**Reducing Fuel Subsidies to Finance the Chronic Deficits of the UHC in Indonesia**

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## The Road to UHC

The Universal Health Coverage (UHC) is now the World Commitment as it is listed as the Goal 3.8 under the Sustained Development Goals of 2030. Although the UHC covers comprehensive risks of health care, covering all aspects leading to good health of the people, covering medical care, become the most important element. High health care costs threats people to be impoverished and non productive. In this paper, I focus the discussion on the covering health care costs of the National Health Insurance of Indonesia, called the JKN.

Indonesia started to implement social health insurance (SHI) scheme in 1968 when all civil servants and their family members were covered by a government agency called BPDPK and then known as Askes. Twenty-five years later, another SHI scheme was implemented under social security system for private employees, called JPK Jamsostek. The two schemes were contradict each other. The Askes scheme was fully contributed by government employees only while the Jamsostek scheme was fully contributed by employers. In addition, the Askes scheme provided no opt out while the Jamsostek scheme provide opt out option for employers who could provide better health services. The opt out option resulted in poor coverage. Until early year of 2000, the Jamsostek scheme covered only about 5% of private employees. Since the formal sector absorbed only about 30% of labor forces, the Ministry of Health also launch commercial insurance models of Health Maintenance Organization (HMO) of the US starting 1993. When Indonesia suffering from severe financial crisis in 1998, the social safety net program was introduced using social assistance (SA) scheme. The SA schemes, provided by National and Regional Governments, undertook evolution until 2017.

The fragmented and variations of benefits of all different coverage was viewed as injustice. At the same time, after the severe crises Indonesia underwent massive government and economic reforms. The Constitution was amended in 2002 (article 34.2) to mandate the country to develop social security for all. To follow up the amendment, the Law of the National Social Security System (NS3) was passed in 2004. The law stipulates health coverage for all and four other social security programs (occupation injuries, provident fund, pension scheme, and life insurance) for all labors. However, the new Cabinet as the result of 2004 election hesitated to implement the NS3 law, fearing economic hardship. Labors movements by massive protests—coordinated by KAJS (people movements for social security for all) every May Day for three consecutive years pushed the government to agree to implement the law. To implement the law, another law—regulating how the NS3 will be operated, passed in 2011. This law, called the Law of BPJS (Social Security Corporations) provides a new landmark of the reform. There are two BPJS established by the law of BPJS, one to administer the National Health Insurance (Called JKN) and the other to administer four other social security programs. The BPJS is a quasi-government organization, a public entity operated by non-civil servants.[[1]](#footnote-1) This model is was introduced by the World Bank in 1993 as “Public Ends Private Means”[[2]](#footnote-2), or it could be called as the scheme of “publicly funded, privately delivered”. This design solves the market failure to reach equity and allows public failure in delivering quality of care”. By this design, the comprehensive single benefits of JKN (defined as medically necessary)—the same benefits for all citizens, could be accrued in public and private health care providers.

After almost a decade debates and controversies, finally in January 2014, the JKN was implemented. This JKN integrated all previously fragmented systems of SHI and SA program into the single payer of JKN. The JKN anticipates the growing NCDs and prevent people from impoverishments due to high costs of medical care. By December 2018, the JKN covers more than 208 million people, about 78% of the total 266 million people of Indonesia. The single payer JKN is now the biggest UHC under a single database in term of population coverage. The JKN is also an instrument to stimulate higher health expenditures.

 Historically, Indonesia has spent too little for health care. The total health expenditure (THE) of Indonesia has been the lowest among low-middle income countries (see Figure below), both in term of per capita THE or the proportion of GDP which has been below 3.5% of GDP for the last four decades.[[3]](#footnote-3) A study by the World Bank recommends Indonesia to spend more, spend right, and spend better.[[4]](#footnote-4) Has Indonesia spend more and better now?

Figure . Position of Indonesia in the Total Health Expenditure per Capita among Some Countries 2000-2015.



## Funding for the JKN

As mentioned before, Indonesia has been very miser in investing on health for the people. The World Bank data indicated that in 1995, the government of Indonesia spent only 0.7% of GDP for health and in 2015; the share was only 1.3%. While the government spending on health of China, Malaysia, Thailand and Vietnam in 1995 were consecutively 1.8%, 1.7%, 1.7% and 1.8%. In 2015, the governments of those Indonesian neighbors spent consecutively 3.2%, 2.1%, 2.9%, and 2.4%. Those government spending were include SHI contributions. The JKN of Indonesia require mandatory contribution of 5% salary share 1% from private employees and 2% from public employees. The employers match the remaining 4% and 3%. However, under the heavy influence of employers’ association, the Government set very low ceiling of salary at IDR 8 million (about US$ 600) per month. As the result, the initial aim of cross subsidy from high income to low income did not happen. The contributions become regressive. The non-wage individual may chose three options, which related to classes of hospital rooms if the people need inpatient care. The three options are aimed to represent different income groups. The nominal contributions are IDR 25,500 (about US$ 1.8) for third class, IDR 51,000 (US$ 3.6) for the second class, and IDR IDR 80,000 (US$ 5.5) for the first class. The poor and the low income are fully subsidized for third class room entitlements at the contribution of IDR 23,000 per person per month, set by the Government. Currently 96.4 million poorest Indonesia are in this category.[[5]](#footnote-5)

## Implementation.

Because of inadequate contributions, the JKN suffered from deficits in five years (2014-2018) in a row amounting of IDR 3.3 Trillion, IDR 5.7 Trillion, IDR 9.7 Trillion, IDR 9.0 Trillion, and IDR 16.5 Trillion.[[6]](#footnote-6)

 The deficits invite public debates on sustainability and options to finance the JKN. Most people and politicians agree that the JKN has been very good and beneficial to overcome impoverishments. Claim data indicated increasing rates of utilization for inpatients and outpatients. In 2018, the government was trying to take the cigarette tax money to fill the deficits. However, the policy becomes controversial until now. As prescribed by the Law of NS3, the Government must fill the deficits of the BPJS whatever the amount. The question then, is there a fiscal space for Indonesia to bear the burden of health care costs.

The author always argues that Indonesia has the capacity and can afford to finance UHC. If Thailand can finance the Universal HealthCare Scheme since 2002, Indonesia can do. Indonesian economy, measured as GDP per capita now is much higher than the Thailand GDP per capita in 2002. The main problem has been the mindsets of the officials who treat health care as the privilege, not as the right of the people. Although the Indonesian Constitution (article 28H.1) clearly stated the right to health care for everyone, most Indonesian officials and budget makers do not care. Instead, the care more to subsidize energy (diesel, petrol, electricity, and cooking gas). This populism policy by heavily subsidizing energy has been implemented long before the crisis. After financial crisis, the fuel subsidies became the major expenses by the government. The current government actually has better vision on not subsidizing fuels too much, instead the government use the money to construct infrastructures. However, the money goes mostly to physical infrastructures such as roads and ports. The human infrastructures, especially the health sector remains marginally considered. The table below shows how small the Government budget for health and for UHC.

Table . Government Spending on Fuel Subsidies, Health, Claim of JKN, and Excise Income 2014-2018, IDR Trillions

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Items  | 2014  | 2015  | 2016  | 2017 | 2018 |
| Energy Subsidies | 341.8  | 119.1  | 106.8  | 97.6 | 163.5 |
|  *Fuel subsidies* | *240.0*  | *60.8*  | *43.7*  | *47.0*  | *103.5* |
|  *Electric subsidies* | *101.8*  | *58.3*  | *63.1*  | *50.6*  | *60.0* |
| Health Budget | 49.4 | 51.4  | 59.6 | 57.2  | 64.3  |
| JKN Claim costs (medical) | 42.7  | 57 .2 | 67 .2 | 84.4 | 87\* |
| JKN subsidies for the low income | 20.0 | 20.0 | 25.0 | 25.0 | 25.5 |
| Cigarette Excise Income[[7]](#footnote-7) | 118 | 144 | 143 | 153 | 155 |

\*) estimate

## Value for Money and Strategic Purchasing

Since the implementation of JKN, the BPJS spent roughly about US$ 25-30 per capita per month for a comprehensive benefits, including open hear surgery, cancer therapy, hemodialysis, and renal transplant. How can the spending were very low? The answer is the since the beginning the JKN is design to contain costs or to apply strategic purchasing. The single payer scheme has the advantage of monopsony power. The JKN pay all primary care providers with capitation that include medical fee, lab tests, drugs, and all other necessary care at the primary level. The Medical Council and the Ministry of Health define the scope of PCP with 155 medical conditions. Only when the care beyond those 155, the PCP can refer to specialist in hospital or secondary clinics. All secondary care is paid using DRG type of payment called Case mix Based Groups (CBGs) for out patient and inpatient care. In total, there are about 1,200 CBGs codes. Only few drugs for NCDs are reimbursed separately. To control drug prices, the JKN utilize e-catalog in which pharma companies bid for volume and prices of non-patent drugs at the provincial prices. Only the winner of lowest prices could supplies the medicines.

The prospective payments applied nation wide to about 20,000 PCPs and 2,600 public and private hospitals have pushed the management of health care providers very efficient. The medical association and specialty associations are pushed to define clinical pathways in order to comply with the prices and provide guidance to the doctors to choose the most cost-effective medicines and medical procedures. In can be understood that most medical professionals are unhappy with this. Yet, there are growing concerns that health care providers sacrifice quality of care to fix the CBG prices. Evidences on the quality issues are mix. Longer observations are needed to proof the JKN has impact on quality outcome of health of the people and the system sustain with satisfactions of health professionals at an acceptable level.

## Conclusion and Recommendations

Despite the scattered population in more than 5,000 islands, Indonesia is boldly reforming its health care system to achieve UHC by 2019 with massive reforms on integration of services, applying strategic purchasing using massive prospective payments, and utilizing electronic transaction. Current evaluation shows the system is working to reduce impoverishment, increase equity, and stimulate modestly the private sector. The reform on increasing funding is recommended to fix the chronic deficits of the JKN.

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3. Thabrany H. Presentation at the Conference on Indonesia Inequality. University of Melbourne, November 1-3, 2018 [↑](#footnote-ref-3)
4. World Bank. Indonesia: Health Financing System Assessment. WB, October 2016 [↑](#footnote-ref-4)
5. Agustina, et.al. Lancet 2018. Op cit. [↑](#footnote-ref-5)
6. Minister of Health. Presentation of Indonesian Health Care: Progresses and Challenges. School of Medicines, Universitas Indonesia. December 20, 2018 [↑](#footnote-ref-6)
7. Ministry of Finance. Information on the National Budget, Jakarta 2018. [↑](#footnote-ref-7)