

## **Evidence-Based Planning in Improving the Health Service and Insurance Utilization in Addressing Child Survival**

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### **Background & Literature review**

Millennium Development Goal acceleration has called for innovations in health. One of the innovations is the Evidence-Based Planning (EBP) for maternal, neonatal and child health (MNCH).

The Evidence-Based planning and budgeting approach is a rational approach, and put forward the scale-up of interventions that have been proven to be effective in reducing women and children deaths globally. The evidence-based interventions package for MNCH was published based on systematic review of over than 190 health interventions (Kerber, 2007) and is part of the Lancet series in maternal and child survival.

In 2010, The AusAID Knowledge Hub introduced the EBP initiative in several Asian countries, including Indonesia. The EBP was designed to improve sub-national MNCH planning and to be used at the district level, by the district health office and district hospital, as well as other health-relevant offices/departments.

In terms of social protection and health insurance, the regulation No. 24/2011 on BPJS (Social Security Managing Organization) and the President decree No. 12/2011 on Health Insurance have instructed that health care providers, including hospitals, have to provide comprehensive health services for poor and near-poor population. However, there is no regulation that specifies any health protection for children living in poverty. Furthermore, health protection should be in line with sound health planning. Hence, It is important to assess the current constraints in health service utilization and the relation with health insurance utilization, particularly for important child health intervention.

### **Research Objectives**

To identify bottlenecks in health system that hinders the scaling up of important health intervention, particular for vulnerable population including poor families. To identify health system environment that would support the utilization of health insurance scheme for important interventions in child health survival.

### **Methodology**

Case study approach was used to analyze two Indonesian districts that have used EBP; Tasikmalaya and Jayawijaya districts. Tasikmalaya is a highly populated urban area with equal distribution. On the other hand, Jayawijaya district is located at highland with geographical barriers and sparsely scattered population. The chosen

evidence-based intervention is the Comprehensive Emergency Obstetric and Neonatal Care (CEONC), an important intervention to reduce neonatal mortality. The analyses use *bottleneck analysis* framework, which is part of the EBP. *Bottleneck analysis* identifies health system problems from both the supply and demand side (Tanahashi, 1978). This study also assesses the utilization of Jamkesmas health insurance in both districts. Data collection period was between 2011-2012.

### **Findings & Analysis**

CEONC utilization in Tasikmalaya was only 50%, despite high availability of human resources and infrastructure for CEONC (100% and 80%, respectively). Tasikmalaya CEONC hospital is accessible for most of the population (98%). The bottleneck analysis shows that the problem lies in the actual utilization by the target population. Some of the identified reasons are; (1) lack of knowledge among the community and the delays by health workers during emergency situation and (2) inadequate referral system.

Jayawijaya district has problems on both *supply* and *demand sides* for the CEONC intervention. Limited human resources and infrastructure has caused low utilization of CEONC services, of which only 17% women with delivery complications attended the CEONC facility. Jayawijaya district has one CEONC hospital, which does not operate 24/7 due to limited human resource (33% of the minimum requirement), and only covers approximately 33% of the population. People had difficulties in reaching CEONC facility, due to geographical constraint and high transportation cost.

From 2012 data, Jamkesmas health insurance utilization at the hospital level for Tasikmalaya district was 21.3 billion rupiah, while it was only 1.1 billion in Jayawijaya. It was evident that Jamkesmas utilization in Tasikmalaya, an urban area, is much higher than the rural Jayawijaya district. Supply side bottlenecks and barrier to access were found to be important factors in determining the utilization of Jamkesmas.

### **Conclusion and Policy implications**

Financial support for poor population such as Jamkesmas, would be useful only in areas with good *supply side* for CEONC. On the other hand, merely providing a generic insurance coverage will not improve CEONC utilization in Jayawijaya, due to the *supply side* constraints and high transportation cost.

The analyses have pointed out a stark difference in health system problems between Tasikmalaya and Jayawijaya district. However, even in a well-supplied district such as Tasikmalaya, the utilization is relatively low. Target population does not necessarily have the knowledge on when and where to get CEONC services, and delays among health care providers have also been documented.

One of the main causes in low utilization in Jayawijaya is the expensive transportation cost, and this cost is much higher compared to Tasikmalaya district. However, Jamkesmas does not currently cover for transportation cost necessary to reach health facility. Hence, transportation cost financing mechanism should be a

priority focus in allocating funds, particularly for the disadvantaged and poor population.

### **Policy Recommendations**

Health insurance, particularly for the poor, should be able to protect and ensure accessibility to the necessary health services. Health insurance scheme should also serve as a control mechanism for sound treatment pathway. For example, in developed countries, patients with health insurance coverage will have to firstly be fully examined at the primary health care. Depending on clinical indication, patient could then be referred to higher-level facility.

However, Indonesia's referral pathway for health insurance is often only a formality, where patients were not carefully examined in the primary setting and referred directly to the district hospital. This would lead to over-referral and burdening the district hospital. On the other hand, patients often could not reach the referral hospital in time, because of the delays in deciding the referral, by both the family and the primary health care providers.

Therefore, health insurance should be well designed and regulations be enforced to obtain more rational and timely health care services. In addition, health insurance scheme should also cover for transportation costs, particularly in geographically constrained areas. Cross cutting collaborations should also be improved in improving access to hospitals and health insurance utilization, particularly for poor and remote area population.

### References:

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