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Field Report

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Making Services Work for the Poor in Indonesia:

A Report on Health Financing Mechanisms in Kabupaten East Sumba, East Nusa Tenggara

A Case Study

September 2005

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Report Prepared for the World Bank Indonesia Office

SMERU Research Institute, September 2005

Making services work for the poor in Indonesia: A Report on health financing mechanisms in Kabupaten East Sumba, East Nusa Tenggara. A Case study/ by Alex Arifianto et al. –
Jakarta: SMERU Research Institute, 2005. vi, 17 p. ; 31 cm.—(SMERU Field Report September 2005). —

ISBN 979-3872-15-2

1. Social Security Systems I. Arifianto, Alex

368.4/DDC 21

SMERU Research Institute, September 2005

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ABSTRACT

Kabupaten Sumba Timur is one of 29 kabupaten/kota that were included in the test piloting of the JPK-Gakin program. Since 2003, the local health agency (Bapel) has been quite successful in managing this program. The program that is funded by the government from fuel subsidy allocations has already touched the poor whose numbers are quite significant (75% of the population are poor families) in Sumba Timur.

Since 2005, the government has appointed PT Askes as the only implementing body for the JPK-Gakin program, while Bapel still operates this program. The involvement of two managers as JPK-Gakin implementers made the government issue a policy on the division of the puskesmas service area.. This transition period provided an opportunity for the local government to undertake an evaluation of the implementation of the program. There are several differences in the type and extent of health services offered by the two of them.

The outcome of the findings shows that puskesmas and hospitals have responsibility for the patient costs of all poor families. However, the number of referrals of the poor to hospitals is small although Bapel provides transport allowances for patients who are referred to the hospital. There are quite a lot of limitations that are faced by the poor who live in a wide area across Sumba Timur. These limitations are the community's very poor socio-economic conditions, endemic malaria, minimal numbers of health workers in rural areas and the long distances of peoples' homes from health services.

The manager of JPK-Gakin needs to give proper attention to the handling of health in Sumba Timur, the majority of whose people are poor.

Key words: JPK-Gakin; Sumba Timur; health; poverty program.

EXECUTIVE SUMMARY

Around 75% of the population in East Sumba is classified as poor. The population of Kabupaten Sumba Timur is 198,940. As many as 129,074 people or 31,214 households were classified as poor in 2003 and this figure rose to 159,037 people or 34,626 households in 2004. In general, the community has low economic, education and health levels. Geographically, people's houses are quite distant from health facilities making it a challenging task for health workers to provide services to local communities.

A large number of health workers, both medical workers and paramedics, are still required considering the poor quality of health in the community and the distance between people's homes and health facilities. Of the 17 community healthcare centers (*puskesmas*) in Kabupaten Sumba Timur, five do not have a doctor. Only one *puskesmas* (the one in the city) has a dentist. There are also a limited number of paramedics. Many secondary healthcare centers (*pustu*) do not have a midwife. For example, Puskesmas Nggongi in Kecamatan Karera, which is 150 km from the *kabupaten* capital, has only one doctor, three midwives, five nurses and four health workers/administrative staff. They serve 10,863 residents spread across ten villages. Three of these villages are located on separate islands, the others are between 3 and 42 km away and public transport is limited. This *puskesmas* however, also provides in-patient treatment. It has a total of ten beds, all of which are usually taken.

Malaria is endemic in East Sumba at most times. It is the second most common disease after acute respiratory tract infection. *Puskesmas* and hospitals admit adults and children with malaria almost every day. While communities in East Sumba try to treat initial symptoms using traditional medicine (i.e. a concoction of herbs), if symptoms persist, they usually seek medical assistance at *polindes* (village maternity clinics) or *puskesmas* with a simple laboratory. The number of patients during the wet season is usually higher than that during the dry season, particularly patients with malaria. This is caused by the humid climate and the amount of animal faeces. The poor live in houses with grass-thatched roofs that usually leak during the wet season and thus are more humid.

Health cards for the poor are fairly well distributed and are used to obtain medical treatment at *puskesmas* (including *pustu* and *polindes*). Health cards were used by 16% of patients at *puskesmas* in 2004, whereas only 0.12% of patients at hospitals used them. While the Executive Body (*Bapel*) provides transport allowances of up to Rp25,000 for short distances and Rp300,000 for long distances for patients referred to hospitals, communities still have doubts about following up treatment at hospitals. This is due to extremely poor households not being able to pay for the transport and food costs of the family member who accompanies the sick individual to hospital. Poverty and the distance between a house and the hospital are obstacles for communities referring families to hospitals.

Health insurance for the poor has been available since 2003. Initially, it was managed by *Bapel* which was established by the East Sumba regional government. At present (2005), the program providing health insurance for the poor (JPK-Gakin) is not only managed by *Bapel*, but also PT Askes. According to the Health Minister's Decree No. 1241/MENKES/SK/XI/2004, PT Askes was to be entrusted with managing the JPK-Gakin

insurance program across Indonesia as of 1 January 2005, however the role of *Bapel*, which has managed the funds so far, has not been eliminated.

Funds from the Regional Budget (APBD) that have to date been used in addition to the funds previously used for the fuel subsidy (PKPS BBM[1]), are still being managed by *Bapel* which covers around 12 *puskesmas*. On the other hand, PT Askes manages the (national) PKPS BBM funds that cover the health needs of up to 81,200 poor people living in five *puskemas* areas.

The determination of a *puskesmas* service area was based upon distance (i.e. the distance from a hospital). The regional government decided that PT Askes would manage patients referred from *puskesmas* to hospitals that were quite close, whereas the remainder would be managed by *Bapel*. PT Askes' policy, that does not cover transport costs for patients referred by *puskesmas* to hospitals, resulted in the five *puskesmas* relatively close to the city being chosen. Because *Bapel* covers transport costs for referral patients, the 12 *puskesmas* that are relatively further away are still managed by them.

There are several differences in the health benefits offered by *Bapel* and PT Askes. Firstly, PT Askes' standard reimbursement for maternity services provided by midwives in villages is much higher than that of *Bapel*. Secondly, hospitals regard PT Askes' standard price of medication to be too low and, thirdly, *Bapel* covers transport costs for patients referred to hospitals, whereas PT Askes does not. There is concern that these differences will give rise to envy between health providers and make their work more difficult. Hospitals are being forced to organize two administrative systems and employ two staff members, whereas previously only one person handled these matters.

The involvement of two insurers in this insurance program is a part of the transition period, and over the first year the regional government will evaluate the effectiveness of the two insurers. After that, the regional government will select the insurer preferred by the public and health providers (*puskesmas* and hospitals). Another possibility is that the regional government will continue to use both *Bapel* and PT Askes simultaneously, although the system will be adapted to ensure uniformity. The evaluation will be based upon the experiences of a number of parties, such as hospitals, *puskesmas*, the Health Office and the community.

Meanwhile, PT Askes hopes that the regional government and its supporting bodies will cooperate because it is unable to work without the supporting data and information from the relevant government offices. To date, the regional government, including the Health Office, has supported the health insurance program for the poor, regardless of who manages it, so that residents of East Sumba – specifically the poor – can obtain adequate health services that meet their needs.

[1] PKPS BBM: *Program Kompensasi Pengurangan Subsidi Bahan Bakar Minyak* (Compensation Program for Reduced Subsidies on Refined Fuel Oil).

I. INTRODUCTION

GENERAL DESCRIPTION OF THE REGION

Kabupaten Sumba Timur is one of 29 *kabupaten/kota* included in the trial of a health insurance program for the poor. The program, which began in 2003, is a national program administered using the funds previously used for the fuel subsidy (PKPS-BBM BIDKES). Between 1998 and 1999, the central government established the Community Health Insurance Program that took the form of Social Safety Net assistance packages in the Health Sector (JPS-BK). This program was almost the same as the health insurance for the poor included in the JPK-Gakin program, however, it was not without flaws. Using the funds previously used for the fuel subsidy, the performance of the health insurance program for the poor was improved in 2003.

Kabupaten Sumba Timur was selected as one region for the evaluation of the JPK-Gakin program because it is a region with a large percentage of poor people (75% of the population in East Sumba is poor). In addition to this, the hilly terrain and distances between houses influence how effectively the program is utilized in this region.

Kabupaten Sumba Timur is located in East Nusa Tenggara. It has an area of 7,005km^2 and is divided into 15 *kecamatan*, comprising 16 *kelurahan* and 126 villages. Based on data from Statistics Indonesia, there were 198,940 people or 37,273 households in this *kabupaten* in 2004 with a fairly low population density of 27 people/km.^{2}

The *kabupaten* is located in a mountainous area made of limestone. It is infertile and dry and thus it is difficult to obtain clean water. A large portion of the population earns their living from working as seasonal farmers and fishermen as well as cattle, buffalo, horse, pig and goat farmers. Their economy is classified as small.

There are two hospitals (one private and one public), 17 *puskesmas* complete with cars to act as mobile health clinics, 60 *pustu*, 82 *polindes*, 391 integrated community healthcare centers (*posyandu*), three pharmacies and seven medical practices (including Waingapu – the *kabupaten* capital).

Table 1: The Distribution of *Puskesmas* in Kabupaten Sumba Timur

	Kecamatan	*Puskesmas*	Population	Number of Poor People	Percentage of the Population That is Poor (%)
1	Kota Waingapu	Waingapu	33,044	10,638	32.23
		Kambaniru	13,946	9,320	66.83
2	Pandawai	Kawangu	17,946	13,658	76.25
3	Kahaungu Eti	Kataka	7,282	5,174	71.05
4	Umalulu	Melolo	14,166	10,406	73.46
5	Rindi	Tanaraing	8,287	6,025	72.70
6	Pahungalodu	Mangili	12,025	7,906	65.75
7	Wula Waijilu	Baing	6,315	5,333	84.45
8	Paberiwai	Kananggar	6,617	4,600	69.52
9	Matawai Lapau	Tanarara	6,443	3,756	58.30
10	Karera	Nggongi	10,836	8,983	82.90
11	Pinu Pahar	Lailunggi	5,881	4,586	77.98
12	Tabundung	Malaha	8,688	6,225	71.65
13	Nggaha Oriangu	Kombapari	11,540	9,083	78.71
		Nggoa			
14	Lewa	Lewa	19,767	15,539	78.61
15	Haharau	Rambangaru	11,230	7,842	69.83
	TOTAL		193,940	129,074	66.55

Source: Statistics Indonesia and data collected on poor households, August 2003.

II. THE HEALTH INSURANCE SCHEME

A. COMMENCEMENT

The JPK-Gakin program began in August 2003 with the formation of the Executive Body (*Bapel*). Before this, preparations such as human resource development for the individuals who would be involved in the program took place over one year. The East Sumba regional government obtained assistance from GTZ and advice from Professor Ali Gufron from Gadjah Mada University in the form of technical guidance (training relating to the administration of funds and institutional management, and analyzing the criteria used to determine poor households). Apart from that, guidance also took the form of determining appropriate tariffs, premiums and unit costs for *puskesmas* and hospitals. Several staff from the Health Office also had the opportunity to study participatory management at Gadjah Mada University.

The preparation phase did not just involve stakeholders such as the Health Office, *Bapel*, public and private hospitals as well as *puskesmas*, but almost all institutions in the regional government and Commission C and E (health sector commissions) of the local assembly (DPRD), which met several times to coordinate the program. This shows that the East Sumba regional government, particularly the *bupati*, is fairly interested in health services for the community. Other than the Malaria Eradication Program that was operating beforehand, this program is considered to be the regional government's "Leading Program".

B. THE INSURERS

Since 2003, the JPK-Gakin program in East Sumba has been managed by *Bapel*, which consists of six staff: four civil servants from the Health Office and two workers who are paid an honorarium. Currently, management of the JPK-Gakin program in East Sumba is going through a transition period. As a result of the Health Minister's decree in 2004 on the assigning of PT Askes to manage the healthcare program for the poor, PT Askes has also managed the JPK-Gakin program since 1 January 2005. Thus, *Bapel* and PT Askes have been managing the JPK-Gakin program at the same time, albeit in different regions. In accordance with the Health Minister's decree, PT Askes only manages health insurance for 81,200 poor people, covering five of the 17 *puskesmas* in Kabupaten Sumba Timur. The remainder, that is the poor in the other 12 *puskesmas* areas, is still managed by *Bapel*.

PT Askes is a health insurance agency established by the Ministry of Health. All decisions regarding this agency are made by the ministry. Similarly, all insurance policies offered by PT Askes in East Sumba, the number of poor households covered as well as benefits, are determined by the ministry. Given the organization of this agency, PT Askes in the regions does not have the freedom to adapt services to the needs of the local community. Based upon a joint agreement between the Ministry of Health, PT Askes and the Ministry of Trade, insurance tariffs for the poor in hospitals in East Sumba are included in Group D, with the tariff reaching Rp63,000 per person per day.

Funds from the central government (PKPS BBM) are transferred to PT Askes, which then uses them for:

1. basic health services at *puskesmas* and the centers included in their network, such as health services provided by village midwives (examination of pregnant women, as well as assistance during labour and neo-natal care);
2. in-patient services at *puskesmas*;
3. referrals to hospitals; and
4. recording and provision of medication at *puskesmas* and the centers included in their network.

Funds provided by the regional government are channeled through the JPK-Gakin Manager at the Kabupaten Sumba Timur Health Office and then used for health services for the poor that are not covered by PT Askes. They are, in other words, used to pay for:

1. basic health services at *puskesmas* and the centers included in their network, such as health services provided by village midwives (examination of pregnant women, as well as assistance during labour and neo-natal care);
2. in-patient services at *puskesmas*;
3. simple medical procedures (small operations and stitches) at *puskesmas*;
4. referrals to hospitals;
5. recording and provision of medication at *puskesmas* and the centers included in their network;
6. revitalisation of *posyandu*; and
7. promotional and preventative health activities.

Based upon the experiences of health providers, particularly the private and public hospitals, there are several differences in what the poor can claim from *Bapel* and PT Askes. These are represented in tabular form in Table 2.

The capitation funds *Bapel* gives to *puskesmas* are broken down so that allocations are clearer. PT Askes' allocation mechanism is not, and so allocations rely more on the creativity of the head of a *puskesmas*. *Puskesmas* heads hold a lot of authority in determining whether funds will be allocated to programs or used to improve medical services.

To date, there have not been any significant problems with either system. After one year (i.e. at the end of 2005), the regional government will evaluate each insurer and determine which one is better. The other possibility is that it will continue to use both insurers, although the system will be standardized. Because it is still in the middle of the evaluation phase, there have not yet been any agreements between the regional government and PT Askes or PT Askes and either the public or private hospitals.

Table 2: Comparison of Services Provided by Bapel and Askes

Indicators	Bapel	Askes
Medication	Medication not included on the DPHO* can be covered where there is an agreement.	Only covers DPHO medication.
Price of medication	Basic price. Reimbursements from *Bapel* are based upon the basic prices (hospitals do not set a margin).	Very low, for example, Askes only values cholesterol medication at Rp4,000, whereas its market value is Rp25,000.
Medical services for in-patients	Services are more flexible.	In-patient benefits reach Rp63,000 per person per day.
Tariffs charged by midwives for assisting with the delivery of babies	Low Rp7,000 – labour through to neo-natal care Rp35,000 – ante natal care	High Rp150,000
Doctor fees during operations	Low Rp4,500	High Rp43,000
Transport for referral patients	Covered Rp25,000 – short distances Rp300,000 – longer distances (ambulance) Rp200,000 – longer distances (public transport)	Not covered
Capitation for *puskesmas*	-40% for medication (managed by the Health Office). -60% for operational support (for example, travel to *posyandu*, transport for workers). Of this 60%, *puskesmas* may use 15% for medical services and 85% for other programs.	-50% for medication (managed by the Health Office) -50% for health services (PT Askes does not break down the details of allocations as they are determined by *puskesmas* policies.
Policy focus	Concentrates on regional conditions (regional culture and geography). For example, *Bapel* allocates money for the transport of referral patients to hospitals in East Sumba.	Centralised (without looking at regional specifications). For example, complaints about policies cannot be resolved in the regions, they must go to the national level.

Explanation: * DPHO is a list of medications covered by health insurance providers and their ceiling prices.

During this transition phase, benefits made available to poor households by PT Askes are the same as that available to Group I and II civil servants, that is they cover in-patient treatment in third-class wards and a restricted number of services. Both the public regional hospital and Kristen Lindimara Private Hospital have questioned the prices of the medication benefits offered by PT Askes, because they are so low that they could cause financial losses for hospitals.

C. THE INSURED

The task of recording the number of poor people in villages was carried out by a village team, consisting of the village head and his/her assistants, village health workers such as midwives, *pustu* workers and assistants, as well as village/*kecamatan* statisticians who were coordinated by the *camat*. Initially, village officials had a larger role in determining who was poor. In the following year, however, the poor paid closer attention to these activities

because of the information they received from different people, such as village midwives and assistants.

In 2003, as many as 129,074 poor people were covered, but this rose to 159,037 people in 2004. Based upon 2003 data from Statistics Indonesia, however, 198,940 people or around 75% of the population in Kabupaten Sumba Timur were poor. The Health Office and associated agencies, such as staff at *puskesmas* including village midwives, village statisticians and assistants, also collected data on the poor. In October 2003, data on the poor was verified and it was found that the number of poor people had actually increased. This increase in the number of poor people was due to the data collection period in the second phase being relatively longer than the first which was only three months. Apart from this, in the first phase the ability of workers to reach poor households was restricted by the fact that most houses are dispersed over a large area and families often move. In the first period (2003), there were many complaints and requests from the poor who had not received health cards, but this was corrected through data verification in 2004.

In 2005, PT Askes will manage funds for 81,200 poor people based upon funding allocations set at the national level (Minister of Health's decree), whereas *Bapel* will manage the JPK-Gakin program for 77,837 people. Each program covers a different service area. PT Askes manages poor households that are serviced by five *puskesmas* in regions close to the *kabupaten* capital while *Bapel* covers 12 *puskesmas* in regions further from the *kabupaten* capital.

D. THE HEALTHCARE PROVIDERS

There are only two types of healthcare providers in Kabupaten Sumba Timur, that is type I and III. There are no type II healthcare providers because outpatient services are not available at the hospitals. In the agreement between *Bapel* and the hospitals (both the public hospital and Lindimara Private Hospital), the holders of health insurance cards are only able to receive outpatient services at *puskesmas*, and thus hospitals become places just for referred in-patients. Health cards cannot be used for outpatient services at the hospitals. This agreement is designed to ensure that *puskesmas* function more as the closest places to obtain community health services, especially considering that *puskesmas* receive capitation funds for services provided to the poor. It is expected that communities can make maximum use of these funds.

Type I healthcare providers are *puskesmas*. There are 17 *puskesmas* in Kabupaten Sumba Timur; five of them have in-patient facilities. There are also 60 *pustu* and 82 *polindes*. These *puskesmas* are spread across 15 *kecamatan*. There are two *kecamatans which* have two *puskesmas*, that is Kecamatan Waingapu – the kabupaten capital – and Kecamatan Nggaha Oriangu. Five *puskesmas* do not have a doctor, that is the *puskesmas* in Tanarara, Kananggar, Mahar and Lailunggi as well as a new *puskesmas* at Nggaha Oriangu.

The *puskesmas* signed one-year contracts with *Bapel*. The obligations of each party were written in the contracts and they became the foundation from which *puskesmas* could work to serve the poor. The contracts also specified the amount of capitation funds and allocations to be paid to the *puskesmas*, as well as the level of service and the obligation of *puskesmas* to reach certain levels of utilization.

Puskesmas services are often available 24 hours a day. Although officially they only provide consultations between 8 and 11am, they continue to see patients outside of these hours in recognition of the fairly long distances between houses and *puskesmas* (in general, patients have to travel 1-2 hours on foot). The staff who work at Puskesmas Nggoni live close to the *puskesmas*, as does the doctor, so that it is easy to see patients who arrive outside of working hours.

Hospitals

There are two hospitals in Kabupaten Sumba Timur; the regional hospital owned by the government and the Lindimara Christian Hospital, a private hospital that also accepts referral patients with a JPK-Gakin card. Referral patients must have a referral from a *puskesmas* and must have stayed in that *puskesmas* for 48 hours. The holders of health cards are allowed to choose which hospital they are referred to.

Village residents who are referred to hospitals usually choose the private hospital because it is closer (transport is easier) and they are more satisfied with the services provided by its doctors. This information, however, is not based on data but anecdotal evidence provided by *puskesmas* patients. In addition, the head of Lindimara Hospital explained that both hospitals have the same standards and provide the same services for patients, but that doctors visit patients more regularly at Lindimara Hospital.

The condition of the buildings and cleanliness at both the public and private hospitals are fairly good. The public hospital has 95 rooms and the private hospital has 40. The class 1 and class 4 rooms used by health cardholders are clean. It is, however, difficult to keep the hospitals clean due to the community's (patients' and their families') habit of chewing betel nut. Because both men and women chew betel nut, there is a lot of red spittle in the hospitals and it is difficult to clean. The private hospital has put up a sign in the corner of one room to warn against spitting.

E. REIMBURSEMENT SYSTEM

Bapel uses a capitation system for *puskesmas*. *Puskesmas* receive JPK-Gakin funds in the form of capitation at the beginning of each year from *Bapel*. In 2005, however, five *puskesmas* received capitation funds from PT Askes rather than *Bapel*. The premium for each poor person who seeks medical treatment at a *puskesmas* is Rp1,000.

Table 3: Capitation Funds Received by P*uskesmas*

	Puskesmas	Capitation Funds (2003) (Rp)	Population In The *Puskesmas* Area	Poor Population In The *Puskesmas* Area
1	Waingapu	127,656,000	33,044	10,638
	Kambaniru	111,840,000	13,946	9,320
2	Kawangu	163,896,000	17,946	13,658
3	Kataka	62,088,000	7,282	5,174
4	Melolo	124,872,000	14,166	10,406
5	Tanaraing	72,300,000	8,287	6,025
6	Mangili	94,872,000	12,025	7,906
7	Baing	63,996,000	6,315	5,333
8	Kananggar	55,200,000	6,617	4,600
9	Tanarara	45,072,000	6,443	3,756
10	Nggongi	107,796,000	10,836	8,983
11	Lailunggi	55,032,000	5,881	4,586
12	Malahar	74,700,000	8,688	6,225
13	Kombapari	108,996,000	11,540	9,083
	Nggoa	NEW *PUSKESMAS* – NO DATA		
14	Lewa	186,468,000	19,767	15,539
15	Rambangaru	94,104,000	11,230	7,842
	TOTAL	1,548,888,000	193,940	129,074

Source: East Sumba JPK-Gakin *Bapel*, 2003.

Fourty percent of the capitation funds received by *puskesmas* every three months are used to purchase medications. Sixty percent is used to increase the quality and scope of health services, of which 15% is used to pay for the services provided by *puskesmas* workers. *Puskesmas* capitation funds are used to pay for the treatment of poor outpatients. Expenses for in-patient care and small operations are claimed instead of being covered by capitation funds. For example, stitches can be claimed from *Bapel* and are not covered by *puskesmas* capitation funds.

Bapel also uses a claim system for the hospitals. Hospitals can claim all expenses related to the supply of medications and provision of services to the poor back from *Bapel*. To date, the agreement between hospitals and *Bapel* relates to prescribing medications and medication premiums. *Bapel* agrees with almost all claims the hospitals make to *Bapel*, although discussions are still continuing about several types of medication used by the hospitals that are not included on the DPHO list.

Hospitals can send claims to *Bapel* once a month but they are often more than a month late. *Bapel* reimburses the money around two to four weeks after the claims have been submitted. Based upon *Bapel*'s experiences, the private hospital is more organized in making claims, both in relation to timeliness as well as the paperwork submitted for each claim. This would definitely assist the claim verification team that works at *Bapel*.

PT Askes has organized a benefits package for in-patient treatment at hospitals that reaches Rp63,000 per person per day. This covers laboratory expenses, the use of simple equipment and doctors' fees. Both hospitals have accepted this package, but in relation to medication claims, they feel that the standard price of medication set by PT Askes is too low and could

result in financial losses for the hospitals. PT Askes values Amoxicillin, for example, at Rp22,000, whereas its market price can reach Rp48,000. There is, as yet, no agreement about how the hospitals can make claims with PT Askes, but in the meantime the system established by PT Askes treats claims from the poor the same as that from level III civil servants.

The hospitals have a lighter workload managing JPK-Gakin compared with the management of funds for the health sector of the national social security scheme (JPS-BK). At present, hospitals can concentrate on just providing health services and leave claiming expenses for treating the poor to *Bapel*. In general, *Bapel* agrees with the claims submitted as long as they correspond with the joint service agreement.

F. THE HEALTH CARD

Each poor household has had a blue health card since 1 January 2004. By showing these cards, they receive free medical treatment at healthcare facilities, such as *pustu, polindes, puskesmas* and hospitals, as well as from midwives. Almost all of the households recorded as poor in the region (32,122 households) have obtained a health card, but not all families have due to restrictions in data collection. There are still complaints from communities, village officials and health workers because some extremely poor households have not received a health card. As a result, data on the poor was verified between August and October 2004, showing an increase in the poor population to 159,037 individuals or 34,626 households.

Meanwhile, PT Askes has organized a different health card for the poor in its areas, but these cards are for individuals rather than households. These cards are different from *Bapel*'s cards that cover one household. The cards for individuals will be distributed by PT Askes through the East Sumba regional government, although no further information was available at the time this research was undertaken about which agencies within the regional government would be responsible for this task.

Bapel is responsible for the supply of cards, but will only provide cards for those poor people covered by a particular *puskesmas*. *Puskesmas* record the names of poor families and family members they are responsible for. The cards include information such as family name, family members, index number and the health card's expiry date. After these cards are signed by the head of a *puskesmas*, they are handed over to a village head via a midwife or *pustu* worker.

Towards the end of January 2005 when the SMERU and World Bank team carried out its field study, people had still not received their new cards. They generally still used their old cards that had expired on 31 December 2004 to obtain medical treatment at a *puskesmas*. These old cards can still be used because *Bapel* has not finished producing the new cards.

III. THE FUNCTIONING OF THE HEALTH INSURANCE SCHEME

A. IDENTIFICATION AND VERIFICATION OF THE POOR

The eight criteria for determining the poor used in verifying the data in 2004 were chosen through consultations with several parties including the Kabupaten Committee Team, or the *camat* and village head as well as their assistants. Based upon the above criteria and complaints from people who had not received a health card (despite being assessed as very poor by village officials and midwives), the number of poor people in East Sumba increased from 129,074 to 159,037 between 2003 and 2004, and this number became a reference for the distribution of cards for the 2005 JPK-Gakin program.

At the initial stage of recording the number of poor people (2003), the regional government did not use the criteria which had been mutually agreed upon, and so the East Sumba regional government relied upon the data from village heads and their assistants, including village health workers such as village midwives, *pustu* workers, *kecamatan* officials, village statisticians and their assistants. It is inappropriate to use the criteria used by the National Family Planning Coordinating Board (BKKBN) in East Sumba because community characteristics are different from Java and other regions. For example, BKKBN's criteria relating to the floor of a house concludes that the house of a poor family would have a dirt floor. For the community in East Sumba, a dirt floor does not necessarily mean that a household is poor, but can in fact mean that it is better off because they own enough livestock to maintain a dirt floor. It is quite difficult to obtain information about the poor in East Sumba because houses are spread out and many people are still nomadic, making it difficult to include families in village records.

Data collection is funded using the regional government's general allocation funds. Initially, each surveyor received a fee of Rp60,000 per person for three days. There was no information regarding the funds for data collection in the second phase (October 2003).

Financing

Funds for the JPK-Gakin program are provided by the central and regional governments. Funds from the central government are transfers from the fuel subsidy reduction fund or PKPS-BBM and these are supported by funds from the East Sumba regional government's budget.

There are two types of activities that are funded by this money, namely main activities and supporting activities. These include:

1. payment for in-patient treatment for patients referred to hospitals;
2. payment for in-patient treatment at *puskesmas;*
3. mobile services provided by *puskesmas;*
4. medication and medical equipment expenses;
5. hepatitis B vaccinations;
6. transport costs for referral patients; and
7. management expenses (participant verification, healthcare management and financial management).

Other activities funded:

1. Payments for transporting medication by *puskesmas* to the district Health Office; and
2. Monitoring and control (e.g. blended food).

The JPK-Gakin program managed by *Bapel* has allocations for expenses relating to patients' transport and retrieving medication from the Health Office's pharmaceutical warehouse. This is important remembering that health facilities and households are spread out and distant from the *kabupaten* capital. There are, however, no payments for these expenses under the insurance program managed by PT Askes, which would make it more difficult for people who have to obtain treatment as an in-patient at hospital. The same applies for *puskesmas*. If there are no reimbursements for retrieving medication, *puskesmas* will be forced to allocate funds themselves. This is quite difficult for *puskesmas*.

Capitation funds transferred to *puskesmas* do not cover expenses associated with transporting referral patients to hospital. Expenses for in-patients, minor operations and stitches are submitted to *Bapel* as claims from *puskesmas*. Thus, *puskesmas* receive two types of funding, that is capitation funds which are distributed every three months and claim funds. Forty percent of capitation funds are provided to purchase medications and 60% to cover *puskesmas* operational expenses. *Puskesmas*, however, only manage 60% of the capitation funds as the remaining 40%, that is used to purchase pharmaceuticals, is managed by the Health Office. *Puskesmas* only obtain their medical supplies as they are required.

Based on *Bapel*'s experiences in handling claims from the two hospitals that receive referral patients, there have been several problems including claims being submitted late (more than a month), claims lacking prescriptions and claims for medication not included in the scheme. This more often occurs with the East Sumba Regional Hospital than the Lindimara Private Hospital.

Based on calculations from the *Bapel* team and consultants from GTZ, the average amount of funding spent on the poor by *puskesmas* and hospitals is only Rp3,450 per person per month, or Rp41,400 per person per year. These calculations take into account promotive, preventive, curative and rehabilitative treatment, and even include individuals who are not poor because they also use medication/facilities directed at the poor.

The small amount of funds spent on the poor indicates that funds allocated by the central and regional governments could be saved and that the remainder – which is quite a lot of money – could be used for services provided in the following year. However, could this also be the case with the funds managed by PT Askes, which has set a premium of Rp5,000 per person per month? If not, then PT Askes will make a fairly large profit.

Benefits Package

In general, both poor and non-poor patients who use a health insurance card do not clearly understand that health treatments or medication is covered by the insurance rather than the *puskesmas* and hospitals. To date, the poor who have a health insurance card can obtain free medical treatment at *puskesmas* and hospitals. There is, however, no clear criteria on the rights of the poor to medical treatment as holders of health insurance cards. Patients attending the *puskesmas* generally said that they did not pay for anything when being treated at a *puskesmas*. Such was the case for *puskesmas* in-patients who were interviewed at

Puskesmas Nggongi. Patients' experiences at hospitals, however, were different. Several in-patients at hospitals as well as *puskesmas* patients who had been in-patients at a hospital said that they still had to pay for medication. Poor patients have been receiving unrestricted free treatment at *puskesmas*, whereas this has not been fully realized for poor patients at hospitals.

Both *puskesmas* and hospitals have signed contracts with *Bapel* regarding their rights and responsibilities in providing medical treatment for the poor. There has not been any explanation in these agreements or contracts regarding the rights of, or health benefits available to, the poor. This weakens the position of the poor because they are unable to obtain a convincing explanation about free treatment. As a result only a small number of the poor use these health cards for referrals to hospitals. This is due to the fact that they are afraid of having to pay for medical treatment.

Such is the case in hospitals. To date, general patients with health insurance (civil servants and pensioners) can obtain free medical treatment but there are still a number of medications not covered. There is an impression that poor patients will be treated similarly if admitted as in-patients at hospitals. The poor are unaware that there are restrictions in the treatment they can receive at hospitals. For example, there is a clause that hospitals shall not provide outpatient services for the poor. The poor still do not have enough information even though they rarely receive outpatient treatment at hospitals due to the fact that they live too far away.

B. PUBLICIZING HEALTH INSURANCE

Several types of media are used to spread information regarding free medical treatment for the poor. According to *Bapel*, the program is publicized on the radio and also through word of mouth between the public and midwives or their assistants, particularly in relation to *posyandu* activities. *Suara Sumba* [Voice of Sumba Newspaper] as well as displays shown and cassettes played at *puskesmas* are other ways *Bapel* spreads information about the free medical treatment program. The effectiveness is greater where communities are more likely to seek medical assistance at *puskesmas* or other close health facilities. The number of patients at *puskesmas* as well as in-patients at hospitals has increased.

Medicine

The Health Office manages those funds that are used to purchase medication for the poor. These are sourced from the compensatory funds for the reduction in the fuel subsidy as well as from the regional government. Based on monthly requests, *puskesmas* can obtain the required medication from the *kabupaten*-level pharmaceutical warehouse. For medication needs, *puskesmas* receive funds from the JPK-Gakin allocation funds. Medication for the poor and non-poor is not separated on either an administrative or funding basis. Both *puskesmas* included in the sample for this study stated that there had not been any problems in relation to the type and quality of medication supplies. Requests for medication from *puskesmas* can always be met by the *kabupaten*-level Health Office.

The Health Office and *Bapel* ensure there is cooperation with hospitals, as well as the DPRD, non-government organizations and community figures, in reaching agreements on the type and price of medication that should be made available for the poor. Meanwhile, PT

Askes is also involved in managing funds for the poor, but decisions regarding the determination of the type and price of medication for the poor have not been discussed with hospitals. The two hospitals complain that the standard price of medication offered by PT Askes is too low.

So far, coordination between hospitals and *Bapel* has been quite good, meaning that the medication prices set by *Bapel* are considered to match the standard market prices. Apart from this, hospitals can also use medication not included on the DPHO list if there is a logical reason. Before coming to an agreement about medication claims, the hospitals and *Bapel* actually discussed the possible situations where hospitals could prescribe medication not included on the DPHO list. In relation to PT Askes, the hospitals were not able to negotiate at the *kabupaten* level because all of PT Askes' policies are centralized.

IV. EXPERIENCES FROM DIFFERENT PERSPECTIVES

Kabupaten Sumba Timur is a poor region because its poor geographical conditions (land is infertile and rocky), low education levels and poor health levels result in poor community health. The community very much needs government assistance in the form of the JPK-Gakin program considering that 75% of its population are poor. In general, health cardholders make use of medical treatment at the available facilities. The major issues for the poor are the distance between houses and the limited, and sometimes even expensive, transport.

Malaria is one of the major diseases for residents in this *kabupaten*. There is a prevailing lack of knowledge in the community about healthy lifestyles, good nutrition, cleanliness in the home and surrounding environment as well as physical fitness. The most important health program other than the provision of free medical treatment for the poor is, therefore, improving the community's basic lifestyle. Animals from chickens, pigs and goats to cattle, buffalo and horses wander around gardens and roads, and their faeces which is everywhere causes bacteria to grow. Both women and men have a habit of chewing betel nut and they spit it out anywhere. In the dry season, residents suffer from water shortages.

The JPK-Gakin program managed by *Bapel* has not resulted in many problems so far for either *puskesmas* or hospitals. Most of the complaints are about administrative matters such as not receiving a health card, whereas there have only been a few complaints regarding the health services provided. As the PT Askes system of managing JPK-Gakin has been applied, health services for the poor in East Sumba will be the same as that for communities in other regions of Indonesia. Distances and the level of difficulty in reaching health facilities is a major problem for the poor. If a family member falls ill, they need transport in order to access health facilities, but they cannot afford the cost. There is a similar problem if they are referred to hospital. Despite hospitals providing free treatment, they often need a lot of money to cover the cost of transporting the family member to hospital as well as food. These difficulties often result in them not wanting to be referred to hospital.

Health Provider I (Puskesmas Nggongi):

This *puskesmas* is located around 150km from the *kabupaten* capital and can be accessed via three different asphalt roads, which are not entirely smooth, but can be used by four-wheeled vehicles. There is only one bus that services this area and it only runs once a day. In the wet season, several parts of these roads wash away, and thus it becomes difficult for four-wheeled vehicles to use them.

Puskesmas Nggongi is located in Kecamatan Karera, which has a population of 10,863. Of this population, a total of 8,983 people are classified as poor. This *puskesmas* which was built in 1972 has had a ten-bed in-patients room since 1972. In-patient facilities are very important for the community in Karera considering the distance they need to travel to reach in-patient facilities at the hospital. The doctor and nurses live next to the *puskesmas* making it easier for patients who arrive outside of working hours.

This *puskesmas* has several sources of funds, including:

1. Fees of Rp1,500 from community members who receive medical treatment (around Rp3 million per year);
2. Operational expenses of Rp15 million per year;
3. Routine expenses (the Health Office reimburses the *puskesmas* for any routine expenses);
4. Ten million rupiah is allocated for in-patient treatment per year;
5. Expenses for the *pustu* under the *puskesmas* of Rp1.5 million per year; and
6. Expenses for the *polindes* of Rp1 million per year.

The *puskesmas* receives funds for all of these expenses from the *kabupaten*-level Health Office.

In 1989, there was a diarrhoea epidemic in the region, but at that time there was only a health worker and no doctor. There was no doctor assigned to this *puskesmas* until 1995, and this doctor has since been replaced seven times, mostly by temporary doctors. The most recent doctor, however, is a civil servant and has worked at the *puskesmas* for two years. In addition to the doctor, there are three midwives and five nurses and health workers. There are 13 people who work at this *puskesmas* but this is insufficient to meet demand because, in addition to serving three *pustu* and 26 *posyandu* in ten remote villages, one of the villages is on an island.

At the time of field research, there were two in-patients: one infected with malaria and the other with wounds from a wild pig attack. On average, only one or two people are referred to hospital per month. Patients who are not too sick can be cared for at the *puskesmas* with its simple in-patient facilities. The most common disease is malaria, although it was not until 2001 that the *puskesmas* had a trained malaria laboratory technician, and since around 2003, with the assistance of World Vision, the *puskesmas* has had an adequate microscope to detect malaria.

<u>Number of patients referred to hospital in 2003 from Puskesmas Nggongi</u>
January – 1
February – 1
March – 2
April – 2
May – none
June – none
July – 1
August – 4
September – 2
October – 2
November – none
December – 3
January (2004) – 2

There are no private doctors or midwife practices because most people are poor. The majority of the population seek assistance from traditional healers during labor as they are close. They pay those who assist during labor with anything, sometimes Rp20,000 or a chicken, that is if they do not feed the midwife, or they just say thank you.

Livestock, such as cattle, horses and pigs, are generally left to wander around the *kecamatan*. Animal faeces is widespread, making the environment dirty, including that near the *puskesmas*. The doctor and *puskesmas* workers are unable to advise the community to tie up their livestock in their yards so that they do not pollute the environment. This is because the community leaders own thousands of animals and let them graze freely. There are three community leaders, one who is referred to as the 'king' and another is the village head. They are classified as rich and own a lot of livestock and land (thousands of cows, pigs and horses). The animals they own are left to graze on the roads around the village and *kecamatan*. Doctors often experience personal conflicts because of this in the areas where they work.

Health Provider II (Puskesmas Lewa):

This *puskesmas* serves around 19,767 people, 78.61% of whom are poor. In December 2004, 1,127 of the 1,578 patients were poor, meaning 71% of the patients who obtained medical treatment at the *puskesmas* were poor. There are 15 health workers, including one doctor, five *pustu*, 12 *polindes* and 31 *posyandu* (three people assist at each *posyandu*). Puskesmas Lewa also has in-patient facilities with 11 beds, which are supervised in three shifts: morning, afternoon and night.

The village head, community leaders, religious leaders and *dusun* heads are all involved in publicizing the health cards in Lewa. Women, however, obtain explanations from the *posyandu*. People who have assisted with *posyandu* activities on a voluntary basis have been involved in distributing and filling in health cards. For their work, they are paid Rp250 per card and free treatment at the *puskesmas*. There is also a male assistant at this *puskesmas*, which is unusual as most workers are female. In this area he has a very important role however, because males are needed to reach isolated areas, especially if they need to ride a horse to deliver immunization medication.

V. IMPORTANT ISSUES REGARDING THE FUNCTIONING OF HEALTH INSURANCE

1. *Bapel*'s management of health insurance in the *kabupaten* at this time is proceeding smoothly. Identification of poor families and the distribution of cards is being fully undertaken by *Bapel*. Shortcomings during the identification process continue to be rectified in parallel with modification of the criteria as well as identification in the field together with reports from the community. Likewise with the health service reimbursement funds which has not drawn a lot of complaints from the hospital.

2. In accordance with the Minister's directive concerning the appointment of PT Askes as the manager of health insurance for the poor, the government of Kabupaten Sumba Timur has split the management of this insurance program on the basis of area of operation. At the time the research was being conducted, PT. Askes had not started operations because it was waiting for an implementation order from PT Askes central administration.

3. Because it is still in the early phase of implementation, PT. Askes cannot yet determine the nature of the operating system that will be applied in East Sumba. If the regulations have been decided by PT. Askes central administration, they will work jointly with the local government authority and especially *Bapel* and the Health Office to obtain the names of poor families. *Bapel* as the previous manager has experience in identifying poor families and the local government administration has the regional authority so good cooperation is absolutely necessary.

4. What is clearly understood by the hospitals, both the local public hospital (RSUD) and Lindimara private hospital is that reimbursement of medications originates from PT. Askes. They hope PT. Askes will not be too rigid in applying the regulations on medications for the poor. At this time, cooperation between the hospitals and *Bapel* has been proceeding smoothly. All obstacles that arise and the adjustment of the regulations on medication can be jointly discussed so that there is no disadvantage to the hospitals or the patients.

5. The decision of the local government administration to split the operational area between two managers of JPK-Gakin also requires adjustment in administration for the hospitals. *Bapel*, who until now applied reimbursement of transport allowances for poor families who were referred to hospital, will continue to apply this policy even though the operational area has now been split into two. On the other side, PT. Askes has already determined that there will be no reimbursement of the cost of transport for the poor who are referred to hospital. This determination could certainly give rise to jealousy among the poor. Likewise with several larger variables on compensation for the type of medication and illnesses that will be covered by PT Askes and *Bapel* that will also be different.

6. It is expected all these differences won't give rise to difficulties for the poor in accessing health services.