INDONESIA ON ITS PATH TO UNIVERSAL HEALTH COVERAGE: EXPANDING COVERAGE FOR INFORMAL SECTOR

PRESENTED BY

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PRESENTATION OUTLINE

1. SITUATION OF UHC IN INDONESIA A DECADE AGO
2. EVOLUTION OF UHC IN INDONESIA: MAJOR MILESTONES
3. OUTLOOK INTO THE FUTURE
4. FACTORS OF SUCCESS
5. STRATEGY AND ISSUES FOR INFORMAL SECTOR

COUNTRY BACKGROUND

- An archipelago between Asia & Australia, >17,000 islands, 5 big islands
- GDP US$ 4,200 (2012)
- Social & Health Indicators :

  -Total population > 240 M, 33 Prov. 497 Districts,

  - 66% in informal sector

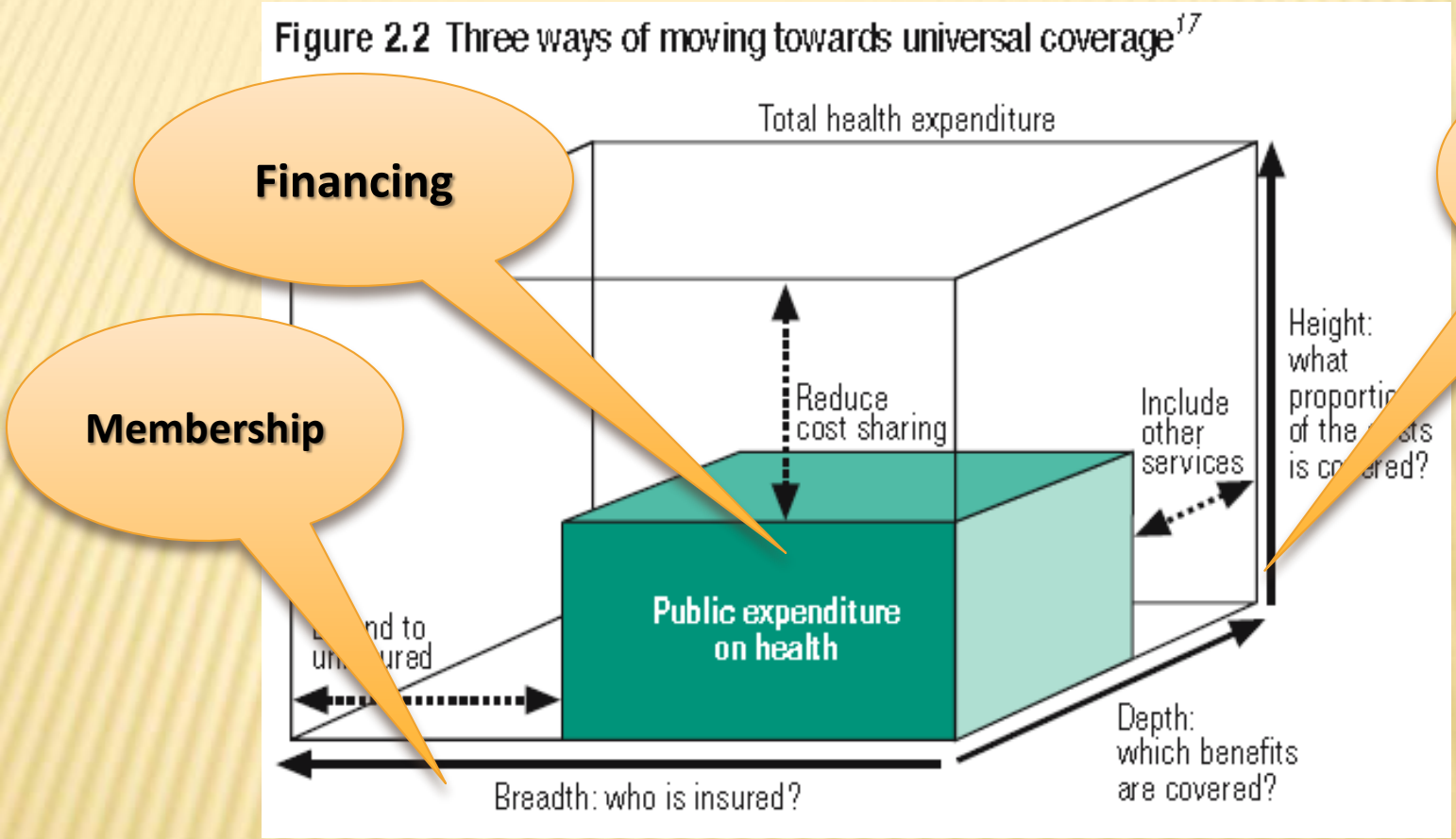
  - IMR 34 ; MMR 228 ; L.E 70.5 (2007)
- Health Systems: Predominantly govt 's facilities :
  - 9,520 health centres & 23,163 sub-centres.
  - 2,100 public and private hospitals; doctor/pop. ratio 1:3,000
  - Health insurance coverage 68% (2012)

INDONESIA'S ROLE AND POSITIONING IN ADVOCATING UHC AT GLOBAL LEVEL

- President of RI as co-Chair in developing draft of Post-MDGs Agenda
- Indonesia's role in WHA
- Indonesia as a member of Foreign Policy and Global Health Initiative → UN UHC Resolution draft
- Ministerial Level Meeting Organized by WHO and WORLD BANK in Geneva
- Comparison of UHC in ASEAN Countries and Bangladesh

Indicators of UHC Achievement

The Universal Health Coverage Dimentions



Source: WHO, T*he World Health Report. Health System Financing; the Path to Universal Coverage*, WHO, 2010, p.12

COMPARISON OF UHC ACHIEVEMENT IN ASEAN COUNTRIES AND BANGLADESH

Country	**(3)** Pop cover age	People covered (Mill)	Pop (Mill) *) WHO	**(2)** Health service coverage	**(1)** Financial protection*
Malaysia	100%	28	28	PHC services focus on MNCH. But long waiting time, and limited number of family physicians; Survey reports 62% of ambulatory care was provided by private clinics	40.7%
Thailand	98%	67	69	Comprehensive benefit package, free at point of service for all three public insurance schemes	19.2%
Indonesia	68%	163	240	Good policy intention but low per capita government subsidy for the poor of US$ 6 per year	30.1%
Philippines	76%	70	93	High level of co-payment, 54% of the bill are reimbursed	54.7%
Vietnam	54.8 %	48	87.8	Benefit package comprehensive but substantial level of co-payment, 5-20% of medical bills	54.8%
Lao PDR	7.7%	0.5	6	Low level of government funding support to the poor results in a small service package	61.7%
Cambodia	24%	3	14	The poor covered by the health equity fund but the scope and quality of care provided at government health facilities are limited	60.1%
Bangladesh *) WHO 2009	?	(?)	148.7	??? (cannot find the data)	66%

Financial protection * measured by OOP as % of THE, 2007

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1. SITUATION OF UHC IN INDONESIA A DECADE AGO

- Population Coverage 11% : 22 Million by various schemes
- Financial Protection : heavy out of pocket 70%
- Poor people : Social Safety Net for 36 Million people with high cost sharing and the rest have to pay (the Poor is forbidden to get sick)

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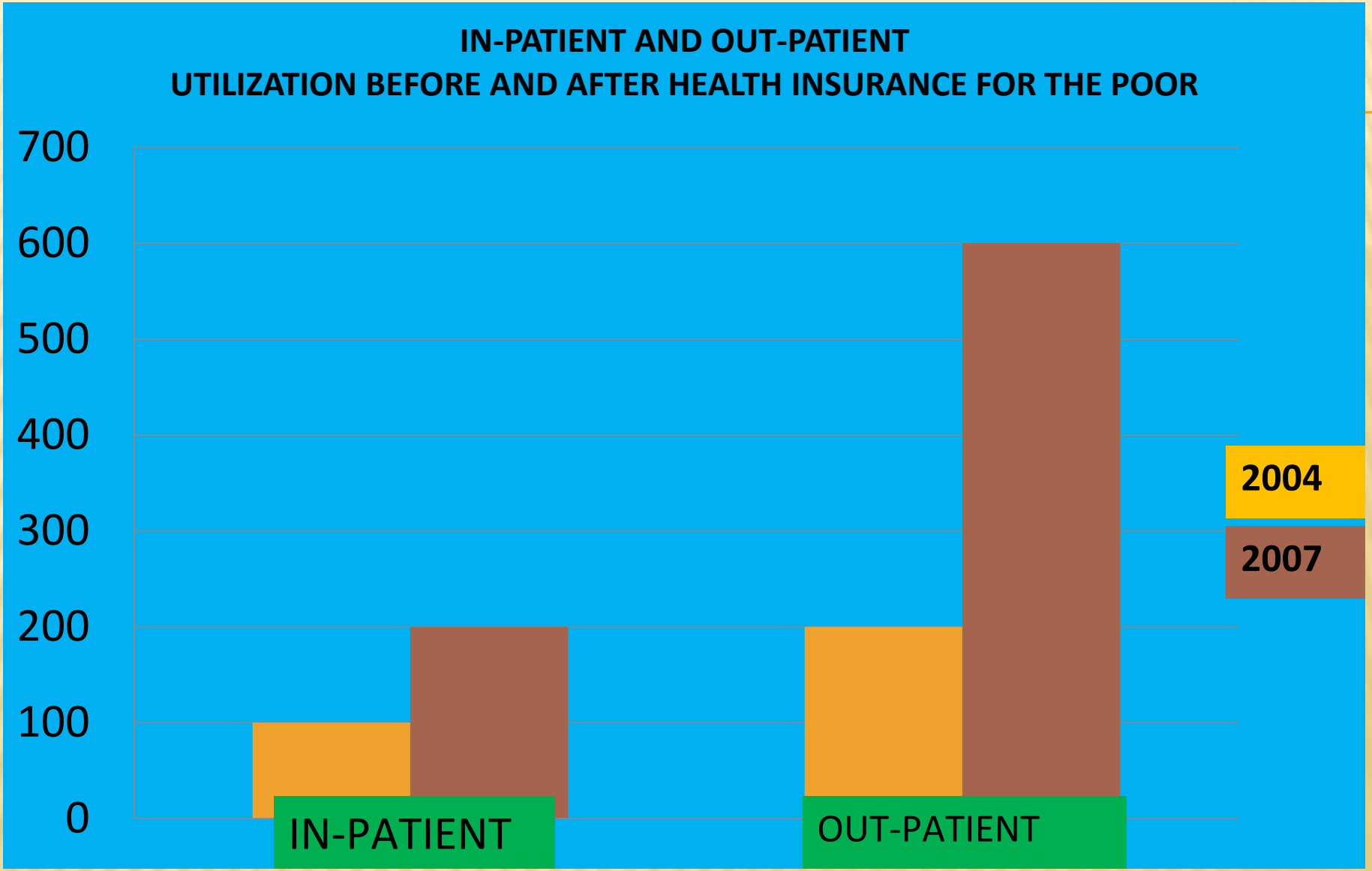
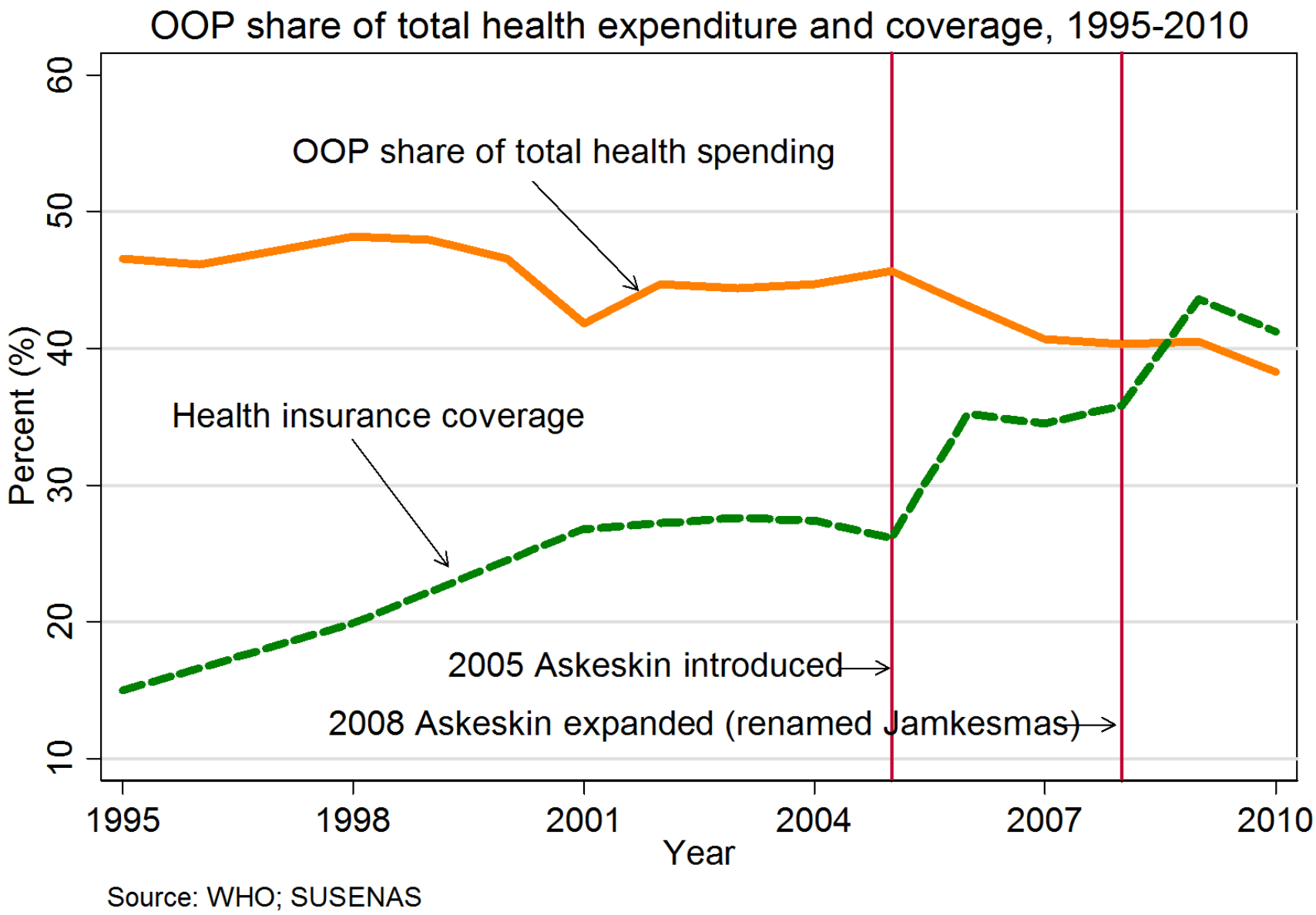
2. EVOLUTION OF UHC IN INDONESIA: MAJOR MILESTONES

- 1969: Civil Servant Benefit Scheme was introduced (ASKES)
- Early 1970s: Health Card
- Early 1990s : Managed Care System was introduced *(JPKM).*
- 1992: Social Security for Formal Sector Employees (JAMSOSTEK)
- 1998 :economic crises, a social safety net program for health was implemented
- 2004, Indonesia enacted the National Social Security System Law
- 2005: The *Health Insurance for the Poor (covers 76,4 Million)* Program was introduced
- 2005: Local government health insurance initiatives grow
- 2008: Implementing prospective provider payment system (INA DRGs and Capitation)
- *In* 2010 Jampersal (HI for pregnancy and delivery) was introduced
- 2011: Act on Health Insurance Carriers (BPJS -> merging various schemes into one scheme & be implemented in Jan 2014)

3. OUTLOOK INTO THE FUTURE



IF THE POOR GET SICK, IT IS FORBIDEN TO PAY


OOP share of total health expenditure and coverage, 1995-2010
OOP share of total health spending
Health insurance coverage
2005 Askeskin introduced
2008 Askeskin expanded (renamed Jamkesmas)
Percent (%)
10
20
30
40
50
60
1995
1998
2001
2004
2007
2010
Year
Source: WHO; SUSENAS

KEMENTERIAN KESEHATAN
REPUBLIK INDONESIA

Membership Roadmap towards *Universal Health Coverage*

96,4 million subsidy
2,5 subsidy for people without ID

124,3 million member be managed by BPJS Health Program

Citizen has been cover with several scheme **148,2** million

50,07 million managed by non BPJS Kesehatan

90,4 million has not yet being member

73,8 million has not yet being member

Activities :
Transformation, Integration, extention

257,5 million (all citizen) manage by BPJS Keesehatan

Membership Satisfaction level 85%

`Company (Perusahaan)	2014	2015	2016	2017	2018	2019
Big company	20%	50%	75%	100%		
Middle company	20%	50%	75%	100%		
Small co	10%	30%	50%	70%	100%	
Micro co.	10%	25%	40%	60%	80%	100%

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

Transforming JPK Jamsostek, Jamkesmas, PT Askes to BPJS Kesehatan

Integration member of Jamkesda/PJKMU Askes comercial to BPJS Kesehatan

President Regulation of TNI POLRI Operational Health Support

Transforming TNI/POLRI membership to BPJS Kesehatan

Setting up Systenm Procedure of Membership and Premium

Companies Mapping and socialization

Membership Extention of big company, midle, smal and micro

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

Sinkronizing Membership Data of JPK Jamsostek, Jamkesmas and Askes PNS/Sosial – using citizen ID

Membership satisfaction measurement periodically, twice a year

Review of Benefit Package and Health Services Refinement

Scenario of Integration From Existing Management

INFORMAL	JAMSOSTEK	ASKES Health Insurance Specialist	TAS PEN	ASABRI	TNI/ POLRI
JAMKESMAS (For the Poor)	HEALTH PROGRAM	HEALTH INSURANCE	LIFE INSURANCE	WORK ACCIDENT	HEALTH
NON PROGRAM	WORK ACCIDENT		OLD AGE	LIFE INSURANCE	
JAMKESDA (Local Initiative)	LIFE INSURANCE		PENSION	OLD AGE	
	OLD AGE			PENSION	

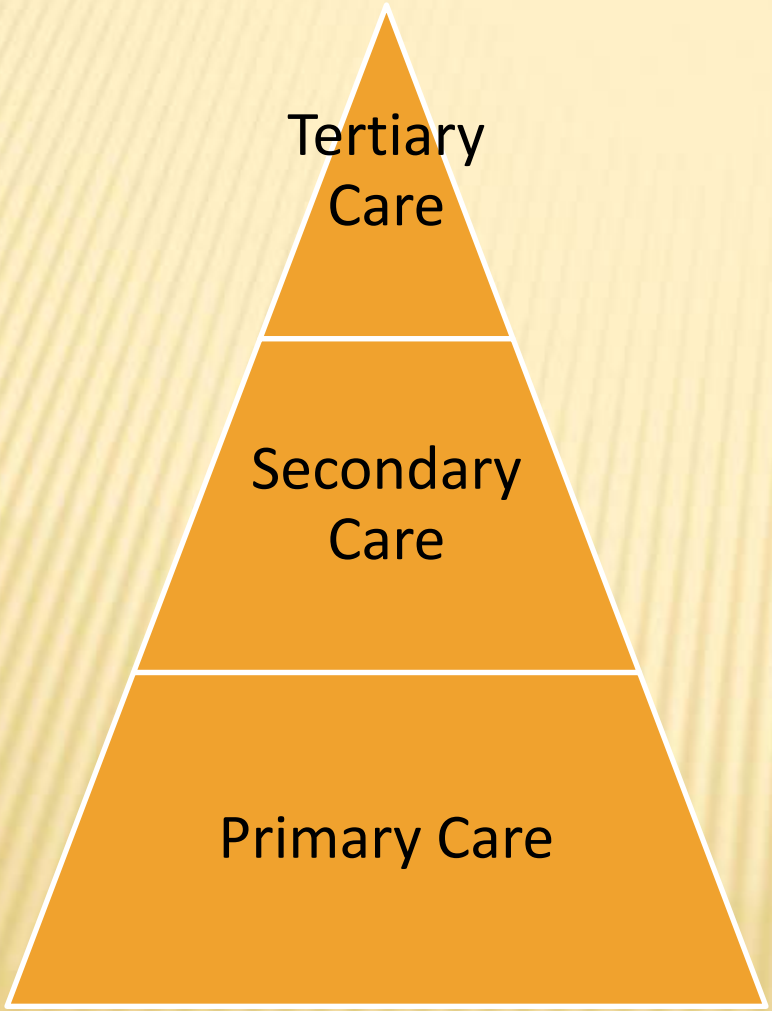
BPJS 1 (Carrier 1)

BPJS 2 (Carrier 2)

PHASE I

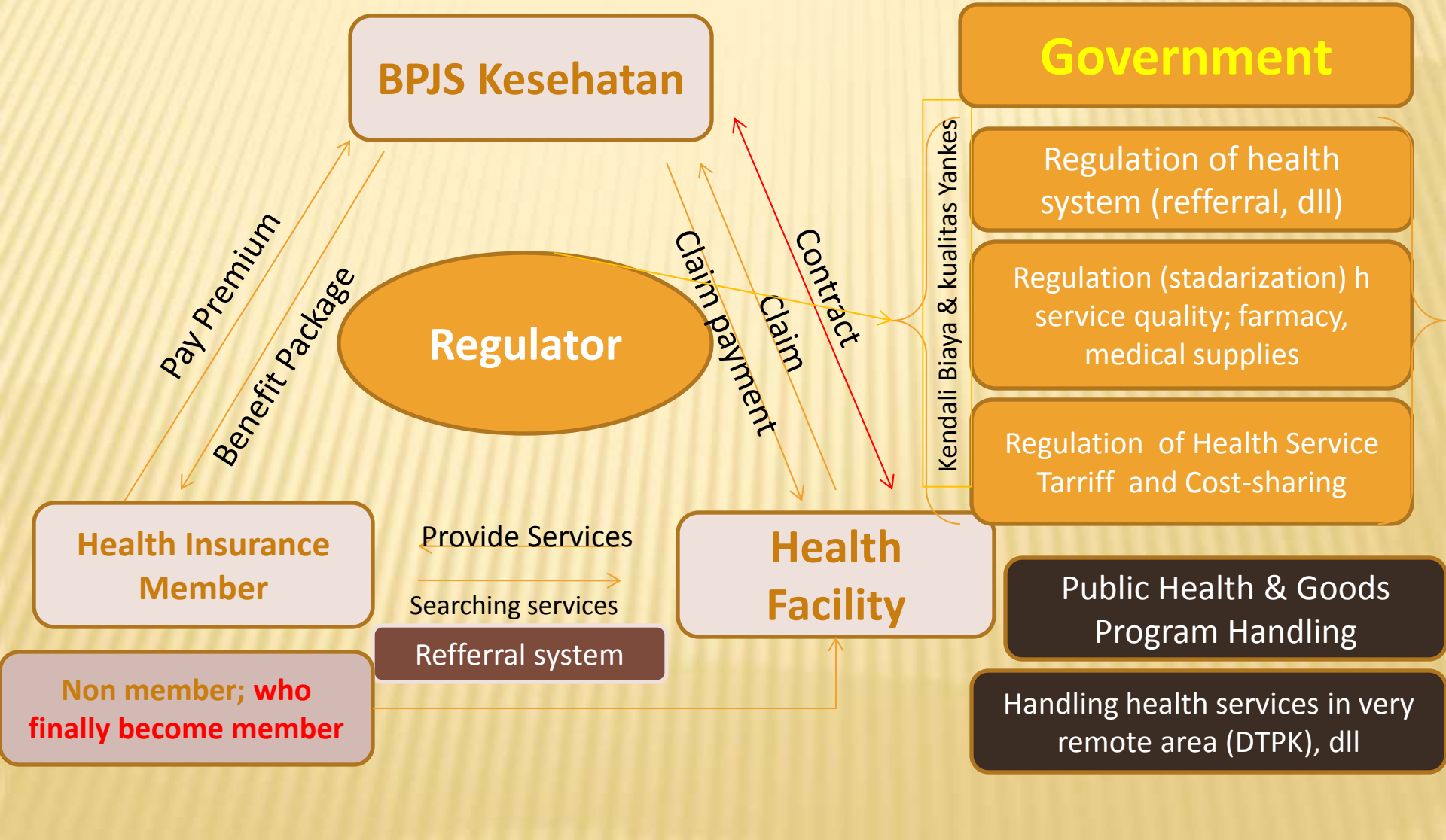
PHASE II

REFERRAL HEALTH SYSTEM



Hospital type A/ B **Hospital with sub-spesialist doctor**
Hospital type D/C Hospital type D: Hospital with GP & 4 basicc specialist (Obgyn, pediatics, surgery, internist)
Health Centers, Private Clinics, private doctors

IMPLEMENTATION NATIONAL SOCIAL SECURITY SYSTEM (SJSN) FOR HEALTH PROGRAM



PRESENT CONDITION OF HEALTH COVERAGE

Coverage : June 2013

176.844.161 (72 % from total population)

- **JAMKESMAS : 86.400.000 (36,3 %)**
- **JAMKESDA : 45.595.520 (16,79 %)**
- **CIVIL SERVANT ASKES : 16.548.283 (06,69 %)**
- **TNI/POLICE/DOD CIVIL SERVANT: 1.412.647 (00,59 %)**
- **JPK JAMSOSTEK : 7.026.440 (02,96 %)**
- **PRIVATE COMPANIES : 16.923.644 (07,12 %)**
- **PRIVATE INSURANCE : 2.937.627 (01,2 %)**

IMPORTANT ISSUES IN INFORMAL SECTOR

- Who is informal sector: unofficial business, with no official entity, such as PT, CV, etc, often do not pay business tax; employment created and run by the employee (such as entrepreneurs). Workers with no structurized payment system, have no formal company-employee formal relationship, employees outside of formal relationship.

- In the health coverage regulation and PBI they are not referred to as Informal Sector but Non-Salary Worker

ISSUES IN INFORMAL SECTOR

- Most of informal sector workers are not yet covered by health insurance.

- There will be a great number of informal workers who are not included in the premium payment assistance scheme, and must pay premium to BPJS –Kes.

ISSUES IN INFORMAL SECTOR

- 1. Certainty in number?
- Different data,
  - For example, 149,8 million of worker population in Indonesia, 103,2 million are informal sector labor and under-employed, whereas 7,2 million are unemployed (Prakarsa, 2013),
  - From BPS the number of worker population (15 years and above) by February 2013 is 114,02 million people and unemployed 7,17 million people, informal sector (60,02%)

IMPORTANT ISSUES IN INFORMAL SECTOR

- 2. Person in charge of premium
  - Should the premium for informal sector be paid or not? Or should it be partially subsidized or if not included in poor category, be asked to pay?
  - What about the legislation?
- 3. What is the benchmark in other countries?

IMPORTANT ISSUES IN INFORMAL SECTOR

4. If paying –
   - What about the premium collection
   - By whom, how to build trust
   - Will the collection cost be more expensive?

5. Which one is more strategic in the achievement of UHC ? etc

IMPORTANT ISSUES IN INFORMAL SECTORS

- Ability to pay and willingness to pay social health insurance premium for informal sector.

- This forum will discuss the above issues based on experience from other countries.

4. CRITICAL SUCCESS FACTORS

- Leadership
- Political committment (Sustainable Budget and Establishing Laws and Regulations)
- Creating and facilitating critical mass of experts and stakeholders interested in Social Health Insurance)
- Technical capacity in system design and implementation
  - Informal sector : Who, How many, How, what is the most strategic way way
- Learning experience in running different schemes of the past
- Preparing and Enhancing Health Infrastructures (HRH)
- Education, Advocacy and awareness of various stakeholders

THANK YOU

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