JAMKESDA in Yogyakarta Province: a Lesson Learned of Developing a Regional Social Assurance in the Context of Decentralization

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Abstract

Background The 1945 Constitution article 18 verse 1 mandated the Government of Indonesia to develop a social security for her people, especially to facilitate poor people in respect to their human rights. However, it is not until recently that the GOI issued Regulation number 32/2004 which obliged the regional governments to develop their social security systems. It was further enforced through The National Social Security System (SJSN) in 2005. In line with the policy, the Ministry of Health had selected some provinces as the pilot test for the implementation of the Healthcare Assurance for Poor Families (JPK GaKin) in 2003 and 2004. Yogyakarta Province was one of the selected areas. Method The method for this study is action research. The Center for Health Service Management (CHSM) established a partnership with the Yogyakarta Provincial Health Office. The Provincial Health Project I (PHP I - World Bank funded project) provided the funding to jumpstart the initial process in 2003. Results One of the PHP I project components was health sector reform, more specifically health financing reform. It was aimed to provide protection for the poor as the Social Safety Net program (funded by ADB) ended. The Governor of Yogyakarta issued a Governor Decree No. 74/2003 to not only implement JPK GaKin (the National program) but also to develop a Social Health Assurance (Jamkessos) for Yogyakarta Province. Yogyakarta Province consists of 4 Districts and 1 Municipality. Initially, every district and municipality has its own scheme and operator (Bapel). The political context for this notion was that decentralization gave the autonomy to the district and municipality, rather than to the province government. After a series of workshops and inter-district meeting, it was agreed that a province-level Bapel should be established as the sole operator to overcome problem of cross-district mobilization of patients and referral system of the providers. In 2005, the Ministry of Health implemented JPK GaKin as a nation wide program, which then was called the ASKESKIN Program. PT. ASKES (a government owned corporation) was assigned to be the national operator. Despite that, Yogyakarta province was one of the provinces that continued the inovation of managing regional health system through Jaminan Kesehatan Daerah/Jamkesda (Regional Health Assurance) program instead, as a continuation of its Jamkessos idea. The main idea in developing a health assurance system is protecting the poor. Although the Central Government has insured the poor through ASKESKIN program, the Provincial Government still provides extra insurance funded by Regional Development Budget (APBD) to cover poor and vulnerable group who are not enlisted in the ASKESKIN program. The vulnerable group comprises of the homeless, the rest home residents, orphans, street children, and prisoners, who are not included in ASKESKIN. Furthermore, JAMKESDA broadened its package/benefit by insuring Dengue patients, women and children suffer from violence related to gender issues and domestic violence, malnutrition and post immunization (KIPI) treatments. The participant of JAMKESDA has shown a growth from 95,000 people (2005) to 324,000 people (2007). Consequently

the funding had increased from Rp 5.7 billion (2005) to Rp. 16.5 billion (2007). The funding is bear entirely by provincial APBD. JAMKESDA is not without problems. One of the main problems is overtreatment. This problem calls for further study to establish a DRG system within the contracted hospitals (providers). Another problem is moral hazard. To overcome this, JAMKESDA expected to implement gradual obligatory membership. Those who are obligated to become members are formal workers, while the membership or informal workers will remain voluntarily. JAMKESDA planned to make the obligatory members pay the premium from a percentage of their salary, while the informal workers are expected to pay a certain amount of money (capitation) as the premium. The poor will be totally subsidized, however, the criteria will be stricter and the list would be continuously verified and updated. Lesson Learned In a way, JAMKESDA was designed as an answer to Provincial Government's dissatisfaction of the SJSN mechanism. JAMKESDA seemed to better handled the classic ASKESKIN's problems, namely listing the poor people and delayed payments to the contracted hospitals. JAMKESDA also emerged as a solution to the long overdue confusion and uncertainty surrounding the type of health assurance that are allowed by Central Government. Different regulations and decrees were interpreted differently for some time. In the middle of this uncertainty, the regions did not want to wait any longer. They implement their own Regional Health Assurance and Regional Social Health Assurance, because people were waiting for it. The moral of the story is that Provincial Governments should issue a Regional Regulation (Perda) to enforce their own Jamkessos. An alteration of policy at the Central Government level often slowed down the development of health assurance institutions at the regional level. Support from all level of governments in conducting Jamkesda is very much needed. In addition, the management scheme and operational processing should be improved. This is a relatively new institution that does not have much experience. Central Government should immediately construct a clear regulation on health assurance system by involving the regions and assuring the existence of Jamkesda. Otherwise, Central Government will become too centralistic once again and undermines the role of the Regions.