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The Nuts & Bolts of Jamkesmas

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Indonesia's Government- Financed Health Coverage Program

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The Nuts & Bolts of Jamkesmas,
Indonesia's Government-Financed Health Coverage
Program for the Poor and Near-Poor¹

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The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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TABLE OF CONTENTS

Abbreviations.....	iv
Executive Summary.....	v
1. Introduction.....	1
2. General Background and Health System Outcomes.....	2
3. Health Care Delivery and Financing.....	5
4. Institutional Architecture of Jamkesmas.....	8
5. Targeting, Identification, and Enrolment of Beneficiaries.....	11
6. Public Financing of Jamkesmas.....	13
7. Jamkesmas Basic Benefits Package.....	14
8. Information Environment of Jamkesmas.....	16
9. Supply-side Constraints and Supply-Side Subsidies.....	17
10. Pending Agenda: Attaining Universal Coverage in Indonesia.....	20
Annex 1 Institutional Capacity – Purchasing Functions.....	23
Annex 2 Spider Web.....	27
References.....	30

FIGURES

Figure 1 Trends in Key Population Health Indicators in Indonesia, 1960–2010.....	3
Figure 2 Under-five and Maternal Mortality Relative to Income in Indonesia, 2010.....	3
Figure 3 Out-of-Pocket Share of Total Health Expenditure, 1995–2010.....	4
Figure 4 Health Insurance Coverage and Out-of-Pocket (OOP) Health Spending in Indonesia, 2010.....	5
Figure 5 Overview of Health Financing and Provision in Indonesia.....	8
Figure 6 Institutional Architecture of Jamkesmas.....	10
Figure 7 Estimates of Coverage and Leakage Rates for Jamkesmas, 2010.....	13
Figure 8 Puskesmas Density by Province.....	18
Figure 9 Beds and Human Resources for Health per 1,000, by Province.....	18

TABLES

Table 1 Outpatient and Inpatient Utilization Rates by Economic Decile, 2010.....	6
Table 2 Roles and Responsibilities of Actors under Jamkesmas.....	9
Table 3 Jamkesmas and Related Health Financing Information, 2006–10.....	14
Table 4 Comparing Indonesia’s Three Major Social Insurance Schemes.....	14
Table 5 Utilization and Financial Protection by Insurance Coverage, 2010.....	16
Table 6 Availability of Core Medicines in Public Facilities.....	19

Abbreviations

BPJS	Badan Penyelenggara Jaminan Sosial
BPS	Badan Pusat Statistik
DHOs	District Health Offices
DRGs	diagnostic-related groups
MoH	Ministry of Health
OOP	out-of-pocket
PODES 2011	village facilities survey
RIFASKES	facility census
Rp	rupiah
SUSENAS	National Economic Survey
THE	total health expenditure
TNP2K	National Task Force for Acceleration of Poverty Alleviation
WHO	World Health Organization

Executive Summary

Indonesia is one of many countries aiming to achieve universal health coverage for its population. Several challenges remain to reaching this goal, which the country hopes to achieve by 2019. Although health insurance coverage has increased significantly in Indonesia over the last decade, almost 60 percent of the population still remains without any coverage, and out-of-pocket spending remains high even among those with coverage. Further expansion of insurance coverage is expected to be especially challenging since many of those currently not covered are in the informal sector. In addition, ensuring access to quality health services remains an issue, especially in rural, remote areas of the country.

Jamkesmas—a government-financed health insurance program for the poor and near-poor—is currently Indonesia’s largest insurance program. The program is expected to be integrated and merged with all other social insurance programs under a single-payer umbrella by 2014. Jamkesmas has been operational since 2005, and an assessment of its implementation can provide valuable lessons for informing future policy initiatives aimed at attaining universal health coverage. The program is centrally managed and financed by the Ministry of Health and provides coverage to more than 76 million people. Although the program is designed with good intentions, it is performing well below its potential in terms of attaining its outcomes.

On the positive side, about 40 percent of poor and near-poor households are covered under the program, outpatient and inpatient utilization rates have increased among program cardholders, levels of catastrophic payments have declined, and there is generally a positive perception with regard to the program among those who are enrolled. There is increasing participation of the private providers under Jamkesmas, and more than 300 complementary local Jamkesmas-inspired programs have been initiated across the country. On the negative side, there is evidence of high levels of mistargeting and leakages to the nonpoor, low levels of socialization and awareness of benefits, low utilization and relatively low quality of care, regional inconsistencies in the availability of the basic benefits package, relatively shallow levels of financial protection, and poor accountability and feedback mechanisms.

The architecture of Jamkesmas functions more like a demand-side “top-up” program rather than a full-fledged insurance program. The program’s reimbursements do not reflect the full cost of services, since public providers still receive government subsidies in the form of salary payments and capital investments. Supply-side constraints conceal the real costs of the Jamkesmas program and serve as an implicit cost-management strategy. Although Jamkesmas offers a comprehensive benefits package of services, in practice, utilization and the associated claims reimbursements do not reflect the cost of health coverage due to limitations in the supply of services. This combination of supply-side constraints and supply-side subsidies (the latter in itself not necessarily a shortcoming) has not been leveraged to improve the program’s overall effectiveness and will likely impact its future sustainability.

Improving the current performance of Jamkesmas will be key to attaining universal health coverage in Indonesia. A greater separation between provider and purchaser functions and implementation of better results-focused provider payment mechanisms would be necessary to address weaknesses in the program’s architecture. Targeting mechanisms need improvement, and

this is an area where global experience and lessons from other countries could be beneficial. Overall, the biggest challenges relating to the implementation of universal health coverage in Indonesia are those related to ensuring supply-side readiness and the financial sustainability of the program.

1. Introduction

This case study describes and assesses Jamkesmas, Indonesia's government-financed health coverage program for the poor and near-poor. The case study provides a detailed description of the scope, depth, and breadth of coverage provided under Jamkesmas, and highlights ways in which the program interacts with the rest of Indonesia's health system. The study also summarizes and discusses evidence on whether Jamkesmas is attaining its stated objectives of removing financial barriers and improving access to health care by the poor and near-poor, what could be improved, and what lessons can be learned from the experience of Jamkesmas that could help inform Indonesia's quest for universal coverage.

The Jamkesmas program was started in 2005 as the Askeskin program for the poor.² In 2007, it was renamed Jamkesmas and was expanded to also cover the near-poor. Jamkesmas currently targets almost a third of Indonesia's population (official estimates indicate that there are 76.4 million poor and near-poor beneficiaries).³ The program is fully financed out of central government revenues and is administered by the Ministry of Health. Jamkesmas has an annual operating budget based on an estimated "premium" rate of Rp 6,500 per person per month (about US\$8 per person per year), amounting to about a quarter of the central government's annual health budget.

Our analysis finds that Jamkesmas, although designed with good intentions, is performing well below its potential in terms of attaining its outcomes. On the positive side, however, about 40 percent of poor and near-poor households⁴ are covered under the program, outpatient and inpatient utilization rates have increased among program cardholders, levels of catastrophic payments have declined, and there is generally a positive perception with regard to the program among those who are enrolled. Increasing numbers of private providers are enlisting under Jamkesmas, and more than 300 complementary Jamkesmas-inspired local programs have been initiated across the country. On the negative side, there is evidence of high levels of mistargeting and leakages to the nonpoor, low levels of socialization and awareness of benefits, low utilization and relatively low quality of care, regional inconsistencies in the availability of the basic benefits package, relatively shallow levels of financial protection, and poor accountability and feedback mechanisms.

The primary theme underlying the Indonesia case study is that supply-side constraints and supply-side subsidies have not been leveraged to increase the effectiveness of the Jamkesmas program. There are significant geographic deficiencies in the availability and quality of the basic benefits package, especially for those living in relatively remote and rural locations of the

² The origins of health-insurance for the poor date to 2001, when the Fuel Tax Compensation Scheme (PKPS-BBM) was established as a response to the end of the pro-rich government fuel subsidies, which were partly redirected into programs to compensate the poor.

³ The poor and near-poor equal roughly the bottom three economic deciles of the population. There are ongoing discussions to increase the number of targeted Jamkesmas beneficiaries to 86.4 million in 2013.

⁴ This is measured using the household consumption sections in the annual National Economic Survey (Susenas). Consumption is adjusted for household size and district differences in the cost of living, and households are classified into deciles of per capita consumption. For the purposes of this analysis, the lowest three deciles of individuals in the survey are considered equivalent to the "poor and near-poor," that is, the population targeted by Jamkesmas.

country, and this limits the effective availability of benefits for many Jamkesmas beneficiaries. In addition, the architecture of Jamkesmas is such that, in effect, it appears to function more like a demand-side “top-up” of essentially a (constrained) supply-side system rather than a full-fledged insurance program that reimburses the full cost of the provision of services. Jamkesmas does not reimburse the full cost of care; salaries, capital, and some of the operating costs at public facilities continue to be paid for by the government (central, provincial, or district, depending on the type of public facility). Estimates suggest that these subsidies account for upwards of two-thirds of the full cost of providing care under Jamkesmas. This combination of supply-side constraints and supply-side subsidies (although in itself not necessarily a shortcoming) has not been leveraged to improve the program’s overall effectiveness and will likely impact its future sustainability. One of the key aspects in attaining universal coverage in Indonesia should be a greater focus on improving the current performance of Jamkesmas.

The remainder of the case study is organized as follows. Section 2 provides general background and information on health system outcomes in Indonesia. Section 3 is an overview of health care financing and delivery. Section 4 describes the institutional architecture of Jamkesmas. Section 5 highlights the process of targeting, identification, and enrolment of beneficiaries under the program. Section 6 focuses on the role of public financing. Section 7 outlines the basic benefits package. Section 8 provides an overview of the information environment of Jamkesmas. Section 9 discusses the special theme of supply-side constraints and supply-side subsidies that dilute the effectiveness of the Jamkesmas program. Section 10 discusses the pending agenda around some of the architectural and operational features of Jamkesmas in the context of universal coverage.

2. General Background and Health System Outcomes

Indonesia is a geographically dispersed and ethnically diverse archipelago of 240 million people, making it the fourth-largest country in the world based on population. It has a per-capita income of about US\$3,500⁵—similar to that of Egypt and Georgia—and is classified by the World Bank as a lower-middle-income country. Recent estimates indicate that about 18 percent of its population continues to live below US\$1 a day, and about half lives below \$2 a day. The country has enjoyed robust economic growth rates over the last decade, averaging over 5 percent per year since 2000. Economic growth is projected to be strong—6 to 7 percent per year over the next three to five years.

Indonesia has made impressive health gains over the last few decades. Life expectancy at birth has increased from 45 years in 1960 to almost 70 years in 2010. The infant mortality rate dropped from 128 per 1,000 live births to 27 per 1,000 live births, and the under-five mortality rate has dropped from 218 per 1,000 live births to 35 per 1,000 live births over the same time period (figure 1). The country is on track to attain the Millennium Development Goal (MDG) for under-five mortality, and its attainment of this indicator is about average for its income level (figure 2). Recent data updates indicate that Indonesia—with a little more effort—could potentially also attain the Millennium Development Goal for maternal mortality, for which Indonesia’s attainment is much lower than what might be expected for its income level (figure 2) (WHO/UNICEF/UNFPA/World Bank 2012).

⁵ Gross domestic product per capita based on Indonesia Country Profile, World Bank (2012a).

Figure 1 Trends in Key Population Health Indicators in Indonesia, 1960–2010

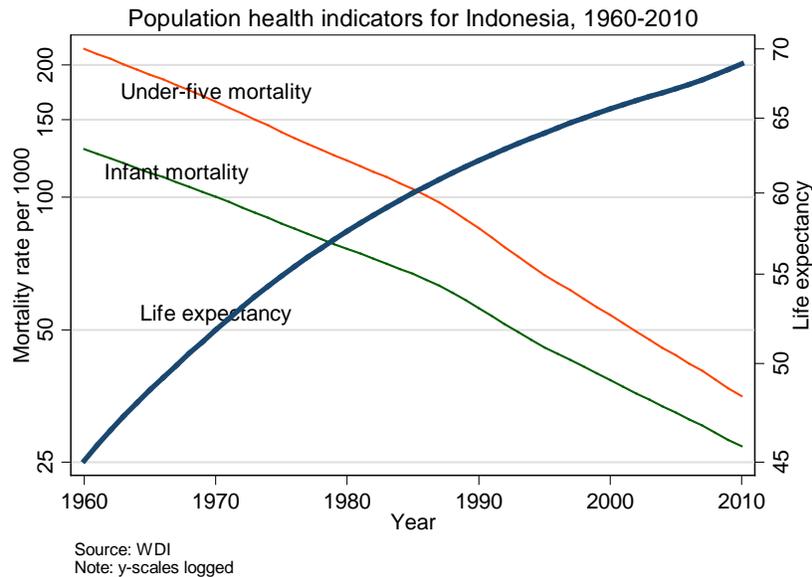
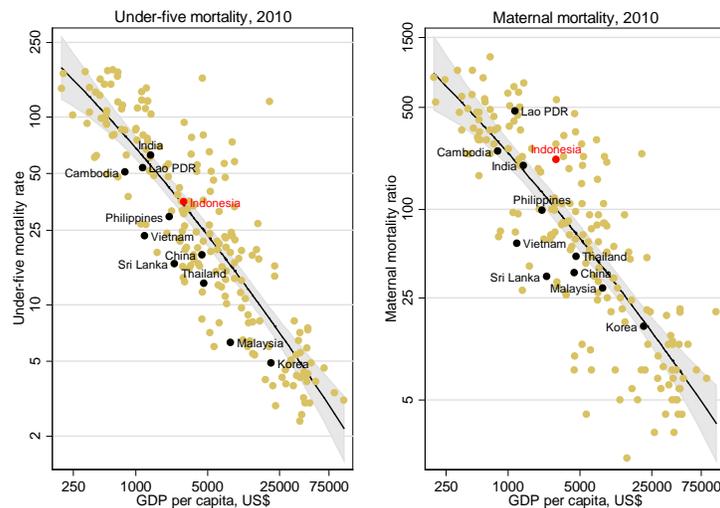


Figure 2 Under-five and Maternal Mortality Relative to Income in Indonesia, 2010

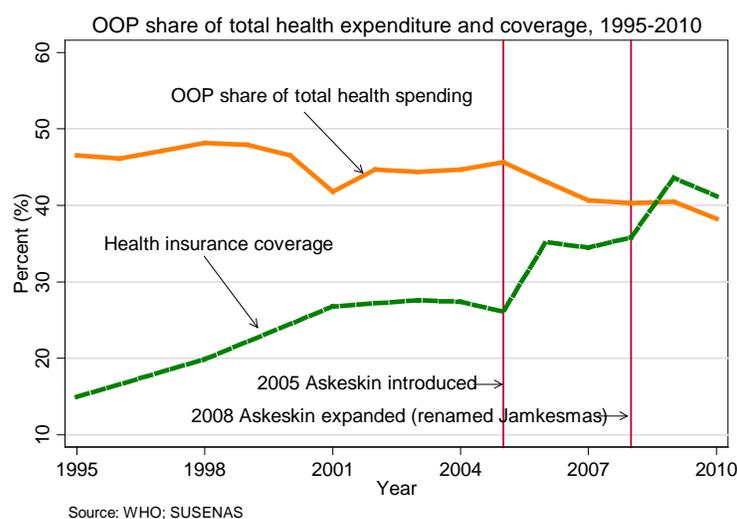


Despite significant progress, Indonesia faces several challenges in the health sector. Malnutrition rates are particularly high in the country, and even more so when one controls for income. For example, 35.6 percent of Indonesian children under age 5 are stunted—levels that are comparable to those observed in poorer Sub-Saharan African countries.⁶ There are large geographic and income-related inequalities in inputs, outputs, and outcomes. For instance, infant

⁶ Indonesia has similar levels of underweight, wasting, and stunting as Cameroon, Sierra Leone, Togo, and Uganda, among others (see UNICEF 2012).

mortality in provinces such as West Sulawesi is two to three times higher than in some of the other provinces. Infant and child mortality rates among the poorest wealth quintile of households are more than double that in the richest. Access remains a huge problem in remote districts, as does quality of care. At almost 40 percent, the out-of-pocket (OOP) share of total health expenditure remains high (figure 3).^{7,8} Although household health insurance population coverage rates have increased in the last decade or so—from 15 percent in 1995 to more than 40 percent in 2010—almost 60 percent of the population still remains without any coverage, and OOP spending remains high even among those with coverage.

Figure 3 Out-of-Pocket Share of Total Health Expenditure, 1995–2010

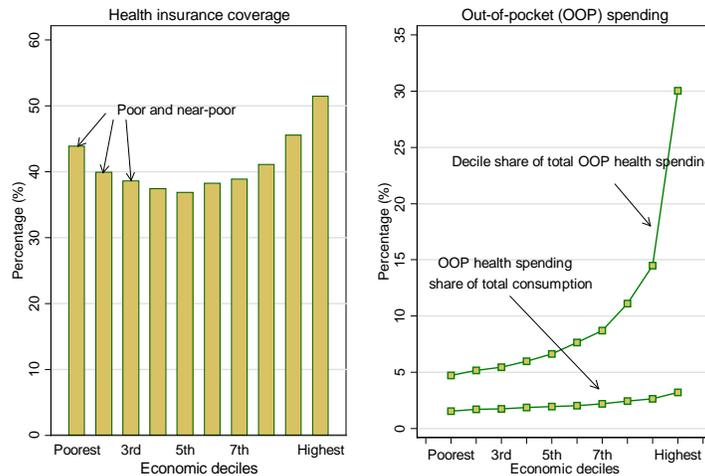


Health insurance coverage among the poor and near-poor is only about 40.8 percent, most being accounted for by Jamkesmas. Coverage rates tend to be highest among the richest economic deciles and lowest among the middle-income groups in Indonesia (figure 4). Almost 60 percent of uncovered households were headed by individuals working in the informal sector, 50 percent of whom were in agriculture. Households spend about 2.1 percent of their total consumption on health, ranging from about 1.6 percent for the poorest decile and 3.5 percent for the richest (figure 4), which is relatively low compared to other countries with similar income levels. The incidence of OOP health spending was heavily skewed toward the rich: about 30 percent of all OOP health spending was incurred by the richest decile alone, and the top three deciles accounted for more than 50 percent of total OOP health spending in the country. The bottom three deciles accounted for less than 15 percent of total OOP health spending.

⁷ The World Health Organization (WHO) recommends out-of-pocket spending to be at most 15 to 20 percent of total health expenditure, because only at those levels is the risk of impoverishment due to catastrophic health spending generally found to be low (see WHO 2010).

⁸ Household health expenditure in Indonesia is comparable to other countries in the region, and is even slightly higher at 1.26 percent compared to the Philippines at 0.8 percent and Thailand at 0.7 percent, but is much lower compared to Vietnam and Cambodia (Xu et al. 2003).

Figure 4 Health Insurance Coverage and Out-of-Pocket (OOP) Health Spending in Indonesia, 2010



Source: SUSENAS (2010)

3. Health Care Delivery and Financing

Indonesia has mixed public-private provision of health care services, with the public sector generally taking the dominant role, especially in rural areas and for secondary levels of care. However, private provision has been increasing rapidly in recent years. For the public sector, provision is decentralized to the district level. The central government remains the dominant source of overall financing of the health sector, but district governments have discretion over how budgets are allocated and how much gets spent on health (Heywood and Harahap 2009; Tandon 2009).

Health service utilization rates are generally low in Indonesia. Analysis of the 2010 SUSENAS survey indicates that about 14 percent of the population utilized outpatient care in the month prior to the survey. Around 60 percent of outpatient visits occurred at private facilities (typically clinics/midwives and nurses) and the remainder at public facilities, mostly at the primary care level. SUSENAS data also show that the better-off used private facilities for ambulatory services—69.5 percent compared to 51.6 percent among the bottom three deciles (table 1). About 2.5 percent of the population utilized inpatient services in the year prior to the survey, almost 60 percent of whom used public hospitals and the rest used private care.⁹ Public facilities continue to dominate inpatient care, except for the top three deciles a larger proportion of whom use private facilities for inpatient care.

⁹ Utilization rates are generally very low in Indonesia. In Vietnam, by way of contrast, the inpatient utilization rate was 8.1 percent in 2010, and in the Philippines, the rate was 4.1 percent in 2008. The WHO uses a benchmark of 10 percent, although this is skewed toward rates seen in Organisation for Economic Co-operation and Development countries.

Table 1 Outpatient and Inpatient Utilization Rates by Economic Decile, 2010

Economic Decile Group	Outpatient Utilization (in past 30 days)			Inpatient Utilization (in past year)		
	Total (%)	Public Share (%)	Private Share (%)	Total (%)	Public Share (%)	Private Share (%)
Bottom 3 deciles	12.1	49.1	51.6	1.5	69.3	30
Middle 4 deciles	14.3	42	59.3	2.5	60	39.5
Top 3 deciles	15.0	31.5	69.5	4.1	47.1	53.4
<i>National</i>	<i>13.7</i>	<i>41.3</i>	<i>59.8</i>	<i>2.5</i>	<i>56.7</i>	<i>43.3</i>

Source: SUSENAS.

Basic primary health care is provided by the public sector via a network of health centers (known as puskesmas), each serving a catchment area at the subdistrict level of about 25,000 to 30,000 individuals. Indonesia has over 9,000 puskesmas, and each is supposed to have at least one medical doctor on staff. About a third of all puskesmas also provide inpatient services. Primary care is also provided by private doctors, including by 70 percent of doctors working at puskesmas who practice privately after hours (the size of the private sector for basic health services is difficult to estimate since there is no reliable provider recording system). In principle, puskesmas are meant to provide referrals to secondary and tertiary public hospitals. However, in practice, the gatekeeping and referral functions of puskesmas are not strong. There are no penalties for self-referring to higher-level facility; patients can go directly to secondary or tertiary hospitals and obtain services without puskesmas referrals (or simply obtain a referral letter from the puskesmas).

Indonesia has 1,632 secondary-care hospitals, of which about 838 are private (BPS 2010; MoH 2011). There are an estimated 163,000 hospital beds in the country, with about 52,000 beds managed by the private sector, implying about 0.7 beds per 1,000 population (which is much lower than the global benchmark of 3 per 1,000). The ownership of tertiary hospitals is mainly public. Indonesia has about 376 tertiary hospitals, some of which are centers of excellence (about 300 of the 376 total tertiary hospitals are public).

One of the key supply challenges in Indonesia is the provision of health services in rural and remote areas and in a dispersed archipelago of over 17,000 islands. The government is in the process of upgrading puskesmas with inpatient facilities, especially in secondary towns and rural locations. Allocations have been made to expand the number of third-class beds (by an additional 1,300 beds) by the end of 2012. The government has also allocated funds to expand inpatient facilities specifically for maternal emergency-ready facilities, but this goal has not yet been realized. In addition, there have been few systematic efforts to address challenges relating to supply-side readiness, both in terms of improving the availability of basic medical equipment and supplies and improving training of frontline health workers.

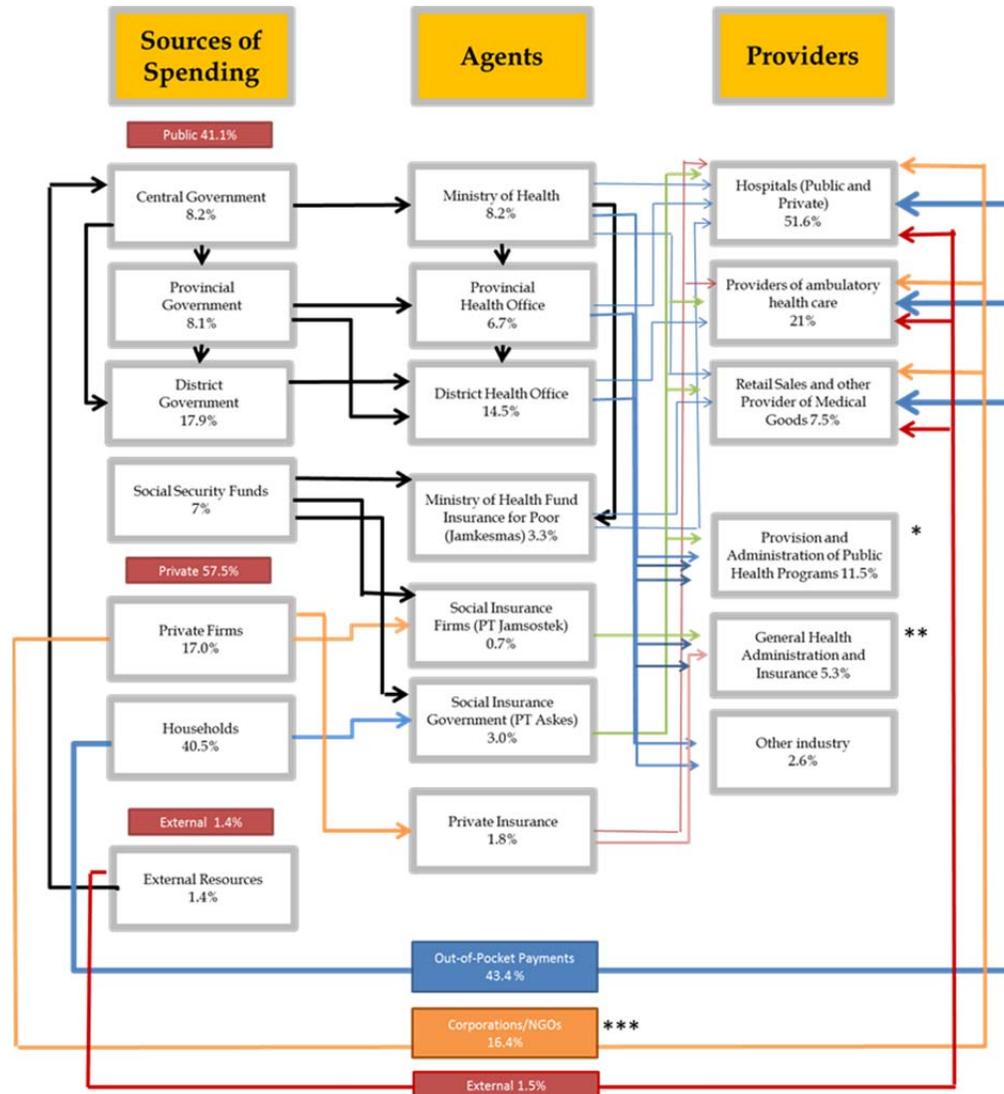
Human resources for health (doctors, nurses, and midwives) are about 2 per 1,000 people, close to the WHO benchmark of 2.3 per 1,000. The key issues in Indonesia are maldistribution and relatively low levels of specialization. To provide incentives for doctors to work in remote, underserved districts, the government provides higher salaries and benefits, as well as shorter contracts (up to one year) to new graduates who serve in remote areas. For some areas, the

incentives are as high as 250 percent of the base salary (Rokx et al. 2010). In addition, a stint as a contract doctor in a remote, underserved area is given positive consideration for future employment as a government civil servant. The program, however, is not compulsory. There is also a government-run program of incentives for midwives to be based in remote, underserved areas.

Even before decentralization started in 2001, local governments were involved in the management of social programs as a response to the 1997 economic crisis (for example, Social Safety Net funds), which established local health-maintenance-organization-like bodies. These schemes lasted for only one year due to insufficient capacity at the subnational level. However, the involvement of subnational governments in some provinces and districts continued, even though it was only limited to the targeting process and to the provision of additional coverage to mitigate the withdrawal of the first fuel subsidy in the post-1998 political reform. In the Askeskin/Jamkesmas program, the participation of subnational governments was initially limited to identification of the poor and near-poor, and local governments had the task of ensuring that the names and addresses of the beneficiaries matched the quota set by the central government. Later, some local governments with strong fiscal capacity established schemes similar to Jamkesmas, mainly to provide coverage to those identified poor or near-poor who were not covered by the central program. The number of these local schemes, also known as Jamkesda, increased significantly from less than 100 in 2008 to more than 300 by the end of 2011. These schemes vary widely in terms of benefits and population covered, depending on the provinces' or districts' fiscal capacity.

Figure 5 provides an overview of health financing and delivery in Indonesia. Indonesia spent 2.6 percent of gross domestic product on health, with total health expenditure (THE) per capita of about US\$77 in 2010. Public spending accounted for 41.1 percent of THE, and almost half of public spending was at the district level. This level of spending is relatively low among countries with comparable income levels. As mentioned, under Indonesia's decentralized system, district governments are responsible for the delivery of health services and therefore account for the greatest share of government spending on health. The low public spending for health may be one of the factors that leads to supply-side constraints. Private spending on health, although declining in recent years, still accounts for 57.5 percent of THE. Household OOP payments continue to represent a major component of health spending (40.5 percent of THE). Corporation and firm health spending also contributed substantially, at 17.0 percent of THE. Hospitals account for 51.6 percent of THE, followed by providers of ambulatory care, which account for 21.0 percent of THE.

Figure 5 Overview of Health Financing and Provision in Indonesia



Source : SHA-Based Health Accounts in the Asia-Pacific Region:Indonesia 2005-2009, Soewondo P, et.al, 2011

Social security funds account for 7 percent of THE, and are used to finance the three major health insurance schemes in the country: Jamkesmas, Jamsostek (the social health insurance program for formal sector workers), and Askes (the social insurance program for civil servants). In many provinces and districts, Jamkesmas is complemented (and sometimes substituted) by other local health insurance schemes (Jamkesda).

The remainder of the case study focuses specifically on Indonesia’s health coverage program for the poor and near-poor, Jamkesmas.

4. Institutional Architecture of Jamkesmas

Jamkesmas is Indonesia’s government-financed health coverage program for the poor and near-poor. As mentioned, the Jamkesmas program was initially started in 2005 as the Askeskin program for the poor. In 2007, it was renamed Jamkesmas and was expanded to also cover the near-poor.

near-poor. Jamkesmas currently targets almost a third of Indonesia's population (official estimates indicate 76.4 million poor and near-poor beneficiaries). The stated objectives of Jamkesmas are to increase access to and the quality of health services for the poor and near-poor. Jamkesmas cardholders and their families can, in principle, utilize primary care services at all puskesmas and inpatient services (for third-class beds) at secondary and tertiary public hospitals and selected enlisted private hospitals without any beneficiary contributions, benefit ceilings, copayments, or balanced billing.

There are five primary actors involved in the overall implementation of Jamkesmas. They are (a) the National Task Force for Acceleration of Poverty Alleviation (TNP2K); (b) national government ministries, including the Ministry of Finance, the Ministry of Health (MoH), and the Ministry of National Development Planning (Bappenas); (c) provincial and district governments; (d) public and enlisted private health care providers; and (e) the insurer/third-party administrator.¹⁰ Table 2 summarizes the roles and responsibilities of the five primary actors. One additional actor (not listed below) is the Vice President's Office, which has the mandate to improve the implementation of various social assistance programs, including Jamkesmas.

Table 2 Roles and Responsibilities of Actors under Jamkesmas

	TNP2K	MoF/MoH/ Bappenas	Provincial/District Governments	Public and Empanelled Private Providers	Insurer/ Third-Party Administrator
Oversight of scheme	X	X			
Financing of scheme		X			
Benefits package determination		X			
Accreditation/ empanelment of providers		X	X		
Enrolment		X	X		X
Financial management/ planning		X			
Actuarial analysis	X				
Setting reimbursement rates		X			
Claims processing/ payment		X	X		
Outreach/social marketing			X		
Service delivery				X	
Clinical information system		X			
Monitoring local utilization		X	X		
Monitoring national utilization		X			
Customer service		X	X	X	

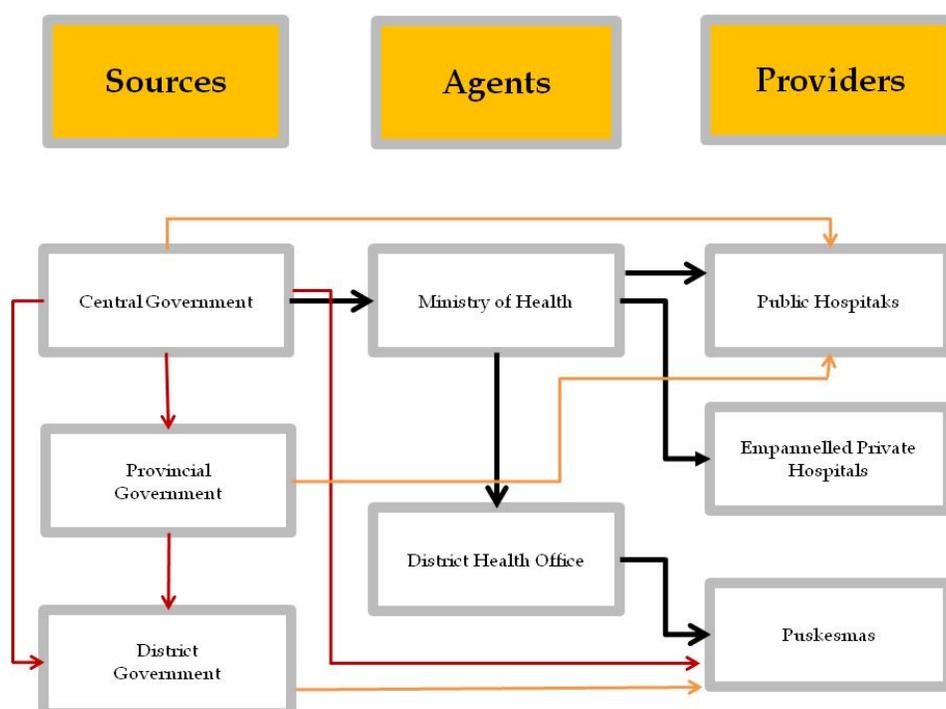
Source: Modified from JLN (2012) Roles and Responsibilities for Universal Coverage.

Note: MoF = Ministry of Finance; MoH = Ministry of Health.

¹⁰ Based on information on the Joint Learning Network website, accessed in June 2012.

The program is fully financed out of central government revenues and is administered by the MoH. A snapshot of the flow-of-funds under Jamkesmas is summarized in figure 6. Funds flow from the Ministry of Finance to the MoH and then down to lower levels of government. The MoH receives funds annually from the central government based on a current “premium” of Rp 6,500 per person per month times the number of targeted poor and near-poor of 76.4 million. In addition, central, provincial, and district governments provide input-based budget transfers to puskesmas and public hospitals for salaries and infrastructure (these are not directly related to Jamkesmas).

Figure 6 Institutional Architecture of Jamkesmas



MoH reimburses hospitals for Jamkesmas coverage based on diagnostic-related groups (DRGs, called INA-CBG). It is not clear, however, whether DRGs have helped contain costs and improve efficiency. Reimbursement rates are the same for both public and private hospitals in the network (although rates vary by the degree of specialization of the hospital). The basis for the policy to use the same reimbursement rate for both public and private providers also remains unclear. Prior to the program implementation, the government already had a policy that required private hospitals to spare at least 10 percent of total beds for the poor.¹¹ The economic justification for this is that private hospitals are expected to cross-subsidize poor patients from their regular inpatient services.

Payments to puskesmas were initially based on capitation. As of 2011, puskesmas are reimbursed based on fee-for-service. District Health Offices (DHOs) receive an envelope of funds from the central government via MoH based on a capitation payment of Rp 1,000 per poor

¹¹ Source: The late Minister of Health’s statement at the Meeting on the Operations of Health Service Delivery, in the article “Private hospitals have the obligation to serve the poor,” *Tempo Online*, October 25, 2011.

and near-poor person per month. DHOs are reimbursed for puskesmas utilization based on fee-for-service from this envelope. Any surplus or deficit of Jamkesmas-related financing at the DHO-puskesmas level is adjusted by transfers to or from the local government treasury. Of total program costs, about 75 percent are for reimbursement of hospital-based care, 20 percent are for puskesmas-based care, and the remainder are for administrative costs.^{12,13}

The failure of a capitation mechanism at the puskesmas level was mainly driven by the inflexibility in the use of Jamkesmas funds at public health providers. In the absence of provider autonomy, incentivizing primary care providers to focus on preventive efforts is difficult to achieve. In addition, there is a government regulation that compels puskesmas to submit all their revenues to the local treasury office but to only get part of them back. These factors combined have led to low disbursement of the Jamkesmas funds for primary care. In 2011, it was estimated that 50 percent of primary care service funds remained undisbursed. In addition, the shift to fee-for-service is expected to ensure better data collection on the utilization of primary care facilities that was not available with the use of capitation payment.

At present, Jamkesmas funds are not pooled with those of any of the other social insurance schemes operating in the country. As mentioned, Indonesia has two additional social insurance schemes: Askes (for civil servants) and Jamsostek (for the private sector). In many provinces and districts, Jamkesmas is complemented (and sometimes substituted) by other local government-financed health insurance schemes (Jamkesda). These insurance schemes, however, are managed and operated largely independently of each other.

Jamkesmas is one manifestation of a landmark legislative commitment made by Indonesia in 2004 specifically to attain universal coverage. In addition, in 2011, the government enacted another law—the Badan Penyelenggara Jaminan Sosial, or the BPJS law—which calls for the merger and unification of Jamkesmas with all other existing social insurance programs by 2014. The current for-profit administrator for the civil servants program, PT Askes, will be modified and converted to BPJS Health, a not-for-profit administrator for all the social health insurance programs in the country, and funds across the different insurance schemes will be pooled and the benefits packages harmonized.

5. Targeting, Identification, and Enrolment of Beneficiaries

The target group for Jamkesmas includes all poor and near-poor households in the country. Officially, the program targets nearly a third of the population of Indonesia, approximately 76.4 million. The poor and near-poor are identified by a combination of means testing and local government eligibility criteria. In 2005, Indonesia's national statistics agency, Badan Pusat Statistik (BPS), conducted a National Poverty Census Survey (PSE05). BPS then used a proxy means test with 14 asset indicators to identify eligible households, and then produced a list of quotas for the poor and near-poor for each district. Districts validated and verified data from BPS using various methods depending on the district's preference (some districts conducted their own

¹² PT Askes manages Jamkesmas membership and receives 1 percent of total Jamkesmas spending from the MoH at the end of each year (see World Bank 2012b).

¹³ Some of the administrative costs were borne by the MoH and subnational health offices budgets, and this was not reflected in the Jamkesmas cost, hence the low administrative cost.

surveys while others mobilized administrative personnel up to the village level, and other districts used the list from BPS that only identifies the head of household). If the number of poor and near-poor was greater than the BPS district allocation numbers, these individuals were encouraged to enroll in the local health insurance scheme (Jamkesda), if available.

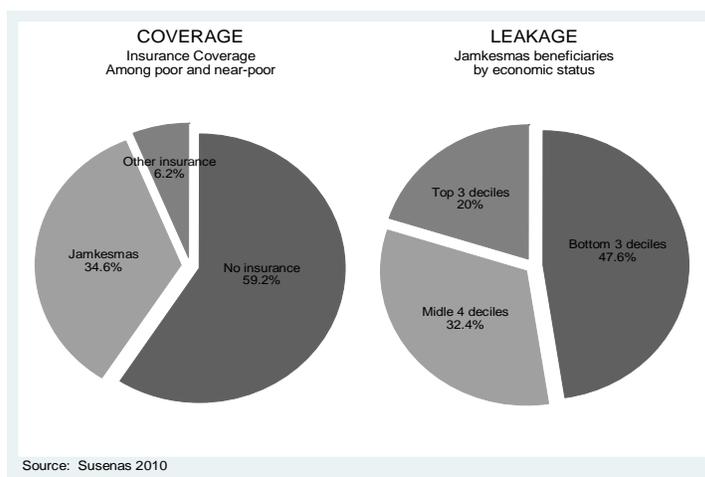
In 2011, a new list of the poor and near-poor was formulated covering over 40 percent of all households in Indonesia. This is being used as the basis for a unified registry of potential beneficiaries for all social assistance programs from 2012 onward, beginning with Jamkesmas and the national conditional cash transfer program. The poor, and near-poor, are now being targeted on the basis of household per-capita consumption. This is done with a mixture of geographic and proxy means testing methods. Proxy means testing indicators are collected on all households, and these are used to generate a consumption estimate using standard proxy means testing methods. The consumption estimate is used to select beneficiaries, but this is done on a district-by-district basis, with a quota set for each district based on poverty rates from the national socioeconomic survey.

Enrolment in Jamkesmas is conducted by district-level health staff: households are identified as eligible and then enrolled. In addition, enrolment is not mandatory, and there are no fees for enrolment. Membership of the program, including issuance of membership cards, is managed by PT Askes. However, enrolment is the responsibility of local governments. The enroller has some flexibility since some of the criteria they use are discretionary and subjective. There is no voluntary enrolment for the nonpoor and no official exit strategy under the program. Eligibility so far has been indefinite. However, with the new targeting system being used to identify beneficiaries from 2012 onward (and with a recertification of the entire database planned to be available in 2015), a three-year recertification appears likely. It is currently unclear whether previous beneficiaries will be able to use their old cards to receive health services, and how long this situation will last.

Jamkesmas targeting identifies eligible households, but membership is individual, with each household member entitled to receive a Jamkesmas card. Qualitative and quantitative evidence suggests that not all family members eligible to receive the card actually possess one. There are some cases of Jamkesmas cardholders preferring not to use their cards and, instead, paying out-of-pocket to avoid perceived stigmatization from health providers, and to avoid the generally longer waiting times because of the need to complete additional administrative requirements. Despite some reports of stigma, there remains a generally positive feeling about Jamkesmas among enrollees (World Bank 2011).

Evidence suggests that the leakages to noneligible beneficiaries are significant. Estimates from the national socioeconomic survey in 2010 suggest that Jamkesmas coverage rates among poor and near-poor households were about 34.6 percent. About 6.2 percent of the poor and near-poor reported having other forms of insurance, and 59.2 percent reported no insurance coverage whatsoever. On the flip side, 47.6 percent of Jamkesmas cardholders were poor or near-poor, indicating a leakage rate of 52.4 percent (figure 7). One-fifth (20 percent) of all Jamkesmas holders belonged to the top three economic deciles (figure 7).

Figure 7 Estimates of Coverage and Leakage Rates for Jamkesmas, 2010



One reason behind the suboptimal performance of Jamkesmas in terms of targeting is likely due to variation in the proxy-means-testing criteria used across districts, and to poor program knowledge among the targeted beneficiaries. The criteria used to identify household characteristics vary across districts; in some districts, village midwives and subdistrict health center officials often distribute health cards according to their own criteria, regardless of economic status (World Bank 2012c). There are no specific incentives in the system to either maximize enrolment or minimize mistargeting. There is some anecdotal evidence and allegations of fraud and political clientelism, but only a few cases have been reported. Since enrolment of the poor and near-poor is not mandatory, there is some evidence that the target beneficiaries enroll only when they need to use health services (that is, there is adverse selection). The list of eligible beneficiaries compiled by district officials is not subject to validation from the central government, resulting in mismatching, poor coverage, and leakage of health insurance benefits to the nonpoor. Furthermore, poor and near-poor households that were denied the card despite being eligible do not have a clear recourse.

6. Public Financing of Jamkesmas

Jamkesmas has an annual operating budget based on an estimated “premium” rate of Rp 6,500 per person per month (about US\$8 per person per year), totaling about a quarter of the annual central government health budget. Jamkesmas is a central program and its budget—virtually all Jamkesmas spending (around 99 percent)—is managed at the central level. A minor share is executed by local governments and allocated to support supervision and monitoring activities.

Table 3 summarizes Jamkesmas expenditure and revenue trends, along with enrolment and other information during 2006–10. The initial 2006 budget for Jamkesmas (then called Askeskin) was based on a cost per person per month of Rp 5,000, derived from preliminary actuarial estimates and the experience of the civil servant insurance scheme, Askes. In the following years, allocation adjustments were made based on expenditures of previous years.

Table 3 Jamkesmas and Related Health Financing Information, 2006–10

Jamkesmas	2006	2007	2008	2009	2010
Premium per person per month	Rp 5,000	Rp 5,000	Rp 5,000	Rp 6,250	Rp 6,500
Target population (millions)	60	76.4	76.4	76.4	76.4
Total revenue (billions)	Rp 3,000	Rp 4,584	Rp 4,584	Rp 5,730	Rp 5,959
Total expenditure (billions)	Rp 3,074	Rp 4,567	Rp 4,448	Rp 4,620	Rp 5,343
Hospital expenditure (billions)	Rp 1,696	Rp 3,402	Rp 3,600	Rp 3,535	Rp 4,003
Health center expenditure (billions)	Rp 1,350	Rp 1,073	Rp 647	Rp 888	Rp 1,122
Jamkesmas share of central government health spending	25%	29%	28%	26%	22%

Note: Jamkesmas was called Askeskin prior to 2007.

Jamkesmas premiums and expenditures are not reflective of the “true” cost of provision of care. Over two-thirds of the average cost of care under Jamkesmas is estimated to come from supply-side subsidies at public facilities. Salaries, capital, and some of the operating costs at public facilities continue to be paid for by the government (central, provincial, or district, depending on the type of public facility), and these can range from 60 to 80 percent of the total cost of care at public facilities (GIZ 2012). Actuarial studies estimate the true cost at at least three to four times the existing premium rate of Rp 6,500, even with existing levels of supply-side constraints (Guerard et al. 2011). The magnitude of these numbers is consistent with the current estimated public and private expenditure on curative and rehabilitative care of about US\$40 per capita per year, about five times the Jamkesmas premium (Soewondo et al. 2011).

7. Jamkesmas Basic Benefits Package

At least on paper, Jamkesmas offers a comprehensive benefits package that is more generous and inclusive than that of other social insurance schemes in the country, including those of the contributory civil servants health insurance program (Askes) and the program covering formal sector employees (Jamsostek) (see table 4 for a comparison of the three major health coverage schemes in Indonesia).

Table 4 Comparing Indonesia’s Three Major Social Insurance Schemes

	Jamkesmas	Askes	Jamsostek
Groups Mandated	Poor and near-poor	Civil servants; retired civil servants, retired military personnel, and veterans	Private employers with >10 employees or that pay salary >Rp 1 million a month
Number Enrolled	76.4 million	16.6 million	5.0 million
Premium	Rp 6,500 per capita per month	2% of basic + 1% government; no ceilings	3% of salary for bachelors; 6% of salary for married employees; Ceiling Rp 1 million per month (not changed since 1993)
Contributor	Government 100%	Employees 66%; Employer 34%	Employers 100%
Carrier	Ministry of Health	PT Askes (for-profit)	PT Jamsostek (for-profit)
Benefits	Comprehensive; drugs are covered if prescribed within formulary; no cost-sharing	Comprehensive, no specific exclusion; Drugs are covered if prescribed within	Comprehensive; cancer treatment, cardiac surgery, hemodialysis, and congenital diseases are excluded ^a ; Drugs are covered if prescribed within

		formulary; Cost -sharing available when services fall outside basic benefits package	formulary; No cost-sharing
Dependents	All family members	Spouse +2 children under age 21 who are not working or married	Spouse +3 children under age 21 who are not working or married
Providers	All puskesmas and public hospitals and selected empanelled private hospitals	Mostly contracted public health centers and public hospitals	Mixed: public and private providers
Provider payment mechanisms	Fee-for-service at puskesmas; DRG for hospitals	Special fee schedules for civil servants; Extra-billing depending on negotiated fees	Fees are negotiated; Extra-billing depending on negotiated fees

Note: a. Starting in 2012, Jamsostek expanded the benefits package to cover catastrophic cases, as well.

The MoH and National Security Council (DJSN) are mandated to revise and set the benefits package. Exceptions include cosmetic treatments, general check-ups, dental prosthesis, alternative medicine, fertility treatment, and fertilization programs (in vitro, in vivo). There are no caps on benefits provided to beneficiaries (on paper). Limitations apply for eyeglasses, hearing aids, and mobility aids (wheelchair, tripod cane, and so forth). Jamkesmas beneficiaries are entitled to coverage of drugs from specific formularies and receive generic versions of medications. There is no copayment, coinsurance, or extra-billing or balance-billing allowed under the program.

The Jamkesmas provider network comprises mainly public facilities. At the primary level of care, the program includes only puskesmas, while for referral services, both public and enlisted private hospitals are included. The participation of private hospitals in the network has been increasing; currently, 30 percent of Jamkesmas network hospitals are private. The reasons private hospitals have joined the network are likely driven by the assurance of volume of patient inflows; some private providers (which have large fixed costs and excess capacity) accept Jamkesmas since, at the margin, benefits from partial-cost reimbursements can outweigh average costs. Some private religious hospitals are not-for-profit and will also accept Jamkesmas patients. In some cases, private hospital participation is mandated by local governments.

In 2007, the use of services by Jamkesmas beneficiaries increased significantly, especially inpatient services, while the program was budgeted historically based on the use of funds from the previous year.¹⁴ This caused a budget shortage, and MoH had to reallocate their budget in order to pay hospital claims, which led to delays in paying hospital reimbursements. This received wide media attention and led to some changes (movement of administration from PT Askes to MoH) and cost-containment measures such as the introduction of a drug formulary and DRG payments.

In reality, however, the actual availability of the basic benefits package is limited, especially in remote, rural locations of the country. We discuss this issue in more detail in section 10.

¹⁴ The spike in inpatient service utilization was mainly due to program maturation (more became aware of the program's benefits) and the absence of cost-containment measures (drug formulary, member verification, and so forth).

8. Information Environment of Jamkesmas

The program has improved utilization of services among the poor and near-poor, especially for inpatient services. However, inpatient utilization rates remain low compared to other population groups in the country, as does depth of coverage. Estimates from SUSENAS 2010 indicate relatively high outpatient utilization rates of 16.1 percent among Jamkesmas beneficiaries, higher than the outpatient rates reported by those under Askes (13.9 percent), Jamsostek (13.8 percent), and among those without any insurance (12.4 percent) (table 5). Inpatient utilization rates among Jamkesmas beneficiaries, however, are lower than those among Askes and Jamsostek beneficiaries—2.7 percent compared to 4.0 percent and 3.3 percent, respectively—but higher than those without any insurance (2.0 percent). Although OOP health spending per capita among Jamkesmas beneficiaries was lower than among Askes, Jamsostek, or those without insurance, OOP health spending as a share of total household consumption in Jamkesmas households was no different from those without insurance (table 5). There is some evidence, though, that the incidence of catastrophic expenditure is lower among Jamkesmas users than among other groups (Bredenkamp et al. 2011).

Table 5 Utilization and Financial Protection by Insurance Coverage, 2010

	Jamkesmas	Askes	Jamsostek	No Insurance
Outpatient Utilization (in previous month)	16.1%	13.9%	13.8%	12.4%
Inpatient Utilization (in previous year)	2.7%	4.0%	3.3%	2.0%
OOP Health Spending Per Capita (annual)	Rp 115,026	Rp 303,772	Rp 230,846	Rp 147,115
OOP Health Spending Share of Total Household Consumption (annual)	2.2%	2.6%	2.2%	2.1%

Source: SUSENAS.

In general, the information environment in which Jamkesmas operates is weak. The MoH has the responsibility to collect, review, and audit information periodically on utilization and claims data, looking for outliers and potential abuse. Annual Jamkesmas reports are submitted to the president every year. The hospital claims analysis has helped identify claim outliers and cases of DRG upcoding. However, the program still focuses on analyzing information related to budgetary allocations and aggregate utilization rates, but does not explicitly monitor or target health or financial protection outcomes among beneficiaries. Information on utilization rates has been used to increase premiums and improve provider payment mechanisms, but not to improve or adjust other health care delivery mechanisms and to ensure improvements in health outcomes. Some basic information about the program is available on the Jamkesmas website, and some social marketing material exists, including those used in print media, television, and the Internet. Media coverage has helped to increase public awareness and has often been the trigger for the government to take measures to improve program implementation.

Key pieces of information that could be used to inform and improve the overall effectiveness of the program are available from other stakeholders. GIZ (the German Society for International Cooperation) and AusAid (Australian Government Overseas Aid Program) recently completed a major costing study that provides information on actual costs of delivering health service. In addition, the National Institute of Health Research and Development has completed the first-ever facility census for Indonesia, analysis of which could be helpful in assessing differentials in the

availability of the basic benefits package across the country. On insurance data and household spending, the national socioeconomic survey, SUSENAS, collects some relevant data from households annually. However, to date none of the above resources have been systematically used or analyzed to improve the effectiveness of the Jamkesmas program.

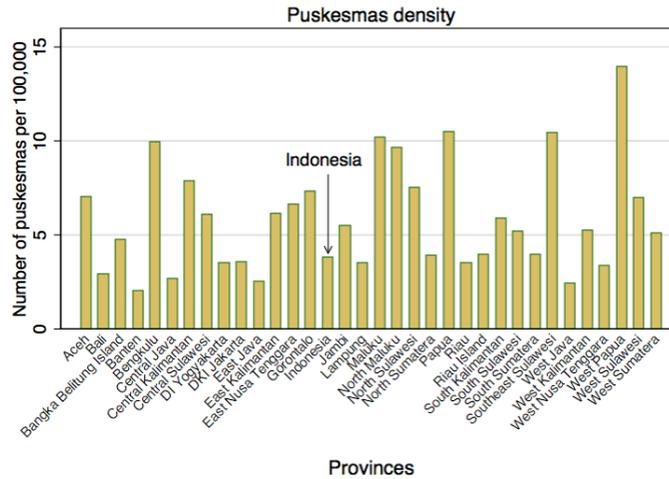
9. Supply-side Constraints and Supply-Side Subsidies

The primary theme underlying the Indonesia case study is that supply-side constraints and supply-side subsidies dilute the overall effectiveness of the Jamkesmas program. There are significant geographic deficiencies in the availability and quality of the basic benefits package, especially for those living in relatively remote and rural locations of the country, and this limits the effective availability of benefits for many Jamkesmas beneficiaries. In addition, the architecture of Jamkesmas is such that, in effect, it functions more like a demand-side “top-up” of essentially a (constrained) supply-side system rather than a full-fledged insurance program. Jamkesmas does not reimburse the full cost of care: salaries, capital, and some of the operating costs at public facilities continue to be paid for by the government (central, provincial, or district, depending on the type of public facility). Estimates suggest that these subsidies account for upwards of two-thirds of the full cost of providing care under Jamkesmas. This combination of supply-side constraints and supply-side subsidies reduces the program’s overall effectiveness and will likely impact its future sustainability.

Supply-side constraints comprise all the factors that limit health care delivery at the point of service, including the number of doctors, nurses, and midwives; the number of beds; medical equipment and technology; medicine supplies; and other basic amenities. Given Indonesia’s geography, supply-side constraints reflect not only shortages in overall numbers, but also in distribution. Rural and remote areas are disadvantaged in that they not only have fewer health facilities but also face the difficulties associated with the retention of health personnel, especially doctors.

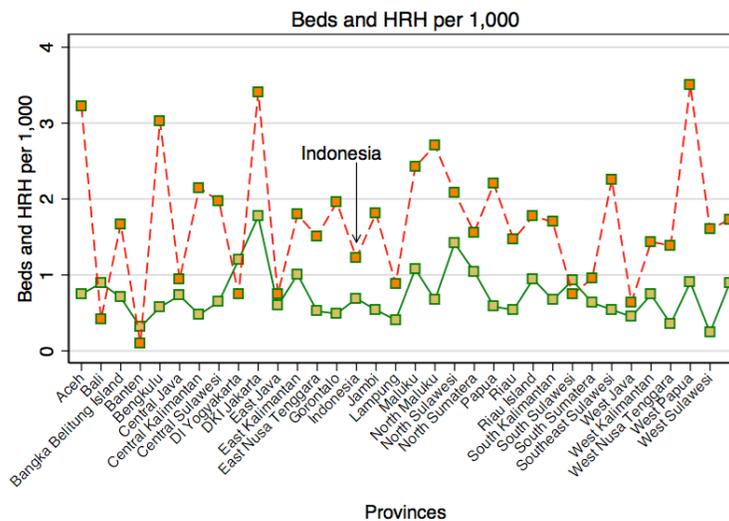
There are inequities even in the availability of basic primary care services across the country. There was an average of 3.79 puskesmas per 100,000 population in 2010. However, the ratio of puskesmas per 100,000 in remote provinces is much higher; for instance, in the eastern part of Indonesia, the ratios ranged from 8 to 12 per 100,000, and these facilities cover geographically remote, difficult, and sparsely populated areas. In addition, private providers are less likely to be available in these areas (figure 8).

Figure 8 Puskesmas Density by Province



Analysis of the stock of human resources for health in Indonesia reveals a sharp shortage of doctors. The ratio of doctors in Indonesia is 0.2 per 1,000, one of the lowest in the region. The PODES 2011 survey (the village facilities survey) reported that 92 percent of Puskesmas had at least one doctor, which is similar to administrative data. However, more realistic estimates suggest that as many as 2,250 Puskesmas (around 25 percent of the total number) are without doctors, most of these being in the more remote areas of the country (*Kompas* 2011). The distribution of doctors is highly concentrated in the Java-Bali region (which accounts for around 65 percent of all doctors); fewer than 6 percent of doctors practice in the eastern part of the country. There are wide variations in both human resources for health per capita and hospital beds per capita across provinces (figure 9).

Figure 9 Beds and Human Resources for Health per 1,000, by Province



Despite improvement in coverage and access to health services, the quality of services has tended to be stagnant in Indonesia. The quality of health personnel remains a problem. Although some improvements can be observed from comparisons between diagnostic vignettes from the 1997 and 2007 Indonesia Family Life Survey, the changes are marginal, and overall quality of services remains low, with only around half of health workers responding correctly to standard questions and procedural vignettes. Although based on several qualitative studies, the satisfaction level among Jamkesmas cardholders with health services they received in general was good. The most common complaints are related to services provided by nurses, waiting time, and complex administrative requirements.

Access to care is also constrained by the lack of basic amenities and medical equipment in puskesmas and other health facilities. Analysis of the 2011 PODES survey indicates that 96.7 percent of puskesmas had electricity, 88.1 percent had a water source, 87.5 percent had a cold-chain facility for the storage of vaccines, but only 36.4 percent had an incubator. In addition, the recently completed facility census (RIFASKES) estimates that 73.3 percent of puskesmas in urban areas had basic emergency obstetric services, but only 53.4 percent of rural puskesmas did. The availability of medical equipment and diagnostic tools is variable across urban and rural areas; preliminary RIFASKES data estimates indicate that few puskesmas had equipment close to stipulated national standards, and only 5.9 percent of urban puskesmas and 6.4 percent of rural puskesmas had more than 80 percent of the 56 ambulatory clinical devices available; around 10 percent of puskesmas had less than 20 percent. In terms of essential drugs, only around 60 percent of puskesmas both in rural and urban areas fulfilled 60 to 79 percent availability of 83 types of essential drugs, and only around 15 percent had 80 percent of the required drugs. Table 6 shows the availability of 6 of the 14 core medicines listed by WHO as one of the tracers for service availability.

Table 6 Availability of Core Medicines in Public Facilities

Drug Name	Availability (%)
Amitriptyline 25mg capsule/tablet	27
Amoxicillin 500mg capsule/tablet	19
Captopril 25mg capsule/tablet	22
Diazepam 5mg capsule/tablet	36
Glibenclamide 5mg capsule/tablet	27
Paracetamol 100mg capsule/tablet	35

Source: Indonesia Health Profile 2010.

There are also clear shortages of qualified doctors and specialist doctors at the secondary level of service. Preliminary RIFASKES estimates from 10 provinces show that only 25 percent of type D, 50 percent of type C, and 70 percent of type B public hospitals have trained doctors on staff for emergency care.¹⁵ For specialist care, the facility census shows that 20 to 30 percent of public

¹⁵ Ministerial Regulations 986/1992 classifies five types of public hospitals; Type A is the top referral hospital; Type B is a provincial-level hospital that provides specialist and subspecialist services; Type C is district/regency hospitals that provide at least four basic specialties (surgeon, internist, ob-gyn, and pediatrician); and Type D provides, at a minimum, a general physician and dentist, but also has a transient status before it is upgraded to a Type C hospital. Type E hospitals are special hospitals, such as mental hospitals, maternal and child hospitals, lung hospitals, or heart/cardiac hospitals.

hospitals were without one of four basic specialties (ob-gyn, pediatrician, internist, surgeon). It is almost impossible for those living in remote and rural areas of the country to receive appropriate first management of care at emergency units and to access basic specialized services at hospitals. The availability of hospital beds is also low in the country. In terms of inpatient capacity, Indonesia faced an estimated shortage of 13,875 beds. Some regions face particularly severe shortages and have less than 50 percent of actual bed needs. Furthermore, hospitals—especially district hospitals—face shortages of both human resources and medical devices/facilities. RIFASKES estimates from 142 hospitals in 10 provinces indicate that 32 had no pediatric specialist, 27 had no internist or surgeon, and 20 had no obstetrician. Regarding basic medical facilities, only 64.8 percent of public hospitals had a 24-hour blood service, 65.5 percent had a 24-hour laboratory service, and 59.2 percent had a 24-hour radiology service.

These supply-side constraints conceal the real costs of the Jamkesmas program and act as an implicit cost-management strategy. Although Jamkesmas offers a comprehensive benefits package of services, in practice, utilization and the associated claims reimbursements do not reflect the actual cost of health coverage due to the limited supply of services. If the utilization rates were higher, the actual costs of the Jamkesmas program would likely be much higher. Furthermore, puskesmas and public hospitals continue to receive government subsidies for salaries and capital, which are also not included in the overall cost of Jamkesmas and therefore skew the perceived cost of the program.

10. Pending Agenda: Attaining Universal Coverage in Indonesia

One of the key aspects of attaining universal coverage in Indonesia should be a greater focus on improving the current performance of Jamkesmas. This section summarizes the pending agenda with regard to the different architectural and operational aspects of Jamkesmas, and the key issues related to the theme of the case study highlighted in section 9. The ensuing issues are discussed within the context of ongoing efforts to attain universal coverage in Indonesia, and highlight some key problems with the current implementation of the program that prevent Jamkesmas from fully attaining its objectives.

Institutional Architecture of Jamkesmas

Lack of results-focused provider payment mechanisms. Under Jamkesmas, payments to providers are basically fee-for-service (including DRGs for hospital-based care). At present, there are no additional incentives to improve quality and provider performance. More fundamentally, there are no mechanisms to incentivize providers to attain population-level targets, for example, at the district or catchment-area level (Langenbrunner and Somanathan 2011). Whereas the incentives on the demand side (for beneficiaries) under the program are relatively clear, supply-side incentives need to be better aligned and adjusted to ensure the program is attaining its objectives.

Incomplete separation of purchaser and provider. Jamkesmas is currently housed within the MoH, which is ultimately also responsible for overseeing and, along with local governments, financing, public health facilities. This incomplete separation of provider and purchaser functions under the program is problematic because it amplifies the lack of incentives for both providers and purchaser to attain the intended policy objectives. In addition, management of

Jamkesmas within the MoH is segregated by level of service, with each level belonging to a different unit. These issues are exacerbated by insufficient MoH experience and capacity in managing large-scale programs, leading to weak monitoring and poor feedback and accountability mechanisms. The implementation of the Social Security Administrator Law requires management of Jamkesmas to be transferred to a single not-for-profit social insurance administrator by 2014. This may improve the situation with regard to some of the above-mentioned problems. Discussions are ongoing regarding the transfer schedule and the readiness and willingness of PT Askes to merge their existing provider payment mechanisms and information systems with those of Jamkesmas.

Targeting, Identification, and Enrolment of Beneficiaries

Reducing mistargeting and leakages. Jamkesmas targeting of the poor and near-poor needs significant improvements. More than half of Jamkesmas beneficiaries are not from the bottom three deciles. As mentioned, the country is in the process of improving beneficiary identification methods to improve coverage and reduce leakages. In expanding coverage to achieve universal coverage, one of the most debated issues is expansion to cover the nonpoor informal sector. According to global experience, other countries, such as Brazil, China, Mexico, and Thailand have had difficulties covering this particular group. The debate involves discussions around the level of premium contributions and collection mechanisms, both of which are expected to be extremely challenging.

Improving coverage rates. Jamkesmas needs to improve socialization, awareness, and availability of benefits to ensure that all those eligible actually enroll in the program. Also, currently the system does not incentivize local governments to enroll targeted beneficiaries. One option would be for the government to tie some proportion of resource transfers to local governments based on verified enrolment numbers rather than on a capitation and utilization basis, as is currently the case. Active validation and enrolment of eligible beneficiaries of the program would be a key aspect to maximize coverage and limit leakage.

Public Financing of Jamkesmas

Sustainability issues. Jamkesmas is entirely financed through central government taxes. Premiums are not based on sound actuarial calculations. Supply-side constraints and supply-side subsidies have given the false impression that financing of Jamkesmas is sufficient. The program does not reimburse the full cost of services and relies heavily on supply-side subsidies. Consequently, the program does not provide strong incentives to the providers to deliver high-quality services. In addition, fund flows from the central levels to public health centers have proven to be problematic in a decentralized setting, given conflicting and confusing financial arrangements between central and local governments that have hampered health center use of funds.

Learning lessons from selected provinces/districts that have attained universal coverage. Some provinces/districts in Indonesia have already expanded toward universal coverage. In looking at issues related to public financing, it is imperative that the government examine these experiences

and estimate costs of universal coverage from these provinces/districts and identify lesson learned.

Jamkesmas Benefits Package

Ensuring supply-side readiness. As discussed in section 9, one of the biggest challenges facing Jamkesmas is ensuring that the basic benefits package is uniformly available, especially to those living in remote, rural areas of the country. Supply-side constraints, in effect, currently limit the effective availability of benefits under the program.

Coordination of benefits across different schemes. In many provinces and districts, Jamkesmas is complemented (and sometimes substituted) by other local health insurance schemes (Jamkesda). These schemes often provide coverage for the “uncovered poor” and, in some cases, additional benefits and coverage for other population segments. These schemes vary widely in scope, from those covering only primary care to those having a comprehensive benefits package. The future of the more than 300 local health insurance schemes in the grand scheme of universal coverage remains unclear, and there are ongoing discussions on this front. The variations in the benefits packages provided by these schemes, reflecting in part the fiscal capacity and preferences of local governments, pose a particular challenge with regard to harmonization of universal coverage efforts. In addition, Indonesia is aiming to merge the three largest health insurance schemes (Askes, Jamkesmas, and Jamsostek) under the management of a single not-for-profit health insurance carrier beginning in January 2014. Challenges remain regarding unification of the different benefits packages, premium rates, membership management mechanisms, and provider payment mechanisms.

The plan to merge the existing social insurance schemes and Jamkesmas, as required by law, was being discussed intensively within the government at the time this case study was being written. A significant change made is that now the government aims to cover the whole population by 2019 instead of by early 2014. The social health insurance administrator, which will be operating a health plan as a result of integrating two social health insurance schemes and the Jamkesmas program, is still expected to be effective on January 1, 2014. Questions remain, however, on how these three health coverage plans with different target population groups and varied benefits packages and provider payment mechanisms will be operated under one administration. Also, these plans have reporting responsibilities to different ministries and have different organizational structures, the integration of which has raised issues on, among other things, the new institutional arrangement and asset management. The ongoing interministerial discussion will produce a government regulation that will serve as the legal basis for its operation. One area that still needs to be thought through and defined, but which does not seem to receive much attention, is the new role of MoH in providing oversight functions, especially in monitoring performance in relation to achieving health objectives.

Annex 1 Institutional Capacity – Purchasing Functions

Selecting, Certifying, Contracting, Negotiating Providers	Contract Monitoring and Management	Information Environment	Cost Containment	Fraud Control	Provider Payment Reform	Targeting
<p>All public providers from the primary and secondary level of care are obligated to join the Jamkesmas provider network.</p> <p>No contract with public providers or local health authorities.</p> <p>Accreditation status is not included as one of the requirements to join the network.</p> <p>No selection or certification process for private providers to join the network.</p>	<p>Since Jamkesmas is a central program, the monitoring and management are the responsibility of the central MoH.</p> <p>Ad-hoc teams established at local health authorities and funded by the central MoH to supervise and monitor program implementation.</p>	<p>MoH has the responsibility to collect, review, and conduct audits on utilization and claims data.</p> <p>The information produced from the data review are mainly on budgetary allocations and aggregate utilization rates, and not on target health or financial protection outcomes among beneficiaries.</p> <p>Information on utilization rates has been used to increase premiums and improve provider payment mechanisms, but not to improve service delivery.</p>	<p>The benefits package is quite comprehensive and no cost sharing is applied.</p> <p>The supply-side constraints act as a cost-containment strategy.</p> <p>Incomplete separation of purchaser-provider functions remains problematic.</p> <p>The cost-containment measures include the use of a drug formulary, utilization review, and payment mechanism.</p>	<p>Validation of membership upon entry to use services at all levels of service.</p> <p>Hospital claim review has managed to identify cases of DRG upcoding, but the review process remains limited to the administrative process.</p>	<p>Capitation payment for primary care facilities was changed to fee-for-service to ensure better reporting of service utilization and to ensure the disbursement of funds.</p> <p>DRG payment mechanism started in 2009 after the program experienced a spike in utilization of inpatient services.</p> <p>The effectiveness of DRG payment to contain cost remains unclear.</p> <p>The DRG rate is currently being adjusted for the first time since 2009.</p>	<p>The target group for Jamkesmas includes all poor and near-poor households</p> <p>The 2005 list, which is being used until 2012, will be updated in the coming year using the 2011 unified data for all social assistance programs.</p> <p>Based on the household survey, leakage for the program was almost 50% in 2010.</p>

Institutional Capacity – Providers

Availability of Inputs	Absorptive Capacity	Internal Financial Management	Quality Management	Supervision	Accountabilities	Respond to Incentives
<p>Public providers receive general subsidy, which depends on budget availability.</p> <p>Based on the 2011 health facility census, only a few (less than 7%) puskesmas have 80% or more equipment stipulated by the national standards.</p> <p>There are issues in human resource distribution; 25% of puskesmas do not have doctors, mainly in rural areas.</p>	<p>The change from capitation to fee-for-service at puskesmas level is to increase the absorption of Jamkesmas funds. Previously, the capitation payment was directly channeled to public primary providers (puskesmas), the use of Jamkesmas funds must follow the government regulation in which all revenue must be submitted to the local treasury. The amount of funding returned to the puskesmas varies depending on local regulations. In some districts, some local regulations prevent puskesmas from receiving revenue from the poor, including Jamkesmas funds. These mechanisms minimize the incentives for puskesmas to use the Jamkesmas</p>	<p>For public facilities, all revenue must be submitted to the local treasury, with the exception of those with autonomous status.</p> <p>The central MoH provides guidance on the use of Jamkesmas funds.</p> <p>The use of Jamkesmas funds is subject to audit by the general audit office.</p> <p>Hospital claims processing goes through multiple verification processes at the hospital level and at the central level, although the verification is limited to administrative review. There is no quantitative information on the timeliness of submission and claim lags.</p>	<p>Standards for service delivery are available for some services, as is protocol guidance, but there is no clear mechanism to ensure provider compliance.</p> <p>Hospitals are required to have a medical ethics committee.</p>	<p>Ad-hoc teams have been established at the subnational health authorities (Provincial Health Offices and District Health Offices) to supervise and monitor the Jamkesmas program. In the last two years, the intensity of supervision has been lacking, with the decrease of supervision funds allocated from the central MoH.</p>	<p>Providers at all levels are required to report periodically utilization of service and financial management. The utilization and claims reports are reviewed by the MoH. The review focuses on analyzing information related to budgetary allocations and aggregate utilization rates, but does not explicitly monitor or target health or financial protection outcomes among beneficiaries.</p> <p>Providers in the network are also subject to audit from the Government Accounting Office.</p>	<p>Primary care providers: Failure of the capitation mechanism was mainly driven by inflexibility to use Jamkesmas funds at public health providers. In the absence of provider autonomy, the intended objective to incentivize basic providers to ensure the health of their captured population by focusing more on preventive efforts is difficult to achieve. Under the capitation payment, it is projected that there is incentive to refer even cases that can be managed at the primary level. Unfortunately, this is not recorded and reported.</p> <p>Secondary/Tertiary: The use of fee-for-service payment has incentivized providers to increase admission and prolong length of stay, until the</p>

funds.	Since the program is managed by the MoH, network hospitals receive advance payment based on historical claims. This mechanism has reduced complaints in delayed payments.	implementation of DRG in 2009. There is evidence of few cases of DRG “creeping” or upcoding ^a in a number of hospitals.
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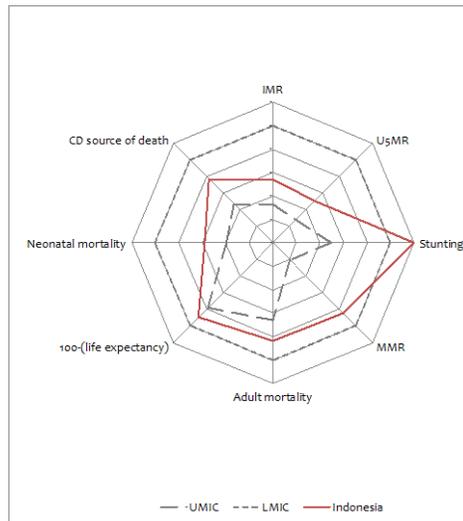
Note: a. DRG “creeping” or upcoding is a practice in which providers deliberately and systematically shift patient’s discharge diagnosis to those with complications or higher in the payment scale in order to receive a higher reimbursement.

Effects on Service Delivery

Availability	Capability	Quality/Patient Safety	Customer Satisfaction	Efficiency / Productivity	Continuity of Care
<p>The number of providers in the Jamkesmas network has increased over time. The growth was due to the increasing number of district hospitals and, mainly, the increasing number of private hospitals joining the network. Private hospitals now constitute 30% of total network hospitals, but their share of bed capacity remains much lower compared to public hospitals.</p>	<p>Primary services are standardized across the country. However, based on the most recent health facility census, the capability of public facilities to provide services varies across the country due to unavailability of health human resources, equipment, and drugs and supplies.</p> <p>There are variations in capability to provide services among hospitals across the country. There are four hospital levels depending on the level of sophistication of services that can be provided. Even in the two lowest levels (Types C and D), the variations are also caused by uneven distribution of human resources, especially specialists, and the availability of equipment.</p>	<p>The low quality of service perceived by consumers, especially of public facilities, has been considered to be one of the factors preventing the use of care.</p> <p>National clinical guidelines, such as case protocols and clinical pathways, are being developed but are not yet in place.</p>	<p>Based on qualitative surveys (the World Bank and Indonesian Corruption Watch Report), most Jamkesmas users are in general satisfied with public services. The most common complaints are related to services provided by nurses and to the lengthy waiting times and complex administration requirements.</p> <p>The complaint-handling mechanism is outlined in the Jamkesmas manual. However, in practice, the mechanism is fragmented and inconsistently implemented in the field, with complaints handled differently at different levels. There is also a direct complaint mechanism to the central MoH. The submitted complaints were not compiled and analyzed properly.</p>	<p>The provider payment mechanism change from non-negotiated fee-for-service in the beginning of the Jamkesmas implementation to the DRG system for hospitals has reduced the length of stay (Susenas 2004–2009).</p> <p>However, the changes at the primary level of care are difficult to measure, because data on the use of primary care are not available (not well collected).</p>	<p>Health services are provided at different levels of care, with a referral mechanism to ensure continuity of care.</p> <p>Puskesmas are projected to have the gatekeeper function, but in practice, Jamkesmas cardholders tend to use secondary-level care (both ambulatory and inpatient services) directly, skipping the first level of care.</p>

Annex 2 Spider Web

I. Outcomes comparisons: Indonesia and Lower Middle Income Countries



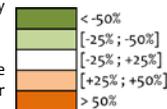
Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

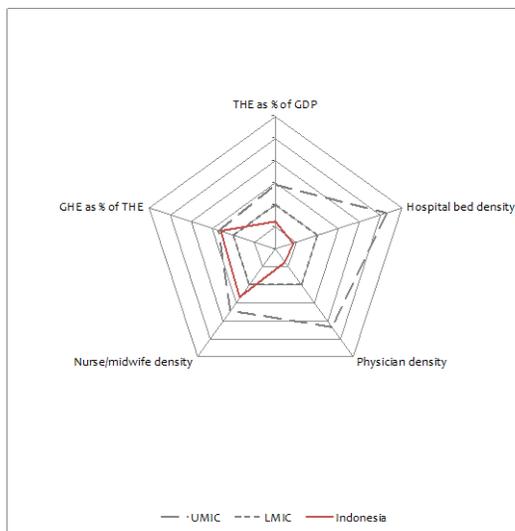
The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
IMR	27.2	50.3	-46.0%
U5MR	35.3	69.4	-49.2%
Stunting	35.6	29.7	19.9%
MMR	220.0	260.0	-15.4%
Adult Mortality	204.7	244.1	-16.1%
100-Life Expectancy	31.1	34.6	-10.1%
Neonatal Mortality	17.0	29.1	-41.6%
CD mortality	36.0	47.0	-23.4%



IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Indonesia and Lower Middle Income Countries



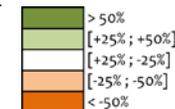
Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

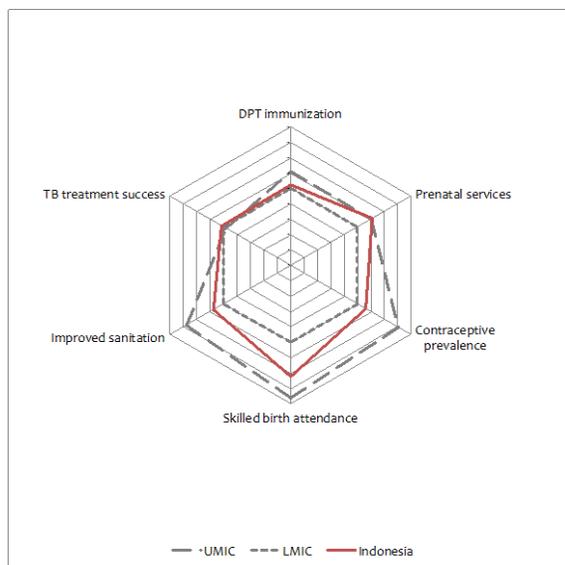
The table below summarizes inputs comparisons with the average lower middle income country (LMIC).

Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
THE %GDP	2.6	4.2	-38.4%
Hosp. bed density	0.6	1.4	-56.8%
Phys. density	0.3	0.8	-62.9%
Nur./midwife dens.	2.0	1.5	35.0%
GHE %THE	51.8	40.2	28.9%



THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons Indonesia and Lower Middle Income Countries

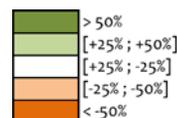


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

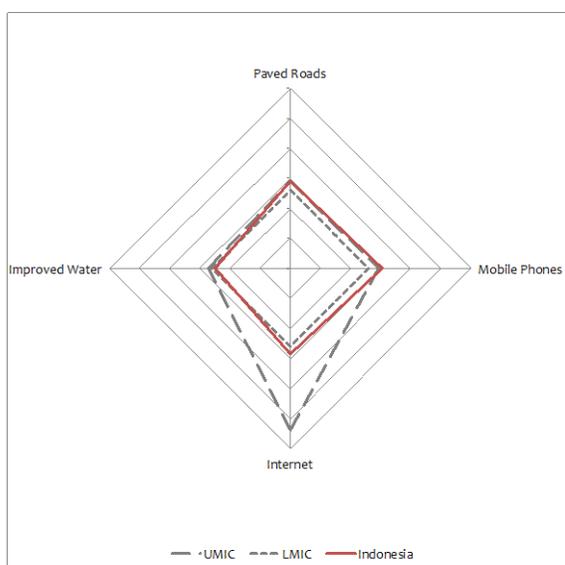
The table below summarizes coverage comparisons with the average lower middle income country (LMIC).



Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
DPT	83.0	78.7	5.4%
Prenatal	95.3	78.1	21.9%
Contraceptive	56.6	50.1	13.0%
Skilled birth	82.2	56.9	44.5%
Sanitation	54.0	47.0	14.9%
TB success	91.0	88.0	3.4%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons Indonesia and Lower Middle Income Countries

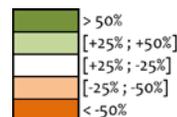


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

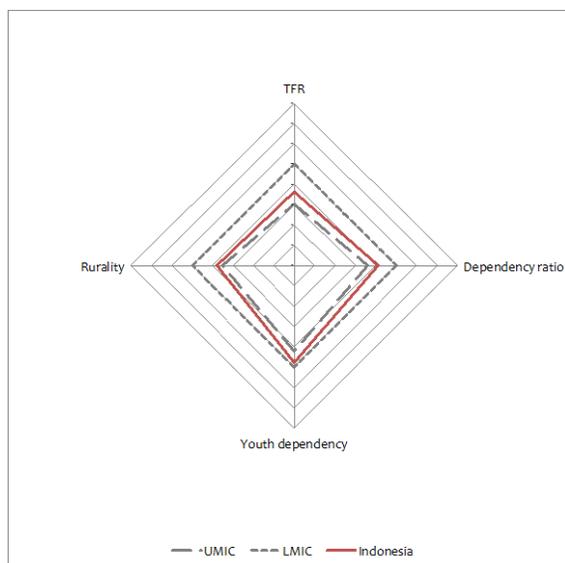
The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).



Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
Paved roads	56.9	49.5	14.9%
Mobile phones	97.7	79.3	23.3%
Internet	18.0	16.0	12.2%
Water	82.0	87.3	-6.0%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons Indonesia and Lower Middle Income Countries

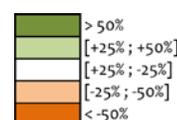


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

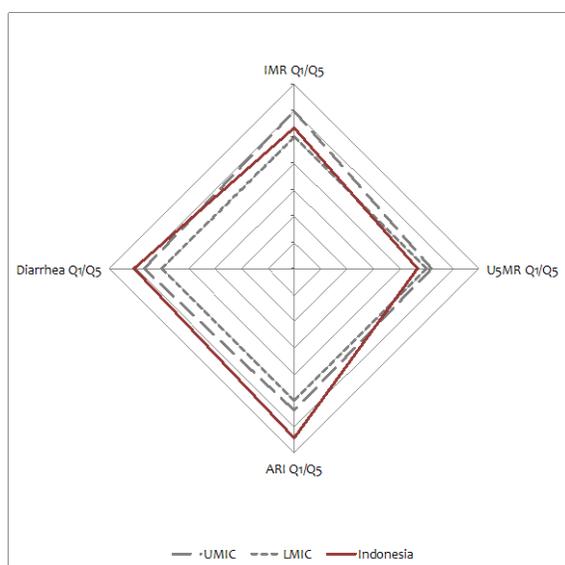
The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).



Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
TFR	2.1	2.9	-27.6%
Dependency (Total)	48.3	58.8	-17.8%
Youth share	83.0	86.7	-4.3%
Rural pop.	46.3	60.6	-23.6%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons Indonesia and Lower Middle Income Countries

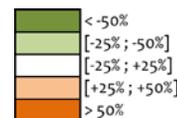


Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).



Country Data	Indonesia	LMIC	% Diff.
GNI pc (2000 USD)	704.4	592.4	18.9%
IMR Q1/Q5	2.1	2.0	7.3%
U5MR Q1/Q5	2.4	2.6	-6.5%
Stunting Q1/Q5	NA	2.7	
ARI Q1/Q5	1.7	1.3	28.4%
Diarrhea Q1/Q5	1.8	1.5	21.6%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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