Different impact after different management: the case of health insurance for the poor in Indonesia.

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Introduction

Although various schemes of health insurance existed in Indonesia, only small fraction of the population is insured, limited mostly to those in the formal sector employees and civil servants. In order to increase health insurance coverage, the government of Indonesia launched health insurance for the poor program in 2005. And the government started to pay health insurance premium on behalf of the poor to health insurance company. It was called ASKESKIN Program. This program was expected to increase the demand for health care and protect the population from catastrophic payment due to sickness. To manage the program, the government appointed the largest health insurance company, called PT Askes a government owned company. However in 2008, due to political and technical reasons, the Ministry of Health (MoH) took over this program and managed it directly under one of its sub department (The Centre of Health Financing and Health Insurance). The program was renamed JAMKESMAS.

Objective of the Study

This study aimed at evaluating the performance of ASKESKIN and JAMKESMAS against its objectives, namely on access and financial protection.

Methodology and Analysis

We used negative binomial regression and ordinary least square applied to a national socio economic survey data (SUSENAS) in 2007 (reflects the time it was managed by PT Askes) and 2009 (reflects the time it was managed by MoH). The model specification was passed by Ramsey test and robust standard error was used to correct unknown heteroskedasticity. Access

was measured by the number of visit made to health care services, while the financial protection was measured by per capita health expenditure, a month prior to the survey.

Results

1. **Access to Health Care**

Health Facilites	**OLS Estimate**		**NB-Estimate**	
	Sus-2007	Sus-2009	Sus 2007	Sus 2009
Health Centre	0.243 (0.008)***	0.210 (0.007)***	0.303 (0.010)***	0.293 (0.010)***
Public Hospital	0.068 (0.005)***	0.033 (0.004)***	0.601 (0.034)***	0.316 (0.040)***
Private doctors	-0.108 (0.005)***	-0.101 (0.004)***	-0.410 (0.019)***	-0.369 (0.016)***
Private Hospital	-0.005 (0.002)**	-0.005 (0.002)***	-0.199 (0.058)***	-0.185 (0.053)***
N	156995	164665	156995	164665

Robust standard errors in parentheses; * significant at 10%; ** significant at 5%; *** significant at 1%

Estimation Coefficient β Askeskin (Sus 2007) > Jamkesmas (Sus 2009)

2. **Out of pocket spending**

	Sus 2007	Sus 2009
Askeskin/Jamkesmas	-0.007**	0.013***
	(0.003)	(0.003)
Civil servant insurance	-0.128***	-0.017***
	(0.005)	(0.005)
Jamsostek health insurance	-0.009	0.076***
	(0.009)	(0.006)
Commercial insurance	-0.003	-0.016
	(0.014)	(0.010)
if sick	0.369***	0.382***
	(0.003)	(0.003)
If male	-0.006***	-0.004*
	(0.002)	(0.002)
Constant	-4.525***	-4.586***
	(0.036)	(0.039)

Observations	1086632	1089905
R-squared	0.21	0.21

Robust standard errors in parentheses; * significant at 10%; ** significant at 5%; *** significant at 1%

Results showed that both programs have positive impact on access. This finding holds true in both data set. However, estimation coefficient of the program derived from 2007 (ASKESKIN) data set was higher than 2009 (JAMKESMAS) data set. Interestingly, financial protection was only observed in 2007 data set. Estimation coefficient of ASKESKIN was negative, while in JAMSKESMAS was positive (p value < 1%). This finding indicates that when insurance company managed the program, the impact of access and financial protection is higher, ceteris paribus.

Discussion

The purpose of health insurance for the poor in Indonesia is to help reduce the incidence of catastrophic out of pocket (OOP) expenditure. Payments of more than 40% of a household's disposable income (income minus expenditure on essential needs) are catastrophic (Xu *et al.* 2003; Xu 2005). Also, given that consumption baskets of the poor typically have higher food shares (Wagstaff and Van Doorslaer, 2003), the relative burden of OOP payments on household budgets may be better reflected by the share of nonfood spending. Axelson et al (2009) and Wagstaff (2010) find the impact of Vietnam's healthcare fund for the poor on reducing OOP health spending. A recent study reports that National Health Insurance Schemes in Ghana (Nkoranza and Offinso) has helped reducing the incidence of catastrophic OOP expenditure among its members (Nguyen et al. 2011).

. Nevertheless, it is regretable that during the implementation of health insurance for the poor program in Indonesia, there are still OOP expenditure, even increasing since 2008. From this study, we cannot conclude the reason behind this. However, we found that there are differences in managerial capacities of PT Askes and The Center of Health Financing and Health Insurance in the Ministry of Health. As state earlier, in 2008, *Askeskin* was renamed to *Jamkesmas*, and was managed by the MoH. Under *Jamkesmas*, the coverage was expanded to the near-poor covering of 74 million poor individual. The budget was also increased to IDR 5 trillion. (MOH, 2009)

PT Askes is a state owned company that was originally an institution under the Ministry of Health. It was established since 1968. The company covers health insurance for civil servants, pensioners and their immediate family. As of 31 December 2009, number of employees of PT Askes reached 2,616 persons, distributed in 12 regions across indonesia. PT Askes has increased its assets value from US$ 313,191,090 in 2005 around US$ 1 billion in 2009. (PT Askes, 2011)

In comparison, The Center of Health Financing and Health Insurance, Ministry of Health has just started to manage health insurance for the poor since 2008. The main role of the center was not only managing Health Insurance for the Poor but also to establish policies in health financing. Although the center has less than 40 employees and there are no branches outside the capital of Jakarta, the center recruited independent verification officers across Indonesia to manage health insurance for the poor. The center, being part of Ministry of Health, have access to coordinate with local health offices all around the country. (MoH, 2009)

There are also slight differences in benefit package before and after 2008. Before 2008, there were strict rules concerning the drug that can be prescribed. At that time only generic drug allowed. But following complaints from health providers and patients, the rules were loosened. When the Center for Health Financing and Health Insurance took over the program in 2008, non generic drugs were allowed. As long as the medical committee in the hospital declared that these non generic medicines are necessary to treat the patients, doctors could prescribe them. No scientific report found the connection between higher out of pocket spending after 2008 and non generic drug usage. However, reports from provinces and districts shows that doctors prescribed non generic medicines to poor patients. And because the hospital pharmacy did not have the stock, patients went to private pharmacies to purchase the drugs (MoH, 2009).

Conclusion

Out of pocket spending and access to health care facilities have changed after the Government of Indonesia changed the policy in managing the program of Health Insurance for the Poor in 2008. Before 2008, OOP spending was less and access to health care facilities was higher than after 2008. This study did not intend to find the causal factors of these results. However, managerial factors and the influence of politics in making public health decision need to be elaborated and further studied.

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