Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS)

Reform Agenda (English version)

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Abbreviations

ADINKES	Association of Heads of Department of Health
AQC	Aid Quality Check
AIPHSS	Australian Indonesia Partnership for Health Systems Strengthening
Bappenas	National Planning Agency
BPJS	Badan Penyelenggara Jaminan Sosial; Social Insurance Administrative Agency
BUKD	Unit for Basic Health Services
CBG	Case-Based Groups
CEL	Context, Evidence, Links
CPMU	Central Program Management Unit
DAC	Development Assistance Committee
DFAT	Australian Department of Foreign Affairs and Trade
DHA	District Health Account
DHO	District Health Offices
EA	Evaluability Assessment
Flotim	Flores Timor
GIS	Geographic Information Systems
GoA	Government of Australia
GoI	Government of Indonesia
HPN	Health Policy Network
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HSR	Health Sector Review
HSS	Health System Strengthening
INA – CBG	Indonesia Case Based Groups
IPR	Independent Progress Report
ISP	Implementing Service Provider
JKN	Jaminan Kesehatan Nasional; National Health Insurance Scheme
M&E	Monitoring and Evaluation

MDG	Millennium Development Goals
MoHA	Ministry of Home Affairs
MoH	Ministry of Health
NHA	National Health Accounts
NTT	East Nusa Tenggara
PERMATA	Primary Health Care Strengthening and Maternal and Newborn Health Program
PHA	Provincial Health Account
PHO	Provincial Health Office
PMU	Program Management Unit (generally refers to PMU staff at province and district level)
PPJK	Pusat Pembiyaan dan Jaminan Kesehatan; Centre for Health Financing and Health Insurance
PPSDM	Centre for Human Resource Development
PSC	Program Steering Committee
PTS	Program Technical Specialist
Roren	Ministry of Health, Bureau of Planning and Budgeting
SBD	Sumba Barat Daya
ToR	Terms of Reference
TTU	Timor Tengah Utara
TWG	Technical Working Group
UKM	Public health services
UKP	Individual health services
WHO	World Health Organization

Background

1. Challenges in health development are increasingly complex and characterised by demographic transition, changes in disease patterns, an “unfinished agenda” in achieving health development targets, dynamic multi-dimensional determinants of health problems, disparities in health status, rapid changes in global and regional environments and a health system which is not ready to face these challenges.

2. The Australia Indonesia Partnership for Health Systems Strengthening (AIPHSS) is a program to strengthen the health system focusing on three health system functions, namely (1) human resources for health, (2) health financing and (3) health care delivery systems, especially within primary health care/Puskesmas. In the implementation of AIPHSS, strengthening of the three functions cannot be separated from the changes in laws and regulations on decentralisation being carried out by the government (Law (UU)-32, Government Regulation (PP)-38, PP-41 and Health Minister Regulation (Permenkes)-741 on Minimum Service Standards (MSS)). Therefore, during 2013–2014, changes in laws and health governance became a focus of AIPHSS, including the strengthening of health offices and Puskesmas.

3. Some of the fundamental developments and changes that occurred during the implementation of AIPHSS (2012–2014) are:

    a. Formulation of the national medium term development plan (RPJMN) 2015–2019 by Bappenas which uses the results of Health Sector Review (HSR) supported by AIPHSS. The HSR analysed nine areas which describe the challenges faced as well as recommendations for health planning in the years to come. Some of the identified challenges include increasing non-communicable diseases, high prevalence of stunting among children under five, high and stagnant TFR followed by high maternal mortality, problems of access to and quality of health services, limited fiscal capacity of the government, problems in Jaminan Kesehatan Nasional (JKN) implementation, disparities in health status between regions, etc.

    b. The Ministry of Health (MoH) formulating the Health Strategic Plan 2015–2019

    c. Amendments of Law (UU)-32, Government Regulation (PP)-38, PP-41 and formulation of new MSS (revision of health minister decree/ KMK-741)

    d. The implementation of the national social security system in the health sector started 1 January 2014 with the target to achieve the universal health coverage (UHC) in 2019.

4. The AIPHSS work plans (2013–2013) proposed by the central and regional levels have not been responsive enough to face the challenges and weaknesses of the health system as stated in the HSR.

5. At the beginning of 2014, an independent progress review team reviewed the concepts, activities and management of AIPHSS. The results of the review were discussed by Department of Foreign Affairs and Trade (DFAT) and Ministry of Health (MoH), which then resulted in the following agreements:

    1. Formulation of the Reform Agenda agreed by the MoH and DFAT

    2. Restructuring of AIPHSS management

    3. Establishment of a Policy Unit to assist MoH high officials in health systems strengthening

1 Principles, purpose and objectives of the reform agenda

A widely accepted definition of health sector reform is "… a sustained process of fundamental change in policy and institutional arrangements guided by the government, designed to improve the functioning and performance of the health sector and ultimately the health status of the populations" (Cassel, 1995). An elaborated definition of health reform as applied to a health system is "sustained, purposeful, fundamental change to improve the health system. 'Sustained' in the sense that it is not a one shot temporary effort that will not have enduring impact; 'purposeful' in the sense of emerging from a rational, planned and evidence based process, and 'fundamental' in the sense of addressing significant, strategic dimension of health system" (Berman, 1995).

Most references suggest that health sector reform should be aimed at and guided by specific normative objectives for reforms which include improving "equity, quality, effectiveness, efficiency, fairness and sustainability" of the health system.

The principles and purpose of health reform as understood in the above definition are used as guiding principles in formulating a Reform Agenda supported by the AIPHSS program. It is stated in the AIPHSS program document that the expected impacts of AIPHSS are (a) the reduction of maternal mortality and (b) improved health services for the poor and near-poor (in terms of access and quality of service). The impacts will be achieved by strengthening the three elements/functions of health systems (HR, Financing and Primary Health Care) at four levels (Central, Province/District, Puskesmas and Poltekkes).

The purpose of the Reform Agenda is to enable AIPHSS activities to be more relevant and focused on the strengthening of health systems, both at the national level (Component-1), regional level (Component-2), primary health care/Puskesmas level (Component-3) and educational institution level (Component-4).

Health Systems Strengthening has a systemic impact in contrast to vertical programs that specifically affect the improvement of certain health problems. It should be mentioned that Health Systems Strengthening affects not only mother and child health (MCH) but also other health problems as well.

With regard to services for the poor, AIPHSS has – by design – selected districts with a high percentage of poor people (Situbondo, Bondowoso, Sampang and Bangkalan in East Java province, and Timor Tengah Utara (TTU), Flores Timor (Flotim), Ngada and Sumba Barat Daya (SBD) in East Nusa Tenggara (NTT) province).

Through this Reform Agenda, it is expected that the AIPHSS program will strengthen the health system at the national and sub-national level in facing challenges of health development and also support the implementation of RPJMN and the health strategic plan.

2 The concept and basis for the formulation of health systems strengthening reform agenda

The formulation of the Reform Agenda was done by involving relevant units in the MoH, Program Technical Specialist (PTS), Technical Advisers (TA) and Program Management Unit (PMU). Discussion of the first draft took place on 8 July 2014 and was attended by MoH echelon 1 and 2 officials and chaired by the Secretary General of MoH as the program director of AIPHSS.

According to the World Health Organisation (WHO), health systems strengthening should be preceded by assessment/ identification of weaknesses of functions and sub-functions of the health system (WHO, Health System Building Blocks). A function/sub-function of health systems is considered to be weak if (i) it is not in accordance with the standards, regulations and theory of health systems (as expressed in the SKN-2012 and other regulations, and Health System Building Blocks according to WHO) and (ii) it is predicted that the system and its function would not be able to face the challenges of health development.

According to the national health system/SKN (Perpres-72/2012) there are seven functions of health systems, including: (1) Stewardship and governance including information systems, (2) Human resources for health, (3) Drugs and medical supplies/equipment, (4) Health research and development, (5) Empowerment and community participation, (6) Health financing and (7) Health programs which consist of public health and individual clinical services. (Note: WHO does not include community empowerment and research & development in the main functions of a health system).

As presented earlier, the focus of AIPHSS is on four functions of health system, i.e.: (1) HR, (2) Financing, (3) Primary health care (service delivery) and (4) Governance, particularly regarding decentralisation. Description of the sub-functions in each function is presented in the following diagram (note: the sub-functions are based on references – including the SKN and regulation used in Indonesia).

Conceptual Framework of sub-functions of HR, Financing, PHC and Decentralisation Regulation

HR		Financing		HSD/PHC		Decentralisation regulation	
1	HR Information System	**1**	What to be financed? (UKM, UKP, Support)	**1**	PH and clinical	**1**	Distribution of functions
2	Planning: ✔ Institutional ✔ Regional & LT			**2**	Community based		
3	Production	**2**	Costing	**3**	PBwK	**2**	MSS (SPM)
4	Recruitment			**4**	HR		
5	Placement/ distribution	**3**	Financing: PH: (BOK etc) Individual services (JKN)	**5**	Financing	**3**	Organisation and institutional status
				6	Puskesmas information system (SP2TP)		
6	Supervision/ Monitoring	**4**	Performance based planning and budgeting	**7**	Facility/equipment	**4**	DHO staff competence
				8	Puskesmas management		
7	Career development	**5**	Money: Health account	**9**	Institution	**5**	Managerial and planning competencies
				10	Referral system		
Capacity Building PPSDM		Capacity Building PPJK		Capacity Building BUKD		Capacity Building Dinkes	

Source: SKN 2012, WHO 2010, Kepmenkes 128/2004, UU-32/2004

Strengthening of the four functions is basically to eliminate or reduce weaknesses in those functions, seen from two perspectives:

a. Whether the functions/sub-functions are in accordance with the standards, regulations and theory of health system;

b. Whether the functions/sub-functions are quite adequate to face challenges.

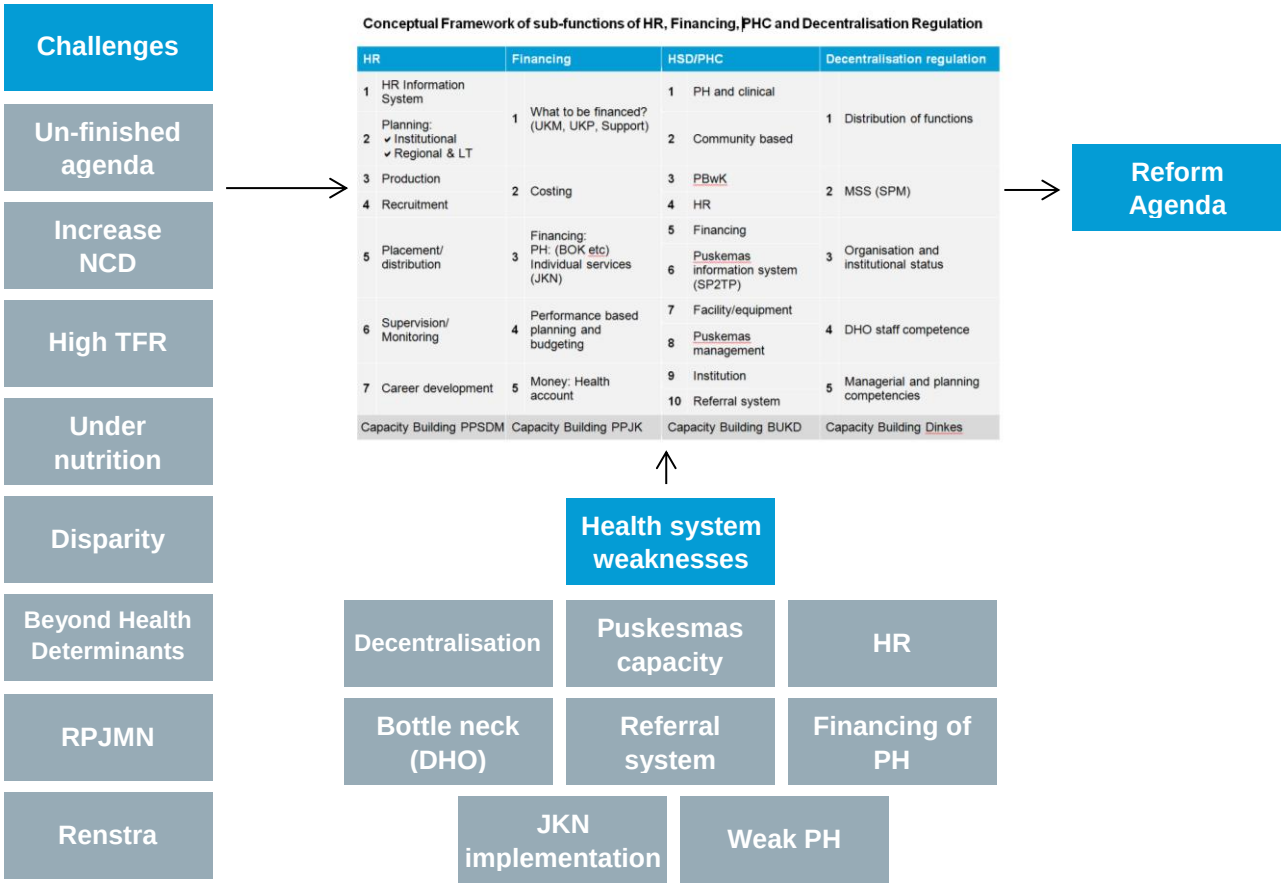
In the preparation and implementation of AIPHSS so far – though the assessment of health systems was not specifically performed – identification of weaknesses in the sub-functions was done in discussions by Implementing Units, PMU, PTS, and TA at the Technical Working Group (TWG) meeting as well as discussions with, and directions from, MoH high officials. Similarly, the preparation at the sub-national level is preceded by the formulation of problems describing the weaknesses of the functions and sub-functions.

The weaknesses of the four functions which became the focus of AIPHSS are also revealed in Health Sector Review (HSR), which was also used to develop this reform agenda (the details are attached).

Furthermore, Bappenas has prepared the draft of the 2015–2019 RPJMN and subsequently MoH is preparing the 2015-2019 Health Strategic Plan. The two processes are linked and both have utilised recommendations generated in the HSR, supported by AIPHSS. The RPJMN and Strategic Plan were also used as references in formulating this Reform Agenda. (The policy directions of RPJMN 2015–2019 and Health Strategic Plan 2015–2019 are attached.)

Finally, there are also the directions and inputs from the MoH senior officials and DFAT. These include the importance of health systems readiness to face the changing patterns of disease, primarily an increase in non-communicable disease; the importance of strengthening the public health program (health promotion and prevention); the importance of revitalising Puskesmas to carry out their four main functions (community participation and empowerment, public health programs, clinical services, and monitoring/promoting healthy development policies). In January 2014, Puskesmas were formally given a new function as the primary care provider for Jaminan Kesehatan Nasional (JKN) participants. Other issues are improvement of JKN effectiveness and the "unfinished agenda" of the achievement of the Millennium Development Goals (MDGs) 2015 target.

Overall, the formulation of this Reform Agenda has been driven by (a) challenges faced and (b) weaknesses of the current functions of the health system. This is described in the following diagram.



3 The Health System Reform Agenda

The following is the Health System Reform Agenda covering the four functions of health systems which is based on the identification of the weaknesses of each function and sub-function. It turns out that many ongoing AIPHSS activities already address the weaknesses of the health system functions.

A system generally consists of interrelated elements. Therefore, this document also presents how the weaknesses and strengthening of a particular element affects other elements, so that in the implementation of this Reform Agenda coordination and synchronisation becomes very important.

As mentioned previously, there are five AIPHSS components, namely (a) central level, (b) provincial/district level. (c) Primary health care/Puskesmas level, (d) Poltekes strengthening and (e) strengthening of the policy analysis network (Health Policy Network (HPN)). The "reform agenda" also presents the linkages between the central, provincial and district levels in the implementation of health system strengthening.

3.1 Reform Agenda of Human Resources for Health (HRH) Strengthening

The policy direction of RPJMN 2015–2019 and Health Strategic Plan 2015–2019 is “improving the availability, distribution and quality of human resources for health”. The HSR has identified several problems as follows:

1. There is no master plan on the number, competencies and production of human resources for health;

2. Mal-distribution of the health workforce;

3. The quality and productivity of the health workforce are not in accordance with the demands;
4. There is no strategy on how to produce “primary health care physicians” as stated in the Law on Medical Education (UU Pendidikan Kedokteran);
5. Insufficient availability and productivity of public health workers.

In the planning and implementation of AIPHSS so far, several weaknesses have also been identified:

1. Lack of availability and updated information on human resources for health
2. Weakness of HR planning, both institutional and regional
3. The quality of graduates does not meet the requirements – especially for midwives
4. Inefficiency and mismatch in the recruitment and placement of HR
5. Uneven distribution and low retention of HR
6. Low quality and productivity of the health workforce
7. There is no career development pattern for the health workforce
8. Low quality of health office personnel, which becomes bottleneck for health administration and management.

From the above descriptions, it is apparent that the weaknesses of HR functions cover almost all sub-functions of HR. Therefore the reform agenda should be directed to overcome these weaknesses. There are also some HR strengthening activities addressed by other funding sources, including by the state (APBN) and local (APBD) budgets.

Table of reform agenda: Human Resources (HR) for Health

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
1	Strengthening HR information system	Enrichment of HR information system	Ongoing	AIPHSS	PPSDM, Ropeg, RoUM, Pusdatin, Dagri, BKAN	PHO BKD (provincial personnel agency)	DHO RSUD BKD (district personnel agency)
2	Strengthening of HR planning	HR regional planning method	Ongoing	AIPHSS	PPSDM		
		HR planning method at institutions (workload analysis)	Ongoing	AIPHSS	PPSDM	Piloting	Piloting
3	Production: improving the quality of graduates	Accreditation	Completed	AIPHSS	PPSDM	Poltekkes	DHO
		Distance education (midwives & nurses)	Completed	AIPHSS	PPSDM	Poltekkes PHO	DHO
		Competencies of primary care doctors	Ongoing	AIPHSS	PPSDM, Diknas (Ministry of Education)		

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
4	Placement/distribution	Study on retention and development of incentive system	Ongoing	AIPHSS	PPSDM		
5	Guidance /supervision	Certification of HR					
6	Career development	?					
7	Strengthening of policies and management of HR	Establishment of HR team at sub-national level	Ongoing and completed	AIPHSS	PPSDM	Jatim	8 districts in NTT and Jatim

3.2 Reform Agenda for Health Financing

So far the focus of AIPHSS has been primarily on the preparation and implementation of the national social security system (SJSN) or JKN. This includes (1) the development of provider payment system (INA-CBGs and capitation), (2) socialisation of JKN, (3) integration of Jamkesda (local schemes) into JKN. Another focus is supporting NHA and training and implementation of DHA in all districts of AIPHSS.

The HSR identified several other important issues on financing:

1. Severe underfunding of public health services, which in the long run will have an impact on the JKN financial burden;
2. JKN membership to include non-PBI (premium assistance recipients) participants, especially workers in the informal sector;
3. Guidelines for benefit package/clinical pathway and procedures of use;
4. There is still cost sharing to be borne by participants at service points;
5. Development of cost control and quality control systems which will also become one of the basic concepts of SJSN in health sector (JKN);
6. Payment of health services provider (provider payment).

It is stated in the policy direction of the 2015–2019 RPJMN that the focus of health financing strengthening includes two main issues, and they are:

1. Strengthening the implementation of SJSN in health (JKN)
2. Developing and strengthening the effectiveness of health financing.

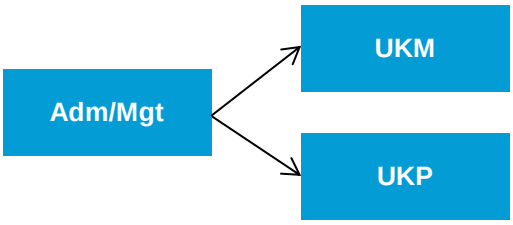
Other issues that also need attention in the health financing reform agenda are (i) defining the basic package of public health and clinical services, (ii) costing the basic package, (iii) ensuring funding for public health programs, (iv) finding innovative alternative sources of health financing, (v) strengthening planning and performance-based budgeting and (vi) strengthening MoH capacity in health financing policy analysis.

First, the initial step in health financing systems – as mentioned above – is defining what is to be financed. In this case, AIPHSS has supported the formulation of the distribution of heath functions between central-provincial-district levels (Adinkes activities). The result is a comprehensive list of health sector activities – which is included into the body of Law No.32 and PP No.38 – describing the details of the distribution of functions. In addition, through the Adinkes activity, Permenkes 741 on the Minimum Service Standards (MSS) has also been revised. The new formulation contains a list of

minimum services which cover all the basic needs of health care according to the life cycle of the population. The MSS is also an obligatory function of the district health development program.

From the two regulatory formulations, there are three groups of activities/efforts that need to be funded, namely:

1. Supporting activities (including salaries/wages of supporting units such as MoH, PHO, DHO, management units of general hospitals (RSU) and Puskesmas);
2. Public health services (UKM), which have been underfunded;
3. Individual health services (UKP), included in service package covered under JKN.



With regard to the individual clinical services (UKP), of which the financing is through JKN, there should be more precise formulation of the service package that will be paid through INA-CBGs and through capitation.

Second, we need to know how much it costs to implement the three groups of activities as shown in the above diagram. So far, cost analysis of health services – especially promotion and preventive services – is very rarely done, though the results are very much needed in the preparation of the health budget, including (i) budget for the supporting activity, (ii) budget for UKM, (iii) determination of a INA-CBG tariff and the amount of capitation payment, (iv) premium setting, and (v) premium subsidy for PBI members of JKN (the poor and near poor)

Third, study on financing of public health (promotion and preventive) programs is rarely done. So far, the implementation of public health programs almost entirely depends on BOK funding. There have been no systematic steps to improve the effectiveness of the BOK (the amount, allocation to various regions/Puskesmas, the effectiveness of its utilisation, the supporting regulations required, etc.)

Fourth, health financing has so far been more conventional: a tax-based (through state and local budgets) service tariff, either directly financed (out-of-pocket payments) or through insurance/health insurance. Other funding sources have not been optimally explored, for example, (a) the use of tobacco tax revenue sharing funds to the regions which could be used as a complement of public health program financing, (b) the use of other budgets for the health sector – such as village fund allocation (ADD), mobilisation of CSR funds from private enterprise, etc.

Fifth, health financing requires a planning-budgeting system which is realistic: evidence based, performance based, cost-effective and efficient (“allocative efficiency” and “economic efficiency”) and affordable. The weaknesses in planning and budgeting at district levels are already known. At the central level, the leaders in the MoH also see the need for refining the planning and budgeting system in the MoH.

Sixth, health financing is undergoing major changes in many countries, in response to the changes in health issues, determinants of health problems, increasing need and demand of the society, global/regional and national economic turmoil, as well as the development of medical science and technology. Those challenges require a strong capacity to perform continuous analysis of health financing policies, particularly in the MoH.

Based on the above issues mentioned, the Reform Agenda that AIPHSS needs to support in the future is described in the following table:

Table of reform agenda: Health Financing

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
1	Distribution of functions Formulation of MSS Determination of JKN package	Revision of Law (UU) & govt. regulation (PP) on decentralisation	Completed (Adinkes)	AIPHSS	MoH/Roren, Hukor, MoHA	Piloting	
2	Cos analysis (costing) * UKM program * INA-CBGs * Primary health care	Not yet	Not yet	AIPHSS, etc.	PPJK, MoH units -	PHO Provincial hospital (RSU)	DHO District hospital (RSUD)
3	Financing: Revision of regulation on BOK fund channelling	Regulatory revisions on BOK ➔ DAK	Under process (Adinkes)	AIPHSS	Rorengar	Provincial govt.	District govt.
	Mobilisation of other funds for UKM (tobacco tax, ADD, CSR, etc.)	Advocacy using DHA results	Ongoing	AIPHSS	PPJK	Provincial govt.	District govt.
	Revision of JKN premium	Premium based on cost/tariff and utilisation probability	Not yet	AIPHSS	PPJK, BUK	RSU and PHO	Puskesmas and DHO
	Revision of hospital tariff and capitation	Determination of “cost based” tariff” and capitation	Not yet	AIPHSS	PPJK		
	Acceleration of membership for informal and formal sectors	Socialisation of JKN	(*)	AIPHSS	PPJK	PHO	DHO
4	Institutionalization of HTA	Policy and guideline on HTA	Not yet	AIPHSS	PPJK, BUK, Yanfar, Litbang		
5	Cost containment: Policy and strategy to contain cost inflation related to ageing etc.	Strengthening promotive and preventive services, etc.	Not yet	AIPHSS	PPJK		DHO/ Puskesmas
6	Budgeting:	Strengthening planning and budgeting	See: table on regulatory reform	AIPHSS	Rorengar, finance and PPJK	PHO	DHO (piloting)
7	Health Account: Implementation and institutionalisation of NHA, PHA and DHA	Training on the implementation of NHA, PHA DHA	Ongoing	AIPHSS	PPJK	PHO	DHO, RSUD, Bappeda, BPS

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
8	Strengthening of financing policy analysis	Strengthening of PPJK (**)	Not yet	AIPHSS, APBN	PPJK, Hukor		

(*) Need to see the result of policy workshop on expanding JKN to informal sector (Jogyakarta, 2013). Policy brief has to be produced from the High Level Forum on the Informal Sector

(**) Formulation of new tasks and function of PPJK, health financing road map, PPJK staff capacity, data bank, etc.

3.3 Reform Agenda for Primary health care/Puskesmas (Delivery System, PHC)

The main task of Puskesmas is *"improving area wide/sub-district regional health status "* through four main activities: (1) promoting community participation and empowerment, (2) implementing public health services/programs, (3) implementing individual clinical health services, and (4) encouraging health oriented development (healthy public policy). Since 1 January 2014, Puskesmas also play a new function as primary health care providers for JKN participants.

Nearly all Policy directions of RPJMN 2015–2019 require the revitalisation of Puskesmas, as presented in the following table:

Policy directions of RPJMN 2015–2019 (draft, Bappenas, July 2014)

No	Policy directions	Reform agenda of PHC/Puskesmas
1	Accelerate the access and quality of services for MCH, adolescents and elderly	Workforce for MCH, adolescent reproductive health and elderly health (*)
2	Acceleration of people's nutrition improvement	Workforce for nutrition services (*)
3	Improve disease control and environmental sanitation	Planning capacity and P2PL management (*)
4	Improve access and quality of primary health care	Capacity of "outreach" activities (*)
5	Improve access and quality of referral health care	Referral system of primary-secondary (*)
6	Improve the availability, affordability, distribution and quality of pharmacy and medical equipment	Drug/pharmaceutical management
7	Improve food and drug control system	Food and drug control management
8	Improve the availability, distribution and quality of HRH	Placement and retention (*)
9	Improve health promotion and community empowerment	Budget, HR, health promotion management and community based health efforts (*)
10	Strengthen the management, research, development and information system	Revision of SP2TP (*)
11	Strengthen the implementation of JKN	Service package and capitation management (*)
12	Develop and improve the effectiveness of health financing	Planning and budgeting at the central, provincial, district and Puskesmas (*)

(*) potential activities to be supported by AIPHSS in the revitalisation of PHC/Puskesmas

Since the implementation of the Social Safety Net system in 1999, and subsequently followed by Jamkesmas and now JKN, the role of Puskesmas has been narrowed down to individual curative care providers. However, as stated in the HSR, Puskesmas are actually not ready to serve as primary care providers of JKN (WB, Supply Readiness, 2012). Many Puskesmas do not have well-functioning medical facilities, standardised health personnel: doctors, analyst, pharmacy, nutrition, health environment, and health promotion personnel.

Financing for UKP mostly comes from capitation funds paid through JKN. Recently, a Presidential Decree 32/2014, which gives authority to Puskesmas to use the capitation fund directly, has been issued. Furthermore Permenkes-19/2014, regarding the use of these funds, has also been issued. In connection with the capitation payment, a Capitation Fund Treasurer (Bendahara Kapitasi) is placed in each Pukesmas. The treasurer is an extension of the Regional District Treasurer. This new funding system requires an increase of Puskesmas ability to manage capitation funds according to regulations.

One of the problems arising from the capitation payment system is the inequality of services for Puskesmas staff (60% capitation). Total capitation will be more in Puskesmas with greater populations than in Puskesmas with smaller populations, which are generally located in remote areas. The solution could be through a "sliding scale" in which the capitation tariff is adjusted based on population, or through other funds such as "equalizing fund" that can be generated from the central or local levels. This solution requires a deeper analysis and needs to be implemented immediately.

Financing for public health services (UKM) in Puskesmas almost entirely depends on the BOK fund, which is now channelled through the TP (Tugas Perbantuan) mechanism. In the revised decentralisation law, the BOK fund will be transferred through DAK (special allocation funds) with a note that in the new regulation, DAK will consist of (i) physical expenditures and (ii) operational expenditures. However it is important to ascertain that there will be specific clause on the "Puskesmas operational fund" in the revised regulation on fiscal transfer. Thus, in the long run operational budgets of Puskesmas for UKM are mostly allocated from the regional budget (APBD), except for regions with weak fiscal ability.

Another issue is the Puskesmas Information System (SIP) known as SP2TP (Puskesmas Integrated Recording and Reporting system). The weaknesses of the current SP2TP have long been known, among others, many data are not collected in accordance with the needs of Puskesmas, data are rarely analysed, Puskesmas rarely receive feedback, a heavy workload for Puskesmas to fill the SP2TP form, the information system has yet to accommodate the new role of Puskesmas as primary health care providers for the JKN. The Pusdatin and BUKD (with the support of state budget/APBN and AIPHSS) are revising the SP2TP.

As observed in the field (as also mentioned in the RPJMN policy directions), the referral system needs to be developed. Currently, there are two ongoing activities in AIPHSS areas: (a) the development of a district-level referral system, from primary to secondary health facilities and (b) the development of a provincial-level regional referral system. Both of these developments are being carried out in eight districts of AIPHSS (district referral) and two provinces, NTT and East Java (regionalisation referral).

Another weakness identified is the managerial capability of Puskesmas. In the health minister regulation (KMK)-128/2004 on Basic Policies of Puskesmas, the management functions of Puskesmas consist of planning (micro planning for planning), mini workshops (for actuating the implementation) and stratification of Puskesmas (for monitoring and evaluation). In addition, a variety of training materials and guidelines for Puskesmas' management has been developed, including the guidelines for performance based annual budget work plans (RKA), planning and management guidelines for various health programs (immunisation, malaria, tuberculosis, filarial etc.) and Puskesmas leadership training. Over the last decade, not many training activities were undertaken to strengthen the managerial and clinical capabilities of Puskesmas.

Table of reform agenda: Revitalisation of Puskesmas/PHC

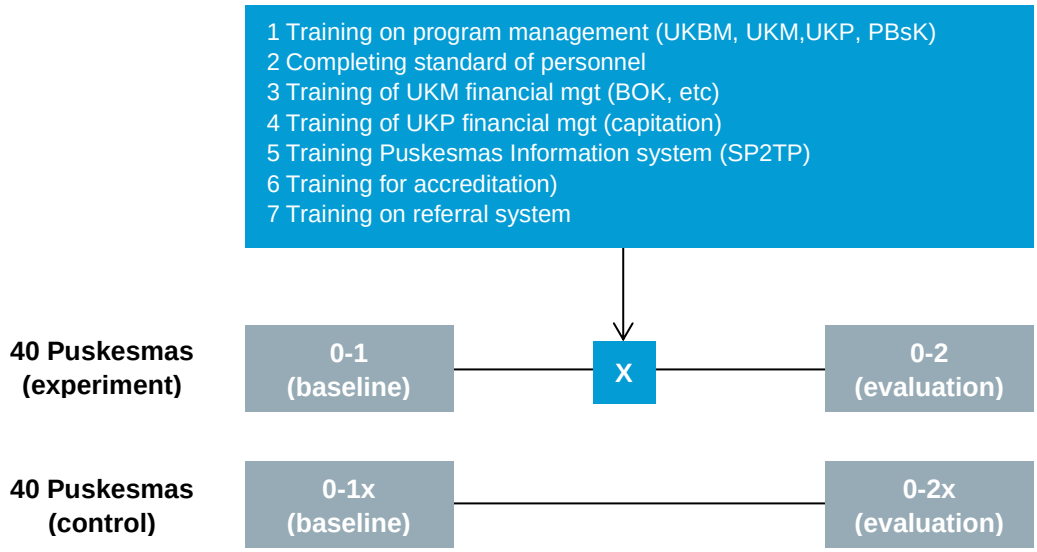
No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
1	Strengthening of Puskesmas: implementing programs of UKM, UKBM and PBwK (healthy public policy)	Revision of UKM, UKBM, PBwK modules/guidelines	Not yet	AIPHSS	BUK, Promkes (health promotion)	PHO	DHO Puskesmas
		Training for Puskesmas	Not yet	AIPHSS	BUK, Promkes	PHO	DHO Puskesmas
2	Placement of Puskesmas personnel according to the standard	Placement of personnel at piloting Puskesmas	Not yet	AIPHSS Tugsus/ APBN/APBD	PPSDM, BUK, Ropeg	PHO	District govt. / DHO
3	Financing of UKM at Puskesmas	Training for Puskesmas in BOK planning & management	Not yet	AIPHSS	BUK, PPJK	PHO	DHO Puskesmas
4	Financing of UKP at Puskesmas	Perpres (presidential regulation) on Retention of capitation	Completed (Perpres-32/14)	APBN	PPJK		
		Health minister regulation (PMK) on the use of capitation	Completed (PMK-19/14)	APBN	PPJK		
		Training /piloting on the implementation of PM-19 (capitation)	Not yet	AIPHSS	PPJK, BUK	PHO	DHO Puskesmas
5	Strengthening of Puskesmas information system	Revision of SP2TP	Ongoing	APBN and AIPHSS	Pusdatin, BUKD, relevant units	PHO	DHO Puskesmas
6	Institutional: Puskesmas accreditation	Development of accreditation instruments	Completed	APBN	BUKD	PHO	
		Piloting of accreditation instruments	Ongoing	AIPHSS	BUKD	PHO	DHO Puskesmas
7	Referral system	Strengthening of district referral system	Ongoing (in 8 districts)	AIPHSS	BUKD	PHO	DHO RSUD Puskesmas
		Regionalisation of referral system	Ongoing (in NTT, Jatim)	AIPHSS	BUKD	RSU PHO	RSUD DHO
8	Developing/Updating model Puskesmas	Piloting the revitalisation of Puskesmas comprehensively (*)	Not yet	AIPHSS	BUKD, PPSDM, Units	PHO	DHO Puskesmas

(*) see separate section on Puskesmas revitalisation

Piloting of Puskesmas revitalisation

The seven groups of Puskesmas strengthening activities as listed in the above table will be piloted to see their effectiveness in improving Puskesmas' performance. The pilots will be conducted in 40 Puskesmas in NTT and Jatim (with other 40 Puskesmas as a control). The pilots will last at least for two years (2015–2016). In the first year, it is expected that the guidelines and training within the seven interventions will have been completed.

The design of the pilots is described in the following diagram. The first step is (a) preparing guidelines, modules and necessary regulations for the pilot study and (b) developing relevant indicators for baseline and monitoring/evaluation of the study. The second step is undertaking the baseline survey. The third step is to carry out the intervention (Puskesmas revitalisation) and finally the fourth step is evaluating the performance change that may have occurred.



Note: Training on UKP is in accordance with the function of Puskesmas as primary health care providers for JKN participants

Note: There are two other activities lead by BUKD which have been continuously carried out. The first is the development of Puskesmas typology according to regional characteristics: urban Puskesmas, rural Puskesmas, and Puskesmas in remote areas and islands. The second activity is to change the institutional status of Puskesmas: from previously a structural unit (with structural echelon) to become a functional unit (without echelon). This change will lead to the need to develop a career path according to technical functions of Puskesmas' staff.

3.4 Reform Agenda for Governance and Decentralisation

During 2013-2014 there are two activities of AIPHSS which give fundamental contributions to the health system, particularly on governance. They are:

1. Formulation of 2015–2019 RPJMN (Bappenas) and 2015–2019 Health Strategic Plan or Renstra (MoH) and

2. Revision of laws and regulations concerning health sector decentralisation (Adinkes activities).

For the formulation of the RPJMN and Renstra, AIPHSS have supported the implementation of Health Sector Review (HSR) which covers nine areas: (1) Changing demand for health and health services, (2) Fertility, family planning and reproductive health, (3) Human resources for health (HRH), (4) Health financing, (5) Institutional analysis under decentralisation, (6) Pharmacy and medical technology, (7) Nutrition, (8) Quality and safety of healthcare, (9) Service delivery and supply side readiness to face JKN.

As for the laws and regulations on decentralisation, the distribution of functions and responsibility between levels of government (central, provincial and district levels) need to be revised for the following reasons:

a. The current functional distribution is not consistent with the health system functions as stated in the Perpres-72/2012 on the National Health System (SKN);

b. The functions are not based on the needs of all population segments from the within the “life cycle” of the population;

c. The Minimum Services Standard as listed in Health Minister Decree-741 do not comprehensively cover essential health needs of all segments of the population (life cycle);

d. In many districts, the recruitment of District Health Officer by the local government (Bupati/Walikota) was not based on the principles of professionalism and “fit and proper test”.

The results of the activities are (i) the revision of UU-32/2004 which outlines the distribution of functions; (ii) the revision of PP-38 which contains the details the functional distribution; (iii) the revision of health minister decree (KMK-741) on the minimum service standards (the new formulation contains services that include essential health need based on “life cycle” of population); (iv) the revision of PP-41 on the organisational structure of provincial/district health office and (v) the formulation of standard competence for District Health Office personnel. The activities have also produced training modules to strengthen management capabilities of district health offices. The results of the revisions need to be socialised to regions, including to AIPHSS areas in Jatim and NTT.

The implementation of decentralisation was started in 2000. One of the problems observed has been poor capacity of district health offices in preparing performance based health planning and budgeting. This poses a “bottle neck” to the implementation of health development at sub-national level. In the past, there was a training module on health planning for districts/cities known as P2KT (integrated health planning and budgeting), which basically is the operationalisation of the principle of performance based planning and budgeting, as endorsed by the Minister of Home Affairs Regulation (Permendagri-59/2007). The module had been revised several times since it was first introduced in 1984 to 2010. With the new development of functions transferred to sub-national as well as the formulation of the new minimum service standards – including changes to the rules on fiscal transfers to regional government – the planning and budgeting module needs to be revised.

Similarly, at the central level (MoH), with the new formulation of functional distribution and with the new RPJMN and Health Strategic Plan 2015–2019, a review and reorientation of health program planning at MoH need to be done as to make it consistent with the principles of principles of performance based planning and budgeting. Officials in MoH see the need to increase the relevance of the planning with challenges faced, and improve coordination and synchronisation of plan between units in the MoH.

Table of reform agenda: Governance and decentralisation

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
1	Revision of regulation on distribution of functions	Revision of PP-38 (Adinkes)	Completed	AIPHSS	Rorengar, Hukor	Socialisation	Socialisation
2	Revision of the content of the minimum service standard	Revision of health minister decree (KMK-741)	Completed	AIPHSS	Rorengar, Hukor	Socialisation	Socialisation
3	Revision of regulations on organisation and personnel of health offices	Revision of PP-41 & formulation of health office personnel competencies	Completed	AIPHSS	Rorengar, Hukor	Socialisation	Socialisation
4	Strengthening the legal aspect of Puskesmas operational budget for public health programs (UKM)	Revision of BOK transfer through DAK (for UKM operational budget in Puskesmas)	Ongoing process	AIPHSS	Rorengar, Hukor	Socialisation	Socialisation
5	Preparation of RPJMN	Health Sector Review and formulation of RPJMN 2015-2019	Ongoing process	AIPHSS	Bappenas		
6	Preparation of Health Strategic Plan	Preparation of Health Strategic Plan 2015-2019	Ongoing process	AIPHSS	Rorengar, all other units of MoH		
7	Strengthening of program planning and budgeting in the MoH	Integration and synchronisation of planning in the MoH through planning process review	Not yet	AIPHSS	Rorengar, relevant units		
8	Preparation of Health system strengthening oriented RPJMD	Preparation of provincial/district RPJMD	Completed in NTT, work plan in Jatim and several districts.	AIPHSS	Rorengar	Provincial Bappeda and PHO	District Bappeda and DHO
9	Preparation of provincial health strategic plan	Preparation of provincial health strategic plan	Completed in NTT	AIPHSS	Rorengar	PHO	
10	Strengthening of regional health system (SKD)	Preparation of SKD in NTT	Not yet (proposal)	AIPHSS	Rorengar	PHO	
11	Strengthening of regional health planning & budgeting	Training on health planning at province	Not yet	AIPHSS	Rorengar	PHO	
		Assistance by TA consultants	Not yet	AIPHSS	Rorengar	PHO	

No	Area of reform	Activities / Work plan	Status	Funding	Relevant units		
					Centre	Province	District
		Revision of P2KT module (TA)	Not yet	AIPHSS	Rorengar	PHO	DHO
		Training on P2KT (TA)	Not yet	AIPHSS	Rorengar	PHO	DHO
		Mapping of regional fiscal capacity	Not yet	AIPHSS	Rorengar	PHO	DHO

Attachment 1

Note: from Health Sector Review

Workhealth force (HRH)

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
HRH Production	No Master Plan to plan and produce the required numbers, and skills, of HRH.	Wasted economic and human resources if increased HRH are not of high quality and well aligned to the changing burden of disease. Political: UHC target for 2019 will fail without sufficient number and quality of HRH	MoH BPPSDM should take the lead in HRH strategic planning. CCF should be revitalized to improve the coordination among stakeholders to formulate the development of a Master Plan.
HRH Distribution	Mal-distribution of HRH	Equity: Poor and rural regions without health workers, with the budget being absorbed in areas with adequate HRH – mainly urban and wealthy regions.	BPPSDM has endorsed stakeholders to develop a special policy for DTPK. Regulations and polices prior to enactment of these primary regulations.
Quality and productivity	Quality of medical training is not fit for changing demand for health care. Many schools are not accredited. Curriculum is not well aligned to changing burden of disease. Lack of HRH planning undermines technical and economic efficiency and productivity. Shortage of leadership and strategic management training for top level staff, and a shortage of planners and economists to shape policy based on evidence	Health Outcomes: Unaccredited schools can produce poor quality graduates Technical: Absence of good data on HRH productivity means poor HR allocation. The standard should be defined and tested for particular type of HRH. Standard competency of HRH links directly to quality of services. Political: JKN requires accredited institutions to be their partners. If the HRH is not accredited, the institutions cannot be the partner of BPJS	(1) MoEC, MoH, and Professional Associations should develop strategy to improve standards and quality of medical education (2) Develop a special program for team based deployment to under-served areas, providing a critical mass of services to support retention (3) Implement capacity development for senior managers through Executive Development and Leadership courses to help improve HRH productivity and efficiency.
Definition of primary health doctors	No strategy for the production of primary health care doctors	Technical: Results in increase in referral to higher level facilities and costs	MoH, MoEC, & IDI/IMA should formulate the definitions, production, career management, and job description of primary health doctors
HRH for public health services	HRH is focused on curative services, although public health services are needed to meet the health	Health outcomes: increased health burden from preventable diseases.	Empowerment of PH-HRH should be led by Professional Association and supported by MoH. Greater focus in the

	challenges of under-nutrition, high prevalence of tobacco consumption, and the rapid rise of NCDs.	Economic: higher financial and economic cost to government and households because HRH are not sufficiently focused on primary and secondary prevention.	curriculum, and in testing of competency, on primary and secondary prevention of NCDs.

Health Financing

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
Financing for Prevention and Public Health Programs	Insufficient funding levels for prevention and public health programs while Indonesia faces new public health challenges	Political: threats to healthcare systems in terms of both cost and capacity (the ability to improve health outcome) in the future. Economic: healthcare costs keep rising (inflation) due to focus on curative care only.	(1) MOF needs to allocate appropriate funding levels for prevention, various public health programs and/or activities; (2) MOH needs to move from a high proportion of funding levels from personal health (UKP) to prevention and public health (UKM) programs.
Insuring all Indonesian in the JKN scheme	Sustainability of paying premium amongst informal workers is low; Higher lapse and evasion rate of the informal workers in the JKN scheme.	Political: Indonesia unable to achieve the goal of universal health coverage by January 2019; Financial: A higher administrative costs to manage informal workers (e.g., premium collections for informal sector may higher than the premium rate itself).	(1) MOF extends contribution assistance and pay premiums for the informal sector. (2) MOH, MOF and Bappenas need to have a pilot to find a strategic solution for extending the coverage to the informal workers.
JKN Benefits Package	JKN provides comprehensive benefits packages without clear definitions on the procedure, treatments, drugs, and medical devices. Failure to settle the SOP (treatment, drugs, and medical devices) for each benefi0ts basket, and devices) for each benefits basket, and failure to regulate the coordination of benefits (COB)	Technical: Given providers payment (Capitation and CBGs), there will be a provider financial incentive to give too few of necessary care, medicines, or of substandard quality; there will be potential dispute between BPJS and providers. Financial: Private insurers creams skim easy patients to their contract hospitals destabilizing CBG tariffs to public hospitals and (over time) private insurers will turn away sick patients from private supplemental insurance. Equity: unequal benefits package due to concessions to civil servants lead to cost	MOH needs to develop SOP for each diseases category; develop clinical guidelines to direct providers' practices. MOH needs to institutionalize Health Technology Assessment - HTA (e.g., do cost-effectiveness and include equity considerations as part of benefit package definition logic). Both BPJS and Clinical Advisory Board do a regular monitor and/or spot-check. BPJS use provider-network only; pay claims or have access to all claims data to monitor; create a firewall between

		impacts on BPJS that will to civil servants lead to cost impacts on BPJS that will hurt the poor.	claims under BPJS and access to all claims data to monitor, create a firewall between claims under BPJS and private supplemental insurance claims systems GOI do not give in to civil servants political demands.
Out-off pocket payment	Failure to regulate healthcare payment made by the insured when they utilised healthcare services	Financial: degree of financial risk protection drops; incident of catastrophic payment can't be stopped leading to reduce the functions of insurance to prevent poverty. Political: risk of perception of meaningless to have insurance if the payment made by the insured is quite significant Equity: unmet need for healthcare services can't be eliminated, especially for the poor and vulnerable.	(1) Vice President and MOH needs to regulate for not allowing providers to ask payment to the insured: (2) BPJS oversight/monitor of the JKN implementation (e.g., do a routine utilisation review management program).
Provider payment reforms and cost containment issues	Unintended consequences of provider payment reforms (e.g., Capitation and INA-CBGs) on both JKN financial and quality of services	Technical: unadjusted capitation promotes enrolment of healthier relative to sicker and promote the financial solvency of providers and their ability to manage risks. Financial fiscal-risk to JKN revenues due to (a) inappropriate CBGs coding systems (e.g., CBGs coding flaw, CBGs grouper doesn't adequately represent Indonesian diseases); and (b) CBGs for outpatient care leading to higher readmission rate.	(1) Capitation must be adjusted by risk factors (for initial steps it can be based on age and gender compositions); (2) MOH and BPJS need to standardise coding system, develop accreditation systems for coding, routine audits of coding of claims. They also need to develop analytic team in house and with universities to modify it with claims data now coming into BPJS; (3) MOH needs to abolish CBGs for outpatient and opt to FFS with a cap, or combine FFS with pay-for-performance .

HSD: Supply side readiness

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
	Insufficient funding for public facilities	Political: government at all levels will be held accountable for impacts of inefficient financing to ensure supply-side	Clarify, specify and socialize the supply-side implications of the JKN benefits package Use demand-side financing to

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
		readiness; Social: JKN beneficiaries and users may become dissatisfied with services; Equity, deficiencies are greater in rural areas, and for the urban poor. Technical: effectiveness and efficiency of health services are reduced due to improper diagnosis and treatment; Economic: poorer health outcomes, higher out-of-pocket spending, and lower economic growth due to reduced human capital development.	improve supply-side readiness by linking provider payment to facility readiness in service provision (accreditation/credentialing systems), introduce carrot and stick approaches to incentivize local governments to spend more on health to meet national standards of service provision, Improve the effectiveness of the use of central level funds (e.g. DAK) to improve supply side readiness of public facilities.
	Insufficient accountability	Political, unclear accountability mechanisms create confusion, lack of oversight, and shifting of responsibility Social, as knowledge about JKN benefits package improves, beneficiaries and users may become dissatisfied with public health services; Economic: Some studies show increased and improved governance and accountability supports economic growth.	Align minimum service standards to better reflect service delivery needs to meet UHC Introduce regulation to prevent the capture of health revenues by the local government, strengthen existing accreditation system, transparency and autonomy of health facilities with more autonomy at the facility level, ensure that facilities are incentivized to improve supply side readiness, (5) introduce social accountability, encouraging citizens voice and action to improve government accountability.
	Weak monitoring and evaluation	Inaccurate policies and planning for investment to ensure supply side readiness in meeting UHC.	Establish an independent monitoring and evaluation system for supply-side readiness institutionalize the recording and collection of relevant facility-level data to track progress
Unclear distribution of function on health matters from central to sub national government followed by unclear MSS (SPM) and NSPK.	The unclear boundary between central and local responsibilities creates overlap in implementation and financing of health among MOH, PHO and DHO.	Unclear distribution of functions will lead to: Political: reluctance and negligence of local governments to be responsible for health.	Revision of Law 32 /2004 by incorporating a clear distribution of health function in the law, which will create a clearer division of responsibilities among tiers of government. (This revision is in process by MoHA and must be finalised and approved by

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
	MOH/Central level is providing funds for the provision of some main health duties and functions of the district level government do not take responsibility and accountability for these duties and functions.	(1) Unclear MSS/NSPK blurs the financial responsibility for MSS and excuses the local government from financing and planning for health services. This also increases the burden on the central level (2) Some district levels ignore responsibility of some of the health workforce needed to implement the MSS (3) Roles and responsibilities for monitoring and evaluation between central and local governments are blurred (4) Reduces accountability of local government and diverting the political pressure to the centre (5) regional inequity is increasing due to the wealthier local governments diverting responsibilities to the centre, leading to unequal economic development and inequities in health outcomes (6) Reduces the accountability of local politicians to their local constituents	parliament) The Permenkes 741/2008 on MSS has been updated and revised based on the Life Cycle approach according to MOH guidance and should be approved by the Minister of Health as a next step The NSPK should be updated, remove the obsolete sections
	Weak coordination between tiers of governments and between MOH, BPJS, and other related ministries and agencies.	Technical: improvements in Health Sector Performance will be achieved without a strong and close coordination between ministries and institutions. Weakness in relationships and coordination create lost opportunity to implement cross-sector/cross-	The coordination of MoH with other ministries/agencies needs a clear legal umbrella, to promote the obedience of the local government to comply. MoH to undertake a mapping of cross cutting issues which need a joint ministerial decree/Presidential Decree or Agreement among partners/agencies, to improve health planning and

Area/Issue	Potential Problems	Potential Impact	Potential Solutions
		cutting plans, supervision and facilitation, and wasting of resources. Health outcomes: reduces the synergy and opportunities to strengthen systems based on primary health care leads to failure of health service delivery. Political: weak coordination between MOH and MOHA will hamper the implementation and Guidance and Supervision (Binwas) of health matters of local governments.	implementation Create the Joint Decree (Joint Ministerial Decree/ Presidential Decree, Agreement) among MOH, MOHA, BPJS or other related ministries agencies for special cross sectoral purpose In order to monitor the target of RPJMN, a high level policy dialogue among ministries is needed, coordinated by Coordinating Minster of Social Welfare

Attachment 2

Policy directions of RPJMN 2015–2019

1. Accelerating fulfilment of access to and quality of health care for mother, child, youth and elderly
2. Improving Community Nutrition
3. Improving disease control and environmental health
4. Improving access to quality primary health care
5. Improving access to quality referral health care
6. Improving availability, affordability, equity, and quality of pharmacy and medical equipment
7. Improving drugs and food control
8. Improving availability, affordability, equity, and quality of human resources for health
9. Improving health promotion and community empowerment
10. Strengthening management, research and development and information system
11. Strengthening the implementation of social security system in health sector
12. Developing and improving the effectiveness of health financing