Policy Analysis on Cardiovascular Disease
Based on DASK (Dashboard Sistem Kesehatan)

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General JKN Policy problems

- Deficit of JKN fund
- The current problem on social justice
- The current Cardiovascular program

Cardiology context

- Distribution of health facility and Cardiologist
- Utilization of JKN Participant for cardiovascular group (CVD) at hospital services
- Portability of JKN participant for CVD

Recommended Policy

- Overcome injustice in BPJS
- Specific prevention policy
- Develop Task Shifting Doctors
The Problem of the Increasing Total BPJS Deficit

Recently emerging policies that have become a controversy event among clinical doctors, hospital, and BPJS Kesehatan.

Overdue claim payment

Hospital claim that is often delayed by BPJS Kesehatan without a clear time frame of payment.

Some hospitals feel uncertain on drugs and services the can be covered for JKN member.
One of the major problems in JKN caused by the effect deficit:

Social Inequity
Cardiovascular disease becomes the number one cause of death in Indonesia.

Source of data: IHME, US

The high prevalence becomes a homework for all stakeholders.
• The prevalence varies from 2.2 in North Kalimantan until 0.7 in NTT

Do NTT, Papua and Jambi provinces have low prevalence because they are influenced by the health system context in their province?
Problems found with DASK

1. Distribution of Health Facility and Cardiologist Human Resources
2. The utilization in BPJS Cardiology service
3. Portability of Cardiovascular Disease
What is DASK?

A Dashboard containing several data from a variety of open sources to facilitate:

1. Researchers in different faculty and research centre to conduct policy research;
2. Policy analyst in conducting activity for providing recommendation for decision maker.
3. Data analysed are several public data such as data from the Ministry of Health, RISKESDAS, and BPJS Big data, and from other sources.

Aside from that the DASK system sought to conduct.
- Training development and group discussion to analyse and advocate for policy
- Other Activities are centred in both national and local level.

http://kebijakankesehatanindonesia.net/datakesehatan/file/Data%20Utilisasi%20BPJS.html
Data from DASK (1)

The distribution of health facility (hospital) and Cardiologist
The distribution of type A and B hospital in Indonesia in 2018

Provinces in Region 5 (Papua, West Papua, NTT, Maluku, and North Maluku) have yet to have type A and limited type B Hospital

Type A and B Hospital is still centered in Java and developed provinces
The distribution of Cardiologist greatly varied

Cardiologist is still centered in Java Island and developed areas.

West Papua, Papua, Bengkulu and regions with low fiscal capacity still have a low number of SPJP.
Problem 2:
Utilization of JKN participants regarding Cardiovascular Service

Source of Data:
Big Data BPJS
Health System Data (DASK)
The trend of the proportion of total claim in several types of hospital service based on CMG.

The higher the type of hospital the higher proportion of CVD group.

BPJS data, 2015-2016.
Utilization of Cardiovascular disease data based on province

The proportion of JKN members visit to access cardio service in type A, B and specialist indicate miniscule number for PBI JKN member.

Papua region, Bengkulu and west Kalimantan are areas with the lowest ratio of visit for CCVD

The availability of Cardiologist and high type hospital influenced the utilization ratio of cardiovascular services

BPJS data, 2015-2016
The Average Cost

Area with concentrated SPJP, type A, B, and cardio specialist hospital is high in North Sulawesi, DKI Jakarta, South Sumatera, Yogyakarta, and North Sumatera on average have higher claim compared to other provinces.

Areas without type A hospital, limited number of type B and cardio specialist such as Papua and West Papua have the lowest claim nationwide

The availability of SPJP and Health Facility in essence influenced the claim value of SPJP disease visit
Problem 3. Portability

Non PBI group dominates in the usage of portability scheme

PBI group that can access cardio services only comes from the provinces of Java and small number from other region

Source of Data: Big Data BPJS, 2015-16 Health System Data (DASK)
Conclusion from the DASK

- The low prevalence of cardiovascular disease is thought to be influenced by the low number of facility (Type A and B Hospital) and the number of cardiologist (SPJP)
- The low prevalence of cardiovascular disease simply put is related with the difficulty of members accessing the health faculty (i.e. Papua and NTT).
- PBI participants visitation in advanced health facilities (type A, type B and Cardiovascular Hospital) is frequently low due to the inability in accessing the health care.
- Social Injustice is present in the cardiovascular service system in Indonesia (the Javanese and other developed provinces participants have higher chance in accessing care for CVD group)
What happened if there is no change in policy?

• Cardiovascular disease becomes life threatening and burden for individual and the country
• There will be a decline of social justice for the people of Indonesia in cardio care
• Education and training for cardiovascular health worker is advancing but leaving behind people in difficult areas
Recommended Policy
(based on the data in DASK and several other researchs)
1. There is a need for compartment scheme for mandated funds (dana amanat)

- Each compartment of money will not get mixed up;
- BPJS will always have funds from PBI APBN bag;
- Policy or program to overcome deficit must be based on segments
- Local government must be involved to bear the deficit

Compensation Policy (the distribution of specialist workers to limited region) from BPJS Kesehatan can be implemented.
2. The improvement of Promotion and Prevention Effort by Local Government and the Community

To reduce the significant cardiovascular disease load there should be sufficient effort for effective promotion and prevention program.

– Change the perspective about health system
– Cardiologist can collaborate with local government for reducing the burden of cardiovascular disease in their area.
The experience of specific preventive program: Universitas Gadjah Mada and RS Sardjito

- Worked with the DIY local government to screen 1,000 children with parents who have abnormalities in heart valve conditions.
- It is important to do a preventive program to be able to save the child.
- When the child become older and want to get married, we ask them to consult with us.
3. Developing Cardiovascular Health Human Resources and Task Shifting Doctors

- Cardiovascular should be improved and distributed more evenly based on the standard.
- Production program for Specialist especially for cardiologist should be improved. Programs for specialist doctors PPDS must improve its production
- There is a task shifting program for the limited area for handling cardiovascular disease.
Task shifting

Is a term given for a process where certain duties are shifted, if needed, to health worker with shorter training time and less qualified.

There is a need for task shifting for general practitioner/internist in some capacity from cardiovascular specialist with the requirements such as:
- Implemented in areas with SpJP scarcity (such competences are not valid in other areas)
- Only temporary until there is the availability of SpJP in those areas.
- Should be recommended by PERKI (the association for Indonesian cardiovascular specialist)
THANK YOU