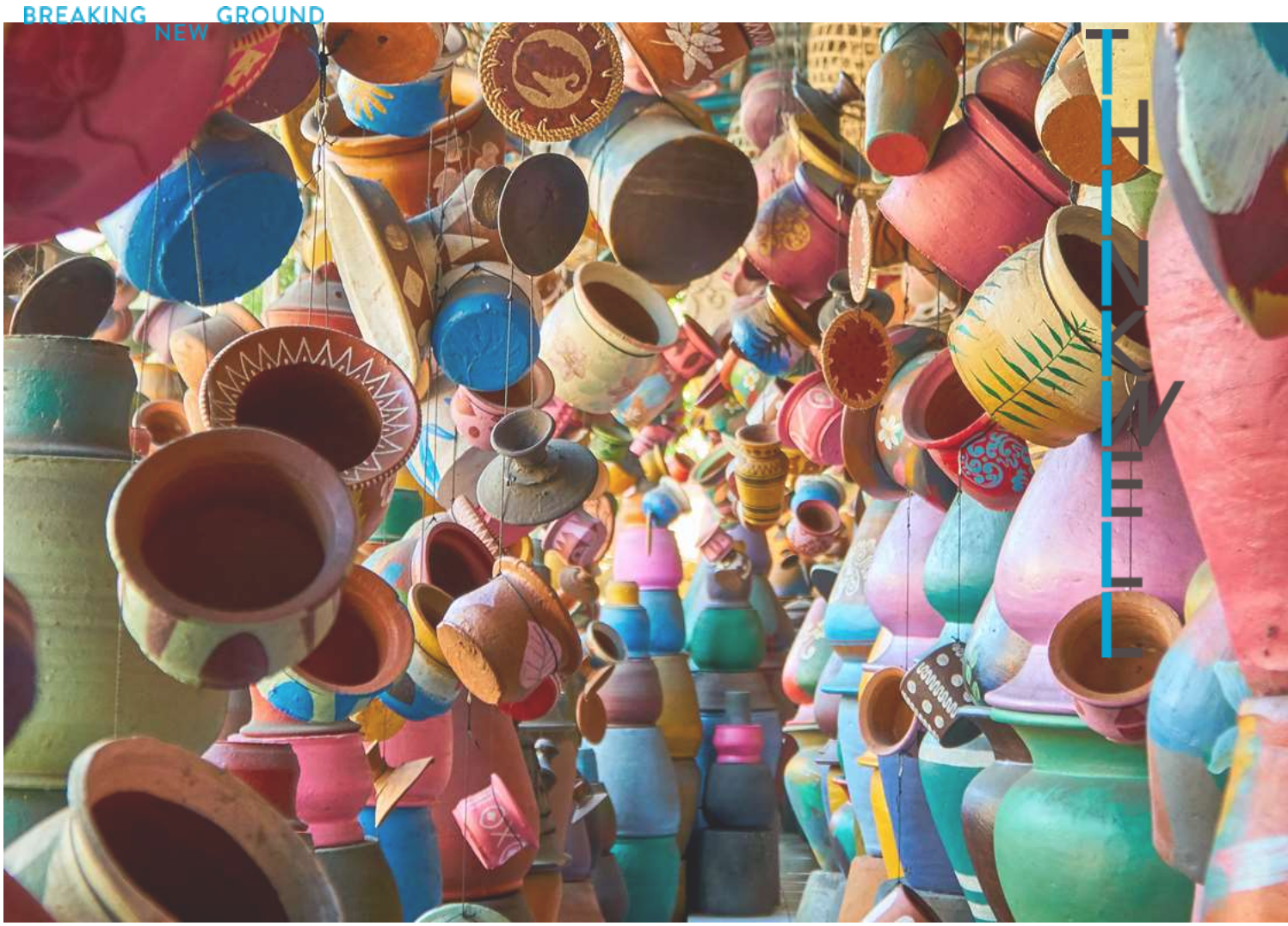
Universitas Gadjah Mada
Center for Reproductive Health

SP4PHC
Strategic Purchasing for Primary Health Care

Bringing Private Midwives into Indonesia's National Health Insurance Scheme: A Landscape Analysis

July 2020



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ABBREVIATIONS

ANC	antenatal care
BAPPENAS	Kementerian Perencanaan Pembangunan Nasional Republik Indonesia (Ministry of National Development Planning)
BKKBN	National Population and Family Planning Board
BMGF	Bill & Melinda Gates Foundation
BPJS-K	Badan Pelaksana Jaminan Sosial—Kesehatan (National Health Insurance Agency)
CBG	case-based groups
C-sections	caesarean sections
DJSN	Dewan Jaminan Sosial Nasional (National Social Security Council)
EmONC	Emergency Obstetric and Neonatal Care
FFS	fee-for-service
FGD	focus group discussion
FKRTL	Fasilitas Kesehatan Rujukan Tingkat Lanjut (secondary and tertiary referral health facilities)
FKTP	Fasilitas Kesehatan Tingkat Pertama (first-level health facilities)
FP	family planning
GDP	gross domestic product
IBI	Ikatan Bidan Indonesia (Indonesian Midwives Association)
IDHS	Indonesian Demographic and Health Survey
IDI	in-depth interviews
IDR	Indonesian Rupiah
JKN	Jaminan Kesehatan Nasional (National Health Insurance Program)
mCPR	modern contraceptive prevalence rate
MDG	Millennium Development Goal

MMR	maternal mortality ratio
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCTN	National Clinical Training Network
OOP	out-of-pocket
PBI	Penerima Bantuan Iuran (Premiums Assistance Recipient—for the poor)
PHC	primary health care
PNC	postnatal care
SBA	skilled birth attendance
SDG	Sustainable Development Goal
SP4PHC	Strategic Purchasing for Primary Health Care
SUSENAS	national socioeconomic survey
UGM	Universitas Gadjah Mada
UHC	universal health coverage

EXECUTIVE SUMMARY

Indonesia suffers from stubbornly high maternal mortality. Addressing this challenge is a key priority for the government. Private midwives provide a substantial proportion of reproductive and maternal services across the country. However, very few of these midwives are contracted under Indonesia's national health insurance scheme, Jaminan Kesehatan Nasional (JKN). On the one hand, a sizeable proportion of women pay out-of-pocket (OOP) for maternal services at varying levels of quality from private midwives, while on the other an increasing proportion of JKN claims are for expensive services, including caesarean sections (C-sections). Integrating this widely accepted frontline provider of maternal services into JKN could have equity, efficiency, and quality benefits.

This report summarizes findings from a landscaping study that ThinkWell and the Center for Reproductive Health at Universitas Gadjah Mada undertook in 2018 on JKN engagement with private midwives under the Strategic Purchasing for Primary Health Care (SP4PHC) project. ThinkWell is implementing SP4PHC in partnership with government agencies and research institutions in five countries, with support from a grant from the Bill & Melinda Gates Foundation. The project's overarching objective is to strengthen how governments purchase primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The team completed a detailed policy review, data analysis, and qualitative interviews to explore why private midwives are not participating in JKN and to generate recommendations about how these underlying factors may be addressed. This information has informed ongoing discussions about improving strategic purchasing for MNCH, which the Ministry of Health (MOH) is leading with key Indonesian stakeholders and partners to ultimately develop and test policies that offer a stronger value proposition to private midwives to participate in JKN.

A detailed review of JKN processes relating to contracting providers and processing claims reveals the complexity and inefficiency of current systems and how these differ by level and provider type. A major reason why a low proportion of private midwives have joined JKN is the uncertainty of getting reimbursed for services. Private midwives must submit claims through local PHC facilities, which adds another layer of bureaucracy that slows down the overall payment process. Also, the reimbursement rates for MNCH services through JKN are low compared to the OOP fees pregnant women are willing to pay private midwives. The current payment system does not show the benefits of joining JKN for private midwives.

While there is an abundant supply of midwives across Indonesia, there is wide variation in the training, certification, and competencies of midwives. Although there are over 700 schools that provide midwifery training, many are not accredited, and there are wide variations in training standards. Additionally, the administrative burden associated with regulating the licensing of private midwives falls onto overburdened local health officials. Government officials hesitate to include private midwives into JKN because they are unable to adequately monitor and ensure the quality of their service delivery.

Addressing these pain points will allow the MOH and other key stakeholders to develop and test policies that offer a stronger value proposition to private midwives to participate in JKN, with support from SP4PHC and other partners. Once private midwives have joined, the purchasing power of JKN can be leveraged to strategically incentivize better-quality practices from this trusted cadre of providers, widen JKN's effective coverage, and reorient the referral and delivery system more toward PHC and away from more costly upstream services.

INTRODUCTION

Strategic Purchasing for Primary Health Care (SP4PHC) is a multi-country project implemented by ThinkWell with support from the Bill & Melinda Gates Foundation. The project aims to improve how governments pay providers for primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project, which runs from 2017 to 2022, implements programs of work in Kenya, Uganda, Burkina Faso, the Philippines, and Indonesia. This document presents evidence generated from the work in Indonesia, focusing on how JKN can improve access to high-quality maternal health services.

Figure 1: Regional comparison of MMR, 2017

Source: World Bank 2017

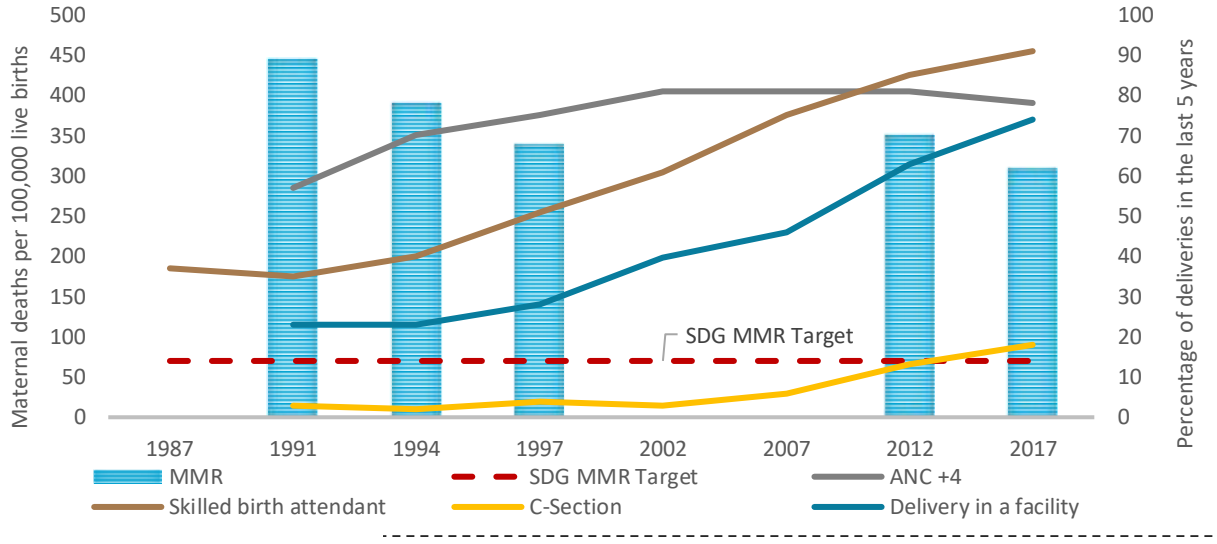
Women in Indonesia die too often from complications of giving birth. Figure 1 shows that the maternal mortality ratio (MMR) in Indonesia is high compared to its neighbors. MMR in Indonesia has declined from 214 in 2012 to 177 in 2017 but remained above the Sustainable Development Goal (SDG) of 70 per 100,000 live births (Ministry of Health 2015).[1] Moreover, some sources dispute these figures and prefer to use data from the 2015 Inter-Censal Survey, which gives a much higher MMR of 305 deaths per 100,000 live births (UN Population Fund 2018).[2] Thus, it is no surprise that the Indonesian government views maternal mortality as a high-priority area to address.

Paradoxically, **MMR has remained stubbornly high, even as skilled birth attendance (SBA) has steadily increased over the last 20 years,** as seen in Figure 2. Much of this high birth attendance can be attributed to midwives, who assisted in over 60% of all deliveries in the last five years in Indonesia. Of these midwife-assisted deliveries, 34% were by private midwives, who were also responsible for 41% of all FP service provision and 35% of antenatal care (ANC) (National Population and Family Planning Board 2018).

[1] This target was the result of extensive consultations hosted by the World Health Organization throughout 2013 and 2014 that involved various experts, stakeholders, advocates, donors, and country representatives. The SDG of reducing MMR to 70 maternal deaths per 100,000 live births is the global target (World Health Organization 2015). The country-level target is to reduce the 2010 baseline MMR level by two thirds, and MMR should be less than 140 deaths per 100,000 live births by 2030.

[2] UNFPA also states, "Differences in estimates of MMR continue to be controversial and often politicized, called for evidence-based consensus on maternal deaths data" (United Nations Population Fund 2018).

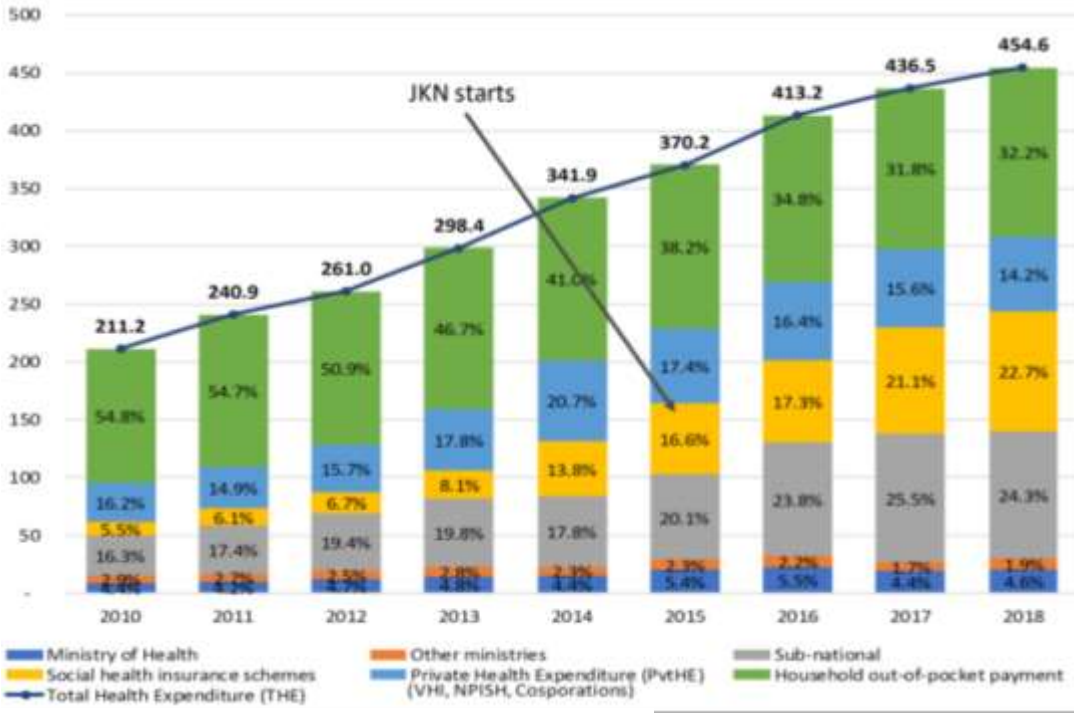
Figure 2: Trends in MMR, ANC, SBA, & C-sections in Indonesia, 1987 – 2017



Source: IDHS 1987-2017
Note: ANC+4 means at least 4 ANC visits

One of the reasons behind this high MMR in the face of rising SBA is the documented weak quality of care among midwives. This includes poor recognition of high-risk pregnancies and weak referral practices during complicated deliveries (Yap et al. 2017; BAPPENAS et al. 2013; National Research Council 2013). Only 30% of deliveries were assisted by doctors and obstetricians in hospitals. At the same time, caesarean sections (C-sections) are rapidly rising since the introduction of JKN; they account for over 17% of all deliveries (orange line in Figure 2), which is above the WHO recommendation of 10 to 15%.

Figure 3: Trends in health expenditure, 2010-2018 (IDR trillion)



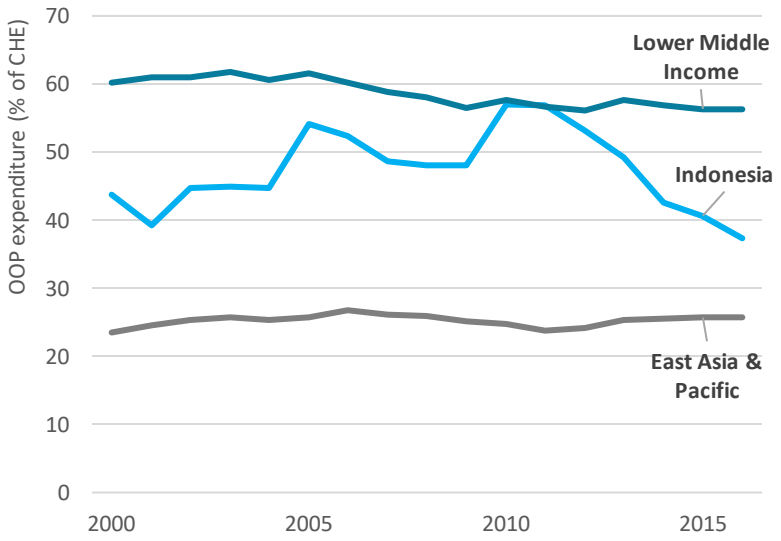
Source: Center of Health Financing and Security, Ministry of Health 2019

The recent increase in C-sections also speaks to the government's concerns about the rising costs of JKN. Since inception, **JKN's expenditures have exceeded its government financial allocations and enrollee contributions, putting its long-term financial sustainability at risk.** Figure 3 shows rising government health spending and the increasing proportion from JKN.

It is a concern that JKN expenditure is increasingly paying for costly secondary and tertiary care (over 80% last year), rather than PHC. This speaks to the need for improving JKN's ability to use strategic purchasing mechanisms to reorient the signals providers receive toward PHC services and away from costlier ones, such as C-sections.

While trending downward over the last five years, **out-of-pocket (OOP) payments are also a major problem in Indonesia, as they account for nearly 40% of all health spending** (World Health Organization 2016). Figure 4 shows that this is high compared to Indonesia's neighbors, especially given that the country has a national health insurance scheme that covers over 80% of the population. Reasons that OOP payments are so high in Indonesia include the fact that the informal sector is still largely uncovered and that many preferred providers (including private midwives) are still not contracted to provide services under JKN. Crowding in these private providers under JKN could be a key mechanism of reducing OOP payments and improving health equity in Indonesia. Because of SP4PHC's goal to improve access to MNCH and FP, ThinkWell's program in Indonesia chose to focus on midwives, particularly private midwives.

Figure 4: Trends of OOP as a percentage of current health expenditure across Indonesia, lower middle income, and East Asia & Pacific countries, 2000-2017



Source: World Development Indicators 2020

Reasons for private midwives not joining JKN are unclear, and ThinkWell agreed to partner with the Universitas of Gadjah Mada (UGM) to conduct a rapid landscaping in 2018. The specific objectives of this work were to:

- Describe the current situation in terms of the overarching policy context and structure of health services, trends in maternal health and health expenditure, and the role of JKN in the health sector.
- Explain the process through which JKN purchases maternal health services and ensures quality standards, focusing on private midwives.
- Explore reasons why so few private midwives choose to contract with JKN for family planning, and why so few claims are made.

From this analysis, this report recommends ways for private midwives to effectively engage to increase access and choice in maternal services in Indonesia.

METHODS

ThinkWell and UGM collaborated in 2018 to conduct several analyses to understand how the health financing and delivery system in Indonesia provides PHC services, with a deeper dive on private midwives. Three methods were used to produce this report: a detailed desk review of relevant literature, quantitative analyses of secondary data from a series of Indonesian Demographic and Health Surveys (IDHS) and service statistics data from the Ministry of Health (MOH), and qualitative data collection via in-depth interviews (IDIs) and focus group discussion (FGDs) with key health system stakeholders.

First, the desk review and quantitative analyses were used to better understand the Indonesian context, especially around the delivery of PHC. This included an exploration of the relevant political, social, and economic trends; health system arrangements and infrastructure; and health outcome patterns.

Then, drawing from the conclusions of this broader analysis, midwife service delivery issues through three interlinked pieces of analyses were explored deeply:

- Analyzing JKN contracting of midwives (number of midwives empaneled, distribution by facility type, volume, type of claims, etc.), using secondary data from the BPJS database.
- Synthesizing findings from existing studies and data sources, as well as collecting additional information via qualitative interviews with midwives to better understand their perceptions and attitudes toward JKN.
- Mapping of current institutional arrangements (policies and procedures for empanelment, claims submission and reimbursements, payment rates, communication and coordination mechanisms, quality assurance and regulatory arrangements, access to subsidized commodities) between private midwives and JKN using existing documentation and key informant interviews with JKN, the Indonesian Midwives Association (IBI), and focus group discussions with midwives.

SOCIODEMOGRAPHIC AND POLICY CONTEXT

Indonesia is a diverse archipelago nation and the fourth most populous country in the world, with a total population of 257.6 million in 2015. With a population growth rate of 1.19%, Indonesia is expected to reach a population of 268 million by 2019. About 45% of the population will include people of productive age, and life expectancy at birth for males and females are 67 and 71 years, respectively (Ministry of Health 2015). In addition, Indonesia has the largest economy in Southeast Asia and the world's tenth largest economy in terms of purchasing power parity. Gross national income per capita increased from US$560 in 2000 to US$3,630 in 2014, and Indonesia has experienced significant drops in poverty rates in the past two decades (World Bank 2016a). Currently, 16% of the population lives on less than US$1.25 per day (UN Development Programme 2015).

The Indonesian Government has been explicit in its goal of achieving universal health coverage (UHC). The government has a 20-year development plan, spanning 2005 to 2025, segmented into five-year plans. The five-year plan that covered 2015 to 2019, and within the health sector the government is focused on reducing maternal and infant mortality, the decreasing the prevalence of low-birth weight babies, improving promotion and community mobilization for health, and financing for preventive and health promotion activities. In addition, the health sector is addressing the number of uninsured people

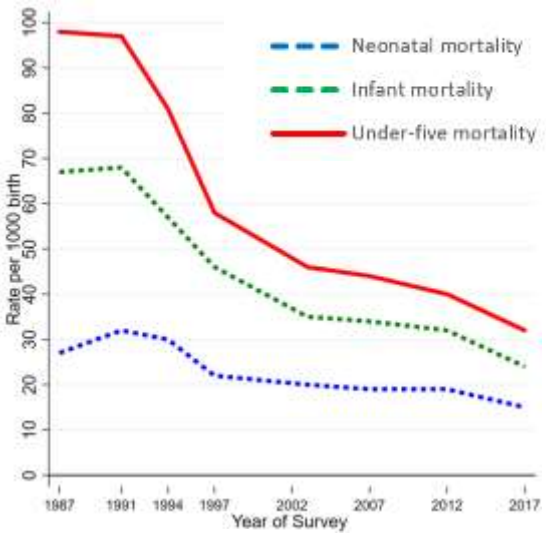
and improving the responsiveness index of health care services (World Bank 2016a; BAPPENAS 2014). In 2013, Indonesia declared that it would provide affordable health care for all its citizens by the end of 2019 (Ministry of State Secretariat 2011). The current government of President Joko Widodo ("Jokowi"), just re-elected in April 2019, has significantly increased government spending on health to support this UHC goal.

The main driver for UHC in Indonesia is JKN, which was launched in 2014. Administered by Badan Pelaksana Jaminan Sosial–Kesehatan (BPJS-K), JKN integrated various public schemes that previously targeted different population segments, becoming the single purchaser for a comprehensive benefit package for all Indonesians. While JKN has made tremendous progress in the past few years—most notably extending coverage to over 80% of the population—Indonesia still needs to enact some health system reforms to realize the three goals of UHC: population coverage, service coverage, and financial protection.

MATERNAL HEALTH CONTEXT

Indonesia performs strongly across key FP indicators; total fertility rate has steadily declined from 4.7 in 1980 to 3.0 in 1990 and stabilized at around 2.3 since 2000. The difference between wanted and observed fertility in 2012 is 0.6 children per woman, with little difference by residence or social status. The modern contraceptive prevalence rate (mCPR) among married women has increased from 5% in early 1970s to 57% in 2016 and averted around 100 million births (National Population and Family Planning Board 2018). FP2020 models suggest that demand satisfied through a modern method is over 80%, above the SDG target. In this respect, Indonesia has also exceeded its FP2020 target and is on track to exceed its additional users commitment (Family Planning 2018, 2020).

Figure 5: Trends in neonatal, infant, and under-5 mortality rates, 1987-2017



Source: IDHS 1987-2017

Indonesia has also seen significant reductions in neonatal, infant, and under-5 mortality, as can be seen in Figure 5. Still, both neonatal and under-5 mortality are slightly higher than the target of the SDGs, at 12 per 1,000 live births and 25 per 1,000 live births, respectively (National Population and Family Planning Board 2018).

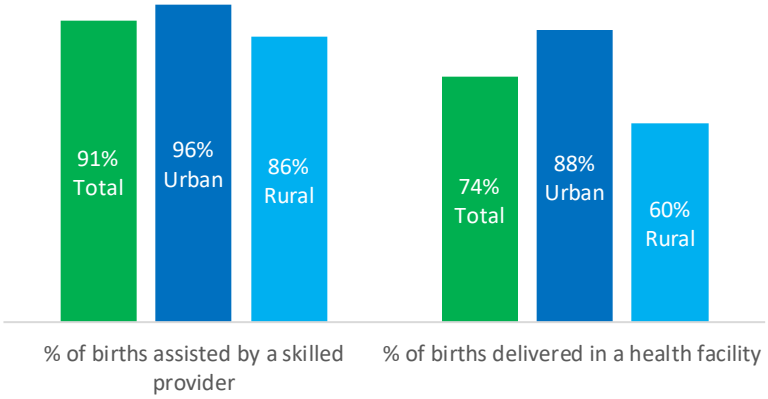
While the trends in FP and child mortality are positive, the patterns around maternal health are less encouraging. Figure 6 shows how MMR fluctuates across the different islands of Indonesia, with the more remote areas exhibiting higher MMR (Cameron, Suarez, and Cornwell 2019). Still, the highly populated areas account for the largest absolute number of maternal deaths, while many of the more remote areas have the highest MMR. Women's access to care in remote areas is a consistent challenge for Indonesia.

Figure 6: Maternal mortality ratio by province (per 100,000 live births)

Source: Cameron, Suarez, and Cornwell 2019

Failure to reach the Millennium Development Goal (MDG) target is also partly attributed to a high proportion of pregnancies among women under 20 years or over 40 years. Nearly half of all marriages (46.7%) occur among women younger than 20 years (National Population and Family Planning Board 2018). It is illegal in Indonesia to provide contraception to unmarried women, a major barrier for women to access reproductive counseling and FP methods.

Figure 7: Percentage of births assisted by a skilled provider or delivered in facility, 2017 (by urban/rural)



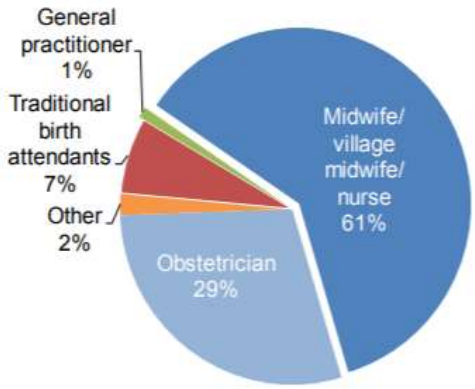
Source: IDHS 2017

Contrary to expectations, MMR has not reduced in line with the increase of skilled birth attendance across the country. Figure 7 shows how SBA is high in both urban and rural areas, while births delivered in health facilities exhibit more dramatic differences between urban and rural areas. A similar trend can be seen with deliveries by wealth quintile: less of the poor (45%) deliver in health facilities than their richer counterparts (67 to 94% from the second quintile to the highest quintile), and poorer women are more likely to deliver via a skilled birth attendant, often a midwife (National Population and Family Planning Board 2018). While access to health facilities (doctors in particular) are a major problem, especially in the more remote areas, this does not mean Indonesian women have no access to maternal health services across the country.

As seen in Figure 8, **midwives play an outsized role in providing maternal health in Indonesia.** This is not surprising, as ensuring the ready availability of midwives to improve reproductive and maternal health has been a priority area in Indonesia since the late 1980s through large-scale government programs, such as the village midwife program (*bidan di desa*). A similar trend can be seen for antenatal care (ANC) visits (52%) and postnatal care (PNC) visits (55%) provided by midwives (National Population and Family Planning Board 2018).

In fact, **private midwives make a significant contribution to FP and maternal service delivery:** 41% of all FP service provision, 35% of ANC, and 34% of midwife-assisted deliveries in Indonesia (National Population and Family Planning Board 2018). About half of all primary maternal health providers were private, and 44% of these private providers were midwives.

Figure 8: Percent distribution of birth attendants for live births in the 5 years before the survey, 2017

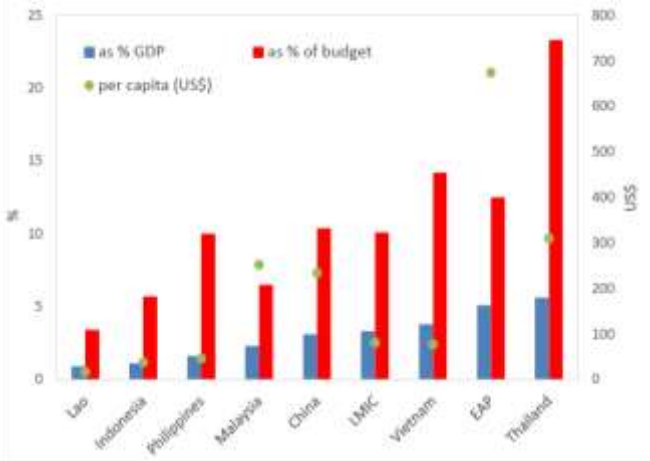


Source: IDHS 2017

HEALTH FINANCING CONTEXT

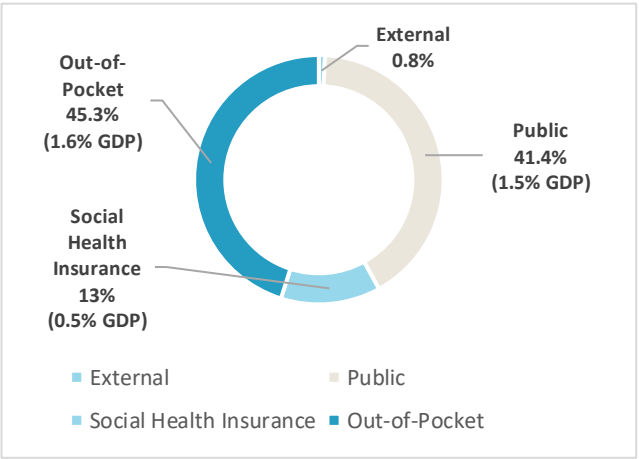
Indonesia lags behind its regional competitors (and global norms) in terms of government expenditure on health, and OOP payments make up nearly half of its total health expenditure, as seen in figures 9 and 10.

Figure 9: Regional comparison of public expenditure on health, 2014



Source: World Bank 2017

Figure 10: Total health expenditure by source, 2014 (% of total)



Note: Social health insurance only accounts for PBI-JKN (subsidized health premiums)
Source: World Bank 2017

However, current trends are encouraging, and Indonesia has recently seen a significant increase in government expenditure on health in absolute terms, as a percentage of total government budget and as a percentage of current health expenditure. The MOH accounts for 93% of government health

expenditure (BKKBN, the National Population and Family Planning Board, spends most of the rest), and MOH expenditure is rapidly growing (World Bank 2017).

Health is financed from general revenues and JKN premiums, but Indonesia's government revenue is influenced by fluctuating oil prices and undermined by a fragile tax base (10% of GDP) and weak tax collection systems (World Bank 2019). Growth in health expenditure has been partly financed by reductions in fuel subsidies under the Jokowi government and supplemented by sin taxes. Roughly 10% of the 150 trillion Rupiah (US$10.6 million) sin tax raised in 2017 was allocated to health.

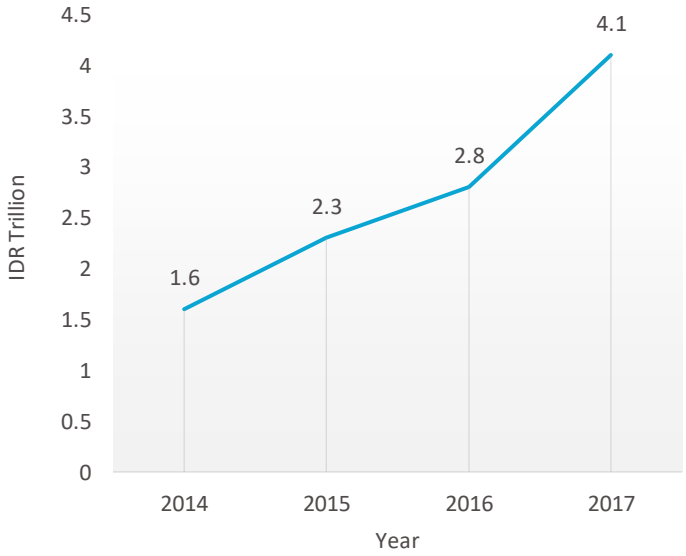
JKN is financed by premiums, but the Government of Indonesia uses general taxation to cover the poor through the *Penerima Bantuan Iuran* (PBI, or Premiums Assistance Recipient) scheme. This represents around 40% of BPJS-K income, or approximately 26 trillion Rupiah of 76 trillion Rupiah in 2017.

A key concern for the government is that JKN routinely overspends its budget, which amounted to 9.7 trillion Rupiah (US$700 million) in 2016, but this deficit is covered by general government funds. The rise of JKN since 2014 has significantly increased the proportion of Indonesia's current health expenditure through social health insurance (World Health Organization 2018).

There is also concern that the proportion of JKN expenditure going to PHC is low and falling. JKN law mentions "access" but not "allocative efficiency." The proportion of payment to PHC was 20%, but by 2017 it dropped to 17%. Causes for the decline in the proportion of funds to PHC include increased claims efficiency and up-coding of claims at the hospital level. It is also important to note that case-based group (CBG) rates at the hospital level have been increased, while the PHC capitation rate for PHC providers has been held steady. PHC is also being bypassed due to the poor quality of frontline workers (e.g., midwives recognizing warning signs of complicated pregnancies) and weak referral systems, especially between private and public providers.

An example of these shifting costs is the surge in the proportion of C-sections (57% of all deliveries covered by JKN) since JKN was launched. Figure 11 depicts the exploding costs of C-sections in just five years of JKN's introduction. A major reason for this is a payment system that incentivizes C-sections rather than primary care obstetric services. The increase in cost of C-sections was US$292 million in 2017, nearly five times the cost of normal deliveries at the PHC level. However, this increase in C-sections hasn't significantly contributed to MMR decline. Deeper analysis is also needed to understand how many of these C-sections were medically necessary, preferred by clients, or performed due to provider incentives or convenience.

Figure 9: Trends of BPJS Expenses on C-Sections, 2014-2017



Source: Authors' calculations using 2014-2017 data obtained from BPJS-K

OOP payments present a major challenge, and untangling where they come from provides interesting findings. A 2015 study that sampled patients across Indonesia found that nearly one-fifth of patients experienced OOP payments at health facilities, especially in the private sector and higher-level hospitals (Hidayat et al. 2015). More patients experienced OOP payments during inpatient visits (28%) than outpatient ones (13%), though this varied by region (e.g., more outpatient in Jakarta versus more inpatient in South Kalimantan). The major driver of OOP expenses was buying medicines (mostly outside of the facility), accounting for 70% of all OOP payments. What is interesting is that the incidence (percentage of each group) of OOP payments did not significantly vary across wealth quintiles. However, as Figure 12 shows, poorer patients faced a much higher burden of costs than richer patients for both outpatient and inpatient services. There is need for a deeper analysis of claims data to explore how five years of JKN implemenation has affected this health equity challenge across Indonesia.

Figure 10: OOP for outpatients as share of household income

Source: Hidayat et al. 2015

STRATEGIC PURCHASING IN INDONESIA

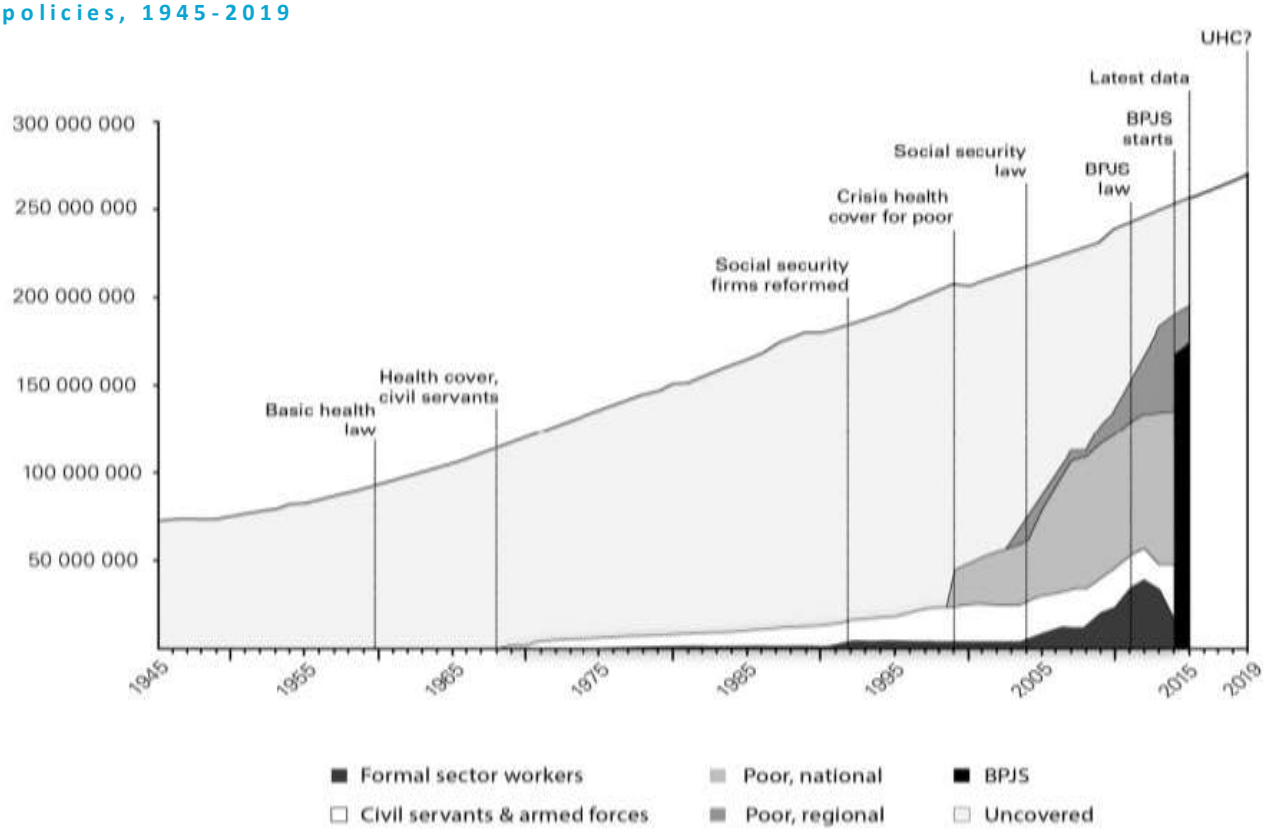
Purchasing refers to the allocation of pooled funds to providers of health services on behalf of a population. Purchasing is strategic if decisions about the allocation of funds are based on information about provider behavior and population health needs in order to maximize health system performance. This section will describe how JKN currently purchases from public and private providers, with a focus on maternal services.

Who Is Covered?

Combining and building from existing schemes, JKN targets the entire population, and current coverage exceeds 80% of the population, with the goal of progressively reaching full coverage by the end of 2019 (World Health Organization 2018). Gaps in JKN coverage are not among the poorest but rather those working in the informal sector (stakeholder interview, National Team for the Acceleration of Poverty Reduction, November 2017). Still, many of these informal sector workers are poor or near-poor and often difficult to reach. Poor people are enrolled free of charge (although they often know little of their rights and benefits).

BPJS-K currently puts most emphasis on enrolling wage earners, who should pay premiums. Only about 5% of the working population pays income tax, thus collection of premiums from wage-earning non-taxpayers is important. In addition, there is an ongoing effort to enroll employees of small- and medium-sized enterprises. All premiums are based on actuarial estimates. Figure 13 depicts how health coverage has evolved in Indonesia through several key health policies, including the introduction of JKN.

Figure 11: Trends in coverage of different segments of population with key health policies, 1945-2019



Source: Pisani, Kok, and Nugroho 2017

There are significant concerns about the impact of JKN on equity of service delivery. A recent analysis by Dewan Jaminan Sosial Nasional (DJSN), the National Social Security Council, shows that wage-earners (i.e., premium payers) consume more JKN services per head than the poor. However, causes of wage-earners consuming more services than the poor could include familiarity with health insurance (since they received insurance through previous programs like Askes and Jamsostek) and less social, cultural, or financial barriers.

Effective coverage may be limited by factors such as practical enrollment (i.e., lack of JKN identification cards), limited understanding of benefits, and physical access to accredited providers. National Socioeconomic Survey (SUSENAS) data suggest that over 20% of households that are covered by JKN do not report being covered (roughly 30 of the 167 million covered). Additionally, BPJS data show that poorer groups are less likely to claim maternity services, while DJSN research argues that flat provider payment rates (and especially capitation rates) do not sufficiently incentivize services in remote areas.

What Is Covered?

JKN's PHC benefits package includes 144 competencies, which include service administration, promotive and preventive services, medical examination, treatment, consultation, non-specialist medical acts, operative and non-operative procedures, medical supplies, and laboratory diagnostics (Adyas et al. 2018).

Reproductive and MNCH services covered in the package include ANC, deliveries (with or without complications), PNC, FP services and commodities, and standard health services for every newborn baby and child. The benefits package is supported with guidelines and protocols that formally forbid co-payments and upper ceilings, except for few types of care that are partially covered or fully uncovered (Mahendradhata et al. 2017). All Indonesians have access to the same benefits package of inpatient and outpatient specialty services, while the poor are fully covered by the government through the PBI premium assistance scheme.

The MOH defines benefits and sets premiums and provider payment rates, while BPJS-K functions principally as an administrative body. Criteria for determining which services will be covered prioritize total cost and fiscal impact, burden of disease, legal mandate to cover certain services, and, to a lesser degree, consumer preferences and financial protection (i.e., OOP spending). Benefits package design is led by the MOH with inputs from BPJS-K, DJSN, local authorities, and professional medical associations (Adyas et al. 2018).

Who Is Providing Services?

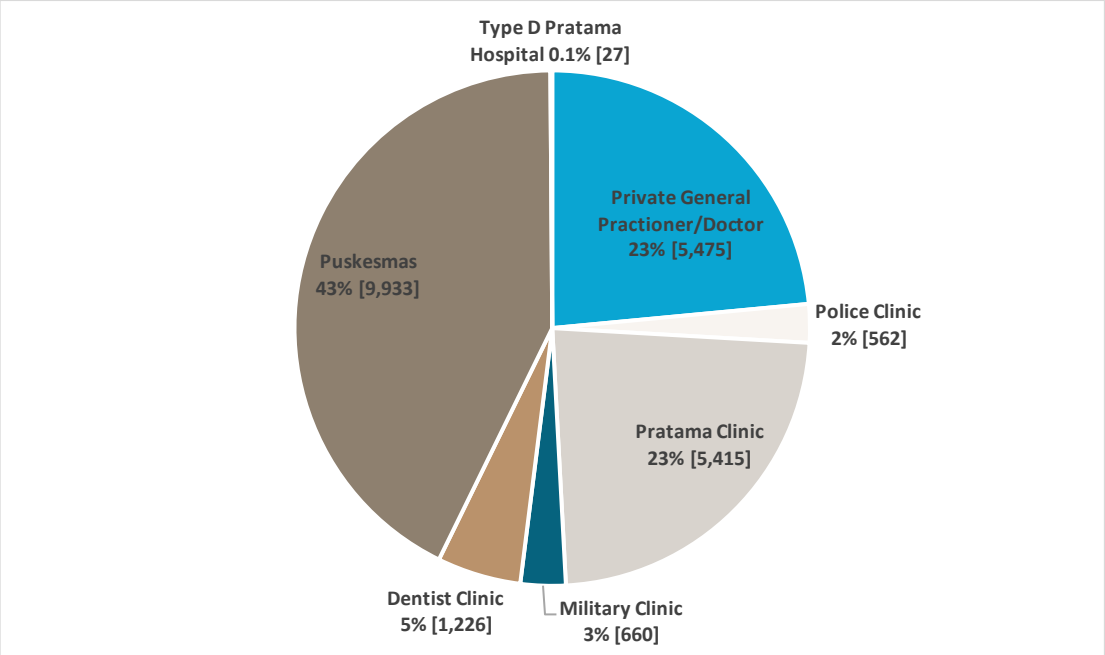
Indonesia has a range of public and private providers, from primary to secondary and tertiary levels. The public sector health delivery system is organized into three tiers:

- The primary care level, made up of frontline workers (e.g., midwives) and first-level primary health care facilities (FKTPs), such as *Puskesmas*, at sub-district levels.
- Secondary hospitals called Type C and D at the city and district levels.
- Tertiary referral hospitals at the provincial and central levels called Type A and B.

The private sector is not organized in a linked, tiered system or formally connected to the public referral system, though there are private providers at each level of the system (from midwives to Type B hospitals).

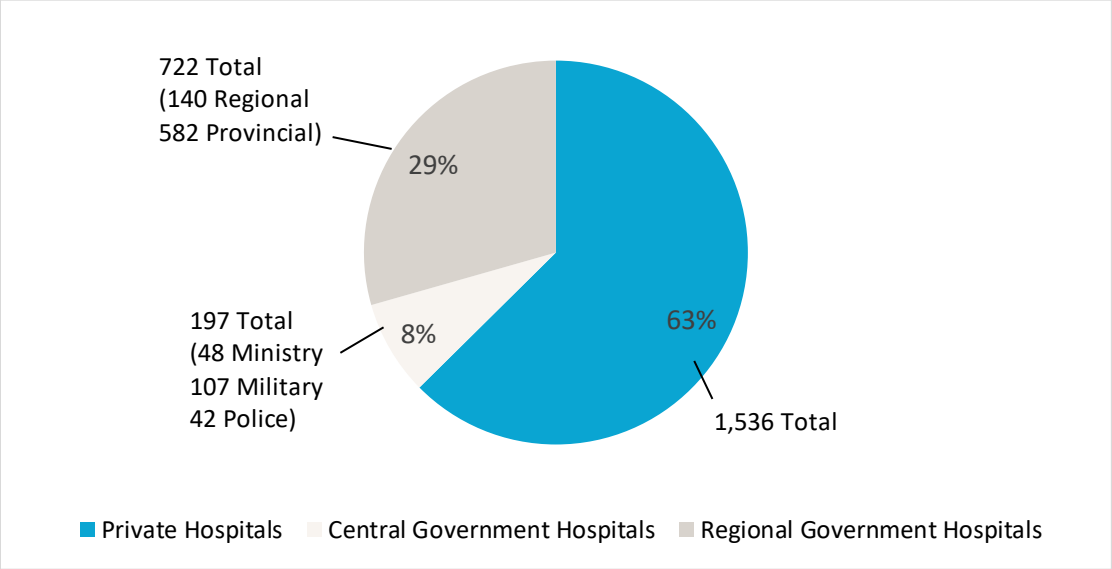
Since the introduction of JKN, the number of PHC level facilities and referral hospitals registered with JKN has grown at rapid rates. In the last five years, PHC facilities experienced a growth of over 26%, and referral hospitals saw 46% growth. Figures 14 and 15 show the breakdown of all facilities contracted by BPJS, and they show that Puskesmas make up the largest proportion at the primary level, while private hospitals dominate referral hospitals.

Figure 12: Proportion of PHC facilities contracted with JKN, 2018



Source: BPJS-K 2018

Figure 13: Proportion of referral hospitals contracted with JKN, 2018



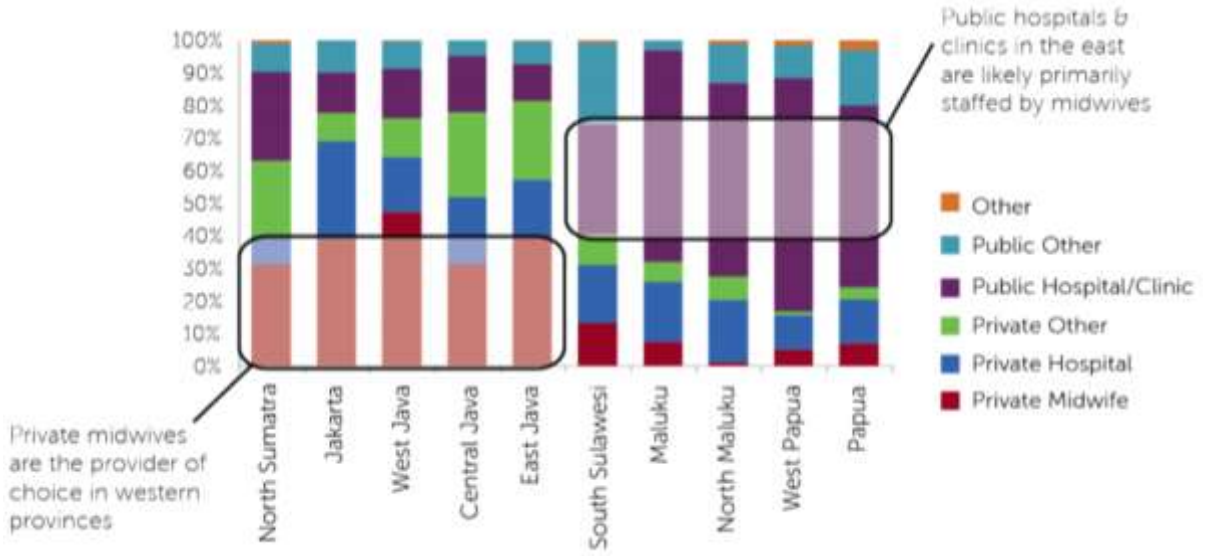
Source: BPJS-K 2018

The public delivery system limits referrals according to the level of care. JKN members are not allowed to receive treatment at referral hospitals without a referral letter from a PHC facility, except in emergency cases. Non-JKN patients can access any level of care, but they need to pay their own OOP fees. Many still do this due to convenience, long waiting lines at JKN-contracted providers, and lack of knowledge about benefits. There is also a referral back system from hospitals to PHC facilities, and the MOH has enacted policies to reimburse the hospital less if cases were not referred down appropriately.

Yet, **there are several challenges with the current functioning of the referral system**, including a lack of medicine available at lower-level facilities, poor recognition/knowledge of when to refer (especially among midwives), and low enforcement of appropriate referrals (World Bank 2018). The private sector does not have a coordinated referral system, leading to patients accessing services at higher levels of care than necessary. With the private sector making up a large proportion at all levels of the health system—a trend that is expected to expand—BPJS will need to develop policies that incentivize private providers to integrate in the formal referral system to improve efficiency and equity.

Private midwives supplement PHC public providers in several ways. As shown earlier, they provide a significant proportion of reproductive and maternal services, and they are often open when the local Puskesmas are closed (e.g., evenings and weekends). Yet, private midwives do not seem to be supplementing service delivery in geographic areas where there are fewer public providers. For example, there are high concentrations of private midwives in Java and Bali, where there already is a high density of public providers (Yap et al. 2017; Rajkotia et al. 2016). Figure 16 below demonstrates the sizeable role of private midwives for deliveries in certain provinces (those included in the figure represent a sample of urban and rural provinces) (Rajkotia et al. 2016). Not only are these midwives a major source of maternal care in urban provinces, but they also play a key role in the more remote ones, as they often staff the local hospitals due to the lack of doctors in these facilities.

Figure 14: Percentage of deliveries by source & urban/rural provinces, 2014

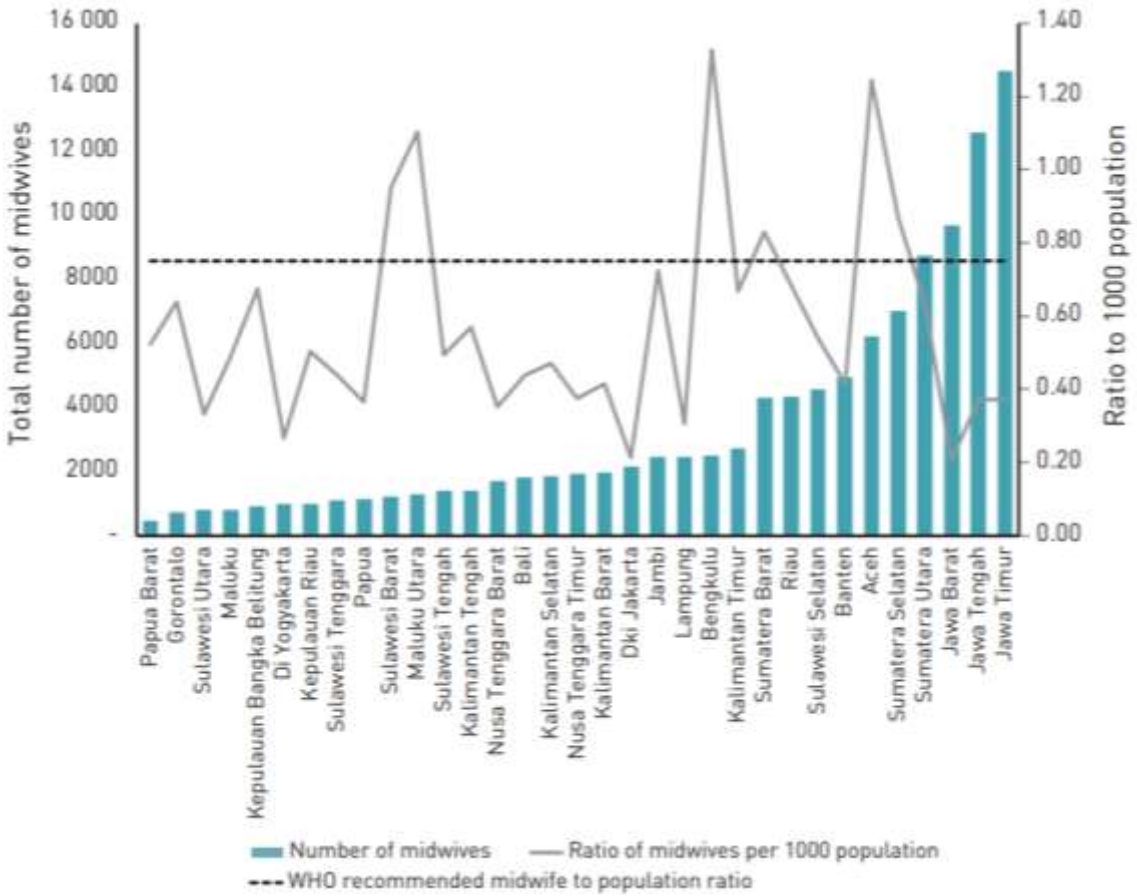


Source: Rajkotia et al. 2016.

There are approximately 250,000 currently practicing midwives who are registered with the midwives' association, Ikatan Bidan Indonesia (IBI), and licensed by the MOH (stakeholder interviews, Indonesian Midwives Association, November 2017). IBI records show that 40,000 (16%) of their members work exclusively in private practice, and many of those who work in Puskesmas will continue their private practice outside the working hours of Puskesmas.

Most private midwives engage in dual practice, largely unsupervised and unregulated. An evaluation of the rural midwife program in Bantem Province found that midwives obtain almost two-thirds of their income from private practice, and those that provide higher quality (as measured by the knowledge and experience of the midwife) receive more patients and income (Ensor et al. 2009). Dual practice was made legal in Indonesia to expand access of PHC services and ensure retention of health workers in the public sector. However, this can reduce the amount of health workers in rural areas, where it is less profitable than in urban areas, and result in more OOP payments. Figure 17 shows how midwife distribution changes from the remote areas such as Papua Barat to the more urban ones such as Java. Yet, MMR can still be disproportionately high even in areas with high ratios of midwives, which points to poor quality of services. More research needs to be done to understand how the introduction of JKN is affecting dual practice and how both practices of a single midwife can be contracted with JKN.

Figure 15: Midwife distribution and ratio to population, 2017



Source: Mahendradhata et al. 2017

While there is an adequate supply of midwives, there is wide variation in their training, certification, skills, and competence. There are more than 700 schools that train midwives. Accreditation for these schools is available from the National Clinical Training Network (NCTN), but many schools are not accredited, and their standards are variable. Licensing is the responsibility of the MOH, and IBI provides support by evaluating midwives every five years. The evaluation is based on a portfolio presentation by

the midwife and covers continuing education components, including clinical training, seminars, and workshops. Stakeholders have suggested that fewer than 250,000 midwives hold active current licenses.

Concerns over midwife competency are widespread and could be a key contributor to why MMR is stubbornly high. Recent studies have shown that both public and private midwives deliver poor quality of care, including such clinical skills as detecting maternal complications and ensuring timely referral (Yap et al. 2017; BAPPENAS et al. 2013; National Research Council 2013; Sharma et al. 2015). This is consistent with global literature that underlines the association between high MMR and low quality of skilled birth attendance. Improving the quality of midwife deliveries is especially vital, given that over 60% of all deliveries were assisted by midwives in the last five years, whereas doctors and obstetricians in hospitals only assisted 30% of all deliveries in the same period.

While JKN has the purchasing power to potentially leverage and incentivize better-quality provision, most private midwives are not contracted with JKN. IBI estimates that only 14,000 (5%) of private midwives are contracted with JKN. In contrast, BPJS-K reports that a total of 92,387 midwives are enrolled in JKN, with 82,607 of them public and only 5,734 private. Discrepancies in these numbers may result from definitions of private practice in a context where dual practice is legally supported and, in fact, the norm.

Private midwives are not considered to have the capacity to be contracted as an individual. Currently, doctors and midwives, not nurses, are legally allowed to have their own private practices. However, unlike doctors, the private midwife must subcontract with a PHC provider that can, in theory, control the quality of midwifery care. In practice, there is little evidence that facilities are closely monitoring and ensuring service quality of the midwives they are associated with.

In 2017, ministerial decree allowed midwives to be paid directly by BPJS-K. Claims must still be submitted through a PHC facility, but midwives can include bank details in their FKTP agreement. The claims are then passed on to BPJS-K, and payments are made directly to the midwife's bank account after claims are approved. BPJS-K described the change as "before, the midwives complained, and now, the Puskesmas complain" (stakeholder interviews, BPJS-K, November 2017).

In general, BPJS-K has different ways of contracting with public and private facilities. All Puskesmas are automatically eligible and mandated to contract with BPJS and provide JKN benefits, regardless of their licensing and accreditation status. Puskesmas are then mandated to undertake accreditation to ensure quality of care is provided. Private providers, such as private clinics, individual hospitals, or private general practitioners, may request to be contracted by BPJS once they accept the prices of the CBGs or capitation rates. BPJS-K only contracts with individual facilities, even if they are part of a chain or franchise.

To ensure quality at the PHC level, BPJS-K mandates that these facilities maintain the Minimum Service Standards for health care, which are set by the MOH. These Minimum Service Standards include the 144 competencies that Puskesmas must provide (World Bank 2018).[3] Protocols that include clinical practices of PHC services, national and regional referrals, and management of Puskesmas have all been designed to improve how well the services in the benefit package are delivered (Adyas et al. 2018).

[3] Minister of Health Regulation No. 5/2014 Clinical Practice Guidelines for Primary Care Physicians

Still, there is no electronic patient record system or strong tracking of the quality of care data that are available, which makes enforcement and strategically purchasing on quality indicators difficult.

During the contracting process, BPJS-K conducts credentialing of the facility as a measure of quality. This involves a selection process to identify service availability, license status of health care professionals, opening hours, locations, and other supporting services. BPJS-K then contracts the providers who pass the credentialing processes. The credentialing is reviewed annually and monitored monthly.

However, **the health provider system in Indonesia suffers from a weak infrastructure that varies significantly across the provinces.** Challenges include an unequal distribution of human resources for health (as seen in Figure 18) and geographical constraints that hinder access to essential medicines. Economic, sociocultural, and physical constraints to health services continue to limit demand as well (Agustina et al. 2018).

Figure 16: Distribution of health infrastructure index scores across Indonesian provinces, 2016

Source: Agustina et al. 2018

Indonesia has made strides to improve its health reporting system through the introduction of P-Care in 2014. This system allows primary-level health facilities to access patient data to improve the coordination and management of service delivery. However, private midwives do not currently have access to P-Care. Including private providers in this system would add a much-needed way for JKN and the government to monitor these providers and to understand the volume, distribution, scope, and quality of services they deliver.

How Are Services Purchased?

JKN uses a range of payment mechanisms for health services from different types of providers. Public and private PHC providers contracted with BPJS are paid via monthly capitation and non-capitation reimbursement (fee-for-service, or FFS), while secondary and tertiary providers (FKRTLs) are paid through case-based groups (CBGs) for specific inpatient and outpatient services (see Figure 19). These CBGs cover medical fees, medicines, consumables, medical devices, and other hospital services related to a case. Both public and private hospitals claims are based on CBG payment set by the MOH, with prices adjusted by differences across the five regions. On the other hand, the capitation payment is

based on the number of members registered, and providers are paid in advance and are expected to fund non-specialty, PHC services. This is supposed to implicitly incentivize gatekeepers to reduce frequency of visits and increase service quality. More research is needed to investigate whether this is really occurring.

PHC capitation payments are higher for private providers who receive 8-10,000 Rupiah per member per month (US$0.60-0.70) compared to 3-6,000 Rupiah (US$0.20-0.40). The reasoning for this discrepancy is that public PHC providers receive budget allocations from the government. However, out of a total of IDR 11 trillion claimed for capitation in 2017, 7 trillion was paid to Puskesmas and only 4 trillion to private clinics (stakeholder interview, National Team for the Acceleration of Poverty Reduction, November 2017).

Still, **there are challenges with PHC facilities effectively using these capitation payments.** Many public PHC facilities do not have the autonomy to use the funds without authorization from the local authority, or they often do not have the in-house public financial management and accounting skills to appropriately use these funds even if they have local approval. Thus, providers are often unable to invest funds back into their facilities and workers, which results in more referrals to higher-tier facilities and unused capitation money sitting at the local authority level (Adyas et al. 2018).

BPJS-K pays fee-for-service for obstetric and neonatal services. BPJS-K incentivizes specific PHC services (i.e., non-capitation services) through claims reimbursement, including first-line midwifery care, pregnancy and postpartum examination, ANC, normal delivery, ambulance services, health screening, and specific FP services (Fachrurrazi n.d.; World Bank 2018). In 2015-2016, FP and MNCH represented nearly 71% of all non-capitation FFS claims reimbursement at the PHC level. More analysis needs to be conducted to study the trends in claims distribution since then. Figure 19 lists the non-capitation reimbursement rates for key maternal services at public and private PHC providers.

Figure 19: Fee reimbursement rates for public and private PHC providers

Service	Reimbursement
Antenatal care	IDR 200,000 (US$14); based on standard four-visit package at one location. In case ANC is not delivered in one location, the reimbursement is paid per visit at IDR 50,000 (US$3.5).
Normal vaginal delivery	IDR 700,000 (US$49) and IDR 800,000 (US$56) by midwives and doctors, respectively
Vaginal delivery with complication conducted in EmONC facility	IDR 950,000 (US$67)
Postnatal care	Three visits for both new mothers and babies, IDR 25,000 (US$1.75) for each visit
Post-delivery procedure conducted in EmONC facility	IDR 175,000 (US$12.3)
Pre-referral complication management	IDR 125,000 (US$8.8)

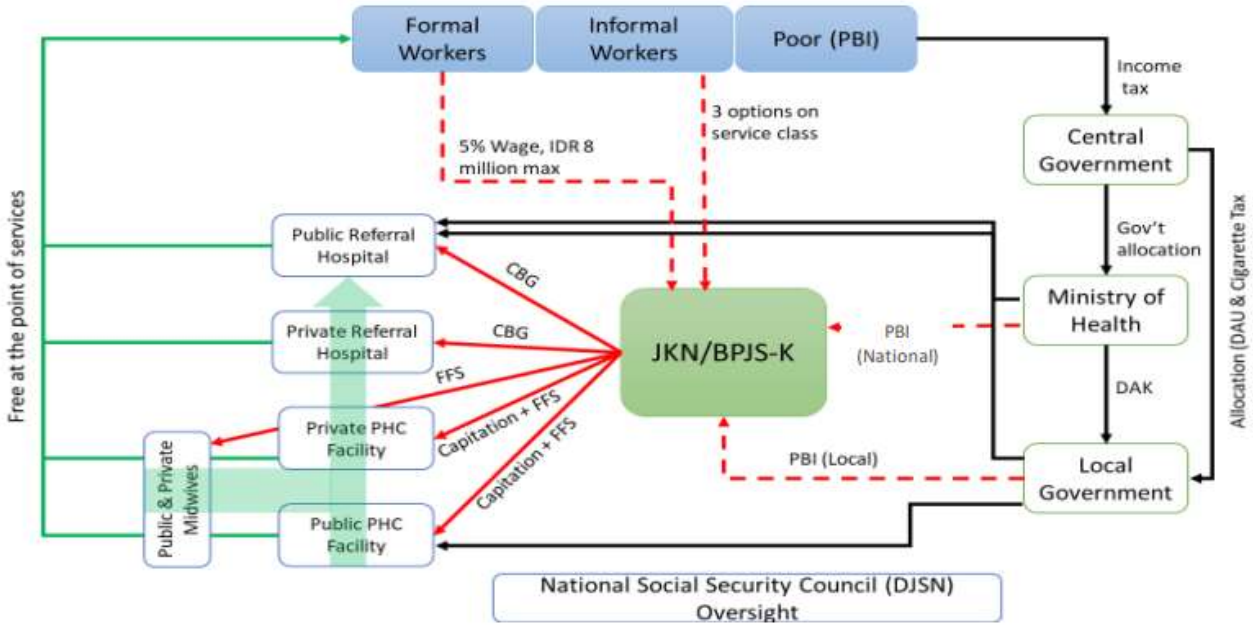
Source: Ministry of Health 2016

Non-capitation (FFS) rates are not different at public versus private providers, in contrast to capitation rates. In addition, market price for maternal services in the private sector is often significantly higher

than the BPJS-K reimbursement. For instance, the BPJS-K rate for normal delivery is IDR 700,000 (US$49), while private providers claim the market price is double this amount. These rates suffice for public providers because the government covers their salaries and capital investment, thus heavily subsidizing them. Ultimately, current payment rates for these services do not appear to have been set with the goal of stimulating the private market in Indonesia. This is problematic because use of services from private providers is common and the private sector is growing. Also, enrolling these providers could be an effective strategy in integrating the referral system, reducing OOP payments, and incentivizing certain PHC services or improved quality.

Figure 20 provides an overview of how the funds should flow under the JKN system, from government institutions to public and private providers to the people. The black lines represent tax or budget allocations, the checkered red lines represent contributions, the solid red lines represent payments or claims, and the green lines represent health services. In this ideal world, there are no OOP payments, and public and private providers are working in sync through a well-functioning referral system.

Figure 20: Diagram of fund and service flows under JKN



Source: Authors' own work

OPPORTUNITY TO INCLUDE PRIVATE MIDWIVES IN JKN

There are several reasons why empaneling private midwives into JKN is a significant opportunity.

First, women experience unnecessary OOP expenses for maternal health services that would be covered by JKN. In Indonesia, the large proportion of OOP spending is a highly regressive impact on the poor (World Bank 2016b). Midwives perceive a high willingness to pay out-of-pocket by their clients, as evidenced by the quote below:

> *They know that we cannot provide free service for BPJS-Kesehatan members, and that is okay with them. They rather pay than waiting a long time at Puskesmas. Sometimes, for FP for*

example, they come bringing the medication and ask for me to inject it. Then basically I just charge them the fee of the needle and other consumables.

Midwife in DI Yogyakarta

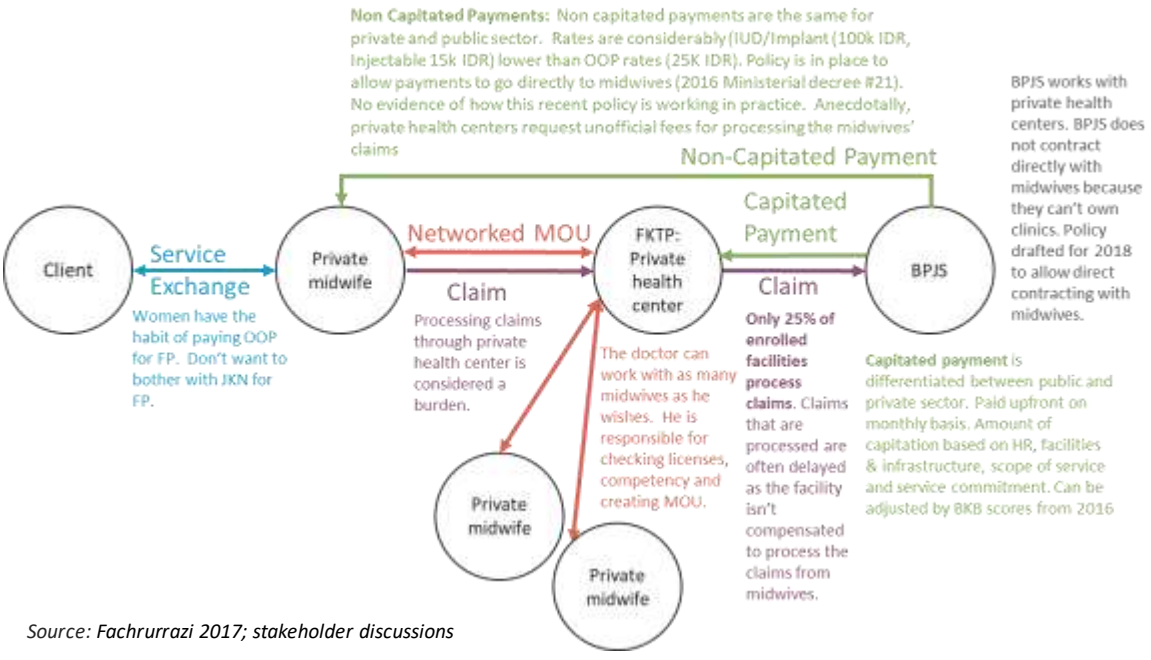
Studies have shown that JKN empanelment is associated with better readiness and quality in Indonesia (Yap et al. 2017). Once these private midwives are in the JKN system, existing licensing and accreditation standards can be designed and applied (with assistance from associations like IBI) in a more systematic way, while more sophisticated provider payment mechanisms can be employed to incentivize better quality. Moreover, including this cadre into JKN is critical, as they already comprise a trusted, consistently utilized entry point into the public health system. Including private midwives into the JKN system responds to patients' preference for midwives (Figure 8) and can improve appropriate referrals by midwives to doctors and hospitals.

Health expenditures have been trending away from PHC and more toward more costly, higher-tier services. This has contributed to the rising costs of JKN. Investing in measures to include the already existing and accepted infrastructure of private midwives who provide maternal services and PHC into the JKN system can help increase the claims coming in at the PHC level and counteract these cost patterns. However, there are several challenges that make this option difficult to implement.

BARRIERS TO ENTRY INTO JKN FOR PRIVATE MIDWIVES

The range of challenges that private midwives face in joining JKN, from contracting to reimbursement, are summarized in Figure 21. These include the complexity of registering for JKN, submitting claims through the facility, low reimbursement rates for FP and MNCH services, and delayed reimbursement through the facility where midwives often cannot check the system for updates and often get charged a processing fee by the facility. The green text relates to payment issues, the purple to challenges around reimbursement claims, and the blue to OOP payments from the patient.

Figure 21: Diagram of challenges private midwives face in joining JKN



Source: Fachrurrazi 2017; stakeholder discussions

A major barrier to private midwives joining JKN is that Indonesian midwives cannot currently contract directly with BPJS-K. Midwives must work under a first-level health facility (either public or private). For a PHC facility to contract with BPJS-K, it is required to have midwives under contract, and the midwife Memorandum of Understanding (MOU) with these facilities should be renewed annually. Through this mechanism, BPJS-K has effectively delegated responsibility for credentialing midwives (and the monitoring of the quality of their provision) to the local PHC facility under which they work. Earlier sections reviewed how quality is a major challenge in Indonesia, especially among midwives and the maternal services they provide. The quote below from the MOH demonstrates their hesitance to directly contract with private midwives.

> *Even right now when they [midwives] are partnering [with the primary health care facilities], the monitoring and evaluation system is not working. What will happen when they can work independently? Who will oversight them? Puskesmas cannot do that, neither IBI. [Ideally] District Health Office should partner with local IBI chapter to do this.*
>
> Ministry of Health

There are also administrative issues on the oversight end of this contract, as many of the processes fall to overburdened facilities that may not update their systems often. This is highlighted in the quote below:

> *We only say that "Oh, that clinic [primary health care facility] has a partnership with this midwife." We also cannot guarantee the up-to-date data on this. We do input the human resources data at first, but it is the facility's responsibility to update the information if there is any change. We also do not know if the midwife is a private midwife or a public servant who opens a private practice in the afternoon. We also do not have any credentialing system for the network in place.*
>
> BPJS-K

Another challenge to private midwife inclusion into JKN is that reimbursement rates for maternal services are perceived to be too low. Again, non-capitation reimbursement rates are the same for public and private providers. Private PHC providers do not receive government subsidies for such costs as salaries, thus the price for a service like a normal delivery is deemed to be too low at IDR 700,000. This fee covers professional services, consumable drugs or materials, food, and a room for about two days per delivery. The chairperson of IBI noted that the minimum price of delivery should be at least double this (IDR 1.5 million).

Since many women are willing to pay higher prices OOP, private midwives have little incentive to go through the complicated processes to be part of JKN, then also receive less than they would directly from women. Furthermore, not only is the reimbursement level low, but there is also the complexity of what can be claimed through JKN, exemplified in the quote below:

> *Even though my contract says that I can claim the reimbursement for ANC, I do not do that. We only claim for delivery. This is because it is just too complicated. There are only four visits covered by BPJS-Kesehatan, although the patients usually come every month. You need to wait until four visits, spread along three trimesters. Often, the patients will move to give birth near her family and will not complete the third trimester visit with me, and I lose the eligibility to claim.*
>
> Midwife in DI Yogyakarta

Another major challenge to the reimbursement process for private midwives is the delay in reimbursement, due to having to contract with a local facility. Significant delays, between six and nine months between midwife service and reimbursement, were reported by the National Team for the Acceleration of Poverty Reduction based on public expenditure tracking studies. There were delays in claim preparation and submission from Puskesmas, delays in processing and payment at BPJS-K, and delays in local government in passing reimbursements back to midwives. BPJS-K only routinely monitors how long it takes from when they receive a claim to when they process a payment, and BPJS-K has a 15-day target and metrics that feed into a director-level performance assessment. One of the reasons behind the delays is that Puskesmas absorb large local government budgets and, therefore, the small number of claims submitted by a single private midwife are not prioritized. This is far from an ideal situation for a private midwife who is heavily dependent on monthly revenue, as can be seen in the quote below:

> *We have to submit the claim through the primary health care facility, and it takes ages. There used to be 10% administration fee, but now BPJS-Kesehatan wires the money directly to us. But we have no clue about the item they reimburse and for which month. Now I just stop thinking about it. If the money comes, it is good, if it is not, money is not everything as I still have the opportunity to help people*.
>
> Midwife in DI Yogyakarta

Private midwives have challenging relationships with the local facilities through whom they need to submit claims. Midwives have suggested that informal payments ("processing fees") back to the PHC facility are the norm. BPJS-K has suggested that midwives formalize arrangements in their agreements with their PHC facility when annual MOUs are updated. However, private midwives experience a lack of access and control over BPJS-K information about their claims and often have no access to P-Care. The lack of accountability is highlighted in the quote below:

> *At some occasion, Puskesmas does not want to partner with private midwives. It has its own set of rules, but it is not written so do not know how to report this [to the government].*
>
> Midwife in Purworejoj

POTENTIAL POLICY OPTIONS

After careful review of the data and literature, as well as conducting multiple IDIs and FGDs with key health system stakeholders, **this landscaping report recommends exploring how to increase the value proposition to private midwives to join JKN.** Since maternal mortality is a persistent challenge in Indonesia and private midwives play a substantial role in maternal service provision, the government can employ techniques to crowd in private midwives into JKN, which opens the door to strategic purchasing approaches and complementary actions to incentivize improved quality of maternal health services. Reorienting the system toward these PHC providers can increase efficiency and rationalize some costs of JKN and OOP payments.

This report identifies several policy options that could be explored. The first three aim to increase the value proposition for private midwives to join JKN. The fourth option seeks to address the concerns of the MOH around ensuring readiness and quality among these critical providers. These options could be explored in more detail through a pilot process. Consensus should be reached across key stakeholders,

including the MOH, BPJS-K, district/city authorities, IBI, relevant provider associations, and patient groups. The MNH Technical Working Group (TWG) in Indonesia can be a forum to share these ideas, design analytics and pilots, and build consensus and buy-in. The SP4PHC project in Indonesia can help guide this process, if these stakeholders are interested.

Recommendation 1: Reduce the administrative burden in JKN contracts, especially for submitting claims and getting reimbursed

- A major barrier cited by private midwives to contracting with JKN was the requirement to contract and submit claims through a local PHC facility. This arrangement causes issues such as complicated administrative processes, delayed reimbursements, and lack of access to reimbursement tracking services (i.e., P-Care).
- One option a pilot can test is streamlining the payment process by allowing private midwives to directly submit claims to and get reimbursed by BPJS-K.
- Instead of direct contracts with individuals, another option that can be pilot tested is having a network of private midwives contracting with a specific PHC facility. This service delivery network would be a system for greater coordination in patient management and payment, such as submitting claims that track and cover services throughout a woman's pregnancy and delivery. This system would also require PHC facilities and private midwives to submit joint claims for services, thereby incentivizing both parties to fully process JKN reimbursements.
- Careful consideration needs to be taken around the administrative capacity of the local JKN offices to implement these options. For example, local JKN offices may not have enough personnel to receive and process the volume of claims from individual direct contracts.
- In both cases, private midwives need greater transparency in the claims process. In order to become more informed providers, it is essential that private midwives have access to patient information and payment tracking systems.

Recommendation 2: Increase take-home pay for key FP and maternal health services

- Another constraint cited by private midwives and IBI was the reimbursement rates for maternal services, such as deliveries, which were much lower than what they receive directly from the population.
- A pilot could test whether increasing the amount private providers (including midwives) take home for key maternal services incentivizes private midwives to join and receive payments from JKN. This could be through an increase in reimbursement rates or top-ups for specific services.
- Deciding which services will be associated with this increase will be key, reflecting population needs and costs. This action is similar in strategy to how capitation payments are different between public and private PHC providers.
- Careful consideration must be applied to what the average unit costs will be for each type of service, because costs may be higher where population densities and utilization rates are low. Consideration must also be paid to the health systems and political risks associated with raising the rates for a specific set of providers.
- For instance, the pilot could design a higher reimbursement fee multiplier in underserved areas, with regular dynamic adjustments to the fee as empanelment and claims increase.
- More sophisticated strategic purchasing mechanisms can be applied once private midwives are within the JKN system and the administrative processes are ironed out. In fact, the purchasing signals that JKN can send to private midwifes are likely to be clearer and less cluttered by government funding than signals sent to public providers. This approach could be used to crowd in midwives to serve areas that are not catered for by public or private health facilities.

Recommendation 3: Test different options to entice private midwives to contract with JKN

- To further build immediate demand for empanelment among private midwives, pilot designs can incorporate and test different sign-up incentives.
- This could include grants for capital investments to equip and stock, loans against future reimbursements, voucher schemes for signing up, or temporary grants.
- Consideration will need to be taken about what incentives would best match subnational contexts, especially among the diverse settings across the regions. Special attention should be paid to try to attract midwives in remote areas where access is a challenge.
- Provider associations, like the IBI, should be consulted in order to better understand the pros and cons of each potential option.

Recommendation 4: Increase empanelment of private midwives into JKN and progressively improve quality

- The MOH has legitimate concerns over empaneling private midwives without having assurances about the quality standards of their provision.
- The pilot could directly empanel private midwives and subsequently provide training and credentialing options, as well as set up supervision processes through agencies like the IBI. This process could be analogous to how Puskesmas are automatically enrolled in JKN, and then quality standards are monitored and improved.
- There could be a progressive leveling-up of standards for private midwives, with different tiers of standards applied on an interim basis. This could be carefully planned with renewal processes.
- One example would be to require training minimums (e.g., licensing by IBI) to be completed at the end of Year 1. Otherwise, JKN payments to these midwives would stop.
- Agree upon routine quality indicators that can be linked with prices and payment schemes. Pilots can test different permutations of quality-based strategic purchasing

CONCLUSIONS

Indonesia has a unique opportunity to use its powerful vehicle for UHC, JKN, to ignite its existing yet disincentivized private sector to help meet its objectives, especially around maternal health. While access to maternal services is reasonably strong, Indonesia still suffers from disproportionately high maternal mortality. In Indonesia, there is a long-standing infrastructure of private midwives that provide a considerable proportion of maternal services to Indonesian women. Unfortunately, these private midwives often have weak pre-service training from non-accredited institutions and are not rigorously monitored and supervised on the quality of their provision. The purchasing power of JKN provides an opportunity to incentivize higher-quality maternal services for providers enrolled in its system and reduces unnecessary C-sections through a variety of strategic purchasing mechanisms. However, this is not currently happening because most private midwives are not empaneled by JKN, which is a major gap in the Indonesian health system. Thus, purchasing currently from these private midwives is largely OOP.

This report provides a variety of approaches that can increase the value proposition of joining JKN for private midwives. Once this cadre of health providers is inside the system, more sophisticated strategic purchasing techniques can be tested to incentivize increased quality of provision and efficiency across the delivery system and help reduce rising costs. By no means does intervening with private midwives address all the issues around PHC and health system issues in Indonesia. Still, by crowding in the private sector, Indonesia can address a critical gap in maternal health provision and move Indonesia closer to its stated goal of UHC, in which all women are ensured a safe and healthy motherhood.

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