HEALTH FINANCING AND UNIVERSAL HEALTH COVERAGE

COMPILATION OF POLICY NOTES

SUPPORTED BY

AUSTRALIA INDONESIA PARTNERSHIP
FOR HEALTH SYSTEMS STRENGTHENING (AIPHSS)

Kementerian Kesehatan
Republik Indonesia

Australian Government
Department of Foreign Affairs and Trade

Australia Indonesia Partnership
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Preface

In 2012 and 2013, over 50 "Pokja" work groups were formed to develop and implement the new Indonesia Jaminan Kesehatan Nasional (JKN) system of universal health coverage under a new single payer health insurance system. The process was a good practice process of ministries working together to design and ready the new system for implementation in 2014. Of course, issues and questions arose on a number of topics, and for these topics, questions often arose regarding what were the best paths, and what were the global best practices that Indonesia could learn from in the process.

These Policy Notes were initiated rather spontaneously to answer these emergent questions, and drafting started in April 2013. Some Policy Notes challenged current approaches by the Pokja groups, while others provided options and alternative approaches. Models and experience from Australia, Western Europe, and East Asia were brought to the discussion in the Notes series.

Following implementation of JKN in 2014, new challenges arose, and new topics for Policy Notes emerged. This continues even to today.

Policy Notes are typically 2-10 pages, intended to be very user friendly, and identify issues facing Indonesian leaders, provide options and alternatives, as well as global best practices. These are mostly written by consultants funded by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program, but about 30 percent have been written by global experts from the Nossal Institute in Australia, University of New South Wales, the World Bank, WHO, UNICEF, the Joint Learning Network, and the faculty of the University of Indonesia. The series has been "open" to anyone who can present on a topic of timely interest and to Indonesian experts and policymakers.

The Policy Notes are written in English, but are translated into Bahasa Indonesia. The Notes are routinely disseminated by email to over 250 people and institutions in Indonesia, including Ministries of Finance, Ministry of Health, Ministry of Home Affairs, Ministry of National Development Planning (Bappenas), the BPJS, the donor community, and faculty and students in universities in Indonesia.

The Policy Notes are individually dated. Some written in 2013 are dated by events, regulations, and legislation. ***Each Policy Note has a footnote at the beginning to inform the reader if aspects of the Policy Note are out of date, and specifically what areas have changed***. In several cases, government utilized the Notes to make the necessary changes in policy and regulation, strongly suggesting the Notes did provide real impact to the health sector in Indonesia.

Finally, Policy Notes are now being used as readings and case studies for students in Public Health at the University of Indonesia, suggesting that these Notes will be read and critiqued for the near term and perhaps for years to come as Indonesia transitions into its new JKN health system.

March 21, 2015

Contents

#1 POLICY NOTES

What Happened to the Capitation Payment for Primary Care?[1]

April 2013[2]

Background

The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) which comprises five programs. The Health BPJS should be established by early 2014 while the BPJS for labor should be established by mid-2015. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

The pooling and integration of multiple insurance funds will allow BPJS to become an effective and equitable purchaser of services, with minimum administrative overhead. Observers agree that BPJS must encourage primary health care services to develop and be the strongest, as a gatekeeper to assure that only necessary cases are referred to higher levels, which lead to an efficient health financing as a whole. Indeed, currently Indonesia spends too much of hospital care, at around 60 percent relative to 29 percent in Canada and less than 40 percent in most Western European countries.[3]

The right payment systems can drive both greater allocative and technical efficiency. Indeed, Indonesia has called for a set of powerful payment systems to help create an efficient financing system. In the Presidential Regulations (Perpres) No. 12/2013 there is a mandate that payment method at Primary PPK/health service providers uses a *prospective payment system* – capitation – and not fee for service (FFS). So far, so good.

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[1] This note was written by Jack Langenbrunner and Cheryl Cashin under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program.

[2] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has revised the capitation formula based on the recommended principles outlined in this Note.

[3] Based on the latest national health accounts workshop reporting in March 2013 and OECD statistics for 2012.

Capitation, defined as 1 payment per 1 defined service package per 1 person (per capita) for 1 defined period of time (the four "1"s). In other words, capitation at its simplest is the money allocated for primary care divided by the population. The overall average is sometimes referred to as the "base rate". The total amount of funds allocated to any singe primary care provider or facility would be the average per capita amount (or base rate) x number of enrolees. Currently, the government has decided upon 6,000 Rp. Ind per month as the base rate, as a percentage of the total 15,500 total premium allocated by the Ministry of Finance.

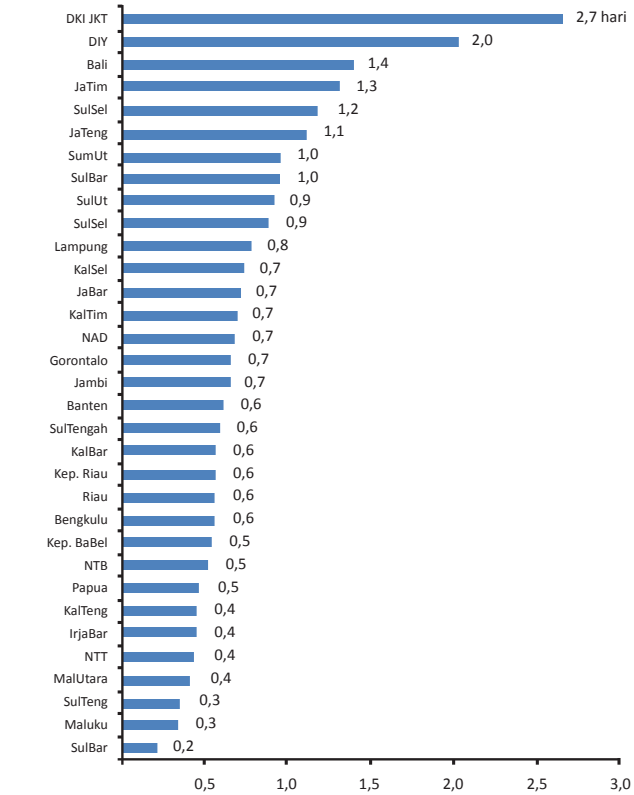
So far, so good in that the base rate is a robust or relatively high percentage of the total amount for delivery of the entire service package of primary, secondary, and tertiary services.

A Perversion to the Definition

However, the government is now considering to redefine capitation as "Utilization x Unit Costs" with some limited ceiling. This is what international experts call "fee-for-service with a cap". In other words, they will not multiply the 6000 by number of enrolees, but will divide the base according historic utilization and relative unit costs. It is certainly not capitation. A fundamental principle of capitation is to de-link payment from utilization. This way providers are not punished if they keep their population healthy and utilization for curative services is reduced. De-linking payment from utilization also is important to begin to shift primary care resources to areas where utilization historically has been low but health need is in fact high.

Medical Claim (National & Provinces): OP & IP 2010

Risiko Biaya Klaim (PMPM) RJTL & RITL by propinsi



	Claim Risiks	Estimasi Klaim MPMP (Rp)
NASIONAL	1.00	26.884
DKI JKT	2.66	71.524
DIY	2.04	54.768
Bali	1.40	37.743
JaTim	1.32	35.410
SulSel	1.18	31.969
JaTeng	1.12	30.040
SumUt	0.96	25.900
SulBar	0.95	25.608
SulUt	0.92	24.697
SulSel	0.88	23.633
Lampung	0.79	21.132
KalSel	0.75	20.083
JaBar	0.73	19.633
KalTim	0.69	18.608
NAD	0.68	18.212
Gorontalo	0.66	17.742
Jambi	0.62	17.616
Banten	0.62	16.595
SulTengah	0.60	16.260
KalBar	0.57	15.355
Kep. Riau	0.57	15.233
Riau	0.56	15.049
Bengkulu	0.55	14.825
Kep. BaBel	0.54	14.425
NTB	0.52	13.849
Papua	0.45	12.221
KalTeng	0.44	11.917
IrjaBar	0.44	11.826
NTT	0.43	11.548
MalUtara	0.41	10.919
SulTeng	0.34	9.142
Maluku	0.33	8.855
SulBar	0.21	5.527

What will this new definition provide? It will provide protection to providers and Puskesmas that last year's revenues will be similar in 2014. There is an advantage to this in that it holds providers "harmless" for the new reforms, and they will entail no financial risks. Indeed, there is huge variation in utilization as well (see figure below), though the reasons for this may not have anything to do with health status per se and rather to do with insurance coverage or consumer expectations.

What does it not do? It does not, however, provide an equitable base for distributing money across rich and poor, sick and healthy. It does not necessarily provide an incentive for all providers to manage care in an improved way, holding down costs and providing the cost –effective inputs of care. Nor, finally, does it provide any incentive to take on and enrol patients that can increase overall provider responsiveness and overall provider distribution.

What it does do is protect urban providers with high levels of utilization, but will squeeze revenues from puskesmas with fewer patient encounters, notably rural.

So, the reforms, while intending to redistribute from rich to poor, from urban to rural, will fail at the level of the primary care service package. Providers will not be attracted to relocate. New graduates will see no reason to leave central Jakarta or other urban centers. It will be business as before...raising the question of why the reforms in the first place?

Critics may argue that there will be still be adjusters for urban-rural placement, for the particular case-mix of enrollees, and maybe other factors such as overall level of poverty. This will help, but the adjusters will not be enough if the capitation is not correctly in the first instance.

Other Considerations

The government, beyond the capitation calculation, will need to address other significant issues. One is contracting with the private sector and bringing back the dual practice doctors who leave the Puskesmas at noon to pursue private patients. While most see the base rate as insufficient for attracting the private sector, government doctors will continue to practice as private providers in the afternoon. This so-called "capitation" proposed approach will only solidify these perverse behavior patterns.

There is the service package. Observers estimate that only 30 percent of the population will have access to the service package in 2014. One option is to open up the options of providers forming new networks to deliver the package or to give local district hospitals a capitation payment to allow them to form new ways to deliver services, perhaps through the existing hospital facilities. Each of these options provide hope of delivery of the service package to more than 30 percent. A true capitation allocation could spur this change. But, without a real capitation payment, there is no real possibility of innovations in the service delivery of the PHC package. And, to date, MOH has not shown much interest in deviating from the traditional puskesmas structure.

Finally, there is the issue of the setting of the "base rates" across different insurers. PT Askes and Jamsostek have historic expenditures per capita much higher than Jamsostek, but have average per capita base rates of 6500 and 6300 (negotiated by region). Should all funds be pooled in January 2104, or do policymakers need to set separate base rates for each type of enrollee. If the former, there could be some minor redistribution of funds from rich to poor, urban to rural.

In the end, the fee-for-service with a cap calculation work just continues to freeze in the past, and not allow the unleashing of a more innovate delivery system and a more equitable future for all Indonesians. Other options need to be considered before it is too late. Adjusters and pooled base rates only on January 1 will probably not be enough.

A Modest Proposal

One option might be to develop a blended payment rate over some number of years…say, 3-5 years…of historic revenues and a true capitation payment. This would move funds in the right direction, while allowing providers to adjust and respond to the new incentives developed by the BPJS. The social objectives of the new BPJS reforms would be delayed but not lost, and social impacts would be more evolutionary than revolutionary. This may be an important point in an election year.

#2 POLICY NOTES

Indonesia Must Develop its Own Grouper: Refinement of the INA CBGs for Hospitals[4]

April 2013[5]

Background

The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) which comprises five programs. The Health BPJS should be established by early 2014. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

Merging of the schemes will allow payment systems to be more effective and have greater impact. At the same time, a single payer model places great responsibility on the purchaser to develop a payment system that is precise and fair. Indonesia boldly implemented a new prospective case-based payment system for Jankesmas a few years ago called INA CBGs (for Indonesia Case-Based Groups). The government is to be lauded for this bold move to such a powerful payment system to encourage greater technical efficiency.

Recent meetings and reports, however, suggest the software which determines final tariffs will need refinement in the years to come, especially since it will be extended to all providers under BPJS. Why? In the beginning, the software was developed by a consulting firm outside Indonesia. Increasingly, evidence suggests the software was not developed based on Indonesian experience of clinical practice and cost structure of care delivery. The CBGs in any country of the world should be developed based on the clinical practice and cost structures in the country, and they are in Australia, United States, United Kingdom and other countries such as Thailand, Kyrgyzstan, and

[4] This Policy Note was written by Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health System Strengthening (AIPHSS) Program.

[5] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed though the government continues to depend upon an outside contract for developing and refining its CBGs.

Poland now using some variant of CBGs. However, in countries which have purchased software from outside the country, failure has most often been the outcome. Countries in this category include Taiwan, Slovenia, and (perhaps) Indonesia could be next.

The current Indonesia grouper has over 1000 categories and 3 levels of severity, strikingly similar to the grouper that can be downloaded from the US-government based Medicare program website. No documentation for the software has been made available by the consultant to date showing how local clinical and cost data was used to develop this software.

What Should be Done Now?

Regardless, the PPJK has done everything it can to date, and has done a good job, but for the future it and the BPJS would be wise to follow a number of steps in the next few months. For example, has there been an evaluation of use of INA CBGS to date? Were original system goals met? What have been the challenges? Have admissions and re-admissions increased? Has average length of stay changed? Has hospital behavior changed and how? Has the government saved funds from the use of the INA CBGs? These are key baseline issues for the MOH, the BPJS, and the Ministry of Finance who will (ultimately) pay much of the bill in the years ahead.

A number of structural questions stand out. For example, the current system has multiple base rates, versus other countries which may start with multiple base rates, but which phase these out and move to 1 single base rate. Why? The answer is straightforward: fairness. Single base rates mean providers which treat similar cases receive the same tariffs. This encourages efficiency and adoption of innovation and best practices.

A second issue is coding. The software in any country runs off ICD codes, of which there are over 10,000. In Indonesia, less than 10 percent of all codes are now used. The use of only a small number of codes will limit precision in payment and limit precision in developing quality assurance against unnecessary admissions, re-admissions, and poor care during the patient stay.

Related, how has coding changed over time? In most countries, coding practices change over time to gain more favorable reimbursement tariffs. Known as “upcoding” this behavior must be tracked and addressed through updating of the software and through administrative sanctions by the purchaser. The BPJS needs to know what has happened since the consultant’s grouper has been implemented.

A third issue is the role – present and future – of clinical protocols in setting the tariffs and in refining the software. Many countries which attempted to integrate protocols and tariffs failed. Why? Protocols take a long time to develop, and are quickly outdated. Protocols are guidelines and cannot possibly specify treatment decisions for every patient, so they leave room for clinical judgment. Furthermore, they are developed for ideal patients, not those with complications and comorbidities. Finally, costing of protocols is

imprecise and is time consuming as well. Countries such as China, Bulgaria, Vietnam, and Slovenia have found that the two approaches are better kept separate than integrated.

Finally, the software in all countries is ALWAYS simulated with providers' revenues before implementation, so as to make sure that tariffs are not adversely affecting cost structures that are necessary for adequate care. Simulation exercises often help refine and improve tariffs as well by identifying gaps in predicting resource use as software should do.

Once the tariffs are set, BPJS needs to reach out to the clinical and quality of care community. There needs to be development of quality and utilization indicators going forward in the reforms including average length of stay (ALOS), changes in admission per capita, unnecessary admissions, premature discharges, readmissions over 30/60/90 days, changes in the case-mix index over time, and post-acute referral patterns. A new cost accounting template for providers may be needed, or the current one may need to be institutionalized. Failure to comply with reporting information should be cause for non-payment of admissions by BPJS. This is an easy article to be built into any contract.

What Should be Done in 2014 and Beyond

Going forward, BPJS will need to take needed next steps for capacity development, data, analysis, and refinement keying off the above list of issues. They will need to develop an intricate strategy for capacity building over next 2-3 years, in the areas of data, development of a refined grouper software, development of a team of internal experts related to coding and IT needs, case-mix refinement, costing, quality, updating, and monitoring of different levels of the system (central, provincial, district, hospital, primary care).

A partnership program could be established in collaboration with one or more universities in Australia and other places such as Thailand, Poland, and the United States, to allow Indonesian experts to work in Australia and other places for 6-9 months in partnership with institutions in the public sector and in academia doing hospital payment or work in key areas related to payment such as grouper development, costing, impact analysis, regulation development, and new coding systems. Additional activities under the partnership would include training courses in Indonesia implemented by Australian and other global experts on specific topics related to INA CBGs, and study tours to Australia for Indonesian officials to see the payment process and meet experts there.


2014
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DIISI OLEH PETUGAS KESEHATAN
CATATAN KESEHATAN IBU HAMIL

#3 POLICY NOTES

Regulating Assets and Liabilities: Not Necessary in a Modern Social Insurance Organization[6]

May 2013[7]

State owned insurance company PT. JAMSOSTEK Rp. 4.7 trillion (US$484 million) in revenue from its investments in the first quarter of 2013, adding to its accumulated investment fund of Rp 140 trillion as of March 31st. With part of these funds, the PT. JAMSOSTEK will build a hospital in North Jakarta for its workers. PT. JAMSOSTEK is increasingly investing, too, in private company bonds as a way to generate greater short-term income.[8][9]

Earlier this year, the government developed a draft Assets and Liabilities" draft regulation. Key in this new proposed regulation is the use of the assets and liabilities of old "private" (but state-owned private) insurers PT ASKES and PT JAMSOSTEK. It is part of the larger reform process. The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) which comprises five programs. The Health BPJS should be established by early 2014 while the BPJS for labor should be established by mid-2015. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

A first read of the regulation is a bit frightening. The proposed regulation is potentially dangerous in that it appears to split BPJS into 2 funds – one for BPI and one for non-BPI. The Assets and

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[6] This is Policy Note #3, and was written for the BPJS teams by Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org. The author gratefully acknowledges that some of the ideas in this Policy Note reflect earlier conversations with Yves Gerard, Asian Development Bank and Mitch Wiener, World Bank. However, the author takes full responsibility for any errors.

[7] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has revised its thinking on assets and liabilities under BPJS and its pooling assets under BPJS.

[8] Jakarta Post, "Jamsostek makes Rp 4.7t in Q1", Page 13, April 23, 2013.

[9] About 30% of residual funds come from insurance for health services according to discussions with Jamsostek experts.

Liabilities and use of surplus funds for each group are handled separately, as are the investment of residual funds in each pool of funds.

By doing this, the fund could effectively could cap spending for the rich and the poor at historic levels. The per capita spending levels for PBI will be driven by government contributions, and the spending levels for non-PBI driven by employer and employee contributions. In effect, there could be two (2) separate funds, one determined by government (as now) and one determined by premiums.

At the same time, it should be pointed out that SJSN law prohibits cross-subsidies across funds, but does not prohibit cross-subsidies among these groups. And this is important. Indeed, the whole point of social health insurance is to pool rich and poor, healthy and sick. This regulation partitions groups and provides management of funds separately. This regulation could –- if taken to its extreme in terms of usage -- create a Vietnam-like 1 payer with several different pools within the 1 fund. Vietnam has six different population group pools and 60 different provinces which hold provincial funds…for a total of 360 risk pools under its "single payer model" which, of course, is "single-payer" in name only. Or, it is even similar to a Thailand-like situation whereby three (3) different groups have different levels of funding at their disposal, and without apparent regard to need. The Thai system is split into civil servants, private, formal employed insurance, and everyone else. The variations across schemes in terms of benefits, utilization, access, payment incentives, and available drugs is quite significant. So, the regulation potentially moves Indonesia from single-payer to a less-desirable Thai-like model with inequities and inefficiencies with its different incentives in place. The BPJS law allows for pooling in usage, however, allowing the government to avoid the Thai health sector limitations which has served as a kind of "black-mark" on an otherwise progressive set of reforms to achieve UHC over the last 10 years.

A better approach, of course, is to not partition these funds in terms of usage, but rather maintain management of these funds under one (1) pooled account, as happens in most Western European countries (UK, France, Sweden) or in once (1) account at a provincial level (Canada, Spain, Australia). Could this be done all at once? Perhaps not, as the cross-subsidization might be significant. Instead, it could be phased-in over several years, as was done in Kyrgzstan, a poor and predominantly Muslim country in Central Asia, which pooled funds over 10 years starting in the 1990s. In China, funds from multiple insurers will be pooled over a similar time frame, not reaching intended full pooling until the year 2020.

What Should be Done Now?

Regardless, the PPJK has done everything it can to date, and has done a good job, but for the future it and the BPJS would be wise to follow a number of steps in the next few months. For example, has there been an evaluation of use of INA CBGS to date? Were original system goals met? What have been the challenges? Have admissions and re-admissions increased? Has average length of stay changed? Has hospital behavior changed and how? Has the government saved funds from the use of the INA CBGs? These are key baseline issues for the MOH, the BPJS, and the Ministry of Finance who will (ultimately) pay much of the bill in the years ahead.

A number of structural questions stand out. For example, the current system has multiple base rates, versus other countries which may start with multiple base rates, but which phase these out and move to 1 single base rate. Why? The answer is straightforward: fairness. Single base rates

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Related, how has coding changed over time? In most countries, coding practices change over time to gain more favorable reimbursement tariffs. Known as "upcoding" this behavior must be tracked and addressed through updating of the software and through administrative sanctions by the purchaser. The BPJS needs to know what has happened since the consultant's grouper has been implemented.

A third issue is the role – present and future – of clinical protocols in setting the tariffs and in refining the software. Many countries which attempted to integrate protocols and tariffs failed. Why? Protocols take a long time to develop, and are quickly outdated. Protocols are guidelines and cannot possibly specify treatment decisions for every patient, so they leave room for clinical judgment. Furthermore, they are developed for ideal patients, not those with complications and comorbidities. Finally, costing of protocols is imprecise and is time consuming as well. Countries such as China, Bulgaria, Vietnam, and Slovenia have found that the two approaches are better kept separate than integrated.

Finally, the software in all countries is ALWAYS simulated with providers' revenues before implementation, so as to make sure that tariffs are not adversely affecting cost structures that are necessary for adequate care. Simulation exercises often help refine and improve tariffs as well by identifying gaps in predicting resource use as software should do.

Once the tariffs are set, BPJS needs to reach out to the clinical and quality of care community. There needs to be development of quality and utilization indicators going forward in the reforms including average length of stay (ALOS), changes in admission per capita, unnecessary admissions, premature discharges, readmissions over 30/60/90 days, changes in the case-mix index over time, and post-acute referral patterns. A new cost accounting template for providers may be needed, or the current one may need to be institutionalized. Failure to comply with reporting information should be cause for non-payment of admissions by BPJS. This is an easy article to be built into any contract.

What Should be Done in 2014 and Beyond

Going forward, BPJS will need to take needed next steps for capacity development, data, analysis, and refinement keying off the above list of issues. They will need to develop an intricate strategy for capacity building over next 2-3 years, in the areas of data, development of a refined grouper software, development of a team of internal experts related to coding and IT needs, case-mix refinement, costing, quality, updating, and monitoring of different levels of the system (central, provincial, district, hospital, primary care).

A partnership program could be established in collaboration with one or more universities in Australia and other places such as Thailand, Poland, and the United States, to allow Indonesian experts to work in Australia and other places for 6-9 months in partnership with institutions in the

public sector and in academia doing hospital payment or work in key areas related to payment such as grouper development, costing, impact analysis, regulation development, and new coding systems. Additional activities under the partnership would include training courses in Indonesia implemented by Australian and other global experts on specific topics related to INA CBGs, and study tours to Australia for Indonesian officials to see the payment process and meet experts there.

At a second and broader-level, why is this new social insurance organization even considering managing surplus funds as (private) investments? In modern social insurance organizations of Europe, such as in Denmark, Netherlands, Germany, and the United Kingdom, the assets in the health fund will be minimal and the fee should be set as a percent of contributions only. The BPJS, as a social insurance fund is not a revenue-generating organization, but a social and "public" organization similar to those of many countries in Europe or Canada. The administrative expenses of running a health fund is for contribution collection and payment of claims.

Social insurance organizations are not private firms with investment arms nor are these separate investment houses. Excess funds should be sent back to the Government Treasury. Many governments will have reserve funds on a public sector accounting sheet, but it is not a fund for private investment. Even the new Obama-care legislation has developed similar provisions now in the United States.

If excess funds are sitting as a residual in the coffers of the social insurance organization, then two (2) possible scenarios should be considered by the President (to whom BPJS formally reports). One possibility is that claims are not being paid for services as they should. This could mean less than adequate access or poor quality of care, and perhaps should be examined or even investigated. A second possibility is that the contributions level is too high. If the latter, the contribution level can be rolled back. Of course, payroll contributions – as outlined under the law -- are well established deterrents to private sector capital formation, to private sector labor formation, and to greater informalization in the economy as found by Wagstaff (2010, 2012) and others in the past few decades.

A third and final option is to use these funds to extend coverage to the uninsured, or to partially subsidize premiums in year 1 to encourage the informal sector to sign up for coverage. This could lead to investing in the human capital of Indonesia which could reap dividends in terms of gains in productivity and macro-economic growth. This could be – both from economic and human terms – the preferred approach with these excess funds.

Excess funds could create moral hazard, for corruption, or for use of funds that are different that the objectives under the BPJS reforms. One possible example that jumps out is the current promise to build PT. JAMSOSTEK workers their own closed-system hospital in North Jakarta, running counter to the new BPJS law.

Does anyone want huge surpluses in the BPJS Fund, suggesting unnecessarily dragging down economic growth? And huge surpluses will change the nature of the Fund, and create risks of misuse of plan assets. It makes more sense to have some type of cumulation rule – if the surplus accumulates to more than a certain percentage of expected claims, then the excess should be returned to the government Treasury, or (perhaps preferably) the fee rate should be adjusted down in future years.

Finally, any short-term and minimal level residual surplus funds should be invested prudently, in securities issued by the Republic of Indonesia or securities issued by Bank Indonesia. No private company bonds for BPJS, please.

#4 POLICY NOTES

Information Systems and the BPJS: Key Next Steps and By When?[10]

May 2013[11]

Insurance integration: what is the first critical step? Those countries that have done it, such as South Korea or Taiwan or Kyrgzstan, will each agree it is the basic information infrastructure. Without this critical and basic first step, the unification, the migration of information, the ability to bring many into one will fail.

Indonesia is in the midst of a path to insurance integration. The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) which comprises five programs. The Health BPJS should be established by early 2014 while the BPJS for labor should be established by mid-2015. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

Where to start with IT infrastructure for BPJS? The Government has taken many important and good steps. It might be useful to recount these steps.

Key Building Blocks

First and foremost, a smart database will be built on the basis of a National Unique Identifier (NUI). That would ensure that the same person is not counted twice when moving between categories or locations. To be able to match claims against contributions and eventually make longitudinal

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[10] This is Policy Note #4, and was written for the BPJS teams by Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program, and by Anis Fuad funded under the Joint Learning Network. For copies of other, earlier Policy Notes, please visit www.aiphss.org .

[11] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has finalized the data dictionary and progressed on its MIS systems within the BPJS, though a number of issue areas remain such as tracking of pharmaceuticals.

analysis of costs a "smart" NUI incorporating some basic information would be necessary. It would also greatly facilitate the determination of eligibility and the administration of provisions about delays, interruptions and reinstatement. Proper assessment of risks in terms of equity and efficiency and fiscal outlays would require the capacity for the BPJS to produce custom aggregates for special risks.

The NUI will need to be coordinated with whatever system will be used for billing purpose, premium collection, or for the collection of medical/administrative statistics by the BPJS.

As the NUI database is being built, it would be relatively easy to cross link NUI of spouses and parents with children that obviously may share similar risks. As genetics is becoming more important both for diagnostic and selection of optimal medication that can improve health outcomes at lower cost. It would also facilitate research focusing on longitudinal studies of genetic effects.

But, the NUI as planned by Home Affairs is supposed to be ready January 1, but will it? Current whispers in the corridors suggest not. If it will not be ready by January 2014, an alternative will need to be developed. This alternative should be started right away. Membership database consolidation between each schemes (at least Askes, Jamsostek and Jamkesmas) in coordination with Ministry of Home Affair should be prepared quickly. The PT Askes and PT Jamsostek have signed an MOU on using the unique ID. The more challenging part will be on the consolidation of Jamkesmas database with BPS (Center for Statistics Bureau), and TNP2K(Povery alleviation Team under the Vice President).

At a ***second level***, each provider – hospital and primary health centers (Puskesmas) – needs to have a unique identifier as well. Fortunately, Directorate General of Medical Services (DJ BUK) has provided a web-based registration of new hospitals. Until presently (May 2013), about 2,103 hospitals have been registered. All hospitals have received their unique IDs during the submission process at the district/provincial health office. The Center for Data and Information has also maintained Puskesmas database including its unique ID. However, national database of pharmacies was not yet available for public. While the licensing process of new pharmacy is under the district health office authority, however any new license should be reported to the Central level. . However, according to the hospital registration database (updated May 2013), it is only 1,180 hospitals that have been accredited. For those are not accredited yet, will these be part of the contracted provider services under BPJS? Are there special issues here?

At a ***third*** level, the data dictionary. How do a provider and payer define their terms, and agree on their language? If they do not, it will be as if one speaks in English and the other in Bahasa Indonesia. There are many functions each must carry out and the interplay between the two means that the data dictionary is a basic platform for communication, and a critical way to avoid fiscal risks and quality problems to both purchaser and providers.

The data dictionary contract process under MOH has recently been cancelled and will need to be restarted. The timeline is uncertain, but realistically it is difficult to imagine it will be finished in 2013. If not, again, a back-up will be needed. Even if the data dictionary is finished, there needs to be public consultation, dissemination, and training for both purchasers and providers. This latter process could take up to at least a year.

At a ***fourth*** level, the delivery of services need to be paid based on claims. Claims will work from agreed upon coding systems that derives from the data dictionary. A standard discharge abstract will be needed to code each claim. The model from Australia's hospitals is provided here.

- Principal diagnosis
- Additional diagnoses (complications and co-morbidities), up to 10
- Significant procedures
- Patient age
- Separation status
- Sex
- Length Of Stay (LOS)
- Newborn's admission weight
- Length of mechanical ventilation
- Same day status and
- Mental health legal status

For ease of handling the information, the principal and additional diagnoses and the significant procedures are coded into alphanumerics by Health Information Managers using a disease and procedure classification system, ICD-10-AM (International Statistical Classification of Diseases and Related Health Problems. Australian Modification).

Indonesia has also developed under PT Askes and Jamkesmas a standard coding sheet. But, to date, only about 800 codes out of over 14,000 ICD codes are actually used. In some hospitals, coding is constrained to under 200 codes. This could be an issue for tracking non-communicable diseases (NCDs) and developing a fair level of payment and developing a tracking system for quality profiling and quality assurance.

Along with coding of claims, BPJS will need standardized and routine cost information from providers. A hallmark of successful payment systems in Europe is that there is a standard costing template and a routine reporting of cost information as part of the payment contract. In Indonesia, there is a template, but reporting is still not a part of the contract. This MUST change starting in 2014 in the contracts now being signed in 2013.

And what about the Puskesmas? For the most part, these facilities do NOT have person-level data systems at this point. This could hamper attempts to develop precise capitation adjusters, pay-for-performance systems, and financial management systems, as well as track referrals.

A Tertiary Hospital Visit

We recently visited an advanced tertiary facility in Java. The hospital has several good features worth mentioning – a trained coding staff (Health Information Managers) each with up to 3 months of training, coding of up to 100 discharges every day taking the chart to a coded and computerized

discharge abstract where it is sent to the Jamkesmas for reimbursement. But, the coding can be slowed by the number of hands it must pass – assembly, coding, indexing, computerizing.

The hospital software was impressively developed by the hospital itself and is used for payment, management and quality. Protocols are developed by the physician and nursing staff, though only a few are developed to date (the global experience due to resource intensity).

On the negative side, the hospital only codes about 800 of over 14,000 possible ICD-10 codes, meaning it is difficult to profile patients with complications and comorbidities. A second – and related -- issue is that the hospital software is different than other hospitals and there are no current standards for hospitals developed by the central government. This means that if protocols are developed by the Center, these won't be usable by hospitals with less than fully compatible software systems.

A final issue was the observed use of the data, or lack thereof. It was impressive that every patient has a computerized file, but how is the data being used for management and quality? It is currently not, or very little. Managers knew little about changes in coding, lengths of stay or even numbers of admissions and re-admissions over time. While sitting on a treasure trove of information, it did not appear to be fully reaping its dividends.

Patient level information systems will be enormously powerful tools for payment efficiency and quality. These data will also be important for national monitoring and evaluation. But these will flow only when the dictionary and national standards are developed, disseminated and followed. And, even when that occurs, there will be a need for training of professional hospital information managers for payers and providers as well as for professional auditors to assure that coding is correct and not manipulated for more favourable levels of reimbursement. The government could consider matching grants to provinces to kick-start training of coding professionals, but this can only be done once the dictionary and coding systems are announced and in place.

By When and What to Do?

In short, the IT system process is moving but questions remain:

- When will the unique identifier system be in place?
- When will the provider ID system be in place for public and private providers?
- When will the data dictionary be ready?
- When will providers code claims consistently and report costs?
- When will the data once generated begin to be integrated into routine monitoring systems for the President and Minister of Health and all other key stakeholders?

Before answering to those question, Indonesia also should agree on who will lead this IT/IS towards UHC due to the involvement of main stakeholders including the MOH, Ministry of Home Affairs, Bappenas, Central Bureau of Statistics, TNP2K, BKF, and local government especially for membership database consolidation as well as to ensure the ownership of the process. A recent Pokja meeting made real progress by deciding PT Askes would lead on the purchaser side, while MOH on the provider side. We appreciated and supported the good discussions and resolution on the way forward.

But, the quick answer to most questions above is no sooner than 2015, perhaps 2016, and for full use of the data, even longer. Let us not lose sight of the global experience here. In OECD countries, it sometimes takes 5-10 years to reap the benefits of fully using information. In the early part of this century, two medium-sized (2) community health plans ("HMOs") merged in the Boston, Massachusetts (USA) geographic area. It took these two organizations about 5 years to merge their MIS systems. In the interim, they ran parallel systems. This is a good lesson for Indonesia, too, that running parallel systems may be needed past January 1.

Overall, for now, Indonesia must decide what interim measures are necessary and sufficient to implement universal health coverage on January 1, 2014.


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#5 POLICY NOTES

Principles of Piloting in the Health Sector The Global Experience [12]

June 2013[13]

Piloting can be done to learn, test, evaluate and perfect new ideas and models in the health sector. In the United States, for example, hundreds of pilots exist in the health sector at any one time. These pilots look at new technologies, new payment systems, new benefit packages and so on. Pilots are found to be useful in big decentralized countries such as China, Brazil, Kazakhstan, Russia, and the United States.

Indonesia and the BPJS Pokjas and PPJK are now looking seriously at payment pilots -- primary care capitation and INA-CBGs, as a way to test out new payment models. Several geographic areas are being considered Gorontolo, Aceh, West Java, Lampung, Jakarta. Some pre-conditions will be needed such as

- good MIS systems;
- quality assurance measures;
- facility autonomy to respond to new incentives; and,
- good financial management systems.

There are also important unanswered questions such as public sector or public plus private sector. But, PPJK should be praised for this bold step forward to begin design now.

Certain principles of piloting are useful to know from global experience:

1) There should be a broad general agreement of design and objectives between the pilot area, province and central government. For example, pilots to deliver the service package of primary care. Or, to test a new system of referrals across levels of care.
2) Often the central government first develops broad guidelines for pilots, publishes or announces a request for proposals (RFP) from local areas and encourages areas to send in a short 5-10

[12] This is Policy Note #5, and was written for the BPJS teams by Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program.For copies of other, earlier Policy Notes, please visit www.aiphss.org

[13] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed as BPJS has now been implemented. However, piloting has been embraced as a way to test and evaluate new policies for health reform in Indonesia.

page proposal of design, objectives, methods or approaches, timeline, agreements with local leaders, and budgets, as well as an monitoring and evaluation plan.

3) Importantly, pilots should not hurt quality or access, and should encourage more cost-effective care delivery.
4) The local governments or health providers interested send in the proposal by a due date given by the Central government.
5) The Central government reviews proposals by a committee, identifies winners, and then coordinates with other ministries as needed. For example, some pilots may require autonomization of facilities and this would need to be coordinated with Ministry of Home Affairs.
6) If more than 2 ministries are involved, a higher level body must coordinate and approve...such as the Vice President's office. If costs are going to increase, then the Minister of Finance needs to be review and approve. In the case of Indonesia, MOUs are already being discussed.
7) Pilots should be at least 3-5 in number, to test any one intervention, since pilots in only 1 or 2 places may not be "generalizable" to other areas or situations. In the case of Indonesia there is this number currently in mind.
8) There should be small funding grants from the Central level to implement these programs.
9) These programs should run for a period of time which allows implementation and evaluation, or for a minimum of 1-2 years, but can be less. There should be control groups wherever possible, not just pre-post designs which bypass scientific rigor. In the case of Indonesia, perhaps BPJS can run the pilots, but PPJK can evaluate the pilots.
10) Every pilot needs to be monitored in case there are negative impacts – to correct or stop the pilot.
11) Every pilot should be evaluated for changes in quality, access, efficiency and equity. The evaluation should be done by some group outside of the pilot program, and be funded by the Central level. Researchers or academics are good evaluators and can be more objective than local providers or policy leaders.
12) Results should be disseminated and available on the website of the MOH.

Pilots also build political consensus. Often they are so successful to local leaders and consumers they are discontinued and scaled up even before evaluation. At other times, they are successful, but politically found to be unpopular. While disappointing to technicians, we know that health is very personal and so this dimension cannot be overlooked.

In general, the PPJK should be applauded for these steps forward. And, they and the pilot areas will need funding. Pilots are not costless. Budgets are needed to:

- Design pilots;
- Evaluate and modify proposals;
- Develop agreements across ministries and levels of government;
- Implement, including funds for equipment or new staffing or any variety of things to start the pilot;
- Monitor and evaluate and disseminate results.

Universal Health Coverage is not a one time effort, but an ever improving story of better coverage and better health sector performance, both in terms of equity and efficiency. Pilots are one method that countries use to continuously update and modernize their sectors. Indonesia could become a global leader in how to pilot and how to integrate new ideas and approaches into its sector to keep pace with the changes in economics, disease profile, aging, health seeking behaviour, and other factors now in play.

#6 POLICY NOTES

Where are the Monitoring Indicators?[14]

June 2013[15]

The Challenge

The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) comprises five programs. This proposal is focusing on the Health program. The Health BPJS should be established by early 2014 while the BPJS for labor should be established by mid-2015. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

The primary goal of social security reform is to build a health system that supports health-improving initiatives, but is adequate, efficient, sustainable, high quality, and affords financial protection. The Health program should make health coverage equally accessible to the poor and non-poor -- a fairness objective. The Health program is particularly important from a poverty alleviation point of view since it helps prevent people from being pushed or kept below the poverty line by heavy health expenses.

At the time it was adopted, the 2004 SJSN law was not supported by a body of analytical work or credible projections of the impacts on health or the impacts on expenditures and fiscal prioritization. In addition, there was no forward-looking analysis of the country's demographics, disease profile, supply capacity, labor market, and economic structure including key parameters such as future wages, labor market participation, and investment returns. The impact on government budgets will depend on how costs are shared beyond the basic premium for the initial PBI group. Equally

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[14] This is Policy Note #6, and was written for the BPJS teams by Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS). The author thanks Dr. Yunita Nugrahani of University of Indonesia for comments on an earlier draft. Mistakes are the sole responsibility of this author. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[15] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has developed indicators and DJSN and BPJS have developed "Dashboards". However, these indicators continue to evolve as data and information systems improve.

important is the burden of health contributions on employers, workers and self-employed including the informal sector. It will impact competitiveness by raising production costs on employers, and on the allocation of resources, and thus, on the performance of the economy.

The uncertainty about the initial impacts on health, equity, quality, access, financial protection, and costs, and their evolution means that the program, given its size and national scope, presents major risks for the GOI, and for the entities and participants that share the costs.

Various projections have been proposed more recently, but estimates will not control the actual impacts of the program that will vary depending on emerging experience. This happens in any -- and every -- country undergoing health reform. Some impacts go as expected, but every country encounters one or more "surprises" and "unintended consequences" as reforms are implemented. For example, in many countries, hospital admissions skyrocket. Some of this increase reflects unmet need, but in other cases admissions are driven by revenue interests of providers. In China, there was another, additional issue: the introduction of insurance failed to improve financial protection. This completely surprised policymakers, but angered families and individuals. The result: to date, the "political dividends" of providing UHC has not really been achieved in China.

Furthermore, how will it impact on the provider community, such as doctors, nurses, and midwives? Will it create challenges due to lack of socialization? Will the newly-initiated card providing "free services" overwhelm the health professionals, as it has to date in Jakarta under the JKS scheme?

To ensure management and governance of the reforms, the GOI needs timely and accurate information. Policy makers need adequate information to make optimal decisions. The new UHC program will have to strike a balance between providing protection for basic needs, as well as unforeseen events and the resources that will need to be mobilized initially and in the longer term. The challenge for universal coverage also involves the readiness in the supply of health resources in the public sector, as well as the private sector resources that could be mobilized by appropriate coordination.

Indicator Development: Horizontal and Vertical Coordination

The government will need to initiate work on monitoring and evaluation that is both "horizontal" that is, across ministries at the central level, and "vertical" that is, across levels of Government from central to village. There will need to be coordination. That is, vertical coordination is different levels of government from central to provincial to district. The horizontal coordination will include development of priorities across different ministries and the government including the President who oversees the BPJS.

Horizontal

Each ministry or actor will have a slightly different focus given its responsibilities, and so the list of indicators will vary. For example, the Ministry of Finance may wish to monitor such elements of efficiency and fiscal impact such as:

- primary and secondary care, as an objective is to promote the use of primary care;
- pharmaceutical costs versus other costs;

- tracking specialist care and tracking out-patient vs. in patient as an objective is to control the unnecessary use of more expensive institutions;
- separating costs for transmissible and non-transmissible diseases anticipating different projections rates since the anticipation is that transmissible diseases will become more controlled, whereas "life style" diseases (non-communicable diseases or NCDs like cardio-vascular or obesity are likely to increase;
- tracking some disease categories which contribute disproportionately to high costs;
- aspects of inpatient care such as occupancy, bed days and average length of stay;
- administrative expenses, as well as collection expenses incurred for non-poor participants using illustrative percentages.

The Ministry of Health, on the other hand, may wish to track a broader number of elements related to access, equity, quality, and financial protection.

A number of ministries will be involved in the health reform including MOH, Ministry of Home Affairs, Bappenas, Finance, TPN2K, and others.

Finally, the President himself will have an electronic "dashboard" of key policy indicators that might include:

- enrollment and re-enrollment;
- utilization of health services, such as outpatient visits per capita, and admissions per capita;
- revenue and expenditures as % of revenue;
- expansion of the number of providers/number of networks;
- access, such as number of working facilities (within 10 kilometers of patient) for rural areas, and waiting times/number patients turned away in urban areas;
- quality of care, such as deaths per admission, and re-admissions within 30 days and 60 days;
- financial protection, such as out of pocket payment, out of pocket as % of income, and % of families impoverished; and,
- changing levels of patient satisfaction.

Some of these indicators won't be easy to track. Example: out-of-pocket payments may require household panel surveys and may not go up initially, but only because people are not yet fully accessing services. The "signal" may be that all is well on OOP measures, but, in fact, people are still suffering from poor access. The President, and others, will need to examine each indicator, but also "triangulate" across indicators.

Vertical

The vertical process of monitoring indicator development will involve coordination with a similar process of identifying different needs, yet coordinating under the MOH umbrella. This will need to be done for several areas such as:

- health policy;
- health financing/health insurance fund (HI);
  - collection of funds
  - pooling of funds
  - purchasing
- health management;

- investment planning;
- health information systems (HIS);
- quality.

For example, with regard to purchasing – the national level will need to focus on monitoring elements such as:

- develop national strategy;
- develop national rules for all provider payment systems;
- drugs for selected vertical programs (TB, vaccine);
- medical services provided by national clinics and institutions;
- capital investments into national clinics;
- health manpower, education, and science;
- legal status of providers.

While provincial and district levels will need to focus on monitoring elements related to:

- implementation of national rules and policies;
- adjustment of tariffs or payment rates based on local input costs;
- contracts with local providers (District);
- quality assurance of services provided by local providers (District or Municipality or Province);
- oversight of capital investments on regional level (within national plan or guidelines);
- consumer satisfaction and dispute resolution (District offices);
- claims processing.

There may also be variation in relative monitoring indicators across provinces given the huge variation in disease profile, health seeking behaviors, utilization, facilities, and providers across sub-national areas.

What Should Be Done Now?

Ministries need to begin the process of identification, consensus on indicators, collection of a baseline before January 1, as well as the estimates of expected levels of change and impact. The variance between expected and real impacts, once the reforms begin, can be used as "flags" to identify areas deviating from expected patterns of impact. This identification of flags can be a first step by leaders to examine, investigate, and address potential unintended consequences in the reforms. These flags can even be colored red ("warning"), yellow ("caution"), and green ("as expected or better than expected"). A simulated dashboard for the President is provided in the figure below.

Indicator	Status
Percentage of beneficiaries enrolled (out of eligible population)	
Net enrollment	
Percentage of previously enrolled beneficiaries re-enrolled	
Enrollment of new beneficiaries	
Number of outpatient visits per capita	
Number of admissions per capita	
Average length of stay	
Percentage difference between total revenue and expenditure	
Net financial result	
Per capita revenue	
Per capita expenditure	
Net accreditation	
Percentage of previously accredited health facilities retained	
Percentage of newly accredited health facilities	
Health facilities per 10,000 beneficiaries	
Average number of readmissions within 30 days	
Number of deaths per 1,000 hospital admissions	
Percentage of beneficiaries with reported complaints with care	

Source: Joint Learning Network, 2013

More would be needed.

The Government would be smart to initiate a series of workshops at the central level across Ministries to identify and coordinate on the horizontal dimension. Secondly, it would initiate a series of workshops to bring together different levels of government to identify and agree on a needed set of indicators for the vertical dimension of M&E.

These workshops would develop an initial monitoring program based on the structure of the current MIS system that will be put in place by BPJS or MOH in response to their own needs. Costs and efforts can be minimized by early planning and coordination between all stake holders; in particular, there should be a common set of definitions and classification of diseases and clinical procedures. Timeliness will be paramount so prompt access should dominate the need for full accuracy. Prompt access to raw data, preferably on line, should be the target instead of waiting for late reporting units, validation and auditing. Preliminary results in one period can be updated in the next.

Secondly, the workshops could identify needed indicators and data currently not available, but necessary for the national monitoring program.

In parallel, the government would be smart to write a "White Paper" co-authored by an academic expert from Indonesia, and an international expert to identify best practices, and the set of indicators used by OECD countries in moving to health financing reform on the size and dimensions similar to Indonesia. Some country examples to be considered could be Canada (with its excellent MIS systems), South Korea, Taiwan, or Malaysia. The White Paper would provide guidance on benchmarking short term and medium-term. Given that we have no normative basis to evaluate health systems, comparative benchmarking is essential for systems assessment. The second part of the paper would discuss gaps in the current generation of data for developing indicators for M&E under the reforms.

OECD-Indonesia Partnership?

The Organization of Cooperation and Development (OECD) across high-income countries, for example, has invested time and resources in developing indicators and establishing annual data collections. For the OECD, using data across countries has found that comparisons with other countries help identify problems and motivate reforms as well.

In Indonesia, for example, coverage is both unequal and low. How would Indonesians know that usage is low? They have to have a means of comparing their usage with countries with good coverage. How would they know if they don't have enough hospital beds? etc. Developing countries increasingly appreciate the need and opportunity for benchmarking. China, for example, uses benchmarking aggressively to identify where they need to catch up. A lot of the reforms in China are about them realizing they are not like a developed country, and they need to do something to close the gap.

Indonesia is fortunate in that OECD is both wanting to engage, and that OECD has decided that it will start including Indonesia in its annual Health Data process (reporting it with the other OECD countries in its annual reporting).

World Health Organization (WHO) Partnership?

The WHO in Geneva, along with the World Bank, are now developing and testing a set of indicators to measure and track UHC. The WHO wishes to identify a small number of pilot countries where these indicators can be tested. Indonesia might be a perfect country in which to test these indicators, given the push to UHC on January 1, and given the diversity of the country in terms of disease patterns, financing, and delivery of care. The UN Assembly provided the opportunity for the Minister to discuss such an idea with the Director General, Margaret Chan.

2013 and Beyond: Medium-Term

Many of the indicators will require surveys or quick assessment to evaluate policy changes and provide routine monitoring, and the secondary analysis will require an academic group to work with MOH, much like the University of Indonesia with the work in NHA in a transition period before it is housed in the MOH. Different groups could do this, but this strategy will need to be developed now, or in later months, but certainly before the end of 2013. The last chapter of the White Paper could include a section on the needs for new surveys and secondary analysis.

But does there still need to be a central body to relocate and refocus studies so there will not be overlap and unnecessary duplication? In addition, it will be important for this body to set standards for reporting and agreements on an analytic strategy, and have this regulation disseminated to many different groups.

Many uncertainties remain about the delivery channels, what proportion of the cost premiums and indirect subsidies will cover, the supply side constraints and how will the utilization of private and public capacity be coordinated. The uncertainty about future costs means that the program, given its size and national scope, presents major risks for the GOI, and for the business entities and participants that share the costs. Hence, timely monitoring and control of the financial risks is of utmost importance.


KMS
KARTU MENUJU SEHAT
Untuk Perempuan
Nama Posyandu : BALITA JAYA
* Timbanglah Anak Anda Setiap Bulan.
** Anak Sehat, Tambah Umur

#7 POLICY NOTES

From Whom to Buy? Contracting Health Services for Improved Cost and Quality in Indonesia[16]

June 2013[17]

Background

Through contracting, the BPJS can establish minimum standards—in terms of staff qualifications and infrastructure — that need to be met to be awarded a contract with the BPJS scheme. The BPJS can also establish service-specific standards, whereby providers are reimbursed for particular services only if they are performed by staff with adequate qualifications and in a manner consistent with established practice protocols and prescription guidelines. At a second level, contracting can be utilized to develop benchmarks and performance standards with an organization such as hospital or clinic or Puskesmas. This could be used as part of civil service code or outside of it in the case of private and non-governmental organizations.

Currently in this region of the world, there also is significant external contracting with providers across most countries. Contracting activity seems to occur across all income groups of countries.

An important issue in contracting is whether the payer is to contract with both the public sector and the emergent private sector in many countries. Progress with contracting both public and private can be found in countries such as Thailand, Malaysia, and Mongolia in addition to high income countries of Japan, South Korea, and Taiwan.

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[16] This is Policy Note #7, and was written for the BPJS teams by Jack Langenbrunner under funding from Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. John McComb, technical director for Health, Coffey International, provided excellent comments. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[17] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has begun contracting with private providers under BPJS. Contracting issues remain, however, and the MOH and BPJS have yet to fully leverage efficiency and quality from contracting policies.

Some countries, such as Thailand and Mongolia, also utilize the element of gate-keeping in contracts with primary care providers to better encourage use of primary care and more cost-effective outpatient services.

High Income Countries

In high income countries, Japan, Taiwan, and South Korea, the insurance system openly contracts with any licensed medical providers in the market place, and the private sector dominates hospital sector (about 90 percent in each of Taiwan and South Korea. In all three of these countries, there is no gate-keeping system, but contracts can be used to terminate or temporarily suspend the contract in the case of fraudulent claims and unlawful practices.

Other countries appear less successful in coordinating and contracting across public and private sectors. In Hong Kong, public sector services are commissioned, funded and directly provided by government, through the statutory Health Authority (except for limited services). In recent years, there have been a few experiments with private-public partnership initiatives, involving the contracting out of some common, high volume procedures to reduce excessively long queues (e.g., cataract surgery). In the private outpatient sector, penetration of various forms of managed care, including contract medicine, prepaid plans and preferred provider networks, is limited in extent and scope, although it has grown considerably in the last decade.

In Malaysia, the government contracts with many providers in the private sector, corporatized entities and also NGOs. The MOH has also outsourced services to private providers in the areas of radiotherapy, cardiothoracic and diagnostic imaging in order to increase access to specialized clinical care and reduce waiting times.[7] Indeed, even the traditional medicine providers within the MOH facility are brought in on a contractual basis. Within the support services for health, the government has contracted out, amongst others, the disposal of medical waste products, cleaning and laundry, pharmaceuticals, food supplies, security and health education campaigns.

Middle-Income Countries

Thailand utilizes gate-keeping. The social health insurance schemes (SHI) for civil service and formal private sector workers require beneficiaries to register with specific health care providers. Public and private hospitals with more than 100 beds are considered eligible contractor providers for SHI members. Past experience indicates that private hospitals can play a major role as contractor providers for SHI. However, the government district health system (district hospital and affiliated health centers in a district) typically plays a significant role as primary care contractor providers for civil service beneficiaries. The civil service scheme and SHI purchased services for their beneficiaries through annual contracts to a network of primary care contractors, typically the District Health Systems owned by MOH in the case of the civil service members, and contractor hospitals (more than 100 beds) for SHI members.

In China, insurance schemes have already established contracts with providers, specifying the package of services to be delivered, the payment methods, quality standards, drug lists, and other things. In some cases, contracts include provisions for terminating the contract if, for example, patients were not charged in accordance with the established price schedule.

In the Philippines, in few isolated cases, some local health departments have contracted out provision of health services of indigents to either private or public hospitals. These have now shifted to enrolling the indigents to the SHI program. The Department of Health often contracts out non-health care services such as training of government health workers and technical assistance to local governments.

Low-Income Countries

Cambodia has utilized contracting extensively since 1998, starting with an Asian Development Bank (ADB) loan, as a way to improve service delivery and improve staff performance in health facilities in different local districts. The initial group contracted consisted of eight districts covering one million people. Three different models were piloted (using a randomized design) from that time until 2003: "contracting in" (3 districts), "contracting out" (2 districts), and continuing existing government policies (3 districts).[18]

The Belgian Development Cooperation Agency (BTC) later introduced a different version of contractual agreements called the New Deal, an attempt to use the district as the main management of the contracted units rather than using NGOs. The selection of contractors was done through a call for bids from NGOs to manage various districts using grants from donors.

The contracting model now in use is a hybrid of the previous pilots, in which an NGO contracts with MOH staff at the supervisory and service delivery levels. Civil service regulations apply to staff, but NGOs can hire additional staff when necessary.

Data from one district (population 176,000) in the original eight districts that used the contracting-in model revealed the output of services increased by 100-700 percent depending on the type of service. The most notable were increases in antenatal care and deliveries (740 and 550 percent respectively). Outpatient contacts showed the lowest increase of only 98 percent one year after the implementation. It was also demonstrated that the population's out-of-pocket health expenditure in the district decreased, while staff salary increased. Some providers faced decreasing income as they received less than from their earlier private practices, but they were willing to comply with the new system. In addition, contracted districts showed a more pro-poor distribution of resources than in non-contracted districts, but large discrepancies still existed, even within contracted districts.

Several reviews have analyzed the factors behind the success of contracting in Cambodia. In brief, they are: (i) contracts have performance orientation and link funding to achieving pre-defined targets; (ii) additional management expertise and skills are brought in by the contractor; (iii) additional financial incentives are paid to the staff; (iv) the Government disburses the health facility operational budget in full and on time; (v) the independent third party role of the NGO is

[18] ***Contracting-out***: Contractor has full responsibility for delivery of specified services in an OD, directly employs staff, and has full management control. Direct funds allocation is made in accordance with bid.
Contracting-in: Contractor provides management support to civil service health staff, while recurrent costs are provided by government through normal channels. An additional budget supplement is provided out of donor funds. Contractors have full management support over allocation and disbursement of the budget supplement, but are obliged to follow government regulations with respect to government-provided resources.

instrumental in monitoring performance, identifying problems, and lobbying the government and donors to address them.

But a review of the outcomes associated with contracting indicates only mixed results. Evaluating six key outcomes indicators: antenatal coverage, delivery in a healthcare facility, delivery with trained staff, full immunization, vitamin A coverage and birth spacing, indicates that in about 50 percent of the districts the results achieved are higher than the national average. In many cases, the target was not achieved even though the contracting model was in place.

The main problem with the contracting model in Cambodia has been the high rate of administrative expenditure. The rate of administrative expenditure ranges from 19 to 46 percent in a summary review of NGOs contracting. Future participation of NGOs could be regulated by limiting overhead expenses through regulatory/contractual terms.[19]

The current contracting arrangements use several mechanisms to improve performance, including: an output and outcome-oriented contract with performance incentives between the MOH and the NGO managing service delivery; increased financial and managerial autonomy for the districts; an independent third party role of the NGO in monitoring staff and services and in governance; improved management capacity; direct disbursement of a block grant to district level; salary supplements and staff performance management. The NGOs involved differ in their approaches.

In Mongolia, primary health care in urban settings is contracted out to medical practitioners (Family Group Practices, or FGPs) assembled as cooperatives. There are 229 FGPs. These cooperatives are regarded as being private, for-profit private entities, established on the basis of assets contributed by their members. However, there is still confusion as to their real status, as these entities do not have common assets and they are funded fully by the government subsidy, which conflicts with the budget law. The budget law defines as public if the organization is fully funded by the state budget/general government revenue. Thus the legal standing of the FGPs is still uncertain.[20] In addition, recent years the government has taken decisions to contract out certain support services such as laundry, kitchen, cleaning and security.

In addition to this type of agreements or contracts, the Social Health Insurance organization enforces contracts with public and private providers (sanatoria, private hospitals) for its reimbursements of services delivered to insured persons; public providers have to conclude at least two contracts with respective organizations.

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[19] A number of other shortcomings and recommendations for improvement have been noted, including:
Providers violating the private practice ban are not sanctioned;
The MOH/local health department are at times unable to meet the obligation of providing adequate, quality staff;
There was sometimes a conflict of human resource accountability: the local health department was responsible for employees but NGOs were supposed to manage them;
Primary care facilities did not have adequate autonomy;
Funding was inconsistent;
Contracting targets often did not match National targets. National programs still have a vertical approach, so there is limited coordination with ODs;
Quality indicators should be included as performance targets, and included as criteria for monitoring performance. Practical assessment tools should be created.

[20] However, it can be noted that their status is not that different to that historically of general practitioners in the UK National Health Service, who were legally independent contractors, but were usually regarded as being public sector doctors.

There is another contracting concept in the Mongolian public system which is still mechanistic in terms of the implementation. The Public Finance and Management Law (2002) requires all budget entities to have a service delivery contract/agreement with the relevant Minister. At the end of every year, the Health Minister signs a contract with local government unit heads agreeing the health sector budget and services to be provided in each local government unit. The Health Minister also delegates his contracting authority to the State Secretary to conclude agreements with tertiary level hospitals and to local governors to conclude contracts with secondary and primary level public providers. Once general agreements or contracts are concluded outlining the overall services and funds for each providers, general managers conclude performance agreements with departmental managers and personnel internally within their organizations. The law brought a new management system for public entities where contracting is intrinsic to their functioning, but capacity is yet to be improved to ensure effectiveness of this concept.

In Vietnam, the SHI reimburses approved facilities, which include contracted private facilities. Enrollees may also use non-contracted facilities including providers abroad, but reimbursement in this case is to the patient who pays the facility and subsequently files a claim up to a ceiling amount of average facility cost.

In Laos, there is more limited contracting, where there is contracting only between community-based schemes and facilities and providers.

In Timor-Leste, currently, the public sector provides a majority of health services in Timor-Leste (Meeting Health Challenge, Prime Minister's Office, 2008). Government services have been complemented by a significant private sector component – estimated at 25 percent of all services -- to provide services the public sector cannot such as ambulatory care), primarily through local and international NGOs (the latter often funded from abroad) which are often church-related (e.g., Caritas associated with the Catholic Church) and which rely mostly on volunteer workers; and by private doctors, nurses, and midwives.

Although it appears that no formal contracts exist between public and private providers, the government of Timor-Leste is working to strengthen public-private partnerships in health. Specifically, it aims to: focus the public sector on those public goods it can effectively deliver; promote appropriate involvement of the private sector in the delivery of private goods such as ambulatory care; and strengthen collaboration between the public and private sectors in service delivery. This will entail further development of the relationship with local employer-labor groups, and increased cooperation with church health facilities (e.g., access to pharmaceuticals and basic health equipment to improve the quality of services in church facilities).

Contracting in Indonesia

Contracting is not new to Indonesia. The AusAID has funded a maternal and neonatal health program in NTT for about 4.5 years. In that program, district governments were able to outsource (contract) specialist obstetric and paediatric teams from public and private hospitals in Indonesia to immediately fill human resource gaps in district hospitals. In a relatively short period of time the program was able to reduce maternal mortality by up to 50% on average. A lot was learned about contracting out of services, both in terms of the capacity of other tertiary hospitals in Indonesia to meet the demand for specialists, and how to improve the contracting process and monitoring of outcomes.

Indeed, contracting is common in this region of the world, regardless of income level. Indeed, there is a rich tradition in some countries such as Cambodia. However, there is little in the way of contract evaluation in any of the countries in the region, and no evidence (outside of Cambodia) of selective contracting on the basis of quality and performance. There is more often the situation of soft, relational contracts where there is an expectation from both sides (purchaser and provider) to automatically extend contracts for ensuing years.

Selective contracting is not easy, either technically or politically. At a technical level, it requires both good and timely information about costs and quality of services delivered. Nevertheless, in the near term, countries with developing capacity may be encouraged along several lines:

- Development of management and information systems (MIS) facility pilots which would adapt standard approaches to capturing clinical and cost information. This information could be used as the basis for negotiation of providers with insurers/purchasers of services.
- With changing epidemiologic patterns emergent in many countries (e.g., non-communicable diseases in China, Vietnam, Thailand) to develop a series of pilots which might be focused on chronic management areas such as asthma and diabetes. These could be supported with good contracting rates of payment and have associated quality and outcome indicators. Pilots could later be scaled-up. These might be developed along similar specific disease management lines that promise more cost-effective provision. These areas might include:
    - diabetes;
    - asthma;
    - hypertension; and,
    - mental health services.

  For example, better management of diabetes might result in less renal failure and a less costly medical situation for individual and family. There are disease management pilots now in Beijing (diabetes) and Nanjing (mental illness) but little is known about these.
- In geographic areas with few or one provider (rural areas), development of contracts which can still build-in performance benchmarks for improved performance. These benchmarks could be matched with performance payment bonuses of some type.
- Development of more contracting internally to organizations such as hospitals and clinics. Little (Vietnam perhaps being the exception) has occurred in the region related to internal contracts with staff of public facilities. The contracts would be used in the first 2-3 years to assess performance and provide feedback. After 3 years, the contracts would be used to improve flexibility of inputs to better hire and fire personnel according to performance and input needs for care services.
- Assessments of whether more countries (in addition to Mongolia, for example) should continue the contracting out of selected services (laundry, food, laboratory and diagnostic services) in its public facilities. This could continue to both improve quality and cut costs.

Contracting out always requires some caution, and requires among other things:

- A competitive environment;
- Well-defined services;
- Coordination with public sector activities;
- Assessment of quality of private management;
- Specification of service standards; and,
- Close monitoring of contract performance.

Immediate Lessons for Indonesia?

Indonesia is very advanced in terms of an emergent private sector for delivery of services. Selective contracting approaches might be expanded in Indonesia, and selective contracting utilized in some geographic areas, such as the large urban areas, with both public and private providers.

Secondly, BPJS ***immediately*** might use their contracting authority to stipulate such things as:

- Following referral guidelines;
- Compliance with coding standards for reimbursement and quality;
- Compliance with pharmaceutical coding system being developed now;
- Compliance with reporting of costs according to a standard cost template as first developed by the Jankesmas scheme, for example; and,
- Contracts for all workers in public sector facilities. Often the complaint is that public facilities are not responsive or efficient. Contracts are the first step to making public facilities more responsive. With the INA CBGs, public hospitals will certainly need to hire, fire, or change their staff input mix. Contracts give the hospital managers flexibility to fully respond to the new incentive structures. There will be similar issues with capitation and primary care facilities.

As a single payer, the BPJS should contract with any and all facilities which expect reimbursement for services provided under the BPJS law. The contracts will allow direct funds flow to the Puskesmas and all providers. This will assuage the Ministry of Finance that funds for Health will actually be utilized for health services, and better assure that all funds reach the providers – as these should.

In the future, as data systems evolve and are more powerful, contracting can be used to address better management of NCDs such as hypertension and diabetes, as well as TB control and other infectious diseases.

Contracting is a powerful tool for both efficiency and equity, and the BPJS must utilize to the extent possible for both public and private sectors.

#8 POLICY NOTES

Monitoring and Evaluating Expansion of Health Coverage: Indonesia Expanding Coverage "Information Dashboard" Pilots[21]

July 2013[22]

Health Coverage Background

The Government of Indonesia (GOI) has initiated a social security reform process by promulgating Law No. 40 on National Social Security System in 2004 (SJSN Law) and Law No. 24 on Social Security Administering Bodies (BPJS) in 2011 (BPJS Law) which comprises five programs. The Health BPJS should be established by early 2014 while the BPJS for labor should be established by mid-2015. The implementation of the new social security administering body entails consolidating all health programs provided by PT. ASKES and PT. JAMSOSTEK into the Health BPJS as well as about 300 local programs sponsored by local governments.

While significant advances have been made in the last few years to increase health insurance coverage rates, the recent figures estimate that approximately 40% of the population is still without health insurance.[23] Improvements in coverage rates are expected from now until 2019 with the full implementation of BPJS. For example, it is anticipated that the population currently covered through Jamkesmas could increase to 96.4 million covered by BPJS in 2014. However, a substantial number of persons without health insurance will remain. According to calculations based on results from the Informal Economy Study (IES) conducted in 2011/2012, 31.2 million (paid) informal workers will not be covered by health insurance in 2014. This and other coverage gaps need to be addressed in order to achieve universal health coverage.

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[21] This is Policy Note #8, and was written for the BPJS teams by Annette Martin of the Joint Learning Network and Results for Development Institute in Washington, D.C., in collaboration with the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org .

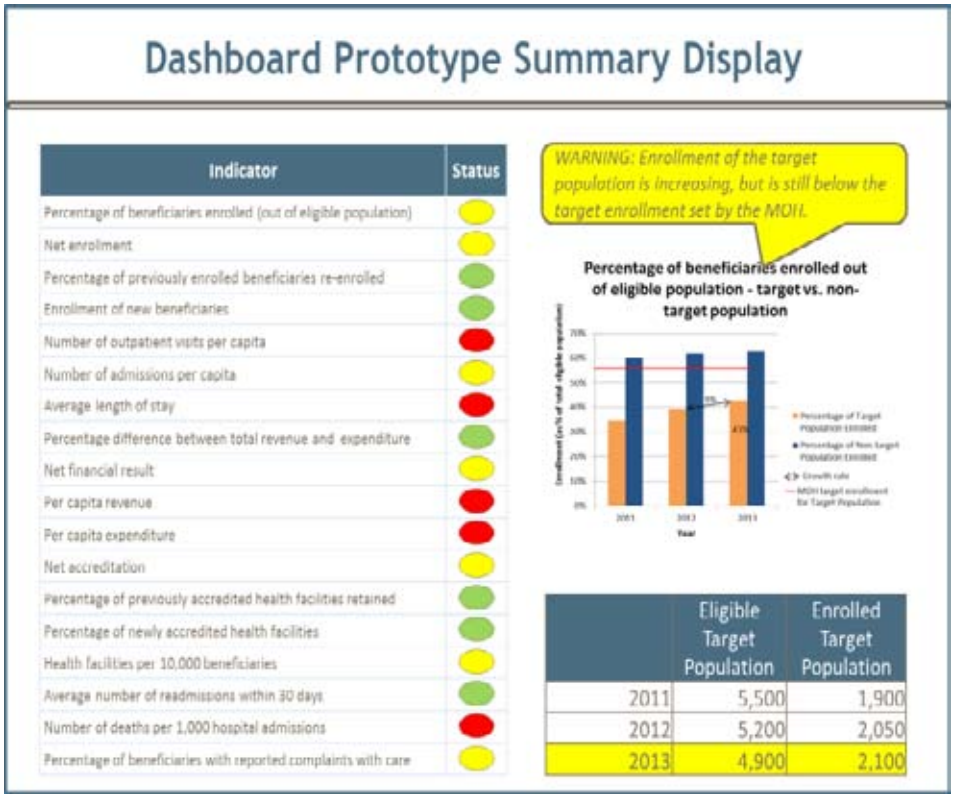
[22] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has embraced and implemented the concepts described here.

[23] Global Extension of Social Security, 2011.

Indonesia is not alone is facing coverage challenges. Most Joint Learning Network (JLN) countries that are progressing towards universal health coverage (UHC) have become stagnant in enrollment – particularly for the poor and informal sectors. With the admirable goal of dramatic coverage shifts over the next six months and the aim of reaching full coverage by the end of 2019, the GOI will need to demonstrate progress over time related to covering all Indonesians. It is necessary, therefore, that the GOI have tools at its disposal to monitor and evaluate (M&E) progress on meeting its targets, and particularly on ensuring its disadvantaged and/or vulnerable populations are covered. One such tool, an Expanding Coverage Information Dashboard, can aid the GOI in tracking and reporting on expansion of coverage.

Information Dashboard

The Joint Learning Network (JLN) Expanding Coverage (EC) technical track developed a prototype for a country-level "information dashboard" – an interactive, electronic interface that will routinely synthesize data from various readily available sources and display progress against key indicators related to expanding coverage to disadvantaged and/or underserved populations.



The following key features of the dashboard work to turn data into actionable information on expansion of coverage:

- A one-page display that allows the user to view key performance indicators and track progress regularly at a glance.
- A "drill-down" feature that allows the user to access and view real-time data at a disaggregate level.
- Management flags that signal when an indicator requires the attention of the user, allowing decision makers to quickly detect and correct negative trends in performance.

The following indicators are a sample set developed as part of the EC Information Dashboard prototype:

Category	Indicators
Enrollment and Re-enrollment	• Percentage of beneficiaries enrolled (out of eligible population) • Net enrollment • Percentage of beneficiaries re-enrolled • Percentage of beneficiaries newly enrolled
Utilization of Health Services	• Number of outpatient visits per capita • Number of admissions per capita • Average length of stay
Financial Management	• Total revenue compared to total expenditure of the scheme • Net financial result • Per capita revenue • Per capita expenditure
Expansion of Provider Network	• Net accreditation • Percentage of previously accredited facilities that renew or retain their accreditation • Percentage of facilities newly accredited
Accessibility of Provider Network	• Health facilities per 10,000 beneficiaries
Quality of Care	• Average number of readmissions within 30 days • Number of deaths per 1,000 hospital admissions • Percentage of beneficiaries with reported complaints with care

The expected primary users of the EC Information Dashboard are policy leaders and scheme managers whose responsibilities include monitoring the expansion of health coverage to underserved and/or disadvantaged populations.

Indonesia Dashboard Pilots

The GOI is planning to develop a dashboard based on the JLN prototype to track performance against key performance indicators to report on progress towards UHC. During a meeting in April 2013 with Vice Minister Professor Ghufron and key stakeholders from BPJS Pokjas, insurance schemes, providers, and Yogjakarta province, wide support was given to the concept of using an information dashboard as an M&E tool to measure progress towards UHC. Representatives from various levels of government and insurance schemes expressed interest in developing a dashboard as a way to track performance and coordinate population coverage across schemes. BPJS also expressed interest in a performance monitoring tool for reporting purposes.

Representatives of PT. ASKES, PT. JAMSOSTEK, Jamkesda, Jamkesos, and Jamkesmas confirmed that they track enrollment, utilization, and financial indicators for their members. It is commendable that insurance schemes already recognize the importance of reporting progress against indicators. The tracking systems, however, are neither consistent nor automated, and do not provide perspective beyond a particular scheme or membership group.

Responding to the clear demand for an M&E tool, AusAID, GIZ, and the JLN are working with counterparts at the Ministry of Health (MOH) to understand current state data availability and quality and to develop key performance indicators on expansion of health coverage. The partners are collaborating to customize the prototype EC Information Dashboard to ensure its relevance for Indonesia's country context and reform objectives. MOH plans to pilot the customized dashboard in up to four provinces – Aceh, Jakarta, West Java, and Yogyakarta – initially focusing on Jakarta and Yogyakarta provinces. MOH prioritized the development of indicators within the Enrollment and Re-enrollment category for the pilots, followed by those within the Utilization of Health Services and Financial Management categories.

While the conceptual framework of the EC Information Dashboard will be consistent across provinces, each pilot may customize the dashboard to accommodate unique factors within each province and potentially within each district health system, such as:

- Available data
- Provincial priorities and targets
- District health office priorities and targets
- Scheme priorities and targets
- Dashboard user needs
- Preferred electronic interface

Some ways in which Indonesia may customize the dashboard for each pilot include tailoring:

- Indicators
- Management flags
- Population groups (e.g., characteristics of the "target population")
- Frequency with which data is reported
- Display of data (e.g., charts, tables, "countdown to target")
- Level of disaggregation of data

The pilots will integrate the EC Information Dashboard into existing scheme information management systems with special attention towards harmonizing the reporting format and designing an interface that is compatible across schemes with the potential for adaptation beyond the four provinces. The pilots will be included as an activity within the DPJS IT Pokja pilot protocol and action plan. The pilot execution will be spearheaded by a Technical Leadership Team and coordinated with extensive input from PT ASKES.[24]

A key first step is to conduct a current state assessment (i.e., situation analysis) of scheme data within Jakarta and Yogyakarta provinces, focusing on data availability, format, quality, and reporting frequency. This assessment will also include documentation of the minimum dataset collected, the indicators that are calculated, the numerators and denominators of those indicators and their data sources, the reporting engines that extract the data, and the associated analytic burden. This effort will also include description of the scheme information systems and specification of the affiliated IT vendors. Additionally, a description of the process for data transmission between the Puskesmas, hospital, district health office, and provincial levels will be specified for each scheme. This current state assessment will serve to provide a greater understanding of the diversity across schemes, districts, and provinces and is a necessary first step prior to initiating discussions on indicator

[24] A more detailed Terms of Reference will be developed following release of this Policy Note to further specify the work effort.

development, dashboard design, and coordination across schemes. With this understanding of the situation today, discussions on how to harmonize the data collection and reporting processes for a dashboard can proceed.

Following clarification of baseline data, systems, and processes, the next step is to convene key representatives from the schemes, provinces, districts, and IT vendors for a technical design and interoperability meeting. At this meeting, discussions will focus on the development of key performance indicators, in addition to the dashboard design interface, data extraction and reporting processes, and database standardization. Operational and governance processes related to coordination across schemes and IT vendors will also be discussed. The months of June and July are proposed for the current state assessment, with August targeted for the technical workgroup meeting. Dashboard development is anticipated for September and piloting for October-December.

Lessons learned from the pilots will be documented and disseminated to inform national efforts to scale up the EC Information Dashboard to monitor expansion of coverage. Lessons will also be disseminated to other countries implementing UHC reforms.

Key Near-term Challenges

The foremost challenge Indonesia faces in tracking coverage of population groups relates to information sharing and coordination across schemes. While membership database consolidation between each scheme (at least ASKES, Jamsostek, and Jamkesmas) is in progress, and a smart database is in development to support a National Unique Identifier (NUI) that would ensure that the same person is not counted twice when moving between categories or locations, these activities will take time to come to fruition and it will be a challenge to track coverage of different population groups in the interim. To ensure effective monitoring of coverage of different population groups, a variety of creative options must be explored in addition to the NUI, eKTP electronic identification card, and voters' list. Cross-scheme information sharing will be essential to capture population movement between categories or locations.

Coordinating these schemes prior to data consolidation will be essential to determine how best to share information across schemes and information systems to ensure a holistic view of population coverage. Access to these data will be important for provincial and national monitoring efforts of member movement across schemes. Practical approaches to facilitate the coordination and consolidation of scheme data may be to:

1) Develop data transmission protocols and standards for participating providers and schemes; and
2) Hold providers and schemes accountable for data transmission by tying payments to timely and accurate reporting in the specified format;
3) Employ an independent Quality Assurance Officer who is responsible for monitoring compliance at the Puskesmas, hospital, and scheme level.

Another significant challenge Indonesia will face relates to the training requirements to assure that enrollment and claims data are correctly recorded and transmitted. Both start-up and ongoing training of Puskesmas and hospital information managers for payers and providers will be essential. Further, it will be necessary to monitor whether the additional data gathering and reporting requirements can be met with current Puskesmas and hospital staffing levels.


Melahirkan
Di Puskesmas
Ibu Dan Bayi

#9 POLICY NOTES

Universal Healthcare Coverage and Healthcare Accreditation in Indonesia[25]

June 2013[26]

Background

The high proportion of user fees in Indonesia has made many people face financial hardship due to health care expenditure, particularly the poor and near poverty line population. The government of Indonesia has committed to improve access to affordable and quality healthcare services for all the population through the universal healthcare coverage programme to be piloted in January 2014. The aim of the programme is not merely to scale up the coverage, but also to improve the quality of health services. The government plans to link the accreditation programme with universal health care coverage by requiring all contracted health facilities to be accredited.

International Experience: Accreditation with Universal Healthcare Coverage

The development of primary care, universal healthcare insurance and accreditation has been a common formula for healthcare reform supported by the international community. Many such combinations failed to achieve their potential, sometimes because the health insurance funds did not recognize accreditation awards in contracts, or in selection of preferred providers. Without the incentive of commercial advantage, providers have limited enthusiasm for voluntary accreditation and minimal commitment to mandatory accreditation. Low uptake of, or minimal compliance with the accreditation

[25] This is Policy Note #9, and was written for the BPJS teams by Dr. Dewi Indriani of WHO and Dr. Charles Shaw of the University of South Wales under funding from USAID and WHO. It is part of a series in collaboration with the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[26] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has moved forward with accreditation both on the primary care level and hospital level. However, not all recommendations discussed in this Note have been implemented as yet, as for example, accreditation from a national independent body.

programme reduce the potential impact on quality and safety across the health system. They also limit the income generation required for a self-financing accreditation programme.

An international survey of 44 national accreditation organisations in 2010[27] identified the leading causes of failure in accreditation programmes, and thus indicate some critical success factors worldwide:

- Accreditation is supported by stable government policy;
- Accreditation is complementary to statutory regulation;
- Awards are linked to financial incentives for providers;
- Accreditation agency has a realistic business plan.

Globally, just under half of all accreditation programmes are underpinned by government policy, but this proportion is higher in lower and middle income countries (Figure 1). A similar proportion reported preferential funding as a key incentive (Figure 2).

Figure 1:
Is accreditation an element of government strategy for healthcare?

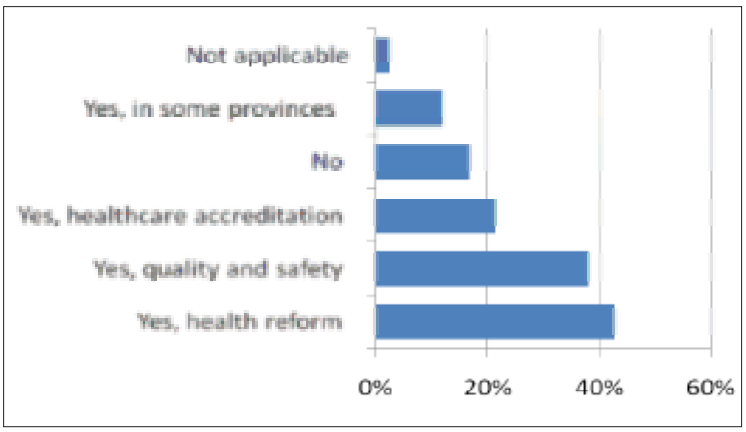
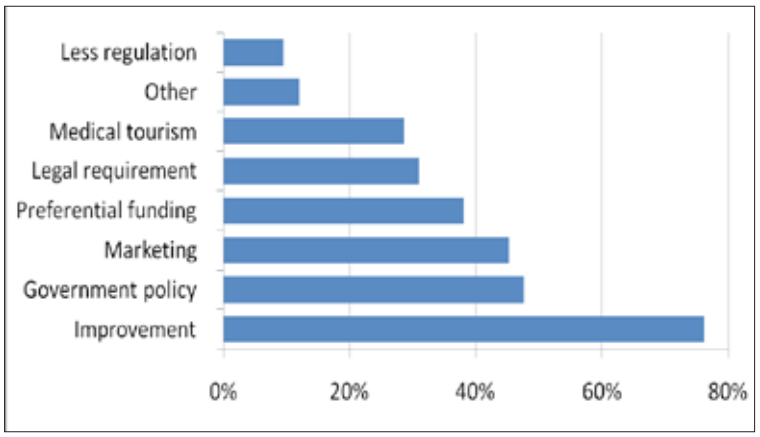


Figure 2:
What are the incentives for institutions to participate?



[27] Shaw CD, Braithwaite J, Moldovan M, Nicklin W, Grgic I, Fortune T, Whittaker S Profiling healthcare accreditation organisations: an international survey. International Journal for Quality in Health Care 2013; pp. 1–10 10.1093/intqhc/mzt011

In Indonesia, accreditation is aimed to raise the quality of health services towards international standards and to comply with the 2009 law which requires all hospitals to be accredited every three years. The intention is to shift the focus of attention away from structure, inputs and resources towards process and outcome. However, the relationship of KARS with regulatory functions, education and health insurance is unclear. Currently there is no explicit national strategy for improvement to describe the synergy of accreditation and health insurance. Collaboration and agreement of principals would be essential such as on:

- Evidence-based standards for clinical practice and service delivery;
- Validated methods of assessment and measurement of performance;
- Information strategy, data definitions and quality; and,
- Data protection and exchange of information, especially billing data used for performance indicators.

Healthcare Accreditation in Indonesia

Indonesia is still facing poor performance in health facilities, particularly in government owned institutions. External assessment on quality of healthcare through accreditation began with the establishment of the national accrediting body "KARS/Komite Akreditasi Rumah Sakit" in 1996. The initial programme focused on hospitals and on input indicators and failed to have the desired impact on the quality of services. The Hospital Law no 44 of 2009 made accreditation compulsory for all hospitals every three years. In most countries accreditation is voluntary, but with substantial incentives. In 2010, the Indonesian government released a ministerial decree no 147 reinforcing mandatory accreditation by linking accreditation with licensure. Despite this, there are still many hospitals which are licensed to operate without being accredited. Meanwhile, national accreditation system for other health facilities such as Puskesmas (primary health centers), clinics and private practices do not yet exist. However, some of these health facilities have undergone other programmes such as ISO 9001 certification and provincial accreditation programmes.

Recently, Indonesia is in the phase of improving their accreditation systems. An Indonesian hospital accreditation programme has been launched in 2011 with support from USAID and WHO. The programme has four main objectives, to:

1. accredit nine "A" level hospitals with an international accreditation body (JCI/ Joint Commission International);
2. accredit KARS with the International Society for Quality in Health Care (ISQua);
3. develop national expertise in accreditation of hospital as a quality improvement measure; and,
4. develop long-term plans for maintenance and continued improvement of quality health services.

Over the past two years, two hospitals have been accredited by JCI, KARS is in the process of restructuring their organization and revising their accreditation standards in order to meet ISQua requirements, and Puskesmas accreditation standards and implementation guidelines are being finalized.

To have a comprehensive quality assurance relevance, hospital accreditation should be contextual at least in a district health system perspective. If primary care is to be an effective "gatekeeper"

there should be a conceptual framework where primary care (public and private) will be able to offer quality care supported by referral services.

Standards for primary health care accreditation should be consistent with international principles defined by ISQua[28], with Indonesian legal and regulatory requirements and with existing service standards such as Standard Pelayanan Minimum (SPM) can be used. These should include the interface between preventive health, primary and secondary care. All standards should be made accessible and publicised in the public domain

Issue and Challenges in Healthcare Accreditation in Indonesia

There are some important questions need to answer in healthcare accreditation programme in Indonesia before it can be link with the universal coverage programme. What will be the implications of the mandatory to be accredited every three years on hospital? Does KARS have capacity to undertake the task with their current situation? Although Puskesmas accreditation are in the final stage of development it standard, tools and implementation guidelines, who will be the accrediting body and how they will implement it?

The obligation of hospitals to be accredited every three years is written in the hospital law and is not subject to amendment by ministerial decree. However, a legal opinion would be valuable to clarify the nature of that obligation (incentives or sanctions on whom), and whether every hospital has to be accredited, or merely assessed (at least) every three years.

If the hospital law is unambiguous in requiring KARS to accredit (rather than assess) all hospitals every three years regardless of compliance with standards, it is not surprising that so few are denied accreditation. Fixing the term of accreditation at three years further disables KARS as an independent and credible assessor. KARS thus appears to be a more sophisticated duplicate of the licensing system operated by each district. Moreover, KARS is the only national accrediting body which is recognized by the government as stated in Ministerial decree (Permenkes) No 428 in 2012. Given the number of hospital across the country (2103 hospitals areregistered in MoH), this decree will give a heavy workload to KARS if all providers to be contracted by BPJS have to be KARS accredited.

In addition, as KARS is in the preparation for ISQua accreditation, they have a lot of homework to be done. Based on self-assessment which has completed, many of the operational systems in the organization require attention and improvement. The self-assessment done in 2010 indicated only 20% compliance with the standards which require 75% for accreditation. To be aligned with ISQua requirements on organizational governance and independence, KARS should have major changes in organizational structure. Furthermore, some technical issues such as accreditation standard, accreditation decisions and awards, planning and finance, human resources management and survey management also need to be improved.

KARS does recognise the general problems, but has yet to scope the time and effort required to resolve them. A working group has been set up to explain for ISQua how JCI standards have been

[28] International Society for Quality in Health Care. International Principles for Healthcare Standards http://www.isqua.org/accreditations.htm

integrated and balanced with national requirements and with MDG; completion of this task is required to secure the tentative date of November 2013 for the assessment of KARS by ISQua.

Most new applicants for ISQua accreditation of organisations take around two years for self-assessment and preparation, but few organisations also have to persuade their MoH to repeal regulations in order to comply with standards of governance and management. Even if revised regulations could be sped through the usual processes in Indonesia, the recruitment and induction of a governing body and restructuring of management are unlikely to be completed by November 2013.

Puskesmas Accreditation

As regards Puskesmas accreditation, although the Directorate of Basic Health Services has finalized the standard, instruments and implementation guidelines for accreditation on Puskesmas and other primary level health facilities, there is no legal basis for a separate accrediting body. The issues and challenges in this programme were very similar to those faced by hospital accreditation. Moreover, the number of Puskesmas and health facilities is much greater than hospitals (Total Puskesmas ± 9000).

It may be too late at this point to try to make a concept of accreditation for primary care, since any new program needs at least two years to really "take off". The Puskesmas accreditation should aim to ensure that public sector primary care can work effectively at least for the essential health care services, and that the poor can access health service in a timely manner. The DHO should identify all primary health care providers at district level, categorized as licensed or not licensed. The licensed primary care providers should be the preferred providers for JKN.

It is believed that the impact of many proven interventions – such as performance indicators, clinical guidelines and accreditation – depends more on organisational culture and incentives than on technical competence. Each element contributes to a cycle of defined objectives, monitoring and measurement, and change management. Each program should have an identified role in the national strategy and contribute to overall improvement of the health system. Many current and recent projects in Indonesia could contribute to improvement, but it appears there is no national strategy to integrate and maximise their benefits across the healthcare system (both public and private).

How to Link accreditation and Universal Healthcare Coverage in Indonesia?

Clearly, there will be no universal accreditation programme to match universal coverage in Indonesia by January 2014, and many factors would have to be favourable to achieve this even within three to five years. Linkage of insurance funding to accreditation status is an essential long-term goal, and must be factored into the design and operation of the two systems. Both must be consistent with an overall national strategy for improving quality and safety in healthcare.

PEMERINTAH KOTA KUPANG
DINAS PENDAPATAN DAN PENGELOLAAN KEUANGAN DAERAH
RETRIBUSI PELAYANAN KESEHATAN (RAWAT JALAN)
PERDA KOTA KUPANG NOMOR : 11 TAHUN 2002
Nomor : 025391
Penda
Rp. 5.000,-sekali berobat
Pemungut

PEMERINTAH KOTA KUPA
DINAS PENDAPATAN DAN PENGELOLAAN KE
RETRIBUSI PELAYANAN KESEHATAN (RA
PERDA KOTA KUPANG NOMOR : 11 TAHU
Nomor Urut : 025349
Besarnya Retribusi : Rp. 5.000,-/sekali berobat
Tanggal Pungut : 10 - 05 - 13
ASLI
Pemungut

#10 POLICY NOTES

Smoking and Universal Health Coverage: What is the Connection?[29]

July 2013 [30]

The Challenge

The World Bank has estimated that Universal Health Coverage (UHC) in Indonesia will cost an additional $13-16 billion once implemented.[31] While the Minister of Finance in Indonesia cannot afford currently to fully subsidize every near poor and informal sector individual, it might consider a phased subsidy strategy which could match central funding with provincial level, district level and minimal family contributions, much as was successfully done in China over the last 5 years.[32] Premiums per capita would be less than $30 per capita per year according to the government's own model.

Part of this phased effort might be to leverage new revenues, such as those associated with a new tobacco tax or phase-out of the fuel subsidy.

Taxes on the consumption of goods that adversely affect health are often earmarked for the health sector. Taxes on the consumption of tobacco and alcohol, for instance, are often considered to be beneficial not only from a public health perspective but also from an economic perspective.[33] Even if not earmarked for health, higher taxes can discourage consumption and reduce illness and

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[29] This is Policy Note #10, and was written for the BPJS teams by Dr. Yunita Nugrahani and Jack Langenbrunner under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through the Australia Indonesia Partnership for Health Systems Strenghtening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[30] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has revised and increased the tobacco tax. However, by global standards it remains quite low.

[31] Randy Fabi and Nilufar Rizki, "Indonesia's Nationwide Health Care Plan Stumbles at First Hurdle," Jakarta Globe, May 20, 2013.

[32] See, for example, Liang, L. and Langenbrunner, J. China: The Long March to Universal Health Coverage, UNICO Case Study Series, World Bank, 2013.

[33] Thailand, Australia, USA, and Korea are examples of countries that have successfully implemented earmarked taxes on tobacco and used the revenues for public health purposes.

accidents (in the case of alcohol), and reduce future demand for health services, which can reduce the pressure for more resources.

The Global Picture

Tobacco use, of any kind, is the leading cause of preventable death in the world. Smoking killed nearly 6 million people in 2011 of which almost 80 percent occurred in low and middle income countries like Indonesia. Big international tobacco countries are preying on middle-income countries such as Russia, Brazil, India, and Philippines with unsuspecting youth. With current trends, the number will rise to 8 million deaths annually by 2030. These deaths and health problems associated with smoking, including chronic diseases such as cancer lung diseases and cardiovascular diseases, cause hundreds of billions of dollars of economic damage worldwide each year.[34] An analysis has suggested that being a smoker in the age of 20-40 will increase 20 times risk of getting lung cancer compared to people who do not smoke. This is supported by the fact that many deaths occur during prime working years (30-69), which both reduces overall productivity and deprives families of wage earners.[35] Sound familiar?

What works? What is the global experience? It has been shown in a number of countries that the most effective method for reducing tobacco consumption and improving health is to increase the price of tobacco products through tax increases.[36] Higher tobacco prices are effective because they encourage existing tobacco users to quit, prevent young people from starting, and reduce the amount of tobacco consumed among continuing users. Also, in spite of reducing demand, tobacco tax revenues increase over time.

The Indonesia Picture

In Indonesia, over 67% of men over the age of 15 do smoke. A quarter of Indonesian boys, age 13-15, also smoke. The prevalence of smoking women in Indonesia is below 10% and it is lower compared to some other countries such as US, Canada, Poland or Brazil of which more than 20% women are smokers. Nevertheless, the prevalence has risen from 4% in 2006 to 5.1% in 2009, and this is started in relatively young age (5). About 1 in 4 girls has tried smoking for the first time before the age of 10 (WHO, 2009). In spite the far lower prevalence of smoking women compared to men, the government cannot neglect this issue.

Second-hand smoke is also an issue. Tobacco smoke contains 7,000 classified toxic poisons literally being thrust down the throats of men, women, and children across Indonesia.

Indonesia has the biggest cigarette industry in the world. There are at least 3800 cigarette companies in Indonesia including the cigarette home industry. Around 3000 of these companies are located in Central Java and East Java. These two provinces are also the biggest tobacco producers nationally. In the length of two decades, the cigarettes sales in Indonesia has risen almost 50 times

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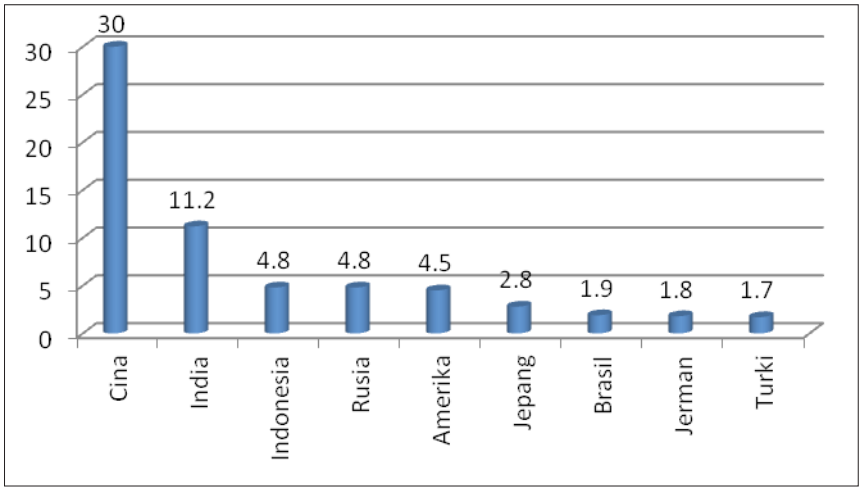
[34] WHO Report on the Global Tobacco Epidemic, 2011.

[35] Anh PH, Efroymson D, Jones L, FitzGerald S, Thu LT, Hein LTT. Tobacco and poverty: Evidence from Vietnam, literature review. HealthBridge Foundation of Canada; 2011. Available from: http://www.healthbridge.ca/tobacco_poverty_Appendix%207%20Vietnam%20Final%20Research%20Report.pdf.

[36] See for example, WHO Report on the Global Tobacco Epidemic, 2011, WHO, Tobacco Free Initiative http://www.who.int/tobacco/en/ , or theTobacco Atlas, op. cit.

from IDR 1.4 trillion in 1981 to IDR 51.9 trillion in 2001. This results in 95% of the country's excise revenue -- from the cigarette industry.

Figure 1:
The 10 Countries with Highest Cigarette Consumption
(in billions of sticks)



***Source*:** WHO Report on Global Tobacco Epidemic, 2008.

Cigarette Industry's and Smokers' 'Behavior'

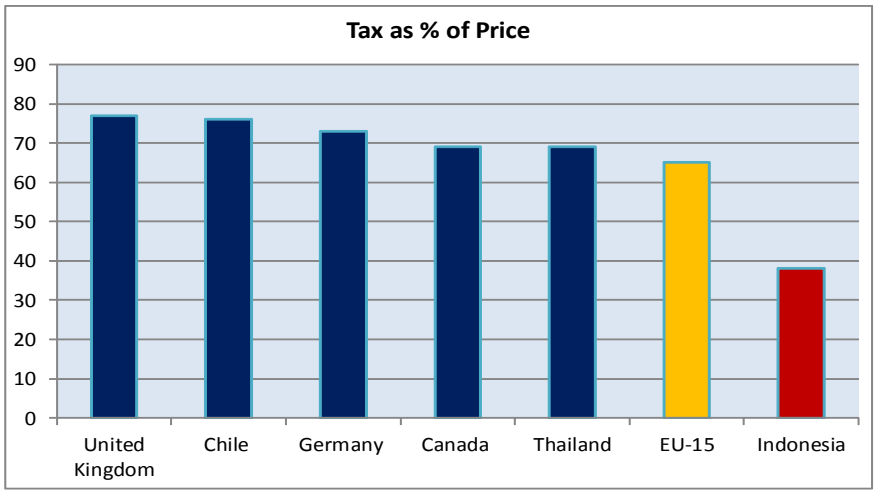
But cigarettes are expensive for the family, and hurt the poor the most. Cigarettes are currently the second largest household expense, after rice, and cigarettes are part of the budget in 57% of all households consumption, and higher for the poor.[37] Tobacco is taxed at 38% of the price of a cigarette, far below better performers in the region such as Thailand and the world as in the European Union and other OECD countries such as Chile and Canada (Figure 2 below). In 2014, it will increase excise taxes but only by 8.5%.

Smoking also is expensive for the Government. The annual total cost of inpatient healthcare due to smoking for 3 major diseases in Indonesia reached at least IDR 39.5 trillion (or USD 4.03 billion). This represents about 0.74% of Indonesian GDP at the same year and 29.83% of total healthcare expenditures. The majority of these expenses were related to chronic obstructive pulmonary disease (COPD) treatment (IDR 35.1 trillion or USD 3.6 billion per year), followed by lung cancer (IDR 2.6 trillion) and ischemic disease (IDR 1.68 trillion).[38]

[37] University of Indonesia, Demographic Institute, as reported in the Demotix website, January 4, 2013.

[38] Nugrahani, Y, Radjiman, D.S., Adawiyah, E., Thabrany, H., The Impact of Smoking to Annual Economic Consequences in Indonesia: Cost of Treatment of Tobacco Related Diseases in Indonesia, International Health Economics Association Conference, Sydney, Australia, July 2013.

Figure 2: New Taxes on Tobacco Products?



Source: WHO, 2012

Indonesia will further add pictorial health warnings on tobacco products. The Indonesian Broadcasting Commission (KPI) and the National Commission on Child Protection (Komnas PA) are calling on the House of Representatives to ban cigarette advertising. The younger generation are often inappropriately targeted at cultural, music or sports events, including those broadcast on television during the day. The WHO has said that a ban on tobacco advertising and sponsorship was one of the most cost-effective ways of reducing demand. Indonesia is the ONLY country in ASEAN still allowing cigarette advertising. Recent laws have made inroads which placed tighter restrictions on tobacco advertising, but enforcement appears to be an issue.

But, to repeat, simply increasing the price on tobacco products has been shown to be the most effective method of cutting prevalence of tobacco use.[39] Raising taxes on tobacco products could be a "win-win-win" with increased revenues to the government for each pack of cigarettes sold, but over time a lower smoking prevalence, and lowered health care costs with a healthier population.

Last year, the government reaped Rp 79.9 trillion in cigarette tax revenues, while on the other hand the country saw economic losses and health costs from smoking-associated diseases of Rp. 240 trillion.[40]

Next Steps?

A modest proposal would be to raise tobacco taxes to cover the economic and health costs of smoking-associated diseases. This should be done immediately, but politics may dictate phasing it over a few years.

To date, why has not the government acted? Most observers suggest it is some form of "corruption" though details are difficult to track. Corruption may take the form of big tobacco companies funding and influencing lawmakers with trips, fundraising, and other activities.

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[39] See, for example, World Bank, Impacts of Health Promotion and Disease Prevention Programs, Adeyi and others, 2009.

[40] Nadya Natahadibrata, "Calls for a complete ban on cigarette ads," Jakarta Post, Page 4, May 31, 2103.

Is this explanation too simple? A second issue might be agriculture crops and revenues for crops especially in poor areas. But, in Indonesia, most tobacco in the industry is imported. And other countries, such as the United States, have shown that farmers, given time, can relatively easily switch to other cash crops.

A final issue is jobs, but this is a worry only over the long run, not immediately. The challenge of raising the price of tobacco will reduce profits to tobacco companies, and might reduce workforce in those companies, an issue that might be taken up with the discussion of raising tobacco taxes. Retraining programs or other types of subsidies could be offered, a small offset to pay in return for higher revenues to the government treasury...for UHC, and most importantly, for improved levels of health for the people of Indonesia. Countries in Europe and North America and in Asia (Singapore, Thailand) have found a much higher tobacco tax to provide a clear path to better funding and better health at the same time.

#11 POLICY NOTES

Primary Health Care and SJSN in the District Health System Context[41]

July 2013[42]

Background

The Alma Atma Primary Health Care (PHC) movement or "health for all by the year 2000" has been a central concept in the Indonesian public health care systems development, and is still relevant today as a concept that could contribute to Universal Health Coverage (UHC) as a way to improve health, health care, equity and social justice. [43]

How is the Sistim Jaminan Kesehatan Nasional (SJSN) expected to improve the district health systems performance?

The SJSN is Indonesia's approach for UHC, one of the four areas advocated for reform of health systems based on primary health care. Reform of UHC will ensure that the health systems contribute to health equity, social justice and to promote social inclusion. In other words, the poor, the vulnerable and the marginalized should be given special attention in moving towards UHC.

There are three major barriers to access of health care and medical services; i.e., physical or geographical, ii) financial, and iii) socio-cultural -- or some combination of all these factors. This is a fundamental problem as many populations may have access to health facilities, but may not

[41] This is Policy Note #11, and was written for the BPJS teams by Dr. Ilsa Nelwan under the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) program. For copies of other, earlier Policy Notes, please visit www.aiphss.org .

[42] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. The new Minister Nila has embraced improved primary care and is testing a new model. Secondly, a new law on decentralization may help strengthen PHC at the district level.

[43] Due to the popularity of PHC, there is also some confusion with people using different terms interchangeably such as Primary Health Care and Primary Care. Primary health care is an approach to health development; it's a broad and comprehensive concept that places the health development into the overall social economic development. Primary care refers only to the first level of contact or close to client health care. This first level of contact varies by geographical area. In the rural area, it is usually the health center, health sub-center, clinic, health post or private practitioner (doctor, nurse and mid wife). In the urban areas, the majority of middle and upper income group visit private practitioners that may be a GP or a specialist, or directly go to a hospital.

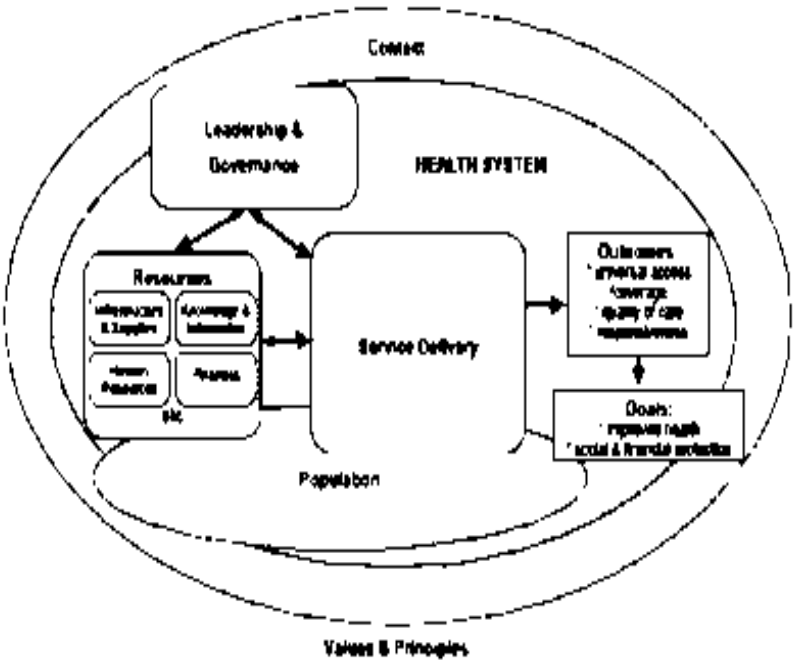
avail the services due to lack of demands or awareness. Health promotion or health education is of prime importance in enhancing demand for services, and awareness that certain conditions might be mitigated, and do not necessarily need to limit human well-being.

The term UHC does not necessarily mean 100% of the population receiving medical services, although the aim is at attaining this, especially when talking about financing of medical care using health insurance schemes. Protecting the poor, the vulnerable and the marginalized, as much as possible, is arguably more important than an attempt to achieve 100% insurance coverage. The reason is, in a health systems based on PHC, improving health equity is as important as improving health status (WHO , SEARO, 2011).

How does the Average Indonesian District Health Systems Look?

A health system consist of multiple organizations, people and actions whose primary intent is to promote, restore, prevent disease or maintain health. This includes efforts to influence determinants of health, as well as more direct health improving activities. A health system is more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programs; vector control campaigns; health insurance organizations; occupational health; legal systems and safety legislation. It includes intersectoral action, for example, encouraging the Ministry of Education to promote female education, a well known determinant of better health, and the Ministry of Transportation to promote the use of safety belts to prevent severe injury to the driver and passengers of motor vehicles.

The District level health system is the most downstream unit of analysis which contains comprehensive sub units and functions in the below illustration.



Source: Health system analysis to make them stronger. Josefine van Olmen et al; ITG Press, Studies in Health Service Organization and Policy 27,2010

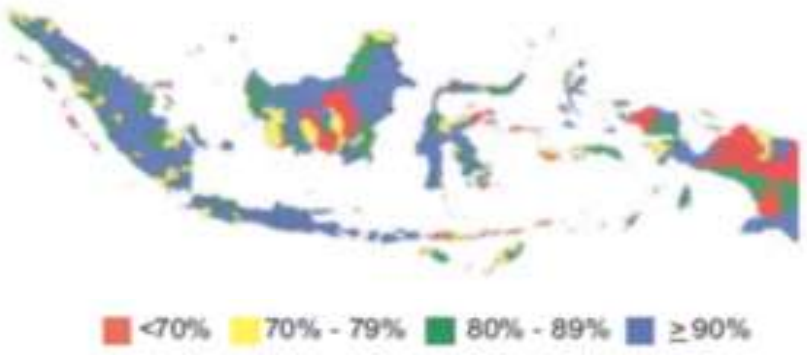
In Indonesia, particularly in Java-Bali, a district usually has a population ranging from under 1 million to 2 million, at least one public hospital, several private (for profit and not for profit) hospitals, and many private practices of doctor, nurse and midwives.[44]

District Health System Performance

Immunization services data can be used as an indicator of district health systems capacity to deliver essential services to the most vulnerable members of the population. The data is available at district level, and is a health activity with a strong impact on child morbidity, mortality, and protecting preschool children by insuring that the end of the first year, the birth cohort is completely immunized. The data can be generated from services statistics, Susenas, or Riskesdas, and is valid, and verifiable. Thus, immunization coverage can be a good proxy of the district health system performance.

The following map showed the DTP3 coverage by districts all over Indonesia,it can be seen that most of the low DTP3 coverage districts (red) are in eastern Indonesia: Nusatenggara, Maluku, Papua. Low DTP3 also can be seen in Central Kalimantan.

Figure 3: DTP-HepB3 coverage by district, 2011



Source: SEAR annual EPI reporting form, 2011 (administrative data)

A study in 2010 revealed the change in health system performance in 10 districts in three areas utilization: in maternal antenatal and delivery care, immunization coverage and contraceptive source and use (Heywood and Choi, 2010). There was a significant decrease in birth deliveries at home and a corresponding increase in the deliveries in 5 of the 10 districts due to the increased

[44] In fact, Indonesia's population problems centre mostly on the issue of population density. Together with the adjoining smaller islands of Madura and Bali, Java accounts for just over 7% of the Indonesia land area, but these islands are populated by some 135 million inhabitants. The population of the special district of Jakarta was 10,187,595 as of November 2011. By contrast, the province of Papua represents 22% of the total land mass, yet has only 1% of the population. The total population of the island of Sulawesi was over 16 million in 2005. So, vast areas of Indonesia have very low population levels. while the majority of the people live in the island of Java and Bali. A lot of districts in Sulawesi, NTT, have less than 100,000. Sulbar, the province, is less than a million; Gorontolo is just about a million. SE Sulawesi is about 4.5 million 10 districts. What is true of Java Bali, is not true of Eastern Indonesia. Sumatra, too, is a world much different than Java.

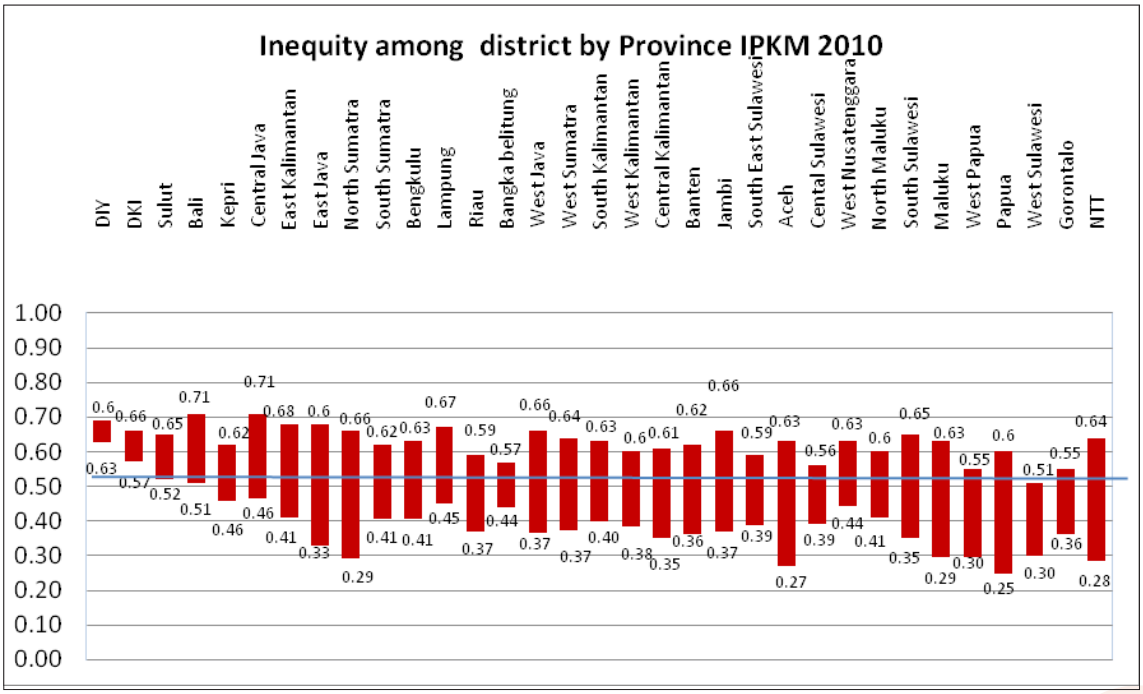
use of private facilities. There was little change in the already low use of public facilities. There was no increase in vaccination of mothers and their children. Of those using modern contraceptive methods, the majority obtained these from the private sector in all districts.

The challenge of district health system monitoring is reported in a study (Heywood and Harahap, 2009) surveying all health care facilities -- public and private -- by type in each of 15 districts in Java. The results showed a much higher number of health care facilities in each district than is shown in most reports, and in the health information systems which concentrate on public, multi provider facilities. A full 86 percent of facilities were solo provider facilities for outpatient services; 13% were multi-provider facilities for outpatient services, and 1% were multi-provider facilities offering both outpatient and inpatient services.

Indeks Pembangunan Kesehatan (IPKM)

In 2010, the Ministry of Health promulgated a ministerial decree on the Health Development Index (IPKM) Indonesia. It is a comprehensive index based on community based health data for specific evidence based health planning guidelines. It is calculated using Riskesdas (*Riset Kesehatan Dasar*), Susenas (*Survei Ekonomi Nasional*) and Survey Podes (Potensi Desa), and consists of 24 health indicators. The 2010 IPKM calculated using the 2007 Riskesdas data, with the range of 0 (the worst) and 1 (the best).

From the 440 Riskesdas districts, the worst district was 0.247059 (Pegunungan Bintang Papua), and the best was 0.708959 (Magelang municipality). The lower IPKM value the worse health problems the district faces. To overcome the problems, districts with low IPKM should be prioritized for health development. For the worse off IPKM districts there should be higher budget support from the government, whether central or local. The figure below showed the Provinces' rank from the highest IPKM Province (DI Yogyakarta) to the lowest IPKM (NTT). The IPKM can be used to identify inequity among districts and provinces as well.



The range for each province lowest-highest IPKM districts; and the ***inequity gap*** is the red bar above. Using the average of the 440 IPKM districts as the cut off points (0.51)[45] there are only four provinces which are above the average namely DIY, DKI, Sulut and Bali. The majority of provinces have more districts with IPKM lower than 0.51.

Implementing the IPKM average to the lowest district at the province, it was found the provinces' with highest inequity issues was in West Papua (0.21), Maluku and North Sumatra (-0.22), NTT (-0.23), Aceh (0.24) and Papua (-0.26).

The following table is showing further breakdown of Provinces' IPKM in each district, as an illustration in four of the NTT districts.

The discrepancy of Flores Timur vs Ngada, TTU or Sumba Barat can be seen from the national rank difference. The socioeconomic issue is much higher in TTU and Sumba Barat compared to Flores Timur and Ngada. Immunization and SBA is higher in the better districts, while safe water access and good sanitation was much lower in the worse off districts.

Selected Public Health Issues by District, NTT

Indicator	Flores Timur	Ngada	Timor TU	Sumba Barat
National rank	187	231	313	406
PSE (social economy data)	14.38	17.26	30.12	42.74
Under nutrition	29.82	26.64	37.55	30.34
Complete immunization	45.93	64.73	38.67	35.55
Skilled birth attendance	76.99	74.84	61.84	39.82
Safe water access	40.56	23.65	6.38	3.01
Good sanitation	51.04	30.04	18.86	9.87
Physical activity	67.32	63.54	58.64	61,6
Fruit & veg diet	7.25	2.97	5.52	4.9
JPK ownership	22.26	30.09	54.28	73.5
Smoking	27,25	30.6	30.98	37.08

Source: District's 440 IPKM data

With high prevalence of under nutrition and low coverage of complete immunization the population will have a high prevalence of infectious diseases. With the low level of safe water access and sanitation, the health status of the population will be very low. Also a low level of fruit and vegetable consumption is a health risk that needs to be addressed in the context of emerging new diseases such as non-communicable diseases (NCDs). The high smoking prevalence in all districts is another high risk behavior that needs to be addressed.

[45] The rank is not weighted by population, also including cities which may have different problems with districts.

From this exercise it can be seen that IPKM is also a potential vehicle for improved efficiency of the health systems, by allocating funds particularly at district and province level towards a more cost effective activities such as public health programs.

Primary Health Care and SJSN

PHC can contribute to a more optimal result of SJSN implementation. PHC refers to three perspective or aspects:

- package of public health interventions;
- level of care; and,
- community empowerment.

In 1978, it was agreed that the package consists of at least eight elements, in which preventive and health promotion measures are emphasized without neglecting curative and rehabilitative measures. In other words, the emphasis in PHC is on public health rather than on medical care. Primary care is an important aspect as a "gate keeper" with an effective referral back up. A PHC approach contains:

- more equitable health care financing through adoption of pre-payment and risk pooling instead of direct payment;
- more responsive or people centred health system;
- community based health workforce and community volunteer rather than institution based health workforce; and,
- development approach instead of merely providing health services.

The SJSN Challenge for Primary Care and the District Manager

January 2014 is the timeline to begin rolling out of the SJSN. The preparation so far is more at national and "conceptual" levels. The existing 63.18% of Indonesia population will be a start (2011 data), including ensuring that the 32.3% of Jamkesmas target group and 13.5% Jamkesda target group will be maintained. The urgent action will be to identify all the registered members of the existing insurance (Askes, Jamsostek, Jamkesmas, and Jamkesda), plus the poor and the vulnerable population which can be identified by the community.
In the meantime, the existing rules and regulation for ensuring the financing and health workforce at various levels should be reviewed and revised. It needs to be consistent with the SJSN responsibilities, and – national fund channelling mechanism.

In the SJSN roll out, what is the best strategy for a district manager for improving Health Systems performance?

In the present SJSN concept, the focus is on curative services. Therefore, the district hospital will be the leader. However, for the SJSN to be effective in promoting the public health efforts lead by the District Health Office who should facilitate changes that will make improvement in district health system readiness for the SJSN roll out.

First and foremost, how will the District navigate during the transition period without the necessary regulatory reform in place? Policy decisions from National and Sub national levels should be prepared.

Other key steps should include:

- The district health office team should prepare for a new role in SJSN roll out including ensuring ownership by the local government for implementation of the necessary new regulations;
- Building a team including the private institutions and professional organization in anticipation of the SJSN roll out. The PT Askes is leading and funding, but the district health office should facilitate necessary change, and adapt to local institutions and situations;
- Prepare a fact sheet and information materials for the primary care institutions and providers cooperation. Prepare the primary care institutions and providers about the new SJSN implication to their practice. The institutions and providers should be able to draw a contextual relevant transition plan from the present situation to be ready for SJSN implementation in January 2014;
- In the SJSN, the Primary Care institutions and provider will act as Gatekeeper. Hence, the District manager needs to ensure that all primary care institutions and providers develop standard capacity with enough consultation sessions and discussion opportunities;
- Prepare the hotline services, and communication network, among various levels, with policy brief about the SJSN concept and roll out plans;
- Plan an assessment of district health system performance which can reveal the strength and weaknesses of the District Health System, focusing on the SJSN roll out, including a Training needs assessment on the SJSN concept and plans;
- Strengthening district capacity in data collecting and data analysis for planning purposes. Evidence-based follow up is necessary to primary care facilities and providers, and district hospitals;
- Seek local government approval for a change in fund management especially for the SJSN roll out.

In addition, district should also seek support, particularly on:

- Developing an effective relationship within the district health office team as well as with all health stakeholders: Askes, Jamsostek, local government, primary care facilities including private institutions and health provider, district hospitals, professional organizations, media and civil society organizations;
- Central and provincial support to district manager should be available, either through information technology, or Central to visit Province, and Province to visit District. This will facilitate more intensive communications and solutions to implementation problems.

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DINAS KESEHATAN
KABUPATEN KUPANG
PUSKESMAS
CAMPLONG

#12 POLICY NOTES

Defining and Managing the Pharmaceutical Benefit Component under the Indonesia Universal Health Insurance Program[46]

July 2013[47]

An Ambitious Effort to Achieve Universal Coverage in Indonesia

Indonesia is currently in the process of preparing the merger of existing insurance systems (PT Askes -- covering public servants; Jamsostek -- covering formal private sector employees; the insurance scheme for the military; Jamkesmas – covering the poor/bottom 40%; Jamkesda – over 300 regional schemes with variable scope). The government plans to expand coverage of the unified scheme with the objective to have the entire population covered by 2019.

Benefit packages, coverage of medicines and management systems differ from scheme to scheme, but all of them include some form or pharmaceutical benefit, meaning a mechanism through which medicines prescribed to patients under the scheme are fully or partially paid. This can be achieved by dispensing free medicines to patients at health facilities, or by reimbursing retail pharmacies that dispense medicines to patients based on a doctor's prescription. From a patient perspective, the pharmaceutical benefit is often the most important part of the benefit package, as the expenses for drugs can quickly amount to catastrophic dimensions in case of chronic or life-threatening diseases. Overall, pharmaceuticals also comprose over 30% of total spending on health in Indonesia according to the recent National Health Accounts report in 2013.

This policy note is meant to assist the designers and implementers of Indonesia's ambitious universal coverage program with an overview of experiences from other countries that struggled, more or less successfully, to provide a pharmaceutical benefit to some or all of their citizens in an

[46] This is Policy Note #12, and was written for the BPJS teams by Andreas Seiter of the World Bank, in collaboration with the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[47] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has developed a national formulary and e-catalogue, while changed the payment incentives for pharmaceuticals which has increased utilization of unbranded generics which are more cost-effective. However, a number of challenges still remain such as expenditure and utilization data and tracking systems.

efficient and equitable way and without bankrupting the health system. The focus here is on a benefit package for outpatient medicines, as medicines dispensed to hospital inpatients are usually paid for through some form of case based payment that covers all inputs, rather than reimbursed separately. In Indonesia, the INA-CBGs will be utilized for payment of inpatient admissions.

Good Planning and Preparation are Key to Prevent Abuse and Overspending

Design and management of the pharmaceutical benefit are critical for success and financial sustainability of any health financing system. Without adequate controls and management tools in place, incentives for suppliers of medicines, service providers and patients are aligned in a way that drives consumption and costs of the pharmaceutical benefit package up faster than costs of other benefit components and faster than funding of the system can grow. Many countries or regions that introduced a third party payer system with pharmaceutical benefit in the past made the mistake of underestimating the dynamics of utilization and cost development. If additional rules, restrictions or management tools are introduced at a later stage, resistance from all stakeholders will be strong and it may be difficult to set a system back on a sustainable path. It is easier to start with a restrictive model and relax rules step by step once the cost implications can be better controlled.

Main cost drivers for the pharmaceutical benefit component of a benefit package are:

- **Increased utilization of health services:** elimination of financial access barriers and an increase in number and quality of service providers brings more patients into the system. Previously untreated patients will now be treated and start consuming medicines;
- **Aging populations:** older patients with chronic diseases consume more medicines than a young population;
- **Sense of entitlement:** both patients and prescribers will naturally lean towards a “more is better” attitude. The elimination of affordability issues on the level of the individual leads to more prescriptions per capita and shifting to more expensive treatments that are perceived as better or more powerful. Another common practice for health providers is to prescribe more expensive brand name drugs even when cheaper generics would be appropriate;
- **Industry marketing and promotion:** both patients (if exposed) and prescribers are susceptible to marketing messages and tangible promotional incentives offered by drug companies, both of which tend to support the trend described in the previous bullet;
- **Financial incentives (supply-side)**: if health service providers (clinics, individual physicians, health workers, pharmacists) make money proportional to the value of medicines they prescribe or sell, they will try to maximize their income by encouraging more use of medicines and preference for expensive (higher margin) products;
- **Innovation:** once new medicines with real or perceived added benefits are on the market, there will be pressure to include them in then pharmaceutical benefit package. Costs per patient can be 100 times or more compared to older medicines, creating a potentially significant funding problem even if only few patients are treated;
- **Price increases:** manufacturers and distributors may try to increase prices at all levels of the supply chain once the factor of individual affordability is no longer relevant: as long as medicines are purchased out-of-pocket, high prices are an obstacle to gaining market share;

- **Fraud and abuse**: every system that separates the user from the payer creates opportunities for fraud and corrupt practices. Examples are bribes and kickbacks to administrative decision makers with control over access to funding and to prescribers; fraudulent claims for medicines that were not dispensed; patients using individual entitlements to obtain medicines for another person without such entitlement;
- **Judicial involvement:** Patients in some countries can take legal action against their governments under "right to health" clauses in their constitution, if the payer is seen to be limiting access to costly new medicines.

Experience shows that in an un-managed system all these factors will come to play over time, which will render any system financially unsustainable unless effective controls are put in place.

Starting with a System for Data Collection and Monitoring

The typical baseline situation in a country that so far had a health financing system based on individual out-of-pocket payments is characterized by absence of any systematic data collection on use of medicines at the provider level. Designing such a (computerized) system, testing it and rolling it out to providers should be the first step towards establishing a pharmaceutical benefit, and measures must be put in place to ensure data is collected continuously. Significant computing power is required for continuous data aggregation and analysis and to create reports that allow the payer to monitor critical parameters in "real time" and put measures in place to correct unwanted trends.

Indonesia already has some experiences in PT Askes and among private insurers with such management systems. Integrating existing systems, closing gaps and rolling the management system out to cover all providers that participate in the new scheme will be a major task under the overall integration effort. PT Askes is leading this effort. Unless the system is functional, several of the cost drivers mentioned above will remain un-managed – sufficient to cause a funding emergency at latest two or three years into the implementation of the pharmaceutical benefit component. Initial costs for updating and rolling out the data collection and management system may appear high, but when put into perspective and compared to a likely cost overrun on pharmaceuticals in a poorly managed system that can easily reach 5-10% of the total budget for drugs or more, these costs will amortize very quickly.

Providers could be asked to pay for individual installation and training (hardware and software) as part of their licensing/accreditation under the financing scheme. Data need to be collected both at the level of prescribers and dispensaries or pharmacies. The payer has a one time opportunity to define the requirements for providers that are interested in participating in a new financing scheme with pharmaceutical benefit. Once the provider is accredited or under contract, it will become more difficult to enforce additional measures that improve management oversight. In case providers do not have access to sufficient financing for making the modest investment into a workstation and software package, the payer institution could provide a loan that is amortized later from reimbursements to the provider.

Parameters that a data collection system should record and feed into a central database are:

- Patient level: unique identifier, age, gender, diagnosis based on a commonly used coding system, potential allergies and contraindications; to define eligibility for certain specialist drugs, additional diagnostic or compliance related parameters (for example: enrollment in a patient education or disease management program) may need to be added; status identifiers

that are relevant for certain privileges, for example income related/socio-economic status, disability, veteran status etc. that may affect patient co-payment or entitlement;
- Unique identifier for the service provider/prescriber;
- Brand and generic name, dosage form, strength and number of units of the medicines prescribed and dispensed, price (price can alternatively be pulled in from a separate database);
- Date and time of prescription and dispensing to identify sequential treatments versus unnecessary double treatments (for example in the case of infections, where one antibiotic might be used first and another one later after the first one has been found ineffective);

Such a system collects personally sensitive data, even if the patient's name is kept separate from the unique identifier used for the aggregation of individual data. A data protection policy and a supervisory body that ensures the confidentiality of patient data would be a "good practice" approach to address this risk. The database in which all information is stored has to be set up in a way that limits access to authorized staff only, keeps track of any data request and identifies who made the request and when, in a way that cannot be manipulated or erased.

What to Do with the Data

The data collected in each transaction are fed into a central database, to which the "pharmaceutical benefit manager" – typically a unit at the payer institution or a sub-contracted service provider specialized in this field – has access. The data are used to create reports that provide information on the performance of the system on a regular basis. They also create a basis for measures to influence provider and patient behavior if needed. Examples for such reports and subsequent measure are:

- Monthly expenditure tracking at high level and broken down to regional, sub-regional or individual facility/prescriber level. Detail data can be used to provide feedback to providers in relation to a budget target that was set at the beginning of the fiscal period. It is also possible to link incentives, sanctions, individual audits or educational measures (e.g. "academic detailing"[48]) to spending levels;
- Search for patterns that suggest potential fraud or abuse, such as pairs of prescribers and pharmacists located near each other that show atypical utilization of certain expensive drugs. Follow up by individual audit;
- Measuring compliance with clinical treatment guidelines, for example by identifying utilization mix for first line, second line and third line treatments for certain chronic diseases at provider level. Providers that over-utilize more expensive treatments than expected without plausible justification can be targeted for measures suggested in the first bullet above;
- Measuring other indicators for rational use of medicines, such as prescribing of antibiotics for minor infections, general poly-pharmacy[49], use of generic drugs versus branded originals – with follow up as described under the first bullet;
- Negotiating lower prices with manufacturers, based on utilization trends found in the data.

[48] http://en.wikipedia.org/wiki/Academic_detailing

[49] Use of too many drugs without adequate indication and consideration of potential side effects, interactions

This list is by no means complete, there are many other possibilities such as evaluations of regional patterns (very relevant for Indonesia due to the decentralized structure of government), differences based on social status or provider structure that can be assessed and may be relevant as triggers for policy measures. The main point is that a solid data collection system is a necessary pre-condition for a functioning pharmaceutical benefit management under any health financing system. Waiting to roll out a data collection system after the benefit is implemented and as first signs of overspending and misallocation become visible can be compared to taking off with an airplane without functional navigation instruments. It is a dangerous path and could lead to system failure or cost a multiple of the initially needed investment over the years.

If for political reasons implementation of the pharmaceutical benefit package cannot wait until good systems are in place, setting fixed drug budgets for health facilities is a potential way to limit budget risk. The facility's accounting system or contract pharmacy monitors the costs of all dispensed medicines against the budget, and informs prescribers in the facility of the remaining budget on a regular basis. Once the budget for a given period (typically a quarter) has been used, patients have to pay out of pocket or wait for the next budget period. Such rationing models are used routinely in some countries in Eastern Europe and they work well in terms of "staying within budget". However, there are obvious problems of fairness against patients who get sick towards the end of the budget period. Chronically-ill patients learn quickly to collect their prescription at the beginning of the period, when funds are still available.

Using Technology as a Potential Solution in Under-developed Areas

Mobile data networks open up new potential ways to monitor transactions and even process payments to providers. Providers could use a smart phone app to register patients and process transactions. The app can be used to guide the provider based on standard treatment guidelines, verify patient identity, for example through a picture taken with the phone's camera, and send all transaction data to a central server. In places that have cell phone based payment and money transfer services, the payment can be sent to the provider immediately after the transaction is completed. Budget caps can be managed on an individual basis, for example by restricting the number of patients one provider can enroll and the number of consultations and prescriptions a patient can get. The system could provide real time data access on the central server (confidential patient data would need to be separated from transaction data needed for management purposes), and therefore allow for immediate adjustments of system parameters, if results do not come in as expected. The problem could be that it may be difficult to manage a comprehensive benefit program through such apps – there is no experience yet with this approach in trying to replace a system based on computers using complex software and wired internet connections.

Setting the Key Parameters

The following parameters define a pharmaceutical benefit:

- An inclusion (positive) or exclusion (negative) list of medicines that are eligible for reimbursement. Most countries use a positive list (formulary), meaning only drugs on this list are reimbursable. Some countries have more than one drug list – typically a priority list for essential medicines that can be prescribed without restrictions and with a lower copayment,

and a "specialist" list that may carry certain restrictions (see below) and/or higher patient copayments. Sometimes there is also a separate list for hospitals as in China;

- A reimbursement rate, expressed as % of the retail price of a medicine. Rates can vary, for example 100% reimbursement for life saving, essential medicines and lower percentages for other drugs. Reimbursement rates can be higher for medicines that the payer considers cost-effective, for example if there are framework agreements with manufacturers of certain generics. The difference between the reimbursement rate and the retail price has to be paid by the patient;
- Patient eligibility: different patient groups may be eligible for different levels of coverage. In a low resource environment, coverage may be limited for example to pregnant women, young children and other vulnerable groups. Possible is also a system that offers coverage in the case of severe and chronic diseases and leaves treatment of acute and minor illness to be paid out-of-pocket;
- Patient co-payment: collected at the point where the medicine is dispensed. Some systems have a flat co-payment per prescription or per item on a prescription. Some have only a percentage co-payment, complementary to the reimbursement rate mentioned before (80% reimbursement means 20% co-payment). Some systems combine a flat co-payment (also called dispensing fee) with the complementary percentage co-payment. Many systems have rules for exemptions from co-payment, based on income status, pre-existing conditions such as disabilities or chronic diseases, age, status as war veteran or others. Usually individuals that fall under the exemption clauses have higher disease burden and higher medicine expenditures, which needs to be considered when estimating the cost savings from introducing patient co-payment. Some systems, instead of using exemptions, limit co-payments to a maximum absolute amount per pay period (for example US$ 50 per year) to reduce the burden on patients with chronic illnesses. Conversely, some systems impose deductibles, whereby an amount of money (deductible) has to be paid out of pocket by the patient, before receiving any of the stated benefits;
- Restrictions for certain medicines on the reimbursement list: some medicines may only be reimbursable when prescribed by a specialist or in a defined institutional environment or after individual pre-approval by a specialist working for the payer. Some payers limit access for certain expensive treatments to a defined number of patients. New patients are put on a waiting list first. Some medicines may be provided only for a limited time and then trigger an expert evaluation and decision on further coverage;
- Reimbursement prices: independent of the percentage that is reimbursed, the payer may set or negotiate a retail price for the medicines included in the reimbursement list. Acceptance of this price may be a condition for a manufacturer to get its medicine included in the list. Widely used models that use a basket of comparable products to define the maximum price for reimbursement;
- Budget caps: budget caps per pay period (often per quarter) can be applied at top level, at regional/district level, per provider or even per patient. Each approach has its pitfalls and implementation challenges. For example, systems that apply budget caps at district level will condition providers and patients to shift activity to the beginning of the fiscal period. Towards the end, once the budget is exhausted, reimbursement will be denied even if there is a medical indication for treatment;
- Role and payment of dispensing pharmacists: it needs to be defined whether pharmacists, who dispense medicines either in a health center setting or in a private pharmacy, have the right to substitute one product for an equivalent alternative;
- Special provision of expensive medicines: Some systems exclude certain expensive drugs from general reimbursement status and procure them separately with a defined budget. Patients

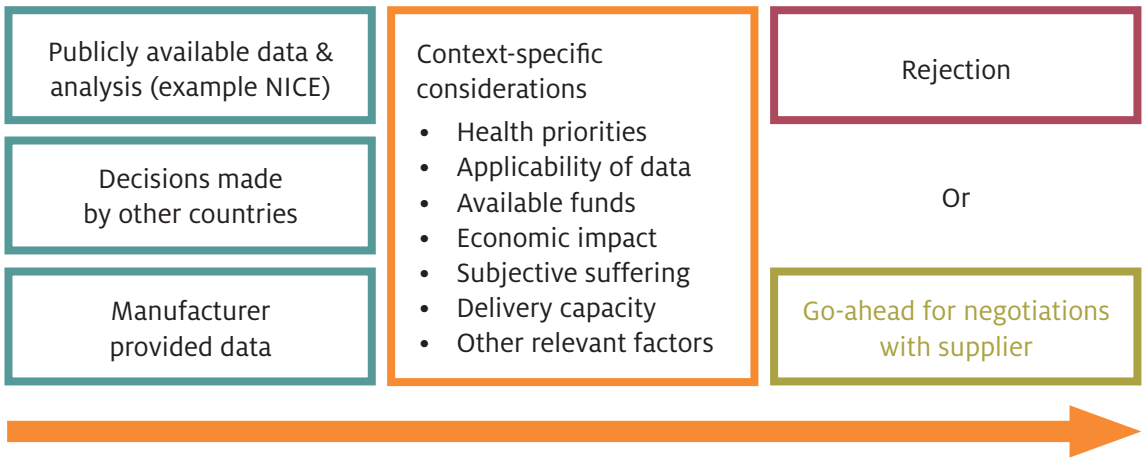
are offered treatment only in specialized centers and the medicines may be delivered through a separate supply channel. Each patient needs to be approved for treatment, in this regard this model is similar to the one described above under "Restrictions for certain medicines." If demand exceeds supply, there will typically be a waiting list for patients.

Defining the Reimbursement List

The process to add a new medicine to the reimbursement list, eliminate an obsolete drug or change reimbursement status if new data become available is at the center of pharmacy benefit management. Manufacturers need reimbursement status for their products in order to have sales in the market segment covered by the payer. Doctors and patients have their own opinions as to which drugs are important and will press for inclusion of those drugs. Manufacturers build and use alliances with prescribers and patient groups to increase pressure on decision makers. As a result, the pressure on the decision makers is high and the decision making process can easily be politicized or even corrupted.

To reduce political pressure, the process for including drugs in the reimbursement list (or changing reimbursement status or removing obsolete drugs) should be based on clearly defined rules and organized in a way that is transparent and inclusive of different viewpoints. Many countries have treatment guidelines, issued often by the Ministry of Health in collaboration with the professional medical societies. If such guidelines exist, it is evident that the reimbursement list should include the medicines that are mentioned in these guidelines. For innovative drugs, however, often the decision to provide limited reimbursement is made long before the treatment guidelines are updated. This creates a need to assess a new medicine based on preliminary data and make a decision on reimbursement. Many developed countries have set up special agencies for the assessment of new technologies (Health Technology Assessment = HTA Agencies).

Low- and middle-income countries will be facing the same dilemma that not all what appears desirable is also affordable, but they might not be able to afford a fully-fledged agency for the assessment of new products and approaches. The challenge is to develop at least the capacity to obtain and understand the work done by other countries' specialized agencies and process it in a rational and transparent decision making process that considers national priorities and economic realities. The flow chart below demonstrates how this could look like in a simplified form:



Indonesia is now moving to establish its own technology assessment process.

Using Purchasing Power in Negotiations with Providers

The flip side of the political pressure on a payer that provides reimbursement for medicines is the purchasing power that comes from the role as a major or even monopsonistic payer. Indonesia will enjoy this single payer model and needs to leverage its purchasing power.

Using this purchasing power wisely is key to providing the best possible value for the patients covered by the drug benefit scheme. This means that payers need to use the process of deciding whether to accept a new drug for reimbursement for negotiations with the supplier. Often such negotiations focus only on price, and almost all insurance and drug benefit schemes are using a form of price discovery and price setting process. For manufacturers of innovative drugs however, the room to make concessions is limited: These pricing systems tend to reference each other; manufacturers therefore are reluctant to offer one country lower prices than another, independent of the per-capita income.

An intelligent negotiation strategy considers these factors and aims at limiting the number of patients that are covered at full price, while the manufacturer has to provide access to the drug for free or at sharply reduced costs if demand exceeds the agreed number of patients. A variation of this model could be that the manufacturer provides a voluntary license for a generic version, which then is used exclusively in a market segment that targets economically vulnerable populations. Details of such "risk sharing" agreements and access programs may vary from drug to drug and country to country. Important is that the decision making process forces both parties (payer and manufacturer) to come together and negotiate for the best possible solution.

The Role of Distributors and Pharmacists

Many systems allow pharmacists to substitute "downwards", meaning to replace an original or more expensive generic with an equivalent that is priced lower. In some systems pharmacists have to offer the patient the most cost-effective version. Critical for the success of such a system is the way the pharmacist is paid. If the payment is a percentage of the retail price, the pharmacist has no incentive to recommend a more cost-effective alternative. In contrast, if the pharmacist is paid through a flat dispensing fee, the self-interest does not stand in the way of cost-conscious dispensing.

There is another factor that is often overlooked in its impact on dispensing practice: for drugs that have many generic equivalents competing for market share, the pharmacist's power to substitute becomes a critical factor in ensuring sales. Instead of persuading doctors to prescribe a specific brand, the drug company reps offer free drugs to wholesalers/distributors and retail pharmacists to crowd out competition. As the payer has usually no control over the books of wholesalers and pharmacists, these can get full reimbursement for the drugs that they sell, whether they paid for them or got them for free as a "bonus". In many countries, this bonus system has distorted the incentives in the distribution chain.

One way to address it is to negotiate directly with manufacturers for low prices and then limit the substitution right for pharmacists to a small number of selected "preferred" alternatives for every drug. The "preferred" status should be re-negotiated or defined in a bidding process in regular intervals (for example every year or every two years) to make sure a sufficient number of

manufacturers remain in the market. Otherwise the longer term outcome will be an oligopoly or monopoly and prices will go up again.

Managing "Politics" of Pharmaceutical Reimbursement Decisions

As pointed out above, for many stakeholders at least part of their economic existence and well-being depends on the pharmaceutical sector. On the supply side, manufacturers, distributors and pharmacists often have powerful lobbies and high level connections. Patients often judge the quality of the entire benefit package based on the pharmaceuticals part, which is the most tangible one and the one they feel most immediately in their own wallet if it does not deliver as expected. "Getting it wrong" can mean the end of the political career of a minister or even cost a government the election.

The best way to reduce the overall noise level and manage expectations is to establish a multi-stakeholder dialog platform, which forces all sides to listen to each other and makes it more difficult to vilify the opponent or distort the facts. Politicians and technical staff working on reforms may see it is waste of time and experience it as inconvenient, but sitting around the table with all major stakeholders can help address tensions before they are being debated in the media; it allows to float ideas and identify the common ground and it enables the reformers in the government to select the fights they want to pick. A good model for such multi-stakeholder platforms in the pharmaceutical sector is the Medicines Transparency Alliance (MeTA)[50], sponsored by DfID in seven countries (in Southeast Asia, the Philippines are the only MeTA country).

Setting up such a platform is not expensive. In Indonesia, there is already a university-based knowledge platform to support health reform. Adding a dialogue platform modeled after MeTA could be synergistic as the data and opinions collected can be shared through the existing website. One critical success element for MeTA is the active participation of civil society, representing the common citizen who is supposed to benefit but who has very little understanding of the complexities of the pharmaceutical sector. MeTA provides modest funding for civil society organizations so that they could regularly participate in meetings, train their members and assist in organizing surveys, monitoring pilots etc.

In communicating with the general public, reform champions need to be careful not to raise unrealistic expectations that later lead to a backlash in public opinion if they are disappointed. It is more effective to practice "dilemma sharing" meaning to educate the public about necessary trade-offs and organize dialog forums or online platforms on which citizens can express their views, comment on potential solutions or suggest alternatives. Such a process creates shared ownership and reduces the likelihood that those in power have to take all the blame if something goes wrong.

Reform Never Ends

As a final thought – reform in the health sector is an ongoing process. What is a good solution today may lead to problems in two years. Therefore, systems should be designed to not become

[50] www.medicinestransparency.org

too “sticky”: laws should define general frameworks and leave technicalities to regulations that can more easily be changed. Contracts should automatically expire and trigger re-negotiations. Monitoring systems need to adjust focus as the providers learn to “play the system”, and all stakeholder should be educated that nothing is final and things can be changed if they do not work. Often, applying an “80/20” rule in decision making is better than losing a lot of time in trying to find the optimal solution -- only to find that once implemented, it is no longer optimal.

#13 POLICY NOTES

Developing the Enabling Factors or "Pre-Conditions" for Provider Payment Reforms under BPJS: Is Indonesia Ready?[51]

August 2013[52]

Payment Models for Indonesia

Provider payment systems can be a powerful tool to promote health systems development and achieve health policy objectives. A *provider payment method* may be defined narrowly as the mechanism used to transfer funds from the purchaser of health care services to the providers. A *provider payment system* may be defined more widely as the payment method combined with all supporting systems, such as contracting, provider accountability mechanisms that accompany the payment method, management information systems, and quality assurance mechanisms.

In the context of health systems, therefore, provider payment systems accomplish far more than simply the transfer of funds to cover the costs of services. The incentives that are created by the provider payment methods, and the responses of the providers to those incentives, the management information systems to support the provider payment methods, changes in quality, and the accountability mechanisms established between providers and purchasers can have profound effects on the way health care resources are allocated and services are delivered.

[51] This is Policy Note #13, and was written for the BPJS teams by Jack Langenbrunner and Cheryl Cashin under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[52] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. The BPJS has suffered from significant upcoding (as predicted) while standardized coding and accreditation standards do not exist. Autonomization at the facility level remains a challenge. Quality has suffered under BPJS in many ways (as predicted) though incentives have also improved efficiency and quality in some areas such as pharmaceuticals. However, most of the challenges outlined in this Note remain.

Many countries have experimented with different ways of paying providers of health care services. Indonesia has chosen good payment models under BPJS: primary care capitation and case-based groups for hospitals.

Expected Impacts?

The effects of provider payment systems on the health care system vary widely depending on contextual factors, including the level of resources available for health care, the degree of competition and choice, and the opportunities and constraints facing providers to respond to provider payment incentives. The way in which the provider payment systems are designed, scaled-up, and run, and the extent to which the contextual factors are addressed, will strongly influence how successfully the provider payment methods contribute to achieving health policy goals.

In other words, good payment design in BPJS law and regulations is not enough. Three contextual areas are outlined below and global experience provides some lessons and warning signs for Indonesia. Observers tend to identify these as enablers or "pre-conditions" for policy success.

Information Systems and Current Constraints

Different provider payment methods require different types of information for design and implementation, as outlined in the table 1 below. Indonesia has chosen two payment models that require sophisticated levels of information.

Table 1
Different Information Requirements of Different Payment Methods

Payment Method	Information Needs
• Salary	• Staff characteristics
• Fixed budgets	• Budgets and case mix
• Fee for each service	• Classification of services
• Per diem payment in hospitals	• Budgets and number of days
• Capitation	• Population characteristics
• Episode based, eg DRGs	• Diagnoses, treatments, costs, demographics
• Pay for Performance	• Services/performance characteristics

Is Indonesia ready? A number of actions are starting.

A smart database will be built on the basis of a National Unique Identifier (NUI). That would ensure that the same person is not counted twice when moving between categories or locations. To be able to match claims against contributions and eventually make longitudinal analysis of costs a "smart" NUI incorporating some basic information would be necessary. It would also greatly facilitate the determination of eligibility and the administration of provisions about delays, interruptions and reinstatement. Proper assessment of risks in terms of equity and efficiency and fiscal outlays would require the capacity for the BPJS to produce custom aggregates for special risks.

The NUI will need to be coordinated with whatever system will be used for billing purpose, premium collection, or for the collection of medical/administrative statistics by the BPJS. But, the NUI as planned by Home Affairs is supposed to be ready January 1, but will it?

If it will not be ready by January 2014, an alternative will need to be developed, or a longer phase-in strategy will need to be developed.

At a ***second level***, each provider – hospital and primary health centers (Puskesmas) – needs to have a unique identifier as well. Fortunately, Directorate General of Medical Services (DJ BUK) has provided a web-based registration of new hospitals. Until presently (May 2013), about 2,103 hospitals have been registered. All hospitals have received their unique IDs during the submission process at the district/provincial health office.

At a ***third*** level, the data dictionary. How do a provider and payer define their terms, and agree on their language? If they do not, it will be as if one speaks in English and the other in Bahasa Indonesia. There are many functions each must carry out and the interplay between the two means that the data dictionary is a basic platform for communication, and a critical way to avoid fiscal risks and quality problems to both purchaser and providers.

The data dictionary contract process under MOH has recently been cancelled and will need to be restarted. The timeline is uncertain, but realistically it is difficult to imagine it will be finished in 2013.

If not, again, a back-up will be needed. Even if the data dictionary is finished, there needs to be public consultation, dissemination, and training for both purchasers and providers. This latter process could take up to at least a year.

At a ***fourth*** level, the delivery of services need to be paid based on claims. Claims will work from agreed upon coding systems that derives from the data dictionary. A standard discharge abstract will be needed to code each claim. Indonesia has also developed under PT Askes and Jamkesmas a standard coding sheet. But, to date, only about 800 codes out of over 14,000 ICD codes are actually used. In some hospitals, coding is constrained to under 200 codes. This could be an issue for tracking non-communicable diseases (NCDs) and developing a fair level of payment and developing a tracking system for quality profiling and quality assurance.

Related, there is a lack of trained claims coders to code in a consistent and standardized way across Indonesia. The BPJS will need to develop standards and guidelines for all providers, as well as develop an auditing function to check that coding standards and guidelines are being adhered.

Along with coding of claims, BPJS will need standardized and routine cost information from providers. A hallmark of successful payment systems in Europe is that there is a standard costing

template and a routine reporting of cost information as part of the payment contract. In Indonesia, there is a template, but reporting is still not a part of the contract. This MUST change starting in 2014 in the contracts now being signed in 2013.

And what about the Puskesmas? For the most part, these facilities do NOT have person-level data systems at this point. This could stop attempts to

- develop a precise capitation payment based on numbers of enrollees;
- refine precise adjusters for case-mix at each Puskesmas; and,
- could prevent the tracking of referrals, not allowing primary care providers to be real gatekeepers.

With the emergence of the private providers, time will be needed to assure that they have adequate MIS systems in place as well.

Patient-level information systems will be enormously powerful tools for payment efficiency and quality. These data will also be important for national monitoring and evaluation. But these will flow only when the dictionary and national standards are developed, disseminated and followed. And, even when that occurs, there will be a need for training of professional hospital information managers for payers and providers as well as for professional auditors to assure that coding is correct and not manipulated for more favourable levels of reimbursement. The government could consider matching grants to provinces to kick-start training of coding professionals, but this can only be done once the dictionary and coding systems are announced and in place, probably after the 2014 start date.

Quality Assurance

No single set of incentives will address the multiple objectives of purchasers, providers, and patients. As a result, purchasers and policy makers must understand and address policy objectives explicitly, while remembering that provider payment systems may lead to both intended and unintended consequences, such as incentives to increase the number of services provided beyond what is necessary or to reduce inputs used to provide care. Other unintended consequences may include “gaming” or manipulation of rules by the providers, cost shifting, or increased paperwork for providers.

Several types of unintended consequences can be expected under the BPJS reforms with its new payment models.

At the primary care level, early referrals to higher and more costly levels of care. “Primary care sensitive” indicators such as areas of asthma, hypertension, and diabetes need to be developed and tracked by BPJS, and its quality teams. Referrals out of primary care facilities have spiked in a number of countries such as Croatia where there were similar payment designs in place.

At the hospital level, there are 3 areas of quality concern that impact on fiscal risk:

1. Unnecessary admissions. In China, 51% of all admissions have been found unnecessary. In Russia, in the 1990s, it was about 40%. In the Jokowi Kard Scheme in Jakarta, physician experts suggest up to 40% of all current admissions may be unnecessary. The incentives under CBGs

will encourage providers to admit "easy" and profitable patients rather than treating them on an outpatient basis;

2. Skimming/not doing needed services while in the hospital. Managers and hospitals now will have the incentive to skim necessary services and discharge patients early, as a way of increasing profits. Established and independent utilization review teams, contracted by BPJS, will be needed to assure established standards and guidelines are followed;
3. Re-admissions. Patients discharged early may find themselves in need of more care services, and will then be readmitted by hospitals for a second CBG payment. This doubles the revenue for hospitals at the expense of employers, employees, and the Ministry of Finance. The dramatic increase in volume of admissions and re-admissions under CBGs in other countries -- such as the United States, Germany, France, Hungary and Ghana -- has led to new policies such as penalties for readmissions, decline of payment altogether in the US for readmissions within 90 days, and volume caps for hospitals. Indonesia's Ministry of Finance faces clear fiscal risk here, and must monitor volumes of admissions on a ***weekly*** basis starting January 1, 2014, similar to the Minister of Finance in the U.S. This will require some rather sophisticated and timely MIS systems.

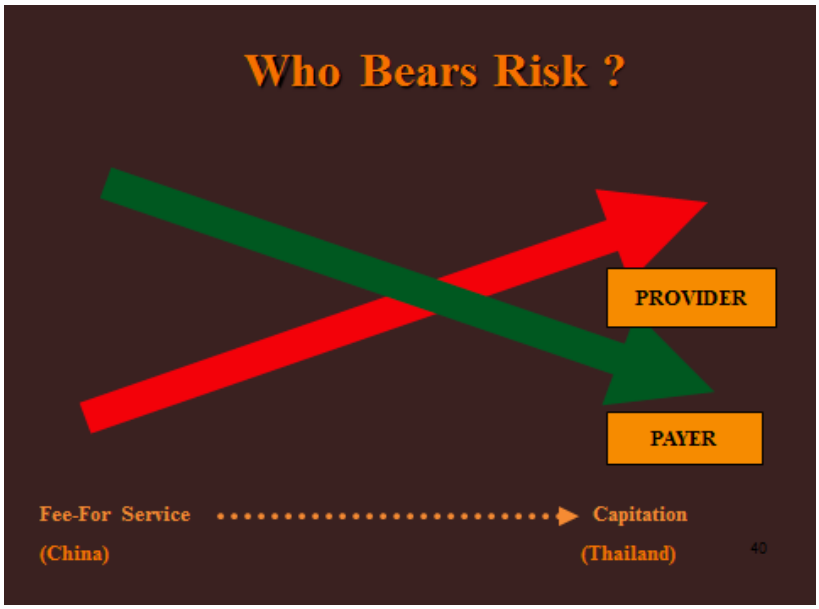
Finally, private providers will be smart and will be the first to take advantage of the lack of precision in the current CBG "Grouper" software. They can be expected to refuse admission to under-reimbursed patients, and welcome patients found to be profitable. This will push off the under-reimbursed, sicker patients to public facilities, potentially creating queues, denial of care, newspaper scandals, and again creating adverse fiscal impacts for the Ministry of Finance.

Management Capacity and Autonomy of Providers

Countries that have experience of new payment systems have recognized that all the achievable efficiency gains do not happen automatically. They require some formal delegation of management responsibility to primary care clinics and to hospitals. In turn, this relies on hospitals having sufficient management capacity to realize the potential of the new payment system. Decentralization of management capacity and of responsibility is an important prerequisite for obtaining micro-efficiency. Further, explicit measures and tools are usually critical and should be built into the payment framework to provide incentives for cost-effective behavior. If providers face new incentives to be more efficient but do not have sufficient autonomy and management skills to respond to the incentives, new payment systems can actually do harm. For example, if payment is made based on outputs but providers do not have the autonomy to reorganize inputs such as staff or reduce inefficient use of space, less money will be available for patient care.

Implementation of CBGs and Capitation means that these new and more sophisticated payment systems will aggregate units of payment and of services, and payments will be made prospectively. Part, or all, of the financial risk will now be transferred from the purchaser arrangement back to the provider and patient (Figure 1). Most observers caution against full risk sharing but encourage some "supply side cost sharing" only, with purchaser and provider sharing in risk arrangements to address moral hazard issues.

Figure 1: Moving to CBGs and Capitation Should Shift Risk to Providers



As financial risk is transferred to providers, they will look for ways to improve efficiency and quality. That may mean new equipment, changes in personnel mix, or it may mean closure of unused beds and services. Will public sector providers in Indonesia be able to do this? No. Public providers have little autonomy to change staff, equipment and beds in the short-run.

In Latin America, public providers faced this with the advent of payment reforms. The providers sometimes made excess revenues in the new payment system, which meant that the Ministry of Finance lost needed funds from the Treasury. In other cases, public providers lost revenues but could not respond to restructure and optimize in terms of changes in staffing and inputs. As a result, they went to the Ministry of Finance for bailouts of debts under the new payment systems. In either case, then, the Minister of Finance lost needed funds, and money was wasted and less was allocated to patient care. The Ministry of Finance quickly ended the payment reforms in many countries as a result.

Will the same thing occur in 2014 in Indonesia? Yes, for two reasons. First, the CBG "Grouper" software now in place under Jankesmas was built for the United States and incorporates different practice patterns and cost structures. Selected impact analysis currently show wild swings in payment relative to cost-based tariff structures developed by hospitals. Some CBG tariffs underpay by 70 percent. Some tariffs overpay by 300 percent. The Minister of Finance is headed for fiscal risk. Second reason is that public providers cannot respond to new incentive structures unless public providers are able to reform civil service rules, and current management regulations. That means civil servants should be on no-guarantee 1-year contracts, managers should have flexibility to buy equipment, open beds and close beds as needed.

Finally, at the beginning of this process, all public hospitals and Puskesmas need financial management systems and financial managers to track internal funds flows. How many facilities in Indonesia are currently ready with these systems and experts.

Western Europe, Hong Kong, and other places autonomized and corporatized hospitals in the 1990s. In parts of China, Philippines, Thailand, Turkey, Eastern Europe, hospital autonomy is starting. Indonesia may need to accelerate its current thinking in this area as well.

Going Forward

Overall, then, Indonesia has a good payment design in regulation, but not yet a good payment model. But, even if it did, a good payment model is simply not enough for success. At least three (3) areas of enabling policies are needed: management flexibility and accountability, good information systems, and good quality assurance systems. The BPJS and the Ministry of Finance are most affected, and will need to work together to assure objectives of the payment reforms actually and fully occur.

The BPJS should do an inventory of readiness on these three dimensions, then develop a slowed down phase-in strategy of the new payment systems. The attached document -- Rapid Assessment of Purchaser Capacity – was developed by Dr. Cheryl Cashin of the Joint Learning Network to help countries do such an inventory of readiness. Indonesia is a member country of the Joint Learning Network.

In the United States, new payment systems were phased in over 5 years, in part to give providers time to respond, and in Germany over 10 years for the same reasons. Germany, like Indonesia, has a mixed public and private provider system.

Why would Indonesia want to move so fast as to threaten the reforms and the overall goal of universal health coverage? Moving too fast will only create negative impacts on quality for its population, and create a potential catastrophe of negative fiscal impact for the Minister of Finance.

#14 POLICY NOTES

Nutrition and the Basic Benefits Package for Universal Healthcare Coverage[53]

August 2013[54]

Background

The Government of Indonesia recently joined the global Scaling Up Nutrition Movement to bolster efforts to reduce malnutrition. Known as the "First 1000 Days of Life Movement", or 1000 HPK, the Movement in Indonesia aims to bring together multiple sectors and stakeholders to lower the prevalence of stunting and other forms of malnutrition in alignment with the National Action Plan for Food and Nutrition (RAN-PG).

Many nutrition interventions that specifically target children and women are delivered through the health sector, but are currently not achieving high coverage throughout the country. In January 2014, the Indonesian government will embark on its ambitious plans to scale up universal health care (UHC) coverage to all citizens by 2019. If nutrition interventions are included in the basic health benefits package of the UHC programme, it will have a great potential to increase the coverage of nutrition services for children and women.

Preparations are currently underway to merge the existing social insurance schemes for health to form the UHC programme under a single administrative body, the Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan. This UHC programme is expected to address weaknesses in the existing schemes, including the significant geographic variation both between and within schemes in the content, availability, and quality of the basic health benefits package.

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[53] This is Policy Note #14, and was written for the BPJS teams by Dr. Harriet Torlesse of UNICEF, Jakarta office, under cooperation with the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[54] Important: this is a time-based policy note written for issues at the time of drafting. Some circumstances have changed, however, most of the challenges discussed here remain the same. Neither the MOH nor BPJS has embraced nutrition as part of the JKN benefits package. Severe fragmentation of programs remains.

The Presidential Regulation 12/2013 on health security explains that the health benefit package will cover promotive and preventative services, including individual health counseling on preventing/managing diseases and healthy and clean living; basic immunizations such as BCG, TT, DPT-HB, polio and measles; birth control; and screening for diseases. It also describes the first level health services and advanced inpatient and outpatient health care services that will be covered. While the Presidential Regulation provides a broad description on the contents of the benefits package, the specific details are still under discussion, and further provisions on the scope of the benefits package will be provided through Ministerial Regulations.

Because of limited resources, the government cannot make all interventions available to the population through the UHC programme. This makes it necessary to set clear priorities for the selection of services in the benefits package. In the past, decisions on health benefit packages in some countries have been ad hoc and not transparent. However, increasingly countries such as Thailand are using systematic priority-setting processes to ensure accountability[55]. Such processes typically consider a range of criteria including the burden and severity of the disease, equity and social implications (whether the disadvantaged, marginalized and poor are most affected), effectiveness of health interventions, and budget impact. This policy brief examines these criteria to examine the evidence on why nutrition services for children and women should be a core component of the health benefits package in Indonesia.

Burden and Severity of Undernutrition in Indonesia

Indonesia has made good progress in reducing underweight children, and is on track to meet the MDG 1 target to halve the prevalence of underweight children by 2015. However, stunting only declined by one percentage point between 2007[56] (37 percent) and 2010 (36 percent)[57] and affected 7.5 million children aged less than five years in 2010, the fifth highest burden in the world[58]. In the same year, wasting affected 13 percent of children aged less than five years, equivalent to 2.8 million children, the fourth highest burden in the world. Severe wasting, which carries a high mortality risk, affected 6 percent of children aged less than five years, equivalent to 1.3 million children.

Undernutrition often originates during fetal development, particularly if the mother is an adolescent or was undernourished herself during pregnancy. About one-third of women aged 20-45 years have their first child during adolescence, [59] and 14 percent of women of reproductive age are thin, as determined by a low mid-upper arm circumference (<23.5 cm)[60]. A recent publication in the *Lancet* estimated that in 2010 1,042,300 infants were born small for gestational age in Indonesia, the sixth highest number of any country in the world.[61]

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[55] Youngkorn et al. (2012). Multcriteria decision analysis for including health interventions in the Universal Health Coverage benefit package in Thailand. *Value in Health* 15, 961-970.

[56] RISKDESAS (2007)

[57] RISKESDAS (2010)

[58] UNICEF (2013). Improving Child Nutrition: The achievable imperative for global progress. UNICEF, New York.

[59] Indonesia Demographic and Health Survey (2007)

[60] RISKESDAS (2007)

[61] Lee et al (2013). National and regional estimates of term and preterm babies born small for gestational age in 138 low-income and middle-income countries in 2010. *Lancet Global Health* 1, e26–36.

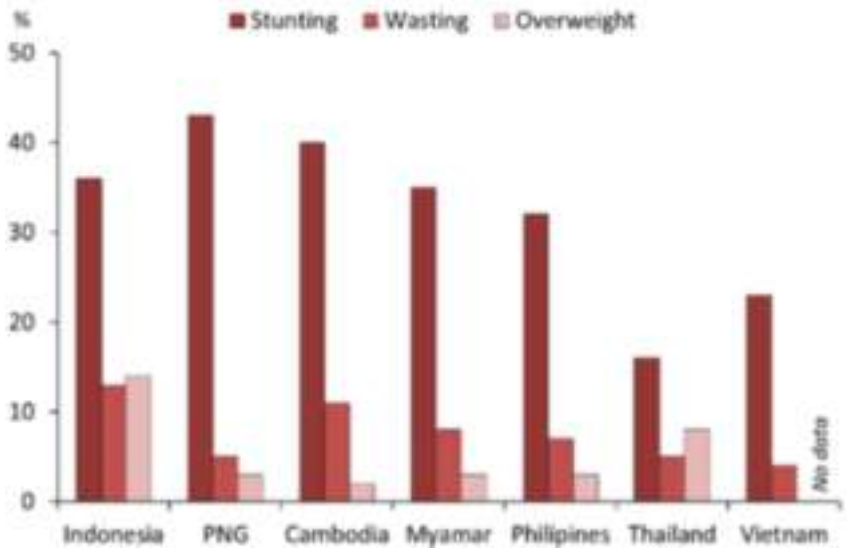
To add to the concerns, overweight is emerging as a public health problem in both children and adults. Between 2007 and 2010, the prevalence of overweight increased from 12 to 14 percent in children and 19 to 22 percent in adults. This "double burden of malnutrition", in which both undernutrition and overnutrition coexist in the same communities, is driving an alarming increase in non-communicable diseases (NCDs) such as diabetes, stroke and heart disease.

According to the results of the 2010 Global Burden of Disease Study, nutritional deficiencies are the leading cause of years lived with disability (YLDs) in children under five years in Indonesia. Malnutrition contributes to 45 percent of child deaths globally, and causes damage that lasts a lifetime. Undernutrition signals that the child has been deprived of essential nutrients not only for growth, but also for building a strong immune system to protect against infection and for healthy brain development. Undernourished children do less well at school and are less productive as adults, which reduces their earnings and keeps families in poverty.

In fact, there is a direct link to economic growth, too. Stunting lowers life-time earnings by up to 20 percent. Malnutrition costs many developing nations an estimated 2-3 percent of their GDP[62] each year, perpetuates the cycle of poverty from one generation to the next, and impedes economic growth.

Figure 1 shows that the prevalence of stunting and wasting in Indonesia is much higher than other regional countries, such as Vietnam and Philippines, and is similar to much poorer countries (low-income countries) such as Myanmar and Cambodia. The prevalence of wasting is higher than all these other countries. Yet, the prevalence of overweight is worse than Thailand, where the per capita GNI is almost double that of Indonesia. In short, Indonesia is behind its neighbors.

Figure 1:
Prevalence of stunting, wasting and overweight in Southeast Asian countries 63



[62] World Bank (2006). Repositioning nutrition as central to development: a strategy for large scale action. Directions in Development. Washington, DC.

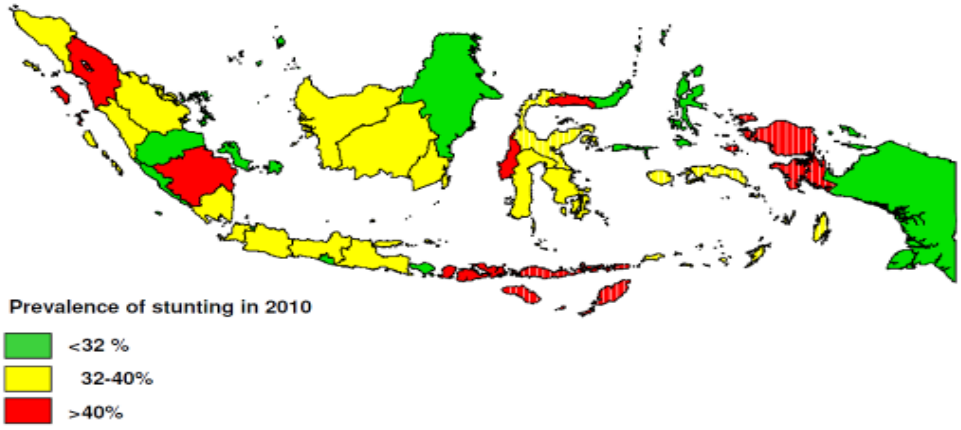
[63] UNICEF (2013). Improving Child Nutrition: The achievable imperative for global progress. UNICEF, New York.

Equity and Social Implications

The UHC programme is more likely to address inequities in health if it includes interventions that prevent and treat diseases or conditions that are more prevalent among disadvantaged and marginalized groups. Undernutrition is much more common among the poor in Indonesia, and disparities in nutritional status between income groups appear to be widening. Between 2007 and 2010 rates of stunting fell in the wealthiest quintile from 30 to 24 percent, but increased in the poorest from 40 to 43 percent. This means that the gap between the poorest and wealthiest quintiles almost doubled during this period, from 10 percentage points to 19 percentage points. The impact of undernutrition on work productivity is felt hardest in poor communities where physical stature and body strength are critical to work productivity. Stunting and anaemia makes people tired and weak, and less able to perform labour-intensive activities.

Geographic disparities are also striking; in 2010 the prevalence of stunting ranged from 22 percent in Yogyakarta to 58 percent in Nusa Tenggara Timur province (Figure 2). By serving districts with the highest prevalence of stunting first, the UHC will more likely reach disadvantaged populations and improve health equity.

Figure 2:
Prevalence of stunting in Indonesia (RISKESDAS, 2010)



Effectiveness of Nutrition Interventions

The good news is that there are effective interventions that can safe-guard children and women from undernutrition. Greatest attention is needed during the first 1000 days of life between conception and a child's second birthday because much of the damage incurred during this period on the growth and development of a child is irreversible in later life.

The National Plan of Action for Nutrition (2011-2015) stipulates the interventions needed to protect children and women from malnutrition. The set of interventions that are recommended for inclusion in the benefits package for the UHC programme are summarized in Table 1. The recent 2013 Lancet series on nutrition estimates that these interventions, if scaled up to 90 percent coverage, could reduce stunting by 20 percent and reduce the prevalence of severe wasting by 61

percent[64]. These interventions are part of existing health care services for children and women in Indonesia. However, several currently have very low coverage. For example, only 28 percent of women receive iron-folate supplements for at least 90 days during pregnancy, and only 45 percent of women receive a vitamin A supplement following delivery.[65]

Table 1:
Proposed Nutrition Interventions for the UHC Health Benefits Package

	Preventative/Promotive	Curative
Pregnant and postpartum women	**Micronutrient supplementation[66]** • Iron-folic acid (IFA) ***or*** Multiple micronutrient (MMN) supplements during pregnancy and for 40 days postpartum • Postpartum vitamin A supplementation **Maternal diet** • Counseling on appropriate diet during pregnancy and breastfeeding	**Treatment of undernutrition in pregnancy** • Balanced protein-energy supplements for undernourished pregnant women
Children age less than five years	**Infant and young child feeding** • Monthly growth monitoring for children age 0-23 months • Promotion of early and exclusive breastfeeding for six months and continued breastfeeding for up to 24 months • Education on appropriate complementary feeding **Micronutrient supplementation** • Twice-yearly vitamin A supplements for children 6-59 months • Micronutrient powders for children 6 -24 months • Deworming for children 12-59 months (once or twice yearly depending on the prevalence of soil-transmitted helminths)	**Management of acute malnutrition** • Management of moderate acute malnutrition • Management of severe acute malnutrition **Treatment of diarrhea** • Zinc supplementation for children with diarrhea

Nutrition interventions during pregnancy and the first two years of life are not only a powerful equalizer for the most disadvantaged and marginalized children and women, they also make economic sense. The Copenhagen Consensus has consistently confirmed that taking action on undernutrition is the single most important cost-effective means of advancing human wellbeing.

[64] Bhutta et al. (2003). Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? Lancet, published online 6 June 2013.

[65] Indonesia Demographic and Health Survey (2007).

[66] Calcium supplements are also recommended during pregnancy by WHO to prevent pre-eclampsia and eclampsia but are not yet included in MoH guidelines in Indonesia; if and when they are included, they should also be added to the package.

Experts estimate that US$1 dollar invested in reducing chronic undernutrition can result in a return of up to US$30 through improved health and education benefits.[67]

Table 2 provides global estimates of the cost per life-year saved of various packages of nutrition interventions when delivered at 90 percent coverage; these packages are similar to those given in Table 1. The cost is less than International $ 200 per life saved for each of three packages targeting children under five years (infant and young child feeding, micronutrient supplementation and management of severe acute malnutrition) and International $ 571 for optimum maternal nutrition during pregnancy. The estimates include nutrition supplements, human resources costs, other direct non-medical costs (such as fuel and stationary), and indirect costs (such as use of buildings, management, supervision and monitoring and evaluation).

Table 2:
Effect of Packages of Nutrition Interventions at 90 Percent Coverage[68]

Package of nutrition interventions	Cost per life-year saved (International $)
Optimum maternal nutrition during pregnancy	$571
Infant and young child feeding	$175
Micronutrient supplementation	$159
Management of severe acute malnutrition	$125

Budget Implications

We estimated the cost of packages of nutrition interventions for pregnant women, postpartum women and children under five years in Indonesia. Table 3 and 4 shows the estimated annual costs of nutrition supplements and deworming drugs for these groups; the costs associated with the delivery of these interventions to women and children (human resource costs, other direct and indicate costs) are not included in these estimates. As there is a large price differential between iron-folate supplements and multiple micronutrient supplements, Table 3 provides two options, the first with iron-folate supplements (IFA), and the second with multiple micronutrient supplements (MMS).

The MMS are more effective than IFA in in reducing the number of low birthweight and small-for-gestational age babies than IFA[69]. Table 4 gives separate estimates for children 0-23 months and children 24-59 months, because micronutrient powders (MNP) add appreciably to the cost of the package for children 0-23 months.

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[67] Copenhagen Consensus, 2012: http://www.copenhagenconsensus.com/projects/copenhagen-consensus-2012/outcome

[68] Bhutta et al. (2013). Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost? *Lancet. Published online* June 6, 2013. http://dx.doi.org/10.1016/S0140-6736(13)60996-4

[69] Haider, BA & Bhutta, Z (2012). Multiple-micronutrient supplementation for women during pregnancy (Review). *The Cochrane Library*, Issue 11.

Table 3:
Annual Cost of Interventions in Indonesia Rupiah per Woman during Pregnancy and the first 40 days Postpartum

	Option 1	Option 2
Iron-folate supplements	15,400	
Multiple micronutrient supplements		220,000
Protein-energy supplements	63,000	63,000
Vitamin A supplements	900	900
Total	**79,300**	**283,900**

Table 4:
Annual Cost of Interventions in Indonesia Rupiah per Children under 5 Years[70]

	Child 0-23 months	Child 24-59 months
Vitamin A supplements	675	900
Deworming	300	600
Zinc supplements	20,000	20,000
MNPs	67,500	-
MAM treatment	51,300	63,000
SAM treatment	77,000	77,000
Total	**216,775**	**161,500**

Next Steps

Inclusion of a set of nutrition interventions in the basic health benefits package will be an important step towards removing financial barriers and improving access to these essential nutrition services, particularly among the poorest households that are most affected by undernutrition.

However, significant preparations are needed to ensure that health facilities are equipped to meet the increase in demand for nutrition services once the UHC programme is launched. One of the greatest challenges will be to minimize the gap between the theoretical benefits package and actual availability, especially in rural and remote locations. This will require not only nutrition

[70] Unit costs for the nutrition supplies were obtained fromhttp://inaproc.lkpp.go.id/v3/public/ekatalog/ekatalog.htm. Annual cost of each intervention was calculated by multiplying the unit cost of nutrition supplements by the expected number of doses within a one year period.

supplies and equipment, but also health workers with the skills and knowledge to provide the nutrition services to children and women, and an informed population that is aware of the services to which it is entitled.

Preparations for the inclusion of nutrition services in the UHC programme between now and the end of the year should include:

- Finalization of the nutrition benefit package for UHC in Indonesia, in line with the governments existing policies and plans related to nutrition, including the 1000 HPK, and RAN-PG. This will require deliberations between BPJS and the Ministry of Health on which nutrition interventions should be included in the UHC benefit package, and which should continue to be managed by the MoH.
- Assessment of health worker capacity gaps to implement the nutrition service package, in particular, gaps in the knowledge and skills of health workers in delivering nutrition services.
- Inclusion of all nutrition services in the benefits package in the Maternal and Child Health (MCH) booklet provided to pregnant women and mothers of young children.
- If the inclusion of nutrition interventions in the benefit package requires new funding from Ministry of Finance, then it may be necessary to increase the premium for poor households to ensure these services are delivered from 2014.

The monitoring and evaluation framework for the UHC should pay special attention to documenting the impact of the UHC programme on nutrition service delivery as well as on nutrition outcomes. Globally, there is very little evidence on how UHC programmes have enhanced the access of children and women to essential nutrition services and contributed. With the 2013 RISKESDAS providing baseline data for the start-up districts, there is an excellent opportunity for Indonesia to track the impact of the UHC programme on the coverage of nutrition services and on reducing stunting and other forms of malnutrition.


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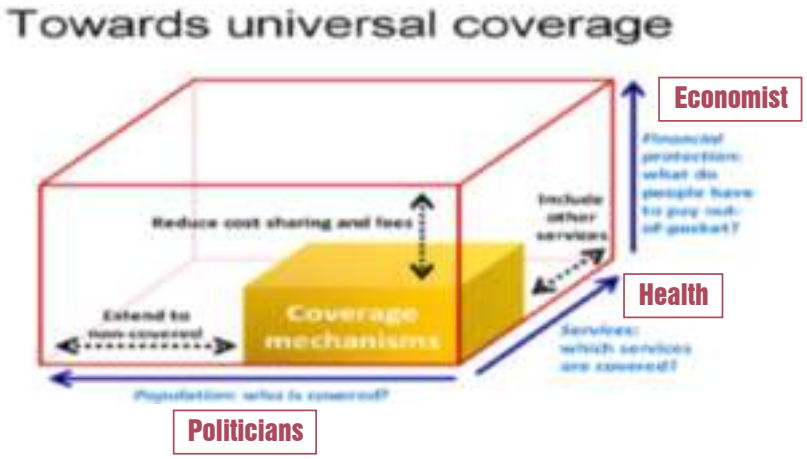
#15 POLICY NOTES

The Political Economy of Universal Health Coverage Implications for Indonesia[71]

September 2013[72]

The "UHC box" represents the Political Economy of Health Reforms

Readers of this policy note series will be familiar with the Universal Health Coverage (UHC) box presented in the World Health Report of 2010[73], which outlines the main policy choices facing governments as they scale up health coverage. In trying to fill the UHC box using limited resources, countries face trade-offs between the dimensions of: who is covered, which services are covered and how much financial protection is provided to consumers. But how do societies decide which dimensions should be given priority and therefore how they will make the journey towards UHC?



[71] This is Policy Note #15, and was written for the BPJS teams by Dr. Rob Yates of the World Health Organization (WHO), Jakarta office, in coordination and funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org .

[72] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. As suggested and predicted in this Policy Note, Mr. Jokowi embraced UHC and won the election in part by using Health as a key plank in his platform. The principles outlined in the Policy Note remain.

[73] WHO 2010 Health Systems Financing: The Path to Universal Coverage. http://www.who.int/whr/2010/en/index.html

Another way to look at this box is to consider that it represents the political economy of the health sector, in that its different dimensions represent the different priorities of the main stakeholders in reaching UHC (see above). For example, the population axis "Who is covered?" is an inherently a political question and tends to be the main area of interest for politicians (especially in the run up to elections!). Whereas the vertical axis which basically asks, "Who is Paying?" tends to be the main area of interest for economists and financial actors, such as the Ministry of Finance and employers organisations. Finally health workers tend to have the greatest interest in the service delivery axis, in determining which services should be provided, and to what quality levels, to improve health outcomes.

The beauty of the UHC approach, is that it forces all these actors to recognize that progress along only one of these axis isn't sufficient. So politicians need to learn that promising everybody access to free health services is ineffective in reaching UHC, if the services are not available or are of poor quality. Likewise the Ministry of Finance needs to understand the impact of adjusting the relative burden of public and private financing on the health system, both in terms of service and population coverage. Finally, a UHC approach can help health professionals appreciate the important political imperative of increasing population coverage and help them recognize that it is sometimes appropriate to trade-off more expensive inputs in order to reach more beneficiaries.

The best way to make progress towards UHC is to involve all these stakeholders (including the general population) in producing a strategy that agrees which route to UHC is most appropriate for that country's context. This strategy should agree priority actions and investments along each axis but will also recognise that trade-offs are necessary. So for example, if more financing becomes available, should this be invested in covering more people in the informal sector, purchasing more medical equipment or reducing or eliminating co-payments for some services?

Across the World: The Political Priority of Population Coverage is Driving UHC Reforms

Increasingly health researchers are recognising that in practice, UHC reforms are predominently driven by political rather than technical processes. This is especially true of health financing reforms.[74]

In an excellent analysis of global transitions towards UHC, Savedoff et al[75] show that whereas overall health financning levels tend to be determined by economic growth and technological advances, the shift towards people being covered by pooled financing is largely driven by political considerations. In particular, as economies develop and more funds become available to finance health care, there is a tendency for political demands to grow from uncovered population groups for universalising health coverage.

[74] Stuckler D et al 2010 The political economy of universal health coverage. Background paper to the First Global Symposium on Health Systems Research: http://www.pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF

[75] Savedoff W 2012. Transitions in Health Financing and Policies for Universal Health Coverage. Results for Development Institute Available here: http://t.co/zNdm5VdX

Achieving this objective is inherently political, because it requires the state to invervene to force healthier and wealthier members of society to subsidise the health care of the the sick and the poor.

In countries at all income levels, political leaders are recognising that it is a good idea to respond positively to these demands in order to improve health indicators, increase health sector efficiency and most importantly for them: to reap major **political** benefits.

If financed and implemented well, UHC reforms can be extremely popular with the general population and political leaders that associate themselves with these reforms can see their personal popularity increase as a result.

Reflecting this, it is striking how many major UHC processes have been initiated by political leaders in the run up to elections and immediately following a transition of power. The following table provides some examples of significant UHC reforms which have been largely driven by a political agenda:

Country	Year	UHC Reform	Political Timing / Reason
United Kingdom	1948	Tax financed National Health Service with universal entitlement to services	Welfare state reforms of new government following WWII
Japan	1961	Nationwide universal coverage reforms	Provide popular social benefits to the population in order to counteract political pressure for communism
Brazil	1988	Universal (tax-financed) health services	Quick-win social policy of new democratically-elected civilian government
South Africa	1994	Launch of free (tax-financed) services for pregnant women and children under 6	Major social policy of incoming ANC government after collapes of apartheid
Thailand	2001	UCS extends coverage to the entire informal sector	Main plank of the populist platform of incoming government
Uganda	2001	Universal free health care	Launched suddenly 10 days before a Presidential election
Zambia	2006	Free health care for people in rural area (extended to urban areas in 2009)	Presidential initiative in the run up to elections
Burundi	2006	Free health care for pregnant women and children	Presidential initiative in response to civil society pressure
Nepal	2008	Universal free health care up to district hospital level	Flagship social policy of left wing parties in coalition government in 2008 election campaign
Ghana	2008	National Health Insurance coverage extended to all pregnant women	Leading up to a Presidential election
China	2009	Huge increase in public spending to increase service coverage and financial protection	Response to growing political unrest over inadequate coverage

Sierra Leone	2010	Free health care for pregnant women and children	Presidential initiative which was a major factor in the incumbent's re-elction campaigm
USA	2010	National health reforms designed to reduce number of people without health insurance	Major domestic social policy of the President

It is noticeable how many of the political leaders that led these processes, have derived substantial political benefits from their successful reforms which has helped them retain power in subsequent elections.

This would even appear to have been the case in the recent re-election of President Obama in the USA: http://www.dailymail.co.uk/news/article-2233169/Obama-won-election-gifts-low-income-voters-young-Americans-minorities-says-Romney.html

Indeed some political pioneers of UHC have become national heroes. For example in 2004, the Canadian public voted in a national poll for Greatest Canadian[76] and chose the architect of their UHC reforms, Tommy Douglas. He had been the Premier of Saskatchewan Province and after a long political battle brought UHC to his province. When it proved successful and popular it was adopted nationwide.

In the United Kingdom the architect and political driving force behind the National Health Service (NHS), Aneurin Bevan has also become a national hero. This BBC documenatary programme shows vividly the political battles Bevan fought (particularly with the powerful medical profession) to establish the NHS. http://liberalconspiracy.org/2011/10/11/watch-how-life-was-before-the-nhs/ The world was able to appreciate Britain's gratitude to Bevan for winning these battles, when the NHS featured so prominently in the opening ceremony of last year's Olympic Games in London.

More recently and closer to Indonesia, the major UHC reforms in China, Thailand and Sri Lanka have all been driven by a politicians responding to pressure to deliver full population coverage. For example political pressure had a major role in securing the successful UHC reforms in Thailand. The role of civil society advocacy is described in detail in the 10 year independent evaluation of the Thai UC scheme[77]. In particular 11 NGOs led by a senator managed to mobilise 50,000 signatures to support a draft UHC bill which was put to the Thai Parliament in 2000. This spurred the Government into action which then produced its own bill and co-opted 5 members of the CSO group into UC policy formulation process.

Implications for Indonesia

Reviewing recent and current health coverage developments in Indonesia one can clearly see political considerations taking centre stage – just like in other middle income countries. Responding to growing calls from uncovered members of the population, it was Parliament in October 2011,

[76] http://www.cbc.ca/archives/categories/arts-entertainment/media/media-general/and-the-greatest-canadian-of-all-time-is.html

[77] Assessment of Thailand's Universal Coverage Scheme – Synthesis Report available here: http://www.gurn.info/en/topics/health-politics-and-trade-unions/development-and-health-determinants/development-and-health-determinants/thailand2019s-universal-coverage-scheme-achievements-and-challenges

that passed law 24 mandating the Government to initiate major health financing reforms in 2014 with a view to achieving universal coverage by 2019.[78]

In accordance with the new law, the Government is now planning major insitutional and financing reforms in the health sector, which will include an additional 10 million people being covered by the publicly financed Jamkesmas insurance scheme and a significant increase in subsidy levels for members in 2014.

However ongoing political demonstrations (http://www.thejakartaglobe.com/news/thousands-of-workers-rally-in-jakarta-for-better-health-care-wages/) would tend to suggest that some groups (notably trades union members) are unhappy with the pace of change and are likely to oppose significant insurance contributions from low paid workers.

Moreover, it is apparent that these political demands are being heard and responded to by political leaders at Provincial and District level. Evidence of this can be seen in the explosion of hundreds of Jamkesda insurance schemes across the country, where politicians are using local tax revenues to accelerate population coverage rates. It is noticeable that many of these Jamkesda are proving very popular in provinces such as Aceh, Bali, South Sumatra and most recently in Jakarta....

I got it!: Residents proudly display their free healthcare (KJS) cards while Jakarta Governor Joko "Jokowi" Widodo looks on during the distribution of the cards at a community health center in Koja, North Jakarta, on Tuesday. (JP/P.J. Leo)

Jakarta Post May 29 2013: http://www.thejakartapost.com/news/2013/05/29/healthcare-scheme-fiasco-will-be-resolved-soon-assures-jokowi.html

[78] http://www.thejakartaglobe.com/archive/social-security-bill-passed-at-last-gasp/474887/

With these reforms clearly delivering political benefits to their initiators and with Indonesia moving towards national elections, it is interesting to speculate: will accelerating progress towards UHC be a major election campaign issue in Indonesia in 2014? Specifically, will a national political leader make a popular campaign commitment to achieve coverage for ALL Indonesian people before 2019, using tax revenues to cover the informal sector? This would undoubtedly require larger increases in public financing than are currently being anticipated, but the lessons from neighbouring countries suggest that this could be a very effective political strategy to help secure an election victory.


DINAS KESEHATAN

#16 POLICY NOTES

How to Reach the Unreached in Jaminan Kesehatan Nasional (JKN)[79]

October 2013[80]

The Problem

JKN/health SJSN in Indonesia is an effort to reach Universal Health Coverage by making health care accessible to everyone and enabling them to have socially and economically productive lives. However, inequity remains a challenge to health, and global trends show widening health inequities within and across countries.

Universal health coverage is one of the Primary Health Care (PHC) reforms advocated by the World Health Report 2008 to channel resources toward equity and inclusion. The Alma Ata declaration that enshrined the principles of health equity, people centred care and a central role for communities in health action were considered radical in 1978. However, social research suggest that these values are now mainstream in modernizing societies. The PHC reforms are intended to meet rising social expectations regarding health and health care (WHR 2008).

In spite of the poverty reduction there are still people left behind; in the program interventions there are still groups that are "unreached". This Policy Note is an attempt to unravel how to reach the unreached people.

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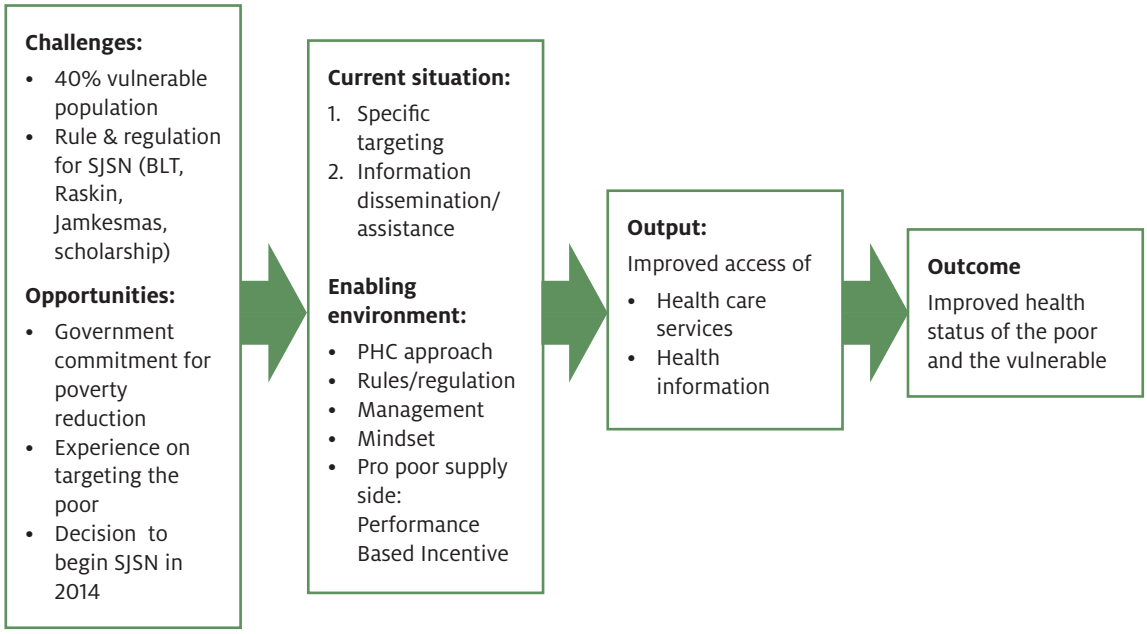
[79] This is Policy Note #16, and was written for the BPJS teams by Dr. Ilsa Nelwan of Coffey International and formerly of the World Health Organization (WHO). It was funded by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. The author thanks Dr. Kumara Rai, Simon Payne, Dr. Peter Heywood, and Dr. Meiwita Budiharsana for comments on a previous draft. For copies of other, earlier Policy Notes, please visit www.aiphss.org .

[80] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. President Jokowi has initiated a new Health Card for those populations hard to reach and an estimated 4-5 million will receive cards this year. However, issues of access and supply remain for the poor and vulnerable groups.

Figure 1:

Conceptual Framework: How to Reach the Unreached in JKN/ health SJSN

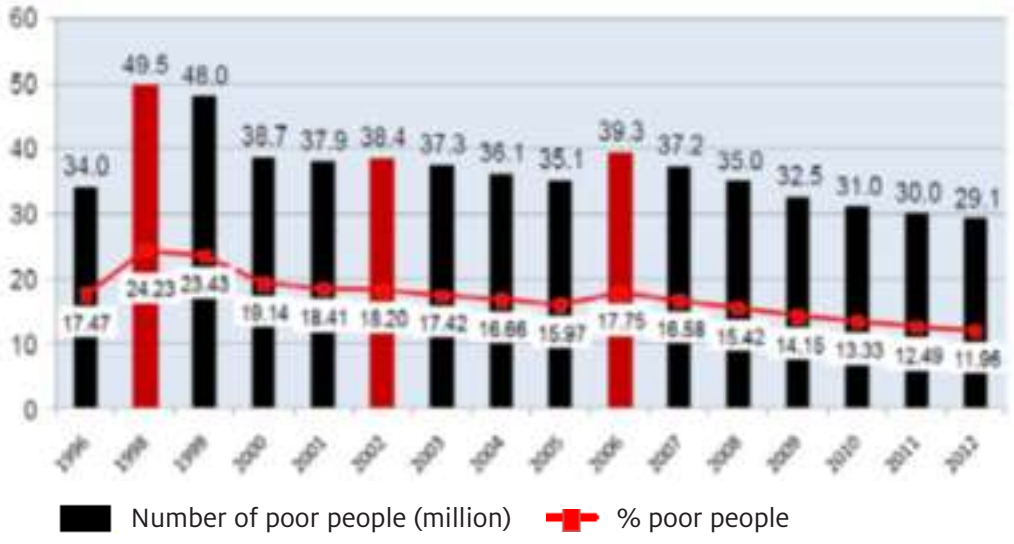


Who are the Poor and the Most Vulnerable?

With the exception of the 2006 which saw an increase in poverty due to the international food price crisis, the decrease in the official poverty rate from 12.5 per cent of all Indonesians in 2011, to 12 per cent in 2012 was the smallest since 2003.

Figure 2:

Trend of Poverty in Indonesia 1996-2012



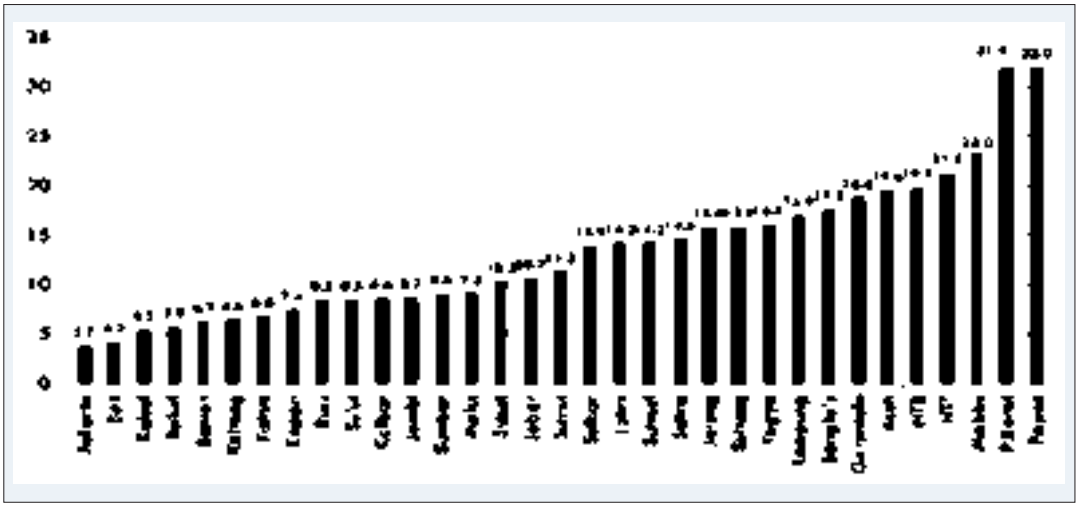
Source: Indonesia poverty data governance, BPS 2012

Efforts to reduce poverty often fail, however, the issue is to address the broader number of Indonesia's economically vulnerable population. For instance, while 12 per cent of Indonesians live below the official poverty line, nearly 40 per cent are "near poor" in that they live below 1.5 times this line, or on less than Rp12, 400 per day (around US$ 1.80 adjusted for purchasing parity power).

There is a term "dynamic poverty" whereby the poor and the near poor are a pool which interchanges in a dynamic way. The estimated number of the poor is 12% of the population, or about 29 million living below the poverty line. Up to 40% of the population are just above the poverty line, still vulnerable to any economic shock that they may easily go back below the line. The reason of this inequity is unequal growth; during 2008-2011 the poor grew 2% per year while the rich grew 9% per year.

Another challenge is that there is an unequal distribution of poverty as illustrated below in Figure 3:

Figure 3:
Percentage of Poor Population by Province 2012



Source: Indonesia Poverty data governance, BPS 2012

The data show wide disparities among provinces. NTT, Maluku, Papua Barat and Papua are poor provinces that need special attention from the national government. This challenge is also at the district, village and community levels and a special effort is needed at every level to reach these pockets of poverty.

Conceptual Framework of Reaching the Unreached

The challenges of JKN/ health SJSN is how to reach universal coverage including the poor and the vulnerable. The process of reaching the unreached is done through:

- specific targeting;
- information dissemination and assistance to the poor;
- the intermediary activities and the enabling environment (PHC approach);

- improved rules and regulations;
- improved management;
- changing mindsets; and,
- increasing or enhancing pro-poor supply side through Performance-Based incentives.

The expected output of an effective intervention to reach the unreached is “no one is left out” in the implementation in social support. Although the poorest of the poor is the hard core, the most difficult to reach, they cannot not forgotten.

Opportunities

Government Initiatives

The government commitment for protecting the poor is obvious from the current government initiatives to reach the Millennium Development Goal 1 to achieve a poverty level of 8-10% by 2014. The government has implemented various programs to protect the poor such as the provision of rice, health, education and the empowerment of communities and business.

National Team for Accelerating Poverty Reduction (TNP2K). The cross sectoral effort harmonized under the President Regulation 15/2010 seeks to create a poverty reduction policy and program, synergic the poverty reduction activities among ministries and institutions, and monitor and evaluate progress. A database of potential beneficiaries (Basis Data Terpadu or BDT) includes 76.4 million names for the new JKN cards including Jamkesmas and Jamkesda.

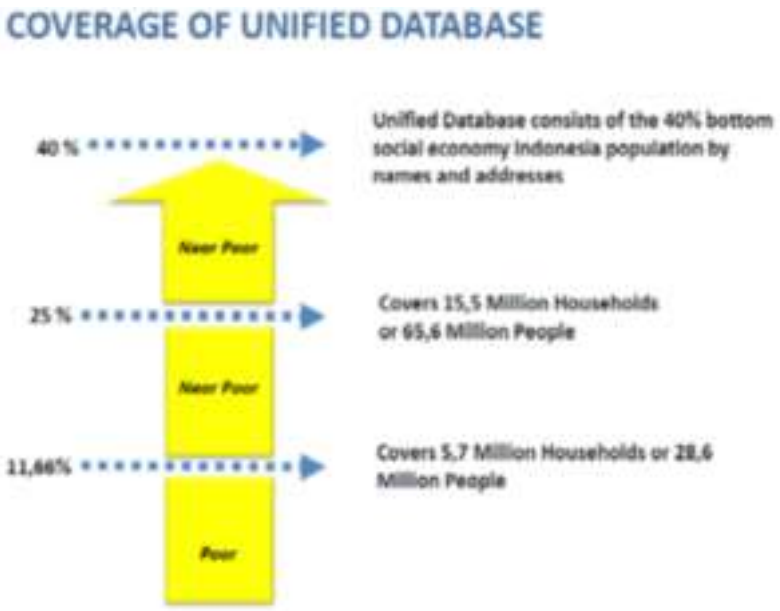
Beneficiary List Updating. The government will be coordinating with local communities to help identify poor households which are currently excluded from the BDT database.

Social Security System. Indonesia is implementing the new social security system (SJSN=Sistem Jaminan Sosial Nasional). The legal base for the new system is laws 40/2004 on National Social Security System and law 24/2011 on Social Administrative Bodies (Badan Penyelenggara Jaminan Sosial or BPJS). The SJSN implementation is now underway, including institutional transformation. Based on the BPJS law there will be only two administrators -- one for health (PT Askes) to begin in 2014, and one for the employment programs (PT Jamsostek) begin in 2015. A successful system will require attractive benefits at a fair and affordable price.

Current Situation

The government social support for the poor and the vulnerable are targeted through family, community and micro- and small enterprises for Social Health assistance. One of these is the JKN (together with unconditional cash transfers/BLT; conditional cash transfer/PKH; scholarship program/BSM and rice for the poor/Raskin).

Figure 5



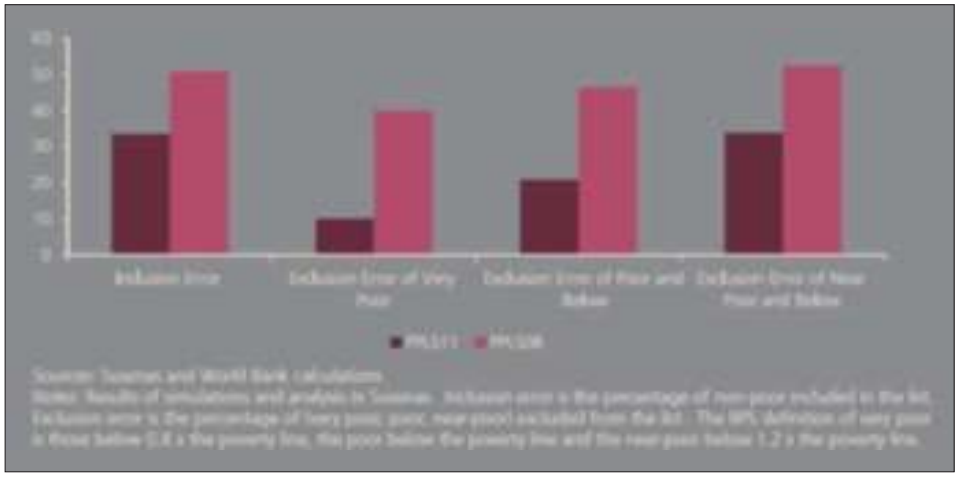
Source: TNP2K presentation Poverty alleviation academic conference 2013, June 2013

Previously the social assistance schemes were applied differently in different sectors; for instance only 30% of the poor received BLT, and even smaller coverage in the other social support. Three largest poverty reduction programs exclude around half of this group due to flaws in both targeting design and implementation.

Even though the bantuan langsung tunai (BLT) has the best targeting of the major program, over half of the poor and the vulnerable households were excluded. The Jamkesmas program uses a list of the poor, but actual targeting depends on local decisions. Jamkesmas cards should be given to those households on statistics from Indonesia's official list of the poor such as that for BLT. But how cards are handed out is done differently in different places. Some districts use the official lists while health officials in other districts select beneficiaries themselves. Even until recently households could receive Jamkesmas benefits simply with a letter from the village head. Jamkesmas covers 45 percent of households it is trying to find, but non-poor households make up 55 percent of all beneficiaries. As a result, the Jamkesmas targeting is poor with only 16 out of 100 covered actually poor.

A unified registry has already been mandated in the RPJM, so in 2011 statistics Indonesia conducted PPLS11 -- a very large scale updating of the list of poor households. This is a significant expansion from the previous list increasing the number of households surveyed from around 19 million in 2008 to 25 million. The Figure 6 below compares estimates of the targeting accuracy of the 2008 and 2011 lists. The exclusion of the poor and the near poor is expected to fall by around 20 percentage points in the 2011 list. The many strengths of the PPLS11 make it a good basis for the unified registry.

Figure 6:
Estimated Targeting Accuracy of PPLS08 and PPLS11



1. Specific Targeting: Social Protection Card as Identification

In 2011 an entirely new list of potentially poor households was developed that called the "National Targeting system" (NTS). This latest list combined recent census information with modern poverty mapping techniques to identify poor areas on a small scale, as well as using referrals from poor households in the community. The NTS is now being adopted by the major programs, including PKH, Jamkesmas, Raskin and BSM.

The poor is given a unique identification card "Kartu Perlindungan Sosial", this card (below) has been used in the BLT distribution of 2012 and 2013. This unified identification is used to improve targeting of the poor since previously many poor and vulnerable people missed out.

Source: TNP2K presentation Poverty alleviation academic conference 2013, June 2013.

Coordination among line ministries in program complementarities is important. The expectation is the various interventions will result in a balanced improvement for the poor.

How to Reach the Poorest of the Poor or the Marginalized?

The NTS still misses "the invisible group"; namely those without home address, without ID card or KTP: street children, the homeless, the poor in institutions such as orphanage, nursing homes and prisons. The "Program Nasional Pemberdayaan Masyarakat"/PNPM (National Program for

Community Empowerment) is one of the interventions trying to reach the invisible called "PNPM Peduli". In the pilot phase, PNPM Peduli reaches 231 villages in 91 districts across 24 provinces in Indonesia. They work with CSOs such as Kemitraan and Nahdatul Ulama (NU). The program is empowering marginalized groups become more self-reliant and lives more dignified, with greater quality of life.

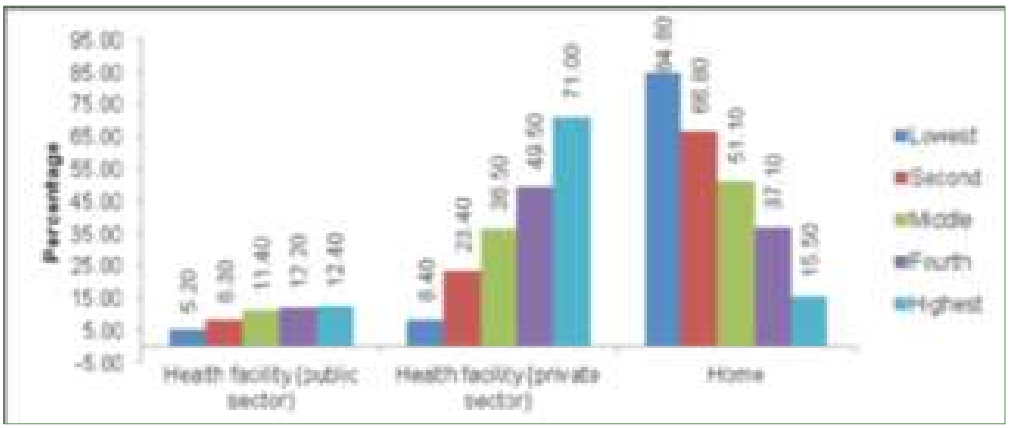
The program's objective is to strengthen the capacities of Indonesian civil society organizations to reach and empower marginalized groups to improve their socio-economic conditions. In its first year, PNPM Peduli has helped over 12,000 marginalized individuals gain new skills, access information, access services, build confidence and create new opportunities to participate in community life.

To increase access of health care to the invisible group requires a special effort. Working with the existing CSO and across sectors is one of the possible efforts. Improving access to health care services for these specific groups can be done in a specific place. For instance, at the drop-in centre (rumah singgah) for the street children, a special outreach camp for the homeless, and specific scheduled visits for the institutions.

There are steps to improve the poor enrollment such as extracting program beneficiary list as a source of high quality data on potential beneficiaries. A separate process should be used to identify beneficiaries for each program.

How is the health service access of the poor? The Riskesdas data below (Figure 7) gives an indication health service access by wealth quintile by mapping place of birth delivery by wealth quintile.

Figure 7: Percentage of Births
by Place of Delivery and by Wealth Quintile, Indonesia, 2007



Source: Riskesdas 2007

Of the lowest 20% wealth group, 5.2% used public facilities and 8.4% private facilities for birth delivery, but 84.8% delivered their babies at home. Of the highest quintile wealth group, 12.4% used pubic facilities, 71% used private facilities, and only 15.5% delivered at home. The recommendations of post-2015 development agenda illustrate how poverty and gender become barriers to health care services. The recommendations are to: reduce poverty among women and children, guarantee access to primary and secondary education to all girls, and deliver comprehensive

sexuality education to adolescents. Maternal Mortality becomes then, one indicator of intersecting inequalities.

Other Issues

There are also other issues to be considered: the supply side; second, explicit consideration of inclusion of the private sector; and third, quality of care.

Supply Side: There is an agreement on the demand side about poverty, but when the demand side restrictions are lifted (i.e., in this case making health care free), there are problems with the supply of services. Moreover, the JKN intends to limit the recognized providers who can be reimbursed for provision of services to doctors. This limit is imposed even though doctors (in both their public and private roles) deliver less than half of the ambulatory care. At the same time, nurses are not recognized even though they deliver more ambulatory care than any other professional group. The problem is that nurses may deliver lower quality than doctors and midwives. The fact remains, though, that there are not enough doctors.

Private Sector: Most of the ambulatory care delivered in Indonesia is from the private sector. It is important that the JKN can be attractive to the private sector providers including doctors, nurses and midwives.

Quality of Care: There is a need to open opportunities for providers to improve the quality of services. This cuts across the questions of training and incentives as well as what the patient knows. Universal health coverage should improve the health status by improving health care access and coverage as well as quality.

2. Information Dissemination/Assistance

Proper dissemination of information is needed to ensure the public understand the benefits and importance of the SJSN system. Effective communication within the government and to the public, media and parliament are important for the program success. For the poor the SJSN health information is important; so that they know how to access the services they are entitled. What are their rights and responsibilities, and what institutions are responsible for operating the program? The local government and district health office leadership is also very important in the decentralization context.

An important feature of the information strategy is to improve the health literacy of the population. Every individual should understand that everyone is responsible for their own health, that health promotion and disease prevention is necessary without neglecting curative and rehabilitative health services. The district health office should ensure better implementation of the public health program together with the JKN implementation.

Socio-cultural barriers are among the barriers to health care services for the poor. To overcome this gap the outreach program from health center to communities can be one of the interventions. Effective cross-sectoral collaboration also an important solution to this problem.

There should be an effort to change the health provider attitudes to be more pro-poor, through training and exposure of poverty analysis.

Advocates for the Poorest of the Poor

To increase health service access, the poor also need facilitator assistance, that is, someone who will support them to get the service access at public facilities. This facilitator is someone who can help in supporting the poor individual to get his/her right of getting health services access. The facilitator can also translate the health provider messages, fill necessary forms, and assist the poor for getting referral help.

Enabling Environment

1. Using the Primary Health Care (PHC) Concept

The PHC concept refers to implementation of a total health development strategy that requires an integrated and comprehensive approach:

- Universal accessibility and coverage, this translates into the task of fulfilling needs of the vulnerable and the marginalized. This principle also implies that equity or social justice be upheld while trying to cover the whole population;
- Community and individual involvement and self-reliance, each individual and the community should be held responsible from the planning stage from the enrolment of the poor population for JKN down to the monitoring and evaluation stage;
- Cross-sectoral action for health. Specifically for SJSN the poor population will receive different interventions from different sectors; to implement all the interventions effectively. Increasing cross sectoral coordination will improve JKN implementation;
- Public Health interventions are also an important aspect since this will reduce the disease burden and improving the quality of life of the unreached population. The cost effectiveness of public health intervention will make the JKN more effective. For instance with improving safe water supply access to the poor population there will be less water borne disease morbidity and mortality. With the high coverage of births attended by trained health workers, there will be less morbidity and mortality of birth delivery;
- The causes of ill health are health risks and determinants of health. Health risk emerges from people's life style such as tobacco use, alcohol consumption, diet and physical health. Determinant of health covers a broad spectrum of factors that covers social, educational, economic, gender, political, security and physical environment such as water and sanitation. The poor are more vulnerable to these health risks and poverty is one of the social determinants of health;
- Appropriate and cost effective technology will ensure better efficiency of the health system. The Global Positioning System, mobile and E health technology can support the identification process, health service provision, as well as monitoring of the poor population as a JKN target group.

2. Rules and Regulation

There is a need to review the present financial rules and regulations in the context of JKN. Discrepancies in regulation particularly at district level can be a challenge in JKN implementation. Primary care facilities should be able to manage funding for health service management and health

service improvement. In the beginning there should be an interim regulation that gives flexibility. The experience can be used to update the rule and regulation for a better JKN implementation.

3. Management

One of the obstacles of Jamkesmas management at primary care was difficulties in claim processing. Particularly at low income districts, health care fees reimbursed account for about 30% of the regional income. According to hospital laws Article 7, Act 3, hospitals can directly use the payments received from clients/patients for increasing and expanding health care services. But the funds sent to the health institution particularly in poor district is often less than the claim amount; therefore, the health institutions end up operating with less and less budget. At the same time, the poor can be costlier on average. The poor often delay care and have less social support, creating higher levels of needed care for longer periods of time.

Puskesmas health care claims should be used for improving health care services. There should be a different regulation that will support better the JKN as well as health care financing at district level and below, how to get full payment of claims at a shorter time is the management challenge.

4. Pay for Performance

Reaching the poor for health care services delivery also should be attractive to the provider. The pay for performance concept, or performance-based incentives, would encourage the provider services for the poor. Because provider may need to dedicate more time and effort to reach the poorest patients, the provider could receive an additional subsidy for treating the poorest of the poor.

5. Mindset

Pro-poor mind set among decision makers and health professionals could be encouraged by ”two track approach” tackling the government and working with the marginalized from the ground up. Both equity and empowerment are important in fostering “enabling environments” for poverty reduction and pro poor growth. This is the context of JKN implementation. The changing mindset of the local government; the empowered civil society will make a difference in poverty reduction and pro poor growth.

6. Research and Pilots

Operational research is needed to look for better options in reaching the poor, and could be done through partnerships between the local government (province and district), and the local universities. Monitoring and Evaluation (M&E) of JKN implementation will be needed and can be done in conjunction with local universities

Going Forward

The proportion and numbers of poor people in Indonesia is a big challenge, with the government targeting 40% of the population, or 100 million people, that need comprehensive social protection,

including health services access improvement. The real poor are 12%, or about 29 million population, living under the poverty line. But, there are the near poor up to 40% of the population that are vulnerable to any economic shock that they may easily go back below the line.

The government keeps improving the poor population enrollment. The last effort was developing a database and giving a unique social protection card to the poor. The poor will be able to get various social benefits, one of which is the JKN. However, the coordination and factor in complementarities across the line ministries is not easy to be implemented effectively.

To reach the unreached, JKN cannot be separated from the poverty alleviation efforts. For the poor, health services are not the highest priority. Therefore, the ability of health sector and the leadership of local government are very important. The vast number of poor people in Indonesia needs to be reached through cross-sectoral collaboration and community participation. The inequity of poverty, and the pockets of poor people, must be identified and targeted interventions planned.

What Can Be Done?

1. Using the database and NTS, the health sector can identify the poor population that need to be covered by the JKN. Collaboration with other sectors and local government for the dynamic enrolment of the poor in JKN is imperative.
2. "The invisible" can be reached using the existing pilot of PNPM Peduli experience. This intervention working with CSOs is trying to reach out to this group, - has been working in 231 villages, and has helped 12,000 individuals to create new opportunities to participate in community life.
3. The information dissemination of JKN as universal coverage effort needs to reach all government levels, relevant stakeholders and the general public supported by hotline service. At the individual level, every poor patient needs a facilitator that will help to communicate with health provider, and to be able to fulfil their administrative tasks. The health sector need to increase access and coverage as well as the quality of health service and the non-health aspects such as dignity, confidentiality and prompt attention are challenges for JKN implementation for the poor. It is also important to improve public awareness that everyone is responsible for their own health.
4. A primary health care approach in health development, which entails universal access and coverage, community and individual involvement and self-reliance, cross-sectoral collaboration, appropriate technology and public health intervention. It is indispensable if JKN is to succeed. But currently, most funding goes to hospitals according to the most recent National Health Accounts.
5. Scarce sociocultural data that influence the behaviour of the poor can be utilized in JKN operations research, in partnership with government and local universities. Monitoring and evaluation of the JKN program is, furthermore, an academic opportunity for policy analysis and research.

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#17 POLICY NOTES

Phasing-in of the INA-CBGs[81]

October 2013 [82]

An Oddity by Global Standards: Why Does Indonesia Choose to Implement 100% of the New System in 2014?

In a few months, the BPJS will implement a new provider payment system for hospitals, the INA-CBGs. Provider payment systems can be a powerful tool to promote health systems development and achieve health policy objectives.

Indonesia, unlike other countries of the world, has chosen to NOT phase-in the INA-CBGs. Most countries, rich (Germany) and poor (Armenia), big (United States) and small (Kyrgz Republic), phase-in their INA-CBGs over 3-5 years. Indonesia will not. Yet, several current system signals suggest that Indonesia may wish to consider a phased approach to both improve efficiency and quality.

Indeed, Ric Marshall, of the United Kingdom and Australia, recently gave the government several reasons for considering a phased-approach which revolve around improving the current level of poor and unstable data. By slowing down the implementation over 3-5 years, Dr. Marshall suggested several advantages. These include:

1. Establishment of a quality measurement system, which could include quality tracking systems to i) prevent unnecessary admission, ii) assure needed care for admitted patients and iii) prevent early discharge of patients which can often lead to costly re-admissions to hospitals within 90 days;

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[81] This is Policy Note #17, and was written for the BPJS teams by Jack Langenbrunner, based on his work and the work and findings of Ric Marshall from the United Kingdom and Australia, and with Cheryl Cashin of the Joint Learning Network. It was funded by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[82] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed. Since this writing the government has fully implemented INA CBGs with rather disastrous consequences. Work is under way to revise the system.

2. Improvement of coding systems, including the use of all the ICD-9 and ICD-10 codes. Currently, less than 10 percent of all the codes are being utilized. More time would further allow development of a cadre of trained coding experts and national standards for coding. Currently, hospitals train their own coders which result in variation in coding across facilities. Improvement in coding systems could result in more fairness in payment for sicker patients and fairness in reimbursement across facilities;
3. Simplification and needed revisions to the software Grouper. For example, the National Casemix Center (NCC) has reported that 100 categories have no data, and that about 200 categories have less than 30 cases. Indonesia would be the first country in the world where there are CBG categories with no cases. As a first step, the categories could be dropped and data run through the simplified grouper. Dr. Marshall further suggested that the grouper drop the 6 procedure categories, and other "oddities" such as the Bed Occupancy adjuster, and cost to charge ratios. The severity levels are a final area where the grouper could be simplified right away. The NCC indicated that the 3 levels of severity often did not reflect differences in data. Again, this could be an area for greater logic, simplification and transparency.

Table 1:

Which Data to Collect on Every Admission?

Variables used for grouping in current Australia CBG system

- Diagnosis (multiple)
- Procedures (multiple)
- Sex
- Age
- Event end type
- Length of stay
- Leave days
- Admission weight
- Mental health legal status
- Same-day status.

The Grouper can take up to 30 diagnosis codes and 30 procedure codes per admission

4. Improvement of costing systems, including a new costing template to capture more utilization data. The costing model currently relies too much on average-length-of-stay (ALOS) and is too basic. The GIZ costing study has a more robust template, though could be too complicated. But, it could be utilized to refine the costing template. There was a discussion to break out the 4 hospital departments into more department categories for greater precision. Software programs such as COMBO (level 1) might be used as a next step. He suggests i) starting with a small sample of the hospitals with the best costing systems, ii) moving to a representative sample of hospitals stratified by all types and iii) extrapolating costs to all hospitals in the country. The sample need not be large. He suggests 10% may be enough. In Germany, costs for as few as 70 hospitals were utilized for all Germany. In Philippines, less than 20 hospitals were used as a first step. The MOH/NIHRD currently holds cost data for 200+ hospitals, which could be utilized today;
5. Clearer contracting and purchasing arrangements, where conditions and rules are clear and well-developed, where claims are processed quickly, where there is automated payment of all claims with a 5-10% sample of audits of two (2) types of claims: high cost claims and high risk claims. Today, there is a 100% audit of claims by verificators under Jamkesmas, a clear waste of public funds. Further, there should be clear rules with incentives and sanctions for correct reporting of cost and clinical information, with punishment for fraud;

6. Time to develop budget neutral modelling, or impact analysis, to better understand which facilities will gain revenues under the new systems and which facilities will not. Relative to 2013, how will revenues change for each hospital? Much will change...for example, premiums per person will go up, out-of-pocket payments will go down, the relative base rate allocations for primary care and secondary care will change (though exact share allocations are not yet known), and so on. The BPJS will need to know who will enjoy excess surplus (overpaid) and what facilities will be relative revenue losers (underpaid) due to relative inefficiencies in their cost structure. Dr. Marshall suggests some reallocation in initial years from winners to losers to protect against fiscal risk and allow time for "losing" hospitals to restructure and become more efficient. How do you reallocate in initial years? A commonly used approach in other countries is to utilize a blended formula in the initial years of phase-in, for example, 25% INA-CBG and 75% traditional payment with increasing percentages over 3-4 years. Dr. Marshall suggested a 5%/95% blend in year 1 (2014).

Policy Issues Remain

There are other, practical issues as well. A few of these include:

Capability: Is there adequate capability on the provider side? On the payer side? On the provider side, about 325 of 1600 hospitals have gained absolutely no experience to date with CBGs. Ability to manage and adjust to the cost awareness issues may take some time. And, indeed, the new payer, PT Askes is now administering the scheme for the JKS (Jakarta Card Scheme), but this organization is also new in administering this new system.

Public and Private Facilities: More information of costs and case-mix are needed to more fairly pay public and private facilities. Is case mix severity different in public versus private hospitals? What can be done to "level the playing field" for privates which do not receive public supply side subsidies for capital and equipment and other programs? The public facilities will continue to receive more than half (perhaps as high as 60%) of revenues from subsidies other than payments under the INA-CBGs. The payment for privates will need to be adjusted upward to provide similar subsidies, or supply side financing should be ended on the public side, with all funds pooled under BPJS.

A Volume Cap: A potential explosion of volume of admissions under the new UHC program could occur as financial barriers are reduced, individuals and families feel empowered and will more aggressively seek care. In many countries, the use of CBGs by themselves has led to increases in volumes of admissions. Coupled with the UHC initiatives in Indonesia, the volume of admissions may then explode starting in 2014, similar to what has been seen in Jakarta under the Jakarta Kard Scheme (JKS) in 2013. The BPJS may wish to initiate volume caps through contracts with facilities or with regions. This is done in many other countries – almost all of them in western Europe and some in Asia (Taiwan and Thailand). Indonesia would be smart to start with a "soft cap" that might allow for some flexibility around a volume cap target.

A Phase-in Program

Given these many challenges, a first draft outline might be done to determine what could be done year-by- year in a carefully phased-in program.

Year 0: 2013

The phase-in schedule should be announced immediately for all stakeholders. The first year could be, for example, a blended formula using 5% INA-CBGs and 95% traditional payment mix. Ric Marshall's report spells out a phase-in approach with the percentages changing for the next 4-5 years.

A Phase-In Roadmap would be developed spelling out step-by-step program over the next 3-4 years in the areas of improving:

- Classification
- Coding
- Costing
- Contracting

The roadmap might spell out details as illustrated below:

Year 1: 2014

Classification:

Refine INA CBG grouper as based on some initial impact analysis and budget-neutral modelling. This could include i) elimination of procedure-based groups, ii) simplification of the numbers of categories, and iii) a strategy to move to a single base rate.

Coding:

Develop data dictionary under the new contract, and test it out, and train people to use it. Now under the leadership of MOH's Pusdatin Center, this is essential for standardized and more precise coding systems. The current schedule calls for this to be finished by the end of December.

Unique identifier systems developed for all physicians and all facilities with characteristics such as urban/rural, bed size, teaching status, numbers of beds at each class level.

Develop training program for coders, with a standardized program and manual for coding consistently across all facilities in Indonesia. Clinicians will be responsible for provision of data used for coding. However, physicians should NOT be asked to code.

Coders will need to be accredited in some way just as facilities are accredited. This process tool 4-5 years in Germany, but with the use of INA-CBGs under Jamkesmas in Indonesia, perhaps the program will take less time. Government grants could be initiated to provinces to initiate training programs with teachers and trained coders, could be nurses or other auxiliary personnel. Coders can form professional associations over time.

Development of new coding audit programs by BPJS, including both new software programs and trained verificators for BPJS.

Costing:

New costing template developed using the COMBO level 1 software systems. The costing template could be developed in conjunction with the Australian DRG expert consultants.

Payment Formula:

Blend of INA-CBGs + Historic Payment Amount (adjusted for inflation). A 5%/95% blend was recommended by Dr. Marshall.

Quality:

Development of quality assurance monitoring indicators, by MOH or BPJS, related to preventing unnecessary admissions, related to needed care services during admission, and related to preventing early discharge and re-admissions within 90 days.

Contracting:

Contracts with all providers, with clear rules for all reporting of clinical and costing information.

Monitoring and Evaluation:

Monitoring and evaluation system established using baseline data

Year 2: 2015

Coding:

Develop standardized coding system using ICD 10 – all codes should be included in the claims processing systems.

Upcoding review software developed. Anecdotal reports suggest upcoding has already began occurring in some hospitals in Indonesia, of up to 20% on a year-over-year basis.

Costing:

Development of a new standard coding template for provider and facility costs

Contracting:

Contracts with all accredited verificators and related quality assurance teams

Payment Formula:

Blend of INA-CBGs + Historic Payment Amount (adjusted for inflation). A 25%/75% blend was recommended by Dr. Marshall.

Communications:

Annual Report started and sent to key stakeholders such as the hospital community, Parliament and others on how well the system is working

Year 3: 2016

Coding and Data:

Collection of information on clinical patterns and costs

Classification:

Refinement of the grouper based on the clinical data
New, special adjustments for geographic areas, teaching, bed size, etc.

Costing:

Ongoing Impact analysis – at facility level
Costing template revised based on analysis
Deliberations with Ministry of Finance on what to do with public facilities which are inefficient and failing financially

Communications:

A 2nd Annual Report completed and sent to key stakeholders such as the hospital community, Parliament and others on how well the system is working

Concluding Thoughts

This phase-in series of steps is *illustrative, not to be taken in a literal way*. The Roadmap would certainly specify various steps in much greater detail and with much more precision. This listing is to just provide some examples and ideas on areas to be covered.

More and better detail is further provided in the report of September 2013 of Dr. Ric Marshall from his work in Jakarta the week of August 19, 2013.

#18 POLICY NOTES

Health Workforce in Indonesia Availability of Workforce to Deliver Universal Health Coverage[83]

October 2013[84]

Importance/Relevance of Issue

The distribution and availability of the health workforce is receiving more attention in Indonesia, as the government prepares to introduce the National Social Security System (SJSN) from 2014. While the introduction of financial protection through the SJSN will reduce financial barriers to access care, geographic access barriers may still limit the ability of some populations to benefit from the national system.

This issue was recognized in the World Health Report of 2010 which noted that 'removing the financial barriers implicit in direct-payment systems will help poorer people obtain care, but it will not guarantee it...if services are not available at all, or not available close by, people cannot use them even if they are free of charge' (WHO, 2010).

A key factor limiting the availability of health care services in certain locations and for certain population groups is the shortage of some key health workers, and the uneven distribution of those which are available, with a tendency for concentration in urban areas, and neglect of rural or island areas.

This issue has been recognized in the 'Roadmap to Universal Health Coverage'. 'Quality health services which are available within a relatively short distance are the second key requirement for implementation of UHC.' (p 95). The roadmap notes that the health workforce and health facilities are concentrated in large cities, while the majority of the population are in rural areas. While the

[83] This is Policy Note #18, and was written for the BPJS teams by Krishna Hort (Nossal Institute of Global Health), Andreasta Meliala (University of Gadjah Mada), and Rohan Jayasuriya (University of NSW). Translation was under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[84] Important: this is a time-based policy note written for issues at the time of drafting. However, circumstances have not changed since this writing, and this Note could still be viewed as current.

total number of doctors, estimated at 85,000, and specialist doctors, 25,000, is sufficient for the ideal ratio of 1:3000 population, the problem is in the distribution. (p 96)

What Do We Know of the Numbers and Distribution of the Workforce?

Accurate data on the health workforce in Indonesia is difficult to obtain. As noted in the recent WB report, even official figures in the Ministry of Health are not fully reliable because of incomplete reporting from provinces and districts. Data from the Ministry of Health also does not include those fully in private practice, although a majority of those in private practice are also civil servants, and included in MoH data (Rokx, Marzoeki, Harimurti 2009).

Using MoH data from the 2011 Profile, and comparing the ratio of key health staff to population in the wealthier and more urbanized islands of Java and Bali, with the poorer and more rural islands of Eastern Indonesia (NTB, NTT, Sulawesi, Maluku, and Papua), it is only the ratio of specialist doctors to population which is higher in Java-Bali than in Eastern Indonesia (Table 1).

Table 1: Ratios to 10,000 population

Category	Total (2010)	Ratio total	Target ratio 2010	Ratio-Java-Bali	Ratio – Eastern Indo
Specialist	16836	0.70	0.9	0.79	0.44
Gen doctor	32492	1.35	3.0	1.07	1.74
Nurse	220575	9.15	15.8	6.62	14.66
Midwife	124164	5.15	7.5	3.58	6.26
Total Population		241,182,182		142,202,232	33,388,786

Source: Ministry of Health, Health Profile, 2011; Targets from the MoH Strategic Plan (2010-2014)

However, another perspective on the distribution is to take into account the greater dispersion of the population in eastern Indonesia, and consequently the need for a dispersed network of health workforce. Table 2 uses the number of community health centres (Puskesmas) as an indicator of the dispersion of the health network. This demonstrates that ratios of all health workforce categories to Puskesmas are higher in Java-Bali than in eastern Indonesia, although the difference is much greater for specialist doctors (only one fifth the ratio), and general doctors (60%of the ratio in Java-Bali) than nurses and midwives.

Table 2: Ratios to Number of Puskesmas

Category	Total (2010)	Ratio total	Ratio - Java-Bali	Ratio – Eastern Indo
Specialist	16836	1.87	3.10	0.66
Gen Doctor	32492	3.61	4.19	2.57
Nurse	220575	24.49	25.90	21.72
Midwife	124164	13.79	14.00	9.28
Total Puskesmas		9005	3634 (1:39,130)	2254 (1:14,813)

Source: Ministry of Health, Health Profile 2011

Calculations in Rokx, Marzoeki and Harimurti use PODES survey data in 2006 to compare population ratios for general doctors and midwives in Java-Bali and the rest of Indonesia, and between urban and rural areas.

Table 3: Ratios of Selected Workforce per 100,000 population (2006)

Category	Location	Ratio total	Ratio - Urban	Ratio-Rural	Ratio-Remote
General Doctor	Java-Bali	18.5	34.1	4.5	
	Rest of Indonesia	18.1	40.9	8.3	6.6
Midwife	Java-Bali	26.1	25.1	27.1	
	Rest of Indonesia	52.8	45.4	55.1	58.1

Source: PODES (2006) A question which asked the village head about the number of midwives living within the village area. (From Rokx, Marzoeki and Harimurti 2006)

On the basis of this data, in urban areas in Java/Bali there is one doctor for every 3 thousand people, while in rural areas, there is only one doctor for every 22 thousand people. Outside Java/Bali there are more doctors per population, but still only one doctor for every 12 thousand people in rural areas, one for every 15 thousand people in remote areas while there is one doctor for every 2,430 people in urban areas.

Specialist Doctors

Data on the number of specialists and number of doctors for 30 of Indonesia's 33 provinces was obtained from the Ministry of Health database for 2008. Overall, 12,295 specialist doctors from 30 specializations were reported as practising in the 30 provinces, with an average ratio of 5.38 specialist doctors per 100,000 population. This compares to the Ministry of Health (MoH) target, outlined in Healthy Indonesia 2010, of 6 specialist doctors per 100,000 population. The highest ratio per 100,000 population was 30.95 in the capital city Jakarta and the lowest was 1.61 specialist doctors per 100,000 population in East Nusa Tenggara (NTT) Province.

Nurses and Midwives

The distribution of midwives is more favorable in rural and remote areas. In Java/Bali there is a midwife for every 4 thousand people in urban areas and one for every 3,700 people in rural areas. Outside Java/Bali, there is a midwife for every 2,200 people in urban areas, one for every 1,800 people in rural areas.

There is little information on other Puskesmas workforce, although there appear to be even larger gaps in the numbers of other clinical staff, including pharmacists, health promotion officers, nutritionists and sanitarians.

Underlying Issues in Indonesia

There are several, including:

- Uneven economic development regionally with economic standards higher in Java-Bali and cities than in Eastern Indonesia and rural areas. As a result, marked differences in health status and major health problems, and in the mix of services available. Java –Bali urban areas face a dominance of non-communicable and chronic diseases, and with a well-established private sector, have a mixed public-private system. While poorer regions of Eastern Indonesia face persistent under-nutrition, reproductive health and communicable disease problems, with little private sector engagement and poorly resourced network of public facilities.
- Decentralisation and civil service (PNS) regulation: health workforce are employed by provincial or district governments and cannot be transferred between districts or provinces. Although the central level controls the system, mobility of health personnel among different regions is more restricted during the era of decentralization. The process of staff transfer from one region to other region requires approval from both sides of local governments before agreement from the central level involving complicated bureaucracy on administration and financing. (Kurniati & Efendi).
- Restriction on mobility of civil servants and the abolition of Wajib Kerja Sarjana (a compulsory service for university fresh graduates) have caused difficulty in distribution of health personnel from health facilities with excess number of health workers to the health facilities with shortage number of health workers (Kurniati & Efendi).
- Marketisation of health sector:
  - health workforce greater autonomy to choose where to work, rather than be allocated by MoH;
  - market forces of supply and demand operate more strongly to influence workforce distribution – categories of workforce in scarcity particularly susceptible (doctors and specialist doctors);
  - increasing private sector opportunities and income attract doctors to work in private sector and dual practice allows.
- The potential impact of the introduction of national health insurance on the demand for health workforce. Initial introduction in Jakarta, and Banten resulted in increased utilisation of public health facilities, exceeding current capacities, and thus, increased demand for doctors to provide services. Local governments in Jakarta and Banten have proposed increased recruitment of doctors, which has the potential to exacerbate rural-urban disparities.
- Debate about the future role of the public Puskesmas, and the extent to which the national health insurance system is driving a greater focus on provision of curative services, to the

neglect of its role in health promotion, public health programs and prevention of ill-health, and in mobilizing local communities to address health issues.

Current Policies

The main laws governing the distribution of medical doctors and hospitals are the Medical Act No. 29 of the year 2004, the Health law No 36 and the Hospital law No 40, both of the year 2009. The Medical Act of 2004 established the Indonesian Medical Council, and the requirements for all doctors to register with the Medical Council, and obtain a licence to practice for each location of practice from the relevant Provincial or District Health Office. The maximum number of locations of practice for which a licence may be granted is three (including the location of practice of the state employment).

In order to encourage doctors to work in more rural and remote locations, the Ministry of Health has issued regulations to provide additional allowances or incentives for specialist and general doctors who work in areas classified as rural or remote. The regulations of 2006 and 2010 specify a monthly allowance of up to $750 for specialist doctors and $500 for general doctors to be paid by the central MoH. In addition, Provincial and District governments in certain areas have issued local regulations to provide additional allowances to doctors willing to work in rural locations in their local government areas, with amounts varying from $500 up to $2500 per month.

Despite these allowances, it appears that for most doctors, especially specialist doctors, the contribution to their income from government salary and allowances is less than one quarter, while private sector sources make up the majority of their income (Meliala, Hort, Trisnantoro, 2013). This level of incentive is unlikely to be sufficient, particularly as doctors face paying off the loans taken out to fund their medical education.

The MoH has also tried to address the problem through different periods of compulsory rural service for new graduates, and to provide incentives to complete rural service. These policies include a mix of:

a. Offer vacancies only for remote and very remote posts.
b. Shortening period of service . Previously, the length of service for PTT was ranging from 3 years in non-remote areas to 2 years in remote and very remote areas. The length of service was then shortened, 1 year for remote areas and 6 months for very remote areas.
c. General Practitioners in very remote areas supposedly had a 90% chance of getting into the PNS after completion of their service; General Practitioners in remote areas had a 50 % chance while those serving in ordinary areas had only 10%.

Table 4 (in the Annex) demonstrates the evolution of these policy changes, with the most recent being to increase the period of rural service back to 2 years. While these programs have provided new graduates to rural areas, in most cases the graduates return to urban and central areas of Indonesia once their period of compulsory work is completed. This results in a continual rotation of junior doctors which does little to strengthen the quality of services provided in rural areas.

In 2001, under decentralization, local governments were encouraged to recruit, appoint and pay PTT staff out of local resources, while the central government would continue to recruit PTT doctors for deployment in remote and very remote areas. Local governments could determine and offer

local incentives to attract doctors but, in practice, due to fiscal constraints, very few local governments recruited local PTTs to staff

The MoH has also tried to limit engagement of public sector doctors in private sector work (usually referred to as 'dual practice'), using limits on the number of licensed locations of practice. Doctors are supposed to obtain a licence to practice for each location of their practice, with a limit of three in the total number of locations. However, this policy is administered locally (licences are provided by the district health office), and appears to be frequently ignored (Meliala, Hort, Trisnantoro, 2013).

By 2010 there were 61 medical schools operating in the country (27 public and 34 private) with nearly 30,000 students enrolled. This total represents a substantial increase since 2001, mainly due to the increasing number of private medical schools, and should address the shortage of general practitioners. However, the capacity to provide specialist training is much more limited, and the gap in specialist doctors will take longer to address. The new law on Medical Education will require accreditation of medical education facilities, which may slow the growth of new facilities, but should improve the quality of the graduates.

In 2006, MoH set increased access to specialist services as a priority target for the health sector, with scholarships for up to 7 thousand specialist candidates by 2010.

Analysis of the Problem and Identification of Potential Strategies

(1) Is this a problem of workforce numbers, distribution, quality or performance – or more?

The unbalanced distribution of health personnel between and within countries is a worldwide, longstanding and serious problem. All countries, rich and poor, report a higher proportion of health personnel in urban and wealthier areas. (Dussault and Franceschini, 2006)

The literature suggests that geographical distribution cannot be dealt with in isolation, and the need to avoid fragmented, uncoordinated and sometimes inconsistent strategies. What is needed is a be mutlifaceted, integrated and coordinated approach

Dussault and Franceschini suggest there are two main approaches: economic and normative

Economic: distribution is a function of the health care labour market. Imbalances represent disequilibrium between supply and demand. As wages increase, distribution will improve. The key strategy is to establish a competitive labour market.

Normative: distribution of workforce is planned and managed, based on a comparison of staff densities with agreed norms. Variation from norms represent imbalances. This approach depends on the definition of health care staff and norms. It is based on ratios of staff to population but doesn't take into account productivity of staff or population needs.

The roadmap seems to adopt the economic approach, by emphasizing the principle of 'any willing provider' should be allowed to provide services as part of the national system (without discrimination

of public or private); and suggesting that a re-distribution of workforce and facilities will occur 'naturally' (*secara alamiah* – p 96), through the payment of an economic price for services throughout Indonesia.

However, current policy approaches are based on the normative approach, and do not appear to have taken into consideration other aspects of the problem such as:

- the role and mix of services to be provided in Puskesmas and hospitals in different regions;
- how public services might interact with private services in areas where there are many private providers;
- the role of different workforce within the Puskesmas and the potential for task shifting, particularly including the neglected support workforce, and the (often considerable) 'honorary' workers.

(2) Where is the responsibility for managing this problem?

In addressing this problem, it is also important to refer back to the role and responsibilities of different levels of the health system, as set out in PP38/2007.

According to this regulation, the role of the Central level is: (a) management of strategic health workforce ; (b) national scale workforce strengthening; (c) supervision and monitoring of national scale training and medical education; (d) registration, accreditation and certification at a national scale; (e) provision of licences to foreign health care providers.

The role of the Province is : (a) placement of strategic workforce, and the transfer of specific workforce between districts/cities within a province; (b) provincial scale workforce strengthening; (c) training of workforce at provincial scale; (d) registration, accreditation and certification at a provincial level; (e) recommendation for licencing of foreign health care providers.

While the role of the district is : (a) making use of strategic health workforce; (b) strengthening health workforce at a district level; (c) training at a district level; (d) registration, accreditation and certification at a district level; (e) provision of licences to specified workforce.

Yet policy making has so far been largely confined to the central level, and there has been little effort to engage province and district levels of government in actively managing or addressing the issue. PP 38 also devolves responsibility for the management of provision of basic and referral level services in the district to district levels of government.

While the central level has responsibility for management of provision of services in border, remote, high risk and island areas , its responsibility otherwise is to provide guidance and supervision for province and district level service provision.

Policy Options

(1) Central Level

- Focus on strategies to address critical service areas such as the border, remote, high risk areas noted above, through direct provision of contracted staff on rotation.

- Define 'strategic workforce' with a focus on facility managers, and build the role and capacity of health facility managers.
- Provide guidance to province and district on more flexible interpretation of service delivery models, and adaptation of service delivery models to population health needs, community demands, availability of the private sector, and specific roles for the Puskesmas.
- Provide overall regulation and direction to the health workforce 'market' through planning of workforce education, licensing requirements, and access to specialist training.

(2) Provincial Level

- Take a more active role in managing the distribution of workforce among districts within the province to ensure critical workforce available, with potential for rotation between provincial level and district level facilities.
- Examine appropriate incentives to encourage workforce to locate in rural and remote areas within the province.

(3) District Level

- Review and define the role of Puskesmas in different areas of the district, the mix of services to be provided and the workforce requirements.
- Manage the placement of workforce among the different health facilities to ensure the most effective use of available workforce.
- Examine appropriate incentives to encourage workforce to locate in rural and remote areas within the district.

Need for Further Research

A number of policy decisions are being made with limited understanding of the perceptions, expectations and attitudes of the workforce. International experience stresses the importance of adequate research as the basis for policy decisions, and to monitor the impact of policy changes. In the Indonesian context, there is a need for more understanding of the preferences of new entrants to the workforce (particularly in regard to rural postings); the experiences and preferences of those completing initial rural postings; and the experience of workforce following introduction of social health insurance.

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Annex

Table 4:
Evolution of Policy in regard to Rural Service for new Contract Doctors (PTT)

	1992-2001	2002-2004	2005	2006	2007
Legal basis	Keppres 37/1991 Kepmenkes 08/1992	UU No 32/1992 Keppres 37/1991 Kepmenkes 1540/2002	UU No 23/1992 Keppres 37/1991 Kepmenkes 1540/2002	Kepmenkes 132/2006 Kepmenkes 312/2006	Kepmenkes 508/2007
Workforce policy	Zero growth of public service as background Compulsory rural service for new contract doctors (PTT) Appointment based on position in queue Appointment for 3 periods of one year Province determines district of appointment	Voluntary rural service for new contract doctors (PTT) 3 choices: postpone; period of service, other means Open and closed provinces determined Appointment based on position in queue, but available to view on internet (transparent) Appointment for 3 periods of one year Province determines district of appointment	All provinces declared open again Appointment based on ranking and scores (marks, year of graduation, location of home) Province determines district of appointment	Duration of appointment varies with rural and remote locations Incentives for doctors and midwives who agree to be placed in very remote areas Criteria and location of appointment determined by MoH Personnel bureau	Voluntary rural service Priority for remote and very remote areas For normal areas, use of permanent civil servants or extension of contracted staff from centre Incentives for agreement to work in very remote areas Appointment directly to district / city based on criteria. Duration of appointment in remote areas: 2007: 1 yr 6 months 2011: 1 yr 2013: 2 yrs
Problems	Queues for preferred provinces Issue of human rights Delays in receipt of salary	Districts unable to recruit and appoint directly so their needs not fulfilled	After arriving at the province of appointment, doctors unwilling to be placed in remote districts.	Criteria for placement not in accordance with the relevant letter of appointment (SK)	

#19 POLICY NOTES

Closing the Gap
The Global Experience Providing Health Insurance Coverage for Informal Sector Workers[85]

November 2013 [86]

Contents

[85] This is Policy Note 19, written for the BPJS teams by Anna Monfert, GiZ, Annette Martin, Joint Learning Network, and Jack Langenbrunner, under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. This paper was written for the Informal Sector Conference in Yogjakarta September 29-October 2, 2103. For copies of other, earlier Policy Notes, please contact Jack Langenbrunner at John_Langenbrunner@aiphss.org.

[86] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances may have changed, though the authors are aware of no policy changes nor new evidence since the writing of the Policy Note.

I. Introduction and Objectives

In 2004 Indonesia adopted a social security law with the objective of creating a social security system covering all Indonesian workers in both the formal and informal sectors and their dependents under five different benefit programs. Indonesia faces the "missing middle" problem: whereas enrollment rates are high among low-income and high-income groups (the former being covered through government-financed health insurance and the latter primarily under employer-based insurance schemes), the law stipulates that the government will not pay the contributions for the non-poor within the informal sector. The law does not state whether this applies to the central government only, or to the provincial governments as well. In order to reach their 2019 target of universal coverage, the Indonesian government and its newly-integrating social insurance system needs to develop a strategic plan to extend coverage to its sizable informal sector.

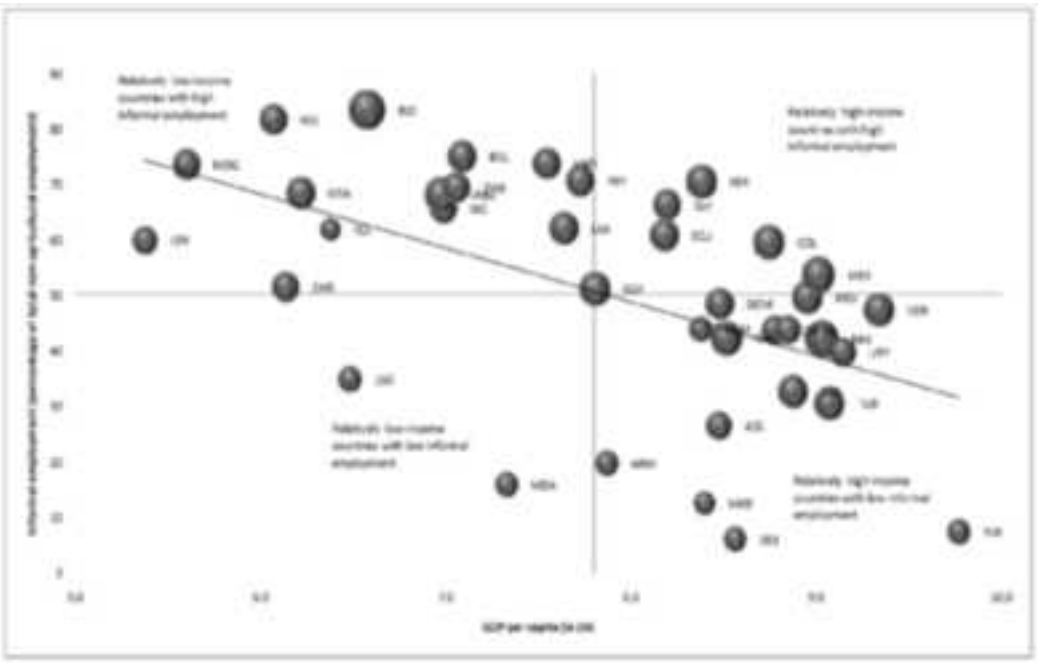
The first issue is to clearly define the informal sector to be able to target it effectively. The Indonesian Central Bureau of Statistics (BPS) adopted the definition of the informal sector developed by the International Conference of Labour Statisticians (ICLS, 2003) as the "total employment in the informal economy relates to the sum of persons who in their main job were employed either in the informal sector or were in informal employment". Informal sector enterprises consists of units that are unincorporated (i.e., not constituted as separate legal entities of their owners), produce goods or services for sale or barter, and satisfy a number of criteria, for example, they are unregistered, small, have unregistered employees and/or they do not maintain a complete set of accounts. It is estimated that 13% of informal workers are poor, and as such, many are currently targeted by the national Jamkesmas health insurance program for the poor and the supplemental local government Jamkesda insurance schemes. Non-waged workers in Indonesia make up the vast majority of the working population (15+ years of age). In 2012, the proportion of non-waged workers was around 60% (66.6 million) of the active labor force, which was slightly lower than 2011 (62.% or 68.2 million). In comparison, workers in the formal sector (including private sector, civil servants and members of the armed forces) consisted of 40% (44.2 million) of the population in 2012 and 38% (41.5 million) in 2011.

Globally, the informal sector has been defined in various ways. The definition adopted by the International Labour Office (ILO) in 1993 (Fifteenth International Conference of Labour Statisticians) states that the informal sector is composed of entities engaged in the production of goods or services with the main objective of generating employment and income. These entities tend to operate at a low level of organization, with little or no division between labor and capital, and on

a small scale. Labor relations are based mostly on casual employment, kinship, or personal and social relations, not on contractual arrangements with formal guarantees.[87]

Globally, there is a negative statistical relationship between GDP per capita and the proportion of the labor force in informal employment (International Labour Office, 2011): richer countries tend to have a smaller proportion of informality than poorer ones, suggesting that over the long term, as countries become richer, their informal employment will fall (see Figure 1). Yet this trend has been questioned lately as informality, especially in the Eastern Asia Pacific, has proven to be more persistent than predicted (BPS - Statistics Indonesia & Asian Development Bank, 2011). Over the next few decades, most developing countries will continue to have a large informal sector and the associated problem of limited ability to raise public revenue from income- and labor-related taxes.[88]

Figure 1 Informal employment and GDP per capita in 38 countries



Source: International Labour Office 2011, as cited in Bitrán 2013.

[87] According to the ILO, informal sector production units have the following characteristic features of household enterprises: (a) fixed and other assets used do not belong to the production units but to their owners; (b) units cannot engage in transactions or contracts with other units, nor incur liabilities, on their own behalf; (c) owners must raise needed financing at own risk and are personally liable, without limit, for any debts; (d) expenditure for production is often indistinguishable from household expenditure; and (e) capital goods (buildings, vehicles, and so forth) may be used indistinguishably for business and household purposes.

[88] The existence of an informal sector limits the local tax authority's ability to collect revenue. Cobham estimated that developing countries' tax revenue foregone from the informal economy, including both corporate income taxes from unregistered firms and personal income taxes from informal employment, amounted annually to about US$285 billion, representing 31percent of all potential tax revenue in developing countries (Cobham 2005; GTZ 2010). Informal sector entities do not necessarily function deliberately to evade payment of taxes or social security contributions, or infringe on labor or other legislation or administrative provisions. Informal sector activities should be distinguished from the concept of activities of the hidden or underground economy.

Since Jamkesmas already targets poor informal sector workers in Indonesia, the focus of this paper is on non-poor informal workers, i.e., those not currently eligible for tax-funded health insurance coverage. The Government of Indonesia (GoI) is currently discussing how to identify and enroll the non-poor informal sector, whether through premiums alone, additional general revenue subsidies, or some mix of each. This paper contributes to the discussion by synthesizing the global evidence and succinctly summarizing how other countries have attempted to cover the non-poor informal sector in their quest for universal health coverage.

While different approaches to tackle this complex issue have been implemented globally, successfully reaching the informal sector remains a challenge in many countries. The most common problems encountered in providing health insurance for the informal sector include low enrollment rates, difficulties with payment collection and re-enrollment, and adverse selection (Van der Gaag and Stimac, 2012). Despite these challenges, there are success stories. The global experience can serve as a source of best practices and contribute lessons on remaining challenges as Indonesia considers its options within the context of its own national experience.

II. Options for Financing the Informal Sector

There are two basic approaches to mobilize the necessary resources to provide health insurance for informal sector workers. A country can: (1) Extend non-contributory general tax financing from the poor to the informal sector, and indeed, to the rest of the population ("squeezed bottom-up"); or (2) Extend contributory schemes from the formal to the informal sector ("squeezed top-down") (Tangcharoensathien et al., 2011). There is no strict dichotomy between these financing mechanisms. There is a "third-way" as well: financing the health care system through a mix of contributions and tax-based subsidies[89] (Kwon, 2011), which is increasingly happening in the world today (see, for example, Kutzin, Cashin and Jakab, 2010; Langenbrunner and Somanathan, 2011). The decision to finance according to one of these three approaches is typically country-specific and can reflect political, economic, or cultural factors, or some mix. When a country like Indonesia debates the optimum approach, an initial issue to evaluate is whether it is more cost-effective (from an administrative perspective) to develop a premium collection infrastructure, or whether it is better to fully subsidize the non-poor informal workforce as well.[90] The next two sections discuss the arguments for and against contribution collection from the informal sector within a national Social Health Insurance framework[91].

a. Non-contributory General Tax-based Financing

One way to cover the informal sector is to link coverage with citizenship or national residence and to enroll the whole (as opposed to only the poor) informal population with payment from general government revenues. Covering the informal sector through an extension of non-contributory general tax-based funding can prove to be more cost-effective than establishing a distinct contribution mechanism that reflects willingness and capacity to pay of the different informal

[89] For example, there is partial subsidization in Mali and the United States to attract those not covered through employment to enroll and pay premiums for the balance of costs.

[90] Arguably, this is too simplistic, and many other questions may be asked in a country depending upon the context such as timing, impact on productivity, or political pressures, which this paper cannot address.

[91] i.e., it is assumed that, for formal workers, a mandatory, withholding at source, employment income-based, contribution-based system is already in place.

segments of the population. Global experience has proven it to be very cumbersome to distinguish the poor from the non-poor in the informal sector in order to assign contribution amounts.

Countries that have embarked on the path of transfers from general revenues have seen coverage rates improve significantly and relatively quickly. For example, after introducing its universal coverage scheme (UCS)[92], Thailand saw coverage climb to nearly 100 percent. Financing the UCS through general tax revenues was a pragmatic approach given that the politically motivated Thai government sought to expand coverage as quickly as possible. Covering the 30% formerly uncovered population — mostly informal workers — via a distinct membership contribution would not have been feasible at the same speed (Li et al., 2011; Tangcharoensathien et al., 2011). Apart from the benefit of rapid extension to the informal sector, tax-based financing (if based on income or asset-based tax) is advantageous in that it can be more progressive than social health insurance, as the contribution for social health insurance usually is either proportional to current income subject to a cap or a flat rate (Kwon, 2009).[93] Other countries, such as China, Hungary, Moldova, and others, have reverted to a greater reliance over time to use of general revenues to cover the informal sectors (Wagstaff et al, 2009; Kutzin, Cashin, and Jakab, 2010).

There are, however, important limitations to the sole reliance on a tax-financing approach. First, if implemented without introducing new tax revenues, this approach incurs immediate budgetary impact, reduces a government's overall fiscal space across all sectors, and could threaten fiscal discipline. This approach creates an ongoing -- and too often growing -- dependence on Ministry of Finance allocations, which could jeopardize financial sustainability. Indeed, Thailand which is a model for rigorous expenditure management also faces the challenge of long-term funding, especially considering that its population is both aging and demanding better and more health care (Tangcharoensathien et al., 2011). The National Health Security Office in Thailand is struggling with additional cost recovery mechanisms as each year lower budgets per capita get approved (Hanvoravongchai and Hsiao, 2007). South Korea and The Philippines are addressing these issues through "sin taxes." South Korea currently finances 3.5% of its insurance program through a tobacco tax (Jeong, 2011), and The Philippines plans to increase revenues through taxes on tobacco and alcohol sales (*Republic Act No. 10606*, 2012).

Additionally, there is evidence that tax-financing for the informal sector might actually induce an increase in informality. If health insurance for informal workers is provided at no cost or reduced cost, there is an incentive for employers and/or workers to stay informal – or to switch to informal arrangements – in order to avoid paying mandatory contributions associated with formal employment. This phenomenon was observed in several countries. In Colombia, researchers found an increase in informal employment between 2 and 4 percentage points attributable to the design of the health sector reform[94] (Bitran, 2013). A study on Thailand suggests that universal coverage increased informal sector employment by two percentage points after the reform, growing to 10 percent over the first three years (Wagstaff and Manachotphong, 2012). While more likely when informal sector coverage is fully financed through taxes, an increase in informality may also result from partial subsidization reforms where the informal sector is required to pay contributions.

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[92] The UCS is a tax-funded health insurance scheme, targeting 47 million people who were not covered by the existing Civil Servant Medical Benefit Scheme (CSMBS) or Social Security Scheme (SSS).

[93] However, in practice, the progressivity of income tax is questionable due to tax evasions in many low-income countries (Kwon, 2011).

[94] See Bitran, 2013, for more information on the design of the reform which followed an Enthoven-like managed competition model, but included subsidized premiums for the poor and non-working populations.

Further, with full or partial subsidies there can be a behavioral response from the formal sector: employers and employees can report lower payrolls, or allocate pay to tax-exempted bonus-schemes as has occurred in countries such as China, Colombia, and Iran (Wagstaff et al, 2009; Bitran, 2013; World Bank Health Sector Review Iran, 2007). Employers can also use contracting methods to sidestep contributions. Each of these approacheseffectively lower expected contributions and/or create larger pools of informality.

b. Contribution-Based Financing

If no additional resources are provided from the government budget, the expansion of health insurance coverage to the non-poor informal sector will have to be financed by contributions, either in whole or in part. Many countries subsidize the premiums to make participation more attractive and affordable to informal workers. Vietnam financed its recent coverage expansion through tax subsidies (Tangcharoensathien et al., 2011), subsidizing premiums for the near-poor at 70 percent (World Bank, 2013). China almost completely (90 percent) subsidizes premiums to farmers under the New Rural Cooperative Medical Scheme (NRCMS)[95] (Yip and Hsiao, 2008).[96] Mali subsidizes premiums at 50 percent and the United States administers subsidies on a sliding scale.

Similarly, health insurance schemes in the higher-income countries of Japan, South Korea, and Taiwan provide a partial subsidy to informal sector workers, which contributes to a smooth extension of health insurance (Kwon, 2011). Advantages to partial subsidization is that paying contributions creates a sense of participation and ownership among informal workers, empowers them in that they may demand better quality service, and disincentivizes informality as membership in the informal sector does not mean that one can avoid paying contributions.

However, extending the contributory approach to the informal sector has several significant disadvantages as well. The main problem is the difficulty to assess the real income of informal sector workers –- on the basis of which social security contributions would be deducted. Even if a flat rate premium is applied to all informal workers (see Section IVa below), the cost of identifying and enrolling as well as collecting contributions (on an ongoing basis) from informal workers can be high given the mobility and often-fluctuating incomes of this population. Additionally, revenue collection for social health insurance can be constrained and fall below estimates and expectations (Kutzin, Cashin, and Jakab, 2010). The subsequent sections below describe how different countries have proceeded in tackling these issues associated with a contribution-based system.

[95] The NRCMS is a "voluntary" health insurance program for rural residents piloted during 2003-05 and rolled out between 2006 and 2013.

[96] Partly due to the high subsidization of NRCMS, coverage for rural residents increased from 13 to 19 percent between 2003 and 2008 (Barber and Yao, 2010).

III. Identification/Targeting Mechanism and Enrollment Procedures

a. Voluntary vs. Compulsory Enrollment

The first question is whether enrollment in a contribution-based scheme should be voluntary or mandatory. Mandatory enrollment is more efficient than voluntary enrollment in order to avoid problems of adverse selection (Kwon, 2009). The question that remains is whether compulsory enrollment can be effectively enforced.

In China and Vietnam, informal sector workers can voluntarily enroll in the national health insurance schemes, whereas in Colombia they are required to enroll (Wagstaff et al. 2009). While China's NRCMS is a voluntary scheme in name, the economic incentive to enroll is strong because of high government subsidies.[97] NRCMS is matched by strong incentives of central-level funding and by specific enrollment targets to be met by local Communist Party officials that make it *de facto* a mandatory scheme (Liang and Langenbrunner, 2013).

In Thailand, voluntary expansion of coverage to informal sector workers was attempted with the voluntary health card scheme (VHCS) in 1991. A key reason the VHCS program failed was its voluntary nature, which subjected the scheme to adverse selection and system abuse[98]. Similarly in the Philippines, members enrolling through the Individual Paying Program (IPP) are mostly chronically ill and have higher utilization rates than the average beneficiary of PhilHealth, the national social insurance organization (Tangcharoensathien et al., 2011). Enrollment in the IPP is mandatory for all individuals not covered by the other programs, but due to lax enforcement the IPP has been a *de facto* voluntary scheme (PhilHealth, 2012).

On the heels of new financing for the near-poor, the Philippines is currently transitioning from voluntary enrollment to mandatory enrollment for this group (*Republic Act No. 10606*, 2012). In 1999, PhilHealth launched the Individually Paying Program (IPP) in order to extend social health insurance to all non-poor informal sector workers. Enrollment through the IPP was mandatory for all individuals not covered by the other programs, and the IPP scheme therefore became the only coverage option for the near-poor in the informal sector. From 1999 to 2012, various approaches were tried to enforce enrollment for the near-poor and the non-poor in the informal sector, such as requiring proof of PhilHealth membership to obtain and renew driving, business, and other professional licenses. Under the 2013 amendment to the health insurance law, the near-poor are eligible for coverage under the Sponsored Program.

Rwanda's Mutuelles shifted from having voluntary to mandatory enrollment in 2005-2006. Local government units are responsible for enrolling populations. The central government uses enrollment targets and financial incentives to encourage local governments to enroll populations. In order to ensure accountability, performance on achieving enrollment targets is reviewed by top-level government officials, including the President.

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[97] In 2010, the annual premium was at 120 RMB (approximately 18 USD) with 50 RMB each from central and local governments – leaving beneficiaries to contribute only 20 RMB a year (Barber and Yao, 2010).

[98] Not only did VHCS beneficiaries use health services more often than the general population, they also tended to join the program following diagnosis (pregnancy, chronic diseases, etc.). Consequently, by 2001, the program was phased out (Hanvoravongchai and Hsiao, 2007).

b. Family-Based Enrollment

One comparatively simple identification mechanism that can help extend population coverage is to require the enrollment of the whole family. This approach is often a means to avoid adverse selection by not allowing individuals with high probability of need for care to enroll. In South Korea, family-based membership contributed to rapid expansion of population coverage moving toward universal health care (Kwon, 2009). Many countries have followed South Korea's example. In the Philippines, each membership category of PhilHealth entitles the legal dependents of the principal member to standard benefits. This includes the spouse, all children below 21 years of age, as well as parents and children above the age of 21 who have physical or mental disabilities (Obermann et al., 2006). Likewise, China's NRCMS also imposes a requirement that participation in the scheme be at the household level (Wagstaff et al. 2009). In general, East Asia and Pacific countries that have successfully expanded social health insurance have typically placed a strong emphasis on family-based enrollment (World Bank, 2013).

c. Group-Based Enrollment

Group-base enrollment requires the individual to enroll in an insurance scheme on a household or community or other type of defined membership basis. The rationale for group enrollment is compelling: it is easier to administer and allows faster expansion. It reduces administrative costs and limits adverse selection if all members of a given group are enrolled. Given the nature of their work, informal sector workers may or may not be organized in groups or associations based on their occupation, but more likely be members of community-based organizations such as women's groups, self-help groups, credit and savings groups, religious groups, etc. (Mathauer et al., 2008). They can, however, be organized through their occupation, such as the case of female market sellers in Senegal and elsewhere in Africa.

There have been several attempts to tap into the potential of these groups. In Vietnam, the Vietnam Social Security (VSS) sells voluntary insurance for everyone not eligible for compulsory insurance; an important target group of this scheme is the informal sector. The VSS has focused on enrolling organized groups, including students and members of mass organizations such as farmers' and women's unions[99] (Nguyen and Knowles, 2010).

The Philippines has been successful[100] in enrolling formerly uncovered segments of the population with their use of organized groups to identify informal sector workers (Oberman et al., 2006). In 1999, PhilHealth launched the Individually Paying Program (IPP) in order to extend social health insurance to all non-poor informal sector workers[101]. In practice, the IPP was also the only coverage option for the near-poor in the informal sector. PhilHealth launched the KaSAPI Program to target organized groups, and in particular institutions that provided microfinance services[102] to the

[99] As of now, almost all of the voluntary beneficiaries are students – an indication that the VSS has yet to establish a mechanism for selling insurance to the general population including the informal sector.

[100] However, even using this approach, the non-poor informal sector workers continue to be the least covered population group with coverage at approximately 40 percent (Weber, 2009).

[101] The individual paying program (IPP) under PhilHealth is for all Filipinos who do not belong to either of these categories: (i) formally employed workers; (ii) indigents; and (iii) retirees. The individually paying members are voluntarily enrolled and have to pay 100 percent of the contribution.

[102] PhilHealth signed Memoranda of Agreement with two of the largest micro-finance institutions in the country, namely CARD – MBA (Centre for Agriculture and Rural Development – Mutual Benefit Association, Inc) and TSKI (Taytay sa Kauswagan or Bridge to Progress) (Basa, 2005).

informal sector (Weber, 2009). Providing insurance through an affordable group payment scheme, PhilHealth offered incentives to groups if they delivered a minimum of 70 percent of their eligible members into PhilHealth's IPP (Jowett and Hsiao, 2007). These schemes not only provide access to the informal sector and sensitize the population for contribution payments, but can also respond in a timely basis to local needs. Different schemes in the Philippines have experimented with flexible contribution rates and benefit packages (Oberman et al., 2006). Thus, group-based approaches can be effective outreach vehicles.

Nicaragua's Social Security Institute (INSS) also aimed to extend its health insurance program to informal sector workers using microfinance institutions (MFI) as delivery agents. Given the high rate of MFI use among informal sector workers in Nicaragua, policymakers hypothesized that it would be convenient for these workers to enroll and make contribution payments at MFIs (Thornton et al., 2010). However, it was found that there was actually a negative effect on enrollment among those assigned to the MFIs. Informal workers preferred to enroll in the insurance directly with INSS rather than through MFIs due to its perception as a more stable institution focused on insurance provision. There was also lack of clarity around the purpose of the MFI as an agent for the insurance[103].

d. Convenient Enrollment

The Nicaragua study also points to the importance of convenience in terms of time and proximity. If the (perceived) costs of enrolling and paying contributions due to time and travel are too high, potentially interested beneficiaries will be deterred from signing up. Qualitative data indicated a strong preference for a more direct and convenient registration process. Time constraints were cited as an important reason for not enrolling in the insurance, even when it was subsidized (Thornton et al., 2010). Convenient enrollment can remove this barrier to signing up: it eliminates beneficiaries' travel costs and reduces time costs associated with taking photographs and making copies of ID cards[104]. Providing potential new clients the convenience of signing up for insurance directly from their market stall had a large effect on enrollment rates in the Nicaragua study (Thornton et al., 2010).

In China, local Party officials often go door-to-door to sign up households and explain the benefits of the new coverage (Liang and Langenbrunner, 2013). In India, under the new public-private RSBY scheme, private insurance organizations are assigned geographic areas to target by going into the community to sign up beneficiaries (LaForgia and Nagpal, 2012).

The Philippines is piloting a point-of-service electronic enrollment system in six public hospitals. The pilots of the Onsite Rapid Enrollment Program (ORE) began in April 2013 and have shown promising initial results; more than 1000 eligible members have been enrolled into PhilHealth's Sponsored Program across the six pilots as of June 2013.

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[103] Additionally, coordination problems between central MFI management and MFI branches about the enrollment process seemed to have discouraged enrollment (Thornton et al., 2010).

[104] Individuals enrolling, for insurance, at either the INSS central office or at an MFI were required to provide photocopies of their government identification cards, two passport size photos, and birth certificates of all beneficiaries. They also had to complete a registration form and then travel to the INSS or MFI office and wait in line to register in person. According to a survey, this process took about one day's time, a substantial cost for small business owners who would need to find someone to watch their market booth or forego a day's revenue (Thornton et al., 2010).

In Indonesia, several banks have recently developed an agreement with the new BPJS to allow for premium payments through existing accounts.

e. Single Identity Number

A common identification problem is the lack of reliable and systematic population data. Introducing a single identity number has not only improved enrollment outcomes but also administrative efficiency in different countries.

The importance of enrollment records is exemplified by the experience in Thailand. The country achieved universal coverage through three different health insurance programs: the Social Security Scheme (SSS) for private formal sector employees, the Civil Service Medical Benefit Scheme (CSMBS) for government employees, retirees and their dependents, and the universal coverage program that covers the remainder of the population. The third program was the last to be implemented and faced several challenges. The government struggled to identify those who were uninsured as there was no database for CSMBS beneficiaries. In response, it created a comprehensive information system since 2002 using a government registration database to avoid the duplication of health insurance benefits across different population groups. More than 50 million beneficiary records were created (Hanvoravongchai and Hsiao, 2007). To date, the centralized database covers the entire Thai population and is updated twice a month (ILO, 2013).

In China, everyone has a unique social security or enrollment scheme number. Each person or family (depending upon the scheme) has computerized enrollment records for providers. Many areas are now issuing ID cards to validate enrollment, with some areas doing it as a public-private partnership with local banks (Liang and Langenbrunner, 2013). In the Philippines, members are assigned a permanent and unique PhilHealth Identification Number, or PIN. An individual member data record is established for each enrollee and cards are given to member containing their PIN (Basa, 2005).

IV. Contribution Design

In contribution design, a key issue relates to whether to require a single payment for all or income-related contribution – contribution based on the capacity to pay.

a. Income-related Contribution

The informal sector is very heterogeneous and comprises various income groups. Better-off income groups are able to pay higher contributions than lower-income groups. For example, the fixed annual premium of PhilHealth's IPP is relatively inexpensive for self-employed professionals, but prohibitively expensive for many farmers and other workers in the informal economy (Obermann et al., 2006). If possible, health insurance should be segmented to reflect divergent payment capacities across population groups (Pauly, 2008). This requires some kind of assessment of income or assets to determine the capacity to pay.

Because reliable information about the incomes of the self-employed was only partially available, South Korea based its contribution formula for the self-employed on both income and assets. The income contribution is based either on taxed income (for those whose annual income is over 5,000

USD) or on estimated income (for those whose income is below 5,000 USD) (Kwon, 2009). The asset contribution is measured by ownership of property such as a house or vehicle (Kwon, 2009). The South Korean case demonstrates that social health insurance can use an income- or asset-related contribution formula for the self-employed.

Rwanda is implementing a stratified premium system for its Mutuelles to shift to a more equitable premium contribution system. Members previously paid a flat contribution of 1000 Rwandan Francs, which was paid by the head of the household on behalf of all family members. Under the new contribution system, the state subsidizes contributions (3000 FRW) for the poorest populations. Other members pay 2000 FRW, 5000 FRW, or 7000 FRW based on their income level.

At a more macro-level, the social health insurer can try to incrementally segment the informal sector by occupation types for the purpose of differentiating premiums (Kwon, 2009). Differentiation of contribution collection can also be based on group characteristics (Mathauer et al., 2008), or vary according to geographic location. In Vietnam, premium rates for the VHI range from $3 USD in rural areas to $21 USD in urban areas (Ekman et al., 2008). However, there is an important trade-off in differentiating premiums, whether by income or asset assessments or by groups as the determination of capacity to pay are cumbersome, may require good data and analysis over time, and/or may lead to high adminstrative costs or corruption similar to other aspects of tax collection policies and practices. Therefore, when large numbers of the population work in the informal sector, a flat premium contribution may be more feasible –- at least to start -- as is the case for China's NRCMS and the Philippines' IPP.

b. Benefits Package and Willingness to Pay

The willingness to pay for health insurance is not only related to the size of the contribution, but also to the benefit package that will be offered to informal sector workers. Insurance scheme design features, particularly the benefit package, influence people's expected utility of health insurance (Mathauer et al., 2008). It should be both attractive and affordable, otherwise take up can be expected to be low. Demand for health insurance is sensitive to premiums and features of the insurance plans, such as whether copayments are required, benefit ceilings are adopted, and comprehensive care is covered (Lofgren et al., 2008). China and South Korea, for example, started with a very limited benefit package that was expanded incrementally with time so that population coverage could be broadened more quickly than with a more generous package[105] (Jeong, 2011; Liang and Langenbrunner, 2013). Yet the limited benefits packages may have limited impact on financial risk, as experienced in China, the Philippines, and Vietnam until 2006. Rapid expansion of a limited benefits package rather than slower expansion of a more comprehensive package may also deter momentum for sustainability, evidenced by South Korea's struggles to provide a depth of coverage comparable to its OECD peers.

A related and important question is whether one uniform health package[106] should be offered to all or if benefits should vary for different population groups (Ekman et al., 2008). If multiple

[105] In South Korea even today, benefits remain comparatively low (if compared to countries of similar economic standing), but it is mainly due to high utilization of out-of-coverage services and new medical technology induced by private providers. In addition, beneficiaries of national health insurance are faced with copayments of 20 to 55 percent for outpatient care.

[106] Currently, this is the case in most countries. In Thailand, the UCS provided a comprehensive benefit package including outpatient, inpatient and preventive health services, which it is now attempting to standardize across the UCS, CSMBS, and SSS (Li et al., 2011). In Vietnam, beneficiaries of the VHI are entitled to the same benefit package with identical

packages, policymakers can target packages to willingness to pay and a greater number in the informal sector may be willing to enroll. Looking at the demand from informal sector workers in China, Baerninghausen (2007) found that "they do not value the Basic Health Insurance[107] as a mechanism to recover the relatively frequent, but small financial losses associated with common illnesses, but because it protects against the rare but large financial losses associated with catastrophic care". Likewise, in Vietnam, an alignment with the needs and wishes of the target group is recommended in order to increase demand for voluntary health insurance (Ekman et al., 2008). At the same time, multiple packages in a single payer context can create fragmentation, inequity across groups, and the burden of uncovered services falling on individuals or the public system.

V. Administrative Issues and Contribution Collection

Not only the enrollment of informal sector workers is challenging, but also the regular collection of contributions once the individuals and households have been defined and identified. Contrary to formal sector workers who automatically pay their social security contributions, informal workers need to proactively initiate payment of premiums and continue paying them over time. In order to support participation in these schemes among informal workers, contribution payment mechanisms should be as convenient as possible.

a. Flexibility of Payment Collection

Irregular and varying income flows experienced by informal sector workers complicate regular contribution collection. To accommodate informal workers' payment capacity, there needs to be flexibility in the frequency of premium payments. In fact, the flexibility of premium contributions is often more important to informal sector workers than the amount of the payment (Jowett and Hsiao, 2007). In Kenya, informal sector workers had to make upfront annual payments in order to obtain coverage under the National Hospital Insurance Fund. Focus groups with members of this population found a strong preference for more frequent and smaller contributions (Mathauer et al., 2008). More flexible collection schedules could thus help increase compliance. For the informal sector working in agriculture, the ability to pay is greatest just after harvests and least just before them. Structuring payment schedules around the agricultural cycle can address willingness and capacity to pay.

Working with partner organizations, PhilHealth sought to offer greater payment flexibility to its beneficiaries (Jowett and Hsiao, 2007). South Korea has at times informally offered waivers, but this was controversial due to concerns of moral hazard and was at times politically motivated (Kwon, 2013). However, even with a higher degree of flexibility, many informal workers are in arrears with their payments and determining eligibility for waiver requires administrative mechanisms that might not be readily available.

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exemptions as those covered by the CHI programs (Ekman et al., 2008). As to the benefit package, the Vietnamese health insurance system identifies a relatively broad and undefined benefit package that is uniform across all programs.

[107] The central government in China introduced a social health insurance scheme for urban formal sector workers in 1998 called Basic Health Insurance (BHI). Municipal governments can opt to offer voluntary participation in the BHI to informal sector workers.

b. Organized Groups

The same groups that are used to identify informal workers can be used to collect contributions. The Philippines' PhilHealth uses groups not only to identify and enroll informal workers, but also to collect contributions. The KaSAPI Program developed a tailor-made membership and contributions software application, a web-based platform to verify eligibility and conduct financial transfers online. This platform was supported by offices in multiple provinces and municipalities to respond to needs of local organized groups (KaSAPI, 2007).

c. Collaboration with other Social Security carriers

Existing contribution collection mechanisms for other social security programs can be used for the collection of health insurance premiums as well. In South Korea, the National Health Insurance Service (NHIS) collects all social insurance contributions including long-term care, pension, unemployment, and workplace injury (Kwon, 2013). Colombia successfully linked its national health insurance to the pension scheme in an effort to "reduce evasion and elusion" of payments[108] (Bitran, 2013).

d. Mobile Payments

An innovative approach to reach the informal sector is through the use of mobile money solutions, which offer a convenient mechanism to conduct or send payments using mobile phones. Since mobile phone penetration is high in most countries and offers a convenient way to reach informal sector populations, mobile money mechanisms have potential to reach informal sector populations and can serve as tools for financial inclusion for the poor and near-poor. The prime example of mobile money use in health insurance is Kenya's National Hospital Insurance Fund, which forged a partnership with M-PESA – a mobile-phone enabled money transfer and microfinancing service – to enable enrollment and premium collection through mobile telephones. PhilHealth launched a similar program for mobile payment in 2013 – BayaLoad – which allows users to pay premiums via text message (CGAP 2013).

e. Supply-side Strengthening

Informal workers may be reluctant to pay contributions if they do not feel they receive value for their money (Mathauer et al., 2008). Many countries have experienced this problem. In Cambodia, a reason for low coverage of the voluntary community-based health insurance (CBHI) schemes[109] is the low perception of health care quality in government health facilities (Bitran, 2013). Similarly, in Vietnam, informal sector workers in a randomized study received both subsidies and information

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[108] "In Colombia, the government decided to link workers' health contributions to their pension contributions in order to reduce evasion and elusion. Since pension funds are individual and not pooled, the amount of money that individuals will receive from their pension fund is proportional to the money they put in. Therefore, individuals do not have an incentive to substantially under-declare their income. In contrast, the health benefits that individuals received in the Contributory Regime were the same irrespective of their declared income. By linking pension and health payments, the Colombian government was able to reduce evasion and elusion of SHI." (Bitran, 2013)

[109] The CBHI schemes aim to cover the non-poor informal sector. They are implemented in several districts and rely exclusively on government health care providers. Currently, CBHI has shown limited success in enrollment of the informal sector, and coverage is at only 2 percent of the population.

about health benefits of enrolling in the new insurance scheme. However, those in the treatment group were no more likely to choose to enroll because the value of health insurance is not perceived as being commensurate with the cost of enrollment (Nguyen, Wagstaff, Dao, and Bales, World Bank, 2013).

To make paying contributions worthwhile, a functioning health services infrastructure needs to be in place. Improving the quality of care is essential to induce informal workers to pay contributions. Quality improvements are not limited to medical/technical quality, but also include soft factors such as waiting times and cordial treatment by administrative staff. Hence, in order to expand membership, a highly visible increase in the quality of participating clinical facilities should be part of any attempt to roll out voluntary health insurance (Van der Gaag and Stimac, 2012).

In Indonesia, a study by the ILO and PT Jamsostek (2010) revealed that 29 percent of workers in the informal sector included in the sample identified access to health insurance as a priority. The study also found 64% of workers in the informal sector were willing to provide monthly premium contribution up to Rp. 20,000, though 90 percent of informal workers failed to re-enroll, perhaps suggesting a low level of satisfaction with the quality of the services.

VI. The Challenge of Decentralization: National and Subnational Harmonization

Extension of social protection may be more difficult without the strong involvement of provincial and district governments and the harmonization of efforts on the national and subnational levels. Subnational schemes can make national schemes less effective through fragmented risk pools and create inefficiencies such as higher administrative costs, for example. Therefore, in the case of decentralized government-initiated schemes, central government regulation and leadership is needed to guarantee a certain degree of harmonization. In Indonesia, much of the financing remains decentralized with the Jamkesda and BOK mechanisms. Likewise, service provision is decentralized to the district level, requiring harmonization with central priorities.

The most notable country experience comes from China. China's NRCMS required strong guidance from the central government to fulfill the objectives of financial protection and inclusion of the low-income population as mandated in the NRCMS design. Wherever clear targets were lacking, the implementation progressed only slowly and came to a complete halt eventually (Carrin, 2002). In response, China staggered premium contributions to incentivize local governments to act. The great proportion of premiums were paid by the central government, with provincial and district governments only providing a minimal match of funds. Insurance funds are pooled locally, giving local leaders the ability to take ownership, and align funds with local needs and participation. The management of pools of funds at local levels further strengthens local interest in the performance and outreach of the health system. Specific enrollment targets are set, and local authorities are assessed on how successful they are in meeting these targets.

Yet there are benefits of improved efficiency and equity in a single (national) pooling mechanism, compared with multiple (sub-national) pooling mechanisms (Kwon, 2011). In the Philippines, the balance between economies of scale through national pooling and decentralization is a contentious and ongoing issue. Whereas national pooling of health risks would improve financial stability, better target health funds, and increase equity, some form of local independence in benefit design and modes of delivery could help to gain acceptance in the population (Obermann et al., 2006).

However, progress thus far to gain population acceptance has been hampered by money targeted for health being diverted by local government units to other sectors, as has been the case in Indonesia as well since decentralization took root across sectors.

VII. Information and Social Marketing

In their systematic review on the impact of health insurance schemes for the informal sector in low- and middle-income countries, Acharya and colleagues (2013) found that low enrollment is commonly observed for many schemes. The decision to enroll seems to be determined by perceptions, education, and cultural factors of the target population rather than factors related to health and health care (like initial health status or distance to health center). In fact, many studies have shown that informal workers lack knowledge of existing schemes and the benefits of health insurance. In Kenya, the most important factor preventing enrollment is informal workers' lack of awareness about the National Hospital Insurance Fund (Mathauer et al., 2008). Information dissemination and sensitization of informal workers is critical to influencing their willingness to pay.

Globally, there have been attempts to promote demand for insurance, mainly through radio and television awareness campaigns. Part of Thailand's rapid coverage expansion is ascribed to mass media coverage (van Lente et al., 2012). The global evidence suggests that proximity to health insurance carriers has a positive effect on beneficiary sensitization and communication. PhilHealth, for example, operates a large network of regional offices. Originally conceived as extension offices for claims processing, they now serve a wider purpose: the regional offices manage contributions, conduct marketing campaigns, and local operations research (Oberman et al., 2006). Likewise, the single payer of Korean health insurance uses local branches for enrollment and premium collection (Kwon, 2009).

In Ghana, it is common that district mutual insurance schemes organize sensitization exercises in the communities to increase enrollment (Chankova et al., 2010). For rural residents in China, media advertising has provided an incentive to enroll in the voluntary health insurance NRCMS. Reimbursement of claims for individual patients is even posted on village bulletin boards to publicize tangible monetary benefits of the health insurance program (Lilin and Langenbrunner, 2013).

To further increase the acceptability of contributions, more efforts may be needed in other countries. Nguyen et al. (2012) tested the effect of an educational video highlighting the importance of health insurance on voluntary insurance uptake, but found no significant impact of showing the videos. They hypothesized that this is due to quality issues in the Vietnamese health system, and not on the effectiveness of the social marketing approach.

In Indonesia, the Informal Economy Study (IES) (2012) conducted by Bappenas has found that the main barrier to access health protection is the lack of information about the health protection options. This prevented people from enrolling and from utilizing the services to which they are entitled. Nearly a quarter of the informal workers questioned in the IES stated that they have never heard of any of the Indonesian health protection programs. Around 38% did not know how to enroll in a health protection program. Briefly informed about health and social protection programs, non-members explicitly stated that their willingness to enroll in social protection programs would increase if they had more access to information, but also developed confidence in the benefits.

The results from Vietnam (discussed in the section on Supply-Side Strengthening) suggest this latter part is key to making effective use of more information, and that information and convenience alone in Indonesia will not be enough.

VIII. Conclusion

Different countries have attempted different approaches and combinations of approaches to expand coverage to the informal sector. The country examples illustrate why informal workers are commonly considered the "hardest-to-reach". In contribution-based systems, coverage of the informal sector remains low in most countries even if subsidies are provided. Many countries continue to struggle including Ghana, Kenya, the Philippines, and Vietnam.

This does not mean, however, that there has not been any progress in the past years. Whenever countries have introduced innovative and convenient means to overcome the challenges associated with the expansion of social health insurance to the informal sector, results have been tangible. Perhaps South Korea has demonstrated greatest success while maintaining a mostly contributory scheme. It utilized not one, but several different and innovative programs to identify and bring-in its informal sector. Arguably, South Korea is also a relatively homogenous population with a more centralized government structure, rapid economic development and smaller population overall which aided the rapid enrolment of informal workers. Other countries, such as China and Thailand, have largely or completely abandoned the contributory scheme in favour of tax financing to quickly expand coverage. In each case, there was an important political dimension that responded to call for improved services by an underserved population. China enjoyed a robust and growing economy which provided fiscal space. It also wanted to shift macroeconomic policy to a greater consumption-based model. Insurance coverage freed up individual and family savings to spend more on consumer goods (Barnett and Brooks, IMF, 2009). In Thailand, the economic collapse in the late 1990s was responded to with countercyclical fiscal policy that included spending on improved protection for a young and productive workforce.

Reliance on premium contributions by individuals and families may reflect multiple policy objectives by ministries of Finance and Health, but these may be conflicting policy objectives in the end. Population coverage and revenue collection are both desired and become twin policy objectives, but the high cost of identification and collection means that revenues overall will be lessened, or even eclipsed by administrative costs, especially if a separate revenue collection mechanism is developed with the new social insurance program. South Korea largely avoided these administrative burdens in its reliance on the existing tax collection mechanisms. But, many countries in recent years have either opted for new, separate collection systems (Kutzin, Cashin, and Jakab, 2010), or are not operating well-functioning existing tax collection mechanisms. In the future, extension of coverage for informal workers may well depend on how well countries can adopt to local circumstances, offer a variety of innovative approaches, but also manage to streamline processes of registration and contribution collection.

In addition, there should be a well-functioning system of high-quality health care that is perceived of as of value for workers and families. Finally, there may need to be a social marketing program to increase familiarity with the concept of social health insurance among informal workers and how it will work for them. Without the necessary knowledge on the importance of paying contributions and the benefits of coverage, expansion attempts are likely to fail.

Indonesia is at a crossroads: the bold decisions taken in the last couple of years have initiated a reform process at the end of which insurance coverage for all Indonesians is in reach. The issues regarding the informal sector should be addressed now to ensure that by the end of 2019 they are indeed covered. The country experiences presented in this paper – adapted to the Indonesia context – give an example of what is possible.

Indonesia, with its rapidly growing economy, probably has the fiscal space to extend coverage to the informal sector over time (see Box 1). By contrast, different ways through which workers in the informal sector could join any formal social insurance schemes, the kind of social security benefits (products) and how best premium are collected, might be feasible though are yet to be identified for Indonesia.

Box 1. Is There Fiscal Space for Health Coverage in Indonesia?

The World Bank has estimated that UHC will cost an additional $13-16 billion once implemented.[24] While the Ministry of Finance in Indonesia may not afford currently to fully subsidize every near poor and informal sector individual, it might consider a phased subsidy strategy which could match central funding with provincial level, district level and minimal family contributions, much as was successfully done in China over the last 5 years.[25] Premiums per capita would be less than $30 per capita per year according to the government's own model. Part of this phased effort might be to leverage new revenues, such as those associated with a new tobacco tax or phase-out of the fuel subsidy.

In Indonesia, over 67 percent of men over the age of 15 smoke. A quarter of Indonesian boys, age 13-15, also smoke. Cigarettes are currently the second largest household expense, after rice, and cigarettes are part of the budget in 57 percent of all households.[26] Tobacco is taxed at 38% of the price of a cigarette, far below better performers in the region such as Thailand, and the world as in the European Union and other OECD countries such as Canada and Chile. In 2014, Indonesia will increase excise taxes, but only by 8.5%.

A second option for increased revenues is the current estimated $31.8 billion per year fuel subsidy in Indonesia.[27] The fuel subsidy, while politically popular and in place for decades, is regressive, contributes to air pollution and Indonesia's souring reputation for clogged streets and perpetual traffic jams. In March of 2013, the Government announced it will begin to phase out the subsidy, which it has begun in June, though it will need to be careful in how, and how quickly, it will do it to avoid jumps in inflation in an economy that is already experiencing levels above 6 percent per year, as well as an estimated at 94 million people vulnerable to economic shocks.[28] Even allocating a mere 10% of the fuel subsidy to premiums (at Rp. 19,200 per month) would be enough to bring in roughly 110 million new enrollees at the current estimated premium per capita.

[24] Randy Fabi and Nilufar Rizki, "Indonesia's Nationwide Health Care Plan Stumbles at First Hurdle," Jakarta Globe, May 20, 2013.
[25] See, for example, Liang, L. and Langenbrunner, J. China: The Long March to Universal Health Coverage, UNICO Case Study Series, World Bank, 2013.
[26] University of Indonesia, Demographic Institute, as reported in the Demotix website, January 4, 2013.
[27] Estimates for 2012, according to World Bank, 2013.
[28] World Bank estimate, 2013, as reported in the Jakarta Post, W. Zain, "Fuel Subsidy and SBY Leadership," page 6, April 19, 2013.

However, a number of local health coverage schemes (Jamkesda) in Indonesia already cover informal workers. Different approaches are taken in different Jamkesda with some covering the entire population (therefore not specifically targeting informal workers) and some specifically addressing informal workers. Some collect contributions at a community level using cadre or community groups and some at health facilities. The period for which contributions must be paid

and how much the contributions are also varies between schemes. Within the framework of global experience, lessons might, therefore, be learned from the effectiveness, benefits and drawbacks of a range of these approaches in order to: a) make recommendations on options for including informal workers in the national scheme; and specifically b) to identify what aspects of covering informal workers for health care might still warrant piloting with an accompanying robust evaluation to provide evidence on the most cost efficient, effective, equitable and sustainable approaches to implement in national policy.

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#20 POLICY NOTES

Who Does What? Charting a Future Course for MOH in Indonesia[110]

December 2013 [111]

The Challenge

As Indonesia and its health sector moves into the last few months before full implementation of the new health insurance program under BPJS, it will be critical for the Ministry of Health to take on new leadership roles for the management of the health sector. The MOH, under the day-to-day leadership of the Sec Gen and the Pokjas, has demonstrated superb performance with the focus on BPJS and the integration of the insurance schemes over the last several months.

With the Eid holidays behind, the MOH now faces a new set of tasks to transition to a new era of leadership and management for the sector.

The global experience gives us a glimpse, a model, for what the MOH might consider in the months ahead. The global experience, espcecially in transition economies similar to Indonesia, is that countries moving to Social Health Insurance create new and relatively autonomous insurance organizations. These are often outside of any ministry, whether it be Health or Labor or Social Protection. These new organizations are reporting to a Board or Council with public and transparent audits of management of funds and responsibilities, with direct lines to higher sources such as the Ministry of Finance, the Parliament or Prime Minister or President. This has happened in countries such as Hungary, Philippines, Czech Republic, Slovenia, Slovakia, and so on. This is similar to the new governance arrangement in Indonesia.

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[111] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances may have changed such as program developments in technology assessment and quality. A new law on medical education reform is being implemented.

Globally, the Social Health Insurance organization typically takes responsibilities over several areas of concern, including:

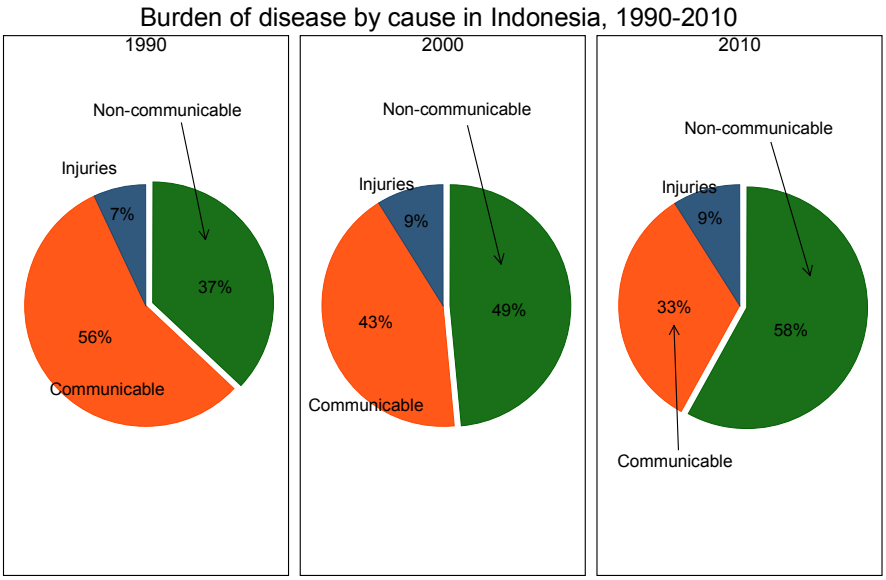
- Collection of funds (often in conjunction with the general Treasury function of funds collection as is being discussed in Indonesia);
- Pooling and management of fund;
- The Benefits Package;
- Contracts, with both public and private providers;
- Payment systems, including both capital and recurrent costs;
- Quality assurance and quality review of day-to-day services;
- Monitoring and Evaluation of the service provision program.

The MOH in other countries and in Indonesia, in the process, will be giving up some functions. At the same time, it will need to "step up" and provide leadership in other areas, some of which may be new or expanded areas of responsibility. Past January 1, 2014, the global experience would suggest MOH will focus its leadership in several areas, as outlined below.

The "New" Public Health

Public health, including areas such as safe drinking water, sanitation, epidemic surveillance and response, basic public health activities, air quality, road safety, but also encouraging better individual behavior and lifestyles in an era of increasing incidence and prevalence of non-communicable diseases (Figure 1) through consumer education, and many other issues related to public goods[112] and health status.

Figure 1



Source: IHME

[112] By "public goods" economists generally refer to goods and services which have impact on the public citizenry and not just on the individual. Immunizations, clean air or clean water are classic examples.

In particular, can the MOH finally take a leadership role on curbing tobacco products? Data from the Health Ministry showed that around 260,000 Indonesians died from tobacco-related diseases last year. About 25,000 of them were not smokers but exposed to the cigarette smoke in their surroundings.

To date, observers agree that MOH has not done enough. Among predominantly Muslim countries in the world, only Somalia and Indonesia have yet to sign the Framework Convention on Tobacco Control. Why the delay? Facts defy logic. Cigarettes are expensive for the family in Indonesia, and hurt poor Indonesians the most. Cigarettes are currently the second largest household expense, after rice, and cigarettes are part of the budget in 57% of all households' consumption, and higher for the poor.[113] Tobacco is taxed at 38% of the price of a cigarette, far below better performers in the region such as Thailand, and in other parts of the world as in the European Union and other OECD countries such as Chile and Canada. In 2014, the government will increase excise taxes, but only by 8.5%. Smoking also is expensive for the Government. The annual total cost of inpatient healthcare due to smoking for 3 major diseases in Indonesia reached at least IDR 39.5 trillion (or USD 4.03 billion). This represents about 0.74% of Indonesian GDP at the same year and 29.83% of total healthcare expenditures. The majority of these expenses were related to chronic obstructive pulmonary disease (COPD) treatment (IDR 35.1 trillion or USD 3.6 billion per year), followed by lung cancer (IDR 2.6 trillion) and ischemic disease (IDR 1.68 trillion).[114]

According to the Health Ministry's human resources development and empowerment agency head, Untung Suseno Sutarjo, more than 43 million children live with parents who smoke and as such are exposed to cigarette smoke daily at home. "These children will experience slower lung development and higher possibilities of contracting asthma, which will later hinder their performances at school. This condition will put those children and the nation's future at stake," Untung has said.[115]

Indonesia will add pictorial health warnings on tobacco products. The Indonesian Broadcasting Commission (KPI) and the National Commission on Child Protection (Komnas PA) are calling on the House of Representatives to ban cigarette advertising. The younger generation are often inappropriately targeted at cultural, music or sports events, including those broadcast on television during the day. The WHO has said that a ban on tobacco advertising and sponsorship was one of the most cost-effective ways of reducing demand. Indonesia is the ONLY country in ASEAN still allowing cigarette advertising. Recent laws have made inroads which placed tighter restrictions on tobacco advertising, but enforcement appears to be an issue.

There is also a simple solution that can generate more revenues for the government. Simply increasing the price on tobacco products has been shown to be the most effective method of cutting prevalence of tobacco use globally.[116] Raising taxes on tobacco products could be a "win-win-win" with increased revenues to the government for each pack of cigarettes sold, but over time lower smoking prevalence, and lowered health care costs with a healthier, more productive population. Last year, the government reaped Rp 79.9 trillion in cigarette tax revenues, while on

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[113] University of Indonesia, Demographic Institute, as reported in the Demotix website, January 4, 2013.

[114] Nugrahani, Y, Radjiman, D.S., Adawiyah, E., Thabrany, H., The Impact of Smoking to Annual Economic Consequences in Indonesia: Cost of Treatment of Tobacco Related Diseases in Indonesia, International Health Economics Association Conference, Sydney, Australia, July 2013.

[115] Jakarta ***Post***, October 11, 2013, page 4.

[116] See, for example, World Bank, Impacts of Health Promotion and Disease Prevention Programs, Adeyi and others, 2009.

the other hand the country saw economic losses and health costs from smoking-associated diseases of Rp. 240 trillion.[117] What could be holding the Minister back on this issue?

Pharmaceuticals

Pharmaceutical regulation, including identification and assessment of new drugs and devices and monitoring of utilization and appropriateness of existing drugs and devices, as well as pulling outmoded drugs and devices out of the health sector once outdated or found harmful to the patients and general population. Currently, new formularies are being developed for the BPJS reforms.

In the future, the Vice Minister has called for a new and expanded technology assessment process To prioritize cost-effective interventions, optimize the benefits package, and allow for dynamic updating, the BPJS will need to institute routine interactions with the MOH which in turn will need to establish processes to support policy decision making at the central and provincial levels and to implement benefit policies and medicines management at all levels, including provinces, districts and in primary care.

Technology assessment, as defined here, is useful at a macro level for purposes of planning and organization, as well as reimbursement and coverage decision making. It is useful at a meso level for monitoring of utilization and acquisition. At a micro level, it is useful for monitoring adherence to treatment guidelines, quality assurance, and quality assessment.

Box 1: Cost Challenges Related to Pharmaceuticals in Middle Income Countries

1. **Aging populations:** older patients with chronic diseases will demand more.
2. **Sense of entitlement:** both patients and prescribers will naturally have a "more is better" attitude. Another common practice for health providers is to prescribe more expensive brand name drugs even when cheaper generics would be appropriate.
3. **Industry marketing and promotion:** both patients (if exposed) and prescribers are susceptible to marketing messages and tangible promotional incentives offered by drug companies.
4. **Financial incentives (supply-side)**: Use of Fee-for-Service. If health service providers (clinics, individual physicians, health workers, pharmacists) make money proportional to the value of medicines they prescribe or sell, they will try to maximize their income by encouraging more use of medicines and preference for expensive (higher margin) products. Huge problem in China.
5. **Innovation:** once new medicines with real or perceived added benefits are on the market, there will be pressure to include them in then pharmaceutical benefit package.
6. **Price increases:** manufacturers and distributors may try to increase prices at all levels of the supply chain.
7. **Fraud and abuse**: every system that separates the user from the payer creates opportunities for fraud and corrupt practices. Examples are bribes and kickbacks to administrative decision makers with control over access to funding and to prescribers; fraudulent claims for medicines that were not dispensed; patients using someone else's card.
8. **Judicial involvement:** Patients can take legal action against their governments under "right to health" clauses in their constitution, if the payer is seen to be limiting access to costly new medicines. A growing problem in South America.

[117] Nadya Natahadibrata, "Calls for a complete ban on cigarette ads," Jakarta Post, Page 4, May 31, 2013.

At the same time, technology assessment can help generate evidence for pharmaceutical policy development related to:

- Utilization review based on data in the delivery system to assess cost, appropriateness, and quality of care;
- Pricing, of both new and existing products;
- Development of a national formulary and its continuous updating.

Currently, Indonesia reviews new drugs pre-market and post-market for safety and efficacy, as well as effectiveness. With the new BPJS to initiate in 2014, the purchaser will need to include drugs as well as devices and procedures according to safety and efficacy, as well as quality, appropriateness, and cost-effectiveness.

To support the rollout of the BPJS, the government's objectives should include a progressive development of

- Human capacity;
- Information technology, being careful to include information on drug utilization that could be lost under the new payment reforms of primary care capitation and INA-CBGs;
- Policy and monitoring; and,
- Frameworks and tools for its pharmaceutical benefit management.

The Ministry of Health envisions strengthening an existing unit within the MOH to support pharmaceutical benefit management under the BPJS and for technology assessment more generally.

Quality

Structure

The issues are many around structure and process of good quality care. Analysis of the 2011 PODES survey indicates that 96.7% of public sector primary care facilities ("Puskesmas") had electricity, 88.1% had a water-source, 87.5% had a cold-chain facility for the storage of vaccines, but only 36.4% of Puskesmas had an incubator. In addition, the recently-completed facility census (RIFASKES) estimates that 73.3% of Puskesmas in urban areas had basic emergency obstetric services, but only 53.4% of rural Puskesmas did. In terms of essential drugs, only around 60% of Puskesmas both in rural and urban areas fulfilled 60-79% availability of 83 types of essential drugs, and only around 15% that had 80% of the required drugs. Interestingly, the MOH currently has less data on the private sector, even though the private sector is growing rapidly.

Processes of Care

Quality of practice by health personnel has been a traditional issue. A 2007 survey "Riskesdas" by the government shows that the actual number of mis-diagnoses per year in the population is a very large number – 55% -- and the level of misallocation of scarce resources within the health sector is very high. This error rate would not be tolerated in any other sector of the economy. Households bear a large share of the burden in the form of out of pocket payments for things they do not or should not be paying. People buy treatments for health problems they do not have more

than half the time, and, buy treatments for the wrong health problems, which they consume but do not need. What is the cause for the mis-diagnosis, and what are the short-term and medium-term solutions?

In 2007, the degree of inaccuracy was most prevalent among cardio-vascular disease (CVD), which comprises one of the most prevalent NCDs in the Indonesian population and is a leading cause of mortality in the country. Cardio Vascular Disease (CVD) is symptomatically diagnosed accurately less than 10% of the time, and, even among the most affluent in the population only 16% of the time. Given the 2007 Riskesdas survey, it has been estimated there are about 2 million persons with cardio-vascular disease, and this error rate in diagnosis can have major repercussions in individual lives, as well as clear performance challenges for the health care delivery system. For all care, the estimate (to repeat) is about 55% of all diagnosis are inaccurate.

Although some improvements can be observed from comparisons between diagnostic vignettes from the 1997 and 2007 Indonesia Family Life Survey (IFLS), the changes are marginal and overall quality of services remains low with only around half of health workers responding correctly to standard questions and procedural vignettes. There are high rates of absenteeism, similar in some regions to countries like India, with physicians setting up private practice in the afternoon and evening hours.

Finally, there is a lack of focus on medicines use, and therefore, there is a lack of information on whether money on medicines is spent wisely, that is, on medicines that translate into health benefits, cost-effectively. Funds are thought to be wasted on overuse of antibiotics, underuse of chronic disease treatment, and especially chronic disease treatment delivered in primary care). As coverage is expanded, it is crucial that all stakeholders understand the importance of appropriate medicines use; its relationship to access to medicines and to household, and system affordability of medicines.[118]

There are already important inroads to better care. The Askes (civil servants) scheme has an IT system with detailed, patient level utilization data, and has used it to identify high-cost, inefficient care and to design, and implement at least one program in response (use of Prolanis), to shift diabetes care from hospitals to primary care by community physicians. The unified formularies are now being developed, and a new e-pharma system will make pharma prices charged more transparent.

Licensing and Accreditation

A new accreditation program is now in place for hospitals and will be extended for primary care facilities. About 70%of all hospitals have now received accreditation. Because of the public and private nature of the health delivery system in Indonesia, the accreditation process will need to move outside of the MOH in the next few years, but guidance and leadership of the institutionalization of the process will be necessary. A previous Policy Note #9 details these issues and provides some suggested next steps.

[118] Wagner, A., Harvard University, personal communication, Jakarta, Indonesia, May 23, 2013.

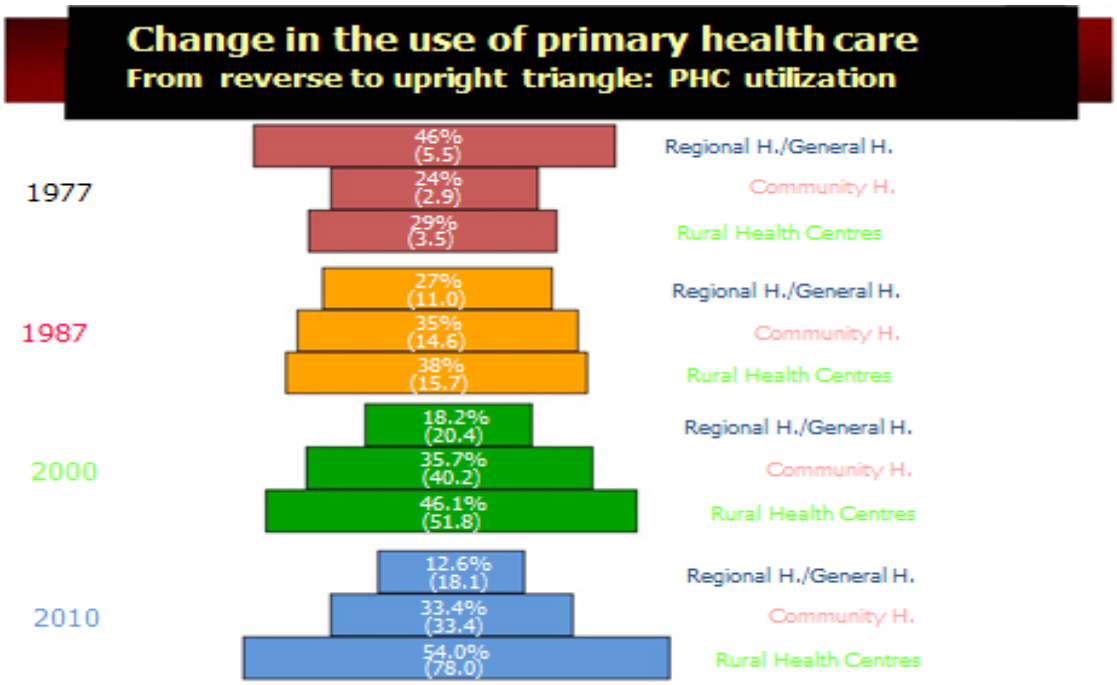
Health Education and Manpower

Indonesia faces a significant shortage in the numbers of doctors, nurses, midwives and auxiliary personnel. For doctors alone, there are huge issues related to education, curriculum, specialists training, and ongoing maldistribution. A new law has been passed on medical education reform. The MOH is not (strictly speaking) the producer, but rather user. Its responsibility is to ensure quality recruitment and in-service training opportunities. However, MOH need to move out from the previous role. A good collaboration with Ministry of Education is important for the transition period.

The MOH will need to provide leadership on curriculum modernization and finding ways to train and retain physicians for underserved areas. Some of the international evidence is that physicians trained in underserved areas are more likely to be retained in these areas once out of school.

Health Education and Manpower initiatives and reforms will be key building blocks for longer-term strengthening of primary care. While the government envisions relatively rapid scale up of primary care reforms, experience from other countries such as Thailand suggest that actually changing practice patterns may be done only over many years. Figure 2 (below) provides data on Thailand, though similar timeframes have occurred in the United States where primary care reforms initiated in the 1970s are still struggling to capture most of the utilization in the United States. How did Thailand do it? And could Indonesia move faster? If Indonesia moves at the same pace, real impacts would not be realized until the year 2043.

Figure 2:
Slow Reforms in Primary Care in Thailand Over 30 Years



Source: IHPP, MOH, Thailand, 2013

Monitoring and Evaluation

The uncertainty about the initial impacts on health, equity, quality, access, financial protection, and costs, and their evolution means that the program, given its size and national scope, presents major risks for the Government, and for the entities and participants that share the costs.

Various projections have been proposed more recently, but estimates will not control the actual impacts of the program that will vary depending on emerging experience. This happens in any -- and every -- country undergoing health reform. Some impacts go as expected, but every country encounters one or more "surprises" and "unintended consequences" as reforms are implemented. For example, in many countries, hospital admissions skyrocket. Some of this increase reflects unmet need, but in other cases admissions are driven by revenue interests of providers. In China, there was another, additional issue: the introduction of insurance failed to improve financial protection. This completely surprised policymakers, but angered families and individuals. The result: to date, the "political dividends" of providing UHC has not really been achieved in China.

Furthermore, how will it impact on the provider community, such as doctors, nurses, and midwives? Will it create challenges due to lack of socialization? Will the newly-initiated card providing "free services" overwhelm the health professionals, as it has to date in Jakarta under the JKS scheme?

To ensure management and governance of the reforms, the MOH should spearhead development of timely and accurate information. Policy makers need adequate information to make optimal decisions. The new UHC program will have to strike a balance between providing protection for basic needs, as well as unforeseen events and the resources that will need to be mobilized initially and in the longer term. The challenge for universal coverage also involves the readiness in the supply of health resources in the public sector, as well as the private sector resources that could be mobilized by appropriate coordination.

The government will need to initiate work on monitoring and evaluation that is both "horizontal" that is, across ministries at the central level, and "vertical" that is, across levels of Government from central to village. There will need to be coordination. That is, vertical coordination is different levels of government from central to provincial to district. The horizontal coordination will include development of priorities across different ministries and the government including the President who oversees the BPJS. Is not MOH the logical ministry to help identify and organize key health-related indicators?

Among its longer-term goals in MOH is, furthermore, the shift of chronic disease management to primary care settings, which will require new systems for monitoring of expenditures, utilization, and quality of prescribing at the primary care level. "Primary care sensitive" indicators such as areas of asthma, ulcers, hypertension, and diabetes need to be developed and tracked by BPJS, and its quality teams. Referrals out of primary care facilities have spiked in a number of countries such as Croatia where there were similar payment designs in place.

At the hospital level, there are 3 distinct areas of quality concern where indicators need to be developed:

1. Unnecessary admissions. In China, 51% of all admissions have been found unnecessary. In Russia, in the 1990s, it was about 40%. In the Jokowi Kard Scheme in Jakarta, physician experts suggest up to 40% of all current admissions may be unnecessary. The incentives under CBGs

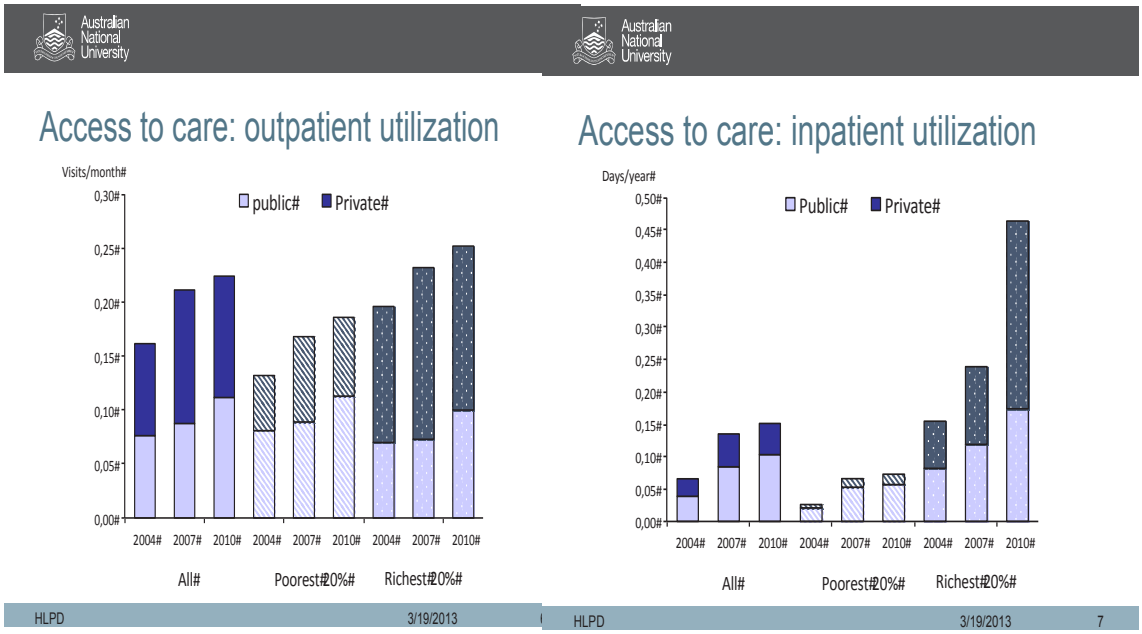
will encourage providers to admit "easy" and profitable patients rather than treating them on an outpatient basis;

2. Skimming/not doing needed services while in the hospital. Managers and hospitals now will have the incentive to skim necessary services and discharge patients early, as a way of increasing profits. Established and independent utilization review teams, contracted by BPJS, will be needed to assure established standards and guidelines are followed;
3. Re-admissions. Patients discharged early may find themselves in need of more care services, and will then be readmitted by hospitals for a second CBG payment. This doubles the revenue for hospitals at the expense of employers, employees, and the Ministry of Finance. The dramatic increase in volume of admissions and re-admissions under CBGs in other countries -- such as the United States, Germany, France, Hungary and Ghana -- has led to new policies such as penalties for readmissions, decline of payment altogether in the US for readmissions within 90 days, and volume caps for hospitals. Indonesia's leadership faces clear fiscal risk here, and must monitor volumes of admissions on a ***weekly*** basis starting January 1, 2014, similar to the leaders in the U.S. and other OECD countries. This will require some rather sophisticated and timely MIS systems.

Coordination and Regulation of Public and Private Service Delivery

There may need to be a new evolutionary delivery model in Indonesia which embraces the current public and private mix of providers and which will address the needs of the population in the years 2020, 2030, and beyond. Indonesia is currently assessing and supporting a public sector infrastructure upgrade, especially important for the rural and underserved areas. Capital investments policies will need to continue for the medium-term. Figure 3, however, shows the rapidly increasing impact of the private sector in the delivery of services, with some clear trends that the upper income groups are moving to the private sector.

Figure 3: Changing Patterns of Public and Private Utilization



Source: Robert Sparrow, Australian National University

Lippo Karawici's Siloam Hospitals plans to invest $500 million by 205 to build 20 new hospitals that cater to middle and upper-income groups, and to capture the $11.5 billion medical tourism market of Indonesians now going to nearby Singapore for care. Issues remain such as whether current law will allow the establishment of non-governmental and non-profit hospitals not subject to tax.

As Indonesia moves forward, the MOH will need to coordinate and manage this public and private mix. That means stronger regulation and tracking of performance by public and private providers.

Public providers will be given greater autonomy to:

- Respond to the new incentive structure;
- Retain residual funds, yet be accountable for revenue loss;
- Have flexibility to hire and fire personnel, to initiate contracts for public servants;
- Purchase equipment, change the organization and number of beds; and yet,
- Still serve the poor and vulnerable groups.

The MOH can lead the changes to these new autonomized organizations, and can learn from the pilots now in place in China, VietNam, Thailand, Turkey, Australia, and Western Europe on autonomized and corporatized hospitals.

Can We Learn from Germany, and other Countries?

Finally, the MOH might consider learning from other countries which have gone through similar transitions in moving health insurance into separate parts of the government Germany is one such country., In Germany, the Federal Ministry of Health is responsible for a variety of policy areas. Its activities focus predominantly on the drafting of bills, ordinances and administrative regulations. Thematically, the activities pursued by the Federal Ministry of Health can be condensed into the areas of **health, prevention** and **long-term care**. At the very core of the area 'health' lies the task of safeguarding and further developing the effectiveness of the statutory health insurance. The Federal Ministry of Health conducts prevention campaigns and initiatives such as: '3,000 Steps' (a campaign against a lack of exercise), 'Life has Weight' (campaign against eating disorders), initiatives regarding women's and children's health and the action plan to implement the HIV/AIDS control strategy. Alongside national health care policy, the tasks incumbent on the Federal Ministry of Health also include European and international health policy.

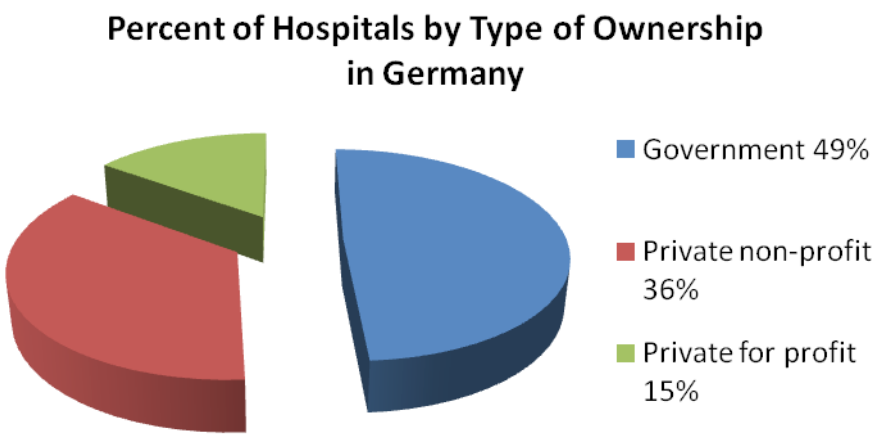
The remit of the Federal Ministry of Health includes the following institutes which are under the Ministry's technical and administrative supervision:

- *Robert Koch Institute* is responsible for the control of infectious diseases and health reporting
- *Paul Ehrlich Institute* is the Federal Institute for Vaccines and Biomedicines and tasked with the marketing authorization of particular groups of medicinal products and the approval of clinical trials
- *German Federal Institute of Medical Documentation and Information* is responsible for medical information classification and management.
- *Federal Center for Health Education* elaborates principles and guidelines concerning the content and methods of practice of health education, trains professionals in the field of health education, and coordinates health education in Germany

- *Federal Institute for Drugs and Medical Devices* is a medical regulatory body.

The German MOH further manages and coordinates and delivery sector that is mixed public and private sector, much as with Indonesia (Figure 4 below).

Figure 4:



Source: European Observatory, Brussels, 2011.

The German case suggests that the central government plays a crucial role in many activities outside of health insurance, but will continue to support and help improve health insurance as it interacts with issues of service delivery but increasingly with disease control, medical products, human behaviors, and learning from the past to improve the future health status of its citizens.

#21 POLICY NOTES

Physicians, Incentives and Rural Placement

March 2014[120]

The Challenge[121]

While the problem of inequitable distribution of healthcare professionals has existed for many years and contributes to the "gross inequality in the health status of the people particularly between developed and developing countries as well as within countries" (International Conference on Primary Health Care, 1978), there have been few successful schemes addressing the issue. The problem is compounded by the fact that the rural populations are often lower socioeconomic groups, and are subsequently at higher risk for poor health.

Asymmetrical distribution of healthcare providers exists worldwide. However, low- and middle-income nations often experience a more extreme situation than more developed counterparts. In the United States, for example, the population is 80% urban, and 91% of physicians practice in urban areas. In Thailand, however, only 34% of the population is urban yet 96% of medical doctors work in urban areas (WHO, 2011). This leaves the vast majority of the population with very few healthcare providers.

Because there are so few healthcare providers in rural areas, those that do work in these areas are often overworked and understaffed relative to the large demographic and geographic areas that they serve, making the option of working in an underserved area even less desirable to the newly graduated doctor.

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[119] Policy Note # 21 was written by Jack Langenbrunner under funding from Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program at the request of Bappenas in February 2014 to provide some relatively fast guidance on steps Indonesia might take in the near future on this issue, based on global evidence. Professor Barbara McPake and Akiko Maeda provided very useful source materials. This is not meant as a comprehensive piece, especially given the time constraints, and readers may wish to consult additional materials listed in the references section. Any and all mistakes are the responsibility of the author. For other *Policy Notes* please visit www.aiphss.org

[120] Important: this is a time-based policy note written for issues at the time of drafting. Circumstances have changed with new leadership introducing new primary care models for rural and underserved areas. The global best practices remain unchanged.

[121] This first section summarizes from "Reducing Inequities in Doctor Distribution: Literature Review, Thai Case Study and Policy Recommendations", by M.L. Kiernan, Journal of Global Health, 2013

In order to break this cycle and provide equitable access to healthcare for the vast rural population, policy strategies are needed to recruit and retain rural healthcare workers.

Thailand

Thailand has used a variety of strategies to attempt to combat the problem of skewed physician distribution. The most significant regulatory measure was taken by the Thai government in 1968, requiring all students who attend public medical schools — which are highly subsidized and comprise 11 of the 12 medical schools in Thailand — to serve the public in rural areas for three years upon graduation. Although these new physicians are still permitted to practice privately, they are encouraged not to do so. How? This was done by a special allowance of about 250 USD per month to keep them focused on the underserved, rural populations.

The government also invested funds in developing the rural health infrastructure.

Third, the Ministry of Public Health in 1994 responded to the "internal brain drain"— the exodus of physicians to the cities from other parts of the country — by introducing a 10-year project called the Collaborative Project to Increase Production of Rural Doctors (CPIRD). By recruiting 2,982 students between 1995 and 2006, the program has reached 99.4% of its admission target (Lertsukpresert, 2008). The program has graduated 1,096 students during the academic years of 2000 to 2006, with just 44 students or 1.4% dropping out.

What do they do? They recruit students at the provincial level and continue training them in regional and district hospitals. The CPIRD program has increased the proportion of rural medical students from 23% in 1994 to 31.5% in 2001 (Lertsukpresert, 2008). The program has been equally successful in terms of retention. Of the 815 graduates from 2000 to 2005, 613 (75%) are working in rural community hospitals, and 152 (19%) have been working there for more than the required three years. Only 50 (6%) graduates have broken the contract requiring them to work in rural areas, which is substantially less than the national average of 50%.

In addition to these regulatory and educational strategies, there was more:

- professional replacement strategies (task shifting, training of paramedical staff);
- financial strategies (voluntary scholarships, fines for breaking compulsory public service, direct financial incentives);
- social strategies (recognition, satisfaction, the Rural Doctor Society support network) have all been used in attempts to increase the number of physicians practicing in rural Thailand. The TMWA scholarship program combines these strategies, providing educational, financial and social support systems for aspiring rural doctors.

The TMWA Rural Scholarship Program fully funds women to attend medical school in return for a commitment to return to practice in the rural areas from which they came. The recipients are selected from the CPIRD program by the TMWA in consultation with the Rural Health Department of the Ministry of Health and Welfare. The program is less than 10 years old, and has produced 15 scholarship recipients thus far, averaging about three per year. It was developed ad hoc, in part as a response to the devastation of rural areas after the 2004 tsunami. While some recipients have already graduated and returned to work in their local rural areas, the majority of the recipients are still in medical training.

Global Evidence

The global evidence identifies three (3) main types of strategies employed to address the asymmetrical distribution of rural and urban doctors:

1) Recruiting based on student characteristics — most notably those of rural background;
2) Financial incentives — including scholarships, loan repayment and allowances; and,
3) Educational strategies — including the use of rural schools, increasing rural rotations and requiring rural health modules.

Student Characteristics

Of the studies that assessed whether rural background increased the likelihood of physicians actually practicing in rural areas, almost all studies found a positive correlation or predictive effect (seven out of eight studies). Included in this group is a rigorous systematic review examining the literature from the United States, Australia and Canada, which found a two-fold increase in the likelihood of rural practice among those of rural background in all three settings.

It is important to note, however, that some studies defined rural background as rural upbringing, and others also included those with past rural exposure (during medical training or otherwise). While both definitions of rural background were found to increase the likelihood of rural practice in various studies, the one study that examined the differences in the definitions found that only rural upbringing had a predictive effect on rural practice (Owen, Conaway, Bailey & Hayden, 2007).

Of the remaining studies on characteristics, two examined physician satisfaction, suggesting that satisfaction level amongst rural physicians may predict longevity of rural practice. The first study, from Malawi, used a quantitative survey as well as qualitative interviews and suggested that areas of particular dissatisfaction for the rural physicians surveyed included "what they perceived as unfair access to continuous education and career advancement opportunities as well as inadequate supervision". This study suggested that these issues contribute to rural physician demotivation and thoughts about leaving rural practice. The second study, which took place in the United States and also used survey data, similarly concluded, "Retention was independently associated only with physicians' satisfaction with their communities and their opportunities to achieve professional goals".

Two studies, one from the United States and one from India, examined the "temperament and traits" of rural doctors, attempting to illuminate those traits which are more common in rural versus urban doctors; these traits included "novelty seeking" and the "willingness to change or try something new" as well as an "attitude, aptitude, desire and dedication to adapt to a setup that is not as sophisticated as that in the cities".

Financial Incentives

Another common theme in global experience is the use of financial incentives to increase the number of doctors in rural areas. Incentives have been found to place large numbers of doctors in rural areas.

Types of incentives that have been used include scholarships, loan repayment and direct financial incentives or allowances. This variety of financial support has had variable levels of success. One of the main issues that arises in making comparisons between programs is that each study or setting used different monetary values, which have different implications depending on the income level in the setting.

Financial incentive programs have placed substantial numbers of health workers in underserved areas and that program participants are more likely than non-participants to work in underserved areas in the long run". But, most evaluations have been in high-income settings (all but one), and may have limited applicability to other economies such as Indonesia unless there is real capacity to offer or support such schemes.

There are also large variations in the monetary value of the incentive, which could also lead to variations in results. Many middle income countries offer bonus payments of 5-10-20% for rural work. This sometimes has been shown to be too small to retain physicians. The size of the bonus would need to be more, perhaps closely approximating the levels of pay in urban areas. Importantly, approximating pay levels must include formal plus informal payments – the "real income" of an urban physician. In Japan, rural physicians make more income or equal income to surgeons from Tokyo. This is the best example in the world of equitable payment for rural placement.

Indonesia could develop pilots or do focus groups or discrete choice experiments (DCEs) to assess how much of a bonus percentage would attract physicians to rural areas. Case studies of bonus payments from several countries are provided below.

What kind of payment model for services? Capitation or Fee for Service?

The Philippines, China, and the United States have used fee-for-service payment for rural physicians to some success for increasing access and utilization. The FFS approach may increase expenditures more than expected, however.

But FFS may not work in extremely remote areas with few patients…in Kazakhstan, physicians lost money because of too few physicians. In the case of Kazakhstan, they went back to capitation and bonus.

Educational Strategies

The final type of strategy is the use of education-based initiatives including increasing the application and admission of rural students to medical schools, establishing more rurally based schools, expansion of rural internships/rotations, introducing a required rural health module and providing more training and continuing education for those working in rural areas.

Medical schools designed specifically for rural doctors and situated in rural areas reported significantly higher percentages of their graduates working in rural areas as opposed to non-rural schools, but only one evaluation reported increasing long-term retention.

Universal Health Coverage (UHC) and Worker Remuneration and Distribution

Recently, the World Bank (2013) completed 11 case studies of countries which are moving to UHC and looked specifically at human resource policies as part of the countries efforts to achieve UHC. The countries examined some at every income level and included Japan, Indonesia, Vietnam, Thailand, Turkey, France, Ghana, Ethiopia, Peru, Brazil, and Bangladesh.

All the 11 countries are grappling with maldistribution of health workers. Countries that have had relative success in reducing rural–urban disparities have done so through (not surprisingly) multiple strategies that address health workers' career aspirations via both monetary and nonmonetary incentives, as well as improvements to working conditions and supportive supervision in health facilities. These strategies include:

- recruiting students from underserved areas;
- encouraging their enrollment through scholarships;
- setting quotas in schools;
- ensuring that curricula include rural service components; and,
- offering monetary and nonmonetary support for career development.

Compulsory service through bonding is another common policy for deployment in underserved areas.

Another important strategic approach is to invest in primary care workers, both because investments in the hospital sector tend to skew the health workforce distribution toward urban areas and because investments in these health workers have additive benefits for health outcomes. Brazil made major investments in its Family Health Strategy (ESF) and Community Health Agents Program (PACS), which contributed to achieving near universal coverage over the last decade. Turkey, too, has been successful in reducing geographic disparities, notably through its Family Medicine Program, which emphasizes primary care (see Box 1).

In 1979, Thailand faced a 21-fold difference in physician density between Bangkok and the rural Northeast regions. From 1975, and as noted above, financial incentives in the form of monthly hardship allowances were introduced for rural recruitment and retention in rural areas with a focus on primary care services, and since 1997, these allowances have been adjusted to reflect inflation and differentiated by hardship levels. By 2009 the physician density had been reduced to a 5-fold difference, and the difference in the nurse density from 18-fold to 3-fold.

Box 1: Turkey's Strategy for Reducing Regional Disparities in the Health Workforce

The Family Medicine Program explicitly encourages doctors and health workers to serve among rural populations. When family practitioners have registered patients in rural areas, health house midwives are assigned to them. In addition, periodic mobile outreach services are provided to those who live in rural areas. The monthly base payment of family medicine physicians is adjusted for the socioeconomic level of their area of practice. Family physicians working in underserved areas receive a "service credit" on a sliding scale, also linked to the socioeconomic development index of the district. In the least advantageous areas, the service credit can be as high as 40 percent of the maximum base payment. Since the introduction of the Family Medicine Program, disparities in the distribution of health personnel across the country have declined.

Enforcement of compulsory service for all public and private medical school graduates is another factor contributing to improving geographic distribution. Further, the Regulation on Appointment and Transfer ensures more balanced distribution of health care personnel across all MOH health care facilities. Under this regulation, specialists, general practitioners, dentists, and pharmacists are appointed through a computer-based lottery, and other personnel are appointed by a central examination conducted in accordance with general provisions.

Source: Turkey Country Summary Report 2013, World Bank.

Remuneration for workers at public facilities would need to be set high enough to attract competent students to become health workers, and retain them in the priority sectors (i.e., the public sector and rural/remote areas), at the same time avoiding overpayment. Remuneration of health workers is one of the key factors affecting both recruitment (attractiveness of the profession) and job satisfaction. In many low and middle income countries remuneration for public-sector health workers is low, leading to many problems in access to and quality of care. These include dual practice (health workers employed in government health facilities work in private clinics to maintain an acceptable standard of living); movement of health workers to private health care providers and abroad; and transfer of competent graduates to non-health occupations.

The globalization of the health labor market has greatly increased mobility of health workers across national borders, requiring countries to consider this broader global health labor market when formulating their health workforce policies. Emigration of health workers abroad is substantial in some countries. When Thailand had to contend with a rapidly growing private sector and strong pull from abroad, the government raised remuneration for public-sector health workers (Box 2).

Box 2: Raising the Remuneration Rate of Public Sector Health Workers in Thailand

Thailand has made good progress in expanding the health workforce to meet growing demand. Beyond increasing the production of doctors and nurses, the government raised basic salaries and introduced incentives to attract and retain health workers to counter the strong pull from growing alternative jobs in the private sector and abroad. A non-private practice incentive was introduced in 1995. A long-term service allowance was introduced in 2005 for those who had worked more than three years and for those in four southern provinces suffering from unrest.

Source: Thailand Country Summary Report 2013, World Bank

Improving Health Worker Performance for Productivity and Quality

It is essential for policy makers to understand the level and determinants of health workforce performance in order to address the shortcomings and build on its strengths. While comprehensive global evidence is lacking, partial evidence suggests that health workforce performance is far from optimal in most countries, irrespective of national income. Assessing the extent to which health workers perform well in the workplace would provide important feedback to guide education

reform as well as inform changes in the system of incentives, human resources management, and broader labor market issues.

Adequate remuneration of health workers that takes into account labor market conditions, and a system that links health worker performance to payment and is complemented by a supportive work environment, are essential for improving performance. Linking payments or other forms of incentives to health worker performance is becoming increasingly important in countries at all stages of UHC, but evidence so far is mixed on this strategy's effectiveness.

Nonmonetary incentives appear to be as important as monetary incentives, often relating to health workers' career development aspirations and working environment. Examples of nonmonetary incentives linked to job satisfaction, and so indirectly to quality of care, are:

- individualized mentoring;
- periodic performance reviews with specific feedback and development plans;
- opportunities for continuing education (including the free time needed); career structures that offer the potential for promotion to posts with additional responsibilities and rewards; and,
- verbal and other nonmonetary recognition of good performance.

High Income Countries[122]

High Income countries in this region utilize a mixed strategy as well, including bonus payments and grants. Australia and New Zealand are briefly highlighted below.

Australia

Australia provides a Rural Relocation Incentive Grant (RRIG) which aims to increase the number of GPs in rural and remote areas of Australia through the provision of relocation grants. Incentive grants are calculated according to the location GPs relocate from and relocate to, as well as their clinical workload following relocation.

Secondly, Australia provides incentive payments are scaled according to:

- location (the practice's Remoteness Area (RA) location);
- practice time (length of time medical services have been provided in rural and remote locations);
- clinical workload (number of services).

GPs are eligible for payments when they meet a qualifying period of continuous service and progress by completing active quarters in categories of eligible rural and remote locations, with varying qualifying periods which are dependent on the location.

The Practice Incentives Program (PIP) started in July 1998 in response to a series of recommendations made by the GP Strategy Review Group, appointed by the then Minister for Health and Family Services. The Group recommended a program that would move toward a "blended payment"

[122] Australia and New Zealand case studies based on case studies for the OECD in 2013 written by Cheryl Cashin, soon to be published by the OECD, Paris.

model of capitation, pay-for-performance, and fee-for-service, aimed to create incentives for practices to provide longer visits and discourage a high volume of brief consultations.

The main objective of the PIP is to encourage continuing improvements in general practice through financial incentives to support quality care, and improve access and health outcomes for patients. Practices are required to be accredited or registered for accreditation to participate in the PIP. PIP practices may be eligible for a number of incentive payments, providing a more flexible payment model that can influence both short- and long-term changes in service delivery. The program is under the umbrella of wider incentive initiatives which also comprise the Rural Incentive Program, Mental Health Nurse Incentive Program, and the GPII Scheme.

The program was designed around 13 incentive areas organized in three main streams--quality of care, capacity, rural support. Not all of the incentives are strictly related to performance, and some of them could be considered to be conditional cash transfers to practices upon implementation of certain services.

The Quality Stream incentives pay for coverage of services that comply with evidence-based guidelines, which the program treats as a proxy for outcomes. The Capacity Stream incentives give additional resources to GP practices that invest in infrastructure, such as computerization, or to expand services, such as providing after hours care or providing care in Residential Aged Care Facilities.

The Rural Support stream incentives provide additional resources (supplemental payments) to GP practices in more rural and remote settings and compensate them for bringing services to these areas that otherwise would be difficult to access for these populations, such as some more specialized surgical and obstetric procedures. The PIP has a positive effect on access and provision of care in rural areas, contributing to the reduction of rural-urban inequalities.

For some rural practices, PIP represents an important source of revenue, and the rural loading payment is an important component of the financial viability of rural practices. The supplemental payments to practices seem to have contributed to enhancing quality of care to some degree, especially for chronic conditions.

New Zealand

Throughout its evolution, primary health care in New Zealand has traditionally been funded by a partial fee-for-service payment from the government for consultations and pharmaceuticals, supplemented by substantial co-payments from patients. Despite some targeting of government subsidies to higher need populations, inequalities in access have persisted, with low-income groups and ethnic Māori populations often having higher health needs but using services at a lower rate than the rest of the population.

A new Health Strategy was introduced in 2000 with a set of 13 population health priorities and three priorities for reducing specific health inequalities included. Under the umbrella of the New Zealand Health Strategy, a separate Primary Health Care (PHC) Strategy introduced population-based approaches to address growing inequalities, with a reduction in ethic health disparities an over-arching goal of the strategy. A new organizational structure for service provision, primary health organizations (PHOs), was established to focus on the priority health areas identified in the

New Zealand Health Strategy and to address problems of access to services and a lack of coordination between providers.

A pay-for-performance program was introduced in 2006 with 10 indicators. The PHO Performance Management Program aimed to sharpen PHOs' focus on the population health and inequality priorities through supporting clinical governance and rewarding quality improvement within PHOs.

Some indicators are measured separately for "high-need populations," and are rewarded at a higher rate. The PHO's high needs population is defined by the sum of individual enrolled patients who are ethnic Māori (the indigenous population of New Zealand), Pacific Islanders or living in geographic areas with high relative socioeconomic deprivation. To strengthen the incentives to reduce health inequalities, payments for performance are weighted more heavily when measuring progress and outcomes amongst the high needs populations.

Flat-rate payments for the majority of indicators are made to PHOs for each six-month performance period based on the percentage attainment of each target. Performance payment amounts are based on the following:

- population enrolled with PHO for the performance period;
- progress toward targets for each performance indicator;
- payment amount defined in the PHO Agreement per performance period per enrolled person.

All ten performance indicators have shown some improvement since the Program was introduced in 2006, but improvements are modest. For example, average breast cancer screening rates increased from about 55 to 66 percent for the total target population between 2006 and 2009, and cervical screening coverage increased from 66 percent to 73 percent. Rates of diabetes detection and follow-up increased from 46 to 55 percent for the total population. Other initiatives also were introduced during that time, however, which also could have contributed to these improvements, including the MOH "Diabetes Care Improvement Package" to strengthen community-based diabetes care. Rates of flu vaccination remained almost flat over the period, while the greatest progress achieved was for childhood immunization, with rates increasing from under 60 percent to 87 percent. There is some progress on the objective of reducing health disparities, as a number of indicators have improved relatively more for high-need populations than for the population as a whole. But, the levels of bonus payments have been small, and less than 1% of the overall budget for primary care. In the United Kingdom, for example, these were set at 25% of primary care income.

Mixed Methods and Review Conclusions for Indonesia

Many countries have developed a strategy that approaches the problem from multiple angles and may offer the best chance of success. This includes countries on the path to Universal Health Coverage. Not all lessons are applicable. For example, in comparing Thailand and Indonesia one must remember the extreme heterogeneity in Indonesia and its differences in governance characteristics.

Nevertheless, Indonesia will probably want to do all three types of interventions, with perhaps higher payment levels and payment incentives coming first – perhaps as early as this year -- and

other strategies following over the next 3-5 years. Many doctors' placement policies in Indonesia in the past were political decisions, and policies in the future should better follow international evidence;

The WHO team in Indonesia has also recently developed some strategies for the government specific to the Indonesia context. These include:

- Don't place doctors in remote areas, instead promote regular doctors' visits from the neighbouring district as a more feasible short-term solution;
- Primary care teams -- including doctor, mid-wife nurse, and fieldworker may be more feasible than the doctor alone.

Finally, the World Bank's summary table from its recent report is included below.

Table 1: Health Worker Imbalances in Distribution, and Policies and Interventions

Country	Distributional imbalances	Policies and interventions
Bangladesh	Health professionals, paraprofessionals, and medical technologists are highly concentrated in urban areas, with severe shortages in rural and remote communities. Vacancy rates in rural public facilities are high, but lower among health field workers. There are more primary health care centers in rural areas, and more hospitals in urban areas. This leads to more demand for physicians and nurses in urban areas, and more demand for community health workers and paramedics in rural areas. Almost all training institutions are in urban areas. Most trainees are from urban areas because the required science classes are unavailable in rural schools.	Overall distribution of health workers is the responsibility of the Ministry of Health and Family Welfare, but deployment and appointments are administered by multiple units and at different governmental levels. The allocations are often subject to political influence, and do not necessarily follow policy directives. Many interventions are showing some impact in addressing shortages of health workers in rural areas, including training by nongovernmental organizations of community health workers and increases in the number of skilled birth attendants. However, scaling up these interventions would help to address these challenges, which should be done in a coordinated manner across the many entities involved in the policy design and implementation process.
Ethiopia	There is substantial regional variation in health worker density between regions. The density per 1,000 population is in the range of 0.01–0.33 for physicians, 0.003–0.06 for health officers, 0.07–1.18 for nurses, 0.01–0.08 for midwives, and 0.23–0.70 for health extension workers.	Health extension workers and health officers are recruited from rural communities, and trained in rural contexts. This has helped in deploying and retaining them. There is no specific financial incentive scheme to attract health workers to rural areas.

Country	Distributional imbalances	Policies and interventions
Ghana	Access to health workers has generally improved in recent years. However, distribution still favors urban areas, and hospitals rather than clinics. Health worker density is highest in the Greater Accra and Ashanti and Volta regions, and lowest in the North. Preservice training for physicians remains concentrated in a few urban areas, but nurse and midwife training institutions are more widely distributed.	Government measures to reduce disparities in health workforce distribution include investing in setting up training institutions for physicians in regions and districts, and offering incentive packages such as housing support, additional allowances, and career opportunities. A five-year bonding program with service commitments to high-priority areas, in exchange for preservice support, has been launched.
Indonesia	Significant geographic disparities remain in the density of health workers, with concentration in Java (except North Java), and low densities in remote provinces of Nussa Tenggara Timur, Maluku, and Papua. Large, urban hospitals attract specialists and doctors, and the high density of doctors coincides with hospital distribution. Local governments hold strong powers to regulate and influence hiring and deployment of health workers, but provincial wealth and availability of fiscal capacity is not always correlated with availability of doctors.	The central government has tried a range of policies to improve distribution, including the Health Act, which gives government the responsibility for national distribution of health workers based on standards on inputs, processes, and outputs; the Medical Act, which restricts medical doctors from working at more than three sites; and the Hospital Act, which sets standards for hospitals, including human resources. Central and local governments offer financial incentives to health workers to deploy in remote areas, but have yet to develop strategies on nonmonetary incentives.
Peru	Geographic maldistribution of health workers is significant. The density of doctors per 1,000 habitants in Lima is 0.77 but below 0.4 in most Andean and Amazon jungle regions. The disparity also holds for nurses and midwives.	The fragmentation of the governance of health workforce deployment policies and the lack of accurate information on the number and distribution of providers present major challenges in coordinating allocation of health workers.
Vietnam	There is significant maldistribution of health workers, especially in remote and mountainous areas, which worsened in 2005–10: 59 percent of medical doctors practice in urban areas, but only 27 percent of the total population is urban. Each province also has imbalances, with the lowest availability of health workers at commune level: only one-third of communes have medical doctors.	The government has issued a series of decrees to address maldistribution, including: provision of financial incentives to workers in rural areas; continuing education (24 hours/year); access to four-year medical training for assistant doctors from rural areas; incentives for access to medical training for minority groups; and short-term rotation system from higher to lower facilities. Still in early implementation, these initiatives have yet to be evaluated.

Country	Distributional imbalances	Policies and interventions
Brazil	Disparities in health worker densities have narrowed greatly through expansion of Family Medicine coverage, but recruitment and retention remains a problem, especially in the rural Northern and Northeastern states.	The Enhancement Program for Professionals in Primary Health Care (PROVAB, 2011) offers various incentives for a minimum of one year working in primary health care in areas designated as underserved by the federal government. (These incentives are monetary as well as bonus points in the examinations for admission into medical residency programs and specialization courses in family health.) Recently, given the persistence of vacant posts in remote and underserved areas, the government decided to recruit doctors trained abroad through the "Mais Medicos" (More Doctors) program. Alongside these federal initiatives, at municipal level administrators adopt different types of incentives to recruit health workers, most often by raising salaries and introducing flexible working hours.
Thailand	In 1979, there was a 21-fold difference in physician density between Bangkok and the rural Northeast regions. This was reduced to a five-fold difference by 2009. Over the same period, the gap in nurse density was cut from an 18-fold to three-fold difference.	After 1975, financial incentives (a monthly hardship allowance) were introduced for rural recruitment and retention. In 1997, rates were adjusted to reflect inflation and differentiated by levels of hardship; efforts are continuing to further reduce density disparities.
Turkey	Between 2002 and 2011, the personnel gap between the highest and lowest provinces fell: for specialists from 1:14 to 1:2.7; for general practitioners from 1:9 to 1:2.3; and for nurses and midwives from 1:8 to 1:4. In 2011, Western Anatolia had 2.6 physicians per 1,000 population; Southeastern Anatolia had the lowest density, with 1.16 physicians per 1,000 population. The Eastern Black Sea region had 1.84 times the density of nurses and midwives of Southeastern Anatolia.	Government policies narrowed the distributional imbalances. The Family Medicine Program encourages doctors and health workers to serve among rural populations; when family practitioners have registered patients in rural areas, health house midwives are assigned to them; the monthly base payment of family medicine physicians is adjusted for the area of practice; and family physicians who work in underserved areas receive a "service credit" on a sliding scale, linked to the socioeconomic development index of the district (this can be as high as 40 percent of the maximum base payment). Compulsory service is required from all public and private medical school graduates.

Country	Distributional imbalances	Policies and interventions
France	The geographic distribution of health workers is skewed to well-off regions, with a 1.55 times difference in physician density between the highest (Provence-Alpes-Côte d'Azur in the southeast) and lowest regions.	Government measures to reduce geographic disparities include increasing quotas for entrance to medical schools; offering financial incentives (taxes, allowances) for group practice in medically deprived areas; and offering Public Service Involvement Contracts to medical students with financial provision to set up practice in underserved areas. To improve effective use of human resources, particularly in areas of shortage, the government has also introduced measures to enhance multidisciplinary cooperation between MDs and paramedics at local level through skill mix and task shifting.
Japan	As measured by the ratio of physician density between the prefectures with the highest and lowest densities, from 1990 to 2010 geographic disparity in physician availability declined from 2.24 to 2.00. In 2010, the same ratio for nurses was 2.10 and for midwives, 2.00.	To reduce geographic disparities in distribution of physicians, prefectural governments pay for the tuition and living expenses for the two to three entrants to the special medical school whose graduates are obligated to work in remote areas, and award scholarships to a few entrants in their contracted medical school under similar conditions. Physicians earn higher wages in rural hospitals than in urban cities, while the wage differential is reversed for nurses. Fee schedule conditions set the same price for health services regardless of location, which allows hospitals to set wages based on labor market conditions: since physicians prefer working in urban areas, they have to be offered more. Nurses in rural settings are more willing to work at lower wages in rural areas because they tend to have closer ties with their home communities.

Source: Country summary reports on UHC, 2013, World Bank.

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#22 POLICY NOTES

Considerations for Establishing a Health Technology Assessment Process or Program

March 2014

This brief discussion sets out some of the key issues that need to be considered in relation to establishing a process for health technology assessment in Indonesia.

Definition

The World Health Organization defines Health Technology Assessment (HTA) as the 'systematic evaluation of properties, effects and/or impacts of health technologies and interventions....The approach is used to inform policy and decision-making in health care, especially on how best to allocate limited funds to health interventions and technologies. '[124]

HTA is based on a multidisciplinary approach, including clinical epidemiology, health economics, biostatistics and appropriate qualitative research methods. Depending on the policy framework for HTA in a given country, the output of an assessment can be a complex report, advice to guide health investment decisions or academic work, or combinations of these. HTA is resource intensive, requiring skills and capacity to carry out the analyses and although a useful tool, should not be seen in isolation from other polices to manage investment and coverage decisions for health care. Other types of health economic evaluation, including pharmacoeconomic evaluation, should now generally be considered as being within HTA as the fundamental techniques used are the same.

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[123] Policy Note # 22 was written by Suzanne Hill and Professor Budiono Santoso under funding from the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program at the request of Bappenas in late February 2014 to provide some relatively fast guidance on steps Indonesia might take in the near future on this issue, based on global evidence. The government has since initiated an HTA program. For other *Policy Notes* please visit www.aiphss.org

[124] WHO Executive Board Paper, EB134/30, Jan 2014.

Outputs from HTA are described as being assessment reports, rapid reviews, clinical guidelines or consolidation of reviews produced by other agencies. The approach can be carried out at national, regional or local level within a health care system.

Policy framework

The policy framework for establishing and using HTA in any country needs to be decided first, as it will determine the structure and scope of the HTA process.

Issues to consider are:

- Given the structure of the health system (centralized/decentralized/mixed) where is HTA going to be used;
- Whether HTA reports will be used as information and advice but not as key decision-making tools;
- Whether HTA will be used as part of the decision criteria for all reimbursement decisions for all technologies being provided through an insurance scheme, or selected technologies;
- How HTA will be used in relation to other expenditure control policies, for example, reference pricing for pharmaceuticals;
- Whether the HTA process is to be independent of government, for example, based in an academic unit, with an independent agenda for reports, or whether it is to be linked to government policy agendas;
- Whether HTA reports will be used as the basis for legally binding decisions or advisory only.

Historically, HTA in high-income countries most often started with a base in independent academic units, preparing assessment reports on topics of interest to the authors. Examples are the original structure of the Catalan HTA group in Spain or the NHS Health Technology Assessment Program in the UK that preceded the establishment of the National Institute for Health and Care Excellence (NICE). In the early 1990s, Australia and Canada started to use cost-effectiveness evaluation to determine funding decisions, initially for pharmaceuticals but then also for medical technologies and devices. These systems evolved structures to specifically support ministry of health decision-making as well as linking with academic centres. Decisions in Australia relate to national health insurance coverage whereas in Canada the final coverage decision is made at the provincial level. Many systems now use a mixture of approaches.

Legislation

The role of HTA needs to be supported by legislation depending on the policy framework that is adopted.

For example, initially the recommendations made by NICE were not binding on the implementing authorities at the local level; this was later altered so that Commissioning Authorities are now required to ensure that there is budget available for health technologies that NICE recommends should be used. In Australia, the National Health Act was amended in 1989 to require the consideration of cost and effectiveness by the Pharmaceutical Benefits Advisory Committee, which is the independent advisory committee that makes recommendations to the Minister of Health on what medicines should be reimbursed through the national health insurance scheme. The law allows the Minister to say no to a positive recommendation from the committee but does not allow the Minister to list a product if the committee has recommended against it.

Structure

The structure of a HTA unit should follow from the policy framework and legislation but will also depend on the human resources available. Options include

- Having an independent academic-focused unit, in a university, that prepares HTA reports to inform policy makers, but that are not the basis for coverage or subsidization decisions
- Having a HTA team or unit within the Ministry of Health, to carry out HTA on selected topics or appraise HAT reports submitted by manufacturers
- Developing a separate authority or structure to carry out HTA, such as the Canadian Agency for Drugs and Technologies in Health (CADTH) or the Health Intervention and Technology Assessment Program, (HITAP) in Thailand.

Hybrid structures are also used. For example, in Australia, the Ministry of Health has two technical teams who coordinate the HTA processes- one for pharmaceuticals and one for medical technologies, devices and diagnostics test. The reports are prepared by manufacturers (in the case of pharmaceuticals) and appraised by contracted academic groups, who provide additional reports to the Department and the advisory committees for decision-making. Structures tend to evolve over time as systems and policies change as well as depending on the availability of skills and staff.

The International Network of Agencies for Health Technology Assessment (INAHTA) and Health Technology Assessment International (HTAi) are two global networks of HTA agencies that can provide additional examples.

Scope

HTA can cover all health technologies. However, pharmaceuticals are usually the easiest group to start with as data sources are expensive and there is usually good quality evidence. Diagnostic tests, devices, medical services (such as consultations or procedures) and complex technologies are more complex and require more skill in finding and interpreting the evidence, which is also usually of lower quality. Most agencies have started with one component of HTA and then slowly expanded.

Resources, capacity and environment

As noted above, carrying out effective HTA for decision making is resource intensive.

Before starting a HTA process, it is critical to undertake an inventory of existing capacity and human resources. The scale of HTA agencies ranges from NICE – several hundred staff and many academic collaborating centres – to small new centres in the EU candidate states, which may have 1 or 2 nominal staff in a health department.

HTA is a multidisciplinary activity and the following skills are needed: clinical medicine, clinical epidemiology, health economics, biostatistics, pharmacy, information specialists. Many HTA groups/authorities struggle to maintain adequate staffing, particularly in health economics. While the number of staff required will depend on the scope of the work, experience suggests that to

have an effective team, at least 10 FTE professionals will be needed. If the HTA outputs are to form the basis of decision making, additional resources may be needed to support whatever decision-making process is set up. In Australia, the PBAC has 19 members (17 part time and 1 full time) who are mostly clinical specialist, but who also include a consumer representative, a health economist and a community pharmacist. The memberships is specified in eth National Health Act and members are appointed by the Minister for a 4 year term.The committee is supported by a secretariat within the ministry of approximately 15 full tine staff , who have a mix of pharmacy, economics, policy and administration as backgrounds.

HTA functions most effectively in an environment where evidence-based medicine is accepted and used; it can also be a tool to promote that adoption of evidence based medicine. Such a culture change generally requires time and leadership – which can be provided by effective HTA.

The European Network for Health Technology Assessment (EuNetHTA) has developed a 'handbook on HTA capacity building' that provides a useful overview based on the experience of several countries in the EU.[125]

HTA process

The actual process used for HTA varies from country to country and agency to agency, depending on the legislation, scope and resources available.

NICE, as a large and well–resourced agency, carries out its own analyses and prepares its own reports, with input from commercial sponsors and stakeholders. It selects the topics and technologies that it will assess, based on a formal political and consultative process. All of these aspects are then considered when its advisory committees (it now has several) decide on the recommendations. The time from commissioning a report to a recommendation varies from 6 months to 2 years and reports and recommendations are reviewed every 4-5 years.

Estonia, on the other hand, as a country of 1.4 million people with one academic centre, appraises HTA reports that are applications from commercial companies for reimbursement of technologies through the Estonia Health Insurance fund. It is required to comply with European Union requirements for time frames for reimbursement decisions, approximately 4 months. It assesses all applications submitted to it by commercial sponsors, and may share some of its assessment work where possible with its Baltic country neighbours, Latvia and Lithuania.

Australia, with a population of 23 million and 20 years experience in HTA, uses mostly reports from commercial sponsors, but has some capacity to commission independent reports from academic centres for its decision-making. The PBAC and the Medicare Services Advisory Committee (MSAC) assess all applications submitted to them by pharmaceutical sponsors or technology sponsors respectively. The time from submission of application to committee recommendation is approximately 4 months for PBAC matters and 6 to 12 months for MSAC matters, depending on the complexity.

[125] At http://www.inahta.org/upload/HTA_resources/eunethta_wp8_hb_hta_capacity_building1.pdf, accessed Jan 21 2014

One thing all agencies have in common is a set of local requirements for what should be in HTA reports. Although there are international standards for HTA, the application needs to be localized to take account of local data sources, values and preference and cost information.

Options for Indonesia

In the context of the implementation of universal health coverage, here is a suggested approach should Indonesia decide it wishes to invest in the development of HTA to support its health insurance program.

Legislation and policy framework

HTA appears in the Indonesian Government Regulation (PerPres) No 111 of 2013 on health security. For instance, HTA is mentioned in the passage 43 "In order to ensure quality and cost control, the MoH responsible for doing (i) health technology assessments, (ii) clinically advisory, (iii) ...." Other passage also mentioned that "complementary, alternative and traditional medicine including acupuncture, since chiropractic, which has not been declared effective by the HTA will not be covered" .

If not specified elsewhere in the legislation, consideration should be given to whether the legislation should be refined or expanded to specify exactly how HTA will contribute to the process of defining the benefits package for JKN. For example, will all items and services currently covered be subject to a new appraisal or will they be accepted initially and reviewed in stages over the next several years? What criteria will be used to determine whether an item or service is acceptable according to the HTA – a rigid cost effectiveness threshold as adopted by NICE or several factors? Will budget impact also be assessed as a criterion? Who will have the legal authority to list or de-list items and services? The Minister directly or the MOH or the HTA body?[126]

Structure

If the MOH is considering a "National Committee on HTA", the membership will need to be defined. It is essential that HTA advisory committees include independent clinical experts, health economists

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[126] As an example, the Australian National Health Act 1953 gives the PBAC the following authority, so that if the PBAC does not recommend listing a product, the Minister cannot decide to do so:

(3A) For the purpose of deciding whether to recommend to the Minister that a drug or medicinal preparation, or a class of drugs and medicinal preparations, be made available as pharmaceutical benefits under this Part, the Committee shall give consideration to the effectiveness and cost of therapy involving the use of the drug, preparation or class, including by comparing the effectiveness and cost of that therapy with that of alternative therapies, whether or not involving the use of other drugs or preparations.

(3B) Without limiting the generality of subsection (3A), where therapy involving the use of a particular drug or medicinal preparation, or a class of drugs and medicinal preparations, is substantially more costly than an alternative therapy or alternative therapies, whether or not involving the use of other drugs or preparations, the Committee: (a) shall not recommend to the Minister that the drug, preparation or class be made available as pharmaceutical benefits under this Part unless the Committee is satisfied that the first-mentioned therapy, for some patients, provides a significant improvement in efficacy or reduction of toxicity over the alternative therapy or therapies; and (b) if the Committee does recommend to the Minister that the drug, preparation or class be made available as pharmaceutical benefits under this Part, the Committee shall include in its recommendation a statement that the Committee is satisfied as mentioned in paragraph (a).

and consumer representatives. Usually HTA committees are made up of between 15 and 20 members, covering the main clinical disciplines, but including at least 2 or 3 members who have expertise in clinical epidemiology and HTA methods. Members must be independent and have no financial ties to pharmaceutical or device manufacturers. (Ideally, their immediate family members should also have no financial ties).

The roles and functions of a HTA committee will depend on what is decided about the authority to add or remove items from the Benefits package. If the Minister retains the final authority, the Committee can provide advice to the Minister, either directly, or through the Ministry of Health. There is considerable value in having a Committee that is independent of the Ministry. Other principles that will need to be considered are the degree of transparency of the operations of a HTA committee, the role of commercial sponsors, how other policies to manage cost and expenditure will be implemented by the committee (for example, reference pricing for pharmaceuticals) , and the relationship between the HTA committee and those who make procurement decisions. In Australia, the HTA committees set the price of products for inclusion on the lists of items reimbursed; NICE will commence setting prices of pharmaceuticals this year.

In the context of Indonesia's approach to health insurance, a decision will need to be made about what aspects of the system the HTA committee can cover. Technologies used in primary care may require a slightly different group of committee members and expertise to technologies used only in hospitals. However, in the first instance it is recommended that there is a single HTA committee to establish the process and standards for decision-making.

Most HTA committees that are providing advice in relation to insurance meet several times a year. NICE now has 4 appraisal committees, all of whom meet monthly. In Australia, the PBAC and MSAC each meet at least 3 times a year. However, the meetings need to be supported by an adequate structure such as a unit or secretariat within the MOH.

A decision will need to be made about the role of any supporting unit in the Ministry of Health. While it is essential that the staff of such a unit have skills and expertise relevant to HTA, it is unusual for a Ministry-based to actually carry out all of the appraisals, mainly due to workload. (As an example, the PBAC agenda for March 2104 includes 52 applications for new pharmaceutical products or variations on existing listings.[127]) Partnerships and linkages with academic centres will be needed to support the technical work.

Scope of work and processes

Mature HTA authorities around the world have all evolved over time; it is extremely challenging to implement a HTA process that covers all technologies and all possible HTA products from the outset. We strongly recommend implementing HTA in a stepwise process. Pharmaceuticals are the easiest place to start; there are data, many published assessments that can be used and adapted for local needs, and as they account for at least 30% of expenditure, appropriate management of the cost of pharmaceuticals will make a substantial difference to the sustainability and affordability of the insurance scheme.

The process for HTA chosen will depend on the availability of skills and capacity, and therefore there needs to be an inventory of

[127] See: http://pbs.gov.au/info/industry/listing/elements/pbac-meetings/agenda/03-2014

- Which academic centres currently have relevant capacity and skills?
- Are there links between the MOH and these centres?
- Policies for reducing and managing conflicts of interest, financial and academic.

Initially, the HTA Committee will need to establish guidelines for the information it needs to review. There are many international models that could be adapted, but the first version should be simple and not allow for complex economic modelling as this require high level capacity to evaluate and critically appraise. The Government of Indonesia may want to seek advice from a number of established HTA agencies as to the best approach to establish its own guidelines.

The HTA committee could also:

- Evaluate utilization data for consumption and expenditure, utilization reviews, Pareto analysis, feedback into selection and pricing decisions
- Develop EBM capacity for assessing clinical evidence, developing evidence based clinical guidelines through links with the Cochrane Collaboration, Guidelines International Network and others

The preconditions for success are:

- Political will and support
- Information technology
- Inventory of national academic capacity, identification of experts
- links with relevant organizations (Cochrane, GIN, HTAi, etc)
- Links with other agencies – for example, regionally Thailand, Philippines, Australia, Singapore, South Korea.

Funding and resources

The funding and resources required will depend on many of the decisions noted above. However, as a guide, a minimum estimate might include:

- Funding for 20 full time health professional staff within the Ministry
- Support for capacity development and training
- Support for access to electronic resources (such as the Cochrane Library and other databases) and international networks, such as HTAi
- Support for engagement of academic groups, for example through contractual arrangements to prepare HTA reports
- Funding as appropriate to engage the experts who are on the Committee (this will depend on what is currently accepted locally; for example, NICE pays expenses for its committee members but no fees; Australia pays part-salaries for its committee members).

A critical component is training for committee members. Experience suggests that for new committees it takes time to establish methods of working efficiently and consistently. There are models of training approaches that could be adopted, from WHO in collaboration with Australian and UK academic groups (most recently in the Philippines and Brunei) or NICE International (for example China and Colombia), depending on the scope of activities that will be carried out by the Committee.

#23 POLICY NOTES

Republic of Korea ("South Korea")[128]

Extending Health Coverage to the Informal Sector

June 2014

Country Context	
Population (Millions) (2012)	50.0
Share of National Population in Informal Sector (2011)	28.2%
GDP per Capita (Current USD) (2012)	$22,590
Share of National Population Covered by Insurance (Public and Private) (2011)	100%
Out-of-Pocket Expenditure on Health (as Percent of Total Expenditure on Health) (2012)	36.1%
Life Expectancy at Birth (2012)	81
Under-5 Mortality Rate per 1,000 Live Births (2012)	4

Sources: OECD, 2013; World Bank, 2013

Policy Context	
1976	Medical Insurance Act is passed requiring mandatory insurance coverage
1977	Medical Insurance Act is implemented and social health insurance (SHI) is introduced to employees of large businesses (500+ employees); Medical Aid Program (MAP) is launched for the very poor
1979	SHI is extended to employees of businesses with 300+ employees; SHI is extended to government employees and teachers

[128] Translation into Bahasa Indonesia funded by Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) and Policy Note written by the Joint Learning Network with authors: Lara Wilson, Annette Ozaltin, Khizer Hussein, Soonman Kwon.

1981	SHI is extended to industrial workers of corporations with 100+ employees; Government initiates pilot program for the self-employed* in 3 rural areas
1982	Government initiates pilot program for the self-employed* in 1 urban area and 2 additional rural areas
1983	SHI is extended to employees of businesses with 16+ employees
1987	President is elected after campaigning on the expansion of social welfare programs
1988	Subsidized SHI is extended and made mandatory for rural self-employed* workers
1989	Urban self-employed* workers are the final population group to be extended SHI
1999	National Health Insurance (NHI) Act is passed describing the framework for health protection under a single payer system
2000	All health insurance societies are consolidated under a single payer – the National Health Insurance Corporation (NHIC) – which administered the compulsory National Health Insurance Program (NHIP)
2003	Separate accounts for employee insured and self-employed* insured are merged
2006	Legal amendment mandates new subsidy structure and sources

Sources: Kwon, 2009; Jeong, 2011; Mathauer and Xu, 2009

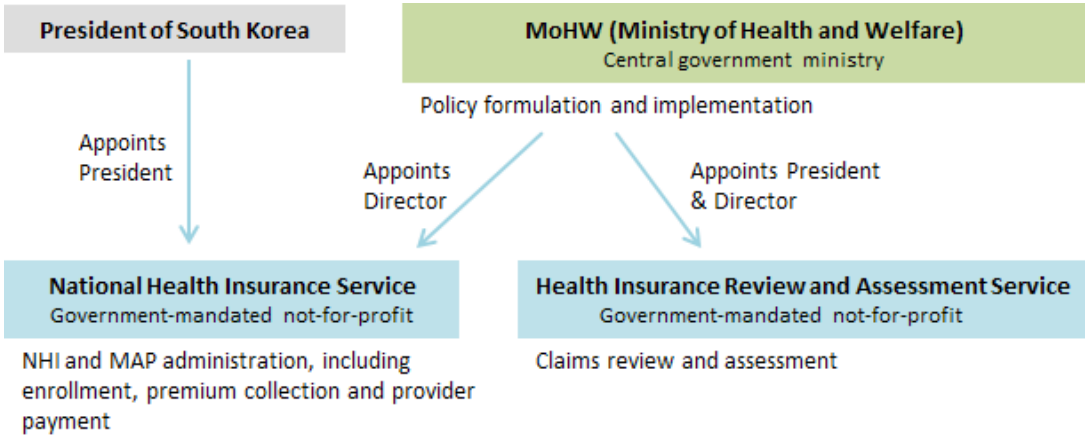
* "Self-employed" is the term used by South Korea to describe the informal sector.

National Health Insurance (NHI)	
Timeline for extending coverage to the self-employed*	• Pilots: 1981-88 • National scale-up: 1988 for rural self-employed and 1989 for urban self-employed
NHI Target population	• National non-poor population
Target population covered under scheme (2006)	• 100%
National population covered under scheme (2006)	• 96.3% (remaining 3.7% of population is covered by MAP)
Employee insured covered under scheme (2006)	• 57.7%
Self-employed insured covered under scheme (2006)	• 38.6%
Enrollment	• Mandatory

Benefits package	• Uniform benefit package for employee insured, self-employed insured, and poor includes inpatient care, outpatient care, drugs, some preventive services and funeral expenses (the poor are exempted of copayment) • Copayment ceiling of ₩ million (USD1,926), with lower ceiling for lower income
Government subsidy	• 20% of NHI contributions per law: 14% of contributions from general revenues and 6% of contributions from earmarked tobacco tax revenues
Contribution amount	Employee insured: • Contributions are paid through payroll tax and are a fixed 5.33% (2010) of gross salary • Employers and employees each pay half of the contribution Self-employed insured: • Contributions are calculated through a point system drawing on both taxed income and estimated income based on property assessment

Sources: Jeong, 2010; Kwon, 2008, 2013; Mathauer and Xu, 2011; Song, 2009; Xu et al., 2010

Figure 1. Organizational Structure of National Health Insurance



Sources: Chun, Kim, Lee, & Lee, 2009; Kwon, 2014; Xu et al., 2010

Highlights

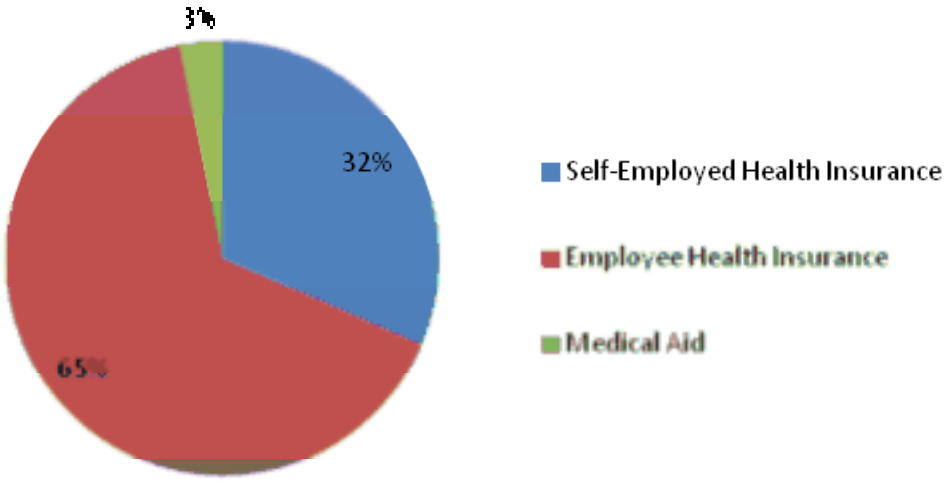
- The self-employed were the final population group covered, 12 years after the introduction of social health insurance.
- Political commitment, strong economic growth, and family-based membership were major factors contributing to rapid population coverage.
- An organized informal sector provided political pressure for subsidies and top-down political support ensured availability of funding for subsidies.
- The central government provides a partial subsidy to the NHI, financed from general taxes and a tobacco tax, composing 20% of total expected health insurance revenue as dictated by law.
- Contribution payments for the self-employed are calculated by income reported on taxes and assessment of the value of property – a formula criticized for its complexity and lack of transparency.
- Contributions were initially collected at National Health Insurance Service local branch offices, but today payments are primarily made via automatic bank transfer, deposits at physical banks, and credit card payments over the internet.
- A significant number of self-employed households are behind in their contribution payments, resulting in fines being applied to their next claim. This may imply either an inability to pay or problems with the contribution mechanism.
- Low contribution requirements, and consequently a benefits package that provides low coverage both in terms of depth and breadth, facilitated rapid population coverage expansion.
- The current system does not provide sufficient financial protection as high out-of-pocket payments are required due to demand inducement by providers paid by fee-for-service as well as a significant number of non NHI-covered services, including vision corrective devices and elective and high-cost new technology services.

1. Political Context and Background

- South Korea is a high- income country that has enjoyed strong economic growth since the 1980's, with GDP per capita (current US$) growing at an average annual rate of 8.8% since 1980 (World Bank, 2013).
- Health insurance was introduced in 1977, at the beginning of the country's most dramatic period of economic growth. South Korea's GDP per capita (current US$) more than tripled between 1980 (the first year for which the World Bank has GDP data) and 1989 when universal health coverage was achieved (World Bank, 2013).
- The government first extended National Health Insurance (NHI) to employees of large businesses (500+ employees) in 1977. The poor were covered that same year under a separate scheme, identified through an income/property criteria and accounting for between 2% and 5% of the population since 1977 (Kwon, 2000). The government gradually expanded NHI coverage to employees of smaller businesses, teachers, and government employees. Eleven years after introducing NHI, the government extended subsidized, mandatory coverage to the rural self-employed, and one year later to the urban self-employed. Pilots targeting the self-employed were implemented from 1981-1988 prior to extending coverage to this population (Kwon, 2003).
- Both economic and political factors contributed to the extension of insurance to the self-employed. Annual economic growth rates around 12% between 1986 and 1988 created favorable conditions for extension to this population; the government used some of its growing fiscal space to provide a subsidy and households were better able to contribute to premiums.

- Expanding coverage to include the self-employed was a priority for the leading political party. The presidential candidate, Roh Taewoo, campaigned in 1987on the expansion of social welfare programs to appeal to the large rural population. There were concerns about inequities in out-of-pocket healthcare payments between the insured employed and uninsured self-employed. The former benefited from the regulated NHI fee schedule used to pay providers; the latter suffered from unregulated market prices set by providers.
- **South Korea achieved universal health coverage in 1989**. Total population coverage in 1977 was 15%, climbing to 100% by 1989. The NHI currently covers 96.8% of the population, including the self-employed. The Medical Aid Program, a non-contributory, tax-financed program covering the poor, covers the remaining 3.2% (Kwon, 2014).

Figure 2. Republic of Korea Population Coverage, 2011



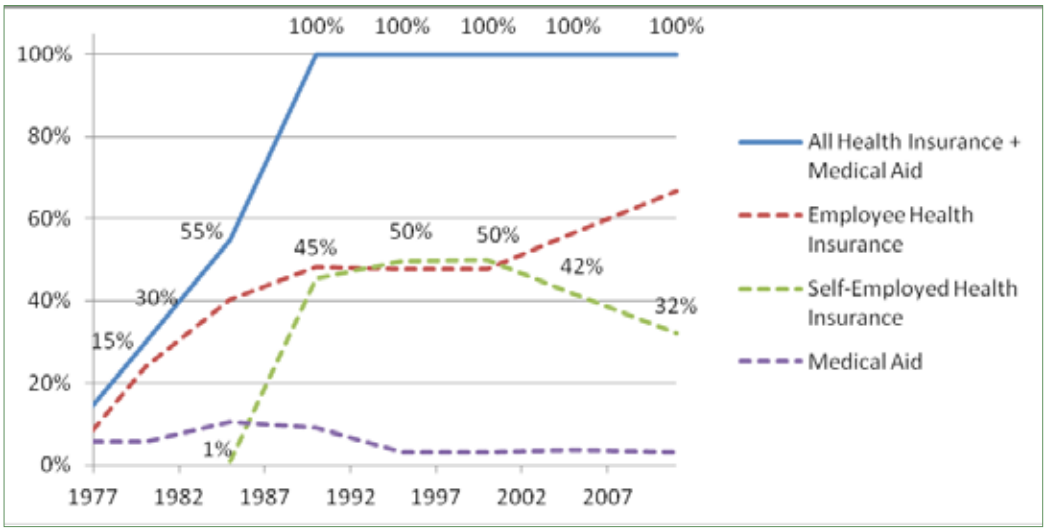
Source: Kwon, 2014

- The self-employed (primarily farmers) initially resisted paying contributions, demanding exemptions, discounts, changes in the contribution method, a higher government subsidy, and expansion of healthcare facilities in rural areas (Kwon, 2009).
- Employed insurees were offered insurance through non-profit, quasi-public insurance societies based on their workplaces and **self-employed insurees were provided insurance through insurance societies based on their region of residence**. In 1998, 227 insurance societies provided coverage to self-employed insurees (Kwon, 2003).
- **Contribution rates for people with the same income were different depending on the insurance society** even though benefits were the same. Self-employed households in poor areas contributed a higher portion of their income than those in rich areas. This horizontal inequity, coupled with the financial troubles of many rural insurance societies due to small risk pools, inspired the government to **merge all societies in 2000** into the National Health Insurance Corporation, which recently became known as the National Health Insurance Service (NHIS)[129] (Kwon, 2009).

[129] In order to avoid confusion, this case study will refer to the organization as the NHIS even in referring to times when its name was the National Health Insurance Corporation.

- The combination of the country's economic trouble from the Asian financial crisis and IMF bailout in 1997, and a change in government for the first time in 40 years in 1998, enabled the government to push through healthcare and social policy reforms (Kwon and Reich, 2005). In the 1997 Presidential election, candidate Kim Dae-jung ran and won on the merger of health insurance societies to address the inequity in healthcare financing and improve social solidarity (Kwon, 2009).

Figure 3. Population coverage of health insurance and Medical Aid*



Sources: Kwon, 2014; World Bank, 2013
* The total members of all health insurance programs, using numbers from various sources, slightly exceed 100% beyond the year 1987.

- The rural population and labor unions of self-employed insurance societies had long proposed the merger (Kwon and Reich, 2005), while employees and employers objected to the integration because of concern that they would bear the cost of cross-subsidizing the self-employed. The structural adjustment reforms imposed by the IMF preoccupied employers so that they were not a strong oppositional force for the government to reckon with (Kwon, 2009).
- The merger resulted in two separate funds under a single insurer, one targeting industrial workers (i.e., employees) and the other self-employed workers (Kwon, 2009). The two funds were merged in 2000 (Kwon, 2009) creating a unified financing mechanism in 2003 (Jeong, 2011).

2. Identification, Targeting, and Enrollment

a. Informal sector identification

- The National Health Insurance Act of 1999 established **two categories of insurees: employed insurees and self-employed insurees**. The "self-employed" category, encompassing the informal sector, characterizes the following types of workers (Mathauer and Xu, 2009):
  - Self-employed
  - Daily workers employed less than one month a year
  - Military personnel

- Elected public officials without a monthly salary
- Part-time workers that work less than 80 hours a month
- Temporary workers
- Workers without a fixed work location
- Employers of workers without a fixed work location
- Employees with contracts of less than 24 months

b. Informal sector targeting

- Self-employed workers comprised 28.2% of the total workforce in 2012 (World Bank, 2013).
- Individuals who do not receive health insurance through automatic payroll deductions (i.e., the "employed" category) or through the Medical Aid Program for the poor are **mandatorily enrolled** as "self-employed." The intensive pilot in 1981-1987 engaged local community leaders to help enroll the self-employed, and used **household enrollment for easier targeting and faster enrollment** (Jeong, 2010).
- Over time, **the number of self-employed insurees has declined** as the number of businesses with registered employees has risen. From 1995 to 2009, the proportion of self-employed insurees declined from 51% to 35% (Jeong, 2010).
- When previously employed individuals become eligible for self-employed insurance, they are required to report their new insurance status to NHIS (Mathauer and Xu, 2009).
- The boundary drawn between the poor eligible for full subsidies under MAP and the near-poor under the NHI contributory scheme may need to be revisited as a significant number of self-employed households are behind in their contribution payments. One option is to increase the population that is fully subsidized by revisiting the poverty targeting criteria (Kwon, 2013). The MAP currently targets those with monthly income of less than □230,000 (USD196) and less property value of less than ₩9,000,000 (USD24,775) (Kwon, 2000).

c. Informal sector enrollment

- **Enrollment and membership is family-based**, thus the spouse, descendants, brothers, sisters, and direct lineal ascendants of self-employed workers also fall within the self-employed category unless they could separately be considered employed insurees (Song, 2009). However, the household is the defining unit; dependents not living in the same household as the self-employed insuree have to pay separate contributions (Mathauer and Xu, 2009).
- A strong family registration system mandates that children be registered with the social security system within three months of birth. When members of the employee program become ineligible for that program and therefore eligible for the self-employed program, they must register the change at an NHI regional office. A strong cultural appreciation for the value of health insurance, twenty-five years of the tradition of universal health coverage, as well as high costs for healthcare without insurance, provide strong incentive to comply with this regulation (Kwon, 2014).
- The NHIS is considering adjusting its enrollment procedures to better fit its current situation. Family-based membership worked well to extend coverage when most self-employed households had a single breadwinner. Because many self-employed households now have multiple earners, **there are discussions on transitioning to individual enrollment** (Kwon, 2013).

3. Financing and Subsidization

a. Health spending and subsidies

- South Korea's health spending per capita has been increasing at almost 8.0% per year since 2002, growing the fastest among OECD countries at double their average of 3.6% a year (OECD, 2012).
- While South Korea's overall growth in health spending is significant, **government expenditures on health are on the lower end of its OECD peers**, at 4.1% of GDP. This leaves households to cover 32.9% of total health expenditure, one of the highest rates in the OECD (World Bank, 2013).
- **The central government provides a partial subsidy to the self-employed.** The amount of subsidy was initially linked to health expenditures, but the law did not stipulate the amount of the subsidy and it ranged significantly (e.g., 54.5% of NHI expenditure in 1988, 24.6% in 1999, and 37.9% in 2001). A 2002 law committed the government to pay half of NHI total expenditures on benefits and administrative costs for the self-employed. The formula was amended in 2006 to link the amount of subsidy to general government revenue rather than expenditure (Mathauer and Xu, 2009).
- **The current subsidy rate is mandated to be 20% of expected NHI revenue**, comprised of 14% general tax revenue and 6% tobacco taxes, though this is often varies as a portion of actual revenue. For example, subsidies accounted for 15% of total NHI revenue in 2011 – 13% from general taxes and 2% from tobacco taxes. This subsidy applies to NHI revenue for the self-employed, effectively applying a flat subsidy rate to the entire self-employed sector. The subsidy structure emerged out of concern over the challenges of accurately assessing income for the self-employed, but has been criticized for not offering more support to those with less ability to pay. There is no movement to change the subsidy structure due to political obstacles, chief among them a belief that the informal population is dwindling and will soon be negligible (Kwon, 2014).
- Cross-subsidization from employee insurees to self-employed insurees is minimal (<2.5%) as the average employed contribution per capita (employee + employer contribution) exceeds the average employee benefit amount per capita. In contrast, the average contribution per capita for the self-employed group is only 57% of the average per capita benefit amount for that group (Mathauer and Xu, 2009).
- **Expenditures on health have been rising at a faster rate than government subsidies and contribution** (Mathauer and Xu, 2011). One contributor to this trend is the fee-for-service provider payment system, which encourages demand inducement on the part of providers – especially private providers (Kwon, 2014). The NHIS also consistently ran annual deficits between 1997 and at least 2008, partly related to health care reforms on pharmaceuticals (Kwon, 2007; Yang, 2008). The financial sustainability of the NHI is a concern in the face of deficits, rising health care costs, tight fiscal constraints, and an aging population and shrinking workforce (OECD, 2012).

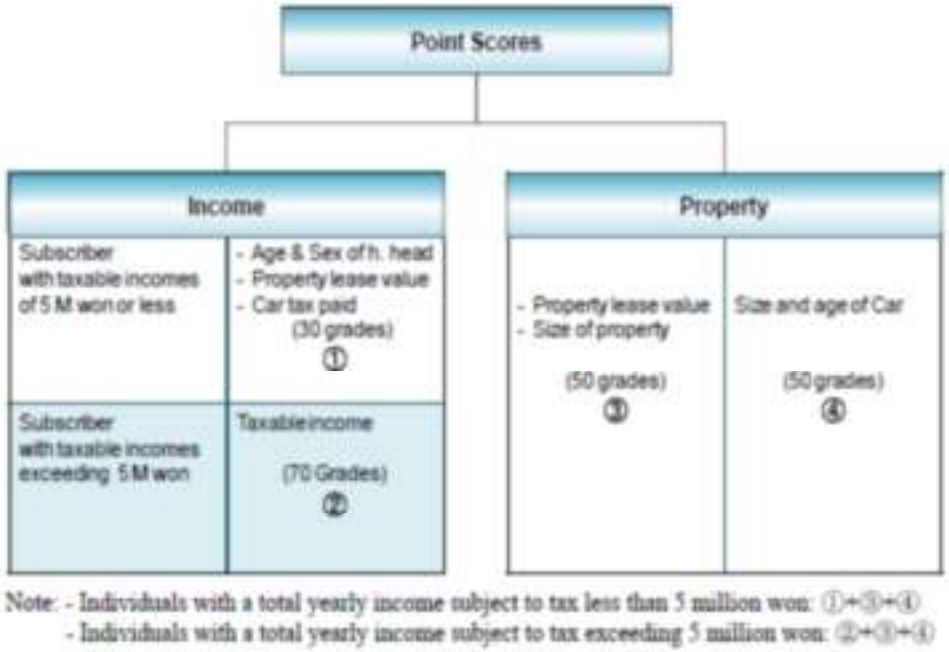
b. Contribution amount

- **Contributions for the self-employed are calculated both by income estimates and assessment of the value of property**. In 2007, the average self-employed contribution per household was approximately ₩24,065 (USD23) (Mathauer and Xu, 2009).
- There are two methods of calculating income for the self-employed, depending on whether annual self-reported income is above or below ₩6,000,000 (USD3,707). The total taxable income calculation for those whose income is above ₩6,000,000 (USD3,707) differentially

weights different categories of income (e.g., business income, farming income, rental income, part-time work income, pensions, etc.). For those making less than ₩5,000,000, the calculation of *estimated* income considers property lease value, car tax paid, and the age and sex of the insured (Jeong, 2010).

- Contributions for the self-employed are also calculated based on property ownership as assessed annually by the tax administration, including property lease value, and the size of property and car (Jeong, 2010; Kwon, 2014).
- To determine the household contribution amount, **the income and property of all related household members is combined**. Non-related household members have the option of being assessed separately as individuals or jointly as one household (Mathauer and Xu, 2009).
- Final contributions are calculated by assigning point scores to the relevant factors, summing these, and multiplying by a point value (see Figure 3) (Jeong, 2010).

Figure 4. Point Score Calculation for Self-Employed



Source: Jeong, 2010

- A key challenge for South Korea is that only an estimated 50% of self-employed income is reported. While the property estimate attempts to capture some of this, **the self-employed are still assumed to underpay** (Jeong, 2010).
- Another challenge relates to the frequency with which beneficiaries appeal the determined contribution. Because the administrative workload of assessing income for the self-employed is significant, and still often appealed, **the NHIS is considering creating a single contribution calculation for both the self-employed and employed** (Kwon, 2013; Newsworld, 2013). Additionally, the income-related **contribution formula has been criticized for being too complex** and has led to certain inequities in contributions. Contributions as a share of household expenditure are two times higher among the poorest quintile than the richest quintile of all covered (Mathauer and Xu, 2009).
- Lastly, concerns have been raised about the burden of the contribution on the marginal poor who do not qualify for the Medical Aid Program for the poor but still have limited capacity to pay the contribution (Kwon, 2009).

Box 1. Health Insurance Pilots for Self-employed Population, 1981 – 1987

The pilots were considered to be important steps to test "proof of concept" and political and administrative viability. The specific goals of the pilots targeting the self-employed population were to develop contribution collection methods, design insurance benefit packages, and determine models for health care delivery.

The first pilot began in 1981 and was implemented in three rural counties. The household contribution consisted of a flat rate payment of ₩000 (US$1.5) and a second 'graded' contribution determined by a local committee and based on the level of taxes paid, property owned, standard of living, and other factors.

The second pilot began in 1982 and was implemented in two rural counties and one urban county. A more complex 'four-variable' approach was used to calculate contributions. The basic contribution included a per-household flat rate and an additional amount based on the number of insured individuals in the household. A capacity-based contribution included an income-rated portion determined by level of income and taxes on farmland and a property-rated portion calculated from property tax payments. The contribution collection method used in the second pilot is similar to the one used today, with some modifications. The pilots revealed the need for subsidies in order for the model to be sustainable, as initial collections fell well short of targets. The pilots were focused in rural areas dominated by farming and fishing, so there have been challenges in the relevance of the contribution mechanism for urban households (Jeong, 2010).

c. Contribution collection

- While contributions were initially collected at NHIS local branch offices, today **about 90% of households transfer contributions via the banking system.** A small number continue to pay directly at NHIS branch offices, convenience stores, or post offices. Alternative collection methods, such as automatic bank transfer and internet payment via credit card are also offered to increase collection rates. Of self-employed insurees, 60% paid by automatic fund transfer and 9% paid by electronic methods (Mathauer and Xu, 2009; Jeong, 2010).
- **Over 1,500 NHIS employees are in charge of contribution collection** with each employee responsible for more than 10,725 self-employed insurees. These employees accounted for 2.4% of NHIS expenses in 2008 (Jeong, 2010).
- Self-employed households receive a monthly invoice from NHIS and can choose to **pay contributions on a monthly or quarterly basis** (Mathauer and Xu, 2009).
- **Contribution collection may not be administratively efficient** as NHIS must collect very small contributions from millions of self-employed households. More than 75% of households contribute less than ₩00,000 (under 100USD) per month. Additionally, collection performance is not optimal, as the difference between actual and target premium collection for self-employed insurees (26.2% in 2006) is much greater than for employee insurees (6.3% in 2006) (Mathauer and Xu, 2009).
- **More than 25% of self-employed households are in arrears with their payments**, a result of the marginal poor's inability to pay the premium and – to a lesser extent – a refusal to pay by some who can afford the mechanism but realize there is little penalty in skipping regular premium payments (Kwon, 2014). Households can apply for waivers if they temporarily cannot make payments, otherwise a penalty system is applied whereby NHIS identifies late payment during claims review and applies a 5-15% fine depending on the length of nonpayment (Mathauer and Xu, 2009).
- The contribution collection rate and population coverage for health insurance contributions was historically higher than pension, employment, or worker's compensation insurance, thus

the NHIS began issuing a single bill to the self-employed in 2011 for all social insurance programs (Kwon, 2013).

4. Benefit Package

- South Korea offers **one universal package**, limited in scope compared to most other high-income countries. By offering a limited benefits package, the government could rapidly expand enrollment while restricting the initial financial burden associated with coverage expansion (Kwon, 2009).
- The basic insurance basket includes both services benefits (inpatient care, outpatient care, drugs, and some preventive services) and cash benefits (funeral expenses, compensation for copayments beyond the copayment ceiling). The co-insurance rate is 20% for inpatient care, 30-60% for outpatient care, and approximately 30% for pharmaceuticals. Almost all prescription drugs and some non-prescription drugs are covered (Xu et al., 2010).
- A co-payment ceiling was introduced in 2004 at □3 million (USD2,906), and was reduced in 2007 to ₩2 million (USD1,937) (Xu et al., 2010). Then it was differentiated into 3 levels depending on the income of the insured, which was further segmented into 7 levels in 2014 (lower ceiling is applied to lower income group).
- Individuals purchase non NHI-covered products and services directly from providers. These include contacts, glasses, elective procedures, and high-cost new technology services (e.g., MRI, Da Vinci robotic surgery). Providers are paid by fee-for-service and private providers represent a large portion of the healthcare system in South Korea. These providers have strong incentives to adopt new technology-related services and provide those un-insured services frequently and at high, unregulated prices. **Out-of-pocket expenditure in the NHIS is therefore significant** (Kwon, 2014).
- As incomes rise and the population ages, the demand for healthcare will increase along with pressure to provide more extensive benefits coverage and cover a greater proportion of costs (Mathauer and Xu, 2011).

5. Information and Awareness

- The scheme was careful to organize outreach efforts during the roll-out stage. The central government, which was highly authoritarian at the time, organized a **national campaign** and encouraged quasi-public **local organizations** (e.g., women's associations) to advertise the scheme using methods adapted to the locality (Kwon, 2013).

6. Lessons Learned

- The mix of tax-based financing and social insurance worked well for South Korea, a relatively homogenous country with a small geographical area, strong central government, and limited decentralization.
- The quick transition to full population coverage resulted in a shorter period of inequities related to coverage. However, the comprehensiveness of the benefit package (depth of coverage) and the financial protection of the population (breadth of coverage) are limited.
- Strong political commitment and the timing of expansion of social programs around elections were instrumental.
- Rapid economic growth and relative shrinking of the self-employed share of the population made subsidies to the latter group affordable and politically palatable.
- The pilots were important steps to test "proof of concept" and political and administrative viability.

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#24 POLICY NOTES

Becoming a Strategic Purchaser: Some Ideas for BPJS[130]

August 2014

What is "Strategic Purchasing"

"Strategic Purchasing" in social health insurance systems means spending wisely and pro-actively, as well as protecting the poor, and includes at least three (3) important policy levers: benefits package, contracting, and provider payment. Quality assurance systems are increasingly important and models in Korea, Thailand, and Taiwan are excellent models for Indonesia.

Benefit Package

The benefit package has been unified, creating greater equity, at least "on paper". However, different people have different levels of hotel coverage with PBI having less quality hoteling than others. This should be phased out. Special privileges for civil servants are creeping back into the package, sometimes in secret negotiations.

The Benefits Package still requires expansion and integration on certain dimensions. One example is the Primary Health Care Services Package. The PHC package has been defined in law, including medical services, medicines, routine lab, investment, training, and certification. The BPJS covers maternal and neonatal health (absorbing Jampersal), vaccines provided by the government (no syringes, needles, etc.), treatment of communicable diseases, medicines. Outside of capitation payment are drugs for Puskesmas and home visits, and the latter may be an issue for providers in remote areas, as well as some outpatient specialty services.

As a result, delivery of key services such as reproductive health lack coordination and clarity of what is covered. There also are government centers which separately provide comprehensive PHC services outside the package through vertical programs such as HIV/AIDS and tuberculosis (TB) control. These need to be reviewed, costed, and integrated into the mainstream package.

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Needed nutrition benefits for mothers and young children are relatively inexpensive, and provide the potential for extraordinary positive investments in future human capital of the Nation's children.

The benefit package could be reduced as well in some other ways. Cost-sharing for the non-poor may be needed. Cost sharing could encourage growth in private supplemental health insurance which would inject more money into the sector.

The benefits package process must be dynamic, ever changing. The Benefit Package will need to be updated continually through Technology Assessment and analysis of the changing disease profile and consumer preferences.

Contracting

Contracting is very much underutilized. It should continue to be expanded in this health system with both public and private providers. Contracting can be used to improve quality and efficiency as well as allow for better information and tracking systems. Some of the international experience suggests Indonesia is significantly behind other countries in the region on use of this policy lever.

The new BPJS may need to step up with greater contracting, both selective and otherwise. The BPJS ***immediately*** might use their contracting authority to stipulate such things as:

- Following referral guidelines;
- Compliance with coding standards for INA-CBG reimbursement and quality;
- Compliance with pharmaceutical coding system being developed now;
- Compliance with reporting of costs according to a standard cost template. This was first developed by the Jankesmas scheme on a voluntary basis, but the cost template needs refinement and should be mandatory, as in other social health insurance systems;
- Compliance with quality of care guidelines, standards, and protocols, and,
- Contracts for all workers in public sector facilities. Often the complaint is that public facilities are not responsive or efficient.

Provider Payment

Sophisticated payment models have been introduced. However, these models are not yet precise and will need ongoing work to refine and improve. There may need to be an adjustment for regional cost variations and case-mix variations, as well as a monitoring and evaluation systems on a number of dimensions such as use of pharmaceuticals, early referrals, immunizations, and so on.

Going forward, BPJS will need to take needed next steps for capacity development, data, analysis, and refinement keying off a long list of issues in the longer report. They will need to develop – with MOH and PPJK -- an intricate strategy for capacity building over next 2-3 years, in the areas of data, development of refined grouper software, and development of a team of BPJS-based internal experts related to

- coding and IT needs;
- case-mix refinement;
- costing;

- quality and utilization review, and,
- updating, and monitoring of different levels of the system (central, provincial, district, hospital, primary care).

Here are some more specific ideas for the leadership team at BPJS.

Contracts

The BPJS ***immediately*** might use their contracting authority to stipulate such things as:

- Following referral guidelines;
- Compliance with coding standards for INA-CBG reimbursement and quality;
- Compliance with pharmaceutical coding system being developed now;
- Compliance with reporting of costs according to a standard cost template as first developed by the Jankesmas scheme, for example; and,
- Contracts for all workers in public sector facilities. Often the complaint is that public facilities are not responsive or efficient.

Contracts are the first step to making public facilities more responsive. With the INA CBGs, public hospitals will certainly need to hire, fire, or change their staff input mix. Contracts give the hospital managers flexibility to fully respond to the new incentive structures. There will be similar issues with capitation and primary care facilities.

As a single payer, the BPJS should contract with any and all facilities which expect reimbursement for services provided under the BPJS law. These include primary care facilities and doctors. Currently, BPJS has begun to allocate funds directly to the Puskesmas and not through the local district health office. The new direct contractual relationships can provide a platform for a more direct funds flow to the Puskesmas and all providers. This will assuage the Ministry of Finance that funds for Health will actually be utilized for health services, and better assure that all funds reach the providers – as these should.

For private providers, contracts should be only with individual private providers, and not private provider associations, which act as intermediaries, but which creates potential for fraud and abuse and does not allow for monitoring and evaluation of performance.

In the future, as data systems evolve and are more powerful, contracting can be used to address better management of NCDs such as hypertension and diabetes, as well as TB control and other infectious diseases. The former PT Askes demonstrated its leadership already in these areas.

Contracting is a powerful tool for both efficiency and equity, and the BPJS must utilize to the extent possible in the next years for both public and private sectors.

The Biggest Challenge: Improving INA-CBGs

The hospital INA CBG system for all covered under BPJS is of particular concern. The software is “bootleg” in that it was developed from stolen software actually developed outside of Indonesia, and based on United States clinical practice patterns and cost structures.

In future years, the CBGs need to reflect local cost structures and clinical practice patterns. This will require development of a cadre of national technical experts who are not hospital managers (as currently and which could encourage corruption). Instead a new technical team is needed to be established in BPJS which can objectively and empirically assess and refine the software groupers that generate tariffs. This requires a partnership across MOH, BPJS, and the universities or other experts in Indonesia.

The leadership for software refinement should move from MOH to BPJS immediately.

Box 1: Accuracy in Current INA CBGs?

How accurate are claims forms for INA CBG reimbursement? A study by the University of Indonesia suggests that over 50% of all cardiovascular (CVD) diagnosis in Indonesia may be inaccurate. Could this be extrapolated to other areas of care beyond CVD?

A second study by the WHO across countries found that Indonesia charts and coded correctly only about 31% of the time. The combination of mis-diagnosis and poorly coded claims forms suggests that ***more than 80%*** of all claims for reimbursement may not reflect accurately patient needs for care or relative resource use.

These studies together create questions about how precise the current INA CBGs may be and how problems could emerge if these continue to be used for payment in the current form.

Sources: D. Dunlop, University of Indonesia and G. Hatta, MOH (2014)

An analytic data base is needed to refine the grouper software**.** A partnership program might be established in collaboration with one or more universities in Indonesia, with Australia and other places such as Thailand, Poland, and Germany, to allow Indonesian experts to work in partnership with institutions in the public sector and in academia doing hospital payment or work in key areas related to payment such as grouper development, costing, impact analysis, regulation development, and improved coding systems.

Provider Readiness? Currently, the payment systems lack a good information and coding infrastructure, and quality assurance systems may be weak. Public hospitals may need greater autonomy through BLUD and other policies to "react" to the new market signals under the new payment systems.

Monitoring and Evaluation. A strategic plan needs to be developed for monitoring and refining payment systems over the next five (5) years.

Pay-for-Performance. The government should consider pay-for-performance measures for priority areas such as maternal and child health, immunizations, and TB and HIV care services. Pilots in NTT and East Java are not being designed. The global experience suggests some principles which the full report provides in more depth.

Going Deeper: Refining the INA-CBGs

A partnership program could be established in collaboration with one or more universities in Indonesia, with Australia and other places such as Thailand, Poland, and the United States, to allow Indonesian experts to work in Australia and other places for 6-9 months in partnership with institutions in the public sector and in academia doing hospital payment or work in key areas related to payment such as grouper development, costing, impact analysis, regulation development, and new coding systems. Additional activities under the partnership would include training courses in Indonesia implemented by Australian and other global experts on specific topics related to INA CBGs, and study tours to Australia for Indonesian officials to see the payment process and meet experts there.

Professor Ric Marshall, of the United Kingdom and Australia, recently gave the government several reasons for considering step-by-step approach which revolve around improving the current level of poor and unstable data. By following an implementation strategy over 3-5 years, Dr. Marshall suggested several advantages. These include:

1. Establishment of a quality measurement system, which could include quality tracking systems to i) prevent unnecessary admission, ii) assure needed care for admitted patients and iii) prevent early discharge of patients which can often lead to costly re-admissions to hospitals within 90 days;
2. Improvement of coding systems, including the use of all the ICD-9 and ICD-10 codes. Currently, less than 10 percent of all the codes are being utilized. More time would further allow development of a cadre of trained coding experts and national standards for coding. Currently, hospitals train their own coders which result in variation in coding across facilities. Improvement in coding systems could result in more fairness in payment for sicker patients and fairness in reimbursement across facilities;

Table 1: Which Data to Collect on Every Admission?

Variables used for grouping in current Australia CBG system

- Diagnosis (multiple)
- Procedures (multiple)
- Sex
- Age
- Event end type
- Length of stay
- Leave days
- Admission weight
- Mental health legal status
- Same-day status.

The software “Grouper” can take up to 30 diagnosis codes and 30 procedure codes per admission

3. Improvement of costing systems, including a new costing template to capture more utilization data. The costing model currently relies too much on average-length-of-stay (ALOS) and is too basis. Software programs such as COMBO (level 1) might be used as a next step. He suggests i) starting with a small sample of the hospitals with the best costing systems, ii) moving to a representative sample of hospitals stratified by all types and iii) extrapolating costs to all

hospitals in the country. The sample need not be large. He suggests 10% may be enough. In Germany, costs for as few as 70 hospitals were utilized for all Germany. In Philippines, less than 20 hospitals were used as a first step. The MOH/NIHRD currently holds cost data for 200+ hospitals, which has been utilized today. The MOH also holds data for over 100 hospitals but the cost reports have never been audited and verified;

4. Clearer contracting and purchasing arrangements, where conditions and rules are clear and well-developed, where claims are processed quickly, where there is automated payment of all claims with a 5-10% sample of audits of two (2) types of claims: high cost claims and high risk claims. Before 2014, there was a 100% audit of claims by verificators under Jamkesmas, a clear waste of public funds. Further, there should be clear rules with incentives and sanctions for correct reporting of cost and clinical information, with punishment for fraud;
5. Time to develop budget neutral modelling, or impact analysis, to better understand which facilities will gain revenues under the new systems and which facilities will not. Relative to 2013, how are revenues changing for each hospital? Much will change...for example, premiums per person will go up, out-of-pocket payments will go down, the relative base rate allocations for primary care and secondary care will change (though exact share allocations are not yet known), and so on. The BPJS will need to know who will enjoy excess surplus (overpaid) and what facilities will be relative revenue losers (underpaid) due to relative inefficiencies in their cost structure. Dr. Marshall suggested in late 2013 some reallocation in initial years from winners to losers to protect against fiscal risk and allow time for "losing" hospitals to restructure and become more efficient. How do you reallocate in initial years? A commonly used approach in other countries is to utilize a blended formula in the initial years of phase-in, for example, 25% INA-CBG and 75% traditional payment with increasing percentages over 3-4 years. Dr. Marshall suggested a 5%/95% blend in year 1 (2014) though the government rejected the idea.

INA-CBG Policy Issues Remaining

There are other, practical issues as well. A few of these include:

Capability: Is there adequate capability on the provider side? On the payer side? As of January on the provider side, about 325 of 1600 hospitals have gained absolutely no experience to date with CBGs. Ability to manage and adjust to the cost awareness issues may take some time.

Public and Private Facilities: More information of costs and case-mix are needed to more fairly pay public and private facilities. Is case mix severity different in public versus private hospitals? What can be done to "level the playing field" for privates which do not receive public supply side subsidies for capital and equipment and other programs? The public facilities will continue to receive more than half (perhaps as high as 60%) of revenues from subsidies other than payments under the INA-CBGs. The payment for privates will need to be adjusted upward to provide similar subsidies -- or -- supply side financing should be ended on the public side, with all funds pooled under BPJS. The latter approach would be preferred.

A Volume Cap: A potential explosion of volume of admissions under the new UHC program could occur as financial barriers are reduced, individuals and families feel empowered and will more aggressively seek care. In many countries, the use of CBGs by themselves has led to increases in volumes of admissions. Coupled with the UHC initiatives in Indonesia, the volume of admissions may then explode starting in 2014, similar to what has been seen in Jakarta under the Jakarta Kard Scheme (JKS) in 2013. The BPJS may wish to initiate volume caps through contracts with facilities or with regions. This is done in many other countries – almost all of them in western Europe and

some in Asia (Taiwan and Thailand). Indonesia would be smart to start with a "soft cap" that might allow for some flexibility around a volume cap target.

A Phase-in Program for Needed Changes

Given these many challenges, a first draft outline is provided here regarding might be done to determine what could be done year-by- year in a carefully phased-in program.

Year 0: 2014

A Phase-In strategy should be developed spelling out step-by-step program over the next 3-4 years in the areas of improving:

- Classification
- Coding
- Costing
- Contracting

The roadmap might spell out details as illustrated below:

Year 1: 2015

Classification:

Refine INA CBG grouper as based on some initial impact analysis and budget-neutral modelling using the BPJS data for the first six (6) months of implementation. This could include i) elimination of procedure-based groups, ii) simplification of the numbers of categories, and iii) a strategy to move to a single base rate. Experts from one or more universities in Indonesia could begin this work immediately by building the analytic data set.

Coding:

Several steps are needed.

Develop and finalize the data dictionary under the new contract, and test it out, and train people to use it. Now under the leadership of MOH's Pusdatin Center, this is essential for standardized and more precise coding systems. The current schedule calls for this to be finished by mid-2014.

Unique identifier systems developed for all physicians and all facilities with characteristics such as urban/rural, bed size, teaching status, numbers of beds at each class level.

Develop training program for coders, with a standardized program and manual for coding consistently across all facilities in Indonesia. Clinicians will be responsible for provision of data used for coding. However, physicians should NOT be asked to code.

Coders will need to be accredited in some way just as facilities are accredited. This process tool 4-5 years in Germany, but with the use of INA-CBGs under Jamkesmas in Indonesia, perhaps the program will take less time. Government grants could be initiated to provinces to initiate training programs with teachers and trained coders, could be nurses or other auxiliary personnel. Coders can form professional associations over time. BPJS could announce every contracted hospital MUST have 1 accredited coder starting in 2017 to force a ramp up in trained coders.

Development of new coding audit programs by BPJS, including both new software programs and trained verificators for BPJS.

Adopt ICD-10 or ICD-11. The system ICD-9 is now used but only because it fits with the stolen grouper software that is now outdated.

Costing:

New costing template developed using the COMBO level 1 software systems. The costing template could be developed in conjunction with the Australian DRG expert consultants.

Payment Formula:

If payment tariffs continue to create havoc for providers, a blend of INA-CBGs + Historic Payment Amount (adjusted for inflation) could be implemented. A 50%/50% blend could be considered.

Quality:

Development of quality assurance monitoring indicators, by MOH or BPJS, related to preventing unnecessary admissions, related to needed care services during admission, and related to preventing early discharge and re-admissions within 90 days. Table 2 (below) lists the indicators for Korea health insurance system.

Contracting:

Contracts with all providers, with clear rules for all reporting of clinical and costing information.

Monitoring and Evaluation:

Monitoring and evaluation system established using baseline data

Year 2: 2016

Coding:

Develop standardized coding system using ICD 10 – all codes should be included in the claims processing systems.

Upcoding review software developed. Anecdotal reports suggest upcoding has already began occurring in some hospitals in Indonesia, of up to 20% on a year-over-year basis.

Costing:

Development of a new standard coding template for provider and facility costs

Contracting:

Contracts with all accredited verificators and related quality assurance teams

Payment Formula:

Blend of INA-CBGs + Historic Payment Amount (adjusted for inflation). A 75%/25% blend could be recommended similar to the recommendations of Dr. Marshall.

Communications:

A public Annual Report should be started and sent to key stakeholders such as the hospital community, Parliament and others on how well the system is working

Year 3: 2017

Coding and Data:

Collection of information on clinical patterns and costs

Classification:

- Refinement of the grouper based on the clinical data
- New, special adjustments for geographic areas, teaching, bed size, etc.

Costing:

- Ongoing Impact analysis – at facility level
- Costing template revised based on analysis
- Deliberations with Ministry of Finance on what to do with public facilities which are inefficient and failing financially

Communications:

A 2nd Annual Report completed and sent to key stakeholders such as the hospital community, Parliament and others on how well the system is working.

Coding deserves special attention outside of Health Financing circles as it has impact on Quality of Care as well. Faculties in Medicine in Indonesia should teach and emphasize more practical work skill in clinical documentation. If their time table is already full, allow students to enroll in special classes in clinical documentation program. If faculty does not have that kind of program yet, let other bodies such as other educational health institutions, professional organizations create it. The MOH should be aware on the importance of this skill, as well as the Ministry of Education and the Indonesian Medical Association.

Medical students will need to learn more how to make a final diagnose and prepare a standard guidance book on establishing diagnoses.

The PORMIKI (Indonesian Professional on Medical Record and Health Information Organization, established 1989) has been asked to develop modules related to ICD-10, and these will be used nationally for coders. The ICD 10 Coders should be graduates of Health Information Management Diploma Degree Courses (known as School of Medical Record and Information Management). While there are almost 40 available "HIM" schools in Indonesia, tutors or ICD 10 lecturers do not always have the same qualification background or method ability in teaching ICD 10, an issue to be addressed medium-term as well.

Pay For Performance ("P4P") Pilots

Pilots should be designed and developed by BPJS and MOH to test what works and where in Indonesia, and these should be evaluated and scaled up if found to be successful. DFAT/AusAID is also designing pay-for-performance programs for its new maternal and child health programs in selected provinces and districts in NTT and elsewhere.

The pilots might be especially important for targeting priority areas such as maternal and child health care. The government can work with DFAT but also embark on its own pilots as well.

Table 2: Monitoring Indicators of Korean CBGs

Categories		N	Indicators	Explanation
Quality (13)	Process (5)	1	Proportion of the patients with medical problems	% of the No. of patients with medical problems (when one or more condition exist among blood pressure, pulse, body temperature, pain, surgical site hemorrhage and surgical site infections) within 24 hours before discharge
		2	Ratio of length of stay (LOS)	The ratio of the actual LOS to average LOS of total hospitals
		3	Rate of pre-operative medical services provided	% of the No. of basic healthcare services provided*
		4	Comparison between costs paid by DRG and converted costs from FFS	% of the actual costs per the average costs of total hospitals (when convert DRG into FFS)
		5	Appropriate timing of prophylactic antibiotics for surgery	The review of an appropriate use of prophylactic antibiotics for surgery (different criteria on each DRG)
	Out-come (8)	6	Accident rate during hospitalization	% of the No. of case with accidents (fall, blood transfusion, medication and anesthesia related)
		7	Infection rate during hospitalization	% of the No. of cases with infection during hospitalization
		8	Surgical complication or adverse event rate	% of the No. of cases with surgical complication or adverse events during hospitalization or within 14 days after discharge
		9	Readmission rate	% of readmission with the same primary diagnosis of previous hospitalization or complication within 14 days (or 30 days) after discharge at the same or another hospitals
		10	Surgery or procedure rate for complications during hospitalization	% of the No. of cases with surgery or procedure due to complications
		11	Rate of emergency department (ED) visits after discharge	% of the No. of emergency department visits within 14 days (or 30 days) after discharge at the same hospital
		12	ICU Utilization rate during hospitalization	% of the No. of Intensive Care Unit (ICU) utilization during hospitalization
		13	Mortality rate	% of the No. of deaths during hospitalization or within 30 days after discharge
Claim or physician's behavior change (4)		14	Rate of severe level	% of the No. of patients with severity 1 or over (severity of disease ranges from 0 to 4)
		15	Case-mix index per healthcare facilities	The ratio of the No. of cases in each hospital to the total No. of cases in the whole hospitals by disease categories
		16	No. of ambulatory visits before/after discharge	The ratio of the No. of outpatient visits within 14 days before and after hospitalization and to its total No. of cases
		17	Ambulatory expense before/after discharge	The ratio of the outpatient costs within 14 days before and after hospitalization and to its total costs
Clinical Documentation(1)		18	Accuracy of coding & documentation	% of the No. of concordant cases between claim data or quality measurement and medical records

Source: Soonman Kwan, 2014.

* Basic healthcare services included test items before surgery are as follow.

A. When get general/spinal anesthesia
   i. Seven DRGs: CBC, U/A, LFT, Electrolyte, BUN/Cr, PT/PPT or Coagulation, ABO/Rh, Chest PA, EKG
   ii. Lens procedures: (add) Fundoscopy, Keratometry, Slit lamp exam, Tonometry
   iii. Tonsillectomy and/or adenoidectomy: (add) Impedance Audiometry (for otitis media patients)

B. When get local anesthesia
   i. Seven DRGs (except lens procedures): CBC, PT/PPT or Coagulation
   ii. Lens procedures: (add) Fundoscopy, Keratometry, Slit lamp exam, Tonometry

Tonsillectomy and/or adenoidectomy: (add) Impedance Audiometry (for otitis media patients)

#25 POLICY NOTES

What Can Be Done About Public Health Enemy #1?[131]

August 2014

The Problem

Mr President, today, tobacco is a public health emergency in Indonesia.

In Indonesia, over 69% of men over the age of 15 do smoke. A quarter of Indonesian boys, age 13-15, also smoke. The prevalence of smoking women in Indonesia is below 10% and it is lower compared to some other countries such as US, Canada, Poland or Brazil of which more than 20% women are smokers. But, and particularly worrisome, are the recent significant increases in smoking prevalence among women, evidenced by a 64% rise from 2010 (4% prevalence) to 2013 (7%), as well as a 61% increase among young people aged 10-14, from 2007 (11% prevalence) to 2010 (17%).[132] Cigarette smoking can start as early as age 5. About 1 in 4 girls has tried smoking for the first time before the age of 10 (WHO, 2009).[133]

Second-hand smoke also is an issue. Tobacco smoke contains 7,000 classified toxic poisons literally being thrust down the throats of men, women, and children across Indonesia.

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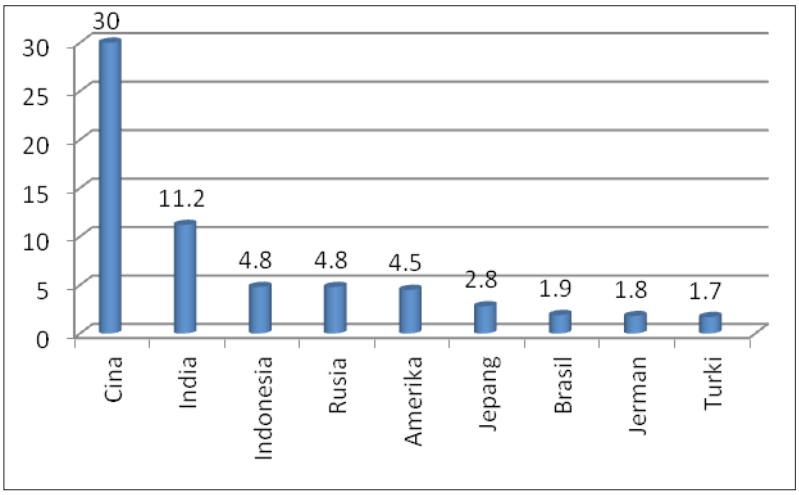
[131] Health Policy Notes are occasional notes on Health and Health Policy reforms in Indonesia written by academics, donors, and policy analysts. The Notes are funded by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. For copies of other, earlier Policy Notes, please visit www.aiphss.org

[132] Association of Southeast Asian Nations (ASEAN); Tobacco Tax Report Card (2012).

[133] World Health Organization (2009).

Figure 1:
The 10 Countries in the World with Highest Cigarette Consumption
(in billions of sticks)



Source **:** WHO Report on Global Tobacco Epidemic, 2008.

But cigarettes are expensive for the family, and hurt the poor the most. Cigarettes are currently the second largest household expense, after rice, and cigarettes are part of the budget in 57% of all households consumption, and higher for the poor.[134]

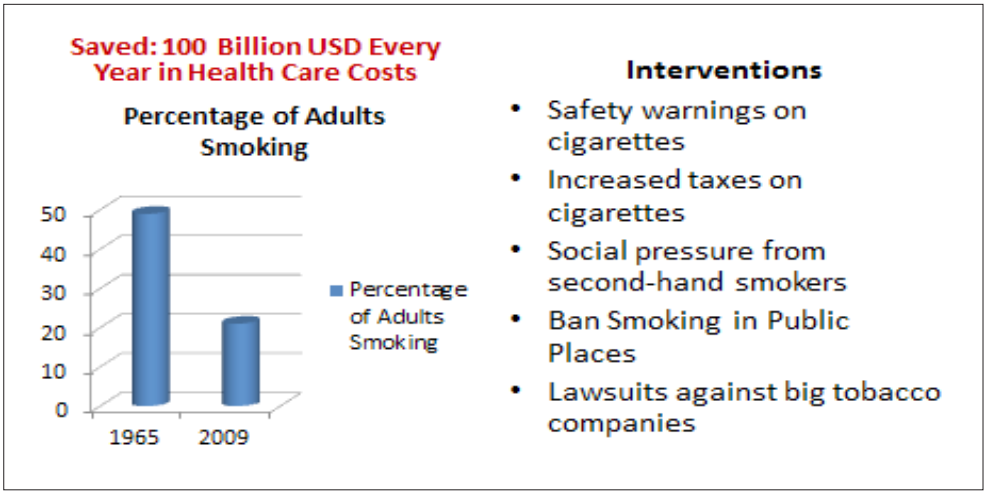
Smoking also is expensive for the Government. The annual total cost of inpatient healthcare due to smoking for 3 major diseases in Indonesia reached at least IDR 39.5 trillion (or USD 4.03 billion). This represents about 0.74% of Indonesian GDP at the same year and 29.83% of total healthcare expenditures. The majority of these expenses were related to chronic obstructive pulmonary disease (COPD) treatment (IDR 35.1 trillion or USD 3.6 billion per year), followed by lung cancer (IDR 2.6 trillion) and ischemic disease (IDR 1.68 trillion) (Nugrahani et al, 2013).[135]

Experience from the United States suggest significant cost savings of 100 billion USD every year in lowered demand for health care services if tobacco use is decreased as outlined in Figure 2 below.

[134] University Indonesia, Demographic Institute, Demotix Website, 2013.

[135] Nugrahani, Y, Radjiman, D.S., Adawiyah, E., Thabrany, H., The Impact of Smoking to Annual Economic Consequences in Indonesia: Cost of Treatment of Tobacco Related Diseases in Indonesia, International Health Economics Association Conference, Sydney, Australia, July 2013.

Figure 1:
United States



Big international tobacco countries are preying on middle-income countries such as Russia, Brazil, India, Indonesia and Philippines with unsuspecting youth. Outsiders see the number of smokers in Indonesia as a signal that Indonesia is still stuck as a low-income country of its past.

Higher levels of illness mean lower productivity and lower macro-economic growth. Taiwan reports higher numbers of sick days for workers who smoke. Impact on GDP in other countries has been up 3.5% as reported in Poland (Lu Ling 2008).[136] The impact of economic loss in the United States has been reported at 50% for health care costs and 50% for productivity (World Bank, Tobacco Tax Workshop, Manila, February 2014).[137]

What Can We Do, Mr. President?

Indonesia's very high smoking prevalence is attributable to many factors, particularly cigarette prices that are among the lowest and most affordable globally.

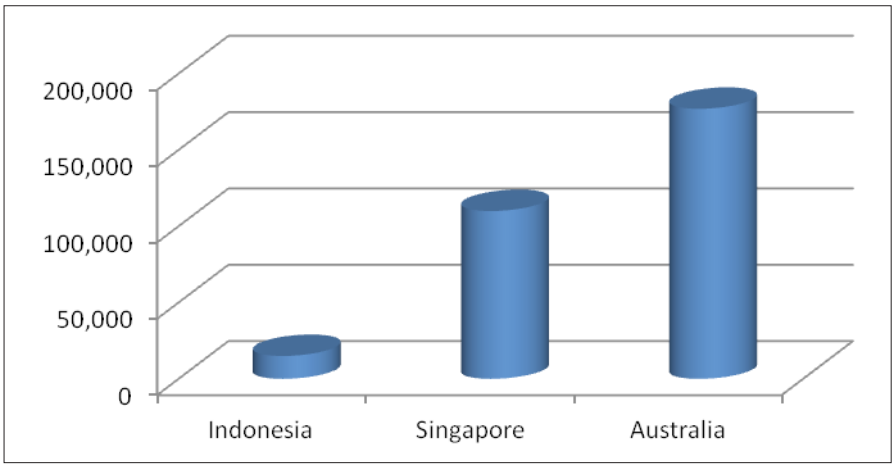
What works to stop tobacco addiction? What is the global experience? It has been shown in a number of countries that the most effective method for reducing tobacco consumption and improving health is to increase the price of tobacco products through tax increases (WHO, 2011). Higher tobacco prices are effective because they encourage existing tobacco users to quit, prevent young people from starting, and reduce the amount of tobacco consumed among continuing users. Also, in spite of reducing demand, tobacco tax revenues increase over time.

Currently, prices for a pack of cigarettes are surprisingly low by international standards (Figure 3). For example, a pack of Super Djarum is around 12,000 IDR while in nearby Australia the price is around 170,000 due to differences in taxes.

[136] Lu Ling (2008) as reported at the Tobacco Tax workshop, Manila, Philippines, February 2014.

[137] World Bank (2014). Regional Tobacco and Alcohol Tax Workshop, Manila Philippines, February.

Figure 3:
How Much Does an Average Pack of Cigarettes Cost in Indonesia, Singapore, and Australia?



Source: Based on reported prices in Duncan Graham, "By the Way…Tobacco Road" page 1, Jakarta Post, January 12, 2014, using an exchange rate of 12,000 IDR per USD as of February 2014.

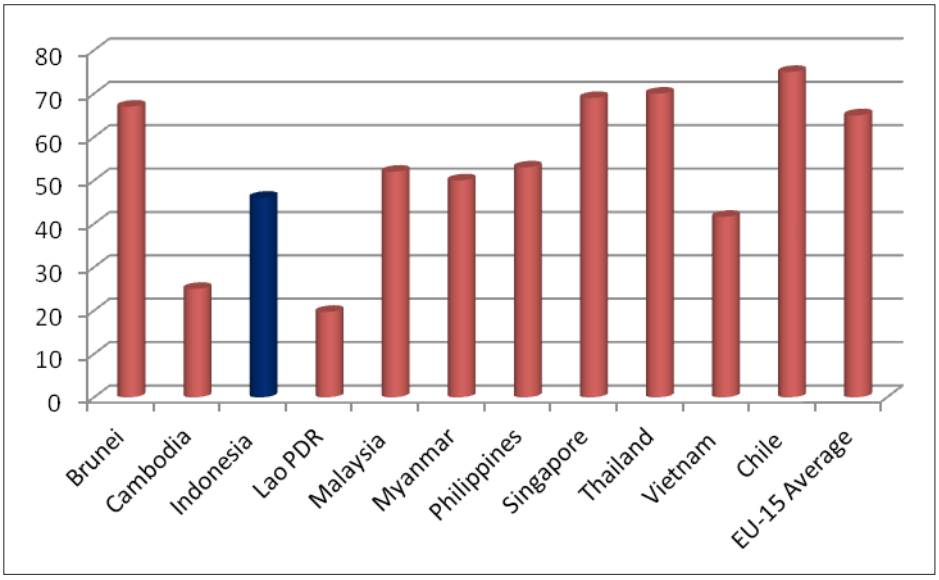
Indonesia will add pictorial health warnings on some limited percentage of tobacco products. The Indonesian Broadcasting Commission (KPI) and the National Commission on Child Protection (Komnas PA) are calling on leaders to ban cigarette advertising. The younger generation is often inappropriately targeted at cultural, music or sports events, including those broadcast on television during the day. The WHO has said that a ban on tobacco advertising and sponsorship was one of the most cost-effective ways of reducing demand. Indonesia is the ONLY country in ASEAN still allowing cigarette advertising. Recent laws have made inroads which placed tighter restrictions on tobacco advertising, but enforcement appears to be an issue.

But, to repeat, Mr. President, simply increasing the price on tobacco products has been shown to be the most effective method of cutting prevalence of tobacco use (for example, World Bank, Adeyi et al, 2009).[138] Raising taxes on tobacco products could be a "win-win-win-win" with increased revenues to the government for each pack of cigarettes sold, but over time a lower smoking prevalence, lowered health care costs with a healthier population, and higher productivity in the work force.

Increased taxation of tobacco could be an important way to increase revenue generation. Tobacco in 2013 was taxed at 38% of the price of a cigarette, far below better performers in the region such as Thailand and the world as in the European Union and other OECD countries such as Chile (Figure 4 below). In 2014, Indonesia has increased excise taxes but only by 8.5%.

[138] World Bank (2009). Impacts of Health Promotion and Disease Prevention Programs, Adeyi, O., and others.

Figure 4:
Tobacco Tax Burden as % of Retail Price, 2013



Source: Asean Tobacco Tax Report Card, May 2013, and WHO, 2012

In 2012, the government reaped IDR 79.9 trillion in cigarette tax revenues, while on the other hand the country saw economic losses and health costs from smoking-associated diseases of IDR 240 trillion (Natahadibrata, 2013).[139]

A modest proposal would be to raise tobacco taxes to cover the economic and health costs of smoking-associated diseases. This should be done immediately, but politics may dictate phasing it over a few years.

Challenges

Several issues may need to be addressed. One is current levels of corruption or funds being poured into the political process by tobacco companies. The richest man in Indonesia owns Djarum tobacco.

A second issue might be agriculture crops and revenues for crops especially in poor areas. But, in Indonesia, most tobacco in the industry is imported. And other countries, such as the United States, have shown that farmers, given time, can relatively easily switch to other cash crops.

[139] Nadya Natahadibrata (2013). Calls for a Complete Ban on Cigarette Ads. Jakarta Post, Page 4, May 31.

Box 1: Sin Taxation for Financing Universal Health Coverage in the Philippines

Context and Rationale

Tobacco and alcohol excise tax rates in the Philippines are among the lowest in Asia and the world (Kiyoshi et al, IMF, 2011). This may be one factor that explains why the country has one of the highest smoking rates and the second most consumers of alcohol in Southeast Asia. The Philippines is home to an estimated 17.3 million tobacco smokers, with 1,073 cigarette sticks being consumed per capita annually, 38.9 % of its populations are occasional alcohol drinkers, and 11.1% of population are regular alcohol drinkers (DO, GAT Report, Philippines 2010; sin-tax website; Labajo, PDF). Tobacco and alcohol consumptions in the Philippines has significant social and economic consequences: WHO estimates that ten Filipinos die every hour from cancer, stroke, lung and heart diseases caused by cigarette smoking, while the country loses nearly PHP500 billion annually from costs of healthcare and productivity losses resulting from cigarette and alcohol consumption News info inquirer, Philippines, no date).

Since the 1980s, various legislations have been enacted on sin taxes in the Philippines. With the enactment of Republic Act 8240 in 1996, the Philippines introduced a multi-tiered schedule for excise tax on tobacco and alcoholic products based on the net retail price (exclusive of VAT) of each brand, with cheaper brands being taxed less than more expensive brands. The Republic Act No. 9334 which took effect in 2005 mandated varying rates of increases in all brands of cigarettes and alcohol products every two years, until 2011 (Albert, 2012). However, the multi-tiered tax system contributed to the deterioration of the excise tax effort and resulted in the erosion of excise tax revenues, as well as a downshift by manufacturers to cheaper brands.

The Republic Act 10351 (a.k.a. the Sin Tax Reform 2012) was signed in to law in December 2012 with the objective of restructuring the excise tax on alcohol and tobacco and generating government revenue to finance expansion of Universal Health Coverage (UHC). Major features of the Sin Tax Reform 2012 include a gradual shift from a multi-tiered tax structure to a more unitary and specific tax structure (to keep manufacturers and consumers from downshifting to lower taxed brands and to under-invoice products, to have more predictable revenue, and easier tax administration); automatic tax rate increase of 4% annually for distilled spirits effective 2016, and for cigarettes and beer effective 2018 (to prevent inflation erosion); proper tax classification of tobacco and alcohol products to be determined every two years (to remove the price classification freeze); adherence to the WTO's ruling on distilled spirits and WHO-Framework. It has been reported that the sin tax collection has reached PHP21.75 billion (USD504.2 million) within the first four months of 2013, which is nearly 25% increase compared with same period in 2012, despite the fact that there is an increase in smuggling and unreported production following the excise tax increases (tax news.com, no date). Coverage for the poor and near poor increased by almost 10 million families.

Source: Bi, et al., World Bank, 2013

A final issue is jobs, but this is a worry only over the long run, not immediately. Indonesia has the biggest cigarette industry in the world. There are at least 3800 cigarette companies in Indonesia including the cigarette home industry. Around 3000 of these companies are located in Central Java and East Java. These two provinces are also the biggest tobacco producers nationally. In the length

of two decades, the cigarettes sales in Indonesia has risen almost 50 times from IDR 1.4 trillion in 1981 to IDR 51.9 trillion in 2001.

The challenge of raising the price of tobacco will reduce profits to tobacco companies, and might reduce workforce in those companies, an issue that might be taken up with the discussion of raising tobacco taxes. Retraining programs or other types of subsidies could be offered, a small offset to pay in return for higher revenues to the government treasury...for universal health coverage (UHC), and most importantly, for improved levels of health for the people of Indonesia. Countries in Europe and North America and in Asia (Singapore, Thailand, and most recently Philippines) have found a much higher tobacco tax to provide a clear path to better funding and better health at the same time.

The First Step

The current system of tax, while it accounts for 95% of all excise taxes in Indonesia, is overly complicated and underperforming. The complicated current system for tobacco and alcohol has a multi-tiered tax rate structure, and the recent increases will in part be shared by local governments for health promotion programs. However, the current model may be contributing to the deterioration of the excise tax effort. Further, the sharing of revenues with local governments will not be tracked in terms of actual expenditure commitments nor can the government assure that new funds will not encounter fungibility issues of deterioration of health commitments from other local programs.

It would be useful for MOH and MOF to work together on developing a proposal for sin tax reform, especially in the context of the new 5 year plan. A new analysis by the World Bank Jakarta office in September found that a gradual increase of the specific tax rate to 70 percent would lead up to 14 trillion IDR more revenues by 2019, enough to cover millions of individuals currently with no coverage. Further analysis would need to look at such things as

- Design features, to simplify the tax structure and develop some elasticity analysis to optimize revenue enhancement and encourage behavior change;
- Work on whether it should be earmarked. But earmarking in most countries is soft earmarking and this is a relatively minor issue from an analytic standpoint;
- Analyze the industry to both help forecast revenues but also to help regulate against misbehaviors such as tax avoidance through “frontloading” warehouses before implementation and repackaging with smaller number so of sticks to avoid taxes on standard size packs;
- Assess impact on farmers and other workers producing cigarettes and possibly develop retraining or crop subsidy programs;
- Assess ability to stop smuggling and administer law enforcement programs under a new law;
- Develop a phase-in strategy.

However, it was clear that Indonesia is different from the Philippines in one important way. President Acquino always supported the measure. The current President of Indonesia, however, has never fully supported this idea.

Where Should the Money Go?

Should new tobacco taxes be earmarked? Although earmarked taxes can help add to fiscal space, they may also displace existing funding and thereby end up having no significant impact on overall resources for health (World Bank, 2001; Schieber and Cashin, 2012).[140]

Other earmarked taxes could be explored as a source of fiscal space for health in Indonesia. Some countries such as Ghana have earmarked VAT taxes for financing UHC. The revenue from the VAT earmark has been shown to be a highly stable and progressive revenue source in Ghana (Schieber and Cashin, 2012).[141] While increasing revenues via additional contributions or through additional earmarked taxes may ease fiscal constraints for UHC, the way in which revenues they are raised is crucial: regressive, inefficient, and excessive taxes can do more harm than good to the overall economy. Developing some of these options would require additional background analyses, and detailed discussions of the pros and cons for each of the options.

[140] Schieber G, Cashin, C. (2012). Health Financing in Ghana World Bank. Washington, D.C.: World Bank.

[141] Schieber and Cashin (2012) op. cit.

#26 POLICY NOTES

Making Government Work: The Case of BPJS [142]

February 2015

The National Planning Model

The coordination of government is a difficult problem in every country, but in Indonesia today it is especially fraught. Everyone has complaints about the difficulty of achieving coordinated government action. The old model of governance involved strong central command, implemented through three channels: the army, the Big Man's 'cronies', and the national planning agency. It was an arrangement that allowed a few people to control the nation, and effectively excluded the rest. The National Plan was a critical component of this political arrangement, and use of power. Thankfully, those days are over.

Other newly independent countries have often followed similar models of governance in their early years. Some kind of National Planning model was used almost everywhere in the years after the Second World War, when many countries first gained their independence. Initially this approach to state building helped to kick-start a more modern economy, through direct project interventions. However, over time the problems of the economy, society, and government gradually became too complicated to be solved in that way, and politics also evolved. The national planning approach proved increasingly ineffective in handling development complexity, and unsuited to democratic forms of governance. About forty years ago some countries began tentatively moving towards different ways to coordinate development, and since then the shift away from "the Plan" as a tool of governance has gathered pace. With the sudden arrival of its own democracy twenty years ago, Indonesia began a journey in this direction, away from the Plan.

So the question arises, where is that process of change going, and how is Indonesia doing as it unfolds? To put that in proper perspective (and benchmark Indonesia's progress) we have to look across a range of countries. When we look at countries that have abandoned the national planning approach we see they have generally evolved towards what we might call a national policy management model. Something like this also seems to be under way in Indonesia, but so far it is only happening in small steps. This country often seems to be caught in mid-channel between two

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[142] This Policy Note was written by Kenneth Sigrist and Jack Langenbrunner of the PRSF/TNP2K organization, and funded under the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program. Copies of other Policy Notes are available at www.aiphss.org . The views expressed are solely those of the authors.

land masses, one land mass that it cannot return to (the old National Plan model), and one land mass it cannot quite reach (the new policy management model). Frankly, Indonesia has made the transition trickier for itself, by creating a form of political decentralization and localization that can sometimes confound the efforts of the centre to coordinate policy implementation.

However, Indonesia is not unique. Many other countries have found the process of transition equally tricky for a range of reasons. Part of the difficulty arises because planning, as an activity, has to continue in some way, even though the national plan is no longer actually used. In that case, understanding what is real, and what is just nominal and a matter of appearances, can be difficult to ascertain. Countries will sometimes continue to prepare official plans out of habit even though they no longer actually use them in practice! Key decisions on allocation of resources are made without reference to the plan, so the so-called national plan is truly 'ornamental', but this fact is not always obvious. Countries that successfully combine planning activities with a policy management process will use a range of cross-sector planning techniques as a way of coordinating government decisions. Among them are 'perspective' plans, or non-binding 'indicative' plans, or multi-year national investment programs.

However, while considerable planning activity may continue as before, the type of planning also changes. 'Policies and programs' replace conventional 'projects' in the thinking of senior officials, and the 'planners' find they have a new role as 'policy managers'. Once the straitjacket of a fixed five-year national plan has been abandoned the emphasis can shift to an adaptive, exploratory process for implementing a variety of different policies and policy intentions. Planning that now takes place is ideally happening within an all embracing policy management process.

Moving to Policy Life Cycles

In the better cases, countries that successfully make the transition away from the fixed national plan have usually put in place at least three key organizational elements, to organize and manage:

(i) a *design process* for generating the flow of new policies and new programs, to be decided by government,
(ii) a *strategy process* that economizes on scarce resources for implementing policies, as decided by government, and
(iii) a *delivery process* for overseeing the implementation of policy, and for holding different agents properly accountable for results, to be reported to government.

These are the processes governments use to manage the three most critical stages in the 'life cycle' of policies. A government that is determined to manage these processes coherently also needs to put in place some apparatus, or appropriate 'machinery' to oversees the way the three processes work together. In professional literature the term "centre of government" is attached to this apex organization of the state, which combines the key elements of the machinery for managing national public policy. Note that this term does not refer to a location; it is implies an actual organization at the apex. And needless to say, not all governments have one. However, governments that manage policy coherently and effectively always do have a well-established centre of government. Indonesia has only partially built this machinery in the Presidency and the Vice Presidency, but has not yet brought it all together as a functioning apparatus.

Turning to the health sector's policy reforms, new policies and programs are evident in the country's drive to universal health coverage (UHC). The social health insurance organization BPJS was legislated in 2004 in order to provide UHC to all of the country's citizens by 2019. Key dimensions in meeting this policy objective include: improvement in access to care, improved quality of care, equity in treatments provided, and financial protection against excessive or catastrophic cost.

A strategy process was then developed by GOI in its 2013 "Health Insurance Roadmap" which unpacked this policy decision and outlined the steps to be taken. While the Roadmap may not be rigidly adhered to over time, its considerable achievement lies in identifying the important priorities and necessary processes for the achievement of the policy goal, with some analysis of how these could be realized. This flexible use of the Roadmap is consistent with the modern adaptive approach to policy management described above.

As the "Jokowi" administration takes over the reins, the BPJS is still in a formative stage of addressing the delivery process. It has achieved one of its most important operational objectives, critical for its institutional credibility, namely the timely payment of claims. Other key operational objectives remain out of reach for the moment, including: precision in payment systems, development of health quality assurance systems, and reliable forecasting of claims within its organization. Most important, it now faces a great strategic challenge in that it must quickly extend cover to an additional 60 million people, and it must also somehow deal with (i.e. harmonize, embrace, and absorb, or where that proves impossible, sideline and supplant) up to 400 local insurance organizations that need to be "brought into" its single payer organizational model, according to the national policy. So how can that be done, in a context where the national policy management system for overseeing policy implementation is itself incomplete? To help address that question we must return for a moment to the topic of the policy management system as a whole.

So what does this policy management model look like in practice, when implemented? Inevitably the answer varies, and every country is somewhat different.

System Design Features

Unlike the old national plan, which had a clear and logical simplicity, and was therefore relatively easy to set up and manage, there is no single dominant model for central policy management. But there are important features that are commonly found across many countries. A sort of 'genotype' can be discerned, which may provide a template for Indonesia to use as a guide in deliberations about system design.

One of the insights of the better national policy management systems is that policies, like projects, have a life cycle that needs to be managed. It is not enough just to design polices and launch them. Some policies may last a long time but in the modern world a national policy may only have effective duration of five and ten years before it begins to degenerate, and needs to be fixed or replaced. Its decay contains the seeds and the lessons with which to devise its successor. But this will only happen efficiently when there is a management apparatus in place that "sees" the whole cycle in a strategic and holistic way.

Here are a few important features of the policy management systems used in a number of well-run countries – a list that would include most EU member countries, Canada, Australia, Chile, Colombia, Ghana, Korea, Malaysia, Taiwan, as well as others

- The political leadership is brought into play at key points in the policy cycle, especially in regard to (a) the collective decision regarding policy choice and which policy design to implement, and (b) the immediate oversight of how policies are actually implemented. In the case of BPJS, the President has already indicated his careful watch and request for action with the new Kartu Indonesia Sehat (KIS) cards for 1.6 million people left out of the UHC scheme to date. It will be necessary to report back to the President from time to time, as further important details of policy emerge.
- Enormous importance is placed upon implementation or 'delivery' as the true test of good policy making, with corresponding emphasis on accountability for performance and results. In the case of BPJS, oversight of delivery is strengthened by the creation of a Board of Seven Commissioners which can assist the leadership by giving strategic direction. The Commission can lead the outreach process to the 19,000+ islands, can lead in development of benchmarks for the organizational performance, and can provide longer-term vision to the BPJS management team on difficult policy issues such as coverage of the informal sector and how to engage with the 400+ Jamkesda local insurance schemes. Internal management of BPJS frankly, have little time for such strategic thinking, given the exacting operational standards and daily demands of claims processing..
- Great care is taken to build an information architecture for evidence-based policy making. Here the BPJS has launched an ambitious program a national HMIS system of unique identifiers and demographic, clinical and utilization data that can emerge as a system for strategic purchasing similar to Western Europe. Issues remain, such as the lack of indicators regarding pharmaceuticals and readmissions, but the basic foundations have been laid ;
- More generally, an open architecture of the policy process supports participation, contest of ideas, accountability and transparency - but without loss of central control. In the case of BPJS the concept of an open architecture defines two important aspects of how the system of health insurance can work: (1) it can be implemented in a way that openly benchmarks the performance of all health providers against each other and against international norms; and (2) it can ensure that this performance benchmarking is openly observed by the policy makers and the Indonesian public, to provide pressure for continuous performance improvement.
- There is institutional learning to make continuous improvements in policy making, as well as improvements in individual policies. However, in the case of BPJS, it is notable that the insurer is a sole national provider of this service, and therefor its core activity cannot be benchmarked against others – it has no comparators. However, the Board of Health Commissioners can to some extent compensate for that fact by applying international benchmarks to the national health insurance system. They will need to set this up as a free-standing effort, probably under the umbrella of the DJSN.

Can Indonesia's BPJS really achieve this, and if so how? In fact most of the key organizational pieces are already here, and waiting to be connected up. There are no fixed blueprints for some of this, such as coverage of the informal sector, but it is clear enough what would have to be done. Every country develops by using the pieces it has available to it, and Indonesia is no different. At a national level, Indonesian agencies and outfits like Bappenas, TNP2K, Kesra, and UK4P have roles and functions appropriate to the task outlined. Together they pretty well cover the range of activities required. In the health sector, there is again a variety of actors – Ministry of Finance, DJSN, BPJS, MOH, Provincial and District Health Offices, the multiple Jamkesda, etc. But adjusting them and getting them to work together is a complicated collective action problem for the leadership.

For example, will technology assessment processes be well coordinated across departments and organizations? Right now, BPJS has no role even though a litany of new drugs, devices, and procedures will be identified through claims. Likewise, if the MOH decides a new drug is effective but costly, who arranges with the MOH to confer with BPJS to see if actuarial forecasts allow the new drug's inclusion in the benefits package? If, to take another example, existing care facilities are clearly inadequate, who decides whether there is a role for the private sector in the delivery of care? How do each of the sector players work together to respond to issues such as the emergence of new disease profiles, the burgeoning private sector, and fairness in reimbursement that allows performance competition across public and private delivery organization? There are now many difficult issues emerging and there should be no doubt this change calls for leadership.

A leader like Jokowi must demand it and indeed already has. But he is too busy to go deep into the running of MOH and BPJS. Champions will be needed to unleash the change, and a network of motivated and clever technicians will be required to carry the change through. Given that kind of dedicated leadership, there is no fundamental reason why the centre of government cannot deliver what the modern state needs.

Evaluating Success

Finally, who will decide if that mission is accomplished, and how will the message be disseminated and integrated into a process that allows constant and continual change? We still do not know the answer to this question.

However, Figure 1 below gives a process found in other social health insurance organizations globally. The BPJS based on policy parameters utilizes its information architecture to collect routine information for claims, but also for quality and performance. Data, with the right indicators can be utilized to assess care management at the facility, to look at utilization trends and to drill down on quality of care at the provider level. Benchmarks can be developed across providers and over time. The right data can pay claims, monitor performance, and continually provide policy guidance to improve care.

Do we trust BPJS alone to implement all this? If we look to other countries for advice on this point, the clear answer is "no". *Independent researchers and evaluators must have routine access to public data sets from BPJS, usually obtained for nominal amounts of money, for use to independently assess performance, publish and provide evidence for policy change as needed*. They also have to be able to established and support independent government processes of review and evaluation. Who has to take charge of this in Indonesia's case? Is Bappenas the right organization? TNP2K? Or is some other arrangement to be preferred at this point? The exercise of governance oversight for the sector as a whole is a higher order question than the Health Commissioners alone can answer, and is definitely an issue that needs to be clarified and to be given some concrete form in the coming months. Certainly, we should not wait years for that answer to emerge. If it takes too long, BPJS will almost certainly turn into a promise that is well made, but not kept.

#27 POLICY NOTES

Policy Note #27

Research and Evaluation: The Role of BPJS[143]

February 2015

Global Experience

Modern social health insurance systems do more than play claims. They also do research and evaluation, for one. It is important, indeed critical, to update and refine and constantly improve as new drugs, devices and procedures come to the markets globally. There are also new management innovations. For example, payment for "integrated care" across levels of care is sweeping the United Kingdom, Germany, Denmark, Netherlands, Canada and the United States. Integrated Care models are especially important for chronic care.

Modern social health insurance systems typically spend a budget equal to 1-2% of claims expenditures just on evaluation and research, at a minimum. The process and funding is for both intramural and extramural research.

Intramural research can be done by in-house staff at BPJS. It typically uses in-house data, such as the claims data. Or, the research team merges data sets for wider analysis. The team also does monitoring and qualitative analysis.

Extramural research can be done by any individual or institution with a proposal of scientific merit of interest to the BPJS. It would benefit with real BPJS claims data, stripped of unique individual identifiers. Or, it can develop new surveys on impacts to provider or consumers as an example.

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[143] This Policy Note was written by Jack Langenbrunner of the PRSF/TNP2K organization, and funded under the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS). Copies of other Policy Notes are available at www.aiphss.org The views expressed are solely those of the author.

10 Steps to Evidence-Based Policy: Extramural Research and Evaluation

For the future, BPJS should consider to:

1. Develop an extramural grants and contract application process;
2. Write up a short 3-5 page summary of areas of research and evaluation interest, such as refinement of payment systems, quality, MIS, actuarial forecasting, impacts of coordination of benefits program, impact of the new KIS program, and so on. This summary of interest areas would be revised every 6-12 months;
3. Publish on its website, the areas of interest and priority for research and evaluation;
4. Request proposals to be sent to them by a due date;
5. Develop a rigorous and scientific as well as completely transparent review process;
6. Award contracts and grants for research and evaluation for projects of 1-2-3 years;
7. Manage and monitor these contracts and grants with BPJS staff;
8. Encourage publication in peer-reviewed journals after the research and evaluation final reports are submitted and accepted by BPJS.
9. Sponsor forums for showcasing its research and findings;
10. Create a website of ongoing research and evaluation activities.

These 10 steps will be an investment in a dynamic and ever improving BPJS. Work can be on social impacts, consumers, the poor, the provider community, improving the supply side…any area of interest to an improving social health insurance system.

Competition should be open to any individual and institution – either in Indonesia or in other countries. The BPJS could encourage joint partnerships to bring in expertise from abroad. All results would need to be provided in Behasa Indonesia first, other languages later.

It is not too early to start with this critical process.

WASPADA

Demam Berdarah

Public Health Unsoed©2009

Yang Perlu
Anda Ketahui
Tentang **HIV/AIDS**
& **Tes HIV**

- Klinik VCT "Sobat"
  RSU. Prof. Dr. W.Z. Johanes Kupang
- Klinik VCT "Seroja"
  RST. Wirasakti Kupang
- Klinik VCT "Senati"
  RSUD. Dr. TC. Hillers Maumere

#28 POLICY NOTES

Jamkesda: or the Goose That Laid the Golden Egg for UHC[144]

February 2015

1. Background and History of Sub-national Health Insurance Schemes in Indonesia.

Health insurance has been a part of the Indonesian health financing scene for more than 75 years, with the civil servants during the Dutch colonial period obtaining health insurance coverage in the mid-1930s. In Indonesia, sub-national health insurance schemes began to flourish beginning in the 1970s when small community based health insurance was introduced via the Dana Sehat program, and many other communities had already implemented community savings programs to provide financial assistance to people in the community in need, including for medical care. Beginning in the 1980s, many schemes were created using the model of health maintenance organizations (HMOs) which were gaining popularity in the US at that time.

The Ministry of Health created a special office in the early 1990s to oversee, monitor and report on the development of these schemes. The office has now known as the Center for Health Economics and Health Insurance, or (PPJK) which continues to be one foci of health financing expertise in the country.

Efforts to move social security reform forward in Indonesia worked during the presidency of Megawati to get a law enacted in 2004 (Law 40) which provided for the enactment of a single payer national social health insurance type scheme. This law has been the basis for the further development of the national health insurance (JKN) scheme which has just been implemented beginning in January 2014. The law 24/2011 has created a single payer institution, known by its acronym BPJS, which has been created to amalgamate several nationally supported health insurance

[144] This policy note was prepared by David W. Dunlop with the assistance of Ibu Kurnia Sari and other members of the Jamkesda Study team from the Center of Health Economics and Policy Studies (CHEPS), at the Faculty of Public Health, University of Indonesia who made insightful comments on earlier drafts. Prof Ascobat Gani has also been helpful in getting many aspects of this brief factually correct. Jack Langebrunner made useful comments on several earlier versions of this brief. Thanks also goes to Ms Rachael Cintron of USAID, now based in West Africa who was instrumental in getting this work funded. The study was funded by USAID via the TRAction project implemented by URC, Bethesda, MD. Funding for translation was provided by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program.

programs designed to address the specific needs of particular constituents. It now has over 128 million enrollees according to recent BPJS information.

But many local schemes remain, perhaps as many as 460. The remainder of this brief spells out what is currently known about the many local schemes known as Jamkesda, which currently cover between 65 and 70 million persons, based on a recent study. It also explores how these, in the process of integrating with the national scheme, can contribute to the national goal of UHC by 2019.

2. Legal Framework of Sub-national Health Insurance Schemes

According to a recently completed national study of Jamkesda commissioned by the DJSN to provide information regarding their current status, it was found that local schemes had made a number of individual efforts locally to upgrade their legal status [145]/. As of 2013, nearly 80% of the sampled districts in the study had developed the legal basis for their Jamkesda in the form of a local parliament law or a decree which had been vetted with the local parliament at either the district or province level, whereas when the initial legal documents were enacted at the time of creation (typically after 2008) only 65% had such legal status.

Further, many Jamkesda have changed their legal status more than three times (55%) over their short life, mainly because of changes in the sources tapped for scheme financing (many have introduced provincial funding into their schemes). The only other significant reasons for changing their legal status has been changes in: a) the political leadership of the district, or b) for technical changes such as a change in membership regulations. As of the end of 2013, most schemes were legally more secure and could begin to plan for operations in future years. However, a further survey is warranted to be able to assess the changes in the legal situation of local schemes after the end of the first year of implementing the new national health insurance program, where the roadmap for its implementation has suggested local schemes, "will be integrated" within the national scheme by the end of 2016.

3. The Benefits of Jamkesda

A. Increased Population Coverage

In Table 1, data are presented to show the importance of Jamkesda in achieving the national goal of Universal Health Coverage (UHC) by 2019. Over the decade since 2003, Table 1 shows how the health insurance map of Indonesia has changed dramatically. Health insurance coverage has grown scheme from about 10% of the total population in 2003, to almost 85% in mid-2014. Both the development of the national single payer for the health insurance scheme as well as the continued expansion of Jamkesda schemes, in terms of numbers and coverage, has meant coverage in Indonesia is now close to UHC. Without the mechanism of Jamkesda in place in at least 460 districts today (up from 367 in 2010), many currently enrolled in Jamkesda schemes would not have

[145] See CHEPS Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014)

ready access to BPJS, as its predecessor entity, Askes, in 2013, had contracts to run Jamkesda schemes in only about 175 districts of the nearly 540 districts in the country.

B. Increasing Number of Jamkesda Throughout the Country

Second, the numbers of Jamkesda have grown over the period from the early part of the last decade until today. From the stratified random sample of Jamkesda in the study, the growth in the number of Jamkesda can be estimated for the total throughout the country. From very few Jamkesda in existence prior to the enactment of law 40/2004, the numbers began to swell after a successful Constitutional Court challenge of law 40 in 2005 on behalf of Jamkesda, and followed up in 2008 by the encouragement of the Minister of Health to districts to create local schemes. The major increase in Jamkesda occurred from 2008 through 2010, when over 70% of the sampled Jamkesda were created. From 2011 through the end of 2013, another 14% of the total sampled Jamkesda began.

Table 1:
Health Insurance Coverage in Indonesia, 2003 To mid-2014, Millions of Persons

Insurance Scheme	2003	2008	2012	Mid-2014
1. BPJS 1/	NA	NA	NA	124.0
2. Jamkesmas/Askeskin	0	76.4	76.4	BPJS
3. Private Health Insurance	2.0	7.0	15.4	>15.4
4. Jamkesda Schemes	0.8	4.0	31.8	65.0
5. Askes Civil Service	13.0	15.0	17.3	BPJS
6. Jamsostek (Priv. Sector Workers)	2.5	2.9	5.6	BPJS
7. Asabri & Taspan (Military & Police)	4.5	5.0	2.2	BPJS
8. Askes Commercial Hea. Ins.	NA	1.0	2.9	BPJS
9. Private Firm Employees	NA	NA	6.4	6.4
Total Coverage	**22.8**	**111.3**	**158.0**	**>210.8**
Total Population		~230	~245.0	~252.0
Share of Population Covered	**~10.0**	**46.8**	**64.5**	**>83.6**

Notes: 1. At the beginning of 2014, BPJS took over the control of operations of the following health insurance programs: a) Jamkesmas, b) Askes civil Service scheme, c) Jamsostek for private sector large scale company workers, d) Asabri and Taspan schemes for the police and military, and e) the commercial health insurance programs of Askes.

By the end of 2010, the MOH conducted a survey of Jamkesda to learn how many schemes there were and what their level of coverage was. That survey counted 367 Jamkesda in place. By extrapolation, from the findings of that survey in conjunction with the survey CHEPS conducted in 2014, the number of Jamkesda schemes now in place is likely to be around 460, though the exact number remains unclear. The number of Jamkesda in newly created districts is particularly unclear. But, what is clear, is the number of local schemes is large and they exist in most all areas of the country[146].

[146] In the CHEPS sample of 72 Jamkesda, in 2013, 27 of the 34 provinces are represented.

C. Provincial Fund Mobilization

A third major achievement of the Jamkesda program is found in the fact that they have tapped into provincial health funding for additional resources over the 2008 to 2014 period. Table 2 shows the trend in resource mobilization by Jamkesda disaggregated according to source of funding.

These data show when the source of financing changed, from being dominated by the district to the province. The main change occurred in 2010, when the provincial government spending began to comprise the largest share of revenue for Jamkesda. Nearly 80% of total revenue came from that source in 2013.

Table 2:
Jamkesda Funding by Source, 2008 to 2013 within the Jamkesda Study Sample Districts, Million IDR.

Year	APBD Kab/Kota	Share of Total	APBD Province	Share of Total	Total Funding
2008	14.841	83	3.040	17	17.881
2009	44.764	65	24.492	35	69.256
2010	155.085	16	797.236	84	952.321
2011	857.175	40	1,277.592	60	2,134.767
2012	990.593	42	1,374,694	58	2,365.288
2013	763.868	21	2,866.807	79	3,630.674

Source: Data from the CHEPS Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014).

D. Jamkesda are Consistent with Decentralization

Finally, Jamkesda are consistent with the decentralized design of the health sector according to the laws which were enacted after the government change in 1998. As of 2013, nearly 30% of the population in districts with Jamkesda are enrolled in such schemes, a significant achievement.

4. Jamkesda Challenges

While a number of important accomplishments have been accomplished by Jamkesda, there are a number of additional issues which require further policy direction. These issues include: a) divergence in benefit package breadth, b) predominance of FFS use in provider reimbursement, rather than either capitation or Case Based Groups (CBGs), analogous to DRGs, c) and the lack of transparency in the use of funds received by Jamkesda. These issues are documented below.

A. Benefit Packages

To learn about the comprehensiveness of the schemes' benefit packages, CHEPS developed a synthetic benefit package comprised of 26 services which are thought to be included in a

comprehensive package as deemed appropriate in the DJSN Roadmap for Achieving UHC by 2019 via the implementation of national health insurance[147]/. These services ranged from care for headaches and diarrhea, to HIV/AIDs care and organ transplantation. Each Jamkesda in the survey was asked about whether each of these services were included in their benefit packages, and, if so, was there some form of limitation on the benefit like a maximum service benefit or a time limit on the benefit, i.e., an annual maximum. These responses were analyzed and developed into an index of benefit package breadth. See the distribution of scores in Table 3.

Table 3:
The Frequency Distribution of Benefit Package Scores in Sample Districts, 2013.

Benefit Package Breadth Score	*Frequency of Districts*
100%	2
90 to 99%	10
80 to 89%	19
70 to 79%	8
60 to 69%	13
50 to 59%	11
40 to 49%	4
30 to 39%%	3
Less than 30%	2
Total Districts	**72**
Mean	**71%**

Source: CHEPS, Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014).

The data suggest a bimodal distribution of the sample districts with considerable differences across the sample. The important question to additionally be addressed is how much it might cost for all schemes to have a fully comprehensive benefit package. The Ministry of Finance is clearly one stakeholder with this concern. The items least covered across the sample were services which were costly and where the treatment was not very reliable to achieve a positive health status outcome.

One of the policy challenges for the DJSN is the development of regulations for harmonizing the benefit packages when there is divergence in the capacity of financing these packages across the country. This divergence in capacity can be measured by the ratio of the highest APBD per capita spending on health divided by the lowest. According to MOF 2012 district expenditure data, that range ratio was 164 to 1, meaning the highest spending district is spending 164 times more than the lowest [148]/ per capita on health. This issue is also important to achieve membership portability.

[147] See DJSN, Peta Jalan Menuju Jaminan Kesehatan Nasional 2012 -2019, (Jakarta: DJSN, 2012).

[148] See Page 130, chapter 10, CHEPS Sub-national Health Insurance Scheme Study Final Report, Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a national Social Health Insurance Program, op. cit. , 2014)

When an analysis was conducted of the determinants of the benefit package score, two variables were significantly related (negatively) to the benefit package score. The first variable was the level of coverage of the population, measured as the total number of persons enrolled in the scheme, and the second, was whether the local parliament was involved in determining items in the benefit package. In both cases these independent variables were negatively related to the Jamkesda's benefit package score. The first finding regarding coverage suggests that there is a trade-off between the numbers of persons enrolled and the numbers of services which can be included in the benefit package. The second finding, regarding the negative relationship between local parliament involvement in the decision making process about the services included in the benefit package, suggests they tend to reject items from inclusion, given one of their roles in local government is controller of the budget. Both findings are consistent with what economic theory might predict.

B. Provider Payment

A second issue requiring thoughtful consideration is the method employed to pay providers for their services. The study inquired about this issue. The national BPJS scheme have implemented two payment methods: for ambulatory care based at Puskesmas and family practice clinics, capitation is considered the preferred modality of payment for these services. For inpatient care, BPJS uses the case based group (CBG), or in many other countries, known as diagnostic related groups (DRGs). These approaches are said to be cost-effective according to international practice. The problem with this argument is that there is no counter factual, so who knows for sure [149]/. What was unearthed from this study, however, is useful for those who want to move to these payment methods. These findings are summarized in Table 4.

Table 4 shows the importance of Fee-for-Service (FFS) amongst the service providers in the sample Jamkesda districts. This finding is in spite of the fact that over the last nearly decade there has been considerable effort made by designers of the JKN program to eliminate this form of payment and substitute either capitation and/or CBGs.

Table 4:
Use of Payment Mechanisms in the Sample Jamkesda Schemes, 2013.

Possible Providers	Frequency of Payment by Capitation	Frequency of Payment by FFS	Frequency of Payment by CBGs	Total Frequency of Payment Systems Employed
1. Public Hospital	1 (1.3)	49 (62.8)	28 (35.9)	78
2. Provincial Public Hospital	1 (1.8)	33 (57.9)	23 (40.4)	57
3. Central Referral Hospital	1 (3.1)	15 (46.9)	16 (50.0)	32
4. Private Hospital	0 (0.0)	7 (36.8)	12 (63.2)	19
5. Puskesmas	26 (40.6)	37 (57.8)	1 (1.6)	64
6. Family Doctor	13 (92.9)		1 (7.1)	14

[149] Indonesia may want to conduct a randomized clinical trial of these several payment methods to resolve the matter.

7. Other Specialized Service Providers		8 (47.1)	9 (52.9)	17
8. Other		2 (50.0)	2 (50.0)	4
Total	42 (14.7)	151 (53.0)	92 (32.3)	285

Note: Other specialized service providers is comprised of: a) pharmacies, b) blood transfusion units, c) dental clinics, and d) private midwifery and nursing clinics.

Most providers feel more comfortable with and understand better what FFS payments are based upon. It is going to be a hard sell to get all parts of the country to adopt these forms of payment, especially when: a) capitation payments have been set inappropriately low, and b) when institutions which may be paid by CBGs remain unclear how these payments are related to service delivery costs.

C. Expenditure Transparency

Besides assessing the extent to which Jamkesda obtain funding from district and provincial sources, the Jamkesda study also investigated the level of expenditures by the same Jamkesda. The study's findings were not from all Jamkesda in the survey as there were a number which did not report this information. But there was enough reporting from all strata of the sample to be able to report several important findings. They are summarized in Table 5. These findings are based on a sub-sample of 43 districts which reported most of these data and extrapolated to the estimated number of Jamkesda throughout the country as of the beginning of 2014.

Table 5: Estimated Total Revenue and Expenditures for All Jamkesda in Indonesia (N=460), as of the Beginning of 2014

Items in The Financial Statement of a "Typical"/Average Jamkesda	Amount in Trillions of IDR	Percent of Total Revenue
1. Estimated Total Revenue	13.155	100.0
2. Estimated Total Expenditures	2.238	12.2
A. Est. Total claims Payments	0.619	5.3
3. Net Revenue After Expenditures	10.916	87.8
4. Est. Overhead Payments	3.070	24.1
5. Net Revenue After Overhead	7.847	63.7

These data speak for themselves. Estimated claim payments are clearly not large relative to total revenue. Estimated total expenditures by Jamkesda are low relative to total revenue. Overhead payments comprise the largest single source of expenditure, more than 5 fold the size of estimated claim payments. The net surplus after all payments is greater than 60% of total revenue. What do we know about the net surplus? Not much. Is it in the bank? Maybe ok. Has it been used for other purposes.....?

In 2007, there was a great concern in the media and among senior decision making circles about local government spending. At that time the World Bank estimated a large amount of district

revenues from DAU/DAK sources were not being spent, and were sitting idly n Banks [150]/. This was worrisome at the time as it withheld important financing from local levels, and the multiplier effect on local economies were not being realized as a consequence.

By 2012, this issue had departed the scene, and it is not a matter for policy makers to worry about. According to the financial data on districts within the Jamkesda survey in 2012 from the MOF, most districts were running a deficit of about 5% of revenue [151]/. However, it remains a concern of this study to better understand the resource flows the Jamkesda program and to monitor them over time.

D. Supply Side Challenges

First, there appears to be enough primary health care workers with training to provide basic curative health care services at most Puskesmas throughout the sample districts incorporated into this assessment (See Table 6). Very few facilities do not have a physician available. None of the districts in the sample had no physicians available and only 3 of 72 had less than one physician

Table 6: Staffing Indonesian Puskesmas in 72 Jamkesda Sample Districts, 2011 Risfasdas Survey

Type of Staff	Ave. No./ Puskesmas	SD	No. Districts w/No Staff	No. Districts w/< 1 Staff	No. Dists w/>= 1 Staff
1. Doctors	2.14	0.06	0	3	69
2. Dentists	0.82	0.27	3	49	23
3. Nurse	12.81	2.61	0	0	72
4. Midwife	12.15	3.49	0	0	72
5. Dental Nurse	1.24	0.22	0	23	49
6. Pharmacist	0.25	0.18	18	69	3
7. Pharm Asst.	1.12	0.15	0	31	41
8. Nutritionist	1.33	0.30	0	24	48
9. Sanitarian	1.64	0.33	0	15	57
10. Hea. Ed	0.45	0.16	8	66	6
11. Med. Records Exp.	0.19	0.13	29	69	3
12. Lab Tech	0.87	0.38	5	45	27
13. X-Ray Tech.	0.64	0.64	2	57	15
14.Skilled Admin	4.51	0.34	0	3	69
15. Total Trained staff	40.16	7.65	0	0	0

Data from the National Risfasdas survey conducted by Litbangkes in 2011.
per Puskesmas in the district. The standard deviation of the available physicians also suggests that there is little difference between the districts in physician staffing.

[150] Cite the WB study on district financing, (Jakarta: World Bank, 2008).

[151] Chapter 6, "Analysis of Jamkesda Financing, CHEPS, Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014).

Second, Table 6 suggests there is enough nurses and midwives available, with the average suggesting about 4 of each staff cadre would be available at a Puskesmas throughout the entire day (and night) assuming each staff works an 8 hour shift [152]/. Even the lowest numbers of nurses and midwives suggest that there is adequate staffing by these types of personnel [153]/.

Third, the data show there are significant shortages of staff throughout the entire Puskesmas system of primary health care for such specialized services as pharmaceutical expertise and the conduct of lab or radiographic tests. Without these types of staff readily available, key services for each type of health problem may not be provided according to the expectations of the public as well as the health professions these groups represent. It is also possible these types of specialized services are performed by persons without the specialized knowledge required to perform them with a high degree of quality.

Third, without these key staff available at the Puskesmas level, it will be difficult to make any headway in reducing the misdiagnosis rate which was found from the data available from the 2007 Riskesdas survey [154]/. In that study the misdiagnosis rate across all reported individual illnesses in the survey (both communicable and non-communicable diseases) was greater than 50% and the rate for all forms of heart disease was 92%! Standards of care delivered at a Puskesmas is required so that the adoption of these basic diagnostic services are conducted before a reimbursement is made from any form of health insurance in that locality. Without these key staff around, lack of these services will be an impediment to achieving UHC and delivering quality primary health care services.

Fourth, key services involved in claims verification is required by health insurance programs. However, this verification process is likely to be adversely affected by the general lack of specialized medical records personnel, as there are very few of these personnel working in Puskesmas. Given the lack of such trained personnel in most Puskesmas, this type of required verification service is either not being done, or being done by persons not trained for the work they do. As this aspect of claims processing is vital for health insurance to assure quality service delivery to the persons they represent to providers, it is important for this service verification function be staffed more responsibly than is the case currently, particularly because over 1/4th of the claims are initially rejected due to poor claim verification.

Fifth, key public health staff such as health educators/promoters which have an important role for improving long term health status maintenance of NCD afflicted patients are not well staffed at most Puskesmas. Few workers with this specialized education are currently working across the country, given their staffing in the sample Jamkesda districts. This cadre is particularly vital for improving the delivery of care for the increasing numbers of persons afflicted by NCDs among the population.

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[152] This statement is based on the assumption that staff work an 8 hour shift. There is some evidence from other recently completed studies that suggest the average work day may likely be considerably less than 8 hours at a puskesmas. See for example the paper by Tim Ensor, et al., "Budgeting Based on Need: A Model to Determine Sub-National Allocation of Resources for Health Services in Indonesia", Cost-Effectiveness and Resource Allocation, (2012), Vol 10-11, 1478.

[153] Unless these staff also substitute for other lacking staff in the delivery of care. This is a topic for further research investigation.

[154] David W. Dunlop, "Riskesdas Survey Results Regarding Income Group Disparities and Quality of Care Implications, 2008", (Jakarta: AusAID Working Paper, April 22, 2009). Concerns about the quality of health care delivery has been a topic of concern for a number of years. See for example, World Bank, Changes in the Supply and Quality of Health Services in Indonesia (1996 to 2007), A Health Work force study,(Jakarta: World Bank, October 26, 2009). They estimated the quality of diagnosis was about 50% overall from the IFLS data set.

Finally, there generally appears to be adequate staffing of other administrative services within most district Puskesmas. However, there are 15 districts where the administrative staffing levels on average is 2 persons or less, and at least 4 districts having less than one person on average performing administrative activities.

One other indicator of supply side shortages in a given market is the extent to which the health insurers are contracted with the available providers in that market. Table 7 provides an indication of the extent of market penetration by the Jamkesda within the 72 districts. With the exception of Public Hospitals, virtually no other provider group is well integrated by Jamkesda.

Table 7: Share of Total Providers in Jamkesda Sample Districts Having Contracts with Jamkesda

Type of Provider	Number of Providers Paid by A Jamkesda in Sample Districts [1]/	Number of Providers in All Jamkesda Sample Districts [2]/	Share Column 2 is of Column 3. An Indicator of Market Penetration
1. All Public Hospitals [3]/	167	124	134.7
2. All Private Hospitals	19	247	7.7
3. Puskesmas	64	1,326	4.8
4. Family/Private Doctor	14	11,432	0.1
5. Private Midwife	1	2,054	< 0.1
6. Private Apotek	1	3,916	< 0.1
7. Private Pharmacy	3	98	3.1
8. Private Clinical Lab.	2	566	0.4
9. Other	4	81	4.9
10. Total	275	19,844	1.4

Notes: 1. This number is the same number in Table 5-4 Column 5.
2. These numbers come from Table 1-5 in Chapter 1.
3. Includes Referral Hospitals.

This problem of market penetration is particularly true for the capitation form of payment, as the only types of providers which have been paid on this basis include Puskesmas and private/family physicians. Together Jamkesda has penetrated this segment of the market (these two types of providers) to 6 tenths of one percent of the numbers of providers which may be paid on this basis.

Even though the data in Table 7 suggest market penetration of public hospitals has been virtually complete, over one half of these providers are paid on a Fee-for-Service (FFS), rather than on a CBG basis. This finding further re-enforces the fact that many facilities are continuing to be paid on a basis which is not according to the suggested guidelines of the Road Map for achieving UHC by 2019.

5. A Way Forward?

A. What do DHOs and Pemda's Think?

What should be done with Jamkesda? During the course of the study, questions were posed to two key decision making entities, the District Health Office (DHO) and the Pemda (the district level planning agency) for the Bupati and the district parliament, known as the DPRD. These two groups were asked their opinion regarding: a) what should be the future of Jamkesda after the target date for Jamkesda integration with the BPJS, at the end of 2016, and b) if the respondents suggested they thought Jamkesda should continue, what should their role be?

The respondents answer to the first question, should Jamkesda continue to exist, was mixed, half thought yes, and half, no. A larger share of the Pemda responses indicated Jamkesda should be shut down (55% to 45%) [155]/. Perhaps as important are the responses to the second question posed, what should their role be if they are not closed? The most frequently mentioned response to this second question was a) Jamkesda should continue to play a role in determining membership matters at the local level (35%), followed by b) some oversight responsibility regarding financial and regulatory matters affecting Jamkesda (20%) and c) about 17 % thought the Jamkesda could become a franchise entity of BPJS, providing local representation on behalf of the BPJS at the local level. Other responses comprised the remaining nearly one third of the responses. From this review, there is no one clear view about the future of these entities. This is in spite of the fact that the legal basis for shutting them down is uncertain.

B. Review of the Accomplishments

The review of the accomplishments of Jamkesda outlined in section 3, suggests at least two important roles for the future of Jamkesda. First, they have mobilized new resources for social health insurance from the provinces. Second, they have expanded coverage to as many as 65 to 70 million additional persons throughout the country. These additional enrollees are primarily persons without any other coverage from the many programs which existed prior to 2014. They do not pay premiums directly (except through the taxes they pay via many fees and tariffs). It is highly likely that the poor pay at least the equivalent of the annual premium proposed for the BPJS scheme for the poor at nearly 240 thousand IDR per person per year in the form of various types of taxes or tariffs.

The Susenas data for 2012 show people spend more than that level in the form of taxes, fees and tariffs. These data raise questions regarding whether the GOI at this time, should try and collect formal premiums on those who are working in the in-formal sector. This issue of premium collection, if UHC is one of the main priorities of the GOI currently, should be placed on the back burner for the time being and let people get used to having greater access to health care services, particularly those which are provided on an inpatient basis. Other than a tax on tobacco products which should be implemented now, further economic growth which can enable an increase of nearly all incomes, will enable further targeting of tariffs and taxes which can be introduced over the coming two decades. This approach, by the way is consistent with the historical evolution of social health insurance in Asia, where those countries which have introduced some form of premium payment

[155] Chapter 10, Integration of Jamkesda with the National Health Insurance Program JKN, and its Carrier, BPJS: Opportunities, Challenges, and Obstacles, in CHEPS, Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014).

into their evolving programs have experienced reductions in enrollment. The most notable examples include Mongolia and South Korea [156]/.

C. Co-financing the Health Sector

In the context of Indonesia, the health sector has become a decentralized function of government [157]/. Given this situation, how can the GOI best achieve important social goals like UHC? To answer this question, it is useful to carefully review the extent to which each level of the government contributes to the financing of the sector. This analysis demonstrates the fact that the central government is not the leading player. The districts are, by a large margin. See Table 6 for further information regarding this matter.

These data from Table 8 show district level governments spend more than half of the total public expenditures for health as of 2012. The central government spends less than one quarter of the total and the provincial governments contribute the remainder.

The Jamkesda study conducted an analysis to determine what might happen if a co-financing regime were introduced into the system, to increase total government expenditures on health as well as re-distribute funds to districts which have the lowest levels of per-capita health spending.

Table 8: Amounts and Shares of Health Sector Spending by Different Layers of the Government of Indonesia, 2012, Amounts in Trillion IDR.

Source of Public Spending	Est Exp.	Share of Total
Central Government Expenditure	18.1	24.4
Provincial Government Expenditure	14.2	19.1
District Government Expenditure	41.9	56.5
Totals	**74.2**	**100.0**

Note for Table 6.The source of the spending data is from the MOF APBD 2012 data file. The data presented for 2012 from the Indonesia NHA Team, Indonesian National Health Accounts: Updates and Challenges, Presentation at NHA meeting held in Paris, April 2014, show different spending figures for provincial and district governments as the NHA team allocated a share of the central government spending to districts or provinces where the funds were spent.

The 2012 MOF data set showing the amounts spent by each district throughout the country was utilized as the initial starting point for this analysis [158]/. For illustrative purposes, to develop the two scenarios which have been analyzed to date, the districts were grouped into 5 categories, based on their total per capita APBD as of 2012. See Table 7 for the particulars of these two scenarios.

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[156] See Aviva Ron, Dorjsuren Bayarsaikhan, and Thunen Sein, Social Health insurance: Selected Case Studies From Asia and the Pacific, (Delhi and Manila: WHO, 2005). Also cite the recently completed review of Social health insurance conducted by the World Bank, 2013.

[157] See the introductory remarks regarding the legal basis of the sector.

[158] See Chapter 9, CHEPS, Supporting Indonesia's DJSN to Develop National Guidelines for Implementing a National Social Health Insurance Program by 2019, Final Report, (Depok: CHEPS/FKM/UI, December 24, 2014).

So, for the lowest spending group, the co-financing offer in the scenario was, for each 1% additional spending on health above what was spent in the previous year for: a) local health insurance coverage (personal health care services), or b) public health programs which addressed key MDG related health problems or emerging NCD concerns, the central government would add 9% to the total spending on health. The highest group could increase their spending but no additional funding would come from the central government. The three intermediate groups would be able to obtain varying amounts of additional central government funding based on their initial level of per capita APBD. See Table 9 for the particulars.

In the interim period of completing the final report draft, CHEPS has extended this analysis over a 5 year time horizon. It shows there would be considerable increases in total spending in the health care sector and particularly for social health insurance support and primary health care service delivery. If all districts decided to seek this central government financial support at the maximum level envisioned in one of the two scenarios assessed, average per capita health expenditure levels would rise from about 320 thousand IDR per parson per year to around 750 thousand IDR per person per year in 5 years. Further, the share of central government expenditures of public contributions to the health sector would also increase to over 50% over the same period. Finally, the equity index of the ratio of highest to lowest per capita spending theoretically would drop from 164 to 1 to 15 to 1 over the period. The standard deviation of the total distribution would also decrease relative to the mean.

These last remarks provide an interesting policy option for the GOI to introduce over the coming 5 year planning period of 2014 to 2019. It is thought it may well mark a change in thinking about this form of financing support. This model is not new, but the one utilized in China under the rural health insurance scheme. Insurance is administered at the district level, with multiple levels of government contributing to the premium. Peasant farmers contribute very small nominal amounts.

Table 9: A Comparison of the Co-Financing Scenarios for Improving the Financing of District Health Systems in Indonesia

Groups 1/	**Scenario 1: Co-Financing Rates 2/**	**Scenario 2:** Co-Financing Rates	**No of Districts**
Group1:< 1 million IDR APBD/Cap/Year	1% D, 9% C	1% D, 9% C	29
Group 2: Between 1 @ 1.499 Million IDR APBD/Cap/Year	1% D, 3% C	1% D, 5% C	79
Group3:Between 1.5 @ 1.99 Million IDR APBD/Cap/Year	1% D, 2% C	1% D, 3% C	68
Group 4: >= 2 Million IDR APBD/Cap/year, @< 2SD Mean Health Sector Exp. IDR APBD/Cap/Year	1% D, 1.5% C	1% D, 1% C	282
Group 5: >2 SD Mean Health Sector Exp. IDR APBD/Cap/Year	1% D, No C	1% D, No C	28
Total			486
Year			2012

Notes: 1. Groups are based on per capita APBD and per capita health sector expenditures.
2. D = district government co-financing rate, C = central government co-financing rate.

D. The Current Legal Status of Jamkesda, Nationally

While law 40/2004 was created to implement a single payer health insurance scheme throughout the entire country of Indonesia, this law was challenged by a number of districts in which sub-national health insurance schemes had been established prior to 2004 to provide coverage to all or parts of their local population. The Constitutional Court overturned the sections of law 40/2004 requiring a single payer mechanism be established via their ruling (007/UU-III/2005). This ruling was based on the decentralization laws of 1999 and 2004 and subsequent governmental regulation in 2007 regarding decentralized functions of government. The local government law (No. 32/2004), Article 167, Paragraph 2, explains that the local government has a responsibility to develop Social Security in order to improve the quality of life of the community. It has been amended by a new law (No. 23/2014), stating the role of local government in social protection and assurance is to: a) cover persons who are locally defined poor (PBI status) and/or have social welfare problems, and b) collect data regarding the management of who is poor within the district (the concern which many districts mentioned in the survey about what their role should be in the future development of JKN). Further, the statement about the local government function according to law (No. 23/2014), does not suggest that the earlier defined functions as was mentioned in Law (no. 32/2004) has been changed regarding the local government's role in the financing of local/district social security.

The financial support for those who are deemed to be poor (PBI status) by district authorities will continue to be covered by the local government in the form of an annual premium payment. It is stated in MOH regulation (No.28/2014) that "*Premiums for the participants who are registered by the local government will be paid by the local government at a rate equal to the rate established by the national BPJS for those poor persons identified by the central government*." But that regulation does not state to whom the premium must be paid, which could be to the local Jamkesda or the BPJS.

In addition, the MOH regulation No. 28/2014 provides local government authorities (PEMDA) with the responsibility to define a person(s) as "poor" (Local PBI), or those with social welfare problems (PMKS) and the responsibility to pay for their health insurance coverage. Further, the recently approved Presidential regulation (PP 12/2013) provides PEMDA with the authority and responsibility for providing health facilities and services which can address the needs of those deemed poor and/or have other social welfare problems.

The new law (23/2014), in conjunction with PP (12/2013) and related MOH regulation (28/2014) also support the basis for the constitutional court's ruling in 2005 (ruling 007/UU-III/2005), indicating decentralized government responsibilities for the health sector, which also overturned the section in Law (40/2004) providing for a single health care payer, on the grounds of the decentralization law (32/2004). This 2004 decentralization law was crafted to address issues in earlier decentralization laws (22/1999 and 25/1999) establishing the role and responsibilities of local governments, right after the change in the organization of the government of Indonesia, upon the end of the Suharto period [159]/.

While some currently argue that the single payer provisions of the national carrier law (24/2011) has resolved the decentralization issue for health insurance, there is no language in the law which addresses the legal status of sub-national schemes. They are not mentioned at all in the law. Must

[159] See Bambang Brodjonegoro, "The Indonesian Decentralization After Law Revision: Toward a Better future?" Document of the Economics Department of the Universitas Indonesia, 2005.

another law be enacted to overturn the Constitutional court's ruling of 2005? The recently elected current parliament in which local government's now have a large share of the total seats (132 of 692 or 19.1%) [160]/ suggests the enactment of such a law will be more difficult.

By enacting the proposed co-financing of the sector by the central government (see section 5.B above), coverage at the level of BPJS benefit package would immediately bring in over 60 million people, raising national coverage levels to over 85%. A victory for the Jokowi team. For local cardholders, benefits and financial protection immediately increase. For provincial leaders, new benefits mean greater political acceptance by local constituency. That would be a win-win-win situation.

Over time, the central government may be able to obtain greater financial leverage with respect to the local governments so that the central government may be able to persuade most local governments that it is willing to work for a common goal with local governments. The IT systems should be standardized with the BPJS to assure there is no duplication of coverage, which according to the Jamkesda study amounts to about 23%.Claims payment systems could be standardized to track equitable access and utilization, as well as minimum standards of quality of care. Regulation could assure payout ratios improve. Audits might be needed to review Jamkesda with unacceptably high administrative costs[161]/.

If local Jamkesda choose, within 5-10 years, standardized systems could be merged into the single national database for claims payment and quality. Local Jamkesda could be utilized to provide important services related to enrollment, consumer outreach, consumer satisfaction, claims processing and local quality assurance teams.

If local Jamkesda do not merge, they would need to demonstrate – through the standardized administrative systems – that care and access are at least as high as via the BPJS system. If not, the local Jamkesda would be designated by BPJS as a "local social protection" program, which would not have the same benefits as the national scheme. These differences could be widely disseminated to the public in those local areas. The smaller risk pools of the local Jamkesda would generally be an impediment for Jamkesda to continue – all things equal, administrative costs for Jamkesda would be higher than for the BPJS. Finally, it could be announced to the public in those districts which do not adhere to the rules of the BPJS that all members could have the "once in a lifetime" option to switch from Jamkesda to BPJS without financial penalty. But this penalty would not be in effect in the near term as Jamkesda members do not pay any premiums currently.

Some in Jakarta would like to believe that local governments will be willing to relinquish their control over local financial resources and opportunity to provide political benefits in the form of health services. But this may be wishful thinking. Instead, the central government might consider a strategic path over 5-10 years to bring everyone up to some minimal standard of benefits and financial protection. Jamkesda would then need to perform or close their doors.

By cost-sharing, the Ministry of Finance saves funds by having local provinces and districts pay some of the premium or the cost of the member's health benefits. President Jokowi increases coverage. Provinces keep their programs. Local schemes are small laboratories of potential

[160] Kompas, October 8, 2014 page 1.

[161] The Jamkesda study has found that more than 90% of the Jamkesda have annual financial audits.

innovation. But if performance is sub-standard, the central level folds the schemes under BPJS, or over time, Jamkesda take on new roles as local representative offices for BPJS.

First and foremost is the citizen. Shutting down Jamkesda could be very disruptive and scary for the local population. And, without a significant political benefit from the center, local leadership may resist immediate closure of Jamkesda in the next several years.

#29 POLICY NOTES

Public-Private Partnerships In Health Sector? When?[162]

March 2015

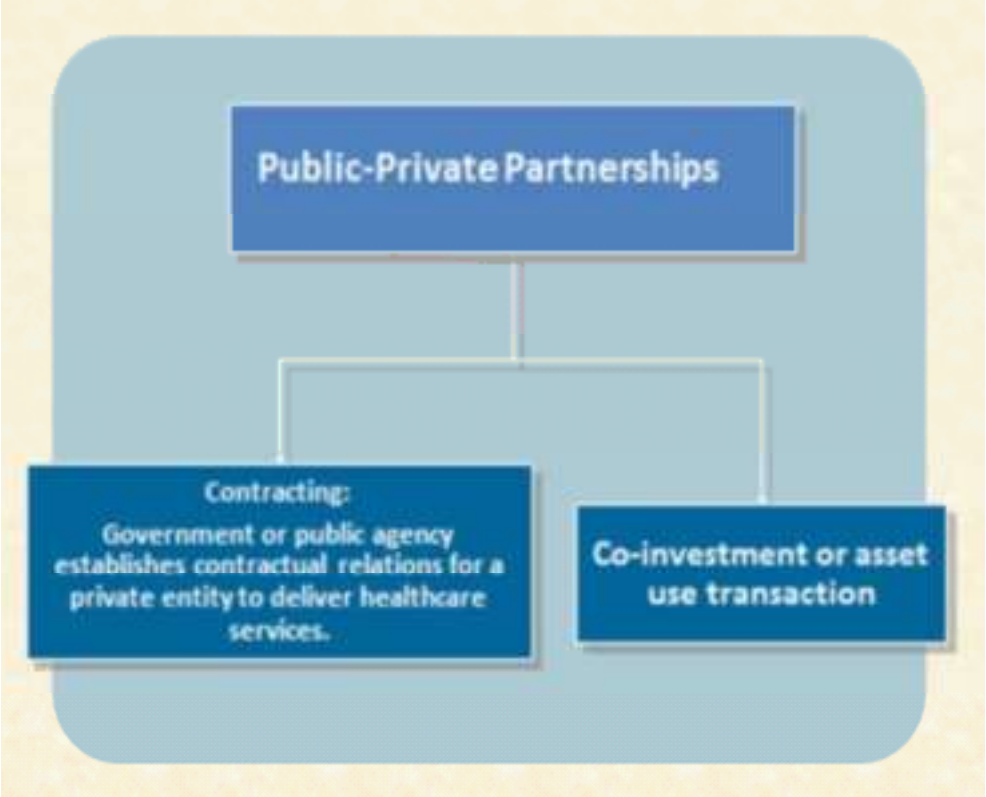
Ibu Nila, Minister of Health, has recently called for more Public Private Partnerships (PPPs) in Health. It is long overdue.

The private sector is growing at a robust pace. Yet, there is no clear policy on the role of the private sector. Indeed, too little is even known about it. While the private sector is growing rapidly on the supply side, the Government oversight of the private sector is either missing or limited, and there is very little knowledge on the numbers and distribution, and of the scope and quality of their services. The Ministry of Health has been relatively blind to the private sector until early 2014 when the President called for more contracting with the private sector under JKN. As Figure 1 suggests, this is a first type of PPP.

The private sector may be one option to provide a faster and more responsive service delivery system for the country. The government should immediately look for ways to promote a harmonized public and private delivery system. Given past corruption, Government should examine ways to focus on demand side financing, and encourage the private and non-profit sectors to develop the supply side. A radical option would be to have capital allocations for new public facilities stopped or frozen until a master plan is developed for the organization of the supply side.

[162] This Policy Note was written by Jack Langenbrunner of funded by the Australian Department of Foreign Affairs and Trade (DFAT) through Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) Program.

Figure 1: Two Broad Types of Public Private Partnerships



Source: April Harding, World Bank, 2012[163]

Globally, there are public-private partnership (PPP) arrangements where government provides tax credits, subsidies, and even appoints a private 'partner' to finance development of a health facility – and sometimes operate it. They can range from the private finance initiatives (PFI) that were in vogue in some richer countries as the United Kingdom over a decade ago and under which a private company finances and builds a hospital for the public sector to operate, to arrangements where the private sector builds and operates a government hospital employing its own staff over a lengthy period of time. Under most arrangements, government owns the hospital at all times and contractual arrangements endeavour to ensure 'cost neutral' access for public patients and for government recurrent expenditures. Governments used PFI to raise money 'off budget' i.e., off the public finance balance sheet and not showing in the public sector borrowing requirements.

Consumers increasingly desire health services attuned to their interests and perceptions. Not only in developed countries but also in middle- (Brazil, Chile, Mexico, South Africa, Thailand) and even low-income (Ghana, Ruanda, Kyrgyzstan) countries when there is a move toward universal health coverage approaches and schemes, aiming at providing quality services to (ideally) the totality of the population.

In terms of the role of the private sector, much of the discussion about "PPP" comes from experience in Europe and other high-income countries (US, Canada, Australia, etc.). In a summary form, the challenge is to turn a typical "Design, Build, Finance and Operate (DBFO)" contract into a long-term

[163] Private Sector Flagship Course, Hong Kong, 2012.

investment project. The PPP is a replicable and scalable business model, generating *a long-term* (say, 25-30 years) *risk-sharing relationship between public and private sectors,* with the objectives of:

- ✓ bringing about the desired public policy outcome of desirable services under the overall control of the public sector partner; while
- ✓ generating profits for the private sector partner.

The PPPs turn a (traditional) ownership of assets into a services purchase – the government no longer owns the hospital but buys access on an ongoing basis to various hospital or other healthcare services. This implies a switch in deciding within a project development from an *input* specification (the state client specifies what size of facility is built and how it will be run) to an *output* basis (guaranteed access to a given flow of services at specified quality, in whatever way the private partner contractor chooses to deliver them). International experience on healthcare PPPs can be categorized, according to Antonio Duran of the European Observatory,[164] in the following ways:

1. "Accommodation-only" provision. In this PPP variant, probably the most common worldwide (and effectively, a managed lease), a private partner provides the buildings -and potentially the equipment- and maintains them for the life of the contract. All medical provision remains in the hands of the state. The UK for example has built more than 100 hospital units this way using the so-called Private Finance Initiative (PFI). In some cases, a separately-incorporated public sector company carries out the real estate operation, and operates the serviced space for a public sector hospital organization;
2. "Twin-Special Purpose Vehicles". Is a PFI-style estate provision under one private contractor which is twinned with a separate private sector medical services company, responsible for all clinical services and the medical equipment too;
3. "Clinic/Hospital Full-Service Franchise". Most hospitals in many European countries – not in the US – are owned, developed and run by the state. There are occasionally non-profits (e.g. church) hospitals within the system. What has been new is that private, commercial, for-profit clinic groups and hospital companies enter into the market contracted essentially 100% to the social health insurance organization or other public funding. The private hospital then fits within the public sector's clinic and hospital planning system (that is, has to provide comparable services), and cannot "cream-skim" which patients it accepts, earning revenue on the same basis as public hospitals (through published CBGs or other tariffs). The commercial companies concerned have fairly complete operational freedom for clinical and other processes, irrespective of whether or not it takes public capital grants for construction;
4. "Regional Healthcare Franchise". This is a further extension of 3 above, with the private company having a concession for provision of both hospital and primary care services – the full continuum of care. There is considerable experience in Spain with this model. The payment system is "capitation", bench-marked against public sector comparators and with protections for patient choice. The concessionaire cannot choose which patients to accept at any level of the system, but can incentivize patients to be managed at the most efficient levels (primary care is often cheaper for the company than admitting a patient to a hospital).

More information and details on global models of PPPs can be found in the Bappenas papers funded by DFAT in 2014 for the new 5 Year Plan. Interested readers can refer to these papers.

[164] Readers may go to the European Health Observatory website for a deeper discussion by Duran and others.

A substantial part of the success of modernizing interventions depends on the capacity to innovate in servicing health needs, but also on integrating those functional innovations in the design and physical layout of the centers.

Any use of innovative mechanisms in Indonesia would need to be set in this country's context. The Indonesian health system is substantially mixed already (i.e., has a major independently-organized private health sector). As a result, using the PPP mechanism may constitute an advantage in Indonesia.

In contrast, the existing context of rather weak public governance may become even more problematic when agencies other than the public sector deliver services to the public (with the possibility to escape state obligations if with hitherto-public service structures are transferred to the private sector). For this reason, using the PPP mechanism in Indonesia will require carefully designed balancing elements of regulation, monitoring and supervision.

Nevertheless, health leadership in Indonesia could consider pilots and begin and:

- Identify a geographical area where the pilot experience could be organized;
- Explore the preferred modality of service delivery organizations to be developed;
- Choose the preferred governance and management scheme to run it;
- Indicate the time terms and conditions under which the experience would be organized;
- Address any other issue of relevance for possible discussion.

Finally, Indonesia's health system and service delivery apparatus will remain highly vulnerable to all types of major natural disasters, given the country's location on the Pacific "Ring of Fire" and as a result of climate change that is increasing both the frequency and intensity of natural disasters.

Next Steps

The MOH and Bappenas could develop a global call for proposals for PPPs. The Government should indicate criteria and objectives, geographic areas of interests, a timeline and due date. Once proposals are received, have a panel of experts select the best, and invite them to elaborate their ideas before a government panel in a 2-3 day symposium. This can be the start of a dialogue and PPP pilots in Indonesia.

Once agreed and started, pilots will need to be carefully monitored and evaluated, and then scaled up.

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