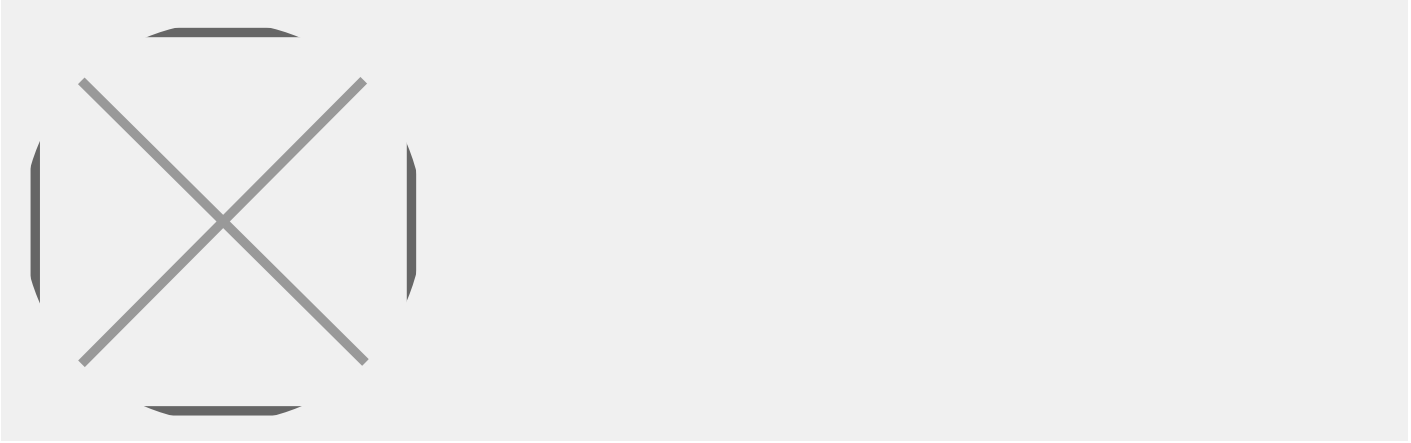
Interview: Dr. Nafsiah Mboi, Ped, MPH Minister of Health of the Republic of Indonesia



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Dr. Nafsiah Mboi, who currently serves as the Minister of Health of Indonesia, has more than 40 years of experience in national and global public health, including a full career as a civil servant in the Ministry of Health and six years as Secretary of Indonesia's National AIDS Commission. She shares with us her aspirations for Indonesia's healthcare in the future, problems with medical tourism and her efforts to diversify and decentralize the medical community.

The implementation of the universal healthcare coverage plan will start in Indonesia in January 2014. How significant is this plan for the country and its citizens?

This is a very significant step for the country that reflects the ambitions the government had in 2004. More than health insurance alone, the 2004 Act spoke about the implementation of a comprehensive social security system. On the health side, the idea is to provide total health care coverage to the population by ensuring that every citizen has access to health care. A period of ten years of preparation was foreseen – i.e. from 2004 to 2014 – and has been accelerated by the 2009 Health Bill.

At present, health insurance schemes already exists for civil servants, the military, police and for workers – a program referred to as Jamsostek. For these workers, we

pay two per cent of our salary while the employer tops up another two per cent. Since 2004, health insurance for the poor has also been introduced under the so-called Askes program. This program changed into Jamkesmas in 2008. For these poor people, the premium is being paid for by the government.

While Jamkesmas has traditionally been managed by the Ministry of Health, the universal health care plan will be managed by the National Social Security Agency (BPJS) as from January 2014. The creation and integration into a national health insurance scheme will be more cost-effective and host better standards and regulations.

By May 2013, 72 per cent of the population – 176,844,161 Indonesians – was already part of some type of health financing scheme. Among the different schemes, Jamkesmas is the largest, which covers 86.4 million people. The local government – Jamkesda – covers 45.6 million people. Combined, these 52 to 53 percent of the population – the poor – are already covered through government-subsidized premiums. In addition to that, 16.5 million civil servants and 1.4 million police and military are covered through the cost-sharing contribution system. Besides that, there is also the so-called Jamsostek for the workers, which covers an additional 7 million people. In addition to that, company insurance schemes account for another 16.9 million people while commercial insurance stands at 2.9 million.

Providing access to health care to the entire population by 2019 will provide limited room – or budget – for more expensive innovative or specialty pharmaceuticals. What do you see as a healthy balance between quality innovative or specialty medicines on the one hand, and cost-conscious universal health care access on the other hand?

From past studies – from Jamkesmas data for instance – we know that around 50 to 60 per cent of the expenses goes to medicines. We have subsequently created a formulary of quality generic and non-generic drugs, which match quality with cost-effectiveness.

We have also created an e-catalog more recently, which eliminates the need for a bidding process. As a result, we have seen price reductions of 40 per cent and more compared to the bidding process from the past.

In the formulary, the current balance is 92 per cent of branded or unbranded generic drugs, while 2.5 per cent are the innovator drugs. The remaining balance refers to dental materials and diagnostics.

What is your ambition for the future of healthcare in Indonesia?

We really aim to have quality care and would like to see the Indonesian people in healthy conditions at all stages of their lifecycles. We would like to see them being responsible for their health too. However, if they do fall ill, they should have the necessary financial support. No one should suffer if they cannot pay. We are working intensely on providing the right equity and the right quality all over Indonesia.

You have been praised on launching fellowships for doctors. What steps have you taken to raise the level of education of Indonesia's medical community?

A first issue at stake is the disparity. In the past, we have been trying to fill areas where there are no hospitals with doctors from Jakarta. This did not work.

What we have now been doing instead is to enter into dialogue with the local governments. Together with them, we identify the good doctors and offer them a fellowship – on the condition that they later return to their region to work there. This system enables us to provide the necessary equity and quality of services that is need everywhere in Indonesia.

We have also created a model of regionalization, which no longer requires all medical staff to come to Jakarta for training. We have created local educational institutions for nurses, doctors, midwives and even specialists.

For many years, there has been an outflow of medical tourism from more affluent Indonesians to look for treatment in neighboring countries such as Singapore. What can you tell the Indonesian population to stop this outflow?

Today we have nine internationally accredited hospitals in Indonesia, two of which are government-owned: one in Jakarta and one in Bali. At the same time, we are working on the international accreditation of three to four more public hospitals. Nonetheless, international or national accreditation is fairly similar. What matters is for patients to be happy with the services provided.

After all, a sick Indonesian will want his or her family close by. Getting help from outside of Indonesia should truly be a last resort for any services or treatments that are not being provided in the country.

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