IMPROVING THE QUALITY OF INDONESIA’S HEALTH SPENDING IN THE CONTEXT OF THE HEALTH FINANCING TRANSITION

HEALTH SECTOR PUBLIC EXPENDITURE REVIEW

Hotel Borobudur, Jakarta
December 18, 2017
PRESENTATION OUTLINE

Overview of Indonesia’s Health Financing

Health Expenditure at the Central Level

Health Expenditure at the Sub-National Level

Key Findings and Recommendations
Indonesia has struggled to manage the “Health Financing Transition” and build a sustainable health care financing system for UHC despite strong growth in THE

• In nearly all countries growth in income is accompanied by a growth in Total Health Expenditure (THE) – particularly through pre-paid or pooled mechanisms – and a decrease in out-of-pocket (OOP) spending as a share of THE. At the same time, access to external financing falls as eligibility criteria is frequently tied to income thresholds. These two trends are sometimes referred to as “the health financing transition”.

• But countries often struggle to smoothly manage this transition and build sustainable health care financing systems that provide universal health coverage (UHC).

• In Indonesia, despite strong growth in THE, OOP spending remains high as a source of THE.

Source: World Bank. World Development Indicators; Note: using constant LCU

Source: NHA, 2014; Note: Social health insurance only accounts for PBI-JKN (subsidized health premium)
While national public health spending has increased in recent years, it remains low relative to comparator countries

- Increases in public health spending were mainly driven by increases in district level spending and the introduction of subsidized health insurance (PBI).
- However, national spending averages hides wide variations in district level health spending.

Sources: NHA, 2014 (The NHA’s definition of public health expenditure is slightly different to that of MoF. It is used here so that it can be compared to other categories of health spending and health spending in other countries.) and World Bank World Development Indicators.
This underinvestment in health can limit the depth of coverage and also undermine service delivery

- Despite overall improvements in facility readiness to provide essential health services since 2011, gaps remain.
- Notable improvements in service availability and service readiness

**Puskesmas General Supply Side Readiness, 2011 and 2016**

% of Puskesmas with basic elements of service

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Source: Rifaskes 2011; Indonesia QSDS, 2016; Note: Quantitative Service Delivery Survey (QSDS) 2016 - covering more than 900 Puskesmas (National representative sample of 268 Puskesmas in 22 districts), service network (Polindes, Posyandu), and private health providers
While overall service readiness has improved demand has not been fully met

- Epidemiological changes also affects the demand for basic health services changes
- JKN provides a generous benefit package with no caps or copayments on services received leading to implicit rationing of services
- Improvement in facility readiness in testing and diagnostic inputs for infectious and non-communicable disease alike
- Insufficiency in program guidelines and personnel training hinder the effective coverage and treatment of priority programs

Only 32% of TB cases are detected (an estimated 690,000 missing cases each year) contributing to the continued high prevalence of TB (1.6 million cases in 2016) – the 2nd largest contributor to the global TB burden.

Similarly, an additional 3 million tests a year would need to be conducted to meet the MOH’s scale-up targets as only 13% of people living with HIV were on antiretroviral therapy in 2015.
International benchmarking also suggests that Indonesia can improve health outcomes by improving the quality of its health spending.

Data envelopment analysis reveals that for the same level of health spending, Indonesia underperforms on healthy life expectancy at birth compared to countries such as Sri Lanka and Vietnam.

Source: World Bank World Development Indicators
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4. Key Findings and Recommendations
As the responsibility of service delivery is decentralized to the subnational level, the central government manages only 35% of total public health spending.

- Sub-national governments (provinces and districts) deliver 65% of public health spending, and thus play a dominant role in achieving national health outcomes.
- Still, within the central government, 93% of health spending is managed by the Ministry of Health (MOH).

Composition of public health spending by level of government (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>Central</th>
<th>Provinces</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001-04</td>
<td>45</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>2005-09</td>
<td>18</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>2010-14</td>
<td>38</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>2015-16</td>
<td>35</td>
<td>15</td>
<td>50</td>
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Composition of CG health expenditure by line ministries (percent of total health, average 2015-17)

- Ministry of Health: 92.6%
- BPOM: 2.4%
- BKKBN: 5.0%

Note:
- 2011-16 data are actual, 2017 data is budget.
- The subsidized health premium for the poor for national health security (PBI-JKN) started in 2014, previously it was called JAMKESMAS/PERSAL.
- Total CG health expenditure refers to total CG spending on health function comprising 3 line ministries/agencies i.e., Ministry of Health (MoH), Drugs & Food Supervision Agency (BPOM); Population and Family Planning Agency (BKKBN).
MOH Discretionary Spending is limited with increasing PBI-JKN and BLU make up a larger share of MOH spending

- With the introduction and gradual expansion of JKN, PBI subsidies make up an increasingly larger share of the MOH budget, and the MOH merely acts as pass-thru releasing money to BPJS to pay providers.
- BLU funding, accounts for 18%, is also earmarked as recurrent spending for 53 centrally managed hospitals and health centers.
- As a result, MOH discretionary spending (non-PBI & non-BLU) accounts for only 38% of total MOH expenditure.

Note:
- 2011-16 data are actual; 2017 data is Budget.
- MoH currently manages 53 BLUs, comprising 40 hospitals and 13 health centers (balai kesehatan).
As a large share of MOH spending is earmarked for PBI/BLU, the composition of spending is geared towards curative care rather than promotion and prevention.

- PBI-JKN and the BLU component of Health Service programs predominantly fund curative interventions in hospital settings.
- As a result, there is less scope for the MOH to fund key public health promotion and prevention activities.

Note: 2011-16 data are actual; 2017 data are Budget.
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- Key Findings and Recommendations
65% of public health spending happens at the district level with facilities receiving revenue from several sources of financing.

- Revenue at the district level is strongly dependent on MOF transfers.
- But they are mostly unconditional and not-earmarked for health (with the exception of health DAK).
- As a result, allocation to health is at the discretion of local governments.
- The share of MOH sector specific financing (e.g., Dekon) that gets sent to district health offices is small.
Even though district health spending has increased between 2001-2013 to reach 10% of total district spending, national averages hide wide variations in spending.

- 8/20 districts sampled spend <10% of their government budget on health despite the legal mandate. And health spending as share of district spending varied between 3-27%.

Health spending by district (per capita and as share of government expenditure), 2016

Sources: World Bank COFIS database using MOF data and QSDS (2016); Note: data is based on a nationally representative sample of 22 districts
Integration of Financing – Central and Sub National

- Although vary across sampled districts, in general there is an increasing trend in sub national financing for programs;
- The increase of sub national government funding may be driven by increased of interfiscal transfers or local commitment;
- In some of the sampled sites, a significant amount of local funds were spent on program drugs which were the responsibility of the Central government;
- Information on central funds often missed local planning cycle, and lack of details on activities financed.

Source: CHEPS-UI & WB, PET 2017
Shifts in health financing at the sub national level

- Revenue from BPJS has become the largest source of revenue for district health offices, mostly from *puskesmas* in the form of capitation payments.
- Up to 40% of capitation revenue is designated for operational expenditures with the remainder going towards bonuses and financial incentives for health workers.
- However, capitation payments are regulated by 11 regulations and there is confusion between local governments, providers, and BPJS on what operational expenditures are covered under JKN capitation (individual health care) and what is covered under the government budget (public health functions) especially where individual treatment also serves a public health function (e.g. screening and outreach for TB).
- In 2015, 54% of *puskesmas*’ spending was on staff incentives and only 13% on medicines, consumables, and equipment.
- Over 85% of the *puskesmas* were unable to utilise all the funds received through capitation.

![Diagram showing sources of district revenue as percentage of total revenue, 2013 – 2015](chart.png)

- **Revenue from BPJS** has become the largest source of revenue for district health offices, mostly from *puskesmas* in the form of capitation payments.
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*Source: QSDS (2016)*

*Note: data is based on a nationally representative sample of 22 districts*
Weak accountability and a lack of checks and balances in the way JKN is implemented undermines services delivery where supply side readiness is ill equipped to meet demand and threatens the financial sustainability of JKN.

- Earmarked transfers for health (DAK, PBI) make up the largest share of district revenue, but neither are linked to performance.

- On the supply side, DAK transfers (in green) – used to purchase infrastructure, medical equipment, and drugs – does not appear to be correlated with the level of supply side readiness (in orange) which measures whether health facilities are able to provide basic health services. This may mean result in lower capacity puskesmas’ referring patients to the hospital sector for services that would be more cost-effective to treat at the primary health care level.

- On the demand side, in a weakly monitored environment, puskesmas’ close-ended operating budget may also incentivize them to underprovide services and refer patients to hospitals.

- As a result, BPJS ends up double-paying for some services, first through the capitation payment and second through the referral. Here too, limited monitoring of hospital claims may incentivize hospitals to ‘up-code’ to INA-CBG tariffs that have higher payment rates and discharge patients early for later readmission as hospital reimbursements are essentially open-ended – with no caps on their spending.

Source: Indonesia QSDS, 2016
DAK=average share 2013-2015

Districts

DAK vs General Supply Side Readiness Index
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Key Findings and Recommendations
## Key Findings and Recommendations (1/3)

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<th>Key Recommendations</th>
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| 1a. Overall allocation and adequacy of health spending                       | Increase total public health spending (at the central and sub-national level) to 2.3% of GDP by 2020; Increase fiscal space with earmarked revenues (e.g. tobacco taxes), improved efficiency, and reprioritization to fund:  
  • Supply-side readiness, especially: Primary health care; MOH's Healthy Indonesia through the Family Approach program; Maternal health; Vaccinations; Disease control; Community-based interventions in nutrition  
  • JKN-PBI: Obtain 100% coverage of bottom 40% and increase in CMPM |
| Indonesia’s public spending for health is among the lowest in the world (1.4% GDP in 2016). |  
| 1b. Intra-health-sector Central (35%) & SNG Government expenditure (65% of the total health budget) | Ensure coordination and consistency in planning, budgeting, and implementation with sub-national governments to achieve overall health outcomes |
| CG delivers only 1/3 of public health spending                               | Improve the efficiency and effectiveness of BLUs spending as part of sector spending reform.  
  • Identify sources of inefficiencies in BLU spending (personnel and material are the largest spending categories)  
  • Assess the implementation of the Key Performance Indicators (on financial and medical management) and the linkage with the remuneration policy (see notes for more detail)  
  • Strengthen linkages between BPJS payment and APBN transfers with BLU Key Performance Indicators measurements (Strategic Purchasing) |
| Spending by BLUs (central hospitals and health centers) accounts for 18 percent of CG spending. | |
Key findings and recommendations (2/3)

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<td><strong>1b. Intra-health-sector Central (35%) &amp; SNG Government expenditure (65% of the total health budget)</strong></td>
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<td>• Spending continues to focus on curative rather than promotive &amp; preventive</td>
<td><strong>Strengthen readiness and quality of primary health care</strong> – linking DAK with performance indicators related to improved primary care facilities such as accreditation, fulfillment of basic inputs to national priority programs.</td>
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<td>• Fragmentation of financing especially at SNG and (public) health facilities</td>
<td><strong>Incentivize and enforce Local Governments (LG) in achieving Health Minimum Service Standards (Standar Pelayanan Minimal)</strong> using existing financial transfer mechanisms. The SPM indicators are emphasizing on preventive and promotive, and they are also in line with the MOH strategy ‘Healthy Indonesia through family approach’.</td>
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<td>• Duplication leads to wasteful spending</td>
<td><strong>Strengthen links of JKN payment to primary care facilities with performance related to improved public health</strong>; The indicators used for payment for performance are linked priority health programs for instance TB case management (case finding, treatment, and success of treatment);</td>
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<td><strong>Encourage engagement with CSOs</strong> in delivering some of the services (outreach, patient follow up, IEC) that are proven to be cost effective by clarifying the existing fund channeling mechanisms (BanTah, Swakelola) esp at SNG;</td>
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<td><strong>Improve tracking of health expenditure</strong> – assess and develop better PFM mechanism that enables tracing public spending from various sources and links with results;</td>
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**World Bank Group**

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## Key Findings and Recommendations (3/3)

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| **2a. Service delivery at the facility level: Health facility service availability (1/2)** | **Strengthen the health facility accreditation process.** Accreditation certifies that a health facility meets the Government’s regulatory requirements and standards to ensure quality of services.  
  • Improve the implementation of the existing accreditation programs for FKTP (primary health care) and FKTL (hospitals/referral services).  
  • Use existing financial mechanism as levers to improve supply side readiness: DAK transfers and JKN payment to incentivize health facilities to achieve accreditation and implement Continuous Quality Improvement (CQI). Accreditation status may offer a tool to better coordinate supply side planning and resources allocation (e.g. DAK) by making transfers more performance-oriented. Upon accreditation, districts/facilities would receive:  
    • a one-time performance bonus, paid as part of DAK (paid to the district and then shared with the health facility)  
    • higher payments through JKN (differential between public and private sector). |

- **There is a disconnect between health expenditure and the level of supply side readiness at public health facilities**  
  • The availability and readiness of health services is improving, but gaps remain and regional disparity persists  
  • Lack of supply-side readiness means that the share of out of pocket expenditure has remained high

- **Strengthen Governance and Accountability**  
  • Develop Performance Dashboard including a health facility performance report card and supporting tools; introduce the health facility performance report card to provincial and district health offices
  • **Improve Health Management Information System** that can produce timely and useful information for budget and planning, provider performance monitoring, and overall benchmarking will be an essential building block; Streamlining existing HMIS will improve efficiency as well
  • **Build local government capacity for planning, budgeting, budget execution, financial management and reporting, especially for districts with low performance.**
TERIMA KASIH
Annex

• STRATEGIC HEALTH PURCHASING FOR UHC BASED ON INTERNATIONAL EXPERIENCE
Many countries face similar challenges as they strive towards UHC and global evidence suggests that strategic purchasing offers a holistic framework to addressing the underinvestment in health, JKN sustainability, and UHC

- Many countries face similar challenges as they strive towards UHC often having to choose between increasing revenues, limiting coverage (either through limited benefit packages or cost-sharing arrangements), and/or improving efficiency in the use of funds.

- But global evidence has shown increasing revenue is limited by the fiscal capacity of the government – a relevant constraint in Indonesia.

- And in countries where the benefit levels remain relatively shallow (e.g. Cambodia, Laos, Myanmar) or where breadth of coverage is prioritized over depth of services (as in Indonesia, Vietnam, Philippines), access and financial protection has been limited.

- This highlights the importance of improving the quality of health care spending, often prompting a transition from passive towards more strategic purchasing.

- Strategic purchasing involves making decisions on which services to provide, who is best placed to provide them (public vs private sector) and at what level of care (primary vs secondary or tertiary care), and how should they be purchased to ensure the right quantity and quality of services.
Defining an explicit benefit package, essential drugs list, and target population that is commensurate with all available resources – on both the demand and supply side – through a systematic and transparent process for prioritizing interventions.

Commonly used criteria for prioritizing activities and interventions under a benefit package include burden of disease, equity, cost-effectiveness (based on an economic evaluation or health technology assessment), budget impact, and the public health nature of interventions that have either positive or negative externalities (e.g. immunizations, infectious disease control).

This will require improvements in health management and information systems (HMIS) that are currently fragmented and of low compliance to be able to provide useful data to inform policy formulation.

There are often trade offs that must be weighed between high impact cost-effective services and those that impose the greatest financial burden on patients. And population targeting may be one way to ensure that limited resources are matched to populations that would benefit the most.

Globally, health promotion and prevention, immunization and vaccinations, infectious disease control, and essential primary health care services are usually provided freely by the government.
• Selecting providers from whom to buy will typically involve some form of contracting between purchasers of health care (e.g. local governments, BPJS) and providers (e.g. public and empaneled private facilities) to clarify each party’s obligations.

• Private providers play a significant role in service delivery in Indonesia and increased private sector engagement should be contingent on stronger mechanisms to ensure a minimum standards.

• In 2015, the MOH adopted the accreditation of public and private facilities as a regulatory mechanism for improving facility performance and ensuring continuous quality improvement.

• Once up and running, the GOI could share information on accreditation status and facility performance through the use of performance score cards to enable patients to make more informed decisions on where to seek quality care. The use of score cards has also been shown to help reinforce providers’ intrinsic motivation to quality care.

• In addition, accreditation status may offer a tool to better coordinate supply side planning and resources allocation (e.g. DAK) by making transfers more performance-oriented.

• At the same time, it would be important to strengthen government capacity to identify the incentives that encourage engagement with non-state providers, especially as local governments are often unaware of available mechanisms that would allow contracting with non-state providers.
How services should be purchased typically will require setting the terms of the contract, selecting provider payment methods, setting provider payment rates, and monitoring provider performance to find the right mix of incentives that influence the quantity and quality of services.

On the demand side, the current allocation of purchasing functions under JKN will necessitate greater collaboration between MOH and BPJS as currently BPJS has the responsibility to manage the JKN deficit but limited levers to influence service delivery patterns that drive expenditure growth.

Although the original 2004 social security law allocated most of the key purchasing functions (provider payment methods, tariff-setting, and quality monitoring) to BPJS, a series of regulations brought these functions back largely under the control of the Ministry of Health.

The main lever BPJS currently has to reduce unnecessary hospital costs is to strengthen the power of capitation to shift utilization from hospitals back to puskesmas. There are several ways BPJS can strengthen the power of capitation, but dialogue and collaboration will be needed with MOH, MOF, and local governments

- Improve the KBK scheme by selecting performance-oriented indicators that focus on puskesmas performance and avoidable hospital admissions making them more effective gatekeepers to higher level care
- Ensure puskesmas have the capacity to provide all basic PHC services so that BPJS does not ‘double-pay’ for services through capitation and again when referred
- Reduce the regulatory constraints on how puskesmas can utilize capitation to improve absorption of capitation funds

Here too, HMIS that can produce timely and useful information for budget and planning, provider performance monitoring, and overall benchmarking will be an essential building block. Claims data through Pcare and Eklaim offer promising sources of data however initial steps may be needed to improve coding practices, reporting requirements, data quality, and validation.

Looking at health financing of primary health care more holistically (both demand and supply side sources of financing to puskesmas), globally, facilities that can pool all resources and have greater autonomy in the use of funds have better outcomes and it would be important to assess the performance of BLUD vs non-BLUD facilities.
Foundational elements to strengthen strategic purchasing

**Who does what?**
- Clarity on roles and responsibilities
  - Benefit package selection
  - Supply side planning
  - Purchasing
  - Provider payment rate-setting
  - Service delivery and quality standards
  - Monitoring provider performance

**How is it done?**
- Public budget system that can link inputs to outcomes
- Provider payment system that rewards performance
- Health management and information system
- Monitoring and evaluation system

**What skills are needed?**
- Revenue projections
- Budget and planning
- Resource management
- Contracting ability