**IBRD PROGRAM DOCUMENT FOR A PROPOSED
UNIVERSAL HEALTH COVERAGE DEVELOPMENT POLICY LOAN
TO THE REPUBLIC OF INDONESIA**

1. INTRODUCTION AND COUNTRY CONTEXT

1. **This Program Document proposes a loan to the Republic of Indonesia for EUR 937.7 million (US$1 billion equivalent) for a Universal Health Coverage (UHC) Development Policy Loan.** The DPL is a stand-alone single tranche IBRD loan to support the Government of Indonesia's (GoI) efforts to strengthen the supply of medical care professionals.

2. **While Indonesia has made impressive progress in reducing poverty and boosting shared prosperity, low absolute levels of human capital represent a key structural bottleneck to achieving the country's development objectives.** The DPL will support Indonesia's Long-Term National Development Plan (RPJPN) 2005–2025 (which focuses prominently on developing quality human capital and health services), the Medium-Term National Development Plan (RPJMN) 2020–2024, and the GoI's Health System Transformation Agenda. The period 2010 to 2019 saw robust economic growth, job growth and poverty reduction. The poverty headcount ratio fell from 13.3 percent in 2010 to 9.4 percent in 2019. In parallel, Indonesia's performance in the World Bank (WB)'s Human Capital Index (HCI) – which quantifies the contribution of health and education to the productivity of the next generation of workers – improved from 0.50 in 2010 to 0.54 in 2020. Nevertheless, significant development challenges remain, including the need to strengthen the competitiveness and resilience of Indonesia's economy, ramp up investments in infrastructure, manage natural assets for enduring prosperity, strengthen public finances, and further nurture human capital. Indonesia's HCI score remains below the average for East Asia and the Pacific (EAP) and outcomes differ significantly across space and socio-economic groups.

3. **COVID-19 put recent development gains at risk.** Indonesia was one of the countries worst hit by COVID-19, with 6.7 million confirmed cases and 161,000 deaths as of April 2023. The poverty rate increased to 10.1 percent in 2021. While a strong fiscal response helped mitigate even more far-reaching impacts, the pandemic led to substantial losses of labor income and business revenue that affected households' consumption and ability to invest in human capital. As the virus has come under control and the economy has recovered, poverty fell to its pre-crisis level of 9.4 percent in March 2023.

4. **As pandemics and climate-change-related shocks become more frequent, proactive health policies will be critical.** Indonesia is the 49th most climate-vulnerable country in the world, with potential economic losses from climate change projected to reach up to US$ 37.8 billion between 2020 and 2024. Given the key role of the health sector in addressing global challenges including climate change adaptation and mitigation and pandemic prevention and preparedness, as well as for building human capital, proactive health policies can play a particularly transformational role in helping Indonesia to 'build back better' and increase the country's resilience to shocks.

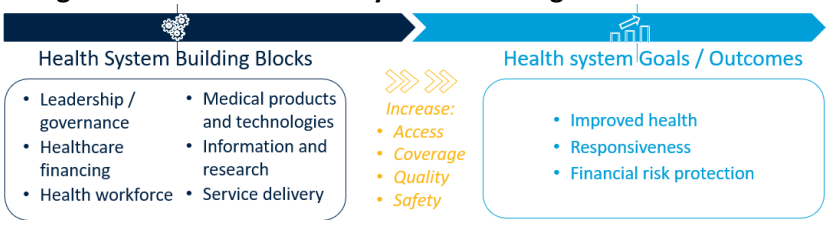
5. **Indonesia has achieved momentous gains in health outcomes.** Between 2000 and 2022, life expectancy rose from 66.2 to 71.9 years, and between 2000 and 2020 both the under-five mortality rate and the infant mortality rate more than halved, to 19.8 per 1,000 live births and 16.9 per 1,000 live births, respectively, according to data from *Badan Pusat Statistik* (BPS). The introduction of *Jaminan Kesehatan Nasional* (JKN) – one of the world's largest single-payer social health insurance programs – in 2014 led to a dramatic increase in the coverage of health insurance (95 percent enrollment in 2023) and utilization of healthcare services. In addition, 5 percent of households primarily rely on private health insurance. Combined with an increase in public health spending (which accelerated in response to COVID-19), the expansion of JKN led to a dramatic reduction in out-of-pocket payments (OOPs) as a share of total health expenditure, from 45.3 percent in 2014 to 32.1 percent in 2019 and 25.1 percent in 2021. Overall JKN and private health insurance make up 14.7 and 2.4

percent of total health spending, respectively. General health expenditure is 10 percent of general government expenditure – higher than in Malaysia (8.6 percent), the Philippines (9.3 percent) and China (8.4 percent) but less than the Organization for Economic Co-operation and Development (OECD) average (18.6 percent) and in Thailand (13.2 percent).

6. **However, Indonesia continues to trail its regional and economic peers in most health outcomes.** At 189 deaths per 100,000 live births, Indonesia's maternal mortality ratio (national BPS estimate) remains significantly higher than the average for EAP. Indonesia also continues to compare unfavorably in life expectancy, infant, under-five, and neonatal mortality, as well as tuberculosis (TB) burden. Moreover, the share of deaths due to non-communicable diseases (NCDs) increased from 61 percent to 76 percent between 2000 and 2019. These trends are increasingly straining the health system, which lacks physical and human resources to diagnose, treat, and adequately manage chronic conditions.

7. **Insufficient supply of medical care professionals – in particular, generalist and specialist medical doctors – limits access and quality (Figure 1).** There are only 0.7 medical doctors for every 1,000 people, against an average for upper-middle income countries of 2.1. As of September 2023, there are 132,765 general practitioners and 47,960 specialists with active registration letters (STRs), suggesting a gap of 65,596 general practitioners and 29,180 specialists to meet the World Health Organization (WHO) indicative threshold of one doctor (0.28 specialists and 0.72 general practitioners) per 1,000 people. Across medical specialties and sub-specialties, the top three gaps are a deficit of 3,941 obstetricians and gynecologists (OBGs), 3,662 pediatric specialists, and 2,581 internal medicine specialists. In addition, almost no districts meet the MoH standard of 0.45 and 0.11 general practitioners and specialists practicing in the public sector per 1000 population, respectively. In some remote provinces less than 20 percent of community health centers are fully staffed. The shortage of general practitioners is a key constraint to improving access to quality primary health care while the lack of specialists constrains access to referral-level hospital services. Every year, 50,000 Indonesian children face untreated congenital heart disease and over 70 percent of cancer cases are detected at late stages of disease progression.

Figure 1. The WHO Health Systems Building Blocks Framework



8. **Policy bottlenecks have been a prime reason for the shortage of medical doctors, including specialists such as oncologists or OBGs.** For doctors to practice, they need both a registration letter (STR) issued by the Indonesian Medical Council (IMC) and a license (SIP) issued by the local government. Until recently, a set of policies limited the supply of doctors. First, both SIPs and STRs had to be renewed every five years, leading to overlapping renewal requirements open to abuse. Second, the Indonesian Doctors' Association (IDI) needed to provide recommendation letters for the issuance and renewal of STRs and SIPs. This introduced subjectivity and recommendations were susceptible to being based on personal preferences. Third, the IDI had authority in validating fulfillment of continuous learning requirements, while at the same time the IDI offers continuous learning programs, creating the appearance of a conflict of interest. Fourth, Indonesian doctors who had graduated from abroad and even more so non-Indonesian doctors faced significant entry barriers. As a result, only 0.13 percent of new STRs issued during the first nine months of 2023 went to Indonesian doctors who graduated from abroad. While according to IFC (2023) the share of foreign medical doctors among all medical doctors is 15.7 percent in Singapore, 7 percent in Malaysia and 0.45 percent in Thailand, regulatory restrictions mean that there are currently no foreign medical doctors practicing in Indonesia. Sixth, training of specialist doctors was limited to the capacity of higher education institutions, with significant concentration in a few, mostly more developed geographic areas.

9. **The shortage and uneven distribution of OBGs has resulted in a critical lack of such specialist doctors to provide essential maternal and obstetric care, leading to increased probability of maternal and infant death.** This is partly linked to the inadequacy of educational institutions that can produce enough qualified specialists. Only 35 percent of married women give birth with the assistance of obstetricians, with 25 percent in rural areas and 42 percent in urban areas, suggesting large spatial inequities. According to the same research, the lack of OBGs in health facilities was a contributing factor in 88 percent of the 90 maternal deaths examined across 11 hospitals in Indonesia (Baharudin *et al.*, 2019).

10. **Renewed efforts are needed to strengthen health system resilience and pandemic prevention and preparedness.** Indonesia scored quite low on human resource readiness indicators on the 2017 Joint External Evaluation (JEE) Report. While the JEE assessed that Indonesia has a multidisciplinary workforce available, it also highlighted that capacity is lacking at the local level. Accordingly, the JEE's priority recommendations included to review and update national disaster plans, including building surge capacity and providing training opportunities to non-healthcare workers.

11. **Against this backdrop and in response to a request from the GoI (see Annex 3), this DPL supports a major policy reform undertaking centered around the Health Omnibus Law (HOL) promulgated in August 2023.** Initiated by Parliament and spearheaded by the Ministry of Health (MoH), the HOL replaces 11 formerly distinct laws. It undertakes major policy reforms to unlock critical policy constraints that, inter alia, (i) strengthen the domestic, foreign and foreign-trained supply of medical care professionals by addressing entry barriers for domestic and foreign-trained medical doctors and instituting a hospital-based residency program for training specialist medical doctors, and (ii) enhance health system resilience by establishing a healthcare worker reserve. To assure the policy reforms strengthen the supply of both primary and referral-level care on the ground, the HOL is complemented by detailed implementing regulations currently under preparation. A first set of Government Regulations is expected to be completed by October 2023 and a second set of Ministerial Regulations by December 2023. In addition, the HOL is complemented by significant investments in implementation capacity including in equipment procurement, installation, operation, maintenance and training at primary and referral public health facilities supported by the WB's Health Systems Strengthening Investment Project Financing.[1] The HOL also signals the GoI's commitment to both human capital development and to increasing FDI as the lowering of entry barriers for medical doctors is expected to encourage foreign investors especially in the hospital sector.

2. MACROECONOMIC POLICY FRAMEWORK

2.1. RECENT ECONOMIC DEVELOPMENTS

12. **Amidst global uncertainty, commodity windfalls, private consumption and the services sectors have sustained robust growth in Indonesia in 2022, but signs of normalizing demand emerged recently.** Growth strengthened to 5.3 percent in 2022, the highest in the last decade and above East Asia and Pacific countries' average. Growth came on the back of positive terms-of-trade led by commodity related exports and a recovery in private consumption (Table 1). This momentum continued in 2023 growth recording 5.1 percent in the first half of the year (H1-23). Nevertheless, there are signs that both domestic demand and terms-of-trade are starting to normalize. This includes a softening in imports and investment growth, a deceleration in private sector credit, a slowdown in core inflation since the beginning of the year, and a softening of commodity-led exports. From the supply side, growth came from services (retail trade, hospitality, transport and communication) (40 percent) and manufacturing (20 percent). Those sectors have benefited from pent-up demand largely attributed to improving mobility and tourism activities.

[1] Concept Project Information Document. Washington, D.C.: World Bank Group.
http://documents.worldbank.org/curated/en/099071023173535578/P18081105f58ed0e0b2350a471f429f1c4

13. Inflation is easing faster than anticipated and is back within Bank Indonesia's (BI) target band,[2] while becoming broader-based. Headline inflation declined to 3.3 percent (yoy) in August 2023. It almost halved since the September 2022 peak when global inflationary pressures forced authorities to hike electricity and fuel prices.[3] Slowing inflation is attributed to the decline in global oil prices, improved harvest, and government intervention at the sub-regional level to ease food supply bottlenecks. Nevertheless, inflation became broader-based, reflecting a pick-up in goods and services demand as headline and core inflation are converging.

14. Moderate external financing needs and stable financing helped offset global financial pressures. The narrowing current account surplus, from 0.7 percent of GDP in H1-22 to 0.2 percent in H1-23, is mostly linked to rising services imports and weakening exports. The latter have decelerated as prices of major export commodities like coal, palm oil, and other metals dropped, while manufacturing exports' contribution remains limited. External financing needs remain moderate at 1.9 percent of GDP in H1-23. The bulk of external financing came from FDI and other private investments including loans, trade credits, and advances. Despite tightening global financial conditions and capital outflows in many emerging market and developing economies (EMDEs), investor confidence in Indonesia's assets led to portfolio inflows of 0.1 percent of GDP. This reverses outflow trend in 2022. As a result, foreign currency reserves reached 6.1 months of imports in June 2023. Adequate external buffers support the Rupiah, which appreciated by 3 percent in the first 8 months of 2023. Nevertheless, the currency is likely to remain under pressure, as with other EMDEs, given the expected higher for longer US Fed policy interest rates.

15. The fiscal stance has normalized reflecting faster-than-planned fiscal consolidation owing to a broad-based rise in revenues and prudent public spending. With a fiscal deficit of 2.4 percent of GDP in 2022, the GoI returned to its fiscal rule (3 percent of GDP) one year earlier than targeted. This was possible due to a strong revenue performance buoyed by a mix of high commodity prices, rising domestic demand, and tax reforms.[4] Spending was contained through the roll-back of COVID-19 programs, upward adjustments to fuel prices, and under-execution of public investment. This trend continued with the fiscal surplus reaching 0.7 percent of GDP in July 2023, up from 0.6 percent of GDP over the same period last year. Public debt gradually declined to 37.8 percent, albeit above pre-pandemic levels. Debt composition changed with non-residents ownership declining. Domestic debt account for 72.4 percent of total public debt with commercial banks increasing their sovereign lending.[5] This change comes amid ample domestic liquidity availability and a cessation of BI temporary budgetary financing scheme during COVID period.

Table 1. Key Macroeconomic Indicators 2020-2026

	2020	2021	2022	2023	2024	2025	2026
	Actual			WB projection			
Real economy							
Real GDP (% change)	-2.1	3.7	5.3	5.0	4.9	4.9	5.0
Consumer Price Inflation (CPI) (year-average, %)	2.0	1.6	4.2	3.9	3.3	3.0	3.0
Demand side (contribution to growth, in percentage points)							
Private Consumption	-1.5	1.1	2.7	2.6	2.6	2.6	2.6
Government Consumption	0.2	0.3	-0.4	0.3	0.2	0.3	0.3
Gross Fixed Investment	-1.6	1.2	1.2	1.4	1.4	1.5	1.6
Exports	-1.7	3.5	3.6	0.8	1.0	1.0	1.0

[2] BI's inflation target band is 3 ± 1 percent. Starting January 2024, this target band will become 2.5 ± 1 percent.
[3] To ease fiscal pressure from a rising energy subsidies bill, the authorities raised electricity tariffs for selected households in July 2022 and implemented a 30 percent fuel price hike in September 2022.
[4] This includes primarily raising the VAT rate, reversing a planned reduction in corporate income tax rate, and reforms to tax administration.
[5] Banks now hold 29.9 percent of domestic government debt while the public holds 35.2 percent.

Imports	-3.3	3.9	2.8	0.4	0.5	0.5	0.5
Supply side (contribution to growth, in percentage points)							
Agriculture	0.2	0.2	0.3	0.5	0.4	0.4	0.4
Industry	-1.1	1.3	1.6	1.6	1.5	1.6	1.6
Services	-0.6	1.6	2.9	2.7	2.7	2.8	2.9
Net Taxes on Production	-0.5	0.6	0.6	0.2	0.3	0.2	0.2
Fiscal accounts, central government, percent of GDP							
Revenues	10.7	11.8	13.5	12.6	12.4	12.6	12.7
of which Tax Revenue	8.3	9.1	10.4	10.0	10.1	10.3	10.4
Expenditures	16.8	16.4	15.8	14.7	14.6	14.9	15.0
Primary Balance	-4.1	-2.5	-0.4	-0.1	-0.2	-0.3	-0.3
Fiscal Balance	-6.1	-4.6	-2.4	-2.2	-2.3	-2.3	-2.3
Central Government Debt	39.4	40.7	39.5	39.1	39.0	38.4	37.5
Balance of Payments, percent of GDP unless indicated otherwise							
Current Account Balance	-0.4	0.3	1.0	-0.1	-0.5	-1.0	-1.0
Exports, Goods and Services	16.8	20.8	23.9	22.6	22.0	21.8	21.6
Imports, Goods and Services	-15.1	-18.3	-20.7	-20.1	-20.0	-19.9	-19.7
Net Foreign Direct Investment	1.3	1.5	1.1	1.0	1.3	1.5	1.5
Gross Reserves (months of imports of goods & services)	7.5	6.4	5.9	5.8	6.3	6.7	7.2
Memorandum items							
Nominal GDP (IDR trillion)	15,443	16,977	19,588	21,449	22,902	24,531	26,361

Source: MoF, BI, WB staff projections.

16. BI's monetary stance is becoming more accommodative given softening inflation and resilient capital flows. After a cumulative 225 basis point increase last year and despite the US Fed's successive interest rate hikes, BI has held its policy rate unchanged at 5.75 percent since January 2023.[6] This comes as inflation expectations are now well-anchored with headline inflation dropping within BI's target band. With inflation trending downwards and BI maintaining its policy rate unchanged, the real interest rate is picking up (from 0.8 percent in end-2022 to 2.0 percent in July 2023). This raises borrowing costs for the private sector further and could impact economic activity. In the past two years, BI has been actively using a combination of policy rate adjustments, forex interventions to stabilize the currency, and exchange rate flexibility to navigate external market pressures amidst synchronous global shocks. It has also resorted to monetary financing of the budget as a temporary measure during the pandemic.

17. BI also utilized non-monetary instruments to manage excess liquidity and boost credit. BI performed twist operations[7] to support the currency and raised the reserve requirement ratio (RRR) in June and September 2022. It then introduced in September 2023 the *Sekuritas Rupiah Bank Indonesia*, a monetary sterilization instrument that is tradeable on the second market. As a result, M2 growth decelerated to 6.4 percent yoy in July from 8.4 percent in end-2022. Meanwhile, BI recently implemented macroprudential policies to encourage banks to disburse credits to priority and green sectors. It has also introduced new regulations related to credit card usage aimed at boosting credit. BI also decided to cut the RRR for banks that lend to eligible sectors such as downstreaming, tourism, and micro, small and medium-sized enterprises (MSMEs). The decision takes effect in October 2023. This new measure is expected to release liquidity in the market to boost private sector credit growth, which decelerated to 8.5 percent yoy in July (vs. 11.6 percent in end-2022).

18. Bank asset quality remains generally high, and bank capital and provisioning levels adequate to withstand potential adverse shocks. The system-wide non-performing loan (NPL) ratio has not changed much since mid-2020 and

[6] The gap between BI's policy rate and the US Federal Reserve's policy rate is now at an all-time low.

[7] Twist operation is where BI selling short-term government securities and purchasing long-term ones in the secondary market to increase the attractiveness of these securities yields.

stands at 2.5 percent as of June 2023. The average loan at risk (LAR) ratio[8] for the top banks has been on a downward trend for some time and stood at 13.2 percent as of June. The capital adequacy ratio remains stable at 25.4 percent as of June 2023, well above the regulatory minimum of 8 percent. Provisioning levels relative to NPLs stood at 215 percent in May 2023 compared to 198 percent a year ago. Nevertheless, NPL data could reflect the deterioration in asset quality only with a lag. In anticipation for the end of the forbearance measures on March 31st, banks were encouraged to increase the coverage of the allowance for impairment losses for restructured loans. This is especially the case for current quality loans and special mention loans, which could become NPLs.

2.2. MACROECONOMIC OUTLOOK AND DEBT SUSTAINABILITY

19. Growth is expected to remain robust, though the pace is moderating. With the pandemic recovery cycle now over, GDP growth is projected to moderate from 5.3 percent in 2022 to 5.0 percent in 2023 and stay broadly flat at 4.9 percent in the medium-term (Table 1). This is slightly above the country's estimated 4.7 percent potential growth. As inflationary pressures subside, growth will continue to be supported by private consumption as purchasing power of households is maintained. Consumption is also projected to receive a temporary boost from campaigns related spending in the upcoming elections in 2024.[9] Exports are projected to remain stable despite softening commodity prices as regional trade partners, like the Association of Southeast Asian Nations (ASEAN) and India, recover and offset part of the declining global demand. Meanwhile, rising borrowing costs are projected to soften private sector credit while global uncertainties impact foreign investment. As a result, weak investment could put a drag on economic activity and supress growth potential if ongoing structural reforms, like those linked to financial sector deepening or competitiveness related reforms, stall. On the supply side, services such transport, communication, trade, and hospitality will continue to benefit from the consumption drive and support growth. Manufacturing is also expected to play a more important role as more investments, linked to the downstreaming agenda, are realized.[10]

20. Inflation is projected to moderate and remain within the medium-term target. The authorities have announced that there will be no further increase in the VAT or electricity tariffs in 2023, easing inflationary pressure on administered prices. As such, inflation is projected to drop to 3.2 percent by December 2023 (yoy). With signs of moderating demand, inflation would stabilize averaging 3.25 percent in 2024-2025. Easing inflation provides greater space for monetary policy to remain accommodative in supporting growth. Nevertheless, the planned lowering of the inflation target band by half a percentage point to 2.5±1 starting in 2024 could offset some of the policy space.

21. Vulnerability to tightening external financing conditions is expected to be moderate. The outlook assumes that global financing conditions will continue to tighten in 2024 given the US Federal Reserve's policy signal and persistent global inflation. Although debt selloffs could increase, commodity prices and structural reforms over the outlook period are expected to encourage FDI. The implementation of investment reforms adopted in 2021[11] and the Omnibus Law on Health, together with the GoI's strategy around downstreaming of minerals, are expected to further open sectors for foreign investments. External financing needs are expected to increase but remain contained as the current account deficit widens gradually from a lower pre-pandemic base (Table 2). Indonesia will have policy space to manage tighter global financial conditions while supporting growth given its macroeconomic position. This includes a relatively stable Rupiah,

[8] LAR calculation includes restructured loans in collectability, restructured & non restructured special mention loans, and NPLs.
[9] Indonesia will hold parliamentary and presidential elections in February 2024. If needed, there will be a second round of presidential elections.
[10] The country's policy objective of developing downstream industries such as batteries, electric vehicles, and other higher value-added industries from processing Indonesia's natural resources like nickel, bauxite, other minerals among others. For this purpose, the government has introduced tax incentives for investors, subsidies, and enacted bans on export of raw minerals like nickel (since 214) and Bauxite (since June 2023).
[11] For example, the adoption of the Job Creation Omnibus Law has eliminated the negative list for sectors and opened the door for FDIs. See World Bank (2022a) for more details.

adequate official reserves, a positive interest rate differential with the US, anchored inflation expectations, and lower levels of non-resident debt.

Table 2. Balance of Payments (BoP) Financing Requirements and Sources (US$, billions)

	2020	2021	2022	2023	2024	2025	2026
Current account deficit	4.4	-3.5	-12.7	0.9	8.0	15.8	16.8
Scheduled government debt amortization	9.1	8.7	8.2	12.0	11.9	13.7	12.2
Private sector debt repayment	23.4	24.8	25.1	27.2	29.1	31.1	33.5
Total financing needs	**36.9**	**30.0**	**20.7**	**40.1**	**49.0**	**60.6**	**62.5**
Total financing sources	**36.9**	**30.0**	**20.7**	**40.1**	**49.0**	**60.6**	**62.5**
FDI inflows (net)	14.1	17.3	14.8	14.3	19.9	24.1	25.5
Portfolio inflows (net)	-4.1	-4.1	-14.2	-4.5	2.5	8.4	9.2
Other investment (net)[a]	11.8	16.0	8.8	9.5	10.2	10.9	11.7
Government borrowing (gross)	20.0	16.2	15.4	17.1	20.4	21.7	23.8
Loans	9.1	4.0	7.1	6.6	7.3	7.8	8.6
o/w WB Development Policy Loans	0.6	1.2	1.7	0.8	0.9	0.4	0.4
Securities	10.9	12.2	8.4	10.5	13.1	13.9	15.2
o/w BI fiscal financing schemes[b]	3.0	2.1	1.3	0	0	0	0
Other items (net)[c]	-2.3	-1.8	-0.9	-0.3	0.7	-1.7	1.5
Use of reserves[d]	-2.6	-13.5	-3.3	3.9	-4.7	-2.9	-9.4

Note: (a) Including other equity, trade credits, loans etc. but excludes government and private borrowing and currency swaps. (b) Numbers for 2022 are based on a government announcement in August 2021. (c) Comprising capital account, derivatives, and errors and omissions components; for historical data also includes discrepancy between balance of payments and fiscal data on government borrowing. (d) Use of reserves: '–'denotes an accumulation; '+' denotes a reduction. Source: BI, WB staff projections.

22. The fiscal deficit will remain below the 3 percent of GDP target in 2023-2025. In 2023, the fiscal deficit is estimated to be around 2.2 percent of GDP, lower than the 2023 Budget target of 2.8 percent of GDP. This is attributed to strong revenue performance from commodity windfalls and pent-up domestic demand. Fiscal consolidation will be maintained in 2024 with the new budget law setting a deficit target of 2.3 percent of GDP. This includes public spending on both the election process and the construction of the new capital. In the medium-term, revenues are projected to improve gradually as the 2022 Tax Harmonization Law reforms generates results. Public spending is projected to remain stable at around 15 percent of GDP with a shift towards medium-term priorities such as health,[12] social assistance, and infrastructure investment. Nevertheless, spending quality and disbursement constraints remain issues that will put a drag on the impact of fiscal policy. The subsidies bill is expected to drop with declining global energy prices. The GoI is expected to comfortably meet its fiscal financing needs (averaging 4.5 percent of GDP in 2023-2026). This is due to fiscal consolidation and ample domestic liquidity. The proposed DPL will support though public debt management. It will help authorities reduce risks of potential crowding out in domestic financial markets, provide access to more competitive sources of financing compared to international markets, and help rebalance the currency composition of public debt.

Table 3. Baseline Medium-Term Fiscal Framework (Central Government), percentage of GDP

	2020	2021	2022	2023	2024	2025	2026
Overall fiscal balance	-6.1	-4.6	-2.4	-2.2	-2.3	-2.3	-2.3
Primary fiscal balance	-4.1	-2.5	-0.4	-0.1	-0.2	-0.3	-0.3
Revenue	10.7	11.8	13.5	12.6	12.4	12.6	12.7
Tax revenue	8.3	9.1	10.4	10.0	10.1	10.3	10.4

[12] Public spending allocated for the health sector in the 2024 budget law is 0.8 percent of GDP. This remains lower than middle income countries average public spending on the sector.

Income tax	4.0	4.2	5.2	4.7	4.8	4.8	4.8
Sales tax	2.9	3.3	3.5	3.6	3.6	3.8	3.9
Excises	1.1	1.2	1.2	1.2	1.2	1.2	1.2
International trade tax	0.2	0.4	0.5	0.2	0.2	0.2	0.2
Other taxes	0.1	0.0	0.0	0.3	0.3	0.3	0.3
Non-tax receipts	2.2	2.7	3.0	2.5	2.3	2.2	2.2
Grants	0.1	0.0	0.0	0.0	0.0	0.1	0.1
Total expenditure	16.8	16.4	15.8	14.7	14.6	14.9	15.0
Primary expenditure	14.8	14.4	13.8	12.7	12.6	12.9	13.0
Central government	11.9	11.8	11.6	10.9	10.8	10.8	10.6
Personnel	2.5	2.3	2.1	2.4	2.4	2.4	2.4
Material	2.7	3.1	2.2	2.2	2.2	2.3	2.3
Capital	1.2	1.4	1.2	1.2	1.1	1.3	1.4
Subsidy	1.3	1.4	1.3	1.3	1.2	1.1	1.0
Social assistance	1.3	1.0	0.8	0.7	0.8	0.7	0.7
Others	0.8	0.5	2.1	1.1	1.2	0.9	0.8
Transfers to subnational	4.9	4.6	4.2	3.8	3.8	4.1	4.4
Interest	2.0	2.0	2.0	2.0	2.0	2.0	2.0
Net financing	6.1	4.6	2.4	2.2	2.3	2.3	2.3
Investment in financial assets	-1.9	-0.6	-1.2	-0.5	0.1	0.5	0.7
Net borrowing	8.0	5.1	3.5	2.7	2.2	1.8	1.7
Net local currency	7.0	4.7	3.1	2.3	1.9	1.6	1.5
o/w BI fiscal financing[(a)]	3.0	2.1	1.3	N/A	N/A	N/A	N/A
Net foreign currency	1.1	0.5	0.4	0.3	0.3	0.2	0.2
Central government debt	39.4	40.7	39.5	39.1	39.0	38.4	37.5
Gross fiscal financing needs	9.0	7.9	4.6	4.7	4.7	4.4	4.1

Note: (a) 2022 is based on an August 2021 government announcement. Source: MoF and WB staff projections.

23. Indonesia's highly leveraged infrastructure SOEs may pose fiscal risks, especially in the wake of the insolvency in one of these entities, but risks remain manageable. As infrastructure SOEs have increasingly taken on debts to fund large projects, their liability-to-equity ratios have risen. Indonesia's infrastructure SOEs leverage ratios are comparable to those of global SOEs in the same industry, but they are significantly higher than peer private firms listed on the Indonesia Stock Exchange (IDX) and in EMDEs.[13] One such SOE has been unable to meet its debt obligations since February 2023 and is now in need of debt restructuring. Infrastructure SOEs main creditors are state-owned banks (SOBs). Contagion risk to the banking sector is expected to be limited though as infrastructure SOEs borrowing represents only 0.4 to 1.4 percent of overall SOB's lending portfolio (around 0.2 percent of GDP). MSOE has consolidated several SOEs so far to enhance their performance and competitiveness. Between 2019-2022, the total number of SOEs has been reduced from 114 to 41 through consolidation.[14]

24. The WB's Debt Sustainability Analysis (DSA) shows that central government debt would remain overall low and manageable under plausible adverse shocks. Under the baseline, central government debt is projected to rise over the medium-term and stabilize at around 37.5 percent of GDP in 2026, well below the government debt ceiling (60 percent of GDP). The debt trajectory is more vulnerable to a currency depreciation shock but would remain sustainable under

[13] Liability-to-equity ratio average in same industry private firms listed on IDX and in emerging market countries is respectively 1.4 and 1.6. For Indonesia's infrastructure SOEs it ranges between 2.9 to 5.5 in Q3-2022 (except for one entity whose scored 0.8). Source: World Bank (2023b).
[14] Furthermore, the MSOE is planning to reduce the number of infrastructures SOEs from 9 to 4.

plausible scenarios. More specifically, an expenditure shock of 1 percent of GDP lasting through 2024 and 2025, to respond to a protracted crisis or a natural disaster for instance, would increase the debt-to-GDP ratio by 1.0 percentage points relative to the baseline by 2025 (Figure 2). A permanent 30 percent exchange rate depreciation shock starting in 2024 would increase the debt-to-GDP ratio by 2.0 percentage points relative to the baseline. A negative growth shock, subduing GDP growth in 2024 to 3 percent from 5 percent, combined with a proportional revenue decline, would increase the debt-to-GDP ratio by 0.8 percentage point relative to the baseline. The interest-to-revenue ratio is projected to increase from 14.1 percent to at most 16.6 percent over 2019-2026, under all scenarios considered. After rising sharply in 2020 due to exchange rate and GDP shocks, external debt is expected to return to pre-COVID levels as the economy rebounds, gross financing needs fall, and equity inflows gradually rise (Figure 3 and Table 4).

25. Risks to the outlook are skewed to the downside given uncertain global conditions, tightening global finances, and the upcoming elections cycle that can stall implementation of structural reforms. Unfavorable global conditions could weigh on Indonesia's growth and tighten policy space. Sustained global monetary tightening could keep financing costs high and tighten credit conditions. Banking sector shocks in the US have increased global financial uncertainty and may prompt capital outflows from EMDEs, including Indonesia, which could incite further policy tightening. Moreover, deteriorating global economic activities as well as China's structural slowdown can lead to adverse impact on exports and further weaken investment. Domestically, despite moderating, inflation could prove stubborn and put a strain on consumer purchasing power. This could be exacerbated by upside risk coming from recently rising global oil prices. Moreover, the long election cycle in 2024 could stall structural reforms which are critical to boost the competitiveness of the economy, boost potential growth, and attract foreign direct investment. With low levels of debt, anchored inflation and adequate financial buffers, Indonesia has the fiscal and monetary policy space to stimulate the economy and mitigate those risks going forward.

Figure 2. Central government debt is projected to remain overall manageable...

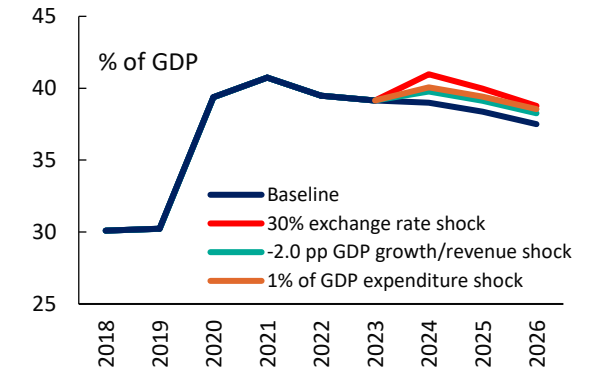
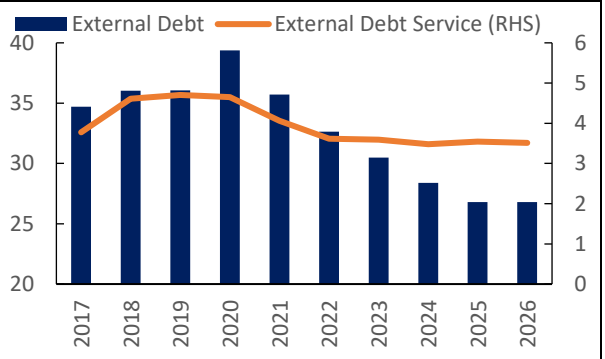


Figure 3. .... while external debt is expected to decline and return to pre-COVID-19 levels



Note: DSA last updated in June 2023. Source: MoF, WB staff projections.

26. Exit strategies from macroprudential easing, particularly loan forbearance measures, will need to be carefully designed and the insolvency strengthened to facilitate private sector debt restructuring. Exit from macroprudential easing faces difficult trade-offs between exiting too early which could increase bankruptcies and exiting too late which could fuel zombification (i.e., supporting unviable firms). Banks have been required to implement additional measures under the oversight of the Financial Services Authority (OJK) to ensure adequate monitoring of the implementation of the forbearance measures. The Financial Sector Omnibus Law, enacted in January 2023, provides an opportunity to address gaps in financial sector depth and stability. The law promotes legal certainty and clarity in the legal frameworks on financial innovation, macro prudential mandates, and supervision.

Table 4. External debt composition, as of June 2023

	US$ (billions)	Share of total debt	% of GDP[a]
Monetary authorities	9.3	2.3	0.6
Central government	192.5	48.6	13.5
Banks	32.7	8.3	2.3
Other private	161.8	40.8	11.3

Note: (a) Percent of estimated 2023 GDP. Source: BI, WB staff calculations.

27. The macroeconomic policy framework is adequate for the purposes of the proposed operation. Indonesia has built a strong track record of prudent macroeconomic management. This has been evident in the authorities' macro policy response during COVID and more recent commodity price shock. The authorities have maintained transparent communication of fiscal and monetary policies, consistency in policy mix, and prudent countercyclical policies. This has enabled Indonesia to maintain policy space to respond to shocks and maintain investment grade in sovereign credit ratings. The current monetary policy stance is appropriate given the current global economic circumstances. Maintaining a slightly elevated policy interest rate, despite its impact on growth, leans against the risks of capital flight from EMDEs and supports BI's macro stability anchor. The fiscal policy stance, on the other hand, remains prudent. The authorities achieved fiscal consolidation including through tax revenue reforms and the partial unwinding of energy subsidies. The GoI renewed its commitment to the fiscal rule by presenting parliament with a 2024 budget that targets a fiscal deficit of 2.5 percent of GDP. Financial buffers also remain strong. Foreign currency reserves are above 6 months of imports and short-term debt, while the public debt is sustainable. The banking sector remains overall stable with strong capital adequacy as well as adequate balance sheet and liquidity indicators that provide a cushion against potential interest rate and liquidity risk shocks.

2.3. IMF RELATIONS

28. Indonesia does not have an ongoing program with the International Monetary Fund (IMF). The IMF Executive Board concluded the 2023 Article IV consultation with Indonesia on May 22, 2023 (see Annex 2 for press release). The IMF Board considers Indonesia's forward-looking, and well-coordinated policies helped it close out the challenging global environment of 2022 with healthy growth, falling inflation, and a stable and profitable financial system. Going forward, the IMF expects Indonesia to continue with strong and inclusive growth, supported by broad-based reforms to promote an enable business environment, diversify the economy, and mitigate climate change. Risks are broadly balanced in the near-term, but a highly uncertain global economic environment continues to cloud the outlook. IMF staff had supported Indonesia with technical assistance in a variety of areas, including on tax policy and recommended the use of additional revenues to finance spending on infrastructure, education, and health.

3. GOVERNMENT PROGRAM

29. The GoI's program and priorities to be supported by this DPL are guided by the RPJPN 2005–2025. As further specified in the RPJMN 2020–2024, the development goal of the RPJPN 2005–2025 is to realize an Indonesian nation that is advanced, self-reliant, and just. The RPJPN aims to strengthen noble morals, competitiveness, democracy, security, equity, sustainability, self-reliance and Indonesia's role in the international community. In order to realize a nation that is competitive, it aims to develop quality human capital, strengthen the economy, and utilize science and technology.

30. The RPJPN highlights the important role of improving health services for developing quality human capital. It stipulates that the development of health is to be carried out on the basis of humanitarian considerations, as well as considerations on empowerment and self-reliance, justice and equity, with special attention to vulnerable populations,

such as mothers, babies, children, the elderly, and poor households. For this purpose, the RPJPN requires the development of health to be implemented through increasing health services, health financing, health personnel, medicines and health instruments accompanied by increasing supervision, community empowerment, and health management.

31. The HOL provides a robust legal foundation for the six pillars of the Health System Transformation Agenda. Based on a mandate from President Joko Widodo, the Health System Transformation Agenda aims to establish a well-structured public health system that integrates and standardizes all levels of public health facilities and laboratories. The agenda has six pillars: (i) primary care transformation; (ii) secondary care transformation; (iii) health resilience transformation; (iv) health financing and system transformation; (v) health workforce transformation; and (vi) health technology transformation. The agenda aims to create a cohesive framework where different levels of public health facilities, including primary health centers, district hospitals, and specialized hospitals, work together in a coordinated manner. It emphasizes the importance of collaboration and data system integration. The DPL primarily supports pillars (iii) and (v) as well as pillars (i) and (ii), complementing support by a large WB health portfolio including several PforR and IPF operations (see paragraph 53) and in alignment with the WHO Health Systems Building Blocks Framework (Figure 1).

32. The policy reforms supported by this DPL will have a non-negligible impact on health expenditures. While the impact of some of the reforms will only build gradually, over time they are expected to increase the supply of medical doctors, which will increase utilization of primary and referral health services. Thus, it will ultimately increase the wage bill and operational costs including consumables and equipment maintenance. It will also require additional medical equipment. If the reforms enable Indonesia to achieve the physician to population ration of 1 per 1000 population by 2030 as per the WHO threshold, the number of general practitioners and specialists will increase by 43 percent and 75 percent, respectively. Assuming all new additions will be hired in the public sector and accounting for the cost of scholarships for training new doctors, an upper bound estimate for additional cost of salaries, functional allowances and scholarships is 1.63 percent of general health expenditures in 2023 (US$ 340 million) and 6.43 percent in 2030 (US$ 2.7 billion). Also considering complementary investments in (i) the resilience pillar of the Health System Transformation Agenda, (ii) medical equipment procurement, (iii) cost of maintenance of this equipment and consumables, (iv) and spending associated with expected increases in utilization of primary and referral-level services, the upper bound total cost of the reforms is estimated at 6.63 percent and 10.84 percent of general health expenditure in 2023 and 2030, respectively.

33. The additional expenditures of the policy reforms supported by this DPL are expected to remain fiscally manageable. Efficiency gains from reforms supported by this DPL and strengthened sectoral governance and implementation fidelity supported by the Strengthening JKN Reforms and Results PforR[15] are expected to create the fiscal space to cover some of the additional costs. However, given Indonesia's already low public health spending, in the medium term the sector will need additional resources. As the upper bound total cost of the reforms of 10.84 percent of general health expenditure in 2030 translates to only 0.2 percent of projected GDP in 2030, this is expected to remain manageable.

4. PROPOSED OPERATION

4.1. LINK TO GOVERNMENT PROGRAM AND OPERATION DESCRIPTION

34. The Program Development Objective (PDO) is to support the government's efforts to strengthen the supply of medical care professionals. Within the GoI's program and priorities as defined by the RPJPN and RPJMN, the DPL includes

[15] World Bank. 2021. Indonesia - National Health Insurance (JKN) Reforms and Results Program. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/33653188

a set of Prior Actions (PAs) that support select high-impact policy reforms centered around the HOL[16] with selectivity based on three filters: (i) complementarity to other WB health operations including to support the GoI's large-scale procurement of medical equipment (see paragraph 53), (ii) consistency with WB corporate priorities and the PDO, and (iii) alignment with WB comparative advantages ('value add') such as consistent track record of impactful policy dialogue and advisory services and analytics (ASA).[17]

- **PA 1** supports policy reforms that change the previously overlapping and convoluted policies for the registration and licensing of medical doctors which limited the domestic supply of doctors and created opportunities for rent-seeking.
- **PA 2** supports policy reforms to improve the supply of foreign medical doctors and Indonesian medical doctors who graduated abroad, including by exempting certain such professionals from a competency test**.**
- **PA 3** supports policy reforms to create viable pathways for non-Indonesian medical doctors to practice in Indonesia, to improve the supply of such doctors by extending their permitted duration of practice.
- **PA 4** supports policy reforms to expand the supply of specialist medical doctors through a nationwide hospital-based residency program with codified competency standards.
- **PA 5** supports policy reforms to enhance health system resilience through establishing a healthcare worker reserve.

35. The policy reforms supported by the DPL are expected to unlock critical constraints in the health system. All policy reforms are expected to contribute to the health system building blocks of healthcare workforce and health service delivery, and those supported by PA5 also to the cross-cutting theme of pandemic prevention and preparedness. While policy reforms supported by PAs 1 and 2 are both expected to strengthen primary care, those supported by PAs 1 to 4 will all strengthen referral-level care. Altogether, the policy reforms will foster the health system goal of improved health and responsiveness. While the policy reforms will not directly and immediately improve spatial inequality, over time they are expected to help relieve relevant constraints including regarding the uneven supply of medical care.

36. The DPL is aligned with the goals of the Paris Agreement and consistent with Indonesia's climate commitments. This includes the country's National Adaptation Plan, which has a focus on increasing the health system's capacity to cope with outbreaks of climate-sensitive diseases, which the DPL supports through its thematic focus on increasing the availability of care and improving resilience in the face of shocks. Analogously, the DPL also aligns with Indonesia's 2022 Enhanced Nationally Determined Contribution (ENDC), which underlines the need for universal health service provision to ensure archipelagic climate resilience by 2030. The health sector has, therefore, been identified as a priority field to address the drivers of vulnerability to climate change impacts. Moreover, WB (2023a) *Indonesia Country Climate and Development Report (CCDR)* points out that the expansion of health programs underpins climate resilience, needed for growth, which the DPL supports by expanding JKN. All PAs of the DPL are universally aligned with the mitigation goals of the Paris Agreement as human health-oriented service activities without infrastructure component. None of the PAs are likely to cause a significant increase in greenhouse gas (GHG) emissions, thereby not hindering Indonesia's transition to a lower GHG emissions pathway with an unconditional emission reduction target of 31.89 percent in the ENDC. The strengthened and more equitable health service delivery the DPL pursues is also consistent with the mitigation goals of the Long-Term Low Carbon and Climate Resilience Strategy (LTS-LCCR) 2050, striving for a national GHG emissions peak in 2030, by providing care closer to communities, reducing health-related travel needs. Similarly, risks from climate hazards are unlikely adversely affect the PAs' contribution to the PDO, while these contribute to the resilience and adaptation of

[16] Some aspects of the GoI's broader reform program under the HOL are beyond the scope of the DPL, such as the abolition of a mandate for government to allocate a certain share of spending to health.
[17] Relevant WB ASA outputs include *Health Workforce in Indonesia* (2021) on strengthening the supply of medical care and *Planning for Contingent Health Workforce* (2022c) on enhancing health system resilience.

Indonesia's public health sector to the adverse impacts of climate change through more equitably distributed care and a workforce reserve tailored to responding to climate shocks. See Annex 5.1 for a detailed review of the Paris Alignment.

4.2. PRIOR ACTIONS, RESULTS AND ANALYTICAL UNDERPINNINGS

Prior Action 1: To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MoH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law.

Result indicator: Number of medical doctors with a valid STR (including general practitioners, dentists, specialists, and sub-specialists) – Baseline 238,318 (09/2023), Target 251,099 (12/2024)

37. Rationale. Indonesia is grappling with a critical shortage of medical doctors. The shortage creates a barrier to accessing medical care, a situation that is to a significant extent attributable to policy hurdles. To practice, medical doctors must obtain both an STR from the IMC and an SIP from local government. Until recently, there was also a dual requirement of renewing both SIPs and STRs every five years, which created opportunities for abuse and bureaucratic inefficiency. Besides, for issuing and renewing STRs and SIPs recommendations letters from the IDI were needed, which resulted in a process often marred by subjectivity and personal bias and undermined the government and IMC's roles in ensuring transparency and equitable healthcare distribution. Additionally, the IDI's authority in validating continuous learning requirements, coupled with its role in offering these programs, led to the appearance of potential conflicts of interest.

38. Substance. PA 1 supports the GoI in implementing a groundbreaking reform concerning the licensing and registration process for medical doctors, according mainly to Chapter VII on Health Human Resources of the HOL. This reform encompasses several significant changes. First, it extends the validity of the STR from five years to a lifetime duration. Second, it enhances the central government's authority, particularly through the MoH, in overseeing the STR processing. Third, it eliminates the previous requirement for medical doctors to obtain a recommendation letter from the IDI to acquire or renew either an STR or SIP. Lastly, the reform bestows the MoH authority to validate the fulfillment of professional credits, a necessity for the renewal of SIPs and previously required for the renewal of STRs.

39. Expected impact. This policy reform is expected to significantly augment the number of general practitioners and specialist doctors in active service from 238,318 in September 2023 to 251,099 in December 2024 while also ensuring timely recertification for their SIPs. It will reduce costs for physicians, eliminating the need to renew specific requirements and will act as a safeguard against opportunities for abuse and bureaucratic inefficiency. By granting the MoH the authority to validate the fulfillment of professional credits for SIP renewals, a uniformed and transparent professional credit validation process will be established. This policy reform will also incentivize the MoH to develop continuing medical education programs, ensuring that medical doctors remain current with their knowledge and skills. The overarching benefits will include not only increased access to primary and referral-level medical care and administrative efficiency but also the preservation and enhancement of medical standards, aligning with the broader goal of healthcare excellence.

Prior Action 2: To increase the number of medical doctors who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law.

Result indicator: Percentage of new STRs issued to foreign and Indonesian medical doctors who graduated from abroad (including general practitioners, specialists, and sub-specialists) – Baseline 0.13% (09/2023), Target 0.22% (12/2024)

40. Rationale. Previously, there was no pathway for foreign specialist medical doctors to practice in Indonesia and significant barriers hindered Indonesian nationals who had graduated from medical schools abroad from practicing in their home country. This significantly contributed to the shortage of general practitioners and specialist medical doctors. Challenges for non-Indonesian medical specialists included multiple manual applications with payments submitted to MoH, the Ministry of Education, Research, Culture and Technology (MoECRT), the IMC, and collegiums as well as a complex competency test, which created significant uncertainty and served as a practical deterrent. The competency test was also mandatory for all Indonesian medical doctors who had graduated from abroad (in addition to the verification of administrative requirements). In principle, these competency tests were aimed at assessing doctors' qualifications and skills to ensure that they met medical standards. In practice, however, they posed a specific barrier because they often involved stringent examinations and assessments that could be difficult to pass, as well as subjectivity. Not only did these measures slow down the entry of skilled medical professionals, but they also contributed to a sense of uncertainty and hesitation among many who were considering returning to Indonesia to practice. In the span of 2016-2021, only 163 Indonesian specialist doctors, who had graduated from medical schools abroad, were able to practice in Indonesia.

41. Substance. PA 2 supports the GoI's policy reform to recognize foreign degrees by exempting certain professionals from the standard competency test, according mainly to Chapter VII on Health Human Resources of the HOL. These exemptions apply to four distinct categories of medical doctors: (i) Indonesians who have graduated from a recognized medical school and have accrued at least two years of experience abroad,[18] (ii) Indonesians who possess expertise in a flagship medical field, proven by a certificate of competency, (iii) foreign specialists who either graduated from a recognized medical school and have at least five years of experience abroad, and (iv) foreign specialists who are experts in a specific medical field with at least five years of experience in said expertise. This reflects an acknowledgment of international standards and the valuable experience gained overseas and encourages foreign specialists and Indonesian general practitioners and specialists who had graduated from abroad to contribute their skills and knowledge to Indonesia. By easing the process of licensing and recognizing international credentials, the reform lays a promising foundation for attracting and retaining a talented pool of medical professionals. In addition, Indonesian medical doctors who graduated from abroad will also benefit from the replacement of the previous 5-yearly STR validity with a lifetime validity STR supported by PA 1. This move is a symbol of trust and permanence, signifying a long-term commitment to these professionals and ensuring that the renewal of their credentials will no longer be a hindrance in their career.

42. Expected impact. By granting lifetime validity to STRs and exempting certain professionals from competency tests, over time Indonesia is likely to see a significant increase in the number of foreign and Indonesian medical diaspora returning to Indonesia, especially those with specialized skills. While in the short term the percentage of new STRs issued to foreign and Indonesian medical doctors who graduated from abroad is only expected to increase from a very low baseline of 0.13 percent during the first nine months of 2023 to 0.22 percent in 2024 the opening up of the market holds significant potential to increase the medical workforce in the medium term. Indirectly, this is expected to lead to improved healthcare access. Moreover, recognizing international qualifications and specific expertise is also expected to foster a more diverse and globally aligned healthcare environment, promoting knowledge transfer and collaboration. Through this strategic policy reform, the GoI is not only investing in Indonesia's immediate healthcare needs but also laying the groundwork for a sustainable and innovative healthcare future.[19]

[18] The list of recognized medical schools will be specified in an upcoming MoH Regulation. It is likely to be reviewed periodically.

[19] Even in the medium term not all Indonesian medical doctors who graduated from abroad are expected to choose to return to their home country, due to reasons such as living standards, salary, and education opportunities for their children that are unrelated to the specific policy environment.

Prior Action 3: To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law.

Result indicator: Percentage of STRs issued to non-Indonesian specialist medical doctors practicing in the Special Economic Zones among newly issued STRs to non-Indonesian specialist medical doctors – Baseline 0% (09/2023), Target 10% (12/2024)

43. Rationale. According to the MoH, in 2022 42 percent of hospitals lacked the minimum required staffing in seven specialized fields, including Pediatrics, Obstetrics and Gynecology, Internal Medicine, Surgery, Anesthesia, Radiology, and Clinical Pathology. In parallel, specialist medical doctors who were not Indonesian citizens faced almost insurmountable challenges to practicing medicine within the country. These challenges included multiple manual applications as well as a complex competency test, which created significant uncertainty and served as a practical deterrent for non-Indonesian medical doctors. Even after non-Indonesian medical doctors fulfilled all these requirements, they were only allowed to practice in Indonesia for a maximum of two years. This contributed to the shortage of specialist medical doctors and indirectly limited the access to and quality of healthcare for the Indonesian population.

44. Substance. PA 3 supports the GoI to expand access to medical care in Indonesia by extending the allowed duration of work permits for foreign specialist medical doctors to practice in Indonesia, according mainly to Chapter VII on Health Human Resources of the HOL. The HOL together with MoH Ministerial Regulation Number 6/2023 on the empowerment of foreign health workers facilitates their ability to practice in Indonesia under carefully regulated conditions. First, it increases the maximum duration of practice from two years to four years if there is demand for the foreign specialist's services from a specific health facility. Second, it waives the restriction on the four year maximum duration of practice for specialists practicing in Special Economic Zones (SEZs).[20] SEZs are areas endowed with geo-economic and geo-strategic advantages where special facilities and incentives are extended to attract investment in industry and tourism. They are scattered across various islands, some in lagging regions with a particularly critical shortage of medical professionals such as North Maluku and West Papua. Special consideration for SEZs holds huge potential as a policy laboratory for demonstrating the impact of new initiatives. In addition, multiple manual applications are being replaced by a single digital application through, significantly reducing hurdles in the application process. The implementation of this policy reform puts relatively stringent regulations in place that ensure that the quality standards of medical practice are maintained.

45. Expected impact. Due to the decentralized nature of Indonesia's health care system with the majority of medical facilities run either by subnational governments or the private sector, there is currently no specific target or plan for the hiring of foreign doctors. However, the MoH is committed to meet the WHO target of 0.28 specialists per 1,000 population. Given population growth, to achieve this by 2030, Indonesia will need an additional 35,450 specialists, which will require at least 4,431 new specialists every year. MoH also has a very specific and in fact frontloaded fulfillment plan encompassing concrete initiatives such as scholarships and fellowships to address the needs for specialists at public referral hospitals. This plan highlights a need of 5,593 additional specialists (mostly in oncology and cardiology) that needs to be fulfilled in two phases (3,679 additional specialists in 2022–2024 and another 1,914 in 2025–2027). Against this backdrop, the policy reform supported by PA 3 is expected to contribute to addressing the shortage of specialist doctors. Similar to PA2, the impact is expected to be relatively small in the short term but significant over the medium term. First, Indonesia will likely see an increase in the number of specialist medical doctors, contributing towards the attenuation of the current shortage while ensuring that quality standards are not compromised. Second, the influx of diverse skills and knowledge from other

[20] While the HOL uses the term 'waive', the GoI may still impose a different (more relaxed) maximum practice duration on foreign specialist medical doctors practicing in SEZs. More specific details will be clarified in the upcoming implementing regulations.

medical cultures is expected to enhance innovative approaches to healthcare and foster a more dynamic healthcare system. Third, the policy reform has the potential to improve overall access to healthcare, including in regions that have been grappling with particularly acute shortages in specialist doctors and those that are vulnerable to the impacts of climate change. In the short run, the percentage of STRs issued to non-Indonesian specialists practicing in the Special Economic Zones among newly issued STRs to non-Indonesian specialists is expected to reach 10 percent in 2024.

Prior Action 4: To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law.

Result indicators: (i) Number of teaching hospitals that start medical residency program – Baseline 0 (09/2023), Target 6 (03/2025), (ii) Number of teaching hospitals that start medical residency program in oncology – Baseline 0 (09/2023), Target 1 (03/2025) (ii) Number of teaching hospitals that start medical residency program in obstetrics and gynecology – Baseline 0 (09/2023), Target 1 (03/2025)

46. Rationale. In September 2023, there were only 47,960 specialist medical doctors in Indonesia. At 0.16 specialists per 1,000 population, this number falls 29,180 specialists short of Indonesia's target ratio of 0.28 specialists per 1,000 population. A key reason for the significant shortage of specialist medical doctors is the restricted production of these professionals, which was previously confined to the capabilities of a small number of higher education institutions. In fact, out of 93 medical schools in Indonesia only 18 provide specialist training. This situation was further complicated by a disproportionate focus on certain geographic locations, with most of these institutions concentrated in the more developed regions of the country, namely Java, Sumatera, and Bali. The limitation in the educational infrastructure meant that aspiring specialist medical doctors in less developed or remote areas had fewer opportunities for training.

47. Substance. PA 4 supports the GoI in augmenting the production of specialist medical doctors by complementing the existing university-based residency training by more practical hospital-based residency training, according mainly to Chapter VI on Health Facilities and Chapter VII on Health Human Resources of the HOL. Quality assurance of specialist medical education will be a collaborative effort involving close coordination among the MoH, the MoECRT, and various medical collegium branches. This tripartite alliance will promote a synergistic cooperation to safeguarding the quality and relevance of the curriculum while increasing the availability of specialist medical care. Alongside these measures, the GoI's establishment of clear and codified competency standards will serve as a benchmark for medical specialists. The policy reform, which includes a dedicated assessment of local needs for medical specialists, is keenly attuned to the diverse requirements of different regions within Indonesia. This targeted approach is positioned to ensure that the most needed types of specialists are trained in the regions where they are most required. To ensure equity and align supply and demand, local students will be prioritized in the admission process and graduates will initially be assigned to hospitals by the MoH.

48. Expected impact. The policy reform is expected to increase the availability of specialist medical care and close the shortfall by 2030. Given previous trends, the time required to achieve the necessary number of specialists in the three most deficient fields would have been approximately 36 years for OBGs, 26 years for pediatricians, and 23 years for internists. However, with the policy reform it is expected that the time will be shortened to eight years for OBGs, eight years for pediatricians, and six years for internists. This will represent a significant stride towards addressing healthcare shortages and improving medical care, especially in terms of addressing the leading causes of death (NCDs such as cancer, heart, stroke and uronephrology diseases). By early 2025 alone, it is expected that at least six teaching hospitals will start medical residency programs, at least one of which will cover oncology and another one obstetrics and gynecology. The geographic reach of the initiative, which is expected to gradually extend into underserved lagging regions sensitive to climate-induced natural disasters, is expected to lay the groundwork for mitigating longstanding inequalities in access to maternal and obstetric care. Expanding the overall supply of OBGs may enable lagging regions to tap on the capacity created to institute future residency programs in their own regions. As such, unlocking the overall shortage is the critical

entry point to addressing maternal mortality issues both across the country and in those regions with poorer health outcomes. The intentional assignment of graduates to hospitals in regions with the most pressing need for specific specialists is also expected to gradually promote a more equitable distribution of medical expertise across the country.[21]

Prior Action 5. To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.

Results Indicator: Head count of healthcare worker reserve in accordance with the mandates and provisions of the Health Omnibus Law – Baseline 0 (12/2022), Target 13,723 (12/2024). The reserve will meet peak demands for care during natural disasters and extreme events, including those fueled by climate change. It is expected to contribute to a substantial improvement of the adaptive capacity of Indonesia's public healthcare system to the impacts of climate change as 80% of disasters that occurred in Indonesia between 1998 and 2018 were attributable to climate change.

49. Rationale. The inadequate availability and inequitable distribution of healthcare workers across geographic areas[22] were critical bottlenecks to Indonesia's COVID-19 response effort. Healthcare workers play critical roles to mount public health and medical countermeasures during health emergencies. During the early phases of the pandemic, the COVID-19 rapid response taskforce estimated the country would need an additional 1,500 medical doctors and 2,500 nurses to manage the surge in COVID-19 patients. Quickly recruiting volunteers, training, and deploying them to meet this surge capacity proved difficult. In addition to infectious disease outbreaks, the demand for a surge capacity in Indonesia is huge given its exposure to various climate-related and geophysical natural disasters, including those driven by climate change. Until recently, the lack of a comprehensive database that identifies the competency and mobility restrictions of a health reserve workforce also made it difficult quickly identifying suitable personnel based on specific needs.

50. Substance. PA 5 supports the GoI in providing the necessary legal foundation for the establishment of a healthcare worker reserve and accompanying legal provisions to facilitate mobilization and utilization of the reserve, according mainly to Chapter VII on Health Human Resources and Chapter XII on Extraordinary Events and Outbreaks of the HOL. The HOL obliges every doctor, dentist and other healthcare worker (e.g., paramedics, nurses and midwives) to participate in disaster and epidemic management activities and provides them the legal ground to provide services beyond their authority in exceptional circumstances such as during disease outbreaks and climate-induced or geophysical natural disasters. By doing so, the reform expands both the number of people who can be mobilized as well as the types of services they can provide with appropriate training. Accompanying provisions also specify that the reserve workforce can include non-practicing healthcare workers (e.g., medical students and lecturers) who will receive appropriate training on handling disease outbreaks and disasters, and that this will be managed though a centralized registration and credentialing information system. MoH has recently established a centralized dashboard for tracking the healthcare worker reserve. It meticulously records various essential details, such as the current reserve count, the number of personnel mobilized, the different types of healthcare workers included, their levels of competency, and the geographic distribution of individuals.

51. Expected Impact. The establishment of a healthcare worker reserve is expected to expand the number of healthcare workers that can be quickly mobilized in the event of disease outbreaks and natural disasters, including those driven by climate change, and ensure the continued provision of essential health services during emergency situations. By December 2024, the head count of the healthcare worker reserve in accordance with the mandates and provisions of the HOL is expected to reach 13,723. This policy reform is also expected to reduce the time it takes to respond to an emergency and contain a disease outbreak, and thereby avoid the likelihood of an epidemic. Over the medium term, this surge

[21] By shifting the focus of medical training from university-based residency to a more hands-on, hospital-based approach, this policy reform is also expected produce a new generation of specialist medical doctors who are equipped with practical experience and specialized skills.
[22] A quarter of all pulmonologists, internists, anesthesiologists, and radiologists work in Jakarta, a province with three percent of the total population.

capacity is also expected to protect disadvantaged geographic areas that would otherwise face even more severe shortage of doctors and other healthcare workers in the midst of an emergency situations.

Table 5. DPL Prior Actions and Analytical Underpinnings

Prior Actions	Analytical Underpinnings
PA 1: To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MOH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law.	MoH (2023b) and WB (2022b) *Indonesia's Health Labor Market* underscore the shortage and inequitable distribution of medical doctors as a major constraint to strengthening care. WB (2014) *The Production, Distribution and Performance of Physicians, Nurses and Midwives in Indonesia* posits the need for rationalizing, simplifying, and unifying health workforce regulations. Blair et al. (2019) show that burdensome licensing reduces the supply of medical workers by 11.4 to 27 percent.
PA 2: To increase the number of medical doctors who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law.	MoH (2022) highlights that there is potential for leveraging Indonesian medical doctors who graduated abroad to leverage the complementary objectives of (i) giving these medical doctors an opportunity to contribute to Indonesia's health development, (ii) empowering the diaspora to support the Health System Transformation Agenda, and (iii) increasing the number of medical doctors available in Indonesia. Similarly, WB (2021) *Health Workforce in Indonesia* recommends alleviating the shortage of medical doctors by easing entry requirements for Indonesian medical doctors who have been trained abroad.
PA 3: To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law.	WB (2021) *Health Workforce in Indonesia* recommends easing entry requirements for foreign medical doctors to help address Indonesia's shortage of medical doctors. This point is picked up in the Academic Paper providing the GoI's official rationale for the HOL. According to WB (2010) *Indonesia: Health Workforce Study and Policy Options for Service Delivery Reform*, ensuring the quality of care provided by foreign-trained medical doctors is a critical factor in the success of policies aimed at addressing the shortage.
PA 4: To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law.	MoH (2023b) highlights the shortage of medical specialists in Indonesia, particularly in rural areas. WB (2014) *The Production, Distribution and Performance of Physicians, Nurses and Midwives in Indonesia* highlights that opportunities to undergo specialist training can be an incentive for medical doctors from Java to serve in remote areas.
PA 5: To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.	According to WB (2017a) *Investing in Health*, improved health system resilience reduces losses during emergencies. For Indonesia, MoH (2023a) emphasizes the importance of a healthcare worker reserve for health resilience while WB (2022) *Planning for Contingent Health Workforce* highlights the importance of information systems for health workforce resources and training planning in disaster response.

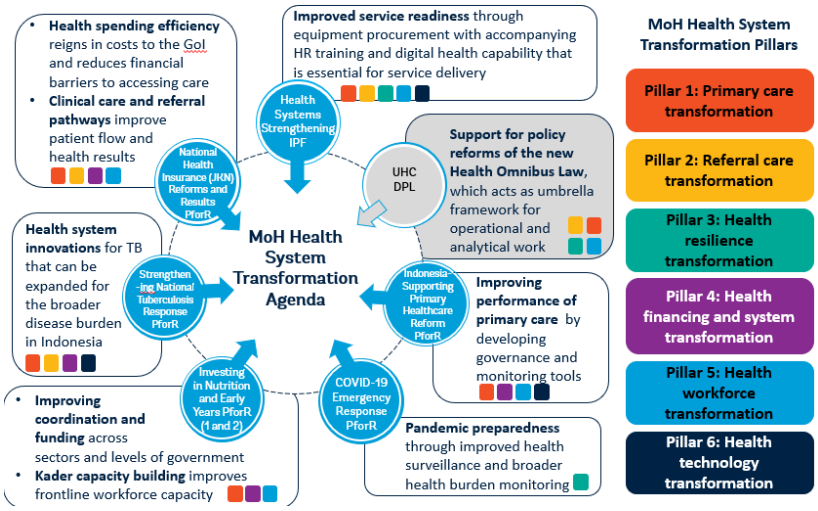
4.3. LINK TO CPF, OTHER BANK OPERATIONS AND THE WBG STRATEGY

52. The proposed DPL is fully aligned with the WB Country Partnership Framework for Indonesia for Fiscal Years

2021–25[23], the WB's mission to end extreme poverty and boost shared prosperity on a livable planet, the WB's Evolution Roadmap with its emphasis on global challenges including pandemic prevention and preparedness, and with corporate priorities including gender and climate change. The DPL directly speaks to the WB's vision and mission. It contributes to the third CPF engagement area on nurturing human capital and its objective to strengthen quality and equity in nutrition and health. The policy reforms supported by PA5 are directly related to the global challenge of pandemic prevention and preparedness. The DPL also directly addresses climate vulnerabilities and reduces climate risks that threaten Indonesia's UHC ambitions, as assessed during the climate change and disaster risk screening, a screening for Paris Alignment and a preliminary assessment of climate co-benefits. Finally, the DPL fosters gender equality, as documented through a gender results chain, including gender gaps, actions to tackle the gaps, and a result indicator to monitor progress.

53. The DPL is a vital complement to the large WB health portfolio in Indonesia in support of the Health System Transformation Agenda (Figure 4). The WB has been supporting the strengthening of sectoral governance and implementation fidelity through the Supporting Primary Healthcare Reform PforR,[24] the Strengthening National Tuberculosis Response PforR,[25] and the Investing in Nutrition and Early Years Phase 2 PforR,[26] the JKN Reforms and Results PforR, and the Emergency Response to COVID-19 PforR.[27] In addition, a new Health System Transformation Multi-Donor Trust Fund will provide recipient-executed technical assistance and the Reforms to Strengthen UHC Programmatic Advisory Services and Analytics support. Together with the policy reforms on the human resources for health transformation supported by the DPL, the Health Systems Strengthening IPF will strengthen the supply of medical care through equipment procurement, installation, operation, maintenance and training at public health facilities. It is a US$ 1.5 billion pipeline operation, complemented by US$2.35 billion co-financing from other multilateral development banks.

Figure 4. The proposed DPL as a complement to the larger WB health portfolio in Indonesia



[23] Country Partnership Framework for the Republic of Indonesia for Fiscal Years 2021-25 https://openknowledge.worldbank.org/server/api/core/bitstreams/b459c991-a781-5603-b3ca-47a7d784f87b/content

[24] World Bank. 2018. Indonesia - Supporting Primary Health Care Reform Program and Supporting Primary and Referral Health Care Reform Program Projects. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/29935019

[25] World Bank. 2022. Indonesia - Strengthening National Tuberculosis Response Program. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/33947945

[26] World Bank. 2023. Indonesia - Second Phase of Investing in Nutrition and Early Years Program-For-Results Project. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/34175424

[27] World Bank. 2020. Indonesia - Emergency Response to COVID-19 Program. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/32067189

54. Taking advantage of the window of opportunity presented by the approval of the HOL – which includes several meaningful one-off policy actions that achieve results with a direct impact on the ground – the DPL is designed as a stand-alone operation. The large portfolio of sectoral operations and ASA will foster sustainability of all policy actions supported by this DPL and the GoI's broader Health System Transformation Agenda. The sectoral portfolio will also provide support to the strengthening of sectoral governance and to on-the-ground implementation in the medium term.

55. The DPL builds on lessons learned from previous DPLs in Indonesia and internationally. Both the Rwanda First Programmatic Human Capital for Inclusive Growth DPF[28] and Madagascar's Investing in Human Capital DPF[29] had PAs on human resources for health. Madagascar's experience showed the importance of complementary ASA work, and of collaborating with other donors. Other DPLs in Indonesia, namely the Fiscal Reform DPL series[30] and the Human Capital DPL[31] demonstrated the importance of closely linking PAs to the achievement of the PDO. The Implementation Completion and Results Report of the Fiscal Reform DPL noted (i) the importance of ASA activities to support achievement of the PDO, (ii) that the design of DPLs should rest on a strategy that reflects high-impact priorities, and (iii) that evidence-based reforms that support existing government efforts are more likely to succeed.

4.4. CONSULTATIONS AND COLLABORATION WITH DEVELOPMENT PARTNERS

56. The GoI has conducted extensive consultations on the reform program with internal and external stakeholders, including the WB. The WB's dialogue with the GoI on health policy reform is long-standing, and the WB has supported the development of the ambitious Health System Transformation Agenda. The MoH, as the lead ministry for the HOL, conducted several rounds of public hearings and socializations regarding the substance of the Law. These events included a large range of relevant parties (including other ministries and governmental bodies, experts and academics, professional organizations, non-governmental organizations, development partners, BPJS-Kesehatan, regional health offices, patient advocacy groups, and chambers of commerce) and occurred primarily between March 13 and April 3, 2023, using two main modalities: (i) a web portal where everyone could access the draft law and raise questions and inputs (questions were answered by MoH in a three to four day window time), and (ii) a series of hybrid and face-to-face meetings during which key aspects of the HOL were presented, followed by an open forum where participants could ask questions and express concerns and feedback was collected. The inputs gathered as part of these consultations were used to improve the final draft of the HOL.

57. The DPL also draws on consultations conducted by the WB with various stakeholders for the WBG CPF for FY21–FY25. The proposed DPL is a key activity in the CPF's Engagement Area 'Nurturing Human Capital.' As such, it has undergone several rounds of consultations with a wide set of stakeholders, including from government, academia, civil society, the private sector, as well as development partners. These consultations are summarized in Annex 8 of the CPF. The annex highlights that '[v]irtually all stakeholders strongly supported the proposed CPF's focus on nurturing human capital for a modern economy. The support includes ensuring equity and quality of services in the health sector […].'

58. The reform program supported by the proposed DPL complements initiatives by key development partners,

[28] World Bank. 2020. Rwanda - First Programmatic Human Capital for Inclusive Growth Development Policy Financing. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/32607645
[29] World Bank. 2020. Madagascar - Investing in Human Capital Development Policy Financing Program. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/31847376
[30] World Bank. 2016. Indonesia - First Phase of Fiscal Reform Development Policy Loan Project. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/26366124
[31] World Bank. 2022. Indonesia - Human Capital Development Policy Loan. Washington, D.C.: World Bank Group. https://documentsinternal.worldbank.org/search/33840187

including the Asian Development Bank (ADB). There have been a series of exchanges with the ADB on respective budget support operations in the broader human capital space to assure alignment. In particular, the ADB's Boosting Productivity through Human Capital policy-based loan supports a series of complementary reforms in the broader human capital and health space, including reform initiatives aimed at enhancing public health systems by better linking budget allocations to health system goals. The documentation for the ADB's policy-based loan has been carefully reviewed to assure that the policy advice and support from the WB and ADB is consistent and complementary. More broadly, the GoI and the WB collaborate with various development partners on the UHC agenda. For instance, relevant recipient- and WB-executed technical assistance activities are supported by development partners including the Global Fund, the Global Financing Facility, the Bill & Melinda Gates Foundation, Germany's KfW, the Government of Japan, and the Government of Australia.

5. OTHER DESIGN AND APPRAISAL ISSUES

5.1. POVERTY AND SOCIAL IMPACT

59. **Taken together, the DPL's PAs are expected to improve access to healthcare services, reduce risks of catastrophic healthcare costs among the poor and vulnerable, and increase the progressivity of the fiscal and regulatory system (see Annex 4).** PAs 1,2,3 and 4 have clear, significant, and progressive distributional implications. One action has direct poverty reducing effects (PA 5) through its impact on reducing risks of catastrophic health expenditure, while four are expected to indirectly generate poverty reduction by improving healthcare access.

60. **PAs 1 to 4 address regulatory barriers that limit the number of practicing medical doctors.** The shortage of medical workers is prevalent across Indonesia and particularly affects its poorest provinces. In 2022, only Jakarta surpassed the average density of medical workers among UMICs. The reforms are expected to have progressive distributional effects by increasing the provision of healthcare services to disproportionately poor and vulnerable people. To the extent that adding more medical professionals enables better access to services among the poor and vulnerable, the reforms are also expected to increase the health and duration of healthy life of beneficiaries, and thus improve multi-dimensional wellbeing and indirectly reduce monetary poverty.

61. **Reforms included under PAs 1 to 4 are expected to benefit the poor and vulnerable through several channels.** First, an increase in the number of doctors accompanied by capitation is expected to increase competition for patients and increase incentives to provide better services. Greater competition will also partially reverse the deadweight loss associated with past quantity restrictions on provision of care and increase the cost effectiveness of healthcare spending compared to a counterfactual in which regulations remain. Second, a larger pool of medical workers is expected to increase the diversity of healthcare services by increasing the scope for specialization both in professional training and in modes of service provision. Third, while the policy reforms will not directly and immediately improve spatial inequality, over time they are expected to help relieve relevant constraints including regarding the uneven supply of medical care. This is expected to especially benefit the most underserved parts of Indonesia, which are significantly poorer on average than the best-served locations. Though incomplete, a range of small studies suggest that severe wait times linked to shortages of skilled professionals limits healthcare access especially in underserved areas. As a lack of available doctors encourages rationing of scarce services (and a concentration of medical talent in the most affluent areas), addressing shortages is expected to increase access to care especially for the poor.

62. **Over time, PA 4 will also support the complementary objective of incentivizing doctors to practice in underserved areas where a disproportionately large population of poor and vulnerable people reside.** By creating training and certification pathways in hospitals countrywide, the reform is expected to increase the availability of medical professionals outside of urban centers that currently enjoy substantially above average access to medical services.

63. Despite the clear benefits of PAs 1 to 4 for equity and poverty reduction, the reforms included under these PAs also come with modest risks. With the simplification of registration and licensing comes the potential for less qualified doctors obtaining the right to practice. However, this concern is mitigated by the features of the reform which focus on maintaining high quality standards. Changes enacted to administrative procedures focus on those aspects of traditional practice that were most discretionary and the least evidence based. In addition, the reform does not remove license renewal procedures that are intended to ensure the continued competency of doctors. Standards remain as well-aligned with tested practice in high-performing healthcare systems elsewhere in the world.

64. PA 5 aims to increase the resilience of the health system. It is expected that this reform will have neutral distributional impacts. It will likely contribute to poverty reduction by reducing risks of catastrophic health expenditure in the aftermath of epidemics and natural disasters as care comes closer and quicker to the affected households.

5.2. ENVIRONMENTAL, FORESTS, AND OTHER NATURAL RESOURCE ASPECTS

65. The policy reforms supported by this DPL are not likely to result in significant effects on Indonesia's environment, forests, and other natural resources. The expected policy-induced changes in human behavior supported by the DPL are not expected to lead to significant changes in the quantity or quality of environmental resources of a magnitude, duration or intensity to have non-negligible effects on ecosystems or human welfare. Any effects on environmental, forest and natural resource aspects are expected to be negligible. The strengthened supply of medical care resulting from the policy reforms may increase the volume of medical waste generated, but because the policy changes are not promoting construction of new medical facilities, the incremental additions will not be substantial. In any event, this DPL comes at a time when Indonesia is implementing a comprehensive program to remedy shortfalls in medical waste treatment capacity, in accordance with the Road Map on Hazardous Waste Management for Health Care Facilities (2019-2028) issued by the Ministry of Environment and Forestry (MoEF) and being implemented under the joint oversight of MoEF and MoH. One of its objectives is to have a properly-designed medical waste treatment facility in every province, and 15 of them had come into operation by 2023. The Ministry of National Development Planning (BAPPENAS) has a target of 10 more to be built in 2024. United Nations Development Programme (UNDP) and WHO have supported some of the construction. Special budget allocations are also available for waste treatment infrastructure such as temporary storage, freezers, autoclaves, and incinerators at the local level. The private sector is also contributing to medical waste management capacity; on Java, there are six companies licensed by MoEF to treat medical waste. The WB is supporting capacity-building via three PforR operations. In remote areas where medical waste management is not yet well-advanced, the MoH in collaboration with the Ministry of Home Affairs is intensifying outreach and education with support from the Investing in Nutrition and Early Years Phase 2 PforR. The Program Action Plan (PAP) for the Emergency Response to COVID-19 PforR includes medical waste handling advice and training for hospitals and laboratories, all shown as completed in the most recent ISR. One action in the PAP for the Supporting Primary Healthcare Reform PforR is finalization of accreditation standards for community health centers to include medical waste management capacity and performance. The standards were issued on March 15, 2023, as per Minister of Health Decree No. 165/2023.

5.3. PFM, DISBURSEMENT AND AUDITING ASPECTS

66. Public Financial Management (PFM) in Indonesia has important strengths, with the development of instruments that have allowed prudent fiscal management and control of budget execution. Indonesia's PFM has reliable fiscal management and budget control instruments, effective fiscal rules, and a well-defined treasury management system. Automation and integration provide improved financial reporting and oversight. The forex system has been strengthened with the implementation of the Central Bank Law and Forex System Law. The latest Public Expenditure and Financial

Accountability (PEFA) report (WB, 2017b) concludes that Indonesia has established a strong legal and regulatory framework that aligns with most international standards on PFM[32]. National budget documents are available to the public through the Ministry of Finance (MoF) website. Improvements to strengthen the effectiveness of the PFM systems and performance monitoring are ongoing, including strategic allocation of resources, budget implementation accountability, public investment management, and the efficient delivery of public services.

67. The BPK, Indonesia's Supreme Audit Institution, conducts financial audits on the central government's financial statements (LKPP), and the audit reports are timely submitted to the parliament within two months after the issuance of the unaudited financial statements. FY 2022 audit report was submitted to the parliament on June 20, 2023, and to the President on June 26, 2023. BPK expressed a clean opinion to LKPP for the last five years, including FY 2022. The audit report is publicly available on MoF and BPK websites.

68. BI is mandated to manage foreign reserves for monetary operations and international obligations. BI set up the forex system and has the authority to require information for forex activities. The IMF safeguards assessment of BI has not been completed. Nevertheless, several DPF packages were disbursed successfully in 2019–2022. The program's foreign currency account is held at the BI. There is a monthly bank reconciliation between treasury and spending units. BPK has expressed a clean opinion of BI's financial statements for the last five years.

69. The loan disbursement will follow the standard WB procedures for DPOs. The borrower is the GoI, and this operation is a single-tranche IBRD loan of US$ 1 billion equivalent. The same with the previous DPOs, the loan amount will be disbursed to a foreign currency account of the Borrower at BI, and the equivalent rupiah amount will immediately be transferred to the Borrower's General Operational Treasury account. The Borrower, within 30 days, will provide to the WB a written confirmation that this transfer has been completed and provide to the WB any other relevant information, including the exchange rate of the conversion from US dollars to rupiah, that the WB may reasonably request. The project is expected to close on December 24, 2024.

70. Disbursements of the loan will not be linked to any specific purchases, and no procurement requirements have to be satisfied, except that the Borrower is required to comply with the standard negative list of excluded items that may not be financed with WB loan proceeds, as defined in the General Conditions for IBRD Financing: Development Policy Financing (2018). If any portion of the loan is used to finance excluded expenditures as so defined in the General Conditions, the WB has the right to require the GoI to refund the amount to the WB promptly. Amounts refunded will be canceled from the loan**.**

71. Fiduciary risk. Based on the assessment of the PFM Systems and FOREX control environment, the fiduciary risk is moderate. Given the fiduciary risk level, no DPL audit will be required.

72. Procurement activities done by ministries/agencies/local government are currently governed by Presidential Regulation (Perpres) No. 16/2018 as amended by Perpres No. 12/2021. Perpres No. 16/2018 as amended by Perpres No. 12/2021 introduced some key provisions in the following areas: (i) increasing quality of procurement planning; (ii) promoting transparent, open and competitive procurement; (iii) strengthening the institution and human resource capacity; (iv) developing procurement e-marketplace; (v) using ITC technology and electronic transaction; (vi) increasing the opportunities for the MSMEs; (vii) promoting use of research and creative industries; and (viii) implementation of sustainable procurement. All procurement activities carried out by ministries/institution/local government are required

[32] Overall, the average PEFA performance score is slightly below 'B' (basic level of performance broadly consistent with good international practices, with nine out of 31 PEFA performance indicators receiving an 'A' (the highest rating), including public access to fiscal information.

to use e-procurement system (*Sistem Pengadaan Secara Elektronik*, SPSE) to ensure more transparency and efficiency of the public procurement process. However, the measure of the performance of the procurement system is currently limited to few indicators (see Appendix 6) and requires a well-developed mechanism to adequately monitor and evaluate the success of the reform initiatives in improving the quality and the performance of the country's public procurement system. A comprehensive assessment of the Indonesia public procurement system, using the Methodology for Assessing Procurement Systems (MAPS), jointly conducted by LKPP, the WB, and ADB has been completed and its key recommendations have been discussed and validated with all relevant MAPS's stakeholders during a validation workshop held in June 2022. The MAPS assessment recommendations and action plan are expected to help the Government prioritize the reform activities needed to enhance the effectiveness of the public procurement system in supporting Government policy objectives, improve the efficiency in public services delivery particularly in emergency situations like the COVID-19 pandemic, and increase the public trust while achieving value for money with high transparency and good governance. GoI is currently preparing the Public Procurement Law, which include encouraging and strengthening MSMEs and promoting sustainable development. In addition, GoI issued recently the Perpres No. 17/2023 for the acceleration of the digital transformation in the field of public procurement of goods and services and the designation of PT Telekomunikasi Indonesia (SOE) to develop new platform of the country's electronic government system and its supporting systems including interoperability among the existing government systems.

5.4. MONITORING, EVALUATION AND ACCOUNTABILITY

73. Progress on the results indicators will be monitored and evaluated by the Borrower. The MoH will be the executing agency for the proposed DPL. As executing agency, the MoH will take the overall responsibility for monitoring and evaluation, while coordinating relevant activities with the other ministries and professional associations involved in the agenda and reporting to the WB. Given its experience as executing agency for a series of WB PforR operations as well as one of the implementing agencies for the WB Human Capital DPL, MoH is comparatively well prepared to obtain and share data on the agreed results indicators. MoH also has the required monitoring capacity. Accordingly, the proposed DPL will rely on the existing systems of MoH to monitor the progress of its results indicators. The WB team will provide close support to ensure the monitoring takes place in a way that will facilitate timely reporting on the indicators. This will be particularly important for indicators that lie outside the standard government reporting.

74. Grievance Redress. Communities and individuals who believe that they are adversely affected by specific country policies supported as PAs or tranche release conditions under a WB DPL may submit complaints to the responsible country authorities, appropriate local/national grievance mechanisms, or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address pertinent concerns. Project affected communities and individuals may submit their complaint to the WB's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at any time after concerns have been brought directly to the WB's attention, and WB Management has been given an opportunity to respond. For information on how to submit complaints to the WB's corporate GRS, please visit http://www.worldbank.org/ GRS. For information on how to submit complaints to the WB's Accountability Mechanism, please visit https://accountability.worldbank.org.

6. SUMMARY OF RISKS AND MITIGATION

75. The overall risk rating is moderate, with one substantial source of risk. The source of residual risk rated as

substantial is the stakeholder risk. The potential benefits of the DPL outweigh the residual risk and warrant the WB's assistance.

76. The stakeholder risk is substantial given challenges in ensuring unanimous buy-in for the reforms of the HOL. While the GoI has conducted in-depth consultations with internal and external stakeholders on the reform program and these consultations have confirmed a broad support towards the objectives of the HOL (see paragraph 56), there is some stakeholder risk regarding the sustainability of the reform program supported by this DPL due to concerns by interest groups in particular regarding PAs 1 to 3 (such as by some representatives of medical doctors and other medical professionals) and PA 4 (such as by some representatives from universities). Some stakeholders have also criticized certain aspects of the GoI's larger reform program under the HOL beyond the scope of the DPL, such as for instance the abolition of the mandate for national and sub-national government to allocate 5 percent and 10 percent of spending to health, respectively. There is also some legal uncertainty as certain stakeholder groups may challenge the validity of the HOL in court. To mitigate these stakeholder risks and reduce the likelihood of reversal of reforms, the GoI is (i) continuing with proactive outreach and socialization measures, (ii) complementing the HOL with detailed implementing regulations (a first set of Government Regulations is expected to be completed by October 2023 and a second set of Ministerial Regulations by December 2023), and (iii) progressing quickly with implementation and complementary investments in equipment procurement to demonstrate tangible results on the ground: Part of the readiness criteria for the large-scale procurement effort of medical equipment for each level of facility across the country currently ongoing is putting in place the required human resources that would utilize the equipment. There is very strong interest from subnational governments for the equipment with the readiness criteria in place which indicates commitment to immediately embark on the hiring at subnational level. In parallel, the WB will provide technical support to the GoI throughout the reform implementation phase, monitor closely developments regarding the GoI's responses to stakeholder concerns, and disseminate evidence underlying the reform program supported by this DPL with a wider group of stakeholders. The WB will also continue to regularly consult and engage with a wide set of stakeholders as part of its health engagement in Indonesia.[33]

Table 7. Summary Risk Ratings

Risk Categories	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Moderate
7. Environment and Social	Low
8. Stakeholders	Substantial
9. Other	
Overall	Moderate

[33] As the HOL was approved with support by 7 out of 9 parties represented in Parliament and there were extensive consultations with internal and external stakeholders (see paragraph 56), the risk of a policy reversal following the upcoming national elections in 2024 is not deemed substantial.

ANNEX 1: POLICY AND RESULTS MATRIX

DETAILED RESULTS FRAMEWORK

Prior Actions		Results		
Prior Actions	**Lead Counterpart**	**Indicator Name**	**Baseline**	**Target**
Prior Action 1. To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MOH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law.	MoH	Number medical doctors with a valid STR (including general practitioners, dentists, specialists, and sub-specialists)	238,318 (09/2023)	251,099 (12/2024)
Prior Action 2. To increase the number of medical doctors and specialists who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law.	MoH	Percentage of new STRs issued to foreign and Indonesian medical doctors who graduated abroad (including general practitioners, specialists, and sub-specialists)	0.13% (09/2023)	0.22% (12/2024)
Prior Action 3. To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law.	MoH	Percentage of STRs issued to non-Indonesian specialist medical doctors practicing in the Special Economic	0% (09/2023)	10% (12/2024)

Prior Actions		Results		
		Zones among newly issued STRs to non-Indonesian specialist medical doctors		
Prior Action 4. To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law.	MoH	Number of teaching hospitals that start medical residency program	0 (09/2023)	6 (03/2025)
	MoH	Number of teaching hospitals that start medical residency program in oncology	0 (09/2023)	1 (03/2025)
	MoH	Number of teaching hospitals that start medical residency program in obstetrics and gynecology	0 (09/2023)	1 (03/2025)
Prior Action 5. To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.	MoH	Head count of healthcare worker reserve in accordance with the mandates and provisions of the Health Omnibus Law	0 (12/2022)	13,723 (12/2024)

RESULTS INDICATORS BY PILLAR

Baseline	Closing Period
Strengthening the supply of medical care professionals	
Number medical doctors with a valid registration letter (STR) (including general practitioners, dentists, specialists, and sub-specialists) (Number)	
Sep/2023	Dec/2024
238318	251099
Percentage of new STRs issued to foreign and Indonesian medical doctors who graduated from abroad (including general practitioners, specialists, and sub-specialists) (Percentage)	
Sep/2023	Dec/2024
0.13	0.22
Percentage of STRs issued to non-Indonesian specialist medical doctors practicing in the Special Economic Zones among newly issued STRs to non-Indonesian specialist medical doctors (Percentage)	
Sep/2023	Dec/2024
0	10
Number of teaching hospitals that start medical residency program (Number)	
Sep/2023	Mar/2025
0	6
➢Number of teaching hospitals that start medical residency program in oncology (Number)	
Sep/2023	Mar/2025
0	1
➢Number of teaching hospitals that start medical residency program in obstetrics and gynecology (Number)	
Sep/2023	Mar/2025
0	1
Head count of healthcare worker reserve in accordance with the mandates and provisions of the Health Omnibus Law (Number)	
Dec/2022	Dec/2024
0	13723

ANNEX 2: FUND RELATIONS ANNEX

Press Release: IMF Executive Board Concludes 2023 Article IV Consultation with Indonesia

June 25, 2023

(To be replaced with an IMF Assessment Letter if Board Submission date exceeds 6 months from date of press release publication)

The Executive Board of the International Monetary Fund (IMF) concluded the Article IV consultation[34] with Indonesia on May 22, 2023.

Indonesia's forward-looking, and well-coordinated policies helped it close out the highly challenging global environment of 2022 with healthy growth, falling inflation, and a stable and profitable financial system. With the recovery underway, policies have been geared toward restoring the pre-pandemic macroeconomic policy frameworks and accelerating structural reforms, to reinforce macroeconomic stability and build policy space against future shocks. Going forward, Indonesia is well-placed for continued strong and inclusive growth, supported by broad-based reforms to promote an enabling business environment, diversify the economy, and mitigate climate change.

The Indonesian economy performed strongly in 2022, growing by 5.3 percent, driven by a recovery in domestic demand and solid export performance and amid high international commodity prices. Growth is projected to moderate slightly to 5 percent in 2023, given tighter policy settings and the normalization of commodity prices. Inflation, having peaked at 6 percent last year, is forecast to return to Bank Indonesia's target range (3±1 percent) in the second half of 2023. The current account balance stood at 1.0 percent of GDP in 2022, on the back of high commodity prices, and is projected to turn into a small deficit in 2023. Risks are broadly balanced in the near-term, but a highly uncertain global economic environment continues to cloud the outlook.

Executive Board Assessment[35]

Executive Directors noted that the Indonesian economy is performing strongly, inflationary pressures are moderating, and macroeconomic policies have been appropriately returned to their pre-pandemic settings. The outlook remains favorable, and risks are broadly balanced, but with considerable uncertainty related to the external environment.

Directors welcomed the authorities' achievement of the 3 percent deficit ceiling one year earlier than envisaged and commended their commitment to fiscal discipline. Directors emphasized the importance of a concrete medium-term fiscal strategy going forward, including efforts to increase revenue mobilization, implement energy subsidy reform and expand social protection.

Directors noted that monetary policy has been tightened appropriately to preserve price stability. However, they emphasized the need for monetary policy to act decisively if inflation surprises on the upside. Directors also welcomed the end of the central bank primary market purchases of government bonds as scheduled.

[34] Under Article IV of the IMF's Articles of Agreement, the IMF holds bilateral discussions with members, usually every year. A staff team visits the country, collects economic and financial information, and discusses with officials the country's economic developments and policies. On return to headquarters, the staff prepares a report, which forms the basis for discussion by the Executive Board.

[35] At the conclusion of the discussion, the Managing Director, as Chairman of the Board, summarizes the views of Executive Directors, and this summary is transmitted to the country's authorities. An explanation of any qualifiers used in summing up can be found here: http://www.IMF.org/external/np/sec/misc/qualifiers.htm .

Directors noted that the Indonesian financial sector remains resilient, but intensive supervision remains important to tackle vulnerabilities related to higher interest rates and the sovereign bank nexus. They agreed that crisis-related regulatory relief measures should not be extended when they expire in March 2024 to reduce risks, including those of delayed loss recognition.

Directors observed that Indonesia has ample policy space to respond to adverse shocks. They agreed that the exchange rate should play a shock-absorbing role, noting that the use of foreign exchange intervention may be appropriate under certain shocks and circumstances.

Directors welcomed the recently adopted legislation on job creation and the financial sector, while noting the importance of prompt implementation and continued reform momentum, to promote an enabling business environment, enhance financial deepening, and mitigate the scarring effects of the pandemic.

Directors noted Indonesia's diversification strategy focusing on downstream activities from its raw commodities, such as nickel. They welcomed Indonesia's ambitions to increase value added in exports, attract foreign direct investment, and facilitate transfer of skills and technology, and noted that policies should be informed by further cost-benefit analysis, and designed to minimize cross-border spillovers. In that context, Directors called for considering phasing out export restrictions and not extending the restrictions to other commodities.

Directors welcomed the steps taken by Indonesia to limit greenhouse gas emissions and deforestation. They noted that energy subsidy reform and carbon pricing are critical to facilitate a green transition, but also agreed that the transition needs to be managed carefully and that mobilizing private financing is critical.

Table A2.1. Indonesia: Selected Economic Indicators, 2020–25

	2020	2021	2022	2023	2024	2025
				Proj.	Proj.	Proj.
Real GDP (percent change)	-2.1	3.7	5.3	5.0	5.1	5.0
Domestic demand	-3.8	2.9	3.8	4.6	5.0	5.1
Of which:						
Private consumption 1/	-2.7	2.0	4.9	4.9	5.1	5.1
Government consumption	2.1	4.2	-4.5	1.0	3.5	3.5
Gross fixed investment	-5.0	3.8	3.9	5.0	5.4	5.4
Change in stocks	-0.7	0.1	0.1	0.0	0.0	0.0
Net exports 2/	1.5	-0.4	0.8	0.6	0.4	0.3
Statistical discrepancy 2/	0.1	1.4	0.9	0.0	0.0	0.0
Output gap (in percent)	-3.4	-2.8	-1.1	-0.2	0.0	0.0
Saving and investment (in percent of GDP)						

Gross investment 3/	32.3	31.4	29.7	29.7	29.8	29.9
Gross national saving	31.9	31.7	30.7	29.5	29.1	28.8
Prices (12-month percent change)						
Consumer prices (end period)	1.7	1.9	5.5	3.2	2.8	2.7
Consumer prices (period average)	2.0	1.6	4.2	4.4	3.0	2.7
Public finances (in percent of GDP)						
General government revenue	12.5	13.6	15.2	14.5	14.5	14.6
General government expenditure	18.6	18.2	17.5	17.1	17.0	17.0
Of which: Energy subsidies	0.7	0.8	0.9	0.8	0.5	0.4
General government balance	-6.1	-4.6	-2.4	-2.6	-2.5	-2.4
Primary balance	-4.1	-2.5	-0.4	-0.6	-0.5	-0.4
General government debt	39.7	41.1	40.1	39.3	39.0	38.7
Money and credit (12-month percent change; end of period)						
Rupiah M2	12.5	14.0	8.4	7.6	6.6	6.3
Base money	0.4	19.3	23.9	8.6	7.4	7.8
Claims on private sector	-0.4	6.1	10.1	10.0	9.8	9.6
One-month interbank rate (period average)	4.5	3.6	4.2	...	...	...
Balance of payments (in billions of U.S. dollars, unless otherwise indicated)						
Current account balance	-4.4	3.5	13.2	-3.8	-11.2	-17.1
In percent of GDP	-0.4	0.3	1.0	-0.3	-0.7	-1.0
Trade balance	28.3	43.8	62.7	42.1	37.8	36.0
Of which: Oil and gas (net)	-5.4	-13.0	-24.8	-25.1	-21.3	-20.5
Inward direct investment	18.6	21.1	22.0	26.3	29.3	31.5
Overall balance	2.6	13.5	4.0	5.3	9.9	6.2
Terms of trade, percent change (excluding oil)	1.4	12.5	21.5	-9.5	-1.9	-0.8
Gross reserves						
In billions of U.S. dollars (end period)	135.9	144.9	137.2	142.5	152.5	158.6

In months of prospective imports of goods and services	7.5	6.4	5.9	5.5	5.3	5.0
As a percent of short-term debt 4/	209	244	206	208	207	198
Total external debt 5/						
In billions of U.S. dollars	416.9	414.0	396.8	403.8	419.1	441.4
In percent of GDP	39.2	34.9	30.1	29.0	27.8	27.1
Exchange rate						
Rupiah per U.S. dollar (period average)	14,529	14,297	14,874	...	...	...
Rupiah per U.S. dollar (end of period)	14,050	14,253	15,568	...	...	...
Memorandum items:						
Jakarta Stock Exchange (12-month percentage change, composite index)	-5.1	10.1	4.1	...	...	...
Oil production (thousands of barrels per day)	806	803	800	797	794	791
Nominal GDP (in trillions of rupiah)	15,443	16,977	19,588	21,459	23,229	25,048

1/ Includes NPISH consumption.
2/ Contribution to GDP growth (percentage points).
3/ Includes changes in stocks.
4/ Short-term debt on a remaining maturity basis.
5/ Public and private external debt.

ANNEX 3: LETTER OF DEVELOPMENT POLICY

MINISTER OF FINANCE
OF THE REPUBLIC OF INDONESIA

Number : S-900/MK.08/2023 5 November 2023

Mr. Ajay Banga
President
World Bank

Dear Mr. Banga,

1. The Government of Indonesia has placed a particular emphasis on reforms to advance Universal Health Coverage (UHC). In the Government's view, these reforms are crucial to support the country's economic transformation into a more sophisticated and prosperous economy. One of the priorities of the Long-Term National Development Plan (RPJPN) 2005-2025 is to improve the quality of Indonesia's human capital through initiatives to improve health services. The purpose of this Letter of Development Policy is to provide an overview of the Government's reform agenda with regard to advancing UHC by strengthening the supply of medical care and enhancing financial protection.
2. On behalf of the Government of Indonesia, we would like to express our appreciation for the technical assistance provided by International Bank for Reconstruction and Development (the "World Bank") to reforms in the health sector recently (including linked to the COVID-19 pandemic) and over prior decades. We would also like to request the support of the World Bank in the form of the Indonesia Universal Health Coverage Development Policy Loan.
3. In recent years, Indonesia has achieved momentous gains in health outcomes. Between 2000 and 2022, life expectancy rose from 66.2 to 71.85 years (BPS data), while between 2000 and 2020 both the under-five mortality rate and the infant mortality rate more than halved, to 19.83 per 1,000 live births (BPS data) and 16.85 per 1,000 (BPS data) live births respectively. In addition, the introduction of JKN as one of the world's largest single-payer social health insurance programs in 2014 led to a dramatic increase in the coverage of health insurance (95 percent enrollment in 2023) and utilization of health care services.
4. Despite these gains, Indonesia continues to trail its regional and economic peers in most health outcomes. At 189 per 100,000 (BPS data) live births, Indonesia's maternal mortality ratio remains significantly higher than the average for EAP. Indonesia also continues to compare unfavorably in life expectancy, infant, under-five, and neonatal mortality, as well as tuberculosis burden. Moreover, the share of deaths due to non-communicable diseases increased from 61 percent to 76 percent between 2000 and 2019. These trends are

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MINISTER OF FINANCE
OF THE REPUBLIC OF INDONESIA

increasingly straining the health system, which lacks physical and human resources to diagnose, treat, and adequately manage chronic conditions.

5. Recognizing the urgency and importance of reforms to advance UHC, the Government has undertaken an ambitious health sector transformation agenda. The transformation agenda includes five crucial policy reforms that follow the development goal of the RPJPN 2005–2025, which is to realize an advanced, self-reliant and just Indonesian society. The RPJPN highlights the important role of improving health services for developing quality human capital and achieving the RPJPN's development goal. For this purpose, the RPJPN requires the development of health to be implemented through increasing health services, health financing, health personnel, medicines and health instruments accompanied by increasing supervision, community empowerment, and health management.

6. The five reforms are centered around the Health Omnibus Law approved by Indonesia's Parliament in July 2023, and promulgated on August 8, 2023, as Law No. 17/2023. Omnibus Laws have been used in Indonesia to achieve major policy reforms by amending a set of relevant multiple laws through one piece of legislations. The first such law was the Job Creation Omnibus Law in 2020 followed by the Financial Sector Omnibus Law in 2022. The Health Omnibus Law revokes and combines a significant number of existing laws and regulations in the health sector.

7. The first policy reform concerns the licensing and registration process for medical doctors and addresses an important entry barrier for these doctors. This reform encompasses several significant changes. First, it modifies the status quo ante by extending the 5-year validity of doctors' registration letters (STRs) to a lifetime duration. Second, it enhances the Government's authority in overseeing the STR processing. Third, it eliminates the previous requirement for medical doctors to obtain a recommendation letter from the Indonesian Doctors' Association to acquire or renew either an STR or practicing license (SIP). Lastly, the reform bestows the Ministry of Health authority to validate the fulfillment of professional credits, a necessity for the renewal of SIPs and previously required for the renewal of STRs.

8. The second policy reform exempts certain Indonesian medical doctors who graduated from abroad from the standard competency tests. These exemptions apply to four distinct categories of medical doctors: (i) Indonesians who have graduated from a recognized medical school and have accrued at least 2 years of experience abroad, (ii) Indonesians who possess expertise in a flagship medical field, proven by a certificate of competency, (iii) foreign specialists who graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, and (iv) foreign specialists who are experts in a specific flagship medical field as proven by a competency certificate with at least five years of experience in said expertise abroad. In addition, Indonesian medical doctors who graduated from abroad will also benefit from the

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replacement of the previous 5-yearly STR validity with a lifetime STR validity supported by the first reform.

9. The third policy reform aims to increase the number of foreign medical doctors in Indonesia by extending the maximum duration that foreign specialist medical doctors are allowed to practice in Indonesia. First, it increases the maximum duration of practice from 2 years to 4 years if there is demand for the foreign specialist's services from a specific health facility. Second, it waives the four-year limitation for specialists practicing in specific areas of the country that are Special Economic Zones.

10. The fourth policy reform complements the existing university-based residency medical training by more practical hospital-based residency training by allowing teaching hospitals to host such residency programs for specialist medical doctors. Quality assurance of specialist medical education will be a collaborative effort involving close coordination among the Ministry of Health, Ministry of Education, Research, Culture and Technology, and various medical collegium branches. This tripartite alliance will promote a synergistic cooperation between teaching hospitals, universities, and collegiums to safeguarding the quality and relevance of the curriculum while increasing the availability of specialist medical care.

11. The fifth policy reform provides the necessary legal foundation for the establishment of a healthcare worker reserve *(Tenaga Cadangan Kesehatan)* that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters. The healthcare worker reserve may include professionally trained medical or health personnel who are not or no longer practicing such as medical students, medical lecturers and retired health professionals.

12. The Government is firmly committed to the health reform program set out above in order to increase the number of medical care professionals. To ensure that these policy reforms will achieve their full effects, the Health Omnibus Law will be complemented by detailed implementing regulations in a timely manner. Some of these implementing regulations are currently under preparation. By December 2023, the drafting of both a first set of Government Regulations that will provide broad guidance for the implementation of the Health Omnibus Law and a second set of Ministerial Regulations that will go more into detail is expected to be completed. The Government believes these reforms will help advance UHC and accelerate the transition of Indonesia's economy to high-income status.

13. The Government hopes the World Bank can allocate its resources to monitor and evaluate the implementation of this program in cooperation with the Government. The evaluation results will be an input for the next reform agenda. In this regard, the World Bank could provide advice on the proposed areas for the next reform.

14. The Government greatly values the support provided by the World Bank over the years to help finance Indonesia's development priorities and the provision of technical assistance

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that is helping us to identify issues and further the ambitious health sector transformation agenda. We look forward to your continued engagement and support in the coming years.

Minister of Finance,

Ditandatangani secara elektronik
Sri Mulyani Indrawati

Cc.:
1. Minister of Health;
2. Director General of Budget Financing and Risk Management.

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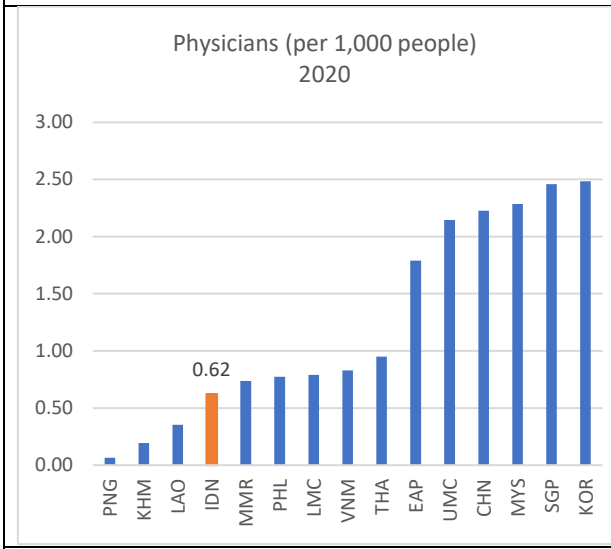
ANNEX 4: ENVIRONMENT AND POVERTY/SOCIAL ANALYSIS TABLE AND BACKGROUND

Prior Actions	Significant positive or negative environment effects	Significant poverty, social or distributional effects positive or negative
Prior Action 1. Streamlining the process for medical doctors to be entitled to practice in Indonesia	No	Positive distributional benefits, likely net indirect poverty reduction
Prior Action 2. Increasing supply of Indonesian medical doctors who graduated abroad	No	Positive distributional benefits, likely net indirect poverty reduction
Prior Action 3. Increasing supply of non-Indonesian medical doctors	No	Positive distributional benefits, likely net indirect poverty reduction
Prior Action 4. Expanding the supply of specialist medical doctors	No	Positive distributional benefits, likely net indirect poverty reduction
Prior Action 5. Establishment of reserve health workforce	No	Neutral distributional impacts, likely poverty reduction.

Taken together, the DPL's PAs are expected to improve access to health care services, reduce risks of catastrophic healthcare costs among the poor and vulnerable, and increase the progressivity of the fiscal and regulatory system. The DPL covers five PAs. Of these, four PAs have clear, significant, and progressive distributional implications (PAs 1,2,3 and 4). One has a direct poverty reducing effect (PA 5) through its impact on reducing risks of catastrophic health expenditure in the aftermath of epidemics and natural disasters as care comes closer and quicker to the household, while four are expected to indirectly generate poverty reduction by improving healthcare access.

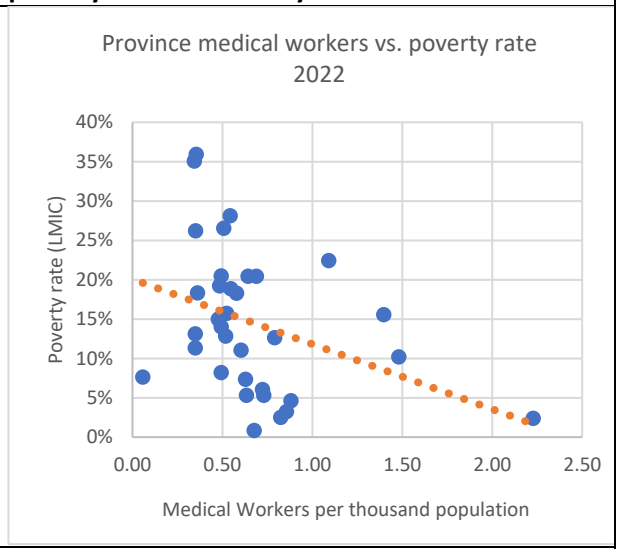
PAs 1 to 4 aim to address regulatory barriers that limit the number of practicing medical doctors. At 0.62 per 1,000 residents, Indonesia had about one third the number of physicians typical of the EAP region in 2020 (Figure A4.1). To reach the average level of its income group would require increasing the number of doctors by more than three-fold. In addition, at 0.02 percent the share of foreign medical practitioners to total medical practitioners in Indonesia is very low compared to neighboring countries such as Singapore (15.7 percent), Malaysia (7 percent) and Thailand (0.45 percent). These foreign medical doctors are also not practicing doctors but trainers and teachers. Regulatory restrictions to the entry of these doctors are a key bottleneck (IFC 2023). The shortage of medical workers particularly affects the poorest provinces of country (Figure A4.2). In 2022, nearly 88 percent of the poor lived in a province with a below average density of medical workers, while only the city of Jakarta (at 3.5 times the national average) surpassed the average density in other UMIC countries. Before reform, a complex licensing and registration process raised significant barriers to train and certify new doctors, artificially restricting the potential supply of healthcare services. Streamlining bureaucratic functions is expected to have progressive distributional effects by increasing the provision of healthcare services to disproportionately poor and vulnerable people. To the extent that the addition of more medical professionals enables better access to services among the poor and vulnerable, the reforms are expected to increase the health (and duration of healthy life) of beneficiaries, and thus improve both multi-dimensional wellbeing and indirectly reduce monetary poverty.

Figure A4.1. Physicians per 1,000 population



Source: World Development Indicators database

Figure A4.2. Association between provincial poverty rate and density of medical workers



Source: Badan Pusat Statistik, 2023

PAs 1 to 4 are expected to benefit the poor and vulnerable through several channels. A first channel through which the reform may affect the poor and vulnerable is through increased competition. An increase in the number of doctors (and other medical professionals) accompanied by reform introducing capitation compensation is expected to increase competition for patients and increase incentives to provide services. Greater competition will also partially reverse the deadweight loss associated with past quantity restrictions on provision of care and increase the cost effectiveness of healthcare spending compared to a counterfactual in which regulations remain. In addition, a second channel is the expected impact on the diversity of healthcare services. A larger pool of medical workers increases the scope for specialization both in professional training and in modes of service provision. Third, while the policy reforms will not directly and immediately improve spatial inequality, over time they are expected to help relieve relevant constraints including regarding the uneven supply of medical care. Increasing supply is expected to especially benefit the most underserved parts of the country, which are significantly poorer on average than the best-served locations. Though incomplete, a range of small studies suggest that severe wait times are a widespread challenge that limits access healthcare especially in underserved areas, and that challenges with providing sufficient care are linked to shortages of skilled professionals. For instance, Astiena and Azmi (2020) found that 9 of 10 patients waited more than the government target of 60 minutes in the clinics they studied, with average waiting times of more than 2 hours. As a lack of available doctors encourages rationing of scarce services (and a concentration of medical talent in the most affluent areas), addressing shortages is expected to increase access to care especially for the poor.

In addition to increasing the number of medical professionals, over time PA 4 will support the complementary objective of incentivizing doctors and other medical professionals to practice in underserved areas where a disproportionately large population of poor and vulnerable people reside. By creating training and certification pathways in hospitals countrywide, over time the reform is expected to increase the availability of medical professionals outside of Jakarta and other centers that currently enjoy substantially above average access to medical services.

Despite the clear benefits of PAs 1 to 4 for equity and poverty reduction, the reforms included under these PAs also come with modest risks. With the simplification of registration and licensing comes the potential for less qualified doctors obtaining the right to practice. However, this concern is mitigated by the features of the reform which focus on

maintaining high quality standards. Changes enacted to administrative procedures focus on those aspects of traditional practice that were most discretionary and the least evidence based. In addition, the reform does not remove license renewal procedures that are intended to ensure the continued competency of doctors. Standards remain as well-aligned with tested practice in high-performing healthcare systems elsewhere in the world.

PA 5 aims to enhance health system resilience. It is expected that this reform will have neutral distributional impacts and that it will likely contribute to poverty reduction by reducing risks of catastrophic health expenditure in the aftermath of epidemics and natural disasters as care comes closer and quicker to the affected households.

ANNEX 5: CLIMATE CHANGE AND PARIS ALIGNMENT ASSESSMENT

This Annex provides a detailed summary of the Paris Alignment assessment and climate-co-benefits of the proposed operation. The Paris Alignment assessment (Table A5.1) is carried out in a consolidated manner for all PAs, both for the mitigation and adaptation and resilience dimensions, given the universally aligned nature of all PAs allows for responses to be applicable to all PAs.

The DPL has been screened for exposure to and impact of long- and short-term climate disasters and risks, and residual risks to the PDO are considered to be low after mitigation measures have been accounted for. Projections estimate that potential economic losses from climate change impacts in Indonesia will reach some US$ 37.8 billion in the 2020-2024 period, including some US$ 2.1 billion from health sector losses[36]. This cost is set to grow to anywhere between 2.5 and 7 percent of GDP by 2100 due to climate change, and the poorest bearing the brunt of this burden[37]. The climate disaster risk index is considered "high" in 221 out of the 514 districts of Indonesia (43 percent)[38]. There is a significant disparity in the lower share of districts at high risk on the central islands of Java and Bali (27.1 percent of districts being classified as facing high climate disaster risk) compared to the concentration of high risk in districts designated as 'lagging' by the Government of Indonesia. In these 'lagging' areas, which consist primarily of remote and border areas which will disproportionally benefit from the Program, 43.5 percent of districts is highly vulnerable to climate disasters. Strengthening the capacity and equity in qualified human resources for health is critical in these areas, which the PAs of the DPL aim to ensure. Moreover, the Special Economic Zones[39] referred to in PA 3 are situated mostly in highly vulnerable coastal areas, and again will benefit particularly from the DPL execution, allowing to increase the resilience of health systems in these disaster-prone areas.

Eighty percent of the disasters that occurred in Indonesia between 1998 and 2018 were attributable to climate change[40]. Natural hazards, extreme events, and geophysical hazards pose particularly significant threats to population health and challenge Indonesia's health system. Under a high greenhouse gas emission scenario, Indonesia is projected to face an extreme heatwave as often as once every two years by the end of the 21st century[41]. Changing temperature and rainfall patterns are moreover projected to significantly increase climate-sensitive vector-borne diseases in Indonesia, such as outbreaks of dengue and malaria, as well as a structural increase in cases linked with changing rainfall and temperature patterns caused by climate change.[42] Similarly, extensive evidence suggests that Indonesia is particularly prone to infectious disease outbreaks – including cholera and diarrheal diseases – in the wake of climate shocks, for instance floodings, as climate change and related natural events create habitats for bacteria to flourish[43]. In addition, the country – in its entirety – is exposed to medium to high seismic risk, while the most densely populated islands of Java and Bali, representing some 56 percent of the population, face high volcanic risk across the islands[44]. These climate and geophysical risks will further strain an already-overexerted health system which needs to be endowed with the additional capacity to tackle a steep increase in climate-related diseases and health conditions as well as peak demand in case of climate change-induced natural disasters. This burden of increased demand for care due to climate

[36] Antara (2022).
[37] WB and ADB (2021).
[38] Disaster Risk Index by Districts in Indonesia. (2021).
[39] National Council Special Economic Zone Indonesia (2023). Peta Sebaran KEK. Available at: *https://kek.go.id/peta-sebaran-kek*
[40] Haryanto *et al.* (2010).
[41] WB and ADB (2021).
[42] Fatmawati and Sulistyawati (2019).
[43] Case *et al. (*2007).
[44] World Bank (2023c).

change thus needs to be addressed urgently, and the proposed DPL intends to implement activities to adapt to the impact of climate change and mitigate GHG emissions as detailed in Table A5.2.

Table A5.1: Paris Alignment Assessment of the UHC DPL

***PDO*: The Program Development Objective is to support the government's efforts to strengthen the supply of medical care professionals.**	
Step 1: Taking into account our climate analysis, is the operation consistent with the country climate commitments, including for instance, the NDC, NAP, LTS, and other relevant strategies?	**Answer:** Yes **Explanation**: The DPL's proposed program and PAs are fully consistent with the country's National Adaptation Plan, which has an explicit focus on increasing the health system's capacity to cope with outbreaks of climate-sensitive, vector-borne diseases, which the DPL supports through its thematic focus on increasing the availability of care and improving resilience in the face of shocks. Analogously, the DPL also connects to Indonesia's 2022 ENDC through the recognition of the need for universal health service provision in Indonesia as part of the country's objective to ensure archipelagic climate resilience by 2030. Moreover, the WB's Indonesia CCDR points out that the expansion of health programs underpins climate resilience and human capital accumulation, which the DPL seeks to achieve through its attention to the expansion of JKN.
Mitigation goals: assessing and reducing the risks	
Prior Action 1. To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MOH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law. **Prior Action 2.** To increase the number of medical doctors and specialists who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law. **Prior Action 3.** To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law. **Prior Action 4.** To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law. **Prior Action 5.** To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.	
Step M2.1: Are the PAs likely to cause a significant increase in GHG emissions?	**Answer:** No **Explanation**: Neither the structural expansion of nor the creation of surge capacity for the body of human resources for health is likely to cause a significant increase in GHG emissions. In fact, the more equitable availability of medical professionals will reduce the travel needs of patients, as care will be accessible closer to the home. Similarly, the expansion of Indonesia's health insurance system does not entail a significant increase in GHG emissions in Indonesia. All PAss are universally aligned.
Step M2.2: Are the PAs likely to introduce or reinforce significant and persistent barriers to transition to the country's low-GHG emissions development pathways?	**Answer:** N/A

Step M3: Is the risk of the PAs introducing or reinforcing significant and persistent barriers being reduced to low after mitigation measures have been implemented?	**Answer:** N/A
Conclusion for PA 1 through 6: All PAs are universally aligned with the mitigation goals of the Paris Accord.	
Mitigation goals: Conclusion of the Paris Alignment Assessment for the Program: **ALIGNED**	
Adaptation and resilience goals: assessing and managing the risks	
Prior Action 1. To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MOH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law. **Prior Action 2.** To increase the number of medical doctors and specialists who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law. **Prior Action 3.** To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law. **Prior Action 4.** To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law. **Prior Action 5.** To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.	
Step A2: Are risks from climate hazards likely to have an adverse effect on the PAs' contribution to the Development Objective?	**Answer:** No **Explanation**: The outcome and success of the resilience-focused PAs of the DPL, seeking to extend and improve the availability and quality of, as well as access (financial and geographic) to public healthcare for all Indonesians, are unlikely to be affected by the impacts of climate change, while they will play a critical role in the strengthening of Indonesia's capacity to cope with natural disasters and extreme climatic events. The risk level is considered to be low following the Climate and Disaster Risk Screening performed for the DPL, despite the moderate exposure level of medical doctors and patients alike which is mitigated by the participation in disaster and epidemic management activities, underpinned by broad client support for this priority project for MoH.
Step A3: Does the design of the PAs reduce the risk from climate hazards to an acceptable level, considering climate adaptation good practices applicable to the country context?	**Answer:** N/A **Explanation**: All PAs are at low risk, and none warrant dedicated mitigation measures.
Conclusion for PA 1 through 5: All PAs are universally aligned with the adaptation and resilience goals of the Paris Agreement, and in-depth analysis for all two adaptation and resilience steps demonstrates that none are at significant risk from climate hazards having an adverse effect on the PA's contribution to the Development Objective. The DPL supports climate resilience in Indonesia through these health sector reforms which comprise measures that will improve climate resilience of the population relieving pressure off health systems through the significant and equitable bolstering of the human resource for health capacity, with particular benefits to lagging areas.	
Adaptation and resilience: Conclusion of the Paris Alignment Assessment for the Program: **ALIGNED**	
OVERALL CONCLUSION OF PARIS ALIGNMENT ASSESSEMENT: ***ALIGNED***	

Table *5.2* details how the UHC DPL present significant climate co-benefits to allow a more robust, resilient, and responsive public healthcare system to cope with the burden of increased demand for care due to climate change, in particular during times of crisis with peak demand.

Prior Action	IBRD Financing	Climate-Related Action and how it will adapt to or mitigate against climate change
Prior Action 1. To increase the number of practicing medical doctors, the Borrower has streamlined the process for medical doctors to be entitled to practice in Indonesia by: (i) making Registration Certificate valid for life; (ii) removing the requirement for medical doctors to obtain a recommendation from the IDI; and (iii) giving the MOH authority in validating the fulfilment of professional credits for the renewal of Practicing License, as evidenced by the Health Omnibus Law.	US$ 200 million	The increase in number of medical doctors practicing across Indonesia will allow the country's public healthcare system to respond to the changing pattern of the disease burden in Indonesia, including the steep projected increase in climate-sensitive diseases, in particular dengue as pointed out by the ENDC. It will also substantially increase Indonesia's resilience when confronted with peak demand for care during and in the wake of natural disasters and extreme events fueled by climate change. This resilience is particularly critical in the remote, lagging parts of the country, which are currently underserved yet extremely vulnerable to climate change and disaster impacts as highlighted in the vulnerability context. PAs 1 and 2 will remedy the current shortage of health workers by removing barriers to adequate staffing across the country. The abolition of core registration documents constraining the development of the medical workforce (PA 1), together with the increase in supply from high-quality, competent medical doctors who graduated abroad (PA 2), and the geographic equity with particular focus on lagging, remote areas where the impacts of climate change are felt particularly strongly by vulnerable communities is critical to Indonesia's climate objectives and resilience, and demonstrates significant substantiality compared to the current limiting framework for the medical profession. (**adaptation**)
Prior Action 2. To increase the number of medical doctors and specialists who graduated from abroad, the Borrower has (i) exempted Indonesian medical doctors who graduated from abroad from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least two years of experience abroad, or are an expert in a specific flagship medical field as proven by a competency certificate; and (ii) exempted non-Indonesian specialist medical doctors from a competency test to practice in Indonesia if they either graduated from a recognized overseas medical school and have at least five years of experience as a specialist abroad with a certain level of competency, or are an expert in a specific flagship medical field as proven by a competency certificate and have at least five years of experience in said expertise abroad, as evidenced by the Health Omnibus Law.	US$ 200 million	
Prior Action 3. To increase the number of non-Indonesian specialist medical doctors, the Borrower has (i) increased the maximum duration that such professionals are allowed to practice in Indonesia from two to four years if there is a demand for the foreign specialist's services from a specific health facility; and (ii) waived the four-year limitation that such professionals are allowed to practice in Indonesia if they practice in the Special Economic Zones, as evidenced by the Health Omnibus Law.	US$ 200 million	PA 3 relaxes critical restrictions on the supply of non-Indonesian medical doctors, with particular attention to the waiving of restrictions on these doctor's practicing in specific parts of the country which include the climate-vulnerable Special Economic Zones highlighted in the vulnerability context. This is a considerable incentive for the health system strengthening and health service delivery in districts exposed to the increasingly critical impacts of climate change and natural disasters. The PA thereby is tailored to serving with priority currently underserved vulnerable areas and their communities, enhancing community resilience and adaptive capacity during short-term climate shocks and longer-term climatic changes which are set to cause a shift in the pattern of disease. (**adaptation**)
Prior Action 4. To increase the number of specialist medical doctors across Indonesia, the Borrower has enabled the establishment of hospital-based residency programs in teaching hospitals for specialist medical doctors subject to applicable requirements, standards and accreditation, as evidenced by the Health Omnibus Law.	US$ 200 million	The nationwide residency program under PA 4 is fundamental to strengthening the adaptive capacity and resilience of Indonesia's health system in light of natural hazards and the impacts of climate change. The relevant draft implementing regulation of the HOL stipulates that "*The implementation of specialist and sub-specialist*

		medical education at the Teaching Hospital is based on an analysis of the needs of the district/city level". This local needs assessment will determine the development of the residency program. In climate-vulnerable areas and areas where the disease pattern is likely to change due to climate change, the program will therefore be tailored to addressing these climate change-related challenges for health system adaptation. As an example, this could drive the training of infectious disease specialists in areas where increased outbreaks of climate-sensitive infectious diseases such as dengue or cholera are expected. This is particularly relevant to the lagging regions described in the vulnerability context,. This improved capacity to prevent, diagnose and treat these diseases will therefore be central to the adaption of communities to climate change in the health sector. (**adaptation**)
Prior Action 5. To increase health system resilience, the Borrower has required its government to establish a healthcare worker reserve (which may include professionally trained non-practicing health or medical personnel) that can be mobilized at both national and subnational levels for prevention of and response to epidemics and natural disasters, as evidenced by the Health Omnibus Law.	US$ 200 million	A fully climate change-oriented PA, the establishment of a human resource for health reserve tailored to meet peak demands for care in the event of geophysical and climate-related natural disasters and extreme events fueled by climate change, presents a unique, substantial improvement of the adaptive capacity of Indonesia's public health care system to the impacts of climate change. As the vulnerability context demonstrates, climate disasters are linked with immediate, short-term needs for strengthened health service delivery to meet peak demand, while climate change is also likely to cause increased frequency of infectious disease outbreaks that are climate-sensitive. As the vulnerability context demonstrates that 80 percent of disasters that occurred in Indonesia between 1998 and 2018 were attributable to climate change, this reserve workforce will primarily respond to climate-related emergencies, and as such makes an invaluable contribution to tackling both climate-related health challenges directly. It is thereby a critical step for Indonesia to meet its adaptation objectives laid out in its national climate commitments and has the potential to save numerous lives during and in the wake of climate-related crisis situations. (**adaptation**)

ANNEX 6: PROCUREMENT PROFILE AND PERFORMANCE OF THE PROCUREMENT SYSTEM

Dimension	Performance indicator	Value	Observations
Competition	% of total value of contracts procured using open competitive bidding (e-tender and fast tender).	71.5 %	The other procurement process is done through non-competitive method such as e-purchasing (11.7%), direct contracting (2.2%), direct procurement (13.1%), procurement for emergency situation and procurement excluded (0.1%) and self-management (swakelola) (1.4%)
Efficiency	% of finalized bidding processes	99.1 %	The % has increased from 94.2% in 2019 and 99.1% in 2021
	% of failed/canceled bidding processes	0.9 %	The % has been substantially reduced from 5.8 % in 2019 and 0.9% in 2021
Transparency	% of total procurement expenditures conducted through e-procurement system	60.5 %	The % has been substantially increased from 43.9% in 2019 and 60.5% in 2021. Use of e-procurement planning tool (SIRUP) is mandatory for all activities regardless of value and methods since 2018. SIRUP and SPSE have been fully interoperable since 2019, which enable automated processing of registered activities (contracts) using e-tendering and e-purchasing platform.

Source of data: Public Procurement Profile Fiscal Year 2021 published by LKPP

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