

# The Local Health Financing Scheme (Jamkesda) in the Transition Time to the Universal Health Coverage: A Story from the Field



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## What is UHC?

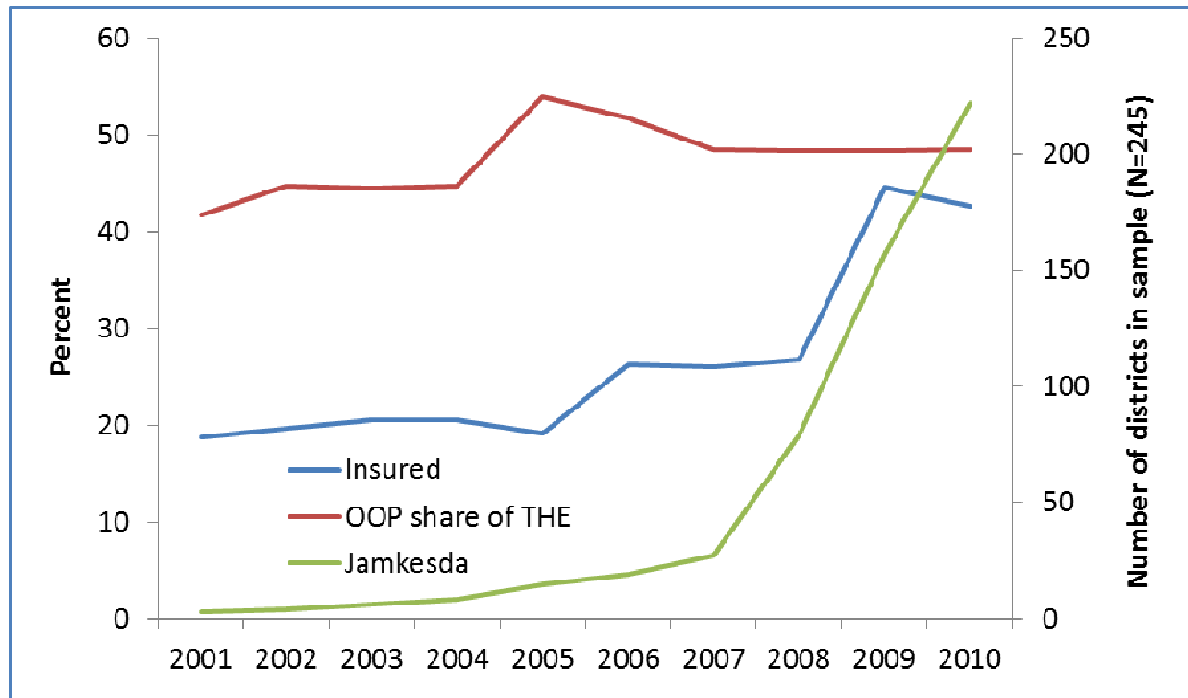
all people receive essential health services they need at good quality without suffering financial hardship from out-of-pocket expenses.



- Universal Health Coverage/*Jaminan Kesehatan Nasional* (JKN) started on 1 January 2014 and aims to achieve universal coverage by 2019. The UHC is also a growing movement worldwide.
- At the same time, the local governments are still operating local health financing initiatives
  - Coverage gap in the national scheme
  - Local political economy in the decentralization era



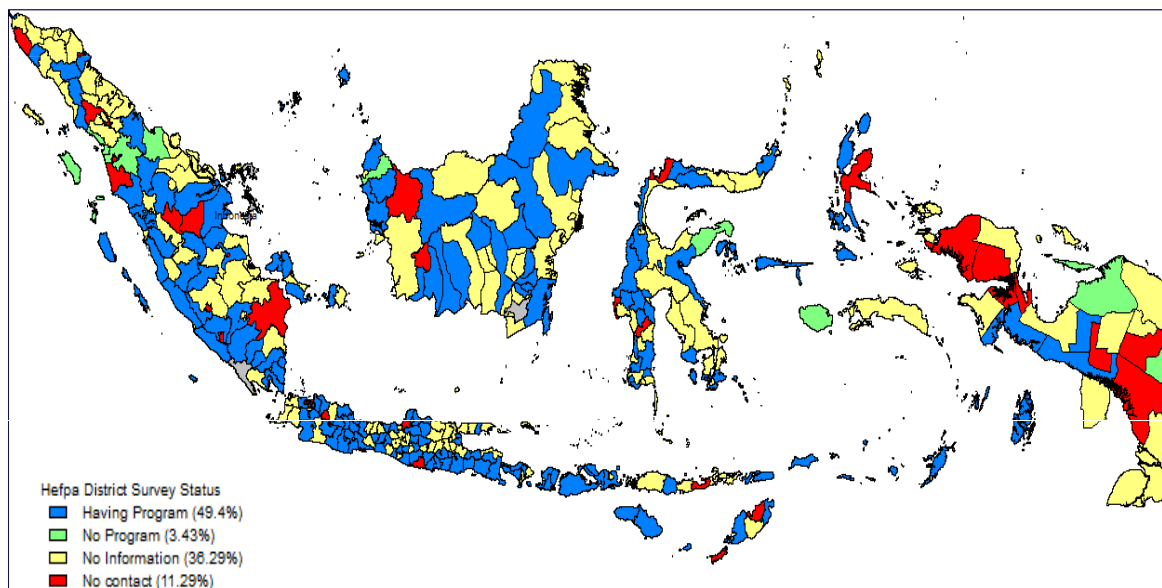
- This presentation is a subset finding of a larger study on ‘baseline assessment of UHC scheme for maternal neonatal and child health services’ funded by UNICEF.



Source: Budiya *et al.* (2013)

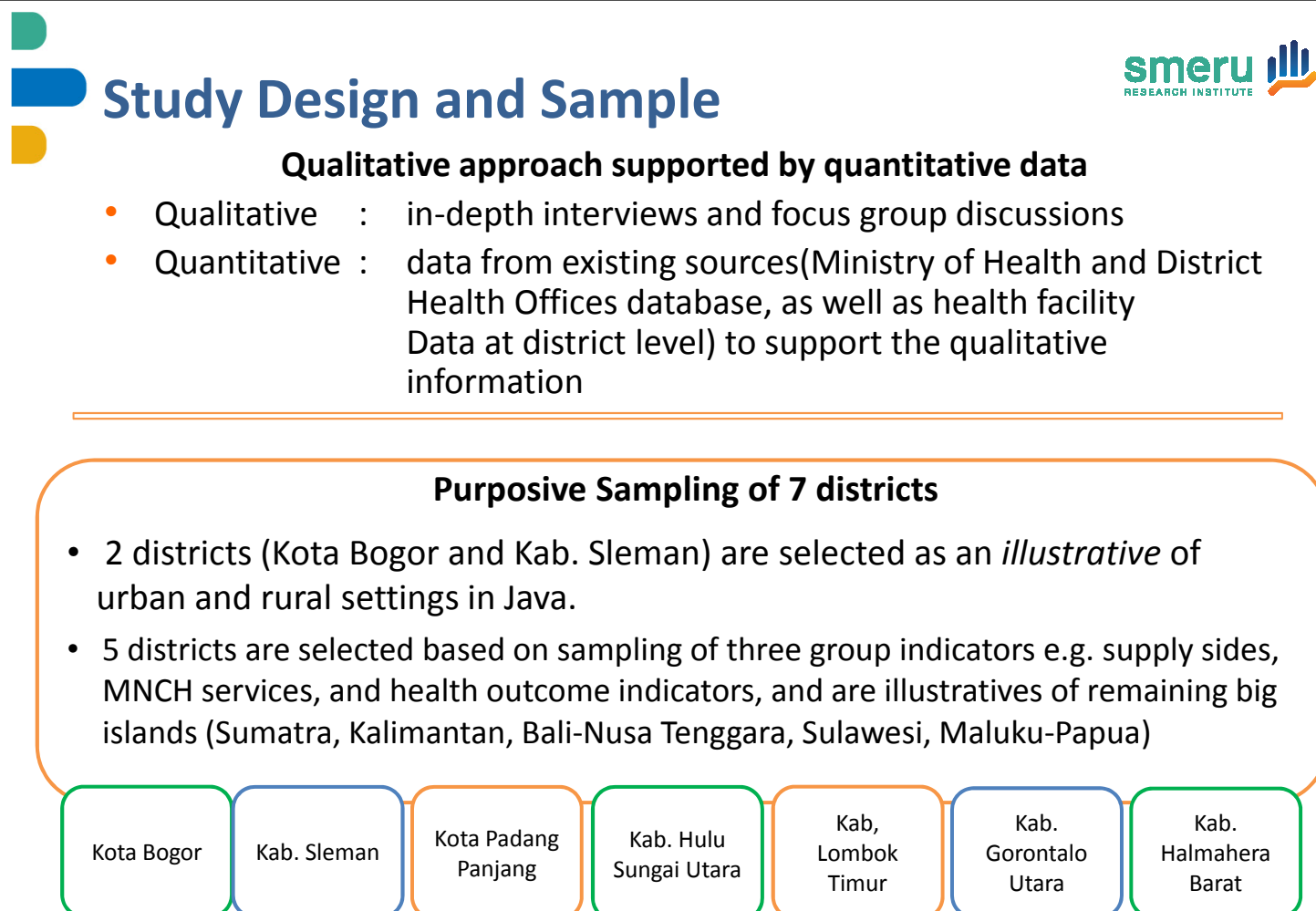
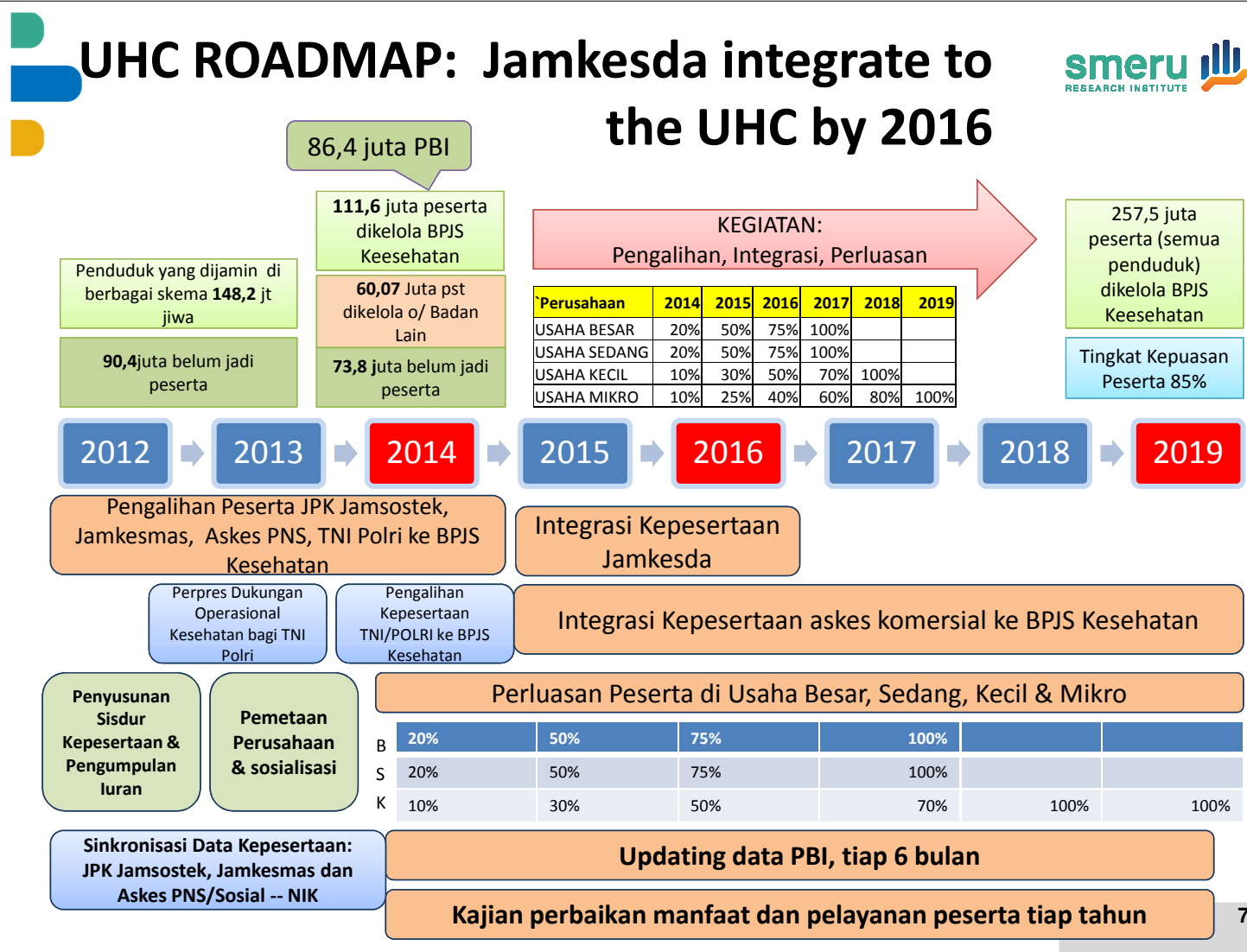
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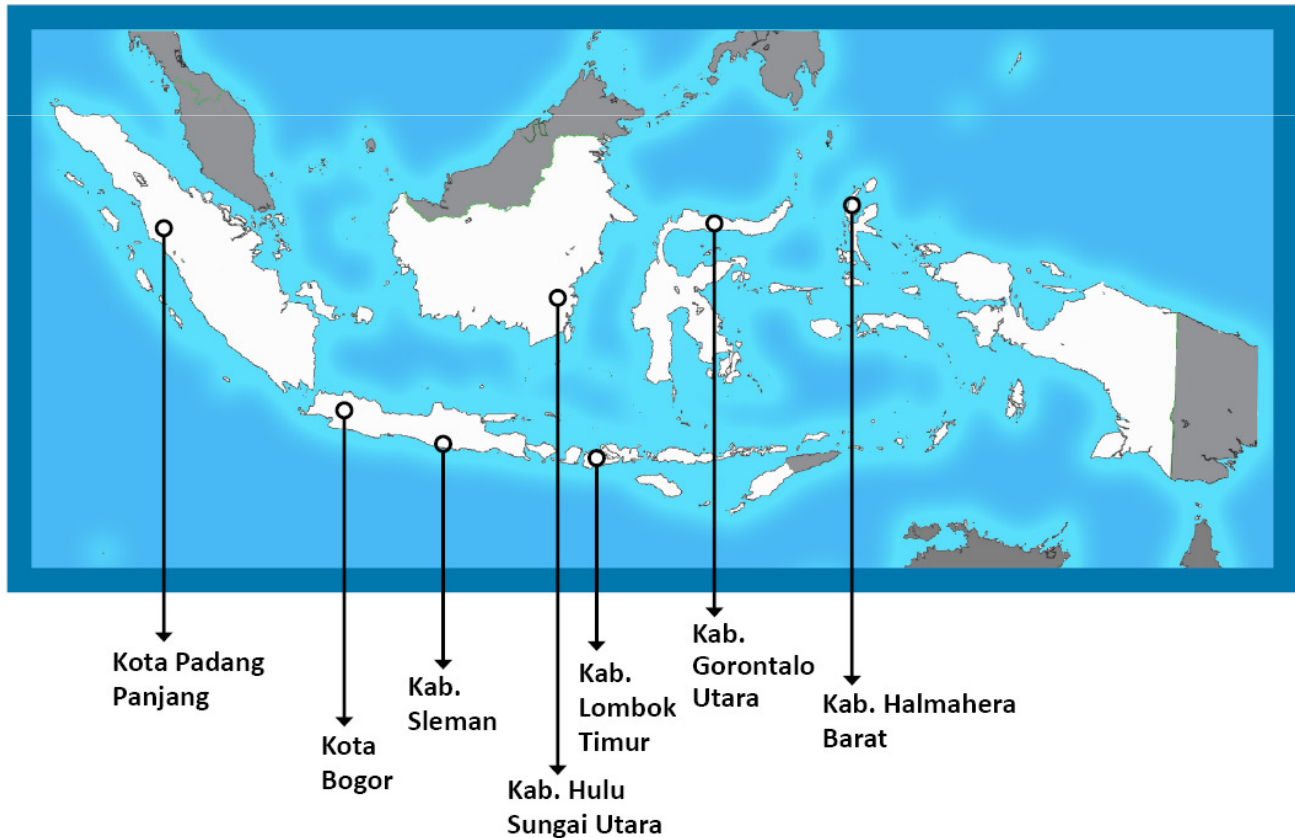
## Jamkesda Map (N=262 districts)



Source: Budiya *et al.* (2013)

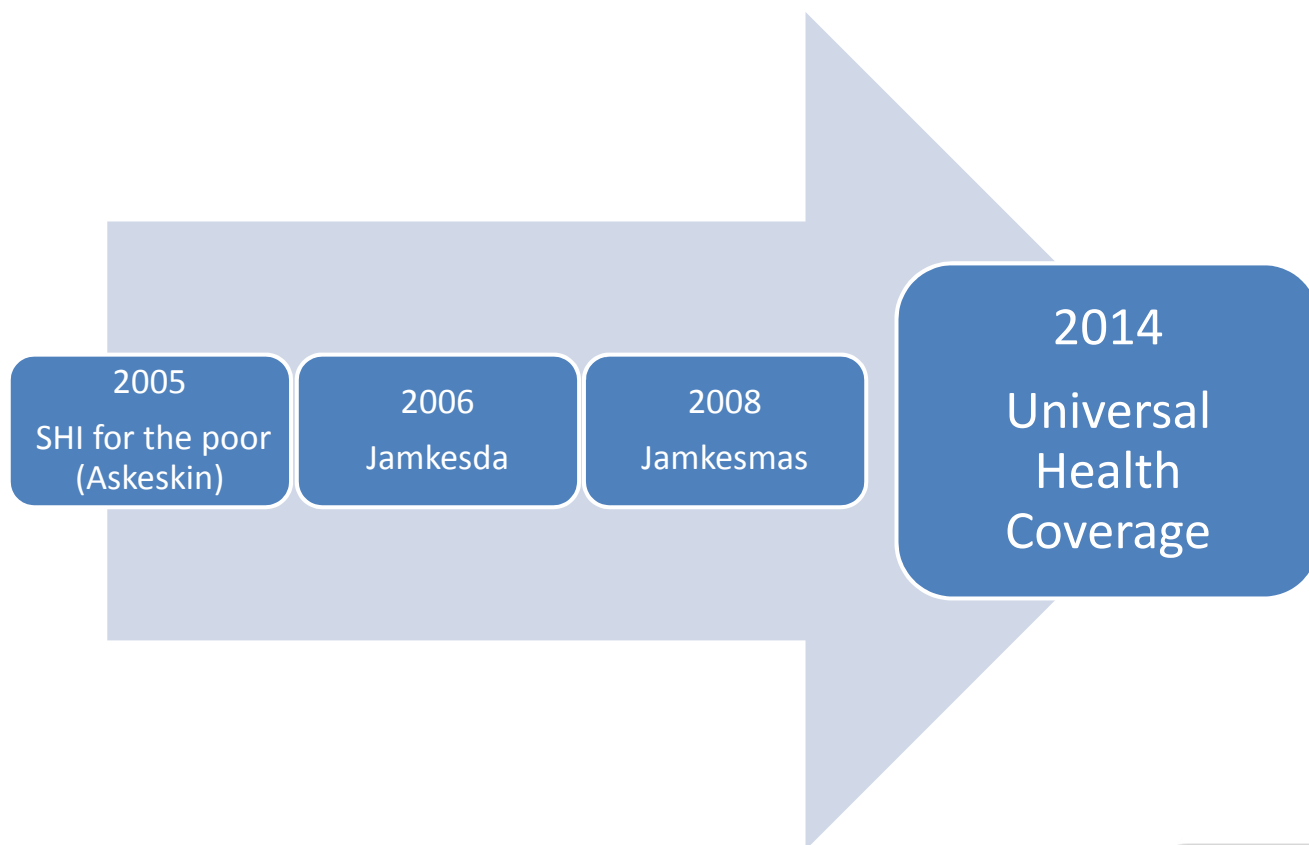
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### Key Finding:

The UHC has consequences on local health financing schemes and, in turn, on insurance coverage. However, the impact varies considerably across district.



District/municipality	Scheme before 2014	Alternative scheme after 2014
Kota Bogor	Jamkesda (managed by the DHO) Subsidized premium for uninsured poor – opened quota	Local PBI* covered 32,431 people in 2014
		Jamkesda – opened quota
Sleman	Jamkesda (managed by technical units under the DHO) -subsidized premium for uninsured poor -voluntary premium from non-poor	Jamkesda (managed by technical units under the DHO) → same scope and design -the district government covered about 33,000 poor and 68,000 near poor in 2014
Kota Padang Panjang	Jaminan Kesehatan Masyarakat Padang Panjang (JKMPP) since 2006 -universal coverage for uninsured population, cover 31,142 population	Local PBI (district and provincial governments' sharing=60:40) -covered 3,000 people in 2014 and 4,500 in 2015
Hulu Sungai Utara	Kartu Sehat Amuntai (KSA) since 2006	Local PBI -cover 9,535 people
		Kartu Sehat Amuntai -opened quota for 9,071 people
		Jaminal Persalinan Daerah (Jampersalda) -Jampersal-look like, a universal delivery scheme for uninsured pregnant mothers

District	Scheme before 2014	Alternative scheme after 2014
Lombok Timur	Jamkesda (sharing district and provincial governments)	Local PBI (sharing district and provincial governments) -covered 10,081 people in 2014. 80% of it by name by address, 20% opened quota (peserta tumbuh)
Gorontalo Utara	Jamkesda (district scheme)	Local PBI (sharing district and provincial governments) -Opened quota and covered 42,016 people
	Jamkesda (province scheme)	
Halmahera Barat	Jamkesda (managed by the DHO)	Jamkesda (managed by the DHO) -covered 27,000 people

## Integration to the UHC

- Main motivations of Jamkesda:
  - Filling the gap of the UHC national coverage
  - Local leader's commitment
  - Flexibility in managing the fund
- Jamkesda integration to the UHC influenced by, among others, district fiscal capacity and data integration readiness.



- Progressive universalism: ensure the poor gain at least as much as those who are better off at every step of the way toward universal coverage
- In the absence of determination to include people who are poor from the beginning, drives for universal coverage are very likely, perhaps almost certain, to leave them behind (Gwatkin & Ergo, 2010)
- Current experience of Indonesia?



## Conclusions

- It is such ambitious target to integrate all Jamkesda by 2016, let alone to achieve universal coverage by 2019.
- We cannot ignore the sub-national governments' roles in the process toward achieving UHC.
- We need to make sure that health equity is along the line of three coverage dimensions of UHC (population, health services, and financial protection)





- In the light of achieving universal coverage as well as health equity across region and across income level, we need to do further research on:
  - Possibility of multilevel financing (national and sub-national governments) in the UHC

TERIMA KASIH





Supply-side Indicators	MNCH Services Indicators	Health Outcome Indicators
<ul style="list-style-type: none"><li>• Puskesmas Ratio per 30,000 population in 2013</li><li>• General Practitioner Ratio per 100,000 population in 2013</li><li>• Nurse Ratio per 100,000 population in 2013</li><li>• Midwife Ratio per 100,000 population in 2013</li><li>• Ratio of GPs at the Puskesmas per total Puskesmas in 2013</li><li>• Number of hospitals at province/district in 2013</li></ul>	<ul style="list-style-type: none"><li>• Skilled birth attendants</li><li>• First antenatal care coverage (K1)</li><li>• Complete antenatal care coverage (K4)</li><li>• First post-natal care coverage (KN1)</li><li>• Complete post-natal care coverage (KN3)</li><li>• Complete basic immunization coverage</li><li>• Fe (iron) coverage</li><li>• Vitamin A coverage</li><li>• Infant care services</li></ul>	<ul style="list-style-type: none"><li>• Infant mortality rate per 1,000 live births</li><li>• Low birth weight</li><li>• Malnutrition in children under 5</li></ul>

Sources: Health Profile at National and Province levels (2013) and District Health Profile (2012), MoH's Bank of Data (2013), MoH's RS Online Data (2014).