SP4PHC
Strategic Purchasing for Primary Health Care

BRINGING PRIVATE MIDWIVES INTO INDONESIA'S NATIONAL HEALTH INSURANCE SCHEME: BRIEF

THINKWELL

The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project is supported by a grant from the Bill & Melinda Gates Foundation and implemented by ThinkWell in collaboration with country governments and local research partners in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda.

In Indonesia, SP4PHC is helping to improve how the national health insurance scheme, Jaminan Kesehatan Nasional (JKN), engages and incentivizes the full range of health providers to increase access to quality MNCH services. Indonesia still has an alarmingly high maternal mortality ratio (MMR), even though it has seen increased utilization of MNCH services and expanded JKN coverage to over 80% of the population.

This brief summarizes findings from a landscaping study conducted by Universitas Gadjah Mada's (UGM) Center for Reproductive Health, ThinkWell's learning partner. Drawing from an extensive review of the literature, interviews with key stakeholders, and focus group discussions with private midwives, the study documents how important private midwives are in delivering MNCH services. The study also explores why private midwives are often left out of the JKN system and offers policy recommendations about how strategic purchasing can be leveraged to incentivize them to join JKN and improve the quality of the services they provide.

Universitas Gadjah Mada Center for Reproductive Health

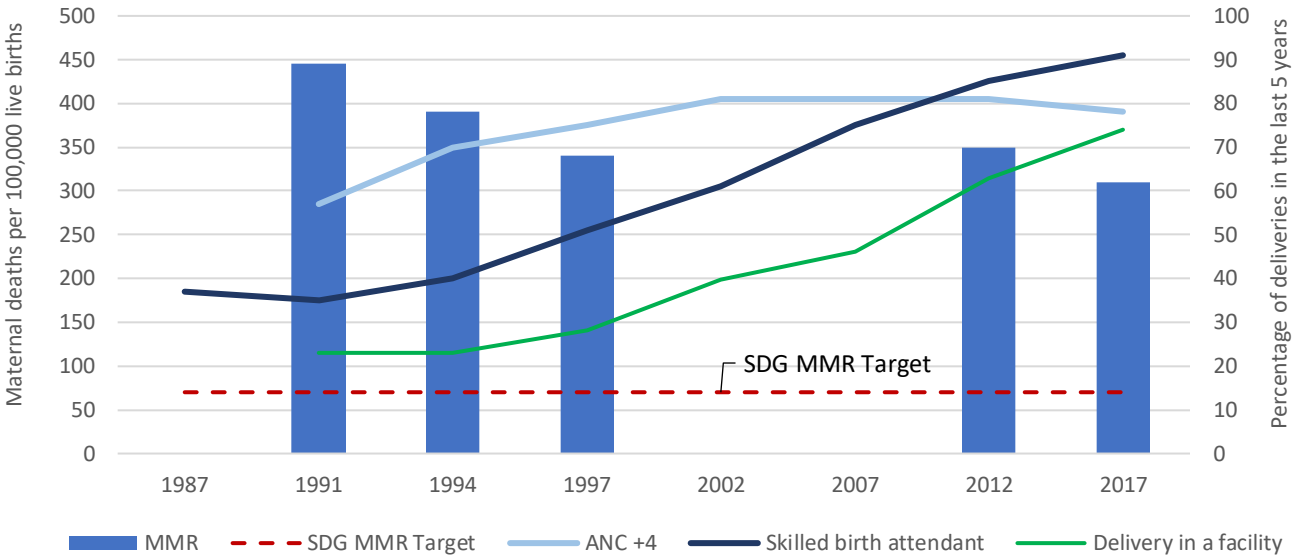
EXPANDING JAMINAN KESEHATAN NASIONAL

The Government of Indonesia has made significant progress in implementing universal health coverage (UHC). JKN was officially launched in 2014. Previously, Indonesia had multiple state-run health insurance schemes that catered to different segments of the population. After a 2004 law mandated the creation of a national social security system, the Government consolidated the existing schemes in 2014 to create a single one that would serve the entire population, and the national health insurance agency, Badan Penyelenggara Jaminan Sosial – Kesehatan (BPJS-K), was put in charge of overseeing it (Agustina et al. 2019). By 2019, JKN enrollment reached 221 million, over 80% of the population (Prabhakaran et al. 2019). Under JKN, citizens are entitled to a comprehensive set of MNCH services. Despite this expansion in coverage and an inclusive package, Indonesia has not been able to reduce its MMR in kind.

RISING COVERAGE, STAGNANTLY HIGH MMR

Indonesia's MMR estimates range from the globally accepted 177 maternal deaths per 100,000 live births to the government's official figure of 305 (Ministry of Health 2015). However, even the most conservative number is more than double the Sustainable Development Goal (SDG) of 70 deaths per 100,000 live births. In comparison, as seen in Figure 1, trends in skilled birth attendance (SBA), women receiving at least 4 antenatal care checkups during pregnancy (ANC+4), and deliveries in a health facility have all steadily improved over the last 20 years. For SBA, the positive trend can largely be attributed to midwives; over the past 5 years, they assisted more than 60% of total deliveries and 34% of these assisted deliveries were conducted by private midwives (BKKBN 2018).

Figure 1: Trends in MMR, ANC+4, SBA, and deliveries in a facility in Indonesia, 1987-2017

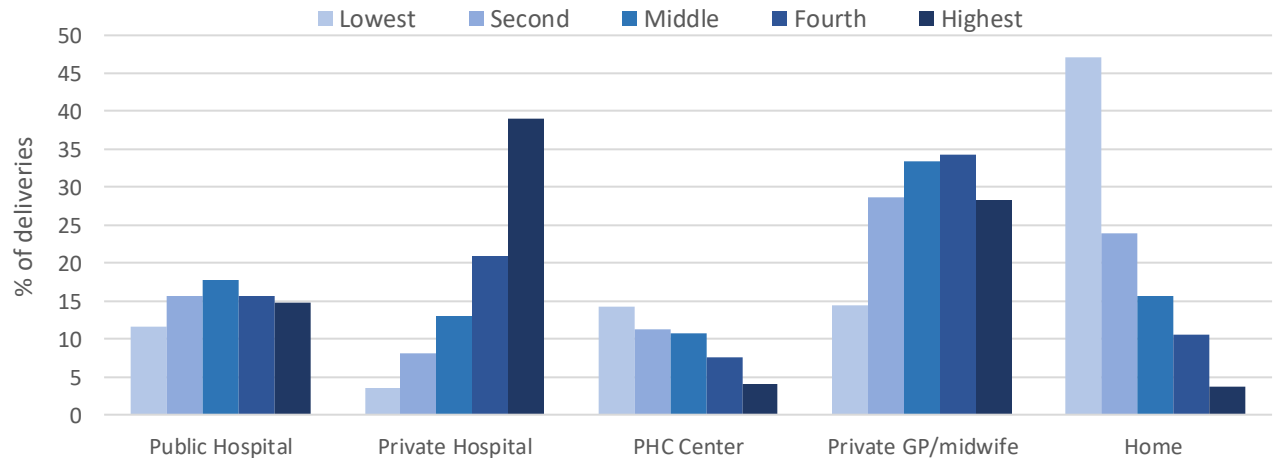


Source: Indonesia Demographic and Health Survey 1987-2017

While midwives expand access to much-needed MNCH services, the quality of the care they provide has been variable. Access to health facilities and physicians is a major problem for the archipelagic nation, so it is no wonder that many women rely on midwives to receive care. Ensuring the country had a significant midwife workforce was a priority for the government in the 1980s, exemplified by the large-scale government village midwife program Bidan di Desa. This emphasis on midwives in the health delivery system has had a considerable impact on poorer Indonesian women. Figure 2 shows that women in the highest wealth index quintile primarily go to private hospitals to give birth, while women in the lower wealth index quintiles deliver their babies with the help of a private midwife or general practitioner. While access has increased, it will not improve maternal mortality if midwives are failing to detect complicated pregnancies early on or not referring women to higher level facilities on time. Several studies have shown that the quality of care among midwives is a serious problem in Indonesia (Yap et al. 2017; BAPPENAS 2013; National Research Council 2013).

The system to train and supervise midwives is not well-coordinated or regulated. There are approximately 250,000 midwives currently practicing who are registered with the Indonesian Midwives Association (IBI) and licensed by the Ministry of Health (IBI, interview, 2018). Of the

Figure 2: Percentage of deliveries by provider type and wealth quintile



Source: Indonesia Demographic and Health Survey 2017
Note: GP = General Practitioner

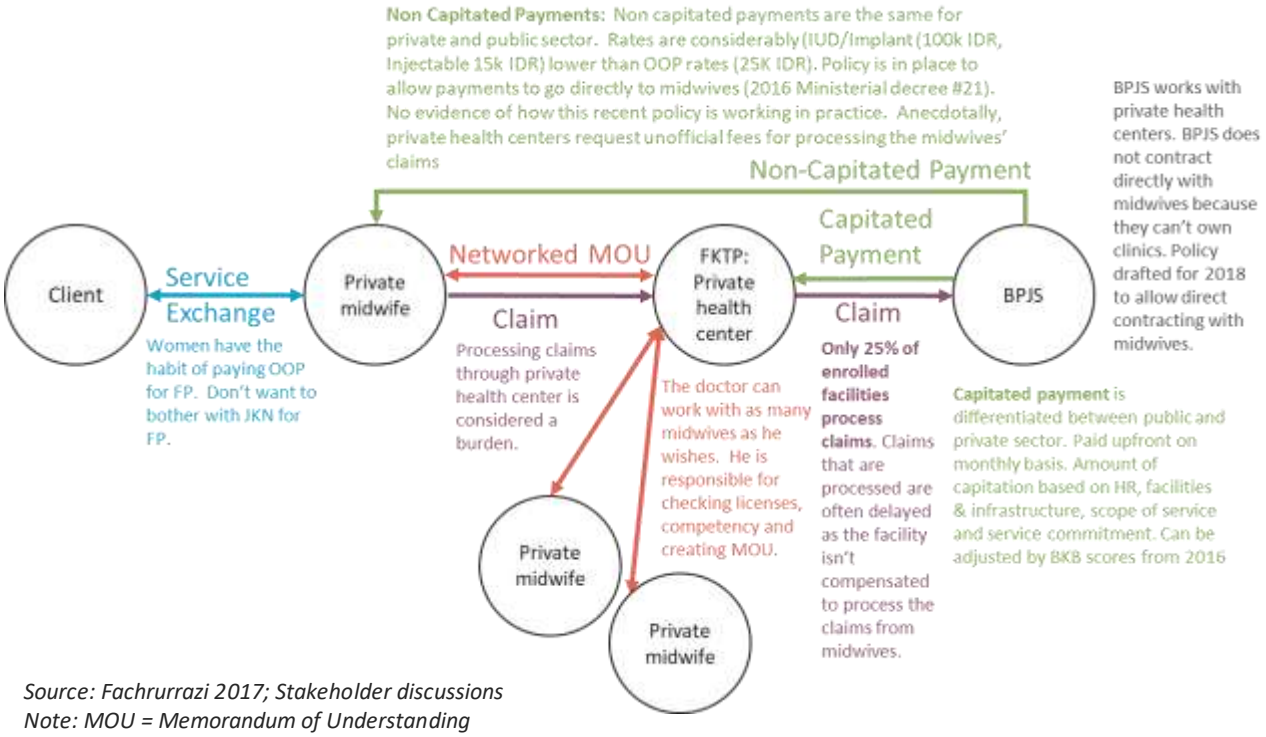
registered members, 16% work exclusively through a private practice and most continue working in private practice after their shifts at public facilities end (IBI, interview, 2018) – a custom widely known as dual practice. There is wide variation in the training and certification of midwives in Indonesia. There are over 700 schools that provide midwifery training and accreditation for these programs is available through the National Clinical Training Network. However, schools often operate without accreditation and training requirements are not standardized. Although the Ministry of Health is responsible for checking and issuing licenses, it is widely believed that many midwives practice even without active licenses (IBI, interview, 2018).

JKN can incentivize higher quality for private midwives enrolled in its system, but few are joining. JKN can use licensing requirements, provider payment mechanisms, and other methods to positively influence the behavior of contracted providers. Private midwives empaneled with JKN can have their MNCH services covered under the scheme, which allows more patients to seek care and not face costly out-of-pocket (OOP) payments. However, IBI estimates that only 5% of private midwives are empaneled in JKN. There are two main reasons for why midwives are not joining JKN.

Private midwives face burdensome administrative and bureaucratic processes to join JKN. They cannot contract directly with BPJS-K and, instead, must subcontract with a public PHC facility. This measure theoretically allows PHC facilities to check the quality of their services but, in practice, overburdened PHC facilities often do not do this. Interviews with health officials also revealed that their guidelines do not clarify how to monitor midwives and whose responsibility it is to oversee them. For private midwives, subcontracting with a PHC facility has often led to delays in reimbursements, as these facilities do not prioritize their claims and midwives do not have access to the digital system to track the status of their claims. Figure 3 outlines these challenges in detail.

In addition to these process barriers, private midwives are not financially incentivized to enroll in JKN. Indonesian women are willing to pay high OOP fees to receive MNCH services from a private midwife, often due to convenience and familiarity with the provider. The OOP payments are often also higher than JKN's reimbursement rates for these services, so private midwives do not see the benefit of navigating through all the bureaucratic hurdles. For instance, a private midwife empaneled under JKN would be reimbursed the set rate of IDR

Figure 3: Challenges Private Midwives Face in Joining JKN



Source: Fachrurrazi 2017; Stakeholder discussions
Note: MOU = Memorandum of Understanding

700,000 for a normal vaginal delivery. However, private midwives, and the Chairperson of IBI, claim that the market price is double this amount. Unlike public providers, private midwives do not receive additional government subsidies that help cover wages and other operating costs, which makes current reimbursement fees too low.

POLICY RECOMMENDATIONS

This study offers several policy recommendations for government officials that address private midwives as crucial providers of MNCH services and the potential for JKN to facilitate higher quality service delivery.

1. Private midwives should have greater ability to directly engage, submit claims to, and get reimbursed by BPJS-K instead of going through a public facility.
2. Reimbursement rates for FP and MNCH services should be increased to incentivize private providers to serve JKN members.
3. Quality assurance measures should be incorporated into the JKN enrollment process for practicing private midwives.
4. Once enrolled, strategic purchasing mechanisms should be used to incentivize higher quality provision of MNH services.

These recommendations were informed by in-depth interviews with key stakeholders, focus group discussions, literature reviews, and quantitative data analyses. Detailed explanations of the recommendations can be found in the full report *Bringing Private Midwives into Indonesia's National Health Insurance Scheme: A Landscape Analysis* by Siswanto et al.

CONCLUSIONS

Increasing the value proposition for private midwives to join JKN is an opportunity to improve the quality of MNCH services from a much relied upon healthcare source for Indonesian women. While coverage of services has increased, in part, due to these midwives, many have questionable training and/or capabilities. This may be a key contributor to why the MMR is stubbornly refusing to fall. The Government can use the findings and recommendations in the study to make a better pitch to these midwives to encourage them to join JKN. Once they have joined, JKN can employ strategic purchasing mechanisms to incentivize better quality of care from these providers, reduce high OOP payments, and integrate these frontline providers with the larger health delivery system.

SP4PHC is committed to supporting the Government of Indonesia achieve its UHC goals. Currently, the team is taking the lessons from this work to the Ministry of Health's Technical Working Group on Maternal and Newborn Health to design and implement a strategic purchasing pilot for MNCH. The pilot will test approaches to improve the value proposition to private midwives and to revise payment mechanisms to incentivize higher quality MNCH services.

SP4PHC is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation.

For the full report as well as more information about the project, please visit our website at **https://thinkwell.global/projects/sp4phc/.** For questions, please write to us at **sp4phc@thinkwell.global**.

Recommended citation:
Wilopo, Siswanto, Amirah Wahdi, Paulina Limasalle, and Anooj Pattnaik. 2020. "Bringing Private Midwives into Indonesia's National Health Insurance Scheme: Brief." Washington, DC: ThinkWell.

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