Health Sector Review

Policy briefs

Kementerian PPN/ Bappenas

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Health Sector Review

Policy briefs

Australian Government
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Australia Indonesia Partnership
for Health Systems Strengthening
(AIPHSS)

Australian Aid

Preface

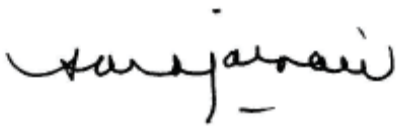
In preparing the Technocratic Draft of the 2015 – 2019 National Medium Term Development Plan (RPJMN), the Ministry of National Development Planning/ National Development Planning Agency (KemenPPN/Bappenas) has coordinated the preparation of the Health Sector Review (HSR). The document is a review of the health development which includes current achievements, challenges faced, policy options, recommended strategies and agreed selected indicators.

Ten (10) areas were analyzed in the review, namely: 1) Disease Burden and Changing Demand for Health Services; 2) Fertility, Family Planning and Reproductive Health; 3) Maternal and Child Health; 4) Health Financing; 5) Human Resources for Health; 6) Pharmaceuticals and Medical Technology; 7) Institutional Analysis in the context of Decentralization; 8) Nutrition and Food Security; 9) Supply Side Readiness; 10) Quality and Safety of Health Care. These areas were selected as they required the support of strong data and analysis, and they were considered to have a strong linkage with the 2015-2019 Medium Term Development Plan (RPJMN) of Public Health and Nutrition Sub Division.

This collection of policy briefs were developed from 10 areas of the Health Sector Review which present current situations and trends up to 2019, challenges, policy options, recommended strategies, and risk matrices. It also aims to serve as a dissemination material to related stakeholders, such as government counterparts, international partners, civil society, academia, and the media, and to ease the process for decision-makers in developing evidence-based health policies.

This collection of policy briefs is developed by the guidance and advice of Minister and Vice Minister of Ministry of National Development Planning/ National Development Planning Agency (KemenPPN/Bappenas), and the collaboration between KemenPPN/Bappenas and the Australia-Indonesia Partnership for Health Systems Strengthening (AIPHSS) supported by the Australian Department of Foreign Affairs and Trade (DFAT). Our gratitude and appreciation to national and international experts, ministries and government institutions, professional organizations, universities and the community components for their continuous and active participation in the development of the collection of these policy briefs.

Hopefully this policy brief can be useful as a reference for health development in an attempt to improve the health status of the people.



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Health Development Agenda 2015-2019

Health Development Agenda 2015-2019

Health development aims to "**improve the health and nutrition status according to the life cycle at individual, familial, or societal level.**" Achieving this goal requires a reform that focuses on: (a) efforts to decrease maternal and infant mortality; (b) strengthening promotive and preventive efforts; (c) strengthening the quality primary health care; (d) strengthening the drug and food control system; and (e) strengthening the national health insurance system

This policy brief presents brief descriptions of the strategic issues and the health policy directions for 2015-2019. Elaboration and the strategy guidelines of each policy are discussed in this collection of policy briefs. These briefs could be used as a basis for the Ministry of Health of the Jokowi-JK Cabinet in developing future health workplans.

National Strategic Issues

"Situational analysis" of ten strategic health issues have been conducted by the Health Sector Review (HSR). These issues are presented with factual conditions and challenges. Other than serving as empirical evidence, these factual conditions and challenges of each strategic issue can provide the direction to formulating strategies that needs to be taken to address the challenges.
Figure 1 shows the relationship between the 10 strategic issues and the formulation of the 12 health policy directions to achieve the goal of health development, which is to **improve the health and community nutrition status.**

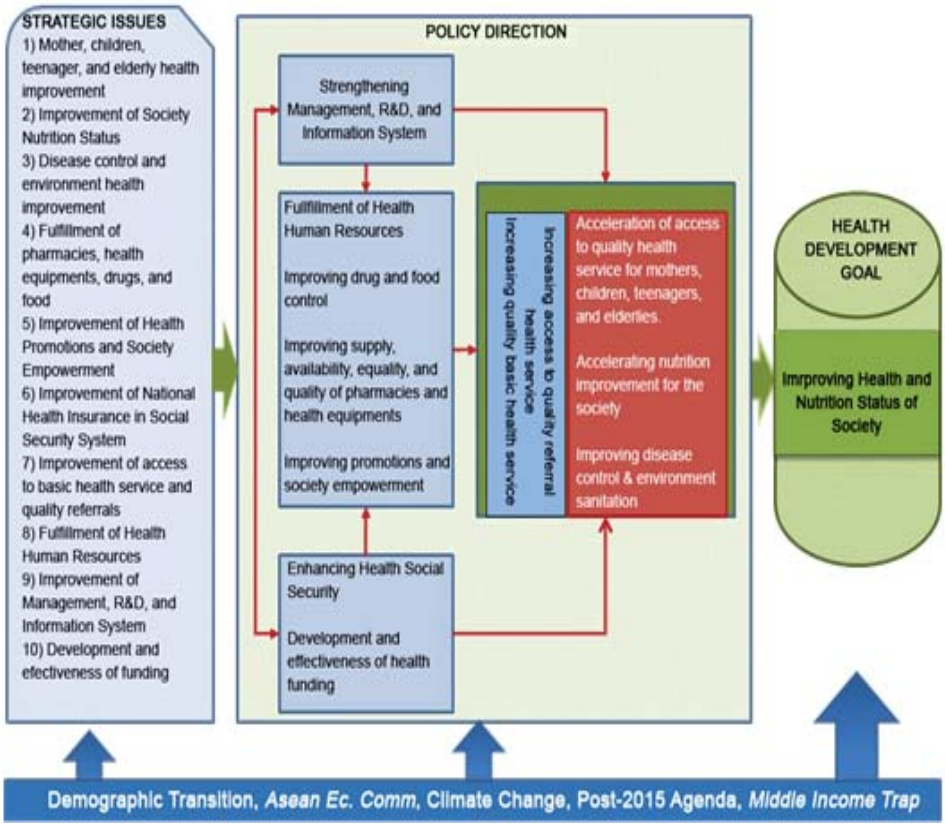


Figure 1 Strategic Issues and Health Development Policy Direction 2015-2019

Issue 1: Improving Maternal, Child, Adolescent and Elder Health

Maternal Mortality Rate (MMR) increased from 228 (2007) to 359 (2012). Meanwhile, the decline of Infant Mortality Rate (IMR) slowed down, especially Neonatal Mortality Rate (NMR) (Figure 2). The disparity of MMR and IMR happens between socio-economic levels, regions, as well as urban-rural. This health status portrait is due to several factors:

- The continuum of care is not maintained;
- Coverage of visits and deliveries by health workers is high, but quality of deliveries is inadequate due to challenges in the provision of drugs, medical equipment, health workers;
- Scope of K1, K4, skilled birth attendance increased, but births in health facilities only 36.8%;
- Anemia in female teenagers between 15-19 years old is 46.6% (not pregnant) and 38.8% (pregnant);
- Inadequate conditions of health facilities and workers. Most districts have not met the standard of BEONC health centers (only 7.6% CEONC hospitals met all standards) and shortage of health workers in Puskesmas and hospitals.

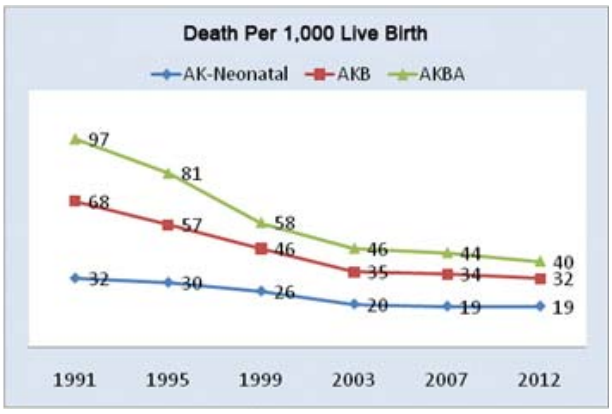


Figure 2 Trend of IMR, U-5 Mortality Rate and NMR between 1991-2012

The government must address these challenges by:

1) Improving the continuum of health care, including availability and quality of health workers and health care facilities;
2) Increasing efforts to improve nutrition for female teenagers and pregnant mothers; and
3) Developing quality health services for the elderly.

Issue 2: Improving Community Nutrition

Indonesia faces the double burden of child nutrition, overweight and obesity for adults, and food security. Double burden of child nutrition is happening across all socioeconomic levels. From 2010 to 2013, the percentage of child malnutrition (underweight, stunting, wasting) has increased (Figure 3). The same occurred with overnutrition (overweight and obesity). Other challenges are (i) micro nutrition (anemia, calcium deficiency), and (ii) public behavior on health, nutrition, sanitation, hygiene, and childbearing.

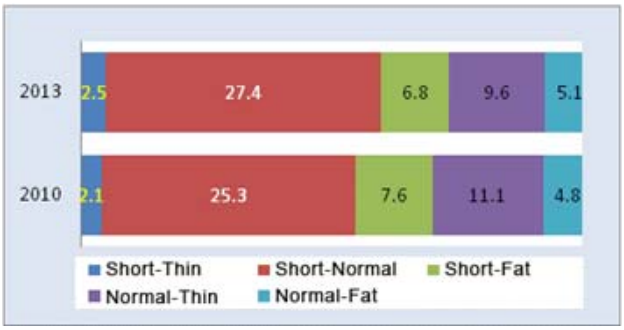


Figure 3 Children Nutrition Challenges in 2010 and 2013

These four strategies is needed to address the challenges:

1) Nutrition-specific interventions (iron folate, iodized salt, supplementary food);
2) surveillance and control over nutrition status (e.g., weighing, malnutrition treatments, mapping of areas lacking adequate food and nutrition);
3) coordination and integration of sensitive interventions (cross-sectoral); and
4) increase the role of community-based health efforts.

Issue 3: Disease Control and Environmental Health

Double burden—non-communicable disease (NCD) rate increases while communicable diseases (CD) rates are still high. High CD rates are due to low access to drinking water and sanitation. Meanwhile, the rise of NCD rates is due to the increase in risk factors: hypertension, high blood glucose, and overweight (due to diet, lack of physical activity, and smoking).

The portrait of CD: high prevalence of AIDS and incidences of HIV (new infections). Malaria, dengue fever, diarrhea, and TB decreased, however (i) the prevalence of malaria and dengue fever in endemic regions is still high; (ii) diarrhea and TB is among the top 10 causes of death; (iii) emerging risk of multi-drug resistant TB . Neglected diseases still exists: leprosy is the third largest in the world and yaws in Southeast Asia is only found in Indonesia and East Timor. Globalization introduced additional threats of CD (Polio, SARS, Avian Flu, MERS) from other countries.

For disease control and environmental health, the government must:

1) Improve surveillance and procedures for NCD and CD;
2) improve extraordinary incident prevention;
3) decrease risk factors and improve environmental health;
4) improve access to drinking water and adequate sanitation.

Issue 4: Availability of Pharmaceuticals, Medical Equipment, and Drug and Food Control

A number of challenges concerning pharmaceuticals, medical equipment, drugs, and food (Figure 4):

- Inequity in the supply of drugs and vaccines. National supply quantities in 2013 (93%) with very high variation (>100%) was found in 13 provinces and less than 80% in other provinces.
- Meeting quality, efficacy and safety standard for drugs was at 96.8% and medical equipment was at 85.84%. However, those certified were at 78.22% (drug production facilities) and 78.18 % (medical equipment and household health supplies production facilities).
- Utilization of generic drugs in Puskesmas (96.1%) was higher than in hospitals (74.89%).
- Low rational drug utilization and generic drug knowledge.
- Although 71.63% of pharmacy installations meet standards, compliance to pharmacy services is only 35.3% (hospitals) and 25% (Puskesmas).

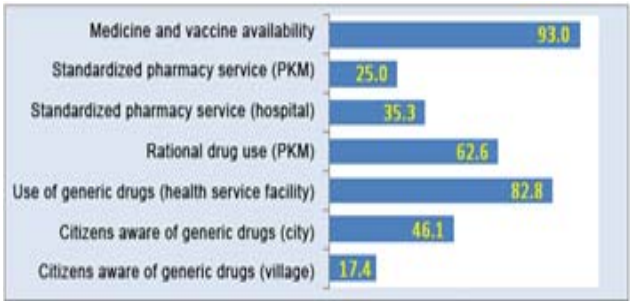


Figure 4 Availability of Pharmacies, Drugs, and Prescription

The government must address the challenges by:

1) Improving drug prescription, rational drug utilization and knowledge of generic drugs;
2) determining and controlling drug prices through fiscal and financial incentives;
3) decreasing dependency of imported ingredient of drug and medical equipment;
4) developing traditional drugs.

Issue 5: Improving Health Promotion and Community Empowerment

Health promotion and community empowerment is still lacking:

- Lack of public health-related policies;
- lack of support to improve clean and healthy lifestyle;
- lack of community empowerment, including community-based health efforts;
- low clean and healthy lifestyle, especially vegetable and fruit intake, exclusive breastfeeding, hand washing, and physical activities (Figure 5); and
- lack of health promotion.

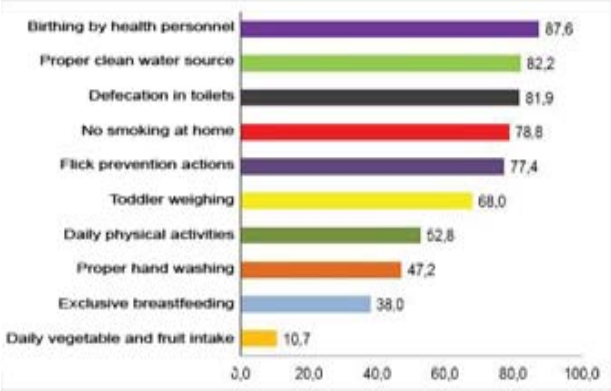


Figure 5 Overview of Healthy Lifestyle

In the future, the government must consistently:

1) Improve the promotion of public health-related policies;
2) increase support for the promotion clean and healthy lifestyle;
3) strengthen cooperation and coordination between institutions;
4) improve community empowerment and community-based health efforts participation; and
5) support in increasing health promotion at health facilities.

Issue 6: Improving National Health Insurance (JKN) of National Social Security System (SJSN)

The JKN program faces a number of challenges, which are: (1) membership, (2) services, (3) provider payment, (4) implementation, monitoring, and evaluation, and (5) regulation, as follows.

- Scaling up of members is required to achieve Universal Health Coverage (UHC) by 2019. This is challenging because the population is dominated by informal workers. Furthermore, most members (aid recipients/PBI) are not aware that they are insured. The integration of previous existing insurance schemes (Jamkesda, TNI/Polri, and JPK Jamsostek) are not optimal. The JKN registration from the private sector also has not been optimal.
- Challenges in its services include: (i) difficult access due to high indirect cost and geographical conditions; (ii) health care facilities not meeting standards for medical equipment, health workers, and quality; (iii) low number of primary private health care facilities collaborating with BPJS; (iv) referral system is not optimal, and (v) standard practices for health care needs to be established.
- Provider payment challenges include reform and implementation of the Capitation and INA-CBG schemes, which needs to be improved, including efforts to minimize the implications of both payment schemes on quality, cost, and protection of members.
- Implementation, especially information dissemination and advocacy, still needs to be improved. The JKN monitoring and evaluation design needs to be institutionalized, which potentially causes JKN deviations in achieving its goals.
- Other challenges concern the synchronization of regulations.

Development and strengthening of the JKN implementation needs to be conducted through:

1) Strengthening JKN as part of SKN to achieve the health development goal.
2) Establishing the essence of UHC which covers three dimensions: membership, benefits, and financial protection.
3) Scaling up the JKN to achieve UHC by 2019.
4) Developing standards for services of JKN benefits, including optimizing the role and function of HTA in formulating service standards (drugs, therapy procedures, and treatments)
5) Strengthening the function of JKN as a financial protection tool as members use the service, including control of what is charged to patients outside the Capitation and CBG payment scheme.
6) Widening the network of BPJS providers, not only public but also private providers.
7) Developing and improving the referral system and tiered health care.
8) Formulating the payment scheme reform, especially INA-CBG which has a number of weaknesses in design and implementation.
9) Developing a payment scheme which ensures quality and efficiency, including integration of Capitation and INA-CBG with performance-based payment.
10) Developing payment and incentives for health workers to ensure the increasing primary health efforts and health workers distribution in remote and underserved areas.
11) Formulating and institutionalizing the monitoring and evaluation framework as a reference for all actors.
12) Improving and synchronizing regulations on the implementation of JKN.

Issue 7: Improving Access to Quality Primary and Referral Health Care

The sub-system of primary and referral health care proposes challenges:

- Limited access to health services at remote and underserved areas.
- Lack of quality of health care due to lack of service standards and information system (medical records and information).
- Poor accreditation system of health care facilities (puskesmas, clinics, and hospitals).
- Weak promotive and preventive health efforts.
- Poor referral system.

Readiness of health facilities in delivering services needs to be increased. The World Bank analysis concluded that, based on the result measured by a number of indicators on readiness of health facilities, there is room for improvement (Table 1).

Table 1 Readiness of Health Care facilities in Indonesia

Indicator	Achieved
Number of inpatient care beds per 10,000 residents	12.6%
Number of admissions per 10,000 residents	1.9%
Average bed occupancy rate (BOR)	65%
Percentage of hospitals in districts providing Comprehensive Emergency Obstetric Neonatal Care (CEONC)	25%
Readiness of public services in health centers	71%
Readiness of Basic Emergency Obstetric Neonatal Care (BEONC) in health centers	62%
Readiness of non-communicable disease services in health centers	79%
Readiness of CEONC in public hospitals	86%
Source: WB Analysis based on Rifaskes data, 2011	

The government must ensure that health facilities are equipped with adequate facilities, drugs, health equipment, health workers, and quality. Therefore, (i) the provision of facilities, equipment, and drugs, and (ii) the improvement of competence of health workers and the quality of health facilities (including referrals, information, medical records, and accreditation) are the main agenda. Furthermore, the government must develop an incentive framework for health workers in remote and underserved areas, as well as strengthening primary health care.

Issue 8: Provision of Human Resources for Health

Number, distribution, and quality of health workers is a crucial challenge in Human Resources for Health. Shortages of health workers are found in a number of health care facilities. From 9,550 health centers, 9.8% health centers without doctors, 2,194 health centers without nutritionists, and 5,895 health centers without health promotion workers. Health workers shortages are worsened by mal-distribution.

In addressing the challenges, the government has to:

1) Ensure the provision of health workers by improving the alignment between production, distribution and placement, and quality and performance;
2) fulfill the number of health workers in health care facilities;
3) improve the system of recruitment and distribution of health workers.

Issue 9: Strengthening Management, Research and Development, and Information Systems.

Data availability for evidence-based planning is deemed enough. Unfortunately, it is not supported by an adequate information system. Other problems concerning the capacity of research and development which is not optimal, and the weak synchronization between planning at the national, provincial, and district level.

A number of efforts must be undertaken to address the challenges:

1) Improving technical and program management capacity;
2) strengthening the health information system as part of planning, monitoring, and evaluation of the development program;
3) improving support for research and development;
4) improving health care for disaster management;
5) developing management, especially improving health care to be accurate, effective, and efficient; and
6) developing maternal and child health data information systems.

Issue 10: Health Financing

Indonesia's health expenditure is relatively small. In 2011, total health expenditure was 2.9% of GDP, around USD 95 per capita per year. Of that expenditure, most (62.5%) was expenditure from community funding source (private and out of pocket), and the remainder from the government.

Low health financing is exacerbated by allocative and technical inefficiency:

- The portion of budget allocated for primary health care is very small compared to secondary health care;
- The budget allocation for public health program (health promotion, prevention, nutrition, maternal and child health, family planning, environmental health, etc.) is very low compared to curative health;
- Drug expenditure absorbs a significant portion (> 40%) of total health expenditure

On the other hand, the increase in health expenditure in the future is unavoidable due to: (i) epidemiology transition where non-communicable disease treatment is

more expensive; (ii) health demand surges due to increasing JKN members; (iii) improvement of health technology, etc.

Future challenges include how to obtain adequate funds for a series of activities as presented in strategic issue review 1 to 9 above. The following efforts should be conducted simultaneously:

1) Pursuing new funding sources to add to fiscal space to later increase budget allocation to the health sector
2) Ensuring efficiency through (1) strengthening the primary health care system and evaluating the referral system; (2) decreasing unnecessary long-term care; (3) controlling expenditures, including drug expenditure.
3) Focusing the development agenda on public health programs.
4) Increasing effectiveness of existing funds, by: (1) adequate budget allocation for community-based and individual-based health efforts, (2) improving promotive and preventive efforts, (3) improving fund management, including monitoring and evaluation of the Special Allocation Fund (DAK) and Health Operational Aid (BOK); (4) improving technical and managerial capacity of health programs.

Health Policy Direction 2015-2019

Situational analysis of national strategic issues is then formulated to health policy directions. Box 1 provides 12 health policy directions to be further formulated in the 2015-2019 Health Workplan of the Ministry of Health. Elaboration of the health policy directions is presented in the technocratic document of the 2015-2019 RPJMN. A brief review of the development policy direction and strategy guidelines can also be found in the collection of these RPJMN policy briefs.

Twelve health policy directions 2015-2019 are aimed at achieving the goal of health development, which is "*improving the health and community nutrition status according to the life cycle at individual, familial, or societal level*".

To achieve the development goal, health sector reform is needed. The reform is focused on the following five areas:

1) Efforts to lower maternal and infant mortality,
2) Strengthening promotive and preventive health,
3) Strengthening the quality primary health care,
4) Strengthening drug and food control,
5) Enhancing health sector national social security system.

Implementation of the five reformation areas above needs to also be supported by a financing and regulation framework, as well as adequate bureaucratic system and institutional structure.

Box 1 Health Policy Directions 2015-2019

1. Accelerating the Fullfilment of Quality Maternal, Child, Adolescent and Elder Health Care Access
2. Improving the Acceleration of Community Nutrition
3. Improving Disease Control and Environmental Health
4. Improving Access to Quality Primary Health Care
5. Improving Access to Quality Referral Health Care
6. Improving the Provision, Accessibility, Equity, and Quality of Pharmaceuticals and Medical Equipment
7. Improving Drugs and Food Control System
8. Improving the Provision, Distribution, and Quality of Health Human Resources
9. Improving Health Promotion and Community Empowerment
10. Strengthening Management, Research and Development, and Information System
11. Strengthening National Social Security System (SJSN) in the Health Sector
12. Developing and Improving Effectiveness of Health Financing

Fertility, Family Planning and Reproductive Health

Fertility, Family Planning and Reproductive Health

Being the 4th most populous country in the world, Indonesia's population trends have both international and national importance. Population and family planning is one of the key issues addressed in the 2015 – 2019 RPJMN. In the past, Indonesia's fertility rate has fallen with rising levels of economic and social development and assisted by a vigorous family planning program; the changing age structure resulting from a steady decline in fertility provides a 'demographic window of opportunity' - an increase in the proportion of working age population in the total population - which can facilitate more rapid economic development.

Unfortunately, progress in the reduction of fertility rates has stalled in the last ten years. Meanwhile, reduction of infant mortality rate (IMR) and the under-five mortality rate have been minimal, making it difficult to reach the Millennium Development Goal (MDG) targets.

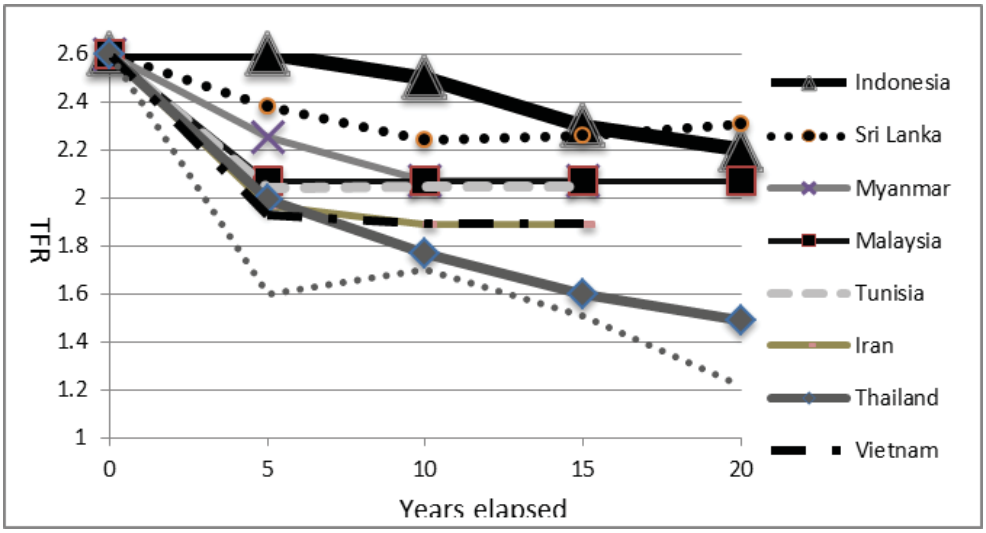
Table. Demographic Trends According to the Official Indonesian Population Projection

	2014	2015	2016	2017	2018	2019
TFR target RPJMN 2009-2014	2.1					
Official population projection						
TFR		2.4	2.4	2.3	2.3	2.3
CBR		19.2	18.8	18.5	18.2	17.8
CDR		6.4	6.4	6.4	6.5	6.5
Rate of growth		1.3	1.2	1.2	1.2	1.1
# births (x1000)		4,985	4,869	4,840	4,810	4,780
# deaths (x1000)		1,622	1,653	1,684	1,717	1,753
Population increase (x 1000)		3,362	3,216	3,156	3,093	3,027

Key Challenges

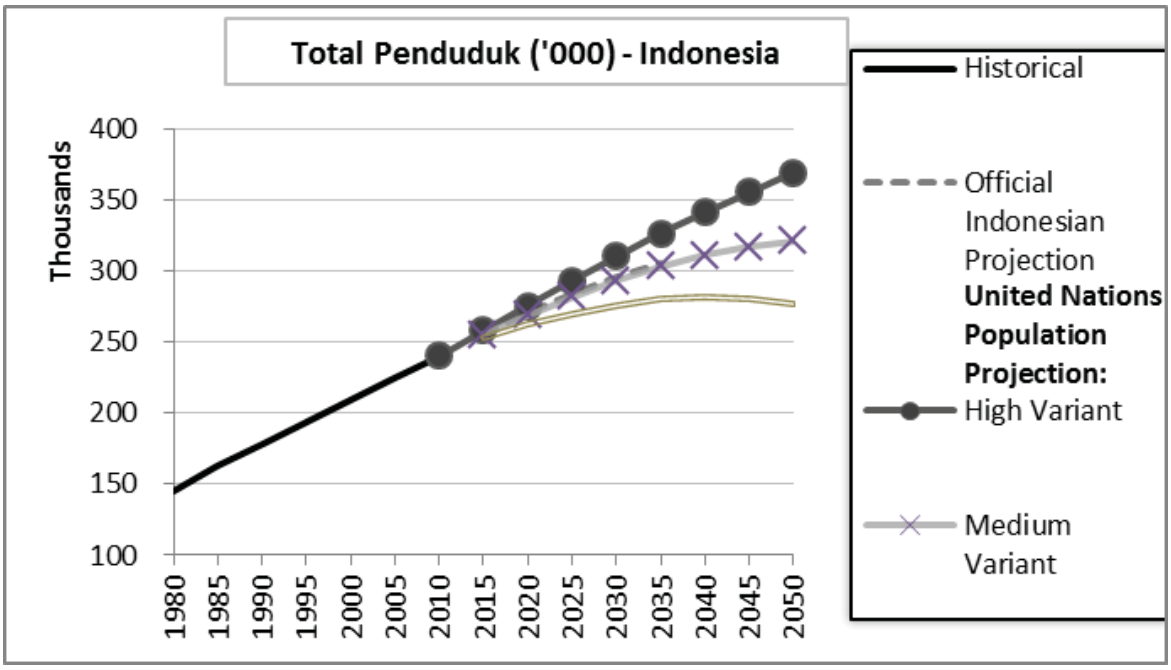
The total fertility rate (TFR) in Indonesia has stalled over the past decade at around 2.6 (half a child per woman higher than replacement level fertility). In contrast, fertility rates in the other countries shown in Figure 1 continued to fall after reaching this level.

Figure 1. Trend in TFR after Reaching 2.6, Various Countries



The stalling of the TFR influences population projections; whether fertility decline can be resumed quickly or not influences future total population and its age structure.

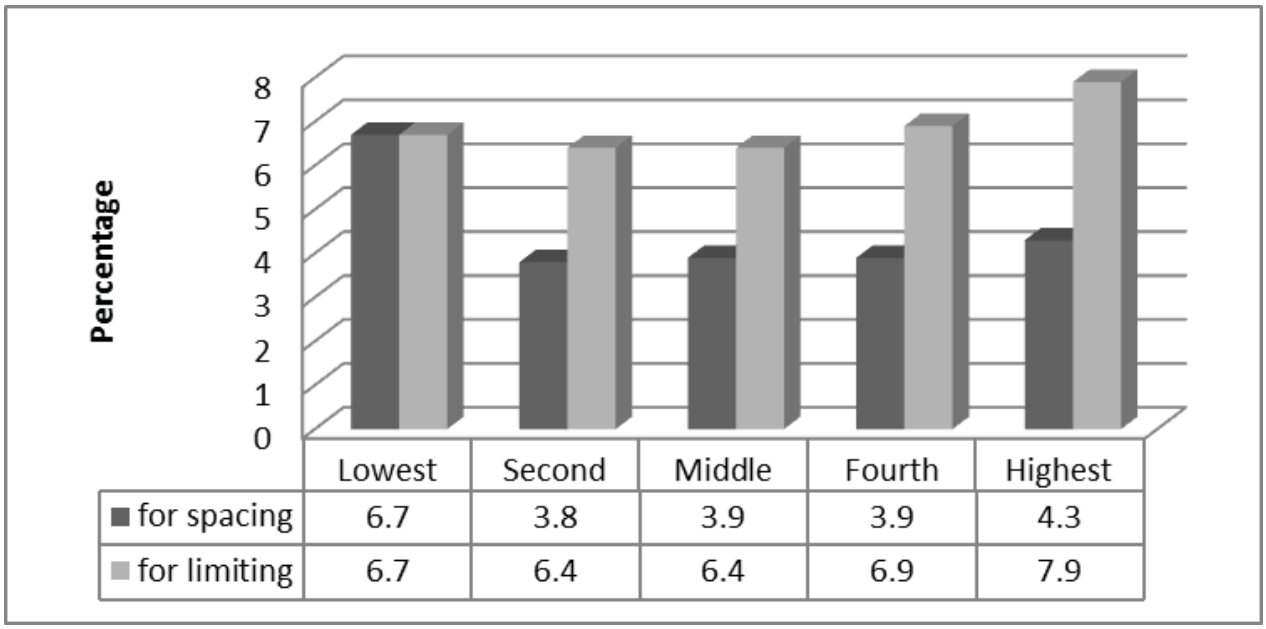
Figure 2. Alternative projections of Indonesia's population



Notes: graph of the official Indonesian Projection overlaps with the UN Medium Variant, since the difference between the two is very small.

Unmet need for family planning is an urgent matter to be addressed, including inequities in use, access and quality of family planning and reproductive health services. The family planning and reproductive health needs of the young must be given special attention, especially since early marriage and teenage fertility is a key reason for the high TFR.

Figure 3. Percentage of Married Women who Want to Space or Limit Childbearing but are not using Contraceptives (Unmet Need), by Wealth Index, IDHS 2012



	Lowest	Second	Middle	Fourth	Highest
for spacing	6.7	3.8	3.9	3.9	4.3
for limiting	6.7	6.4	6.4	6.9	7.9

Further social and economic development should help bring fertility rates to the replacement level, but the revitalization of the family planning program is also essential. For such a revitalization, the key challenges are:

1. the need for effective collaboration between BKKBN (National Coordinating Board of Family Planning), Ministry of Health (MOH), and the private sector at the national level, and between these actors and local government at the kabupaten/kota level, and
2. the need to develop effective mechanisms for the family planning program under the new universal health care program (*Jaminan Kesehatan Nasional*/JKN).

Key Policy Options

The key policy objective for population, family planning and reproductive health should be to **lower the fertility rate to replacement level** as soon as possible, while respecting the rights of individuals and couples to have the number of children they desire. It is expected that continuing success in economic and social development (rapid economic growth, further lowering of mortality rates, urbanisation, further increase in educational enrolment ratios, growth of formal sector employment) will play a major role in delaying marriage and lowering desired family size, as has been the experience in other more developed countries. However, in order to more rapidly and effectively reduce the TFR, key strategies, which should come under the responsibility of multiple ministries, should be pursued.

Recommended Strategies

1. **Raise the average age at marriage, with special emphasis on reducing teenage marriage, and enforcing the legal minimum age at marriage.**

   Early marriage is likely to result in early childbearing, and this will cut short the studies of many teenagers, and can also cause serious health issues for both the girl and her child, including increased risk of dying in childbirth. When marriage results from premarital pregnancy, it reflects a need for reproductive health information and family planning services to be available to unmarried young people. If marriage occurs when the girl is aged below 16, it reflects the need to enforce the minimum legal age at marriage. Where the marriage is arranged without the consent of the bride, it reflects the need to enforce human rights legislation.

2. **Revitalise family planning programs, in order to meet the reproductive health needs of the population and sharply lower the level of unmet need for family planning through more focused and efficient provision of family planning information and services.**

   The strategy should clearly delineate the respective roles of the BKKBN, MOH and local government in (1) providing public sector family planning/reproductive health information and services, and in advocacy activities related to such activities; (2) supporting the private sector and community groups involved in provision of contraceptive supplies and services; and (3) promoting contraceptive use by couples in planning their families (demand creation).

   The strategy should aim to meet unmet need both for spacing and for access to long-term methods by those who have completed their families. It needs to cover the needs of unmarried youths as well as married teenagers. It also needs to address how family planning services will be financed under JKN and how commodities will be made available and what the respective roles of the public and private sector will be.

Nutrition

Nutrition

Indonesia continues to have a high prevalence of under-nutrition in children under the age of five and is not on track to meet the MDG (Millennium Development Goal) of halving the prevalence of underweight children, neither will it meet the 2009 – 2014 RPJMN targets.

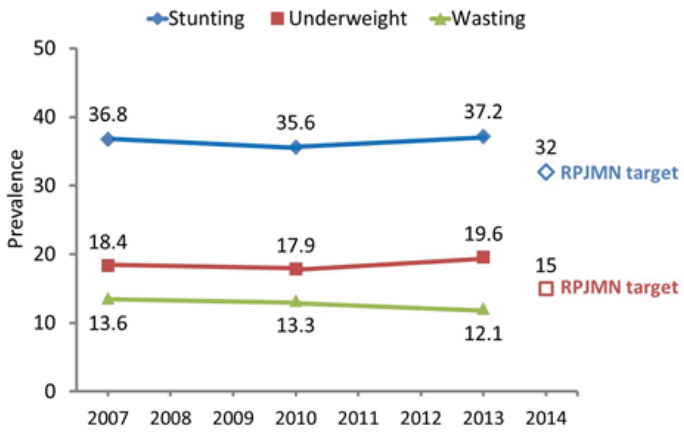
The persistent problem of under nutrition has a serious impact on the quality of human capital of some of the poorest regions in Indonesia. This situation hampers educational outcomes and economic growth which risks national social development goals and furthers inequity.

Underweight, Stunting and Wasting

Despite a decrease in the prevalence of underweight children from 31 per cent in 1989 to 17.9 per cent in 2010, prevalence rose to 19.6 per cent in 2013[1], and the prevalence of stunting also increased from 35.6 per cent in 2010 to 37.2 per cent in 2013. These prevalence rates are high by regional and global standards. The prevalence of wasting declined marginally from 13.3 per cent in 2010 to 12.1 per cent in 2013, and it remains a serious public health problem.

However Indonesia has made progress in improving certain nutrition indicators, with the proportion of people who suffer from hunger projected to halve between 1990 and 2015. The proportion of the population below the minimum level of dietary energy consumption decreased from 22.2 per cent in 1992 to 9.1 per cent in 2012, placing Indonesia in the category of low level of undernourishment.

Figure. Recent trends in underweight, stunting and wasting in children aged less than five years, 2007-2013 (Riskesdas)



Low Birth Weight

The rising proportion of thin adolescent girls and young women, the high prevalence of low birth weight (10.3 percent) and the presence of stunting in very early life underlie the need to give greater attention to the health and nutritional status of adolescent girls and women before and during pregnancy, as well as to children during the first two years of life.

[1] 1989 data determined using WHO Growth Standards. Available at http://www.who.int/nutrition/nlis/en/.

Overnutrition

Rapidly increasing over-nutrition in the adult population is alarming, and points to the need to address the Double Burden of Malnutrition (DBM) in Indonesia. There has been no increase in overweight/obesity in children aged less than five years since 2007 (12 percent), however, overweight/obesity is rising at an alarming rate in the adult population and is no longer an issue for the upper wealth quintiles alone. Between 2010 and 2013, overweight more than doubled in adult women (increase from 14.8 to 32.9 percent) and almost doubled in men (increase from 14.8 to 26.6 percent). As undernourished children who gain weight rapidly in later life are at an increased risk of overweight, obesity and non-communicable diseases, the first priority for addressing DBM in Indonesia should be to focus efforts on reducing maternal and child under-nutrition, especially stunting.

Anaemia

Lastly, anaemia remains a public health problem in children and women- 28.1 per cent in children aged 12-59 months and 53.7 per cent in children aged 6-23 months in 2013.[2,3] Anaemia was also reported in 37.1 per cent of pregnant women, with similar prevalence in urban areas (36.4 per cent) and rural areas (37.8 per cent).[4] This rate has not substantially reduced from the 40 per cent in 2001.[5] This high prevalence of anaemia may be partly responsible for the lack of progress in reducing neonatal deaths; a study has suggested that 20 per cent of early neonatal deaths in Indonesia could be attributed to a lack of iron and folic acid supplementation during pregnancy.[6] Severe anaemia in pregnancy is also a risk factor for maternal deaths.

Key Challenges

The major remaining challenges in enhancing the coverage and quality of nutrition-specific and nutrition-sensitive interventions by various sectors to reach women and children during the first 1000 days of life include:

1. Unclear stewardship and accountabilities for nutrition, insufficient inter-sectoral and vertical coordination and inadequate financial resources at all levels
2. Weaknesses in the commitment and capacity to plan, implement, monitor and evaluate services, particularly at provincial and district levels
3. Outdated pre-service training of nutritionists and other service providers, uneven distribution of nutritionists, and unclear nutrition service standards

[2] RISKESDAS 2013.

[3] Sandjaja et al (2013). Food consumption and nutritional and biochemical status of 0.5-12 year old Indonesian children: the SEANUTS study. *British Journal of Nutrition* 110, S11-S20.

[4] RISKESDAS 2013.

[5] RISKESDAS 2001.

[6] Titaley et al. (2009). Iron and folic acid supplements and reduced early neonatal deaths in Indonesia. *Bulletin of the World Health Organization* 87, 1–23.

4. Gaps in the design, implementation and monitoring of laws, regulations and standards related to BMS (breast milk substitutes), fortified food products, complementary foods and processed foods high in saturated fat, trans fatty acids, sugar and salt
5. Inadequate sustained coverage of communication and education interventions to promote positive nutrition behaviours
6. Inadequate attention on nutrition outcomes by other key sectors, including agriculture and food security, social protection, early childhood education and development, education and public works to ensuring their policies and programmes are nutrition sensitive

The emerging challenges include:

1. Rapidly increasing overnutrition point to the need to address the overweight and obesity in the same communities still struggling with undernutrition (Double Burden of Malnutrition)
2. The full package of promotive, preventative and curative essential nutrition services are not included in the basic health benefit package of the National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) or the Minimum Services Standards for heath (*Standar Pelayanan Minimal*/SPM)
3. Government and private sector currently appear to lack a natural forum to engage in dialogue and to discuss joint solutions toward some of Indonesia's issues

Key Policy Options

One policy is recommended for the health sector: **Improve access to quality nutrition services across a continuum of care to address under-nutrition, focusing on the first 1000 days of life, and over-nutrition.**

Recommended Strategies

1. **Enhance the coverage and quality of a package of integrated health and nutrition services to address under-nutrition and over-nutrition.**

   The full set of nutrition-specific services needs to be delivered at scale to at least 90 percent of target populations to effectively reduce malnutrition. Inclusion of these services in the basic health benefits package of the JKN and SPM is essential to improve access to services and accountability of local governments for delivering the services. The central MoH and PHOs must work to build the commitment and capacity of DHOs to design, plan, implement, and monitor and supervise the delivery of these interventions.

2. **Promote appropriate health, nutrition, sanitary, hygiene and parenting behaviours.**

   The Ministry of Health, in coordination with other relevant sectors, should design appropriate communication messages and materials on appropriate health, nutrition, sanitary, hygiene and parenting behaviours to reach pregnant women, caregivers of young children and the general population.

3. **Strengthen competencies of nutritionists and health workers providing nutrition services.**

   The Ministry of Health should work closely with university and education institutes to ensure that course curricula and competencies reflect the focus on nutritional status during the first 1000 days of life as well as the double burden of malnutrition. Competency standards for nutritionists need to be developed, and an accreditation process introduced. In-service training opportunities to update knowledge, skills and competencies for nutritionists, health workers and cadres should also be strengthened.

4. **Strengthen the design, implementation and monitoring of laws, regulations and standards for nutrition.**

   The Ministry of Health, Ministry of Industry and Ministry of Trade should work together to ensure that there is legislation in place for food fortification and to protect against inappropriate marketing of breast milk substitutes, complementary foods, and foods high in salt, free sugars and trans-fatty acids. Appropriate mechanism for monitoring and enforcement of legislation also need to be established

Box. Essential nutrition interventions and services

Adolescent girls and pre pregnant women

- Iron-folic acid (IFA) or multiple micronutrient supplements (MMS)

Pregnant women

- IFA or MMS during pregnancy
- Calcium supplementation for women at risk of low intake
- Counseling on appropriate diet during pregnancy and breastfeeding
- Balanced protein-energy supplements for undernourished pregnant women

Postpartum women

- IFA or MMS for 40 days postpartum
- Postpartum vitamin A supplementation
- Counseling on appropriate diet during breastfeeding

Children

- Monthly growth monitoring for children 0-23 months and twice-yearly height measurement for children 6-36 months
- Promotion of early and exclusive breastfeeding for six months and continued breastfeeding for at least 2 years
- Education on appropriate complementary feeding
- Twice-yearly vitamin A supplements for children 6-59 months
- Micronutrient powders for children 6 -23 months
- Deworming for children 12-59 months (once or twice yearly depending on the prevalence of soil-transmitted helminths)
- Management of moderate and severe acute malnutrition
- Zinc supplementation for children with diarrhoea

General population

- Food fortification (salt, wheat flour, vegetable oils and others)
- Screening for overnutrition
- Public education on appropriate sanitary and hygiene behaviours
- Public education on balanced diet; reduction of salt, fat and sugar intake; and healthy lifestyle.

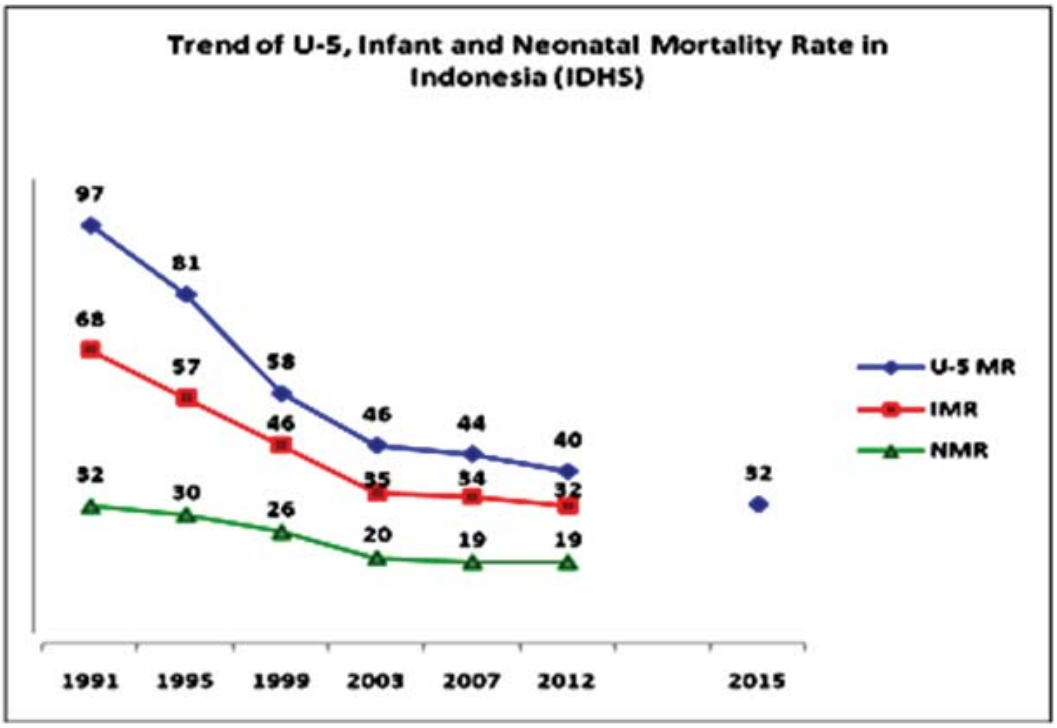
Maternal, Neonatal and Child Health

Maternal, Neonatal and Child Health

Indonesia is aiming to meet the child-health related Millennium Development Goal (MDG) which calls for a two-thirds reduction in under-five mortality between 1990 and 2015, to reach 32 per 1000 live births. According to IDHS (Indonesian Demographic and Health Survey) data, Indonesia's under-five mortality decreased significantly between 97 in 1991 to 46 in 2003, but has since slowed down to 40 in 2012. The pattern of infant mortality rate (IMR) trend is similar, decreasing rapidly from 68 in 1991 to 35 deaths per 1,000 live births in 2003,then slowing down to 32 in 2012

The contribution of neonatal mortality rate (NMR) on IMR and under-five mortality is significant, the reduction in NMR is significantly slower which means Indonesia will not meet the MDG target for a two-thirds reduction in IMR between 1990 and 2015 unless there is an accelerated effort for reduction in its NMR.

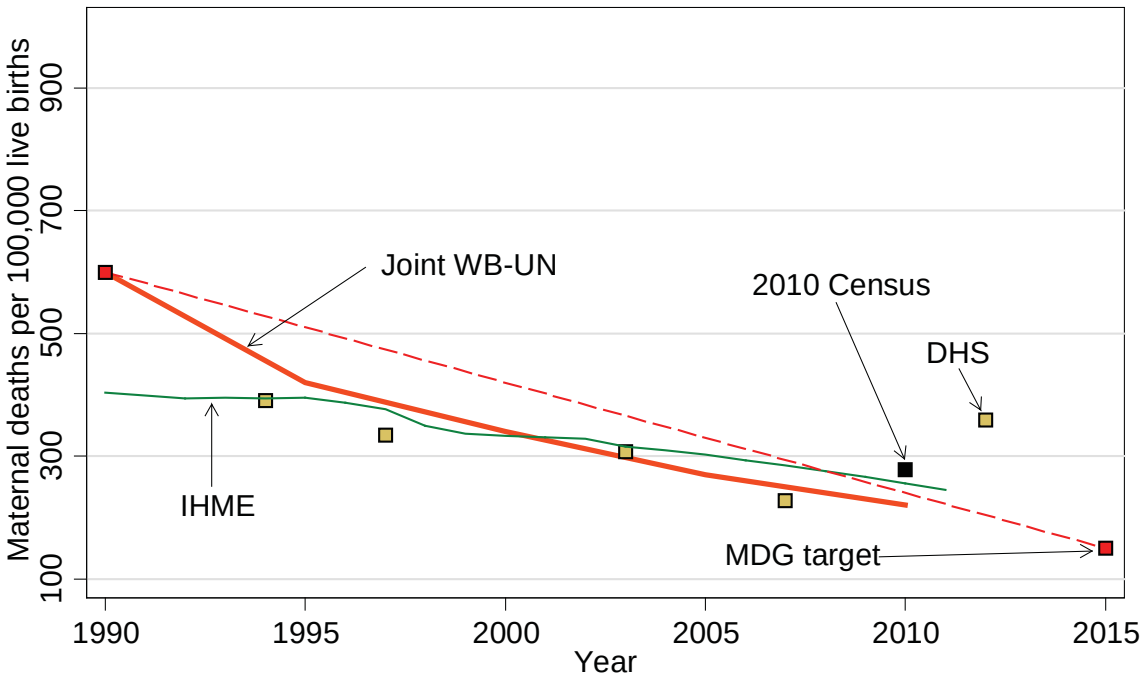
Figure 1. Trend of Under-five, infant and neonatal mortality Rates in Indonesia (IDHS)



Some indicators show that the maternal mortality ratio (MMR) has become stagnant at a high level, and some indicators even show an increase since 2007. However this trend is not consistent with other indicators, such as the number of skilled birth attendance and facility birth attendance, which have increased steadily. The reasons for this are likely caused by the lack of accurate information or poor effectiveness of programs, or both.

The measurement of maternal deaths remains a problem; the country lacks accurate data on MMR, and there are wide estimates of MMR in Indonesia. The limited data also shows discrepancies with the estimates produced by UN and the World Bank.

Figure 2. Maternal mortality ratio trends in Indonesia, 1990-2015



Sources: Joint WB-UN estimates; Indonesia census
DHS; Institute of Health Metrics and Evaluation (IHME)
Note: Shaded area represents joint WB-UN estimation uncertainty

Key Challenges

The reduction of IMR and under-five mortality rate has been affected by the stagnation in the reduction of neonatal deaths. Neonatal deaths will need to be reduced in order to restart the decline in infant and under-five deaths. This will need particular focus and effort over the next five years aiming towards a reduction of neonatal mortality by about 50%.

Table 1. The estimated decline of infant and under-five deaths if neonatal deaths decreased by 50%

	Current rates		Rates if NMR were reduced by 50%		
	Deaths/ 1,000 live births (IDHS 2012)	Number of deaths (Census 2010)	Estimated deaths/ 1,000 live births	Estimated number of deaths	Estimated % decline of death rates
Neonatal deaths	19	92,110	9.5	46,055	50%
Infant deaths	32	155,132	23	109,077	30%
U-5 deaths	40	193,915	31	147,860	24%

An important and urgent factor in reducing neonatal deaths is the number of low birth weight which is closely related to maternal nutritional status including anemia. The main causes of death among neonatal, infant and under-five children are preventable diseases and primarily infection.

Improvement in maternal health also faces significant challenges:

1. **Information:** Lack of reliable MMR measurement
2. **Leadership:** Lack of maternal **continuum of obstetric care** that requires coordination between programs within the health sector, including hospital and DHO system, as well as high commitment from other sectors. Therefore, a strong local government leadership is critical.
3. **Community Awareness:** Lack of awareness of the community, especially on the need for "Birth Preparedness" and "Emergency Readiness".
4. **Equity:** Disparities by province, residence, education level and wealth quintiles in almost all important indicators.
5. **Health Financing:** The change from Health Insurance for Deliveries (Jampersal), to National Health Insurance (JKN) scheme which has a different package of services.

Key Policy Options

To improve maternal, neonatal and child health the priority policy is to ensure an **effective and quality continuum of care for women and children**, with particular focus on effective interventions during the first 1,000 days of a child's life, from conception to two years (and covering the mother's health prior to conception).

Recommended Strategies

1. Ensure availability of and access to quality continuum of obstetric care, including
   a. Quality 24/7 (24 hour a day, 7 days a week) basic emergency obstetric and neonatal care (PONED)
   b. Quality 24/7 comprehensive emergency obstetric and neonatal care (PONEK)
   c. Effective referral systems
   d. Continuity of neonatal, infant and child care between different levels of care.
2. Focus on reducing neonatal deaths by addressing two principal causes and risk factors: improved maternal care (particularly during delivery and postnatal care in the first 24 hours after delivery) and reducing the incidence of Low Birth Weight (LBW).
3. Improve maternal nutritional status prior to pregnancy and during pregnancy to reduce the risk of low birth weight, and the risk of maternal and neonatal morbidity and mortality, as well as to break the intergenerational cycle of malnutrition.
4. Strengthen the strategies to prevent and manage the main infectious diseases and malnutrition in infants and children under five, paying special attention to those provinces with particularly high mortality rates.
5. Focus on reducing disparities based on urban/rural residence, education level, and wealth quintiles, ensuring that sufficient resources are allocated to disadvantaged groups to reduce inequities in health outcomes.

6. Increase demand for MNCH (maternal, neonatal and child health) services, in particular through improving the understanding by community health providers of “birth preparedness” and “emergency readiness” (P4K) and its implementation in communities.
7. Increase community participation in health care, particularly through the strengthening of the role of posyandu.
8. Improve health information systems. Timely and reliable data is required to design and monitor effective programs. The responsibilities for collecting and reporting data should be clear for each level of the health system. Particular attention is needed to improve the quality of data on maternal mortality, including province, district and municipality-specific data.

To improve maternal, neonatal and child health the priority policy is to ensure an effective and quality continuum of care for women and children, with particular focus on effective interventions during the first 1,000 days of a child’s life, from conception to two years (and covering the mother’s health prior to conception)

Changing Demand for Health Services

Changing Demand for Health Services

Indonesia has undergone rapid demographic and epidemiological changes in the last decade that include significant declines of fertility and mortality as well as increase of life expectancy at birth. The growth of population and change of population structure is the primary driver in increasing demand. At present (2013) the total population is 248,818,100 and it will become 255,461,700 by 2015 and 268,076,600 by 2019. The average life expectancy at birth in 2015 will reach 70.1 years and in 2019 will be 70.9 years. Indonesia will become the fourth country in the world with the largest elderly population, which is 21,695,400 in 2015 and increasing to 25,901,900 by 2019.

The health transition as influenced by demographic and epidemiological changes is characterized by urbanization, industrialization, rising incomes, expansion of education and advancement of medical and public health technology. Indonesia shows good progress in reducing mortality from communicable diseases; however changing pattern of burden of disease, due to Non-Communicable Diseases (NCD) & Injuries with disabilities have become the main agenda.

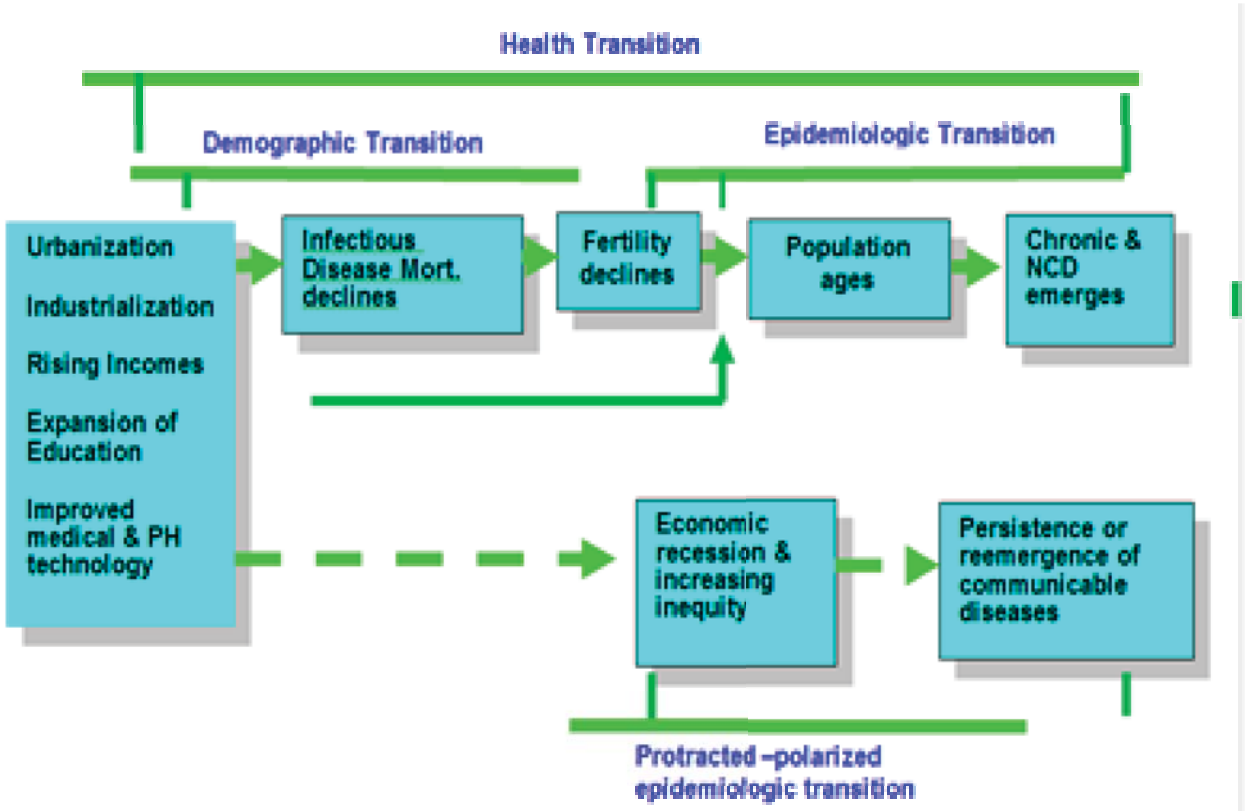


Figure 1. Relationships among Demographic, Epidemiological and Health Transition

Indonesia Burden of Disease

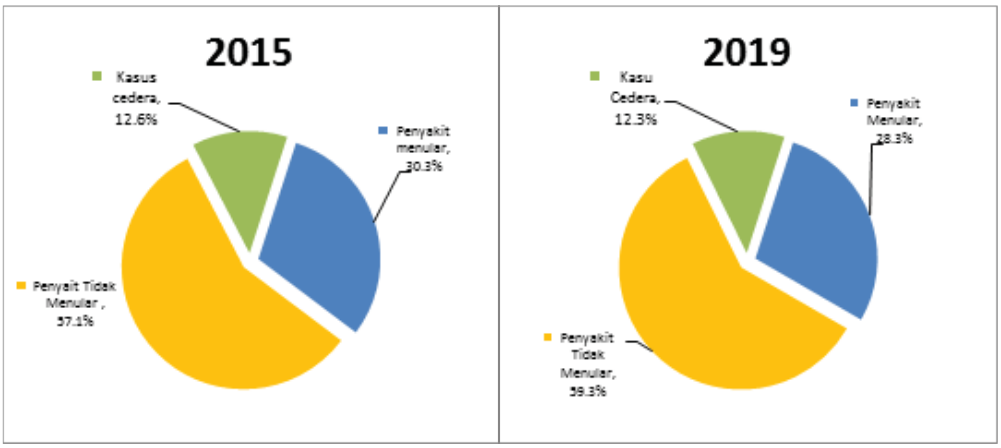


Figure 2. Prediction of Disability Adjusted Life Years (DALYs) Loss in Indonesia, 2015 and 2019

The demand for quality health services, disability management and long-term care combined with the increased of GDP per capita (US $ 3,509.00; IMF 2013) are anticipated to increase significantly in the near future. These will affect the complexity of health care services required (personnel, specialization, sophisticated medical equipment & technology) and increased expenditure on health care services (primary, secondary and tertiary). In general, with the implementation of the National Health Insurance since January 2014, the utilization rates of health services (in-patient and out-patient) will increase significantly and will affect the burden of demand on health care facilities and the health system as a whole.

Key Challenges

Demographic Transition

Predicted life expectancy at birth in 2015 will be 70.1 years and in 2019 will be 70.9 years (Indonesian Population Projection 2010-2035). There is an increasing number of elderly people (60 years and older) this will reach 21,685,400 in 2015 and 25,901,900 in 2019. The Ministry of Social Affairs data shows that in 2012 there were three million elderly people who live alone, poor and displaced (Ministry of Social Affairs, 2012). Furthermore, estimates of the elderly with dementia amounted to 960,000 in 2013, this will increase to 1.89 million in 2030 and 3.98 million in 2050 (World Alzheimer's Report, 2012).

Epidemiological Transition

The growing number of NCD cases and Injury cases require more sophisticated services and well trained health personnel. Projected numbers of NCD cases and Injury cases will be 111,895,440 and 2,662,730 respectively; Projected numbers in 2019 will be 120,946,480 and 2,788,180 respectively will be a large burden to the Indonesian Health Care System. Thus, the need to control major risk factors in order to lower the disease burden must be planned and implemented.

Unequal progress of health development in different regions

Many regions of Indonesia are located in isolated, remote or border areas with poor transport facilities. Those area should be managed differently, since the pace of demographic and epidemiological transition will be different than the more developed areas.

Barriers to access

Social culture, economic conditions, level of education, availability and distribution of health care facilities and availability of quality health resources (health personnel, drugs, medical equipment, laboratory facilities, standard procedures) may influence access of the people. In this case, the private sector becomes more important in meeting the demands for health services

Funding for Health

Overall health spending (both private and public) is still low by international standards, and much of current public sector health spend

Key Policy Options

Indonesia needs to accelerate efforts to improve the population health status, by accelerating reduction of major burden of disease and injuries; and special efforts should be prioritized, planned and implemented. The strategies are already in place but they should be reviewed, identify why they are not working and adjusted to ensure they reach the 'hard to reach' populations. A particular effort needs to be undertaken to control TB.

There is a need to estimate the future demand for health services, including renovation and constructing new health facilities at primary and secondary levels, availability of health personnel, medical & laboratory equipment, drugs, transport facilities for outreach activities, referral system and operational costs.

There is need to improve the role of the private sector in health care and formulate the cooperation mechanism between public sand private sector health care facilities. Better anticipation of the implications of National Health Insurance on the health care financing system and fiscal capacity.

Equity in access to health care needs to be monitored and improved and efficiency of the health care system at various levels need to be improved.

Recommended Strategies

1. Health inequity in Indonesia exists due to differences in urban – rural, geographic condition, physical infrastructure, socio-economic condition, education level, level of development; with those who are better off show better health status, mostly in urban areas. To prioritize public goods interventions, the Ministry of Health needs to assure implementation of Obligatory Public Health Functions and Minimum Service Standards.

2. A policy that pursues the universal availability of high quality primary health care needs to be developed by improving the primary care and secondary care facilities based on evidence and location.
3. Provision of health services at the local level should always consider the social cultural context due to the fact that public health services are provided mostly to people who are poor, have low education and low social status.
4. The local media should be included in health promotion campaigns focusing on improving food intake of healthy diet, refrain from smoking and safe and responsible sexual behavior. Each individual is influenced by their genetic makeup and their living environment especially clean water sources and sanitation.
5. The management of communicable diseases such as diarrhea requires a combination of environmental sanitation, micronutrient supplementation, treatment and water disinfection.
6. HIV infection requires safer injection practices and antiviral medication. Combating cardiovascular disease through lowering cholesterol, education on lowering salt intake especially in processed foods.
7. National and regional health institutions must have a priority agenda, focusing on fighting against under nutrition, water sanitation, tobacco free areas, and surveillance of blood pressure and cholesterol levels in the general population.

To accelerate the reduction of the burden of disease due to Non-Communicable Diseases, policies need to be developed and agreed to lower the risk factors, as follows:

1. Reduction of salt consumption
2. Reduction of the consumption of foods high in saturated fat and sugar
3. Regular consumption of fruits and vegetable
4. Routine physical activity
5. Early detection and control of hypertension and diabetes
6. Reduction of smoking rates

Policies to address these will be contentious with both the food industry and the tobacco industry and they should be involved in policy development. International experience would suggest that though working with the food industry can bring benefits, working with the tobacco industry is unlikely to achieve anything.

Health Financing: Strengthening the Implementation of the National Social Security System (SJSN) in the Health Sector

Health Financing: Strengthening the Implementation of the National Social Security System (SJSN) in the Health Sector

The title of this Policy Brief is one of the 12 (twelve) policy directions in RPJMN 2015-2019. The inclusion of the National Health Insurance (Jaminan Kesehatan Nasional/JKN) program in the RPJMN policy direction is expected to strengthen the achievement of JKN objectives, as well as supporting the other 11 (eleven) RPJMN policy directions, and ensure the improved performance of the Indonesian health development. This Policy Brief includes opportunities, challenges, and a number of strategies in strengthening the implementation of the JKN program.

Opportunity and Challenges of JKN

Regulation on BPJS (*Badan Penyelenggara Jaminan Sosial*/Social Security Administrative Bodies) mandates Health BPJS (*BPJS Kesehatan*) to manage the JKN program starting January 2014. Since then, members from other insurance schemes, such as: Jamkesmas, Askes for civil servants/retirees, JPK Jamsostek, TNI/Polri, and Jamkesda, were transferred to the JKN program which is managed by Health BPJS. As much as 121 million citizens are now JKN members in 2014. The number of JKN members is expected to increase to achieve UHC (Universal Health Coverage) by 2019.

Opportunity of JKN SJSN (Sistem Jaminan Sosial Nasional/National Social Security System)

JKN is to be the largest social insurance program in the world. The Indonesian population (237.6 million) is the fourth largest in the world after China (1,343.2 million), India (1,205.1 million) and US (313.8 million). Referring to the 2019 UHC commitment, JKN members are predicted to be 257.5 million.[1] The number of members is the reason of JKN being the largest social insurance program in the world.

JKN implements single payer system. Global experience shows that single payer provides optimal performance in pooling risks. Cross-subsidy expands vertically and horizontally. Other positive aspects include: (1) more efficient administration costs due to the achievement of optimalization of the economic scale, (2) stronger purchasing power due to monopsony system, and (3) ensure equity in access and health status.

Challenges

1. Implication of health reform
2. Different motives between JKN actors
3. Domination of informal sector workers
4. Integration of Jamkesda which varies in benefits, fees, and institutions
5. Ensure payment and premium continuity, and technical JKN policy management

[1] *Peta Jalan Jaminan Kesehatan Nasional* 2012-2019, Pg. 28

Challenges of JKN SJSN

Implementation of JKN SJSN program faces a number of challenges.

- The first challenge is concerning the policy on JKN which currently brings fundamental changes in the health system. Health financing, health services, and provider payment reform are examples of the ongoing changes. The reform would impact all actors. For example, payment reform (Capitation and INA-CBG) has implications on changes in health care practices, distribution and drug utilization (which, if not monitored, would result in quality decline).
- The second challenge is concerning the different motives of JKN actors (members, BPJS, health facilities, and government) which contradict each other. Members demand high quality health services. Facilities expect adequate payment on the services they provide. BPJS aims to satisfy its members and that the accumulation from the JKN fees is sufficient. Meanwhile, the government, as the regulator, aims to improve access while keeping health financing under control. These different motives cause problems that may compromise JKN.
- The third challenge is concerning the UHC target of JKN which must be achieved by 2019. The achievement of the target is challenging considering the Indonesian workforce is dominated by the informal sector, which is around 70 million. International experience has yet to have a good strategy in implementing instruments of social insurance and obligatory clauses, on informal sectors.
- The fourth challenge is concerning the effort to integrate around 360 Jamkesda which varies in benefits, fees, and institutionalization. Furthermore, the dynamic of aid recipients (*Penerima Bantuan Iuran*/PBI) need constant updating.
- Another challenge is concerning the main task of BPJS in accordance to the regulation on BPJS. BPJS faces challenges in: (1) ensuring continuity of contribution collection from informal participants, (2) ensuring financial sustainability, (3) management of various policies, such as: payment of providers, service utilization monitoring, including service quality.

Incomplete Agenda

Other than the challenges above, JKN alo has incomplete policy agendas, such as:

1) Neutralizing moral hazards. A number of policy agendas: referral system, budget setting, utilization control, budget shifting, clarification of benefits and the formularium have to be included in JKN to avoid moral hazard in both the patients' and the providers' side.
2) Improving BPJS capacity in actuarial capacity, information systems, utilization monitoring, and efforts to ensure service quality.

Strategy to Enhance JKN Implementation

There are 11 strategies to enhance the implementation of JKN. The strategy is designed to improve the performance of three funding functions (Figure 1), which are: revenue generation, pooling of funds, and purchasing of health, to achieve the goal of the health system, which is to improve (i) health status, (ii) financial protection, and (iii) health system responsiveness.

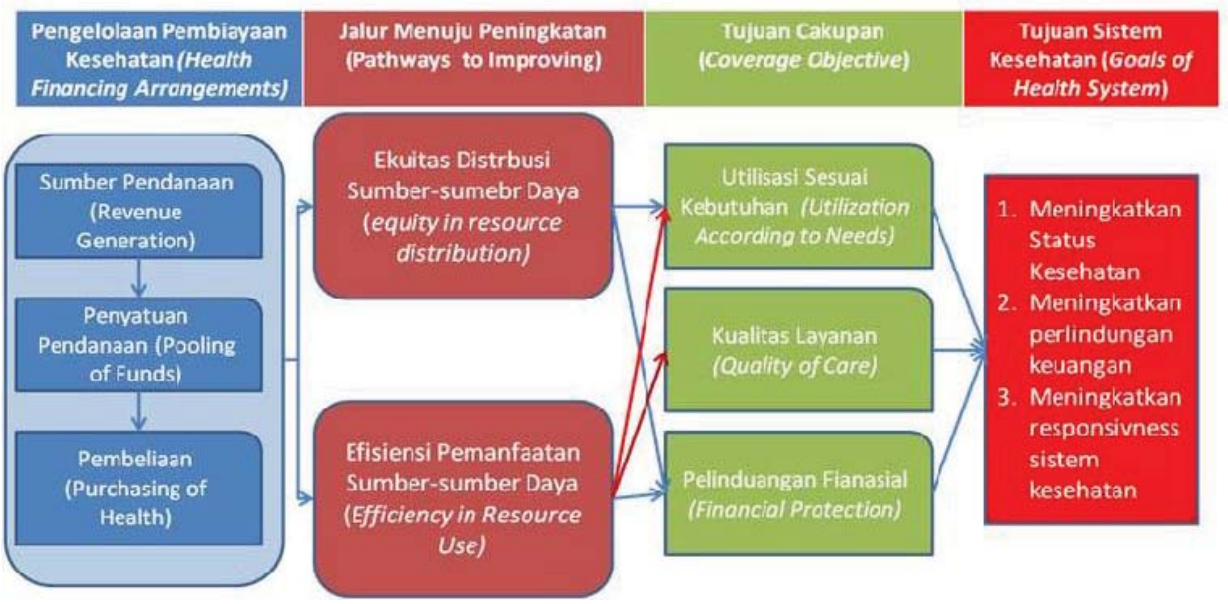


Figure 1 Framework of JKN Enhancement in RPJMN 2015-2019

Optimalization of the Achievement of JKN Targets in Supporting the Health Development Priority

Strengthening of JKN must be directed to optimalize the achievement of JKN targets, as well as the final goal of health development. JKN program aims to improve (i) access to service; (ii) equity in access and health status; and (iii) financial protection from risk of illness.

Increase of JKN Members Coverage

Increase of insurance coverage is essential to achieve the UHC by 2019. As mentioned previously, the coverage expansion of JKN faces a number of challenges. There are two critical matters concerning the insurance coverage for the informal workers that need to be addressed. First, what would happen if they do not or cannot pay the premium? Second, collecting contributions from informal workers can be both challenging and costly, and the costs could be more than the income generated through premiums.

The government needs to conduct a trial on the coverage expansion instruments for informal workers. For example, (i) involving TPA (Third Party Administrator) or Jamkesda and testing their feasibility in executing some of the BPJS functions in the collection of the contributions and its socialization, and (ii) testing the contribution subsidy mechanism.

Development of JKN Benefits

One of the three dimensions of UHC is the range of benefits (Figure 2). Strengthening of JKN needs to be accompanied by the regular review of benefits in accordance with the Health Technology Assessment (HTA). The goal is that the benefits accommodate the needs of the members (reflecting the disease profile, considering the changes of clinical and technological guidance) and ensuring equity and the government fiscal capacity.

Standardization of benefits (procedure, actions, and drugs) needs to be formulated. The service delivery for the same disease and degree varies greatly.

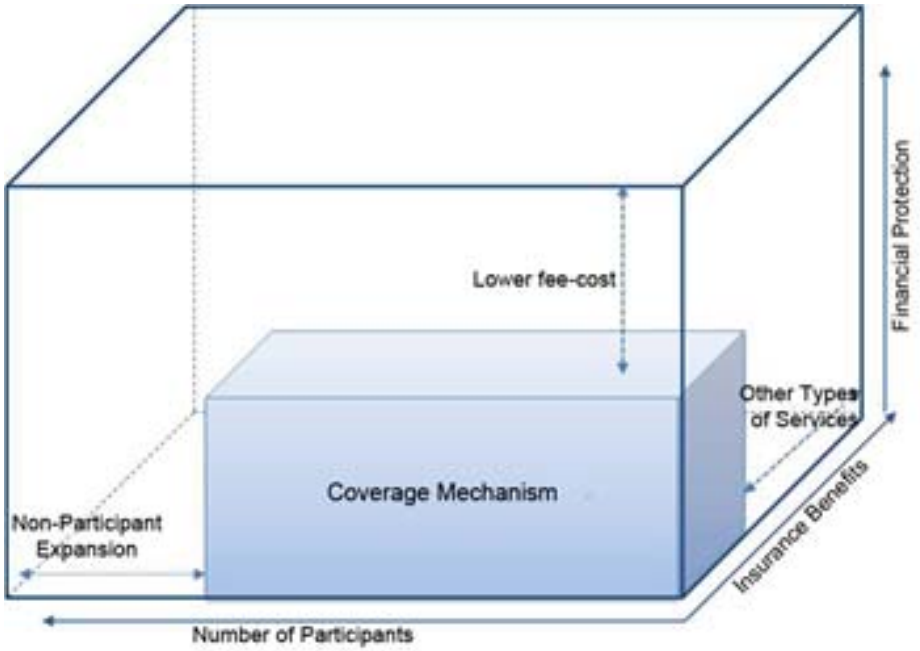


Figure 2 Universal Coverage Dimensions

Establishment and institutionalization of HTA unit is needed to formulate the standardization of JKN benefits. This unit must be capable of determining health technologies and formulating it for the JKN benefit package.

The next step is to ensure the compliance of providers to the service standards of JKN benefits. For this, the optimalization of the utilization review program, as well as the optimalization of the roles and functions of the clinical advisory board needs to be ensured.

Improving Financial Protection

Another dimension of UHC, other than insurance coverage and benefit range, is financial protection (Figure 2). The health care costs, theoretically, is ensured entirely by JKN. However, in practice, JKN members might be charged for several things. Therefore, improvement in financial protection in the JKN is needed, for example, from the catastrophic payment (expenditure that causes bankruptcy).

The strategies to optimize JKN in providing financial protection are:

1) Providing adequate payment (according to economic cost) to health facilities;
2) Enforcing the coordination of benefits between social insurance schemes and commercial insurance;
3) Ensuring health facilities from not charging additional cost for JKN patients being treated;
4) Ensuring service delivery by health facilities, including drugs, to comply to the standards of the JKN benefit;
5) Ensuring BPJS monitors the health service delivery;
6) Socializing to members on the utilization of health services in accordance with the mechanism, procedure, and policies of JKN program.

Improving Network of Providers

Network of the BPJS providers must cover public and private health facilities. This is important considering the role of private health facilities is significant. Data analysis (from Susenas & IFLS) states that private facilities are preferred for both outpatient and inpatient care.

Contract of BPJS and provider must be optimized as a gateway to ensure quality, compliance to clinical protocol, information sharing, and tracking system. Contract process has to start by the credentialing of providers. The contents of the contract must underline the rights and responsibilities of both parties and agreed.

Development of the Referral and the Competence Standardization of Providers

The probability of diseases that requires expensive treatments is relatively small, while the probability of diseases requiring inexpensive treatments is relatively high. This requires the referral system to be designed and implemented. Example of referral implementation, for example, mandates patients to firstly utilize the primary health facility. Primary health facilities screen patients who needs to be referred to the next health facility. Primary health facilities function as a gatekeeper. Patients must be referred if the disease is outside the competence standard of primary health facilities.

The lack of referral system is inefficient, that is a risk for the continuity of JKN. In the future, the government has to:

- Develop referral system and tiered service;
- Develop competence standardization for primary health facilities as gatekeepers;
- Determination of the standards of health services to be referred in accordance with the competence of the provider.

Design and Implementation Improvement of INA-CBG

The design of INA-CBG does not consider the clinical practice and cost structure in Indonesia. INA-CBG adopts the clinical practice and cost structure from another country (USA). In the future, CBG needs to be adjusted to the Indonesian context. Therefore, local experts are needed to assess and improve the design, from the development of the cost structure, practice analysis, to CBG grouper application. This effort requires a strong partnership between the Ministry of Health, BPJS, universities, and experts in Indonesia.

Implementation of INA-CBG has not been complemented by an information system to gather data for evaluation of inputs and decision making. Data on the utilization of each type of service with INA-CBG, for example, is not recorded in the CBG grouper application. The implication, for example in the adjustment of the premium, would be difficult to do in the future. Furthermore, monitoring of drug use is also difficult to be conducted, considering the CBG claim process does not require the facility to record that information.

Development of Payment System to Ensure Service Quality and Efficiency

Capitation and INA-CBG payment is implemented in JKN. The implementation of these two

payment schemes must be supported by the effort in increasing quality, achievement of priority programs, and efficiency.

Therefore, in the future, the government must consider the payment scheme that is performance-based from the achievement of priority programs. The pay-for performance scheme would be combined with capitation and INA-CBGs. For example, the introduction of pay-for performance related to primary health service intervention such as immunization, non-communicable disease screening, and adequate management of chronic disease control (hypertension and diabetes).

Development of Payment Scheme and Incentives for Special Region

Development of payment and incentive for health workers in remote and underserved areas needs to be conducted. Not all primary health facilities can be paid through capitation. For example, due to the distribution of the insurance members, provider cannot be paid with capitation or there are no adequate health facilities. To address this challenge, the government needs to develop an incentive to encourage the effort for primary health services and adequate distribution of health workers.

Development of Monitoring and Evaluation

Development of monitoring and evaluation of JKN, including operational research, needs to be conducted. Both monitoring and evaluation (MonEv) activities complement each other to achieve different targets. Both are systematic processes to assess improvements and identify problems for corrective measures. Both activities also measure effectiveness and efficiency required by the JKN program.

- Monitoring involves continuous observation to supervise the implementation of the JKN procedures. Monitoring is to be conducted regularly to track progress on planned activities. Monitoring activities also includes sustainable management, which is conducted by optimizing the recording system to provide information for all actors.
- JKN evaluation provides in-depth analysis on the implication of JKN to the achievement of targets. Evaluation must be conducted periodically, systematically, and objectively. Therefore, a framework for JKN evaluation program is needed, data requirements, evaluation design, dissemination, as well as follow-up actions.

Synchronization of Regulations

Joint Secretariat (under the command of Ministry of Health) has coordinated in the past two years towards the introduction of JKN in 2014. The result is the formulation of regulations, elaborating the SJSN and BPJS Law. A number of sub-systems and/or technical procedures to implement JKN have also been established.

Synchronization of a number of existing regulations must be done. The addition to the JKN regulation needs to be put in the agenda along with the development of other JKN technical policies in other aspects, such as: coverage expansion, quality and cost control, institutionalization of HTA, institutionalization of monitoring and evaluation, and mechanism and coordination between institutions.

Health Financing: Increasing the Effectiveness of Health Financing

Health Financing: Increasing the Effectiveness of Health Financing

The slogan "*preventing is better than treating*" is accepted as a general agreement. Unfortunately, this slogan is only rhetoric. The politics of health budget allocation is biased towards curative health, meanwhile, promotive and preventive health is not prioritized. The government must include public health in the main agenda of health development. The government has to allocate adequate budget for both public health and curative health programs. Recommendations suggested in this policy brief should be a reference for the Jokowi-JK government in formulating the health programs for 2015-2019.

A Portrait of Health Financing

National Health Financing

The total health expenditure in Indonesia is extremely low. The total health expenditure (combining public and private expenditure) has never exceeded 3.1% of the GDP. The average total health expenditure over 7 years (2005-2011) was only 2.6% of the GDP. The per capita health expenditure in Indonesia in 2011 (US $95) was far lower than Malaysia and Thailand, US $346 and US $201 per capita during the same period. As such, Indonesia is ranked 14th out of 15 countries in Southeast Asia on its health expenditure (Figure 1). Indonesia is lucky to still be ranked higher than Myanmar, although still far below Timor Leste and Nepal which have health expenditure totaling more than 5% of their GDP.

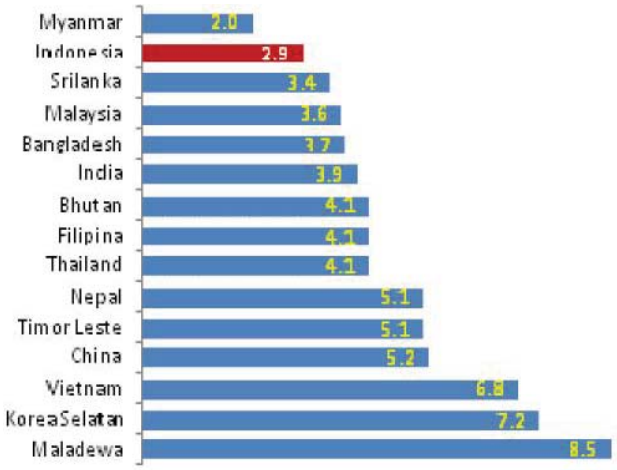


Figure 1 Total Health Expenditure (%GDP) in Southeast Asia, 2011

Public health expenditure is also very small, contributing only 31% of the total health expenditure. The majority of health expenditure (62%) up to 2.9% of GDP in 2011 was from the community and the private sector.

Is the population deemed healthy, that there is reluctance from the government to contribute adequate health expenditure? This is a false argument. The health status barometer based on maternal mortality rate (MMR) and infant mortality rate (IMR) shows a bad report in health development. MMR rose from 228 (2007) to 359 (2012), while the decrease in IMR slowed, particularly for neonatal mortality rate. There is a large disparity in MMR and IMR between socioeconomic levels, regions, and between urban and rural areas. The low health budget allocation is likely a significant contributor to this decline in health outcomes.

The two points below are believed to be the cause behind the low health budget allocation in Indonesia:

- Firstly, fiscal limitations. Taxes are the main source of the national budget (78%). However, the tax ratio in Indonesia is only 12%, far below Malaysia (30%) and China (22%). Fiscal space is limited. This is homework for the Jokowi-JK government to increase the tax ratio in Indonesia.
- Secondly, the commitment of the government in the health sector has to be strengthened. Compared to countries with similar income, Indonesia is an outlier in terms of health budget allocation. Indonesia is in the lowest 10th percentile in the world in allocating health budget.

Sub-National Health Financing

Health should be prioritized in local governments. Its health budget allocation has not comply the minimum requirements as stated in Health Regulation no. 36/2009, Article 171 Clause (2): "*The provincial and district government must allocate at least 10% (ten percent) of the Local Budget,* ***excluding wages***".

Efforts to increase the health budget allocation have been undertaken. However, its implementation and effectiveness needs improvement. The BOK program (Health Operational Aid) was established in 2010 and aimed to increase the health status, becoming a key source of Puskesmas financing. However, disbursement of funds was often delayed due to bureaucracy. BOK funds went into local government revenue which was spent in the Local Budget. "*BOK is channeled from the State Budget through the Ministry of Health to be allocated to the local government. After which the local government funnels the funds to the District Health Office (DHO) to subsequently fund Puskesmas*". The bureaucracy (local government to DHO to Puskesmas) is often referred as the cause of delay.

Advocacy is needed to increase budget allocation. Without advocacy, health budget will be misallocated. "*Further health budget allocation is the prerogative of the local government budgeting*". Therefore, the recommended health budget is allocated for non-health sectors, with the assumption that health is financed by the provision of BOK. For example in 2010, the health budget allocation in the NTT Local Budget decreased. Commitment from the government were made after advocacy efforts, and in 2011 more than two thirds of the districts in NTT allocated more than 10% of their Local Budget to the health sector.

Challenges in Health Financing

Inefficiency: Allocative and Technical

The low health budget allocation is exacerbated by allocative and technical inefficiencies.

1) The budget allocation for primary health services in Indonesia is very low compared to developed countries. Therefore, the utilization of secondary and tertiary health services (those requiring higher costs) is increasingly high. This reflects the dominance of specialized health care.
2) Drug costs have a significant portion of the total health costs (comprising more than 40%). This is much higher compared to a number of developed countries where its proportion is only 10-20% of the total health costs. The high drug costs are caused by irrational prescription of drugs and demand from patients.

Inefficiencies are also caused by chronic problems in disbursing funds which often occurs at the end of each quarter. Hence, its expenditure is no longer able to fund programs with optimal leverage towards health outcomes. The delay in disbursement also causes health facilities (Puskesmas) to rely on rent patterns which cause total costs to rise.

Public Health is not Prioritized

Preventing is better than treating. Unfortunately, this statement is only rhetoric. Public health programs focusing on preventive and promotive efforts get the lowest budget allocation (Figure 2).

- In the NTT province, 13% of the Local Health Budget is allocated to public health, while 58% and 30% is allocated to supporting activities and curative efforts.
- Analysis of the DHA data in 8 provinces is even more concerning. The largest proportion (52% of the health budget) is allocated for capacity building and supporting activities, 42% for curative health, and only 6% for public health programs. Public health programs comprises of 19 items (maternal and child health, nutrition, malaria, etc.) which has less than 1% budget allocation each.

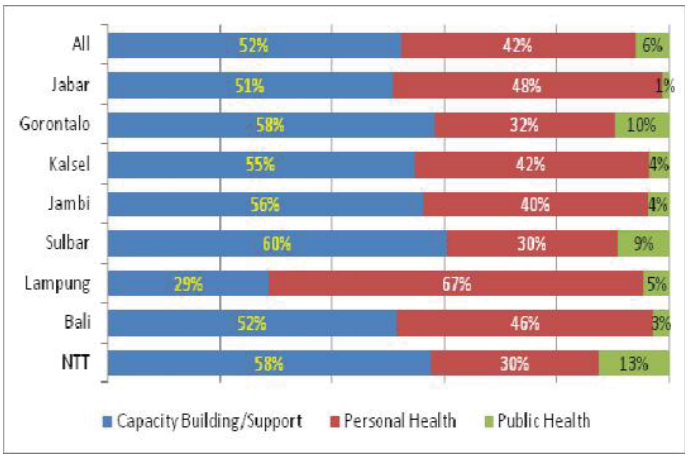


Figure 2 Allocation of Regional Budgetper Program (%), DHA 2011

Recommendations

The following recommendations are strategies to be implemented simultaneously to address the challenges and increase the effectiveness of health financing in Indonesia.

Diversification of Fund Sourcing and Increasing Health Budget Allocation

The government must increase the fiscal capacity to increase the health budget allocation. Potential sources of funds which can be utilized to increase the fiscal capacity are: increasing tax ratios, increasing tobacco taxes and innovative public-private partnerships. The technical details to increase the fiscal capacity can be found in attached technical briefs.

Public Health Mainstreaming

Public health is an essential component of the National Health System. The Public health program focuses on the preventive and promotive health, targeting the population rather than individuals as in curative health. Increased investment in public health programs has significant implications in decreasing curative health costs and improving the health status of the population. Based on two reasons (Box 1), investment in public health can save lives and result in macro efficiency.

Box 1. The Urgency of Increasing Investment for Public Health Programs

1) Investment in public health saves lives, increases the quality of life, and results in economic gains through decreasing treatment costs and increasing productivity.
2) Investing in public health increases the effectiveness of other health interventions. Public health intervention saves 90% (and 140%) more lives in ten years (in 25 years) compared to curative programs and approaches.

Adequate Budget Allocation for Community-Based Health Efforts and Individual-Based Health Efforts

The government must increase allocation of health budget to not be biased towards curative health. Nineteen public health programs need to be implemented. This requires adequate allocation of health budget between Community-Based Health programs and Individual-Based Health programs, as well as supporting activities, should also be prioritized.

In addition, allocative inefficiencies of curative health care must be addressed. The dominance of specialized health care should be decreased, by adequately financing primary health services. The government should also review the health referral system.

Increasing Preventive and Promotive Efforts

Up to70% of burden of diseases can be avoided through preventive and promotive health efforts (WHO 2002). Therefore, increasing budget and providing adequate budget allocation for Community-Based Health programs and Individual-Based Health programs can strengthen the development of Community-Based Health programs. Health promotion and disease prevention programs must be prioritized.

Improving Management of Funds

Increasing the health budget allocation does not guarantee improvement in health status if the bureaucracy and fund management is weak. The government must improve the management and governance of the utilization of funds to ensure the budget allocation is effective and has significant implications to achieve health development goals. For example, the effort of strengthening BOK funds must include assessing the bureaucratic process and the management of funds.

Improving Technical and Management Competence of Health Programs

Health management requires adequate funds and management from the planning, implementation, monitoring, and evaluation. Therefore, along with increasing budget allocation, a strategy to improve the technical capacity of the human resources and program management capacity has to be developed.

Institutional Analysis under Decentralization

Institutional Analysis under Decentralization

Due to the many changes facing the Indonesian Health Sector, it is necessary to focus the health system on the delivery of known, effective evidence-informed, high-quality interventions in health development, this will require addressing the institutional barriers.

Two of the key drivers of system effectiveness are decentralisation and the implementation of JKN (*Jaminan Kesehatan Nasional*/National Health Insurance). Building upon the changes to the current legislative framework for health, the transformation of governance, systems, structures and processes will be needed to ensure that the strategic intentions of the government development agenda are achieved.

The WHO's "health systems *building blocks*" approach to health care development, adopted by the Ministry of Health, requires a high degree of inter-organisational co-operation, and adaptive planning. The "*building blocks*" approach requires planning to be managed, synchronised and harmonised between Ministry of Health (MoH), Ministry of Education (MoE), Ministry of Public Works (MPW), BPJS (*Badan Penyelenggara Jaminan Sosial*) and Ministry of Home Affairs (MoHA).

The management of **uncertainty and risk** particularly around the impact of the introduction of JKN; increasing JKN coverage and the "insurance effect" due to either the need for care or moral hazard from both consumer and the provider will create a movement from one type of coverage, and one type of service provision to another, this can produce unintended and unpredictable consequences. In such a policy context the challenge for leaders and managers is to balance the need for **agility** but to secure **transparency** and **conformity to good governance practices**. This requires a management framework which is sufficiently flexible to be able to respond to shocks. For example, mechanisms need to be in place which can respond to unexpectedly high increases in demand arising from JKN, or to react to significant overspending or underspending against the funding pool. This requires a planning process which enables short-term adjustments within the context of a wider strategic framework.

Three critical issues for institutional governance are;

1. **Leadership:** The MoH needs a leadership role in the context of a decentralised constitutional structure, and how inter-ministerial relationships can be managed in a transparent and effective way.
2. **Legitimacy:** Legal and policy mechanisms are needed at a very high-level to empower the MoH to exercise its duties of strategy formulation, policy setting and supervision within the context of decentralised government and in partnership with other national institutions whose have an impact on health.
3. **Accountability:** How can the MoH hold to account provincial, district and subdistrict health offices for the delivery of locally-appropriate, high-quality, equitable services. Bottom-up planning systems which are contestable and which require MoH authorisation will be required.

Key Challenges

Political level: Ensuring the legitimacy of national, provincial and district governments in the management of the SKN (*Sistem Kesehatan Nasional*/National Health System), and clarifying the roles of MoH, Provincial and District Health Offices within the SKN.

Policy level: How national priorities such as equity, developing the role of primary health care, can be implemented locally, and how service planning can be integrated at all levels in the system, and across all sectors

Governance level: How can the MoH manage governance and accountability for the performance of institutions not directly managed by the MoH but have an impact on health.

How to undertake health systems strengthen to align health financing, human resources for health, information and supervision/reporting.

Structural level: how to clarify the relationships vertically (MoH, PHOs, DHOs) and horizontally (MoH – BPJS – MoHA, MoE etc). Particularly, there is a lack of clarity about the roles of PHOs and DHOs, and the relationships between provider institutions like the hospitals within the stewardship of different levels of government within the SKN in relationship to each other, where roles are often perceived differently or are as yet undeveloped in the case of new institutions.

Capacity level: how to ensure the right capacities are built so that the health institutions provide effective leadership and governance at all levels to manage the changing health need and expectations of the community.

Leadership level: How can the MoH exercises its supervisory responsibilities particularly quality of care, standard setting and enforcement.

Key Policy Options and Recommended Strategies

1. Ensure that under decentralisation and the introduction of JKN roles and responsibilities for the delivery of health policies, strategies and annual plans at all levels of government are clear.

   Recommended strategy: Review the regulations and legislation of roles and responsibilities of the key players in the health sector following the introduction of JKN. This will include clarifying who is responsible for meeting the targets at both national and regional level for the 2014-2019 RJPMN targets and the other targets set out in the institutional analysis.

2. The second overarching policy is to ensure key health outcomes are delivered by the successful implementation of policies and strategies at national provincial and district level.

   Recommended Strategy: put in place a performance management system which will allow the MoH to work with the MoHA to monitor performance in the decentralised system. This needs to be incorporated into the annual planning system with performance monitoring frame works incorporated into annual MoH, Provincial and district health plans with clear deliverables. These should be agreed annually between MoH and provinces and between provinces and districts.

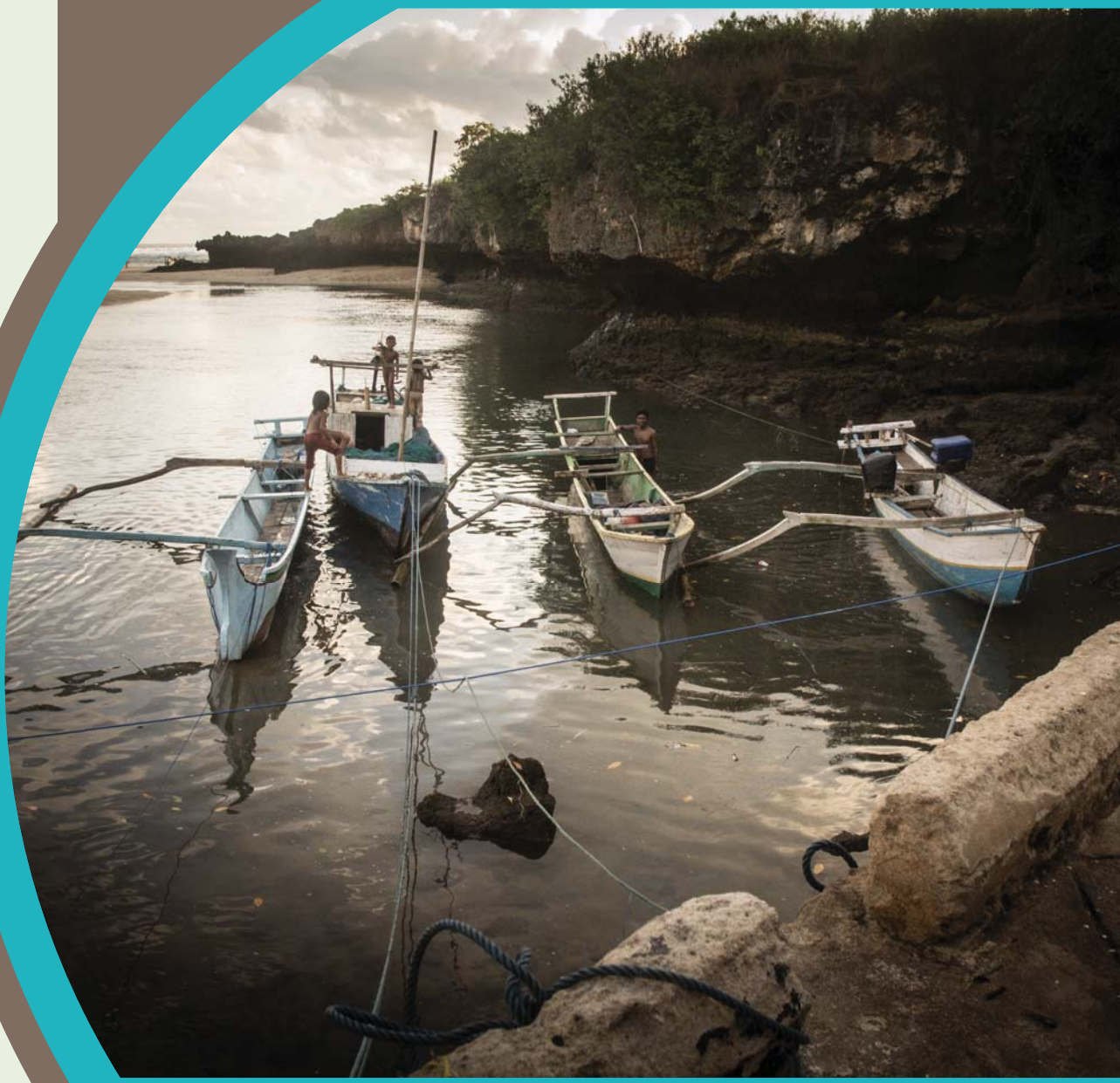
Further Policy Considerations

1. Consider the development of a priority legislative program which establishes the requirement to submit business plans and facilitates inter-ministerial collaboration for health development.
2. Consider the development a program which will include developing and implementing a contracting framework, which includes the creation of standard contracts for different service types.
3. Consider the development of a quality management system which will lead towards the accreditation of all health public and private facilities.
4. Consider a system development program which includes developing a business planning framework which aligns financial, information and governance systems.
5. Consider the appointment of a Chief Medical Officer, a Chief Nursing Officer, a Chief Pharmaceutical Officer and a Chief Scientific Officer, and leadership development, particularly at sub-national level.
6. Consider capacity development program in contract and service level agreement development, and in delivering quality, including that of clinical coding.
7. Consider further infrastructure development will include capital investment in Puskesmas and providing support for developing the role in community empowerment, health promotion and planning.

Further Recommended Strategies

Strategy	Action
Formulate regulations on the clarity of distribution of health functions and authority between levels of government as referred to in the Local Government Act	Revise regulations on the distribution of functions and authority
Identify the overall Norms Standards Procedures and Criteria (NSPK)	Undertake NSPK inventory: update, revise those which are obsolete, and develop those which are not established
Socialising NSPK and facilitation at the sub-nationals	Dissemination of information and monitoring and evaluation of implementation
Regulate relationships between DHO with hospital and health centre	Revise PP 41/2007 to set out clear and unequivocal relationship between DHO with District hospitals or health centres
Strengthen relationships between the MoH with PHO/DHO	Develop a Permenkes referring to the revised PP 41/2007 that regulates the relationship between the MoH to PHO/DHO for clarity of coordination and facilitation.

Strategy	Action
Develop a regulation to clarify government institution is responsible for public hospitals	Develop Permenkes which regulates the level of government that is responsible for the hospital
Strengthen business and operational planning in autonomous/semi-autonomous Government entities (hospitals, DHOs, PHOs) to prepare tri-annual business plans and annual operational plans for submission up to the next hierarchical tier	• Develop a Permenkes to require autonomous/semi-autonomous Government entities (hospitals, DHOs, PHOs) to prepare tri-annual business plans and annual operational plans for submission up to the next hierarchical tier • Use Binwas (stewardship) to support business planning
Adjust the Standard Operational Procedures (SOP) between the MoH to DHO	To formulate Permenkes on SOP of relationship between MoH and DHO
Strengthen health systems based on PHC (Primary Health Care)	To formulate the operationalization of Health Systems Strengthening based on PHC
Harmonise MoH programmes with DHO, especially in achievement of Minimum Service Standards (MSS)	To harmonise the MoH and DHOs' programmes, especially in achieving the MSS target
Strengthening coordination between MoH and MoHA in imposing sanctions	To formulate a joint ministerial decree between MoHA and MoH in imposing sanctions when local authorities do not comply with the national health policy



Supply Side Readiness

Supply Side Readiness

Service Delivery and Supply-side (SDSS) Readiness are fundamental and critical health system elements to achieve Universal Health Coverage (UHC), to ultimately improve health outcomes, and support human capital development, a key driver for economic growth.

Service Delivery has undergone substantial improvements over the past decade. The number of hospitals has almost double since 2004 to an estimated 2,228 in 2013, more than half of all hospitals are now private. The number of puskesmas has also increased over the same period in 2004 to 9,654 in 2013, with almost a third having inpatient beds. Outpatient and inpatient utilization rates have risen steadily, especially among the bottom 40% of the population, and is occurring increasingly at private facilities.

However, the issue of SDSS Readiness is a vital factor due to the Changing Burden of Disease and UHC. The demands on both the public and private sector will increase in the coming years and the equity risks related to a potential shortage in supply versus demand need to be addressed by government through both the public and private sector involvement.

Key Challenges

There remain significant deficiencies in service delivery and supply side readiness, as well as huge disparities across provinces and districts, which will risk achievement of UHC. The bed density ratio remains far below World Health Organisations (WHO) recommendation of 25 per 10,000, and maldistribution is an issue, with significant differences in bed density ratio across provinces.

Geographical access remains a challenge is some regions. Although the median distance to a health facility in Indonesia is only 5 km, in provinces such as West Papua, Papua, and Maluku the median distance is much higher, over 30 km. On average 18% of Indonesians took more than one hour to reach a public hospital over 40% of people in West Sulawesi, Maluku, and West Kalimantan faced this barrier to access to health care.

Utilization rates still remain very low by global standards and there remain huge disparities across provinces: Indonesia's inpatient utilization rate is1.9% this is well below the WHO standard of 10 discharges per 100 population with large scale differences in this rate across provinces.

Across Indonesia, no puskesmas meets with the standard 38 indicators for general service readiness across the five areas of

1) Basic amenities

2) Basic equipment

3) Standard precautions for infection prevention,

4) Diagnostic capacity

5) Essential medicines.

Many challenges remain regarding puskesmas service-specific availability and readiness, across essential health services, for example analysis of Risfaskes 2011 found that:

Antenatal care – in North Sulawesi, Maluku, and Papua, less than 60 % of puskesmas could undertake haemoglobin testing (essential to detect at anaemia as a risk factor for at risk pregnancies) , while urine tests were almost completely unavailable in Gorontolo, North Sulawesi, and Maluku.

Basic obstetric care – only 62% of BEONC (Basic Emergency Obstetric Neonatal Care)[1] puskesmas had at least one staff trained in BEONC in the previous two years; and there is poor availability of fundamental equipment to manage safe deliveries (such as transport, manual vacuum extractors and Dopplers) in provinces with some of the highest maternal mortality ratios, such as Papua, West Papua, and North Maluku.

Immunisation – less than 80 % of puskesmas in Papua, West Papua and Maluku reported availability of the measles, DPT, polio and BCG vaccines. Only about a quarter of private facilities, and less than 10% of those in eastern provinces, reported availability these vaccines.

Child health – low availability of training on integrated management of childhood illness (43 % of puskesmas) and growth monitoring (57 %).

TB – only 65% of puskesmas had staff trained in TB management, and only 73% had the capacity to diagnose TB from sputum samples, first-line treatment was not widely available either in puskesmas or public hospitals. Fixed-Dose Drug Combinations I and III were only available in less than half of puskesmas and only 27% of public hospitals.

Malaria – low puskesmas availability of antimalarial medicine (62%) and malaria blood tests (71%) in the ten provinces with the highest malaria prevalence rates.

Diabetes – only 54 % of puskesmas reported the ability to test for blood glucose and 47 % the ability to test urine. In Gorontalo, Papua, West Papua, Southeast Sulawesi, Maluku, North Sulawesi, East Nusa Tenggara, and West Papua, less than 25 % of puskesmas reported the capacity to conduct these tests.

Basic surgery – very low availability for provision of many key basic surgery items such as pediatric resuscitators, oxygen, and scalpel and poor availability of guidelines trained staff

Blood transfusion – only 20% of all public hospitals, and none of the 30 private hospitals surveyed, maintained all six tracer items.

Comprehensive surgery – only 18% of all public hospitals, and 33% of the 30 private hospitals surveyed, maintained all nine comprehensive surgery tracer items.

[1] *Pelayanan Obstetri Neonatal Emergensi Dasar* (Basic Emergency Obstetric Neonatal Care).

Key Policy Options and Recommended Strategies

Attainment of Indonesia's goal of UHC and improvement in health outcomes will require service delivery and supply side readiness to meet rising demand and increase quality as coverage expands. Key policy options and strategy include:

1. Increase public health financing, combined with targeted investments to improve service delivery and supply-side readiness, and assess budget processes to understand priority setting and where rigidities or other factors are inhibiting funding allocations that reflect government priorities and health sector commitments.
2. Socialize the supply-side implications of the National Health Insurance benefit package, including related governance and accountability mechanisms,
3. Establish a regular and independent accreditation process for public and private facilities.
4. Compile systematic information on the number and distribution of private health facilities, and conduct independent and regular private sector facility assessments. A rising number of private facilities are being contracted by BPJS Health to provide services under JKN.
5. Benefit package specifications to include equipment, training, diagnostic capabilities, and medicines to be provided at different levels of health care providers. BPJS Health should only use public and private facilities that are accredited.
6. Improve accountability through a better system of regular and independent monitoring and evaluation, and use and link appropriate and effective incentive and provider payment mechanisms to ensure service delivery and supply-side readiness.
7. Institutionalize collection of regular, independent, and relevant facility-level data that reflect national guidelines and norms, and understand where and why the gaps exist.
8. Research to collected data from beneficiaries to ensure that service provision is occurring as intended and that patients are receiving the care they are entitled to.
9. Systematically and regularly assess and improve service delivery, including the capacity of providers, and ensure that the basic inputs in facilities are available but maintained and utilized; and assess whether or not health workers have the necessary skills and motivation to provide high-quality services.
10. Adapt existing systems and practices from community empowerment programs to incentivize village governments to invest in priority health needs and hold village governments accountable for health expenditures.

Attainment of Indonesia's goal of UHC and improvement in health outcomes will require service delivery and supply side readiness to meet rising demand and increase quality as coverage expands

Human Resource for Health

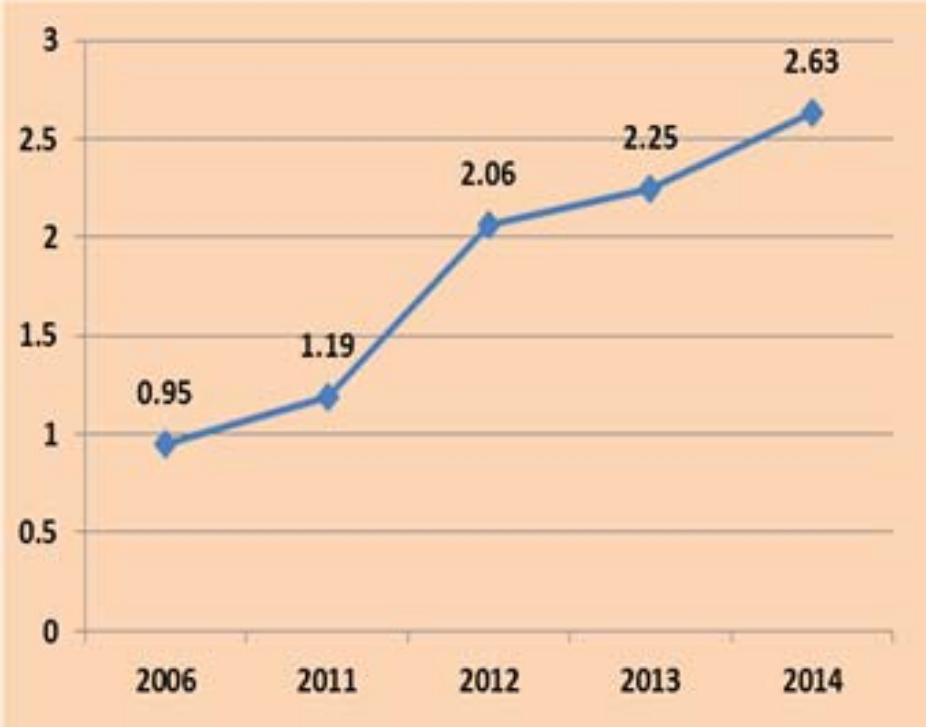
Human Resources for Health

Indonesian Government commenced implementation of the National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) scheme in early 2014 to ensure access to quality and equity of health care services to the Indonesian population. The Human Resources for Health (HRH) are essential in supporting the success of JKN, especially in providing quality and appropriate health care services and supply side readiness for JKN.

There is a diverse population density throughout the country due to geographic diversity, which poses a challenge to the provision of equitable health care services. In remote areas there are significant challenges to accessing health care services in puskesmas, including in the provision of the appropriate numbers of competent health workers. This poses a serious challenge for health development and achieving the goals of JKN.

Indonesia has achieved a noticeable increase in the ratio of health workers to the overall population, rapidly increasing the overall number of health workers and surpassing the minimum number recommended by the World Health Organization (WHO), 2.3 doctors, nurses and midwives per 1,000 population. Much of the increase has come from the private sector, particularly through investment in medical schools. Of the 72 medical schools about 60 per cent are private.

Figure. Increasing ratio of health workers to the population



Source: BPPSDM 2014

Key Challenges

The three key areas that require a policy response are:

1. Production – ensuring there are sufficient numbers to meet the demands of JKN and Universal Health Coverage (UHC);
2. Distribution – ensuring their availability in remote and rural areas to meet the challenge of equity;
3. Improving the quality and performance of health workers by ensuring training institutions meet government standards and continuous competency training.

Production

Despite the growth in the number of health workers, this is still insufficient to meet population growth and growing demand for health care. The shortfall in health workers especially at the primary health care level (puskesmas): a critical gap if Indonesia is to achieve UHC and focus more on prevention and promotion. There is also a pronounced shortfall of nurses and midwives in hospitals which is a critical gap if Indonesia is to reduce maternal and infant mortality, and respond to the growing burden of Non Communicable Diseases (NCD) and injuries. There is a shortage of other key health workers for public health and health promotion.

Distribution

The geographical distribution of health workers has been a longstanding challenge in Indonesia, 30 of the 33 provinces do not have the WHO recommended standard of 1 physician per 1,000 population. Indonesia's dual practice system of allowing health personnel to work in both public and private facilities relieves budgetary pressure on government, but is a contributing factor to mal-distribution of health personnel, in particular specialist doctors.

Geographical distribution of nurses and midwives is better than that for doctors, but there are still important inequities. Many factors contribute to this mal-distribution of health workers, the Government of Indonesia, at both central and local level, has trialed a range of policies and programs to improve the impact and distribution of health workers but more needs to be done. Mal-distribution of health workers, in in remote and underserved areas is of special concern. Currently there are no specific policies for human resources in remote and underserved areas, and distribution policy has not considered the need of these specific regions.

Quality and performance

Another challenge is the competency of health workers which is insufficient to respond to the challenges of service provision. A health workforce without the appropriate competencies to respond to the changing demand for health care services will decrease the performance of the health system and decrease people's trust in the health care system. This situation is a fundamental issue and has become the main concern from health service managers and the public.

Indonesia does not have enough health workers and needs to ensure it is getting maximum benefit from those that it has. The quality of the health workforce starts with the quality of training facilities where there is a great deal of variability and only half of the schools are accredited. The government's 2009-2014 medium term development plan stated that

accreditation of health professional schools and certification of their graduates is a priority. However the curriculums remain outdated and not aligned with current health care challenges and future demands. For those currently leaving the medical training system the graduating pass mark is low and there is variation in the quality and performance of staff. The systems for continuing education, in-service training, and ongoing competency testing and accreditation remain mixed. For example, weaknesses in the original training for midwives means that there is a continued requirement for subsequent in-service training, this introduces inefficiency and waste in the education system.

The new and emerging challenges includes

1. Growth in population and changes in disease burdens

Indonesia is undergoing a demographic, epidemiological and nutritional transition. This will put new and additional strains on a decentralized health system as the country moves coverage targets of JKN by 2019.

2. Free trade agreement

The development of an ASEAN Economic Community, with its goal of "free movement of goods, services, investment, skilled labour, and free flow of capital" will have implications for labor mobility and recognition of professional qualifications of health workers. This provides opportunities – and risks – for Indonesia. Medical tourism offers the potential for generating additional revenue, but also carries risks in terms of access to essential services for the poor and potential quality health workers' migration to work abroad.

3. Production

While there is no "right" number of health workers, it is clear that Indonesia does need to increase the production of front line health personnel that actually deliver quality services. There are projections for health workforce needs, but these projections need to be improved and aligned with the Burden of Disease and JKN supply side readiness, and also need to be fully costed.

Determining the total number of health workers actually needed is important, but so is ensuring that different categories of health workers align well with the changing burden of disease challenges in Indonesia. Particular priorities would appear to be increasing the number of nutritionists; maternal and child health professionals; public health professionals engaged in primary and secondary prevention of NCDs; and health management skills. Understanding the reasons for the gap between production, and subsequent employment, of nurses, and then responding appropriately to close that gap will increase coverage of services and improve the efficiency of the health workforce system.

The definition of health workforce does not align so that it better align with the changing health needs of the country. The traditional approach of – doctors, nurses and midwives – is important, But there is also now a need to expand the production and definition of other health workers to meet future needs including, for example, anesthetists, laboratory technicians, and public health officials competent in primary and secondary prevention of NCDs. The definition of health worker should also be expanded to include health economists and health administrators – essential analytical and management skills needed as Indonesia faces the new and complex challenges to the health sector

4. Distribution

Several innovative policies have been identified that could help improve the distribution of health workers geographically. Deploying a single specialist – for example a surgeon – into a remote area which does not have complementary health workers such as anesthetists reduces the surgeon's effectiveness, efficiency, and willingness to remain at the post. Deploying whole teams that work together and complement each other would therefore be an appropriate strategy for increasing effective health services in rural and remote areas. There are current policy considerations for the need to have an specific policy for deployment of health workers to Eastern Indonesia.

5. Equity and financial protection

A key objective of JKN is to improve equity of access and outcomes, and to ensure financial protection. Indonesia's 'dual practice' system for health workers offers the potential to move in that direction but it requires stronger regulation to achieve equity and financial protection under JKN. A review and trialing of different provider – payment systems is needed. The policy challenge for Indonesia as it scales up JKN is to use the private sector incentives available under the dual practice system to then meet broader public health needs and JKN goals.

Key Policy Options and Recommended Strategies

1. Human Resource Policy Development

Develop policies that are suitable and appropriate to accommodate different needs and geographical characteristics across Indonesia, as well as reformulate quantity and quality standards and widen the definition of health workers in Indonesia.

Recommended Strategies

Re-establish CCF (Country Coordination Forum) as a high policy forum. This is essential because there are many high level stakeholders that are involved in HRH management, from production, distribution, performance assessment, remuneration, and termination. Alongside this many regulations that are in effect for Indonesian health workers are overlapping with each other, so a high policy forum is needed to align these issues.

2. Production and Distribution

Determine the projected gaps in Indonesia's health workforce, taking into account skills needed to respond to the current and future burden of disease, the scale up of JKN, the effects of policy changes, geographical access and socio-economic inequity.

Cost and budget for these projections, including training, and an estimate of the input from the private sector.

Increase the budget of the Ministry of Education (MoE) so that the numbers and categories of health workers are better aligned to current and future health needs. Determine the need for other health care workers – such as nutritionists, public health officials and health planners – in relation to scaling up JKN.

Strengthen dialogue and information sharing between the MoE, the MoH (Ministry of Health) and the private sector.

Recommended Strategies

Production

1. A country coordination and facilitation mechanism to promote inter-ministry and inter-sectoral dialogue and planning would help reduce fragmentation.
2. As scaling up the number of health workers will take time, consider licensing qualified and accredited nationals under the ASEAN Economic Community agreement to practice in Indonesia in areas of critical shortage.
3. Undertake comprehensive projection of human resources aligned with Changing Demand for Services, Burden of Disease and JKN supply side readiness

Distribution

1. Formalise the policies for deploying health workers to Eastern Indonesia and the minimum standards of service delivery expected there.
2. Review the entrance standards and availability of bridging courses for potential entrants to medical colleges in remote areas.
3. Give greater emphasis to deploying health worker teams (rather than individual specialists).
4. Trial and monitor compulsory deployment rules.

3. Equity and Financial Protection

Build on the strengths of Indonesia's existing 'dual practice' system to align it more closely with the goals of JKN and the major health burdens facing Indonesia.

Improve the quality and performance of health workers through a reward system program including: training, rotation of location, career advancement.

Recommended Strategies

1. Strengthen the implementation of existing dual practice regulation.
2. Provide investment and support to training schools to meet government standards, and close those that do not.
3. Strengthen the focus on competency. This would include conducting regular competency tests for medical doctors, midwives, pharmacists and nutritionists as an early priority, and increasing the competency of health workers in identifying risk factors for and supporting the prevention of NCDs.
4. Review and update the curricula for health care workers so that more health workers are produced who can address the critical health burdens of Indonesia and the requirements of UHC including nutrition, maternal and child health, prevention and treatment of NCDs (especially reduction of tobacco).
5. Investigate the underlying reasons for the low pass marks of graduating health workers.

6. Measure the productivity, efficiency and quality of key health personnel services as part of the evidence base for reallocating scarce human resources to those functions and locations with the highest health payoff.
7. Provide appropriate material and non-material reward with significant leverage.

ompulsory deployment rules.

Build on the strengths of Indonesia's existing 'dual practice' system to align it more closely with the goals of JKN and the major health burdens facing Indonesia.

Pharmaceutical Review and Medical Technology

Pharmaceutical Review and Medical Technology

The (national) average availability of medicines and vaccines in public health facilities has continued to increase from 2010 – 2013, and it is anticipated it will reach the 100% target in 2014 (see Figure 1).[1] Based on the annual report of the Ministry of Health, Directorate General of Pharmaceutical Services and Medical Devices 2012, the availability of medicines and vaccines was 92.5%, compared with the target of 90% for 2012, and it should reach 100% in 2014.

However, if one looks at the between-provinces differences in 2012 (Figure 2)[2], or even between districts within a province, there are striking disparities. In three provinces (Maluku, Gorontalo and Kepulauan Riau) the average availability is well below 80%: reported as between 65% to 73%. In contrast, in six provinces (Kalimantan Timur, Sumatra barat, Maluku Utara, Yogyakarta, Jawa Timur and Kalimantan Barat) the average availability is far higher than 100%, ranging from 105% to 129%.

It is just as important to avoid overstocking and wastage of medicines, as it is to avoid under-supply. While monitoring of the average availability at provincial levels can bring about performance improvement at provincial levels, it is important to also look at the data by district so that appropriately targeted actions can be taken.

Tantangan

1. Increased demand from the public on a better governance and more transparency.
2. As Universal Health Coverage (UHC) is implemented, there will be increasing pressure on the health system to ensure there is equal access to services throughout the country. This is especially a heavy burden on a decentralized health system that is currently implemented in Indonesia. Lack of data on provincial and district level also proposes continuing problems, affecting the supply chain management and the estimation of health expenditure for provinces and districts.
3. The implementation of National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) proposes challenges such as:
    - There is no one comprehensive list of products (medicines) that can be used as a national standard and be included in the JKN benefit package.

[1] Laporan Akuntabilitas Kinerja Direktorat Jendral Bina Kefarmasian dan Alat Kesehatan Tahun 2012, Kementrian Kesehatan Republik Indonesia 2013. Ministry of Health, Directorate General of Pharmaceutical Services and Medical devices, Accountability Report 2012. **http://binfar.kemkes.go.id/buku-kinerja-program-kefarmasian-dan-alat-kesehatan/**

[2] Laporan Akuntabilitas Kinerja Direktorat Jendral Bina Kefarmasian dan Alat Kesehatan Tahun 2012, Kementrian Kesehatan Republik Indonesia 2013. Ministry of Health, Directorate General of Pharmaceutical Services and Medical devices, Accountability Report 2012.

- There are challenges regarding the payment system through JKN. Calculation of costs cannot rely on previous year's consumption/utilization of medicines and commodities due to the likeliness of the increase of the number of patients and range of treatments.
- There are no comprehensive and accurate estimate of expenditure on medicines and technologies at a national level.

4. The supply chain management and distribution still poses many challenges that need to be addressed to support national health goals. There appear to be problems all the way through the chain, from having adequate data for planning procurement, to warehouse management, to human resources skilled in managing supply at the province and district level.
5. Irrational use of medicine due to lack of human resources capacity and lack of enforcement shows potential impact on quality of care and waste of resources.
6. There is need to balance affordable prices with purchase of quality assured products. Current practices show that Indonesia currently only controls a small segment of the market through its pricing controls on some generics and through prices as published in the e-catalogue. The government has put price controls on 499 generic products. It should be noted, however, that excessive price control may reduce the incentives for manufacturers, affecting availability of generic products such that products may disappear.
7. Quality, safety and efficacy of medicines and devices are a priority. Some of the challenges that need to be addressed include lack of enforcement capacity which results in weak enforcement of regulation of the production of medicines and technologies and lack of human resource capacity and lack of understanding on the Guideline for Good Production Practice for Medical Devices to improve the standard of production facilities for medical services. Not all manufacturers have received GMP (Good Manufacturing Practices) certification, and GMP inspection capacity needs to be expanded to strengthen the quality assurance system.
8. Unclear organizational structure within the government on the role of, and policy direction for, traditional medicine. There are still problems with respect to the efficacy, safety and cost effectiveness of traditional medicines, which pose more problems should traditional medicines need to be included in the JKN benefit package.

Key Policy Options

Once pharmaceuticals and medical technology targets are identified for 2019, policies to achieve the targets for pharmaceuticals and medical technology should focus on two major areas:

(1) Improving the access, equity, availability, supply chain distribution of medicines and health technologies and their rational use by providers and consumers; and

(2) Strengthening control of pre- and post-market medicines to ensure safety, efficacy and quality.

Recommended Strategies

Policy area 1: Improving the access, equity, affordability, availability, supply chain management, pharmaceutical services and rational use of medicines and health technologies.

1. Improve the availability and affordability of essential medicines, especially generics.
2. Promote rational use of medicines and health technologies to providers and consumers.
3. Strengthen institutional capacities in SCM (supply chain management) of medicines and technologies, including monitoring and supervision, especially at district and institutional levels (health centers and hospitals).
4. Support systematic research and development of traditional medicines coordinated by the National Institute for Health Research and Development.
5. Strengthen self-reliance on vaccines.
6. Strengthen pharmaceutical infrastructure and services in health offices and facilities.
7. Monitor price, consumption and expenditure on medicines.
8. Improve transparency and good governance in medicines selection, management and use.

Policy area 2: Strengthening control of pre- and post-market medicines to ensure safety, efficacy and quality

1. Strengthen medicines control in communities through a BCC (Behaviour Change Communication) programme
2. Strengthen human resource capacities in food and medicine control to be able to address emerging issues
3. Strengthen cross sector partnership in medicine control with law enforcement agencies and local authorities to enforce regulation
4. Continue improving transparency and good governance in medicine regulation and registration
5. In order to compete on the international market, medicines and food products need to improve their safety, quality and credibility

In addition to these key policy areas, there are a number of remaining issues which will need to be addressed.

1. JKN coverage

The approach used to specify the medicines, devices and technologies covered under the benefits package of JKN still needs to be clarified.

2. Funding and payment mechanism for medicines/technologies used in primary care.

There is still a lack of clarity about how medicines will be funded under JKN for use in primary care settings. Currently, no health systems provide global coverage of medicines/technologies using a capitation formula. Numerous aspects of the current system in Indonesia make it likely that the proposed payment model will result in increasing costs, poor quality prescribing and

declining access to medicines. Therefore, it is suggested that other policy options for payment of medicines and technologies should be considered; for example a modified fee for service system, limited list, or reimbursed products.

3. Control and enforcement of the supply chain

Most countries with universal coverage schemes have had to take control of the supply chain for pharmaceuticals and devices. This includes registering the community pharmacies that are able to claim reimbursement, controlling supply chain mark-ups, and enforcing legislation with respect to dispensing doctors. Developing the stepwise strategy required to implement effective control of the supply chain, and the components of this, will be possible only when the policy choice about control is made.

4. Define the role of community and private sector pharmacies

Community and private sector pharmacy roles should be well-defined, complementary to one another, and avoid overlap in order to effectively ensure access to medicines in the community. For example, public sector supply chain weaknesses can be overcome by allowing the private sector to take on this role; and the potential workforce made up of the 5,000 pharmacy students who graduate each year could be used to fill in gaps not currently filled. The number of community private pharmacies being endorsed and listed to claim reimbursement to JKN is still far from the ideal figure, and there should be transparency in the listing of these pharmacies.

5. Separation of prescribing and dispensing

In order to promote rational prescribing, it is essential to remove perverse incentives such as allowing doctors to prescribe and dispense medicines directly to the patient. This is particularly relevant in an environment where pharmaceutical company promotional activities are not controlled. This is a sensitive issue and any change would require extensive stakeholder consultation once the policy choice is made.

6. Optimise the use of existing human resources and develop additional capacity for pharmaceuticals and supply chain management

The introduction of JKN is an opportunity to re-evaluate the most effective use of pharmacists and other groups in the health workforce while considering appropriate task-shifting strategies to improve health outcomes. For example, allowing midwives to prescribe and administer a limited list of medicines could improve maternal health outcomes, and continuing to work with the People that Deliver partnership could improve the workforce currently managing the supply chain. Again, these changes would require extensive consultation with stakeholders.

7. Develop the infrastructure to support efficient and effective management of the pharmaceutical sector

Efficient management of the supply of medicines and devices under JKN will require adequate data on supply and consumption of these commodities. Developing a system to do this should be considered a priority at the national level, notwithstanding the decentralised responsibilities for delivery of health care. Along with IT and infrastructure, the human capacity required to implement the administration of JKN effectively with respect to supply of medicines and devices must be identified. Once the policy choice is made, options for approaches to this task can be developed.

Quality and Safety of Health Care

Quality and Safety of Health Care

In Indonesia's attention to quality has focused on resource inputs and on access to healthcare. But investment in these will be lost and the national and international goals of improved health outcomes, safety or public satisfaction are at risk if quality of care is not addressed.

To reduce wasting resources a coordinated national approach is necessary, adopting evidence-based clinical standards, sharing reliable performance indicators, aligning incentives for improvement and integrating existing systems between governments and non-government organisations including Social Security Administrative Bodies (*Badan Penyelenggara Jaminan Sosial*/BPJS).

Key Challenges

1. No coherent national vision or framework for quality and safety

The focus in the past has been on increasing resource inputs, and access to health care facilities. Attention must turn to promoting and rewarding performance, making better use of existing resources, and joining up existing systems within an integrated national framework of collaboration.

2. Incentives for improvement unclear, confused or absent

Adoption of best practice, and improved performance (in terms of clinical outcome, patient experience and safety) should be consistently rewarded; conversely, consistent non-compliance with "compulsory" licensing, accreditation and data reporting should not be ignored.
The introduction of the National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) offers a real opportunity to align incentives with reimbursement being linked to accreditation of facilities and to standardised numerical indicators of performance. The Ministry of Health (MoH), BPJS and Hospital Accreditation Committee (*Komisi Akreditasi Rumah Sakit*/KARS) need to work together to align standards, requirements, information and incentives.

3. Unclear role of institutional accreditation

There is confusion between the regulatory function of licensing, the supervisory function of the Hospital Supervisory Board (Badan Pengawas Rumah Sakit/BPRS) and the developmental function of accreditation. Accreditation is a third-party assessment of compliance with published standards, independent of government; it is not a substitute for weak or ineffective supervision, or for a nationally coherent quality strategy.

The national accreditation agency for hospitals, KARS, was set up within the MoH in 1995 and the Hospital Law of 2009 made accreditation compulsory for all hospitals every three years. In 2010 a ministerial decree reinforced this by making accreditation a condition of hospital licensing. BPRS, was established in 2012, with responsibilities at national and provincial level. Responsibility for hospital licensing is shared between district, provincial and national level.

Puskesmas accreditation is being developed by The Directorate of Primary Health Care (*Bina Upaya Kesehatan Dasar*/BUKD) for implementation at provincial government level. Unlike KARS, this programme is not aligned to national legislation or to international standards for accreditation organisations.

Inconsistency between external assessment programmes (of accreditation, supervision, inspection) and between district, provincial and national agencies is a recipe for inequality, inefficiency and confusion. The contribution of external assessment to improving quality and safety should be explicitly stated in a national framework document.

4. Fragmented Roles and Responsibilities

There is widespread fragmentation and uncertainty of roles and responsibilities within the MoH and between institutions and agencies, such as:

Local Governments: Provincial health authorities operate inspectorates, and District Health Offices issue professional licenses and are responsible for licensing the facilities they own and operate, as well as private providers in their districts.

Professional Organisations: Professional regulation of doctors was formalised in 2004 with the establishment of the Indonesian Medical Council (*Komisi Kedokteran Indonesia*/KKI) and Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia*/MKDKI). The medical committee in each hospital is responsible for annual credentialing of all medical staff. The Indonesian Health Workforce Assembly (*Majelis Tenaga Kesehatan Indonesia*/MTKI) was introduced in 2011 for 23 types of health workers excluding doctors and pharmacists.

MoH commissions: by ministerial orders, commissions have been set up to address key issues such as patient safety and technology assessment, but without formal infrastructure, resources or authority to engage with the healthcare system at national level.

Other national entities: Other agencies related to quality include ISO certification bodies, the healthcare branch of the National Agency on Consumer Protection, the National Blood Committee, and the Indonesian Medical Association, which is designated by the MoH as a partner in the formulation of national clinical guidelines.

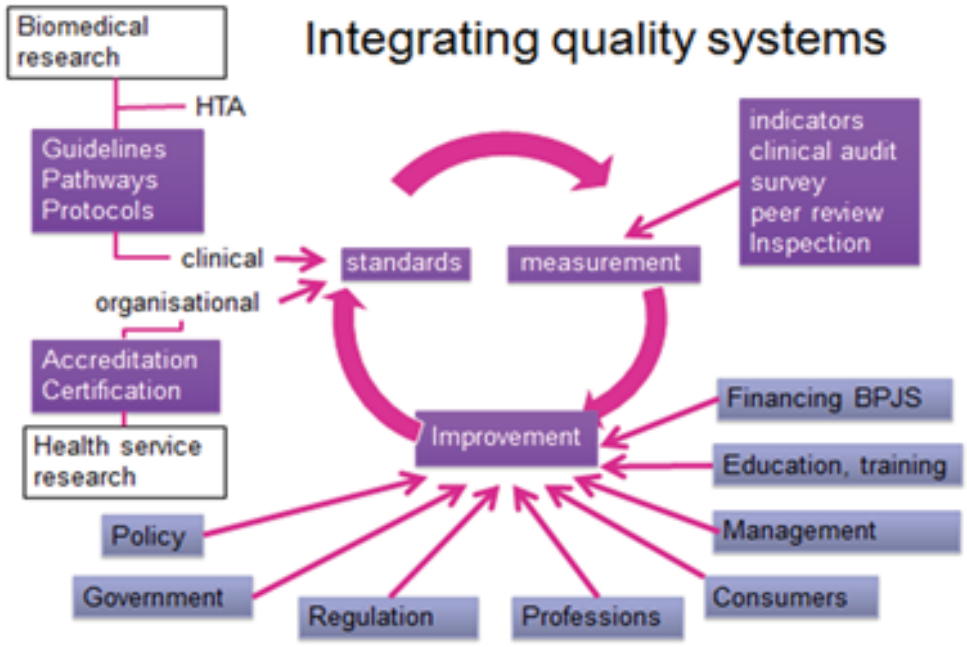
5. Unclear Patient Rights and weak mechanisms for Protection

The rights of patients in terms of eligibility for health coverage are defined by health insurers, especially BPJS. Rights to informed consent are regulated but there is no national charter to describe, in simple language, the rights of patients to choice, privacy or information. An exception is the 'Patient Charter for TB Care' issued by the patients' association PAMAL in 2009.

6. Lack of Baseline on Quality and Safety

There is no baseline to describe achievements in quality and safety over the last RPJMN, and there has been little discussion among stakeholders to define what steps are appropriate. The recommended policy direction is to start consultation in Indonesia towards a coherent plan, rather than to prescribe solutions based solely on international experience.

Mapping Quality in the National Health System



Key Policy Options and Recommended Strategies

1. Establish a National Quality and Safety advisory group

Establish a national policy advisory group to represent all stakeholders, to identify clear values and dimensions for quality in health services, and to focus on performance in three dimensions: clinical effectiveness, safety and patient experience. Design a national framework for quality in healthcare for consultation, publication and acceptance as a basis for operational planning and development of quality systems.

2. Identify a central mechanism for coordination and sharing of resources

Several governmental and independent agencies are investing effort in elements of a national quality system, such as data collection, organisational standards and clinical guidelines, but there is little coordination or opportunity to share and learn from collective experience. A real or virtual centre is needed to join up standards, measurements and improvement, such as for:

- Clinical practice: HTA (Health Technology Assessment), guidelines, indicators, audit tools
- Patient safety: incident reporting, risk management, safe systems, learning from errors
- Performance management: collation, analysis and feedback of standardised performance indicators; benchmarking
- Training: Quality and risk management systems, clinical audit, clinical coding
- Reference source: National and international protocols and standards (eg AGREE for clinical guidelines, OECD for indicators, WHO for safety, ISQua for accreditation), guides, methods, tools and findings

3. Develop an explicit information strategy

The rationale of pay for performance, casemix costing, risk management, public reporting and quality improvement relies on an assumption of having complete, accurate and timely data from every provider institution at patient level as a basis for aggregation, analysis and comparison.

The MoH should identify partners in developing a comprehensive national strategy and standards for data protection, data definitions, capture, coding and information management. This should identify the needs of various users (eg BPJS, MoH, clinicians and managers) and how they may be met by aligning existing and new systems. For the purpose of quality improvement, this may include:

- Consistency with CPDMS (Clinical Performance Development and Management System)
- Compatibility of clinical coding in hospitals and primary care
- Data quality standards and measures; validation of case-mix grouping
- Definition of indicators of clinical, managerial and financial performance at institutional and national level consistent with international principles (eg OECD, WHO PATH)
- Aggregation, presentation, benchmarking and feedback to local hospitals, clinics or Puskesmas.

Targets and timescale for achievement

It would be inappropriate to define targets for planning and implementation until the baseline situation analysis is agreed and owned by all stakeholders, and responsibilities are defined and accepted among them.

Health Sector Review

Technical Brief

Australian Government
Department of Foreign Affairs and Trade

Australia Indonesia Partnership
for Health Systems Strengthening
(AIPHSS)

Australian Aid

Creating Fiscal Space for Health in Indonesia: 9 Ideas
A Bappenas Policy Brief

Creating Fiscal Space for Health in Indonesia: 9 Ideas
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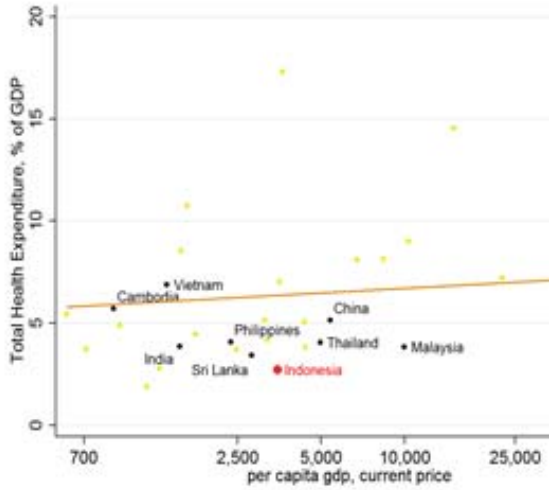
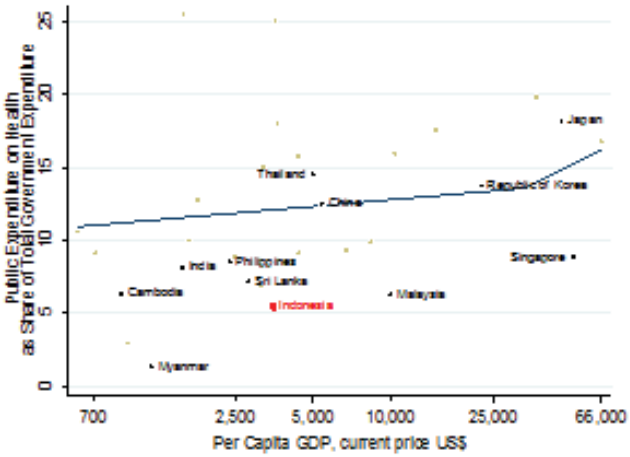
Policy Problem

The government remains a true global outlier in terms of extremely low levels of public spending at less than 2 percent of GDP. Public and private spending together are less than 3 percent. Regression analysis (below) suggests Indonesia commitment for health spending lower than other countries with similar levels of per capita income and GDP.



Total Health Expenditure as a Share of GDP vs. Income (2011)



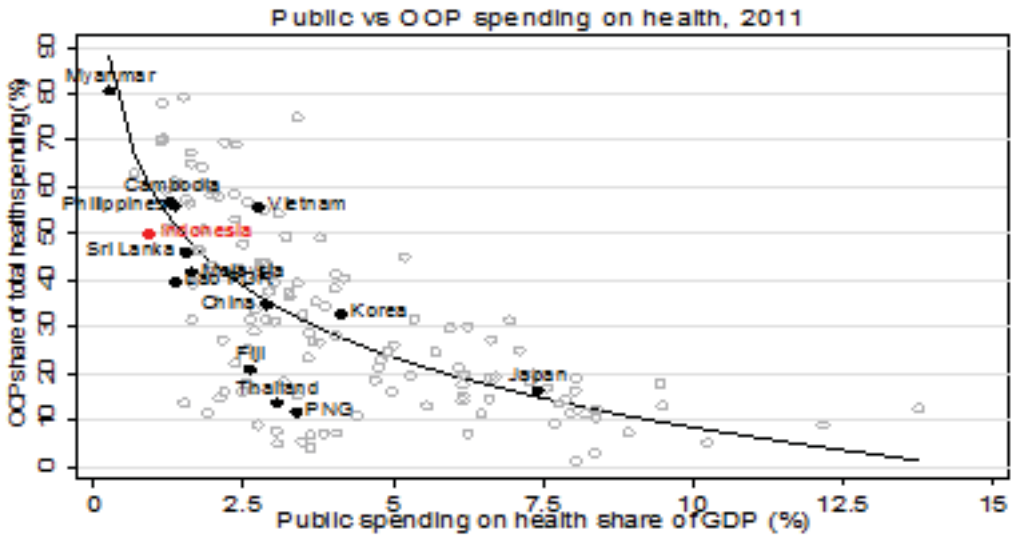
Public Expenditure on Health as Share of Total Government Expenditure vs Income (2011)

Why the low public funding for Health? In part this is due to poor fiscal capacity at the central level, with just over 12% of GDP going to the Treasury (relative to 30% in Malaysia, 22% in China), and in part due to low prioritization of spending for health compared to other sectors (in the lowest decile or 10% in the world as a percentage share).[1] Allocation to health remains a lower priority for local governments. Most do not reach the 10% minimum national guideline figure.

[1] World Bank, Fiscal Health database, 2013

Impact on People

Public Spending on Health Reduces Dependence on Out-of-Pocket Spending



Source: J. Kutzin, World Health Organization, presentation in Yogjakarta, October 2013

Implications

More Public Sector Funding Needed for Future Demand

Demand for health care is expected to rise significantly in the next few years due to a combination of factors:

- A growing population at a rate of 5 million per year, about the size of Singapore;
- An aging population, where by 2025, the elderly population will almost double to 23 million;
- A changing disease profile from infectious diseases like TB to non-communicable diseases like diabetes, hypertension, cancers which require ongoing management of chronic diseases – not a one-time episode of care. Increases in costs per person by age and selected high prevalence disease categories such as stroke and TB suggest real increases of 35% in the next 5 years, suggesting premiums will need to be adjusted upward over the next five years by 7% per annum in real terms (excluding inflation);
- A rising middle class of almost 100 million by 2015, with higher expectations of high quality care, and with more aggressive health seeking behaviors;
- The “insurance effect” with more people covered the demand for services may increase. Under Jamkesmas, outpatient utilization rose by 106% in 5 years and over 50% for inpatient care. The Jakarta Card Scheme saw outpatient utilization go up by over 500% in 1 year alone.

Greater demands for care may mean the need for greater funding. The Ministry of Finance has shown a commitment in 2014 by increasing premium levels for the PBI population by about 3x the level in 2013. This is a good first step.

Now is the Time

Health Financing cannot be de-linked with the macroeconomic context as it relates to sources of financing, insurance coverage and targeting allocation of resources.

Indonesia is a country of robust growth with GDP growth of 5-6 percent a year with an expectation of growth at similar levels to 2016/7 according to the IMF. The deficit in the current accounts will reduce to 2.6 percent of GDP by 2014. This will give Indonesia potentially more "fiscal space" in the future.

At the same time, levels of informal sector in the workforce remain high, estimated at just under 60% of the labour force. The demographic transition may have a "demographic bonus" in the short term with those coming of working age being employed, producing more and paying taxes if informalization reduces.

If Indonesia is to go beyond Middle-Income status, and avoid the "Middle-Income" trap, it will need to invest in Health and recognize as an investment in future productivity and macro-economic growth. To date, the government does not. The recent Lancet Commission on Investing in Health (Jamison, et al., 2013)[3] estimates that up to 24% of economic growth in low- and middle-income countries has been due to better health outcomes. The payoffs are potentially significant – the Commission concludes that investing in health yields a 9 to 20-fold return on investment. It will be important for the new President and the Minister of Finance to see Health as an investment in future improved health status, productivity (at a micro-level) and growth in GDP (at a macro-level).

Policy Options: How to Find Greater Funding?

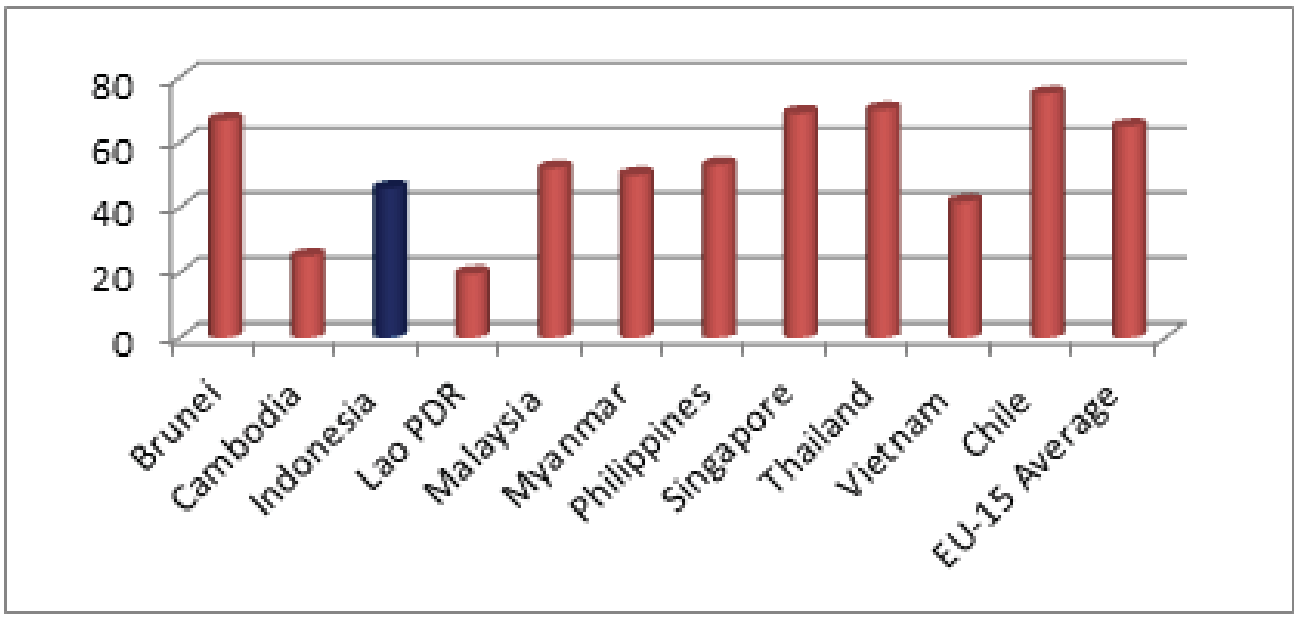
A fiscal space analysis shows that new sources of revenues are possible through several options:

1. New excise tobacco tax which could be increased every year for the next 5 years, and could be earmarked for Health. Whether earmarked or not, taxing tobacco would raise revenues, lower prevalence of smoking, cut health care costs, and improve productivity of workers;

[2] World Bank, Fiscal Health database, 2013.

[3] Jamison DT, Summers LH, Alleyne G, et al. (2013). Global health 2035: A World Converging within a Generation. Lancet 2013; 382: 1898-1955.

Tobacco Tax Burden as % of Retail Price, 2013



Source: Asean Tobacco Tax Report Card, May 2013, and WHO, 2012

2. Modest increase in the current VAT tax, for example, 1% increase;
3. Continued phase-out of the energy and electricity subsidies, and the fuel subsidy. The fuel subsidy alone was the equivalent of $32 billion at the start of 2013 and is around $20 billion at the start of 2014;
4. Eliminate the income cap on civil servants' payroll tax, as well as on private formal sector employers and employees. Currently, premiums are community-based. By lifting or eliminating the cap, a policy exercised in many countries, the government will both increase equity and progressivity by taxing upper income groups, and can generate new revenues;
5. Increase the payroll tax by up to 2x for civil servants as a percentage share. Civil servants continue to hold privileged benefits in terms of pharmaceuticals and hoteling under the benefits package. Civil servants in any country have high inelastic demand and will comply with the new tax;

   Premiums for the informal sector uninsured should be either kept the same level or reduced, depending upon analytic results from pilots to cover the uninsured and informal sectors. Increases in payroll taxes should be frozen to minimize the impact on small and medium enterprises, which are the engines of future economic growth. Payroll increases should be limited to civil servants; for civil servants, payroll taxes could be doubled or even tripled without harm on macroeconomic growth.

6. Capturing needed efficiencies in the current system, and taking steps toward reductions in corruption could generate significant additional fiscal space as well. The "Riskesdas" (2007) survey by the government shows that the actual number of mis-diagnoses per year in the population is a very large number and the level of misallocation of scarce resources within the health sector is very high. For all care, the estimate is about 55% of all diagnosis are inaccurate. Other areas of potential savings would be reductions in unnecessary hospital admissions which were estimated by physician focus groups at around 35-40% under the Jokowi Kard Scheme (JKS) in 2013. A recent BPJS study in Surabaya suggested the number was above 60%.

7. Improve efficiencies with pharmaceutical expenditures. The official NHA number suggests that pharmaceutical spending is 33%, but a separate calculation for this report suggest that the share of pharmaceutical spending (overall) is even higher – perhaps as high as 44%. This compares to a much lower 10-20% share of total health expenditures in most OECD countries. Studies reported by Dunlop (2013)[4] of limited scope have found, for instance, that 42% of antibiotic prescriptions written in two hospitals were unnecessary.

8. Related to improved efficiency is merely slowing or stopping graft and corruption. The Indonesian Corruption Watch has found that the State has lost IDR 466 billion between 2009 and 2013 in the health sector due to graft and corruption including stealing budgets for political campaigns, drugs and equipment mis-procurement, packing procurement committees with preferred candidates, budget mark-ups for facility construction and renovation, and MOH contracts for research and services. Banten and North Sumatra were provinces with the worst records last year.[5]

9. Efficient allocations of government health expenditures within the overall BPJS "envelope" are also important, as is the extent to which public financing for health is pro-poor in its outlays (Tandon, 2007).[6] For example, the base allocation for primary care is only 15% of the overall budget under BPJS...could this be increased to 20-30% in the years ahead, with adjustments upward for poor and underserved areas, so as to encourage more cost-effective care of NCDs and other types of care management? What matters is where and how public spending on health is spent, not just how much.

[4] Dunlop, D. (2013). Inefficiency in prescribing of drugs in Indonesia, University of Indonesia, unpublished report and estimates.

[5] Halim (2014). Jakarta Post.

[6] Tandon, A (2007), "Measuring government inclusiveness: an application to health policy," Asian Development Review, 24: 32-48.

Each of the options above should be analysed for sustainable levels of funding, administrative ease, impacts on macro economic growth, coordination with other policy reforms, and impacts on health status. The Ministry of Finance and the World Bank, for example, are now looking in depth at phasing out subsidies and increasing the tobacco tax. A fiscal space strategy year-by-year can then emerge.

Do the poor benefit from health financing in Indonesia?

Do the poor benefit from health financing in Indonesia?

KEY MESSAGES

- *Out of pocket payments have not significantly decreased in Indonesia as a proportion of health spending due to increased utilization of hospital services and persistent unofficial and official point of service charges. These impact poor Indonesians more than wealthy including being a barrier to needed health care use.*
- *Hospital services benefit wealthier Indonesians and those living in more densely populated areas more than the rural and poor. Government spending on hospital services has increased disproportionately to spending on primary care and the proportion of health care spending benefiting poorer Indonesians has therefore declined. Significant risks of continued increased costs and spending on hospital care in Indonesia exist under Kartu Indonesia Sehat. Without tighter control and appropriate health financing structures, benefits of the national health scheme may not return to the poor and vulnerable in Indonesia as much as hoped.*
- *Further adjustment for variation in health care NEED as well as costs of providing health care such as distance to hospital are required to enable investment in services to increase access to and therefore utilisation of health care in poorer rural regions and bridge the equity gap.*

Policy problem

Out of pocket payments remain high and continue to hurt the poor. Geographic and cost barriers mean lower access to hospital care and greater risk of impoverishment when used.

Out of pocket health payments have declined slightly in Indonesia but not as much as might be expected with the increased coverage of health insurance. In 2005 Indonesian households spent an average of 3.5% of their income on health services[1]. In 2007 as a proportion of total household expenditure (rather than income) this declined to 2.05% but rose again to 2.13% in 2012[2].

[1] World Bank (2008). Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending, Health Public Expenditure Review, Washington, D.C

[2] Author calculations from Susenas 2007 and 2012

Out of pocket payments remain regressive with poorer households paying a higher proportion of their capacity to pay (household expenditure after necessary subsistence spending) (Table 1).

There has been a narrowing of the burden, however, on poorer households, giving some evidence of improved financial protection for them between 2007 and 2012. Table 1 shows out of pocket payments declined by over 1% as a percentage of capacity to pay for poor households versus only a small decline for higher quintiles (the small increase for the wealthiest driven by few households with large expenditures on particularly private hospital care).

Quintile (of equivalized per capita expenditure)	2007	2012	Change
Quintile 1 (poorest)	4.98%	3.89%	-1.09%
Quintile 2	4.71%	3.69%	-1.02%
Quintile 3	4.32%	3.63%	-0.69%
Quintile 4	3.98%	3.45%	-0.53%
Quintile 5 (wealthiest)	3.80%	4.25%	+0.45%
Indonesia average	4.36%	3.78%	-0.58%

Table 1: Comparison of health care out of pocket spending as a proportion of capacity to pay by quintile – Indonesia 2007 – 2012 (Susenas, 2007 & 2012)

Whilst increased financial protection for health for the poor should have contributed to this, lower use of hospital care by the poor also plays a significant role.

Hospital costs are the highest contributors to out of pocket health spending and the greatest reason for health cost related impoverishment. Greater hospital use by wealthier Indonesians, often with greater geographical access, is associated with much larger out of pocket health spending. Only 1.2% of Indonesian's in the poorest quintile paid for hospital care in 2012 versus 10.8% in the wealthiest.

Figures 1a and 1b show the breakdown of health related out of pocket expenditure by quintile. A number of interesting point arise from these charts

- More of out of pocket spending is on hospital and private doctor practices for wealthier quintiles
- A higher proportion of poor Indonesians OOP spending is on self-treatment with non-prescribed medication
- Size of family planning payments are more consistent quintiles, possibly reflecting its perceived necessity. It therefore impacts poor households more highly.
- Poor households tend of have higher proportions of health OOP on private midwife/nurse practices due to ease of location and opening hours

Hospital payments and catastrophic health spending

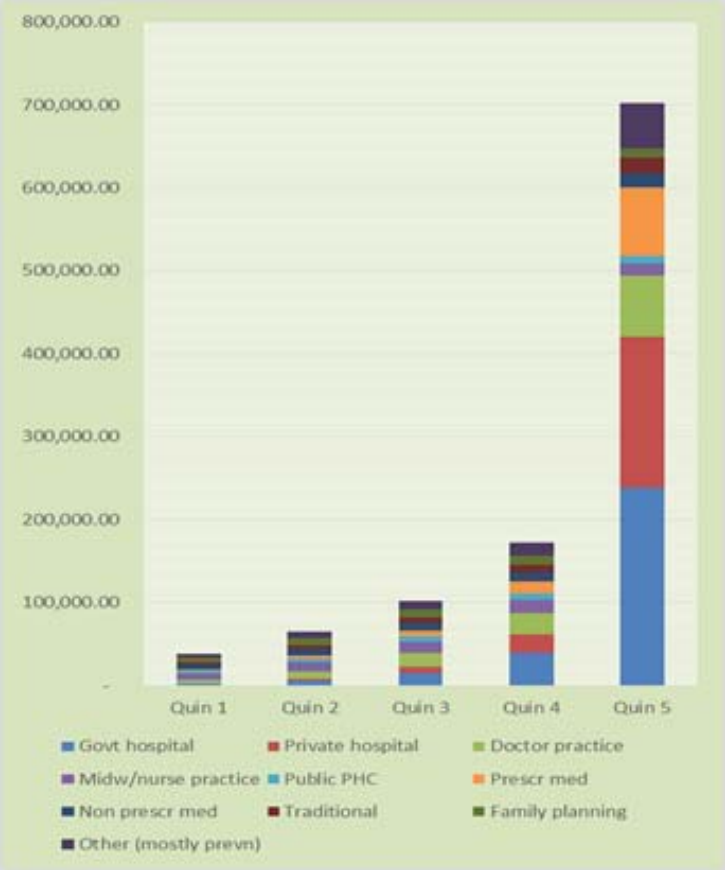
Catastrophic health care spending is most common in those using hospital care. Catastrophic health spending (when health care expenditure represents over 40% of a households capacity to pay i.e. expenditure not including subsistence spending has increased slightly to 1.3% of households in 2012 up from 1.2% in 2006.

Increased hospital use is a key driver of this increase. Over 19% of Indonesian's paying for hospital services experienced catastrophic levels of health spending in 2012 versus only 0.3% of those who did not.

Hospital use, in large part determined by both financial and geographical access, determines patterns of catastrophic spending both by quintile (more frequent in wealthier quintiles) and by province (where catastrophic payments are more common in more densely population provinces with easier access to hospitals).

Analyzing out of pocket expenditure does not tell the full equity story though, as it only looks at what is paid if health care is actually used. Poorer Indonesians may have lower out of pocket expenditure because the cost itself is a barrier to using care in the first instance.

Various evidence in Indonesia bears this out. The 2007 Indonesia Demographic and Health Survey notes expected cost was the most common reason women did not seek care when needed. This was a far greater barrier for women in the poorest quintile (46%) than in the wealthiest quintile (just 10%).



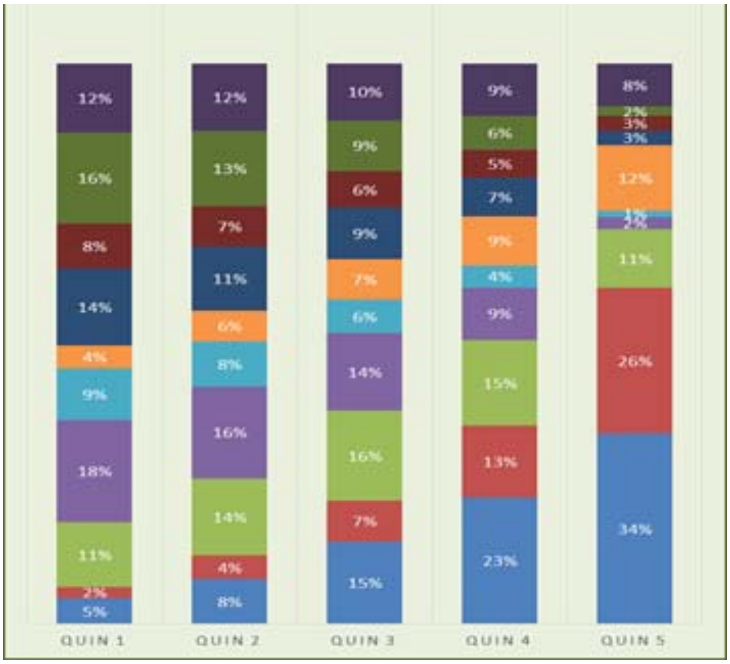


Figure 1a & 1b Breakdown of out of pocket health spending by service type and quintile (Susenas 2012)

A recent health seeking behaviour study of poor and near poor households across 14 districts of East Java and NTT confirms this, showing that expectation of remaining out of pocket payment is one of the largest barriers to health care utilisation for the poor. Households suggested they would be 40% less likely to use services where payment of between Rp2,000 and 20,000 was levied, 70% if the payment was between Rp 20,000 and Rp 200,000. A number of households, however, confirmed they had been required to pay remaining charges at government health facilities, though over 80% of them had health care coverage (90% of which was Jamkesmas). When using a government hospital inpatient services, for example, though 40% of poor and near poor households in East Java and NTT paid nothing nearly a quarter (21%) paid over Rp 1 million. This was better for Jamkesmas card holders but still 13% paid over Rp 1 million suggesting that coverage may not be as effective as hoped. Health care costs were far lower at primary care facilities, one reason that over three quarters of individuals from the poor and near poor households surveyed in NTT and East Java used public primary care providers, largely Puskesmas and Poskesdes / Polindes.

Across all facilities more than two thirds of households said they were not aware what the payments were used for. Where reasons were given this was most commonly for medicines supplied by the health provider along with administrative costs and injections. Knowledge of what health services were in fact covered if they had Jamkesmas whilst reasonable for basic examinations, was poor for hospital care. Around 20% of households sometimes chose not to use their Jamkesmas cards at health services as they perceived they receive worse treatment when using Jamkesmas (staff attitude, drugs provided and longer waiting times).

Government health spending has an over concentration on hospitals which give less benefit to health for the poor

In 2006, the World Bank estimated that subsidies to hospitals accounted for 40 percent of all health spending, noting that this benefits the better off economic quintiles (the highest income quintile captures 38% of this public spending, compared to 13% for the lowest income quintile, given the relatively low access the poor have to hospital care (World Bank, p. 61, 2008). More-over, this imbalance is long-standing; using Susenas data the World Bank found little change between 1985 and 2005.

Hospital spending comprised 49% of total health spending and 50% of government health spending in Indonesia in 2011 according to that year's national health accounts data. Using utilization figures of health care facilities by quintile and average cost of a relevant hospital admission and outpatient visit from the 2012 facility costing survey, of the total expenditure by hospitals between 18% and 22% of the value is received by the poorest 40% of the population in Indonesia showing the regressive nature of hospital spending (where 40% of spending returning to the poorest 40% would be equitable – though it may be hoped that public expenditure would be even more progressive than this).

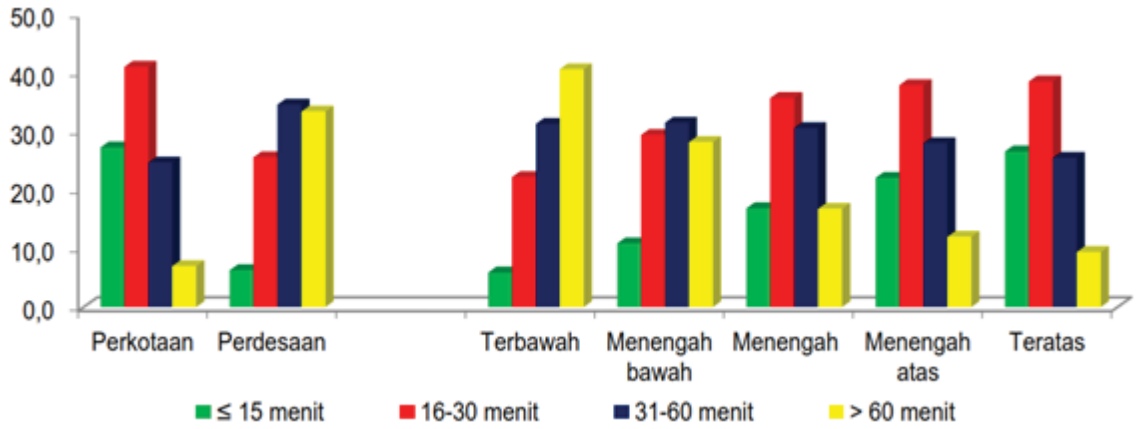


Figure 2 Time to hospital in Indonesia by rural urban living and quintile (Riskesdas, 2013, NIHRD, MoH)

Lower utilisation of hospitals by the poor may not be an easy equity gap to close. Figure 2 above taken from the Riskesdas survey of 2013 shows the far greater geographical access wealthier Indonesians have to hospital services versus those in poorer quintiles with over 40% of Indonesians in the poorest quintile having to travel more than an hour to the nearest hospital versus less than 10% of those in the wealthiest quintile.

Policy implications

Benefits from JKN / KIS may not protect the poor and vulnerable as much as hoped and / or may differentially benefit wealthier members

Continued high hospital spending under the national health scheme may result in greater inequity in benefits. This is contrary to policy aims of increasing access, service utilisation and therefore health for the poor under Kartu Indonesia Sehat. High and increasing resources are being consumed by hospital care in Indonesians a proportion of government health care spending. Poor Indonesians use hospital less than wealthier due to lower geographic and financing access. Disproportionately high hospital spending under KIS will crowd out allocations for primary care that is utilized more by poorer rural remote Indonesians, and will result in its benefits accruing to wealthier members more than poorer ones. Indonesia will be judged on the success of its national health scheme in closing the equity gap in a range of health outcomes in the country. Equity, along with the cost and efficiency, of Indonesia's health system is at risk with continued domination of hospital spending.

Where additional formal and informal charges remain these still present a barrier to use of health care by the poor. There is significant evidence of remaining charges being levied at health facilities even for those possessing health scheme membership. These charges are a barrier for often necessary health care use for the poor. Unless these charges can be reduced having health scheme membership may not be sufficient financial protection to support health service coverage for the poor. In addition out of pocket payments both due to low access to services and so greater reliance on self treatment as well as remaining payments at facilities will continue to place a proportionately higher burden on poor households.

Inequitable geographic access may result in inequity in benefits from national health coverage schemes unless adjustments in payments are made to invest in appropriate services. Distance to health services largely determines their use. If health care financing provided to facilities, districts and provinces is based solely on existing utilisation and age and sex adjusted population numbers, areas of higher population density, numbers of health facilities and therefore greater geographic access to services will be disproportionately advantaged over generally poorer, rural remote areas. This is true of both hospital and primary care services and greater inequity in health financing will result. More adjustment for remoteness (including distance to nearest hospital), poverty and population density as well as for deprivation and health care need is required in calculations of health provider and area payments (see policy options).

Policy options

Greater investment in quality primary health care, establishment of effective referral mechanisms, financing structures and mechanisms that promote equity and reducing unnecessary point of service payments are ways to promote greater equity in health financing in Indonesia

Greater investment in primary care will promote equity. With poorer Indonesians living in remote areas making greater use of primary care services, investment in these not only makes good sense for cost control and efficiency of the health system but also promotes equity. A package of community health and facility based primary care services, aligned to new minimum service standards, should be clearly defined and costed. Finance for primary care should be calculated, prioritised and allocated on this basis rather than from what is “left over” after hospital payments have been allocated. Higher weightings for poor, rural remote areas should be included to cover financial investment that should be made in greater outreach services and community level health facilities needed per population. Performance financing to promote effective primary care should also be considered in the short to medium term (see separate policy brief).

Effective referral mechanisms with appropriate financing incentives need to be put in place to provide better equity in access to hospital care when needed. Even when referred, it is more difficult for poor rural remote Indonesians to use hospital services given geography and potential cost. There is a lack of transport or it is frequently not covered by health schemes. Past financing structures for Jamkesda and Jamkesmas could work against effective referral where only last facility of treatment, such as the hospital, was reimbursed for that patient’s care. Disincentives arose for quality first treatment including stabilization of the patient prior to

referral, when primary care facilities felt they were unlikely to be financially rewarded for such care. Greater investment in facilitating effective referral (transport, shared facility payments) is needed under KIS. Expected numbers of patient referrals and costs of pre referral treatment should be included in the primary care package and appropriately financed. Financial and non-financial incentives are needed to promote better referral coordination between the referring primary care facility and receiving hospital.

Instituting financing structures that clearly prioritise equity and support the above changes will be crucial. Financing for primary health care and hospitals should include better adjustment to promote equity in health and health care. Adjustments for both a) variation in cost of service delivery of health services AND b) greater NEED for health and health services should be made. For cost adjustment, greater weightings for lower population density, distances to hospital and distance to nearest health care facility should be considered to allow for investment in health services that will better address the needs of poor rural remote communities such as outreach, patient transport and other referral needs. For health care need adjustment use of Indonesia's health human development index (HHDI) could be considered along with child mortality rates, poverty measures and other indicators. The HHDI is currently calculated but little used for health policy or service delivery and should be further assessed for use in financing considerations.

To ensure the best chance for equity promotion, financing across all levels of the health system should be considered simultaneously. Equity adjusted target financial allocations could be defined and gradually moved toward to reduce risk to health service delivery from large and sudden changes in financing. Village grants could include equity weightings as they will play an important role in community health service provision. Primary care capitation calculations should include adjustments for cost and health care need as described. Block grants for hospitals can accompany INA CBGs based payments to provide needed time for efficiency adjustment to the new financing approach and can include equity adjustment for variation in health care need and referral investment. Such grants would give greater control of cost, timing and phase out and are therefore preferable to bargaining up of INA CBG payments by hospitals.

Monitoring and reduction in remaining point of service charges – Needed changes in financial autonomy for hospitals and Puskesmas should not lead to further increases in point of service charges. Additional required services charges for essential treatment should not be levied by government health facilities and providers outside coverage under the national health scheme. This should be ensured through education of members on their entitlements under KIS and what they should not pay additional for as well as periodic monitoring (through community survey, complaints handling etc) and sanctions for health providers levying such charges.

Ensuring equity is monitored as a key outcome of progress toward universal health coverage. This should include both health service coverage as well as financial protection. As mentioned above measures of out of pocket expenditure, catastrophic health expenditure and other financial protection measures only relate to those that have actually USE services. A great inequity exists in Indonesia in access to and therefore utilisation of services. Monitoring of services use and quality for the poorest and most remote rural populations is very important to measure true progress toward universal health coverage which would mean that all in the Indonesian population have equal access to the same essential health care services.

Efforts toward health financing equity should be accompanied by other health systems interventions for equity such as in availability of human resources (distribution, efforts towards regulation of dual practice etc), drugs and medical supplies and infrastructure and equipment.

POLICY RECOMMENDATIONS

- To promote equity primary care investment should be prioritized over hospital care through defining and costing packages of services and making financing allocations accordingly rather than calculating from available premium amounts after hospital payments have been accounted for
- Area and provider payments should be appropriately adjusted for equity particularly greater health care "need" as well as costs of service delivery.
- Mechanisms to provide or include coverage for transport to health services should be explored to ensure poor remote Indonesians have easier access to hospital services when needed
- Monitoring and accountability mechanisms should be introduced to reduce remaining point of service charges being levied at government health facilities
- Equity should be included as a core outcome for monitoring progress toward universal coverage and should prioritise measuring health and health service performance for the most disadvantaged Indonesians rather than only looking at trends across the population

References

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