The development of Community Health Care Insurance Program (Jaminan Pemeliharaan Kesehatan Masyarakat - JPKM) in West Java Province, Indonesia

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I. Introduction

The Ministry of Health of the Republic of Indonesia has proclaimed that the programs in community health development will be geared towards HEALTHY INDONESIA 2010. Four operational strategies to achieve the above are redefinition of paradigms in community health, improvement of professionalism, decentralization of programs and resources, and introducing the community health care service insurance termed *Jaminan Pemeliharaan Kesehatan Masyarakat* or JPKM. Figure 1 shows the position of these strategies in the scheme of community health development both in the Province of West Java and national level. With respect to those strategies, JPKM has been given emphasis as an alternative form of health insurance in Indonesia.

In the province of West Java, JPKM has been implemented since 1973 in three districts namely *Garut, Sumedang* and *Bekasi.* Later, it was implemented in six other districts namely *Indramayu, Cirebon, Pandeglang, Tangerang, Purwakarta, Bandung* and in the *municipality of Bandung.* The progress was rather slow as the actual methods were varied and the implementations were sporadic. The program has only covered about 15% of the total population.

Current economic crisis in Indonesia has led to Reformation movement in many aspects including community health sector. In this regard, it is very appropriate to develop the JPKM even further, especially for low-income (poor) families.

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A special program for these families has been set up in which the premium is paid by the government. The program termed JPKM-*JPSBK (Jaring Pengamanan Sosial Bidang Kesehatan/* Social Safety Net in Health Sector) that is carried out by certain organizations appointed by the Provincial Health Office upon recommendation given by the District Health Office. At present, there are thirty-nine (39) JPKM-JPSBK organizers in the Province of West Java. They are located in twenty-six (26) districts and municipalities in West Java. Within the next two years, it is expected that these organizers could develop and extend their coverage. The support from the Governors Office has been excellent and community participation is improving. Nevertheless, the skills and professionalism of the human resources need to be improved. This requires, among others, learning the community health insurance program in the developed countries.

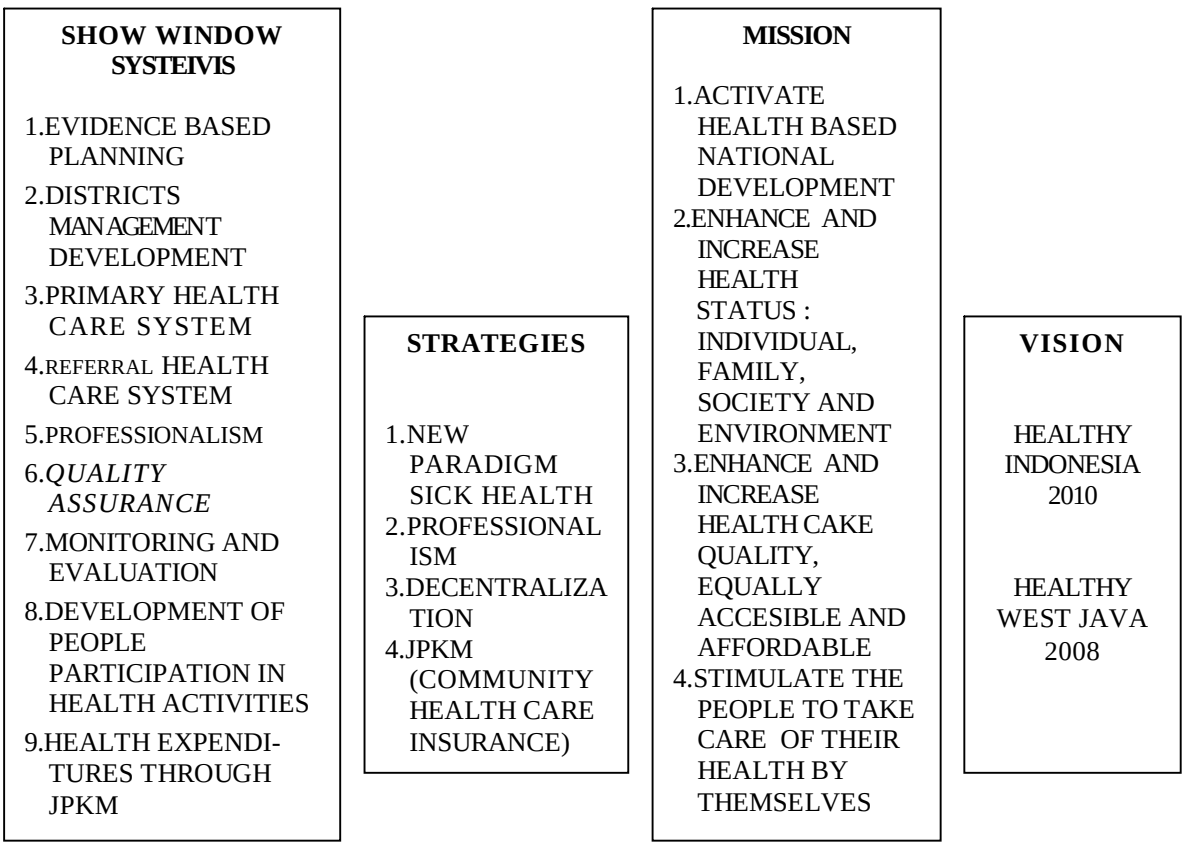

Figure 1. Health Sector Vission, Mission, Strategies and Policies in West Java

II. Objectives

The objectives of JPKM development program in the Province of West Java are as follows :

- To search and to implement the most appropriate and feasible model of JPKM
- To carry out training programs for JPKM supervisors both in provincial and district levels
- To carry out training programs for JPKM organizers in district level
- To socialize the JPKM effectively in all regions of the Province of West Java
- To establish a monitoring_ and evaluation system of JPKM implementation.

III. Targets

The JPKM development program has the following targets :

- Within the next two years, the existing JPKM organizers will convert into registered institutions that are able to extend their coverage to wealthier families.
- Every management level in the JPKM program will be staffed by professionals through human resources development.
- The health service packages will be shifted from primary services to the secondary (referral) system services.

IV. Performance Indicators

The success of the JPKM development program will be indicated by the following performance indicators:

- The existence of team of well trained supervisors team in provincial and district levels
- The existing thirty nine organizers will be converted into registered institutions
- The total coverage of the JPKM should exceed 370,000 low income families
- The quality of services given to the low-income families should be such that the number of complaint should be insignificant.

V. Situation Analysis

1. The total population of West Java is 42,234,900 or 9,233,707 families (1998 data)
2. The number of low-income (poor) families: 3,700,000
3. In the recent years, the health service institutions in the province have expanded both in the kinds of service as well as in the ownership. Table 1. shows the existing health service facilities in the province. Despite the increase, the ratio between the available health service facilities and the population is still considered insufficient. Some forms of extensive health service involve community_ participation. Two of them are the Integrated Health Post *(Posyandu)* and the Village Maternal Huts *(Polindes)*. There are 48,206 *Posyandu* and 1491 *Polindes* in the province. The activities in *Posyandu* include reducing maternal and infant mortality rate through immunization, providing nutritious food supplements, weighing babies and infants, and providing information and means for family planning. In *Polindes*, the activities include encouraging pregnant women to deliver the baby by the certified village midwives. Since the *Posyandu* and *Polindes* are community and voluntary based programs, the progresses are not easily identifiable.

Table 1. Health Service Facilities in the Province of West Java (As of September 1999)

No.	Health Services	Ownership			Total
		Public	Military	Private	
A.	Primary Healthcare Facilities				
1.	Community Health Center (puskesmas)	1,115		-	1,115
2.	Medical Clinic	-	-	1,572	1,572
3.	Maternity Clinic	-	-	212	212
B.	Referral Healthcare service				
1.	Maternity Hospital	1	-	6	7
2.	Mother and Child Hospital		-	-	7
3.	General Hospital	30	12	55	97
4.	Special Hospital	8	-	1	9

4. At the moment, the existing **health insurance schemes** are:

A. Health Insurance for Civil Servants (ASKES)

This insurance plan is intended for both active and retired the civil servants and their family members. The rate of the premium is 2% of the salary, which is deducted automatically from the payroll. This insurance is based on claim, which covers most curative treatments. As the cost of services increases dramatically in the last couple of years, some cost has to be paid by the participants (cost sharing program). This circumstances, is considered to oppress the participants.

B. Military Health Insurance

This insurance plan is similar with ASKES but intended for the members of the armed force including the state police.

C. Laborers Social Insurance (JAMSOSTEK)

This comprehensive plan covers not only health related expenditures but also the `the lost salary' due to sickness, job accident, pregnancy and maternity leave. This is also serve as pension plan in case of retirement or death.

D. Health insurance developed by private organization :

- Students health insurance

  This insurance plan is intended for students at secondary level education and above. The premium of this claim payment system is paid once during the school admission. The plan covers accidents.

- Religious boarding school *(Pesantren)*

  Similar plan with that Student health insurance is also applied in religious boarding school or *Pesantren*.

- Village people health fund (DUKM)

  In some villages, people collect money or crop (such as rice) on regular basis and use them to assist those who need most in their community. This arrangement is to be developed into JPKM in the near future.

- JPKM organizing institution

  Three organizations in the province are already registered by the Ministry of Health. One of them is located in Tangerang while two others in Bekasi. The participant coverage of these organizations is still modest (27,661 people) and marketing is certainly need to be intensified.

E. **Community Health Care Insurance- Social Safety Net Health Sector** (JPKM-JPSBK)

- 39 organizers
- Target : 3,700,000 low income families
- Method of payment : Capitation
- The annual fee of Rp. 10,000 per family is paid by the government. Eight percents (8 %) of the premium are allocated for the management fee of the organizer while the rest (92 %) is for the community health centers as health providers. In the community health centers, the funding is further allocated as follows: 36% for honorarium, 40% preventive and promotive (such as nutrition, immunization, and health education),

20% for curative supplement cost, and 10% for community social activities.

- Comprehensive health service package, emphasizing preventive and promotive instead of curative and rehabilitative program.
- The number of JPKM organizer has been rapidly increased in the recent years. This JPKM-JPSBK gives a substantial big impact in the JPKM extension in the future.

VI. IMPLEMENTATION

Until recently, the number of people with health insurance coverage is still very low. Further information shows in the Table 2 below :

Table 2. Number of People Covered by Health Care Insurance in West Java

No.	Type of Insurance	Number of Participants	Percentage (%) Compare to Total Population (42.234.900)
1.	Civil Government Employee (ASKES) - Compulsory - Volunteer	 1.550.712 21.786	 3.67 0.05
2.	Industrial Labour (JAMSOSTEK)	721.752	1.71
3.	Village People (DUKM)	27.601	0.07
4.	Community (JPKM)	722.001	1.71
5.	Social Safety Net (JPKM-JPSBK)	3.070.000	7.27
	TOTAL	**6.113912**	**14.8**

SWOT Analysis

A. Strength and Other Supporting Factors

- Government intention and priority (the President of the Republic of Indonesia has declared the plan for national development with priority in

health sector, the Ministry of Health has released its vision in community health development)

- Supports from provincial government (the Governor has decreed the structure of provincial supervisory team)
- Supports from local governments for the district supervisory team
- High population of workers and laborers in industrial centers in Bogor, Tangerang and Bekasi
- Trained personnel from the JPKM organizers.

B. Weakness

- Lack of experience of the supervisors since the program is relatively new
- The professionalism of program management is yet to be improved
- Efforts for socialization are still limited
- Limited budget for certain activities.

C. Opportunity

- Huge population in the Province of West Java
- Low number of people with health insurance (less than 15% of the total population)
- Opportunity to learn the skills and experiences from those in the developed countries that can be applied in Indonesian insurance system.

D. Threat

With current economic crisis, a lot of people could not afford to pay the health insurance premium.

VII. Actions Have Been Taken

- Training of provincial supervisor
- Dissemination of necessary information to the organizer

- Program monitoring and evaluation.

VIII. Follow-up Planning

- Stratified socialization
- Increase of the participation of wealthier families
- Increase of health service package
- Comparison study to the developed country

IX. Conclusion

Despite of limitations and restrictions, the health insurance system in Indonesia, particularly in West Java Province, is progressing. This seminar is hopefully invaluable to improve our knowledge and broaden our insight so that we could help find and implement the most appropriate system in our beloved country.