

INEQUITY IN INDONESIAN HEALTH SOCIAL SAFETY NET PROGRAM



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Background

- Monetary & economic crisis that hit Indonesia in 1998, produce negative impact to the community health status
- The crisis caused increased unemployment, decreased value of Rupiahs against foreign currencies, increased prices of imported commodities including drugs, increased incidence of malnourished children and decreased utilization of health facilities
- The poor is more vulnerable to diseases due to poor access to health care as well as poor environmental conditions and poor nutrition
- There were discrepancy in health status indicators, such as Infant Mortality Rate: 53 per 1,000 Live Births among the poor vs 24 per 1,000 Live Births among the rich



Background

- Wagstaff & Van Doorslaer (2000): “Medical care ought to be allocated on the basis of medical need, rather than on the basis of income or willingness or ability to pay”
- Social Safety Net program in the health sector has been implemented by the Indonesian government since 1998 up to now, to enable the poor getting adequate access of health services, including hospitalization
- Results of National Socio-economic Survey 2005 showed 35.1 million of poor population (12.4 million in urban area and 22.7 million in rural area)
- The increased of oil prices in 2005 increased the number of the poor population



Objectives

- To evaluate the targeting of the distribution of health SSN Program
- To recommend improvement of program implementation
- To adapt to the new law on National Social Security (Law No. 40/2004, including social health insurance)



Source of Data

- Results of National Socioeconomic Survey 2004
- Total sample: 68,000 households, covering all cities and districts in Indonesia (448)
- Instruments designed by NIHRD and implemented by Central Statistical Bureau/BPS
- Participants of health SSN were selected by village committee and were given “Kartu Sehat/Health Card”



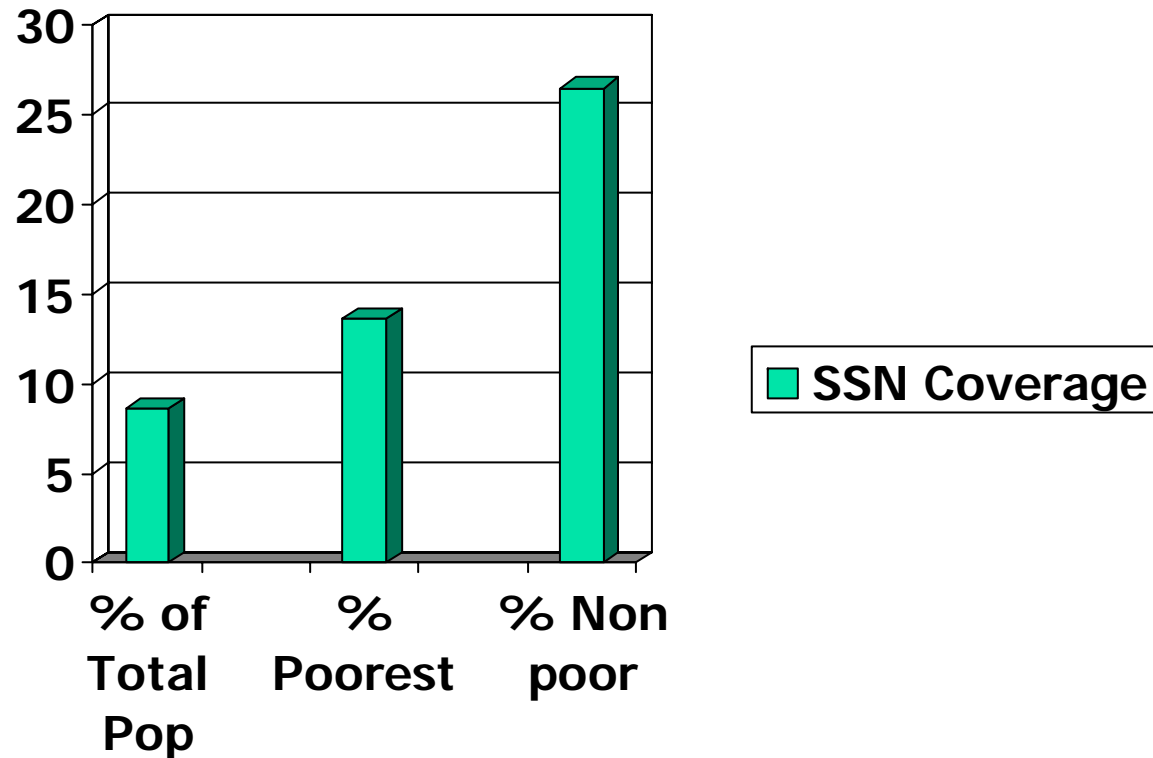
Disease Prevalence By Quintile of Income (National Socioeconomic Survey 2004)

	Q-1	Q-2	Q-3	Q-4	Q-5
Disease Prevalence (Percent)	30.2	26.3	25.4	24.2	24.2

Expenditures of Indonesian Households in One Month (Rupiah) By Quintile of Income (National Socioeconomic Survey 2004)

Type of Expenditures	Q-1	Q-2	Q-3	Q-4	Q-5
Food	255,966 (69.4 %)	389,793 (69.0%)	499,549 67.3 %)	634,683 (64.1%)	952,288 (50.6%)
Health	9,432 (2.6%)	14,455 (2.6%)	20,184 (2.7%)	29,012 2.9%)	77,216 (4.1%)
Education	5,685	11,833	19,549	31,138	93,157
Tobacco & Alcohol	7,067	13,153	18,066	23,470	31,589
Total	368,810 (100 %)	564,743 (100 %)	742,323 (100 %)	989,858 (100 %)	1,883,291 (100 %)

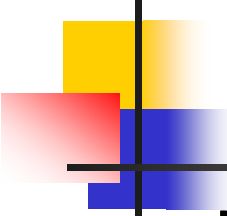
Coverage of Health SSN Program Among The Poorest (Q-1) and Non-Poor (Q-4 & Q-5) (National Socioeconomic Survey 2004)





Coverage of Health SSN Among The Poorest By Province, 2004

- National Average: 12.4 %
- Lowest: Maluku (3.0 %)
- Highest: Aceh (36.5 %)



Utilization of Out-Patient and In-Patient Services (Public Hospital) By Quintile of Income, 2004

Type of Service	Q-1	Q-2	Q-3	Q-4	Q-5
Out-Patient	3.8	3.6	4.6	5.9	7.9
In-Patient	41.1	45.3	44.3	49.6	45.0



Barrier to Utilization of Health Services

- Financial Barrier
- Availability of Health Facilities In Remote Area
- Transportation cost
 - The cost for transportation in difficult area can be 4 to 8 times the Health Center Service Fee (Rp. 10,000/Rp. 20,000 compared with the service fee of Rp. 2,500)



Improved Health SSN Program

- In responding to the recommendation, the central government modified the Health SSN Program since January 2005; also to adapt to the Social Insurance Program based on National Social Security Law 2004; the coverage increased from 36 Million population to 60 million population
- Managed by PT ASKES Indonesia, a Health Insurance Company (para-statal, managing civil servant health insurance) with extensive services (similar to civil servant health insurance)
- Premium increased from Rp 10,000.00 per family per month to Rp. 5,000.00 per capita per month
- Total fund provided: 3.1 trillion rupiahs (A \$ 450 millions)
- Controversy: third party administrator vs health insurance provider
- Participants of the program were re-registered and given the AsKesKin Card; shifting from supply based to demand based



Conclusions

- Poverty is a common problem of developing countries
- The important effort is how to reduce the number and how to narrow the gap between the “have” and the “have not”
- The health service costs is a burden for the poor
- The Health SSN is a part of “poverty reduction program” (MDGs)
- Need to improve the criteria for the recipient of SSN Program:
 - Current criteria (National Poverty Line 2005):
 - Urban area: Rp. 150,799,- per capita per month
 - Rural Area: Rp. 117,259,- per capita per month
- Implementation of Social Health Insurance needs to be accelerated to cover all groups of population

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