

JAMKESMAS and District Health Care Insurance Schemes

Assessment Reports from 8 Districts/
Municipalities and 2 Provinces

Prepared By

IBP Indonesia Core Team



Perkumpulan INISIATIF

Institut untuk Inovasi Kebijakan, Pembangunan Partisipatif,
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Adenantera Dwicaksono
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Preface

After 2004, the health insurance scheme has been widely applied in various regions in Indonesia. The implementation of health insurance scheme is intended to overcome the affordability issue of community (especially the poor) in accessing health care. In addition of central government, local government also took a role in organizing and financing the health insurance scheme. The rise of health insurance practices based on some fundamental reasons.

The implementation of Law No. 40/2004 on National Social Security System has created euphoria of decentralization and restructuring the authority of central-local government has open the opportunity for local governments to develop health insurance scheme based on actual need of the community. The implementation of the decision of constitutional court (*Keputusan Mahkamah Konstitusi*) Number. 007/PUU-III/2005 has shown the way for local governments to develop health insurance scheme as a sub-system of social security scheme called "Local Health Insurance/ Jaminan Kesehatan Daerah" (Jamkesda). In the same time, the election process for local government leader (mayor) has provide a greater opportunity for the growth of health insurance practices through the use "free health care services" as one of popular campaign tagline of the candidates.

Those situations has been given some opportunity for local government to develop Jamkesda scheme as complement to National Health Insurance scheme (Jamkesmas) which is conducted by central government. The objective of Jamkesda is to give effective protection for some group of communities who have not covered by Jamkesmas.

The growth of various Jamkesda schemes in many regions has created problems for government. Some of those are related to the system for managing the implementation of various health insurance schemes that not yet integrated, portability issue, sustainability issue, discrimination, and the capacity of local governments to financing the scheme. If those problems cannot be solved immediately, universality of health insurance scheme will be hard to achieve.

Based on those situations, Perkumpulan INISIATIF in cooperation with Seknas FITRA, PATTIRO, LAKPESDAM NU and IDEA who is consolidated in *International Budget Partnership (IBP)-Indonesia Core Team* agreed to further elaboration on health insurance scheme which is relevant to Indonesian context. This idea came up for the first time in year 2010 when the 2nd Annual IBP-Indonesia Core Team Workshop in Bandung was conducted by PATTIRO. One of recommendation of the workshop is to conduct study and assessment on the various health insurance schemes and practiced at local level.

The “Jamkesmas dan Program Jaminan Kesehatan Daerah/*Jamkesmas and District Health Care Insurance Schemes*” book is a report study of various experiences on health insurance in 8 (eight) districts/municipalities and 2 (two) provinces in Indonesia. This book hopefully could be a reference for civil society whose interested in advocacy work on health issue in the way to enhance the better implementation of health insurance scheme at national or local level.

Many collagues and friends have contributed to the writing of this book. We are grateful to all members of IBP-*Indonesia Core Team*, CSOs network at local level and all researchers for good team work during the implementation of the study. Also to all resource persons, respondents, local governments in study areas and other collagues who have given many advices and valuable inputs.

Our special gratitude for Dr. Debbie Budlender who always gave us valuable inputs and assistances since the preparation of the study untill the completion of this book. Also, we are gratefull to IBP and their staffs (Thoko Madonko, Ravi Duggal, Warrent Krafchik, Helena Hofbauer and Manuela Garza) for support and cooperation.

Lastly, we hope this book could contribute to better implementation of universal health insurance in Indonesia.

March 2012

Donny Setiawan

Executive Director of Perkumpulan INISIATIF

On behalf of IBP-*Indonesia Core Team*

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Chapter 1

Introduction

Introduction

In 2004, the Government of Indonesia established the first milestone toward universal coverage of social insurance as part of government's obligation as mandated by the constitution to provide protection and welfare to all citizens. The Law No. 40/2004 on National Social Insurance System paved the way for the reform effort particularly in respect of the health-care system. The first scheme introduced as Indonesia's initial phase to achieve universal health coverage through a mandatory public health insurance scheme was *Asuransi Kesehatan Masyarakat Miskin* (Health Insurance for the Poor), which was administered by the state-owned insurance company PT Askes. The Scheme was later on replaced by *Jaminan Kesehatan Masyarakat/JAMKESMAS* (Social Health Insurance) scheme, which targets the poor and near poor people. Today, JAMKESMAS covers approximately 76.4 million poor people in Indonesia.

Eventhough JAMKESMAS covers 76.4 million poor people in Indonesia, it is expected that there are a substantial number of eligible people who are not yet covered by the scheme. These people have become local government's responsibility as stated in the Ministry of Health's Decree on JAMKESMAS's operational guideline. Moreover, the Law 32/2004 on Regional Autonomy has provided an opportunity for the local government to provide social protection schemes, including health insurance, to all its citizens. These two regulations have motivated local governments to respond by introducing various local schemes of social health insurance to complement JAMKESMAS. Therefore, in recent years, there have been a substantial number of local scheme introduced in many areas.

This situation may lead in two directions. First, it may add complexity to the efforts to achieve the objective of universal coverage of health insurance in Indonesia. The existing system may become more fragmented and difficult to integrate into a single system. It may introduce issues of portability, i.e. wheter the benefits of the scheme are accessible for all legitimate circumstances regardless of the locations where the member needs access, and sustainability, i.e. whether the scheme is able to guarantee that the the member will obtain the benefits to which they are entitled regardless of changes in the system and regulation. The portability issue is due to



schemes in the different districts having different eligibility criteria and benefits. The sustainability issue arises because the fragmented system contradicts the principle of pooling resources and sharing risk in social health insurance.

The second direction is that the proliferation of social health insurance practices at local level will become an invaluable resource for learning about the types of social health insurance that will work in the Indonesia context. The unique context of Indonesia is unprecedented by the experience from other countries. Therefore, the existing local practices can be treated as the learning ground about social health insurance models that best suit the Indonesia context.

This rapid assessment of the implementation of JAMKESDA takes the second direction as its focus. It will assess the potential of local schemes of social health insurance (JAMKESDA) to complement JAMKESMAS in achieving the objective of universal coverage. The results of the assessment will become the basis for IBP Core Team for Indonesia Budget Movement to decide the direction of its advocacy strategy to push forward universal coverage of health insurance in Indonesia.

Research Objectives

The main objective of this assessment is to obtain baseline data on the existing status of JAMKESDA in conjunction with the implementation of JAMKESMAS. The assessment of JAMKESDA attempts to answer these key questions:

1. To what extent has the JAMKESMAS program covered the local needs of health insurance particularly for poor people?
2. To what extent has the existing JAMKESDA scheme been sufficient to cover poor and disadvantaged people who have not been covered by JAMKESMAS?
3. To what extent has the existing targeting method employed by each individual JAMKESDA scheme been effective in targeting the main target of JAMKESDA i.e. poor and disadvantaged people?
4. What is the prospect of long-term sustainability of the schemes?
5. What factors have contributed to different legislative outcomes of the JAMKESDA scheme policies?
6. To what extent has the JAMKESDA scheme fulfilled beneficiaries' expectation of health care services?

Expected Outputs

Two kinds of outputs were expected from this exercise. The first output was a field report for each district assessed. (There were thus 10 field reports). The field reports consist of narratives on JAMKESDA schemes and the completed datasheet. The field reports were prepared by the assessors (see below).

The second output is the synthesis report, which contains a synthesis of the findings from field reports. The initial draft was prepared by the INISIATIF team. The draft was discussed with a view to in-depth analysis and interpretation in the Workshop of Analysis on Assessment Findings. In this workshop, IBP resource persons assisted the Core Team in analyzing the assessment result. The final report was prepared by the INISIATIF team.

Methodology

Background to the Assessment

This study was the follow up of the Second IBP Annual Learning Workshop event, which was hosted by PATTIRO in 2010. The assessment of the district health insurance scheme was conducted as a preparatory activity for the Third IBP Annual Learning Workshop, for which the INISIATIF acted as the host. The study was supported by the International Budget Partnership's Partnership Initiative and was delivered as a joint assessment involving all the IBP-Indonesia core organizations that consist of Seknas FITRA, PATTIRO, Perkumpulan Inisiatif (INISIATIF), IDEA Yogyakarta, and LAKPESDAM- NU.

As the host of all the activities of the Third IBP Annual Learning Workshop, INISIATIF also acted as the coordinator for the study. INISIATIF prepared the initial draft of the assessment instrument, conducted training on the assessment instrument for assessors, facilitated a series of synthesis workshops and meetings, prepared the synthesis report draft, as well as finalized the final report. However, all of the important decisions related to the assessment study were discussed and decided upon collectively by all the core team members. The synthesis of the study was also obtained through collaborative work and deliberation involving participation by all core team members.

The initial draft of the assessment instrument was prepared by INISIATIF team. The draft was later circulated by email to all core team member for feedback. INISIATIF also held a core team meeting to discuss the instrument of the assessment. The INISIATIF team finalized the instrument based on the feedbacks received from email discussions as well as the meeting.

The study is a collaborative research effort involving participation by each member of the IBP Indonesia Core organizations. The data collection was done by a team of assessors, which was formed from field personnel nominated by each core organization. The recruitment of the assessors team was entirely left to each core organization. Priority was given to candidates who were members or staff of the organizations and resided in the location of assessment. These criteria aimed for easy access to policy and budget documents related to district health care insurance schemes. It was assumed that the core organization had established a good relationship with the government and the local partners were knowledgeable about key contacts to obtain information as well as to conduct FGD in a very short time period.

All the assessor team members were required to attend a training workshop on the assessment instrument hosted by INISIATIF. The training aimed to familiarize the assessors with the instrument and to equip the assessors with the required skills to obtain information through interview, a series of FGDs, as well as secondary document collection. In order to assist the assessor in collecting all the important information with standard quality, the assessors were given a secondary datasheet and key information forms. These forms were expected to be filled out with all the required information. The forms also helped all the assessors to compile obtained information and to present it in a structured form that was ready for analysis.

Following the field work, all assessors were required to attend a synthesis workshop where each of them was expected to present and clarify all the information obtained in the field work process. In this workshop, the key findings from the fieldwork

process were clarified and discussed. The core team facilitated the discussion for the preliminary analysis involving the assessors and core team members to identify similarities and differences that might be used for further analysis.

Data Collection Methods

The assessment obtained information from primary and secondary resources. The information acquired from primary sources was a detailed description of JAMKESDA and how the scheme complements JAMKESMAS. The information acquired from secondary sources was facts and figures on the JAMKESDA such as the number of targeted people, the actual beneficiaries, the budget of the scheme, other related demographic information, etc.

The method of primary data collection was key informant interviews. The key informants involved were those who hold key positions in the decision/policy making process in the District Health Agency (*Dinas Kesehatan*); in the institution that is responsible for managing the scheme; and in the service providers (Community Health Service/PUSKESMAS and District Hospital/Rumah Sakit Daerah).

The assessor also contacted key persons that hold important secondary data related to the JAMKESDA Scheme. They were for the most part data/information officers in the agency. It was important to obtain permission from the head of the agency/institution to access data related to JAMKESDA implementation. These secondary data were required to complete the datasheet.

Methods of Data Analysis

The full framework of data analysis is presented in table 1.

Assessment Locations

The assessment took place in 8 districts (*Kabupaten*¹)/municipalities (*Kota*²), (Kab. Lebak, Kota Tasikmalaya, Kab. Kutai Timur, Kota Balikpapan, Kota Makassar, Kab. Kendal, Kota Palembang, Kab. Kulonprogo) and 2 provinces (Jawa Tengah and Sumatera Selatan Provinces). The selection of assessment locations was based on the needs to analyze the different roles of governance in providing health insurance in conjunction with JAMKESMAS. The law No. 32/2004 mandated the regional government (both district/municipality and province level) to develop a social security scheme, including health insurance. However, the law also emphasises the different roles of various governance levels in providing the schemes.

The selection process for the assessment process involved all the core team members. Each of the team members was asked to identify all possible districts for assessment based on team members' knowledge of the location related to the district health insurance practices. The core team also agreed to established criteria to identify and select the districts for assessment. The criteria for selection included:

1. The assessment location should represent balanced representation between *Kabupaten* dan *Kota*.
2. The assessment location should have not been assessed or studied before in respect of a similar theme (e.g health or health financing).
3. Priority should be given to locations that are part of the core organization

1 *Kabupaten* (district) is a sub-national jurisdiction status, under the province which pertains the major characteristics of rural areas

2 *Kota* (municipality) is a sub-national jurisdiction status, under the province which shows strong urbanized characteristics compared to *Kabupaten*.

network (including project locations, activists who are affiliated with the core organization, or contact persons)

4. The selection of assessment location should also consider balanced representation of districts ranging from relatively high to low fiscal capacity.
5. The selection of assessment location should also consider the representation of Java and non-Jawa situation.
6. Two of the locations should include province level government because provincial government also plays important roles in delivering universal access to a health insurance scheme. The provincial governments should be chosen from provinces in which one of the district level assessment locations was situated.

Table 1.
Research Questions, Hypothesis, and Analysis Framework

Perhaps briefly explain the process by which these questions etc were agreed

No.	Research Questions	Hypothesis	Data & Information needed	Data Collection Technique	Source of Information	Data Analysis
1.	To what extent has the JAMKESMAS program covered regional need on health care security?	<ul style="list-style-type: none"> • The JAMKESMAS Program aims to provide protection to the poor people based on the data in Bureau of Central Statistic (BPS). The central government set a JAMKESMAS-membership quota for every region. • Regional governments are responsible for providing support for those who are not covered by JAMKESMAS. • The JAMKESMAS is considered as covering the local need if the quota of JAMKESMAS is at least equal to the number of poor people from the perspective of regional government. 	<ul style="list-style-type: none"> • Data of JAMKESMAS participants' quota that have been agreed by the central government for regional government. 	Secondary document study	Appendix of JAMKESMAS technical guidelines	<p>For every region, official data of JAMKESMAS membership quota str compared to poverty data provided by regional government. Based on the data, we can calculate the percentage of poor people that can potentially be covered by JAMKESMAS. The percentage should be corrected by comparing the data to the <i>membership enrollment</i> level of JAMKESMAS. The final percentage shows the real scope of JAMKESMAS for poor people in regions. The analysis can be :</p> <ul style="list-style-type: none"> • What factors that can cause the differences between quota determination and the poverty data provided by regional government? • What factors cause the gap between JAMKESMAS enrollment membership and the quota that has been determined?
			<ul style="list-style-type: none"> • Data on the poor according to regional government 	Secondary document study	Regional Bureau of Central Statistic (BPS)/ Regional Development Planning Board (Bappeda)/ Health Agency	
			<ul style="list-style-type: none"> • Membership level of JAMKESMAS enrollment in region. 	Secondary document study	Health Agency/regional Social Security Administering Body (BPJS)	
2.	To what extent has the existing JAMKESDA scheme been sufficient to cover poor and disadvantaged people who have not been covered by JAMKESMAS	<p>Because the regional government is responsible for covering those who are not covered by JAMKESMAS, regional schemes should at least:</p> <ul style="list-style-type: none"> • cover poor people and disadvantaged people based on local indicators who are not covered by JAMKESMAS • offer similar level of benefits to JAMKESMAS 	<ul style="list-style-type: none"> • The policy option of regional government in covering JAMKESMAS participants who outside the quota 	<ul style="list-style-type: none"> • Informant interview 	<ul style="list-style-type: none"> • The Head of Agency/ BPJS manager/ Regional Development Planning Board (Bappeda) of social culture sector 	<ul style="list-style-type: none"> • First, it needs mapping of regional government schemes based on the following questions: <ul style="list-style-type: none"> • Does regional government give additional budget to broaden JAMKESMAS scope? OR • Does regional government have their own scheme to cover poor people who are not covered by JAMKESMAS? • What are they?

No.	Research Questions	Hypothesis	Data & Information needed	Data Collection Technique	Source of Information	Data Analysis
			<ul style="list-style-type: none"> The service provided in Regional Health Insurance (JAMKESDA) scheme The numbers of JAMKESDA scheme participants Data on the poor provided by regional government. 	<ul style="list-style-type: none"> Document Study Document Study Document Study Secondary document study 	<ul style="list-style-type: none"> Regional Medium-Term Development Plan (RPJMD)/ Long-Term Development Plan (RPJP)/ Strategic Plan of Health Agency Regional Regulation/Regional Head Regulation of Can Regional Health Insurance (JAMKESDA) Report [of JAMKESDA accomplishment in Health Agency/ regional BPJS Health Agency/regional BPJS 	<ul style="list-style-type: none"> Second, each scheme should be analyzed as to whether the scheme has covered those who are not covered by JAMKESMAS. The analysis is made by calculating the percentage of poor who are not covered by JAMKESMAS and covered by JAMKESDA Third is comparing benefits offered by different JAMKESDA schemes with the benefits provided by JAMKESMAS. The analysis may consider some examples as follows: <ul style="list-style-type: none"> More, if JAMKESDA gives the services such as support for transportation cost for health care received outside the region, or gives transportation cost for deliverymen, etc. similarly, if the service provided by JAMKESMAS and JAMKESDA is the same. Less, if service provided by JAMKESDA is more restricted than JAMKESMAS, for example JAMKESDA only covers basic health care in Public Health Center (Puskesmas)
3.	To what extent has the existing targeting method employed by each individual JAMKESDA scheme been effective in targeting the main target of JAMKESDA i.e. poor and disadvantaged people?	A universal scheme is considered as the ideal way of targeting because it may minimize the risk of mistargeting since it includes the whole population in the respective region. However, specific targeting can also be effective in targeting those who are eligible for the scheme when the existing scheme is dealing with limited financial resources.	<ul style="list-style-type: none"> The rule for determining JAMKESDA participants. Information on criteria used to determine target. Data statistics of JAMKESDA 	<ul style="list-style-type: none"> Document study Document study 	<ul style="list-style-type: none"> Regional Regulation/Regional Head Regulation of JAMKESDA Regional Head Regulation/technical guidelines to manage JAMKESDA participant determination Report of JAMKESDA accomplishment in Health Agency/regional BPJS. 	<ul style="list-style-type: none"> The analysis is conducted by comparing the mechanism used by the regions with the experiences of other countries that have conducted the same targeting method (based on the literature review).
4.	What is the prospect of long-term sustainability of the schemes?	The prospect of sustainability of the JAMKESDA scheme can be assessed in two ways: <ul style="list-style-type: none"> Institutional sustainability; and Financial sustainability. 	<ul style="list-style-type: none"> Regulations in regions that manage JAMKESDA scheme 	<ul style="list-style-type: none"> Document study 	<ul style="list-style-type: none"> Regional Regulation/Regional Head Regulation of JAMKESDA 	<ol style="list-style-type: none"> To assess the continuity of the JAMKESDA scheme in institutional aspect is conducted by using qualitative analysis of JAMKESDA scheme institutional system. The first step is by analyzing policy documents which are relevant to JAMKESDA. In principle, if JAMKESDA scheme is legalized in the form of regional regulation, it will have greater policy legitimacy. It may also be

No.	Research Questions	Hypothesis	Data & Information needed	Data Collection Technique	Source of Information	Data Analysis
		<p>The institutional sustainability can be assessed based on the following aspects:</p> <ul style="list-style-type: none"> The legal framework of the scheme. If there is institutional separation in JAMKESDA functions including function of regulation, cost management, and service management. Particularly, the institution that focuses on budget (cost) should be a relatively independent legal entity, non-profit oriented. <p>JAMKESDA can be continued in financial aspect if the scheme is as follows:</p> <ul style="list-style-type: none"> Not only reliant on budget from Regional Budget Revenue and Expenditure (APBD) The allocation of APBD for JAMKESDA scheme is not overwhelming and it is assumed that it can cover the scheme at least for next 5 years. 	<ul style="list-style-type: none"> Institutional management of JAMKESDA General data of Regional Budget Revenue and Expenditure (APBD) Data of Regional Budget Revenue and Expenditure (APBD) in Health sector Expenditure allocation of JAMKESDA scheme Unit cost of JAMKESDA that has been agreed Demography data Assumption on population data Assumption on average inflation level 	<ul style="list-style-type: none"> Document study 	<ul style="list-style-type: none"> Regional Regulation/ Regional Head Regulation of JAMKESDA The officer of Health Insurance Management in regions. Implementation of Regional Budget Revenue and Expenditure (APBD)/ pure APBD Regional Bureau of Central Statistic (BPS), Regional Development Planning Board (Bappeda) Regional Bureau of Central Statistic (BPS), Regional Development Planning Board (Bappeda) Regional Bureau of Central Statistic (BPS), Regional Development Planning Board (Bappeda) 	<p>assessed whether the scheme has also been included in the Long and Medium Term Development Plan document.</p> <p>2. In the institutional analysis, scheme continuity is parallel with the institutional infrastructure level. The institutional infrastructure can be seen in term of to what extent the JAMKESDA functions are distributed? [What do you mean by 'distributed' ?]</p> <p>3. In the sustainability analysis from the financial aspect will be conducted in several level, that are:</p> <ul style="list-style-type: none"> First, the analysis of Regional Budget Revenue and Expenditure (APBD) trend especially for JAMKESDA to identify whether JAMKESDA allocation is sufficiently allocated in APBD to cover all associated costs. The analysis will be better if it includes the correlation of regional fiscal capability. Second, the analysis of projection of regional fiscal capability to cover existing JAMKESDA scheme. Up to this point, the methodology analysis can be investigated in detail in the book published by <i>Inisiatif</i> entitled "Budget Analysis of Regional Health Insurance".
5.	What factors have contributed to different legislative outcomes of the JAMKESDA scheme policies?	<p>JAMKESDA scheme policy can come about in three ways:</p> <ul style="list-style-type: none"> The Policy proposal comes from the executive 	<ul style="list-style-type: none"> Information about the process of regional regulation making/ policy of JAMKESDA 	<ul style="list-style-type: none"> Interview of Key informant 	<ul style="list-style-type: none"> Head of Health Agency JAMKESDA Officers Experts who are involved in policy making 	

No.	Research Questions	Hypothesis	Data & Information needed	Data Collection Technique	Source of Information	Data Analysis
		<ul style="list-style-type: none"> The Policy proposal comes from the house of parliament The civil society has a concept and which is proposed either to the parliament or to the executive 				
6.	To what extent has the JAMKESDA scheme fulfilled beneficiaries' expectation of health care services?	<p>JAMKESDA is considered to meet the public needs and expectations if:</p> <ul style="list-style-type: none"> It addresses poor people's concerns and expectation for health insurance services 	<ul style="list-style-type: none"> Public perception of JAMKESDA service 	<ul style="list-style-type: none"> Focus Group Discussion 	<ul style="list-style-type: none"> Civil society that are participants of JAMKESDA and have utilized JAMKESDA service. 	

Glossary:

- Bappeda **Regional Development Planning Board**
- BPJS **Social Security Administering Body**
- BPS **Bureau of Central Statistic**
- FGD **Focus Group Discussion**
- JAMKESDA **Regional Health Insurance**
- JAMKESMAS **Public Health Insurance**
- Kartu Keluarga **Family Card, issued by local government that explain the identity of each member of a family.**
- KTP **Acronym of Kartu Tanda Penduduk (Residents Card). Is a formal Identity card issued by local government.**
- Puskesmas **Public Health Center**
- RPJM **Medium-term Development Plan**
- RPJP **Long-term Development Plan**

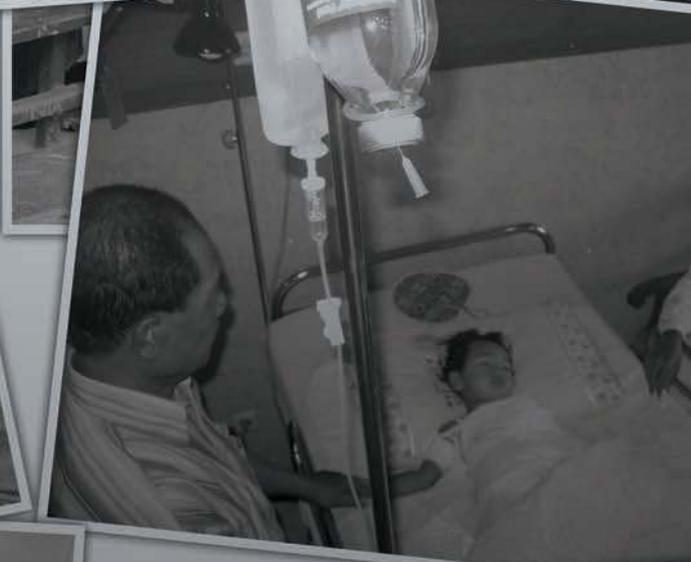


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Chapter 2

JAMKESMAS and District Needs for Health Care Insurance

In order to assess whether the JAMKESMAS quota set by central government for each district/municipality has fulfilled the local needs of health care security, the JAMKESMAS quota should be compared to the number of poor and disadvantaged people according to regional perspectives/criteria. It is assumed that the local needs of health care security equals the region's estimate of the number of poor and disadvantaged people.

Overview of the JAMKESMAS Scheme

Jaminan Kesehatan Masyarakat (JAMKESMAS)/Social Health Insurance Program is a national program providing financial protection in respect of the health care costs for the poor and near poor population in Indonesia. This program was introduced by the Ministry of Health in 2007 to respond to the Constitutional mandate to provide social security system to the entire Indonesia population as stated in the article 34 point 2 of the UUD RI 1945. The JAMKESMAS replaced a similar program ASKESKIN which was managed by PT ASKES.

According to the technical guidelines of JAMKESMAS 2011, the overall objective of JAMKESMAS is to increase access to and the quality of health services of all JAMKESMAS members to ensure that optimal health is effectively and efficiently achieved. The specific objectives of the program are (i) to provide easy access of all members to the JAMKESMAS health service providers network; (ii) to promote standardized health care to all members in order to prevent excessive service that may create an additional burden of costs; and (iii) to implement transparent and accountable JAMKESMAS financial management.

The targeted beneficiaries of the JAMKESMAS program are the poor and near poor population of Indonesia amounting to 76.4 million people who are not covered by any kind of insurance schemes. The JAMKESMAS 2010 database membership is based on macro demographic data of 2005 provided by the National Bureau for Statistics (BPS). Based on these data, the Ministry of Health set the membership quota for each district/municipality. The final list of JAMKESMAS members was signed by the District/Municipality Head in 2008. Towards the end of 2008, the BPS provided new data on poverty by name and address which indicated that the

number of poor people had reduced to 60.3 million people. The update of the list was carried out by BPS in 2010 through PPLS-2010 (Pendataan Perlindungan Sosial – 2010) although the list will become available in 2012.

BPS update the date periodically. For demographic statistics, the BPS conducts a census every ten years. Five years after the census, the BPS conducts the Inter-census survey (SUPAS). The data used for the poverty line are based on the Social-economic Survey, which is conducted every five years. The JAMKESMAS data require specific data which also identify those who are categorized as poor. These data were generated through the Social Service Beneficiaries Identification Program 2008 (Program Pendataan Layanan Sosial 2008), which aimed to identify beneficiaries for the Cash Transfer Grant Program of 2008. In 2011, BPS planned to conduct a similar exercise in order to update the 2008 data.

JAMKESMAS is funded from the national budget through the health ministry budget under the con-current allocation scheme. This funding scheme is used to fund shared government functions between central and district/municipality government. In this scheme, the Ministry of Health controls the fund in respect of planning and disbursement to the health facilities. The JAMKESMAS fund is disbursed to the health facilities, whose contract with the JAMKEMAS is based on the claims submitted by health service providers.

In order to control health care costs and to provide a standardized package of interventions in JAMKESMAS, the MoH has implemented the Indonesian Diagnosis Related Group (INA-DRG), a coding system to classify hospital cases into one of pre-determined 500 diagnosis groups for payment purposes.

JAMKESMAS Financing

Providing health care cost protection to the poor has become a concurrent function of the central and local government. This means that the responsibility for providing health care cost protection is shared between the central, provincial, and district level government. Thus the burden of JAMKESMAS financing is shared among the levels of government. Most of the JAMKESMAS fund is from the national budget (APBN), allocated in the Ministry of Health's budget. The JAMKESMAS fund from central government only covers the those who are listed in the Ministry of Health's decree of JAMKESMAS beneficiaries that include the poor and the near poor people based on the BPS criteria of poverty.

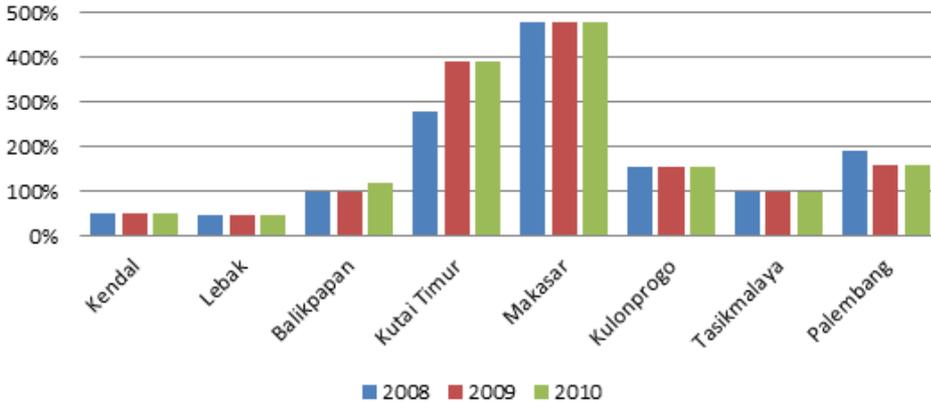
JAMKESMAS and the needs of health care cost protection in districts

Based on the data of JAMKESMAS quota and the poverty statistics provided by the local institution³ from 8 districts/municipalities from 2008-2010, some variations in the proportion of JAMKESMAS coverage compared to the poverty figures are identified. First, the quota of JAMKESMAS in Kab. Kendal and Lebak are found to be lower than the number of poor people in the respective districts. The JAMKESMAS quota only covers 49% of the poor people in Kab. Kendal, and covers 47% of the poor in Kab. Lebak. Second, the quota of JAMKESMAS is found to be more or less equal to the number of poor people in Kota Balikpapan (105%) and Kota

³ The BPS is the only government institution which is mandated to provide data and statistics for development programming and policy making in Indonesia. BPS has branches at province and district level to perform a similar function. However, in many cases, the local governments also produce their own data for their respective purposes. This may cause differences in data due to different criteria.

Tasikmalaya (100%). Third, the quota of JAMKESMAS is found to be greater than the number of poor people in 4 areas: Kab. Kutai Timur (353%), Kota Makassar (480%), Kab. Kulonprogo (156%), and Kota Palembang (169%).

Figure 2a. Trend and Percentage of Poor People Covered by Jamkesmas, 2008-2010



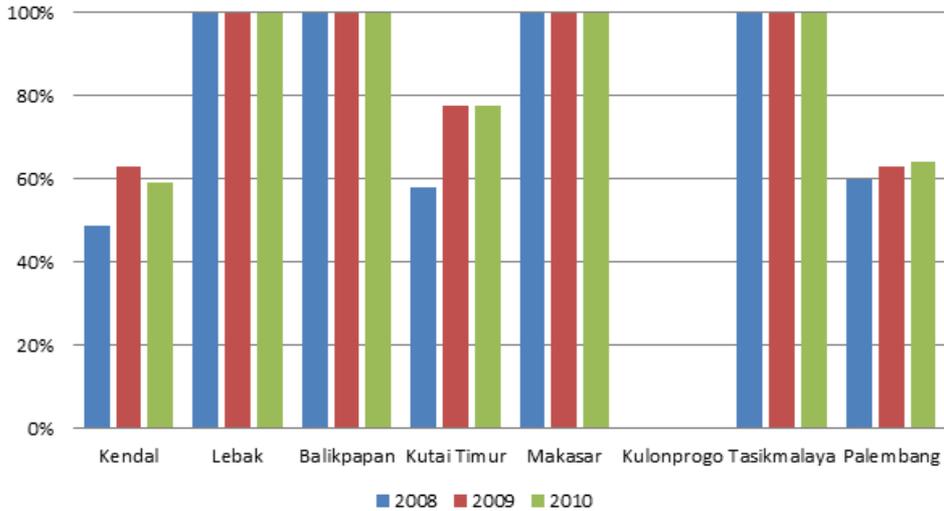
These variations may be attributed to a number of factors. The first factor is the poverty data which are used for setting up the membership quota of JAMKESMAS for every region. The quota is based on poverty data provided by BPS. BPS uses the latest SUSENAS (*National Social Economic Survey*) data to estimate the number of prospective beneficiaries of the schemes, who are categorized as poor and near poor people. In the beginning of the JAMKESMAS Program, BPS used data from SUSENAS 2005. Therefore some inaccuracies were expected in the estimation due to time lag. In 2009, using SUSENAS 2006 data, the Ministry of Health set the target population of 74.6 million people who are categorized as poor and near poor people. In 2010, The Ministry of Health maintains the number for the target population, which are 74.6 million people even though BPS has corrected the number using the latest data to 60.4 million people. This number was based on the poverty line produced by the BPS. The identity of the prospective beneficiaries is based on the data produced by the Social Assistance Beneficiaries Identification Program 2008 (PPLS 2008).

The second factor is the way in which the beneficiaries are identified. Once the quota of JAMKESMAS membership is set by the Ministry of Health, the next step is to identify the beneficiaries of JAMKESMAS by name and address. To do so, the population in each district is filtered out using micro-poverty assessment. The most common poverty criteria used for membership identification are the BPS poverty indicators. The poverty criteria used for membership identification are disputable. Some regional governments have different poverty criteria, which may lead to unmatched poverty data between central government and regional government.

The realization data of JAMKESMAS indicate that only a few of the assessed districts/municipalities can fully utilize the given JAMKESMAS quota. These regions are Kab. Lebak, Kota Balikpapan, Makassar, and Kota Tasikmalaya. The utilization

of JAMKESMAS quota varies in the rest of regions ranging from 57% to 71%. The utilization rate in Kutai Timur is 71%, while Palembang and Kendal only reach 62% and 57%.

Figure 2b. Percentage of Jamkesmas Realization, 2008-2010



This situation may be caused by several factors. The first factor is poor information dissemination about the program in the regions. In Kutai Timur, it is reported that approximately 4000 JAMKESMAS cards of the 40.000 issued by PT ASKES did not reach the card holder due to poor distribution mechanism. The PT ASKES dropped the JAMKESMAS card with BAPPERMAS (*People Empowerment Body*) to be distributed to villages. However, the cards only reached the village offices and were not distributed to the actual holder. Another factor is poor membership identification. The JAMKESMAS card is not completed with the full address, which makes the distribution efforts harder.

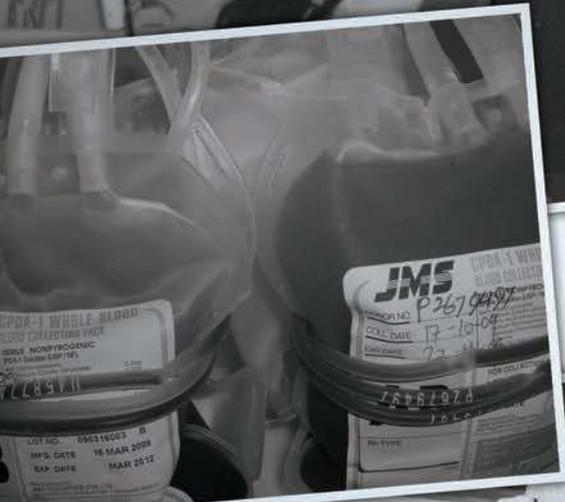


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Chapter 3

District Health Care Insurance Scheme (JAMKESDA)

This chapter discusses a number of local schemes of health insurance (JAMKESDA) as local government responses to the need to provide health care insurance to the citizen, particularly for poor people. There are two drivers that motivate local government to introduce a local health insurance policy. The first driver is the regulation factor. The Law No. 32/2004 on Local Governance provided the opportunity for local government to develop its social security program including health insurance. The Constitution Court Decree No. 007/PUU-III/2005 has allowed local government to establish its own agency specializing in managing the health insurance scheme in each locality. The Implementation Manual of JAMKESMAS Program which is published each year advises that poor people who are not included in the list of JAMKESMAS membership as stipulated by the head of district/municipality will become local government's responsibility.

The second driver is the political interest of the head of district/municipality. The direct election system of local leadership has implications for how local government formulates its development policy. The direct election system has shifted the focus of accountability of the elected leader. The head of district/municipality has become subject to accountability to his or her voters as against to the former representative election system. Therefore, the new elected leader will seek out popular policies which will maintain his or her popular support. The health insurance policy is among these popular policies.

Regional Policies to Provide Health Care Security for the Poor and Disadvantaged People

The regional governments, particularly the district/municipality governments have demonstrated that to some extent they take responsibility to provide health care security for the poor and disadvantaged people who are not covered by the JAMKESMAS Program. From the cases studied, there are at least two types of regional governments' response. The first is that the regional government simply budgeted

some amount of funds as health care cost subsidy for health providers. The regional governments that have this kind of policy are *Kab. Lebak, Kota Tasikmalaya, and Kab. Kutai Timur*. The second response is that the government took more progressive action by developing health care security schemes. The regional governments with this kind of policy are *Kab. Kendal, Kota Balikpapan, kab. Kulonprogo, Kota Makassar, and Kota Palembang*. The overview of regional governments' responses to provide health care security can be found in the following table.

Table 3a.
Various Government Policies in Providing Health Care Security

No.	District/Municipality/Province	Government Policies
1.	Kab. Lebak	The Lebak District government allocated health care subsidy funds, which are budgeted through Social Assistance budget line
2.	Kota Tasikmalaya	The Tasikmalaya Municipality government allocated health care subsidy funds, which are budgeted through Social Assistance budget line
3.	Kab. Kutai Timur	The Kutai Timur District government allocated health care subsidy funds, which are budgeted through Social Assistance budget line
4.	Kota Balikpapan	The Balikpapan Municipality government established a number of health insurance schemes in order to provide universal coverage for all citizens. Some schemes are financed fully from its own APBD, but also involve cost-sharing with provincial government. The existing schemes: <ul style="list-style-type: none"> • JPK – GAKIN (health insurance for poor family) • JAMKESDA Informal (in-patient care subsidy for individuals working in informal sector who are not covered by any insurance scheme) • JPK – PNS (health insurance for government officials which add to the benefits coverage of the existing ASKES) • Jamkesorga – health insurance for athletes
5.	Kab. Kendal	The Kendal District government introduced District Health Insurance, which provides health care security to poor and disadvantaged people who are not covered by JAMKESMAS
6.	Kab. Kulonprogo	The Kulonprogo District government introduced District Health Insurance, which provides health care security to poor and disadvantaged people who are not covered by JAMKESMAS
7.	Kota Makassar	The Makassar Municipality government introduced District Health Insurance, which provides universal coverage to the Makassar Municipality residents.
8.	Kota Palembang	The Palembang Municipality government introduced Universal Social Health Insurance (Jamkesosta), which provides universal coverage to the Palembang Municipality residents.
9.	Prov. Jawa Tengah	The Jawa Tengah Provincial government introduced Provincial Health Insurance, which provides financial support for the beneficiaries who use the referred health services.
10.	Prov. Sumatera Selatan	The Sumatera Selatan Provincial government introduced Universal Social Health Insurance, which shares health care costs burden with district and municipality government in Sumatera Selatan province, in order to promote universal coverage of the health insurance system. Kota Palembang is part of this insurance scheme. Kota Palembang is one of the municipalities in Sumatera Selatan Province.

Whilst the district/municipality governments are at the front line of providing health care security to the people, the provincial government plays a supportive role. The Jawa Tengah and Sumatera Selatan Provincial Governments introduced Provincial Health Insurance scheme. However, these schemes are not directly channeled to beneficiaries. Instead they go through district and municipality government.

District Scheme Categories of Health Insurance

From the ten cases studied, there are at least three categories of scheme ranging from the simplest subsidy system to a more complex and comprehensive scheme of universal health insurance program.

The first category is **Health Care Cost Subsidy**. In this category, the local government allocates funds which can only be used for paying the health care cost of poor people. These funds are often budgeted in the Social Assistance post or managed by the Health District Agency. The district government will pay health service providers (community health center and public hospital) for the services utilized by poor and disadvantaged people.

This scheme does not need a formal list of beneficiaries. Instead a local regulation stipulates the criteria of eligibility and mechanism to apply for this fund. All the schemes assessed in this category use the *Surat Keterangan Tidak Mampu/SKTM (Certificate of Disadvantaged)*. In order to access the benefit, the eligible beneficiaries are required to apply for the *Certificate of Disadvantaged*. In order to obtain the certificate, the applicant needs to obtain a recommendation from all level of authorities where he or she reside. Once all the requirements are completed, the head of village will issue the Certificate of Disadvantaged. The certificate needs to be authorized by appointed officers in the District Health Agency. After receiving approval, the applicant may use the certificate to receive a health care fee waiver for that visit. District governments that use this system are Lebak, Tasikmalaya, Kutai Timur. However, the certificate is only for one medical visit or treatment. If the same person were going to visit the health facilities for different medical treatment that are not related to previous illness in the future, he or she is required to re-apply the certificate.

The second scheme is the **Poverty Targeted Insurance Scheme**. This kind of scheme is designed to provide health care security to poor and disadvantaged people who are not covered by JAMKESMAS. In this scheme, the regional government issues a scheme membership card as the proof that the card holder is one of the eligible beneficiaries of the schemes. As a consequence, the regional government has to set up and maintain a membership database. A task team is formed to verify and validate whether both existing and prospective members meet the eligibility criteria as required. The membership database must be updated regularly. This scheme is used by Kab. Kendal and Kab. Kulonprogo. In Kab. Kendal, every year the District Government publishes a District Health Decree with a list of non-quota JAMKESMAS members who will be covered by JAMKESMASDA, the local scheme of JAMKESMAS. The government of Kab. Kendal also has anticipated the possibility that there are still a number of eligible people who have not been covered by the JAMKESMASDA. Therefore, the government still accepts applications for exemption in respect of health care services costs using *Surat Keterangan Tidak Mampu/SKTM (certificate of disadvantaged)*.

The third scheme is the **Universal Health Care Security Scheme**. This scheme is used by Kota Makassar, Kota Palembang and Kota Balikpapan. This type of scheme provides health care insurance to all citizens of the respective districts. Everyone who wishes to access the benefits is only required to show an ID card indicating that he or she is a legitimate resident of the respective region. Kota Makassar and Kota Palembang share similar policies in providing health care security to all their citizens. In reality, the policies are an extension of the provincial policy of free health care services, in which the municipality and provincial government agree to share health care costs. In Balikpapan the universal coverage is composed of four health security schemes, namely: JPK-Gakin, JAMKESDA Informal, JPK-PNS, and Jamkesor.

Table 3b.
Comparison of JAMKESDA Scheme Categories

No.	Category of Schemes	District – Name of Scheme	Features
1.	Health Care Cost Subsidy.	1. Kab. Lebak – Health Care Subsidy for Poor Family (Gakin) 2. Kota Tasikmalaya – (Health Care Subsidy for Poor Family (Gakin) 3. Kab. Kutai Timur – (Health Care Subsidy for Poor Family (Gakin)	<p><u>Main features</u></p> <ol style="list-style-type: none"> The government has budgeted a floating fund that can only be used for covering the costs of health care utilized by poor and disadvantaged people. The government stipulates criteria of eligibility to access this fund and mechanism to apply for the scheme. The Certificate of Disadvantaged (<i>Surat Keterangan Tidak Mampu/SKTM</i>) is commonly used as proof of eligibility. Each certificate can only be used for one case of health treatment The government is not obliged to establish a list of beneficiaries of the scheme It covers both basic and referred treatment <p><u>Pros</u></p> <ol style="list-style-type: none"> It does not require a formal list of beneficiaries. The scheme is practically easy for the government. <p><u>Cons</u></p> <ol style="list-style-type: none"> The beneficiaries often experience discrimination in respect of services from health services providers; The actual cost always exceeds from the allocations. In many cases, the government is burdened by large debts to the health service providers. The application procedure for SKTM is prone to abuse. Better off people may also apply and obtain the SKTM due to poor oversight in application process. It places more burdens on the poor as they are required to apply for the SKTM each time they want to access the health care services
2.	Poverty Targeted Insurance Schemes	1. Kab. Kendal – Jaminan Kesehatan Daerah (District Health Insurance) 2. Kab. Kulonprogo – Jaminan Kesehatan Daerah (District Health Insurance)	<p><u>Main features</u></p> <ol style="list-style-type: none"> The scheme is designed to cover poor and disadvantaged people who are not covered by the quota of JAMKESMAS. The non-coverage is due to a number of reasons. First, it may be caused by beneficiary identification problems. Second, it may be caused by differences in poverty criteria between central and district government. The government stipulates the eligibility criteria and procedure of eligibility assessment. The government must establish and maintain the beneficiary database. A membership card will be issued by the government and given to the beneficiary. <p><u>Pros</u></p> <ol style="list-style-type: none"> The system provides certainty of services for the beneficiaries The system allows the government to have more control over the allocation because the budget allocation for the scheme can be projected based on the beneficiaries database and the health care utilization data from the preceding years.

No.	Category of Schemes	District – Name of Scheme	Features
			<p>3. Usually, the governments establish a separate institution to take care of the scheme, allowing better and more responsive services.</p> <p><u>Cons</u></p> <ul style="list-style-type: none"> • It still poses problems of mistargeting, due to problem in identification of beneficiaries.
3.	Universal Coverage of Health Insurance	<p>1. Kota Makassar – Jaminan Kesehatan Daerah (District Health Insurance)</p> <p>2. Kota Balikpapan – 1) JPK-Gakin; 2) JAMKESDA Informal; JPK</p>	<p><u>Main Features</u></p> <ol style="list-style-type: none"> 1. The scheme is designed to provide health insurance to all citizens of the district. 2. It does not require a database of beneficiaries because the scheme covers all the citizens who reside in the jurisdiction. However, in the case of Balikpapan, the term universal means that all the citizens are covered but with different schemes based on the specific groups (poor, informal-worker, government official, sportspersons) 3. In order to access health care services, the users are only required to show proof of residence. <p><u>Pros.</u></p> <ol style="list-style-type: none"> 1. The system allows easier management, as the basis for eligibility is status of residency 2. The system also allows easier access to health services and provides certainty of access <p><u>Cons</u></p> <ol style="list-style-type: none"> 1. It may require high fiscal capacity because it requires bigger allocation in advance compared to its targeted counterparts. However, the cases also shows that the pre-allocated fund are often under-utilized. 2. The poor and disadvantaged people may still experience discrimination in access due to lack of proof of residency.

The Benefits of JAMKESDA Schemes

Except for the provincial schemes of health insurance, almost all the schemes studied offer similar benefits. The benefits include full exemption from costs of health care services in basic health services provided in Puskesmas (Community Health Center) and referral for ambulatory and third class in-patient service in district public hospitals. Referral cares in provincial public hospital are also supported in the provinces which have introduced the provincial health insurance such as Jawa Tengah and Sumatera Selatan province. The provincial scheme in Jawa Tengah differs from its Sumatera Selatan counterpart in term of membership coverage. The Jawa Tengah scheme only covers poor and disadvantaged people while Sumatera Selatan provide coverage to all citizen of Sumetara Selatan province. The following table summarizes the benefit of each individual scheme.

Table 3c.
Comparison of Health Care Insurance Scheme's Benefits

Items of comparison	Kab. Lebak	Kab. Tasikmalaya	Kab. Kutai Timur	Kab. Kendal	Kab. Kulon progo	Kota Balikpapan		
Name of the Scheme	Health care subsidy for poor family using SKTM			Jaminan Kesehatan Masyarakat Daerah (District Social Health Insurance)	JPK – GAKIN (Health Care Insurance for Poor Family)	JAMKESDA Informal (District Health Care Insurance for Informal workers)	JPK-PNS (Health care insurance for Government Officials)	Jamkesorga (Health Care Insurance for Sport Athletes)
Scheme Category	Health care cost subsidy			Poverty Targeted Health Care Insurance	Poverty Targeted Health Care Insurance	Targeted Health Care Insurance		
Target Beneficiaries	All poor people who have Certificate of Disadvantage, which is authorized by the village leader.			Poor people who are on the list of JAMKESDA beneficiaries published by the district government	Poor people who are on the list of JAMKESDA beneficiaries published by the district government	All district citizens who working in the informal sector	All district government officials	All district athletes and officials who are currently assigned to represent the district and province in regional, national, and international sport events.
Benefit	<ul style="list-style-type: none"> Free basic health care services in community health center (Puskesmas) and its village network Full exemptions for third class⁴ referral (tertiary) health care services in District Health Hospital (RSUD) 					Partial subsidy for referral ambulatory and third class in-patient care in the district public hospital	<ul style="list-style-type: none"> Basic benefits from ASKES (mandatory health care insurance) Additional benefits based on the government echelon leveling 	<ul style="list-style-type: none"> Free basic health care services in Puskesmas and its village network Full exemptions for third class referral health care services in District Health Hospital
Medical treatments covered	<ul style="list-style-type: none"> Puskesmas: <ul style="list-style-type: none"> Basic ambulatory care; Basic in-patient care (only in puskesmas equipped with in-patient care facilities); pharmaceuticals; basic dental care; normal birth deliveries and basic maternal care. District Public Hospital: <ul style="list-style-type: none"> Referral ambulatory care; third class referral in-patient care; Pharmaceuticals; dental care; Birth deliveries with complications. 					Referral ambulatory and third class in-patient care in the district public hospital facilities	<ul style="list-style-type: none"> Basic general benefits from ASKES (mandatory health care insurance for government officials) Additional benefit based on district government echelon level: 	<ul style="list-style-type: none"> Puskesmas: <ul style="list-style-type: none"> Basic ambulatory care; Basic in-patient care (only in puskesmas equipped with in-patient care facilities); pharmaceuticals; basic dental care;

4 Third class health services refersto the classification of level of health services. The third class care services usually refers to basic services received by the patient (patient is placed in shared room, with basic amenities, whilst the first class patient will enjoy private accommodation equipped by air conditioning and television set. The first class is much expensive than the third class.

Items of comparison	Kab. Lebak	Kab. Tasikmalaya	Kab. Kutai Timur	Kab. Kendal	Kab. Kulon progo	Kota Balikpapan	
						<ul style="list-style-type: none"> Ambulatory care from appointed family doctors Ambulatory care from appointed specialist doctors Ambulatory and in-patient care in appointed hospitals Laboratory test 	<ul style="list-style-type: none"> normal birth deliveries and basic maternal care. District Public Hospital: <ul style="list-style-type: none"> Referral ambulatory care; third class referral in-patient care; Pharmaceuticals; Dental care; Birth deliveries with complications.

Items of Comparison	Kota Makasar	Kota Palembang	Prov. Jawa Tengah	Prov. Sumatera Selatan
Name of the Scheme	Free Health Care Service for Residents of Makassar Municipality	JAMKESOSTA (Universala Social Health Insurance)	JAMKESDA Provinsi Jawa Tengah (Provincial Health Insurance)	Jaminan Kesehatan Sosial Sumatera Selatan (Social Health Insurance)
Health Care Insurance Scheme Category	Universal Health Care Insurance Coverage	Universal Health Care Insurance Coverage	Universal Health Care Insurance Coverage	Universal Health Care Insurance Coverage
Target beneficiaries	All Makassar resident who live and work in Makassar Municipality proven by certificate of residency	All Palembang residents proven by the certificate of residency	The scheme is targeted at all residents of Jawa Tengah Province, however, in the first stage of the scheme, the target beneficiaries are residents of districts whose governments have signed agreement with the provincial government	All residents of Sumatera Selatan Province
Benefit	<ul style="list-style-type: none"> Free basic health care services in community health center (Puskesmas) and its village network Full exemptions of third class referral health care services in District Health Hospital (RSUD) 		<ul style="list-style-type: none"> Provide cost sharing of referral in-patient care in provincial public hospital, for referrals from district public hospital. 	<ul style="list-style-type: none"> The Provincial government provides a grant to each district/ municipality government to provide universal health care insurance for all its residents Shared support for referral medical treatment in provincial and national public hospital facilities

Items of Comparison	Kota Makassar	Kota Palembang	Prov. Jawa Tengah	Prov. Sumatera Selatan
Medical treatments covered	<ul style="list-style-type: none"> • Puskesmas: <ul style="list-style-type: none"> • Basic ambulatory care; • Basic in-patient care (only in puskesmas equipped with in-patient care facilities); • pharmaceuticals; • basic dental care; • normal birth deliveries and basic maternal care. <ul style="list-style-type: none"> • District Public Hospital: <ul style="list-style-type: none"> • Referral ambulatory care; • third class referral in-patient care; • Pharmaceuticals; • Dental care; • Birth deliveries with complications. 		<ul style="list-style-type: none"> • Referral in patient care in provincial public hospital • Any costs related to transporting patients to the hospital facilities 	



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Chapter 4

Effects of Targeting

Overview of Targeting in JAMKESDA Schemes

Targeting is a key policy issue for a health care security program in order to ensure that the limited public resources are distributed effectively to those who are eligible. According to Walle (1998), 'targeting' in social/health policy involves a set of systematic and purposeful efforts to concentrate limited public resource so as to effectively reach those who are poor, left behind, or who are vulnerable to risk. This definition suggests that the outcomes of policies and programs to reduce poverty can be achieved effectively if the limited resources available can be concentrated on the target groups who are in particular need. The underlying assumption of targeting is that it is possible to distinguish who is poor and who is not. From the cases studied, there are at least three methods of targeting used in JAMKESDA schemes.

The first method of targeting is employed by *Kab. Lebak, Kota Tasikmalaya, and Kab. Kutai Timur*. In these regions, the health care security benefits can be accessed by poor and disadvantaged people by showing the *Certificate of Disadvantaged (Surat Keterangan Tidak Mampu/SKTM)* document, which is issued by the village chief and authorized by assigned officials from District Health Agency. This method of targeting can be called the means testing method.

Based on the three cases covered in the study, the means testing method using SKTM has both pros and cons. This method of targeting is easy in practical terms for the government officials to administer. It also does not require a pre-identified list of beneficiaries. The method work best when reliable and valid data in respect of poor and disadvantaged people is not available. Issuing of the SKTM requires criteria of disadvantage. The local government may use criteria related to a formula to identify who are eligible for the SKTM, mostly using their own local poverty criteria that differ across regions. However, the criteria are often arbitrary and subject to the personal judgment of the village chief. In these three regions, the district and municipality governments do not have poverty data. However, this method of targeting poses a number of problems. First, it is prone to abuse. Because the SKTM is issued by

the village chief, it may be accessed by people regardless of their actual economic status. Better off people may apply and obtain the SKTM due to poor oversight of the application process. It also places more burdens on the poor as they are required to apply for the SKTM each time they need to access health care services. To avoid those problems, Kutai Timur has a regulation that the recipient of health assistance using SKTM must sign a statement saying that they are eligible in terms of all the poverty criteria, and willing to pay all of the expenses if the feasibility survey team proves that they are not eligible.

The second method of targeting is employed by Kab. Kendal and Kab. Kulonprogo. In these two regions, the JAMKESDA schemes target poor and disadvantaged people who are not covered by the JAMKESMAS program. Those who wish to access the JAMKESDA's benefits are required to show their JAMKESDA membership card. Therefore, membership of these JAMKESDA schemes is pre-determined from the onset. In Kab. Kendal, the district government's District Health Agency issues a District Head's Decree on the list of JAMKESDA beneficiaries, which is updated annually. The District Health Agency forms a team to conduct regular membership verification and validation to ensure that the scheme is accessed by eligible individuals. This method of targeting can be referred as *Proxy Means Testing*.

The *Proxy Means Testing* identifies individuals using proxies that reflect his or her well-being. Usually *Proxy Means Testing* involves scoring each household based on a small number of easily observable characteristics and a weight (ideally obtained from factor or regression analysis of household data). Eligibility is determined by comparing the score against a predetermined cut-off. The district of Kendal in developing its list of JAMKESDA beneficiaries uses poverty criteria which are slightly different from those used by BPS.

The third targeting method, which is employed by Kota Makassar, Kota Balikpapan, Kota Palembang, with their universal district health security schemes, is *broad targeting*. These schemes simply target all residents of the municipality, regardless of their social and economic status. In order to access the scheme benefits, the prospective user in Makassar and Palembang is only required to show his or her proof of residency (KTP/ID Card and *Kartu Keluarga*/Family Card). In Balikpapan, the Jamkesda cards (JPK Gakin, Jamkesda Informal and JPK-PNS card) are still used along with the KTP to identify the beneficiaries of the Jamkesda program.

This targeting scheme is likely to be easier to manage for the district government. The district government does not need to develop and maintain a beneficiary database. Mis-targeting possibilities can be reduced as the scheme is for all citizens who reside in the respective region. Even though this targeting method minimizes the risk of mis-targeting, it still creates discrimination in access to health care services for poor and disadvantaged people. This happens because poor and disadvantaged people often do not have proof of residency.

The following table presents an overview of targeting methods employed in district health insurance schemes.

Table 4a.
Overview of Targeting Methods of Health Care Security Schemes

No.	Targeting Methods	Districts/ Municipalities	
1.	Means testing using SKTM (Certificate of Disadvantage)	<ul style="list-style-type: none"> • Kab. Lebak • Kota Tasikmalaya • Kab. Kutai Timur • Partially used by Kab. Kendal for those who are eligible for the JAMKESDA Scheme but have not been included in the district list of JAMKESDA beneficiaries 	<p><u>Pros</u></p> <ul style="list-style-type: none"> • Uncomplicated in practical terms for district government to administer; • Works simply despite the lack of data on eligible individuals; • It does not require the district government to have an updated database of beneficiaries; • Can be used to complement other methods of targeting in order to minimize the risk of mis-targeting e.g. Kab. Kendal <p><u>Cons</u></p> <ul style="list-style-type: none"> • Prone to abuse due to poor verification and validation procedure • May place greater burden on poor and disadvantaged people, due to long application process. Each SKTM is only applicable for single treatment.
2.	Proxy means testing using district's poverty indicators	<ul style="list-style-type: none"> • Kab. Kendal • Kab. Kulonprogo 	<p><u>Pros</u></p> <ul style="list-style-type: none"> • Provides certainty of status for the member of JAMKESDA to access benefits • Provides certainty to district government about the number of people covered in the JAMKESDA scheme, which allows the district government to anticipate the need for resources in advance and have control over the financial resources. <p><u>Cons</u></p> <ul style="list-style-type: none"> • May still run the risk of mis-targeting • Requires district government to develop membership database which is maintained and regularly updated. • Requires a more advanced institutional capacity to administer.
3.	Broad Targeting using proof of residency	<ul style="list-style-type: none"> • Kota Balikpapan • Kota Makassar • Kota Palembang 	<p><u>Pros</u></p> <ul style="list-style-type: none"> • Easy to administer in practical terms • The risk of mis-targeting can be reduced because the scheme is targeted to all residents of the respective region <p><u>Cons</u></p> <ul style="list-style-type: none"> • Depending on the conditions, it may still exclude those who are eligible due to administrative requirement to access the benefit.

The Effects of Targeting

The previous section discussed the targeting method used by various JAMKESDA schemes. This section focuses on the effects of different targeting methods on how the scheme includes or excludes legitimate potential beneficiaries. A well-designed targeted transfer is one that is effective in addressing specific problems and target groups (beneficiaries) and avoids providing services to non-beneficiaries. It could also be used as a mean for redistribution. Despite the promises of targeting, we need to give more attention to the fact that poverty is not static. So, targeting requires aiming at a moving target. Accuracy, validity, and updating data become crucial.

The fact that poverty is dynamic means that a poverty-targeted model of health care security is not always reliable in covering all poor people. We cannot say that all of the poor are covered if the number of beneficiaries is the same as the number of poor people, because every day there are people who become newly poor or escape from poverty. In addition, if the number of poor people who are not covered is the same as the number of non-poor people who are covered, the total number of beneficiaries will be the same as the total number of poor people, but there will be poor people who are not covered. So, the quality of the membership system – including whether it is up-to-date – is a key point that must be considered to assess the effect of targeting.

To estimate the effects of targeting on potential inclusion and exclusion of prospective beneficiaries, this section uses poverty data as a benchmark to determine the eligible group. Despite the fact that the number of poor people is dynamic, these data are still reliable because they reflect the real state of poverty that should be used in determining the number of beneficiaries when the program is formulated.

The effect of the targeting methods used in JAMKESMAS and JAMKESDA is measured in terms of the extent to which these methods succeed in reaching the intended beneficiaries and in excluding those who are ineligible. The analysis is divided into three parts. The first part explains the differences between the national and local poverty data. The problems related to poverty data are crucial to evaluate because they affect the targeting methods that are used by each region given that most regions use poverty data to determine who is eligible and who is not. Failure to determine the problems related to poverty data and counting the poor will result in anti-poverty programs—including JAMKESDA—operating incorrectly, being ineffective and sub-optimal. The second part of this analysis discusses targeting error problems that are revealed by statistical data, and the third part will attempt to classify the error problems based on the theory of E-type and F-type errors and double dipping problems.

Overview of the Poverty Data Problems

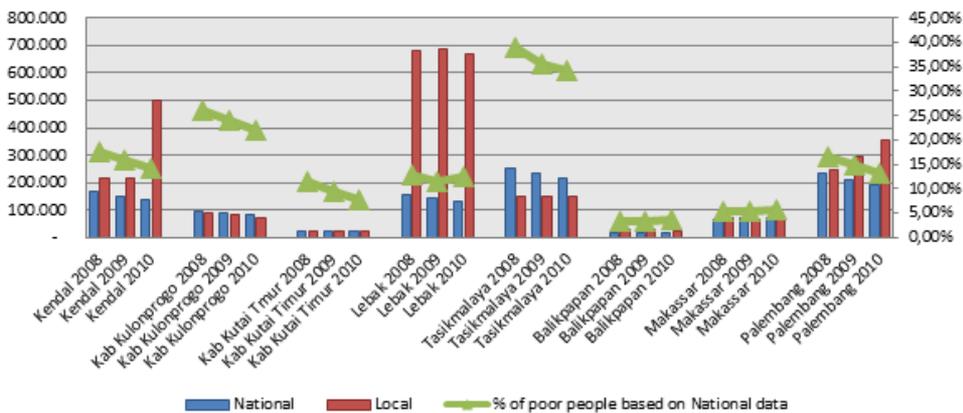
Before proceeding to the analysis, it is worth overviewing the poverty data that will be used in the analysis. There are differences between national poverty data (from BPS) and local poverty data. The poverty data that are published by BPS are widely used to determine the recipients of government anti-poverty programs, including JAMKESMAS. They are also used for most of the JAMKESDA programs organized by local government. Unfortunately, some local governments feel that the BPS data are poor quality, outdated, do not reflect the characteristics of local poverty problems, etc. These problems then become reasons for using their own collected

poverty data as the basis of eligibility criteria for their local anti-poverty programs. The use of their own poverty criteria which are different from the national results in complexity of mis-targeting problems.

Problems in respect of BPS data also occur in determining the eligibility criteria of the JAMKESMAS program. The program uses poverty data from 2007 to determine the recipients for the 2010 period. Because poverty is dynamic, the people who are not eligible anymore because of increases in family welfare, the new poor that are not listed in the data, and the people who do not reside in the same area where they are listed in the data make the targeting system of JAMKESMAS ineffective and sub-optimal in covering the poor.

The differences in the number of poor people in national and local poverty data can be seen in the chart below. Kendal and Lebak district have the greatest differences between the national and local poverty data. In 2010, the difference in the number of poor in Lebak is 542.570 people, where the local poverty rate is greater than national. In Kendal, the conspicuous difference between the local and national data only occurred in 2010, amounting to 361.576 people. This sharp difference occurred due to political influence that used poverty issues for election purposes.

Figure 4a. Difference Between National and Local Poverty Data, 2008-2010



The Targeting Problems in JAMKESMAS Implementation

Having evolved from the Social Safety Net-Health Sector program in 1998, JAMKESMAS is a national health care security system that was designed to provide access for the poor to health services. This program was targeted exclusively at the poor and executed with financing support from the social assistance budget allocated from APBN.

The constituencies of the poor are defined through the criteria adopted by the Central Bureau of Statistics. After being implemented and adjusted for more than 12 years, the beneficiaries and budget of JAMKESMAS multiplied from only 2,23 trillion rupiah to cover 36,1 million people in 2005, to 5,1 trillion rupiah to cover 76,4 million people in 2010.

Table 4b.
Budget Allocation of Jamkesmas, 2005-2010

Year	Budget Allocation (in Rp. Trillion)	Coverage/quota (in million people)	Number of Poor People (in million)
2005	2,23	36,1	35,1
2006	2,6	60	39,05
2007	3,53	76,4	37,1
2008	4,7	76,4	34,96
2009	3,6	76,4	32,53
2010	5,1	76,4	31,023

The above data show that the coverage of JAMKESMAS always exceeds the number of poor people. Even in 2010, the total allocation for the non-poor population is greater than for the poor. This indicates the existence of a targeting error problem whereby many non-poor are included in the program. This issue becomes more complex because of the fact that although the coverage exceeds the poverty rate, there are still many poor people who are not covered by the program.

If the beneficiaries of JAMKESMAS are confined to the poor and government tries to minimize the targeting errors by updating the data regularly, then the budget spending for JAMKESMAS can be efficient. However, with the existing allocation system, in which the number of beneficiaries of JAMKESMAS is always greater than the number of poor and updating is not done, the use of the budget is inefficient.

The chart below illustrates the trend in the ability to allocate sufficient budget for JAMKESMAS. The chart shows that the budget allocation tends to increase when JAMKESMAS is designed to focus only on the poor, while the amount of the per-poverty budget allocation is considerable. However, if we are using the current allocation model (per-quota budget allocation), the allocation of the budget looks likely to stagnate.

Figure 4b. Per-quota and Per-poverty Number Budget Allocation, 2005-2010



Although JAMKESDA aims to overcome problems in the implementation of JAMKESMAS, the implementation of Jamkesda also experiences various problems. The next section will explain the various issues that can arise in the implementation

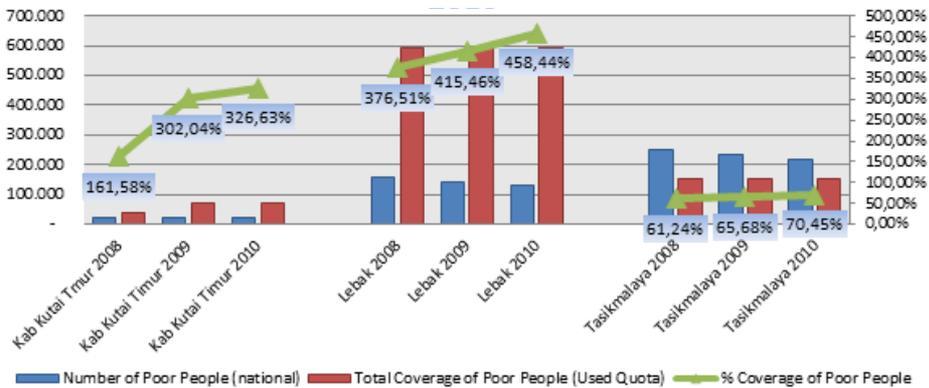
of JAMKESDA, The discussion covers several models: the health care cost subsidy, poverty targeted health assistance, universal coverage, and mixed model of health care assistance.

• **The Health Care Cost Subsidy**

The first model is health care cost subsidy, which is applied by Lebak district, Tasikmalaya district and Kutai Timur district. In respect of selection of target group, the characteristic of this model is the absence of beneficiary data. The selection of target groups is based solely on claims/demand through SKTM and is not based on a membership system. As a result, it is difficult to assess and estimate the extent of targeting error that has happened from the implementation of JAMKESDA in these three districts. However, the focus group discussions suggest that targeting error is a serious problem that occurs in the implementation of this model of JAMKESDA.

Due to the lack of detailed data, the estimation of targeting error is based on JAMKESMAS membership data. The analysis is conducted by comparing the number of poor people with the used quota of JAMKESMAS. Used quota is chosen because it reflects the actual situation in terms of how the quota of JAMKESMAS is actually distributed to and reaches the public. The comparison between the poor and the coverage of JAMKESMAS can be seen on the chart below.

Figure 4c. Coverage of Health Care Security Programs in Lebak, Tasikmalaya and Kutai Timur District, 2008-2010



The chart shows the capacity of JAMKESMAS in covering all the poor people in the three districts. In Kutai Timur and Lebak, the real coverage of JAMKESMAS (used quota compared with the number of poor people) is much greater than the national poverty number. In 2010, the coverage of JAMKESMAS in Kutai Timur and Lebak amounted to 327 percent and 458 percent of the poor. This indicates that JAMKESMAS is not only enjoyed by the poor, but also by non-poor people. Moreover, there is an enormous number of non-poor people who enjoy the JAMKESMAS, in that the number of non-poor who get JAMKESMAS is three times greater than the number of the poor.

Unlike the two other districts, the allocation of JAMKESMAS in Tasikmalaya is lower than the poverty number, so that in 2010 more than 29 percent of poor people are not covered by JAMKESMAS. The problem in this situation is compounded by the finding that some non-poor obtain the JAMKESMAS.

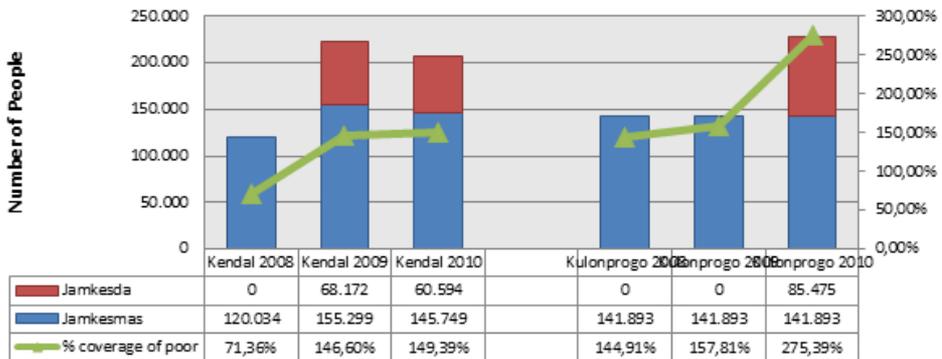
The inadequate updating system in JAMKESMAS contributes to the ineffectiveness of the implementation of health care security in these three areas. For example, although the JAMKESMAS allocation in Lebak is more than 400 percent, JAMKESMAS failed to cover the entire population of the poor who should be its primary mission.

The JAMKESDA program can be used to complement the JAMKESMAS by covering those who are missing from the beneficiary identification program (Program Perlindungan Sosial - 2008/PPLS-2008). However, in the absence of a membership database (and in general, the regions that use this model also do not have detailed data of the regional poverty number), this scheme fails to cover the poor, and also adds to the complexity of the targeting error problems in these districts because of inadequate verification systems.

- **Poverty Targeted Health Assistance Program**

The second model is poverty targeted health assistance. This model is applied in Kendal and Kulonprogo districts. The characteristics that distinguish it from others are the presence of a membership identification mechanism in JAMKESDA. Therefore, the actual beneficiaries of the program can be calculated, despite the fact that the districts still use the SKTM to cover the poor who failed to be included in the JAMKESDA and JAMKESMAS membership system.

Figure 4d. Coverage of Health Care Security Programs in Kendal and Kulonprogo, 2008-2010



In Kendal district, the existence of JAMKESDA actually increases the possibility of the targeting error. For example, in 2010, with 138.128 poor people, the coverage of JAMKESMAS in Kendal is 145.789. This shows us that through JAMKESMAS alone, the poor should be covered by the health insurance, and that 7.621 non-poor people also get the JAMKESMAS. With the 60.594 additional quota which is obtained from JAMKESDA, the number of non-poor people who obtain government health care security increased to 68.215 people.

But, if we reevaluate the problems in the implementation of JAMKESMAS, where a lot of the poor are not getting health care security, JAMKESDA can be considered as an effort "to patch" this targeting error problem. However, it can only be done on condition that the poverty data which they use are valid.

The practice of JAMKESDA in Kulonprogo is not different from Kendal, but the JAMKESMAS quota is much greater than the number of the poor. In 2010, with 82.563 poor people, the coverage of JAMKESMAS is 141.893. This means that 59.393

non-poor populations enjoyed the JAMKESMAS. Moreover, with the presence of JAMKESDA that covered 85.475 people in Kulonprogo, the number of non-poor people who obtained the government health care security was estimated to be 144.804 people. This calculation does not include the potential of targeting errors that occurred because of SKTM, which is difficult to estimate.

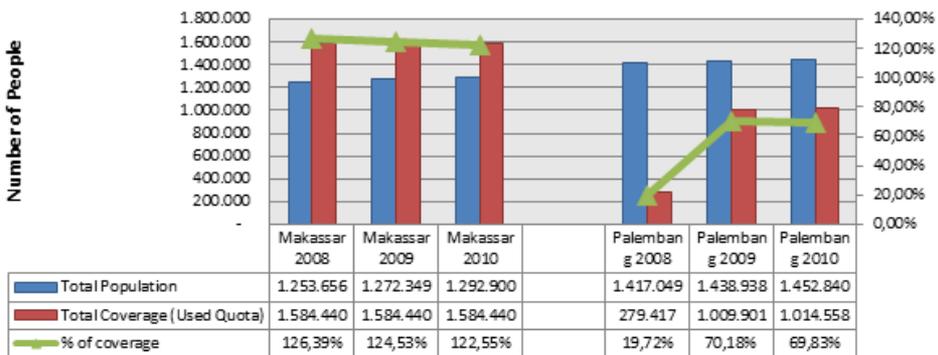
- **Universal Coverage**

The third model is universal coverage, which is applied by Makassar and Palembang city. Both of these city declared regional health care security that applied to the entire population.

Based on the membership data of the government health care security programs (JAMKESMAS and JAMKESDA), in Makassar, the total coverage is larger than the total population. In 2010, the JAMKESMAS beneficiaries stood at 336.004 and JAMKESDA covered 1.248.436 people. Thus, the total coverage of JAMKESMAS and JAMKESDA is 1.584.440 people, which is more than the total population of Makassar which is only 1.292.900 people. From these data, we can conclude that 291.450 people are covered by both JAMKESMAS and JAMKESDA program.

From the data below, there are things that must be underlined related to the data updating in the administration of JAMKESDA in Makassar. The total coverage from 2008 to 2010 is unchanged, proving that the coverage number, both in JAMKESMAS and JAMKESDA, is not updated regularly. Although the JAMKESDA was intended to cover all the residents of Makassar, the membership data must be updated regularly. This is to avoid the mistake of service delivery to someone who is not a resident of Makassar and to control the use of the budget of Jamkesda.

Figure 4e. Coverage of Health Care Security Programs in Makassar and Palembang, 2008-2010



In the city of Palembang, although the regional government has applied the universal coverage model, based on the total coverage data, only 1.014.558 or 69,8 percent of people were covered by the government health care security programs in 2010. This number is less than the total population which amounted to 1.452.840 people. Thus, there are more than 400.000 people of Palembang who do not get health care security provided by the government.

- ***The Mixed Model: Work Based and Poverty Targeted Health Assistance***

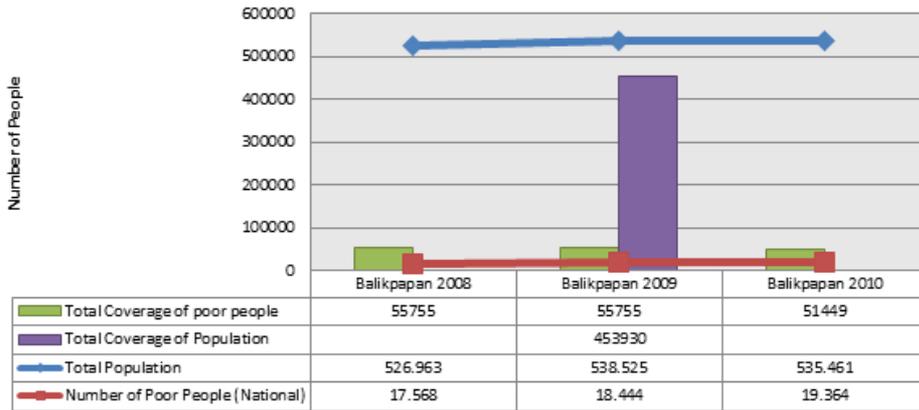
Balikpapan uses a mixed model of work-based and poverty based health assistance. This is because in one hand, Balikpapan is implementing a special health assistance program to cover the poor, where the local government pays all of the costs of medical expenses of poor people. On the other hand, Balikpapan has also developed health care assistance that is based on the type of job (informal sector (JPK for the poor/JPK-Gakin), formal sector (JPK for civil servants/JPK-PNS), and athletes (JPK-OR/Jamkesorga). The development of this multi-scheme program aims was intended to achieve universal coverage. However, in contrast to Makassar and Palembang which implemented a single model to cover all the population, the version of universal coverage in Balikpapan aims to include all the population through the introduction of different schemes to cover various targeted economic groups in population.

The implementation of health care security in Balikpapan is also different if it is compared with other regions in terms of eligibility criteria. Balikpapan has specific criteria in assessing the poor, where the effect on the difference in the number of poor people is quite large, 42.369 people in 2010. If the total coverage is considered as the sum of the population who are covered by JAMKESDA and JAMKESMAS, total coverage of the poor in Balikpapan stands at approximately 51.449 people (in 2010). This number is greater than the number of poor (national version) which is only 19.364 people, or 23.733 people if the local poverty figure is used.

However, the actual numbers who get the JAMKESMAS and JAMKESDA may be only 23.733 people. This is because the policy states that people who have a JAMKESMAS card should also get the JAMKESDA scheme due to the differences in what is covered. In other words, the JAMKESDA complements the JAMKESMAS in terms of both membership and benefit coverage. Therefore, if the national version of the poverty data is used as the benchmark, there are at least 19.364 people who have two health care security cards, and there are approximately 4.369 non-poor people included in the programs. But, if the local poverty data are used, there are no non-poor people are included in the program, and there are at least 19,364 of poor people who are "double carded", with the assumption that there are no mis-targeting problems in the JAMKESMAS program.

"Double carding" is not only happening in JPK-Gakin program, but also in JPK for the civil servants (JPK - PNS), which covered 19.882 people in 2009. Double carding is happening because the benefits offered by JPK-PNS are more comprehensive than those in the basic ASKES program given to all public officials. The coverage of health care security programs in Balikpapan is shown on the chart below.

Figure 4f. Coverage of Health Care Security Programs in Balikpapan, 2008-2010



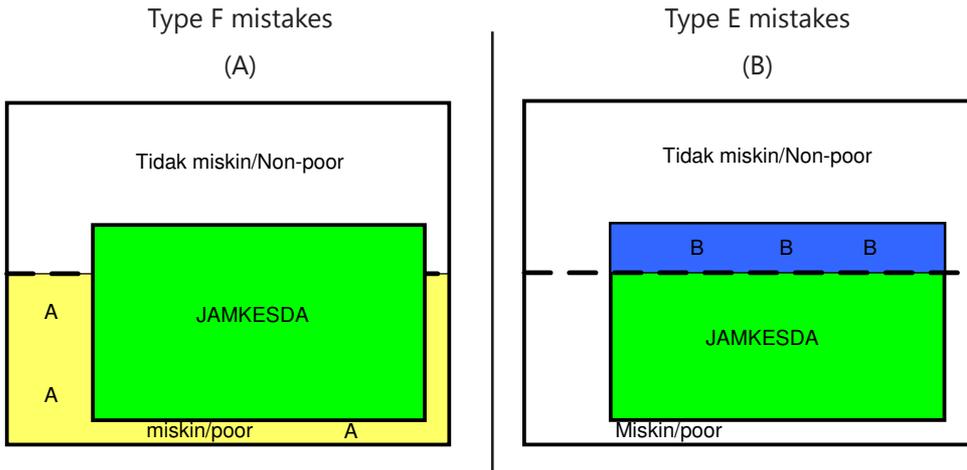
If all the schemes of health care security in Balikpapan are intended as a system to achieve universal coverage, the number of people not covered by any health insurance is still relatively quite high. In 2009, the number of people who did not receive any kind of health insurance program was 85.595 people, while the total numbers who were covered by health care security programs was 453.930 people. This number is composed of JAMKESMAS beneficiaries who were 27.716 people, the real JPK-Gakin beneficiaries (who only have JPK-Gakin) who were 232 people, the recipients of JAMKESDA informal who were 194.271 people and the members of other health insurance (Askes, Jamsostek, private health care insurance, etc) which might cover 231.620 people. Thus, the health care security schemes in Balikpapan have not yet been able to cover all of the Balikpapan residents.

The Targeting Error Problems: F-type, E-type, Double Dipping

There is a considerable literature that examines effectiveness and efficiency of targeting. Cornia and Steward (1995) categorize the failure of targeting into two types. The F-type mistake is failure of the intervention to reach the target group. The E-type mistake is failure where the intervention benefits the non-target group.

Table 4c. Targetting Error: Type-E and Type-F

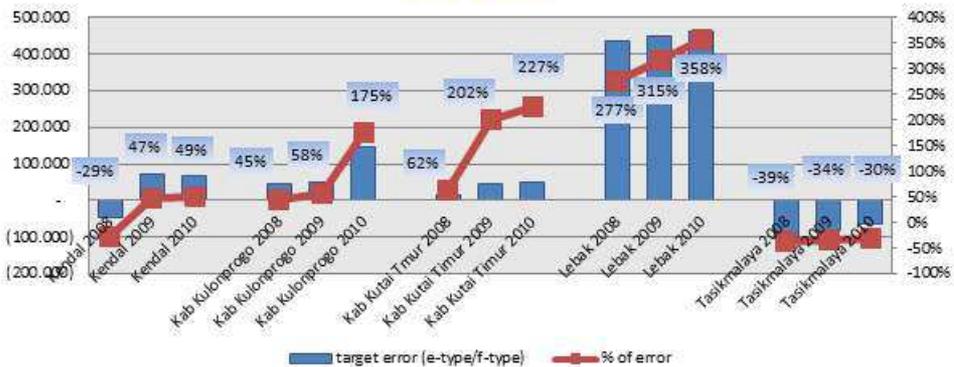
Classification matrix	Poor	Non-Poor	TOTAL
Receive JAMKEDA/ JAMKESMAS	Target group	Type E mistake	Total insured
Not receive	Type F mistake	Non-target	Total un-insured
TOTAL	Total Poor	Total Non Poor	Total Population



In the implementation of health care security in Indonesia, besides the type-E and type-F errors, there is also the double dipping problem, where one person receives benefit packages from two different programs. This might happen because in the Indonesia context there is duality of health insurance, those that are managed by the central government and those managed by local government. Based on the assessment, this problem is found in Balikpapan. The double dipping in Balikpapan was introduced intentionally because of the distrust of the national poverty data and the differences in the benefit coverage of health care insurance programs.

Based on the previous discussion, the most common type of targeting errors that occur in the five districts, which are implementing the poverty-targeted programs, is the Type-E error. This error occurs because people who are ineligible are covered by the JAMKESDA or JAMKESMAS programs.

Figure 4g. The Problems of Targeting Error in 5 Regions 2008-2010



The district of Kendal (2009 and 2010), Kulonprogo, Kutai Timur, and Lebak are regions which experienced the Type-E error. The percentage of this error varies across periods and regions. For example, in Lebak, the Type E-error rate is approximately

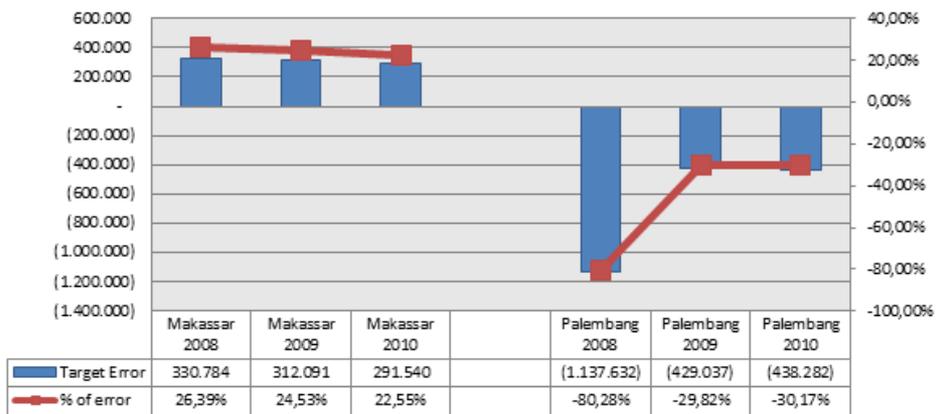
358% in 2010. This means that the number of non-poor who get government health care security program (JAMKESMAS and JAMKESDA) is three times higher than the number of the poor.

The Type-E error also commonly occurs because the quota of JAMKESMAS program is higher than the number of the poor. In reality, many of the JAMKESMAS data are also mis-targeted and outdated. Therefore, despite the higher quota that has been allocated in JAMKESMAS compared to the number of the poor, there are still a substantial number of poor people who are not covered by JAMKESMAS. To overcome these problems, some areas such as Kendal and Kulonprogo have introduced the JAMKESDA program.

Tasikmalaya is found to experience the F-type error, where many of the poor residents who are eligible for the scheme are not covered by the JAMKESMAS program. Although the local government has introduced the JAMKESDA program, the actual number of coverage cannot be assessed due to the poor program membership database system in the district. The records of those who use the SKTM to obtain health care services are virtually absent. The F-type error is also found in Kendal in 2008.

In the regions that implement universal coverage, as in Makassar and Palembang, the scheme still potentially suffers from targeting error. As described in the previous section, there are 291.450 people or 22,6% of residents of Makassar who are covered by the two government health insurance programs in 2010. In other word, some people are potentially received two benefits at the same time (double dipping). Although the double dipping problem has declined each year in Makassar, poor updating system of Jamkesda beneficiaries may result in this problem becoming worse.

Figure 4h. The Potential F-Type Error and Double Dipping in Makassar and Palembang



The chart illustrates the problem of targeting in the implementation of government health care security programs in Makassar and Palembang. In Palembang, there are at least 400.000 or 30,2 percent of the residents who did not receive health care security programs from the government (2010). Thus, in this city, the type-F error has occurred.

The Budget Capacity Relating to the Model of Targeting

In terms of budget allocation, Balikpapan has the highest budget allocation per-capita and per-quota when compared to other regions. From the 3 years of budgeting analyzed, the average budget allocation per capita per year is 37.946 rupiah, and per-quota budget is 61.459 rupiah. This calculation is based on the budget allocation of JAMKESDA informal, and does not include the other schemes such as JPK-Gakin and JPK for civil servants.

Balikpapan also has relatively high fiscal capacity to allocate budget to cover all of the costs of health care for poor patients through JPK-Gakin program. In 2009, Balikpapan allocated 5,51 billion rupiah to cover 28.039 poor people through JPK-Gakin. On average, Balikpapan allocates approximately 196.512 rupiah per-year of the allocated quota. This coverage also includes poor people who are double carded. If the actual allocation of JPK-Gakin is considered in respect of poor people who have only the JPK-Gakin card, the actual per-quota budget allocation of JPK-Gakin is 17.058.823 rupiah. With this amount of budget, Balikpapan can cover all of the poor to obtain free health care optimally.

Unfortunately, the capacity to allocate a large amount of budget to finance JAMKESDA to achieve universal coverage varies across regions. Low financing capacity, poor ability in managing the program, and high burden in regions with health infrastructure problems are among the factors that prevent regions from providing universal health coverage. In districts which implement the SKTM system, the per-capita budget expenditure for JAMKESDA is relatively small. Lebak for example, only allocates 1.359 rupiah percapita per-year or 2.679 rupiah per-quota per-year to finance the JAMKESDA program. In Kutai Timur, although the per quota budget is relatively high, the total health care costs in this district are very high (caused by inadequate health facilities, especially in remote areas, poor transportation facilities, and other infrastructure problems). Moreover, the budget includes additional administrative costs such as feasibility surveys which are required as they do not have poverty data as the basis for targeting. With low capacity to finance the programs, the implementation of regional health insurance will not be optimal, especially if they are implementing a policy to cover all of the costs of health services.

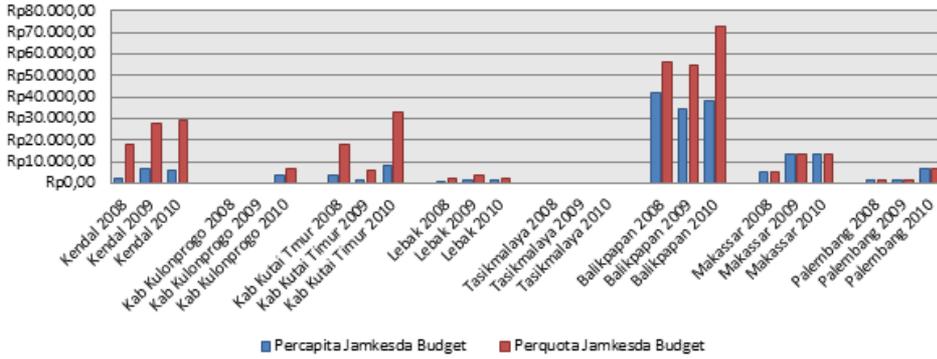
In the areas where the health insurance system are based on a membership system, the budget allocation for financing health care security is also relatively small, especially in Kulonprogo. In Kendal, despite the increasing trend of perquota budget allocation each year, the allocated budget has not been sufficient to cover all of the health care costs for the poor who participate in the JAMKESDA program.

In the two areas that introduced a universal health care security scheme, Makassar and Palembang, the budget allocations for their schemes are still inadequate. Makassar city is only able to provide 10.903 rupiah percapita peryear and Palembang 3.217 rupiah percapita to finance the program. With this amount of budget allocation, Makassar and Palembang may find it difficult to provide high quality health services.

The comparison of the per-capita and per-quota budget allocations in each region can be seen on the chart below⁵.

⁵ Balikpapan is only using Jamkesda Informal Program, not include the other scheme such as JPK-Gakin, JPK-PNS, JPK-OR/JAMKESOR

Figure 4i. Comparison of Per-capita and Per-quota Budget in all Regions, 2008-2010





Departemen Kesehatan
Republik Indonesia



kartu peserta
JAMKESMAS

image source: <http://images.google.co.id/>

Chapter 5

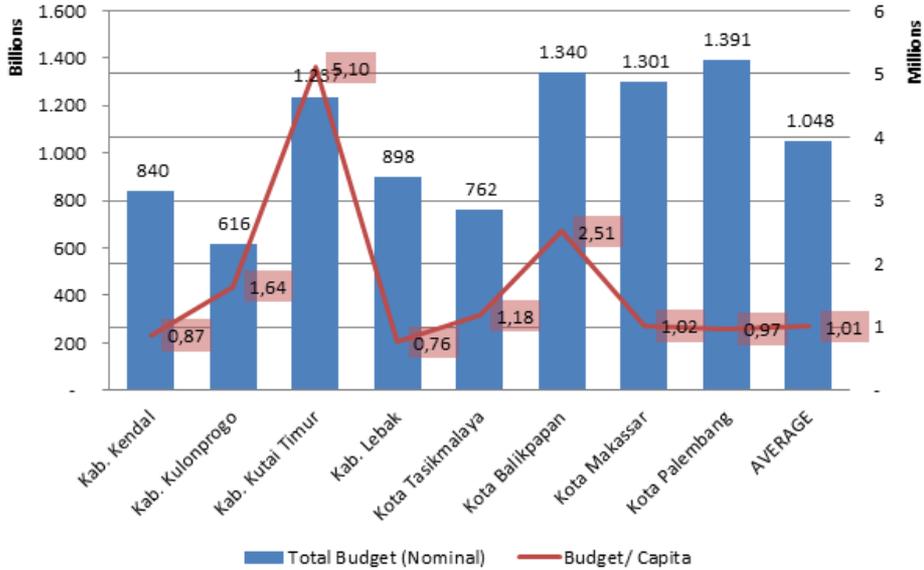
District Financing Capacity for Health Care Insurance Scheme

This chapter discusses the district financing capacity to implement a health care insurance scheme. The first part of the chapter discusses general budget profiles . The next parts of the chapter discuss the comparison of district revenue and how it may affect the the fiscal capacity of districts. The chapter also compares the district spending pattern, health budget in general, and budget allocation for district health insurance scheme.

General Budget Profiles

The districts that are located outside Java Island have higher total budget allocation than their counterparts in Java Island. The average of total budget from 2008-2010 in 8 districts ranges from Rp. 616 billions (Kab. Kulonprogo) to Rp. 1,4 trillion (Kota. Palembang). Interestingly, the districts that have average total budget allocation above the average are located outside Java Island. These district are *Kab. Kutai Timur (Rp. 1,237 billions)*, *Kota Balikpapan (Rp 1,340 biliions)*, *Kota Makassar (Rp. 1,301 billions)*, and *Kota Palembang (Rp.1,391 billions)*. *Kab. Kutai Timur* and *Kota Balikpapan* are located in Kalimantan Timur, that is rich with abundant timber and coal mining resources. *Kota Makassar* is the capital of Sulawesi Selatan Province that has become the most industrialized capital and the busiest trading hub in eastern Indonesia. *Kota Palembang* is the capital of Sumatera Selatan Province which has abundant oil and gas resource.

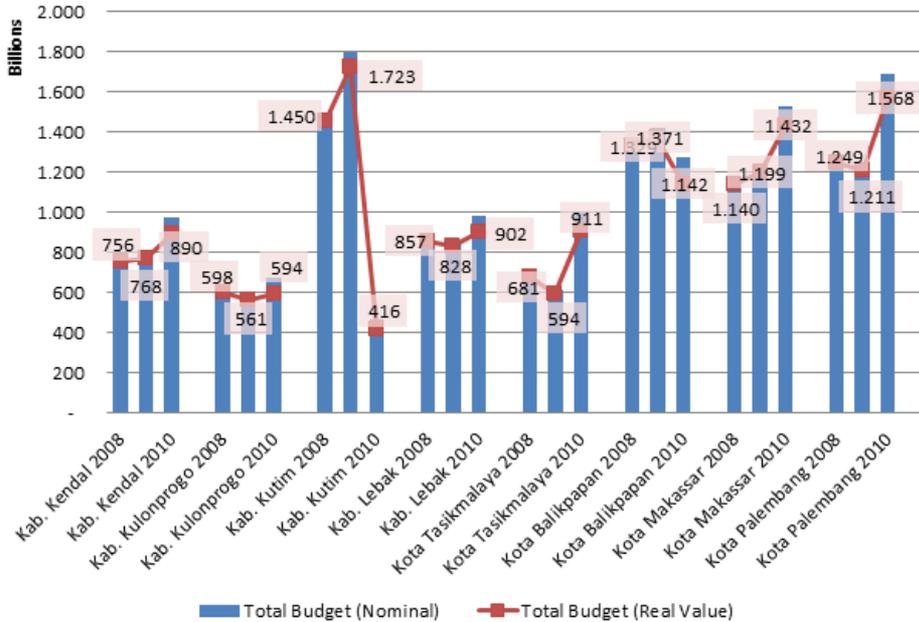
Figure 5a. Comparison of Total District Budget Average 2008-2010



A big budget allocation does not necessarily imply that members of the population in the respective district will benefit more than his/her counterparts who reside in districts which have lower total budget allocations.

The comparison of budget per capita shows a different picture on how the district population benefits from the high budget allocation. The total budget per-capita of the assessed districts ranges from Rp. 0.76 millions per capita (Kab. Lebak) to Rp. 5.10 millions per capita (Kab. Kutai Timur). The districts that have budget per capita figure above the average are *Kab. Kulonprogo, Kutai Timur, Tasikmalaya, Balikpapan, and Makassar*. Among these five districts, there are two districts that have exceptionally high budget per capita figures: Kab. Kutai Timur (Rp. 5.10 millions per capita) and Kota Balikpapan (Rp. 2.51 millions per capita). Tasikmalaya and Makassar are just slightly above the average. Kab. Kutai Timur and Kota Balikpapan share similar characteristics in that they are located in a resource rich region (Kalimantan Timur) and have relatively low population density.

Figure 5b. The Nominal and Real Value Budget Growth Trend

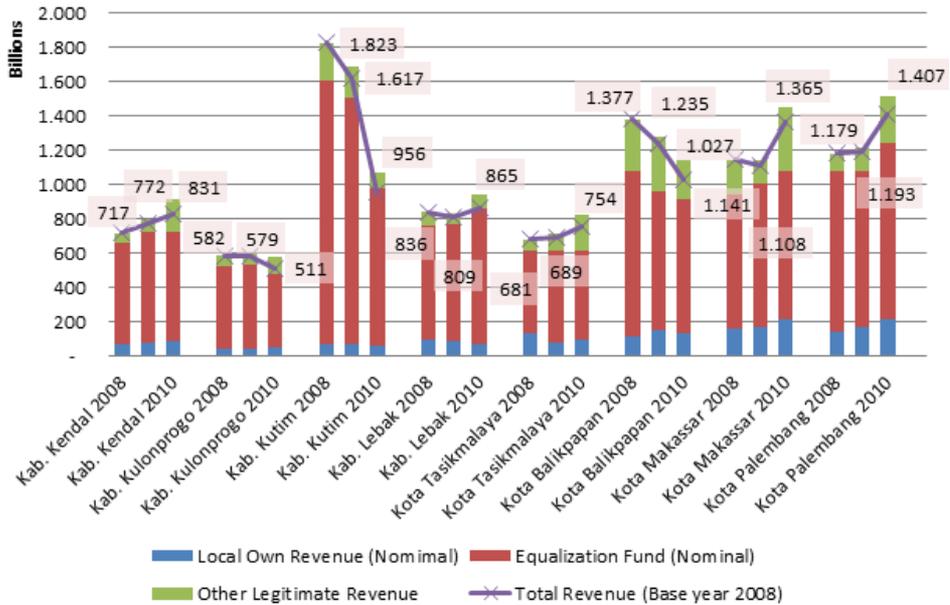


The trend of total budget allocation in terms of nominal and real value (2008) shows mixed trends with Kab. Kutai Timur and Kota Balikpapan experiencing a substantial declining trend. In general, most of the assessed districts have an increasing trend of total budget allocation in nominal value from 2008-2010 ranging from 6.4% (Kab. Kulonprogo) to 26.3% (Kota Tasikmalaya). Although Kab. Kulonprogo indicates an increasing trend in nominal value, its real value was actually decreasing (-0.19%). Kab. Kutai Timur and Kota Balikpapan are the only two districts among the assessed districts that experienced a declining trend of total budget allocation in term of their nominal and real value. The total budget allocation of these districts in 2010 dropped 74.1% in Kab. Kutai Timur and 10.6% in Kota Balikpapan from the previous year. The factors that may have caused this result will be discussed in the following section which discusses in more detail the revenue and spending allocation of the budget.

Budget Revenue Profile

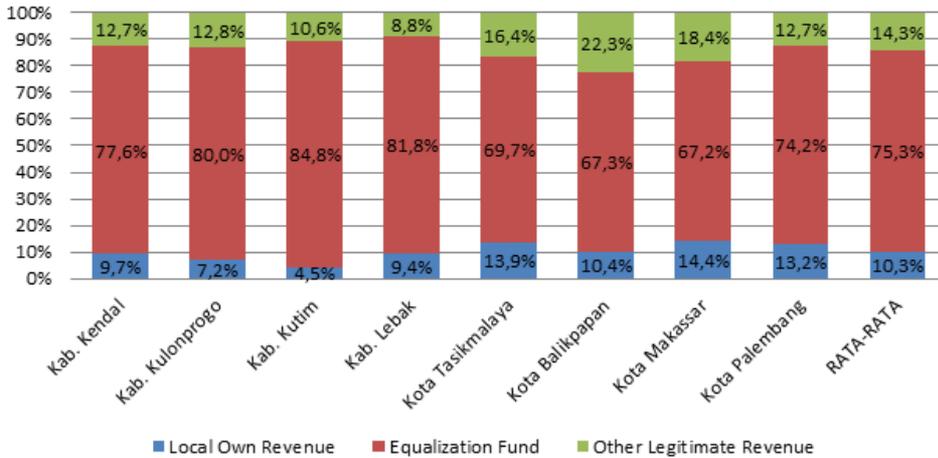
There is a mixed trend in the pattern of the district total revenue growth in term of nominal and real value. The district revenue growth shares a similar pattern with the total budget figures discussed earlier. Among the assessed districts, there are only 5 of 8 districts that show an increasing trend in both nominal and real value terms. Kab. Kendal shows a steady increase of its total revenue from Rp 717 billions in 2008 to Rp 831 billions in 2010. However, if the nominal figure of these districts are corrected by the inflation rate, the trend of the real value revenue growth is smaller than the nominal.

Figure 5c. Revenue Nominal Growth Trend 2008-2009



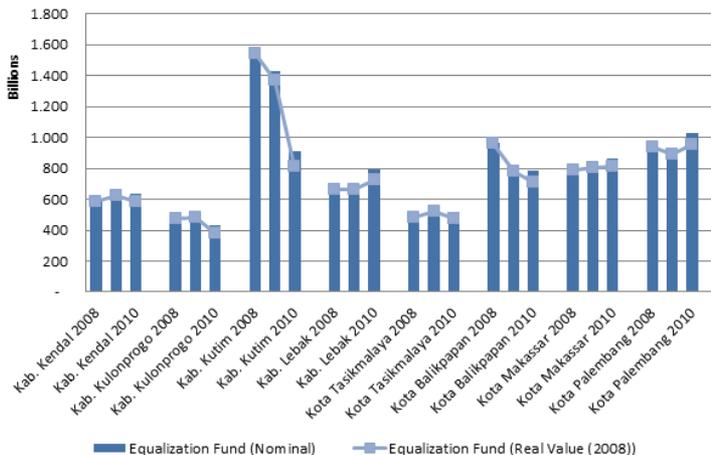
The districts still rely heavily on the Equalization Fund transfer from the central government as the main source of district revenue. The Equalization Fund (*Dana Perimbangan*) still contributes substantially to the district revenue budget. The average contribution of the equalization fund to district revenue ranges from 67.3% in Kota Balikpapan to 84.8% in Kab. Kutai Timur. Referring to the Law 33/2004 on Fiscal Decentralization, the Equalization Fund has three components: the General Allocation Fund (*Dana Alokasi Umum*), the Specific Allocation Fund (*Dana Alokasi Khusus*), and Revenue Sharing Fund (*Dana Bagi Hasil*). The General Allocation Fund is a government transfer from central government to regional governments which is specifically assigned to fill the regional government fiscal gap in performing basic government functions and essential public services in line with the principle of decentralization. The Specific Allocation Fund is specifically allocated to For specific purposes which are pre-assigned by the central government that might not be the priority of the district government Therefore the high contribution of the equalization fund transfer to district revenue indicates that there is a relatively high degree of dependency of the district government on central government resource.

Figure 5d. Average Composition of District/Municipality Revenue based on 2008-2010 Budget



The sharp decline in district revenue found in some of the assessed districts is due to the substantial decrease in the equalization fund transfer received by the respective government. In term of nominal value, 5 of the 8 districts experienced positive overall growth of the equalization fund transfer allocation from 2008-2010. These districts are Kab. Kendal (9.1%), Kab. Lebak (19.9%), Kab. Tasikmalaya (6.7%), Kota Makassar (9.8%), and Kota Palembang (9.6%). However, in terms of real value (base year 2008), the value of equalization fund transfer received by Kab. Kendal, and Kota Tasikmalaya actually decreased by 0.5% and 2.2% respectively during the 2008-2010 period. Kab. Kutai Timur and Kota Balikpapan are among the districts that experienced the most substantial decrease of equalization fund transfer by 40.8% and 18.3% respectively.

Figure 5e. Trend of Equalization Fund Transfer Growth 2008-2010



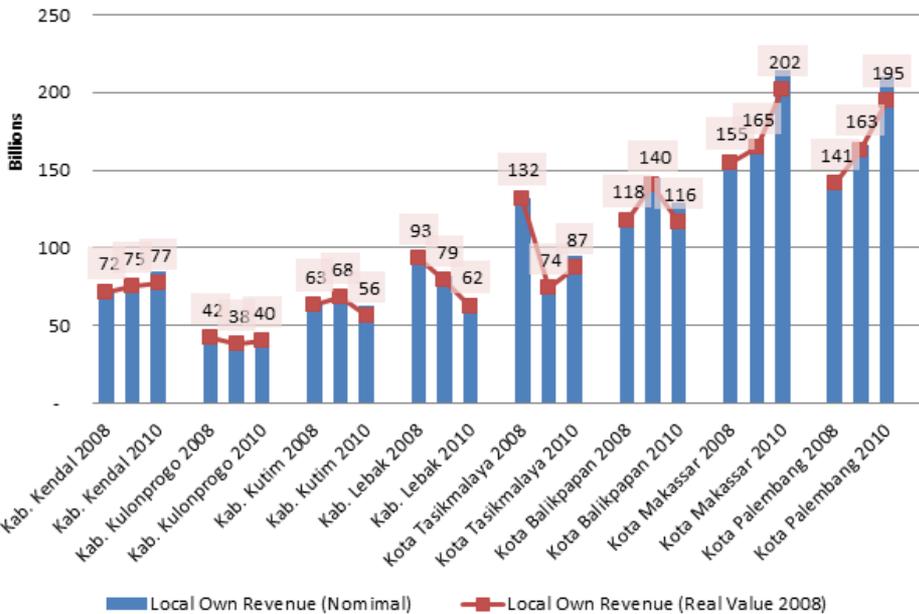
This figure explain the significant decreasing pattern of overall budget growth found in Kutai Timur and Balikpapan, as discussed in the previous section. The substantial decreasing trend is due to the decrease in the equalization fund transfer received by these districts. This hints at the implication of the relatively high dependency of district government to central government transfer. In the natural resource rich regions, the decrease in the equalization fund may be caused by the diminishing amount of transfer from revenue sharing of the natural resource extraction activities. This may due to depleted deposit or reserve of the natural resources in the respective region due to over-extraction/over-exploitation. Districts that are too dependent on natural resources without developing other economic sectors will be more affected. According to the Law 33/2004 on Fiscal Decentralization, one of the component of Equalization Fund is Resource Revenue Sharing Fund (*Dana Bagi Hasil*). The fund received by the resource regions is calculated based on pre-determined proportion as dictated by the Government Regulation, from the total resource revenue collected by the central government. The non-resource region may also receive the Resource Revenue Sharing Fund because the law also mandated that a part of sharing proportion should be distributed to other districts region within the same province in order to minimase inter-region disparity.

Another factor that may cause the decrease in equalization fund transfer is the decrease of Specific Allocation Fund (DAK). The specific Allocation Fund is a transfer from a ministerial budget and is managed and distributed by the Ministry of Finance. The Specific Allocation Fund aims to provide support to regional governments to attain specific objectives that have become concurrent obligation and functions of central and regional government. This fund can only be used for specific purposes which are pre-determined by the central government. Therefore the allocation of Specific Allocation Fund by the central government is determined by the extent to which the respective policy objective has been achieved or there have been changes in priority areas and issues of policy concerns from the leading ministry.

The General Allocation Fund transfer is unlikely to decrease because the variables involved in calculating General Allocation Fund are determined primarily by objective conditions in each regional government. The general allocation fund is calculated based on two components: basic allocation and fiscal gap of the respective district. The basic allocation is based on the number of government official working in the districts. The fiscal gap is calculated by subtracting [from fiscal capacity (based on estimated local own revenue and revenue sharing fund) the regional fiscal needs, which are estimated using population number, area, construction expense Index, regional GDP per-capita, regional human development index.

Onaverage the overall contribution of Local Own Revenue to total district revenue in all assessed districts is only 4.5% - 14.4%. Of the 8 assessed districts, only 5 districts have a positive trend in the overall Local Own Revenue growth in terms of nominal value (2008-2010). These districts are Kab. Kendal, (17.8%), Kab. Lebak (7.6%), Kota Balikpapan (9.8%), Kota Makassar (38.5%), and Kota Palembang (48.8%). However, in terms of real value (base year 2008), local own revenue of Kab. Lebak and Kota Balikpapan actually decreased by 4.9% and 1.3%. Only Kota Makassar and Kota Palembang indicate relatively high growth rate of local own revenue in terms of nominal and real value. The local own revenue of Kota Makassar and Kota Palembang increased by 38.5% and 48.8% respectively during the 2008-2010 period.

Figure 5f. Trend of Local Own Revenue Growth 2008-2009



It is worth noting that the amount of local own revenue generated reflects the economic performance in the respective districts. Among the sources of Local Own Revenue, local tax and user charge fees are the two most important sources for district government. In order to increase the revenue from these sources, the district governments are required to be creative and develop policy innovation and appropriate incentives that will promote economic activities that will later contribute to local own revenue.

In generating local own revenue from local tax and user fee charge, the municipal government has better leverage than the district government. This is because of the different demographic and geographic context between municipality and district. The municipality is commonly characterized as more urban than its district counterpart, and economic activities are naturally agglomerated and the population are more densely resided. The dominant economic base of the municipality are secondary and tertiary sectors which offer more added value, compared to its district counterpart which is commonly characterised by the primary/extractive economic sector. It is consistent with the figure of the trend of local revenue growth which indicates that the municipality (Kota Makassar and Kota Palembang) is in better position to generate more revenue from local tax and user charge fees. In the long term, the municipal government is more likely to generate more resources from local own revenue.

Budget Spending Profile

The general pattern of the average budget spending from 2008 to 2010 in the 8 districts is mostly dominated by indirect expenditure with the exception of Kab. Kutai Timur and Kota Balikpapan. According to Ministry of Home Affairs Regulation No. 13/2007, total budget expenditure can be classified into indirect

expenditure and direct expenditure. The indirect expenditure is all budget spending that are not directly related to program and project implementation. Budget spending that is included in his category includes personnel cost, bank interest, subsidy, grant, social assistance, cost sharing, financial assistance, and contingency spending. The direct expenditure is all government spending that are directly related to program and project implementation. It comprises personnel cost, goods and services, and assets/capital. This suggests that indirect expenditure is more likely to benefit government apparatus than the general population in the respective districts. On average indirect expenditure from 2008 to 2010 contributes 52.8% to 72.6% to the total budget spending.

The exceptional pattern of budget expenditure found in Kab. Kutai Timur and Kota Balikpapan budget can be explained by their status as districts in resource rich region. The revenue gained by these two districts exceeds substantially the 'normal' cost of government apparatus and operations. In other words, districts which are blessed by abundant resources have the leverage to develop more programs and projects that will benefit the general population rather than use their resources only for sustaining the government bureaucracy.

**Figure 5g. Average Proportion of Budget Spending
2008-2010**

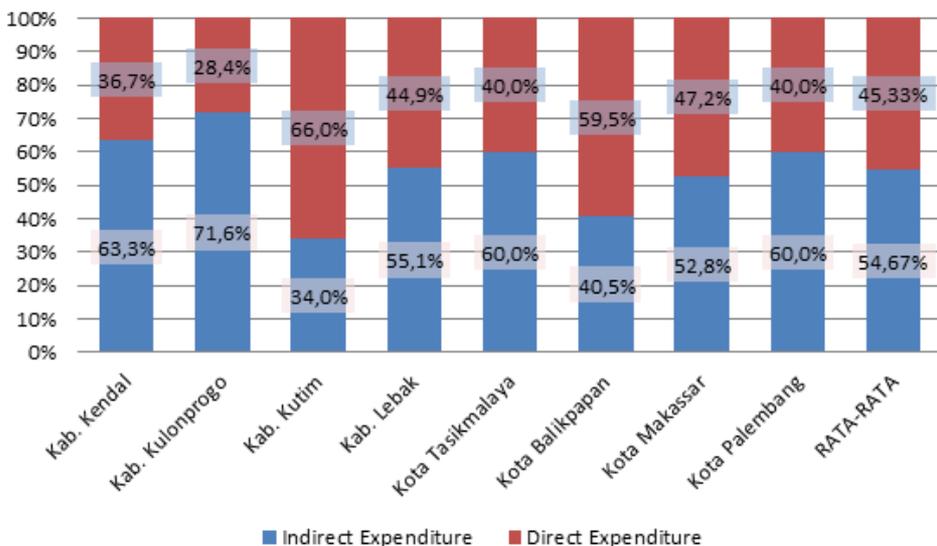
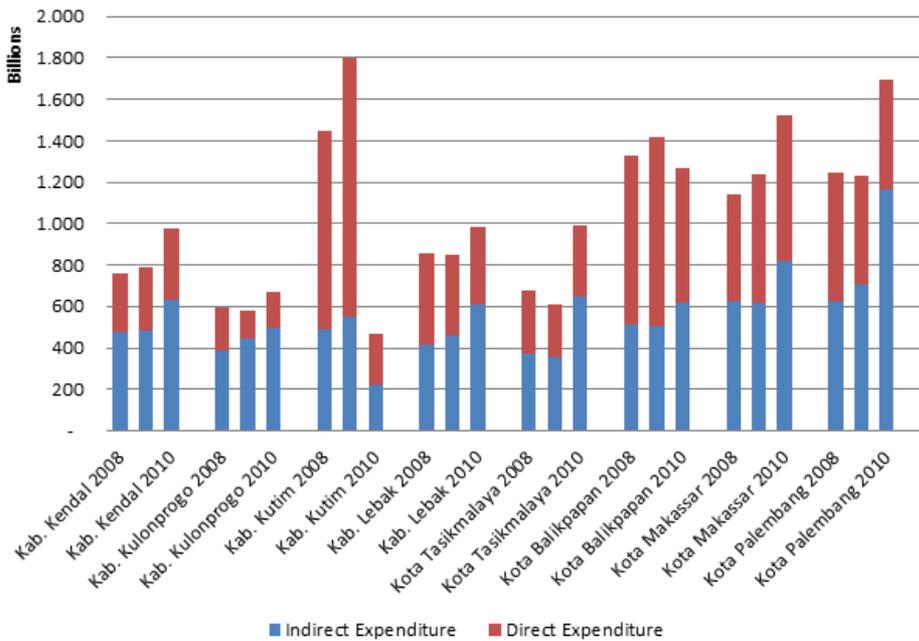
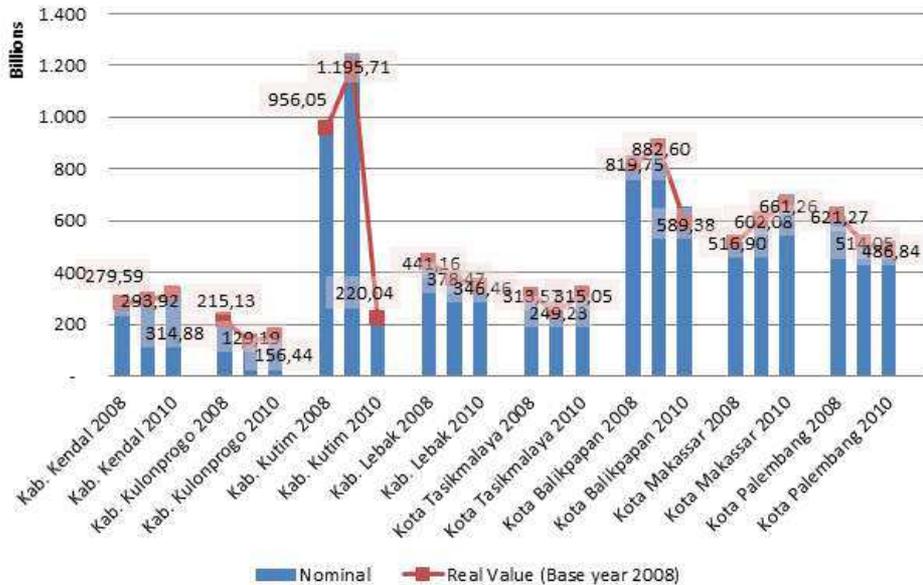


Figure 5h. Trend of district budget expenditure

In almost all districts, the overall trend of direct expenditure allocation of district budget decreased with the exception of Kab. Kendal, Kab. Tasikmalaya, and Kota Makassar. Direct expenditure, which comprises allocations for capital/ assets, goods and services, and personnel cost⁶, is an important component of budget expenditure to attract economic investment and deliver quality public services. The decreasing trend in the majority of districts may affect the investment growth rate and the quality of public service delivery. In term of nominal value, the three districts that experienced positive overall growth of direct expenditure are Kab. Kendal (11.19%), Kota Tasikmalaya (7.94%), and Kota Makassar (16.72%). However, in term of real value (base year 2008) only Kab. Kendal and Kota Tasikmalaya that experienced positive overall growth.

⁶ The personnel cost in the direct expenditure is different with that in the indirect one. In the direct expenditure, the personnel cost covers all costs that attached to the duty in delivering activities or services. For example fees for being resource persons or organizing committee members of an activities.

Figure 5i. Trend of Districts Direct Expenditure 2008-2010



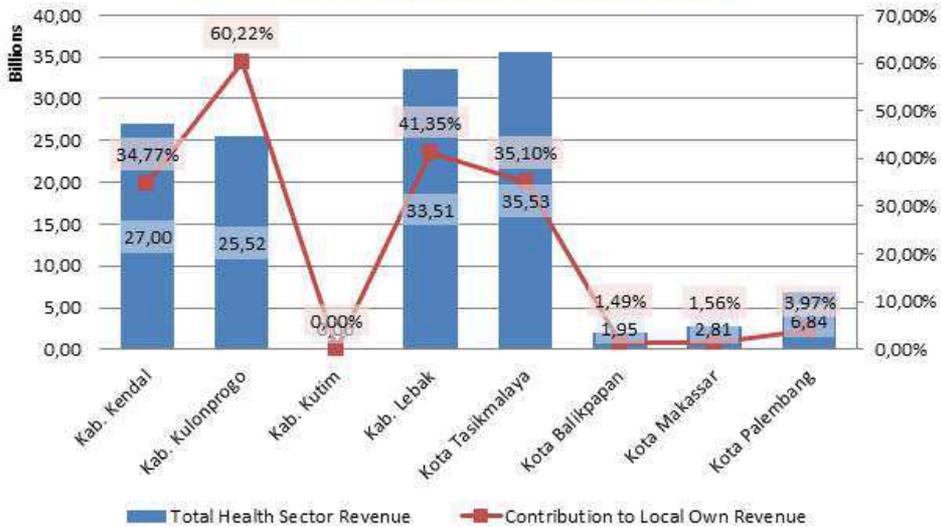
District Health Budget

Revenue from Health Sector

Local Own Revenue in 4 of the 8 districts benefits from revenue earned from the health sector. The districts in which the health revenue earnings contribute substantially to district local own revenue are Kab. Kendal (34.8%), Kab. Kulonprogo (60.2%), Kab. Lebak (41.4%) and Kota Tasikmalaya (35.1%). Interestingly, these districts have similar characteristic in that they are all districts with low fiscal capacity. In other districts, Kota Balikpapan, Kota Makassar, and Kota Palembang, the revenue earnings from health sector only contribute 1.5%-4.0% to total district local own revenue. In Kutai Timur, the health sector has not contributed revenue to district local own revenue because the public hospital facilities, where most of the health revenue is generated through user fees, became operational only in October 2010.

This situation implies that in the districts where revenue earnings from the health sector contribute substantially to district local own revenue, introducing a policy that eliminates or reduces the earning may erode the fiscal capacity of the respective districts. This situation may encourage district government to cut the allocations for public services, which will reduce the quality and/or the coverage of services provided. In term of district health insurance policy, these districts are unlikely to adopt universal and comprehensive health care insurance because these policy options are relatively too costly.

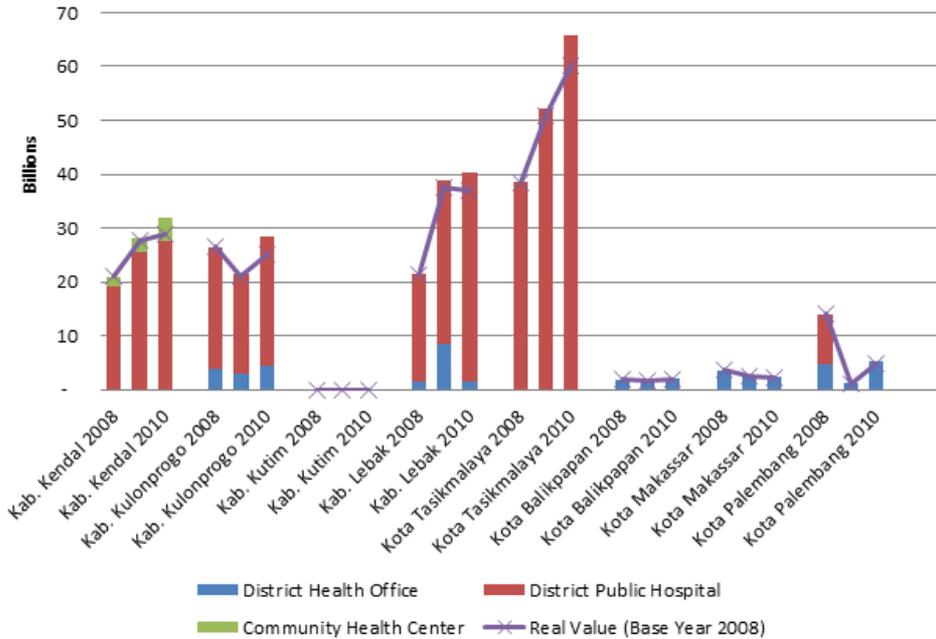
Figure 5j. Average of Revenue Earnings from Health Sector and Its Contribution to District Local Own Revenue



User fees for health services are the major contributor to district health sector revenue earnings. The public hospital is the major contributor of district health sector earning. This means that user fees charged by public hospitals are the main source of district health revenue. This pattern is found in Kab. Kendal, Kulonprogo, Kab. Lebak, and Kota Tasikmalayan. Kota Balikpapan, Kota Makassar, and Kota Palembang are no longer generating revenue from user fees as these districts have implemented health care insurance schemes which are applicable to all population. The districts that rely on user fees are more likely to adopt a more targeted health care insurance scheme, particularly for poor people.

In the districts where user fees charge is still applied, the contribution from public hospital user fees charge have increased over time. The trend indicates that the district governments still rely heavily on user fees charge from public hospital and community health centers to cope with the increasing burden of health care costs. The districts that are no longer applying user fee charges in public health facilities are commonly characterized by their relatively high fiscal capacity which is gained through Revenue Sharing Fund for the resource rich districts, or relatively high contribution from local own revenue.

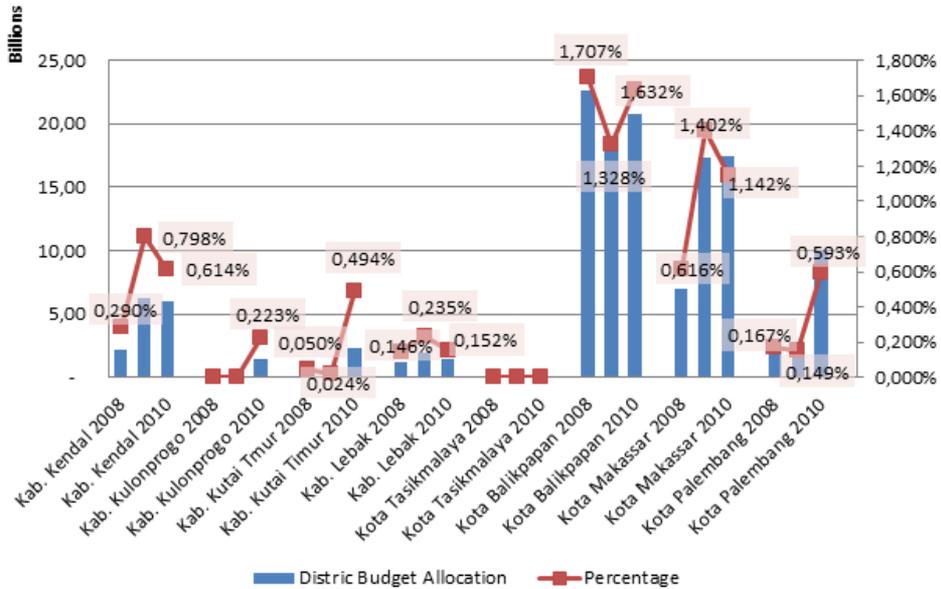
Figure 5k. Trend of District Health Sector Revenue Earnings 2008-2009



District Health Budget Spending

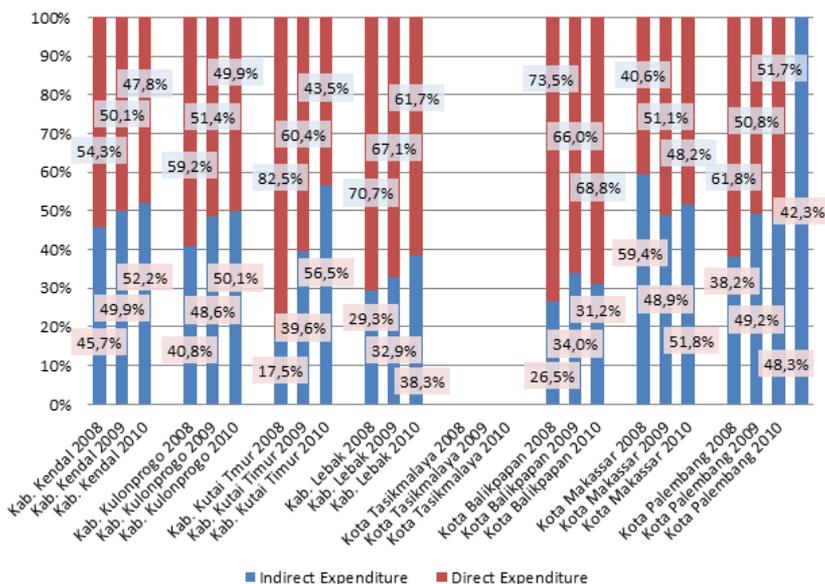
The majority of the assessed districts have allocated more than 10% of the total district budget allocation, but the substantial portion of this allocation is still for government apparatus and operational. The Law No. 36/2009 mandated the provincial and districts government to allocate a minimum of 10% of their total budget for the health sector, excluding allocation for salary. In the figure, 5 of 8 districts have allocated funds for health sector exceeding the 10% minimum requirement, as mandated in the Law No. 36/2009 on Health. These districts are Kab. Kendal (15.6%), Kulonprogo (18.1%), Lebak (13.0%), Tasikmalaya (14.3%), Makassar (10.2%), and Palembang (10.3%). However, a more in-depth overview of this allocation reveals that a substantial portion of the health budget allocation is still for government apparatus and operations. In other words, all of the assessed districts have not fulfilled their obligation to allocate a minimum of 10% excluding allocation for salaries for health services.

Figure 5l. District Budget Allocation for District Health Care Insurance and Proportion to Total District Budget



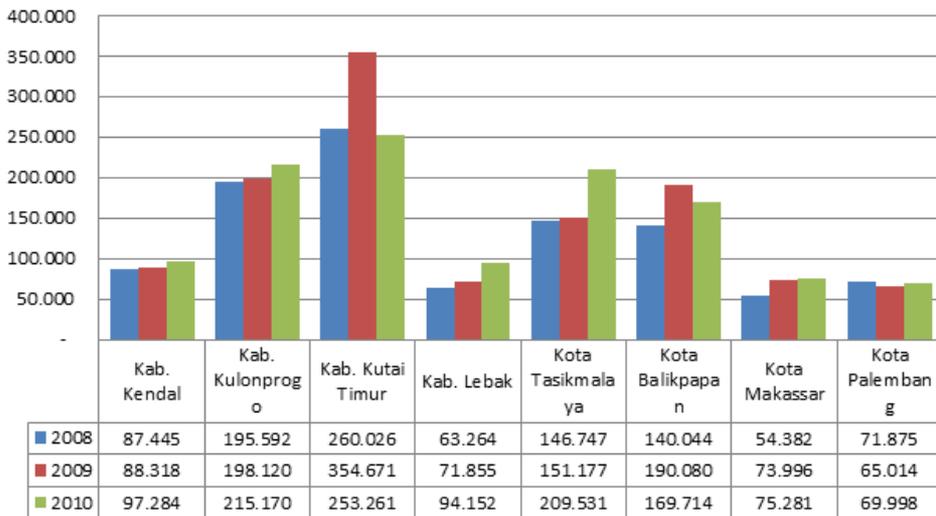
Approximately 42.3% of the total district health expenditure is allocated for indirect health expenditure items, which most of the funds are for government apparatus salary and operations. Thus the amount of the health district budget that really benefited the general population is much lesser than 10% of the total district budget.

Figure 5m. Proportion of District Health Budget Expenditure 2008-2010



Most of the district health budget expenditure has not fulfilled World Health Organization (WHO) and World Bank recommendation on minimum standard of health budget. The WHO recommends \$35-\$40 (Rp. 315,000.- Rp 360,000.-) per capita as the minimum standard of budget allocation for health sector that will ensure essential health service delivery. The World Bank Office in Jakarta in 1999 recommended that the minimum standard of health sector is Rp 41,000.- per capita (using present value estimation, the standard should be Rp. 72,000.- per capita in 2009). Using this standard, Only Kab. Kutai Timur in its 2009 budget allocated health budget as much as Rp 354,671.- per capita. However the 2009 allocation of Kutai Timur budget is an exception because the health budget allocation in the previous year was only Rp 260,062.- and it was only Rp 253,261.- afterwards. If the lower World Bank standard is used, the districts that have allocated a health budget that exceeds the minimum standard are Kab. Kendal, Kab. Kulonprogo, Kutai Timur, Tasikmalaya, and Balikpapan, and Makassar in 2010 budget.

Figure 5n. District Health Expenditure per Capita 2008-2010



Budget for District Health Care Insurance Scheme

Districts that implemented universal health care insurance allocate more substantially than their district counterparts that have adopted health care cost subsidy for the poor. The districts that have adopted universal coverage of health care insurance, which are Makassar, Palembang, Balikpapan, allocate more money for the scheme than others. The proportion of the budget allocated for district health care insurance ranges from 0.6% to 1.7% of the total budget. Palembang introduced the universal scheme in 2010, which explains the abrupt increase of budget allocation for the district health care insurance scheme. In other districts that are still using the subsidy scheme, the budget allocation for district health care insurance is much smaller ranging from none to 0.5%. However, Kendal which claimed to implement JAMKESDA was basically did not provide universal coverage as it still focus to prioritize the coverage on poor people who had not been covered by the JAMKESMAS

Figure 5o. District Budget Allocation for District Health Care Insurance and Proportion to Total District Budget

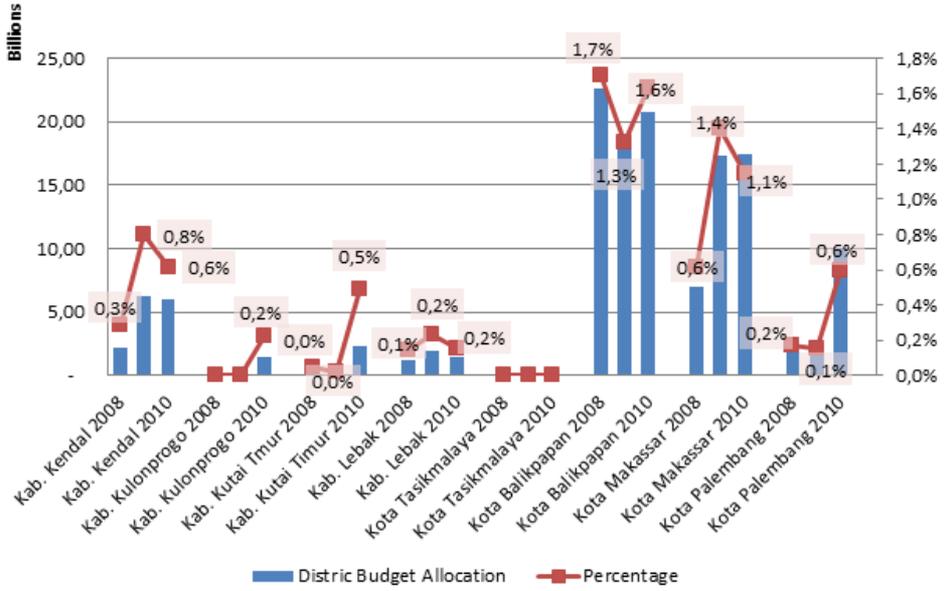




image source: <http://images.google.co.id/>

Chapter 6

Institutional Setting of the Scheme

The Legal Framework of the Scheme

The sustainability of the district scheme is also determined by its legal framework status. In practice, district governments adopt various legal frameworks for the schemes. However there are two kinds of legal framework status of the scheme identified in the assessed districts, which are *Peraturan Daerah* (local regulation) and *Peraturan Bupati* (Bupati Decree) or *Peraturan Walikota* (Mayor Decree). The status of the scheme's legal framework determines the degree of the political legitimacy of the scheme. This, in turn, influences the opportunities for the district leader to set up an institutional system for the scheme in order for it to operate effectively and to mobilize and allocate adequate resource for the scheme. This section discusses how differences in the legal framework status of the schemes may affect the scheme's sustainability.

The District Scheme with *Peraturan Daerah* Legal Framework Status

Among the assessed districts, *Kabupaten* Kulonprogo, Kota Balikpapan, and Kota Makassar adopted *peraturan daerah* (local regulation) as their legal framework basis for the district health insurance scheme. In addition to the aforementioned districts, the two provinces that established provincial health insurance schemes, Sumatera Selatan and Jawa Tengah, also adopted *peraturan daerah* as the legal basis for the scheme. The choice of *peraturan daerah* as the legal framework basis for the scheme is based on the consideration that *peraturan daerah* is recognized as one of the legitimate legal framework statuses for government actions and decisions in Indonesia's national legal framework system as stipulated in the Law No. 12/2011 on Legal Framework Development. According to this law, *peraturan daerah* is recognized as the sixth form of national legal framework after *peraturan presiden* (Presidential Regulation)⁷.

⁷ The six form of legal framework in Indonesia' legal framework system is 1) Undang-Undang Dasar Republik Indonesia 1945 (Indonesia's National Constitution); 2) Undang-Undang (Law); 3) Peraturan Pemerintah Pengganti Undang-Undang (Government Regulation for Law's Amendment) ; 4) Peraturan Pemerintah (Government Regulation); 5) Peraturan Presiden (Presidential Regulation); and 6) *Peraturan Daerah* (Local regulation)

The stipulation of a *peraturan daerah* requires joint approval of the Dewan Perwakilan Rakyat Daerah/DPRD (District House of Representative) and the district leader although the initial draft of the regulation may come from DPRD or district leader. As a consequence, *peraturan daerah* binds all parties (government, parliament, and the citizen) to comply with the content of *peraturan daerah*. Therefore, *peraturan daerah* provide the strongest legal basis at the regional level to require the authorities to set up the district health insurance scheme system, mobilizing and allocating resources.

In order to ensure that the stipulated *peraturan daerah* is operational, the district governments is required to produce various derivative and more technical regulations in the form of district leader's decree (*Keputusan/Peraturan Bupati or Walikota*). These derivative regulations are required to ensure the sustainability of the scheme in term of planning, resource allocation, execution, and monitoring and evaluation in the years to come.

Kabupaten Kulonprogo, *Kota Balikpapan*, and *Kota Makassar* have established specific *peraturan daerahs* and their respective regulation such as *peraturan/keputusan bupati or walikota*. The city of Balikpapan for example, has establish the *Peraturan Daerah* no. 6/2008 to regulate the system of the program. This regulation is specified into the *Peraturan Walikota* (Mayor Regulation) no. 05/2008 which focused on the formulation of organization and administration of the *Unit Pelaksana Teknis Jamkesda* (Technical Implementation Unit of the District Health Insurance) and *Keputusan Walikota* (Mayor Decree) no. 188.45-207/2010 on establishment of Jamkesda provider which is updated annually. *Peraturan Daerah* no.6/2008 has become the main reference of the Balikpapan government in formulating the detailed regulation and provides a foundation to build a more effective system and optimal way in mobilizing and allocating resources of the program.

The establishment of *peraturan perda* in *Kota Makassar* has a different basis than the other aforementioned districts. The *Kota Makassar's peraturan daerah* is an extension of the provincial regulations related to the implementation of universal health care security program at provincial level. This regulation has different implications compared to the other districts because it only outlines the mandated task that must be delivered by the Makassar government as part of the implementation of the provincial program of universal health insurance program. The advantages of this system is that the framework provides for easy financial transfer from provincial government to *Kota Makassar*. However, the system may not provide the flexibility to adjust the delivery system of the scheme so as to better suit the need of *Kota Makassar* citizens. Thus the *Kota Makassar* government and other municipalities and districts in Sulawesi Selatan Province are only positioned as implementer of the program. *Kota Palembang* shares a similar policy structure to *Kota Makassar* but uses *Keputusan Walikota* (Mayor Decree) as its legal basis.

The District Scheme with Keputusan/Peraturan Kepala Daerah (District Leader Decree/Regulation) Legal Framework Status

Kabupaten Kenda and *Kota Palembang* adopted *Keputusan/Peraturan Kepala Daerah* (District Leader Decree/Regulation) as the legal basis for their health insurance schemes. Unlike *peraturan daerah*, the *Keputusan/Peraturan Kepala Daerah* is not recognized as one of the legitimate legal bases for the government policy and regulations in the Indonesia legal framework systems. The decree or regulation is only signed by the district leader without approval from the house

of representatives. As a consequence, the decree/regulation only regulates the technical aspects of the scheme such as who is in charge, who is entitled to benefits from the scheme, how the money is disbursed, and so on.

This approach provides relatively weak political legitimacy for the scheme. This means that the future of the scheme is highly dependent on the political will of the district leadership and political support from the parliament to allocate adequate resource to ensure that the scheme is able to operate effectively. The district election system may also affect the sustainability of the scheme. Once the district leader is replaced through election, the scheme may be discontinued or disbanded altogether because the successors see the scheme as the product of the former leader. The successor feels compelled to replace the scheme with a different scheme that reflect his/her interests.

The District Scheme without Clear Legal Framework Status

Among the assessed districts, there are three districts that do not have a clear regulation framework for the district health insurance scheme. These districts are *Kabupaten* Lebak, Tasikmalaya, and *Kabupaten* Kutai Timur. The schemes in these districts take the form of a government project that requires approval from the house of representatives. The existence of the scheme is highly dependent on the planning and budgeting process which is performed annually. The projects are commonly financed through the social assistance budget line under the auspices of the District Secretariat (*Sekretariat Daerah*). The disbursement of the money is dependent on the district head's directives.

The absence of a clear legal framework of the scheme may affect the sustainability of budgetary support for the project. This is because the budgeting process is highly political and the outcome of the political decision in relation to budget allocation for the district health insurance scheme may not necessarily conform with the technocratic planning process. Instead, it depends on the political interests of the district leader and political pressure from the house of representative.

Unlike Lebak and Tasikmalaya, *Kabupaten* Kutai Timur has set up Bupati Decree no. 440/K/117/2010 on the establishment of task force for health care security program and District Health Agency Decree (SK *Dinas Kesehatan*) no. 188.4.45/755/HK/XI/2009 on the criteria of poor people in Kutai Timur that will be used as the basis for targeting. This regulation will at least ensure increases in the quality of Jamkesda services by creating special task division to operate the project, and will also improve the accuracy of target beneficiaries. However, these regulations can not ensure the project's sustainability because it is only based on Bupati Decree and District Health Agency Decree, which can be removed or replaced more easily than other legal frameworks.

The detail of the legal frameworks that are used by regions can be seen in the table below.

Table 6a.
Legal Framework of regions' Health Care Security Schemes

No.	District/ Municipality/ Province	Local regulation related to the schemes of Jamkesda	Local regulation related to the model of institution	Local regulation in detemining the eligible population
1.	Kab. Lebak	Not available	Not available	Not available
2.	Kab. Tasikamala	Not available	Not available	Not available
3.	Kab. Kutai Timur	Not available	<ul style="list-style-type: none"> • <i>Kepbup No. 440/K.117/2010 tentang Pembentukan satgas penyelenggaraan program jaminan pemeliharaan kesehatan bagi masyarakat miskin (PPJKMM) kabupaten Kutai Timur</i> (Kepbup no. 440/K.117/2010 on establishment of task force of health care security program in Kutai Timur). 	<ul style="list-style-type: none"> • <i>SK bupati Kutai Timur no. 188.4.45/755/HK/XI/2009 tentang kriteria penduduk miskin kabupaten Kutai Timur</i> (SK no. 188.4.45/755/HK/XI/2009 on the criteria for defining poor people in Kutai Timur).
4.	Kota Balikpapan	<ul style="list-style-type: none"> • <i>Perda No. 6/2008 tentang Sistem Jaminan Kesehatan Daerah kota Balikpapan</i> (Local regulation no. 6/2008 on regional health care security system in Balikpapan); • <i>Perda No 8/2004 tentang Penanggulangan Kemiskinan</i> (Local Regulation No. 8/2004 on Poverty Alleviation). 	<ul style="list-style-type: none"> • <i>Perwalkot no. 05/2008 tentang organisasi dan tata kerja UPT Jamkesda kota Balikpapan</i> (Perwalkot no. 5/2008 on organization and administration of UPT Jamkesda in Balikpapan); • <i>Kepwalkot no. 188.45-207/2010 tentang pembentukan penyelenggara program Jamkesda kota Balikpapan tahun 2010</i> (Kepwalkot no. 188.45-207/2010 on establishment of Jamkesda provider in year 2010). 	<ul style="list-style-type: none"> • <i>Kepwalkot no. 188.45-229/2009 tentang kriteria penduduk miskin</i> (Kepwalkot no. 188.45-229/2009 on the criteria for defining poor people).
5.	Kab. Kendal	<ul style="list-style-type: none"> • <i>Perbup No. 89/2008</i> (Perbup No. 89/2008). 	<ul style="list-style-type: none"> • <i>Perbup No. 71/2001 tentang tupoksi dinas kesehatan kabupaten Kendal</i> (Perbup no. 71/2001 on main tasks and function of district health office) 	
6.	Kab. Kulonprogo	<ul style="list-style-type: none"> • <i>Perda No. 6/2009 tentang Sistem Jaminan Kesehatan Daerah</i> (Perda No. 9/2009 on District Health Insurance System) • <i>PerBup No. 21/2010 tentang Petunjuk Pelaksanaan Perdano 6/2009</i> (District Head Regulation No. 21/2010 on Implementation Guidelines of the District Regulation No. 6/2009) • <i>Perbup 23/2010 tentang Perubahan atas Perbup 21/2010</i> (Perbup No. 23/2010 on Amendment of District Head Regulation No. 21/2010) 	<ul style="list-style-type: none"> • <i>Perbup no. 86/2008 tentang uraian tugas UPTD Jamkes</i> (Perbup no. 86/2008 on job description of Jamkesda UPTD); 	<ul style="list-style-type: none"> • <i>Perda No. 6/2009 pasal 1, pasal 6 ayat (2); dan PerBup No. 21/2010 pasal 5 ayat (1) dan pasal 6</i> (Perda No. 9/2009, article 1 and 6 (2); perbup no. 21/2010 article 5 (1) and 6).
7.	Kota Makassar	<ul style="list-style-type: none"> • <i>Perda No. 7/2009 tentang Pelayanan Kesehatan di Kota Makassar sebagai tindak lanjut Perda Provinsi No. 2/2009 tentang Kerjasama Penyelenggaraan Pelayanan Kesehatan Gratis</i> (Perda No. 7/2009 on Health Care Services in Kota Makassar as the follow up of Provincial Regulation No.2/2009 on Inter-government Cooperation for Free Health Care Services.) 	<ul style="list-style-type: none"> • <i>Perda Provinsi no 2/2009 tentang kerja sama penyelenggaraan pelayanan kesehatan gratis antara kota Makassar dengan provinsi Sulawesi Selatan, mengamatkan pembentukan lembaga pengendali pembiayaan kesehatan</i> (Provincial Regulation no. 2/2009 on intergovernment cooperation for free health care services). 	

No.	District/ Municipality/ Province	Local regulation related to the schemes of Jamkesda	Local regulation related to the model of institution	Local regulation in detemining the eligible population
8.	Kota Palembang	<ul style="list-style-type: none"> Keputusan Walikota No. 62/2009 tentang Pedoman Penyelenggaraan Program Jaminan Sosial Kesehatan Semesta Kota Palembang (Kepwalkot No. 62/2009 on the Implementation Guidelines of Universal Social Health Insurance Program in Kota Palembang). 	<ul style="list-style-type: none"> Keputusan Walikota 61/2009 tentang Pembentukan Tim Koordinasi dan Tim Pengelola Program Jamsoskesta (Mayor Decree No. 61/2009 on the Establishment of Coordination and Management Team of Universal Health Insurance Program) 	
9.	Prov. Jawa Tengah	<ul style="list-style-type: none"> Perda 10/2009 tentang Penyelenggaraan Jaminan Kesehatan Daerah (Perda No. 10/2009 on the Implementation of Provincial Health Insurance) Pergub Jawa Tengah 73/2010 tentang Petunjuk Peraturan Daerah Prov. Jateng no. 10/2009 (Pergub No. 73/2010 on Technical Guidance of Provincial Regulation No. 10/2009) 	<ul style="list-style-type: none"> Pergub Jawa Tengah 73/2010 tentang Petunjuk Peraturan Daerah Prov. Jateng no. 10/2009 (Governor Regulation No. 73/2010 on Technical Guidance of Provincial Regulation No. 10/2009) 	<ul style="list-style-type: none"> Perda 10/2009 tentang Penyelenggaraan Jaminan Kesehatan Daerah (Provincial Regulation No. 10/2009 on the Implementation of Provincial Health Insurance)
		<ul style="list-style-type: none"> SK Kepala Dinas Kesehatan Prov Jateng No. 441.91/10379/2010/4 Tentang Petunjuk Teknis Penyelenggaraan jaminan Kesehatan Daerah Prov Jateng tahun 2010 (Head of Provincial Health Office Decree No.441.91/10379/2010/4 on Tencnical Guidelines of Provincial Health Insurance Year 2010) 		
10.	Prov. Sumatera Selatan	<ul style="list-style-type: none"> Peraturan Daerah No. 2/2009 tentang Penyelenggaraan Jaminan Sosial Kesehatan Semesta Sumatera Selatan (Provincial Regulation No. 2/2009 on the Implementation of Universal Health Insurance Program in Sumatera Selatan Province) Pergub No. 23/2009 tentang Pedoman Penyelenggaraan Jaminan Sosial Kesehatan Semesta (Governor Regulation No.23/2009 on Implementation Guidelines of Universal Health Insurance Program. 		

Institutional Arrangements of the Scheme

The sustainability of a scheme is also determined by the mode of institutional arrangement of the district scheme. This provides the framework for key actors in delivering district health insurance scheme effectively in term of authority definition, task assignment, resource allocation, and decision making process. In practice, there are a number institutional arrangements encompassing a variety of institutions and ranging from utilizing the existing district government's organization unit structures such as Bappeda and District Health Agency to establishing a special unit that is specifically designed to manage the scheme such as Unit Pelaksana Teknis Daerah (District Technical Implementation Unit) under Dinas or Badan (District Agency). Each of these institutional arrangements may create different outcomes that affect the sustainability of the project. This section will describe the institutional arrangements that have been implemented by the assessed regions and analyse

the long-run potential of the program. The assessment reveals that there are at least four models of institutional arrangements identified from the assessed districts.

District Scheme as a Project Allocated Through Social Assistance Budget Item

The first model is an institutional arrangement in which the district health insurance scheme is treated as a government project financed through a budget allocation in the social assistance budget item. In this arrangement, BAPPEDA (District Development Planning Board) and the *Sekretariat Daerah* (District Secretariat) play a major role in establishment of regulations and project financing. The *Dinas Kesehatan* (District Health Agency) plays the operational roles of the scheme. As the operator, the *Dinas Kesehatan* usually performs verification tasks of payment claims. The approval of claim payments is in the hand of the *Sekretariat Daerah* while BAPPEDA has the responsibility for development of the scheme. This institutional arrangement is adopted by *Kabupaten* Lebak, Tasikmalaya and Kutai Timur.

Despite its simplicity, this model faces a number of shortcomings. The first problem is related to budget disbursement for claim payment. The assignment of scheme's budget controlling responsibilities to the *Sekretariat Daerah* has created delayed in claim payment. This is because of the long procedure of disbursement that is required in *Sekretariat Daerah* because the organization tasks assignment of *Sekretariat Daerah* is not specifically designed for project implementation. Furthermore, there is no specific function and there are no specific human resources in *Sekretariat Daerah* organization for health financing issues. This organizational problem may cause delayed claims payment which may result in instability and uncertainty of cash flow of the health services providers.

A variant of this model is found in *Kabupaten* Lebak where the responsibility of budget execution as well as project delivery is assigned to the *Dinas Kesehatan*. This arrangement may increase scheme delivery quality. This is because the performed tasks to ensure quality scheme delivery correspond to the organizational expertise and competence of *Dinas Kesehatan*. However, the lack of special organization unit (or task force) that is assigned specific duty to take care of the district health care insurance scheme financing issues may prevent efficient scheme delivery. This is because the scheme is treated as one of several projects in *Dinas Kesehatan*. The establishment of such an organization unit is required to ensure that the scheme is allocated adequate resources (personnel, time, labor, and capacity) to cope with substantial workloads and focus on handling those tasks. In this arrangement, the district health insurance is treated as a side job by the *Dinas Kesehatan* personnel because they are also required to take care of other projects or programs.

District Scheme with Separation of Regulation and Financial Organization Function

The second model is to distribute regulation function of the scheme to *Dinas Kesehatan* and financial function to *Sekretariat Daerah*. This model has been adopted by Kendal and Kulonprogo. The difference between this and the previous model is in the regulatory function that is assigned to *Dinas Kesehatan*. Under this arrangement, the scheme is more adaptable in respect of health financing related issues of the scheme. This may allow the district government to adjust the existing regulations promptly to respond to any situation that develops related to health issues which may affect the financing of the scheme. The *Dinas Kesehatan* knows better about the changes in the trend of diseases, the verification system for the claim payments, and the membership system of the health care security program,

and is better able to determine the appropriate benefit packages and to network with health care providers. These advantages can be utilized to control the quality and cost of health service effectively. However, this institutional setting still faces a problem of delayed disbursement of claims payments.

Interestingly, the governments of Kendal and Kulonprogo have set up a special organization unit in *Dinas Kesehatan*, namely Pra-BAPEL (Pre-Implementation Agency) in Kendal and *Unit Pelaksana Teknis Daerah/UPTD* (District Technical Implementation Unit), and have assigned to them the responsibility for scheme implementation. The Pra-BAPEL is an interim organization unit which will be transformed into full Badan Pelaksana (Implementation Agency) or UPTD of the district health insurance scheme. The Pra-BAPEL has been assigned specific tasks where the personnel are able to focus in managing the program. However, the Pra-BAPEL is not yet considered as a legitimate organizational unit in the government structure. This status has constrained the Pra-BAPEL from taking more progressive actions in the scheme delivery. In Kulonprogo, despite the existence of a UPTD, they still face problems in coordinating with the *Dinas Kesehatan*⁸. The problem in Kulonprogo may be rooted in the fact that the organization was imposed as one of mandates given to *Dinas Kesehatan* as outlined in Peraturan Daerah. The situation may differ if the organizational setup grows from below as with the development process of district health insurance scheme in Kulonprogo.

The Dinas Kesehatan as the Main Organization in Government for Scheme Delivery

The third model of institutional arrangement is where *Dinas Kesehatan* is assigned as the key organization for scheme delivery. Kota Balikpapan is one of the assessed districts that has adopted this model. In this model, the regulation and financing function is assigned to *Dinas Kesehatan*. The operational function is also assigned to *Dinas Kesehatan* by establishing *Unit Pelaksana Teknis Daerah/UPTD* (District Technical Implementation Unit). In this arrangement, *Dinas Kesehatan* is able to handle a number of common problems in the scheme administration such as long procedure in budget disbursement, inefficient use of budget, low quality of services, inflexibility in coordination with the health service provider and other programs, as well as obstacles in developing a package of benefits that meets the needs of society.

In the operations of the scheme, the existence of UPTD allows better management of the program because the personnel are able to focus on their tasks of delivering the scheme effectively. The UPTD in Kota Balikpapan is not only responsible for managing the verification of claims, but also plays an important role in directing the development of the scheme, ensuring easy access to scheme's service by establishing special counters for handling claims and complaints of the scheme's beneficiaries, broadening the scope of health service providers who accept the the patients, monitoring the quality of health service received by the beneficiaries, encouraging the community to support the program, and evaluating the program process.

The District Scheme as Subordinate of Provincial Scheme

The last model is the model that is applied by Kota Makassar and Palembang. In these two municipalities, the district scheme is subordinate to the provincial

⁸ UPTD, although it is technical institution whose job is separated from the local health office, still remain bound to the local health office, mainly in terms of regulation and budget to finance their operational cost.

health insurance program. In this model, the district scheme is an extension of the provincial scheme, by which the district governments are mandated to control the implementation of the scheme in the respective district. The district government is usually mandated to form *Tim Pengendali* (Controlling Team) which is assigned to perform both regulation and operational functions. The regulation function is coordinated by BAPPEDA and the operational function is coordinated by the *Dinas Kesehatan*. The financial function is performed by *Sekretariat Daerah* (District Secretariate), both at the district and provincial level.

The main advantage of this arrangement is the portability aspect of the scheme. The beneficiary of the scheme may access the services in all public hospital regardless of the districts/municipalities that he or she visit as long as they are in the same province. However, despite the advantages of this model, the scheme still faces the problem of delayed claim payment. This is because the scheme financing is allocated from the social assistance budget item. Inefficiency in the use of budget also occurs, particularly in Makassar, due to the absence of payment claim verification procedure.

At the provincial level, Jawa Tengah and Sumatera Selatan have introduced Peraturan Daerah to provide a framework of coordination between province and districts/municipalities for scheme delivery. This Peraturan Daerah assigns a mandate to establish the coordination team in provincial level and also in each district/municipality. The tasks of this provincial coordination team include coaching, controlling, synchronizing the scheme implementation and monitoring and evaluation. However, the decentralization framework in Indonesia which provides more authority and power to district government may prevent effective coordination to deliver the scheme. This is identified particularly in Jawa Tengah Province, where some of the districts/municipalities in the province are not willing to participate in the provincial scheme.

Table 6b.
Regions Health Care Security Institutional Arrangement

No.	District/ Municipality/ Province	Institutional Function			
		Regulation	Financing	Operational	Service Providers
1.	Kab. Lebak	Bappeda- District health office	District secretariate	District health office	Local Public Hospital (RSUD) Fee for Services (FFS) payment; Puskesmas capitation payment
2.	Kota Tasikmalaya	Bappeda- District health office	District secretariate	District health office	Local Public Hospital (RSUD) FFS payment; Puskesmas capitation payment
3.	Kab. Kutai Timur	Bappeda- District health office	District secretariate	District health office (Satgas)	Local Public Hospital (RSUD) FFS payment; Puskesmas capitation payment

No.	District/ Municipality/ Province	Institutional Function			
		Regulation	Financing	Operational	Service Providers
4.	Kota Balikpapan	District health office	District health office (JPK-Gakin, Jamkesda Informal), Provincial District health office (JPK-Gakin)	UPTD (in transition to LTD)	Local Public Hospital FFS payment system, Private hospital Puskesmas (capitation payment system), Midwife, Private practitioner.
5.	Kab. Kendal	District health office	District secretariate	District health office (Prababel)	Local public hospital (FFS payment system), Puskesmas (capitation system)
6.	Kab. Kulonprogo	District health office	District secretariat	UPTD	Local public hospital (FFS payment system), Puskesmas (capitation payment system)
7.	Kota Makassar	Tim koordinasi pengendali (coordination controlling team): Bappeda, setda, bawasda, DPRD, local hospital director.	District secretariate	Tim pelaksana pengendali (implementation controlling team): head of administration affairs in district health office.	Local public hospital (capitation payment system), Puskesmas (capitation payment system)
8.	Kota Palembang	Bappeda	District secretariat	District health office	Local public hospital, Puskesmas
9.	Prov. Jawa Tengah	District health office	District health office	District health office (through Bapel implementator board)	Provincial public hospital
10.	Prov. Sumatera Selatan	District health office	District health office	District health office	Provincial public hospital



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Chapter 7

Beneficiaries Perspectives of Health Care

This chapter aims to provide an overview of public perceptions about the health services they received, either from private and public providers. In addition, the perceptions of Jamkesmas and Jamkesda beneficiaries in using their card to claim the health services are also discussed. This overview is based on focus group discussions (FGDs) conducted in assessed regions.

Beneficiaries' Health Treatment Seeking Behavior

PUSKESMAS is the primary health treatment seeking destination for poor people who reside in urban and rural areas. FGD participants from all assessed regions share the same view in seeing this as their primary destination when seeking medical treatments. Other options of medical treatment destination that are also frequently visited by poor people are village midwife, private health clinic, and district public hospital.

The village midwife is sometimes visited by rural people in seeking general medical treatment, even though midwife's responsibility is to assist normal birth delivery and provide advice related to maternal and children health. The selection of midwives when seeking medical treatment by the rural people related to accessibility they could received the midwife's services anytime and midwives can be reached easily. However, in general, rural people still prefer visiting PUSKESMAS rather than village midwives because PUSKESMAS offers better equipment and services with lower fees. The FGD participants from Dusun Tempuran, Desa Banyuringin, Kabupaten Kendal share their experience that:

"Actually, there is a medical treatment facility nearby, that is Balai Kesehatan Desa (Village Health Post) ran by village midwife. Unfortunately, if we want to be treated by the midwife, we have to pay more. So we decide to go to PUSKESMAS. Even though the Puskesmas is quite far from here, the service quality in PUSKESMAS is much better. It has good doctor, equipment, and free of charge."(FGD participant from Dusun tempuran, Desa Banyuringin, Kabupaten Kendal)

In urban areas where more health facility options are available, the private health clinic is also often visited by poor people. These health facilities are often managed

by not-for-profit and religious organizations. They charge the patient for the treatment and medicine at modest but affordable prices. The FGD participants from Kelurahan Maccini Sombala, Kota Makassar said that the reasons why they visit *Klinik Swasta Alifia* (a private health clinic) is because of the close proximity from their home, good service, and they are only required to pay Rp. 5,000.- (Approx. US\$ 0,5) for the treatment and the medicine they receive. A similar response was given by the FGD participants from *Kelurahan Pattingalloan, Kota Makassar*, where they are required to pay Rp 10,000.- (Approx. US\$ 1) for good service and good quality medicines.

Although the private health clinic offers better services than PUSKESMAS, almost all FGD participants argue that PUSKESMAS also has its advantages over private health clinics. The cost of service in PUSKESMAS is considered more affordable and it can provide a referral letter for those seeking referral treatment to hospital. In many cases, for those who wish to get hospital care fee exemption in the district public health facilities, the referral letter is required alongside the certificate of disadvantaged (SKTM).

In seeking medical treatment, Puskesmas is preferred as the primary destination by people, and the public hospital is chosen if the Puskesmas can not treat their illness. The public hospital (provided by both districts/municipalities or province), is often the second destination in seeking health care in a situation where the Puskesmas cannot handle the treatment for their disease, or when they feel that their illness is in the chronic stage which must be treated in hospital. In some regions, such as Balikpapan, they have a regulation to encourage people to use the Puskesmas first before using the hospital. With this system, the hospitals can not provide the service before receiving a letter of referral recommendation from Puskesmas, except for people who should be treated immediately.

On a number of occasions, the patient is referred by the doctor in PUSKESMAS to a private hospital. The District Public Hospital may not provide specific medical treatment for particular illnesses. In this case, the doctor in PUSKESMAS may refer the patient to a private hospital. This is a case shared by an FGD participant in *Desa Kedungboto, Kabupaten Kendal*. This suggests that even though the District Public Hospital facility is the primary referral health care service provider for poor people, it may not provide the services needed by patients. This will not be a problem for those who can afford the treatment cost in a private hospital. However, poor people may not visit the referred private hospital due to financial factors. Moreover, the JAMKESDA scheme only covers health care services in public health care facilities.

Barriers to Access to Formal Health Care Facilities

Financial and distance factors are the most significant barriers to access formal health care facilities for poor people in rural remote areas. This is the response given by the majority of FGD participants from villages that are in relatively remote areas. Those villages are *Desa Cimenteng Jaya - Kabupaten Lebak*, *Desa Kedungboto - Kabupaten Kendal*, and *Desa Martadinata - Kabupaten Kutai Timur*. For the participants from *Desa Cimenteng Jaya - Kabupaten Lebak*, financial factors are more important than other factors such as bureaucracy of service, distance, quality of service, etc. In *Dusun Jengkol - Desa Kedungboto - Kabupaten Kendal*, distance and access to the health facility are the most determining factors. In the FGD, the participant said that:

“The distance between Dusun Jengkol and Puskesmas Pembantu (Extension of Community Health Center) Biting is approximately 3 kms. The road to Pustu Biting is damaged heavily halfway. In a number of spots, even a motor cycle cannot go through. So if there were a person seeking for health heath treatment to Pustu, he or she needs to be carried on a stretcher for about 2.5km”

For FGD participant from Desa Martadinata - Kabupaten Kutai Timur, the district public hospital, RSUD Sangatta, is very far from their village. The trip time from their village to the hospital is approximately 1.5-2 hours by car. It is also worsened by the damaged road and expensive transportation cost.

Even in urban areas, the distance and bureaucratic complexity may discourage people from accessing health services in PUSKESMAS. This is the response from FGD participants from Kota Makassar, particularly from Kelurahan Maccini Sombala Kota Makassar. Kelurahan Maccini Sombala is situated on the periphery of Kecamatan Tamalate. The location of Puskesmas is in the center of *kecamatan*(Sub-district), which is quite far from their homes. There is a Puskesmas in the neighbouring *kecamatan* that is much closer than the Puskesmas for the *kecamatan* in which they reside. They cannot access the health service in the nearer Puskesmas because they are not resident in the respective *kecamatan*. In Kelurahan Pattingalloan -Kota Makassar, the FGD participants feel that the PUSKESMAS is more concerned about administrative requirements than about providing quality services to the patients. Those who reside in the respective *kecamatan* will get a referral letter for hospital treatment easier than those who are not residents of the *kecamatan*.

Poor health care service quality in the PUSKESMAS is a significant factor that encourages people in urban areas to seek other health care options. This is the response from FGD participants who reside in relatively urban areas where access to health care facilities is relatively easy. A number of FGD participants complain about the operational time of PUSKESMAS. For instance, in Puskesmas Kecamatan Ujung Tanah the doctor sometimes is not available even on formal working days, from Monday to Saturday. On Saturday, only midwives and nurses are in service. The participants from Desa Kedungboto, Kabupaten Kendal share their experience when visiting Puskesmas Kecamatan Limbangan:

A number of occasions when we visited Puskesmas in the morning, we see nurses are still cleaning the floor even though it was already in Puskesmas working time. So we have to wait quite a while.

The quality of health care service is also a significant factor that may discourage people from seeking medical treatment in the district public hospital. The district public hospital is considered to be too bureaucratic which places more burdens particularly for poor people because they have to provide the administrative requirement in order to receive medical treatment. For patients who wish to use JAMKESDA or JAMKESMAS schemes, they are required to bring completed documents which include a referral letter from PUSKESMAS, proof of residency, and membership card. For those who apply to get full exemptions from the hospital care fees, they are required to provide the certificate of disadvantaged.

Some of the FGD participants from Kelurahan Patingalloan – Kota Makassar share their experience when they wish to use hospital health services. For those who are in an emergency situation, the requirement to provide the referral letter from the

PUSKESMAS in the *kecamatan* where they reside results in the delay in delivery of health service.

A similar view of this bureaucracy-related problem is also raised by FGD participants from Balikpapan, who feel that the administrative procedure in district public hospital is more complicated than in private hospitals.

Another problem that we have to deal is the complicated administrative procedure and bureaucratic complexities in obtaining medical treatment in district public hospital. Every time we wish to use hospital services, we are required to copy a lot documents. In doing so, we need to prepare the transportation by ourselves because there are no copying services available near to the hospital. We have to spend at least Rp 10,000,- (US\$ 1) every time we have to prepare document requirements. We also have to pass through a long queue line for almost anything such as obtaining prescribed medicines and deposit money through assigned bank.

Discrimination is often experienced by patients from poor family who wish to use medical treatment in district public hospital. The FGD participants from Kelurahan Lima Ulu Kota Palembang mention that the patients who wish to use JAMKESMAS/JAMKESDA to cover the health treatment in the hospital feel that they are being ignored or they are given the lowest priority to get the hospital service. They are often required to wait for quite a long time until they get treated.

The participants from Desa Kenten Laut - *Kabupaten* Banyuasin and desa Kedungboto- *Kabupaten* Kendal also share similar experience. They compare how the hospital officials respond differently to patients who use JAMKESMAS and JAMKESDA. They feel that the hospital officials are often less friendly to JAMKESMAS/JAMKESDA patients compared to the full paying patients. In particular of JAMKESDA patients are not equipped with acard like the JAMKEMAS holder, they have to follow a long and complicated administrative procedure. This places a burden on the patients because they have to complete all the documentation from each level of authorities where they reside.

Beneficiaries' Perception of Health Care Services Received

The major advantage of a public health facility over a private health facility is the affordability of its services. The services are affordable for two main reasons, the cost of the services and the distance to the facilities. The FGD participants in all regions agree that the cost of health services delivered by public health facilities is cheaper than health services provided by private facilities. In the puskesmas, some regions provide health services at no cost, and even in the regions which charge user fees, the cost that they must pay are lower than in private facilities. In public hospitals provided by regional governments, although fees are charged, the amount of this charge is more affordable for them, compared to the fees charged by the private hospitals.

In private health facilities, the major advantage is the quality of services delivered. The services delivered by private providers are of higher quality in terms of ease of administration procedures, good sanitation, complete and modern health facilities and equipment, faster response in taking care of the patients, availability of the doctor, qualified health paramedics, and quality of medicines used. This contrasts

with the services that delivered by public providers in most assessed regions, where the administration procedures are too complicated, there is poor sanitation quality, health workers are unresponsive in taking care of the patients, health paramedics are unqualified, doctors are not in attendance and service delivery is denied due to unavailability of bed and inadequate facilities.

However, the superiority of private over public health services in terms of its quality does not apply in *kota* Solo. The FGD participants claimed that they receive better services in the municipaly public hospital compared to private hospitals, including administration procedure, qualified and adequate facilities, and quality used by the hospital. In health services provided by private, a participant complained that she had been abandoned because of using Jamkesmas card.

Beneficiaries' Perception of JAMKESMAS

Program Socialization

JAMKESMAS Program has not been publicized adequately to the target beneficiaries and this may prevent those who are eligible for the program from using the benefits to which they are entitled particularly in the rural remote areas. The common response echoed by the majority of FGD participants is that JAMKESMAS program is not sufficiently socialized to the public and this makes them unaware what the program is about, who the target beneficiaries are, and what the procedure are to access it. In Desa Limbangan - *Kabupaten* Kendal, the participant shared their experience that they were unaware about the program until they were notified by the puskesmas officials when they visited puskesmas seeking medical treatment. They were told that they should use the JAMKESMAS card that had been distributed to each village chief. A similar experience wa also shared by a participant from Desa Ulak Segelung- *Kabupaten* Ogan Ilir who shared her story of when she visited the village midwife and did not bring the JAMKESMAS card. She was told about the program and encouraged to check the card with her village chief.

In Desa Cimenteng Jaya – *Kabupaten* Lebak, the participants were also unaware about JAMKESMAS program until suddenly JAMKESMAS card was given to them by the village staff. In Kecamatan Lebak, the participants were never told by the village or *kecamatan* authorities about the program, however there was a survey by the neighborhood association (Rukun Warga) to identify the potential beneficiaries of JAMKESMAS. Participants from Dusun Tempuran – *Kabupaten* Kendal, and Desa Martadinata – Kutai Timur assert that they never received any socialization about the program. Participants from Kelurahan 5 Ulu and Gelora – Kota Palembang are more familiar with the label of “Free health Service” or *Askeskin* rather than JAMKESMAS.

In more urbanized areas, the beneficiaries are more likely to receive some sort of socialization about JAMKESMAS program. In Desa Kedungboto *Kabupaten* Kendal and Kelurahan Laweyan – Kota Solo, the socialization of JAMKESMAS program involves the various levels of authorities under the coordination of Kecamatan. Camat (the chief of Kecamatan) invites all the village chiefs under his coordination to an information sharing meeting about the program. Every village chief then passes the information to all neighborhood unit officials who inform and coordinate the survey of JAMKESMAS beneficiaries. The program is socialized through regular neighborhood meetings. In keluarah Laweyan, the participants say that there is no formal socialization of JAMKESMAS. The beneficiary survey for JAMKESMAS was conducted by the neighborhood (Rukun Warga/Rukun Tetangga)

officials together with the survey for Cash Transfer Program (Bantuan Tunai Langsung). In Kelurahan Maccini Sombala - Kota Makassar, the FGD participants state that the information on JAMKESMAS program was obtained from Puskesmas officials who were performing routine community health services in POSYANDU in their neighborhood. However, on that occasion the information given by the Puskesmas officials was limited to distribution of JAMKESMAS card, and was not about the JAMKESMAS program itself. In Kelurahan Pattingalloan Kota Makassar, the FGD participants were told by the PUSKESMAS officials that the ASKESKIN card could not be used anymore because it was replaced by JAMKESMAS card.

Targeting in JAMKESMAS Program

The targeting mechanism of JAMKESMAS does not accurately target those who are in real need of health care insurance. The majority of participants assert that JAMKESMAS has not effectively reached those who really needs health care insurance. The participants from Dusun Tempuran, Desa Banyuringin - *Kabupaten* Kendal and Desa Cimenteng Jaya – *Kabupaten* Lebak say that there are still a lot of poor people that should be covered by JAMKESMAS who are not listed as JAMKESMAS beneficiaries. Moreover, in Desa Cimenteng Jaya – *Kabupaten* Lebak and Desa Limbangan *Kabupaten* Kendal, the participants say that those who get JAMKESMAS in their village are actually those who are relatively well off. Only a small portion of the poor are actually listed as JAMKESMAS recipients.

The participants from Desa Martadinata - *Kabupaten* Kutai Timur also express the same view as other participants:

We do not know how to assess whether JAMKESMAS is distributed effectively to those who really need the program. However, in reality, there are a lot of people in Teluk Pandan who really need JAMKESMAS coverage but do not receive the program at all. The majority of people in Teluk Pandan work in the wood, which makes them vulnerable to malaria and scarlet fever. Even worse, there might be an issue in the card distribution because people who get the JAMKESMAS card are those from the neighboring municipality Bontang. There are only a few people in Teluk Pandan who actually get the card.

However, the participants from Kelurahan 5 Ulu – Kota Palembang have a different opinion. For them, JAMKESMAS has successfully targeted the right people particularly in Kelurahan 5 Ulu. The majority of the population in this kelurahan is considered poor.

The poor poverty database and identification system may be one the factors that affect the effectiveness of the targeting of JAMKESMAS. This is the response that was frequently given by FGD participants from Kelurahan Pajang - Kota Surakarta, Kelurahan Maccini Sombala and Kelurahan Pattingalloan – Kota Makassar. Most of the FGD participants question the validity of the poverty database which is used as the basis to decide the JAMKESMAS recipients. They argue that the survey that was conducted by volunteers did not adequately identify those who really need the scheme. Therefore they suggest that the government should improve its poverty assessment methodology.

The Advantages of the Program

JAMKESMAS card holder receive comprehensive benefits that are really needed by the poor people. This is the dominant response from all FGD participants. The FGD participants state that they can use JAMKESMAS particularly for chronic illness virtually free of charge. The JAMKESMAS card can be also used in public hospitals and in a number of private hospitals. The participants had used JAMKESMAS for a number of medical treatments from basic health services in Puskesmas to medical treatment in hospital, which include: in-patient care, heart operation, blood transfusion, caesarean section operation, and other complex health treatments. These services are virtually free of charge. One of the FGD participants from Desa Limbangan – Kabupaten Kendal shares her experience using JAMKESMAS card:

I was experiencing miscarriage during my first pregnancy and the doctor in Puskesmas diagnosed that I should be treated in the hospital. So I was referred to Permaa Medika Hospital in Semarang. I was afraid that it would be very expensive to be treated in a private hospital. Fortunately, the hospital accepted patients covered by JAMKESMAS. So I did not need to pay for the medical treatment I received, and the hospital service was very good.

The Weaknesses of the Program

Although JAMKESMAS covers the treatment cost of the patient, the patients still bear additional costs to obtain the needed medical treatment in the health facilities. The majority of the participants argue that even though the JAMKESMAS has covered health treatment costs, it does not necessarily mean that everything is free. The participants from Desa Limbangan – Kabupaten Kendal assert that JAMKESMAS Program is basically fine, however different hospitals may have different quality of human resource, culture, and standard operational procedure of the service that may determine the quality of service received. Further, even though JAMKESMAS covers almost everything the cost of transporting the patient to the hospital using ambulance is not covered. So, they are required to bear the transportation costs. A participant from Kelurahan Pattingaloan – Kota Makassar shared her experience when she was undergoing a caesarean section operation in the hospital. She was still charged for additional costs for thread and anesthetic.

A participant from Kelurahan 5 Ulu – Kota Palembang shared an experience of her relative who used the JAMKESMAS card to obtain treatment for her cervical cancer. The patient was referred to Mohammad Husni Hospital owned by provincial government. The patient has been receiving treatment for about a year. According to the patient, JAMKESMAS does not cover everything. Every time she visited to get medical treatment she was required to pay for about \$500,000.- (\$50.-) for prescribed medicines, and additional medical treatment equipment.

I was going to give birth in Siti Khodijah Hospital. Unfortunately, there was a problem with my pregnancy, so I was referred to Muhammad Hussein Hospital. When I was undergoing treatment to save my baby, my husband was requested to buy some medicines required for the treatment because the requested medicine was not available in the hospital. After delivery, my husband was again requested to buy additional medicines for the baby.

Beneficiaries' Perception of JAMKESDA

Program Dissemination

Similar to JAMKESMAS program, JAMKESDA program in the majority of districts is not adequately publicized. It seems that the the majority of district governments do not equip their jamkesda program with a proper program dissemination component. This is evident from the responses given by the majority of FGD participants. The participants from Dusun Tempuran and Desa Limbangan – *Kabupaten* Kendal, Kelurahan 5 Ulu and Kel Gelora – Kota Palembang, Desa Ulak Segelung – *Kabupaten* Musi Banyuasin assert that they have never received any information from the District Health Agency officials about the scheme. Some of them are even unaware that they are actually the beneficiaries of the scheme, as told by a participant from Kelurahan 5 Ulu – Kota Palembang:

I was unaware that I was actually one of the JAMKESOS beneficiaries until when I was about to deliver my baby in the hospital. I was notified that the cost of treatment was already covered by JAMKESOS. As far as I know I am not a member of that scheme because I do not have JAMKESOS membership card, but I can use the benefits.

Other participants shared similar experience that they became aware of the program only when they were about to get the medical treatment in the public hospitals. Participants from Kelurahan Pattingalloan – Kota Makassar claimed that they became aware of the program when they visited Puskesmas to seek medical treatment. A participant from Kelurahan Gelora – Kota Palembang shared his experience when he was going to be referred to the hospital to get medical treatment, he was asked by Puskesmas officials whether he brought a JAMKESOS card. He did not have the card and was unaware of the program. He was told by the Puskesmas officials to prepare all the identification documents and the certificate of disadvantage from the local authority. He was required to report to the District Health Agency in Palembang.

Despite poor dissemination component of JAMKESDA program, people may become aware of the program through a number of ways. The poor dissemination component of the JAMKESDA program does not necessarily means that there are no efforts to disseminate information about the program to the Public. Some participants shared some experiences of efforts done by local authorities and puskesmas and hospital officials to disseminate information about the program. In Kelurahan Maccini Sombala – Kota Makassar, the Puskesmas officials were publicising the program by distributing program brochures to health cadres of Posyandus. The brochure only outlines the procedures of beneficiary survey to identify eligible beneficiaries of JAMKESDA. These cadres are expected to pass the information to the wider community. Participants from Kelurahan Pattingalloan – Kota Makassar said that they were aware of the program from the television program when the Mayor was launching a campaign around the program as one of his priorities.

Participants from Kelurahan Pajang – Kota Surakarta state that they receive information from regular neighborhood meetings. In these meetings, information on the registration procedure and the detail of health care services covered by the JAMKESDA program are shared with all neighborhood residents.



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Indonesia

kartu peserta
UKESMAS

image source: <http://images.google.co.id/>

Chapter 8

Conclusion

The assessment of districts health care insurance schemes has identified a number of key issues that need to consider in realizing the universal coverage of health care insurance in Indonesia. These issues can be grouped in three broad themes as follow.

The Prospect of Universal Coverage of Health Care Insurance in Indonesia

The assessment result shows that the proliferation of variety of different approaches across Indonesia indicates that there is a possibility to extend the health insurance to cover all Indonesian Population. The existing national scheme of JAMKESMAS is proven insufficient to cover the need of health care insurance of those who desperately need the insurance. This situation leads to the flourishing development of local scheme of health care insurance (JAMKESDA).

The JAMKESMAS failed to meet the need of health insurance of the poor due to a number of factors. First, the assigned quota of JAMKESMAS often does not meet the real need of insurance in the district level. As discussed in Chapter 2, the factors that causes this situation is related to the dynamics of poverty at district level that cannot be capture accurately by the beneficiaries identification process of the scheme. The number of JAMKESMAS beneficiaries is based on poverty statistics published by BPS based on the annually conducted *Survey Sosial Ekonomi Nasional/ SUSENAS* (National Socio-Economic Survey). The lag time between the survey was conducted to the time of publication may result in deviation between the statistics with the real figure of poverty.

The second factor is related to the poverty indicator that is being used by the BPS and the district level stakeholder. The BPS uses 16 poverty indicators in *Pendataan Program Perlindungan Sosial 2008/ PPLS-2008*, to identify the beneficiaries of JAMKESMAS by name and address. The vast diversity of geographical context in Indonesia may create differences in defining poor condition from districts to district. Some may be bounded by the cultural context in its respective localities. For

example, one of the indicators in PPLS 2008 is *“the type of floor of the house is made of dirt/bamboo/cheap wood”*. In some areas in Indonesia the house typically made of bamboo or wood regardless of the socio-economic status. The local architecture of housing is part of the cultural context of housing architecture to respond the geographical situation that may be characterized by the swamp or wet land areas. This relative definition of poverty may yield difference in number of entitled beneficiaries of the scheme.

The third factor is related to scheme delivering program. The ineffective scheme dissemination, and unprepared district institution arrangement to support the JAMKESMAS are among the few factors that may exacerbate the problem of beneficiaries outreach.

These shortcomings have motivated district level governments to develop their own local scheme to complement the national scheme. The proliferation of the local scheme may indicate some prospects in realizing the universal coverage of health care insurance in Indonesia in terms of coordinated actions between national and local governments. In this perspective, the national government can be regarded as the backbone of the national scheme bearing the basic and essential coverage particularly for the poor section of the population. The provincial and district governments are required to take the complementary and supportive roles to ensure that the scheme is delivered to the beneficiaries. However, this system poses some challenges that will be discussed in the next theme.

Adequacy of the District Scheme as the Complementer of the National Scheme to Achieve National Universal Coverage of Health Care Insurance

If the Government of Indonesia were heading to a more fragmented system of health care insurance system, in which there is a distribution of responsibilities among central, provincial and districts government, there are a number of issues that need to be addressed.

The first issue is related to how the existing district scheme is capable to cover those who are in need of insurance health care. The basic assumption of the proliferation of district scheme of health care insurance is that the district schemes will complement the national scheme to capture those who are not covered by JAMKESMAS. However, the assessment shows that even though the district that has already introduced district scheme, many poor people are not covered. This is found in almost assessed districts, which among them are a well off districts.

The next issue is related to the long-term sustainability of the district. The assessment also identifies variations in number of covered people and budget allocations. This indicates that the district schemes are not solid yet and unsustainable. This variation may be caused by a number of factors. It may be caused by the inaccuracy of the number of eligible people due to methodological or technical weaknesses of beneficiaries identification. This problem may also arise because of the political dynamics at the district level. Since the inception of decentralization and direct election of district leader, the district has become more dynamic. The policy and budget process in district level is more politicized than ever. The direct election in district level has created a fertile soil for district scheme to flourish as district scheme of health care insurance can be seen as popular policies.

The assessment also reveals that many district will not be able to cover the cost of proper health insurance unless most of the money is provided by the central government. This is due to different fiscal capacity of the district as the result of Indonesia fiscal decentralization framework. For the district that has relatively high fiscal capacity, the cost of health care insurance can be covered from the local revenue although it may not catch up with the increasing cost of health care services. The poorer regions may not be able to afford the health care insurance for all its citizens. Therefore they will introduce user fees for the better off people so that these district governments can generate additional financial resources to be used to subsidize the poor people. However, unless there are lots of rich people in a district using public facilities, which is very very unlikely as the rich will use private health facilities, the government may not be able to generate sufficient resource to cover the costs. Moreover, user fees contradicts the idea of health insurance.

Another issue is related the portability and eligibility to access the scheme. Having a fragmented system where different schemes are found across districts or regions may restricts mobility and 'choice' of people to live in different places as they will not be eligible if they move out of where they live. As a developing country where urbanization phenomena is one of the major characteristics, this fragmented system may prevent the poor people to access their entitlements. Poor people has been found to migrate to urban areas from rural areas in order to find better livelihood. In the cities those poor people cannot access affordable health care services because they are not eligible due to their status of residency.

The fragmented system also create difficulties in delivering effective socialization of the scheme. This is due to different districts has different schemes and require different socialization program that suits with the need of the scheme. As the assessment result showed, the problem in scheme socialization is one of the problem that prevent effectiveness of scheme outreach. Thus as the result, the poor people may not be aware about their rights and entitlements.

Agenda for Research and Advocacy of Civil Society Organization in Indonesia

The civil society organization in Indonesia shares the same idea to realize the universal coverage of health care insurance in Indonesia. It is evident in the extent of CSOs engagement through research and policy advocacy in the areas of health care financing. The CSOs' action span from research and advocacy in the budget process aiming to increase allocation for health sector in general to working out the system to implement the idea of universal access of health care insurance. Their works have something in common that is they mostly work at the district level. There are only limited number of CSOs/NGOs that are working at the national level system, namely Perkumpulan Prakarsa and GAPRI. One factor that explain this situation is the decentralization context in Indonesia, which has transferred most of the essential government functions and responsibilities to provincial and district level government. Thus, the need for reform process at these level in order to ensure better public service deliveries has been captured by the NGO/CSOs as their key strategy for advocacy.

The assessment shows that in the context of Indonesia, in order to realize the universal coverage of health care insurance , there is a need to maintain the responsibility of the central government as the main actor holding the responsibility of the whole system of health care financing system nation-wide. This will ensure that the benefit

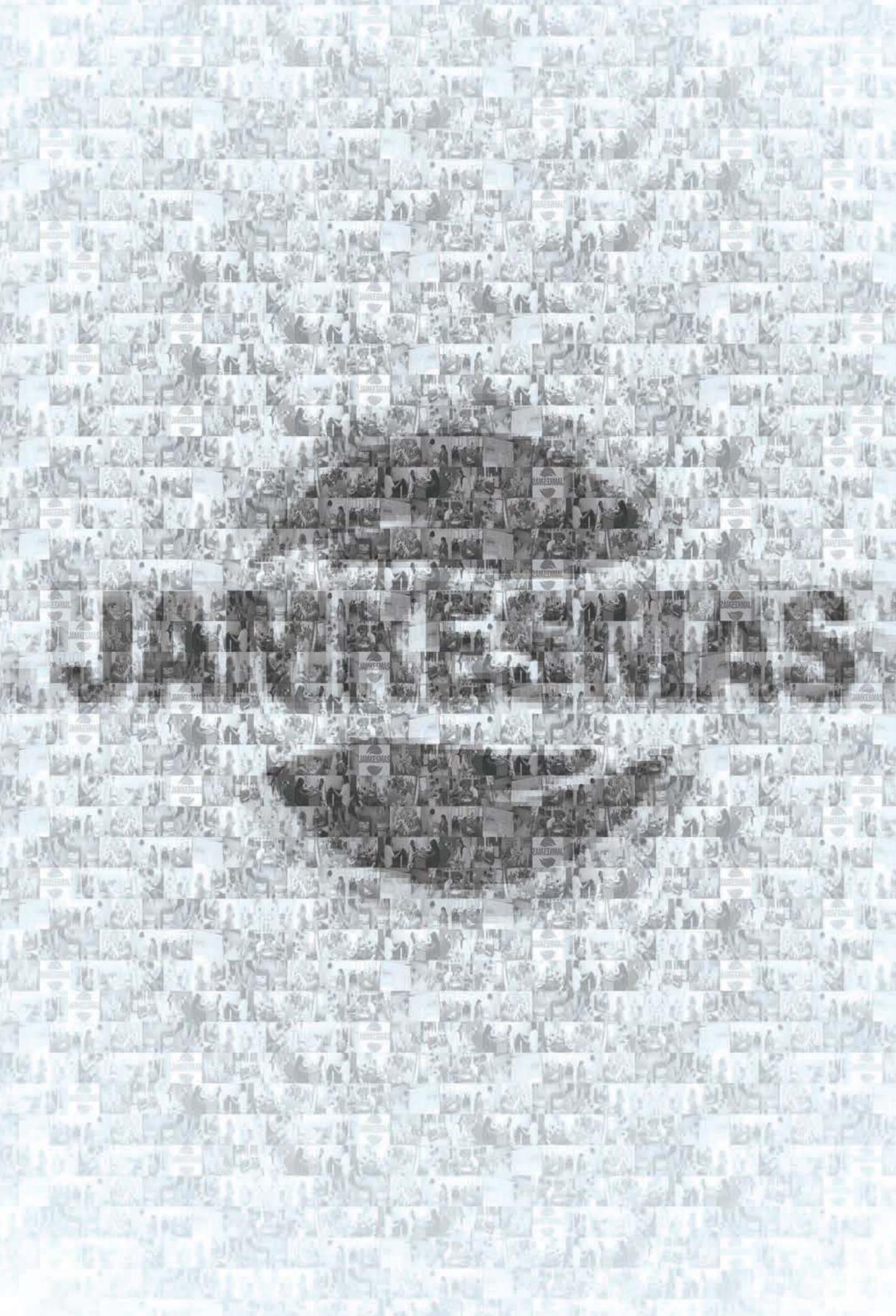
of the scheme will be accessible by all of the population or the targeted groups of the scheme regardless their status and location of residency. Moreover, by this system the central government will be better to mobilize financial resources from different sources and pool it in one system that can be used for benefits improvement and deliveries. However, leaving the bear all the responsibility to central government to fund the system will be unjustified to. Since the inception of decentralization the resources has been also directed to provincial and district governments. Therefore in order to ensure that this system is adequately funded, there is a need that the provincial and district level governments also bear the burdens. This arrangement offer new agenda for research how to distribute the responsibility to bear the cost of the system across government level based on the functional and responsibility assignment as dictated by the existing decentralization framework.

If the nation-wide system of health care insurance were adopted and provincial and district government were expected to take the responsibility, there are a number of advocacy agenda particularly for NGO/CSOs working at district level. The adcoacy actions should be aimed to encourage provincial and district level government to support the nation-wide system. This can be done through budget analysis and advocacy that focus on pushing the government to allocate adequate financial resource that can be use to support or complement the nation system (to cover those who have not been covered yet), to provide additional the benefit baskets from the basic benefits offered by the national scheme, to fund the supporting programs for the national scheme, which include institution, personels, and activities, that are required to ensure that the national scheme's benefits will reach the entitled beneficiaries.

The assessment also demonstrates that there are tehcnical weaknesses of the existing national scheme that undermine the positive aspect of the programs. The beneficiaries identification methodology and its implementation is one among the issues. Research aiming to improve the methodological aspect of beneficiaries identification is needed particularly to address the differences between the national and provincial and district level governments. The disagreement about the indicators of poverty has caused disputes about the real number of eligible beneficiaries and their real identities.

The assessment also revelas that the poor updating mechenisms of the lists of beneficiaries also pose problems that plagues in any schemes. The conventional updating procedures is time consuming and expensive. The existing national scheme relies on the updating process conducted by BPS through the PSE-2005, PPLS-2008, PPLS 2010. This situation demand new research agenda in identifying various alternative of beneficiaries database updating mechanism which is more efficient, effective, and reliable.

The accountability mechanism of service deliveries is also another research agenda. The views from beneficiaries shows that the poor accountability system at every level of government has become a major concerns among the users of the scheme. The mechanism for accountability is required to ensure that the benefits are delivered to the beneficiaries as what they are entitled to. The research and advoacay agenda in developing the accountability mechanism that exploit the current development of community based monitoring and auditing can be promoted as key CSOs/NGOs agenda.





JAMKESMAS



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