INDONESIA STUDY VISIT TO THAILAND

October 12-14, 2016

Indonesian partners visited HITAP to discuss the developments on HTA and future work. They also attended a workshop on peritoneal dialysis implementation in Thailand.

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Reported by Health Intervention and Technology Assessment Program

Disclaimer Page

This report is written as documentation for the Health Intervention and Technology Assessment Program (HITAP) and HITAP International Unit's (HIU) activities. The information may not be fully representative of all the discussions during the meetings. HITAP and HIU's activities are funded by the grant to the International Decision Support Initiative under the Bill and Melinda Gates Foundation (BMGF), the Rockefeller Foundation (RF), and the Department for International Development (DfID, UK). HITAP operations are supported by the grant through the Thailand Research Fund (TRF).

The findings, results, and conclusions do not necessarily reflect the views of the funding agencies.

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List of Acronyms

Badan POM	Indonesian National Agency of Food and Drug Control
BPJS	Badan Penyelenggara Jamina Sosial (Agency for the Organization of Social Insurance)
CAPD	Continuous Ambulatory Peritoneal Dialysis
CSI	Customer Satisfaction Index
ESRD	End-stage renal disease
GEAR	Guide to Health Economics Analysis and Research Online Resource
HePTA/HTA	Health Technology Assessment Program in the Mahidol University
HITAP	Health Intervention and Technology Assessment Program, Thailand
HTA	Health Technology Assessment
InaHTAC	Indonesia Health Technology Assessment Committee
IDR	Indonesian Rupiah
iDSI	International Decision Support Initiative
JICA	Japan International Cooperation Agency
JKN	Jaminan Kesehatan Nasional, universal healthcare program
MoH	Ministry of Health, Indonesia
MoPH	Ministry of Public Health, Thailand
MoU	Memorandum of Understanding
NHSO	National Health Security Agency, Thailand
PAH	Pulmonary Arterial Hypertension
PEN	Package of Non-Communicable Disease Interventions
PPJK	Pusat Pembiayaan dan Jaminan Kesehatan Centre for Healthcare Financing, Indonesia
NLEM	National List of Essential Medicines, Thailand
PD	Peritoneal Dialysis
PICs	Persons in Charge
PSI	Provider Satisfaction Index
THB	Thai baht
TNP2K	National Program for Poverty Alleviation, Indonesia
UHC	Universal Health Coverage
UCBP	Universal Coverage Benefits Package, Thailand
WHO	World Health Organization

Executive summary

The Indonesian HTA Committee (InaHTAC) was formally renewed and continues its work as a facilitator of national HTA studies as of 2016. Under their oversight and technical support provided by iDSI, three HTA economic evaluation studies were completed from 2014-2016: the economic evaluation of sildenafil as a first line treatment for pulmonary arterial hypertension (PAH); the economic evaluation of the package of essential non-communicable disease interventions (PEN); and, the economic evaluation of the renal replacement therapy options for Indonesia.

In order to facilitate future activities, HITAP invited representatives from the Centre for Healthcare Financing (Pusat Pembiyaan Jaminan Kesehatan or PPJK), the Social Security Healthcare Administrator or Agency for the Organization of Social Insurance (Badan Penyelanggara Jaminan Sosial or BPJS Kesehatan), as well as members of various Directorates within the Ministry of Health, Indonesia. Many of these representatives are also part of the InaHTAC, which is HITAP's main partner. The visitors discussed developments in the country as well as upcoming projects and activities with HITAP.

As part of HITAP's goal to facilitate the implementation of the HTA studies, HITAP also introduced the partners to a workshop in Thailand that discusses the implementation of peritoneal dialysis in Thailand. They attended a one-day forum and went on field visits to understand the mechanics of the program. This will help with their consideration of the renal replacement therapy options in Indonesia and the next steps should they decide to scale up peritoneal dialysis provision from pilot testing to the national level.

Introduction

At the beginning of 2014, Indonesia launched its universal healthcare program, the Jaminan Kesehatan Nasional (JKN), which will cover all Indonesians by 2019. By the end of the year, the Badan Penyelenggara Jamina Sosial (BPJS Health), became the administrator of the largest health insurance scheme in the world with over 133 million people enrolled[1]. In terms of financing, the JKN is a tiered premium-based system supplemented by government subsidies fully covering the poorest. The costs of the program are estimated to be around USD 13-16 billion per year until the JKN is fully rolled out[2]. The ambitious nature of the program, challenges for implementation and high costs associated with bringing healthcare to all brought priority setting to the fore and a Presidential Regulation in 2013 that called for the use of health technology assessment (HTA) in deciding the benefits covered by the scheme[3].

The Health Technology Assessment Committee (InaHTAC) was set up in the Ministry of Health (MoH) to serve as the secretariat for HTA activities. It has received support from various international partners including the International Decision Support Initiative (iDSI) through which the Health Intervention and Technology Assessment Program (HITAP) has been providing technical assistance. To date, three HTA studies have been completed as part of this collaboration, one on the treatment of End Stage Renal Disease (ESRD), another on the use of sildenafil as treatment of Pulmonary Arterial Hypertension (PAH) and the third, an economic evaluation of the Package for Non-Communicable Disease Interventions (PEN) in Indonesia.

This visit is part of HITAP's ongoing efforts to assist the development of HTA in the country through support for the ESRD study as well as discussing the next steps for HITAP's assistance to establish HTA in the country.

Objectives:

1. To support the implementation of the policy recommendations from the study on renal replacement therapy in Indonesia.
2. To develop a regional network related to universal access on renal dialysis for Indonesian team
3. To support the development of HTA in Indonesia and plan next steps.
4. To explore opportunities and avenues to introduce HTA and collaborate with local and international partners on future activities.

[1] "Indonesia Economic Quarterly In times of global volatility", The World Bank Group, October 2015. Available at: http://www.worldbank.org/en/news/feature/2015/10/22/indonesia-economic-quarterly-october-2015
[2] "Indonesia's universal health care goals", Oxford Business Group, 2015, Available at: http://www.oxfordbusinessgroup.com/overview/indonesias-universal-health-care-goals
[3] "Regulation Of President Of The Republic Of Indonesia No. 12 Year 2013 Concerning Health Care Benefits", Translation – Presidential Regulation No. 12/2013 Social Protection Team, The World Bank, Jakarta Office. Available at: www.social-protection.org

Main Meetings

Study Visit to HITAP

The meeting discussed the developments regarding the Indonesia Health Technology Assessment Committee (InaHTAC) as well as the system in the Badan Penyelanggara Jaminan Social or Social Security Healthcare Administrator (BPJS Kesehatan). HITAP staff also provided them with a background on the Thai National List of Essential Medicines (NLEM) and Universal Coverage Benefits Package (UCBP) schemes and processes under the National Health Security Office (NHSO).

The roadmap and plan are still in Bahasa and draft form. It is being discussed with another unit of the MOH (Directorate of Referral) for approval. They have also discussed it with the BPJS Kesehatan's Director of Research Development. HITAP affirmed its support to the roadmap development and creating an Indonesia-specific one.

The InaHTAC have new members (currently, there are 9 members) and will be in tenure until 2019. Each of them will stay in term for 3 years. The head is still Prof. Sudigdo Sastroasmoro; however, there are now two new members (Prof. Budi Hidayat and Ari Fahrial Syam) to replace Prof. Edhie and Prof. Rianto. There are also several members from hospitals. The committee has meetings every month, with the first being the last month. The budget comes from the PPJK (Pusat Pembiayaan dan Jaminan Kesehatan or Centre for Healthcare Financing) and the MoH (Ministry of Health) budgets. This budget supports pilot activities and meetings. InaHTAC will also continue to build their in-house research capacity as well as collaborate with other HTA agencies (some 15 teaching hospitals have HTA units). They plan to have 6-8 topics/research from 2018-2020 and requested the continuous support from HITAP as well as other iDSI partners. From 2020-2026, they plan to be an independent unit with a credible process, involving units from other universities or organizations.

By regulation, BPJS should cover all citizens under the social security system. They handle the payment and services system, including the quality and cost beneficiary (though it does not have decision-making power for service provision or unit cost determination). They are not involved directly in HTA, but they are involved in the HTAC. There are many services that are not supported by the HTAC; however, the BPJS will collect data from their claim system and provide recommendations to them regarding the potential topics for HTA.. In addition, the BPJS can provide necessary information for HTA e.g. now there are 2,000 cases of hemodialysis in their program In this case, the BPJS recommends exploring whether they should they change to peritoneal dialysis given the smaller cost compared to hemodialysis, which they support financially in the reimbursement system. These catastrophic illnesses and their treatments are only 7% of all the diseases but they cost 30% of the BPJS Kesehatan budget. The BPJS Kesehatan has around 130 branches and offices around the country that collects data claims and information. Confirming the quality of services is excluded from the BPJS mandate; however, they will have a team for quality

control. They should have a cost containment system, which they hope to be part of HTA recommendations.

As a social security body, BPJS Kesehatan should organize all these healthcare programs. They plan to cover all citizens by 2019. The BPJS Kesehatan began the Jaminian Kesehatan Nasional (JKN) for this reason, but they in the beginning had members who already have existing medical conditions given that they are the ones with the incentive to seek treatment. In this case, preventive care and interventions weren't a focus yet. Registration costs Indonesian Rupiah (IDR) 19,000; the local government covers the costs of vulnerable and poor populations. Monthly contributions were IDR 23,000/mo (or2$/mo) for indigents, which were the main targets. There are 3 different class types of hospitalization and will have a different contribution systems. For the formal sector, e.g. class 1, the contribution is IDR 80,000 or 7-8$/mo. However, the challenge became the collection of the contribution as well as the registration of non-Indonesians in the country. Around 0.86% of the population are non-citizens, for which the government has passed an act to have them included in the UCS and provided with an identification no. Like indigents, they are receiving free treatment. For the financial issues, the BPJS Kesehatan system put in sanctions (2% of the monthly costs) on top of contribution if they seek treatment but had failed to pay for the previous months, with a maximum sanction of IDR 30 million. They have also publicly announced that the system is paid by contributions and not co-payment with the government.

Private and public hospitals both can join this program as providers. There is a new mandate that these healthcare providers should be members of the BPJS Kesehatan by 2018. There are 2,300 hospitals in Indonesia. At the time of their report, all of the public services (Puskesmas) were registered as well as 75% of university hospitals and 50% private hospitals. The regulator sets the contribution. For the first year, the collection was IDR 42 trillion; however the cost was IDR 47 trillion and they had a deficit. The government covered this, but the budget may not be able to support continuous coverage. For indigents, the government pays 100%, and the formal sector covers themselves fully. Workers should pay in proportion the contribution. BPJS Kesehatan can work with different agencies and ensure cost and quality control.

BPJS Kesehatan only purchases the health services; PPJK manages the case mix. The hospitals manage the services and reimburse with the BPJS Kesehatan through the Indonesian case-based group (CBG) and social system. The CBG has a different payment system for different classes of hospitals, types, and approach. All hospitals pay the same money based on the case mix and should receive the same amount, category, and ration. They also pay for health facilities with this system through a capitation basis. However, medicines have a different system - they pay the cost of the drugs directly. They also have a referral system for certain diseases and conditions under a disease management program. Some of the costs are higher due to monopolies or lack of local supply (e.g. continuous ambulatory peritoneal dialysis or CAPD). Most patients go to the hospital instead of the primary healthcare provider, however, so this area needs to be improved to focus on health promotion and disease prevention. They do not cover traditional medicines, however. The BPJS Kesehatan tries to ensure that all patients under coverage receive the same benefits and treatment. An independent and externally managed evaluation system called the CSI (Customer Satisfaction Index) and PSI (Provider Satisfaction Index) are conducted for this purpose.

BPJS Kesehatan does some research through its research and development (R&D) department, though it has received questions regarding conflict of interest. They conduct surveys on healthcare provision and services, out-of-pocket expenditures, and service quality assessments. These projects are on an ad-hoc basis and respond to the needs of BPJS Kesehatan.

Post-Meeting Discussions

It was agreed that the English versions of the guidelines and roadmap after they complete it will be shared to HITAP and iDSI partners. HITAP can provide support for the English translation, if needed. Both parties will also follow-up on the MoU between Thailand and Indonesia.

The InaHTAC is focusing on supporting the JKN. Potential support for the CE thresholds study can include partners such as Dr. Ryota Nakamura from Japan, as well as possibly the Japan International Cooperation Agency (JICA). HITAP is now working with York so it is possible to support them as well as mobilize resources for the project. HITAP aims to involve BPJS Kesehatan more in the HTA work in Indonesia, particularly Ibu Maya Amiarny, the Director of Research. HITAP could potentially provide workshops with BPJS Kesehatan staff along with the InaHTAC staff. There will also be a workshop for payers around Asia to discuss the use of HTA in their work; BPJS Kesehatan will be invited.

HITAP will focus on implementing the policy recommendations of the studies that have already been completed. InaHTAC should also endorse the EQ-5D-5L value set for economic evaluations that was completed in 2016.

As per their request, HITAP will also inform InaHTAC that the average cost of conducting HTA is between THB 100-200,000 depending on the type of research (the scale, the researcher and labor, and data collection costs). Around 25% of the cost will be allocated for data collection and utility information, and another 25% for the cost of the meetings required for the research. In general, if the research requires more data collection or be a clinical trial, then it may cost more.

After-Action Review

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Peritoneal Dialysis Workshop

The Indonesian partners also attended a two-day event on peritoneal dialysis (PD) implementation in Thailand. Given that Indonesia also conducted a HTA on renal replacement therapy options in the country, this visit is intended to assist them in scaling up their current PD program on a national level. HITAP had introduced the Indonesian partners to this workshop and facilitated their involvement. Dr. Yot Teerawattananon and Ms. Alia Luz also presented on the economic evaluation evidence of PD coverage in Thailand which was presented to the Thai Universal Coverage Benefits Package (UCBP) board.

The participants learned about: the key strategies and the initial steps done to implement Thailand's PD First policy; the kidney disease fund management and supported systems; the human resource preparation and investment; the patient data management infrastructure; and, the patient home delivery infrastructure. The next day, they also visited the National Health Security Office (NHSO) call center and patient management system for PD. Then they went to the Banphaeo Hospital PD center, the Thailand Post warehouse that facilitates delivery of the solutions, and also met some patients who receive the PD solutions and use them at home.

Appendices

Appendix 1: Agendas

Indonesia Partners Study Visit to HITAP

Date: Wednesday, October 12, 2016
Location: HITAP offices, 6th floor, 6th building, Department of Health, Ministry of Public Health, Nonthaburi 11000 Thailand

Objectives:

1. To learn about the UHC and HTA development in Indonesia
2. To understand the Jaminan Kesehatan Nasional management and how HTA work can be incorporated
3. To share the experiences of Thailand in using HTA
4. To discuss future collaboration between HITAP and our partners

HITAP staff:

1. Dr. Yot Teerawattananon, Program leader
2. Waranya Rattanavipapong, Researcher
3. Pattara Leelahavarong, Researcher
4. Suthasinee Kumluang, Researcher
5. Nitichen Kittiratchakool, Researcher
6. Suradech Doungthipsirikul, Researcher
7. Pitsaphun Werayingyong, Researcher
8. Thanaporn Bussabawalai, Researcher
9. Benjarin Santatiwongchai, HIU
10. Alia Luz, HIU
11. Sneha Rajbhandari, HIU

Indonesian partners:

1. dr. Slamet, MHP, Senior Advisor for the Minister for Health Technology and Globalization, MoH, Jakarta
2. dr. Tri Hesti Widyastoeti, Sp. M, MPH; Director of Referral Health Services, MoH, Jakarta
3. Dra.R. Dettie Yuliati, Apt, MSi; Director of Pharmacy Services, MoH, Jakarta
4. drg. Armansyah, MPPM, Center for Health Financing and Health Insurance, MoH, Jakarta
5. Sari Mutiarani, Apt; Directorate of Pharmacy Services, MoH, Indonesia
6. Ibu dr. R. Maya Amiarny Rusady, Director of Health Services, BPJS Kesehatan , Jakarta
7. Bapak Mundiharno, Director of Planning, Development and Risk Management, BPJS Kesehatan, Jakarta
8. dr. Eva Herlinawaty; Center for Health Financing and Health Insurance, Jakarta

Time	Activity and Presenter	Notes
Wednesday, October 12, 2016 *Bangkok, Thailand*		
9:00 – 9:15	Introductions and Welcome • HITAP and partners	
9:15- 9:35	Roadmap of HTA Development in Indonesia as part of the UHC movement • PPJK representative (TBC)	
9:35 – 9:55	Discussion	
9:55 – 10:15	The Jaminan Kesehatan Nasional (JKN), its management, and potential roles of HTA • BPJS representative (TBC)	
10:15 – 10:35	Discussion	
10:35 – 10:50	Coffee Break	
10:50 – 11:20	Introduction to HITAP and HTA in Thailand • Benjarin Santatiwongchai, head of HITAP International Unit (HIU)	
11:20 – 11:40	Discussion	
11:40 – 12:00	HTA for the National List of Essential Medicines • Pattara Leelahavarong, Researcher	NLEM team (Suthasinee Kumluang and Nitichen Kittiratchakool) will attend this section.
12:00 – 12:20	Discussion	
12:30 – 13:30	Lunch Break	

13:30 – 13:50	Role of HTA in the Universal Health Benefits Package • Suradech Doungthipsirikul, Researcher	
13:50 – 14:10	Discussion	
14:10 – 15:50	Previous collaboration between partners • Alia Luz, HIU • Discussion to be led by HITAP team ○ Presentation and discussion include PEN, PAH, and RRT studies ○ Institutionalization and other activities	Pitsaphun Werayingyong, Thanaporn Bussabawalai, and Waranya Rattanavipapong will attend
15:50 – 16:00	Coffee / Tea Break	
16:00 – 17:30	Potential or future collaboration between partners	
18:00 – 20:00	Dinner hosted by HITAP	

PD-First On-Site Forum

Dates: Thursday to Friday, October 13-14, 2016

HITAP staff:

1. Dr. Yot Teerawattananon, Program leader
2. Alia Luz, HIU

Confirmed Indonesian partners:

1. dr. Slamet, MHP, Senior Advisor for the Minister for Health Technology and Globalization, MoH, Jakarta
2. dr. Tri Hesti Widyastoeti, Sp. M, MPH; Director of Referral Health Services, MoH, Jakarta
3. Dra.R. Dettie Yuliati, Apt, MSi; Director of Pharmacy Services, MoH, Jakarta
4. drg. Armansyah, MPPM, Center for Health Financing and Health Insurance, MoH, Jakarta
5. Sari Mutiarani, Apt; Directorate of Pharmacy Services, MoH, Indonesia
6. Ibu dr. R. Maya Amiarny Rusady, Director of Health Services, BPJS Kesehatan , Jakarta
7. Bapak Mundiharno, Director of Planning, Development and Risk Management, BPJS Kesehatan, Jakarta
8. dr. Eva Herlinawaty; Center for Health Financing and Health Insurance, Jakarta

To be confirmed:

1. Chairman of Indonesian Society of Neprology (Ina SN)
2. Chairman of Indonesian Renal Registry (dr. Afiatin, Sp.PD-KGH)

Agenda

Day 1
Thursday 13 October 2016
Room BB204, Vayupak Convention Centre,
Centra Government Complex Hotel
and Convention Centre Chaeng Watthana

Host:
Banphaeo Hospital and the
Nephrology Society of Thailand

Moderator/Facilitator:
Dr Piyatida Chuengsaman
Dr Yot Teerawattananon

Time	Topic	Speaker
08:00–08:20	Registration	
08:20–08:30	Opening remarks	Banphaeo Hospital
Morning session: Key evidence for Thailand's PD First policy and funding management		
08:30–09:30	Economic evaluation of palliative management versus PD and HD for ESRD: Evidence for coverage decisions in Thailand	Dr Yot Teerawattananon Ms Alia Luz
09:30–10:45	Key strategies and 7 steps towards Thailand's PD First policy	Dr Thanom Supaporn
10:45–11:00	Coffee break	
11:00–12:00	Kidney disease fund management and supported systems	Dr Chuchai Sornchamni
12:00–13:00	Lunch	
Afternoon session: Infrastructure considerations for implementation of PD First		
13:00–14:00	**Human resource preparation:** • Regional RRT Technology and Training Center – a supporting mechanism for the policy • Nurse and physician training center and curriculum course	 Dr Dhavee Sirivongs Dr Talaungsak Kanjanabucha
14:00–15:00	Ministry of Public Health system preparation for pre- and post-dialysis patients	Dr Sakarn Bunnag
15:00–15:15	Coffee break	
15:15–16:45	**Patient data management infrastructure:** • PD patient registry system • Importance of setting up a concrete patient registry system and utilize data to analyze further on clinical quality	 Datuk Dr Ghazali Ahmad Dr Siribha Changsirikulchai
16:45–17:30	Patient home delivery infrastructure	Mr Somprasong Netsawang
17:30–17:40	Closing remarks	Dr Yot Teerawattananon

Day 2
Friday 14 October 2016

Time	Topic	Venue
08:15–08:30	Gather in the hotel lobby	Centra Government Complex Hotel and Convention Centre Chaeng Watthana
08:30–09:00	Travel from hotel to NHSO office	
09:00–10:00	NHSO call center and patient management system	NHSO Office
10:00–11:00	Travel from NHSO office to Banphaeo Hospital	
11:00–12:30	Banphaeo PD Center visit	Banphaeo Hospital
12:30–13:30	Lunch	
13:30–14:30	Travel from Banphaeo Hospital to Thailand Post warehouse	
14:30–15:30	Thailand Post warehouse site visit	Thailand Post warehouse
15:30–15:50	Closing remarks	Dr Piyatida Chuengsaman
15:50–17:00	Travel from Thailand Post warehouse to hotel	

Appendix 2: Photos


HITAP strategies