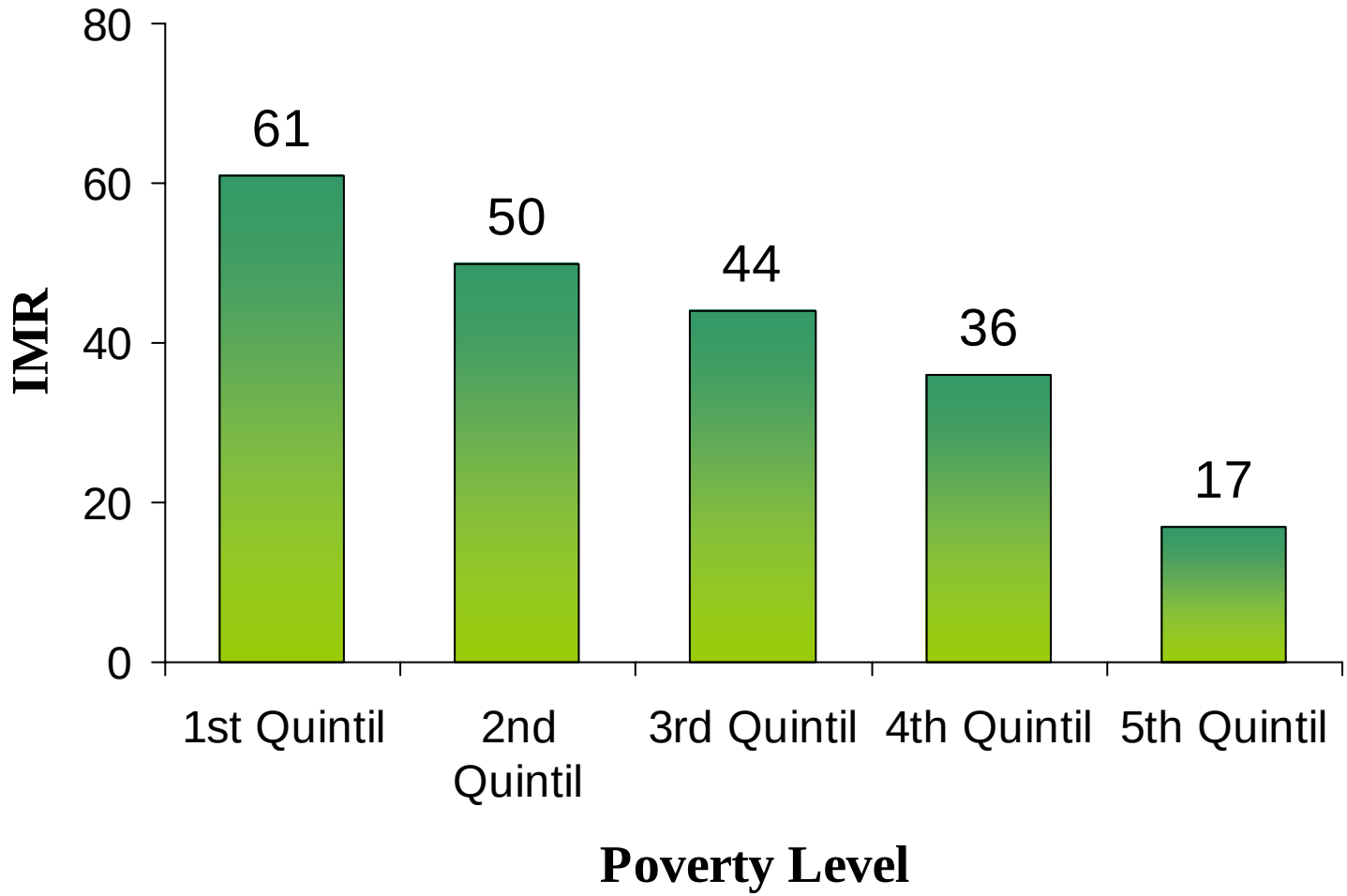
Health Insurance for the Poor

Country: Indonesia

Overview

- There has been increased health status of Indonesian community
- The disparity, especially, among different social economic status, remains high

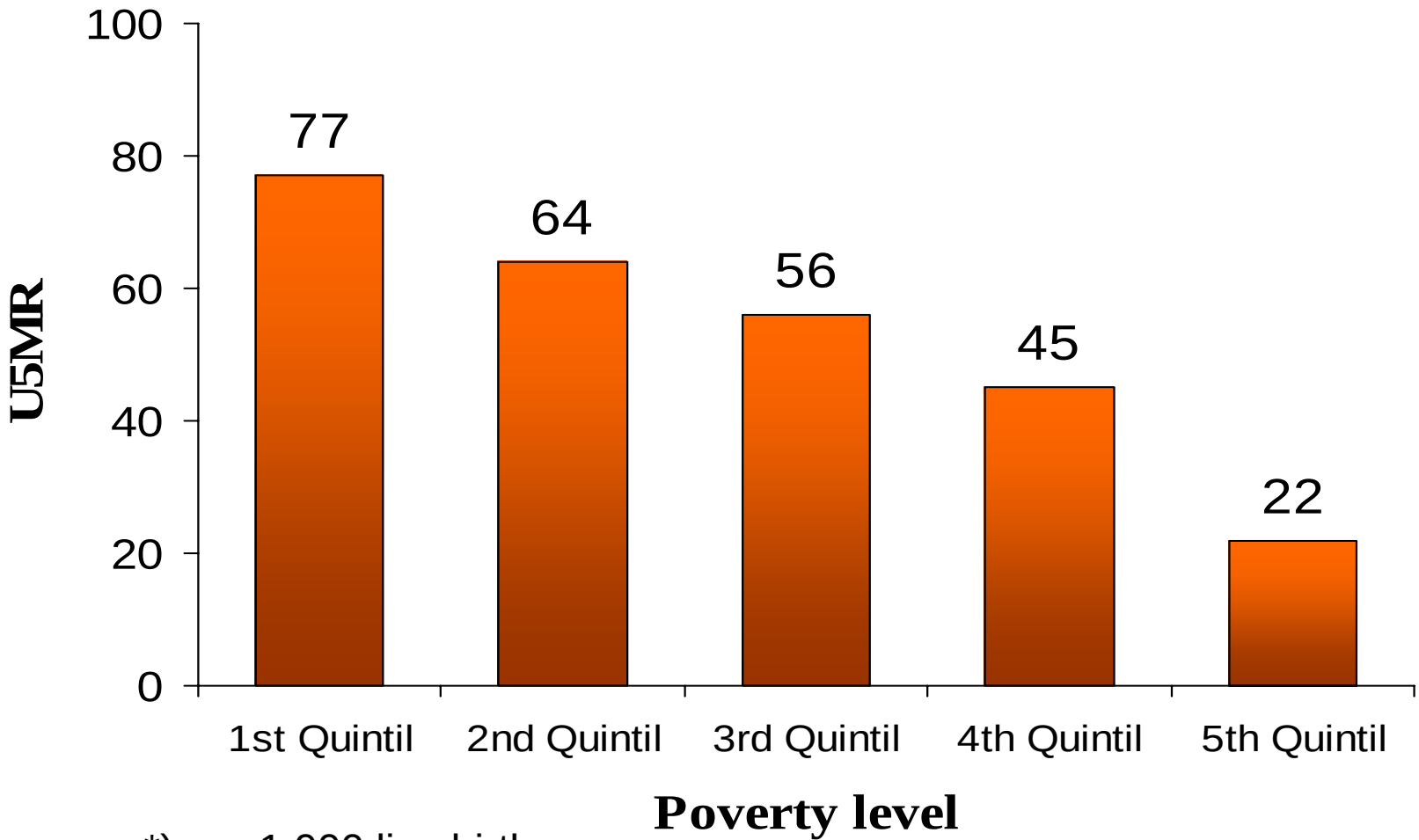
- Infant Mortality are much higher among the poor :



*) per 1.000 live births

Source: IDHS 2002-2003

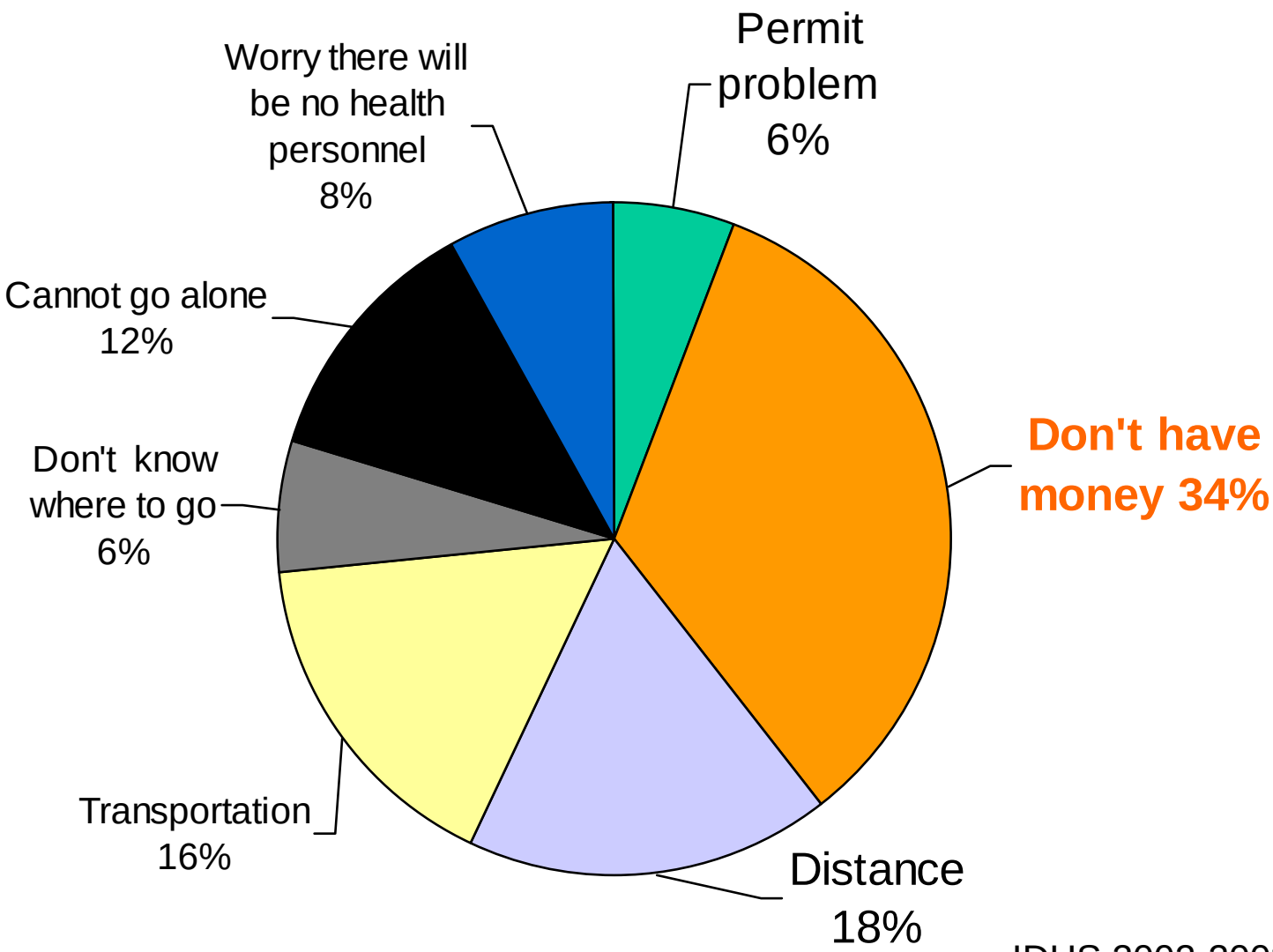
- Also, Under Five Mortality are much higher among the poor



*) per 1.000 live births

Sumber: SDKI 2002-2003

Why don’t people utilize health facilities?



IDHS 2002-2003

Free health services for the poor

- Initiated in 1998-2001: Social Safety Net. ADB Loan funded. Providing health card for the poor for free access of health services
- 2001-2004: compensation to oil subsidy alleviation: free health service
- Starting 2005: compensation to oil subsidy alleviation budget. Health insurance mechanism, the premium being paid by the central government

Health Insurance: Target

- 1st phase (Jan-June 2005)
  - All poor people (36,1 mill)
  - Rp 1 trillion (appr US$ 100 mill)
- 2nd Phase (Jul-Dec 2005)
  - Poor + near poor: (60 mill)
  - Rp 1.3 trillion (US$ 130 mill)

Positive Result (First phase)

Increased visits to health centers/hospitals by the poor

Health Center.

- **32.818.763 visits (utilization 15,13 % per month)**
- **Pregnancy visit: 386.711 (coverage 92,83 %).**
- **Delivery 374.468 (89,89 % of pregnancy)**
- **Infant care (94,21 % of delivery)**

Hospitals

- **Total visit: 293.739 .**
- **Pregnancy visit 30.167.**
- **Delivery: 27.529 (91,3 % of pregnancy)**
- **Infant care 25.923 (94,17% of delivery)**

Positive Lessons

- Fulfillment of people rights (constitution)
- Reducing inequality of access by removing cost barriers
- Potentially can leverage health status of the community
- Synergy increasing health status → Free access to basic educations and providing basic infrastructure to rural community
- Government role as: “price regulator” by establishing service standard, medical equipment standard and medicine standard

Negative Lessons

- Dependent to oil subsidy alleviation program. Question on the sustainability of the program
- Difficulties in finding “ the poor”
- Moral hazard: jealousy among the beneficiaries and non beneficiaries

Questions

Primary Policy that have major effects on health inequalities

- Oil booming during 1980s
  - Health infrastructure built nationally
  - Ample fund for supporting national helath agenda
  - Successful family planning
- Monetary crisis 1998-2000
  - Decreasing purchasing power
  - Poor people grew and unable to afford helath services
  - Dependency on foreign loan
- Desentralization in 2001
  - Information flow not working
  - Gov budget for health decrease proportionally
  - Helath policy are fragmented by district autonomy

Support for health goals form other sectors

- Mainly through health related project such as nutrition, water and sanitation
- During the crisis, agricultural sector provide free staple (rice) for the poor
- Familiy planning education has significat role in reducing maternal mortality

Opportunity exists

- Enactment of National Social Security System Law → trigering social protection to the community
- Decentralization→ advocacy to local governmnet is effective measure
- Mass Media freedom→ watchdog to any government program