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POLICY NOTE
July 15, 2018

Overview of Strategic Purchasing Functions Under JKN

With over 70% of the country's population having coverage under *Jaminan Kesehatan Nasional* (JKN), Indonesia now has one of the largest national health insurance programs in the world, at least in terms of population coverage. However, at present only about 15% of total health expenditures come from JKN and there remains significant co-financing from supply-side budgetary expenditures at public facilities. The government plans for everyone to have coverage under JKN, with universal health coverage (UHC) by 2019 as part of implementation of the Health Social Security Act.

Despite recent increases, however, the level of public financing for health remains low. The country faces a tighter macro-fiscal environment on the one hand, versus a growing demand for and utilization of health care as coverage expands under JKN. Expenditures on JKN are increasing more rapidly than revenues, and financial sustainability has emerged as a concern. Improving the efficiency of JKN expenditures is necessary for making progress towards UHC, and there is an imperative to make better use of existing funds through strategic purchasing of JKN services.

The dual challenges of JKN sustainability and ongoing under-investment in the health sector create an urgent need for action to realign revenues and expenditures in the entire health system. How the government addresses the current deficits will set the stage for the future ability to expand effective coverage under JKN. Most countries face a similar challenge at this point in the journey to UHC, and they typically have 3 options: (1) increase revenues in the system; (2) cut costs by limiting coverage, such as reducing the benefits package or increasing cost sharing, or cutting payments to providers; or (3) increase efficiency in the use of funds through **strategic purchasing** to reduce unproductive cost growth and shift resources to more cost-effective parts of the system. Some combination of the three options is almost always necessary. But global experience shows that option 1 is limited by the fiscal capacity of the government, and as international experience shows, voluntary contributions rarely contribute significantly to revenue. Relying only on option 2 will erode coverage and reduce access and financial protection. Therefore, there is an imperative to make better use of existing funds through strategic purchasing levers without eroding effective coverage, even if it is possible to increase revenue for JKN.

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA
BPJS Kesehatan Badan Penyelenggara Jaminan Sosial
DJSN
USAID FROM THE AMERICAN PEOPLE
WORLD BANK GROUP
Australian Aid
Health Finance & Governance
RESULTS FOR DEVELOPMENT

Overview of Strategic Purchasing

Stakeholders defined strategic purchasing for Indonesia as:

> Ability to purchase preventive, promotive, curative and rehabilitative services to improve the health of community members and get maximum results.

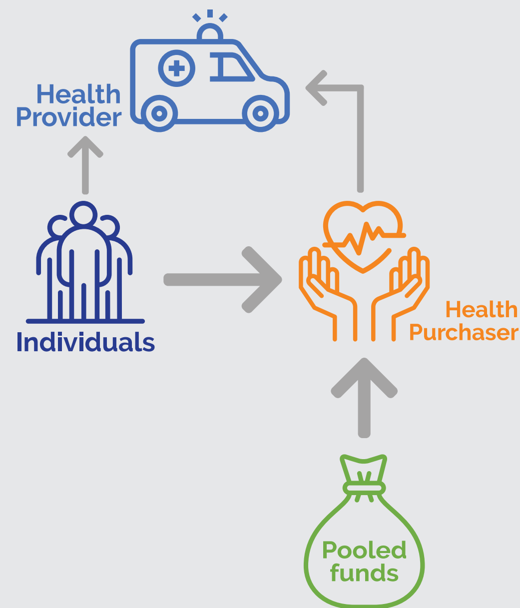
Strategic health purchasing organizes relationships between individuals, health providers, and (typically) a third-party purchasing agency acting on behalf of covered individuals (Figure 1). Strategic purchasing involves three main sets of decisions (Figure 2):

1. Strategically decide **what to buy**: which interventions, services, and medicines
   - E.g. buying more primary health care vs. expensive tertiary services; specifying quality standards; buying generic instead of branded drugs
2. Strategically decide **from whom to buy**: which providers and suppliers of medicines/other commodities
   - For example, contracting only with accredited providers or with both public and private providers
3. Strategically deciding **how to buy**: which payment methods, payment rates, other contractual conditions
   - For example, introducing blended payment methods to get the right incentives or setting payment rates to be in line with available resources

There are some foundational steps that are pre-conditions for strategic purchasing and that make more sophisticated strategic purchasing approaches possible in the future as systems mature (see Box 1).

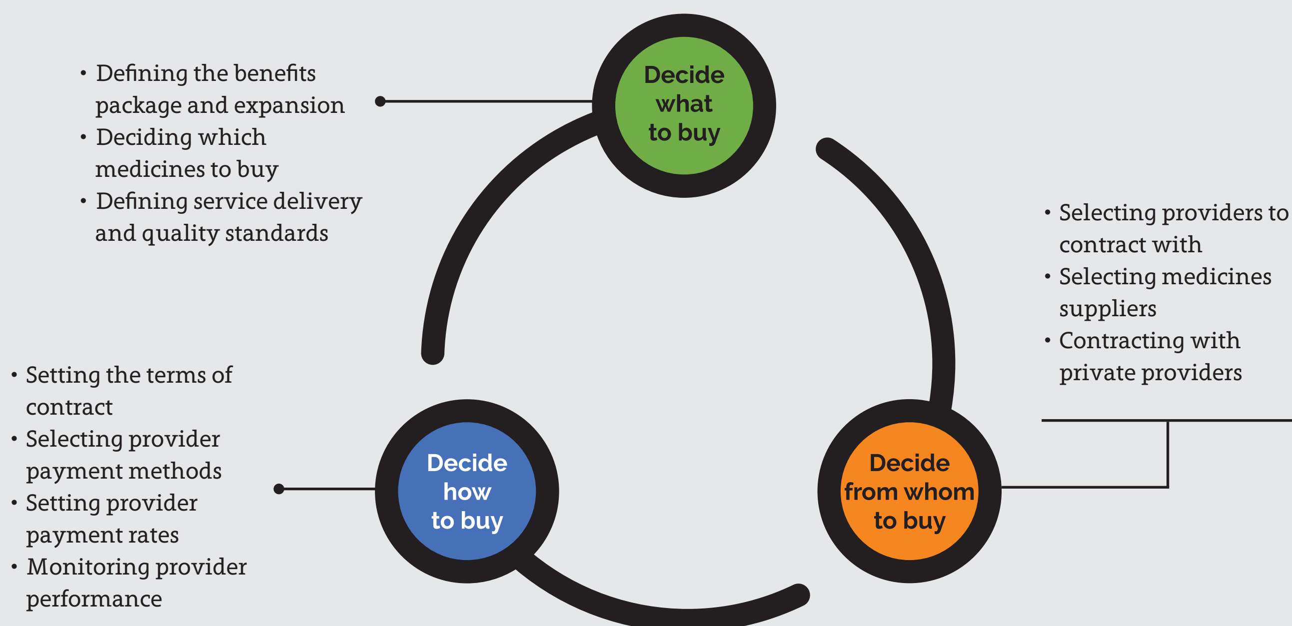
First, strategic purchasing requires an **institutional home** for the purchasing function, with roles and responsibilities clearly defined to carry out the specific functions (e.g. which institution decides the benefits that will be included in the benefits package, and which institution decides how to pay health care providers). In Indonesia the institutional home for health purchasing is *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), but some purchasing functions continue to be carried out by the Ministry of Health (MOH).

Figure 1 Strategic Health Purchasing Relationships



Next, strategic purchasing requires being clear and deliberate about **what is being purchased**. A first step some countries take is to specify **a benefits or essential services package** that the covered population is entitled to receive at an affordable cost. Once the service package is defined, the purchaser then pays health providers specifically to deliver these services, which is referred to as **output-based payment**. Output-based payment typically goes hand-in-hand with some form of **contracting** to clarify the obligations of the provider and also the purchaser. It also requires that providers have some **autonomy** to make decisions to respond to incentives—they can decide to shift their staff around or other inputs. All of this requires new **accountability** measures and better use of **information**.

Figure 2 Strategic Health Purchasing Decisions



BOX 1. FOUNDATIONS OF STRATEGIC HEALTH PURCHASING

Strategic purchasing requires an **institutional home** where most purchasing functions will be carried out, although other institutions will likely be responsible for some purchasing functions. being clear and deliberate about **what is being purchased**, which starts with a well-defined benefits or essential services package. Once the service package is defined, the purchaser pays health providers specifically to deliver these services, which is referred to as **output-based payment.** Output-based payment typically goes hand-in-hand with some form of **contracting** to clarify the obligations of the provider and also the purchaser. It also requires that providers have some **autonomy** to make decisions to respond to incentives—they can decide to shift their staff around or other inputs. All of this requires new **accountability** measures and better use of **information**.

Institutional Structure for Strategic Health Purchasing Under JKN

Effective strategic purchasing requires that the purchasing functions are distributed appropriately across the institutions involved, and the roles and responsibilities are clear. The institutional structure, or which institutions are performing which health purchasing functions for JKN, is still transitioning and urgently needs to be clarified. BPJS-K has responsibility to manage the single pool of funds in the health insurance system, but many purchasing functions continue to be housed within the MOH. There is little guidance from international experience on best practices for the institutional arrangements to enable strategic purchasing, but there are some lessons (Box 2).

In partnership with USAID, the World Bank, Abt Associates and Results for Development (R4D), the Social Security Council (*Dewan Jaminan Sosial Nasional*--DJSN) commissioned a functional and regulatory review of strategic purchasing under JKN. The review examined existing legislation and regulations that relate to strategic health purchasing functions to identify:

a. which institutions are responsible for carrying out which purchasing functions according to the regulations;
b. whether there are any regulations that are in conflict with one another;
c. how the functions are being carried out and whether a different allocation across institutions would improve the implementation of the function.

The set of laws and regulations that were reviewed is provided in Annex 1.

BOX 2. GLOBAL LESSONS ON INSTITUTIONAL ROLES AND RESPONSIBILITIES FOR STRATEGIC PURCHASING

A coherent institutional structure is needed with clear roles and responsibilities

- It should be clear who does what even if some functions are shared
- Supporting regulations should be clear

Some functions should be separated and carried out by different institutions

- E.g. definition of benefits and purchasing services (although purchasing levers should be used to drive service delivery objectives for services in the benefits package)

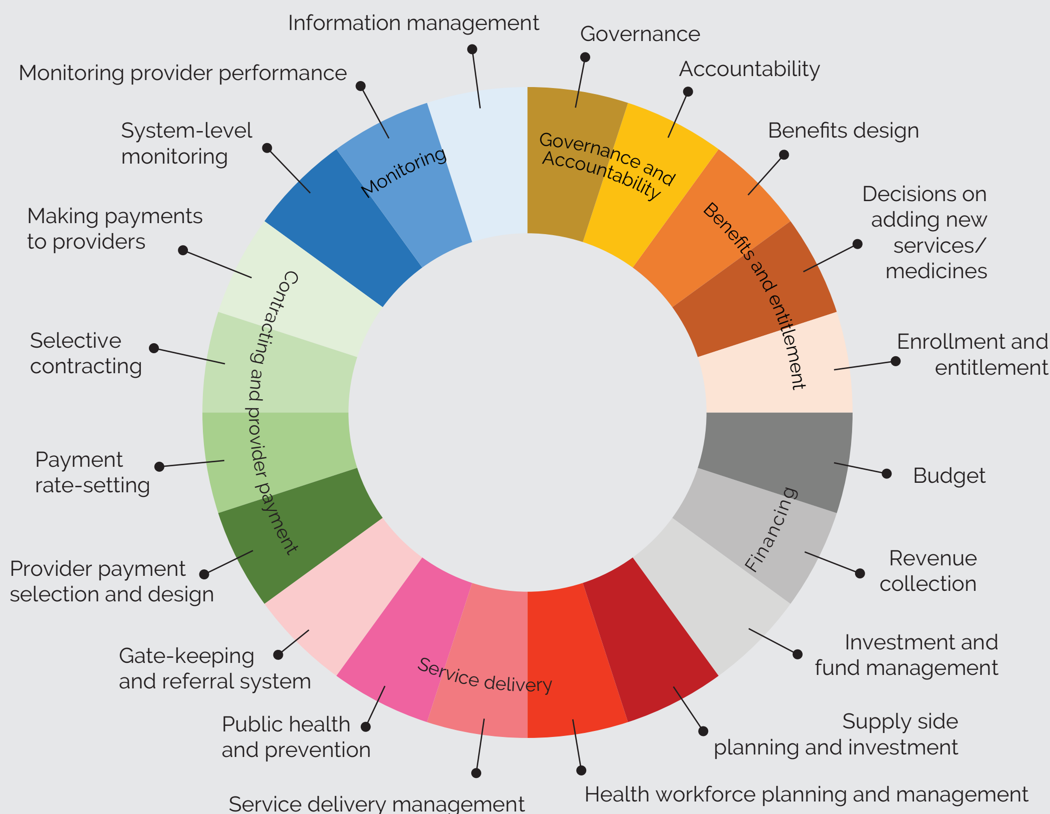
Some functions should be carried out in coordination

- Supply-side planning
- Provider payment rate-setting
- Quality assessment and monitoring

Results of the Strategic Purchasing Functional and Regulatory Review

The review examined the allocation of 17 purchasing functions covered by the laws and regulations of Indonesia related to JKN implementation (Figure 3). The purchasing functions were grouped and color-coded to facilitate analysis of how they are distributed across the responsible institutions: DJSN, BPJS-K, Ministry of Health (MOH), Ministry of Finance (MOF), Ministry of Social Affairs, Ministry of Home Affairs, and local governments. The pie charts are made up of equal-sized slices for each function the institution is responsible to carry out, so larger slices of one color indicate that there are multiple sub-functions.

Figure 3 Strategic Health Purchasing Functions



Summary of the Findings

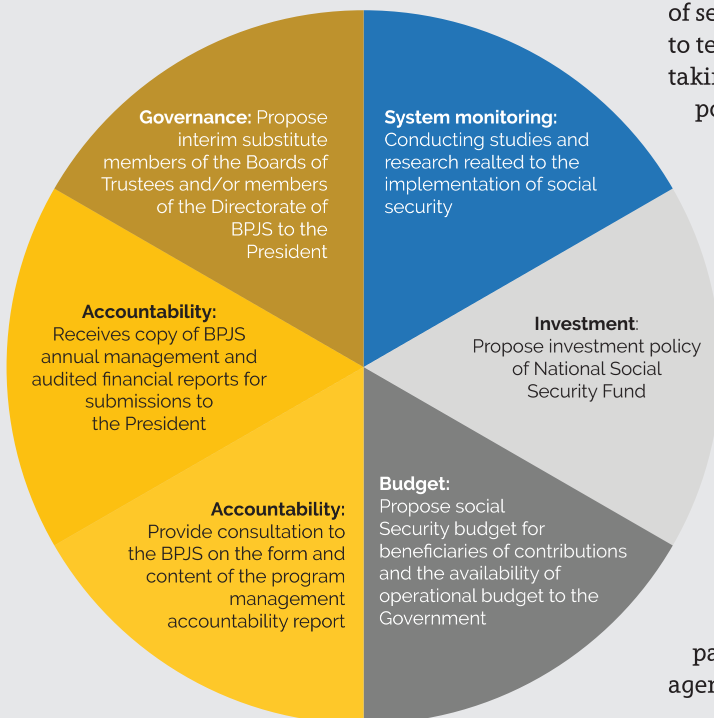
The findings are summarized in Annex 2 where strategic purchasing functions covered by various laws and regulations are mapped to the responsible institution(s).

DISTRIBUTION OF FUNCTIONS

DJSN

DJSN has overall supervisory authority over the implementation of JKN and the operations of BPJS-K [*Law No. 24 of 2011 on the Implementing Agency of Social Security Chapter IX Supervision Article 39*], although the MOH has authority over the supervisory team for monitoring and evaluation of JKN [*Decree of Minister of Health No.046/Menkes/Sk/Ii/2014 regarding Monitoring and Evaluation Team of National Health Insurance Implementation*].

Figure 4 Strategic Purchasing Functions of DJSN Under JKN



The main functions of DJSN relate to governance and accountability and providing special studies and research as part of monitoring the implementation of JKN. DJSN also has responsibility for contributing to budget proposals and the investment plan of the National Social Security Fund.

BPJS-K

According to the original legislation, BPJS-K has responsibility for the main purchasing functions under JKN, but more recent regulations make that unclear, and the MOH has retained many functions that would be considered the responsibility of the health purchasing agency.

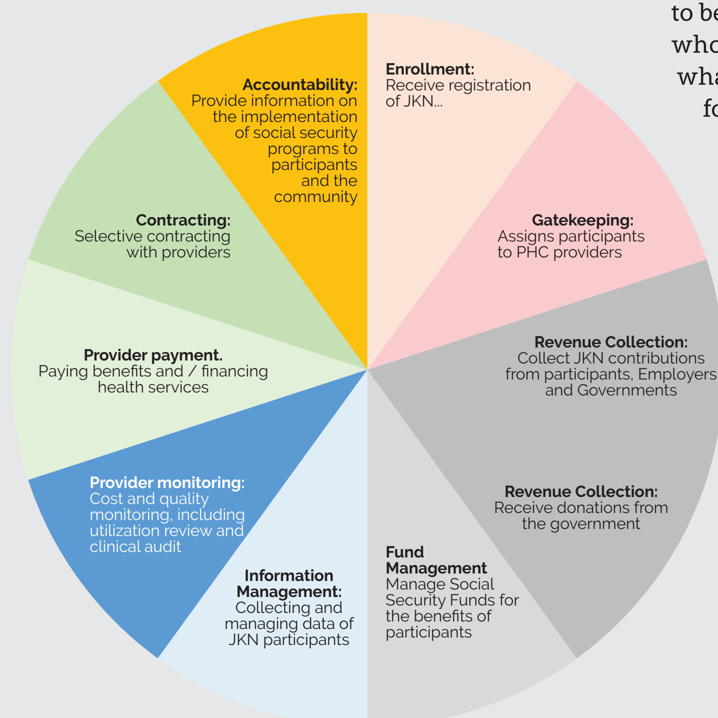
BPJS-K has the responsibility to enroll members and initially assign them to a primary health care (PHC) provider for the gate-keeping function, after which members are free to choose their PHC provider [*Presidential Regulation No. 12 of 2013 article 29 clauses 1 and 2*]. BPJS-K is responsible for the function of selective contracting with providers according to technical criteria established by the MOH and taking into consideration access to services by the population [*Regulation of Minister of Health No. 71 of 2013 CHAPTER III*]. The technical criteria include human resources, infrastructure and facilities, scope of services available, and service commitment. BPJS-K does not have the authority to specify certain terms of the contract, such as reporting requirements, which are specified by the MOH [*Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39*].

Law No 40/2004 Article 24 states that BPJS-K is responsible for implementing quality control and cost control systems, the role of MOH is to support hospitals accreditation, and the role of local government is to contribute incentive payments for specialized physicians. Purchasing agencies often have the authority to select which

service delivery and quality standards (e.g. standard clinical practice guidelines) will be used for purchasing services, even if they do not develop them. The role of BPJS to establish quality and service delivery standards, however, has not yet been operationalized.

Presidential Regulation Number 19 Article 43 A stipulates that the MOH should coordinate with BPJS-K on the technical operation of the health care system, quality control, and provider payment. Presidential Regulation Number 12 Article 37 states that payment rates should be based on agreement between BPJS-K and the association of health facilities "with reference to" the standard tariffs specified by the Ministry. The regulation is unclear, and in practice BPJS-K has had a very limited role in provider payment policy and rate-setting.

Figure 5 Strategic Purchasing Functions of BPJS-K Under JKN



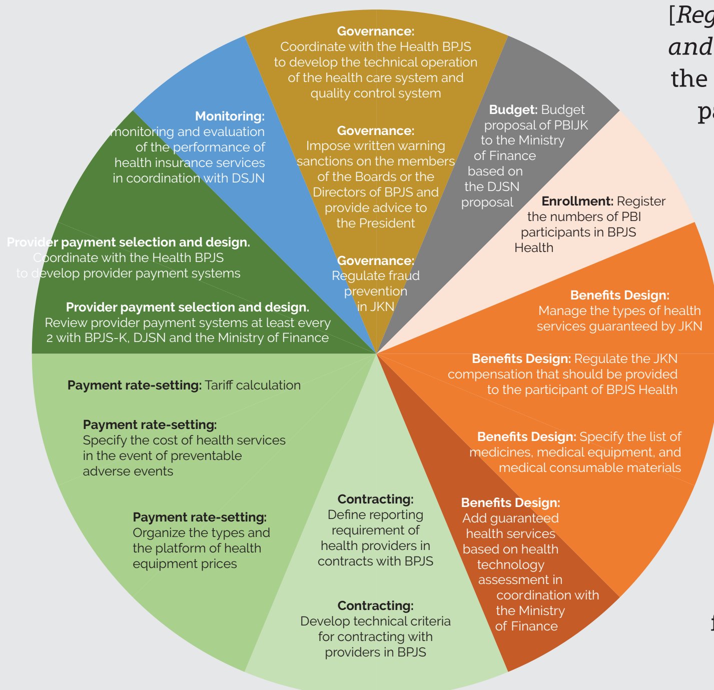
Both *Presidential Regulation Number 12 of 2013 on Health Care Benefits* and *Regulation of the Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Article 38* state that BPJS-K is responsible for monitoring provider performance, although the same regulations also give the MOH responsibility for monitoring and quality control, so the institutional responsibility for this function is unclear. Regulation of the Minister of Health Number 71 states that BPJS-K should monitor quality through a cost and quality control team (*Tim Kendali Mutu dan Biaya, TKMKB*) made up of representatives of professional organizations, academicians, and clinical experts. The TKMKBs monitor compliance with quality standards of health facilities, compliance with health care processes and standards, and monitoring the health outcomes of JKN participants [*Regulation of the Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Article 38*]. The TKMKB is authorized to use instruments such as utilization review and medical audit to carry out the provider monitoring function. The results from the utilization review are supposed to be reported to DJSN and MOH, but is it not clear who has the responsibility to act on the results and what those actions can be. BPJS-K is also responsible for establishing a formal communication forum between health facilities and local branch offices of BPJS-K [*Implementation Manual of the National Health Insurance of BPJS-K*].

Finally, BPJS-K is responsible for collecting and managing information related to JKN participants and their health service utilization. BPJS-K maintains several data sources, including claims data for services paid using INA-CBGs and the P-Care database of PHC service utilization under capitation. BPJS-K has produced a number of standalone analyses and reports, but a routine monitoring system with a standard set of indicators analyzed and reported regularly has not yet been put in place.

MINISTRY OF HEALTH

The MOH retains the majority of health system functions, including most of those related to strategic purchasing. The MOH has the mandate to protect the health of the population, set clinical standards, and regulate the benefits package under JKN [*Presidential Regulation Number 12 of 2013 Chapter IV on Health Care Benefits*]. The MOH is responsible for quality and cost control together with BPJS-K [*Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control*] and is authorized to use a number of instruments to carry out this function, including health technology assessment, establishing a clinical advisory board to resolve clinical disputes, standard payment rate calculations, and monitoring and evaluation of health services to ensure compliance with medical service standards specified by the Minister [*Article 33*].

Figure 6 Strategic Purchasing Functions of the MOH Under JKN



The MOH also continues to carry out some functions that are typically functions of the health purchasing agency, including:

- Specifying the technical criteria for health facilities contracting with BPJS-K (credentialing) [*Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities with BPJS Healthcare Section Two Article 9*]
- Specifying the data reporting requirements in BPJS-K contracts [*Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39*]
- Developing provider payment systems and setting payment rates [*Regulation of Minister of Health Number 69 on Health Services Standard Rates at First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation*]

The MOH also has the authority to regulate how public primary health care facilities (*puskesmas*) use the funds they receive from BPJS-K for capitation payment [*Regulations of Minister of Health Number 19 of 2014 and 21 of 2016*]. These regulations specify the role of the District Health Office in implementing JKN, and in particular guidelines on the utilization of capitation funds and the proportion of the capitation payment to providers that can be allocated for operational costs and staff incentives, procurement of drugs, medical equipment, and consumables.

MINISTRY OF FINANCE

The Ministry of Finance has the main responsibility for oversight of transfer of contributions from the various funding sources for JKN, including the national budget, local budgets, and employers. The Ministry of Finance also provides management and oversight for the asset and fund management for BPJS-K.

LOCAL GOVERNMENTS

The local government has full responsibility for health service delivery and investment decisions on the supply side, as well as public health and prevention activities [*Law Number 23 year 2014 concerning local government*]. There is some lack of clarity on setting provider payment rates, where the local government has some authority, as well as the rules for how providers can use JKN funds [*Regulation of Minister of Health Number 19 of 2014 and 21 of 2016*].

OTHER MINISTRIES

The Ministry of Social Affairs plays a governance role related to data on population covered by PBI, and the Ministry of Home Affairs is responsible for governing the health insurance contributions from local governments for civil servants and ensuring that local governments are adequately implementing JKN as a strategic program.

Figure 7 Strategic Purchasing Functions of the MOF Under JKN

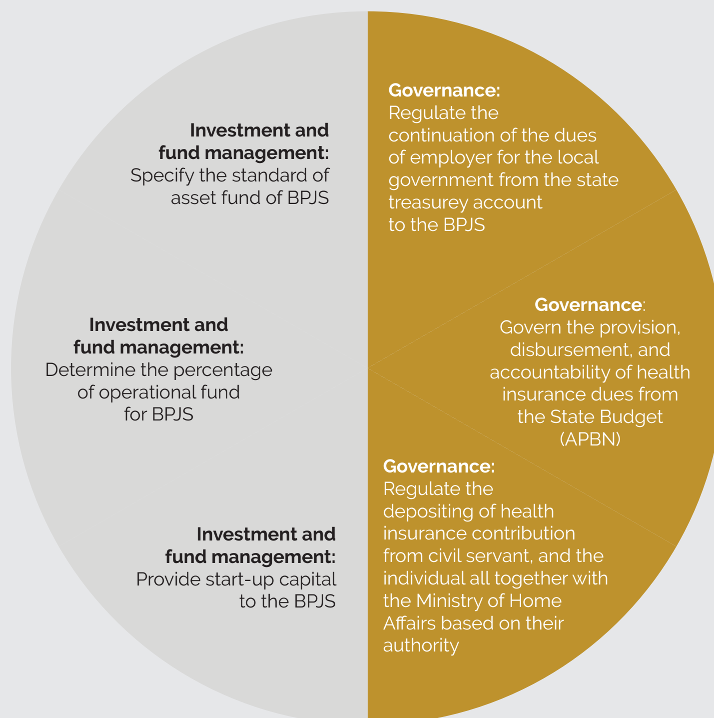
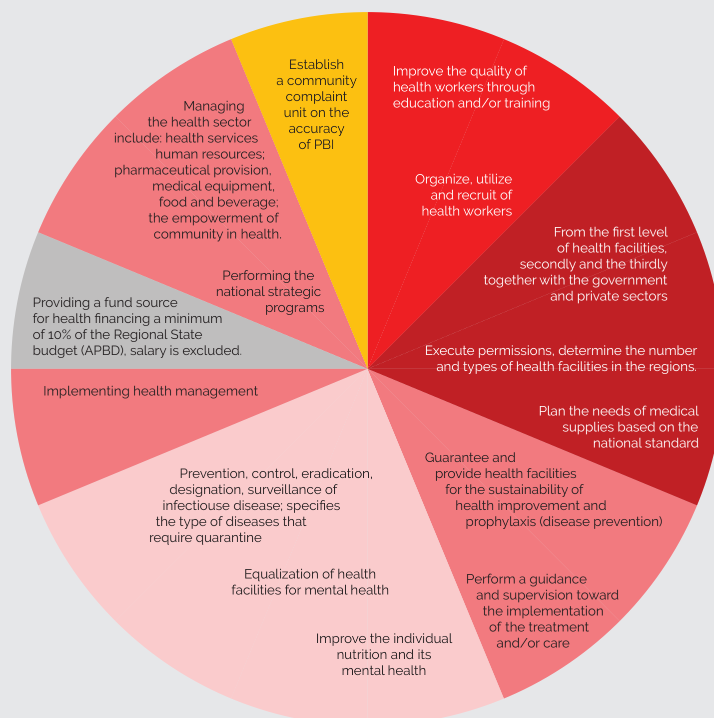


Figure 8 Strategic Purchasing Functions of Local Government Under JKN



Key Areas of Contradiction, Mismatch or Gaps in the Regulations

OVERALL RESPONSIBILITY FOR HEALTH PURCHASING UNDER JKN

The main finding of the review is that **there is lack of clarity in the legislation and regulations supporting the implementation of JKN related to the overall responsibility for strategic purchasing**. Although the original 2004 social security law allocated most of the key purchasing functions (provider payment methods, tariff-setting, and quality monitoring) to BPJS, a series of regulations brought these functions back at least partially back under the control of the Ministry of Health.

The original social security law of 2004 [*Law no. 40 Article 44 the National Social Security System*] states that "The Social Security Administering Body shall develop a health service system, a service quality control system, and health service payment system to improve the effectiveness and efficiency of health insurance." A 2013 regulation [*Presidential regulation no 111 of 2013*], however, states that the BPJS-K should coordinate with MOH to develop the technical operation of the health service system, quality control system, and health care payment system to improve the efficiency and effectiveness of the JKN. BPJS as a legal entity reports directly to the President, but its position relative to the MOH (at the same level or under it) has not yet been defined. This lack of clarity and contradiction has prevented BPJS-K from taking on the overall function of health purchasing under JKN.

The current functional roles of BPJS-K are primarily those of a financial institution rather than a health institution, so BPJS-K is serving as a passive intermediary to transfer payments to health providers and carry out some other largely administrative functions, rather than as a strategic purchaser. Most of the functions that make it possible to create incentives for more effective service delivery, efficient provider behavior, higher quality of care continue to be housed within the MOH. BPJS- K is responsible for managing the social security fund for health for the benefit of its members, but it has few effective levers to manage that fund, either to manage costs effectively or to use the fund to ensure access to high-quality services for the covered population.

ACCOUNTABILITY

Overall the review found that although accountability for the implementation of JKN is mentioned throughout the regulations, and it is one of the core principles of the social security law [*Law no. 40 of 2004 article 4*], there are few mechanisms to ensure accountability. Aside from some oversight functions of several ministries and other bodies, it is not clear which institutions are held accountable for which outcomes of JKN implementation. BPJS-K has no specific accountability for access to and quality of services it purchases, or for obtaining value for money with JKN funds. The regulations states that BPJS-K has the responsibility to manage JKN funds "for the benefit of participants" but it is not clear how that is defined or measured. And although BPJS-K is responsible for the prudent management of funds, the agency does not have levers to manage claims liabilities, or drive service delivery and quality improvements. A further concern is that it remains unclear whether the responsible institutions have adequate capacity to ensure accountability.

In addition, according to the regulations reviewed, there is no specific role for local governments in the governance and accountability of JKN implementation. The Ministry of Home Affairs has the authority to warn local governments if they are not adequately implementing JKN as a national strategy, but adequate implementation is not clearly defined and no consequences for non-compliance are specified. Local governments are accountable to the public for JKN only so far as they are obligated to establish a community complaint unit on the accuracy of PBI targeting.

SUPPLY SIDE READINESS

The supply-side readiness function is almost entirely the responsibility of local governments in Indonesia. The regulations on the role of local government

create a con flicting incentives and priorities for ensuring the effective implementation of JKN within limited resources. There is a highly variable service delivery structure with uneven capacity because of different priorities across local governments, and sometimes a mismatch between investment and the service delivery needs of the population, which has implications for both cost and effectiveness of JKN implementation. The extent of decentralization in Indonesia means that local governments are not obligated to harmonize their policies, such as investment decisions and health provider remuneration policies, with national policies such as those related to health purchasing.

Based on stakeholder interviews, there is indication of local governments (1) redirecting local budget funds to pay JKN premiums as they integrate *Jamkesda* into JKN; (2) reducing budgets for PHC in response to JKN capitation revenue at the facility level; (3) over-investing in hospitals; and (4) not effectively pursuing private sector investment or public-private partnerships to fill capacity gaps. Furthermore, the investment decisions of the local governments have financial implications for BPJS-K, which bears a growing responsibility for funding recurrent costs, and curative services that are covered by JKN and paid per service may be crowding out public health services, which are still the responsibility of local governments. Local governments have wide authority to make decisions that increase financial risk for the national JKN, especially supply-side investment decisions and funding for public health, which when neglected can shift additional curative care costs to JKN. The MOH has tried to address this through the Healthy Indonesia Program as a priority program to strengthen promotive and preventative activities at primary care level since BPJS-K spending on non-communicable disease management (NCDs) has been inadequate and referrals have increased significantly. Local governments will be accountable for maintaining minimum service standards for NCD management. There are possible financial levers through the central-level transfers to sub-national governments that could be used to create some accountability for the implementation of JKN.

On the other side, local governments and BPJS-K district/city health offices do not have access to BPJS-K claims and utilization data, which are sent directly to the national level. This deprives local governments of useful data to make investment decisions and leaves little incentive to improve data quality. There does not seem to be an organized platform for dialogue at the local level between local governments, district/city health offices, and local BPJS-K branches to harmonize planning of health infrastructure and implementation of JKN.

SUPPLY-SIDE READINESS IN RURAL AND REMOTE AREAS

The geographical conditions in several Indonesian regions are less advantageous to implement JKN and this impedes the JKN participants to enjoy the JKN benefits and they should have been. Limited fiscal capacity in some regions has limited the infrastructure, supply of health personnel, and availability of health facilities adequately equipped to provide health services as needed by the local population. Regional governments in these areas are often not able to provide sufficient incentives to attract the specialists to work in these places. As a result of difficult access/transportation to the health facilities due to poor geographical conditions and transportation, the populations of these areas are not able to make use of JKN services, although they are equally entitled to services.

Geographic challenges also increase the distribution costs of drugs purchased through e-catalog to the district capital cities. Regional governments have limited budget to absorb the costs of distributing drugs to the regional *puskesmas*. Often the drugs needed are not available in e-catalog and the procurement outside of e-catalog is more expensive. As a result, certain drugs are not available at all in some of these areas.

One of the funding sources that could be better leveraged is the compensation funds as regulated under *Article 23 paragraph 3 of Law No. 40 of 2004 on SJSN* that reads as follows: "Compensation funds could be an alternative for source of health expenditure in some rural and remote areas with low fiscal capability." The policy on the use of compensation fund has not been further regulated in the lower regulations, however, thus making it difficult to implement.

CONTRACTING AND PROVIDER PAYMENT POLICY

The divisions in responsibility between the MOH and BPJS-K on contracting providers under JKN weakens the power of contracting as a strategic purchasing

mechanism. BPJS-K cannot specify the criteria for selective contracting or specify the provisions of the contract, such as reporting requirements, or enforcing the contracts and imposing consequences for violations. So there is very little leverage over the efficiency and quality of service delivery by providers.

The regulations are also unclear about how the function of provider payment policy and rate-setting are shared between the MOH and BPJS-K, giving the authority to the MOH to develop the payment systems, but stipulating that it should be carried out in coordination with BPJS-K. BPJS-K has the authority to negotiate payment rates with provider associations with reference to MOH standard tariffs. In practice, the MOH retains authority for the function of provider payment policy and rate-setting, while BPJS-K is responsible for paying provider claims. BPJS-K has the responsibility to selectively contract providers, with criteria for provider selection defined by the MOH. While this division of functional responsibility may be appropriate for Indonesia, stakeholders suggest the need to examine and clarify responsibilities for purchasing functions across BPJS-K and the MOH. For example, the MOH PPJK, together with BPJS-K calculates the costs of services in the INA-CBG and sets the hospital tariffs. Since most of the public hospitals, in particular type A and some type B, are owned by central MOH, there is concern that the MOH may have conflicting interests in the price-setting. International experience also suggests that purchasing agencies typically have a strong role in, or complete responsibility for, provider payment policy and rated-setting.

PROVIDER AUTONOMY

The level of provider autonomy over financial, personnel, service delivery and other decisions affects providers' ability to respond to incentives by changing the mix of inputs and services they deliver. The more areas over which providers have decision rights, the more flexibility they have to respond to the incentives of purchasing and provider payment policies and the more powerful the incentives will be. Although primary health care providers *puskesmas* receive capitation payment from BPJS-K, the MOH has authority to determine how those funds can be used and how providers can allocate funds between staff payments and other operational costs. A provider that receives funds from multiple revenue streams must allocate and account for them separately. In addition, some regions consider capitation income as regional income and utilized according to local government policy. *Puskesmas* are increasingly given discretion to manage their own financial affairs, and a number of the facilities have been converted to BLUD Puskesmas, which allows them to manage their own finances. Even in autonomous *Puskesmas*, however, the complicated rules on the allocation of capitation revenue have led to low absorption in some cases, with the revenue taken back by the government treasury if it remains unspent at the end of the year. These financial rules greatly diminish the potential of the capitation payment system to encourage efficient use of resources and better service delivery.

MONITORING AND QUALITY ASSURANCE

The review showed a 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. *Article 43 of Presidential Regulation Number 12* states that the MOH has the responsibility for "the monitoring and evaluation of health care benefit services," and Article 44 states "further regulation on implementation and enhancement of services quality control system as referred in Article 42 and guarantee of quality control and cost as referred in Article 43 shall be under Minister Regulation." So there is some confusion over the responsibility for the quality monitoring and control function. It is also unclear whether BPJS-K has the authority to act on the findings of the cost and quality control teams, such as from the utilization reviews, and what actions they would be authorized to take. This lack of clarity and mismatch has weakened the provider monitoring function overall. In addition, BPJS-K maintains several data sources, including claims data and P-Care database, but a routine monitoring system with a standard set of indicators analyzed and reported regularly has not yet been put in place.

Options for Improvement of the Institutional Structure for Strategic Purchasing Under JKN

In order to strengthen strategic health purchasing under the JKN, the government needs to decide how purchasing functions can be more effectively allocated between BPJS-K and the MOH. As it is now, BPJS-K is in the role of a passive intermediary. To strengthen the role of strategic health purchasing, and of BPJS-K to play that role, there is a need to strengthen some functions (e.g. **accountability**), possibly reallocate others (shifting responsibility for **setting service delivery standards, contracting, provider payment policy and rate-setting** at least partially to BPJS-K), and creating better cooperation and shared responsibility for others (e.g. **supply side planning and provider performance and quality monitoring**). While stakeholders discuss the options for strengthening, redistributing, or better coordinating these functions, the opportunity may be explored to establish better platforms for dialogue, analysis, and joint decision-making. There is also a general need to strengthen the capacity of all institutions to carry out their functions, and clear leadership to manage the shift and strengthening of the health purchasing functions under JKN and continue to monitor and evaluate these changes, and overall program performance. While from the regulatory review it would appear that this leadership and oversight role would be the responsibility of DJSN, the power and capacity to carry out this role would need to be strengthened.

KEY ISSUES TO ADDRESS IN THE INSTITUTIONAL STRUCTURE FOR STRATEGIC HEALTH PURCHASING UNDER JKN

Purchasing Function	Related Regulations	Options for Improvement
Accountability	Law no. 40 on the National Social Security System Law No. 24 of 2011 Chapter VIII Accountability Article 37	• Strengthen accountability through improved governance system of JKN with clear definition of which institutions are responsible for which outcomes of JKN implementation. • Clarify the mandate and accountability of BPJS-K as both a health and a finance institution, increasing accountability for access to service by JKN participants, effective and efficient service delivery, quality of care, and cost management. • Establish a routine monitoring system based on a jointly used database of BPJS-K claims data, other MOH service utilization data, and other key indicators and data sources. • Establish a link between central-level financial transfers to sub-national governments and accountability for JKN implementation.
What to purchase		
Service delivery standards	Law No 40/2004 President Regulation number19/2016 article 43 A	Gradually shift authority to BPJS-K to select which service delivery and quality standards (e.g. standard clinical practice guidelines set by MOH) will be used for purchasing services, even if the agency does not develop them.
From whom to purchase		
Supply-side readiness	Law Number 23 year 2014 concerning local government Regulation of Minister of Health No. 71 of 2013	• Establish regional-level joint service delivery planning team including representation of local governments, District Health Offices, professional associations (public and private), and local branches of BPJS-K to discuss service delivery investment needs to meet service delivery standards but in consideration of the budget impact on BPJS. • Increase regional commitment to allocate funds used to build adequate health facilities, particularly in rural and remote areas. • Improve regulations to allow compensation funds as an alternative for source of health expenditure in some rural and remote areas with low fiscal capability. • Increase partnerships with the private sector, particularly for rural and remote areas, with the payer for the health care, BPJS-K, as the guarantor.

Purchasing Function	**Related Regulations**	**Options for Improvement**

Selective contracting	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the contracting function by giving greater authority to establish provider selection criteria, establish the terms of contracts, negotiate contracts with providers, and monitor and enforce contracts.
		• Implement the BPJS-K credentialing process in a participatory way with DHOs, local governments, professional associations (public and private), and other stakeholders to jointly carry out mapping in the regions, analyze population growth, and project future PHC supply needs for JKN.
		• Create more opportunity for private FKTPs to contract with BPJS-K:
		  • Specify the role of private providers in JKN/BPJS-K regulations
		  • Engage private professional associations in credentialing

How to purchase		
Contracting and provider payment policy	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the selection and development of provider payment systems, and provider rate-setting. • Explore options to better harmonize between capitation payment for PHC and INA-CBG payment for secondary and tertiary services. • Provide fair contracting conditions for private providers, including tariff adjustments and access to government medicines prices. • Consider establishing an independent provider payment policy analysis unit to gather cost information, conduct analysis to inform provider payment system design and parameter development, and budget impact analysis (possibly built from the MOH Case Mix Unit) Capitation • The capitation rate-setting should be more explicitly linked to the package of services and, include adjustments for geography and other factors related to health need. • The capitation payment system should be refined to include regulations on the upper and lower limits of ratios of registered participants to physicians in a FKTP. • The pay-for-performance component should be evaluated and revised to ensure that incentives are aligned with service delivery objectives and rural and remote FKTPs are not disadvantaged. INA-CBGs • The INA-CBG payment system should be refined to improve alignment between case groups and relative costs. • The hospital costing system should be evaluated and possibly refined • Consider transitioning the INA-CBG payment system to a budget-neutral payment system (either volume caps or adjustable base rate).

Purchasing Function	Related Regulations	Options for Improvement
Provider autonomy	Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities MOH regulation no 21/2016	Test a capitation waiver that allows puskesmas meeting certain criteria to pool revenues from multiple sources (capitation, BOK, local funds, etc.) with increased autonomy for management and allocation of funds. • Set up a district-level platform for communication and monitoring among 4 entities: DHO, BPJS, puskesmas providers, and local government • Monitor effects on service delivery
Provider performance monitoring	Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Articles 33, 37 and 38 Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39	• Establish an integrated health information system that can be used by multiple stakeholders for multiple purposes. • Improve the P-Care data system to that it can be used effectively by all stakeholders, especially FKTPs, for planning, management, and performance monitoring and improvement and link it to the BPJS-K claims database. • Establish a routine monitoring system within BPJS-K that analyzes and reports on a set of standard indicators related to service delivery and other key JKN outcomes. • Build on the BPJS-K cost and quality control team to build Joint provider monitoring and quality assurance commissions at the district level, including representation of the local branch of BPJS, DHO, and local government. • Establish the authority of BPJS-K to act on results of the cost and quality control teams utilization reviews, etc. and possible link to financial or other incentives. • Establish a routine reporting system for BPJS-K to report routine monitoring and evaluation results to MOH and DJSN on a regular basis

Annex 1.

Health Sector Laws and Regulations in Indonesia Related to Health Purchasing

NO	TOPIC	LEGISLATION
THE EXECUTIVE AGENCY (BPJS HEALTHCARE)		
2	Selection of Health Care Providers (PPK) by participants	To determine PPK Presidential Regulation No. 12 of 2013 article 29 clause 1 • Initially BPJS-K will register each Participant to one first level Healthcare Facility which will be appointed by BPJS-K based on the recommendation from Health Department at regency/city level. Presidential Regulation No. 12 of 2013 article 29 clause 2 • After the first 3 (three) months, Participant has the rights to select their own first level Healthcare Facility.
2.A	Policies related to Gender Issues	Presidential Regulation No. 12 of 2013 article 21 clause 4-7 4. Family planning as referred in clause (1) letter c consists of: counseling, basic contraception, vasectomy and tubectomy working with family planning institution. 5. Vaccine for basic immunization and basic contraception materials as referred in clause (3) and clause (4) are provided by Government and/or Regional Government 6. Health screening services as referred in clause (1) letter d is provided to selective individual to detect disease risk and further impact of certain diseases. 7. Regulation on procedure of health screening, type of diseases and schedule of health screening services as referred in clause (6) shall be regulated on Minister Regulation
3	Selection of Benefit package by participants	• Presidential Regulation No. 12 of 2013 article 20 – article 26 of Chapter IV Health Care Benefits of (essentially, comprehensive benefits unless there are some that are not excluded *) • And article 27 - article 28 of Chapter VI Benefit Coordination (essentially, Participants of Healthcare Benefit can enroll in additional healthcare insurance)
4	Mechanisms to ensure the accountability of executive agency to participants	Law no. 40 of 2004 article 4 the National Social Security System is administered on the principles of: • mutual assistance; • not-for-profit; • transparency; • prudence; • accountability; • portability; • mandatory participation; • trust fund; • return on management of the Social Security Fund to be used entirely for developing programs in the best interests of participants Elucidation of Article 4 of the Law of the Republic of Indonesia Number 40 Year 2004 on the National Social Security System and Elucidation of Article 4 Letter E of the Law of the Republic of Indonesia Number 24 Year 2011 on Implementing Agency Of Social Security, that: *The principle of accountability in this provision is the principle of accurate and accountable program implementation and financial management.*
5	Types of PPK contracted	• **PPK qualified to work with the** BPJS-K in Regulation of Minister of Health No. 71 of 2013 CHAPTER III • **Cooperation of Health Facilities With BPJS-K article 5** 1. To be able cooperate with BPJS-K, Health Facilities referred to in Article 2 shall comply with the requirements. (This requirement is described in article 6 - article 8) 2. In addition to provisions must comply with the requirements referred to in clause (1), BPJS-K in cooperation with Health Facilities should also consider the adequacy of the number of health facilities and the number of participants to be served.
6	Mechanism for selecting PPK	• Could you tell us about the mechanism of the selection of health care providers. • Regulation of Minister of Health No. 71 of 2013 CHAPTER III • **Cooperation of Health Facilities With BPJS-K** **Article 5** 1. To be able cooperate with BPJS-K, Health Facilities referred to in Article 2 shall comply with the requirements. (This requirement is described in article 6-article 8) 2. In addition to provisions must comply with the requirements referred to in clause (1), BPJS-K in cooperation with Health Facilities shall also consider the adequacy of the number of health facilities and the number of participants to be served. **Article 9** 1. In determining the choice of Health Facilities, BPJS-K shall perform selection and credentialing using technical criteria that include: human resources; a. infrastructure and facilities; b. scope of services; and c. service commitment. 2. Technical criteria referred to in clause (1) shall be used to determine the cooperation with BPJS-K, the type and extent of service, capitation, and the number of participants that can be served. 3. BPJS-K in establishing technical criteria referred to in clause (1) shall be based on the Regulation of the Minister.

NO	TOPIC	LEGISLATION
7	Agreement with the provider regarding a. Registration / credentialing and accreditation b. Payment method and service leveling c. Benefit package provided d. Monitoring and evaluation of health care quality e. Monitoring and evaluation of health care costs f. Reports / Information to be submitted by the provider	• Credentialing is explained in the Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities With BPJS-K Section Two Article 9 • Payment Method is explained in the Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation • The benefit package provided is explained in the Presidential Regulation Number 12 of 2013 Chapter IV on Health Care Benefits article 20-24, article 25 regarding the services that are excluded. Article 26 concerns the assessment of service specifications. • Supervision of health care quality: Regulation of Minister of Health Number 71 of 2013 CHAPTER VI QUALITY CONTROL AND COST CONTROL **Article 33** 1. In order to ensure quality and cost control, the Minister is authorized to: a. health technology assessment; b. clinical advisory; c. standard rate calculation; d. monitoring and evaluation of healthcare services implementation. 2. Monitoring and evaluation referred to in clause (1) letter d is in order that health professionals who provide health care at first-level health facilities and advanced-level referral health facilities have complied with authority and medical services standard specified by the Minister. **Article 37** Implementation of quality and cost control by Health Facilities as referred to in Article 36 shall be performed through: a. organization of health professionals' authority in performing professional practice according to the competence; b. utilization review and medical audit; c. development of professional ethics and discipline to health professionals; and / or d. monitoring and evaluation of the use of drugs, Medical Devices, and medical consumables in health care are carried out periodically through the utilization of health information system. **Article 38** 1. Implementation of quality control and cost control by BPJS-K referred to in Article 36 is performed through: a. compliance with quality standard of health facilities; b. compliance with healthcare process standard; and c. monitoring of the outcomes of participants' health. 2. In respect of the implementation of quality control and cost control as referred to in clause (1), BPJS-K establishes a team of quality control and cost control consisting of elements of professional organizations, academician, and clinical experts. 3. The team of quality control and cost control as referred to in clause (2) can perform: a. socialization of the authority of health professionals in performing professional practice in accordance with the competence; b. utilization review and medical audit; and/or c. development of professional ethics and discipline to health professionals. 4. In certain cases, a team of quality control and cost control as referred to in clause (2) may request information on the identity, diagnosis, medical history, examination history and treatment history of the Participant in the form of photocopy of the medical records to the health facilities as needed. a. Monitoring and evaluation of health services cost (Fraud): There is no regulation b. Report: Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review **Article 39** 1. Health facilities shall make a monthly report of health care activities submitted on a regular basis to BPJS HealthcareBPJS-K. 2. BPJS HealthcareBPJS-K shall implement Utilization Review on a regular and sustainable basis and provide feedback of the Utilization Review results to Health Facilities. 3. BPJS HealthcareBPJS-K shall report the results of Utilization Review to the Minister and DJSN. 4. Provisions concerning the reporting mechanism and Utilization Review as described in clause (2) and clause (3) shall be determined by Regulations concerning BPJS HealthcareBPJS-K.
8	Financial flows of Executive Agency, PPK and the related parties	• Regulation of Minister of Health No. 69 of 2013 regarding Health Care Standard Rates On First-Level Health Facilities And Advanced-Level Health Facilities in the Implementation of Health Insurance Program • Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities
9	Communication the executive agency with the central government	**Law No. 24 of 2011 Part Fourth Entitlement Article 12** During implementing its authority as set forth in Article 11, the BPJS-K shall be entitled to: 1. obtain operational fund for the implementation of the Social Security program of which originates from Social Security Fund and/ or other sources in accordance with the provision of law and regulation; and 2. obtain the monitoring and evaluation result on the implementation of Social Security program every 6 (six) months.

NO	TOPIC	LEGISLATION
10	Regulation on benefit package, Rate of claims and operational budget of the executive agency	• Benefit package: Presidential Regulation Number 12 of 2013 Chapter V regarding Healthcare Benefits article 20 - article 26 • Rate of Claims: Regulation of Minister of Health Number 69 of 2013 • Operational budget of the executive agency: Law No. 24 of 2011 Part Fourth Operational Cost **Article 44** 1. Operational cost of the BPJS consists of personnel cost and non-personnel cost. 2. Personnel as set forth in section (1) above consist of Supervisory Board, Directors, and employees. 3. Personnel cost includes Salary or Wage and other additional Benefits. 4. Supervisory Board, Directors, and employees receive Salary or Wage and other additional Benefit of which is in accordance with the authority and/ or responsibility in implementing the tasks in the BPJS. 5. Salary or Wage and other additional Benefits as set forth in section (4) with due regard to the applicable level of fairness. 6. Supervisory Board, Directors, and employees could receive incentive in accordance with the performance of the BPJS of which is paid from the result of its expansion. 7. Provision regarding on the Salary or Wage and other additional Benefit as well the incentive for the employees shall be established by the Directors. 8. Provision regarding on the Salary or Wage and other additional Benefit as well the incentive for the Supervisory Board and Directors shall be established by the President. **Article 45** 1. Operational fund as set forth in Article 41 section (1) point d shall be determined based on percentage of the received Dues and/ or from the result of expansion fund. 2. Further provision regarding on the percentage of the expansion fund as set forth in section (1) shall be regulated in the Government Regulation.
11	Mechanism to pay attention to the priority of National Health	Law No. 40 of 2004, Law No. 24 of 2011
12	Government supervises executive agency	• Supervision towards BPJS : **Law No. 24 of 2011** on the Implementing Agency of Social Security Chapter IX Supervision **Article 39** 1. Supervision towards BPJS shall be conducted both externally and internally. 2. The internal supervision of BPJS shall be conducted by the supervisory organ of BPJS of which consists of: a. Supervisory Board; and b. Internal supervisory unit. 3. The external supervision of BPJS shall be conducted by: a. DJSN; and b. independent supervisory institution (in the explanation of law, it is mentioned that The independent supervisory institution shall be the Financial Service Authority. In certain condition in accordance with its authority, Audit Board of the Republic of Indonesia could conduct examination.) • The Corruption Eradication Commission (KPK) • Monitoring and Evaluation Team of the National Health Insurance (JKN) : Decree of Minister of Health No.046/Menkes/Sk/Ii/2014 regarding Monitoring and Evaluation Team of National Health Insurance Implementation in 2014
GOVERNMENT		
13	Government communicates with the executing agency	**Law No. 24 of 2011 Part Fourth Entitlement Article 12** During implementing its authority as set forth in Article 11, the BPJS shall be entitled to: 1. obtain operational fund for the implementation of the Social Security program of which originates from Social Security Fund and/ or other sources in accordance with the provision of law and regulation; and 2. obtain the monitoring and evaluation result on the implementation of Social Security program every 6 (six) months.
14	Rules regarding benefit package	• Presidential Regulation No. 12 of 2013 article 20 – article 26 of Chapter IV Health Care Benefits of (essentially, **comprehensive benefits unless there are some that are excluded** *) Health care is not guaranteed: a. Health services are performed without going through the procedures as stipulated in the regulations; b. Health services in health facilities which do not cooperate with BPJS-K, except for emergency cases; c. Health services has been guaranteed by the program of work injury insurance against illness or injury due to accidents or employment relationship; d. Health services carried out abroad; e. Health care for aesthetic purposes; f. Services to overcome infertility; g. Leveling services of teeth (orthodontic); h. Health disorders / diseases caused by drug addiction and / or alcohol; i. Health problems caused by accidentally hurt themselves, or due hobbies endanger yourself; j. Complementary medicine, alternative and traditional, including acupuncture, shin she, chiropractic, which has not been declared effective by health technology assessment (health technology assessment); k. Treatment and medical actions categorized as an experiment (experimental); l. Contraceptives, cosmetics, baby food and milk; m. Household health supplies; n. Catastrophic health care in emergency relief, extraordinary events / outbreaks; and Cost of other services that are not related to health insurance benefits provided. • And article 27 - article 28 of Chapter VI Benefit Coordination (essentially, **Participants of Healthcare Benefit can enroll in additional healthcare insurance**)

NO	TOPIC	LEGISLATION
15	Supervision and evaluation of the executive agency	**Law No. 24 of 2011 CHAPTER VIII ACCOUNTABILITY** **Article 37** 1. BPJS shall be obliged to deliver accountability on the implementation of the tasks in the form of program management report and financial report of which have been audited by the public accountant to the President with carbon copy delivered to DJSN at no more than 30th June of the next year. 2. The period of program management report and financial report as set forth in section (1) above starting from 1st January up to 31st December. 3. Format and content of the program management report as set forth in section (1) above shall be proposed by the BPJS after consulting the DJSN. 4. Financial report of BPJS as set forth in section (1) above shall be prepared and presented in accordance with the applicable financial accounting standard. 5. The program management report and financial report as set forth in section (1) shall be published in the form of exclusive summary through electronic mass media and at least 2 (two) printing media of which have circulation nationally, no more than 31st July of the next year. 6. Format and content of the publication as set forth in section (5) shall be determined by the Directors upon approval of the Supervisory Board. 7. Provisions regarding on the format and content program management report as set forth in section (3) shall be regulated by the Regulation of the President.
16	Mechanisms to ensure accountability of executing agency	• Law no. 40 of 2004 article 4 the National Social Security System is administered on the principles of: a. mutual assistance; b. not-for-profit; c. transparency; d. prudence; e. accountability; f. portability; g. mandatory participation; h. trust fund; and i. return on management of the Social Security Fund to be used entirely for developing programs in the best interests of participants • Elucidation of Article 4 of the Law of the Republic of Indonesia Number 40 Year 2004 on the National Social Security System and Elucidation of Article 4 Letter E of the Law of the Republic of Indonesia Number 24 Year 2011 on Implementing Agency Of Social Security, that: *The principle of accountability in this provision is the principle of accurate and accountable program implementation and financial management.*
17	Government funding for Executive Agency to perform functions in health insurance	• **Yes, from conribution of PBI and the initial Fund of Rp 2 Trillion** • **Law No. 24 of 2011 Part Fourth Entitlement Article 12** • During implementing its authority as set forth in Article 11, the BPJS shall be entitled to: a. obtain operational fund for the implementation of the Social Security program of which originates from Social Security Fund and/ or other sources in accordance with the provision of law and regulation
18	Government supervises Executive Agency	• Supervision towards BPJS: **Law No. 24 of 2011** on the Implementing Agency of Social Security Chapter IX Supervision **Article 39** 1) Supervision towards BPJS shall be conducted both externally and internally. 2) The internal supervision of BPJS shall be conducted by the supervisory organ of BPJS of which consists of: a. Supervisory Board; and b. Internal supervisory unit. 3) The external supervision of BPJS shall be conducted by: a. DJSN; and b. independent supervisory institution (in the explanation of law, it is mentioned that The independent supervisory institution shall be the Financial Service Authority. In certain condition in accordance with its authority, Audit Board of the Republic of Indonesia could conduct examination.) • The Corruption Eradication Commission (KPK) : - • Monitoring and Evaluation Team of the National Health Insurance (JKN) : Decree of Minister of Health No.046/Menkes/Sk/II/2014 regarding Monitoring and Evaluation Team of National Health Insurance Implementation in 2014
PROVIDER (PHC AND HOSPITAL)		
19	How and how often Provider communicate with the Executive Agency	Communication Forum between Health Facilities is established by each Branch Office of BPJS-K in accordance with the working area by appointing Person in charge (PIC) from each of the Health Facilities. Task of PIC health facilities is to provide information needed for referral services (in the Implementation Manual of the National Health Insurance of BPJS-K)

NO	TOPIC	LEGISLATION
20	Agreement with the Executive Agency regarding: a. Registration / credentialing and accreditation b. Payment method and service leveling c. Benefit package provided d. Monitoring and evaluation of health care quality e. Monitoring and evaluation of health care costs f. Reports / Information to be submitted by the provider	• Credentialing is explained in the Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities With BPJS-K Section Two Article 9 • Payment Method is explained in the Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation • The benefit package provided is explained in the Presidential Regulation Number 12 of 2013 Chapter IV on Health Care Benefits article 20-24, article 25 regarding the services that are excluded. Article 26 concerns the assessment of service specifications. • Supervision of health care quality: Regulation of Minister of Health Number 71 of 2013 CHAPTER VI QUALITY CONTROL AND COST CONTROL Article 33 3. In order to ensure quality and cost control, the Minister is authorized to: a. health technology assessment; b. clinical advisory; c. tandard rate calculation; d. monitoring and evaluation of healthcare services implementation. 4. Monitoring and evaluation referred to in clause (1) letter d is in order that health professionals who provide health care at first-level health facilities and advanced-level referral health facilities have complied with authority and medical services standard specified by the Minister. Article 37 Implementation of quality and cost control by Health Facilities as referred to in Article 36 shall be performed through: a. organization of health professionals' authority in performing professional practice according to the competence; b. utilization review and medical audit; c. development of professional ethics and discipline to health professionals; and / or d. monitoring and evaluation of the use of drugs, Medical Devices, and medical consumables in health care are carried out periodically through the utilization of health information system. Article 38 5. Implementation of quality control and cost control by BPJS-K referred to in Article 36 is performed through: a. compliance with quality standard of health facilities; b. compliance with healthcare process standard; and c. monitoring of the outcomes of participants' health. 6. In respect of the implementation of quality control and cost control as referred to in clause (1), BPJS-K establishes a team of quality control and cost control consisting of elements of professional organizations, academician, and clinical experts. 7. The team of quality control and cost control as referred to in clause (2) can perform: a. socialization of the authority of health professionals in performing professional practice in accordance with the competence; b. utilization review and medical audit; and/or c. development of professional ethics and discipline to health professionals. 8. In certain cases, a team of quality control and cost control as referred to in clause (2) may request information on the identity, diagnosis, medical history, examination history and treatment history of the Participant in the form of photocopy of the medical records to the health facilities as needed. • Monitoring and evaluation of health services cost (Fraud): There is no regulation • Report: Regulation of Minister of Health Number 71 of 2013 CHAPTER VII REPORTING AND UTILIZATION REVIEW Article 39 1. Health facilities shall make a monthly report of health care activities submitted on a regular basis to BPJS-K. 2. BPJS-K shall implement Utilization Review on a regular and sustainable basis and provide feedback of the Utilization Review results to Health Facilities. 3. BPJS-K shall report the results of Utilization Review to the Minister and DJSN. 4. Provisions concerning the reporting mechanism and Utilization Review as described in clause (2) and clause (3) shall be determined by Regulations concerning BPJS-K
21	Accountability mechanism of PPK to the Executive Agency	Report: Regulation of Minister of Health Number 71 of 2013 CHAPTER VII REPORTING AND UTILIZATION REVIEW Article 39 1. Health facilities shall make a monthly report of health care activities submitted on a regular basis to BPJS-K. 2. BPJS-K shall implement Utilization Review on a regular and sustainable basis and provide feedback of the Utilization Review results to Health Facilities. 3. BPJS-K shall report the results of Utilization Review to the Minister and DJSN. 4. Provisions concerning the reporting mechanism and Utilization Review as described in clause (2) and clause (3) shall be determined by Regulations concerning BPJS-K.
22	The financial flow between the Executive Agency, PPK and other parties involved in the National Health Insurance	• Regulation of Minister of Health No. 69 of 2013 regarding Health Care Standard Rates On First-Level Health Facilities And Advanced-Level Health Facilities in the Implementation of Health Insurance Program • Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities
23	Executive Agency encourage innovation in the provider	In accordance with its Tasks and Functions, the Executive Agency supervise PPK in Cost Control And Quality Control. And Credentialing before the Contract.

NO	TOPIC	LEGISLATION
PUBLIC / PARTICIPANTS		
24	Participants' opinion about the performance of the Executive Agency	Law no. 40 of 2004 article 16: Each participant is entitled to receive benefits and information about implementation of social security programs in which he or she is participating.
25	Mechanism to channel the aspirations of the people in choosing the PPK and health care benefits	• Presidential Regulation No. 12 of 2013 article 29 clause 1 **Initially BPJS Healthcare will register each Participant** to **one first level Healthcare Facility** which will be appointed by BPJS Healthcare based on the recommendation from Health Department at regency/city level • Presidential Regulation No. 12 of 2013 article 29 clause 2 **After the first 3 (three) months, Participant has the rights to select their own first level Healthcare Facility.** **• Participants cannot select secondary health care**.
26	Mechanism that integrates between the needs of the participants' preference and the PPK as well as benefit package that will be received by Participants	Presidential Regulation No. 12 of 2013 article 20 – article 26 of Chapter IV Health Care Benefits of (essentially, **comprehensive benefits unless there are some that are excluded** *) Health care is not guaranteed : • Health services are performed without going through the procedures as stipulated in the regulations; • Health services in health facilities which do not cooperate with BPJS-K, except for emergency cases; • Health services has been guaranteed by the program of work injury insurance against illness or injury due to accidents or employment relationship; • Health services carried out abroad; • Health care for aesthetic purposes; • Services to overcome infertility; • Leveling services of teeth (orthodontic); • Health disorders / diseases caused by drug addiction and / or alcohol; • Health problems caused by accidentally hurt themselves, or due hobbies endanger yourself; • Complementary medicine, alternative and traditional, including acupuncture, shin she, chiropractic, which has not been declared effective by health technology assessment (health technology assessment); • Treatment and medical actions categorized as an experiment (experimental); • Contraceptives, cosmetics, baby food and milk; • Household health supplies; • Catastrophic health care in emergency relief, extraordinary events / outbreaks; and • Cost of other services that are not related to health insurance benefits provided. And article 27 - article 28 of Chapter VI Benefit Coordination (essentially, **Participants of Healthcare Benefit can enroll in additional healthcare insurance**)
27	a mechanism to express participants' displeasure/ complaints to the PPK and / or the Executive Agency	Presidential Regulation No. 12 of 2013 CHAPTER 10 COMPLAINT HANDLING Article 45 1. In case Participant is not satisfied with Healthcare Benefit services performed by Healthcare Facilities in partnership with BPJS-K, complaint can be raised to Healthcare Facilities and/or BPJS-K. 2. In case Participant do not received proper services from BPJS-K, complaint can be raised to Minister. 3. Complaint raised as referred in clause (1) and clause (2) shall be handled appropriately and in short period and shall provide feedback to complaining Participant. 4. Raising complaint as referred in clause (3) shall be in accordance of prevailing law.
28	The Executive Agency guarantees its accountability to participants	Law no. 40 of 2004 article 4 the National Social Security System is administered on the principles of: a. Mutual assistance; b. Not-for-profit; c. Tansparency; d. Prudence; e. Accountability; f. Fortability; g. Mandatory participation; h. Trust fund; and i. Return on management of the Social Security Fund to be used entirely for developing programs in the best interests of participants Elucidation of Article 4 of the Law of the Republic of Indonesia Number 40 Year 2004 on the National Social Security System and Elucidation of Article 4 Letter E of the Law of the Republic of Indonesia Number 24 Year 2011 on Implementing Agency Of Social Security, that: *The principle of accountability in this provision is the principle of accurate and accountable program implementation and financial management.*
29	Mechanism for participants to know the performance of the Executive Agency	There is no mechanism. However, the Laws have mandated • Law no. 40 of 2004 article 16: Each participant is entitled to receive benefits and information about implementation of social security programs in which he or she is participating. • Law No. 14 of 2008 on Public Information Disclosure. Consisting of 64 articles, this law in essence gives liability to any Public Agency for opening access to every public information applicant to obtain public information, except for some specific information.

Annex 2.

Mapping of Strategic Health Purchasing Functions to Responsible Institutions

FUNCTION		INSTITUTION						
		DJSN	BPJS-K	MOH	MOF	MINISTRY OF SOCIAL AFFAIRS	MINISTRY OF HOME AFFAIRS	LOCAL GOVERNMENT
Governance and Accountability	Governance	Propose interim substitute members of the Board of Trustees and / or members of the Directorate of BPJS to the President.	Provide information on the implementation of social security programs to participants and the Community	Coordinate with the Health BPJS to develop the technical operation of the health care system and quality control system	Regulate the continuation of the dues of employer for the local government from the state treasury account to the BPJS	Verify and validate BPJS data, establish criteria for the poor and vulnerable people into an integrated data set	Provide written warning to governors and/ or vice-governors not implementing JKN as a national strategic program.	No role for local governments in governance and accountability
				Regulate the fraud prevention system in JKN Fraud prevention is typically a function of the purchasing agency.	Govern the provision, disbursement, and accountability of health insurance dues from the State Budget (APBN).	Regulate the procedures and the change of requirements of PBI health insurance data	Regulate the depositing of health insurance contribution from civil servants, government employee non-civil servant, and the individual all together with the Ministry of Home Affairs based on their authority	
				Impose written warning sanctions on the members of the Board or the Directors of BPJS and provide advice to the president	Regulate the depositing of health insurance contribution from civil servants, government employee non-civil servant, and the individual all together with the Ministry of Home Affairs based on their authority.	Regulate the procedure of verification and validation of the alteration of PBI JK data, set the alteration of such data, and deliver it to the Minister of Health and DJSN		
	Accountability	Provide consultation to the BPJS on the form and content of the program management accountability report.	Insufficient accountability mechanisms					Establish a community complaint unit on the accuracy of PBI
		Receives copy of BPJS annual management and audited financial reports for submission to the President.						

FUNCTION		INSTITUTION						
		DJSN	BPJS-K	MOH	MOF	MINISTRY OF SOCIAL AFFAIRS	MINISTRY OF HOME AFFAIRS	LOCAL GOVERNMENT
Benefits and entitlement	Benefits design			Manage the types of health services guaranteed by JKN				
				Regulate the JKN compensation that should be provided to the participant of BPJS Health				
				Specify the list of medicines, medical equipment, and medical consumable materials.				
	Decisions on adding new services/ medicines			Add guaranteed health services based on health technology assessment in coordination with the Ministry of Finance				
	Enrollment and entitlement		Receive registration of JKN participants	Register the numbers of PBI participants in BPJS Health				
Service delivery	Supply side planning and investment							Plan the needs of medical supplies based on the national standards Investment decisions made without dialogue on payment of recurrent costs through JKN
	Health workforce planning and management							Organize, utilize, and recruit of health workers
								Improve the quality of health workers through education and/or training
	Service delivery management							Managing the health sector included: health services; human resources; pharmaceutical provision, medical equipment, food, and beverage; the empowerment of community in health
								Implement national strategic programs
	Health promotion and prevention							Prevention, control, eradication, designation, surveillance of infectious disease
								Improve the individual nutrition and mental health

FUNCTION		INSTITUTION						
		DJSN	BPJS-K	MOH	MOF	MINISTRY OF SOCIAL AFFAIRS	MINISTRY OF HOME AFFAIRS	LOCAL GOVERNMENT
Financing	Budget	Propose social security budget for beneficiaries of contributions and the availability of operational budget to the Government.		Budget proposal of PBI JK to the Ministry of Finance based on the DJSN proposal.				
	Revenue collection		Collect JKN contributions from Participants, Employers and Governments. Receive donations from the government					Providing a fund source for health financing a minimum of 10% of the Regional State budget (APBD), salary is excluded.
	Investment and fund management	Propose investment policy of National Social Security Fund.	Manage Social Security Funds for the benefit of participants Responsible for fund management but do not have levers to manage claims liabilities.		Provide start-up capital to the BPJS Determine the percentage of operational fund for BPJS Specify the standard of asset fund of BPJS.			
Contracting and provider payment	Provider payment selection and design		Although the regulation states MOH should coordinate with BPJS on payment system development that has not happened in practice. The purchasing agency typically is responsible for or has a role in provider payment selection and design and payment rate-setting.	Coordinate with the Health BPJS to develop provider payment systems Review provider payment systems (capitation, INA-CBGs, etc.) at least every 2 together with health BPJS, DJSN, and the Ministry of Finance				
	Payment rate-setting			Tariff calculation Organize the types and the platform of health equipment prices Specify the cost of health services in the event of preventable adverse events.				
	Selective contracting		Selecting providers for contracting based on established technical criteria Purchaser typically has role in determining criteria for selecting providers	Setting the technical criteria for contracting with BPJS				
	Making payments to providers		Paying benefits and / financing health services					

FUNCTION		INSTITUTION						
		DJSN	BPJS-K	MOH	MOF	MINISTRY OF SOCIAL AFFAIRS	MINISTRY OF HOME AFFAIRS	LOCAL GOVERNMENT
Monitoring	Monitoring	Conducting studies and research related to the implementation of social security	Cost and quality monitoring at the provider level, including utilization review and medical audit. Duplication with MOH function.	Monitoring and evaluation of the performance of health insurance services in coordination with DJSN				
	Information management		Collecting and managing data of JKN participants	Disconnect between data collection and monitoring. Overall weak monitoring function.				