Financing Universal Health Coverage (UHC) Policy: Lesson Learned From Indonesia and Thailand

Comparative Social Policy
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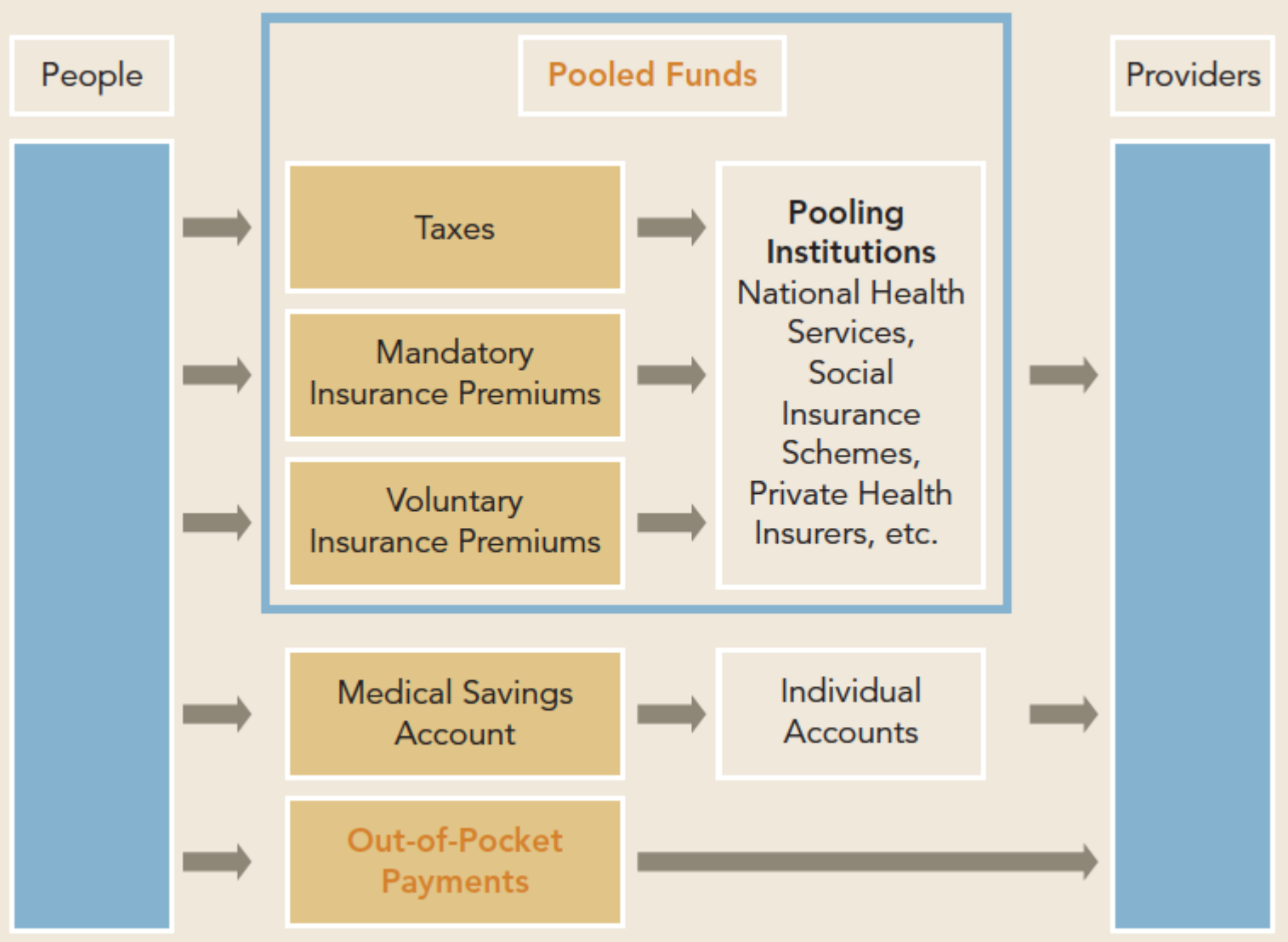
Topics

1. UHC (*Universal Health Coverage*) Policy: Objectives, Profiles, and Policy Directions
2. Financing health insurance: Indonesia, ASEAN Countries, and international practices
3. Policy implementation: The Evolving BPJS Health Schemes
4. Health insurance in a decentralized system.

Health service quality comes from a good social policy…

“Governments have choices about how to best allocate their resources within the health sector — between different types of health services, between different modes of financing and delivery, and between different levels of care — all of which have implications for improving the health of the poor (Shah, 2005).

Pooled (Universal) Funds vs. OOP Health Services



Source: Savedoff et al, 2012

Health Finance Models

1. **Beveridge**: provided by government-financed health facilities, managed by government agencies. Examples: UK, Spain, Scandinavians, Cuba, New Zealand, Hongkong.
2. **Bismarck**: provided by private institutions; financed by non-profit insurance system, the premium is paid by employees, corporates, and the government; managed and controlled by the government. Examples: Germany, France, Switzerland, Belgium, Japan.
3. **National Health Insurance System:** provided by private institutions, financed by the government from the levied taxes. Examples: Canada, Taiwan, South Korea.
4. **Out-Of-Pocket (OOP)**: provided by private health facilities, financed by the patients through direct payments, no institutional management. Examples: most developing countries in Sub-Saharan Africa, India, China (before 1990s), Latin American countries.

International Experience

- USA: allocated 17.9% of its GDP for health, but 15.4% of its citizens are uncovered by health insurance → currently shifting toward UHC policy with the Obamacare.
- Western Europeans (Germany, France, UK, Netherlands, Switzerland) have been adopting UHC since WW II.
- The BRIC (Brazil, Russia, India, China) are moving towards the UHC policy.
- In Asia: Kyrgystan, Malaysia & Thailand have been successfully adopting the UHC policy in the last two decades.
- A strong commitment is fundamental for UHC policy. Example: The government in Turkey stated clearly that it is illegal for clinics and hospitals to hold patients who are unable to pay for health services.

UHC in Indonesia & Thailand

- Universal Health Coverage (UHC) policy in ASEAN countries has been a crucial issue; how should a country provides health care for their citizens? The access to quality health service, provision of health services, benefit to health scheme, and institutional design are amongst the features of UHC (Lagomarsino, 2012; Simmonds and Hort, 2013).

- The problem of inequality and poor quality still remains as the basic problem for both UHC in Indonesia and Thailand (Prakongsai et al. 2009; Limwatananon et al. 2009; Pitayarangsarit, 2012; Harimurti et al.2013; Mboi, 2014; Simmonds and Hort, 2013).

UCS Policy in Thailand #1

The UCS (Universal Coverage Scheme) was started as the 30-Baht Policy in 2001, with the initial phase of implementation in six pilot provinces that April (Hughes and Leethongdee, 2007). The policy later expanded to cover 15 additional provinces in June, and then to all areas except Bangkok in October. It was officially and institutionally established when the National Health Security Act was promulgated on November 11, 2002. National Health Security Office (NHSO), was created, which serves as a state (autonomous) agency under the authority of the National Health Security Board (NHSB).

Universal Coverage Scheme (UCS) implemented based on the National Health Security Act 2002. A long continuous fight the Universal Coverage Services to get equal health services to every citizen strategically aim to achieve the following objective:

- to focus on health promotion and prevention as well as curative care;
- to emphasize the role of primary health care and the rational use of effective and efficient integrated services;
- to foster proper referrals to hospitals;
- to ensure that subsidies on public health spending are pro-poor, at the same time ensuring that all citizens are protected against the financial risks of obtaining health care.

UCS Policy in Thailand #2

- As a results of the reform, at present the health care system in Thailand had been cut down to three major schemes: Civil Servant Medical Benefit Scheme (CSMBS), Social Security Scheme (SSS), and the National Health Security Scheme (NHSS). The 30 Baht project had been transformed to be NHSS. Each scheme targets different groups of Thai populations with different benefit packages. The one in focus of this study is the last one since it covers about 47 million 75% of population, while 8%, 15.8% are in the CSMBS and SSS respectively.
- The Thai health system is financed mainly by general government revenue (tax-based financing).
- Latest National Health Accounts study (2008) by the International Health Policy Program-Thailand, almost two-thirds of all health funding came from the central government. Local government contributed only 4 percent, and the rest was a direct contribution from households or private firms. The introduction of the UCS and the continuously rising costs of the Civil Servant Medical Benefit Scheme (CSMBS) were the main drivers of the high share of public spending on health.

Comparative Performances

No.	Parameters	Thailand	Indonesia
1	Standard procedures for hospital admission	4.68	4.10
2	Communication among agencies of UHC	4.56	3.77
3	Human resource readiness	4.46	4.18
4	Facility and infrastructure convenience	4.35	4.20
5	Pharmaceutical sufficiency	4.46	4.10
6	Equal treatment	4.62	4.12
7	Timeliness	4.32	4.03
8	Service adequacy	4.15	3.99
9	Outpatient care	4.67	4.17
10	Service improvement	4.17	4.15
11	Safety	4.27	3.99
12	Customer care	4.53	4.12

Source: Mutiarin & Thamronglak, 2015

Lack of Budget Commitment in Indonesia

Country	Per Capita GDP (US$)	Health Expenditure to GDP (%)	Doctors		Nurses and Midwives	
			N	Density per 10,000	N	Density per 10,000
Indonesia	4,700	3.0	65,722	2.9	465,662	20.4
Cambodia	1,006	5.4	3,393	2.3	11,736	7.9
Viet Nam	1,910	6.6	107,131	12.2	88,025	10.1
India	1,498	4.1	757,377	6.5	1,146,915	10
Malaysia	10,538	4.0	25,021	9.4	72,847	27.3

Source: WHO, 2013; World Bank, 2014

2014 Budget: Rp 44.9 trillion committed for the JKN (86.6 mil PBI) of the Rp 602.3 trillion total MoH budget.
2015 Budget: Rp 47.8 trillion from the total Rp 647.3 trillion MoH budget → need for premium increase?

Health Finance in Indonesia: General Issues

1. Lack of integration in implementation and coverage.
2. Fragmented fund-pooling & management
3. Different benefit packages and inadequate schemes
4. Variations in management systems of different providers
5. Insufficient government control, lack of policy coordination.

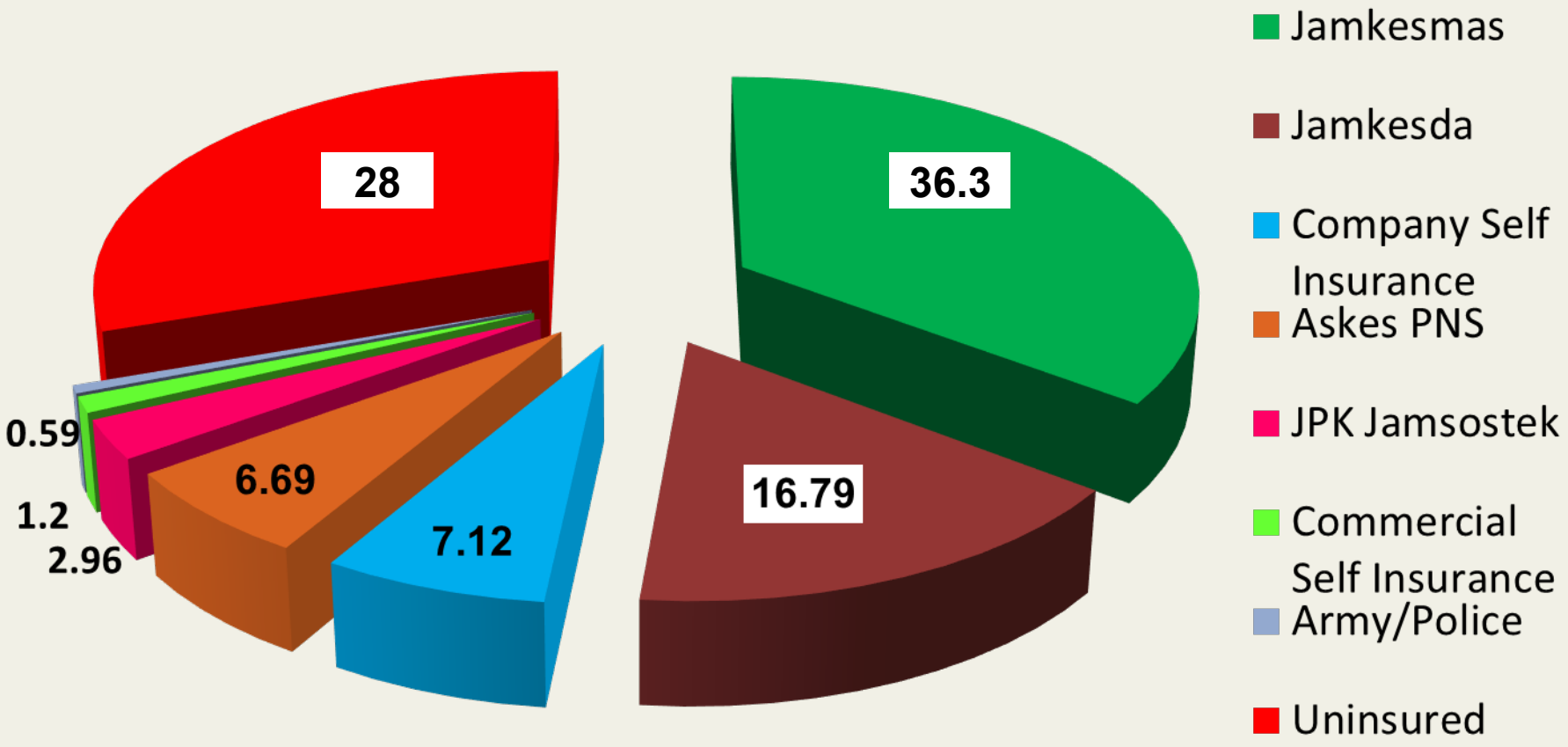
INDONESIAN HEALTH FINANCE

- GDP per capita US$ 4,700
- Total Health Expenditure → Rp 214,9 Trillion,
  → 2.9% of GDP
- Per capita Health Expenditure → US$ 101.10
- 37.5% from public spending,
  61.4% from private spending
- 72% of population → now covered by insurance (various schemes),
- 28% of population → uninsured

COMPONENTS OF SOCIAL SECURITY SYSTEM

1. Health Insurance
2. Accident insurance
3. Old age pension
4. Public pension
5. Life insurance

HEALTH INSURANCE COVERAGE (PRIOR TO THE JKN, 2014)



ROADMAP TO UHC

86,4 mio PBI

121,6 mio covered by BPJS Keesehatan

50,07 mio covered by other schemes

73,8 mio uninsured people

Coverage of various existing schemes **148,2mio**

Uninsured people 90,4 mio

Activities:
Transformation, Integration, Expansion

257,5 mio (all Indonesian people) covered by BPJS Kesehatan

Level of satisfaction 85%

`Enterprises	2014	2015	2016	2017	2018	2019
Big	20%	50%	75%	100%		
Middle	20%	50%	75%	100%		
Small	10%	30%	50%	70%	100%	
Micro	10%	25%	40%	60%	80%	100%

2012 → 2013 → 2014 → 2015 → 2016 → 2017 → 2018 → 2019

Transformation from 4 existing schemes to BPJS Kesehatan (JPK Jamsostek, Jamkesmas, Askes PNS, TNI Polri)

Integration of Jamkesda into BPJS Kesehatan and regulation of commercial insurance industry

Presidential decree on operational support for Army/Police

Pengalihan Kepesertaan TNI/ POLRI ke BPJS Kesehatan

Procedure setting on membership and contribution

Company mapping and socialization

Membership expansion to big, middle, small and micro enterprises

	20%	50%	75%	100%		
B						
S	20%	50%	75%	100%		
K	10%	30%	50%	70%	100%	100%

Synchronization membership data: JPK Jamsostek, Jamkesmas dan Askes PNS/Sosial – single identity number

Consumer satisfaction measurement every 6 month

Benefit package and sevices review annually

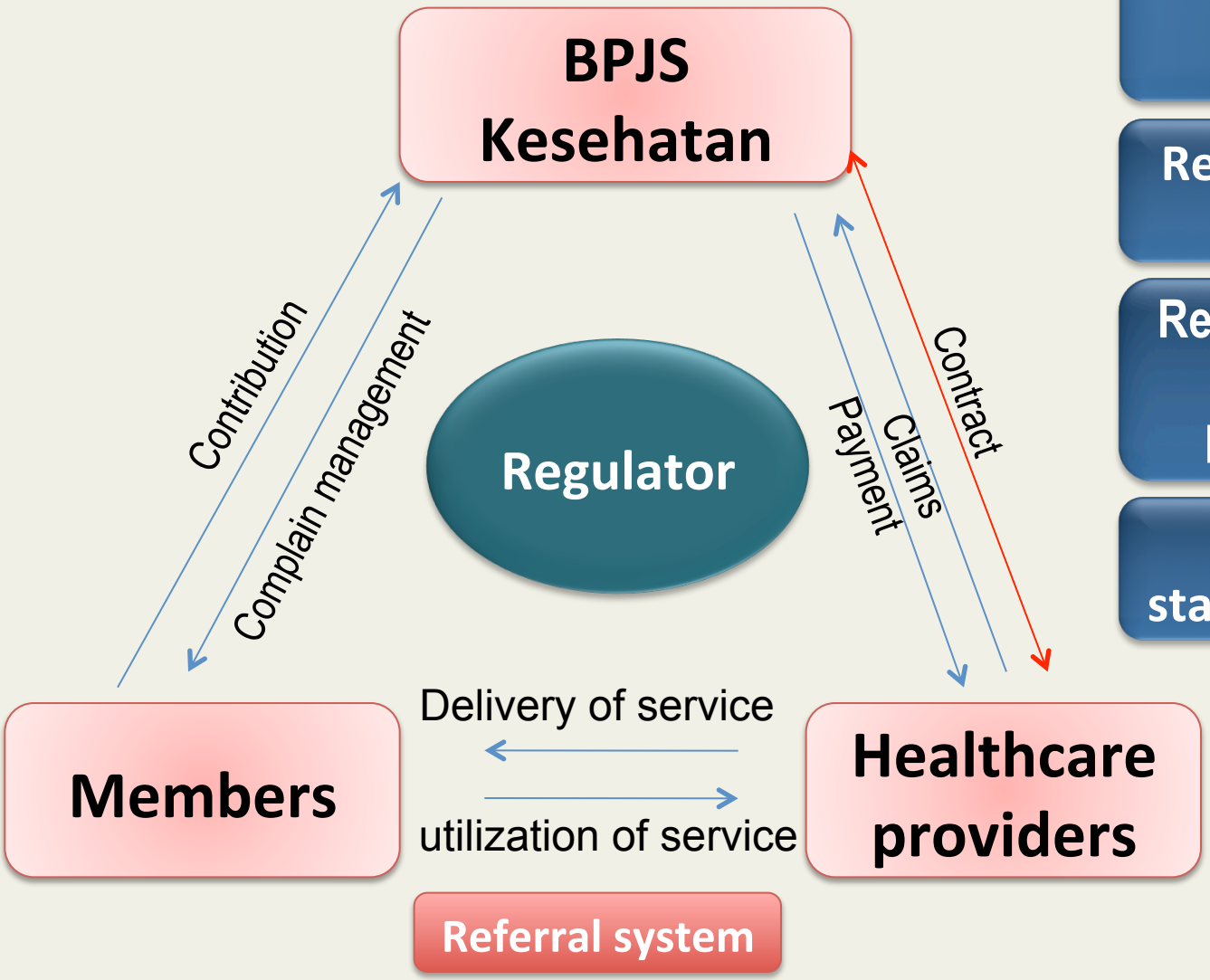
LEGAL FOUNDATION FOR INDONESIA'S NATIONAL HEALTH INSURANCE

- **Constitution of** 1945
- Act No 40/ 2004 on **National Social Security System** (**UU SJSN**)
- Act No 24/2011 on **Social Security Agency** (**BPJS**)
- Governmental Decree No 101/2012 **on Beneficiaries of Governmental Subsidy** (**PBI**)
- Pres Decree No 12/2013 **on Social Health Insurance**
- Other ancillary regulations

ADMINISTRATION & MANAGEMENT

- **Administered by BPJS** Kesehatan (single payer)
- **BPJS Kesehatan: managing** members, healthcare providers, claims, complaints, etc
- **Government:** (MoH, MoF, DJSN), regulates, monitors and evaluate implementation
- **MoH:** sets regulations on delivery of health services, drug and medical devices, tariffs, etc

NATIONAL HEALTH INSURANCE: THE JKN POLICY



Government

Regulation on delivery of health services

Regulation on Quality of care, HR, Pharmaceutical, etc

Regulation on standardization of tariff

TASK-FORCES OF THE JKN

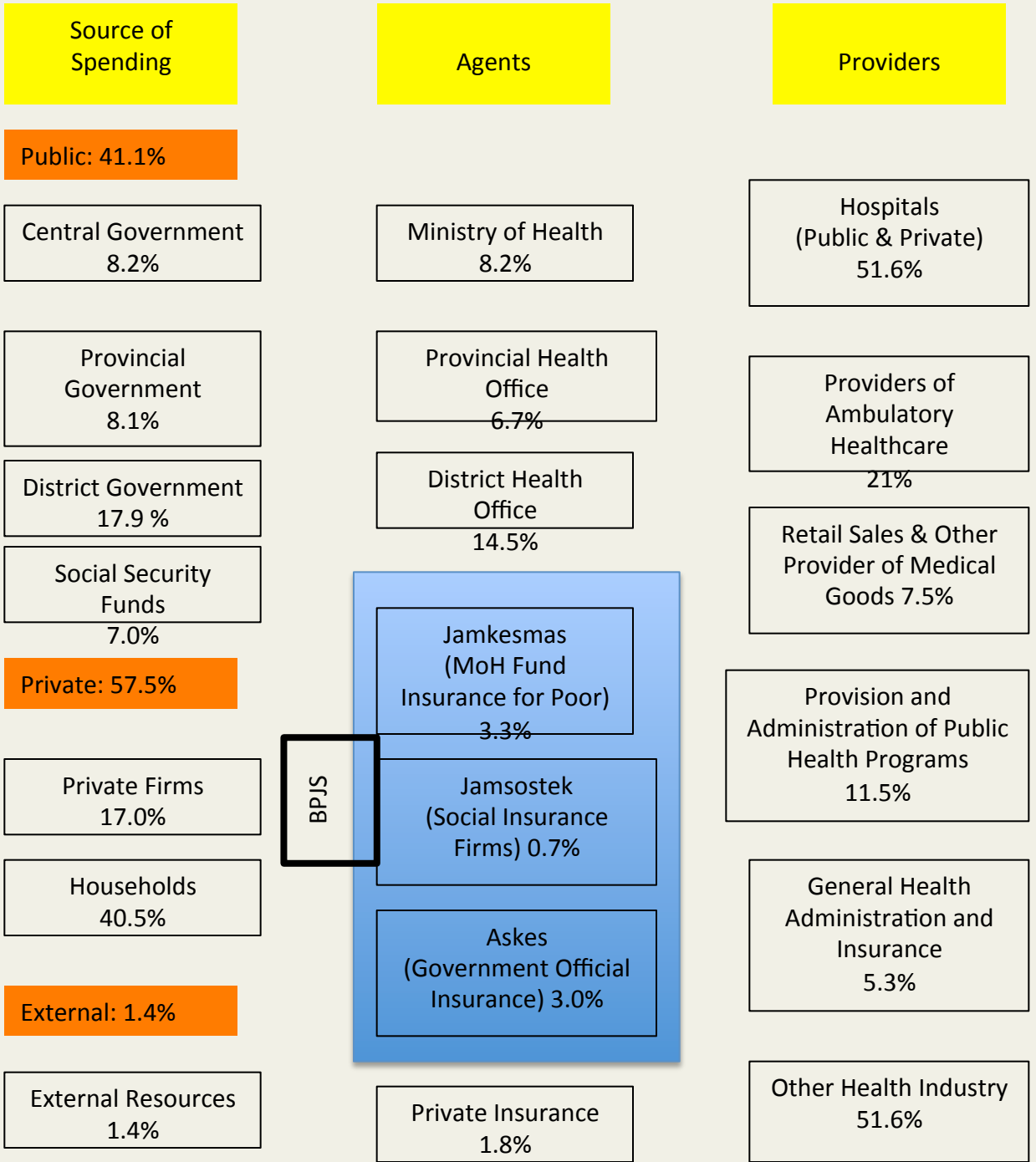
1. Health facilities, referral system & infra-structure
2. Finance, transformation of program & institutions, as needed
3. Regulations
4. Human resources & capacity building
5. Pharmaceutical & medical devices
6. Socialization & advocacy.

The Premium of National Health Insurance

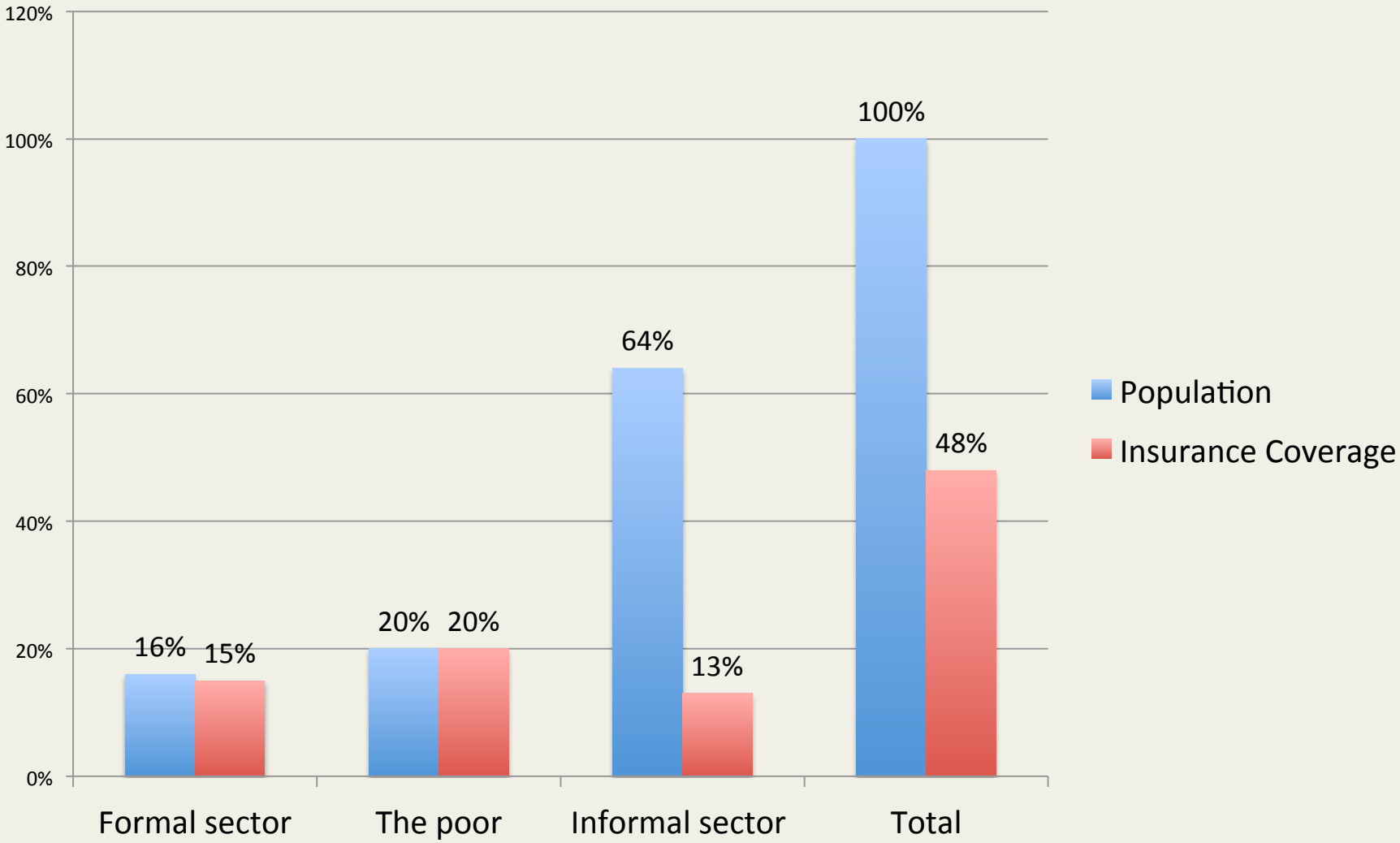
MEMBER	PREMIUM	Monthly membership fee (IDR)	REMARK
SUBSIDIZED MEMBER	NOMINAL (per member)	19.225,-	Class 3 IP care
CIVIL SERVANT/ ARMY/POLICE/ RETIRED	5% (per household)	2% from employee 3% from employer	Class 1 & 2 IP care
OTHER WORKERS WHO RECEIVE MONTHLY SALARY/ WAGE	4,5 % (per household) And 5% (per household)	**Until 30 June 2015:** 0,5% from employee 4% from employer **Start from 1 July2015:** 1% from employee 4% from employer	Class 1 & 2 IP care
NON WAGE EARNERS/ INDEPENDENT MEMBERS	NOMINAL (per member)	1. 25,500,- 2. 42,500,- 3. 59,500,-	1. Class 3 IP care 2. Class 2 IP care 3. Class 1 IP care

Finance and Provision

Source:
SHA (System of Health Accounts), Soewondo, 2011; BPJS, 2014

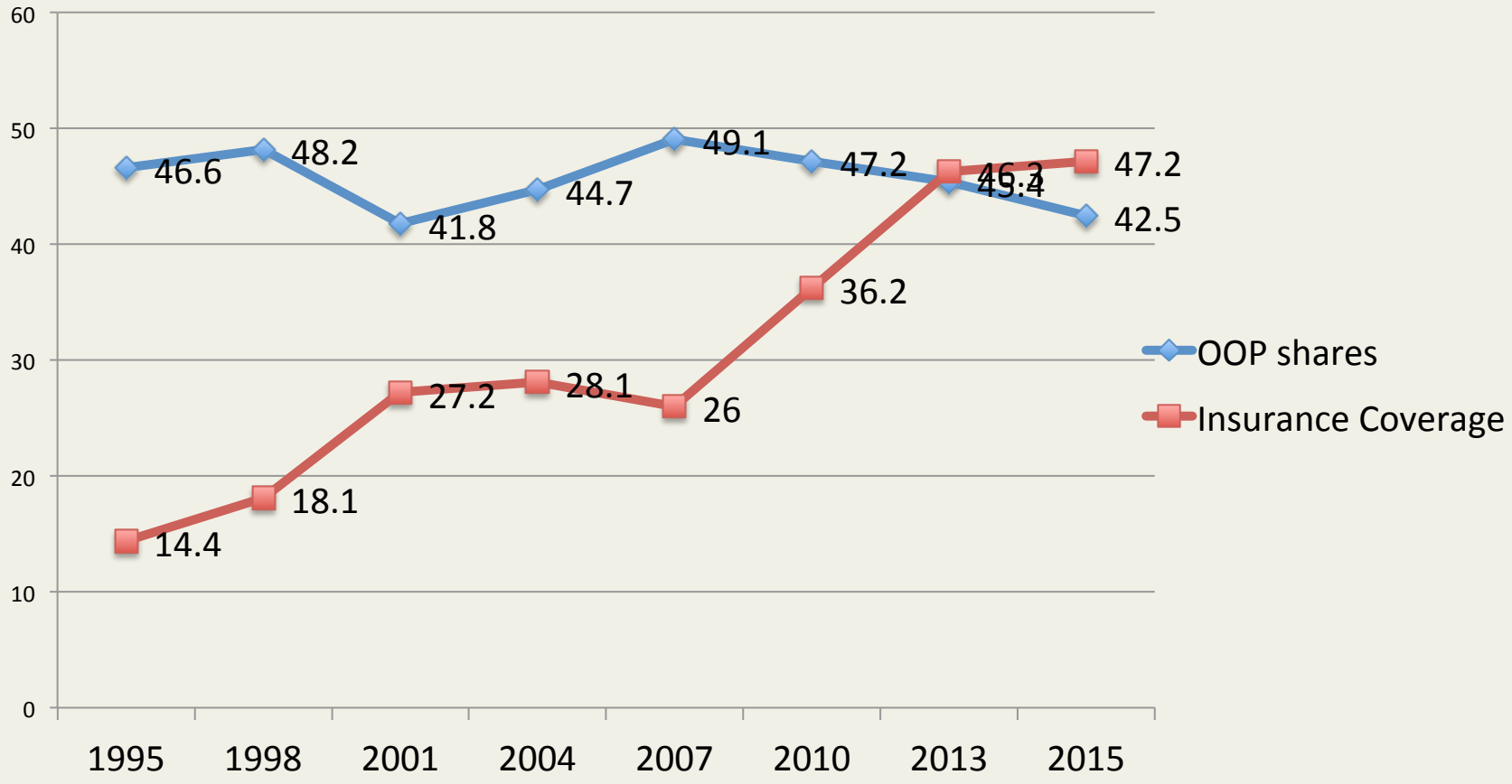


Policy Challenge: Informal Workers



Sumber: Thangcharoensathien, 2011; MoH, 2014

Reducing the OOP



Source: WHO, Susenas, 2014. The 2015 figure is an estimate.

Long queues in BPJS counters…

Variables in Medical Records

1. Patient identity
2. Date of admission to hospital
3. Date of discharge
4. Length of stay
5. Date of birth
6. Age (years) when hospitalized
7. Age (days) when hospitalized
8. Age (days) when discharge
9. Sex
10. Medical status when discharge
11. Weight on birth (gram)
12. Main diagnosis
13. Secondary diagnosis
14. Medical procedures / surgery.

Catastrophic Disease Treatment: How to Prevent "Adverse Selection"?

Components	General Hospital Class A (N=6)			General Hospital Class B (N=2)			Special Hospital (N=3)		
	CD	C	S	CD	C	S	CD	C	S
Accommodation	9.86	12.84	13.47	11.74	7.61	13.89	26.69	9.71	11.23
Ward treatment	15.7	9.87	14.79	26.17	9.75	25.15	28.36	8.38	32.12
Laboratory	19.19	11.17	23.01	14.94	6.63	11.87	10.85	11.25	12.35
Radiology	2.55	3.05	12.17	5.33	1.55	12.91	3.45	2.98	8.33
Surgery	2.44	21.74	5.29	1.46	12.53	2.61	0.00	32.77	0.00
Non-surgery	10.45	0.05	0.13	0.00	0.00	0.00	0.00	0.00	0.00
Medical rehab	3.12	0.09	1.27	0.00	0.00	0.00	0.00	0.00	2.21
Other treatment	4.74	3.47	2.12	4.69	1.04	5.34	8.78	14.83	2.23
Medicine	28.09	37.53	26.46	26.61	11.78	19.96	21.87	20.07	31.42
Medical consumables	3.86	0.18	1.30	9.06	49.12	8.27	0.00	0.00	0.00
Total	100	100	100	100	100	100	100	100	100
Average Costs (Million Rp)	410.00	236.24	228.68	396.13	136.48	305.97	38.22	86.71	62.13

Note:
CD: Cardiac Disease
C : Cancer
S : Stroke

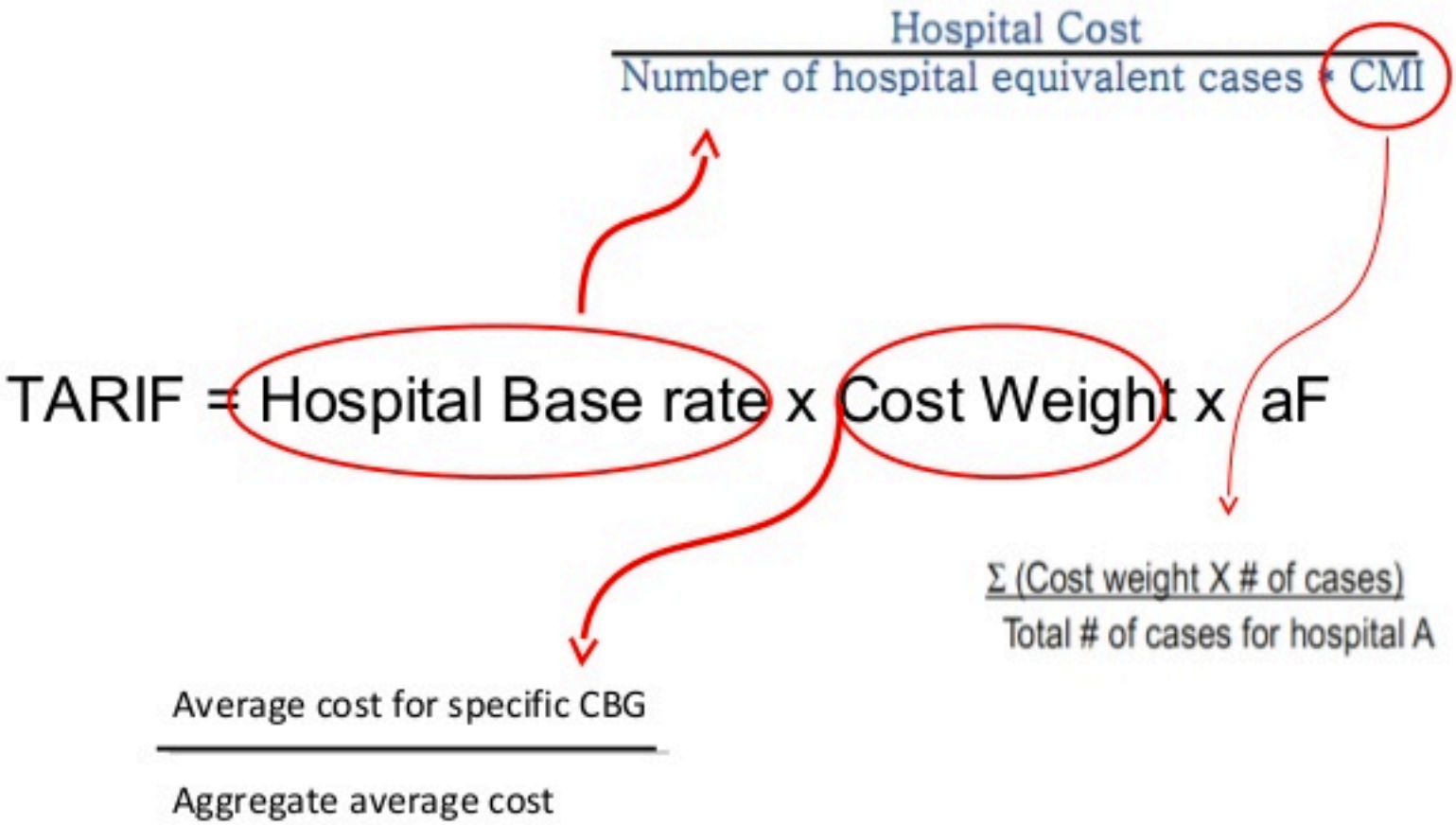
Sumber: Budiarto & Sugiharto, 2012

The Evolving Components of Capitation

No.	Elements	INA-DRG (2008)	INA-CBG (2012)	INA-CBG (JKN, 2014)
1	Data coding	127,554 records	1,048,475 records	6,000,000 records
2	Costing benchmark	15 hospitals	100 hospitals	137 hospitals
3	Contributors	Class A & B	Class A, B, C, D and Special Class	All classes in public and private hospitals
4	Case distribution	Non-normal	Non-normal	Normal
5	Trimming method	L3H3	IQR	IQR
6	Tariff reference	Mean	Median	Mean
7	Number of case-base group	1077	1077	1077 + 6 Special CMG
8	Tariff grouping	12	12	6
9	Proportion of implemented tariff	75%	75%	100%
10	Clustering	-	4 regions	5 scales
11	Medical care class	3	3	3, 2, 1

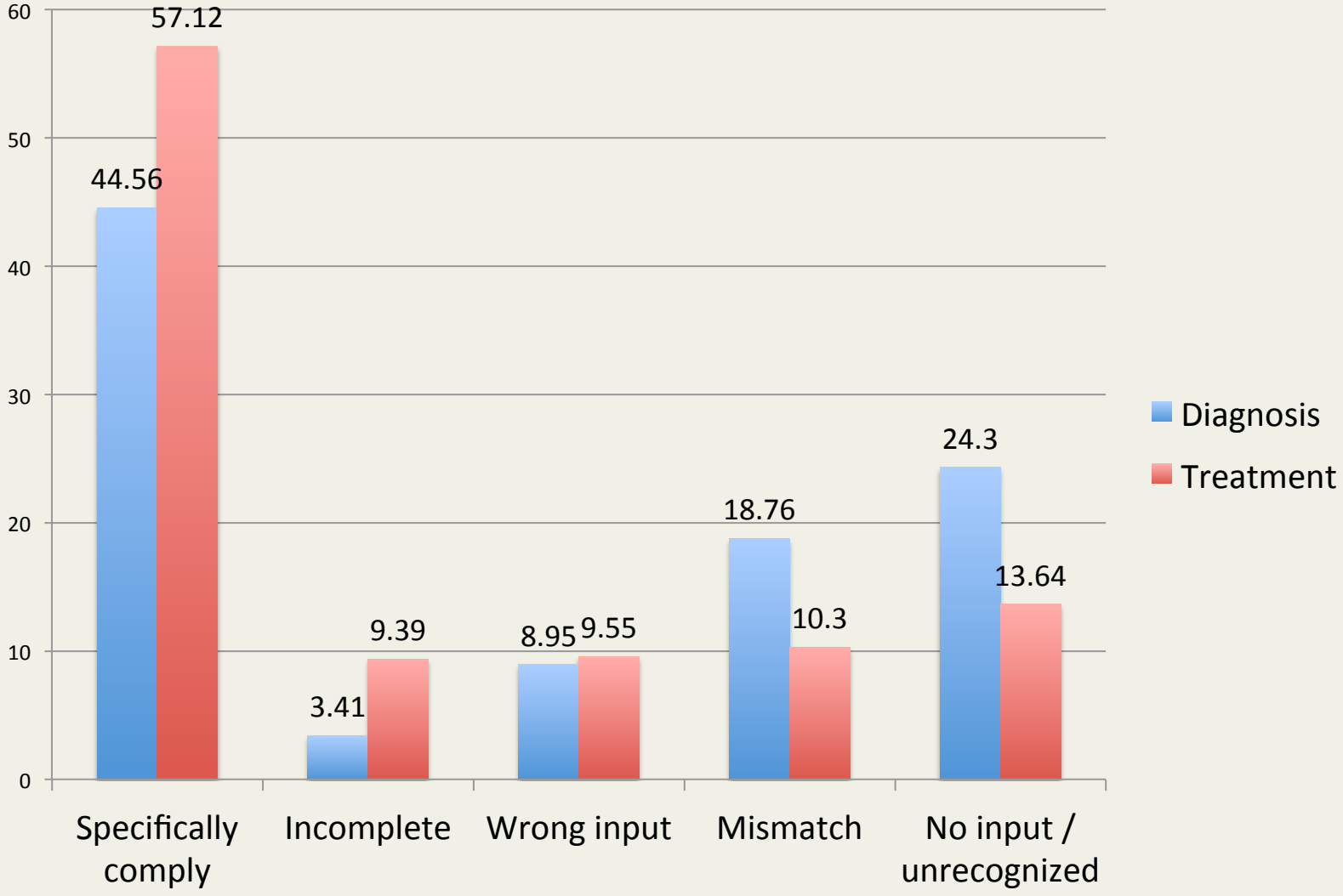
Source: Wibowo, 2014

Formula tarif:



aF: adjustment Factor

Medical Code Entry in Panti Rapih Hospital After the UHC Policy (%)



Source: Nuryati, 2014

Integration Performance in BPJS Kesehatan

No.	Regional Division	Number of Hospital	Completed Bridging			
			Comprehensive Services	%	INA-CBG Capitation	%
1	Medan	166	4	2.41	162	97.59
2	Pekanbaru	116	6	5.17	115	99.14
3	Palembang	102	1	0.98	100	98.04
4	Jakarta	157	11	7.01	157	100.00
5	Bandung	200	8	4.00	185	92.50
6	Semarang	259	37	14.29	259	100.00
7	Surabaya	199	6	3.02	198	99.50
8	Balikpapan	67	2	2.99	66	98.51
9	Makassar	115	2	1.74	113	98.26
10	Manado	73	1	1.37	73	100.00
11	Denpasar	84	3	3.57	84	100.00
12	Papua	37	0	0.00	37	100.00
	Total	1,575	81	5.14	1,549	98.35

Source: Info BPJS, Edisi X, 2012

Variations in Local Policy

- **Membership system**: in some regions, poor patients are automatically registered when admitted to BPJS and entitled to Class-III insurance; in others, registration is based on ability-to-pay and PBI categorie; and in certain regions patients are required to have the poor-family cards (SKTM) from the Local Social Agencies.
- **The insurance coverage**: four provinces provide free-of-charge services, majority (25 provinces) provide subsidy below the BPJS rate (Rp 19.225), and three provinces provide subsidy above the BPJS rate.
- **Benefit packages**: 18 provinces follow national JKN policy (preventive & curative, rehabilitative, in-patient treatment); 16 provinces determine the package with Local Regulation (under considerations that the JKN standard is either too high or too low).

Jamkesda Membership by Province

No.	Province	Population	Jamkesda Member	% Population
1	Aceh	4,842,238	2,226,352	45.98
2	North Sumatra	12,982,204	1,208,893	9.31
3	West Sumatra	4,846,909	1,141,149	23.54
4	Riau	5,538,367	1,341,395	24.22
5	Jambi	3,092,265	254,167	8.22
6	South Sumatra	7,450,394	4,868,723	65.35
7	Bengkulu	1,715,518	73,560	4.29
8	Lampung	7,608,405	4,513,155	59.32
9	Bangka Belitung	1,223,296	739,027	60.41
10	Riau Islands	1,679,163	174,730	10.41
11	Jakarta Capital Region	9,607,787	4,300,000	44.76
12	West Java	43,053,732	5,082,200	11.80
13	Central Java	32,382,657	2,926,402	9.04
14	Jogja	3,457,491	1,007,153	29.13
15	East Java	37,476,757	706,982	1.89
16	Banten	10,632,166	479,170	4.51
17	Bali	3,890,757	2,440,964	62.74
18	West Nusatenggara	4,500,212	572,976	12.73
19	East Nusatenggara	4,683,827	725,824	15.50
20	West Kalimantan	4,395,983	585,157	13.31
21	Central Kalimantan	2,212,089	840,339	37.99
22	South Kalimantan	3,626,616	1,077,575	29.71
23	East Kalimantan	3,553,143	1,868,741	52.59
24	North Sulawesi	2,270,596	490,981	21.62
25	Central Sulawesi	2,635,009	483,968	18.37
26	South Sulawesi	8,034,776	4,892,070	60.89
27	South-East Sulawesi	2,232,586	89,643	4.02
28	Gorontalo	1,040,164	495,869	47.67
29	West Sulawesi	1,158,651	48,447	4.18
30	Maluku	1,533,506	657,470	42.87
31	North Maluku	1,038,087	319,196	30.75
32	West Papua	760,422	n.a.	n.a.
33	Papua	2,833,381	n.a.	n.a.
34	North Kalimantan	723.005	n.a.	n.a.
	National	**237,989,154**	**46,632,278**	**19,59**

Source: MoH, 2014

New Implementation Challenges

- Majority of hospitals (1,720 of 2,302) joined the JKN. Yet because of overdue claims, many private hospitals are becoming disinterested. → Patients are crowding in public hospitals.
- Dec 2014: BPJS could only collect Rp 41 trillion from the premiums, but the government have to pay Rp 42.6 trillion for claims (a 3.88% deficit). Should the minimum premium be increased? (MoH proposal: Rp 19,225 to Rp 27,000 or to Rp 60,000)
- There are potentials of overlapping policy between the BPJS provisions and Jokowi's KIS (Kartu Indonesia Sehat).
- Lack of preventive program. Example: only 46% of citizens have healthy life-style; Rp 138 trillion for cigarettes, and the Indonesian smokers increased by 3.4% per annum while in developed countries it is decreased.

Conclusions

1. Indonesia has been in a policy course towards the UHC (prospective payments, compulsory insurance, poor individuals coverage case-base mix capitation), however there are many challenges in its implementation. For the time being, a double-track system is applied: the government subsidizes the PBI, and public & private insurance companies covers the bigger segment.
2. Budget commitment is low (3% or $ 104.25 of the per capita PDB). A bunch of informal sector workers remain uninsured.
3. Fragmented policy among different levels of governments (national-provincial-local), among health service providers (public vs. private hospitals) and among different schemes (compulsory vs. optional) have complicated policy integration.
4. Immediate policy challenges: adverse selection, double-counting, database inconsistencies, gaps between actuarial and claims, clinical pathways, and lack of human resource capability for prospective payments.
5. Stronger commitment among stake-holders are fundamental (policy makers, economist and public finance experts, doctors and paramedics, ICT experts, technical staffs, and patients). It is important to monitor the policy, increase capability among medical professionals, systematic corrections on policy, and collective awareness for the UHC.

Thank You