Improving Health Financing (in Indonesia)

Ascobat Gani

Ina-HEA/AIPHSS/FKMUI

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4 strategic policies to improve HF

- What are you going to buy ?
- Financing Public Health
- Containing health care cost inflation
- UHC: the fallacy of the *"magic cube" (SHI)* vs the *"flying spider web" (tax based)*

1. What to buy ??

Nanda Putri :
“Mom I am going to the mall, give me 2 millions”

Mother:
“What are you going to buy ?

Knowing clearly what we are going to pay for is the basic fundamental and first step in health financing system

Are we going to buy *"financial risk protection"* ?

➔ go for insurance (e.g. JKN/BPJS)

➔ Cover curative individual clinical services

Are we going to buy *"health risk reduction"* ?

➔ go for tax based financing (e.g. BOK, APBN/APBD)

➔ PH interventions

Are we going to buy both ?

Mostly **"public goods"**
Need strong role of government: execution
Tax based financing (insurance does not fit)

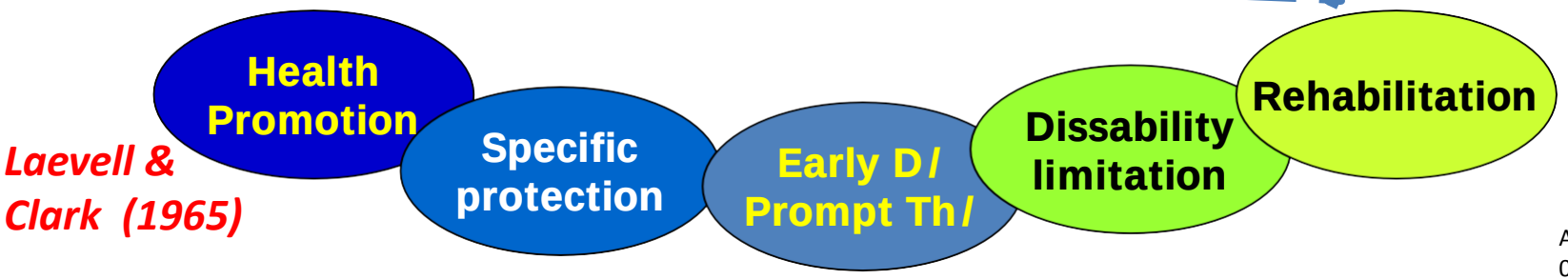
*** Through organized community effort**

Mostly **"merit goods" & "private goods"**
Government : steering & monitoring
Financing: insurance, OOP, tax (for the poor)

*** Individual clinical services**

PUBLIC HEALTH
[UKM] *Tax based financing*

CLINICAL MEDICINE
[UKP] *JKN/insurance or OOP*



Laevell & Clark (1965)

Ascobat Gani
08/03

Promosi kesehatan, KB, immunisasi, sanitation, lingkungan, gaya hidup, regulasi, mobilisasi masy, lintas sektor

Pelayanan medis primer, sekunder, tertier (termasuk promotif/preventif perorangan)

Works trying to define a comprehensive basic health services package

1. WDR-1993
2. Commission on macroeconomic and health (WHO/2000)
3. WB Jakarta (2000)
4. MoH & MoHA (2014) ➔ AIPHSS/DFAT

WB: World Development Report 1993: Investing in Health

Basic PH Program	Essential Clinical Services
1.Immunization 2. School Health 3. CIE & FP services 4. Nutrition 5.Reducing tobacco and alcohol consumption 6. HIV/AIDS prevention	1. MCH 2. FP 3. Tb treatment 4. STD treatment 5. Treatment of sick children
US $ 4.2/cap/yr	US $ 7.8/cap/yr

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SEARO/0902

Cost effective intervention (WHR 2000) Commission on macroeconomic and health

1. TH/ of TB: DOTS
2. MCH/SAFE MOTHERHOOD : ANC, safe delivery
3. FP: CIE and FP services
4. SCHOOL HEALTH: Hlth Education, nutrition, worm treatment , micronutrient and supplementary food
5. IMCI: Case mgt of ARI, diarrhea, malaria, measles, under nutrition, immunization, breast feeding, micronutrient & Fe, worm th/
6. PREVENTION OF HIV/AIDS: CIE for CSW & general public, safe blood supply, mass th/ for STD
7. TH/ STD: case management: standard D/ and Th/
8. EPI plus: BCG, OPV, DPT, HepB, TT
9. MALARIA: case mgt + prevention (e.g. treated bed net)
10. TOBACO CONTROL: CIE, tax on cigarette, legal action
11. NON-INFECTION & INJURY: screening and secondary prevention

US $ 30 – 40/cap

Macro estimate

(WB Indonesia, 2000)

$ 5/capita/yr

Estimate of cost needed per capita per year				
Program	Type of services	Coverage	Total for 600.000 pop (*)	Per Capita
EPI	Basic	90% infant	4.282.279.351	7.137
	Hb	90% infant		
	TT	90% pregnant mothr		
	Elem shool grade I	100% pupil		
	Elem shool grade II	100% pupil		
Lung TB	Case finding	70/100.000 pop	115.948.591	193
	Cure rate	91%		
		th/ for 20% poor		
Malaria	Case finding	300/100.000 pop	334.442.104	557
		th/ for 20% poor		
	Larva control	100% targeted village		
	Mosquito control	100% targetd village		
DHF	Case finding	10/100.000 pop	2953904.274	4.923
		th/ for 20% poor		
	Fogging	50% target		
	Abatisasi	10% target		
	Breeding place (**)	10% target		
Diarrhea	Case finding	28/1000 pop	105.0185.998	1.750
		th/ for 20% poor		
ARI	Case finding	11/1000 pop	678.813.851	1.131
		th/ for 20% poor		
STD	Case finding	12/1000 pop	233.939.381	390
		th/ for 20% poor		
Treatment	Basic service for poor people	20% population	1.113.856.683	1.856
MCH	4 x ANC	80% pregnant mother	2.759339.727	4.599
	Delivery + emergency	80% pregnant mother		
	Post natal care	80% pregnant mother		
Nutrition	Pregnant women	80%	1.888.814.976	3.148
*iron pill	Child coverage	100%		
*Vit. A	Child coverage	80%		
*Yodium	Lactating mother	100%		
	Kapsul yodium	100%		
	Salt monitoring	100% school		
School hlth	Th/ worm	100%	353.071.552	588
	Screening	100%		
PHN	Home visit	100%	2.505.518.244	4.176
FP	Activ acceptor	60%	2.326.362.506	3.877
	Contraceptive for the poor			
Water/sanitation			335.315.403	559
IMCI	Sick child (0-4 th)	80%	3.772.445.850	6.287
		Total	24.704.238.491	41.174

Minimum Services Standard (MSS) 2014/2015

- Formulation of new MSS by MoH & MoHA
- Supported by AIPHSS in collaboration with Adinkes (DHO-Association)
- Based on :

  a. Constitutional right

  b. Life cycle approach

  c. Empirical experiences

no	MSS (definition, indicator, performance standard)
1	Health promotion at schools
2	Health promotion at *Puskesmas*
3	Public health promotion and community empowerment
4	Health services package for pregnant women at *Puskesmas*
5	Health services package for child delivery at *Puskesmas*
6	Neonatal services by *Puskesmas*
7	Child health services at *Puskesmas*
8	Health screening/surveilance for elementary school
9	Screening and adolescence health (15- 19 yrs) at *Puskesmas*
10	Screening and reproductive health for adult population including FP
11	Screening for aging population (> 60 yrs) at *Puskesmas*
12	Exam for suspect tb at *Puskesmas* and district hospital
13	Test for suspect HIV at *Puskesmas* and district hospital
14	Environmental health activity at elementary school by *Puskesmas*
15	Environmental health program at traditional market by *Puskesmas*
16	Early Warning and Response against disaster less then 24 hours for cases with outbreak risk

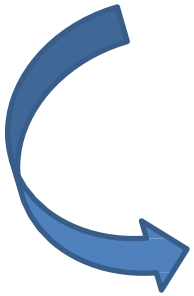
AIPHSS support

MSS = gov't obligatory functions

2. Financing PH

Most PH interventions (listed in MSS) are Public goods and Merit Goods

1. No or little Marginal Cost
2. Non excludable (free rider phenomena)
3. Non rivalry (no competition to consume)
4. *Large externality*



- *Most people do not want to pay*
- *Price mechanism would not work*
- *People don't see financial risk*
- *Insurance is not appropriate* ➔ *would not work*

Regulation on Health Financing

UU-36 (Health Law 2009)

114.Pembiayaan pelayanan kesehatan masyarakat merupakan barang publik (*public good)* yang menjadi tanggung jawab pemerintah, sedangkan untuk pelayanan kesehatan perorangan pembiayaannya bersifat privat, kecuali pembiayaan untuk masyarakat miskin dan tidak mampu menjadi tanggung jawab pemerintah. ➔ UKM: tax based

115.Pembiayaan pelayanan kesehatan perorangan diselenggarakan melalui jaminan pemeliharaan kesehatan dengan mekanisme asuransi sosial yang pada waktunya diharapkan akan mencapai *universal health coverage* sesuai dengan Undang-Undang Nomor 40 Tahun 2004 tentang Sistem Jaminan Sosial Nasional (SJSN) dan Undang-Undang Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial. ➔ UKP: askes

PH: public good, gov't funded

Clinical services: insurance

Currently PH is severely underfunded

DHA in 7 province (2009/2010)

Jenis Program	Provinsi						
	NTT (21 Districts)	Bali (9 Districts)	Lampung (10 Districts)	Sulbar (5 Districts)	Jambi (4 Districts)	Kalsel (4 Districts)	Gorontalo (3 Districts)
PR.1 Program Kesehatan Masyarakat	**12,05%**	**2,89%**	**4,58%**	**9,12%**	**3,94%**	**3,73%**	**9,76%**
PR 1.1 KIA	1,70%	0,17%	0,35%	0,39%	0,38%	0,61%	1,27%
PR 1.2 Gizi	1,83%	0,22%	0,24%	1,49%	0,43%	0,36%	2,22%
PR 1.3 Imunisasi	0,22%	0,05%	0,09%	0,02%	0,22%	0,20%	0,05%
PR 1.4 TBC	0,07%	0,04%	0,07%	0,03%	0,07%	0,12%	0,01%
PR 1.5 Malaria	0,83%	0,03%	0,13%	0,60%	0,13%	0,25%	0,12%
PR 1.6 HIV/AIDS	0,12%	0,06%	0,00%	0,00%	0,02%	0,00%	0,00%
PR 1.7 Diare	0,02%	0,00%	0,00%	0,00%	0,00%	0,00%	0,00%
PR 1.8 ISPA	0,00%	0,01%	0,02%	0,00%	0,00%	0,01%	0,01%
PR 1.9 Demam Berdarah	0,01%	0,16%	0,07%	0,01%	0,06%	0,14%	0,00%
PR 1.10 Penyakit Menular Lain	0,35%	0,26%	0,08%	0,08%	0,12%	0,10%	0,06%
PR 1.11 Penyakit Tidak Menular	0,01%	0,00%	0,01%	0,02%	0,01%	0,15%	0,00%
PR 1.12 KB	1,01%	0,53%	0,47%	0,49%	0,21%	0,27%	0,99%
PR 1.13 UKS (Usaha Kesehatan Sekolah)	0,20%	0,04%	0,04%	0,00%	0,07%	0,12%	0,00%
PR 1.14 Kesehatan Remaja	0,02%	0,02%	0,00%	0,00%	0,00%	0,02%	0,00%
PR 1.15 Kesehatan Lingkungan	3,20%	0,16%	0,30%	2,28%	1,58%	0,38%	0,51%
PR 1.16 Promosi Kesehatan	0,26%	0,72%	1,02%	0,08%	0,34%	0,32%	0,13%
PR 1.17 Penanggulangan Bencana	0,04%	0,01%	0,01%	0,03%	0,00%	0,03%	0,00%
PR 1.18 Surveilans	0,03%	0,02%	0,04%	0,10%	0,03%	0,09%	0,04%
PR 1.19 Program Kesehatan Masyarakat Lainnya	2,13%	0,40%	1,65%	3,49%	0,27%	0,55%	4,35%
PR 2 Program Upaya Kesehatan Perorangan	**32,54%**	**45,53%**	**66,60%**	**30,45%**	**39,88%**	**41,56%**	**32,02%**
PR 2.1 Pelayanan Rawat Jalan	3,20%	1,31%	2,98%	1,74%	0,41%	0,71%	0,16%
PR 2.2 Pelayanan Rawat inap	2,36%	0,73%	1,85%	0,32%	0,43%	0,26%	0,29%
PR 2.3 Pelayanan Rujukan	0,40%	0,42%	0,10%	0,04%	0,04%	0,03%	0,00%
PR 2.4 Pengobatan Umum (tidak jelas masuk PR 2.1- 2.3)	26,58%	43,07%	61,68%	28,35%	38,99%	40,57%	31,57%
PR 3 Program Yang Menyangkut Capacity Building/Penunjang	**55,41%**	**51,57%**	**28,84%**	**60,43%**	**56,18%**	**54,72%**	**58,22%**
PR 3.1 Administrasi & Manajemen	24,38%	27,55%	15,80%	24,87%	26,78%	28,80%	28,88%
PR 3.2 Sistem Informasi Kesehatan	1,48%	0,06%	0,02%	0,01%	0,13%	0,16%	0,10%
PR 3.3 Capacity Building	1,34%	0,16%	0,17%	0,49%	0,36%	0,91%	0,56%
PR 3.4 Pengadaan dan Pemeliharaan Infrastruktur	18,55%	12,28%	7,58%	25,63%	15,41%	13,83%	16,28%
PR 3.5 Pengawasan (Monitoring dan Supervisi)	1,16%	0,01%	0,01%	0,15%	0,03%	0,74%	1,67%
PR 3.6 Obat dan Perbekalan Kesehatan	7,53%	4,38%	2,49%	5,97%	12,70%	4,88%	10,33%
PR 3.7 Jaminan Kesehatan	3,15%	7,07%	2,69%	3,29%	0,67%	5,40%	0,40%
PR 3.8 Program Capacity Building/Penunjang Lainnya	0,49%	0,06%	0,09%	0,01%	0,09%	0,00%	0,00%
Grand Total	**100,00%**	**100,00%**	**100,02%**	**100,00%**	**100,00%**	**100,00%**	**100,00%**

Public Health

3 – 12%

30– 66%

Curative services

Salary & infrastruc-ture

30– 60%

Reason for "BOK" funding

BOK (Bantuan Operasional Kesehatan)
➔ MoH response to DHA results

* Since 2010
* Central funding chanelled directly to Puskesmas
* Only for operating cost of PH activities
* Support 9,500 Puskesmas
* Back bone of PH financing

	2010	2011	2013	2014	2015
BOK	390 M	990 M	1.16 T	1.22 T	1.4 T
PBI (*)				19.75 T	19.9 T

(*) PBI = premium subsidy for the poor

How to improve PH (MSS) financing

- Costing of MSS (on going) → basis for allocating APBD(District Budget)
- Maintain and increase BOK → equalizing role of central gov't based on district fiscal capacity
- Tobacco tax for PH to complementary to BOK and APBD (*)
- Village Grant for PH program

Tobacco tax for MSS

(2014: 117.5 Trilions)

Flotim 2013: Pattern of household expenditure

Pengeluaran	Per Rumah Tangga Per Tahun					Total Kabupaten Setahun	
	Q1	Q2	Q3	Q4	Q5	Rp.	%
Total	12.474.523	13.467.182	14.167.662	15.272.649	33.344.303	870.779.449.502	100,00
Makanan	9.434.667	9.798.369	10.012.873	10.415.117	17.964.640	586.256.764.659	67,33
Non Makanan	3.039.856	3.668.814	4.154.789	4.857.532	15.379.664	284.522.684.843	32,67
Kesehatan	212.628	234.173	230.489	221.333	957.512	18.287.854.641	2,10
Pendidikan	332.498	405.370	495.505	780.972	1.316.200	34.050.013.520	3,91
Pulsa	121.488	159.340	189.932	283.193	809.212	15.320.933.362	1,76
Alkohol	6.347	17.200	13.983	25.680	41.385	1.204.080.229	0,14
Rokok	148.721	156.990	180.149	280.690	497.107	11.835.540.574	1,36
Sirih Pinang	29.694	21.001	27.845	33.930	24.298	1.709.960.162	0,20

Population : 202.305

Poo r : 51 %

Spending for cigarette : 11.835.540.574

The poor contribution (3 lowest Quintiles) : 4.550.614.402

Sharing tobacco tax (DBHCT) : 6.000.000.000

- Advocating local goverment
- Revision of manual on “Tobacco tax for health”

NGADA DISTRICT
DBHCT → COMPLEMENT
BOK

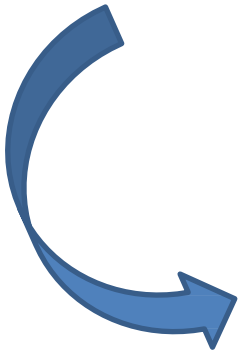
Village grant (Dana Desa) for MSS

UU-06/2014 (Village Law 2014)

Article-74 (2) Village fund for basic services:

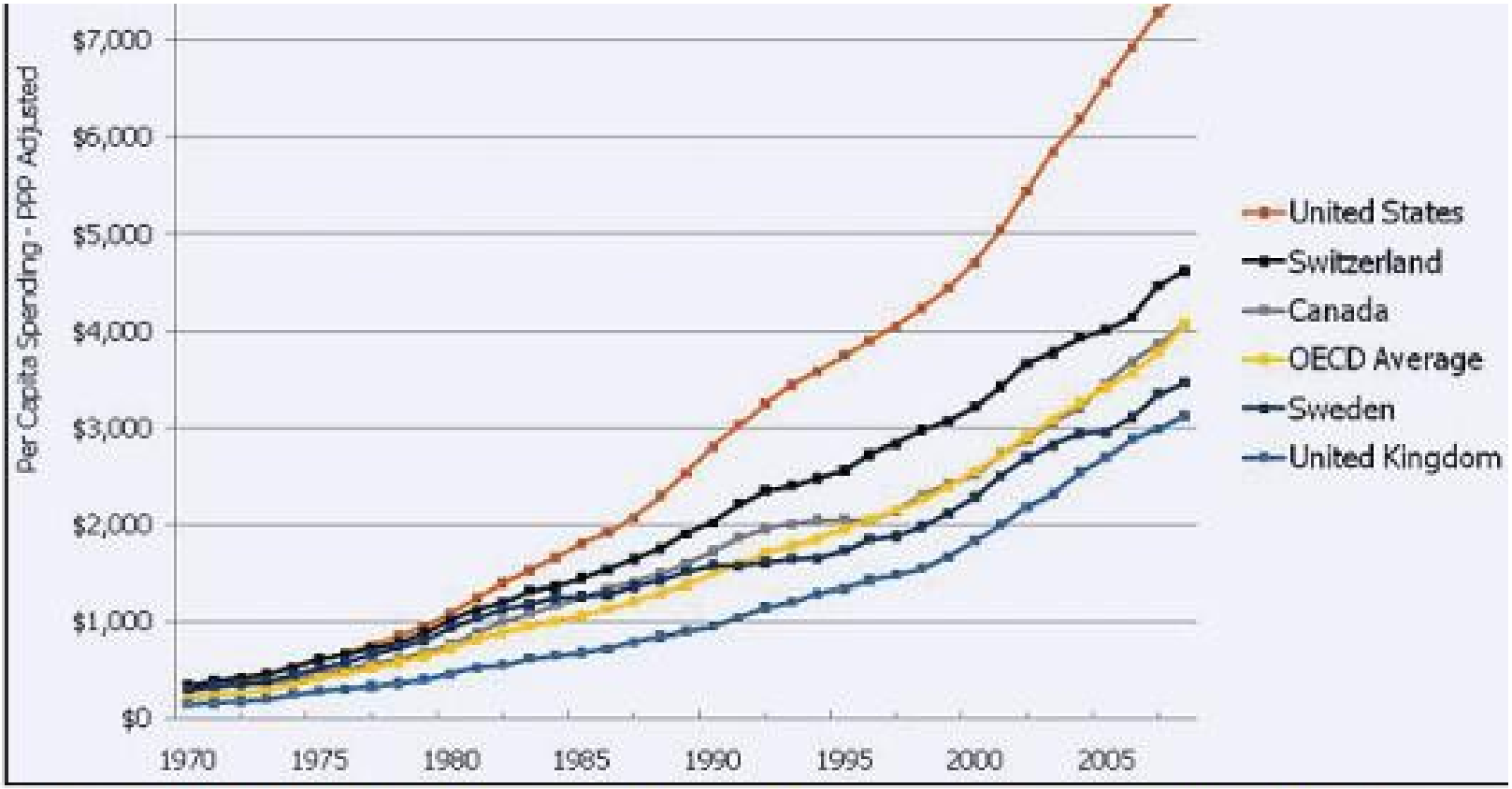
1. Education
2. Health
3. Basic infrastructure

1. **Village Health Post**
2. **Posyandu**
3. **Health Promotion**
4. **Promoting Healthy Behavior (PHBS)**



2015: 9.066.199.999.794 (9 T)
Average: 500 mills/village
73.000 villages
➔ Village health social movement

3. Controlling Health Care Cost Inflation



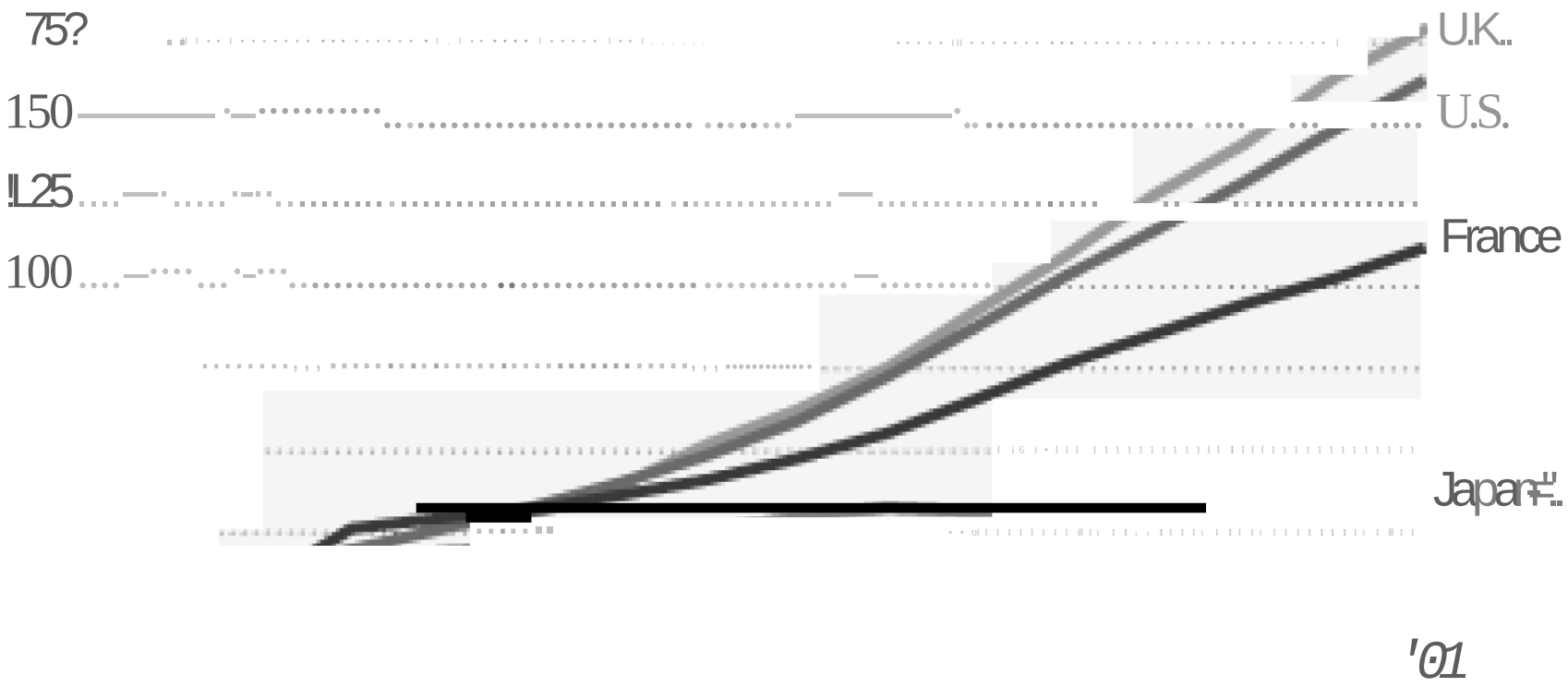
KFF sources and notes: *"**Source:** Organisation for Economic Co-operation and Development (2010), "OECD Health Data", OECD Health Statistics (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011).*

Notes: *Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK (1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008."*

Different but the same

Health expediture in France is growing quickly and even sma 11 changes to the current: system are hard it won

Cumulative percentage change -n total e:qJendlture on health



*Through 2006

Soorce: GEID Hilattfu Da a 2009

Figure 2. Global average medical trend rates by country: 2011 - 2014

	2012	2013	2014 (expected)	2012	2013	2014 (expected)
Global	7.7%	7.9%	8%	3.8%	4 4%	4.8%
Americas	9. %	91%	9%	5.3%	5 3%	5.8%
Brazil	129%	!!3.2%	1..0%	7.5%	6.8%	8.2%
cariada ·	1 19%	!!.12%	113%	!!0.4%	10.1%	9.7%
Chile	d5%	48%	d5%	!!..5%	3.0%	!!..5%
Coornbia'"	6.6%	6.2%	64%	3.4%	4.0%	3.4%
Costa Rca	10.0%	!!.10	12.0%	5.5%	6.3%	70%
Oominican Republ-e	5.0%	60	8.0%	!!3%	1.5%	3.3%
=cuador	75%	8.8%	105%	2.4%	6.0%	8.1%
=l Salvador	10.0%	8.0l<	8.0%	8.3%	6.1%	5.6%
Guatemala	8.0%	7.5%	9.0%	4.2%	3.0%	4.5%
Honduras	10.0%	8.0l<	10.0%	48"16	2.6%	50"16
Mexico..	6.6%	6.5%	69%	2.5%	2.9%	3.9'..
Paoarna	12.0%	!!.20	12.0%	6.3%	7.8%	8.0%
Peru	6.3%	5.7%	5.9%	2.6%	2.8%	3.4%
Venezuea	j 2 _ 5.0%	35.0l<	..00%	3.9'..	- 2.9%	2.0%
Asia Pac fic	84%	8.8%	9%	4.3%	51%	5.5%
Austraa	7.0%	7.0l<	7.0%	5.2%	4.8%	4.5%
a.a ,gadesh	10.0%	100	10.0%	!!3%	2..1%	3.5%
China..	74%	7.8%	8.3%	48%	5.0%	5.4%
Hong Kong..	9.8%	10.1%	9.3%	58%	6.6%	58%
ndia'"	10.6%	!!.14%	11.2%	0.2%	0.5%	2.3%
ndonesa	115%	!!.2.5%	135%	7.2%	5.2%	6.0%
Ma aysa	10.3%	103%	12.0%	8.7%	8.3%	9.4%
Phippines..	8.8%	9.2%	9.8%	5.6%	6..1%	6.3%
Singapore	7.!!.%	8.1%	85%	2.6%	5.8%	58%
S:>uth Korea	8.0%	5.0l<	10.0%	58%	3.6%	7.7%
Taiwan	3.8%	43%	5.0%	!!8%	3.1%	3.0%
Thaand	6.3%	63%	8.7%	3.3%	4.1%	6.5%
V e:nam	10.0%	100	10.0%	0.9'..	1 2%	2.6%

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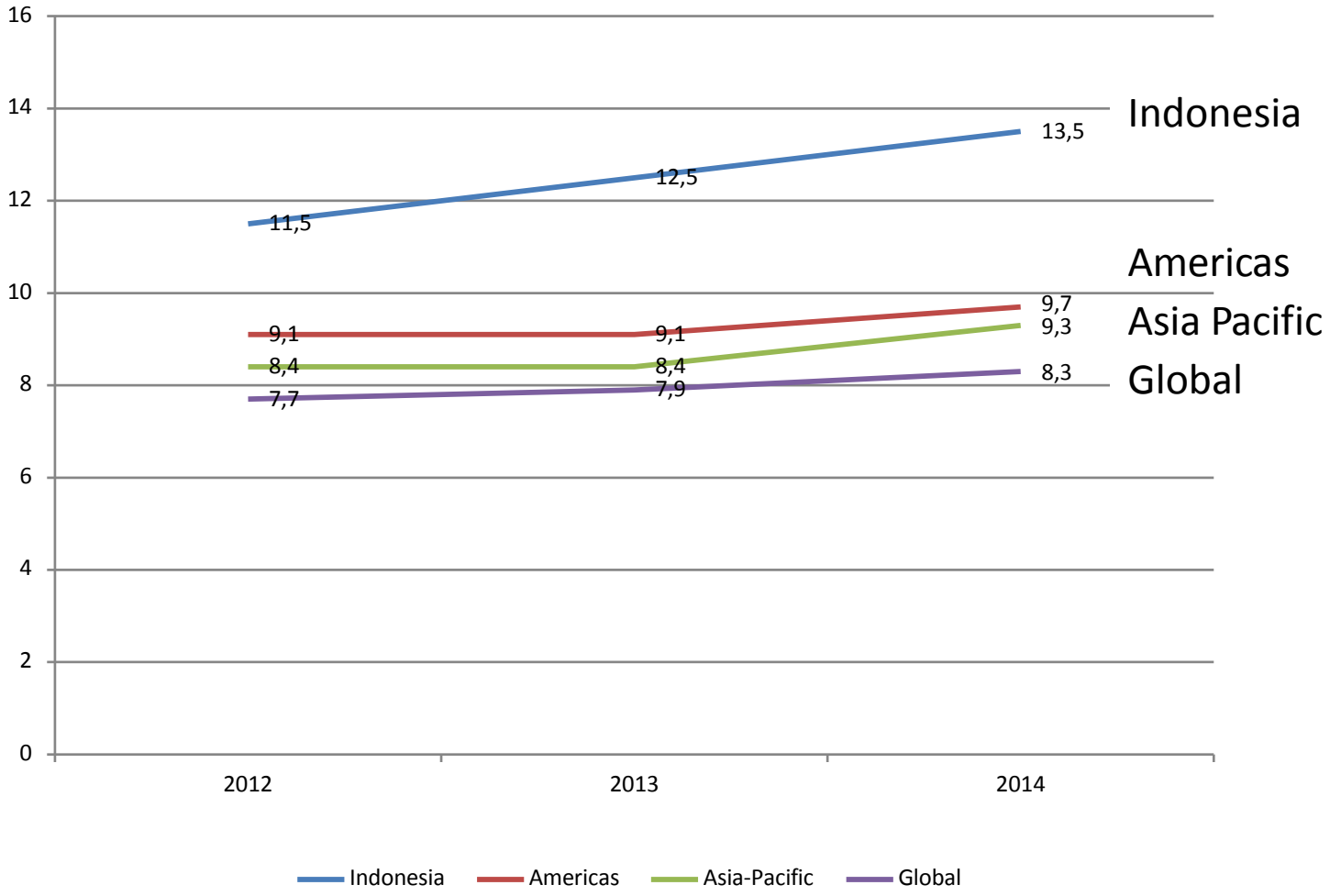
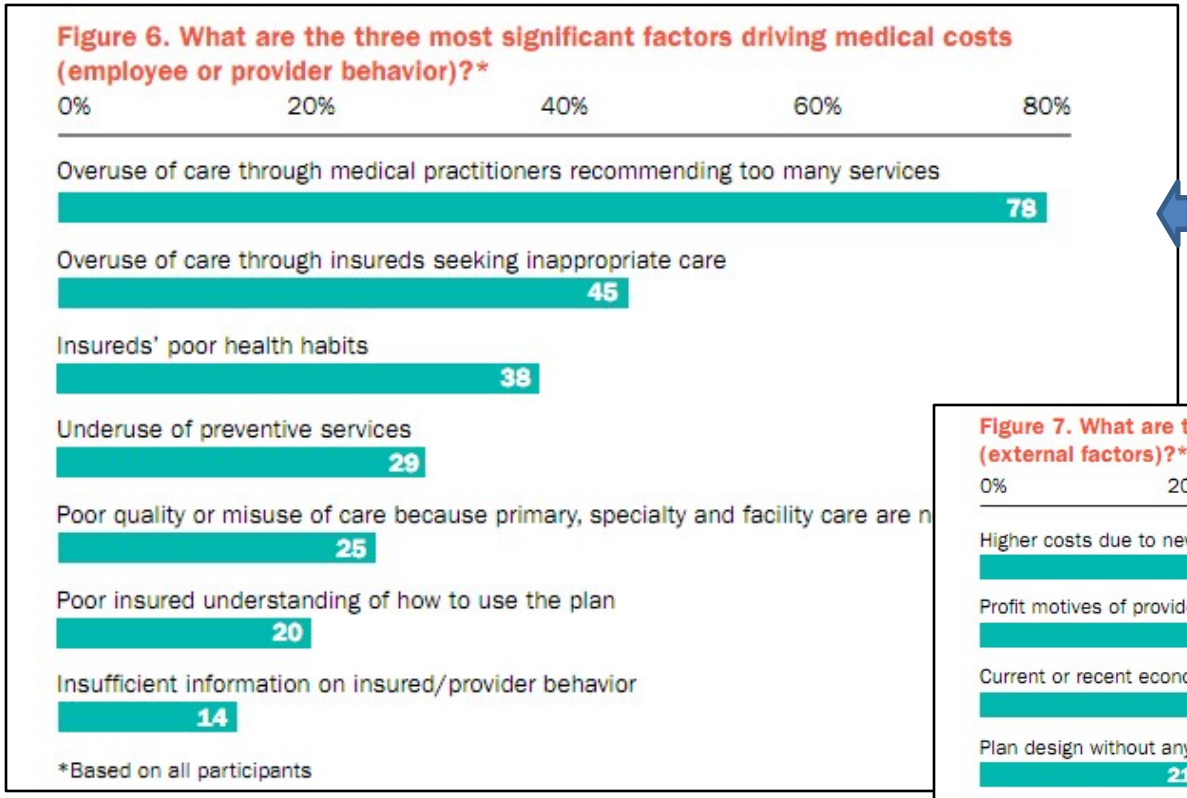
Health Care Cost Inflation Rates

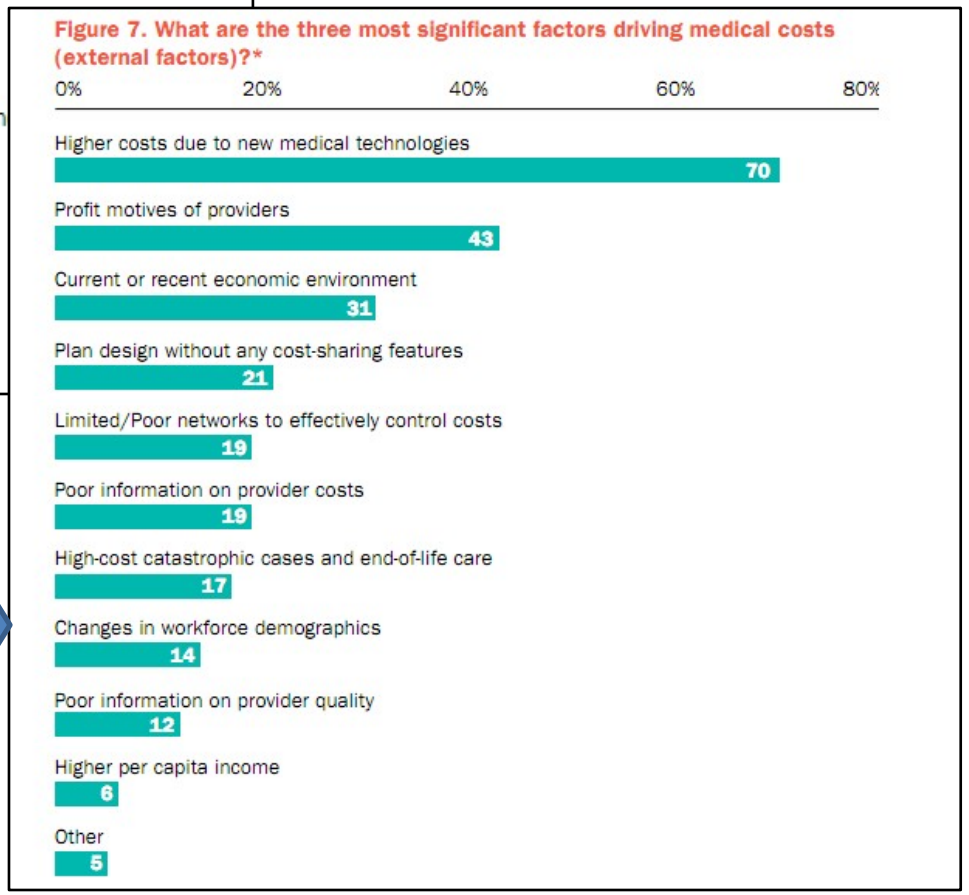


COST DRIVERS



Providers & member behavior

- Supplier push; over utilization
- Demand pull; over utilization
- Weak preventive services

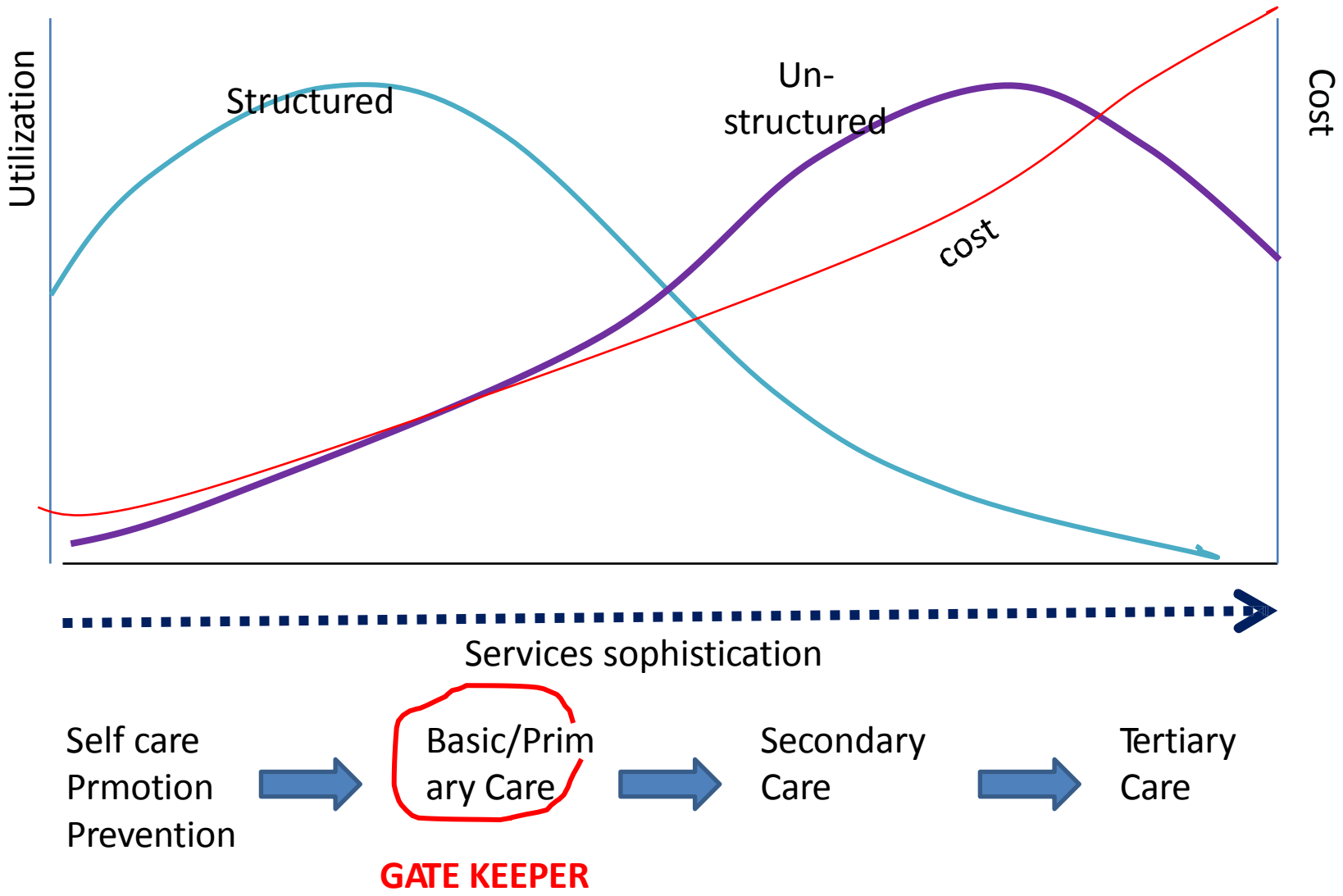


Extenal factors

- Higher cost med. tech
- Providers profit motive
- Economic environment

COST DRIVER: weak PH intervention

Utilization structure in health insurance system



COST DRIVER:
Hi spending on 2nd and 3rd care (hospitals)

14 national hospitals

20 provincial Referal hosps

3rd Care

Provincial Reff Hosp

Regional Reff Hospital

Regional ref hospital

Regional ref hospital

Regional ref hospital

Regional ref hospital

110 regional referal hospitals @ Rp 20 billions

RSUD (district Hospital)

2nd and 3rd Care

Puskesmas:

Pustu:

Poskesdes:

1st Care

9.500 Puskesmas

National
Provincial

Regional

District

Sub-district

Health care cost containment

General

* Policy on rational drug price
* Beyond health ➔ other sectors

Primary Health Care: 9.500 Puskesmas

- Strengthen PHC : promotion and prevention; comm. empowerment
- Strengthen primary care: early D/ and prompt-Th/

Within JKN:

- Strong gate keeper (primary care provider)
- Establish effective referral system
- UR (utilization review): *managing admission*
- Medical audit: in all hospitals ➔ to ensure compliance to standards
- Strategic purchasing (improve current CBGs and capitation payment)
- Fraud control

4. UHC: The fallacy of the “magic cube”

What is universal coverage ?

[WHO: WHR-2010]

Tax financing

JKN

Universal coverage (UC), or universal health coverage (UHC), is defined as ensuring that all people can use the **promotive, preventive, curative, rehabilitative and palliative** health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UC embodies three related objectives:

- **equity in access** to health services - those who need the services should get them, not only those who can pay for them;
- that the **quality of health services** is good enough to improve the health of those receiving services; and
- **financial-risk protection** - ensuring that the cost of using care does not put people at risk of financial hardship.

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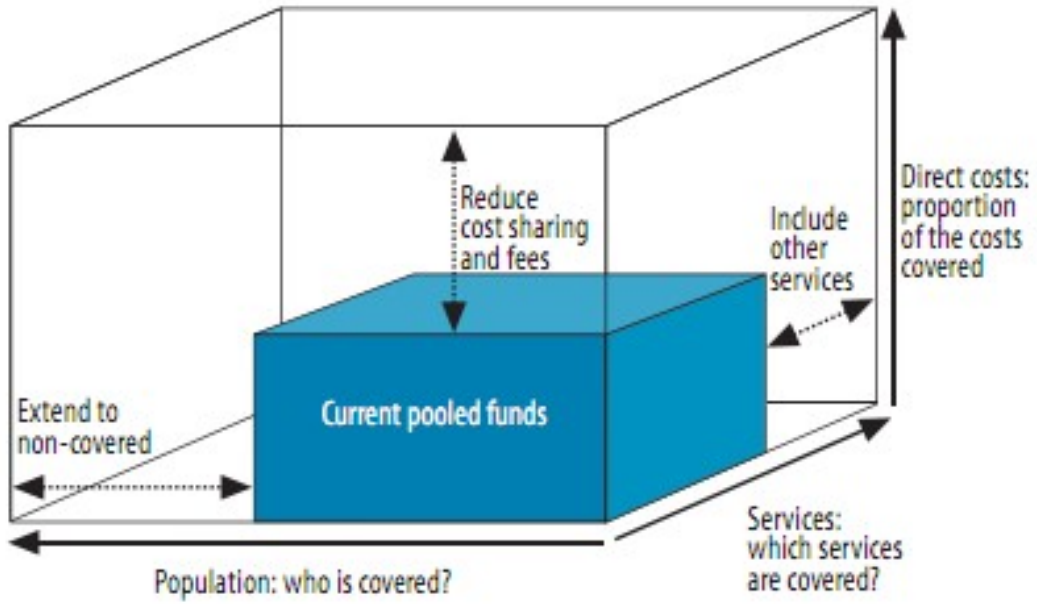
JKN

Fig. 1. **Three dimensions to consider when moving towards universal coverage**



Thee dimensions of UHC

- % population with health insurance
- Comprehensive health services
- No cost sharing

The fallacy:

- Provide financial protection
- But not risk reduction

Missing from the cube:

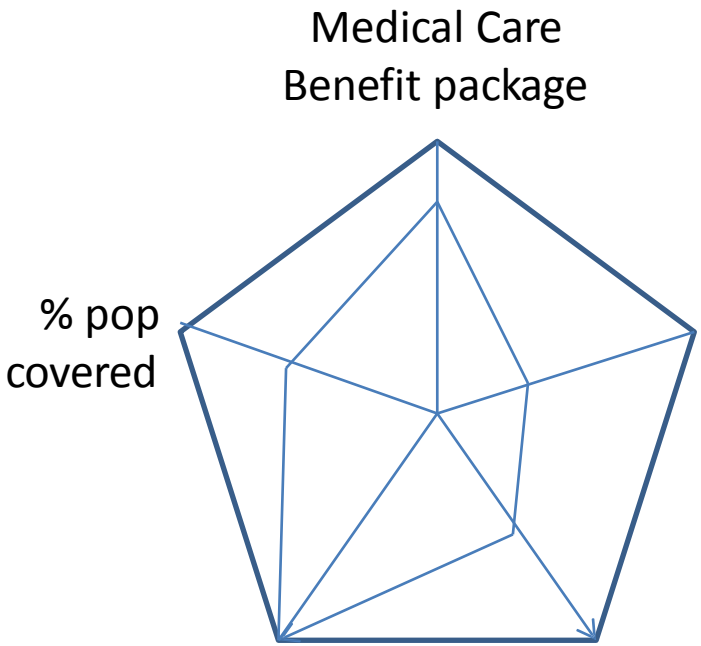
- Access to PH program
- Supply side: access and quality

- INEQUITY >>
- FAIRNESS <<

* AG 2010
* SEARO 2011

5 dimension of UHC

DEPARTED FROM THE ISSUE OF HEALTH RISK



BPJS

Demand

(protection against financial risk)

BOK etc

Supply

(access and utilization)

Protection against health risk

Ascobat, 2010

Health y Indonesia Program

Health Paradigm

- Risk Reduction

- PH programs
- Promotion
- Prevention

Strentthen HealthServices

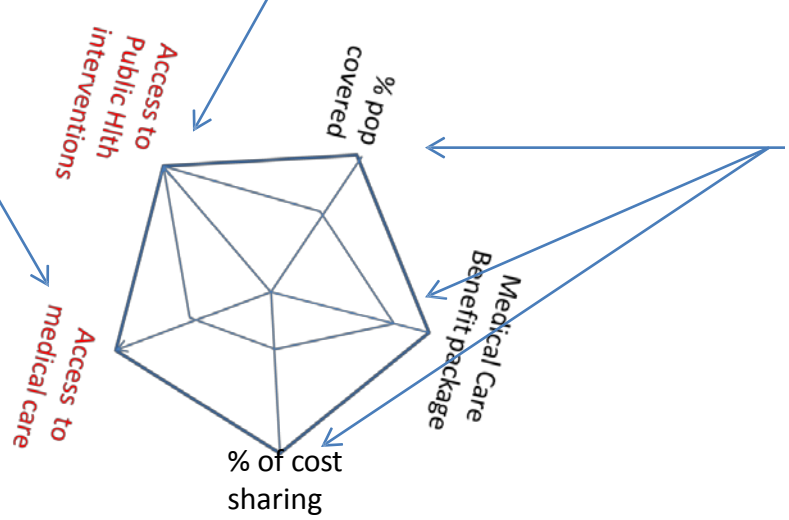
- Access
- Quality

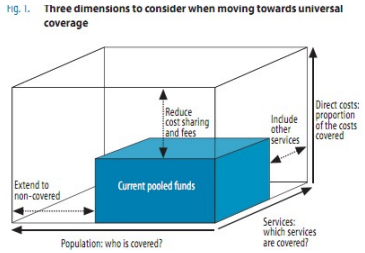
- Infrastrucure
- WHF

NHI (JKN)

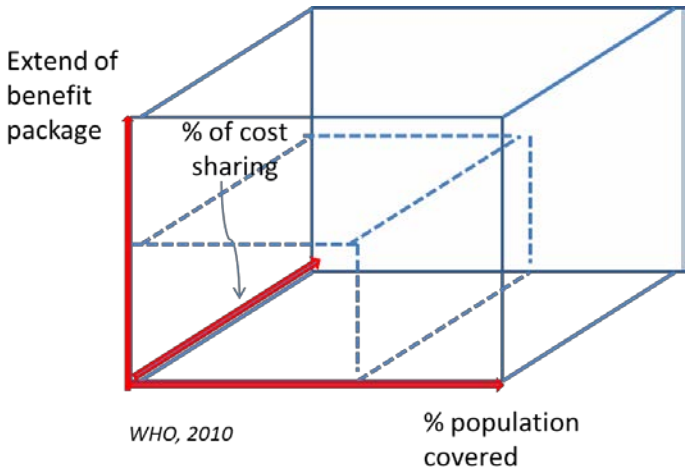
- Financial protection

- Treatment
- (1st, 22nd, 3rd)



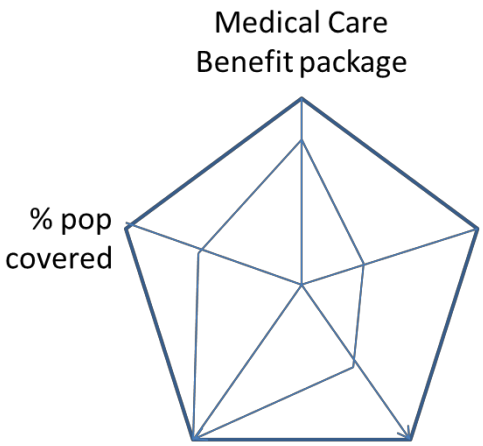


Three dimensions of UHC



WHO, 2010

5 dimension of UHC



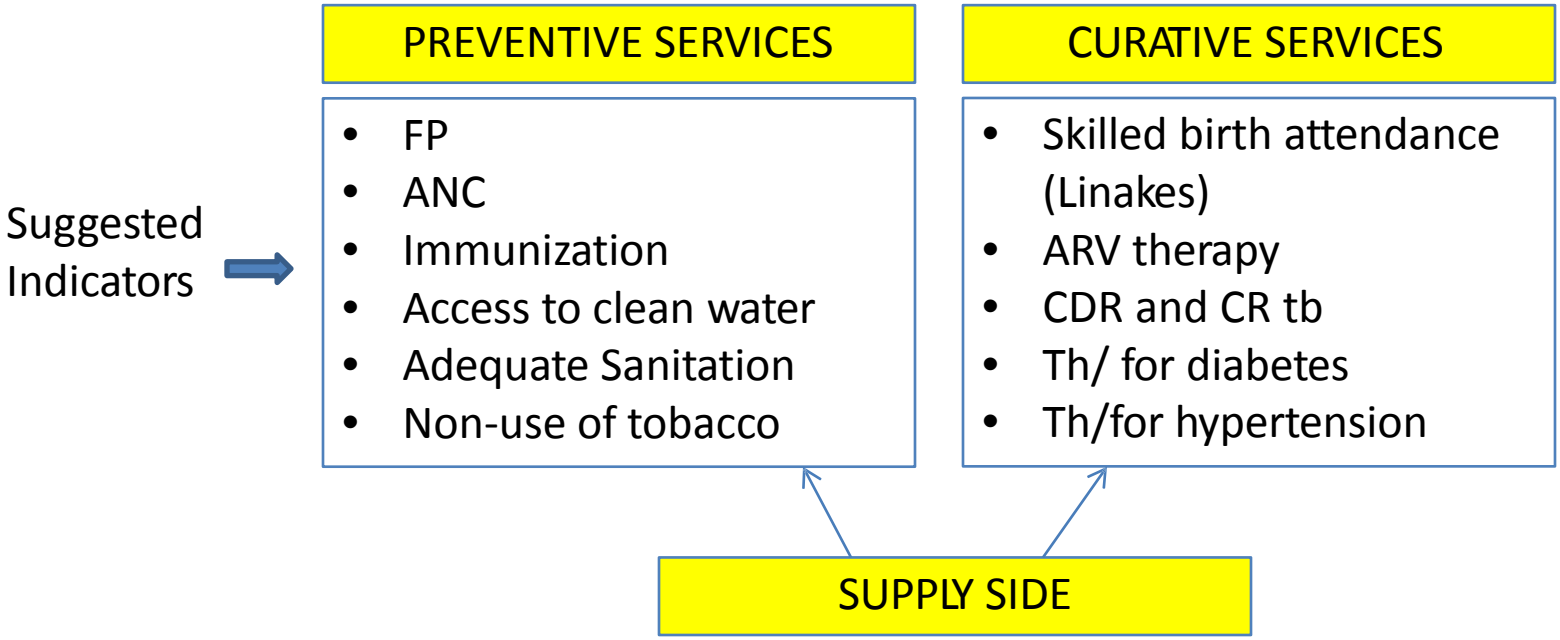
BPJS
Demand
(protection against financial risk)

BOK etc
Supply
(access and utilization)

Protection against health risk

Ascobat, SEARO 2010

WHO & WB, May 2014
"Monitoring progress toward UHC"



- **Social Health Insurance (SHI) is essential element to achieve UHC (financial protection)**
- **PH is also essential element of UHC (risk reduction)**
- **Without effective PH → SHI may become un-affordable**
- **UHC should move from "the magic cube" to "the flying spider web"**

Summary
Improving Health Financing

- Define and clarify comprehensive services both (i) clinical services and (ii) public health
- Reform PH financing
- Control cost inflation
- UHC: move from “magic cube” to “spider web”

Terima kasih