Mutu Struktur Pelayanan Kesehatan di Indonesia dengan Program Jamkesmas

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Outlines

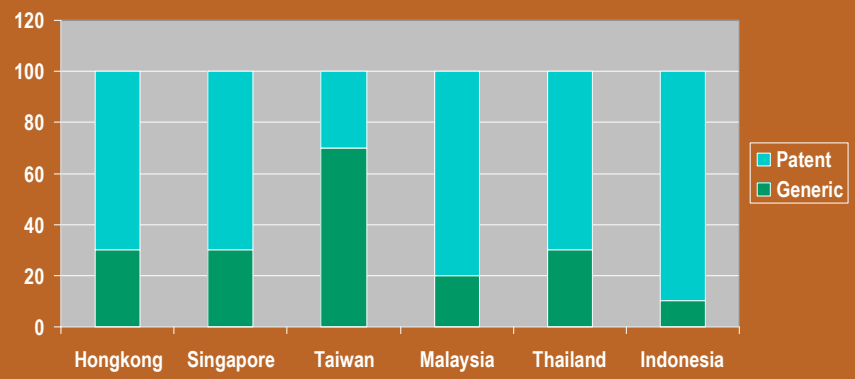
1. Pendahuluan
2. Konsep dan Penilaian Mutu
3. Jamkesmas
4. Provider Payment Method
5. Mutu Pelayanan Jamkesmas
6. Penutup

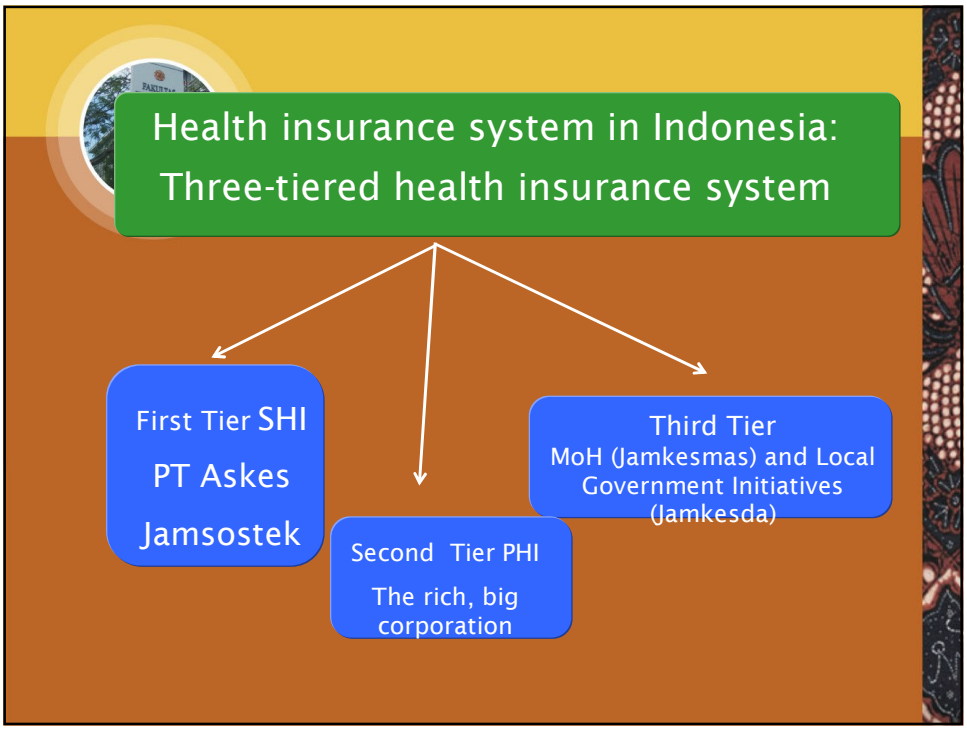
PENDAHULUAN

- Tingkat kesehatan masyarakat Indonesia masih ketinggalan di banding negara tetangga
- HDI < negara Vietnam & Kinerja kesehatan < Filipina (no 60 dan 92).
- Terkait dengan besarnya alokasi untuk kesehatan dan akses ke pelayanan kesehatan → Perubahan pembiayaan

Analysis of the Patent and Generic Split by Country,

Source : EIU, Pricewaterhouse Coopers 1999





Main Characteristics of Health Financing in Indonesia, 2008

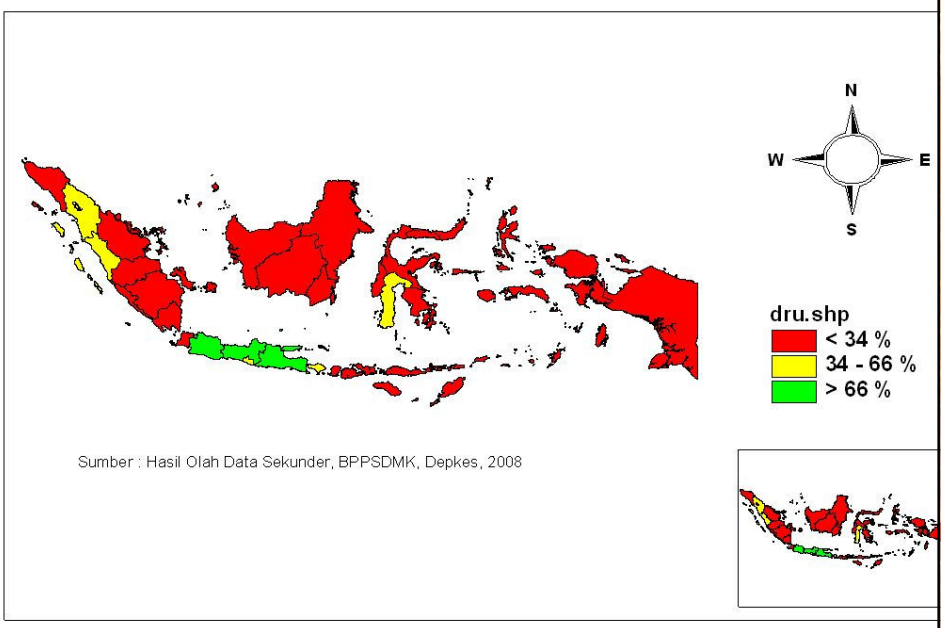
Main Characteristics of Health Financing, 2008				
Scheme	Target Pop	Coverage	Source of fund	Carriers
Civil servant (SHI)	Civil servant	13,5 Mln	employees	PT Askes
	pensioners		Government	
Formal sector (SHI)	formal sector	2,5 +2 Mln	Employer	PT Jamsostek
				PT Askes, PI
Formal sector /MSOE	Employees	1 Mln	Employer	Self-insured
	of big corp			Private Insurance
Jamkesmas	The poor + near	76.4 Mln	Tax (Central	MOH
			Govern.Budget)	
Informal Sector	Not covered by	3 Mln	Community	Local Government
	Jamkesmas		Local Government	

KEADAAN TENAGA KESEHATAN TAHUN 2006 DAN PERKIRAAN *KEBUTUHAN PENAMBAHAN* TENAGA KESEHATAN
TAHUN 2007-2010

No	Jenis Tenaga	Indikator Tenaga /100.000 pddk 2010	Kebutuhan Jumlah Tenaga th. 2010	Jumlah Tenaga s/d Tahun 2006	Rasio Tahun 2006	Pertambahan Nilai Ratio /tahun	Kebutuhan Penambahan Nakes			
							2007	2008	2009	2010
A	MEDIS		*117,969*	*68,227*			*12,664*	*12,047*	*12,358*	*12,674*
1	Dokter Spesialis	9	21,234	12,374	5.53	0.87	2,258	2,145	2,200	2,257
2	Dokter Umum	30	70,782	44,564	19.93	2.52	6,765	6,322	6,483	6,648
3	Dokter Gigi	11	25,953	11,289	5.05	1.49	3,640	3,580	3,674	3,770
B	KEPERAWATAN		*587,487*	*395,688*			*59,583*	*53,919*	*38,542*	*48,369*
4	Perawat	158	372,783	308,306	137.87	5.03	18,731	14,903	15,247	15,597
5	Bidan	75	176,954	79,152	35.40	9.90	33,677	31,762	15,848	25,128
6	Perawat Gigi	16	37,750	8,230	3.68	3.08	7,176	7,254	7,447	7,644
C	FARMASI		*63,703*	*49,313*			*3,975*	*3,389*	*3,471*	*3,555*
7	Apoteker	9	21,234	10,207	4.56	1.11	2,756	2,687	2,757	2,828
8	Asisten Apoteker	18	42,469	39,106	17.49	0.13	1,219	703	714	726
D	KES. MASYARAKAT		*42,469*	*27,833*			*3,808*	*3,519*	*3,609*	*3,700*
9	SKM	8	18,875	9,739	4.36	0.91	2,297	2,222	2,279	2,338
10	Sanitarian	10	23,594	18,094	8.09	0.48	1,511	1,298	1,329	1,361
E. 11	Gizi	18	42,469	15,342	6.86	2.78	6,676	6,641	6,816	6,995
F.12	Keterapian Fisik	4	9,438	5,290	2.37	0.41	1,052	1,006	1,032	1,058
F.13	Keteknisan Medis	6	14,156	10,318	4.61	0.35	1,030	913	936	959

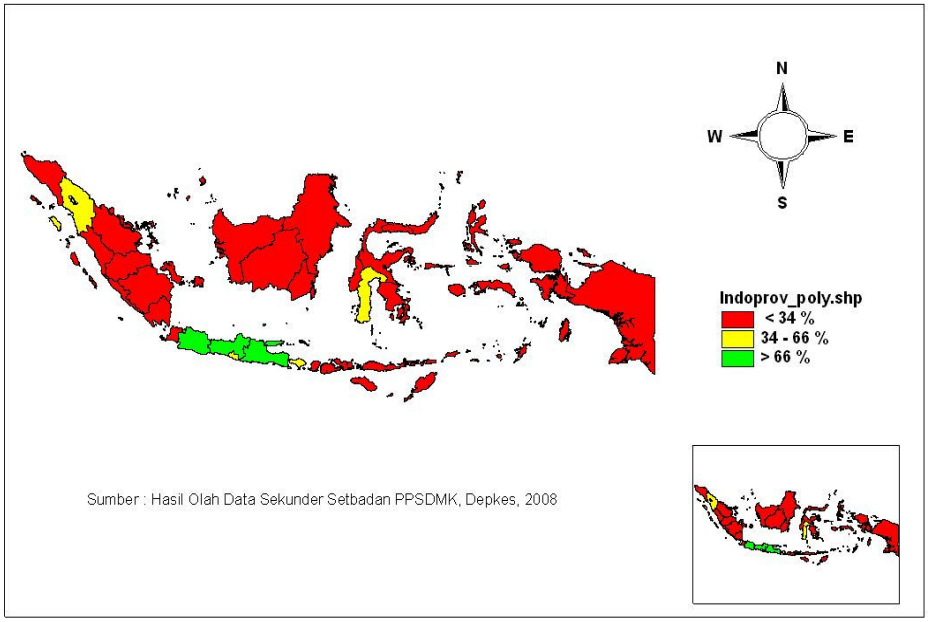
Catatan: Ratio/100000 penduduk

DISTRIBUSI DOKTER UMUM MENURUT PROPINSI DI INDONESIA TAHUN 20



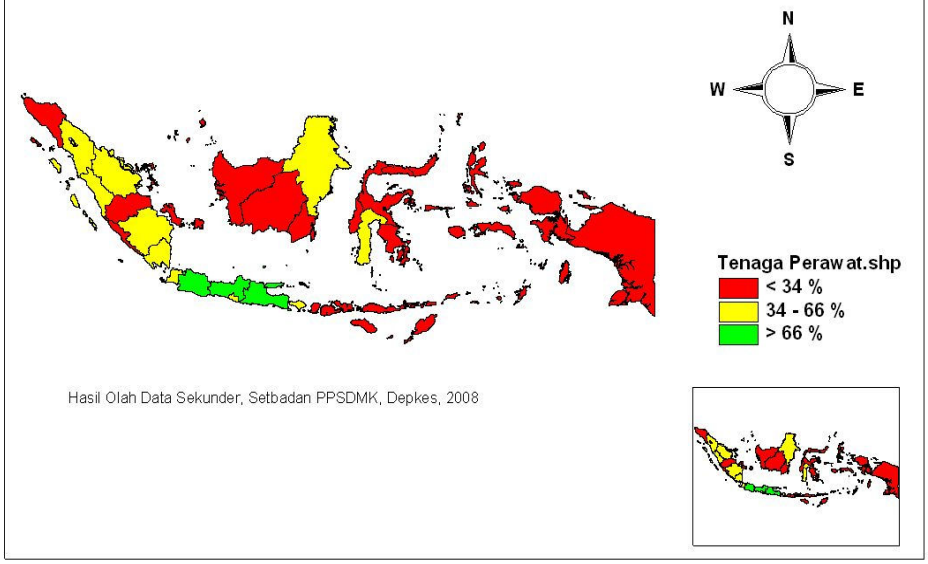
Sumber : Hasil Olah Data Sekunder, BPPSDMK, Depkes, 2008

DISTRIBUSI DOKTER SPESIALIS BERDASARKAN PERSENTASE MENURUT PROPINSI DI INDONESIA TAHUN 2007



Sumber : Hasil Olah Data Sekunder Setbadan PPSDMK, Depkes, 2008

DISTRIBUSI TENAGA PERAWAT MENURUT PROPINSI DI INDONESIA TAHUN 2007



Hasil Olah Data Sekunder, Setbadan PPSDMK, Depkes, 2008

KONSEP DAN PENILAIAN MUTU

What is quality ?

- Quality is multi-faceted and multi-dimensional
- Donabedian
  - Individualist (patient's expectations)
  - absolutist (valued by practitioner)
  - Socialist (valued by the pop. in general)

What is quality

- Customer's perspectives
- Providers' perspectives
- Payor's perspectives
- Donabedian's model of quality evaluation:
  - Structure (institutional aspects of a health care facility)
  - Process (steps undertaken to perform procedures)
  - Outcome (results of procedures undertaken)

Characteristics of quality of care

- Doing the right thing
  - Efficacy
  - Appropriateness
- Doing the right thing right
  - availability
  - timeliness
  - effectiveness
  - continuity
  - safety
  - efficiency
  - respect and caring

Characteristics of quality of care

- Effectiveness
  - Ratio of improvements in health expected from care to be assessed to the improvements in health expected from the best care
- Efficiency
  - Achieveing the best outcome with the least resources
- Acceptability
  - Meeting the needs, expectations, views and preferences of the recepients
- Legitimacy
  - Conformity to social preferences expressed in ethical principles, values, norm, laws and regulations

Definitions of quality

- The extent to which actual care is in conformity with present criteria for good care (Donabedian, '80)
- The degree to which health services increased desired outcomes and consistent with current professional knowledge.
- Meeting and exceeding (all) customer needs and expectations

QUALITY ACTIVITIES

- RISK MANAGEMENT
  - A program for preventing problems and improving system based on past problems
- UTILIZATION REVIEW
  - Activitiy to evaluate and monitor the allocation of resources
- PEER REVIEW
  - A Review of care undertaken by a group of one's peers
- INDICATOR
  - Performance indicator (monitor and evaluate performance)
  - Clinical indicator (measure of the clinical outcome of care)

QUALITY ACTIVITIES

- Practice guidelines
  - Derived from the objective evidence that the treatment of a given condition varies widely
- Medical audit
  - A systematic approach to peer review of medical care in order to indentify opportunities for improvement
- **Clinical pathways**
  - care maps as reflection of pattern or trends of care for the "usual" patient
- **Algorithms**
  - Used to assist in decision making where variation occurs from a clinical pathway

Quality activities

- BENCHMARKING
  - Observation and comparison with another similar health care facilities to determine what is achievable and how best to achieve it.
- Internal Benchmarking
- Competitive Benchmarking

Tools for Measuring Quality

- Donabedian: (5 steps in measuring quality)
  - Collect information about the process of care
  - Analyse this information to deterimine trends of performance
  - describe and explain these trends
  - Correct any deficiencies that were identified
  - Continue to monitor performance

Tools for Measuring Quality of care

- Quality Cycle
  - Monitoring
  - Assessment
  - Action
  - Evaluation
  - Feedback
  - Documentation

Tools and Measuring Quality of Care

- Brainstorming
- Seven Step Method
- Flow Charts
- Checsheets
- Pareto Charts
- Histogram

Tools for Measuring quality of care

- Run chart
- Control chart
- Scatter diagram
- Cause and Effect Diagram (fishbone diagram)

Program Jamkesmas 2008

- Merupakan kebijakan strategis untuk mewujudkan keadilan dan kesejahteraan rakyat
- Merupakan terobosan yang sangat tepat guna meningkatkan aksesibilitas masyarakat miskin terhadap pelayanan kesehatan
- Merupakan upaya untuk mempercepat pencapaian sasaran pembangunan kesehatan dan peningkatan derajat kesehatan
- Merupakan dasar pengembangan jaminan kesehatan nasional

Dasar Penyelenggaraan

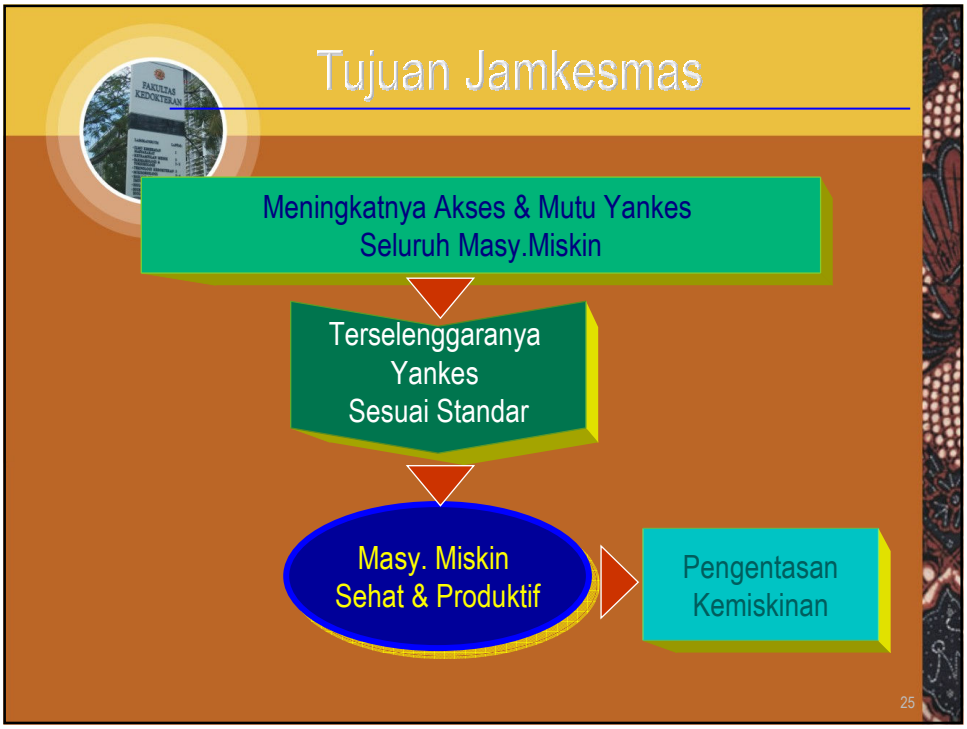
UUD 1945

UU 23/92 | UU 01/04 | UU 17/03 | UU 45/07 | UU 40/04

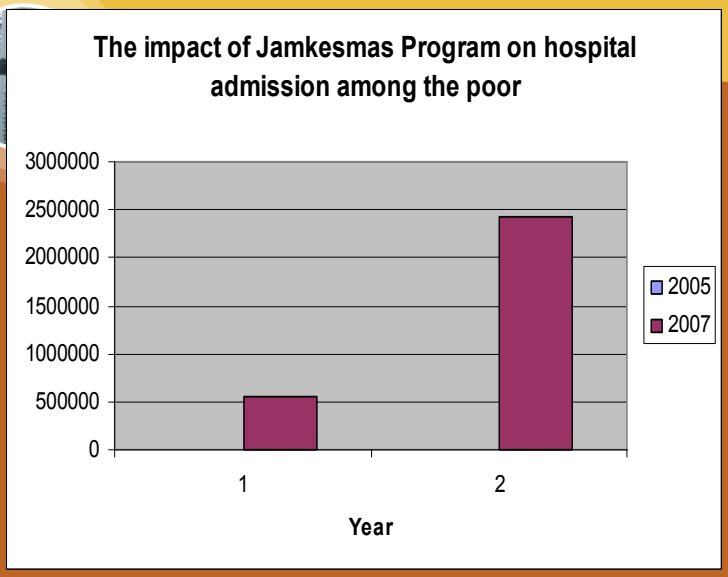
Kesehatan Adalah Hak Fundamental Setiap Penduduk

Setiap Orang Berhak Hidup Sejahtera Lahir Dan Bathin, Bertempat Tinggal Dan Mendapatkan Lingkungan Yang Baik Dan Sehat Serta Berhak Memperoleh Pelayanan Kesehatan

Pelayanan Kesehatan Bagi Masyarakat Miskin


Tujuan Jamkesmas
Meningkatnya Akses & Mutu Yankes
Seluruh Masy.Miskin
Terselenggaranya
Yankes
Sesuai Standar
Masy. Miskin
Sehat & Produktif
Pengentasan
Kemiskinan
25


Beberapa Prinsip Penyelenggaraan
Nasional
Gotong Royong & Subsidi Silang
Portabilitas
Yankes Lintas Batas Wilayah
Ekuitas
Kesetaraan Mendapatkan Yankes
Nirlaba
Dana Semata-Mata Untuk Yankes



Struktur

- Fasilitas yang relatif terbatas BOR >>
- Pendidikan dokter yang merupakan Input Pelayanan Kesehatan Masih Menghadapi Kendala
- Kuantitas, kualitas dan distribusi tenaga kesehatan khususnya dokter masih bermasalah

Case Study:

A Universal Tax-paid Healthcare System the Danish Healthcare System Compared to Kaiser Permanente, US by A Frølich, M Schiøtz, M Strandberg-Larsen, A Krasnik, J Hsu, J Bellows, F Diderichsen, J Søgaard, K White

Comparability between KP and DHS

- Responsibility
  - Complete care from birth to death
  - Comprehensiveness of services
- Population size
- Similar challenges
  - A high prevalence of people with chronic conditions in KP and in the DHS

Both KP and DHS has focus on Chronic Care

- Motivation:
  - Increasing prevalence of chronic conditions in DHS
  - Substantial interest in improving chronic care in DHS
- Models:
  - KP is recognized for integration of care
  - Chronic care model
- Benchmarks:
  - Kaiser as a benchmark for the Danish healthcare System

Basic Comparisons between
DHS and KP (Preliminary Data)

1. Structure / Workforce
2. Hospitalizations
3. Performance - Chronic Care
4. Costs

Organization of healthcare in KP and in DHS

Secondary care sectors comparable – physicians employed by hospitals

Primary care sectors are very different

- Single handed practices comprise about 38% of practices in Denmark
- Medical centers in KP has 20-40 physicians per practice

Workforces in KP and the DHS

• Input	KP	DHS
Physicians per 100 000 subjects:	134	311
Health professionals per 100 000 subjects:	1,125	2,025

Utilization pattern in KP and the DHS
Mean length of stay in KP and in the DHS

Diagnoses	KP Days (mean)	DHS Days (mean)
Stroke	4.3	23.0
Coronary bypass	3.8	5.1
AMI	4.4	7.2
Angina pectoris	2.2	4.5
Hip replacement	4.5	9.5
Hip fracture	4.9	12.1
Kidney or urinary bladder infection	3.8	5.0

Chronic care –performance in KP and the DHS

Diabetes care	KP	DHS
Patients with diabetes who received annual retinal examination	70% < 65 years 80% for > 65 years	46%
Patients with acute myocardial infarction who received beta blockers	93%	70%

Remarkable differences between the DHS and benchmark system (KP)

- Substantially different organization and workforce size
- Higher hospitalization levels in DHS than in KP
- Lower performance on chronic care delivery in DHS than in KP
- Comparable overall health care expenditures in DHS and in KP

MANAGED CARE

Alternatif Pengelolaan Mutu Struktur Pelayanan Kesehatan Di Indonesia Yang Efektif Dan Efisien Dengan Program Jamkesmas

WHAT IS MANAGED CARE?

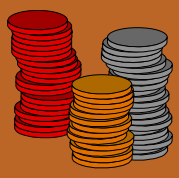
A system that integrates financing & delivery of appropriate medical care through the following:

- Prospective pricing or limits on payment
- Bundling of services
- Utilization management
- Benefit Design
- Patient channeling
- Quality criteria
- Health promotion

Prospective Pricing or Limits On Payment

Hospital Pricing

- Usual & Customary
- Negotiated Discounts
- Per-diems
- DRGs
- Capitation



MDC.14
Pregnancy disorder, delivery and post-partum

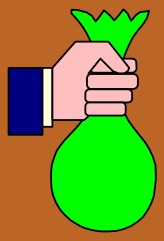
No	ICD-10-CM	
1	**O00-O08**	**Pregnancy with abortive outcome**
2	O10-O16	Oedema, proteinuria and hypertensive disorders……
3	O20-O29	Other maternal disorders……
4	O30-O48	Maternal care……
5	O60-O75	Complication of labor and delivery
6	O80-O84	Delivery
7	O85-O92	Complications predominantly…….
8	O95-O99	Other obstetric conditions …….

Australian Refined Diagnosis Related Group Classification, Version 4.1 (Indonesia→ INA-DRG)

DRG	ALOS	COST / Private Sector		
		Direct	Overhead	Total
O01A	9,01	5,292	2,154	7,445
O01B	6,29	3,984	1,591	5,574
O01C	5,10	3,834	1,456	5,289
O01D	4,61	3,243	1,264	4,507

Physician Pricing

- Billed Charges
- Negotiated discounts
- Fee schedule
- Capitation
- Salary



Different Models of Capitation (C. Hsiao, 2003)

Responsible:

Model 1
- GPs — -All primary care services & drugs
- Specialists — - All specialty services
- Hospitals — - All inpatient care

Capitation

Model 2
- GP Fundholder
- Hospitals

Contract specialist — - All primary care services & specialty care

Model 3
- GP Fundholder

Contract specialists & inpatient care — - All inpatient care — - All PC, spec., & inpatient care

Model 4
- Multispecialty Clinic
- Hospitals

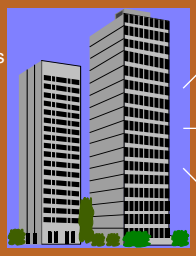
- All primary care & specialty services
- All inpatient care

Model 5
- Multispecialty Clinic

Contract inpatient — -All PC, spec. & inpatient care

Premiums

Insured



MCO

Source: Hsiao 1997

PPMs: Policy Goal Trade-offs (C. Hsiao, 2003)

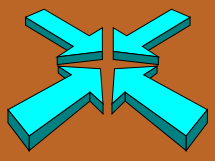
Greater Efficiency	Greater Patient Risk Selection	Higher Quality	Better Cost Containment
Total capitation	Total capitation	Case	Global Budget
Case payment	Case, global budget	FFS	Capitation Salary
Salary, per diem Global budget FFS	Per diem	Per diem	Case per diem FFS
	FFS, Salary	Capitation Global budget	
Less Efficiency	Less Patient Risk Selection	Lower Quality	Poorer Cost Containment

Bundling of Services

- Grouping of related items into bundles, that is sold as complete package instead of individual services
- Ex: Prospective price may be negotiated for hospital inpatient day that includes:
  - Room and board costs
  - X-Ray services
  - Pharmaceuticals
  - Other ancillary services

Utilization Management

- Prospective Review
  - Pre admission certification
  - Second surgical opinions
  - Medical/treatment protocols
- Concurrent Review
  - Continued stay review
  - Discharge Planning
  - Case Management



- Retrospective Review
  - Analysis of MD Practice Patterns
  - Variation Analysis
  - Development of Treatment Protocols
  - Asses Outcomes
- Peer Review
  - Utilization & Quality

Benefit Design

- Comprehensive set of Benefits
- Benefit Package designed to make beneficiaries more sensitive to the price of medical services that cost less
- Ex: The benefit Package may require a greater level of co-payment for inpatient services rendered on an outpatient basis

Patient Channeling

- Health plan develops contract with selected group of providers in order to deliver patient volume and better manage the cost and quality of care
- Providers trade discounts for patient volume
- Patient channeling is achieved by establishing lower co-payments for enrollees that utilize contracted providers

Quality Criteria

- STRUCTURAL CRITERIA
  - Physician credentialing
  - Hospital JCAH Accreditation
  - Appearance of facilities
- PROCESS CRITERIA
  - Are the standards of medical practice acceptable?

- OUTCOME CRITERIA
  - Recovery time
  - Frequency/Severity of complications
  - Patients satisfaction

Efisiensi dan kualitas Tinggi

Kualitas	Rendah	Tinggi
Rendah	1	2
Tinggi	3	4

Efisiensi

PENUTUP

- Dalam Konteks Jamkesmas maka Mutu Struktur Pelayanan Kesehatan belum optimal
- Hal ini diperberat dengan belum siapnya sistem pembayaran ke prodiver yang menggunakan prospective provider payment system (INA-DRG)
- Mutu pelayanan menjadi dipertanyakan
- Seharusnya Jamkesmas menggunakan pendekatan managed care, dengan pendekatan ini diharapkan mutu pelayanan kesehatan menjadi lebih baik dan efisien tetapi ini tidak akan berhasil tanpa perbaikan struktur/input pendidikan kedokteran di Indonesia