MAKING SERVICES WORK FOR THE POOR IN INDONESIA

CASE STUDY 6:
HEALTH INSURANCE REFORM
IN JEMBRANA DISTRICT, BALI PROVINCE

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ABSTRACT

The *Jaminan Kesehatan Jembrana* (JKJ or Jembrana Health Insurance) scheme begun in Jembrana District, Bali Province in March 2003 provides free primary healthcare to all members; free secondary and tertiary care is also provided for poor members. The scheme has improved the access of both poor and non-poor citizens to healthcare. Before JKJ, only 17 percent of district citizens were covered by any kind of health insurance; now, 63 percent are covered. The percentage of ill people who sought treatment in Jembrana more than doubled from 40 percent in 2003 to 90 percent in 2004. For the poor, the increase was from 29 to 80 percent. Increased access of the poor to health services is due primarily to the inclusion of private providers in the JKJ scheme. Though on paper, out-of-pocket healthcare costs have increased sharply for poor non-members, in practice most public providers still provide free care for all poor clients. This increases access of even non-member poor to healthcare, but subjects them to the discretion of providers who have the legal right to refuse them free services. Meanwhile, JKJ registration requirements have kept many of the poor from joining. JKJ's attempts to become self-financing have focused recently on a new one-membership-card-per-person system (rather than the old one-card-per-family scheme), and this is likely behind a drop in membership of the poor, from 66 percent in 2004 to 22 percent (re-registered under the new system) by May 2005, since many poor families cannot afford to re-enroll all members. By increasing access to private providers, JKJ has increased competition between public clinics and private doctors for clients. JKJ has also improved both healthcare quality and client satisfaction. It is likely that JKJ's enforcement of strict standards on equipment, treatment, medication, and referral has contributed to the improvement. JKJ does not, however, appear to be financially sustainable. There has been a rapid, unbudgeted increase in district spending on JKJ. JKJ's inclusion of non-poor citizens adds greatly to its cost—in 2004, 95 percent of the Rp. 9.5 billion in JKJ claims were made for services to non-poor clients. The informal inclusion of poor non-members also increases JKJ costs, as those who provide free services to poor non-members are in fact usually reimbursed by JKJ. Finally, investment in JKJ administration is grossly inadequate, and JKJ's legal basis is challenged by a 2004 law centralizing health insurance.

This case study was written by Arya B. Gaduh, World Bank (Indonesia) and Laila Kuznezov, consultant (U.S.A.). Research was based on a field visit to Jembrana in March 2005. Reference is made to Steven Block, "Maternal Nutrition Knowledge and the Demand for Micronutrient-Rich Food: Evidence from Indonesia" in issue 40:6 of *The Journal of Development Studies* (2004); Eko Prasojo, Teguh Kurniawan and Azwar Hasan, *Identifikasi dan Pemetaan Inovasi Program Pemerintah Kabupaten Jembrana,* Universitas Indonesia: Jakarta (2004); I. Made Sudaarsena, "*Jaminan Kesehatan Jembrana, Satu Inovasi Peningkatan Pelayanan Kesehatan di Kabupaten Jembrana*" (mimeo), (2003); and ADB, *Policy for the Health Sector*, Manila (1999). Research team members included Laila Kuznenov, consultant (U.S.A.), Janes Ginting, World Bank (Indonesia) and Gregorius Kelik Agus Endarso, consultant (Indonesia). Managerial, analytical, and editorial support was provided by Menno Prasad Pradhan, Stefan Nachuk, and Lina Marliani, all of the World Bank (Indonesia), and Winthrop Carty, Ash Institute of Democratic Governance, Harvard University (U.S.A.). Analytical and editorial assistance was provided by Susannah Leisher, consultant (Australia).

INTRODUCTION

As part of its mandate to alleviate poverty in Indonesia, the World Bank is undertaking a series of case studies to promote better service provision, especially for poor and disadvantaged people. The case studies were chosen from the many innovative practices seen in Indonesian local government in recent years, through a competitive outreach process managed by the World Bank. Donors, non-governmental organizations, and local government staff were contacted and encouraged to submit proposals regarding innovative service delivery work that they either were undertaking or knew about. The *Jaminan Kesehatan Jembrana* (JKJ) health insurance reform scheme in Jembrana District, Bali, touches upon a theme that is central to making services more pro-poor, to wit, the use of private providers to expand service coverage and improve quality by increasing competition. Hence its selection as one of the case studies.

THE STUDY SITE: JEMBRANA DISTRICT

The district of Jembrana in the province of Bali has a population of around 250,000 (2004). Jembrana's annual *per capita* income in 2002 was Rp. 5.83 million (US$610), below the provincial average of Rp. 6.46 million (US$680). Its poverty rate was 9.0 percent in 2000, slightly higher than the provincial rate of 8.6 percent.[1] In both *per capita* income and poverty rate, Jembrana ranks fifth of Bali's nine districts.[2] There are four sub-districts (*kecamatan*) in Jembrana, including the capital, Negara. Most people outside the capital are farmers, raising rice, cloves, cacao, coconuts and other foodstuffs. Most of the poor are unskilled farm laborers; many work as fishermen, tradesmen, and farmers. Some areas are hilly, and a lack of public transport means that travel from the countryside to Negara can be expensive and time-consuming.

HEALTHCARE IN JEMBRANA DISTRICT

Jembrana has 12 private clinics, 5 public clinics (*pusat kesehatan masyarakat* or *puskesmas*), 49 public village clinics (*puskesmas pembantu* or *pustu*), 2 public hospitals and 1 private hospital. The population-to-clinic ratio of 14,800:1 is quite good—half the provincial ratio—as is the population-to-hospital ratio of 84,000:1, which is two-thirds the provincial ratio (2003). There are 84 doctors (including 8 specialists and 12 dentists), 169 paramedics, and 113 midwives (2004), yielding population-to-provider ratios that are roughly in line with ratios at the provincial level (2,990:1, 1,470:1, and 2,220:1, respectively). Over 70 percent of the doctors are civil servants; however, most also have private practices. With the introduction of JKJ, private practitioners compete directly with public clinics and hospitals for primary healthcare patients.

Healthcare in Jembrana is managed by the District Bureau of Health and Social Welfare (*Dinas Kesehatan dan Kesejahteraan Sosial*). *Puskesmas* provide primary healthcare (*pemberi pelayanan kesehatan I* or PPK I), including preventative and basic curative care for common illnesses, health education and promotion, and reproductive health services.[3] They are staffed by general practitioners and paramedics, who manage not only the *puskesmas* but also all village clinics in the area (between 9 and 14 village clinics per *puskesmas*). The *puskesmas,* especially in poorer and remote areas, often face a shortage of doctors. Hence, in a mutually beneficial arrangement, the district government hires newly graduated (*Pegawai Tidak Tetap* or PTT) doctors, who agree to work in these less-desirable locations in order to gain the public clinic experience required for a physician's license. Patients who require it are referred to secondary healthcare providers (PPK II), usually the district

[1] Central Body of Statistics. The district's 2002 survey found a higher rate, 12.5 percent, but the national data are cited here to enable cross-district comparison.
[2] Technically, there are 8 districts and one municipality.
[3] ADB (1999).

hospitals. More difficult cases requiring specialist doctors and equipment are referred to tertiary healthcare, or PPK III, providers.

JKJ: WHERE DID IT COME FROM, AND WHAT IS IT?

A 2001 district-initiated survey focusing on quality and cost of health services initiated by the newly-elected Regent uncovered several inefficiencies. First, with 11 public clinics, the population-to-clinic ratio was around 20,000:1, half the national average of 40,000:1, indicating a service provision surplus. The Regent responded by upgrading one clinic to a hospital in a sub-district which was under-supplied, while downgrading five others to sub-clinic status, resulting in savings from cutting administrative structures, since sub-clinics fall under the management of nearby *puskesmas*. Second, clinic and hospital utilization rates were low. The district felt this stemmed from inefficient use of health subsidies, and decided that instead of subsidizing clinics and hospitals directly, it would provide all citizens with free basic healthcare, as well as additional healthcare services for the poor.

The first step in this direction was taken in December 2002 with the establishment of a JKJ (*Jaminan Kesehatan Jembrana* or Jembrana Health Insurance) Preparation Team, responsible for the design, pilot-testing, and dissemination of the new district-wide fee-for-service health insurance scheme, a first in Indonesia. In January 2003, the JKJ Management Body (*Badan Pelaksana* or *Bapel*) was established, and implementation of JKJ began in March 2003. JKJ provides all members with free primary healthcare, including some dental treatment, from any participating provider, either public or private; poor members are additionally entitled to free secondary and tertiary care. Any general practitioner, midwife or dentist, public or private, may sign a JKJ contract to provide services to members which will be reimbursed at standard rates by JKJ; paramedics are not eligible. JKJ was set up on the premise that all Jembrana citizens are entitled to quality health services; hence, *ensuring benefits to the poor was not the most important aspect of its design.*

JKJ is managed by the JKJ Management Body (*Bapel*) which has a staff of fourteen, five of whom are doctors or have medical-related diplomas. Their main task is to manage reimbursement of claims made by health providers, first verifying the service against a set of standards for equipment, treatment, and medication established for quality control, and then making payments to the providers based on set rates. They also ensure that the health referral system is implemented, restricting healthcare providers to providing only those services for which they are licensed and referring all other services to other providers.

METHODOLOGY

The fieldwork sought to prove five theses:

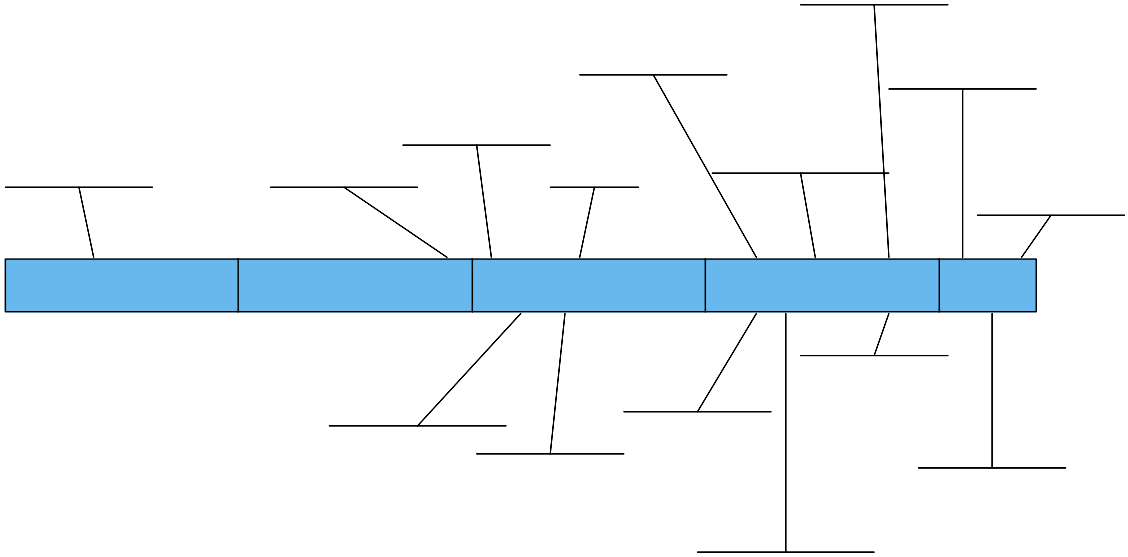
1. JKJ has improved access of the poor to health services.
2. JKJ has made Jembrana a more attractive place to work for all types of health professionals.
3. JKJ has intensified competition for clients among health care providers.
4. JKJ has improved the quality of healthcare services and increased client satisfaction.
5. JKJ is not sustainable.

Research was conducted in two of the four sub-districts in Jembrana: Melaya and Negara. These were selected because they each have a public clinic which serves many poor families. In each sub-district, the team visited the lead public clinic (*puskesmas*) to speak with directors and staff, as well as a sub-clinic under its management, and then selected a village within the coverage area of that sub-clinic or nearby in which to conduct focus group discussions with poor citizens. Manistutu village in Melaya and Brangbang village in Negara were the chosen study sites. Manistutu was chosen because it had not been served by a doctor prior to JKJ but had two doctors at the time of the research. This village was also considered to be relatively remote (about 45 minutes' drive from the district capital). The

team also visited a *banjar* (hamlet) in a far corner of that village. Brangbang was selected because it has a large number of poor families, although it is not within the coverage area of the visited sub-clinic. In addition, the team randomly visited doctors holding private hours outside Negara but not necessarily in the coverage areas of the visited *puskesmas*.

The team used a combination of semi-structured interviews, informal interviews, and focus group discussions. In each village, separate focus group discussions were held with women and with men. The team also spoke with the head of the village and *kelian adat* (hamlet head), as well as midwives and doctors holding private hours in or near the area. Respondents included over 40 healthcare informants and over 70 citizen-clients. Healthcare informants included doctors, midwives, paramedics, *puskesmas* directors and other staff, public and private hospital directors, and local officials, including the Regent (the head of the district), the head of the Health and Social Welfare Bureau, and the head and staff of the JKJ Management Body. The team began and ended the week by speaking with local officials.

IMPACT OF JKJ



DID JKJ IMPROVE ACCESS OF THE POOR TO HEALTH SERVICES?

Yes, because the poor now have access to most private (as well as all public) healthcare providers for free. Before JKJ, only 17 percent of citizens were covered by any kind of health insurance; now, 63 percent are covered. JKJ is by far the most significant health insurance provider in Jembrana, covering nearly half the population. The second most widely-used provider, *Kartu Sehat* (a government health insurance scheme targeting the poor), covers only 13 percent. Given that 9 percent of the population is poor, the implication is that all the poor are covered by the *Kartu Sehat* already, though there are no data to verify this. Though many of the poor may thus be double-insured, JKJ membership has the important advantage of providing the poor with access to private providers.

By providing free health care at both private and public facilities, JKJ has increased the healthcare facility utilization rate by both poor and non-poor clients. Prior to JKJ, poor clients could only get free healthcare at the 11 public clinics (as well as local sub-clinics). Under JKJ, in addition to free care at the local sub-clinics and the remaining 5 public clinics, the poor also have access to more than 20 doctors whose practices are fully private, 2 hospitals providing secondary and tertiary care now covered by JKJ, and the private practices of more than 40 civil servant doctors who have signed individual JKJ contracts to provide additional private services after their working hours in public facilities. The increase in healthcare options has been dramatic. According to the National Socio-Economic Survey, the percentage of people in Jembrana who reported seeking treatment when they were ill more than doubled from 40 percent in 2003 (when JKJ was just starting) to 90 percent in 2004.[5] *For the poor, the increase was from 29 percent to 80 percent.* As one male interviewee noted, "Now we can see the doctors any time for free." A woman stated, "We can receive free family planning services frequently now from midwives."[6]

Health insurance coverage in Jembrana[4]
(% of the population)

Provider	2003	2004
Kartu Sehat (government Health Card scheme targeting poor households)	5.8	12.7
P.T. Askes (for government employees)	8.8	9.4
Astek/*Jamsostek* (for private sector workers)	0.6	0.8
Perusahaan/kantor (for private sector workers)	0.2	0.5
Dana Sehat (a village level Health Fund scheme)	1.9	0.1
JPKM (*Jaminan Pemeliharaan Kesehatan Masyarakat*) (government HMO)	0.0	0.1
Others (including JKJ)	0.2	45.6

On paper, healthcare costs have increased sharply for poor non-JKJ members, but most public providers still provide free care for all poor clients. Public clinics have increased their service charges for non-JKJ members from Rp. 2,500 (US$0.26) per visit before JKJ (when the poor did not have to pay) to up to Rp. 27,000 (US$2.8) for poor and non-poor non-members alike, more than ten times the pre-JKJ charge. Public hospital doctors that previously did not charge any service fee (since it was internalized in their salary) now charge non-members Rp.10,000 (US$1) for emergency room consultations. The high fees for healthcare for non-members are intended to encourage people to join the JKJ scheme. However, a list of poor households (*keluarga miskin* or *gakin*) is given to all public providers (and is available for private providers as well). Poor clients whose names are on this list will almost always get free care from public providers, whether they are JKJ members or not, and this care will almost always be reimbursed to the provider by JKJ. As the head of the Kaliakah *puskesmas* in Jembrana district stated, "We always provide free

Healthcare payments by the poor, pre- and post-JKJ

Service	Pre-JKJ payment of the poor	What JKJ members pay	Theoretical payment of poor non-members
Puskesmas (primary and ante-natal care)	Free	Free	Up to Rp. 27,000
Public hospital	Free	Free	Rp.10,000
Private doctor	Rp. 20,000	Free	Rp. 20-30,000
Midwife (ante-natal care)	Rp.10,000	Free	Rp.15,000
Midwife (delivery)[7]	Rp. 50-150,000	Free	Rp. 500-600,000

[4] SUSENAS (2003/2004). Some people have more than one provider, so annual totals cannot be tallied in this table; some people with *Kartu Sehat* (health card) insurance may actually be covered by JKJ but don't realize it.
[5] The authors' calculation based on the 2003/2004 National Socio-Economic Survey.
[6] Brangbang village interviews.
[7] Child delivery services were only added to JKJ coverage in early 2005.

medication to the poor. And in general, most of them have a JKJ card or are listed in the poor household list." Further, it is very unlikely that there are any poor people not registered in the *gakin* book as *gakin* registration is done annually and conducted carefully at the grassroots level.[8] The willingness to provide free services even for non-members may be due to public clinics' sense of social obligation or to their desire to maintain a good reputation in the midst of stiff competition among providers. The informal arrangement, though it does increase access of the poor to healthcare, means services to poor non-members are at the discretion of providers. One doctor talking about his private practice asserted, "I will not receive patients with only a *gakin* (i.e., poor household) card; if the poor client does not have a JKJ card, they still have to pay. Such cases rarely happen, however."

The degree to which the poor have increased access to healthcare depends on whether they are JKJ members or not, and JKJ registration requirements have kept many of them from joining. The number of *poor* people seeking healthcare increased from 24 percent to 64 percent *if they were uninsured*, but from 46 percent to 95 percent *if they were insured*.[9] Though the improvement is greater for uninsured poor (an increase of 2.6 times) than for the insured poor (an increase of 2.0 times), being insured still makes a difference: insured poor are more likely to seek care. All citizens of Jembrana are eligible to participate in JKJ. However, to apply for membership, a citizen must produce a Jembrana identity card. Though these ID cards are free, a free, government-issued "family card" must be shown in order to get one, and since not all citizens have family cards, not all can get the ID cards required for JKJ membership.[10] Moreover, JKJ membership cards must be purchased and renewed annually. Initially, only one membership card was required per family, costing Rp. 10,000 (US$1.1) for non-poor households and Rp. 5,000 (US$0.55) for poor households. JKJ's Management Body claims that all poor households were registered under this arrangement, but National Socio-Economic Survey data contradicts this claim: according to the survey, only 66 percent of the poor in Jembrana were insured in 2004. The discrepancy can only partially be accounted for by the use of different criteria in identifying the poor.

In February 2005, ostensibly to "introduce the concept of a premium to citizens" but more likely to raise much-needed funds, district government began to require one JKJ membership card per person, rather than per family. Each individual card costs the same as a family card. By May 2005, only about 22 percent of poor citizens had been re-registered in this new system.[11] Even at the low cost of Rp. 5,000 per card, many poor families have had to borrow money to enroll in JKJ, either from a local micro-credit scheme or from friends and family. Men from poor families revealed that they often choose to enroll their wives and children in JKJ first, although they all have plans to sign themselves up eventually as well. Given the close correlation of being insured with seeking care, under this new registration system JKJ may actually have reduced the access of the poor to healthcare.[12]

DID JKJ MAKE JEMBRANA MORE ATTRACTIVE TO HEALTH PROFESSIONALS?

JKJ may have made Jembrana a more attractive place for midwives to work, but has had either a negligible, or a negative, impact on the numbers of doctors, dentists, paramedics and specialists. According to the Jembrana District Bureau of Health and Social Welfare, the percentage increase in the number of general practitioners working in Jembrana was roughly the same from 2002 to 2003 (before JKJ) and from 2003 to 2004 (after JKJ began)—however, the increase did slow slightly. The number of paramedics did

[8] Head, district health office.
[9] Prior to JKJ, some of the poor were insured through other schemes. National Socio-Economic Survey (2003, 2004).
[10] For instance, some families who have moved into the area temporarily do not bother to get a card.
[11] JKJ Management Body.
[12] Dentist, *Bapel* staff, and head of district health office.

not change between 2003 and 2004, stopping what had been a small decline in their numbers between 2002 and 2003. Specialist numbers also did not change between 2003 and 2004, although they had increased by a third in the year prior to JKJ. The number of dentists increased by the same absolute number after JKJ began, but by a far smaller annual percentage: 50 percent between 2003 and 2004 (after JKJ was introduced), down from a 100 percent increase between 2002 and 2003.

Change in numbers of healthcare workers, 2002-2004

	2002	2003	*% increase 2002-2003*	2004	*% increase 2003-2004*
general practitioners	52	58	*12%*	64	*10%*
specialists	6	8	*33%*	8	*0%*
dentists	4	8	*100%*	12	*50%*
midwives	81	83	*2%*	113	*36%*
paramedics	171	169	*-1%*	169	*0%*

Midwife numbers, on the other hand, soared after the introduction of JKJ—at least according to the District Bureau of Health and Social Welfare. In 2003, there were 83 midwives in the district, a mere 2 percent increase over the previous year, but by 2004 the number had grown to 113—a 36 percent annual increase.[13] Though strict referral regulations no longer permit them to administer primary care services which were a large part of their work prior to JKJ, JKJ reimbursements for antenatal care and child delivery services are high enough to make work in the district quite attractive for midwives.

Specialist numbers did not grow in response to JKJ because JKJ reimbursements are too low to attract them. In addition, the only workplace for specialists in Jembrana is the Negara public hospital (the only provider of secondary and tertiary healthcare services that has signed a JKJ contract), so supply is self-limiting. Paramedic numbers did not respond to JKJ because their services are not reimbursable by JKJ at all; paramedics cannot sign individual JKJ contracts as health care providers. In fact, a decrease in the number of paramedics might have been expected, as prior to JKJ, paramedics (as well as midwives) often used their primary care skills to provide general practitioner services outside office hours, though in theory this was illegal. With the strict referral regulations, this is no longer possible, significantly cutting paramedics' potential income.[14]

DID JKJ INTENSIFY PROVIDER COMPETITION FOR CLIENTS?

Yes. By increasing access to private providers, JKJ has increased the competition between public and private clinics for clients. Now even the poor can access private doctors registered with JKJ because services are free, whereas pre-JKJ a visit to a private doctor cost Rp. 20,000.[15] The increase in the supply of doctors to the poor (all costing the same) *ipso facto* increases competition. Before JKJ, poor clients who wanted the care of doctors had only one choice: the *puskesmas*. JKJ has removed the doctor-staffed *puskesmas'* monopoly on poor patients. This has resulted in a decrease in the number of clients at local clinics, especially where private doctors have nearby practices, as the poor now choose their healthcare providers based largely on convenience. For instance, patient numbers at the Manistutu *pustu* (village clinic) are decreasing rapidly since a private clinic only 100 m away began holding the same hours as the *pustu*. The heads of the Melaya and Kaliakah *puskesmas* concurred that since JKJ began, the *puskemas'* patient numbers have both decreased by a third, to just 20 per day.

[13] The head of the district health office, however, thinks the annual increase is only 7-8 midwives.
[14] Some villagers still go to paramedics in an emergency, or when doctors are unavailable.
[15] About 30 percent of Jembrana's doctors are fully private.

At the district capital, competition between public and private providers for clients is even more intense than in the villages, simply because there are more providers. While to some degree competition has pushed the district hospital to improve service quality, its main response has been to focus on secondary and tertiary care provision and on paying non-JKJ clients, whose fees can be set at a profit-maximizing level. Other public clinic directors suggest they would also like to increase the number of paying clients. So far, the hospital's preference for paying clients has not had a negative impact on access of the poor, since the hospital still has a low bed-occupancy rate. In the future, however, if JKJ extends secondary and tertiary care coverage to non-poor members, and as the hospital continues to recruit paying non-JKJ members, poor JKJ members may be crowded out.

DID JKJ IMPROVE THE QUALITY OF HEALTHCARE AND INCREASE CLIENT SATISFACTION?

Yes. It is likely that the JKJ-applied standards for equipment, treatment, and medication, and sanctions for standard violators, have improved service quality, though there is no supporting data. JKJ standards were adapted by the JKJ Preparation Team from the standards of the Indonesian National Medical Association (IDI, or *Ikatan Dokter Indonesia*). The team ensures adherence to the standards by visiting doctors' offices, reviewing paperwork such as medical stock lists and prescription records, and interviewing clients. Investigations are also initiated based on client complaints, such as complaints about demands for additional fees for non-generic medications. Violators are sanctioned by up to a year's suspension of their JKJ contract, although no provider has yet been permanently banned or brought to court.

Anti-corruption measures. In September 2004, after noticing irregularities in his claims, *Bapel* investigated the home-based private practice of Dr. S. and his wife, who is a midwife, in Brangbang village. About 80 percent of family planning services had been conducted by Dr. S. and just 20 percent by his wife. This was suspicious because usually such services are provided by midwives. A team checked the JKJ card signature of one of Dr. S.'s patients: it was Dr. S.'s, but the patient stated that actually the midwife had checked her. Since doctors get a higher service fee (about Rp. 8,000/patient) than midwives (about Rp. 5,000/patient), their average of 10 patients per day represented a significant financial benefit from cheating. Though the patient later claimed that she had actually been treated by the doctor, the team, believing her first statement, issued Dr. S. a summons. Investigations of 11 other of his patients uncovered the same story. With such strong evidence, *Bapel* canceled the remaining 6 months of Dr. S.'s contract. Though he can continue his private practice, he is unlikely to have many patients, as his care will no longer be free.[16]

In quantitative terms, the quality of healthcare for the poor seems to have improved. Although the overall morbidity rate in Jembrana increased slightly from 29.17 percent in 2003 to 29.49 percent in 2004, the morbidity rate for the poor declined by nearly 6 percentage points in the same period, to 28.53 percent in 2004.

The qualitative data available indicate that both healthcare quality and client satisfaction have improved. Providers list better explanations of medications, improved packaging of generic drugs, "service with a smile,"[17] and shorter queues when asked to define high-quality service provision. In response to the increased competition for clients, *puskesmas* are deliberately trying to improve service quality and client satisfaction by:

- Sending mobile clinics and doctors to remote areas at least monthly (rather than just providing health education in these remote areas, as before JKJ);
- Improving medicine packaging; and
- Provide "full smile" reception for patients, which was never done before.

[16] Ex-*Bapel* investigation team members.
[17] Melaya *Puskesmas* Director and staff.

The focus on quality-as-client-satisfaction is mainly due to the lack of client-borne costs and stringent quality-control standards for treatments, medication and equipment, which reduce the potential for variation among providers.

Clients also feel better packaging of generic medicines is a measure of high-quality services. Before JKJ-induced competition, generic medicines were not "blister-packed" as separate doses, but—despite the medicines themselves being the same—with the nice new packaging, patients feel the medicines are now better. Patients also define quality services as services that cure. According to this definition, health services are rated highly as patients almost always feel they are cured after visiting clinics.

A strict referral system aims to maintain quality standards but has also restricted services previously available from certain providers; increased numbers of providers and longer working hours have maintained an adequate supply of healthcare services. JKJ has likely improved the quality of healthcare by implementing a strict referral system to ensure that providers only provide services in their own areas of professional expertise. For example, *Bapel* rejects dental care claims from general practitioners since dental care should be provided by dentists. Similarly, *Bapel* rejects claims for antenatal care from general practitioners that should have been handled by midwives. However, the referral system may have reduced access of the poor to healthcare by reducing health provider options; most importantly, midwives are prevented from providing primary care and paramedics are ineligible to sign up as JKJ providers; both of these providers were previously the first source of care for many of the rural poor. Since JKJ began, there are many more midwives, but referral standards mean that the services they provide are restricted, shunting potential clients to the care of doctors. Only a small number of midwives continue to provide their traditional range of services. Also, together with the preference of many clients for doctors over midwives, and doctors' financial incentive to maximize the number of clients, doctors' hours are now longer to accommodate the increased number of clients. Yet, according to clients, this has not decreased the quality of services.[19] Moreover, the ratio of population to doctors is still much better in Jembrana (2,840:1) than at the national level (4,000:1). Any negative impact of the referral standards has likely been mitigated by the concomitant increase in the number of doctors and midwives in the district.

Even highly reputable doctors have been investigated by *Bapel*. Between October 2003 and October 2004, a total of 40 rebukes and suspensions were handed down among the 197 healthcare providers.[18] Of them, thirteen providers, or about 7 percent, received contract suspensions of between one and six months.

Slow reimbursements to providers may affect provider performance. At the time of research (early March 2005), JKJ doctors were experiencing a three-month delay in reimbursements of their claims. This directly affects service providers' cash flow, and may have a negative impact on service provision, especially of doctors who are fully private, and thus do not receive the civil servant income. Public clinics were also reallocating resources to cover the cash shortage. However, the shortage may have more to do with annual year-end delays in national-to-provincial budget transfers, than to a flaw in JKJ's administration.

Health education by the wayside? *Puskesmas* are the main provider of health education to the poor, who are their main beneficiaries, yet JKJ provides a strong financial incentive to providers to focus on client care to the detriment of the non-remunerative health education function, which includes public health education campaigns and other preventive measures.

[18] 2004 figures; some providers were rebuked more than once, or both rebuked and suspended, so the total number of providers disciplined was less than 40.
[19] According to one doctor, these factors have also decreased the length of a typical consultation, from 5-6 minutes prior to JKJ to 2-3 now.

At the same time, though the District Health Office claims the budget for health education is actually increasing, at least one *puskesmas* has not received any of this money. Therefore, some of the *puskesmas*' own profits must be set aside for any health education activities they continue to provide. There is thus a double disincentive to clinics: the opportunity cost of spending time providing education is higher, and the received funds for the activity are reduced. Indeed, at least one *puskesmas* director has observed a trend away from providing health education.[20]

IS JKJ SUSTAINABLE?

No. District spending on JKJ is increasing rapidly. Increasing utilization of healthcare services is, of course, increasing the cost of the scheme since there is no cap on the amount of services each citizen may receive. In 2003, Jembrana spent Rp. 3.7 billion on JKJ, representing less than 2 percent of total district spending. By 2004, reported direct JKJ spending on claims reimbursements had increased 2-and-a-half times, to Rp. 9.5 billion.[21] The research team estimates that this accounted for at least 4 percent of the total district budget,[22] much higher than the comparable rate for health spending at the national level (2.9 percent of total spending in 2003).[23] The plan to increase JKJ coverage for non-poor members to include secondary and tertiary healthcare will further increase the scheme's cost to the district despite provisions to include a measure of cost-sharing through charging of premiums.

The JKJ scheme is financed by a pool of funds from different sources, mainly the district's locally-generated revenue, which comprised 80 percent of this pool in 2003 and 2004. The remainder of the funds come from central and provincial government subsidies and *P.T. Askes,* the state-owned insurance company, that had each, in the past, supported a different part of Jembrana's public health system. Given that other JKJ funding sources are unlikely to increase significantly, any increases in JKJ spending will have to be borne by the district. Yet in 2004, Jembrana's own-source revenue declined from Rp. 11.1 billion (2003) to Rp. 9.8 billion (USD 1 million), a drop of 12 percent, while JKJ spending increased dramatically—one reason district officials have become very interested in exploring options for self-funding.

As with any new program, government must either locate new sources of funding or reallocate funding from other expenditures. In the first year of implementation, Rp. 3 billion in new spending on JKJ came from cutting a number of government bureaus as part of a wider restructuring effort, but it is unknown where the much greater 2004 JKJ funding came, or was diverted, from (district budget data for 2004 is not yet available for analysis).

As a result of JKJ's high and rapidly increasing cost, officials are exploring ways of making the scheme self-financing. The replacement of family with individual membership cards was the first step. In addition, a card renewal fee has been initiated—essentially the same as buying a new card each year, as the cost is the same: Rp.10,000 or USD 1.1 for the non-poor, and Rp. 5,000 or 55 US cents for the poor. Even with 100 percent coverage, though, these initiatives would earn only Rp. 2.4 billion (US$250,000)—less than a third of the district's 2004 spending on JKJ.[24] Future plans to provide secondary and tertiary

[20] Director, Melaya public clinic.
[21] No data is available on JKJ spending for administration, management, and other non-claims-related costs, though these would necessarily increase total JKJ spending above Rp. 9.5 billion.
[22] Rp. 982 million in non-district sources was put toward the 2004 JKJ budget. Subtracting this from reported 2004 JKJ expenditures yields about Rp. 8.5 billion; the team assumes Jembrana had to pay this amount itself—roughly 4 percent of the district's total expenditure.
[23] Total Jembrana spending on health, including health education, JKJ, and other expenses, is closer to 5 percent of total district expenditures.
[24] Assuming a population of 253,000 with a 12 percent poverty rate.

coverage for non-poor citizens include payments of a premium to further boost JKJ revenues.

The scheme's very flexibility threatens financial sustainability. The willingness of providers to serve poor non-members for free if they appear on the *gakin* list (or even if they do not), is an informal aspect of the system that is reinforced by *Bapel's* willingness to reimburse those providers. This does help ensure access of the poor to healthcare in the short run. However, it reduces the incentives for the poor to register: only 66 percent of the poor were registered with JKJ in 2004, and as of May 2005, only 22 percent (under the new one-card-per-person system). The short-term benefits to the poor are thus a threat to both financial sustainability of the scheme and long-term benefits to the poor.

Inclusion of non-poor clients in the scheme adds greatly to its cost. Of the Rp. 9.5 billion in 2004 JKJ claims, 95 percent were made by non-poor citizens, most of whom could have paid for their own basic healthcare. Yet JKJ may need to court these citizens as clients who can afford to pay premiums as part of a future expansion of the scheme.

Public healthcare providers are adjusting to the radically new funding situation. With the new JKJ scheme, *puskesmas* and public hospitals no longer have direct subsidies from central, provincial or district governments to cover most operational costs (civil servant salaries are still paid by central government). *Puskesmas* still receive a small amount of funding directly from the central government and the district Health and Social Welfare Bureau for programs such as national immunization campaigns. JKJ fee-for-service reimbursements now cover most costs, as well as being used for staff bonuses: all five *puskesmas* directors in Jembrana now use 25 percent of JKJ reimbursements to motivate staff and improve service quality in this way. The *puskesmas* potentially face lower revenues due to fewer clients as a result of competition with other providers, entering a vicious cycle as declining revenues prevent their taking measures to increase quality that would allow them to attract clients to earn greater revenues.

JKJ payments to healthcare providers. For basic healthcare and antenatal care, general practitioners and midwives are reimbursed up to Rp. 27,000 (US$2.8) for each visit, and midwives are reimbursed up to Rp. 250,000 for child deliveries, including a two-day "hospital stay".[25] JKJ providers are not allowed to ask for co-payments, but as long as approved medications and treatment are used, the cost per visit will not exceed the limit. If it did, the provider would bear the additional cost. In fact, a recent evaluation by JKJ officials found the cost of an average general practitioner's visit is just Rp.17,000.[26]

Inadequate investment in the administrative framework threatens the sustainability of JKJ impact. At present, the verification team consists of only three members with no special training, each responsible for verifying over 500 claims a day,[27] and reimbursing a fortnight's-worth of claims within a week. In addition, staff must carry out claim verifications in the field and register new members—a monumental task given the new one-card-per-person system introduced in early 2005. Apart from their civil servant salary, verification team members also get a fixed honorarium, but they see this as still quite small compared to their work. Funding for adequate staffing is essential for an effective quality control mechanism, which in turn is vital to JKJ's long-run success in improving health outcomes.

Wildly inaccurate JKJ budget projections imply poor financial planning. Though 2003 spending on JKJ was in line with budget projections, actual spending on JKJ in 2004 was nearly double the projected Rp. 5.5 billion. Officially, Jembrana reported total health spending in 2004 of Rp.13.7 billion (US$1.5 million), of which Rp. 7.9 billion (US$830,000)

[25] If a midwife provides the antenatal care, the "hospital stay" is actually a two-day stay in her house.
[26] Evaluation by the district Health and Social Welfare Bureau and the JKJ Management Body.
[27] Assuming 26 working days per month and 8 hours per day. *Bapel* verification staff.

went for non-personnel spending such as JKJ. However, given that Rp. 9.5 billion (USD 1 million) in JKJ claims was reimbursed in 2004, the official figure is clearly too low. With time, better data collection, and greater transparency, budget projections might become more accurate, but with the current inaccurate financial planning, progress toward financial sustainability is certainly less likely to be made.

JKJ's uncertain legal basis is a challenge to its sustainability. At present, JKJ is founded on the rather weak legal basis of a Regent Decree. The Decree gives the district the flexibility to experiment with the scheme for maximum positive impact; however, once the current Regent is gone, an unsympathetic replacement could change, or even remove, JKJ. It can be argued that, given the scheme's popularity, attempts to dismantle the system by a new Regent would face stiff popular resistance. When asked what they would think if another Regent was elected and discontinued JKJ, one women's focus group exclaimed in unison, "No, no—don't take it away!"

The enactment of Law No. 40/2004 on Social Security in September 2004 presented a much more serious challenge to JKJ. This law centralized the authority to provide health insurance to a central-government-appointed state-owned enterprise, *P.T. Askes*. Several districts with their own insurance systems have protested the law, and it is currently being contested in Indonesia's Constitutional Court. Until the official implementing regulation is issued, though, JKJ will be able to continue to function unchanged.

SUCCESS FACTORS

JKJ gave the poor access to private as well as public healthcare providers. The poor had already had access to public doctors pre-JKJ; it is the inclusion of most private doctors and clinics in the JKJ scheme which significantly increased access of the poor to healthcare. In addition, inclusion of private providers in the scheme initiated competition between public and private clinics, leading to increased quality of services for all, as seen by provider attention to client satisfaction.

Strong support and creative vision of the Regent. JKJ created major changes in health services financing, placing a heavy burden on the district budget. Despite the objections of central government, the district used payments from *P.T. Askes*, the central government's official insurance firm, to support the scheme. In addition, the Regent rationalized his administration by converting clinics and reorganizing the district government structure, creating annual savings of Rp. 2-3 billion (US$200-300,000), but laying off 48 people in the Bureau of Health and Social Welfare alone. JKJ also put some civil servants, particularly the staff of public health facilities, under greater pressure with few added benefits. Under a different leader, all these changes might have created trouble in the district parliament, but the Regent, himself a health professional, provided the strong leadership that made the difference by championing the reform, speaking publicly, mustering support in the parliament, being personally involved in decision-making together with personally-recruited top officials, and selecting remaining *puskesmas* directors who believe in his vision and are also capable managers.

Flexibility of design. JKJ has had great initial success in increasing the percent of the population seeking healthcare when ill. Though there are major challenges to continued positive impact, the scheme's flexibility has already allowed some changes in implementation, and could support more. For instance, child delivery services were finally included in JKJ coverage starting in early 2005; in another example, service reimbursement rates were reduced in June 2004 from Rp.10,000 to Rp.8,000 for visits to doctors, and from

Rp.6,000 to Rp.4,000 for midwives,[28] in an effort to move toward financial sustainability.[29] It is JKJ's legal basis on a Regent Decree, rather than a district law (*Peraturan Daerah* or Perda) which requires the agreement of the district parliament, that allows this flexibility.

Strong incentives for providers to serve a large number of patients. JKJ's price cap has eliminated price variations for members, while its rigid primary care standards have practically removed objective variations on quality. Thus, providers mainly seek to increase the quantity of clients. Clients are already eager to be seen by doctors now that treatment at most public and private clinics is free, but providers are still motivated to improve service quality in subjective terms ("service with a smile", better medicine packaging, etc.) to further increase client numbers.

Increased public expenditure on midwives. The favorable conditions created by JKJ for midwives—an adequate level of reimbursement rates, and adjustments to include child delivery and antenatal care—were likely responsible for the increase in their numbers in Jembrana.[30]

Clear and enforced regulatory framework. The JKJ-induced competition on quantity of clients creates the temptation for providers to cheat. Improprieties may include inflating the number of clients, inflating medicine charges, charging clients co-payments, and claiming treatments for which providers are not authorized. JKJ incorporates strict standards for types of medication that may be used, fees that may be charged, types of services that may be provided by each type of provider, and other variables. Without a doubt, *Bapel,* the JKJ management, regulatory and enforcement body, is the institutional key to the success of JKJ*.* Verifications conducted by *Bapel* protect the district from provider improprieties that could lead to inflated costs and loss of quality; enforcement of standards and cost control have already led to improved service quality, and should ultimately lead to financial sustainability and better health for the district population.

LIMITATIONS TO THE POSITIVE IMPACT OF JKJ

Insufficient dissemination of information has contributed to low member numbers. No written material was handed out to potential members or providers about the JKJ scheme. Instead, information was disseminated via meetings and visits to villages by a campaign team. Villagers rely on village leaders for information about the scheme, and there are continuing misconceptions about it, such as the belief that clients may have to pay if services exceed the Rp. 27,000 reimbursement limit per visit. Some poor people are unaware that membership includes free secondary and tertiary healthcare, and so may not take advantage of the benefit.

Ever-stronger barriers to membership have limited JKJ's potential positive impact on the poor. The new registration system costs families much more than the one-card-per-family system, which itself was too expensive for some of the poor. Even families who feel

[28] The Rp. 27,000 reimbursement fee includes Rp. 10,000 for services and up to Rp. 17, 000 for medicine. Medicine reimbursement levels remain unchanged.

[29] It is possible the decrease in reimbursement rates led some providers to focus on paying non-member clients, and to increase their prices for non-members, to the detriment of the poor. On the other hand, the fee cut may, by reducing doctors' financial opportunity cost, have encouraged doctors both to serve JKJ members, and to cut their fees to non-members, the lower JKJ fees serving as an "anchor" for the reduction of fees for paying clients. The team did not gather data to support or deny either of these possibilities.

[30] There are conflicting data on the extent to which midwife numbers actually increased.

they can afford the increased costs may still not be able to register because they lack the required identification, or cannot find the time to attend too-brief registration drives.[31]

Unintentional disincentives to *puskesmas* may have reduced preventive health education activities that particularly benefit the poor. JKJ in effect rewards *puskesmas* that maximize client numbers. As health education does not yield financial rewards, it may be "squeezed out" of *puskesmas'* activities.

Poor financial planning may have pushed JKJ officials to attempt self-financing without adequate attention to the impact on the poor. The JKJ budget projection for 2004 was much lower than actual 2004 spending. In response to the apparent surprise of high and rapidly increasing expenditures, JKJ officials have begun to implement self-financing mechanisms such as the one-card-per-person system that have kept the number of poor members low.

Because JKJ provides nearly the same benefits for both non-poor and poor members, it channels significant public spending toward the non-poor. Though the poverty rate in Jembrana is just 9 percent, if JKJ covered all the poor, the percentage of claims for services to the poor should be well *above* 9 percent,[32] yet in 2004 this figure was just 5 percent.[33] The numbers imply that the JKJ scheme is not the most efficient use of public money if the goal is free healthcare and improved health outcomes for the poor.

MAKING IT REPLICABLE

Public clinics will have to increase revenue in order to improve quality and attract more clients. They already report that their client satisfaction efforts are aimed at changing the perception that they are low-quality providers since they see mainly poor clients. If unable to compete for non-poor clients who can afford to pay, the poor may be left as the only clients at public clinics stigmatized as "low-quality". Clinics would like to be able to provide certain secondary services in order to earn additional revenue from paying clients, but are currently not allowed to do so.

Consider the impact of the scheme on non-members, particularly the poor. Public providers continue to provide free healthcare to poor non-members, in part because of the sense of social obligation, and in part because they continue to be reimbursed by JKJ for these services. Yet because they are not members, these clients are only served at the discretion of providers, who are under no legal obligation to serve them for free; moreover, they have no recourse to *Bapel*'s complaint mechanism. The social ramifications of such a provider-client relationship are likely to be at least partly negative for these poor clients. Free care for non-members may be no favor to them, in the long run. For instance, free care for non-members increases the cost of the scheme, which may be passed on to members, including the poor. In a vicious cycle, higher costs further discourage poor non-members from joining, reducing revenue but increasing costs of the scheme.

Ensure regular data collection and analysis to provide a sound basis for scheme improvements. There is apparently no regular data collection and analysis on such key topics as: how many of the poor are actually registered; how midwife numbers have actually responded to JKJ; the actual impact on the poor of the exclusion of paramedics from the JKJ

[31] Due to the management team's resource limitations, registration was often conducted within a very short time period.
[32] If JKJ does not cover the whole population, but does cover all the poor, then the poor will be disproportionately represented among JKJ members and, assuming even behavior among poor and non-poor members, the percentage of claims made for services to the poor should also be higher than their share of the district population.
[33] The remainder were claims for services to the non-poor or to those insured by *P.T. Askes*.

scheme, and of strict referral requirements; the objective and subjective quality of services; quantitative health statistics; where JKJ funding is coming from; actual JKJ expenditures; and the long-term financial impact of JKJ on *puskesmas*. Clearly, attempts to improve the scheme's performance related to any one of these topics require accurate and well-analyzed qualitative and/or quantitative data.

Anticipate the over-use of services that comes with subsidized healthcare, and design the scheme accordingly. A typical problem inherent in a fee-for-service scheme is that a fully subsidized system encourages clients and providers to become less economical in their use and provision of healthcare. Clients pay more visits to healthcare workers, even when it is not absolutely necessary. Providers become inefficient in their use of resources. A scheme can be designed to anticipate and avoid these problems by, for example, incorporating the use of different payment methods, such as co-payments. In JKJ's case, however, there was little political motivation to anticipate the heavy long-term costs, as the Regent reaps a great deal of short-term political goodwill from his schemes for "free" healthcare and education. The implementing departments, used to following rather than examining and challenging policies decided by the Regent (due to the nature of the Indonesian bureaucracy after decades of centralized management), and staffed by medical professionals rather than health policy specialists, were unprepared and unable to propose alternative designs for the scheme, though there has been an informal internal discussion on JKJ's efficacy.

Invest in management. At present, the tiny *Bapel* staff laboriously verifies thousands of individual provider claims each month, as well as shouldering responsibility for registration and re-registration of many thousands of members. It is unlikely that they have time to improve their management capacity. The work overload has certainly contributed to: a lag in claim reimbursements, which may have an impact on service quality; a backlog of providers who must be investigated (and know that the team is overworked); and still-low member numbers, at least among the poor. The potential gains from increasing staff numbers and investing in capacity building for them are high.

A health insurance scheme that is not deliberately pro-poor must address the risk of becoming anti-poor. Non-targeted health insurance schemes such as JKJ, which attempt to include all citizens, both poor and non-poor, risk disproportionate diversion of public funds to the non-poor. In 2004, 95 percent of JKJ reimbursements were for services to the non-poor; only 22 percent of the poor are JKJ members under the new one-card-per-person system. Membership constraints faced by the poor, increased fees for non-members (among whose numbers the poor are disproportionately represented), and skyrocketing costs that are indirectly passed on to members and non-members alike, have all been some of the unplanned-for effects of JKJ's inclusiveness, for which the poor have borne the brunt.