Make Up As We Go:
Universal Health Coverage Policy in Indonesia

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Why is UHC in Indonesia important?

Indonesia is a complex setting

- 17,500 islands
- Much variability in health delivery and outcomes
- Decentralized governance
- UHC aims to cover 250m+ people by 2019

UHC is a complex intervention

- Centralized policy
- Multiple interactions between multiple stakeholders on multiple levels
- Complex funding and payment mechanism
- Huge potential for unintended outcomes

Point-of-No-Return?

- UHC is a political commitment and political decision
- The implementers are bureaucracies at different levels in different institutions
- UHC is a major health financing reform

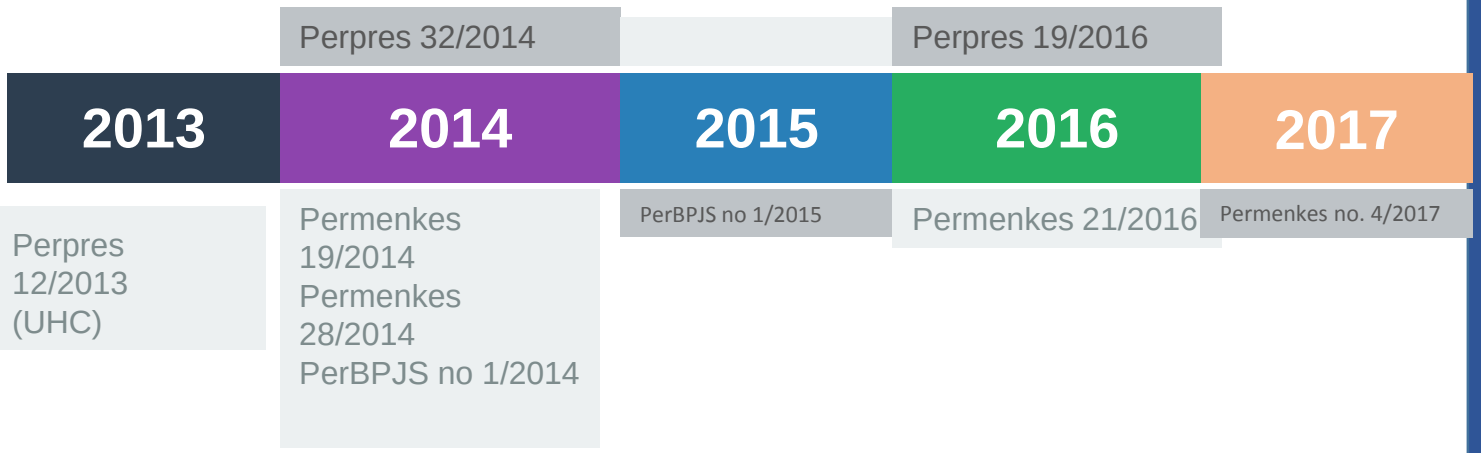
Indonesia initiated national health insurance (*Jaminan Kesehatan Nasional*/ **JKN**) in 2013 to achieve Universal Health Coverage (**UHC**)

Implementation began in 2014.

The administering agency is *BPJS Kesehatan* (National Health Insurance Agency) an independent agency, responsible directly to the President.

The policy for implementation is still evolving.

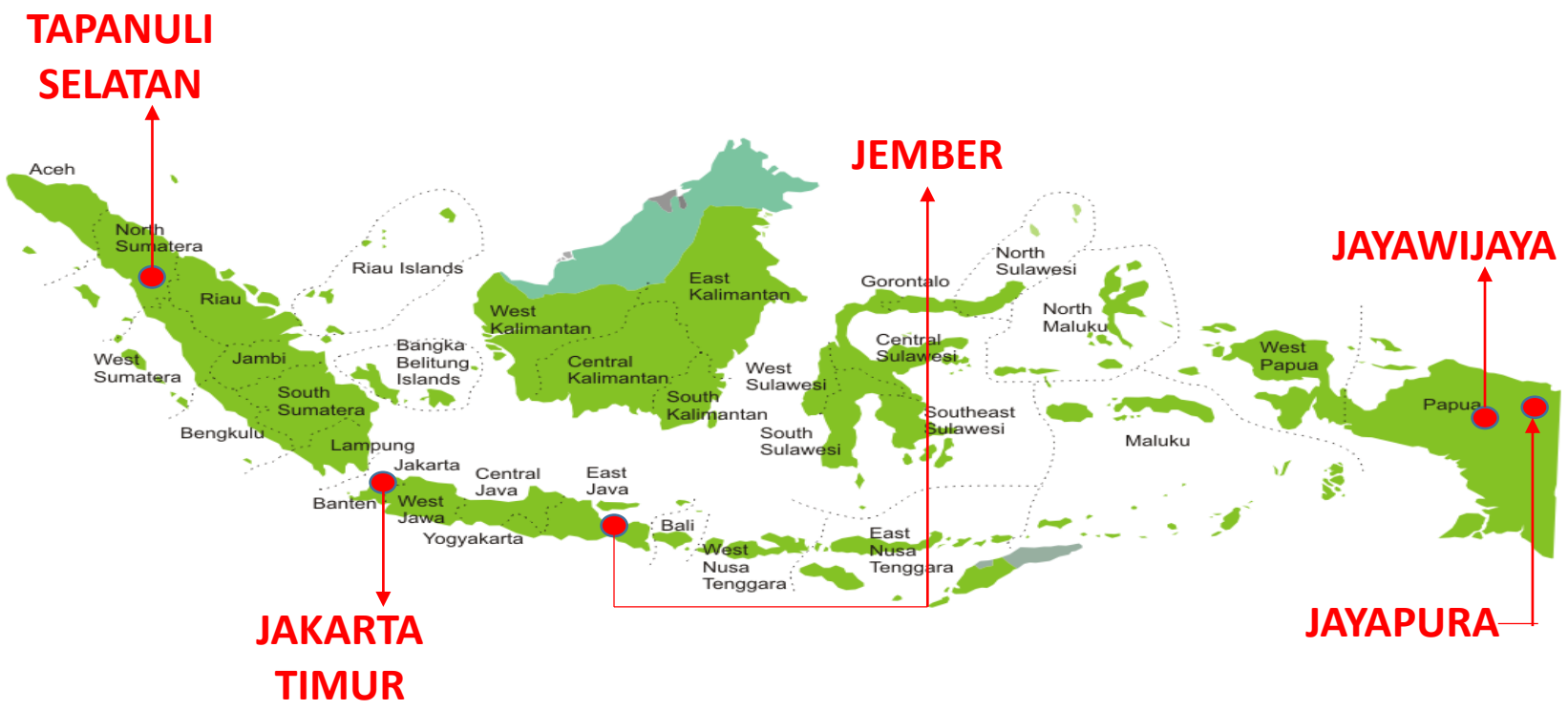
UU no 40/2004 (Social Security System)
UU no 24/2011 (Agency)



What is the role of CHPM?

- CHPM works with Ministry of Health + National Health Insurance Agency to identify issues in implementation at district level
- Implementation research involves:
  - Engaging stakeholders in
    - Ministry of Health (5 Depts)
    - National Health Insurance Agency
    - District health offices
    - Local development planning agencies
  - 5 Districts, 88 health facilities
  - 4 research partners
  - 2 cycles: identify challenges + address challenges
- Research supported by USAID, and in some parts by KSI

Study Sites


TAPANULI SELATAN
JEMBER
JAYAWIJAYA
JAKARTA TIMUR
JAYAPURA
Aceh
North Sumatera
Riau
Riau Islands
West Sumatera
Jambi
Bangka Belitung Islands
South Sumatera
Bengkulu
Lampung
Jakarta
Banten
West Jawa
Central Java
East Java
Yogyakarta
Bali
West Nusa Tenggara
East Nusa Tenggara
West Kalimantan
East Kalimantan
Central Kalimantan
South Kalimantan
West Sulawesi
South Sulawesi
Gorontalo
North Sulawesi
Central Sulawesi
Southeast Sulawesi
North Maluku
Maluku
West Papua
Papua

2014

The merging of all existing insurance systems and Out of Pocket (OOP) payment into a single pooling social insurance

Changes in payment system to health facilities

PRIMARY CARE → prospective payment (capitation)

SECONDARY & TERTIARY CARE → Case-based package (INA-CBGs)

APBN (national)

APBD (local)

Private sectors

Single pool
National Health Insurance Agency

Primary health care facilities

Hospitals

PATHWAY TOWARD UNIVERSAL COVERAGE

Informal sectors

- Poor
- Near poor
- Civil servants
- Police
- Military
- SOEs

Integration of Jamkesda (local health insurance) and other commercial insurances

Small and micro enterprises

Large and medium scale enterprises

UNIVERSAL COVERAGE

2014 → 2015 → 2016 → 2017 → 2018 → 2019

Decentralized health system

Local government has full autonomy for health affairs within its region

TENSION

UHC is a top-down program
Most regulations established by central government with one-size-fits-all rule

Rates of capitation, non-capitation and premiums set without considering characteristics among regions

Multi-interpretation of national regulations by local governments

Some local governments refuse to integrate their Jamkesda into UHC due to unequal “real” benefits

National Health Insurance Agency has a centralized structure; local government’s authority becomes weak, particularly reporting and data sharing

Current situation

National Health Insurance Agency deficit
± IDR 10 trillion 2015
± IDR 6,7 trillion (September 2016)
Deficit expected ± IDR 7 trillion (end of 2016)(Kompas, 2016).

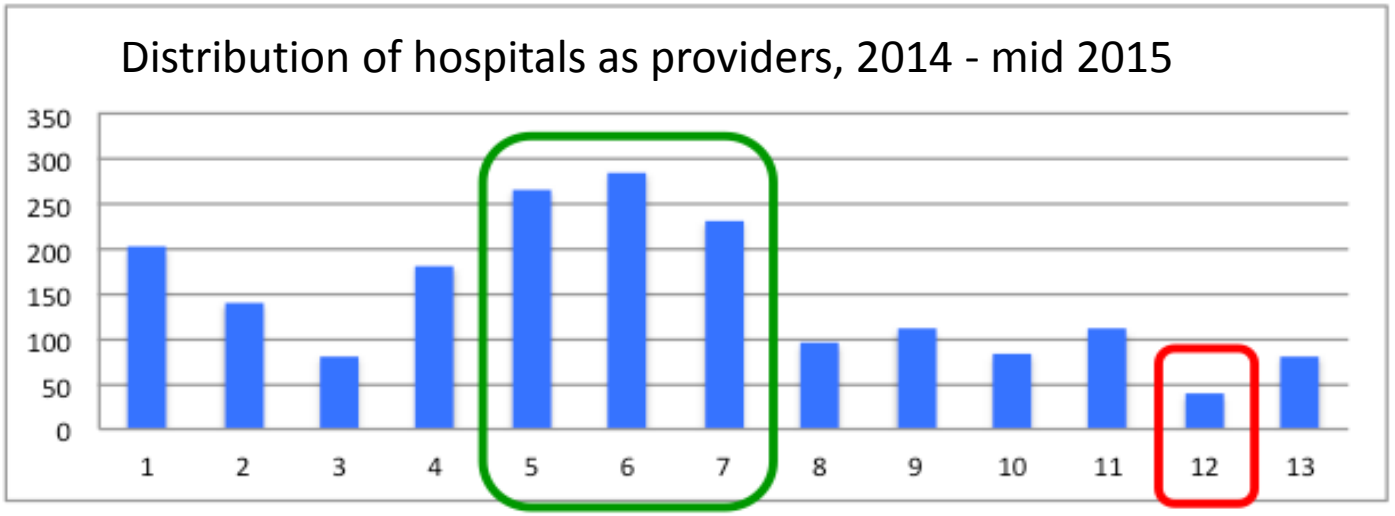
Coverage: 66% (175 million people)
Local governments asked to contribute more by immediately integrating *Jamkesda* (local health insurance) into UHC

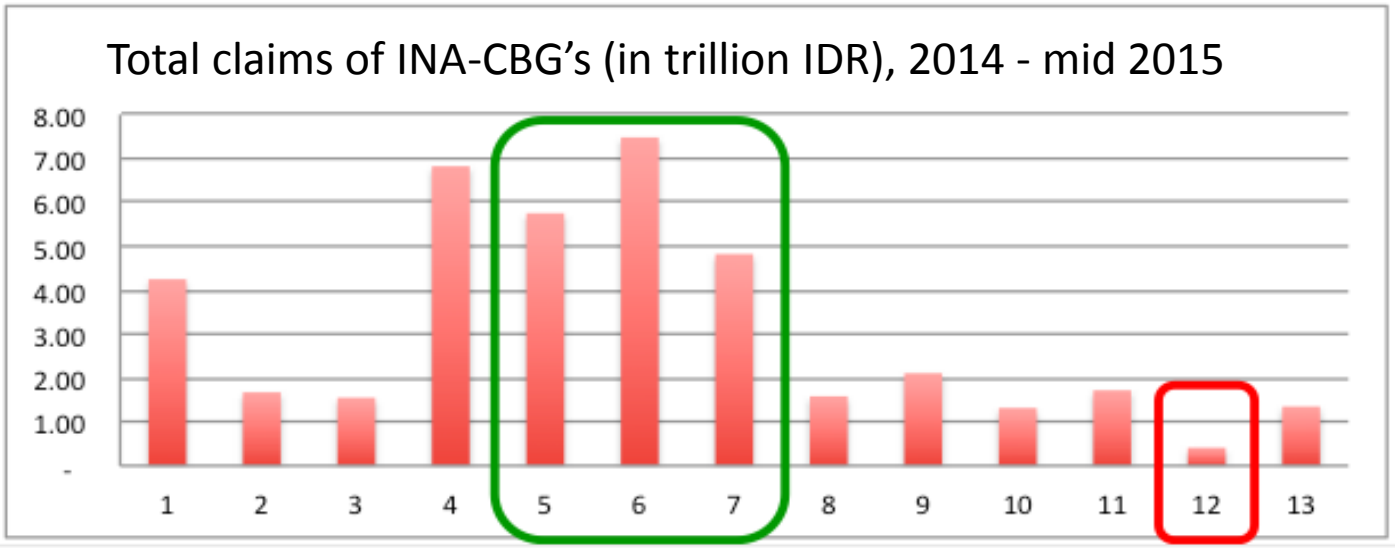
Presiden Jokowi memimpin Rapat Terbatas tentang Pembiayaan BPJS Kesehatan, di Kantor Presiden, Rabu (9/11). (Foto: Humas/Jay)

Source : http://setkab.go.id/

"I propose that the central and local government could share roles and responsibilities based on cooperation spirit. However the shared role and responsibility has to be clear. ”
(President Jokowi)

Challenges rooted in the supply side problems





Study results and Recommendation

Rates of capitation, non-capitation and premium were set without considering the various characteristics among regions	Strengthen the role of health facility associations in provincial and district levels to advocate 'fair' premium setting
As National Health Insurance Agency is a centralized structure, local government authority becomes very weak, particularly in terms of reporting and data sharing	Strengthen the role of District Health Office and local government to oversee UHC implementation
	Encourage bridging of information systems to allow data accessibility
Disparity of members' distribution, leads to disparity of income of health workers at different Primary Care Facilities	Clearly define the regulation on member redistribution between different health facilities

Potential roles for international development aid? (1)

- Need to address policy and implementation gap:
  - policy changes at national and local government level
  - strengthening learning & exchange of knowledge between implementers
  - capacity building for implementers
  - building stronger monitoring capacity, including by third parties (research institutions and universities)
  - need to enable changes in bureaucratic approach

Potential role for international development aid? (2)

- Need to build a UHC policy community:
  - developing capacity for research institutions and universities
  - more systematic interactions between knowledge producers and users
  - sustain ongoing monitoring and advocacy role of CHPM
    - network of researcher and universities
    - joint research and monev
    - community of practice

Better Policies Better Lives ™

Thank You

http://indonesia-implementationresearch-uhc.net/