HFG INDONESIA
STRATEGIC HEALTH PURCHASING
NOVEMBER 1, 2016 – AUGUST 31, 2017

FINAL REPORT

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The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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HFG INDONESIA STRATEGIC HEALTH PURCHASING (NOVEMBER 2016-AUGUST 2017): FINAL REPORT

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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GLOSSARY

Acronyms	Title
ARSADA	Indonesian Regional Hospital Association
ARSANI	Indonesia Non-Profit Hospital Association
ARSSI	Indonesian Private Hosptial Association
DJSN	National Social Security Council
IAI	Insittute of Indonesia Chartered Accountants
IBI	Indonesian Midwives Association
IDAI	Indonesian Pediatric Society
IDI	Indonesian Medical Association
IPMG	International Pharmaceutical Manufacturers Group
LKPP	Government Procurement Office
MOF	Ministry of Finance
MOH	Ministry of Health
PDGI	Indonesian Dental Association
PDUI	Indonesian General Practitioners Association
PERSI	Indonesian Hospital Association
PMK	Coordination Office for Human Development and Culture
POGI	Indonesian Society of OB-GYNs
POLRI	Indonesian Police
TNI	Indonesian Armed Forces
TNPPK	National Team for Accelerated Poverty Reduction

1. EXECUTIVE SUMMARY

With over 60% of the country's population having coverage under *Jaminan Kesehatan Nasional* (JKN), Indonesia now has one of the largest national health insurance programs in the world, at least in terms of population coverage. However, at present only about 15% of total health expenditures come from JKN and there remains significant co-financing from supply-side budgetary expenditures at public facilities. The government plans for everyone to have coverage under JKN, with universal health coverage (UHC) by 2019 as part of implementation of the Health Social Security Act.

As countries move toward UHC, they are faced with the ongoing challenge of generating sufficient resources to provide access to necessary health services with financial protection and ensuring total expenditures are fiscally sustainable. Making progress toward UHC is costly, particularly as coverage expands to populations with higher health needs, utilization of services increases as financial access barriers are reduced, and available technologies drive up costs further. Countries often face sustainability challenges as expenditures increase faster than revenue allocated to achieving UHC objectives, often very early on in new UHC programs. Indonesia's JKN was launched in 2014 and already encountered deficits in 2016.

Indonesia's movement toward UHC is therefore at a crossroads. The dual challenges of JKN sustainability and ongoing under-investment in the health sector create an urgent need for action to realign revenues and expenditures in the entire health system. There is a "strategic health purchasing imperative" to make better use of existing funds through purchasing levers without eroding effective coverage, even if it is possible to increase revenue and appropriate to introduce some limited cost-sharing.

HFG Strategic Purchasing Support

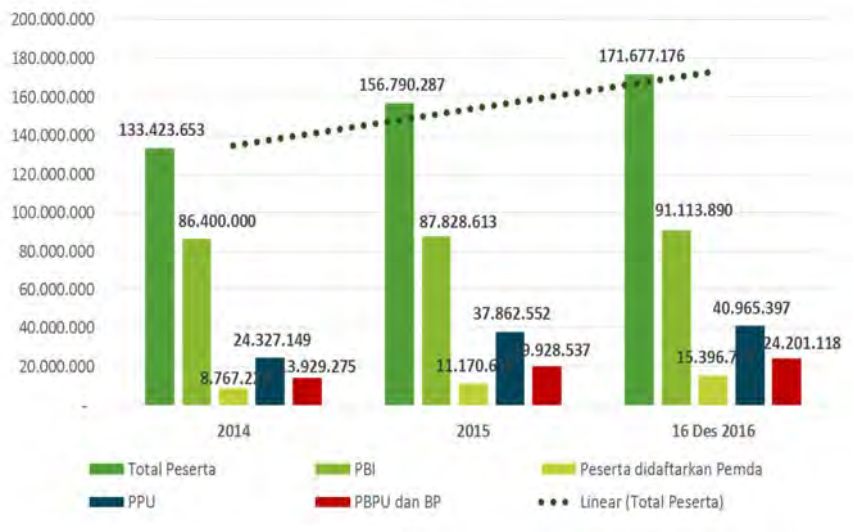
The purpose of HFG Indonesia's work in SHP was to support the National Council for Social Security (DJSN) establish a participatory process, supported by locally driven analytics, to assess the current institutional and regulatory foundation for strategic purchasing under JKN and propose options to improve this foundation as part of an upcoming revision of the presidential decree governing JKN implementation. The activities were implemented through a SHP Technical Working Group (TWG), which was supported by an analytical review of regulations supporting strategic purchasing in JKN completed by a researcher from the University of Gadjah Mada (UGM) and supporting capacity-building sessions for the institutions participating in the TWG.

Main Messages

- **JKN is making progress expanding health coverage for Indonesia's population**

With over 60% 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. More than 170 million Indonesians were covered by JKN by the end of 2016 (Figure 1).

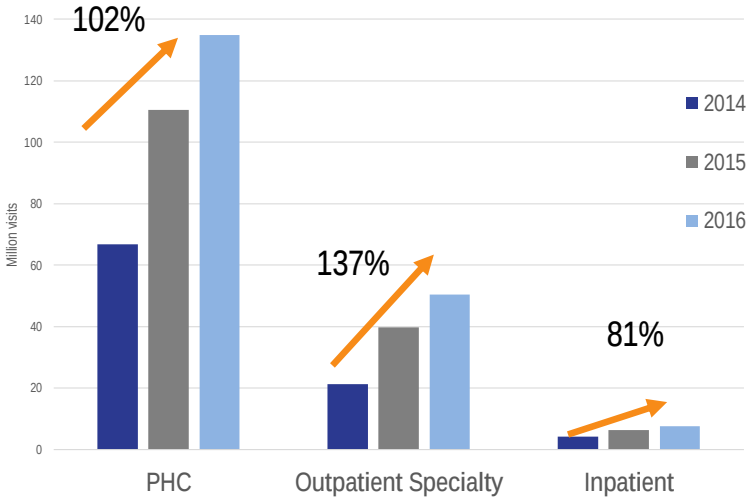
Figure 1. Trends in JKN Coverage



Source: MOF presentation

Increased population coverage has been accompanied by a more than 100% increase in service utilization since JKN began in 2014 (Figure 2).

Figure 2. Trends in JKN Utilization



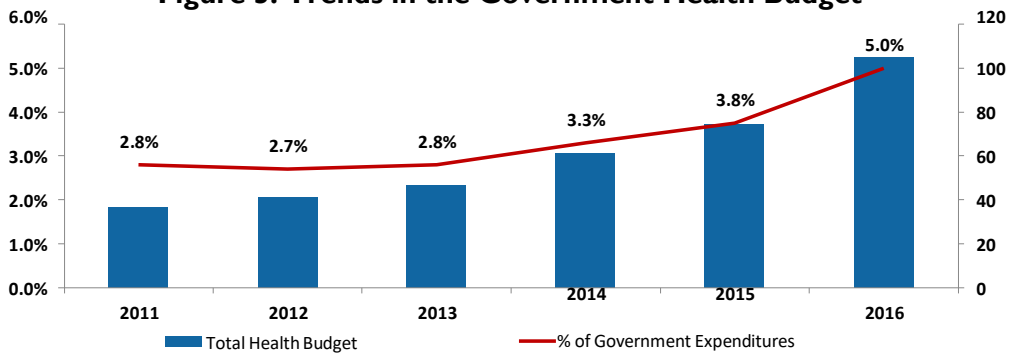
Source: BPJS reports

Although some of the new utilization may be unnecessary, most of the increase utilization is for primary care. Nonetheless, in spite of the emphasis on PHC by the MOH and in JKN, BPJS-K data show that less than 20% of expenditures by BPJS-K in 2016 went toward PHC, with the remaining spent on hospital-based services. Although there is no benchmark for the share of spending on PHC, countries that prioritize PHC in universal health coverage often allocate 25% or more of resources to PHC (e.g. 24% in the U.K., 25% in Vietnam, 28% in Chile, and 38% in Australia).

- **The Government of Indonesia is backing its commitment to JKN with increased public spending**

The health budget increased significantly in 2016 as the Government commitment to meet the mandate of 5% health budget of the total national budget (104.8 T Rp). 58.3 T Rp (55% of the health budget) under MOH's control. 26.1 T Rp (45% of the MOH's budget) allocated for premium for the poor (PBI). The entire government budget faced cuts in 2016, however, so it is not yet clear whether the final allocation to health remained at 5%.

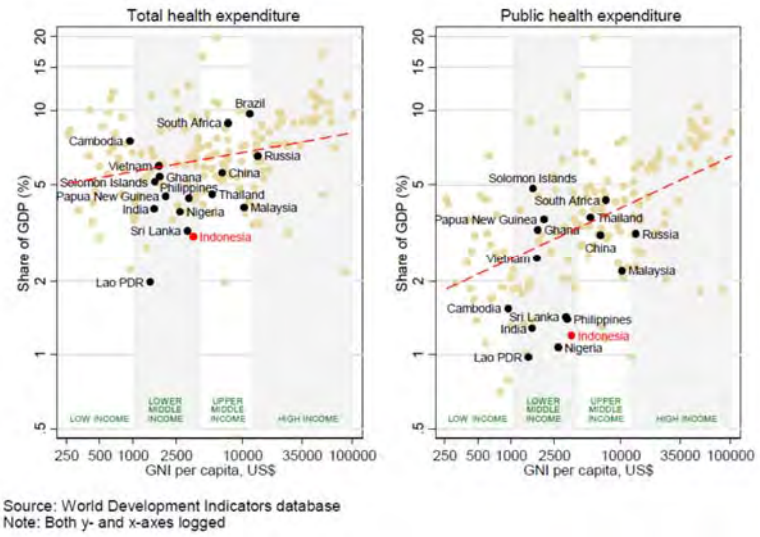
Figure 3. Trends in the Government Health Budget



Source: MOF presentation

- **But public spending on health as a share of GDP remains low in Indonesia by international standards, particularly given the government's commitment to achieving UHC by 2019.**

Figure 4. Health Spending in Indonesia Relative to International Comparisons



Source: World Development Indicators database
Note: Both y- and x-axes logged

Source: World Bank Health Financing System Assessment

- **JKN expenditures are increasing more rapidly than revenues, and financial sustainability has recently emerged as a concern.**

The country faces a tighter macro-fiscal environment on the one hand, versus a growing demand for and utilization of health care on the other.

The GOI should expect that the cost of JKN will continue to increase as coverage expands—so revenue may need to grow over time**.** The main challenge is to get the healthy non-poor contributing into the pool, which will improve revenues relative to costs. Additional general revenue may also be needed to adequately subsidize PBI participants.

But deficits need to be managed mainly on the expenditure side by stabilizing the growth in expenditure per member without limiting access to necessary services or negatively impacting quality**.** The challenge of financial deficits therefore provides the opportunity to focus attention on the value of the money that the GOI is allocating to the JKN program--what services of what quality are being purchased with contributions and the PBI premium, and what health outputs and outcomes can be expected from JKN.

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- **Global experience shows that how the government addresses the current deficits will set the stage for the future ability to expand effective coverage under JKN in a sustainable way.** [1]

Most countries face a similar challenge at this point in the journey to UHC, and they typically have 3 options:

i. increase revenues in the system;
ii. cut costs by limiting coverage, such as reducing the benefits package or increasing cost sharing, or cutting payments to providers; or
iii. increase efficiency in the use of funds through **strategic purchasing** to reduce unproductive cost growth and shift resources to more cost-effective parts of the system. Some combination of the three options is almost always necessary.

Global experience shows that option (i) is limited by the fiscal capacity of the government, [2] and as international experience shows, voluntary contributions rarely contribute significantly to revenue.[3] Relying only on option (ii) will erode coverage and reduce access and financial protection. Therefore, countries find that option (iii) is critical to make better use of existing funds through strategic purchasing levers without eroding effective coverage (even if it is possible to increase revenue).

Countries that are most successful expanding access to services and improving health outcomes within limited funds use the power of the public purchaser to shape the health care market and service delivery system. In these countries the public purchaser strategically purchases services, often from both public

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[1] Maeda A., Araujo E., Cashin C., Harris J., Ikegami N., and Reich M. 2014. *Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies*. Washington, DC: The World Bank.

[2] Cashin, C. 2016. Health financing: the macroeconomic, fiscal and public finance context. Washington, DC: The World Bank.

[3] Kutzin, J., Yip, W. and Cashin, C. (2016) Alternative Financing Strategies for Universal Health Coverage. World Scientific Handbook of Global Health Economics and Public Policy: pp. 267-309.

Box 1. Foundations of Strategic Health Purchasing

Strategic purchasing requires an **institutional home** with authority to carry out purchasing functions. Generally, this is considered the primary payer, although other institutions will likely be responsible for some purchasing functions. In addition, strategic purchasing means being clear and deliberate about what is being purchased, which starts with a well-defined and **explicit 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. Output-based payment 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**.

and private health providers, using deliberate mechanisms to drive high quality, responsive care and efficient service delivery. 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.

- **Countries that most effectively use strategic purchasing give the purchaser the responsibility for key purchasing functions.**

Countries that most effectively use strategic purchasing give the purchaser the responsibility for key purchasing functions, including defining the provider payment methods and rate-setting, provider contracting, and quality monitoring (Figure 5).

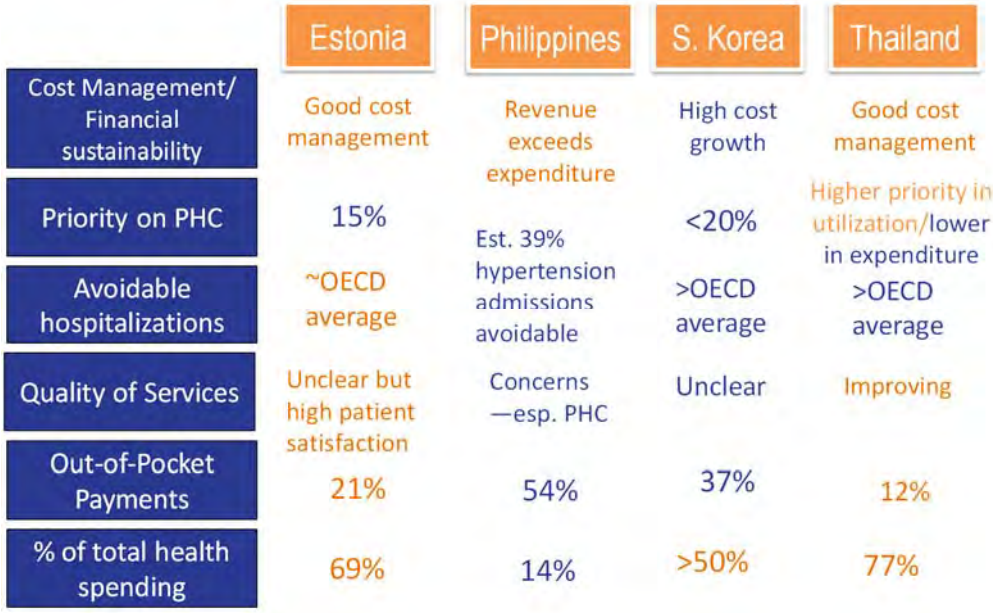
Figure 5. Select Country Experience Allocating Purchasing Functions Between the MOH and Purchasing Agency

In these systems health providers have a high degree of autonomy to manage revenues, make decisions regarding the use of inputs, and make service delivery decisions. The providers are accountable for outputs and outcomes rather than inputs. As the purchasing agency assumes the main purchasing functions, the role of the Ministry of Health typically transitions to one of stewardship, regulation, standard-setting, and monitoring.

- **Effective strategic purchasing can bring improvements in allocative and technical efficiency, quality and financial protection.**

Countries such as Estonia and Thailand that have been most effective at strengthening the role of the strategic purchaser and channeling a large share of health funds through the purchasing agency have **improved cost management and financial sustainability** (measured by cost growth relative to revenue), **efficiency** (as measured by share of utilization and spending on PHC vs. higher cost services), **quality**, and **financial protection** (as measured by share of out-of-pocket payments in total health spending). Countries such as the Philippines and Korea that have not strengthened the role of the purchaser as much or channel a low share of total health funding through the purchasing agency have seen less success on these measures.

Figure 6. Select Country Experience on the Results of Strategic Health Purchasing



- **Better use of health resources through strategic purchasing can ultimately improve health outcomes.**

Better health outcomes are reflected in lower rates of avoidable hospitalization in Estonia and Thailand, as conditions are managed more effectively at the PHC level and increased severity and complications requiring hospitalization are reduced. In spite of relatively low spending on health among OECD countries, Estonia has achieved some of the best outcomes in child health, with one of the lowest infant mortality rates in OECD countries. Strategic health purchasing also has provided the information and platform for Estonia to continuously analyze and improve health financing and service delivery to address new problems, such as the burden of NCDs.

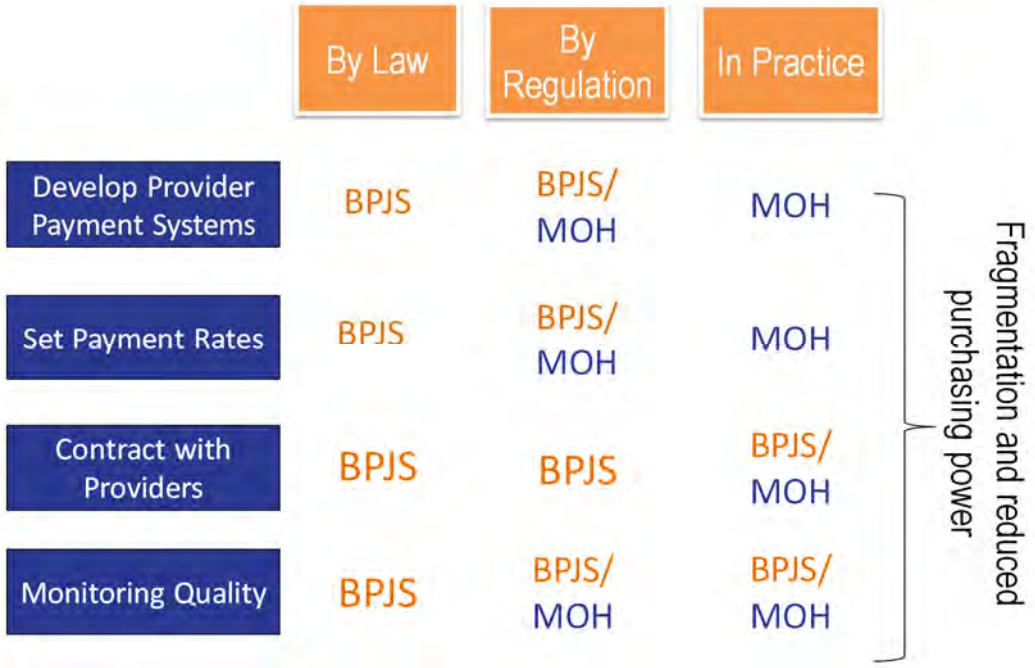
- **The regulations on the institutional roles and functions for JKN related to strategic purchasing are still transitioning, and the power of strategic purchasing remains weak.**

BPJS-K has responsibility to manage the single pool of funds in JKN, but many decisions on purchasing functions continue to be housed within the Ministry of Health (MOH). 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 largely under the control of the Ministry of Health (Figure 7).

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

effective levers to manage that fund, either to manage costs effectively or to use the fund to ensure access to high-quality services for the covered population.

Figure 7. Allocation of purchasing functions in JKN



- **How can strategic purchasing be better leveraged to achieve sustainability of JKN while continuing to improve equity, access to services, and quality of care?**

Strategic purchasing needs to better leveraged in JKN to ensure that funds are used effectively to purchase high-quality services that can address the priority health needs of Indonesians and improve health outcomes. To strengthen the role of strategic health purchasing, and of BPJS-K to play that role, there is a need to:

- strengthen some functions (e.g. accountability)
- possibly reallocate others (shifting responsibility for contracting, provider payment policy and rate-setting largely to BPJS-K), and
- creating better cooperation and shared responsibility for others (e.g. supply side planning and provider performance and quality monitoring).
- Increase the autonomy of public health providers to respond to strategic purchasing incentives by giving them more authority to manage revenues, make decisions regarding the use of inputs, and make service delivery decisions. The providers should be held accountable for outputs and outcomes rather than inputs.

While stakeholders discuss the options for strengthening, redistributing, or better coordinating these functions, better platforms for dialogue, analysis, and joint decision-making should be established. There is also a general need to strengthen the capacity of all institutions to carry out their functions, and clear leadership to manage the shift and strengthen health purchasing functions under JKN, and continue to monitor and evaluate these changes and overall program performance. According to current laws and

regulations, this leadership and oversight role would be the responsibility of DJSN; however, DJSN's power and capacity to carry out this role would need to be strengthened.

- **Indonesia's decentralized context creates special challenges for strategic purchasing that need to be addressed.**

The extent of decentralization in Indonesia means that local governments are not obligated to harmonize their policies, such as investment decisions and health provider remuneration policies, with national policies such as those related to health purchasing. There is a highly variable service delivery structure with uneven capacity, and sometimes a mismatch between investment and the service delivery needs of the population. There is indication of local governments (1) redirecting local budget funds to pay JKN premiums as they integrate Jamkesda into JKN; (2) reducing budgets for primary health care in response to JKN capitation revenue at the facility level; (3) over-investing in hospitals; and (4) not effectively pursuing private sector investment or public-private partnerships to fill capacity gaps. Better mechanisms to share financial risk and ensure accountability between the central and local governments for JKN implementation, and platforms for dialogue and shared decisionmaking need to be established.

2. BACKGROUND AND CONTEXT

As countries move toward UHC, they are faced with the ongoing challenge of generating sufficient resources to provide access to necessary health services with financial protection and ensuring total expenditures are fiscally sustainable. Making progress toward UHC is costly, particularly as coverage expands to populations with higher health needs. Utilization of services increases as financial access barriers are reduced, and available technologies drive up costs further. Countries often face sustainability challenges as expenditures increase faster than revenue allocated to achieving UHC objectives, often very early on in new UHC programs.

With over 60% of the country's population having coverage under *Jaminan Kesehatan Nasional* (JKN), Indonesia now has one of the largest national health insurance programs in the world, at least in terms of population coverage. The government plans for everyone to have coverage under JKN, aiming to achieve universal health coverage (UHC) by 2019 as part of implementation of the Health Social Security Act. Despite recent increases, the level of public financing for health in absolute terms remains low.[4] 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; JKN was launched in 2014 and already encountered deficits in 2016.

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

Furthermore, given that there is general under-investment in the health system in Indonesia, improving efficiency needs to be seen as reallocating spending: shifting unproductive expenditures into higher-priority parts of the system (such as reducing avoidable hospitalization and re-investing savings in primary health care) and generating better value for money (such as through more effective procurement of medicines), rather than simply cutting costs. In fact, under-spending is source of inefficiency itself. There is an understanding that investment is needed on the supply side to make the investment on the demand side productive.

[4] World Bank (2016). Health financing system assessment: Indonesia. Jakarta, Indonesia.

3. STRATEGIC HEALTH PURCHASING ACTIVITY SUMMARY

As part of USAID's ongoing health system strengthening work in Indonesia, the Health Finance and Governance project (HFG) was tasked with supporting the development of a roadmap to improve strategic health purchasing within JKN and across all sources of health financing in Indonesia. This report presents a final narrative summary of the work done from November 2016 until August 2017. The HFG Indonesia Strategic Health Purchasing work was led by Cheryl Cashin, Senior Program Director at the Results for Development Institute (R4D); Chelsea Taylor, R4D Senior Program Officer; Aaron Pervin, R4D Program Officer (from June 2017); and Cynthia Charchi, R4D Senior Program Associate; and supported by a team from Abt Associates.

3.1. Purpose

The purpose of HFG Indonesia's strategic health purchasing work was to support the National Council for Social Security (DJSN) to establish a participatory process, supported by locally driven analytics, to assess the current institutional and regulatory foundation for strategic purchasing under JKN and propose options to improve this foundation. These inputs would contribute to a planned revision to the Presidential Decree governing JKN implementation, expected to be drafted in 2018.

3.2. Activities

HFG supported three streams of work related to strategic health purchasing in Indonesia:

(1) Facilitation of Strategic Health Purchasing Technical Working Group (TWG): HFG supported DJSN to establish and facilitate a working group housed in and chaired by DJSN officials that included technical experts from the Ministry of Health (MOH) Center for Health Financing (PPJK), the health insurance purchasing agency *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), the Ministry of Finance (MOF), private provider associations, and other stakeholders. The TWG identified issues and challenges with institutional roles and relationships related to strategic purchasing under JKN in four key areas: primary health care (PHC), referral services, pharmaceuticals, and special issues of rural and remote areas (Calendar of TWG meetings is presented in Annex 1).

(2) Functional and regulatory review of strategic health purchasing under JKN. The HFG/R4D team developed a matrix for analyzing strategic health purchasing functions (Annex 2), and then engaged a technical team of local consultants from the University of Gadjah Mada (UGM) to support a review of existing legislation and regulations that relate to those functions. Led by Dr. Yulita Hendrartini, the UGM team identified the institutions responsible for carrying out each purchasing function according to the regulations, how the functions should be carried out according to the regulations, how they have been carried out in practice, and whether there are any regulations that are in conflict with one another.

(3) Capacity building for GOI stakeholders: With support from the HFG/R4D technical team, the UGM team developed and delivered targeted half-day sensitization trainings on core strategic health purchasing concepts for GOI stakeholders at various levels. The trainings were conducted both in person and through a UGM virtual platform for the following stakeholder groups: MOH PPJK, MOH program departments, BPJS, MOF, and local government officials. In addition, HFG supported representatives from PPJK to attend strategic purchasing training workshops in Dublin, Cyprus, and Avignon. The project also supported field visits and participation in international meetings for GOI officials, includuing the April 2017 UHC Financing

Forum in Washington, DC, and the World Health Organization's Global Meeting on Strategic Health Purchasing held in Geneva, Switzerland in April 2017.

The HFG/R4D team also collaborated with the Joint Learning Network for UHC to address specific concerns raised by the Indonesian Vice President's office and the National Team for the Acceleration of Poverty Reduction (TNP2K) about the role of local governments in ensuring the sustainability of JKN. The team facilitated a ½-day learning exchange on Strategic Health Purchasing in Decentralized Contexts. Since several countries have identified decentralization as a key challenge to strategic health purchasing and making sustainable progress toward UHC, HFG co-sponsored the learning exchange meeting in Washington in April 2017 with the Joint Learning Network for UHC as part of the World Bank's UHC Financing Forum. Participants from Argentina, Chile, Indonesia and Nigeria discussed how best to allocate health purchasing functions across administrative levels; how to balance financial risk across national, subnational, and health provider levels; and how to ensure accountability across all levels (See Annex 7 for the final report).

3.3. Organization of this report

The final report will present a conceptual overview of strategic health purchasing as defined by the TWG; the methodology HFG used for each stream of work; findings related to the institutional structures for strategic health purchasing under JKN; and findings from "deep dives" analyzing the institutional arrangements for purchasing for primary health care, referral services, medicines, and special issues for rural and remote areas. The final section will present options to improve strategic purchasing under JKN.

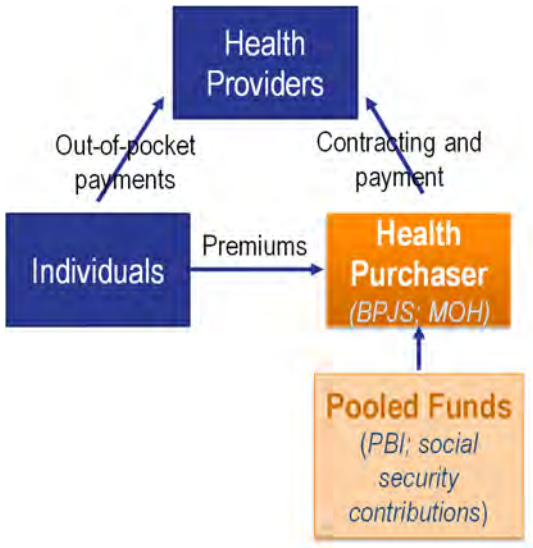
4. OVERVIEW OF STRATEGIC HEALTH PURCHASING

Through TWG consultations, stakeholders defined strategic health purchasing for Indonesia as:

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

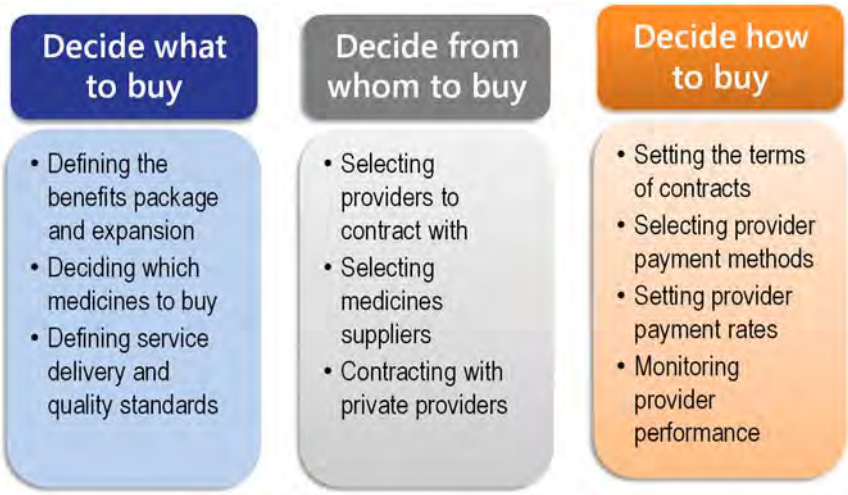
Strategic health purchasing organizes relationships between individuals, health providers, and (typically) a purchasing agency acting on behalf of covered individuals (Figure 7).

Figure 7. Health Purchasing Relationships



It involves three main sets of decisions (Figure 8):[5]

Figure 8. Stategic Health Purchasing Decisions



Examples of deciding "**what to buy**" include considering whether to buy more primary health care vs. expensive tertiary services; specifying quality standards; or buying generic instead of branded drugs. The decision about "**from whom to buy"** might include for example choosing to contract only with accredited providers or with both public and private providers. Deciding "**how to buy**" might entail introducing blended payment methods to establish the right incentives, or setting payment rates to be in line with available resources.

Several foundational steps are pre-conditions for strategic purchasing. These also make more advanced strategic purchasing approaches possible in the future as systems mature. First, strategic purchasing requires an **institutional home** for the purchasing functions, with roles and responsibilities clearly defined to carry out the specific functions (e.g. which institution decides the benefits that will be included in the benefits package, and which institution decides how to pay health care providers). In Indonesia the institutional home for JKN health purchasing is BPJS-K, but some purchasing functions continue to be carried out by the MOH.

Next, strategic purchasing requires being clear and deliberate about what is being purchased. A first step some countries take is to specify **a benefits or essential services package** that the covered population is entitled to receive at an affordable cost**.** Once the service package is defined, the purchaser then pays health providers specifically to deliver these services, which is referred to as **output-based payment**. Output-based payment typically goes hand-in-hand with some form of **contracting** to clarify the obligations of the provider and also the purchaser. Effective output based payment arrangements also require that providers have some **autonomy** to make decisions and

[5] Preker, Alexander S.; Liu, Xingzhu; Velenyi, Edit V.; Baris, Enis. 2007. Public Ends, Private Means : Strategic Purchasing of Health Services. Washington, DC: World Bank. © World Bank. https://openknowledge.worldbank.org/handle/10986/6683 License: CC BY 3.0 IGO.

respond to incentives—they can decide to shift their staff around, for instance. All of this requires new **accountability** measures and better use of **information**.

5. METHODOLOGY FOR THE FUNCTIONAL AND REGULATORY REVIEW

Effective strategic purchasing requires that the purchasing functions are distributed appropriately across the institutions involved, and the roles and responsibilities are clear. The institutional structure for JKN health purchasing – meaning which institutions are performing which health purchasing functions for JKN – is still transitioning from the purchasing arrangements in the previous public insurance schemes and urgently needs to be clarified. BPJS-K has responsibility to manage the single pool of funds in the health insurance system, but many purchasing functions continue to be housed within the Ministry of Health (MOH). This functional and regulatory 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.

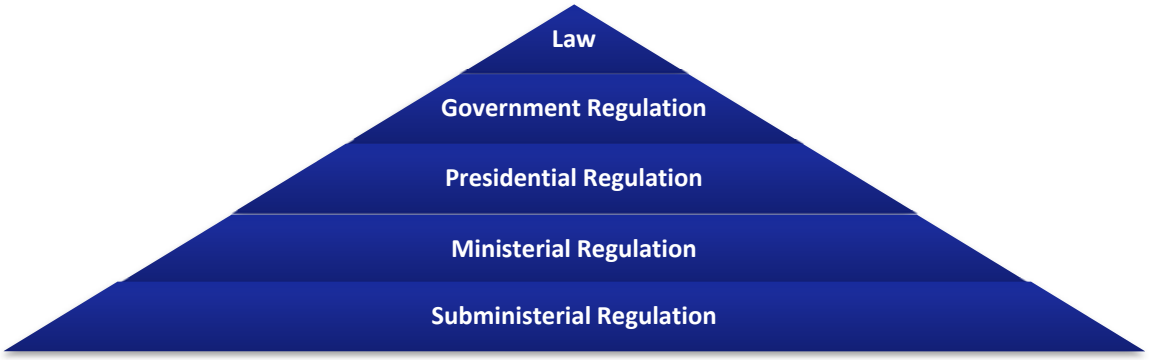
The review was conducted through a desk review of regulations, stakeholder interviews, and TWG meetings. The interviews and meetings solicited feedback on perceptions of whether particular institutions are actually carrying out particular functions, and explored stakeholders' views on the appropriate allocation of functional responsibility across institutions. The review was conducted simultaneously with the TWG process so that institutional relationships could be discussed and the analysis could be validated.

5.1. Review of Regulations

The analysis of health purchasing regulations followed Indonesia's five-level hierarchy for health governance (Figure 9). *De jure* responsibilities were determined through a review of the existing laws and regulations for purchasing. Purchasing regulations for JKN are structured within this hierarchical system, meaning that each regulation is subordinate to other higher-ranking statutory regulations set up by the higher governing agency. Each regulation written by lower agencies must be consistent with the regulations created by the higher authority. A new regulation can be legally recognized if it is not in contradiction to the applicable regulations at higher levels.

Regulations that were analyzed in this regulatory review included regulations that were written into the Indonesian constitution that formed the basis for the overarching JKN law. Subordinate to that were government regulations and then presidential regulations. Ministerial regulations that were analyzed came from the Ministry of Health, Ministry of Finance, and Ministry of Home Affairs. Subministerial regulations that were analyzed were from the primary public health purchaser, BPJS-K.

Figure 9. Hieeirarchy of Indonesia's Health Sector Governance



In addition to the regulations, there are a series of decrees that are issued by different implementing agencies. These are issued at the presidential level and at the agency level. Decrees are akin to policy decisions that are made in the field during the implementation process. The decrees that were part of the regulatory review included decrees at the presidential level and also at the minister level from the Minister of Health, Minister of Social Affairs, and the Minister of Finance.

The final type of regulations are policy rules that can fill in the missing pieces during the implementation of any major social policy. Policy rules are expressed in various forms, such as guidelines, circulars, resolutions, instructions, or announcements. Policy rules that were analyzed were circulars from the Ministry of Health, circulars of the Minstry of Social Affairs, circulars of the Minstry of Home affairs, and circulars from BPJS-K.

In total, HFG reviewed 102 laws, regulations and decrees related to purchasing under JKN (Table 1) constituting the theoretical regulatory framework used to implement the purchasing arrangements within JKN. The complete list of regulations that were analyzed as part of the regulatory review is provided in Appendix 4.

Table 1. Summary of Laws, Regulations and Decrees Related to Purchasing Under JKN

JKN REGULATION	TOTAL
Law on National Social Security System (SJSN) and Law on BPJS	2
Government Regulation	13
Presidential Regulation	12
Minister of Health Regulation	17
Minister of Finance Regulation	2
Minister of Home Affairs Regulation	1
Presidential Decree	5
Minister of Social Affairs Decree	3
Minister of Health Decree	14
Minister of Health Circular Letter	6
Minister of Social Affairs Circular Letter	1
Minister of Home Affairs Circular Letter	1
BPJS Regulation	14
BPJS Board of Directors Regulation	3
BPJS Service Director Circular Letter	1
TOTAL	102

5.2. Technical Working Group Meetings

To further validate and disseminate the findings from the regulatory review, the HFG/R4D team facilitated a series of meetings by the Techincal Working Group on strategic health purchasing. At the suggestion of DJSN the TWG organized their discussion around four strategic purchasing themes:

- Primary health care
- Referral services
- Medicines
- Special issues of rural and remote areas

At each of these meetings, issues related to the topic of the meeting were discussed and current institutional roles were outlined. These roles were then compared to preliminary findings of the regulatory review, and any role that was in contradiction to the regulations were discussed. There were 8 TWG meetings and 3 consultation workshops convened between February and August 2017.

5.3. Capacity Building Workshops

In addition to the Techincal Working Group, the HFG/R4D team facilitated three half-day capacity building workshops for academics, providers, and BPJS-K, and one full-day workshop for stakeholders within the TWG. These workshops were meant to inform and train different communities that generally influence or implement strategic purchasing. Evaluations of the capacity building workshops and their Kirkpatrick participation scores are provided in appendix 7.

Table 2. Summary of Capacity-Building Sessions

Date	Location	Participants
May 23, 2017	Secretariat DJSN-UGM	Researchers/Academia
May 23, 2017	Secretariat DJSN	Medical Health Providers
June 7, 2017	BPJS Center Hall	BPJS
July 25, 2017	Secretariat DJSN	Government purchasing stakeholders

6. RESULTS FROM THE FUNCTIONAL AND REGULATORY REVIEW

The review examined the allocation of 17 purchasing functions covered by the laws and regulations of Indonesia related to JKN implementation (Figure 10).[6] The purchasing functions were **grouped and color-coded** to facilitate analysis of how they are distributed across the responsible institutions: DJSN, BPJS-K, Ministry of Health (MOH), Ministry of Finance (MOF), Ministry of Social Affairs, Ministry of Home Affairs, and local governments. The pie charts are made up of equal-sized slices for each function the institution is responsible to carry out, so larger slices of one color indicate that there are multiple sub-functions.

Figure 10. Strategic Health Purchasing Functions

Governance and Accountability	Governance
	Accountability
Benefits and entitlement	Benefits design
	Decisions on adding new services/medicines
	Enrollment and entitlement
Financing	Budget
	Revenue collection
	Investment and fund management
Service delivery	Supply side planning and investment
	Health workforce planning and management
	Service delivery management
	Public health and prevention
	Gate-keeping and referral system
Contracting and provider payment	Provider payment selection and design
	Payment rate-setting
	Selective contracting
	Making payments to providers
Monitoring	System-level monitoring
	Monitoring provider performance
	Information management

6.1. Distribution of Functions

6.1.1. DJSN

DJSN is a council formed by the SJSN Law responsible for formulating general policy and synchronizing JKN implementation. DJSN has overall supervisory authority over the implementation of JKN and the operations of BPJS-K, although the MOH has authority over the supervisory team for monitoring and

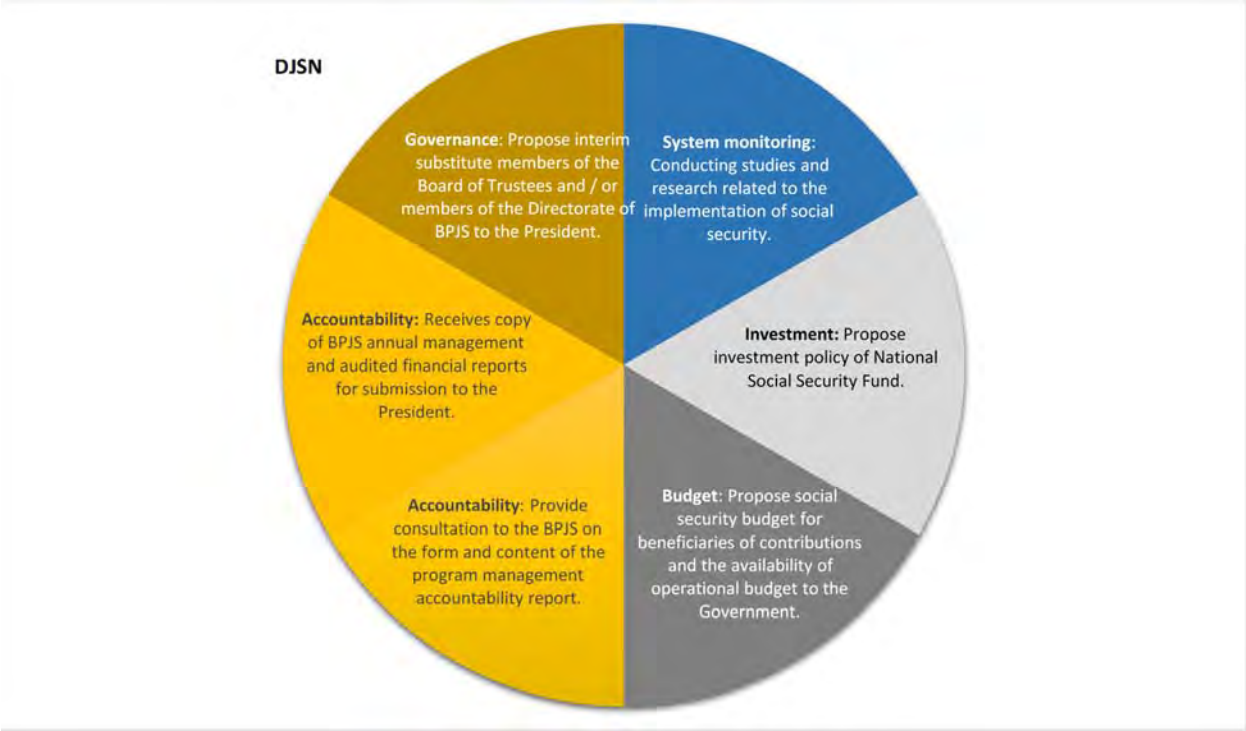
[6] The methodology for the review and the functional matrix used for data collection and analysis were developed by the authors using as a reference Preker et al. (2007) and Figeras, J., Robinson R., and Jakubowski E., eds. (2005) *Purchasing to Improve Health System Performance,* Eureopean Observatory on Health Systems and Policies.

evaluation of JKN. DJSN also has responsibility for contributing to budget proposals and the investment plan of the National Social Security Fund.

Specificly DJSN is tasked with:

1) Conducting studies and research related to the implementation of social security.
2) Proposing the investment policy of the National Social Security Fund.
3) Proposing the social security budget for beneficiary contributions and the availability of operational budget to the Government.
4) Providing consultation to BPJS on the form and content of the program management accountability report.
5) Receiving a copy of annual management reports and annual financial reports audited by a public accountant for the submission of annual accountability of BPJS to the President.
6) Submitting to the President the proposal of interim substitute members of the Board of Trustees and/or members of the Directorate of BPJS.

Figure 11. DJSN Purchasing Functions



6.1.2. BPJS-K

This instution is a legal entity formed by Indonesian Law number 24/2011 to organize the health insurance program. By regulation, BPJS-K is not under the Ministry of Health but directly responsible to the President. In order to implement the function as the organizer of the social health insurance program for the entire population of Indonesia, BPJS-K is responsible to:

1) Receive registration of JKN participants
2) Collect JKN contributions from participants, employers and governments

3) Receive donations from the government
4) Manage Social Security Funds for the benefit of participants
5) Collect and managing data of JKN participants
6) Pay benefits and finance health services in accordance with the provisions of the Social Security program
7) Provide information on the implementation of social security programs to participants and the Community

According to the original legislation, BPJS-K has responsibility for the main purchasing functions under JKN, but more recent regulations make that unclear, and the MOH has retained many functions that would be considered the responsibility of the health purchasing agency (see section below). BPJS-K has the responsibility to enroll members and initially assign them to a PHC provider for the gate-keeping function, after which members are free to choose their PHC provider. BPJS-K is responsible for the function of selective contracting with providers according to technical criteria established by the MOH and taking into consideration access to services by the population. The technical criteria include availability of human resources, infrastructure and facilities, and scope of services available. BPJS-K does not have the authority to specify certain terms of the contract, such as reporting requirements, which are specified by the MOH.

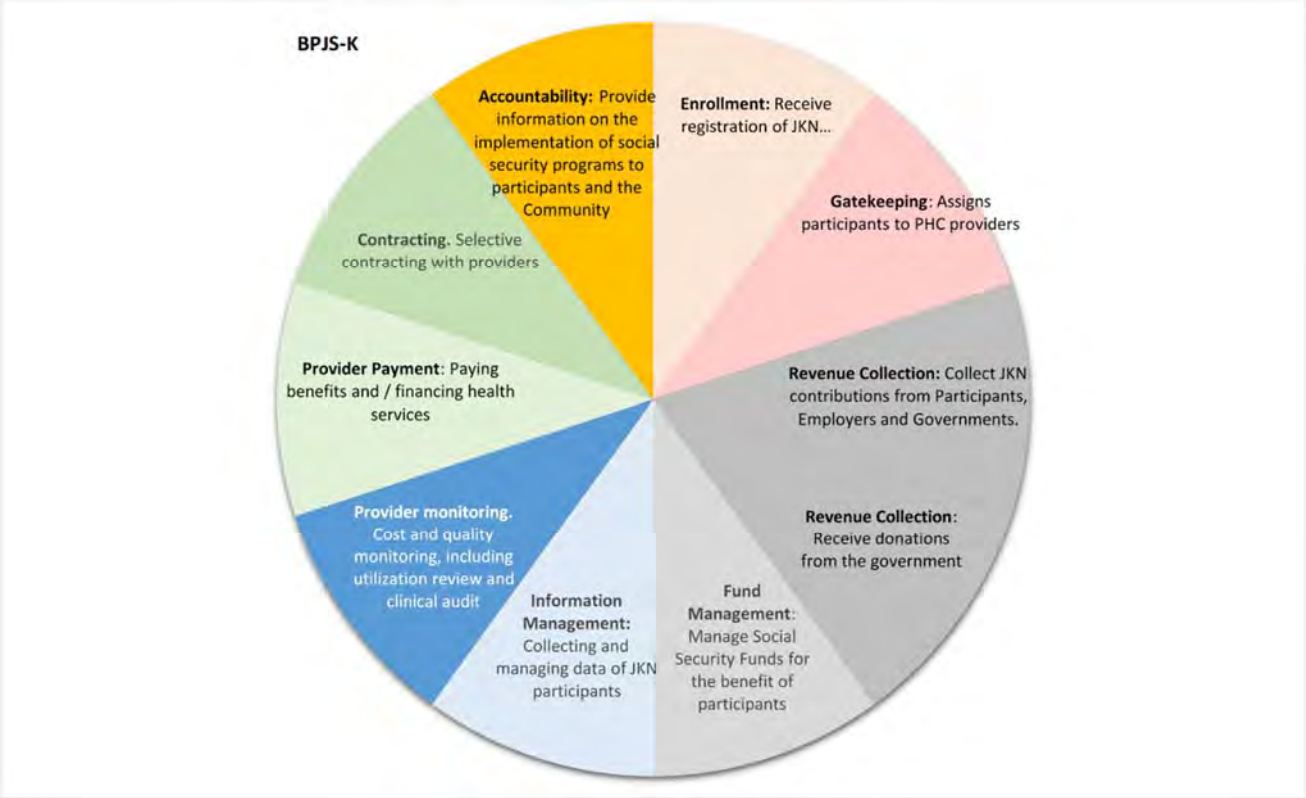
Law No 40/2004 Article 24 states that BPJS-K is responsible for implementing quality control and cost control systems; the role of MOH is to support hospital accreditation; and the role of local government is to contribute incentive payments for specialized physicians. The role of BPJS to establish quality and service delivery standards, however, has not yet been operationalized.

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

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

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

Figure 11. BPJS-K Purchasing Functions



6.1.3. Ministry of Health

According to current regulations, the MOH retains the majority of health system functions, including most of those related to strategic purchasing. The Ministry of Health is tasked with the following functions under JKN:

1. Delivering the budget proposal for premiums for subsidized beneficiaries (PBI JK) to the Ministry of Finance (MoF) based on the DJSN proposal.
2. Registering the numbers of PBI participants with BPJS-K
3. Imposing written warning sanctions to the members of the Board or the Directors of BPJS
4. Providing advice to the president in the case of suspension sanctions and/or fixed sanction to the members of the supervisory Board and chef Director of Health BPJS
5. Managing the types of health services guaranteed by JKN
6. Organizing the types and the platform of health equipment prices
7. Regulating the JKN compensation that should be provided to the participants of BPJS-K
8. Ensuring quality and cost control through:
    a) Health technology assessment;
    b) Clinical consideration (clinical advisory);
    c) Standard fare calculation, and d. monitoring and evaluation of the performance of health insurance services.

9. Assigning other guaranteed health services based on the health technology assessment with the consideration of the contribution adequacy, after coordination with the Ministry of Finance
10. Specifying the cost of health services in the event of unexpected avoidable (preventable adverse events).
11. Specifying the drugs services, medical equipment, and medical consumable materials in a transparent and accountable way by the national committee. For insured participants, establishing the price of medicines, medical equipment, and consumable medical materials.
12. Reviewing the non-capitation and capitation, Indonesian Case-Based Groups (INA-CBGs) and non-Indonesian Case-Based Groups (non-INA CBGs) at least every two years, along with BPJS-K, DJSN, and the Ministry of Finance
13. Coordinating with BPJS-K to develop the technical operation of the health care system, quality control system, and health care payment system to improve the efficiency and effectiveness of health insurance.
14. Regulating the fraud prevention system in JKN
15. Regulating JKN compensation for the participants
16. Coordinating with DJSN to perform monoitoring and evaluation of health insurance implementation

The MOH has the mandate to protect the health of the population, set clinical standards, and regulate the benefits package under JKN. The MOH is responsible for quality and cost control together with BPJS-K and is authorized to use a number of instruments to carry out this function, including health technology assessment, establishing a clinical advisory board to resolve clinical disputes, standard payment rate calculations, and monitoring and evaluation of health services to ensure compliance with medical service standards specified by the Minister.

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

- Specifying the technical criteria for health facilities contracting with BPJS-K (credentialing) [Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities with BPJS Healthcare Section Two Article 9]
- Specifying the data reporting requirements in BPJS-K contracts [Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39]
- Developing provider payment systems and setting payment rates [Regulation of Minister of Health Number 69 on Health Services Standard Rates at First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation]
- The MOH also has the authority to regulate how public primary health care facilities use the funds they receive from BPJS-K for capitation payment [*Regulations of Minister of Health Number 19 of 2014 and 21 of 2016*]. These regulations specify the role of the District Health Office in implementing JKN, and in particular guidelines on the utilization of capitation funds and the proportion of the capitation payment to providers that can be allocated for operational costs and staff incentives, procurement of drugs, medical equipment, and consumables.

Figure 12. MOH Purchasing Functions

6.1.4. Ministry of Finance

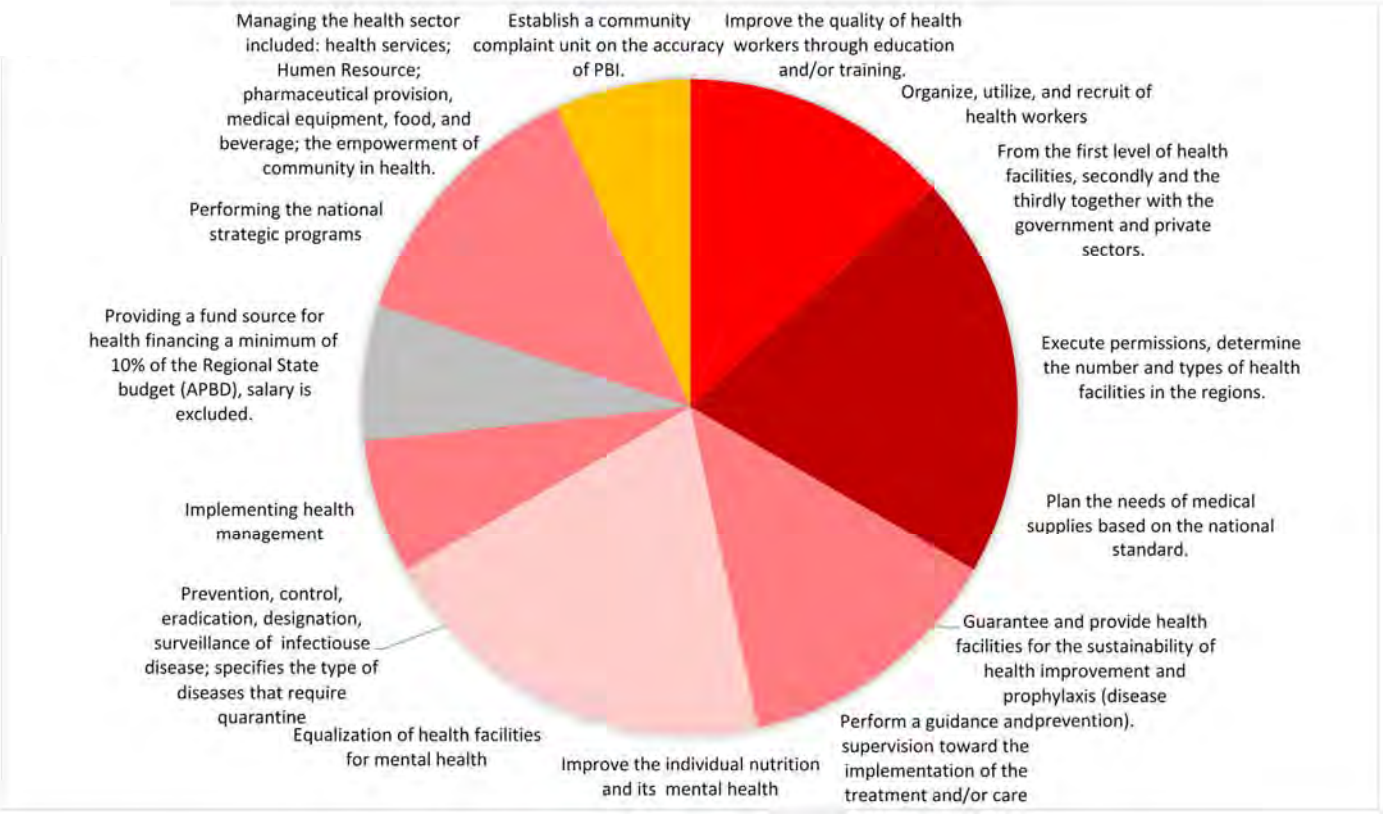
The Ministry of Finance has the main responsibility for oversight of transfer of contributions from the various funding sources for JKN, including the national budget, local budgets, and employers. The Ministry of Finance also provides management and oversight for the asset and fund management of BPJS-K.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

1. Regulating the contributions of employers for the local government from the state treasury account to the BPJS
2. Governing the provision, disbursement, and accountability of health insurance contributions from the State Budget (APBN).
3. Regulating the depositing of health insurance contributions from civil servants, government employee non-civil servant, and individuals all together with the Ministry of Home Affairs based on their authority.
4. Providing start-up capital to BPJS
5. Determining the percentage of revenues that can be used for BPJS operation
6. Specifying the standard of asset fund of BPJS.

6.1.5. Local Governments

Local (district and provincial) governments have full responsibility for service delivery and investment decisions on the supply side, as well as public health and prevention activities. There is some lack of clarity on setting provider remuneration rates, where the local government has some authority, as well as the rules for how providers can use JKN funds.

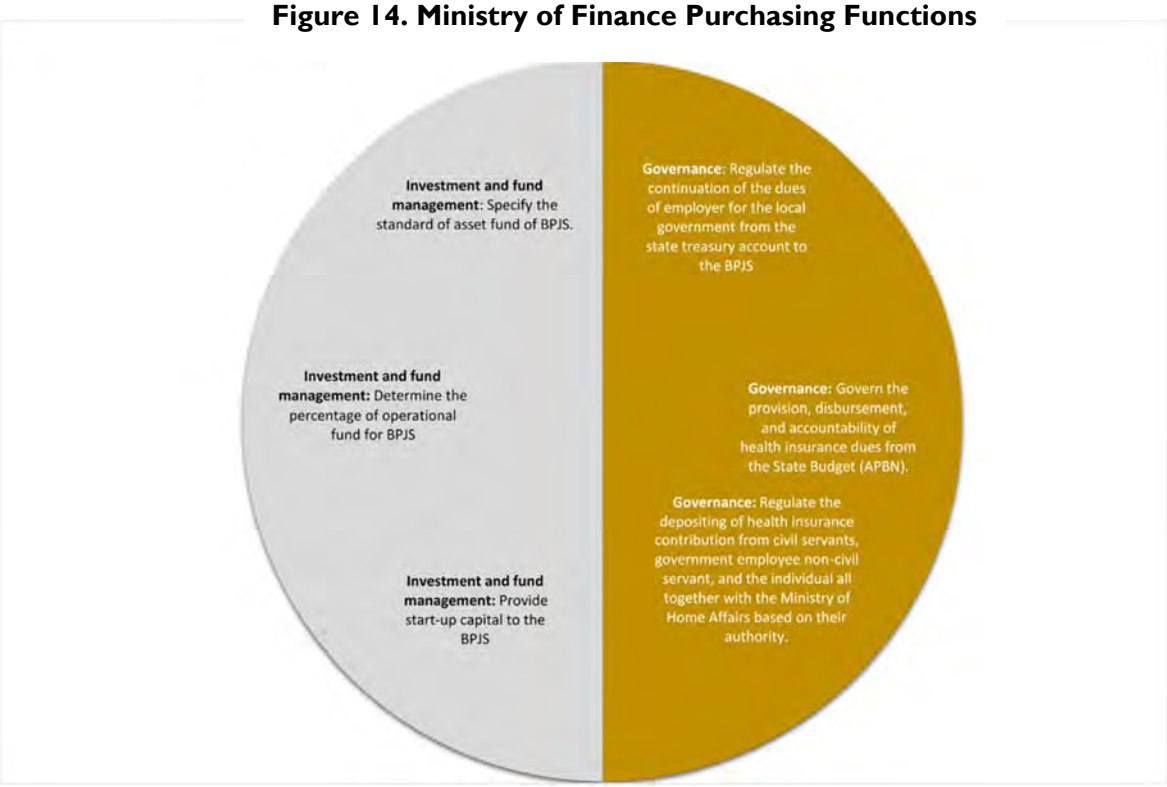
Figure 13. Local Government Purchasing Functions



6.1.6. Other Ministries

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

Figure 14. Ministry of Finance Purchasing Functions



6.2. Deep-Dive Analyses: Purchasing PHC, Referral Services and Medicines

6.2.1. PHC

JKN entitles participants access to a comprehensive package of necessary health services, including comprehensive PHC. The PHC service package is further defined by the MOH in terms of minimum service standards for health care in "first level health facilities" (FKTPs). These minimum service standards include 144 competencies (services) that public primary care facilities, known as *puskesmas,* must provide. A new MOH program makes local governments accountable for 12 new minimum service standards for promotion and prevention programs related to conditions such as mental health, hypertension, diabetes, tuberculosis (TB) and HIV. These services are intended to be complementary to JKN and help reduce the need for curative services.

There is a gatekeeping policy in place in Indonesia that regulates how patients can be referred to different levels of the health system. 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. There is also a back-referral system from hospital to primary care. Unfortunately, the system is not running well largely due to the lack of availability of certain medicines in *puskesmas*.

The MOH has broad responsibility to strengthen the foundation of preventive and promotive care to reduce the burden of chronic disease. This promotive-preventive program is considered the foundation of health development, community empowerment and engagement in health promotion across sectors. This program also aims to reduce high-cost catastrophic illness events in JKN. The MOH is also responsible for strengthening capacity at the primary care level, optimizing the referral system, and

improving quality. District Health Offices supervise *puskesmas* and also have some role in operational arrangements. According to the *Indonesian Law on Regional Autonomy*, local governments have the responsibility to ensure the infrastructure is adequate to deliver guaranteed PHC services.

BPJS-K contracts with health providers that meet the criteria for credentialing specified by the MOH. The purpose of credentialing is to improve the availability and accessibility of health facilities as well as to standardize health facilities' quality. As part of their role in ensuring the quality of primary care services, District Health Offices collaborate with BPJS Health to do the credentialing for public PHC providers. Some challenges to credentialing and selective contracting by BPJS-K have emerged in practice, include uneven distribution of health personnel and health facilities, particularly in remote and very remote areas. In more remote areas, FKTP facilities and infrastructure are often insufficient, and there is wide variability in FKTPs' capability to thoroughly manage non-specialist cases.

Although many stakeholders agree that private providers need to be better engaged via BPJS-K contracting to help close supply-side gaps, private providers argue that they are not included actively in the credentialing process to ensure that private FKTPs and individual doctors have the opportunity to contract with BPJS-K. Some stakeholders noted that the role of private providers is not addressed in the laws and regulations governing JKN and BPJS-K, which may at least partially explain the lack a formal role for private professional associations and FKTPs in the credentialing process.

BPJS-K contracts with selected FKTPs and pays them to provide the PHC package of services using capitation payment (a fixed payment each month for each person registered with the clinic). Obstetric and neonatal services, such as antenatal care, normal delivery and services for family planning programs, are not paid by capitation but rather by fee-for-service. The capitation rate is considered to be low and based only on the cost of staff without relation to service needs, particularly for private clinics. There are currently no adjustments for age, sex or other indicators of health need; the only adjustments made are for supply-side variables such as availability of medical doctors and dentists and 24-hour services. *MoH Regulation No. 52 of 2016 article 5* set the special capitation tariff for remote areas, but the amount is considered too low to compensate physician practices in remote areas. Private providers complain that they are disadvantaged by capitation because their costs are inherently higher than those of public facilities, because unlike public providers, they cannot access medicines at favorable prices through the government procurement system and they do not have tax exempt status.

There are concerns that the distribution of registered participants across FKTPs is highly imbalanced. Although the average ratio of registered JKN participants per doctor in FKTPs is 5,000:1, which is the target, the ratio exceeds 8,500:1 for *puskesmas* in 7 provinces (Figure 2). On the other hand, FKTPs that are not *puskesmas* have much lower ratios, typically below 1:2,500. Private providers in particular appear to be at a disadvantage in the distribution of participants with low enrollment leading to low revenue.

A more general concern with all of the payment systems used to purchase services under JKN is that they are fragmented across different levels of care. There are no linkages between capitation for PHC and the INA-CBG payment system for secondary and tertiary services.

In 2016 the MOH and BPJS-K agreed to add a performance-based element to capitation payment, known as Capitation Based on Service Commitments (KBKP). KBKP was started in 33 provincial capital cities as part of phased implementation. Under KBKP, the final portion of capitation payment to a FKTP is based on performance against 4 indicators that are self-reported through P-Care:

(1) Contact rate (target=15/1,000 members per month)
(2) Referral rate

(3) Chronic Disease Management Program (*Prolanis*): prevention for NCDs following protocol

In 2017 the implementation of KBKP is being expanded in health centers outside the capital of the province, an indicator related to home visits will be added, and private FKTPs will be included although private provider associations complain that they have not been involved in any of the process of determining performance indicators and targets. KBKP has not been properly monitored and evaluated, the results of which could be used to improve the program.

The capitation payment is paid directly to private primary care clinics and *puskesmas* that have bank accounts in the local treasury system. The use of the capitation revenue is restricted, with 11 different regulations governing how *puskesmas* revenue can be used. In general, up to 40% can be designated for operational expenditures (e.g. supplies) and 60% or more must be used to pay fees directly to health workers.

The utilization of capitation funds paid by BPJS-K to *puskesmas* or District Offices is regulated by *Presidential Regulation: 32/2014*, but some regions consider capitation to be regional income that can be utilized according to local policy. *Puskesmas* are increasingly given discretion to manage their own financial affairs, and a number of the facilities have been converted to BLUD (Financially Autonomous) *Puskesmas*, which allows them to manage their own finances. Local governments have also been advised not to overly exploit *Puskesmas* for revenue purposes. According to *Presidential Regulation No. 32* even if a *Puskesmas* has not been converted to BLUD status, the capitation funds no longer go to the local treasury but directly to *Puskesmas* account. However, they still need approval for spending the money held in the local treasury.

Even in autonomous *Puskesmas*, 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. There is also a heavy administrative burden for the reporting of expenditures. There are different treasury accounts for each funding source (e.g. JKN, MOH budget, local government, Jamkesda) and different financial reports for each account. A different health facility staff member has to complete the financial report for each account, so clinical staff spend a significant amount of time on financial reporting.

In spite of strong policies in support of PHC in the MOH and JKN, challenges continue with unequal access to primary-level clinics that meet service delivery standards and low priority for PHC in total BPJS-K spending. In spite of the emphasis on PHC by the MOH and in JKN, BPJS-K data show that less than 20% of expenditures by BPJS-K in 2016 went toward PHC, with the remaining spent on hospital-based services. Utilization of PHC has increased under JKN, but outpatient specialty care utilization has increased at a faster rate. As FKTP utilization has increased, the gate-keeping policy has been difficult to enforce, which keeps the share of total expenditure on referral services high.

6.2.2. Referral Services

The health system in Indonesia has clearly defined classes of hospitals that form the basis for a tiered referral system. The tiered referral policy that limits referrals according to level of care (e.g. Level C hospitals can only accept referrals from *puskesmas*; Level B hospitals can only accept referrals from Level C hospitals, etc.). Inappropriate referrals are not supposed to be paid for by BPJS-K, although it is not clear how effectively this policy is being enforced. Some stakeholders note that the policy is discouraging inappropriate referrals in some cases. For example, the national referral hospital noted a steep decline in lower severity cases, which is likely to be a more appropriate case mix for that level, but there is also now less opportunity to cross-subsidize more costly cases with excess revenue from simpler cases.

Nonetheless, BPJS-K found that 1.2 million cases were referred directly to Type A hospitals by *puskesmas*.

Local governments have the overall responsibility to ensure there is adequate infrastructure to supply the referral services covered by JKN. The licensing of private hospitals has also been decentralized, with subnational authorities responsible for issuing two-year licenses, according to standards set by the MOH. The MOH Directorate of Referral Services of the Ministry of Health also provides an overall roadmap for ensuring that there is a match between supply and demand of health services. Mismatch between supply and demand for JKN referral services continues, however, with under-supply in many rural and remote areas. On the other side, there can be over-supply of higher level facilities when investment decisions are made at the local level that are based on political pressures rather than an assessment of service need. As with primary care clinics, BPJS-K contracts with referral hospitals that meet the criteria for credentialing specified by the MOH. These supply-side decisions also affect the costs to BPJS-K, because the agency is obligated to contract with all public facilities that meet credentialing criteria and when a hospital is upgraded to a higher level BPJS-K is obligated to pay higher tariffs.

Presidential Regulation number 12 year 2013 states that BPJS-K should pay referral facilities based on *Indonesian Case Base Groups* (INA-CBGs), with the INA-CBG tariffs reviewed at least every two years by MOH in coordination with the Finance Minister. In practice, the MOH sets the INA-CBG tariffs based on input from the National Casemix Center within PPJK. BPJS-K and professional associations have not been significantly involved in tariff calculations. Since most of the public hospitals, in particular type A and some type B hospitals, are owned by the central MOH, the MOH may have conflicting interests in the price-setting.

There are many challenges with the current INA-CBG payment system that have limited its effectiveness for strategic purchasing. The INA-CBG payment system consists of several components that are inter-related. The first component is the set of case groups that organize diagnoses into groups for payment. The case groups relate to the service output, the clinical pathway, and coding. A separate component is based on costing that assigns a weight and any accompanying tariff to each case group.

In addition to the payment rates (tariffs) being considered to be low overall, representatives from hospitals and hospital associations noted that the grouping and weights are inadequate to capture actual relative cost differences. The INA-CBG tariffs are adjusted by the class of hospital, based on a review of the average cost-per case discharged from the hospitals in that class obtained from costing exercises across several hospitals. Under the JKN program, the tariffs of specialty hospitals are differentiated from non-specialty hospitals. There are a number of inconsistencies in the regulations on classification and tariff calculations for specialty hospitals that create confusion and lack of transparency. 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. There are incentives to invest in expensive equipment to upgrade hospitals to a higher classification to receive higher tariff payments. On the other hand, it may be appropriate to differentiate INA-CBG tariffs by region because of Indonesia's geographic diversity, but this has not been done.

The INA-CBG system also disadvantages private hospitals. BPJS-K pays the same INA-CBG rates to both public and private providers, although public providers are highly subsidized by the government, which covers health worker salaries and investment costs. Furthermore, private providers complain that unlike public providers, they cannot access medicines at favorable prices through the government procurement system. Some private, not-for-profit hospitals are forming networks to be able to negotiate better prices for medicines. Private hospitals are at a further disadvantage as they are taxed as business enterprises. The MOH has raised the issue of tax exemption status for private hospitals, but it has not yet been addressed.

BPJS-K should monitor quality through cost and quality control teams (*Tim Kendali Mutu dan Biaya*--TKMKB) made up of representatives of professional organizations, academicians, and clinical experts. BPJS-K also periodically conducts claims audits with agreement of all parties involved. The auditors come from the Financial Services Authority (OJK), Financial Examination Agency (BPK), Corruption Eradication Committee (KPK), Public Accountant Office (KAP), as well as internal auditors of the hospital and BPJS-K.

6.2.3. Medicines

Medicines are a key part of JKN entitlements, and the arrangements for procurement and delivery of drugs is a critical aspect of strategic purchasing under JKN. More than 50 percent of total BPJS-K payments to health facilities are for medicines. The large list of regulations and lack of clarity in responsibilities greatly limits the ability of BPJS-K to ensure strategic purchasing of medicines (Table 3). The MOH and district health offices are responsible for managing the entire drug supply and pricing system, especially for the JKN benefit package. In particular, the MOH has the important role of establishing the national formulary for Indonesia. By design, thenational formulary was set to ensure the effectiveness of drugs and guidelines for drug utilization for all relevant indications. In addition, the MOH is also responsible for preparing the list of essential drugs needed for JKN implementation and providing that list to the drug procurement agency (LKPP).

Table 3. Regulations Related to Drug Pricing and Procurment

No	Regulation	Article	Content
1	President Regulation: 70/2012		Procurement guideline for government agency (e-catalog)
2	President Regulation: 19/2016	Article 32 A	The Government and Local Government are responsible to the availability of drugs in the JKN
3	MoH Regulation: 63/2014	Article 3	All units in health sector at both central and regional; both public primary and referral care facility should implement the drugs procurement through E-Purchasing based on the electronic catalog (E-Catalog) in accordance to the regulation
4	MoH Regulation: 63/2014	(access to drugs purchasing)	Both private hospital and primary care facility which cooperate with BPJS Health can perform the procurement of drugs based on Electronic catalogue (E-Catalogue).
5	MoH Regulation: 71/2013	Article 36	Monitoring and evaluation of drug usage, medical devices and medical supplies by BPJS and Healthcare Facility
6	MoH Regulation: 9/2014		Private clinics which organize the pharmaceutical services must have a licensed pharmacist
7	MoH Regulation: 52/2011		n case of remote areas where there is no pharmacist, doctors or dentists who already have a Registration Certificate have the authority for dispensing medicine.
8	President Regulation: 111/2013	Article 32	Before stipulated by the Minister of health, the list and price of medicines, medical devices and medical consumables as referred to in paragraph (1) shall be prepared in a transparent and accountable manner by the national committee.
9	President Regulation: 19/2016	Article 46	Minister of Health, Head of Provincial-District Health Office, supervise the implementation of JKN program in accordance with their respective authorities

LKPP has the responsibility to organize the e-catalog for drugs procurement. The e-catalog is established for any government procurement, not only drugs but also general devices, office supplies, and even vehicles. Thus, LKPP has a crucial role to allow e-purchasing which should be accessible by health facilities. Under JKN, e-catalog is employed to organize all drug procurement, even though it is still restricted to government institutions, such as puskesmas, the district health office or public hospitals.

Some challenges limit strategic purchasing of medicines under JKN. First, although the Indonesian Law for SJSN stated that BPJS-Kesehatan as a purchaser should have important role in negotiations for drug prices and procurement, the role of BPJS-K in the national formulary committee is not clear. Moreover, in terms of the drugs management at the health facility level, BPJS-K is responsible for developing the regulation of drugs for back-referrals (chronic disease management drug program). Back-referral drugs are often not available in primary care facilities or partner pharmacies, however, causing the back-referral program to not work well.

Second, although e-catalog should facilitate strategic purchasing of medicines, shortcomings in the system have limited its effectiveness. The regulation that district health offices should only buy drugs through e-catalog is not always feasible to follow, since not all of the drugs in national formulary are available in e-catalog so government agencies responsible for procurement are often forced to purchase drugs that are in e-catalog but not on the formulary and may not be the most cost-effective option. Local governments can issue regulations that allow the purchase of some drugs outside of e-catalog in the case that a drug is not available. In addition, data inaccuracies related to the availability of drugs in e-catalog can make planning difficult for health care facilities. Distribution of drugs to remote areas is still hampered by the fact that drug price in e-catalog are only applicable at the provincial level.

In addition, private primary care facilities have not been able to access drug prices based on the price list in e-catalog and often pay higher prices, which are not compensated by BPJS-K. By regulation, the government and especially LKPP should give access to private facilities to e-purchasing. In addition, certain drugs, especially for selected programs such as tuberculosis (TB) and HIV can only be accessed in public health centers.

Finally, monitoring and evaluation of drug usage has not been undertaken systematically, as drug utilization data is not reported.

6.2.4. Special Issues of Rural and Remote Areas

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

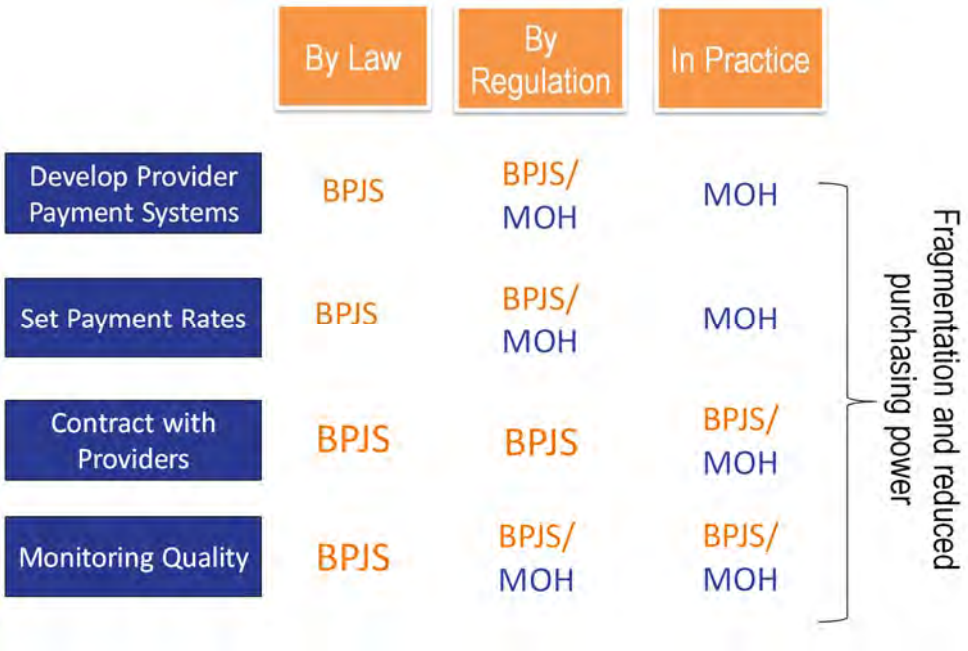
Geographic challenges also increase the distribution costs of drugs purchased through e-catalog to the district capital cities. Regional governments have limited budget to absorb the costs of distributing drugs to the regional *puskesmas*. Often the drugs needed are not available in e-catalog and the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

One of the funding sources 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 source of health expenditure in some rural and remote areas with low fiscal capability." The policy on the use of compensation funds has not been further articulated in lower regulations, however, thus making it difficult to implement.

6.3. Key Areas of Contradiction, Mismatch or Gaps in the Regulations

The main finding of the review is that there is lack of clarity in the legislation and regulations supporting the implementation of JKN related to the overall responsibility for strategic purchasing. The original social security law is clear about allocating the main purchasing functions to BPJS-K, but subsequent regulations has made the allocation more unclear and the allocation of functions in practice ("de facto") shows that the MOH retains all or most of the responsibility for the key functions of developing provider payment systems, setting rates, contracting with providers and monitoring quality (Figure 15).

Figure 15. Allocation of Purchasing Functions Under JKN

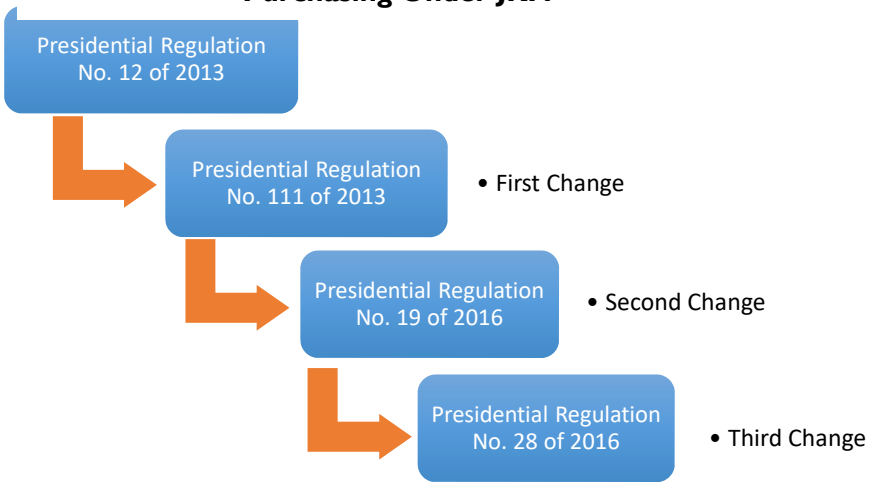


Some of the lack of clarity is attributed to the dynamic nature of the regulatory environment, with three major changes introduced since the original social security law and supporting presidential regulation of 2013 (Figure 16). The resulting unclear functional responsibilities for purchasing under JKN has limited the strategic potential of purchasing as an important lever to ensure the sustainability of JKN while continuing to improve access, quality of care, and financial protection.

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

The current functional roles of BPJS-K are primarily those of a financial institution rather than a health institution, so BPJS-K is serving as a passive intermediary to transfer payments to health providers and carry out some other largely administrative functions, rather than as a strategic purchaser. Most of the

Figure 16. Changes in the Regulatory Basis for Purchasing Under JKN



functions that make it possible to create incentives for more effective service delivery, efficient provider behavior, higher quality of care continue to be housed within the MOH. BPJS- K is responsible for managing the social security fund for health for the benefit of its members, but it has few effective levers to manage that fund, either to manage costs effectively or to use the fund to ensure access to high-quality services for the covered population.

6.3.1. Overall Responsibility for Health Purchasing Under JKN

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

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

6.3.2. Accountability

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

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

6.3.3. Supply-Side Readiness

The regulations on the role of local government create a mismatch in the responsibilities for ensuring the effective implementation of JKN within limited resources. The extent of decentralization in Indonesia means that local governments are not obligated to harmonize their policies, such as investment decisions and health provider remuneration policies, with national policies such as those related to health purchasing. There is a highly variable service delivery structure with uneven capacity, and sometimes a mismatch between investment and the service delivery needs of the population.

Based on stakeholder interviews, there is indication of local governments (1) redirecting local budget funds to pay JKN premiums as they integrate Jamkesda (district- and provincial-level health insurance schemes) into JKN; (2) reducing budgets for primary health care in response to JKN capitation revenue at the facility level; (3) over-investing in hospitals; and (4) not effectively pursuing private sector investment or public-private partnerships to fill capacity gaps. Furthermore, the investment decisions of the local governments have financial implications for BPJS-K, which bears a growing responsibility for funding recurrent costs. Curative services that are covered by JKN and paid per service may be crowding out public health services, which are still the responsibility of local governments.

Local governments have wide authority to make decisions that increase financial risk for JKN, especially supply-side investment decisions and funding for public health, which when neglected can shift additional

curative care costs to JKN. The MOH has tried to address this through the Healthy Indonesia Program, which aims to strengthen promotive and preventative activities at primary care level; BPJS spending on non-communicable disease management (NCDs) has been inadequate and referrals have increased significantly. Local governments will be accountable for maintaining minimum service standards for NCD management. There are possible financial levers through the central-level transfers to sub-national governments that could be used to create some accountability for the implementation of JKN.

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

6.3.4. Contracting and Provider Payment Policy

The divisions in responsibility between the MOH and BPJS-K on contracting providers under JKN weakens the power of contracting as a strategic purchasing mechanism. BPJS-K cannot specify the criteria for selective contracting or specify the provisions of the contract, such as reporting requirements, or enforcing the contracts and imposing consequences for violations. BPJS-K thus has very little leverage over the efficiency and quality of service delivery by providers. Based on international experience, purchasing agencies often have the authority to select which service delivery and quality standards (e.g. standard clinical practice guidelines) will be used for purchasing services, even if they do not develop them.

The regulations are also unclear about how the function of provider payment policy and rate-setting are shared between the MOH and BPJS, giving the authority to the MOH to develop the payment systems, but stipulating that it should be carried out in coordination with BPJS-K. BPJS-K has the authority to negotiate payment rates with provider associations with reference to MOH standard tariffs. In practice, the MOH retains authority for the function of provider payment policy and rate-setting, while BPJS-K is responsible for paying provider claims. BPJS-K has the responsibility to selectively contract providers, with criteria for provider selection defined by the MOH. While this division of functional responsibility may be appropriate for Indonesia, stakeholders in the TWG suggested the need to examine and clarify responsibilities for purchasing functions across BPJS-K and the MOH. International experience also suggests that purchasing agencies typically have a strong role in, or complete responsibility for, provider payment policy and rate-setting.

6.3.5. Provider Autonomy

The level of provider autonomy over financial, personnel, service delivery and other decisions affects providers' ability to respond to incentives by changing the mix of inputs and services they deliver. The more areas over which providers have decision-making rights, the more flexibility they have to respond to the incentives of purchasing and provider payment policies and the more powerful the incentives will be. Although primary health care providers receive capitation payment from BPJS-K, the MOH has authority to determine how those funds can be used and how providers can allocate funds between staff payments and other operational costs. A provider that receives funds from multiple revenue streams must allocate and account for them separately. In addition, some regions consider capitation income as regional income and utilized according to local government policy. *Puskesmas* are increasingly given discretion to manage their own financial affairs, and a number of the facilities have been converted to BLUD *Puskesmas*, which allows them to manage their own finances. Even in autonomous *Puskesmas*,

however, the complicated rules on the allocation of capitation revenue have led to low absorption in some cases, with the revenue taken back by the government treasury if it remains unspent at the end of the year. These financial rules greatly diminish the potential of the capitation payment system to encourage efficient use of resources and better service delivery. For more on provider autonomy and how it relates to primary health care capitation utilization, please see the deep dive section above on strategic health purchasing for PHC.

6.3.6. Monitoring and Quality Assurance

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

7. OPTIONS FOR IMPROVING THE INSTITUTIONAL STRUCTURE FOR SHP UNDER JKN

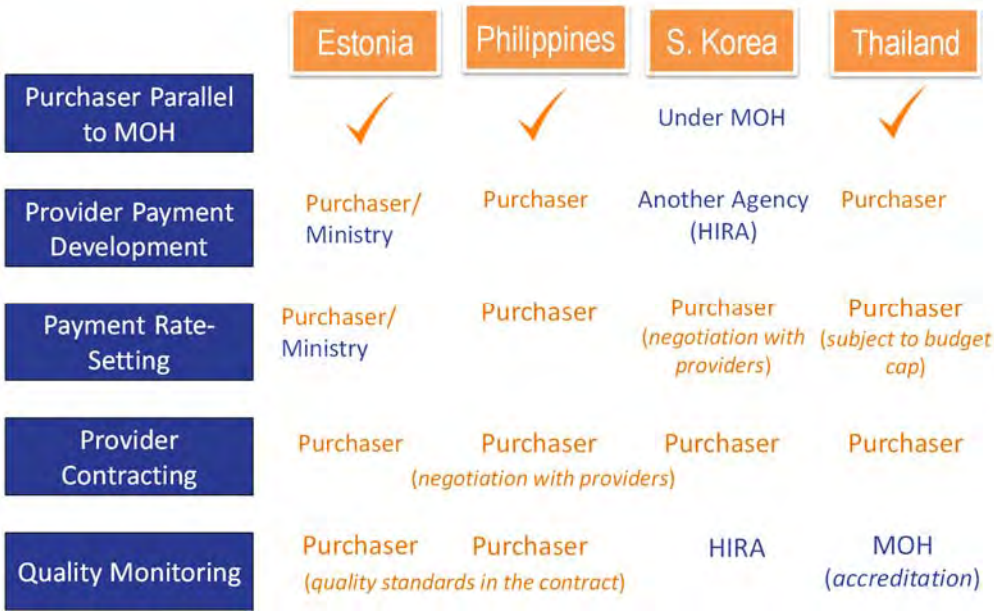
In order to strengthen strategic health purchasing under the JKN, the government needs to decide how purchasing functions can be more effectively allocated between BPJS-K and the MOH. As it is now, BPJS-K is in the role of a passive intermediary. An important decision needs to be made regarding which institution will have primary responsibility for strategic purchasing under JKN (BPJS or the MOH), and what is the right distribution of purchasing functions across the key institutions and what will be the role of each actor.

7.1. International Experience

Countries that have organize the purchasing agency and functions both in parallel to or under the control of the MOH, but in most countries, the purchasing agency is responsible for most purchasing functions, while the MOH retains a strong role in stewardship, regulation, and standard-setting (Figure 17). There is typically a complex allocation of functions and accountability, and countries create institutional and governance structures to avoid conflict of interest and achieve balance power and risk. To achieve this balance and avoid conflict of interest, some functions are separated and carried out by different institutions and some functions are carried out in a coordinated way. For example, most countries assign the function of payment rate-setting to the purchaser, but with checks and balances, such as approval by the MOH or outside agency and caps or other external cost control mechanisms. In Estonia, for example, the Estonian Health Insurance Fund manages payment systems and rates but the Government and Ministry of Social Affairs give final approval. The EHIF then negotiates individual

price/volume contracts with providers based on the approved payment rates.[7] In Thailand, for example diagnosis-related group (DRG) payment for inpatient hospital services capped at the regional level based on allocation determined by Budget Bureau.[8]

Figure 17. Select Country Experience Allocating Purchasing Functions Between the MOH and Purchasing Agency



Most countries also assign the function of quality monitoring to the purchaser, but with multi-stakeholder participation. In the Philippines, PhilHealth accreditation standards incorporated into contracting. The Department of Health adopted the PhilHealth accreditation standards and incorporated them into the licensing requirements.[9]

In these systems health providers have a high degree of autonomy to manage revenues, make decisions regarding the use of inputs, and make service delivery decisions. The providers are accountable for outputs and outcomes rather than inputs. As the purchasing agency assumes the main purchasing functions, the role of the Ministry of Health typically transitions to one of stewardship, regulation, standard-setting, and monitoring.

Countries such as Estonia and Thailand that have been most effective strengthening the role of the strategic purchaser and channeling a large share of health funds through the purchasing agency have **improved cost management and financial sustainability** (measured by cost growth relative to

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[7] Lai T., Habicht T., Kahu, K, Reinap M, Kiivet R, and van Ginneken E. (2013). *Estonia: Health System Review*. Health Systems in Transition: European Observatory on Health Systems and Policies.
[8] Tangcharoensathian, V., ed. (2015). *The Kingdom of Thailand Health System Review*. Health Systems in Transition. Health Systems in Transition: Asia Pacific Observatory on Health Systems and Policies.

[99] Kwon S. and Dodd R., eds. (2011). *The Philippines Health System Review*. Health Systems in Transition. Health Systems in Transition: Asia Pacific Observatory on Health Systems and Policies.

revenue), **efficiency** (as measured by share of utilization and spending on PHC vs. higher cost services), **quality**, and **financial protection** (as measured by share of out-of-pocket payments in total health spending) (Figure 18). Countries such as the Philippines and Korea that have not strengthened the role of the purchaser as much or channel a low share of total health funding through the purchasing agency have seen less success on these measures.

Figure 18. Select Country Experience on the Results of Strategic Health

	Estonia	Philippines	S. Korea	Thailand
Cost Management/ Financial sustainability	Good cost management	Revenue exceeds expenditure	High cost growth	Good cost management
Priority on PHC	15%	Est. 39% hypertension admissions avoidable	<20%	Higher priority in utilization/lower in expenditure
Avoidable hospitalizations	~OECD average		>OECD average	>OECD average
Quality of Services	Unclear but high patient satisfaction	Concerns —esp. PHC	Unclear	Improving
Out-of-Pocket Payments	21%	54%	37%	12%
% of total health spending	69%	14%	>50%	77%

Better use of health resources through strategic purchasing can ultimately improve health outcomes. Better health outcomes are reflected in lower rates of avoidable hospitalization in Estonia and Thailand, as conditions are managed more effectively at the PHC level and increased severity and complications requiring hospitalization are reduced. In spite of relatively low spending on health among OECD countries, Estonia has achieved some of the best outcomes in child health, with one of the lowest infant mortality rates in OECD countries. Strategic health purchasing also has provided the information and platform for Estonia to continuously analyze and improve health financing and service delivery to address new problems, such as the burden of NCDs.

International experience shows that there is no specific model or allocation of purchasing functions that is ideal. The important feature of the successful systems is that the allocation of functions is clear, the institution with the main responsibility for purchasing has control over the main purchasing functions of contracting, provider payment, and provider monitoring but with checks and balances. The key is selecting the governance arrangements and distribution of purchasing functions that is appropriate for the country context to ensure that the purchasing function is strong and the purchaser has enough power to create incentives for service delivery improvmenets and to manage costs.

7.2. The Way Forward for JKN

To strengthen the role of strategic health purchasing, and of BPJS-K to play that role, there is a need to strengthen some functions (e.g. accountability), possibly reallocate others (shifting responsibility for setting service delivery standards, contracting, provider payment policy and rate-setting at least partially to BPJS-K), and creating better cooperation and shared responsibility for others (e.g. supply side planning and provider performance and quality monitoring). While stakeholders discuss the options for

strengthening, redistributing, or better coordinating these functions, the opportunity may be explored to establish better platforms for dialogue, analysis, and joint decision-making. There is also a general need to strengthen the capacity of all institutions to carry out their functions, and clear leadership to manage the shift and strengthening of the health purchasing functions under JKN and continue to monitor and evaluate these changes, and overall program performance. While from the regulatory review it would appear that this leadership and oversight role would be the responsibility of DJSN, the power and capacity to carry out this role would need to be strengthened. For a full list of the options to improve strategic purchasing under JKN, please see Table 1.

Table 3. Options for Improving Strategic Purchasing Under JKN

Purchasing Function	Related Regulations	Options for Improvement
Accountability	Law no. 40 Article 4 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 services 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. • Increase regional commitment to allocate funds used to build adequate health facilities, particularly in rural and remote areas.

Purchasing Function	Related Regulations	Options for Improvement
		• When the BPJS funding is adequate and deficits are stabilized, improve regulations to allow compensation funds from BPJS 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: o Specify the role of private providers in JKN/BPJS-K regulations o Engage private professional associations in credentialing
How to purchase		
Contracting and provider payment policy	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the selection and development of provider payment systems, and provider rate-setting 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

Purchasing Function	Related Regulations	Options for Improvement
		ratios of registered participants to full time physicians in a primary care facility. • 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 facilities 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).
Government 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	The government should 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. o Set up a district-level platform for communication and monitoring among 4 entities: DHO, BPJS, *puskesmas* providers, and local government o 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 primary care providers to evaluate their performance 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 joint provider monitoring and quality assurance commissions at the district and/or regional level, including representation of the local branch of BPJS, DHO, and local government.

Purchasing Function	Related Regulations	Options for Improvement
		• 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.

ANNEX 1-CALENDAR OF SHP TWG MEETINGS

Date	Topic	Stakeholders[10]
November 8, 2016	*Workshop*: Scoping of the SHP Activities	DJSN, BPJS, MOH, MOF
February 2, 2017	Introducing SHP Concepts	DJSN, BPJS, MOF, MOH, PMK
Februray 16, 2017	Purchasing of Drugs and Medicines	DJSN, BPJS, MOH, PMK
February 23, 2017	JKN Strategic Expenditures	DJSN, TNPPK, MOH, BPJS
March 9, 2017	Drugs and Procurement	DJSN, MOH, LKPP, IDI
April 4, 2017	Purchasing Referral Services	DJSN, PERSI, PDGI, POGI, IDI
April 11, 2017	*Workshop*: Interim results	Entire Technical Working Group
May 9, 2017	Purchasing Referral Services	DJSN, PERSI, PDGI, POGI, IDI, IBI, PDUI, IPMG, IDAI, IAI, ARSSI, PERSI, ARSADA, ARSANI,
May 16, 2017	Special Issues of Remote and Disadvantaged Areas	DJSN, BPJS, IDI, IBI, PDUI, POGI, IDAI, PDGI, IAI, GP Farmasi, ARSSI, PERSI, ARSANI
May 30, 2017	INA CBG Implementation	DJSN, MOH, ARSANI, ARSSI, ARSPI PERSI, TNI Health Center, POLRI Health Center
August 3, 2017	Workshop: Validation of Functional and Regulatory Review Results	Entire Technical Working Group

[10] See Glossary for explanations of acronyms

ANNEX 2-SHP FUNCTIONAL MATRIX

[attached file]

ANNEX 3-REGULATIONS RELATED SHP UNDER JKN

I. Laws and Regulations in the National Health Insurance Sector

National Health Insurance Legislation (JKN) Regulations are structured in a hierarchy system, meaning that the position of one rule is a sub delegation of other higher-ranking statutory regulations. In the hierarchy system, the Rule one with another must be harmonious, in order to be operational in achieving the objectives set by the 1945 Constitution of the Republic of Indonesia (UUD NRI).

Based on Article 7 paragraph (1) of Law no. 12 of 2011 on the Establishment of Laws and Regulations (Act P3), JKN Regulation can be classified into 2 kinds, namely:

a. Regulation JKN ordered formation by legislation that is higher (Delegation).
b. JKN regulation established under the authority of officers / officials concerned.

JKN regulations can be sorted by type of laws and regulations, as follows:

1. Constitution/Law

The law on which JKN is based:

1. Law No. 40 of 2004 on National Social Security System (SJSN)
2. Act No. 24 of 2011 concerning Social Security Agency (BPJS)

Other related laws:

3. Law no. 25/2004: National Development Planning System
4. Law no. 33/2004: Financial Balance between the Central Government and Local Government
5. Law no. 36/2009: Health
6. Law no. 44/2009: Hospital
7. Law no. 36/2014: Health Workers

2. Government Regulations

Government Regulation in the field of National Health Insurance, namely:

1. PP no. 73 of 2016 on Income Tax on Social Security Program Conducted by Social Security Administering Body
2. PP no. 84 of 2015 on Amendment to Government Regulation No. 87 of 2013 on the Management of Social Security Assets
3. PP no. 15 Year 2015 on Amendment to PP. 101 of 2012 on Beneficiaries of Health Insurance Contributions
4. PP no. 55 of 2015 on Amendment to Government Regulation No. 99 of 2013
5. PP no. 48 2015 Increase in Investment Negar a Republic of Indonesia in Mo dal Social Security Agency of Health
6. PP no. 89 Year 2013 concerning Revocation of Government Regulation No. 69 Year 1991 concerning Health Care for Civil Servants, Pension Recipients, Veterans, Independence Pioneers, and Their Family Members
7. PP no. 88 Year 2013 on Procedures for Imposing Administrative Sanctions for members of the Supervisory Board and Member of the Board of Directors BPJS

8. PP no. 87 Year 2013 on Social Security Assets P anagemen Health
9. PP no. 86 Year 2013 on Imposing Administrative Sanctions to Employer addition to State Officials and Everyone, In addition to the Employer, Labor, and Beneficiaries Contribution
10. PP no. 85 Year 2013 on Method Inter-Institutional Relations BPJS
11. PP no. 82 Year 2013 on Equity for BPJS
12. PP no. 90 Year 2013 concerning Revocation of Government Regulation No. 28 of 2003 on Subsidies and Contributions Government in the Implementation of Health Insurance and Pension Recipients for civil servants
13. PP no. 101 Year 2012 on Health Insurance Contribution Recipients

3. Presidential decree

Presidential Regulation in the field of National Health Insurance, namely:

1. Presidential Regulation No. 28 of 2016 on Third Amendment to Presidential Regulation No. 12 of 2013 on Health Insurance
2. Presidential Regulation No. 19 of 2016 on the Second Amendment of Presidential Regulation No. 12 of 2013 on Health Insurance
3. Presidential Regulation No. 81 Year 2015 on Procedures for Election and Designation of the Supervisory Board Member of the Board of Directors Member and Candidate and Intertemporal Substitute Member of the Supervisory Board and Board of Directors BPJS
4. Presidential Regulation No. 32 Year 2014 on the Management and Utilization of the National Health Insurance Fund capitation on Faskes First Level Local Government Owned
5. Presidential Regulation No. 111 of 2013 on Amendment to Presidential Regulation No. 12 of 2013 on Health Insurance
6. Presidential Regulation No. 110 Year 2013 on Salary or Wages and Other Supplemental Benefits and Incentives for the Supervisory Board Member and Member of the Board of Directors BPJS
7. Presidential Regulation No. 109 Year 2013 on Social Security Program Participation Phasing
8. Presidential Decree No. 108 of 2013 on Form and Content Management Reports Social Security Program
9. Presidential Regulation No. 107 Year 2013 on Certain Health Services Relating to the Operations of the Ministry of Defense, the Indonesian Armed Forces, and the Indonesian National Police
10. Presidential Decree No. 106 Year 2013 concerning Health Care Insurance Chairman, Vice Chairman, and Members of the House of Representatives, the CPC, KY, and Judge of the Constitutional Court and Judge Adung MA
11. Presidential Regulation No. 105 Year 2013 about Health Care Insurance for Ministers and Specific Officials
12. Presidential Regulation No. 12 Year 2013 on Health Insurance

4 Ministerial Regulation

A. Regulation of the Minister of Health

Regulation of Minister of Health in the field of National Health Insurance, namely:

1. Regulation of the Minister of Health No. 4 of 2017 on the Second Amendment to Regulation of the Minister of Health No. 52 of 2016 on Health Service Tariff Standard in the Implementation of Health Insurance Program
2. Regulation of the Minister of Health Number 137 Year 2016 regarding National Formulary 2016
3. Regulation of the Minister of Health No. 64 of 2016 on Amendment of Regulation of the Minister of Health No. 52 of 2016 on Health Service Tariff Standard in the Implementation of Health Insurance Program
4. Regulation of the Minister of Health Number 52 Year 2016 on Health Service Tariff Standard in the Implementation of Health Insurance Program
5. Regulation of the Minister of Health Number 43 Year 2016 regarding Minimum Service Standard for Health Sector
6. Minister of Health Regulation No. 21 of 2016 on the Use of the National Health Insurance Capitation Fund for Health Services and Support Services Operational Costs in Health Facilities First Level Local Government Owned
7. Minister of Health Regulation No. 12 Year 2016 on Amendment to Regulation of the Minister of Health No. 59 of 2014 on the Standard Rates of Health Services in the Implementation of Health Insurance Program.
8. Regulation of the Minister of Health No. 11 of 2016 on the Implementation of Executive Outpatient Services at the Hospital
9. Regulation of the Minister of Health No. 99 of 2015 on Amendment to the Regulation of the Minister of Health No. 71 of 2013 on Health Service of National Health Insurance
10. Minister of Health Regulation No. 36 of 2015 on the prevention of fraud (fraud) in the Implementation of Health Insurance Program At National Social Security System
11. Regulation of the Minister of Health Number 59 Year 2014 on Health Service Tariff Standard in the Implementation of Health Health Insurance
12. Regulation of the Minister of Health Number 28 of 2014 on Guidelines for Implementation of National Health Insurance Program
13. Minister of Health Regulation No. 27 Year 2014 on Technical Guidelines for Indonesian Systems Case Base Groups (INA CBGs)
14. Minister of Health Regulation No. 19 Year 2014 concerning the Use of the National Health Insurance Capitation Fund for Health Services and Support Services Operational Costs in Health Facilities First Level Local Government Owned
15. Regulation of the Minister of Health No. 5 of 2014 on Clinical Practice Guidelines For Physicians in Primary Health Care Facility (along with attachments)
16. Regulation of the Minister of Health No. 71 of 2013 on Health Services on National Health Insurance
17. Minister of Health Regulation No. 69 Year 2013 on Health Care Standard Rates In First Level Health Facilities and Facility Services Advanced Health of the Health Insurance Program Implementation

B. Regulation of Minister of Finance

Regulation of the Minister of Finance in the field of National Health Insurance, namely:

18. Regulation of the Minister of Finance No. 206 / PMK.02 / 2013 Concerning Procedures for the Provision, Disbursement and Accountability of Contribution Funds Health Insurance Beneficiaries
19. Regulation of the Minister of Finance No. 205 / PMK.02 / 2013 Concerning Procedures for the Provision, Disbursement, and Accountability of Health Beneficiary Benefit Contribution Fund from the Government (+ annex)

C. Regulation of the Minister of Home Affairs

Regulation of the Minister of Internal Affairs in the field of National Health Insurance, namely:

Minister Regulation No. 37 Year 2014 on Guidelines for Budgetary Revenues and Expenditures for Fiscal Year 2015, as amended by Regulation Mernteri the Interior No. 72, 2015.

5 BPJS Health Regulation

Regulation of the BPJS Health (Per BPJS Kes), namely

1. Regulation of the Agency for the Provision of Social Security Health Number 1 Year 2014 on the Implementation of Health Insurance
2. Regulation of the Social Security Administering Body Number 2 Year 2014 on Quality Control Unit and Complaint Handling of Participants
3. Regulation of the Social Security Administering Body Number 3 Year 2014 on Procedures and Work Mechanism of Supervision and Inspection of Compliance in the Implementation of Health Insurance Program
4. Regulation of the Social Security Administering Body Number 4 of 2014 on the Procedure for Registration and Payment of Individual Participants of the Social Security Administering Body
5. Regulation of the Social Security Administering Body No. 1 of 2015 on Registration Procedures and Payment of Contributions to Non-Wage Workers and Non-Workers
6. Regulation of the Social Security Agency of Health No. 2 Year 2015 concerning the Stipulation Norma Capitation Payment Amount of capitation and Commitment Fulfillment Services Based On First Level Health Facilities
7. Regulation of the Social Security Administering Body No. 1 of 2016 on the Registration Procedure, Billing, Payment and Reporting of Online Dues for Wage Employee Recipients from New Business Entities in the Framework of Ease of Business
8. Regulation of the Agency for the Provision of Social Security Health Number 2 Year 2016 on Payment Procedures of Health Insurance Contributions and Payment of Fines Due to Delayed Payment of Health Insurance Contribution
9. Regulation of the Social Security Administering Body No. 4 of 2016 on Technical Guidelines for the Implementation of Benefit Coordination in the National Health Insurance Program
10. Regulation of the Social Security Administering Body No. 5 of 2016 on Amendment to Regulation of the Social Security Administering Body No. 1 of 2015 on the Registration Procedure and Payment of Contributions to Non-Wage Workers and Non-Workers

11. Regulation of the Social Security Agency of Health No. 6 of 2016 concerning Workers Party Membership Status Changes Not Receiver Wages and Participants Not Employed in the National Health Program Implementation Jamiban
12. Regulation of the Social Security Agency of Health No. 7 of 2016 on the System of Prevention of Fraud (Fraud) In Health Insurance Program Implementation
13. Regulation of the Agency for the Provision of Social Security of Health Number 8 of 2016 concerning the Implementation of Quality Control and Cost Control in the Implementation of the National Health Insurance Program
14. Regulation of the Social Security Agency of Health No. 1 Year 2017 on Health Facility Equity Participants in the First Level.

II. Decisions in the the National Health Insurance Sector

1. Presidential Decrees

Presidential Decree in the field of National Health Insurance, namely:

1. Presidential Decree No. 116 Year 2015 concerning the Establishment of the Candidate Selection Committee of the Supervisory Board Member and Board Member Candidate Social Security Agency Employment
2. Decree No. 115 Year 2015 concerning the Establishment of the Candidate Selection Committee Member of the Board of Directors BPJS
3. KEPPRESS No. 165 of 2014 on Appointment of Members of the National Social Security Council Term 2014-2019
4. Decree No. 161 Year 2013 on the Appointment of the Board of Commissioners and Directors PT Jamsostek into the Supervisory Board and the Board of Directors of the Social Security Agency Employment
5. Decree No. 110 of 2008 on the appointment of members DJSN

2. **Minister of Health Decree**

Decree of the Ministry of Health in the field of National Health Insurance, namely:

1. Health Ministerial Decree No. 228 / Menkes / SK / VI / 2013 of the National Committee for Preparation of National Formulary 2013
2. Decree of the Minister of Health Number 312 / Menkes / SK / IX / 2013 on National Essential Medicines List 2013
3. Decree of the Minister of Health Number 326 / Menkes / SK / IX / 2013 on Preparation of National Social Security Implementation Activity
4. Health Ministerial Decree No. 328 / Menkes / IX / 2013 on National Formulary
5. Health Ministerial Decree No. 455 / Menkes / SK / XI / 2013 of the Association of Health Care Facilities
6. Health Ministerial Decree No. 046 / Menkes / SK / II / 2014 concerning the Implementation Monitoring and Evaluation Team Health Insurance Nasioanal 2014
7. Health Ministerial Decree No. 159 / Menkes / SK / IX / 2014 on the amendment to the Decree of the Minister of Health No. 328 / Menkes / SK / IX / 2013 About the National Formulary
8. Decree of the Minister of Health Number KF.03.01 / Menkes / 312/2014 on Drug Reference Basic Price Price
9. Health Ministerial Decree HK.02.02 / MENKES / 141/2015 on the National Committee for the National List of Essential Drugs List
10. Health Ministerial Decree No. HK.02.02 / Menkes / 363/2015 regarding the Second Amendment to the Decision of the Minister of Health No. 328 / Menkes / SK / IX / 2013 About the National Formulary
11. Health Ministerial Decree No. HK.02.02 / Menkes / 372/2015 on Basic Price Drug Program Refer Balik, Chronic Diseases and sitostatica
12. Health Ministerial Decree No. HK.02.02 / Menkes / 523/2015 on the National Formulary
13. Health Ministerial Decree No. HK.02.02 / Menkes / 524/2015 on Guidelines for Preparation and Implementation of the National Formulary

14. Health Ministerial Decree No. Hk.02.02 / Menkes / 137/2016 on the amendment to the Decree of the Minister of Health No. Hk.02.02 / Menkes / 523/2015 on the National Formulary

3. Decree of the Minister of Social Affairs

Decree of the Minister of Social Affairs in the field of National Health Insurance, namely:

1. Decree of the Minister of Social Affairs Number 146 / HUK / 2013 on Stipulation of Criteria and Data Collection of Poor and Disabled People
2. Decree of the Minister of Social Affairs Number 147 / HUK / 2013 on Stipulation of Beneficiaries of Health Insurance Contributions
3. Decree of the Minister of Social Affairs No. 170 / HUK / 2015 on the Stipulation of Beneficiaries of the Health Insurance Contribution of 2016

4. Decree of the Minister of Finance

Decree of the Minister of Finance in the field of National Health Insurance, namely:

1. Regulation of the Minister of Finance Number 246 Year 2015 Percentage Percentage of Operating Fund of the Health Insurance Provider Body of 2016
2. Regulation of the Minister of Finance No. 108 of 2015 on Percentage of Operational Funds of the Health Insurance Authorization Body of 2015
3. Regulation of the Minister of Finance No. 34 of 2015 on Other Additional Benefits in Incentives for Members of the Board of Trustees and Members of the Board of Directors of the Social Security Administering Body
4. Regulation of the Minister of Finance No. 245 of 2014 concerning the Percentage of Operational Funds of the Health Insurance Administering Body of 2015
5. Finance Minister Decree No. 244 of 2014 regarding the Amount Percentage Operational Fund Social Security Agency Employment 2015
6. Regulation of the Minister of Finance No. 212 of 2013 concerning the Percentage of Operational Funds for the Employers' Body of Social Security Employment of 2014
7. Finance Minister Regulation Number 211 Year 2013 regarding the Amount Percentage Operational Fund for Social Security Agency of Health 2014

III. Policy rules for JKN

1. **Letter/Circular Letter** of the Ministry of Health

    1. Minister of Health Circular Letter No. 149 Year 2013 on Public Health Insurance Program Membership in 2013
    2. Letter of Minister of Health Number HK / MENKES / 31 / I / 2014 on the Implementation of Health Service Tariff Standard on First Level Health Facilities and Advanced Health Facilities in the Implementation of Health Insurance Program
    3. Letter of the Minister of Health Number HK / MENKES / 32 / I / 2014 on the Implementation of Health Services for Participants of BPJS Health at First Level Health Facilities and Advanced Health Facilities in the Implementation of Health Insurance Program
    4. Letter of the Minister of Health Number HK.03.03 / MENKES / 63/2016 on Guidelines for Settlement of Claims of INA-CBG in the Implementation of Health Insurance
    5. Letter of the Minister of Health Number HK.03.03 / MENKES / 434/2016 on the Additional Cost of Outpatient Outpatient Services at the Hospital for Participants of National Health Insurance (JKN)
    6. Letter of the Minister of Health Number HK.03.03 / MENKES / 518/2016 on Guidelines for Settlement of INA-CBG Claim Issues in the Implementation of Health Insurance
    7.
2. Letter of the Minister of Social Affairs

    1. Letter Number 02 Year 2013 on the Implementation of the Health Insurance Beneficiary (PBI) of 2014

3. Letter of the Minister of Home Affairs

    1. The Home Ministry No. 900/2280 / SJ of 2014 on Technical Guidelines for Budgeting, Execution and Administration, as well as the accountability of the National Health Insurance Fund capitation on Health Facilities First Level Local Government Owned

4. Letter of BPS Health

    1. Letter of the Director of Health Services BPJS No. 32 of 2015 on the Coordination of Benefits Policy / Coordination Of Benefits (COB)

ANNEX 4-MAPPING OF SHP FUNCTIONS TO INSTITUTIONS

Function		Institution						
		DJSN	**BPJS-K**	**MOH**	**MOF**	**Ministry of Social Affairs**	**Ministry of Home Affairs**	**Local Government**
Governance and Accountability	Governance	Propose interim substitute members of the Board of Trustees and / or members of the Directorate of BPJS to the President.	Provide information on the implementation of social security programs to participants and the Community	Coordinate with the Health BPJS to develop the technical operation of the health care system and quality control system	Regulate the continuation of the dues of employer for the local government from state treasury account to BPJS	Verify and validate BPJS data, establish criteria for the poor and vulnerable into an integrated data set	Provide written warning to governors and/or vice-governors not implementing JKN as a national strategic program.	No role for local governments in governance and accountability
				Regulate the fraud prevention system in JKN Fraud prevention is typically a function of the purchasing agency.	Govern the provision, disbursement, and accountability of health insurance dues from the State Budget (APBN).	Regulate the procedures and the change of requirements of PBI health insurance data	Regulate depositing of health insurance contribution from civil servants, government employee non-civil servant, and the individual all together with the Ministry of Home Affairs based on their authority	
				Impose written warning sanctions on the members of the Board or the Directors of BPJS and provide	Regulate depositing of insurance contributions from civil servants, government employee non-	Regulate the procedure of verification and validation of the alteration of PBI JK data, set the		

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
				advice to the president	civil servant, and individuals together with the Ministry of Home Affairs	alteration of such data, and deliver it to the Minister of Health and DJSN		
	Accountability	Provide consultation to the BPJS on the form and content of the program management accountability report.	Insufficient accountability mechanisms					Establish a community complaint unit on the accuracy of PBI
		Receives copy of BPJS annual management and audited financial reports for submission to the President.						
Benefits and entitlement	Benefits design			Manage the types of health services guaranteed by JKN				
				Regulate the JKN compensation that should be provided to the participant of BPJS Health				

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
				Specify the list of medicines, medical equipment, and medical consumable materials.				
	Decisions on adding new services/medicines			Add guaranteed health services based on health technology assessment in coordination with the Ministry of Finance				
	Enrollment and entitlement		Receive registration of JKN participants	Register the numbers of PBI participants in BPJS Health				
Service delivery	Supply side planning and investment							Plan the needs of medical supplies based on the national standards Investment decisions made without dialogue on payment of recurrent costs through JKN
	Health workforce							Organize, utilize, and

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
	planning and management							recruit health workers
								Improve quality of health workers through education and training
	Service delivery management							Managing: health services; human resources; pharmaceutical provision, medical equipment, food, and beverage; the empowerment of community
								Implement national strategic programs
	Health promotion and prevention							Prevention, control, eradication, designation, surveillance of infectious disease
								Improve the individual

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
								nutrition and mental health
Financing	Budget	Propose social security budget for beneficiaries of contributions and the availability of operational budget to the Government.		Budget proposal of PBI JK to the Ministry of Finance based on the DJSN proposal.				
	Revenue collection		Collect JKN contributions from Participants, Employers and Governments.					Providing a fund source for health financing a minimum of 10% of the Regional State budget (APBD), salary is excluded.
			Receive donations from the government					
	Investment and fund management	Propose investment policy of National Social Security Fund.	Manage Social Security Funds for the benefit of participants Responsible for fund management but do not have levers to manage claims liabilities.		Provide start-up capital to the BPJS			
					Determine the percentage of operational fund for BPJS			
					Specify the standard of asset fund of BPJS.			
	Provider payment		Regulation states MOH	Coordinate with the Health BPJS				

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
Contracting and provider payment	selection and design		should coordinate with BPJS on payment system development but has not happened in practice.	to develop provider payment systems				
				Review provider payment systems at least every 2 together with health BPJS, DJSN, and the MOF				
	Payment rate-setting			Tariff calculation				
				Organize the types and the platform of health equipment prices				
				Specify the cost of health services in the event of preventable adverse events.				
	Selective contracting		Selecting providers for contracting based on established technical criteria Purchaser typically has role in determining criteria for	Setting the technical criteria for contracting with BPJS				

Function		Institution						
		DJSN	BPJS-K	MOH	MOF	Ministry of Social Affairs	Ministry of Home Affairs	Local Government
			selecting providers					
	Making payments to providers		Paying benefits and / financing health services					
Monitoring	Monitoring	Conducting studies and research related to the implementation of social security	Cost and quality monitoring at the provider level, including utilization review and medical audit. Duplication with MOH function.	Monitoring and evaluation of the performance of health insurance services in coordination with DJSN				
	Information management		Collecting and managing data of JKN participants	Disconnect between data collection and monitoring. Overall weak monitoring function.				

ANNEX 5-POLICY NOTES FROM THE SHP FUNCTIONAL AND REGULATORY REVIEW

[In separate file]

ANNEX 6-CAPACITY BUILDING WORKSHOP PARTICIPATION FEEDBACK

[In separate file]

ANNEX 7-DECENTRALIZATION LEARNING EXCHANGE FINAL REPORT

[In separate file]