LESSONS FROM INDONESIA'S STRIDES TOWARDS UNIVERSAL HEALTH COVERAGE OVER THE LAST DECADE

RGHI Rotterdam Global Health Initiative

Kemenkes

WORLD BANK GROUP

IHEA Pre-conference Bali · July 20, 2025

SUPPORTED BY

Australian Government
Department of Foreign Affairs and Trade

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Erasmus University Rotterdam

FUNDED BY
NIHR | National Institute for Health and Care Research

UK International Development
Partnership | Progress | Prosperity

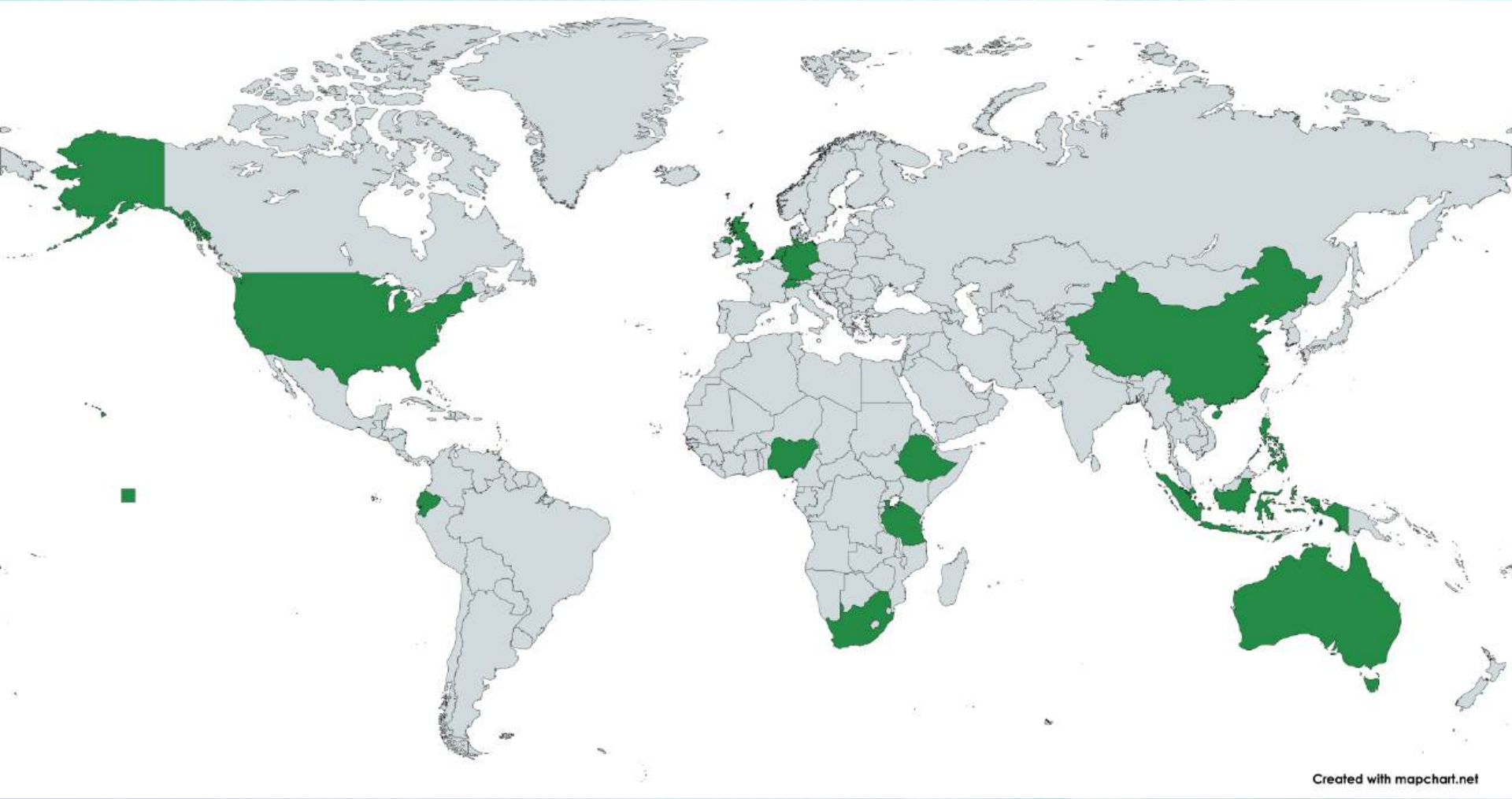
UNIVERSITAS INDONESIA

UNIVERSITAS GADJAH MADA

Opening

Welcome and goals of the day

Igna Bonfrer, Ph.D.
Associate Professor Global Health Economics, Erasmus University Director Rotterdam Global Health Initiative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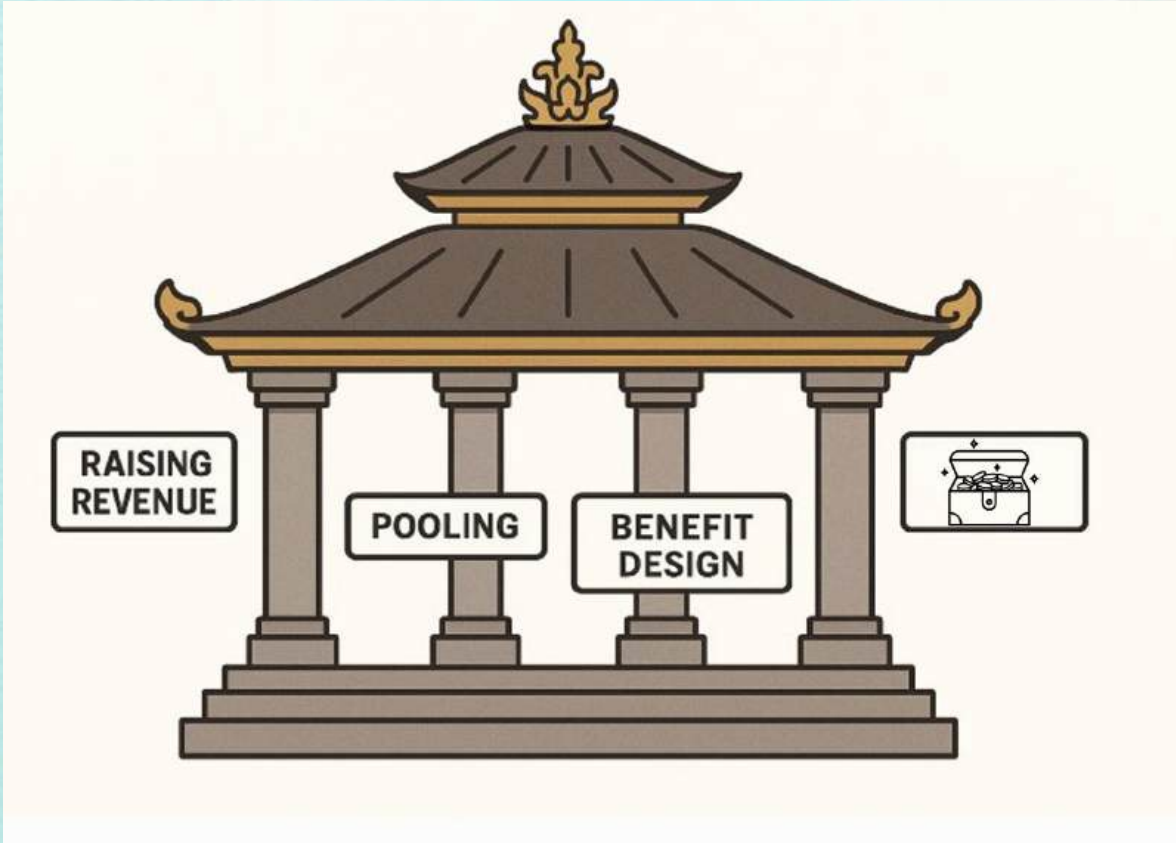
GOALS



GOALS

Mentimeter

ENJOY

PRACTICALITIES

OPENING

Prastuti Soewondo

Senior Advisor to the Minister of Health

Asnawi Abdullah

Director General of Health Policy Agency,
Ministry of Health

Ali Ghufron Mukti

President Director of BPJS Kesehatan,
Indonesia's Social Security
Administrator for Health

Igna Bonfrer

Associate Professor Global Health Economics,
Erasmus University Rotterdam
Director Rotterdam Global Health Initiative

QUALITY IMPROVEMENTS

Somil Nagpal

Lead Health Specialist, World Bank Indonesia

Roy Himawan

Director of Primary Health Care Service Governance, Ministry of Health

Nadhila Adani

Economist, World Bank

Imran Pambudi

Acting Director of Primary Health Care Facilities and Service Quality, Ministry of Health

Dan Han

Assistant Professor, National University of Singapore, World Bank consultant

Amalia Hasnida

Researcher, Erasmus University Rotterdam

PROVIDER PAYMENT

Prastuti Soewondo

Senior Advisor to the Minister of Health

Riris Dian Hardiani

Head of Working Team for DRG and Casemix, Ministry of Health Indonesia

Atik Nurwahyuni

INA-Grouper Team member, Ministry of Health Indonesia, CHEPS Faculty of Public Health Universtas Indonesia

Ahmad Irsan Moeis

Head of Centre of Health Financing, Ministry of Health Indonesia

PANELISTS

Prastuti Soewondo

Senior Advisor to the Minister of Health

Lily Kresnowati

Director of Health Service Assurance, BPJS

Patrick Mullen

Lead Health Specialist, World Bank Indonesia

RESEARCHERS

Igna Bonfrer

Associate Professor Global Health Economics, Erasmus University Rotterdam
Director Rotterdam Global Health Initiative

Margarita de Vries Mecheva

Erasmus University Rotterdam

Novat P Sambodo

Universitas Gadjah Mada

Relmbuss Fanda

Universitas Gadjah Mada and Erasmus University Rotterdam

CLOSING

BUDI GUNADI SADIKIN

INDONESIA'S MINISTER OF HEALTH

PROGRAM

Indonesia's health system reform over the last decade:

-Prof. Asnawi Abdullah, Ph.D. Director General of Health Policy Agency, Ministry of Health

-Prastuti Soewondo, S.E., M.P.H., Ph.D. Senior Advisor to the Minister of Health

A decade of Indonesia's JKN

-Prof. dr. Ali Ghufron Mukti, M.Sc, PhD, President Director of BPJS Kesehatan

Questions from the audience

Refreshment break 10:00 – 10:30

Quality improvements

Lunch break 12:00 –13:00

Provider payment

Refreshment break 14:30-15:00

Researcher perspectives on innovations in Indonesia's health care

Introduction of the Minister of Health of Indonesia

Closing keynote address: Mr. Budi Gunadi Sadikin, His Excellency, Minister of Health of Indonesia

Valedictory remarks by organizers

Indonesia’s health system reform over the last decade

Prof. Asnawi Abdullah, Ph.D. Director General of Health Policy Agency, Ministry of Health

Prastuti Soewondo, S.E., M.P.H., Ph.D - Senior Advisor to the Minister of Health

A decade of Indonesia's National Health Insurance (Jaminan Kesehatan Nasional /JKN)

Prof. dr. Ali Ghufron Mukti, M.Sc., Ph.D., AAK
President Director of BPJS Kesehatan, Indonesia's Social Security Administrator for Health

BPJS Kesehatan
Badan Penyelenggara Jaminan Sosial

A DECADE OF INDONESIA'S NATIONAL HEALTH INSURANCE: *JAMINAN KESEHATAN NASIONAL* (JKN)

Indonesia's Experience

Prof. dr. Ghufron Mukti, M.Sc., Ph.D., AAK.

President Director Of BPJS Kesehatan

IHEA PRE-CONGRESS SESSION
BALI, JULY 20, 2025

BPJS Kesehatan
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THE JOURNEY OF SOCIAL HEALTH SECURITY IN INDONESIA

For four decades (1968-2005), social security covered a small part of the society and was still unable to provide equal and appropriate protection to its beneficiaries

1968
Establishment of BPDPK (1968)
Civil servants, retirees, and family
Pre-independence: reimbursement for Dutch officials
Post-Independence: Tax-Funded, fee-for-service

1977
BPDPK → PERUM HUSADA BAKTI (PHB)
Establishment of labor insurance

1984
PHB → PT. ASKES
Civil servants, retirees, veterans, and family members

1992
Labor insurance → PT. JAMSOSTEK

2004
Social Security Law No. 40 Year 2004
Commercial insurance for private sector

2005
2008 Social health insurance for the poor
Covers members of PT Askes + health insurance for the poor (60 million) + sub-national health insurance

2011
BPJS Law No. 24 Year 2011
Integrating 5 different health insurance schemes into a single pool
Coverage of 121.6 million

2014
PT. ASKES → BPJS KESEHATAN
The era of universal health coverage
UHC means Everyone has access to quality health services without financial difficulties
VISION
Quality, Sustainability, Equity, Engagement-Stakeholder, Agency Capability.

2022
248.7 mill. members per Dec 2022; 256.8 mill. members per 16 June 2023

2024

- Before 2014, there are at least 6 different health insurance schemes operating in Indonesia
- Each scheme had its own benefit package, payment system, and health financing provision
- Relevant government ministries agreed that JKN benefit package would be comprehensive provided medical necessities
- No cost sharing arrangements were used in JKN

FACTS ABOUT BPJS KESEHATAN

PUBLIC LEGAL ENTITY
NOT BUSINESS ENTITY

By Law Number 24 of 2011

INSTITUTIONAL POSITION

DIRECTLY UNDER THE PRESIDENT
NOT UNDER SPECIFIC MINISTRIES / INSTITUTIONS

Comes from a small portion of the Social Security Fund (DJS) of Health, NOT directly from the APBN (State Revenue and Expenditure Budget)

Minister of Finance Regulation (PMK) Number 236 of 2022, BPJS Kesehatan obtains operational funds taken from social health security funds, the amount is 2.89% of the health insurance program contributions that have been received.

- BPJS Kesehatan reports performance to the President as the Head of State
- BPJS Kesehatan also synergizes with the Ministries

Trust Funds (Participant Contributions)
NOT APBN (State Revenue and Expenditure Budget)

The source of Health Insurance Funds managed by BPJS Kesehatan comes from participant contributions. If there are funds from the APBN in the form of:

- Contributions for "Contribution Assistance Recipient" (PBI) participants / the poor borne by the state in accordance with the constitutional mandate
- Participant contributions for wage earners for the State Civil Service and the Indonesian National Army/Police where the Government is the Employer

BPJS KESEHATAN REPORT

Description of institutional assets sourced from initial government capital, transfer of BUMN assets, development of BPJS assets, as well as operational funds taken from DJS or other legitimate sources. BPJS assets themselves are used for operational costs for implementing social security programs, procurement of goods and services, increasing service capacity, and investment.

SOCIAL SECURITY FUND REPORT

Overview of trust fund assets resulting from contributions from all participants and their development. BPJS Kesehatan manages these funds for the payment of benefits to participants, as well as operational financing for the implementation of social security programs.

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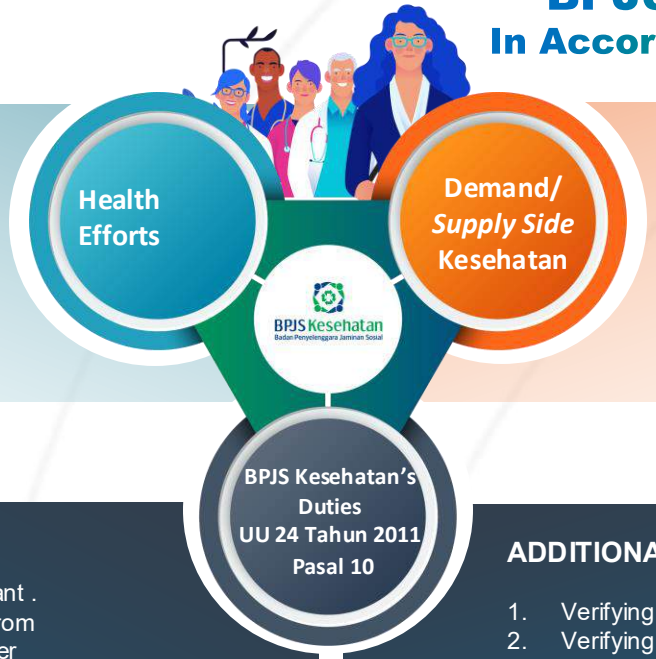
BPJS KESEHATAN's DUTIES
In Accordance With The Law Mandatory

BPJS Kesehatan Manages Individual Health Efforts (UKP) in the JKN Program

Public Health Efforts (UKM) are the role and responsibility of related ministries and agencies in local governments.



BPJS Kesehatan manages *Demand Side* (coverage participant)

Meanwhile, fulfilling the need for health facilities (supply side) is the role and responsibility of the relevant ministries, regional governments and the private sector.

MAIN TASK

1. Do and/ or accept registration participant .
2. Collecting and gathering contribution from participants/employee and the employer
3. Receive contribution assistance from the Government.
4. Manage Social Security Funds for the benefit of participants
5. Collect and manage data on social security program participants.
6. Pay benefits and/or finance health services in accordance with the provisions of the social security program.
7. Provide information on the implementation of social security programs to participants and the community.

ADDITIONAL TASKS FROM THE GOVERNMENT

1. Verifying Covid-19 claims
2. Verifying claims for the Maternity Insurance Program (Jampersal)
3. Supporting the acceleration of the Covid-19 vaccination process in Indonesia (through P-Care Vaccination)

The JKN program is a real mutual cooperation action throughout Indonesia

BPJS KESEHATAN's BUSINESS MODEL IN JKN

BPJS Kesehatan
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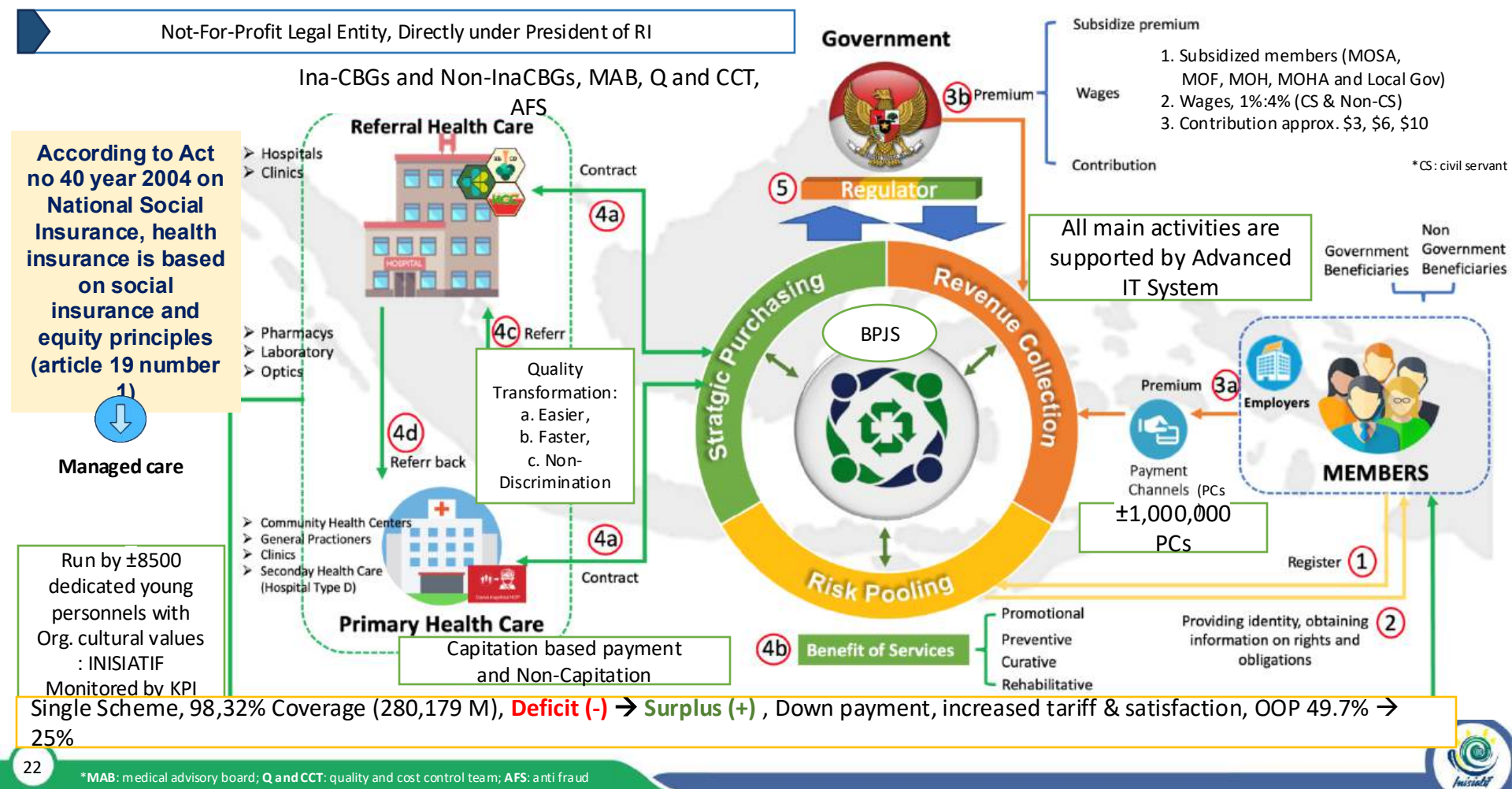
Not-For-Profit Legal Entity, Directly under President of RI



According to Act no 40 year 2004 on National Social Insurance, health insurance is based on social insurance and equity principles (article 19 number 1)

Managed care

Run by ±8500 dedicated young personnels with Org. cultural values : INISIATIF Monitored by KPI

Single Scheme, 98,32% Coverage (280,179 M), **Deficit (-)** → **Surplus (+)** , Down payment, increased tariff & satisfaction, OOP 49.7% → 25%

*MAB: medical advisory board; Q and CCT: quality and cost control team; AFS: anti fraud

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JKN MEMBERSHIP COVERAGE

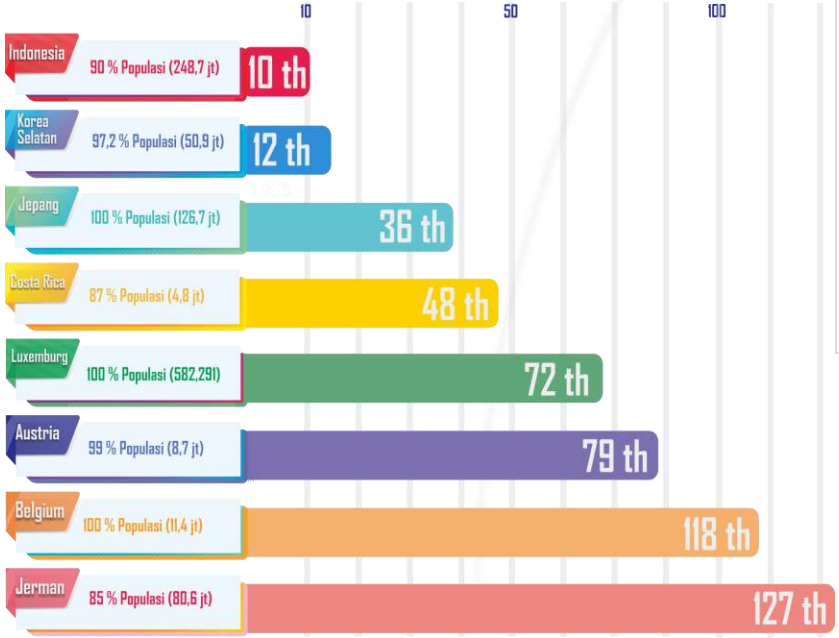
MEMBERS OF JKN PROGRAM AS JULY 01, 2025

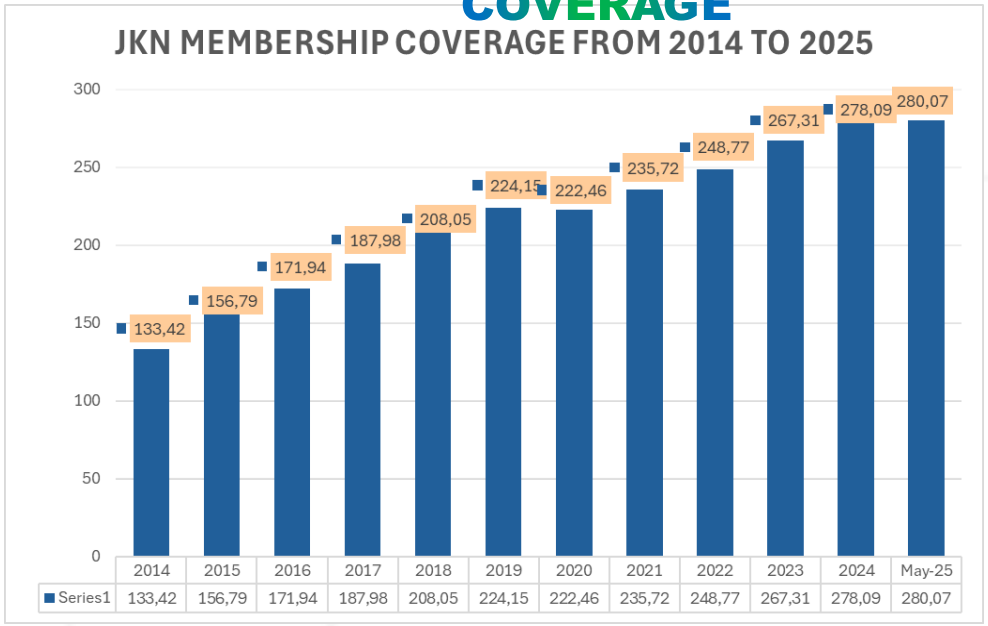
280,179,005

98,32 %
Of total populations (284.973.643)

*) Total population in semester II 2024: **284.973.643**

Source: https://gis.dukcapil.kemendagri.go.id/peta/





Lancet 2012; 380: 924-32 : *Political and Economic Aspects of The Transition to Universal Health Coverage*

CHALLENGES IN INCREASING JKN MEMBERSHIP COVERAGE

Informal Sectors

1) Willingness to register (middle and upper class people who have Private insurance)
2) Ability to pay of JKN members from informal sector (economic issues, etc)
3) Inactive members

Policy & Regulation

Law enforcement in public services has not been fully implemented esp. for informal sectors

Formal Sectors

The Compliance of Private Company to register all workers and family members in JKN Program

Hidden Middle

1) Population with low ability to pay, yet has not been validated as beneficiaries/registered in local scheme by the local government
2) Workers from a small & micro company with salary far under minimum wage

Challenge in fulfilling the quota for the Beneficiaries:

Poor & near poor population data validation to be included as beneficiaries (DTKS) paid by Government

Local Scheme (population registered by local government)

The government fiscal limitation in the election year

STRATEGIES ON EXTENDING HEALTH COVERAGE IN INDONESIA

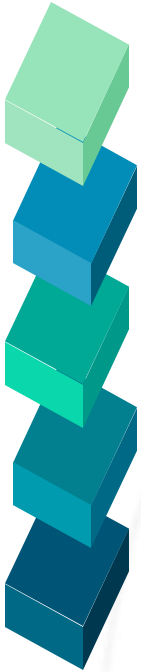
1 Policy & Regulation Inforcement

Presidential Instruction number 1 year 2022 to 34 Ministries/gov. institutions dan local government:

- Sinergy in policy & regulations
- Law enforcement to increase the compliance of formal & informal sectors (SIM, SKCK)
- Integration of system & data

2 Data & System Integration

Data Integration with ministries: populations mapping for the uninsured (formal and informal sectors)



3 Community funding

- Donation Program for informal sectors (PIPMPJ-JKN Care Community Funding Program)
- Collaboration in paying contributions through the SRIKANDI Program (Synergy of Participant Reactivation Recruitment between Regional Government and Third Parties)

4 Innovations to increase membership coverage & service

- Digital registration channel:
  - Informal Sectors: Mobile JKN, Care Center 165, Pandawa (registration through WhatsApp),
- Centralized outbound call & WhatsApp Blast (Jelita Program) to increase active JKN members
- Synergy and collaboration with village officials in Program PESIAR (mapping, tracing, advocating & registrating)
- Face recognition to improve services to JKN members

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"PESIAR" (PEtakan SIsir Advokasi Registrasi) Program

Mapping, Canvassing, Advocacy and Registration

A planned social marketing activity in order to recruit participants and increase the activeness of JKN participants carried out by a third party assigned on the recommendation of the relevant Regional Apparatus.

GOALS:

Mapping village communities that are not yet protected by JKN.

Canvassing/Reaching out to vulnerable communities (poor communities/layoff victims/stunted communities/pregnant women) etc. who are not yet included in JKN membership.

Canvassing through the formal sector workers whose employers have not registered them for the JKN Program.

Conducting socialization and advocacy for village communities regarding JKN participation.

Ensuring that non-JKN village communities become JKN participants in order to create UHC villages – Healthy and Prosperous Villages

Benefits of the PESIAR for Villages/Districts/Cities:

SDGs Achievement Healthy and Prosperous Villages in 2023	Validity of population data and combing vulnerable communities: ✓Poor population potential DTKS ✓Disability ✓Toddlers/children with stunting ✓Pregnant women ✓Laid-off workers who have not worked ✓Residents who do not have Health Insurance	Helping to achieve a reduction in extreme poverty rates

OUTPUT

1. Availability of : JKN and Non-JKN Participant **Mapping** in each Village/Sub-district and other data **(stunting, extreme poverty, pregnant women, etc.)**
2. Increased **Understanding** of the JKN Program
3. Increased **engagement** of JKN Participants
4. Creation of Partnerships between BPJS, Local Government, and Village Apparatus as the Smallest Government Unit
5. **Synergy** in supporting Government Programs related to Welfare (sweeping of pregnant women who are not yet JKN, prevention of stunting, extreme poverty, etc.)
6. Increased Employer Compliance

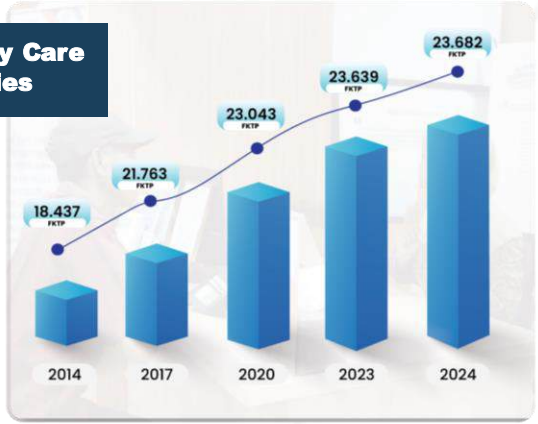
OUTCOME:

UHC Villages

JKN HEALTHCARE PROVIDERS

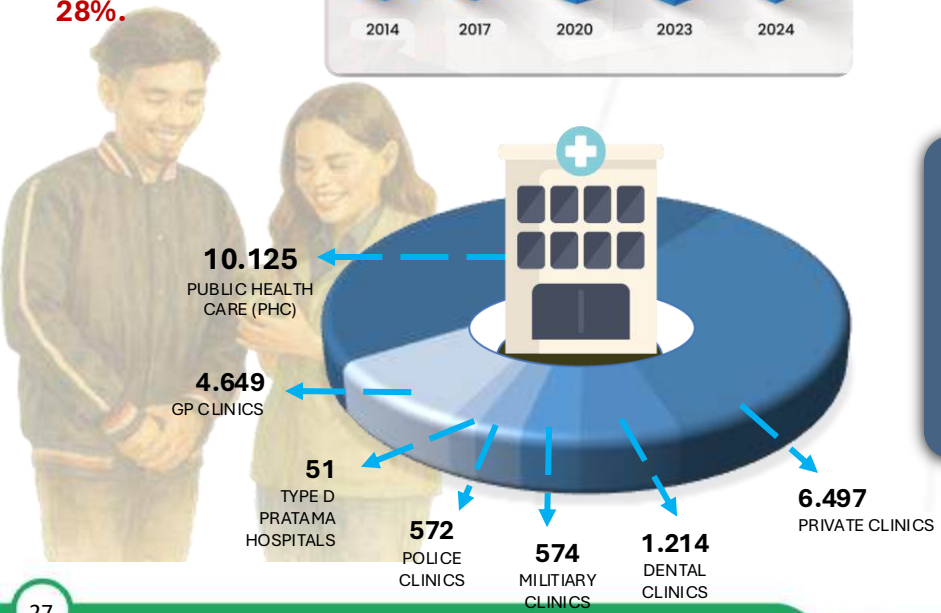
Primary Care Facilities

Between 2014 and 2024, the number of contracted Primary Health Care Facilities (PHC providers) **increased by 28%.**



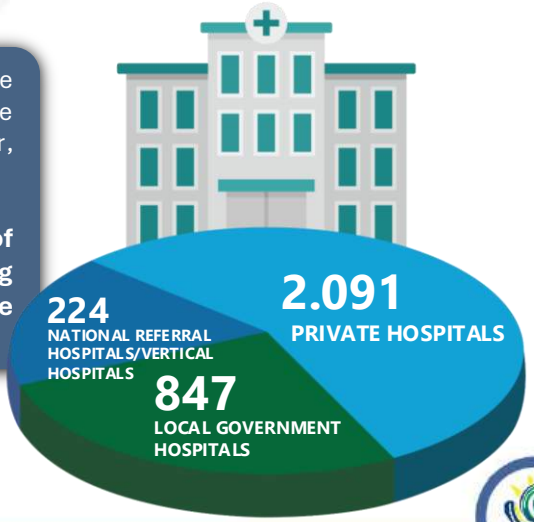
Referral Care Facilities

From 2014 to 2024, the number of contracted hospitals with BPJS Kesehatan **increased by 88%.**



The National Health Insurance (JKN) Program has driven the growth of the private health sector, particularly hospitals.

As of the latest data, 66.13% of hospitals has been partnering with BPJS Kesehatan are privately owned.



HEALTH CARE SERVICE UTILIZATION

HEALTH CARE EXPENDITURE

2024
IDR 175.07 trillion *(USD 10.26 billion)*

2023
IDR 158.85 trillion *(USD 9.31 billion)*

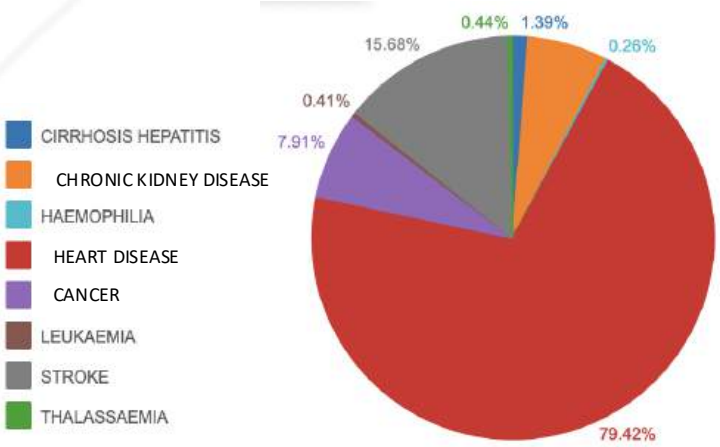
2014
IDR 42.65 trillion (USD 2.50 billion)

Total health care expenditure
in 11 years of JKN implementation
IDR 1,087.4 Trillion (USD 63.77 billion)

2024
- 1.9 million visits/day
- 700.42 million visits/year

2014
- 252 thousand visits/day
- 92.3 million visits/year

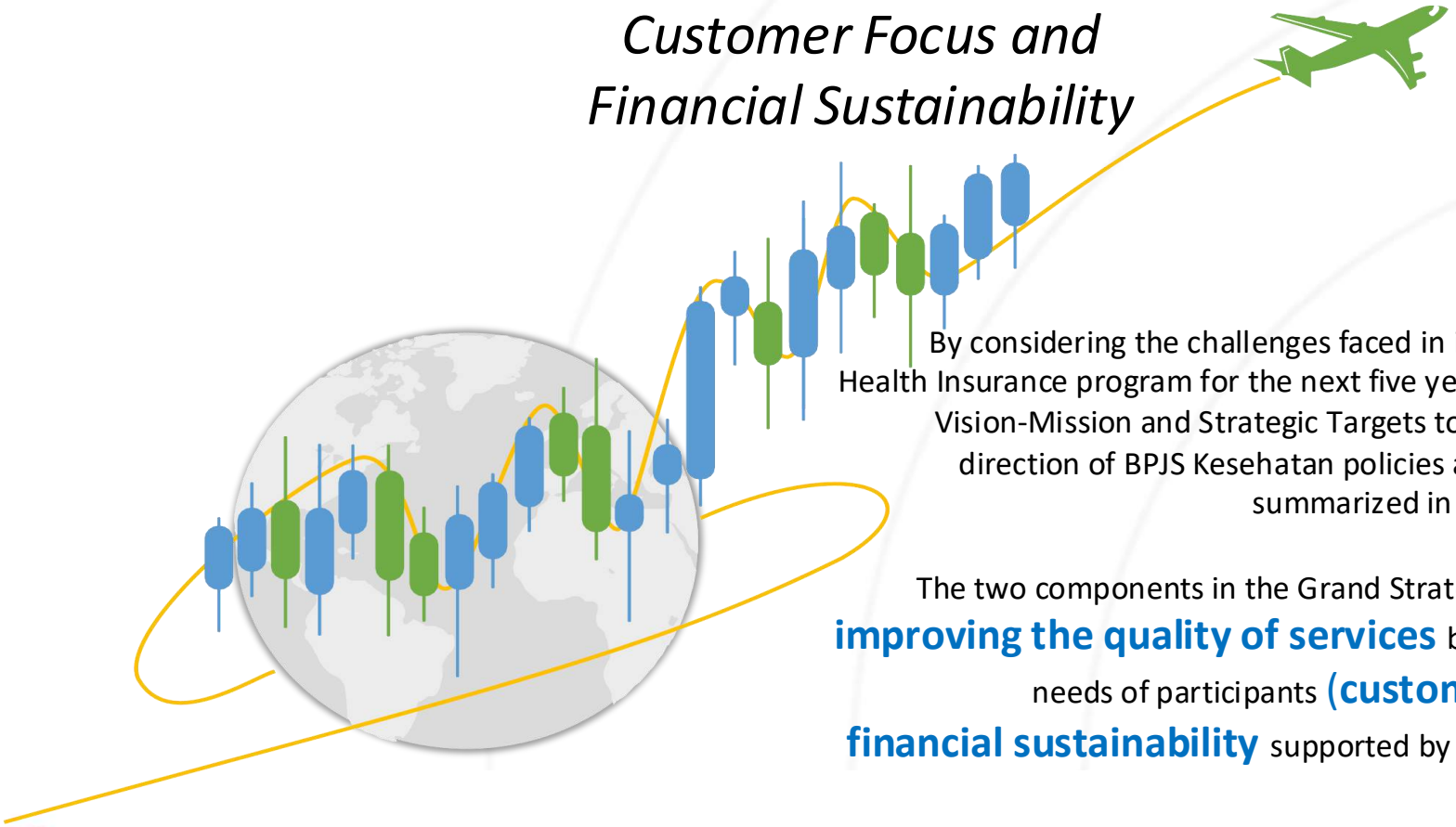
CATASTROPHIC EXPENDITURE



- **Catastrophic expenditure took part about 24-31%** of the total health care expenditure
- The total of catastrophic expenditure from 2014 to 2024 is no less than IDR 235 trillion (USD 13.78 billion)
- Catastrophic expenditure due to heart diseases is the largest proportion

BPJS KESEHATAN's GRAND STRATEGY

Customer Focus and Financial Sustainability



By considering the challenges faced in implementing the Health Insurance program for the next five years, as well as the Vision-Mission and Strategic Targets to be achieved, the direction of BPJS Kesehatan policies and strategies are summarized in a Grand Strategy.

The two components in the Grand Strategy are related to **improving the quality of services** by focusing on the needs of participants **(customer focus)** and **financial sustainability** supported by strong Capability.

SERVICE QUALITY TRANSFORMATION

Healthcare with just your National ID number

JKN participants no longer need to bring photocopies such as JKN card, ID card, or family card when visiting healthcare facilities.

convenient

- Access to health services
- Health care administration

fast

- Queue for services at health facilities (medical services, medical procedures, drug services)
- Response to information and complaint services

equity/non-descrimination

There are no discrimination in health facilities for JKN members

Foreign nationals satisfied with Indonesia's JKN Program

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DIGITAL TRANSFORMATION OF HEALTHCARE SERVICE ACCESS

BUGAR

The Internet of Things (IoT) technology supports a healthy lifestyle and enables real-time health monitoring for National Health Insurance (JKN) participants.

Health History Screening

Helping participants conduct their own health screening independently.

Medication Schedule

Reminders for taking medication for participants undergoing long-term treatment using AI technology.

ANDROID 4.3★ IPHONE 4.8★ HUAWEI 4.7★

Total User Mobile JKN

47.889.250

as of May 2025

Online Queue

A solution to simplify access to services at healthcare facilities and reduce waiting times from over 6 hours to under 2 hours.

Service History Information

Making it easier for participants and primary care doctors (DPJP) to view the patient's healthcare service history.

Telemedicine

Enabling participants to consult with doctors and receive medication.

- Doctor Consultation
- Medication Delivery

FRISTA Mobile JKN

Innovation in Face Recognition Technology for identity recognition as an alternative option in validating the eligibility of JKN participants in hospitals.

Availability of Beds & Surgery Schedule

Providing real-time information on bed availability in hospitals.

Bridging System

Healthcare Facilities

Implementation of the Latest Technology :

- Face Recognition (FR)
- Optical Character Recognition (OCR)
- Human AI
- Robotic Process Automation (RPA)
- Generative AI
- SOON Blockchain

I-CARE JKN
(DIGITAL MEDICAL RECORD IN THE HAND OF PHC PATIENTS)

I-CARE JKN
INFORMASI PENCARIAN RIWAYAT PELAYANAN KESEHATAN JKN

- Improving the quality of health
- Increase the accuracy of diagnosis by doctors
- Integrated medical health records
- Support promotion and comprehensive care

PHC= Primary Health Care

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INFORMAL SECTOR GROUPS DEBT COLLECTION EFFORTS UNDER JKN PROGRAM

REHAB Program

- The number of Registration Participants through REHAB Program **2.111.172 participants**
- Amount of contributions received: **IDR 993 B**
- Amount of remaining contribution receivables: **IDR 837 B**

AUTODEBIT

The Informal Sector Group that utilize autodebit program: **9.294.771 participants**

TELEKOLEKTING

By 2024, tele-collecton efforts had succeeded in collecting contributions amounting to **IDR 1,18 T**

KADER JKN

Educating, doing socialization, collecting the contribution, and doing social marketing of the JKN Program **1.434 People of Kader JKN**

WA Blast

- The number of text WA had been sent in 2024: **91,89 M texts**
- Amount of contributions received: **IDR 1,15 T**

DONATION

By 2024, the JKN Caring Community (PIPMPJ) funding has mobilized business entities, communities and zakat collection agencies with an amount of **IDR12,5 B**

BANKING
42 BANK

1. Stated-owned bank (central gov): 4 Bank
2. state-owned bank (locall gov) : 24 Bank

TRADITIONAL PPOB : 28 PARTNERS

Cooperation with micro-finance (Bisa, Delima Point, Arindo, PosFin, Uang Kita, Bima Sakti, etc.)

UP TO MAY 2025, THERE ARE **1.044.18 4** CHANNELS THROUGHOUT INDONESIA

E-COMMERCE/ FINTECH : 12 PARTNERS

Dana, Doku Wallet, Finpay, Gopay, I-saku, Link Aja, Ovo, Shoopee, Tokopedia, Buka Lapak, Blibli, Sakuku (BCA) dll.

RETAIL MERCHANT/ MODERN CHANNEL: 8 PARTNERS

Indomaret,Alfamart, PosIndonesia,Pegadaian, Superindo,Yomart, Alfamidi, Lawson

JKN CONTRIBUTION FOR NATIONAL HEALTH DEVELOPMENT

Reduce Poverty

- 2016 1,16 Juta orang
- 2019 8,10 Juta orang
- 2022 5,7 Juta orang

Reduce OOP

- 2013 Turun dari 47%
- 2018 menjadi 31,9%
- 2023 menjadi 28,9%

Lowering GINI coefficien

- 2016 Berkurang 0,0012
- 2019 Berkurang 0,0070
- 2022 Berkurang 0,0020

Stimulatin g Economy

- 2016 PDB Perkapita Rp1 Juta/tahun
- 2019 PDB Perkapita Rp1,1 juta/tahun

Improvin g healthcar

- 2019 Rawat Jalan 3,60% / Rawat Inap 3,20%
- 2023 Rawat Jalan 6,70% / Rawat Inap 13,30%

Creating Work Field

- 2016 2,09 Juta Orang
- 2019 3,17 Juta Orang

Increasing Life Expectancy

- 2019 AHH: 2,1 Tahun
- 2022 AHH: 0,5 Tahun

Creating Work Field Output

- 2016 Rp139 triliun
- 2019 Rp212 triliun

LPEM FEB UI
Universitas Indonesia

ISSA GOOD PRACTICE AWARD

BPJS Kesehatan has again achieved brilliant achievements in the international arena. At the "International Social Security Association (ISSA) Good Practice Award competition for Asia and the Pacific 2024" BPJS Kesehatan won 10 prestigious awards in the form of 4 Certificates of Merit with special mention and 6 Certificates of Merit.

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INDONESIA'S NATIONAL HEALTH INSURANCE (JKN) IN THE GLOBAL SPOTLIGHT: STRENGTHENING NATIONAL REPUTATION THROUGH ADVANCING UNIVERSAL HEALTH COVERAGE

From Indonesia to the World: BPJS Kesehatan as a Global Learning Hub for Health Insurance Governance

Invited to the UN's Official Forum for the first time, BPJS Kesehatan introduce JKN to the World

BPJS Kesehatan meeting with the International Social Security Association (ISSA)

Prof. Byron Good and Prof. Mary Joo of Harvard were impressed by the implementation of JKN in Indonesia

A World Bank delegation visited BPJS Kesehatan's headquarters to study the implementation of JKN in Indonesia.

Introducing JKN to international delegations at the INSPIRE Health Forum.

BPJS Kesehatan has been invited to numerous universities around the world


University of California (UCLA), Los Angeles

UCL Global Business School for Health


Monash University Australia


John Hopkins University, Maryland, USA


Melbourne University, Australia


Sharing session with Prof. Guy Daly, Coventry University England

A delegation from the Joint Learning Network (JLN) and AeHIN visited the BPJS Kesehatan Command Center to study the implementation of a digital health system

Interview by South African media outlet (BizNews)

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BPJS Kesehatan

has gone global & has become **a benchmark** for various countries

What do they say about BPJS Kesehatan?

GLOBAL TESTIMONIALS

Vrishali Shekhar
World Bank

Anthony Ofusu
Ghana Health Services

Meredith Dyson
UNECEF for South Asia

Ethan Wong
Bill & Melinda Gates Foundation

Zoljargal Lkhagvajav
The Onom Foundation
Mongolia

BPJS KESEHATAN'S ACHIEVEMENTS IN 2024 AND 2025

2024

CONTINUOUS IMPROVEMENT RECOGNITION AWARD 2024
ASEAN SOCIAL SECURITY ASSOCIATION (ASSA)

PENGHARGAAN PEMANTAUAN KEBERLANJUTAN & REPLIKASI INOVASI PELAYANAN PUBLIK KATEGORI PENYELENGGARA INOVASI TERBAIK
KEMENTERIAN PANRB

PREDIKAT BADAN PUBLIK INFORMATIF 2024
KOMISI INFORMASI PUSAT (KIP)

10 PENGHARGAAN
INTERNATIONAL SOCIAL SECURITY ASSOCIATION (ISSA) GOOD PRACTICE AWARD 2024

6 PENGHARGAAN
THE BEST CONTACT CENTER INDONESIA(TBCCI) 2024 OLEH INDONESIA CONTACT CENTER ASSOCIATION (ICCA)

Penghargaan Lengkap pindai di sini

2025

ELSHINTA AWARDS 2025

PUBLIC RELATIONS INDONESIA AWARD (PRIA) 2025

THE MOST REPUTABLE SOCIAL SECURITY AGENCY CEO IN DIGITAL BRAND 2025

MOST TRUSTED FINANCIAL BRANDS AWARDS 2025

AWARDING MNC DIGITAL INNOVATION IN PUBLIC SERVICE 2025

6TH INDONESIA TOP INSURANCE AWARD 2025

GOLD CHAMPION HEALTH INSURANCE & PUBLIC SERVICE APPLICATION 2025

LESSONS LEARNED

- Coordination among government institutions that require a multisectoral approaches.
- Increasing the commitments between the local and central governments on various aspects of UHC, including supply side and financing supports.
- Strengthening primary care and promotion and prevention is essential to deliver quality healthcare services and control health expenditure
- Routinely educate the society the importance of the community's role in UHC and maintaining community's health.
- Find additional source for funding the program activities such as domestic resources mobilization, multisectoral coordination with other government and private institution

CLOSING REMARKS

Social health insurance in Indonesia emphasizes the presence of the State of Indonesia, by providing a real safety net for the benefit of each and every Indonesian residents.

After a decade, BPJS Kesehatan has carried out the tasks of operating social health insurance on the right track. There has been a real continuous improvement.

As a single-payer of social health insurance, BPJS Kesehatan has been trying to promote effective and efficient budget execution, as well as practicing good governance and accountability as an independent public legal entity as direct subordinate to the President of Indonesia.

BPJS Kesehatan (collaboratively with the Indonesian Government), is committed and optimistic to reach universal health coverage of 98% population in 2024.

You Are NOT AWARE

Composer : Ghufron Mukti

BPJS Kesehatan
Badan Penyelenggara Jaminan Sosial

TERIMA KASIH

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Interactive Session

Questions from the audience

Moderator:
Somil Nagpal
Lead Health Specialist, World Bank Indonesia

Refreshment Break

(resume at 10:30 WITA)

Quality Improvements

Introduction to quality improvement initiatives in Indonesia and to the session speakers

Somil Nagpal
Lead Health Specialist, World Bank Indonesia

Assessing primary care provider competency and the Introduction of Indonesia's Practical Approach to Care Kit (I-Pack)

Roy Himawan, S.Farm., Apt., M.K.M., Director of Primary Health Care Service Governance, Ministry of Health

Nadhila Adani, M.Sc., Economist, World Bank

Kemenkes

Australian Government
Department of Foreign Affairs and Trade

Gates Foundation

Knowledge Translation Unit

WORLD BANK GROUP

Assessing Primary Care Provider Competency and the Introduction of Indonesia's Practical Approach to Care Kit (I-PACK)

Directorate of Primary Healthcare Service Governance
Ministry of Health, Indonesia

IHEA Pre-Conference, 20th July 2025

1. **Backgrounds**
2. Strategy
3. Preliminary Results

Most deaths in Indonesia are preventable

Kemenkes

Main causes of death by age group

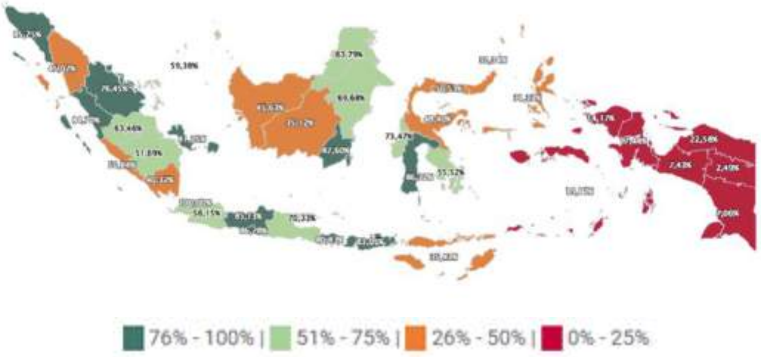
Preventable | Partially preventable | Accidents and others

Rank	Infants	Children	Adolescents	Productive Age	Elderly
1	Neonatal disorders	Neonatal disorders	Transport accidents	Cancer	Stroke
2	Congenital birth defects	Congenital birth defects	Cancer	Heart disease	Heart disease
3	Sexually transmitted infections exc. HIV	Diarrheal diseases	Tuberculosis	Stroke	Cancer
4	Lower respiratory infections	Lower respiratory infections	Unintentional injuries	Lower respiratory infections	Diabetes Mellitus
5	Diarrheal	Unintentional injuries	Typhoid and paratyphoid	Diabetes Mellitus	Chronic obstructive pulmonary disease (COPD)
6	Unintentional injuries	Dengue fever	Cirrhosis and other chronic liver diseases	Tuberculosis	Cirrhosis and other chronic liver disease
7	Tetanus	Sexually transmitted infections exc. HIV	Self-harm and interpersonal violence	Transport accidents	Tuberculosis
% of total deaths	96,8%	76,4%	63,9%	72,6%	73,5%

Source: Institute for Health Metrics Evaluation, Ministry of Health data 2019

Persistent shortages of essential health workers threaten the ability of Puskesmas to deliver basic services nationwide

4.361 Puskesmas (41.97%) lack the minimum 9 required health worker types



Shortage of 8,347 Health Workers Needed to Fill Puskesmas Vacancies

581	General Practitioners
2.921	Dentists
140	Nurses
181	Midwives
627	Health Promotion Officers
1.385	Environmental Health Officers
919	Nutritionists
614	Pharmacists
979	Medical Laboratory Technologists (ATLM)

Without improved diagnostic capacity, primary care facilities risk misdiagnosis and poor patient outcomes

The majority of primary care facilities face insufficient resources, hampering the accuracy of diagnosis and treatment amid the growing complexity of disease burden.

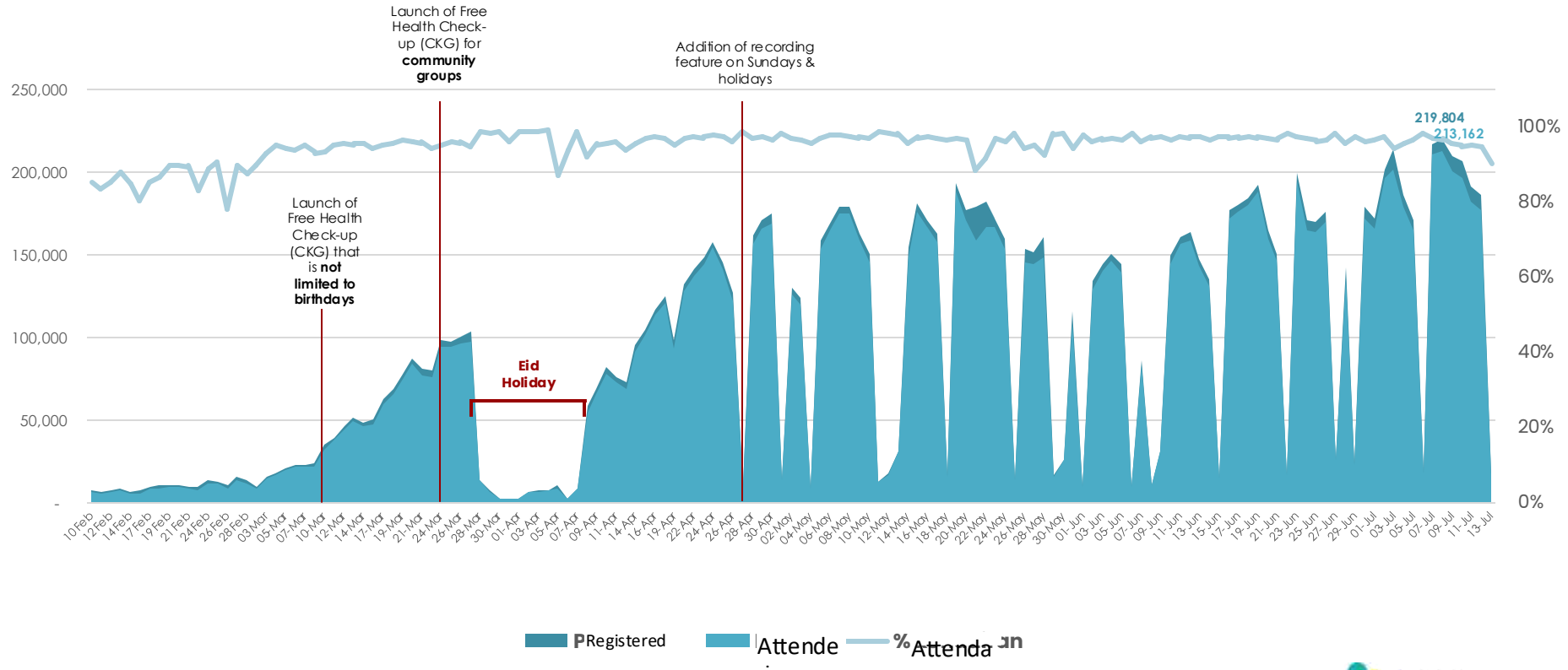
Many non-referral diagnoses carry significant risks due to limited diagnostic support.

- **Migraine (G43)** can mimic stroke, AVM, or brain tumor.
- **Vertigo (H82)** needs to be differentiated from brainstem stroke (HINTS test).
- **HIV/AIDS (B20)** requires monitoring for ARV side effects and drug resistance.
- **Tuberculosis (A15)** requires laboratory testing and monitoring for OAT side effects.
- **Gastritis (K29) & GERD (K21)** are difficult to distinguish without endoscopy.
- **Somatoform disorder (F45) & Insomnia (G47)** may be associated with severe mental health disorders.

Source: Lee & Kim (2019); Kattah (2009); NIH (2023); Heartland National TB Center (2024); UpToDate (2023); UpToDate (2023)

Trends in Free Health Check-up Registration and Attendance (10 February – 13 July 2025)

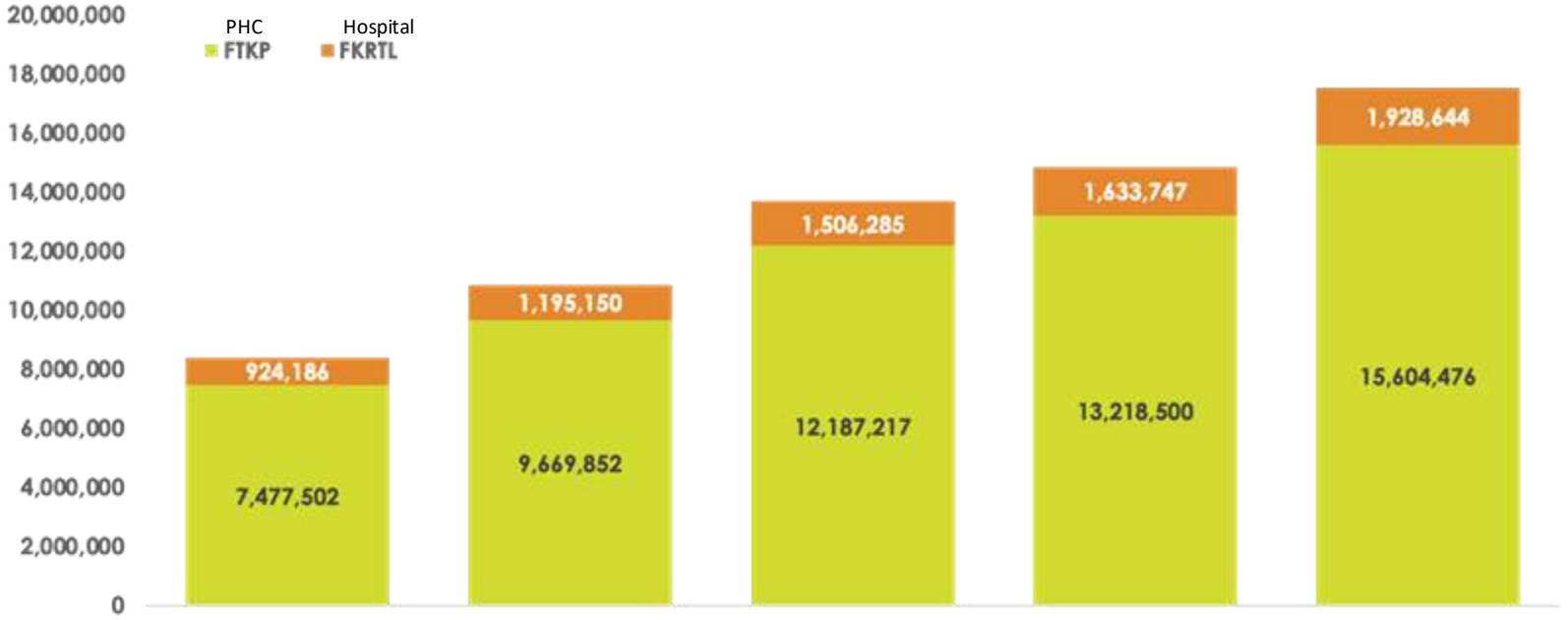
Registrations peaked at 219,804 per day, with attendance reaching 213,162 per day on 8 July 2025



Data update: 13 Juli 2025 , 10 pm

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Additional Hypertension Cases Detected in Adults (18+) Due to Free Health Check-ups (CKG) at Primary (FKTP) and Referral (FKRTL) Facilities, 2025–2029

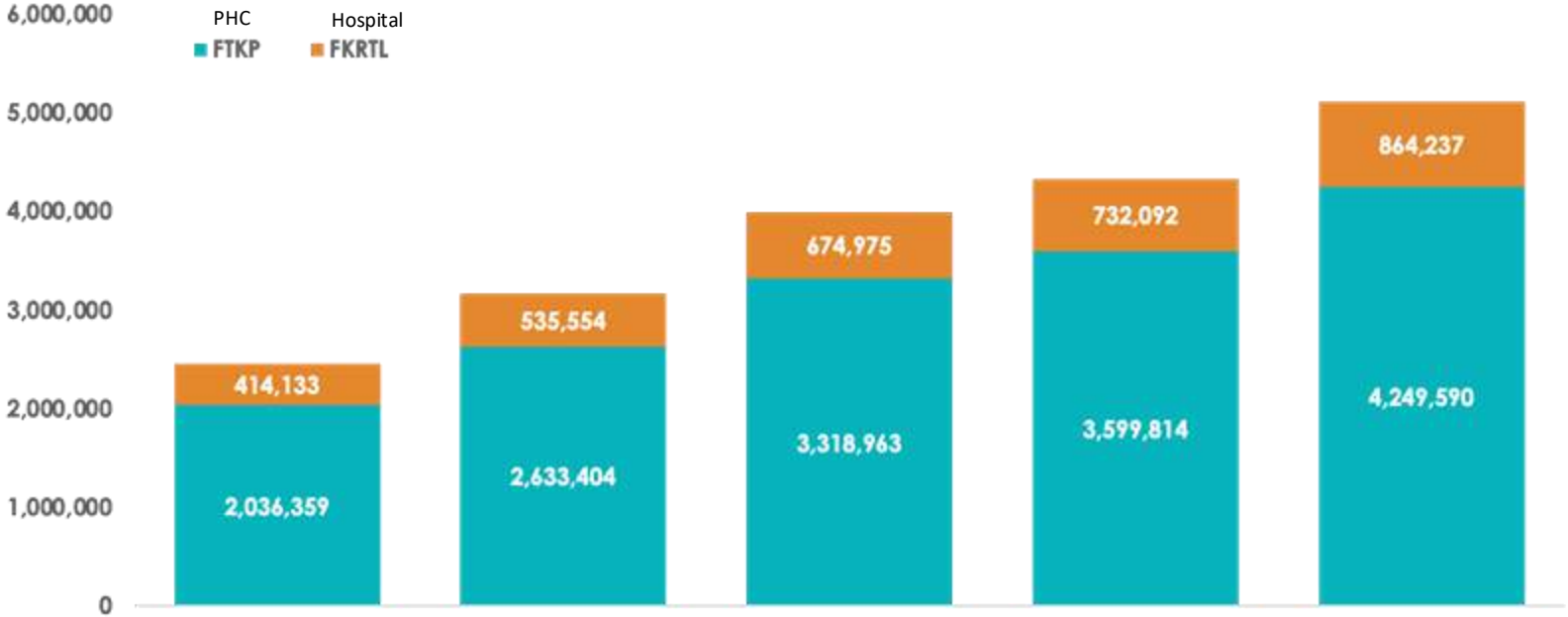


	2025	2026	2027	2028	2029
Total Additional Case	8,401,688	10,865,002	13,693,502	14,852,247	17,533,120

Calculated based on a hypertension prevalence of 21% among CKG participants (February–April 2025),
9% prevalence in the absence of CKG (SKI 2023, Ministry of Health),
and the estimate that 11% of hypertension cases at FKTP require referral to FKRTL (BPJS, 2023).

Kemenkes

Additional Diabetes Mellitus (DM) Cases Detected Among Adults (18+) Due to Free Health Check-ups (CKG) at Primary (FKTP) and Referral (FKRTL) Facilities, 2025–2029



	2025	2026	2027	2028	2029
Total Additional Case	2,450,492	3,168,958	3,993,938	4,331,906	5,113,827

Calculated based on a diabetes prevalence of 5.9% among CKG participants (February–April 2025),
2.2% under conditions without CKG (SKI 2023, Ministry of Health),
and an estimated 16.9% of DM cases at FKTP requiring referral to FKRTL (BPJS, 2023).

Kemenkes

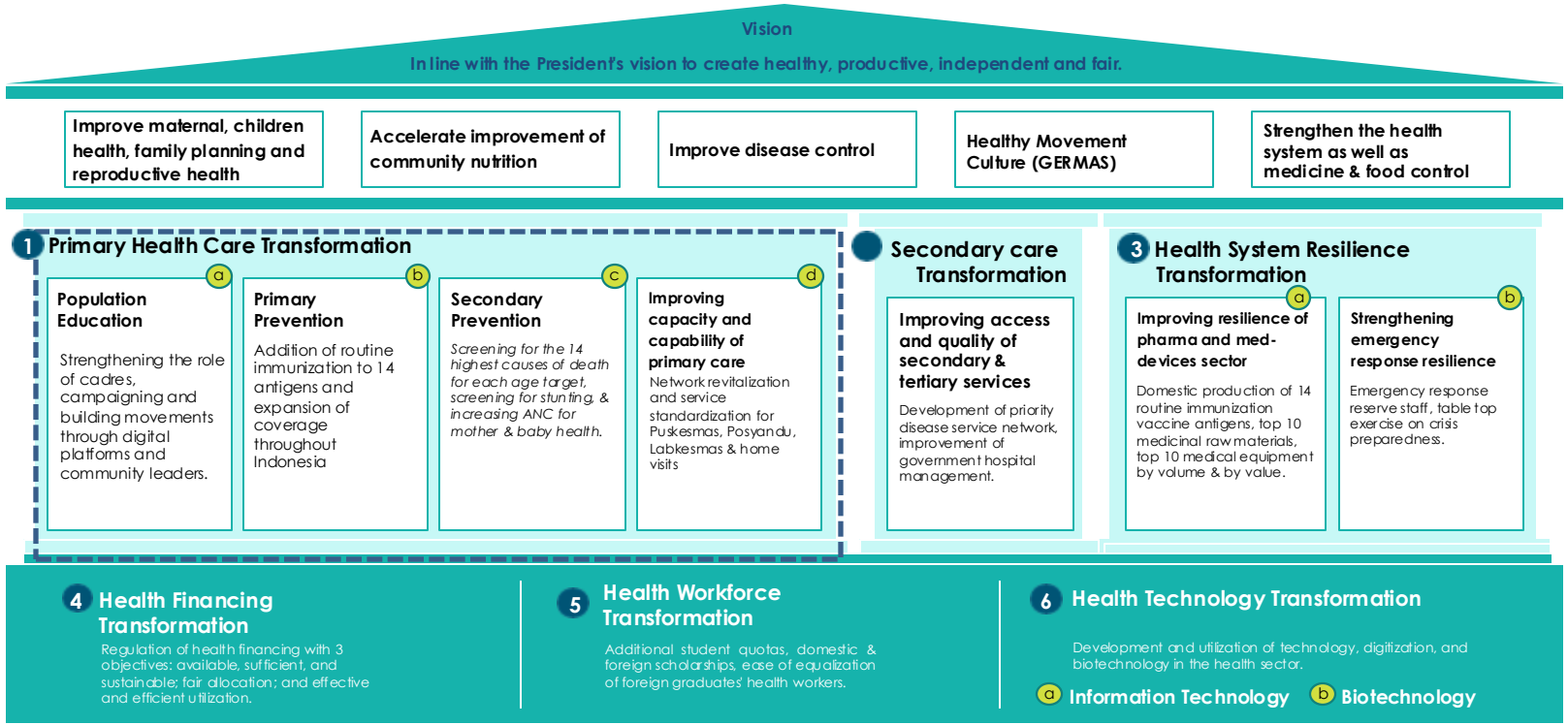
1.Backgrounds

2.Strategy

3.Preliminary Results

Primary Health Care as the first pillar in Indonesia's Health System Transformation

The 6 pillars of transformation supporting the Indonesian health system:



Kemenkes

The Ministry of Health Has Set 3 Focus Areas for Primary Health Care Integration

1. **Life cycle as the focus of health service integration**, while also strengthening health promotion and prevention.

2. **Bringing health services closer through networks down to the village and hamlet level,** including strengthening promotion, prevention, and pandemic resilience.

3. **Strengthening Local Area Monitoring (PWS)** through digitalization and dashboards to monitor village-level health conditions, including family visits.

280+ million people in Indonesia receiving **quality primary health care**

300,000+ primary health care service units equipped with standardized facilities and human resources

100% of regions and population health conditions regularly monitored.

1. PWS: Pemantauan Wilayah Setempat

The Ministry of Health is equipping health centers with medical equipment up to 100%. All community health centers are targeted to have all types of equipment by 2028

Health Center Medical Equipment

No	Name of Tool
1	Ultrasonography
2	CO analyzer
3	Infant T-piece resuscitator + PEEP valve
4	Infant incubator
5	Neonatal laryngoscope with straight blade
6	Infant radiant warmer
7	Portable suction pump
8	Infusion pump
9	Manual delivery bed
10	Manual bed
11	Dental chair
12	Hematology analyzer
13	Urine analyzer
14	Clinical chemistry analyzer
15	Binocular microscope
16	Micropipette
17	Rotating plate
18	Centrifuge
19	Electrocardiograph (ECG)
20	Direct Current Counter Shock (DC Shock)
21	Laryngoscope
22	Stretcher

No	Equipment Name
23	Electrocautery
24	Thermal ablation
25	Non-contact tonometer
26	Battery-powered examination lamp
27	Autoclave
28	Dental chair
29	Spirometer
30	Sanitation kit
31	Medical Waste Cold Storage

No	Perbekkes
32	Instrument table
33	Emergency trolley
34	Dehumidifier
35	Molecular Rapid Test
36	Vaccine refrigerator
37	Analytical scale
38	Spray can

Life-saving

No	Life-saving equipment (under 5 million)
39	Fetal Doppler
40	Standard IV pole
41	Baby Box
42	Standard Wheelchair
43	Nebulizer

No	Life-saving equipment (less than 5 million)
4	Oxygen Tank 1m³
4	Oxygen Cylinder 6m³

Quick Wins (QW) Support

No	Medical Equipment for CKG Needs (<5 million)
4	Optalmoscope
47	Otoscope
48	Tuning fork

Single Medical Equipment
Medical Supplies
Medical Equipment Kits

QW-CKG Support
QW-TB Support
Life-saving
DAKF P2 Surplus
SOPHI 2025 (20 medical devices)

Kemenkes

Given the increasing disease burden, particularly the shift toward conditions requiring long-term care, and the continued challenges in health workforce production and distribution**, ensuring the quality of health workers** already deployed at the frontline has become increasingly critical.

Assessing their current competencies and establishing continuous, systematic mechanisms to guarantee and enhance the quality of their performance is necessary.

Kemenkes

Attempts have been made to assess providers quality at primary care

	Hafianti, Silvi (2022)	Ministry of Health (2012)
Method	Used three waves of data from the Indonesia Family Life Survey (IFLS), evaluated healthcare providers' responses to a series of clinical vignettes by calculating raw performance scores.	Used direct observation to public health facilities, assessed how providers comply with clinical guidelines for ante-natal care, delivery, and post-natal care. The assessment was conducted prior to the implementation of the National Health Insurance Program (JKN)
Result	Between 2007 and 2014, a decline in medical competence was observed among doctors, a trend that was consistent across both the least competent and the most competent providers.	Highest coverage: Use of maternal and child health books, and not restricting breastfeeding. Lowest coverage: General examination and vital signs during ANC. Delivery care practices like oxytocin injection have high compliance, but partograph completion is low, indicating a gap in intrapartum monitoring.
Conclusion	While providers demonstrated relatively stronger performance on the childcare vignette, **improvements are still needed in other areas of clinical competence (diabetes, ante-natal care, and pneumonia), which would improve the overall gatekeeping function of primary care.**	There was **much room to improve provider's quality** especially in examining patients and completing partograph. Incentivizing providers to provide the necessary care was enforced through the JKN program.

Kemenkes

The Government of Indonesia, in collaboration with the World Bank, initiated a program aimed at reforming the National Health Insurance, known as the *Jaminan Kesehatan Nasional* (JKN) Program-for-Results. A key objective is to improve quality in the primary healthcare

Strengthen the Quality of Care

1. **Improve quality of care in primary care health facilities**
2. Improve quality of care at referral hospitals

Improve Efficiency

3. Incorporate findings from health technology assessments into the benefit package
4. Improve claims management and prevention of ineligible claims
6. Improve design and implementation of primary health care payment methods
7. Improve INACBG implementation

Support JKN Policy Formulation and Implementation

5. Improve use of data in decision making
8. Improve policy formulation and oversight of JKN
9. Improve management and coordination of JKN across stakeholders

Kemenkes

As part of the JKN PforR, the Ministry of Health assessed baseline data on Provider's knowledge in 2024

Survey Objective

Assess provider knowledge to diagnose, treat, manage and educate patients at primary care level

Survey Design

40 multiple-choice questions

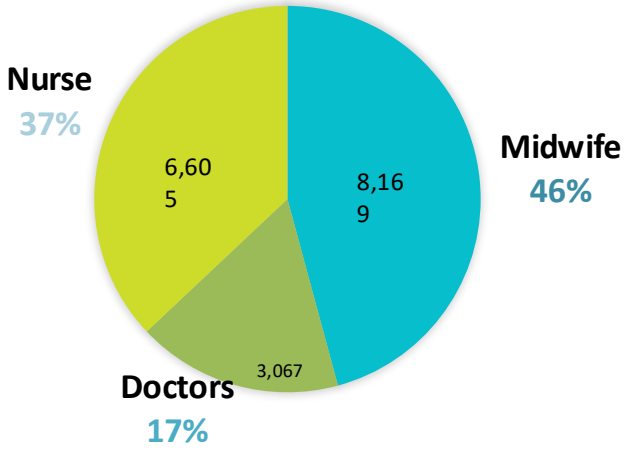
Topics: TB, hypertension, diabetes, maternal health

Questions grouped by: 13 on diagnostics, 20 on treatment and management, 7 on education

Roll out

Google form distributed to primary care doctors, nurses, and midwives across Indonesia

Survey Respondents



Consistent with the availability of health workers at primary care, most of the respondents are midwives, followed by nurses and doctors, totaling to around **17,800**.

Kemenkes

Validating Vignette's Quality

Routine examination carried out at each visit for Drug-Sensitive TB (DS-TB) patients is...

A. Body Mass Index measurement

B. Chest x-ray

C. Close contact

D. Blood sugar

E. HIV test

65.76% of doctors answered correctly

59.93% of nurses and

51.9% of midwives

Column	Details
Difficulty Level	**Easy** – The question is considered basic and suitable for most frontline providers.
GP (General Practitioner)	**Yes** – Relevant and answerable by general practitioners.
Nurse (Vocational Nurse)	**Yes** – Suitable for vocational nurses. *Linked to TB screening competency (Skill Level 3).*
Midwives	**Yes** – Relevant for midwives. *Includes facilitation of screenings for TB, HIV/AIDS, Hepatitis, Malaria, and Syphilis.*
Reasoning	Routine monitoring (e.g., weight, symptoms, adherence) falls within the expected roles of both nurses and midwives it doesn't involve complex clinical decision-making.

To validate whether a vignette is easy, moderate, or hard, we ask general practitioners (GPs) to answer the question and indicate their perceived difficulty level. If most GPs find it easy and respond correctly, the vignette is classified as easy. We then conduct internal validation by reviewing whether the task aligns with national competency standards for doctors, nurses and midwives to ensure the question is appropriate for each cadre's scope of practice.

Kemenkes

Baseline survey result confirmed the need for providers competency improvement

- **Overall doctors' performance is moderate**, with an average of 66.5 out of 100
- **Treatment and management skills require focused capacity building (63.8)**, despite relatively better performance in diagnostics and counseling (69.3 and 69.0, respectively).
- **Maternal health knowledge is alarmingly low (35.4)**, demanding urgent targeted interventions and training to improve care quality.
- **Younger workforce dominance** presents an opportunity to shape practices early through structured continuous professional development programs.
- **Maternal health and cardiovascular care remain the weakest areas** in both private and public PHC (average of 35.3 for maternal health and 44.33 for cardiovascular)
- **Emergency, diabetes, and HIV care show strong competencies** across the board (88.8, 87.2, and 84.0, respectively).
- Differences between private and public PHC are minimal, suggesting **system-wide strengths and weaknesses** rather than sector-specific issues.

Kemenkes

Indonesia's Practical Approach to Care Kit (I-PACK) is a clinical decision support tool that strengthens frontline primary care

- Seeing the challenges in strengthening the ability of health workers at FKTP, the Ministry of Health needs to create the tools that can be used to improve ability.
- Supported by The World Bank and the Knowledge Translation Unit of University of Cape Town, established in 2022.
- Transformed what used to be hundreds of pages of disease-based clinical guidelines, into easy-to-use document with **clear algorithms that provide an integrated approach to screening, diagnosing, and treating common symptoms**.
- Introduced to primary care facilities in phases since 2024 after the baseline survey was conducted.

Kemenkes

The tool guides doctors to assess and establish diagnosis and plan management

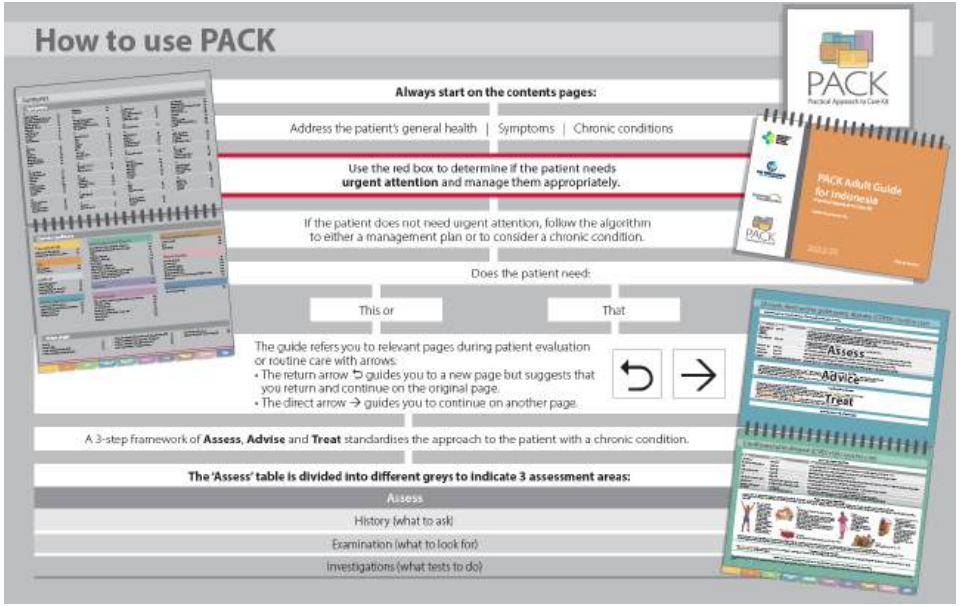
Comprehensive and integrated: Supports integrated, person-centered care, helping providers manage comorbidities and avoid the siloed approach of disease-specific programs.

Team-based: Clarifying roles enables task-sharing across doctors, nurses, and community health workers.

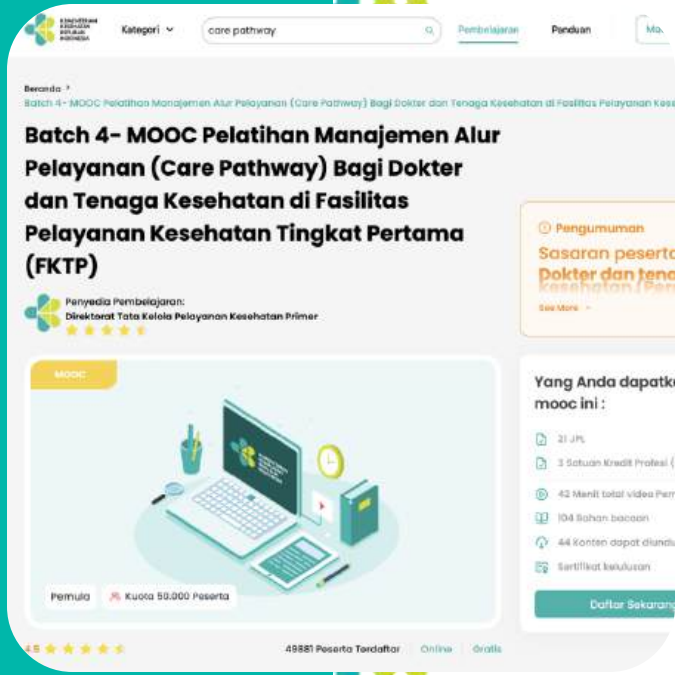
Practical format: Organized by symptoms rather than diagnoses, uses color-coded algorithms and checklists to guide decisions during consultations.

Tailored to Indonesia : Includes promotive and preventive efforts and aligns with national policies and available resources.

Capacity-building: Delivered with on-site training and mentoring to support continuous improvement



Kemenkes



I-PACK Training via *Plataran Sehat* ensures a more efficient and wider coverage

- I-PACK is now part of the Indonesia Care Pathway module
- I-PACK training is currently underway, taught through the Ministry of Health's Learning Management System (Plataran Sehat platform) using the Massive Open Online Course (MOOC).
- MOOC enables providers from across Indonesia to participate, and lowers cost of training compared to in-person
- In 2026, the Ministry of Health will conduct an endline survey to assess whether provider knowledge and competencies have improved following the rollout of I-PACK.
- The results will inform future implementation and scale-up efforts.

1.Backgrounds

2.Strategy

3.Preliminary Results

The training collects pre- and post- training scores, which can be used to illustrate the immediate improvement in knowledge after training

In October 2024, the total number of training participants was **95.722** health workers

Proportion based on participant profession

- **Doctor** 14.523 (15,17%)
- **Nurse** 35.208 (36,78%)
- **Midwife** 45.991 (48,04%)

Average pre- and post-test scores

	Pre-test	*Post-test*	*Difference*
Doctor 14.523 (15,17%)	**69,38**	**88,44**	**19,05**
Nurse 35.208 (36,78%)	**55,70**	**86,26**	**30,55**
Midwife 45.991 (48,04%)	**51,35**	**86,91**	**35,56**

Number of Primary Health Facilities (FKTP: Puskesmas and Primary Clinics) Collaborating with BPJS and Trained in the Care Pathway

Category	2024 Achievement	2025 Achievement*
Number of FKTPs (Puskesmas and Primary Clinics) collaborating with BPJS Kesehatan	17.646	17.646
Number of FKTPs (Puskesmas and Primary Clinics) trained in the Care Pathway	5.106	215
Percentage of FKTPs trained nationwide	28,94	1,22
Achievement (2024–2025)	5.106+215 = **5.321 (30,16%)**	
Target by end of 2025	**15.882 (90%)**	

*Achievement from MOOC Care Pathway Batch 3 (March 21–26, 2025)
** MOOC Care Pathway Batch 4 (April 28–June 26, 2025) — data under analysis

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Summary of On-the-Job Training (OJT) in 2024

No	Type of Training	Province	Districts	Puskesmas	Professional Organization
1	Emergency Care for Newborns	25	52	180	IDAI
2	Hypertension and Complication Management at Puskesmas	27	73	440	PAPDI
3	Screening, Diagnosis, and Management of Vision Disorders	26	74	412	PERDAMI
4	Screening and Management of Hearing Disorders and Deafness	26	63	421	PERHATIKL
5	Maternal Emergencies for Doctors, Midwives, and Nurses	26	53	170	POGI
	Total	**28**	**173**	**1.226**	

Summary of Training in 2024

No	Type of Training	Province	Districts	Puskesmas	Professional Organization
1	Management of Sensory Disorders for Health Workers in FKTP	11	98	318	Bapelkes/ poltekes/RSUP/B BPK/Balatkes
2	Healthcare Facility Waste Management	9	54	394	
3	ACLS Training (Advanced Cardiac Life Support)	4	73	318	
4	Contraceptive Services for Doctors and Midwives in Health Facilities	19	116	449	
5	Early Detection of Breast and Cervical Cancer for Doctors at Puskesmas	3	28	90	
6	COPD and Asthma Management Training	15	183	518	
7	Basic Skills Training for Posyandu Cadres	22	77	706	
	Total	**32**	**306**	**2.240**	

OJT and Training Beneficiaries in 2024:
Puskesmas = 3,032
Districts/Cities = 350
Provinces = 33

Regions yet to receive OJT/training:
DKI Jakarta (*not a Sophi focus locus*), West Papua, Papua Pegunungan, South Papua, and Central Papua

Planned OJT and Training in 2025 — Target: 8,655 participants

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

What to Expect After PACK Roll-out

- Becomes a reference for medical personnel and health workers in providing health services at Primary Health Facilities (FKTP).
- All medical personnel and health workers at Primary Health Facilities (FKTP) participate in Care Pathway training.
- Monitoring and evaluation of training implementation.
- Monitoring and evaluation of health system challenges in PACK implementation.
- Post roll-out survey.
- Care Pathway training should be one of the requirements for Health Worker's credentials / facilities' recredentialing to contract with BPJS Kesehatan.
- Support the Provincial, Regency and City Health Offices and BPJS Kesehatan in facilitating training and monitoring and evaluation of the implementation of Care Pathway at Primary Health Facilities (FKTP).
- Periodic updates involving stakeholders.

Kemenkes

Thank you

Indonesia’s Primary Care Accreditation Program

dr. Imran Pambudi, MPHM, Acting Director of Primary Health Care Facilities and Service Quality, Ministry of Health

Dan Han, Ph.D. Assistant professor, National University of Singapore, World Bank consultant

Indonesia's experience in implementing accreditation programs for primary healthcare facilities

IHEA Conference
Bali, July 20th 2025

dr. Imran Pambudi, MPHM
Ministry of Health Republic of Indonesia

Australian Government
Department of Foreign Affairs and Trade

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KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Background: Indonesia, the world's largest archipelagic nation

Decentralized health system

- designed to ensure that healthcare policies and services can be tailored to the specific needs of each region, while still adhering to central government policies

Healthcare Facilities

- Hospitals: 3,236
- **Puskesmas (community health centre): 10,268**
- **Private Clinics:19,780 (primary)** and 3,601 (specialist)
- Public Health Laboratories: 294
- Medical Health Laboratories: 689
- Blood Management Units: 255 (independent), 193 (hospital)
- **Private Practitioner (14,148 GPs and 8,317 Dentists)**

Geographical Diversity

- more than 17,000 islands; 6,000 inhabited islands

Ethnic and Cultural Diversity

- rich cultural and ethnic diversity

Population

- Over 285 million people, making it the fourth most populous country in the world

Administrative Divisions

38 provinces, 514 Districts, 7,277 sub-districts, > 83,000 villages

- Primary Health Care is the **backbone of the healthcare system** in Indonesia
- Challenges in implementing healthcare policies: **ensuring quality of services** to maintain effective healthcare delivery (good, equitable and affordable)

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

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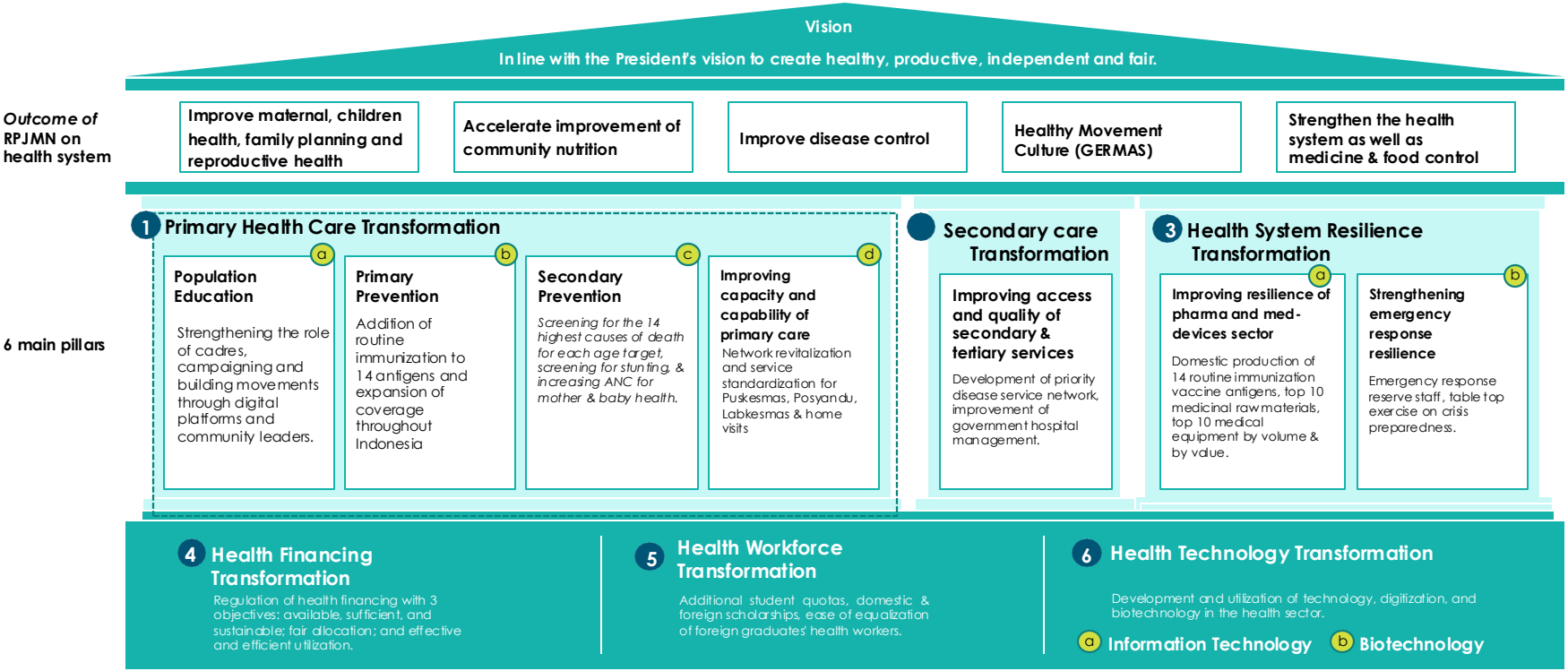
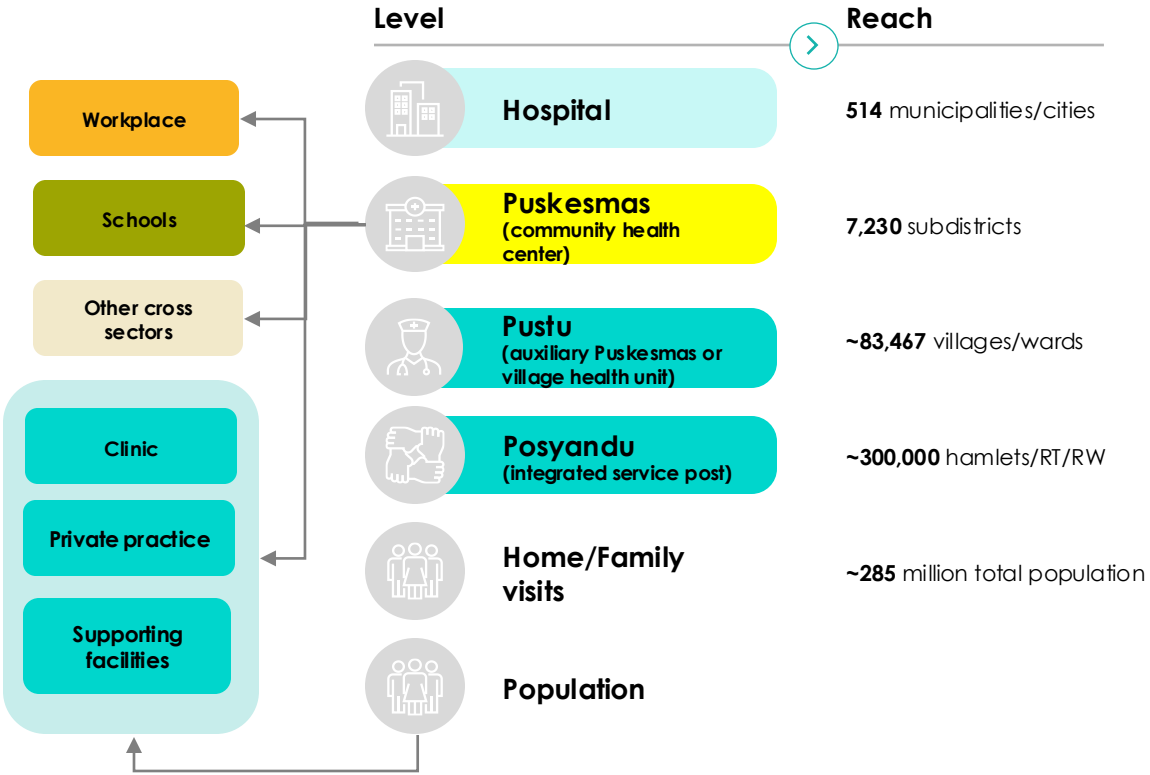
Primary health care is the first pillar in Indonesia health system transformation

The 6 pillars of transformation supporting the Indonesian health system:



The transformation is conducted by restructuring primary healthcare network



Puskesmas and its 5 networks:

1. **Primary care facilities**
   - Clinic/private practice
   - Pustu/village health unit
   - Posyandu
2. **Educational facilities (schools)**
3. **Workplace**
4. **Referral care**
5. **Cross-sector agencies**

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

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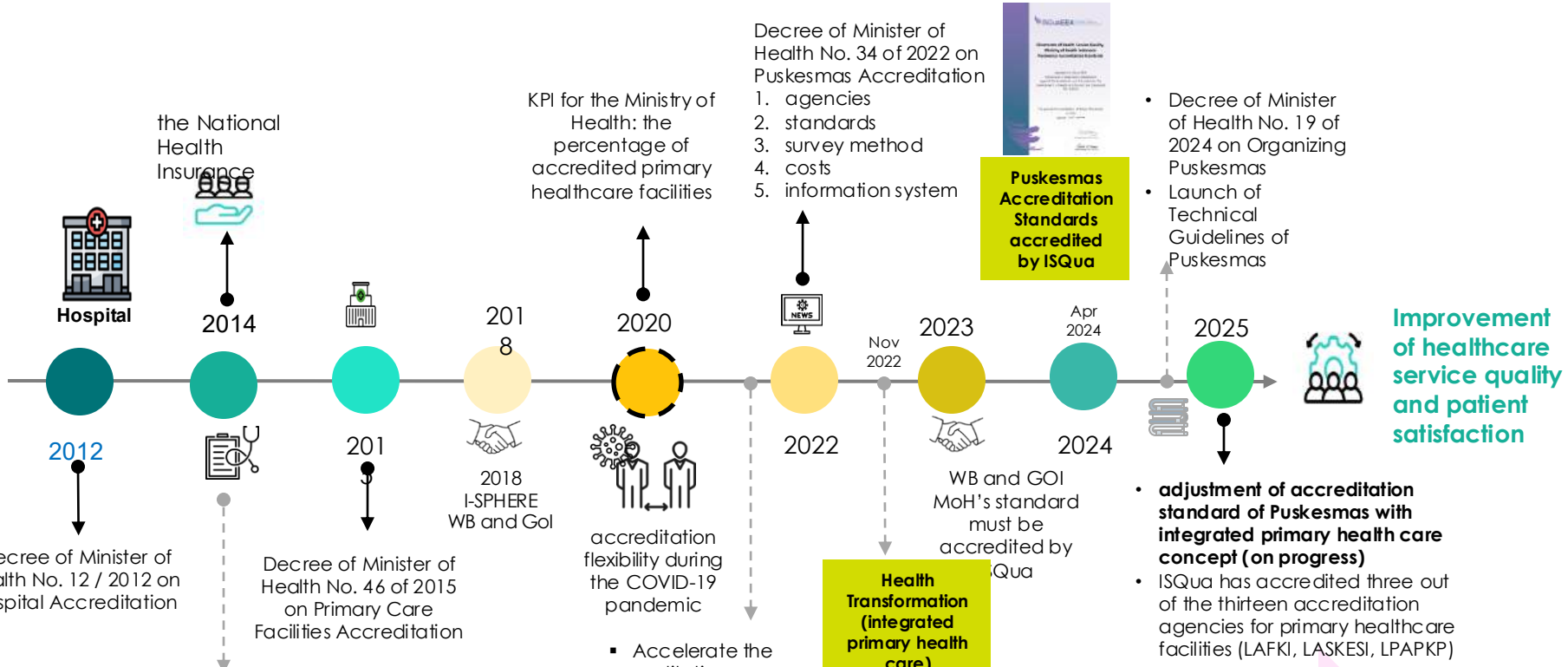
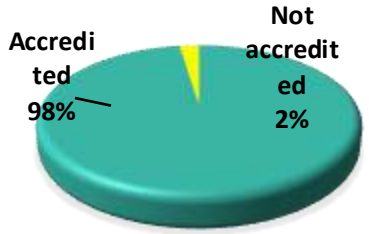
KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Overview of the evolution and implementation of healthcare facility accreditation in Indonesia



Accreditation of primary healthcare facilities and public health laboratories

Puskesmas

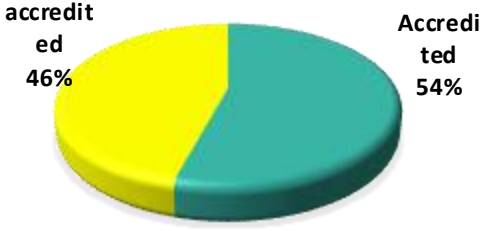


- Number of accredited **10,023 (97,6 %)**
- Number of not accredited **245 (2,4 %)**
- Total number of Puskesmas **10,268***

Status of Accreditation

Paripurna	**6,362 (63,5%)**
Utama	2,678 (26,7%)
Madya	818 (8,2%)
Dasar	165 (1,6%)

Clinic (Pratama)



- Number of accredited **10,337 (54,2 %)**
- Number of not accredited **8,735 (45,8 %)**
- Total number of Clinic in primary care: **19,072***

Status of Accreditation

Paripurna	**8,390 (81,4%)**
Utama	1,534 (14,9%)
Madya	385 (3,7%)

Public Health Laboratory

- Number of accredited **124 (42,2 %)**
- Number of not accredited **170 (57,8 %)**
- Total number of Public Health Laboratory **294***

Status of Accreditation

Paripurna	18 (14,5%)
Utama	**106 (85,5%)**

- * SINAF 30 Juni 2025

Kemenkes

Accreditation in Primary Health Care Facilities

Decree of Minister of Health No. 34 of 2022 : on Accreditation of Puskesmas, Clinic, PH Laboratory, Blood Management Unit, Private Practitioner (GP and Dentist)

1. Puskesmas, clinic, health laboratories, blood management units, private practitioner (GP and dentists) **must be accredited**

2. Accreditation is carried out no later than after operating 2 (two) years since obtaining an operational license

3. Every Puskesmas, clinic, health laboratory, blood management unit, private practitioner (GP and dentists) must be re-accredited periodically every **5 (five)** years.

4. Accreditation is conducted in accordance with the standards set by the Minister of Health.

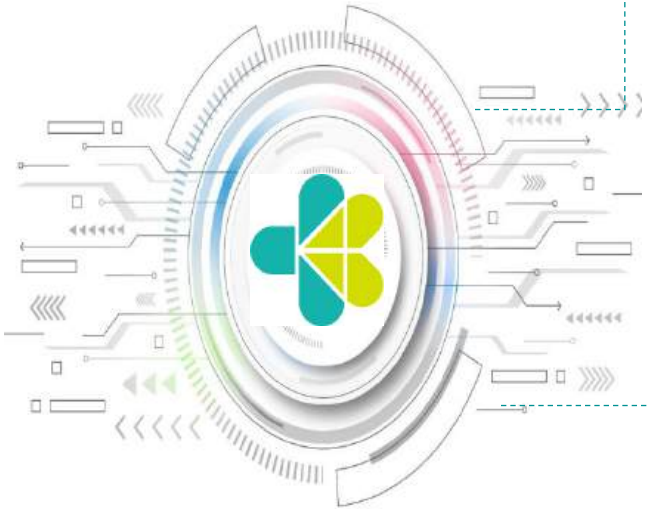
5. The Minister of Health determines the accreditation agencies that has met the requirements

   The Accreditation agencies assists the Minister of Health to carry out self-managed accreditation surveys.

6. The accreditation agencies must be accredited by the **accreditation institution** either **nationally** or **internationally** no later than 5 (five) years since it was established.

   ex: ISQUA, National Accreditation Body

Healthcare Facility Accreditation Process



PREPARATION

Fullfillment of infrastructure and medical devices, human resources, and standardized health service

- Self Assessment
- Preparation of a quality improvement program
- Measurement and reporting of national quality indicators
- Reporting of incident of patient safety

IMPLEMENTATION

External Assessment by Surveyors

- Assesment/Survey (online and onsite)
- Determination of accreditation status.

POST ACCREDITATION

Improvement Post Accreditation

- Create and implement a strategic improvement plan (progress report)
- Maintain through quality improvement program

LIST OF CONTENT

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

Indonesia as a global frontrunners in upper middle-income countries by the number of accredited primary care facilities

...Although more than 97 percent of Puskesmas have been accredited by the ISQua-accredited standards, there are still 245 Puskesmas that have not been accredited yet because of geographic and access challenges. Accreditation achievements for clinic and public health laboratories also still need to be improved....

Moving Forward:

- Adjustment of accreditation standard of Puskesmas with integrated primary health care concept
- Enhancing PHO and DHO's ability on continuous supervision, monitoring and evaluation to:
  - ensuring credible accreditation process
  - ensuring quality improvement before and post accreditation, including patient safety and patient satisfaction
- Strengthening the accreditation information system
- Accreditation agencies by national accreditation body

Update 2025: all areas are dark green (accreditation rate 75-100%), except for Mountain Papua (59%) and Central Papua (40%)

Accreditation rate in (%) across regencies by 2023

Kemenkes


Kemenkes

Analysis of Indonesia's Primary Care Accreditation

Dan Han

National University of Singapore, World Bank

Presentation at the 2025 IHEA Congress

Accreditation: Independent Audit of Compliance With Set Standards

- Mitigate information asymmetry (e.g., service quality difficult to observe)
  - Minimum standards
  - Administrative accountability (Hanushek and Raymond, 2005)
  - Quality signals via public disclosure of accreditation status (Dranove and Jin, 2010)
- Provide feedback and alter intrinsic motivation
  - Reveal how a provider performs compared to standards and peers (Kolstad, 2013)
- Risk of regulatory fatigue or distraction?
  - Standards matter little for quality; burdensome (Ibrahim et al., 2022; Morey et al., 2015)

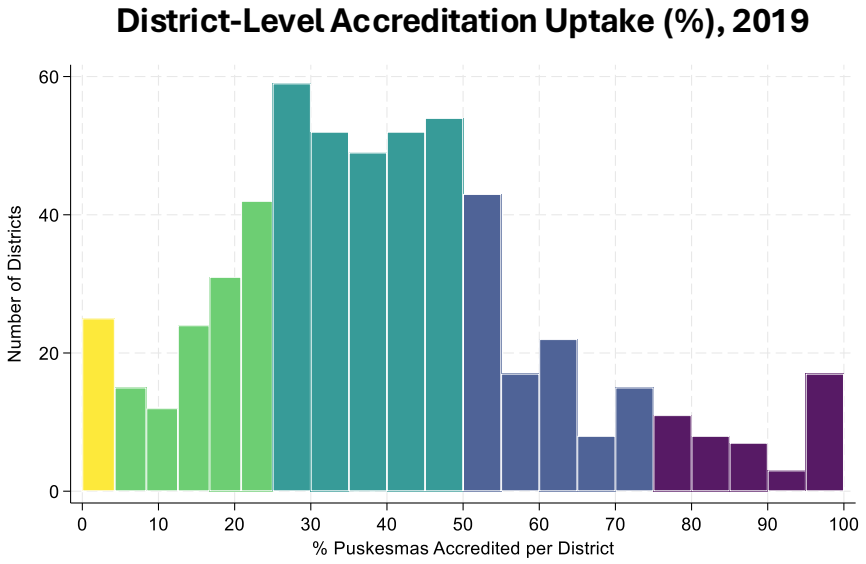
Indonesia's Primary Care Accreditation Phase 1 (2015-2019)

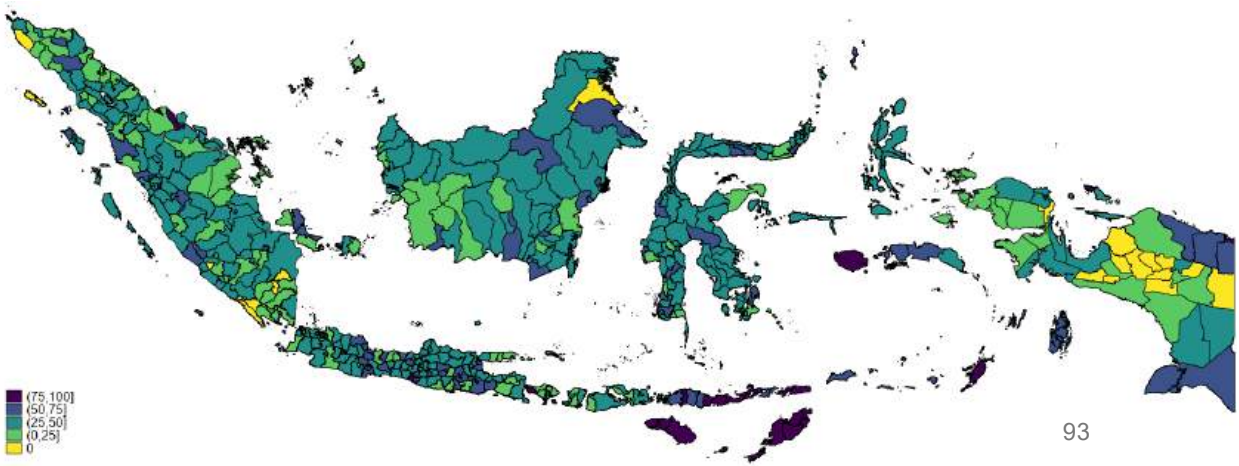
- Govt-run community health centers *Puskesmas* (**PKM**)
- Voluntary participation
- Resource from central govt
- MOH developed the standards, carried out accreditation assessment
  - 164 criteria across 9 chapters

Chapters	
I.	Implementation of Puskesmas Services
II.	Puskesmas Leadership and Management
III.	Puskesmas Quality Improvement
IV.	Target-Oriented Puskesmas Programs and Efforts
V.	Leadership and Management of Puskesmas Programs and Efforts
VI.	Performance Targets and Millennium Development Goals
VII.	Patient-Oriented Clinical Services
VIII.	Clinical Service Support Management
IX.	Improving Clinical Quality and Patient Safety

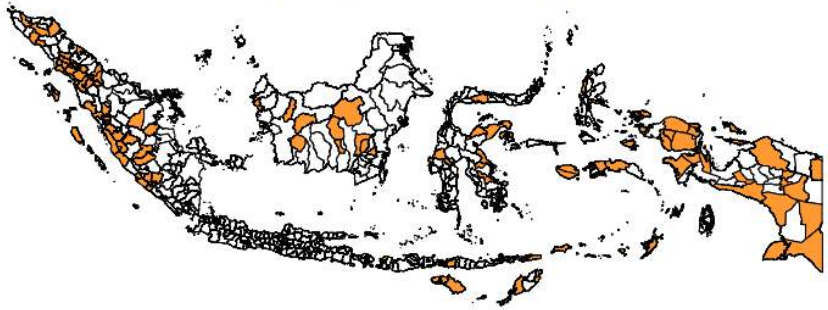
By the End of 2019

- 3,951 (39%) Puskesmas were accredited
  - Low uptake in 2015-16
  - Faster rollout during 2018-19
    - Early adopters concentrated in cities/urban areas
- Most districts (out of 514) had at least one accredited Puskesmas
  - Substantial variation in accreditation rates

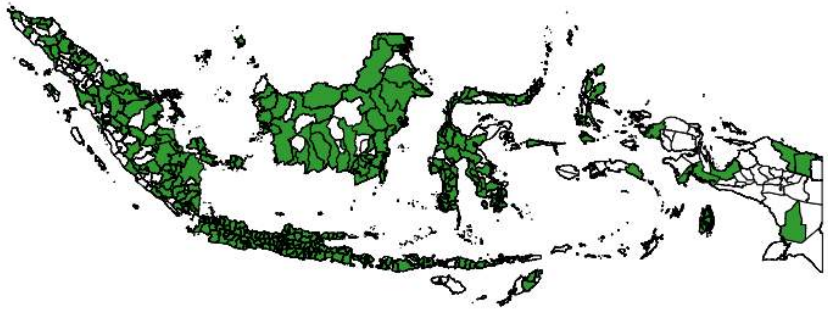




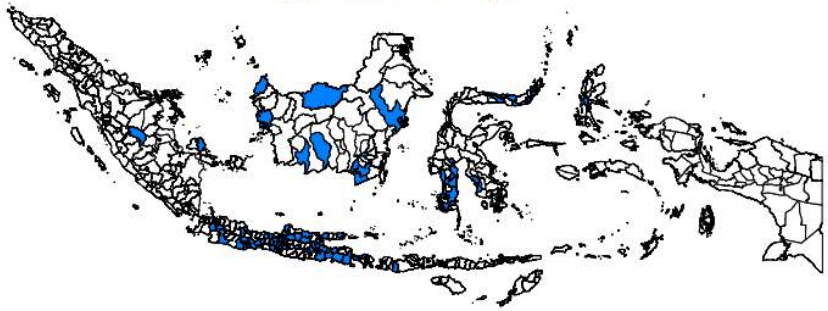
(1) Districts with Only Dasar/Madya



(2) Districts with Utama



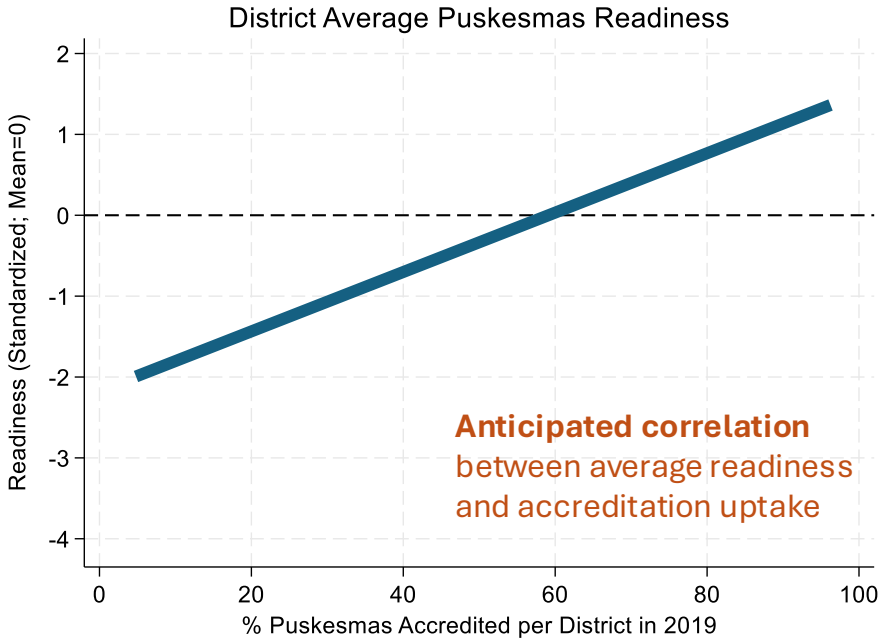
(3) Districts with Paripurna

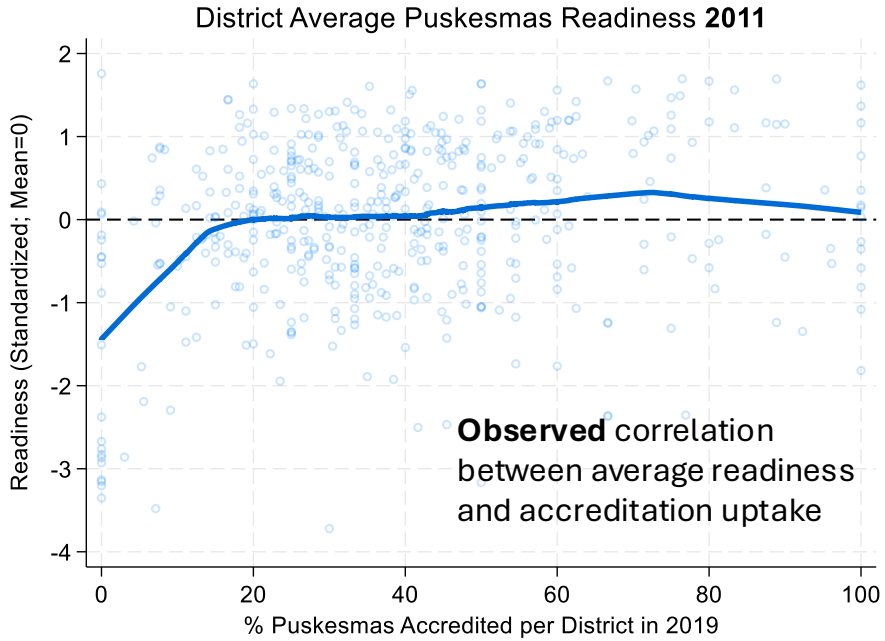


- 6% of accredited Puskesmas achieved Paripurna (plenary), the top tier
  - 41% achieved Utama (main)
  - 38% were Madya (intermediate)
  - 14% were Dasar (basic)
- Many districts had only Dasar or Madya-tier Puskesmas
- Paripurna-tier facilities mainly in cities/urban areas

Figure: District average Puskesmas **service readiness** (standardized) over **district accreditation rate.** Readiness based on structural inputs captured in ***Rifaskes.***

- Accreditation rates show **weak overall link** with average readiness
- **Wide variation in readiness** among districts with similar levels of accreditation uptake





* Rifaskes aggregated to the district level. Local regression smoothing.

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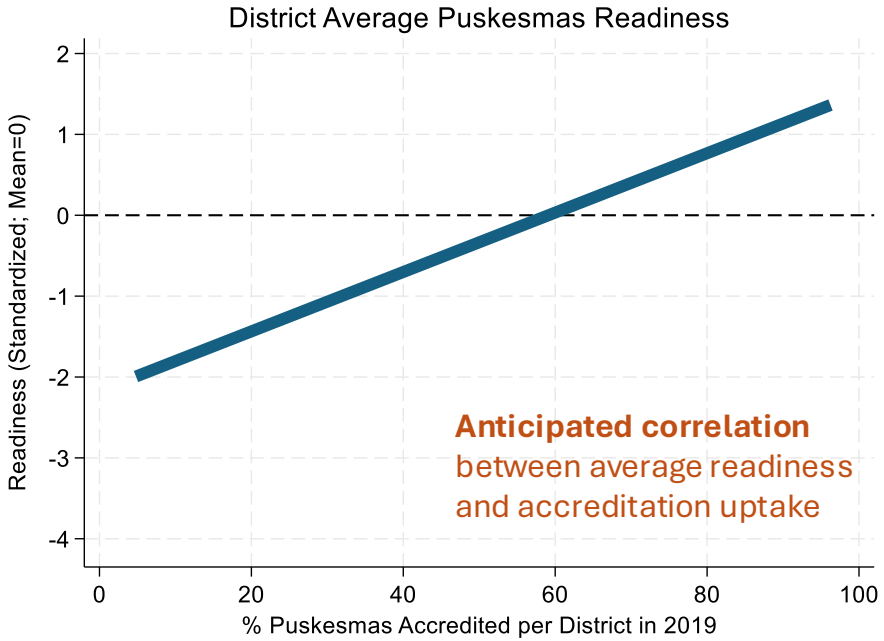
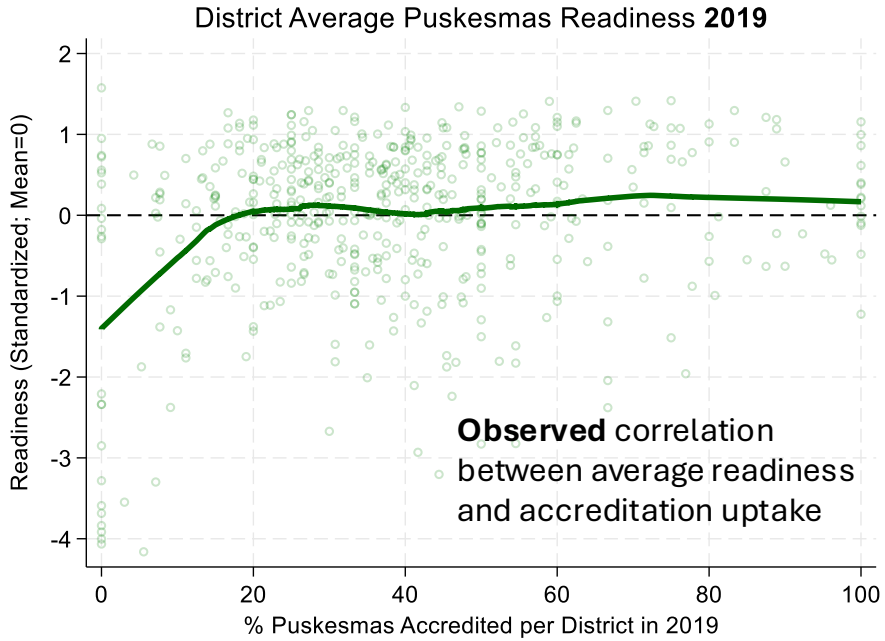
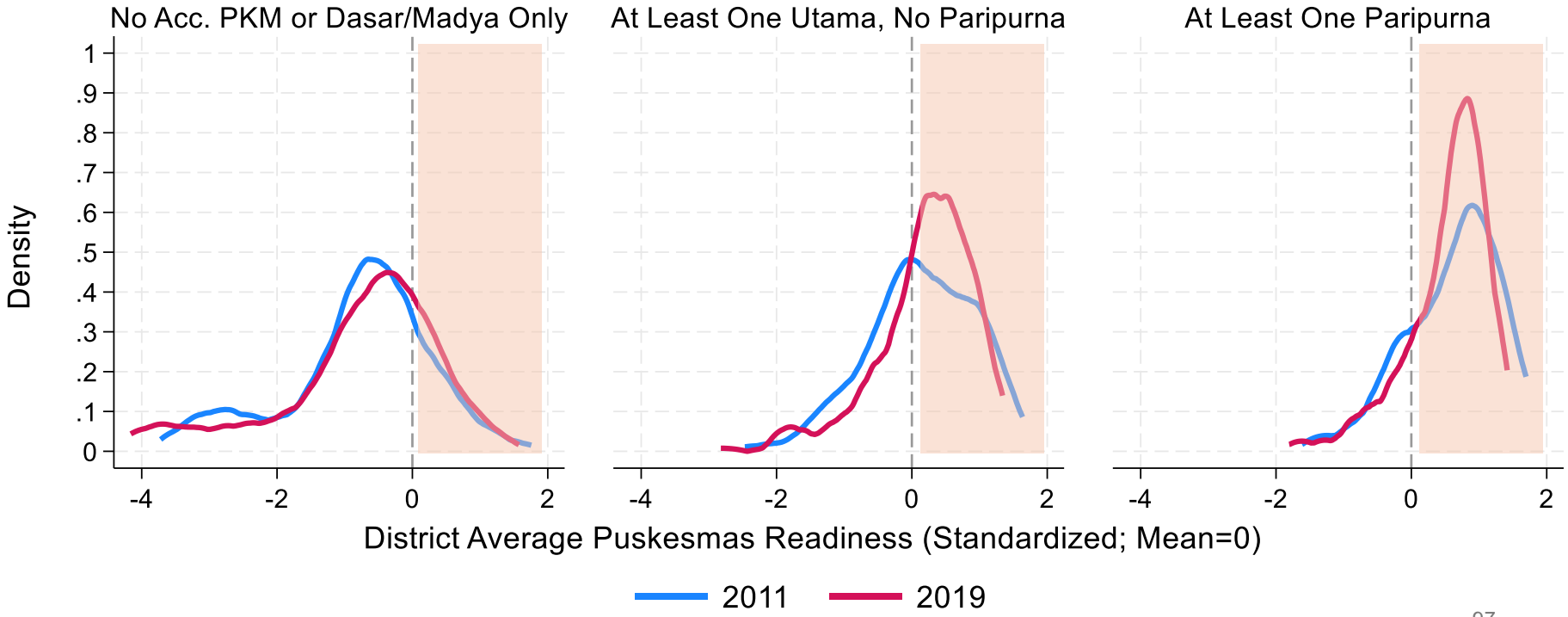




* Rifaskes aggregated to the district level. Local regression smoothing.

Figure. Distribution of average Puskesmas **service readiness** (standardized), grouped **by the highest accreditation tier achieved** by any Puskesmas within each district.

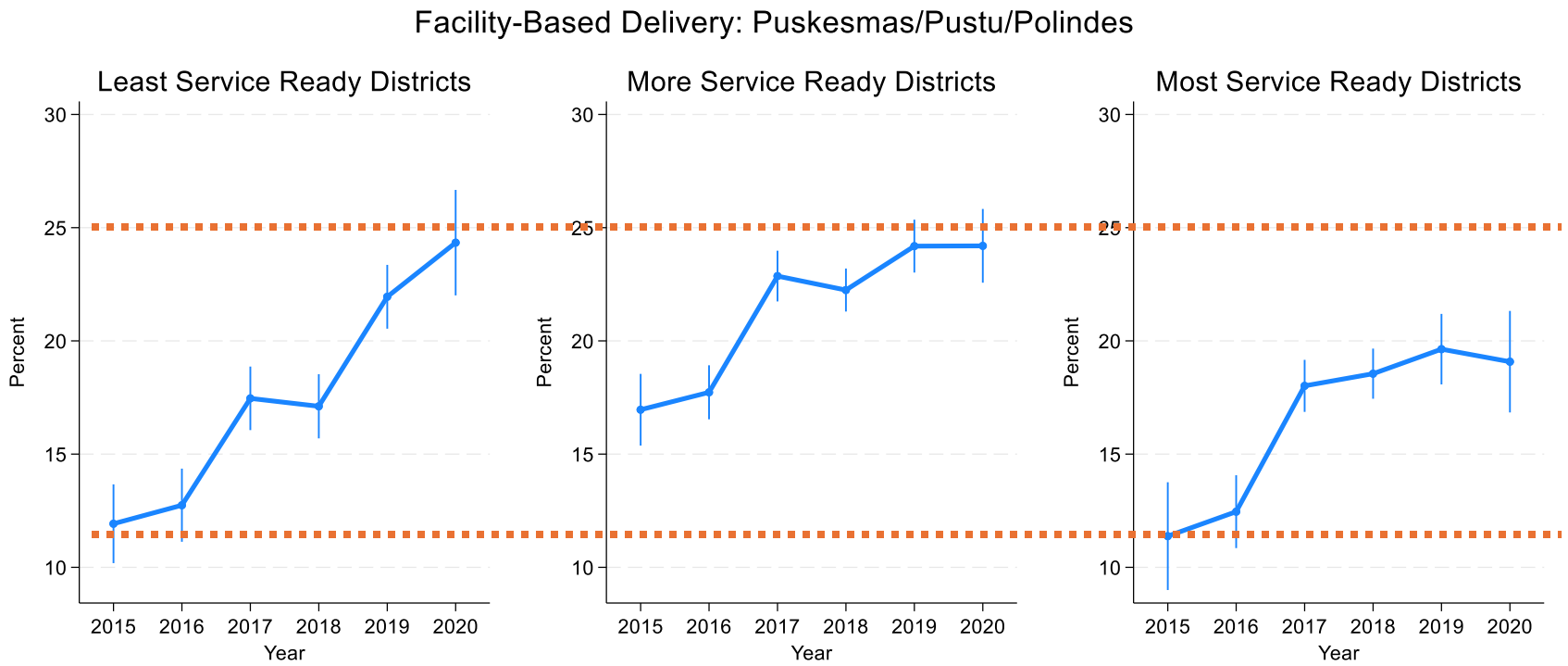
Average readiness **varies meaningfully** by the **highest accreditation tier achieved** by any Puskesmas in a district



* Rifaskes aggregated to the district level. Kernel density.

Figure: Adjusted time trends of **facility-based delivery** at Puskesmas/Pustu/Polindes. Data from ***SUSENAS*** (aggregated to district level).

- **Least ready** districts see **most growth** in Puskesmas-based delivery, more support needed to help them keep up.
- Accreditation **alone** won't be **sufficient** but **can help identify constraints.**



* Pustu: auxiliary Puskesmas, serving villages too far away from the main Puskesmas. Polindes: village maternity post, part of the Puskesmas network.

Accreditation Phase 1 Takeaway

- **More** "service-ready" Puskesmas
  - Adopted accreditation earlier or achieved higher tiers
  - Less room for improvement toward accreditation standards
    - **How to encourage continuous quality improvement?**
  - Still, some high-readiness facilities stayed unaccredited
    - **What drove some to participate, and what held others back?**

- **Less** "service-ready" Puskesmas
  - Accreditation presents an opportunity to improve
    - Feedback, benchmarking, aspiration, learning or knowledge spillover
  - Recognize the constraints facilities face, e.g., rural area staffing challenges
    - Risk of undue burden
    - **How can we support these facilities?**

Accreditation Phase 1 Takeaway

- **Accreditation ≠ Outcome**
  - A step toward quality improvement – feedback, learning, monitoring essential
- **Standards** and **scoring** method able to **differentiate** high- from low-quality facilities
  - Standards well-defined; scores correlated with other performance measures
  - Clear, meaningful cutoff points for the tiers
    - Lower tiers – attainable, but not easy, targets
    - Higher tiers – aspirational targets
- Pay close attention to the **burden of accreditation** and **uneven distribution of cost-benefit** across areas

Going Forward

- Program scaled up rapidly in 2023/24 under a new MOH decree
  - Accreditation tied to BPJS empanelment – effectively mandatory
  - Simplified instrument; assessment outsourced to 13 accreditation agencies
- **Challenge: Quality control** in the accreditation process
  - Accreditation agency **independence**, **qualification**, and **accountability**
  - Subjectivity in scoring system → discretion, scoring variation across agencies
  - Assessment data quality and **creditability** of accreditation
    - Data collection is costly – make every effort count

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Thank you.

Dan Han, Ph.D.
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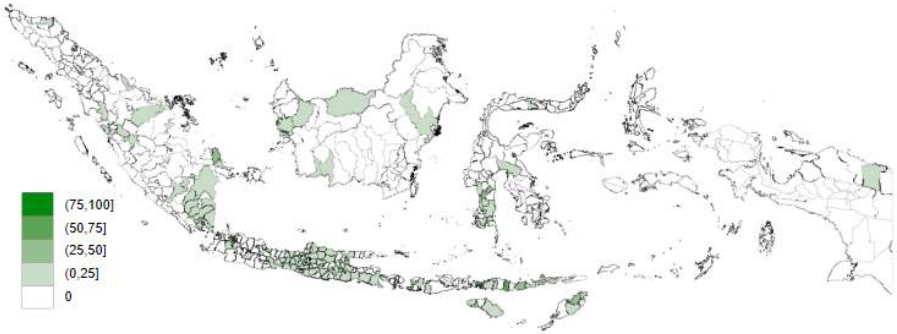
Appendix

Chapter	Focus
I. Implementation of Puskesmas Services	Services are planned, delivered, and continuously improved through community engagement, performance monitoring, and effective feedback mechanisms to meet the needs of the community.
II. Puskesmas Leadership and Management	Management ensures clear roles and duties, competent leadership, effective communication channels, regulatory compliance, appropriate code of conduct, and community engagement.
III. Puskesmas Quality Improvement	Management ensures continuous quality improvement through designated leadership, regular evaluation, community involvement, corrective actions, and external benchmarking.
IV. Target-Oriented Puskesmas Programs and Efforts	Programs are planned and implemented based on community needs, with active community participation, timely feedback, and continuous evaluation and improvements to ensure target achievement.
V. Leadership and Management of Puskesmas Programs and Efforts	Program managers have clearly defined responsibilities, foster communication and coordination across programs and stakeholders, and their performance is regularly monitored against regulations and targets with clear accountability.
VI. Performance Targets and Millennium Development Goals (MDGs)	Puskesmas drives ongoing performance improvement toward MDG-related targets through accountability, documentation, and benchmarking, with a focus on programs related to maternal/child health, HIV/AIDS, and tuberculosis.
VII. Patient-Oriented Clinical Services	Clinical services ensure efficient registration, comprehensive initial assessments, personalized care planning, referrals, adherence to clinical guidelines, respectful and attentive care, safe procedures, nutritional support, and standardized discharge and follow-up processes.
VIII. Clinical Service Support Management	Lab, pharmacy, radiology services, medical records, health care wastes, and equipment are managed systematically, with the designated staff being adequately trained and having the authority to carry out their duties.
IX. Improving Clinical Quality and Patient Safety	Clinical service quality and patient safety are enhanced through active clinical staff involvement, effective measurement and data collection, team-based efforts, and continuous evaluation.

District-Level Accreditation Rate (% Puskesmas Accredited)

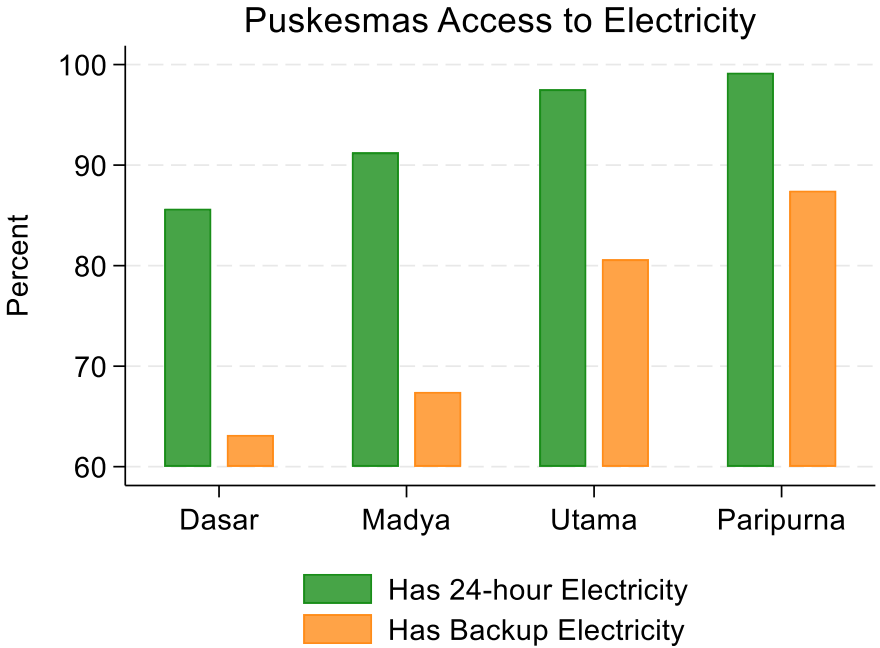
(1) Year 2017

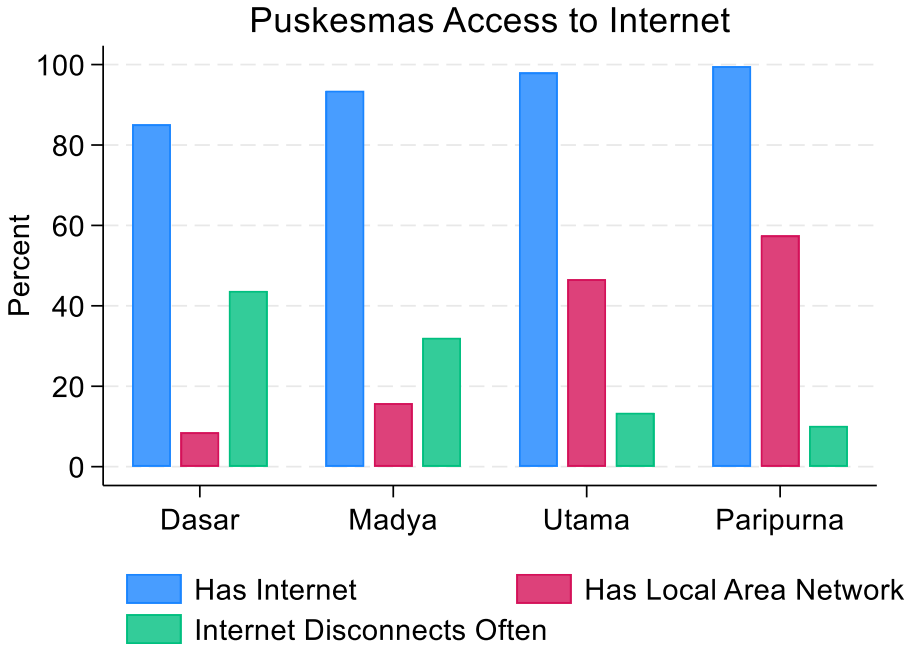


(2) Year 2018

(3) Year 2019

Figure: Percent Puskesmas with access to electricity and internet by accreditation tier. Data from 2023 MOH internet quality survey.





Maintaining medicine quality while aiming for universal health coverage

Amalia Hasnida, M.Sc., Ph.D (cand.).
Researcher, Erasmus University Rotterdam

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RGHI Rotterdam Global Health Initiative

Maintaining **medicine quality** while aiming for **Universal Health Coverage:** ***a political economy perspective***

Amalia Hasnida, S.Si, M.Sc, Ph.D (cand.)

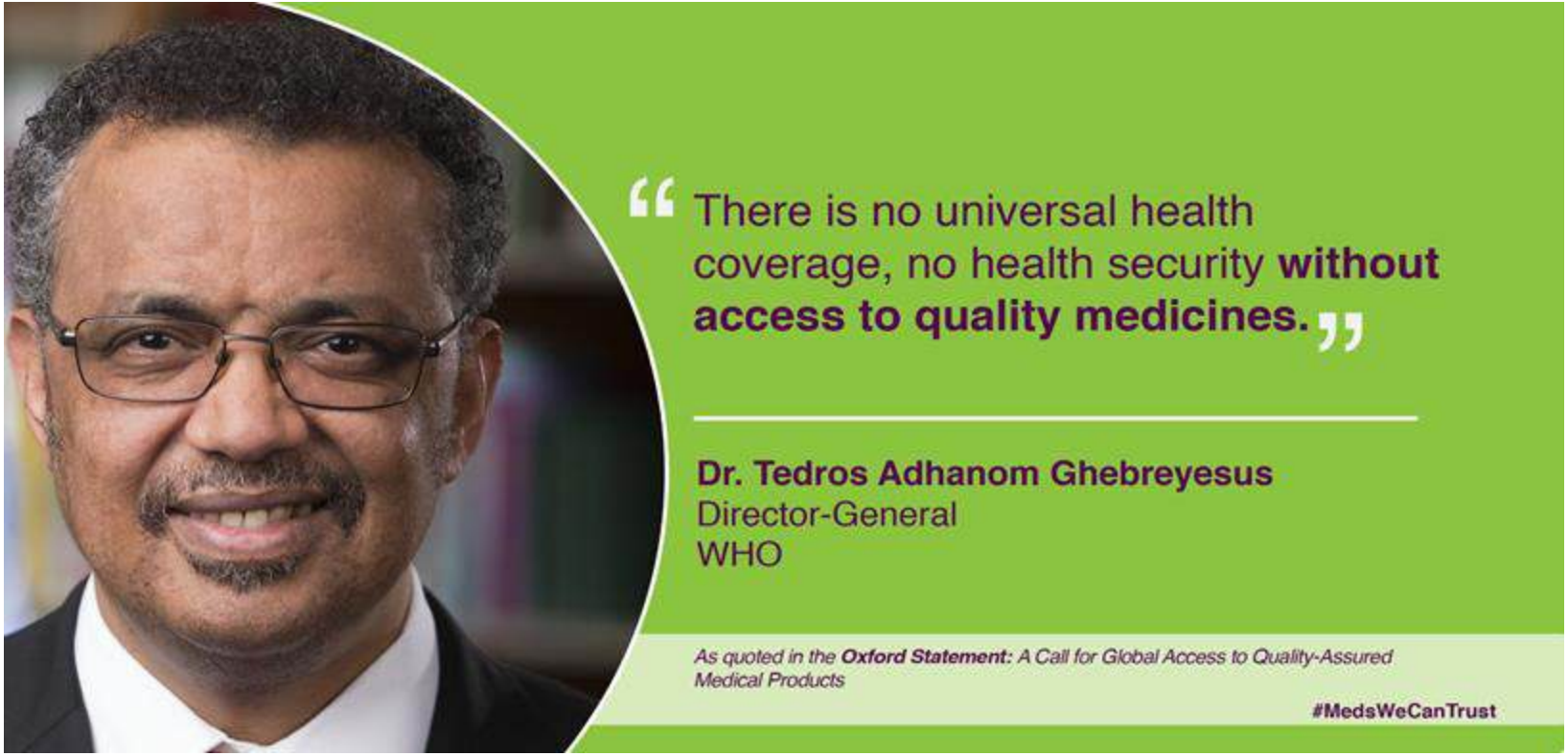
Postdoctoral researcher

Erasmus School of Health Policy & Management (ESHPM), Erasmus University Rotterdam

IHEA Pre-congress Session

Bali, 20 July 2025

The global attention to medicine quality in UHC



What falls into the category of poor-quality medicines?

SUBSTANDARD
Also called "out of specification", these are authorized medical products that fail to meet either their quality standards or their specifications, or both.

FALSIFIED
Medical products that deliberately/fraudulently misrepresent their identity, composition or source.

UNREGISTERED/ UNLICENSED
Medical products that have not undergone evaluation and/or approval by the national and/ or regional regulatory authorities for the market in which they are marketed/distributed or used, subject to permitted conditions under national or regional regulation and legislation.

Source:
1) https://iris.who.int/bitstream/handle/10665/332635/WHO-MVP-EMP-SAV-2019.04-eng.pdf?sequence=1

Substandard and falsified medicines (SFM) can potentially harm patients & health system globally

10.5% of the 48,000 analyzed medical products, collected in 88 low- and middle-income (LMICs), failed at least 1 quality test[1]

Prevalence of substandard & falsified medicines in low- and middle-income (LMICs) was overall 13.6% (19.1% for antimalarials & 12.6% for antibiotics)[2]

Sources:
1) WHO (2017). A study on the public health and socioeconomic impact of substandard and falsified medical products. Report.
2) Ozawa et al. (2019). Prevalence and estimated economic burden of substandard and falsified medicines in low- and middle-income countries: a systematic review and meta-analysis. *JAMA Open*

Why is the quality of medicine essential in achieving UHC?

- A country with an existing UHC scheme also struggles with SFM

  -- Ozempic case in high-income countries (2023-2024)

  -- Falsified vaccine case in Indonesia (2016)

- Other pharmaceutical policy dynamics might intersect with quality:

  -- Affordability: price-pressure on medicines

  -- Affordability: out-of-pocket

  -- Availability: shortage

- Expensive costs of medicine quality testing

Novo's Weight-Loss Drug Demand Fuels Rise in Illegal Sales

Sanne Wass, Bloomberg News

Packets of Ozempic move along a conveyor at the Novo Nordisk A/S production facilities in Hillerod, Denmark, on Tuesday, Sept. 26, 2023. Novo's Ozempic and Wegovy injectable drugs, a class of medicines known as GLP-1s, have been causing ripple effects across the stock market, for the makers of everything from snacks to booze. Bloomberg

(Bloomberg) -- Growing demand for Novo Nordisk A/S's weight-loss and diabetes drugs is fueling a rise in illegal sales in its home country of Denmark, where authorities are now seeking to clamp down on the illicit activity.

The Danish Medicines Agency has reported to police 26 websites which claim to sell products such as Novo's Ozempic and Wegovy as well as potency drugs. The websites aren't approved to sell medicines and there are no guarantees the products are legitimate, the agency said in a statement.

Sources:
1 Hasnida et al. (2021). Challenges in maintaining medicine quality while aiming for universal health coverage: a qualitative analysis from Indonesia. ***BMJ Global Health***
2 Valente de Almeida et al. (2024). Value for money for medicine sampling and quality testing: evidence from Indonesia. ***BMJ Global Health***

Ensuring medicine quality in a nation of 17,500 islands

- Total population: 278.8 millions[1]
- Registered medicines & vaccines: 24.703[2]
- Registered pharmaceuticals companies: 225 (88% domestic)[3]
- Out-of-pocket spending on medicines: 37% (private) & 63% (public sector)[4]

Sources:
1) Statistics Indonesia (2021). Indonesia population census results in 2020
2) Cek BPOM (2023).
3) Pharmaboardroom (2017). Healthcare and sciences review: Indonesia
4) WHO SEARO (2019)

Research focus

Main research question:

What can we learn from a political economy approach and how does it shape the efforts in tackling substandard and falsified medicines (SFM) while aiming for UHC in Indonesia?

Source:
Hasnida (2025). Bridging the interagency silos: taking a political economy perspective to tackle substandard and falsified medicines in Indonesia. *Doctoral dissertation*. Erasmus University Rotterdam (accepted for public defense)

Taking a political economy perspective in research entails bridging medicine quality with other policy areas

- Emphasis on each actor's economic incentives & political interests
- Linking medicine quality with the national policy priority: UHC
- Connecting different areas in pharmaceutical policies:
  - -- Quality
  - -- Availability: shortage
  - -- Affordability: price
  - -- Irrational use of medicines: purchase in unregulated channels
- Conducting mixed-method research with a participatory approach of stakeholders e.g., medicine regulators (2018-2023)
- Focus on the private sector e.g., retail pharmacies, drug stores, online webstores

Source:
Hasnida (2025). Bridging the interagency silos: taking a political economy perspective to tackle substandard and falsified medicines in Indonesia. *Doctoral dissertation*. Erasmus University Rotterdam (accepted for public defense)

What are the insights from taking a political economy perspective?

Research findings

#1: Political & economic factors can drive production & trade of SFM differently

Substandard medicines

- Pressure on profit margins incentivizes cost-cutting
- Limited technical capacity
- Limited oversight

Falsified medicines

- Shortages: market opportunity for falsification
- Falsifiers can make a (huge) profit
- Risk of punishment is low

Sources:
1 Pisani et al. (2019). Identifying market risk for substandard and falsified medicines: an analytic framework based on qualitative research in China, Turkey, Romania. ***Wellcome Open Research***
2 Hasnida et al. (2021). Challenges in maintaining medicine quality while aiming for universal health coverage: a qualitative analysis from Indonesia**.** ***BMJ Global Health***

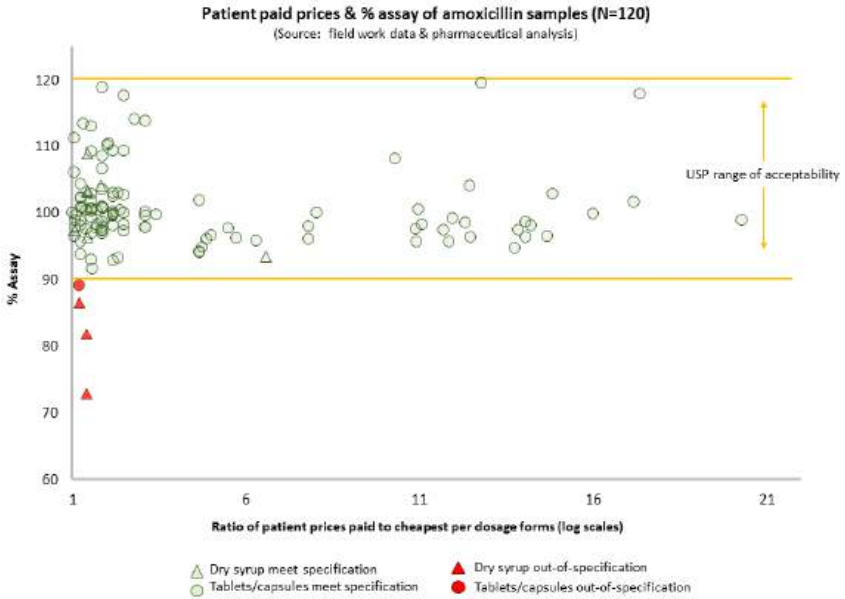
#2: Out-of-specification antibiotics were found in regulated and unregulated channels

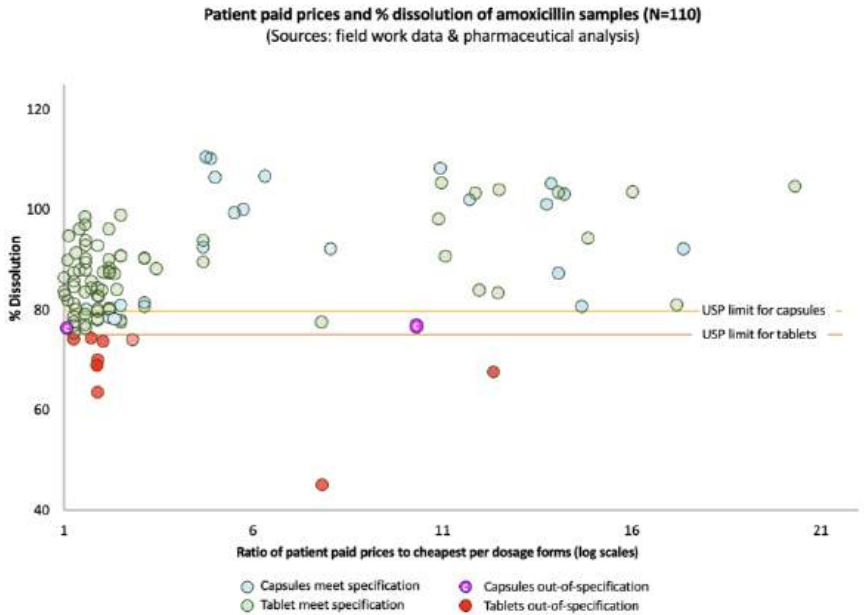
Oral Solid Dosage Forms			
By sampling regions			
Regions	**Total samples collected (N=110)**	**Meet specification**	**Out-of-specification (OOS)**
Jakarta	29	25 (86.2%)	4 (13.8%)
East Java	34	31 (91.2%)	3 (8.8%)
Bekasi	18	15 (83.3%)	3 (16.7%)
Online	15	13 (86.7%)	2 (13.3%)
East Nusa Tenggara (NTT)	14	14 (100%)	0 (0%)
By types of outlets			
Outlets	**Total samples collected (N=110)**	**Meet specification**	**Out-of-specification (OOS)**
Pharmacies	66	58 (87.9%)	8 (12.1%)
Drug stores*	25	23 (92%)	2 (8%)
Health providers (i.e., physicians & midwives)*	4	4 (100%)	0 (0%)
Online vendors*	15	13 (86.7%)	2 (13.3%)
Dry Syrup Dosage Forms			
By sampling regions			
Regions	**Total samples collected (N=10)**	**Meet specification**	**Out-of-specification (OOS)**
Jakarta	6	5 (83.3%)	1 (16.7%)
Bekasi	4	2 (50%)	2 (50%)
By types of outlets			
Outlets	**Total samples collected (N=10)**	**Meet specification**	**Out-of-specification (OOS)**
Pharmacies	5	2 (40%)	3 (60%)
Drug stores*	5	5 (100%)	0 (0%)

**Unlicensed outlets to sell antibiotics*

Source:
Hasnida et al. (2025). Assessing the quality of amoxicillin in the private market in Indonesia: a cross-sectional survey exploring product variety, market volume, and price factors. ***BMJ Open (accepted for publication)***

#3: There is no relation between medicine price & quality





Source:
Hasnida et al. (2025). Assessing the quality of amoxicillin in the private market in Indonesia: a cross-sectional survey exploring product variety, market volume, and price factors. ***BMJ Open (accepted for publication)***

Four concluding remarks

Four concluding remarks

- There is no UHC without access to quality-assured medicines
- Political and economic factors can drive production, distribution, and consumption of substandard & falsified medicines
- Quality is intertwined with other areas in pharmaceutical policies e.g., availability, affordability, and irrational use of medicines
- Medicine quality is a shared responsibility among actors & institutions across sectors – *how can we foster and sustain intersectoral collaboration in the policy environment?*

Terima Kasih

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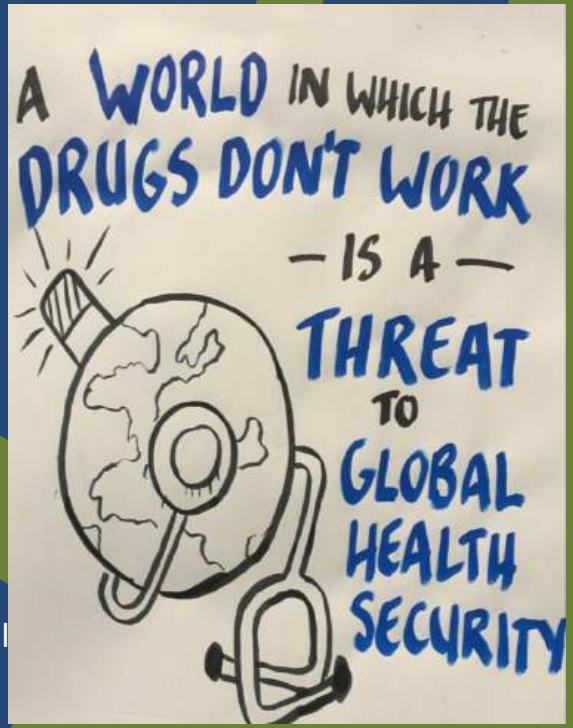
Dr. Maarten O. Kok

Study collaborators:
Migunani Research Network
Faculty of Pharmacy, Pancasila University
Imperial College London

Study funders:
The Wellcome Trust
US Pharmacopoeia (USP) Quality Institute Fel
National Institute of Health Research/NIHR



Twitter: Prof. Dame Sally Davies

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Interactive Session

Questions from the audience

Moderator:
Somil Nagpal
Lead Health Specialist, World Bank Indonesia

Interactive Session (digital)

What does the audience think?
Share your lessons learnt with us digitally

Moderator:
Igna Bonfrer, Ph.D.
Associate Professor Global Health Economics, Erasmus University
Director Rotterdam Global Health Initiative (RGHI)

Lunch break
(resume at 13:00 WITA)

Provider Payment

Introduction to provider payment and to session speakers

Prastuti Soewondo, S.E., M.P.H., Ph.D.
Senior Advisor to the Minister of Health

iDRG Tariff Setting Policy and iDRG Sustainability Strategy Development

Dr. Ahmad Irsan Moeis, S.E., M.E., Head of Centre of Health Financing, Ministry of Health

iDRG Payment Policy and Sustainability Strategy Development

Presented at IHEA on 20th July 2025

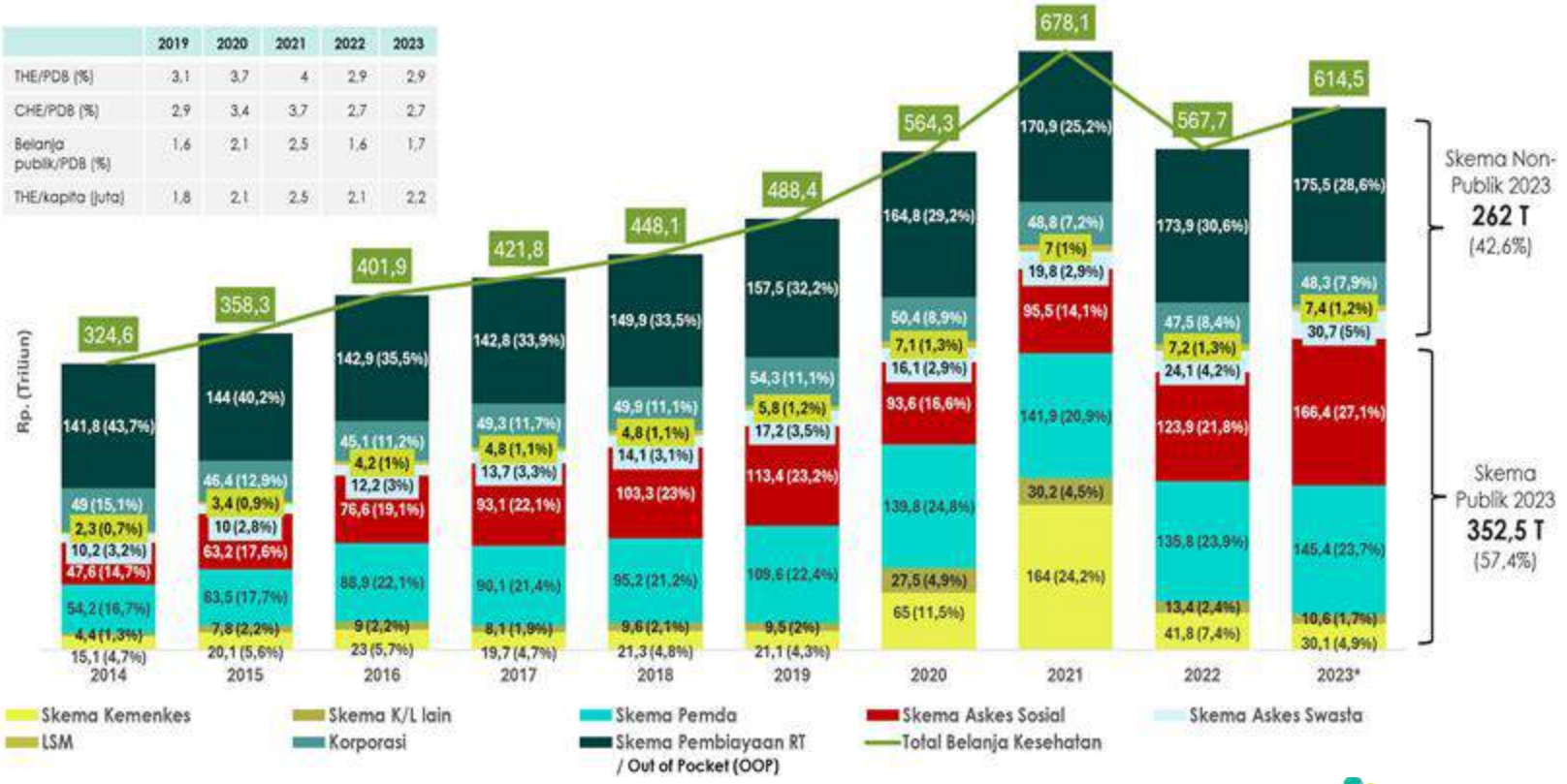
Center for Health Financing

Ministry of Health, Republic of Indonesia

The portion of JKN spending continues to grow, while OOP health spending declining

National Health Accounts

	2019	2020	2021	2022	2023
THE/PDB (%)	3,1	3,7	4	2,9	2,9
CHE/PDB (%)	2,9	3,4	3,7	2,7	2,7
Belanja publik/PDB (%)	1,6	2,1	2,5	1,6	1,7
THE/kapita (juta)	1,8	2,1	2,5	2,1	2,2

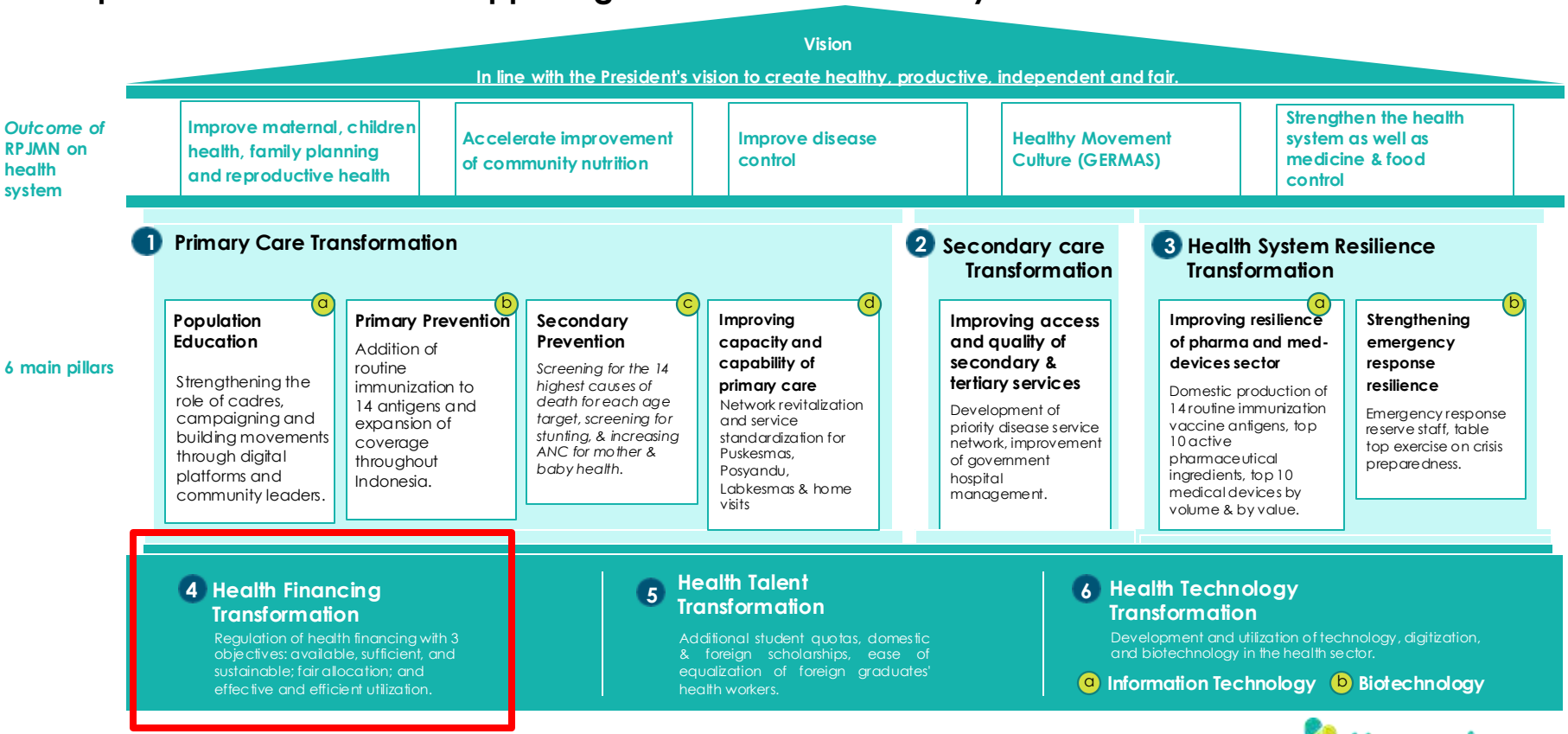


Sumber: *National Health Accounts*, 2023 PDB: Produk Domestik Bruto

Kemenkes

MoH Commitment in Implementing The Health System Transformation

The 6 pillars of transformation supporting the Indonesian health system:



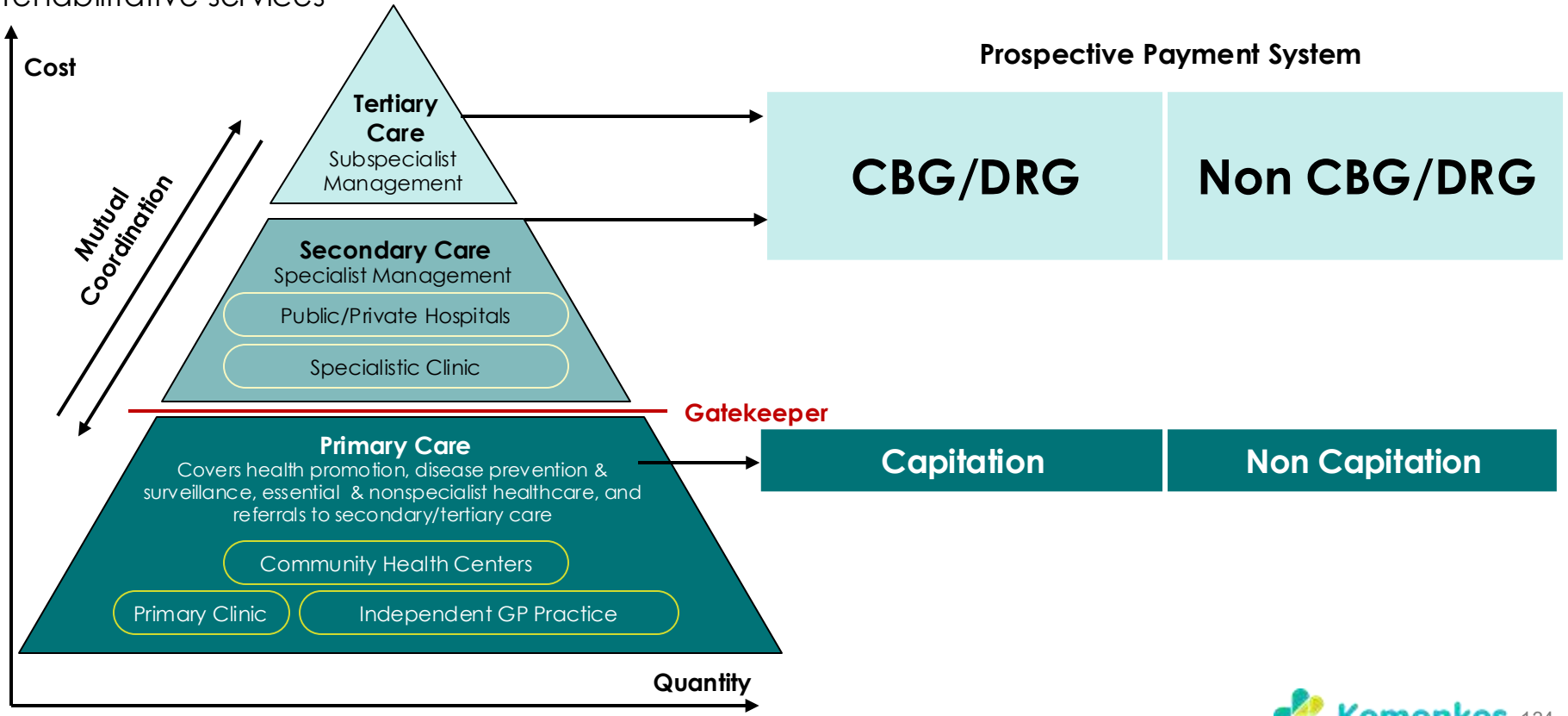
Indonesia Policy to Achieve UHC : Mandated on Law no. 17 Year 2023

- **Personal Health Service** → JKN → Social Health Insurance with Contributory Scheme
- **Population Based Health Service** → MoH/ DoH → Disease Control Program funded by Government/ Local

Kemenkes

Health Benefits covered by JKN

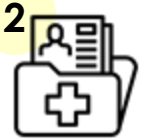
JKN provides comprehensive healthcare benefits across promotive, preventive, curative, and rehabilitative services



Justification for iDRG Reform

1. 

Indonesian National Health Insurance (JKN) Program has been implemented for **more than 10 years** since 2014.

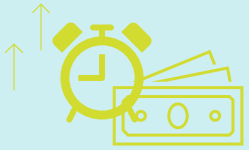
2. 

Indonesia already has its own **epidemiological data.**

3. 

Restoring the basic principles of JKN as social insurance

The Goals of iDRG Reform



Efficiency

iDRG incentivizes hospitals to provide care more efficiently, as payments are based on the **average cost of care** for each group rather than on individual services rendered.

This encourages hospitals to manage resources better and avoid unnecessary procedures or prolonged hospital stays.

Fairness

iDRG is intended to establish standardized tariffs for hospital services, supporting the implementation of prospective payment mechanisms and promoting equity in hospital reimbursements

Transparent

By classifying patients into standardized groups based on diagnoses, treatments, and other factors, iDRG makes hospital billing and resource allocation more transparent and easier to monitor

The Benefits of iDRG Reform

Reflected the disease characteristics in Indonesia
- ✓ Classification is developed using JKN claims data
- ✓ Adopted the Indonesian Modification (IM) codes for ICD-10 (2010) & ICD-9-CM (2010)

Improved group homogeneity
- ✓ Improved costing methodology by using patient level costing
- ✓ Better homogeneity within iDRG, as indicated by improved Coefficient of Variation (COV) and Reduction in Variance (RIV) metrics
- ✓ Enables more accurate severity levels, both clinically and resource utilization complexity

Governed by the Ministry of Health
- ✓ Enables continuous refinement which is adjusted to the development of cases policies in Indonesia
- ✓ Enables to integrate advanced medical technologies and incorporate up-to-date medical practices
- ✓ Enables to adjust fair financing for respected iDRG groups
- ✓ Enables to support future development of innovative care models including One Day Care (ODC), emergency care, as well as the introduction of new DRGs, such as Respiratory TB & Drug-Resistance Respiratory TB

Inclusiveness support from various stakeholders and DRG experts
- ✓ Hospitals and Hospital Association in Indonesia
- ✓ Professional Association/Organisation
- ✓ BPJS Kesehatan

Note: also supported by NGOs

Development of iDRG and costing study

Riris Dian Hardiani, S.K.M., M.K.M., Head of Working Team for DRG and Casemix, Ministry of Health Indonesia

Atik Nurwahyuni, S.K.M., M.K.M., INA-Grouper Team member, Ministry of Health Indonesia/CHEPS Faculty of Public Health Universitas Indonesia

Development of iDRG and Costing Study

Presented at The 16th IHEA World Congress 2025
Bali, 20th July 2025

Center for Health Financing

Ministry of Health, Republic of Indonesia

Outline

1. Background
2. Development of iDRG
3. Costing to Improve Appropriateness of iDRG Payments

Background

Background

Indonesia's National Health Insurance (JKN) uses a DRG payment system in which cases are grouped using the INA-CBG (Indonesian Case Base Group) classification.

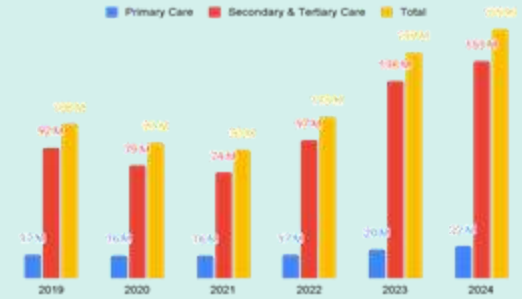
Indonesia first introduced JKN in 2014 along with the establishment of BPJS Kesehatan (Social Security Administration for Health).

Two types of healthcare payment systems are currently in use:

Capitation in Primary Care

INA-CBG in Secondary & Tertiary Care

Annually, **more than 80%** of total claims for JKN are secondary & tertiary care (hospital services).



M = in Trillion Rupiah

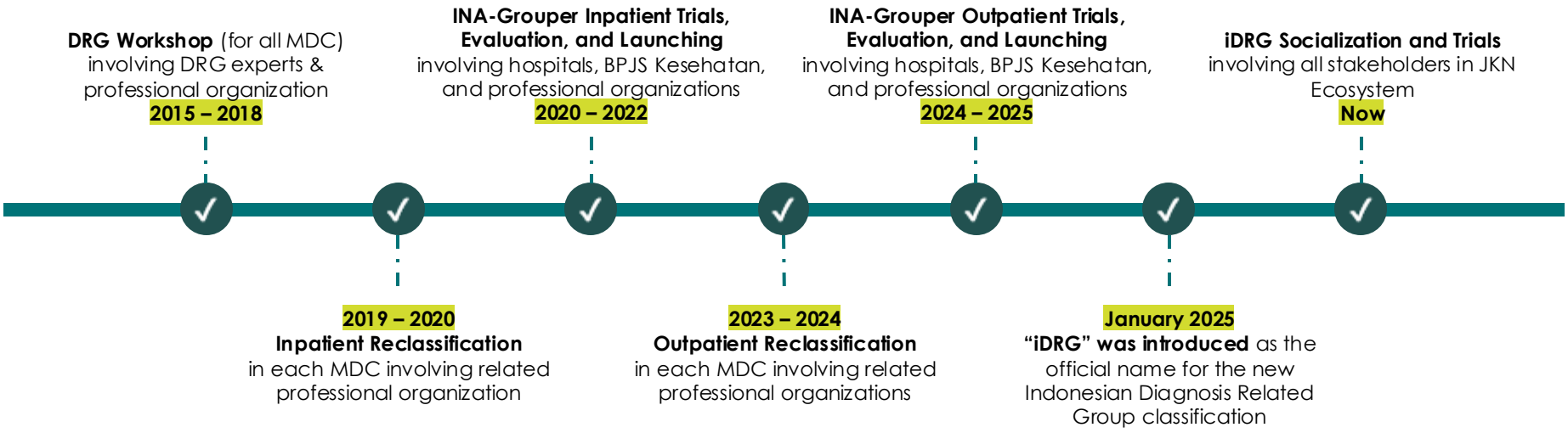
	2019	2020	2021	2022	2023	2024
Primary Care	15%	17%	18%	15%	13%	13%
Secondary & Tertiary Care	85%	83%	82%	85%	87%	87%

The need to develop Indonesia's own DRG payment system:

1. To enhance the precision of case classification based on clinical relevance and similarity in resources utilization;
2. To provide a more accurate representation of diseases patterns within the population;
3. To integrate advanced medical technologies and reflect an up-to-date medical practices
4. To adapt to fluctuations in the cost of pharmaceuticals, medical supplies, and other healthcare inputs.

Development of iDRG

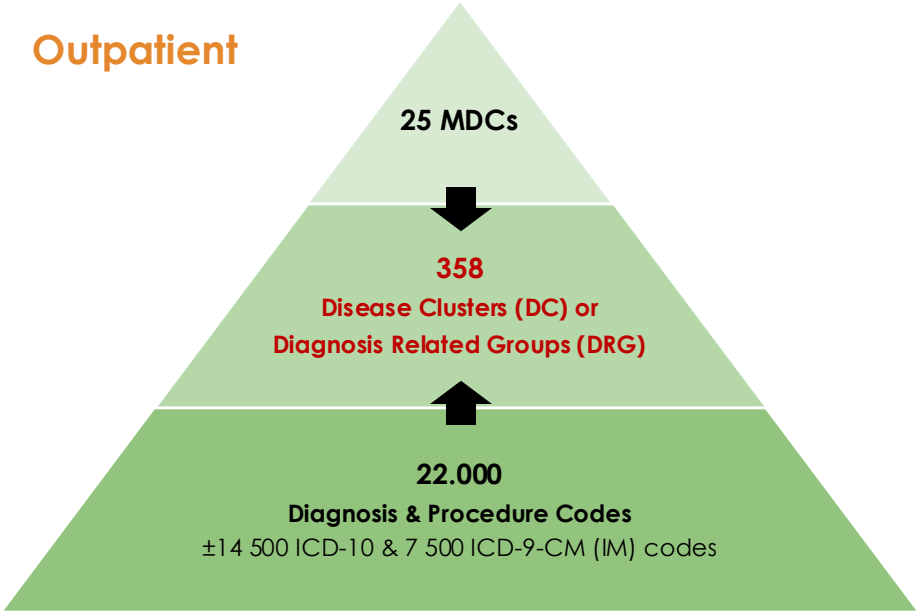
The Long Journey Towards Developing Indonesia's Own iDRG



The 1st Version of iDRG

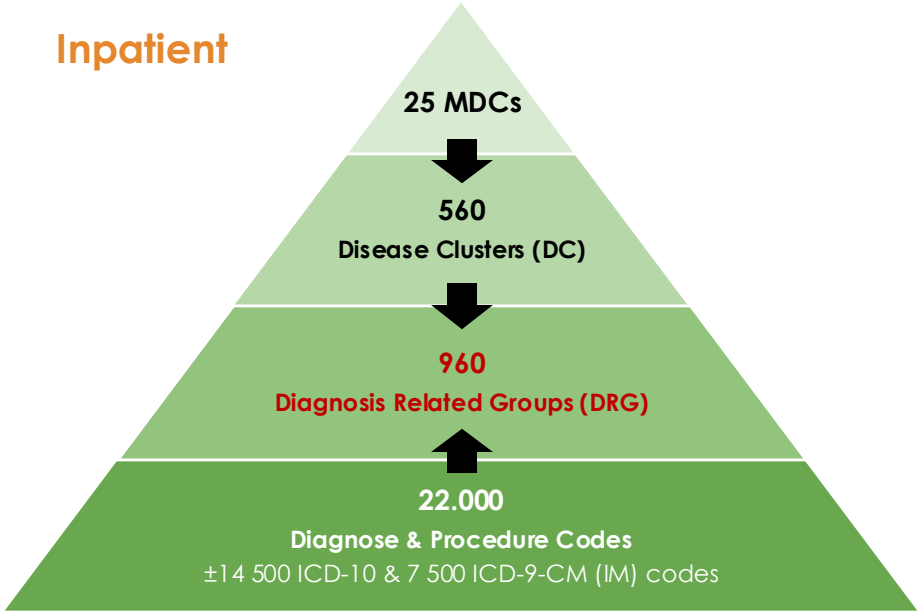
- **iDRG includes both inpatient and outpatient care** at the hospital which allows Indonesia to calibrate incentives towards outpatient rather than inpatient care
- **The iDRG increased the number of groups** compared to INA-CBG, to better reflect the morbidity patterns and resource use differentials in the different groups

Outpatient



Classification System	CMG/MDC	DC	CBG/DRG
INA-CBG	22	289	289
iDRG	**25**	**358**	**358**

Inpatient

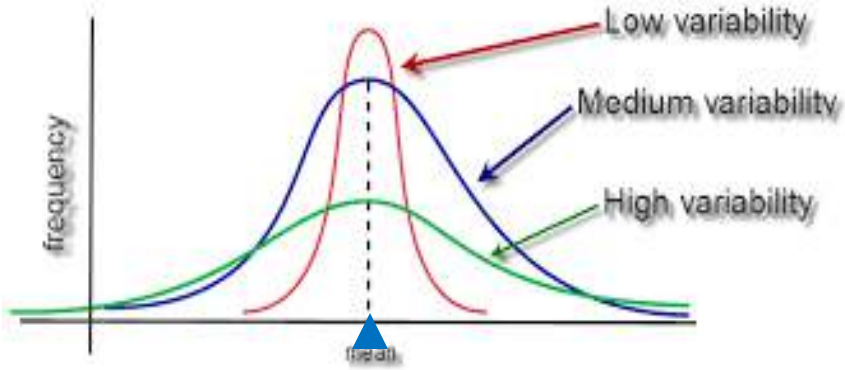


Classification System	CMG/MDC	DC	CBG/DRG
INA-CBG	22	262	786
iDRG	**25**	**560**	**960**

Basic Concept of DRG classification and its relationship with DRG Tariffs

- The homogeneity of resources required for the treatment of one DRG is measured by the Coefficient of Variation (CoV) value.
- The iDRG grouping achieves **low variability**, indicated by CoV < 1

Graph of Normal Distribution of Variability within 1 DRG Group



Analysis of Cost Variation Led to Significant Changes in The Grouper Including

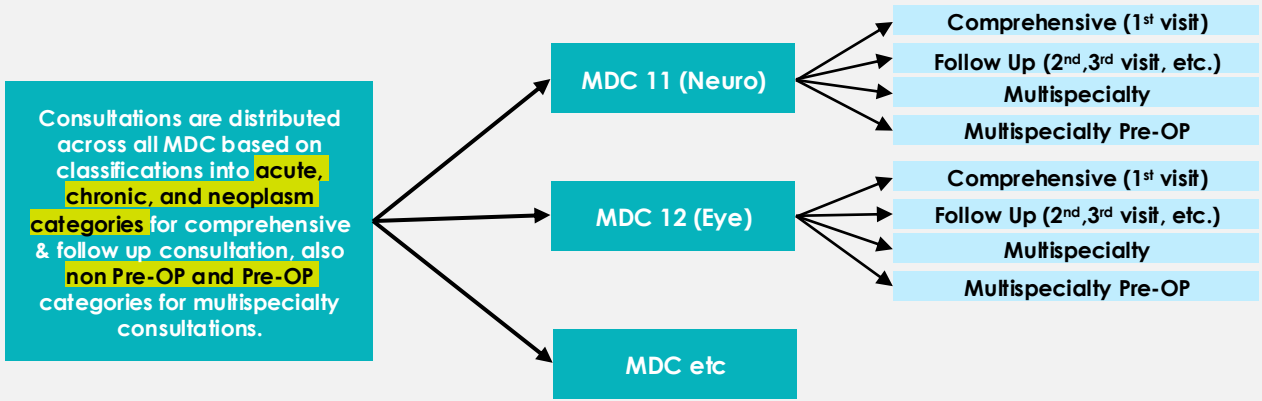
Split large heterogeneous groups into a larger number of groups, each of which had similar clinical and resource use features. This ensures payment is closer to costs of providing care in the group.

Merge groups with small cases when there was little meaningful difference in costs.

In a limited number of cases, merging combined with unbundling the key cost driver (e.g. chemotherapy drugs) to be paid as a top-up when the clinical criteria met the requirements of the treatment protocol for use of the drug.

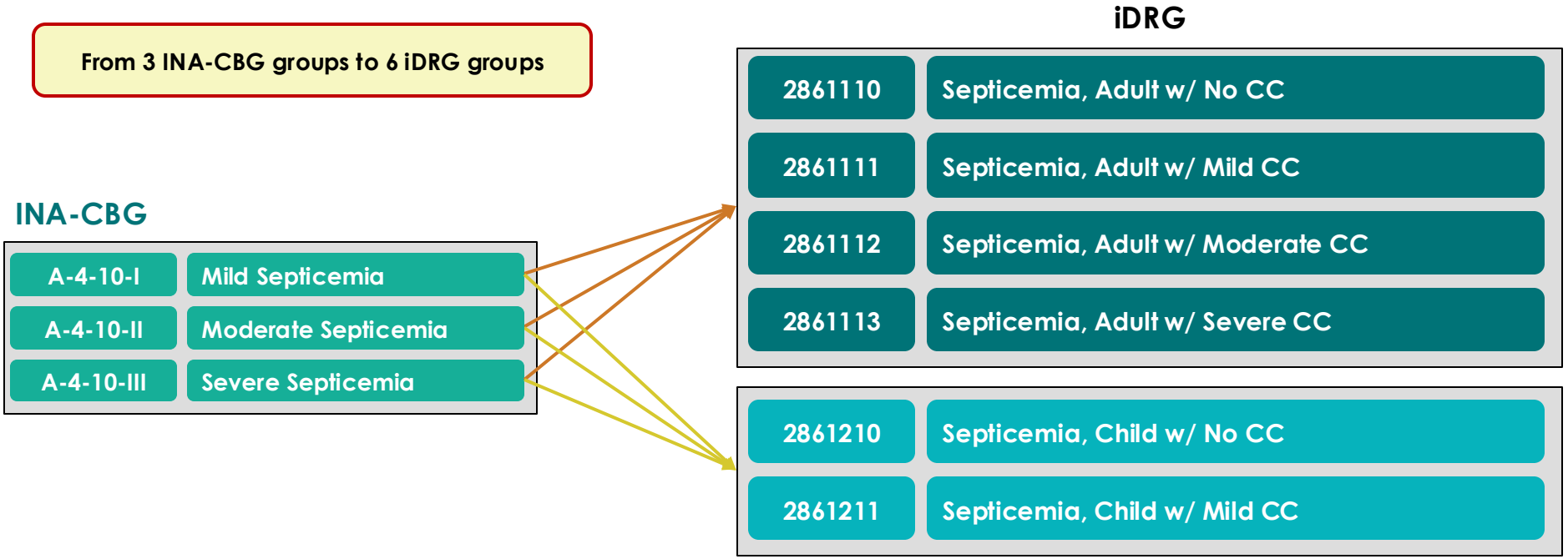
Reclassification of Outpatient Group: Other Minor Chronic Conditions (Q-5-44-0)

- **Group Q-5-44-0** includes consultation services for all diseases, including follow-up consultations coded with Z codes as the primary diagnosis.
- **The concentration of consultation services** within Group Q-5-44-0 has made it **difficult to identify specific disease types** in outpatient care, such as the top 10 most frequent diseases.
- **A reclassification** was conducted to divide Group Q-5-44-0 into **159 more specific groups including:** comprehensive, follow-up, multispecialty and multispecialty preoperative consultations in different MDCs.

INA-CBG	iDRG
Consultation (Q-5-44) Total visits in 2023: 70.9 Millions (55% of total outpatients visits) Total claim in 2023: 16.2 T IDR (increase 35% compared to year 2022) **Concentration of consultation services within group Q-5-44 (Other Minor Chronic Diseases).**	 • **Group Q-5-44 has been reclassified by remapping it across all MDCs, making it easier to identify cases based on disease type.** • **Consultation services are now divided into four distinct groups: comprehensive, follow up, multispecialty, and multispecialty Pre-OP consultations**

Example: Septicemia Reclassification in Inpatient Care

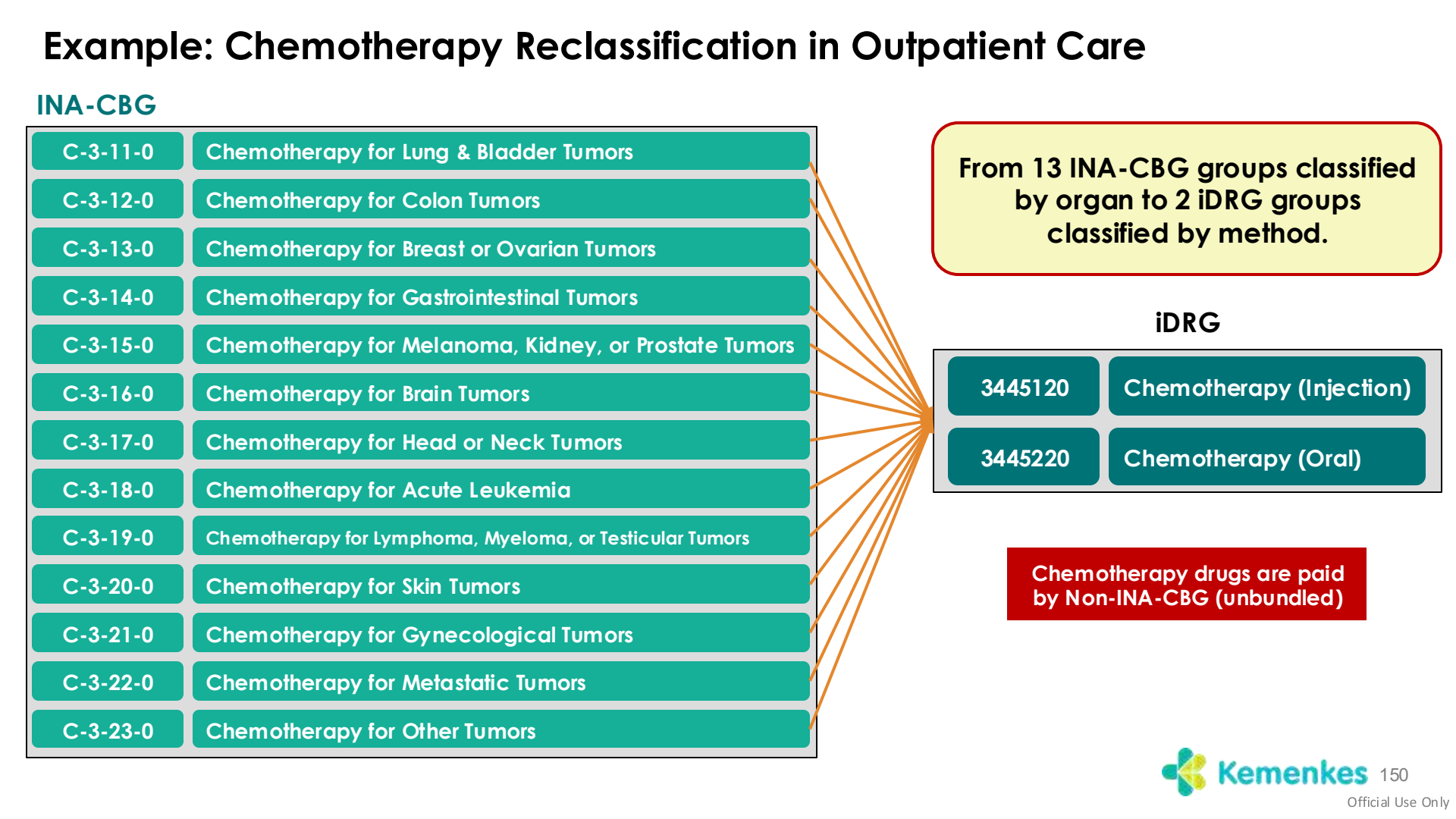
From 3 INA-CBG groups to 6 iDRG groups



Example: Chemotherapy Reclassification in Outpatient Care

INA-CBG

C-3-11-0	Chemotherapy for Lung & Bladder Tumors
C-3-12-0	Chemotherapy for Colon Tumors
C-3-13-0	Chemotherapy for Breast or Ovarian Tumors
C-3-14-0	Chemotherapy for Gastrointestinal Tumors
C-3-15-0	Chemotherapy for Melanoma, Kidney, or Prostate Tumors
C-3-16-0	Chemotherapy for Brain Tumors
C-3-17-0	Chemotherapy for Head or Neck Tumors
C-3-18-0	Chemotherapy for Acute Leukemia
C-3-19-0	Chemotherapy for Lymphoma, Myeloma, or Testicular Tumors
C-3-20-0	Chemotherapy for Skin Tumors
C-3-21-0	Chemotherapy for Gynecological Tumors
C-3-22-0	Chemotherapy for Metastatic Tumors
C-3-23-0	Chemotherapy for Other Tumors



From 13 INA-CBG groups classified by organ to 2 iDRG groups classified by method.

iDRG

3445120	Chemotherapy (Injection)
3445220	Chemotherapy (Oral)

Chemotherapy drugs are paid by Non-INA-CBG (unbundled)

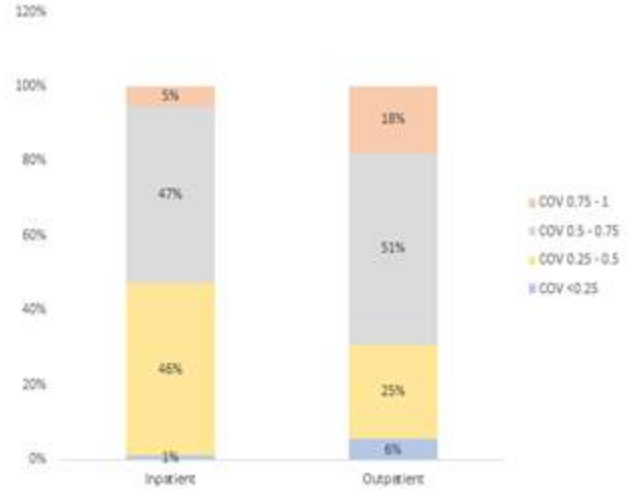
COV & RIV of iDRG

- **Diagnosis Related Group (DRG) classification** is a system used to categorize hospital cases into groups that are expected to have similar hospital resource use.
- **Two important statistical measures** used to assess the effectiveness of DRG grouping are **Coefficient of Variation (COV)** and **Reduction in Variance (RIV)**.

Coefficient of Variation (COV)

COV is used to evaluate the *homogeneity* of resource consumption (such as costs or length of stay) within each DRG group.

Distribution of CoV iDRG



Reduction in Variance (RIV)

RIV assesses how well the DRG system explains differences in resource consumption between groups in each MDC (within MDC).

Distribution of RIV Total iDRG

RIV Total Inpatient	RIV Total Outpatient
iDRG = 0.76	iDRG = 0.71
INA-CBGs = 0.67	INA-CBGs = 0.65

Notes:
- COV: the lower the COV, the more homogenous the groups
- RIV: the higher the RIV, the better the variance reduction

Costing to Improve Appropriateness of iDRG Payments

Costing Study for iDRG Development

Background for iDRG Tariff Calculation

1. **The policy of using iDRG in 2025** requires updated tariff calculations

2. **iDRG Tariff =**
   Cost Weight x National Base Rate x Adjustment

   to obtain the cost weight, costing data is necessary

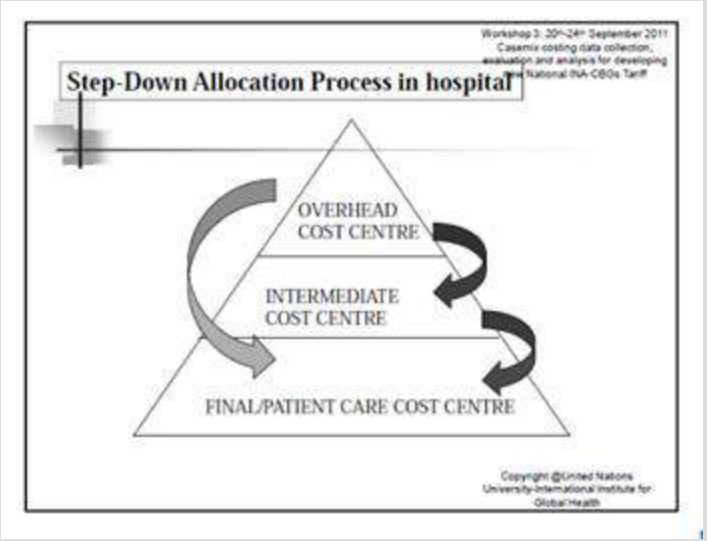
3. **Robust costing data requires:**
   - Adequate sample size, requiring hospital participation.
   - User-friendly costing template for hospitals.
   - Improved and more accurate methodology for calculating cost per DRG.

Key Principles for Cost Data Collection

1. **Hospital data confidentiality guarantee**
2. **Anonymity of hospital names** in Analysis and Results Presentation
3. **Data use is strictly limited** for iDRG Tariff Analysis Only
4. **Ease of data entry**
5. **Increased number of contributing hospitals**
6. **Data validation**
7. **Incentives for contributing hospitals**

Old Costing Methodology 2013-2018: Important shortcomings

Top Down



The output of inpatient calculation is unit cost per day per department

INA-CBGs cost
= ALOS x Unit Cost per Day per Department

No	INA-CBG	Description	Department	ALOS	UC per Day (Rp)	Total (Rp)
1	A-4-10-II	Septicemia (mild)	Digestive	6	1.301.713	7.810.278
2	A-4-12-III	Unknown Fever (Severe)	Digestive	5	1.301.713	6.508.565
3	K-4-11-I	Gastritis & Peptic Ulcer (Mild)	Digestive	3	1.301.713	3.905.139
4	B-1-13-I	Pancreatic Procedure & Others Hepatobiliary (Mild)	Surgery	8	2.012.865	16.102.920
5	I-1-06-I	Other Cardiothoracic Procedures (Mild)	Surgery	8	2.012.865	16.102.920

Potentially **Under Cost** and **Over Cost**

Improvements in Costing Methodology were needed

Patient Level Costing Using a Hybrid Top-Down and Bottom-Up Method: Improved accuracy

Methodology in Other Countries

Patient Level Costing is widely adopted in many countries as an approach for calculating healthcare costs.
(Thailand, Mongolia, France, England, Estonia etc)

Data Availability

Costing Template (Top-Down)

Costing template was used by hospitals for INA-CBG tariff setting in 2013-2018.

Tariff Components (Bottom-Up)

Tariff components per case are entered in e-claims (per patient).

Availability of hospital tariff components data in e-claim systems enables patient-level costing

18 Tariff Component Variables

1. Non-Surgical Procedures
2. Surgical Procedures
3. Consultation
4. Expert Personnel
5. Nursing Care
6. Supporting Services
7. Radiology
8. Laboratory
9. Blood Transfusion Services
10. Rehabilitation
11. Room/Accommodation
12. Intensive Care
13. Medication
14. Chronic Medication
15. Chemotherapy Drug
16. Medical Devices
17. Consumables
18. Equipment Rent

Evolution of Costing Studies in Indonesia

In the development of iDRG, a more accurate costing study was conducted using patient-level costing

Tariff INA-CBG	2013	2014	2016	2018	2025 (iDRG Tariff)
Number of Hospitals	100	137	157	67	303 hospitals (for aggregate cost), **130 hospitals for Detailed Costing**
Hospital Ownership	Public	Public	Public, Private	Public, Private	Public, Private
Type of Hospital	A-B-C-D	A-B-C-D	A-B-C-D	A-B-C-D	A-B-C-D
Data Year	2010	2011	2014	2016	2022
Costing Methodology	Top down	Top down	Top down	Top down	**Patient Level Costing**
Data Used	Hospital costing template & LOS per CBG	Hospital costing template & LOS per CBG	Hospital costing template & LOS per CBG	Hospital costing template & LOS per CBG	Hospital costing template, Operational Report, and tariff per service component in JKN claims

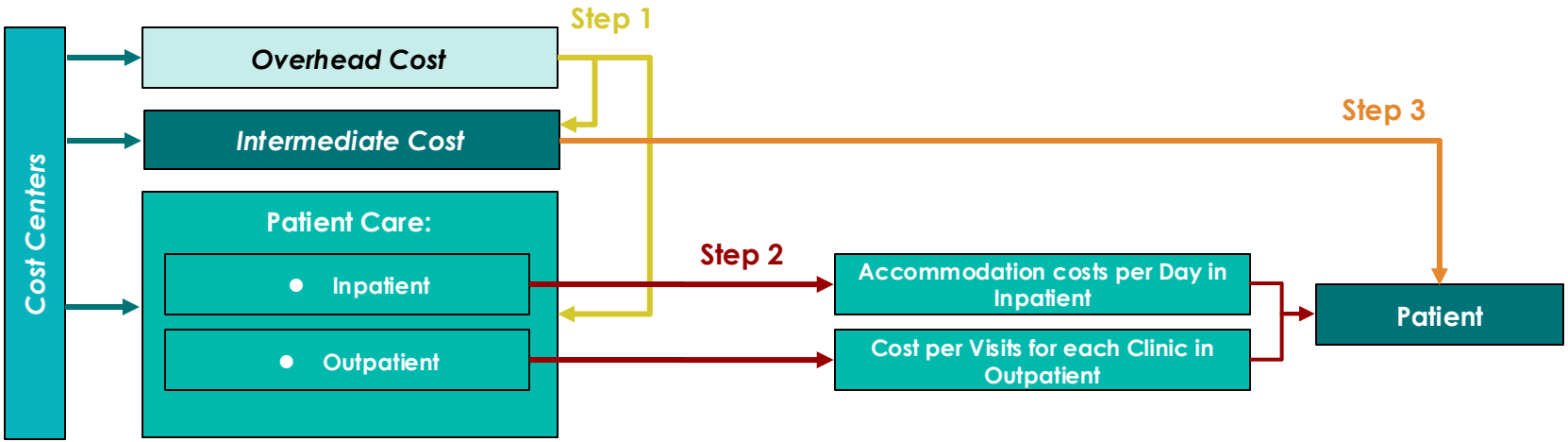
Patient-Level Costing for iDRG Tariff 2025

Patient-level costing uses a top-down and bottom-up approach

Step 1
Allocate **overhead costs** to **intermediate costs**, and patient care (**inpatient**, and **outpatient)**

Step 2
Calculate the **accommodation costs per day (inpatient) and cost per visit for each clinic (outpatient)**, followed by determining the cost per patient based on their utilization

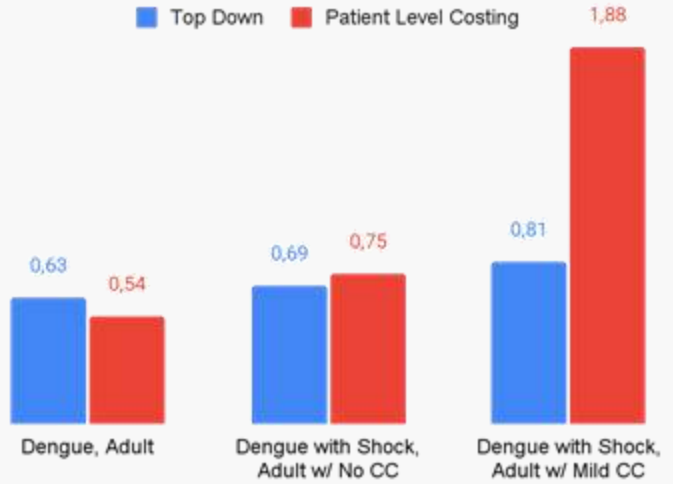
Step 3
Distribute **Intermediate costs** directly to the patient, based on the proportion of the hospital tariff component.



Switching from Top-Down to Patient-Level Costing Improves Matching of Payment to Costs

Cost Weight of Group

A-4-13-X Other Viral and Non-Bacterial Infections

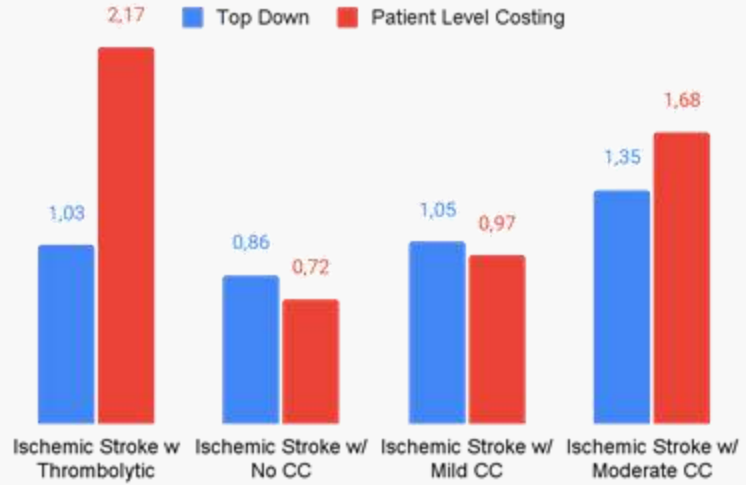


ALOS		
4,67	5,05	5,99

- **Top Down calculation** shows that cost weight for Dengue with shock is 1.1-1.3 times greater than Dengue because the ALOS is almost the same, namely 4.67 with 5.05-5.99
- **Calculation of patient level costing** for Dengue with shock shows 1.38-3.5 times greater than Dengue

Cost Weight of Group

G-4-14-X Cerebrovascular Injury with Infarct



ALOS			
5,91	4,9	6,02	7,73

- **Top Down calculation** shows that cost weight for Ischemic stroke with thrombolytics is only 1.2 times greater than Ischemic stroke because ALOS is 4.90 and 5.91
- **Calculation of patient level costing** for ischemic stroke with thrombolytics shows that it is 3.01 times greater than ischemic stroke.

Key Lessons

1. **Indonesia is proud to have established its own classification system — iDRGs,** built on Indonesia's disease patterns and calibrated using detailed, patient-level costing data to support the government in achieving its policy objectives.
2. Indonesia continues to **strengthen the methodology, sampling, and data inputs of its DRG costing** study to ensure results are robust, accurate, and transparent for improved tariff setting.
3. **Collaboration across hospitals, hospital associations, professional organization, BPJS Kesehatan, DJSN, and the Ministry of Finance,** is key to build shared understanding and a common vision for a sustainable implementation of iDRGs

Way Forward

1. **Costing studies must be conducted every two years** to align with DRG classificationupdates to cover inflation
2. **DRG classification must be regularly updated** to reflect changes in disease patterns, advancements in medical technology and evolving prices and costs.

Interactive Session

Questions from the audience

Moderator:
Prastuti Soewondo, S.E., M.P.H., Ph.D.
Senior Advisor to the Minister of Health

Panel Reflections

Lessons from Indonesia's strides towards UHC over the last decade

Chair:
Igna Bonfrer, Ph.D.
Associate Professor Global Health Economics, Erasmus University Director Rotterdam Global Health Initiative (RGHI)

Panel members:

- **Prastuti Soewondo, S.E., M.P.H., Ph.D. Senior Advisor to the Minister of Health**
- **Lily Kresnowati, M.Kes., Director of Health Service Assurance, BPJS Kesehatan**
- **Patrick Mullen, Lead Health Specialist, World Bank Indonesia**

Refreshment break (resume at 15:00 WITA)

Researchers’ perspective on innovation in Indonesia’s health care

Introduction to “researcher perspectives” and welcome to session speakers

Igna Bonfrer, Ph.D., Associate Professor Global Health Economics, Erasmus University and Director Rotterdam Global Health Initiative

Nutrition transition and rising overweight and obesity

Margarita de Vries Mecheva, Ph.D.,
Erasmus University Rotterdam

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

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Nutrition transition and rising prevalence of overweight and obesity

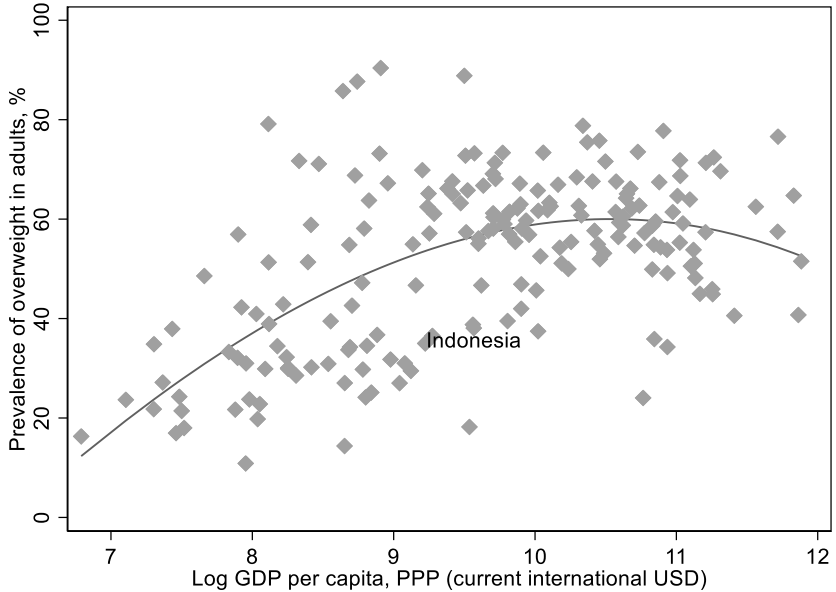
Nutrition Transition

Main contribution to the global burden of chronic disease

- **Shift in dietary patterns and physical activity** levels associated with urbanization and industrialization (Popkin, 1993)
- Linked to **a rise in obesity** – the major risk factor for non-communicable diseases (NCDs) and a major cause of mortality and death worldwide
- Obesity is **a major risk factor for noncommunicable diseases (NCDs)** => a considerable **economic burden** to society (treatment, productivity, mortality) (Popkin et al., 2020; Okunogbe et al., 2021; Hendarto, 2019)
- Obesity prevalence is **on a rise globally** and is forecasted to reach 1 billion adults by 2030 (World Obesity Federation, 2022)

Obesity Prevalence Worldwide

Relationship between GDP and adult overweight and obesity, 187 countries in 2022



Note: GDP p.c. - current international USD converted by factor (WDI, 2025). Adult (18+) overweight ≥ 25 kg/m2 (WB Health Nutrition and Population Statistics, 2025). Latest publicly available data.

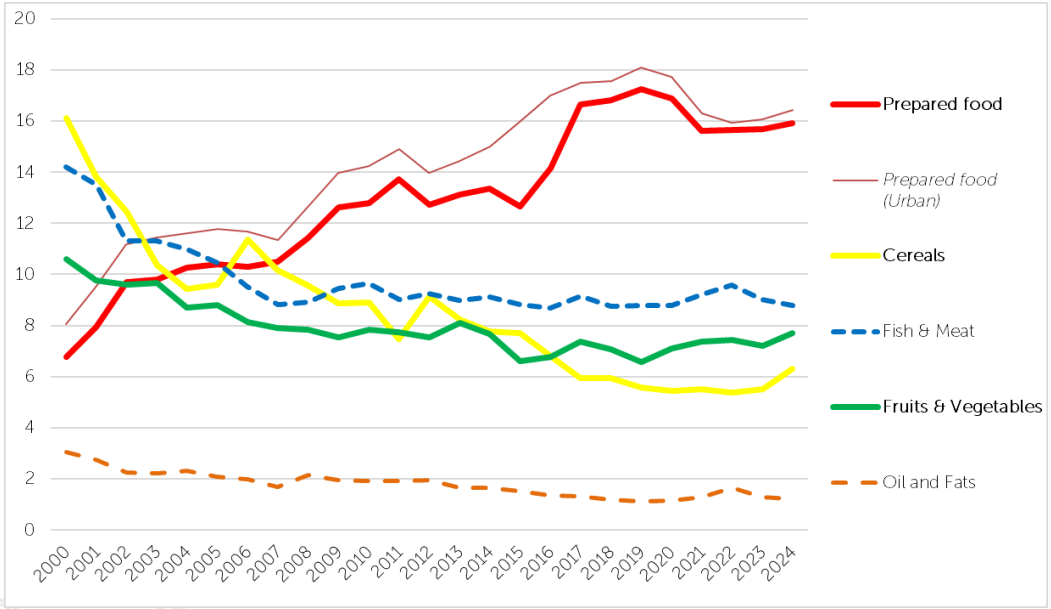
Rapid Transitions in Indonesia

Nutrition, Anthropometric and Epidemiological Transitions:

- Early nutrition transition - growing income => ▲calorie intake, ▼physical activity
- **Relatively low** obesity rate: The aggregate picture may mask dynamics and within country heterogeneity (Wahidin et al., 2024)
- Double Burden of Malnutrition – 38% of adults and 20% of children 5-12 y.o. are overweight, 22% of children under 5 y.o. are stunted (WB Health Nutrition and Population Statistics, 2025; Indonesian Health Survey, 2023)
- Shift in morbidity and mortality from CDs to **NCDs**:
  - Unhealthy diets and high BMI – **top contributing risk factors** (GBD 2021 Risk Factors Collaborators, 2025)
  - Overweight and obesity prevalence has **doubled** over last 15 years from 18% to 38%, alongside significant **changes in dietary patterns**

Shifting Dietary Patterns

Monthly Average Expenditures per Capita by Commodity Group in 2000-2024, %



Source: Badan Pusat Statistik (2025), own calculations.
Note * Prepared food includes packaged food and various types of convenience foods (ready-to-eat products), frozen foods, mixes and snacks.

Lessons Learned

- **High healthcare financing risks given the high costs of NCDs**
- Importance of **screening, monitoring, and management of NCDs' risk factors** (smoking, diet, PA, BMI), but the evidence on the efficiency of the recent programs (*Posbindu, Pandu, Prolanis*) is limited (Wahidin et al., 2024)
- Need for **environmental interventions** to tackle overweight and obesity
  - New governmental school meal programs – **increase focus on nutritional quality**
  - **Attention** to informal street **food vendors**, driving consumption of prepared foods and drinks high in sugar, fat and calories
- **Ability of universal health coverage to adjust to changing nutrition patterns?**

Effects of performance-based capitation payment on the use of public primary health care services in Indonesia

Novat Pugo Sambodo., S.E., MIDEC., Ph.D.,
Universitas Gadjah Mada

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Effects of performance-based capitation payment on the use of public primary health care services in Indonesia

Novat Pugo Sambodo
Lecturer and Researcher
Department of Economics, Faculty of Economics and Business, Universitas Gadjah Mada

Pre-Congress Session iHEA 2025
20 July 2025

Background

- In 2015, **BPJS Kesehatan** funding accounted for **more than half of the total budget of puskemas**, supplemented with funds from local governments and donors (World Bank, 2018).
- **Hospital care accounted for 82 percent of total JKN expenditure** in 2015, primary care for 17 percent and the remaining 1 percent is for health promotion activity.
- **Rising costs at the hospital level for avoidable advanced care** provided one of the main rationales for BPJS Kesehatan to introduce financial incentives for community health centres.
- The Kapitasi Berbasis Kinerja (KBK) or performance-based capitation for primary care providers was accompanied by a reform of the referral system to improve efficiency and effectiveness of service delivery and access to health services.
- KBK aimed **to encourage more contacts between users and primary care providers**, increase the number of primary care visits for chronically ill and discourage hospital referrals for a subset of so-called “non-specialistic” conditions, which should fall within the standard competency of general practitioners

Research objective

- This study aims to evaluate the effects of KBK on its three incentivized monthly outcomes:
  1. The number of JKN insured patients with a visit to the puskesmas per 100 enrolees.
  2. The number of JKN insured chronically ill with a visit to the puskesmas per 100 enrolees.
  3. The hospital referral rate for insured with a non-specialistic condition.

Performance Based Capitation Setting

- KBK was implemented in **province capitals, non-randomly and stepwise** between August 2015 and May 2016, with the majority of districts joining the program in January 2016.
- The KBK program used three performance indicators, as shown in namely **Contact Rate, Chronic disease contact rate, Non-specialistic referral rate**.
- Puskesmas **not meeting** at least the sufficient target for any of the three performance indicators incurred a **25 percent** malus on their capitation-based payment. Facilities performing **excellent** on all three indicators received a **15 percent** bonus on their capitation payment.

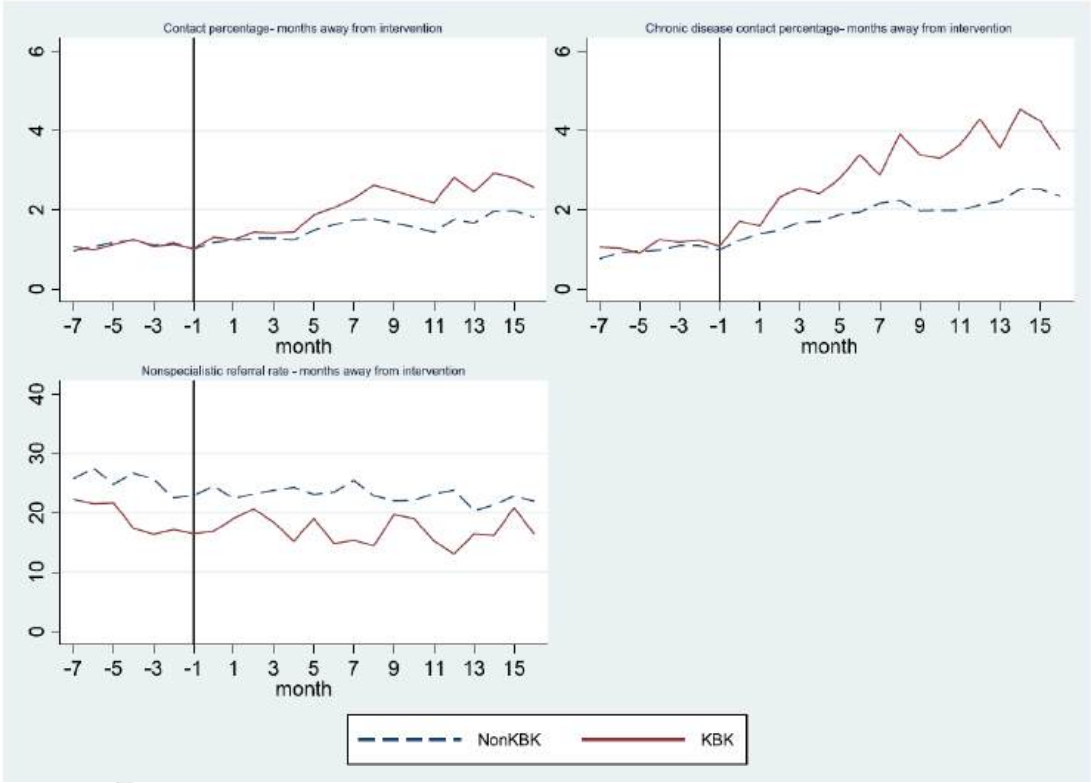
KBK monthly performance indicators.

	Sufficient	Excellent
Contact rate	>15 per 100	> 25 per 100
Chronic disease contact rate	> 50 per 100	> 90 per 100
Non-specialistic referral rate	<5 per 100	<1 per 100

Performance-based capitation payout based on number of performance indicators meeting the thresholds

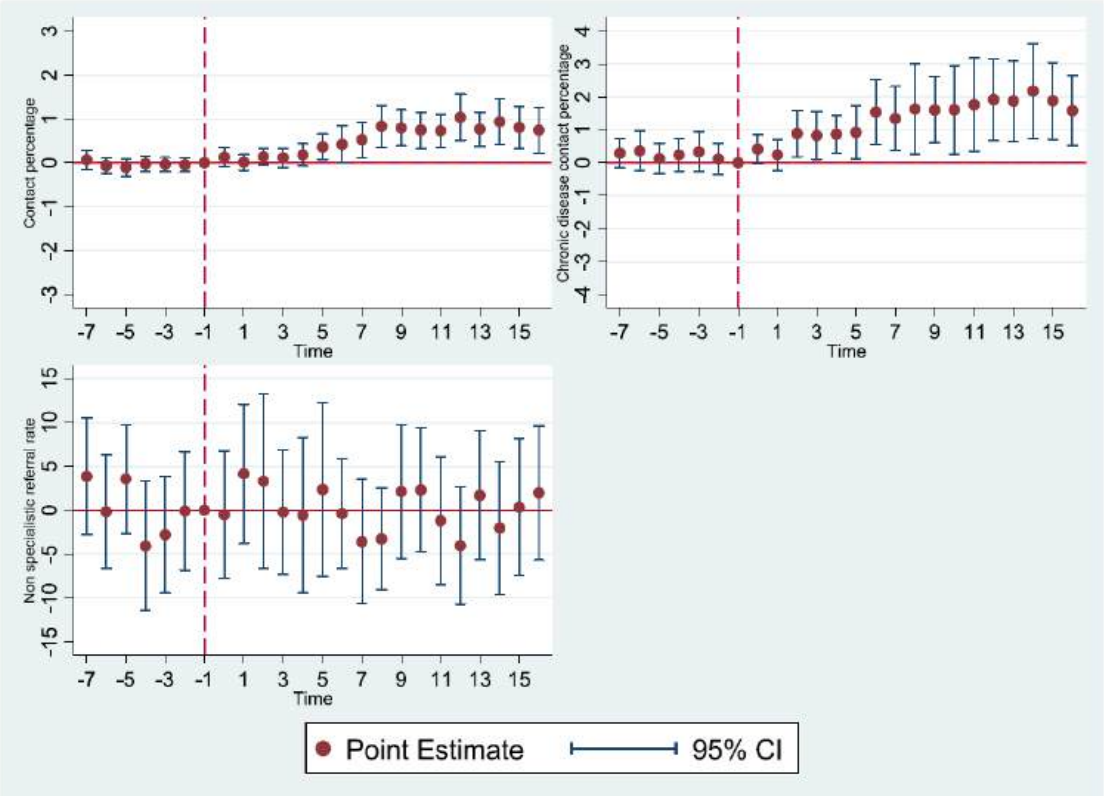
Not sufficient out of 3	Sufficient out of 3	Excellent out of 3	Percentage of KBK capitation paid out
3	0	0	75%
2	1	0	80%
1	2	0	90%
0	3	0	100%
0	2	1	105%
0	1	2	110%
0	0	3	115%
2	0	1	90%
1	1	1	95%
1	0	2	98%

The outcome for contact percentage and chronic disease contact percentage are parallel for treated and control districts. The treated districts outcome are rising after introduction of KBK.



Event study graph of the effect of KBK on puskesmas healthcare use

The point estimates are increasing after the implementation of KBK.



Coarsened Exact Matching weighted outcomes – months away from intervention

Estimation Results

1. We conclude that KBK implementation raised the contact percentage by 0.735 points, following an anticipation effect of 0.146 percentage points. Combined, this caused an increase of 0.578 percentage points since the announcement of the KBK.
2. The KBK effects are positive for the contact percentage and the chronic disease contact percentage.
3. The non-specialist referral rate does not appear to have been affected, as neither of the effect estimates is statistically significant.

		CEM Weighted DiD		
		(1)	(2)	(3)
		Contact percentage	Chronic disease contact percentage	Non specialistic
Sufficient threshold		15	50	5
Baseline value		1.21	1.32	18.95
Model 1	KBK (announcement)	0.578***	1.149***	0.101
		(0.0534)	(0.147)	(1.084)
	N	7795	7795	7334
Model 2	KBKI (actual implementation)	0.735***	1.377***	−0.340
		(0.165)	(0.402)	(1.402)
	KBKA (anticipation)	0.146**	0.520***	1.320
		(0.0646)	(0.161)	(2.004)
	N	7795	7795	7334

KBK effect estimates from CEM weighted two-way fixed effects regression model with announcement starting from August 2015 compared to separate anticipation and implementation estimates.

Lesson learned

- BPJS is the first to supplement capitation-based payment with performance-based financing.
- This new payment program aims to encourage primary care use.
- Using difference-in-differences we find a small increase in primary care visits.
- The effects of the program were far below the targets initially set by BPJS.
- We recommend the Indonesian government to initially lower the targets and subsequently increase these step by step on an annual basis.
- We suspect that applying same targets for all puskesmas may have discouraged some facilities to act if these targets were out of reach, while for relatively well-endowed facilities less effort is required to meet the KBK targets.

Moving forward

- Performance based capitation shows an effect (even small) changes the provider behaviour, and also improve accountability and transparency.
- **BPJS Kesehatan shows interest in implementing a pay-for-performance system in hospital** settings, with the primary goal of maintaining financial efficiency within the JKN program (call for paper research topic).
- However, implementing this approach at the hospital level—which is inherently more complex than primary care—requires careful consideration of several key challenges, including:
    1. **Data quality and availability**
    2. **Defining appropriate performance metrics**
    3. **Risk of unintended consequences**
    4. **Capacity and incentive design**
    5. **Administrative burden**
    6. **Resistance from health workers**
    7. **Alignment with existing payment system**
    8. **Sustainability and funding**

Thankyou!

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Most of this presentation is based on the published article: Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, Eddy van Doorslaer, Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, Social Science & Medicine, Volume 327, 2023, 115921, ISSN 0277-9536, https://doi.org/10.1016/j.socscimed.2023.115921.

Enhancing pharmaceutical logistics systems in Indonesia to strengthen UHC: insights from local system dynamics

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Enhancing pharmaceutical logistics systems in Indonesia to strengthen UHC: Insights from local system dynamics

iHEA Pre-congress session
20th of July 2025

Meet our best team:

Reimbuss Fanda, PhD(Cand)

Pusat Kebijakan dan Manajemen Kesehatan
Fakultas Kedokteran Kesehatan Masyarakat dan Keperawatan
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Erasmus School of Health Policy & Management

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Collaborators:

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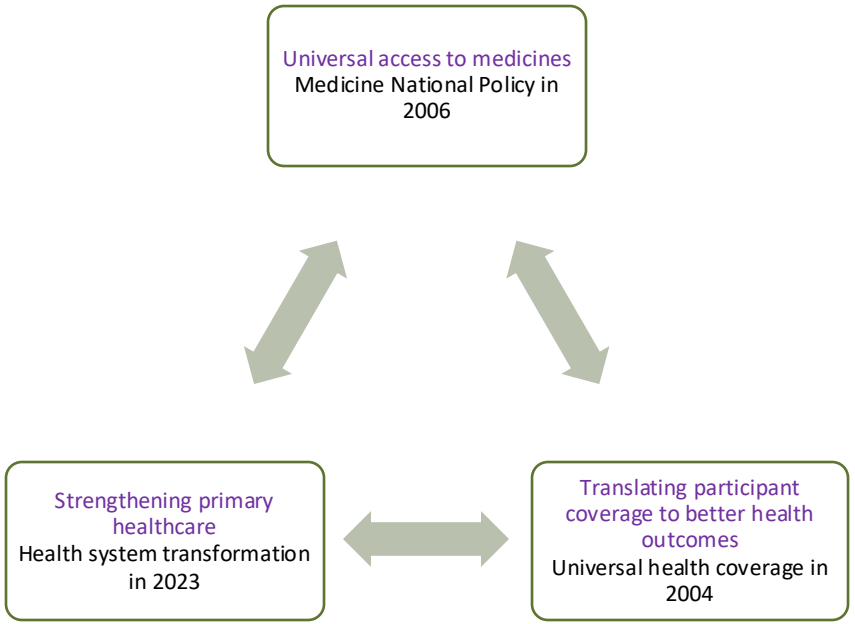
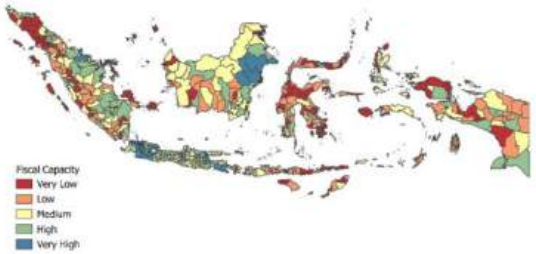
INSTITUTE OF TROPICAL MEDICINE ANTWERP

Interconnection of universal health coverage, access to medicines and health system transformation has been addressed as *Indonesia's political commitments*



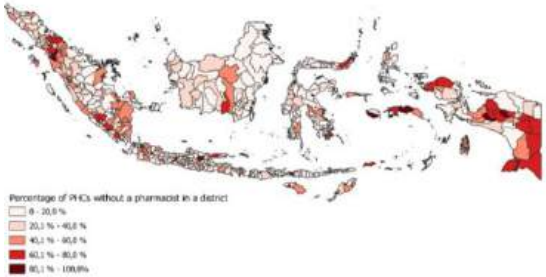
The **Primary Healthcare Centre function is crucial** to achieve universal Health Coverage and ensure Access to Medicines in Indonesia

Variations in PHCs and their district capacities



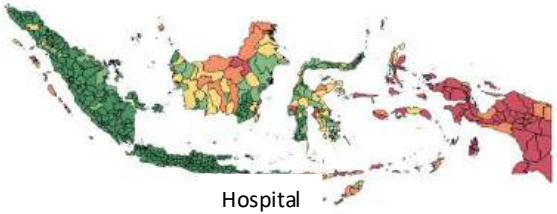
Variations in district fiscal capacities

Variations in numbers of PHCs

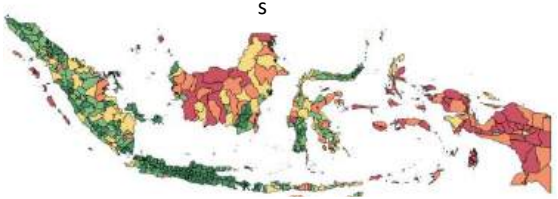


Variations in the percentage of PHCs without a pharmacist

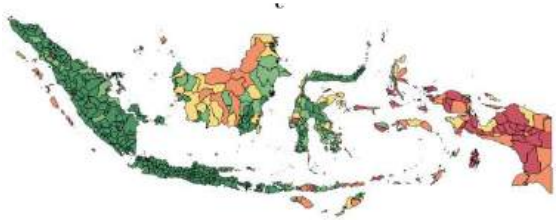
PHCs

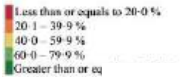


Hospitals



Alternative health facilities

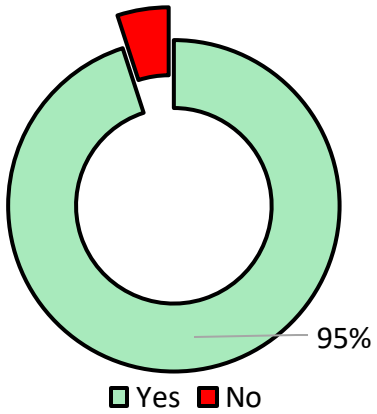




Variations in accessibility to health facilities

Previous studies into the availability of medicines in public facilities offer a mixed picture.

The availability of medicines reported by MoH

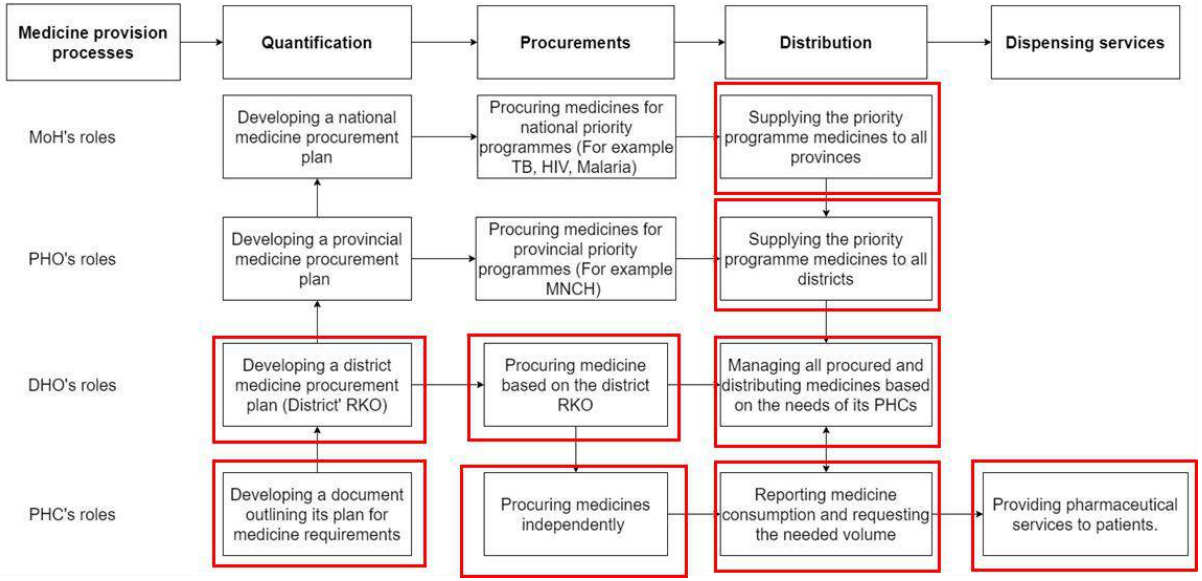


The 17 most needed essential medicines in PHCs reported by the Indonesian Ministry of Health **were highly available**.

Smaller studies, whereby researchers visited facilities and looked for specific medicines, **paint a more worrying picture**

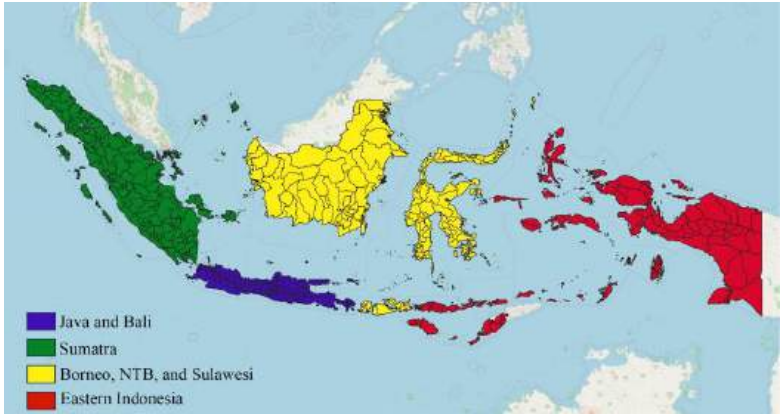
> “A need to understand which essential medicines are actually available and why some medications are not available.”

Understanding the context of medicines management in public primary healthcare centres in Indonesia – is naturally complex



Local system perspectives on medicine management logistics for PHCs within the decentralised system in Indonesia.

Variations in health system readiness and socioeconomic status are a natural property of Indonesia



	Region				Type of districts		National
	Sumatera	Java and Bali	Borneo, NTB and Sulawesi	Eastern Indonesia	Rural	Urban	
Population (in million people)	59·3	162·4	42·5	15·0	206·9	72·5	279·4
Population density	10864	110741	8242	3693	9495	293389	15038
Districts	154	128	147	85	416	98	514
Primary Health Centres	2547	3696	2373	1215	8131	1700	9831
Hospitals	711	1.466	437	177	1.583	1.208	2.791
Private pharmacies	5611	14647	5203	1227	17283	9405	26688
Drug stores	3933	10952	1828	147	12684	4176	16860
Villages	25621	25988	18996	13332	78691	5246	83937
Percentage of population with JKN coverage	73%	79%	86%	80%	76%	88%	79%
Percentage of JKN participants that are subsidised	47%	45%	55%	62%	51%	38%	48%

NTB: West Nusa Tenggara; JKN, Jaminan Kesehatan Nasional; PHC, Primary Health Centres; M, Median; IQR, Interquartile range, *included facilities: primary health centres, pharmacies, private clinics, general practitioner practices and hospitals and ** included medicine providers are pharmacies, hospitals and drug stores.

Our analytical approach to answering the questions

Quantitative data

- Collaborate with the Ministry of Health (Balitbangkes) to manage the Health facility survey in 2019:
  - Surveyed 9831 PHCs
  - Surveyed 514 District health offices
  - Inspected 60 essential medicines in Indonesia

- Combined the data with another national representative dataset in 2019
  - Village potential
  - Sismonev JKN 2019

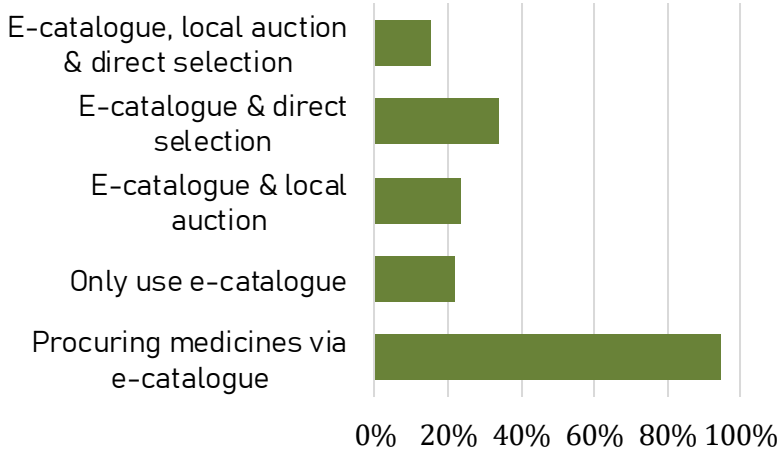
Qualitative data

- Interviewed 81 participants from
  - 3 districts
    - 1 in Java (Bantul) and 2 in Eastern Indonesia (in South Central Timor and Kupang).
  - 3 DHOs: Pharmacists, Procurement staff, Health Programme managers
  - 14 PHCs: Pharmacists, GPs, Health Programme managers, nurses and midwives.
  - 6 Medicine suppliers: National suppliers and private pharmacists

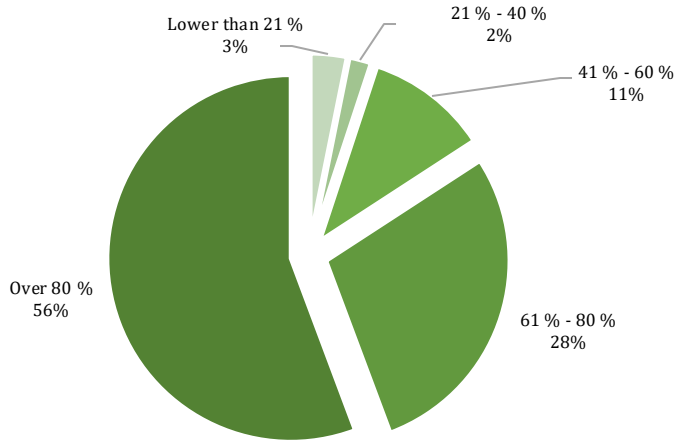
Dynamics in ensuring medicine provision in public healthcare in Indonesia

Our findings

The majority of medicines in the primary healthcare centres are expected to come from the e-catalogue platform.



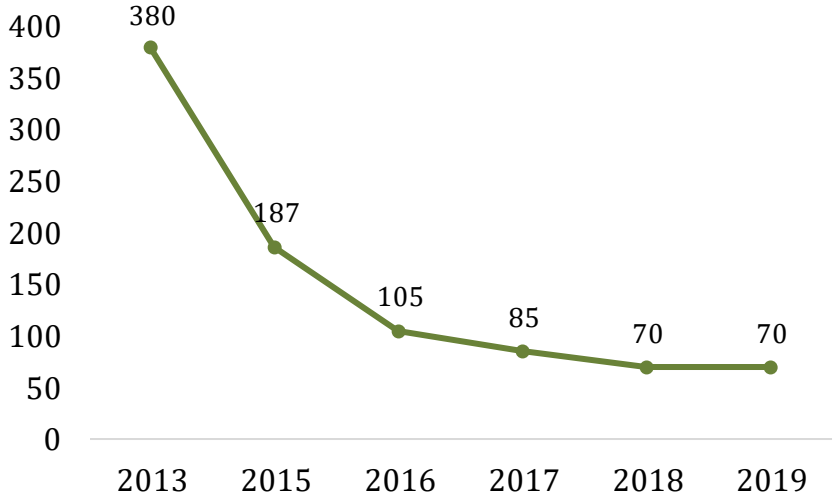
Distribution of the 514 DHO medicine procurement planning based on the channel/ platform in 2019.



Distribution of DHO expectations regarding the use of e-catalogue purchasing to meet medicine stock needs

Reasons from local governments to use the e-catalogue

- Lowest price points in the market
- More accountable to avoid a corruption speculation
- Supporting the central government programs



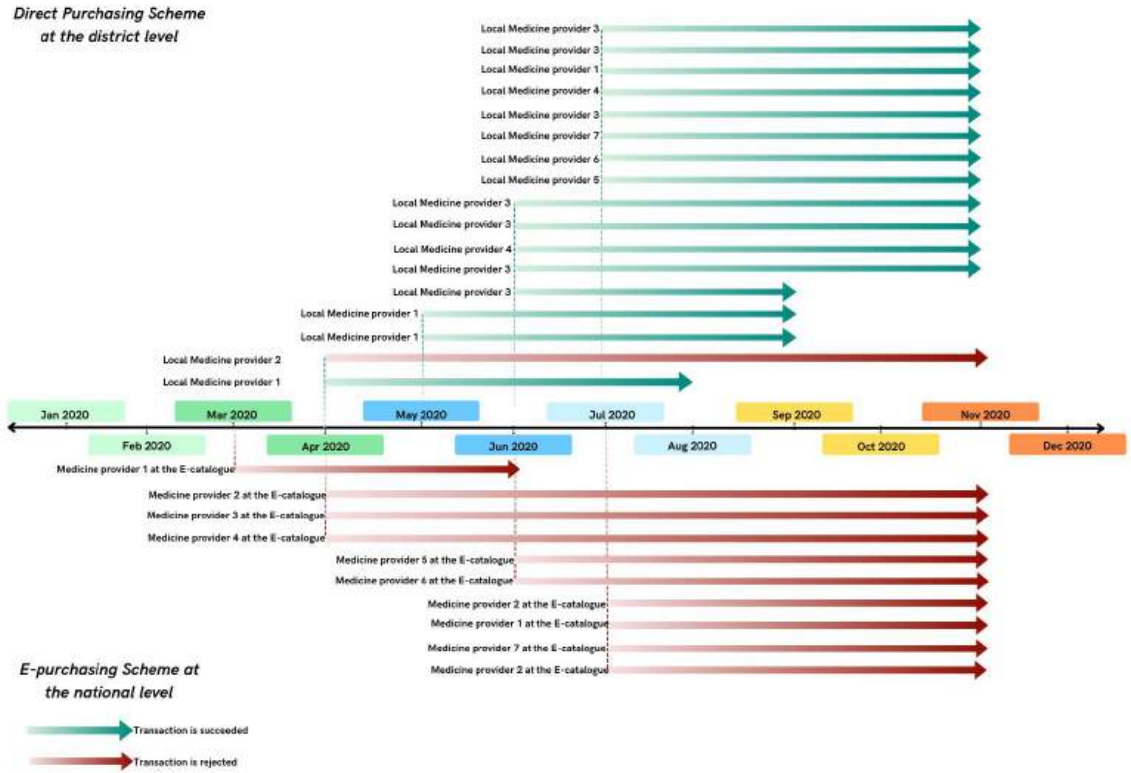
Prices of Amlodipine 5 Mg at the e-catalogue platform per tablet (IDR)

No room for error or no medicines for you: A case study in a district

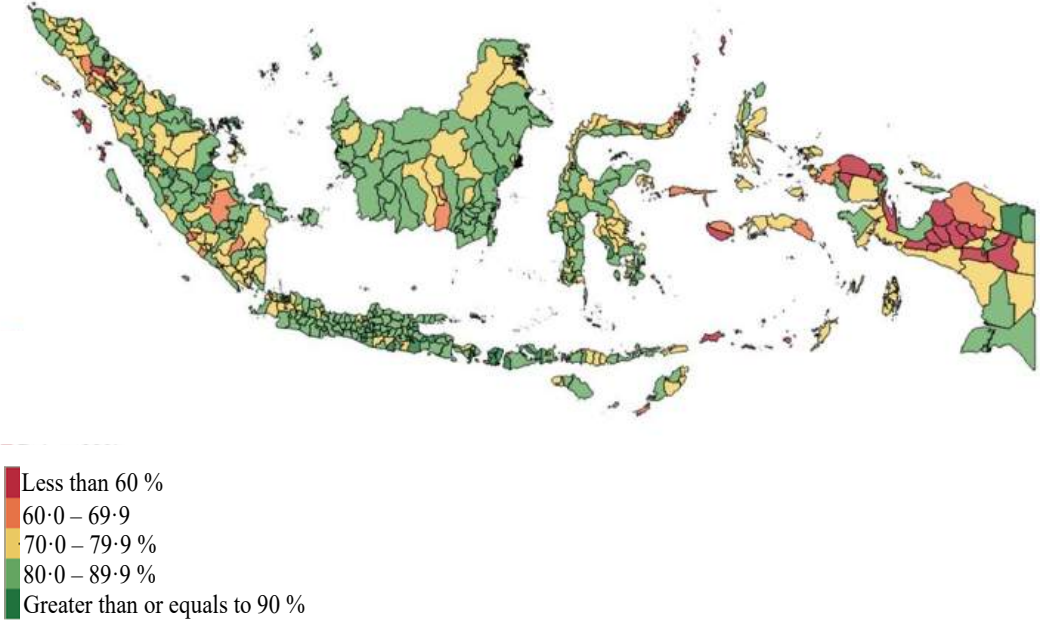
"In 2020, our achievement of budget absorption for medicine procurement was only 2,1 out of 4 billion rupiah. This was due to the staff responsible for the DAK (Central government funding) not submitting our revised draft of the financial applications to the Ministry of Finance. ***We incurred a debt*** *of 200 million rupiah in 2019".*
Procurement staff 1 in the DHO A.

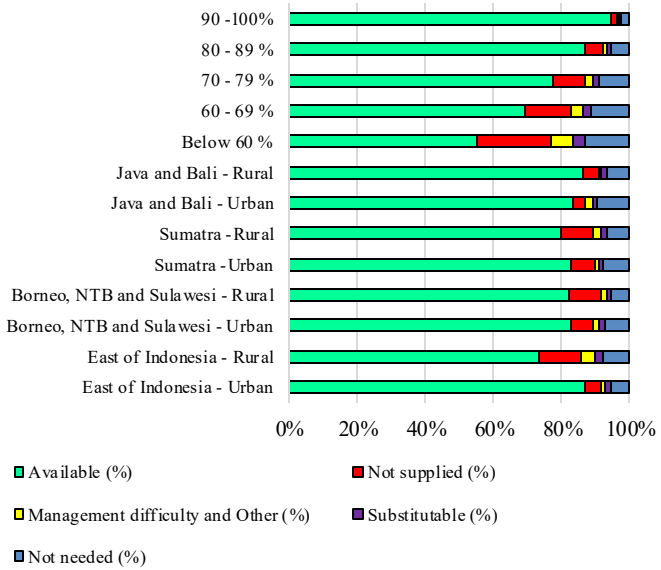
"When I saw their application, I directly threw it into the bins…Our capital cost was stuck there. We sent medicine, but there was no money… ***We and four or five national distributors don't want to distribute*** *[their medicine] again and put them into a black [bad customer] list".*
Manager, National Distributor I.

Stockouts of many medicines in 2020 -2021



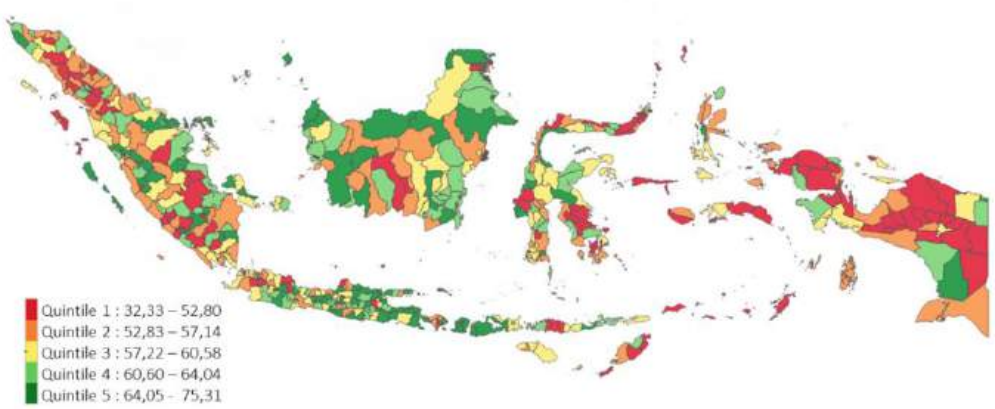
The most needed essential medicines in PHCs at the district level were generally available with 82 %; however, the availability remains varied across the regions



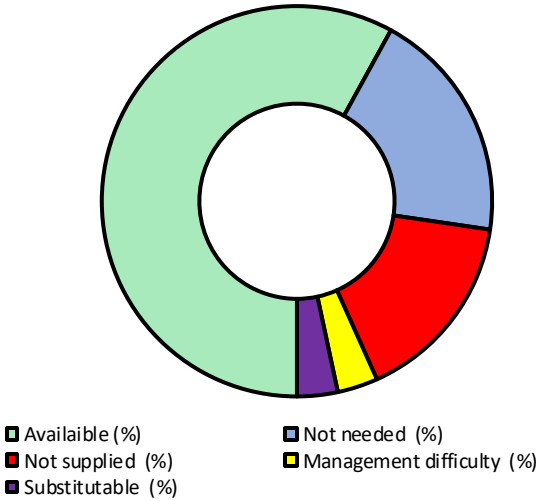


Average availability of 17 most needed essential medicines in PHCs at district level.

A broader selection of 60 selected essential medicines shows that the availability rate was significantly lower (58%) and varied across the regions.



Average availability of 60 selected essential medicines in PHCs at the district level.



Average availability of 60 selected essential medicines in PHCs at the district level.

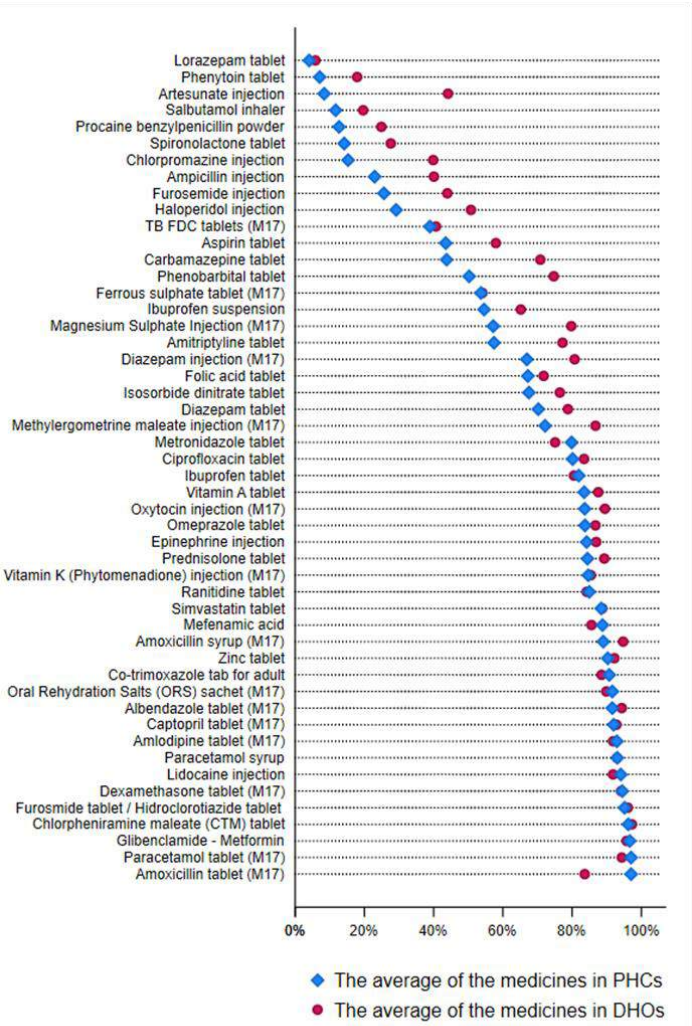
The main source of medicine provision in PHCs is their DHOs

The availability of medicines in PHCs is similar to their associated DHOs

- “If we (the DHOs) can procure all needed medicines, our PHCs will be fine.”. A staff member in the DHO in Kupang district

- “All medicines are supplied by the DHO”. A staff member in the DHO in South Central Timor.

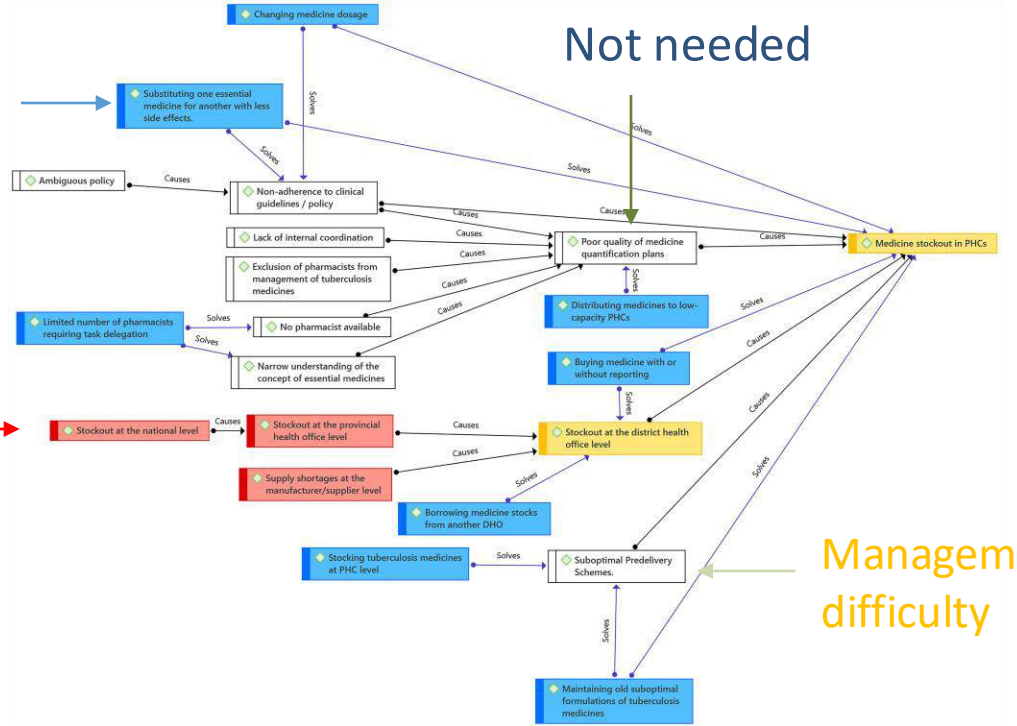
- “Our capitation fund is limited in use; the maximum we can use is Rp 1.000.000 (USD)”. The staff in PHC 1 in Bantul.



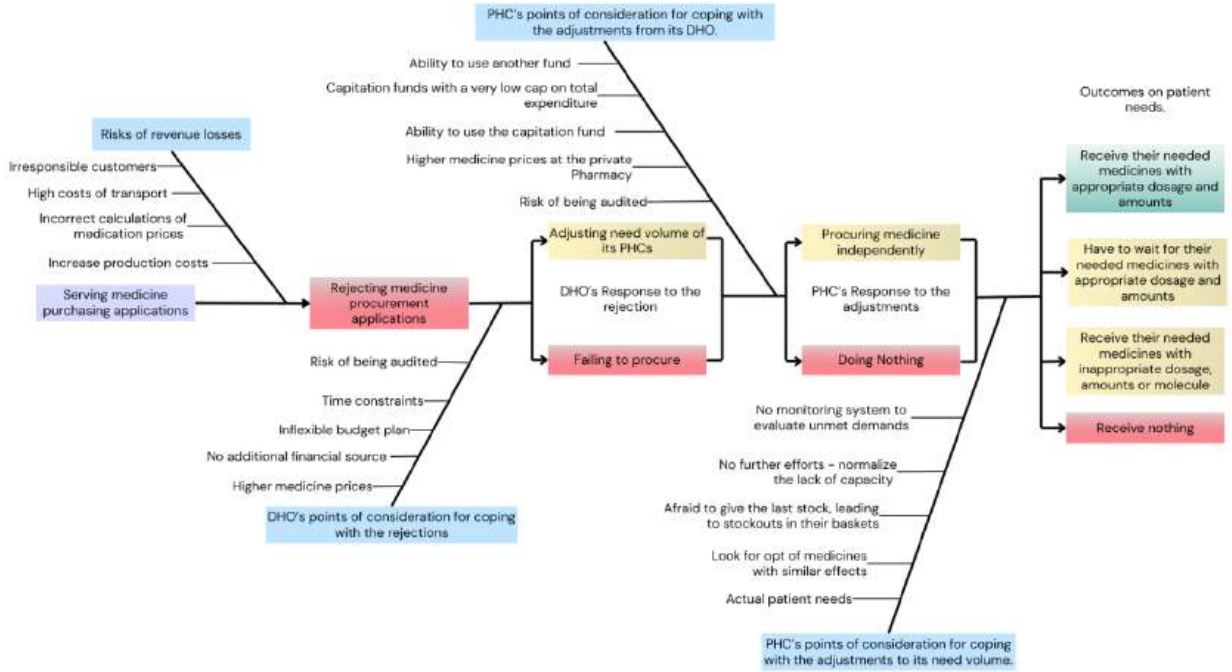
Repair works - important to cover temporary stockouts. They may conceal deeper systemic issues, and not resolve or identify the root problem

repair works

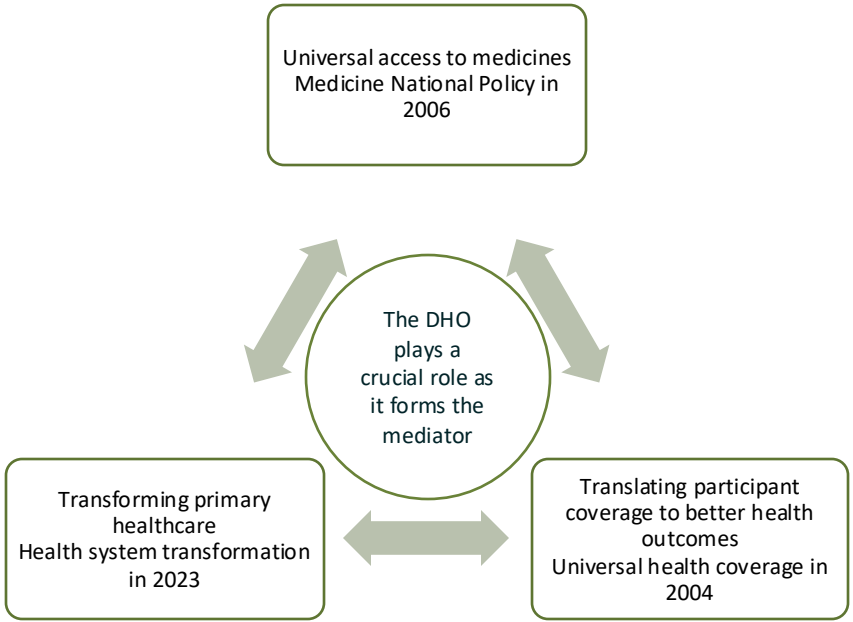
Not supplied



The consequences of medicine application rejections in the e-catalogue vary based on the repair works performed by DHOs and PHCs



Conclusions and implications



- Variations in medicine availability are a **natural property of this large system**.
- Empowering **all DHOs to enhance their medicine management** is vital, particularly in promoting awareness of risks linked to failed medication applications **in the e-catalogue**.
- Local system functions to manage medicine are **dynamic and should be adaptive**, involving **repair work** to ensure the system's sustainability.
- Current plans to bypass the DHO by strengthening primary care — while this strengthening in itself is good — **might be counterproductive**.
- **Designing pool procurement mechanisms in the Eastern Indonesia** region to better ensure adequate medicine supply dynamics.

Thank you
Terimakasih
Dank u wel

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Grand Finale: Closing Session Featuring the Honorable Minister of Health of Indonesia

Welcome to His Excellency, the Minister of Health of Indonesia

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Indonesia's bold health sector reform: moving towards universal health coverage – Closing Keynote Address

Mr. Budi Gunadi Sadikin
His Excellency, the Minister of Health of Indonesia

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Valedictory remarks by organizers

Speakers:

- **Ronald Mutasa, World Bank Indonesia**
- **Prastuti Soewondo, S.E., M.P.H., Ph.D. , Senior Advisor to the Minister of Health**
- **Igna Bonfrer, Ph.D., Associate Professor Global Health Economics, Erasmus University Director Rotterdam Global Health Initiative**

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World Bank: Opening IHEA Congress

20 July 2025

MINISTRY OF HEALTH
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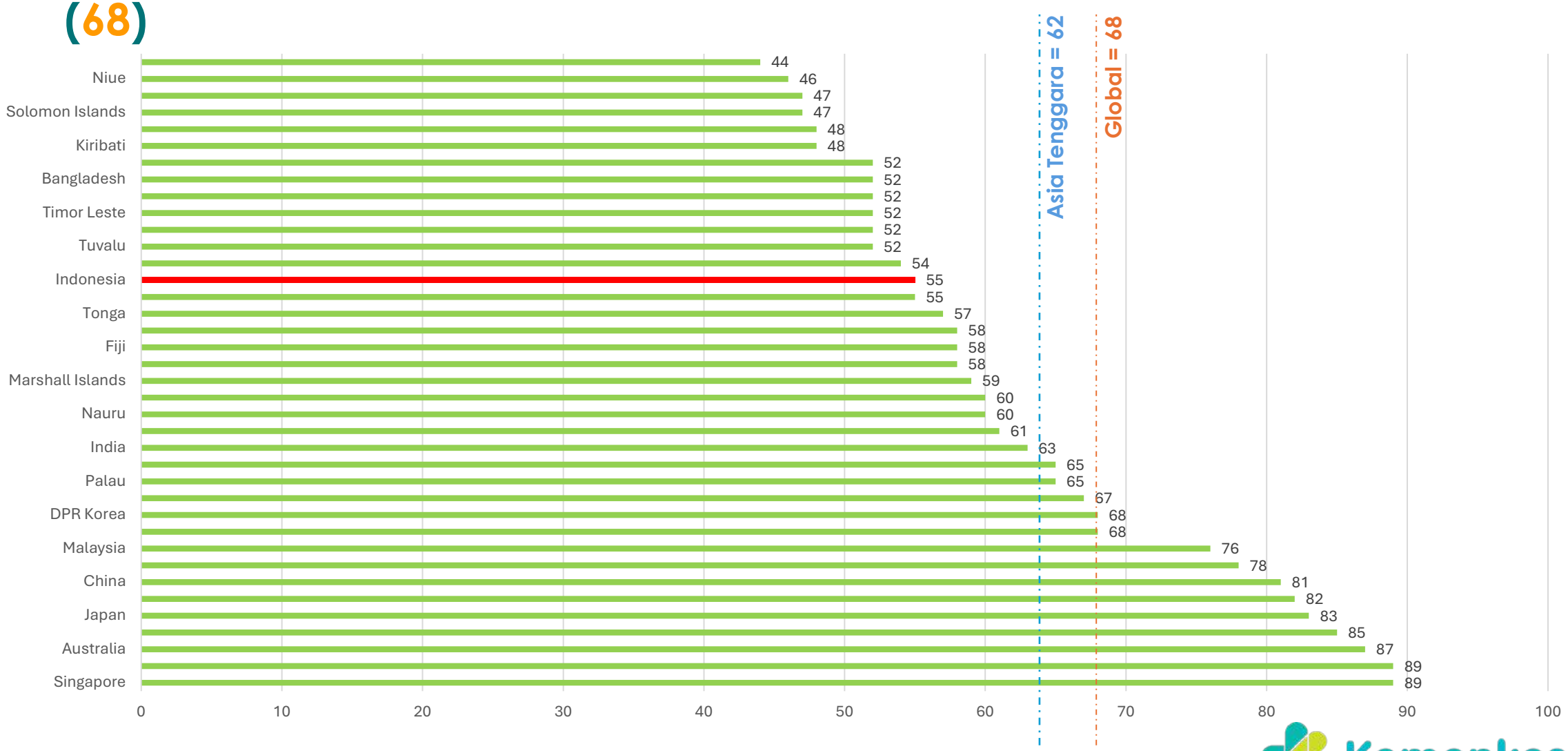
Despite a high membership coverage rate, Indonesia's Universal Health Coverage (UHC) Service Coverage Index was only 55 (WHO, 2021), below the average of the Southeast Asia (62) and the global (68)



Source : https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage

Kemenkes

UHC improves people's access to healthcare facilities

*"UHC means that **all people** have **access to the full range** of **quality health services** they need, **when** and **where** they need them, **without financial hardship**" – WHO Action Framework*

All People;

have the same right to:

Timely, quality, and affordable access;

to essential health services, and this must be ensured

Financial protection

in the face of major health conditions

Kemenkes

MoH is committed to implementing a health system transformation

The 6 pillars of transformation supporting the Indonesian health system:

Vision

In line with the President's vision to create healthy, productive, independent and fair.

Outcome of RPJMN on health system

- Improve maternal, children health, family planning and reproductive health
- Accelerate improvement of community nutrition
- Improve disease control
- Healthy Movement Culture (GERMAS)
- Strengthen the health system as well as medicine & food control

6 main pillars

1 Primary Care Transformation

a Population Education

Strengthening the role of cadres, campaigning and building movements through digital platforms and community leaders.

b Primary Prevention

Addition of routine immunization to 14 antigens and expansion of coverage throughout Indonesia.

c Secondary Prevention

Screening for the 14 highest causes of death for each age target, screening for stunting, & increasing ANC for mother & baby health.

d Improving capacity and capability of primary care

Network revitalization and service standardization for Puskesmas, Posyandu, Labkesmas & home visits

2 Secondary care Transformation

Improving access and quality of secondary & tertiary services

Development of priority disease service network, improvement of government hospital management.

3 Health System Resilience Transformation

a Improving resilience of pharma and med-devices sector

Domestic production of 14 routine immunization vaccine antigens, top 10 active pharmaceutical ingredients, top 10 medical devices by volume & by value.

b Strengthening emergency response resilience

Emergency response reserve staff, table top exercise on crisis preparedness.

4 Health Financing Transformation

Regulation of health financing with 3 objectives: available, sufficient, and sustainable; fair allocation; and effective and efficient utilization.

5 Health Talent Transformation

Additional student quotas, domestic & foreign scholarships, ease of equalization of foreign graduates' health workers.

6 Health Technology Transformation

Development and utilization of technology, digitization, and biotechnology in the health sector.

a Information Technology b Biotechnology

Strengthening the Primary Care: Revitalizing the structure and network of primary health services and public health laboratories

The levels of primary service facilities

Institution Level	Target Reach
Hospital	**514** Regencies / Municipalities
Puskesmas	**7,230** Districts
Puskesmas Pembantu	**~85,000** Villages
Posyandu	**~300,000** Hamlet / RT/RW
Home Visit	**~273.5** Million population

Levels of health laboratories, referring to WHO standards

	Level of laboratory	Number of Lab
5	**NATIONAL LABORATORY** National Lab of Prof. dr. Sri Oemiyati dan B2PVRP	2
4	**REGIONAL LABORATORY** BBTKL, BBLK, EKS BALAI LITBANGKES	23
3	**PROVINCIAL LABORATORY**	38
2	**REGENCIES/MUNICIPALITIES LABORATORY**	514
1	**PUSKESMAS LABORATORY**	10.416

Birthday PKG is divided according to the life cycle and is carried out at Community Health Centers and Private Clinics

Life cycle	Examination
Newborn	1. Congenital Hypothyroid 2. G6PD Enzyme Deficiency 3. Congenital Adrenal Hyperplasia 4. Critical Congenital Heart Disease 5. Biliary Tract Disorder 6. Growth (Weight)
Toddler and Preschool	1. Growth 2. Development 3. Tuberkulosis 4. Ears 5. Eyes 6. Teeth 7. Thalassemia (Blood test at age 2 years only) 8. Blood Glucose (Blood test at age 2 years only)
Adult and Elder	1. Smoking 2. Physical Activity 3. Nutritional Status 4. Teeth 5. Blood Pressure 6. Blood Glucose 7. Stroke, Heart (≥40 year) 8. Kidney Function (≥ 40 year) 9. Tuberculosis 10. Chronic Obstructive Pulmonary Disease (PPOK) 11. Breast Cancer (≥ 30 thn) 12. Cervical Cancer (≥ 30 thn) 13. Lung cancer (≥ 45 thn) 14. Colon Cancer (≥ 50 thn) 15. Eyes 16. Ears 17. Mental health 18. Liver (Hep B, C, Cirrhosis) 19. Bride/Groom to be (Anemia, Syphilis, HIV) 20. Geriatric (≥ 60 thn)

Kemenkes

PKG for School Age Children and Adolescents and implemented in Schools during the New Academic Year in July 2025

* Hepatitis B in Elementary School Children and Hepatitis B + C in Middle School to High School Children

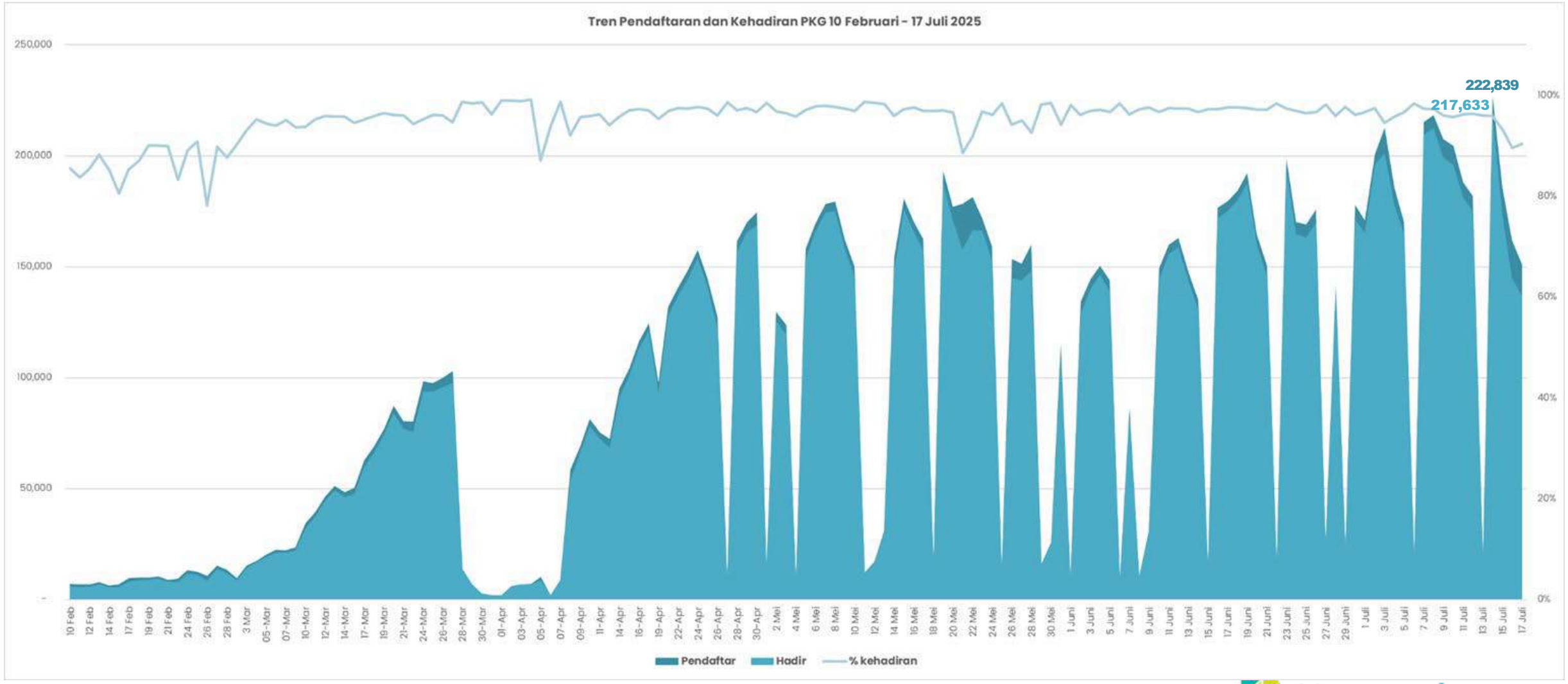
** Once in a lifetime, for ages 7-12 years if they have a family history

School Grade	Examination
Elementary School (7 - 12 year)	1. Nutritional Status 2. Smoking (grade 5-6) 3. Physical Activity (grade 4-6) 4. Blood Pressure 5. Blood Glucose 6. Tuberculosis 7. Ears 8. Eyes 9. Teeth 10. Mental health 11. Liver (Hepatitis B)*
Junior High School (13 - 15 year)	1. Nutritional status 2. Smoking status 3. Physical Activity 4. Blood Pressure 5. Blood Glucose 6. Tuberculosis 7. Thalassemia** (grade 7 students) 8. Anemia in Adolescent Girl (grade 7 students) 9. Ears 10. Eyes 11. Teeth 12. Mental health 13. Liver (Hepatitis B and C)*
Senior High School (16 - 17 year)	1. Nutritional status 2. Smoking status 3. Physical Activity 4. Blood Pressure 5. Blood Glucose 6. Tuberculosis 7. Anemia in Adolescent Girl (grade 10 students) 8. Ears 9. Eyes 10. Teeth 11. Mental Health 12. Liver (Hepatitis B and C)*

Kemenkes

PKG Registration and Attendance Trends (10 Feb-17 Juli 2025)

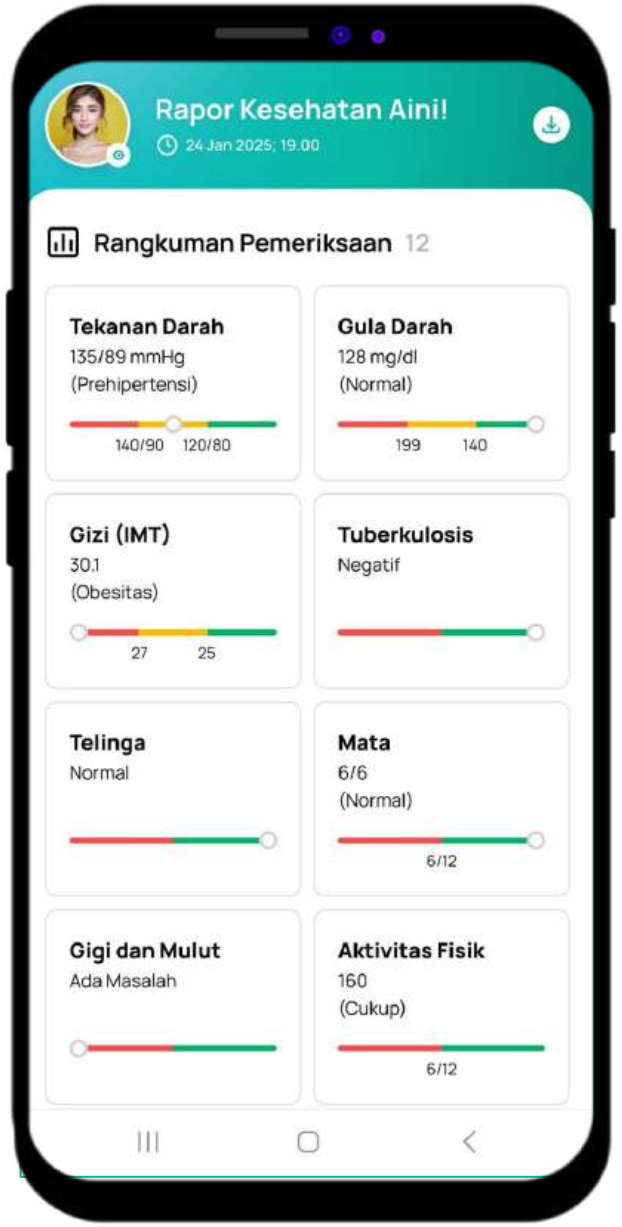
PKG Registrants reached 222.839/day (14 July) with Attendance at 217,633/day (14 July)

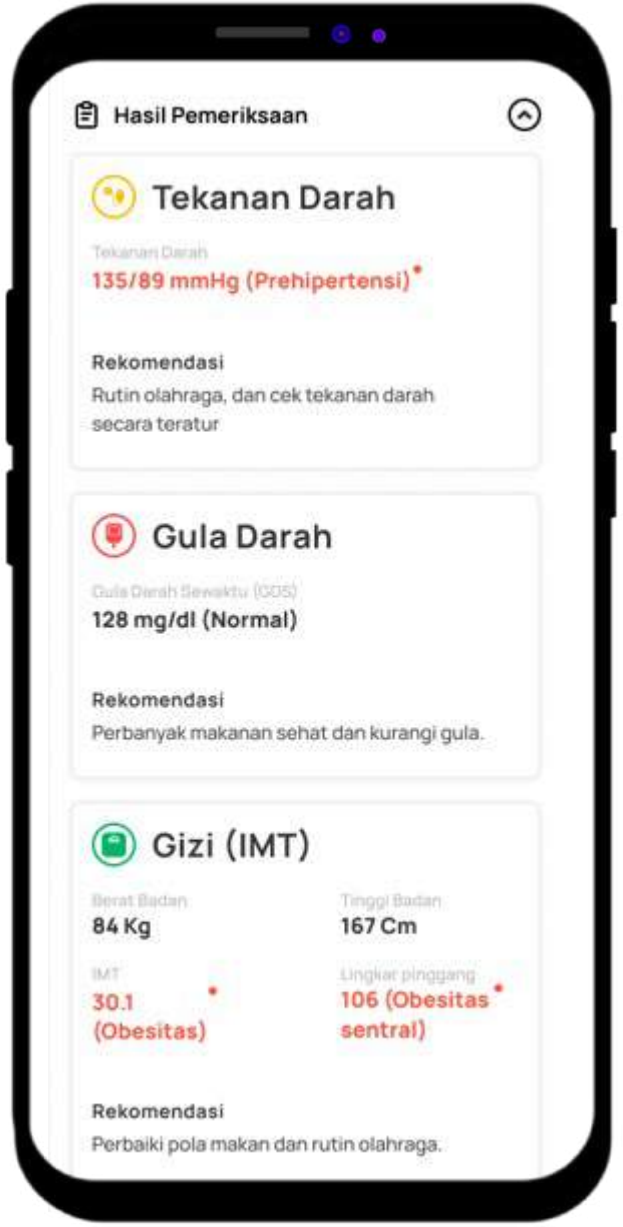


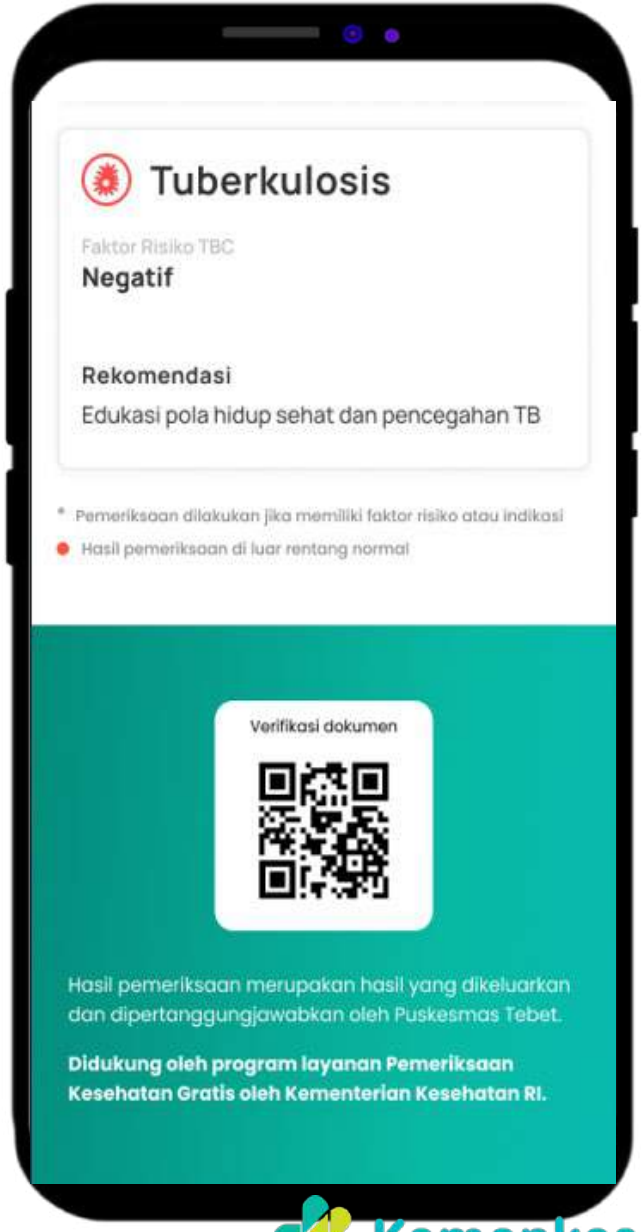
Data update: 18 Juli 2025 pukul 08.20 WIB

Kemenkes

Health Report







Kemenkes

Fulfillment of laboratory equipment for disease detection and health risk factors

with special allocation funds (DAK) and other funding sources until 2027

No.	Group of Laboratory Equipment	Tier				
		2	3	4	5	Total
1	Hematology, Blood Chemistry, and Immunology Equipment	4.179	197	130	7	4.513
2	Biological Molecular Equipment	4.433	305	326	49	5.113
3	Microbiology Equipment	6.435	452	244	19	7.150
4	Environmental Health Equipment	47.476	3.520	714	21	51.731
5	Clinical and Environmental Toxicology	804	120	103	9	1.036
6	Vector and Reservoir Equipment	29.390	4.035	495	32	33.952
7	Calibration Equipment	-	980	12	-	992
8	Supporting equipment, Storage, and others	5.143	305	914	136	6.498
	TOTAL	**97.860**	**9.914**	**2.938**	**273**	**110.985**

Example of laboratory equipment

Biological Molecular

NGS (High troughput)

Digital PCR

Olygosynthetizer

Super Bioinformatic Computer

Hematology, Blood Chemistry, and Immunology (including newborn screening)

Newborn screening (TSH, G6PD, CAH)

Hematology analyzer

Kimia analyzer

Enzyme Immuno Assay (EIA)

Microbiology

ID/AST

Automatic Culture

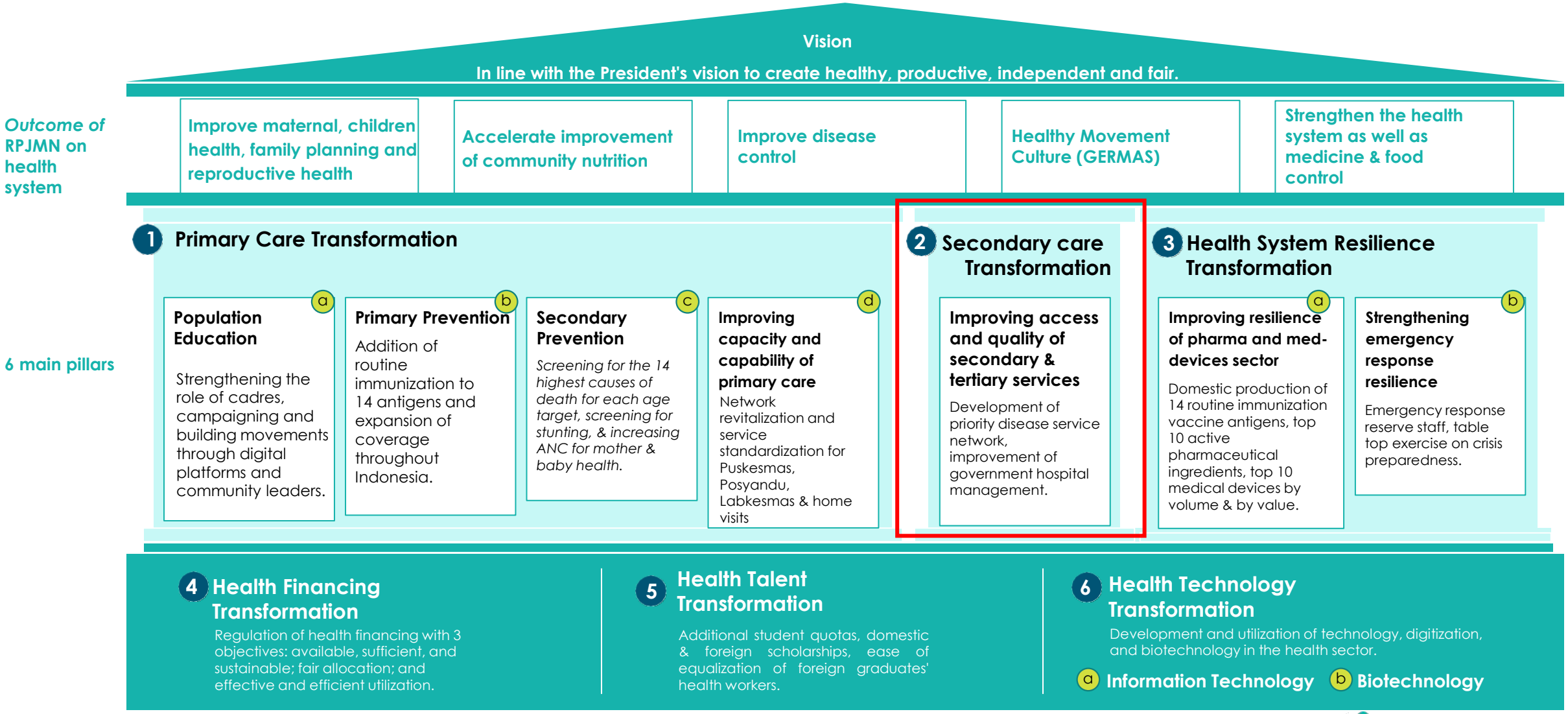
Clinical Toxicology

AAS

GCMS

MoH is committed to implementing a health system transformation

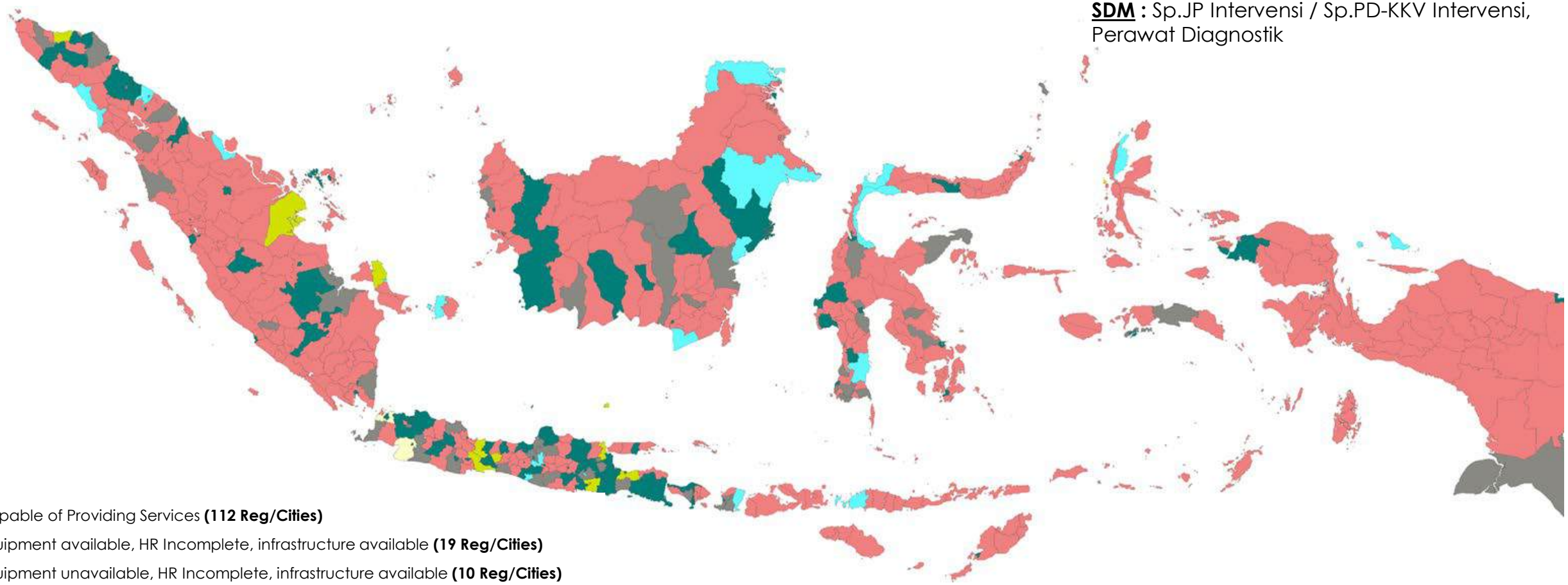
The 6 pillars of transformation supporting the Indonesian health system:



Update on Cardiac Catherization Service Capability

Distribution of Regencies/Cities with Cardiac Catherization Service Capability

Alat : Cathlab
SDM : Sp.JP Intervensi / Sp.PD-KKV Intervensi, Perawat Diagnostik



- Capable of Providing Services **(112 Reg/Cities)**
- Equipment available, HR Incomplete, infrastructure available **(19 Reg/Cities)**
- Equipment unavailable, HR Incomplete, infrastructure available **(10 Reg/Cities)**
- Equipment unavailable, HR Incomplete, infrastructure unavailable **(2 Reg/Cities)**
- Equipment unavailable, HR Incomplete, infrastructure unavailable **(46 Reg/Cities)**
- Equipment unavailable, HR Incomplete, infrastructure unavailable **(325 Reg/Cities)**

Kemenkes

Provinces with Coronary Artery Bypass Graft (CABG) Servies in 2012

Equipments : HLM, Set Bedah CABG, ICU

HR: Sp.BTKV, Sp.An-KIC, Sp.An-KAKV, Cardiac Surgical Nurses, Perfusionists

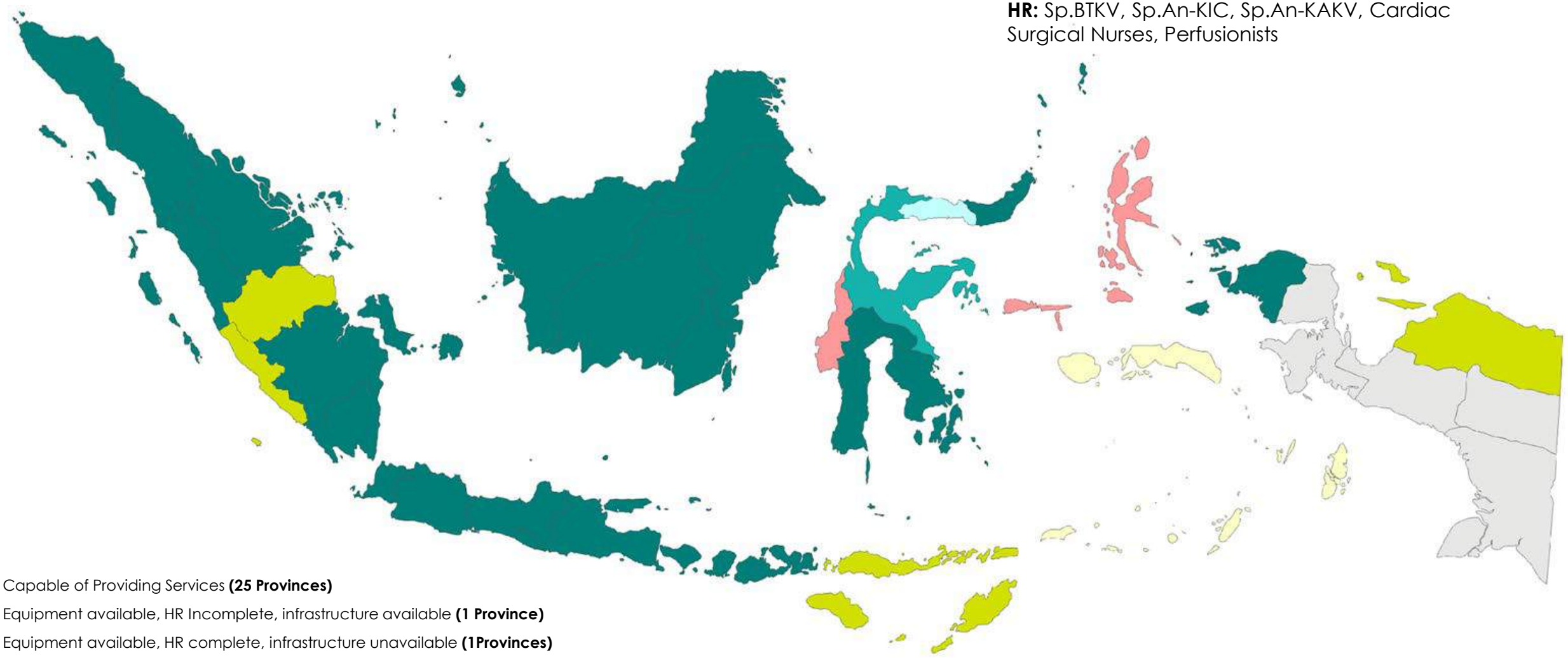
- Capable providing services (9 Provinces)

Kemenkes

Distribution of Provinces with Open-Heart Surgery Services in 2025

Equipments : HLM, Set Bedah CABG, ICU

HR: Sp.BTKV, Sp.An-KIC, Sp.An-KAKV, Cardiac Surgical Nurses, Perfusionists



- Capable of Providing Services **(25 Provinces)**
- Equipment available, HR Incomplete, infrastructure available **(1 Province)**
- Equipment available, HR complete, infrastructure unavailable **(1Provinces)**
- Equipment available, HR Incomplete, infrastructure unavailable **(4 Provinces)**
- Equipment unavailable, HR complete, infrastructure available **(1 province)**
- Equipment unavailable, HR Incomplete, infrastructure unavailable **(2 Provinces)**
- New Provinces (4 Provinces)

Kemenkes

Improving access: the Ministry of Health supports the allocation of medical equipment for priority disease services by providing 9,740 medical equipment units valued at ~IDR 27.3 trillion (SIHREN)

	Special Allocation Fund (DAK) and Grants (Banper)		SIHREN			
5 Top High Value Alkes	**2022**	**2023**	**2024***	**2025**	**2026**	**2027**
PET CT	2	-	-	8	3	2
MRI *(1,5 & 3T)*	9	5	-	13	2	1
CT Scan *64 Slice*	28	46	-	153	114	39
Linac	2	12	-	12	9	2
Cathlab *(monoplane & bi-lane)*	13	42	-	124	261	53
Sub-Total Top 5 High Value	**54**	**105**	**-**	**310**	**389**	**97**
Total Equipment (All Types)	**465**	**234**	**-**	**8308**	**1246**	**186**

***** : 2024 allocations were shifted to 2025 due to licensing and procurement processes

Peningkatan kuota fellowship dilakukan untuk percepatan pemenuhan dokter spesialis layanan prioritas KJSU tahun 2024 - 2027

Heart

Layanan Kateterisasi Jantung

- **Alat:** Cath lab *(569)**
- **SDM: Sp.JP Intervensi / Sp.PD KKV Intervensi**

569 ***RS membutuhkan…*** **Fellow** Intervensionis Jantung

132 ***Telah tersedia***

437 ***Kekurangan***

Stroke

Layanan Trombektomi & coiling

- **Alat:** Cath lab *(571)**
- **SDM: Sp.N Neurointervensi / Sp.BS Vaskular / Sp. Rad Neuroradiologi Intervensi**

571 ***RS membutuhkan…*** **Fellow** Intervensionis Stroke

110 ***Telah tersedia***

461 ***Kekurangan***

Cancer

Layanan Terapi Sistemik Kanker (kemoterapi)

- **Alat:** *Cytotoxic drug safety cabinet (570)**
- **SDM: Sp.PD Fellow Onkologi**

570 ***RS membutuhkan…*** *Internist* **Fellow** Onkologi

88 ***Telah tersedia***

482 ***Kekurangan***

Uronefrologi

Layanan Hemodialisis dewasa*

- **Alat:** USG *Doppler*
- *dan* Mesin HD
- **SDM: Sp.PD Fellow Dialisis**

512 ***RS membutuhkan*** Internist **Fellow** Dialisis

190 ***Telah tersedia***

322 ***Kekurangan***

*Jumlah RS Jejaring tahun 2024-2027

Kemenkes

Ditjen Nakes & Koordinator Pengampuan KJSU melakukan kunjungan kerja ke India dan RRT untuk peningkatan kuota Fellowship

India, 23 – 27 Juni 2024

8 Private Hospitals
2 Gov't Institution*

1 Bangalore
1. Narayana Hospital
2. HCG Hospital

2 Hyderabad
1. AIG Hospital
2. Nephroplus
3. Apollo Hospital
4. KIMS Hospital[1]

3 New Delhi
1. Max Hospital
2. Ministry of Health and Family Welfare India*
3. National Medical Commission*

4 Kerala [2]
Baby Memorial Hospital

[1]*Extended visit (RSPON, Dharmais, Tenaga Ahli Menkes)*
[2] *Extended visit (RSPON)*

Stroke Kanker Jantung

RRT, 5 – 9 Agustus 2024

6 Public Hospitals
1 Govt. Centre*

1 Shanghai
1. Shanghai Chest Hospital
2. Ruijin Hospital

2 Ningbo
Ningbo Clinical Pathology Diagnosis Centre*

3 Hangzhou
Second Affiliate University, Zhejiang University

4 Nanjing
1. Zhongda Hospital
2. Jiangsu Provincial Hospital

5 Henan
Henan Provincial People's Hospital

Stroke Uronefro Jantung

Kemenkes

Jantung, Layanan Kateterisasi Jantung

Alkes utama: Cath lab

SDM user: Sp.JP Intervensi / Sp.PD KKV Intervensi

RRT 2 **25**

- Shanghai Chest Hospital: 5
- Ruijin Hospital: 5
- Zhejiang University Hospital: 5
- Zhongda Hospital [1]: 5
- Jiangsu Provincial Hospital: 5

India ***20****

45/tahun

	Dalam Negeri	Luar Negeri	Total
Sebelum **Produksi** /tahun	**44** Dari **14 Centre** Pendidikan	**98** • Japan : 4 • RRT 1 : 94	**142/th**
Setelah **Produksi** /tahun	**58** Dari **14 Centre** Pendidikan	**143** • RRT 2 : 25 • India : 20	**201/Th**
Target Produksi di tahun 2027	**174**	**429**	**603**

Naik **41%**

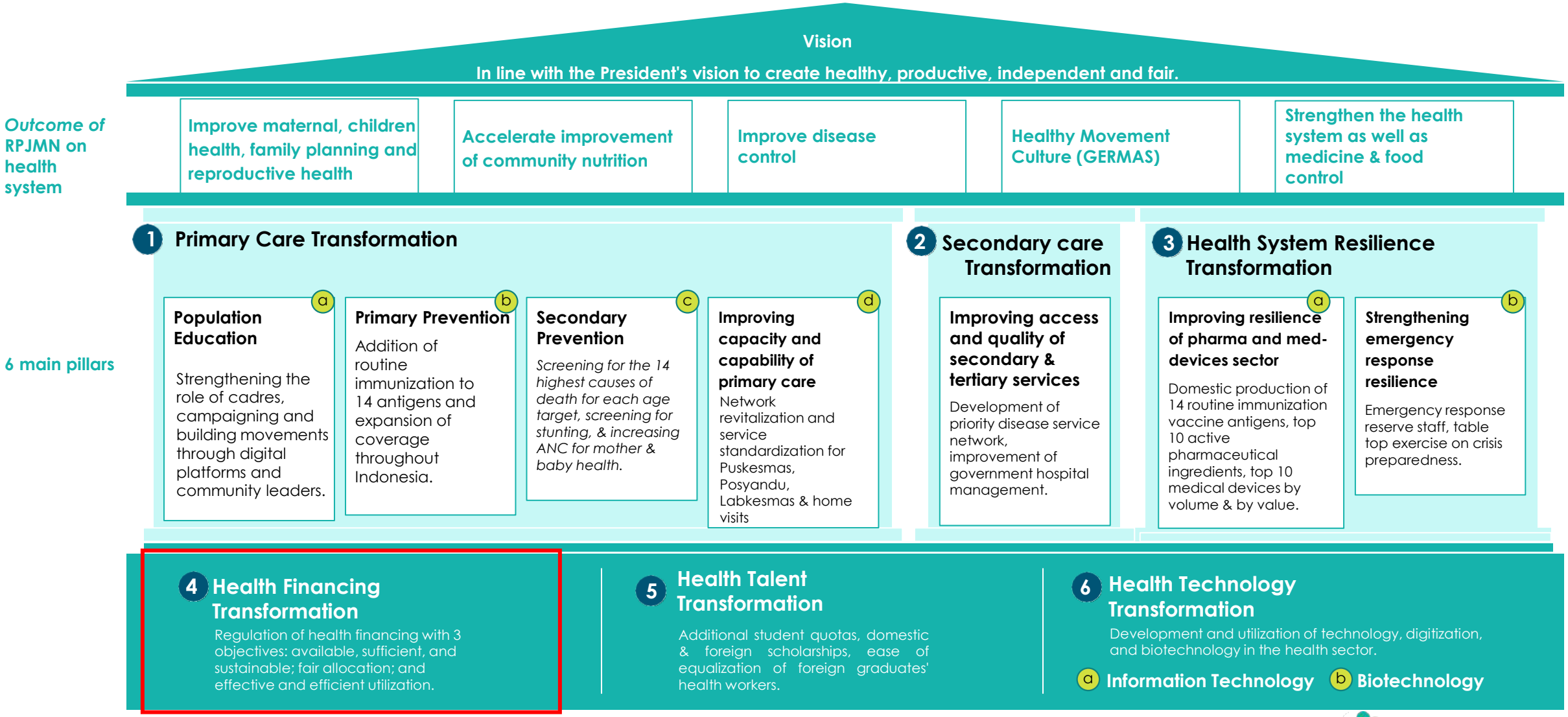
** Terdapat penawaran seat fellowship dari India. Namun, fellowship intervensionis jantung di India kurang direkomendasikan.*

[1] Tambahan kuota training **perawat kardiologi**: **5/tahun**

Kemenkes

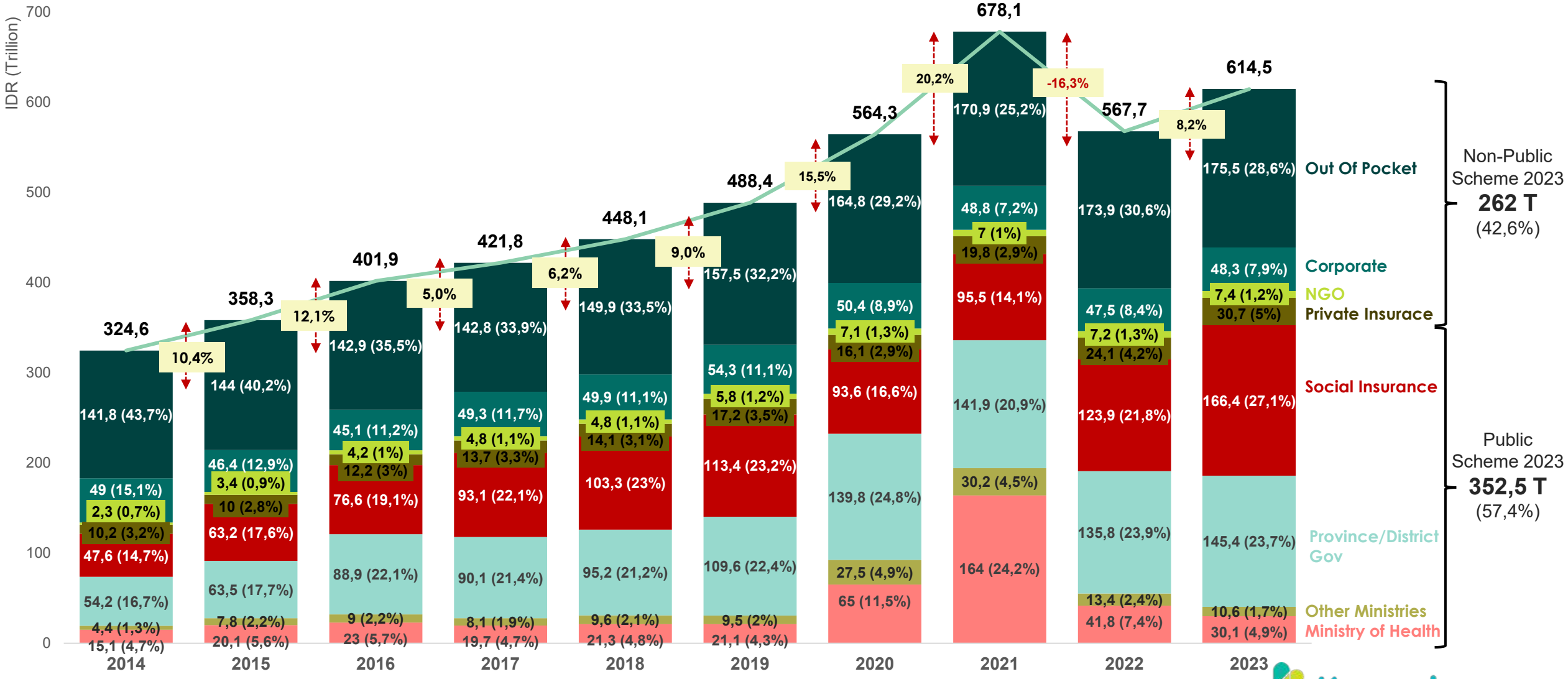
MoH is committed to implementing a health system transformation

The 6 pillars of transformation supporting the Indonesian health system:



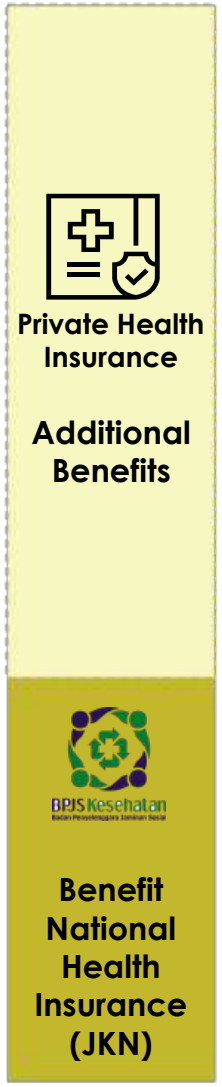
Indonesia's total health spending continues to increase

From 2014, **social health insurance** has increased from **14.7% to 27.1% in 2023**, yet **out-of-pocket** spending still accounts for **28.6% in 2023.**



Source: National Health Accounts, 2023

Enhancing the Role of Social and Private Health Insurance through Coordination of Benefits (COB)



Service cost difference: maximum 125% of the JKN tariff

Service cost: 75% of the JKN tariff

Coordination of Benefit

	National Health Insurance	+ Private Health Insurance
Benefit Coverage	**Basic needs**	**additional benefits** beyond participants' basic entitlements
Inpatient Room	standard inpatient class	Above standard inpatient class
Medicines	According to JKN benefits	medicines not covered by JKN benefits

Sumber: KMK 1366 Tahun 2024 tentang Pedoman Pelaksanaan Selisih Biaya oleh Asuransi Kesehatan Tambahan melalui koordinasi antar penyelenggara jaminan

Provider Payment Reform — Secondary Care: Indonesian-Diagnosis Related Group (iDRG)

Updating the Disease Grouping System for JKN Hospital Payments to Better Reflect the Indonesian Population's Disease Patterns

Outpatient

Grouping System	MDC	DC	CBG/DRG
INA-CBG (PMK 3/2023)	22	289	289
iDRG	**25**	**358**	**358**

Inpatient

Grouping System	MDC	DC	CBG/DRG
INA-CBG (PMK 3/2023)	22	262	786
iDRG	**25**	**560**	**960**

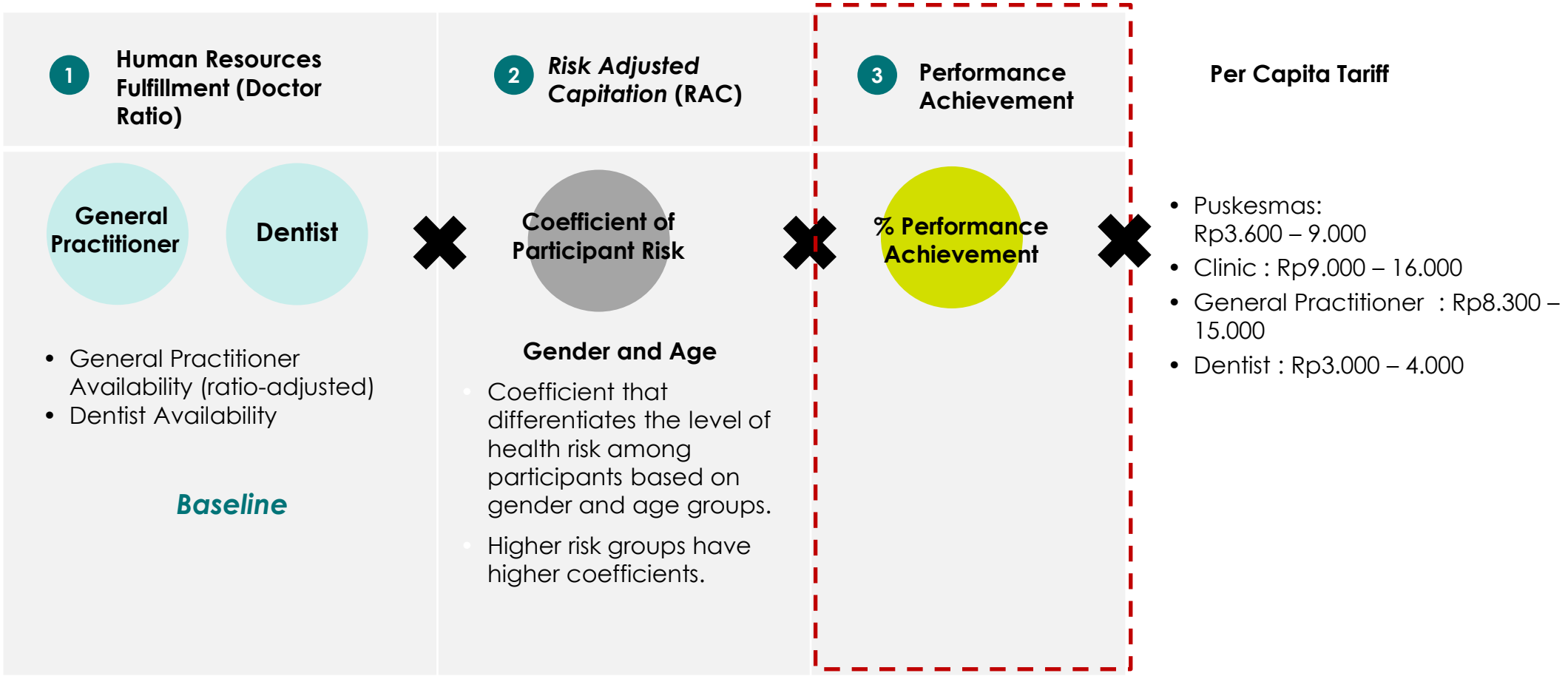
Major Diagnostic Category (MDC) = Broad category of diseases
Case Base Group (CBG) = Patient grouping based on type of case to determine cost
Diagnosis Related Group (DRG) = Patient grouping based on diagnosis and treatment for payment purposes

Kemenkes

Provider Payment Reform — Primary Care: Payment-based Capitation

Linking the capitation payments to provider performance aims to enhance fairness & meaningful service delivery outcomes

Capitation Tariff Variables in the JKN program:




Kemenkes