Challenges in Universal Health Coverage : Can Indonesia improve socio-economic and geographic equity together?

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Background

- In Indonesia the new law on social security agency which targets universal coverage will be effective in 2014.
- The main objective is to improve health equity

- Pose various challenges to access for health services funded by the social security agency
- A real possibility of worsening geographic inequity

Paper Objectives

- Provide historical facts which have influenced health equity in Indonesia
- Discuss a possible dilemma in reducing economic and geographical inequity at present and in the future.

The History

- As a direct response to the economic crisis in late 1990's, financial protection for health care for the poor was set nationally in 1999.
- The protection policy aimed to reduce out of pocket spending by increasing central government funding targeting the poor

- A steady growth of central government funding for health social security

- resulted in a relatively low incidence of catastrophic out of pocket health expenditure, which has declined over time.

Indonesia is increasing Government Expenditure (%)

Location	GDP Per Capita (USD)		diff	GGE on Health		diff
	1995	2008		1995	2008	
Thailand	**2793.79**	**4042.78**	**1249.00**	**47**	**75.1**	**28.1**
Libyan Arab Jamahiriya	5283.52	14802.20	9518.68	51.9	75.9	24.0
Lebanon	3357.11	7137.51	3780.41	28.3	49	20.7
Indonesia	**1055.51**	**2245.49**	**1189.98**	**35.7**	**55.3**	**19.6**
Republic of Korea	11467.81	19161.89	7694.08	36.3	54.9	18.6
Bhutan	563.16	1812.32	1249.15	65.1	80.3	15.2
Nepal	203.52	437.87	234.35	26.5	39	12.5
Yemen	272.91	1174.53	901.63	31.5	40.7	9.2
Qatar	15479.08	86435.82	70956.74	62.2	70.1	7.9
Syrian Arab Republic	780.04	2648.82	1868.78	39.7	45.1	5.4
Brunei Darussalam	16049.59	30390.64	14341.04	76.3	81	4.7
Cambodia	302.38	710.21	407.83	18.9	23.1	4.2
Pakistan	495.49	986.64	491.14	25.8	29.7	3.9
Viet Nam	**284.13**	**1047.13**	**762.99**	**34.9**	**38.5**	**3.6**
Mongolia	540.38	1990.59	1450.21	75.9	78.7	2.8
India	382.22	1066.69	684.47	26.2	28	1.8
Papua New Guinea	984.45	1217.97	233.52	79.4	80.1	0.7
Bangladesh	296.20	497.21	201.01	35.2	35.7	0.5
Bahrain	10125.60	28240.48	18114.88	69.6	69.7	0.1
Jordan	1603.68	3905.18	2301.50	62.1	62.2	0.1

- The financial protection program reduced financial barriers to access for poor households for both hospital and non-hospital services.

The impact of changing financial protection policy

- The incidence of catastrophic OOP health expenditures is relatively low and has declined over time.
- Equity in utilization of health services has improved over time, with significant improvements in access to public hospital services.
- The incidence of public subsidies for health care has also become more pro-poor over time.
- The financial protection program reduced financial barriers to access for poor households for both hospital and non-hospital services.

However

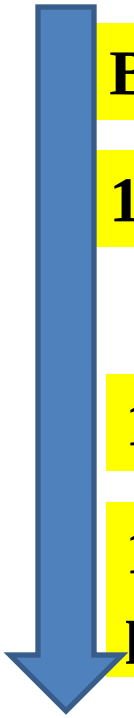
- The regional inequalities in access to services have not improved over time.
- There is regional inequity due to shortages in inputs such as health facilities, medical specialist and trained nurses.

- Why?

Historical Facts

- Indonesia had taken the route of market – based economies since the colonial era.
- Hospitals and health service providers are distributed based on market demands and cluster in the cities and regions with good economic development.

Historical Stage



Before 1945

- Colonial Period

1945 - 1965

- Independence and the "Old Order"

1965 - 1999

- "New Order"

1999 - at present

- Decentralized era

Colonial Period

- The Dutch Indie was not administered as a welfare state
- Health services were provided for government employees, military personnel, and big company employees.
- Missionary hospitals and health services worked with limited coverage

1945 - 1965

- The period of market forces suppression
- There was no clear national health financing policy.
- There was an Act on poor family health services in early 1950s, but poorly implemented.
- Health insurance and social security is limited for government employees, military personnel, and big company employees.

1965-1998

- The market economy was introduced
- The private sector grew rapidly, incl, for profit hospitals.
- There was a corporatization of medical services based on market forces
- There was no clear regulation of health market
- Medical doctors have multiple practice culture and tend to serve the aflluent community
- 1997: Economic crisis induced the Social Safety Net incl. Health.

1999 - current

- Decentralization era since the stepdown of Suharto in 1998
- Direct Presidential and Governor/Major election
- More populist policies at national,provincial, and district level
- Poor family has free health and hospital services
- Poor family scheme becomes political issue

After decentralization and economic crisis: Financial Protection Policy in Health Care (1999)

- Reducing Out of Pocket

- Increasing central government finance for health proctection to the poor.
- Immediate after the crisis, using Social Safety Net
- Have steady growth of central government budget.

The Impact of long history of market based health system to:

- Medical Human Resources
- Hospital Distribution

Problem of Health Workforce Distribution

Developed and less developed kecamatan comparison*

	Less Developed	Developed
Number of Health Worker per Health Center		
Doctor	1,79	2,03
Dentist	0,79	1,30
Midwife	5,72	9,35
Nurse	10,34	11,27
Pharmacist	0,00	0,08
Dietitian	1,28	1,81
Public Health	0,55	1,11
Sanitarian	1,28	1,49
Total	27,14	33,03
PNS	19,21	27,59
PTT	3,59	2,95

*) *Bappenas Study 2005 in 32 District*

Medical Specialist Distribution (2008)

Province	Number of Specialist	%	Cumulative	Population	Ratio
DKI Jakarta	**2.890**	**23,92%**	**23,92%**	**8.814.000,00**	**1 : 3049**
East Java	**1.980**	**16,39%**	**40,30%**	**35.843.200,00**	**1 : 18102**
West Java	**1.881**	**15,57%**	**55,87%**	**40.445.400,00**	**1 : 21502**
Central Java	**1.231**	**10,19%**	**66,06%**	**32.119.400,00**	**1 : 26092**
North Sumatera	**617**	**5,11%**	**71,17%**	**12.760.700,00**	**1 : 20681**
D.I.Jogjakarta	**485**	**4,01%**	**75,18%**	**3.343.000,00**	**1 : 6892**
South Sulawesi	**434**	**3,59%**	**78,77%**	**8.698.800,00**	**1 : 20043**
Banten (Java)	**352**	**2,91%**	**81,69%**	**9.836.100,00**	**1 : 27943**
Bali	**350**	**2,90%**	**84,58%**	**3.466.800,00**	**1 : 9905**
South Sumatera	**216**	**1,79%**	**86,37%**	**6.976.100,00**	**1 : 32296**
East Kalimantan	**203**	**1,68%**	**88,05%**	**2.960.800,00**	**1 : 14585**
North Sulawesi	**173**	**1,43%**	**89,48%**	**2.196.700,00**	**1 : 12697**
West Sumatera	**167**	**1,38%**	**90,86%**	**4.453.700,00**	**1 : 26668**
Other Provinces	**1.104**	**9,14%**	**100,00%**	**52.990.200,00**	**1 : 47998**
Data: Indonesian Medical Council, 2008	12083	100,00%		224.904.900,00	1 : 18613

Specialist distribution

- Jakarta: 24% of specialists, serves around 4% community in a relatively small area

- Provinces in Java: 49% of specialists, serves around 53% community

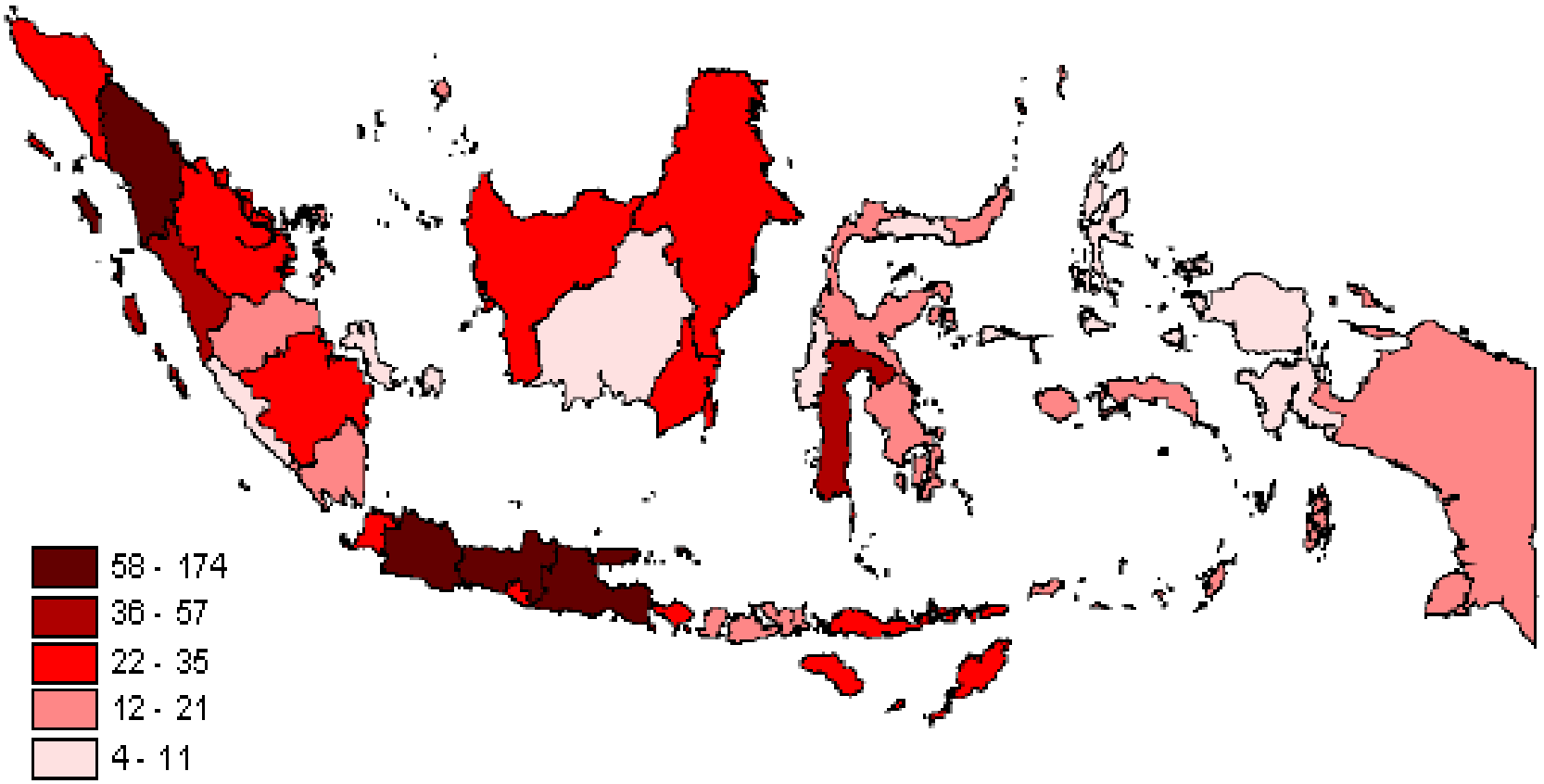
- Rest of Indonesia: 27% of specialists, serves around 43% community in a very large area

Source: Indonesian Medical Council, 2008

Hospital Distribution

- Private Hospital: More concentrated and recently developed in high fiscal capacity districts and Low Poverty Index
- Public Hospital: more developed in high fiscal capacity district

The map of hospitals across province



Most teaching hospitals are in Java and Sumatera

Mean number of private hospitals in various economic enviroments

	Poor community economy	Good community economy
High Fiscal capacity in District Government	1.05	2.11
Low Fiscal Capacity in District Government	0.5	1.91

Mean number of public hospitals in various economic environments

	Poor community economy district	Good community economy district
High Fiscal capacity in District Government	2.6	2
Low Fiscal Capacity in District Government	0.5	0.31

As the impact:

- Regional inequalities in access to services have not improved over time.
- Comparison of trends in inequalities with the distribution of health service infrastructure across Indonesia, suggests that physical barriers to access may underlie the regional inequalities.

The projection

- It is predicted that the costs of hospital utilization (public and private) in big cities will be higher than remote areas.
- The poor patients in big cities will use more government resources compared to the rural and remote areas
- It raises question on geographical equity.

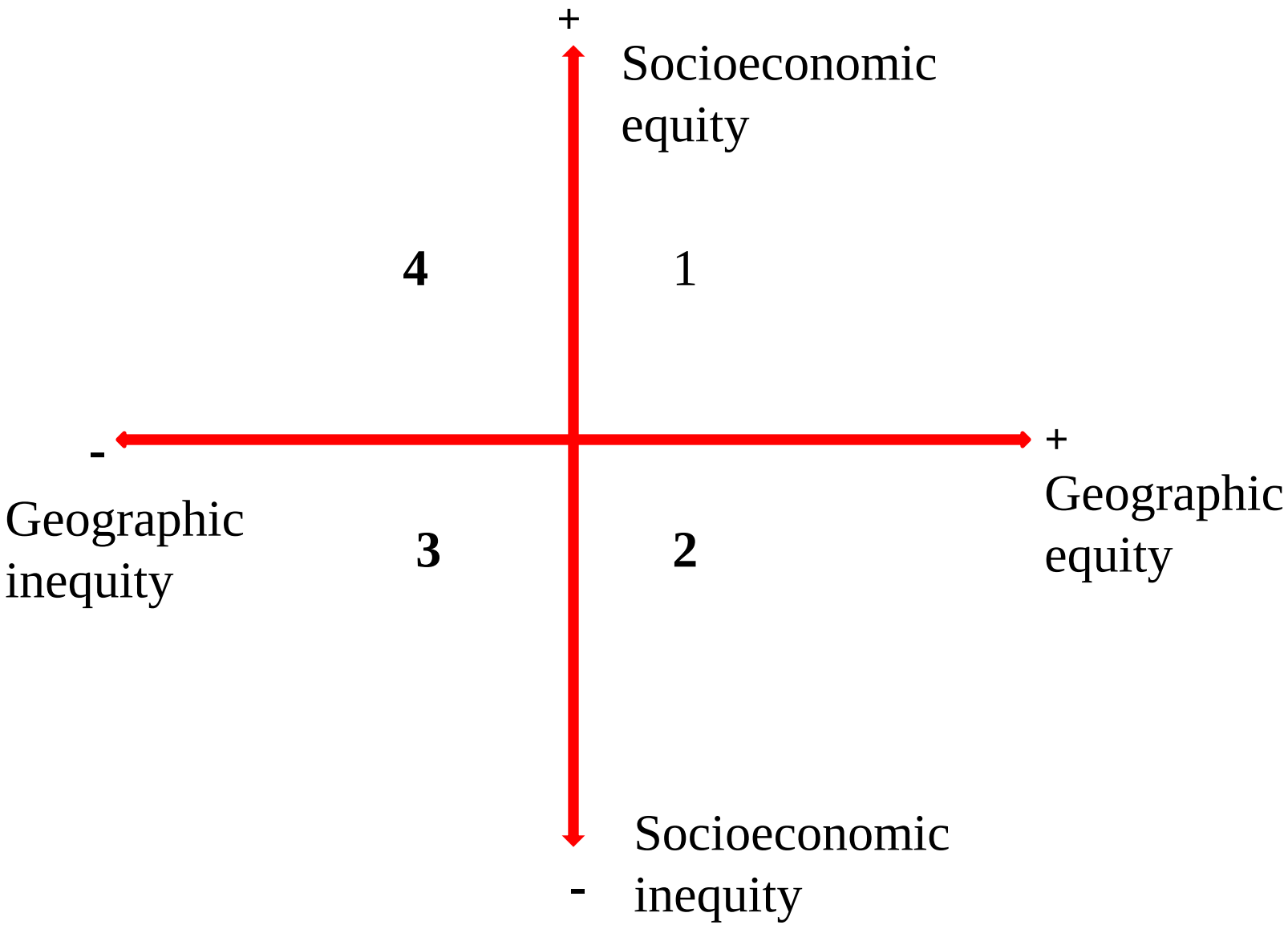
- The new Law faces a difficult challenge in terms of geographic inequity.
- There is a possibility that the improvement of socio-economic equity may worsen the geographic inequity in Indonesia.

The Scenarios

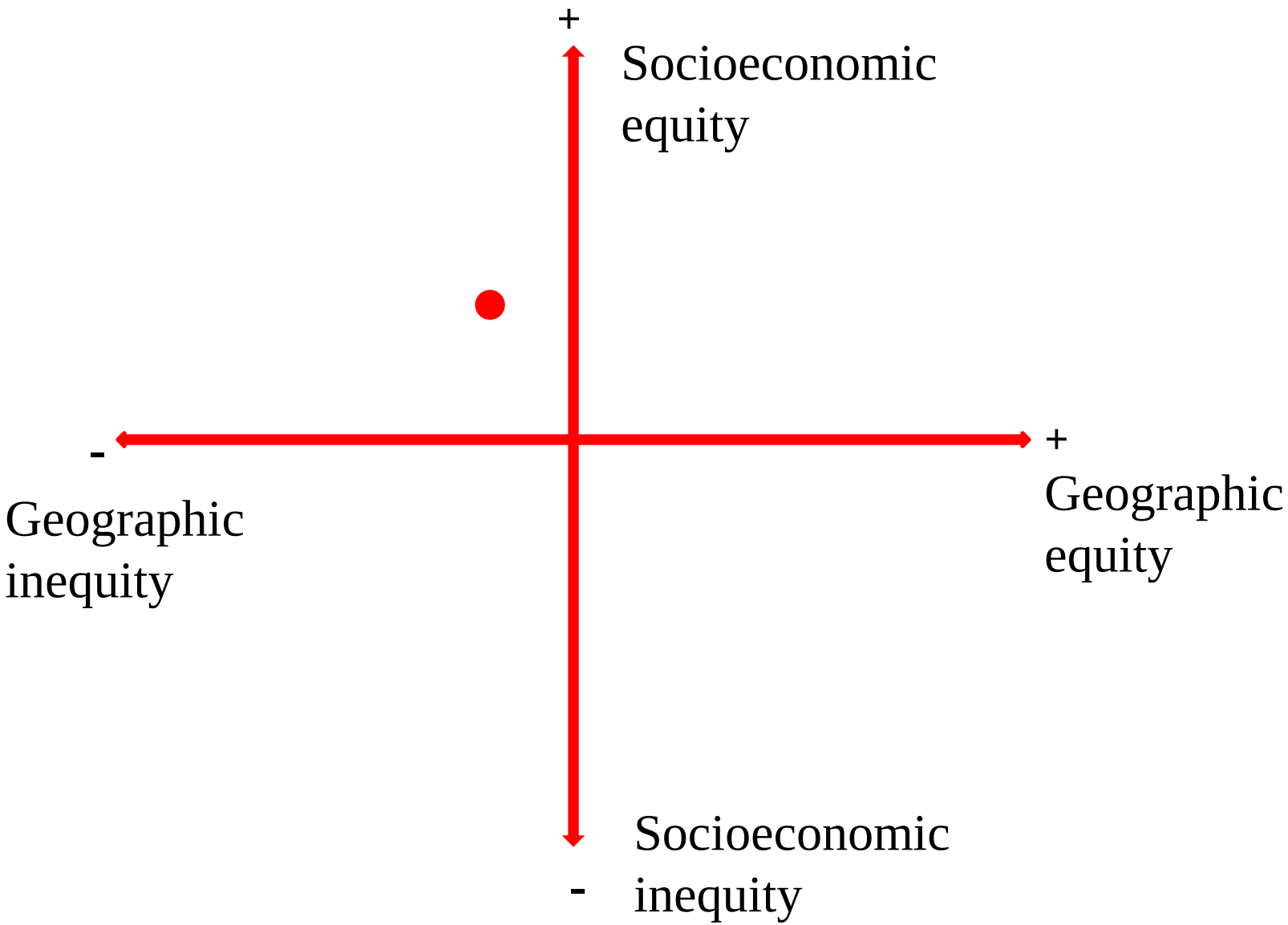
In the future:

- Whether Universal Coverage Policy will improve both: socio-economic equity and geographical equity?
- Or just improving socio-economic equity?

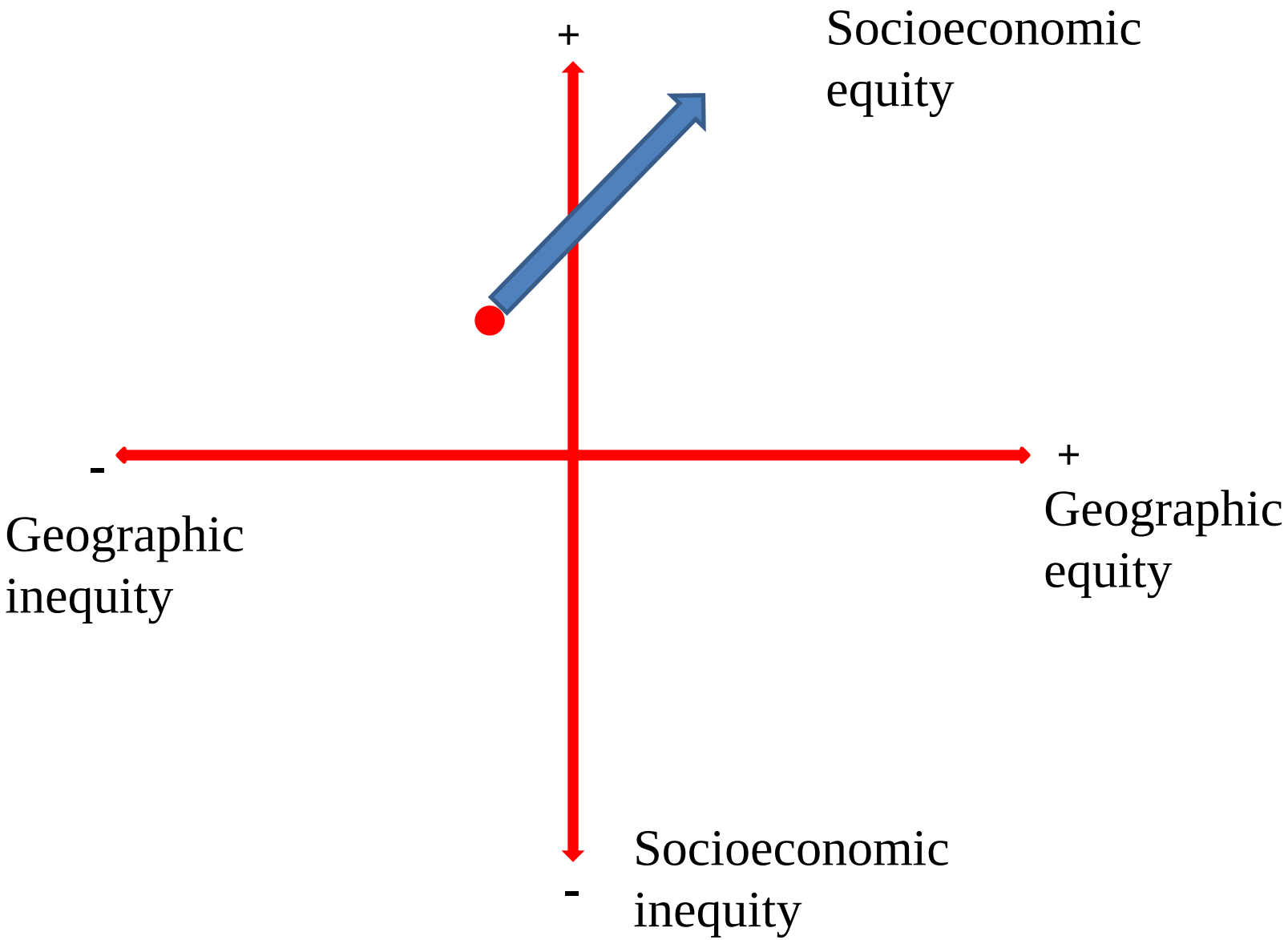
4 Big Scenarios



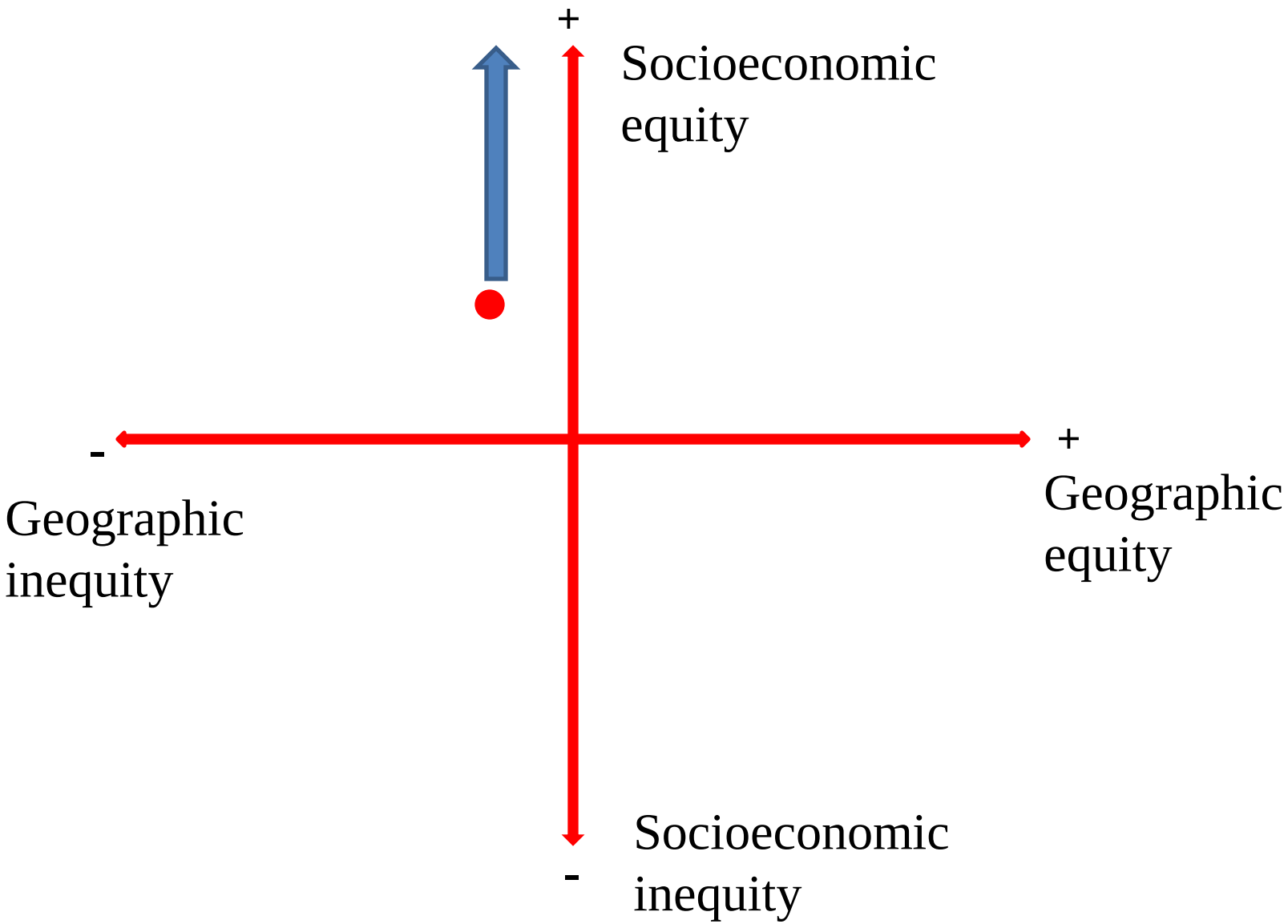
Current Situation



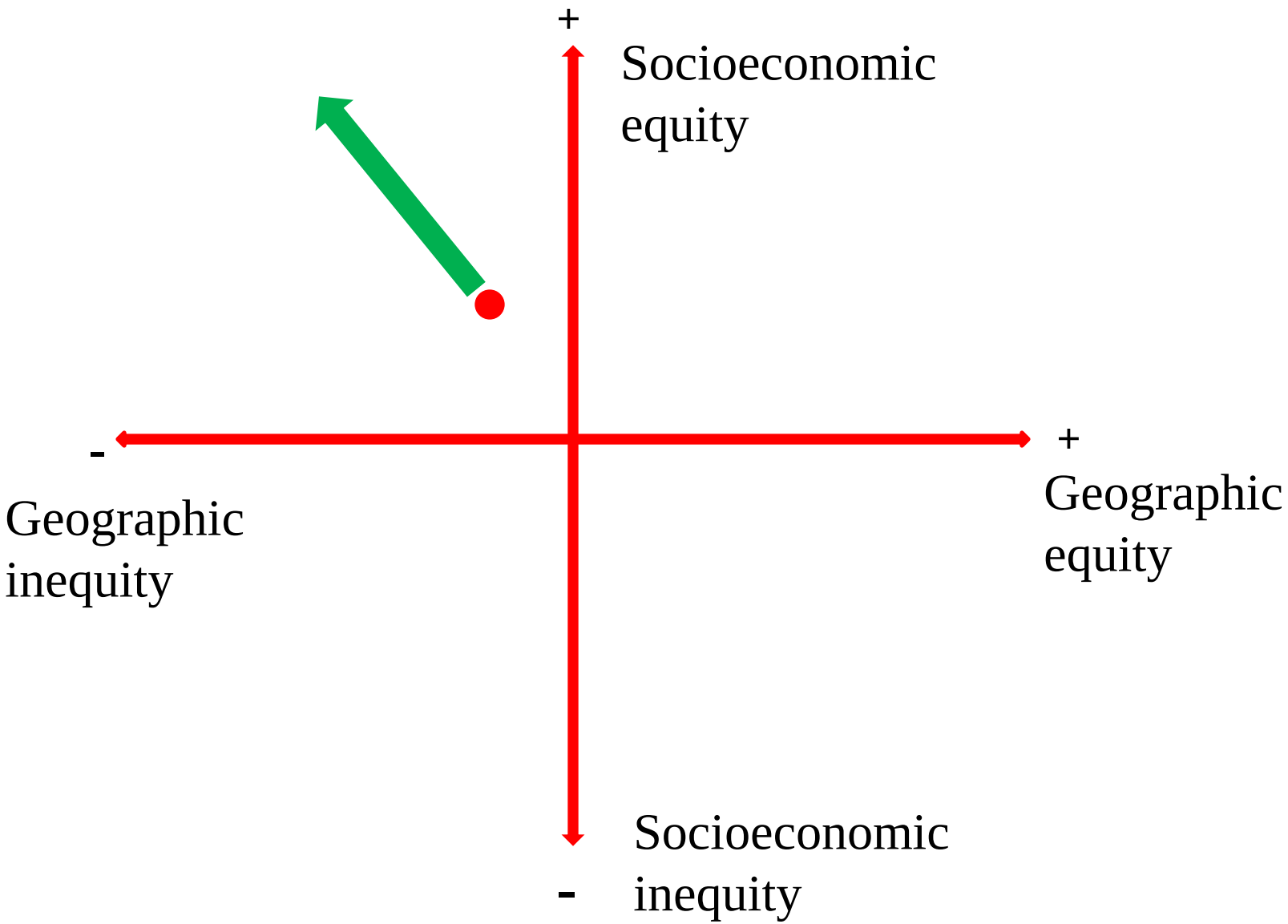
Going to ideal condition



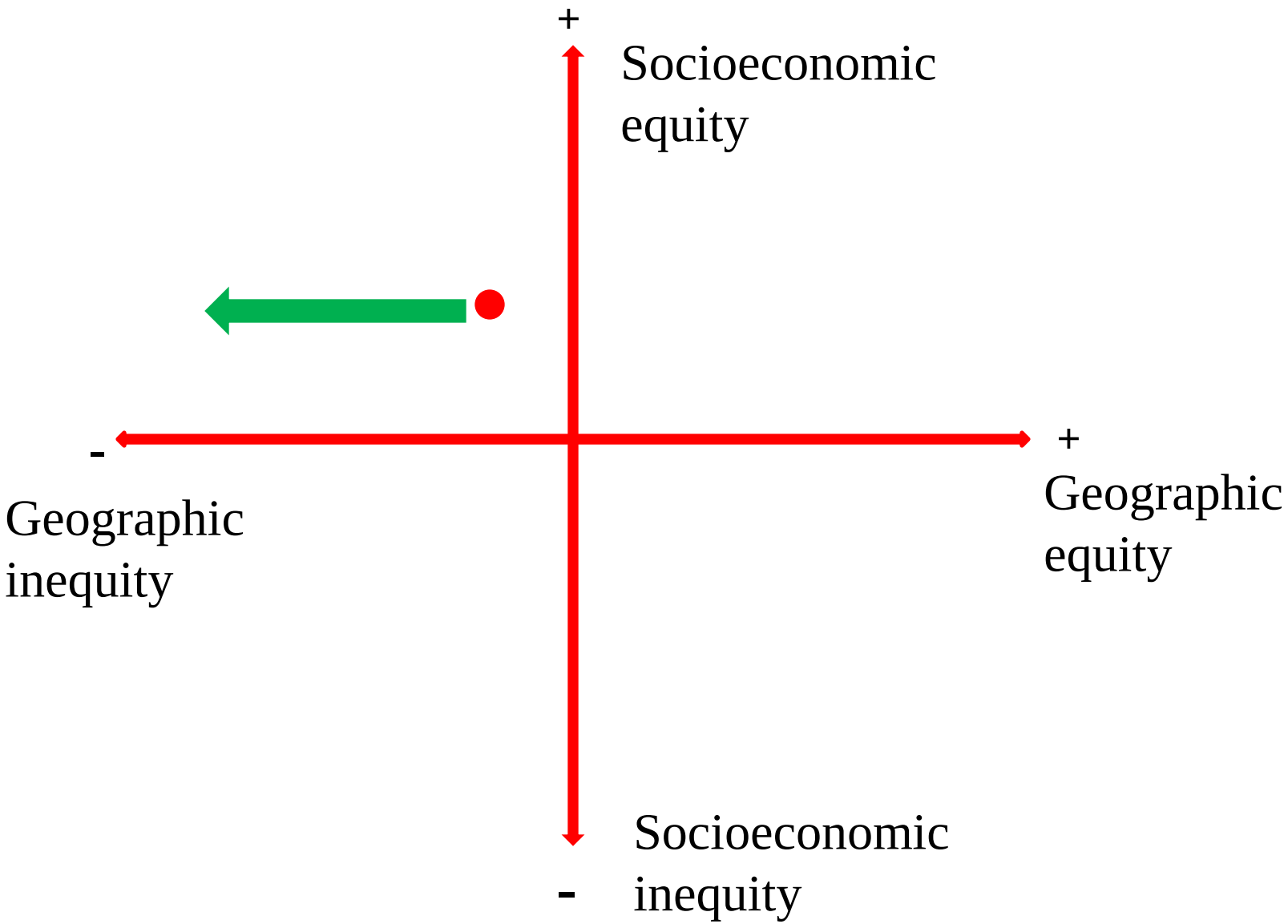
Or going there. Improving the socio-economic equity, but the geographic inequity remains the same



Or going there? Worsening the geographic inequity although improving socio-economic equity.



Or going there?



Thank-you