POLICY NOTE
July 15, 2018

Purchasing of Primary Health Care Under JKN

Introduction

Indonesia's national health insurance scheme -- *Jaminan Kesehatan Nasional*, or JKN –Indonesia aims to guarantee every Indonesian citizen stays healthy rather than to simply insure those who are sick. Therefore, the national health insurance system is built on a foundation of primary health care (PHC)--health promotion, prevention, and rehabilitation. The primary care system is the first point of contact for the population and potentially has the greatest impact on the population's health. Strategic purchasing of PHC should create a foundation that allows adequate resources to flow to the primary care level to make priority interventions accessible to the entire population. Strategic purchasing of PHC should also create incentives across the health system to manage population health and avoid unnecessary services and expenditures at the secondary and tertiary levels. The elements of strategic health purchasing are described in Box 1.

BOX 1. FOUNDATIONS OF STRATEGIC HEALTH PURCHASING

Strategic purchasing requires an **institutional home** where most purchasing functions will be carried out, although other institutions will likely be responsible for some purchasing functions. being clear and deliberate about **what is being purchased**, which starts with a well-defined benefits or essential services package. Once the service package is defined, the purchaser pays health providers specifically to deliver these services, which is referred to as **output-based payment**. Output-based payment typically goes hand-in-hand with some form of **contracting** to clarify the obligations of the provider and also the purchaser. It also requires that providers have some **autonomy** to make decisions to respond to incentives—they can decide to shift their staff around or other inputs. All of this requires new **accountability** measures and better use of **information**.

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA · BPJS Kesehatan Badan Penyelenggara Jaminan Sosial · DJSN · USAID FROM THE AMERICAN PEOPLE · WORLD BANK GROUP · Australian Aid · Health Finance & Governance · RESULTS FOR DEVELOPMENT

Strategic purchasing of PHC under JKN is carried out by *Badan Penyelenggara Jaminan Sosial-Kesehatan* (BPJS-K), with some purchasing functions distributed across other institutions, including the Ministry of Health (MOH) and local government. The Social Security Council (*Dewan Jaminan Sosial Nasional*--DJSN) is responsible for overseeing the implementation of JKN and as part of that mandate commissioned a review of strategic purchasing under JKN in partnership with USAID, the World Bank, Abt Associates and Results for Development (R4D). This policy note summarizes the results of the strategic purchasing review focused on the current status, results, and challenges of strategic purchasing of PHC under JKN.

Strategic purchasing for PHC means deliberately prioritizing PHC in resource allocation and service delivery, and creating incentives throughout the system to strengthen access to and quality of PHC service. This is done be strategically deciding **what to purchase** (which PHC services and interventions, according to which service delivery and quality standards, delivered at which level of care), **from whom to purchase** PHC (ensuring there are adequate PHC providers to meet demand for the service package, and contracting providers based on criteria such as access and quality) and **how to purchase** PHC services (leveraging contracts, provider payment systems, and provider performance monitoring to drive service delivery and other objectives).

What to Purchase

Strategically deciding what to purchase for PHC means:

a. A PHC service package is clearly specified
b. Quality or service delivery standards are defined that are used for purchasing decisions
c. Mechanisms are used by the purchasing agency to allocate funds efficiently between primary, secondary and tertiary care (e.g. ring-fencing funds for PHC, gate-keeping policies, etc.)

The laws and regulations related to JKN implementation make provisions for all three of these strategic purchasing mechanisms, although some challenges have arisen in implementation.

PHC SERVICE PACKAGE AND SERVICE DELIVERY STANDARDS

The JKN entitles participants access to a comprehensive package of necessary health services, including comprehensive PHC (*Presidential Regulation Number 12 of 2013 Chapter IV on Health Care Benefits*). The PHC package include: promotive and preventive services; medical examination, treatment and medical consultation; non-specialty medical treatment either surgical or non-surgical; medicine and medical consumables; blood transfusion according to medical need; first-level laboratory examinations; first-level inpatient care. Promotive services and preventive services cover individual health counseling, basic immunization, family planning, and health screening. The PHC service package is further defined by the MOH in terms of minimum service standards for health care in "first level health facilities" (FKTPs). These minimum service standards include 144 competencies (services) that *puskesmas* must provide [*Minister of Health Regulation No.5/2014 Clinical Practice Guidelines for Primary Care Physicians*].

A new MOH program makes local governments accountable for 12 new minimum service standards for promotion and prevention programs related to conditions such as mental health, hypertension, diabetes, tuberculosis and HIV [*Minister of Health Regulation No. 43/2016*]. These services are intended to be complementary to JKN and help reduce the need for curative services.

GATEKEEPING

There is a gatekeeping policy in place in Indonesia that regulates how patients can be referred to different levels of the health system. Initially BPJS-K registers each JKN participant to one FKTP based on the recommendation of the District or Municipal Health Office. After the first three months the participant has the right to select their own first level health facility. The participant is required to obtain services at first level health facility where he or she is registered unless a referral is made [Presidential Regulation No. 12 of 2013 article 29 clauses 1 and 2]. BPJS-K has developed a computer application (Aplicare) to help JKN participants find the nearest health facilities according to their location, provide brief profiling information on health facilities, and support FKTPs in referring patients according to the competencies of referral facilities.

The MOH also has recently enacted a stricter referral policy, which limits payment for hospital cases that were not referred by the appropriate class of health facility. There is also a referral back system from hospital to primary care. BPJS-K has begun refusing to pay claims for inappropriate referrals, but this has been challenged by specialists. Furthermore, the lack of availability of certain medicines in puskesmas makes it difficult to enforce the referral system consistently

IMPLEMENTATION CHALLENGES

In spite of strong policies in support of PHC in the MOH and JKN, challenges continue with unequal access to PHC that meet service delivery standards and low priority for PHC in total BPJS-K spending. In spite of the emphasis on PHC by the MOH and in JKN, BPJS-K data show that less than 20% of expenditures by BPJS-K in 2016 went toward PHC, with the remaining spent on hospital-based services. Utilization of PHC has increased under JKN, but outpatient specialty utilization has increased at a faster rate. Based on the 2016 BPJS-K non-audited report, the total number of JKN participants who utilized primary cares in FKTPs reached 134.9 million, a 102% increase over utilization in 2014. But outpatient specialty utilization increased 137% over the same period from 21.3 million to 50.4 million visits (Figure 1). As FKTP utilization has increased, the gate-keeping policy has been difficult to enforce, which keeps the share of total expenditure on referral services high. One reason is FKTPs continue to meet patient requests for referrals even when they are not medically necessary. A study by BPJS-K found that up to 50% of referrals are at the request of the patient. Some stakeholders noted that inadequate FKTP infrastructure and supply of essential medicines at the FKTP level can also drive referrals.

From Whom to Purchase

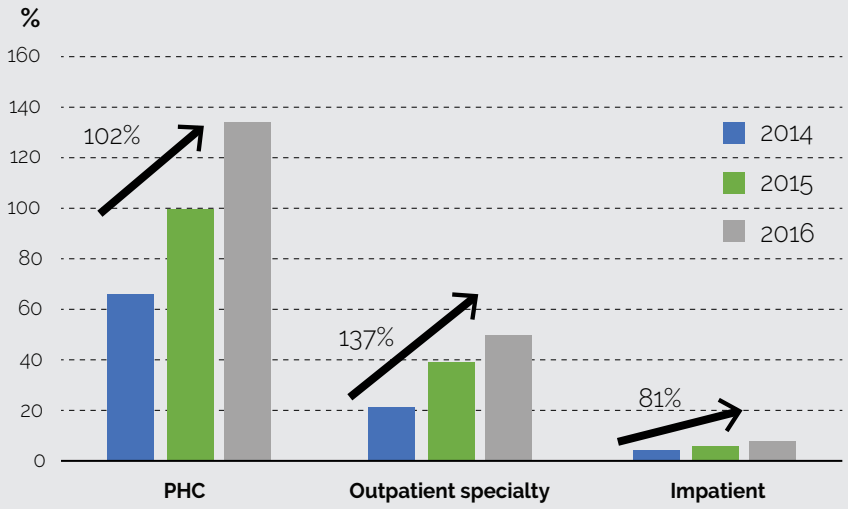
Strategically deciding from whom to purchase PHC means:

a. Ensuring there are sufficient providers with adequate capacity to deliver the PHC service package to all JKN participants ("supply-side readiness").
b. Standards are established for PHC providers to be contracted by the purchaser to deliver services to JKN participants (credentialing), and public and providers can be contracted equally if they meet credentialing criteria.

SUPPLY-SIDE READINESS

The MOH has broad responsibility to strengthen the foundation of preventive and promotive care to reduce the burden of chronic disease [*Minister of Health Regulation No. 75/2004*]. This promotive-preventive program is considered the foundation of

Figure 1 Trends in JKN Service Utilization



Source BPJS-K 2016 unaudited report

health development, community empowerment and engagement in health promotion across sectors. This program also aims to reduce high-cost catastrophic illness events in JKN. The MOH is also responsible for strengthening capacity at the primary care level, optimizing the referral system, and improving quality. District Health Offices supervise *Puskesmas* and also have some role in operational arrangement. According to the *Indonesian Law on Regional Autonomy*, local governments have the responsibility to ensure the infrastructure is adequate to deliver guaranteed PHC services.

CREDENTIALING AND SELECTIVE CONTRACTING

BPJS-K contracts with health providers that meet the criteria for credentialing specified by the MOH (*Regulation of Minister of Health Number 71 of 2013 Chapter III Cooperation of Health Facilities wiith BPJS Healthcare Section Two Article 9*). The purpose of credentialing is to improve the availability and accessibility of health facilities as well as the standardization effort of health facilities quality. As part of their role in ensuring the quality of primary care services, District Health Offices collaborate with BPJS Health to do the credentialing for public PHC providers. The BPJS-K credentialing process is as follow:

mapping of providers ➔ profiling ➔ needs analysis ➔ credentialing ➔ tariff agreement ➔ contract

When selecting health facilities for contracting, BPJS-K not only considers the extent to which facilities meet regulatory standards, but also whether they have a quality commitment that will be continuously monitored. For a health facility to renew its contract with BPJS-K it must continuously meet quality standards.

IMPLEMENTATION CHALLENGES

Some challenges to credentialing and selective contracting by BPJS-K have emerged in practice, including uneven distribution of health personnel and health facilities, particularly in remote and very remote areas. In more remote areas, the facilities and infrastructure of FKTPs facilities and infrastructure is often insufficient, and there is wide variability in the capability of FKTPs capability to thoroughly manage non-specialist cases. For example, according to data presented by BPJS-K, there are 740 public FKTPs in 27 provinces that have no general practitioners, including West Java Province.

Although many stakeholders agree that private providers need to be better engaged in JKN and BPJS-K contracting to help close supply-side gaps, private providers argue that they are not included actively in the credentialing process to ensure that private FKTPs and individual doctors have the opportunity to contract with BPJS-K. Some stakeholders noted that the role of private providers is not address in the laws and regulations governing JKN and BPJS-K, which may at least partially explain the lack a formal role for private professional associations and FKTPs in the credentialing process.

How to Purchase

Strategically deciding from whom to purchase means:

a. Contracting procedures are in place that are leveraged to specify and create incentives to adhere to service delivery and quality standards, specify reporting requirements for providers, and include other provisions that specify the responsibilities of providers and the purchaser.
b. Provider payment systems are selected, designed and implemented to create the right incentives to drive provider behavior and service delivery toward quality, efficiency, and other objectives.
c. Monitoring of PHC provider performance and quality assurance systems are carried out routinely by the purchaser and used to provide feedback to improve provider performance.

CONTRACTING AND PROVIDER PAYMENT FOR PHC

BPJS-K contracts with selected FKTPs and pays them to provide the PHC package of services using capitation payment (a fixed payment each month for each person registered with the PHC). The JKN capitated rate for PHC is set out in *Minister of Health Regulation No. 52 of 2016*, which states that "The tariff for capitation received by FKTP is determined through a selection process and credentialing carried out by BPJS involving the District Health Office / City and / or the Association of Health Facilities considering human resources, the completeness of facilities and infrastructure, scope of services, and commitment to service". Obstetric and neonatal services, such as antenatal care, normal delivery and services for family planning programs are not paid by capitation but by fee-for-service.

The current capitated rate is 3,000 - 6,000. The capitated rate is considered to be low and based only on the cost of staff without relation to service needs, particularly for private clinics. There are currently no adjustments for age/sex or other indicators of health need, only supply side variable such as availability of medical doctor and dentist and 24-hour services. *MoH Regulation No. 52 of 2016 article 5* set the special capitation tariff for remote areas, but the amount is considered too small as the compensation for the physician practices in remote areas. The lack of adequate adjustment for geographic differences in the cost of delivering primary care was raised as a concern by many stakeholders.

The capitated rate also disadvantages private providers, as BPJS-K pays the same capitated rate to both public and private providers, although public providers are highly subsidized by the government, which covers health worker salaries and investment costs. Furthermore, private providers complain that their cost structures are also different because unlike public providers, they cannot access medicines at favorable prices through the government procurement system and they do not have tax exempt status.

Capitation payments are distributed to FKTPs based on the population that selects that provider through BPJS enrollment. Private primary care clinics BPJS maintains enrollment lists on the P-Care site, and in principle providers can access the lists at any time, but they are not notified when an individual is added to or removed from that facility's list. Some FKTPs have complained that data related to the number of participants registered at the FKTP are not provided, which is information needed to perform education and preventive promotive efforts. Some stakeholders noted several problems with P-Care and whether this data source can be used effectively as a management tool.

There are concerns that the distribution of registered participants across FKTPs is highly imbalanced. Although the average ratio of registered JKN participants per doctor in FKTPs is 5,000:1, which is the target, the ratio exceeds 8,500:1 for *puskesmas* in 7 provinces (Figure 2). On the other hand, FKTPs that are not *puskesmas* have much lower ratios, typically below 1:2,500. Private providers in particular appear to be at a disadvantage in the distribution of participants. Some of this imbalance may reflect registration patterns that were inherited from *Jamkesmas* and other previous programs and have not been updated to reflect the new distribution of population under JKN.

Ratios of registered patients to physicians that are either too high or too low are both problematic for capitation payment. If the ratio is too high, registered participants may not have timely access to necessary PHC services. If the ratio is too low, the capitation revenue for the facility may be insufficient to stock necessary medicines, supplies and other inputs, or even to remain financially viable.

A more general concern with all of the payment systems used to purchase services under JKN is that they are fragmented across different levels of care with no linkages between capitation for PHC and the INA-CBG payment system for secondary and tertiary services.

MONITORING PROVIDER PERFORMANCE AND QUALITY

In 2016 the MOH and BPJS-K agreed to add a performance-based element to capitation payment, Capitation Based Service Competence (KBKP). KBKP is governed by a joint regulation between the MOH and BPJS, which was updated in 2017 [*No HK.08.08/111/980/2017 TAHUN 2017 NOMOR 2 TAHUN 2017 on Technical Guidelines for Performance-Based Payment to FKTP*].

KBKP was started in 33 provincial capital cities as part of phased implementation. Under KBKP, the final capitation payment to a FKTP is based on performance against 4 indicators that are self-reported through P-Care:

a. Contact rate (target=15/1,000 members per month)
b. Referral rate
c. Chronic Disease Management Program (*Prolanis*): prevention for NCDs following protocol

The performance of participating FKTPs is assessed every three months, and payment would be adjusted downward if the targets are not achieved, although BPJS-K has not yet begun implementing the financial penalties only the assessment. BPJS-K has decided the maximum adjustment is 10% so, if not all of the targets are achieved, the final capitation payment will be 90% of the original amount.

In 2017 the implementation of KBKP is being expanded in health centers outside the capital of the province, an indicator related to home visits will be added, and private FKTPs will be included although private

provider associations complain that they have not been involved in any of the process of determining performance indicators and targets. KBKP has not been properly monitored and evaluated, the results of which could be used to improve KBKP.

AUTONOMY OF PUSKESMAS AND THE USE OF CAPITATION FUNDS

The capitation payment is paid directly to private primary care clinics and *puskesmas* that have bank accounts in the local treasury system. The use of the capitation revenue is restricted, with up to 40% designated for operational expenditures (e.g. supplies) and 60% or more can be used to pay fees directly to health workers. The portion of the capitation revenue that is distributed to health workers also follows a set of rules and criteria:

- Education
- Years of experience
- Position
- Whether a program manager
- Attendance/absenteeism

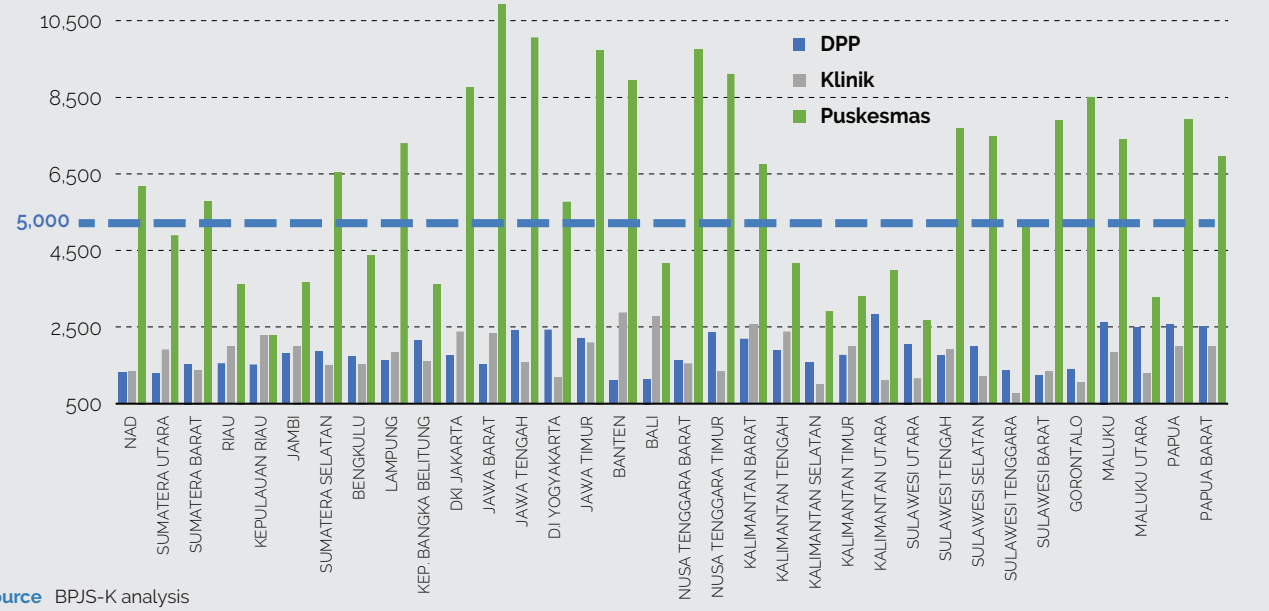
The utilization of capitation funds paid by BPJS-K to puskesmas or District Offices is regulated by Presidential Regulation: 32/2014, but some regions consider capitation income as regional income and utilized according to local policy. *Puskesmas* are increasingly given discretion to manage their own financial affairs, and a number of the facilities have been converted to BLUD Puskesmas, which allows them to manage their own financesLocal governments have also been advised not to overly exploit *Puskesmas* for revenue purposes. According to *Presidential Regulation No. 32* even if the *Puskesmas* has not been converted to BLUD, the capitation funds no longer go to the local treasury but directly to *Puskesmas* account but they still need approval for spending money held in local treasury.

Even in autonomous *Puskesmas*, the complicated rules on the allocation of capitation revenue have led to low absorption in some cases, with the revenue taken back by the government treasury if it remains unspent at the end of the year. There is also a heavy administrative burden for the reporting of expenditures. There are different treasury accounts for each funding source (e.g. JKN, MOH budget, local government, Jamkesda) and different financial reports for each account. A different health facility staff member has to complete the financial report for each account, so clinical staff spend a significant amount of time on financial reporting.

IMPLEMENTATION CHALLENGES

There has been good progress on contracting and provider payment for PHC under JKN, but some implementation challenges have limited the impact

Figure 2 Ratio of registered JKN participants to doctors in FKTPs by Province



Source BPJS-K analysis

of these purchasing mechanisms on FKTP service delivery, quality and efficiency. Referral rates remain high, and the imbalance in BPJS spending between PHC and higher levels of care persists.

The unequal distribution of JKN participants across FKTPs is a major concern, creating risks at both the high and low ends of participant-to-doctor ratios. The current capitation payment system puts rural FKTPs at a disadvantage since there is no adjustment for the higher fixed costs associated with serving populations in rural and remote areas. This disadvantage will become worse when the performance-based payment withholding is put into practice and rural providers are more likely to be penalized for not meeting contact rate targets. There have also been some challenges with absorption of capitation revenue at the puskesmas level, particularly the 40% for operational expenditures because of concerns about violating the regulation and spending the funds inappropriately.

Although progress has been made to generate better PHC-level data through P-Care, stakeholders raise several concerns with the P-Care system. Not all *puskesmas* have access to the P-Care data, so they are not able to use it for managing the health needs of their registered populations, and performance evaluation is not transparent. Another concern is that *Puskesmas*, private FKTPs, and DHOs have no mechanism to identify registered JKN participant for each FKTP and P-Care data is not linked to hospital utilization data, the data have limited value for policymaking, planning, and budget allocation at the regional level. BPJS-K is in the process of developing dashboard portal for stakeholders (Ministry of Health, District Health Offices, health provider associations and professional organizations) is under development to allow them better access to the data.

Options for Improvement in Strategic Purchasing of PHC Under JKN

In order to strengthen strategic health purchasing of PHC under the JKN, some regulations simply need to be implemented better (supply-side readiness and credentialing and selective contracting of FKTPs), while other regulations may need to be revised (contracting and provider payment and use of capitation funds).

OPTIONS TO IMPROVE STRATEGIC HEALTH PURCHASING UNDER JKN

Purchasing Function	Related Regulations	Options for Improvement
Accountability	Law no. 40 on the National Social Security System Law No. 24 of 2011 Chapter VIII Accountability Article 37	• Strengthen accountability through improved governance system of JKN with clear definition of which institutions are responsible for which outcomes of JKN implementation. • Clarify the mandate and accountability of BPJS-K as both a health and a finance institution, increasing accountability for access to service by JKN participants, effective and efficient service delivery, quality of care, and cost management. • Establish a routine monitoring system based on a jointly used database of BPJS-K claims data, other MOH service utilization data, and other key indicators and data sources. • Establish a link between central-level financial transfers to sub-national governments and accountability for JKN implementation.
What to purchase		
Service delivery standards	Law No 40/2004 President Regulation number19/2016 article 43 A	Gradually shift authority to BPJS-K to select which service delivery and quality standards (e.g. standard clinical practice guidelines set by MOH) will be used for purchasing services, even if the agency does not develop them.
From whom to purchase		
Supply-side readiness	Law Number 23 year 2014 concerning local government Regulation of Minister of Health No. 71 of 2013	• Establish regional-level joint service delivery planning team including representation of local governments, District Health Offices, professional associations (public and private), and local branches of BPJS-K to discuss service delivery investment needs to meet service delivery standards but in consideration of the budget impact on BPJS. • Increase regional commitment to allocate funds used to build adequate health facilities, particularly in rural and remote areas. • Improve regulations to allow compensation funds as an alternative for source of health expenditure in some rural and remote areas with low fiscal capability. • Increase partnerships with the private sector, particularly for rural and remote areas, with the payer for the health care, BPJS-K, as the guarantor.

Selective contracting	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the contracting function by giving greater authority to establish provider selection criteria, establish the terms of contracts, negotiate contracts with providers, and monitor and enforce contracts.
		• Implement the BPJS-K credentialing process in a participatory way with DHOs, local governments, professional associations (public and private), and other stakeholders to jointly carry out mapping in the regions, analyze population growth, and project future PHC supply needs for JKN.
		• Create more opportunity for private FKTPs to contract with BPJS-K:
		  • Specify the role of private providers in JKN/BPJS-K regulations
		  • Engage private professional associations in credentialing

Purchasing Function	Related Regulations	Options for Improvement
How to purchase		
Contracting and provider payment policy	Regulation of Minister of Health Number 69 on Health Services Standard Rates At First Level Health Facilities and Advanced Level Health Facilities in Health Insurance Program Implementation	• Increase the role of BPJS-K in the selection and development of provider payment systems, and provider rate-setting. • Explore options to better harmonize between capitation payment for PHC and INA-CBG payment for secondary and tertiary services. • Provide fair contracting conditions for private providers, including tariff adjustments and access to government medicines prices. • Consider establishing an independent provider payment policy analysis unit to gather cost information, conduct analysis to inform provider payment system design and parameter development, and budget impact analysis (possibly built from the MOH Case Mix Unit) Capitation • The capitation rate-setting should be more explicitly linked to the package of services and, include adjustments for geography and other factors related to health need. • The capitation payment system should be refined to include regulations on the upper and lower limits of ratios of registered participants to physicians in a FKTP. • The pay-for-performance component should be evaluated and revised to ensure that incentives are aligned with service delivery objectives and rural and remote FKTPs are not disadvantaged. INA-CBGs • The INA-CBG payment system should be refined to improve alignment between case groups and relative costs. • The hospital costing system should be evaluated and possibly refined • Consider transitioning the INA-CBG payment system to a budget-neutral payment system (either volume caps or adjustable base rate).
Provider autonomy	Regulation of Minister of Health Number 19 of 2014 regarding the Use of Capitation Fund of the National Health Security For Health Care Service And Operational Cost Support on Regional Government-Owned First-Level Health Facilities MOH regulation no 21/2016	Test a capitation waiver that allows puskesmas meeting certain criteria to pool revenues from multiple sources (capitation, BOK, local funds, etc.) with increased autonomy for management and allocation of funds. • Set up a district-level platform for communication and monitoring among 4 entities: DHO, BPJS, puskesmas providers, and local government • Monitor effects on service delivery
Provider performance monitoring	Regulation of Minister of Health Number 71 of 2013 CHAPTER VI Quality and Cost Control Articles 33, 37 and 38 Regulation of Minister of Health Number 71 of 2013 Chapter VII Reporting And Utilization Review Article 39	• Establish an integrated health information system that can be used by multiple stakeholders for multiple purposes. • Improve the P-Care data system to that it can be used effectively by all stakeholders, especially FKTPs, for planning, management, and performance monitoring and improvement and link it to the BPJS-K claims database. • Establish a routine monitoring system within BPJS-K that analyzes and reports on a set of standard indicators related to service delivery and other key JKN outcomes. • Build on the BPJS-K cost and quality control team to build Joint provider monitoring and quality assurance commissions at the district level, including representation of the local branch of BPJS, DHO, and local government. • Establish the authority of BPJS-K to act on results of the cost and quality control teams utilization reviews, etc. and possible link to financial or other incentives. • Establish a routine reporting system for BPJS-K to report routine monitoring and evaluation results to MOH and DJSN on a regular basis

Annex 1.

Health Sector Laws and Regulations in Indonesia Related to Purchasing PHC

STRATEGIC PURCHASING FUNCTIONS	REGULATIONS	IMPLEMENTATION/ ROLE OF STAKEHOLDERS
QUALITY OF CARE To ensure qualified public and private providers are empanelled [e.g. Credential, accreditation, using structural quality, clinical quality, patient safety, infectious control]	Regulation of Minister of Health Number 71 of 2013 article 9, as amended to Permenkes NO. 99 Year 2015.	BPJS-K performs selection and credentialing of FKTPs to establish a contract with BPJS-K using the following technical criteria: a. Human resources; b. the completeness of facilities and infrastructures; c. scope of services; and d. service commitment. These activities involve district/city health agencies and/or the association of health facilities. The technical criteria are based on the ministerial regulation.
	Utilize a structural quality, clinical quality (Requirement) Regulation of Minister of Health Number 71 of 2013 article 6-7. Credential Regulation of Minister of Health Number 71 of 2013 article 10	• Type of FKTP requirements should be met and the follow-up, to be able to form collaboration with BPJS-K. • Recredentialing for extension of FKTP contract utilizing agreed technical criteria, and involving health agencies in the district/ city and /or Health Facilities Association and should be made at least 3 months before the cooperation agreement expires.
	Patient safety Presidential Regulation Number 12 of 2013 concerning health coverage article 42-43.	• THE ROLE OF LOCAL GOVERNMENT: The local government regulates the utilization of Puskesmas funds to be more effective and efficient and the role of local government in subsidizing of Puskesmas is carried out. • The quality control of health assurance services conducted entirely comprising the fulfillment of quality standards of health facilities, ensure health services process carried out based on agreed standards and supervise health outcomes of the members. • Health services for JKN members should consider the quality of services; patient's safety oriented, action effectiveness, appropriate with the patient's needs, and cost efficiency. • The implementation of health assurance quality control conducted comprising the fulfillment of quality standards of health facilities, ensure health services process carried out based on agreed standards and supervise health outcomes of the members. • The provision of the implementation of quality control of health assurance services are referred to the article (2) governs with BPJS regulations. (1) In order to ensure the quality control and cost, the ministry of health has a responsibility to: a. Conduct health technology assessment; b. Clinical advisory and advantages of health assurance; c. Tariff standards calculation; and, d. Monitoring and evaluation to the administrator of health services assurance.

STRATEGIC PURCHASING FUNCTIONS	REGULATIONS	IMPLEMENTATION/ ROLE OF STAKEHOLDERS
HR COMPETENCIES	• UU 20 year 2013 on medical education • The Ministry of Health decree No. 5 year 2014 on clinic practice guidelines for a doctor in primary health services facilities.	• Medical education profession comprises of primary medical services program, medical specialist/sub specialist, and dentist specialist/sub specialist. • Reference for a doctor to provide health services in government health services facilities or private to enhance the quality of services as well as to decrease the number of referrals patients based on the following criteria: a. the disease that has a high prevalence; b. High-risk disease; and c. High-cost disease.
Credentialing and contracting	• The government regulation (UU) No. 9 Year 2009 on health • UU No. 23 Year 2014 regarding Regional Government (Pemda). • Article 36 verse (2) Presidential Regulation (Perpres) No. 12 Year 2013, • The Ministry of Health (MoH) decree (Permenkes) No. 5 Year 2014 concerning a guidelines of clinical practice for a doctor in primary health facility services.	• The role of regions to provide Health Facilities (FKTPs). • The infrastructure of Community Health Center (Puskesmas) not meet the standard, • The national and regional health facilities that meet the credentialing requirements are required to establish a cooperation with the BPJS-K by establishing a written agreement. • BPJS coordinates with health agencies in the district/city on contracting • The guideline of Clinic practice for a doctor in primary health service facilities with aims to provide a reference for a doctor to support primary health services both owned by the government or private to enhance health quality services as well as to decrease the number of patients referrals, with the following criteria: a. the disease that have a high prevalence; b. High-risk disease; and c. High-cost disease.
PAYMENT (CAPITATION)	• Permenkes no. 52 Year 2016 on Tariff standard for health services in JKN program. • Article 24, UU no. 40/2004, The amount of payment to the Faskes determined by the agreement of BPJS with Faskes association in the area. • The MoH decree (Permenkes) No. 21 year 2016 concerning the utilization of capitation assurance National Health Funds for Health services and Operating support funds on the first level of health facilities owned by the government. • The Ministry of Health decree (Permenkes) no. 69 Year 2013 on health services tariff standards on the first level of health facilities to the advance levels in performing health insurance programs. • The regulation of health security agency number 2 Year 2015 on the norm of determination of the amount of capitation and capitation payment based on the commitment to support health facilities for the first level. • Circular letter from the Ministry of Home Affairs (MoHA) Number 900/2280/SJ Year 2014 concerning financing technical guidelines, implementation and administration, and the accountability of the national health assurance capitation funds on the first level of the health facilities owned by the regional government.	ROLE OF MoH: setting up the tariffs • The utilization of capitation funds of JKN, JKN services, the operational cost of health services, utilization of the remaining capitation funds, guidance and supervision. • Capitation tariffs of FKTP equal to the amount of IDR 3,000 (Three Thousand rupiah) until IDR 6,000 (Six Thousand Rupiah). • Technical guidelines for budgeting, implementation and administration and the accountability of JKN capitation funds on FKTP owned by the regional government that has not implement financing pattern of regional Pubic Services (PPK-BLUD)

STRATEGIC PURCHASING FUNCTIONS	REGULATIONS	IMPLEMENTATION/ ROLE OF STAKEHOLDERS
	• Circular letter from the Ministry of Health and BPJS Number HK.03.03/ IV/053/2016 and Number 01 Year 2016 on the implementation and supervision of KBK and implementation of FKTP. • Regulation of Minister of Health Number 71 of 2013 article 9 as amended to Permenkes No. 99 Year 2015 • Regulation of Minister of Health Number 71 of 2013 article 6-7. • Regulation of Minister of Health Number 71 of 2013 article 10.	ROLE OF DHO : credentialing • Determination of contracting with BPJS-K by utilizing the following technical criteria: a. Human resources; b. the completeness of facilities and Infrastructure; c. scope of services; and d. services commitment. These activities involved district/ city health agencies and/or the association of health facilities or determination of the results together with the health agency in the district/city and or association of health facilities. Those technical technic based on the MoH regulations. • The requirements that should be fulfilled by FKTP and in advance to be able to form cooperation with BPJS Kesehatan. • Re-credential to extend cooperation of Faskes with BPJS Kesehatan by utilizing an agreement on technical criteria, and involving health agencies in district/city and/or Health Association Facilities and should be made at least (three) months before the cooperation agreement expiration.
	Joint regulation of General Secretary of the Ministry of Health (MoH) and President Director of BPJS kesehatan Number HK.02.05/III/SK/089/2016 and Number 3 Year 2016 on the technical guidelines for KBK payment on FKTP.	ROLE OF LOCAL GOVERNMENT: Infrastructure fulfillment
	Permenkes regulation no. 455/2013, on the amount of Faskes payment, determined based on the BPJS agreement with Fakes association in the regions with reference to tarrif standard regulated by the ministry.	ROLE OF BPJS: setting up the criteria/performance
	Presidential Regulation (Perpres) 12/ 2013, article 43A verse (1),	ROLE OF DHO: negotiation PCP's performance
UTILIZATION CAPITATION BUDGET	PERPRES 32/2014 on Utilization of capitation fund.	ROLE OF BPJS: negotiation with DHO
MONITORING AND EVALUATION	Presidential Regulation Number 12 of 2013 concerning health coverage Chapter IX Quality Control, cost and the quality of health insurance implementation article 42-43.	Health services should provide a high quality of services to the health assurance members; consider patient's safety oriented, action effectiveness, appropriate with patients needs, and cost effectiveness.
	b. Regulation of Minister of Health Number 71 of 2013 CHAPTER VI QUALITY CONTROL AND COST article 33-38.	ROLE OF MoH: establishment of regulation; The ministry conduct: a. health technology assessment; b. Clinical advisory; c. Tariff standard calculation; d. Monitoring and evaluation to the health assurance administrator; ROLE OF DHO: with the BPJS perform a credentialing.