Health Insurance in Indonesia: Financing *Askeskin*

Bayu Dardias Kurniadi (4478184)[1]

Introduction

This paper discusses the financing process of health insurance for the poor in Indonesia. Health insurance policy for the poor has becoming one of the most significant policies in Indonesia after the end of authoritarian era in 1998. It changes the burden for health relating problem from individual and family responsibilities to the government duty (Erlina 2007). Health insurance policy started as a respond to the economic crisis from 1997 to 1998 which had made more poor people could not received affordable health services. The policy had been three changes to minimize problems in regard to free riders, and financial support (Kristiansen and Santoso 2006; Mukherhee 2006; Arifianto, Alex, Marianti, Ruly, and Budiyati, Sri 2005a, 2005b). Those policies are Health Card Policy (*Kartu Sehat*) from 1998-2003, Poor Card Policy (*Kartu Miskin*) from 2003-2004 and Askeskin[2] policy (2004 until now). This paper is focusing on Askeskin policy at the national level regarding problem with financial dimension of Askeskin, especially with the claiming insurance process.

The paper consists of introduction, explaining problem and proposed solution, identifying groups involve in the policy and their relations, the difficulties may faces and how to overcome those problems and closed with conclusion.

1. Problem: Money Flows in the Askeskin

Although health insurance policy has been changing three times in seven years, the financial dimension of the insurance program has not been significantly transformed. In Askeskin program, the flow of the money is following the previous Poor Card Program. To have more understanding on this issue, it is important to briefly summarize health care system in Indonesia.

Indonesian health care system is a combination between public and private institution where only 35% of all providers are delivered by government institution[3]. In 1968, the government introduced Community Health Center *(Puskesmas)* as a primary health providers, which are now available at least one per 30,000 people, located in sub-district (Kristiansen and Santoso 2006). Secondary health care services are now provided by 1,089 hospitals with 121,996 beds available. The estimated ratio of physician to population is 1:6,875 while the medical specialist ratio to

[1] Presented at the class of Social Policy at the Crawford School of Economic and Government, ANU on 14 April 2008.

[2] *Askeskin* is stand for *Asuransi Kesehatan Masyarakat Miskin* or Health Insurance for the Poor. This program is started on November 2004 based on Health Minister Decree. It claims as the most comprehensive health insurance scheme compare to the former.

[3] http://www.fiens.org/locations/indonesia_program.html

population at public hospital is 1:27,000. Referral hospitals as tertiary health care services are available at province level and major cities.

In the Askeskin scheme, individual who holds Askeskin card should receive free medical services from health providers from primary to tertiary level. Providers then claim for their services to PT Askes, a state insurance company which evaluates and examines claims and pay for claims. The ministry of health transfers the money to PT Askes at a yearly basis. PT Askes transferred money to the providers in every three months. PT Askes receives 10% of total claims for its services (Arifianto, Alex, et all 2005a, 2005b).

Askeskin has been facing serious financial problem in 2006 and reached it peak in mid 2007. It had problem with availability of money and verification process. In December 2006, PT Askes had to pay 248 billion rupiah (AU$ 31 million) from 545 billion rupiah (AU$ 60 million) of total claims while no more money left (Kompas, March 17-25, 2007). At the same time, health providers had to continue to give services to card holders. As the problem continued, in March 2007, Askeskin problem was not only related to health insurance scheme but also health providers as a whole. At that time, hospitals had not received claim money from PT Askes and it made providers no longer had sufficient money to operate. In July 2007, five tertiary hospitals in East Java Province received fund from Provincial government because they did not have any vital medicines as a result of late payment to the pharmacy industries (Kompas, July 26, 2007). This problem is not entirely solve now, the government give more money to close the gab for the moment but the problem remains because there is no significant changes in financial flow from the government to providers.

2. Solution: Make it Simpler

It is shown that PT Askes cannot handle two responsibilities related to predicting the money needed for the following year and doing verification process. Solutions of these problems are *first* reducing PT Askes responsibility only on verification process. The money is directly transferred from ministry of health to health providers which simpler the process. *Second*, increasing budget for health insurance policy.

3. The Groups Involved

Colebatch (2002) identify actors in policy making from two dimension of policy, vertical and horizontal. Vertical dimension sees policy as rule in downward of authorized decision while horizontal dimension discuss the structuring of action and relationship among policy participants in different organization. Related to health insurance in Indonesia, the groups involve as policy communities in vertical dimension are the government, especially the ministry of health (state at any levels), PT Askes and public health providers. Horizontal dimension can be identified as civil society (media, experts and NGOs) and business society (private health providers, pharmacies industry).

4. Key Players and Relation between Policy Community Members

One important aspect that makes policy community differs from policy network is that policy community members share their views, delivery responsibilities and insulation (Richardson 2000). Member of policy community have intensive contact between them. However, despite of working together to achieve goals of insurance policy, every actor in policy community plays their own role in order to gain their own benefits.

PT Askes plays a vital role in solving the problem. Politically speaking, PT Askes, as a state insurance company, receives burdens from the ministry of health which has to provide sufficient support to fund the policy. However, the media is focusing on problem that health providers faces because did not receive money from PT Askes, although PT Askes did not receive either. PT Askes became focal point of the problem. The suggested policy will reduce PT Askes burdens because it makes PT Askes responsible only in administration process related to claim. However, it is most likely that PT Askes will oppose the policy because it reduces their responsibility and benefits. The more responsibility PT Askes has, the more benefits they gets.

The ministry of health is likely opposing the solution due to political aspects. The solution will change the burdens to the ministry of health which has to do two tasks, provide sufficient budget and distribute those money to the health providers. To increase money, the ministry of health has to convince the parliament about the usefulness of the policy in addressing poor people health problems. To distribute money based on PT Askes verification, the ministry of health has to work at monthly basis, not at the yearly basis as happens in the previous.

Health providers, both public and private, are likely accepting the propose solution because it shortens the process and guarantees that they will receive claim payment. Pharmacy industries, civil society, media and NGOs, are likely to have the same positions.

5. Overcome Difficulties

The difficulties that the solutions face can be solved by identifying actors based on authority and expertise. Since the health insurance policy is a centralized policy, which is controlled by the central government through the ministry of health, it is easier to overcome difficulties by persuading the ministry of health to accept the policy. Other actors regarding the issue will accept the conditions. PT Askes has no choice to accept the policy because they were appointed to conduct the task by the ministry of health decree. In terms of authority, the ministry of health can force other actors to follow a new policy related to money flow.

Experts in many areas, especially in public policy disciplines have to convince the ministry of health that health policy is a state responsibility. In other words, the government has to provide

sufficient money by lobby the member of the parliament to increase the budget. Health insurance policy for the poor is a 'sexy' term for 78 million poor people in Indonesia. This 34% of Indonesian population is an essential number to increase positive views both on the government and the parliament. By increasing and distributing government budget to health providers, and make administration process better to reduce 'street level bureaucrats' it will make government more popular.

6. Conclusion

In short, Indonesian health insurance problems related to the availability of money and claiming process can be solved by increasing government budget and more importantly, distribute it directly to health providers.

References

Arifianto, Alex, Marianti, Ruly, and Budiyati, Sri, 2005a, *Making Services Work for the Poor in Indonesia: A Report on Health Financing Mechanisms in Kabupaten East Sumba, East Nusa Tenggara*, (Jakarta: The SMERU Research Institute).

Arifianto, Alex, et al. 2005b, *Making Services Work for the Poor in Indonesia: A Report on Health Financing Mechanisms in Kabupaten Tabanan Bali, A Case Study*, (Jakarta: SMERU Research Institute)

Colebatch, H. 2002, *Policy*, chapter 3, pp. 22-37.

Colebatch, H. 2002, *Policy*, chapter 4, pp. 38-48.

Erlina, Erlina. 2007, *Health Care Service Provision in Indonesia: Does It Reach the Poor*, MA Research Paper, Institute of Social Studies (ISS), Den Haag.

Kompas, March 17-25, 2007 and July 26, 2007

Kristiani, Musril. 2007, *Pemanfaatan Pelayanan Kesehatan oleh Masyarakat Miskin di Puskesmas Simpang Pandan*, Working Paper Series No. 6 (Gadjah Mada University).

Kristiansen, Stein and Santoso, Purwo. 2006, Surviving decentralization? Impacts of regional autonimy on health service provision in Indonesia, *Health Policy,* vol. 77, p.247-259.

Mukherjee, Nilanjana. 2006, *'Voice of The Poor: Making Services Work for the Poor in Indonesia. A Qualitative Consultation with the Poor at Eight Sites* ', the World Bank, Jakarta.

Richardson, J. 2000, 'Government, Interest Groups and Policy Change', *Political Studies*, vol. 48, pp. 1006-1025.

Richardson, J.J. & Jordan, A.G. 1979, *Governing Under Pressure*, Martin Robertson, Oxford.