

# Analysis of Indonesia's Primary Care Accreditation

**Dan Han**

**National University of Singapore, World  
Bank**

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# Accreditation: Independent Audit of Compliance With Set Standards

- **Mitigate information asymmetry** (e.g., service quality difficult to observe)
  - Minimum standards
  - Administrative accountability (Hanushek and Raymond, 2005)
  - Quality signals via public disclosure of accreditation status (Dranove and Jin, 2010)
- **Provide feedback and alter intrinsic motivation**
  - Reveal how a provider performs compared to standards and peers (Kolstad, 2013)
- **Risk of regulatory fatigue or distraction?**
  - Standards matter little for quality; burdensome (Ibrahim et al., 2022; Morey et al., 2015)

# Indonesia's Primary Care Accreditation Phase 1 (2015-2019)

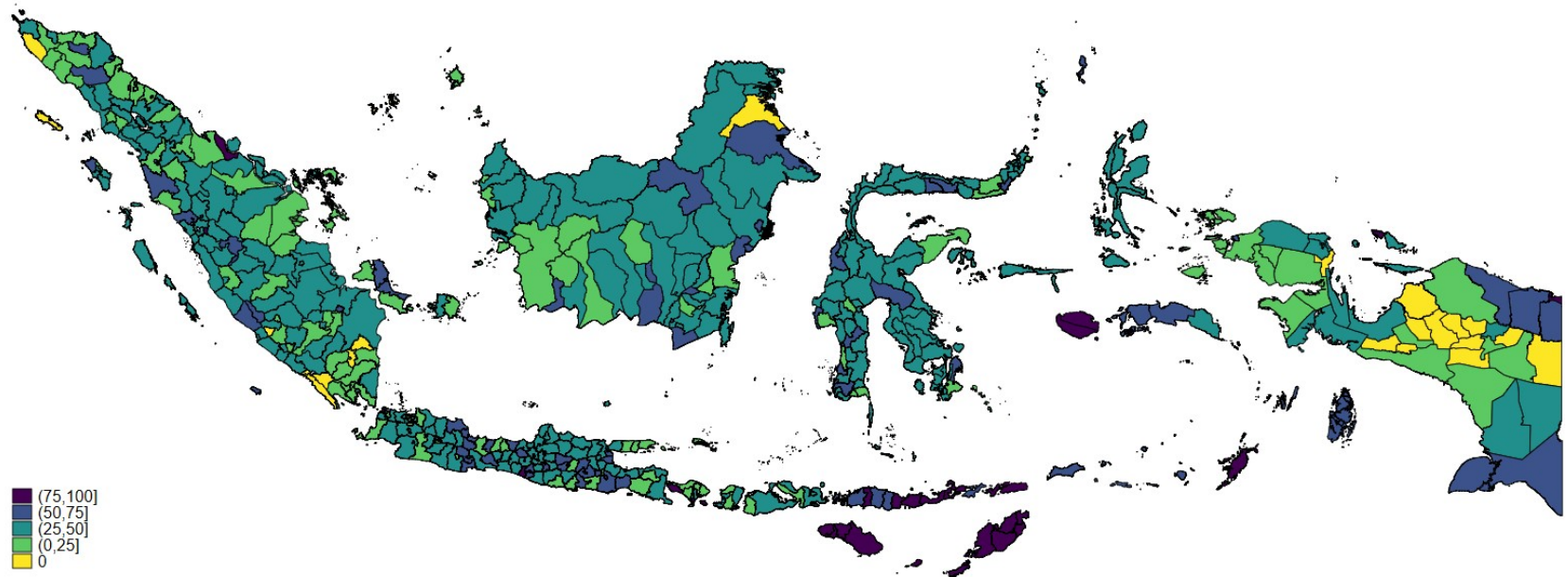
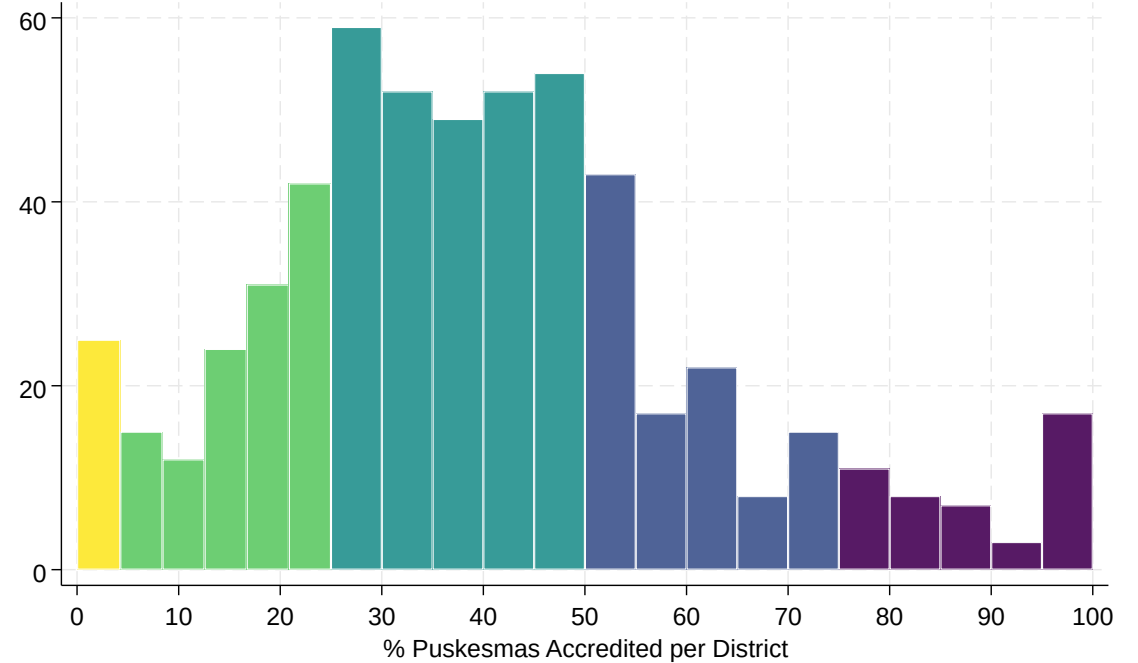
- Govt-run community health centers *Puskesmas* (**PKM**)
- Voluntary participation
- Resource from central govt
- MOH developed the standards, carried out accreditation assessment

Chapters	
I.	Implementation of Puskesmas Services
II.	Puskesmas Leadership and Management
III.	Puskesmas Quality Improvement
IV.	Target-Oriented Puskesmas Programs and Efforts
V.	Leadership and Management of Puskesmas Programs and Efforts
VI.	Performance Targets and Millennium Development Goals
VII.	Patient-Oriented Clinical Services
VIII.	Clinical Service Support Management
IX.	Improving Clinical Quality and Patient Safety

# By the End of 2019

- 3,951 (39%) Puskesmas were accredited
  - Low uptake in 2015-16
  - Faster rollout during 2018-19
    - Early adopters concentrated in cities/urban areas
- Most districts (out of 514) had at least one accredited Puskesmas
  - Substantial variation in accreditation rates

## District-Level Accreditation Uptake



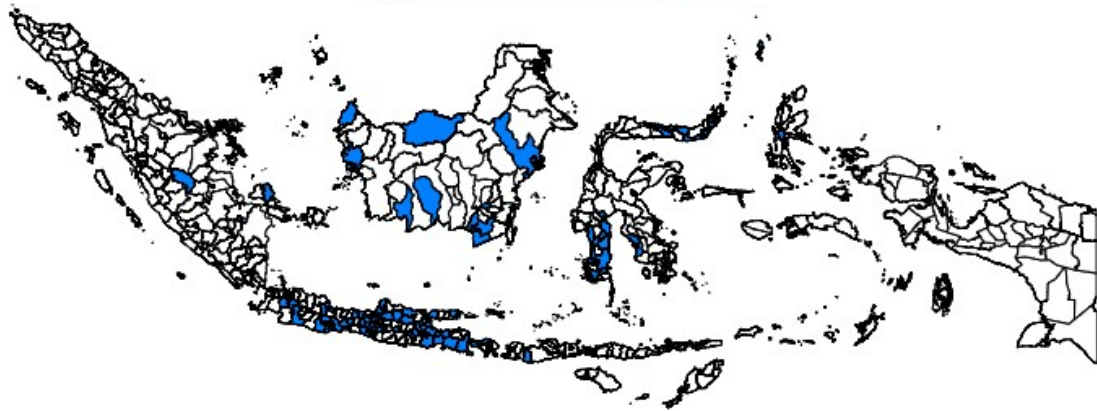
(1) Districts with Only Dasar/Madya



(2) Districts with Utama



(3) Districts with Paripurna

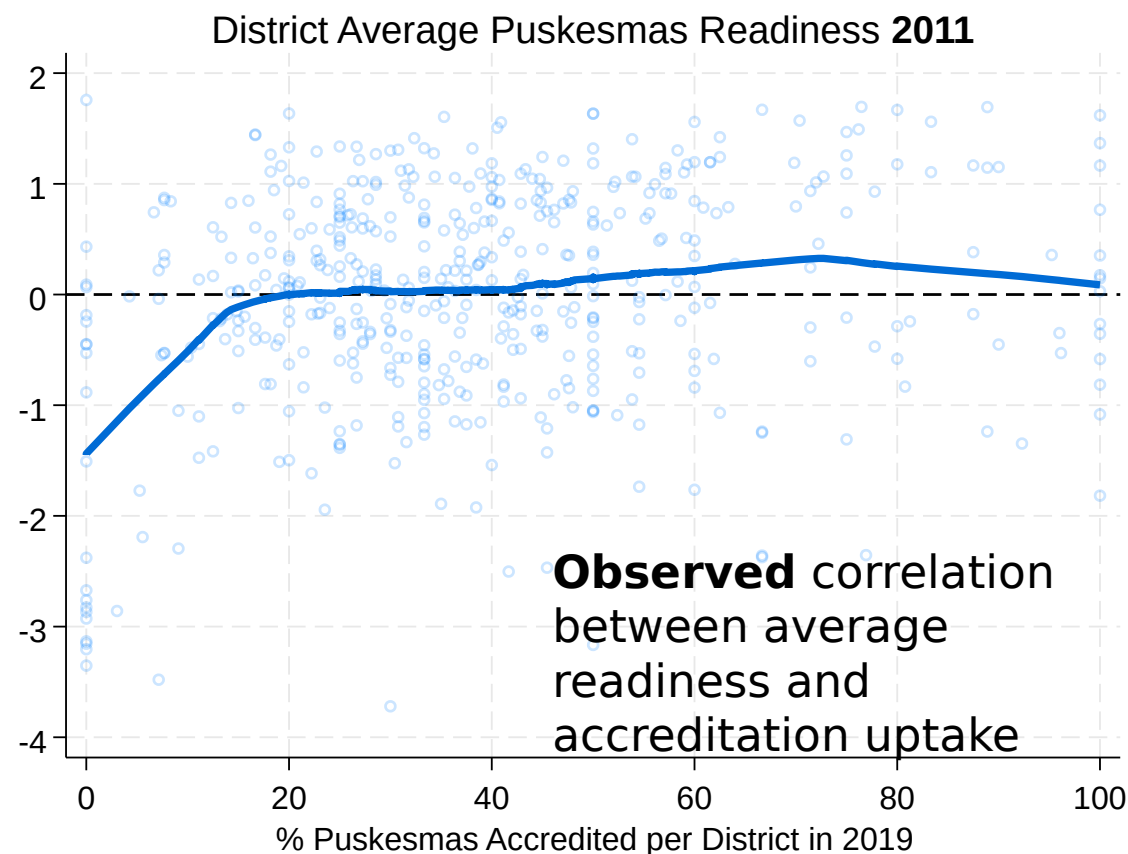
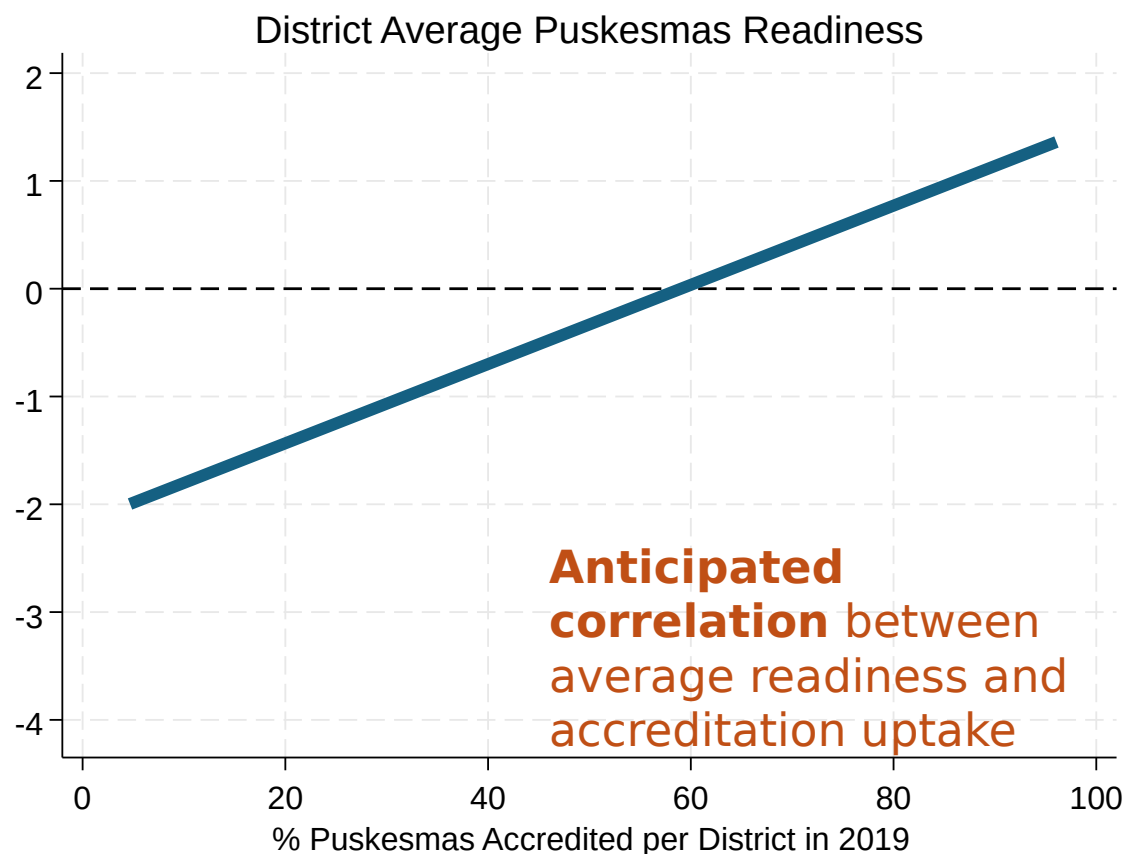


- 6% of accredited Puskesmas achieved Paripurna (plenary), the top tier
  - 41% achieved Utama (main)
  - 38% were Madya (intermediate)
  - 14% were Dasar (basic)
- Many districts had only Dasar or Madya-tier Puskesmas
- Paripurna-tier facilities mainly in cities/urban areas

Figure: District average

Puskesmas **service readiness** (standardized) over **district accreditation rate**. Readiness based on structural inputs captured in **Rifaskes**.

- Accreditation rates show **weak overall link** with average readiness
- **Wide variation in readiness** among districts with similar levels of accreditation uptake

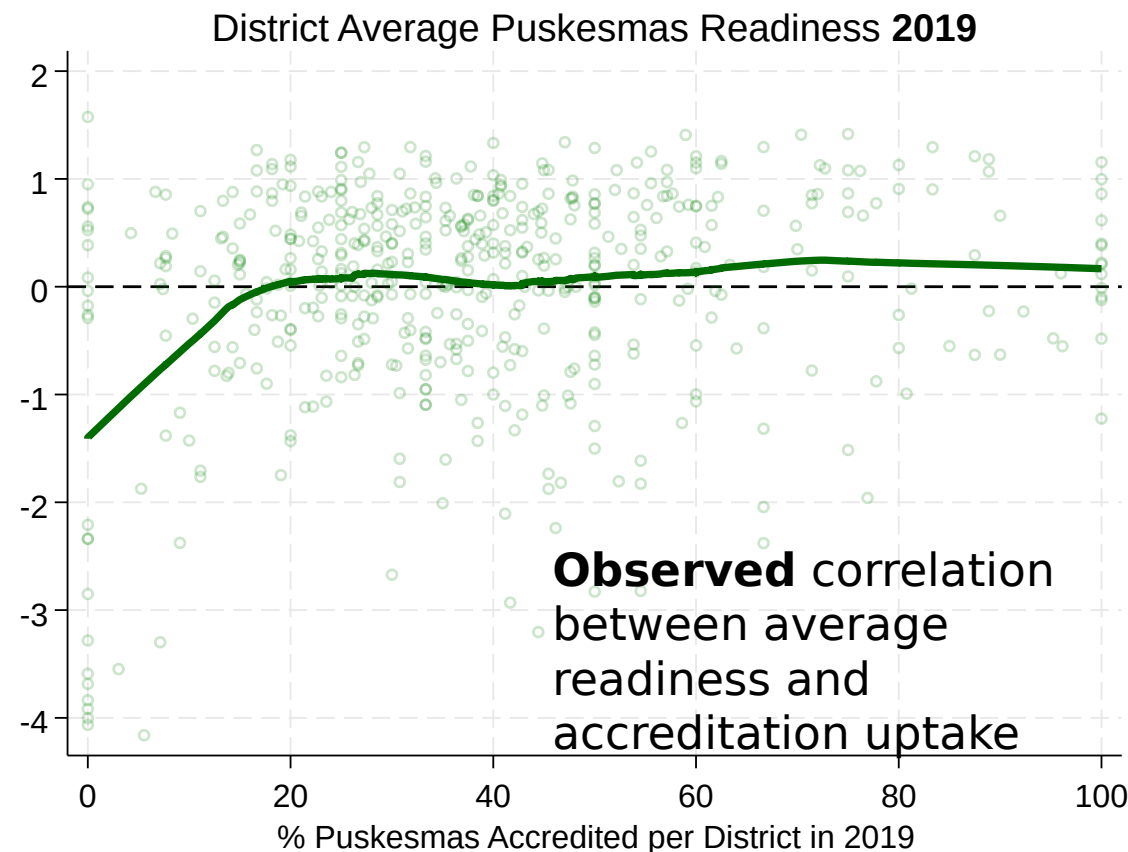
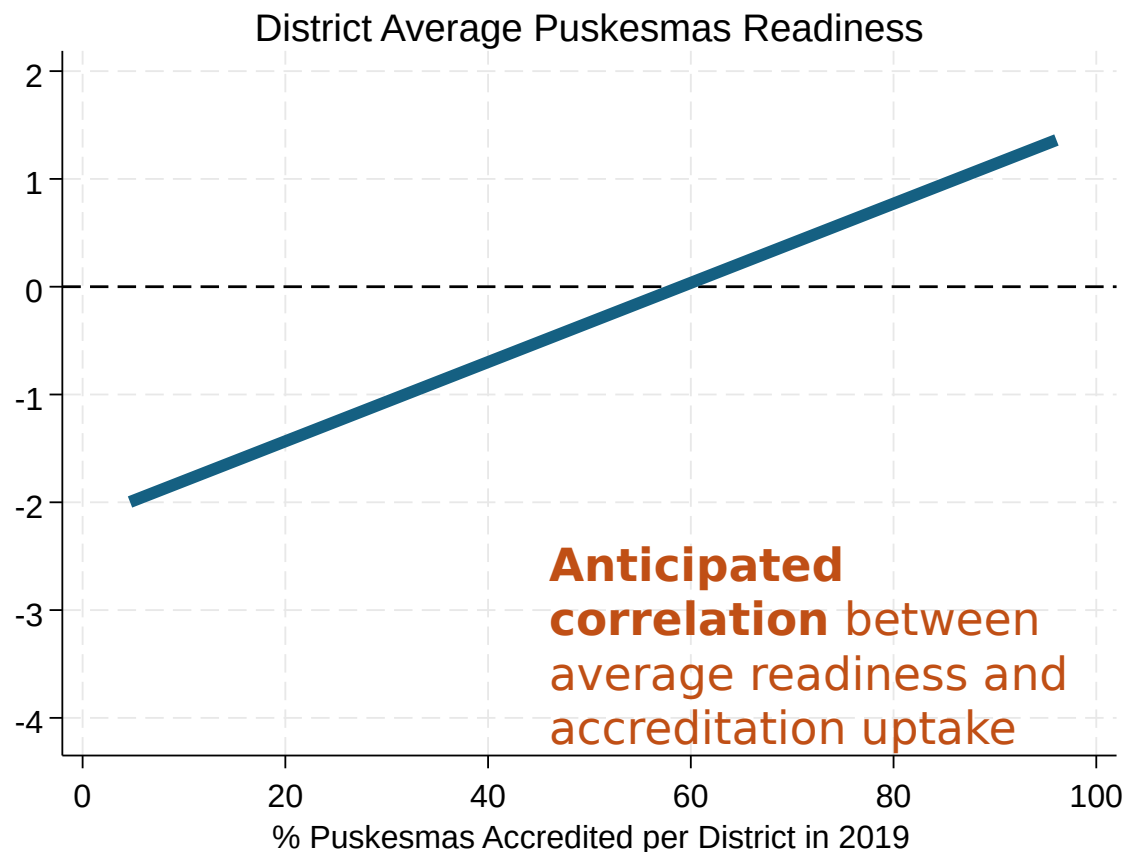


\* Rifaskes aggregated to the district level. Local regression smoothing

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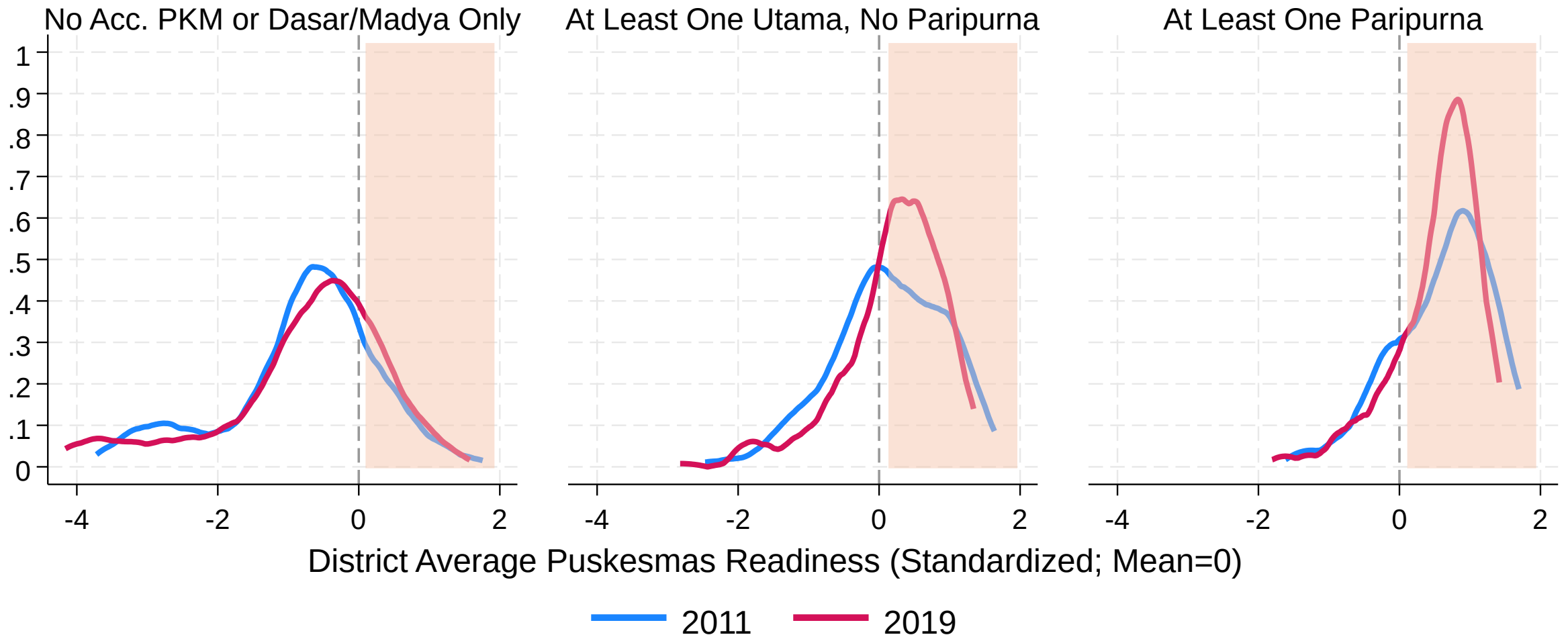
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Figure: Distribution of average Puskesmas service readiness (standardized), grouped by the highest accreditation tier achieved by any Puskesmas within each district.

Average readiness **varies meaningfully** by the **highest accreditation tier achieved** by any Puskesmas in a district



District Average Puskesmas Readiness (Standardized; Mean=0)

— 2011 — 2019

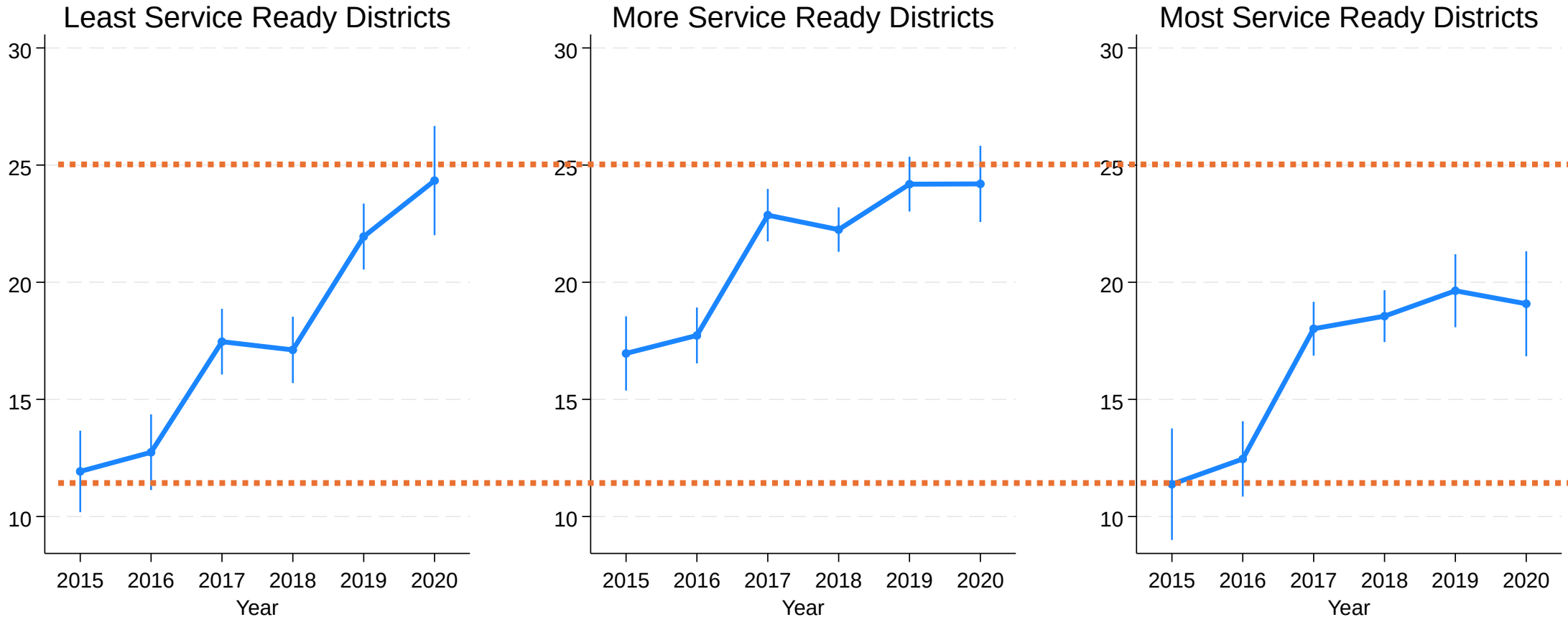
\* Rifaskes aggregated to the district level. Kernel density

Figure: Adjusted time

trends of **facility-based delivery** at Puskesmas/Pustu/Polin des. Data from **SUSENAS** (aggregated to district level).

- **Least ready** districts see **most growth** in Puskesmas-based delivery, more support needed to help them keep up.
- Accreditation **alone** won't be **sufficient** but **can help identify constraints**.

Facility-Based Delivery: Puskesmas/Pustu/Polin des



\* Pustu: auxiliary Puskesmas, serving villages too far away from the main Puskesmas. Polindes: village maternity post, part of the Puskesmas

# Accreditation Phase 1 Takeaway

## ▪ **More** “service-ready” Puskesmas

- Adopted accreditation earlier or achieved higher tiers
- Less room for improvement toward accreditation standards
  - **How to encourage continuous quality improvement?**
- Still, some high-readiness facilities stayed unaccredited
  - **What drove some to participate, and what held others back?**

## ▪ **Less** “service-ready” Puskesmas

- Accreditation presents an opportunity to improve
  - Feedback, benchmarking, aspiration, learning or knowledge spillover
- Recognize the constraints facilities face, e.g., rural area staffing challenges
  - Risk of undue burden
  - **How can we support these facilities?**

# Accreditation Phase 1 Takeaway

## – **Accreditation** ≠ **Outcome**

- A step toward quality improvement – feedback, learning, monitoring essential
- **Standards** and **scoring** method able to **differentiate** high- from low-quality facilities
  - Standards well-defined; scores correlated with other performance measures
  - Clear, meaningful cutoff points for the tiers
    - Lower tiers – attainable, but not easy, targets
    - Higher tiers – aspirational targets
- Pay close attention to the **burden of accreditation** and **uneven distribution of cost-benefit** across areas

# Going Forward

- Program scaled up rapidly in 2023/24 under a new MOH decree
  - Accreditation tied to BPJS empanelment – effectively mandatory
  - Simplified instrument; assessment outsourced to 13 accreditation agencies
- **Challenge: Quality control in the accreditation process**
  - Accreditation agency **independence, qualification, and accountability**
  - Subjectivity in scoring system → discretion, scoring variation across agencies
  - Assessment data quality and **credibility** of accreditation
    - Data collection is costly – make every effort count

# Thank you.

Dan Han, Ph.D.

National University of Singapore, World  
Bank

[spphd@nus.edu.sg](mailto:spphd@nus.edu.sg)

[Faculty webpage](#) | [Website](#)

# Appendix

Chapter	Focus
<b>I. Implementation of Puskesmas Services</b>	Services are planned, delivered, and continuously improved through community engagement, performance monitoring, and effective feedback mechanisms to meet the needs of the community.
<b>II. Puskesmas Leadership and Management</b>	Management ensures clear roles and duties, competent leadership, effective communication channels, regulatory compliance, appropriate code of conduct, and community engagement.
<b>III. Puskesmas Quality Improvement</b>	Management ensures continuous quality improvement through designated leadership, regular evaluation, community involvement, corrective actions, and external benchmarking.
<b>IV. Target-Oriented Puskesmas Programs and Efforts</b>	Programs are planned and implemented based on community needs, with active community participation, timely feedback, and continuous evaluation and improvements to ensure target achievement.
<b>V. Leadership and Management of Puskesmas Programs and Efforts</b>	Program managers have clearly defined responsibilities, foster communication and coordination across programs and stakeholders, and their performance is regularly monitored against regulations and targets with clear accountability.
<b>VI. Performance Targets and Millennium Development Goals (MDGs)</b>	Puskesmas drives ongoing performance improvement toward MDG-related targets through accountability, documentation, and benchmarking, with a focus on programs related to maternal/child health, HIV/AIDS, and tuberculosis.
<b>VII. Patient-Oriented Clinical Services</b>	Clinical services ensure efficient registration, comprehensive initial assessments, personalized care planning, referrals, adherence to clinical guidelines, respectful and attentive care, safe procedures, nutritional support, and standardized discharge and follow-up processes.
<b>VIII. Clinical Service Support Management</b>	Lab, pharmacy, radiology services, medical records, health care wastes, and equipment are managed systematically, with the designated staff being adequately trained and having the authority to carry out their duties.
<b>IX. Improving Clinical Quality and Patient Safety</b>	Clinical service quality and patient safety are enhanced through active clinical staff involvement, effective measurement and data collection, team-based efforts, and continuous evaluation.

# District-Level Accreditation Rate (% Puskesmas Accredited)

(1) Year 2017



(2) Year 2018



(3) Year 2019



Figure: Percent Puskesmas with access to electricity and internet by accreditation tier. Data from 2023 MOH internet quality survey.

