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Out-of-Pocket Payments in the National Health Insurance of Indonesia: A First Year Review

Policy Brief

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Jaminan Kesehatan Nasional (JKN) is a national health insurance scheme launched in 2014 by the Government of Indonesia (GOI). The aim of the scheme is to provide insurance to the entire Indonesian population and to protect it from health-related financial shocks. One year after the launch, achievements have been made in covering about 145 million Indonesians and setting up the operating procedures of the scheme.

This policy brief presents recent evidence on the scheme's coverage effectiveness and the financial protection provided to JKN members. We conducted an empirical assessment of out-of-pocket (OOP) health payments incurred by JKN-insured patients in health facilities. The results show that on average, in 18% of cases patients still make OOP payments. Patients form households classified as poor suffer from the highest burden of OOP health spending (relative to their income). The major cost driver of OOP spending among various hospital services are medicines that patients purchase privately. Further details and policy options for policy makers to address the challenge of persistent OOP spending are presented below.

Introduction

Indonesia introduced a national health insurance programme (known as JKN) in 2014, based on the National Social Security (SJSN) Law No. 40 which was passed in 2004. This law laid out the legal basis for the establishment of a nationwide health insurance as part of the National Social Security system in the country.

Following the SJSN Law, the GOI subsequently enacted the so-called BPJS Law No. 24 in 2011. This required the integration of the various public health insurance schemes existing at that time into a single insurance system. The BPJS law also stipulated that a single health insurance carrier, namely BPJS Kesehatan, should be established to operate the JKN scheme from 2014 onwards.

The JKN programme aims to achieve Universal Health Coverage (UHC) for the entire population by 2019. Another objective of the reform was to protect the insured from the financial burden of healthcare costs by reducing OOP health care payments. According to the JKN regulation (i.e. Presidential Regulation No. 111/2013), there is no cost sharing applied in the scheme - in other words, the insured cannot be charged for a share of service costs at the point of health care use.

Prior to this JKN reform, Indonesia's national data suggested that 40-50% of total health expenditure was privately funded by patients. Since JKN was introduced a year ago, there has been anecdotal evidence, highlighted in the media, that suggests health care service providers still charge JKN members and that patients continue to incur significant OOP expenses. However, so far the magnitude, frequency and size of the phenomenon has not been assessed or measured in a systematic way.

Theoretically, the JKN programme does not apply cost sharing, i.e. the patient does not to have to pay cash at the point of health care use. However, anecdotal evidence suggested that healthcare providers still charged JKN members, and that patients still incurred significant OOP expenses.

Patient Exit Survey

In order to detect whether JKN fulfils its purpose and provides effective financial protection, the National Social Security Council (DJSN) commissioned a large scale study titled "The Financial Sustainability and Coverage Effectiveness of the National Health Insurance In Indonesia: A First Year Review". As one component of this study, a patient exit survey was conducted to generate empirical evidence on the current stage of the programme. The project was executed under the lead of the Social Protection Programme by CHAMPS FKM Institute, University of Indonesia. The project was funded and supported by German Development Cooperation in 2014/2015.

This is the first time in Indonesia that data has been gathered from one coherent pool of insured patients. After a brief depiction of the methodology used, this policy brief presents the main findings on the frequency, extent and type of OOP payments and the implications these have for households, one year after implementation of the JKN programme.

Survey design and data collection

A patient exit survey was conducted, using questionnaires and face-to-face interviews. The questionnaire contained mostly close-ended questions to capture information on individual patient and household characteristics, health insurance membership, the use of outpatient and inpatient care, OOP payments for services as well as patient satisfaction levels. Details on OOP payments were collected for various direct medical cost items, including: administration, consultation, diagnostic and laboratory tests, drugs (purchased in and out of the facilities) and other payments.

Data collectors conducted patient interviews on site. To participate in the survey, a respondent had to be over 18 years old and be either a discharged patient or a family member accompanying a discharged patient. The patient had to be a member of JKN. Data collection took place between March and May 2015. The confidentiality of hospitals and study participants was assured during the survey itself as well as during the analysis, as data were treated anonymously throughout.

The survey sites - except Jakarta - were randomly selected (Table 1). The selection was conducted at regional level, based on the five regional price groups for hospitals (defined in the Ministry of Health decree No. 59/2014). The case-based group (CBGs) tariffs vary in those five regional groups. Such a selection of the survey hospitals ensured that facilities from all five reimbursement groups were represented in the survey. This in turn allowed systematic variations between the regions to be identified.

We then randomly selected a province from each of the regional groups and purposively included Jakarta. The selection of the survey hospitals was done purposively to ensure that hospitals of different specialisations and types of ownership (e.g. private, public) were represented. Moreover, different classes of hospitals were included from each province:

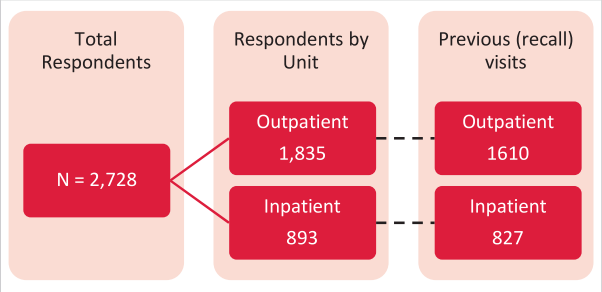
- Class A hospitals offer a broad range of highly specialised services and have more than 400 beds;
- Class B hospitals usually operate multiple specialties and have at least 200 hospital beds;
- Class C are general hospitals with basic specialist services in internal medicine; obstetrics and gynaecology and paediatrics with minimum 100 hospital beds;
- Class D hospitals provide general services and have a minimum of 50 beds.

Table 1. Sample by survey site and type of hospital

	ALL		OUTPATIENTS		INPATIENTS	
	N	%	N	%	N	%
Total respondents	2728	100%	1839	67%	889	33%
Province						
Jakarta	550	20%	368	20%	182	20%
East Java	367	13%	215	12%	152	17%
West Nusa Tenggara	478	18%	250	14%	228	26%
South Kalimantan	499	18%	397	22%	102	11%
East Kalimantan	468	17%	313	17%	155	17%
North Sulawesi	366	13%	296	16%	70	8%
Hospital class						
A	818	30%	593	32%	225	25%
B	1298	48%	928	50%	370	42%
C	433	16%	276	15%	157	18%
D	179	7%	42	2%	137	15%
Hospital ownership						
Local Government	1155	42%	831	45%	324	36%
Central Government	318	12%	206	11%	112	13%
Private	765	28%	583	32%	182	20%
Social Organisation	267	10%	140	8%	127	14%
Military (TNI/Police)	223	8%	79	4%	144	16%
Hospital Specialisation						
Mother & Child	111	4%	40	2%	71	8%
Surgical	84	3%	53	3%	31	3%
Cardio	269	10%	184	10%	85	10%
Cancer	170	6%	144	8%	26	3%
General	2094	77%	1418	77%	676	76%

Exit-interviews were conducted with patients (or accompanying family members) upon discharge from outpatient and inpatient units in 24 hospitals in the six selected provinces. A total of 2,728 respondents participated in the survey, of which 1,835 were outpatients and 893 inpatients. In addition, the survey included recall questions on previous hospital visits. The recall period was one month for outpatient and 12 months for inpatient treatments. The respondents reported 1,610 previous outpatient and 827 inpatient visits. Overall, 3,445 outpatient cases and 1,720 inpatient cases were reported (Figure 1).

Figure 1. Patient sample and recall visits



The patients can be grouped into the following categories of JKN members:

1) Poor and near-poor (Penerima Bantuan Iuran, PBI), whose premiums are fully covered by GOI at a rate of IDR 19,225 per month.
2) Salaried formal employees (Pekerja Penerima Upah, PPU) in the public and the private sector, who are required to pay a contribution equivalent to 5% of their salary (4% paid by the employer and 1% by employee).
3) Non-salaried workers in the informal sector (Pekerja Bukan Penerima Upah, PBPU) and the unemployed (Bukan Pekerja, BP), who - like self-employed and investors - pay a fixed monthly contribution of IDR 25,500-59,500.

Findings

OOP payments can be defined as payments made by patients for health services at the point of use. We report the number of patients who encountered OOP health payments and the amount patients had to pay per episode of care. These sample findings are disaggregated by various subgroups of patients, types of OOP expenses and hospital characteristics. Key findings of the analysis are given in Box 1.

Box 1. Key findings

By law, JKN provides comprehensive benefits free of charge. Hospitals are explicitly not allowed to charge JKN patients for services, yet our findings suggest that patients still incur OOP expenses as follows:

1. Overall, 18% of the respondents paid OOP at health care facilities. About one in eight outpatients (13%) and 28% of the inpatients were charged. The average (mean) OOP expenditure was IDR 235,945 for outpatients and IDR 1,244,786 for inpatients.
2. The incidence of OOP payments did not vary significantly according to patients' socio-economic characteristics. Patients from the wealthiest quartile paid almost as often OOP expenses (14% for outpatients and 29% for inpatients) as the poorest (11% for outpatients and 27% for inpatients).
3. In absolute terms, the richer patients had higher OOP spending, on average IDR 292,372 in outpatients and IDR 1,794,091 in inpatients. The poorest paid on average IDR 202,667 in outpatients and IDR 403,000 in inpatients. However, when comparing the OOP spending to the household incomes, the poorer patients faced a significantly higher burden than patients from the richer quartiles.
4. The major driver of OOP incidence was spending on medicines, which accounted for about 70% of all OOP. Most of the medicines were purchased outside of the treatment facility (for outpatients 210 versus 88 cases for internal purchase and for inpatients, 212 cases versus 122 cases, respectively).
5. We found variations in OOP expenses depending on the type of facility. The highest payments were made in private, cancer and type D hospitals. In Jakarta outpatients paid on average the highest charges, whilst in South Kalimantan inpatients were charged the most.

1. *Incidence and extent of OOP health payments*

For all the reported visits, on average 18% of the patients in our sample paid charges at health care facilities. 13% of the outpatients and 28% of the inpatients paid a bill at the hospital.

To calculate the amount of OOP health payments, we calculated all the payments patients reported to have made for services obtained in the hospital. As the costs data have a large variance and a skewed distribution, Table 2 reports OOP expenditure on average as well as the median, the 75th percentile and the maximum amounts.

Table 2. Overall OOP payments (IDR & US$)

	Outpatients		Inpatients	
	IDR	USD	IDR	USD
Mean	235,945	18	1,244,786	95
Median	95,000	7	256,000	20
p75	200,000	15	975,500	75
Max	6,000,000	459	33,500,000	2,563

While the mean OOP expenditure for outpatients was IDR 235,945 (or US$ 18 in 2015), the median was just IDR 95,000 (US$ 7). Indeed, about 20% of the respondents reported OOP health costs of less than IDR 20,000. The maximum OOP was IDR 6 million (US$ 459).

Overall OOP health costs for inpatients were considerable, with an average of IDR 1,244,786 (US$ 95) per person, with some patients paying up to IDR 33,500,000 (US$ 2,563). To estimate the financial burden of OOP spending on households, we looked at the OOP expenses as a share of monthly household income (Table 3). Overall, OOP health care expenditure amounted to 11% (median 3%) and 78% (median 10%) of household monthly income for out- and inpatients, respectively.

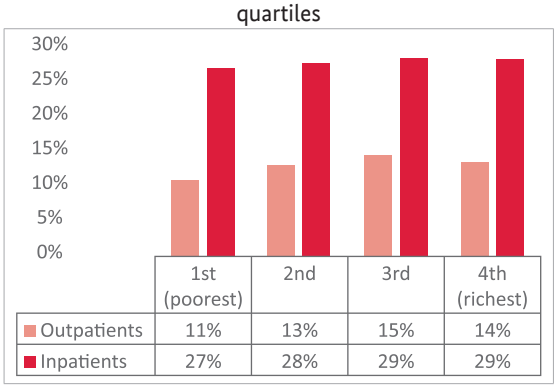
Table 3. OOP payments as share of monthly household income

	Outpatients	Inpatients
Mean	11%	78%
Median	3%	10%
p75	10%	30%
Max	200%	6667%

2. *Incidence of OOP health payments by income groups*

The incidence of OOP expenditure was fairly evenly distributed across patient income quartiles (Figure 2). Higher income groups were slightly more likely to incur OOP costs compared to lower income groups (14% versus 11% in outpatients and 29% versus 27% in inpatients).

Figure 2. Incidence of OOP payments by income quartiles



Looking at absolute OOP amounts for outpatients (Figure 5) and inpatients (Figure 4), the 1st quartile paid – somewhat surprisingly – a bit more than the 2nd quartile (IDR 202,667 and IDR 187,175 for outpatients, IDR 1,066,488 and IDR 730,000 for inpatients), while the third and fourth quartile paid – as expected – considerably more (up to IDR 292,372 for outpatients and IDR 1,794,091 for inpatients).

Figure 3. Average OOP payments (IDR): Outpatients by income quartiles

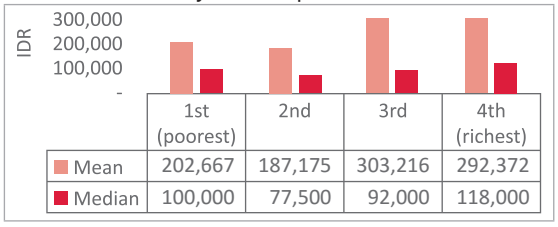
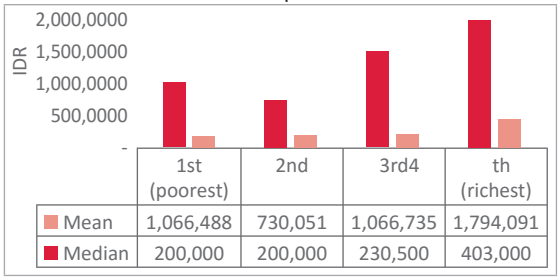


Figure 4. Average OOP payments (IDR): Inpatients by income quartiles



Another way to look at OOP spending is to compare it to patients' household income (see Figure 5 and Figure 6). When OOP expenses were measured as a percentage of monthly household income, lower income groups spent a much larger share. This pattern holds for both out- and inpatients. In our sample, the average OOP costs for outpatients was 21% of monthly income for the lowest quartiles and 3.4% for the highest quartiles. The numbers for inpatient care were much higher. In particular, the gap between the financial burden for the poorest, who on average spend 179.8% of their income, and the richest with 3.4%, shows dramatically.

Figure 5. OOP payments for outpatients as share of household income

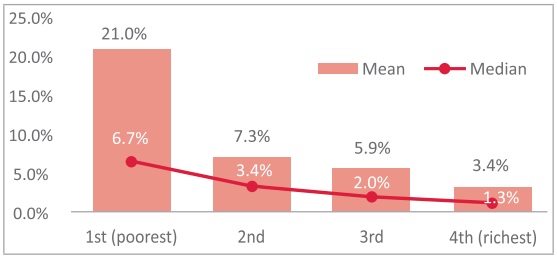
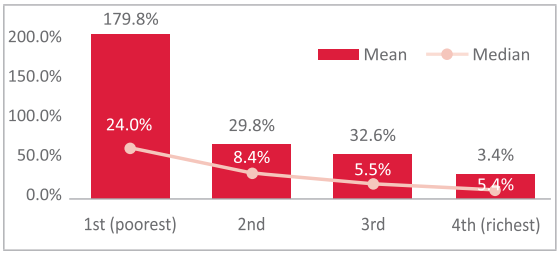


Figure 6. OOP payments for inpatients as share of household income

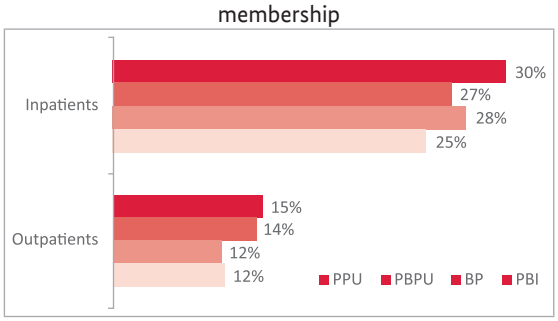


3. *OOP health payments and JKN membership category*

As the JKN membership categories are highly correlated with the socio-economic status of the members (e.g. PBI members are per definition poor), similar OOP payment patterns occur when looking at OOP spending by JKN membership category as above.

A patient's type of JKN membership did not strongly influence the incidence of OOP payments. In other words, patients were charged irrespective of their membership category. The variation in OOP health payments according to JKN membership type is shown below (Figure 7). In outpatients, the lowest incidence of OOP payments (about 12%) is observed among PBI and BP members, followed by PBPU and PPU members (14% and 15%). The pattern is similar for inpatients, where PBI members experienced the lowest incidence of OOP charges (25%) and PPU the highest with 30%.

Figure 7. Incidence of OOP payments by JKN membership

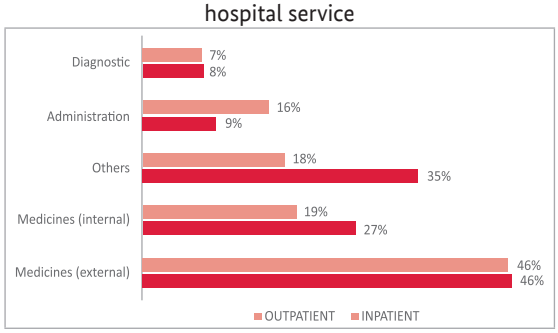


As for absolute amounts, PPU members paid the largest OOP charges for health services. These findings were consistent for both outpatients (IDR 275,031) and inpatients (IDR 1,571,585). PBI members had the smallest expenditure, with IDR 123,299 and IDR 492,392 for out- and inpatients respectively.

4. *OOP health payments by type of service*

Patients who incurred OOP spending were asked about the services they had to pay for. Spending on medicines was the most important driver of OOP expenditure. Figure 8 shows that OOP charges for medicines, purchased within (internal) or outside (external) the facilities, together accounted for about 70% of the OOP health expenditure for outpatients and inpatients. The second largest OOP item was unspecified costs, followed by administrative and diagnostic costs.

Figure 8. Incidence of OOP payments by type of hospital service



5. *OOP health payments by hospital characteristics*

The structure of OOP expenditure varied according to the type of hospital. Patients had to pay charges most frequently in military, surgical, Type C and D hospitals, and hospitals located in West Nusa Tenggara and North Sulawesi.

The largest OOP payments (see Figure 9) were observed among patients who sought services (inpatient and outpatient) at private, cancer and type D hospitals. Geographically, on average the largest OOP payments were charged in Jakarta (IDR 395,441) and South Kalimantan (IDR 2,278,373) for outpatients and inpatients respectively.

Figure 9. OOP payments by hospital type

	OOP in outpatients			OOP in inpatients (IDR)		
	Mean	Median	Max	Mean	Median	Max
Private Hospital	306,610	50,000	4,300,000	2,046,922	250,000	27,000,000
Cancer Hospital	487,448	180,000	6,000,000	1,960,225	450,000	20,000,000
D Type Hospital	358,442	195,000	1,700,000	1,777,375	450,000	33,500,000

Implications and Conclusion

The findings presented in this brief provide a snapshot of OOP health expenditures in six provinces in Indonesia 15 months after the JKN scheme was implemented. The information collected through patient exit-interviews focuses on curative care for outpatient and inpatient care.

In the year since JKN has been implemented the system has demonstrated promising progress in improving access to health care for those insured. However, efforts to prevent OOP expenditure need to be strengthened and become more focused to ensure that such payments can be eradicated in the near future. Against this backdrop, it is important for policy makers to continue to focus on the persistent challenge of guaranteeing financial protection for the population. The urgency of the situation must be taken into account by policy makers with visible policy steps.

The following part of this brief lists policy recommendations for Indonesia. The options are categorised into four steps, and they need to be adopted simultaneously. Future surveys will be useful both to monitor progress of JKN implementation as well as to evaluate the impact of future policy interventions.

The policy implications of this study highlight the need for the Government of Indonesia to provide further regulative and technical support to JKN implementation. The main policy challenge is to realise the government's intent to establish a JKN insurance scheme that does not require additional OOP health care expenses.

Making medicines accessible

The medicines component is the biggest driver of the OOP expenditure for the insured who access healthcare services. One reason for this phenomenon may be the unavailability of medicines at facilities. Consequently ensuring better provision of medicines should be a policy priority to remedy this problem.

There is clearly an urgent need to strengthen and supplement the existing pharmaceutical distribution system at health care facilities. This could be done through refining the national formulary. Furthermore, it is important to frame appropriate regulatory mechanisms to control prescribing practices at health facilities. In addition, an improved management approach to prescription practice by JKN providers is crucial. This would include the development of a computerised system to feed the prescription data, generate evidence and allow regular analysis. The sound management of medicines is the key to effective access for patients but also for the financial sustainability of the JKN scheme.

Improving oversight of JKN implementation

This study provides evidence that OOP health expenses still potentially push some insured patients into poverty. Our findings suggest that it is important to improve oversight of JKN implementation, and in particular the behaviour of providers, as a way of enhancing financial protection of the insured.

A lack of transparency at health facility level is evident, as a significant proportion of OOP payment practices are not recorded. In about 77% of OOP cases the respondents did not receive any upfront explanation from health care providers about why the payment was required. Among inpatients who reported OOP expenditure, the survey also found that 26% did not receive proof of payment or a receipt. Hence, there is a need to enhance the transparency and accountability at provider level as part of the JKN implementation. There is also a need to regulate healthcare providers in order to prevent the current charging practices.

Providing information to JKN members about insurance and JKN

Asymmetric information is one of the main characteristics of the health care market. In general, consumers of health care do not know what type of services they need when they visit health facilities. Insured patients also have limited information about the services they receive and whether the services are covered by JKN or not. A lack of information is evident in our sample as 17% of those insured were convinced that they had to pay additional OOP expenses for hospital services. This finding indicates that JKN members need to be made aware of their patient rights and that medical bills are paid without additional charges to patients. The JKN scheme has undoubtedly made progress towards improving access to health care, but protecting patients from OOP health payments remains a challenge to be addressed especially for poorer population groups. Policy makers and providers need to focus on this challenge and ensure that there is a shift away from OOP payments, which will otherwise hamper the government's goal of UHC.

Acknowledgements

We would like to sincerely thank the Board of Directors of BPJS Kesehatan for granting us access to the claims data and other important information as well as for connecting the research team with the hospitals sampled in the study. We are grateful to the Ministry of Health especially the Director of the P2JK Unit and his team who have provided valuable inputs during the preparation of the study and facilitated that the results of the study were taken into account by the Government of Indonesia (especially in the modification of the contributions). The completion of this study would not have been possible without the great expertise and commitment of CHAMPS FKM UI.

Imprint

Published under the Indonesian-German Social Protection Programme (SPP), a programme jointly implemented by the Indonesian Ministry for National Development Planning and GIZ implementing the German contribution on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ).

Jakarta, November 2015
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