

Exploring innovative approaches to universal health coverage: Lessons from Indonesia's healthcare financing reforms

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Executive summary

Indonesia has made significant strides in health financing reforms, particularly through the implementation of the *Jaminan Kesehatan Nasional (JKN)* programme. These reforms have led to increased government health spending and reduced out-of-pocket expenditures, contributing to improved access to healthcare services. The JKN, a compulsory national health insurance scheme, covers a broad spectrum of healthcare needs and has the highest membership of any single-payer system globally. Indonesia has focused on fiscal measures such as raising tobacco taxes to increase health budgetary space.

Despite successes, challenges remain in extending coverage to informal sector workers and addressing disparities in service accessibility across regions. The review of Indonesia's health financing approaches provides valuable insights for other countries, particularly in leveraging private sector participation, enhancing revenue and risk pooling, and decentralising health spending to improve service delivery.



Key messages

- Single-payer systems can reduce fragmentation and enhance risk pooling
- Addressing coverage gaps in the informal sector requires innovative strategies beyond voluntary contributions
- Decentralisation enhances access to services and allows local prioritisation based on specific needs.
- Leveraging private sector participation can meet healthcare demand effectively.



The review of Indonesia's health financing approaches provides valuable insights for other countries, particularly in leveraging private sector participation, enhancing revenue and risk pooling, and decentralising health spending to improve service delivery.

Background

Indonesia's population as of September 2020 was 270.2 million, with a population density of 141 people/km² and an average population growth rate of 1.25% [1]. It has 34 provinces, with the most populated province (West Java) at 48.27 million, while the least populated province is North Kalimantan at 0.7 million [1]. The poverty rate in 2019 was 9.4%, down from 19% in 2000 [2]. Indonesia's average annual gross domestic product (GDP) growth rate was 5.3% between 2000 and 2018, while the gross national income (GNI) per capita in 2018 was US\$3,840, up from US\$580 in 2000.

The Government of Indonesia's (GOI) health financing sources include social security contributions (from employers, salaried workers, and non-salaried workers) and general and local taxes [3]. In 2021, the domestic general government health expenditure (GGHE-D) as a percentage of current health expenditure (CHE) was 59%, private spending (including out-of-pocket at 27%) was 39%, and external donors accounted for only 2% of CHE. Indonesia's total health expenditure translated to USD161 per capita and 4% of GDP in 2021. The public and private sources significantly contributed to health financing [4].

Universal health coverage (UHC) is a country's global declaration and commitment to ensure people have access to health services without experiencing financial difficulty [5].

UHC is among the targets for achieving the Sustainable Development Goals (SDGs) [6]. Indonesia has made some progress in health service coverage and health financing indicators toward achieving UHC through various financial reforms [7, 8]. The Tracking Universal Health Coverage: 2017 Global Monitoring Report indicators were used to calculate Indonesia's service coverage index, and the UHC service coverage index was reported at 60 out of 100 [8]. Notably, in 2021, the UHC service coverage index was 62/100 in South East Asia and 44/100 in Africa [9] while the indicator SDG 3.8.2, which monitors financial risk protection, recorded Indonesia's financial risk protection at 55% in 2021 [10].

The Indonesian government set ambitious targets for 2019 around various health indicators. There have been significant improvements in health outcomes, such as reduced maternal mortality ratio, nutrition, malaria elimination in some districts, drug availability, and quality at the community health centres [2] (Table 1). This review aims to explore the approaches adopted by the Indonesian government towards achieving UHC and drawing from the lessons learned in the process that could inform African countries' initiatives.

Table 1: Indonesia's health sector development targets

Indicators	Baseline (2014)	Current status (latest data available between 2019 to 2022)
Maternal mortality ratio (per 100,000 live births)	346	173
Infant mortality rate (per 1,000 live births)	32	20
Underweight prevalence, percent of the population	19.6%	17.7%
Stunting prevalence, percent of the population	32.9%	30.8%
TB prevalence (per 100,000 population)	297	385
HIV prevalence, percent of the population	0.33%	0.3%
Number of districts where malaria has been eliminated (# district)	212	266
Hypertension prevalence, percent of the population	25.8%	32.4%
Obesity prevalence, percent of the population	15.4%	20.7%
Smoking prevalence among <= 18year-olds, percent of all Indonesians aged 18 and below	7.2%	8.8%
Number of subdistricts with at least one accredited Puskesmas (# subdistricts)	0	1308
Districts with >= 80 percent fully immunized infants	71.2%	85.4%

Number of districts with at least one nationally-accredited hospital per city	10	201
National Social Health Insurance coverage/membership, percent of the population	51.8%	81%
Number of Puskesmas with five types of health personnel	1015	1618
Percent of type C hospitals with seven specialists	25%	45.2%
Availability of drugs and vaccines at Puskesmas	75.5%	81.6%
Quality drugs at Puskesmas*	92%	98.7%

Sources: Indonesia public expenditure review [2], The World Bank Data [11] *Puskemas (community health centers)

Methods

The review included an in-depth review of relevant data adopting the WHO's framework on health financing that guided the data collection and synthesis. The critical health financing functions identified themes from the WHO framework, including revenue raising, financial and risk pooling, strategic purchasing, governance, and institutional arrangements such as decentralisation [12]. The documents reviewed included health financial reports, policy documents, health survey reports, and research sources, including published literature and gray literature. The review provides a rapid situational analysis of Indonesia's financing reforms landscape.

Findings

Financial and risk pooling

Indonesia launched a compulsory national health insurance scheme, *Jaminan Kesehatan Nasional* (JKN), in 2014 [3, 13]. JKN offers comprehensive healthcare coverage such as promotion of health, services in preventative, curative, and rehabilitative medicine, medically necessary laboratory tests, medications, supplies, and referral ambulance services. Notably, HIV and TB diagnostics and treatment services are included in the JKN benefits package [3]. The JKN was the largest single-payer health insurance scheme globally as of 2021, with 225.9 million Indonesians (about 83% of the population) as members [14]. Some strategies adopted by GOI towards the increased coverage include: subsidising premiums for the informal sector to attract a larger pool of membership, updating the JKN premiums based on sound actuarial analysis, and monitoring and tracking legally mandated health spending [2].

The JKN scheme, which provides total subsidies to the poorest, 40% of the population, is funded by central and local government income [3]. Indonesia has had a steady development trajectory over the past 20 years, primarily attributed to its macroeconomic stability, where the average

annual economic growth between 2000 and 2018 grew by 5.3%. In addition, prudent fiscal management through the public expenditure review has supported quality and efficiencies in spending in the public financial management, intergovernmental fiscal transfer system, and data for better policy-making [2].

The health insurance and risk pooling is from a combination of four public health insurance schemes, namely: *Askes* (social health insurance, SHI for civil servants), *Jamkesmas* (community health insurance, CHI scheme that is government financed, targeting people experiencing poverty), *Jamsostek* (SHI for private sector employees) and *Jamkesda* (local government-financed health coverage) [15]. Between 2018 and 2019, there have been reforms to the JKN, such as restructuring the capitation and provider schemes, piloting the pay-for-performance schemes, enhancing the capabilities for evaluating health technologies, and requiring accreditation of all contracted health facilities [15]. Currently, private hospitals—both for-profit and non-profit—make up 64% of the hospitals offering services under the JKN [15].

Revenue raising

Indonesia has the highest rates of tobacco consumption globally. The top five leading causes of death in Indonesia are tobacco-related risks such as ischemic heart disease, stroke, newborn diseases, diabetes, and tuberculosis (TB) [2]. Notably, tobacco control is critical to decreasing the health and economic burden caused by smoking. The health consequences of smoking are being addressed by more robust policies and regulations as well as tobacco tax reforms that include increasing cigarette excise tax to prevent smoking initiation. The "sin tax" on tobacco offers the opportunity to expand revenue collections earmarked for healthcare. GOI has multiple taxation on cigarette consumption, including cigarette excise, the subnational government (SNG) cigarette tax, and the value-added tax (VAT). As of 2022, the SNG cigarette tax is charged at 10% of the cigarette excise, while the VAT for cigarettes was increased in 2022 to 9.9% of the selling price, up from 8.7%

before 2017 [16]. Further, in December 2022, a tobacco excise tariff was signed to increase the tobacco tax rates to 12.5% [17].

Strategic purchasing

Indonesia's healthcare system operates under a single purchaser model, managed by the *Badan Penyelenggara Jaminan Sosial – Kesehatan* (BPJS-K), where strategic purchasing responsibilities are shared between BPJS-K and the Ministry of Health (MOH) [7]. Unlike some systems, Indonesia's approach does not incorporate co-payments or global caps on expenditures, aiming to enhance accessibility and coverage [7]. GOI strategies in ensuring efficiencies include addressing the financial and institutional fragmentations and reinforcing performance-based financing by (1) investing in health information systems to improve monitoring and evaluation of health spending performance and (2) implementing cost-effective referral pathways [2].

Governance and institutional arrangements

The GOI has elaborate funds transfers of revenues from the central government to the district level with an allocation that is earmarked for health known as *Dana Alokasi Khusus* (DAK) and other unconditional grants at the discretion of the district governments for allocation to the health sector [2]. More than two-thirds of all public health spending takes place at the subnational level compared to a third of spending by the national government [2]. For instance, the share of general expenditure by the level of government (%) was 53% at the district level, 14% at the provincial level, and 33% for the national government [2].

Notably, the JKN subsidy programme for low-income people is the largest source of district and facility health revenue [2]. However, different local health financing changes are being implemented at various times and in multiple ways across districts [18] which has led to the strained capacity of local governments. To address this systemic constraint, the government is exerting efforts to improve coordination among agencies between central and sub-national governments through data-sharing programmes and investments in decision-making. Additionally, aligning districts' revenue autonomy with their spending responsibility incentivizes districts to exert more tax effort [2].

Gaps and challenges from Indonesia's financing reforms

The public insurance programme in Indonesia protects people with low incomes from wasteful spending. However, there are disparities in other districts where certain services are not offered because of structural underfunding and



supply-side limitations [19, 20]. For instance, disparities exist around healthcare utilisation due to limited health infrastructure and workers in rural regions, thus limiting the accessibility and availability of services [3].

The 2021 National Labor Force Survey (*Sakernas*) conducted by the Indonesian Central Bureau of Statistics (BPS) reported approximately 63.57% of total employment in Indonesia was categorised as informal employment, excluding unpaid family workers and employees in informal sector enterprises that operate outside the scope of formal labor regulations and social protection mechanisms [21]. Importantly, informal sector workers and families not included in any social protection programmes still face low health insurance coverage, with only 13.6% registered [3]. Most informal groups do not qualify for the full subsidy meant for people experiencing poverty and struggling to pay their regular contributions independently. Consequently, this leads to insurance coverage gaps [3].

Despite the reduced OOP expenses since the introduction of JKN, the OOP spending of 34.8% in 2018 is still relatively high [15, 22], where 2.71% of Indonesian households were predicted to incur catastrophic medical costs in the same year [3]. In addition, Health-related shocks cause nearly four million people to fall into poverty [2]. Some reported reasons for the increased OOP expense include inaccessible or limited health facilities contracted by JKN, especially in the rural areas, making the residents in the non-contracted health facilities pay directly for medical care; opportunity costs such as the long wait times and transportation costs result to additional non-medical costs and; the need to purchase medications that are not on the JKN's list of approved medications [3, 23].

Discussion

The health financing reforms have seen Indonesian government health spending as a percentage of current health expenditures (CHE) nearly double from 25.7% in 2010 to 59% in 2021 [15, 22]. In addition, out-of-pocket spending has substantially reduced, from 59% of current health expenditure in 2010 to 34.8% in 2018 [15, 22]. Indonesia's health financing focuses on bridging the equity gaps in accessing healthcare services. People with low income obtained a more considerable proportion of the healthcare benefits from health services than people with high income; the distribution of healthcare benefits in the public sector was modestly pro-poor [24]. Further, JKN ensures an elaborate referral system where only patients who have received a valid referral from a primary healthcare provider are allowed access to specialist care [25]. Thus, decreasing the constraints at the higher level of health facilities from non-specialist diagnoses increases the workload that could be managed at the primary health care points.

Indonesia has successfully developed strategies to increase fiscal space for health by raising tobacco taxes, and there has also been a proposal to phase out fuel subsidies. The country has been experiencing a favorable macroeconomic environment. For example, the economy grew by 5.3% on average, supported by prudent fiscal management that enhanced budgetary policy credibility. The fiscal deficit remained at 1.5% of GDP between 2000 and 2019, staying below the standard threshold of 3% of GDP, while the public

debt-to-GDP ratio decreased from 83% in 2000 to 30.2% in 2019, below the standard public debt threshold of 60% of GDP [2]. A macroeconomic modelling study on the cigarette tax increase showed a positive net income in terms of aggregated economic output, household income, and employment by Rp84.2 trillion, Rp24.1 trillion, and 400.3 thousand jobs, respectively [16].

The lessons from the reforms and implementation of prioritised domestic health financing initiatives include: (i) The private sector in Indonesia has over half of all health services and two-thirds of all health financing. Indonesia has tapped into the thriving private sector by including most private health service providers in the JKN [15]. This increases the supply and meets the demand for services; (ii) The JKN single-payer health systems provide increased revenue and a risk pooling mechanism that ultimately expands multiple benefits, including HIV and TB healthcare. Further, JKN reduces fragmentation and provides a single risk pool [3]; (iii) The extension of health insurance coverage from those in the informal sector is quite a challenge, primarily due to the voluntary contributory registration that is mainly ineffective compared to the mandatory contribution targeted principally to those employed [3]; and (iv) GOI has had excellent development success in its decentralisation strategies to over 500 sub-national governments where more than two-thirds of all public health spending takes place at the subnational level providing increased access to services and prioritising based on needs for each of the sub-national governments [2].



Photo: RTI International/ Muhammad Fadli

Conclusion

In conclusion, Indonesia's health financing reforms, particularly implementing the JKN programme, have significantly improved government health spending and reduced out-of-pocket expenditures. The focus on equity in healthcare access has resulted in a more balanced distribution of benefits, particularly favouring low-income individuals. Moreover, the emphasis on an elaborate referral system within the JKN framework has optimised the utilisation of healthcare resources and reduced unnecessary burdens on higher level facilities. Additionally, strategic

fiscal measures, such as increased tobacco taxes, have expanded budgetary space for health while generating positive economic outcomes. Lessons learned from these reforms underscore the importance of leveraging the private sector, implementing single-payer systems, and addressing challenges in extending health insurance coverage to informal sector workers. Overall, Indonesia's experience highlights the potential for effective health financing strategies to drive progress toward universal health coverage and improve health outcomes for all segments of society.

References

1. BPS – Statistics Indonesia. The Indonesian Population Census 2020 Highlights. 2020.
2. Hafez R, Harimurti P, Pambudi E, Rajan V. Indonesia Public Expenditure Review: Spending for Better Results. 2020.
3. International Labour Organization. Extending social health protection: Accelerating progress towards Universal Health Coverage in Asia and the Pacific. 2021.
4. WHO. Global Health Expenditure Database. <https://apps.who.int/nha/database/Select/Indicators/en>. Accessed 2 Jul 2023.
5. World Health Organization (WHO). Universal Health Coverage: What it is. 2013.
6. United Nations. Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development.
7. Atim C, Bhushan I, Blecher M, Gandham R, Rajan V, Davén J, et al. Health financing reforms for Universal Health Coverage in five emerging economies. *J Glob Health*. 2021;11:16005.
8. Herawati, Robert Franzone, Adrian Chrisnahutama. Universal Health Coverage: Tracking Indonesia's Progress. Jakarta; 2020.
9. WHO. UHC service coverage index. 2023.
10. World Health Organization. The Global Health Observatory_Indicators.
11. The World Bank. Indonesia | Data. <https://data.worldbank.org/country/indonesia>. Accessed 22 May 2024.
12. Kutzin J., Witter S, Jowett M, Bayarsaikhan D. Developing a national health financing strategy: a reference guide (Health Financing Guidance No 3). Geneva; 2017.
13. Sharma M, Teerawattananon Y, Luz A, Li R, Rattanavipapong W, Dabak S. Institutionalizing Evidence-Informed Priority Setting for Universal Health Coverage: Lessons From Indonesia. *Inquiry (United States)*. 2020;57.
14. Maulana N, Soewondo P, Adani N, Limasalle P, Pattnaik A. How Jaminan Kesehatan Nasional (JKN) coverage influences out-of-pocket (OOP) payments by vulnerable populations in Indonesia. *PLOS global public health*. 2022;2:e0000203.
15. Asante A, Cheng Q, Susilo D, Satrya A, Haemmerli M, Fattah RA, et al. The benefits and burden of health financing in Indonesia: analyses of nationally representative cross-sectional data. *Lancet Glob Health*. 2023;11:e770–80.
16. Bella A, Swarnata A, Vulovic V, Nugroho D, Meilissa Y, Usman U, et al. Macroeconomic impact of tobacco taxation in Indonesia. *Tob Control*. 2023;0:1–7.

17. Southeast Asia Tobacco Control Alliance. SEATCA Tobacco Tax Index: Implementation of WHO Framework Convention on Tobacco Control Article 6 in ASEAN Countries 2021.
18. Sparrow R, Budiyati S, Yumna A, Warda N, Suryahadi A, Bedi AS. Sub-national health care financing reforms in Indonesia. *Health Policy Plan.* 2017;32:91–101.
19. Pratiwi AB, Setyaningsih H, Kok MO, Hoekstra T, Mukti AG, Pisani E. Is Indonesia achieving universal health coverage? Secondary analysis of national data on insurance coverage, health spending and service availability. *BMJ Open.* 2021;11.
20. Erlangga D, Ali S, Bloor K. The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data. *Int J Public Health.* 2019;64:603–13.
21. Indonesian Central Bureau of Statistics (BPS). National Labor Force Survey (Sakernas) . 2021.
22. The World Bank. The World Bank in Indonesia. <https://www.worldbank.org/en/country/indonesia/overview>. Accessed 28 Aug 2023.
23. Ursu I, Rabovskaja V. Financial Sustainability and Coverage Effectiveness of the Indonesian Health Insurance System The role of benefit package design and pharmaceutical policy. 2017.
24. Asante A, Cheng Q, Susilo D, Satrya A, Haemmerli M, Fattah RA, et al. The benefits and burden of health financing in Indonesia: analyses of nationally representative cross-sectional data. *Lancet Glob Health.* 2023;11:e770–80.
25. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Suparmi, Achadi EL, et al. Universal health coverage in Indonesia: concept, progress, and challenges. *Lancet.* 2019;393:75–102.

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