



JLN PRIMARY HEALTH CARE INITIATIVE  
PRIVATE SECTOR ENGAGEMENT COLLABORATIVE

# REGULATION OF PRIVATE PRIMARY HEALTH CARE IN INDONESIA

## A COUNTRY ASSESSMENT REPORT

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This report was produced by the Joint Learning Network for Universal Health Coverage (JLN), a community of policymakers and practitioners from around the world who jointly create practical guidance to accelerate country progress toward universal health coverage.

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## PREFACE

In 2016, the JLN Private Sector Engagement (PSE) Collaborative completed the first two modules of a five-part practical guide on private-sector engagement, titled [\*Engaging the Private Sector in Primary Health Care to Achieve Universal Health Coverage: Advice from Implementers to Implementers\*](#). These first two modules cover initial communications and partnership around primary health care (PHC) and provider mapping. To inform the third module, and to help fill gaps in guidance on the regulation of private PHC in low- and middle-income countries, six JLN countries—Ghana, Indonesia, Kenya, Malaysia, Mongolia, and Morocco—conducted assessments of their regulation of the private health sector. The assessments addressed the following research questions:

- What types of regulations are in place?
- How are the regulations implemented?
- What outcomes are achieved by those regulations?
- What resources are available for developing and implementing such regulations?

The assessments focused only on regulation of PHC service delivery (the process of providing PHC services and treatments). They did not cover other types of regulation, such as for human resources, training institutions, pharmaceuticals, or medical equipment.

*Regulation* is broadly defined as the imposition of rules backed by penalties or incentives to ensure compliance with standards—in this case, standards for the safety and quality of health services and providers. Regulations may govern activities such as licensing to open a facility, certification and accreditation, and offering incentives to promote better service quality. In outlining the scope of the assessments, the PSE Collaborative chose to look at regulation of both public and private-sector providers. They also agreed to focus on PHC service delivery, while recognizing that in describing the regulatory system they would inevitably touch on secondary and tertiary care.

The countries each conducted a document review using secondary data sources and collected primary data through in-depth interviews and focus groups involving national and subnational government entities (ministries of health, health financing agencies, regional health directors), regulatory boards and medical councils, professional associations and

representatives of provider groups and unions (for both public and private providers), members of the media, academics, and civil society organizations (representing consumers).

Each country assessment report describes the country's regulatory context, health sector objectives and strategy, and demographic and health indicators; the regulatory mechanisms currently in use; insights on implementation and performance based on primary and secondary data collection; and conclusions and recommendations for improvement.

This report documents Indonesia's experience in regulating private PHC.

## INTRODUCTION

In 2014, Indonesia launched its national health insurance scheme, Jaminan Kesehatan Nasional (JKN), as an effort to achieve universal health coverage (UHC) by 2019. The national health insurance agency, Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-K), is responsible for JKN operations. The JKN benefits package covers outpatient and inpatient health care services in primary, secondary, and tertiary facilities, and the system relies on tiered referral. Beneficiaries can access health care services at all public and private health care facilities that are contracted by BPJS-K. More than 190 million people or nearly 75% of the population are currently covered by JKN.

Regulation of private health providers in Indonesia is intended to help the country achieve its health objectives. Official strategic planning documents state that the primary goals of the national health sector are to improve access to basic and referral-based health services and service quality as well as to fulfill health workers' needs. The government recognizes that equal and universal access to health services cannot be achieved through the public health sector alone and that private health providers have a role to play, especially as their numbers and scope of activities increase. Regulations are a means to ensure equitable distribution of health services by the private health sector as well as to make those services more affordable, acceptable, and beneficial to citizens.

## REGULATORY CONTEXT

### Health Sector Objectives and Strategy

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The primary objectives of Indonesia's national health sector for 2015 to 2019, as described in the Ministry of Health's strategic planning document, are as follows:

- Improved maternal and child health and nutrition status
- Improved disease control
- Improved basic and referral health service access and quality, particularly in remote, underdeveloped regions and border areas
- Fulfillment of health workers' needs
- Improved access to and quality of pharmaceutical and medical devices
- Improved health system responsiveness

To achieve these objectives, the Ministry of Health established three main strategic pillars under the umbrella of the Healthy Indonesia Program (as shown in Table 1).

**Table 1. Three Pillars of the Healthy Indonesia Program**

Pillar	Strategy
Pillar 1: Healthy Paradigm	Incorporate health into national development policies, strengthen health promotion and disease prevention, and empower people
Pillar 2: Health Service Strengthening	Improve access to health services by improving the referral system and improving health service quality using a continuum-of-care approach and risk-based intervention
Pillar 3: National Health Insurance	Expand coverage (in terms of membership and benefits) and implement cost containment measures

### Demographic and Health Outcome Indicators

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Table 2 shows selected demographic and health outcome indicators for Indonesia.



**Table 2. Demographic and Health Outcome Indicators**

Indicator	Measure	Year	Source(s)
Total population	255.5 million	2015	BPS
Population age distribution	Age 0–14: 27.3% Age 15–64: 67.3% Age 65+: 5.4%	2015	Proyeksi Penduduk Indonesia 2010–2035, Statistics Indonesia (Biro Pusat Statistik)
Urban and rural population	Urban: 53.3% Rural: 46.7%	2015	Statistics Indonesia
Poverty rate	11.2%	2015	Statistics Indonesia
Infant mortality rate	24.5 per 1,000 live births	2013	WHO
Under-5 mortality rate	26 per 1,000 live births	2016	World Bank
Maternal mortality ratio	126 per 100,000 live births	2015	WHO
Top three illnesses that create demand for health services	Inpatient: <ul style="list-style-type: none"> <li>Mild viral and other nonbacterial infection</li> <li>Cesarean section without complications</li> <li>Mild abdominal pain and gastroenteritis</li> </ul> Outpatient: <ul style="list-style-type: none"> <li>Other mild chronic diseases (e.g., follow-up exam after treatment)</li> <li>Dialysis procedure</li> <li>Physical therapy and small musculoskeletal procedures</li> </ul>	2018	N/A
HIV prevalence	0.5% (adult)	2015	WHO

Indicator	Measure	Year	Source(s)
Diabetes prevalence	1.5%	2013	Ministry of Health (MOH)
Total fertility rate	1.31 per 1,000 population	2015	BPS
Percentage of 1-year-olds who have received DTP3	93%	2016	MOH
Prenatal care coverage (4+ visits)	85%	2016	MOH

## Health System Indicators

Table 3 provides a snapshot of health system indicators in Indonesia, including the mix of public and private resources that go toward PHC and diagnostic services.

**Table 3. Health System Indicators**

Indicator	Measure	Year	Source
Number of hospital beds per 100,000 population	Total: 256,426 Public: 56% Private: 44%	2016	MOH
Bed utilization rate	64.73%	2016	MOH
Outpatient utilization rate (visits per person per year)	170.2 million	2016	BPJS-K
Number of outpatient facilities by type	20,208 (primary) 2,068 (referral) Public ( <i>puskesmas</i> ): 48% Other: 52% Private: N/A	2016	BPJS-K and MOH

Indicator	Measure	Year	Source
Number of laboratory facilities	377	2017	BPJS-K
Number of pharmacies	25,339 (non-BPJS-K) 2,264 (BPJS-K)	2016	MOH
Number of health workers (e.g., doctors, nurses, midwives, technicians, pharmacists, health extension workers)	1,000,780 total 3.9 per 1,000 population	2017	MOH
Percentage of population covered by a public health insurance plan	70%	2017 (July)	BPJS-K
Per capita income (nominal and purchasing power parity)	Nominal: US\$3,400 PPP: \$11,220	2016	World Bank
GDP growth rate (past 5 years for which data are available)	6.03% 5.56% 5.00% 4.88% 5.06%	2016 2015 2014 2013 2012	World Bank
Total health expenditure (THE) per capita	US\$99.41 Local currency: 1,342,035 IDR	2014	World Bank
THE as a share of GDP	2.85% of GDP	2015	World Bank
General government health expenditure (GGHE) per capita and as a share of THE	US\$43 per capita 38.2% of THE	2015	World Bank
Private health expenditure per capita and as a share of THE	US\$68 per capita 61.1% of THE	2015	World Bank
Out-of-pocket expenditure (OOPE) on health per capita and as a share of THE	US\$54 per capita 48.3% of THE	2015	World Bank

## REGULATORY LANDSCAPE

### Regulatory Efforts to Date

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Various regulatory mechanisms are employed in Indonesia, with emphasis on command and control mechanisms, which have legal requirements accompanied by sanctions for noncompliance. (See the Annex for a detailed list.)

Command and control mechanisms applicable to the private health sector include:

- Ministry of Health Regulation on Clinics No. 9/2014. This regulation targets private health facilities to ensure that they provide accessible, affordable, and quality health care services. The technical guidelines for implementing this regulation are under development.<sup>1</sup>
- Ministry of Health Regulation No. 46/2015 on Accreditation of Primary Care Providers. This regulation targets public PHC facilities (*puskesmas*) and primary care physicians and dentists to improve PHC quality sustainably. Accreditation mainly focuses on *puskesmas*.<sup>2</sup>
- Ministry of Health Regulation No. 71/2013 (amended in 2015) on Health Service Delivery under National Health Insurance (JKN). This regulation provides details on JKN implementation for relevant participants who are providing and delivering health care. Implementation has been ongoing in the form of contracting and credentialing health facilities, providing services to members as listed in the regulation, undertaking cost containment through periodic utilization review, and conducting health technology assessments. However, one part of this regulation has yet to be implemented—it concerns compensation to members who live in underserved areas and lack access to health care services to which they are entitled.<sup>3,4</sup>
- BPJS Kesehatan Regulation No. 1/2017. This regulation concerns the distribution of PHC providers to help improve quality of service for JKN members. Members are redistributed from providers that are deemed overcrowded to other providers in order to achieve a better doctor-to-patient ratio. (The redistribution is done by BPJS-K based on recommendations from regional health offices.) In 2017, enrollees were

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<sup>1</sup> Pemerintah Indonesia, 2014 #561

<sup>2</sup> Pemerintah Indonesia, 2015 #557

<sup>3</sup> Pemerintah Indonesia, 2015 #550

<sup>4</sup> Pemerintah Indonesia, 2013 #554

redistributed from *puskesmas* with more than 30,000 members and a doctor-patient ratio of less than 1:10,000 and from private PHC providers with more than 15,000 members and a doctor-patient ratio of less than 1:5,000. The implementation of this regulation has sparked complaints, particularly from private health providers, that some enrollees are moved without being notified and without their consent. This is, in fact, against the BPJS-K law; one of the articles states that members have the right to choose their own primary care provider. In some cases, private providers are disadvantaged when their patients are moved to *puskesmas* because their pool of patients decreases along with the accompanying capitation payments. This regulation also discourages PHC providers, particularly private ones, from competing against one another to improve service quality.<sup>5</sup>

A few regulations employ an incentive mechanism, generally a financial incentive. For instance, BPJS Kesehatan Regulation No. 2/2015 regulates “commitment-based” capitation for public and private PHC providers contracted by BPJS-K in order to increase the efficiency and effectiveness of national health insurance and contain costs.<sup>6</sup> Commitment-based capitation is a form of pay-for-performance in which PHC providers must meet certain criteria in order to receive the full capitation payment. BPJS-K relies on data collected through its P-care system to determine which facilities receive capitation payment, and how much. The technical guidelines for implementing this regulation were developed in 2016 and amended in 2017. The policy has been piloted primarily in *puskesmas*; implementation will extend to private providers in 2018.

Nonfinancial incentives are less popular than other mechanisms in Indonesia. Nevertheless, several district health offices are developing regulations that use nonfinancial incentives to overcome health care coverage issues in underdeveloped regions. The aim is to expand coverage in regions not served by *puskesmas* by offering incentives to private providers.

Another mechanism is self-regulation, whereby providers and professional groups set their own standards. One example is the clinical guidelines for primary care physicians established by the Indonesian Medical Association. These guidelines, which consist of clinical management instructions for 144 diseases or diagnoses, are meant for primary care

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<sup>5</sup> Pemerintah Indonesia, 2017 #555

<sup>6</sup> Pemerintah Indonesia, 2015 #558

physicians and aim to standardize health care delivery in primary care settings. BPJS-K has adopted this list as the diagnoses that cannot be referred to a higher level of care.

## **Regulatory Agents**

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In the early 2000s, Indonesia made a radical change that shifted the government from a centralized system to a decentralized one. Under this system, regulatory authority lies with both national and regional regulators. The highest level of regulation is in the form of laws passed by the House of Representatives. The executive branch, under the president, executes the laws by developing presidential decrees or regulations that refer to the relevant law. Relevant ministries, boards, and agencies then develop detailed technical versions of the regulation in ministerial decrees or regulations or joint regulations. District or municipal governments can adopt the national regulations or pass local versions that have been adjusted to suit local needs.

### ***National Government—Developing Regulations***

The Health Commission of the Indonesian House of Representatives, together with the executive branch (represented by the Ministry of Health), is responsible for updating, amending, and developing health sector regulations. The National Health Insurance Board is responsible for synchronizing health policies. The Regional Representative Council provides advice and recommendations on the substance of the law.

According to Law No. 12/2011, the legislature or executive branch creates a problem inventory list (daftar inventarisasi masalah, or DIM) or drafts a law.<sup>7</sup> Stakeholders are then invited to discuss the DIM or attend legislative hearings. The legislature records who has been invited to hearings and uses this list to generate an invitation list for subsequent hearings. Legislative hearings can be undertaken several times, as necessary, and the participants can include relevant ministries, government bodies, statutory boards, professional associations, and representatives from civil society organizations.

Additionally, the executive branch collects input or proposes new regulations, or amendment of regulations, by inviting relevant stakeholders and disseminating the

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<sup>7</sup> Pemerintah Indonesia, 2011 #552

regulation draft. The body can also conduct a technical coordination meeting in the Ministry. Harmonization of regulation is facilitated by the Ministry of Law and Human Rights, which examines whether there are associations with other regulations.

Even though representatives from civil society organization are invited to participate in the process of developing regulations, their views may not represent those of the larger population. As social media use becomes more widespread, decision-making processes can be influenced by online citizen voices and public petition platforms such as Change.org.

### ***National Government—Implementing Regulations***

According to the Regional Autonomy Laws, the Ministry of Health has primary responsibility for regulating the health sector at the national level. Local governments are responsible for regulating the health sector at the local level, including issuing of permits to the private sector (guided by the regulations of the Ministry of Home Affairs). The Organization and Legal Bureau of the Ministry of Health is responsible for developing and disseminating the technical details of regulations and for monitoring.

According to the Ministry of Health regulation on Organization and Governance in Ministry of Health (enacted in 2015), a division under the Ministry of Health called the Directorate of Primary Health Services is responsible for formulating and implementing policies, standards, and technical guidance for PHC services and providing supervision, monitoring and evaluation, and reporting. The Directorate of Primary Health Services consists of several subdirectorates, including the Sub-Directorate of Clinics and the Sub-Directorate of Individual Health Practitioners.

### ***National Health Insurance Agency (BPJS-K)***

BPJS-K is the operating agent of national health insurance in Indonesia. Its role is defined in Law No. 40/2004 on National Health Insurance, Health Law No. 36/2009 on Health, and Law No. 42/2011 on National Social Insurance Agency. BPJS-K has enacted several laws, including laws on commitment-based capitation, fraud prevention, coordination of benefits, member registration, premium payment mechanism, and cost containment.

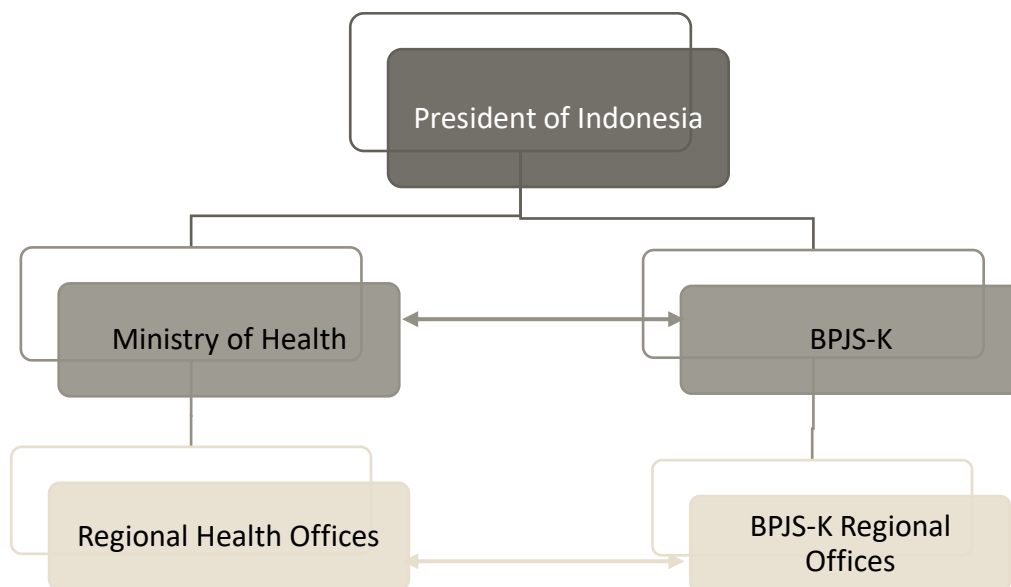
BPJS-K generally develops technical operational regulations, with input from the Ministry of Health. In conjunction with the ministry, it has passed regulations that govern areas such as

health facility credentialing, standardized tariffs for health care services under the national health insurance plan, and member distribution. BPJS-K also works with professional associations to develop cost containment guidelines.

### *Local Government—Developing Regulations*

The local legislative body (the local House of Representatives), along with the provincial health office, is responsible for updating and developing local health regulations and gubernatorial regulations. At the district or municipality level, the local legislative body, together with district or municipal health offices, is responsible for developing district or municipal regulations or district head or mayoral regulations. The local legislative body collects input from stakeholders at provincial, district, or municipal legal bureaus; professional organizations; and citizens. At the local level, new regulations or changes to regulations are proposed by the local legislative body together with the local health office. According to Ministry of Health regulations, subsequent regulations can be delegated to each local government as long as they conform to Ministry of Health regulations. The executive branch conducts dissemination and coordination meetings with various participants to collect input or to propose or amend regulations.

Regulations are sometimes hard to implement on the local level because the language used in the national documents can be interpreted in several ways.





### ***Local Government—Implementing Regulations***

The main bodies responsible for regulating the health sector at the local level are the local legal bureau, the local health office, and the food and drug monitoring agency. The lowest-level offices responsible for implementing regulation are the governor/regent and the investigating officer in the food and drug agency. Their role is primarily to develop and monitor regulatory activities involving other stakeholders, such as professional organizations. Their role is stipulated by higher-level regulations, i.e., the law --> central government regulation --> presidential regulation --> ministry regulation --> local government regulation --> gubernatorial regulation.

### ***Accreditation Commission***

To ensure the quality of PHC service delivery, the Ministry of Health established the Accreditation Commission for Primary Healthcare Providers in 2015 in line with its strategic planning goal of improving access to health care and the quality of services. The commission is an independent body that is responsible for accrediting PHC providers. Its work includes training, monitoring and evaluation, and facility accreditation. The commission is assisted by the permanent secretary in the Directorate of Primary Health Care in the Ministry of Health. The commission's members, who report to the General Director of Primary Health Care on behalf of the minister of health, are appointed by the Ministry of Health and serve for a five-year term. This commission is financed by the Ministry of Health budget.

Despite the establishment of the commission, the Ministry of Health Strategic Planning 2014–2019 document focuses only on accrediting *puskesmas* and calls for one accredited *puskesmas* facility in each district or municipality. However, private clinics have also been preparing for accreditation despite limited resources, according to the Associations of Clinics representative. Private clinics struggle to fulfill the accreditation requirements and finance the accreditation process, given their limited resources.

### ***Health Facility Associations and Professional Associations***

Health facility associations also play a role in national health insurance. Health facility associations at the primary care level include Associations of Clinics (ASKLIN), Indonesian Associations of Clinics and Primary Health Care Facilities (IACP), and Associations of Health Offices (ADINKES). Their main role is to negotiate with BPJS-K on capitation payments for

various types of PHC providers and disseminating the results to their members. In performing this role, the associations may hold forums and provide input to the Minister of Health. Health facility associations, in collaboration with BPJS-K and local health offices, also play a role in assessing and credentialing health facilities before they are contracted by BPJS-K. These roles are defined in the 2013 Ministry of Health Stipulation. However, professional associations are involved only during the early phase of policy planning. They would like to be involved throughout the process and have opportunities to provide feedback before regulations are enacted.

IACP is headquartered in Indonesia's capital, Jakarta, and has local branches all over the country. Its national officials are appointed during the national assembly, once every five years; regional officials are appointed during a regional meeting. The national organization consists of an advisory board, a founding board, an expert board, heads, secretaries, treasurers, and various other divisions. The organization is financed through member contribution fees, organization business units, and other legal contributions and revenues.

Professional associations such as the Indonesian Medical Association (IMA), the Indonesian Dentists Association (IDA), and midwifery and nursing associations also play vital roles, particularly in licensing and registering health professionals. Their roles are stipulated by laws and Ministry of Health regulations on clinical practice for each health profession.<sup>8</sup> These associations are headquartered in Jakarta and operate nationwide through local branch offices. These local offices, in collaboration with local health offices, license health professionals. They also help the central office register members and recertify health professionals. These associations have established mechanisms for organizing their members and have adequate resources to perform their activities. They are financed through member contribution fees; fees for seminars, workshops, and training credits (Sasaran Kerja Pegawai, or SKP); and other sources of revenue. They also develop practical guidelines for health professionals practicing under the JKN plan.

One of the more recently established professional organizations is the Indonesian Association of Family Physicians (Perhimpunan Dokter Keluargo Indonesia, or PDKI). The Medical Education Law enacted in 2013 introduced a new professional designation, Family Medicine/Primary Care Physician, to enhance physician competence in delivering PHC

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<sup>8</sup> Peremintah Indonesia, 2014 #562

services by acknowledging these providers as specialist physicians. The PDKI has developed case guidelines for these family doctors. Despite the law, technical implementation is still unclear. The PDKI relies on volunteers and does not collect fees. To date, they have not established any monitoring mechanisms.

## Tracking Regulatory Performance

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To track regulatory performance, the Ministry of Health coordinates with local health offices across the country. Indonesia has established health information systems in hospitals (SIM RS) and *puskesmas* (SIM PUS); these are connected to local health office information systems (SIM DINKES), which then connect to the central information system in the Ministry of Health. All of the data are pooled into one data bank; the most recent data warehouse is DHIS version 2. Other health information systems—such as SIHA, SITT, and SIMUNDU—collect various types of health indicators each month. The systems in several regions are not connected, and integration is still in progress. In addition, not all *puskesmas* use the electronic information systems; some still manually collect and report information. The health information system available to *puskesmas* are not used in private clinics or facilities, so the activity of those providers is not tracked.

BPJS-K has its own health information system, P-care, for its public and private PHC providers. P-care also connects to the SIM RS system used in hospitals. BPJS-K uses data collected through P-care to review utilization, implement monitoring and evaluation activities, and assess PHC providers for commitment-based capitation payment. One drawback is that *puskesmas* are required to enter data twice—into SIM PUS (their own system) and also P-care—because the two systems are not integrated. Data entry is also challenging for private providers, particularly clinics, because they lack adequate staff for this task; this affects the timeliness and quality of data. BPJS-K uses additional software called Health Facility Information System (HFIS) to track the health facility registration status of facilities that want to contract with BPJS-K.

Some districts and municipalities use an integrated health information system known as SIKDA (Regional Health Information System). (At the central level, this system is called SIKNAS, or National Health Information System.) Using SIKDA, users from different health facilities can enter and access various health data, including epidemiological data. The software also enables patients to register for appointments online. Several districts have

made the software available for download using Google Play. In Indonesia’s decentralized health system, each region develops its own health information system using the resources it has available. This makes it challenging to produce high-quality and standardized data. To overcome this challenge, the government has developed a standardized version of SIKDA called SIKDA Generik. Collected data is processed and published in Ministry of Health websites and in the form of publicly available annual reports and bulletins.

Information on health regulations is published and available for download on Ministry of Health, BPJS-K , and professional organization websites. Other types of regulatory information are released in the form of the annual National Health Profile, bulletins, infographics, basic health data, health maps, situation analysis reports, and annual performance and financial reports from various institutions. The Ministry of Health itself consists of several directorates; each directorate has its own strategic planning division and publishes periodic reports. BPJS-K publishes much less information, particularly on its yearly performance.

Table 4 describes regulatory targets and results in several areas of health care regulation in Indonesia.

**Table 4. Regulatory Activities and Performance**

Regulatory Activity	Performance Indicators	Performance Period	Source
PHC provider coaching: number of districts/municipalities coached	Target: 20 in 2016 Result: 21 (105%)	Jan–Dec 2016	Internal tracking system
PHC provider coaching: number of individual physicians or dentists meeting the standard	Target: 0 in 2016–2017; 102 in 2018	2016–2017, 2018	Internal tracking system

Regulatory Activity	Performance Indicators	Performance Period	Source
Number of new regulations/revisions developed	<p>Target: 5 in 2016</p> <p>Result: 7 (140%)</p> <p>Remarks: Most regulations are still in draft form. New draft regulations governing PHC providers include: 1) revision of MOH regulation on clinics, 2) technical guidelines on clinics, 3) guidelines on private practitioners and dentists, and 4) guidelines on private midwives.</p>	Jan–Dec 2016	Internal tracking system
PHC accreditation: number of districts/municipalities prepared for primary care accreditation	374 of 210 (178%)	2016	Internal tracking system
Number of districts/municipalities agreeing to commitment-based capitation	<p>483 of 514 (93.97%)</p> <p>A pay-for-performance (P4P) mechanism has already been implemented in <i>puskesmas</i>. Although private providers are assessed for P4P indicators, P4P was not applied to them until the end of 2017.</p>	2016–March 2017	Internal tracking system

## Summary of Regulatory Efforts

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The Ministry of Health Regulation on Clinics was enacted to ensure that clinics provide accessible, affordable, and quality health care services. To improve PHC quality, the government enacted an accreditation requirement for primary care providers. After the launch of the national health insurance plan, it enacted a regulation on performance-based

payment to increase the efficiency and effectiveness of national health insurance and contain costs among public and private providers. To standardize health care delivery in the PHC setting, the Indonesian Medical Association developed clinical guidelines. To expand health care service coverage to populations in regions with limited access, local governments plan to offer incentives to private health providers to serve these regions.

Regulation development, enforcement, and implementation are big challenges because of inadequate staffing at both the national and regional levels. Unlike in the central government, where every ministry has its own legal division, each local government has only one legal division for all local government offices, including the local health office.

Several information systems have been established to support tracking and reporting of regulatory activities, but some tasks, such as licensing of health facilities by local health offices, are still carried out manually.

## IMPLEMENTATION AND PERFORMANCE OF REGULATORY ACTIVITIES

This section documents the actual implementation of regulatory efforts and summarizes the views of both regulators and regulatory targets.

### Findings Based on Regulator Input

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The Ministry of Health and BPJS-K, as central regulators, strongly agree that health sector regulations are fulfilling their mandate. According to the ministry, regulatory achievements have included 1) establishment of committee accreditation for *puskesmas* to speed up the accreditation process, 2) development of medical guidelines for physicians on clinical management of 144 diseases and diagnoses, 3) development of practical guidelines for clinical practice licensing, and 4) creation of management manuals for *puskesmas* relating to standard operating procedures and the role of *puskesmas* in providing public health services. The ministry believes that these processes and guidelines improve quality of care. Other achievements include a series of monitoring and evaluation meetings.

The ministry also notes some challenges that weaken regulatory performance, such as lack of staffing capacity and staff quality for implementing guidelines. This may explain low targets set by the ministry—for example, the target number of districts and municipalities undergoing clinic coaching was set at only 20 out of more than 500 districts and municipalities in Indonesia. Moreover, disparities involving geographical and cultural challenges affect implementation and performance. Tackling these issues will involve balancing staffing resources in both public and private facilities and increasing capacity.

One strength of BPJS-K regulation is that it specifies different regulations for public providers and private providers, such as for capitation payment. In addition, recent implementation of commitment-based capitation has encouraged PHC providers to be more patient-centered, improving health promotion and disease prevention rather than providing only curative care. Even though the regulations were developed to accommodate the interests of both public and private providers, they still do not satisfy all providers. The provider payment mechanism requires private providers to shift from fee-for-service

payment to capitation. PHC providers must also compete to deliver the best health promotion and disease prevention services and reduce unnecessary referrals.

Under the decentralized system, regional health offices have a role in implementing central regulations as well as developing regulations at the local level. In terms of JKN implementation, regional health offices often face issues that require them to consult with other stakeholders, such as BPJS-K and the Ministry of Health. However, the pathway of coordination is not clear; district health officials may have no idea whether to consult with BPJS-K or the Ministry of Health. Local health officials believe that private-sector engagement is important for equalizing distribution of health services, given that existing *puskesmas* cannot cover the entire population, so communication among participants must be improved.

## Findings Based on Input from Regulated Parties

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Unlike regulators, regulated parties such as health professional associations and health provider associations do not believe that existing regulations are fulfilling their mandate. Providers have a role in only part of the process of developing regulations, so they perceive that existing JKN regulations are not ready for implementation. Furthermore, they feel that a few regulations are counterproductive, such the BPJS-K regulation on enrollee redistribution, which leads to some private providers' enrollees being moved to *puskesmas*. This can discourage the private sector from competing to provide the best services and also affect patient satisfaction. They are also dissatisfied with the requirement that private providers meet accreditation criteria, which can create hardships for providers. A number of previously accredited private providers have not been reaccredited, so they cannot be contracted by BPJS-K. Given the limited number of *puskesmas* and the large population to be covered, it is unlikely that Indonesia will be able to make progress toward achieving UHC without the support of the private sector.

Despite the regulatory challenges faced by private providers, some have made efforts to adjust, such as by establishing JKN monitoring mechanisms internally and preparing for accreditation.

To address these challenges, health professional associations have suggested several changes. They argue that capitation norms should be reviewed because private providers struggle to manage their operations with limited capitation funds, and they urge



reconsideration of regulations on enrollee redistribution. They also advocate for aligning BPJS-K target indicators with the Ministry of Health Strategic Planning document and for regular monitoring. They want standard operating procedures for private clinics and providers, including tools and infrastructures, as well as guidelines on how to improve efficiency to boost revenue. They want BPJS-K support for continuing medical education, particularly in the areas of health promotion and disease prevention. Finally, they want to be involved throughout the regulation development process.

## CONCLUSIONS

Various laws and regulations have been passed in Indonesia to ensure the accessibility, affordability, and quality of health care services. These laws and regulations have generally been imposed on both public and private health care facilities. Nevertheless, with private facilities outnumbering public ones, and given the different characteristics of private health care facilities, the government passed regulations to synergize regulations across public and private providers. Despite these efforts, private hospitals are still the main targets of regulation.

One challenge that affects the performance of the regulatory system is lack of resources for developing and implementing regulations and for providers to prepare for compliance with those regulations. Regional and local governments have only one legal division, unlike the central government, where every ministry has its own legal division. This situation often holds up development and implementation of regulations at the regional and local levels. Furthermore, regulatory agents tend to working passively, responding only to problems (such as reports or complaints about health provider performance) rather than conducting regular visits to health facilities. Another issue is lack of coordination between regional and central government on regulatory implementation.

Professional associations and organizations play a role in developing and implementing regulations, particularly in monitoring health service delivery in coordination with local health offices, negotiating with BPJS-K on payment systems, and engaging in policy discussions with regulators. However, they are not involved throughout the entire process, which prevents them from providing feedback before regulations are implemented.

In addition, despite the importance of private providers in health care delivery, a few regulations discourage private providers from delivering PHC. In particular, BPJS Kesehatan Regulation No. 1/2017 concerning enrollee distribution disproportionately affects private providers. Under this regulation, BPJS-K can move enrollees from one JKN member facility to another. A decrease in enrollees reduces the capitation payments received by the facility.

The most-used regulatory mechanism in the health sector is the command and control mechanism, under which administrative penalties are imposed when providers violate regulations. Self-regulation is commonly used by institutions such health provider

associations. Only a few existing regulations use incentives. One of these is the BPJS- K performance-based payment mechanism, which pays providers 100% of the capitation amount only if they meet all targets based on quality indicators and lesser amounts if they do not meet the targets.

The Ministry of Health and agents such as BPJS-K have developed electronic information systems that providers must use. Regulators use the data to make decisions. For instance, the BPJS-K P-care application for PHC providers is used to determine which primary care facilities are entitled to receive 100% of the capitation payment. The HFIS application is used by health facilities to apply for, track, and monitor their application for accreditation, which is a requirement for being contracted by BPJS-K.

The Ministry of Health also has a number of electronic information systems that regularly collect on various health indicator data. The national-level information system is connected to some regional systems, but several regions are not yet integrated. Several systems are used only by *puskesmas*, while private clinics and practitioners must report data manually. Licensing of health facilities by local health offices is also done manually. In addition, BPJS-K and the Ministry of Health use different electronic systems for PHC providers; these systems haven't been integrated, so providers must enter data twice. Private practitioners are often inadequately staffed for this task. Consequently, the timeliness and quality of data are compromised.

## RECOMMENDATIONS

If the government hopes to achieve UHC by 2019, countries must strengthen primary care by making the most of available resources, particularly to enable health service delivery in underserved regions. The first priority should be to establish efficient and effective public-private engagement and networking. Private providers lack sufficient resources to carry out operational tasks outside of care delivery, so the government should offer support in areas such as regulatory oversight. Currently, according to Ministry of Health Decree No. 75/2014 and No. 44/2016, *puskesmas* oversee clinics and private practices in their subdistrict but have limited staff and have other priorities that take precedence. Consequently, clinics and private providers rarely engage with *puskesmas* in their region. If *puskesmas* had enough support to make oversight a priority, private providers would be more engaged in the health system and would be better able to comply with national health guidelines.

The second recommendation is to review regulations regularly and involve all participants (including private-sector providers) in the process.

The third recommendation is to include private PHC providers in strategic planning and to measure their performance using regulatory performance indicators so they can improve their service delivery.

The fourth recommendation is to address the lack of coordination in JKN implementation between the regional and national levels by establishing clearer pathways for coordination. This will result in more timely and effective problem solving as well as more efficient service delivery.

Finally, all health information systems (at both the central and regional levels) should be integrated and be made accessible to all relevant stakeholders—including BPJS- K and Social Affairs Offices—to facilitate decision-making based on timely and accurate data.

## REFERENCES

Keputusan Menteri Kesehatan Republik Indonesia No. HK.02.02/Menkes/59/2015 tentang Komisi Akreditasi Fasilitas Kesehatan Tingkat Pertama (2015).

Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan No. 1 tahun 2017 tentang Pemerataan Peserta di Fasilitas Kesehatan Tingkat Pertama (2017).

Peraturan Badan Penyelenggara Jaminan Sosial Kesehatan No. 2 tahun 2015 tentang Norma Penetapan Besaran Kapitasi dan Pembayaran Kapitasi Berbasis Pemenuhan Komitmen Pelayanan Pada Fasilitas Kesehatan Tingkat Pertama (2015).

Peraturan Menteri Dalam Negeri No. 138 tahun 2017 tentang Penyelenggaraan Pelayanan Terpadu Satu Pintu Daerah (2017).

Peraturan Menteri Kesehatan No. 9 tahun 2014 tentang Klinik (2014).

Peraturan Menteri Kesehatan No. 44 tahun 2016 tentang Pedoman Manajemen Puskesmas (2016).

Peraturan Menteri Kesehatan No. 71 tahun 2013 tentang Pelayanan Kesehatan Pada Jaminan Kesehatan Nasional (2013).

Peraturan Menteri Kesehatan No. 75 tahun 2014 tentang Puskesmas (2014).

Peraturan Menteri Kesehatan No. 99 tahun 2015 tentang Pelayanan Kesehatan Pada Jaminan Kesehatan Nasional (2015).

Undang-Undang No. 12 tahun 2011 tentang Pembentukan Peraturan Perundang-undangan (2011).

Undang-Undang No. 36 tahun 2014 tentang Tenaga Kesehatan (2014).

# ANNEX

**Table A-1. Regulatory Mechanisms**

Mechanism Type	Instrument(s)	Target(s)	Rationale (Stated or Inferred)	Implementation Status	Source(s)
<b>Command and control</b> —legal requirements accompanied by sanctions for noncompliance	Ministry of Health Regulation on Clinics No. 9/2014 regulating private clinic requirements	Private health facilities (clinics)	To enable clinics to provide accessible, affordable, and quality health care services	Technical guidelines are under development.	PMK No. 09/2014
	Ministry of Health Regulation No. 46/2015 on Accreditation of Primary Care Providers	PHC facilities ( <i>puskesmas</i> , clinics, primary care physicians, and dentists)	To improve PHC quality sustainably	Several <i>puskesmas</i> have been accredited; few private clinics have been accredited.	PMK No. 46/2015

Mechanism Type	Instrument(s)	Target(s)	Rationale (Stated or Inferred)	Implementation Status	Source(s)
	Ministry of Health Regulation No. 71/2013 on Health Service Delivery under National Health Insurance (JKN)	BPJS-K, health care providers, JKN members	To provide details on JKN implementation to JKN participants who provide and deliver health care	Implementation has been ongoing (contracting and credentialing of health facilities that provide services to JKN members and undertaking cost containment through periodic utilization review and health technology assessments.	PMK No. 71/2013
	BPJS Kesehatan Regulation No. 1/2017 on Member Distribution of Primary Health Care Providers	PHC providers	To ensure and improve quality of service to JKN members	Member redistribution has been disadvantageous for private providers and JKN members.	BPJS Kesehatan No. 1/2017

Mechanism Type	Instrument(s)	Target(s)	Rationale (Stated or Inferred)	Implementation Status	Source(s)
<b>Incentives (financial)</b> —actors change their behavior in response to financial rewards or penalties	Commitment-based capitation for PHC providers, pay-for-performance mechanism	PHC providers	To increase the efficiency and effectiveness of national health insurance and develop a cost containment system	Technical guidelines were developed in 2016 and amended in March 2017. The incentives have been piloted in PHC facilities across the country.	BPJS Regulation No. 2/2015  Joint Regulation of General Secretary of Ministry of Health and President Director of BPJS-K No. 2/2017
<b>Incentives (nonfinancial)</b> —actors change their behavior in response to nonfinancial rewards or penalties	Offering incentives to private health providers who serve underdeveloped areas with few public health providers ( <i>puskesmas</i> ) by redistributing JKN capitation payments	Private health facilities	To expand health care service coverage to populations in underdeveloped regions	The policy is under development.	N/A
<b>Self-regulation</b> —provider and professional groups set their own standards of member behavior	Clinical guidelines for primary care physicians	Primary care physicians	To standardize health care delivery in the primary care setting	The guidelines cover clinical management of 144 diseases/diagnoses in the primary care setting.	Clinical guidelines for primary care physicians: Indonesian Medical Association Decree No. 561/2013



**Table A-2. Implementation and Performance of Regulatory Activities**

Stakeholder	Interview Date	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
<b>Regulators</b>					
Ministry of Health	19 September 2017	5	The capitation norms distinguish between <i>puskesmas</i> (public providers) and private clinics and practitioners.  Recent implementation of commitment-based capitation encourages PHC providers to be more patient-centered, improving their health promotion and disease prevention rather than providing only curative services.	Lack of staffing capacity and quality to implement the guidelines/manuals.  Geographic and other disparities—Indonesia has close to 17,000 islands and more than 300 languages.	Balance resources across public and private facilities through better human resource distribution and increased capacity.  Use special incentives to encourage the private sector to serve remote populations that the government does not currently serve.
BPJS-K	19 September 2017	5	N/A	May not satisfy all health providers.	Private sector should shift its mindset from fee-for-service to capitation.  All PHC providers should compete in delivering health promotion and disease prevention services and reduce unnecessary referrals.

Stakeholder	Interview Date	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
Health office	19 September 2017	3	N/A	Pathway of coordination on JKN implementation is unclear (i.e., it is unclear whether local authorities should consult with BPJS-K or MOH).	Existing <i>puskesmas</i> cannot cover the entire district population; private-sector engagement is needed for equal distribution of health services. Therefore, it is important to improve communication among participants in the system, particularly local government, private providers, and BPJS-K, in order to regulate distribution of JKN members in local areas.

Stakeholder	Interview Date	To what extent are regulations fulfilling their mandate? 1 = strongly disagree 2= disagree 3 = neutral 4 = agree 5 = strongly agree	Implementation and Performance Strengths	Implementation and Performance Weaknesses	Suggested Changes
<b>Regulatory Targets</b>					
Professional associations (associations of medical professionals and health facilities)	19 September 2017	2	<p>Several professional organizations have established National Health Insurance monitoring mechanisms.</p> <p>Associations and organizations have been involved in the regulation development process.</p> <p>Private PHC clinics have been preparing for accreditation.</p>	<p>Existing JKN regulations are not ready for implementation, and a few regulations are counterproductive (e.g., the BPJS-K regulation on enrollee redistribution).</p> <p>Private-sector involvement in the regulation development process is limited.</p> <p>In the meantime, accreditation for PHC providers focuses only on <i>puskesmas</i>.</p>	<p>Review capitation norms.</p> <p>Align BPJS-K target indicators with MOH strategic planning and monitor regularly.</p> <p>Develop standards of practice for all clinics, including tools and infrastructure.</p> <p>Offer continuing medical education for health practitioners with support from BPJS-K, particularly in health promotion and disease prevention.</p> <p>Involve professional associations throughout the regulation development process.</p> <hr/> <p>BPJS-K should develop guidelines on PHC clinic remuneration and how to improve efficiency and disseminate them to all contracted clinics.</p>

Table A-3. Recommendations

Recommendation	Rationale	Impact on Private Health Sector	Priority Level
Private-sector providers should be included in strategic planning, and regulatory performance indicators should be set for both public and private-sector providers.	Focus of primary care strengthening must be on both public and private sectors.	Private provider performance can be measured and improved.	3
Establish efficient and effective public-private <b>networking</b> as defined by the Ministry of Health— with <i>puskesmas</i> responsible for the entire subdistrict, including private clinics.	Given private providers’ lack of resources, the government should provide support to enable them to deliver quality health services.	Private providers will be actively engaged in the health system and have the support to comply with national health guidelines.	1
Review regulations regularly and involve all stakeholders throughout the process.	Several existing regulations are counterproductive and reduce motivation among private providers to deliver quality health care services.	Private providers will be encouraged to participate in the development and review of regulations. A secondary priority is to review regulations regularly and involve all participants (including private-sector providers) in the process.	2