Expanding Healthcare Access through the Private Sector

Indonesia's National Health Insurance and Private Hospitals

Health Policy Plus and National Team for the Acceleration of Poverty Reduction, Indonesia

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Background

Indonesia's national health insurance scheme (*Jaminan Kesehatan Nasional*, or JKN) is a key element of the Government of Indonesia's commitment to ensuring equitable access to healthcare, especially for the poor and the near-poor. JKN's contracting with private providers was expected to expand reach faster than solely working through the public sector. The single-payer agency for JKN, *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), contracts private clinics under capitation and pays hospitals through case-based groups. In September 2017, 60 percent of BPJS-K-contracted hospitals were private. How has the single payer and its associated policies affected these private hospitals?

This analysis, conducted by the U.S. Agency for International Development (USAID)-funded Health Policy Plus (HP+) project and the National Team for the Acceleration of Poverty Reduction (TNP2K), asked how private hospital capacity, utilization, and finances have changed since JKN began. We also assessed whether providers perceive reimbursement processes to be fair.

Methods and Data

HP+/TNP2K collected primary data from 73 private hospitals in 11 provinces. The final sample included 61 BPJS-K and 12 non-BPJS-K-contracted facilities. Survey instruments collected quantitative and qualitative data from 2013 (before JKN initiation) and 2016 (after JKN initiation). At each facility, surveyors interviewed the facility administrator, financial officer, and a service provider to capture perspectives of changes in strategic decision making, facility finances, client demand, and service offering. Surveyors also collected operational and financial data from hospital administrative records.

We used descriptive statistics and statistical tests of change between data years to learn whether there had been a shift in the variables of interest. We employed a difference-in-difference model to test whether the change could be associated with BPJS-K contracting status. We treated non-BPJS-K-contracted facilities as a comparison group in comparing 2013 and 2016 data (Box 1).

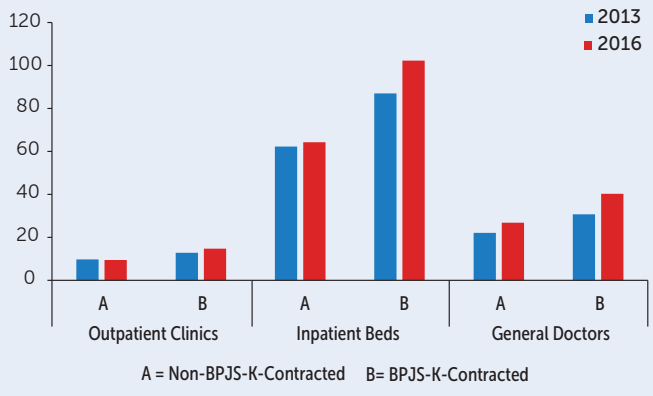
Box 1: Difference-in-Difference Model: Covariates

- Geography (Java, Sumatra, or other)
- Population density by district
- Hospital level (B, C, and D)
- Hospital ownership (nonprofit, faith-based, for-profit individually owned, and for-profit network)
- Clinic/ward diversity (number of different types of clinics/wards)

How Has JKN Implementation Affected Private Hospitals' Capacity, Utilization, and/or Finances?

Private hospital facility capacity increased and offers more services, but contracting with BPJS-K does not significantly affect facility investment decisions. Sampled facilities reported increasing their installed capacity, including number of outpatient clinics, inpatient beds (Figure 1), and diagnostic testing machines. Facilities also hired more staff; the average number of clinical and administrative staff at BPJS-K facilities increased 23% and 15%, respectively, between 2013 and 2016. Meanwhile, the average number of administrative staff decreased by 3% at non-BPJS-K facilities. Despite the observed increasing trends overall, our models did not demonstrate a statistically significant effect of BPJS-K contracting status on these and other capacity measures (Box 2).

Figure 1: Change in Average Number of Outpatient Clinics, Inpatient Beds, and General Doctors



81% of facilities reported increased inpatient and outpatient service utilization since JKN started. Our analyses demonstrate that increased IPD and OPD utilization were affected by ward and clinic diversity and hospital class, rather than BPJS-K contracting status. The average number of tuberculosis services provided annually increased by 84% between 2013 and 2016. The average number of non-communicable disease services

provided annually increased by 72% between 2013 and 2016. Finally, growth was observed in maternal, newborn, and child services and diagnostic testing.

Financial indicators suggest out-of-pocket spending declined significantly in facilities contracting with BPJS-K. However, these facilities appear to become cost-conscious as they depend more on JKN revenue. The proportion of revenue from out-of-pocket spending decreased among BPJS-K-contracted facilities, while it increased in others (Box 2). Drugs as a proportion of total expenditures decreased in BPJS-K-contracted facilities compared to others, significantly. We found BPJS-K-contracted facilities use generic drugs more (58% of total drugs compared to 26% in others) and the e-catalogue for reference pricing more (72% of facilities compared to 33% of others).

Are JKN Reimbursement Processes Perceived to Be Attractive and Fair?

Few private hospitals perceive reimbursement rates to be sufficient to cover direct and indirect costs of all services provided, nor JKN claims simple to process. However, most BPJS-K-contracted hospitals reported that reimbursement rates can cover the direct and indirect costs for some services. New JKN claims processing systems were put in place in 70% of facilities, hiring 5.3 new staff members, on average, to process claims. Though the majority of BPJS-K-contracted facilities reported receiving reimbursements within four weeks of submission, waiting more than one month is not uncommon, given reviews before payment (Figure 2).

Conclusions and Policy Recommendations

This analysis confirms growth in private hospital infrastructure in the JKN era between 2013 and 2016, with a significant decline in out-of-pocket spending at BPJS-K-contracted facilities. However, contracting with BPJS-K does not appear to be significantly connected with investing in capacity. Separately, BPJS-K-contracted facilities are focused on cutting costs and achieving efficiency; however, the claims process remain a problem. For the Government of Indonesia to continue directing the private sector toward investment and greater provision of essential and high-quality services, we recommend the following:

- Increase transparency in the JKN hospital-level tariff-setting process, including the reference to treatment standards, so that hospitals can continue to manage their resources and procedures to control costs as price-takers, while providing acceptable quality
- Improve the e-claims processes to systematize documentation and reduce the administrative burden both for BPJS-K and providers

Box 2: Effect of Contracting with BPJS-K on Select Facility Characteristics

Capacity

- ↑ Total clinics in OPD: 2.2
- ↑ Total beds in IPD: 9.5
- ↑ General doctors: 4.8
- ↑ Specialist doctors: 5.9
- ↑ Inpatient nurses: 13.3
- ↓ Ratio of permanent to contract doctors: -1.35

Utilization

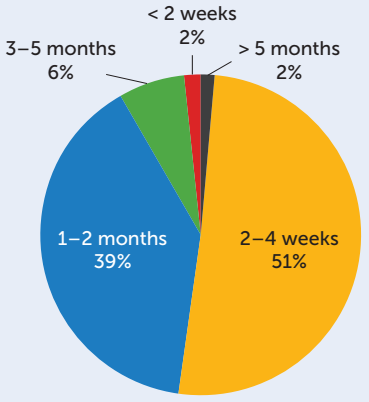
- ↑ OPD patients per day: 76.5
- ↑ IPD annual admissions: 3,944

Finances: Proportion of total revenue

- ↑ Public insurance: 47.5*
- ↓ Private insurance: -9.1
- ↓ Out-of-pocket (OOP): -35.8*

*Results from difference-in-difference models, * $p < 0.05$*

Figure 2: Average Time between Submitting Claim and Reimbursement Received



CONTACT US

Health Policy Plus
1331 Pennsylvania Ave NW,
Suite 600
Washington, DC 20004
www.healthpolicyplus.com
policyinfo@thepalladiumgroup.com

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