

October 28, 2016

## POLICY BRIEF

# INDONESIA

## HEALTH FINANCING SYSTEM ASSESSMENT

# SPEND

MORE,  
RIGHT &  
BETTER



Canada



Swiss Confederation



# KEY MESSAGES

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In the past two decades, Indonesia has experienced robust economic growth, coupled with a number of improvements in both key health indicators and progress towards UHC. By the end of 2016, nearly 172 million individuals, or more than 60 percent of the population, were covered by Jaminan Kesehatan Nasional (JKN) program, one of the largest single-payer social health insurance (SHI) schemes in the world. Nation-wide targets aim to reach the remaining uncovered population and to have universal coverage by 2019. At the same time Indonesians, broadly-speaking, have become healthier in recent generations as progress continues along a number of key health indicators. In particular, a number of improvements to child health have been realized including declines in the under-five mortality rate from 222 per 1,000 live births in 1960 to 27 per 1,000 in 2015 which meant Indonesia achieved MDG 3.

Despite improvements in health outcomes, Indonesia is still facing a number of persistent economic and health challenges which require significant and immediate changes to the way the health system is currently financed in order to reach nationwide universal health coverage (UHC). Indonesia still faces an unfinished Millennium Development Goals (MDG) agenda lagging achievement in reducing high maternal mortality rates and childhood stunting, while faced with new challenges including a rising prevalence of non-communicable diseases and growing aging population. From an economic perspective, relative

reductions in the nationwide poverty rate have been accompanied by growing income inequality. The challenges of ensuring improved access to quality care with the implementation of the national social health insurance (JKN program) and increased of government supply side financing. Moreover, these are compounded by high levels of informality in the labor market, and a highly decentralized system of governance with diffuse accountability mechanisms, including delivery of essential health services. These challenges are projected to continue into the future and present barriers to ensuring all Indonesians are afforded and equitable coverage.

Well-targeted and adequately financed health financing reforms have the potential to improve health outcomes, mitigate household vulnerability and reduce the risk of impoverishment from catastrophic health spending. However, meeting these objectives while accelerating progress towards UHC by 2019 requires significant efforts to improve the efficiency, effectiveness and sustainability of the existing health system. This will require the Government of Indonesia to *Spend More, Spend Right and Spend Better*:

1. Spend More: At just 3.6 percent of GDP, overall health spending in Indonesia continues to be one of the lowest, not only in the region, but globally. This is due primarily to low overall government spending and a relatively low share of government spending going to health.

Currently, public spending on health is only 1.5 percent of GDP. In order to achieve the ambitious target of extending coverage to all Indonesians, the government needs to increase public health spending to ensure adequacy of public financing for health.

2. **Spend Right:** At the same time, increased resources should be focused towards those interventions which are (proven) effective such as increased investments in primary health care, promotive and preventive interventions, particularly for vulnerable populations living in rural and remote locations.
3. **Spend Better:** Moreover, investments can be maximized by focusing on a results-based approach that maximizes the technical efficiency of the limited resources available.

*Accelerating progress towards UHC and meeting nationwide population targets by 2019 will require Indonesia to **Spend More, Spend Right and Spend Better** on the existing health system.* Moving forward several opportunities exist for improving the overall efficiency, effectiveness and sustainability of health financing systems. The objective of the Indonesia public expenditure review using health financing system assessment (HFSA) framework identify critical constraints and opportunities facing Indonesia's health financing system and to offer evidence-based policy recommendations including:

#### Spend More

- Raise additional public financing for health by i) increasing overall government revenues through improved tax collection and introduction of higher 'sin' taxes including those on tobacco ii) encourage labor formality iii) reprioritize health in the government's budget iv) increase enrolment of the remaining formal sector
- Ensure adequate financing for the JKN benefit package, while clearly and explicitly defining the JKN benefits package so that current public financing gaps can be clearly identified and estimated
- Adjust the JKN benefits package to make it commensurate with current public financing resources, economic growth, projected macro-fiscal trajectory, and service delivery capacity
- Increase and expand coverage of the nonpoor informal sector by improving awareness through

alternative strategies for socializing information about JKN

- Incentivize local governments to eliminate mistargeting particularly among the poor and near-poor

#### Spend Right

- Strengthen primary care delivery, most importantly, provision of preventive and promotive public health interventions
- Strengthen quality of health facilities and human resources for health, through accreditation and certification
- Reduce OOP payments by expanding coverage and reducing mistargeting of contribution assistance recipients (PBI)
- Integrate supply-side and demand-side financing to improve public and private provider supply-side readiness including i) making capitation payment to puskesmas contingent on Minimum Service Standard (MSS) attainment ii) provide puskesmas with an appropriate level of autonomy balanced with capacity enhancements iii) inclusion of private providers iv) at the hospital level, making diagnosis-related group payments conditional on the adequacy of services provided

#### Spend Better

- Improve JKN capitation payment mechanism by linking it with provider's performance to incentivize the delivery of preventive and promotive services
- Enhance the effectiveness of intergovernmental fiscal transfers by improving local government capacity, particularly on public sector management (PSM) functions.
- Ensuring greater accountability of local governments by implementing systems for independent verification and incentivizing results through non-financial rewards for districts
- Utilize the MSS as a mechanism for ensuring delivery of essential services at the sub-national level
- Strengthen JKN linkages with much-needed, externally financed health programs by ensuring there is a smooth transition plan in place, including clear mechanisms for government service delivery, to ensure limited interruptions and scalability of programs

# Objective of This Brief

This brief draws from the Health Financing System Assessment (HFSA), which is a diagnostic assessment protocol aimed at identifying critical constraints and opportunities facing Indonesia's health financing system. The overarching objective of the main HFSA Report, as well as this policy brief is to inform the development of short-term and longer-term health financing strategies and reforms aimed at sustaining progress towards UHC.

## Background

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Indonesia has a population of almost 260 million people and is a lower middle income country with a GNI per capita of \$3,238 USD (\$10,680 USD in 2015 PPP terms) in 2015. The country has rebounded strongly from the Asian financial crisis in 1997 and experienced robust economic growth over the past decade with the country's GDP almost doubling from USD 580 billion in 2001 to USD 1.1 trillion in 2012, making Indonesia the 15th largest economy in the world and likely to achieve upper-middle-income status in 2018. While sustained economic growth over the past 15 years helped to pull many people out of poverty, inequality has been increasing and access to basic health and social services varies significantly across regions, for instance some provinces in the Eastern part has infant mortality rate (IMR) double or even triple the national average.. Indonesia also faces persistently high levels of informality in its labor force. Currently, 60 percent of those employed are classified as 'nonsalaried workers', indicating that a large share of the nonpoor remain in the informal sector.

Over the past decades, the country has also achieved significant progress in key health outcomes. Life expectancy has increased to 69 years in 2014, up from 63 years in 1990 and only 49 years in 1960. Likewise, the under-five mortality has declined from 222 per 1,000 live births in 1960 to 27 in 2015 and infant mortality rate declined six-fold since

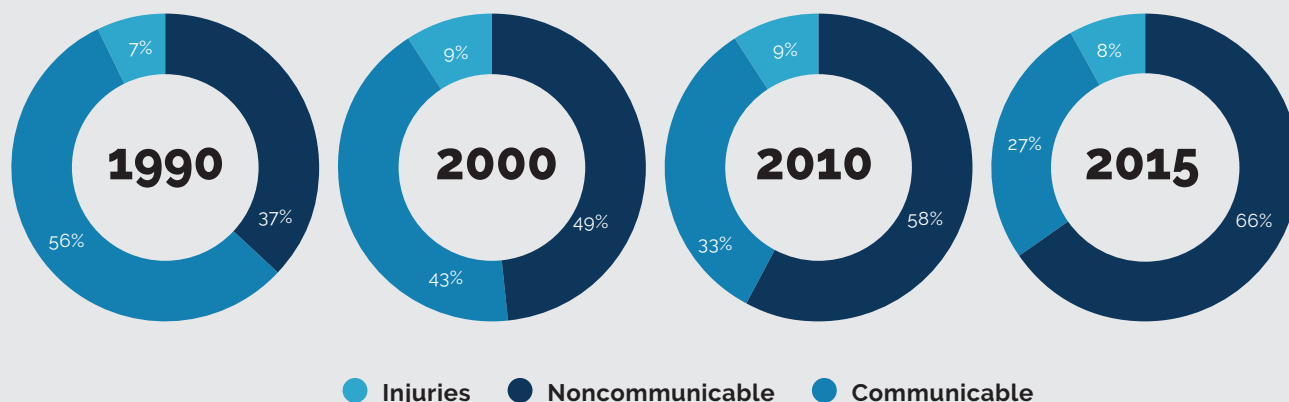
1960 down to 23 per 1,000 live births in 2015. And while Indonesia has met the child-health related MDG, there is an unfinished agenda with regards to reducing maternal mortality and childhood stunting. Indonesia has also faced challenges in reversing HIV and TB epidemic, which have continued to increase over the past several years. Additionally, some parts of the country continue to face challenges with regard to malaria.

At the same time, Indonesia is undergoing a rapid epidemiological transition. At almost 70 percent<sup>1</sup>, non-communicable diseases (NCDs) in 2015 account for the largest share of the burden of disease and this is expected to grow in the coming years. Additionally, a demographic transition is projected in the near future, including a rapid increase among the population aged 65 and above. NCDs are also growing among younger age groups due to physical inactivity, unhealthy diets and tobacco use. These new challenges are expected to increase the burden on the health system for which there is currently a low level of utilization, uneven distribution of services and is largely focused on providing curative rather than promotive and preventative care.

As part of efforts to expand implementation of the national security system, Indonesia plans to reach UHC with everyone covered under its newly unified Social Health Insurance (SHI) program, JKN by 2019. SHI has undergone major reforms in Indonesia in recent years. The universal right to health care was included as an amendment to Indonesia's constitution in 1999. However, the impetus for expansion of SHI came a few years

<sup>1</sup> Institute for Health Metrics and Evaluation, 2015.



**Figure 1** Trends in Burden of Disease in Indonesia (1990 - 2015)

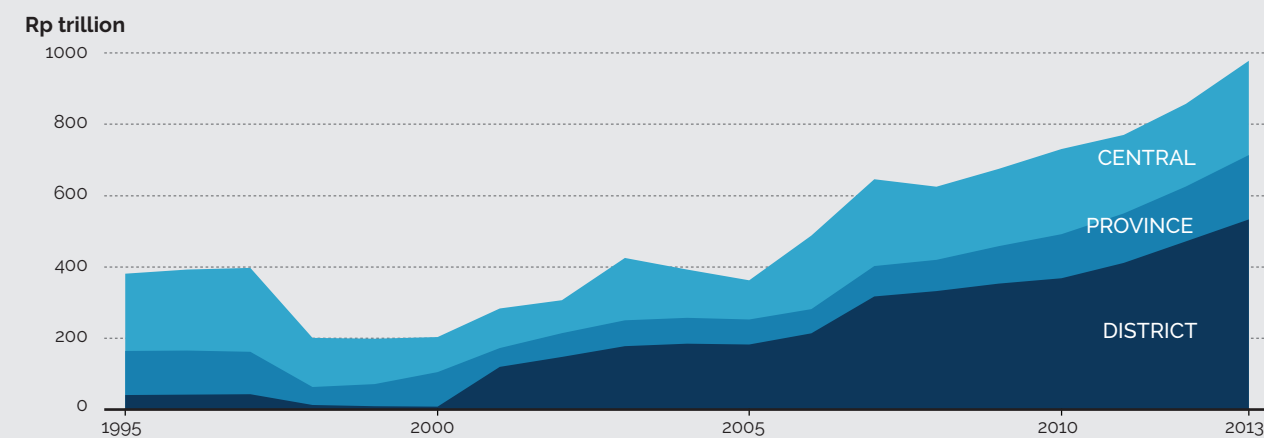
later through landmark legislation in 2004, which established the *Sistem Jaminan Sosial Nasional* (SJSN) law which formed the legal basis for achieving several social protection objectives. Following up from SJSN, in 2011 the Government of Indonesia introduced *Badan Penyelenggara Jaminan Sosial* (BPJS) which further defined the administrative and implementation arrangements. BPJS paved the way for merging all single-payer health insurance (SHI) schemes into one uniform package of benefits under a single-payer umbrella by 2014, which is also known as the JKN program.

However, there have been several challenges with the implementation and scale-up of the JKN program. Currently, only about 7 percent of the nonpoor informal sector population has JKN coverage, raising the challenges of adverse selection, as well as, a “missing middle” with regards to healthcare coverage. The JKN benefits package is not clearly defined in that all medically necessary coverage is automatically covered without any copayments, balanced billing or expenditure caps. This extremely generous basic benefits package stretches thin financial resourcing, as well as, the capacity of the system to provide services leading to implicit rationing and high out-of-pocket (OOP) for households. Other challenges include (but are not limited to) fragmented funding flows, mistargeting of government subsidized beneficiaries (e.g. the poorest households) limited capacity to deliver services and non-collection among nonpoor informal workers.

Meeting nationwide targets and accelerating progress towards UHC by 2019 will not be limited to expanding population coverage, measured in number of JKN cards distributed, but will require significant efforts to improve the efficiency, effectiveness and sustainability of the existing health system.

The decentralization of health service provision, budgeting and government expenditures also poses unique challenges to implementing reforms to the system of health financing. Currently, less than 40 percent of all national government health expenditures occur at the national level, with the largest share, 57 percent, being incurred at the district level and 7 percent at the provincial level. While the central government remains the dominant source of revenues, from around 6 percent of GDP transferred to the sub-national level. The process of interfiscal government transfers is also complex and fragmented, often resulting in disconnects between central-level policy and local-level service provision. Currently, transfers between levels of government are not linked to improved health outcomes or provider performance, limiting the central government’s ability to enforce accountability or incentivize results from the use of resources. Unsurprisingly, issues with channelling sufficient resources for health between levels of government have resulted in continued challenges for the JKN program where supply-side financing and demand-side financing do not necessarily work together to improve service delivery.

**Figure 2** Trends in Government Health Spending by Level of Government (1995-2013)



**Source** Indonesia COFIS database  
**Note** Data in 2013 constant IDR

## Understanding the Main Sources of Health Financing in Indonesia

Currently, there are four main sources of financing for health which determine the equity, effectiveness and efficiency of services being delivered throughout the country. Adjusting the way health care services are currently financed in Indonesia requires a better understanding of the main sources of funding, as well as the particular challenges they pose to sustaining and scaling-up services in the future. Despite some increases in public financing in recent years, the fundamental structure of health financing has remained largely unchanged in Indonesia due to parallel increases in OOP for health. Currently Indonesia's public health financing system is characterized by the coexistence of traditional government budgetary supply-side health financing and demand-side SHI financing. It remains unclear why this dual cofinancing modality remains and whether it is expected to change in the near to medium term.

### OOP BY HOUSEHOLDS

At 45 percent of total health expenditures in 2014, OOP spending by households remains the largest source of financing for health in Indonesia. OOP payments connect utilization of health services to an individual's or household's ability to pay and are largely considered to be an inefficient and inequitable means of financing health systems. There are four main reasons for the continued dominance of OOP spending as a source of health financing: i) consistently low levels of public health spending; ii) incomplete breadth of coverage under the JKN program; iii) poor supply-side readiness; and iv) the public's preference for branded pharmaceuticals which are currently not covered under JKN.

High levels of OOP spending by households are, in large part, a result of low levels of public financing for health. OOP payments are an inefficient and inequitable means of financing health systems and expose households to the risk of impoverishment that results from high levels of health expenditures (which constraints spending on other necessary expenditures). Currently, 7 million households in Indonesia are facing poverty or are pushed deeper

below the national poverty line because of high OOP. OOP should only be used as a means for managing overutilization and reducing waste and not as a primary mechanism for resource generation. In order for OOP spending to decline significantly in Indonesia, public financing for health must increase at a rate faster than the rise of OOP for health.

### GOVERNMENT

Government budgetary supply-side health spending, both at the central and sub-national level, is the second largest component of health financing. Despite recent increases, government health spending in Indonesia remains one of the lowest in the region and in the world, at just 1.5 percent of GDP. Low levels of spending are a result of low prioritization of health and limited ability to generate revenue. Indonesia's revenue share of GDP was only 11<sup>2</sup> percent in 2015, far lower than other lower-middle income countries (28 percent) and less than half the average for other countries in the region. Although there was a significant increase in 2016, at just 4.7 percent, health's small share of the central government budget also reflects low prioritization, and is small in comparison to the Philippines, China and Thailand.

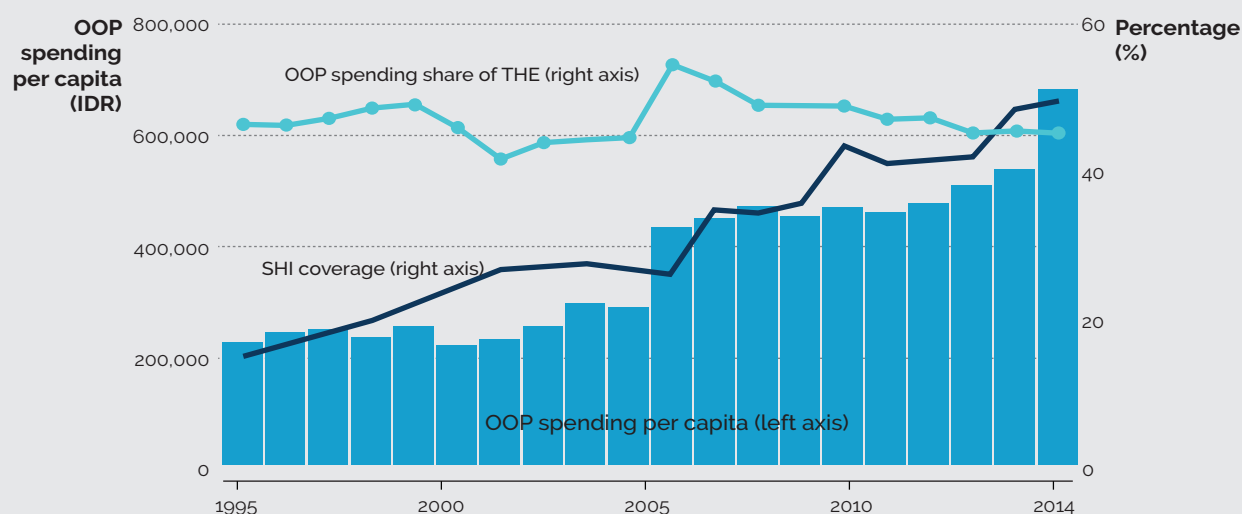
### SHI

SHI expenditures are the third-largest source of financing for the health sector in Indonesia and account for 13 percent of total health expenditures. BPJS revenue from contributions in 2015 amounted to almost IDR 52.8 trillion (USD 3.96 billion) and are pooled from three broad categories of people the poor and near-poor; salaried workers in the formal sector; and nonsalaried, nonpoor workers in the informal sector. Although Indonesia has successfully implemented a single-payer SHI system covering more than 60 percent of the population, it still accounts for only a relatively small share of total health expenditures. This is due to low contribution collection, particularly among nonpoor informal workers (who must contribute to enrol in JKN and for which JKN coverage has been limited), and that SHI reimbursements do not cover the full cost of care.

### EXTERNAL SOURCES

The fourth largest source of financing, funding from external sources such as international donors, accounts for only 1 percent of total health expenditures. Still, they remain a critical source of financing for priority programs such as immunization, HIV/AIDS, TB and malaria.

**Figure 3** SHI Coverage and OOP Share of Total Health Spending (1995-2014)



**Source** World Development Indicators database and SUSENAS (various years).

**Note** OOP spending is in 2014 constant IDR.

<sup>2</sup> University of Indonesia (2105). Taxes and Social Policy: Sustainable Growth under Informality. Institute for Economic and Social Research, University of Indonesia.

## Key Policy Recommendations: Spend More

Increasing public financing for health is a critical condition for reaching UHC in Indonesia. No country has attained adequate SDGs and reduced OOP on health to less than 30 percent of total health spending without public expenditure on health being at least 2.7 percent of GDP. While Indonesia has recently increased its government health spending, it remains one of the lowest in the world at just 1.5 percent of GDP. Public financing for health will need to rise significantly beyond currently levels in order for Indonesia to make progress on improving service coverage and financial protection. Acknowledging the challenges in increasing the fiscal space for public financing, key options to address the current deficit includes a combination of: i) increasing nonoil and gas tax revenues; ii) central government reprioritization of health spending (including from reduced energy subsidies); iii) earmarked tobacco taxes; iv) complementary subnational financing; v) targeted incentives and penalties for enrolling the informal sector; and vi) incentives to formalize participation of informal sector workers.

The sustainability of SHI as a source of health expenditure in Indonesia is contingent on eliminating mistargeting of the poor and vulnerable and expanding coverage for the nonpoor. Although Indonesia has successfully instituted a single-payer SHI system, few nonpoor informal workers have enrolled making contribution collection difficult. Those that have enrolled are those most likely to need health care, which undermines equity and threatens the financial sustainability of JKN. Mistargeting of non-contributory cover also poses challenges for enrolment particularly for the poor and near-poor. Only about half of the poorest 40 percent of households, all of whom should have central government-financed coverage, reported being enrolled in JKN. Although improvements in socialization, awareness and availability of benefits may increase enrolment and prevent mistargeting, global experience indicates that this may not be sufficient and alternatives would need to be considered. In the short to medium-term, measures must be taken to validate lists of eligible beneficiaries at the district level and provide clear options for poor

and near-poor households who are denied cards despite being eligible.

Stronger and clearer links to contextual factors, such as decentralization and JKN are key to the sustainability of much-needed externally financed health programs. Although not a dominant source of overall health financing, external resourcing from international development partners may bring global experiences, introduce innovative interventions and fill a funding gap for critical programs where the government budget has less flexibility. However, decentralization poses a significant risk to the sustainability of externally financed health programs, particularly between public financial management, and procurement and distribution of inputs, such as vaccines and drugs, at the central government level, and to day-to-day management of facilities and services at the district level. Donor-funded programs also come with disadvantages such as reporting and monitoring requirements, fragmentation of planning and challenges to managing funding flows. As JKN expands coverage, the key to the financial and institutional sustainability of these programs will be to better integrate them within the context of UHC. Greater integration would not only serve as an indicator towards UHC attainment, but also as a program element to which a proportion of intergovernmental fiscal transfers and BPJS provider payments can be linked. Some of the additional benefits of closer integration of these programs with UHC include more effective coordination of comprehensive service delivery, including greater collaboration of monitoring and evaluation activities.

In order to clearly identify funding gaps and future health financing needs, the complete JKN benefits package needs to be made explicit and commensurate with financing and service delivery capacity. To ensure that JKN's covered services and benefits are available for all members and that the resources (both financial and human) required to deliver the benefits are available, the JKN benefits package needs to be more explicit and adjusted in line with current public financing resources, economic growth, service delivery capacity and the projected macro-fiscal trajectory. While the current benefits package is comprehensive, it is not explicit in that all medically necessary coverage is automatically deemed to be covered without any co-payments, balanced billing or expenditure caps.



Furthermore, there is only a negative list for items such as formulary drugs, meaning what is positive (or covered under the program) is often inferred by providers from national guidelines. In particular, branded drugs which are not currently included in the JKN package are one of the key drivers of high OOP spending by households. Indonesia may learn from other countries' experiences in how to move from a comprehensive benefit package to a basic set of explicitly defined benefits, guaranteed with adequate financing from public sources (via government budgetary supply-side expenditures or SHI). In the future, mechanisms can be enacted to ensure that subsequent benefit expansions are commensurate with parallel expansions in public financing for health.

## Key Policy Recommendations: Spend Right

Health financing reforms need to consider not just the sufficiency of resources, but also the efficiency, equity and effectiveness of how resources are raised, pooled and allocated towards improving health outcomes.

There are significant geographical differences in the availability and quality of basic health services, especially for those living in relatively remote, rural and low-income communities. For many, these supply-side constraints translate into limitations in the effective availability of JKN benefits. Constraints include fewer numbers of qualified doctors, nurses and midwives; limited hospital beds; shortages or out-dated medical equipment and technology; and the unavailability of medical supplies. Supply-side constraints include not just shortages in numbers, but also in the distribution of services and providers. Rural and remote areas not only have fewer health facilities, but also face difficulties associated with retention of health personnel. In these areas JKN functions more like a demand-side top-up for a constrained and under-resourced supply-side system, rather than a fully-fledged SHI program. JKN still does not yet reimburse the full cost of providing care to patients which includes salaries, capital and some additional operating costs which are currently reimbursed by national and local government funds.

However, improving the efficiency of Indonesia's system of health financing means not only ensuring that resources are directed towards individuals and regions who most vulnerable. Technical efficiency, which is discussed below, requires investing scarce resources in to interventions that ensure service quality and accountability for meeting minimum service standards.

Improving equity and efficiency of coverage also includes providing public health interventions at the population level focused more on preventative and promotive care. The epidemiological transition in Indonesia towards NCDs means growing OOP expenses for many Indonesians not covered by JKN, or in some cases, forgoing needed treatment all together. At a macro-level the epidemiological transition will lead to a mounting fiscal burden on the JKN system which will threaten its long-term sustainability. Providing treatment and education for the population, particularly focused on NCDs, has been shown to be a cost-effective strategy for driving behavior change and lifestyle modification across the greatest number of individuals. For example, tobacco taxes could be used to reduce alarmingly high smoking rates in Indonesia, or at the primary-care level, support provided for early diagnosis and treatment, as well as expanded community-level outreach. Preventative and promotive population-level treatment is also needed to address persistent deficiencies across other public health challenges including access to modern family planning, DPT3 immunization coverage and improved access to sanitation and hygiene behavior change. However, less than 1 percent of JKN expenditures are for any preventative or promotive activities, with the bulk of expenditures going toward hospital-based inpatient care. This supports concerns that the over-emphasis of curative and rehabilitative care in UHC distracts from much-needed improvements to primary health care delivery, as well as population-level public health interventions.

Improving public and private provider supply-side readiness to serve all Indonesians, regardless of income or location, requires greater integration of supply and demand-side financing. As financing gradually shifts from the supply-side to the demand-side in Indonesia's health system, an appropriate level of autonomy for health facilities—coupled with enhanced technical assistance to improve capacity

to manage revenues—needs to be provided to public health facilities. This includes improving the quality of facilities and human resources for health, through implementation of a robust quality framework and additional measures to encourage additional accreditation and certification. It also means providing facilities greater discretion on how capitation funds are utilized, and reimbursed from BPJS so that they are no longer used as 'general purpose' funds for district governments. However, greater autonomy in how facilities can spend funds should be balanced with improvements in supply-side accountability for providing quality care, particularly in rural and remote communities. At the *puskesmas* level, where the predominant provider payment method for health facilities is capitation, payment should be linked either directly or indirectly to the attainment of minimum service standards. Similarly, at the hospital level diagnosis-related group payments could be made conditional on the adequacy of services provided in order to encourage investments in improving service readiness. Additional consideration should also be given to integrating and encouraging greater supply-side readiness for private providers through adequate capitation amounts which would act to level the playing field with public sector facilities, which already receive subsidies. As the system evolves and continues to scale-up, greater consideration should be given to additional measures aimed at mitigating negative incentives of capitation systems, such as over-referral, under-treatment and inappropriate referral to secondary care.

## Key Policy Recommendations: Spend Better

Choosing the right kinds of interventions and implementing them with improving efficiency are as important as spending better with the limited resources available. In order for health financing systems to radically improve in Indonesia, policy needs to focus on promoting not just the right kinds of interventions, but enhancing overall technical efficiency aimed at maximizing and improving service delivery from the limited resources available. In practical policy terms, improving technical efficiency means looking for opportunities to reduce costs without sacrifices to the amount or quality of services available. A WHO report examining the leading causes of inefficiency in the health sector found ten leading sources: i) underuse of generic medicines and higher than necessary prices for pharmaceuticals; ii) use of substandard and counterfeit medicines; iii) inappropriate and ineffective use of medicines; iv) supplier-induced demand and overuse of select services; v) inappropriate staff mix and unmotivated workers; vi) inappropriate hospital admissions and length of stay; vii) low use of infrastructure; viii) medical errors and suboptimal quality of care; ix) waste and fraud; and x) inefficient mix and inappropriate level of interventions.<sup>3</sup>

Linking JKN provider payments with results maximizes limited resources by incentivizing improved provision of quality preventative and promotive care. Performance-based financing has the potential serve as a tool to incentivize health systems and health providers to move towards expanded coverage of quality preventative and promotive care. Recent expansions in both coverage and access to health services have not been accompanied by expansions in the quality of human resources for health. Key challenges to improved quality are a misallocation of workers, shortages of specialists and inadequate skills of healthcare personnel. One of factors contributing to persistently low quality service provision is the tradition of dual practice, whereby clinicians try to combine public-sector clinical work with fee-for-service private

<sup>3</sup> Chisholm, D., and D.B. Evans. "Improving health system efficiency as a means of moving towards universal coverage." World Health Report (2010). Background Paper No. 28. Geneva: World Health Organization



practice in order to ensure adequate salaries and working conditions. Dual practice, which remains largely unregulated and unsupervised in Indonesia, has led to high rates of absenteeism and challenges deploying physicians to remote areas. Currently provider payment mechanisms under JKN are 'passive', meaning that there are no explicit linkages with outputs or outcomes. Tying provider payments to attainment of population-level service coverage targets (including preventative and promotive care) could be piloted as a potential mechanism for improving service readiness, expanding service coverage of key priority programs and enhancing efficient spending in the future.

**Increase effectiveness of inter-governmental transfers by linking them to results and performance in order to improve the quantity and quality of health services in remote and lagging districts (regions).** Decentralization in Indonesia has contributed to a complex and highly fragmented system of interfiscal government transfers, resulting in wide variations in health policy prioritization and spending across districts. While most districts spend approximately 10 percent of their budget on health (as required by law) some view health as a revenue-generating sector, pooling user fees collected from public health facilities with other sources of revenues to allocate across other sectors. Accountability measures such as improved monitoring and evaluation systems and nonfinancial and financial performance incentives can be used as a strategy for linking fiscal transfers with results – such as achievement of the minimum service standards for health. Some examples of nonfinancial incentives that can be used to motivate accountability and incentive achievement include benchmarking, public notification and rewards.

**Improvements to the availability and distribution of health providers needs to be complimented with systemic improvements such as those aimed at improving local governments' capacity to prioritize, plan, budget and effectively use available supply and demand-side financing.** While some allocation

of financial resources from the central government are based on district characteristics, the capacity of districts to plan for, absorb and realize outcomes/ outputs is often not a determining factor in the distribution of financing. Instead, the focus of national policy makers has been on ensuring that districts adhere to regulations rather than on building capacity to more effectively utilize resources for improving health service delivery. More needs to be done to improve the capacity of health facilities and district governments particularly in the area of public financial management (PFM). This includes technical assistance and incentives to strengthen planning and budgeting skills, as well as, reform organizational and overall fiduciary arrangements. Strengthening PFM competencies will ensure that any additional resourcing to districts is absorbed and utilized effectively towards meeting future public health needs.

**Minimum Service Standards (*Standar Pelayanan Minimal*, or SPM) are essential mechanism for ensuring delivery of essential services and promoting accountability at the sub-national level.** Recent changes to the Decentralization Law in Indonesia have provided greater clarity on the distribution of governance affairs and authority between central and regional governments, presenting an opportunity for central government to leverage the SPM as a mechanism for holding regional governments accountable for achievement of minimum services standards. SPM aims to ensure the delivery of essential services and ensures accountability across different levels of government through a shared set of indicators for measuring results. As a planning and budgeting tool SPM is also expected to serve as a reference for how local governments can prioritize budget allocations for basic health services. However, in order for SPM to be used effectively as a mechanism for ensuring sub-national compliance, clear strategies for follow-up and enforcement need to be developed to determine the degree to which SPM can be used to drive sub-national health outputs.

## Looking Ahead Towards other Areas of Future Policy Analysis and Research

This research brief lays the groundwork for additional policy analysis and research needed to explore other cross-cutting issues affecting the overall performance of Indonesia's health system. Additional areas for exploration include:

- Informal Sector: Understanding informal sector is key in expanding JKN population coverage including global best practices, and insights into health seeking behaviour and social insurance coverage among the informal sector in Indonesia.
- Provider Payment Mechanisms & Strategic Purchasing: Improving provider payment mechanisms is central to expanding coverage and ensuring quality. Additional work is needed to explore the challenges to and strategies for improving the effectiveness of the current provider payment mechanisms as instruments to influence providers in their contribution to achieving UHC.
- Fiscal Space for Healthcare Spending: Providing more revenue for health spending in Indonesia will require a mix of strategies including revenue earmarks and the potential implementation of tobacco excise earmark for health.
- Measuring the Financial Protection Functions of JKN: Additional research is needed on understanding the current performance of the national SHI (JKN) in achieving its financial protection goals.
- Exploring issues of Effectiveness and Efficiency: Assessing the ability of the recent health financing reform in addressing inequality issues in health.



*This policy brief was a summary of the Indonesia Health Financing System Assessment (HFSA) report published in October 2016. In addition to the HFSA authors, this brief was prepared by Rebekah Pinto, Emiko Masaki, and Pandu Harimurti. Funding from this policy brief was made available by all development partners funded the production of HFSA report.*

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*The full HFSA report is available for public at the following link  
[http://www.worldbank.org/en/country/indonesia/research/all?majtheme\\_exact=Human+development&qterm=&lang\\_exact=English](http://www.worldbank.org/en/country/indonesia/research/all?majtheme_exact=Human+development&qterm=&lang_exact=English)*