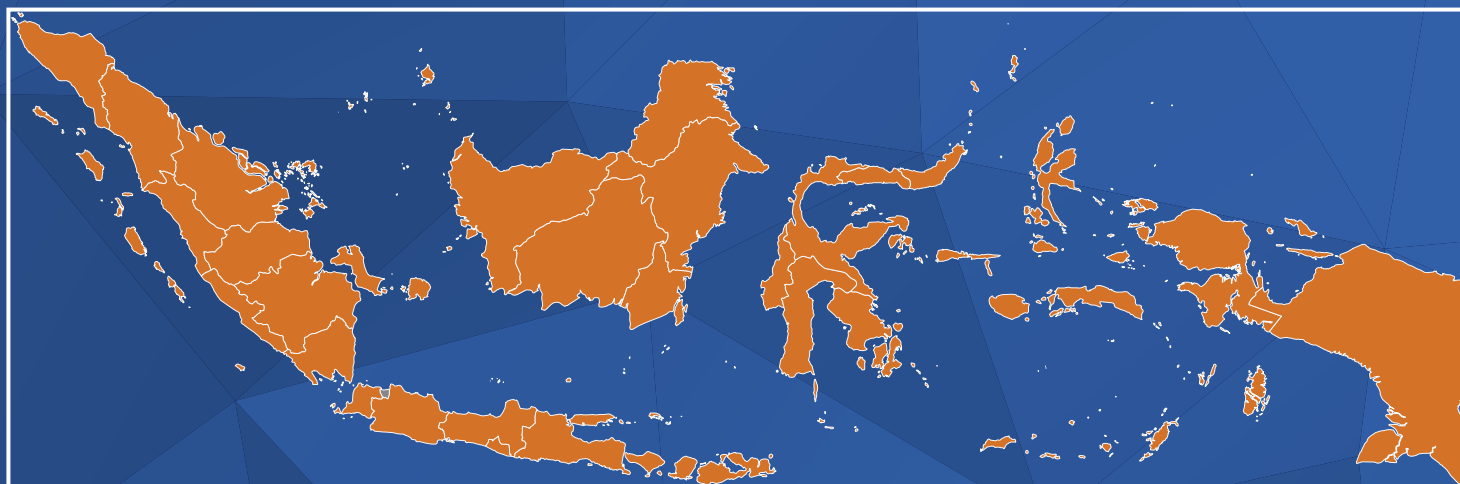


July 2018



OPTIONS TO FINANCE THE RAPID SCALE-UP OF THE HIV RESPONSE IN INDONESIA

The Role of the National Health Insurance Scheme (JKN) and Local Governments



JULY 2018

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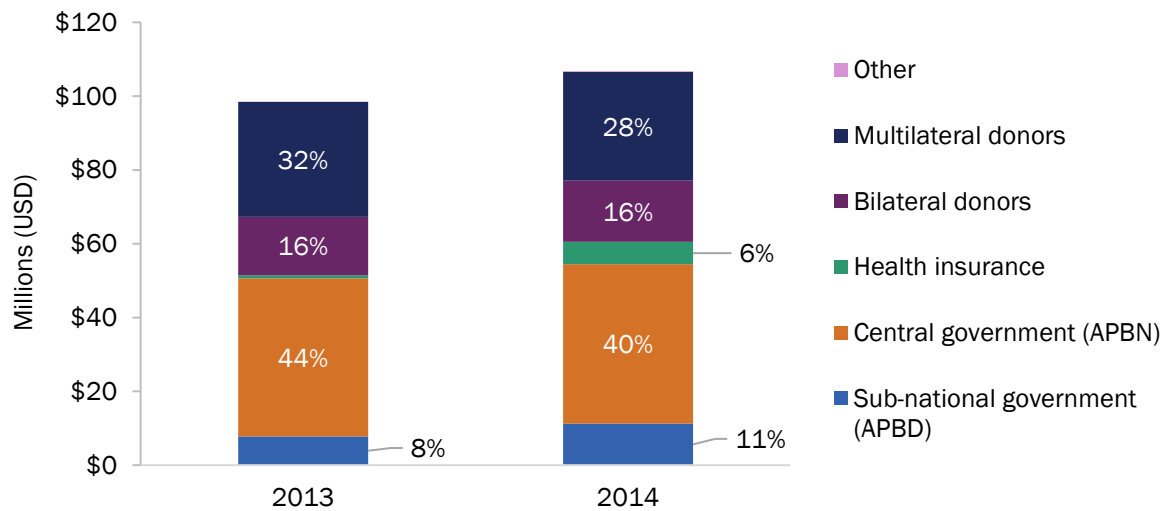
Abbreviations

ART	antiretroviral therapy
ARV	antiretroviral
BPJS-K	Badan Penyelenggara Jaminan Sosial Ketenagakerjaan (Social Insurance Administration Organization)
HP+	Health Policy Plus
IDR	Indonesian rupiah
INA-CBGs	Indonesia case-based groups
JKN	Jaminan Kesehatan Nasional (Indonesian national health insurance)
LKPP	Lembaga Kebijakan Pengadaan Barang Jasa Pemerintah
MOH	Ministry of Health
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SHI	Social Health Insurance
US\$	U.S. dollar
USAID	U.S. Agency for International Development

Introduction

Reductions in external funding for Indonesia's HIV response require a clearer understanding of financing options to achieve epidemic control. While the majority (57%) of Indonesia's HIV response is currently financed by domestic sources, the country faces transitions in external funding and technical assistance support for HIV within the next 5 to 10 years. External support to the Indonesian HIV response has been declining as a share of total spending, even as total spending is rising (see Figure 1). With many HIV prevention and key population activities entirely financed with external funding, declining external financial support necessitates further consideration of financing sources to sustainably plan and advocate for HIV financing.

Figure 1: Sources of Financing for the HIV Response



APBN: Anggaran Pendapatan Belanja Daerah; APBD: Anggaran Pendapatan Belanja Daerah
Source: National AIDS Spending Assessment 2015 (UNAIDS et al.)

These funding shifts come at a time of more ambitious national targets to combat HIV. The country aims to achieve an ambitious goal of 81% of all people living with HIV receiving antiretroviral therapy (ART) by 2030 through the implementation of a fast-track strategy (Fast Track, unpublished). Accordingly, the government of Indonesia aims to increase coverage of people living with HIV on ART from 13% in 2017 to 42% by 2020. Analyses conducted by the Sub-Directorate for HIV/AIDS and STI in the Directorate of Communicable Diseases of the Ministry of Health (MOH), with technical assistance from the Health Policy Plus (HP+) project,¹ estimated that the fast-track strategy requires HIV service delivery costs to increase from IDR 4.2 trillion to IDR 11.6 trillion (US\$300 million to US\$830 million) from 2018 to 2023.

Achieving the fast-track targets necessitates exploring additional domestic financing for HIV. Prior analyses highlight the need to assess domestic capacity to finance the proposed rapid scale-up of the HIV response (HP+ and MOH, 2018). While central government budget allocations will continue to play a substantial role in financing the HIV response, especially for antiretrovirals (ARVs) and diagnostic reagents, tapping alternative domestic sources to sustainably finance HIV service delivery will improve the likelihood of the fast-track

¹ Funded by the U.S. Agency for International Development (USAID) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

strategy's success. To this end, HP+ and the MOH considered the various aspects of HIV service delivery which could be incorporated into the national health insurance scheme (Jaminan Kesehatan Nasional or JKN) and the associated financial implications to the scheme. Further, HP+ assessed the role local governments would need to play to support the provision of specific HIV services not covered by JKN and the provision of all HIV services to populations yet to be enrolled in JKN.

This brief builds on previous analyses of HIV financing in Indonesia. In a study conducted by the World Bank in 2016, the authors highlighted the opportunity for Indonesia to strengthen its national HIV response by integrating key HIV-related services into JKN (World Bank, 2016). In the current analysis, HP+ updated targets and cost information for each province, revised JKN enrollment projections from those in the World Bank 2016 study, and conducted a more in-depth analysis of provider payment methods and reimbursement rates, alongside consideration of the role of local governments in financing the HIV response in Indonesia. **In 2017–2018, the World Bank has also engaged in a “deep dive” assessment of sustainability in the responses for HIV, tuberculosis, and malaria in Indonesia—the results of this analysis are awaited by stakeholders.**

Indonesia can follow the lead of other countries in the region in leveraging health insurance and subnational government budgets for financing HIV. For example, Vietnam has successfully integrated HIV service provision into their health insurance reforms, and also secured financing for HIV from other sources, including national and sub-national governments. In 2013, Vietnam approved the use of social health insurance (SHI) and other modalities, including provincial budgets, to pay for HIV care and treatment services (PEPFAR, 2017). In relation to ARVs specifically, a prime-ministerial decree in Vietnam directed centralized procurement of ARVs by SHI with support from local governments, beginning in 2017. This decision allowed the use of SHI funds for central procurement of ARVs and called for local governments to pay SHI enrollment fees and HIV-related co-payments for people living with HIV. These measures are especially impactful as Vietnam **has already faced a significant decline in external funding for the country's HIV response. While Indonesia's HIV** response is already mostly government-financed, the scale of services is currently inadequate to the needs, and implementing measures similar to those in Vietnam could unlock the domestic resources necessary to achieve ambitious scale-up targets under the fast-track strategy.

Methods

This report summarizes analyses focused on financing the Indonesian HIV response, with the aim to uncover how public resources at the national and subnational level could be leveraged, and how greater integration with the national health insurance scheme could facilitate the fast-track strategy. The analysis considered the following questions:

1. Which HIV services could be included in the JKN benefits package and which would require local government funding?
2. What proportion of people in need of HIV services are covered by JKN?
3. What are the unit costs and cost assumptions associated with the provision of HIV services by JKN and by local governments?
4. At what levels of the health system are HIV services currently provided, and where could they be provided?
5. What payment mechanisms should be used to pay providers for HIV service delivery?

The source of base cost estimates is detailed in a companion brief (see HP+ and MOH, 2018). Several assumptions were made throughout this analysis, which were validated with existing data sources and consultation with stakeholders where possible. The limitations that applied to the costing analysis (HP+ and MOH, 2018) are also relevant to this financing analysis, which relies heavily on those costs. Other limitations include lack of access to more granular and up-to-date local government budget and fiscal space projections. Instead this analysis contextualized local government financing for HIV relative to projected total health spending. Further, results of this analysis are intended to illustrate domestic resources available for HIV financing. This analysis is intended to serve as a preliminary discussion of potential financing sources and the payment modalities to access the increased resources needed for HIV interventions. Further engagement with various counterparts in the government of Indonesia and other key stakeholders is necessary to fully develop the financing options that are feasible and to create a path toward implementation of the desired options.

Data sources for the analysis are discussed in the following sections, which answer the questions posed above. Limitations of this analysis and methodological issues for further exploration are presented in the discussion section.

1. Which HIV services could be included in the JKN benefits package and which would require local government funding?

Some HIV services are supposedly included in JKN, others could be added. This analysis focused on the incremental costs to be incurred by JKN if it assumed a greater role in financing HIV services. HIV services already considered to be provided by JKN include facility-based voluntary screening for and treatment of sexually transmitted infections, facility-based consultations for HIV testing, ART, palliative and other therapy for advanced HIV and AIDS disease and related comorbidities, and routine biochemistry-related laboratory tests. This analysis then **considered the expansion of JKN's benefits package to include commodities and service delivery costs associated with HIV-specific laboratory tests for diagnostic management of patients on or initiating ART (CD4 tests and viral load monitoring) as well as ARVs.** The impact of inclusion of these additional HIV services within **JKN's benefits package were considered in two variants:** an intermediate package and a comprehensive package (see Table 1). Overall, further integration into JKN of HIV interventions and commodities will be beneficial to the HIV response as it encourages more strategic purchasing of these services.

Table 1: JKN Benefits Package Expansion for HIV

Intervention area*	Current JKN provision	Potential further HIV integration	
		Intermediate package	Comprehensive package
Outreach services	✗	✗	✗
Sexually transmitted infections	✓	✓	✓
Needle and syringe program/opioid substitution treatment	✗	✗	✗
Advanced HIV and AIDS disease care	✓	✓	✓
HIV testing			
• Rapid test	✗	✓	✓
• Consultation	✓	✓	✓
ART services			
• Laboratory management			
○ Basic biochemistry	✓	✓	✓
○ CD4 test	✗	✓	✓
○ Viral load test	✗	✗	✓ (hospitals only)
• ARVs	✗	✗	✓ (hospitals only)
• Consultation	✓	✓	✓

* Does not include comorbidities and care for opportunistic infections, which are treated under JKN for all individuals, regardless of HIV status.

JKN reimbursing for ARVs may require regulatory changes, for which a pathway may exist. Amendments to current BPJS-K (health insurance agency implementing JKN) and MOH regulations may be necessary to permit the reimbursement of the costs of ARV drugs through JKN as there is currently an exclusion for centrally purchased drugs and commodities. According to a 2014 MOH regulation (Permenkes 32), there are certain classes of medicines that can be reimbursed outside the tariffs for Indonesia case-based groups (INA-CBGs) used for hospital-level reimbursement. These include chronic care for patients with unstable or stable conditions (specific caveats exist), certain chemotherapy (cancer) medications, and thalassemia and hemophilia medications. One option, also suggested by a BPJS-K workshop participant at the validation of the preliminary results of this analysis, is for the MOH to classify ARV regimens as chronic care drugs, as provision of ARVs for patients responding to therapy requires life-long treatment (Deeks et al., 2013). In this case, JKN-affiliated facilities that purchase ARV drugs for patients under their care could be reimbursed by BPJS-K based on the INA-CBGs claims for ARVs dispensed. Further consideration is needed on how private facilities can access ARVs under a JKN-reimbursed model.

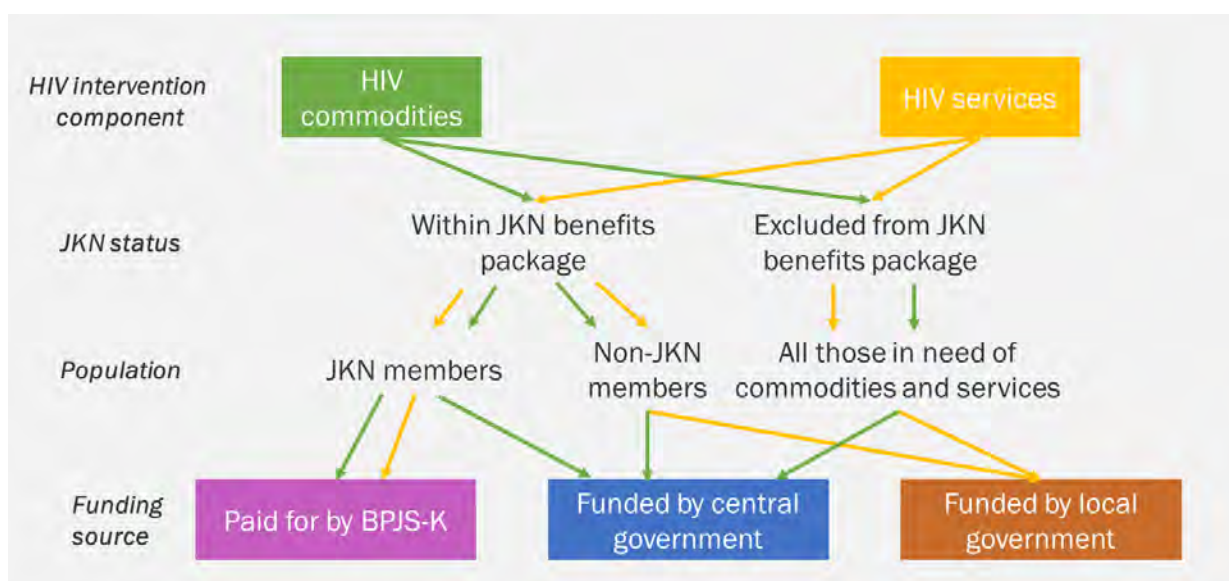
Uninsured people living with HIV will still require non-JKN financing for their service needs, including commodities. For those patients yet to be enrolled in JKN (about 25% of the population as of May 2018), ARV drugs and viral load tests will continue

to be procured by the central government. Central procurement helps to realize economies of scale and reduce the administrative burden of quantification and distribution for local governments. At present, these uninsured people living with HIV either pay for services out-of-pocket or seek care through limited donor-supported nongovernmental organization (NGO) programs. While central governments can continue to procure commodities, local governments will have to play a greater role in funding delivery of HIV testing and ART services for the uninsured. This includes, for example, local governments funding the facility administration fee and any consultation fees requested out-of-pocket from uninsured patients seeking HIV services. Until JKN scales up to universal coverage, local governments can support the removal of financial barriers to accessing care faced by uninsured people living with HIV. Financing mechanisms for the scaled-up HIV response should encourage providers to be indifferent as to whether a patient requiring HIV testing or treatment services has JKN coverage or not—payment modalities and rates should be the same for both insured and uninsured patients.

Some interventions are not currently well suited for reimbursement through JKN and should increasingly be funded through local government budgets as external funding subsidies. In general, JKN is not as well placed to address non-facility-based interventions given BPJS-**K's current contracting and payment mechanisms are linked** to facilities. The minimum service standards (Standar Pelayanan Minimal or SPM) form the basis for local governments to fulfill their obligations in the health sector. Under a 2016 MOH regulation (Permenkes 43), the minimum service standards (SPM) include greater focus on preventive and promotive efforts that support public health. On this basis, outreach services are treated as a responsibility for local government financing. Though not considered in this analysis, in the future, outreach services could be funded through JKN as part of the implementation of performance-based capitation. This could build from the current MOH pilot initiative to encourage health personnel at community health clinics (*puskesmas*) to visit every family in their catchment area once every six months (known as the Healthy Living Community Movement or GERMAS initiative); contact rate indicators (**one of the measures included in JKN's performance**-based capitation model) could then be expanded beyond facility-based contacts.

Some of JKN's regulations make certain HIV interventions challenging to offer through the scheme. Needle and syringe exchange programs and methadone maintenance treatment (a form of opioid substitution treatment) are not currently appropriate for coverage under JKN due to limitations on coverage allowed for health issues caused by drug dependence or self-harm (Presidential Regulation No. 19/2016, Article 25). Methadone maintenance treatment is currently provided in select hospitals and financed by the central government. This arrangement may continue. Local governments are best placed to support provision of needle and syringe exchange services, either directly or through funding of community-based organizations, as they have greater local knowledge of, and accountability to, beneficiaries.

Overall, different funding streams can come into play for HIV financing, depending on who is covered and the services in question. There are various potential pathways to leverage different financing streams to fund the HIV response at a level sufficient to achieve the fast-track targets (see Figure 2). The roles of different financing streams are intended to be complementary and should ensure all people in need of HIV services are able to access the services they require. Inclusion of services **within JKN's** benefits package is the first step to expanding the source and depth of financing for the HIV response. The inclusion of people in need of HIV services within JKN membership is also a critical enabler for greater financing through JKN, explored in detail in the next section.

Figure 2: Potential Roles for Different Financing Streams in Funding the HIV Response

2. What proportion of people in need of HIV services are covered by JKN?

Assumptions of how many people living with HIV can be covered by JKN depend on the future path of expanding national coverage. This analysis required assumptions around the current and future JKN coverage level for the general population and for people living with HIV. HP+ previously developed a model for the financial sustainability of JKN which involved creating projections of potential enrollment scale-up rates from 2017 to 2020 (Prabhakaran et al., Unpublished). The most likely scenario for JKN enrollment scale-up takes into account the employment characteristics of the remaining unenrolled population (civil servants, private formal, and informal sectors) and assumes the subsidized poor and near-poor population (PBI in Bahasa) will remain constant at 92.4 million people, in line with current policy discussions. This scenario is extended through 2023 and a breakdown of coverage by the four enrollment segments (civil servants, private formal, informal, and subsidized) in each province was calculated.

The MOH's current identification and HIV testing strategy emphasizes general population testing, hence JKN's overall coverage is relevant. Access to HIV testing services through JKN is based on total projected JKN enrollment rates by province, as testing is applicable to the general population. The remaining population of non-JKN members are assumed to access HIV testing services funded by the local government. As **costs associated with the provider's time to administer HIV tests are already covered by JKN** (as shown previously in Table 1), integration of HIV test kits and supplies into JKN benefits packages will make HIV testing available for all JKN members.

Alongside planned scale-up of ART, estimation of JKN coverage among the different segments of people living with HIV is necessary.² For ART services, three steps were taken to ascertain the level of JKN coverage of people living with HIV in each province. First, an understanding of the types of people living with HIV was needed to determine their socio-economic status. The estimated share of different people living with

² JKN enrollment segments consist of the following: subsidized (national level), formal private sector, subsidized (local level), public sector workers, informal sector workers, and various (pensioners, etc.).

HIV was based on information from the MOH and assumptions about their likely socio-economic status (see Table 2).

Table 2: Estimated Share of People Living with HIV by Group

HIV-positive populations	Estimated share	Socio-economic classification
Non-key populations	65%	Employed across all sectors
Clients of female sex workers	16%	Employed in private and informal sectors
Men who have sex with men	15%	Employed in private and informal sectors
Other	4%	Employed across all sectors

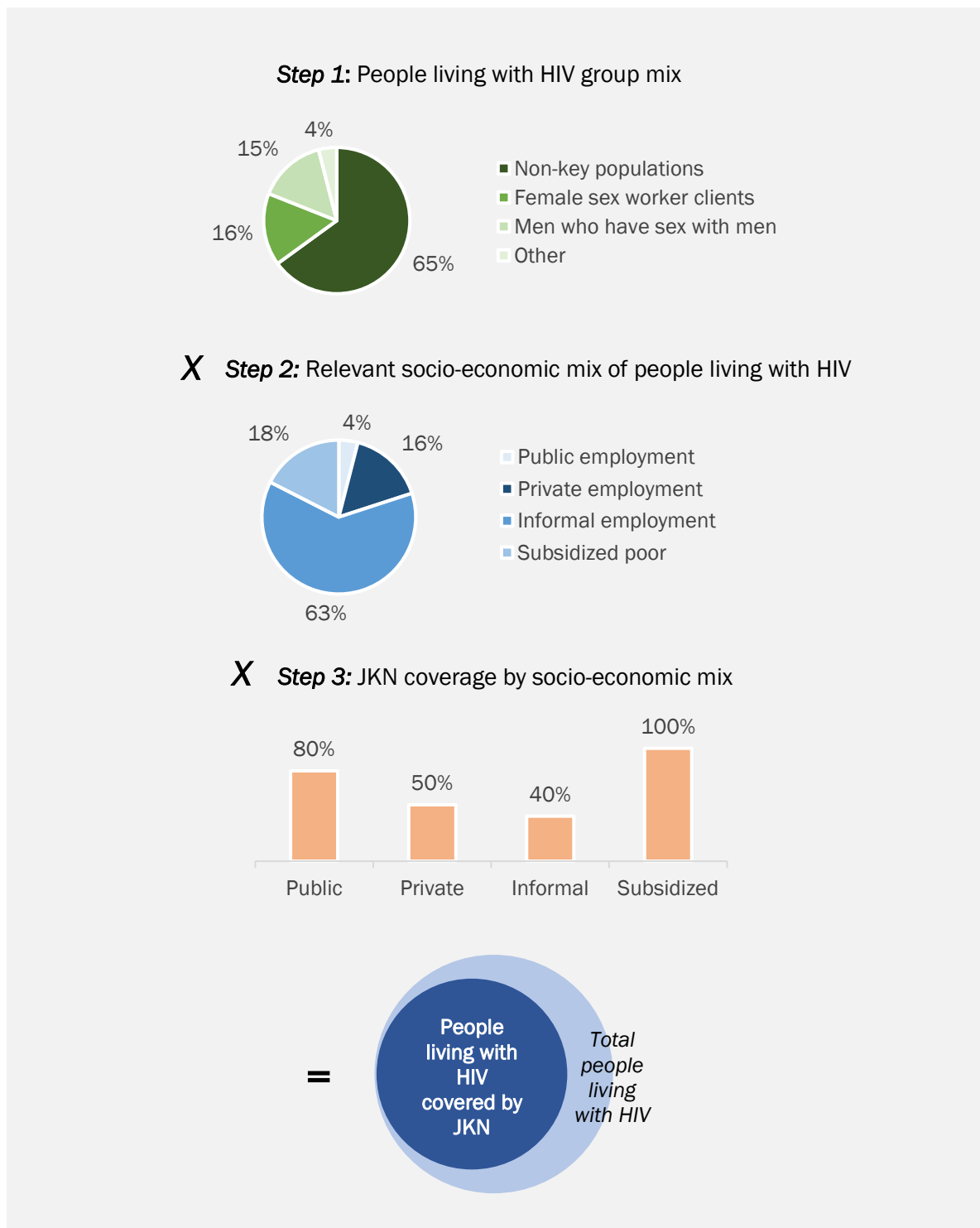
Source: MOH, estimates and projections of HIV/AIDS using Asia Epidemic Model (2017)

Second, with an understanding of the different socio-economic groups that were represented in people living with HIV, recent survey results were used to inform the share of people living with HIV in each socio-economic group (see Table 3). Third, these assumptions were then applied to the projected JKN coverage of each socio-economic group, by province, to derive the projected number of people living with HIV who would be JKN members in each province, and thus be eligible to receive ART treatment services through the JKN scheme.

Table 3: Socio-Economic Characteristics of People Living with HIV

Socio-economic classification	Estimated share of people living with HIV	Notes and data sources
Employed in informal sector + subsidized poor	81%	International Labour Organization study (2014): 62% of people living with HIV were employed in the informal sector (N=300) BPJS-K case mix data (2017): 68% subsidized poor and Class III informal sector members Proportion of people living with HIV who are subsidized poor compared with proportion of general population who are subsidized poor per province: 0.6
Employed in public sector	4%	Validated by stakeholders at preliminary workshop (2018): Remainder split 4:1 private sector to public sector
Employed in private sector	16%	

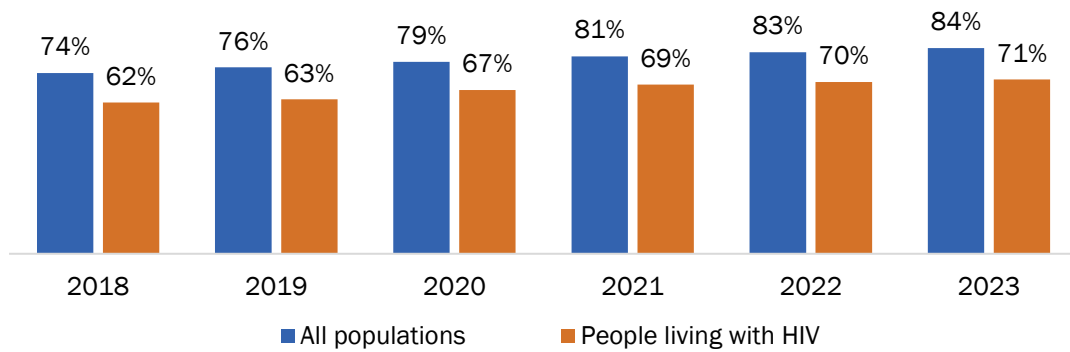
JKN coverage for people living with HIV was ultimately determined by multiplying the results from these various steps for each group of people living with HIV, namely those from non-key populations, clients of female sex workers, men who have sex with men, and other (see Figure 3).

Figure 3: Estimating the Number of People Living with HIV Who May Have JKN Coverage

Though people living with HIV may have lower effective JKN coverage due to the characteristics of sub-groups, those not covered by JKN can still be covered by the local and central government. As of May 2018, approximately 75% of the Indonesian population are enrolled in JKN and this is projected to increase to 84% by 2023 (see Figure 4). Our analysis suggests that people living with HIV have, and will have, lower rates of enrollment in JKN, which could be due to being primarily employed in the informal sector, the segment with the lowest JKN coverage rate. Those people living with HIV who are vulnerable or poor, and thus eligible for subsidized services, may still face registration

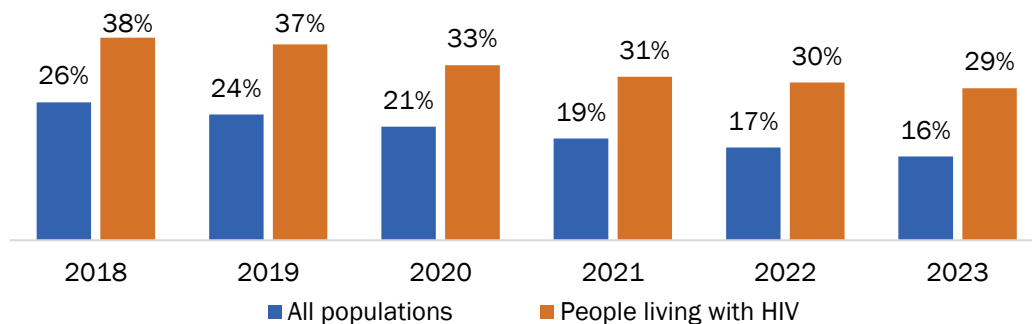
challenges for the unified database of poor beneficiaries due to insufficient identification documentation or frequent changes of address. As previously discussed, we assumed those yet to be enrolled in JKN can still receive HIV testing and ART treatment services through local government funding (see Figure 5). The local governments will not, however, be able to procure ARVs or VL commodities, but will pay for ART visits at the same rate that JKN is proposed to reimburse facilities for ART visits, discussed below.

Figure 4: Projection of Population Able to Access HIV Services* through JKN



* General population will mainly access HIV testing services as per government plans.

Figure 5: Projection of Population Able to Access HIV Services* Funded by Local Governments



* General population will mainly access HIV testing services as per government plans.

3. What are the unit costs and cost assumptions associated with the provision of HIV services by JKN and by local governments?

Reimbursement rates were developed using base costs from a companion analysis (HP+ and MOH, 2018), while considering how HIV services could be strategically purchased to affect provider incentives. Specifically, this analysis used results from cost analyses conducted by the MOH and HP+, including population targets and unit costs for HIV service delivery, accounting for the latest commodity price data and MOH scenarios, projected from 2018–2023 (HP+ and MOH, 2018). In the analysis, costs were estimated by province, year, intervention, and cost category, building upon a 2015 study conducted by the Joint United Nations Programme on HIV and AIDS (UNAIDS), a 2016 World Bank activity-based costing of select HIV services, and latest commodity price data (Suchhya and Mardiati, 2015). In our analysis, baseline costs were estimated for staff, overhead, and commodity unit costs to conduct key population outreach, condom distribution, testing and treatment of sexually transmitted infections, needle and syringe exchange programs, methadone treatment, HIV testing services, and HIV treatment, including laboratory monitoring. Unique multipliers for each province and intervention were developed with stakeholder input to generate province-specific unit costs. Multipliers were

based on provincial variation across four factors: difficulty reaching each key population (based on expert opinion), cost of living (2015 Badan Pusat Statistik data), external funding priorities (2018–2020 Global Fund funding request), and place of service delivery (2016 MOH data). These costs formed the basis of the fee-for-service reimbursement rates put forth in this financing analysis.

Projections of total costs to be incurred by JKN and local governments in each province were derived from the cost and population-level coverage data. A number of adjustments were made to these costs to account for existing JKN-related purchasing arrangements and potential cost differences in using different funding streams to finance the HIV response. Inherent in these adjustments and plans for how providers will be reimbursed is a consideration that making a significant effort to raise HIV service volumes to meet the national fast-track targets will require additional incentives for primary care facilities, and that both public and private-contracted facilities under JKN (especially in geographies where a majority of contracted primary and referral facilities are private) will be involved. All of the purchasing designs proposed are preliminary, and substantial engagement of BPJS-K, providers, districts, and MOH stakeholders will be required over time to refine these and test them for feasibility and impact on the HIV identification, care, and treatment cascade. As currently used, these cost assumptions include:

- A portion of staff and overhead cost elements for public facilities were assumed to be covered by supply-side, tax-funded financing from the central government, such that JKN and local governments only had to take on the incremental staff and overhead costs for the additional HIV services. At the primary care level, the proportion of applicable supply-side financing required a proxy, calculated based on the current differential in capitation rates between *puskesmas* and private general practitioner clinics, which purportedly accounts for this issue.
- While there were differences in base unit costs for HIV services between provinces, reimbursement rates for primary healthcare facilities were calculated at a national level to reflect the current provider payment structures in place under JKN for fee-for-service (*non-kapitasi* in Bahasa) arrangements and capitation rates at this level. Local governments are expected to provide identical fee-for-service reimbursements for non-JKN patients seen at the primary healthcare level to reduce any undue incentives for providers to prioritize JKN or non-JKN patients. This would incentivize local governments to promote JKN enrollment to these patients identified as non-JKN members, serving as an additional mechanism to support the scale up of enrollment toward universal health coverage.
- HIV testing services provided at the hospital level were assumed to be more expensive than testing services provided at the primary healthcare level, due to the type of staff involved and service standards; this analysis assumed hospital-level costs were anecdotally 20% higher than at primary healthcare facilities, but this assumption requires further validation by the MOH and BPJS-K. This analysis also assumed 80% of all facility-based tests occur at the primary healthcare level as a conservative assumption that some tests would still occur at the hospital level if a patient presents there first or for other diagnoses that lead a provider to consider an HIV test necessary. A fee-for-service rate for HIV testing service events was developed for both primary healthcare facilities and hospitals. Local governments are expected to adopt the same fee-for-service rates for those without insurance who seek HIV testing services.
- For all ART services provided at the primary healthcare level, the administration fee per visit, currently charged to uninsured, out-of-pocket-paying patients, was assumed to be covered by local governments going forward. For JKN members, this fee was assumed to be covered under existing capitation arrangements, and a fee-for-service reimbursement rate per ART visit was determined separately for new and existing

patients. Primary healthcare facilities are currently not envisioned to take on procurement for ARVs, so the assumption within this analysis is that, despite the shift in ART service delivery from hospitals to the primary healthcare level, ARVs for JKN or non-JKN members who are seen at the primary healthcare level will continue to be procured by the central government.

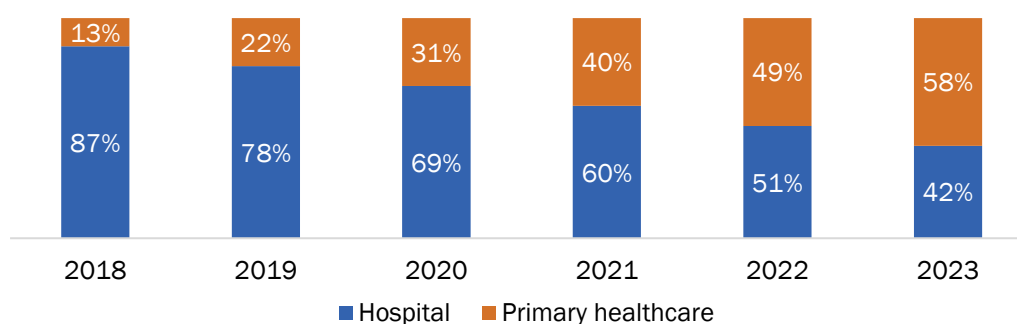
- For ART services provided at the hospital level, the existing INA-CBG payment for HIV-related services was used to determine the total costs projected to be incurred by JKN to implement the intermediate package. This INA-CBG payment excludes the cost of ARVs. A higher case-based group payment was developed for the comprehensive package to account for hospitals purchasing and being reimbursed for ARVs.

4. At what levels of the health system are HIV services currently provided, and where could they be provided?

Current plans assume HIV testing services to be primarily facility-based. The proportions of current facility-based versus community-based testing services were not verifiable with government of Indonesia counterparts. However, there is evidence to suggest that community-based testing approaches would increase uptake of HIV testing and improve linkage to ART services (Sulat et al., 2018). Therefore, to successfully scale up testing services under the fast-track strategy, community-based testing approaches should be considered. The analysis conservatively assumed that 75% of testing services are facility-based (and thus eligible for reimbursement through BPJS-K for JKN members), while 25% of HIV tests are assumed to be performed in the community, as part of outreach services to be funded by the local government.

While ART provision is currently hospital-dominated, the analysis builds in a shift to primary healthcare facilities, which will be more efficient and reduce financing needs over time. At present, ART services are overwhelmingly provided at the hospital level (87%). This reduces access to care for people living with HIV, increases the cost of HIV service delivery, and unnecessarily crowds hospitals, even though these services can be provided at the primary healthcare level for most stable patients. To successfully cope with the significant increase in people living with HIV accessing ART services through implementation of the fast-track strategy, there should be an active effort to refer some stable patients to the primary healthcare level. New patients should be initiated and managed increasingly at the primary healthcare level as well. This analysis assumes that through such sustained effort, 58% of ART services will be provided at the primary healthcare level by 2023 (see Figure 6). This reduces overall financing needs as the cost of service provision at the primary healthcare level is less than at hospitals. The cost of ARV drugs (over 80% of total ART service delivery costs in most provinces) will remain the same.

Figure 6: Projection of ART Service Delivery by Level of the Health System



5. What payment mechanisms should be used to pay providers for HIV service delivery?

Different payment mechanisms for HIV services integrated into JKN can be considered, with pros and cons—further debate and discussion are required. The payment mechanisms adopted to support the provision of HIV services can have a significant impact on the costs incurred by the JKN scheme and local governments, as well as the incentives faced by providers (see Box 1). The nature of HIV services needs to be taken into account when devising an appropriate payment strategy. Certain assumptions were made for **this analysis, based on the authors' judgement**, and these may be varied in future analyses with greater stakeholder engagement and program piloting. In addition to the payment methods adopted in this analysis, in future real-world application, incorporating quality-related tariff adjustments as incentives for achieving certain outcomes (e.g., virally-suppressed ART patients responding on therapy) may make HIV service delivery more efficient and of higher quality within JKN integration. BPJS-K, the MOH, and local governments must balance the additional cost of these quality-related incentives against expected long-term savings due to reduced adverse events and regimen switching, and improvements in overall HIV outcomes.

Box 1. Possible Impact of Potential Provider Payment Mechanisms for HIV Services

Capitation: Costs are capped and predictable for JKN, however, primary healthcare providers may refer people living with HIV to hospitals more and/or focus on short-duration, low-effort interventions (e.g., limited counselling and ancillary health services).

Fee-for-service (*non-kapitasi*): Costs could escalate for JKN and local governments as facilities are reimbursed for each and every service provided, but this payment method incentivizes facilities to scale up HIV testing and ART services (supporting the fast-track strategy).

Case-based payments (INA-CBGs): Current reimbursement method under JKN for HIV cases seen at hospitals, paid retrospectively for outpatient care per ART visit or per case. Overall, managing HIV cases at hospitals with INA-CBGs will be more costly to JKN than reimbursing the caseload with non-capitation payments at the primary healthcare level.

Top-up payments (non-INA-CBGs): A top-up payment (e.g., for viral load) would incentivize providers to scale up provision of underutilized HIV interventions. However, untargeted use has the potential to become costly to JKN and the central government (e.g., if routine viral

Fee-for-service payment at primary healthcare and hospital levels may need to be considered to incentivize provider-initiated voluntary testing efforts, but controls are required to prevent over-spending on testing. For HIV testing services, if HIV test kits and supplies are no longer centrally procured (i.e., distributed to facilities at no charge to them), a fee-for-service (*non-kapitasi*) payment could cover the cost of the test kits, which can be procured by facilities, in addition to the labor and overhead component for the test and counseling. To ensure affordability and quality of test kits, pricing and distributors of test kits accessible to facilities (or districts purchasing for public primary healthcare facilities) would require further procedures. The fixed reimbursement per test would incentivize provision of provider-initiated HIV testing. However, approaches to **balance the MOH's desire to promote efficiency through higher testing yields, BPJS-K's efforts to manage spending, JKN members' right to request an HIV test, and some providers' incentives to inflate testing volumes**, will warrant further consideration. For example, testing yield targets could be set at the district level based on HIV prevalence and incidence data, and **"global budgets" for HIV testing fee-for-service payments** at a district level could be set. These or alternate controls would support the appropriate use of testing algorithms to

identify those most at risk of contracting HIV. This analysis uses payment rates that were set nationally for HIV testing based on 2018 testing targets by province, adjusted for the relative cost differences of HIV testing in each province (see Table 4). These rates were set for both primary care facilities and hospitals.

Managing an increasing ART patient volume at primary healthcare and hospital levels will require adopting a chronic care model, with incentives to retain patients successfully at their assigned healthcare level. ART services could be considered similar to chronic non-communicable disease services, which JKN tries to manage increasingly at the primary care level. However, including ART services within the list of services to be managed under capitation payments at the primary care level may not sufficiently incentivize the added effort as current ART guidelines in Indonesia require monthly clinical visits, hence, may result in primary care providers making excessive referrals by classifying the patient as unstable. Overall, capitation may see providers with little incentive to manage patients on a lifelong therapy that requires frequent facility visits. This would not help to reduce the current over-reliance on hospitals for the provision of ART services. The alternative proposed in this analysis is to provide a fee-for-service (*non-kapitasi*) payment for each ART-related patient visit to the facility. This fee-for-service payment will be paid by BPJS-K for JKN members and local governments for remaining people living with HIV on ART. The reimbursement rate is set nationally for all ART services at the primary care level with a higher rate per visit in the first year for new patients due to their increased lab monitoring costs (see Table 4). It assumes ARVs continue to be funded by the central government.

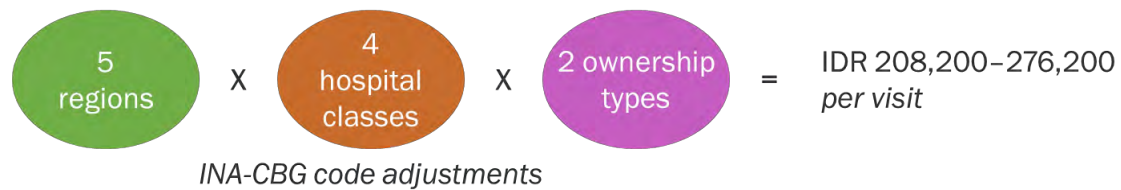
Table 4: Reimbursement Rates per HIV Test and ART Visit

Service	Reimbursement for primary care facility	Reimbursement for hospital
HIV testing	IDR 393,000	IDR 472,000
ART visit: new patients	IDR 80,000	(see Figure 7)
ART visit: existing patients	IDR 58,000	(see Figure 7)

Pending further investigation of whether new INA-CBGs are required for the proposed intervention, ART services provided at the hospital level can continue to be reimbursed by BPJS-K through the existing HIV-related INA-CBG codes and tariffs. The rates for INA-CBG payment code Q-5-34-0 were developed by the MOH, with adjustments based on geographic region, hospital class, and ownership type resulting in a range of reimbursement rates per visit (see Figure 7). The exact scope of services and supplies included in the INA-CBG tariff needs further exploration. Nevertheless, as an indicative step, this analysis assumes that HIV patients will receive their ART services, i.e., physician consultation and basic biochemistry lab tests for ongoing monitoring, within this reimbursement. Receiving such services at hospitals versus primary healthcare is more expensive, hence the importance of increasing the capacity and incentives for primary healthcare facilities to treat stable ART patients and reduce the overall cost of implementing the fast-track strategy for JKN and local governments. The current INA-CBG payment code Q-5-34-0 does not include the cost of ARVs and is used as the relevant rate for implementation of the intermediate package. In this scenario, these drugs are procured and distributed by the central government to participating facilities. The proposed comprehensive package includes the provision and reimbursement of ARVs through JKN; the potential financial implications to the scheme are detailed below, including the necessary revisions to the current INA-CBG reimbursement rates.

Figure 7: INA-CBG Reimbursement Rate for ART Service Visits at Hospital Outpatient Departments

Q-5-34-0 "Infeksi virus HIV"



Certain tests associated with ART are still high cost, available only at the referral level in Indonesia and require additional investment in staff training and equipment, which may require a supplementary payment. Viral load tests, which can currently only be provided by certain hospitals and specialist laboratories, will not be covered under the case-based payment due to their high costs and as they are not required at every outpatient visit (i.e., an annual need for existing patients and twice in the first year for new patients). A special “top-up” payment (in addition to INA-CBG tariffs for case-based payments under JKN) can be made to hospitals and laboratories who provide these services, on a per test basis. This will ensure they are appropriately reimbursed for conducting viral load monitoring services and incentivize more laboratories to equip themselves or utilize dual-purpose machines such as GeneXpert (if available) for this. Provider incentives and reactions to the new top-up payment for viral load monitoring should be monitored closely after implementation to ensure efficiency and quality. As these technologies become available more broadly, the potential for phasing out the top-up could be considered.

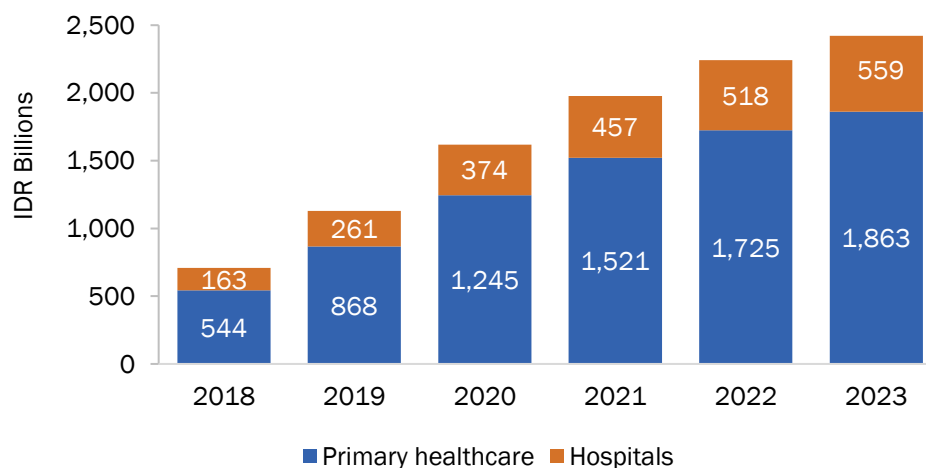
Results

The results of this analysis are detailed first in terms of cost by HIV intervention area, and then in terms of total financing necessary through JKN to implement each package. The costs borne by the JKN scheme and local governments are presented for each of the four key HIV intervention areas: (1) HIV testing services, (2) ART services (with separate sections for primary care and hospital-based care), (3) viral load monitoring services, and (4) community-based prevention, outreach, and harm reduction services. The total projected cost impact for both JKN and local governments in absolute terms and relative to their current levels of health expenditure is considered on the basis of integration of either the intermediate package or the comprehensive package within JKN. The necessary local government funding is determined in response to the level of JKN integration, and so the financial impact is quantified as a range, considering JKN implementation of the comprehensive package or no change from the status quo.

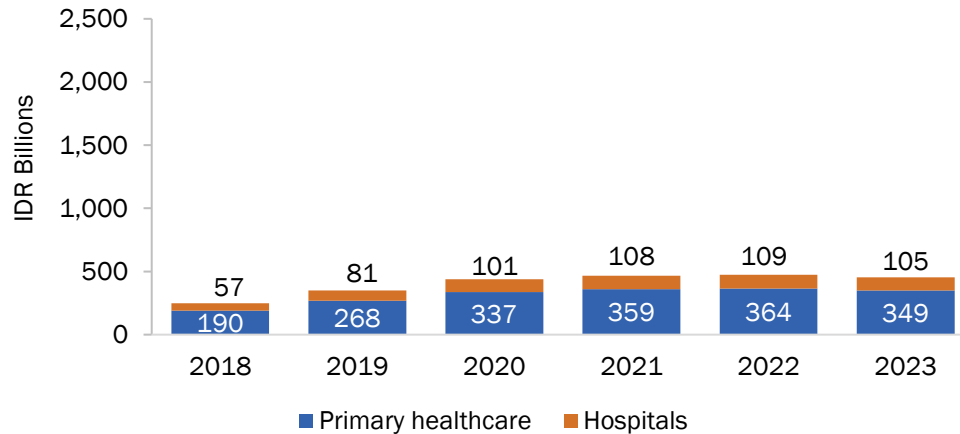
What financing needs could be borne by JKN and local governments in funding the fast-track strategy?

Due to the ambitious fast-track targets for HIV testing, financing required for HIV testing services triple for JKN and nearly double for local governments between 2018 and 2023. HIV testing is the intervention with the highest total spending across all years due to the large number of individuals targeted for testing under the current testing strategy (including testing all pregnant women for HIV by 2023). These expenditures could be reduced through the adoption of more efficient testing strategies including active-case finding. Total financing needs for HIV testing services funded by JKN rise rapidly from 2018 to 2023 (from IDR 708 billion to IDR 2.4 trillion, US\$50.6 million to US\$172 million) due to the increase in the number of tests under the fast-track strategy and increased JKN enrollment, and thus access to services funded through JKN (see Figure 8). Local governments are expected to fund HIV testing services for those yet to be enrolled in JKN, and as this proportion of the population declines, so does the total financing needs for testing after a peak in 2022 of IDR 473 billion (US\$3.8 million) (see Figure 9).

Figure 8: Projected Total Financing Need for HIV Testing Services* Funded by JKN

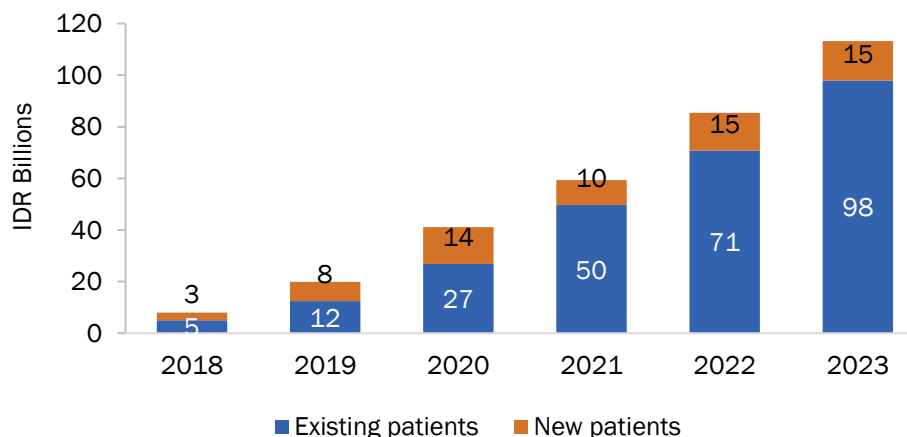


* Includes rapid test kits and consumables.

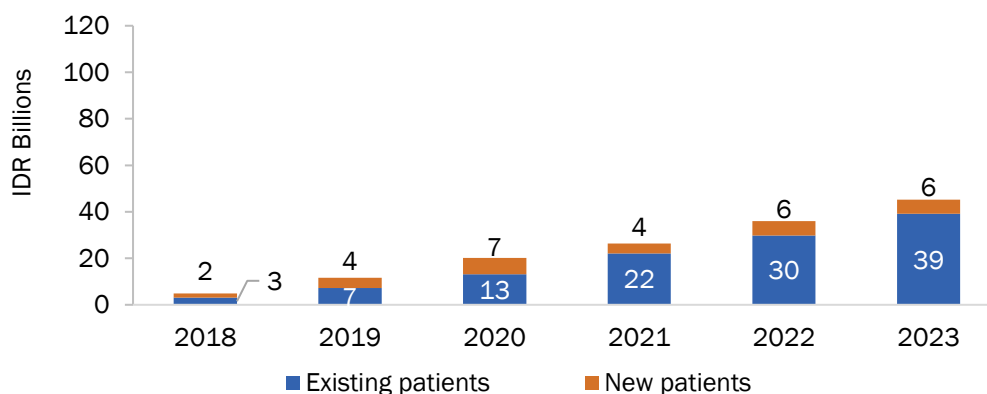
Figure 9: Projected Total Financing Need for HIV Testing Services* Funded by Local Governments

* Includes rapid test kits and consumables.

ART services reimbursed through a fee-for-service per visit at the primary care level increase financing required through JKN but are more efficient than scale up primarily at the hospital level. ART services available at the primary healthcare level are the same under both the intermediate and comprehensive packages (i.e., no ARVs and no viral load tests, as shown previously in Table 1). Integration of ART service delivery causes expenditures to continue to rise for both JKN and local governments as the proportion of ART services sought at primary care facilities increases from 13% in 2018 to 58% in 2023. Primary healthcare level fee-for-service reimbursements for ART visits through JKN are projected to rise to IDR 113 billion (US\$8.1 million) by 2023 (see Figure 10), while local government financing requirements rise to IDR 45 billion (US\$3.2 million) (see Figure 11). If this shift in service provision from hospital outpatient departments to primary care facilities deviates from the projection, primary care financing requirements could be significantly lower, but more expensive hospital-based expenditure would increase the overall financing needs for the HIV response. The financing required for new patients stabilizes over time as their proportion diminishes.

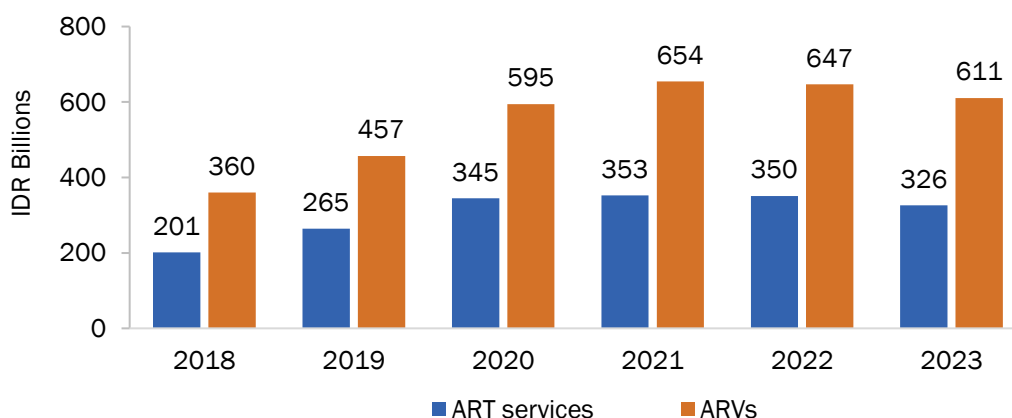
Figure 10: Projected Total Financing Needs for Primary Care ART Services* Funded by JKN

* Excludes ARV and viral load test costs.

Figure 11: Projected Total Financing Needs for Primary Care ART Services* Funded by Local Governments

* Excludes ARV and viral load test costs.

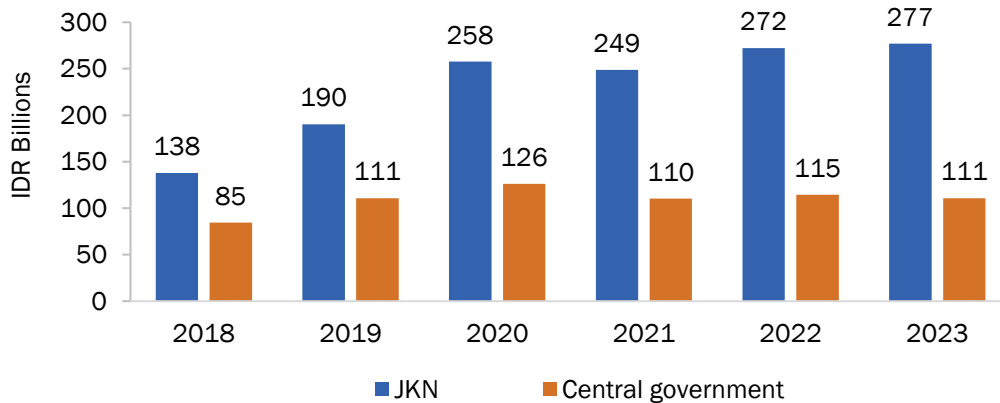
Total financing required for ART services and ARVs at the hospital level are estimated to peak in 2021 and then decline. This analysis assumes concerted efforts to provide ART services preferentially at the primary healthcare level. As a result, under the intermediate package, total ART service financing needs at the hospital level peak in 2021 at IDR 353 billion (US\$25.2 million) and then decline, despite the rapid increase in people living with HIV on ART expected through implementation of the fast-track strategy (see Figure 12). These financing needs were calculated based on average national reimbursements, though there are variations in the INA-CBG reimbursement rate by region, hospital type, and ownership (as shown previously in Figure 7). If the comprehensive package was adopted, and hospitals were to start to buy their own ARV drugs, JKN's policies would need to change to allow BPJS-K to reimburse for ARV drugs, and the INA-CBG code would need to almost triple to accommodate the additional IDR 611 billion (US\$43.7 million) in annual financing required in 2023. The procurement process for hospitals to purchase and be reimbursed for ARV drugs should follow the same process they currently employ for other drug purchases through the e-Catalog system.

Figure 12: Projected Total Hospital-Level ART and ARV Financing Needs Funded by JKN

As use of GeneXpert testing is scaled up, the reimbursement rate under JKN per viral load test will decline; coupled with declining numbers of new patients over time, financing requirements of JKN and the central government stabilize. As proposed earlier, given the nature of viral load monitoring services, a non-CBG top-up payment is required to appropriately reimburse facilities through JKN. The reimbursement rate per viral load test declines over time due to the plan to scale up GeneXpert testing in place of more costly Abbott testing. This, along with a decline in the number of new patients

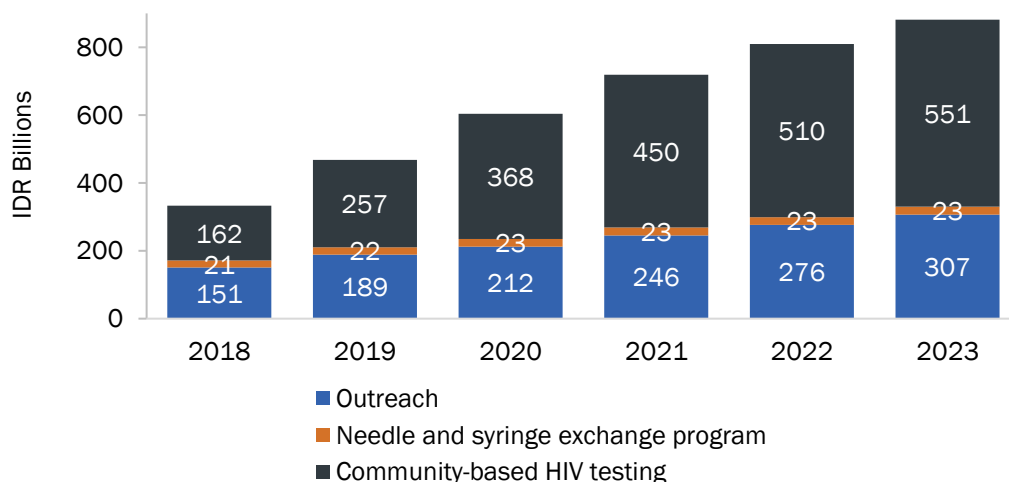
requiring two tests after 2021, allows JKN financing needs to stabilize, reaching IDR 277 billion (US\$19.7 million) in 2023, despite the rapid scale-up of people living with HIV on ART, who would be eligible for an annual viral load test (see Figure 13). As JKN enrollment continues to scale up, the financing required by the central government to cover non-JKN members also declines, from a peak of IDR 126 billion (US\$9 million) in 2020 to IDR 111 billion (US\$7.9 million) in 2023.

Figure 13: Projected Total Viral Load Monitoring Financing Needs



Community-based prevention, outreach, and harm reduction services are not currently appropriate for inclusion in the JKN benefits package and will require local governments to finance the projected increased costs. To the extent non-facility-based services are provided by civil society organizations that are primarily funded through external support, an appropriate strategy is necessary to either facilitate social contracting by the government with these organizations or commit to direct provision of essential interventions by local governments. As discussed earlier, JKN is a less appropriate financing mechanism for non-facility-based services, therefore this analysis calculates the financing required for local governments to take on and scale up these specific HIV services for the entire population regardless of JKN membership, as part of the fast-track strategy. HIV testing performed in the community will be a majority of the cost and could be even more significant if assumptions that costs per test will be similar to facility-based tests do not hold. Total financing required by local governments is projected to increase to IDR 881 billion (US\$63 million) by 2023 (see Figure 14).

Figure 14: Projected Total Financing Needs for Prevention and Other Outreach Services Borne by Local Governments



What is the projected total financing impact on JKN and on local governments in supporting the fast track strategy?

Based on this analysis, the projected costs to JKN may be manageable initially but do increase substantially. The total financing requirements for the intermediate and comprehensive packages of HIV services shown in **Table 1** as a proportion of JKN's current and projected total scheme expenditure (as enrollment coverage scales up), increases from 1% in 2018 to 2.3% in 2023 for the intermediate package, and 1.5% in 2018 to 3.0% in 2023 for the comprehensive package. To assess the reasonableness of these proportions of total JKN expenditure on health, an assessment of HIV relative to the burden of other diseases faced by JKN patients is required. This assessment would also need to consider the public health impact and long-term financing implications of under-financing the HIV response at present. Total financing required from JKN to implement the intermediate or comprehensive packages of HIV services reaches approximately IDR 2.9 trillion (US\$207 million) and IDR 3.8 trillion (US\$268 million) by 2023, respectively.

Figure 15: Projected Total Financing Needs under JKN for the Intermediate HIV Package

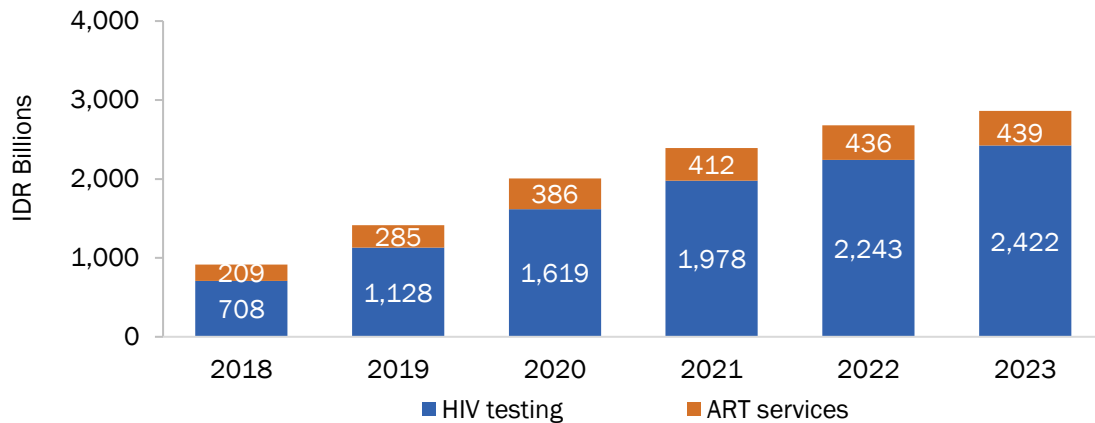
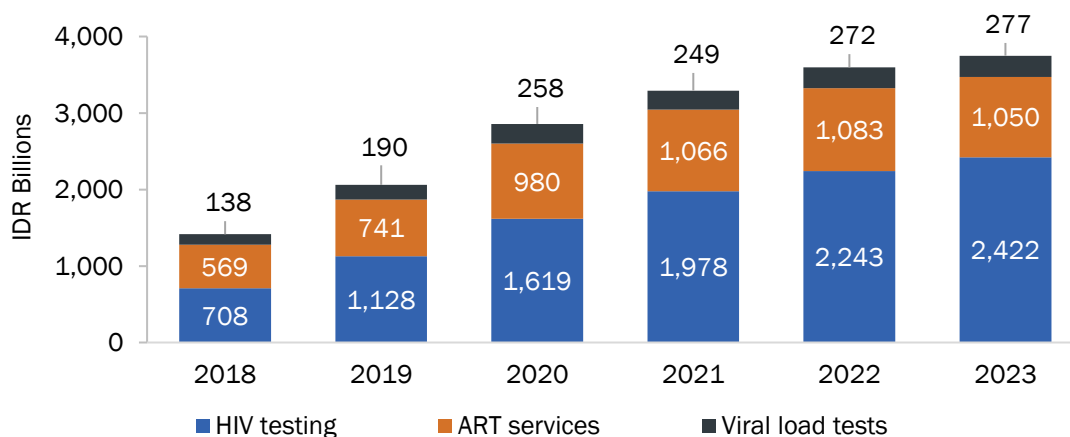


Figure 16: Projected Total Financing Needs under JKN for the Comprehensive HIV Package



Note: for figures 15 and 16, options to bolster JKN revenue, either through contributory (i.e., changes to premiums for specific segments) or non-contributory means, should be considered to offset this increased expenditure.

The level to which HIV services are integrated within JKN will have a significant impact on the financing required from local governments. If the comprehensive package of HIV services is adopted by JKN, local governments will cover the remaining non-JKN members as well as community-based services. The financing needs for these services equate to approximately 0.6–1.0% of total projected local government health spending from 2018 to 2023 (approximately IDR 587 billion in 2018 to IDR 1.4 trillion in 2023; see Figure 17), based on HP+ analysis and projections of local government spending using the National Health Accounts and economic data from Badan Pusat Statistik. However, if integration with JKN is not feasible or is delayed (i.e., integration with JKN remains at its current level), then the burden on local governments to absorb all HIV testing and ART services is significantly higher, equating to 1.4–2.8% of total local government health spending from 2018 to 2023 (approximately IDR 1.3 trillion in 2018 to IDR 4 trillion in 2023; see Figure 18). This scenario assumes that all ARV commodities and viral load tests remain funded by the central government.

Figure 17: Projected Total Financing Needs under Local Governments if JKN Adopts Comprehensive HIV Package

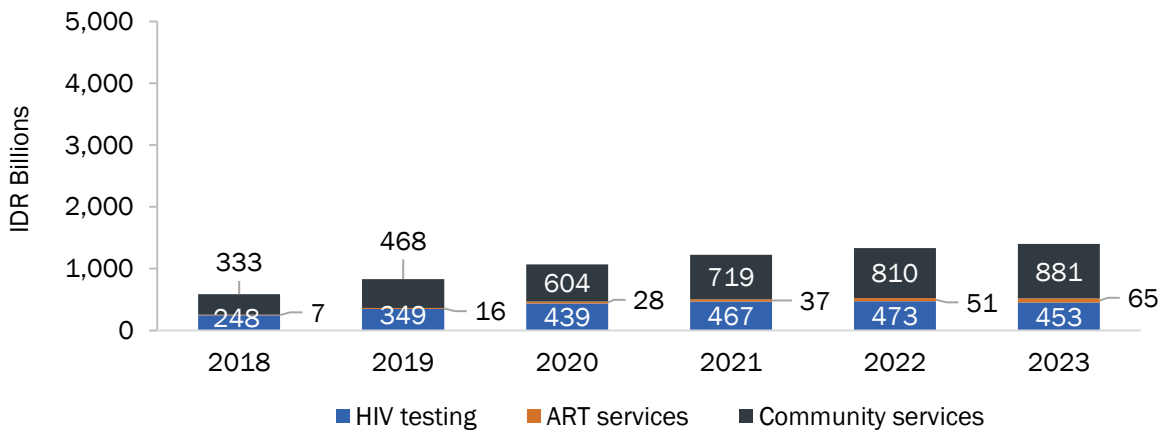
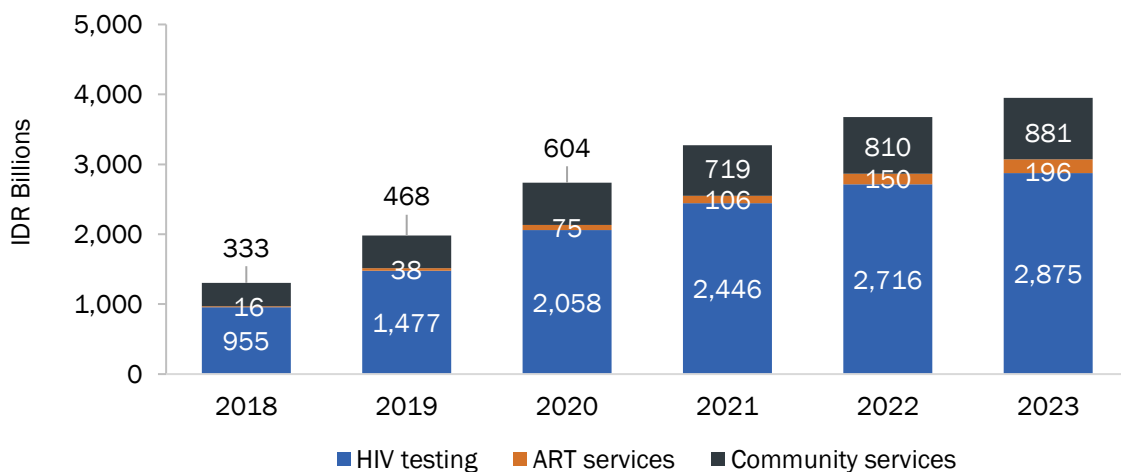


Figure 18: Projected Total Financing Needs under Local Governments if JKN Maintains Current Level of HIV Integration



Discussion

The central government will continue to play a significant role in Indonesia's HIV response, particularly around commodity financing. However, there are options to generate additional resources and leverage more strategic purchasing mechanisms for the provision of HIV services through greater integration with the JKN scheme. Local governments should also play an increasing role in the funding and provision of HIV services. With more information on which HIV services will definitively be integrated into JKN, more specific analysis on the remaining HIV services and costs by province can be **compared to local and provincial governments' fiscal space to highlight provinces with the** largest resource gap. Further engagement with various stakeholders would support the refinement of payment modalities and payment rates.

Nevertheless, this analysis demonstrates that while the increase in cost to implement the fast-track strategy are significant, greater integration of HIV services into JKN may be a critical and effective way to fund these services. Further, JKN becomes increasingly relevant as insurance coverage scales up and more and more Indonesians expect to receive healthcare through the scheme. A shift to funding HIV services through JKN also supports implementation of strategic purchasing mechanisms that can increase efficiency and sustainability by reducing reliance on input-based, supply-side financing from central or local governments. To the extent JKN does not cover people living with HIV or HIV services, the local government will need to fill this financing gap to facilitate the scale-up of the HIV response.

Local governments are well-placed to pick up key services not suited to inclusion in JKN benefits packages and for uninsured populations. These include community-based prevention, testing, and outreach services that are almost exclusively supported by donors at present. However, policymakers should be mindful of not fostering increased fragmentation that could lead to variable quality and access to services as well as greater difficulty in tracking progress and expenditure. To this end, the central government still has a significant role to play in oversight, coordination, and commodity procurement.

There are a number of areas for further investigation, including the legal and regulatory amendments necessary to facilitate JKN and local governments as key financing mechanisms for the HIV response. The steps to implement the amendments to JKN regulations needed to facilitate greater integration of HIV services need to be assessed. These regulations could pertain to service delivery at different levels of the health system, payment methods, drug and commodity procurement protocols, and beneficiary inclusion criteria that impact key populations. In particular, the reimbursement of ARVs through JKN will need to be facilitated. At the local government level, an assessment of current regulations governing the provision of HIV services and the contracting of health services more generally from NGOs is required. This would include exploring the expansion of social contracting mechanisms to support the provision of key community-based activities, where civil society organizations are best placed to deliver these services. Recent regulations from the government procurement agency—Lembaga Kebijakan Pengadaan Barang Jasa Pemerintah or LKPP—pertaining to sub-contracting with NGOs to procure and deliver HIV commodities should improve responsiveness. Meanwhile, efforts to integrate local targets for a scaled-up HIV response into local government planning and budgeting activities are also underway with support from NGOs and development partners.

Improving efficiencies, both in service delivery and commodity procurement should be a key focus to increase the affordability of the HIV response. The rapidly rising annual costs, particularly for HIV testing, reveal that an increased focus on the adoption of efficient HIV payment modalities is crucial if this strategy is to be accepted by payers as an effective use of limited resources. In this analysis, indicative HIV testing costs

soar due to a large increase in tests to be performed, coupled with a fee-per-test payment structure. Further exploration of ways to incentivize yield and new cases identified and linked to care could significantly increase the efficiency in spending on HIV testing. From a technical efficiency standpoint, unit costs for ARV drugs and viral load lab reagents are significant cost categories in the current scale-up plan and achieving reductions in commodity costs will be critical in determining the affordability of the fast-track strategy and addressing the current resource gap. In addition, the ability to shift ART services to the primary healthcare level is a key factor in this analysis that will improve access for patients and reduce per patient costs. If this shift in service delivery model fails to materialize, per patient costs will escalate and the ability to reach scale-up targets will be hampered by **patients' access to hospital outpatient departments.**

Development and validation of provider payment mechanisms and rates require extensive consultation. The development of appropriate provider payment mechanisms should be conducted through the convening of a technical working group that represents the interests of providers, payers (BPJS-K and a representative for local government interests), civil society (to represent patients), and the government. This working group would consider various nuances in implementing different payment mechanisms for various HIV services at each level of the health system. For example, fee-for-service (non-capitation) payments at the primary healthcare level could differentiate between the type of visit (for example, if a doctor or a nurse provides counselling or if any lab tests or other health services are performed) or be a flat rate per visit based on the average estimated usage of each of these types of services by each ART patient over the course of a year. Coordination between various paying entities is necessary to ensure providers are indifferent **to a patient's JKN enrollment status.** Otherwise, there is a risk that non-JKN members, who may be more marginalized members of the community, suffer from decreased access to and quality of HIV services.

Outcome-oriented financing mechanisms should be considered, comparing the additional upfront cost with a potential impact on patient outcomes and long-term efficiency of HIV service provision. As the payers, both BPJS-K and local governments have incentives to increase HIV testing cost efficiency and yield. For ART services, facilities that achieve key performance metrics (for example, proportion of patients retained in care, adherence rates, and viral suppression rates) can be rewarded to promote scale-up of successful patient management practices. BPJS-K and districts can use such outcome-oriented payments, sometimes called value-based healthcare, to supplement fee-for-service payments, with a view to align facility and HIV program objectives. High-performing facilities staying within a global budget could also be made eligible for bonus payments on an annual basis, as a way to incentivize quality and efficiency in service delivery. Any new initiative should fit within the context of the existing JKN architecture and be assessed for the administrative burden imposed on BPJS-K, as well as the potential impact of displacing provider effort in relation to other essential health areas. As a start, assessing the current performance-based capitation pilots as a potential mechanism for addressing quality of HIV care may have merit.

Considering the significant role of the private sector in JKN service provision, its ability to support scale-up of HIV services requires further exploration. The results presented in this brief have focused on public sector provision of HIV services. The private sector has increased its participation in the JKN scheme at the primary and hospital level significantly over the first four years of implementation and this trend is set to continue. The private sector could have an important role to play in the provision of HIV services. Reimbursement rates for HIV testing and ART services provided through the private sector would need to account for the fact that private providers do not get government supply-side financing. In particular, the procurement process to be used by private hospitals to access HIV commodities would warrant further investigation. **Private providers can currently view the LKPP's e-Catalog to verify prices and distributors accessed**

by the government to use in their own negotiations with manufacturers and distributors (Britton et al., 2018). Given ARV drug regimens are included within the e-Catalog, the same process could apply for the provision of HIV services. A process is currently underway to **facilitate private providers' ability to order directly from the e-Catalog**, accessing the same prices and distributors as public facilities. Unlike *puskesmas*, which will continue to rely on government provision of commodities, private clinics could explore ways to procure ARVs directly and be reimbursed by JKN for both drugs and services provided, in reaction to market forces. This will become increasingly relevant as the patient load for HIV service delivery shifts from the hospital level to the primary healthcare level. Further analysis and consultation is needed to develop appropriate reimbursement rates for such directly purchased ARVs. Increased private sector participation is critical to support the significant **scale-up in Indonesia's HIV response by increasing access and choice** for people living with HIV.

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