Program Information Documents (PID)

Appraisal Stage | Date Prepared/Updated: 20-Mar-2018 | Report No: PIDA148665

BASIC INFORMATION

A. Basic Program Data

Country	Project ID	Program Name	Parent Project ID (if any)
Indonesia	P164277	Indonesia - Supporting Primary Healthcare Reform	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EAST ASIA AND PACIFIC	19-Mar-2018	23-May-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Program-for-Results Financing	Ministry of Finance	Ministry of Health	

Proposed Program Development Objective(s)

Strengthening the performance of Indonesia's primary health care system

COST & FINANCING

SUMMARY (USD Millions)

Government program Cost	13,826.00
Total Operation Cost	150.00
Total Program Cost	150.00
Total Financing	150.00
Financing Gap	0.00

FINANCING (USD Millions)

Total World Bank Group Financing	150.00
World Bank Lending	150.00

B. Introduction and Context

Indonesia, the fourth most populous country (~250 million) in the world, has made significant gains in economic growth and poverty reduction. Strong economic growth (5.5% per year since 2000) has been accompanied by a sustained decline in poverty rates to 31% and 6.8% of the population living on US$3.1 a day and US$1.9 a day, respectively, in 2016. Its human capital indicators also show impressive gains, with adult literacy at almost 95%, gross enrollment of 100, 83, and 32% in primary, secondary and tertiary education, respectively, and the share of female enrollment exceeding that of males at each level.

Health outcomes and outputs in Indonesia have improved in recent years with life expectancy increasing to 69 in 2015 and under-five mortality declining to 27/1,000 live births in 2015. Landmark legislation in 2004 and 2011 have helped realize a potential pathway to Universal Health Coverage (UHC). As of 2014, Indonesia has one of the largest single-payer social health insurance programs, *Jaminan Kesehatan Nasional (*JKN*)* or National Health Insurance, in the world; and is projected to reach full coverage by 2019. The JKN is administered by the *Badan Penyelenggara Jaminan Sosial (*BPJS*)* Health. At the same time, key challenges jeopardizing Indonesia economic development remain**,** including slow progress on addressing inequalities in health outcomes, especially in Eastern Indonesia. In addition, Indonesia is facing a double burden of disease, with new challenges rapidly emerging due to demographic (ageing population) and epidemiological transitions as persistent communicable diseases are met with a rising prevalence of non-communicable diseases.

The Government of Indonesia is committed to UHC but is keen to see "quality of health spending" improve as a basis for increased investments in health. One of the key pathways to improve quality of health spending is by improving the performance of primary healthcare. Some of the key issues that need to be addressed to improve the performance of primary healthcare are: (i) lack of performance monitoring and enforcing accountability in a decentralized setting, (ii) underdeveloped ability to enforce clinical and managerial standards at the facility and district level, (iii) weak performance orientation of intergovernmental fiscal transfers and *JKN.*

Sectoral and Institutional Context

The public health care system at the primary care level consists of more than 9,750 puskesmas and a network of auxiliary puskesmas, and village health posts, forming the backbone of Indonesia's health system. There are wide variations in district-level performance on health facility service readiness to provide good quality health care services, including at the primary care level. While districts in central Java had almost all puskesmas fulfill at least 80% of the readiness indicators, districts in Indonesia such as Papua and Maluku had only half of the puskesmas fulfill 80% of these indicators. Despite having attained the minimum WHO norm, Human Resources for Health (HRH) remains a key challenge for Indonesia's health sector that further impedes the ability to provide high quality services. Discrepancies between urban and rural facilities persist, with higher level of availability and readiness among urban health facilities. Many Indonesians also face significant physical and time barriers to accessing health care.

Health financing in Indonesia is marked by low public health expenditures (PHE), high out of pocket expenditures (OOPE), and a complex and fragmented intergovernmental fiscal transfer system. PHE at 1.5% of the GDP is amongst the lowest in the world and forms only 41% of the total health expenditures per capita in 2014. Government

revenue as a share of GDP is also low at 17% and PHE is only 5.3% of the national government expenditure. OOPE is very high at 46% of total health expenditures and is 1.2% of GDP. Both supply-side financing of public sector provision and demand-side financing through the JKN exists. On the supply-side financing, several intergovernmental fiscal transfer mechanisms from Ministry of Finance to local government exist: the main ones are general allocation funds (*Dana Alokasi Umum,* DAU), revenue sharing (*Dana Bagi Hasil,* DBH), and special allocation funds (*Dana Alokasi Khusus,* DAK). Multiple financing lines and conflicting regulations have strained local governments to do more integrated planning and budgeting**.** DAK is the largest conditional transfer and an important lever for the national government to influence subnational service delivery outcomes. There are two forms of DAK: DAK *fisik* is focused mainly on infrastructure, equipment and medicines; and DAK *non-fisik* finances some operational expenditures (largely for outreach, institutional delivery and facility accreditation). The Government of Indonesia (GOI) has articulated a broad commitment to making fiscal transfers more results-oriented since the release of the Blueprint for Institutional Transformation of the Directorate-General of Fiscal Balance, Ministry of Finance in 2014. For the first time, the 2018 allocation of DAK *non-fisik* takes into account "performance" elements. These performance indicators for DAK *non-fisik* can be expanded to have more direct impacts on health service delivery quality and outcomes.

The JKN, at 42 percent of the district health budget in 2015, is an underused financial lever to improve health outcomes and supply side readiness. Strategic purchasing under JKN provides an opportunity for increased efficiency and accountability in primary care service delivery. Opportunities for linking financing to performance are emerging. In 2016, the GOI implemented *Kapitasi Berbasis Komitmen* (KBK) – a capitation payment to primary health facilities that is linked to agreed performance indicators. Strengthening performance based capitation under JKN by developing an additional set of indicators would provide strong financial incentives to improve primary care performance. It is also important that the *DAK* and *JKN* performance based indicators are aligned towards a complementary set of performance improvements at the primary care level.

For improving the quality of primary health care, the MOH enacted regulation no. 46/2015 mandating the accreditation of primary health care facilities, and also establishing an Accreditation Commission for Primary Health Care Facilities *(Komisi Akreditasi Fasilitas Kesehatan Tingkat Primer* – KAFKTP*).* While accreditation by itself does not lead to improved clinical outcomes, it is an important part of a "package" of interventions that would improve primary healthcare performance. In addition to building capacity in the primary care facilities, it also provides a governance framework for the sector, directing investments, and signaling to beneficiaries and payors of managerial and clinical competence. However, for accreditation to work, the credibility of KAFKTP and its processes need to be strengthened. While the current capacity of the KAFKTP is not very strong; its vision is to expand its capacity, become fully independent, cover both the public and private sector, and eventually get accredited by the International Society for Quality in Health Care (ISQua). There are four levels of accreditation for primary healthcare and hospitals, namely *dasar, madya, utama, and paripurna*. As per MOH reports, approximately 4,200 *puskesmas* have been accredited as of December 2017, of which 30% have received *basic* and 58.5% *madya* accreditation.

Health information management in Indonesia is characterized by high fragmentation, poor compliance, weak data verification and underutilization of data for decision making. MoH's Center of Data and Information (*Pusdatin*) has developed a data application for puskesmas (SIKDA-Generic), but it is currently used in only about 10% of facilities. Another 20-30% of puskesmas use other electronic systems, with the remaining using paper-based systems. BPJS-Health collects data through two systems distinct from MOH (p-Care and e-Klaim), that are widely used (upwards of 90% coverage, both public and private providers), although only for JKN patients. Very little exists to verify the quality

(including completeness) of data and there is no system of comprehensively benchmarking performance of districts and facilities.

The use of mobile health technology can enable improved accountability of, and better service delivery from, frontline workers has been piloted but not yet a part of the government's service delivery strategy. Given the high penetration of mobile phones in Indonesia, mhealth technology is a real opportunity to strengthening frontline service delivery. The Healthy Indonesia through the Family Approach Program *(*PIS-PK*)* is a key intervention to support improved prevention and promotion, which has three objectives: (i) improving family access to a comprehensive health care package covering prevention services, health promotion, basic curative care and rehabilitation; (ii) supporting the local governments to achieve the Minimum Service Standards (MSS) by improving access to health care and health screening; and (iii) improving community awareness to become a JKN member. PIS-PK, supported by mHealth interventions, will enable more accountable and efficient frontline service delivery.

PforR Program Scope

The GOI introduced the flagship "Healthy Indonesia Program" in 2015, aimed at improving the health and nutritional status of the community through health and community empowerment efforts, backed by financial protection and the equitable distribution of health services. The Healthy Indonesia program is an umbrella program that encompasses the entire public health expenditure, through central and local governments, and was IDR 178 trillion (US$ 13.2 billion) in 2016. Conservative estimates of the Government program over a five-year period is about US$ 79.5 billion.

Health Indonesia organized around three pillars: Pillar 1 - Promoting a healthy paradigm; Pillar 2 - Strengthening healthcare services; and Pillar 3 - The national health insurance scheme (JKN). Figure 1 below visualizes the GOI health program and the PforR scope.

The World Bank PforR Program will focus on supporting key aspects of Healthy Indonesia to improve the performance and quality of primary health care nationally, with an additional focus on the three lagging provinces of East Nusa Tenggara, Maluku and Papua. The transformational impact would be sought through a set of three coordinated and converging interventions – improved accountability through improved governance and better use of data, strengthened facility performance especially through better management and primary healthcare functions (individual clinical care and community health), and performance based financing and incentives from both the supply (DAK) and demand (JKN) side.

The PforR Program will focus on supporting key aspects of the Healthy Indonesia Program to improve performance and quality of primary health care service delivery across Indonesia, with an additional focus on the three lagging provinces of Nusa Tenggara Timur, Maluku and Papua. The PforR Program will achieve transformational impact through a set of three **coordinated** and converging results areas outlined below, and illustrated in Figure 2.

- **Results area 1:** Strengthening performance monitoring for increased local government and facility accountability
- **Results area 2:** Improving implementation of national standards for greater local government and facility performance
- **Results area 3:** Enhancing performance orientation of health financing for better local service delivery

Results area 1 (strengthening performance monitoring for increased local government and facility accountability) is to improve performance monitoring and benchmarking of health care delivery, including developing and publishing

district level "performance dashboards." These performance dashboards would also be used to monitor progress made in DAK and JKN related performance indicators under results area 3. Quality of data would also be improved by enabling interoperability of key systems, introduction of verification protocols, and making electronic data systems more compliant with a standard data dictionary. It will also include introducing mHealth to enable more accountable and efficient frontline service delivery through the *PIS-PK*.

Results area 2 (improving implementation of national standards for greater local government and facility performance) will support the strengthened implementation of a quality assurance program and accreditation of *puskesmas.* This would involve supporting *puskesmas* to reach higher levels of accreditation, which are associated with more stringent clinical quality and managerial performance standards that are difficult to achieve. However, additional focus will also be given to Eastern Indonesia where *puskesmas* would be supported to achieve any level of accreditation, which would be difficult in itself. In addition, the proposed operation will support capacity building of the primary care accreditation commission and MOH by introducing better programs to drive clinical quality, community outreach, continuous quality improvement programs as well as begin to cover the private sector. The proposed operation will also support the accreditation commission to help it gain credibility by becoming independent, making its standards and results more transparent, and implementing the necessary improvements needed to get ISQua certification. This results area will also support strengthening capacity of selected lagging districts to do more data-driven planning and budgeting. These districts would be given intensive training in data driven integrated planning and budgeting to produce multi-year workplans with annual budgets that have clear financing requests from various funding sources like the DAK. To address the issue of human resource scarcity in remote areas, this results area also supports the deployment of teams and individual doctors under the *Nusantara Sehat* initiative.

Results area 3 (enhancing performance orientation of health financing for better local service delivery) supports the introduction of incentives for improved primary healthcare readiness and availability of front line health services through supply side inter-governmental fiscal transfers (*DAK non-fisik*) as well as through improved demand side purchasing of primary care (the national health insurance scheme or the *Jaminan Kesehatan Nasional – JKN).*

The Program cost over five years will be IDR 186.65 trillion (US$13.8 billion), supported by a World Bank loan of US$150 million. The Program boundaries include expenditures from relevant budget lines of the MoH's national budget (APBN), capitation and administrative expenditure of *BPJS-Health*, and *DAK non-fisik*. There are no high-value contracts to be excluded from the Program boundary.

The key development partners involved in supporting GOI's program are: the Department of Foreign Affairs and Trade (DFAT), Government of Australia; United States Agency for International Development (USAID); the Global Fund to Fight Against AIDS, TB, Malaria (The Global Fund or GFATM); and the Global Alliance for Vaccines and Immunization (Gavi). The World Health Organization (WHO) provides technical assistance to GOI in supporting various programs, including achievement of UHC. Other UN agencies (UNFPA, UNICEF and UNAIDS) also support GOI under various programs.

Figure 1. Government (Healthy Indonesia) program to PforR (I-SPHERE) Program

Government Program – *Program Indonesia Sehat* (Healthy Indonesia)		
Key health priority • **Family health (RMNCH)** • **Nutrition** • **Communicable Diseases** • **Non-Communicable Diseases**		
Pillar I: Implementing Healthy Paradigm	**Supported by PforR**	
Prevention and Promotion (PIS PK)	RA1	
Community empowerment (GERMAS)		X
Pillar II: Strengthening Health Services		
Quality of primary care	RA2	
Quality of referral care		X
HRH	RA2	
Pharmaceutical & Equipment		X
Food and Drugs Regulation		X
Pillar III: "*Jaminan Kesehatan Nasional" or JKN,* the national health insurance scheme		
Capitation	RA3	
INA CBGs		X
Non-capitation		X
Cross-cutting:		
Health Information Systems	RA1	
Management	RA2	
Health Financing	RA3	
Research and Development		X

PforR Program - I-SPHERE

Program Development Objective: Strengthening the performance of Indonesia's primary health care system.

Results Area 1: Strengthening performance monitoring for increased local government and facility accountability
- **Dashboards:** publish performance dashboards to benchmark facilities and districts
- **Data:** improve quality of reported data

Results Area 2 Improving implementation of national standards for greater local government and facility performance
- **Primary care accreditation capacity:** strengthen credibility (independence, transparency, validity of results) and capacity of accreditation commission
- **Improved facility managerial and clinical processes:** increase achievement of higher accreditation levels for *puskesmas* nationally, and any levels of accreditation for Eastern Indonesia
- **Human resources:** ensure availability in remote areas
- **Local government capacity:** Build capacity for planning, budgeting and management of health services

Results Area 3: Enhancing performance orientation of health financing for better local service delivery
- Performance oriented DAK: enhance indicators and allocation processes
- Performance oriented JKN: link primary health care capitation to performance

Total GOI program: US$79.5 billion

Total PforR Program: US$13.8 billion; WB loan: US$ 150 million

C. Proposed Program Development Objective(s)

Program Development Objective(s)

Strengthening the performance of Indonesia's primary health care system.

The key indicators to measure the accomplishment of the PDO are:

i. Districts covered in MOH's published performance dashboard;
ii. *Puskesmas* that have received higher levels of accreditation;
iii. Pregnant women delivering at a health care facility;
iv. Primary care providers that are implementing performance based JKN capitation; and,
v. Districts showing an improvement on at least half of the performance indicators in the enhanced DAK *non-fisik*.

D. Environmental and Social Effects

The potential social and environmental risks and impacts associated with the PforR are moderate, with environmental risks requiring further mitigation measures. The key environmental and social risks are likely to arise from: poor waste management; lack of, or ineffective, implementation of health and safety measures leading to impacts on patients, workers, and the public; multiple and poor complaint handling procedures; and limited training and capacity of workers in managing those risks. As the PforR is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities, there are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources, or to assets or livelihoods of people.

Only about a quarter of Indonesia's primary health care facilities meet all the criteria regarding infection prevention and waste disposal (National Report on QSDS 2016 - forthcoming), putting many health workers at risk. *Puskesmas* and private sector clinics commonly use the services of third-party professional waste management agencies for disposal of sharps-related waste, however the disposal of non-sharps medical waste is of concern, with the waste commonly being disposed of in the ground, and often uncovered. Emphasis should be given to standardizing solid and liquid waste management practices through strengthening the accreditation process.

With regards to inequalities, the inclusion of a Program focus on three Eastern Indonesia provinces with the worst health outcomes and access to healthcare recognizes national geographical disparities. This is complemented by support for medical and managerial human resources in lagging regions. The Program's support for improved community level outreach has the potential to further improve outcomes at the household level. Improved social and environmental performance will contribute to ensuring that the services to these groups are undertaken in a safe and culturally appropriate manner. The Program Action Plan incorporates actions for MOH and local governments to address any gaps in managing, avoiding, minimizing or mitigating impacts and risks. The engagement strategy aims to ensure meaningful engagement, consultations, feedback, and that any grievances (that may emerge through Program preparation) are dealt with appropriately. The ESSA will be disclosed in draft and a series of consultations at national and sub-national levels will be organized during or prior to appraisal. The final version of the ESSA will be made public in Bahasa Indonesia and English upon completion of appraisal.

Climate change amplifies public health risks in Indonesia and presents additional challenges to the health care system and the climate-vulnerable populations it serves. Climate variability and change are already exacerbating many of the disaster risks that Indonesia faces, including drought, flooding, landslides and sea level rise. These disasters directly affect the health and well-being of millions of people and can cause critical damage to public health infrastructure. The Program is focused on improving health services in remote areas of Indonesia, thus supporting these populations to access quality health care, as a climate adaptation strategy.

There are no significant gender differentials for basic health services coverage in Indonesia though there are gender specific health issues, such as maternal mortality. The program is focused on improving the quality of maternal health services nationally through the accreditation program, and increasing institutional deliveries for pregnant women, specifically in the three provinces in Eastern Indonesia.

Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

E. Financing

Program Financing

Sources	Amount (USD Million)	% of Total
Counterpart Funding	**13,676.00**	**98.92**
Borrower	13,676.00	98.92
International Bank for Reconstruction and Development (IBRD)	**150.00**	**1.08**
Total Program Financing	**13826.00**	

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