Institutional analysis of Indonesia’s Universal Health Coverage policy

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Analysis of Indonesia’s UHC design

- **Commitment for UHC by 2019**
- **2012 : Roadmap toward UHC launched**
- **Documentary analysis of Roadmap**
  - health financing functions (eg. Mathauer & Carrin 2010)
  - social and political aspects (Savedoff et al, 2012)
  - Laws and Regulations
  - Recommendations for UHC (eg. WHR 2010)
- **Identified issues with:**
  - the system design
  - translating the design into a functioning health financing system
  - impact of health financing strategy on the rest of the system
Indonesia’s path to UHC

- Institutional framework for UHC established

- **2 key laws:**
  - **2004:** the law for a National Social Security System *Law 40/2004 (SSJN)*
    - health insurance for entire population
  - **2011:** the Social Security Provider’s Bill (BPJS) *Law 24/2011*
    - national agency for health insurance

- **From 2004:** Health insurance for the poor and near poor (*Jamkesmas*) expanded to 76.4 million people

- **2012:** Roadmap toward UHC - *Peta Jalan Jaminan Kesehatan Nasional 2012-2019*
  - Implementing Regulations
  - Activities eg. MOH Action Plan
# Table 1: Health Insurance coverage in Indonesia, 2012

<table>
<thead>
<tr>
<th>TYPE OF HEALTH INSURANCE</th>
<th>PERSONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants of Health Insurance for Civil Servants (Askes PNS)</td>
<td>17,274,520</td>
</tr>
<tr>
<td>TNI/Polri - military and police</td>
<td>2,200,000</td>
</tr>
<tr>
<td>Jamkesmas Participants* (Ministry of Health) - health insurance for the poor</td>
<td>76,400,000</td>
</tr>
<tr>
<td>JPK Jamsostek Participants (workforce social security) - Private employees and employers</td>
<td>5,600,000</td>
</tr>
<tr>
<td>Jamkesda/PJKMU Participants - regional health insurance for the poor</td>
<td>31,866,390</td>
</tr>
<tr>
<td>Corporate Insurance (Self-Insured)</td>
<td>15,351,532</td>
</tr>
<tr>
<td>Commercial Health Insurance Participants</td>
<td>2,856,539</td>
</tr>
<tr>
<td>Total</td>
<td>151,548,981</td>
</tr>
</tbody>
</table>

Proposed UHC system

• National agency by 2014 (BPJS I) to manage the INA-Medicare system

1. Integrate existing schemes by 2014
   - public contributions + government’s contributions for the poor (Jamkesmas) into a single pooled fund
   - Regional government schemes (Jamkesda) - to be progressively integrated
   - 151.5 million participants

2. Expand coverage to uninsured by 2019
   - projected population 257.5 million
<table>
<thead>
<tr>
<th>Resource collection</th>
<th>Pooling</th>
<th>Purchasing/Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government budget to public facilities (ongoing)</td>
<td>Existing funds to be pooled : BPJS to manage</td>
<td>Payments to public and private health facilities</td>
</tr>
<tr>
<td>Government contribution for poor and near poor: Rp. 22.000-27.000 per month ($2.20-2.70)*</td>
<td>- Jamkesmas - PT Askes - Jamsostek - Jamkesda (some)</td>
<td>PHC public &amp; private providers: capitation</td>
</tr>
<tr>
<td></td>
<td><strong>2014: 121.6 million</strong></td>
<td>Hospitals : DRGs (INA-CBG) based payments to be negotiated and vary according to region</td>
</tr>
<tr>
<td>Self funded contributions</td>
<td><strong>2019:</strong> Entire population, including remainder of Jamkesda schemes</td>
<td>Benefit package: - comprehensive - initially third class hospital for govt funded +</td>
</tr>
<tr>
<td>Laborers – 5-6% of monthly wages</td>
<td></td>
<td>second class for self funded - second class for all by 2019*</td>
</tr>
<tr>
<td>Non-wage laborers/informal sector – 5-6% of monthly wages</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR to be covered by government?*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Findings: 1. The system design

- **Costing of the design**
  - Absence of fiscal study
  - Design recommended Rp. 22,000-27,000 per month ($2.20-2.70) government contributions for the poor
    - ↓ to Rp. 15,500 per month ($1.50) as per MOF

- **Informal sector (~62% of all workers)**
  - Design has government paying contributions, but
    - defined as contributors in Pres. Reg. on Health Insurance
    - collection of contributions unresolved
    - social protection?
1. The system design (con’t)

- **Targeting the poor**
  - underutilisation of Jamkesmas benefits, esp. rural and remote
  - less than 50% Jamkesmas are poor or near poor
    - existing issues not addressed in design

- **Ongoing supply-side funding for public health facilities**
  - distorts cost of Jamkesmas
  - limits incentives for service improvement/local government investment in health
  - compensation for private sector?
2. Translating the design into a functioning HF system

- Collection of contributions
  - Law 40/2004: contributions to be jointly borne by employers and laborers
  - changes to existing schemes (eg. Jamsostek)
- Integration of regional funds (Jamkesda)
  - concerns re centralised management
  - regions to continue providing health insurance
- PT Askes’ integration of existing insurance schemes
  - need to standardise contribution values, provider payment mechanisms, benefit packages
- Inter-institutional arrangements
  - reaching consensus?
3. Impacts of the HF strategy on the rest of the system

- **Potential for inequities**
  - eg. experience of poor accessing Jamkesmas, limits of benefit package
  - MOH Action Plan to address health services access and quality?

- **Addressing inefficiencies**
  - Not strong focus in Roadmap
  - Capitation, but may result in user fees
  - Eg. rise in pharmaceutical spending expected

- **Private sector participation**
  - Incentive?
Conclusion

• Good progress, has institutional framework
  – Health financing approach follows key recommendations for UHC

• Evolving design expected, but
  – departures from Roadmap made in absence of key technical information (eg. fiscal capacity study)
    • Eg. decisions on govt. contributions
    • Implications for sustainability

• Response to increased demand for services
  – MOH Action Plan yet to be developed
  – Impact on OOP?
  – Private sector
Conclusion (con’t)

- Large role of government, but
  - central government driven?
  - socialisation rather than consultation
  - engagement with local government, civil society, private sector

- Ambitious timeframe
  - weak inter-agency cooperation

- UHC and health goals
  - Coverage for poor, informal sector, govt. contributions for poor
  - Affordability - reduction in service coverage, benefit package
    - Equity and social health protection?
Terima kasih ~ Thank you