Indonesia:
Strategic purchasing strategies and emerging results
SELAMAT DATANG DI INDONESIA

- Indonesia is the largest archipelago in the world. Over 16,000 islands make up this diverse nation, but only 10,59% of them are inhabited.
- Indonesia is the fourth most populous country in the world, and its population is expected to keep growing (1.1% annually).
- The country is facing a double-burden of communicable and non-communicable diseases.
- Although GDP is increasing (5.02% annually) up to 2019, many Indonesians still live below the poverty line (2.7% of the total population). However, due to COVID, GDP in 2020 is rapidly decreasing (-2.07).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total population (million)</td>
<td>273.5</td>
</tr>
<tr>
<td>Population growth (annual %)</td>
<td>1.1</td>
</tr>
<tr>
<td>Urban/Rural divide (% of pop.)</td>
<td>57/43</td>
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<tr>
<td>Population ages 0-14 (% of total)</td>
<td>25.9</td>
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<tr>
<td>Population ages 15-64 (% of total)</td>
<td>67.8</td>
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<tr>
<td>Population ages 65 and above (% of total)</td>
<td>6.3</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>71.7</td>
</tr>
<tr>
<td>GDP growth (annual %) 2020, 2019</td>
<td>-2.07, 5.02</td>
</tr>
<tr>
<td>GDP per capita, PPP (current international $)</td>
<td>12,072.7</td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.90 USD/day (% of population) (2019)</td>
<td>2.7</td>
</tr>
<tr>
<td>Human Development Index Rank (2019)</td>
<td>107 (out of 189)</td>
</tr>
</tbody>
</table>

Sources: World Bank Development Indicators 2020; UNDP 2020; Ministry of Marine Affairs and Fisheries, 2019.
The modern contraceptive prevalence rate (mCPR) has increased from 5% in the early 1970s to 57% in 2002, and mCPR has not changed in the 15 ensuing years.

The unmet need among married women is still at 13.8%.

Due to many milestones having been met, there is a risk that local stakeholders no longer view FP as a health priority even though many FP indicators have not continued to improve.

Sources: IDHS 2017; Family Planning 2020
Among the modern methods, injectables and oral contraceptives are the two most popular FP options.

Similar to maternal, newborn, and child health (MNCH), a large proportion of women access FP services from the private sector.

Modern Contraceptive Method Mix in Indonesia

- LAM: 0.2%
- Sterilization (female): 6.8%
- Condom (male): 4.4%
- Pill: 21.1%
- Implant: 8.2%
- Injectable: 50.6%

Source: Family Planning, 2020
LAM = Lactational Amenorrhea Method
IUD = Intrauterine Device

Percent distribution of current users of modern methods age 15-49 by most recent source of method

- Private sector: 48%
- Public sector: 34%
- Other sources: 18%

Source: IDHS, 2017
While neonatal, infant, and under-5 mortality have reduced significantly over the last 20 years, the maternal mortality ratio (MMR) remains stubbornly high.

- Indonesia did not reach the Millennium Development Goal for maternal health. The maternal mortality ratio in Indonesia is high compared to other countries in the region.
- This is in the face of high coverage rates for most MNCH services, including antenatal care (ANC) visits and skilled birth attendance (SBA). For example, 94.7% of births are assisted by a skilled birth attendant (BPS, 2018).

The Minister of Health recently released a directive to accelerate the decline of MMR and infant mortality rate (IMR) in the effort to achieve national (National Mid-term Development Plan - 9.5%) and global targets (Sustainable Development Goals - 5.5%).

**Trends and Future Target in MMR**


**Trends and Future Target in IMR**

Source: Indonesian Demographic and Health Survey Series 2002 - 2017

*ARR: Annual Reduction Rate*
PRIVATE PROVIDERS, PARTICULARLY MIDWIVES, ACCOUNT FOR A LARGE PROPORTION OF MNCH SERVICE PROVISION

Distribution of ANC by type of health personnel (%)

- Midwives, 51.9%
- OB-GYN, 27.8%
- Village Midwives, 15.2%
- Nurse, 1.2%
- Traditional Birth Attendant, 0.4%
- No ANC, 1.8%

Source: IDHS, 2017

Percentage of deliveries by provider type and wealth quintile

Source: IDHS, 2017
Jaminan Kesehatan Nasional (JKN) is a single-payer scheme managed by the Social Insurance Administering Body for Health (BPJS-K).
Contributions by the different types of members (PBI/poor & vulnerable people, formal, and informal workers) are pooled by BPJS-K.
JKN has a tiered referral system to provide health services for members, including primary, secondary, and tertiary care.
JKN applies capitation and non-capitation for primary health care (PHC), while higher levels of care use case base groups (CBGs).

Diagram of fund and service flows under JKN

- Formal Workers
- Informal Workers
- Poor (PBI)
- Central Government
- Ministry of Health
- Local Government
- National Social Security Council (DJSN) Oversight

5% Wage, IDR 12 million max
3 options on service class

5% Wage, IDR 12 million max
PBI (National)
PBI (Local)
Allocation (BAU & Cigarette Tax)
Gov’t allocation
DAK
PROPORTION OF HEALTH EXPENDITURE FROM JKN INCREASING, BUT OUT-OF-POCKET (OOP) STILL HIGH

Source: PPJK- NHA Dissemination 2019, on 21 October 2021
Indonesia decentralized nearly two decades ago, transferring the planning, management, and some financial responsibilities for health to the provincial and district government levels.

Private providers at the PHC and referral levels are a significant source of health services. The proportion of private providers in the health system has grown rapidly since the introduction of JKN in 2014. By the end of 2020, 30,251 health facilities have been registered with JKN.

However, the referral system is weak and uncoordinated both horizontally (e.g., public to private providers) and vertically (e.g., PHC to referral levels).

### PHC Facilities Registered in JKN by Type of Facilities, 2016-2020

- Puskesmas
- Pratama Private Clinic
- Private GP
- Dentist Clinic
- Military Clinic
- Police Clinic
- Pratama Hospital Class D

### Referral Hospitals Registered in JKN by Type of Facilities, 2016-2020

- Central Govt Hospital
- Local Govt Hospital
- Private Hospital

Source: BPJS Kesehatan, 2016-2020
Since 2014, BPJS-K has recorded a total deficit of 25 trillion

- In 2020, the surplus was caused by a decrease in visitations (thus in claims too), while the contribution increased by 27%

The number of visitations increased by almost 300% from 2014 to 2019

- The number of JKN members increased steadily at 10% per year

- 60% of JKN members come from the PBI segment (subsidized group for the poor), which has increased by 7% per year

Source: BPJS Kesehatan, 2014-2020
Support making purchasing of MNCH services more effective and equitable
- Conducted a landscaping assessment to understand barriers to PHC providers joining JKN and providing quality services
- Collaborating with the MNCH Technical Working Group (TWG), led by the MoH, to test policies that offer a stronger value proposition to PHC providers to join JKN and work within a service delivery network
- Conducting analyses to understand JKN’s impact on MNCH services and potential policy reforms of the JKN benefits package

Helping to make district purchasing from PHC providers more efficient
- Helping these districts address the pain points identified, including analyzing the relationship between supply side readiness and JKN coverage at the district level
- To increase PHC service delivery, in collaboration with MoH, SP4PHC is working with the district health office to evaluate the public health indicators reflected in the healthy family index, and design the strategy for JKN member redistribution from public PHC to private PHC

Supporting a rethinking of how FP services are purchased
- Working with the Universitas of Gadjah Mada (UGM) to map how FP funds flow from source to provision.
- Analyzing the relationship between OOP payments and JKN enrollment status, with key control variables like SES and geography
- Using these to contribute to ongoing discussions on JKN reforms & COVID, such as providing inputs into how BKKBN, MoH, and BPJS align their purchasing arrangements for FP and demonstrating the role of the private sector in the purchasing of FP

Aligning purchasing in the time of COVID-19
- The government needs critical inputs to grapple with the new priorities and challenges that the virus presents to its system, including:
  - Clarifying how funds flow to frontline providers for COVID-19 and how purchasing of essential services was revised and affected
  - Demonstrating how PFM challenges related to budget refocusing and reallocation had an impact at the subnational levels
  - How COVID services will be purchased in steady state (by JKN), not just in crisis response
- Consistent documentation to capture learnings and inform policy reforms to deal with future pandemics and make the system more resilient

Strengthening JKN as the main purchaser
- Provided strategic facilitation of reform discussions led by the Center for Health Financing and Decentralization Policy (PKPDK) on how to make JKN more sustainable.
- This included cost-benefit analyses for potential inclusion or exclusion of services (e.g., MNCH screening and immunizations), scoping around a possible redistribution of JKN members from public to private PHC facilities, and hosting over a dozen meetings for stakeholders to discuss the reforms.
ThinkWell provides TA to the MoH’s MNH strategic purchasing pilot that offers private midwives a greater value proposition for joining JKN.

- Partnering with the MOH and USAID Health Financing Activity (HFA) for this pilot
- Completed budget impact analysis that estimated the cost of the pilot interventions and the potential cost-savings to the government
- Pilot aims to network midwives and local PHC facilities together as a unit
- BPJS-K then pays the unit, using strategic purchasing mechanisms to incentivize more utilization and higher quality from the integrated unit
- Local midwife association, IBI, provides ongoing testing and supervision for midwives in the PHC unit
- Pilot implementation will be conducted by HFA and the MNH TWG
ThinkWell also conducted a Budget Impact Analysis (BIA) to estimate the cost of the pilot intervention and potential cost-savings to the government.

- Partnering with the MOH, the World Bank, and USAID Health Financing Activity (HFA) for agreed numbers and assumptions used in the estimation
- Focus on the pilot intervention in certain pilot area (3 sub-districts at Serang District, Banten Province)
- Modeling using BPJS-K as the purchaser of MNH services in JKN
- This work was presented to and was well-received by the key relevant stakeholders.
- The team also conducted capacity-building workshops with PPJK-MOH staff, so they could do this type of analysis in the future
ANALYSIS OF THE GAP BETWEEN MNH UTILIZATION AND JKN CLAIMS

- **Objective**: quantify the gap between MNH service use and claims to JKN and better understand the reasons for this gap and how to lessen it
- Analyzed this for antenatal care (ANC), deliveries, and postnatal care (PNC)
- The smallest gap is for deliveries (38%), whereas the gap for ANC is 65%, and PNC is 84%.
  - This may be due to women largely accessing ANC at private midwives who are largely not contracted by JKN and using traditional methods at home for PNC
- Utilization gap is also higher in the east compared to the West due to lack of facilities and resources
- This study will be published as a policy brief in early 2022
The study aims to map the capability of districts/cities in providing Puskesmas BEmONC and hospital CEmONC.

Indonesia has been experiencing persistently high maternal and neonatal death.

- Indonesia's MMR and NMR remain high, with 359 per 100,000 live births in 2015 and 24 per 1,000 live births in 2017, respectively.

The capability assessment was conducted based on the readiness of infrastructure and human resources for health within each Puskesmas and hospital.

- MoH guidelines about Puskesmas BEmONC and hospital CEmONC were used to develop composite indicators for the capability assessment.
- The study used official data/reports from MOH.

Districts/cities with at least one hospital CEmONC and no less than 4 Puskesmas BEmONC were identified as capable/qualified.

This study is being prepared for journal submission by June 2022.
COLLABORATION WITH WHO: DEVOLUTION CASE STUDY IN INDONESIA

- Two overlapping systems for health financing and service delivery: vertical programs and JKN
- Decentralization gave sub-national governments autonomy
  - Power to raise funds and spend them based on local priorities
  - Relationship among levels (provincial, district, village) not hierarchical
- Decentralization has not improved health spending
  - 34.6% of current health expenditure was OOP health spending
  - District-level budgetary commitment for health ranged from 3% to 18% in 2013
- Decentralization has not improved regional inequality
  - Some intergovernmental transfers for health investments require co-financing
  - Health workforce not equally distributed, private providers not incentivized to join JKN

Source: Mahendradhata et al., 2017
Note: Continuous line denotes line of authority; Dotted line represents technical supervision role
Our objective was to estimate how a province’s JKN coverage rates and supply-side readiness effects household OOP health expenditure. Analyze how the combination of both influences OOP within the different provinces, not just at the national level.

Used 2018 and 2019 data from Indonesia’s National Socioeconomic Survey (Susenas).

Our study found that provinces with high JKN membership and stronger readiness show larger reductions in household OOP. Lots of variation under the national surface. Health systems infrastructure is especially weak in the East. Urban centers drive private sector growth and readiness. Private providers need to be contracted under JKN to ensure financial protection. Less OOP is seen in the East, where there are fewer private providers but little choice.

A brief has been published on our website here.
DISTRICT-LEVEL INNOVATION ON MNH SERVICES

- At the request of the Directorate Family Health at the MOH, the team qualitatively examined district-level innovations that addressed maternal and neonatal mortality with a focus on health financing.

- Data were collected via 31 FGDs about regulation, funding, and implementation processes on district-level innovations across eight districts in November 2021.

**Results:**

- There is high variation in each district’s innovations, from the expansion of service for maternity waiting homes to periodical obstetrician shift in public primary healthcare centers. In line with various innovations, multiple funding sources were identified, including Regional Budget, Special Autonomy Fund, National Health Allocation Fund, and Corporate Social Responsibility/Philanthropy.

- Potential barriers identified are lack of sustained budget allocation, pandemic-related disruptions, and many innovations that are not evidence-based.

- This study is a pilot for future studies on district-level health financing-specific innovations. A brief of this study will be completed in June 2022.
Our research objective was to estimate the effect JKN enrolment has on OOP expenditure for FP by method, health provider, and economic status. Findings will be shared with MOH, BKKBN, and other government stakeholders to inform decision-making around the JKN benefits package reform.

Used 2017 data from the Indonesian Demographic and Health Survey (IDHS).

Conducted a cross-sectional regression analysis with propensity score matching method.

JKN members experience significant cost savings for short-acting methods at public PHCs (-26%), for LARCs at public hospitals (-26%), and short-acting methods at private midwives (-0.5%).

Private midwives may play a role in reducing OOP, but cost-saving is relatively small because only a limited number joined the JKN network.

PBI members pay less OOP for long-acting methods (-22% compared to poor uninsured), in contrast with non-PBI members who pay less OOP for short-acting methods (-2% compared to non-poor uninsured).
FAMILY PLANNING (FP) FUND FLOW MAPPING

- Mapped how funds flow through the Indonesian health system for FP. This work was subcontracted to the Center for Reproductive Health of Universitas Gadjah Mada (UGM).

- As FP in Indonesia comprises of population control, reproductive health, and family welfare programs, it is difficult to single out a budget that specifically addresses FP.

- There were three main ministries responsible for FP financing in Indonesia, namely the National Population and Family Planning Agency (BKKBN) [35.76%], the Ministry of Finance [26.19%], and the Ministry of Health (MOH) [2.00%].

- Most funding comes from the national budget (65.41%), with out-of-pocket (OOP) payments (34.58%) making up the rest.

- 57.26% of FP spending was at public facilities and 28.62% at private facilities.

- JKN only contributed a sliver at 0.37% of total FP spending.
  - JKN is only responsible for FP service claims
  - All FP supply chain, advocacy & education, and monitoring & evaluation are covered by BKKBN
Even after JKN started in 2014, mCPR and postpartum family planning (PPFP) trends have not improved.

Although included in the benefits package, there are still regulation issues that hinder contraceptive use.
- All contraceptive procedures must be done at the PHC level, except for sterilization.
- Referrals are required to perform the procedures at the hospital level. Otherwise, JKN could not cover it.
- Medical indication is needed to obtain the service
- PPFP payment is bundled with the caesarean operation; thus, providers are not encouraged to offer the service after delivery

Conducted qualitative study in 6 provinces to confirm and address these issues, taking into account regional differences, and LARCs as well as PPFP take-ups.

- Local regulation, health workers, and health facilities’ capacities vary between provinces, which all affect the supply side of the system.
- Local beliefs and myths also play a role in the demand side for contraceptives.
- This study is being prepared as a policy brief and will be submitted to a journal publication.
COVID’S IMPACT ON ESSENTIAL SERVICES

- In collaboration with the Vice President’s Office of the Government of Indonesia (GOI), ThinkWell conducted this study between April – August 2020 to
  - Analyze how the central government provided technical and budget guidance to maintain routine essential services (FP, MNCH, nutrition, and immunizations);
  - Understand the challenges district health officials faced when implementing the new guidelines; and
  - Develop policy options to mitigate the impact of accessing these essential services

- The team conducted 28 focus group discussions with key stakeholders and analyzed budget and utilization data for four provinces and eight districts

- Our study found that several districts did not have the capacity to revise their budgets and submit them to the central government accurately and quickly, which
  - Led to delays in fund disbursements from central government to district-level government and providers
  - Affected how PHC providers delivered services (i.e., task shifting of frontline workers)

![Percentage budget change per essential service, across sampled districts](attachment:image)

Note: DKI = Special Capital Region; 2 districts removed due to data issues; FP could not be separated from MNCH
COVID’S IMPACT ON ESSENTIAL SERVICES (CONT.)

- Disseminated study results on how the financial flows for essential services (FP, MNCH, nutrition, and immunizations) were impacted by the government’s COVID-19 response
- Shared final report with government officials
- Presented at the Indonesian Public Health Association’s National Conference on Reproductive Health and a summary of the event can be found [here](#)
  - How Family Planning Services Responded to the COVID-19 Pandemic: Case Studies in 8 Districts in Indonesia (selected as top ten best conference submissions)
  - Sustainability of Private Midwife Services during the COVID-19 Pandemic: Case Studies in 8 Districts in Indonesia (selected as top ten best conference submissions)
  - Snapshot of Nutrition Service Adaptation and Innovation during the COVID-19 Pandemic: Case Studies in 8 Districts in Indonesia
- A brief summarizing key findings published on our website [here](#)
At the request of the Vice President’s Office, Former Country Director Ibu Becky helped the government assess the need for hospital medical supplies in high-risk areas and liaised with private medical suppliers to procure them. This was completed in March 2020 as part of the government’s initial COVID-19 response efforts.

Our team continues to document how the COVID-19 response changed purchasing and funding flows in Indonesia to share lessons learned locally and internationally.

- Published blogs in October and December 2020 on the Social Health Protection Network (P4H) on how MOH and BPJS-K leveraged their purchasing strengths to coordinate their COVID response and its effects on local hospitals.

Leveraging the strengths of a mixed purchasing system for COVID-19: a perspective from Indonesia
In collaboration with the Vice President's Office, ThinkWell reviewed how COVID-19 policies were implemented in health facilities.

- MOH pays for the cost of hospital care for COVID-19 patients but claims management and verification are assigned to BPJSK.
- Qualitative data collection was conducted through a series of in-depth interviews with 15 stakeholders as informants at national and subnational levels during May – June 2021.
- The result has been disseminated to MOH & related stakeholders at national and sub-national levels, and has been part of the evidence used to determine the Case-based payment (INA-CBGs) rate for COVID-19 cases.

<table>
<thead>
<tr>
<th>Lessons Learned</th>
<th>Recommendation</th>
<th>Strategy 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy</td>
<td>Ministry of Health</td>
<td>Rapid response in adjusting SPO to the latest policy amendments</td>
</tr>
<tr>
<td>Frequent amendments of policy might pose challenges for hospitals, TPKD, and BPJS-K in interpretation and implementation.</td>
<td>Intensive socialization and strict monitoring are required.</td>
<td>BPJS-K</td>
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<tr>
<td>Technical Coordination</td>
<td>Strict monitoring and evaluation of P/DHO and TPKD roles are required.</td>
<td>Routine coordination with Ministry of Health and hospitals for BPJS-K branch office.</td>
</tr>
<tr>
<td>Human Resources &amp; Infrastructure</td>
<td>Recruitment of human resources as contact persons and PIC for dispute claim settlement process.</td>
<td>Routine coordination with MOH, BPJS-K, and P/DHO</td>
</tr>
<tr>
<td>Adjustment of the number and capacity of human resources at hospital and verifiers at BPJS-K branch offices, as well as other supporting infrastructure, is needed.</td>
<td>• Strengthening of verifiers’ capacity</td>
<td>Hospital</td>
</tr>
<tr>
<td>Claim Submission &amp; Verification</td>
<td>As simplification of supporting documents has been authorized following the KMK 5673, intensive monitoring and evaluation are required.</td>
<td>• Strengthening of administrators’ capacity</td>
</tr>
<tr>
<td>Cost-per-day required complex and rigid paperwork which increased complexity and required time for claim submission and verification.</td>
<td>As simplification of supporting documents has been authorized following the KMK 5673, verifiers will need to adjust with the new regulation.</td>
<td>• Anticipation for surge of cases</td>
</tr>
<tr>
<td>Claim Dispute</td>
<td>The implementation of routinely integrated socialization between hospitals and BPJS-K branch offices</td>
<td>Rapid response in adjusting SPO to the latest regulation and mechanism, as well as intensive socialization to the health workers</td>
</tr>
<tr>
<td>Varied understanding of the insurance criteria.</td>
<td>Strengthening of internal claim review/verification prior to submission</td>
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HOSPITAL CLAIM MANAGEMENT OF COVID-19 PATIENTS
BASIC HEALTH NEED (KDK) REFORM IN JKN BENEFIT PACKAGE

- To ensure the sustainability of the JKN scheme, the MoH initiated a review of the JKN benefits package in 2021
  - How it can be reformed while maintaining coverage for an essential set of services (called Basic Health Needs).

- Our team was deeply involved in this policy reform process through the following activities:
  - Conducted budget and cost-benefit analyses for potential inclusion or exclusion of services (e.g., MNH screening, immunizations, stunting, and 14 diseases screenings)
  - Scoping around a possible redistribution of JKN members from public to private primary healthcare facilities
  - Hosting over a dozen meetings for stakeholders to discuss the reforms
  - Co-developing an academic paper with the Government of Indonesia and will produce an implementation research policy process brief in early 2022.
ANALYZING JKN’S EFFECT ON OOP HEALTH EXPENDITURE

- **Objective:** estimate the effect JKN membership has on household OOP health expenditure, especially among the poor and rural, at a range of health facilities
  - Analyze if JKN is achieving its universal health care goal of financial protection
- **Used 2018 and 2019 data from Indonesia’s National Socioeconomic Survey (Susenas)**
  - 2018 Susenas was the first iteration that collected information on households’ OOP health spending
- **Conducted a pooled regression analysis at the household level using a Two-Part Model (2 PM), with the specification of a logit model in the first part and a Generalized Linear Model (GLM) with gamma error distribution and a log link function in the second part.**
- **Found JKN membership is associated with a reduction in household OOP for health and the association is statistically significant**
  - On average, households with JKN had lower OOP health spending (39%) when compared to households without insurance. The cost-savings are slightly higher for households in rural areas (40%) when compared to urban areas (38%)
  - JKN seems to have a pro-poor effect, as poorer members are far less likely to incur any OOP payments when obtaining health care than their uninsured counterparts
  - JKN members save more at public primary health care facilities vs. private ones (who often do not contract with JKN) and also save significantly more (over 50%) than uninsured households at both public and private hospitals
  - The manuscript was submitted to Plos Global Health Journal (being reviewed) in June 2021
SHIFTING THE JAMPER SAL FUND FLOW FOR MATERNAL HEALTH TO JKN

- Jampersal is a mechanism that transfers funds from the MoH to DHOs to fund maternity waiting homes, transportation costs, MNH costs for those who are without insurance

- **Challenge:** many districts and health facilities overuse Jampersal rather than filing claims to JKN because of the administrative ease and quicker reimbursement

- **Starting from 2022, MoH is going to integrate Jampersal into JKN**
  - MoH would transfer the costs directly to health facilities. That way, the fund is pooled at the central level, and would avoid districts’ over/under-using the fund
  - The budget for this is Rp 800 billion for 2022
  - Implemented in two steps process:
    - 2022: JKN acts as a verifier of Jampersal reimbursement process
    - 2023: Full integration between Jampersal fund and JKN

- **ThinkWell is conducting a qualitative study with district stakeholders regarding this change. Several issues were identified:**
  - There are still citizens who do not have ID cards. Thus, it may be difficult to verify their insurance enrolment.
  - Not all complications will be covered by this integration. Thus, there will be moral hazard among health facilities.

- **Once the policy is in place, ThinkWell will conduct additional interviews with key national stakeholders.** This study will be published as a policy brief and will inform further policy roll-out in 2023
Pivoting to the Pandemic

As the COVID-19 pandemic rapidly spread around the world in 2020, the SP4PHC project pivoted to incorporate activities to respond to the crisis even as it continued to work towards its original mission.

In all five project countries, ThinkWell staff responded to government requests for support and more information on our COVID-related activities and learnings can be found here.

To stay updated on all the latest insights and events from the SP4PHC team, visit our Latest News page.
MODELS OF TECHNICAL ASSISTANCE

The topic study relates to current Gov. Priority Program; Study requires MOH or other institutions’ points of view to enrich the substantial analysis

(+) Strengthening Institute partnership with the Government; Allows for better knowledge sharing between the TW team and GOI; Establishes partnership that enables new opportunities; Comprehensive side-by-side analysis and capacity building

(-) Time management will purely depend on the stakeholder agenda; The final product belongs to both GOI and Institute

The study supports MOH Health System Transformation

(+) The result could be implemented as a new regulation; directly feeds the policy process

(-) A collaboration product between Institute and The Reformation Team, which could not be claimed

The topic study is independent and mostly emphasizes secondary data analysis

(+) Quality and punctuality can be controlled by Institute; Final product belongs to Institute

(-) Depends on the team member(s) that have the right qualification and technical expertise

The study requires massive resources/personnel. The topic study relates to certain Institute professional expertise

(+) Choose Subcon who is reliable and offers expertise that the team does not have; investment in local learning partner

(-) Punctuality (time-management) issues; Limited supporting role; Final product often owned by a subcontractor
Learning products completed:

Publications:
1. Bringing private midwives into Indonesia’s National Health Insurance Scheme: Brief
2. Bringing Private Midwives into Indonesia’s National Health Insurance Scheme: A Landscape Analysis
3. Maintaining essential services during the COVID-19 pandemic in Indonesia
4. Capturing Adjustment and Innovation of Nutrition Services Program during COVID-19 Pandemic: Case Study at 8 Cities/Districts in Indonesia
5. Continuation of Private Midwifery Practices (PMPs) during COVID-19 Pandemic in 8 Districts/Cities across Indonesia
6. How JKN coverage and supply-side readiness influence out-of-pocket payment across Indonesia
7. How does family planning service respond to COVID-19 pandemic in Indonesia: a case study in 8 districts/cities May – June 2020
8. Country Factsheet: Indonesia 2020

Blogs:
1. Public Financial Management (PFM) in a Pandemic: What Can the Experiences of Bangladesh and Indonesia During Their COVID-19 Response Teach Us About the Importance of PFM?
2. Presenting Research at the Annual Scientific Forum of the Indonesian Public Health Association
3. Leveraging the strengths of a mixed purchasing system for Covid-19: a perspective from Indonesia
4. The Puzzle of Indonesia’s Midwives and Health Insurance
5. Challenges Faced in Purchasing Family Planning and Maternal, Newborn and Child Health Services in Indonesia, Kenya and the Philippines
6. How JKN coverage and supply-side readiness influence out-of-pocket (OOP) payments by vulnerable populations in Indonesia (under review in Plos Global)
7. The effect of Jaminan Kesehatan Nasional (JKN) coverage on paying out-of-pocket for family planning services in Indonesia (under review in Studies in Family Planning)
8. Utilization gap of MNH service within the JKN population
9. Exploring District-level Innovations to Address Maternal & Neonatal Mortality in Indonesia: A Qualitative Study
10. Assessing gatekeeping function with the utilization of primary care-level diseases
11. Implementation of FP in JKN: Stakeholders perspective
13. Stratification of Districts’ Health Facilities Readiness for Maternal and Neonatal Health Services
14. Shifting Jamipersal's cost of delivery to JKN
15. Exploring Variety of Technical Assistance Models Provided to Government of Indonesia: Lessons Learned in Phase 1 of Indonesia SP4PHC Project
16. Updated Country Factsheet

Upcoming learning products:
1. Journal article – How Jaminan Kesehatan Nasional (JKN) coverage influences out-of-pocket (OOP) payments by vulnerable populations in Indonesia
2. Journal article – The effect of Jaminan Kesehatan Nasional (JKN) coverage on paying out-of-pocket for family planning services in Indonesia
3. Policy brief – Utilization gap of MNH service within the JKN population
5. Journal article – Assessing gatekeeping function with the utilization of primary care-level diseases
6. Policy paper – Implementation of FP in JKN
8. Journal article – Stratification of Districts’ Health Facilities Readiness for Maternal and Neonatal Health Services
9. Policy Paper – Shifting Jamipersal’s cost of delivery to JKN
10. Blog - Exploring Variety of Technical Assistance Models Provided to Government of Indonesia: Lessons Learned in Phase 1 of Indonesia SP4PHC Project
11. Updated Country Factsheet
FINAL REFLECTIONS: SP4PHC’s CONTRIBUTION

Against the backdrop of COVID-19 and JKN reforms, provide support and targeted analytics on how the purchasing system in Indonesia can ensure effective coverage of the most vulnerable populations while maintaining long-term sustainability. Documenting the policy processes taken by the Government in dealing with COVID-19, especially in hospital claim management and public financial management at the national and subnational levels.

Former lead in the Minister of Health’s office aiding in tying support and analytics to the government’s latest purchasing priorities, including making district purchasing of PHC services more efficient and infuse evidence into JKN policy reform discussions.

Support multiple government agencies as they implement policy reforms around FP and MNH purchasing, especially around how to crowd-in and incentivize the often-used private sector to improve quality and facilitate integration into provider networks, as well as Jampersal integration into JKN program to increase access to MNH services.
Thank you

https://thinkwell.global/projects/sp4phc/indonesia/