**Program Name** | Indonesia – Supporting Primary and Referral Healthcare Reform in the Eastern provinces (I-SPHERE)
---|---
**Region** | East Asia Pacific Region
**Country** | Indonesia
**Sector** | Health (80%), Public administration- Health (20%)
**Lending Instrument** | Program for Results (PforR)
**Program ID** | P164277
**Parent Program ID** | 
**Borrower(s)** | Republic of Indonesia
**Implementing Agency** | Ministry of Health, Ministry of Finance
**Date PID Prepared** | June 7, 2017
**Estimated Date of Appraisal Completion** | November 27, 2017
**Estimated Date of Board Approval** | February 27, 2018
**Concept Review Decision** | Following the review of the concept, the decision was taken to proceed with the preparation of the operation.
**Other Decision** | 

**I. Introduction and Context**

**A. Country Context**

1. **Indonesia, the fourth most populous country (~250 million) in the world, has made significant gains in economic growth and poverty reduction.** Relatively strong economic growth (5.5% per year since 2000) has been accompanied by a sustained decline in poverty rates: about 36% and 8% of the population lived on US$3.1 a day and US$1.9 a day, respectively, in 2014, down from 82% and 48% (respectively) in 1998\(^1\). With a GDP per capita of about US$3,350 in 2015, Indonesia is currently classified as a lower middle-income country and will transition to an upper middle-income country with continued economic growth. Its human capital indicators also show impressive gains, with adult literacy at almost 95%, gross enrollment of 100, 83, and 32% in primary, secondary and tertiary education, respectively, and the share of female enrollment exceeding that of males at each level.

2. **Health outcomes and outputs in Indonesia have improved in recent years.** Life expectancy has increased from 67 in 2002 to 69 in 2015 and under-five mortality has declined from 48/1,000 live births in 2002 to 27/1,000 live births in 2015. Pregnant women receiving four or more antenatal care visits have also increased from 81% in 2002 to 88% in 2012. Percentage of moderately/severely underweight under-five children has decreased from 23% in 2002 to

---
\(^1\) World Development Indicators, 2017
19.6% in 2013. Landmark legislations in 2004 and 2011 have helped realize a potential pathway to Universal Health Coverage (UHC). As of 2014, Indonesia has one of the largest single-payer social health insurance programs, *Jaminan Kesehatan Nasional* (JKN), in the world. Health insurance coverage rates in Indonesia have increased significantly in recent years: from ~27% in 2004 and to ~70% in 2016. By 2019, everyone in Indonesia is supposed to have coverage under the JKN.

3. **However, key challenges remain, including slow progress on addressing inequalities in health outcomes, and access to primary and secondary healthcare, especially in Eastern Indonesia.** The national maternal mortality ratio (MMR) is 126/100,000 live births, closer to low-income countries; MMR in provinces in Eastern Indonesia is even higher (above 200/100,000 live births). Post-partum hemorrhage (PPH), eclampsia and infections are the key causes of maternal death with underlying factors including lack of continuum of care, young age pregnancies, unsafe abortions and a stagnating family planning program. Similarly, infant mortality rate (IMR) in Eastern Indonesia is higher than the national average of 34/1,000 live births; IMR in NTT and Maluku province are close to 60/1,000 live births. Large regional and income-related inequalities remain across the country and IMR in the poorest wealth quintile of households are more than double those in the richest. While overall coverage rates of key maternal health services are high, it varies widely across regions and income: there is a two-fold difference in skilled birth attendance (SBA) across some provinces and home delivery rates are six times higher in the lowest quintile compared to richest quintile.

4. **Indonesia is facing a double burden of disease, with new challenges rapidly emerging** due to a demographic (ageing population) and an epidemiological transition (persistent communicable diseases with rising prevalence of non-communicable diseases (NCDs)). Indonesia is among few countries in the world that reported an increase of HIV incidence among key affected population groups. Although the epidemic in concentrated in key affected population groups, there is generalized HIV epidemic in Papua and West Papua. Indonesia has the second highest Tuberculosis (TB) burden in the world; TB is still the second highest cause of premature deaths in Indonesia, with only a third of the cases being detected (2013). In addition, new challenges such as Multi Drug Resistant-TB (MDR-TB) have emerged, with annual incidence now estimated 30,000 cases, which poses a significant financial burden and program management challenge. Malaria remains endemic in some regions, including Papua. At 66%, NCDs now account for the largest share of burden of disease in Indonesia, almost doubling the burden in 1990. Indonesia face a challenge of ensuring supply side readiness for basic health services, including for NCDs, in primary health facilities, especially those in Eastern Indonesia. A provincial-level basic health services readiness mapping revealed substantial deficiencies in service provision, with Papua, West Papua and Maluku being the worse off.

---

2 Revealing the missing link: private sector supply side readiness for maternal health services in Indonesia (Draft World Bank report, 2017; Wei Aun, et al)
3 The consumption gini index, a measure of income inequality) grew from 30 (2003) to 40 (2016).
4 The 2012 district household surveys (IDHS) shows the following: 4 ante natal care (ANC) visits - 88%, SBA – 83% and post-natal care (PNC) at 80%; institutional delivery is low at 63% (17% public; 46% private).
5 Only 1,848 cases of MDR-TB are currently receiving treatment.
5. Decentralization has increased the complexity of fiscal transfers, blurred governance and accountability and strained sub national capacity to achieve improved health outcomes. In 2001, responsibility for the delivery of most health services was shifted to the district level, with fund transfers being made directly to the district level, bypassing the provincial level. In principle, decentralized health sector decision-making, coupled with large fiscal transfers from center to sub-national levels, was intended to empower local governments (LGs) to efficiently and effectively design and implement health programs, especially by adapting to local contexts. However, in practice health financing flows are much more complex and difficult to manage, marked by seven vertical intergovernmental financing channels, each with different rules and procedures. The introduction of demand-side financing through the JKN in 2015 has further fragmented the fund flows. This splintered model strains LGs capacities to plan, manage, and allocate funds efficiently in order to maximize results, and hinders governance and accountability systems.

6. Central government has limited levers through which to direct service delivery improvement at the local level. The majority of intergovernmental transfers are unconditional, and those transfers that are conditional are neither oriented to achieving results nor used to drive implementation of policy guidance from center to local levels. There are multifaceted and competing mixtures of central and sub-national regulations governing authority over key decisions which complicates health service delivery, and is one reason behind the disparity of human resources for health (HRH) distribution in the country. Finally, another challenge of decentralization in the health sector has been the disruption to and varying quality of monitoring, reporting, and data systems.

B. Sectoral and Institutional Context of the Program

7. Indonesia has a mixed model of public-private provision of health care services. The public sector is more dominant in inpatient services, especially in rural areas. Two-thirds of outpatient care (for the poor and general population), about half of inpatient care for general population and one-third of inpatient care for the poor are provided by the private sector. There are about 2,400 hospitals in Indonesia and about two-thirds of them are private. The public health care system is decentralized to the district level with about 9,600 puskesmas forming the backbone of Indonesia’s health system. Private clinics increasingly provide primary care but there is no systematic information on their numbers, nature and distribution. The public primary care system also includes 23,000 auxiliary puskesmas (pustu) for outreach activities in remote regions, village-level delivery posts (polindes, often the home of the village midwife) and village

---

6 Local governments (LGs) refer to provincial and district governments
11 Please refer to annex 3 for further information on the organization of service delivery in Indonesia.
12 Puskesmas are primary health centres that cover a population of about 25,000-30,000, with almost a third having inpatient beds.
health posts (poskesdes). Frontline service delivery at the ~75,000 villages is undertaken through posyandu\textsuperscript{13} and also by village midwives (who are formally part of the health system). Kader\textsuperscript{14} - who work on a voluntary basis - are not part of the formal health system and do not get paid (only minimum transport allowance). Service delivery is challenging as Indonesia has over 6,000 inhabited islands.

8. **Many Indonesians face significant physical and time barriers to accessing health care, especially in Eastern Indonesia.** This is likely resulting in higher morbidity and mortality rates, and inefficient use of potentially productive time by beneficiaries as well as accompanying family members and friends.\textsuperscript{15} Although the median distance to a health facility in Indonesia was only 5 km, the median distance in provinces such as West Papua, Papua, and Maluku was over 30 km. Widely divergent geographic accessibility is correlated with the time ranges that Indonesians experience to reach public health facilities. According to Riskesdas 2013, whereas over 18% of Indonesians took more than one hour to reach a public hospital (using any travel means), over 40% of people in West Sulawesi, Maluku, and West Kalimantan faced this barrier to access. Measured in time, puskesmas were more accessible, as only 2% of the national population took more than one hour to reach a puskesmas, but the proportion of population facing this travel time was much higher in Papua (28%) and NTT (11%).\textsuperscript{16}

9. **There are wide variations in district-level performance on health facility service readiness to provide good quality health care services.** The service readiness survey for health facilities\textsuperscript{17} across Indonesia revealed that not even one puskesmas had met all of the 38 tracer indicators. There is significant variation across districts - while districts in central Java had almost all puskesmas fulfill at least 80% of the readiness indicators, districts in Indonesia such as Papua and Maluku had only half of the puskesmas fulfill 80% of these indicators. More recent data\textsuperscript{18} suggests overall improvements in availability of maternal health related tracers but there

\textsuperscript{13} Posyandu is a monthly event manned by at least five types of community health workers that cater to the five essential services: registration, weighing and monitoring children’s growth, recording of child growth in health cards, counselling and education; immunization and ANC as part of outreach services of primary health care centers (puskesmas).

\textsuperscript{14} Kader is a volunteer health worker organized under PKK (Family Welfare Program) that is administered by Ministry of Home Affairs (MoHA). PKK is responsible for supporting kader technical training and on-going capacity building.


\textsuperscript{16} It is noted that the time to walk to a private health facility or drug outlet to access affordable essential drugs on a sustainable basis is a key indicator used for MDG tracking, with one hour identified as the benchmark. See: UN. Indicators for Monitoring the Millennium Development Goals. Definitions, Rationale, Concepts and Sources. (2003).

\textsuperscript{17} The readiness to provide basic services was measured by a set of 38 tracer indicators that were collected as part of the 2011 Health Facility Census (Rifaskes) across five domains: basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines.

\textsuperscript{18} Quantitative Service Delivery Survey or QSDS, 2016
are still variations seen. In general, puskesmas are more accessible than hospitals in terms of time taken to reach these facilities but this varies widely across districts. Only 39% of public hospitals and 3% of the 30 private hospitals surveyed, maintained all 23 basic obstetric care tracer items. Twenty percent of all public hospitals and none of the 30 private hospitals surveyed, maintained all six blood transfusion tracer items and there was a four-fold variation between some districts. A large majority of provinces (25 out of 33) had less than 30% of public hospitals with all tracer items, including eight provinces with zero hospitals reaching this target. For communicable diseases such as TB, overall primary care facility readiness index has not changed over the years. While the availability of first line TB drugs has reached 95% from 48%, and diagnosis using sputum smear has also increased to 95% from 77%, but the availability of functioning microscopes actually declined from around 85% to 77%, including amongst puskesmas that are supposed to be a diagnostic referral facility (79%). The other tracers that are below par is availability of program guidelines and trained health personnel. Discrepancies between urban and rural facilities persist, with higher level of availability and readiness among urban health facilities. Hospitals in Eastern Indonesian provinces also lag on facility accreditation; for example, 4 out of 18 and 4 out of 17 public hospitals only are accredited in Papua and NTT, respectively.

10. **Referral systems are weak and primary care providers do not play a role in “gate-keeping” to integrated health care despite JKN capitation.** In theory, GOI’s regional referral system provides a pathway for patients to be referred from primary care facilities to district public hospitals and 110 regional referral hospitals for secondary care, with 20 provincial referral hospitals and 14 national referral hospitals providing tertiary care. However, in reality, the referral system in Indonesia is hampered by weak coordination and poor follow-up, a shortage of specialists and ill-equipped referral facilities, resulting in patients being turned away from referral hospitals or patients being referred to facilities unable to handle complicated cases. Also, despite JKN, referral systems are easily by-passed, creating inefficiencies in the referral system and leading to large hospital claims for higher end procedures for JKN. For more efficient and improved quality of case management, especially with the rise of NCDs, a strong patient centric referral system is essential. It is imperative that Indonesia considers introduction of “integrated care models” that treats patients at the appropriate level of care, improving quality, and also ensuring more efficient use of resources. The MOH is introducing an information system, “sisrute”, to support more effective referral between different provider care levels, and this provides an opportunity to further build effective integrated service delivery.

11. **Health financing in Indonesia is marked by low public health expenditures (PHE), high out of pocket expenditures (OOPE), complex intergovernmental fiscal transfer systems without a results-based approach, as well as lack of clear integration with demand-side financing through JKN.** PHE at 1.5% of the GDP (IDR 118 trillion or US$ 9.1 billion) is amongst the lowest in the world and forms only 41% of the total health expenditures (THE:

---

19 Basic obstetric care readiness index was 72 versus 56 for a district Yalimo in Papua
20 The comparison between service readiness index for TB services from Rifakes 2011 and the Quantitative Service Delivery Survey (QSDS) from nationally representative selected districts in 2016
21 Data from Rifakes 2011, indicates poor TB diagnostic capacity in provinces such as Papua and West Papua (<40%)
23 1US$ = IDR 13,000 approximately.
3.6% of GDP, US$126 per capita in 2014). Government revenue as a share of GDP is also low at 17% and PHE is only 5.3% of the national government expenditure. OOPE is very high at 46% of THE and is 1.2% of GDP. Both supply-side financing of public sector provision and demand-side financing through the JKN exists. On the supply-side financing, several intergovernmental fiscal transfer mechanisms (from Ministry of Finance (MoF) to LGs) exist: the main ones are general allocation funds (Dana Alokasi Umum, DAU), revenue sharing (Dana Bagi Hasil, DBH), and special allocation funds (Dana Alokasi Khusus, DAK)\textsuperscript{24}. About 75% of DAU is allocated to spending on personnel, so in reality districts have little discretion over their expenditures. Indonesia’s health sector has low dependency on external financing with the exception of some health programs.\textsuperscript{25}

12. **DAK, as the largest conditional transfer fund, is an important fiscal lever available to the national government to influence service delivery outcomes at the subnational level.** DAK has traditionally been focused mainly on infrastructure investments. However, in the health sector it also finances the purchase of medicines, and also includes operational expenditures (DAK Non-Fisik). Total DAK allocation for health increased about four times between 2014 to 2016, from ~IDR 4 trillion (US$ 300 million) to ~IDR 15 trillion (US$ 1.15 billion).\textsuperscript{26} It forms close to 9.4% of the district health budget, and is an important source of capital spending. The incorporation of operational funding for *puskesmas*, and funding for accreditation process of *puskesmas* and hospitals as non-physical DAK from 2016 onwards presents opportunities to unify planning and budgeting for capital and recurrent financing. However, DAK allocations are not strongly linked to results and no monitoring mechanism exists, although DAK transfers have been shown to crowd in spending on capital by district governments.\textsuperscript{27} Despite these shortcomings, inputs from DAK represent an important opportunity for governments to influence and achieve tangible results such as accreditation at the subnational level. More importantly, DAK forms a pivotal source of additional resources for the health sector in under-developed districts, such as those in Eastern Indonesia.

13. **The JKN with expenditures at ~ IDR 53 trillion (~US$ 4.1 billion), and formerly 42 percent of the district health budget in 2015, is an underused financial lever to improve health outcomes and supply side readiness.** Key challenges include clarifying institutional roles, covering the informal non-poor, a non-explicit benefits package, and absence of strategic purchasing of services. The JKN is also poorly integrated with supply side financing to improve public sector supply side readiness, and is also being underused to harness private sector provision. JKN needs to ensure the poorest 40% of the population are targeted better, and that contribution collection among non-poor informal workers increases.\textsuperscript{28} JKN implementation is done through *Badan Penyelenggara Jaminan Sosial* (BPJS) Health, which is not well integrated

\textsuperscript{24} Please refer to annex 4 for further information on the funds flow to districts.
\textsuperscript{25} HIV, TB, malaria and immunization program budgets are significantly donor financed and sustainability is a key issue as Indonesia transitions out of donor financing.
\textsuperscript{26} There is also a clear shift in favor of primary health care - the DAK physical allocation to primary health care increased 300% between 2015 and 2016, and the allocation to pharmaceuticals has increased by more than 350%.
\textsuperscript{27} An additional IDR per capita of DAK financing leads to an additional 1.21 IDR per capita increase in capital spending. B. Lewis (2013), “Local Government Capital Spending in Indonesia, Impact of Intergovernmental Fiscal Transfers.” Public Budgeting and Finance, Spring 2013
\textsuperscript{28} Few non-poor informal have enrolled to date and those that have are adversely selected.
with other health authorities across all levels. The overall claims ratio\textsuperscript{29} was 104\% in 2014, with wide variations between different types of members, leading to concerns on sustainability. About 65\% of the expenditure claims were hospital-based and another 20\% were used for non-capitated fee-for-service payments to facilities. Claims for NCDs dominate, with cardiovascular diseases, kidney failures, and stroke among the top five diseases accounting for the majority of JKN’s expenditures. Even though JKN capitation forms a large source of revenue for puskesmas, its use for supply-side readiness continues to be problematic due to a lack of clear guidance on capitation spending.

14. Despite having attained the minimum WHO norm, Human Resources for Health (HRH) remains a key challenge for Indonesia’s health sector that further impedes the ability to provide good quality services and reducing unequal access to healthcare in Indonesia. The HRH to population ratio in 2013 was estimated at 2.3 per 1,000,\textsuperscript{30} equal to the minimum recommended by WHO as necessary to attain an 80\% skilled birth attendance rate. Key issues include unequal distribution, a shortage of specialists, and poor quality of HRH workers. For example, the physician to population ratio in Maluku-NTT-Papua is one-third of that in the Java-Bali region. The unequal geographic distribution for specialists is even worse than for general physicians. The shortage of nurses is especially acute in public facilities. Financial resources are often not the only factor to attract HRH in remote areas: good management and better facilities were viewed as equally important.\textsuperscript{31} Provision of continuing professional education and eventual opportunities for civil service employment have also been found to be important.\textsuperscript{32} Competency of HRH workers is generally low and variable: evidence from vignette responses indicates poor clinical knowledge and awareness in several parts of the country.\textsuperscript{33} ANC quality scores were below 40\%, and generally lower in rural areas and amongst private clinics but quite similar across Indonesia. Only 8\% of the 700 midwifery schools have gone through the accreditation process specific for midwifery program. MoH has introduced standard in-service trainings but there is no information on the quality of the training programs. An assessment on basic midwifery care at the puskesmas shows low compliance to quality standards: only 61\% completed a medical history, only 57\% completed a physical examination and only 68\% used partographs.

15. An opportunity to improve the quality of primary care has recently emerged with the establishment of a primary care accreditation commission, based on the two decades of experience in hospital accreditation. The hospital accreditation commission, established in 1995, is now fully independent (since 2011), and has accredited over 1277 public and private hospitals (out of 2,200). While the capacity of the primary care accreditation commission is not very strong owing to it being in its incipient stages, its vision is to expand capacity, become fully independent, cover both public and private sector and eventually get accredited by ISQUA\textsuperscript{34}. For

\textsuperscript{29} The ratio of expenditures to revenue.
\textsuperscript{30} Of the 2.3 HRH workers per 1,000 population, physicians were 0.5, nurses were 1.3, and midwives were 0.5 per 1,000; WHO norms is 4.45 by 2030 to respond to NCDs.
\textsuperscript{34} International Society for Quality in Healthcare – an accreditor of accreditation agencies.
the public sector, plans for accreditation of *puskesmas* include a staggered approach, where at least one *puskesmas* in 5,600 sub-districts is to be accredited by 2019. There are four levels of accreditation for primary healthcare and hospitals, namely *basic, madya, utama, and paripurna*. As per MOH reports, approximately 1500 *puskesmas* have been accredited as of date, of which 45% have received only basic level accreditation. Only a limited number of *puskesmas* have been accredited in provinces of Eastern Indonesia.

### C. Relationship to CAS/CPF

16. The proposed operation is consistent with and derived from the World Bank’s Country Partnership Framework (CPF)—which reflects government priorities as specified in the latest Medium-Term National Development Plan (RPJMN)—covering the period FY2016 through FY2020. The CPF emphasizes six engagement areas across two supportive beams (leveraging the private sector; and shared prosperity, equality, and inclusion). The proposed operation falls under the fourth engagement area on delivery of local services and is consistent with both pillar 1 (strengthening the decentralization framework to support local service delivery engagement area) and pillar 2 (supporting the delivery of quality health services). The proposed operation is also consistent with several strategies under pillar 1, including strengthening the capacity of central government to support LGs, building capacity of LGs and also possibly contribute to development of a performance-oriented fiscal transfer system. The proposed operation is also consistent with the priorities outlined in the 2014 East Asia Pacific (EAP) HNP strategy which emphasizes a focus on UHC. EAP’s HNP strategy underscores the need for countries in the region to improve HNP outcomes and make progress towards UHC, especially among the poor and vulnerable, as well as enhance the performance and resilience of health systems in financially affordable and sustainable ways. The proposed operation is also consistent with the World Bank’s Health, Nutrition and Population Global Practice’s overarching objective of ending preventable deaths and disability through UHC.

### D. Rationale for Bank Engagement and Choice of Financing Instrument

17. The proposed operation supports the GOI’s national development plan (RPJMN) through improving access to quality health services in disadvantaged and remote areas of Indonesia, that has worse off population outcomes compared to the national average. The World Bank has already been supporting the GOI on the achievement of UHC, through analytical and advisory work on supply-side readiness and health financing, that clearly outlines the need to reduce inequalities in healthcare access; and on the broader goal of reducing inequality in the country. More recently, on the request of the highest levels at MOF, the World Bank has also made specific recommendations on improving the quality of public spending in the health sector by focusing on budgetary efficiency. Some of these recommendations that could become part of the operation include use of budgetary resources to achieve results (facility accreditation), strengthen LG capacity (public sector management function of health offices and quality assurance systems), strengthening monitoring systems and use of health performance scorecards, fostering innovations to improve access in remote areas (mHealth and task shifting), and improving performance orientation of fiscal transfers. These could be implemented in the three provinces, and could be taken to scale nationally and sustained based on lessons learnt or implemented nationally in the operation itself. The operation takes forward some of the recommendations from the analytical work to support the GOI program in reducing inequities by improving access.
to quality primary health care and referral services in Eastern Indonesia. Given that external financing is less than 1% of total health expenditures, the value added of this operation would be to support the shift to use budgetary resources towards achieving results rather than just financing of inputs, which has also been reflected in the recommendations to MOF on improving quality of spending. This operation would also complement ongoing engagements managed through the Governance Practice, such as a PASA (Programmatic Advisory Services and Analytics) on decentralized service delivery that is providing support to the Ministry of Finance (MOF) to implement a more results based approach to the fiscal transfers for health, by providing an operational platform to implement approaches that have been discussed with MOF. The World Bank can also try to supplement the operation with technical assistance funds during implementation to build capacity of the implementing local governments (LGs) as well as share international experience on key issues such as performance based intergovernmental fiscal transfers, developing “integrated service delivery” models, introducing innovations such as mHealth, and strengthening implementation of social health insurance. Ongoing technical assistance being delivered through the health PASA related to improved public sector management and strengthening of JKN could also be directed to these LGs, creating greater synergies to help improve local service delivery in these disadvantaged geographies.

18. The proposed operation intends to support the Government health program in Eastern Indonesia through the Program-for-Results (PforR) financing instrument\textsuperscript{35}. The MOH has expressed strong interest in the use of the PforR instrument, and has been supported by the Ministry of Planning (Bappenas) as well as MOF. Though the instrument is relatively new for Indonesia, there is now precedence through the Indonesia Social Assistance PforR, and there are other operations in the pipeline using the PforR approach. The World Bank team has also spent time orienting MOH, Bappenas and MOF with the PforR approach, including with associated procurement, financial management, as well as social and environmental safeguards issues.

19. The PforR instrument is appropriate for the proposed operation because it promotes a focus on results, which is key to increasing efficiency of intergovernmental fiscal transfers to achieve better health results. More specifically:

a. By linking disbursements to achievement of results that are tangible, transparent, and verifiable, PforR can be an effective instrument to shift focus towards achievement of results by central and local government, rather than just financing of inputs in Investment Project Financing;

b. Given that external financing is less than 1%, the PforR instrument is well placed to support GOI’s own programs to improve local service delivery by leveraging domestic financing at the central and local government levels;

c. The PforR instrument will enable Bank financing to support efficiency gains in the GOI’s programs, strengthen institutions, and build implementation capacity in LGs with low capacity;

d. The PforR instrument will also allow for improvements, as necessary, in the implementation of governments’ own technical, fiduciary and safeguard systems; and,

\textsuperscript{35} Lessons from other health projects indicate that financing of inputs by themselves may not provide the necessary incentives to achieve results as many processes that supplement these inputs may lay outside the direct control of the Program.
e. The PforR is an effective instrument for scaling up successful interventions (capacity building, performance scorecards, innovations, fiscal transfer reforms, integrated service delivery pilot) based on lessons learnt during the operation.

II. Program Development Objective and Results

A. Program Development Objective(s)

20. Strengthening governance, financing and integrating service delivery to improve access to quality primary health care and referral services in three provinces (NTT, Maluku and Papua) in Eastern Indonesia.

B. Key Program Results

21. The proposed Bank lending operation is expected to have the following key results areas:

Result area 1: Strengthening access to quality primary health care, especially in remote areas of three provinces in Eastern Indonesia

Result area 2: Strengthening referral systems and improving quality of referral hospitals in three provinces in Eastern Indonesia

Results area 3: Supporting national government initiatives to strengthen financing, local government capacity and performance orientation to enable achievement of service delivery results

22. Key Program result indicators are as below:

- Number of Puskesmas and hospitals that have fulfilled the necessary infrastructure, medical equipment, and minimum standard of human resources
- Number of TB/Diabetes Mellitus/Hypertension patients who have been detected and received treatment as per national guidelines in puskesmas
- Percentage of children having received complete basic immunization
- Percentage of patients in referral hospital (provincial, regional and district) who have been referred as per clinical guidelines for tracer diseases
- Number of Puskesmas accredited
- Number of referral hospitals accredited
- Number of vertical hospitals accredited

At present, the indicators only cover results area 1 and 2, and indicators related to results area 3 will be developed during further preparation.

III. Proposed Program-for-Results Operation Context

A. PforR Program Boundary

23. Program description: Introduced in 2015, the GOI’s flagship health program is the
**Healthy Indonesia program**, which aims to improve the health and nutritional status of the community through health and community empowerment efforts, backed by financial protection and the equitable distribution of health services. The Healthy Indonesia program stands on three main pillars: (1) promoting a healthy paradigm; (2) strengthening healthcare services; and (3) the national health insurance, or the JKN. The first pillar, the healthy paradigm, is implemented through strengthening of preventive and promotive efforts such as the Healthy Indonesia through the Family Approach Program and through a community empowerment program (GERMAS). The second pillar, strengthening healthcare services, is to improve access to quality primary healthcare and hospital services, and to strengthen the referral system. The third pillar, which is the national health insurance or the JKN, is focused on beneficiary enrollment and expansion of benefits, as well as a focus on achieving quality and cost control. The RPJMN and the national health strategic plan (2015-2019) also places emphasis on achievement of facility level accreditation, with the target of at least one accredited *puskesmas* per sub-district and at least one accredited government hospital per district by 2019. To support this, there is expansion of the national capacity of the accreditation commission in terms of surveyors, and also planned expansion of local government capacity to have district level facilitators to assist with the accreditation process. There are three broad areas of focus for accreditation: management services, community health services, and for individual care. The process followed for accreditation is: selection of *puskesmas* by the district, self-assessment, six-month facilitation for process improvements, pre-accreditation survey, independent assessment by surveyors, and finally getting accredited by the commission. Once accredited, the status is retained for three years. The overall program also emphasizes reduction of unequal access to quality health services by focusing efforts in disadvantaged and remote areas, such as in Eastern Indonesia. The Healthy Indonesia program is an umbrella program that encompasses the entire public health expenditure, through central and local governments, and was IDR 178 trillion (US$ 13.7 billion) in 2016.

24. The GOI has articulated a broad commitment to making fiscal transfers more results-oriented since the release of the *Blueprint for Institutional Transformation of the Directorate-General of Fiscal Balance* in 2014. The rigidities of the current fiscal transfer system have meant that scope to develop a performance-based DAK have been limited, and the main instrument for performance-based approaches has been the “hibah”, an ad hoc grant which does not form part of the ‘balancing fund’ that is the source of most transfers. *Hibah* was initially developed as an output-based grant in the water sector, which reimbursed district governments for expenditure on connecting poor households to piped water. The use of *hibah* has expanded to include large urban infrastructure projects such as Jakarta metro and Palembang sewage treatment plant, and some project teams within the World Bank are exploring the potential to use *hibah* in a more performance-oriented, rather than an output-based, context.

---

36 *Hibah* is an ad hoc intergovernmental grant which is payable for achieving a defined output or performance achievement. It is proposed by line ministry and subject to Ministry of Finance (MoF) approval. The source of *hibah* can be from external loan, external grant, or domestic revenue. Once approved, the *hibah* is reflected in the treasury budget (MoF). The conditions of each *hibah*, performance indicators for disbursement, and transfer are determined in a bilateral agreement signed by MoF and the District head. Payment is disbursed when evidence of the output or performance is received by MoF, once verified by the line ministry.
25. **The proposed operation, I-SPHERE, is focused on strengthening pillar 2 of the Healthy Indonesia program in three provinces of Eastern Indonesia, namely NTT, Maluku and Papua.** These provinces have some of the worst health outcomes and access to healthcare as stated earlier, and have Human Development Index (HDI) rating of 3, 1 and 11, respectively. The population in these provinces are 5.1 million, 1.7 million and 3.5 million, respectively but have a disproportionately higher poverty rates as well. Public spending on health for these three provinces include those that are spent directly or indirectly on the province and district through the national budget, JKN (through the BPJS), as well as provincial and district budgets (through their own revenue and intergovernmental fiscal transfers). The full picture of public spending at the provincial and district level is difficult to capture due to data gaps (such as with JKN as BPJS does not publish spending per province or district). Planned national budget (APBN) related to the Program and provincial and district budget (APBD) for 2016 for these three provinces, including districts is in the following table:

<table>
<thead>
<tr>
<th></th>
<th>NTT</th>
<th>Maluku</th>
<th>Papua</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABPN (National Budget) IDR million</strong></td>
<td>493,981</td>
<td>115,433</td>
<td>441,861</td>
<td>798,233</td>
</tr>
<tr>
<td><strong>ABPN (National Budget) US$ million</strong></td>
<td>38</td>
<td>9</td>
<td>34</td>
<td>61</td>
</tr>
<tr>
<td><strong>APBD (Provincial and District Budget) IDR million</strong></td>
<td>2,541,698</td>
<td>1,292,205</td>
<td>4,740,695</td>
<td>8,574,598</td>
</tr>
<tr>
<td><strong>APBD (Provincial and District Budget) US$ million</strong></td>
<td>196</td>
<td>99</td>
<td>365</td>
<td>660</td>
</tr>
<tr>
<td><strong>Total IDR million</strong></td>
<td>3,035,679</td>
<td>1,407,638</td>
<td>5,182,556</td>
<td>9,372,831</td>
</tr>
<tr>
<td><strong>Total USD million</strong></td>
<td>234</td>
<td>108</td>
<td>399</td>
<td>721</td>
</tr>
</tbody>
</table>

26. This includes national budget allocations related to health services and relevant health programs, and provincial and district level budgets that reflect intergovernmental fiscal transfers, provincial and district allocations to health from their own revenues, and JKN capitation for non-Badan Layanan Umum (BLU) (or non-financially autonomous spending units) puskesmas. It does not include JKN capitations to private sector or BLU puskesmas, and JKN payments to hospitals. Total DAK allocations for health in these provinces in 2017 were IDR 5.63 trillion or US$ 433 million.

27. **The Program for Results will form part of the public spending on health in these three provinces, including from national, provincial and district budgetary resources as outlined above.** The Program will be focused on improving access to quality primary healthcare and hospital services, and strengthening referral systems to move towards a more “integrated service delivery” model in these three provinces. The Program will also support national government initiatives to strengthen financing, capacity and performance orientation of these local governments to deliver results. The Program cost, over five years, is about IDR 6.5 trillion (US$ 500 million) will be supported by a World Bank loan of US$ 150 million. While the focus is on strengthening pillar 2, there will be linkages made to pillar 1 of the overall program (for

---

37 This includes district data for 19 out of 22, 11 out of 11 and 27 out of 29 districts for NTT, Maluku and Papua respectively.
example, by strengthening the community outreach function of the *puskesmas*, and to pillar 3 as well (for example, ensuring better use of capitation funds available through JKN at the *puskesmas*). The operation will also focus on supporting the shift of the use of budgetary resources, through the DAK and other sources, to achieving results such as facility accreditation, rather than just support financing of inputs as is the case now. There are three main result areas for the Program; the first and second focus on the three provinces towards improving access to quality primary health care services, and to quality referral services, respectively. The third result area is focused on how to support national initiatives to build capacity and incentivize the local governments in these three provinces to achieve the results outlined in the first two result areas. Some of these national initiatives could be rolled out nationally from the start of the Program or then scaled up based on experiences from the three provinces. Some of the system wide efforts could be strengthening public sector management functions of local government health offices to plan and manage resources more efficiently, strengthening accountability through improved monitoring systems and introduction of “health performance score cards”, strengthening quality assurance and systems for accreditation as well as making fiscal transfers more performance oriented and linked to achievement of results. Other areas for potential scale up could include implementation of an “integrated service delivery” model with effective referral, and innovations (such as mHealth and task shifting) to improve access to care in remote areas. These reforms are also in line with the recommendations made to MOF. Results area 3 needs further work during preparation, including specifying reform areas, getting high level buy-in for this reform, as well as identifying indicators that could be used for the Program, including potential DLIs. The results areas are outlined below:

28. **Result area 1:** Strengthening access to quality primary health care, especially in remote areas of three provinces in Eastern Indonesia. This result area would focus on strengthening primary healthcare in these three provinces, and will target a total of 81 remote and very remote *puskesmas* (NTT - 25; Maluku - 15; Papua – 41) to achieve accreditation. This would also support the necessary system strengthening required to strengthen primary care, including strengthening clinical and managerial capacity, addressing HRH requirements, use of technology innovations, strengthening information systems and use of data, better planning and budget execution by facilities, and implementation of various priority programs. Specific activities include:

   a. Strengthening the clinical and managerial capacity of the *puskesmas* to achieve accreditation;
   b. Strengthening infrastructure, equipment, supplies as well as provide for the human resources required to achieve accreditation;
   c. Implement necessary continuous quality improvement approaches at the *puskesmas*;
   d. Strengthen the use of the information systems for reporting, as well as for patient tracking and referral;
   e. Strengthen the planning and use of funds received through both supply side – and JKN capitation for better quality service provision;
   f. Strengthen implementation of priority programs for maternal and child health, nutrition, immunization, communicable and non-communicable diseases;
   g. Implement “*Family Approach*” at the community level and strengthen delivery of community health outreach by the *puskemas*; and,
h. Pilot innovations such as mHealth and alternate service delivery models of HRH, especially to overcome barriers such as availability of doctors in remote areas.

29. **Result area 2:** Strengthening referral systems and improving quality of referral hospitals in three provinces in Eastern Indonesia. This result area would focus on strengthening referral systems, as well as referral facilities (13 regional hospitals, 2 provincial hospitals, and 3 vertical hospitals) to achieve accreditation. This would also support strengthening of the referral system, through expanding use of a referral software system, “sisrute”, but also through adoption of integrated service delivery models done in other countries. This would involve;

a. Strengthening the clinical and managerial capacity of the hospitals to achieve accreditation;

b. Strengthening infrastructure, equipment, supplies as well as provide for the human resources required to achieve accreditation;

c. Implement necessary continuous quality improvement approaches at the hospitals;

d. Strengthen the use of the hospital information systems, for better facility management, as well as *sisrute* for better referral management;

e. Strengthen the planning and use of funds received through both supply side – and JKN capitation for better quality service provision;

30. **Results area 3:** Supporting national government initiatives to strengthen financing, local government capacity and performance orientation to enable achievement of service delivery results. This results area would focus on strengthening the capacity of the local governments and reforming the fiscal transfer systems to ensure implementation of central government policy and programs at the subnational level, and will be key to the achievement of both results area 1 and results area 2 (except in relation to vertical hospitals which are owned and managed by the central government). The specific elements of results area 3 will be developed during the Program preparation in conjunction with the Ministry of Health, Ministry of Finance, Ministry of Home Affairs and Bappenas, who are jointly, but variably, responsible for the systems for managing across levels of government. *Indicators for this result area, if necessary, will be developed during further preparation.* This is likely to include:

a. Defining key performance milestones at the local level which capture the responsibilities of local governments and facilities for delivery of outputs that are critical for delivery under results areas 1 and 2;

b. Developing a monitoring system, including third party validation, that supports benchmarking of facility performance, and also provides the foundation for linking financing to performance;

c. Introducing a result focus into fiscal transfers, to incentivize local governments and facilities to focus on performance of systems, delivery of outputs, and monitoring of outputs and outcomes; and,  
d. Developing a capacity building program for improving public sector management functions (financial management, planning, procurement, human resources management, monitoring and evaluation and management of information systems) and clinical functions (quality assurance and priority program implementation), and identifying clear responsibilities of central and local governments for this.
31. A key area of the program which is yet to be developed is the selection and adjustment of fiscal transfers that will deliver resourcing to local governments to implement the program, but will also finance incentives that stimulate an increased attention to delivery of results. Fiscal flows and incentive arrangements will be designed with attention to the alignment of responsibilities and control of financing at the local level. For example, since the majority of discretionary funding for facilities no longer flows through the district level, incentive arrangements should be focused at both facility and district level, with a clear focus on the responsibilities of each to contribute to program implementation. The fiscal transfers on the supply side includes the DAK Fisik (Afirmasi, Penugasan and Regular) and Hibah for capital inputs, DAK Non-Fisik (Akreditasi, Bantuan Operasional Kesehatan (BOK)) for recurrent inputs and the DAK Fisik, DAK Akreditasi and Hibah as options for fiscal incentives. The specific incentive arrangements, including fiscal incentives, will be designed during program preparation. Some possible options for fiscal incentives are set out in annex 5. JKN is another lever on the demand side, and would also be used, if the opportunity to engage further with BPJS arises during Program preparation. It is also possible that engagement of JKN related to the Program may arise from the ongoing technical assistance to improve JKN efficiency.

32. Institutional Arrangements for Implementation: At the Central level, a Steering Committee comprising high level officials from MOH, Bappenas, MOF, MOHA and the Governors of the three provinces will be established to provide policy guidance, support intersectoral coordination and overall implementation oversight. The Director General of Health Services, MOH will be the Program Director for the proposed operation. High level appointed representatives from the Bureau of Planning and Budgeting, the Directorate General of Health Services, Directorate General of Disease Control, Directorate General of Public Health, and Health Human Resources Development will sit in a Technical Committee to provide technical inputs to the Program Director and monitor Program implementation for the attainment of result indicators. There will not be a parallel Program Management Unit (PMU), and MOH will instead house the functions of a PMU within the Directorate General of Health Services, with the Director of Health Facilities as the Program Manager. Selected staff from the Directorate will support various functions of the PMU. The primary functions of the “PMU” will be to coordinate, plan, ensure budget availability, address cross-directorate issues, hiring of the independent verification agency (IVA) and overall monitoring of the Program progress. The central level Program Implementation Unit (PIU) will be sourced from the technical units within MOH responsible for the implementation of central level activities related to specific results area within the proposed Program. The PIU is not a stand-alone unit but sourced from within MOH to implement various activities related to the Program at the central level, including, coordinating for HRH, accreditation, priority program implementation, procurement at central level, and Program monitoring. Depending on the agreements reached on results area 3 during preparation, the implementation arrangements will be updated to reflect these changes, including involvement of MOF.

33. Institutional arrangements at the provincial and district levels mirror those at the central level. At the sub-national level, the head of the Steering Committee will be the Governor at the provincial level, or the Bupati (Mayor) at the district level. A PMU will be set up at the Provincial Health Office (PHO)/District Health Office (DHO) in each participating
Province/District. The Technical Committee will involve representatives from various agencies at the provincial/district level, such as the Environmental Management Body (BPLHD), Public Works Office, and Subnational Civil Service Agency (BKD). All province and regional hospitals involved in the Program will be a PIU as they are financial autonomous entities, while the DHO will be the PIU for results area one related to the strengthening of primary healthcare as well as for the results area 3, related to strengthening of capacity at the local government level. The PIU will be sourced from within the respective local governments, and will not be standalone units. Given the low capacity of these provinces and districts to implement programs, PIUs can help focus the attention of the local governments on achieving specific results under the Program. Also, achieving the DLIs will need time bound implementation, testing innovations as well as coordination across several functions, and hence the justification for PIUs. Given below is an abbreviated schematic of the implementation arrangements with a detailed diagram in annex 6. The task team will work closely with MOH to see if these proposed units can be streamlined while addressing the concerns about low capacity.

II. Initial Environmental and Social Screening

Please refer to the disclosed “Environment and Social Systems Assessment (ESSA)” initial screening.

III. Tentative financing

Source: ($m.)
Borrower/Recipient 350.00
IBRD 150.00
IDA
Others (specify)
Total 500.00
IV. Contact point

World Bank
Contact: Vikram Sundara Rajan
Title: Senior Health Specialist
Tel: +622152993338
Email: vrajan@worldbank.org

Contact: Kathleen Anne Whimp
Title: Lead Public Sector Specialist
Tel: +622152993009
Email: kwhimp@worldbank.org

Borrower/Client/Recipient
Contact: Robert Pakpahan
Title: Director General for Debt Management, Ministry of Finance
Tel: +6221-3861489
Email:

Implementing Agencies
Contact: Bayu Teja Muliawan, Apt, Mpharm, MM
Title: Head of Bureau of Planning and Budgeting
Tel: +621-5201590
Email: rorendepkes@gmail.com

V. For more information contact:
The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: http://www.worldbank.org/infoshop