Moving towards UHC in the Indonesian Context: A brief overview of JKN

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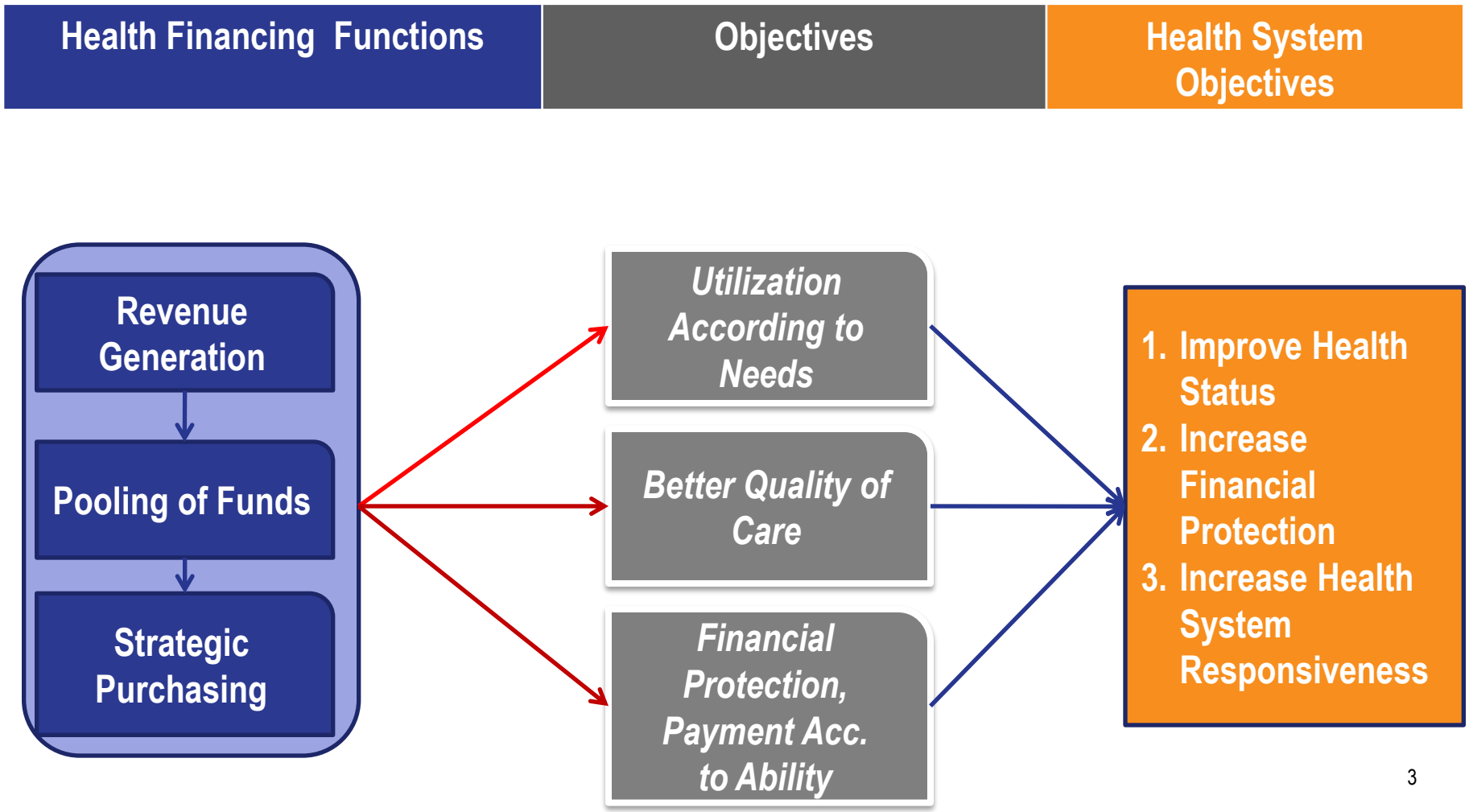
Abt Associates Inc.
In collaboration with:
Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

Pop quiz …. What are those health financing functions again?

Health Financing Functions	Objectives	Health System Objectives

Pop quiz …. What are those health financing functions again?



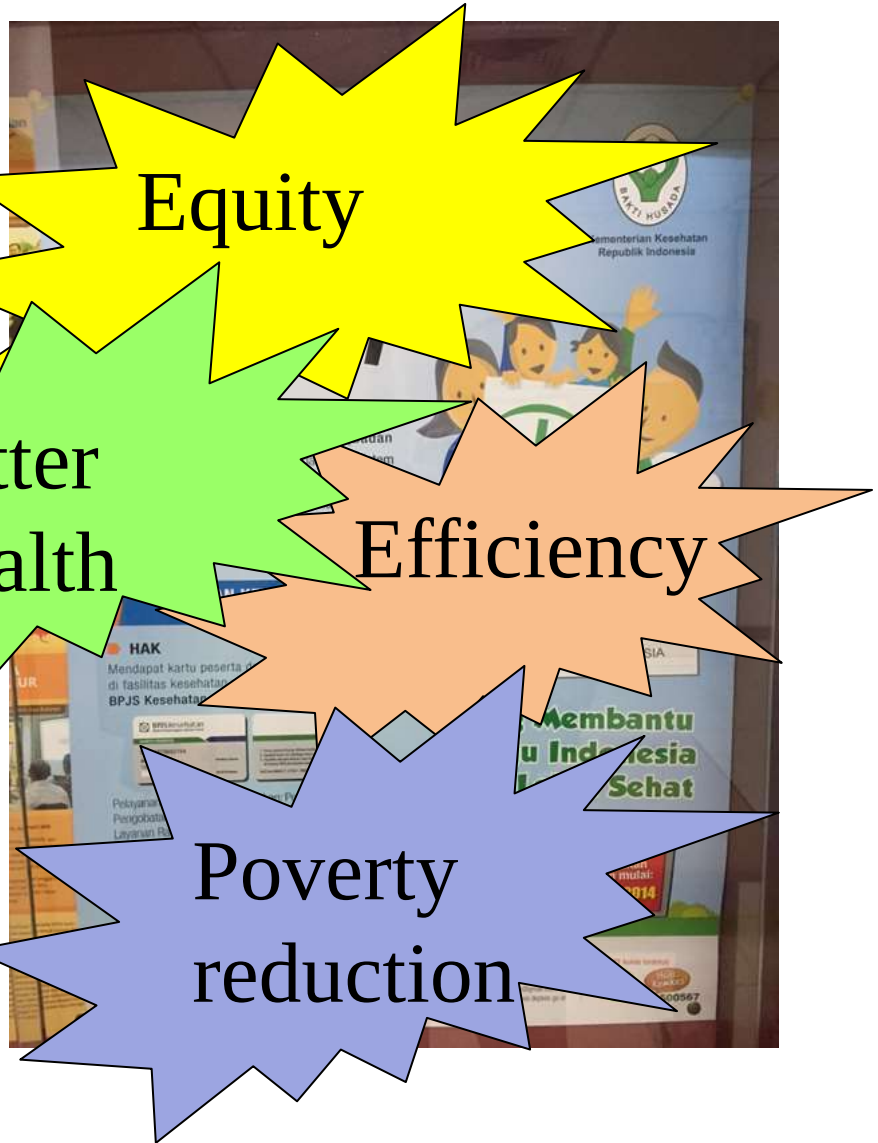
Pop quiz: What do you already know about JKN?

- How are revenues collected?
- How are funds pooled together?
- Who and how many people are covered?
- How are providers paid?

- How much of Indonesia's health financing flows through JKN? What are some other sources of funding for health?
  - Answer: **Not certain yet, but less than 20% of government health spending, and probably less than 10% of total health spending**
  - Central and district government budgets cover ~80% of government health spending

What is the vision of JKN?

- Achieve UHC by 2019 – *access to quality care, financial protection for all Indonesians*
- Provide fully subsidized coverage to the poor & near-poor
- Improve equity – same benefits for a
- Consolidate previous schemes u… one "single payer" umbrella, … mandatory employer and empl… contributions
- Promote phased, voluntary expansion to cover the informal sector
- Increase resources for health – but also improve efficiency and value for money



A brief history …

Act No 40/ 2004 on National Social Security System (**UU SJSN**)

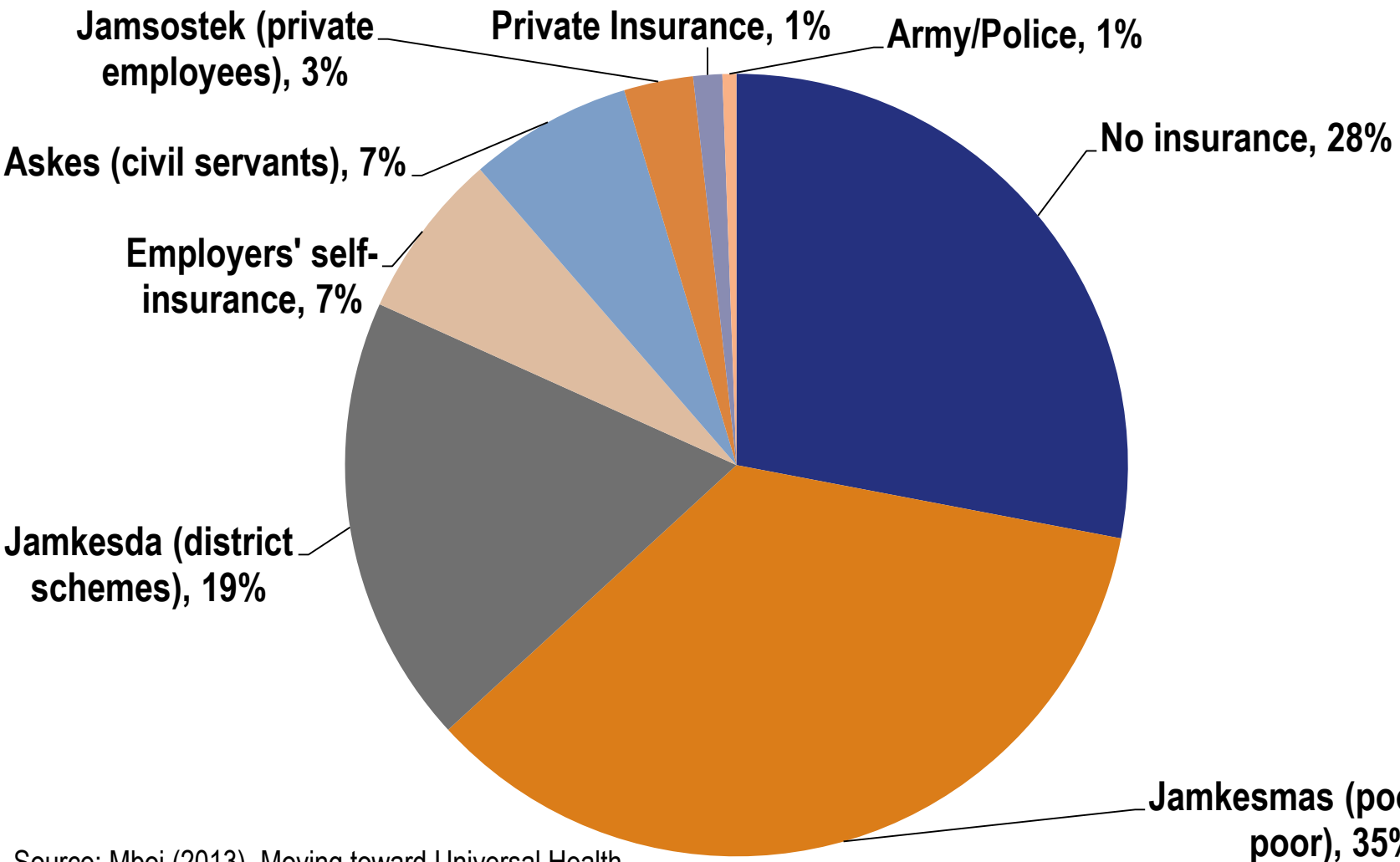
Act No 24/2011 on Social Security Agency (**BPJS**)

A brief history …

- **2004: Law 40** established framework for national social security system for Indonesia (health, old-age pension, workers' comp)
- **2005**: **Askeskin** initiated – government-financed health insurance for the poor and near-poor (renamed **Jamkesmas** in 2007)
  - Covered 76 million people by 2013 (~poorest third)
- **Since 2005:** various complementary **Jamkesda** district and provincial schemes emerge, mainly targeting the poor
- **2011: Law 24** established the Social Security Agency (BPJS) to administer national health insurance
- **2014: JKN** initiated

2019: UHC?

Insurance coverage before JKN (2013)



Source: Mboi (2013), Moving toward Universal Health Access in Indonesia

ROADMAP TO UHC

86.4 million PBI

Coverage of various existing schemes **148.2 million**

Uninsured people 90.4 million

121.6 mil. covered by BPJS Kesehatan

50.07 mil covered by other schemes

73,8 mil uninsured people

Activities:
Transformation, Integration, Expansion

257.5 million (all Indonesian people) covered by BPJS Kesehatan

Level of satisfaction 85%

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

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

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

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

Presidential decree on operational support for Army/Police

Transfer membership from TNI/POLRI to BPJS Kesehatan

Procedure setting on membership and contribution

Company mapping and socialization

Membership expansion to big, medium, small and micro enterprises

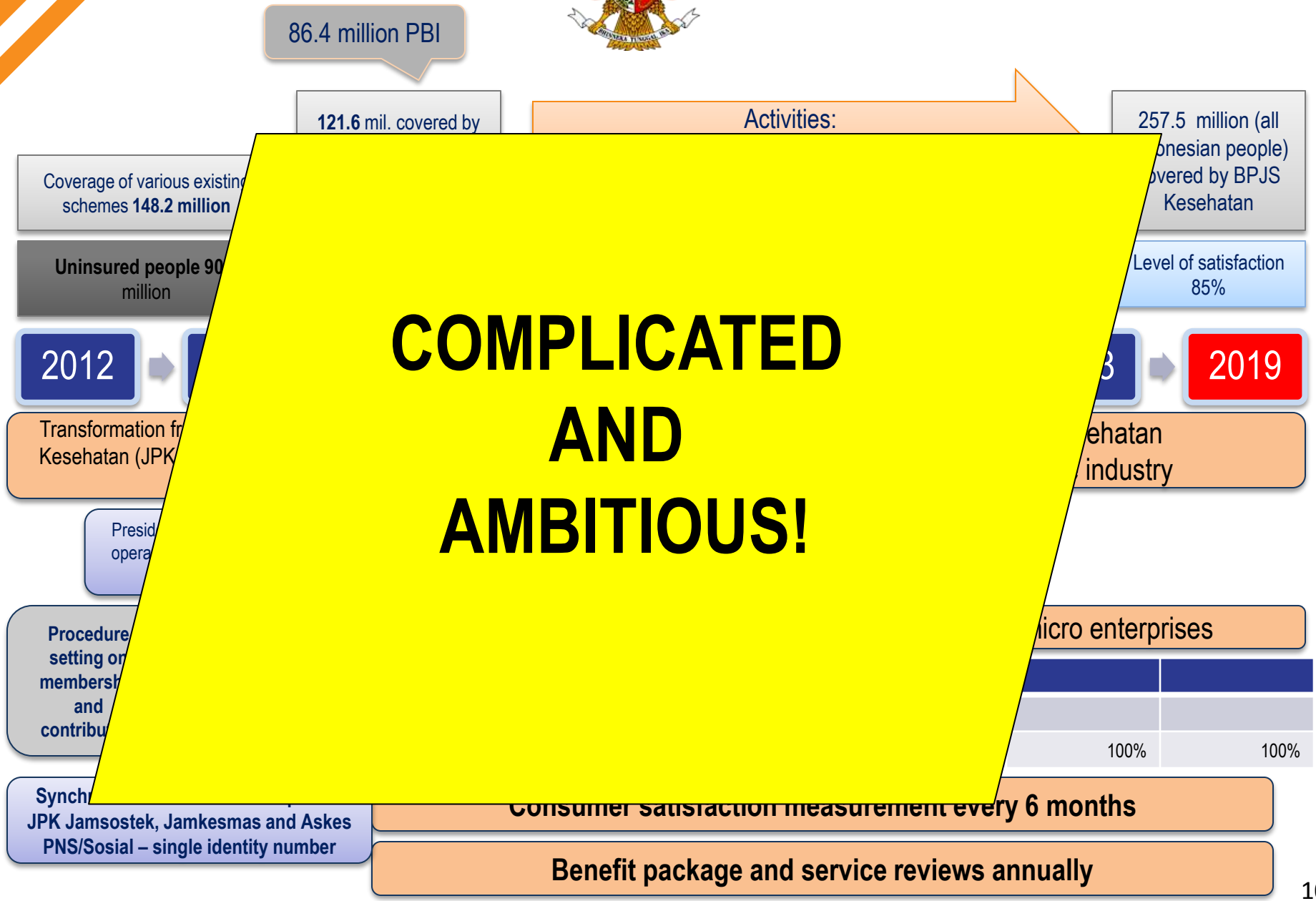
BSK	20%	50%	75%	100%		
	20%	50%	75%	100%		
	10%	30%	50%	70%	100%	100%

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

Consumer satisfaction measurement every 6 months

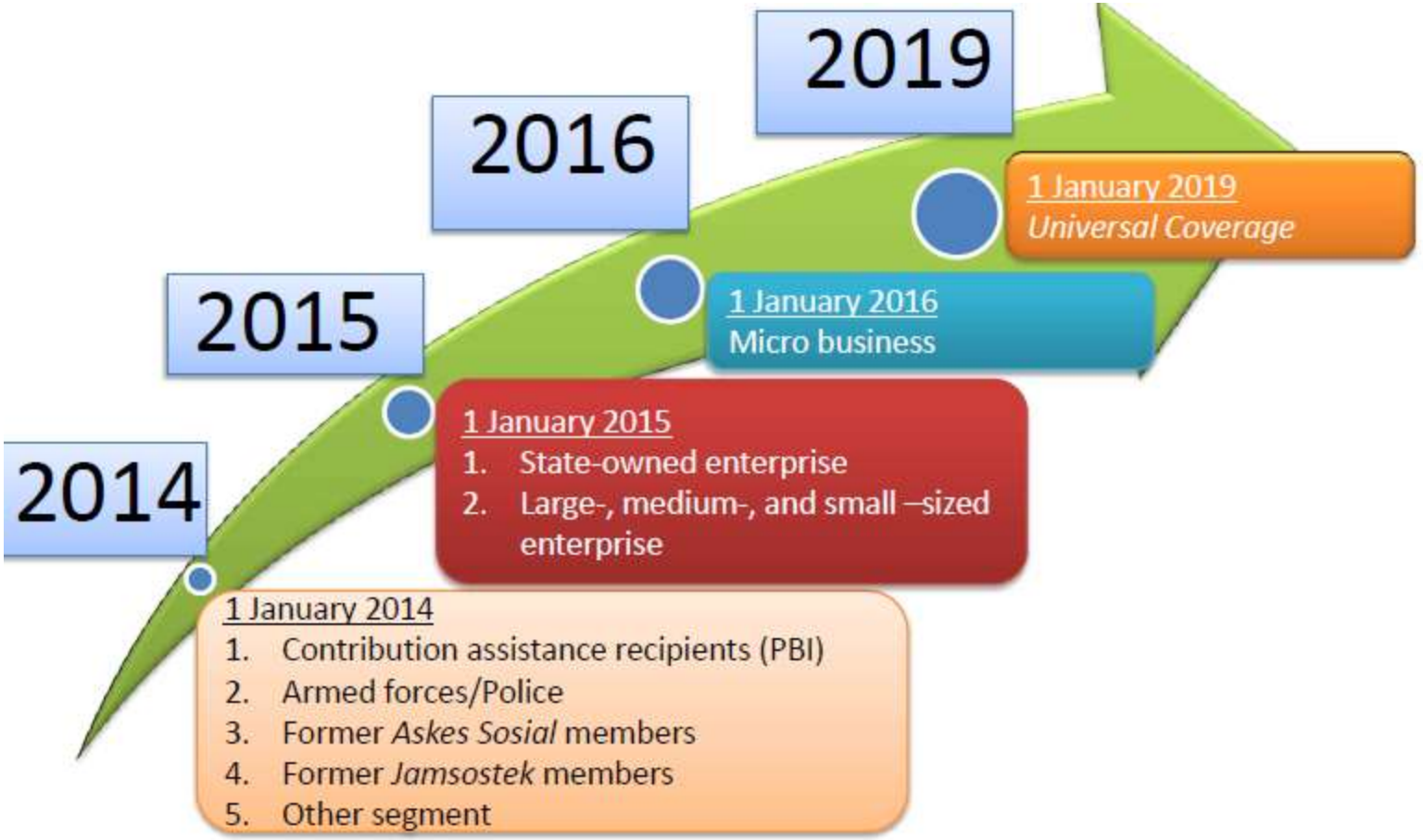
Benefit package and service reviews annually

ROADMAP TO UHC



COMPLICATED AND AMBITIOUS!

Consolidation of the different risk pools



What are some key national institutions?

Ministry of Finance

- Sets national budget, including for MOH

Ministry of Health (PPJK)

- Pays premiums for poor & near-poor (PBI)
- Oversees development of health financing policy and regulations
- Sets JKN payment rates and premiums
- Develops drug lists, clinical guidelines

What are some key national institutions?

DJSN = National Social Security Council

- Appointed Board that reports to the President
- Formulates social security policies, including health
- Oversees and monitors the implementation of JKN

DJSN

BPJS Kesehatan
Badan Penyelenggara Jaminan Sosial

BPJS-K = National Health Insurance Agency

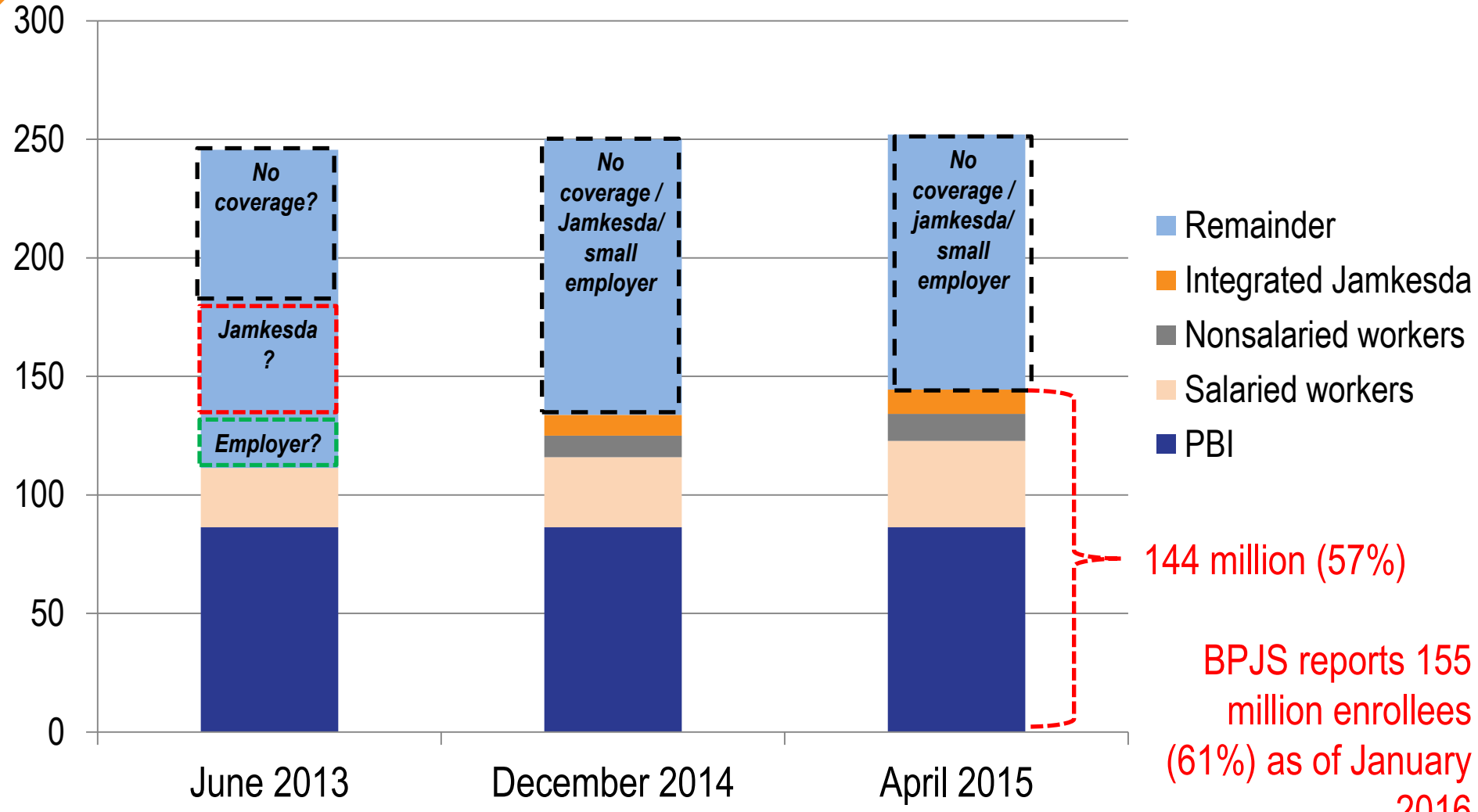
- Implements the JKN insurance scheme, including enrolling beneficiaries, collecting premiums, managing funds, and processing payments to health care providers
- "Credentials" and contracts with private facilities

Where do JKN revenues come from?

Poor and near-poor (PBI)	• Premium paid by government, per person	Rp. 19,225 per person per month (Class 3 hospital wards)
Informal workers and nonworkers	• Premium paid individually, per person	Class 1: Rp. 59,500 per month Class 2: Rp. 42,500 per month Class 3: Rp. 25,500 per month
Formal sector workers	• Payroll tax paid by employer and employee, per household	Employer 4%/ Employee 1% Gov't 3%/Employee 2% (Class 1 and 2 wards)

Increases in premiums are planned for 2016, from 8,000-10,000 per month.

Estimated* trends in JKN coverage (millions)



*Sources: Mboi 2013; BPJS 2015; BPJS 2016; Author's calculations

How are the poor targeted?

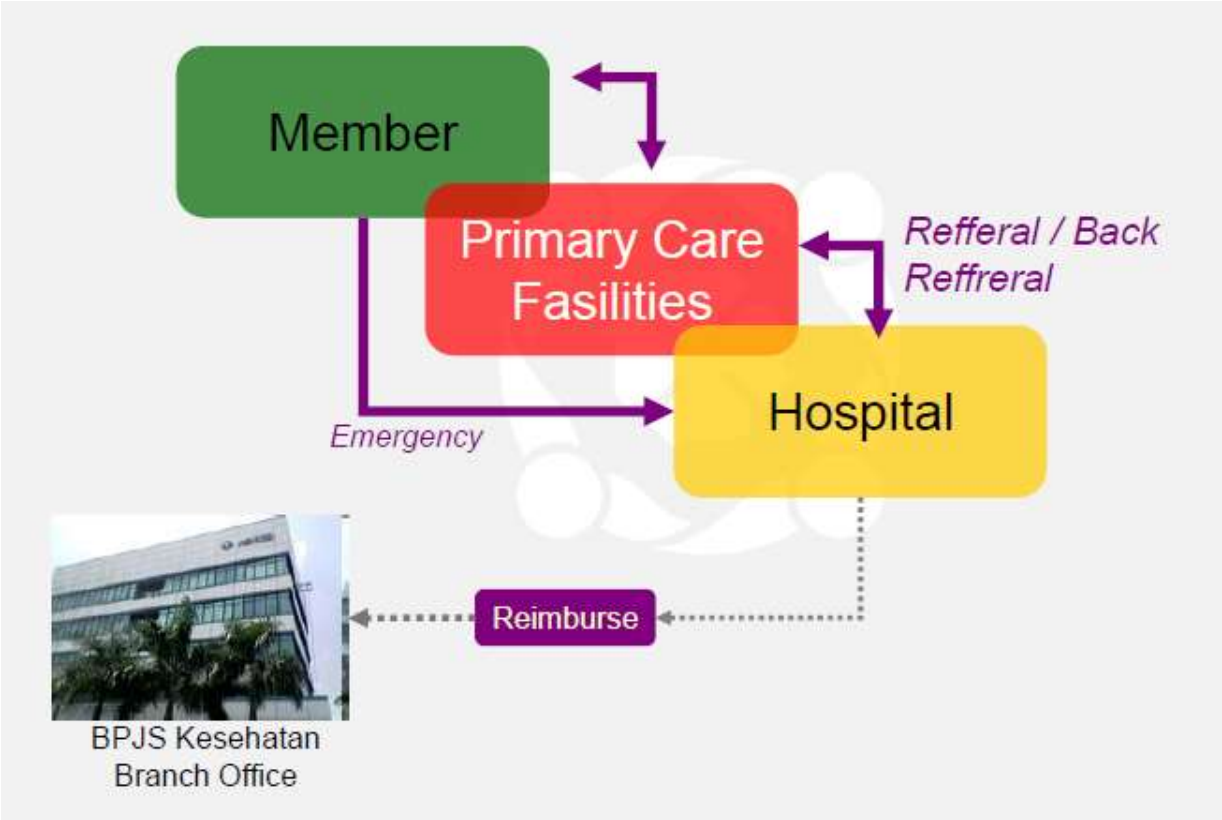
- Prior to 2010, inconsistency in targeting the poor across different social programs. Substantial leakage and undercoverage.
- National poverty mapping survey conducted 2011 (PPLS11). Proxy means tests used to rank households by socioeconomic status
- **"Unified database"** established listing all households in the poorest 40% of the population
  - Reduced errors of exclusion and inclusion
  - Systematic eligibility for social assistance programs
- **Households in poorest 35% are eligible for government-funded JKN coverage**
- PPLS 2015 enumeration conducted to update the targeting list
- **Challenges**: household poverty status is not static; difficult to keep Unified Database up to date; local modifications can be politicized

What services are covered?

- Comprehensive benefit package – same for all enrollees:
  - health promotion
  - preventive, curative, and rehabilitative medicine services
  - medically-indicated lab tests, drugs and supplies (including blood)
  - ambulance services for referrals
- Medical benefits are the same for everyone, but hospital ward depends on premium paid
- No lifetime limits on benefits. No co-pays.

How do referrals work?

- Primary care facilities are supposed to function as gatekeepers



- Hospitals are supposed to “down-refer” patients that can be handled at primary care level

What services are *not* covered?

- **Healthcare services performed without going through the procedures as stipulated in regulations**
- Services in facilities that do not contract with BPJS, except for emergency cases
- Services provided in foreign countries
- Cosmetic surgery, orthodontia
- Infertility services
- Health disorders caused by drug or alcohol addiction
- Health problems resulting from deliberate self-harm, attempted suicide, or dangerous hobbies
- Complementary and alternative medicine

Which health care providers can take part in JKN?

- **Credentialing** is the process by which BPJS-K approves which facilities may participate in JKN
  - Different from hospital accreditation, which is handled by the Hospital Accreditation Commission (KARS)
  - Largely administrative documentation process (staffing, facility structure, equipment)

- **All public facilities** must participate in JKN and automatically become credentialed
- **Private health facilities** can voluntarily participate in JKN by becoming credentialed and contracting with BPJS-K
  - Facilities formerly credentialed by Askes and Jamkesmas are automatically credentialed for JKN

How does JKN pay providers?

- BPJS-K is the ‘single payer’ agency.

- Primary health care providers (puskesmas, clinics):
  - **Capitation**: Facilities receive a fixed monthly payment per enrolled beneficiary, based on the size and staffing of the facility. At least 60% of the payment must be allocated for staff incentives and up to 40% may be allocated to operational costs
  - **Fee-for-service**: Facilities are reimbursed for selected priority services (ANC, maternity care, family planning)
- Secondary and tertiary health care providers:
  - **INA-CBGs** (Case-Based Groups): Hospitals are reimbursed on a “per-case” basis for a list of specific clinical diagnoses. Facilities must submit claims on behalf of JKN beneficiaries.

New variations on capitation

- As of 2016 BPJS-K began varying capitation payments according to a larger set of service-readiness criteria, including
  - size of the facility
  - presence of particular types of health workers (dentists, nurses, midwives, physicians);
  - patient contact ratios for selected health services;
  - accreditation indicators;
  - and extent of opening hours.

- Capitation rates could be increased by up to 15 percent if a facility meets the targeted service readiness indicators and reduced by up to 25 percent for not meeting any indicators.

ASSESSING STRENGTHS AND WEAKNESSES

What are some of the successes thus far?

- **An increased level of political commitment to health**
- **Consensus to achieve UHC by 2019**
- Government expenditure on health has increased
- Over 90 million poor and near-poor individuals can access free health care
- Reducing the fragmentation of risk pooling, and hopefully reducing reliance on out-of-pocket spending

Source: Antara news

What are some of the big picture challenges? (1)

- Financial sustainability and cost containment
  - Sick people are more likely to enroll voluntarily. How can we get more healthy people to enroll?
  - Insurance effect – people use more health care than they need when it's free
  - Lack of continuity – people pay the premium for one month, use care, then stop paying the premium
  - Claims fraud and "upcoding" by hospitals – BPJS is still building its capacity to do claims verification
- Additional sources of revenue for health?
  - Village funds, tobacco taxes, reprogrammed fuel subsidies, VAT & payroll increase are alternatives sources being considered to increase national health expenditure.

What are some of the big picture challenges? (2)

- Shortages, unequal distribution of Infrastructure and health workers
  - Residents in rural and remote areas have less access to health care than those in urban areas → so government subsidies for JKN flow to areas where service coverage is greatest.
- Challenges consolidating previous schemes into one pool
  - Some private employers slow to join JKN → quality of services at many participating facilities is poor; benefits package less generous than what their workers had access to previously; not all private facilities participate
  - Local Jamkesda schemes – How will integration into JKN happen? Different benefits & eligibility, JKN as political commodity

What are some of the big picture challenges? (3)

- Enrolling the non-poor informal sector
  - Large, diverse group – 64 to 100 million people
  - Enrolling and getting cards to people is challenging
  - Collecting voluntary premiums on a continuing basis is administratively difficult
  - Low willingness to pay
  - International evidence is not optimistic. …
  - Need for dedicated, targeted marketing and outreach approaches

http://www.weltrekordreise.ch/a_akte_indonesien.htm

- Communications to consumers and providers (“socialization”)
  - Still many areas of confusion regarding how JKN works, what benefits are covered, and how the payment system works

What are some of the big picture challenges? (4)

- Misaligned incentives and unintended consequences
  - Provider payments may stimulate more focus on curative care
  - Need to maintain focus on prevention and health promotion, especially as Indonesia ages
  - Payments are not tied with performance, quality
- BPJS growing into its role as a strategic purchaser
  - Credentialing process is mainly administrative – not quality-based accreditation
  - Quality of care at participating facilities can be poor
  - Need to improve processes for contracting with private providers
- Payment system implementation challenges
  - Problems with INA-CBGs and reimbursement rates -- overcompensate some services, undercompensate others – some serious distortions.
  - Public and private providers receive same amounts. Not level playing field
  - Learning how to do diagnosis coding, claims submission and review

Opportunities?

- Strategic purchasing – Leverage the huge purchasing power of BPJS
- Make primary care gatekeeping work as intended
- Intensify focus on prevention
- Health technology assessment to improve efficiency in purchasing
- Build skills in accreditation, contracting, and claims-based provider payment systems
- Fix problems with INA-CBGs and potentially improve health outcomes
- Pay-for-performance and its link with quality and priority services
- Explore complementary roles that Jamkesda might play in health financing (transportation subsidies; meal allowances for family members; long-term care)

Questions for you!

- What has your experience been with JKN so far?
  - What seems to be working?
  - What are the major challenges?

- Where do you think USAID support could be most valuable?

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