JLN Learning Exchange on Strategic Health Purchasing in Decentralized Contexts for Indonesia

Convened by the Health Financing Revisited and Provider Payment Mechanisms Technical Initiatives

April 19, 2017

Washington, D.C.

Key Messages

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Background

As countries move toward universal health coverage (UHC), they are faced with the ongoing challenge of generating sufficient resources to provide access to necessary health services with financial protection and ensuring total expenditures are fiscally sustainable. Making progress toward UHC is costly, particularly as coverage expands to populations with higher health needs, utilization of services increases as financial access barriers are reduced, and available technologies drive up costs further. Countries often face sustainability challenges as expenditures increase faster than revenue, often very early on in new UHC programs. In Ghana's National Health Insurance Scheme (NHIS) launched in 2003, for example, expenditures exceeded revenue for the first time in 2012 and the NHIS reserve fund was completely depleted in 2015 requiring a government bail-out of the Scheme. Indonesia's national health insurance system, *Jaminan Kesehatan Nasional* (JKN) was launched in 2014 and already encountered deficits in 2016.

Therefore sustainable progress toward UHC not only requires that governments allocate adequate funding to the health sector within macroeconomic and fiscal constraints, but it is also essential that resources are allocated and used most efficiently. How public health funds are used to purchase services and medicines for the population is a key lever that countries have to improve efficiency while expanding access to and quality of services. Countries such as Thailand that have achieved UHC or achieved significant progress with a relatively low level of resources employ **strategic health purchasing** levers to get the most value for government health spending by creating incentives for efficiency and sharing financial risk across purchasers and providers of care. In decentralized settings, the strategic purchasing power of national purchasers may be diluted as subnational governments have authority over many decisions that affect resource allocation and incentives at the local level. Furthermore, financial risk may be shifted to the purchaser as subnational governments make investment and other decisions that drive up health care costs. Indonesia is facing similar challenges encountered by many countries simultaneously implementing a national health insurance system with a single purchaser and a high level of fiscal decentralization and local government responsibility for health service delivery. There is an opportunity to learn from the experience of peer countries as Indonesia continues to shape its policy responses to the challenges of decentralization (See Appendix 1). The Joint Learning Network for Universal Health Coverage (JLN) provided the opportunity for this learning exchange. The JLN is a community of practitioners and policymakers from around the globe who share knowledge and co-develop new tools, guides and resources that address the practical challenges of health systems reform to achieve universal health coverage (See Appendix 2).

The Learning Exchange

A half-day learning exchange was hosted by the JLN Health Financing Revisited Initiative (facilitated by the World Bank) and the Provider Payment Mechanisms Initiative (facilitated by R4D) on April 19, 2017 in Washington, D.C. as a side event of the Annual UHC Financing Forum. Delegations from four countries participated in the learning exchange: Indonesia, Argentina, Chile, and Nigeria (See Appendix 3).

The objectives of this JLN learning exchange were to:

- Create an opportunity for Indonesia to learn from other countries facing the challenge of implementing a national UHC program in a highly decentralized context
- Share experience across several countries on the specific implementation challenges of strategic health purchasing in decentralized settings, practical solutions, and other learnings from experience

building effective models of strategic health purchasing and financial risk-sharing in decentralized contexts.

- Explore country demand for a deeper JLN engagement on this topic

Key Questions

The purpose of this **JLN Learning Exchange on Strategic Health Purchasing in Decentralized Contexts** is to provide Indonesia with access to experience from peer countries through a facilitated ½-day learning exchange meeting. The meeting will provide an initial opportunity for countries to share experience on the implementation challenges, practical solutions, and other learnings from experience building effective models of strategic health purchasing and financial risk-sharing in decentralized contexts. Specifically, the learning exchange will explore country experience with the challenges of:

- Allocating purchasing responsibilities across national and subnational levels clearly and effectively
    - What is an effective allocation of purchasing responsibilities between national and subnational levels of government?
    - How does a national purchasing agency effectively engage with subnational governments?
    - How is the allocation of purchasing responsibilities across national and subnational levels of government operationalized? E.g. regulatory frameworks, local branches of national purchasing agencies, platforms for dialogue and decision making, etc.

- Ensuring a balance of financial risk, roles and responsibilities across the national health purchaser, subnational governments, and health care providers
    - What approaches and mechanisms can effectively distribute financial risk? E.g. performance-based contracting between the national purchaser and sub-national governments, and purchasers and providers
- Putting effective accountability mechanisms in place.
    - What mechanisms are effective to ensure accountability and how do they function within decentalization laws and regulations?

Country Experience

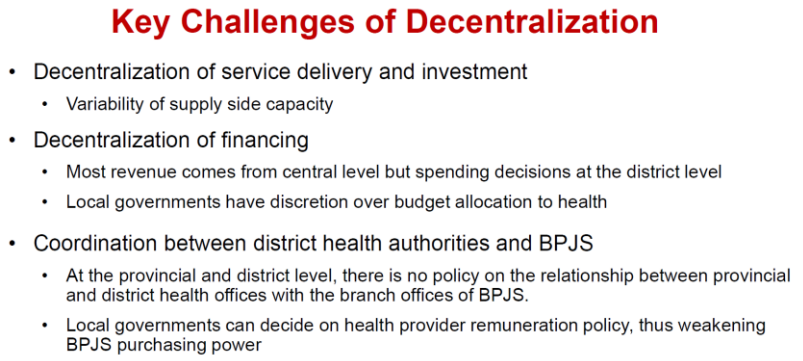
Indonesia

With over 60% of the country's population having coverage under the newly-unified JKN, Indonesia now has one of the largest social health insurance programs in the world, at least in terms of population coverage. JKN funds flow through a single health purchasing agency, *Badan Penyelenggara Jaminan Sosial* (BPJS). However, at present only about 15% of total health expenditures come from JKN and there remains significant co-financing from supply-side budgetary expenditures at public facilities. The government plans for everyone to have coverage under JKN and, by doing so, aims to attain UHC by 2019. Indonesia has developed a roadmap to achieve universal health coverage by 2019 as part of implementation of the Health Social Security Act.

There are concerns, however, about the ability of Indonesia to attain UHC by 2019, not just in terms of population coverage but more so in terms of other equally (if not more) important dimensions of UHC related to service coverage and financial protection. Despite recent increases, the level of public financing for health remains low and the country faces a tighter macro-fiscal environment on the one hand versus a growing demand for and utilizat\ion of health care on the other. At the same time, JKN expenditures are increasing more rapidly than revenues, and financial sustainability has recently emerged as a concern. The Ministry of Finance recognizes that the spending per member per month is exceeding revenue per member per month, and while the MOH and BPJS proposed to revise the premium-setting to reflect the increasing costs, but the MOH for now has opted to provide additional funds close the gap without a longer term adjustment to the premium. There is recognition on all sides that a focus on improving the efficiency of public financing will be necessary for sustainable progress towards UHC.

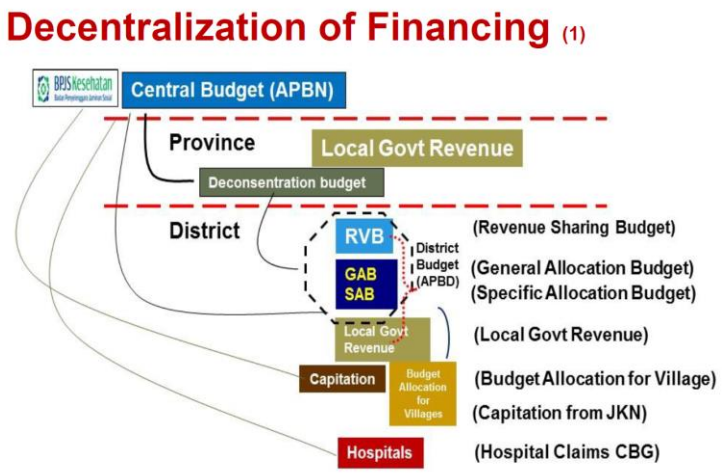
Decentralization and Strategic Health Purchasing in Indonesia's JKN

The extent of decentralization in Indonesia means that local governments are not obligated to harmonize their policies, such as investment decisions and health provider remuneration policies, with national policies such as those related to health purchasing. There is a highly variable service delivery structure with uneven capacity, and sometimes a mismatch between investment and the service delivery needs of the population. There is indication of local governments (1) redirecting local budget funds to pay JKN premiums as they integrate Jamkesda into JKN; (2) reducing budgets for primary health care in response to JKN capitation revenue at the facility level; (3) over-investing in hospitals; and (4) not effectively pursuing private sector investment or public-private partnerships to fill capacity gaps. Furthermore, the investment decisions of the local governments have financial implications for BPJS, which bears a growing responsibility for funding recurrent costs, and curative services that are covered by JKN and paid per service may be crowding out public health services, which are still the responsibility of local governments.



On the other side, local governments and BPJS district/city health offices do not have access to BPJS claims and utilization data, which are sent directly to the national level. This deprives local governments of useful data to make investment decisions and leaves little incentive to improve data quality. There does not seem to be an organized platform for dialogue at the local level between local governments, district/city health offices, and local BPJS branches to harmonize planning of health infrastructure and implementation of JKN.

Finally, decentralization exacerbates the lack of coordination and inefficiencies created by fragmentation in funding across different programs and services. For example, the capitation payment BPJS makes to puskesmas and private clinics for primary health care (PHC) includes payment for immunization services, but the vaccines are provided by local government, other operational expenses (e.g. vaccine delivery, surveillance) are funded from central government grants, and some immunization services are delivered by schools. The fragmentation in funding compounded by variation in local government fun ding levels and mechanisms greatly impedes strategic purchasing of immunization services and other priority programs.



Distribution of Functions, Financial Risk, and Accountability

Under JKN, the distribution of health purchasing functions is clear for some functions. For example, the national government agencies (MOH and BPJS) have responsibility for overall stewardship of the program, defining the benefits package, and designing provider payment systems for covered services, and paying providers. The local government has responsibility for service delivery and investment decisions on the supply side. There is some lack of clarity on setting provider remuneration rates, where the local government has some authority, as well as the rules for how providers can use JKN funds. There are no clear financial risk-sharing arrangements, and local governments have wide authority to make decisions that increase financial risk for the national JKN, especially supply side investment decisions and funding for public health, which when neglected can shift additional curative care costs to JKN. The MOH has tried to address this through the Healthy Indonesia Program as a priority program to strengthen promotive and preventative activities at primary care level since BPJS spending on non-communicable disease management (NCDs) has been inadequate and referrals have increased significantly. Local government will be accountable for maintaining minimum service standards for NCD management. Finally, accountability mechanisms are weak for both the national JLN agencies and local government.

Table 1. Distribution of Functions, Financial Risk, and Accountability in Indonesia's JKN

Key questions	National Government Role	Local Government Role
Distribution of health purchasing functions	Overall stewardship Program design Benefits package (but not clearly defined) Provider payment design for JKN services Provider payment (transfer of funds) for JKN services Monitoring health provider performance	Service delivery Investment decisions in supply side Payment for public health services Some authority over provider remuneration and rules governing use of funds
Financial risk-sharing arrangements	No sharing of risk with local government	
Accountability mechanisms	No accountability of local government to national health authorities	

Argentina

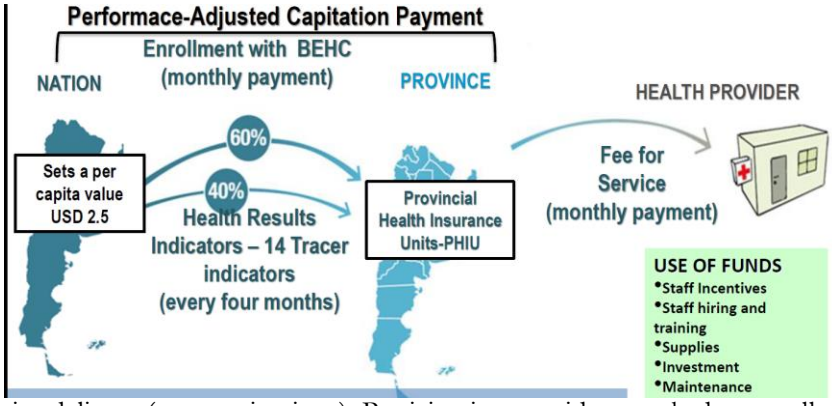
Argentina is a federal nation with 23 provinces and an autonomous city, Buenos Aires. The population is about 40 million. The constitution has guaranteed universal health coverage since 1994. At the time the public health system was also decentralized reflecting the government's federal structure, with provincial governments taking primary responsibility for providing health services and most public health financing flowing through provincial health offices. Formal sector workers received health coverage through the social security system, *obras sociales* and private services, but with high unemployment most individuals received coverage through the public service delivery system. The public delivery system was chronically underfunded. Health funds flowed from the national to provincial budgets with no strings attached, so the national Ministry of Health had little leverage to ensure efficiency, accountability or impact of provincial health spending on health outcomes.

Program Sumar

In Argentina, Program SUMAR - a national program with local as well as international funding - provides health coverage for close to 15 million people across the country who do not have formal health insurance. Program SUMAR is an expansion of Plan NACER, a federal program of the National Ministry of Health launched in 2004 to address the health impacts of the economic crisis by strengthening the public health system to reduce maternal and infant morbidity and mortality rates. Plan Nacer specified a package of priority maternal and child health services for coverage. The program had five components:

- Legally binding agreements between national and provincial health ministries
- Enrollment of health providers
- Enrollment of target population
- Increased funding for delivery of priority services
- Improved use of information for record-keeping, reporting, audits, and evaluation

Plan Nacer staff established contractual relationships between central and provincial health ministries and between provincial health ministries and public providers. At the national level, the Ministry of Health determined the health targets the provinces were expected to achieve across 10 performance indicators, including health outcomes (e.g. birthweight), and service delivery (e.g. vaccinations). Participating providers worked to enroll eligible people, and enrollment was voluntary. Once enrolled, the beneficiaries were entitled to receive the package of covered services for free and providers bill them to the Provincial Health Insurance Unit (PHIU) in a fee for service payment scheme.

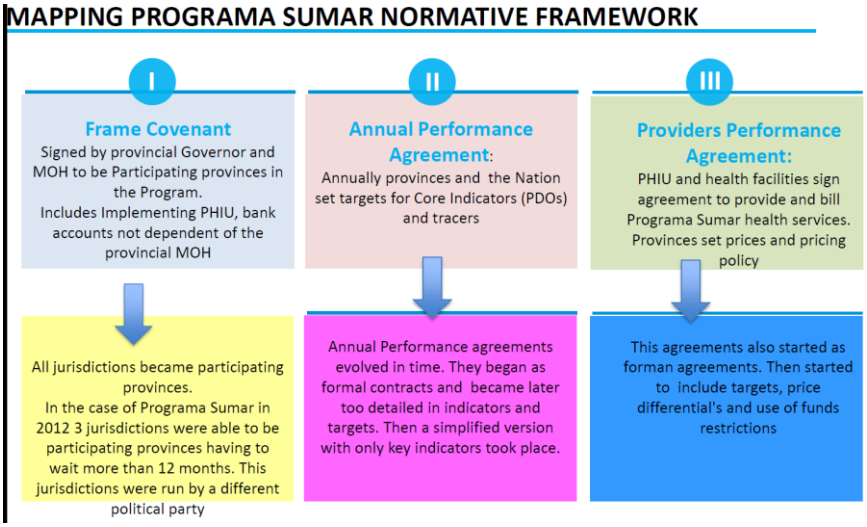


The National Ministry of Health allocated a per capita payment to the provinces for each beneficiary that was estimated to be the amount needed to close the gap in funding to deliver the covered services. The per capita amount was transferred in two parts: 60% paid monthly linked to enrollment in the program, and 40% contingent upon the performance of the province against 10 tracer indicators paid every four months. The PHIUs paid providers for each covered service delivered, so providers had incentives both to enroll more beneficiaries and deliver the covered services.

Program SUMAR was launched in 2012 to further expand benefits and population coverage, including children between 6 and 9 years of age (not eligible previously in Plan Nacer), teenagers and women in addition to the maternal and infant population, and to improve quality standards of public health services. In April 2015, men between 20 and 64 years were also included. The performance based payment was refined with the capitation transfer now made with 60 % paid monthly linked to Basic Effective Health Coverage (defined as the share of the eligible the population receiving at least one priority service in the last 12 months) and 40% linked to 14 tracer indicators for preventive care and 3 tracers for high-complexity care, such as congenital heart disease and high-complexity neonatal care).

Distribution of Functions, Financial Risk, and Accountability in Argentina's Program Sumar

Under Program Sumar the national functions include overall stewardship, program design, specification of the benefits package, provider payment design, and monitoring and accountability of performance of the provinces. The local governments have the responsibility for service delivery. Provinces also participate in investment planning, but it is a coordinated annual process between provincial governments and health insurance teams at the national and sub-national level. Financial risk-sharing and accountability are governed



through a detailed normative framework. The national Ministry of Health and provincial governors sign a framework contract ("Frame Covenant"), which is supported by annual performance agreements that specifies performance targets for the provinces to achieve under the agreed core indicators and tracers. Provincial health insurance units in turn enter into contracts with health providers, setting payment rates for Program Sumar services. Providers have autonomy in how they use Program Sumar revenues.

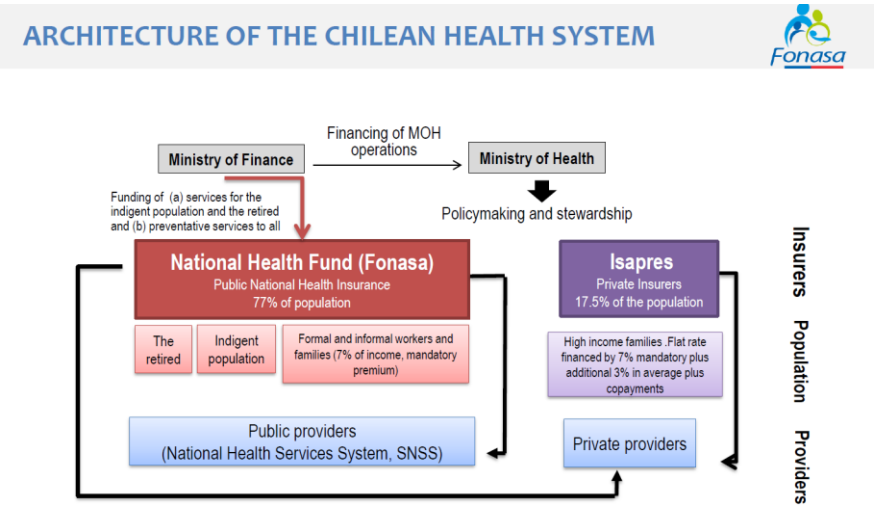
To share financial risk for the expenditure under the Program Sumar insurance scheme, the national program pays a per capita payment to the provincial health insurance unit for each person enrolled in the program. A portion of the payment is withheld and paid contingent upon the performance of the province according to indicators of effective coverage. In this way the province holds some of the risk for utilization, since the payment is a fixed per capita allocation, and is accountable for clearly defined performance indicators. Provinces contract with providers and pay fee-for-service for each service in the package delivered to a Program Sumar beneficiary.

Table 2. Distribution of Functions, Financial Risk, and Accountability

Key questions	National Government Role	Local Government Role
Distribution of health purchasing functions	Overall stewardship Program design Benefits package Provider payment design Monitoring and accountability of province performance	Service delivery Joint national/sub-national investment planning – "health service production and funds allocation plan" – implemented annually with health insurance teams at national and sub-national levels Manage program enrollment Contracting individual providers Provider payment rate-setting Provider payment (transfer of funds) Monitoring of provider performance
Financial risk-sharing arrangements	Capitation payment to provinces Withholding a portion of financial transfers based on performance	Provincial health insurance units have financial risk for fee-for-service payment to proviers
Accountability mechanisms	A Normative Framework for formal coordination between the national government and provinces: included a Framework Agreement between the national government and each participating province, an Operating Manual for the program, and Annual Performance Agreements. Clearly defined service package and monitoring indicators	Performance-based contracts with health providers paying fee-for-service Autonomy of providers for using revenue from Program Sumar services

Chile

Chile is a South American country with a population of about 18 million people. Chile's health system is largely based on a public service delivery system that is financed through a public purchasing agency (the National Health Fund, or Fonasa). Fonasa operates as an independent directory of the Ministry of Health, and is responsible for the management of the public financed system. Fonasa covers about 77% of the population, while the remaining 23% opt out of the public system and use their mandatory 7% contribution from salaries to purchase private insurance through Isapres, private insurance institutions that administer mandatory contributions of health of people who elect them, with access to private service providers.



In 2000 a reform was introduced called the Explicit Guarantee System (AUGE), that aimed to improve public service quality by selecting 56 health problems for which several guarantees would be made to insured patients — primarily that they would receive care in accordance with clinical guidelines and wait no longer than preset periods for diagnosis, treatment, or follow-up. In addition, out-of-pocket expenditures for these services were capped. If Fonasa cannot provide services within the designated waiting times, it has to pay alternative (usually private) providers for the services.

Decentralization of Health Service Delivery

In the 1980s the public health service delivery network (SNS) was restructured and decentralized through the 29 regional health services. These regional entities, while legally autonomous, are administered by civil service public employees and controlled by the Ministry of Health. The regional health services provide all public secondary and tertiary care in the country through a network of 232 public hospitals and contracted private providers. Beginning in 1981, nearly all responsibility for primary health care was devolved to the country's 308 municipal governments. This transfer took place within a more generalized program of administrative decentralization, which included the establishment of 13 regional governments and the transformation of municipal governments throughout the country.

Fonasa contracts with municipalities to carry out the 103 activities in the PHC service package ("Family Health Plan"), paid by capitation, and complementary programs or strategies (activity-based payment). Many municipalities make additional direct financial allocations to PHC. Fonasa monitors the performance of municipalities against 13 indicators of PHC activity, including coverage of priority services and continuity of care.

Distribution of Functions, Financial Risk, and Accountability in Chile's Fonasa

There is clear allocation of responsibility for purchasing functions, financial risk-sharing and accountability in Chile's national health insurance system. The national government has responsibility for overall stewardship

of the system, investment planning, and all aspects of design and implementation of service delivery. The local government role is limited to service delivery. Because all financing for 77% of Chile's population is integrated under Fonasa, there is the opportunity to be strategic and avoid such imbalances in the system as crowding out of public health services by curative services that may be more lucrative for providers. Fonasa shares financial risk with the municipalities by fixed per capita allocations to the municipalities to deliver a clearly defined PHC package. Municipalities manage within capitation payment for PHC package and absorb some financial risk, but clear referral mechanisms help manage that risk. Fonasa shares some of the financial risk for referral services with the regional service delivery networks by paying providers a combination of a fixed budget allocation and a budget neutral payments using diagnosis-related groups (DRGs) for referral services delivered in public hospitals. The payment system is budget neutral because Fonasa can adjust the base payment rate downward if volume increases beyond what can be accommodated in the budget. A different approach using tenders is used for Fonasa contracts with the private sector.

There are a variety of accountability mechanisms between Fonasa and the municipalities. The main mechanism is a clearly defined PHC service package that Fonasa contracts with the municipalities to deliver. Fonasa monitors the delivery of the package by municipalities using a set of 13 performance indicators. Allowing Fonasa beneficiaries free choice of provider—within municipalities, between municipalities, and between public and private providers—is another way to hold municipalities accountable for the access and quality of PHC services. Finally, an agency external to both Fonasa and municipalities—the Superintendencia de Salud—ensures accountability of the system as a whole.

Table 3.Distribution of Functions, Financial Risk, and Accountability

Key questions	National Government Role	Local Government Role
Distribution of health purchasing functions	Overall stewardship National supply side investment planning Insurance program design Benefits package Provider payment design Provider payment (transfer of funds) Monitoring and accountability of municipality performance	Service delivery
Financial risk-sharing arrangements	Capitation payment to municipalities for PHC package so allocation is fixed Budget-neutral DRG payment for referral services All funds flow through FONASA so no crowding out of public health services	Municipalities manage within capitation payment for PHC package and absorb some financial risk Referral mechanisms help manage financial risk
Accountability mechanisms	Clearly defined service package 13 monitoring indicators Free choice of service providers by covered population External agency controls quality	Municipalities accountable to deliver services in the defined PHC package

Nigeria

With a population over about 184 million people, Nigeria is a highly decentralized federation with 36 states spread across six regions. The states are fiscally autonomous, and decisions on health service delivery and financing are made at the state level. Despite numerous past efforts to improve health system performance, Nigeria's health outcomes remain some of the poorest in the sub-Saharan African region. Nigeria held a Presidential Summit on Universal Health Coverage in 2014, where the stakeholders and the government committed to implementing reforms in health financing and service delivery towards achieving universal health coverage (outlined in a Presidential declaration on UHC). The enactment of the National Health Act (NHAct) signaled an official recognition of the right of all Nigerians to health, entitling all Nigerians access to a Basic Minimum Package of Health Services (BMPHS) made available with financial resources from/through the Basic Health Care Provision Fund (BHCPF, or the Fund). The current vision of the health authorities is to revitalize PHC delivery and expand access to health services. Approximately half of the BHCPF will be utilized to deliver the basic minimum package of health services to citizens in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS). The other half will be utilized to strengthen the delivery of PHC services through supply side investments through State Health Care Development Agencies (SPHCDAs). With simultaneous attention to supply-side and demand-side financing, the NHAct and associated Fund have the potential to fuel dramatic public health improvements.

Decentralization and the BHCPF

The Fund serves to increase the fiscal space and overall financing to the health sector to assist Nigeria achieve its UHC goals. Funding of the BHCPF would be derived from contributions including

- an annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF)
- grants by international donor partners;
- funds from any other source

For the portion of the BHCPF allocated to supply-side strengthening, National Primary Health Care Development Agency (NPHCDA) is responsible for transferring funds from the Federal Ministry of Health to the SPHCDAs for operational support to heath facilities. The SPHCDAs disburse funds directly to accredited health facilities in each ward,[1] and the facilities are expected to use the funds to strengthen demand generation through increased community outreaches and also for basic repairs. The PHC facilities will have substantial autonomy in the use of the funds to meet their operating needs, but will submit data on quality- and management-related indicators. The SPHCDAs will receive an annual bonus, if they disburse the funds to the PHC facilities in a timely manner, publish audited accounts and meet other performance related targets.

For the portion of the BHCPF allocated to direct service payment, the government will shift from funding inputs to being a purchaser of services, buying services from both public and private providers. The provider payment mechanism for services funded through the NHIS will be paid using a modified fee-for-service with an added incentive for facility-based outcomes.

Distribution of Functions, Financial Risk, and Accountability in Nigeria's BHCPF

In Nigeria's highly decentralized context, the federal and state levels share a number of the health purchasing functions under the BHCPF and there are multiple joint accountability mechanisms. For example, while the

[1] A ward is the smallest political unit, with a population of 10,000-30,000 people.

Federal Ministry of Health has overall responsibility for stewardship of the system, SPHCDAs are responsible for implementing the program and ensuring the PHC system functions well. The National Health Insurance Scheme has responsibility to design provider payment systems, but the State Health Insurance Schemes and Third Party Administrators accredit, empanel, and pay health care providers. Responsibility for oversight and accountability is typically shared between the federal and state levels. For example, both the National Primary Health Care Development Agency and State Primary Health Care Development Agencies have responsibility for oversight over PHC facilities, although the NPHCDA retains some leverage by transferring funds to PHC providers via the SPHCDAs using results-based financing.

No clear mechanisms exist at either the federal or state level to manage the potential financial risk associated with open-ended fee-for-service provider payment mechanisms. Health worker productivity (caseload per day) in Nigeria is quite low, however, with estimates of less than patients per day per health worker, and one objective is to increase access to and utilization of necessary PHC services. Therefore fee-for-service payment is considered to be the most appropriate method without bringing substantial risk of cost escalation. Nevertheless, there are plans to invest in health information systems to monitor utilization of services and provider billing practices.

Table 4. Distribution of Functions, Financial Risk, and Accountability

Key questions	National Government Role	State Level Role
Distribution of health purchasing functions	Overall stewardship of the program Core funding for the BMPHS services via the NHIS and NPHCDA Design of provider payment systems NHIS develops regulations covering accreditation and quality of care NPHCDA has oversight over PHC facilities	State Primary Health Care Development Agencies have overall responsibility for implementing the program and improving PHC State Health Insurance Schemes and or Third Party Administrators (TPAs) accredit, empanel, and pay primary and secondary health care facilities on behalf of the NHIS NPHCDA disburses funds to PHCs through SPHCDAs SPHCDAs have oversight over PHC facilities Service delivery
Financial risk-sharing arrangements	Unclear since open-ended fee-for-service payments	
Accountability mechanisms	NPHCDA uses results-based financing to disburse to LGHAs NPHCDA will provide technical support to the state boards and review the performance of the PHC systems in the states based on various sources of data	

Key Messages

The overarching message that came out of the of the learning exchange is that strategic health purchasing needs to be approached with a view of the whole system—the organization service delivery and investment in the supply side, the consolidation and effective use of financing and incentives, and the roles and responsibilities of all actors at all levels. The participants agreed that strategic health purchasing is an important lever but cannot solve all problems, especially those related to achieving service delivery objectives. The vision for service delivery should be defined nationally, then strategic purchasing organized around that. Strategic purchasing levers need to send the right signals, but it is not a substitute for system-wide policy and planning.

Some specific messages related to the key questions related to strategic health purchasing emerged from the discussion. For example, the countries offered several examples of performance-based contracts between national and sub-national levels that address financial risk-sharing, such as financial caps tied to results. Many options for accountability mechanisms were discussed, and although a well-functioning information system is an enabling factor for accountability, it is not necessary to wait until there is a fully developed IT system. Several of the countries started with simple Excel-based monitoring. A set of key elements countries in the exchange use to ensure balanced financial risk-sharing and accountability is provided in Box 1. Other key messages are summarized below, and good practices that may be relevant for Indonesia are identified.

Box 1. Key Elements of Financial Risk-Sharing and Accountability

- ✓ Broader accountability frameworks that include both the national and sub-national levels
- ✓ Clearly-defined service packages
- ✓ Performance-based contracts between national and local governments
- ✓ Performance indicators and targets for local governments
- ✓ "Closed-ended" financial allocations and provider payment

Role of Local Government

- **The main role of local government is to ensure that services to which the population is entitled are available and delivered appropriately.**

  In all of the countries in the learning exchange the main role of the local government is to ensure that services are available and delivered appropriately.

- **Local governments still play the role of service providers, but this may be diminishing over time as private providers become more engaged.**

  Local government is the main service provider in all of the countries, but there is a growing role for private service provision and the role of local government as provider may diminish over time.

- **Local governments participate in supply side planning and investment but are not the main drivers.**

  Local governments participate in investment planning but as part of a national/sub-national coordinated process. Indonesia and Nigeria are the exceptions, with local governments retaining most or all of the responsibility for investment planning.

Good practices relevant for Indonesia

- Chile's annual national consolidated investment plan
- Argentina's Joint national/sub-national investment planning – "health service production and funds allocation plan"

- **Purchasing is more strategic the less local governments are involved in financing**

  In Chile where all financing is consolidated in the purchasing agency there are more levers to ensure funds are used effectively and efficiently. All three of the other countries have implemented an interim solution of consolidating at least a portion of funds in a national purchasing agency. Challenges remain when funding is fragmented, including inequity, crowding out of public health services, etc.

Good practices relevant for Indonesia

- Chile's consolidated financing for public and personal health services through Fonasa

Distribution of Purchasing Functions

- **Clear distribution of purchasing functions improves purchasing power.**

When the health purchasing functions are governed by a large set of regulations, lack of clarity can emerge in which institution is responsible for which function, and the effectiveness of health purchasing is diminished. A clear framework laid out in one document that specifies each purchasing function, which institution is responsible for carrying it out at which level, and guidance for how the function should be performed has provided a helpful foundation in Argentina and Nigeria.

Good practices relevant for Indonesia

- Argentina's Normative Framework for Programa Sumar
- Nigeria's Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund

Financial Risk-Sharing and Accountability

- **Performance-based contracting between national and local government linked to a clear service package**

  Argentina and Chile have specified clear service packages that the covered population is entitled to receive and local government is responsible for making available with funds from the national purchasing agency (via provincial agencies in Argentina). The responsibilities are delineated in performance-based contracts that specify performance indicators and targets. In Argentina, the contract is further strengthened by withholding a portion of payment to the province contingent

upon performance (although the total payment and withhold represent only a very small share of total health spending at the provincial level).

Good practices relevant for Indonesia

- Argentina's performance-based contracting between the national health insurance program and the provinces, and between the provinces and health care providers (and portion of payment to province withheld contingent upon performance)
- Chile's Family Health Plan with 103 defined PHC activities and 13 monitoring indicators

- **Budget-neutral resource allocation and provider payment**

Both Argentina and Chile provide per capita allocations to local governments to deliver a defined package of PHC services. Chile further manages financial risk by paying public providers per case for referral services using a budget-neutral DRG system (i.e. when volume increases too much the base payment rate can be adjusted downward).

Good practices relevant for Indonesia

- Chile's consolidated financing for public and personal health services through Fonasa

Appendix 1. Strategic health purchasing in decentralized contexts

Strategic purchasing is widely used in health systems of all types to create the right incentives and manage health funds efficiently. Aligning financial incentives with the objectives of the health system requires flexibility to pay providers for service outputs and performance and to fine-tune incentives as health needs and objectives change.[2,3]. Other strategic purchasing approaches include negotiating with pharmaceutical suppliers to manage drug costs, deliberately channeling resources to more cost-effective services, and building in incentives for both providers and patients to limit the use high-cost and unnecessary services. Strategic health purchasing requires institutional authority to make purchasing decisions, including the selection and design of provider payment systems, and enter into contracts with providers. It also requires flexibility to allocate funds to pay for outputs and outcomes, and well-functioning information systems to design, implement and monitor purchasing mechanisms. A large purchaser or multiple purchasers operating under a unified set of rules and regulations can exert influence over how health care resources are used and how providers deliver services. In countries with a single purchaser or a few large purchasers covering the entire population, the power to shape overall resource use in the health sector can be profound.[4]

In many countries the movement toward a single health purchaser with effective purchasing power is occurring alongside decentralization of health financing, service delivery, and management functions to sub-national levels of government. Purchasing power is often strengthened by centralizing some purchasing functions, but decentralization policies often do not take sector-specific functions into account and can work against central purchasing policies. For example, decentralization in Indonesia means that local governments are not obligated to harmonize their policies with national health purchasing policies, such as investment decisions and health provider remuneration policies. And in Nigeria, the states will be provided guidance from the federal-level, but they retain significant autonomy to decide how to implement policies.

In some cases more centralized purchasing functions are considered to be in direct contradiction with decentralization laws and policies. In Peru, for example, efforts to improve pooling and purchasing by channeling a larger share of health budgets through the national health insurance fund are meeting resistance from the Ministry of Finance because of concerns about violating decentralization policies.[5] In Chile, on the other hand, the delivery of primary health care services has been decentralized to the municipal governments, but the national health purchaser (FONASA) retains central control over most purchasing functions.[6] In Nigeria, the government is launching a new process to make fiscal transfers from the federal level to the constitutionally autonomous states (and to their local governments) to expand coverage of the most vulnerable populations through a Basic Health Care Provision Fund, with a minimum primary care benefits

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[2] Fuenzalida H, O'Dougherty S, Evetovits T et al. Purchasing of health care services. In: Kutzin J, Cashin C, Jakab M, editors. Implementing health financing reform: lessons from countries in transition. Copenhagen: World Health Organization; 2010.

[3] Figueras J, Robinson R, Jakubowski E. Purchasing to improve health systems performance. European Observatory on Health Systems Policies Series. Maidenhead, UK: Open University Press; 2005.

[4] Maeda A, Araujo E, Cashin C, Harris J, Ikegami N, Reich M. Universal health coverage for inclusive and sustainable development: a synthesis of 11 country case studies. Washington (DC): World Bank; 2014.

[5] Francke P. Peru's comprehensive health insurance and new challenges for universal coverage. UNICO Studies Series 11. Washington (DC): World Bank; 2013.

[6] Bossert T and Leisewitz T. Innovation and change in the Chilean health system. *New England Journal of Medicine* 374: 1; 2016.

package defined at the federal level. To facilitate demand-side financing and strategic purchasing, states are asked to set up state-based health insurance.[7]

Decentralization therefore can lead to several challenges for strategic purchasing, and sustainable progress toward UHC more generally:

- Lack of clarity in the institutional structure of health purchasing—that is, the specification of which institutions carry out which functions at which administrative level
- Imbalance in financial risk, with local governments able to make decisions that shift financial risk to the national purchaser that then has fewer levers to manage that risk through strategic purchasing approaches.
- Unclear accountability for results, outcomes, and financial sustainability

Appendix 2. Joint Learning Network for Universal Health Coverage (JLN)

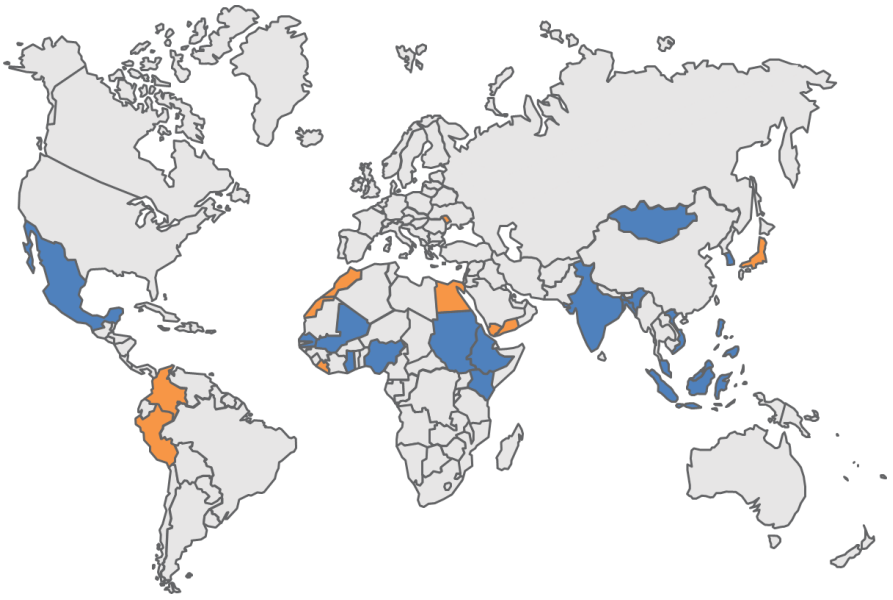
The JLN is a community of practitioners and policymakers from around the globe who share knowledge and co-develop new tools, guides and resources that address the practical challenges of health systems reform to achieve universal health coverage (UHC). As the global movement towards UHC has inspired more and more countries to make commitments to achieve UHC by implementing complex reforms, the need for access to high quality information about health systems reforms to get to UHC is increasing. Countries and the global community are interested in what works, what doesn't work, what is promising, what can be adapted, what is scalable, what is sustainable, and what new research can help inform decision making at the country-level. They are also very interested in *how to* implement reforms to get to UHC, and need access to tacit knowledge about practical implementation issues. The network currently includes 27 countries from Africa, Asia, the Americas, and Europe.

Members of the network participate in a variety of joint learning activities to share their experiences, learn from one another, and co-produce new knowledge. Most JLN technical activities include 5 core steps:

1) Identify common challenges
2) Collectively solve common problems
3) Synthesize practical knowledge
4) Adapt knowledge within JLN countries
5) Disseminate knowledge to other countries

[7] Federal Republic of Nigeria, National Health Bill of 2014.

Figure 1. JLN Member Countries



Full Members
Bangladesh
Ethiopia
Ghana
Indonesia
India
Kenya
Philippines
Malaysia
Mali
Mexico
Mongolia
Nigeria
Senegal
South Korea
Sudan
Vietnam

Associate Countries
Bahrain
Colombia
Egypt
Japan
Kosovo
Liberia
Moldova
Morocco
Namibia
Peru
Yemen

Appendix 3: Learning Exchange Agenda and Participant List

Participant	Position	Country
Ibu Prastuti Suwondo	Head of Health Team, TNP2K	Indonesia
Dr. Taufiq Hidayat	DJSN Council Member	Indonesia
Dr. Donald Pardede	Senior Adviser to the Minister on Health Economics, MOH	Indonesia
Dr Mundiharno Sumarno Hizboel	BPJS Director for Planning & Policy Development	Indonesia
Prof DR Hasbullah Thabrany	Senior Adviser to DJSN	Indonesia
Mr Ronald Pasaribu	Center for Financial Sector Policy Ministry of Finance	Indonesia
Mr Didik Kusnaini	Deputy Director, Budget Development, DG Budget, MOF	Indonesia
Prof DR Laksono Trisnantoro	UGM Center for Health Policy and Management	Indonesia
Humberto Silva	Consultant, Programa Sumar	Argentina
Dr. Jeanette Vega	Director, FONASA	Chile
Camila Medina	Head of the DRG Unit, FONASA	Chile
Oyebanji Filani	Technical Advisor to the Minister of Health	Nigeria
Technical Facilitators		
Cheryl Cashin	Results for Development	
Chelsea Taylor	Results for Development	
Amanda Folsom	Results for Development	
Somil Nagpal	World Bank	
Lydia Ndebele	World Bank	
Observers:		
Zohra Balsara	USAID/Indonesia	
Edhie Rahmat	USAID/Indonesia	
Pandu Harimurti	World Bank/Indonesia	
Ajay Tandon	World Bank	
John Langenbrunner	Bill and Melinda Gates Foundation	
Amrita Agarwal	Bill and Melinda Gates Foundation	

Appendix 4: Presentations