



# Program Information Document (PID)

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Concept Stage | Date Prepared/Updated: 18-Jun-2020 | Report No: PIDC225133

**BASIC INFORMATION****A. Basic Program Data**

Country Indonesia	Project ID P172707	Parent Project ID (if any)	Program Name National Health Insurance (JKN) Reforms and Results Program
Region EAST ASIA AND PACIFIC	Estimated Appraisal Date 26-Apr-2021	Estimated Board Date 05-Jul-2021	Does this operation have an IPF component? No
Financing Instrument Program-for-Results Financing	Borrower(s) Republic of Indonesia	Implementing Agency BPJS- Kesehatan, Dewan Jaminan Sosial Nasional (DJSN)	Practice Area (Lead) Health, Nutrition & Population

**Proposed Program Development Objective(s)**

Strengthening the performance and sustainability of Indonesia's National Health Insurance program.

**COST & FINANCING****SUMMARY (USD Millions)**

<b>Government program Cost</b>	2,750.00
<b>Total Operation Cost</b>	250.00
Total Program Cost	250.00
<b>Total Financing</b>	250.00
<b>Financing Gap</b>	0.00

**FINANCING (USD Millions)**

<b>Total World Bank Group Financing</b>	250.00
World Bank Lending	250.00

Concept Review Decision



The review did authorize the preparation to continue

## B. Introduction and Context

- 1. Indonesia has made significant progress in recent years with a steadily growing economy and declining poverty rates.** Supported by a sound macroeconomic framework, real gross domestic product (GDP) expanded by an average of 5.5 percent annually between 2010 and 2019, and the size of the economy<sup>1</sup> nearly doubled from IDR 5,478 trillion in 2006 to IDR 10,949 trillion (US\$1.1 trillion in current prices) in 2019. Strong growth also helped contribute to a decline in poverty lifting 13.6 million people out of poverty between 2000 to 2019.<sup>2</sup> Currently classified as a lower-middle-income country, Indonesia had been projected to reach upper-middle-income status within the next five years – an outcome now threatened by the COVID-19 outbreak. While quantifying the magnitude of the economic impact will likely change drastically given the evolving transmission dynamics and containment measures, preliminary estimates for Indonesia’s GDP growth in 2020 extends from -3.5 percent to 2.5 percent.
- 2. However, economic growth has not been accompanied by increases in government revenue. This has significant implications for investments in health which remains underfinanced for a government priority sector.** Indonesia has one of the lowest revenue-to-GDP ratios in the world at 14 percent in 2017 – consistently trailing its emerging and developing market peers by more than 11 percentage points. And, at 14.9 percent of GDP in 2018, total government expenditure is half the average of other emerging markets, making Indonesia a small spender compared to its peers. This has significant implications for investments in health and other sectors. Public expenditure on health—at 1.5 percent of GDP or 8.8 percent of total government expenditure—is less than what countries with a similar level of income spend on average. In 2018, government health expenditure amounted to just US\$56 per capita. To put this in perspective, per capita health spending would have to double to US\$110 to finance a minimum package of essential universal health coverage (UHC) services.
- 3. The COVID-19 outbreak has demonstrated now more than ever the importance of UHC and a sustainable national health insurance solution.** A common approach for financing UHC has been to cover formal sector workers via social health insurance (SHI) schemes while using tax-based financing to cover poor and vulnerable households. Yet countries differ on how to expand coverage beyond this group. Expansion via SHI is slow and only as the capacity to enforce contributions from the informal sector increases and participation becomes mandatory do countries attain high coverage rates. Indonesia’s persistent informality (76 percent of workers) makes it difficult to raise significant revenue for social health insurance. In addition, 25.1 million Indonesians still live below the national poverty line and many remain vulnerable to economic and health-related shocks as well as natural and climate-related disasters. The ongoing COVID-19 outbreak puts nearly 43 million workers (or 34.6 percent of the labor force) at risk of job and income losses.

Sectoral (or multi-sectoral) and Institutional Context of the Program

- 4. Over the past 15 years, Indonesia has made significant progress towards UHC.** Prior to 2004, only formal sector workers had access to health insurance – 27.4 percent of the population. With the introduction of *Jaminan Kesehatan*

<sup>1</sup> Measured in GDP at constant prices.

<sup>2</sup> Statistics Indonesia (Badan Pusat Statistik, BPS) Data.



*Nasional (JKN)* or National Health Insurance in 2014, Indonesia undertook a massive reform that few, if any, multi-payer countries have been able to achieve. Between 2014 and 2019, coverage expanded to 83 percent of the population (although active membership is slightly lower at around 75 percent of the population, but impressive nevertheless) and out-of-pocket (OOP) expenditures as a share of total health spending decreased from 47 to 34 percent – an unprecedented achievement in such a short time.

5. **However, significant gaps in financing and coverage remain.** JKN has incurred a cumulative deficit of IDR 31.7 trillion<sup>3</sup> (around US\$ 2.2 billion) as of end of May 2020. Seventy million Indonesians, mostly in the informal sector, remain uninsured and 4.2 percent of households incur catastrophic health expenditures<sup>4</sup>. Additionally, quality of care is low, as the health care system continues to grapple with an unfinished Millennium Development Goal agenda: one woman dies in childbirth every 1.4 hours; 8 million children are stunted; and Indonesia is the third largest contributor to the global tuberculosis (TB) burden. At the same time, non-communicable diseases account for 66 percent of the disease burden with stroke, ischemic heart disease, and diabetes among the top five killers in Indonesia.
  
6. **Systemic challenges in JKN's governance and accountability, health financing, and service delivery hinder progress towards UHC.** The GOI made many of the right decisions when it: i) consolidated schemes into a single national risk pool to allow greater subsidization from rich to poor, from healthy to sick, and from working to non-working populations; ii) targeted and subsidized premiums for poor and vulnerable households and provided the same benefits package to all beneficiaries ensuring equity of access; iii) chose capitation and case-based payments as the predominant provider payment methods for primary health care and secondary/tertiary care respectively which are known to promote efficiency in the use of resources; and iv) nominated BPJS-K as the single purchaser of health care services which in principle provides the national health insurance program with strong purchasing power to negotiate payment rates, payment methods, and contract terms with providers to manage costs more efficiently. However, the rapid roll-out of JKN has meant that some have faced challenges that have hindered some of the expected results from JKN implementation and threatened the financial sustainability of the scheme. In particular:
  - a) **Challenges to governance and accountability**
    - i) **The Social Security Agency (Badan Penyelenggara Jaminan Sosial-Kesehatan or BPJS-K) needs greater empowerment to effectively carry out its mandate as fund manager.**
    - ii) **The Social Security Council (*Dewan Jaminan Sosial Nasional* or DJSN) needs strengthening to exercise strong accountability measures as per its supervisory mandate..**
    - iii) **Weak or absent health management and information systems inhibits informed decision making.** Lack of standardized reporting and accounting formats, the low prevalence of electronic health records, unreliable internet connectivity, and poor reporting compliance make claims verification a laborious and time-consuming process.
  - b) **Challenges in financing of JKN**
    - i) **Incomplete participation of the informal sector leads to lower than expected revenues.** JKN is financed by two regimes: i) a contributory regime for formal sector workers (who pay 5% of their salaries) and the informal sector

<sup>3</sup> R Sianturi, Equitable and Sustainable JKN Program, Webinar BKF May 29<sup>th</sup> 2020.

<sup>4</sup> Catastrophic is defined as households spending more than 10 percent of their household consumption on health expenditures.



(who are expected to pay a fixed premium); and ii) a non-contributory regime known as *Penerima Bantuan Iuran* (PBI) – subsidies that the Government pays on behalf of the poor and near poor. While a benefit of the scheme’s single national risk pool allows for cross-subsidization across membership groups, it cannot absorb the large claims imbalances created by the incomplete enrolment of the informal sector and non-workers, resulting in deficits to be financed by the government.

- ii) **Input-based financing does not reflect need or performance.** In JKN, PHC is paid by capitation<sup>5</sup> (a fixed budget) covering 144 competencies or services that first level healthcare facilities (*fasilitas kesehatan tingkat pertama* or FKTP) are meant to perform. The capitation amount a PHC facility receives is based on the number and type of providers and the number of beneficiaries assigned to facilities. This reinforces existing imbalances in provider and beneficiary distribution. In the absence of a strongly enforced gatekeeping system, it may also lead to over-referrals, and under-delivery of outreach services.
  - iii) **Open-ended hospital expenditures drive the deficit.** Hospital expenditures accounted for 84 percent of all JKN expenditures in 2018, up from 74 percent in 2014. Implementing close-ended hospital payments has the greatest potential to curb expenditure growth.
  - iv) **Private sector tariffs do not reflect the cost of service delivery.** Private sector facilities receive a marginal mark-up from public sector tariffs – despite the fact that public facilities receive significant resources (supply side financing) from the government. As a result, private facilities have less motivation to focus on diagnostic capacity and low-margin public health and preventative conditions and more on treatment.
- c) **Challenges in service delivery**
- i) **Good access to key services at the national level masks wide variations by socioeconomic status and geography.** Almost all women receive at least one antenatal care visit, and 77 percent receive at least four – meeting the national target for 2015-2019. However, women with no education and those in the poorest households are 2.4 and 1.5 times less likely to receive all four visits compared with more educated and richer households. The narrative is similar for delivery by a skilled provider, postnatal care in the first 48 hours, and full basic vaccination. Access to services also differs across the country; utilization in the Java-Bali region is generally 2 times higher utilization than in North Maluku, Papua, and Maluku which have some of the lowest utilization rates in the country.
  - ii) **Access to care also does not guarantee quality care.** Primary health care facilities – public and private – often lack basic diagnostic tests, essential medicines, and diagnostic and treatment guidelines, especially among the private sector. Supply side financing used to purchase drugs, medical equipment, and infrastructure from the MOH and local government does not correlate with the level of supply readiness which measures whether health facilities are able to provide basic health services. These are factors that lie beyond the control of BPJS-K, requiring investments in supply side readiness, as well as broader public financial management reforms to introduce better coordination, accountability, and performance orientation in public spending. However, JKN can incentivize better access and quality care through increased performance-based provider monitoring and financing. Importantly, most interventions listed under the JKN benefit package do not have clinical diagnostic

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<sup>5</sup> Capitation does not cover the full cost of care as there is significant co-financing by supply-side government spending.



and treatment protocols or referral pathways making it difficult for BPJS-K to assess quality and hold providers accountable.

7. **The GOI has introduced new policies to help narrow BPJS-K's budget deficit (Presidential regulations 82/2018, 75/2019, and 64/2020) but these changes focus mostly on increasing revenue not managing expenditure growth.**

Relationship to CAS/CPF

8. **This operation is in line with the World Bank Group's Country Partnership Framework FY2016-2020<sup>6</sup> (CPF), Report # 99172, approved by the Board on December 1, 2015, as it focuses on access to quality health services and financial protection for the poor, vulnerable, and high-risk populations in Indonesia, and is in line with the World Bank's strategic priorities to end extreme poverty and boost shared prosperity. It contributes to protection of the country's human capital and supports engagement area 4 of the CPF (on the delivery of local services and infrastructure) by reinforcing the readiness and accessibility of health facilities across the country and improving the quality of health services provided—the CPF's second pillar in this engagement area. As JKN is the flagship initiative for UHC in one of the largest countries in the world, the operation also promotes the World Bank Health, Nutrition and Population Global Practice's strategy to support countries in their progress towards UHC. Last but not least, the project provides an opportunity for improved efficiency and effectiveness of development partner support for JKN by aligning their financing and technical assistance around the results areas of the project.**

Rationale for Bank Engagement and Choice of Financing Instrument

9. **This operation is designed as a Program-for-Results (PforR), looking at the sustainability challenge for JKN, and the potential for design reforms in JKN to bring about system-wide improvements in the country's health system.** As JKN is one of the largest health sector programs in Indonesia (in terms of the financing), the PforR instrument will be optimal as an accountability and monitoring tool for the needed reforms, while focusing attention on key reform priorities that will be essential for the sustainability and effectiveness of JKN. The World Bank, with its global knowledge on health financing and UHC and its technical expertise in the design and implementation of health insurance programs and use of results-based instruments to achieve policy objectives, is well positioned to play a catalytical role as a trusted partner and ally to the GOI in its pursuit of sustainability for the national health insurance program. The program will be complemented by technical assistance, in close coordination and/or partnership with the Global Fund, the Gates Foundation, the Government of Australia, the Joint Learning Network for UHC, USAID, WHO, and other sources of technical assistance and knowledge to complement the World Bank's efforts.

### **C. Program Development Objective(s) (PDO) and PDO Level Results Indicators**

Program Development Objective(s)

10. Strengthening the performance and sustainability of Indonesia's National Health Insurance program.

PDO Level Results Indicators

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<sup>6</sup> <http://documents.worldbank.org/curated/en/195141467986374707/pdf/99172-REVISED-World-Bank-Indonesia-Country-Partnership-Framework-2016-2020.pdf>



11. Achievement of the PDO will be measured by a set of PDO-level results indicators to be finalized during project preparation. At concept stage, some possible PDO indicators include:

*To measure performance:*

- (1) Coverage defined as the number of active members as a share of the total population of the country (available from BPJS-K administrative data);
- (2) Financial protection defined as total OOP health expenditures as a share of total household consumption (available from Susenas household survey);
- (3) Member satisfaction rate as defined by BPJS-K (available from BPJS-K administrative data);
- (4) JKN spending on primary care defined as total JKN expenditure paid to primary healthcare facilities as a share of total JKN expenditures (available from BPJS-K administrative data).

*To measure sustainability:*

- (5) Claims ratio defined as total JKN expenditures over total contributions (available from BPJS-K administrative data);
- (6) Government expenditure on JKN defined as total government expenditure on JKN as a share of total government expenditure.

#### D. Program Description

12. **Improving JKN performance and ensuring its long-term sustainability will require reforms on both the revenue and expenditure side.** Three main results areas proposed at the concept stage and to be further elaborated during preparation will focus on addressing challenges that are integral to the JKN system, namely improving the governance and accountability of JKN, raising additional revenues for BPJS-K, and increasing value for money of JKN expenditures. However, the activities under each results area also help strengthen primary health care and leverage improvements in the health sector such as equitable access and quality care.

#### PforR Program Boundary

13. **The PforR supports the larger government program supporting JKN, including expenditures by BPJS-K, DJSN and the MOH.** It will include all relevant expenditures being incurred by these agencies for the claims being paid under the JKN Program, as well as for administrative and program monitoring purposes, as relevant to the results areas of the program.

14. **Expenditure boundaries.** The PforR expenditures include only areas needed to achieve the PDO and disbursement-linked indicators (DLIs). There is no duplication of expenditures under other World Bank operations in Indonesia such as the Investing in Early Years (INEY P164686) and ISphere (P164277) PforRs. No large contracts needing Operations Procurement Review Committee (OPRC) approval are anticipated. It is estimated that total expenditures for procurement will not exceed 10-20 percent of the Program financing. The World Bank's share of the PforR accounts for less than 2 percent of the expected expenditures under the government program over the next five years.

15. **Program duration, geographic scope, and beneficiaries.** The PforR is designed for a period of five years from July 2021 to July 2026. The scope will be nationwide, benefiting the entire population of 268 million and covering all 514 districts. The primary beneficiaries will include all persons enrolled and/or seeking health services under JKN.



16. **Implementation arrangements:** Although institutional arrangements for the PforR will require further analysis and consultation, the main counterparts for this operation are expected to be DJSN and BPJS-K, along with the MOF and the MOH.

**E. Initial Environmental and Social Screening**

17. **The overall social and environmental rating is expected to be moderate.** The overall environmental and social outcomes resulting from the proposed PforR are expected to be positive. The PforR endeavors towards achievement of the UHC through systematic reforms of JKN, addressing the program’s governance, financing sustainability and value of money. None of the activities being proposed under the Result Areas fall under the exclusion criteria contemplated under the Bank Guidance for PforR Environmental and Social Systems Assessment (ESSA).

18. **An initial screening process of the proposed PforR was carried out based on the expected indicators in the Result Areas at the Concept Stage.** Further assessment of the Gol’s program system, including any consultations required will be conducted during the Program preparation. Due to the ongoing COVID-19 outbreak, preliminary stakeholder engagement and required consultations for the purpose of the Program’s ESSA will be undertaken virtually. For the purpose of ESSA consultations, public health precautionary measures will be taken into considerations when travel restrictions and social distancing measures have been lifted.

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