

An Error in Policy Level, Effect on Doctor and Patient?—Indonesia experience in 2005–2009

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At the end of 2008, a front-page story in Indonesia's most widely circulated newspaper reported that some communicable disease control programs in Indonesia had failed to rein in key scourges, namely leprosy, filariasis and malaria.¹ After that news, some critics confronted the Health Ministry. The critics' concerns were not only about communicable disease control programs but expanded to encompass all the health programs in Indonesia. One of them found that the recent health program in Indonesia has been run without clear direction.² Another suggested the orientation of these health programs was more curative than preventive.³

Objectively, the World Bank found that the current Indonesia health system is the root of the health program failure. In the report on investing in Indonesia's Health, Health Expenditure Review, 2008, the World Bank wrote "...the performance of the current health system is inadequate for achieving today's and future health outcomes ... and even though... Indonesia has made major improvements over the three decades in its health system, but is struggling to achieve important health outcomes, especially among the poor..."⁴ The unclear orientation of the health service system to benefit poor people—which is heavy on cure, light on prevention—consumes a good portion of the very limited health budget. Consequently, the Health Ministry has been late in paying hospital bills for poor people in the 2005 to 2008 period.⁵

Pro Poor Health Insurance Program in Indonesia

In 2004, the health minister launched a pro poor

health insurance program with the acronym Askeskin, or PPHIP in English. There had been no formal health insurance plan (akin to a UK sickness fund or the US medicare scheme) for poor people in Indonesia to date. The newly elected Indonesia President made PPHIP a priority from the outset of his term. PPHIP has an unquestionable noble goal. Unfortunately, the president's will was not correctly implemented. The health minister was in a hurry to roll out the program, glossing over the need for regulations and guidelines.

Based on good will alone, the health minister has consistently said anyone who is low-income can receive free treatment in those public or private hospitals which collaborate with PPHIP. The government's health insurance company (PT. Askes) was contracted by the government to channel this sickness budget. The problem is, the health minister's regulation allowed for an "open system." Eligible patients only had to self-identify as low-income to qualify for the coverage, leaving an open portal for abuse of the benefit.

During the first year program, PPHIP appeared successful. Askes reimbursed all claims from hospitals both public and private. The program ended its first year with a budget surplus. A widespread public awareness campaign made many more people aware of the program in 2006, but the size of the PPHIP budget remained the same. The health minister based his budget estimates on the previous year's performance. The gap came to light as soon as many more now-informed poor started using the health insurance scheme.⁵ The utilization of the health service by poor people significantly increased.

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Reimbursement Problem: Threat for the adequacy of medical service

Due to PPHIP's emphasis on distributing the fund upon request, and the weak guidelines governing medical procedure, the number of patients who were covered by the program significantly increased in 2006. Hospitals and their doctors worked according to government guidelines in which the principles of cost and treatment quality control were poorly articulated. The government budget could not pay more than half the reimbursement request coming in from hospitals and doctors. The situation was chaotic.

Askes, unsure of its role in this distribution-focused scheme, served no intermediary purpose except to pay the hospitals and doctors. Since the money came from the Health Ministry, as soon as the ministry had no more funds to dole out, Askes could not pay the hospital service and doctors' medical fee for service already rendered. Askes and the health minister started to blame each other.⁵

The PPHIP failure then affected the hospital cash flow.⁶ The ministry debt to hospitals from 2006 was carried over to the 2007 budget. All hospitals had to wait between five and seven months for reimbursement from the government. Hospital bills continued to mount. By September 2007, Askes only had Rp. 123 billion (US\$11 million) left whereas PPHIP's debt to hospitals already tallied around Rp. 1.56 trillion (US\$140 million).

At that point the ministry decided to allocate additional funds to the tune of Rp. 1.7 trillion (US\$152 million) to cover the debts. However, the additional funding could only pay hospital expenses incurred through mid-2007. After mid-2007, a new reimbursement lag began which continued until the end of 2008. Despite these regulatory and fiscal problems, patients would continue to show up every day without knowing or caring about systemic woes. For doctors, mismanagement and squabbling between Askes and the Health Ministry is not their concern. Doctors are in the business of helping patients. Of course, doctors must not forget that all problems at the policy level will affect the patients on a daily basis.⁷

The hospital credit problems can affect its operation, and hospitals with meager cash flow might end up compromising patients' care. If this happens, it would be an expensive lesson learned

in terms of the health system improvement, especially in managing the health insurance system.

Lesson Learned from the 24th CMAAO Congress in Seoul

Unlike national health insurance systems in some CMAAO (Confederation of Medical Associations in Asia and Oceania) countries like Japan, Korea, and Taiwan with a long history of universal coverage of the National Social Health Insurance, Indonesia is still managing the system today.⁸⁻¹⁰ Looking again at CMAAO documentation and the papers of Indonesian delegates at the 24th CMAAO Congress, the situation of national social health insurance has just been started in the new law, a law on the National Social Security System.¹¹

A law on the National Social Security System in Indonesia, Law No. 40/2004, was actually enacted in October 2004. It is a law that will reform the existing Social Security System (SSS) in Indonesia. For health insurance, the SSS was started in 1968, under the Presidential Decree No. 230/1968 to provide healthcare benefit to government employees and retirees, based on the social insurance principle, but 2% of the contribution was paid by the employees. The benefit is a comprehensive healthcare, including renal dialysis, open heart surgery and serious illnesses. PT. Askes Indonesia is responsible for implementing the program.

In the private sector, SSS was introduced in 1976, providing "working accident" and old age benefit to the workers of formal groups, based on social insurance principles, defined contribution, paid by employee and employer, based on a percentage of the salary. In 1992, healthcare benefit was added to the private sector, based on social insurance principles, but the contribution was paid by the employer. There has been a limitation to the benefit, including length of stay in the hospital and also for expensive care, for example renal dialysis, open heart surgery and serious illnesses. PT Jamsostek is responsible for the program.

According to the Law No. 40/2004, the objective of healthcare benefit in Indonesia will be provided based on social insurance mechanisms and equity. Participants will pay a contribution on a percentage of the salary/wage and will get the benefit of comprehensive health services

regardless of the amount of contribution. The carrier (PT Askes and Jamsostek) will provide the benefit based on the “*managed healthcare concept*.” In fact, it is a social health insurance program (SHI), implemented by the Social Security Carrier or Badan Penyelenggara Jaminan Sosial (BPJS).

The carrier of SSP (BPJS) will provide healthcare benefit through an appointed network of healthcare providers, introducing the family-physician concept, referral concept and prospective payment system (PPS). According to the Law No.40/2004, the BPJS is responsible for introducing an efficient delivery and financing of healthcare.

The Government will regulate the amount of contribution, paid by the employee and employer and the government for the recipient of contribution assistance (the poor and unable to pay contribution), standard of benefit, services, quality and also standard and ceiling price of drugs and medical equipment. Referring to our Constitution (UUD 1945), there is a criteria for those who are considered as poor and unable to pay contribution to become recipients of contribution assistance.

According to the law, the coverage of the SHI program will be based on a stage by stage approach. We will begin with the formal group, recipients of contribution assistance and finally the informal group. There will also be regulation, on the development of the program, based on the feasibility of the program, considering the availability of providers, capability of the carrier (MS) and economic condition at large. “*A macro scenario*” will be very important to formulate the “*road-map*” to cover the entire population.

The employer is responsible for collecting

contribution from the employees and registering their employees with the carrier/BPJS. The Government will register the recipient of contribution assistance with the carrier/BPIS and the BPJS will provide a single Identification Card, with a social security number to the participant. Participants have the right to the standard benefit, and have to pay additional cost for additional services, above the standard. They also have to share the cost (cost-sharing) for certain services, to avoid unnecessary utilization. This regulation was not well implemented at PPHIP from 2005 to 2008, and will remain problematic until 2009 and early 2010.

Conclusion

The noble goal of providing health insurance for poor people has to be translated into good regulation and good guidelines, especially for health service providers, including doctors. Indonesia in fact already has a law to regulate universal health insurance for all Indonesians, Law No. 40/2004. Despite existing statutes, the hasty and poor implementation of PPHIP, which was not based on accepted standards, has become a lesson for all doctors.

Errors at the policy level have adversely affected medical practice in the field. Hospitals' enormous outstanding invoices have been driving operational disturbances in managing both hospitals and doctors. Consequently, the adequacy of service to patients by the hospital and the doctor could be affected. If the situation happens, whatever the condition is, the doctor community has to prevent it through continuing advocacy to the government to fix policy errors. In Indonesia, the Indonesian Medical Association has been doing that.

References

1. Tropical diseases not handled well. Kompas Newspaper. 2008 Aug 11;p.1 (col. 1–4).
2. Muhammad K. Health development without direction. Kompas Newspaper. 2008 Aug 12;p.6 (col. 2–5).
3. Not focus handling, un solving health problem. Kompas Newspaper. 2008 Aug 11;p.13 (col. 4–7).
4. The World Bank Office Jakarta. Investing in Indonesia's Health, Health Expenditure Review; 2008.
5. Health insurance, be sensitive with health minister advertorial. Tempo Weekly Magazine. 2008 Sep 15;86–88.
6. Indonesia Medical Association Press Release. Monthly public discussion. 2007 Sep 20.
7. Bodenheimer TS, Grumbach K. Understanding Health Policy, A Clinical Approach. 4th ed. Singapore: McGraw Hill; 2005.
8. Aoki S. Present situation of health insurance in Japan. Pointers in Symposium Present Status of National Health Insurance in Asia and Oceania Region, 24th CMAAO Congress; 2005 Sep 11; Seoul.
9. Shin CR. Korean health insurance system. Pointers in Symposium Present Status of National Health Insurance in Asia and Oceania Region, 24th CMAAO Congress; 2005 Sep 11; Seoul.
10. Huang YC. Present status of Taiwan's health insurance. Pointers in Symposium Present Status of National Health Insurance in Asia and Oceania Region, 24th CMAAO Congress; 2005 Sep 11; Seoul.
11. Idris F, Soelastomo. National health insurance reform (as a part of social security system reform) in Indonesia. Paper in Symposium Present Status of National Health Insurance in Asia and Oceania Region, 24th CMAAO Congress; 2005 Sep 11; Seoul.