Executive Summary

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

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

Stakeholders defined strategic purchasing for Indonesia as:

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

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

- Strategically decide **what to buy**: which interventions, services, and medicines
- Strategically decide from **whom to buy**: which providers and suppliers of medicines / other commodities
- Strategically deciding **how to buy**: which payment methods, payment rates, other contractual conditions

There are some foundational steps that are pre-conditions for strategic purchasing and that make more sophisticated strategic purchasing approaches possible in the future as systems mature (see Box 1). Strategic purchasing requires that the purchasing functions are distributed appropriately across the institutions involved, and the roles and responsibilities are clear.

The regulations on the institutional roles and functions for JKN are still transitioning and need to be clarified. BPJS-K has responsibility to manage the single pool of funds in JKN, but many purchasing functions and decision-making authority continue to be housed within the Ministry of Health (MOH).

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

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

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BOX 1. FOUNDATIONS OF STRATEGIC HEALTH PURCHASING

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

Summary of the Findings

The review found that the regulatory environment for implementing JKN is dynamic—in terms of and can cause confusion with implementation on the ground. Changes in regulations in terms of their number and revisions reflect the dynamic process in the implementation of JKN. Other issues include overlapping regulations, unclear regulations, and discrepancies between the rules for the central and regional governments. Some consequences of these challenges are summarized below.

OVERALL RESPONSIBILITY FOR HEALTH PURCHASING UNDER JKN

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

The 2004 social security law states that "The Social Security Administering Body (BPJS-K) shall develop a health service system for the members, a service quality control system, and health service payment system to improve the effectiveness and efficiency of health insurance." A 2013 regulation [*Presidential regulation no 111 of 2013*], however, states that BPJS-K should coordinate with "relevant ministries" to develop the technical operation of the health service system, quality control system, and health care payment system to improve the efficiency and effectiveness of the JKN. So the ultimate responsibility for the implementation of JKN is unclear. Furthermore, BPJS-K as a legal public entity reports directly to the President, but its position relative to the MOH (at the same level or under it) has not yet been definedThis lack of clarity and contradiction has prevented BPJS-K from taking on the overall function of health purchasing under JKN.

The key areas where conflicts or overlap in regulations are creating challenges for JKN implementation are summarized below.

Accountability

Although accountability for the implementation of JKN is mentioned throughout the regulations, and it is one of the core principles of the social security law, there are few mechanisms to ensure accountability. Financial accountability is clearly the function of the Audit Board, and some oversight functions are assigned to several ministries and other bodies. But overall, it is not clear which institutions are held accountable for

which outcomes of JKN implementation and whether the responsible institutions have adequate capacity to carry out their functions and ensure accountability. Finally, local governments are accountable for "adequate implementation of JKN implementation," but adequate implementation is not defined and no consequences for non-compliance are specified.

WHAT TO PURCHASE: SERVICE PACKAGES AND REFERRAL POLICY

The JKN entitles participants access to a comprehensive package of necessary health services, including comprehensive primary health care (PHC) and referral services. There is lack of clarity in the JKN law and regulations, however, about authority for setting standards of care for referral services purchased by BPJS-K. Although *Law No 40/2004 Article 24* states it is the role of BPJS-K to establish quality control and cost control systems, implementation is incomplete, and BPJS-K is limited in its ability to enforce some policies.

For example, reducing inappropriate referrals is an important strategic objective for BPJS-K as a purchaser to manage costs and improve quality. There is a tiered referral policy in place that limits referrals according to level of care (e.g. class C hospitals can only accept referrals from primary care providers (PCP); class B hospitals can only accept referrals from Level C hospitals, etc.). In the future, this referral system will move toward competency level of hospitals. But it is unclear to what extent the BPJS-K has the power to enforce the tiered referral policy by, for example, refusing to pay for inappropriate referrals. The MOH also has recently enacted a stricter referral policy, which limits payment for hospital cases that were not referred by the appropriate class of health facility. BPJS-K has begun refusing to pay claims for inappropriate referrals, but this has been challenged by specialists. Furthermore, the lack of availability of certain medicines in *puskesmas* makes it difficult to enforce the referral system consistently. The rate of inappropriate referrals remains high, and BPJS-K found that 1.2 million cases were referred directly to class A hospitals by primary care providers.

The continued high rate of inappropriate referrals is both caused by under-spending in the PHC sector, and continues to exacerbate the imbalance of spending as less than 20% of expenditures by BPJS-K in 2016 went to first-level providers (FKTPs). Inadequate infrastructure and supply of essential medicines at the FKTP level were identified by stakeholders as factors driving referrals.

FROM WHOM TO PURCHASE: SUPPLY-SIDE READINESS, CREDENTIALING AND SELECTIVE CONTRACTING

Strategic purchasing requires adequate service delivery capacity ("supply-side readiness") and effective instruments to select and contract with available providers. The supply-side readiness function is almost entirely the responsibility of local governments in Indonesia. The regulations on the role of local government create a conflicting incentives and priorities for ensuring the effective implementation of JKN within limited resources. There is a highly variable service delivery structure with uneven capacity because of different priorities across local governments, and sometimes a mismatch between investment and the service delivery needs of the population, which has implications for both cost and effectiveness of JKN implementation. There is indication of local governments:

- Redirecting local budget funds to pay JKN premiums as they integrate *Jamkesda* into JKN;
- Reducing budgets for primary health care in response to JKN capitation revenue at the facility level and over-investing in hospitals.
- Not effectively pursuing private sector investment to fill service capacity gaps.

Supply-Side Readiness in Rural and Remote Areas

The geographical conditions in several Indonesian regions create obstacles to implementing JKN, which limits access of JKN participants promised services. Below are problems faced by remote areas and special areas in general:

- Limited fiscal capacity in some regions has limited the infrastructure, supply of health personnel, and availability of health facilities adequately equipped to provide health services as needed by the local population. Regional governments in these areas are often unable to provide sufficient incentives to attract the specialists to work in these places.
- As a result of difficult access/transportation to the health facilities due to poor geographical conditions

and transportation, the populations of these areas are less able to make use of JKN services, although they are equally entitled to services.
- Geographic challenges increase the distribution costs of drugs purchased through e-catalog to the district capital cities. Regional governments have limited budget to absorb the costs of distributing drugs to the regional *puskesmas*.
- Often the drugs needed are not available in e-catalog and the procurement outside of e-catalog is more expensive. As a result, certain drugs are not available at all in some of these areas.
- One of the funding sources which may be optimized is the utilization of compensation funds as regulated under Article 23 paragraph 3 of Law No. 40 of 2004 on SJSN that reads as follows:
- Compensation funds could be an alternative for source of health expenditure in some rural and remote areas with low fiscal capability. The policy on the use of compensation fund has not been further regulated in the lower regulations, however, thus making it difficult to implement. In addition, with the continous deficits of BPJS-K, the compenstion funds may not even be available. In contrasts, many local governments can not absorb their budgets for various reasons.
- Coordination between local governments, national government, and BPJS-K need to be established to overcome access problems in remote areas.

Credentialing and Selective Contracting

To ensure service quality for JKN participants, providers contracted by BPJS-K must meet certain standards (credentialing). The regulations state that credentialing and re-credentialing for facilities to contract with with BPJS-K must use technical criteria, agreed performance assessment, and involve District/ City Health Offices and/or Health Facilities Association. In reality, professional organizations have not been significantly involved in the credentialing process. The JKN credentialing criteria demand accreditation certificates of such health facilities, but until 2017, only 56% of hospitals and about 15% of *puskesmas* contracted by BPJS-K are accredited. The regulations have been amended, and now the accreditation must be accomplished by 2020.

HOW TO PURCHASE: CONTRACTING, PROVIDER PAYMENT AND QUALITY MONITORING

The presidential regulations stipulate that provider payment system development should be carried by the MOH in coordination with BPJS-K. Payment rates should be determined through negotiation between BPJS-K and related associations at the regional level (market region) with reference to the standard tariffs specified by the MOH. [The market region is more important and more flexible compared to the administrative region, since the production costs of providing services may encompass various districts or provices with relative similar costs.] In practice, the MOH retains authority for the function of provider payment policy and rate-setting, while BPJS-K is mainly responsible for paying provider claims.

Capitation payment is used to purchase PHC services from FKTPs (*puskesmas* and private clinics) and case based payment (INA-CBGs) is used to purchase referral services from hospitals under JKN. The capitation rate and INA-CBG tariffs are considered to be low overall, but a more general concern is that the payment systems used to purchase services under JKN are fragmented across different levels of care. There is currently no linkages between capitation for PHC and the INA-CBG payment system for secondary and tertiary services. Furthermore, current JKN purchasing mechanisms do not create a level playing field for private providers and encourage investment. BPJS-K pays the same capitation and INA-CBG rates to both public and private providers, although public providers are highly subsidized by the government for health worker salaries and investment costs which are not counted in payment rates. Private providers also cannot access medicines at favorable prices through e-catalog and are subject to business taxes. If the funds fbwed through APBN and APBD are counted, the current payments to public health care facilities are actualy higher.

Capitation

A number of challenges have been identified in the design and implementation of capitation:

- There are currently no adjustments to capitation for age/sex, geography or other indicators of health need, only supply side variable such as availability

of medical doctor and dentist and 24-hour services are taken into account to a small degree. *MoH Regulation No. 52 of 2016 article 5* set the special capitation tariff for remote areas, but the amount is considered too small as the compensation for the physician practices in remote areas.

- The distribution of registered participants across FKTPs is highly imbalanced. The average ratio of registered JKN participants per doctor in FKTPs is 5,000:1 (which is the target), but the ratio exceeds 8,500:1 for *puskesmas* in 7 provinces. On the other hand, private PHC providers appear to be at a disadvantage in the distribution of participants, with ratios typically below 1:2,500.
- Presidential regulation 32/2014 regulates the utilization of capitation funds, but some regions consider capitation income as a regional income that is utilized in accordance with local policy *puskesmas* are increasingly given discretion to manage their own financial affairs, and a number of the facilities have been converted to BLUD *puskesmas*, which allows them to manage their own finances autonomously. Even in autonomous *puskesmas*, however, the complicated rules on the allocation of capitation revenue have led to low absorption in some cases, with the revenue taken back by the government treasury if it remains unspent at the end of the year.

Performance-based capitation (KBK) for *puskesmas* was implemented in 33 provincial capital cities as part of phased implementation. There has been no evaluation of KBK, so it is not possible to determine whether it has been effective. In the private PCPs, the KBK has been suspended due to lack of supports from the professional association.

INA-CBGs

MOH PPJK, together with BPJS-K, calculates the costs of services in the INA-CBG and sets the hospital tariffs. Since most of the public hospitals, in particular class A and some class B, are owned by the central MOH, there are concerns that the MOH may have con flicting interests in the price-setting. A number of challenges have been identified in the design and implementation of capitation:

- CBG grouping and weights do not adequately capture relative cost differences for different diagnoses and severity of cases. While in many cases the relative tariffs are too low, in some cases (e.g. cataract) the relative tariff is too high.
- Because tariffs are higher for hospitals of higher classes, there are incentives to invest in expensive equipment to upgrade the hospital. If the case groups for the INA-CBGs were technically valid, however, the level of hospital would not need to be part of the tariff, because higher level hospitals would treat more severe cases and automatically receive higher payments.

Monitoring and Quality Assurance

The review showed a duplication in the responsibility for provider monitoring and quality assurance, with ultimate authority over the function residing with the MOH but the data required for adequate provider monitoring are under the control of BPJS-K without clear sharing mechanisms. Both *Presidential Regulation Number 12 of 2013 on Health Care Benefits and Regulation of the Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Article 38* state that BPJS-K is for monitoring provider performance, although the same regulations also give the MOH responsibility for monitoring and quality control, so the institutional responsibility for this function is unclear.

It is unclear whether BPJS-K has the authority to act on findings of the cost and quality control teams, such as from the utilization reviews, and what actions they would be authorized to take. In addition, BPJS-K maintains several data sources, including claims data and P-Care database but these data are not linked or shared for monitoring and evaluation. Routine monitoring system with a standard set of indicators analyzed and reported regularly has not yet been put in place.

Options to Improve Strategic Purchasing Under JKN

The table summarizes key issues and options to improve strategic purchasing of services under JKN.

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

Purchasing Function	Related Regulations	Options for Improvement
Accountability	Law no. 40 on the National Social Security System Law No. 24 of 2011 Chapter VIII Accountability Article 37	• Strengthen accountability with clear definition of which institutions are responsible for which outcomes of JKN implementation. • Clarify the mandate and accountability of BPJS-K as both a health and a finance institution able to purchase health services effectively and efficiently, increasing accountability for access to service by JKN participants, effective and efficient service delivery, quality of care, and cost management. • Establish a routine monitoring system based on a jointly used database of BPJS-K claims data, other MOH service utilization data, and other key indicators and data sources. Strengthen the DJSN mandated role to monitor JKN. • Establish a link between central-level financial transfers to sub-national governments and accountability for JKN implementation.
What to purchase		
Service delivery standards	Law No 40/2004 Article 19 President Regulation number19/2016 article 43 A	Gradually shift authority to BPJS-K to select which service delivery and quality standards (e.g. standard clinical practice guidelines) will be used for purchasing services by regions, even if the agency does not develop them
From whom to purchase		
Supply-side readiness	Law Number 23 year 2014 concerning local government Regulation of Minister of Health No. 71 of 2013	• Establish regional-level joint service delivery planning team including representation of local governments, District Health Offices, professional associations (public and private), and local branches of BPJS-K to discuss service delivery investment needs to meet service delivery standards but in consideration of the budget impact on BPJS-K. • Increase regional commitment to allocate funds used to build adequate health facilities, particularly in rural and remote areas. • When the BPJS-K funding is adequate and deficits are stabilized, improve regulations to allow compensation fund from BPJS-K as an alternative for source of health expenditure in some rural and remote areas with low fiscal capability. • Increase partnerships with the private sector, particularly for rural and remote areas, with the payer for the health care, BPJS-K, as the guarantor.

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

Purchasing Function	Related Regulations	Options for Improvement
How to purchase		
Contracting and provider payment policy	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the selection and development of provider payment systems, and provider rate-setting by regions to consider cost differences. • Explore options to better harmonize between capitation payment for PHC and INA-CBG payment for secondary and tertiary services. • Consider establishing an independent provider payment policy analysis unit to gather cost information, conduct analysis to inform provider payment system design and parameter development, and budget impact analysis (possibly built from the MOH Case Mix Unit and DJSN) Capitation • The capitation rate-setting should be more explicitly linked to the package of services and, include adjustments for geography, the age and sex of registered individuals, and other factors related to health need. • The capitation payment system should be refined to include regulations on the upper and lower limits of ratios of registered participants to full time physicians in a PCP. • The performance-based component of capitation should be evaluated and revised to ensure that the prices and incentives are aligned with quality of service delivered and rural/remote PCPs are not disadvantaged. INA-CBGs • The INA-CBG payment system should be refined to improve alignment between case groups and relative service delivery costs. • The hospital costing system should be evaluated and possibly refined for both public and private hospitals. • In some appropriate regions, consider transitioning the INA-CBG payment system to a budget-neutral payment system (either volume caps, global budget, or adjustable base rate).
Provider autonomy	Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities MOH regulation no 21/2016	Test a capitation waiver that allows *puskesmas* meeting certain criteria to pool revenues from multiple sources (capitation, BOK, local funds, etc.) with increased autonomy for management and allocation of funds. • Set up a district-level platform for communication and monitoring among 4 entities: DHO, BPJS-K, *puskesmas* providers, and local government. • Monitor effects on service delivery.
Provider performance monitoring	Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Articles 33, 37 and 38 Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39	• Improve the P-Care data system and bridge to local data systems to effectively allow PCPs to evaluate their performances for planning, management, and improvement of clinical services and link it to the BPJS-K claims database. • Establish a routine monitoring system within BPJS-K that analyzes and reports on a set of standard indicators related to service delivery and other key JKN outcomes. The monitoring results should be fed back to the health care provider association to improve performance. • Build on the BPJS-K cost and quality control team to build a joint provider monitoring and quality assurance commissions at the district and/or regional level, including representation of the local branch of BPJS-K, DHO, and local government. • Establish the authority of BPJS-K to act on results of the cost and quality control teams utilization reviews, etc. and possible link to financial or other incentives.