NATIONAL HEALTH INSURANCE (JKN) REFORMS AND RESULTS

PROGRAM-FOR-RESULTS (PFORR)
P172707

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT REPORT (ESSA)

November 2021

Prepared by the World Bank

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
BPJS-K	*Badan Penyelenggaran Jaminan Sosial – Kesehatan/*Social Health Insurance Agency
CRVS	Civil Registration and Vital Statistics
DHO	District Health Offices
DJSN	*Dewan Jaminan Sosial Nasional*/National Social Security Council
DLI	Disbursement-linked Indicators
DPL	Development Policy Loan
DPO	Difabel Person Organization
DRG	Diagnosis-related group also referred to as Indonesian Case Base Groups or INACBGs
ESSA	Environmental and Social System Assessment
FKTP	*Fasilitas Kesehatan Tingkat Pertama/*Primary level healthcare facilities
GHG	Green House Gas
GoI	Government of Indonesia
GRS	Grievance Redress System
HTA	Health Technology Assessment
INACBG	Indonesia Case Base Groups
I-SPHERE	Indonesia's Supporting Primary Health Care Reform
JKN	*Jaminan Kesehatan Nasional*/National Health Insurance Program
UHC	Universal Health Coverage
KARS	*Komite Akreditasi Rumah Sakit*/Hospital Accreditation Committee
KBK	*Kapitasi Berbasis Komitmen*/Commitment-based Capitation
MKDKI	*Majelis Kehormatan Kedokteran Indonesia*/Indonesian Medical Disciplinary Board
MoH	Ministry of Health
MoF	Ministry of Finance
MoHA	Ministry of Home Affairs
MoSA	Ministry of Social Affairs
NIK	*Nomor Induk Kependudukan*/Civil Registration Number
OOP	Out-of-Pocket
PAP	Program Action Plan
PBI	*Penerima Bantuan Iuran*/Receipients of JKN premiums
PDO	Program Development Objective
PforR	Program for Results
PHO	Provincial Health Offices
PODES	*Potensi Desa*/A Survey of Village Potentials
Puskesmas	*Pusat Kesehatan Masyarakat*/Public Primary Health Centers
PPU-BU	*Pekerja Penerima Upah Selain Penyelenggara Negara/*Non-government salaried workers
PPU-P	*Pekerja Penerima Upah Pemerintah/*Government salaried workers
PBPU	*Pekerja Bukan Penerima Upah/*Non-salaried workers
RENSTRA	*Rencana Strategis* (Strategic Plan)
RPJMD	*Rencana Pembangunan Jangka Menengah Daerah/*Regional Mid-Term Development Plan
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional/*National Mid-Term Development Plan
TA	Technical Assistance
TB	Tuberculosis
TKMKB	*Tim Kendali Mutu dan Biaya*/A Cost and Quality Control Team

TNP2K	*Tim Nasional Percepatan Penanggulangan Kemiskinan/* National Team for the Acceleration of Poverty Reduction
SIPP	*Saluran Informasi dan Penanganan Pengaduan*/Complaint Handling and Information System
SJSN	*Sistem Jaminan Sosial Nasional/*National Social Insurance System
SOP	Standard Operating Procedure
UHC	Universal Health Coverage
WHO	World Health Organization
YLKI	Yayasan Lembaga Konsumen Indonesia/Indonesia Consumer Organization NGO

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EXECUTIVE SUMMARY

1. **The Program Development Objective (PDO) is to strengthen the quality and efficiency of Indonesia's National Health Insurance Program (*Jaminan Kesehatan Nasional* or hereafter JKN).** The main objective of the JKN program is to address existing inequities in access to and quality of healthcare for all citizens and by doing so, ensure that the Universal Health Coverage (or hereafter 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) improved member satisfaction rate, c) increase in the percent of outpatient utilization among bottom two quintiles, and d) more sustainabile JKN claims ratio.

2. **The implementing agencies for this PforR include the Ministry of Health (MoH), Ministry of Finance (MoF), Social Health Insurance Agency (*Badan Penyelenggaran Jaminan Sosial – Kesehatan* or hereafter BPJS-K) and National Social Security Council (*Dewan Jaminan Sosial Nasional* or hereafter DJSN).** As a hybrid PforR, this operation includes a PforR component as well as a grant-funded investment project financing (IPF) component. MoF is the lead executing agency for the proposed PforR, as well as the implementing agency for the IPF component of the PforR, and as the coordinating ministry, it will convene a high-level Steering Committee (SC)[1] to provide overall policy guidance and oversight to Program implementation. The committee will set policy and annual targets, review progress and performance, and resolve specific issues as required.

3. **The PforR is nested in the GoI's health sector program, defined in its five-year National Development Plan (or hereafter RPJMN) for the period of 2020 – 2024[2].** The PforR seeks to support elements of the JKN reform. The Program focuses on management of JKN expenditure growth and does not address reforms to raise revenues. Activities are organized around three result areas, focusing on:

   a. Result Area 1: Strengthening the quality of care. Activities include: i) developing clinical pathways/processes of care for facilities (*Fasilitas Kesehatan Tingkat Pertama* or hereafter FKTPs) and hospitals for most common conditions, ii) training of frontline providers in utilizing clinical decision support tool(s), 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 health technology assessments into benefits package (DLI 3), ii) improving claims management and fraud detection processes (DLI 4), iii) improving capitation design to reflect need and service availability at FKTPs (DLI 6), iv) improving Indonesia Case Base Groups (or herafter 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), iii) improving management and coordination of JKN across stakeholders (DLI 9)

4. **The environmental and social risk is overall moderate**, with environmental risk being rated as low and social risk as 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

[1] The SC will comprise of echelon one staff from the MoH, BPJS-K, MoF, DJSN, Ministry of National Development Planning/ National Development Planning Agency (Bappenas), Coordinating Ministry for Human Development and Cultural Affairs (Kemenko PMK), and Ministry of Home Affairs (MoHA and will meet twice a year.

[2] RPJMN 2020-2024 is the fourth and final plan of Indonesia's National Long-Term Development Plan (RPJPN) for the period of 2005 - 2025

and natural disasters) since such risks are not relevant to the operation. The operation is not likely to have adverse impacts on Green House Gas (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 benefitted from weak systems and monitoring and consequently may potentially stand to lose due to greater efficiency gains (i.e., health facilities).

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 (i.e., hospital tariffs), iii) benefits package.

c. data protection and privacy

5. **While activities and investments under the PforR do not have significant direct environmental impacts, the improved performance of the Program may encourage an increased in utilization of health services; with a potential downstream environmental implication such as safe handling of medical waste.** Since the JKN PforR does not include health service readiness and that expansion of hospitals and facility accreditation fall outside the scope of the Program, management of such risks will not be directly conducted through the JKN PforR. Instead, this risk will be addressed through another complementary operation such as I-SPHERE – MOH's primary healthcare reform PforR.

6. **Both JKN and I-SPHERE Programs focus on improving the quality primary healthcare facilities (FKTPs)**. During the preparation of ESSA for I-SPHERE, it was identified that the need to improve management practices for medical wastes generated by FTKPs. To address this issue, two Program Action Plans (PAPs) were agreed: i) KAFKTP (Primary Healthcare Accreditation Committee) and MoH to develop necessary work instructions or Standard operating protocols (SOP) to improve the existing guidelines for surveyors and for environmental sanitation officers on proper management of medical waste management and, ii) KAFKTP and MoH to strengthen facilitator and surveyor capacity in areas such as safe handling of medical waste, emergency response, management of complaints and grievances, and patient consent processes and rights. Provided that both JKN and I-SPHERE aims to improve quality of services of primary healthcare facilities, improving medical wastes management through the implementation of the PAPs in I-SPHERE Program will result in the same improvement of medical waste management in FTKPs in JKN Program. The I-SPHERE Program is currently supporting the development of an improved Guideline on Proper Management of Medical Waste Management. In this context, MOH will ensure the adoption and compliance with the Guideline. The latest update as of May 2021 was the KAFKTP (Primary Healthcare Accreditation Committee) is still finalizing its accreditation standards, including specific requirements for medical waste management, and more workshops to work out the proposal have been conducted. The revised accreditation standards are currently being reviewed by the Legal, Organization and Public Relations Department (HUKORMAS) of Ditjen Yankes of MOH. The principle of Cradle to Grave for hazardous waste management will be in place for the new accreditation standard, among the significant changes is the use of manifest to track the medical waste management, from the time it was generated to the final treatment and disposal. One outstanding task is for the safeguard team to have site visits to verify the management of medical waste in primary healthcare facilities.

7. **Introduction of risk-based capitation to FKTPs, revisions of the Indonesian Case-base Groups (INA-CBG), 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 exarcebate 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 PforR implementation.

8. **Other risk factors stem from i) the context within which the PforR is operating, ii) institutional capacity and complexity of the needed reforms, and iii) political and reputational risks.** Further details of the risk assessment are presented in **Error! Reference source not found.**, with a summary in the following:

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 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 access to health care system towards UHC will require addressing various social, cultural and psychological barriers that may confront poor and marginalized segments of the population. Exclusion in access in healthcare 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 check and balance under JKN require 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 non-essential services and services prone to over utilization. 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 operational challenges above as well as political interests. Further, in order to achieve UHC, JKN is facing complex operational challenges, particularly with regards 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 as well as fiscal sustainability.

c. Political and reputational risks: key policy areas which may be revisited under the PforR include among others benefit package and entitlements, including class consolidation and co-sharing, upper ceiling caps, etc. Going forward, fiscal sustainability will require tough policy decisions, including shrinking benefit package if necessary. While inclusion of these contentious reform elements under the PforR boundary is yet to be agreed, the Program overall 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 are required as part of the environmental and social action plans.

9. **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) enhancement of public communication on patients' rights and responsibilities, c) strengthening stakeholder engagement and disclosure of public information, d) enhancement of grievance handling mechanisms under the JKN, e) development/enhancement of data protection measures for the purpose of system integration and data interoperability. The PforR will also seek to support enhancement of quality of care, including in lagging regions, through DLIs 1 and 2 which focuses development of clinical pathways/processes of care for FKTPs and hospitals, capacity building and accountability.

10. **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**. 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.

11. **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.

A BACKGROUND AND SCOPE

A.1 Introduction

- **The Program Development Objective (PDO) is to strengthen the quality and efficiency of Indonesia's National Health Insurance Program (*Jaminan Kesehatan Nasional* or hereafter JKN).** The main objective of the JKN program is to address existing inequities in access to and quality of healthcare for all citizens and by doing so, ensure that the Universal Health Coverage (or hereafter UHC) objective can be achieved. UHC is an equity-related health policy that aims to divorce ability to pay from need for services and reduce socio-economic inequalities between individuals of different health need. It is also an instrument of social protection with an explicit concern to tackle poverty, invest in human capital, and promote economic growth.

12. **At a request of the Ministry of Budget and Planning (Bappenas) and the Ministry of Finance, a Program-for-Result (PforR) operation is being considered as the most appropriate financing instrument to leverage the Government of Indonesia's (GoI) overall JKN reform agenda**. The PforR focuses on systematic, behavioral, and institutional changes needed to enhance the effectiveness and efficiency of JKN. Since disbursements are linked to the achievement of priority reform areas, the PforR offers added assurance and accountability that tangible results will be achieved. The PforR is the first opportunity to engage directly with the Social Security Agency (*Badan Penyelenggara Jaminan Sosial-Kesehatan* or BPJS-K) on a substantive level to improve the performance and sustainability of JKN. The operation focuses on reforms to JKN implementation and by doing so, it seeks to foster collaboration of four JKN stakeholders, including BPJS-K, the Ministry of Health (MoH), the Social Security Council (Dewan Jaminan Sosial Nasional or hereafter DJSN) and the Ministry of Finance (MoF). Hence, for the purpose of the PforR implementation, the Program offers an opportunity to improve coordination among the key stakeholders and other development partners involved in the sector.

13. **The PforR focuses on systematic, behavioral, and institutional changes needed to enhance the effectiveness and efficiency of JKN**. The PDO will be measures through the following result indicators a) improved provider competency score in FKTPs, b) improved member satisfaction rate, c) increase in the percent of outpatient utilization among bottom two quintiles, and d) more sustainable JKN claims ratio. As disbursements are linked to the achievement of priority reform areas, the PforR offers added assurance and accountability that tangible results will be achieved. The GoI will also benefit from complementary capacity building and institutional strengthening activities. 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.

A.2 Program Boundaries and Activities

14. **The PforR is nested in the GoI's health sector program, defined in its five-year National Development Plan (or hereafter RPJMN) for the period of 2020 – 2024[3].** The RPJMN serves as a reference for the MOH as it pursues its Strategic Plan (Renstra) 2020 – 2024 and for sub-national governments as they implement their Regional Medium-Term Development Plans (RPJMD). The GoI's draft National Security System (SJSN) Roadmap (2020 – 2024) provides impetus for JKN reform. Key strategic focus, which is also highlighted in MOH's Renstra include: i) improving JKN's system governance and accountability, ii) redefining the benefit package, iii) increasing access and service readiness, iii) improving member satisfaction, iv) strengthening strategic purchasing arrangements, and v) enhancing the system's monitoring, evaluation and fraud detection.

[3] RPJMN 2020-2024 is the fourth and final plan of Indonesia's National Long-Term Development Plan (RPJPN) for the period of 2005 - 2025

15. **The PforR seeks to support elements of the JKN reform.** The Program focuses on management of JKN expenditure growth and does not address reforms to raise revenues**.** The latter will be supported under other complementary operations, including human capital Development Policy Lending (DPL)[4] and the digital ID project[5]. Activities are organized around three result areas, focusing on:

d. **Result Area 1: Strengthening the quality of care**. Activities include: i) developing clinical pathways/processes of care for FKTPs and hospitals for most common conditions, ii) training of frontline providers in utilizing clinical decision support tool(s), iii) identifying tracer indicators to monitor compliance with clinical guidelines (DLIs 1 and 2)

e. **Result Area 2: Improving the efficiency of JKN spending**. Activities include: i) incorporating findings from health technology assessments into benefits package (DLI 3), ii) improving claims management and reducing ineligible and unnecessary claims (DLI 4), iii) improving capitation design to reflect need and service availability at FKTPs (DLI 6), iv) improving INACBG implementation (DLI 7)

f. **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), iii) improving management and coordination of JKN across stakeholders (DLI 9)

Under Result Area 2, the new design potentially involves switching from an input based per capita formula to a budget neutral or risk-based design, taking into the following considerations i) historical utilization patterns at FKTPs by age, gender, diagnosis/reason to visit to better account for risk/need, ii) ability of FKTPs to deliver interventions listed in the benefit package, and iii) historical allocation and use of capitation, including undisbursed capitation. For hospitals, this would entail revising the DRG tariffs, including introducing a reform for hospital payments to curb expenditures**.** This could include introduction of global budgeting[6], base-rate adjusted INA-CBG payments, or spending caps. Specific decisions on reform types will be determined during the PforR implementation.

The PforR boundaries are presented in Table 1 with further details of the Result Framework appended in **Annex 1**.

Table 1: Government program and PforR

	Government program	**Program supported by the PforR**
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.
Duration	2014 onwards	2021-2026
Geographic coverage	All the country	All the country
Results areas	RA1-3	RA1-3

[4] Under the Indonesia's Human Capital Development Policy Loan (DPL) (P175742) are prior actions to complete the purchaser-provider split between BPJS-K and the MOH enabling BPJS-K to act as a more strategic purchaser of health care services, and, increasing the tobacco tax rate and introducing a tax on sugar-sweetened beverages to raise additional resources for the sector.

[5] Indonesia's Digital ID and Registration for Inclusive Service Delivery (P175218 – Investment Project Financing) aims to strengthen the GOI's population and civil registration to close legal identity coverage gaps and develop a digital identification system to facilitate inclusive, reliable, and efficient service delivery.

[6] Global budgeting is a fixed payment for all services and for the entire enrolled (or eligible population for a given period.

Overall Financing	US$ 41 billion	USD 18.7 billion (of which US$ 400 million is the PforR envelope)

16. **The PforR does not address other systems and capacities under the broader GoI's JKN program within which the PforR is being proposed.** These include aspects related to i) expansion of JKN membership, ii) increasing financing in health, iii) raising JKN revenues, iv) strengthening the supply-side readiness of health care facilities to deliver services. On strengthening the quality of care, the PforR is expected to contribute to improving the quality of health care provisions through production of clinical guidelines, training of frontline providers, and enhanced accountability at the facility level (Result Area 1). Aspects that are not covered under the ESSA are being addressed through other complementary operations, including:

a. Indonesia's Human Capital Development Policy Loan (DPL – P175742). The project aims to improve the effectiveness of existing spending for human capital and protect existing human capital investments by deploying them more effectively. Under consideration are prior actions to complete the purchaser-provider split between BPJS-K and the MOH enabling BPJS-K to act as a more strategic purchaser of health care services and increasing the tobacco tax rate and introducing a tax on sugar-sweetened beverages to raise additional resources for the sector.

b. Indonesia's Digital ID and Registration for Inclusive Service Delivery (P175218) aims to strengthen the GOI's population and civil registration to close legal identity coverage gaps and develop a digital identification system to facilitate inclusive, reliable, and efficient service delivery. Improvements in digital identification will help improve the targeting, coverage, eligibility, and contribution compliance of JKN. It is a US$ 250 million loan with an expected board approval in November 2022.

c. Indonesia's Supporting Primary Health Care Reform (I-SPHERE – P164277) aims to strengthen the performance and quality of Indonesia's primary health care nationally, with an additional focus on Eastern Indonesia. It is a US$150 million PforR with a focus on supporting primary care reform by improving data use and accountability, strengthening the accreditation of primary health care facilities, and enhancing performance-based financing through JKN and DAK.

d. The Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services project (P162172) is US$ 0.73 million project that aims to improve access and quality of health services delivery for poor and vulnerable population in selected districts of Indonesia through collaborative social accountability mechanisms among stakeholders. It especially focuses on bringing forth women's voices from the field-level implementation of JKN in selected districts. Thus, from a gender as well as community engagement perspective, it is expected to provide valuable feedback and insights to inform the design and implementation of JKN and this PforR. It engages primarily with AKATIGA Foundation – a local civil society organization.

A.3 Objective and Scope of the Environmental and Social System Assessment (ESSA)

17. **The ESSA seeks to independently assess and verify environmental and social performance of relevant GOI systems using the Bank Policy Program-for-Results Financing (December 2017) and the Bank's interim note on ESSA as guidance, as well as against good practice** in order to:

a. Establish the current status of the potential environmental and social risks and impacts (within constraints of scope and time)

b. Identify key challenges, including gaps, and opportunities to maximise environmental and social benefits; and

c. Make recommendations to address these key challenges and shortcomings.

18. **The ESSA focuses on relevant systems and capacities for the management of environmental and social aspects under the proposed PforR.** No infrastructure investments are being envisaged under the

scope of the PforR. The ESSA is assessing the following environmental and social aspects of the PforR, including:

a. potential environmental and social risks and benefits

b. environmental and social systems that apply to the GoI's program

c. implementation experience and capacity

d. whether system and performance are consistent with key principles; and

e. steps to be taken to improve scope of system or capacity.

19. **The environmental and social screening assessment (Annex) indicated that potential social and environmental risks and impacts associated with the activities supported by the PforR are moderate**. 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 benefitted from weak systems and monitoring and consequently may potentially stand to lose due to greater efficiency gains (i.e., health facilities).

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 (i.e., hospital tariffs), iii) benefits package.

c. data protection and privacy

20. **Introduction of risk-based capitation to FKTPs, revisions of the Indonesian Case-base Groups (INA-CBG), 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 exarcebate 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 PforR implementation.

A.4 Approach to the ESSA

21. **The ESSA process is guided by the key policy elements as established by the Bank Policy Program-for-Results Financing (December 2017) and as they apply to the assessment of the GoI systems and the relevant agencies' capacity to plan and implement effective measures for managing environmental and social risks and impacts.** Relevant key policy elements with regards to environmental and social management systems of the Bank Policy for the PforR include:

a. promoting environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts and

b. giving due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

22. **Relevant system assessments with corresponding stakeholders' capacities for the implementation of the JKN inform the ESSA findings**. The ESSA builds on the technical assessment for the PforR, including:

a. measures to enhance access and equity, particularly for vulnerable groups, PBI-JKN members, and citizens in lagging regions.

b. measures to incentivize performance and quality of care at the facility level, including patients' safety. This includes payments to partner hospitals and performance-based capitations to FKTPs.

c. measures to promote transparency, accountability, public engagement and participation.

23. **The assessment focuses on the adequacy of the relevant systems, including implementation and the GoI's capacity to enforce**. The system review is approached in two parts:

a. identification of relevant systems that are pertinent to JKN is addressed in **Section C** on Review of Policy, Regulatory, and Institutional Frameworks; and

b. analysis on the implementation of the systems including capacity and enforcement of certain environmental and social measures is addressed in **Section D**.

24. **The ESSA was informed by review of relevant information and analytics of the JKN Program and virtual consultations for the PforR preparation.** Relevant previous consultations were summarized in Section B on Stakeholder Engagement. The draft ESSA report was circulated ahead to the meetings and a summary in Bahasa Indonesia was also be shared with the stakeholders invited. The draft ESSA report and its executive summary in Bahasa Indonesia were disclosed publicly through the World Bank's website and public comments were solicited during a period defined and reserved for comments. All stakeholders's inputs both verbally and in writing have been recorded in **Annex 5** of the report.

B STAKEHOLDER ENGAGEMENT

25. **This section provides a summary of the engagement activities undertaken for the PforR preparation, including the ESSA.** Stakeholder groups consulted with include the following:

Table 2: Stakeholders consulted in the preparation of the JKN PforR

Stakeholder Group	Date	Key Engagement Areas
National Level		
BPJS-K	February – November 2021	• Improvement in claims management, fraud detection, better use of BPJS-K data, and revision of the capitation formula • Role and responsibility sharing arrangement with MOH • Monitoring and evaluation system to track performance indicators • Expansion of JKN coverage to the informal sector • Improvement in public and members engagement as well as in capturing and responding to complaints/feedback • Improvement in data sharing, confidentiality, and safety protocols • Technical Assistance (TA) Plan
Ministry of Health	February – November 2021	• Alignment of the benefits package with the RPJMN indicators • Formulation of a risk-based capitation design and revisions to KBK • Review of clinical practical guidelines at FKTP • Updating of the INACBG (Indonesia Case Base Groups) payment system • Data exchange and/or interoperability of Management Information System (MIS) • TA Plan
Ministry of Finance	March – November 2021	• JKN reform target to achieve fiscal and program sustainability and UHC • Clarity on baseline and end targets • Clarity on activities related to the proposed Results Areas • Clarity on strategic health purchasing issues • Expansion of JKN coverage to the informal sector • Scope of the RETF financing and environmental and social requirements
DJSN	February – November 2021	• Dashboard development (internal dan public) to track key performance indicators • Improvement in public engagement and representation of public interest in the decision-making process • TA Plan
Consumer and Member Representative Groups		
NGO Into The Light	November 11, 2021	• PforR Program Design and Technical Assistance • Findings of the Environmental and Social Systems Assessment (ESSA)
Global Mental Health		
Komunitas Peduli Skizofrenia Indonesia		

Stakeholder Group	Date	Key Engagement Areas
(the Indonesian Community Care for Schizophrenia/ KPSI)		• Social system enhancement action plans
Perhimpunan Organisasi Pasien TB (Tuberculosis Patient Organization)		
Non-Government and International Organizations		
Gerakan Kesehatan Ibu dan Anak (Maternal and Child Health Moverment - GKIA)	November 11, 2021	• PforR Program Design and Technical Assistance • Findings of the Environmental and Social Systems Assessment (ESSA) • Social system enhancement action plans
Indonesia AIDS Coalition (IAC)		
NGO Prakarsa		
Save the Children		
Thinkwell Global	November 12, 2021	
USAID – Health Financing Activity		
Professional Associations		
Ikatan Bidan Indonesia (Indonesian Midwives Association/IBI)	November 12, 2021	• PforR Program Design and Technical Assistance • Findings of the Environmental and Social Systems Assessment (ESSA) • Social system enhancement action plans
Persatuan Ahli Gizi Indonesia (Indonesian Nutrition Association/ PERSAGI)		
Forum Peduli Kesehatan Ibu dan Anak (Maternal and Child Health Care Forum/FOPKIA)		
Perhimpunan Klinik dan Fasilitas (Clinic and Facility Association)		
Konsil Kedokteran Indonesia (Indonesian Medical Council/ KKI)		
Asosiasi Rumah Sakit Swasta Indonesia (Indonesian Private Hospital Association/ ARSSI)		

26. **As part of Program 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. 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 the **Annex 5**. 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, persons with drug dependence, and other marginalized groups; b) inclusiveness of health services, particularly in contexts where trust in 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.

C POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

27. **The following assessment focuses on relevant aspects for the management of environmental and social aspects of the PforR.** Analysis pertinent policies, laws and regulations is presented in the following sub-section. Two main legislations which serve as the foundation of the Universal Health Coverage (UHC) include Law no. 40/2004 on the National Social Security System (or hereafter SJSN) and Law no.24/2011 on the Social Security Managing Agency (BPJS-K). These laws seek to protect all citizens from financing risk arising from illnesses, injury, old age and death. Relevant derivative regulations, including presidential, ministerial and BPJS-K regulations have also been assessed.

C.1 Policy, Legal, and Regulatory Frameworks

28. **All citizens have the rights to be physically, mentally and spiritually healthy by the constitution**. While such basic rights are encapsulated in the Basic Health Law of 1960, the realization of UHC has taken place since 2000, followed by an ambitious government declaration in 2012 to achieve UHC by 2019. The National Social Security Council (*Dewan Jaminan Sosial Nasional* – DJSN) was established following issuance of Presidential Regulation no. 46/2014, with the main mandate to formulate policies and provide oversight for the implementation of the National Social Security System. UHC was further enacted through Law no. 24/2011, which established the BPJS-K[7]. BPJS-K is a non-profit trust fund implementing the JKN program and replaced the previous health insurance schemes[8] which were sub-optimal due to targeting and operational issues. As of 2019, JKN already covers 83 percent of the whole population or 222 million Indonesians. 60 percent of whom are the poor and non-poor who represent non-contributory members.

29. **While the prevailing laws and regulations governing the JKN are non-discriminatory, implementation of these laws and regulations has been of a mixed success, particularly on aspects related to equity and inclusion.** Effective UHC hinges upon various inter-related operating mechanisms, often outside JKN's direct sphere of influence. These include supply-side readiness, civil registry database for accurate targeting of the poor and vulnerable, employment database, sub-national governments' contributions, etc. Sub-national governments assume the overall responsibility to ensure that there is adequate infrastructure to supply the referral services by JKN (Law no. 23/2014 on Sub-national Governments; Law on Health no. 36/2009; Presidential Regulation no. 12/2013). Law no. 36/2009 requires a minimum of 5 percent of central government budget and 10 percent of sub-national government budget (excluding salary) to be allocated for health. While such legal requirements have resulted in an increase of real health public expenditure by 19.5 percent annually on average between 2001 and 2018, Indonesia's total health spending is low relative to comparative countries at about half of that in countries with a similar level of income and much of this spending is Out-of-Pockets (OOPs – World Bank 2020). Further, at the same time, many local governments also several experimented financing options to JKN, such as local subsidies (Janah and Rahayu 2020). However, rapid expansion of JKN to achieve UHC has created governance, accountability and financing challenges, undermining the program's sustainability. Further assessments of the JKN performance are presented in **Section D**. The following sub-sections present policy and regulatory analyses based on relevant concerns covered under the ESSA.

C.1.1 Equity of Access

30. **JKN includes a subsidy scheme for the poor and vulnerable.** Law no. 40/2004 on SJSN, followed by the Presidential Regulation no. 82/2018 adopted social security and equity principles in the overall implementation of the JKN. While JKN requires a contribution payment, an exemption is made for the poor to encourage their uptake of services and avoid additional economic burden. This includes introduction of a

[7] Another entity, BPJS Workforce is responsible for administering employment benefits, including those related to injury, retirement, pension and death.
[8] Such as PT. JAMSOSTEK, JAMKESMAS, PT. ASKES

non-contributory scheme known as *Penerima Bantuan Iuran* (PBI) for the poor and near poor in the bottom 40 percent poverty quintiles[9]. JKN also provides non-discriminatory health treatments regardless of class types[10]. Direct family members, including newborns of PBI recipients are included as beneficiaries (Government Regulation no. 76/2015). PBI members receive 100 percent subsidy from the government for the lowest class of membership. The Law also introduces social security nets through government subsidies for members who are unable to continue their contributions due to job losses and disabilities for six months (article 21 of Government Regulation no. 82/2018). Other measures to accommodate demographic characteristics and geographical inequities such as transfers of FKTPs for mobile populations, access to emergency services, compensation entitlements have also been addressed in the Presidential Regulation, which is further detailed in MOH Regulation no. 71/2013, amended through MOH Regulation no. 99/2015.

31. **While flexibility in JKN enrolment enables non-PBI households to be covered in times of need, such flexibility tends to create adverse selection.** By design, JKN participation is supposed to be mandatory. However, short re-activation periods for returning members[11], caps on back-paying arrears and an open-enrolment period encourage members to only sign up when sick and stop paying premiums once treatments have been received. Class upgrades are also flexible under JKN, thus enabling members to upgrade class once they anticipate hospital admission and drop down once released. Such flexibility has in turn created adverse selection and contributed to imbalances between claims and revenues generated. Such loopholes are undermining JKN's sustainability in the long run.

32. **Low entry barriers mean that access to services covered under JKN is not as pressing an issue as quality and accessibility of care**. The latter reflects systemic constraints in the country's health system. JKN operates through referral and back-referral systems, starting from the lowest-tier empanelled FKTPs (MOH Regulation no. 28/2014). As a gatekeeping measure, patients are not allowed to directly access hospital care unless they are referred by FKTPs, with exceptions for emergency cases, including disasters, health complications, geographical considerations and facility constraints (MOH Regulation no. 71/2013). Under-equipped FKTPs are required to establish a networking contract with other better-equipped FKTPs, such as those with lab-testing facility to minimize up-referrals. However, enforcement of such a referral system has been hampered by the lack of supply-side readiness at FKTPs, resulting in up-referrals, and inefficiencies.

C.1.2 Availability and Quality of Care

33. **As a single institution managing pooled funds, BPJS-K has not been able to exercise its leverage towards health-care providers in relation to quality of care and health care costs.** While BPJS-K contracts health facilities that meet credentialing criteria (MOH Regulation no.71/2013, Presidential Decree no. 19/2016), there is lack of clarity in the JKN law and regulations about the authority for setting standards of care for referral services purchased by BPJS-K. Higher tariffs are paid to health facilities with a higher level of accreditation. However, credentialing is sub-optimally enforced to create leverage to improve health facilities' readiness, and their accessibility and availability of services through standardization of services. Responsibilities for regulatory setting, contracting and enforcement are divided between MOH and BPJS-K (Law no.40/2014, Presidential Regulation no. 19/2016) with contradictions across the laws and regulations. This has resulted in sub-optimal exercise for setting standards for service delivery and quality of care by BPJS-K as a purchasing agency. In practice, BPJS-K has had a very limited role in provider payment policy and price-setting, with such roles being assumed by MOH. Since most of the public hospitals are owned by MOH, such practice may represent a conflict of interest.

[9] JKN is financed by two mechanisms: (i) a contributory scheme for formal sector workers (who pay 5 percent of their salaries shared between employee and employer) and informal sector workers (who are expected to pay a fixed nominal premium); and (ii) a non-contributory scheme known as Penerima Bantuan Iuran (PBI) for the poor and near poor.

[10] The only difference across classes is the type of accommodation.

[11] Two weeks for outpatient care and 45 days for inpatient service.

34. **While by law, BPJS-K is supposed to empanel accredited health facilities to incentivize performance, its implementation has been inconsistent.** Health facility accreditation is an external quality assurance mechanism and serves as an instrument to improve standards compliance and quality of services for hospitals and FKTPs. Hospitals in Indonesia must be accredited every three years. Hospital accreditation has been conducted by an independent body, called the Hospital Accreditation Committee (KARS) since 1995 (KARS, 2012)[12]. A similar scheme also applies to FKTPs. MOH Regulation no. 71/2013, amended by MOH Regulation no. 99/2015, requires that eligible FKTPs and hospitals are those that have been accredited. However, only a fraction of public hospitals was compliant with the minimum requirements set forth in the MOH Regulation no. 56/2014 on classification and hospital licensing (World Bank, 2018).

35. **The legal framework for monitoring of providers' performance and quality of care within JKN is blurred with mixed institutional responsibilities.** The Presidential Regulation no. 12/2013 on Health Care Benefits and MOH Regulation no. 71/2013 delegates the responsibility for service provider monitoring to BPJS-K. BPJS-K is required to monitor service quality through a cost and quality control team (*Tim Kendali Mutu dan Biaya* or hereafter TKMKB), consisting of representatives of professional organizations, academicians and clinical experts. However, the same MOH Regulation also gives MOH responsibility for monitoring and quality control, resulting in blurred institutional responsibilities. The recent Presidential Regulation No. 82 of 2018 (art. 82) gives the discretion to monitor and evaluate the JKN to MOH as part of quality and cost control efforts of the program while BPJS is mandated to provide all the necessary data and information to MOH. At the same time, Law No. 40/2004 on Social Security System stipulates that DJSN is responsible to monitor and to evaluate the overall social security system including the overall performance of BPJS-K as an agency. BPJS as an agency also has responsibility for quality control of healthcare services purchased according to the Law No. 24/2011 and BPJS Regulation No. 2/2014. However, how all these quality control mechanisms link and complement each other is not evidenced.

36. **There is no systematic mechanism to collect and report on quality.** Further, while medical audits are required by the Medical Committee of each hospital by law (Ministerial Regulation of MOH no. 755/2011 and MOH Decree no. 495/2005), in practice, such audits have been undertaken on a voluntary basis with no obligation to report the findings. Assessment of service quality and patient safety is most often conducted by researchers in educational institutions or donor organizations. However, how such findings have been used for service improvements are not evidenced.

C.1.3 Patient Rights

37. **Patient rights are established and protected by law.** Such rights include the right to confidentiality, to information about treatment and costs, to give consent to any procedures and not to be treated negligently (Law no. 36/2009 on Health). Consumers have the rights to choose services, to information about the services, to be heard and file complaints, to be treated without prejudice and discrimination are protected (Law no. 8/1999 on Consumer Protection). The Laws on Hospital, Health and Medical Practice require that patients have the right to information and be provided with informed consent, including receiving information regarding medical treatments and access to medical records and seeking second opinions (MoH Regulation no. 269/2008 on Medical Records) as well as to access the summary of their medical history. Patients are also entitled to decline any suggested medical procedures (Article 52. Law No. 29 of 2004 on Medical Practice). Such information will need to be provided to patients regardless they ask for it or not. Disciplinary sanctions to doctors and medical practitioners may be applied upon failure to provide such

[12] The accreditation standard is based on the standards of the Joint Commission International (JCI), the International Principles of Health-care Standards from the International Society for Quality in Healthcare (ISQUA) and the previous KARS standard as well as local content from national priority programs. MOH issued the accredited status for a hospital following a recommendation from the KARS.

information (Indonesian Medical Council, 2019, MOH Regulation no. 512/2007 on Medical Practice License and Implementation).

38. **The JKN entitles participants access to a comprehensive package of necessary health services, including comprehensive referral care** (Presidential Regulation no. 12/2013). JKN covers promotive, preventive, curative, and rehabilitative health services (WHO 2017). The benefit package of the JKN was first introduced in MOH Regulation no. 69/2013, which has been subject to multiple revisions. JKN offers comprehensive basic benefit package provided based on medical diagnosis, covering outpatient and inpatient care at the primary level up to tertiary hospital, including costs of equipment/devices with upper limit or quantity. Exclusions include i) administered services not in accordance with prescribed protocols, ii) treatments for cosmetic purposes, iii) general check-up, iv) prosthetic dental care, v) alternative and/or traditional medication and therapy, vi) in vitro fertilization and infertility programs. According to Presidential Regulation (Perpres) No. 82 of 2018, JKN also exempts treatment and services related to self-harm as well as health services for victims of criminal conduct including sexual assaults, rape, and terrorist attack. Within the JKN scheme, patients are allowed to upgrade their treatment class at their own expense, with the exception amongst PBI beneficiaries (Article 51 of Presidential Regulation no. 82/2018). Further, the Presidential Regulation no. 82/2018 opened the door for co-payments for certain services prone to misuse and abuse. However, such co-payments are yet to be further defined and enacted.

C.1.4 Stakeholder Engagement and Participation

39. **In terms of supply-side healthcare provisions, citizens' rights to public participation are protected by law.** Multiple legal references govern public participation. In general, Law No. 25 of 2009 on Public Service stipulates that all service providers are obliged to create standards of service, standard operating procedures (SOPs) for each type of service, and monitoring and evaluation mechanisms, as well as complaint-handling mechanisms through participatory processes. Communities have the right to monitor the implementation of service standards, to report complaints whenever these standards are not met, and to have those complaints redressed. Ministerial Regulation of MOH no. 46/2015 on Primary Health Facility Accreditation requires establishment of community and/or client agreement on service standards and operating hours, an internal code of conduct, and complaint-handling mechanisms. Community participation is to be sought in terms of inputs and feedback on the overall implementation of service delivery. The regulation also recognizes that the community has a right to monitor and advocate for changes in health services through existing empowerment forums (Laugen et al. 2018). Similar provisions can also be observed in Government Regulation no. 47/2021 on Hospital Administration, particularly on information disclosure, community engagement, non-discriminatory treatments, and grievance handling. Accordingly, hospital accreditation includes such indicators in their scoring of hospital performance (Ministerial Regulation of MOH no. 12/2020).

40. **JKN is obliged to proactively engage the public on the program's entitlements and responsibilities.** Law no. 24/2011, MOH regulation No. 71/2013 and MOH No.99/2015 incorporate BPJS's responsibilities to inform members of their rights and obligations and relevant procedures to access services, including availability of rooms at hospitals, benefit coverage, procedural change, etc. Within the current operating system of JKN, the program is also required to establish a functioning grievance redress mechanism which is accessible to the public. Law 24/2011 also stipulates that an executive summary of BPJS annual financial audit report and program by a public accountant be made public through electronic mass media. The Law also calls for the establishment of a supervisory council with representation from the civil society. The council is responsible for the overall monitoring, provisions of technical advisory, and reporting of JKN implementation. Within the broader system of social insurance, a National Social Security Board (DJSN) has been established to provide overall policy guidance, coordination and external monitoring across social insurance schemes being administered by BPJS, including representing the broader public. DJSN directly reports to the President (Presidential Regulation no. 24/2014).

41. **It is not explicit under the current operational framework of JKN whether the broader public should be engaged for policy and procedural changes.** While for instance, policy on FKTP capitation payments and any related changes are only enforceable following agreement between BPJS-K and FKTP associations at the provincial level. BPJS-K is responsible to engage provincial and district stakeholders, including Provincial Health Offices (PHOs), District Health Offices (DHOs), FKTP Associations, FKTP representatives, Quality and Cost Control Teams (or hereafter TKMB). Another example is selection and credentialing of health facilities which involve DHOs and health facility associations (MOH no. 99/2015). **While the National Social Security Board (DJSN) technically represent the broader public, their capacity to exercise their leverage and influence policies and regulations on JKN has been limited.** Law no. 24/2014 mandates a formation of a supervisory council that is responsible to monitor the implementation of BPJS policies, to advise and provide recommendation as well as to oversee BPJS annual plan and budget.

C.1.5 Grievance Handling

42. **Grievance handling pertaining to healthcare is mandated by law and regulated**. In general patients have rights to grievance redress arranged by each provider. Such grievance submission and redress mechanism are more established at the referral or hospital level than the primary care. The first layer of grievance mechanism is within hospital management. Grievance and complain can be escalated to the next level: through the court procedure or through Indonesian medical disciplinary board (MKDKI), an independent authority of the Indonesian Medical Council that supervises conducts of medical doctors and dentists. The MKDKI has the authority to place disciplinary and administrative sanction to individual practitioners (Mahendradata 2017).

43. **Grievance handling has been institutionalized within JKN**. Law No. 24 of 2011 mandates BPJS to create a unit responsible for quality control and for handling grievances from members called *Unit Pengendali Mutu Pelayanan dan Penanganan Pengaduan Peserta* (a quality control and grievance handling team). The Law also specifies that BPJS needs to handle the complaints at least 5 days following receipt of grievances. According to BPJS Regulation No. 2 of 2014, members can submit complaints through several avenues by directly visiting BPJS branch offices or by calling BPJS Call Center (500400) and/or through other channels such as letters, email, SMS gateway, whistle blowing and BPJS social media. In addition to this, MoH Regulation No. 99 of 2015 and Presidential Regulation No. 82 of 2018 reiterate that both BPJS and health facilities should install a unit to receive and handle grievances pertaining to the JKN at respective facilities. MoH Regulation No. 16 of 2019 expanded the task to establish grievance handling mechanism (whistleblowing system) across all components of the JKN ecosystem, mandating BPJS-K, health facilities contracting with BPJS-K, suppliers of pharmaceutical and other medical equipment, and sub-national governments to prevent and manage cases of fraud. In addition to the whistleblowing system (WBS), other complaints unrelated to fraud cases are to be channelled through a different application called SIPP (*Saluran Informasi dan Penanganan Pengaduan*). Complaints that cannot be settled internally by BPJS will be brought to mediation process or through court process (Law No. 24/2011, Presidential Regulation No. 82/2018, BPJS Regulation No. 2 of 2014). In addition, the Presidential Regulation No. 82/2018 also covers conflicts between BPJS and health facilities, members with health facilities, and BPJS with association of health facilities. The Regulation includes MoH's Clinical Advisory Council as the mediator for conflict and grievance settlement. Implementation capacities are presented in **Section D**.

44. **Measures to protect the confidentiality and safety of complainants has been incorporated into BPJS-K grievance handling mechanism, particularly in reporting sensitive cases such as frauds and corruption.** Concerns around frauds and misuse of JKN's entitlements and funding prompted the government to issue Ministerial Regulation No. 36 of 2015 on fraud detection and prevention, updated with Regulation No. 16 of 2019. According to the regulation, there are four entities responsible for fraud conducts the healthcare provider, the members, the BPJS-K management personnel, and the drug and equipment suppliers. Public oversight is encouraged, and the public can report fraudulent cases to the head of local

government or sub-national health offices, as well as to BPJS-K's channel for whistle-blowing system (WBS – Perdireksi BPJS-K No. 9/2019) which uses multiple platforms. Confidentiality of complainant/reporter is already incorporated in the BPJS-K Whistle Blowing System (WBS) standard of procedure, along with the option for anonymized report/complaint submission, protection of complainant/whistle blower and investigators, non-repudiation for complainant/whistle blower (unless submission is proven to be false/fabricated), and independence of WBS management team. Nevertheless, there is not yet any reported/inventory of standardised mechanisms for WBS enshrining confidentiality and protection against repudiation to complainants across all institutions mandated with the task by the Ministerial Regulation.

C.1.6 Data Protection and Confidentiality

45. **Protection of civil rights to privacy and private data is fragmented across regulations and no overarching law in existence for the purpose, with weak protection of individual rights to personal data.** Indonesia has 32 laws and regulations which govern the protection of personal data/ privacy. No single comprehensive law is in place for the protection of private data, which in some circumstances results in abuse of private data collected through Banking transactions and social media for commercial purposes, with risks of fraudulent appropriation of personal data for criminal conducts. The Bill on Private Data Protection, which consolidates citizens' rights to data protection and privacy, is pending approval from Parliament. This represents a gap in the regulatory framework.

C.2 Institutional Responsibilities

46. **The main agencies implementing the PforR include BPJS-K, MOH, MOF and DJSN with whom implementation of social actions will fall into**. Other entities contributing to the management of environmental and social aspects of the PforR, including health providers, Ministry of Home Affairs (MOHA), and Ministry of Social Affairs (MOSA) are included in the analysis and further engagement and collaboration will be sought during the PforR implementation and through other complementary operations for the purpose of environmental and social management under the Program. Preliminary analysis of institutional roles and responsibilities within the JKN and more specifically on environmental and social aspects of the PforR is presented in **Table 3**.

47. **Delivering JKN's social outcomes, which hinge upon people's ability to access quality health services at accessible delivery points, has been hampered by BPJS-K's limited legal and operational leverage to establish quality and service delivery standards for referral services**. Although the original 2004 Social Security Law allocate most of key purchasing functions to BPJS-K, such as developing provider payment methods, setting payment rates, setting contracting terms with providers), a series of regulations has brought these functions back under the Ministry of Health (MoH). This renders BPJS-K to serve mainly as an intermediary, transferring payments to health providers and carrying out administrative functions. Further, BPJS-K's capacity to monitor delivery of health services is limited due to weak health management and information systems. Claim processing at the primary care and hospital levels is not connected to one another, limiting the ability to track patients as they move throughout the system. On the output and outcome side, the lack of standardized reporting and accounting formats, the low prevalence of electronic health records, unreliable internet connectivity, and poor reporting compliance also make claims verification a laborious and time-consuming process.

48. **Promoting check and balance and public accountability of JKN is limited due to institutional weaknesses of DJSN**. Although by function DJSN serves as an overall oversight body, one-way information flow and limited authority weakens its ability to exercise strong accountability measures. Supervisory lines from DJSN and MOH to BPJS-K are missing. DJSN has limited influence as the representation and funding of the Council gives more weight to the represented ministries. As a result, DJSN has no institutional power to veto any draft regulations that may adversely compromise JKN's sustainability. DJSN also lacks the capacity to make informed decisions as its members are not supported by technical advisors. Its Secretariat

is also housed and financed by the Coordinating Ministry which has limited knowledge and expertise in health and insurance to effectively oversee BPJS-K operations.

Table 3: Institutional Responsibilities for Environmental and Social Performance within the JKN PforR.

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
JKN Implementing Entities			
Ministry of Finance (MoF)	- Serves as the funder of BPJS-K and Maintains the tax ID (NPWP) database that can be used to verify contribution compliance from contributing members. - Pays PBI premiums and functions as the payer of last resort	- Financial accountability, sustainability and overall efficiency of spending.	- Coordination support (DLI 9) and budget allocation for PforR, including environmental and social action plans
BPJS-K	- Manage day to day implementation of JKN, including collecting premiums and enrolling beneficiaries, including verification (at enrolment and point of service); contracting providers; verifying claims (using patient information and MOH protocols); monitoring quality of care; developing provider payment methods to reimburse providers.	- Ensure UHC, financial sustainability and efficiency of JKN, while promoting quality of care	**Access and equity:** - Improve primary care payment methods (capitation and KBK – DLI 6) - Conduct simulation of any revision to existing service and payment mechanism (e.g., HTA, clinical guideline, revisions to capitation and DRGs) with representative samples from FKTPs and FKRTLs with low capacity or from underserved areas. **Patients' rights**: - Inform and educate public (e.g., through the patients' charter at every facility or periodic release of public communication materials) of the standard of services, and the treatments that are covered by JKN at primary and referral care points, and any changes related to services resulting from PforR **Quality of Care**:

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
			- Hold service providers accountable through claims management processes and further development of hospital payments and claims management to incentivize service quality (DLI 4) - Managing service providers' payments, including revisions in payment modalities **Stakeholder engagement and public participation**: - Lead JKN communication strategy implementation, including on aspects related to: i) Consultations with representatives of health facilities from lagging and underserved regions as well as the consumer/patient groups and members representatives (eg. Disabled Person Organizations (DPOs), Indonesian Consumer Organization (YLKI), etc.) during the development of new formula for capitation for FKTPs and any revisions of INA-CBG. ii) Consultations with public and relevant NGOs/CSOs in developing data sharing and privacy protocols. iii) Public dissemination of policy decisions and changes made to JKN's procedures

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
			Grievance handling: Patients' grievance handling and case settlements. Enhance and strengthen FGRMs associated with JKN together with MoH at all level of governance based on robust analysis of current mechanism. **Data and Privacy:** in collaboration with MOH, develop data sharing and privacy protocols and determine the boundary of use of individual data, including medical records
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; clinical coding guidelines; a health data dictionary for common terms; and standardized medical record forms. MOH has a significant role in setting provider reimbursement rates and to a large extent, influencing premium contribution amounts.	- Ensuring UHC, health outcomes and quality of care, particularly by prioritizing public health and preventive and promotive benefits in the JKN package.	**Access and equity:** - Development of provider payments (DLI 6 & 7), including capitation and DRG tariffs to incentivize supply-side readiness in underserved and underperformed areas. **Patients' rights**: - Enhance and strengthen FGRMs associated with JKN together with BPJSK at all levels of governance based on robust analysis of current mechanism. - Ensuring patients' access to services covered under JKN **Quality of Care**: - Translate clinical diagnostic and treatment protocols and referral pathways into processes of care for FKTPs and hospitals (DLIs 1 and 2). This includes improving quality and

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
			content of maternal care visits and/or institutional deliveries. - Revise benefits package selection in line with health technology assessment (HTA) studies (DLI 3). **Stakeholder engagement and public participation**: in collaboration with BPJS-K: - Consult with representatives of health facilities, professional organizations, patient representatives, including those representing marginalized groups (i.e., NGOs/CSOs) for the purpose of development of diagnostic and referral guidelines, risk-based capitation for FKTPs, INA-CBG revisions, and Health Technology Assessments. - Publicly disseminate policy decisions. **Grievance handling:** handling of patient and provider-related grievances submitted to MOH's channels **Data and Privacy:** in collaboration with BPJS-K, develop data sharing and privacy protocols and determine the boundary of use of individual data, including medical records
DJSN	- Provides overall oversight for the JKN, including ensuring transparency and accountability on key performance indicators. - Advocates on behalf of beneficiaries	- TBD	**Access and equity:** advocate on behalf of beneficiaries, including commissioning impact analysis of impacts following premium increases, JKN annual performance, KPI tracking, and policy

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
			formulation or counter policy that is against the interest of the public. **Patients' rights:** oversight of JKN implementation, including patients' rights, benefit package, enrolment, etc. **Stakeholder engagement and participation**: - Promote social accountability of JKN, including public participation, grievance handling, fraud monitoring and transparency. This includes annual report compiling and analyzing public grievances and settlements. - Act on behalf of the beneficiaries **Grievance handling**: receiving grievances, monitoring grievance settlements, including mediating with relevant parties
Indirect Stakeholders with roles in JKN Implementation			
Health Providers	- Deliver services based on MOH diagnostic and clinical protocols, referral pathways and quality of care standards. Recipient of JKN payments for services delivered - Maintain records on number of patient visits, symptoms, diagnosis, drugs, procedures and treatment outcomes	- Payments of JKN, representing the largest sources of operational revenues	- Not implementing the PforR.

Institutions	Institutional Responsibilities	Institutional Interest in JKN	Relevant Responsibilities for E&S management under the PforR
Ministry of Home Affairs (MoHA)	- Maintains foundational systems such as the national ID (NIK) and the civil registration statistics (CVRS) databases to ensure an up-to-date population registry. - Coordinates with sub-national governments to operationalize JKN, including evaluate the planning of sub-national governments for resource allocation for health.	- Regulations around the use of capitation as issued by sub-national governments	- Not implementing the PforR.
Ministry of Social Affairs (MoSA)	- Primarily responsible for maintaining an up-to-date social registry (i.e., DTKS targetting database), drawing on the population registry that ensures the bottom 40 percent of households (PBI) beneficiaries are automatically enrolled in JKN.	- Social registry updates particularly civil registration and vital statistics, used as the basis to update the DTKS and JKN PBI targeting	- Not implementing the PforR.

D CAPACITY AND PERFORMANCE ASSESSMENT

49. **This section summarises the key findings or gaps of the assessment of implementation of systems including capacity of the relevant institutions to effectively implement the environmental and social management systems summarised in the previous section**. The section also summarises the extent to which the applicable systems are consistent with the key elements (details of the analyses is presented in the matrices in **Error! Reference source not found.**) as well as statements on the commitment of the relevant institutions to undertake measures to address the key gaps.

D.1 Overall JKN Performance

50. **The government needs to double its current publich health expenditure to finance a minimum package of essential universal health coverage (UHC) services.** Public expenditure on health, at 1.5 percent of GDP or 8.8 percent of total government expenditures, is less than what countries with a similar level on average. As a result, front line providers frequently lack the drugs, equipment and training needed to deliver quality services. This in turn leads to the implicit rationing of services, foregone care and limited financial protection. In 2018, government health expenditure amounted to just US$ 56 per capita, which has to be doubled to US$ 110 to meet minimum UHC requirements.

51. **Over the past 15 years, Indonesia has made significant progress towards UHC.** Prior to 2004, only formal sector workers had access to health insurance, at 27.4 percent of the population. Between 2004 and 2014, various schemes were set up, each catering to specific population groups and being managed independently with many variations in design (e.g., financing, eligibility, benefits, and provider payment arrangements). With the introduction of *Jaminan Kesehatan Nasional* (JKN) or National Health Insurance in 2014, the government consolidated all schemes and over 300 risk pools into a single national scheme managed by a semi-autonomous public agency – *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), entitling all Indonesians to the same benefit package, and applying a uniform set of rules for providers (e.g., payment methods, reimbursement rates, and quality standards). The strong purchasing power of a single-payer system is expected to improve the efficiency of the entire system. The government has also provided targeted and subsidized premiums to the poor and vulnerable and provided the same benefits package to all beneficiaries ensuring equity of access. Between 2014 and 2019, coverage expanded to 83 percent of the population, although active membership is around 75 percent and is declining due to COVID-19. Out-of-pocket (OOP) expenditures as a share of total health spending decreased from 47 to 34 percent – an unprecedented achievement in such a short time.

52. **The achievement in decreasing OOP and increasing memberships notwithstanding, JKN still suffers from governance, accountability and health financing challenges.** There have been blurred lines of accountability across key stakeholders, with BPJS-K having limited authority to perform its roles as a single-payer. Important roles such as determining benefit package and setting provider reimbursement rate are still being retained by Ministry of Health (MoH), thus rendering BPJS-K as an intermediary with heavy emphasis on administrative functions. Weak health management and information systems have also prevented monitoring of contribution compliance across membership groups, tracking of patients as they move through the healthcare system, verification of claims submitted by providers. Multiple information systems, including hospital and primary health care accreditation, human resources for health and facility equipment operate independently, leading to costly data-sharing transaction costs. Further, financing challenges have continued to persist with a cumulative deficit of IDR 31.7 trillion (around USD 2.2 billion) as of end of May 2020. Lower than expected revenues and weak expenditure gatekeeping, combined with adverse selection due to low entry barriers have contributed to enlarging JKN's deficit.

53. **The approach for UHC in Indonesia has been to prioritize the breadth of coverage over the depth of services, resulting in limited financial protection.** While Out-of-Pocket (OOP) expenditures

have decreased since the introduction of JKN in 2014, they remain high at 35 percent of total national health spending in 2019, compared to other levels in developed and middle-income countries (20 to 30 percent). As many as 2.3 million people experience catastrophic health spending[13] and over 4 million people are pushed deeper into poverty due to health-related shocks (World Bank, 2020).

54. **Furthermore, while the availability of healthcare facilities is relatively high, quality of care varies and is low especially in the country's outer regions, thus limiting the overall objective of UHC**. The availability and distribution of health human resources are uneven, despite the extensive network of public health facilities. As of December 2018, only six districts out of 514 had at least one doctor per 1,000 population. Around 247 districts had at least one midwife and 303 districts at least one nurse per 1,000 population (PODES, 2018). In addition to health personnel, primary health care facilities lack basic diagnostic tests, essential medicines and knowledge to accurately diagnose and treat patients based on clinical vignettes. Only 34 percent of FKTPs could accurately diagnose diabetes and only 35 percent of patients had their diabetes under control (World Bank, 2020). This consequently caused patients to seek treatment at higher-level facilities, either out of necessity or preference for better quality care.

55. **Availability of healthcare and perceptions of quality has positive correlation with retention of JKN membership**. A study using data from BPJS survey found that availability of professional healthcare service correlates positively with the compliance of self-enrolled members to pay routine premiums (Dartanto et al. 2020). This suggests that sustainability of JKN is also influenced by the availability and fair distribution of quality healthcare services, which is critical to maintain demand and utilization of services.

D.2 Environmental and Social Considerations

56. **ESSA findings and recommendations have been publicly consulted and refined following the public consultations**. Specific analysis of each relevant themes is presented in the following sub-sections.

D.2.1 Equity of Coverage

57. **While a scheme to protect the poor and vulnerable through the subsidized JKN-PBI is in place, exclusion issues persist.** JKN-PBI targets the bottom 40 percent of the poor. However, 42 percent of non-poor households are benefitting from the subsidy (inclusion errors) and thus displacing poor households from the coverage (World Bank, 2021). Targeting relies on the beneficiary registries, which collect information to assess eligibility status from other sources, such as social registries. Such inclusion and exclusion errors often stem from infrequent updating of social registries and inadequate integration of JKN identification and authentication systems with the national ID and civil registration and vital statistics systems (CVRS), which increase the risk of duplication, frauds and identity misuse. Lower coverage of national identity numbers (NIKs) and national ID cards (KTP/e-KTPs) particularly amongst the poor segments of the population is also attributable to such exclusion issues. Targetting of JKN-PBI is outside the scope of the PforR and is expected to be addressed through the forthcoming Indonesia's Digital ID and Registration for Inclusive Service Delivery (P175218).

58. **Further, significant gaps in coverage remains since JKN was first launched in 2014.** There are around 50 million Indonesians who remain uninsured, mostly informal worker groups. This group is often called as the "missing middle" of social protection coverage where they may be not eligible for poverty-targetted social assistance but excluded from employment-based contributory arrangements, nor unwilling

[13] Defined as households who spend more than a quarter of their total household expenditures on health.

to be enrolled in insurance schemes[14] (OECD 2019). Any change in JKN's policy, including increase in premiums will likely affect this group the most. Starting January 1, 2020, premiums rose 65-110 percent depending on the membership group and class selected following the schedule listed in **Table 4**. The impact of the premium increase has been felt by the informal sector the most, resulting in a drop in coverage and increased adverse selection. Estimates suggest that the premium increase results in 7.8 million informal sector workers dropping out of JKN. As of the end of March, there has already been a 34.5 percent drop in membership among informal sector class 1 and a 36.7 percent drop among informal sector class 2. While the informal sector class 3 has seen a 10 percent increase during the same period from those dropping down from higher classes (World Bank 2020). The impact of COVID-19 (which will also affect formal sector workers) will further see coverage shrink. A recent estimate indicates that more than four million members have dropped out.

Table 4: JKN's Premiums Increase

Membership Group	Previous JKN premiums	Premiums as of January 1, 2020
Subsidized PBI scheme	IDR 23,000 per-person, per-month	IDR 42,000 per-person, per-month
PPU-BU (formal private sector)	5% of salary, ceiling IDR 8 million/month	5% of salary, ceiling IDR 12 million/month
PPU-P (civil servants)	5% of basic salary	5% of total salary (basic salary + family allowance and benefits)
PBPU (informal sector)[15]	Class 1: IDR 80,000 per person, per-month	Class 1: IDR 150,000 per person, per month
	Class 2: IDR 51,000 per person, per month	Class 2: IDR 100,000 per person, per month
	Class 3: IDR 25,500 per person, per month	Class 3: IDR 42,500 per person, per month (IDR 16,500 to be subsidized by MOF in 2020, dropping to IDR 7,000 in January 2021).

D.2.2 Access to Healthcare Services

59. **Improvements in access to and quality of outpatient primary care services will likely benefit lower income households and lagging regions.** Members and populations from low socio-economic backgrounds tend to have lower utilization than the rich members. However Lower income households were more likely to seek outpatient care compared to those with higher income. Households in the lowest income quintile benefited from the largest increase in utilization following the introduction of JKN. In contrast, higher income households were more likely to use inpatient services compared to lower income households (Susenas analysis 2013 and 2019). Improving the competence of providers at FKTPs would therefore predominantly impact lower income households.

[14] Short activation periods for new or returning members, caps on back-paying arrears, and an open-enrollment period encourages members to only sign up when sick and stop paying once treatment has been received. Further, participants are allowed to switch classes at any time during the year, leading many to upgrade class once they know they will be admitted to hospital and/or drop down once released.

[15] The difference between membership class is only meant to be on amenities (e.g., private room) not quality of care received.

60. **Low Out-of-Pocket (OOP) expenses do not necessarily reflect financial protection offered by JKN since utilization remains low in areas with supply-side constraints**. Health seeking behaviour is usually lower amongst the poor than the richer quintile. JKN's expenditure is skewed toward non-PBI-JKN members and members from middle to high socio-economic status (Health Policy Plus and National Team for the Acceleration of Poverty Reduction/TNP2K 2018). A study by TNP2K in 2016 documents that the ratio of cases per 1000 enrolled patients was three times higher among the rich members than the poor. Another study on birth delivery estimates that only 15 percent of mothers in the lowest economic quintile used JKN for their delivery expenses (Nugraheni, Mubasyiroh, and Hartono 2020).

61. **Supply side readiness affects service uptake and spending patterns**. JKN utilization is low in the country's outer regions as well as amongst the poor and near poor. Lowest utilization is reported in Kalimantan and Eastern Indonesia (Health Policy Plus, 2018). OOPs were low in areas where the healthcare service coverage is limited such as in Papua and East Nusa Tenggara (Prakarsa 2020). A study by Faculty of Public Health, Universitas Gadjah Mada looks at payment and spending rate in several districts and provinces in Indonesia. Findings suggest that a nationally centralized single pooled payment has allowed a reverse cross-subsidy from underserved regions to areas with better healthcare facilities. For instance, in Malaka district, NTT, BPJS paid healthcare facilities IDR 17 billion and received IDR 30 billion from premiums whereas in Yogyakarta, BPJS paid facilities an amount of IDR 2 trillion and received only IDR 458 billion. The difference of IDR 13 billion from Malaka district could not be used for that district due to single-pooled approach (2018). Several interrelated causes for this low utilization rate include lack of understanding on how to access services and distance from FKTPs (Agustina et al. 2019). As JKN operates within an unequal environment of supply side readiness, with better FKTPs and hospitals concentrated in urban areas and Java regions, members and populations residing in remote, rural, and non-Java regions are persistently at a disadvantage.

62. **Stigma and fear of discrimination may also influence health seeking behavior.** A study commissioned by NGO Into The Light found that only 27 percent of respondents with mental health illnesses access mental health services. The majority of these respondents (7 out of 10) were also unaware that JKN covers mental health services (Prawira et al., 2021). Amongst marginalized groups, including people with HIV/AIDS, LGBTQI groups recognize the need of safe-space and trust as an important factor which influences their decisions to access services. In the scope of mental health care, the public consultations also raise how exclusion of self-harm and suicide attempts in the JKN coverage may miss the need for inclusion of such mental health needs within the benefit package. The public consultations also brought the issue of discrimination against patients with HIV/AIDS due to drug use to the fore. Anecdotes indicate that these patients were sometimes denied from accessing JKN benefits since such illnesses are considered self-inflicted rather than being part of the spectrum of wider mental health problems. The lack of cultural representation and cultural competence in health facilities and the wider health system also contributes to stigmatization and low utilisation of healthcare services. Some observations in Papua, which may also likely apply elsewhere, demonstrate that misrepresentation of Indigenous communities' social and cultural practices enriched with contextualised meanings into stigmatized risky behaviours may lead to not only stigmatisation by health providers but also ineffective or mistargeted health interventions (Butt et al, 2002). Further, local mistrust and suspicions of the health system, fuelled by legacy of militarization and conflicts in Papua, were also cited as a factor that influence people's health seeking behaviour, particularly amongst indigenous Papuans (Anderson, 2015; Butt, 2005).

63. **Ineffective gate keeping functions of FKTPs tend to reinforce inequities due to higher transaction costs for seeking referrals.** JKN is operating through a referral system, with FKTPs serving as frontline service providers. However, providers' limited competencies for proper diagnosis and lack of health resources, combined with service providers' perceptions of whether JKN payments and reimbursements are sufficient to cover direct costs of certain treatments are some of the main drivers for up-referrals. Since hospitals are mostly located in urban and peri-urban settings, there are additional direct and

indirect costs and trade-offs, including forgone daily wages borne by patients and families due to illnesses. Utilization of fee-for-service funds (from BPJS-K non-capitation) for referral services, such as transportation costs is sub-optimal due to cumbersome administrative requirements that often discourage providers from using the funds (Wilopo et al., 2020). Sub-national governments often do not allocate enough to subsidize referral transportation costs and patients need to bear the transportation costs for back-referrals[16] (Rakhmadi et al, 2020). Behavioral study amongst Tuberculosis (TB) patients indicates that private facilities are favoured over public facilities due to perceptions of availability, accessibility, and quality of care (Fuady et al. 2020). However, since private clinics often lack relevant capacities and equipment for proper diagnosis, many of these patients were referred to public facilities, either Puskesmas or hospitals, thus increasing the indirect costs of seeking treatments. The costs are likely higher amongst patients with disabilities due to additional logistics in seeking treatments.[17] Such evidence indicates that although OOP expenditures, in general, have reduced since the roll-out of JKN, hidden costs in seeking treatments may still be persistently high amongst the poor and people in remote areas. Hence, the risks of sliding into poverty still remain (Nugraheni, Mubasyiroh, and Hartono 2020).

64. **Issues in the accessibility of the JKN's referral system for maternal and neonatal health (MNH) care have been identified to contribute to persistent high maternal and newborn mortality rates** (Rakhmadi et al, 2020). Improving MNH outcomes require high-quality and responsive care, and ability to diagnose complications and refer women with high-risk pregnancies as early as detected. In a study commissioned by USAID, key constraints affecting women's care-seeking behavior and health providers' readiness are manifold, including: i) transport barriers with private transport incurring costs; ii) uncertainty about where to seek emergency care that results in patients travelling multiple health facilities prior to receiving treatments; iii) difficulties in coordinating between public and private systems, including with private hospitals and midwives; iv) lack of standardized protocols for managing emergency complications and referrals; v) reluctance to admit poorer women covered by JKN; vi) lack of health facility readiness, including shortage of qualified health workers; vii) overcrowded health facilities (Rakhmadi et al, 2020, Pedrana et al., 2019). Utilization of fee-for-service funds (from BPJS-K non-capitation) for referral services, such as transportation costs is sub-optimal due to cumbersome administrative requirements that often discourage providers from using the funds (Wilopo et al., 2020). Sub-national governments often do not allocate enough to subsidize referral transportation costs and patients need to bear the transportation costs for back-referrals[18] (Rakhmadi et al, 2020).

D.2.3 Quality of Health Care

65. **Aside from unequal geographical distribution of healthcare facilities and human resources, many primary healthcare facilities are also below the minimum level of preparedness.** The majority of the current JKN's expenditure (84%) is spent on purchasing referral services at the hospital level, suggesting an issue with FKTP readiness. A survey in 2017 found that 33% of community health centers did not pass the minimum grade for service preparedness (compared to only 18% of public hospitals that scored below the standard). This suggests that many FKTPs at frontline level might have resorted to unnecessary referrals due to their lack of capacity and they might not be capable of following up back referrals (Agustina et al. 2019). Furthermore, there is a large gap in the number of medical staff across puskesmas, with the number of doctors varies from zero to as many as ten, and nurses from zero to 50, and midwives from zero to 61

[16] BPJS-K covers reimbursement for back-referral services under certain conditions, such as emergency and/or special treatments that can only be provided at hospitals.

[17] Around 8.6 percent of the population over the age of two have some forms of disabilities and half (48.5 percent) report multiple disabilities. Rates are higher for females than for males and for rural residents than for urban residents (OECD 2019).

[18] BPJS-K covers reimbursement for back-referral services under certain conditions, such as emergency and/or special treatments that can only be provided at hospitals.

across puskesmas in Indonesia (World Bank 2018). Such figures indicate that there are numbers of understaffed puskesmas in Indonesia. COVID-19 outbreak puts further strain on accessibility of health care services. Demand for health care falls due to an inability to afford OOP costs for medical care and insurance coverage has been eroded by job losses. The supply-side suffers as falling general and payroll tax revenues force governments to cut back on health budgets, with consequences for further impacts on service delivery access and quality from their existing levels.

66. **Input-based financing tends to reinforce the existing distributional imbalances in health resources.** FKTPs are paid by capitation as a fixed budget covering 144 competencies and/or services that they are meant to perform. However, FKTP package covered by capitation was never costed nor was based on an assessment whether facilities can provide services. The formula of capitation payments FKTPs receive are based on the number and types of providers and the number of beneficiaries assigned to facilities without any adjustment for geography, demographic and health characteristics (i.e., age, sex, health needs). This reinforces existing imbalances in provider and beneficiary distribution. As a result, FKTPs often lack basic diagnostic tests, essential medicines, and diagnostic and treatment capacities. This has resulted in low quality of care, resulting in high rates of up-referrals. Further, such an input-based capitation formula also does not consider the existing absorptive capacity of facilities, with FKTPs frequently reporting unspent capitation funds due to various regulatory issues. As of June 2020, the total cumulative undisbursed capitation amounted to IDR 2 billion.[19]

67. **Government decentralization has created a fragmentation in the supply side and coordination aspect of healthcare services**. Most discretions and responsibilities are devolved to subnational government especially district and city. Laws and regulations pertaining BPJSK suggest an attempt to decentralize some extent of discretion to subnational level to enable coordination with district health offices for more locally attuned measures. However, in practice, decision making within BPJS Kesehatan is centralized at the national level with little discretionary power given to local branches (UGM 2020). The laws are also unclear about the institutional relations between BPJS-K and subnational government. Furthermore, the study finds that BPJS-K's data about services and JKN financing at the sub-national level were inaccessible thus preventing sub-national health offices to use the information for their policies and programs, including health prevention and promotion activities (PKMK FKKMK UGM, 2016)

68. **Lack of standardization of care, including clinical pathways, has resulted in varying quality of care**. The predominant approach for improving health workers' competence has been the provisions of clinical guidance. However, due to a combination of the plethora of clinical guidelines, lack of their readability and lack of dissemination, such an approach is not effective, especially amongst frontline health workers. The existing guidelines are diseased-based, and do not have clear algorithms that encourage an integrated approach to screening, diagnosing and treating common symptoms. While there have been efforts by professional associations[20] to standardize guidance for hospitals, there is no adoption nation-wide being reported.

69. **Revisions in service providers' incentives could have adverse implications on their ability to deliver services if not based on a solid assessment of the actual costs to deliver services**. A recent analysis by the World Bank (2020), introduction of a new Performance-based Capitation Payments (KBK) resulted in deductions up to 10 percent of the total Community Health Centers (Puskesmas) revenue compared to the previous KBK at 5 percent of deductions. Lower figures were observed in private clinics

[19] Capitation does not cover the entire cost of care, since capitation is complemented by significant financing and in-kind support from other government sources (e.g., DAK).

[20] These include the national hospital associations (*Perhimpunan Rumah Sakit Seluruh Indonesia* or PERSI) and the Indonesian Association of Internists (*Perhimpunan Dokter Spesialis Penyakit Dalam*).

where there is no substantial difference between the previous and new KBK. In Indonesia, the Diagnostic-related Groups (DRGs) establishes a reference for hospital reimbursements. However, the DRG structure is based on unrepresentative cost data. For instance, the tariffs are only three percent higher for private hospitals although public hospitals receive significant supply-side financing. Further, tariff adjustments are based on standard percentage increases and hence, do not necessarily reflect the cost of actually delivering services.

70. **Going forward, revisions in the payment design and formula for service provisions must consider potential implications on the populations served by lagging health facilities, providers' overall ability to deliver services, and potential impacts on the poor**. While risk-based capitation payment will help correct the distributional imbalance in capitation payment by linking capitation with the burdens of services in each FKTP, the development of risk-based capitation also needs to account for non-medical costs incur by geographical spread and the supply-side readiness of each FKTP. Any additional performance-based incentive calculation in the formula should minimize the possibility of penalizing underperforming facilities due to the existing gaps in health resources. Further, the development of any revision to capitation formula should promote inclusive participation of affected parties, including community representatives. Any reform to introduce new formula to calculate capitation payments and payment caps should take into account the gaps in health facility readiness across the country, feasibility of a new approach being introduced, and risk mitigation measures to prevent lagging FKTPs from accessing much needed resources. Further, cost sharing options for health services prone to moral hazard and abuse may potentially reduce both necessary and unnecessary utilization particularly for the poor and vulnerable.

D.2.4 Patient Rights

71. **Efforts to inform patients and increase their awareness of their rights are left to service providers.** Although there are multiple laws and regulations that affirm and detail patient's rights in health service, to date these rights have not been translated into a national charter that describes the rights of patients especially pertaining to rights to privacy and information (Mahendradata 2017). A study notes that as of 2017, only TB patients' association have issued a patient charter for TB care in 2009 (Mahendradata 2017). There is no national guideline on how to develop this charter and ways to inform patients of their rights. Hospitals, for instance, are experimenting with several approaches; through publishing pamphlets, and patient survey tools although this practice is not universal. At the community level, there are several programs, with support from international development partners, to introduce and increase social accountability through the development and publication of patient's charter either in general at puskesmas or specific to certain programs (for instance DESA SIAGA for maternal and newborn health) (Laugen et al. 2018). These programs, however, have not been upscaled at the national level and efforts remain limited to several programs in several areas. Furthermore, it is not known whether these practices also include efforts to inform patients about their entitlements within JKN's purview and what are the mechanisms for grievance when such rights are violated

D.2.5 Stakeholder Engagement and Participation

72. **Within the JKN system, efforts to promote stakeholder engagement and participation have been established.** BPJSK has developed both online and offline platforms to inform the public about the program, such as members' rights and responsibilities, guideline to use services, benefit coverage (here). In addition, offline platforms such as posters, banners, pamphlets have also been produced and disseminated nationwide. Within DJSN, Standard Operating Procedures (SOPs) for monitoring and evaluation, including how they solicit and receive feedback from the broader stakeholders, are in place. However, since specific expertise is not required to represent the general public by law, such representation has been sought through

the existing commissioners who represent the general public are assumed to be represented by commissioners who represent employers and workers.

73. **However, with commissioners are only appointed from the labor unions, a significant proportion of the public (including members and patients of JKN) are underrepresented**, including workers from the informal sector, non-workers, and non-members, as well as marginalized communities with relevant characteristic to JKN services (such as people with disabilities, indigenous people, and LGBTIQ+ persons). Recently there are efforts to reach informal workers (e.g., association of small traders) through separate consultations with the assistance of World Bank to understand informal sector's willingness to pay and ability to pay. However, this consultation is yet to be institutionalized as part of the DJSN regular procedure.

74. **The JKN has adopted a proactive approach in the form of a customer satisfaction survey to capture public perceptions and sentiments related to the available services under the program.** BPJSK performs an annual assessment of customer satisfaction (in the form of Customer Satisfaction Index or CSI) to assess customers' journey in utilizing the JKN services. Such a survey is typically administered as an exit survey following hospital discharge. In addition to the CSI survey, BPJSK also periodically commissions a quantitative survey and Focus Group Discussions (FGDs) to assess members' (and non-members) awareness and understanding about the JKN program. Such an assessment involves paying members, beneficiaries of the JKN-PBI as well as members from other categories. Starting from this year, BPJS-K has started a new study to explore the experience of population groups with disability. Furthermore, in addition to the satisfaction survey, BPJS-K holds an annual assessment of the organization's image, utilizing organizational image indices, in collaboration with an independent surveyor. A new stakeholder engagement program called BPJS Kesehatan Mendengar was launched starting in 2021. Among the targeted stakeholders include professional organizations (e.g., Indonesian Doctor Association/IDI), sub-national health office association (ADINKES), DJSN, and hospital associations.

75. **Miscommunication about JKN persists**. While BPJS-K has made efforts to avoid miscommunication and disinformation by providing information about the JKN and BPJS-K on their website as well as putting up pamphlets regarding the necessary procedures to access the JKN in health facility providers and a call center through a hotline, there is a high level of misinformation (Mahendradata 2017). The public has limited information regarding the quality of health services available to them at both the public and private providers (Asia Pacific Observatory, 2017). As of to date, there is no publication of medical errors. Cases that are discussed by the medical disciplinary board are closed to the public, although the decision is read to the public (Mahendradata 2017).

D.2.6 Grievance Handling

76. **Multiple platforms are in place to enable public access to log grievances and inquiries related to the JKN program.** The BPJSK has developed an integrated FGRM platform called SIPP (Complaint Handling and Information System/Saluran Informasi dan Penangan Pengaduan or). The SIPP platform receives feedback and/or complaints from multiple channels within BPJS's remit and oversight, such as JKN web-based application, call center (1500400), direct reporting through officers and branch office staff (through the BPJS SATU program), and social media accounts. BPJSK officers are stationed at partner hospitals to enable direct filing of grievances and/or inquiries. In the event complaints are deemed to fall outside the purview of BPJS-K, such case(s) will be referred to relevant institutions. A tracking system, with color codes to indicate status of grievance settlements, is integrated within the SIPP. A separate channel for whistle blowing system (WBS) has also been installed through which the public can report on fraud allegations. The WBS platform could be accessed through the BPJS-K website. Grievance handling within the BPJSK follows stipulation in Law No. 25 of 2009 on Public Services whereby complaints are to

be resolved in five days, with the exceptions for cases requiring high level escalation and mediation. To date, inter-opeability with an external platform was only reported with LAPOR, which is a government-run grievance channel for public services, administered by the Ministry of State Apparatus Utilization and Bureaucratic Reform (PANRB). Interoperability with other relevant platforms, notably MoH's FGRMs, including Halo Kemkes and Hotline 119 as well as the Ombudsman is yet to be established.

77. **BPJS-K publishes monthly reports that summarize and rank top ten categories of feedback and complaints received through their channels.** However, such reports are internally circulated and are not for public viewing. It is also not clear whether such reports include an analysis of system responsiveness and quality of grievance resolution and corresponding enhancements. Certain topics and/or issues with high frequency of submissions would typically be discussed internally within thein BPJS-K, on the basis of which policy, programmatic and troubleshooting measures are formulated. Summary and analysis of the received complaints and feedback are also included in periodic report to the President on a semi and annual basis.

D.2.7 Data Protection and Confidentiality

78. **Institutional arrangements for data protection are in place within the BPJSK's organizational structure.** BPJS-K manages and oversees the overall Management Information System (MIS) under the for JKN program, with relevant tasks and divisions of responsibilities under the coordination and oversight of the Directorate of Information Technology. The division for the Strategy, Planning and Development of Information Technology (*Strategi, Perencanaan, dan Pengembangan Teknologi Informasi* or SPPTI). is responsible for the technical aspects of JKN's network including the safety of the network infrastructure. The division of Data and Information Management (*Manajemen Data dan Informasi* or MDI) is in charge of the content of data exchange including the protocols for data sharing with different institutions. Lastly, the division on the Information Technology Operation (*Operasional Teknologi Informasi* or OTI) unit oversees the infrastructure and data architecture which includes operating a protocol for investigation of data leakage or any breach to the data security.

79. **Cyber threats against data protection represent one of the major risks under the JKN program.** BPJS-K has obtained ISO/IEC 27001 certification on Information Security Management and has been audited where findings confirmed adherence to the standards. However, notable gaps were observed with regards to the absence of a dedicated security unit and data officer. Likewise, the absence of multi-factor authentication and background checks of staff and lack of ability to trace data users' usage of the databases may likely expose risks associated to human related misconduct and data abuse. Since May 2021, a criminal investigation has been launched on a case of sale and transaction over the internet of 279 million private data allegedly sourced from BPJS-K's database, including data on unique individual identification number (NIK). According to BPJSK, investigation to this case is still ongoing, involving other stakeholders outside BPJSK. There are gaps with regards to institutional mechanism for data protection especially due to the presence of loopholes in all the applications in the digital ecosystem of JKN, as well as shortage in infrastructure and human resources with the skills to perform internal IT audits.

80. **Enhanced interoperability across databases may heighten the risks associated with data protection and privacy.** At the national level, the JKN MIS database is periodically synchronized with the MoHA's Population Administration Information System/*Sistem Informasi Administrasi Kependudukan* or hereafter SIAK). Under the PBI-JKN scheme, BPJS-K receives updates of PBI-JKN members (due to birth, death, or removal from poverty database) from the MoSA. However, whether the two databases are interlinked or interoperable is yet to be confirmed. At the facility level, BPJS-K utilizes an application called P-CARE that stores all relevant information about member patients, diagnosis, and status. P-CARE is also currently used as a database for COVID-19 vaccination and there are plans to synchronize P-CARE with MoHA's SIAK and the Ministry of Communications and Informatics' (Kominfo) Peduli Lindungi

application for COVID-19 surveillance. Data sharing and interoperability between JKN's MIS and databases outside JKN's environment (e.g., SIAK) are implemented swith reference to institutional cooperation agreements (*Perjanjian Kerja Sama* or PKS). Such agreements specify eligible information to be be shared and/or accessed and relevant confidentiality protocols whereby cooperating parties are liable to any leakages and/or misuse within the period of the cooperation framework. Parties stated in the agreements are liable for any leakage and/or misuse during data exchange. Going forward, it is critical for any action related to the integration and interoperability of multiple MIS within the JKN environment to proceed based on a comprehensive assessment of the strengths and weaknesses of the existing system, including the robustness of safeguarding mechanisms against leakage, breach, or unauthorized use (who have access to the databases and for what purposes) and the protocol to protect individual privacy. In addition, in anticipation of the enacement of the long-awaited Personal Data Protection Bill, further analysis of potential implications on the current governance and operational aspects of data management are yet to be assessed by BPJS-K.

E ENVIRONMENTAL AND SOCIAL ACTIONS

81. **The measures (on the following page) were consulted and subsequently refined following a series of workshops on the PforR design and draft ESSA.** The draft ESSA report and its Executive Summary in Bahasa Indonesia was publicly disclosed and circulated prior to the meetings. Both verbal and written comments were received during these consultation processes.

Table 5: Environmental and Social Actions

Action Description	DLI (if applicable)	Respon-sibility	Re-current	Freq-uency	Due date	Completion Measurement
Equity						
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, and revisions to HTA and benefit package).	Sub-sets of DLI 3, 5, 6 and 7	MOH	Yes	During imple-mentation	During imple-mentation	Evidence of inclusivity of sampling in forms of analysis report; Evidence of
Promote inclusivity of the delivery of frontline provider training, including development of alternative media and training modalities as relevant.	Sub-set of DLI 1 and 2	MOH	Yes	During imple-mentation	During imple-mentation	Post-training evaluation report
Quality of Care						
No new action since relevant measures are covered under DLI 1 and 2 on improving the quality of care and referral pathways.	*DLI 1 and 2*	*MOH*	*N/A*	*N/A*	*N/A*	*Consistent with the DLI 1 and 2 verification criteria*
Patients' Rights						
Enhance public communication on patients' rights and responsibilities through: - production of communication materials, protocols, and training of staff. - increasing availability and accessibility of information to JKN members to strengthen their awareness of rights and responsibilities, claim processing, fraud and mismanagement indicators, grievance channels, etc.	N/A	BPJSK, DJSN	Yes	During imple-mentation	During imple-mentation	Production and dissemination of communication materials on patients' rights and responsibilities and relevant capacity building

Action Description	DLI (if applicable)	Respon-sibility	Re-current	Freq-uency	Due date	Completion Measurement
Stakeholder Engagement and Participation						
Enhance stakeholder engagement and public participation processes under JKN, incorporating the following measures: - inclusive public engagement and disclosure of information - development of inclusive mechanisms to solicit public perceptions, including amongst vulnerable groups - ensuring availability of updated information about the JKN program in an accessible manner.	Sub-set of DLI 8 and 9	BPSJK/ DJSN	Yes	During imple-mentation	During imple-mentation	A roadmap and strategy to enhance public engagement and participation, evidence of public consultations
Grievance Handling						
Periodic evaluation of the existing JKN complaint handling channels through consultative processes to inform relevant system enhancements and disclosure of grievance reports and settlements	Sub-set of DLI 8	BPJSK	Yes	During imple-mentation	During imple-mentation	Publication of periodic review of JKN complaint handling mechanism(s) on the JKN dashboard
Data Protection						
Strengthen data protection measures for the purpose of data system integration and digitization in line with international standards and good practices. Measures include establishment of a dedicated security/data protection unit, application of multi-factor authentication system and background checks, users tracking, data sharing protocols, routine system updates, oversight and application of sanctions.	Sub-set of DLI 5	BPJSK	N/A	N/A	Prior to roll out of system integration	Measures of having assessed data security status and interventions to address it, have been undertaken. This includes Standard Operating Procedure (SOP) for data protection, system debug report etc.

F ENVIRONMENTAL AND SOCIAL RISK RATING

82. **The environmental and social risk is overall moderate**, with environmental risk being rated as low and social risk as moderate (refer **Annex 2**).

83. **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 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 Green House Gas (GHG) emissions.

84. **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 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 that 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 – MOH's health care reform PforR.

85. **Both JKN and I-SPHERE Programs focus on improving the quality primary healthcare facilities (FKTPs)**. During the preparation of ESSA for I-SPHERE, it was identified that the need to improve management practices for medical wastes generated by FTKPs. To address this issue, two Program Action Plans (PAPs) were agreed: i) KAFKTP (Primary Healthcare Accreditation Committee) and MoH to develop necessary work instructions or Standard operating protocols (SOP) to improve the existing guidelines for surveyors and for environmental sanitation officers on proper management of medical waste management and, ii) KAFKTP and MoH to strengthen facilitator and surveyor capacity in areas such as safe handling of medical waste, emergency response, management of complaints and grievances, and patient consent processes and rights. Provided that both JKN and I-SPHERE aims to improve quality of services of primary healthcare facilities, improving medical wastes management through the implementation of the PAPs in I-SPHERE Program will result in the same improvement of medical waste management in FTKPs in JKN Program. The I-SPHERE Program is currently supporting the development of an improved Guideline on Proper Management of Medical Waste Management. In this context, MOH will ensure the adoption and compliance with the Guideline. The latest update as of May 2021 was the KAFKTP (Primary Healthcare Accreditation Committee) is still finalizing its accreditation standards, including specific requirements for medical waste management, and more workshops to work out the proposal have been conducted. The revised accreditation standards are currently being reviewed by the Legal, Organization and Public Relations Department (HUKORMAS) of Ditjen Yankes of MOH. The principle of Cradle to Grave for hazardous waste management will be in place for the new accreditation standard, among the significant changes is the use of manifest to track the medical waste management, from the time it was generated to the final treatment and disposal. One outstanding task is for the safeguard team to have site visits to verify the management of medical waste in primary healthcare facilities.

86. **Introduction of risk-based capitation to FKTPs, revisions of the Indonesian Case-base Groups (INA-CBG), 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 exarcebate 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 PforR implementation.

87. **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 benefitted from weak systems and monitoring and consequently may potentially stand to lose due to greater efficiency gains (for example, some health facilities).

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 (i.e., hospital tariffs), iii) benefits package.

c. data protection and privacy

88. **Other risk factors stem from i) the context within which the PforR is operating, ii) institutional capacity and complexity of the needed reforms, and iii) political and reputational risks.** Further details of the risk assessment are presented in **Error! Reference source not found.**, with a summary in the following:

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 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 access to health care system towards UHC will require addressing various social, cultural and psychological barriers that may confront poor and marginalized segments of the population. Exclusion in access in healthcare 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 check and balance under JKN require 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 non-essential services and services prone to over utilization. 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 operational challenges above as well as political interests. Further, in order to achieve UHC, JKN is facing complex operational challenges, particularly with regards to coverage expansion to the informal sector, though this area is outside the scope of the current PforR. Such expansion has been hampered by the absence of robust database, lack of legal and institutional framework to enforce enrolment as well as fiscal sustainability.

c. Political and reputational risks: key policy areas which may be revisited under the PforR include among others benefit package and entitlements, including class consolidation and co-sharing, upper ceiling caps, etc. Going forward, fiscal sustainability will require tough policy decisions. Though not part of the Program's overall scope, it 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.

89. **Error! Reference source not found. Annex 2 provide a risk analysis of each DLI and Annex 4 provides further information against the policy elements of the Bank Policy Program-for-Results Financing (December 2017).**

G INPUTS TO THE PROGRAM IMPLEMENTATION SUPPORT PLAN

90. **A Recipient Executed Trust Fund (RETF) through an Investment Project Financing (IPF) component is being prepared to complement the proposed PforR.** The purpose of the IPF Component 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. The IPF component will be financed through a US$ 2.33 million-dollar grant by Gates Foundation to the Government of Indonesia for the first two years of the PforR. More specifically, the component will support:

a. hiring a pool of consultants and technical experts for the Secretariat to provide technical support to stakeholder agencies (including the Ministry of Health, the National Health Insurance Purchaser (BPJS-K), and the Social Security Board (DJSN),) implementing the PforR. These include relevant consultants and experts to support the implementation of social measures recommended through the ESSA

b. coordinating broader JKN stakeholders (President's office, Ministry of Home Affairs, Bappenas), including regular communications and convening of technical working group comprised of 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. generate knowledge and provide lessons learned for other countries for continuous learning

91. **The grant will serve as catalytic investment to leverage the government's JKN reform by supporting the critically important technical assistance to improve the quality and efficiency of the government's JKN spending of over US$ 40 billion until 2026**. This financing will also contribute to fostering government ownership of the PforR by channelling the funds as recipient-executed under the management and coordination of the MOF.

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ANNEXES

Annex 1: Program Results Framework

	Main challenges	Inputs and activities	Outputs and intermediate outcomes	Expected outcomes
RA1	Providers unable to diagnose common conditions (e.g., diabetes, hypertension, high risk pregnancies) Clinical standards, pathways, and protocols not available at front line facilities	• Review of doctor's clinical practice guidelines at FKTPs and hospitals • Draft clinical pathways for common conditions • Train providers in use of clinical decision support tools	• MOH has developed a clinical decision support tool for FKTPs and hospital pathways for high-volume, high-cost conditions (DLI 1+2) • Number of FKTP workers trained in use of clinical decision support tools (DLI 1)	
RA2	Benefits not aligned with available resources Input-based financing does not reflect need, absorptive capacity, or service readiness of FKTPs Issues in the quality of coding and costing lead to errors, waste, and fraud in DRG implementation Weak claims management and fraud detection processes	• Revised HTA guidelines • Review of basic benefits package • Assessment of capitation (incl. undisbursed) and utilization at FKTP by age, gender, diagnosis • Roadmap developed for revised capitation design (base rate and KBK indicators) • Revised clinical coding guidelines • Standardized cost accounting template developed • Assessment of tariff structure and grouper algorithm • Assessment on utilization at hospitals by age, gender, diagnosis/reason for visit, INACBG – with focus on most common/costly conditions • Revised claims, fraud investigation, and audit manuals	• Number of HTA studies done in accordance with revised HTA guidelines and whose findings are incorporated in the benefits package (DLI 3) • Implementation of revised capitation design according to roadmap (DLI 6) • Clinical coding audit protocol developed and deployed (DLI 7) • Trained/certified coders in all hospitals (DLI 7) • Improved accuracy of clinical coding • Revised DRG tariffs (DLI 7) • Number of tracer indicators embedded in claims verification software to monitor compliance with protocol-based care (DLI 4) • Decrease in share of claims unverified/rejected (DLI 4) • % of hospital claims audited (DLI 4)	Improved provider competency score in FKTPs (linked to DLIs 1 and 2) Improved member satisfaction rate (linked to DLIs 1, 2, 6 and 7) % of claims that are unverified or rejected (linked to DLIs 4 and 5) Improved Quality and Appropriateness of Services Delivered under JKN (contributions from DLIs 1, 2, 4, 6 and 7 lead to this outcome) More sustainable claims ratio for JKN (linked to DLIs 3, 4, 6, and 7)
RA3	Weak or absent health management and information systems hinder decision making Lack of interoperability across information systems Low reporting compliance of essential data	Review of data collected by BPJS and MOH including intake forms/applications/reporting processes Revised/simplified intake forms/applications and simplified reporting processes Roadmap of data system integration Formation of PforR Secretariat (DLI 9)	Number of information systems integrated according to roadmap for data system integration (DLI 5) Dashboard developed to monitor key JKN performance indicators (DLI 8) Annual report on JKN performance (DLI 8)	

Annex 2: Environmental and Social Risk Assessment of PforR's DLI actions

DLI	Potential Activities	Agency	Potential Implications	
			Social	Environment
DLI #3: HTA findings incorporated into the benefit package	MOH has published revised HTA guidelines Number of HTA studies done in accordance with revised guidelines and disseminated findings to the public	MOH	Depending on the criteria for selection and revision to the benefit package, some diseases/conditions or treatment may be removed from the package or the extent may be reduced, and so this needs a systematic and consultative process as part of the HTA.	Further analysis of environmental impacts of new health technology to be adopted
DLI #1 and 2: **Improved quality of care**	MOH has developed a clinical decision support tool for FKTP workers MOH have trained FKTP workers in use of clinical decision support tool MOH has developed hospital clinical pathways for 20 conditions	MOH	Without consideration into the uneven state of supply-side readiness among FKTPs, a nation-wide universal clinical and referral guideline may not be feasible to be adopted. Furthermore, if compliance to universal guidelines is tied to capitation payment, there is a likelihood that FKTPs with low supply-side readiness would see reduction in their revenue and will further disadvantage JKN's members in lagging areas.	Compliance with the improved guidelines on Proper Management of Medical Waste Management; developed under MOH's I-SPHERE.
DLI #4: Improved claims management	Revisions of claim, fraud investigation, and audit manuals (incorporating elements from DLI #2) to track compliance with diagnostic treatment, and referral processes	BPJS-K		

	Number of tracer indicators embedded and automated in claims verification software Audit hospital claims			
DLI # 5: Improving the use of data in decision making	Development of a roadmap of data system integration Agreement on list of essential data needs from all stakeholders Review and simplification of data collection and reporting processes Number of information systems integrated as per roadmap	BPJS-K/MOH	Integration and interoperability of multiple MIS often mean more people and institutions having access to JKN database that consists of very sensitive individual information. Without strong safeguarding mechanisms and data privacy/confidential protocol in place (with reference to GDPR principles), there is likelihood of data leakage, breach, and unauthorized/illegal use of individual data.	
DLI #6: Improved capitation design	Review of historical utilization patterns and allocation and use of capitation at FKTPs Develop a roadmap to improve the design and implementation of capitation Number of additional quality indicators included in KBK scheme Number of FKTPs piloting/implementing capitation changes as per roadmap	BPJS-K/MOH	Without substantial consideration regarding the availability, quality and equity of services at FKTPs in underserved regions (and without efforts to increase the supply-side readiness in these areas), revision to KBK that moves toward performance-based assessment may unintendedly penalize lagging FKTPs and their beneficiaries. Revisions will need to be informed through FKTP readiness assessment/accreditation processes on the basis of which differentiated treatments at	

			FKTPs with weak capacities can be considered. Robust simulation of proposed new formula for capitation must be conducted with inclusive sample from lagging regions.	
DLI #7: Improved INACBG implementation	Standardization of cost accounting template Revision of coding guidelines, course/certification process for clinical coders developed Development of coding audit protocol Availability of at least 1 certified clinical coder in each hospital Number of hospitals randomly assessed for coding accuracy Assess utilization and expenditure at hospitals by age, gender, diagnosis, and INACBG Revise INACBG tariffs	BPJS-K/MOH	Without robust training for clinical coders at facility level to follow the new revisions, multiple interpretation and confusions might ensue and this may result in claim being denied.	
DLI #8: Improved policy formulation and oversight of JKN	Development of key performance indicators and a dashboard Annual JKN performance assessments	DJSN	No social implications	No environmental implications
DLI #9: Improved coordination, impact, and sustainability of JKN	Establishment of PforR secretariat Track progress on PAP, DLIs, and RF Support implementation agencies Compile and analyze JKN data and provide recommendations on	MOF, BPJS-K, MOH, MOHA, DJSN	No social implications	No environmental implications

	JKN-related objectives in the new RPJMN			

Annex 3: Concept Stage Environmental and Social Risks and Impacts Screening Matrix

INDONESIA – National Health Insurance (JKN) Reforms (P172707)

Program-for-Results (PforR)

Environmental and Social Initial Screening

Introduction: The proposed Program Development Objective (PDO) is strengthening the performance and sustainability of Indonesia's National Health Insurance (*Jaminan Kesehatan Nasional*) program. The proposed PforR seeks to support the Government of Indonesia (GoI) towards Universal Health Coverage (UHC) through supporting the GoI's flagship JKN program. The program consolidated existing health insurance schemes and over 300 risk pools into a single national scheme managed by a semi-autonomous public agency – *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS-K). By 2019, coverage expanded into 82 percent of the population, with active membership at around 75 percent.

However, JKN has continued to face systemic challenges in the program's governance and accountability, financing sustainability and service delivery. JKN has incurred a cumulative deficit of IDR 31.7 trillion (around US$ 2.2 billion) as of end of May 2020. All of these factors combined hinder progress towards UHC, with seventy million Indonesians, mostly among the informal sector, remaining uninsured. Out-of-Pocket (OOP) expenditures remain high at 37 percent of the total health spending. The PforR is being prepared against this backdrop and intends to respond to such systemic challenges in order to promote its sustainability and coverage.

Program Boundary: The PforR supports the larger government program supporting JKN, including expenditures by BPJS-K, DJSN and MOH. The PforR includes relevant expenditures incurred by these agencies for claims being paid under JKN as well as administrative and monitoring costs as relevant to the result areas of the Program. The Program boundary will be re-confirmed prior to appraisal.

The Program's three main result areas focus on addressing challenges that are integral to the JKN system, namely:

- Result Area 1: Improving the Governance and Accountability of JKN.

  RA 1 focuses on clarifying the roles and responsibilities of key stakeholders, particularly BPJS-K, Ministry of Health (MoH), and the Social Security Council (*Dewan Jaminan Sosial Nasional* or DJSN). Improving JKN's governance and accountability may encompass enhancing financial, performance and public accountability of the program. RA 1 may also support interventions to improving the quality and use of data, which is essential to inform fund management, enhance service delivery and quality of care and at the same time reduce transaction costs and inefficiencies.

- Result Area 2: Raising additional revenues for BPJS-K

  RA 2 supports JKN coverage to the informal sector to enhance its financing sustainability. Coverage expansion not only allows a predictable source of revenue, but also enables economies of scale, hence, potentially lowers the average cost per-member per month by bringing in healthier informal sector workers who have lower utilization rates and claims into the system.

- Result Area 3: Increasing value for money of JKN expenditures

RA 3 focuses on streamlining JKN's business processes by consolidating class coverage to reduce inefficiencies and adverse selection, ensuring that benefits match with available resources and improving the design and implementation of provider payment methods across levels (i.e., primary care and hospital levels). This RA seeks to support reforms in financial incentives for service providers to enforce gatekeeping, increase service utilization (i.e., outreach), focus on value for money rather than volume (i.e. close-ended hospital payments) and overall claims analysis to improve spending efficiencies at service provider levels.

Geographic Scope and Duration: The GoI's program has a nation-wide coverage and covers both public and private hospitals and primary care facilities across 514 districts. The PforR is designed for a period of five years from July 2021 to June 2026.

Choice of Instrument: JKN is one of the largest health sector programs in Indonesia (in terms of the financing), the PforR instrument is considered as a strategic accountability and monitoring tool of the needed reforms. The PforR will look at the sustainability challenge of JKN and the potential for design reforms in JKN to promote system-wide improvements in the country's health system.

Purpose of initial screening: The initial screening mainly serves as a preliminary diagnostic exercise to identify potential environmental and social issues as well as opportunities that may be associated with and/or leveraged through the PforR, specifically:

a. Environmental and social contexts and associated risks

b. Sustainability

c. Institutional complexity and capacity to manage environmental and social risks associated and/or linked with the Program and

d. Reputational and political risks

Once a decision is obtained to proceed using the proposed PforR instrument, a more technical environmental and social system assessment (ESSA) will be carried out and measures to address weaknesses and to enhance risk and impact management will be identified and agreed with the implementing ministries and agencies.

Key results and findings of the initial screening:

Initial screening was carried out based on the expected indicators in the Result Areas. Further assessment of the GoI's program system, including any consultations required will be conducted during the Program preparation. Due to COVID-19, preliminary stakeholder engagement and required consultations for the purpose of the Program's ESSA will be undertaken virtually. For the purpose of ESSA consultations, public health precautionary measures will be taken into considerations when travel restrictions and social distancing measures have been lifted.

An initial analysis of the environmental and social aspects of the proposed Program is presented in the following table:

PDO	Results Indicators (Tentative)	Expenditures	E&S Effects	Risks
Strengthening the performance and sustainability of Indonesia's National Health Insurance program.	**Result Area 1: Improve Governance and Accountability** Potential outputs include: <u>On clarifying roles and responsibilities of BPJS-K, MOH and DJSN</u>: a. BPJS-K empowered to carry out key purchasing functions (*Perpres*) b. An independent DJSN or revised representation and decision-making authority of the Council (*Perpres*) c. Clear protocols and transparent criteria for priority setting d. Clear diagnostic and treatment protocols including referral pathways e. Clear and transparent guidelines on how beneficiaries are assigned to FKTPs, including criteria for maximum or minimum number of enrollees per provider f. Harmonized regulations around the use of capitation funds <u>On improving quality and use of data</u>: a. A whole-of-government digital data governance solution b. Data access and privacy protocols c. Clear coding guidelines, claims verification/adjudication manuals	The estimated GoI's program expenditure is 2,750 million USD. The PforR budget is 250 million, which represents approximately 9 percent of the GoI's budget.	The overall environmental and social outcomes resulting from the proposed PforR are expected to be positive. RA 1 seeks to promote good governance of JKN through clarification of roles and responsibilities and improved data quality and use to promote transparency, accountability and efficiency. None of the activities being proposed under RA 1 falls under the exclusion criteria contemplated under the Bank Guidance for PforR ESSA. No infrastructure investments are envisaged under the project. The PforR does not tackle supply-side health system readiness. Improvements in data quality may require procurement of IT systems and related infrastructure (both soft-ware and hard-ware), warranting environmental and social considerations in terms of Occupational Health and Safety (OHS) and e-waste management. No adverse social effects are anticipated under RA 1. However, further caveats will need to be entered with regards to the implications of private data management, particularly in the handling of medical records. Data improvements may entail data	The overall social and environmental rating is expected to be *Moderate;* with environmental risk rated low and social risk rated moderate. The Program is not working 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 the environmental risk factors (including those related to climate change and natural disaster) because they are not relevant to the operation. The operation is not likely to have adverse impacts on GHG emissions. While the JKN PforR does not have significant direct environmental impacts, the improved performance of JKN may encourage an increased in utilization of health services, with a potential downstream environmental implication such as safe handling of medical waste. MOH will ensure the adoption and compliance with the improved guidelines on Proper Management of Medical Waste Management; developed under I-SPHERE. The PforR endeavors towards UHC through systematic reforms of JKN,

	including fraud detection protocols d. Standardized cost accounting template from hospitals e. Standardized medical records formats including for electronic health records		sharing and disclosure, warranting privacy and data protection measures. The scope of this activity is yet to be defined during the Program preparation. Further assessments of the environmental and social aspects of the Program, along with the corresponding GoI's system(s) to address potential impacts and risks will be undertaken through a consultative process during the ESSA preparation. Relevant environmental and social measures to address gaps (if any) and enhance positive outcomes and sustainability will be consulted and agreed with GoI prior to the Program's appraisal.	addressing the program's governance, financing sustainability and value of money. Contextual risks: reforms supported by the PforR may be implemented under challenging political-economy operational and fiscal contexts, which have been further compounded by 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 access to health care system towards UHC will require addressing various social, cultural and psychological barriers that may confront poor and marginalized segments of the population. Exclusion in access in healthcare 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. The PforR is not envisaged to exacerbate such issues nor intended to address them. Expansion of JKN to the broader population is expected to promote equity and access to health care services. Institutional capacity and complexity: The JKN program has a nation-wide coverage, with an ambitious target towards UHC. Operational challenges
	Result Area 2: Raise Revenue for BPJS-K a. *Perpres* extending coverage to informal sector b. A strategy to ensure contribution compliance		Expanding JKN coverage to the informal sector and ensuring contribution compliance will not only allow a predictable source of revenue to sustain JKN over the long term, but also benefit the wider population with improved health safety nets, particularly in times of need (i.e., pandemic, disasters, etc.). Overall social effects are positive under RA 2. However, key planning elements to be considered cover inclusion of vulnerable and marginalized groups, including poor households, Indigenous Peoples, and people who may not be formally registered. Furthermore, disparities in health access and quality of care across socio-economic groups and	

			geography may further reinforce the existing inequities in JKN if a blanket approach is being applied and no systemic improvements in the healthcare system, including grievance management at the health facility level are being envisaged. Since the latter is outside the scope of the Program, further understanding of the proposed PforR's engagement with other government initiatives as well as on-going health PforRs[21] such as I-SPHERE will be sought as part of the ESSA process. Within the scope of the PforR, expansion of hospitals and facility accreditation, including training of health providers fall outside the scope of the Program. Further expansion of JKN may encourage an increase in utilization of health services, with potential downstream environmental and social implications. However, since the PforR does not include health service readiness, management of such risks will be outside the scope of the PforR's boundary and further understanding of how such risks will be addressed as part of the ESSA process.	are complex, particularly with regards 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 as well as fiscal sustainability. Furthermore, JKN's oversight and check and balance require inter-agency decisions, which may potentially further complicate the needed reforms. Furthermore, curbing expenditure growth may involve revisiting per-capita rates which may be linked to performance-based allocation, introduction of hospital sending caps and cost-sharing arrangements for non-essential services and services prone to over unitization. All of these reforms warrant not only sound evidence-informed technical considerations, but also clear and transparent public communication, which may be compromised due to operational challenges above as well as political interests. Political and reputational: key policy areas which may be revisited under the PforR include among others coverage expansion to informal

[21] Complementary PforRs, including Indonesia-Supporting Primary Health Care Reform (I-SPHERE – P164277) and Indonesia-Emergency Financing Support for COVID-19 (P173843) are being implemented to improve the health system readiness, with the former focusing on primary health care facilities and the latter on emergency health response for COVID-19

	Result Area 3: Increase Value for Money - Perpres on consolidating class types - Publication and dissemination of health technology assessment findings - Conflict of interest disclosures and/or an independent health technology assessment unit - Assessment of FKTP service readiness for 144 services included in the benefit package - Assessment of FKTP service readiness for 144 services included in the benefit package - A budget neutral capitation formula (a switch from existing input-based per-capita formula) - Refined base per-capita rate according FKTP service readiness - Increased planning and budgeting capacity at FKTPs - Introduce ceiling or hard budget on hospital expenditures - Improved/revised INACBG tariff/grouper design - Drug prescriptions added to claims system		Enforcing gate keeping at the primary care level and appropriate referrals as well as and ensuring benefits match with available resources represent the necessary foundations to JKN's sustainability. However, necessary for RA target achievement, potential unpopular reform measures, such as expenditure caps for hospitals and primary care facilities, cost-sharing arrangements, may be introduced. This warrants further understanding of the feasibility and implications of such measures in any given contexts. The capacity of the agencies involved in the PforR in communicating and phasing reforms to minimize political and public backlash will be assessed as part of the ESSA.	workers, benefit package and entitlements, including class consolidation and premium rates. Moving forward, fiscal sustainability will require tough policy decisions, including increasing premium rates and/or shrinking benefit package. While inclusion of these elements under the PforR boundary is yet to be determined, the Program overall 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 addressed as part of the ESSA process. ESSA findings and recommendations will be refined through public consultations, which are expected to conclude prior to the Program's appraisal.

Annex 4: Analysis Against Key Policy Elements of Bank Policy Program-for-Results Financing

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program** (i.e., Relevant / Not relevant / Partially Relevant	**Provisions in System**	**Practice**
Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the Program level.	Partially relevant. JKN does not include specific investments warranting environmental and social impact assessments. Relevant mitigation measures to promote equity and coverage of health services are embedded into the Program design.	Equity and social inclusion provisions, stakeholder consultations, grievance handling are encapsulated in the JKN legal framework further elaborated in the program operational manuals. Further specifics are provided in the sub-sequent sections.	Over the past 15 years, significant achievement towards UHC through JKN is widely reported. Between 2014 and 2019, coverage expanded to 83 percent of the population, although active membership is around 75 percent and is declining due to COVID-19. Out-of-pocket (OOP) expenditures as a share of total health spending decreased from 47 to 34 percent – an unprecedented achievement in such a short time. However, inclusion issues, particularly affecting remote populations who face significant health supply-side constraints and the broader marginalized groups, still persist.
Incorporate recognized elements of environmental and social assessment good practices	Not relevant	N/A	N/A
(a) early screening of potential effects;	Not relevant	N/A	N/A

(b) consideration of strategic, technical, and site alternatives (including the "no action" alternative);	Not relevant	N/A	N/A
(c) explicit assessment of potential induced, cumulative, and trans-boundary impacts;	Not relevant	N/A	N/A
(d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized;	Not relevant	N/A	N/A
(e) clear articulation of institutional responsibilities and resources to support implementation of plans	Not relevant	N/A	N/A
(f) responsiveness and accountability through stakeholder consultation, timely dissemination of Program information, and responsive grievance redress measures.	Relevant	Grievance handling has been institutionalized within JKN. Law No. 24 of 2011 mandates BPJS to create a unit responsible for quality control and for handling grievances from members. The Law also specifies that BPJS needs to handle the complaints at least 5 days following receipt of grievances. Refer to subsequent section on the consultations and engagement.	While there are various grievance channels supporting JKN implementation, no systematic tracking and analysis of such channels is available. Refer to subsequent section on the consultations and engagement.
Policy Element b) Program systems are designed to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program. Program activities that involve the significant conversion or degradation of critical natural habitats or critical physical cultural heritage are not eligible for PforR financing.			
Key Attributes related to Core Principles	**Relevance to Program** (i.e., Relevant / Not relevant / Partially Relevant	**Provisions in System**	**Practice**

Identify, screen for adverse effects on potentially important biodiversity and cultural resource areas and provide adequate measures to avoid, minimize or mitigate adverse effects.	Not Relevant	N/A	N/A
Support and promotes the conservation, maintenance, and rehabilitation of natural habitats.	Not Relevant	N/A	N/A
Avoid the significant conversion or degradation of critical natural habitats. If avoiding the significant conversion of natural habitats is not technically feasible, include measures to mitigate or offset the adverse impacts of the PforR Program activities.	Not Relevant	N/A	N/A
Take into account potential adverse impacts on physical cultural property and as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.	Not Relevant	N/A	N/A
Policy Element c) Program E&S systems are designed to protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program** (i.e., Relevant / Not relevant / Partially Relevant	**Provisions in System**	**Practice**

Promote adequate community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed. Promote measures to address child and forced labor.	Not relevant. The PforR does not address supply side financing and investments where purchase of medical supplies and equipment are envisaged.	N/A	N/A
Promote the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated under the Program.	Not relevant	N/A	N/A
Promote the use of integrated pest management practices to manage or reduce pests or disease vectors; and	Not relevant	N/A	N/A
Provide training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous biological wastes in accordance with international guidelines and conventions			

Include measures to avoid, minimize, or mitigate community, individual, and worker risks when Program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.	Not relevant	N/A	N/A
Policy Element d) Program systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Avoid or minimizes land acquisition and related adverse impacts;	Not relevant. No physical investments and land acquisition are envisaged under the PforR.	N/A	N/A
Identify and address economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;	Not relevant	N/A	N/A
Provide compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;	Not relevant	N/A	N/A

Provide supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment);	Not relevant	N/A	N/A
Restore or replace public infrastructure and community services that may be adversely affected by the Program. Include measures in order for land acquisition and related activities to be planned and implemented with appropriate disclosure of information, consultation, and informed participation of those affected.	Not relevant	N/A	N/A
Policy Element e) Program systems give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**

Undertake meaningful consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program.	Partially relevant. JKN program is supporting Universal Health Coverage and has a national coverage. Relevant consultations and engagement apply to the broader public, including Indigenous Peoples where they are members.	JKN is obliged to proactively engage the public on the program's entitlements and responsibilities. Law no. 24/2011, MOH regulation No. 71/2013 and MOH No.99/2015 incorporate BPJS's responsibilities to inform members of their rights and obligations and relevant procedures to access services, including availability of rooms at hospitals, benefit coverage, procedural change, etc. Within the current operating system of JKN, the program is also required to establish a functioning grievance redress mechanism which is accessible to the public. Law 24/2011 also stipulates that an executive summary of BPJS annual financial audit report and program by a public accountant be made public through electronic mass media. The Law also calls for the establishment of a supervisory council with representation from the civil society.	Efforts to promote stakeholder engagement and participation have been made, however its effectiveness is unknown. BPJSK has developed both online and offline platforms to inform the public about the program. Within the Availability of information about public participation in the decision-making process of JKN is overall limited. While a supervisory council within BPJS-K and DJSN as an external oversight body have been established, there is lack of clarity with regards to the mechanisms through which public opinions and feedback are solicited by these oversight bodies. In most cases, public participation occurs sporadically, post-facto, and more importantly is not part of normal decision-making process within BPJS-K.
Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples.	Not relevant	N/A	N/A

Give attention to groups vulnerable to hardship or discrimination, including, as relevant, the poor, the disabled, women and children, the elderly, ethnic minorities, racial groups, or other marginalized groups; and if necessary, take special measures to promote equitable access to PforR Program benefits.	Relevant	JKN includes a subsidy scheme for the poor and vulnerable. Law no. 40/2004 on SJSN, followed by the Presidential Regulation no. 82/2018 adopted social security and equity principles in the overall implementation of the JKN. While JKN requires a contribution payment, an exemption is made for the poor to encourage their uptake of services and avoid additional economic burden. This includes introduction of a non-contributory scheme known as *Penerima Bantuan Iuran* (PBI) for the poor and near poor in the bottom 40 percent poverty quintiles. JKN also provides non-discriminatory health treatments regardless of class types. While the prevailing laws and regulations governing the JKN are non-discriminatory, implementation of these laws and regulations has been of a mixed success, particularly on aspects related to equity and inclusion. Effective UHC hinges upon various inter-related operating mechanisms, often outside direct JKN's direct sphere of influence. These include supply-side readiness, civil registry database for accurate targeting of the poor and vulnerable, employment database, sub-national governments' contributions, etc. Sub-national governments assume the overall	While a scheme to protect the poor and vulnerable through the subsidized JKN-PBI is in place, exclusion issues persist. JKN-PBI targets the bottom 40 percent of the poor. However, 42 percent of non-poor households are benefitting from the subsidy (inclusion errors) and thus displacing poor households from the coverage (World Bank, 2021). Targeting relies on the beneficiary registries, which collect information to assess eligibility status from other sources, such as social registries. Such inclusion and exclusion errors often stem from infrequent updating of social registries and inadequate integration of JKN identification and authentication systems with the national ID and civil registration and vital statistics systems (CVRS), which increase the risk of duplication, frauds and identity misuse. Lower coverage of national identity numbers (NIKs) and national ID cards (KTP/e-KTPs) particularly amongst the poor segments of the population is also attributable to such exclusion issues. Further, significant gaps in coverage remains since JKN was first launched in 2014. There are around 50 million Indonesians who remain uninsured, mostly informal worker groups. This group is often called as

		responsibility to ensure that there is adequate infrastructure to supply the referral services by JKN (Law no. 23/2014 on Sub-national Governments; Law on Health no. 36/2009; Presidential Regulation no. 12/2013).	the "missing middle" of social protection coverage where they may be not eligible for poverty-targeted social assistance but excluded from employment-based contributory arrangements, nor unwilling to be enrolled in insurance schemes.
Policy Element f) Program E&S systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Considers conflict risks, including distributional equity and cultural sensitivities.	Partially relevant. JKN is not envisaged to exacerbate social conflicts and/or have impacts on cultural practices. Further, the Program is not intended to deepen inequities but address them.	As above on equity of benefits	As above on equity of benefits

Annex 5: Stakeholder Engagement and Validation Workshop

Virtual Public Consultation with the general public, consumer and JKN member representative groups – Round 1

Date/Time: November 11th, 2021 (9-11 am Jakarta time)

Participants: five representatives from the consumer and JKN member groups (one female and four male). For the purpose of confidentiality, the details of the participants are not disclosed.

Minutes of the meeting

Questions/Feedback	Response
On socialisation to patients. How to ensure that patients are updated with changes in coverage policy of pharmaceuticals? The current JKN Program policy on referral and drug prescription have caused disruption in treatment continuity; The referral policy ignores doctor-patient therapeutic relationship, and limitation for prescriptions for long-term medicine and different operating hours between the doctor's consultation schedule and the pharmacy has increased the likelihood of dropouts. A Survey from Into the Light community indicates that only 29.6% people are aware that JKN benefit package covers mental health care. Suicide and self-harm are not covered because these are considered as being intentional acts. These create issues because people that often perform self-harm do require mental support that should be covered by JKN.	The PforR seeks to support fiscal sustainability while focusing on improved quality of care. The Program intends to address system strengthening and sustainability issues where negative implications on accessibility are not envisaged. The social system assessment seeks to promote and enhance inclusivity. The results areas which focus on quality, efficiency and improvement in policy making can potentially address the questions. Wider availability of mental health service is an important issue for the health system, though beyond the scope of the PforR itself. The PforR will encourage evidence-based reviews of the benefit package, where excluded conditions such as suicidal attempts may need to be advocated for further consideration. The Program also seeks to support inclusive policy making, by ensuring representativeness of the sampled respondents prior to any reform decisions which may result in impacts, i.e., benefit package, clinical guidelines, etc. In terms of strengthening JKN governance, it was noted that reporting channels are often not optimally used for the purpose of collecting information from all institutions. Hence, one of the measures also seek to accommodate feedback from users.
Agree with the previous respondent that self-harm and suicidal acts and induced injuries should be covered by JKN. There are challenges to access mental health services. There is a problem with portability -- it is very difficult for patients to access services outside their domicile area. Patients often have to play the system by entering via the ER or assisted by the Social Service through unusual procedures. Services must be made easier and provide concessions for patients who have problems with population administration.	
Solutions for patients, especially TB patients, who still are still not enrolled in JKN, particularly those with other complications like hepatitis or HIV/AIDS.	Complexities with TB treatments are often caused by presence of other comorbidities such as HIV/AIDS and Hepatitis. However, since TB is one of the current government priorities, there may be solutions to address such issues. It may be

Some TB patients were known [by the participant] to experience difficulties in accessing BPJS-K. Their domicile status is not always the same as their residential address on their identity card. At the same time, changing domicile status is also difficult. There are anecdotal examples of patients with MDR-TB dying untreated as they were not able to access JKN benefits. In an example quoted from Papua, long waiting period for MDR-TB cases causes issues because illnesses may worsen by the time treatment was received.	necessary to design a system capable of accommodating multiple doctor visits in a day -- so that patients' needs for complex tuberculosis services can be overcome. The PforR may potentially support through strengthening of protocols in TB treatments at the primary and referral levels and hence, by doing so, promote continuous care amongst these patients. Further understanding of key barriers for people with TB in accessing BPJS-K will need to be understood. This also includes analysis of barriers which prevent these patients from receiving continuous care. Clinical pathways and improved referral systems supported by the Program should also help reduce such delays in diagnosis or treatment.
Public awareness about the JKN is often limited. There are many cases of borrowing BPJS cards from participants to non-participants. In some circumstances, members can lend their JKN card to their relatives. This can cause governance issues and problems with continuity of care.	Such concerns may potentially be addressed through strengthening public communication on patients' rights and responsibilities, how to register, etc., including for those who are currently not a member. Cards used in addition to the owner also have dimensions of problems related to data protection. In cases like this, the patient has access to other patient data. This problem is also related to the membership data verification process, because the service provider should be able to identify discrepancies. If left unchecked, there will be a potential for discrepancy in the patient's medical record and the potential for malpractice due to misinformation.

Written input:

Access to care for cases of suicide attempt and their connection with mental health problems. As a fact on the ground, cases of victims of self-harm (suicide) are not covered by JKN. We consider this a form of discrimination and injustice of JKN against mental health issues, the strong stigma against the issue of suicide and the lack of knowledge of JKN policy makers. Various literature state that self-harm and suicide are the pinnacle of mental health problems. Therefore, it is unjust for the victims to not receive health care or coverage under JKN. A review regarding the issue of suicide and its interrelation with JKN/BPJS is necessary. A person exhibiting self-harm or suicide attempts are in need of BPJS/JKN support in order to access health care so as to achieve recovery. The exclusion of suicide from health care coverage is a step backward. We wish that victims of suicide can receive similar support in terms of BPJS/JKN services.

Data protection and privacy. We hope that personal data such as diagnosis, for example mental health problems, must be protected fully as patients' privacy, because in mental health, when a diagnosis is written down in the system it holds the potential of creating stigma. If necessary, there must be a program to improve the knowledge and skills of healthcare workers on the ground.

Improvement of skills and knowledge of healthcare workers at the primary care level regarding care for mental health patients. Based on the result of our interviews with several communities of mental

health [consumers], there are many complaints by people living with mental health problems and their families when interacting with healthcare workers/staff at the primary care facilities (FKTP). Patients and their families encounter healthcare workers who are not skillful enough in providing care. Many workers stigmatise in various forms, from their verbal statements to unfriendly attitude and body language. This can be a barrier for people living with mental illness and their families in accessing care. Health care workers at FKTP needs to have their sensitivity and skills improved in facing mental health patients and their family/caregivers so as to avoid stigma and to provide care with dignity and humanity.

Ease of services by primary care (FKTP). In particular to patients who are living faraway from their original home/residence. We, on the ground, find it difficult to access care when we facilitate patients who are stranded in other districts/regions. Many healthcare workers at the puskesmas or hospitals do not know the pathways of services when there are administrative hurdles that we consider to be complicated and unreasonable. For instance, when a person is without family card (KK) or identity card (KTP) of the same district with their primary care facility (FKTP), these patients are required to find referral letters from their district of origin which may not be accessible at the time. We hope the policy can be more flexible for emergency cases. Information about a bypass for emergency care must be informed to the patients and health facility staff. Emergency care [protocol] must be socialized/informed to staff at FKTP, so that patients can receive help/care quickly.

Virtual Public Consultation with the general public, non-governmental organisations (NGOs) – Round 2

Date/Time: November 11th, 2021 (1-3 pm Jakarta time)

Participants: five participants representing NGOs (three female, two male). For the purpose of confidentiality, the details of the participants are not disclosed.

Minutes of the meeting

Questions/Feedback	Response
What has been planned for sampling from the marginalised and minority groups?	At the moment, the program's planning is at a design level with the implementing agencies (BPJS-K, DJSN, and MoH) while these details are usually developed during implementation. Among the terms of the agreement will be the principles of inclusion and participation. Meanwhile, the analytical work that has been conducted to support and inform the planning of this program has been a secondary analysis from the existing data from the Susenas (National Socioeconomic Survey).
There are community concerns for the issues of maternal and child health as well as nutrition. Will these be covered? Ideally the marginalized communities receive state support and service. Will issues of equity and justice for the marginalized groups be covered under the program?	Action plans for JKN reform are still being negotiated with the implementing agencies. For such stakeholder consultation activities, there is room for technical assistance which will be funded by grant funding. The design of the program focuses on improvements in primary healthcare which will also help with maternal and child health as the largest users of these services.
There is an impasse in service coverage between JKN and other financing sources (such as donors or state budget//APBN), such as the case for doctor's consult (covered by JKN) for patients living with HIV/AIDS (PLWHA) whereas the lab tests for viral load being covered by donor/APBN. Will the program support in looking at how services covered by JKN and those covered by donors can collaborate within one health facility?	This is an important issue, though broader than JKN and this Program itself. Coordination and alignment between different sources of financing will indeed be a good direction. Coordination between financing modalities and between facilities for referrals, including through the use of clinical pathways, will assist to achieve an ideal where patients are not confused by which financing sources support which part of the services they receive.
At the moment BPJS-K is in deficit, because there is no standardized rate for basic benefit between one service and another.	
Rooms for improvement is not only in BPJS-K but also in DJSN, as well as Coordinating Ministry of Human Development and Cultural Affairs and Ministry of Health, and regional/subnational governments. • For BPJS-K, as according to the Law on BPJS (2011), one task that still needs to be	All inputs provided were well received and relevant and some of the key elements are expected to be strengthened under the PforR, particularly on access to information, transparency and accountability, grievance handling. The PforR also seeks to promote efficiencies during referral

improved is how BPJS-K provides information about JKN program to the wider public (how to sign up, what services are covered). • The JKN road map needs to be updated. • BPJS-K also needs to have more transparency and accountability. How can the public understand what contributes to the deficit, or that the non-PBI utilisation is very high? • Regarding data protection, it still requires integration with database systems of other ministries, so that the validating and updating of membership data can be done in real time. • Complaints handling mechanism is one of DJSN's indicators for BPJS-K's performance. So far, reports of complaints are only aggregate reports, categorized by types of issue of complaints (admin, facilities, services, etc.). More transparency is needed to the public, on which regions/locations have high rate of complaints, what the complaints pertain to, and the status of redress/solution of complaints. If this is addressed, the community will have an incentive to contribute to submitting complaints for system improvement. • Inefficiencies during referrals, as not all type C hospitals are of good quality. After being admitted to type C hospitals, then will require referrals to type B or A hospitals, during which the condition worsens.	processes by promoting development of clinical guideline tools and capacity building.
Services should put primacy in urgent situations, without requiring for referral documents first. The right to health should be the main paradigm.	Inputs were well received
There needs to be communication media for vulnerable groups. The comfort of vulnerable groups and minority groups should be accommodated.	Inputs were well received
There are many [patients from vulnerable group] facilitated who used to be members of JKN but dropped out because at the clinic they are still required to pay out-of-pocket for registration and for the doctor's consult. In addition, opportunistic infections and laboratory tests are not covered by JKN.	Inputs were well received, and the team agreed that there needs to be tools to monitor and address such issues.

JKN's inclusion for the poor and marginalized has grown better. But the frontline providers are not fully inclusive or non-discriminatory. There are instances of discrimination against minority groups such as transgender or at-risk population for HIV/AIDS. Services should be able to accommodate these groups, such as using special queue line, or accessible entrance/access. Only 50% of puskesmas infrastructure are considered elderly-friendly, raising questions about the proportion in private healthcare facilities.	Inputs were well received, and the concerns were recognized as part of the broader improvements in supply-side readiness.

Virtual Public Consultation with health facilities associations and healthcare professional groups – Round 3

Date/Time: November 12th, 2021 (8.30-10.30 am Jakarta time)

Participants: 20 representatives of professional associations, including international donors (13 female, seven male). For the purpose of confidentiality, the details of the participants are not disclosed.

Minutes of the meeting

Questions/Feedback	Response
We need to elaborate how to integrate primary and secondary care. Currently midwives find it very hard to do referral. It could be because of limited capacity during pandemic. When we have an integrated system, the secondary care should train/brief the primary care facilities on how to do referral. Also need referral back system. Midwives need information to ensure follow up care. Currently the risk of deaths doubled after hospitalization. Ensuring comprehensive and integrated referral system will help reducing these issues.	The project is translating the very comprehensive national guideline into a very simple algorithm. The clinical guideline will help health care providers to understand the algorithm to work. In Indonesia there is a good level of utilization of ANC, but this does not necessarily translate into receiving care as needed. The project will track what happens during each visit and how to improve the quality of care. The project will also help to track patients from primary to secondary care and will develop clinical guidelines to help increasing quality of care. Some of the quality improvement will contribute to concerns from IBI dan PERSAGI. These issues need broader policy measures, to ensure tools are ready to help strengthen supply sides readiness.
Patients with nutrition problems need hospital care. These patients need comprehensive care, from primary care to secondary care. Patients with malnutrition need 90 days care. Without JKN it will be impossible to treat such cases. Obesity, increase into 23%, also need coverage from JKN. Who will lead to refer patients from primary care to hospital?	
We receive complaints from marginalized group population about JKN services. One of the most common complaints regarding to patients' rights are the increase for JKN contribution fee. Patients also facing difficulties in accessing care after their membership were transitioned to PBI. Patients are confused on how to report complaints. Information about communication canal to report complaints are not widely accessible. Need easy-to-access information canal to report complaints. Is it possible to involve civil society to monitor the implementation process?	The project will be working with MoH to revise the BPJS tariffs. Regarding medical equipment and drugs approved by BPJS, the project will work with MoH to review HTA. The project will help revising the guideline to add inclusion and exclusion criteria for HTA. To strengthen complaint mechanism is to transparency and access to information. Currently we are working on the major points that should be improved. It will include capacity building of field officers to provide reliable and responsive information. In the implementation phase, the project will help detailing the process. It will ask for further inputs from stakeholders on grass root level. The over referrals can create cost for the system and for the JKN. We need better prepare the primary care, to make the system more efficient
Agree with the previous respondent on how to create integrated and comprehensive system for referral between primary and secondary care. The system will increase patient's satisfaction and quality of care. There have been years that fee are not increased. Tariff should be revised every two years. With	

surplus cash flow in BPJS, increase tariff will help health care providers to increase quality of care. Patients need recommendation from BPJS-K again every time they need supportive diagnostic or intervention. If the process could be simplified, with monitoring, quality of care will be increased. Access to purchase diagnostic tools will help hospitals to increase quality of care. Access to get medical doctor in remote areas is very hard. How can we accelerate access to get specialized doctors in remote areas? Could it be by providing trainings that are shortened to increase number of specialized doctors?	and to save patients money. We agree on the need to minimize unnecessary reference. There will be interventions for tariffs revisions. We need better cost data available to make sure there is no disincentive to provide service because of underpayment. We need more systematic evidence, and it will be part of the project areas. How telemedicine can be extended, while it will not be part of this project directly, but it will be part of the analytical part. We will work on details in helping challenges in remote areas.
There are confusions in referring maternity patients. There needs synchronization between POGI, midwives and primary care to make sure that referral system runs smoothly without rejection from hospitals. Oftentimes, patients who are referred by midwives are rejected to give birth in hospitals. In contrast to the midwives' judgments the doctors in hospitals might say there is no indication for referral and the JKN cannot cover normal delivery in hospitals.	The examples highlight the need of clinical pathways and guidelines. We need input to understand which referral guideline are contradictory. The referral guideline will be revised and should not be contradictory.
Based on guideline, post-term patients need referral, but usually get rejected by hospitals. There is a need for synchronization of guidelines.	
We received complaints from patients, especially from marginalized groups. The most common complaints at the moment are about JKN payment system. For example, when patients who are BPJS member but have long standing due and need hospitalization. When they want to pay the outstanding payment, they found out that their membership was transitioned to PBI. But the PBI membership has become inactive. When it's is inactive, it takes 14 days to activate their membership. The waiting time makes patients unable to access care. There is also one year waiting time policy for patients. All these challenges become barrier for the poor to access care. There are participants who initially joined JKN membership class 1. But after increase of membership fee, they now have outstanding due around 10 million rupiahs that they cannot afford to pay. There are also problems with participants who have inactive NIK data to get JKN membership.	Part of the activities from standardizing care should identify current challenges and compliance to monitor the implementation of clinical guideline through JKN system. This information will become an important input for WB team, particularly on the referral system between primary and secondary care, and clear clinical guideline that become standard of care, as well as tracer to monitor quality of care.

What would be helpful to tackle these challenges? At the moment people are more comfortable filing complaints with CSO. Many time BPJS officers are very strict on regulation and not providing solutions. The JKN's call centre is not accessible for many of the marginalized group. Not everyone knows how to access online registration. The call centre needs to be accessible, responsive and provide solutions. Need third party to help participants in filing complaints.	
Practitioner are facing challenges because many times patients cannot get optimal treatment due to limited payment from JKN. Sometimes doctors would need to discharge the patients and ask them to be readmitted to the hospital in order to strategize around the limited payment. This create complaints to the doctors, while providers see it as actually because the BPJS' system.	
Pregnant women with Dengue infection case. The patients still need treatment, but JKN applies limit of period of care so the patient need to be dismissed with catheter. The patient then got complications from using catheter at home and need to be re-hospitalized. These limitations of care create complications to patients.	

Written input:

- The conditions to register for BPJS-Kesehatan membership needs to be simplified to make it easier for members to apply without citizenship administrative barriers especially for pregnant mothers and newborns, and for membership activation time to not take a long time especially for the poor/vulnerable, and certainly for the members' data security to be better ensured.
- There needs to be a solution for members of BPJS-K from the vulnerable groups with outstanding premium payments, and if there is a transition [of type of membership] from 'independent' to PBI (premium assistance beneficiary) it should not disadvantage the members especially those from vulnerable groups.
- Implementation of the regulation on primary health facilities (FKTP)/hospitals (FKRTL) which still conduct fraud by asking for additional (out-of-pocket) payment for inpatient care or medications to members of BPJS-K.
- Civil society needs to be involved in information dissemination to the community with regards to JKN program, in the form of information media or as a monitoring on the running of public services in health, as well as a media for grievance/complaints from the community (civil society as the media for socialisation, education, and advocacy).