personnel are administered by Jamsostek covering four programs. Meanwhile, the SS for civil servants is administered by two different programs: health care and old-age benefits by two different carriers (Askes and Taspen). The initial proposal of the National SS system in Indonesia would be organized under one roof with two administrators: one to organize short-term benefits such as health care and worker' compensation and the other to organize long-term benefits of old-age and death benefits. This integration later faced very tough resistances from two existing carriers, namely Taspen and Jamsostek causing delays

in submitting the Bill. Later, a compromise proposal to establish just a Council for the National SS will be established to harmonize and synchronize the administration of the existing diverse SS systems. Many players still perceived that the current design would still lead to a way of integrating the existing systems.

- **Monopolistic/government control system.** Consultants of the USAID and the private sectors have the same views that even if SS including SHI would be implemented, they oppose monopolistic system. They advocate that the NSS would mandate employers and employees, including self-employed, to participate but the administration of the system should be left to the private sectors such as fund managers to administer pension plans. Of course such private management would stimulate the growth of private businesses. However, there is no evidence that this private management would result in better and secure benefits for the people. On the other hand, private management of SS has never been fully implemented in developed and developing countries. On paper, this privately managed SS sounds attractive. But, private sector management would never guarantee that all citizens could be protected to meet their basic living needs. The Law finally approved monopolistic otherwise an oligopoly system
- **Shared contribution.** Employees are interested to contribute less. Under the current SS system, civil servants must contribute all (fully contributory) of SHI while private employees contribute nothing (non contributory). The Bill prescribes shared contribution between employers (including government as an employer for civil servants) and employees. Employees in the private sector who have been in non-contributory system strongly oppose the Bill. The Minister of Labor who was a chairman of a National Union even threat to boycott the Bill if the Parliament approved an equal contribution by employers and employees. Discussions and explanations of the concept along with improvement of benefits that require more contributions did not work, due to rigid stands of employee and employer association.
- **Levels of contribution.** Employers are very anxious to know how much contributions will be mandated to them. Many of them tried to estimate based on their own calculations and oppose the Bill fearing that they would face financial difficulties. They link this Bill to another Law just passed in 2003 (Labor Law) that mandates employers to pay a separation payment once a lay off being made. They

came with an estimate of 27% contribution for five SS programs, shared by employees and employers. Coupled with corporate income tax that on average could reach 30% of profits, they reject this Bill. Actually, the Task Force once made some estimate that in a later stage, after 15-20 years, the final contribution level would reach such level for five different programs. The level of such contribution still below current old-age contribution level of 36% in Singapore, much below current contribution levels of many European SS system and will be about contribution level in Malaysia that is 23% for provident fund only. Until the Act was passed, the level of contribution has not been determined. The Task Force will implement gradual rise of contribution of the existing 12.7% total contribution.

3.2. After The Passage of the Act

The NSSS Act was expected to boost previous Megawati position, the incumbent President, to run for the second term. She was actually very keen to see a sound social security system runs in Indonesia. However, she failed to win the second term. At the last date of her stay in the palace, she signed the Act by inviting all relevant ministers. This was the first time in Indonesian history that a President signing an Act by inviting many ministries with a special ceremony. By doing that, she would like to tell the Indonesian people "I produced this Act as a gift for you".

The following day, the new President, Susilo Bambang Yudoyono entered the Palace. Three days after swearing or taking on oath for his cabinet, the Minister of Health, Mrs Siti Fadillah Supari, a cardiologist, without knowing the NSSS Act was signed few days before, announced that she would provide free inpatient care at 3rd class room of public hospitals. However, some technical problems occurred. Almost all of about 700 public hospitals, except about 30s, are under the jurisdiction of local governments. The Minister has no power to control or to directly finance local government hospitals. The President Director of Askes, Mrs. Orie Andari, by chance paid a visit to Her Excellency Minister of Health, and discussion came into agreement to conduct the political interest using the new Act that was signed a week ago. The Minister then invited about ten public health experts, including myself to discuss the solution of political interest of providing free hospital care. At the meeting it was agreed to use the NSSS Act as the legal basis. The Ministry of Health would pay Askes a contribution of Rp 5,000 (about 60 cent US$ or about International $2) per person per month. The benefits are very comprehensive, including haemodyalisis, open heart surgery, cancer treatment, and unlimited length of stay. However, one should notes that the payment to public providers is actually is as additional to the partial funding. Health centers and public hospitals are also funded by local governments for basic salary, investment, and some also receive operational costs. The benefits and the provision of benefits are administered integrated with the existing SHI for civil servants, except the payment level is different and the scheme is administered under a special account. This program was later given a nickname "Askeskin".

Askes is the SHI carrier for civil servants and their families, including pensioners of government employees for 40 years. It has regional and branch offices in all 33 provinces and more than half of about 450 districts/cities. The NSSS law spell out clearly that Askes is a designated carrier to administer a social security program. Before the passage of the NSSS

law, several HMO types commercial health insurance were established by the MOH (previous minister) to develop managed care products (in contradiction) to the poor. The MOH gave some funds to cover the poor with the expectation that the HMO (called JPKM) could later develop and sell the products to the non poor. One month after the implementation of Askeskin, those HMOs (representing by HMO in Rembang district) and the association of HMOs (Perbapel) influenced the East Java pronvincial legislature (called DPRD) to take the NSSS law to Constitutional Court, the court established to examine whether a law in contradiction with constitution. The main objective of the "law suite" is dismiss designation of Askes as the administrator of Askeskin noting that this article (article number 5 item 3 of the NSSS law) is monopolistic and against decentralization article in the Indonesian Constitution. After six months debates and examination, in which I provided testimony for the Government, the Court decided that the NSSS law is general is in line with the Constitution. The appeal by the HMOs (JPKM) and the Association of HMOs (called Perbapel) were rejected by not having legal standing. It means that the two organizations, that submitted the appeal, are legally not recognized, because there is no legal basis or law that supports the establishment of HMOs in Indonesia. The MoH decree providing license has been challenged for more than 10 years, because there was no insurance law authorizing MoH to provide license to sell HMO/insurance products in Indonesia. This was the first political challenge to the implementation of NHIP in Indonesia.

During the first two years of implementation, critics and bad news were continued to be thrown by those who oppose Askeskin. Some public health activists, academicians, politicians, and even international NGOs accused the MoH of running wasting program absorbing about 1,5% of the National budget for providing curative care. Many critics came on inappropriate means testing instruments. Some others claimed that the services provided by hospitals under Askeskin contract were in poor quality because the program was underfunded and the payments to public hospitals were too low. Surprisingly, in the third year, about 120 private hospital signed contract with Askes to accept the level of payment to serve the poor. It is a simple calculation of marginal costs equal marginal revenues. Since private hospitals already spending fixed costs to serve the non poor, serving the poor was just adding small incremental costs. During hearing of MoH with Parliaments, criticisms and supports from difference party leaders emerged during the first three years of implementation of Askeskin. At the first and second year, all the funds channeled to Askes as contribution for the poor were surpluses. As guided by the assignment of the MoH to Askes, the surpluses ought to be carried out to the following year. The surpluses were due to not all eligible poor were enrolled, the trust were not grown among the poor, and some other factos.

At the second semester of the third year, as the program becoming more mature, the MoH had shortage of the fund because of misallocation. Taking lessons from the first two years that there were surpluses, and then the MoH allocated some funds for infrastructure development of local public hospitals. As the result, fund for Askeskin program was reduced and delayed. Hospital claims were not paid and delayed more than three months. A lot of statements of Directors of hospitals and association of hospitals were in the news. Many television channels broadcasted problems of Askeskin program. Some hospitals already rejected serving the poor because the previous claims had not been paid. At this time, several high official at the MoH started to throw issues that management of Askes was corrupt and the fund was invested in banks to get interests resulting in delay of claim payments. Parliaments conducted hearings to many stakeholders, academicians, and NGOs. The war on accusing one another was inevitable. As one of the Task Force member, I was so desperate that this misconduct will result of losing the public trust on Askes, as a designated carrier for the NHIP. Fund in the MoH had not been added until the end of the third year. Many poor

people were rejected from care by many hospitals, despite of a strong consensus among the association of local public hospital (ARSADA) to keep serving the poor to its members.

At the beginning of the fourth year, 2008, the MoH announced that it would break contract with Askes. Before that, the Minister of Health, Mrs Supari, received countless short messages via her hand phone (from various sources blaming that Askes was not doing well, or claiming that hospitals could not run because of the claims had not been paid, or stating that some poor people were rejected care by hospitals, and many others. Most of the time, the good news were not quoted the bad ones appeared more frequently. To objectively examined the situation, the School of Public Health University of Indonesia conducted study and stakeholder analyses. Local governments, NGOs, public hospitals, Askes managers, academicians, and even officials at MoH were invited to have Nominal Group Process to vote for a statement about Askeskin after intensive discussion. The Nominal Group Processes were conducted in ten provinces. In addition, an exit poll was conducted to examine goodness of means testing and the burden of health care costs measured by hospital charges to the poor and near poor. The study found about two third of stakeholders did not believe that that was misconduct by Askes. In addition, those stakeholders did not believe that a new scheme to replace Askeskin would be better. The majority of stakeholders preferred to fix some minor problems rather than breaking the contract or assignment to Askes. The exit poll showed that more than 90% of the near poor, who were temporarily included (by exempting the hospital charges and hospitals claimed to Askes), were actually were not wrong target. Without such exemption, they would experience catastrophic health expenditure because the hospital charges were much higher (above 40%) of their disposable income.[13]

In 2008, the MoH would run the program directly and pay hospital directly from the Central government account. Controversies and debates in media (newspaper, magazine, television, and seminars) became intense. The Parliament and House of Representative (DPD) had many meetings with stakeholders, especially with MoH, to discuss current move of the MoH. Surprisingly for me, all parties were questioning of why the MoH did not use the NSSS law as the basis to continue Askeskin. Why the MoH would take greater risks by administering program that they had no experience on it? However, several local governments supported the move by MoH to run a new scheme. Tension between MoH and other Ministries, such as Ministry of Finance and Ministry of State Enterprises that have some involvement of Askeskin became quite high. To solve the problem, the Coordinating Minister of People's Welfare (Menko Kesra), Mr. Aburizal Bakrie, finally involved in mediating the tension. Finally it was agreed that the administration of membership (identifying the eligible persons was made by local government), issuing insurance card was the task of Askes, and MoH would pay hospital claim directly.

3.2.1. ACKNOWLEGMENT

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