Public Health in the Decentralization Era Towards Universal Coverage

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Abstract: Every citizen has the right to have access to quality health services, at a reasonable cost. To ensure universal coverage, it is important for governments to take policy measures aimed at expanding pre-paid systems and reducing as quickly as possible dependence on out-of-pocket systems. The objectives of this research was to find the efficiency administrative, which is necessary to limit the number of insurance companies. This goal can be realized by developing a broader and fairer system of pre-effort financing through taxes, social health insurance, or a mixture of both systems. Through the positive elements of "managed care", the government can establish regulatory and control mechanism on the demand side and the provision of health services, in order to control the cost, quality, access of health services for all citizens in Indonesia. For the long-term and well-performing insurance companies in managing insurance on a national scale continue to function as private and social health insurance managers in parallel with national health insurance (Jamkesmas) managed by the government. The government needs to strengthen the regulation on the financing side and the provision of services in the system of insurance, so that every citizen can actually access quality health services at affordable cost.

1 INTRODUCTION

Health is not viewed as a citizen's right but also an investment capital that determines the productivity and economic growth of a country. Therefore the state is concerned that all its citizens are healthy ("health for all"), so there is a need to institutionalize universal health services. There are two fundamental issues for the realization of health services with mental health, namely how to finance health services for all citizens, and how to allocate health funds to provide health services effectively, efficiently and equitably.

The appropriate financing system for a country is a system capable of supporting achievement. Universal coverage is a health system in which every citizen has fair access to quality, promotive, preventive, curative and rehabilitative services, at a reasonable cost. Scope of the universe consists of two core elements: (1) Access to fair and quality health services for every citizen; and (2) Fire Protection of Communities Using Health Services (WHO, 2005).

Fair access to health services uses the principle of vertical justice. The principle of vertical justice, the contribution of citizens in health financing based on ability to pay (ability to pay), not based on health condition / pain of a person. With vertical justice, lower-income people pay lower cost than higher-income people for health service of the same quality. In other words, cost should not be an obstacle to getting required health care (needed care, necessary care) (Bhisma, 2011). This paper will further discuss the strategy (dual health care system) for the management of financing to achieve health care coverage in Indonesia.

2 METHODS

A scientific study should use systematic compilation techniques to facilitate the steps to be taken. Similarly, the authors conducted in this paper, the steps taken are through literature studies on reading journals and research results that deal with the insurance system and health financing. The data

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obtained from this literature study can be used as a reference analysis to discuss innovation of health financing system in Indonesia.

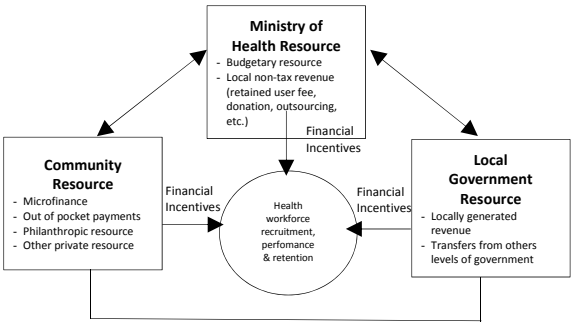
3 RESULTS

Universal Health Coverage (UHC) is defined as ensuring that all people have access to needed promotion, 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. Universal health coverage has therefore become a major goal for health reform in many countries (WHO, 2017).

The Indonesia's Universal Health Coverage/*Jaminan Kesehatan Nasional* (JKN) was launched on 1 January 2014 to initially cover around 120 M population who are already engaged in various social health insurance (SHI) schemes under one fund-management agency called Health-BPJS. The targeted all population coverage is around 250 M people to be covered by 2019. With the targeted coverage, JKN will be the world largest SHI (WHO, 2017). There are some JKN issues raised in this year include:

a. Availability and equitable distribution of health services in outer islands to serve JKN members and overall quality of healthcare services
b. Provider payment: issues with long time laps for government primary care facilities in receiving capitation payment due to regulation on decentralization; and low tariff set in INA-CBG prospective payment.
c. Lack of JKN socialization activities for the people at large and coverage issues of people in the informal sectors.
d. Assurance of sustainable financing towards UHC.

This paper looks at the potential for decentralization in Indonesia to lead to better health workforce recruitment, performance and retention in rural areas through the creation of additional revenue for the health sector; better use of existing financial resources; and creation of financial incentives for health workers. According to the rationale of decentralization, smaller local entities that have more autonomy and funds can better respond to local needs and may also better manage human resources. As explained in Fig. 1, decentralized health financing systems are built around one or more of the three main sources of health-care finance: ministry of health, local government and the community. Where the decentralized health financing system relies on more than one source, the sources are seen to be interdependent (as indicated by two-headed arrows in Fig.1).



Source : WHO. Bulletin of The WHO. 2010

Figure. 1: Decentralized health financing and its links with the health workforce

Decentralization, where it involves the dispersion of human resource functions to the local (government, health-care delivery or community) level, is an especially challenging process as it is influenced by various institutional and contextual factors. Although financial resources are finite (but well accounted for under decentralization), decentralized health financing systems present opportunities to maximize resource availability and utilization. In particular, as shown in figure below, three prominent sources facilitate this purpose: (i) autonomy within the ministry of health or decentralization of health-care delivery, (ii) local or decentralized government resources, and (iii) community resources (WHO, 2010). This paper mainly focuses on strategy for achieving public health in the decentralization era towards universal coverage.

4 DISCUSSIONS

The dual financing system consists of two parallel components, namely health financing for the formal sector and the informal sector. The dual system has been applied to the universal coverage policy in Thailand since 2001 and has successfully achieved the goal of equitable healthcare financing, preventing catastrophic health spending and impoverishment due to out-of-pocket healthcare payments (Somkotra and Lagrada, 2008).

With a double-finance system, methods for the formal sector go as they have been through the Askes scheme, Jamsostek, and private health insurance. But the coverage of the insurance beneficiaries needs to be extended to include all family members, not just the workers concerned. The government needs to regulate the amount of premium and regulation of health service provision.

Informal sector health financing can be done through Jamkesmas and Jamkesda schemes, to finance the health services of workers in the informal sector, such as farmers, casual workers, small traders, self-employed, unemployed, poor families, near-poor families, almost non-poor families, others, and his family. To achieve universal coverage, quality health services must be accessible to all citizens, not only poor, but also non-poor.

The implications of the wish to extend coverage of Jamkesmas and Jamkesda schemes to all citizens require more funds than the APBN or APBD to finance the scheme. To do so requires the political will of the government and parliament to reallocate the state budget in such a way that there is sufficient budget to run the universal coverage scheme of health insurance. At the same time, it is necessary to extend the coverage of social health insurance (payroll tax-based insurance for workers in the formal sector). On the other hand, to control health costs, it is necessary to regulate demand-side health cost control, by applying co-payment to prevent moral hazard, even though poor and near-poor families need to be freed from co-payment.

Starting from 2014 Jamkesmas managed by the Social Security Management Agency (BPJS). In accordance with the "big law of law" JAMKESDA funds from each district and city will be more efficient if pooled on a provincial scale, thus making the risk of illness of the insurer to the average. The pooling of JAMKESDA funds from each regency / municipality at the provincial level is useful for the cost of health services divided by all JAMKESDA, thereby reducing the burden of certain district / municipality Jamkesda that have participants with greater relative risk of illness. Certainly need to avoid overlapping insurance protection. The coverage of Jamkesda insurance beneficiaries or the health care benefits package should be differentiated with Jamkesmas.

Funding at the provincial level is also useful to prevent disparities in the benefits of health services that can occur if Jamkesda is managed by each regency / city, in addition to the usefulness of insurance services can be used between regions (portability). The social insurance system (mandatory) always requires community solidarity, solidarity and political commitment of district / city governments to be willing to collect JAMKESDA funds on a national scale.

Musrifah (2014) state that the forms of regulation and government intervention that health is through the creation of modern health institutions in line with the order of universal healthcare. The existence of direct local elections in Indonesia are very influential on public policy in health financing. National Health Insurance Program and the Health Insurance (Jamkesda) is an instrument of the State to make public welfare. When finished instrument state, the second program is often used by politicians to win the regional head elections (elections) or get legitimacy. Therefore it needs to be a synergy between the Central and Local Government relating to the health insurance policy. The most important thing in healthcare synergy between the Central and Local Government is the problem of financing. The poor and can not afford that contained in the Decree of the Regent/Mayor will be financed from the state budget, poor and can not afford beyond the quota are borne by the local government with a source of costs from the budget, financed the Workers' Group of the respective institutions (PNS, Asabri, Jamsostek) and group of individuals (the rich and very rich) pay for themselves and those who are not covered by the state budget and budgets.

In addition, it is important for BPJS to apply the positive elements of “managed care”. BPJS needs to be obeyed by important and professional people in the field of providing managed health care services with insurance system. The government and BPJS apply regulatory on the demand side and the provision of health services, in order to control the cost, quality, and access of health services for all citizens. On the supply side, BPJS needs to apply quality control tools and health care costs, for example by the selection method, and deselection, to hospital, Puskesmas, and doctors, who provide service in the pre-effort scheme (Bhisma, 2011).

JKN new policy could be implemented as a whole, if it is consistent and commitment to the mandate of the Health Act which requires a minimum of 5% of the budget for health development. If the 2014 budget are difficult to change the implementation of at least JKN conducted early in 2016, after realizing the government's health budget by 5% of the total state budget. Step by step, local governments are also encouraged to commit to the health budget by 10% of the total budget. Thus universal health coverage will still be able to be achieved in 2019.

5 CONCLUSIONS

Every citizen has the right to have access to quality, promotive, preventive, curative and rehabilitative services, at a reasonable cost. Through the positive elements of "managed care", the government can establish regulatory and control mechanism on the demand side and the provision of health services. To ensure universal coverage, with SJSN Law no. 4/2004, it is important for the government to take policy measures aimed at expanding the scope of pre-paid system and reducing as soon as possible reliance on out-of-pocket systems. With the characteristics of the majority of citizens working in the informal sector with uncertain income and some others formal, the goal can be realized by developing a wider and fairer system of pre-effort financing through general taxes and extending the coverage of payroll-tax (dual health care system).

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