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A REGULATORY REVIEW ASSESSING JKN IMPLEMENTATION VERSUS DESIGN

June 2018
This publication was produced for review by the United States Agency for International Development.
It was prepared by the Center for Health Policy and Management, led by Dr. Shita Dewi, and reviewed by the Health Finance and Governance Project's Dr. Lisa LeRoy and Kelley Laird.

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JUNE 2018

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Likke Putri, Insan Adiwibowo, M. Faozi Kurniawan, Yanti Leosari, Budi Siswoyo, Crista Dewi Shita Dewi, Susan Gigli, Kelley Laird, and Lisa LeRoy. April 2018. *A regulatory review assessing JKN implementation versus design.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

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| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)

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CONTENTS

ACRONYMS

APBN	Anggaran Pendapatan dan Belanja Nasional
BOK	Salary and Operational Cost
BPJS-K	Social Security Administrative Body for Health
BPS	The National Bureau of Statistics
CHPM	Center for Health Policy and Management of the University of Gadjah Mada
DAI	Development Alternatives Inc.
DAK	Specific Purpose Grants
DHO	District Health Offices
FKTP	Primary or "First-level" Care Facility
GOI	Government of Indonesia
HFG	USAID's Health Finance and Governance project
IgM	immunology Test of Salmonella Typhi
IR for UHC	Implementation Research for Universal Health Coverage
JHSPH	Johns Hopkins Bloomberg School of Public Health
JKN	National Health Insurance in Indonesia
MOH	Ministry of Health
NIK	Indonesian Citizenship Identity Number
P2JK	Pusat Pembiayann dan Jaminan Kesehatan
P4P	Pay for Performance
PAD	Pendapatan Asli Daerah
PHC	Primary Health Care
PRB	Program Rujuk Balik
R4D	Results for Development Institute
SJSN	National Social Security System
TRG	Training Resources Group, Inc.
UKM	Public Health
UKP	Individual Health
USAID	United States Agency for International Development

ACKNOWLEDGMENTS

This regulatory review was funded by the United States Agency for International Development (USAID), and developed by the Health Finance and Governance project led by the Center for Health Policy and Management at the University of Gadja Mada with collaboration from the Ministry of Health (MOH).

The leadership, support, collaboration, and input of many Indonesian stakeholders were critical in completing this regulatory assessment. The authors also are grateful for the support provided by USAID|Indonesia, with special thanks and appreciation to Dr. Zohra Balsara and Dr. Edhie Rahmat.

1. PURPOSE OF THE REGULATORY ANALYSIS

The Health Finance and Governance (HFG) Project led by the Center for Health Policy and Management of the University of Gadjah Mada (CHPM) together with the Pusat Pembiayann dan Jaminan Kesehatan (P2JK), USAID, and other government of Indonesia (GOI) stakeholders implemented the Implementation Research for Universal Health Coverage (IR for UHC) project from August 2015 – April 2018. IR for UHC supports policy-makers and implementers in developing UHC-related research questions, undertaking cycles of research that explore implementation gaps and bottlenecks, and offering improvements to implementation of National Health Insurance (Jaminan Kesehatan Nasional/JKN) in Indonesia.

The advent of the Social Security Act and JKN has reduced some fragmentation by creating a single purchaser, the Social Security Administrative Body for Health (Badan Penyelenggana Jaminan Sosial- Kesehatan/BPJS-K) as a third party payer, contracting both public and private providers at primary, secondary, and tertiary care. Prior to JKN's introduction in January 2014, health care services were purchased using various payment models, including prospective payments, fee-for-service,[1] and cost-based reimbursement. JKN has been in place for almost four years in Indonesia, and has brought notable changes in health care financing, provision, and utilization. Health care provider levels are more clearly defined, with primary healthcare strengthening as the main strategy within the national health system for achieving the goal of effective and efficient health care service.

Assessing JKN's success in achieving the robust goals established for national health insurance, requires understanding the complex regulatory landscape that defines JKN's structure and implementation mechanisms.

The purpose of the regulatory review undertaken in late 2015 was to understand the effectiveness of existing regulations in implementing JKN, potential shortcomings and opportunities for revisions or clarifications, as well as how implementation deviated or aligned to the original design in the regulations. The regulatory review findings would in turn feed into IR for UHC national and subnational stakeholder engagement process and support the identification of the research questions for cycle 1 of implementation research.

Provision of care at the primary level is the backbone of JKN system and requires effective regulation. Primary health care is provided in puskesmas (public health centers) and private practices. The regulatory review focuses on five major features of JKN implementation in primary health care (PHC) including: provider payment and incentives, service package, utilization of capitation payment, referral within a multi-tiered system, and enrollment of the poor and vulnerable. Such features were identified by stakeholders early in the IR for UHC

[1] National Team for the Acceleration of Poverty Reduction. 2015. The Road to National Health Insurance (JKN). Available:http://www.tnp2k.go.id/images/uploads/downloads/FINAL_JKN_roadpercent20topercent20nationalpercent20healthpercent20insurance.pdf

process as important themes to untangle the major problems in the implementation of JKN. Hence, the study team completed the regulatory review to understand the existing regulations surrounding the five features and their potential shortcomings and opportunities. Each of the five topics is addressed below. We first describe the background for each topic, what the regulations say and then what happened during implementation.

2. THE METHODS FOR ASSESSING JKN IMPLEMENTATION VERSUS DESIGN

The IR for UHC process included extensive stakeholder engagement and feedback in the design of this regulatory review. To examine five major features of JKN implementation in primary health care (PHC) including provider payment and incentives, service package, utilization of capitation payment, referral within a multi-tiered system, and enrollment of the poor and vulnerable, we reviewed a number of Acts, namely Act no 40 year 2004 on National Social Security System (Sistem Jaminan Sosial Nasional, SJSN), Act no 36 year 2009 on Health, and Act no 24 year 2011 on the Social Security Managing Agency for Health (Badan Penyelenggara Jaminan Sosial, BPJS-K). We then looked at how these Acts have been translated into detailed policies to assess whether or not they are in line with each other, and whether or not the operational regulations enable implementation of the original purpose of the law. By doing this we were able to identify gaps in these regulations, and use this information in further stakeholder engagement to narrow and define the research questions for cycle one of implementation research.

3. FINDINGS FROM THE REGULATORY REVIEW

3.1 Primary Care Provider Capitation Payment and Incentives

3.1.1 Background

BPJS-K pays contracted puskesmas and private clinics using mostly capitation-based payment for services. This is on top of other government funding to puskesmas, namely salary and operational costs through the Ministry of Health assistance fund for operational costs at the health center level (Bantuan Operasional Kesehatan/BOK) which is known as a Special Allocation Fund[2] (Dana Alokasi Khusus/DAK). Theoretically capitation offers potential to contain costs by shifting financial risk to providers. Ideally, in an effort to capture more revenue, providers will offer more preventative healthcare and less costly curative care. In reality, if not carefully planned for, adverse consequences occur, including less effective curative care and increased referrals to tertiary care which drives up costs, as BPJS-K annual reports have shown.

3.1.2 What do the regulations state?

The amount of capitation paid to facilities is currently determined by an agreement between BPJS-K and the Association of Health Facilities,[3] and the agreement uses standardized pricing set by the Government.[4] For PHC, capitation payment is based on the number of enrollees at each facility (recorded in the BPJS-K data system), and the JKN capitation rate (per enrollee) set by regulations.[5]

The per enrollee capitation rate is based on standardized pricing of health care services set by MOH and adjusted taking into consideration local characteristics—e.g., availability of a health care facility in the area, consumer price index, and construction cost index.[6] BPJS-K has indicated that the capitation rate may vary from IDR 3,000-6,000 based on the following variables: number of doctors, doctor-to-enrollee ratio, dentist availability, and operating hours (i.e., opens 24 hours a day or not).[7]

These regulations demonstrate the government's recognition of the need for capitation rate adjustment for different conditions in facilities, districts, and provinces.

[2] Fund sourced from revenue in APBN allocated to certain regions with the aim of funding special activities of the region in accordance with national priorities
[3] Stipulated in Law no. 40 of 2004 on the National Social Security System
[4] Law no. 24 of 2011 on BPJS-K
[5] According to Presidential Regulation No. 32 of 2014 articles 3 and 4
[6] Presidential Regulation No. 12 of 2013, which was revised twice by Presidential Regulation No. 111 of 2013 and later by Presidential Regulation No. 19 of 2016
[7] Through BPJS Regulation No.2 of 2015

The MOH regulation also provide directives on how capitation payments may be used.[8] PHC facilities may use capitation revenue from BPJS-K for two main expenses—health worker incentives or salary bonuses and operational costs. The latter includes drugs, medical equipment and consumables, Upaya Kesehatan Masyarakat/UKM or public health investments in outreach (restricted to groups of patients enrolled in chronic disease management) and Upaya Kesehatan Perorangan/UKP or operational investments to reach individuals for healthcare services. Thus, the operational incentives can cover a comprehensive set of promotive, preventive, curative, and rehabilitative care, home visits, mobile service provision, administrative expenses, and information systems.

Box 1. Key findings on potential inequity in application of capitation rate

Regulations on the capitation rate exist, and incorporate adjustments based on local characteristics. However, no regulation exists that decentralizes authority to local governments to make adjustments to the capitation rate and no information on how to formulate based on local characteristics is present. Thus capitation is implemented uniformly across the five districts studies. This ultimately leads to inequity in provider payment across regions in Indonesia.

Also, further clarifications on utilization of capitation revenue within facilities is needed.

3.1.3 How is capitation actually being implemented?

Capitation reimbursement rates. In the five districts in Indonesia studied through IR for UHC, we observed a uniform application of capitation rates across all primary care facilities, with little or no adjustment to the base capitation rate per person based on local characteristics.

Sub-provinces appear to not be making these adjustment due to a lack of information about how to incorporate influencing factors (i.e., health facility availability, consumer price index, and construction cost index) into the capitation calculation. It is also unclear who should determine the local adjustment, for example, should it be determined by local government?

There is currently no regulation at district or provincial levels on capitation rate adjustment to provide a legal reference on how adjustment should be made. This situation may lead to inequity of provider payment across regions, with varying health care services supplied according to economic conditions.

Capitation revenue use in PHC facilities. The regulation outlines two main variables to be considered in the calculation of the capitation payment to puskesmas and private clinics: 1) types of health workers (including their responsibilities and length of employment); and 2) days/hours of compulsory presence.

Although MOH allows provincial and district health offices (DHO) to add health worker performance as a variable in the incentives formula,[9] there is no evidence of PHC facilities routinely link performance indicators with incentives due to the complexities of performance measurement. In terms of how incentives are formulated and distributed, Pay for Performance (P4P) has not been implemented consistently.

[8] MOH Regulation No. 21 of 2016, which is the updated version of MOH Regulation No. 19 of 2014 on Management of Capitation Fund in PHC Facilities

[9] MOH Regulation No. 28 of 2014

3.2 Promotive and Preventive Care as a Part of the JKN Service Package

3.2.1 Background

The capitation scheme offers increased provision of promotive and preventive care a means to contain costs by avoiding future illness. However, there is a growing concern that the capitation revenue is not adequate to sufficiently fund promotive and preventive care, majorly emphasized within community-based health care approaches. Relatedly, there is concern that UKM activities are neglected under JKN due to an imbalance in resource allocation between UKM and UKP activities.

In addition to capitation, puskesmas also receive funding from the national budget (Anggaran Pendapatan dan Belanja Nasional/APBN) via the Ministry of Health assistance fund for operational costs at the health center level (BOK). This grant is transferred through a Special Allocation Fund (DAK) to support puskesmas in delivering promotive and preventive services, specifically outreach activities targeting their catchment community.[10]

3.2.2 What do the regulations state?

The Government is responsible for JKN implementation for delivering health services, the JKN benefit package includes coverage for promotive and preventive care in primary health care (PHC) facilities, as well as curative and rehabilitative care in both PHC facilities and hospitals.[11] JKN covers puskesmas level promotive and preventive care that targets individuals, instead of the community, including individual counseling, routine immunization, contraceptive care, and screening.

Although relevant regulations on JKN have been revised twice,[12] UKM is still not included in the JKN benefit package. Funding for UKM or community public health activities flows to puskesmas through a separate fund. Previous regulation on Capitation Fund emphasized the exclusion of UKM in the JKN system.[13] Revisions to regulations in 2016[14] included the provision of promotive and preventive care through outreach programs, but only targeting those JKN members or groups of JKN members, such as those enrolled in the Chronic Disease Program (Program Penyakit Kronis (Prolanis) not the overall population public health needs. The majority of UKM activities tasked for puskesmas, such as health promotions at school, community-based maternal and child health care, immunization screening, nutritional status screening, community empowerment, environmental health care, etc.,[15] are paid through the separate fund.

[10] MOH Regulation No. 82 of 2015
[11] Law No. 36 of 2009 on Health, article 20, and underlined by Presidential Regulation No. 12 of 2013 on Health Insurance
[12] First by Presidential Regulation No.111 of 2013 and then by Presidential Regulation No.19 of 2016
[13] MOH Regulation on the Utilization of Capitation Fund in Public PHC Facilities (No.19 of 2014)
[14] MOH Regulation on the Utilization of JKN Capitation Fund for Incentives and Operational Costs in Public PHC (No. 21 of 2016)
[15] MOH Regulation on Public PHC (No. 75 of 2014)

3.2.3 How is promotive and preventive care actually being implemented?

There are information gaps in how JKN capitation revenue could be invested for preventive and promotive care. For example, a minimum percentage of capitation revenue that should be allocated to promotive and preventive care has not been specified. Thus, puskesmas are not obligated to make a strong financial commitment to these types of care, and the incentives to do so appear to be weak. Nevertheless, UKM provision is still the responsibility of government, and debate is ongoing about using a portion of capitation revenue to fund UKM activities. JKN-related regulations are assumed to prohibit use of capitation for a full range of UKM activities, yet decentralization gives sub-national governments' full autonomy to manage their revenues and expenditures.

Capitation received by puskesmas from BPJS-K is considered local government revenue, and can be classified as other legitimate local government revenue.[16] Consequently, local governments have authority to manage and allocate capitation for funding both UKP and UKM health care services particularly through puskesmas with Local Public Service Agency status and flexibilities in financing management (Puskesmas BLUD).[17] Although the management and utilization of capitation revenue from Puskesmas BLUD should be carried out in accordance with BLUD regulations, many Puskesmas BLUD are reluctant to use capitation revenue for UKM activities in case of audit findings for fraud or impropriety.

Box 2. Key finding on potential marginalization of the promotive and preventive community-based activities

Current JKN regulations limit the use of capitation revenue to fund promotive and preventive services (UKM) mostly within the scope of UKP activities. Yet, UKM activities can be financed using other source of funds (such as local government budget or BOK). However, the minimum budget allocation earmarked for UKM services is not regulated, increasing the likelihood of such services being neglected by local government.

Unfortunately, BOK is an additional fund and not intended to be the main funding source for UKM. The minimum percentage of local government budget allocated to health is 10 percent,[18] of which a portion should be spent for UKM—but this portion has not been set in regulation nor do the regulations establish ranges or key considerations for setting allocations in promotive and preventive services.

3.3 Utilization of Capitation Funds in PHC Facilities

3.3.1 Background

The President of Indonesia commissioned BPJS-K in 2011 to initiate implementation of the JKN program by January 1, 2014.[19] Some puskesmas, as the government-owned facilities, began receiving capitation payment in January 2014 indirectly through local government bank accounts. However, neither regulations on the utilization of capitation funds, nor the responsibilities of the stakeholders involved in JKN, had been enacted at that time. Despite meeting the targeted timeline for JKN launch in January 2014, Indonesia was not ready to roll out the program in early 2014.

[16] According to Law No.32 of 2014
[17] According to MOH Regulation No.28 of 2014
[18] Law No. 36 of 2009 on Health
[19] Law No.24 of 2011

3.3.2 What do the regulations state?

In April 2014, the government passed legislation which regulated the following: utilization of the capitation fund; transfer mechanisms of the capitation fund; BPJS-K's role; and the responsibilities of DHOs and health facility regarding capitation budget and expenditure planning.[20] As mentioned, regulations require a 60 percent/40 percent split of capitation funds between health workers incentives and operational costs. After four months of JKN implementation, puskesmas and private clinics received payment from BPJS-K through direct transfer to the bank account of the capitation fund treasurer of each facility. This system avoided delays in the use of funds for timely provision of health care services. It was not until May 2014 that health facilities could legally start spending capitation funds based on a new regulation on utilization of JKN's capitation funds for provider incentives and operational costs in puskesmas.[21]

Capitation as a source of local revenue or Pendapatan Asli Daerah/PAD funds for puskesmas was legally confirmed in May 2014 via a circular from the Ministry of Internal Affairs.[22] The same circular also provided technical guidance on the institutional management of capitation in puskesmas, particularly those not holding BLUD status. For Puskesmas BLUD, capitation can be managed according to regulations on financing management of public service agency.[23] To improve the accountability in capitation management, every puskesmas sends a monthly financial report on actual capitation revenue and actual capitation spending.

3.3.3 How is capitation in primary health care actually being implemented?

It appears that health facilities were still not able to use the capitation fund because the regulation required further Ministry-level regulation to clarify the incentive payments and define operational costs.

Puskesmas still needed to revise their budget documents to incorporate capitation funded expenditures, and obtain approval from the head of the local government. This resulted in low absorption of capitation funds by puskesmas. The unspent capitation funds at the end of the year are taken back by the local government treasury, but can be used by puskesmas in the following year after gaining approval from the head of local government. Therefore, the capitation fund can be used for health care services, instead of being reallocated by local government to other sectors, and the financial stability of puskesmas can be maintained.

Box 3. Key finding on the need for district-level policy on management of capitation fund

Regulations exist on how capitation funds should be managed and utilized, although it took some months after JKN's commencement to establish them. The regulations on capitation fund management do not contradict pre-existing regulations on local government financial management. However, an effort at the district level to synchronize all existing regulations is required to ensure a well-run system.

Development of district-level regulation on capitation fund is recommended, particularly since there are several sources of funding other than capitation.

[20] Presidential Regulation No.32 of 2014
[21] MOH Regulation No.19 of 2014
[22] Circular Letter of Ministry of Internal Affairs No. 900/2280/SJ of 2014
[23] Government Regulation No.74 of 2012

In addition to JKN-specific regulations, there are several pre-existing regulations on local government financing that influence how the capitation fund can be managed by local government. For example, local government has a mandatory role in the provision of health care,[24] and thus should allocate its local budget and APBD accordingly. Also, regulations related to financial management of local government were developed before JKN.[25] Capitation has not been listed as a source of local government revenues within APBD. Currently APBD consists of local generated revenues, i.e. PAD, fiscal balance transfers from central government, Dana Perimbangan, and revenues from grants and loans. Although, it can be inferred that capitation is a part of the PAD fund, there was confusion at the district-level about its legal status, particularly during the first few months after JKN commenced.

Legal support at local levels is required to synchronize national JKN-related regulations with the regulations related to financial management at a local government level. Given that district/city do not currently have a district-level regulation on the use of capitation funds, which accommodates local policies and prioritized health programs for the locality. District governments need support in considering regulations on other funds received by puskesmas, including the management of the BOK fund,[26] managing the de-concentration fund,[27] and on the local insurance scheme (Jaminan Kesehatan Daerah/Jamkesda).

3.4 Referral and Back Referral Systems

3.4.1 Background

As stipulated in Law No.36 of 2009 article 30, there are 3 types of health care facilities: primary or "first-level" care facility (Fasilitas Kesehatan Tingkat Pertama/FKTP), secondary care facility, and tertiary care facility. To achieve effective and accessible health care and efficient and sustainable health financing in the era of JKN, a solid referral system was developed to reduce unnecessary referrals to secondary and tertiary setting. . The FKTP health facilities empaneled with JKN are the gatekeepers of referrals and receive capitated payments for the population they serve, theoretically this leads to an optimum level of primary and public health care, and reduction of unnecessary referrals to secondary and/or tertiary care facilities.

3.4.2 What do the regulations state?

The provision of health care services is conducted in a multi-tiered system, starting from the lowest-tier "empaneled" facilities, which are FKTP (MOH Regulation No.28 of 2014, chapter IV). These services are paid by BPJS in a form of monthly capitation payment (MOH Regulation No.59 of 2015, article 1 and 3). As JKN's gatekeeper, patients are not allowed to directly access hospital care unless they obtain a referral from FKTP. Exceptions to the referral requirement can be made in emergency cases and when certain patient conditions requiring special management, or if there is an access to care issue due to lack of staff or geographical distance. Because of the importance of gatekeeping in the JKN system to reduce secondary and tertiary costs, the list or package of necessary PHC services and service components should be accessible and well defined for every JKN enrollee in FKTP. Per regulation, this package or list

[24] Government Regulation No.38 of 2007
[25] Such as Law No.33 of 2004; Government Regulation No.58 of 2005
[26] Presidential Regulation No.55 of 2005
[27] Presidential Regulation No.7 of 2008

should include administrative cost, promotive and preventive care, medical examinations, treatment, medical consultations, non-specialty medical procedures including surgical and non-surgical procedures, medicines and medical consumables, blood transfusion, first-level laboratory examinations, and first-level inpatient care (Presidential Regulation No. 111 of 2013).

To provide comprehensive primary care, any facility that does not have a laboratory facility, must establish a networking contract with another FKTP that has one or with private laboratory facility (MOH Regulation No.99 of 2015). There are several regulations related to the provision of diagnostic tests at the primary care-level, including: (a) the minimum requirements for the building, tools and equipment, and types of diagnostic tests (MOH Regulation No. 411 of 2010); (b) basic competencies of doctors working at PHC facilities which includes the recommended (laboratory or non-laboratory) diagnostic tests to perform (MOH Decree No.514 of 2015 on Clinical Practice Guideline for PHC Doctors); (c) minimum standards for equipment that should be provided by puskesmas (MOH Regulation No.75 of 2014 on puskesmas); and (d) standard requirements for laboratory facility within puskesmas and types of laboratory diagnostic tests provided (MOH Regulation No.37 of 2012).

The referral back system from hospitals to health facility is also regulated, particularly for chronic diseases that typically require multiple patient visits under the Program Rujuk Balik (PRB). Per regulation, patients diagnosed with one or more the following diagnosis: diabetes mellitus; hypertension; hearth disease, asthma; Chronic Obstructive Pulmonary Disease; epilepsy; schizophrenia; stroke; and Systemic Lupus Erythematosus, who have achieved "stabilized status" must be referred back to FKTP under PRB (MOH Regulation No.28 of 2014, Chapter IV).

The GOI led by DJSN and BPJS-K has attempted to enhance the gatekeeping role of health facility by improving the non-capitation payment, previously limited to inpatient care (per diem) and maternal and neonatal care (fee for service). Now, as stipulated in MOH Regulation No.59 of 2014, FKTP may receive the non-capitation payment (reimbursement based on a specific rate set by BPJS) from BPJS for the provision of ambulance services, health screening services (for instance, blood glucose test), inpatient care, maternal and neonatal care (including 4 antenatal care visits for uncomplicated pregnancy, normal delivery care, and postnatal care), contraceptive care, and blood transfusion service. The same regulation also states that a health facility can claim for non-capitation payment for the provision of medicines for chronic diseases patients that are back-referred from hospitals, along with any monthly laboratory tests. These last two changes in regulation should be studied, as the hypothesis is that these changes will strongly support improved back-referrals.

Box 4. Key finding on regulations on referral and back-referral system identify gaps in capability at primary health care level for ensuring appropriate protocols are followed

Several regulations regarding the mechanism of multi-tiered provision of care and the role of health facilities within the JKN system exist. However, they are not enough to ensure a well-functioning referral and back-referral system to enact standards of care for many conditions, particularly non-specialty procedures and the back-referral criteria for chronic disease patients. Regulatory updates detailing the critical diagnostic tests needed at the PHC to determine patient referrals, and the essential PHC tools/equipment to enable appropriate care are needed. Last but not least, a protocol defining all stakeholders involved and their responsibilities in the referral and back-referral system should be developed to support the implementation of the system.

3.4.3 How are referral systems actually being implemented?

The GOI and stakeholders know the importance of successful referral and back-referral systems. Budget overruns for JKN have occurred since the first year,

mostly due to high secondary and tertiary service utilization, and officials have blamed problems in the referral and back-referral system. The research identified implementation processes that could be clarified through revised regulations or improved by standardized operating procedures in facilities.

For example, per Presidential Regulation No. 111 of 2013, there is still lack of consensus among providers on what "non-specialty medical procedures" should be included at PHC level. Thus, health facilities often avoid providing relatively time-consuming medical procedures, i.e. referring on to secondary or tertiary care, to shorten an already long queue of patients and/or for cost containment reasons, i.e. to capture more revenue from capitated payment.

The regulations around developing a workable diagnostics/lab network and medical supply system are commendable. Unfortunately supply side issues still make actual implementation ineffective because many geographic locations face shortages of medicines in health facility or private pharmacies. Also, in some cases the regulations regarding diagnoses do not correspond well to MOH clinical guidelines. For example there are several diagnostic tests that are not required for puskesmas, but according to MOH clinical guidelines are needed to support the diagnosis of certain diseases, e.g. Tuberculin Test, which is part of diagnostic scoring system for Tuberculosis in children; immunology (IgM) test of *Salmonella typhi*, which is the recommended test for diagnosing typhoid fever; and pulse oxymeter, which is an essential equipment to measure oxygen saturation for patient needing oxygen therapy or in emergency condition. Unavailability of diagnostic tests in PHC facilities also leads to under-service, unnecessary referral to hospitals, and reluctance from specialists in hospitals to refer their patients back to health facility if they can't be assured of quality of care at PHCs.

Finally, the current back-referral regulation No. 28 2014 lacks clarity around what constitutes "achieving stabilized status" for various patient conditions, leading specialists at the hospital level to use their individual clinical judgment with the result that the back-referral system operates inconsistently and inefficiently.

3.5 Enrolling Beneficiaries in the Contribution Subsidy

3.5.1 Background

In Indonesia, long before the introduction of JKN, the GOI demonstrated strong commitment to excluding the poor and vulnerable from compulsory contribution payments to the social security program.

During the 4-year implementation of JKN, government-subsidized members dominated enrollment percentages. Of 138,524,669 JKN participants in 2014 overall, government subsidized members accounted for more than 68 percent.[28] As of 1 July 2017, they still constituted about 61percent of total JKN participants.[29] Identifying the beneficiaries of the government subsidies on JKN contribution (Penerima Bantuan Iuran/PBI) is very important in JKN implementation. The number must be accurately determined and strongly regulated to aid the poor and vulnerable, and exclude the non-poor group. However, multiple reports found inaccurate targeting of PBI occurring frequently during implementation, ranging from non-poor inclusion in subsidized JKN to decreased subsidy recipients.

[28] Mahendradhata, Y, et al. 2014. The Republic of Indonesia Health System Review. India: WHO.

[29] Healthcare and Social Security Agency. 2017. Peserta Program JKN per 1 Juli 2017 (JKN Program Membership as of 1st of July 2017). Available at: https://bpjs-kesehatan.go.id/ bpjs/index.php/jumlahPeserta, accessed 1 July 2017

3.5.2 What do the regulations state?

Like many national health insurance schemes, JKN requires a contribution payment from non-poor enrollees in the form of a monthly premium. An exemption is made for the poor to encourage their uptake of services, and avoid additional economic burden. These contributions were fully subsidized by the government, as stipulated in Law No.40 of 2004, article 17, of the National Social Security System.

Determination of beneficiaries for subsidies is outlined in detail in the Government Regulation No.101 of 2013 prior to JKN introduction. The National Bureau of Statistics (Badan Pusat Statistik/BPS) conducts data collection on potential beneficiaries, based on the criteria for identifying the poor and vulnerable established by the Ministry of Social Affairs, and then the local government at community level verifies and validates the data. After consulting with the Ministry of Finance and other stakeholders, such as MOH, the Ministry of Social Affairs establishes the unified database of PBI, broken down by each province and district/city. Given the involvement of several different institutions, effective inter-sector coordination is a vital part of this process. In terms of PBI data changes, the regulation allows deletion, substitution, or addition of beneficiaries, although verification and validation from Ministry of Social Affairs still need to be obtained[30].

To provide subsidies, the government is responsible for registering the identified PBI's households as JKN members. The listed PBIs are obliged to provide accurate and complete data on him/her-self and household members to the government which is forwarded to BPJS-K as a part of the registration process (Law No.24 of 2011, article 18). Approximately a year after JKN implementation, Government Regulation No.76 of 2015, updated the policy to define the PBI status of newborns and to account for changes to the beneficiaries' status. According to this regulation, babies born to PBI mothers are subsidy beneficiaries as well.

Ensuring health coverage of the poor and vulnerable is not only a central government affair, but also a local government's responsibility. Presidential Regulation No.111 of 2013 allows the provincial or district/city government to enroll people currently not covered by health insurance in the JKN program. For this type of enrollment, the local government pays the participant's contribution. This corresponds with the notion of health as a mandatory benefit provided by the local government, as stipulated in the Government Regulation No.38 of 2014. Local government, consequently, should allocate a portion of its financial resources for JKN contribution subsidies for the poor and vulnerable groups in its area. Many provinces have passed regulations to clarify how this national regulation will be rolled out in their province. For example, the North Sumatera Province passed Governor Regulation No.9 of 2014 to define the criteria for potential beneficiaries of local subsidies, financed by the provincial budget. Papua, a province with the most remote areas in Indonesia, aimed to improve universal access to health care for all its residents, by introducing a local health coverage scheme, namely Kartu Papua Sehat/KPS, which is regulated through Governor Regulation No.6 of 2014. The government of Papua also equipped its KPS scheme with a referral system that differs from that of JKN, to address problems of access to health facilities in Papua, as regulated in the Government Regulation No.7 of 2014.

[30] Government Regulation no. 101 year 2012

3.5.3 How are subsidies actually being implemented?

The Government Regulation No.76 of 2015 establishing the PBI status of newborns and accounting for changes to the beneficiaries' data is intended to improve access and avoid delays in child health care, one of national health priorities.

However, inaccurate targeting of PBI remains an implementation issue, mostly due to lack of recent data on poor and vulnerable households. For example, the unified database of PBI published by Ministry of Social Affairs in 2013 for 2014 JKN coverage, was based on 2011 data. The same database was used for 2015 JKN coverage, because the Ministry of Social Affairs did not update the data until December 2015.

Other issues related to the inaccuracy of personal information listed on the JKN-PBI card, whether it was the name, ID number, or date of birth. Despite Presidential Regulation No.19 of 2016 stipulating that every JKN enrolee shall receive a single identity number that is also integrated with the Indonesian Citizenship Identity Number (Nomor Induk Kependudukan/NIK), mismatches of identity were often reported by health facilities during the patient registration process, leading to delays in treatment. Interestingly, this type of error occurs primarily in the PBI group, potentially showing a lack of coordination between the stakeholders developing PBI and Indonesian Citizenship ID number.

Failure to address timely identification, appropriate targeting, and updates for those who should receive PBI subsidization for JKN prevents the access gap between the poor and non-poor. It can cause scarce health resources to be allocated to non-poor instead of supply side investments to reduce barriers to care. A strong monitoring and evaluation mechanism is required to assess and improve the performance of the regulated institutions, and monitor the entire JKN PBI enrollment process from identifying beneficiaries, registering members, issuing and distributing JKN cards and regularly updating data. Local government needs to play a larger role in facilitating data updates that feed into the Ministry of Social Welfare data to improve accuracy. More investment is needed to ensure that all residents of the administrative area have identity cards with unique ID number (Nomor Induk Kependudukan/NIK).

Box 5. Key findings regarding implementation of the regulations on enrollment of the subsidized populations.

Regulations on the enrollment of subsidy beneficiaries in JKN are available at the national-level and appear to be harmonized to one another. Local government regulations are also available, allowing the local government to subsidize those who are left out from central government subsidies. Nevertheless, implementation issues result in inaccurate targeting of all beneficiaries of the contribution subsidy.

ANNEX A: LIST OF REGULATIONS REVIEWED

- Act no 40 year 2004
- Act no 36 year 2009
- Act no 24 year 2011
- Act no 33 year 2004
- Government Regulation no 55 year 2005
- Government Regulation no 58 year 2005
- Government Regulation no 38 year 2007
- Government Regulation no 7 year 2008
- Government Regulation no 19 year 2010
- Government Regulation no 74 year 2012
- Government Regulation no 101 year 2012
- Presidential Regulation no 12 year 2013, which then revised to Presidential Regulation no 111 year 2013, which then revised to Presidential number 19 year 2016
- Presidential Regulation no 32 year 2014
- Ministry of Health Regulation no 411 year 2010
- Ministry of Health Regulation no 69 year 2013 , which then revised to Ministry of Health Regulation no 59 year 2014
- Ministry of Health Regulation no 71 year 2013, which then revised to Ministry of Health Regulation no 99 year 2015
- Ministry of Health Regulation no 5 year 2014
- Ministry of Health Regulation no 19 year 2014
- Ministry of Health Regulation no 28 year 2014
- Ministry of Health Regulation no 59 year 2014
- Ministry of Health Regulation no 75 year 2014
- Ministry of Health Regulation no 82 year 2015
- BPJS Regulation no 2 year 2015
- Circular letter from Minister of Home Affairs no 900/2880/SJ year 2014

Disclaimer: some of these regulations may have been revised and/or replaced with new regulations at the time of the writing.

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