The Indonesian Health Card Program was part of the Social Safety Net Program (SSN) mounted by the Indonesian Government in response to the economic crisis in the fall of 1997. Even though similar schemes existed, both the coverage and scope of the program were changed and expanded as part of the SSN program. The program was part of an overall effort to address the impact of the crisis, including a rise in price of items like food and medicine, leading to increased poverty. The use of public health services fell dramatically as the poor had to struggle to meet the basic needs of livelihood rather than seek health care. This in turn, caused the deterioration of the quality in the public health care facilities.

The research focused on an evaluation of this scheme. Even though the design had several limitations, the study found that the program (where direct subsidies were provided for basic health services for the poor) was effective in increasing the utilization of these services. The SSN provided the poor households with health cards. The scheme also tested mechanisms to channel funds directly to the facility level with increased budgetary support to the public sector to respond to the increased demand. However, there was a drawback in providing the subsidy only to the public service providers and not to the private providers.

The Health Card Program

Health Care Subsidies (Health Card) program provided a “health card” to poor households in all provinces in Indonesia through the districts. The health card was used to receive free health services from designated public hospitals, local health centers, and village clinics for medical or family planning purposes. Free public services offered to the health cardholders consisted of: (1) outpatient and inpatient care, (2) contraception for women of child bearing age, (3) prenatal care, and (4) birth assistance. Service providers were compensated for the additional workload by a lump sum transfer based on the number of health cards allocated to the district, which was a loose relationship between the utilization of the health card—which entitled the owner to the subsidy—and the compensation the health care providers received in return.

Eligibility in this program was based on village level lists, which primarily encompassed the National Family Planning Agency’s “prosperity” rankings, with some modifications by local administration via a “health committee.” A household was deemed in need when it had too little money to worship by faith; eat basic food twice a day; have different clothing for school or work and home; have a floor not made out of earth; or have access to modern medical care for children or modern contraceptive methods. Any one of these conditions qualified a household for a card. The national family planning board (BKKBN) collected this information through census. Local leaders were also permitted to distribute health cards to people they thought needed them. The health card given to any household could be used by all members of the household.

Results

After the health card program began in September 1998, poor beneficiaries’ use of health services increased, and the non-poor switched from private to public providers. (Figure 1)

Studies show the following results. 10.6 percent of Indonesian households own health cards. Cardholders appeared to be poorer, less-educated, and more often employed in agriculture than people who did not have health cards. Their households were also more frequently headed by a woman.
Utilization of health cards was also pro-poor but slightly less so, showing the supply side subsidy was less successful. Figure 2 compares ownership and use of health cards. The people receiving benefits were on average wealthier than the pool of card recipients. The poorest 20 percent of the population owned 35 percent of the health cards, but there was a fair amount of leakage (to the non-poor). Considering that about 10 percent of Indonesian households received a health card, perfect targeting would mean that the poorest 10 percent of the population should have obtained all the cards. In fact, about 39 percent of the health cards were owned by households from the wealthiest three quintiles.

In a three-month period, 15 percent of the health card owners visited an outpatient provider, compared to 13 percent for the non-health card owners. However, health card holders did not always use their health card—4 out of 11 percent of the health card owners reported not using the card when seeking care from a public provider. (Table 1.) Besides the technical reasons for why this could have happened, there were several possible explanations why cardholders did not present their card at treatment. Some public facilities reportedly limited the time spent with health card patients, and some patients thought care received with a card was of lower quality than services and medicines obtained without a card. In remote areas, lack of access to the nearest public facility may have deterred use.

**Lessons Learned**

Both the ownership of the health card and the services delivered under the health card program were shown to be pro-poor. The utilization of services was, however, less pro-poor than ownership. Conditional on ownership, the rich were more likely to use their health card. As the subsidy was provided to the supply side and not to the households directly, this may have contributed to this finding.
Ownership of a health card had a positive impact on the use of outpatient treatment medical services for households from the poorest two quintiles. For all households, ownership resulted in a large substitution effect away from the private sector to the public sector. Because the health card was valid only with public service providers, health card holders used those services more frequently than non-cardholders. The health card program resulted in a net increase in utilization for the poor beneficiaries. For non-poor beneficiaries, the program resulted mainly in a substitution from private to public providers. The largest effect of the program seems to have come from a general increase in the supply of public services resulting from the budgetary support received through the SSN program. It may have also contributed to some measure of quality of public services. Studies indicate that the health card program (card distribution and supply side subsidy) resulted in a 0.65 percent increase in the outpatient contact rate. The increased utilization of health card owners contributed only 0.25 percent to that. If this is true, the revival of the public sector as a provider of outpatient care could be attributed to the health card program. Without

---

**Figure 2.** Health Card Ownership versus Use for Outpatient Treatment

![Health Card Ownership versus Use for Outpatient Treatment](image)

*Source: Saadah, Pradhan, and Sparrow 2001.*

---

**Table 1. Health card Use**  
(percent seeking care in previous three months)

<table>
<thead>
<tr>
<th>Patient reports</th>
<th>Head of household reports owning health card</th>
<th>Head of household reports not owning health card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received outpatient care</td>
<td>15.10</td>
<td>12.91</td>
</tr>
<tr>
<td>Went to public provider</td>
<td>10.61</td>
<td>6.75</td>
</tr>
<tr>
<td>Went to public provider and used health card</td>
<td>6.74</td>
<td>0.15</td>
</tr>
<tr>
<td>Went to public provider and did not use health card</td>
<td>3.88</td>
<td>6.60</td>
</tr>
<tr>
<td>Went to private provider</td>
<td>4.82</td>
<td>6.48</td>
</tr>
<tr>
<td>Did not seek health care</td>
<td>84.57</td>
<td>86.77</td>
</tr>
</tbody>
</table>

*Source: Saadah, Pradhan, and Sparrow 2001.*
the health card program, outpatient utilization of public services could have further declined in 1999.

The program link between the delivery of services to health card owners and financial compensation is relatively weak. Service providers were reimbursed using a lump sum transfer based on the number of health cards distributed to their area of influence. As a result, serving a health card owner did not result in a direct financial reward to the service provider. High rejection rates sometimes followed from the delays in the lump sum transfers made to the providers.

Overall, the combined effects of the health card and the supply impulse have increased utilization. However, more focus on the demand side financing and inclusion of both public and private providers could have enhanced the program impact. Still, having a SSN helped. In the absence of the SSN program, the utilization of outpatient services would have been by 5.4 percent lower, relative to the observed contact rate. The results indicate that a closer linkage between health card utilization and funding would have resulted in a better targeted program.

This brief is intended to summarize good practices in Health, Nutrition, and Population. It was adapted from Fadia Saadah, Menno Pradhan, and Robert Sparrow, “The Effectiveness of the health card as an Instrument to Ensure Access to Medical Care for the Poor during the Crisis,” paper prepared for the Third Annual Conference of the Global Development Network, Rio de Janeiro, Brazil, December 9–12, 2001, at www/gdnet.org. The views expressed in this note do not necessarily reflect those of the World Bank.