Prioritising Financing for Diseases Elimination in the context of Universal Health Coverage

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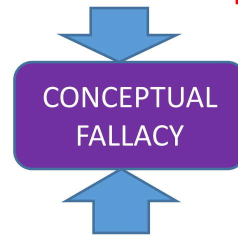
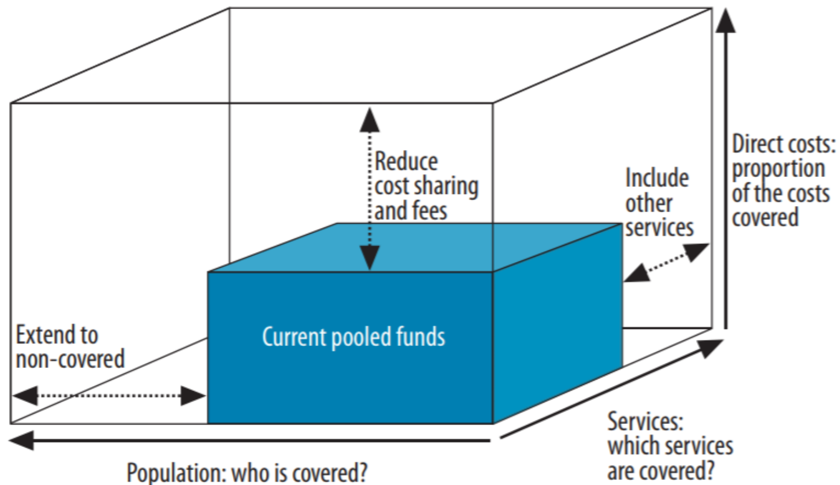
WHAT IS UHC ?

- UHC ➔ ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services (WHO, 2010)



- How does UHC is financed ? ➔ The Cube (WHO, 2010)



X1 = everyone enrolled/covered
X2 = benefit package is comprehensive
X3 = no cost sharing in utilization (full financial protection)

Financing mechansism:
- Collecting
- Pooling
- Purchasing

THIS IS BASICALLY IS INSURANCE

Why I called it "conceptual fallacy"

- Health services is not a homogeneous commodity
- Broadly:

  (1) Some are "public goods" ➔ pricing and insurance does not work

  (2) Some are "private goods" ➔ pricing and insurance may be applied

	PUBLIC GOODS	PRIVATE GOODS
MC (Marginal Cost)	No	Large
Free rider (non-excludable)	Yes ➔ no one willing to pay	No ➔ one has to pay to consume
Externality	Large	No or small
	• Light house • Public park	• Luxury goods • Cars
	• Vector control • Mass immunization	• Cosmetic surgery • Heart Surgery

Indonesia JKN (Social Health Insurance) ➔ seen as UHC

1998 Asian Economic Crisis
➔ Large number of poor:
➔ 86 millions

Gov't introduce SSN programs:
1. Work for food
2. Free education
3. **Free health care**

2014 "big bang"
➔ JKN (SHI) or UHC
➔ Start with 110 mills

- 86 mill poor
- 16.5 mill go'vt employees
- 4 mills worker (formal sector)
- Comprehensive package

	2015	2016	2017	2019 (UHC)
Coverage			180 mills	256 mills
Total	USD 4 billions	USD 4.6 billions	USD 4.9 billions	
Subsidi for the poor	1.96 B	1.96 B	1.96 B	
Defisit	261 mills	450 mills	692 mills	

- Rapidly close to UHC (by 2019)
- Prevented impoverishment due to catasthropic med

PH programs	Before JKN (2013)	After JKN (2015)	% change
IMMUNIZATION			
• BCG	91.4	86.4	-5.5
• DPT	88.5	80.5	-9.0
• Polio	88.4	86.7	-1.9
• Measles	76.9	69.8	-9.2
• Hep-B	84.5	78.6	-7.0
• Complete Imm	74.5	64.0	-14.1
EXCLUSIVE BREAST FEEDING			
• 04	94.4	35.0	-62.9
• 24	94.4	0.0	-100.0
USE OF FP METHODS:			
• Tubectomy	3.2	2.3	-25.9
• Vasectomy	0.6	0.2	-68.6
• IUD	5.6	4.6	-17.8
• Injection	56.3	44.7	-20.7
• Implant	7.1	6.4	-10.3
• Pill	22.5	16.3	-27.5
• Condom	0.7	0.7	-3.6
• Tissue	0.0	0.1	70.2
• CDR tuberculosis	60.0	60.5	+0.5

Declining performance of preventive services after 4 years of JKN implementation

JKN = National Social Health Insurance Scheme

Prof. Budi Hidayat
(Personal communication)

MAPPING KLB DIFTERI s/d MINGGU KE 44 NOVEMBER 2017

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

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DIPTHERY OUTBREAK NOVEMBER 2017

Prov. Aceh
76 Kasus
3 Kematian

Prov. Sumatera Utara
2 Kasus
0 Kematian

Prov. Sumatera Selatan
1 Kasus
0 Kematian

Prov. Kalimantan Tengah
1 Kasus
0 Kematian

Prov. Kalimantan Barat
5 Kasus
1 Kematian

Prov. Sulawesi Utara
1 Kasus
0 Kematian

Prov. Riau
8 Kasus
0 Kematian

Prov. Lampung
1 Kasus
0 Kematian

Prov. Kalimantan Timur
6 Kasus
0 Kematian

Prov. Gorontalo
1 Kasus
0 Kematian

Prov. Kalimantan Selatan
1 Kasus
0 Kematian

Prov. Papua
1 Kasus
0 Kematian

Prov. Sumatera Barat
30 Kasus
0 Kematian

Prov. Jambi
3 Kasus
0 Kematian

Prov. Bangka Belitung
3 Kasus
2 Kematian

Prov. Sulawesi Tengah
1 Kasus
0 Kematian

Provinsi Banten
81 Kasus
3 Kematian

Provinsi DKI Jakarta
16 Kasus
2 Kematian

Provinsi Jawa Barat
95 Kasus
10 Kematian

Provinsi Jawa Tengah
11 Kasus
0 Kematian

Provinsi Jawa Timur
271 Kasus
11 Kematian

Provinsi Sulawesi Selatan
4 Kasus
0 Kematian

Provinsi Sulawesi Tenggara
4 Kasus
0 Kematian

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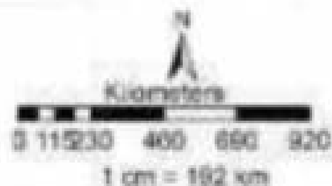

Legend
Rekap KLB Difteri
KLB

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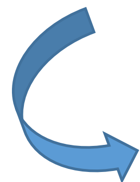
Why ?

- Disease elimination would not succeeded without “promotive, preventive and surveylance (early D/ and promt Th/”
- JKN follows the “Cube” → insurance
- JKN do not finance “public goods” interventions
- JKN pay health center on capitation basis → 60% for staff remuneration
- Public health become less attractive → staff spent more time treating patients
- Less time to support outreach services in the community
- Gov’t budget for PH relatively small



- Subsidy for the poor premium → USD 1.9 billions
- Allocation for PH → USD 0.3 billions

TABEL 6.23

ANNUAL PARASITE INSIDENCE (API) MALARIA PER 1.000 PENDUDUK

MENURUT PROVINSI TAHUN 2013-2016

No	Provinsi	API			
		2013	2014	2015	2016
(1)	(2)	(3)	(4)	(5)	(6)
1	Aceh	0,44	0,16	0,08	0,05
2	Sumatera Utara	1,30	0,69	0,49	0,25
3	Sumatera Barat	0,26	0,18	0,14	0,10
4	Riau	0,23	0,13	0,10	0,03
5	Jambi	1,11	0,84	0,47	0,14
6	Sumatera Selatan	0,39	0,30	0,31	0,27
7	Bengkulu	3,89	2,17	2,03	1,36
8	Lampung	0,34	0,55	0,49	0,40
9	Kepulauan Bangka Belitung	1,28	0,86	1,08	0,11
10	Kepulauan Riau	0,49	0,41	0,35	0,36
11	DKI Jakarta	0,00	0,00	0,00	0,01
12	Jawa Barat	0,00	0,01	0,00	0,01
13	Jawa Tengah	0,04	0,05	0,06	0,03
14	DI Yogyakarta	0,02	0,02	0,03	0,03
15	Jawa Timur	0,00	0,01	0,00	0,01
16	Banten	0,01	0,00	0,00	0,00
17	Bali	0,00	0,00	0,00	0,00
18	Nusa Tenggara Barat	0,57	0,78	0,42	0,24
19	Nusa Tenggara Timur	16,37	12,81	7,04	5,17
20	Kalimantan Barat	0,23	0,17	0,13	0,06
21	Kalimantan Tengah	2,00	1,32	0,42	0,19
22	Kalimantan Selatan	1,43	1,35	0,68	0,52
23	Kalimantan Timur	0,47	0,32	0,46	0,35
24	Kalimantan Utara	-	0,09	0,03	0,03
25	Sulawesi Utara	1,11	0,94	0,88	0,72
26	Sulawesi Tengah	1,13	0,80	0,68	0,48
27	Sulawesi Selatan	0,25	0,10	0,10	0,12
28	Sulawesi Tenggara	0,62	0,46	0,41	0,44
29	Gorontalo	1,08	0,84	0,57	0,15
30	Sulawesi Barat	0,40	0,25	0,17	0,09
31	Maluku	8,25	6,00	5,81	3,83
32	Maluku Utara	4,51	3,32	2,77	2,44
33	Papua Barat	38,44	20,85	31,29	10,20
34	Papua	42,65	29,57	31,93	39,93
	Indonesia	**1,38**	**0,99**	**0,85**	**0,77**

Sumber: Ditjen P2P, Kemenkes RI, 2017

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	API
2013	1.36
2014	0.99
2015	0.85
2016	0.77

Key factors

Focused:

- identify highly endemic province (API > 5)
- Search district with high API in the respective province
- Search sub-districts with high API in the district ➔ down to village

Total interventions in the focus area:

- Mass fever survey
- RDT confirmation
- Treatment of (+) cases
- Distribution of treated bed net
- IRS
- Breeding places elimination ➔ village chief & other sectors
- MFW ➔ at village levels
- Midwives in the village ➔ administered treatment

Multiple and join funding:

- MFW → Surveylance → local district gov't
- RDT → central MoH bgt
- ACT → central MoH bgt
- Treated nets → GF, CSR (mining in the endemic areas)
- VC: Insecticide → Central MoH + Local gov't
- Operating cost for IRS → local gov't
- IEC: local and MoH (integrated in health centers bgt)

Issue on Tobacco tax

Political

- API reduction is formally used as district gov't performance indicator (monitored by Governor)

Conclusions

- Elimination of any disease requires comprehensive health services:
  1. Promotive services
  2. Preventive services
  3. Screening (early D/ and promt Th?
  4. Treatment
  5. Rehabilitation
- Promotion, prevention, screening is essential → PUBLIC GOODS
- PUBLIC GOODS → publicly funded → tax based

Health Insurance

- Is not panacea (Brian Abel Smith, WB on Hlth financing)
- Is just “cleaning murky water downstream”
- It provides ➔ financial protection, nothing to do with risk reduction
- Is necessary but not sufficient (it prevents impoverishment)

Financing disease elimination :

- Sufficient public funding (tax based) ➔ PH interventions
- Effective Health Insurance ➔ treatment interventions
- Collaborative financing:
  a. Central government
  b. Local government
  c. Development partners

UHC

Access of all to comprehensive hlth services
No financial hardships

PROMOTIVE – PREVENTIVE – SCREENING – TREATMENT - REHABILITATIVE

`1

PUBLIC HTLH INTERVENTONS

CLINICAL INTERVENTONS

PUBLIC GOODS

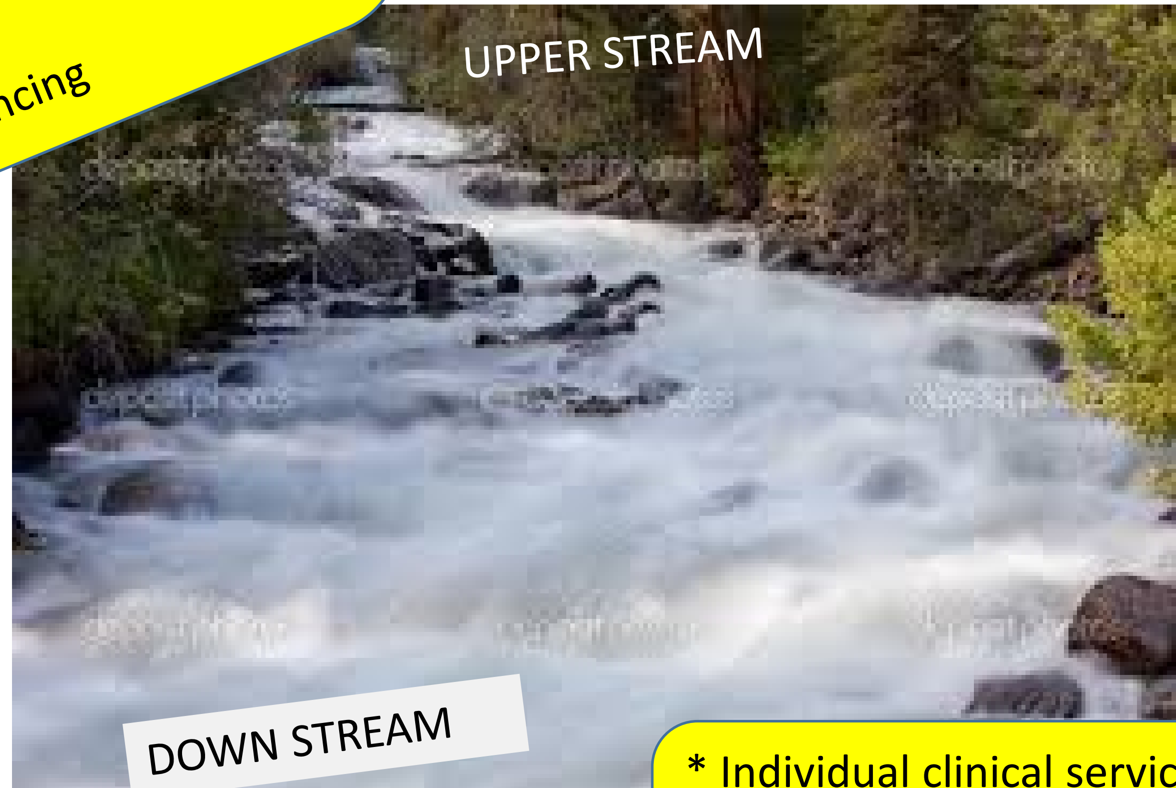
PRIIVATE GOODS

TAX BASED FINANCING

HEALTH INSURANCE

How do we clean murky water ?

- Hlth promotion
- Prevention
- Surveylance (early D/ & Th/)
- Environmental hygiene
- Organized community
- Beyond health sector
- Public goods
- Tax based financing



* Individual clinical services
* Financial protection
* Health insurance
* Collecting, Pooling, Purchasing

Laevell & Clark (1958)
The five levels of prevention

(a) health promotion (serving to further general health and well-being), and
(b) specific protection (measures applicable to a particular disease or group of diseases in order to intercept the causes before they involve man). Secondary prevention consiste d of
(c) early recognition and prompt treatment (with the objectives of preventing spread to others if the disease is communicable, complications or sequelae, and prolonged disability). Tertiary prevention consisted of
(d) disability limitation (prevention or delaying of the consequences of clinically advanced disease), and
(e) rehabilitation (aiming at prevention of complete disability after anatomic and physiologic changes are stabilized).

UHC in malaria elimination in Indonesia

- Identify most affected area (API > 1%)
- UCH:
  * everyone were surveyed ➔ by community and malaria field worker
  * all detected cases were treated ➔ antimalarial drugs were secured by central MoH bgt ➔ channeled down to Health Centers (Puskesmas)
  * all household were given treated bed nets ➔ funded by GF
  * Health Center operating cost ➔ specified block grant from MoH to district ➔ to HC