White Paper: Indonesia’s Health Sector Development (2024–2034)

Invest Wisely, Execute Strategically, Achieve More: Indonesia's Pursuit of Universal Health Coverage

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Center for Indonesia’s Strategic Development Initiatives (CISDI)

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INDONESIA'S PURSUIT OF UNIVERSAL HEALTH COVERAGE

Published in Indonesia November 2023 by

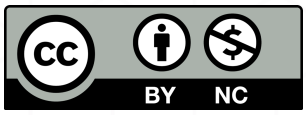
Center for Indonesia's Strategic Development Initiatives

Probo Office Park

Jl. Probolinggo No. 40C Menteng, Jakarta Pusat 10350

www.cisdi.org

Cover design by Dedi Suhendi



How to cite

(CISDI, 2023)

Center for Indonesia's Strategic Development Initiatives. *White Paper: Indonesia's Health Sector Development (2024-2034)*. 2023. Jakarta: CISDI

List of Abbreviation

ADD	:	Alokasi Dana Desa (Village Fund Allocation)
ATP	:	Ability to Pay
BKPM	:	Badan Koordinasi Penanaman Modal (Investment Coordinating Board)
BKKBN	:	Badan Kependudukan dan Keluarga Berencana Nasional (National Population and Family Planning Board)
BOK	:	Biaya Operasional Kesehatan (Operational Cost for Health)
BOKB	:	Biaya Operasional Kesehatan Bencana (Operational Cost for Health in Disaster)
BPJS-K	:	Badan Penyelenggara Jaminan Sosial Kesehatan (Social Security Administration for Health)
COB	:	Coordination of Benefit
CSOs	:	Civil Society Organizations
DAU	:	Dana Alokasi Umum (General Allocation Fund)
DAK	:	Dana Alokasi Khusus (Special Allocation Fund)
DBH	:	Dana Bagi Hasil (Revenue Sharing Fund)
DHO	:	District Health Office
DJS	:	Dana Jaminan Sosial (Social Security Fund)
DJSN	:	Dewan Jaminan Sosial Nasional (National Social Security Council)
DRGs	:	Diagnosis-Related Groups
GDP	:	Gross Domestic Product
GoI	:	Government of Indonesia
HiAP	:	Health in All Policies
IDM	:	Indeks Desa Membangun (Village Development Index)
JKN	:	Jaminan Kesehatan Nasional (National Health Insurance)
LMICs	:	Lower-Middle-Income Countries
LPG	:	Liquefied Petroleum Gas
MoH	:	Ministry of Health

NCDs	:	Non-Communicable Diseases
OTSUS	:	Otonomi Khusus (Special Autonomy)
PAD	:	Pendapatan Asli Daerah (Local Own-Source Revenue)
PCare	:	Primary Care (refers to a system or software used in Indonesian health care)
PBI	:	Penerima Bantuan Iuran (Beneficiaries of Contribution Assistance)
PFM	:	Public Financial Management
PHO	:	Provincial Health Office
PNPK	:	National Clinical Practice Guidelines
PPP	:	Public-Private Partnerships
PVHI	:	Private Voluntary Health Insurance
Riskesdas	:	Basic Health Survey
Rifaskes	:	Healthcare Facility Census
RPJMN	:	Rencana Pembangunan Jangka Menengah Nasional (National Medium-Term Development Plan)
SDGs	:	Sustainable Development Goals
SDoH	:	Social Determinants of Health
SNGs	:	Sub-National Governments (duplicate, may be removed)
SOEs	:	State-Owned Enterprises
UGM	:	Universitas Gadjah Mada
UHC	:	Universal Health Coverage
VAT	:	Value-Added Tax

List of glossaries

Ability to Pay (ATP): An economic principle that states individuals should be taxed based on their ability to pay, meaning the wealthier should pay more taxes relative to their income.

Alokasi Dana Desa (ADD): Village Fund Allocation in Indonesia, funds provided by the government to support village development.

Badan Layanan Umum Daerah (BLUD): Regional Public Service Agency in Indonesia, which has financial management flexibility to improve service quality.

Coordination of Benefit (COB): A system used by insurance providers to enable multiple policies to pay their fair share of a claim without overlapping.

Diagnosis-Related Groups (DRGs): A system to classify hospital cases into one of originally 467 groups, with the intent of identifying the products that a hospital provides.

Economic Co-benefits of Health: The economic benefits that arise from improving population health, such as increased productivity and reduced healthcare costs.

Fiscal Policymaking: The process of deciding how a government collects and spends money to influence the economy.

Fiscal Policy: Government policies regarding taxation and public spending, to influence the economy.

Health in All Policies (HiAP): An approach to public policies across sectors that systematically considers the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.

Kinerja Berbasis Kompetensi (KBK): A competency-based performance system to evaluate and improve the performance of government services and workers.

Lower-Middle-Income Countries (LMICs): A classification of countries with a gross national income per capita between $1,036 and $4,045.

National Clinical Practice Guidelines (PNPK): Guidelines in Indonesia that provide standardized procedures for diagnosing and treating specific health conditions.

Non-Communicable Diseases (NCDs): Medical conditions or diseases that are non-infectious and non-transmissible among people.

Otonomi Khusus (OTSUS): Special Autonomy status granted to certain regions in Indonesia, allowing greater local governance and budgetary powers.

Out-of-pocket (OOP) Spending: Direct payments made by individuals to healthcare providers at the time-of-service use.

Private Voluntary Health Insurance (PVHI): Health insurance that is optional and purchased in the private market, offering additional coverage beyond that of public health programs.

Public Financial Management (PFM): The management of a government's revenues and expenditures to achieve fiscal sustainability and macroeconomic stability.

Public-Private Partnerships (PPP): Collaborative agreements between government agencies and private sector companies to fund and operate services or projects.

Purchasing Power Parity (PPP): An economic theory that allows the comparison of the purchasing power of various world currencies to one another.

Social Determinants of Health (SDoH): Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

State-Owned Enterprises (SOEs): Companies where the government has significant control through full, majority, or significant minority ownership.

Sustainable Development Goals (SDGs): A collection of 17 global goals set by the United Nations General Assembly for the year 2030.

Universal Health Coverage (UHC): An initiative to ensure that all individuals and communities receive the health services they need without suffering financial hardship.

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Health for All on the Brink: Navigating Financing Reform in Indonesia in its Quest for Universal Coverage

The Political Declaration of the High-level Meeting on Universal Health Coverage (UHC) acknowledges that despite notable progress in global health, there has been insufficient effort to meet the health needs of everyone. The expansion of service coverage has slowed compared to gains before 2015, with little to no improvement since 2019. Financial protection trends have worsened, leading to an increase in catastrophic out-of-pocket (OOP) spending on health. This rose from 12.6% in 2015 to 13.5% in 2019, pushing 4.4% of the global population into extreme poverty due to health-related payments. The world fell short by 523 million individuals in meeting the pledge outlined in the 2019 political declaration. This commitment aimed to gradually deliver an extra one billion people with high-quality essential healthcare services, along with safe, effective, affordable, and vital medications, vaccines, diagnostics, and healthcare technologies by the year 2023.

Increasing and sustaining political leadership at the national and sub-national levels in improving fiscal policymaking and strengthening its budgetary institution and public financial management system is pivotal. UHC is an ambitious goal, but it is an affordable dream[1]. And we have economics on our side. For a long time, we have understood that good health contributes to economic prosperity and fosters the development of equitable, secure, and cohesive societies. Japan, Moldova, Peru, Sri Lanka, and Thailand, for example, show that countries can make dramatic progress towards UHC through health system reforms that can deliver substantial health, economic, and political benefits[2].

Fiscal policy refers to how a government manages its revenue generation and expenditure. There are various designs for fiscal policies, but they generally aim to either change the prices of health-related products or influence their availability[3]. A good fiscal policy should be impactful, streamlined, and economically efficient, while also advancing or preserving equity objectives. A well-designed tax or subsidy should accurately target its intended recipients and influence health-related behaviour in the desired way. An efficient policy minimises economic disruptions and requires minimal administrative expenses. Additionally, a cost-effective policy achieves the desired health outcome at the lowest cost.

This paper will focus on analysing key policy choices regarding Indonesia's health financing system configuration. As outlined in Figure 1, this study focuses on the key health financing functions of revenue collection, risk pooling, and purchasing. This study concerns their respective objectives of (i) equitably and efficiently raising sustainable revenues; (ii) pooling funds efficiently and equitably to ensure financial protection for the Indonesian population; and (iii) purchasing services in an allocatively and technically efficient manner[4].

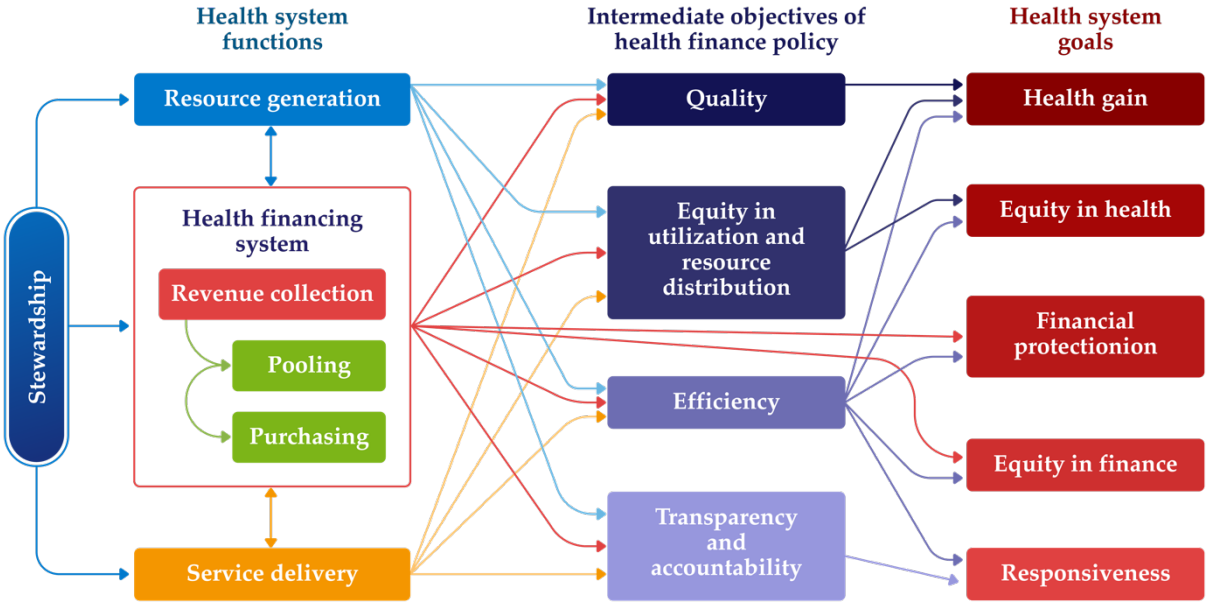


Figure 1. Links of health financing system to policy objectives, and other system functions and overall system goals. Source: Kutzin[5] © Health Policy. 2001.

However, the financing of social determinants of health (SDoH) and the economic impact of health co-benefits fall outside the purview of this paper. A fiscal policy may be designed to affect some other sphere of behaviour or a good other than health—for instance, education—and the effects on health or the use of health care may be indirect[3]. Acknowledging Health in All Policies (HiAP), research on financing the SDoH will be useful for budgetary decisions as well as for estimating investments in and outside of healthcare across the life course, as well as for creating revenue strategies to support such expenditures[6].

The paper will proceed by examining the current organisation of Indonesia's health financing system, serving as the foundation for any potential reforms. It will elucidate the transformation undergone by Indonesia in the incorporation of various health financing schemes on both the demand and supply sides. It will analyse the interplay between these components and their impact on the attainment of policy objectives, as well as on broader systemic functionalities and overarching system-level objectives. The section on structural challenges will involve recognizing and analysing how critical contextual elements impact Indonesia's ability to maintain the attainment of policy objectives, as well as the array of policy alternatives that can be contemplated. Finally, the paper will conclude with a set of recommendations that explore the direction in which reforms should aim to steer the system.

Cracking the Code: Indonesia's Health Financing System Faces Structural Hurdles

It is increasingly crucial to shape the future of Indonesia's health financing system in response to the swiftly evolving financial environment. As outlined in the introductory chapter, all health financing approaches should try to fulfil three basic public finance principles. First, to raise enough revenues to provide individuals with the intended packages of health services that assure health and financial protection against catastrophic medical expenses caused by illness and injury in an equitable, efficient, and financially sustainable manner. Second, to manage these revenues to pool health risks equitably and efficiently. Third, to ensure the payment for or purchase of health services is carried out in allocative and technically efficient ways.

Different policymakers see different problems with the way people get health coverage and, correspondingly, propose different solutions. Politicians often champion populist pledges for 'free healthcare for all at all costs' without a clear grasp of the intricate technicalities required to implement these commitments[7]. The policy regarding benefits and patient cost-sharing represents one of the most immediate links between the healthcare system and the population, making it inherently political. Concerns about the electoral consequences of modifying benefit packages and cost-sharing arrangements often lead to a failure in conducting realistic deliberation. There are also opposite sides of the coin considering cost sharing in the healthcare sector– challenges our assessment of the relative significance between the supply-side and demand-side moral hazard[8].

Furthermore, to transition smoothly, focus should also be given to the quantum of financing required and the governance and service delivery mechanisms in place to deliver UHC. The challenges in these areas have hindered some of the expected results from the implementation of the health financing system and threatened financial sustainability.

This chapter will proceed by analysing the three core financing functions: collection, pooling, and purchasing. It will begin with an examination of the various sources of funding that are channelled into the health system (collection), followed by a discussion on risk pooling. The chapter will then analyse different types of payment mechanisms (purchasing) and their potential impacts on provider behaviour. Finally, it will integrate the context of governance and service delivery, as outlined in the 'Governance' and 'Health System' book of this White Paper series, to provide insights into how various elements of the health system influence the efficiency, effectiveness, equity, and sustainability of UHC.

2.1. Have we hit the revenue collection glass ceiling?

2.1.1. Indonesia's spending capacity is constrained by its relatively insufficient ability to generate revenue

The macroeconomic context is inextricably related to health financing in terms of funding sources, insurance coverage, and resource allocation targets. Indonesia boasts one of the globe's most significant economies, standing at the 16th position worldwide in GDP based on market prices and 7th in terms of purchasing power parity (PPP). The government holds an optimistic outlook, envisioning Indonesia as the fourth-largest economy globally by 2045.

Amidst the global uncertainty, Indonesia's economic growth will continue its momentum in 2023 and inflation is easing at a faster pace. Due to a broad-based rise in revenues, prudent public spending, and fiscal reform that strengthened economic fundamentals (Figure 2), the Government of Indonesia returned to its fiscal rule mandate one year sooner than intended in 2022, with a fiscal deficit of 2.4 percent of GDP (Figure 3). Public debt dropped from its peak of 40.7 percent of GDP in 2021 to 39.5 percent in 2022 and stands at 39.1 percent in March 2023 (Figure 4).

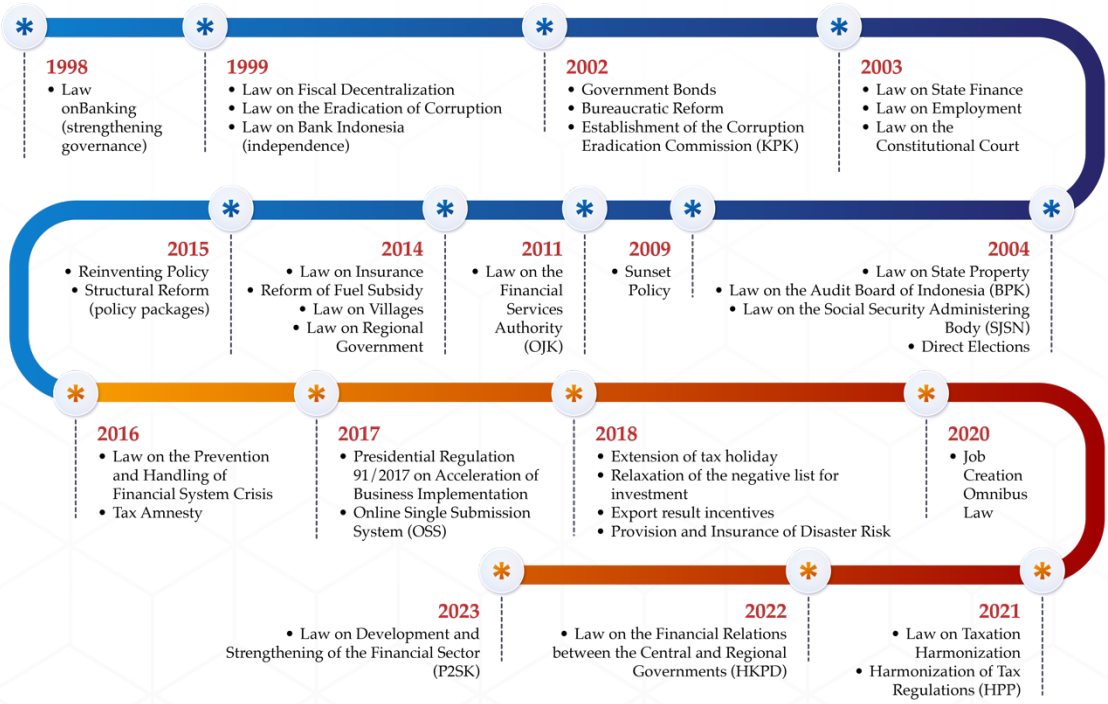


Figure 2. Indonesia's fundamental economic reforms. Source: Indrawati[9] © Ministry of Finance Republic of Indonesia. 2023.

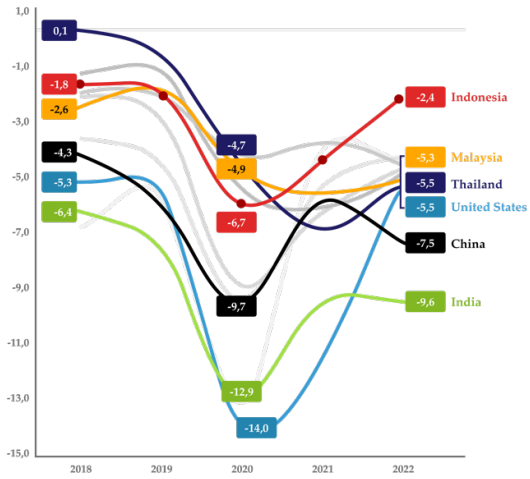


Figure 3. Indonesia's fiscal deficit

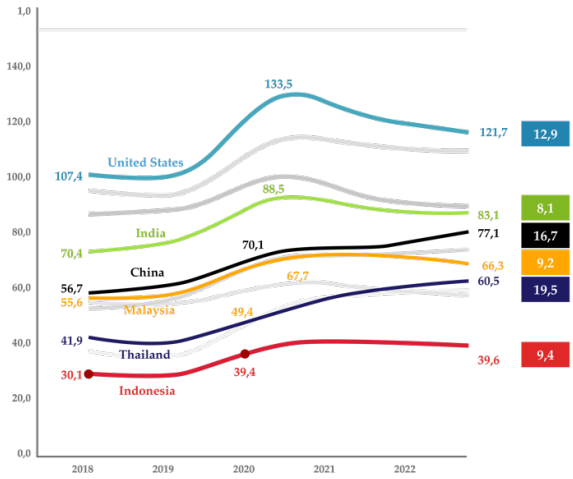


Figure 4. Indonesia's fiscal debt

Source: Indrawati[9] © Ministry of Finance Republic of Indonesia. 2023.

Economic recovery also appears to be evenly distributed across all regions. Maluku and Papua have the highest % year-on-year quarterly growth, indicating that fiscal policy has expedited the country's economic recovery and improved GDP growth distribution throughout Indonesia. Poverty levels in most provinces are lower than their pre-pandemic levels, except for DKI, West Java, Banten, Bali, Central Kalimantan, East Kalimantan, South Sulawesi, Southeast Sulawesi, and West Sulawesi.

While sustained economic growth in Indonesia has helped to reduce poverty and create a growing middle class, potential GDP growth is declining due to weakening labour input and productivity growth[10]**.** Indonesia remains below the GDP growth levels of 6-8 percent needed to reach high-income status as outlined in Indonesia Vision 2045. If the economic growth figures are interpreted differently, it appears that Indonesia's economic growth has not exceeded the 5 percent mark. Moreover, the country has never seen annual loan growth surpass the 15 percent threshold. The combination of these two factors could potentially increase the risk of insolvency and disrupt economic stability[11].

Despite the government's achievements in cutting subsidy expenses, there has not been a substantial rise in capital spending[11]**.** Although there has been some growth, since 2009, spending on personnel and goods has outweighed government investments in capital. Starting from 2012, there has been a rise in the allocation for servicing debt interest payments. Consequently, the government will confront the task of augmenting the budget for capital expenditure, which is anticipated to bolster the economy and expand the tax base.

Moreover, over the last ten years, most of the growth has favoured the top 20 percent of the population, leaving approximately 219 million people lagging[12]**.** As living conditions become more disparate and wealth becomes increasingly concentrated among a select few, Indonesia's level of inequality is now regarded as relatively high and is rising at a faster pace than many of its East Asian counterparts.

The total amount that Indonesia can spend is limited by inadequate revenue-raising capabilities for a country of its size and income level. At 17.54 percent of GDP in 2022, Indonesia's general government expenditure is about half that of other emerging market and developing economies (EMDEs), which spend 32 percent of GDP on average. This is because Indonesia's revenue-to-GDP ratio is low and remains one of the lowest among its regional and emerging market peers. From 2007 to 2021, the tax-to-GDP ratio in Indonesia decreased by 1.4 percentage points from 12.2% to 10.9%. These are below the Asia and Pacific average of 19.8% and the OECD average of 34.1%.

The weak tax effort can be attributed to multiple factors. This encompasses considerations of tax policy, like the widespread use of tax holidays and allowances, the adoption of a presumptive tax system, elevated tax exemption limits, and tax administration inefficiencies resulting in poor compliance[11]. Nevertheless, widespread informality[1] also plays a role in these issues since informal employment and informal firms typically fall outside the taxation net (for income and general sales taxes)[13]. The underutilisation of externality-correcting taxation such as tobacco and sugar-sweetened beverages taxation also possess challenges to collecting more revenues[14].

2.1.2. Subnational governments are relying on intergovernmental transfers for survival

A striking feature of Indonesia's intergovernmental system is the weak role of provinces. In 2018, provinces were only responsible for 12 percent of total spending compared with 32 percent for districts. Provinces have some responsibility for regional infrastructure, but otherwise primarily play the role of regional representatives of the central government, in charge of coordinating districts. While this weakness is partially by design for historical reasons, it exacerbates intergovernmental coordination challenges especially as the number of districts has nearly doubled since decentralisation from 298 in 1996 to 514 today.

Indonesia's sub-national governments (SNGs), especially districts and villages, are playing an increasingly important role in delivering basic infrastructure services. Following decentralisation reforms in 2001, the amount of transfer funds increased significantly from IDR 81.05 trillion (2001) to IDR 812.97 trillion (2019) but decreased slightly to IDR 762.54 trillion in 2020 due to the COVID-19 pandemic[15]. SNGs have become responsible for carrying out 43 percent of general government expenditure (2015-2018), compared with 23 percent pre-decentralisation (1994-2000).

[1] Since 2016, the rate of informal employment in Indonesia has risen, a trend significantly exacerbated by the COVID-19 pandemic. According to data from the International Labour Organization (ILO), which uses a more comprehensive definition of informal employment than mere self-employment, 80% of workers in Indonesia hold informal jobs. This figure is substantially higher than the average for East Asia and the Pacific (EAP) or for Emerging Market and Developing Economies (EMDEs), where it stands at about 56%. The province of Papua stands out with the highest level of informal economic activity, accounting for nearly 80 percent of its total economy, followed by three provinces in the eastern part of the country—East and West Nusa Tenggara, and West Sulawesi—where informal activity represents approximately 70 percent of their economic output.

Box 1. Scholarly works on decentralisation discuss from contrasting angles

On the bright side, decentralisation is considered one of the strategies to improve public sector efficiency, promote effective governance, and increase government accountability. These improvements are predicated on the idea that local authorities are more attuned to their constituents' needs.

Decentralisation is also believed to be the solution to socio-economic and political challenges, with some scholars arguing that it can stimulate regional economic development performance as well as reduce poverty and regional disparities.

On the downside, critics argue that decentralisation may be ill-suited for regions where local governments lack institutional robustness and budgetary means to accommodate public preferences.

Further, there are concerns that decentralisation can lead to inflated costs, corruption, power abuse, diminished government service efficiency, economic distortion, increased regional inequalities, and macroeconomic instability.

SNGs have a relatively high degree of expenditure decision-making but they have limited revenue autonomy. Intergovernmental transfers from the state budget (*Anggaran Pendapatan dan Belanja Negara*, or *APBN*) made up 66.81% on average of total regional revenue. The bulk of district revenue comes from intergovernmental transfers from central to district-level budgets. Despite the effort to increase district autonomy in raising own-source revenues[ii], compliance with local tax has been poor largely due to limited administrative enforcement capacity where local tax-to-GDP ratios have not grown and SNGs' dependency on transfers remains high.

As of 2019, transfers to villages have been steadily increasing and constitute about 96.7% of their revenue. The total value of fiscal transfers to villages was US$8.1 billion in 2019, 4.3% of the national budget, and 0.7% of the GDP. The Village Fund has consistently had high realisation rates, reaching over 99.3% every year. There is a large variation in the share of village revenue from Dana Desa between provinces, ranging from 23% in Bali to 81% in Papua. While the Village Fund has increased from IDR 20.8 trillion (2015) to IDR 72.0 trillion (2020), PADes are declining in nominal terms and as a share of total village revenue.

[ii] About a decade ago, the GoI significantly increased district autonomy in raising own-source revenues with the passing of Law No. 28/2009 on Local Government Taxes and Retributions. The law authorized districts to expand local tax and user fees (retribusi), increasing their discretion for setting their own tax and fee rates. Its centerpiece was the devolution of property taxes to districts, including both recurrent (PBB P2) and property transfer taxes (BPHTB). Property taxes have since become the most important source of district own source revenues, representing 41 percent in 2017.99 These reforms contributed to significant growth of own-source revenues, to about one-third of SNG expenditures by 2018, compared with only one-seventh in 2001.

However, these intergovernmental transfers remain only weakly associated with service delivery needs. The distribution of the main transfer, such as the DAU and Dana Desa, for example, start with an assumption of uniform 'average fiscal needs' across all districts and villages, which disregards variation in population size and proxy of development needs specific to each region. One major reason is that the allocation formulae still emphasise 'by place' rather than 'by person' equity. Consequently, in 2017, districts with the smallest population quintile received approximately five times the revenue per person compared to those with the largest population quintile.

Moreover, the formulas for the DAU and Dana Desa inadvertently encourage excessive spending on salaries by incorporating a 'basic allocation' that correlates the transfer amount to the number of government employees in the SNGs. Additionally, the performance-based DAK, contrary to the GoI's intentions, has not been effectively targeted towards districts in need, as measured by poverty statistics and accessibility to services. A contributing factor could be that districts with lower capacities struggle to draft qualified proposals. This proposal-driven method has also resulted in unpredictable funding, complicating the ability of SNGs to strategize long-term investments.

Table 1. Village revenue trends before and after the village law

Revenue Source	2013	2014	2015	2016	2017	2018	2019
Village Own Source Revenue (PADes)	4.1	4.2	4.2	3.5	3.1	3.5	2.9
Transfer Revenue	17.5	21.3	47.2	78.3	96.7	98.0	113.4
• Dana Desa (DD)	-	-	19.5	45.6	57.6	56.9	67.3
• Shared Tax and Levies from District Govt (BH-PRD)	0.6	0.9	1.7	2.0	2.5	3.0	3.6
• Alokasi Dana Desa (ADD)	8.1	10.2	22.8	26.4	30.5	31.8	35.2
• Financial Assistance (from Central/Province/District)	8.8	10.1	3.2	4.3	6.1	6.2	7.3
Other Revenue	1.0	1.1	0.6	0.5	0.5	0.7	1.2
Total Village Revenue IDR (trillions)	22.6	26.7	52.1	82.3	100.2	102.1	117.4
Total Village Revenue USD (billions)	1.6	1.8	3.6	5.7	6.9	7.0	8.1

Village revenue trends before and after the village law (BPS Data). Dana Desa transfers contribute more than half of overall village revenues (53%), followed by ADD (31%), financial assistance from district and provincial governments (9%), and shared revenue from district taxes and levies (4%). Financial Assistance (Bankeu) consists of assistance from districts and provinces, with a slightly larger share from districts (4.4%) compared to provinces (4.1%).

Lastly, in its current form, the national government's support for infrastructure investments discourages SNGs from mobilising their own finances, including borrowing. Indonesia's subnational debt is exceptionally low, accounting for only 1.2% of the total public debt and 0.46% of the GDP, even when compared to its LMICs counterparts (where it constitutes 6.5% of total public debt and 1.9% of GDP). To prevent the accumulation of fiscal risks that could lead to debt distress, SNGs are required to navigate a time-consuming central government approval process. Additionally, there is no mandate for local counterpart funding, and the unpredictable nature of transfers makes it impossible for SNGs to effectively plan for large, complex investments that span more than one year of implementation. Without significant reforms to the intergovernmental fiscal system that encourage SNGs to generate their own financial resources, the growth of the SNG debt market will remain severely restricted.

2.1.3. Will JKN's contribution scheme collect enough to keep BPJS-K afloat?

Reflecting on the comprehensive overhaul of National Health Insurance (Jaminan Kesehatan Nasional, or JKN) is a deeply humbling endeavour. JKN is one of the most ambitious and largest single-payer programs in the world. Managed by a quasi-governmental agency, the BPJS-K, JKN entitled all Indonesia's residents to the same benefits package and applied a uniform set of rules for providers (e.g., payment methods, reimbursement rates, and quality standards).

By 2022, the JKN program has covered 248 million individuals, accounting for 90.34% of the country's population. Most of these members, 44.63%, are part of the PBI APBN category. There was a decline in the growth rate of members in 2020, notably within the self-employed (PBPU) and non-wage earners (BP) categories. However, the trend is now reversing, moving back toward the growth seen prior to the COVID-19 pandemic.

The Joko Widodo's administration's guiding principle has always been that Indonesians who can afford contributions need to start paying. The peak of the government's desperation was seen when President Jokowi took a risk by signing Presidential Regulation No.64 of 2020 which kept the planned hike in JKN contributions on the table. This decision was not only deemed to have disobeyed the decision of the Supreme Court but also seemed unsympathetic amid the pandemic.

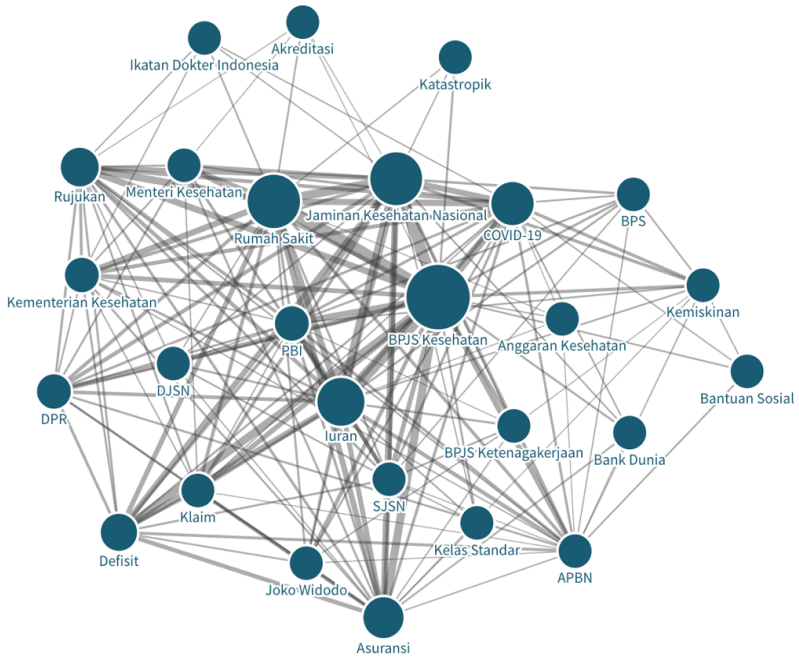


Figure 5. Nearly every policy the government enacts concerning JKN garners significant public attention. Source: Author.

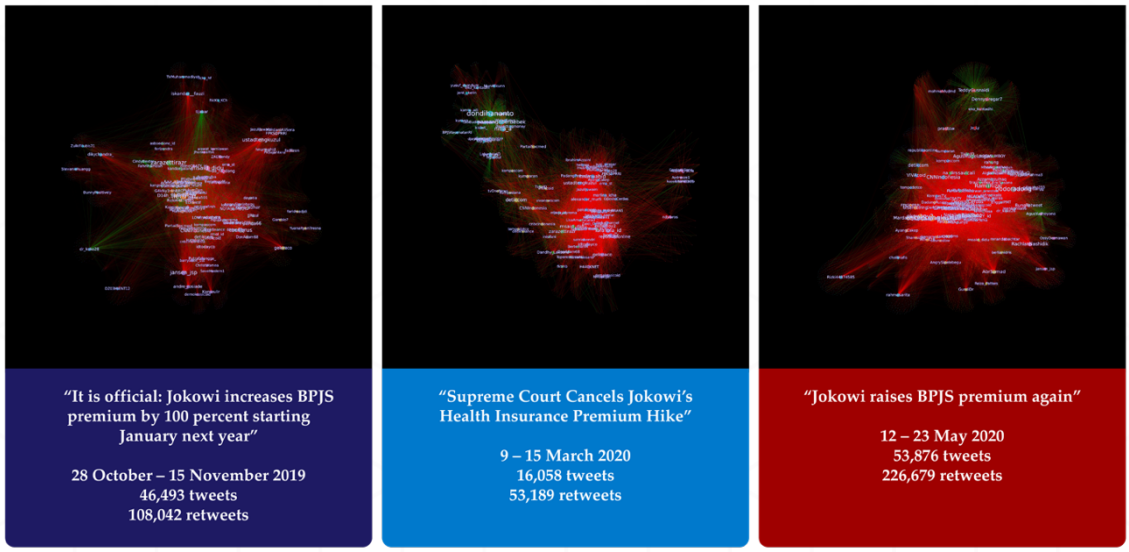


Figure 6. The evolution of the JKN contribution discourse. While the JKN's benefits and BPJS's financial shortfall capture public interest, the rise in JKN contributions has sparked the greatest controversy and debate. The initial surge of contention peaked in March 2016, with forceful criticisms of government. Source: Author.

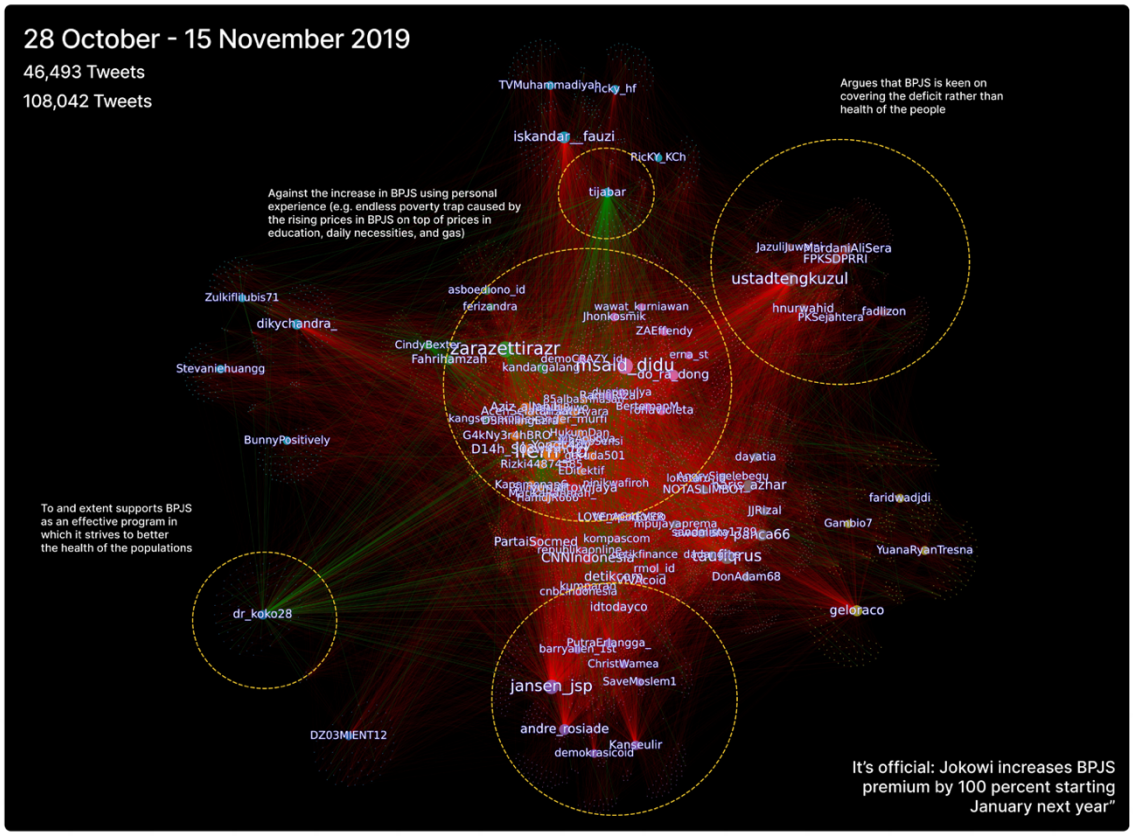


Figure 7. Discourse Network Analysis highlights divergent debates across political spectrums on JKN contribution increase. Source: Author © CISDI. 2023.

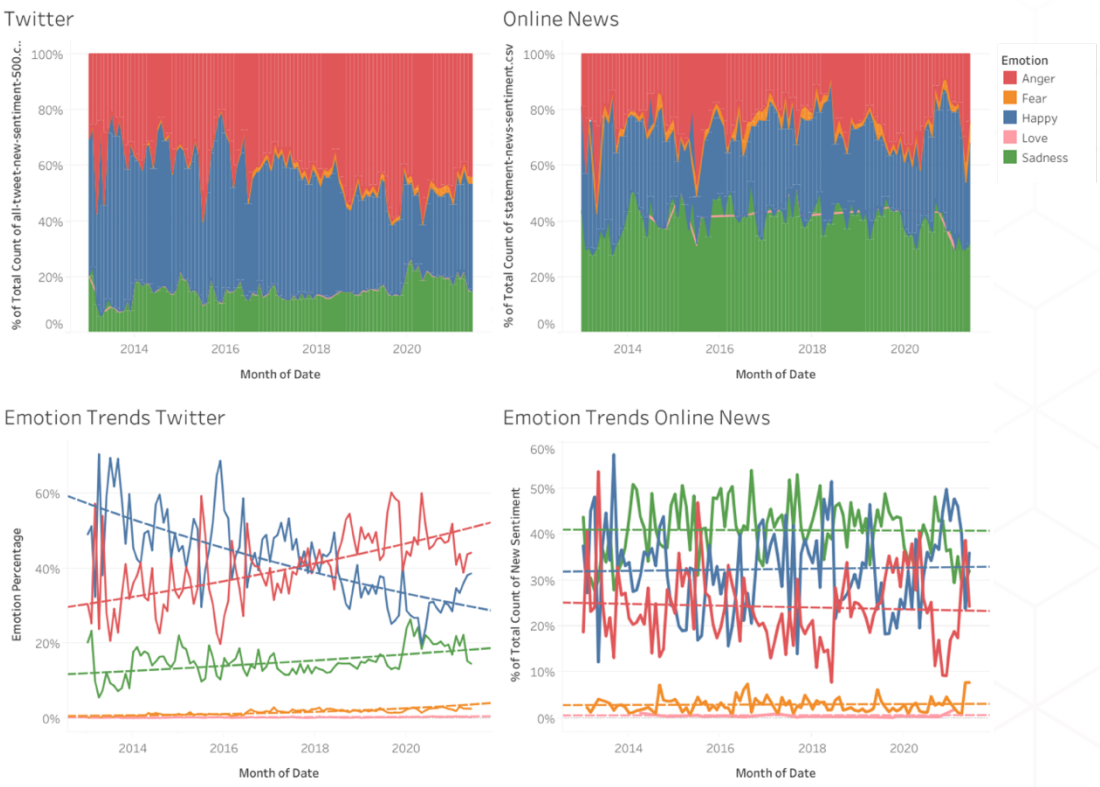


Figure 8. Sentiment analysis reflects growing discontent with JKN program. Employing machine learning techniques with a high accuracy rate of 96%, the data suggests that a majority of tweets carry a negative sentiment and reflect a growing trend of pessimism towards the JKN program. Analysis of Twitter sentiment reveals a declining trend in 'happy' emotions associated with JKN and a rise in 'anger'. Meanwhile, the sentiment derived from online news content generally seems even keeled, pointing to a neutral stance in their reporting. Source: Author © CISDI. 2023.

During that period, the Government had to make some hard decisions to keep the political promise of "no-cap, no-co-payment" in the face of the recurring deficits affecting JKN. Until just prior to the pandemic, the 2019 BPJS-K Audited Report indicated that JKN experienced a deficit of IDR 17.0 trillion, bringing the total accumulated deficit to IDR 51 trillion since its establishment. JKN's claims ratio regularly exceed 100 percent, indicating a shortfall in how funds are managed.

Beginning on January 1, 2020, membership contributions increased between 65% and 110%, based on the selected membership category and plan, in accordance with the announced schedule. The Ministry of Finance committed to subsidising the hike for Class 3 informal sector contributions at IDR 16,500 but planned to reduce this subsidy to IDR 7,000 starting January 2021. To provide context, for a typical family of four, the cost of the lowest tier JKN membership, which is compulsory for each household, would amount to about US$12 monthly. This represents approximately 4.3% of the family's monthly earnings, presuming a minimum wage of US$280 per month. BPJS-K has resolved to maintain the current rates for membership contributions steady until 2024, a move that aligns with Indonesia's entry into the political calendar.

However, the pandemic was probably a 'blessing in disguise' as BPJS-K concluded the year 2020 without incurring a deficit for the first time. This pattern has persisted until the end of year 2022. The Social Security Fund (DJS) maintains a surplus in net assets, totaling IDR 56.51 trillion, which can cover projected claim payments for approximately 5.98 months[16].

Experts have warned that even greater challenges lie ahead. There is a potential for increased spending due to a surge in utilisation as the COVID-19 situation bounced back. It is anticipated that complications arising from delays in health services will begin to reverse the situation from 2024 onwards. Furthermore, there will be added pressure as tariffs rise and the nationwide introduction of the Basic Health Needs and Standard Inpatient Classes policy faces delays at least until the political year ends. It is also important to highlight that by the end of December 2022, there were 28.6 million members (11.5%) who were not actively participating, and there were 15.7 million members (6.35%) who had fallen behind on their payments. The comparative trend graph of per capita contributions and per capita benefits indicates a possible intersection point in 2024 (see Figure 10). BPJS forecasts a prospective deficit of IDR 11 trillion. This will necessitate the government to implement another contribution hike by 2025.

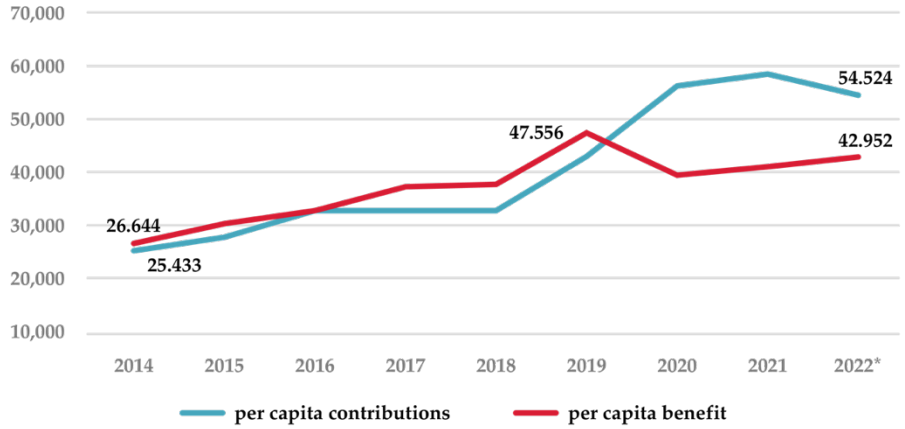


Figure 9. The comparative trend graph of per capita contributions and per capita benefits. Source: Ruby[17] © BPJS Kesehatan. 2023.

The hike in contributions will, as is often the case, predominantly affect the informal sector, leading to a decline in coverage and a rise in adverse selection[18]. Those working in the informal economy, the self-employed, and part-time workers which constitute a large part of the Indonesian workforce are not able to afford to pay contributions as COVID-19 has substantially decreased working hours and earnings[10]. As the pandemic bounced back, spells of unemployment lasted longer as some of the informal jobs disappeared and fresh labour market entrants faced difficulties finding jobs[13].

Actuarial estimates have indicated that the JKN scheme is currently under-resourced for the benefit it provides. This is due to premiums that were not set based on sound actuarial estimates considering age, sex, case mix, utilisation patterns, and regional differences in price levels across the country. The setting of JKN premiums was based on the expectation that all individuals would participate, with the willingness to intentionally redirect funds usually spent on phone credits and cigarettes to cover the increased JKN premium payments. In practice, however, the informal sector and non-workers join on a voluntary basis. Short activation periods for new or returning members and poor verification of contribution compliance further encourage members to only sign up when they fall sick and to stop paying once treatment has been received. A study by Muttaqien *et al.* also found that informal workers' average ability and willingness to pay fell below the national health insurance scheme's premium amount[19].

The government has put in place certain enforcement strategies to ensure that people comply with making their contributions to the JKN scheme[20]. These strategies involve making participation in the JKN a prerequisite for accessing some public services. However, this approach of tying compliance with JKN payments to the provision of essential services might not be entirely effective and could have unintended negative consequences by impeding progress in other areas of public services.

Key policy areas concerning JKN revenue include appropriate setting of contribution rates and enhancing collectability. To balance increasing revenues with rising expenses and reduce JKN's primary deficit, a sustainable approach requires not just increased revenue but

also improved management and efficient expenditure targeting, which will be discussed later. Decisions to modify contribution rates must take into account the wider economic environment and labour market conditions, particularly their impact on enrolment and collectability in both formal and informal sectors. Additionally, the capacity of BPJS-K to effectively implement and enforce revised contribution management rules should be factored into holistic reform strategies.

2.1.4. Navigating the transition from development assistance

As Indonesia graduates from a low-middle-income country, it confronts a decrease in international health development aid and must shift towards greater domestic funding for its health initiatives. If not handled carefully, this reduction in foreign donor support could pose substantial obstacles to the advancement of the health sector.

While development assistance represents only a small share of overall health spending in Indonesia, it does make up a significant share of resources for certain health programs that are traditionally donor-funded—mainly TB, HIV, and immunisation. In 2016, donor funding accounted for less than 1 percent of total health expenditure. However, the MoH estimated that the donor-funded share was as high as 60 percent for spending on TB and HIV, and between 10 and 15 percent for immunisation program spending. Ensuring a smooth transition away from externally financed health programs as Indonesia loses access to donor aid has become a key concern. There will likely be significant gaps in service delivery if activities currently supported by donors are not picked up by the GoI.

Donor-funded activities such as HIV, TB services, and malaria prevention in Indonesia are not adequately provided by the private sector due to low profits and high labour requirements. These health services are often the responsibility of Puskesmas, but they face challenges like limited funding, insufficient staff, and social stigma. As a result, donors and Civil Society Organisations play a critical role in delivering these essential services that have broad public health benefits beyond the individuals treated.

2.1.5. Private Sector Involvement

Private providers have started to step up their investment in health as the growing demand for privately funded health services. Besides providing needed scarce capital, greater private investment could promote local innovation, technology transfer, and low-cost solutions for health services and products such as medical devices and drugs. According to the Investment Coordinating Board (*Badan Koordinasi Penanaman Modal or BKPM*), private investment in the health and human services subsector reached US$148.7 million in 2018, growing some 130 percent per year, on average, since 2014[21]. Data on utilisation rates suggest that the private sector provides close to half of outpatient health services and 30–40 percent of inpatient services in Indonesia.

Private investment in the secondary/specialist health care sub sector has grown more rapidly than the primary given the recent opening of the sector to foreign investment and the rapid expansion of JKN[21]. Private investments in the healthcare sector, particularly specialty hospitals, are primarily controlled by major hospital groups like Siloam, Hermina, Mitra Keluarga, and Awal Bros. Despite recent growth, these entities are still comparatively small on a global scale, indicating significant room for expansion in the industry. The diagnostics sector mirrors this structure, with specialised groups such as Prodia, BioMedika,

and Paramita dominating the private sector, leaving ample opportunity for increased investments in response to escalating demand. The emergence of digital health providers like HaloDoc, YesDoc, and Alodokter, offering online access to consultations, medications, and information, has played a crucial role in addressing limited access to primary healthcare services.

The perception of healthcare quality in Indonesia often falls short, particularly for its wealthier citizens who have the means to pursue higher standards of care. The President complained about approximately 2 million Indonesian citizens seeking medical treatment overseas every year[22]. Malaysia was the top destination for these medical tourists, followed by Singapore, and the rest to Japan, the United States, and Germany. When considering indirect expenditures, the financial impact on Indonesia due to its citizens seeking health services abroad is believed to be around $11.5 billion annually. Nonetheless, while those Indonesians who can afford it opt for treatment abroad, private domestic hospitals continue to primarily serve the segment of the population that is slightly below the threshold for affording international healthcare options.

The challenge now is threefold. First, several factors continue to limit increased and enhanced private involvement in primary health care, secondary/specialist health care providers, and diagnostic providers. The list of constraints includes (a) lack of a clearly articulated strategy for private sector engagement by the GoI; (b) restrictive establishment rules for private sector players—foreign in particular; (c) lack of an enabling government environment to design, manage, and monitor PPPs; and (d) unclear and at times overly restrictive e-health regulations[21].

The second challenge involves navigating the trade-offs between equity and efficiency, growth and access to health, and private and public sector participation. Evidence does not necessarily support the assumption that private sector delivery by itself provides better quality care more efficiently[iii,iv]. An expansion of the private sector could even worsen or create inequities in the distribution and quality of health services by creaming off the top consumers and human resources in the system[23]. In addition, a rapid expansion of the private sector in the health sector may generate the challenges of ensuring quality of care in a system with limited oversight capacity[24].

Third, transferring the benefits of healthcare investments from the private to the public sector presents difficulties due to the distinct regulatory frameworks they each operate within, encompassing diverse compliance and accountability requirements. The launch of private hospitals such as Bali International Hospital and Tzu Chi Hospital has been highlighted by the narrative of contributing to the foreign exchange[25]. Experts view this development positively in terms of macroeconomic benefits, but there's an ongoing debate about its effectiveness in enhancing the overall health system. The critical issue lies in what

[iii] While the private sector performs better on drug supply, timeliness, and patient hospitality, some reviews point to poor quality of care and worse patient outcomes and efficiency than in the public sector—partly because of the perverse incentives for unnecessary testing and treatment that are provided by fee-for-service systems. This may also be reflective of the enormous heterogeneity of providers in the private sector.

[iv] In Indonesia, a study on primary health care (PHC) supply-side readiness indicated that publicly funded Puskesmas were in fact more prepared to provide both general and specific PHC services compared to private general practitioner (GP) clinics. Among private sector facilities, those empaneled for BPJS-K tend to be more supply side ready than those that were not. For all the specific clinical and outreach services, such as for child health, immunization, and communicable diseases, Puskesmas were better prepared than the private clinics to offer services.

definitive measures the government will implement to redirect the foreign exchange earnings into public health investments, aiming to bolster the capacity, facilities, and financing of the JKN program. Without strategic actions, the differentiation of service levels could lead to creating a two-tiered health system whereby JKN system would experience decline in quality, aligning only with the basic standards, reminiscent of the older healthcare models like Jamkesmas and Askeskin, rather than achieving a 'top standard' class.

2.2. Streamlining the Pooling Mechanism

In the realm of health financing systems, pooling represents the critical function by which collected health revenues are transferred to purchasing entities. This mechanism, often overshadowed by the more discussed areas of revenue raising and purchasing, is essential to advancing universal health coverage (UHC).

The core function of pooling is to distribute the financial risk of health interventions across all members of the pool, rather than each individual bearing their own. Risk pooling effectively means that the healthy subsidise the sick, and by implication due to their lower health risks, the young subsidise the old. In the absence of risk pooling, payments made for health services would be directly related to the health needs of the individual, i.e. sicker individuals would have to pay more because they would need more health services.

Risk pooling serves the dual purpose of sharing the financial risk of unpredictable health needs and promoting both equity and efficiency. Equity is served as it reflects societal values that deem it unfair for individuals to shoulder all their healthcare risks alone. Efficiency benefits emerge as pooling contributes to overall improvements in population health, enhances productivity, and reduces the financial uncertainty associated with healthcare costs.

In Indonesia, pooling is operationalised through three mechanisms: consolidation of social insurance funds by BPJS-Kesehatan, pooling of central government funds (health budget), and fiscal transfers to provincial and district governments.

2.2.1. Consolidation of social insurance funds by BPJS-Kesehatan

JKN uses a single-payer model, with BPJS-Kesehatan (a quasi-government agency) managing a single trust fund (Dana Amanat). JKN is consolidating hundreds of financing schemes under one umbrella. As mandated in Law No. 24/2011, BPJS Health is handling all payments to public and private health facilities (creates a purchaser-provider split) and is responsible to the President.

Although BPJS-Kesehatan holds a substantial public funding pool, a notable portion of the Indonesian population remains outside the pool. Given the large number of insured who were transferred from prior schemes, the biggest change in enrolment through the implementation of JKN was the targeting of the informal sector[26]. As experienced in other countries, the informal sector's early adopters of insurance are often those in immediate need of healthcare services[27]. While it is desirable that these members were able to access the care needed without incurring any financial hardship, adverse selection (where the insurance pool is disproportionately composed of high-need individuals) undermines the insurance principles of risk pooling and cross-subsidisation[28]. As coverage levels rise, it may become more challenging to recruit members from the informal sector and, crucially, prevent them from discontinuing their participation in the pool. Those conditions limit the mix of healthy

and sick members within the pool. The continuation of this trend will have significant implications for the long-term financial sustainability of JKN scheme.

Many stakeholders view raising the PBI rate as a quick measure to enhance JKN's fiscal health, given that the PBI contribution rate is the smallest in absolute terms among all segments and is entirely under the government's purview to modify and fund[26]. The government could initially focus on minimising errors in pinpointing eligible recipients for the PBI program. Nonetheless, any alteration in the PBI contribution rate depends on fiscal capacity. Both actions are also political decisions that would be challenging to reverse.

The effectiveness of risk pooling can be evaluated only by considering the utilisation levels of each segment in relation to their contributions[26]. Should the poor utilise healthcare services less than their contributions warrant, it might imply that the government is indirectly subsidising care for those in contributory membership segments. For instance, areas with scarce hospital facilities may not fully benefit from their premiums, leading to an unintentional redistribution of funds to regions with better hospital access. Overcoming the obstacles to accessing health care, a topic we will explore further in this chapter, has the potential to be a significant turning point. As the utilisation within the PBI sector increases, the persistent argument that revenues derived from PBI subsidise services for wealthier segments will become less relevant.

2.2.2. Indonesia's Main Health Financing Risk Pool: The Health Budget, Not JKN

2.2.2.1. Supply-side budgets for health play a much larger role

It is important to emphasise that JKN is not the primary mechanism for pooling health financing risks in Indonesia. In fact, only less than one-quarter of all government spending on health flowed through JKN. These supply-side budgets for health are managed by the Ministry of Health, financed through taxes and other general revenue sources, play a much larger role. The Ministry of Finance pools funds into the "health budget" and allocates them to ministries and institutions that carry out health functions, primarily through the Ministry of Health.

MOH transfers their funds to public owned facilities therefore there is no purchaser-provider split. The MoH also channels funds vertically to provincial health offices (PHO) through two mechanisms: (1) the delegation of authority (in a form of Dekonsentrasi – Dekon fund) and; (2) co-administration (in the form of Tugas Perbantuan – TP fund) as well as to district/city health offices (DHO) through the co-administration mechanism. All support salaries for public sector health workers; government health infrastructure construction and maintenance; some of the operating costs for Puskesmas and government hospitals (utilities, drugs, supplies, fuel, in-service training, and administrative costs); health sector management; and pre-service training for health workers.

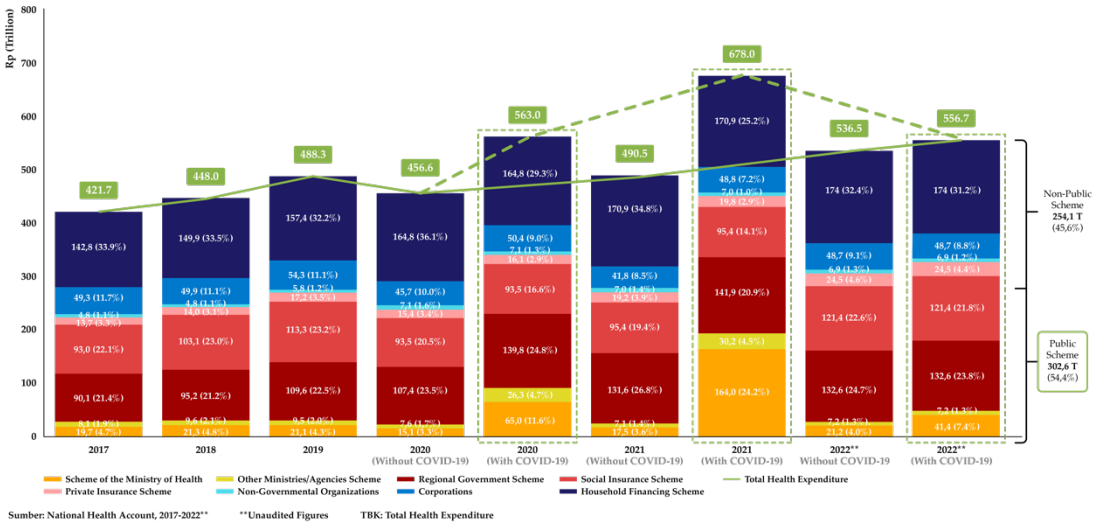
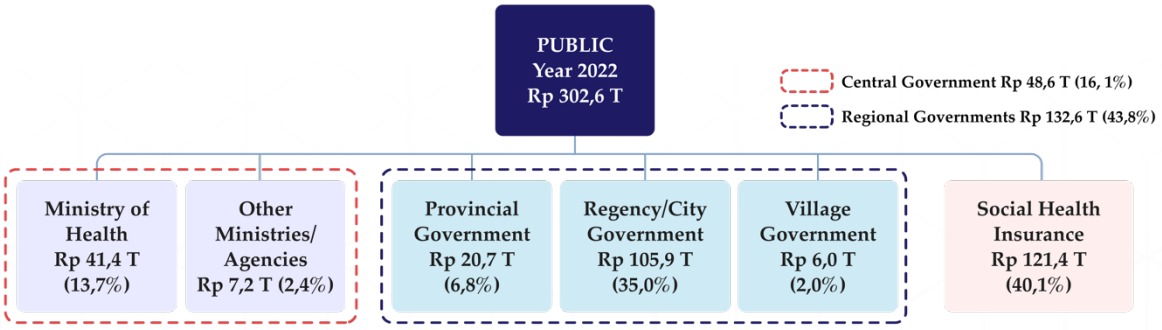


Figure 10. Indonesia's National Health Account 2017-2022. Source: Soewondo[29] © Direktorat Tata Kelola Kesmas. 2023



Health Financing Scheme	2017	2018	2019	2020 (COVID-19 expenses not included)	2020 (COVID-19 expenses included)	2021 (COVID-19 expenses not included)	2021 (COVID-19 expenses included)	2021** (COVID-19 expenses not included)	2020** (COVID-19 expenses included)
Public Health Spending	211,0	229,3	253,6	223,5	324,6	251,5	431,5	282,4	302,6
Ministry of Health	19,7	21,3	21,1	15,1	65,0	17,5	164,0	21,2	41,4
Other Ministries/Agencies	8,1	9,6	9,5	7,6	26,3	7,1	30,2	7,2	7,2
Provincial Government	14,3	15,5	16,2	13,7	21,3	21,6	22,5	20,7	20,7
Regency/City Government	75,8	79,7	88,4	87,7	106,9	101,4	106,6	105,9	105,9
Village Government	-	-	5,1	6,0	11,5	8,6	12,7	6,0	6,0
Social Health Insurance	93,1	103,1	113,3	93,5	93,5	95,4	95,4	121,4	121,4

Figure 11. Indonesia's Public Health Budget. Source: Soewondo[29] © Direktorat Tata Kelola Kesmas. 2023

2.2.2.2. Potential perils of cutting Mandatory Spending: weighing the costs

In the broader context, however, a weak commitment to prioritising health care in Indonesia seems to coexist with the governments' struggles to satisfy increased budgetary needs. Public spending on health remains far below what nations with comparable levels of affluence spend on average, notwithstanding recent increases (1.4 percent of GDP or 8.5 percent of total government spending). This comes to only US$49 per person, which is significantly less than the regional and lower-middle income average[30].

The decline of real central government health spending may have been a risky and costly retreat. To achieve Indonesia's development targets, as stated in the National Medium-Term Development Plan (RPJMN 2020-2024), indicative (pre-COVID) estimates suggest that

additional spending of 4.6 percent of GDP is needed per year. This means an estimated need of IDR 112.7 trillion, while the available funding stands at IDR 61.1 trillion[29].

The growing population, demographic shift towards an ageing population, changes in disease patterns, changes in expectations and "insurance effect" are anticipated to escalate the financial demand. Projections indicate a 73-fold increase in needs by 2045 compared to the year 2000[29]. The Total Health Expenditure is anticipated to range from IDR 3,974 trillion to IDR 5,823 trillion, equivalent to approximately 5.7% to 8.3% of the GDP. In contrast, public financing is projected to constitute between 13% and 19% of the APBN. This estimate aligns with the level of health expenditure observed in developed nations worldwide and the suggested US$110 per person needed to provide the essential UHC package[30]. Taking the latter benchmark alone, Indonesia should more than double its present public health spending.

The abolition of mandatory spending on health could be a perilous and expensive step back for Indonesia unless alternative measures are put in place. The improvement of actual expenditure on public health prior to the pandemic was a result of the enforcement of Law No. 36/2009. This law stipulates that a minimum of 5% of the central government budget and 10% of sub-national government budgets (excluding salaries) must be allocated for health. Looking at it from a benchmarking standpoint, every country with substantial population coverage, except for Brazil, Indonesia, and Vietnam, dedicates a minimum of 10 percent of their government budget to healthcare.

Law Number 17 of 2023 eliminates mandatory spending and introduces performance-based budgeting in line with the Health Sector Master Plan (RIBK). This allows regions to adjust their budgets based on their specific health needs and priorities. This approach aligns with Law Number 1 of 2022, which emphasises performance-based budgeting for regional governments.

Table 2. Comparison of Law Number 36 of 2009 and Law Number 17 of 2023

	Law No. 36/2009 Conventional Budgeting	Law No. 17/2023 Performance-based budgeting
Source of Financing	Article 170(3): The sources of health financing come from the Government, local government, communities, private sector, and other legitimate sources	Article 401(3): The sources of Health funding come from the Central Government, Local Government, and other legitimate sources in accordance with the provisions of laws and regulations
Budgeting	Article 171: The Government must allocate a minimum of 5 percent of the State Budget and 10 percent of the Regional Budget, excluding personnel expenses, for health.	Article 409(4): "Regional Governments allocate the Health budget from the regional revenue and expenditure budget in accordance with the needs of the regional Health, referring to the national Health program outlined in the Health sector master plan, taking into account performance-based budgeting
Monitoring		Article 402: (1) The Central Government monitors national and regional health financing to ensure the achievement of health financing goals as stipulated in Article 401 paragraph (1). (2) To support the monitoring of health financing as referred to in paragraph (1), the Central

		Government develops an integrated Health financing information system linked to the National Health Information System.
Incentives		There will be incentives for regions that achieve good performance.

At the subnational level, there are still considerable regional disparities. By calculating the coefficient of variation of the proportion of health expenditure, which involves determining the average percentage of mandatory spending (10%) subtracted from the actual percentage of local health expenditure, and then dividing it by the standard deviation, it is found that 132 regions (districts/cities) have dynamically adjusted health spending percentages according to their needs, while there are areas where they cannot meet mandatory spending at all (163 regions/districts/cities).

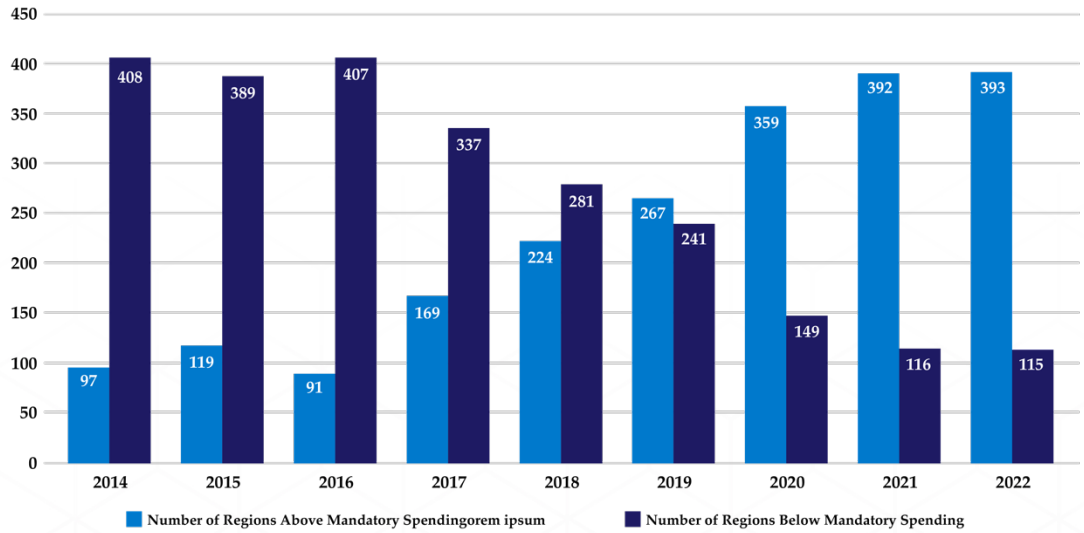


Figure 12. Number of regions with health spending proportions above and below Mandatory Spending. Source: Nuryakin et al. [11] © LPEM FEB UI. 2023

In general, if a budget process works well and health is well prioritised, then earmarking should not be needed–discussions regarding whether Indonesia has met these two requirements have been highly divisive. Globally, the varying nature of this prerequisite from one nation to another has resulted in contradictory evidence regarding the advantages of specific financial commitments[31]. The abolition of mandatory spending on health could indeed provide more budget flexibility, allowing Ministry of Finance to allocate resources based on current needs and priorities–or in popular term: 'money follow program'.

However, it also raises concerns about ensuring that the health sector receives adequate funding and attention when the link between budgeting and policy is weak or when other external pressures interfere with effective priority-setting. The presence of mandatory spending instils confidence that the budget for the health sector is a government priority, both in normal situations and in uncertain economic times. Predictable budget also allows for the government, especially SNGs to plan. Therefore, at least 80 countries are still using

earmarking policies in some forms[31]. Balancing between meeting mandatory spending obligations and achieving optimal value for money requires careful fiscal management, prioritisation, and deliberative reforms.

As with all practices, softer earmarks should be pursued with safeguards and an understanding of local conditions and impacts. Presently, there is limited research on the outcomes experienced by countries that previously had earmarks in operation but subsequently removed them. There is also limited evidence regarding modelling scenarios for countries in transition to sustain improvements in health financing operations, their effectiveness in accelerating the achievement of health financing goals, and their ability to anticipate changes as donors shift their focus from supporting specific programs following the removed earmark policy. Additionally, there is insufficient data on the time frame required to facilitate policy transitions from rigid earmarks to more flexible ones.

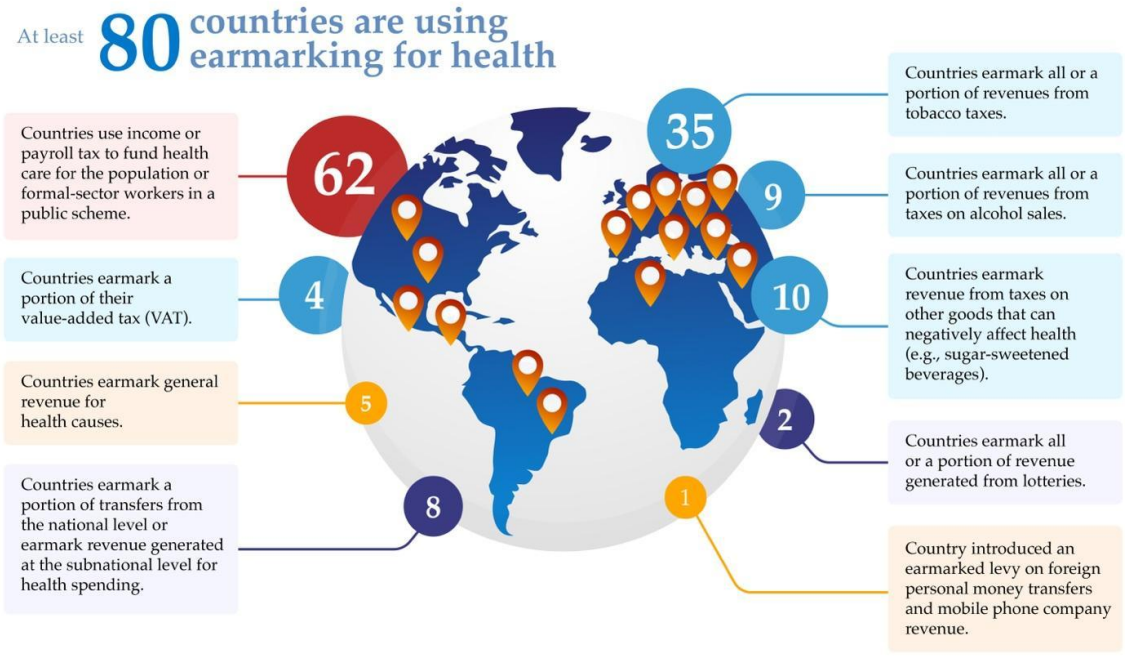


Figure 13. How countries use earmarking for health. Source: Cashin *et al.*[31] © WHO and Results for Development. 2023

2.3. Expenditure Management

Increasing Indonesia's expenditures without also increasing its efficiency will not advance its development objectives. "Spending better" implies optimising both the efficiency and effectiveness of expenditures. Inefficiencies arise from the misallocation of resources, where funds are not channelled to the most impactful activities (allocative inefficiency), or from using more resources than needed to achieve certain outcomes (technical inefficiency)[32].

Health spending is not always effective in achieving the desired outcomes. Current expenditure trends favour curative over preventive care due to financial incentives that encourage primary health care referrals to hospitals. Curative care is most of the total health budget, with more that 82% of JKN (Indonesia's National Health Insurance) funding allocated to hospital care. In contrast, preventive measures, which are more cost-effective, receive only a third of the health budget.

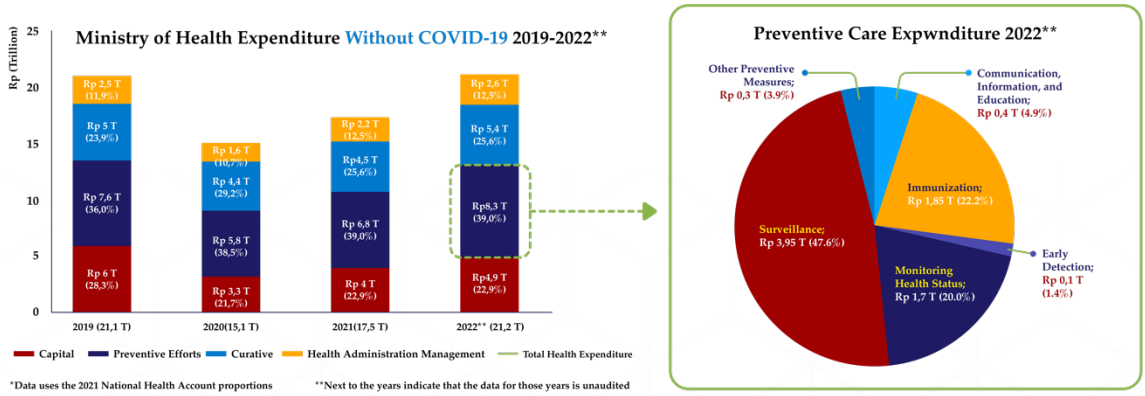


Figure 14. Ministry of Health spending. Source: Soewondo[29] © Direktorat Tata Kelola Kesmas. 2023

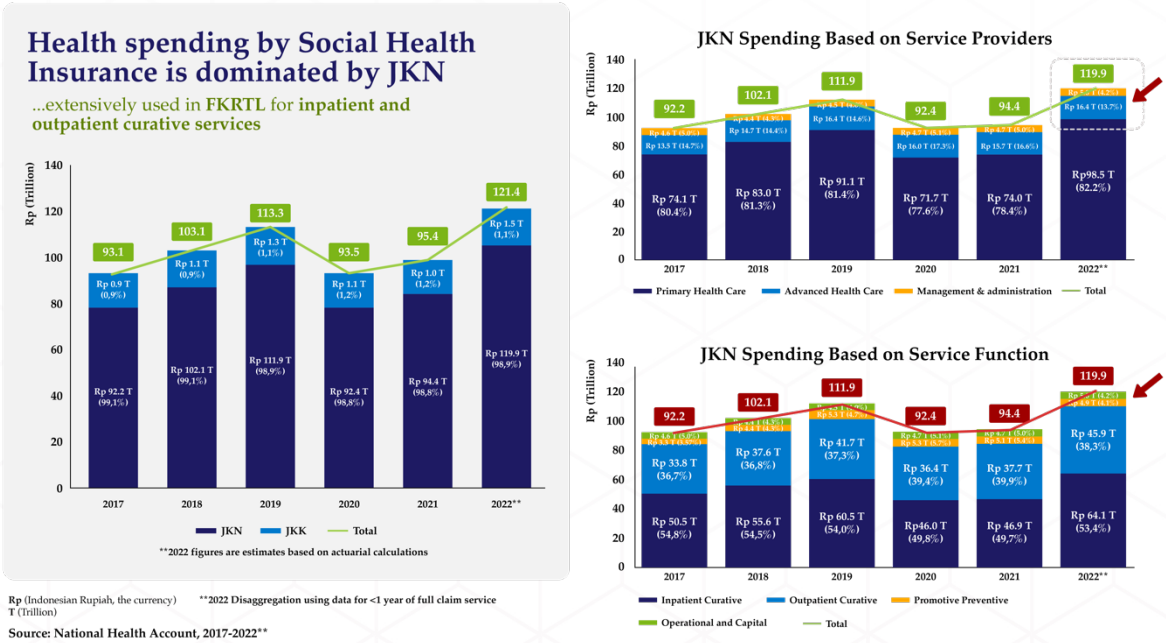


Figure 15. Social Health Insurance spending. Source: Soewondo[29] © Direktorat Tata Kelola Kesmas. 2023

The discussion will begin by addressing the significant impact of public financial management at both the national and local levels. In the section on demand-side financing, we will examine issues stemming from the design of the JKN system's benefits packages and provider payments, along with the resulting behavioural incentives. The final part of the section will present an examination of the contracting procedures with civil society groups and the interaction between the JKN system and voluntary health insurance plans through the coordination of benefit schemes.

2.3.1. Public Financial Management (PFM)

Public Financial Management (PFM) encompasses the methodologies, regulations, and infrastructures deployed by governmental bodies to mobilise revenue, distribute funds, expend resources, and chronicle financial transactions. PFM is imperative for assuring that governmental expenditures are conducted with efficiency, efficacy, accountability, and transparency. It envelops the entirety of the budgetary process, from its creation, implementation, to its oversight, as well as the stewardship of public finances throughout the entire fiscal period.

Notwithstanding notable advancements in various facets of Public Financial Management, persistent systemic impediments are evident across diverse sectors, health included. Post the 1997/98 Asian economic tumult, Indonesia has been recognised for its steadfast commitment to fiscal prudence. Nevertheless, the misalignment among the planning framework, budgetary structure, performance management systems, and the governmental organisational configuration continues to attenuate the synergy between policy formulation, strategic planning, and fiscal allocation.

The principle of 'money follows program' has yet to be fully actualised, as programmatic plans are predominantly aligned with national strategic priorities, whereas budget allocations are contingent upon the structural organisation. The enactment of Government Regulation No. 17/2017 did delineate a definitive role for Bappenas within the budgetary framework, mandating collaborative management of the fiscal process with the Ministry of Finance at each procedural juncture. Despite this, the regulation falls short of delineating the operationalisation of this collaborative endeavour. A further delineation of their reciprocal functions is crucial for enhancing the efficacy of their joint operations.

Overseeing expenditures related to healthcare and subsequently evaluating them poses a challenging endeavour. Institutional constraints reflect the capacity gaps on overall PFM, but also at the specific human resources capacity. At the sub-national level, the ability of governments to plan and execute their budgets very much depends on the skill and capacity of the human resources to conduct proper planning and budgeting, including to make good quality estimations of project costing. Over-estimation of the costing—in addition to the lack of capacity in the implementation process such as on the procurement, evaluation, and monitoring—has resulted in the under-execution of capital expenditure, which relates pretty much to the quality of infrastructure services. Furthermore, although significant monitoring is taking place, but it is fragmented, often duplicative and predominantly focused on monitoring absorption rates, rather than measuring the impact of spending.

The fragmentation in financing adds to the already complex task of local governments. SNGs must follow varying schedules and protocols, necessitating numerous coordination meetings. This places an extra strain on district-level planners with limited resources and capacity to prepare activity plans and coordinate resources.

Moreover, there is an opportunity to refine the institutional and structural frameworks that gauge performance to more accurately reflect the GoI aspirations and to enhance accountability across all governmental tiers. Yet, in Indonesia, the mapping of budget programs to outcomes and budget activities to outputs lacks a coherent results chain framework, obfuscating the relationship between policy goals, program design, management of effective interventions, and outcomes.

The delineation of outputs and outcomes is frequently ambiguous. Outputs, as determined by the discretion of line ministries, may alter arbitrarily and often resemble inputs, processes, or activities. This challenge is exacerbated in Indonesia's decentralised context of public service delivery, where the inputs and outputs managed by numerous line ministries cannot be logically deemed adequate for achieving the outcomes they are held accountable for, as these outcomes are contingent on contributions from SNGs.

Furthermore, the resources associated with those targets originally set in the RPJMN are often reduced through the annual budgeting process. This is why many governments today use rolling planning processes, which allow for the adjustment of targets in line with available resources and provide a more meaningful mechanism for monitoring the performance of government agencies.

The paucity of reliable data on target demographics, service utilisation, and sector performance further complicates budget tracking and expenditure reviews. On the expenditure side, the integration of financial management information systems at village and district levels is lacking. There is also an absence of standardised classifications for sectors, programs, and activities. While district governments are mandated to report on village spending in their financial statements, these reports are tendered as separate appendices and are consolidated at the bidang level ((which encompasses village development, village administration, community empowerment, and community development),, rather than by sector, impeding the GoI's capacity to enhance spending quality, as improvement is contingent on measurable parameters. The dearth of quality performance information has led to the misallocation of beneficiaries for certain programs.

The implementation of the logical framework remains suboptimal, notwithstanding the regulatory inclusion of an intervention logic framework. The definition of outputs and outcomes frequently lacks clarity. The practice of the Medium-Term Expenditure Framework (MTEF) is also not complemented by top-down medium-term budget ceilings from the Ministry of Finance to line ministries, which would serve as guidance for preparing spending plans. A clear visibility of fiscal constraints would likely precipitate resource competition, challenge proposals, and facilitate strategic resource allocation. Although monitoring is conducted, it is fragmented, often repetitive, and predominantly fixated on budget absorption rates, rather than on the impact of spending.

The introduction of the Minister of Home Affairs Regulation No.84 of 2022 heralds a more consistent and mutually agreeable standard for monitoring and recording subnational government expenditure. Nonetheless, decentralisation introduces additional complexities for central line agencies in terms of accountability and monitoring. Coordination difficulties are amplified for programs that fall under the joint purview of local and central governments.

Robust fiscal data and sector-specific output and outcome data are crucial for assessing and enhancing governmental efficacy. However, reliable, and credible SNG spending data categorised by function are scarce, hindering the assessment of subnational spending efficiency within sectors. Although some sectors do have data on outputs and outcomes, it is not systematically utilised and is of substandard quality. Even at the central government level, limitations exist in tracking the quality of spending in pivotal sectors such as health and education, since data is not consistently shared among key agencies and ministries, nor is it sufficiently detailed for profound analysis.

2.3.2. National Health Insurance Benefit Package

JKN offers a benefits package in the form of a negative list that is unexplicit, relatively more generous, and not aligned with available resources. JKN's benefit package covers all necessary treatments, except those explicitly excluded with no caps or co-payments on treatment. Actuarial estimates have suggested that the scheme is currently under-resourced for the benefits it provides[33].

The attempt to provide access to the same medical care regardless of membership type was an important step in the single-payer reform. The only difference in benefits across segments is in the type of ward where members access services, not in the services covered themselves. Starting from January 2022, the government has begun piloting the uniform standard of National Health Insurance (JKN) classes. Under this revised Standard Inpatient Class (*Kelas Rawat Inap Standar*, or *KRIS*) policy, the previous distinctions of class 1, class 2, and class 3 will be eliminated[34]. From the viewpoint of beneficiaries, the term 'standard' is often associated with a reduction rather than an enhancement, perceived as a shift towards lower quality. Additionally, the introduction of a benefit package policy based on Basic Health Needs (KDK) is also in place[35]. While both moves are intended by health insurance fund administrators to be efficiency improvements, the labels 'standard' and 'basic' could have unintended negative connotations if not properly conveyed[36].

BPJS-K does not cover infectious diseases that are covered under other government health programs. However, in practice, there are often comorbidities associated with these types of conditions that fall within interventions covered by JKN[26]. To better manage treatment for these diseases holistically, and to promote access and availability of these interventions, it is preferable to integrate all services associated with these conditions within JKN.

The expansive package of covered services does not necessarily guarantee access, equity, or quality. Despite the expansion in the supply of service, supply-side constraints continue to be a major factor in limiting access to the benefits package and implicitly controlling costs[37]. The benefits of healthcare spending since the introduction of Indonesia's JKN program are distributed disproportionately favouring the wealthier population groups, as well as urban areas and islands Java and Bali[38]. There is also substantial variation in healthcare unit costs across districts because regions with well-equipped health facilities are associated with relatively higher unit transfers for healthcare services. PBI members preferred to seek

treatment at PHC while secondary and tertiary services utilisation cases were dominated by PBPU members. The same analysis found that PBI members had an average hospital index utilisation value higher than PBPU members, which indicated that PBI members seeking secondary and tertiary services or treatment had poorer health conditions than PBPU members[39]. Poorer JKN households living in the eastern part of Indonesia–the less urbanised and developed regions–are often statistically found to experience the most cost-savings, which is largely due to supply-side constraints[40].

Ensuring that drugs and medicines are accessible, affordable, and properly distributed via the JKN is vital for the effective rollout of the benefits package. Indonesia is working to better integrate its national drug formulary, intended to control quality, and its procurement catalogue, which sets prices, to improve the efficiency of drug procurement through JKN[26]. However, there is a need to strengthen the monitoring and feedback process in place on drug procurement and consumption through JKN.

2.3.3. Strategic Purchasing and Provider-Payment System

BPJS-Kesehatan has operational autonomy to manage its finances, ensuring that its expenditures are aligned with its revenues by acting as a strategic purchaser that disburses funds based on performance metrics. To achieve this balance, BPJS Kesehatan must work in tandem with the Ministry of Health, which has the authority to control other policy levers (provider payment methods, rate setting, and quality monitoring). Conversely, the Ministry of Health can utilise the authority of BPJS-Kesehatan as a payor to enforce adherence to clinical standards and guidelines through claims management.

When it comes to strategic purchasing, the partnership between BPJS Kesehatan and the Ministry of Health plays a crucial role in making key decisions about what to buy, whom to buy from, and how to buy. Strategic purchasing stands out from passive purchasing by its reliance on informed decision-making and the critical evaluation of options, as illustrated in the referenced diagram. Such frameworks incentivise service providers financially to contribute towards the health system's goals. The act of purchasing is deemed strategic when the buyer intentionally employs evidence-based frameworks to choose which services and products to procure.

Table 3. Strategic Purchasing functions

Knowing health needs (health needs) and available services		**Knowing the available budget and maintaining its balance**
Use evidence about health needs and available services, medications, and technology		Use purchasing instruments to manage expenditures
Decide what services will be purchased	**Decide who will provide the services to be contracted**	**Decide how to purchase services**
• Defining benefit package and its expansion • Deciding on interventions/services/medications to be purchased (including type and amount)	• Choosing service providers to be contracted • Choosing a medication supplier • Contract with private providers	• Establish contract terms • Choosing and designing the method of payment to providers • Monitor the performance of providers and the system (utilisation of services,

• Defining methods of service delivery and quality standards		efficiency, quality, and financial protection

The decision-making process for purchasing healthcare services in JKN era involves several key steps: licensing, credentialing, empanelment, and accreditation[v]. These steps ensure that services are procured from qualified providers. Regarding regulatory compliance, BPJS-K can only contract with health facilities that have an accreditation certificate, as mandated by the Minister of Health Regulation No. 71 of 2013. Additionally, credentialing criteria for hospitals and primary healthcare providers, such as Puskesmas, are laid out in Minister of Health Regulation No. 99/2015. Presidential Regulation No. 19 of 2016 further asserts that all government health facilities are required to meet certain standards to participate in the National Health Insurance Program (JKN).

When it comes to contracting with health facilities, BPJS-K evaluates not only compliance with regulatory standards but also the quality commitments of facilities, which are subject to ongoing monitoring. Health facilities looking to renew their contracts with BPJS-K must undergo a thorough credentialing process addressing human resources, infrastructure, service scope, and commitment to service quality.

A significant challenge in this process is that the data supporting empanelment, credentialing, licensing, and accreditation activities are fragmented across separate databases within the Ministry of Health. Additionally, district and city offices maintain independent records of the licensing statuses for both public and private providers. Unfortunately, these records are not consistently reported back to the Ministry of Health or BPJS-Kesehatan, which could lead to inefficiencies and potentially hinder the overall effectiveness of the health system.

2.3.3.1. Primary Health Care Payment System

Salaries and fee for service are now combined with capitation and performance-based components to increase motivation and higher productivity at the Puskesmas (Community Health Centers) level. Only regional governments with better fiscal capacity can set higher salaries, implement new incentive structures to reward performance, and reduce the pay gap

[v] Licensing is concerned with verifying that only those individuals who are properly trained and qualified are allowed to provide healthcare services. It is considered a subset of the broader credentialing process, which is responsible for identifying which service providers are qualified and thus should be considered for healthcare contracts. Empanelment is the next step, which involves the selection of healthcare providers to be included in BPJS-Kesehatan's network. This process takes into account patient and family preferences, ensuring that patients are connected to the right healthcare providers within the network. Accreditation goes beyond credentialing by establishing a quality assurance benchmark that exceeds the minimum standards. Through accreditation, BPJS-Kesehatan can assure that healthcare providers not only meet the basic qualifications but also adhere to higher standards of quality. Credentialing is particularly critical as it ascertains that all healthcare providers within the BPJS-Kesehatan network are competent and without significant performance issues, maintaining a good professional standing. This comprehensive process compiles information about the location of providers, services offered, and past performance, which is vital for BPJS-Kesehatan to make informed strategic decisions about the appropriate mix and distribution of providers to meet the needs of those insured.

between the highest and lowest paid civil servants. In areas with low fiscal capacity, there is a missed opportunity to motivate improvements in quality and performance.

Fee for service payments cover maternal and neonatal services, such as pregnancy check-ups, normal childbirth, etc. For midwives under Puskesmas with financial autonomy (Regional Public Service Agencies-BLUD), BPJS-K transfers funds to the Puskesmas which then pay the midwives. For midwives in non-BLUD Puskesmas (the majority), BPJS-K transfers funds to the district health office which then pays the midwives. The mechanism varies from one district to another because it is based on local regulations, and there are anecdotal stories that village midwives often do not receive these transfers. For private midwives, BPJS-K transfers funds directly to the private midwives' accounts.

Capitation can be defined as a payment system in which a paying agent pays healthcare providers a fixed amount per covered patient for a specified set of benefits over a certain period of time – regardless of how much healthcare is actually used by the patient. The theoretical advantages of capitation include the ability of the payer to control costs for a range of services, and incentives for service providers to maintain the health of the covered population (through preventive services and good quality care) so as to minimise the use of expensive curative healthcare. For it to be effective, a capitation-based payment system requires the payer to have an effective quality monitoring system, and providers are accountable for any lack of service provision or excessive referrals. Without mechanisms to monitor and hold providers accountable for quality, those receiving capitation payments have an incentive to cut costs by reducing or lowering the quality of services.

Capitation rates are perceived as inadequate, being determined by supply readiness without adjusting for service demand or risk, particularly affecting private clinics. Adjustments for patient demographics or health indicators are absent, relying solely on metrics such as facility capacity and staff availability. The regulation does acknowledge the need for higher capitation in remote areas, but the incremental amount is criticised for being insufficient. The uniform capitation rate paid by BPJS-K to both public and private providers is also controversial; public providers receive government subsidies for salaries and infrastructure, unlike their private counterparts who face different cost structures, including higher prices for medicines due to exclusion from government procurement system that offers favorable prices and tax obligations.

Capitation payments are made to primary care facilities based on patient registrations with BPJS. Private primary care clinics maintain a patient list on the PCare system, yet there is a lack of timely updates to this list, hindering providers' preventive and educational initiatives. The reliability of PCare as a management tool is also questioned due to data issues.

There is a marked imbalance in the distribution of patients among providers. While the target patient-to-doctor ratio in FKTPs is 5,000:1, it can exceed 8,500:1, notably in Puskesmas across several provinces. Non-Puskesmas facilities often report much lower ratios. This disparity suggests an uneven playing field for private providers and may be a legacy of previous healthcare programs not yet recalibrated for the current JKN system.

A high or low patient-to-doctor ratio equally impacts the effectiveness of capitation payments. Too many patients per doctor restricts timely access to community health centre services, while too few can make the centres financially nonviable due to inadequate capitation revenue.

Government-owned Puskesmas receive many supply-side subsidies from other sources, as described above. For these facilities, capitation payments act as a "top-up" rather than a prospective payment designed to cover the full cost of service provision. On the other hand, private clinics do not receive other supply-side subsidies from the government. While capitation payments are slightly higher for private clinics, they effectively cover only a small portion of their full-service costs. This becomes a disincentive for private facilities to contract with the Health Social Security Agency (BPJS).

The utilisation of capitation funds paid by BPJS Health to Puskesmas or District Offices is regulated in Presidential Regulation (Perpres) No. 46/2021. This regulation was issued to provide clearer guidelines on how capitation should be managed to avoid multiple interpretations at the regional level and to reduce the potential for budget surplus (SILPA) in public facilities (as per the Ministry of Finance's view, SILPA is idle funds). Article 7.3 states that unused funds in the current fiscal year will be used by BPJS as consideration for allocating payments for the following fiscal year. The goal is to encourage Puskesmas to use these funds. This can potentially create perverse incentives to disburse funds for activities that are not actually needed or to burden primary health care facilities (FKTP) with limited capacity.

It's suggested that Puskesmas have more autonomy over their finances, with some transitioning to self-managed BLUD status. Local governments are encouraged not to overutilise Puskesmas for generating revenue. Even without BLUD status, according to Perpres No. 32, capitation funds should be directly accessible to Puskesmas, albeit with regional treasury approval for expenditure.

Complex rules regarding the allocation of capitation revenue result in low fund absorption in some cases. This impedes the potential of capitation to improve the quality and efficiency of healthcare due to low fund utilisation in the public sector. Despite direct transfers of capitation funds to Puskesmas bank accounts, often 40% of funds intended for operational expenses go unused. In 2018, more than IDR 2.5 trillion (USD 175 million) in capitation funds lay dormant in Puskesmas accounts, mainly because 85% of them reported an inability to spend all the received funds in 2015.

The main reasons for this weak utilisation are unclear regulations governing the use of fragmented funding sources, poor public financial management capacity, and an unresponsive healthcare service market. Ambiguity in guidelines and differing reporting requirements for various funding sources adds administrative burdens to Puskesmas, forcing them to verify which funds can be used for what activities. Also, primary healthcare facilities (FKTP) tend to underestimate capitation revenue in budget planning, resulting in underutilisation as Puskesmas cannot spend the available funds. This issue is compounded by a healthcare market that doesn't respond effectively, as the procurement of small quantities of medication at Puskesmas is unattractive to suppliers.

Moreover, administrative burdens hamper the reporting process. Different cash accounts for each funding source (like JKN, the Ministry of Health budget, regional budgets) require separate financial reports. Health facility staff must complete financial reports for each account, leading to clinical staff spending significant time on financial reporting. Puskesmas also face challenges in capitation revenue absorption, especially the 40% designated for operational expenses, due to concerns about violating regulations and improper fund expenditure.

Although there has been progress in contracting and provider payments for Puskesmas under the JKN system, some implementation challenges have limited the impact of this purchasing mechanism on service provision, quality, and efficiency. Referral rates remain high, and the imbalance of BPJS spending between Puskesmas and higher-level care persists.

Uneven distribution of JKN participants across FKTP is a major concern, creating high-risk and low doctor-to-participant ratios. The current capitation payment system disadvantages rural FKTP because it lacks adjustments for higher fixed costs associated with serving populations in rural and remote areas. This disadvantage could worsen if performance-based payment reductions are implemented, likely penalising rural providers for not meeting contact rate targets.

Although improvements have been made to produce better Puskesmas-level data through the PCare system, stakeholders express concerns about its effectiveness. Not all Puskesmas have access to PCare data, hindering their ability to manage the health needs of their registered population and making performance evaluation opaque. Other worries include the lack of mechanisms for Puskesmas, private FKTP, and local health offices to identify JKN participants registered at each FKTP, and PCare data is not linked to hospital utilisation data, limiting its value for policy-making, planning, and budget allocation at both the central and regional levels. BPJS-K is developing a stakeholder portal dashboard (involving the Ministry of Health, District Health Offices, health service provider associations, and professional organisations) to improve access to available data.

A broader concern with all payment systems used under JKN is their fragmentation across different levels of care without a link between capitation for Puskesmas and the INA-CBGs payment system (a claim application for hospitals, Puskesmas, and Health Service Providers for the poor) for secondary and tertiary services.

2.3.3.2. Hospital Payment System

Open-ended hospital expenditures and unrepresentative cost data incentivises volume and gaming over quality or efficiency drives the deficit. Hospitals are paid based on diagnosis-related groups (DRGs). Normally in DRG-based systems, the payment rate is set prospectively based on average cost (or the cost of the best-performing hospital); the provider is meant to bear some of the financial risk if the cost of treatment for a given case exceeds the payment rate for that case. Of critical importance is the presence of a budget and/or volume ceiling; but, in Indonesia, payment to hospitals is essentially open-ended shifting the burden to BPJS-K as hospitals get reimbursed for all or most of their claims – removing any incentive they might have to manage resources more efficiently. Implementing close-ended hospital payments has the greatest potential to curb expenditure growth.

While DRGs are generally considered the most efficient provider payment method for hospitals, they are complex to administer – requiring substantial coding and costing expertise, strong data systems, and active oversight. The two main design characteristics of a DRG-based payment system are the patient classification system (i.e., how diagnoses are grouped into cases of similar clinical aspect and resource use) and the payments associated with each DRG. This requires detailed data on hospital activity (e.g., diagnosis, tests and services provided) and cost data for each admission. But poor documentation by providers, a lack of clear coding guidelines, and the low competence of clinical coders, lead to the wrong

DRG being assigned. A few small-scale studies in Indonesia found that coding accuracy ranged from 40–75% depending on the condition assessed.

In a weakly monitored hospital sector, DRGs incentivise providers to "up-code" to charge codes that have higher payment rates and discharge patients early for later re-admission and an additional claim. Strong coding and data systems are especially vital because in 2019, hospital expenditures accounted for 84 percent of all JKN expenditures. The DRG tariff structure is also based on unrepresentative cost data and is unnecessarily complicated, which may further encourage gaming and inefficiency. First, the costing template is not detailed enough to get accurate estimates of unit cost. Filling out the templates is also not based on a representative sample of public and private hospitals and the tariffs are only 3 percent higher at private hospitals even though public hospitals receive significant supply-side financing. When the cost data is inaccurate or unfair it may incentivise providers to underprovided services or upcoded.

Second, Indonesia has 1,075 codes – many of which are not being used. Tariffs also have several adjustments for hospital type, region, and JKN membership class – but these adjustments were not adequately cost and do not reflect the cost of delivering care. Instead, adjustments are standard percentage increases – the justification for which is unclear.

2.3.4. Contracting Civil Society

Feasibility studies to unlock the potential of private providers[41] and civil society organisations (CSOs)[42] in service delivery highlighted the type of contracting mechanisms most suitable for different types of non-state providers. As private providers do not receive the significant supply-side financing that public providers do, here too JKN offers the strongest lever to incentivise improvements in the quality of services provided in the private sector. However, other existing budget mechanisms may be better suited for engagement with civil societies.

Although there are systems in place to support a wide range of activities by CSOs[42], various obstacles hinder their broader application. Despite eligibility for government funding, awareness of the mechanisms is low among both parties. Governments lack a unified platform and coordination to assess CSOs' capabilities and track records, while CSOs have limited information on government opportunities and face challenges in meeting funding requirements like providing documentation and managing accountability elements. Subnational agencies often lack the capacity to contract CSOs, and CSOs struggle to engage in the government's extensive planning processes. Governments are hesitant to allocate public funds to CSOs due to perceived risks and administrative burdens, and CSO activities are often driven by donor rather than national priorities, possibly reflecting capacity issues on both sides. Lastly, CSOs find the government's lack of transparency in planning and budgeting as a barrier to engagement.

2.3.5. Private Voluntary Health Insurance and Coordination of Benefit Scheme

Private Voluntary Health Insurance (PVHI) with a supplementary role also operates in Indonesia, albeit a minor role. It provides a higher level of access such as ward upgrades, expensive patented drugs and supplements compared to the coverage in the public system. Prior to JKN, some private sector employees were covered under more generous private

insurance schemes; there is some resistance to giving up these superior benefits, and integrating these beneficiaries into the broader scheme is a challenge.

The role of PVHI in a universal mandatory public system is an area in which the government needs to make some important policy decisions. For example, whether PVHI can fill in the cost-sharing in the public program. Coordination of Benefit (COB) scheme is therefore an area needing careful examination and coordination as National Social Security Council (Dewan Jaminan Sosial Nasional, or DJSN) conducts actuarial studies related to the impact of the Basic Health Needs policy (KDK), Standard Inpatient Care Class (KRIS), and adjustments to the JKN rates

The current COB scheme that provides access to private hospitals currently not included in the JKN network might pose challenges. From a system point of view, again, there are benefits to this arrangement because these forms of PVHI can fill explicit gaps in publicly funded coverage. If the KDK policy is not meticulously crafted and PHVI functions entirely in an unsubsidised free market, the advantages will be limited to those with the means to pay, perpetuating existing disparities. The concept of allowing the wealthy to opt out of JKN needs careful reconsideration. Given the inadequate mechanisms for the rich to contribute to the national system and support the nation's poor, especially with a weak tax system and the regressive nature of JKN payments, this approach could exacerbate equity and financing issues.

The practice of private insurers transferring lucrative patients to their own hospitals leads to JKN-affiliated hospitals treating a more ill and financially less beneficial population. Without the ability to cross-subsidise, these hospitals struggle to maintain profitability under JKN. Should these conditions render their operations unprofitable, private hospitals may withdraw from the JKN network, diminishing the accessibility for JKN members. Consequently, public hospitals may find themselves operating at a loss, facing either a continual need for financial rescue or a compelled reduction in the quality of their services.

The situation in Indonesia draws parallels to Chile's 1981 reform, where citizens could add private coverage to their national health program, FONASA, similar to JKN[43]**.** Private insurers screened out pre-existing conditions and older individuals, leaving those who were older, poorer, or sicker in FONASA, and selecting the more profitable patients for their private offerings. This resulted in a financial drain from the public to the private sector, causing a deficit. Continuing the current COB approach could steer the Indonesian health system toward a scenario akin to Chile's, with FONASA offering lower quality and being the fallback for those unable to afford private insurance — an outcome undesirable for JKN. Instead, COB should be enforced only across all JKN hospitals, not including the out-of-network ones. This would ensure the COB's intended role is fulfilled, curb the migration of profitable patients between facilities, help JKN hospitals remain financially viable, and maintain the overall quality of healthcare services.

2.4. Governance and Accountability System

2.4.1. Supply-side financing

Effective coordination between coordination between various centrals agencies and between levels of government is key for efficient service delivery. While improving the quality of current spending is likely the most feasible entry point for increasing fiscal space for health, weak governance and accountability, financial and institutional fragmentation, and limited performance-orientation for service delivery have made it difficult to link health sector spending with performance ensuring greater value for money.

Decentralisation poses additional challenges for central line agencies' accountability and monitoring, which is key for successful implementation of result- oriented budgeting. Line ministries have expressed concern at their inability to control or even monitor program outputs and outcomes once the responsibility for service delivery is passed to SNGs. Weak central-local coordination and accountability appear to have disconnected line ministry from outcomes, including program information and performance.

Coordination problems are exacerbated for programs that are the joint responsibility of local and central governments. In the previous section, we have seen how fragmented management and information systems, and poor coordination among key stakeholders, have made it difficult to assess the efficiency of public health spending. Within the MoH, each health program (e.g., HIV, TB, malaria, maternal health) collects its own data, distinct from regular primary care data (SIKDA-generik) and hospital data (SIRS) systems. The data are also housed in separate departments within the MoH. Reporting requirements at the facility level are burdensome (e.g., 16 different forms for TB), the format is predominantly paper-based, and data quality and reporting compliance is low.

There is limited use of institutional and fiscal levers to incentivise better performance. There are promising signs of better coordination of ministries in the management of fiscal transfers, but instruments for managing across levels of government need more work. Examples of better coordination include the trilateral processes between the MoF, Bappenas and line ministries for managing sector DAKs. Improving the institutional arrangements for managing across levels of government is complex and challenging in any country, but more so in Indonesia where there are more than 500 district governments. Effective intergovernmental transfer instruments are highly context-specific and prone to perverse incentives (for example, gaming of data used to assess performance). There should be more investment in evaluating their effectiveness in stimulating performance improvements.

Holding SNGs to account for spending effectively remains a central challenge for Indonesia. The inefficient use of public money by SNGs is likely driven by a combination of weak incentives to perform, lack of performance information, and capacity constraints. Indonesia's choice to largely decentralised service delivery implies that it is ultimately citizens who need to hold their local leaders to account for providing better services. Central government can, however, play a key role in empowering citizens to do so, by providing them with credible information about their SNGs' performance, by making SNG fiscal and performance information public, and by benchmarking SNGs' performance.

Furthermore, existing top-down accountability mechanisms do not effectively incentivise SNGs to make efficient use of, in particular, of conditional transfers. The main conditional transfer—Dana Alokasi Khusus, or DAK As an earmarked grant, however, in many sectors, its allocation is poorly correlated with need or performance, resulting in wide variation of services DAK health spending at the district level was not correlated with the level of health infrastructure, medical equipment, drugs and supplies available—items that DAK is meant to finance.

2.4.2. Demand-side financing

Coordination challenges and fragmentation among central agencies also limit the effectiveness of major JKN program. The regulations on the institutional roles and functions for JKN especially related to strategic purchasing are still transitioning. Unclear institutional responsibility and accountability of purchasers as well as weak governance arrangements hinder BPJS-K to act strategically were discussed in depth in the expert consultations.

Even though the institutional home for purchasing health services in the JKN era is Badan Penyelenggara Jaminan Sosial-Kesehatan (BPJS-Kesehatan), many purchasing functions are also carried out by Ministry of Health (MOH), and other ministerial/agencies who govern community-based healthcare facilities in the village. For instance: The Ministry of Health and Sub-National Health Offices have a role in ensuring that facilities and human resources evenly distributed as needed, maintaining minimum standards for licensing and accreditation, promoting public health, and delivering benefits (Standar Pelayanan Minimal) according to Law No.33/2004, Law No.23/2014, Government Regulation No.2/2018, and Minister of MOH Regulation No.4/2019.

BPJS-Kesehatan, as health insurance agencies, retains operational autonomy to carry out the main purchasing functions albeit limited. It has a crucial responsibility to control healthcare expenditure by strengthening strategic purchasing and making significant strides in this area through the implementation of performance-based payment. However, Indonesia stands out from its peers in that the MOH determines how much providers are paid and how they are paid. On the other hand, BPJS-Kesehatan involvement in ensuring compliance with clinical standards and guidelines through claims management is limited. The Ministry of Religious Affairs, the Ministry of Home Affairs, the Ministry of Villages, and the National Family Planning Coordination Board, as well as subnational governments (SNGs), support Posyandu functions by managing volunteer cadres and ensuring sufficient operational funds for Posyandu activities.

In short, the current functional roles of BPJS-K are merely a passive intermediary to transfer health payment to health providers and carry out some other largely administrative responsibility[44]**.** BPJS Kesehatan is responsible for balancing revenue with expenditure but does not have the authority to determine the policy levers (provider payment methods, tariff-setting, and quality monitoring) that would enable this control. In contrast, the Ministry of Health makes policy decisions that affect purchasing and provider payment, but it is not accountable for the financial consequences of these policies. As a result, strategic purchasing has been limited and JKN expenditures are rising rapidly, with limited evidence of improvements in service delivery, quality, efficiency, and financial protection Despite these divisions of labour, what is clear is that health insurance agencies and Ministries of Health cannot work in isolation from each other. Weak or absent health management and information systems inhibit information flow and coordination between stakeholders. Lack of

standardised reporting and accounting formats, the low prevalence of electronic health records, unreliable internet connectivity, and poor reporting compliance make claims verification a laborious work.

2.5. Service Delivery

In nations with less comprehensive benefit levels or where the scope of coverage takes precedence over the intensity of services provided, such as in Indonesia, both the access to and the quality of healthcare are constrained. Evaluations of supply-side readiness in the public sector and the private sector have identified deficiencies in care quality, particularly concerning diagnostic capabilities, the presence of diagnostic and treatment protocols, and the proficiency of healthcare providers in diagnosing and treating conditions, notably in primary care[45]. These assessments also indicate that despite the private sector delivering a substantial portion of healthcare, the public sector tends to offer higher quality services.

The JKN has the potential to promote enhanced access to and quality of healthcare by implementing heightened monitoring of providers based on performance, as well as by improving funding methods. Yet, it faces challenges in the domains of clinical care interventions and information systems: Firstly, there is a need for the establishment and accessibility of clinical guidelines, care pathways, and protocols; secondly, the execution of clinical audits and feedback mechanisms is required, which would include reviews of morbidity and mortality data; and thirdly, there is an imperative for information systems capable of consistently gathering standardised data on key indicators to track and ensure the quality of care.

Per Ministerial Decree No. 1428/2010, the development of clinical guidelines and care pathways was intended to commence with conditions that are most common and costly. Despite this, advancements have been modest. For more than 500 health conditions, National Clinical Practice Guidelines (PNPK) have been established for just 62 at the national level[46]. Moreover, the dissemination of these guidelines to healthcare facilities has been inadequate, leading to significant inconsistencies in clinical protocols among different healthcare providers.

Medical auditing, as a means to ensure both quality and cost management of medical and dental practices, is mandated under Law No. 29/2004. In the context of hospitals, these audits are conducted under the auspices of each hospital's Medical Committee, following the stipulations of Ministerial Regulation no. 755/2011 and Ministerial Decree no. 496/2005, with the latter decree serving as the guide for conducting medical audits in hospital settings. Nonetheless, the execution of medical audits tends to be on a voluntary basis, and there is no compulsory reporting of the outcomes, except in instances where the medical treatment results in the patient's death. Consequently, there is an absence of a systematic approach for notifying providers about the conclusions of medical audits or for delivering constructive feedback on clinical practices.

The process of gathering and reporting on the quality of healthcare services lacks a uniform, systematised approach. Nation-wide assessments of service quality do occur, such as through the Basic Health Survey (Riskesdas) and the Healthcare Facility Census (Rifaskes), but these are infrequent, taking place only every five and eight years, respectively. Typically, evaluations of service quality and patient safety are conducted by academic researchers or through the efforts of donor-funded organisations. However, their findings are not effectively

integrated into policymaking processes, and there is no clear evidence that these activities have led to enhancements in the national healthcare quality, as per findings from UGM and MOH in 2019. Additionally, there is a notable scarcity of real-time data on quality performance indicators, as reported by the Asia Pacific Observatory on Health Systems in 2017[47].

Inadequate health information systems impede effective decision-making, particularly in the areas of claim verification and fraud detection, resulting in considerable inefficiencies and waste. The absence of uniform reporting and accounting protocols, the sparse use of electronic health records, inconsistent internet access, and lax adherence to reporting requirements all contribute to making the process of verifying claims cumbersome and protracted.

BPJS Healthcare's current efforts in basic claims verification show substantial scope for enhancement. A major challenge is the lack of established clinical diagnostic and treatment protocols or defined referral pathways for numerous interventions included in the JKN benefit package, which hampers the ability of BPJS-K to evaluate service quality and hold healthcare providers accountable. The effectiveness of claims management is also limited by the inability of claims data to interface with supplementary information sources, such as electronic health records, prescription details, laboratory and procedure results, and data on the licensing, accreditation status, and service availability of providers and facilities, which are crucial for verifying claims.

Telehealth has the potential to make healthcare more effective, organised, and available. During the COVID-19 pandemic, there was a significant surge in the use of telehealth, and rapid progress was made in its development and the policies that govern its use by both hospital and non-hospital providers[vi]. However, there is still considerable opportunity to further integrate telemedicine with traditional healthcare practices and to solidify the legal framework for telemedicine use as we emerge from the pandemic era.

Moreover, prevailing health regulations define e-health or e-Kesehatan to include a variety of digital tools such as health management and knowledge management systems, health surveillance, telemedicine, mHealth, consumer health informatics, and digital education in health sciences and research. Despite these regulations, current digital health laws are primarily focused on telemedicine within healthcare facilities, which suggests a significant regulatory vacuum.

To address these shortcomings, the government must act swiftly to establish more encompassing and precise regulations. This will ensure that telemedicine is implemented without compromising patient privacy, confidentiality, and will safeguard against fraud, abuse, and the provision of inaccurate healthcare solutions.

[vi] In collaboration with 11 digital health start-ups, the government launched the national COVID-19 telemedicine service to alleviate strain on the health care system during the crisis and provide much needed health care to patients undergoing isolation. While Indonesia is not alone in experiencing such an acceleration in update of digital health technologies – the global health market is expected to grow at a compound annual growth rate (CAGR) of 17% from 2021 to 2026 to reach USD 385 billion.

Table 4. Comparison between the characteristics of telemedicine services provided by non-hospital providers with those provided by hospital providers

	Telemedicine service provided by non-hospital providers	Telemedicine service provided by hospital providers
Fees	Relatively more affordable than telemedicine services provided by hospital providers	Similar to fees charged for physical consultations at hospitals
Data storage	Electronic medical record data hosted on the cloud	Electronic medical record data hosted in data centres
Service coverage	Access to general practitioners, medical specialists, laboratory tests, and e-prescriptions	Access to general practitioners, medical specialists (including physical examination at the hospital), laboratory tests, and e-prescriptions
Applicable laws and regulations	• Law Number 36 of 2009 concerning Health (as amended by Law Number 11 of 2020 concerning Job Creation) • Minister of Health Regulation Number 90 of 2015 concerning Healthcare Services in Remote and Very Remote Areas • Minister of Health Regulation Number 20 of 2019 concerning Telemedicine Services Implementation between Health Services Facilities • Minister of Health Decree Number HK.01.07/Menkes/4829/2021 concerning Guidelines for Health Services through Telemedicine during the Corona Virus Disease 2019 (COVID-19) Pandemic (as amended by Minister of Health Decree Number HK.01.07/Menkes/243/2022	• Law Number 36 of 2009 concerning Health (as amended by Law Number 11 of 2020 concerning Job Creation) • Minister of Health Regulation Number 90 of 2015 concerning Healthcare Services in Remote and Very Remote Areas • Minister of Health Regulation Number 20 of 2019 concerning Telemedicine Services Implementation between Health Services Facilities • Minister of Health Decree Number HK.01.07/Menkes/4829/2021 concerning Guidelines for Health Services through Telemedicine during the Corona Virus Disease 2019 (COVID-19) Pandemic (as amended by Minister of Health Decree Number HK.01.07/Menkes/243/2022

The way forward

To enhance the benefits derived from health sector investments, the government of Indonesia might explore a range of strategic measures, which include: (1) expanding fiscal space to bolster investment in sectors critical to human development; (2) addressing systemic constraints to the efficiency and effectiveness of spending; (3) confronting challenges within the healthcare sector that compromise spending efficiency and effectiveness; (4) collecting and analysing more data to more accurately determine the allocative and technical efficiency of health sector spending; (5) initiating pilot programs before implementing them on a national scale

3.1. Expanding fiscal space to bolster investment in sectors critical to human development

3.1.1. Collecting better and more tax revenues[30]

To raise more revenue, the Government of Indonesia (GoI) should prioritise changes that extend the tax base for the unhealthy foods (tobacco, sugar-sweetened beverages, and high-fat, -salt and sugary foods) and income taxes, as well as raise tax rates, to improve tax progressivity and meet health objectives. The GoI could also enhance tax administration to reduce the cost of paying taxes, thus encouraging greater voluntary compliance. Increasing local governments' own-source revenues will give them greater autonomy for their spending. Reforms to the non-tax revenue system also have the potential to generate more money.

3.1.2. Reducing or completely removing energy subsidies and reallocating those funds towards healthcare subsidies[30]

It is estimated that the poor and vulnerable only receive about 21 percent of the kerosene and LPG subsidies, 3 percent of the diesel subsidy, and 15 percent of the electricity subsidy. Politically, reassigning energy subsidies to health care can help compensate the bottom 40% of the population to offset the impact of tax reform. A hypothetical scenario where energy subsidy reforms involve reducing spending by 0.7 percent of GDP annually, removing VAT exemptions, and increasing tobacco excise taxes to generate 1.1 percent more revenue each year. To counterbalance the effects of VAT exemptions and energy subsidy reforms on the bottom 40 percent of the population, targeted cash transfers costing 0.5 percent of GDP would be implemented. This entire plan would result in a net positive fiscal impact of 1.3 percent of GDP per year.

3.1.3. Scaling up the use of impact bonds in public health

Over the last twenty or so years, four encouraging and intersecting approaches to the funding of public health care in developing countries have evolved. These are: 1) outcomes- or results-based grant funding; 2) private sector investment through public-private partnerships; 3) the expansion of the “impact investing” community and innovative “blended finance” structures; and 4) more recently, over the past twelve or so years, “impact bonds”. Palladium Impact Capital and The Power of Nutrition, for example, are now developing Nutrition Ventures—a nutrition innovative financing hub to identify, market test and scale a range of innovative financing products, including bonds, in the same way green bonds have catalysed hundreds of billions of investment dollars in climate and environment[48].

3.2. Addressing systemic constraints to the efficiency and effectiveness of spending

3.2.1. Emphasise the quality of outputs and outcomes and closely track progress along the continuum of the results chain

To enhance the effectiveness of national and sector planning, it is essential to prioritise the quality of outcomes over sheer quantity. This involves monitoring progress across the entire results chain to promptly detect and rectify any shortcomings. By doing so, the government can increase the likelihood of achieving sector outcomes. Furthermore, GoI should implement more comprehensive intervention logic for programs, clearly defining intermediate steps and establishing measurement criteria to track progress. This is particularly crucial for initiatives involving collaboration between central and subnational governments, as it will clarify the expected contributions of subnational governments and facilitate performance monitoring.

3.2.2. Give priority to programs and interventions that are more efficient and impactful

Prioritise more effective programs and interventions by reallocating resources away from less productive ones. High-impact primary healthcare investments include focusing on community empowerment, people-centered care, and advanced community health workers, supported by improved digital and educational systems[1].

Shift the focus towards preventive care for older and chronically ill patients due to the ageing population and rising chronic diseases. The use of clinical decision support tools can help coordinate care across provider levels throughout the continuum of care. Improve monitoring and evaluation systems to assess program performance, especially in subnational delivery.

Three of the most important functions played by the Ministry of Health are: (1) establish a robust pre-implementation assessment of proposed interventions to create a compelling rationale for resource allocation.; (2) set up a robust monitoring and evaluation of whether key interventions are achieving their goals, as well as (3) conduct pending reviews and performance budgeting to allocate resources where they yield results.

3.2.3. Strengthen public financial management for health

To enhance Public Financial Management (PFM) and elevate the quality and effectiveness of government spending, a series of measures can be implemented. These measures include improving coordination between the Ministry of Finance (MoF) and Bappenas to align planning and budgeting efforts. Additionally, there is a need to strengthen the implementation of the 'money follows program' approach, ensuring that financial resources are allocated in a manner that supports program objectives.

Furthermore, it is essential to reinforce the integration of medium-term perspectives into the planning and budgeting processes, allowing for a more forward-looking and strategic allocation of resources. Moreover, there is a requirement to refine the conceptual framework for program and performance design, ensuring that interventions are logically structured and aligned with intended outcomes.

Reducing the frequency of in-year budget revisions, including mid-year budget revisions (APBN-P) and self-blocking budget cuts, can enhance stability and predictability in financial planning. Cultivating a 'performance management environment' that encourages and supports higher-quality spending by the public sector is also crucial.

Finally, enabling a performance-based budgeting system that is adapted to the requirements of a significantly decentralised fiscal process can further improve the efficiency and effectiveness of government spending. These combined efforts can contribute to a more streamlined and impactful allocation of public resources.

3.2.4. Improve coordination across and between levels of government

Enhance collaboration between central government agencies and foster better cooperation between central and subnational governments to enhance service delivery. This can be achieved by improving the integration and alignment of programs, sharing data more effectively, and promoting coordination in critical national priority programs. Additionally, strengthen the coordination between central and local authorities in policymaking, investment decisions, and program implementation to achieve improved outcomes.

3.2.5. Reform the fiscal transfer system

Reforming the fiscal transfer system is essential to incentivise improvements in service delivery, guided by three fundamental principles. Firstly, there is a need to establish vertical balance by aligning districts' revenue autonomy with their corresponding spending responsibilities, motivating districts to increase their tax efforts in the process. Secondly, achieving horizontal balance entails transitioning the fiscal equalisation formula towards a per-client basis, while implementing a gradual strategy to mitigate the impact on districts losing funding. This transition should also involve making conditional transfers under the DAK program more integrated into the local budget process, ensuring predictability. Lastly, in pursuit of efficiency, it is advisable to explore the introduction of performance-oriented transfers, which can further enhance the impact and effectiveness of fiscal transfers in promoting service delivery improvements.

3.2.6. Enhance data collection and upgrade information system management

This entails enhancing both data collection and information system management, alongside the implementation of the new subnational budget Charts of Accounts. These changes will form the basis for a more comprehensive assessment of subnational expenditure in the future. Nevertheless, implementing these reforms is a substantial undertaking. At the central level, line ministries should gather and report data on predetermined outputs and outcomes across various sectors and integrate these datasets into shared platforms. These platforms can then be utilised to enhance service delivery and program targeting across all government levels. Ultimately, the utilisation of data should drive improved performance, fostering enhanced accountability both from the top-down and bottom-up perspectives.

3.2.7. Draw in increased private sector investment for infrastructure development

Enhance the conditions to incentivise greater private sector investment in infrastructure. Achieving this goal involves bolstering the regulatory framework for public-private partnerships (PPP), revising incentives for state-owned enterprises (SOEs), refining pricing

mechanisms, and expanding financial markets. It is crucial to establish regulatory frameworks that effectively address potential market failures stemming from private sector participation in service delivery. These frameworks should ensure that private healthcare markets align with the broader objectives of health policy.

3.3. Confronting challenges within the healthcare sector that compromise spending efficiency and effectiveness

3.3.1. PBI targeting, subsidization and progressive premium setting

A significant number of workers in the informal sector would have to pay more than the standard 5% of their income above the survival level for health insurance premiums, which is considered high for lower-middle-income countries (LMICs). Therefore, the approach to assigning reduced insurance premiums (PBI) should be reassessed. It was found by the Finance and Development Supervisory Agency (BPKP) that there were instances of four million people being registered twice for the JKN health insurance program, and the system for PBI had errors including fraudulent claims and omitted qualified individuals. Although the regulations for PBI state it's for those who are 'unable to pay,' they don't provide specific income thresholds for eligibility. The government could consider using a detailed assessment of individual incomes rather than a general assessment of district wealth to determine who is 'unable to pay,' allowing for a more nuanced allocation of PBI that provides either partial or full premium assistance. This method of offering partial assistance to those in the informal sector has been effective in several Asian countries. The study suggests that willingness to pay can be influenced by adjusting to people's ability to pay (ATP), recommending that a tiered premium system be developed that aligns with ATP to improve payment rates among those with lower incomes.

3.3.2. Update JKN premiums based on sound actuarial analysis

To obtain a more precise evaluation of premiums that align with increasing coverage and usage trends, an in-depth actuarial analysis should be conducted using individual claims data. This analysis would account for factors like age, gender, geographical differences, membership categories, and the diversity of cases, instead of relying on basic forecasts based on historical growth patterns—for example, simply extending observed trends from the past three years. The current approach presumes that these factors remain unchanged, but this is an unrealistic assumption, particularly for a health system that is still developing.

For instance, claim rates within the informal sector are expected to decrease as the insurance pool expands to include healthier individuals, which would lower the average claim costs compared to those presently insured, who may be the ones with more severe health issues. Furthermore, the mix of health cases will likely shift as non-communicable diseases (NCDs) become more common, or as new methods for provider payment are implemented. By adjusting the assumptions to reflect these changes, more equitable premium rates can be established for different groups.

Following this actuarial assessment, there should be an open and clear discussion about the potential for cross-subsidization between different member groups, which is essential for setting fair and sustainable premium rates.

3.3.3. Facilitating payment collection

The primary reason informal sector workers stop making payments is due to difficulties in paying premiums and catching up on missed payments. This includes the methods available for payment, and how often and in what form payments are made. Other studies have shown that the ease and time it takes to make payments can affect the likelihood of informal workers settling their premiums. In addition, government studies have suggested revising the payment structure for informal workers to better suit their inconsistent earnings. According to the research, the impact on the likelihood of repaying overdue payments is particularly strong, especially when workers are expected to make large, lump-sum payments to restore their insurance coverage. While BPJS has implemented a door-to-door collection system known as Kader-JKN, evidence points out that collection efforts are most successful in countries where local governments face strong pressures to meet collection targets.

3.3.4. Incentivising premium upgrading

To encourage ongoing enrollment and motivate these workers to opt for higher coverage levels in tune with their ability to pay (ATP), there needs to be an incentive structure. However, the current JKN health insurance policy permits on-the-spot upgrades for hospital services, such as better rooms, which may discourage people from subscribing to more extensive insurance plans in the first place. A positive step toward addressing this issue has been the implementation of regulations that limit the extent of these upgrades to just one level up. Nonetheless, to properly evaluate and choose among various insurance options, there needs to be a collective understanding of the value of insurance, the financial safety it provides, and the concept of making advance payments for health benefits. This understanding should be fostered through more widespread promotion and education about the JKN system.

3.3.5. Strengthen the purchasing role of BPJS Kesehatan

It's crucial to specify the roles and responsibilities for determining the scope of healthcare services, deciding on contribution rates, establishing provider payment mechanisms, and overseeing the delivery and quality of services. While there's no universally applicable model for the distribution of these functions, global practices indicate that effective health service purchasing requires collaboration between the MoH and BPJS Kesehatan, as seen in global comparisons. This may involve redistributing or sharing essential purchasing roles to or with BPJS Healthcare. BPJS Healthcare has access to extensive data regarding the implementation of the JKN system, which is essential for informing policy decisions.

Internationally, most health insurance entities have autonomy over several operational facets, including setting tariffs, contracting, and determining provider payment structures, and they have some say in defining the benefits package. Nonetheless, tasks such as provider accreditation and quality assurance are typically handled by the MoH.

3.3.6. Reinforce performance-based financing

As the GoI aims to enhance accountability in healthcare, it is considering improvements to performance-based indicators at the primary care level and the implementation of additional metrics to evaluate the performance of DAK allocations. Since DAK funds and JKN payments are specifically for health services and are tied to outcomes, they represent substantial

portions of district health funding and have great potential for performance-based financing strategies.

From the perspective of service demand, the GoI could refine the existing KBK (Kinerja Berbasis Kompetensi or Competency-Based Performance) indicators to promote service delivery enhancements, especially in key national health priority areas like maternal health, nutrition, and tuberculosis (TB). By improving these indicators, the GoI can create incentives for increasing both the quantity and quality of healthcare services.

On the supply side, MOH in 2018 suggested integrating a performance-based component into the allocation of DAK resources to districts. This offers an excellent chance to better align supply-side investments with the actual healthcare service delivery capacity across districts. Utilising facility accreditation as a framework or tool could help district governments coordinate their planning and resource distribution more effectively. Incentivizing health facilities to meet accreditation standards could be achieved by making DAK transfers more contingent on needs and performance outcomes.

3.3.7. Socialisation of JKN

Research has indicated that enrollment in health insurance is influenced by an understanding of its benefits. The suggestions for refining the eligibility for reduced premiums, the cost of insurance, payment methodologies, and the structure of insurance offerings rely on informal workers being able to make knowledgeable decisions. Dror and Firth's review challenges the notion that informal workers make decisions based on individual cost-benefit analysis, proposing instead that decisions are influenced by community affiliations and the collective recognition that purchasing health insurance is beneficial and a sign of responsible adulthood.

3.3.8. Introduce an explicit benefit package commensurate with available resources

Efforts to modify the scope of the healthcare benefit package have faced considerable opposition due to the lack of a clear and open method for determining what should be included or excluded. This has made it politically challenging to reduce benefits, especially when media coverage and public opinion frequently overturn evidence-based recommendations from health technology assessments and cost-effectiveness studies. To navigate the complex political landscape of these decisions, it's crucial to leverage detailed data from JKN claims, budget impact analyses, and economic evaluations to provide policymakers with robust evidence to support their decisions. These resources exist but are not currently being utilised to shape policy.

3.3.9. Use JKN claims data to inform and improve service delivery and increase efficiency

Worldwide, hospitals in middle-income countries could achieve efficiency savings estimated to range from 5 to 11 percent of their total expenditure. When applied to the JKN hospital expenses, this translates into potential savings of approximately IDR 3.6 trillion to IDR 7.9 trillion within the hospital sector. BPJS Healthcare is currently performing basic claims reviews and verification, but a more thorough analysis of claims could uncover additional opportunities for enhancing service delivery and fund management. Specifically, analysis of JKN claims could help ensure compliance with care guidelines and protocols, which in turn could enhance service quality, such as by identifying and preventing adverse events,

unnecessary or ineffective treatments. Furthermore, claims data analysis could pinpoint items with high costs or usage frequency, offering insights to devise policies that address the issue of open-ended hospital payments. Policy development could be informed by simulations and budget impact assessments reflecting actual service use. Nevertheless, the current quality of data presents a significant obstacle to such analyses, highlighting an urgent need to improve medical reporting quality and the skills of clinical coders.

3.4. Collecting and analysing more data to more accurately determine the allocative and technical efficiency of health sector spending

Data is key to measuring and driving effective government performance. Broadly speaking, two types of data are needed to evaluate the quality of spending: (1) Fiscal data on government spending (inputs) classified according to type (economic classification), function, and policy purpose (program/activity); (2) Sector-specific data on outputs and outcomes, especially MOH and BPJS-Kesehatan claim data. Such data are necessary to measure the relationship between inputs and outputs (allocative and technical efficiency) and between outputs and outcomes (effectiveness). These data should be available at both the central and subnational levels, and sufficiently disaggregated to undertake meaningful analysis.

3.4.1. MOH Data

To enhance the assessment of allocative and technical efficiency in health sector spending, comprehensive information collection is essential. This includes the creation of a master facility list that provides a detailed overview of all healthcare facilities, categorised by type, ownership, and accreditation status, complete with unique facility identifiers. Equally important is the compilation of a master human resources list, which records all healthcare providers along with their qualifications, positions, and salary scales. In addition, maintaining an up-to-date pharmaceutical and medical supply inventory is crucial; this inventory should detail the number and distribution of drugs and equipment, their expiration dates, and costs, each item tagged with unique identifiers.

Financial transparency is also a critical component, requiring the collection of both budgeted and realised health spending data. This financial data should be dissected by level of government—central, provincial, and district—and by facility type, such as hospitals and primary healthcare providers. It should further be broken down into economic classifications, including salaries, infrastructure investments, and goods and services. To monitor and improve health service delivery, prioritised process, output, and outcome indicators at national and district levels must be established. These indicators can include metrics such as healthcare provider density, bed occupancy rates, the average length of hospital stays, staff turnover rates, budget execution rates, and the number of training events. Furthermore, specific indicators like bed density and vaccination rates provide insights into the effectiveness of healthcare delivery and can highlight areas in need of improvement.

Finally, to gain a deeper understanding of the efficiency within pharmaceutical and hospital spending, it's advisable to analyse common indicators such as maternal mortality rates, the proportion of hospital deliveries via caesarean section, tuberculosis notification and treatment success rates, and overall disease prevalence. These indicators should align with national strategic health priorities, providing a framework for a targeted approach to health system strengthening. By focusing on these detailed and multifaceted aspects of health sector

spending, stakeholders can ensure that resources are utilised effectively to meet the health needs of the population.

3.4.2. BPJS-Kesehatan Claim Data

At the aggregate level, BPJS Healthcare is encouraged to share with the Ministry of Health comprehensive statistics on the implementation of their health programs to inform general management and oversight, facilitate disease surveillance, and optimise the allocation of resources. This should include membership data, categorised by region, province, and district, as well as by membership type, such as for the poor, near-poor, civil servants, private sector, informal sector, non-workers, and beneficiaries of district government. Additionally, this data ought to be cross-referenced by type of membership and geographical location on a monthly and yearly basis to track changes and trends.

Expenditure data should also be collected and categorised overall by facility type and by the nature of the visit, such as inpatient or outpatient services. This data should further be segmented by ownership type, whether public or private, and cross-referenced by region, province, and district, as well as by type of visit and facility ownership, again on a monthly and yearly basis. Furthermore, the utilisation data should be collected in a similar, detailed manner, including the type of facility, type of visit, and ownership, broken down by membership group and primary diagnosis, allowing for a per capita analysis that is as granular as daily figures and as broad as monthly and yearly statistics.

For a more specific analysis, the 'Top 10 primary diagnosis' data should be gathered overall and by each administrative division, to pinpoint the most common health concerns faced by the population on a daily, monthly, and yearly basis.

At the individual claim level, for a more focused inquiry, BPJS Healthcare could examine purposive samples to identify inefficiencies in service delivery. This involves member-centric analysis that reviews all the claims for a single member, ensuring that the progression of diagnoses and services rendered makes sense and adheres to the appropriate level of care. This would entail linking different databases and including tracking of prescribed medications

Provider-centric analysis involves scrutinising all the claims associated with a particular physician or hospital to determine if the patterns of disease and services match the known trends for the area, thus identifying any outliers for further investigation. Network analysis looks at claims data across providers to validate whether the shared diagnoses and services are consistent and logical

Lastly, integrating claims data with other databases could answer further policy questions and help in ensuring compliance with health guidelines and protocols. This could also assist in safeguarding against fraudulent claims, improving disease surveillance, and verifying compliance factors like tax collection, membership premium payments, class verification, and in conducting actuarial analyses. Such integrations would support a more robust health system that is both efficient and effective in meeting the healthcare needs of the population.

3.5. Learning and adapting by initiating pilot programs before implementing them on a national scale

Cost control measures, such as global budgets for hospitals, are currently being piloted. cost-sharing for non-essential services, services prone to utilisation, and/or to incentivise more cost-effective referral pathways are now also in the design phase. BPJS-K has many pilots underway, and it is necessary to rationalise which fits an overall strategic vision and pick with broad stakeholder guidance those results that can inform the development of future reforms in expenditure management and maximising health outcomes. The Ministry of Health and DJSN should prioritise the provision of flexible funding to BPJS-K to design, implement, and evaluate its pilots. These pilots suggest there is potential for BPJS-K to drive a culture of innovation and continuous improvement that will underpin the efficient and effective delivery of health services and thus promote the eventual financial sustainability of JKN.

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Annex 1. Proposed reform activities, targets, and indicators

Goals		Targets		Indicators	
1	The optimization and effective allocation of public spending for maximum societal benefit and fiscal responsibility	1.1	Public Sector Financing for Health Increased	1.1.1	GDP growth rates ranging from an average of 6.1-6.5% per year from 2024-2035
				1.1.2	Total expenditure on health as 9% of gross domestic product by the year of 2045 to match the OECD average.
				1.1.3	Increased domestic general government expenditure on health as a percentage of total health expenditure by 10% each year compared to the previous year's position
				1.1.4	Increase per capita expenditure on health by $58 per person by 2030
		1.2	Increased Allocation of Public Financing for Public Health	1.2.1	NHA for 2030 shows public health, prevention, and primary care relative allocations of total health expenditure increased by 50% over 2022 allocations.
				1.2.2	Allocation share for primary health care under BPJS increased by 50% over 2022 allocations.
				1.2.3	NHAs for 2030 show pharmaceutical spending reduced to 20% or less of total health spending
		1.3	Updated premiums rate for the poor, near poor and informal sector	1.3.1	A model is built and updated each year to look at the ability to pay and willingness to pay for the poor, and near-poor starting in 2025, disaggregated by age, gender, household size, household income, and district wealth.
				1.3.2	A model is built and updated each year to look at the ability to pay and willingness to pay for informal sectors starting in 2025, disaggregated by age, gender, household size, household income, district wealth, and other informality-related indicators.
		1.4	Increased private sector involvement	1.4.1	Every year starting in 2024, the realized value of investments mobilized by the private sector for public health infrastructure in regions with a supply-side readiness index below the national average meet the target set by the Minister of Investment/Head of the Investment Coordinating Board (BKPM)
				1.4.2	Increase the supply-side readiness and quality index for private healthcare facilities by 10% compared to the baseline of the previous year
2	The transformation of overall expenditure patterns into a more	2.1	Expenditures more pro-poor	2.1.1	Distribution of health care utilization and spending as measured by Biennial Benefit-Incidence Analysis is pro-poor

Goals		Targets		Indicators	
	equitable and pro-poor distribution, ensuring fairness in resource allocation and enhanced well-being for marginalized populations.	2.2	Expenditures more equitable across geographic areas	2.2.1	Distribution of health care utilization and spending as measured by Biennial Benefit-Incidence Analysis shows reduction in geographic inequity
3	The strategic identification and mobilization of new revenue sources for bolstered health financing, ensuring sustainable and inclusive access to quality healthcare services	3.1	Achieved 'go big, go fast' excise tax strategy	3.3.1	Excise Tax on Tobacco is set on the good equal to its external marginal cost
				3.3.2	Excise Tax on SSBs fat is implemented in 2025 on the good equal to its external marginal cost
				3.3.3	Excise Tax on foods in in sugar, sodium and fat is implemented in 2030 on the good equal to its external marginal cost
		3.2	Earmarked new funds for the health sector	3.2.1	VAT exemptions for health service outside JKN's network gradually removed starting in 2025
				3.2.2	Annually, additional GDP coming from VAT exemptions for medical services and energy subsidy reforms is earmarked for extending JKN membership to the informal sector.
				3.2.3	Annually, MOF to issue social impact bond that aim to reduce hospital readmission rates for chronic illnesses by 15% from the baseline year
		3.4	Improved Private Supplemental Health Insurance Market	3.4.1	Establish implementing regulations that govern co-payments for the wealthy who wish to access services beyond Basic Health Needs and Standard Inpatient Care classes by 2025
				3.4.2	In 2025, the regulation for the Coordination of Benefits Scheme to be updated to exclusively encompass hospitals within the JKN Network
		3.5	Increased progressivity in payment of premiums under BPJS	3.5.1	Amend the presidential regulation to increase payroll tax cap for civil servants in 2025
				3.5.2	Amend the presidential regulation to increase payroll tax cap for everyone in 2029
		3.6	Enhanced donor practices	3.6.1	Amount of direct budget support funds secured under multi-year commitments relative to annual commitments.
				3.6.2	Percentage of direct budget support tracked in real-time through development assistance databases, and frequency of database updates
				3.6.3	The existence and functionality of a transparent financial reporting system, assessed by the timeliness and accuracy of financial reports

Goals		Targets		Indicators	
				3.6.4	Proportion of aid that is managed by use of national procedures
				3.6.5	Percentage of donor funds harmonized
				3.6.6	Frequency of scheduled meetings and communications between donor and recipient to review funding flows and program progress
5	The establishment and strengthening of measures for increased financial protection against catastrophic spending	4.1	Catastrophic expenditures for families reduced	4.1.1	Reduced OOP spending overall as share of total health expenditures (THE) by 10% compare to previous year baseline
				4.1.2	CCTs and demand-side vouchers available for the poor and rural populations to cover time and transportation costs
				4.1.3	Increase Capitation Payment to PHC providers and facilities for each enrolled poor person
		4.2	DAK shifted to be more pro poor	4.2.1	DAK funds shifted to subsidies for premiums for the uninsured – starting with informal pilots
				4.2.2	DAK funds shifted for demand side subsidies for the poor
5	More effective BPJS Kesehatan governance system	5.1	The issuance of road maps	5.1.1	Road Map for BPJS governance issued in 2025
				5.1.2	Road Map for improved internal operations in actuarial forecasting, MIS, quality, payment systems issued in 2025
6	Coverage and pooling mechanism redesigned	6.1	Pooling extended	6.1.1	100% Coverage Under BPJS in 2025
				6.1.2	70% of all public funding pooled under BPJS
		6.2	Pooling of other Supply Side Subsidies under BPJS budgets and payment mechanisms established	6.2.1	Pooling of funds under Vertical Programs such as HIV, TB, Malaria
		6.3	Administrative Budget Adequate relative to overall claims expenditures	6.3.1	Maintain claim ratio below 90% annually
		6.4	Establishment of Research and Evaluation Program as part of BPJS	6.4.1	Annual Evaluation of BPJS performance and report to Parliament
				6.4.2	Establishment of pilots program for global budget at district level
				6.4.2	Establishment of pilots program for informal sector coverage
7	Strategic purchasing mechanism re-governed	7.1	JKN Innovation Pathways set up	7.1.1	Road Map for Technology Assessment
				7.1.2	Benefit Package updated through Health Technology Assessment Process

Goals		Targets		Indicators	
		7.2	Transition to explicit benefit package	7.2.1	10 new PNPK issued each year for high cost and high volume diagnosis
				7.2.2	MOH to issue decision support tools covering the continuum of promotive, preventive and case management procedures with a clear division of authority among healthcare workers in 2024
		7.3	Information Management systems revamped	7.3.1	Tracer indicators inserted in claim management system and all claims made available for monitoring and evaluation by 2026
				7.3.2	Information Management systems for the JKN providers network are standardized and interconnected between the PHC network and hospitals to facilitate care coordination in 2029
		7.4	Contracting at all levels of care strengthened	7.4.1	BPJS Kesehatan contracts with each PHC provider or facility directly by 2024
				7.4.2	BPJS Kesehatan contracts for all employees in public facilities by 2024
				7.4.3	Increase private clinics and hospital contracts with BPJS as 100% share of private market by 2029
		7.5	Costing Template revised	7.5.1	Standardized costing templates instituted in every contracted hospital under BPJS by 2025
				7.5.2	10% sample of hospitals routinely audited annually
		7.6	Payment for PHC redesigned	7.6.1	Capitation payment refined (Risk-adjusted) by 2025
				7.6.2	Capitation monitoring and evaluation systems established in 2025
				7.6.3	Ministry of Health regulation issued in 2025 to allow for greater autonomy and improved risk management for PHC under capitation system
				7.6.4	Monitoring and evaluation system developed for payment incentives in 2028 to analyse PHC provider's behaviour
		7.7	INA CBGs refined	7.7.1	Hospital payment system uses new grouper software based on Indonesia clinical and cost patterns in 2028
				7.72	Monitoring and evaluation system developed for payment incentives in 2028 to analyse hospital provider's behaviour
		7.8	Coding system refined	7.8.1	Coding accreditation and adequate numbers of trained coders by 2029
				7.8.2	All ICD codes are utilized by 2029
				7.8.3	Coding Standards and Coding Practice improved as measured by claim analysis

Goals		Targets		Indicators	
		7.9	Quality Assurance programs established	7.9.1	Pay for performance programs for PHC and for hospital programs redesigned and issued in 2029
8	**Public Management of Funds**	8.1	Increased credibility of the health budget	8.1.1	Aggregate expenditure out-turn compared to original approved budget
				8.1.2	Composition of expenditure out-turn compared to original approved budget
				8.1.3	Aggregate revenue out-turn compared to original approved budget
		8.2	Increased comprehensiveness and transparency	8.2.1	Improved classification of the budget as measured by high compliance, low variance, and accuracy
				8.2.2	Improved comprehensiveness of information included in budget documentation
				8.2.3	Extent of unreported government operations
				8.2.4	Public access to key fiscal information
		8.3	Predictability and control in Budget Execution	8.3.1	Transparency of taxpayer obligations and liabilities
				8.3.1	Effectiveness of measures for taxpayer registration and tax assessment
				8.3.1	Effectiveness in collection of tax payments
		8.4	Improvement in accounting, recording and reporting	8.4.1	Timeliness and regularity of accounts reconciliation
				8.4.2	Availability of information on resources received by service delivery units
				8.4.3	Quality and timeliness of in-year budget reports
				8.4.4	Quality and timeliness of annual financial statements
9	Local managers of funds trained	9.1	Training session on financial management, budgeting and fund allocation techniques implemented	9.1.1	20% improvement in pre- and post-training assessment
				9.1.2	15% percentage reduction in budget variances
				9.1.3	95% of reports submitted on time
10	Fraud Detection and corruption mechanism	10.1	Robust fraud detection and corruption prevention	10.1.1	Tracer indicators inserted in claim management system and all claims made available for monitoring and evaluation by 2026

Goals		Targets		Indicators	
			mechanisms implemented	10.1.2	Confidential whistle-blower hotline where employees, stakeholders, and the public can report suspected fraud or corruption anonymously established in 2025
				10.1.3	Data analytics and artificial intelligence (AI) tools utilized to identify unusual financial transactions and patterns that may indicate fraudulent activities by 2028