Has Indonesia's National Health Insurance Scheme Reached the Most Vulnerable?

A Benefit Incidence Analysis of JKN Hospital Expenditure

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Background

Improving equity in healthcare access has been a major objective of Indonesia's national health insurance scheme, Jaminan Kesehatan Nasional (JKN), since its launch in 2014. This benefit incidence analysis, conducted by the U.S. Agency for International Development-funded Health Policy Plus (HP+) project and the National Team for the Acceleration of Poverty Reduction (TNP2K), aims to understand the extent to which JKN has achieved this goal during its initial scale-up and provide a baseline to measure future progress. It examines the distribution of JKN hospital expenditure, which accounts for nearly 80% of total JKN expenditure, across island and socioeconomic groups for both inpatient (IPD) and outpatient (OPD) services. The analysis also considers the factors that may produce inequities in JKN expenditure across these groups in order to inform future policy action.

Understanding JKN Expenditure Distribution

The assessment team calculated JKN hospital expenditure based on the number of cases and the average cost per case for each island and socioeconomic group using data from the national health insurance agency (BPJS-K) and the Susenas household survey for 2014–2016. Caseloads and cost per case are affected by a variety of factors including enrollment levels, unobserved health-seeking behaviors, and sufficiencies of infrastructure and human resources.

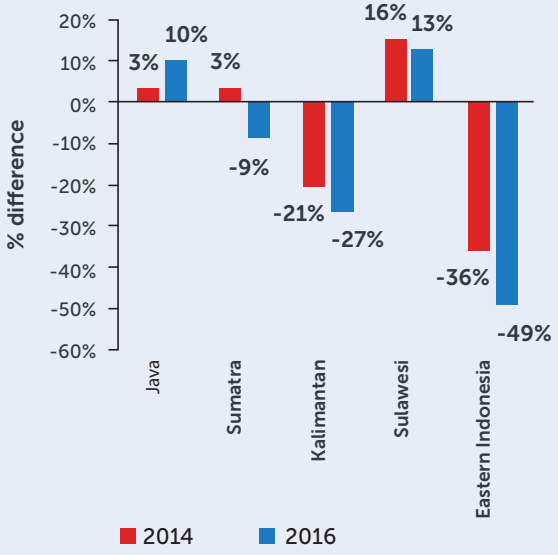
While the number of hospitals and beds per capita varies slightly across island groups, the greatest variation was found in the number of doctors per 100,000 people: from 24 in Eastern Indonesia to between 46 and 49 in the other island groups. Further, populations in rural areas such as Kalimantan and Eastern Indonesia often live far from facilities, which results in low service utilization and therefore low JKN expenditure.

Geographic Distribution of JKN Expenditure

Analysis revealed significant variation in per capita JKN hospital expenditure across island groups. Kalimantan and Eastern Indonesia comprise 6.0% and 6.6% of Indonesia's population, respectively, yet accounted for only 4.4% and 3.4% of expenditure in 2016, respectively. Benchmarking against the equitable share of hospital expenditure by population, where per capita expenditures are equal across all sub-groups, the actual expenditure in these geographies were 27% and 49% below this equitable share. This inequity was more pronounced for OPD than IPD services; Kalimantan and Eastern Indonesia spent 37% and 67% below the equitable amount, respectively.

Between 2014 and 2016, the share of JKN hospital expenditure represented by Kalimantan and Eastern Indonesia declined for both IPD and OPD services. In contrast, Java's share of

Percent difference between actual and equitable shares of JKN hospital expenditure, by island group and year



Source: HP+ calculation based on unpublished data from BPJS-K

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expenditure increased from 60% to 64%, while its share of the population, approximately 58%, declined slightly over the same period.

Much of the observed variation in expenditure across island groups was driven by variation in the per capita healthcare use, particularly for OPD services. While Java experienced 346 OPD cases per 1,000 enrollees in 2016, Eastern Indonesia had just 109 OPD cases per every 1,000. For IPD, the number of cases per 1,000 enrollees was highest in Sulawesi (58) and lowest in Eastern Indonesia (31).

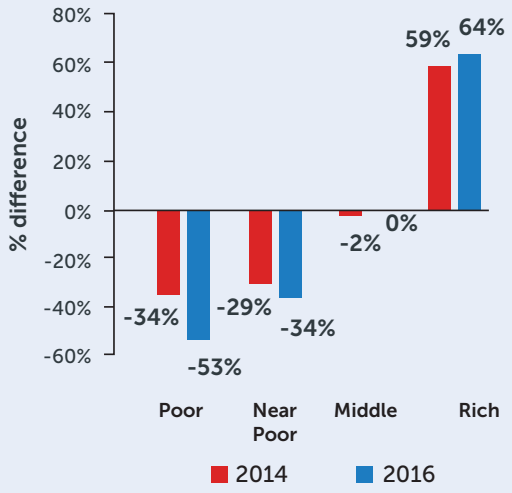
Socioeconomic Distribution of JKN Expenditure

Similarly, JKN hospital expenditure varied significantly across socioeconomic groups. In 2016, the poor and near-poor represented just 5% and 18% of JKN hospital expenditure, respectively, compared to 11% and 27% of their respective populations. Expenditure across socioeconomic groups became less equitable between 2014 and 2016.

Between 2014 and 2016, JKN hospital expenditure on the poor declined from 34% below the equitable share to 53% below, while expenditure on the near-poor's share declined from 29% to 34% below. In contrast, the rich accounted for 59% above the equitable share in 2014 and 64% above in 2016. This trend was primarily driven by greater inequity in IPD expenditure over 2014–2016; OPD expenditure became more equitable across socioeconomic groups over the period.

Inequities in expenditure across socioeconomic group were again largely driven by variations in healthcare use. For both IPD and OPD services, the caseload per 1,000 enrollees was more than three times higher among the rich than among the poor in 2016. While utilization of OPD services increased most among the poor, improving equity in OPD expenditure, utilization of IPD services increased most among the rich, worsening inequity.

Percent difference between actual and equitable shares of JKN hospital expenditure, by socioeconomic group and year



Source: HP+ calculation based on unpublished data from BPJS-K

Conclusions and Policy Recommendations

This benefit incidence analysis finds that JKN hospital expenditure has been inequitable—and is becoming increasingly inequitable—across both island and socioeconomic groups. Further investigation is needed to examine the root causes of these inequities and the drivers behind current trends. However, to address inequity and increase JKN expenditure on the poor and near-poor, the following recommendations can be made:

- Build additional facilities and/or shift certain hospital-level services in rural and remote or disadvantaged areas to primary healthcare facilities
- Geographically target financing for infrastructure and human resources for health to rural and remote or disadvantaged island groups
- Ensure that the enrollees, particularly the poor, understand and can benefit from JKN enrollment

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