Social Health Insurance in Indonesia: Towards universal coverage for the poor?

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Indonesia Update 2010
Motivation

• Indonesia’s ambition of universal health insurance 2014
  – Shift from subsidized care with targeted fee waivers for the poor
to universal social health insurance
• Health care utilisation and public spending relatively low
  – Falls behind its Southeast Asian neighbours
• Inequality in health care utilisation relatively high
• Potential impacts
  – Equity: health care utilization and overall health status
  – Social risk management: financial protection from health shocks
Contribution of this chapter

• Questions remain regarding
  – Main drivers of inequity and financial risk
    • Direct costs: medical expenses
    • Indirect costs: foregone income, travel
  – Scope for public intervention
    • Existing coping strategies to deal with health shocks
      (reduce savings, incur debt, sell assets, forgo health care, …)
    – Potential effectiveness of SHI
• Explore lessons and future challenges for universal SHI
  – Health care utilization and financial protection 2001-2007
  – Health financing programs for the poor in last decade
    • Overview and impact
Financial risk of illness

Illness → Medical costs → Indirect costs → Reduced Income → Coping strategies

Coping strategies → Living conditions Consumption Poverty

Long term effects
- Assets
- Human capital

SHI, SSN
Policy context: health financing and insurance

• Social health insurance up to 2005
  – SHI for formal sector employees; mandatory contributions
• SSN health card program 1998-2005
  – User fee waiver, targeted to the poor; crisis response
• Social health insurance for the poor after 2005
  – SHI to the informal sector; subsidized contributions
  – Comprehensive benefit package
• Decentralization 2001
  – Public health spending decentralized to districts
  – Districts are operating their own HI initiatives
• Current challenge
  – Move from situation with parallel systems and half population uninsured, to universal SHI
Access to care: health care utilization

- Inequity in access to health care reduced, but still sizable
- Health care utilization has increased strongly
- Public care pro-poor
- Private care mainly non-poor
Health shocks and coping

- Households’ ability to self-insure against health shocks
  - Small shocks can be insured, but full insurance not feasible
  - Large shocks and chronic illness not able to insure
  - Main financial risk lies with infrequent “catastrophic” spending and loss of income

- Micro finance institutions and informal credit
  - Seem effective in dealing with direct costs (medical expenses) and indirect (reduced income) of illness

- Remaining questions
  - Transmission channels?
  - Coping strategies by households?
Impact of SHI

• Reducing direct costs of health care has increased access to public services
  – Effects are larger for the poor than the non-poor, suggesting poor are more responsive to price changes
  – Direct costs of care remain a sizable barrier
  – UC could potentially reduce gap poorest-richest by half

• However, effectiveness hampered by:
  – Poor (perceived) quality of care leads to reluctance to use subsidized public care
  – Awareness and knowledge about social programs lacking
  – Direct and indirect costs of using social programs relatively higher for the poor

• Premiums for subsidized SHI too low
Conclusions

- Inequity in access to health care reduced, but still sizable
  - The poor still under-utilize health care
- SHI could reduce financial risk and barrier to health care
- However, not all barriers overcome:
  - Quality of public care is (perceived) low
  - Medical expenses only part of financial burden from illness
  - Benefit package needs to be carefully considered
    - Comprehensive package feasible?
    - Focus on spreading risk of catastrophic spending
- Future research:
  - Channels of financial risk and coping behavior
  - Provider payment mechanisms