UNIVERSAL HEALTH COVERAGE: COST ESTIMATION

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Content:

Part 1:

- Overview existing practices of HI scheme, looking at several key structures

Part 2:

- Review on the implementation of Jamkesmas, addressing rooms for improvement

Part 3:

- Cost Estimation needed for achieving Universal Coverage

BACKGROUND:

Indonesia established Social Health Insurance (SHI)

Several Key Structural differences:

(1) Separate Risk Pooling for different Population Groups

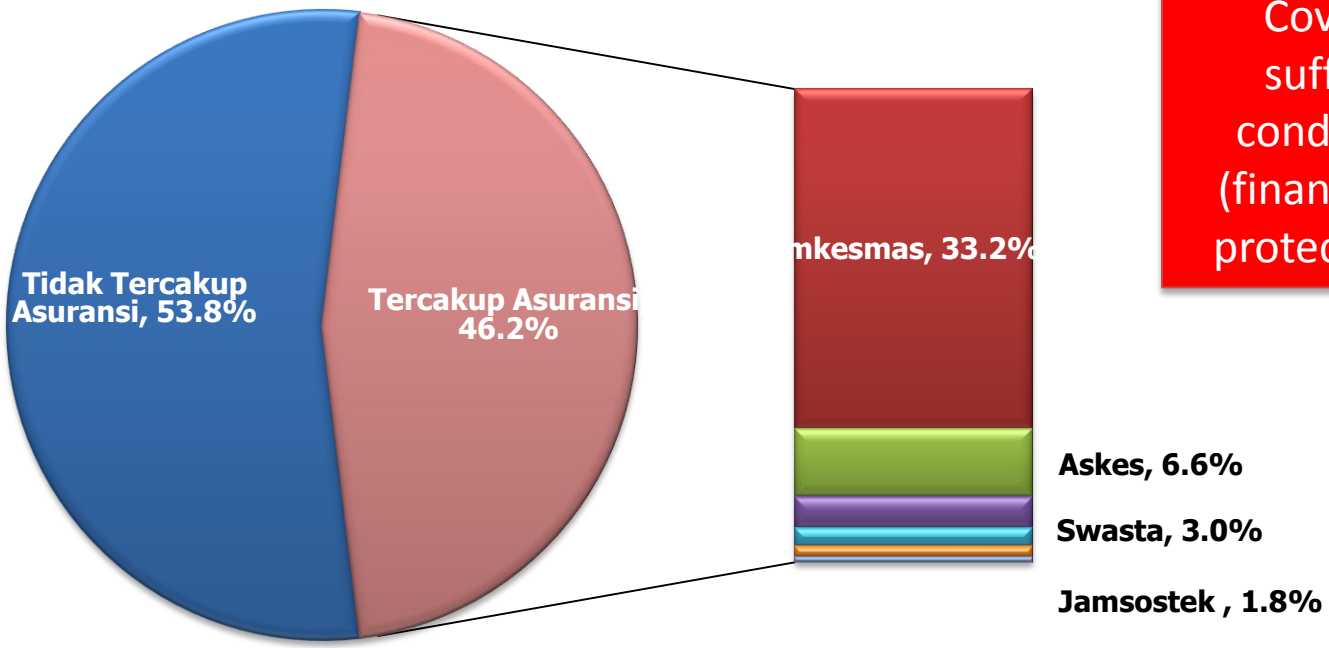
Insurance Careers	Started	No Years	No. Coverage	Who Covered	Premium
Askes	1969	42 yrs	15 million	Civil servant, pension, family	2% Gov + 2% Employees
Jamsostek	1992	17 yrs	4.5 million	Workers and family	3% Single/6% Family
Asabri (Military Pers)			2 million	Productive Military Personnel & Family	
Askeskin/Jamkesmas	2005	6 yrs	76.4 million	The Poor	Rp 5,000 - Rp 5,500/kapita
Jamkesda	2005	6 yrs	27.49 million	Non-Quota to All Pop	Rp 1,000 - Rp 18,500/kapita

Population Coverage in INDONESIA

53,8% of total population have no health coverage to protect from financial risk due to illness

46,2% of total population have health coverage

Is Population Coverage sufficient condition to (financial) risk protection ???



Source: Susenas (BPS) 2010.

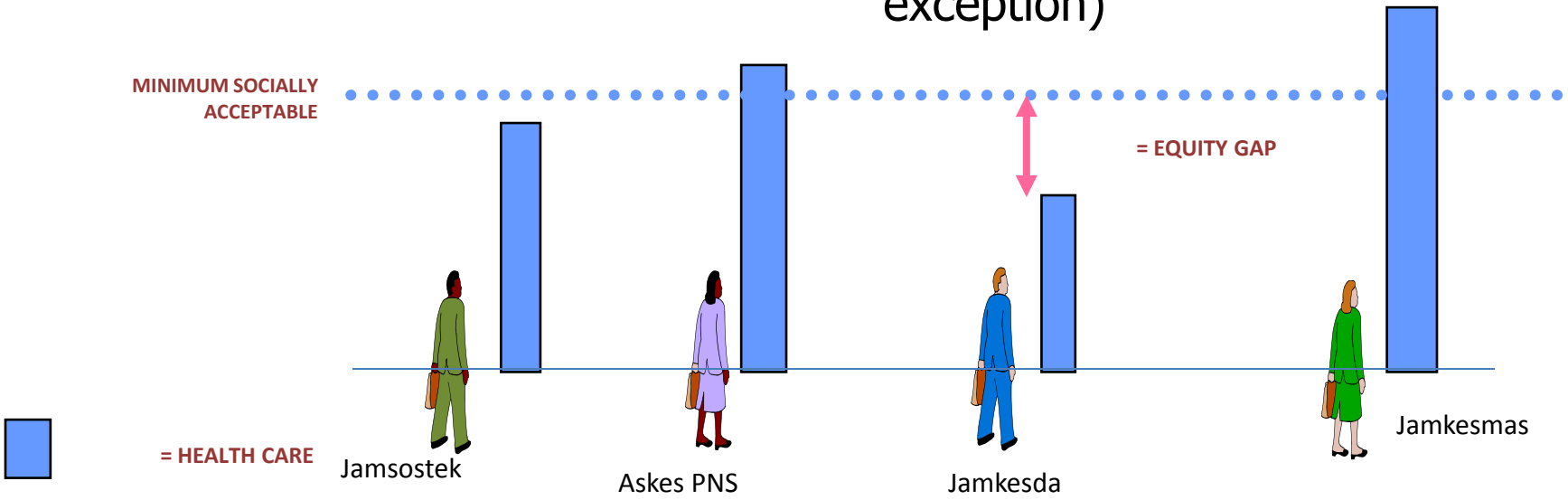
(2) Benefit Package of Several Tiers ?

Benefit Packages	Jamkesmas	Jamkesda	Askes	Jamsostek
OP Doctor	Covered	Covered	Covered	Covered
OP Specialist	Covered	Covered	Covered	Covered
IP at Primary Care	Covered	Covered	Covered	Covered
Hospital IP	Covered	Covered	Covered	Covered, maximum 60 days/year per disability
Catasthopic Benefit (hemodialisis, heart surgery,etc)	Covered	Covered, limited, local, if available	Covered	Not Covered
Specific Benefits	Eye glasses, hearing aids, disability aids, etc	Eye glasses, hearing aids, disability aids, etc	Eye glasses, hearing aids, disability aids, etc	Eye glasses, hearing aids, disability aids, others, etc
Exclusion	Services not in accordance w procedures, infertility, cosmetic, natural disaster, social activities, dental prothesa	Services not in accordance w procedures, infertility, cosmetic, natural disaster, social activities, dental prothesa	Services not in accordance w procedures, infertility, cosmetic	Services not in accordance w procedures, infertility, cancer theraphy, hemodialisis, etc
Thalasemia	Covered, including total population	No specific description, but not listed in the	covered	Not covered due to genetic diseases

Affordability of Providing Same Benefit Package for All ?

Types of Services Covered → Varies
Depth of Coverage → Copayment and Ceiling on Benefits

Benefit Package Varies starting from cover only Outpatient at Primary Care to a very comprehensive packages → JAMKESMAS provide quite generous benefit packages (almost no limitation and exception)



Benefit Coverage
Sub-National Health Insurance Scheme - 1

Rich Kab/kota

Provide health benefits up to the Top Referral Hospital

Additional benefit by providing transportation cost for patient, family including living cost during referral treatment

Siak

Rich Kab/Kota

Provide Health Benefits up to Provincial Hospital with shared-cost

Jawa Timur

Note: Not allowed to utilize health facilities owned by vertical hospital since APBD funds can not be paid to non-local public hospitals

Benefit Coverage
Sub-National Health Insurance Scheme - 2

Specific Areas

Provide health benefits up to top referral at vertical hospital

Not using referral mechanism, specially for outpatient at primary care . Patients are allowed to receive care at the hospital

Biak numfor

Poor Kab/Kota

Provide limited benefits, according to the availability of health facilities at the Kab/Kota

Buru

Access to Providers is limited only to local Kab/kota

Benefit Coverage
Sub-National Health Insurance Scheme - 3

Other Kab/Kota

Local Government provides free care to all population at the Puskesmas

For hospital services, free care is given only to Jamkesda participants

Palangkaraya

Others

Jamkesda contract with PT. Askes (Persero) - JPKMU

Bolmut

Kab Bolmut do not own RSUD, so they refer to RSUD di Propinsi Gorontalo (care across provinces) is allowed through PT Askes

Source: Thabrany H, Budi H, Mundiharno, et.al. "Laporan Akhir Kajian Program Penanggulangan Kemiskinan Bidang Kesehatan" TNP2K, Jakarta 2010

(3) Agency to Manage SHI:

Insurance Careers	Manage & Operate SHI	Legal Endorsement
Askes Civil Servant	BUMN	PP
Jamsostek	BUMN	UU No.2/3 1992
Asabri (Military Pers)	BUMN	PP
Askeskin/Jamkesmas	MOH	SK Menkes
Jamkesda	Pemda/Third Party	Perda/Perbu/Perwalko/SK Bu

Jaminan Kesehatan Daerah (Jamkesda) is often used as political vehicles during Pilkada→ Limited Fiscal Capacity and Lack of National Guidelines create huge variation of benefit packages

Legal Endorsement Jamkesda	Total	
	n	%
Perda Provinsi	4	9,3
Perda Kabupaten/Kota	11	25,6
Peraturan Gubernur	4	9,3
Peraturan Bupati/Walikota	7	16,3
Perjanjian Kerjasama dengan Pihak Ketiga (Perusahaan Asuransi)	17	39,5
Total	43	100,0

Sumber: Metaanalisis dari beberapa penelitian Jamkesda di 15 Propinsi

(4) Access to Health Providers

Benefit Package	Jamkesmas	Jamkesda	Askes	Jamsostek
Outpatient at Primary Care	Puskesmas, Bidan Desa dan Polindes	Puskesmas	Puskesmas dan Klinik DK	Puskesmas, Klinik dan Dokter Praktik
Outpatient at Hospital	RSUD kab/ kota, RSUD provinsi dan RSU vertikal	RSUD kab/ kota, RSUD provinsi dan RSU vertikal*)	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal
Inpatient at Primary Care	Puskesmas, Polindes untuk persalinan	Puskesmas dengan TT	Puskesmas dengan TT	Puskesmas dengan TT
Inpatient at Referral Hospital	RSUD kab/ kota, RSUD provinsi dan RSU vertikal	RSUD kab/ kota, RSUD provinsi dan RSU vertikal*)	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal
Catasthropic Benefit (hemodialisis, heart surgery dll)	RSUD kab/ kota, RSUD provinsi dan RSU vertikal	RSUD kab/ kota, RSUD provinsi dan RSU vertikal*)	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal	Not Covered
Special Health Benefit	RSUD kab/ kota, RSUD provinsi dan RSU vertikal	RSUD kab/ kota, RSUD provinsi dan RSU vertikal*)	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal	RSUD kab/ kota, RSUD provinsi, RS Swasta, RSU vertikal

Source: Thabrany H, Budi H, Mundiharno, et.al. "Laporan Akhir Kajian Program Penanggulangan Kemiskinan Bidang Kesehatan" TNP2K, Jakarta 2010

Access to Health Providers - Program Jamkesda

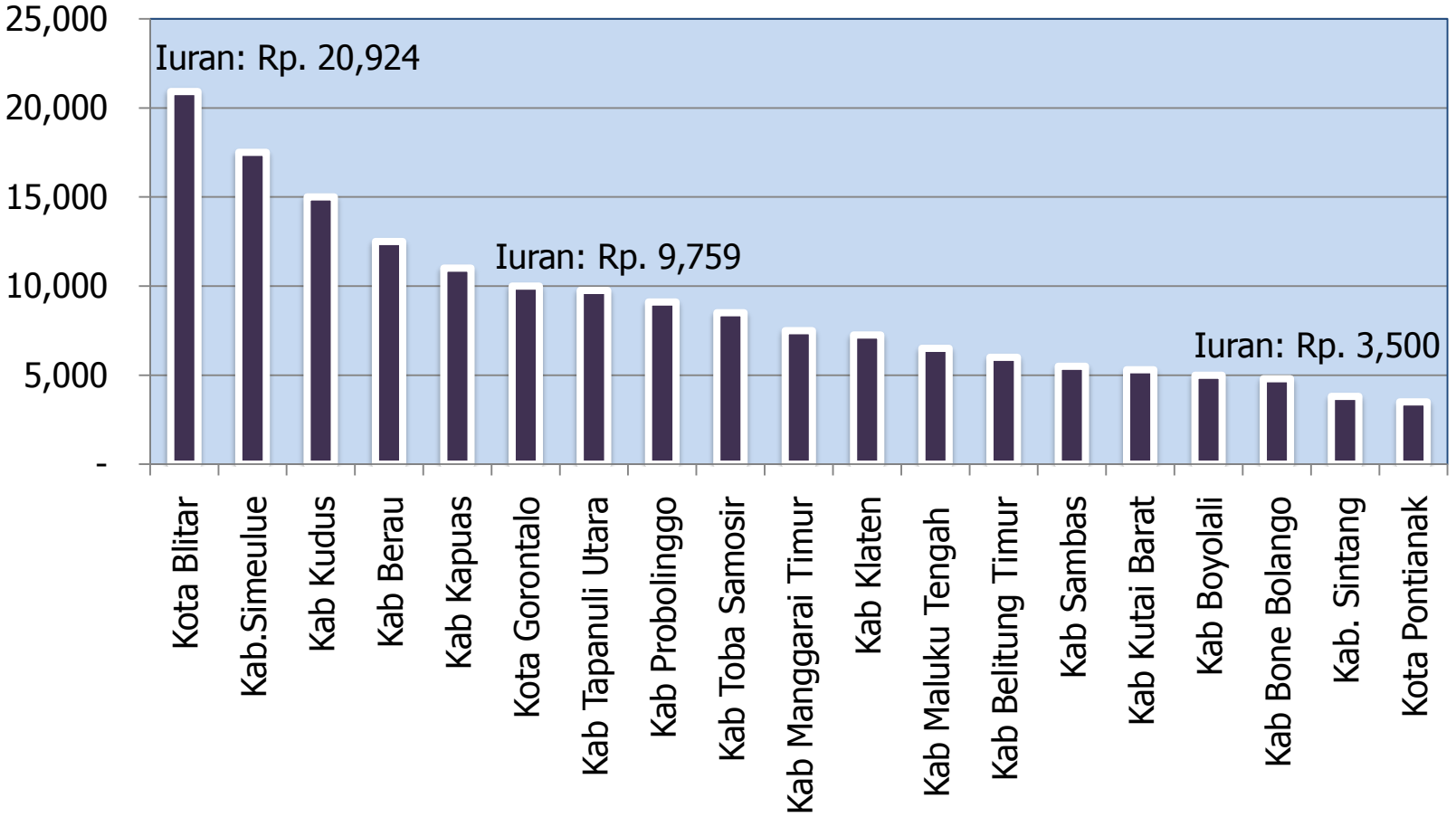
Jamkesda	Puskesmas	Polindes	RSUD Kab/ kota	RSUD Provinsi	RSU Vertikal	Faskes Swasta
Siak	digunakan	digunakan	rujukan Puskesmas	rujukan RSUD Kab/ kota	dengan rujukan RSUD Provinsi	Not included
Pasuruan	digunakan	tidak digunakan	rujukan Puskesmas	rujukan RSUD Kab/ kota	Not Covered	Not included
Mataram	digunakan	digunakan	rujukan Puskesmas	rujukan RSUD Kab/ kota	Rujukan ke Sanglah	Not included
Palangkaraya	digunakan	digunakan	Not Available	digunakan sebagai RS utama	Rujukan RSUD provinsi	Not included
P. Buru	digunakan	Digunakan	rujukan Puskesmas	Not Covered	Not Covered	Not included
Bolmut	digunakan	digunakan	Not Available refer to RSUD di Gorontalo	rujukan Puskesmas	tidak dijamin	Not included
Biak Numfor	tidak banyak digunakan karena keterbatasan SDM dan Obat	tidak digunakan	rujukan Puskesmas	rujukan RSUD Kab/ kota	Rujukan dari RSUD Provinsi	Not included

Source: Thabrany H, Budi H, Mundiharno, et.al. "Laporan Akhir Kajian Program Penanggulangan Kemiskinan Bidang Kesehatan" TNP2K, Jakarta 2010

Population Coverage and Premium (2009)

Insurance Scheme	Total Number of Beneficiaries	Total Budget (Rp.)	Premium/ capita/ month (Rp.)	Notes
Jamkesmas	69.468.376	4.600.000.000.000	5.518	
Askes	16.313.452		30.000	
Jamsostek	4.402.525		18.000	
Siak	4.000	1.700.000.000	35.417	No of Beneficiaries are not exactly known
Pasuruan	99.585	12.635.855.728	10.574	
Mataram	67.270		5.000	
Palangkaraya	94.167	838.270.400	741,83	Only for OP and IP at primary care
P. Buru	N/A			
Bolmut	2.808	336.960.000	10.000	PJKMU

PREMIUM FOR JAMKESDA BASED ON AGREEMENT BETWEEN LOCAL GOVERNMENT AND PT ASKES (PER PERSON PER MONTH)



Catatan: Per Juni 2010 telah 183 kabupaten/kota yang telah melakukan kontrak kerja sama dengan PT ASKES untuk jaminan kesehatan. Source: PT. Askes (Persero)

Part 2:

Critical Issues:

1. How to achieve Universal Coverage under such various and complex HI Schemes?
2. Has Jamkesmas been implemented as a good practice scheme?
3. Would it be possible to expand the practice of Jamkesmas to national level, covering total population (*universal coverage*)?
4. If yes, what should we do ? What national benefit standard should be expanded and what is the cost implication ?

Has Jamkesmas been implemented as a good practice scheme ? (1)

- **Miss-Targetting Beneficiaries**
- **Utilization of Jamkesmas for OP and IP varies widely across provinces**
  - Hospital OP - Maluku Utara 1.6/1,000/month – Bali 9.3/1.000/month
  - Hospital IP – Papua 0.7/1.000/month – Bali 2.8/1.000/month
- **Benefit packages – continously expand**
  - difficult to estimate premium using actuarial approach due to limitation on hospital claim data: (a) data infrascture – linkage between utilization data and demographic data ; (b) low compliance of Hospital to send softcopy to data center - PPJK; (c) low capacity at the center of data management; (d) lack of cost breakdown by services, diagnosis, drugs, room, under DRG payment system.
  - Unit Cost differs due to different payment system (FFS, negotiated Tariff, reimbursement), hospital class (class III, class II, and class I), and benefit packages (comprehensive no exception and no limitation ... To .. comprehensive with no exception but lots of limitation)
  - Premium estimation is ideally based on list of benefit packages (clear list on exception and limitation), real-time data on utilization, and unit cost. For example limitation of drug formulary.

Has Jamkesmas been implemented as a good practice scheme ? (2)

- **Limited Supply Side**
  - Infrastructure, availability of medical personnel esp. doctors and specialist, competency of doctors, availability of medical equipments, limited sources of funds, etc.
  - Distribution
  - Quality of care – lack of national standar medical protocol guidelines
- **Jamkesda**
  - Local initiatives → .....huge variation of practice of Jamkesda.
  - How to harmonize Jamkesmas and Jamkesda ?
- **Institutional Arrangement**

Part 3:

Cost Estimation for Universal Coverage

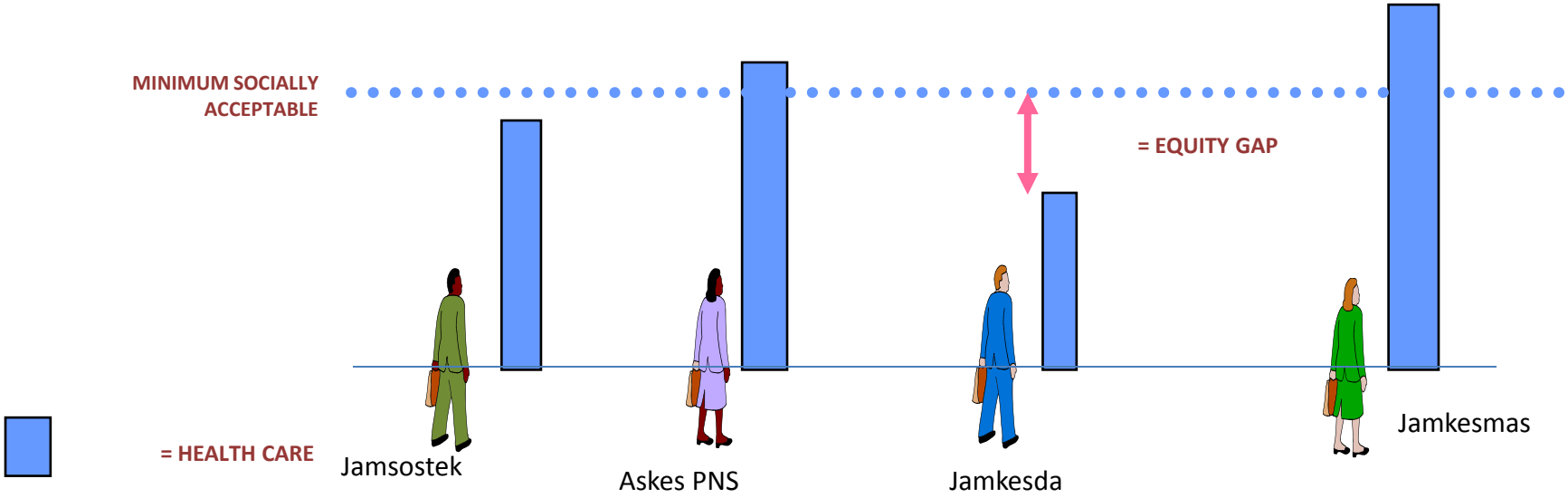
Current National Policy in Health Insurance:

- Develop Social Health Insurance System (Law 40/2004)
- Characterized by Compulsory Universal Coverage based on the principle of social solidarity

- ✓ Risk Taker
- ✓ Risk Pooling
- ✓ Portabilitas
- ✓ Paket Manfaat yang sama
- ✓ Reform Payment System (DRGs) → Tarif yang terkendali sehingga ada standar dan jaminan pembayaran
- ✓ Standar *Protocol Guidelines* → Kualitas Pelayanan Meningkat
- ✓ Pemakaian Obat Rasional → DPHO (Jamkesmas)
- ✓ Purchasing & Contracting punya bargaining power → *credentialing*

Providing Same Benefit Package for All ?

Types of Services Covered →
Varies
Depth of Coverage →
Copayment and
Ceiling on Benefits



Potential Tradeoffs between Population Coverage vs Benefit Coverage

Too Extensive Benefit and

High Premium may deter

the extension of Population Coverage

SIMULASI BESARNYA IURAN
(Berdasarkan realisasi pelaksanaan Jamkesmas)

Utilization Rate	**10,0**
Unit Cost	**Rp. 205.758**
Iuran (A)	**Rp. 2.058**
Utilization Rate	**3,0**
Unit Cost	**Rp. 303.393**
Iuran/Hari	**Rp. 910**
ALOS	**7**
Iuran/kasus (B)	**Rp. 6.371**
Rawat Jalan Tingkat Pertama (RJTP) (C)	**Rp. 2.000**
Total (A + B + C)	**Rp. 10.429**
Load Factor – 5%	**Rp. 521**
TOTAL IURAN	**Rp. 10.950**

Dengan perhitungan yang rasional dibutuhkan sekitar RP. 10.950 perorang-perbulan untuk memperoleh manfaat Jamkesmas seperti saat ini.

PENYESUAIAN BIAYA KESEHATAN UNTUK UNIVERSAL COVERAGE

JUMLAH PENDUDUK	PREMI/BULAN	PREMI/TAHUN
242,000,000	10,950	131,400

	Triliun Rupiah	Persen
Jumlah Biaya Premi	32	
Subsidi Tidak Langsung (+/- 30%)	10	
SUB TOTAL	41	
Tambahan biaya administrasi (5%)	2	
TOTAL BIAYA YANG DIBUTUHKAN UNTUK MELAKSANAKAN UNIVERSAL COVERAGE	43	
PROYEKSI GDP TAHUN 2010	5,981	0.7%
PENGELUARAN PEMERINTAH	1,048	4.1%

Ilustrasi Beban Pemerintah/Pemda, untuk cakupan universal

Total Penduduk Indonesia, 2010	237.556.363
Jumlah penduduk keluarga pekerja bukan penerima upah (65%), iuran dibayari oleh Pemerintah/Pemda (PBI)	154.411.636
Premium using assumption Rp 40.000 /family	Rp.18.5 Trillion (± 1,5% APBN)
Premium using assumption Rp 15,850/capita/month	Rp.32.78 Trillion (± 3% APBN)

Note: Premium of Rp 15,850 allow private hospital to provide care with appropriate drugs

PENGELUARAN KESEHATAN NASIONAL MENURUT PELAKU, 2009

Dalam Juta Rupiah

	2009	%
1. Sektor Publik	**61,717,406**	**46.6**
1.1. Pemerintah Teritorial/Wilayah	52,324,428	39.5
1.1.1. Pemerintah Pusat	16,014,998	12.1
1.1.1.1. Kementrian Kesehatan	12,985,024	9.8
1.1.1. 2. Kementrian Lain	3,029,974	2.3
1.1.2. Pemerintah Provinsi	11,354,560	8.6
1.1.3. Pemerintah Daerah Kabupaten/kota	24,954,870	18.8
1.2. Dana Jaminan Sosial	9,392,978	7.1
2. Sektor Non-Publik	**68,836,734**	**52.0**
2.1. Asuransi Sosial Swasta	N/A	
2.2. Asuransi Swasta (selain Asuransi Sosial)	2,367,661	1.8
2.3. Pengeluaran Rumah Tangga / *out-of-pocket payment*	46,690,642	35.2
2.4. Badan Nir-Laba Penyedia Layanan Perorangan (selain asuransi sosial)	30,393	0.0
2.5. Perusahaan - (selain asuransi kesehatan)	19,748,039	14.9
2.5.1. Perusahaan BUMN	5,010,154	3.8
2.5.2. Perusahaan Swasta Non-Parastatal (selain asuransi kesehatan)	14,737,885	11.1
3. Bantuan dan Pinjaman Luar Negeri	**1,917,947**	**1.4**
TOTAL	**132,472,087**	

Sumber: Analisis Pembiayaan Kesehatan Nasional (NHA): 2005-2009

Thank You