

Reality Check Approach

Insights Paper, March 2016 :

People's perspectives on the national health insurance scheme.

Background:

Badan Penyelenggara Jaminan Sosial, (BPJS) is the agency responsible for organizing the Jaminan Kesehatan Nasional (JKN) programme under its BPJS health programme. The goal is universal health coverage by 2019 through a compulsory national insurance scheme which came into effect in January 2014. For those identified as in need of social assistance, the Government pays the insurance premium on their behalf. These are referred to as Penerima Bantuan Iuran (PBI) or recipients of premium assistance. These people are or will be issued with Kartu Indonesia Sehat (KIS). All other recipients pay according to a sliding scale for their health insurance coverage. The scheme is intended to cover everyday ailments through to major surgery.

The uptake of the PBI has been lower than expected, especially as this is free health insurance. The uptake of the lowest premium level of insurance which is intended for informal workers is also low. A number of experiments are being undertaken (e.g. By J-Pal) to establish what would attract people to register for the scheme.

Reality Check Approach

RCA is a qualitative approach to research which involves members of the research team living in the homes of ordinary people or local service providers and joining in their everyday lives for several days and night. This informal 'hanging out' enables easy and open conversations, first-hand experience and observation of daily life. There is no note taking and very little disruption to routines and normal interactions. The researcher takes the position of the household and learns from them, giving them space to share their insights and perspectives in their own time and own way.



Insights on the national health insurance scheme

Over the period 2014-2016, the RCA research team in Indonesia has participated in a number of RCA research studies. A number of the studies have specifically looked at health and social assistance (www.reality-check-approach.com). However, the open nature of the conversations and the attention to context within these studies means that the issue of health insurance has come up in many of the other studies too where health has not been the main focus. The following insights are gathered from people's own perspectives and experiences from RCA studies which were specifically focused on social assistance, health frontline service provision, migration for work, basic education in Papua and village governance. The insights come from Java, Sumatra, Kalimantan, Sulawesi, NTT, NTB, Maluku and Papua.



'We are healthy'

By and large the more than 150 families living in poverty we have stayed with have indicated that they feel they are mostly healthy. They point to their consumption of simple food, often rice and fresh fish, and relatively active lifestyles as contributing to this. The mild ailments they tell us they experience such as headaches, dizziness, gastric problems and mild blood pressure issues are all either ignored or treated by traditional means or self-medication, often by buying medicines conveniently and cheaply from pharmacies, local kiosks and directly from frontline health providers themselves. People living in poverty tell us that recently there has been an increase in non-communicable diseases such as hypertension, diabetes, asthma and cancers and blame pollution, pesticide over-use and the over consumption of salt and sugar, especially in packaged food.

The preference for treatment of more serious ailments is always private providers or to go directly to sub-district or district public facilities rather than local facilities. In these cases, people draw on their family networks to raise the needed cash for transport and treatment. We have been struck throughout the RCA studies by how irrelevant *puskesmas* provision seems to be for most people and how these facilities often open late, close early and, in the over fifty locations we have been to, rarely see more than a handful of out-patients in a day.

Of course there are exceptions and it is the families who have experienced health crises who are much more likely to decide to take up health insurance. The RCA study narratives clearly point to small numbers of families which have experienced a death or a long-lasting ailment who have suffered financially as a result and are then motivated to take up insurance. Although some chronic conditions are, of course, not covered by the scheme.

'Free means it is not good quality'

There is a strongly and widely held belief that the treatment and medicines provided under the BPJS scheme (and indeed Government free health schemes which preceded it) are inferior. People share that they prefer to pay 'for better medicines' and, as well as seeking out private practitioners and pharmacies, will often opt to see public health providers after hours 'to get more potent medicines'.

Some of these assumptions are based on past experience with earlier schemes where people experienced being sent to the back of the queue if they wanted to use a health card to access services and peremptory treatment. In many cases, they felt their consultations were hasty, their questions were not answered, and the medicines provided were less good or were 'generic'.

However, some *puskesmas* staff also shared their frustrations that despite promoting BPJS assiduously, their facilities were not able to respond adequately to those who had signed up to the scheme as they were not provided with the needed medicines and supplies. Bottlenecks were sometimes attributed to the procurement process which health providers say is more centralised since the introduction of BPJS and allows less local autonomy. This results in health providers having to prescribe substitute drugs which 'people will have to pay for..... so, what was the point of the insurance?' The RCA studies revealed many examples of frontline staff prescribing only vitamins as the required drugs were not in stock.

‘Why pay if we are healthy?’

The concept of health insurance is difficult for many to grasp. People often share that the old system of free health care if you held a *jamkesmas* (or equivalent) card was easy to understand, but now ‘*you have to pay monthly like electricity*’ and why should ‘*we have to do this if we are not using the service*’.

Often consultation fees for private practice and medicine prices in markets and kiosks or after hours in *puskesmas* are considered quite low for ‘*ordinary ailments*’, so people ‘*do their sums and work out that it (insurance) is not a good investment*’ based on the family history of seeking medical care. People often conclude, ‘*this is for the rich, they can afford it*’.

Some shared with us the belief that insurance is ‘*haram*’ (forbidden) in Islam and cited TV programmes where this had been stated. Others had seen news which indicated that there are long queues for people using health insurance and as a result argue that on the few occasions they need health treatment, it is better to pay and get quicker service.

‘Why do they have to change and change all the time?’

This quote is typical of many people’s frustrations about various social assistance programmes and particularly the health assistance programmes. There is a pervasive sense of confusion, not just among ordinary people but also among health frontline service providers regarding the scheme. This is despite extensive socialisation efforts including posters displayed prominently in *puskesmas*. The continuing existence of local schemes (e.g. Jakarta Health Card, Aceh Health Insurance etc) leaves people confused about how these dovetail, complement or duplicate cover. While the RCA studies have shown that confusions have eased somewhat over time, some are persistent and act as a block to people wanting to access health insurance.

‘Is my family eligible?’

In 2014, the RCA team looked specifically at people’s understanding of poverty and found that people were frustrated and confused about who was and who was not eligible for social assistance. They pointed to many inconsistencies and claimed bias in the way the ‘*lists were drawn up*’. Since, it has been shown through quantitative and qualitative research that there are major errors in the unified database and the continued use of this flawed instrument in allocating the subsidized insurance category is questionable. The RCA also pointed out that there are certain populations which are often not properly surveyed or are not included at all, e.g. permanent plantation housing ‘*we are not counted*’, minority groups (especially those without a political representative or those who have been relocated), seasonal workers, squatters or floating populations, elderly living alone or in parts of houses owned by better off family members and those who feel shy in the presence of official surveyors. In some areas the survey for identifying eligible families was conducted over the phone thereby excluding anyone without a phone or without a phone signal. The difficulties people face and their lack of confidence in trying to redress mistakes leads to many who should be eligible accepting the status quo.

Old *Jamkesmas* cards and other local versions of health cards should have been automatically converted into the new system of free health care (underwritten by the government e.g. by exchanging with new KIS cards) but in many cases these schemes still co-exist and ,in others, people with *Jamkesmas* have not been able to automatically enrol with BPJS.



'I don't live with my family'

The schemes are family based and where members of the family live and work outside the home of the family, coverage is thought to be invalid. There is much confusion about this but consistently throughout different RCAs, researchers have been told by frontline health staff and ordinary people alike that the BPJS scheme only works in your own locality. This is typified by the comment from a *puskesmas* nurse *'you can only use it in your own area where you live as the Government only sends limited medicines and we really can't give to others'*. Only a handful of times have RCA researchers heard that the card can be used in facilities outside of the home area and just one case where a doctor urged a patient who had done this to *'please tell your neighbours that they can use the card anywhere'*.

As a result, those working, studying and living away from the home where their ID is registered assume that the insurance does not cover them. So they have become used to simply relying on pharmacies and medicines from kiosks. Some successfully pass on health costs to their employers but few, if any, will expend time and money to travel back to their home areas purely to avail free health services.

BPJS socialisation staff themselves have shared that *'this is a weakness of the scheme... but, at least people are covered in emergencies'*. Although interactions of the researchers suggest few people even know this.

'What does it cover?'

Given that people most value the insurance when they are facing a health emergency, the lack of information about what is covered under the scheme is particularly concerning for people. With the need for quick decisions, people often opt for the decision over which they are sure to have control. So, for example, if it is not clear whether the ambulance cost is covered, people chose to mobilise resources through their personal networks as quickly as possible and pay the driver and purchase fuel themselves.

'More paperwork and delayed repayment'

Across locations, RCA researchers found that frontline health service staff were increasingly frustrated by the quantity of paperwork which is required for getting reimbursements from the BPJS as well as the delays in payments, sometimes resulting in health staff having to use their own money to ensure continuity of service provision. There is some suggestion that this works against health providers promoting the scheme as their preference then becomes provision of private after-hours services where they get paid immediately.

'Getting the card is complicated'

Many frontline health providers have shared with the RCA team their frustration in trying to interest people in the insurance scheme. *'We have explained over and over, and they still won't go and get it'*. In part this is related to the concern about paying for something they might not need but it is also about the bureaucratic hurdles. In particular, is the requirement to open a bank account in order to make monthly premium payments. Bank accounts can only be opened in the district in which one's ID is registered. Temporary residence IDs specifically prohibit use for any banking and financial actions. Anyway, despite being free the *'contribution costs'* required by officials to facilitate a temporary ID can be as much as IDR 250,000. For many self-employed people the idea of getting a bank account is frightening. This includes the whole interaction with officialdom but also concern that their business might be subject to more scrutiny. For people working in the informal often unregulated sectors this is a major barrier. Others who can be union members have benefitted from socialisation efforts through their unions by the BPJS team but there are many who cannot be or do not want to be members of unions.

Many people still do not have basic documentation such as ID. Furthermore, mistakes in people's personal documents are prevalent (names spelled differently, dates of birth wrongly noted, family members left off etc.) and unless all documents are consistent, people are often subjected to lengthy (and costly) processes to harmonise their documents. In addition it is very difficult to change details, for example for a spouse who moves to his/her partners home area and for additional members to be added to family cards, such as might be required as a result of divorces, re-marriage, adoption and caring for dependents.

Newborn babies are not automatically covered by their parents' insurance and this has led to people checking out of maternity care facilities early or incurring high costs for their babies' care, if they fall ill, over the (usually many) months it takes to arrange this.

Many share concern that the insurance cover is not instant after registration so they feel they are paying for something they cannot actually avail.

RCA + Team
March 2016