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Report No: PAD4416

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROGRAM APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF

US\$400 MILLION

TO THE

REPUBLIC OF INDONESIA

FOR A

NATIONAL HEALTH INSURANCE (JKN) REFORMS AND RESULTS PROGRAM
PROGRAM-FOR-RESULTS

November 24, 2021

Health, Nutrition and Population Global Practice
East Asia and Pacific Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective October 31, 2021)

Currency Unit = Indonesian Rupiah (IDR)

IDR 14,168 = US\$1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
APBD	<i>Anggaran Pendapatan dan Belanja Daerah</i> (Local Government Budget)
APBN	<i>Anggaran Pendapatan dan Belanja Negara</i> (National State Budget)
<i>Bappenas</i>	<i>Badan Perencanaan Pembangunan Nasional</i> (Ministry of National Development Planning)
BMGF	The Bill and Melinda Gates Foundation
BPJS-K	<i>Badan Penyelenggara Jaminan Sosial-Kesehatan</i> (National Health Insurance Agency)
BPKP	<i>Badan Pengawasan Keuangan dan Pembangunan</i> (Finance and Development Supervision Agency)
CISA	Certified Information System Auditor
COVID	Coronavirus
CPF	Country Partnership Framework
CPS	Country Partnership Strategy
DA	Designated Account
DAK	<i>Dana Alokasi Khusus</i> (Special Allocation Grant)
DAU	<i>Dana Alokasi Umum</i> (General Allocation Grant)
<i>Dekon</i>	<i>Dekonsentrasi</i> (Deconcentrated fund)
DFAT	Department of Foreign Affairs and Trade
DG	Directorate General
DHO	District Health Office
DIPA	<i>Daftar Isian Pelaksanaan Anggaran</i> (Budget Implementation List)
DJSN	<i>Dewan Jaminan Sosial Nasional</i> (National Social Security Council)
DKI Jakarta	<i>Daerah Khusus Ibukota Jakarta</i> (Special Area of the Capital City of Jakarta)
DLI	Disbursement-Linked Indicator
DRG	Diagnosis-Related Group
DTKS	<i>Data Terpadu Kesejahteraan Sosial</i> (Integrated Social Welfare Data)
EMR	Electronic Medical Record
ESSA	Environmental and Social Systems Assessment
F&C	Fraud and Corruption

FKRTL	<i>Fasilitas Kesehatan Rujukan Tingkat Lanjutan</i> (Advanced-Level Referral Health Facilities/Hospitals)
FKTP	<i>Fasilitas Kesehatan Tingkat Pertama</i> (Primary-Level Health Care Facilities)
FSA	Fiduciary Systems Assessment
FY	Fiscal Year
F&C	Fraud and Corruption
GDP	Gross Domestic Product
GHG	Greenhouse Gas
GOI	Government of Indonesia
GPSA	Global Partnership for Social Accountability
GRS	Grievance Redress Service
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HR	Human Resources
HTA	Health Technology Assessment
IA	Implementing Agency
IBRD	International Bank for Reconstruction and Development
ID	Identification
ICD	International Classification of Diseases
IFR	Interim Financial Report
INACBG	Indonesia Case Base Group
IPF	Investment Project Financing
I-SPHERE	Indonesia's Supporting Primary Health Care Reform
IT	Information Technology
IVA	Independent Verification Agency
JKN	<i>Jaminan Kesehatan Nasional</i> (National Health Insurance)
JLN	Joint Learning Network
KBK	<i>Kapitasi Berbasis Komitmen</i> (Performance-Based Component to Capitation Payments)
Kemenco PMK	<i>Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan</i> (Coordinating Ministry for Human Development and Cultural Affairs)
LKPP	<i>Lembaga Kebijakan Pengadaan Barang dan Jasa Pemerintah</i> (National Public Procurement Agency)
LMIC	Lower-Middle-Income Country
MAPS	Methodology for Assessing Procurement Systems
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoH	Ministry of Health
MOHA	Ministry of Home Affairs
MOSA	Ministry of Social Affairs
NA	Not Applicable
NCD	Noncommunicable Disease
OECD	Organisation for Economic Co-operation and Development
PAP	Program Action Plan
PBI	<i>Penerima Bantuan Iuran</i> (subsidies the MoF pays on behalf of the poor and the near poor to cover their health insurance premiums)
PCare	BPJS-K's primary health care

PDO	Program Development Objective
PforR	Program-for-Results
PHE	Public Health Expenditure
PKBK	<i>Pembiayaan Kapitasi Berbasis Kinerja (Performance-Based Capitation Financing)</i>
PP	Procurement Plan
PPJK	<i>Pusat Pembiayaan dan Jaminan Kesehatan (Center for Financing and Health Insurance)</i>
PPSD	Project Procurement Strategy for Development
<i>Poskesdes</i>	<i>Pos Kesehatan Desa (Village Health Posts)</i>
<i>Posyandu</i>	<i>Pos Pelayanan Terpadu (Integrated Health Service Posts)</i>
<i>Pusdatin</i>	<i>Pusat Data dan Informasi (Center for Data and Information)</i>
<i>Puskesmas</i>	<i>Pusat Kesehatan Masyarakat (Public Primary Health Centers)</i>
RA	Results Area
<i>Renstra</i>	<i>Rencana Strategis (Strategic Plan)</i>
RETF	Recipient-Executed Trust Fund
RPJMN	<i>Rencana Pembangunan Jangka Menengah Nasional (National Mid-Term Development Plan)</i>
SC	Steering Committee
SIAF	<i>Sistem Informasi Akreditasi FKTP (FKTP Accreditation Information System)</i>
SISRUTE	<i>Sistem Rujukan Terintegrasi (Integrated Referral System)</i>
SPM	<i>Standar Pelayanan Minimum (Minimum Service Standard of Care)</i>
STG	Standard Treatment Guideline
TB	Tuberculosis
THE	Total Health Expenditure
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name		
Indonesia	National Health Insurance (JKN) Reforms and Results Program		
Project ID	Financing Instrument	Does this operation have an IPF component?	Environmental and Social Risk Classification (IPF Component)
P172707	Program-for-Results Financing	Yes	Low

Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Fragile State(s)
<input type="checkbox"/> Contingent Emergency Response Component (CERC)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Small State(s)	<input type="checkbox"/> Conflict
<input type="checkbox"/> Alternate Procurement Arrangements (APA)	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Hands-on Enhanced Implementation Support (HEIS)	
Expected Project Approval Date	Expected Closing Date
15-Dec-2021	30-Sep-2026

Bank/IFC Collaboration

No

Proposed Program Development Objective(s)

The program development objective is to strengthen the quality and efficiency of Indonesia's National Health Insurance program.

Organizations

Borrower : Republic of Indonesia

Implementing Agency : BPJS- Kesehatan

Contact: Ali Ghuftron Mukti



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 Implementing Agency : Ministry of Finance
 Contact: Luky Alfirman
 Title: DG of Budget Financing and Risk Management
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 Implementing Agency : Dewan Jaminan Sosial Nasional (DJSN)
 Contact: Mohamad Subuh
 Title: Acting Chair/Council Member
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 Implementing Agency : Ministry of Health
 Contact: Kunta Wibawa Dasa Nugraha
 Title: Secretary General
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COST & FINANCING

SUMMARY

Government program Cost	18,350.00
Total Operation Cost	402.33
Total Program Cost	400.00
IPF Component	2.33
Total Financing	402.33
Financing Gap	0.00



Financing (USD Millions)

International Bank for Reconstruction and Development (IBRD)	400.00
Trust Funds	2.33
Indonesia - Free-standing Trust Fund Program	2.33

Expected Disbursements (USD Millions)

Fiscal Year	2022	2023	2024	2025	2026	2027
Absolute	70.00	50.00	50.00	70.00	85.00	75.00
Cumulative	70.00	120.00	170.00	240.00	325.00	400.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	● Moderate
2. Macroeconomic	● Moderate
3. Sector Strategies and Policies	● Substantial
4. Technical Design of Project or Program	● Substantial
5. Institutional Capacity for Implementation and Sustainability	● Substantial
6. Fiduciary	● Substantial
7. Environment and Social	● Moderate
8. Stakeholders	● Substantial



9. Other	● Substantial
10. Overall	● Substantial

COMPLIANCE

Policy

Does the program depart from the CPF in content or in other significant respects?

Yes No

Does the program require any waivers of Bank policies?

Yes No

Legal Operational Policies

	Triggered
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Not Currently Relevant
Community Health and Safety	Not Currently Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant



Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank’s due diligence assessment of the Project’s potential environmental and social risks and impacts, please refer to the Project’s Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description

By no later than 2 months after Effective Date, or such later date as may be agreed between the Bank and the Borrower, the Borrower shall establish and thereafter maintain, at all times during the implementation of the Program, the Program Secretariat within MOF, which shall be responsible for day-to-day Program management, coordination, and monitoring. (Section I.A of Schedule 2 to the Loan Agreement).

Sections and Description

By no later than three (3) months after the Effective Date, or such later date as may be agreed between the Bank and the Borrower, the Borrower shall establish and thereafter maintain, and cause the PIE to establish and thereafter maintain, at all times during the implementation of the Program, the following entities, with staff, functions and resources satisfactory to the Bank: a Steering Committee, consisting of Echelon I officials from Bappenas, BPJS-K, DJSN, Kemenko PMK MOF, MOH, and MOHA, a Board Member of BPJS-K, and member of the DJSN, which shall be responsible for providing overall policy guidance and oversight on Program implementation, through, inter alia, setting policy and annual targets, reviewing progress and performance, and resolving specific issues as required. (Section I.A of Schedule 2 to the Loan Agreement).

Sections and Description

Except as may otherwise be explicitly required or permitted under this Agreement or as may be explicitly requested by the Bank, in sharing any information, report or document related to the activities described in Schedule I of this Agreement, the Borrower shall ensure, and cause the PIE to ensure that such information, report or document does not include Personal Data. (Section III.B of Schedule 2 to the Loan Agreement).

Sections and Description

No later than one (1) month after the Effective Date, or such later date as may be agreed between the Bank and the Borrower, the Borrower shall appoint BPKP to act as an independent verification agent to undertake the DLR verification process in accordance with the terms of reference acceptable to the Bank (Section I.C of Schedule 2 to the Loan Agreement).



Conditions

Type	Financing source	Description
Effectiveness	IBRD/IDA	The Borrower shall cause the PIE to deliver a letter to the Borrower and the Bank, in form and substance acceptable to the Bank, confirming its commitment to implement activities of the Program and carry out its obligations under the Program in accordance with Schedule 2 to this Agreement (Article 5.01 of the Loan Agreement).



I. STRATEGIC CONTEXT

A. Country Context

1. **Before the COVID-19 pandemic, Indonesia had made significant progress with a steadily growing economy and declining poverty rates.** Supported by a sound macroeconomic framework, real gross domestic product (GDP) expanded by an average of 5.5 percent annually between 2010 and 2019, and the size of the economy¹ nearly doubled from IDR 5,478 trillion in 2006 to IDR 10,949 trillion (US\$1.1 trillion in current prices) in 2019². Strong growth also helped contribute to a decline in poverty from 19.1 percent of the population in 2000 to 9.2 percent of the population by March 2019—lifting 13.6 million people out of poverty³. Indonesia was also classified as an upper-middle-income country for the first time in 2019—an outcome that was reversed during the pandemic.
2. **However, the pandemic has halted progress to inclusive growth.** Indonesia leads the East Asia and the Pacific Region in the number of COVID-19 cases and deaths and is facing the worst recession since the 1997–98 Asian financial crisis. The economy contracted by 2.1 percent in 2020 with economic losses due to COVID-19 in FY20 and FY21 estimated to be US\$161 billion. About 25 million Indonesians still live below the national poverty line, and many remain vulnerable to economic and health-related shocks⁴. The economic downturn has resulted in reduced employment in both formal and informal sectors—the latter accounting for 76 percent of the workforce. Poverty increased from 9.2 percent to 10.2 percent in September 2019–20. Although the economic situation improved gradually since January 2020, pandemic risks remain high.
3. **Policy makers face three key challenges to improving the economic recovery.**
 - (a) **Containing the pandemic.** Pandemic risks remain high as highlighted by the COVID-19 surge in July–August driven by the Delta variant. Despite significant progress in the capital city Jakarta and the tourist hub Bali, the vaccine rollout at the national level will need to continue at a steady pace for timely coverage of the target population.
 - (b) **Mitigating the potential long-lasting effects from COVID-19 to human capital accumulation.** According to the latest human capital index, Indonesia’s next generation will only be 53 percent as productive as it could have been with full health and complete education. But COVID-19 has disrupted access to schools and essential health services. Hospital and outpatient utilization decreased by 18 percent and 16 percent, respectively, between 2019 and 2020⁵. While reduced mobility, facility closures, and the fear of contracting COVID-19 have contributed to the short-term decrease in demand for health care, the economic implications of the pandemic will have a long-lasting effect on households’ ability to access health care services.

¹ Measured in GDP at constant prices.

² World Bank. 2021. *World Development Indicators*. Washington, DC: World Bank.

³ Statistics Indonesia . 2020. Jakarta: Badan Pusat Statistik.

⁴ World Bank. 2020. *Indonesia Economic Prospects, July 2020: The Long Road to Recovery*. Washington, DC: World Bank.

⁵ World Bank. 2021. *Monitoring basic frontline services in Indonesia during COVID-19*. Washington, DC: World Bank Group.



(c) **Maintaining adequate support for households.** Low tax revenues and the shallow domestic debt market constrain the fiscal policy response to COVID-19. The Government suspended the fiscal deficit limit of 3 percent of GDP until 2022, and the fiscal deficit rose from 2.2 percent to 6.2 percent of GDP in 2019–20. Spending grew strongly, although from a low base compared to peers, while the narrow revenue base contracted even more. Higher informality further constrains Indonesia’s fiscal capacity to respond to COVID-19 and address development bottlenecks. In the health sector, many households lost access to health care during COVID-19. Total job losses were estimated between 2.92 million and 5.23 million by the Social Security Agency or *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K). As of August 2021, nearly 3.5 million Indonesians had already lost health insurance coverage or had stopped actively paying their premiums⁶ as the country’s national health insurance scheme or *Jaminan Kesehatan Nasional* (JKN) is partly financed by employment-based contributions. This has renewed the commitment of the Government of Indonesia (GOI) to universal health coverage (UHC)—defined as access to quality essential health services for all, without having to suffer financial hardship to pay for health care.

4. **This Program-for-Results (PforR) aims to ensure households’ continued access to quality essential health services, enabling a healthier and more productive workforce.** It uses JKN—the GOI’s flagship policy for increasing access to affordable health care services—as the financial instrument to incentivize improvements in the quality and efficiency of service delivery. While the GOI already provides JKN coverage for 60 percent of Indonesians (poor and vulnerable households) through tax-based financing, COVID-19 has prompted the GOI to consider expanding coverage to the informal sector which is currently required to make income-based contributions. However, the Ministry of Finance (MoF) is reluctant to embark on a UHC solution without the sector’s commitment to also manage the upward trajectory of health expenditures. In nearly all countries, economic growth has been accompanied by a growth in health expenditures, but the quality of spending varies widely across health care systems. Globally, potential efficiency savings in middle-income countries have been estimated between 20 percent and 40 percent of total health expenditure (THE)⁷. A 2017 audit report of JKN found that inefficiencies in hospital service alone amounted to 15 percent of JKN spending or IDR 16 trillion (US\$1.1 billion)⁸.

5. **The design of the PforR was informed by an extensive analytical engagement over the last five years:**

(a) A health financing systems assessment⁹ and public health expenditure (PHE) reviews in health¹⁰ and nutrition¹¹ highlighted the need to raise additional revenue and improve the quality of spending. Findings showed that the two sources of health financing that offer the greatest potential for

⁶ In 2019, of the 30 million informal sector workers, only 55.5 percent were actively paying their membership. In 2020, this number dropped to 47 percent.

⁷ Chisholm, Dan, and David B Evans. 2010. *Improving health system efficiency as a means of moving towards universal coverage*. Geneva: World Health Organization .

⁸ Pramita, D, A Sedayu, and E Hermawan. 2020. *Bolong-Bolong BPJS*. June 6.

<https://majalah.tempo.co/read/investigasi/160658/investigasi-penyebab-sebenarnya-bpjs-kesehatan-selalu-defisit>.

⁹ World Bank. 2016. *Health financing system assessment: spend more, right & better*. Washington, DC: The World Bank.

¹⁰ World Bank. 2020. *Indonesia public expenditure review: spending for better results*. Washington, DC: The World Bank.

¹¹ World Bank. 2020b. *Spending better to reduce stunting in Indonesia*. Washington, DC: The World Bank.



improving the quality of health spending are DAK, a fund that finances capital investments, medicines, and commodities in the public sector, and JKN spending that finances service delivery in the public and private sectors (Box 1).

- (b) Functional and regulatory reviews¹² of JKN highlighted design challenges on the revenue and expenditure sides that threaten the financial sustainability of the scheme. While reforms to expand membership and improve contribution compliance have dominated the Government's policy dialogue, the most pressing is the need to reform provider payments, especially at the hospital level, to manage expenditure growth. As the largest source of revenue for primary health care facilities, JKN also offers a significant financial lever to incentivize improvements in the quality of primary health care among public and private providers.
- (c) Supply-side readiness assessments in the public^{13,14} and private¹⁵ sectors highlighted gaps in the quality of care, especially diagnostic capacity, the availability of diagnostic and treatment guidelines, and provider's competence to diagnose and treat conditions, especially at the primary care level. They also revealed that while the private sector provides a significant share of health care, the quality of services is generally better in the public sector.
- (d) Feasibility studies to unlock the potential of private providers¹⁶ and civil society organizations¹⁷ in service delivery highlighted the type of contracting mechanisms most suitable for different types of non-state providers. As private providers do not receive the significant supply-side financing (DAK) that public providers do, here too, JKN offered the strongest lever to incentivize improvements in the quality of services provided in the private sector.

6. **The World Bank is already engaged in supporting the health sector and the social security apparatus through several related lending operations.** However, this PforR presents the first opportunity to engage directly with BPJS-K at a substantive level.

- (a) Indonesia's Human Capital Development Policy Loan, currently under preparation, is considering prior actions to increase the tobacco tax rate and introduce a tax on sugar-sweetened beverages to raise additional resources for the sector.
- (b) Indonesia's Digital ID and Registration for Inclusive Service Delivery aims to strengthen population and civil registration and develop a digital identification system. Improvements in digital

¹² World Bank. 2018. *Functional and regulatory reviews of strategic health purchasing under JKN: 1. Executive summary. 2. Overview of strategic purchasing functions under JKN. 3. Purchasing primary health care under JKN. 4. Purchasing referral services under JKN.* Washington, DC: World Bank Group.

¹³ World Bank. 2018. *Is Indonesia ready to service? An analysis of Indonesia's primary health care supply-side readiness.* Washington, DC: The World Bank.

¹⁴ The World Bank. 2018. *Assessing HIV, TB, malaria and childhood immunization supply-side readiness in Indonesia.* Washington, DC: The World Bank.

¹⁵ World Bank. 2017. *Revealing the missing link: private sector supply-side readiness for primary maternal health services in Indonesia.* Washington, DC: The World Bank.

¹⁶ World Bank. 2019. *Partnerships for a healthier Indonesia: unlocking constraints for a better private sector participation.* Washington, DC: The World Bank.

¹⁷ World Bank. 2019b. *Engaging with civil society in the health sector.* Washington, DC: The World Bank.



identification will help improve the targeting, coverage, eligibility, and contribution compliance of JKN. It is a US\$400 million loan with an expected board approval in November 2022.

- (c) The Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services project is a US\$0.73 million project, funded by a grant from the Global Partnership for Social Accountability (GPSA), that aims to improve access and quality of health service delivery for poor and vulnerable populations in selected districts of Indonesia.
- (d) Indonesia's Supporting Primary Health Care Reform (I-SPHERE)¹⁸ engages primarily with the Ministry of Health (MoH) and supports public supply-side financing and resource allocation decisions from the MoH by improving the use of data in decision-making, the accreditation of primary health care facilities, and performance-based financing. It is a US\$150 million PforR.

7. While the first three operations focus on increasing revenue and JKN coverage, this PforR focuses on system strengthening for managing the expenditure side and its leverage on the overall health system, which will ultimately allow the MoF to sustainably reach UHC. Achieving UHC would mean that more people will have access to quality health services in an affordable manner. Its activities aim to strengthen core business processes related to provider payment, claims management, service delivery, and health care analytics. It also brings together four key JKN stakeholders—BPJS-K, the MoH, the Social Security Council or *Dewan Jaminan Sosial Nasional* (DJSN), and the MoF—facilitating the coordination and sequencing of needed reforms.

B. Sectoral (or Multi-Sectoral) and Institutional Context

Health Sector Context

8. **Following decentralization in 1999, Indonesia transferred the bulk of health care delivery to district and village governments.** Indonesia is divided into 34 provinces, 514 regencies and cities, 7,252 districts, and over 83,000 villages. Facilities at the district level and above provide secondary and tertiary care (~1,000 public and 1,700 private hospitals). Sub-district and village facilities offer preventive, promotive, and basic primary health care with Public Primary Health Centers or *Pusat Kesehatan Masyarakat* (*puskesmas*) (~10,000)—the backbone of the public health system—serving a catchment area of 25,000–30,000 individuals. They are generally staffed with a general practitioner, nurses/midwives, and a nutritionist. At the village level, village health posts (*poskesdes*), often the home of the village midwife, act as *puskesmas* satellites bringing maternal and child health-related services closer to the community. Finally, integrated health service posts (*posyandus*) are organized by village governments to provide a form of community-based health care. They are run by voluntary community health workers (*kadres*). While the public sector is dominant in the provision of inpatient services, two-thirds of outpatient care is provided by private primary care clinics, individual practices, and pharmacies.

9. **Outside of out-of-pocket spending, PHE and JKN are the largest sources of health financing accounting for 31 percent and 23 percent of THE, respectively¹⁹.** However, PHE are mostly used for

¹⁸ World Bank. 2018. *Indonesia - Supporting Primary Health Care Reform Program and Supporting Primary and Referral Health Care Reform Program Projects*. Washington, DC: World Bank Group. <https://imagebank2.worldbank.org/search/29935019>.

¹⁹ Ministry of Health. 2018. *National Health Accounts*. Jakarta: Kementerian Kesehatan RI.



funding inputs (that is, the salaries of public health personnel, capital investments, medicines, and health commodities) not what is being purchased or delivered (that is, health care services or treatment). Instead JKN can be tied directly to service delivery offering a clearer link between health financing and health outcomes. JKN is also able to influence quality improvements among private providers who do not receive public funding. As such, JKN is the strongest financial lever to influence provider behavior to improve quality and efficiency in service delivery, especially in a heavily decentralized context. Box 1 describes the health financing landscape in Indonesia's decentralized context, Box 2 summarizes key features of JKN, and Box 3 maps the respective mandates of key stakeholders with respect to JKN.

Box 1. Health Financing in Indonesia's Decentralized Context

I. Sources of Health Financing

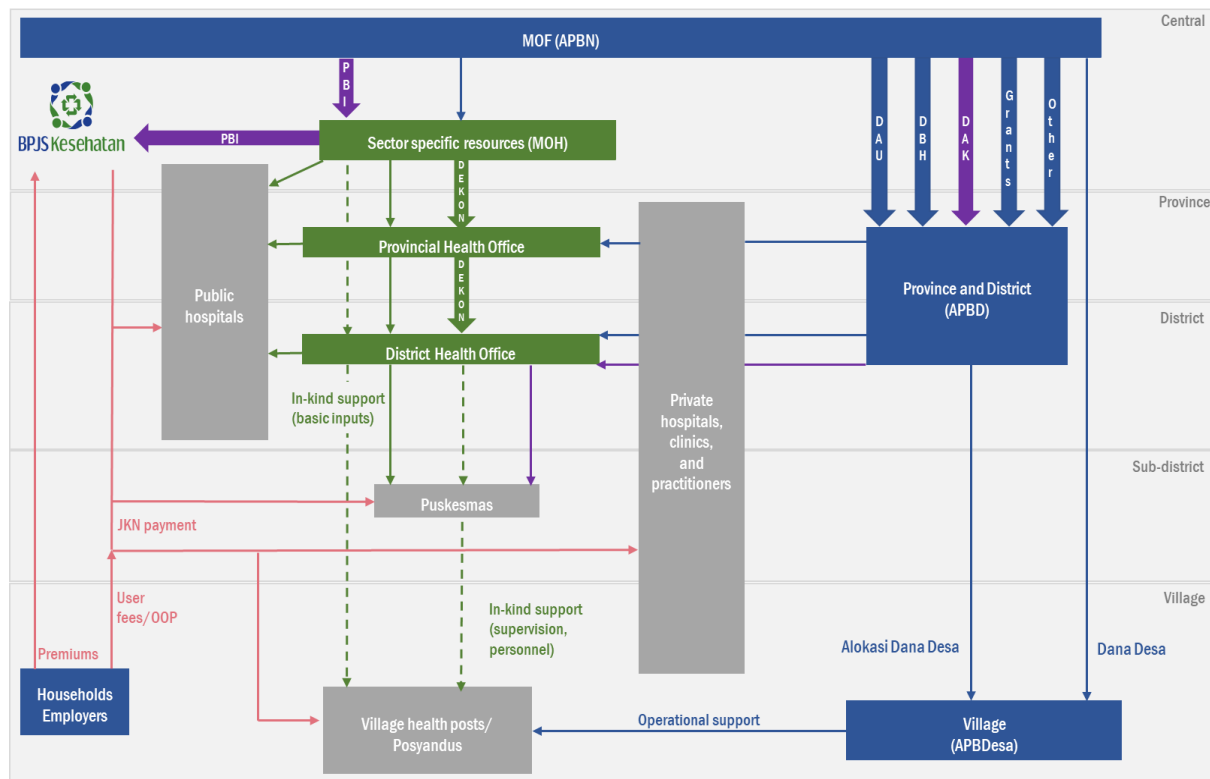
- (a) PHE account for 30.7 percent of THE. The bulk of PHE takes place at the subnational level—21.5 percent at the central level, 16.6 percent by the provincial governments, and 61.9 percent by district governments.
 - (i) At the central level, the MoH is mainly responsible for policy and regulation, technical assistance and capacity building, investment support for large infrastructure projects, and performance monitoring. It is also responsible for providing in-kind support—basic inputs such as vaccines, medicines, basic equipment and supplies, and standard operating procedures for activities via the District Health Office (DHO).
 - (ii) At the provincial level, the provincial health office is mostly responsible for ensuring the capacity of human resources (HR) and coordinating service delivery within the region. *Dekonsentrasi* (Dekon) funds, when available, are used for capacity building of health personnel at districts and facility levels. However, allocation is small and expected to shrink.
 - (iii) At the district level, local governments are responsible for the delivery of health services. Financing at the district level is strongly dependent on central-level transfers. Inter-fiscal transfers from central (National State Budget or *Anggaran Pendapatan dan Belanja Negara* [APBN]) to district (Local Government Budget or *Anggaran Pendapatan dan Belanja Daerah* [APBD]) level budgets include revenue sharing (*Dana Bagi Hasil*), general allocation grant or *Dana Alokasi Umum* (DAU), and specific allocation grant or *Dana Alokasi Khusus* (DAK). DAU and revenue sharing are unconditional transfers so allocation to specific sectors or activities is at the discretion of local governments, with DAU mostly being used to pay civil servants' salary. Only DAK—a special allocation fund used to finance capital investments, medicines, commodities, and some operational expenditures of frontline delivery units such as outreach—is earmarked for health.
 - (iv) At the village level, two new transfers are meant to provide operational support to village-level institutions to bring services closer to communities. Before 2014, districts were meant to support and oversee village-level activities. However, poor follow-through from districts resulted in limited funding and support. In 2014, Law No. 6/2014 (also known as the Village Law) mandated new fiscal transfer arrangements directly from central (*Dana Desa*) and district (*Alokasi Dana Desa*) governments. While village funds can be used to hire additional midwives or provide financial incentives for *kadres*, here too, allocation to health care activities is subject to village governments. The size of the village-level financing that is dedicated for health remains largely unknown and is not yet included in the national health accounting reports.
- (b) JKN accounts for 22.9 percent of THE and spans across all administrative levels as BPJS-K reimburses providers directly for service delivery. JKN covers the majority of the health service delivery landscape,



contracting with all public providers, 86 percent of private hospitals, ~6,500 private clinics (out of ~9,025), and ~5,500 individual private physicians (out of ~7,000).

- (c) The voluntary health insurance market is small accounting for 2.5 percent of THE.
- (d) Out-of-pocket spending accounts for 31.9 percent of THE.
- (e) The remaining 11 percent of THE is made up of non-profit institutions and big corporations, including state-owned enterprises (for example, national oil company, power, and telecommunications). It should be noted that this figure represents work-related occupational and safety expenses and not expenses related to health care providers¹⁹.

II. Health Financing Flows



Note: OOP = Out-of-pocket; PBI = *Penerima Bantuan Iuran*, which are the subsidies the MoF pays on behalf of the poor and the near poor to cover their health insurance premiums.

Box 2. An Overview of Indonesia’s National Health Insurance Scheme or JKN

Who is covered?

JKN is a mandatory health insurance scheme covering 223 million Indonesians. Of the beneficiaries, 60 percent, or 135 million people, are financed by the GOI. Civil servants and private formal sector workers make up 8 percent and 16 percent, respectively. The remaining 16 percent are informal sector workers and retirees. About 70 million Indonesians, mostly in the informal sector, are not yet covered.



What is included in the benefit package?

JKN offers a comprehensive benefit package including all medically necessary treatment with no caps or copayments. All members are entitled to the same benefit package and quality of care standards. While a new regulation in 2018 allowed the introduction of copayments for some services, these have yet to be defined and implemented.

How is it financed?

JKN is financed from a mix of wage-based contributions from formal workers (5 percent of salary), a flat fee for informal workers (IDR 42,000 or about US\$3 per month), and general government revenues for the poor and the near poor (bottom 40 percent of households) also known as *Penerima Bantuan Iuran* or PBI.

How does it interact with public and private providers?

JKN covers the majority of the health service delivery landscape, contracting with both public and private providers. JKN contracts with all public facilities and an equal if not larger number of private providers (see Box 1). Both public and private providers are subject to the same quality care standards and are paid under the same provider payment arrangements. However, JKN does not cover the full cost of care. In the public sector, providers receive additional financing and in-kind support from the central and subnational governments (see Box 1).

How are providers paid?

Primary health care is paid by capitation—a fixed per capita budget covering 144 competencies or services. Hospitals are paid a fixed amount per admission depending on patient and clinical characteristics, regardless of their length of stay or resource use (that is, diagnosis-related groups [DRGs]).

What does the health insurance sector in Indonesia look like?

JKN is the main provider of health insurance in Indonesia, covering 83 percent of the population and 23 percent of THE. Private voluntary health insurance is small - covering mainly households in the richest income quintile and some formal sector entities opting for dual coverage. It covers 8 percent of the population and less than 3 percent of THE.



Box 3. Respective Mandates of Key Stakeholders with Regard to JKN



The Ministry of Home Affairs (MOHA) maintains foundational systems such as the national ID (NIK) and the civil registration and vital statistics (CVRS) databases to ensure an up-to-date population registry. MOHA also ensures the JKN program can be operationalized at the subnational level - evaluating the planning of subnational governments to make sure enough resources have been allocated in the budget to deliver services at facilities.



The Ministry of Social Affairs (MOSA) draws on the population registry to develop and maintain an up-to-date social registry (i.e., DTKS targeting database) that ensures the bottom 40% of households (PBI beneficiaries) are automatically enrolled in JKN.



The Ministry of Finance (MOF) uses the social registry to pay PBI premiums. The MOF also maintains the tax ID (NPWP) database that can be used to verify contribution compliance from contributing members. As the largest funder of BPJS-K and payer of last resort, the MOF's main objectives are financial accountability, sustainability and overall efficiency of spending.



The Ministry of Health (MOH) develops licensing and accreditation criteria and maintains information on the number and distributions of providers; develops diagnostic and clinical protocols, referral pathways, and quality of care standards for services included in the benefit package; develops clinical coding guidelines, a health data dictionary for common terms, and standardized medical record forms; determines provider payment rates and approves provider payment methods. MOH's main objectives are to ensure UHC, health outcomes, and quality of care, especially by prioritizing public health and preventive and promotive benefits in the JKN package.



Providers deliver services based on MOH diagnostic and clinical protocols, referral pathways, and quality of care standards. They also maintain records on number of patient visits, symptoms, diagnosis, drugs, procedures, and treatment outcomes.



The National Health Insurance Agency (BPJS-K) collects premiums and enrolls beneficiaries; uses information on licensing and accreditation status to empanel providers; uses foundational ID systems to authenticate identity at enrollment and point of service; uses patient information from providers and MOH protocols and standards to verify claims; and develops provider payment methods to reimburse providers. BPJS-K's main objectives are to ensure financial sustainability and efficiency while promoting quality of care.



The Social Security Council (DJSN) provides the main oversight mechanism for the JKN ecosystem (e.g., ensuring transparency and accountability on key performance indicators) and advocates on behalf of beneficiaries.

Health Sector Outcomes

10. **Indonesians have become healthier over the past several decades; however, they are now faced with an unfinished Millennium Development Goal agenda and a growing burden of noncommunicable disease (NCD).** Between 1960 and 2018, life expectancy increased from 47 to 72 years. Under-five mortality declined from 223 to 25 per 1,000 live births, and infant mortality declined sevenfold to 21 per 1,000 live births over the same period. However, at 177 deaths per 100,000 live births, Indonesia's maternal mortality ratio (MMR) remains high relative to its income level and regional peers. About 7 million children suffered from stunting in 2018—the fifth-highest prevalence in the world. Indonesia is also the third-largest contributor to the global tuberculosis (TB) burden. NCDs now account for 66 percent of the disease burden².

11. **Over the initial years of JKN implementation, between 2014 and 2019, health coverage, financial protection from health expenditures, and utilization of health care services rose dramatically.** In five years, JKN coverage rose from 52 percent to 83 percent of the population and out-of-pocket



expenditures as a share of THE decreased from 53 percent to 32 percent. The share of households that spent more than 10 percent of their income on health expenditures also stayed relatively stable at around 4 percent throughout this period despite significant increases in utilization, mostly incurred by households in the highest two income quintiles²⁰. Outpatient utilization at primary-level health care facilities or *fasilitas kesehatan tingkat pertama* (FKTP) increased by 288 percent, and advanced-level referral health facilities/hospitals or *fasilitas Kesehatan rujukan tingkat lanjutan* (FKRTL) increased by 94 percent. Inpatient utilization also increased but more modestly, with growth rates of 20 percent at FKTPs and 31 percent at FKRTLs²¹. Despite the dramatic increases in health care services, utilization is likely still below where it needs to be. In 2018, there were 1.7 outpatient visits per capita and 6,740 admissions per 100,000 population compared to the Organisation for Economic Co-operation and Development (OECD) averages of 6.4 and 15,010, respectively^{21,22}.

12. **As JKN coverage is relatively high, the challenge now is delivering quality care in a sustainable manner, especially in the aftermath of the COVID-19 pandemic.** Among the main gaps are inequalities in access and shortcomings in the services received. For example, almost all women receive at least one antenatal care (ANC) visit and 77 percent receive at least four. However, women with no education and those in the poorest households are 2.4 and 1.5 times less likely to receive all four compared with more educated and richer households. The story is similar for basic vaccinations, assisted deliveries, and postnatal care (Figure 1). Access to care also does not guarantee that patients will receive all intended services. For example, blood and urine tests—essential for the diagnosis of high-risk pregnancies— were done in only 47.6 percent and 38.7 percent of ANC visits, respectively. And less than half of the mothers received counseling on danger signs during postnatal care (Figure 2)²³. ANC, institutional deliveries, postnatal services, and basic immunizations have all been adversely affected by the pandemic and decreased by 7.5 percent, 6.1 percent, 10.8 percent, and 4.7 percent, respectively, between 2019 and 2020 with forgone care more likely among poorer households. Treatment for TB saw an even bigger drop of 28 percent during the same period⁵.

²⁰ BPS. 2020. "The National Socioeconomic Survey (SUSENAS)".

²¹ BPJS-K. 2018. "JKN Statistics Yearbook."

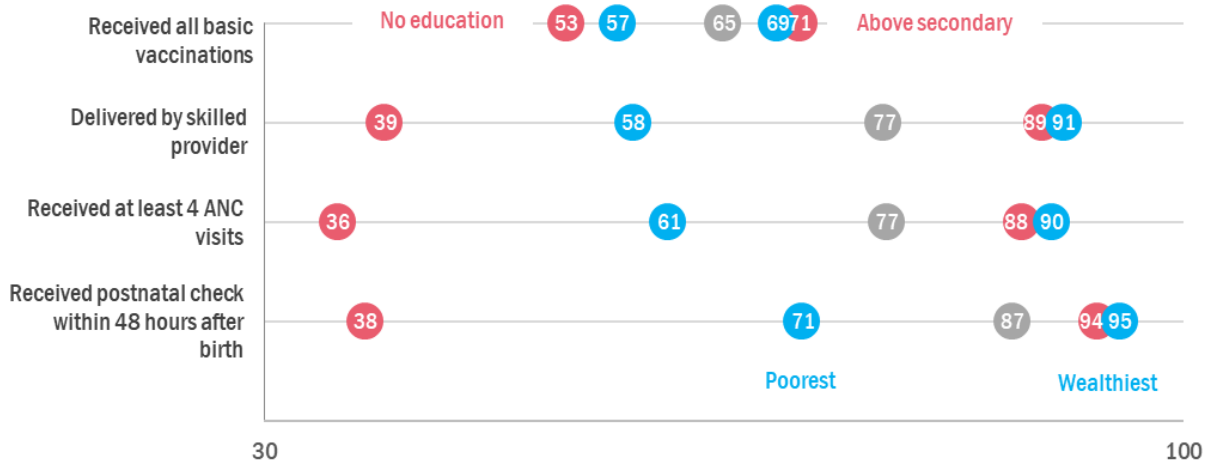
²² OECD. 2019. *OECD Statistics*. https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_PROC.

²³ BPS. 2017. *Indonesia Demographic and Health Survey*. Jakarta: National Population and Family Planning Board, Ministry of Health.



Figure 1. National Averages on Access to Key Services Mask Wide Variations by Socioeconomic Status.

Access to services (%) by mother's education and income (top and bottom quintiles)



Source: Indonesia Demographic and Health Survey 2017; Susenas 2017.

13. **The breakdown in service delivery happens early in the continuum of care as providers struggle to accurately diagnose and treat conditions.** Doctor’s knowledge of basic conditions is low. Of the over 700,000 active TB cases, more than one-quarter went undiagnosed and only one-third were successfully treated. A little over half of the active TB patients ever even initiate protocol-based treatment. Similarly, of the more than 11 million adults thought to have diabetes, only 21 percent were diagnosed and only 7 percent had their diabetes under control. Even more worrisome is that diabetes knowledge among primary health care providers in Indonesia decreased from an already low level between 2007 and 2014²⁴. There are even greater concerns about the pre-service and in-service training for pregnancy care (Figure 2)¹³. A study of 11 Indonesian hospitals found that 90 percent of maternal deaths were preventable²⁵. COVID-19 also highlighted gaps in Indonesia’s surveillance preparedness. According to the 2019 Global Health Security assessment, Indonesia did not show evidence of conducting ongoing event-based surveillance and analysis for infectious disease nor did it collect ongoing or real-time laboratory data, limiting its ability to carry out contact tracing and treat positive COVID-19 cases.

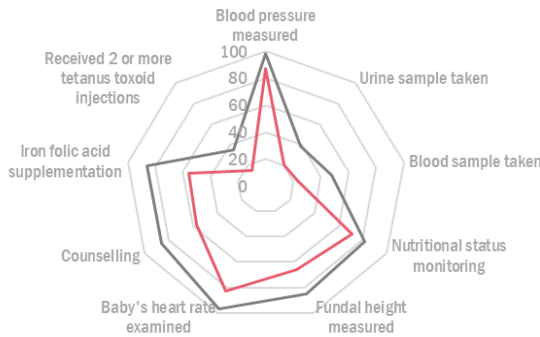
²⁴ Stein, Dorit T, Nikkil Sudharsanan, Shita Dewi, Jennifer Manne-Goehler, Firman Witoelar, and Pascal Geldsetzer. 2020. "Change in clinical knowledge of diabetes among primary healthcare providers in Indonesia: repeated cross-sectional survey of 5105 primary healthcare facilities." *BMJ Open Diabetes Research & Care*.

²⁵ Baharudding, M, D Amelia, S Suhowatsky, A Kusuma, M Suhargono, and B Eng. 2019. "Maternal deaths reviews: a retrospective case series of 90 hospital-based maternal deaths in 11 hospitals in Indonesia." *International Journal of Gynecology and Obstetrics* 144, 59-64.

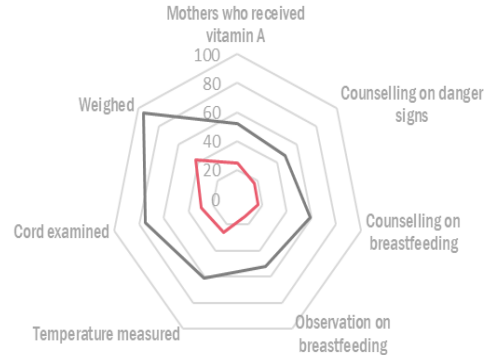


Figure 2. Mothers and Newborns Do Not Receive All Intended Interventions during Visits, especially among Women with No Education

Antenatal care content for pregnant mothers, national average vs mothers with no education (%), 2017



Postnatal care content for newborns, national average vs mothers with no education (%), 2017



Source: Indonesia Demographic and Health Survey 2017.

14. **Beyond improving coverage and access to quality health services, UHC is also dependent upon JKN’s financial sustainability.** BPJS-K has incurred a deficit in nearly every year since its inception—IDR 31.5 trillion (around US\$2.2 billion) cumulatively as of end of May 2020—threatening the financial sustainability of the scheme. JKN’s claims ratio regularly exceeds 100 percent, indicating inefficiencies in how its expenditure aspects are designed and managed (Table 1). For instance,

- (a) JKN offers a nearly unlimited benefit package that is not aligned with available resources;
- (b) Input-based financing at FKTPs does not reflect need, absorptive capacity, or the service readiness of primary care facilities;
- (c) Open-ended hospital expenditures and unrepresentative cost data incentivize volume and gaming over quality or efficiency; and
- (d) Weak or missing health information systems hinder informed decision-making, especially for assessing the appropriateness of care, evaluating the need for referrals and/or hospitalizations, verifying claims, and detecting fraud—leading to significant waste and inefficiency.

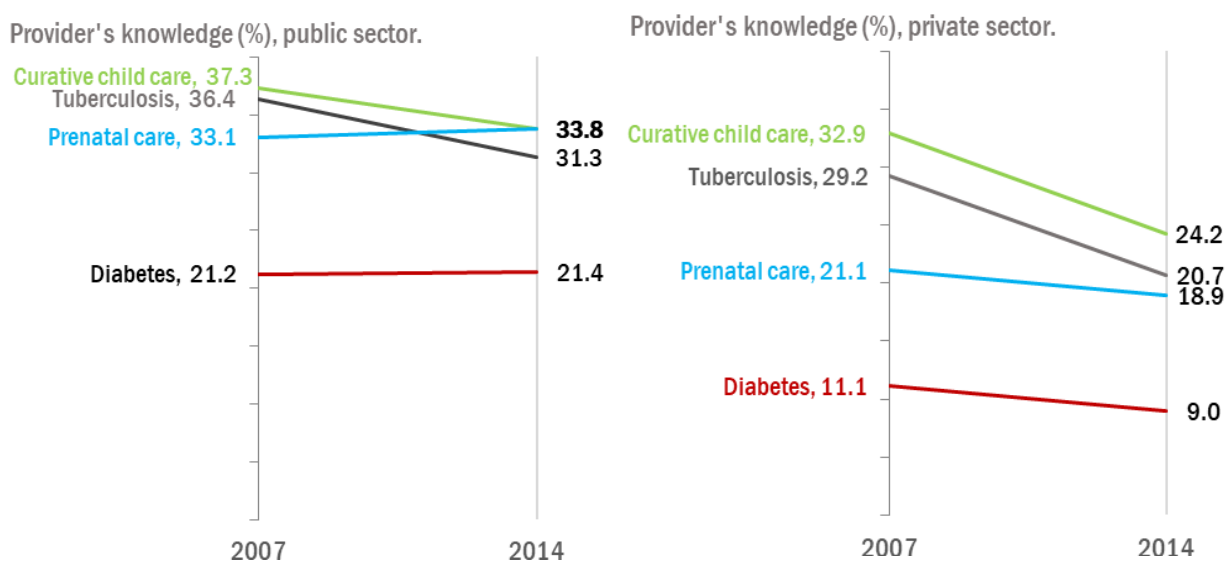
15. While BPJS-K ended 2020 with no deficit, this is expected to be temporary for two reasons. The GOI increased premiums by 65–110 percent depending on the membership group and class²⁶ selected. The premium increase, effective in 2020, offset the loss of revenue from those who lost coverage or were no longer able to pay their premiums because of reduced or lost income from COVID-19. At the same time, COVID-19 also led to decreased utilization of health care services and expenditures. However, in the medium to long term, this will likely lead to higher health care costs for the system from the delayed detection of illness and increased case severity and cost of treatment. The persistence of the COVID-19

²⁶ There are three classes of care that differ primarily on amenities (for example, number of beds per room and air conditioning), with Class 3 being the most basic.



challenge will further add to the health sector’s costs as it may become endemic and part of the overall health burden.

Figure 3. Doctor’s Knowledge of Basic Health Conditions Is Low and Decreasing



Source: Indonesia Family Life Survey 2007 and 2014.

Note: Provider knowledge is measured as the percentage of medical history questions asked, laboratory tests/exams recommended, and treatment suggested by the provider most likely to treat the tracer condition based on a list of items deemed essential for responding to each clinical vignette scenario.

Table 1. JKN Has Incurred a Deficit in Nearly Every Year since Its Inception

IDR, trillions	2014	2015	2016	2017	2018	2019	Total
Premium revenue	40.7	52.7	67.4	74.2	82.0	106.0	423.0
Medical expenses	42.7	57.1	67.2	84.4	94.3	108.7	454.4
Deficit	-2.0	-4.4	0.2	-10.2	-12.3	-2.7	-31.4

Source: BPJS-K Monthly Report December 31, 2019.

Challenges to Quality Care

16. While there are many interventions to improve the quality-of-service delivery, in Indonesia, the most pressing shortcomings concern (a) clinical care interventions, (b) performance-based financing, and (c) quality monitoring information systems.

- (a) **The sector’s predominant strategy for improving the competence of health workers has been the provision of clinical guidance.** However, this has not been very effective. At the primary care level,



the MoH²⁷ has consolidated the plethora of clinical guidelines into an overwhelming manual (~500 pages) for doctors. However, dissemination and knowledge of its existence at the frontlines are lacking. The guideline is also disease-based—assuming all doctors are already able to diagnose patients. It treats each condition in silos and does not account for patients with comorbidities. Finally, conditions do not have clear algorithms that provide an integrated approach to screening, diagnosing, and treating common symptoms. At the hospital level, clinical care pathways are not mandatory for every guideline, only high-cost, high-volume conditions.

- (b) **In 2016, a performance-based component to capitation payments (known as *Kapitasi Berbasis Komitmen* or KBK) was introduced at the primary care level; however, quality is weakly incentivized.** Capitation payments could be deducted up to 10 percent if targets on three performance indicators were not met. Initially, indicators focused on utilization (for example, contact rate and rate of visit of chronic disease patients) and referral rates. In 2020, KBK was revised to include quality measures. However, the changes were modest. While the chronic disease visit rate was replaced with two quality measures on diabetes and hypertension control, the weight of these indicators is small. The KBK capitation received is still determined predominantly by achieving referral and contact rate targets.
- (c) **There is no systematic standardized mechanism to collect and report on quality.** While there are several nationwide surveys that cover service quality such as the Basic Health Survey (*Riset Kesehatan Dasar*) and the Health Care Facility Census (*Riset Fasilitas Kesehatan*), they are carried out every 5 and 8 years, respectively. Assessment of service quality and patient safety is mostly conducted by researchers in educational institutions or by donor organizations. However, findings are not adequately used in decision-making and have not demonstrated improvements in national health care quality²⁸. Real-time performance data on quality indicators remain limited²⁹.

17. **Indonesia’s rapid rollout of JKN left many questions about the finer details of implementation unanswered, such as who is responsible for quality of care.** A functional and regulatory review of the MoH and BPJS-K revealed duplication in the responsibility for provider monitoring and quality assurance, with ultimate authority over the function residing with the MoH but the data required for adequate provider monitoring under the control of BPJS-K. In the absence of an existing quality monitoring system, BPJS-K’s claims system provides the most immediate solution but a routine monitoring system with a standard set of indicators analyzed and reported regularly has not yet been put in place¹².

Challenges to JKN’s Sustainability

18. **JKN offers a nearly unlimited benefit package that is not aligned with available resources.** JKN’s benefit package covers all medically necessary treatment with no caps or copayments at the point of service. Actuarial estimates have suggested that the scheme is currently under-resourced for the generous

²⁷ According to Ministerial decree No. 1438/2010, it is the responsibility of health professional organizations to develop clinical guidelines, which are then endorsed by the MOH. Out of more than 500 conditions, guidelines for only 44 have been completed at the national level, and dissemination down to the facility level has been limited. Professional organizations have drafted an additional ~250 clinical guidelines but they are yet to be endorsed.

²⁸ UGM and MOH. 2019. *National Quality Policy and Strategy (NQPS)*. Jakarta: Center for Health Policy and Management and The Directorate of Healthcare Quality and Accreditation.

²⁹ Asia Pacific Observatory on Health Systems. 2017. *The Republic of Indonesia Health System Review*. New Delhi: WHO.



benefits it provides³⁰. As a result, FKTPs often lack basic diagnostic tests, essential medicines, and diagnostic and treatment guidelines, especially among the private sector where it is estimated more than 50 percent of health care takes place.

19. **Input-based financing does not reflect need, absorptive capacity, or the service readiness of FKTPs, nor does it create incentives to improve their performance.** Primary health care is paid by capitation³¹—a fixed per capita budget covering 144 competencies or services that FKTPs are meant to perform. Normally, the capitation amount is based on the average expected health care utilization of patients, generally varying by age, gender, and health status. However, the average patient cost was never assessed nor was the FKTP package based on whether facilities could actually provide all services. Instead, the amount an FKTP receives from BPJS-K is based on the number and type of providers and the number of beneficiaries assigned to facilities—an input-based formula—without any adjustment for geography, age, sex, or other indicators of health need. This reinforces existing imbalances in provider and beneficiary distribution. It also leads to provider over-referrals and patients seeking care at higher-level, better-resourced, and more expensive facilities, adding to JKN’s costs. The input-based capitation formula also does not consider the absorptive capacity of facilities, accentuated by limited autonomy and capacity in public financial management.

20. **Open-ended hospital expenditures incentivize volume over quality or efficiency.** Hospitals are reimbursed based on diagnosis-related groups (DRGs, known locally as INACBGs [Indonesia Case Base Groups]). Normally, in DRG-based systems, the payment rate is set prospectively based on average cost (or the cost of the best performing hospital); the provider is meant to bear some of the financial risk if the cost of treatment for a given case exceeds the payment rate for that case, which is expected to be compensated and balanced out by other cases that need lesser resources. Of critical importance is the presence of a budget and/or volume ceiling, but in Indonesia, payment to hospitals is essentially open-ended, shifting the burden to BPJS-K as hospitals get reimbursed for all or most of their claims. This encourages unnecessary or inappropriate care and removes any incentive to manage resources more efficiently.

21. **While DRGs are generally considered the most efficient provider payment method for hospitals, they are complex to administer—requiring substantial coding and costing expertise, strong data systems, and active oversight.** The two main design characteristics of a DRG-based payment system are the patient classification system (that is, how diagnoses are grouped into cases of similar clinical aspect and resource use) and the payments associated with each DRG. This requires detailed data on hospital activity (for example, diagnosis, tests, and services provided) and cost data for each admission. But poor documentation by providers, a lack of clear coding guidelines, and the low competence of clinical coders lead to the wrong DRG being assigned. On one hand, underreporting the care received during a hospital admission or not listing a secondary diagnosis (known as downcoding) can result in the loss of significant revenue for hospitals. On the other hand, clinical coders may face pressure from doctors or hospital administrators to report complex diagnoses, services, or procedures that command higher reimbursement rates (known as upcoding). Both downcoding and upcoding also have implications for

³⁰ Gerard, Y, M Wiener, C Rokx, G Schieber, P Harimurti, E Pambudi, and A Tandon. 2011. *Actuarial costing of universal health insurance coverage in Indonesia*. Washington, DC: World Bank .

³¹ Capitation does not cover the full cost of care. In the public sector, capitation is complemented by significant financing and in-kind support from central and subnational governments (e.g., DAK).

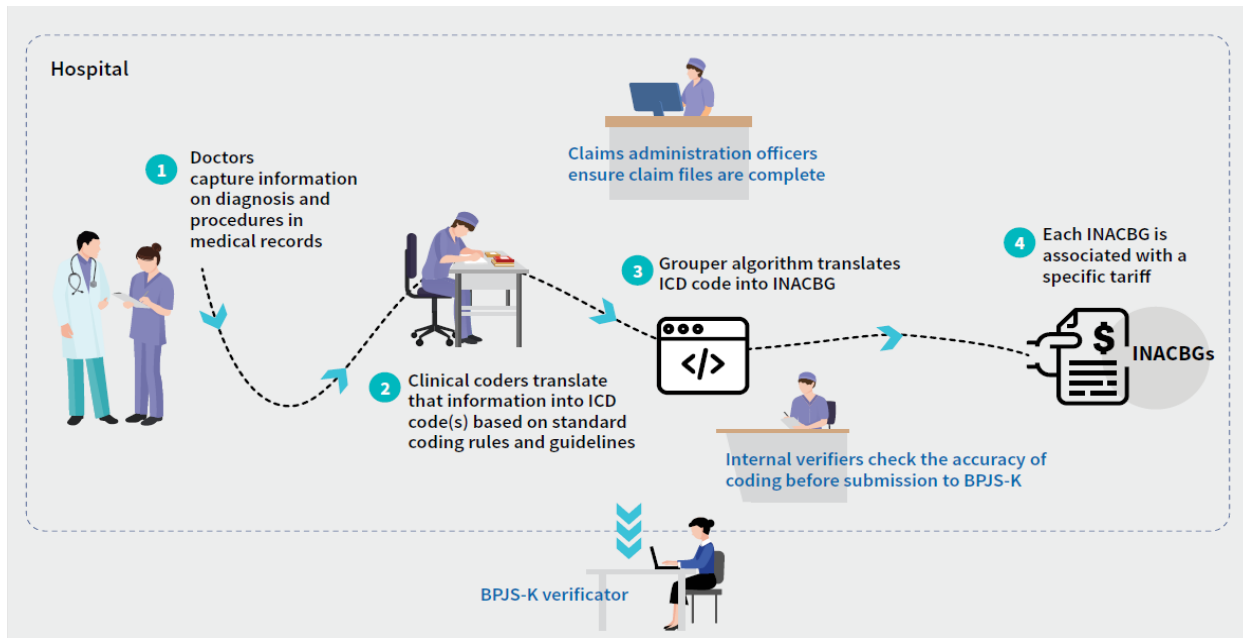


patient safety and continuity of care, especially when the care received (or required) is not accurately reported in a patient’s medical record for future or follow-up visits.

22. **Strong coding and data systems are especially vital for assessing the appropriateness of care and evaluating the need for referrals and/or hospitalizations (Figure 4 and Figure 5).** In 2019, hospital expenditures accounted for 84 percent of all JKN expenditures even though they made up less than one-quarter of all visits. Outpatient hospital visits in particular may present an opportunity to redirect health-seeking behavior. Improving the quality of care at primary care facilities together with the enabling information and referral systems and gatekeeping environment could help push some of these visits down to FKTPs—reducing hospital overcrowding and expenditures.

23. **The DRG tariff structure is also based on unrepresentative cost data, which may further encourage gaming and inefficiency.** The costing template is not detailed enough to get accurate estimates of unit cost. Filling out the templates is also not based on a representative sample of public and private hospitals. When the cost data are inaccurate or unfair, it may incentivize providers to underprovide services or upcode. Tariffs also have several adjustments for hospital type, region, and JKN membership class, but none of these adjustments were costed and the tariffs do not reflect the cost of actually delivering care. Good quality data on costs and resource use at hospitals are vital to regularly updating DRG tariffs so that any unintended distortions can be corrected.

Figure 4. Accuracy of Clinical Coding Is Essential for Assigning the Correct Payment

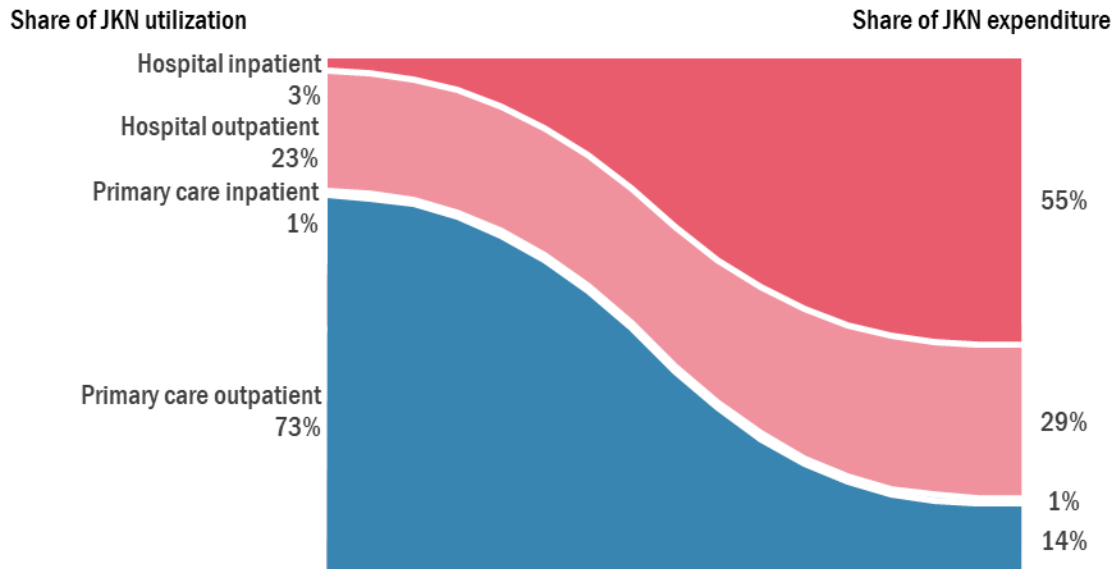


Note: ICD = International Classification of Diseases; Blue text indicates quality assurance measures.



Figure 5. Only One-Quarter of JKN Visits Take Place at the Hospital Level, but They Account for 84 percent of Spending

JKN utilization and expenditure by place of visit, %, 2019.



Source: JKN statistics Yearbook 2018 and BPJS-K Monthly Report December 31.

24. **Finally, weak or missing health information systems hinder informed decision-making, especially for verifying claims, leading to significant waste and inefficiency particularly in a decentralized context.** The lack of standardized reporting and accounting formats, the low prevalence of electronic health records, unreliable internet connectivity, and poor reporting compliance make claims verification a laborious and time-consuming process. While BPJS-K is conducting basic claims checks and verification, there is significant room for improvement. Most interventions, listed under the JKN benefit package, do not have clinical diagnostic and treatment protocols or referral pathways, making it difficult for BPJS-K to assess quality and hold providers accountable. Claims management is further constrained because claims data cannot connect to other sources of information (for example, electronic health records; prescription information; results of labs and procedures; and licensing, accreditation status, and service availability of providers/facilities) to support its efforts to verify claims.

Government Initiatives

25. **The GOI has introduced policies to help narrow BPJS-K's budget deficit (Presidential Regulations 82/2018, 75/2019, and 64/2020), but these changes focus mostly on increasing revenue, not managing expenditure growth.** First, part of the cigarette levy will be earmarked for JKN to help local governments expand coverage. Second, cost sharing will be introduced for health services prone to moral hazard and abuse. However, while modest cost sharing may be appropriate for high-cost/low-effectiveness services, it is considered a blunt cost-control instrument, reducing both necessary and unnecessary utilization, particularly for the poor and vulnerable. International evidence also suggests that it is unlikely to contribute significantly to revenue. Third, the GOI dramatically increased premiums for all membership groups leading to an increase in revenue but also a drop in coverage. In the wake of COVID-19, the MoF has considered exploring the feasibility of extending premium subsidies to the informal sector. However,



it is reluctant to do so without commitment from the health sector to also manage expenditure growth and address the inefficiencies highlighted above.

26. **While systemic reforms around governance and accountability, health financing, and service delivery are mentioned in several of the sector’s strategic documents, the GOI has struggled to operationalize their contents.** The GOI’s National Mid-Term Development Plan or *Rencana Pembangunan Jangka Menengah Nasional (RPJMN)* (2020–24), the MoH’s Strategic Plan or *Rencana Strategis (Renstra)* (2020–24), and the draft National Security System Roadmap (2020–24) cite improving governance and accountability; strengthening strategic purchasing arrangements; enhancing the system’s monitoring, evaluation, and fraud detection systems; and accelerating the integration of the sector’s information systems, among others. Strengthening purchasing arrangements such as selecting the benefit package, setting provider payment rates, choosing provider payment methods, negotiating contract terms, and monitoring the quality of care are complex reforms involving many different stakeholders. Provider payment reform and the integration of health information systems in particular take on average 7–10 years in resource-constrained and low-capacity settings.

27. **For this reason, the PforR focuses on institutional and capacity strengthening activities to support the GOI in establishing essential processes needed to enable improvements in the quality of care and efficiency of service delivery.** The design of this PforR focuses purposefully on strengthening the nuts and bolts of JKN implementation as core institutional processes were overlooked when JKN was rapidly rolled out. Such processes included (a) a holistic payment regime with incentives that ‘push’ utilization down to the primary health care level; (b) a primary care system that is ready and able to deliver quality care for the services it is meant to provide; and (c) an information system to be able to track patient referrals, monitor appropriateness of care, and identify errors, waste, and/or fraud in service delivery.

C. Relationship to the CPS/CPF and Rationale for Use of Instrument

28. **The proposed operation is in line with the World Bank Group’s Country Partnership Framework (CPF) FY2021–2025³² for Indonesia (Report No. 157221-ID), as well as its broader strategic objectives.** The proposed PforR is aligned with the CPF’s third engagement area to nurture human capital. In particular, CPF objective 3.2 aims to strengthen the quality and equity of health services, and objective 3.3 focuses on inclusiveness and responsiveness of social and worker protection. JKN is essential to both objectives—building human capital among the poor and vulnerable and incentivizing their use of health, nutrition, and other services. The operation also promotes the Health, Nutrition, and Population Global Practice’s strategy to support countries in their progress toward UHC and the World Bank’s overarching strategic priorities to end extreme poverty and boost shared prosperity.

29. **The operation is designed as a PforR as it responds to client demand and focuses on results—building institutional capacity for improved health service delivery and outcomes.** As JKN is one of the largest health sector programs in Indonesia in terms of financing, the MoF requested a PforR as the optimal instrument to leverage the GOI’s overall JKN reform agenda. The PforR focuses on systematic, behavioral, and institutional changes needed to improve quality in service delivery and enhance the sustainability of JKN. As disbursements are linked to the achievement of priority reform areas, the PforR

³² World Bank Group. 2021. *Indonesia - Country Partnership Framework for the Period FY21 - FY25*. Washington, DC: <https://imagebank2.worldbank.org/search/33068329>.



offers added assurance and accountability that tangible results will be achieved. The GOI will also benefit from complementary capacity building and institutional strengthening activities that will be provided as in-kind technical assistance. The World Bank, with its global knowledge on health financing and UHC and its technical expertise in the design and implementation of health insurance and provider payment reforms, is well positioned to play a catalytic role as a trusted partner and ally to the GOI. Finally, the PforR provides an opportunity to improve coordination among other development partners involved in the sector.

II. PROGRAM DESCRIPTION

A. Government Program

30. **The PforR is fully aligned with the Government’s strategic objectives in the health sector, as relevant to the JKN program.** This includes improving the quality of primary care, referral services, and disease prevention; improving governance and accountability; strengthening strategic purchasing including redefining the benefit package; accelerating the integration of information systems; reducing health system inefficiencies; and improving overall patient satisfaction. However, the PforR does not directly support revenue-raising activities and coverage expansion as these are supported by technical assistance and potentially other lending instruments (for example, the human capital Development Policy Loan and the social protection digital identification PforR). Figure 6 summarizes the GOI’s JKN program and specifies the areas that are supported by this PforR. Box 2 and Box 3 in this document provide an overview of the JKN program and its key stakeholder agencies, respectively.

31. **The Government program expenditure for the entire JKN program amounts to US\$41 billion over five years.** This includes the entire budget from four key stakeholders—the MoH, BPJS-K, DJSN, and the MoF. However, the Program boundary supported by this PforR is estimated at US\$18.75 billion over the next five years.

32. **An important distinction between the Government program and the Program boundary is that the Program only includes the MoH’s premium contributions for covering the poor and the near poor beneficiaries under JKN.** It excludes all other financing sources for JKN, the largest among which are the premium contributions from the employers and employees in the formal sector. Other financing sources for JKN, not included in the Program boundary, include contributions from the subnational governments and premium payments made by informal sector workers. The downstream claims payments made by BPJS-K, as the end use of all the premium collected under JKN, are also not included in the Program boundary. All the administrative costs incurred by the relevant units in the MoF, the MoH, BPJS-K, and DJSN are included in the Government program as well as in the Program boundary as summarized below. The US\$400 million World Bank contribution, implemented as a PforR, represents 2.1 percent as a share of the Program boundary (Table 2).

33. **The beneficiaries of the system strengthening dimensions of the Program are the implementing agencies (IAs)—the MoH, BPJS-K, DJSN, and the MoF—and frontline health providers; however, the resulting improvements in the quality of care will be felt by all JKN beneficiaries, especially the poor and the near poor households who make up 60 percent of JKN beneficiaries.**



34. The Program boundary comprises discrete budget lines that have been detailed in the Technical Assessment and summarized in annex 3. The items included in the Program boundary are summarized below:

- (a) **MoH.** Accounting for over 90 percent of the Program boundary, the budget lines for the MoH include those pertaining to the Center for Health Financing and Health Insurance to pay the JKN premium contribution for PBI beneficiaries (comprising the poor and the near poor), as also for their role in carrying out health technology assessments (HTAs) (Disbursement-Linked Indicator [DLI] 3), improving the design and implementation of provider payments (DLIs 6 and 7), and supporting *Pusdatin* and the Digital Transformation Office in the MoH for their contributions to the DLI on strengthening information systems (DLI 5). They also include the budget from the MoH’s Directorate for Health Services for improving the quality of care and clinical pathways for primary health centers and referral hospitals (DLIs 1 and 2).
- (b) **BPJS-K.** The Program boundary includes BPJS-K’s budget lines for its own administrative costs, primarily on account of HR and operational costs, which are included in the Program boundary in respect of their central role in carrying out claims administration for JKN (DLI 4); the Program boundary for BPJS-K excludes the downstream payments made by BPJS-K to health facilities and also excludes any capital expenditure including construction-related expenditure. As more granular information on BPJS-K’s expenditure becomes available, the exact budget lines on administrative costs currently included in the Program boundary will be further streamlined to specifically cover the HR costs and operating costs of BPJS-K.
- (c) **MoF.** The Program boundary includes relevant line items from the MoF’s Fiscal Policy Agency, Directorate of General Budget, and Directorate of General Financing and Risk Management for the overall coordination and support of JKN implementation (DLI 9).
- (d) **DJSN.** DJSN’s budget for JKN policy implementation and coordination under the Coordinating Ministry for Human Development and Cultural Affairs (DLI 8) is included in the Program boundary.

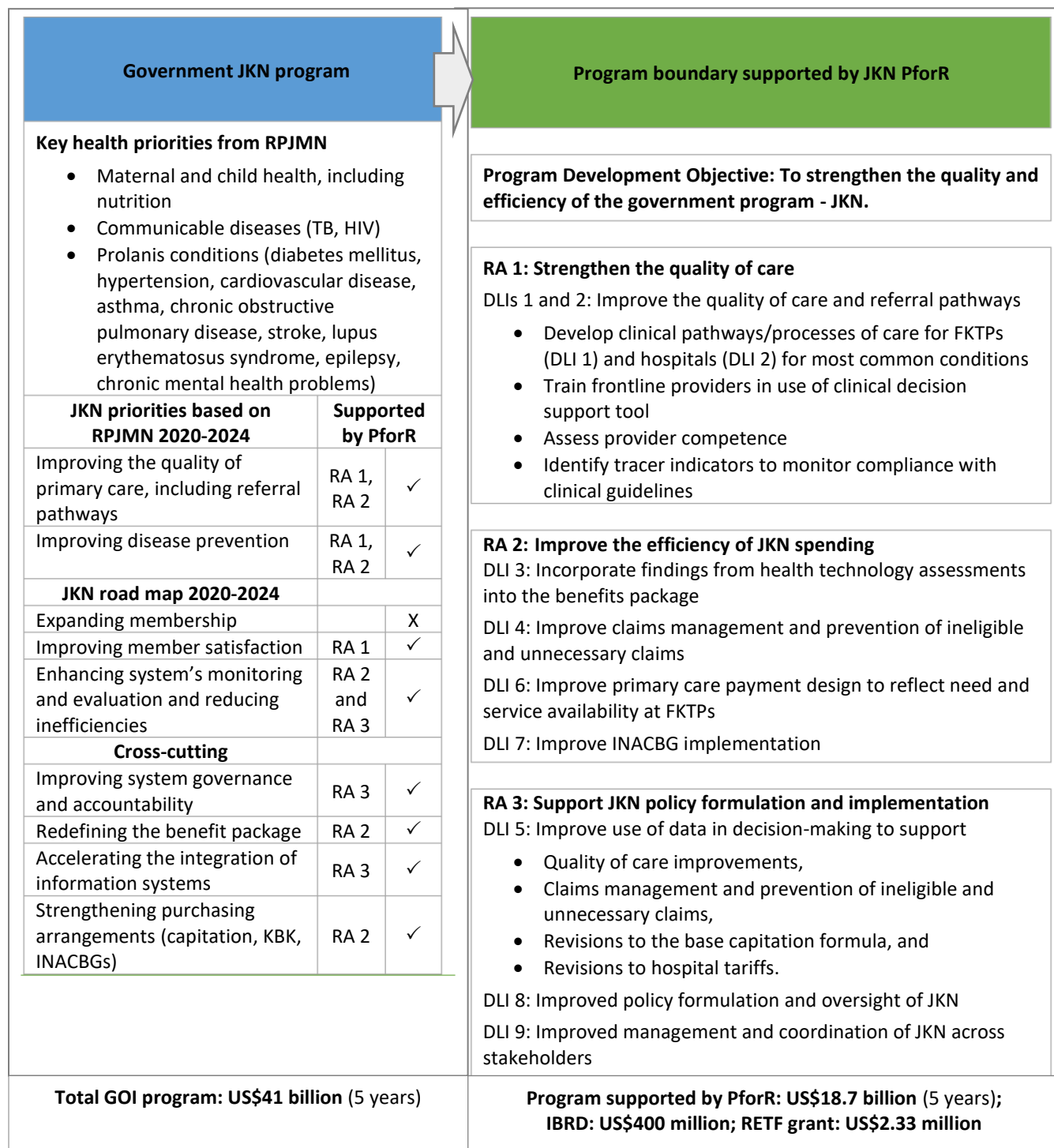
Table 2. Program Boundary for Five Years (2021–26) based on 2021 National Budget

		IDR, in thousands	US\$
Government program	Total MoH (include PBI)	245,274,962,590	17,211,070,282
	Total MoF	44,540,260	3,125,413
	Total <i>Kemenko PMK</i>	60,761,985	4,263,700
	Total BPJS (exclude PBI)	338,892,600,000	23,780,268,051
	Total 3 ministries and 1 agency	584,272,864,835	40,998,727,446
PforR Program boundary	Program boundary MoH	245,274,962,590	17,211,070,282
	Program boundary MoF	44,540,260	3,125,413
	Program boundary DJSN/ <i>Kemenko PMK</i>	60,761,985	4,263,700
	Program boundary BPJS-K	21,820,535,000	1,531,158,164
	Total boundary from 3 ministries and 1 agency	267,200,799,835	18,749,617,559
World Bank contribution	PforR World Bank		400,000,000
	PforR as share of program boundary		2.1%



Note: Kemenko PMK = Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan (Coordinating Ministry for Human Development and Cultural Affairs).

Figure 6. Government’s JKN Program in Relation to the PforR Program Boundaries





Note: RA = Results Area.

35. **All World Bank support is aligned with the development partners that are providing support to the implementation of the JKN program.** The development partners that have committed support to the Government include the following:

- (a) United States Agency for International Development (USAID) has provided around US\$15 million for five years to (i) strengthen the capacity of the key stakeholders, including civil society, to use evidence to improve efficiency; (ii) strengthen strategic health purchasing for priority health programs at the primary care level (in collaboration with the World Bank); and (iii) develop public-private partnerships in the health sector.
- (b) The Bill and Melinda Gates Foundation (BMGF) supports technical assistance on strategic health purchasing for primary health care; in addition, it has partnered with the World Bank to co-finance complementary technical assistance accompanying this PforR through the Investment Project Financing (IPF) grant included in the design.
- (c) The World Health Organization (WHO) provides technical support and capacity building in health financing.
- (d) Indonesia is also one of the founding members of the Joint Learning Network for UHC and several implementation-related knowledge products and capacity-building events that are available to support the GOI.

B. Results Logic

36. **The proposed PforR focuses on reforms to improve the quality and efficiency of JKN.** Activities are organized around three RAs. RA 1 aims to strengthen the quality of care. RA 2 aims to improve the efficiency of JKN spending. RA 3 is cross-cutting and aims to support JKN policy formulation and implementation. Table 3 describes the results logic and how activities help address identified challenges around the quality of care and inefficiencies in service delivery.



Table 3. Results Logic

Challenges	Activities	Outputs	Outcomes
RA 1: Strengthening the quality of care			
<ul style="list-style-type: none"> Providers unable to diagnose common conditions (for example, diabetes, hypertension, high-risk pregnancies) Clinical standards, pathways, and protocols not available at frontline facilities 	<ul style="list-style-type: none"> Draft clinical pathways/processes of care for most common conditions. Identify tracer indicators to monitor compliance with clinical pathways/processes of care. Train providers in the use of clinical decision support tool. Assess provider competence. 	<ul style="list-style-type: none"> The MoH has developed a clinical decision support tool for FKTPs (DLI 1). The MoH has trained FKTP workers in the use of clinical decision support tool (DLI 1). The MoH has developed hospital clinical pathways for 20 conditions (DLI 2). 	<ul style="list-style-type: none"> Improved patient satisfaction (PDO) Improved provider competence in primary care based on pre/post assessment (PDO) Increase in the % of ANC visits in line with clinical protocols (for example, that carry out blood and urine tests) (IO) Increase in the % of adults who have been screened for diabetes and hypertension according to clinical protocols (IO) Increase in the % of outpatient utilization among the bottom two quintiles (PDO)
RA 2: Improving the efficiency of JKN spending			
<ul style="list-style-type: none"> Benefits are not aligned with available resources. FKTPs are not able to deliver all benefits listed in the FKTP benefit package. HTA findings are not always incorporated into the benefits package and disseminated to the public. 	<ul style="list-style-type: none"> Review basic benefits package. Establish explicit criteria for benefit package inclusion/exclusion. Establish explicit criteria for selecting HTAs. 	<ul style="list-style-type: none"> The MoH has published revised HTA guidelines (DLI 3). Number of HTA studies are in accordance with revised guidelines and findings are disseminated to the public (DLI 3). At least 5 HTA studies have informed revision of the benefit package (DLI 3). 	<ul style="list-style-type: none"> An explicitly defined benefit package Improved JKN claims ratio (PDO) JKN beneficiaries more informed of their entitlements and changes to benefit package



Challenges	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> • Input-based capitation formula does not reflect need, absorptive capacity, or service readiness of FKTPs. • Existing capitation formula reinforces existing imbalances in HR and financing. • Quality is weakly incentivized in existing KBK scheme. 	<ul style="list-style-type: none"> • Review historical utilization patterns and allocation and use of capitation at FKTPs. • Develop a road map to improve the design and implementation of capitation. 	<ul style="list-style-type: none"> • The MoH and BPJS-K have jointly developed and adopted a road map for revising capitation design (DLI 6). • Number of additional quality indicators are included in KBK scheme (DLI 6). • Number of FKTPs implementing capitation changes are according to road map (DLI 6). 	<ul style="list-style-type: none"> • Capitation allocations more in line with FKTP member risk profile • Reduced undisbursed capitation • Increase in the % of outpatient utilization among bottom two quintiles (PDO) • Improved quality of care
<ul style="list-style-type: none"> • Poor documentation by providers, lack of clear coding guidelines, and the low competence of clinical coders lead to the wrong INACBGs being assigned. • The tariff structure is not representative and complicated encouraging gaming and inefficiencies. 	<ul style="list-style-type: none"> • Revise clinical coding guidelines. • Develop clinical coding training course and certification process. • Develop standardized cost accounting template. • Assess utilization and expenditure at hospitals by age, gender, diagnosis, and INACBG. • Revise the INACBG tariff. 	<ul style="list-style-type: none"> • The MoH has developed clinical coding guidelines and audit protocol (DLI 7). • The MoH has supported the development of a clinical coding training course (DLI 7). • At least 1 certified clinical coder is available in each hospital (DLI 7). • Number of hospitals is randomly assessed for coding accuracy (DLI 7). • The MoH has developed a standardized cost accounting template (DLI 7). • The MoH has revised INACBG tariffs (DLI 7). 	<ul style="list-style-type: none"> • Increased accuracy of clinical coding • Improved monitoring of morbidity and health outcomes, including for climate change related conditions • Decrease in the % of hospital claims that are rejected/unverified (IO) • Increased savings from reductions in errors • Improved JKN claims ratio (PDO)



Challenges	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> Weak claims management and fraud prevention processes 	<ul style="list-style-type: none"> Draft claims, fraud, and audit investigation guidelines, including identifying tracer indicators to monitor claims performance. Revise, simplify, and/or automate claims investigation processes. Audit hospital claims. 	<ul style="list-style-type: none"> BPJS-K has revised claims, fraud, and audit investigation manuals/processes (DLI 4). Tracer indicators embedded and automated in claims verification software (DLI 4). Number of hospital claims subjected to detailed claims audit per year uses revised audit protocols (DLI 4). 	<ul style="list-style-type: none"> Reduction in unnecessary or inappropriate claims Increased compliance with protocol-base care (for example, % of adults screened for diabetes and hypertension and % of ANC visits in line with clinical protocols) (IO) Increased savings from improvements in claims management Improved JKN claims ratio (PDO)
RA 3: Supporting JKN policy formulation and implementation			
<ul style="list-style-type: none"> Fragmented information systems High reporting burden/low reporting compliance from frontline providers Weak or absent health management information system for decision-making 	<ul style="list-style-type: none"> Agree on list of essential data needs from all stakeholders. Review/simplify data collection and reporting processes. Develop a road map for data integration based on essential data needs and simplified processes. Mandate the submission of a simplified electronic medical resume form with all claim submissions. 	<ul style="list-style-type: none"> Road map for better data use for decision-making, including plan for data system integration, is developed (DLI 5). 	<ul style="list-style-type: none"> Number of information systems integrated according to road map (IO) Increased accuracy of clinical coding Improved compliance with protocol-based care Improved monitoring of morbidity and health trends Improved management of JKN
<ul style="list-style-type: none"> Lack of health insurance specific expertise in DJSN Lack of data sharing from key stakeholders to inform decision-making 	<ul style="list-style-type: none"> Agreement on list of essential data needed to inform JKN policy formulation Development of an internal and external dashboard on key JKN performance indicators Capacity building on key topics and analyses to assess JKN performance Production of an annual report to assess JKN performance 	<ul style="list-style-type: none"> DJSN has developed and is using a dashboard of key performance indicators from BPJS-K and other sources (DLI 8). DJSN has produced and published an annual performance report on JKN (DLI 8). 	<ul style="list-style-type: none"> Improved oversight of JKN implementation More informed policy formulation More informed public



Challenges	Activities	Outputs	Outcomes
<ul style="list-style-type: none"> Lack of coordination among JKN stakeholders 	<ul style="list-style-type: none"> Form technical working groups comprising focal points responsible for achieving DLIs. Track progress on Program Action Plan (PAP), DLIs, and results framework. Investigate and intervene to solve bottlenecks. Support implementation agencies to deliver results through additional budgets and/or hiring of additional technical staff. 	<ul style="list-style-type: none"> PforR Secretariat is strengthened with technical experts and consultants (DLI 9). PforR Secretariat compiles and analyzes JKN data and provides recommendations on the JKN-related objectives for the new RPJMN (DLI 9). 	<ul style="list-style-type: none"> Improved management and coordination across JKN stakeholders DLIs and program development objectives achieved

Note: PDO = Program Development Objective; IO = Intermediate Objective.

C. PforR Program Scope

Table 4. Program scope

	Government’s JKN Program	Program Supported by the PforR	Reasons for Nonalignment
Objective	Achieve financial protection, improve access to quality health services, strengthen health systems, and improve health outcomes.	Strengthen the quality and efficiency of the Government program - JKN.	The PforR is fully aligned with the Government program.
Duration	2014 onward	2021–26	The PforR supports a specific phase of the ongoing Government program.
Geographic coverage	Entire country	Entire country	The PforR is fully aligned with the Government program.
RA	RAs 1–3	RAs 1–3	The PforR is fully aligned with the Government program. However, the PforR does not directly support all Government areas such as revenue-raising activities and coverage expansion.
Overall financing	US\$41 billion	US\$18.7 billion	

37. **RA 1: Strengthening the quality of care.** Activities under this RA focus on (a) improving the clinical guidance at FKTPs and (b) improving the quality of care at FKRTLs.

(a) **Improving clinical guidance at FKTPs.** The aim is to develop an easy-to-use tool that supports the flow of clinical decision-making based on symptoms, syndromes, and risks. Clinical algorithms will



be developed to prompt health care providers to screen and manage patients according to a comprehensive and integrated list of primary care conditions. Training in the use of the clinical decision support tool will follow a cascade approach where master trainers at the national level will further train health care professionals at the provincial level as trainers, cascading down to the DHO and facility levels. While the primary purpose of the clinical decision support tool is to improve provider competence and quality of service delivery at the FKTPs, it will also help improve claims verification and quality monitoring by defining a standard of care for prioritized conditions and identifying tracer indicators to monitor compliance with protocol-based care.

- (b) **Improving the quality of care at FKRTLs.** Similar to the planned activities at the primary care level, this set of activities will entail prioritizing a minimum of 20 clinical conditions and translating their respective treatment guidelines into clinical pathways for hospitals. While quality monitoring is listed as the responsibility of the MoH, BPJS-K can use its financial leverage to help collect data on tracer indicators as part of its claim management system and monitor adherence to guidelines and protocol-based care, thereby helping improve the quality-of-service delivery at the referral hospital level as well.

38. The clinical decision support tools will be useful for all public and private providers in Indonesia—regardless of their involvement in JKN. To reinforce the use of standard treatment guidelines (STGs), tracer indicators to monitor compliance will be embedded into the JKN claims verification process and software (DLI 4) and potentially incentivized with performance-based capitation payments (DLI 6).

39. **RA 2: Improving efficiency.** Activities under this RA focus on (a) revising HTA guidelines and strengthening the production capacity for HTA guidance, (b) improving the design and implementation of capitation payments, (c) improving the design and implementation of DRGs, and (d) improving claims management and fraud prevention processes.

- (a) **Revising HTA guidelines.** Under the Program, the MoH is responsible for stewarding the HTA process. Through the DLIs included in the PforR, HTA guidelines will be revised to include explicit criteria for how conditions are selected and for inclusion and exclusion in the benefit package. This will also include a review of the basic benefit package to be provided at FKTPs. This will help ensure benefits are aligned with available resources and service readiness at different levels of care. Through the potential involvement of academic institutions in supporting HTA, the production capacity for HTA will also be augmented.
- (b) **Improving the design and implementation of capitation payments.** These activities will entail reviewing historical utilization patterns at primary health care facilities by age, gender, and diagnosis to better account for risk/need; the ability of primary health care facilities to deliver interventions listed in the benefit package; the historical allocation and use of capitation, including undisbursed capitation; and the performance of existing KBK indicators. Based on this, a road map will be developed, which will include reforms to the base per capita rate—that is, switching from an input-based per capita formula to a budget-neutral or risk-based design—and additional quality KBK indicators. The DLIs under the PforR will support the timely completion of the road map for capitation design reforms, as well as its implementation timeline, helping realize the potential JKN holds for incentivizing performance improvements in primary care.



- (c) **Improving the implementation of DRGs.** Activities in this area will focus on improving the quality of clinical coding and the representativeness of cost data, essential inputs to the formulation of DRG tariffs. This will entail developing clinical coding guidelines, including a clinical coding audit protocol; training clinical coders in hospitals and claims verifiers in BPJS-K; and carrying out coding audits on a sample of hospital claims. This will help improve the quality of clinical reporting data which underpins all of the information needed to monitor the quality of care, benchmark treatment and patient outcomes, target quality improvement interventions, and reduce hospital and provider variation. This might also require revising the existing cost accounting template to better inform the hospital tariff-setting process. The revised tariffs should consider the historical utilization patterns at hospitals by age, gender, diagnosis, and DRG, with particular focus on the most common/costly conditions, and historical cost data from hospitals based on standardized cost accounting template from a sample of public and private hospitals. Ideally, revising the DRG tariffs should also include a hard budget or ceiling as implementing a close-ended hospital payment has the greatest potential to curb expenditure growth as most JKN spending occurs in hospitals. While it is unlikely that the GOI would have introduced a global budget or cap to DRG hospital payments by the end of the PforR as such reforms take several years to design, pilot, and roll out, the intention of the operation is to introduce the preliminary activities needed to lead to such a change. The PforR also expects to see a substantive improvement in the implementation of DRGs through its strengthened cost and coding data and improved claims and fraud prevention processes. In addition, revising the DRG tariffs to more accurately reflect the cost structure of the private sector may incentivize the greater participation of private sector providers in JKN.
- (d) **Improving claims management and prevention of ineligible and unnecessary claims.** Activities under this area are led by BPJS-K and will focus on revising claims, processes for prevention of ineligible and unnecessary claims, fraud investigation, and claims audit manuals, including the identification of a list of trigger/red flag indicators and building capacity and skills to analyze claims data to identify errors, waste, and/or fraud. This might entail eventually requiring claims verifiers to pass and maintain certification in claims management. This will allow BPJS-K staff to better monitor performance on agreed claims management indicators and fraud detection indicators including carrying out claims audits on a sample of all hospitalized claims and on all triggered or flagged claims. Importantly, this activity will also embed and automate tracer indicators into its claims verification software to monitor compliance with protocol-based care developed by the MoH under its efforts to improve provider competence.

40. **RA 3: Supporting JKN policy formulation and implementation.** Activities under this RA focus on cross-cutting interventions that will affect the quality and efficiency of JKN implementation. These mainly center around improving the use of data from routine information systems, including strengthening these systems so that they are more fit for purpose to inform policy. This will entail the following:

- (a) **Revising/simplifying existing data intake and reporting processes** to ensure that the appropriate data are being produced for each stakeholder.
- (b) **Developing a road map for better data use for decision-making, including planning for data system integration and gradually moving toward the greater digitization and integration of information systems.** Digitization is essential to Indonesia's integration efforts and desire to carry out more advanced health care analytics (Figure 8). Linking primary health care and hospital claims data would allow tracking patient referrals and movement throughout the system. Links to electronic

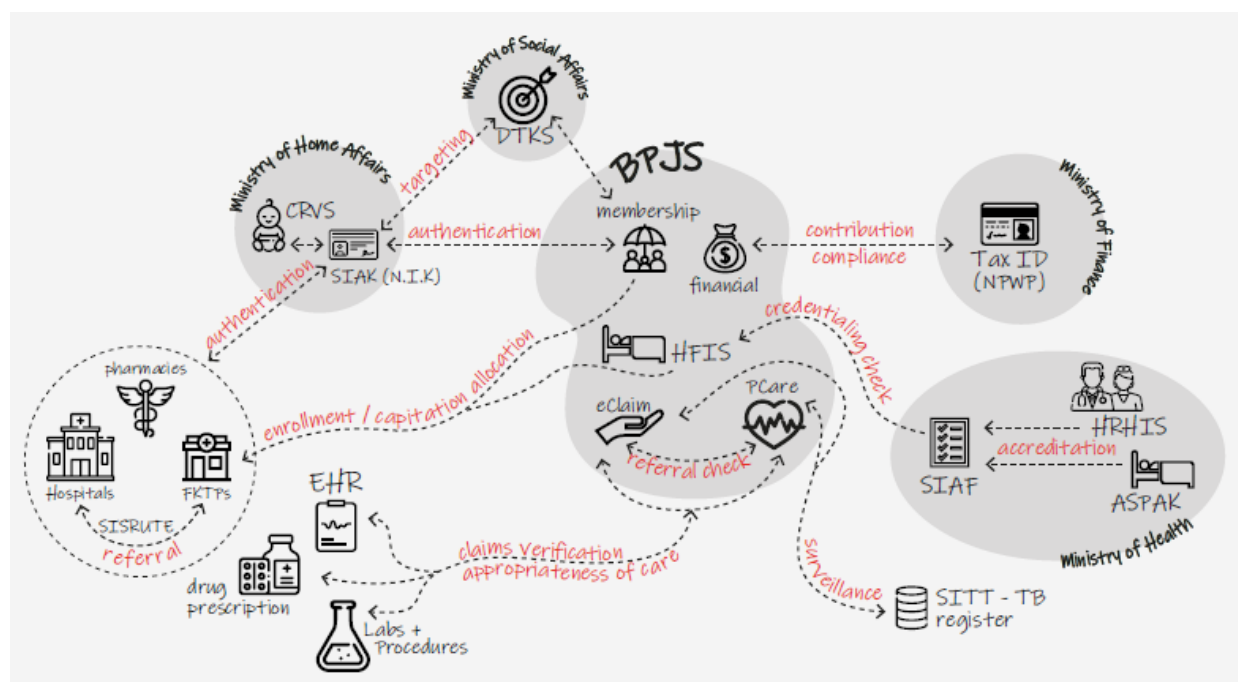


medical records (EMRs) would dramatically increase BPJS-K's ability to verify claims, ensure compliance with diagnostic and treatment guidelines, and identify opportunities for improved quality and efficiency. In the absence of widespread EMRs, introducing additional indicators to claims intake forms, requiring additional claims forms for certain conditions, or mandating the submission of medical resume forms would also work as it would enable checking adherence to guidelines and protocol-based care. Gradually connecting BPJS-K membership data to the Ministry of Social Affairs' targeting database (Integrated Social Welfare Data or *Data Terpadu Kesejahteraan Sosial* [DTKS]) or the MoF's tax database could support contribution compliance and membership eligibility. Likewise, links to the MoH's accreditation database (FKTP Accreditation Information System or *Sistem Informasi Akreditasi FKTP* [SIAF]) would help verify provider's credentials. The DLIs under the PforR provide for the creation of an integration road map and to thereafter assess progress based on this road map.

- (c) **Improving policy formulation and oversight of JKN.** This activity will work closely with DJSN, to oversee the performance of BPJS-K. It will agree on a list of key performance indicators. An internal and external dashboard will support policy formulation and inform the public externally for greater accountability. Capacity-building activities on key topics related to health insurance, health care analytics, and public accountability will also support the production of an annual report summarizing JKN performance.
- (d) **Improving overall management and coordination across JKN stakeholders.** The MoF will form a PforR Secretariat to support the overall implementation and smooth coordination of the multi-stakeholder Program. The DLIs also incentivize further augmented capacity and role of this secretariat to provide appropriate technical assistance for the IAs and build long-term capacity for better monitoring and evaluation of the Program and to provide evidence-based policy inputs into strategic plans such as the next medium-term strategic plan for the GOI.



Figure 7. The More Integrated and More Relevant Health Information Systems Are, the Greater Is the Ability to Inform JKN Policy



Note: ASPAK = facility equipment database; CRVS = civil registration and vital statistics database; EHR = electronic health records; HFIS = service availability database; HRHIS = HR database; NPWP = tax ID database; SIAK = National ID registry; SITT = TB database.

Table 4. Program Financing

Source	Amount (US\$, millions)	% of Total
GOI	18,350.00	97.90
Trust Funds	2.33 ³³	0.01
International Bank for Reconstruction and Development (IBRD)	400.00	2.10
Total Program Financing	18,752.33	

D. Program Development Objective(s) (PDO) and PDO Level Results Indicators

41. The Program Development Objective (PDO) is to strengthen the quality and efficiency of Indonesia’s National Health Insurance program. Achievement of the PDO will be measured by the following PDO-level results indicators:

- (a) Improved provider competency score in FKTPs (quality)

³³ This amount represents the total grant amount which will be received in several installments (US\$1.28 million; US\$0.52 million; 0.52 million). To date the first installment has already been received.



- (b) Improved member satisfaction rate and its continued use as a BPJS-K performance monitoring indicator (quality and citizen engagement)
- (c) Increase in the percent of outpatient utilization among bottom two quintiles (efficiency and equity)
- (d) More sustainable JKN claims ratio (efficiency).

E. Disbursement Linked Indicators and Verification Protocols

42. **DLIs are summarized by RA in Figure 9.** A more detailed description of the DLIs, targets, and verification procedures is included in the verification protocol in annex 2.

- DLIs 1 and 2 support improved quality of care through the MoH’s development and implementation of clinical pathways and processes of care that will prompt health care providers to screen and manage patients based on symptoms, syndromes, and risks. It includes training of frontline workers in the use of clinical decision support tools and assessment of provider competence. It will also identify tracer indicators to be embedded into BPJS-K’s claims management processes to monitor adherence to protocol-based care under DLI 4.
- DLI 3 aims to incorporate findings from HTAs in the benefits package. It will revise the HTA guidelines to transparently lay out the process, methodology, and assessment criteria for HTA studies. The primary purpose of HTAs is to help inform decision-making about the value of new and existing technologies. The revised HTA guidelines are expected to ensure (a) explicit criteria for how diagnostic and/or screening technologies, drug therapies, medical devices, and procedures are selected for evaluation; (b) the methodology for carrying out the HTA; (c) explicit criteria for decision-making; and (d) how findings will be used for informing the benefit package and the extent and form in which they will be disseminated to the public. The DLI also aims to increase the capacity of the MoH to produce HTA studies and also enhance the intended use of these findings so that they are reflected in the JKN benefits package, making it more evidence-based and sustainable.
- DLI 4 aims to improve BPJS-K’s claims verification processes. It requires claims verification and claims audit protocols to be regularly updated to reflect changes to the benefit package (DLI 3) and STGs (DLIs 1 and 2). It embeds and automates tracer indicators from DLIs 1 and 2 into BPJS-K’s claims verification software (DLI 4) to monitor compliance with protocol-based care. It also institutionalizes a minimum number of more detailed hospital claim reviews as part of its post-payment claims audit process. These provisions are expected to result in a cascading effect on the quality of care at health facilities, as well as better reporting of information for monitoring purposes.
- DLI 5 aims to improve the use of data in decision-making by providing a road map for data system integration. It supports the complementary digital transformation agenda needed to ensure improvements in quality monitoring and claims management. Here too, there are links with DLIs 1–4 in that tracer indicators identified under DLIs 1 and 2 and changes to the benefit package under DLI 3 are fed into the data collection process through existing information systems or new data collection processes. BPJS-K then draws on this data to facilitate its claims management function under DLI 4. The objective of the data integration road map is not to connect all data from every existing database; rather, it is expected to focus on key data sets that enable more value or insight from data and to connect the most important systems that enable such value-added analytics from the integration.



- DLI 6 aims to improve the design and implementation of primary health care payment methods. The MoH and BPJS-K will jointly develop a road map of proposed changes to the capitation and KBK scheme based on a review of historical utilization patterns at FKTPs by age, gender, and diagnosis; the ability of FKTPs to deliver interventions listed in the benefit package; the historical allocation and use of capitation, including undisbursed capitation; and the performance of existing Performance-Based Capitation Financing or *Pembiayaan Kapitasi Berbasis Kinerja* (PKBK) indicators. The road map is expected to devise alternative designs to the input-based capitation formula and inclusion of an additional number of quality indicators to the KBK scheme. It will also include a description of the sequencing and timeline for implementation changes.
- DLI 7 aims to improve the implementation of hospital payments. In particular, it focuses on improving the two key elements of Indonesia's DRGs. On the one hand, it will improve the accuracy of clinical coding by updating clinical coding guidelines and audit protocols, developing a training and certification process for clinical coders, ensuring all hospitals have at least one certified clinical coder, and institutionalizing a minimum number of hospital coding audits. On the other hand, it will develop and adopt a standardized cost accounting template and revise the DRG tariffs based on (a) a review of historical utilization patterns at FKRTLs by age, gender, diagnosis, and DRG and (b) a review of expenditure patterns at FKRTLs by age, gender, length of stay, diagnosis, and DRG.
- DLIs 6 and 7 are linked in the sense that together they incentivize patients and providers to treat primary care sensitive conditions at the FKTP level and only refer and treat more complicated conditions at the FKRTL level. Aligning the financial incentives of primary care and hospital payment methods aims to reinforce a primary care-centric model of service delivery.
- DLIs 8 and 9 focus on strengthening coordination across JKN stakeholders to improve policy formulation and oversight of JKN. DLI 8 will be led by DJSN, in its role to oversee the performance of BPJS-K and to report on JKN's overall performance. DJSN will finalize a list of key performance indicators. An internal and external dashboard will support policy formulation and inform the public externally for greater accountability. Thus, DLI 8 is also important in improving the demand-side information environment for JKN. Capacity-building activities on key topics related to health insurance, health care analytics, and public accountability will also support the production of an annual report summarizing JKN performance. DLI 9 builds upon the coordination mechanism (Secretariat) created at the MoF and enhances its role to provide technical expertise and capacity-building support to all the stakeholder teams involved in the design and implementation of JKN reforms. The DLI focuses on this pool of technical expertise being made available by this secretariat and the regular production of synthesized policy inputs.



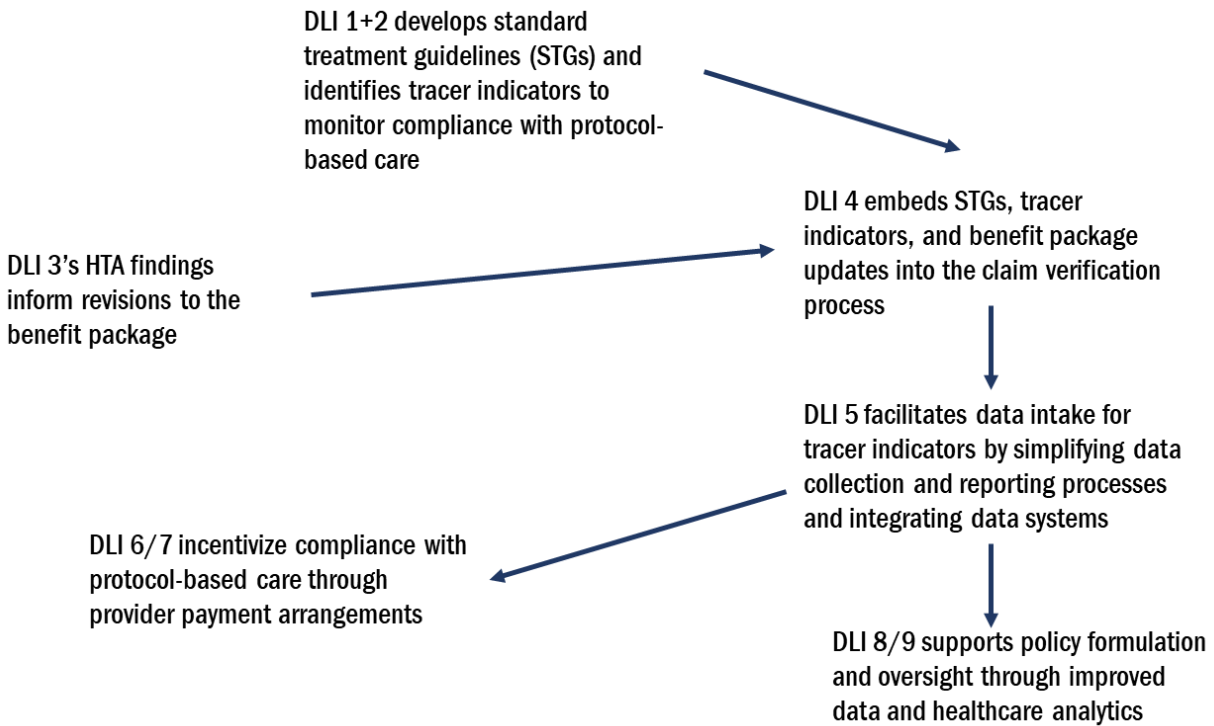
Figure 8. DLI Summary by RA

RESULTS AREA 1: STRENGTHEN THE QUALITY OF CARE	RESULTS AREA 2: IMPROVE EFFICIENCY	RESULTS AREA 3: SUPPORT JKN POLICY FORMULATION AND IMPLEMENTATION
<p>DLI 1+2 Improve quality of care and referral pathways</p> <ul style="list-style-type: none">- Develop clinical pathways/processes of care for FKTPs and hospitals for most common conditions- Train front line providers in use of clinical decision support tool- Identify tracer indicators to monitor compliance with clinical guidelines	<p>DLI 3 Incorporate findings from health technology assessments into the benefits package</p> <p>DLI 4 Improve claims management and prevention of ineligible and unnecessary claims</p> <p>DLI 6 Improve design and implementation of primary health care payment methods</p> <p>DLI 7 Improve INACBG implementation</p>	<p>DLI 5 Improve use of data in decision making to support:</p> <ul style="list-style-type: none">- quality of care improvements- claims management and prevention of ineligible and unnecessary claims- revisions to the base capitation formula- revisions to hospital tariffs <p>DLI 8 Improve policy formulation and oversight of JKN</p> <p>DLI 9 Improve management and coordination of JKN across stakeholders</p>

43. **All the DLIs reinforce each other in improving the quality and efficiency of service delivery.** For example, DLI 3’s HTA findings inform revisions to the benefit package. Any changes to the benefit package are updated in BPJS-K’s claims verification process under DLI 4. DLIs 1 and 2 develop STGs and identify tracer indicators to monitor compliance with protocol-based care. These are also embedded into BPJS-K’s claims verification process under DLI 4. DLI 5 facilitates compliance with STGs and eligibility of services by ensuring data on tracer indicators, and benefit package entitlements are collected in simplified reporting processes and integrated data systems. DLIs 4 and 5 are also needed to support DLIs 6 and 7 that incentivize compliance with protocol-based care through provider payment incentives. Finally, DLI 5 supports policy formulation and oversight under DLIs 8 and 9 through improved data and health care analytics (Figure 9).



Figure 9. DLIs Reinforce Quality and Efficiency through Financial (Provider Payment Incentives) and Non-Financial (Monitoring) Means



III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

44. **The IAs for this PforR include the MoH, the MoF, BPJS-K, and DJSN.** This operation includes a PforR as well as a grant-funded IPF. The MoF will be the lead executing agency for the proposed PforR, as well as the IA for the IPF, and as the coordinating ministry, it will convene a high-level Steering Committee (SC) to provide overall policy guidance and oversight to Program implementation. The SC will comprise echelon one staff from the MoH, BPJS-K, the MoF, DJSN, *Badan Perencanaan Pembangunan Nasional* (Ministry of National Development Planning, Bappenas), Kemenko PMK, and the Ministry of Home Affairs (MOHA) and will meet twice a year. The committee will set policy and annual targets, review progress and performance, and resolve specific issues as required. Key agreements/decisions will be captured in meeting minutes. Efforts will be made to coordinate the SC meetings during the implementation support missions of the Program, also providing an opportunity for the mission to discuss the Program implementation progress and issues with the SC.

45. **The MoF will host the PforR Secretariat, which will be responsible for day-to-day Program management, coordination, and monitoring.** The Secretariat will be hosted by the MoF. It will comprise staff nominated by the directors of the key departments and teams within the MoF. Depending on the skills required, staff will be seconded from the directorates/centers, and where additional capacity is needed, consultants may be hired. The Secretariat will coordinate and interact with a Technical Working



Group (TWG) comprising focal points from the stakeholder teams and units responsible for implementing the DLIs to provide technical guidance, with technical-level representatives from different teams within the MoH, BPJS-K, the MoF, DJSN, Bappenas, Kemenko PMK, and MOHA. The TWG could also be a continuation of the focal point group that was formed during the preparation of the PforR to inform on the design of the RAs, DLIs, and Results Framework. In an augmentation of its role, the Secretariat is also expected to mobilize technical assistance and capacity-building support for all the stakeholder agencies involved in the PforR's implementation. The IPF, financed by a grant and managed by the Secretariat, could provide catalytic support and technical expertise to support the Program, including hiring of consultants (who could be deployed to support all key stakeholder ministries and agencies supporting the Program) and for enhanced monitoring and evaluation costs of the Program, in addition to domestic budgetary resources being made available for the Secretariat. An Operational Manual will be compiled that lays out the processes, terms of reference, and monitoring mechanisms to be used under the IPF grant. The Secretariat's main responsibilities will be to:

- (a) Track progress on the achievement of actions listed in the PAP, DLIs, and the Results Framework;
- (b) Investigate and intervene to solve problems should and when they arise; and
- (c) Support IAs to deliver results on the ground through additional budgets and/or hiring of technical staff or consultants.

46. **Among the four IAs, BPJS-K has a special legal status, as a semi-autonomous Government entity, while all other IAs are Government ministries/departments.** Accordingly, the Borrower, through the MoF, has undertaken to cause BPJS-K to carry out Program activities in line with requirements specified in the Loan Agreement to be signed between the GOI and the World Bank.

B. Results Monitoring and Evaluation

47. **The results logic (Table 3) describes how the Program activities aim to achieve the PDO's twin objectives of improved quality and efficiency in service delivery.** Seven out of nine DLIs are directly reflected in the Results Framework. Output and intermediate outcome indicators help measure important milestones in the implementation of the DLIs. Many focus on establishing and strengthening institutional capacity and system processes needed to monitor improvements in the quality of care and efficiency of spending.

- (a) **Measuring quality.** DLIs 1 and 2 measure essential missing outputs needed to improve the competence of frontline workers who struggle to diagnose common conditions such as diabetes, hypertension, and high-risk pregnancies. The development of a clinical decision support tool for all adult conditions treated at the FKTP level and training in the use of the clinical decision support tool (DLI 1) and clinical pathways for the most common conditions at FKRTL level (DLI 2) will increase providers' competence and compliance with clinical protocols. The latter is measured by several outcome indicators (for example, increase in the percentage of ANC visits in line with clinical protocols, increase in the percentage of adults who have been screened for diabetes and hypertension according to clinical protocols, and the number of maternal deaths caused by hypertension) including improved provider competence in primary care—a PDO indicator directly linked to DLI 1. Improvements in provider competence at the primary care level are also expected



to increase demand for outpatient care and patient satisfaction overall albeit more distally. Together, these three PDOs are used to measure improvements in quality.

- (b) **Measuring efficiency.** DLIs 3, 4, 6, and 7 aim to decrease waste and inefficiency in service delivery, freeing up more resources for JKN to cover and treat additional members. Here too, DLIs focus on essential changes to processes, outputs, and the design of provider payment methods that are essential to reducing unnecessary and inappropriate hospital claims and improving the overall management of claims. This will contribute to a more sustainable JKN claims ratio. Improving the quality of primary care and realigning clinical pathways and payment incentives to promote FKTPs as the first point of entry into the health care system is also expected to increase demand for outpatient care and contribute to a more sustainable JKN claims ratio.

48. **The monitoring and evaluation plan, including indicator definitions, frequency of collection, data source, and responsible agency, is described in annex 1.** Indicators will primarily come from existing MoH information systems, BPJS-K administrative data, and claims systems (PCare and Vklaim). While some indicators in the Results Framework may not currently be collected, they can be calculated using existing claims and administrative data. These will be important indicators to establish as part of BPJS-K's internal operations and claims management processes. However, processes for collecting indicators on hospital coding accuracy, provider competency, and tracer indicators to measure compliance with protocol-based care will need to be established as they currently do not exist. Even though tracer indicators to monitor compliance with STGs may not currently be reported, existing applications like PCare may already have the ability to collect these data (that is, the data entry fields exist in the software, but reporting may need to be prioritized, monitored, and incentivized). This is the case for blood pressure, blood hemoglobin, and glucose levels, for example. As part of DLI 4 on improving the use of data in decision-making, existing reporting processes and systems will be updated so that tracer indicators can be embedded within existing systems.

49. **The Program Secretariat will be responsible for the timely collection of all documentation supporting the achievement of the DLIs as well as Results Framework indicators,** ensuring that the respective lead agency/unit responsible for each DLI has documented and verified the indicators. The MoH will be responsible for the achievement of DLIs 1, 2, 3, 6, and 7; BPJS-K for DLI 4; DJSN for DLI 8; and MoF for DLI 9. DLI 5 will require strong coordination and collaboration between the MoH and BPJS-K. BPJS-K will also be required to share relevant data and information to inform the design of provider payment reforms under DLIs 6 and 7. Responsibility for data collection for PDO and intermediate outcome indicators is also listed in annex 1.

C. Disbursement Arrangements

50. **Disbursements will be made against the achievement of DLI targets.** An advance of 25 percent of loan financing would be available for withdrawal at effectiveness. All releases of DLI amounts will be done after the review and verification of appropriate evidence by Indonesia's Finance and Development Monitoring Agency or *Badan Pengawasan Keuangan dan Pembangunan* (BPKP)—the independent verification agency (IVA)—according to the agreed verification protocol. BPKP has been the IVA for a range of PforR investments across multiple sectors and has been credible and timely in its verification role. The PforR preparation has included a discussion with BPKP on also taking on the verification for this PforR to which it has agreed in principle. The DLI verification protocol includes definitions of agreed DLIs, baseline



and target values, and procedures for measurement (annex 2). Upon achievement (or partial achievement) of a DLI, the Program Secretariat will provide BPKP and the World Bank with evidence that the DLI has been met. Following review of the complete documentation and its verification report from BPKP, including any additional information considered necessary, the World Bank will send an official communication to the Program Secretariat as to the achievement of the DLI(s) and the level of financing to be disbursed against each particular DLI, including any partial disbursement for scalable DLIs where applicable. Other than disbursement-linked results that need to be achieved within the defined year, the timeline for targets is indicative and withdrawal applications for disbursements can be made once the targets are achieved (or partially achieved, as applicable), either individually or in groups. DLIs not achieved in a period can be carried over to future periods unless otherwise specified in any specific case.

D. Capacity Building

51. **The PforR incorporates in its design several activities to build capacity and strengthen the institutions involved in the quality of health care provision, clinical coding, HTA, provider payment design, costing studies, and claims analysis—all relatively complex fields and where the health sector is usually weak in its capacity.** Medical coders are not yet widely recognized as a health care profession, and access to professional training and certification is limited. There is, even otherwise, a shortage of clinical coders in Indonesia. Currently, the production capacity is around 3,000 while the need is estimated to be over 90,000. Claims management also relies on rules and regulations being in place such as clinical pathways and coding guidelines. Only then can a payor such as BPJS-K decide whether the claim is admissible and what the payable amount should be. But with the rapid rollout and expansion of JKN, these rules and regulations are being developed ad hoc as issues are identified and brought to the attention of the MoH which has the mandate/authority to develop guidance. The capacity for undertaking HTA is also limited and needs to be augmented through co-opting universities and academic centers in supporting the MoH in undertaking HTA studies, adding to the available domestic capacity. DLIs 1 and 2 support the development of clinical pathways and capacity building of health facilities nationwide in using these clinical pathways. DLI 3 supports the expansion of capacity for HTA studies. DLI 4 helps improve the capacity for claims management, claims audits, and health care analytics. DLI 7 promotes the professional development of clinical coding experts in hospitals. Finally, DLIs 5 and 8 promote the use of data in decision-making. In addition to the capacity building integrated within the DLIs of the Program, technical assistance available from the IPF grant will also support capacity building across a range of skills and functions that need to be strengthened within the JKN eco-system.

52. **The operation will benefit from analytical work, technical assistance, and capacity-building support provided in-kind by the World Bank, through its program of analytical and advisory activities.** In the last year, World Bank engagement has shifted from core analytics toward technical assistance, just-in-time analysis, and knowledge exchanges with other countries undergoing similar reforms. This includes support to address specific JKN implementation and sustainability issues around targeting and enrollment, governance arrangements, provider payment options, clinical coding and the use of claims data, adopting clinical pathways, and information systems. The analytical work undertaken through the Reforms to Strengthen UHC in the Indonesia Programmatic Advisory Services and Analytics supports the GOI's efforts to accelerate and sustain progress toward UHC. The analytical work addresses systemic challenges in the health sector's governance and accountability, financing beyond JKN, and the quality-of-service delivery that hinder progress to UHC. It also supports the GOI's broader reforms to raise additional revenue for



the sector and expand coverage to the rest of the population—areas not covered under this PforR but ones that this PforR will enable. The Global Fund, Global Financing Facility, and the BMGF co-finance this activity and its analytical support to the JKN PforR. Indonesia’s Identification for Development analytical work aims to strengthen the GOI’s civil registry and identification systems to improve the targeting, coverage, and eligibility of several social assistance schemes including JKN. This will also help BPJS-K improve contribution compliance.

Investment Project Financing (IPF)

53. The purpose of the IPF accompanying the PforR is to strengthen the technical expertise and implementation capacity of the JKN PforR Secretariat which will be hosted by the MoF to support key ministries and organizations involved in the PforR. The IPF will be financed through a total US\$2.33 million grant by the BMGF to the GOI, with the possibility of leveraging more resources throughout implementation. This grant will be received in several installments (US\$1.28 million; US\$0.52 million; 0.52 million); to date US\$1.28 million has been received. The IPF will complement domestic budgetary resources for the Secretariat, especially where civil service rule limitations restrict the Government’s ability to source the necessary expertise for short-term assignments. More specifically, the component will support

- (a) Hiring a pool of consultants and specific technical experts for the Secretariat to provide technical support to other stakeholder agencies (including the MoH, BPJS-K, DJSN, the President’s Office, MOHA, and Bappenas) for their implementation of the PforR;
- (b) Providing enhanced coordination support for JKN stakeholders, including regular communications and convening of TWG comprising representatives from all relevant units and departments within the key stakeholder agencies;
- (c) Strengthening the Secretariat’s monitoring and evaluation function to track progress, learn, course-correct, and evaluate the program’s impact and effectiveness; and
- (d) Generating knowledge and providing lessons learned for other countries for continuous learning as well as to provide synthesized inputs into Government policy.

54. The grant will serve as a catalytic investment to leverage the Government’s JKN reform by supporting the critically important technical assistance to improve the performance and sustainability of the Government’s JKN spending of over US\$40 billion until 2026. This funding will also contribute to fostering government ownership of the PforR by channeling the funds as recipient-executed under the management and coordination of the MoF, helping build long-term capacity within the Government system.

55. The grant will be implemented by the MoF and will follow the standard World Bank procedures and oversight including its technical, fiduciary, and safeguards that are applicable for IPF operations. The World Bank will also provide implementation support and quality control throughout implementation. The grant will also be complemented by World Bank-executed technical assistance that will be deployed to both support and augment the capacity of national consultants.

56. As for institutional arrangements for the IPF grant, the MoF will assume the executing agency/IA role through its PforR Secretariat. The Secretariat will be responsible for all hiring of consultants and



technical experts, who will be deployed to support the capacity building of other stakeholder agencies. Similarly, the Secretariat will be responsible for all aspects of implementation of the IPF grant, including financial management, environmental and social standards, and monitoring and evaluation. A TWG will be established to support coordination functions and will work closely with the MoF Secretariat to coordinate progress across key stakeholders of the JKN.³⁴

IV. ASSESSMENT SUMMARY

A. Technical (including Program Economic Evaluation)

Strategic Relevance and Technical Soundness

57. **There is a strong rationale for public sector financing/provision of the health sector.** The classic arguments justifying the need for Government intervention in health care markets are generally grouped into discussions on:

- (a) **Neglected externalities.** Governments are increasingly considering UHC as a merit good that provides a positive social and fiscal externality, arguing that healthier individuals are more productive, earn higher incomes, contribute to society, and are less dependent on government support;
- (b) **Information failures.** The average person generally has less information than providers about both the need for and quality of health care often leading to misalignment between provider self-interest and patient objectives; and
- (c) **Risk and uncertainty.** Illness can expose individuals to potentially ruinous medical expenditures and loss of earnings during extended sick days.

58. Societal values may impose additional moral arguments such as health as a human right, equity in access to health care, and equalization with regard to income distribution. The PforR is also fully aligned with the GOI's National Development Plan (RPJMN 2020–24), the MoH's Strategic Plan (*Renstra* 2020–24), and the National Security System Roadmap (2020–24). Its' design is also informed by and builds on an extensive body of analytic work carried out over the past five years.

59. **This leaves considerable scope for government action.** The GOI has already taken steps to provide subsidies to the poor and the near poor to enroll in JKN offering a generous benefit package. However, frontline facilities are often ill-equipped to provide quality care, signaling potential efficiency gains from enhancing the competence of health care providers and realigning provider payment incentives to ensure a socially acceptable level of quality health care goods and services.

³⁴ At the time of concluding appraisal, the internal processing for accepting the IPF grant was still ongoing, and so, the grant negotiations are expected to be undertaken at a later date than those for the PforR. The Grant Agreement is initially expected to be undertaken for technical discussions in an amount of US\$1.28 million reflecting the cash contribution already received from the BMGF in the Indonesia Human Capital Acceleration Multi-Donor Trust Fund. The value of the grant will be updated when further contribution is received in January 2022 and January 2023, to the full appraised value of US\$2.33 million.



Economic Rationale

60. **Globally, poor-quality care is a bigger barrier to reducing mortality than is the lack of access to health services.** The Lancet Global Health Commission estimated that 60 percent of deaths (over 8 million people) occur each year from conditions that are amenable to health care. While there is no universally accepted definition of quality, a shared understanding of the basic precepts of quality defines it as being effective, safe, and people centered. The high mortality rates in low- and middle-income countries for maternal and childcare, cardiovascular disease, and vaccine-preventable conditions are worrisome because treatment is widely accessible, evidence based, and among the most cost-effective interventions available³⁵.

61. **The economic implications of premature deaths and morbidity due to poor quality are also substantial.** Between 2015 and 2030, the Lancet Commission projected the cumulative loss due to poor-quality care to be upward of US\$11 trillion in 91 lower-middle-income countries (LMICs). In 2015 alone, the impact of mortality on the labor force and physical capital accumulation amounted to economic losses of US\$6 trillion³⁴.

62. **Beyond the economic losses from premature mortality, poor-quality care can also lead to significant waste and inefficiency.** Misdiagnosing a patient or prescribing the wrong treatment, doing unnecessary cesarean sections, and overprescribing antimicrobials are all examples of inappropriate or low-value care because additional resources are spent on services that produce reduced or no added health benefit. It is estimated that adverse events³⁶ add 13–16 percent of hospital costs, 28–72 percent of which are considered avoidable. Data on adverse events in primary care settings are much more limited, but according to one study, around 80 percent of errors are classified as potentially avoidable process errors. While few studies have estimated the economic impact of antimicrobial resistance globally, it is estimated to cost the US health care system US\$21–34 billion^{37,38}. Unnecessary cesarean sections are estimated to cost an additional US\$2.32 billion, far exceeding the cost of needed cesarean sections³⁴.

63. **The potential savings from improvements in the quality of care and more efficient health-seeking pathways is substantial.** Globally, potential efficiency savings at hospitals in middle-income countries have been estimated at 5–11 percent of total spending⁷. Applying these percentages to JKN hospital-based expenditures yield potential efficiency savings of IDR 3.6–7.9 trillion in the hospital sector alone. And high-quality primary care can prevent the need for hospital admissions altogether. A 2017

³⁵ Kruk, Margaret E, Anna D Gage, Catherine Arsenaault, Keely Jordan , Hannah H Leslie, Sanam Roder-DeWan, Olusoji Adeyi, et al. 2018. "High-quality health systems in the Sustainable Development Goals era: time for a revolution." *The Lancet Global Health Commission* e1119-252.

³⁶ The most common adverse events are related to health care-associated infections (for example, postoperative sepsis), venous thromboembolism, pressure ulcers, medication error, and wrong or delayed diagnosis.

³⁷ Slawomirski, Luke, Ane Auraaen, and Nicolaas Klazinga. 2017. *The economics of patient safety: strengthening a value-based approach to reducing patient harm at national level*. Paris: OECD Publishing.

³⁸ Couffinhal, Agnes, and Karolina Socha-Dietrich. 2017. "Ineffective spending and waste in health care systems: framework and findings." In *Tackling wasteful spending in health*, by OECD, 17-54. Paris: OECD Publishing.



independent audit of JKN estimated even higher hospital sector inefficiencies of 15 percent—amounting to IDR 16 trillion or US\$1.1 billion—that is, nearly half the entire JKN deficit in the hospital sector alone⁸.

64. **To quantify the economic impact of the PforR, the potential savings from improvements in JKN’s overall claims management were estimated.** JKN claims data can help monitor adherence to clinical guidelines and protocol-based care, helping improve the quality-of-service delivery (that is, detecting inappropriate or low-value care). Claims data could also identify high cost and frequency items, which could be used to inform additional areas for improved service delivery and fund management. Using historical JKN expenditure data from 2016 to 2018, JKN spending was forecasted to 2026 under a status quo scenario. Next, it was assumed that incremental improvements in claims management between 2022 and 2026 would decrease total expenditures by 5 percent (low), 7.5 percent (middle), and 10 percent (high) by the end of the operation. Finally, the net present value of expected savings was calculated by taking the difference between the status quo and the low, middle, and high scenarios. Under the middle scenario, the operation will generate savings of over US\$890 million. Given the loan amount of US\$400 million, the operation is deemed a very good investment (Table 5). The technical assessment provides additional details and justifications for the assumptions used.

Table 5. The Operation Will Generate a Positive Benefit-to-Cost Ratio, Making It a Good Investment

Scenario	Expected Savings (US\$)	Cost-Benefit Ratio
Low (5%)	535,868,373	2.12
Middle (7.5%)	892,375,429	3.53
High end (10%)	1,190,305,511	4.71

B. Fiduciary

65. **The Fiduciary Systems Assessment (FSA) has been carried out in accordance with the World Bank Policy on Program-for-Results and the World Bank Directive on Program-for-Results and concluded that the Program fiduciary arrangements adequately meet the requirements laid out in the World Bank’s PforR Policy and Directive and provide reasonable assurances that the financing proceeds will be used for intended purposes.** The FSA also identified potential risks, areas for further strengthening, and proposed measures to mitigate the fiduciary risks under the Program.

66. **The Program is being implemented through four Government agencies:** three ministries including the MoH, the MoF, DJSN under the Coordinating Ministry for Human Development and Cultural Affairs; and BPJS-K which is an autonomous agency. The fiduciary systems of the agencies assessed under this operation consist of two distinct systems: (a) the Government fiduciary systems that will support the Program implementation by the three Government IAs (the MoH, the MoF, and DJSN) and (b) the fiduciary systems used by BPJS-K, which is a public autonomous agency and therefore subject to more discretionary rules. The FSA reviewed the fiduciary systems and the capacities of the four IAs directly responsible for the PforR Program implementation and assessed their ability to manage the PforR Program with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. Based on the Program Expenditure Framework and technical assessment, the Program activities to be implemented by BPJS-K toward achieving DLI 4 would not involve procurement (except for minor procurable expenditures under operating costs).



67. **Key fiduciary risks.** The overall fiduciary risk of the Program is rated Substantial. The GOI has been strengthening public financial systems and accountability frameworks over the last decade. In that context, the FSA noted that (a) the MoH and the MoF have experience in managing World Bank-financed PforR projects and public procurement using their own in-house capacity; (b) *Kemenko PMK* has sufficient capacity in managing projects particularly funded by donors; (c) based on the experience during COVID-19 Program implementation, the Government has been processing budget revisions and payments remotely without relaxing the internal controls; (d) accounting and reporting are operated by the Integrated Financial Management System remotely; (e) the flow of funds has been uninterrupted as the banking system has demonstrated its ability to continue working during this difficult period; (f) the MoH Inspectorate General is willing to share information on internal audit conducted for the Program including findings and follow-up actions; and (g) the MoH external audit report will be submitted timely to the World Bank. However, a number of risks are involved, including the following: (a) 91.7 percent of the Program financing is concentrated in a single expenditure item, the health insurance subsidy for the poor (PBI) in the budget of the Center for Health Financing and Assurance under the responsibility/authority of the Secretary General of the MoH and requires greater attention during program implementation; (b) the IVA for the Program has not yet been appointed; (c) BPJS-K has no experience in implementing a World Bank-financed Program; (d) BPJS-K has not made its audited financial statements available to the public as stipulated by article 14 of Law 14 of FY 2008; (e) internal control risks in BPJS-K, especially the weak information technology (IT) access security, are raised by the external auditor in the 2019 management letter; (f) the IAs may award a contract under the Program to World Bank-sanctioned firms and individuals; and (g) credible and material allegations or other indications of fraud and corruption (F&C) in connection with the Program may not be reported to the World Bank on time.

68. **Mitigation measures.** Risk mitigation would require that the Government takes a number of measures, in compliance with the laws and regulations on public financial management and public disclosure of information, including the following:

- (a) The MoH will report on a semiannual basis the results of the internal audit conducted by its Inspectorate General on health insurance subsidy as the main expenditure of the Program.
- (b) The MoF will appoint BPKP to conduct the independent verification task for the Program and provide sufficient budget for it.
- (c) BPJS-K will take action to remove any regulatory obstacles that would interfere with the requirements of the existing Indonesian law on public information disclosure.
- (d) BPJS-K will improve the capacity of internal audit unit for better internal control:
 - (i) BPJS-K HR unit will conduct an assessment on the capacity needed for Certified Information System Auditor (CISA) certified internal auditor.
 - (ii) BPJS-K internal capacity will be improved to have competency in conducting continuous audit on BPJS-K information systems.
- (e) BPJS-K will improve its records management practice and regulation to ensure secure access to records and retain, preserve, and dispose of records appropriately.
- (f) The IAs shall require their Procurement Services to check the World Bank's debarment (www.worldbank.org/debarr) and temporary suspension lists and record the verification in the bid



evaluation report before contract award to ensure that no contract under the Program is awarded to a firm or individual that is under debarment and/or temporary suspension by the World Bank.

- (g) The IAs shall inform the World Bank promptly of all credible and material allegations or other indications of F&C in connection with the Program that come to its attention, together with the investigative and other actions that IAs propose to take, and provide the World Bank, on a semiannual basis, a report on allegations of F&C under the Program received and registered during such period, as well as any related investigations and actions taken.

69. **The GOI has established mechanisms to prevent and detect corruption in the implementation of JKN program**, including complaint-handling systems and grievance redress systems, and through the Legal Agreement, the GOI will formally be committed to the obligations under the World Bank's Anti-Corruption Guidelines for the Program. The primary responsibility for preventing and combating F&C rests with the GOI, and the four IAs will be bound by the Anti-Corruption Guidelines and will be required to promptly inform the World Bank of any credible and material allegations of fraud and/or corruption regarding the PforR, as part of the overall PforR reporting requirements. The World Bank will inform the GOI about any allegation that it receives.

C. Environmental and Social

70. **The environmental and social risk is overall Moderate**, with environmental risk being rated Low and social risk rated Moderate (refer annex 2).

71. **The Program is not operating in sensitive settings that may contribute to potentially adverse environmental impacts.** There is a low likelihood that the achievement of the operational objectives could be affected by environmental risk factors (including those related to climate change and natural disasters) since such risks are not relevant to the operation. The operation is not likely to have adverse impacts on greenhouse gas (GHG) emissions.

72. **While activities and investments under the PforR do not have significant direct environmental impacts, the improved performance of the Program may encourage an increase in the utilization of health services, with a potential downstream environmental implication such as safe handling of medical waste.** Since the PforR does not include health service readiness and the expansion of hospitals and facility accreditation fall outside the scope of the Program, management of such risks will not be directly conducted through the PforR. Instead, this risk will be addressed through another complementary operation such as I-SPHERE—the MoH's health care reform PforR. As part of its PAPs, I-SPHERE is currently supporting the development of an improved Guideline on Proper Management of Medical Waste Management. In this context, the MoH will ensure the adoption and compliance with the guideline.

73. **Introduction of risk-based capitation to FKTPs, revisions of INACBGs, and clinical guidelines are expected to promote enhancement in the quality of services.** However, such reforms will require inclusive stakeholder engagement and consultations to capture diverse views of affected stakeholders and minimize potential misunderstanding and misconception. While the PforR is not expected to exacerbate the existing inequity in access to JKN and health services, further analysis of potential adverse implications on equity, including impact simulation, representative sampling, and inclusive stakeholder engagement, is warranted during the PforR implementation.



74. **By design, the PforR is expected to generate positive outcomes by improving JKN performance, through enhanced accountability and sustainability.** Adverse social implications may stem from the poor implementation of specific activities and trade-offs to achieve efficiency. Potential social implications warranting risk management include:

- (a) Stakeholders' acceptance of the reform, particularly those who have benefited from weak systems and monitoring and consequently may potentially stand to lose due to greater efficiency gains (that is, health facilities);
- (b) Potential implications on JKN members especially the poor and the vulnerable as a result of potential reforms introduced and/or enhanced, particularly on aspects related to (i) referral procedures, (ii) service provider payments (that is, hospital tariffs), and (iii) benefits package; and
- (c) Data protection and privacy.

75. **Other risk factors stem from (a) the context within which the PforR is operating, (b) institutional capacity and complexity of the needed reforms, and (c) political and reputational risks.**

- (a) **Contextual risks.** Reforms supported by the PforR may be implemented under challenging political economy operational and fiscal contexts, which have been further compounded by the COVID-19 pandemic. Operating under these contexts, reforms may need to be selective and must consider how such contextual risks may undermine results. Promoting equity in the access to health care system toward UHC will require addressing various social, cultural, and psychological barriers that may confront the poor and marginalized segments of the population. Exclusion in access to health care services, including racial and gender discrimination, and marginalization based on sexual orientation are systematic issues, requiring systematic and holistic solutions, involving concerted efforts of the broader sectors. While the PforR is not envisaged to exacerbate such issues, the Program is not intended to address them since such issues will require systemic interventions which fall outside the PforR's boundary and direct mandates of relevant agencies implementing the Program.
- (b) **Institutional capacity and complexity.** Promoting oversight and checks and balances under JKN requires inter-agency decisions, which may potentially further complicate the needed reforms. Managing expenditure growth to promote JKN's sustainability may involve revisiting the existing capitation and hospital payments, including DRG tariffs, introduction of hospital spending caps, and cost-sharing arrangements for nonessential services and services prone to overutilization. All of these reforms warrant not only sound evidence-informed technical considerations and representative sampling to ensure equity issues are properly captured but also clear and transparent public communication, which may be compromised due to the operational challenges above as well as political interests.
- (c) **Political and reputational risks.** Key policy areas which may be revisited under the PforR include benefit package and entitlements, class consolidation and co-sharing, upper ceiling caps, and so on. Going forward, fiscal sustainability will require tough policy decisions. While inclusion of these contentious reform elements under the PforR boundary is yet to be agreed, the overall Program may be associated and/or linked with such unpopular reform measures. Hence, further understanding of potential reputational risks and the existing Government capacity to address such



risks, particularly in terms of public communication and stakeholder engagement, will be required as part of the environmental and social action plans.

76. **Relevant social actions seek to enhance the social outcomes of the PforR.** Proposed actions include (a) promoting social inclusion and representativeness of analysis to inform reforms and capacity building to frontline health workers, (b) enhancing public communication on patients' rights and responsibilities, (c) strengthening stakeholder engagement and disclosure of public information, (d) enhancing grievance handling mechanisms under JKN, and (e) developing/enhancing data protection measures for the purpose of system integration and data interoperability. The PforR will also seek to support the enhancement of quality of care, including in lagging regions, through DLIs 1 and 2 which focus on the development of clinical pathways/processes of care for FKTPs and hospitals, capacity building, and accountability.

77. **As part of Program appraisal, a series of virtual consultation workshops on the PforR as well as the corresponding Environmental and Social Systems Assessment (ESSA) were undertaken on November 11 and 12, 2021.** These consultations involved relevant stakeholders representing consumer and JKN member representative groups, nongovernmental organizations, community-based organizations, and professional organizations, also representing health providers both at the national and subnational levels. The World Bank also received written inputs from these stakeholders, which have been incorporated in the ESSA. These consultations were announced to the general public through the World Bank's social media channels, ahead of the consultation dates, with the draft ESSA and Executive Summary in Bahasa Indonesia being publicly disclosed through the World Bank's website. Key feedback and concerns were reflected in the ESSA report and proposed system enhancements. A full summary is presented in annex 5. In summary, key concerns from the stakeholders consulted include (a) equity of access to JKN, particularly among vulnerable groups (that is, people with HIV/AIDS, TB patients, people with mental illnesses, persons with drug dependence, and other marginalized groups); (b) inclusiveness of health services, particularly in contexts where trust in health care providers represents a critical factor for health-seeking behavior among marginalized groups; (c) the need for system enhancements within JKN on aspects such as public communication, patients' rights, grievance mechanisms, and so on; (d) the need to ensure continuity of care, by strengthening coherent and coordinated health care at the primary and referral levels; and (e) viability of provider payments which need to reflect actual costs of providing care.

Equity

78. **Improvements in access to and quality of care would disproportionately benefit lower-income households and lagging regions, especially in the aftermath of the COVID-19 pandemic.** First, JKN predominantly covers poor and vulnerable households, regardless of their ability to pay. Ensuring the financial sustainability of JKN guarantees continued access to health care services among the most vulnerable populations especially in times of financial hardship. Second, the PforR ensures all patients receive the same minimum quality standards regardless of socioeconomic background. The operation standardizes diagnostic and treatment protocols and embeds tracer indicators within the claims verification process to monitor compliance with STGs. This incentivizes providers to offer the same standard of care regardless of educational status or income level. As mothers with little or no education and those in the poorest income quintile are correlated with receiving fewer health care interventions (as highlighted in the sector context), the PforR's activities will disproportionately affect lower-educated



poorer households. Assessment of provider competence and compliance with the guidelines for ANC, diabetes, and hypertension could also be disaggregated by province, district, and facility in JKN's internal dashboard to help inform how DHOs target and allocate resources and training opportunities to lagging regions.

Gender

79. **Indonesia has closed key gender gaps in health outcomes and access to care.** Girls and women fare slightly better than boys and men in under-five mortality, stunting, and adult survival. The Human Capital Index for females and males is 0.55 and 0.52, respectively. Immunization coverage rates among children 12–23 months and exclusive breastfeeding coverage rate among children above 6 months is similar for boys and girls. Women also access outpatient services more than males in almost every age group, especially during reproductive years. Despite this progress, Indonesia's MMR remains one of the highest in the East Asia and the Pacific Region at 177 deaths per 100,000 live births.

80. **There are wide variations in MMR and the number of maternal deaths across regions.** In 2019, the MMR ranged from 211 per 100,000 live births in West Papua to 60 per 100,000 live births in Special Area of the Capital City of Jakarta or *Daerah Khusus Ibukota Jakarta* (DKI Jakarta). The populous West Java also recorded 684 maternal deaths versus 21 in North Kalimantan in the same year. Figure 10 plots MMR versus the total number of maternal deaths by province. Quadrant 1 represents 'true' priority areas which have both a high MMR and a high absolute number of maternal deaths. Quadrant 2 represents relatively better developed areas where the Government identified 64 high-priority districts (Figure 10, highlighted in red) in provinces targeting the high absolute number of maternal deaths in populous areas. Finally, quadrant 4 represent areas with high MMR but lower absolute maternal deaths due to them being not very populous.

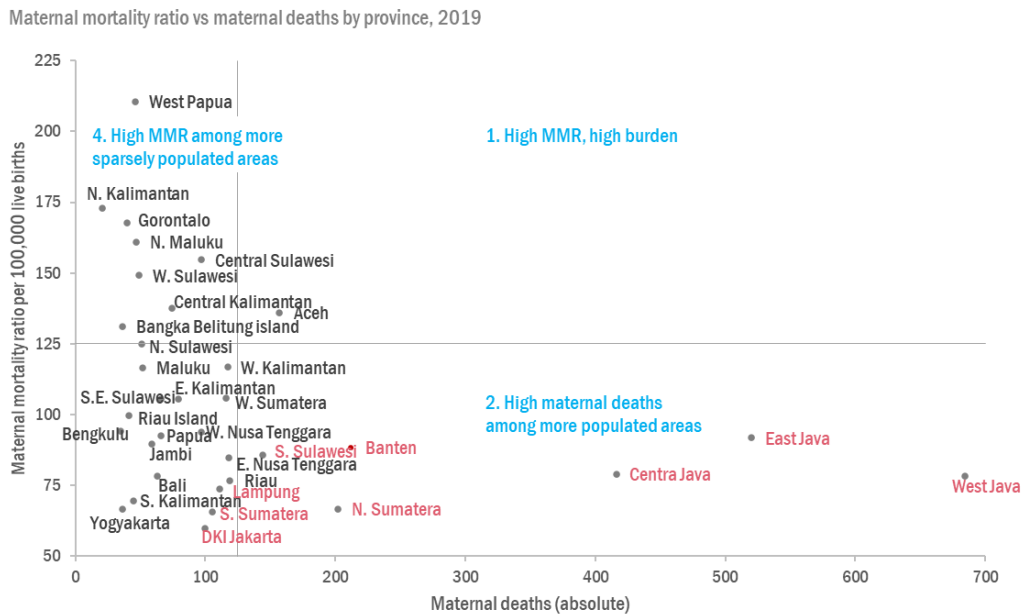
81. **Improving the diagnosis and management of high-risk pregnancies is needed to decrease maternal mortality.** The key causes of maternal deaths include maternal hemorrhage (40 percent) and hypertensive disorders including eclampsia and preeclampsia (28 percent) and infections—with the same wide variations across provinces (Figure 11). Findings from the 2017 Indonesia Demographic and Health Survey and from other facility health surveys show that quality in the provision of maternal health services remains a key issue. Blood and urine tests—essential for the diagnosis of high-risk pregnancies—were carried out in only 47.6 percent and 38.7 percent of ANC visits, respectively, in 2017.

82. **The PforR aims to improve the quality and content of maternal care visits, including in selected remote and disadvantaged provinces in Indonesia.** The PforR will address the gap by ensuring the insurer can oversee and ensure compliance of all service providers with clinical guidelines and standards of care for ANC content and attended deliveries. It will also incentivize improved service provider performance by tying compliance with monitoring and payment. While guidelines may exist at the national level for some maternal health conditions (for example, pregnancy-related diabetes and preeclampsia), they have not been translated into processes of care for frontline providers making them difficult to implement. Translating clinical diagnostic and treatment protocols and referral pathways into processes of care (DLI 2) will help providers' adherence to national guidelines. Tracer indicators will also be incorporated into claims or other data systems to facilitate monitoring (for example, indicators to flag high-risk pregnancies or to verify blood and urine tests were carried out during ANC visits) (DLI 3). BPJS-K could further hold providers accountable through their claim management process (for example, rejecting noncompliant



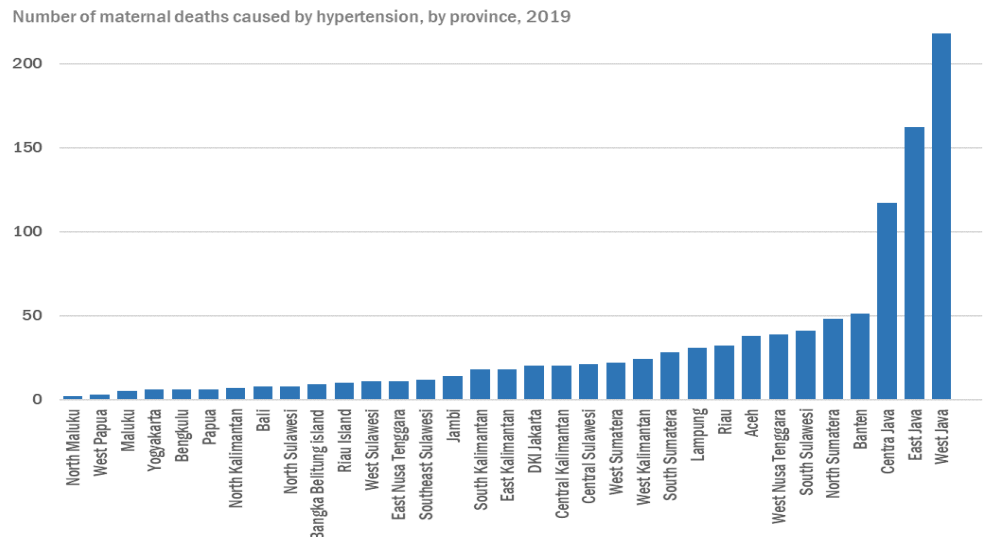
claims) (DLI 3) or through their performance-based capitation scheme (DLI 5). The PforR will prioritize rollout and training in the use of clinical pathways in the high-priority districts the GOI has already identified. To measure progress in closing this gap, the PforR will measure the percentage of ANC visits in line with clinical protocols disaggregated by province and the number of maternal deaths caused by hypertension in each province.

Figure 10. Maternal Mortality Varies Widely within the Country



Source: Family Health Directorate, MoH.

Figure 11. Diagnosing and Managing Hypertensive Disorders Would Have a Larger Impact on the Absolute Number of Maternal Deaths



Source: Family Health Directorate, MoH.



Table 6. Summary of Proposed Gender Analysis, Actions, and Results Indicators

Gender Gap	Action	Results (Indicators)
Indonesia’s MMR remains one of the highest in the East Asia and the Pacific Region at 177 deaths per 100,000 live births. There are wide variations in MMR across regions. In 2019, the MMR ranged from 211 per 100,000 live births in West Papua to 60 per 100,000 live births in DKI Jakarta.	Translate clinical diagnostic and treatment protocols and referral pathways into processes of care, and prioritize rollout and training in their use in high-priority districts (DLIs 1 and 2).	Improved provider competencies, knowledge, and skills on maternal care
Diagnosing and managing high-risk pregnancies is lacking among ANC visits: Blood and urine tests—essential for the diagnosis of high-risk pregnancies—were carried out in only 47.6% and 38.7% of ANC visits, respectively, in 2017.	Incorporate tracer indicators into claims and other data systems to facilitate monitoring (for example, indicators to flag high-risk pregnancies or to verify blood and urine tests were carried out during ANC visits) (DLI 4).	Increase in % of ANC visits in line with clinical diagnostic and treatment protocols (for example, that carry out blood and urine tests) disaggregated by province
The number of maternal deaths caused by hypertension and maternal hemorrhage also varies widely across provinces.	Hold providers more accountable via BPJS claims management process (for example, rejecting noncompliant claims) (DLI 4) and/or BPJS performance-based capitation scheme (KBK) (DLI 6).	Decrease in number of maternal deaths caused by hypertension (disaggregated by province)

Climate Change

83. A climate and disaster risk screening found no/low risk to achieving the PDO. While exposure to extreme precipitation and flooding, strong winds, rising sea levels, and geophysical hazards was rated moderate, the impacts on PforR activities and outcomes was low.

84. Indonesia’s geography makes it prone to climate change exposures and frequent extreme weather phenomena such as La Nina and El Nino. Predictions show temperature will increase by 0.2–0.3°C per decade, increasing the risk of extreme heat events. Precipitation is also predicted to increase across the Indonesian archipelago, with parts of Sumatra and Borneo becoming 10–30 percent wetter by 2080 during their wet seasons. Rising sea levels also put Indonesia’s significant coastal population at risk.

85. Increased vulnerability to climate change puts the health of Indonesians at risk. Prolonged exposure to extreme heat can cause heat exhaustion, heat cramps, heat stroke, and death, as well as exacerbate pre-existing chronic conditions such as diabetes, cardiovascular, and respiratory conditions. Several climate-sensitive communicable diseases are also present including dengue, Japanese encephalitis, malaria, and typhus. While climate change is a countrywide concern, East and West Java, the coastal regions of Sumatra, parts of western and northern Sulawesi, and the country’s easternmost provinces are especially vulnerable. The spread of dengue, for example, has been classified as ‘high risk’ in Sumatra, Java Bai, and Papua. Similarly, the spread of Malaria has been classified as either ‘very high



risk' or 'high risk' in Java-Bali, Sulawesi, Nusa Tenggara, Maluku, and Papua.³⁹ In fact, Indonesia's five easternmost provinces report 70 percent of the country's malaria cases. Flooding also worsens water quality, elevating the risk of diarrhea, typhoid, and cholera.

86. **The PforR strengthens the health care system's response to the health-related impacts of climate change by supporting activities that improve the quality of care.** While the ability to diagnose climate-sensitive conditions is available at most public and private primary health care facilities, staff trained in diagnosis and the diagnostic and treatment guidelines are less prevalent (Figure 12). Variation in diagnostic and treatment standards affects the quality of care. For example, public and private providers use different methods to diagnose malaria. While public providers use laboratory (73 percent) or rapid diagnostic tests (54 percent), private primary care providers rely predominantly on clinical symptoms (94 percent). However, Indonesia is characterized by a complex malaria epidemiology with mosquito vectors commonly infecting humans.

87. **The PforR intends to reduce the country's vulnerability to climate change by introducing adaptation measures that enhance climate resilience.** Figure 13 summarizes how the activities and DLIs build on each other to enhance preparedness and climate resilience in service delivery.

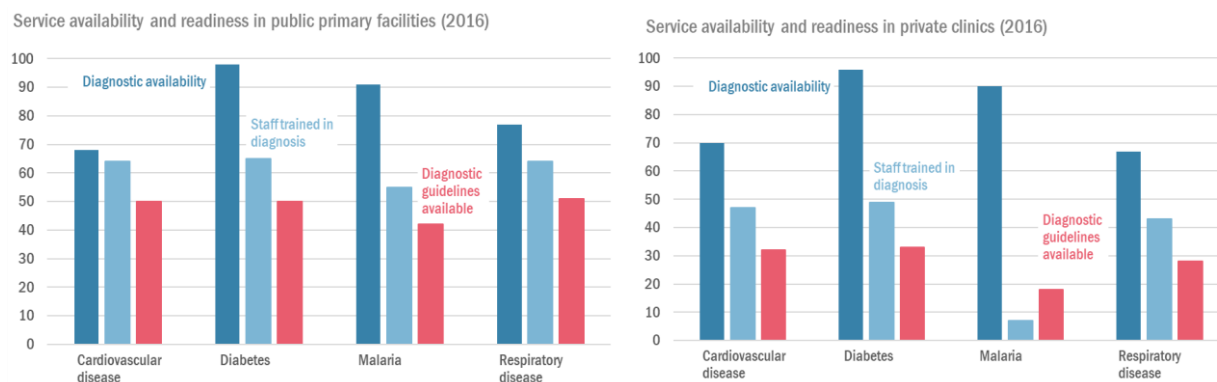
- (a) Under DLIs 1 and 2 (US\$87 million), the PforR will develop diagnostic and clinical guidelines for the most common water- and vector-borne diseases, including malaria, dengue, and diarrhea, as well as climate-sensitive chronic conditions such as diabetes and cardiovascular conditions. The relevant clinical guidelines on climate-related diseases will be translated into processes of care for frontline workers. Training will also be provided in the use of these clinical aids, increasing providers' ability to diagnose and treat climate-related conditions. This will also facilitate decision-making and enable a standard level of quality as JKN contracts with both public and private facilities.
- (b) DLI 4 (US\$70 million) will embed tracer indicators on climate-sensitive conditions into BPJS-K's claims system to monitor compliance with clinical guidelines, improving the quality of care for climate-related conditions. For example, BPJS-K will hold providers accountable through their claim management process by rejecting noncompliant claims.
- (c) DLI 6 (US\$58 million) further incentivizes compliance with clinical guidelines by tying payment to performance. Climate-sensitive conditions are already included in the pay-for-performance capitation scheme at the primary care level. For example, FKTPs receive a performance payment for patients whose diabetes and hypertension are under control; both are conditions that are exacerbated by climate-related conditions. DLI 6 aims to improve the design of the performance-based scheme by including additional quality metrics to verify whether patients are screened for diabetes and hypertension in the first place. Similarly, tracer indicators for conditions aggravated by climate change, such as malaria and dengue and other water and vector-borne diseases, will be incorporated in the claims information system to monitor compliance with clinical guidelines under DLIs 1 and 2 and are expected to be incentivized under DLI 6.
- (d) DLI 7 (US\$78 million) will develop clinical coding guidelines, a training course, and a certification process for clinical coders. This will significantly improve the ability and accuracy of clinical coders to translate written medical record diagnoses into unique alphanumeric codes that will enable

³⁹ https://zerosugar.files.wordpress.com/2014/08/ran-api_synthesis_report_2013.pdf.



increased health care analytics on climate-sensitive and vector-borne diseases. The improved reporting of climate-related disease outbreaks and conditions will be a crucial tool for the MoH use to track climate-related morbidity and health trends, carry out epidemiological surveillance, monitor the quality of care, and target wider health resources to the most climate-affected regions.

Figure 12. Across Services Diagnostic Guidelines Were Not Widely Available Especially in Private Clinics



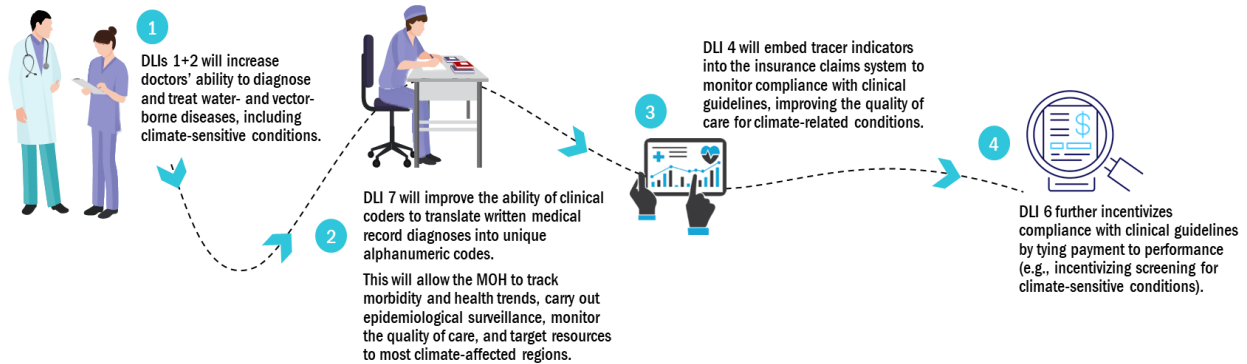
Source: World Bank (2017), Quantitative Service Delivery Survey.

Table 7. Summary of Climate-Sensitive Adaptation Measures

DLI	Adaptation Measures	Mitigation Measures
DLIs 1 and 2 - Development of diagnostic and clinical pathways (IBRD: US\$87 million)	This will include diagnostic and treatment pathways for the most common water- and vector-borne diseases, which will enhance providers' ability to manage climate-sensitive conditions. Tracer indicators for climate-sensitive waterborne and vector-borne diseases will be defined for these conditions as part of this process.	None
DLI 7 - Improved implementation of DRGs (IBRD: US\$78 million)	Activities to improve the quality of clinical coding will allow climate-sensitive waterborne and vector-borne diseases to be identified more easily through medical records and claims data. This will enhance the capacity of service providers to monitor climate-related disease outbreaks and target resources to the most climate-affected regions.	None
DLI 4 - Improved claims management (IBRD: US\$70 million)	DLI 4 will embed tracer indicators identified under DLIs 1 and 2 into BPJS-K's claims system to verify appropriateness of care for climate-sensitive waterborne and vector-borne diseases. For example, whether a diagnostic test was administered to confirm diagnosis and whether the appropriate drug was prescribed.	None
DLI 6 - Improved performance-based capitation (IBRD: US\$58 million)	DLI 6 will further incentivize compliance to clinical pathways and improved performance in the treatment of climate-sensitive waterborne and vector-borne diseases, by tying financial incentives through their performance-based capitation scheme. For example, incentivizing indicators for screening for climate-related conditions.	None



Figure 13. Increasing Awareness and Reporting of Climate-Related Conditions to Better Inform the Climate Response



88. Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB’s independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank’s attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank’s corporate Grievance Redress Service (GRS), please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit <http://www.inspectionpanel.org>.

V. RISK

89. **The overall residual risk to achieving the PDO, after considering mitigation measures, is substantial;** the main risks include (a) sector strategies and policies, (b) the institutional capacity for implementation, (c) the technical design of the project, (d) stakeholders, (e) fiduciary aspects, (f) data privacy, and (g) other.

- (a) **Risks associated with sector strategies and policies are rated substantial.** Health sector strategies and policies are often not fully grounded in the practical actions needed to ensure their success. They also often lack a strong results logic linking activities to outcomes, unrealistic timelines for achieving big policy reforms, and unclear accountability arrangements. To mitigate these risks, the PforR has embedded in its design the development of road maps for two of the biggest sector reforms—improving the design and implementation of primary care payments (DLI 6) and the integration of health management and information systems (DLI 5). The verification protocol will ensure that these road maps are evidence-based, building in requirements for simulating budget and equity impacts where relevant and piloting. It will also require road maps to show a clear results logic, with feasible timelines for achieving key milestones, and delineated roles and responsibilities.
- (b) **Risks associated with the institutional capacity for JKN implementation are rated substantial.** Many of the tasks related to running a national health insurance scheme (for example, prioritization



of the benefit package, clinical coding, claims management, costing of services, and determination of tariffs for reimbursement) are both complex and relatively new for Indonesia. The knowledge and skills may not be adequate. For example, despite the relatively large number of clinical coders (~3,000), claims verifiers (~900), and fraud detection specialists (~300), the potential for detailed processing of over 9 million JKN claims a month remains limited. Regularly updating tariffs, assessing the quality-of-service delivery, and other key oversight functions (for example, coding audits and claims audits) will also require a dedicated Government budget and staff as these are not one-off activities. The ability to augment such technical staffing is also affected by the fiscal constraints in the aftermath of the COVID-19 pandemic. The operational systems needed to inform decision-making may also be underdeveloped and under-financed. For example, the low prevalence of EMRs and fragmented information systems overall limit more advanced predictive and machine learning-based health care analytics. The PforR incorporates in its design several activities to build capacity and strengthen institutions involved in quality of health care provision, clinical coding, HTA, provider payment design, costing studies, and claims analysis. BPJS-K and DJSN are also new IAs for World Bank operations and are not entirely familiar with World Bank processes and the PforR instrument. To mitigate these risks, the PforR will be supported by in-kind technical assistance, hands-on workshops, and knowledge exchange events to build the capacity of MoH, BPJS-K, MoF, and DJSN staff to carry out activities under the PforR. A recipient-executed trust fund (RETF) also allows the PforR Secretariat to hire technical experts to be embedded within IAs.

- (c) **Risks associated with technical design are rated substantial.** Provider payment reforms (DLIs 6 and 7) and the integration of health information systems (DLI 5) are large, complex, and politically sensitive reforms. On average, they take between 7 and 10 years to implement in resource-constrained and low-capacity settings. For example, many preliminary steps are needed to move from an input-based capitation formula toward a risk-based capitation design or from a DRG-based hospital payment arrangement toward a DRG plus global budget payment method. Reforms rely on the analysis of representative utilization and expenditure data; the ability to simulate and assess the budget impact of any changes; and the buy-in of health care providers, medical professional associations, and patients. These reforms are also typically piloted for several years before nationwide rollout. Similarly, successful data integration reforms first need to map out what data are needed, why, and whether existing information systems are able to provide the data in the right frequency and level of aggregation. It is often the case that new data intake and reporting processes need to be introduced or streamlined to reduce the burden on frontline providers. Even when existing information systems can provide the needed data, standardizing definitions and applying coding and data standards can take several years. To mitigate these risks, the PforR breaks down these ambitious reforms into key nuts and bolts activities (DLI 7) that are needed to incrementally move the reform agenda forward. Getting the GOI to develop and agree on a more structured road map (DLIs 5 and 6) with a prioritized list of indicators of progress has been shown to be helpful in other settings where the GOI's own strategy documents do not necessarily spell out reform objectives and timeline.
- (d) **Risks associated with stakeholders are rated substantial.** In the past, key regulations with regard to JKN and service delivery have been developed in silos with little data and stakeholder engagement. The fragmentation of health information systems further hindered evidence-based reforms. The PforR has mapped out the roles and responsibilities of various stakeholders involved in JKN implementation. Throughout the PforR's preparation, DLIs were chosen to reinforce the



collaborative actions needed by the MoH and BPJS-K to leverage results. For example, the MoH will develop STGs and quality standards that BPJS-K could then hold providers accountable through its claim verification, contracting, and reimbursement processes. However, there remains a risk that delays in developing clinical decision tools under DLI 1 will lead to delays in automating and embedding tracer indicators to monitor adherence to clinical guidelines within the MoH and BPJS-K claims systems under DLIs 4 and 5. Introducing additional quality tracer indicators under the pay-for-performance scheme under DLI 6 may also be affected. To mitigate the risk of coordination challenges across entities and sectors, the team has been working with all key stakeholders. The PforR Secretariat at the MoF is expected to coordinate and, where needed, act as an arbitrator between DJSN, BPJS-K, and the MoH and champion the reforms needed to ensure institutions have the appropriate discretion and authority to carry out their functions. The World Bank will also support the GOI through a substantive analytics and advisory work program.

- (e) **Risks associated with data privacy are rated substantial.** Indonesian legislation does not stipulate the definition of anonymized health data. Currently, Indonesia does not have rules or regulations for digital health care systems and patient confidentiality, and safety regulations have not yet been issued. Within the context of electronic service providers, no express regulation covers the liability of a provider for a leak of patient data owing to a failure of its electronic system. Appropriate actions for data security are being listed as an action item in the PAP, and protection of personal data is also proposed as a legal covenant.
- (f) **The fiduciary risk is rated substantial.** This reflects the lack of experience of one of the IAs, BPJS-K, in implementing World Bank projects and implementation challenges arising from a more discretionary fiduciary environment associated with an autonomous agency, including the need to strengthen internal controls and IT security as well as transparency of financial information. The IAs may award a contract under the Program to World Bank-sanctioned firms and may not adhere to the requirement of the World Bank's Anti-Corruption Guidelines on the reporting of F&C under the program. To mitigate this risk, the PAP will stipulate the requirement for BPJS-K to provide public access of its annual audit report with disclosure on the Program and submit to the World Bank full annual audit report (including management letter). IAs' procurement teams will also need to check the World Bank's debarment (www.worldbank.org/debarr) and temporary suspension lists to ensure that no contract under the Program is awarded to a firm or individual that is under debarment and/or temporary suspension by the World Bank and that IAs shall inform the World Bank promptly of all credible and material allegations or other indications of F&C in connection with the Program that come to their attention as well as any related investigations and actions taken. The capacity of the internal audit unit will be improved to conduct IT audit, continuous audit, and monitoring of external audit findings as well as the requirement for BPJS-K to prepare general policy on records management. Appropriate mitigation measures will be agreed with IAs based on the final FSA and included in the PAP.
- (g) **Other risks, namely related to the ongoing COVID-19 pandemic, are also rated substantial.** The overall financial and HR constraints in the health sector are exacerbated as the pandemic response competes for the same resources. The pandemic has also created demand-side challenges in people accessing timely care, which may increase longer-term costs. The pandemic's impact on employment can also affect JKN contributions and beneficiary base. There may also be implications for JKN to cover the costs of booster vaccine doses in the future. Specifically related to the proposed PforR interventions, the ongoing COVID-19 pandemic may limit or prevent the number of face-to-



face trainings needed to train frontline workers in the use of clinical decision support tools and clinical coding certification courses. The increasing vaccination rates in Indonesia should help reduce the magnitude of resources needed for the pandemic response. To mitigate this risk, a virtual training, facilitation, and dissemination plan is being developed as a backup option should in-person trainings/workshops be not permitted due to ongoing mobility restrictions.



ANNEX 1. RESULTS FRAMEWORK MATRIX

Results Framework

COUNTRY: Indonesia

National Health Insurance (JKN) Reforms and Results Program

Program Development Objective(s)

The program development objective is to strengthen the quality and efficiency of Indonesia's National Health Insurance program.

Program Development Objective Indicators by Objectives/Outcomes

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
			1	2	
Strengthened quality					
Improved provider competency score in FKTPs (Text)		To be determined in 2022			Increased above baseline values for at least 70 percent of all providers assessed
Improved member satisfaction rate and its continued use as a BPJS-K performance monitoring indicator (Text)		81.5%	Above 82% (and continued as BPJS performance indicator)	Above 82%(and continued as BPJS performance indicator)	Above 82% (and continued as BPJS performance indicator)
Enhanced Efficiency					
Increase in the % of outpatient utilization among bottom two quintiles (Percentage)		13.20	14.20		15.20
More sustainable claims ratio (Text)	DLI 3	102%	<98%	<98%	<98%



Intermediate Results Indicator by Results Areas

Indicator Name	DLI	Baseline	Intermediate Targets		End Target
			1	2	
Improving quality					
Improved provider competency on maternal care disaggregated (Text)		Baseline to be determined			The competence scores are increased for at least 70 percent of the providers assessed.
Share of FKTPs trained in using the clinical decision support tool (Percentage)	DLI 1	0.00	10.00	50.00	90.00
Number of clinical diagnostic, treatment, or referral guidelines formulated into processes of care for FKRTLs (Number)	DLI 2	0.00	5.00	10.00	20.00
Increase in the % of antenatal care visits in-line with clinical protocols disaggregated by province (Text)		Baseline in Year 2			To be determined
Number of maternal deaths caused by hypertension disaggregated by province (Text)		1,066.00			<900
Increase in the % of adults screened for diabetes and hypertension in-line with clinical protocols (Text)		Baseline in year 2			To be determined
Improving efficiency					
Recommended tracer indicators embedded and automated in the claims verification software to monitor compliance with evidence-based care (Text)	DLI 4	0.00	15 FKTP and 3 FKRTL tracer indicators embedded and automated	15 FKTP and 7 FKRTL tracer indicators (cumulative) embedded and automated	25 (15 for FKTP and 10 for FKRTL)



Indicator Name	DLI	Baseline	Intermediate Targets		End Target
			1	2	
Decrease in the % of hospital claims that are rejected/not verified (by reason...e.g. incomplete, error, ineligible expenditure, abuse) (Text)		To be determined			To be determined
Number of additional performance and quality indicators included in primary care payment system (Number)	DLI 6	3.00	8.00		13.00
Cumulative number of FKRTLs with trained and certified clinical coders (Number)	DLI 7	0.00	500.00	1,100.00	1,800.00
Support JKN policy formulation and implementation					
Number of information systems integrated as per roadmap target (Text)	DLI 5	0.00			To be determined by roadmap
Improved policy formulation and oversight of JKN (Text)	DLI 8	NA	Dashboard for internal policy use in place; Annual report for previous year published	Annual report for previous year published	Annual report for previous year published



Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Improved provider competency score in FKTPs	Average score of FKTP providers' competencies on select tracer conditions	At beginning and end of operation	New Baseline in year 2	Assessment will be based on survey/clinical vignettes before and after the implementation and training of clinical decision support tool	DG primary health care, MOH
Improved member satisfaction rate and its continued use as a BPJS-K performance monitoring indicator	Average score resulting from exit polls The levels of participants' satisfaction are based on scores from exit polls measured at all service levels using a Likert scale as follows: (1) Dissatisfied; (2) somewhat dissatisfied; (3) somewhat satisfied; (4) satisfied; (5) very satisfied.	Annual	BPJS-K administrative data Baseline: 81.5% in 2020 according to website Target: Above 82%	Third party carries out exit poll surveys	BPJS-K
Increase in the % of outpatient utilization among bottom two quintiles	Numerator: Outpatient utilization among bottom two income quintiles Denominator: Total outpatient utilization	Annual	Baseline 2020 quintile 1 and 2 average: 13.2 Target: 15.2	Susenas	BPS
More sustainable claims ratio	Numerator: Total JKN expenditures	Annual	BPJS-K administrative	To be calculated by BPJS-K from	BPJS-K



	Denominator: Total contributions		data	administrative data	
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Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Improved provider competency on maternal care disaggregated	Assessment of provider competence based on pre/post survey/clinical vignette	At beginning and end of operation	New Baseline in year 2	Assessment will be based on survey/clinical vignettes before and after the implementation and training of clinical decision support tool	DG primary health care, MOH
Share of FKTPs trained in using the clinical decision support tool	Numerator: Number of FKTPs enabled in using clinical decision support tool Denominator: Total number of FKTPs	Annual	Baseline: 0 Target: 90%	To be provided by MOH	DG primary health care, MOH
Number of clinical diagnostic, treatment, or referral guidelines formulated into processes of care for FKRTLs	Number of clinical diagnostic, treatment, or referral guidelines formulated into processes of care for FKRTLs	Annual	Baseline: 0 Target: 20	To be provided by MOH	DG Referral Health Services, MOH
Increase in the % of antenatal care visits in-line with clinical protocols disaggregated by province	Numerator: Number of ANC visits in-line with clinical protocols Denominator: Total number of ANC visits	Semi-annual	PCare Baseline in year 2	To be generated by PCare	BPJS-K
Number of maternal deaths caused by hypertension disaggregated by province	Number of maternal deaths caused by hypertension during the preceding year	Annual	MOH administrative data Baseline: 1,066 (see	To be provided by MOH	Family Health Directorate, MOH



			annex for provinces)		
Increase in the % of adults screened for diabetes and hypertension in-line with clinical protocols	Numerator: Number of adults screened for diabetes and hypertension Denominator: Total number of eligible adults (i.e., all adults above 15 years old as per Permenkes on Minimum Service Standard of Care/SPM 2019))	Semi-annual	PCare Baseline in year 2	To be generated by PCare	BPJS-K
Recommended tracer indicators embedded and automated in the claims verification software to monitor compliance with evidence-based care	Based on FKTP and FKRTL clinical pathway adopted under DLIs 1 and 2, the number of recommended tracer indicators embedded and automated in the claims verification software to monitor compliance with evidence-based care	Annual	Baseline: 0 Target: 23 (15 for FKTP and 8 for FKRTL)	PCare and Ekclaim/vklaim	BPJS-K
Decrease in the % of hospital claims that are rejected/not verified (by reason...e.g. incomplete, error, ineligible expenditure, abuse)	Numerator: Number of hospital claims that rejected/not verified in a month Denominator: Total number of hospital claims submitted in a month	Monthly	Vklaim Baseline:	To be generated by Vklaim	BPJS-K
Number of additional performance and quality indicators included in primary care	At least 5 additional performance and quality	Annual	Baseline: 3 Target: 7	PCare	BPJS-K



payment system	indicators included in primary care payment system in line with roadmap				
Cumulative number of FKRTLs with trained and certified clinical coders	Number of FKRTLs with trained and certified clinical coders	Annual	New Baseline: 0 Target: 1,800	TBD as this will be a new activity	PPJK, MOH
Number of information systems integrated as per roadmap target	Number of information systems integrated as per roadmap target	Annual	Baseline: 0 Target: TBD by roadmap	To be provided by MOH	MOH
Improved policy formulation and oversight of JKN	DJSN has produced and published an annual performance report on JKN on its website	Annual	New Target: 1 report per year	To be produced by DJSN	DJSN



ANNEX 2. DISBURSEMENT LINKED INDICATORS, DISBURSEMENT ARRANGEMENTS AND VERIFICATION PROTOCOLS

Disbursement Linked Indicators Matrix				
DLI 1	Improved quality of care in primary care health facilities/ FKTPs			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	47,000,000.00	21.13
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		47,000,000.00	NA
DLI 1.1	MOH has developed, approved and adopted a clinical decision support tool for FKTPs in Year 1			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	20,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	Clinical decision support tool to develop			
Until September 30, 2022	A clinical decision support tool for FKTPs has been developed, approved and adopted in Year 1		20,000,000.00	\$20,000,000 by the end of Year 1



Oct 1, 2022 to Sep 30, 2023	NA		0.00	NA
Oct 1, 2023 to Sep 30, 2024	NA		0.00	NA
Oct 1, 2024 to Sep 30, 2025	NA		0.00	NA
DLI 1.2	MOH has trained 90% (cumulative) of all FKTPs on the clinical decision support tool			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	27,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			
Until September 30, 2022	NA		0.00	NA
Oct 1, 2022 to Sep 30, 2023	MOH has trained 10% (cumulative) of all FKTPs on the clinical decision support tool		3,000,000.00	US \$300,000 for each one percentage point increase in FKTPs trained, up to the maximum of \$27,000,000
Oct 1, 2023 to Sep 30, 2024	MOH has trained 50% (cumulative) of all FKTPs on the clinical decision support tool		12,000,000.00	US \$300,000 for each one percentage point increase in FKTPs trained, up to the maximum of \$27,000,000
Oct 1, 2024 to Sep 30, 2025	MOH has trained 90% (cumulative) of all FKTPs on the clinical decision support tool		12,000,000.00	US \$300,000 for each one percentage point increase in FKTPs trained, up to the maximum of \$27,000,000



DLI 2	Improved quality of care at referral hospitals/ FKRTLs			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	40,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		40,000,000.00	-
DLI 2.1	MOH has formulated and issued at least twenty (20) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs.			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	40,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	0.00			
Until September 30, 2022	MOH has formulated and issued five (5) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs in Year 1.		10,000,000.00	\$2,000,000 per each clinical diagnostic, treatment, or referral guideline formulated, up to the maximum of \$40,000,000



Oct 1, 2022 to Sep 30, 2023	MOH has formulated and issued five (5) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs in Year 2.	10,000,000.00	\$2,000,000 per each clinical diagnostic, treatment, or referral guideline formulated, up to the maximum of \$40,000,000
Oct 1, 2023 to Sep 30, 2024	MOH has formulated and issued five (5) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs in Year 3	10,000,000.00	\$2,000,000 per each clinical diagnostic, treatment, or referral guideline formulated, up to the maximum of \$40,000,000
Oct 1, 2024 to Sep 30, 2025	MOH has formulated and issued five (5) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs in Year 4	10,000,000.00	\$2,000,000 per each clinical diagnostic, treatment, or referral guideline formulated, up to the maximum of \$40,000,000

DLI 3	HTA findings incorporated into the benefit package (BP)			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Process	Yes	Text	35,000,000.00	8.70
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		35,000,000.00	NA



DLI 3.1	MOH has developed, approved, and formally adopted the Revised HTA Guidelines			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	5,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	MOH plan to develop, approve, and formally adopt the Revised HTA Guidelines			
Until September 30, 2022	MOH has developed, approved, and formally adopted the Revised HTA Guidelines		5,000,000.00	Paid in full upon achievement of DLI target
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 3.2	MOH has completed fifteen (15) additional HTA studies in accordance with the Revised HTA Guidelines and disseminated the findings of such studies to the public			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	15,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	MOH has completed five (5) additional HTA studies during Year 2, in accordance with the		5,000,000.00	\$1,000,000 per HTA study up to the



	Revised HTA Guidelines and disseminated the findings of such studies to the public.		maximum of \$15,000,000	
Oct 1, 2023 to Sep 30, 2024	MOH has completed five (5) additional HTA studies during Year 3, in accordance with the Revised HTA Guidelines and disseminated the findings of such studies to the public.	5,000,000.00	\$1,000,000 per HTA study up to the maximum of \$15,000,000	
Oct 1, 2024 to Sep 30, 2025	MOH has completed five (5) additional HTA studies during Year 4, in accordance with the Revised HTA Guidelines and disseminated the findings of such studies to the public.	5,000,000.00	\$1,000,000 per HTA study up to the maximum of \$15,000,000	
DLI 3.3	At least five (5) of HTA studies completed under DLR 3.2 have informed the revision of the Benefit Package			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	15,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	At least five (5) of HTA studies completed under DLR 3.2 have informed the revision of the Benefit Package		15,000,000.00	Paid in full upon achievement of DLI target



DLI 4	Improved claims management and prevention of ineligible and unnecessary claims			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	70,000,000.00	17.40
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		70,000,000.00	NA
DLI 4.1	BPJS-K has revised and adopted the specified manuals, guidelines, and/or protocols for claims management, prevention of ineligible and unnecessary claims, and audit processes			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	20,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			
Until September 30, 2022	BPJS-K has revised and adopted the specified manuals, guidelines, and/or protocols for claims management, prevention of ineligible and unnecessary claims, and audit processes		20,000,000.00	Paid in full upon achievement of DLI target



Oct 1, 2022 to Sep 30, 2023	NA		0.00	NA
Oct 1, 2023 to Sep 30, 2024	NA		0.00	NA
Oct 1, 2024 to Sep 30, 2025	NA		0.00	NA
DLI 4.2	BPJS-K has embedded and automated the recommended tracer indicators into the claims verification software within 12 months of MOH's issuance of the relevant tool/pathway			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	30,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	(a) Based on the FKTP's clinical decision support tool developed under DLR 1.1, BPJS-K has embedded and automated fifteen (15) of the recommended tracer indicators into the claims verification software within 12 months of MOH's issuance of a clinical decision support tool for FKTPs under DLR 1.1; and (b) Based on the FKRTL's processes of care formulated under DLR 2, BPJS-K has embedded and automated 3 of the recommended tracer indicators in the claims verification software within 12 months of MOH's issuance of guidelines under DLR 2;		16,000,000.00	(a) \$10,000,000 Paid in full upon achievement of target (b) \$2,000,000 per tracer indicator embedded and automated within 12 months
Oct 1, 2023 to Sep 30, 2024	(b) Based on the FKRTL's processes of care		8,000,000.00	(b) \$2,000,000 per tracer indicator



	formulated under DLR 2, BPJS-K has embedded and automated 4 more of the recommended tracer indicators in the claims verification software within 12 months of MOH's issuance of guidelines under DLR 2;		embedded and automated within 12 months of MOH's issuance of guidelines	
Oct 1, 2024 to Sep 30, 2025	(b) Based on the FKRTL's processes of care formulated under DLR 2, BPJS-K has embedded and automated 3 more of the recommended tracer indicators in the claims verification software within 12 months of MOH's issuance of guidelines under DLR 2;	6,000,000.00	(b) \$2,000,000 per tracer indicator embedded and automated within 12 months of MOH's issuance of guidelines	
DLI 4.3	At least 250 FKRTL claims have been subjected to the detailed claims audit in each calendar quarter of Years 2-4, using the revised claims audit protocol developed under DLR 4.1.			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	20,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			
Until September 30, 2022	NA		0.00	NA
Oct 1, 2022 to Sep 30, 2023	At least 250 FKRTL claims have been subjected to the detailed claims audit in each calendar quarter of Years 2-4, using the revised claims audit protocol developed under DLR 4.1.		8,000,000.00	4 quarters @ \$2,000,000 for each calendar quarter
Oct 1, 2023 to Sep 30, 2024	At least 250 FKRTL claims have been subjected to the detailed claims audit in each calendar quarter of Years 2-4, using the revised claims audit		8,000,000.00	4 quarters @ \$2,000,000 for each calendar quarter



	protocol developed under DLR 4.1.			
Oct 1, 2024 to Sep 30, 2025	At least 250 FKRTL claims have been subjected to the detailed claims audit in each calendar quarter of Years 2-4, using the revised claims audit protocol developed under DLR 4.1.		4,000,000.00	2 quarters @ \$2,000,000 for each calendar quarter
DLI 5	Improved use of data in decision making			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	30,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	NA
Oct 1, 2022 to Sep 30, 2023	-		0.00	NA
Oct 1, 2023 to Sep 30, 2024	-		0.00	NA
Oct 1, 2024 to Sep 30, 2025	-		30,000,000.00	NA
DLI 5.1	(a) Roadmap for better data use for decision making including plan for data system integration developed & approved; (b) Information systems are integrated as per the targets identified in roadmap			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	30,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			



Until September 30, 2022	MOH has ensured that roadmap for better data use for decision making, including plan for data system integration is developed and approved;		10,000,000.00	Paid in full upon achievement of DLI target
Oct 1, 2022 to Sep 30, 2023	MOH has ensured that information systems are integrated and better data use for decision making is undertaken as per the target identified in the roadmap for Year 2		10,000,000.00	\$10,000,000 for each year in which information systems are integrated as per the targets identified in the roadmaps
Oct 1, 2023 to Sep 30, 2024	MOH has ensured that information systems are integrated and better data use for decision making is undertaken as per the target identified in the roadmap for Year 3		10,000,000.00	\$10,000,000 for each year in which information systems are integrated as per the targets identified in the roadmaps
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 6	Improved design and implementation of primary health care payment methods			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	58,000,000.00	14.91
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		58,000,000.00	-



DLI 6.1	MOH and BPJS-K have jointly developed and approved the roadmap for revising primary care payment system design			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	20,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	MOH and BPJS-K have jointly developed and approved the roadmap for revising primary care payment system design		20,000,000.00	Paid in full upon achievement of DLI target
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 6.2	MOH has ensured that ten (10) additional performance and quality indicators are included in the primary care payment system in line with the roadmap approved under DLR 6.1			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	20,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	MOH has ensured that five (5) additional performance and quality indicators are included		10,000,000.00	\$2,000,000 paid for each additional performance and quality indicator



	in the primary care payment system in line with the roadmap approved under DLR 6.1		included in the primary care payment system
Oct 1, 2023 to Sep 30, 2024	MOH has ensured that five (5) additional performance and quality indicators are included in the primary care payment system in line with the roadmap approved under DLR 6.1	10,000,000.00	\$2,000,000 paid for each additional performance and quality indicator included in the primary care payment system
Oct 1, 2024 to Sep 30, 2025	-	0.00	-
DLI 6.3	MOH has ensured that 90% of FKTPs are implementing the revised primary care payment system as per the roadmap approved under DLR 6.1 by Year 4		
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)
Output	Yes	Percentage	18,000,000.00
Period	Value	Allocated Amount (USD)	Formula
Baseline	0.00		
Until September 30, 2022	0.00	0.00	-
Oct 1, 2022 to Sep 30, 2023	30.00	6,000,000.00	\$200,000 paid for each additional percentage point of FKTPs which are implementing the revised primary care payment system
Oct 1, 2023 to Sep 30, 2024	60.00	6,000,000.00	\$200,000 paid for each additional percentage point of FKTPs which are implementing the revised primary care payment system



Oct 1, 2024 to Sep 30, 2025	90.00		6,000,000.00	\$200,000 paid for each additional percentage point of FKTPs which are implementing the revised primary care payment system
DLI 7	Improved implementation of hospital payments			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	78,000,000.00	18.64
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		78,000,000.00	-
DLI 7.1	MOH has developed and adopted (a) clinical coding guidelines and audit protocol; (b) clinical coding training course; and (c) standardized cost accounting template			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	25,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	MOH plan to develop and adopt (a) clinical coding guidelines and audit protocol; (b) clinical coding training course; and (c) standardized cost			



	accounting template			
Until September 30, 2022	MOH has developed and adopted (a) clinical coding guidelines and audit protocol; (b) clinical coding training course; and (c) standardized cost accounting template		25,000,000.00	(a) 10,000,000 (b) 5,000,000 (c) 10,000,000. Amount allocated to the respective DLR sub-target paid in full upon achievement.
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 7.2	MOH has arranged for training and certification of at least one coder in each of 1,800 FKRTLs (cumulative) by Year 4;			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Number	18,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	0.00			
Until September 30, 2022	0.00		0.00	-
Oct 1, 2022 to Sep 30, 2023	500.00		5,000,000.00	\$ 10,000 per each FKRTL where the coders are trained and certified
Oct 1, 2023 to Sep 30, 2024	1,100.00		6,000,000.00	\$ 10,000 per each FKRTL where the coders are trained and certified
Oct 1, 2024 to Sep 30, 2025	1,800.00		7,000,000.00	\$ 10,000 per each FKRTL where the coders are trained and certified



DLI 7.3	MOH has randomly assessed 40 FKRTLs for coding accuracy during Years 3 and 4			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	10,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	MOH has randomly assessed 20 FKRTLs for coding accuracy during Year 3		5,000,000.00	\$250,000 for each one of FKRTLs randomly assessed during Years 3 and 4, up to the maximum of \$10,000,000
Oct 1, 2024 to Sep 30, 2025	MOH has randomly assessed 20 FKRTLs for coding accuracy during Year 4		5,000,000.00	\$250,000 for each one of FKRTLs randomly assessed during Years 3 and 4, up to the maximum of \$10,000,000
DLI 7.4	MOH has revised, adopted and published on its website INACBG tariffs in line with cost accounting data and any other relevant evidence.			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	25,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			



Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	MOH has revised, adopted and published on its website INACBG tariffs in line with cost accounting data and any other relevant evidence.		25,000,000.00	Paid in full on achievement of the DLI target
DLI 8	Improved policy formulation and oversight of JKN			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	22,000,000.00	6.21
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		22,000,000.00	-



DLI 8.1	DJSN has developed a dashboard of key monitoring indicators from JKN and other relevant data sources, and such dashboard is in use by DJSN			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	10,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	DJSN has developed a dashboard of key monitoring indicators from JKN and other relevant data sources, and such dashboard is in use by DJSN		10,000,000.00	Paid in full on achievement of the DLI target
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 8.2	DJSN has produced and published on its website an annual performance report on JKN in each of Years 2-4			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	Yes	Text	12,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	NA			
Until September 30, 2022	-		0.00	-



Oct 1, 2022 to Sep 30, 2023	DJSN has produced and published on its website an annual performance report on JKN in Year 2	4,000,000.00	\$4,000,000 for each report published in Years 2-4, up to the maximum of \$12,000,000
Oct 1, 2023 to Sep 30, 2024	DJSN has produced and published on its website an annual performance report on JKN in Year 3	4,000,000.00	\$4,000,000 for each report published in Years 2-4, up to the maximum of \$12,000,000
Oct 1, 2024 to Sep 30, 2025	DJSN has produced and published on its website an annual performance report on JKN in Year 4	4,000,000.00	\$4,000,000 for each report published in Years 2-4, up to the maximum of \$12,000,000

DLI 9	Improved coordination, impact, and sustainability of JKN			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Process	No	Text	20,000,000.00	4.97
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			
Until September 30, 2022	-		0.00	-
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		20,000,000.00	-



DLI 9.1	Program Secretariat is strengthened with additional technical experts and consultants in accordance with the Operations Manual;			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	10,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	Program Secretariat plan to strengthen its capacity with additional technical experts and consultants in accordance with the Operations Manual;			
Until September 30, 2022	Program Secretariat is strengthened with additional technical experts and consultants in accordance with the Operations Manual;		10,000,000.00	Paid in full on achievement of the DLI target
Oct 1, 2022 to Sep 30, 2023	-		0.00	-
Oct 1, 2023 to Sep 30, 2024	-		0.00	-
Oct 1, 2024 to Sep 30, 2025	-		0.00	-
DLI 9.2	Program Secretariat compiles and analyzes JKN data and provides recommendations on the JKN-related objectives for the new RPJMN in Year 4			
Type of DLI	Scalability	Unit of Measure	Total Allocated Amount (USD)	As % of Total Financing Amount
Output	No	Text	10,000,000.00	
Period	Value		Allocated Amount (USD)	Formula
Baseline	-			



Until September 30, 2022	-	0.00	-
Oct 1, 2022 to Sep 30, 2023	-	0.00	-
Oct 1, 2023 to Sep 30, 2024	-	0.00	-
Oct 1, 2024 to Sep 30, 2025	Program Secretariat compiles and analyzes JKN data and provides recommendations on the JKN-related objectives for the new RPJMN in Year 4	10,000,000.00	Paid in full on achievement of the DLI target



Verification Protocol Table: Disbursement Linked Indicators

DLI 1	Improved quality of care in primary care health facilities/ FKTPs
Description	This DLI will support the development of a clinical decision support tool for providers at the FKTP level to screen and manage patients. It will also ensure providers are trained on how to use the tool.
Data source/ Agency	DG primary health care, MOH
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of the clinical decision support tool to ensure it includes minimum design features described under DLI 1.1. BPKP will review the training agenda, manual(s), and training documentation, including the list of FKTPs and personnel participating in the training exercise. BPKP may also verify training registration and receipts from training events, and randomly call participants to verify training.
DLI 1.1	MOH has developed, approved and adopted a clinical decision support tool for FKTPs in Year 1
Description	This DLI will support the development of a clinical decision support tool for providers at the FKTP level to screen and manage patients.
Data source/ Agency	DG primary health care, MOH
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of the clinical decision support tool in two formats – a hard copy and an electronic copy. At minimum, the tool should be searchable both by symptoms and conditions, with additional guidance on how to address general health visits and emergencies. Guidance should be arranged in concise algorithms, with clear guidance on what questions to ask to assess patient history, what investigations or tests to conduct, how to interpret findings, and how to treat and manage patients based on diagnosis. The tool should cover all common adult conditions encountered in an FKTP setting as agreed with the GOI. It should include guidance on when and where to refer patients. Finally, it should provide clinical coding guidance for each condition and recommend tracer indicators to monitor compliance with standard treatment guidelines.



DLI 1.2	MOH has trained 90% (cumulative) of all FKTPs on the clinical decision support tool
Description	This DLI will ensure providers are trained on how to use the clinical decision support tool developed in year 1.
Data source/ Agency	DG primary health care, MOH
Verification Entity	BPKP
Procedure	<p>BPKP will review the training agenda, manual(s), and training documentation, including the list of FKTPs and personnel participating in the training exercise, and the assessment of provider competence carried out before and after the training. At least 2 key front line personnel who have a role in seeing patients (e.g., doctors, nurses, midwives) should participate in the training. BPKP may also verify training registration and receipts from training events, and randomly call participants (e.g., 0.05% of participants) to verify training took place.</p> <p>The percent of FKTPs that are trained to use the clinical decision support tool is defined as: Numerator: Total number of public and private FKTPs who had at least 2 of their key front line personnel trained in the use of the clinical decision support tool. Denominator: Total number of public and private FKTPs contracted with JKN. This DLI is scalable and in accordance to the number of FKTPs trained.</p>
DLI 2	Improved quality of care at referral hospitals/ FKRTLs
Description	This DLI will support the formulation of new diagnostic, treatment, or referral guidelines into processes of care for FKRTLs
Data source/ Agency	DG Referral Health Services, MOH
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of the clinical pathways/processes of care to ensure it includes minimum design features described under DLI 2.1.
DLI 2.1	MOH has formulated and issued at least twenty (20) new clinical diagnostic, treatment, or referral guidelines into processes of care for FKRTLs.
Description	This DLI will support the formulation of new diagnostic, treatment, or referral guidelines into processes of care for FKRTLs for at least twenty prioritized conditions.
Data source/ Agency	DG Referral Health Services, MOH



Verification Entity	BPKP
Procedure	<p>Selection of the 20 prioritized conditions should be chosen based on high cost, high volume conditions and availability of existing national clinical guidelines. BPKP will carry out a desk review of the developed clinical pathways and national clinical guidelines to ensure it includes at minimum the features below:</p> <ul style="list-style-type: none"> • A concise algorithmic approach to patient management that guides providers on what questions to ask to assess patient history, what investigations or tests to conduct, how to interpret findings, and how to treat and manage patients based on diagnosis. • Be in-line with existing national clinical guidelines and/or international evidence-base (where national guidance is not available) • Reflect local referral hospital context • Provide clinical coding guidance (i.e. ICD coding) for each condition • Recommend tracer indicators for each pathway that should be incorporated in the claims information system to monitor compliance with standard treatment guidelines. <p>This DLI is scalable and in accordance to the number of clinical pathways formulated and issued.</p>
DLI 3	HTA findings incorporated into the benefit package (BP)
Description	This DLI aims to revise existing HTA guidance to help inform decision-making about the value of new and existing technologies; build capacity within the MOH to carry out HTA studies and inform the benefit package.
Data source/ Agency	PPJK, MOH
Verification Entity	BPKP
Procedure	BPKP will primarily carry out desk reviews to ensure HTA studies were done in compliance with revised HTA guidelines and were incorporated into the benefit package.
DLI 3.1	MOH has developed, approved, and formally adopted the Revised HTA Guidelines
Description	This DLI aims to revise the HTA guidelines to ensure transparency and consistency in how HTA studies are conducted.
Data source/ Agency	MOH, PPJK
Verification Entity	BPKP



Procedure

BPKP will carry out a desk review of the revised HTA guidelines to ensure that they include (i) explicit criteria for how diagnostic and/or screening technologies, drug therapies, medical devices, and procedures are selected for evaluation; (ii) a description of the methodology for carrying out the HTA; (iii) explicit criteria for decision making; and (iv) explanation of how findings will be used for informing the benefit package, including the extent and form in which they will be disseminated to the public.

Explicit criteria for how diagnostic and/or screening technologies, drug therapies, medical devices, and procedures are selected: At minimum, this section should describe (i) who can initiate or request an assessment and what screening process will be used to determine the suitability of the topic (e.g., the MOH, BPJS-K, DJSN, patient’s advocates, health care providers and/or medical professional bodies, HTA committee); (ii) the reasons why an assessment might be needed (e.g., new technology, changes to old technology, new indications for old technology, service delivery changes, safety concerns, ethical concerns, economic concerns, etc.); and (iii) the main research question or type of decision the assessment will support (e.g., investment decision, market licensure, inclusion/exclusion in the benefit package or essential drug list, resource allocation and planning decisions, the appropriate service delivery platform, etc.)

Methodology for carrying out HTA: At minimum, this section of the guideline should describe the preferred key reference case elements for the economic evaluation, in addition to the details for other priority setting criteria highlighted in the guidelines.

1. the evaluation type (e.g. cost-benefit analysis, cost-utility analysis, cost-effectiveness analysis);
2. the perspective on outcomes (e.g., natural units such as life years or cases detected, quality-adjusted life-years, monetary valuation of outcomes);
3. the perspective on costs (e.g., direct costs of the publicly-funded health and social insurance system or broader societal perspective that captures indirect costs including productivity costs);
4. the choice of comparator (e.g., routine care, second line treatments, no intervention);
5. the discount rate;
6. sensitivity analysis (e.g., probabilistic sensitivity analysis);
7. required subgroup analysis (e.g., age, gender, co-morbidities, treatment setting);
8. source of efficacy and effectiveness evidence (e.g., randomized control trials, meta-analysis on outcome data, single study)
9. who is allowed to carry out the assessment (e.g., public or private institution)
10. standardized and transparent reporting format and/or template of HTA findings

In addition, explicit reference to a budget impact analysis should be required along with the economic evaluation.



	<p>Explicit criteria: This section should describe the core criteria (and thresholds if applicable) by which a decision will be made and how each criteria will be weighted and by whom. Among the most common criteria are: efficacy/effectiveness; cost; cost-effectiveness; safety; feasibility of delivery and supply side constraints; equity considerations; financial protection considerations, and budget impact.</p> <p>Dissemination of findings to the public: Based on a standardized and transparent reporting format agreed and included as part of the guidelines, all parameters included in the estimation should be itemized in tabular form with data sources and values for each parameter and all relevant HTA findings on expected mean and total costs and benefits, including subgroup and sensitivity analysis should be disseminated to the public via a public website and press release. In the interests of transparency, findings should include a conflict of interest statement in relation to all those involved in the assessment.</p>
DLI 3.2	MOH has completed fifteen (15) additional HTA studies in accordance with the Revised HTA Guidelines and disseminated the findings of such studies to the public
Description	This DLI aims to increase the production capacity of the MOH to complete additional HTA studies.
Data source/ Agency	PPJK, MOH
Verification Entity	BPKP
Procedure	<p>All completed HTA studies should be in accordance with the above guidelines. A desk review of each HTA study findings will ensure they comply with the criteria laid out in the revised HTA guidelines. Findings disseminated to the public will at minimum consist of publication on the relevant public websites (e.g., BPJS-K entitlement page, MOH HTA Committee website) and issuance of a press release.</p> <p>This DLI is scalable and in accordance to the number of studies completed and published.</p>
DLI 3.3	At least five (5) of HTA studies completed under DLR 3.2 have informed the revision of the Benefit Package
Description	This DLI aims to ensure findings from HTA studies get incorporated into the benefits package.
Data source/ Agency	PPJK, MOH and BPJS-K
Verification Entity	BPKP
Procedure	BPKP to review of BPJS-K’s claims verification manual and/or verification software to confirm that the benefit package was revised in line with the HTA recommendations, and/or the HTA guidance has been incorporated into BPJS-K’s claims verification process and/or automated into its claims verification checks.



DLI 4	Improved claims management and prevention of ineligible and unnecessary claims
Description	This DLI aims to improve the quality of claims management by (i) regularly updating BPJS-K’s claims verification manual and audit protocols to reflect actual rather than aspirational processes as the system matures and processes are automated; (ii) embedding and automating at least 15 service verification tracer indicators for FKTPs and at least 10 of recommended tracer indicators at FKRTLs into the claims verification software to monitor compliance with protocol-based care; and (iii) ensuring detailed claims audits are carried out on at least 250 hospital claims in each calendar quarter using revised claims audit protocol.
Data source/ Agency	BPJS-K
Verification Entity	BPKP
Procedure	<p>BPKP will carry out a desk review of the BPJS-K’s claims verification manual to ensure inclusion of basic information as detailed under DLI 4.1.</p> <p>BPKP will review the clinical decision support tool and algorithms developed under DLIs 1 and 2 to ensure BPJS-K claims verification manual and claims processing systems (PCare, Vklaim/Vidi) have incorporated/embedded recommendations and tracer indicators.</p> <p>BPKP will review the claims audit template and protocol, findings of claims audit reports, and relevant clinical pathways, where applicable to strengthen the claims auditing function and ensure compliance with clinical pathways.</p>
DLI 4.1	BPJS-K has revised and adopted the specified manuals, guidelines, and/or protocols for claims management, prevention of ineligible and unnecessary claims, and audit processes
Description	This DLI aims to strengthen the claims verification process by revising and updating the relevant manuals, guidelines, and/or protocols related to claims management.
Data source/ Agency	BPJS-K
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of BPJS-K’s claims verification manual to ensure the manual at minimum itemizes which basic administrative and service verification checks are required, the criteria for verification for each type of check, and the process for dealing with non-verified or rejected claims. It should also indicate which steps are currently automated and can be done prior to payment and which still require manual verification and may need to be done as part of a post-verification process so as not to unduly delay claims processing. The timeline for completing post-verification checks should also be



listed.

Administrative checks should include (i) a list of supporting documents and information required for considering the claim complete, (ii) the criteria for considering a member eligible (e.g., compliance with premium payments in last 3 months), (iii) eligibility of the benefits (e.g., based on patient type, class, prior-authorization, and/or lifetime or annual limits), (iv) the criteria for considering a claim a duplicate, and (v) the eligibility of providers/hospitals (e.g., are doctors licensed? are facilities empanelled by BPJS-K? does accreditation status match hospital class/tariff?). If a tracer indicator has been identified for a specific condition, it should be listed under the supporting information required for that condition.

Service verification should include which checks are to be carried out for assessing coding accuracy (e.g., diagnosis and procedure codes that should not be seen among certain genders or in certain age groups; diagnosis and procedure combinations that are incorrect or rare, unusual number of diagnosis codes per case) and what kind of analytics or methods are being used to identify red flags or trigger more in-depth manual review (e.g., based on outlier analysis).

Rejected claims: The claims manual should distinguish between the different reasons why a claim may be rejected. For example, claims can be rejected for incompleteness, errors, non-eligible expenditures, or abuse. The claims manual should define and mandate the monitoring of these indicators, including what actions (if any) should be taken in each case. It should also specify the procedure for processing claim rejections.

In addition, there are other types of post-payment controls that can help improve the claims management process. For example, various types of audits (e.g., claims audits, beneficiary audits, hospital audits, death audits), regular benchmarking and trend analysis, investigation of complaint patterns, advanced regression/predictive analysis based on artificial intelligence or machine learning. The manual should explain which of these types of post-payment controls are required and what methodology is followed. At minimum it should require regular claims audits be conducted on a random sample of at least 250 hospital claims each quarter (1,000 hospital claims each year).

The **claims audit protocol** should include an explicit template or checklist for claims verifiers of what questions and information must be collected and reviewed to verify whether (i) the patient's medical record/documentation match the claims details; (ii) the facility's details match information submitted at time of empanelment and claim submission; (iii) the patient's account of visit matches claims details; and (iv) there are any omissions, errors, or inconsistencies across documents/information collected.

This revision of the claims manual should set out processes to update the claims information system as and when standard clinical pathways and tracer indicators are determined in future years, and/or the clinical resume/ discharge summary format is introduced, so that the claims information system and manual could be regularly updated to reflect those changes.



DLI 4.2	BPJS-K has embedded and automated the recommended tracer indicators into the claims verification software within 12 months of MOH’s issuance of the relevant tool/pathway
Description	This DLI aims to verify that BPJS-K has embedded and automated the recommended tracer indicators into the claims verification software to facilitate compliance with clinical pathways developed under DLIs 1 and 2.
Data source/ Agency	BPJS-K
Verification Entity	BPKP
Procedure	<p>Embedding and automating at least 15 tracer indicators at the FKTP level within 12 months of MOH’s issuance of guidelines under DLI 1.1</p> <p>BPKP will review the clinical algorithms developed under DLI 1 for FKTPs, which should also include tracer indicators to monitor compliance with protocol-based care. Based on tracer indicators identified under DLI 1, BPKP will verify that BPJS-K has updated its claims information system verification manual to require the reporting of said indicators and automated the service verification check in its PCare software.</p> <p>For example, if under DLI 1 a tracer indicator for the diagnosis of diabetes is a blood glucose level within a specified the range of X and X, BPJS-K will automate its claims verification software to provide a warning or automatically reject a diagnosis of diabetes if the blood glucose value is missing (or falls outside the appropriate range, as may be specified in the tracer indicator).</p> <p>At minimum, tracer indicators for antenatal care, institutional delivery, diabetes, child immunization, and tuberculosis should be prioritized.</p> <p>Embedding and automating at least 10 tracer indicators at the FKRTL level within 12 months of MOH’s issuance of guidelines under DLI 2</p> <p>BPKP will review the clinical algorithms developed under DLI 2 for FKRTLs, which should include tracer indicators to monitor compliance with protocol-based care. Based on tracer indicators identified under DLI 2, BPKP will verify that BPJS-K has updated its claims processing system to require the reporting of said indicators and automated the service verification check in its Vklaim/Vidi software.</p> <p>Part (b) of this DLI is scalable and in accordance with the number of tracer indicators embedded and automated.</p>
DLI 4.3	At least 250 FKRTL claims have been subjected to the detailed claims audit in each calendar quarter of Years 2-4, using the revised claims audit protocol developed under DLR 4.1.
Description	The aim of the DLI is to strengthen the claims auditing function of BPJS-K and institutionalize the regular practice of carrying out detailed claims audits on a randomly selected sample of hospital claims.



Data source/ Agency	MOH
Verification Entity	BPKP
Procedure	<p>BPKP will verify that 250 hospital claims were audited each calendar quarter (every 3-month period) based on revised claims audit protocol developed by BPJS-K under DLI 4.1. BPKP will verify that claims were randomly selected by BPJS-K for a more detailed manual review following the claims audit template/protocol and in line with the the relevant clinical pathway, where applicable.</p> <p>BPKP will confirm detailed claims audit were carried out in line with audit protocols and that remedial action including warning or recovery notices or penalty notices, in accordance with the claims audit manual, were sent to the hospitals where claim audit suggests any non-compliance or questionable practices.</p> <p>This DLI is scalable and in accordance with the achievement of the target in each quarter.</p>
DLI 5	Improved use of data in decision making
Description	This DLI will support the complementary digital transformation agenda needed to ensure improvements in quality monitoring and claims management.
Data source/ Agency	MOH’s Pusdatin and BPJS-K’s data management unit
Verification Entity	BPKP
Procedure	Desk review of the data integration roadmap, relevant regulations on data access, privacy, and information sharing and spot checks and demonstrations of the integrated data systems.
DLI 5.1	(a) Roadmap for better data use for decision making including plan for data system integration developed & approved; (b) Information systems are integrated as per the targets identified in roadmap
Description	This DLI will develop a data integration roadmap and prioritize the integration of information systems needed to support better decision making, improvements in the quality of care and claims management.
Data source/ Agency	MOH’s Pusdatin and BPJS-K’s data management unit
Verification Entity	BPKP
Procedure	BPKP will review the roadmap to ensure at minimum it includes a clear theory of change, feasible timelines for achieving key milestones, and delineated roles and responsibilities by key stakeholder. In addition, it should include the following sections:



Identification of data needs and objectives: This section should explicitly identify the data needed by each stakeholder (e.g., MOH, BPJS-K, DJSN, MOF, Bappenas, Kemenko PMK, MOHA etc). In keeping with the principles of data privacy, only essential/minimal data should be collected. The purpose and use of said data should be clearly defined. For each indicator, a definition and source of data should also be identified – often after a data mapping and quality assessment exercise. If the same indicator is being collected by multiple sources, the best quality source (i.e., complete, timely, and accurate) should be prioritized for data integration. If needed indicators are not currently being collected, the processes that support data intake and reporting should be described and a timeline for implementation laid out.

Plan for data integration: This section should identify any ongoing integration initiatives, whether international/national standards are being used, and what the expected storage needs and architecture might be as data volume, variety, and scope expand in line with the described business needs of the previous section. For example, databases are often from a single source, the data is captured as is, and is used to process transactions. Data marts are warehouses designed for a specific subject or team (e.g. the claims department). They have less capacity to link multiple data sources together than warehouses and are generally smaller, with fit-for-purpose data. Data warehouses group several databases from multiple sources in a centralized system with multiple subject areas. They are often designed to meet the needs of whole organizations or sectors. Before data is put in the warehouse it must be extracted or conform to a certain structure that is already defined. The data is generally highly curated. As such, the roadmap should specify agreements reached on where this centralized data will be housed, who will be responsible for basic data management and curation (Litbangkes, MOH, BPJS-K, other), and the process for accessing data.

This section should also include a timeline for data integration based on data availability and business needs.

Data privacy and security security measures. Data access should be assigned according to the business needs of each stakeholder. This section should describe the safeguards that will need to be in place for dealing with personal data.

The roadmap should include a clear timeline for integration of all the information systems listed as a ‘minimum’.

All information systems needed to support claims management will be integrated as per the roadmap. At a minimum the following information systems should be integrated by the end of the PforR:

- MOH’s eklaim and BPJS-K’s vklaim system integrated to facilitate hospital claims verification
- BPJS-K’s primary health care (PCare) and hospital claims (vklaim) systems integrated to allow patient tracking across levels of care
- BPJS-K’s membership database integrated with vklaim to allow automated verification of member eligibility
- MOH’s accreditation database (SIAF) and BPJS-K’s vklaim to allow automated verification of provider credentials
- MOH’s electronic referral system (SISRUTE) with BPJS-K’s vklaim system to verify claims



	<p>The following additional information systems are suggested for consideration for integration: Ministry of Home Affairs civil registry and vital statistics database, the Ministry of Social Affairs targeting database (DTKS), the MOF's tax database, and BPJS-Labour's membership database to automatically verify contribution compliance and membership eligibility. Verification that systems have been appropriately integrated will consist of a demonstration of how integrated systems fulfill the data needs and objectives highlighted under the roadmap, including ensuring compliance with any data privacy and security measures listed under the roadmap.</p>
DLI 6	Improved design and implementation of primary health care payment methods
Description	DLI 6 aims to improve the capitation design to reflect need and service availability at FKTPs. It will develop a roadmap based on a review of historical utilization patterns at FKTPs by age, gender, diagnosis; the ability of FKTPs to deliver interventions listed in the benefit package; the historical allocation and use of capitation, including undisbursed capitation; and the performance of existing PKBK indicators. The DLI also tracks the number of FKTPs piloting changes to the input-based capitation design as per timeline indicated in roadmap.
Data source/ Agency	PPJK, MOH, BPJS-K, FKTPs
Verification Entity	BPKP
Procedure	Roadmap for revising primary care payment system and underlying assessments/studies, BPJS-K administrative data on capitation disbursements, FKTP administrative records on capitation revenue
DLI 6.1	MOH and BPJS-K have jointly developed and approved the roadmap for revising primary care payment system design
Description	This DLI aims to develop a roadmap for revising the primary care payment system design
Data source/ Agency	PPJK, MOH and BPJS-K
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of the capitation roadmap and all relevant supporting studies and assessment findings to ensure recommendations are evidence-based and that the roadmap includes at minimum, a proposal for an alternative design to the input-based capitation formula and inclusion of an additional 10 quality indicators to the KBK scheme. It should include a description of the timeline for implementation changes. It should include appropriate incentives and disincentives to reduce over-referrals and encourage improved availability of services at primary level.



	<p>A review of the roadmap should reference evidence-informed assessments/studies for any changes to the capitation payment design, a clear theory of change, with feasible timelines for achieving key milestones, and delineated roles and responsibilities of key stakeholders. For example,</p> <ul style="list-style-type: none"> • Changes to the capitation formula. Alternatives to an input based capitation formula should be simulated to assess the distributional impact of the new formula across FKTPs and districts and then incorporated in the new design. • Supply side constraints. Changes to the services included under capitation should be informed by an assessment of whether FKTPs are able to deliver services. Any changes should also be reflected in the base per capita amount and referral definitions and quotas under the KBK scheme. • Additional incentives. Any additional financial incentives or top-up payments should be simulated to assess the potential distributional impact of the new formula across FKTPs and districts and the likely impact on utilization. If baseline data for simulation is not available, changes should be piloted and assessed before rolling out. <p>Refining performance-based capitation design. Here too, changes should be simulated to assess the potential distributional impact of the new formula across FKTPs and districts and the likely impact on utilization. If baseline data for simulation is not available, changes should be piloted and assessed before rolling out.</p>
DLI 6.2	MOH has ensured that ten (10) additional performance and quality indicators are included in the primary care payment system in line with the roadmap approved under DLR 6.1
Description	MOH has ensured that at least ten (10) additional performance and quality indicators are included in the primary care payment system in line with the capitation roadmap
Data source/ Agency	PPJK, MOH, BPJS-K
Verification Entity	BPKP
Procedure	BPKP to confirm indicators have been included in KBK design and embedded and reported in PCare as per roadmap. At minimum, tracer indicators for antenatal care, diabetes, hypertension, and tuberculosis should be prioritized. The choice of indicators should be informed by the tracer indicators developed under DLI 1 and embedded into BPJS-K’s claims management verification processes. BPKP should also review monthly performance data generated from PCare on each tracer indicator included in the KBK scheme to ensure reporting compliance.



DLI 6.3	MOH has ensured that 90% of FKTPs are implementing the revised primary care payment system as per the roadmap approved under DLR 6.1 by Year 4
Description	This DLI ensures that 90% of FKTPs are implementing the revised primary care payment system design in accordance with the roadmap
Data source/ Agency	PPJK, MOH, BPJS-K, FKTPs
Verification Entity	BPKP
Procedure	BPKP will verify that capitation disbursements are in line with roadmap design. BPKP will randomly call/visit 20 FKTPs to verify payments are in-line with BPJS-K administrative records. The percent of FKTPs that are implementing the revised capitation design is defined as: Numerator: Total number of public and private FKTPs implementing the revised capitation design. Denominator: Total number of public and private FKTPs contracted with JKN.
DLI 7	Improved implementation of hospital payments
Description	The successful implementation of DRGs is dependent on the quality of coding and representativeness of costing data. This DLI ensures that each FKRTL has at least one certified clinical coder; at least 40 FKRTLs have been assessed for clinical coding accuracy each year; and that DRG tariffs have been revised based on more representative cost data.
Data source/ Agency	PPJK, MOH
Verification Entity	BPKP
Procedure	BPKP will carry out a desk review of developed clinical coding and audit protocols, training course curriculum, training records, coding audit reports, cost accounting template, and relevant studies, assessments, and simulations that supported revisions to the INACBG tariffs. BPKP will also carry out limited spot checks and/or phone calls to FKRTLs.
DLI 7.1	MOH has developed and adopted (a) clinical coding guidelines and audit protocol; (b) clinical coding training course; and (c) standardized cost accounting template
Description	This DLI supports the development of clinical coding guidelines, coding training course, and standardized cost accounting template
Data source/ Agency	PPJK, MOH
Verification Entity	BPKP



Procedure

BPKP will carry out a desk review of the clinical coding guidelines and audit protocols, which should at minimum include the following:

- The source of the official coding standards (e.g., WHO’s ICD, Volume 2) used to direct code selection, including all other essential coding resources.
- The parties delegated with responsibility for code assignment and their required qualifications, including how often those qualifications need to be reassessed.
- The parties delegated with responsibility for training and certifying clinical coders and their required qualifications. This should also specify where and by whom information on coding certification status is held and maintained.
- The clinical documentation (e.g., medical record, discharge summary) that should be used to set codes. If there is no standardized forms for medical records, a checklist of information (e.g., diagnosis, procedures, symptoms, age, gender, patient history, test results, medications, etc.) that must be reviewed should be provided.
- The procedure to follow when clinical information is not clear enough to assign the correct code. This should include a statement that codes should not be assigned without supporting documentation from the provider.
- Instructions on where BPJS-K specific requirements may be accessed.
- Areas of risk that have been identified through audits or monitoring.
- The audit plan to ensure coding accuracy and consistency (e.g., frequency and sample size for clinical coding audits). This should include the parties delegated with the responsibility for conducting clinical coding audits and their required qualifications.
- An explicit template or checklist for the audit protocol.
- A process for coding new procedures or unusual diagnoses.
- Appropriate methods for resolving coding or documentation disputes with physicians.
- A procedure for processing claim rejections.
- A statement clarifying that codes will not be assigned, modified, or excluded solely for the purpose of maximizing reimbursement or avoiding reduced payment. Clinical codes will not be changed or amended merely because of either physicians’ or patients’ request to have the service in question covered by insurance.
- Specific guidance for FKTPs and FKRTLs depending on facility-specific casemix.

Guidance by department or specialty is highly desirable. For example, emergency department services may designate coding rules and guidelines that apply only in this setting.

BPKP should also review the curriculum for the clinical coding training course to ensure it demonstrates:

1. Expertise in reviewing and abstracting information from medical records to support accurate inpatient coding.



	<ol style="list-style-type: none"> 2. Expertise in assigning accurate ICD medical codes for diagnoses and procedures performed in the inpatient setting. 3. Knowledge of current rules, regulations, and issues regarding medical coding, compliance, and reimbursement under the INACBG system. 4. Understanding of anatomy, physiology, and medical terminology required to correctly code facility services and diagnoses. <p>Along with the development of this training course, BPKP should verify that an exam was also developed to assess above skills and recommend certification.</p> <p>BPKP should verify that the cost accounting template has been revised to include a more granular breakdown of cost. This should be informed by a review of cost accounting templates in other countries implementing DRG-based hospital payment systems. The template should be submitted to a minimum sample of representative public and private hospitals.</p>
DLI 7.2	MOH has arranged for training and certification of at least one coder in each of 1,800 FKRTLs (cumulative) by Year 4;
Description	This DLI ensures the training and certification of at least one clinical coder in each FKRTL
Data source/ Agency	PPJK, MOH or identified certification agency and FKRTLs
Verification Entity	BPKP
Procedure	<p>BPKP to verify registration and attendance of clinical coders at training course, including receipts and exam certification results. The certification agency should maintain a database of certified clinical coders, the date they passed their exam, and the name, location, and id of the hospital at which they work.</p> <p>BPKP will use above mentioned database to verify that each FKRTL has at least 1 certified clinical coders. BPKP will also carry out spot checks on a random sample of 15 hospitals to verify coder availability, including their training and confirm certification results. If spot checks are not feasible, BPKP should request a scan of the clinical coder certification and payment stub to verify employment at the FKRTL.</p>
DLI 7.3	MOH has randomly assessed 40 FKRTLs for coding accuracy during Years 3 and 4
Description	The aim of the DLI is to strengthen the coding accuracy of clinical coders and institutionalize the regular practice of carrying out coding audits on a randomly selected sample of hospital claims
Data source/ Agency	PPJK, MOH
Verification Entity	BPKP



Procedure	<p>BPKP will carry out a desk review to verify that coding audits were done on 40 randomly selected FKRTLs. They will review the coding audit reports and ensure they were done in compliance with coding guidelines and audit protocols developed under DLI 7.1. In particular, BPKP will ensure</p> <ul style="list-style-type: none"> • the hospital was randomly selected among a list of all FKRTLs contracted by JKN and that a relatively equal number of public and private FKRTLs were selected; • that the coding audit followed the template/checklist developed under DLI 7.1; and • that appropriate methods for resolving coding or documentation disputes with physicians were applied as developed under DLI 7.1. This item may further be verified by follow-up call with clinical coders at FKRTLs.
DLI 7.4	MOH has revised, adopted and published on its website INACBG tariffs in line with cost accounting data and any other relevant evidence.
Description	This DLI aims to revise the INACBG tariffs based on (i) a review of historical utilization patterns at FKRTLs by age, gender, diagnosis, and INACBG; and (ii) a review of expenditure patterns at FKRTLs by age, gender, length of stay, diagnosis, and INACBG.
Data source/ Agency	PPJK, MOH and BPJS-K
Verification Entity	BPKP
Procedure	<p>BPKP should confirm that revisions to the INACBG tariffs have been informed by studies/assessment reviewing:</p> <ul style="list-style-type: none"> • historical utilization patterns at FKRTLs by age, gender, diagnosis/casemix, and INACBG • historical expenditure patterns at FKRTLs by age, gender, length of stay, diagnosis, and INACBG <p>Proposed changes should also have been simulated to assess the distributional impact of the revised tariffs on FKRTLs.</p>
DLI 8	Improved policy formulation and oversight of JKN
Description	This DLI supports the development of a dashboard of indicators to monitor JKN performance and an annual report on JKN performance made publicly available on DJSN's website.
Data source/ Agency	DJSN
Verification Entity	BPKP
Procedure	BPKP will request a demonstration to assess the functionality of the dashboard, verify that monthly, quarterly, and yearly summary reports from the dashboard are used in DJSN briefings, and carry out desk review of the annual report to ensure it includes minimum information as described under DLI 8.2.



DLI 8.1	DJSN has developed a dashboard of key monitoring indicators from JKN and other relevant data sources, and such dashboard is in use by DJSN
Description	This DLI develops a dashboard of key performance indicators from JKN and other relevant data sources to support JKN policy formulation and oversight.
Data source/ Agency	DJSN
Verification Entity	BPKP
Procedure	<p>BPKP to verify that the dashboard at minimum includes the below information at the aggregate level to inform general management and oversight, disease surveillance, and targeting of resources. It should also be able to slice and dice key indicators by different groupings as indicated in parentheses and also by geographic region/province/district and by month and year.</p> <ol style="list-style-type: none"> 1. Coverage (overall and by group and class) 2. Active membership (overall and by group and class) 3. Provider network (overall and by facility type, public/private, accreditation status) 4. Beneficiary to provider ratio at FKTPs (overall and by facility type, public/private) 5. Utilization data (overall and by outpatient/inpatient, facility type, public/private, membership group, gender) 6. Top 20 diagnoses (overall and by outpatient/inpatient, facility type, public/private, gender) 7. Top 10 procedures (overall and by outpatient/inpatient, facility type, public/private, gender) 8. Revenue (overall and by membership group and class) 9. Expenditure data (overall and by outpatient/inpatient, capitation/non-capitation/INACBG, facility type, public/private, membership group, gender) 10. Claims ratio (overall and by membership group and class) 11. % of claims that are rejected (overall and by reason (e.g., incomplete, error, ineligible expenditure, abuse) and by FKRTL) <p>BPKP will verify the dashboard’s functionality by requesting a demonstration. In addition, BPKP will verify that the dashboard can produce monthly, quarterly, and yearly summary reports that are used in DJSN briefing meetings. The format should be standardized from period to period.</p>



DLI 8.2	DJSN has produced and published on its website an annual performance report on JKN in each of Years 2-4
Description	This DLI aims to produce and publish an annual performance report on JKN
Data source/ Agency	DJSN
Verification Entity	BPKP
Procedure	<p>BPKP will carry out a desk review to verify the content of the annual performance report at minimum consists of at least 2 sections.</p> <p>The first section will follow a standardized format from year to year summarizing the key performance indicators for JKN (e.g., findings from the monthly, quarterly, and yearly summary reports produced by the dashboard). This section should include achievements and emerging challenges identified during the ongoing performance monitoring, including a discussion on any upcoming policy changes that might impact JKN outcomes.</p> <p>The second section should summarize findings from supporting assessments/studies commissioned by DJSN to inform specific changes to JKN policy. For example, if an increase to the premium is being proposed for the next year, DJSN should summarize findings from any assessments, studies, or reviews it has commissioned on the topic.</p>
DLI 9	Improved coordination, impact, and sustainability of JKN
Description	This DLI aims to improve the coordination and sequencing of key reforms to improve the implementation of JKN.
Data source/ Agency	MOF
Verification Entity	BPKP
Procedure	Desk review
DLI 9.1	Program Secretariat is strengthened with additional technical experts and consultants in accordance with the Operations Manual;
Description	Activities under this DLI include the appointment of technical experts and consultants, in line with the operations manual.
Data source/ Agency	MOF
Verification Entity	BPKP



Procedure	BPKP will carry out a desk review of terms of reference, appointment procurement documents, contracts, and other documentation ensuring that the requisite experts and consultants are in position.
DLI 9.2	Program Secretariat compiles and analyzes JKN data and provides recommendations on the JKN-related objectives for the new RPJMN in Year 4
Description	Activities under this DLI ensures policy guidance to inform the new RPJMN for 2024-29 is synthesized and shared by the PforR secretariat team with appropriate authorities
Data source/ Agency	MOF
Verification Entity	BPKP
Procedure	BPKP will review the analysis undertaken and the synthesis of this analysis as a government note informing the new RPJMN that was compiled by the PforR secretariat and submitted to the appropriate authorities.



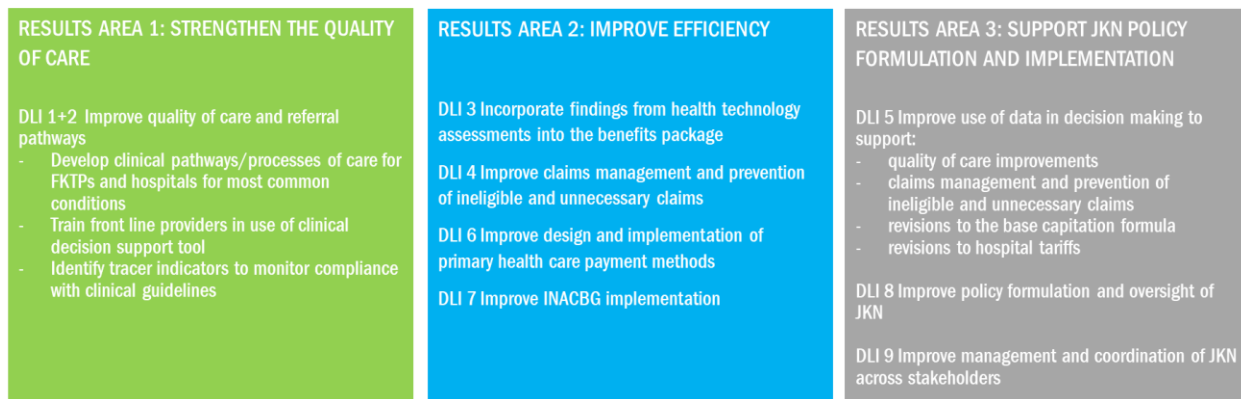
ANNEX 3. SUMMARY TECHNICAL ASSESSMENT

The following is a summary of the technical assessment. The full technical assessment will be disclosed separately.

Program Description

1. The PforR focuses on second-generation reforms aimed at improving the quality of health care interventions and the efficiency of health spending. The PDO is to strengthen the quality and efficiency of Indonesia’s National Health Insurance program. Activities are organized around three RAs. RA 1 aims to strengthen the quality of care. RA 2 aims to improve the efficiency of JKN spending. RA 3 is cross-cutting and aims to support JKN policy formulation and implementation.

Figure 3.1. Summary of Activities by RA



Justification for Choice of DLIs

DLIs 1 and 2

2. A review of common quality interventions in the health sector revealed that overall, the most pressing shortcomings concern clinical care interventions, performance-based financing, and information systems. In Indonesia, the predominant strategy for improving the competence of health workers has been the provision of clinical guidance. However, this has not been very effective. According to Ministerial Decree No. 1438/2010, it is the responsibility of health professional organizations to develop clinical guidelines, which are then endorsed by the MoH. The MoH has consolidated the plethora of sometimes outdated and inconsistent clinical guidelines into an overwhelming manual (~500 pages) for primary health care doctors. However, dissemination and knowledge of its existence at the frontlines are lacking. The guideline is also largely disease-based, assuming all doctors are already able to diagnose patients. It treats each condition in silo and does not account for patients with comorbidities. Finally, conditions do not have clear algorithms that provide an integrated approach to screening, diagnosing, and treating common symptoms.



3. **DLIs 1 and 2 aim to support the development and implementation of clinical pathways and processes of adult care.** At the primary care level, the aim is to develop an easy-to-use tool that supports the flow of clinical decision-making based on symptoms, syndromes, and risks. Based on the services an FKTP is actually able to provide, clinical algorithms will be developed to prompt health care providers to screen and manage patients according to a comprehensive and integrated list of primary care conditions. Training in the use of the clinical decision support tool will follow a cascade approach where master trainers at the national level will further train health care professionals at the provincial level as trainers, cascading down to the DHO and facility levels. At the hospital level, translation of clinical guidelines into pathways will be limited to 20 conditions, as these are only mandated for high-frequency, high-cost conditions. While the primary purpose is to improve provider competence and quality of care, it will also help improve claims verification and quality monitoring by defining a standard of care for prioritized conditions and identifying tracer indicators to monitor compliance with protocol-based care.

4. **Overall, the evidence on the impact of clinical practice guidelines on health outcomes is positive but small.** However, this operation does not just introduce clinical pathways and decision support tools on their own. First, the evidence mostly comes from high-income countries where provider competence is relatively higher compared to lower- and middle-income settings and continuing education opportunities are widespread and mandated. In Indonesia, doctors' knowledge of basic health conditions is low and decreasing; therefore, the potential impact could be much larger. Second, studies assess the effectiveness of decision support technologies on their own. However, the PforR introduces a package of interventions (that is, training, compliance monitoring, and performance-based financing) that together are aimed at improving and incentivizing improved health outcomes. Third, while the impact on health outcomes was limited, the impact on standardizing care practices and improving the process and structure of care was more important^{40,41}. This on its own will be a significant achievement not just in improving the quality of care but also in facilitating BPJS-K's claims management and verification process.

DLI 3

5. **In the absence of an explicit and transparent process to decide what is included/excluded from the benefit package, it has been politically difficult to incorporate findings into JKN.** The HTA provides a globally accepted and structured approach to synthesizing evidence on the cost and effectiveness of interventions alongside other criteria to support evidence-based priority setting and policy decisions. The MoH formally established an HTA unit/committee through Presidential Regulation 13 in 2013 to support decisions on what new diagnostic and/or screening technologies, drug therapies, medical devices, and procedures should be included in JKN. However, a general lack of capacity in the production of evidence and acceptability of the process among high-level policy makers has limited its effectiveness^{42,43}. Despite

⁴⁰ Lugtenberg, M, J S Burgers, and G P Westert. 2009. "Effects of evidence-based clinical practice guidelines on quality of care: a systematic review." *Quality and Safety in Health Care* 385-392.

⁴¹ WHO. 2018. *WHO recommendations non-clinical interventions to reduce unnecessary caesarean sections*. Geneva: World Health Organization.

⁴² Sharma, Manushi, Yot Teerawattananon, Alia Luz, Ryan Li, Waranya Rattanavipapong, and Saudamini Dabak. 2020. "Institutionalizing evidence-informed priority setting for universal health coverage: lessons from Indonesia." *Inquiry*.

⁴³ Teerawattananon, Yot, Waranya Rattanavipapong, Lydia Wenxin Lin, Saudamini Vishwanath Dabak, Brent Gibbons, Wanrudee Isaranuwachai, Kai Yee Toh, et al. 2019. "Landscape analysis of health technology assessment (HTA): systems and practices in Asia." *International Journal of Technology Assessment in Health Care* 416-421.



HTA studies having identified potential annual savings in the order of US\$31.9 million since 2014⁴⁴, the media and public opinion have often helped reverse recommendations from HTAs and cost-effectiveness studies. In the absence of a transparent process, methodology, and criteria for assessment, policy makers have not been able to rely on the HTA findings to support politically sensitive decisions.

6. **DLI 3 revises the HTA guidelines to transparently lay out the process, methodology, and assessment criteria for HTA studies that will help ensure findings are incorporated into the benefit package and in line with available resources.** The HTA guidance helps answer four questions: (a) Does the technology work? (b) For whom? (c) At what cost? and (d) How does it compare to existing alternatives. The revised HTA guidelines should include (a) explicit criteria for how diagnostic and/or screening technologies, drug therapies, medical devices, and procedures are selected for evaluation; (b) the methodology for carrying out the HTA; (c) explicit criteria for decision-making; and (d) how findings will be disseminated to the public.

DLIs 4 and 5

7. **By all accounts, investing in improving claims management will achieve substantial savings.** Claims expenditures are the single largest expenditure item for BPJS-K. Five conditions account for more than half of all JKN spending: outpatient visits for chronic conditions (Q-5-44-0), dialysis (N-3-15-0), and cataract procedures (H-2-36-0) and admissions for mild cesarean sections (O-6-10-I) and bacterial and parasitic infections (A-4-14-I). A study by Deloitte found that insurers that can enforce protocol-based care, build automated and streamlined workflows, and leverage data to provide actionable information can achieve 4–8 percent reductions in annual expenditures. Insurers that adopt advanced fraud detection tools and techniques that identify claims with a high propensity for fraud can achieve additional savings in the order of 5–10 percent. Overall, Deloitte claims that leveraging technology enablement and advanced analytics with the proper training to develop new skills can reduce claims and increase productivity by as much as 20–25 percent⁴⁵.

8. **DLI 4 aims to streamline and strengthen existing processes in claims management and fraud prevention.** A review of claims management processes in other countries suggests a common progression of system maturity. First, digitize and automate the basics. Digitizing as many steps as possible in the claims process from data input to payment has the potential to dramatically improve productivity, accuracy, and savings. Second, as the system matures, use more advanced health care analytics to answer specific policy questions, such as “are resources being spent efficiently?” or “can the quality of care be improved?” Currently, only basic administrative verification is automated in Indonesia. More detailed service verification and analytics are still manual in BPJS-K’s claims processing requiring significant manpower and time to carry out. Given that Indonesia currently only has 926 verifiers and 323 fraud detection specialists to process 9 million hospital claims a month, this more detailed verification is not carried out during the prepayment phase. DLI 4 will embed and automate tracer indicators identified under DLIs 1 and 2 into its claims verification software to monitor compliance with protocol-based care.

⁴⁴ iDSI. 2020. *The International Decision Support Initiative*. <https://idsihealth.org/our-impact/indonesia/>.

⁴⁵ Deloitte. 2011. *Driving operational excellence in claims management*. New York: Deloitte Development LLC.



9. **DLI 5 will support the complementary digital transformation agenda needed to ensure improvements in program oversight, to inform updates to program design and for effective claims management.** Claims data are often a natural entry point for health care analytics as data are standardized, structured, and widely available. Linking primary health care and hospital claims data would allow tracking patient pathways and episodes of care. Links to EMRs could further help verify the appropriateness of care and adherence to clinical protocols. In the absence of widespread EMRs, introducing additional indicators to claims intake forms, requiring additional claims information for certain conditions, or mandating the submission of medical resume forms or electronic discharge summaries would also work as it would enable checking adherence to guidelines and protocol-based care. Reporting compliance would be high because there is a strong financial incentive for providers to submit the required forms to get reimbursed. Gradually connecting BPJS-K membership data to the Ministry of Social Affairs' targeting database (DTKS) or the MoF's tax database could automatically verify contribution compliance and membership eligibility. Also, links to the MoH's accreditation database (SIAF) would automatically verify provider's credentials. As information systems for drug prescriptions, supply chain logistics, and other inventory management systems are developed, they too could facilitate appropriateness of care and facility credentialing. Artificial intelligence can then be applied to identify patterns and inform BPJS-K's operational and financial decisions or influence clinician and patient behavior⁴⁶.

DLIs 6 and 7

10. **DLI 6 aims to improve the capitation design to reflect the need and service availability at FKTPs.** It will develop a road map based on a review of historical utilization patterns at FKTPs by age, gender, and diagnosis; the ability of FKTPs to deliver interventions listed in the benefit package; the historical allocation and use of capitation, including undisbursed capitation; and the performance of existing KBK indicators. The road map should consider the following reforms, especially to the base per capita rate and KBK indicators:

- **Changing the capitation formula.** Alternatives to an input-based capitation formula include (a) a simple budget-neutral formula where the base per capita rate is equal to the total funds in the FKTP pool divided by the total population and (b) a more complex risk-based capitation formula based on the average visit cost by age, gender, and diagnosis. The latter generally requires properly coded/disaggregated historical utilization and costing data.
- **Revising the basic benefit package.** Assessing whether FKTPs are able to deliver all 144 services meant to be delivered at the primary health care level could further inform the base per capita amount and referral quotas.
- **Additional incentives.** Still, capitation incentivizes providers to underprovide services. To ensure essential public health services remain in FKTPs, existing (and/or additional) payment methods may need to be refined and blended with the fixed capitation. For example, Indonesia pays for antenatal and postnatal care on a fee-for-service basis to increase the provision of these services given the higher-than-expected maternal mortality rates for Indonesia's level of income. Similarly, in remote

⁴⁶ McKinsey. 2019. "For better healthcare claims management, think "digital first"." *Healthcare Systems and Services Practice*.



and rural areas, other financial incentives (for example, transport allowance for patients or top-up payments for outreach visits) may be necessary to improve supply and/or increase utilization.

- **Refining performance-based capitation design to reward quality improvement.** In parallel to improving accountability processes, the GOI should consider refining existing performance-based indicators at the primary care level to incentivize improvements in the quantity and quality of service delivery interventions linked with national priority areas (for example, maternal health, nutrition, and TB) and priority programs like the back-referral program, which focuses on nine chronic conditions (namely, diabetes, hypertension, cardiovascular disease, asthma, chronic obstructive pulmonary disease, stroke, lupus, epilepsy, and chronic mental health).

11. **DLI 7 aims to improve the implementation of hospital payments by increasing the accuracy of clinical coding and revising the INACBG tariffs based on standardized more representative cost information.**

- **Certification of clinical coding.** While in some settings doctors may code their own findings, coding is generally done by professional coders with a substantial knowledge of the coding system and its rules. In many countries, employers and health insurance agencies require a professional process of certification and may even stipulate it as a precondition for the accreditation of a medical facility. The bodies responsible for developing curriculums, organizing training courses, and certifying coders tend to be the MoH (or related public entities), professional organizations, or accredited universities. In Indonesia, there is currently no national exam or formal certification process.
- **Internal and/or external coding audits.** Auditors review medical records, coding guidelines, and compliance and usage rules for accuracy and completeness. Findings may form part of key performance indicators or job evaluations for a facility or department. Audits can be carried out by the facility, the MoH, the insurance agency, or an entirely independent agency. Currently, Indonesia does not carry out any clinical coding audits. However, BPJS-K conducts some audit functions as part of its claims management and fraud detection processes.
- **Use of enabling technology.** Increasingly, countries are shifting toward the use of EMRs and other health information technologies. This has allowed doctors in some settings to assign ICD codes directly with only a limited knowledge of coding rules. Drop-down menus that list diagnoses and procedures in text format are automatically mapped to ICD codes, significantly enhancing efficiency. EMR applications can also be designed to flag incomplete medical records and any data entry combinations that should not be accepted. Currently, only about 20 percent of hospitals in Indonesia use EMRs. Furthermore, EMRs are not standardized across the country.
- **Representative cost data.** The content of the standardized cost accounting template should be informed by a best practice on the level of granularity and information needed to inform meaningful average diagnosis and treatment costs for each INACBG.
- **Incentive and disincentive mechanisms.** The INACBG structure can incorporate incentive and disincentive mechanisms to promote or mitigate certain provider behaviors, as well as consider mechanisms to contain costs using volume or other expenditure caps.



DLIs 8 and 9

12. **DLIs 8 and 9 focus on strengthening coordination across JKN stakeholders to improve policy formulation and oversight of JKN.** DLI 8 will work closely with DJSN, in its role to oversee the performance of BPJS-K and to report on JKN's overall performance. It will agree on a list of key performance indicators. An internal and external dashboard will support policy formulation and inform the public externally for greater accountability. Capacity-building activities on key topics related to health insurance, health care analytics, and public accountability will also support the production of an annual report summarizing JKN performance. DLI 9 enables the creation of a coordination mechanism at the MoF that engages with a TWG comprising all the stakeholder teams involved in JKN design and implementation. It also enables a pool of technical expertise being procured by this secretariat and the regular production of synthesized policy inputs.

Technical Soundness

13. **Findings from the World Bank's previous analytical and advisory engagements squarely put the focus on the need to spend more and better to strengthen service delivery and the quality of care, especially at the primary health care level.** This assessment is informed by and builds on an extensive body of analytic work carried out over the past five years.

- (a) A health financing systems assessment⁹ and PHE reviews in health¹⁰ and nutrition¹¹ highlighted the need to raise additional revenue and improve the quality of spending. At 1.4 percent of GDP or 8.5 percent of total government expenditure, public expenditure on health is well below what countries with a similar level of income spend on average. Findings showed that the two sources of health financing that offer the greatest potential for improving the quality of health spending are DAK, a fund that finances capital investments, medicines, and commodities, and JKN spending that finances service delivery.
- (b) Functional and regulatory reviews¹² of JKN highlighted design flaws on the revenue and expenditure sides that threaten the financial sustainability of the scheme. While reforms to expand membership and improve contribution compliance have dominated the Government's policy dialogue, the most pressing need is to reform provider payments, especially at the hospital level, to manage expenditure growth. As the largest source of revenue for primary health care facilities, JKN also offers a significant financial lever to incentivize improvements in the quality of primary health care among public and private providers, where more than 50 percent of health care takes place.
- (c) Supply-side readiness assessments in the public^{13,14} and private¹⁵ sectors highlighted gaps in the quality of care, especially diagnostic capacity, the availability of diagnostic and treatment guidelines, and provider's competence to diagnose and treat conditions—especially at the primary care level. They also revealed that while the private sector provides a significant share of health care, the quality of services is generally better in the public sector.
- (d) Feasibility studies to unlock the potential of private providers¹⁶ and civil society organizations¹⁷ service delivery highlighted the type of contracting mechanisms most suitable for different types of non-state providers. As private providers do not receive the significant supply-side financing (DAK) that public providers do, here too, JKN offers the strongest lever to incentivize improvements in the



quality of services provided in the private sector. However, other existing budget mechanisms may be better suited for engagement with civil societies.

- (e) An ongoing policy note series on JKN sustainability provides just-in-time support on key topics to improve JKN implementation. To date notes on governance and accountability arrangements, targeting, information systems, clinical coding, and claims management have been produced, all of which have directly fed into the design of this PforR.

14. **Many countries face similar challenges as they strive toward UHC often having to choose between increasing revenues, limiting coverage, and/or improving efficiency in the use of funds.** But global evidence has shown increasing revenue is limited by the fiscal capacity of the Government, a relevant constraint in Indonesia. Also, in countries where the benefit levels remain relatively shallow or where breadth of coverage is prioritized over depth of services (as in Indonesia), access and financial protection have been limited. While improving the quality of current spending is likely the most feasible entry point for increasing fiscal space for health, weak governance and accountability, financial and institutional fragmentation, and limited performance orientation for service delivery have made it difficult to link health sector spending with performance ensuring greater value for money. These are the focus areas of this PforR.

Economic Justification of the Program

15. **Globally, poor-quality care is a bigger barrier to reducing mortality than is the lack of access to health services.** The Lancet Global Health Commission estimated that 60 percent of deaths (over 8 million people) occur each year from conditions that are amenable to health care. While there is no universally accepted definition of quality, a shared understanding of the basic precepts of quality defines it as being effective, safe, and people centered. The high mortality rates in low- and middle-income countries for maternal and childcare, cardiovascular disease, and vaccine preventable conditions is worrisome because treatment is widely accessible, evidence based, and among the most cost-effective interventions available³⁴.

16. **The economic implications of premature deaths and morbidity due to poor quality are also substantial.** Between 2015 and 2030, the Lancet Commission projected the cumulative loss due to poor-quality care to be upward of US\$11 trillion in 91 LMICs. In 2015 alone, the impact of mortality on the labor force and physical capital accumulation amounted to economic losses of US\$6 trillion³⁴.

17. **Beyond the economic losses from premature mortality, poor-quality care can also lead to significant waste and inefficiency.** Misdiagnosing a patient or prescribing the wrong treatment, doing unnecessary cesarean sections, and overprescribing antimicrobials are all examples of inappropriate or low-value care because additional resources are spent on services that produce reduced or no added health benefit. It is estimated that adverse events⁴⁷ add 13–16 percent of hospital costs, 28–72 percent of which are considered avoidable. Data on adverse events in primary care settings are much more limited, but according to one study, around 80 percent of errors are classified as potentially avoidable process errors. While few studies have estimated the economic impact of antimicrobial resistance globally, it is estimated to cost the US health care system US\$21–34 billion^{36,37}. Unnecessary cesarean

⁴⁷ The most common adverse events are related to health care-associated infections (for example, postoperative sepsis), venous thromboembolism, pressure ulcers, medication error, and wrong or delayed diagnosis.



sections are estimated to cost an additional US\$2.32 billion, far exceeding the cost of needed cesarean sections³⁴.

18. **The potential savings from improvements in the quality of care and more efficient health-seeking pathways is substantial.** Globally, potential efficiency savings at hospitals in middle-income countries have been estimated at 5–11 percent of total spending. Applying these percentages to JKN hospital-based expenditures yield potential efficiency savings of IDR 3.6–7.9 trillion in the hospital sector alone. And high-quality primary care can prevent the need for hospital admissions altogether.

19. **To quantify the economic impact of the PforR, the potential savings from improvements in JKN’s overall claims management were estimated.** JKN claims data can help monitor adherence to clinical guidelines and protocol-based care, helping improve the quality of service delivery (that is, detecting inappropriate or low-value care). Claims data could also identify high cost and frequency items, which could be used to inform additional areas for improved service delivery and fund management. Using historical JKN expenditure data from 2016 to 2018, JKN spending was forecasted to 2026 under a status quo scenario. Next, it was assumed that incremental improvements in claims management between 2022 and 2026 would decrease total expenditures by 5 percent (low), 7.5 percent (middle), and 10 percent (high) by the end of the operation. Finally, the net present value of expected savings was calculated by taking the difference between the status quo and the low, middle, and high scenarios. Under the middle scenario, the operation will generate savings of over US\$890 million. Given the loan amount of US\$400 million, the operation is deemed a very good investment (Table 3.1).

Table 3.1. The Operation Will Generate a Positive Benefit-to-Cost Ratio, Making It a Good Investment

Scenario	Expected Savings (US\$)	Cost-Benefit Ratio
Low (5%)	535,868,373	2.12
Middle (7.5%)	892,375,429	3.53
High end (10%)	1,190,305,511	4.71

20. The assumptions used in the cost-benefit analysis are listed as follows:

- **Basic discount rate.** Costs and savings are discounted at 6 percent. A good rule of thumb to derive a country’s annual discount rate is to double its GDP growth rate per capita. Indonesia’s per capita growth rate is currently 3.1 percent⁴⁸.
- **Period considered.** The cost-benefits of the intervention are calculated only over the timespan of the operation given that health and JKN policy change often and it is considered difficult to predict health care utilization and expenditure beyond 4–5 years.
- **JKN expenditures.** All JKN expenditures are considered given the scope of the PforR is national and tackles improvements in the quality of care at FKTP and FKRTL as well as interventions to enhance JKN claims management processes.

⁴⁸ The World Bank. (2016). *Discounting costs and benefits in economic analysis of World Bank projects*. Washington, DC: The World Bank.



- **Benefits.** The benefits are likely an underestimate of the PforR's impact given that the economic analysis does not consider the benefits from reduced premature death, reduced morbidity, and increased quality of life, nor the broader welfare costs associated with increased health and productivity. As these will be difficult to quantify during the life of the operation, the cost-benefit analysis was restricted to the more measurable improvements in service delivery and the management of JKN funds.
- **Reductions in JKN expenditures.** The estimates used in the three scenarios were deemed reasonable given a recent review that found insurers that could enforce protocol-based care, build automated and streamlined workflows, and leverage data to provide actionable information which could achieve 4–8 percent reductions in annual expenditures. Insurers that adopt advanced fraud detection tools and techniques that identify claims with a high propensity for fraud can achieve additional savings in the order of 5–10 percent. Overall, leveraging technology enablement and advanced analytics with the proper training to develop new skills can reduce claims and increase productivity by as much as 20–25 percent (Deloitte 2011).

Program's Results Framework and Monitoring and Evaluation

21. **The achievement of the PDO will be measured by the following PDO-level results indicators:** (a) provider competence score in FKTPs; (b) member satisfaction rate; (c) percent of outpatient utilization among bottom two quintiles; and (d) more sustainable JKN claims ratio. Additional intermediate indicators will monitor important milestones and introduce essential process indicators to improve internal operations and claims management processes and complement DLIs. The most notable are the number of tracer indicators to monitor compliance with STGs that are embedded into the claims management software and indicators that monitor improvements in the quality of claims management (for example, % of unverified or rejected claims, number of hospitals claims audited per quarter, and number of hospitals that have certified coders). While some indicators in the Results Framework may not currently be collected, most can be calculated using existing claims and administrative data.

22. **The MoF will host the PforR Secretariat, which will be responsible for the day-to-day Program management, coordination, and monitoring.** It will comprise staff nominated by the directors of the key departments and teams within the MoF. The Secretariat will coordinate and interact with a TWG comprising focal points from the stakeholder teams and units responsible for implementing the DLIs. The Secretariat may also mobilize additional technical assistance, as needed, to support the PforR's implementation. The Secretariat's main responsibilities will be to (a) track progress on the achievement of actions listed in the PAP, DLIs, and the Results Framework; (b) investigate and intervene to solve problems should and when they arise; and (c) support IAs to deliver results on the ground through additional budgets and/or hiring of technical staff or consultants. The MoH will be responsible for the achievement of DLIs 1, 2, 3, 6, and 7; BPJS-K for DLI 4; DJSN for DLI 8; and the MoF for DLI 9. DLI 5 will require strong coordination and collaboration between the MoH and BPJS-K. BPJS-K will also be required to share relevant data and information to inform the design of provider payment reforms under DLIs 6 and 7. Disbursements will be done after the review and verification of appropriate evidence by BPKP—the IVA—according to the agreed verification protocol.



Program's Expenditure Framework

23. **The Government program boundary amounts to US\$41 billion over five years.** This includes the entire budget from all stakeholders that are responsible for achieving the PforR's DLIs. However, the Program boundary supported by this PforR is estimated at US\$18.75 billion over the next five years, and comprises of the following:

- **MoH.** Accounting for over 90 percent of the Program boundary, the budget lines for the MoH include those pertaining to the Center for Health Financing and Health Insurance to pay the JKN premium contribution for PBI beneficiaries, as also for their role in carrying out HTAs (DLI 3), improving the design and implementation of provider payments (DLIs 6 and 7), and supporting the MoH for their contributions to the DLI on strengthening information systems (DLI 5). They also include the JKN-related budget lines from the MoH's Directorate for Health Services for improving the quality of care and clinical pathways for primary health centers and referral hospitals (DLIs 1 and 2).
- **BPJS-K.** The Program boundary includes BPJS-K's budget lines for its own administrative costs, primarily on account of HR and operational costs, which are included in the Program boundary in respect of their central role in carrying out claims administration for JKN (DLI 4); the Program boundary for BPJS-K excludes their direct revenues from the formal/informal sector and downstream payments to health facilities and also excludes any capital expenditure including construction-related expenditure. As more granular information on BPJS-K's expenditure becomes available, the exact budget lines on administrative costs currently included in the Program boundary will be further streamlined to focus on HR costs and operating costs.
- **MoF.** The Program boundary includes relevant line items from the MoF's Fiscal Policy Agency, Directorate of General Budget, and Directorate of General Financing and Risk Management for the overall coordination and support of JKN implementation (DLI 9).
- **DJSN.** DJSN's budget for JKN policy implementation and coordination under the Coordinating Ministry for Human Development and Cultural Affairs (DLI 8) is included in the Program boundary.

24. The US\$400 million World Bank contribution represents 2.1 percent of the share of the PforR boundary. The relevant details of the budget lines are provided in Table 3.2. This table represents costs for one year that are derived from the 2021 budget. The calculation of the Program boundary assumes the same level of expenditure over a period of five years.

25. **The main expected expenditure items under the recipient-executed grant are likely to be the hiring of additional consultants and incremental operational expenditures.** National consultants will likely consist of technical experts (for example, health care quality, claims, data integration, HTA, and provider payment), a monitoring and evaluation specialist and financial management and procurement experts. These technical experts will support IAs as well as the Program Secretariat in achieving the DLIs. Other activities may include operating costs related to meetings, workshops, trainings, printing of training materials and job aides, vehicle transport, computers and accessories, and dissemination and communication activities.



Table 3.2. Expenditure Boundary Detail (in IDR)

BPJS-Kesehatan			
	BPJS-Kesehatan	Operational cost	4,364,107,000
MoH			
Secretary General			
	Center for Health Financing and Assurance		
	024 01 DG Health Service and Insurance (JKN) program		
		5610 QEA Insurance subsidy (PBI)	48,787,200,000
	024 01 WA Management support		
		4398 ABG Health policy	2,295,000
		4398 AEA Coordination	1,444,080
		4398 FAE Monitoring, evaluation, and reporting	1,281,420
		4398 PBG Health policy	4,140,905
DG Health services			
	Director of Quality of Health Services		
	024 04 DG Health Service and Insurance (JKN) program		
		5836 BDB Facilitation and institutional development	6,617,823
	Director of Primary Health Care		
	024 04 DG Health service and insurance (JKN) program		
		2087 AEA Coordination	984,892
		2087 AEF Dissemination and Socialization	3,000,000
		2087 FAE Monitoring, Evaluation, and Reporting	514,050
		2087 PEA Coordination	940,953
		2087 UAE Monitoring, Evaluation, and Reporting	84,600
		2087 UBA Facilitation and Local Government Development	6,089,655
	Directorate of Referral Health Services		
	024 04 DG Health service and insurance (JKN) program		
		2090 AAG Ministerial regulation	1,564,256
		2090 AFA Norms, Standards, Procedures, and Criteria	1,021,361



		2090 BAA Public services	36,517,205
		2090 BDB Facilitation and institution development	190,359,643
		2090 FBA Facilitation and local government development	1,209,745
		2090 PAG Ministerial regulation	548,768
		2090 PEA Coordination	1,262,879
		2090 PFA Norms, Standards, Procedures, and Criteria	262,360
		2090 QDB Facilitation and institutional development	7,652,923
MoF			
Fiscal policy agency			
	Center for state budget policy		
	015 12 CE Program fiscal policy		
		4763 AAC Government regulation	392,982
		4763 PBA Policy in economics and finance	700,000
	Financial sector policy center		
	015 12 CE Program fiscal policy		
		4764 ABA Policy in economics and finance	4,415,929
		4764 PBA Policy in economics and finance	915,227
Directorate General of Budget			
	Directorate of Harmonization of Budgeting Regulation		
	015 03 CB Program management of government expenditure		
		6202 AAD Presidential regulation	175,800
		6202 AAG Ministerial regulation	809,730
		6202 AAH Other regulation	27,300
Directorate General of Financing and Risk Management			
	Directorate of State Financial Risk Management		
	015 07 CD Treasury, Sovereign wealth and risk management program		
		4809 FAE Monitoring, Evaluation and reporting	1,471,084



Coordinating Ministry for Human Development and Cultural Affairs			
DJSN			
	Secretariat		
	036 01 CL Program policy implementation and coordination		
		6336 EAC General services	5,443,032
		6337 ABN Social policy	964,515
		6337 PBN Social policy	5,744,850



ANNEX 4. SUMMARY FIDUCIARY SYSTEMS ASSESSMENT

1. The FSA has been carried out in accordance with the World Bank Policy on Program-for-Results and the World Bank Directive on Program-for-Results to determine whether the Program fiduciary arrangements are adequate and provide reasonable assurances that the financing proceeds will be used for intended purposes. The FSA has concluded that overall, the Program fiduciary systems that will be used to implement the Program are adequate to support the Program and provide reasonable assurance that the Program funds will be used for intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability, subject to the implementation of the fiduciary actions as defined in the PAP. The FSA also identified potential risks, areas for further strengthening, and proposed measures to mitigate the fiduciary risks under the Program. The overall Program's fiduciary risk rating is Substantial.

2. The Program is being implemented through four Government agencies: three ministries including the MoH, the MoF, DJSN under the Coordinating Ministry for Human Development and Cultural Affairs; and BPJS-K which is an autonomous agency.⁴⁹ These agencies consist of two distinct fiduciary systems: (a) the Government fiduciary systems that will support the Program implementation by the three Government IAs (the MoH, the MoF, and DJSN) and (b) the fiduciary systems used by BPJS-K, which is a public autonomous agency and therefore subject to more discretionary rules. The FSA reviewed the fiduciary systems and the capacities of the four IAs directly responsible for the PforR Program implementation. Based on the Program Expenditures Framework and technical assessment, the Program activities to be implemented by BPJS-K toward achieving DLI 4 would not involve procurement (except for minor procurable expenditures under operating costs and related HR costs).

3. **Information collection and methodology for the FSA.** The FSA has been conducted based on information available in (a) FY 2021 Budget Implementation List (*Daftar Isian Pelaksanaan Anggaran - DIPA*) MoH, MoF, and Coordinating Ministry for Human Development and Culture (*Kemenko PMK*); (b) FY 2019–20 annual audit reports of the MoH, FY 2018–19 annual audit reports of the MoF and Kemenko PMK; (c) procurement data publicly available on the MoF, DJSN, and the MoH's website and the National Public Procurement Agency (*Lembaga Kebijakan Pengadaan Barang dan Jasa Pemerintah - LKPP*)'s monitoring and evaluation system; and (d) virtual interviews and meetings. The World Bank team discussed with Procurement Service Units of the three Government IAs using Government fiduciary systems about the procurement process of the entities as well as the role and responsibility for carrying out the procurement activities under the program, procurement method to be used, and the broad list of procurements that would be conducted under the World Bank program. About procurement performance, the World Bank was able to collect publicly available procurement data from the MoF, DJSN, and the MoH's e-procurement system as well as LKPP's website. The FSA has also benefited from the initial findings of the ongoing Indonesia public procurement assessment using 2018 Methodology for Assessing Procurement Systems (MAPS) methodology. Regarding the fiduciary assessment of BPJS-K, the data collected are limited mainly due to BPJS-K information confidentiality. The limited information collected so far includes

⁴⁹ The Government established Law Number 24 of 2011 concerning the Social Security Administrative Body (*Badan Penyelenggara Jaminan Sosial*) and appointed PT Askes (Persero) as the organizer of the social security program in the health sector. PT Askes (Persero) also changed to BPJS-K.



- (a) BPJS-K FY 2019 and 2020 summary financial statements;
- (b) BPJS-K and DJS management letter for FY 2019 audited financial statement;
- (c) sample of BPJS-K FY 2020 internal audit report;
- (d) Selected Government Regulation and BPJS-K Director Decree obtained online and BPJS-K Directors Decree No. 309 FY 2018 regarding the list of information not qualified for public access;
- (e) BPJS-K procurement regulations namely BPJS-K Director Regulation No. 09/2020 on Procurement Guidelines: Goods/Services;
- (f) BPJS-K Director Regulation No. 46/2020 on the amendment to Procurement Guidelines: Goods/Services. The documents are categorized as confidential and are listed in the BPJS-K Director's Decree No. 309/2018 and hence not available except to the organization. The World Bank team was provided special access with the condition to be consulted in their offices on September 30 and October 1, 2021; and
- (g) Series of virtual meetings with planning, internal audit, accounting, prime secretary, treasury, and IT units of BPJS-K.

4. BPJS-K provided access to the above specific information and documents that were required for the completion of the FSA though limited review of the performance of the agency fiduciary system.

5. **Key fiduciary risks.** The GOI has been strengthening the public financial systems and accountability frameworks over the last decade. In that context, the FSA noted that (a) the MoH and the MoF have experience in managing World Bank-financed PforR projects and public procurement using their own in-house capacity; (b) Kemenko PMK has sufficient capacity in managing projects particularly funded by donors; (c) based on the experience during COVID-19 Program implementation, the Government has been processing budget revisions and payments remotely without relaxing the internal control; (d) similarly, accounting and reporting are operated by the Integrated Financial Management System remotely; (e) the flow of funds has been uninterrupted as the banking system has demonstrated its ability to continue working during this difficult period; (f) the MoH Inspectorate General is willing to share information on internal audit conducted for the Program including the findings and follow-up actions; and (g) the MoH external audit report will be submitted timely to the World Bank. However, a number of risks are involved, including the following: (a) 91.7 percent of the Program financing is concentrated in the single item on health insurance subsidy for the poor (PBI) which is allocated to the Centre for Health Financing and Assurance under the responsibility of the Secretary General of the MoH and requires greater attention during Program implementation; (b) the IVA for the Program has not been appointed; (c) BPJS-K has no experience in implementing a World Bank-financed program; (d) BPJS-K has not made its audited financial statements available to the public as stipulated by article 14 of Law 14 of FY 2008; (e) internal control risk is identified in BPJS-K, especially the weak IT access security raised by external auditor in the 2019 management letter; (f) the IAs may award a contract under the Program to World Bank-sanctioned firms and individuals; and (g) credible and material allegations or other indications of F&C in connection with the Program may not be reported to the World Bank on time.



6. **Mitigation measures.** Risk mitigation would require that the Government takes a number of measures, in compliance with the laws and regulations on public financial management and public disclosure of information, including the following:

- (a) The MoH will report on a semiannual basis the results of the internal audit conducted by its Inspectorate General on health insurance subsidy as the main expenditures of the Program.
- (b) The MoF will formally appoint BPKP to conduct the independent verification task for the Program and provide sufficient budget for it.
- (c) BPJS-K will take action to remove any regulatory obstacles that may prevent compliance with the requirements of the existing Indonesian law on public information disclosure.
- (d) BPJS-K will improve the capacity of the internal audit unit for better internal control:
 - (i) BPJS-K HR unit will conduct an assessment on the capacity needed for CISA certified internal auditor.
 - (ii) BPJS-K internal capacity will be improved to have competency in conducting continuous audit on BPJS-K information systems.
- (e) BPJS-K will improve its records management practice and regulation to ensure secure access to records and retain, preserve, and dispose of records appropriately.
- (f) The IAs shall require their Procurement Services to check the World Bank’s debarment (www.worldbank.org/debarr) and temporary suspension lists and record the verification in the bid evaluation report before contract award to ensure that no contract under the Program is awarded to a firm or individual that is under debarment and/or temporary suspension by the World Bank.
- (g) The IAs shall inform the World Bank promptly of all credible and material allegations or other indications of F&C in connection with the Program that come to its attention, together with the investigative and other actions that IAs propose to take, and provide the World Bank, on a semiannual basis, a report on allegations of F&C under the Program received and registered during such period, as well as any related investigations and actions taken.

7. **Exclusions.** The analysis of the Program procurement profile suggests that there are no large-value contracts expected to fall under the Operations Procurement Review Committee review thresholds.

Expenditure Framework and Procurement Profile of the JKN Program

Table 4.1. Program Preliminary Expenditure Framework (2021–26 Total)

Program	Outputs	Estimated Program Boundaries for 2021	Year 1	Five Years Program
		IDR, thousands	US\$ (as of September 15 = 14,251)	US\$ (as of September 15 = 14,251)
Government’s ministry/agency spending	Total MoH (include PBI)	49,054,992,518	3,442,214,056	17,211,070,282
	Total MoF	8,908,052	625,083	3,125,413
	Total Kemenko PMK	12,152,397	852,740	4,263,700
	Total BPJS-K (exclude PBI)	67,778,520,000	4,756,053,610	23,780,268,051



Program	Outputs	Estimated Program Boundaries for 2021	Year 1	Five Years Program
		IDR, thousands	US\$ (as of September 15 = 14,251)	US\$ (as of September 15 = 14,251)
	BPJS-K deficit/surplus	0	0	0
	Total 4 ministry and agency (small p)	116,854,572,967	8,199,745,489	40,998,727,446
Government's JKN Program boundary	Program Boundary MoH	49,054,992,518	3,442,214,056	17,211,070,282
	Program Boundary MoF	8,908,052	625,083	3,125,413
	Program Boundary DJSN/Kemenko PMK	12,152,397	852,740	4,263,700
	Program Boundary BPJS-K	4,364,107,000	306,231,633	1,531,158,164
	BPJS-K deficit/surplus	0	0	0
	Total boundary from 4 ministry and agency (big P)	53,440,159,967	3,749,923,512	18,749,617,559
PforR financing	PforR (World Bank)			400,000,000
	PforR as shared of program boundary			2.1%

8. **The National Health Insurance (JKN) program for five years is valued around US\$40 billion.** Out of this, the World Bank PforR Program is valued at US\$19 billion) with World Bank financing of US\$400 million or 2.1 percent of the total Program. The Program financing allocated to the Centre for Health Financing and Assurance under the Secretary General of the MoH (US\$17.2 billion or about 91.7 percent) is mainly to fund the Health Insurance Subsidy (PBI) while US\$1.5 billion (or 8 percent of the total Program) is allocated to BPJS-K to finance reforms in claims management and improvement in data management. Based on the Program Expenditures Framework and technical assessment, the Program activities to be implemented by BPJS-K toward achieving DLI 4 would not involve procurement (except for minor procurable expenditures under operating costs and related HR costs). The remaining 0.3 percent is allocated to the MoF and DJSN to finance the improvement in monitoring and coordination in JKN program implementation.



ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

1. **The Program Development Objective (PDO) is to strengthen the quality and efficiency of JKN.** The main objective of the JKN program is to address existing inequities in access to and quality of health care for all citizens and, by doing so, ensure that the UHC objective can be achieved. The PforR focuses on systematic, behavioral, and institutional changes needed to enhance the effectiveness and efficiency of JKN. The PDO will be measured through the following result indicators: (a) improved provider competency score in FKTPs, (b) increased member satisfaction rate, (c) increased share of outpatient utilization in bottom two quintiles, and (d) more sustainable JKN claims ratio.

2. **The PforR is nested in the GOI's health sector program, defined in its RPJMN for 2020–24.**⁵⁰ The PforR seeks to support elements of the JKN reform. The Program focuses on the management of JKN expenditure growth and does not address reforms to raise revenues. Activities are organized around three RAs:

- (a) **Result Area 1: Strengthening the quality of care.** Activities include (i) developing clinical pathways/processes of care for FKTPs and hospitals for the most common conditions, (ii) training frontline providers in utilizing clinical decision support tool(s), and (iii) identifying tracer indicators to monitor compliance with clinical guidelines (DLIs 1 and 2).
- (b) **Result Area 2: Improving the efficiency of JKN spending.** Activities include (i) incorporating findings from HTAs into benefits package (DLI 3), (ii) improving claims management and fraud detection processes (DLI 4), (iii) improving capitation design to reflect the need and service availability at FKTPs (DLI 6), and (iv) improving INACBG implementation (DLI 7).
- (c) **Result Area 3: Supporting JKN policy formulation and implementation.** Activities include (i) improving use of data in decision-making to support quality-of-care improvements, claims management and fraud detection, revisions to the base capitation formula, and revisions to hospital tariffs; (ii) improving policy formulation and oversight of JKN (DLI 8), and (iii) improving management and coordination of JKN across stakeholders (DLI 9).

3. **The environmental and social risk is overall Moderate**, with environmental risk being rated Low and social risk rated Moderate (refer annex 2). There is a low likelihood that the achievement of the operational objectives could be affected by the environmental risk factors (including those related to climate change and natural disasters) since such risks are not relevant to the operation. The operation is not likely to have adverse impacts on GHG emissions. By design, the PforR is expected to generate positive outcomes by improving JKN performance, through enhanced accountability and sustainability. Adverse social implications may stem from the poor implementation of specific activities and trade-offs to achieve efficiency. Potential social implications warranting risk management include

- (a) Stakeholders' acceptance of the reform, particularly those who have benefited from weak systems and monitoring and consequently may potentially stand to lose due to greater efficiency gains (that is, health facilities);

⁵⁰ RPJMN 2020–2024 is the fourth and final plan of Indonesia's National Long-Term Development Plan (*Rencana Pembangunan Jangka Panjang Nasional*) for 2005–25



(b) Potential implications on JKN members especially the poor and vulnerable as a result of potential reforms introduced and/or enhanced, particularly on aspects related to (i) referral procedures, (ii) service provider payments (that is, hospital tariffs), and (iii) benefits package; and

(c) Data protection and privacy.

4. **While activities and investments under the PforR do not have significant direct environmental impacts, the improved performance of the Program may encourage an increase in the utilization of health services, with a potential downstream environmental implication such as safe handling of medical waste.** Since the PforR does not include health service readiness and the expansion of hospitals and facility accreditation fall outside the scope of the Program, management of such risks will not be directly conducted through the PforR. Instead, this risk will be addressed through another complementary operation such as I-SPHERE—the MoH’s health care reform PforR. As part of its PAPs, I-SPHERE is currently supporting the development of an improved Guideline on Proper Management of Medical Waste. In this context, the MoH will ensure the adoption and compliance with the guideline.

5. **Introduction of risk-based capitation to FKTPs, revisions of INACBGs, and clinical guidelines are expected to promote enhancement in the quality of services.** However, such reforms will require inclusive stakeholder engagement and consultations to capture diverse views of affected stakeholders and minimize potential misunderstanding and misconception. While the PforR is not expected to exacerbate the existing inequity in access to JKN and health services, further analysis of potential adverse implications on equity, including impact simulation, representative sampling, and inclusive stakeholder engagement, is warranted during the PforR implementation.

6. **Other risk factors stem from (a) the context within which the PforR is operating, (b) institutional capacity and complexity of the needed reforms, and (c) political and reputational risks.**

(a) **Contextual risks.** Reforms supported by the PforR may be implemented under challenging political economy operational and fiscal contexts, which have been further compounded by the COVID-19 pandemic. Operating under these contexts, reforms may need to be selective and must consider how such contextual risks may undermine results. Promoting equity in the access to health care system toward UHC will require addressing various social, cultural, and psychological barriers that may confront the poor and marginalized segments of the population. Exclusion in access to health care services, including racial and gender discrimination, and marginalization based on sexual orientation are systemic issues, requiring systematic and holistic solutions, involving concerted efforts of the broader sectors. While the PforR is not envisaged to exacerbate such issues, the Program is not intended to address them since such issues will require systemic interventions which fall outside the PforR’s boundary and direct mandates of relevant agencies implementing the Program.

(b) **Institutional capacity and complexity.** Promoting oversight and checks and balances under JKN requires inter-agency decisions, which may potentially further complicate the needed reforms. Managing expenditure growth to promote JKN’s sustainability may involve revisiting the existing capitation and hospital payments, including DRG tariffs, introduction of hospital spending caps, and cost-sharing arrangements for nonessential services and services prone to overutilization. All of these reforms warrant not only sound evidence-informed technical considerations and representative sampling to ensure equity issues are properly captured but also clear and



transparent public communication, which may be compromised due to the operational challenges above as well as political interests. Further, to achieve UHC, JKN is facing complex operational challenges, particularly with regard to coverage expansion to the informal sector. Such expansion has been hampered by the absence of robust database, lack of legal and institutional framework to enforce enrollment, and fiscal sustainability.

- (c) **Political and reputational risks.** Key policy areas which may be revisited under the PforR include benefit package and entitlements, class consolidation and co-sharing, upper ceiling caps, and so on. Going forward, fiscal sustainability will require tough policy decisions, including shrinking the benefit package if necessary. While inclusion of these contentious reform elements under the PforR boundary is yet to be agreed, the overall Program may be associated and/or linked with such unpopular reform measures. Hence, further understanding of potential reputational risks and the existing Government capacity to address such risks, particularly in terms of public communication and stakeholder engagement, will be required as part of the environmental and social action plans.

7. **Relevant social actions seek to enhance the social outcomes of the PforR.** Proposed actions include (a) promoting social inclusion and representativeness of analysis to inform reforms and capacity building to frontline health workers, (b) enhancing public communication on patients' rights and responsibilities, (c) strengthening stakeholder engagement and disclosure of public information, (d) enhancing grievance handling mechanisms under JKN, and (e) developing/enhancing data protection measures for the purpose of system integration and data interoperability. The PforR will also seek to support the enhancement of quality of care, including in lagging regions, through DLIs 1 and 2 which focus on the development of clinical pathways/processes of care for FKTPs and hospitals, capacity building, and accountability.

8. **As part of the PforR appraisal, a series of virtual consultation workshops on the PforR as well as the corresponding ESSA were undertaken between 11 – 12 November 2021.** These consultations involved relevant stakeholders representing consumer and JKN member representative groups, non-government organizations (NGOs), community-based organizations (CBOs) and professional organizations, also representing health providers both at the national and sub-national levels. The World Bank also received written inputs from these stakeholders, which have been incorporated in the ESSA. These consultations were announced to the general public through the World Bank's social media ahead of the consultation dates, with the draft ESSA and Executive Summary in Bahasa Indonesia being publicly disclosed through the World Bank's website. Key feedback and concerns were reflected in the ESSA report and proposed system enhancements. A full summary is presented in the Annex 5 of the ESSA report. In summary, key concerns from the stakeholders consulted include a) equity of access to JKN, particularly amongst vulnerable groups (i.e., people with HIV/AIDS, TB patients, people with mental illnesses, drug users, and other marginalized groups; b) inclusiveness of health services, particularly in contexts where trust to healthcare providers represents a critical factor for health seeking behavior amongst marginalized groups; c) the need for system enhancements within JKN on critical aspects such as public communication, patients' rights, grievance mechanisms, etc.; d) the need to ensure continuity of care, by strengthening coherent and coordinated healthcare at the primary and referral levels; e) viability of provider payments which need to reflect actual costs of providing care.

9. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints**



to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.



ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Develop data protection and record management measures, data system integration and digitization, in line with international good practices. This includes data sharing protocols, routine updates, oversight, sanctions and secure access to records.	Environmental and Social Systems	DLI 4.1	BPJS-K	Recurrent	Continuous	Assessment of data security status and interventions to address it have been undertaken, including SOPs for data protection, system debug report etc. Director Decree on record management regulating secure access, retention, preservation and disposal.
Ensure representativeness of sampling analyses in terms of geographical coverage, demographic characteristics, and disease burdens to inform select reforms (i.e., reforms to capitation, revisions in DRG tariffs, development of clinical pathways etc.	Environmental and Social Systems	DLI 2	MOH	Recurrent	Continuous	Evidence of inclusivity of sampling in forms of analysis, reports etc
Technical Working Group (TWG) comprised of technical-level focal points from the stakeholder teams and units responsible for implementing DLIs is set up, including	Technical	DLI 8	MOF	Due Date	31-Jan-2022	Minutes of the first meeting of the TWG are available.



from different teams within MOH, BPJS-K, MOF, DJSN, Bappenas, Kemenko PMK, and MOHA						
<p>Enhance public communication on patients’ rights and responsibilities through:</p> <ul style="list-style-type: none"> - production of communication materials, protocols, and training of staff. - increasing availability and accessibility of information to JKN members etc. 	Environmental and Social Systems	DLI 7	DJSN, BPJS-K	Recurrent	Continuous	Production and dissemination of communication materials on patients’ rights and responsibilities and relevant capacity building
<p>Enhance stakeholder engagement and public participation processes under JKN, incorporating the following measures:</p> <ul style="list-style-type: none"> - Inclusive public engagement - Public disclosure of relevant information - Development of a mechanism to solicit public perceptions 	Environmental and Social Systems	DLI 7	BPJS-K, DJSN, MOH	Recurrent	Continuous	evidence of public consultations
<p>Periodic evaluation of the existing JKN complaint handling channels through consultative processes to inform relevant system enhancements and disclosure of grievance reports</p>	Environmental and Social Systems		BPJS-K, DJSN, MOH	Recurrent	Continuous	Publication of periodic review of JKN complaint handling mechanism(s)



and settlements						
Promote inclusivity of the delivery of frontline provider training, including development of alternative media and training modalities as relevant.	Environmental and Social Systems	DLI 1	MOH	Due Date	31-Dec-2023	Post-training evaluation report
All the Program IAs to require Procurement Service Working Units (UKPBJs)/Procurement Officers and Commitment making officers (PPK) to check the Bank's debarment (www.worldbank.org/debarr) and temporary suspension lists and record in bid evaluation	Fiduciary Systems		All IAs	Recurrent	Semi-Annually	Semi-annual reports provided to the Bank on the verification checks and the results to ensure that guidance provided to UKPBJ/Procurement Officers/PPK is implemented and no such contract under the Program is awarded
All the Program IAs to inform the Bank promptly of all credible and material allegations or other indications of Fraud and Corruption in connection with the Program that come to its attention, together with the investigative and other actions	Fiduciary Systems		All IAs	Recurrent	Semi-Annually	Semi-annual reports provided to the Bank on allegations of F&C under the Program received or registered during such period, as well as any related investigations and actions taken
MoH to report on a semi-annual basis the results of the internal audit conducted by its Inspectorate General on health insurance subsidy as the main expenditure of the Program	Fiduciary Systems		MOH	Recurrent	Semi-Annually	Results of the internal audit received



BPJS-K will take action to remove any regulatory obstacles that would interfere with the requirements of the existing Indonesian law on public information disclosure	Fiduciary Systems		BPJS-K	Due Date	31-Dec-2022	The requirements of the law are confirmed to be complied with.
BPJS-K to improve the capacity of internal audit unit for better internal control: (a) assessment on capacity needed for CISA certified internal auditor; and (b) competency in conducting continuous audit on BPJS-K information systems	Fiduciary Systems		BPJS-K	Due Date	31-Dec-2023	Measures to improve the capacity of the internal audit unit are reported.
BPJS-K to improve its records management practice and regulation to ensure secure access to records and retain, preserve and dispose of records appropriately	Fiduciary Systems		BPJS-K	Due Date	30-Jun-2023	Measures taken to improve records management are reported.



ANNEX 7. IMPLEMENTATION SUPPORT PLAN

Strategy and Approach for Implementation Support

1. The World Bank's implementation support strategy for the proposed Program has been developed based on the nature of the Program, its risk profile, the capacity of the IAs and partners, and the lessons learned from the past World Bank operations.
2. Implementation support will be provided by the World Bank team consisting of staff with relevant competencies in health systems, health financing, health insurance, quality of care, operations, procurement, finance, and safeguards. The World Bank team will undertake periodic field missions throughout the Program's implementation as required (subject to any limitations imposed by the pandemic situation). Experience under previous multi-sectoral operations has shown that, given the complex, sensitive, knowledge-intensive, and challenging nature of such projects, specific World Bank responsibilities require higher-than-normal supervision, technical assistance, and support requirements, including the transfer of knowledge that the World Bank has gained over the past decade in similar operations. The mobility restrictions created by the COVID-19 pandemic have added further complexity to sourcing international expertise during the design stage and may also be a limitation in the initial implementation period. Virtual modalities will be used to manage the necessary client interaction and support needed until the situation allows the resumption of operational travel.

Implementation Support Plan and Resource Requirements

3. The plan includes frequent review of implementation performance and progress. Information from various sources will be used to assess and monitor the progress of the Program throughout its implementation. In addition to the data generated through the Government's monitoring and evaluation systems, the World Bank will review the findings and results of third-party assessments and other studies that will be undertaken during the project implementation. The technical assistance funding available from the IPF grant is a key enabling factor to augment the capacity of the PforR secretariat located in the MoF to enable capacity building and monitoring. Regular review of terms of reference for technical support hired under the IPF grant will form part of this support plan.



Table 7.1. Main Focus of Implementation Support

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First 12 months	Ensuring effective and evidence-informed design of the HTA guidelines, capitation road map, claims manual, coding guidelines and certification course, cost accounting template, and other design-intensive activities.	Health systems, health financing, quality of care, claims management, information systems, health care analytics, costing, operations, fiduciary, and safeguards	96 staff weeks	Close coordination with technical assistance offered by USAID, Department of Foreign Affairs and Trade (DFAT), BMGF, WHO, Joint Learning Network, and other agencies
12–60 months	Ensuring that implementation proceeds according to the original ambitions of the reform and in a coordinated manner, given the sequential and interdependent nature of the various interventions envisaged.	Health systems, health financing, quality of care, claims management, information systems, health care analytics, costing, operations, fiduciary, and safeguards	48 staff weeks per year	Close coordination with technical assistance offered by USAID, DFAT, BMGF, WHO, JLN, and other agencies

Table 7.2. Task Team Skills Mix Requirements for Implementation Support

Skills Needed	Number of Staff Weeks	Number of Trips
<ul style="list-style-type: none"> • Health systems • Health financing • Quality of care • Claims management • Costing • Operations • Fiduciary • Safeguards • Information systems • Health care analytics, including data visualization 	<p>96 in year 1</p> <p>48 during years 2–5</p>	6 per year



Table 7.3. Role of Partners in Program Implementation

Name	Institution/Country	Role
USAID, DFAT, and United Nations Children's Fund	Indonesia	Coordinated technical assistance to the MoH and other key stakeholders
BMGF	Seattle/Delhi	Co-financing



ANNEX 8. INVESTMENT PROJECT FINANCING

Description of the IPF Grant

1. The design comprises a US\$400 million Program-for-Results (PforR) loan, as well as a grant-funded Investment Project Financing (IPF) for a total of US\$2.33 million, financed by the Bill and Melinda Gates Foundation through the Indonesia Human Capital Acceleration multi-donor trust fund. The Grant will provide additional assistance for supporting strategic technical assistance, monitoring and capacity building for the achievement of the objective of the Program. This grant will be available until December 31, 2023⁵¹. Funds will be received in several installments (US\$1.28 million; US\$0.52 million; 0.52 million); to date US\$1.28 million has been received.

2. The purpose of the IPF grant is to strengthen the implementation and coordination capacity of the JKN PforR Secretariat, which will be hosted in the MoF to support key ministries and organizations involved in the PforR. More specifically, the IPF grant will support

- (a) Hiring consultants and technical experts to provide support to stakeholder agencies (including the MoF, the MoH, BPJS-K, and DJSN) involved in the implementation of the PforR;
- (b) Coordinating with JKN stakeholders, including the IAs and other key stakeholders such as the President's Office, MOHA, Bappenas and Kemenko PMK and regular communications and convening of TWG comprising representatives from all relevant units and departments within the key stakeholder agencies;
- (c) Strengthening the Secretariat's monitoring and evaluation function to track progress, learn, course-correct, and evaluate the program's impact and effectiveness; and
- (d) Generating knowledge and providing lessons learned for other countries for continuous learning.

3. Many of the second-generation reforms required by JKN need areas of expertise such as claims management, costing of services, data analytics, quality of health services, and determination of provider payment systems, which are relatively new. While in-kind support will be available from the World Bank as part of the PforR's implementation support and technical assistance, stakeholders may also need regular in-house expertise, at least in the initial years, to build capacity, skills, and expertise. Civil service rule limitations often restrict the Government's ability to source the necessary expertise for short periods. To overcome this limitation, this grant will enable the funding of a pool of technical experts and operating costs to strengthen coordination and oversight.

4. Multi-stakeholder programs like JKN also face challenges in ensuring sequential or interdependent results chains that connect different stakeholders and their policy intentions with actual impact. A Secretariat to be located in the MoF and supported through this grant as well as the Government's domestic budget (APBN) can help invest in the necessary technical assistance and expertise

⁵¹ At the time of concluding appraisal, the internal processing for accepting the IPF grant was still ongoing, and so, the grant negotiations will be undertaken at a later date than the PforR. The Grant Agreement is initially expected to be signed for an amount of US\$1.28 million reflecting the cash contribution already received from the BMGF in the Indonesia Human Capital Acceleration Multi-Donor Trust Fund. The value of the grant will be updated when further contribution is received in January 2022 and January 2023, to the full appraised value of US\$2.33 million.



needed for the success of the PforR program, enable better monitoring and evaluation, coordinate across agencies, support budgeting and planning processes, and address capacity constraints in IAs. Functions to be supported under this grant will help in contracting the technical assistance needed across JKN stakeholders and enable regular communications and coordination across stakeholders, regularly convening a TWG of focal points nominated by all the relevant units and departments within the key stakeholder agencies. This mechanism will also serve to identify, explore, and intervene in key operational problems envisaged during the implementation of the reform agenda. The Secretariat will use the grant funds and domestic budget resources to closely support implementation support missions and complement in-kind technical assistance received from the World Bank. The support from this grant will also enable the secretariat to effectively monitor the status of progress toward the identified reform priorities and to enable timely action where needed.

Implementation Arrangements

5. The IAs for the PforR include the MoH, the MoF, BPJS-K, and DJSN. The MoF will be the lead executing agency for this PforR as well as the IA for the IPF grant accompanying the PforR, and will act as the coordinating ministry. The MoF will host the PforR Secretariat, which will be responsible for the day-to-day program management, coordination, and monitoring. It will comprise staff nominated by the directors of the key departments and teams within the MoF. Depending on the skills required, staff will be seconded from the directorates/centers or, and where additional capacity is needed, consultants may be hired using funds from this grant.

6. The Secretariat will coordinate and interact with a TWG comprising focal points from the stakeholder teams and units responsible for implementing the DLIs to provide technical guidance, with technical-level representatives from different teams within the MoH, BPJS-K, the MoF, DJSN, Bappenas, Kemenko PMK, and MOHA. The TWG could also be a continuation of the focal point group that was formed during the preparation of the PforR to inform on the design of the RAs, DLIs, and Results Framework.

7. The PforR incorporates in its design several activities to build capacity and strengthen institutions involved in the quality of health care provision, clinical coding, HTA, provider payment design, costing studies, and claims analysis—all relatively complex fields that need additional capacity, which can be provided by contractual staff and consultants (individuals/firms) hired using this grant.

8. **Financial management.** The Financial Management Assessment evaluates the adequacy of the financial management system of the JKN PforR Secretariat in the MoF (the Secretariat) as the IA to produce timely, relevant, and reliable financial information on the JKN PforR Secretariat activities. It also assesses whether the accounting systems for the Secretariat expenditures and underlying internal controls are adequate to meet the fiduciary objectives and allow the World Bank to monitor compliance with agreed implementation procedures and appraise progress toward its objectives. A separate FSA has been prepared for the JKN PforR Loan.



9. Based on the Financial Management Assessment, the Financial Management System has identified that the main risk of the Grant is due to nonexistence of the Secretariat during the preparation of the Grant. To mitigate the associated risk:

- (a) The JKN PforR Secretariat will need to be established and necessary staff is to be appointed before the JKN PforR is implemented;
- (b) The Secretariat will prepare Project Operation Manual to guide the Grant implementation and to monitor its progress, covering organization structure, inclusion of program budget into DIPA of the Secretariat, payment verification mechanism, funds flow mechanism, interim financial report (IFR) and financial statement preparation, disbursement mechanism, and internal and external audit arrangement; and
- (c) A financial management consultant may be hired (if necessary, depending on the Secretariat needs) to support the Grant implementation to allow more robust payment verification with a focus on consultant contract and non-consulting services payment verification and assist IFR and annual financial statement preparation.

10. **Disbursement arrangements.** The applicable disbursement methods are Advance and Reimbursement. A segregated Designated Account (DA) in US dollar will be established at Bank Indonesia for this IPF grant for receipts of this RETF only. The DA will be used for funding eligible expenditures of JKN Secretariat Grant implementation. Eligible expenditures for the RETF including consulting services, non-consulting services, trainings/workshops, goods, and incremental operating cost will be financed at up to 100 percent by the RETF, inclusive of taxes. The ceiling of the DA will be flexible and based on forecast of two quarters' worth of expenditures expected to be financed out of the funds in the DA; documentation of eligible expenditures will be based on unaudited IFRs to be submitted on a quarterly basis. Quarterly IFRs for the RETF consist of (a) DAs' Activity Statement, (b) Statement of Expenditures under World Bank's prior review and non-prior review, (c) Project Cash Forecast for six months, and (d) Project Sources and Uses of Funds. Further details of this IPF Grant will be stated in the Disbursement and Financial Information Letter.

11. **Procurement: Applicable Procurement Framework.** All procurement of consulting services under the project financed by the Grant shall be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers (November 2020) and the provisions of the Grant Agreement and the Procurement Plan (PP). The project will be subject to the World Bank's Anti-Corruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The project will use the Systematic Tracking of Exchanges in Procurement to plan, record, and track procurement transactions.

12. **Summary of Project Procurement Strategy for Development (PPSD) and PP.** The MoF Secretariat will procure all the contracts under the project. The PPSD has been prepared by the MoF, and it identifies the appropriate procurement approaches under the project. The grant funds will be utilized for mostly hiring and selection of individual consultants and experts. Based on the PPSD findings, the MoF prepared a draft PP for the first 18 months of project implementation. The PP will be updated at least annually or as required during project implementation to reflect any substantial changes in the procurement approaches and methods to meet the actual implementation needs, market fluctuations, and improvements in institutional capacity. The updated PP will be subject to the World Bank's prior review



and approval. The PPSD includes assessments of the market for individual consultants' services required for project implementation.

13. **PP.** Contracts eligible for financing shall be procured in accordance with the PP, which defines the applicable procurement methods, estimated costs, prior-review requirements, and time frame.

14. **Use of National Procurement Procedures.** All contracts for services to be procured in line with the national market approach shall follow the National Procurement Procedures set out in the Perpres 2018 and amendment 2021, which were assessed and found to be broadly consistent with the requirement of the World Bank Procurement Regulations, Section V - Para 5.4, National Procurement Procedures (subject to a few conditions specified in the PPSD which has been prepared with support from the Bank, and in the project text section of the PP).

15. **Environment and Social:** The project is not envisaged to involve any civil works nor purchase of equipment with environmental and social implications. Most of the upstream TA activities will be coordinated by JKN PforR secretariat and hence, will support specific reforms of the JKN program to achieve the PforR's development objective. Capacity strengthening activities may benefit national and sub-national stakeholders. No physical footprints are envisaged as a result of project activities and no context-specific information pertaining to the salient geographic, environmental and social characteristics is available nor considered relevant for the environmental and social assessments during project preparation. Overall environmental and social impacts are assessed as low to negligible. An appraisal stage Environmental and Social Review Summary was disclosed at the World Bank website on 19th November 2021.