BACKGROUND PAPER ON THE INDONESIAN HEALTH SYSTEM

IN SUPPORT OF THE

GOVERNMENT OF INDONESIA HEALTH SECTOR REVIEW

Government of Indonesia
World Bank
AUSAID
GTZ
ADB
WHO

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BACKGROUND PAPER ON THE INDONESIAN HEALTH SYSTEM IN SUPPORT OF THE GOVERNMENT’S HEALTH SECTOR REVIEW

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<tr>
<td>AAA</td>
<td>Analytical and Advisory Activities (WB- economic and sector work)</td>
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<td>ADB</td>
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<td>ASEAN</td>
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<td>Askeskin</td>
<td>Assuransi Kesehatan Masyarakat Miskin (Health Insurance for the Poor)</td>
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<td>CCT</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>DAK</td>
<td>Dana (GOI funding flow to districts for use to finance capital assets and related inputs)</td>
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<td>Depkes</td>
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<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>MTEF</td>
<td>Medium-Term Economic Forecast</td>
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OVERVIEW AND INTRODUCTION

1. Context

The Government of Indonesia (GoI) requested the World Bank, AusAID, GTZ, ADB and other partners to provide technical support in the form of a comprehensive health systems assessment for Indonesia. The aim of the GoI is to obtain advice for the development of its Medium-Term Development Plan 2009-14, which proposes policies aimed at achieving the long-term vision laid out in the National Development Plan (RPJKM). The broad policy directions in the long-term vision are: to improve health financing; to respond to demographic and epidemiological dynamics; to provide more attention towards promotive and preventive health services; and, to address nutrition cross-sectorally. Main goals and targets in the vision include: improving access to healthcare; reducing the double burden of disease; improving the number and distribution of health workers; reducing the misuse of narcotics and prohibited substances; increasing life expectancy to 73.7 years; reducing maternal mortality to 102 per 100,000 live births; reducing infant mortality to 15.5 per 1,000 live births; and reducing underweight malnutrition to 9.5 percent among children under five.

Indonesia is at critical double crossroads in terms of the development and modernization of its health sector. The country is experiencing demographic, epidemiological, and nutritional transitions, all of which place additional pressure on the health system. This has important consequences on the basic public health program foci, the delivery system configuration and financing. Indonesia is also in the midst of decentralizing its health system, as well as discussing how it might introduce over time universal health insurance coverage through one of several possible health insurance modalities, including a national social health insurance-based scheme. These actual and potential changes are occurring in the context of a district-based health system challenged to achieve important health outcomes, financial protection, equity and efficiency. This context raises fundamental fiscal questions regarding the affordability and sustainability of any new health insurance system. The current system also performs poorly with respect to maternal mortality and nutritional outcomes at the national level, and has large geographic and income inequities for many health outcomes. The GoI-operated system is inadequate in protecting Indonesians from falling into poverty due to illness and catastrophic spending for health. Furthermore, it is becoming increasingly difficult to respond as utilization rates are declining due to people privately seeking services or opting for self-treatment.

2. Audience and Objectives

The Health Sector Review is to provide inputs to the National Development Plan 2009-14. In addition to this, members of parliament and policy-makers in the Ministries of Health, Finance, Home Affairs and the State Ministry of Development Planning at central and decentralized levels are the key audiences for this review. Other parties include the provider community, CSOs/NGOs, academia, and the press. The non-Indonesian
audiences include the international health community in Jakarta, as well as the general global health community, whereby this detailed assessment of the Indonesian reforms will supplement the global evidence base. The reform experiences in Indonesia are an important addition to the global evidence base in terms of the rapid implementation of both decentralization and complementary financing reforms. It is also expected to also document several scenarios regarding the potential cost and outcome impacts of moving towards universal coverage in a developing country setting.

The specific objectives of this assessment are:

1. providing a comprehensive review and diagnostic of the performance of the current public and private healthcare delivery systems, including an analysis of their strengths and weaknesses;
2. assessing currently proposed and other needed reform options to achieve the aforementioned policy objectives;
3. assessing the impacts of critical interactive underlying factors affecting health system performance, including epidemiologic, demographic, and nutrition trends, current health and related (e.g., education) system configurations and policies, current and future economic trends, and decentralization issues, all within the context of underlying political, institutional, and geographic realities of Indonesia; and
4. providing timely evidence-based policy advice on topics regarding health financing, decentralization and intergovernmental fiscal transfers, fiscal space, the organization of the delivery system including the public-private mix, human resources for health, pharmaceuticals, and public health topics, regarding financing and sustainability

3. Main Questions Guiding the Review

Similar to other countries, Indonesia is attempting to improve health outcomes, provide financial protection, and assure consumer satisfaction through reforms and improvements in its health delivery system. In this regard, Indonesia is facing the following basic questions to inform its National Development Plan 2009-14:

a) How will Indonesia’s healthcare system address the implications of its demographic, epidemiological, and nutrition transitions and address the needs of the poor and vulnerable segments of the population, who continue to suffer health problems related to poverty?

b) How will Indonesia address the implementation and financing challenges from enacting Law No. 40/2004, which provides for the enactment of a plan by 2009 to implement a national health insurance scheme that ensures universal coverage?

c) What policies are needed to effectively protect households from falling into poverty because of financially catastrophic health events?

d) How can equity be improved via the health sector and its financing?
e) What systemic and health sector-specific reforms are needed to address the challenges posed by the 2001 decentralization legislation and subsequent modifications?

f) What policies can ensure a high standard of healthcare provision in remote and rural areas in Indonesia?

g) Which policies could help break the cycle of poverty and ill health by promoting higher household investments and greater community involvement?

h) How can Indonesia strengthen its response to unforeseen emergency situations?

To assist the GoI in answering these basic questions, this background paper provides a strategy for addressing the many specific policy issues outlined in Section C.

4. Governance Arrangements

The GOISC ‘policy/technical consultation group’, jointly led by Bappenas Deputy Minister for Human Resources and Culture and the Secretary General of the MoH includes the: a) Director of Health, Population and Community Nutrition of Bappenas, b) MoH Head of the Bureau of Planning, c) MoH Head of Center for Health Policy and Development; d) MoH Chair of the Human Resources Board; and e) MoF Head of Fiscal Policy. This group would meet at least monthly to oversee the technical work involved in this assessment. The group will be responsible for discussing and coordinating analyses of policy and technical issues such as research design, supporting logistics for data collection and discussing draft reports. It will also review and comment on proposed personnel to be used for various assignments identified in this proposed assessment design, and may assign GoI staff to oversee and collaborate in various components of the proposed work, as may be required.

5. Methodology and Outputs

This work entails three main phases and six primary areas. Phase 1 would be an initial assessment of the current functioning of the various priority components of the health system and would seek to highlight its strengths and the weaknesses. The first phase would be concluded with a broad consultation that would be used to finalize the ToR for the second phase which would incorporate the finalization and analysis of the critical policy options. These policy options in each of the different areas of the health system would be assessed from the perspective of the financial cost of designing and implementing them, along with their economic and political feasibility. The third phase would begin in 2009 and aim to work with the GoI to implement, pilot and further evaluate the final proposed policy reforms.

Much of the information and data needed for this diagnosis exist, but are fragmented. Therefore, a systematic review, synthesis, and analysis of existing data, documents, and reviews across the sector will comprise the principal study methodology for this.
Some new data collection may be needed in a number of areas, such as information on private providers, incentive structures and actuarial financial projections. Consultations and interviews with key-stakeholders and academics will be used to fill other knowledge gaps, develop hypotheses for more in-depth analysis to inform policy choices and discuss findings. Broad-based consultations will also be used to inform the feasibility of the proposed options for the reform agenda. The review includes analyses of data related to macro-economic indicators; demographic and epidemiological data; health expenditures and utilization, using existing household survey results (Susenas), the MoF local government expenditures SKDI database, demographic and health survey results (IDHS), the family life survey (IFLS), and the governance and decentralization (GDS), and infrastructure census such as Podes. In the area of Human Resources for Health, an evaluation of the impact of the growing private health sector on access to care, and quality of care and a retrospective career history survey to study health worker decisions to locate (and remain – length of stay) in remote areas are also foreseen. The proposed studies and further data analyses are based on identified knowledge gaps and have been proposed in response to the GoI’s request for better information in ongoing activities.

Other evaluations and pilot testing may occur as a formal part of the review process or as a part of defining the set of next steps along the road of policy reform assessment. For example, in the area of human resources, privileging health workers to perform certain procedures in remote areas conditioned on additional training using innovative distance-learning approaches may be one topic to assess.

To further increase knowledge and learning, it is expected the review may propose developing and evaluating interesting pilots and policy experiments (Phase 3), conditioned on budget availability, to assist the implementation of the policy reform agenda. Finally, a comprehensive capacity building program around the major elements of health systems is foreseen with the assistance of the World Bank Institute (WBI). This capacity building initiative will not only serve to inform all key stakeholders including the donor community but will also stimulate more active utilization of the proposed analytical work.

The initial work phase will consist of pulling together the literature on Indonesia in a policy-relevant context to serve as background for the assessment. Most analyses will be based on secondary data analyses and efforts will be made to update data and trends on health spending, financial protection, equity, availability and utilization of services (both public and privately provided, in- and out-patient care) and a discussion on health outcomes.

The next phase of the work will be organized on the basis of the detailed policy questions in Section D of the background document and will be aggregated into chapters per the draft final report outline in Section E of this document. The government anticipates holding seminars on specific issues and report chapters as the work proceeds. Interim reports of research in progress will be disseminated both for the use in policy-making and to obtain external input and consensus building.
Frequent consultations and workshops will be held around the themes as appropriate. Policy options will be identified through the critical reviews and the cost of implementing each option will be assessed.

The work will cover a broad range of outputs to be delivered over the next 18 months, which will be integrated into a comprehensive report by March 2009. The final report on the Health Systems Assessment and Policy Options to the government will be collated by a team of GoI and international partners, including the World Bank, GTZ, ADB, AusAID and DFID in collaboration with other contributing partners. It will be an overall assessment of the system (public and private) and the proposed set of reform options will be assessed from a financial cost perspective. It will cover:

a) all major aspects of the implementation of Indonesia’s health financing reform along with a financial assessment of reform options and within the macroeconomic context;
b) major issues in human resources for health (HRH) and how the government can change policies to make the current and future health workforce more effective in achieving health outcomes in the context of its decentralized system;
c) public health policy options to achieve health status objectives in reproductive and child health, nutrition, NCDs and tobacco;
d) needed changes in the delivery system configuration;
e) issues in pharmaceuticals, as a health sector input, as a component of the retail industry and as an industrial sector; and
f) options for improving the systems’ organization, management, and accountability.
B: STUDY CONTEXT

The principal challenges under each of the main functions of the health system are discussed in this study context. First the basic socio-economic, demographic, and epidemiological contexts are laid out with respect to health status, health outcomes, and public health interventions, and their implications for health service availability, distribution, and use are assessed. This is followed by discussions of: health financing, human resources for health, physical infrastructure, pharmaceuticals, and health system organization, management, and accountability. The policy issues resulting from the discussions around these topics are incorporated into the final section, including an assessment of the resource requirements to implement each reform measure. Decentralization, quality, gender, and public – private mix are cross cutting issues and are discussed in their relevant contexts within each of the above areas.

1. Socio-Economic

With a population of 220 million, Indonesia is the fourth most populous country in the world. It is a low-middle income country with a per capita GNI of US$1,280 (2007). Indonesia was hit hard by the 1997/8 economic and financial crisis, and has suffered numerous natural disasters since then, including the Aceh tsunami in 2004, and another tsunami in West Java in 2006, the Nias earthquake in 2005, the Jogjakarta earthquake in 2006, and two major quakes in Sumatra in 2007. The growing threat of avian influenza has added another burden to the already challenged management of the country, and in particular that of the health sector.

Since the financial crisis, Indonesia has started to come back with economic growth slowly rising and poverty rates declining. Economic indicators are signaling a strong pick up in economic growth at the end of 2006 and into 2007. Budget deficits are lower in 2006 and contribute to fiscal sustainability.\(^1\) However, poverty remains broad with almost 50 percent of Indonesians living on 2 dollars or less a day and 18 percent lives in deep poverty, i.e. less than US$1 per day.\(^2\) Those highly vulnerable to poverty, living under US$2 a day, are likely to fall into poverty when ill. Indeed, the poverty assessment of 2006 found health spending to be the second main cause of falling into poverty in Indonesia.

2. Health Status and Outcomes

In the early 1970s, Indonesia’s population amounted to about 120 million, the total fertility rate was 5.6 and life expectancy at birth was 43 years. Today the population is 220 million (30 million less than the 1970 projections for the new millennium), the total fertility rate is 2.3 and life expectancy is 69. A successful population strategy that halved child mortality contributed\(^3\) to these trends. As a result, the demographic picture is

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\(^1\) World Bank, Economic and Social Update, (Jakarta, 2007)
\(^2\) World Bank, Poverty Assessment in Indonesia, (Jakarta: World Bank, 2006).
\(^3\) Some argue the engine of the change was less the formal institution of the family planning program than it was the oil boom that began in the 1970s and nourished the economic development, along with the political
changing and by 2050 nearly 20 percent of the population will be over the age of 65 (Figures 1 and 2).

Figure 1: Population pyramids for Indonesia, 1970 to 2030

Health outcomes have significantly improved in Indonesia since the 1960s, with child mortality declining from 220 per 1,000 live births in 1960 to 46 per 1,000 live births in 2002\(^4\) (Figure 3). However, Indonesia needs to be focused to address remaining issues. For example, although infant mortality fell to 35 per 1,000 live births in 2002, neonatal deaths remain high.\(^5\) There are also serious geographic differences in progress; large variations in IMR between provinces, with IMR of almost 80 in Nusa Tenggara Timur (NTT) and less than 20 in Bali (Figure 4). Infant mortality remains four times higher among the poor. Maternal mortality remains very high and, in contrast to child mortality, very little real progress has been made over the past decade.

Graph 3: Indonesia does well on infant mortality given its income level

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\(^4\) IDHS, Jakarta, 2003/04.
\(^5\) Most infant deaths occur in the neonatal period, with 50 percent of infants dying before 1 week and 70 percent of all IMR occurring in the first month of life.
Indonesia has made substantial progress in the nutrition area, reducing the share of underweight children under 5 from 38 percent to 25 percent between 1990 and 2000. However, after 2000, underweight rates have stagnated and are even increasing in a number of provinces (Figure 5). Not only underweight malnutrition but also micronutrient deficiencies remain a problem in Indonesia: about 19 percent of women in the reproductive ages and 53 percent of children between 1 and 4 years of age suffer from anemia. Although severe vitamin A deficiency is rare, sub-clinical vitamin A deficiency may exist due to low rates of vitamin A supplementation. The national average for household consumption of iodized salt is 85 percent. However, many districts still have very low levels and iodine deficiency remains prevalent in some parts of the country.

At the same time, the nutrition transition carries with it new health threats. Rapidly growing obesity especially among poorer people is bringing an epidemic of diet-related

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7 National data on prevalence is not available, but only 43 percent of post-partum women and 75 percent of children received vitamin A supplements
8 Friedman et al., 2006.
non-communicable disease (NCD). Increases in diabetes and the prevalence of heart disease lead to a situation where people need additional and more expensive healthcare, as is currently the case in Sri Lanka.

Regarding HIV/AIDS, the HIV epidemic is still concentrated in high-risk sub-populations: sex workers, and intravenous drug users, with the latter group being particularly high among the prison inmate population. Although nationwide the average incidence remains low, the AIDS epidemic has spread to all parts of Indonesia and reported cases continue to increase. The results of a recent survey in Papua9 show the prevalence of HIV to be much higher in Papua than in any other province in Indonesia, with 2.3 percent of HIV positive cases in the general population sample.

Tuberculosis, despite national data giving the appearance that Indonesia is doing well and has achieved its goal of 70 percent detection rate, is not being detected in most of the population in over half of the provinces.

Most of the progress made in the areas of life expectancy, child mortality and malnutrition until 2000 were due to increases in literacy and economic growth, as well as reductions in respiratory diseases, diarrhea, expanded coverage in immunization, better nutrition and access to safe motherhood and family planning services. Significant investments, made by the GoI and the international community, established and sustained these programs until at least the end of the previous millennium. The underlying disease burden comprised health problems mitigated by these program interventions. However, the major causes of death in early infancy, such as premature birth, low birth weight, asphyxia and respiratory infections, have not improved in an equal manner.

Clearly, the less complicated interventions such as immunizations and basic primary care have been achieved through utilizing the current health system. However, the identified component of the system, the Posyandu, which have achieved many of the primary healthcare (PHC) outcomes, such as high immunization coverage, have been dismantled or eroded of financial and personnel support to such an extent that they are no longer in a position to sustain the outcomes for which they had become known. Furthermore, it is unclear how high the current immunization coverage may be, as recent Susenas data from 2005 suggest that the fully immunized coverage levels are much lower than the 70 percent that is commonly reported. The gradual erosion of immunization coverage has led both the GoI and the international community to focus increasing attention on resolving health system issues that constrain further progress towards achieving and then sustaining the earlier gains that Indonesia has achieved in the past. These concerns have become a focus for the GAVI Alliance program, which has requested the GoI to develop a proposed work plan for addressing the HSS constraints found in Indonesia.

However, the more complicated interventions needed to deal with problems such as neonatal and maternal death require a better functioning health system, including referrals for maternal complications and premature births, and these interventions have not been widely achieved. Part of the problem is geographic inequities e.g., the presence of a

9 IBBS, FHI and World Bank 2008
skilled birth attendant at birth varies from less than 40 percent in NTT and South East Sulawesi to almost 90 percent in North Sulawesi and Bali, and immunization rates show equally large variations among provinces (Figures 6 and 7). However, lack of appropriate incentives, shortages of certain categories of personnel, and lack of essential supplies also contribute to this problem.

Figure 6: Large variations in skilled birth attendance across provinces

Figure 7: Large variance in immunization coverage across provinces

In addition to the challenge of reaching the MDGs, Indonesia is experiencing a shift in its epidemiological situation with important increases in the prevalence of non-
communicable disease and emerging diseases such as avian influenza. Major causes of death now include cardio-vascular diseases, metabolic disease, and cancers, and have surpassed the number of deaths from communicable disease (Figure 8).

Graph 8: Epidemiological transition in Indonesia, 1980-2001

Risk factors such as tobacco use, poor diet and lack of exercise, and traffic accidents, have not received the attention they deserve and are growing in importance, further contributing to the NCD burden. According to 2004 data, 52 percent of adult males are active daily smokers and Indonesia along with Russia, are the only two countries in the world where tobacco use is increasing. According to recent data, the number of deaths due to traffic accidents has surpassed 60,000 per year, with many thousands more injured and impaired for life. Projections of the effects of the epidemiological, nutrition and demographic transitions in two provinces in Indonesia demonstrate the important effects on health financing in the near future: Central Java will experience an increase of 158 percent in demand for bed-days by 2025, the demand for doctors will triple, and financing needs will quadruple. Universal coverage, as mandated by Law No. 40/2004 on social security, will further increase demand.

In summary, Indonesia’s health outcomes are mixed. While the country does well on child mortality and life expectancy relative to other countries, maternal mortality is high and nutritional outcomes are poor. More troubling is that health outcome improvements have stagnated since the turn of the century and outbreaks of immunizable diseases are a growing threat to improvements to health status.

Source: Soewarta Kosen Presentation Bandung Seminar, June 2007.

10 Public Policy and the Challenge of Chronic Noncommunicable Diseases, World Bank 2007
3. Health System Coverage and Utilization

The improvements in health outcomes in Indonesia are in part explained by the impressive expansion of the Indonesian health system starting in the 1980s. During the past three decades, Indonesia established around 7,400 community health centers (Puskesmas), of which 26 percent included beds. Access to public health services was further improved by the establishment of around 21,750 sub-health centers (Puskesmas Pembantu) and about 2,800 mobile health centers (Puskesmas Keliling). In addition to the health centers, an extensive outreach program of so-called Posyandu, monthly village gatherings in which community volunteers promote maternal and child health, immunizations, nutrition, and family planning activities were established in nearly 250,000 villages between 1970 and the 1990s. The number of general hospitals in the country by 2003 was 966, representing an increase of almost 14 percent on 1995. In 2003, there were 112,379 beds or one hospital bed per 1,900 people. An additional 270 public and private hospitals provide special services such as psychiatric, eye and maternity care.

With this system of Puskesmas, district and general hospitals and the outreach system, health services are available to most of the population in Indonesia. However, since the mid-1990s, and especially after the economic and financial crisis in 1997/8, the functioning of this health system deteriorated: increasing numbers of people now rely on self-treatment when ill; private providers are dominating out-patient services without public oversight; and public health services have declined in terms of coverage and impact.12

Community health and nutrition promotion programs and disease prevention have deteriorated since the 1990s. Regular attendance at the Posyandu declined further after decentralization with: high attrition rates among kader (community health workers); preference for alternative services from traditional birth attendants; and little supervision by Puskesmas personnel. All are explanatory factors in the decline. Supervision is a vital element of quality control for these programs and the lack of quality control is largely due to lack of incentive structures for this task.

Despite extensive infrastructure expansions, the bed/population ratio in Indonesia is low by international standards with 1.9 beds per thousand. Nevertheless, average occupancy rates are only a little over 50 percent. Since the introduction of Askeskin, there has been a great expansion in the number of people with health cards, especially among the poor. With the card, people receive free basic primary care and free third-class hospital care, and there is some preliminary evidence from the Susenas 2006 to suggest an initial modest increase in utilization.13 It appears that mainly in-patient use and out-patient

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12 Among the population that reported morbidity in 2004 more than half, 52 percent, relied on self treatment (obtaining some form of treatment at a pharmacy or drug-store); 38 percent sought treatment in a health facility; and 10 percent did not seek treatment at all. In contrast, in 1993, 25 percent relied on self-treatment; 55 percent sought treatment in a health facility; and 20 percent did not seek treatment at all (Susenas data analysis).
13 (Susenas data 2006)
hospital visits increased, with little effect on out-patient visitation rates to public health centers.

The emerging picture is one of a health system that functioned well to deliver a basic package of interventions, but has not been sustained given the significant decline in financial flows during the economic crisis (Table 1) and in light of substantial changes in the pattern of healthcare service needs requiring more complex interventions. What also emerges from utilization data analyses is the phenomenon that the private health sector has grown extensively: 40 percent of those who report being ill visit a private facility when seeking treatment. At the same time, the public health system does not appear to be providing oversight over privately provided services. There appear to be major problems with efficiency and access to quality care, and public health is given only scant attention and focus has diminished with decentralization.

4. Decentralization

Decentralization in Indonesia was promulgated in 1999 with the enactment of Law No. 22/1999 on regional administration, Law No. 25/1999 on fiscal balance and Law No. 34/2000 on regional taxation. Many of these laws were implemented beginning in 2001. While these laws suffer from a number of shortcomings, which have been partially rectified with additional legislation through governmental decrees in 2004 and more recently in 2007, they have set in motion a total change in the roles and responsibilities of various levels of government.

These changes have been accompanied by profound changes in the way services are financed and human, financial and material resources are managed. The responsibility for the implementation of health services was transferred to the local governments at the district level and with that almost a quarter of a million health workers were transferred. This was not a physical relocation, only an administrative one. Although districts are now responsible for employment, deployment and payment, regulations regarding authority to take decisions and budgets or the capacity to carry them out do not exist largely because overall civil service reforms have stalled.14

In addition, existing sectoral laws have not been amended and add to the confusion about the functions of sub-national governments. Sectoral ministries remain deeply involved as a result of the lack of skilled manpower in many districts and reluctance on the part of the central ministries to give up their traditional duties in planning and managing regional staff and programs. Therefore the development of sectoral objectives, policies, plans and related tasks, including the establishment of minimum service and performance standards, manpower planning and preparation of the annual formasi exercise, is still conducted in most cases by the sectoral ministries (World Bank, 2005). In 2004, Law No. 32/2004 was enacted with the purpose of addressing the uncertainties and irregularities of Law No. 22/2004, but it also called for a reversal of the shift in management responsibilities back to the central government by reinstating the provincial level authority. Government Regulation No. 38/2007, distributing government functions

14 Cite Jups Kluyskens report - 2007
among the center, provincial, and district levels, was released in July 2007 to guide the implementation of Law No. 32. However, at least for the health sector part, function statements used in the regulation are too broad and, as such, have not fully clarified or reduced uncertainties. Many details require further clarification going forward.

5. Current Government Health Strategy

The government’s strategy for health as developed by the MoH is built on four pillars: community empowerment; health financing; access to health services; and, surveillance. These pillars are translated into programs to achieve the goals as follows: community empowerment would be achieved through the so-called Desa Siaga program, which foresees a health worker (midwife and or nurse) in every village by 2009. Extra training programs for midwives and nurses, as well as an upgrade for the levels of nurses, are foreseen under this program. What this program does not foresee, however, is how to sustain the deployment of health personnel in remote areas.

In 2003, the Ministry of Home Affairs mandated the MoH to introduce minimum service standards (MSS) for local government obligatory functions in the health sector. The aim is to ensure equitable access and quality of basic health services for the community. The MSS consist of a list of obligatory functions and indicators to measure performance. Evaluation by the MoH found that implementation of the MSS has failed to achieve the intended objectives due to various factors including: too many indicators; too high targets; unclear operational definition of indicators; unavailable data; and inadequate local resources to implement the MSS.

Based on these results, the MoH is in the process of revising the MSS limiting the obligatory functions to only four main services i.e., basic health services, referral services, epidemiologic investigation and outbreak response, and health promotion and community empowerment. Eighteen indicators were selected to measure performance in these four areas. Although the number of functions and indicators has been reduced significantly compared with the original version, debates still continue particularly on selecting the percentage of active Desa Siaga as an indicator for health promotion and community empowerment. More problematic is the confusion between setting MSS for service provision and defining the services to be covered in the insurance benefit package. Clarification of these two related but different concepts is essential.

The Askeskin health insurance for the poor program is the activity under pillar two, with the goal to achieve sustainable financing of health services for the poor. Although Askeskin has only been implemented for about three years, there are positive signs such as an initial increase in utilization of public services by the poor (Aran, 2006). However, further analysis shows that this increase in utilization is rather a substitution of public for private facility use, without showing a net increase in overall utilization. The efficiency, equity, and effectiveness of the use of these resources have to be evaluated in more depth before drawing conclusions.
In addition, under pillar two the MoH lobbies for more central level funding for the health sector to support the delivery of health services at the district level. This is indicated by the steady increase of the allocation of deconcentrated funds, particularly during the past three years. The MoH made the decision to provide more centrally allocated resources for health because of the perceived inadequate spending by local governments on health. As resources are earmarked by the center, such spending tends to disregard district level planning, resulting in even more inefficient spending despite the nominal increase in funds.

Access to health service prescribes the implementation of a strategy that in fact goes back to the Alma Ata years of the 1970s, when access was equated with infrastructure and much less attention was given to local needs, circumstance, staffing needs and incentives. The MoH proposed to increase the number of Puskesmas and Pustu, and upgrade and rehabilitate existing facilities. It is unfortunate that the large contribution made by the private health sector towards service delivery is not adequately reflected in the needs assessments regarding access to services.

The current approach to the reform of health human resources has been ad hoc and is in general not accompanied by evaluations of past reforms. Also, human resource policies in health continue to regard health workers as passive actors who are expected to take positions in remote areas irrespective of their behavioral motivations. For example, the Desa Siaga program of the MoH to place midwives and/or nurses in all villages in Indonesia fails to provide a strategy to motivate them through appropriate incentives as mentioned earlier.

The fourth pillar of the current strategy focuses on improving the surveillance system and ensuring timely and accurately identification of communicable disease such as avian influenza.
C. HEALTH SYSTEMS CONTEXT

1. Financing

Total Health Spending. Indonesia’s health spending is low and dominated by out-of-pocket payments. In addition, expenditure performance in terms of health outcomes, equity, and financial protection could be improved. Table 1 provides an overview of Indonesia’s health spending based on WHO’s 2007 national health accounts (NHA).

Table 1: NHA – WHO, 2007

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</thead>
<tbody>
<tr>
<td>Total expenditure on health (THE) as % of GDP</td>
<td>2.2</td>
<td>2.1</td>
<td>2.3</td>
<td>2.3</td>
<td>2.7</td>
<td>2.8</td>
<td>2.9</td>
<td>2.8</td>
<td>2.7*</td>
<td></td>
</tr>
<tr>
<td>General government expenditure on health (GGHE) as % of THE</td>
<td>28.5</td>
<td>30.0</td>
<td>27.9</td>
<td>30.4</td>
<td>26.3</td>
<td>33.1</td>
<td>33.7</td>
<td>31.6</td>
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<td>34.7*</td>
</tr>
<tr>
<td>Private sector expenditure on health (PvtHE) as % of THE</td>
<td>71.5</td>
<td>70.0</td>
<td>72.1</td>
<td>69.6</td>
<td>73.7</td>
<td>66.9</td>
<td>66.3</td>
<td>68.4</td>
<td>65.8</td>
<td>65.3</td>
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<tr>
<td>General government expenditure on health as % of GGE</td>
<td>4.1</td>
<td>3.4</td>
<td>3.3</td>
<td>3.7</td>
<td>3.7</td>
<td>4.2</td>
<td>5.3</td>
<td>4.6</td>
<td>5.0</td>
<td>5.0</td>
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<td>Social security funds as % of GGHE</td>
<td>9.6</td>
<td>11.5</td>
<td>8.7</td>
<td>6.8</td>
<td>7.5</td>
<td>8.9</td>
<td>10.2</td>
<td>11.7</td>
<td>10.8</td>
<td>21.3</td>
</tr>
<tr>
<td>Private households’ out-of-pocket payment as % of PvtHE</td>
<td>75.4</td>
<td>74.0</td>
<td>74.7</td>
<td>73.6</td>
<td>72.2</td>
<td>75.1</td>
<td>75.3</td>
<td>76.0</td>
<td>74.7</td>
<td>74.3</td>
</tr>
<tr>
<td>Prepaid and risk-pooling plans as % of PvtHE</td>
<td>4.3</td>
<td>4.5</td>
<td>4.5</td>
<td>5.1</td>
<td>4.7</td>
<td>4.1</td>
<td>5.1</td>
<td>5.6</td>
<td>5.9</td>
<td>6.0</td>
</tr>
<tr>
<td>External resources on health as % of THE</td>
<td>1.4</td>
<td>1.6</td>
<td>3.9</td>
<td>3.6</td>
<td>7.9</td>
<td>3.2</td>
<td>2.1</td>
<td>0.8</td>
<td>1.3</td>
<td>1.2*</td>
</tr>
<tr>
<td>Total expenditure on health / capita at exchange rate</td>
<td>28</td>
<td>25</td>
<td>12</td>
<td>17</td>
<td>18</td>
<td>20</td>
<td>25</td>
<td>31</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Total expenditure on health / capita at international dollar rate</td>
<td>80</td>
<td>79</td>
<td>73</td>
<td>76</td>
<td>78</td>
<td>96</td>
<td>105</td>
<td>114</td>
<td>118</td>
<td>122</td>
</tr>
<tr>
<td>General government expenditure on health / cap x-rate</td>
<td>8</td>
<td>8</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>General government expenditure on health / cap int. $ rate</td>
<td>23</td>
<td>24</td>
<td>20</td>
<td>23</td>
<td>21</td>
<td>32</td>
<td>35</td>
<td>36</td>
<td>40</td>
<td>42</td>
</tr>
</tbody>
</table>

Source: GGHE, 2005. External resources do not include expenditures related to health in tsunami relief effort.

Total health spending is 2.7 percent of GDP and per capita exchange rate based spending is some US$34, both low compared with other comparable income countries (Figures 9 and 10).
Figure 9: Indonesia is a low spender on health in terms of its GDP share

Figure 10: Per capita total health spending is also low

Public spending on health accounts for only some 35 percent of total health spending and government health spending is only 4.5 percent of the overall government budget, both low relative to other comparable income countries (Figure 11 and 12).
Inequities in Health Spending Patterns. At the same time out-of-pocket spending accounts for some 50 percent of all health spending (Figure 13), thereby denying individuals the benefits of risk-pooling and financial protection inherent in insurance arrangements.
The Equitap study\textsuperscript{15} of 11 Asian countries clearly defines the inequities and impoverishing effects of catastrophic medical care costs on Indonesians. Such costs are the second leading cause of impoverishment for Indonesians. While recent Susenas evaluations show a reduction in the percent of households experiencing catastrophic spending from 1.5 percent in 2005 to 1.2 percent from 2006, the Equitap study methodology may yield a different set of findings regarding the impact of the grow of the Askeskin program.

\textit{Is Insurance the Answer to Health Spending Inequities?} One strategy for addressing the above identified inequities is to design health insurance mechanisms to financially cover all the poor and ensure universal coverage for the entire population. The GoI has initiated a process for addressing many of the detailed design issues involved in realizing this objective. It is working on the difficult problems of: a) defining a basic benefit package; b) assuring financial protection against impoverishment; c) phasing in coverage of all the poor, including the near poor; and d) coordinating benefits and establishing uniform standards and reimbursement approaches to implement universal coverage via a social health insurance-based system (Figure 14).

Moreover, more attention should be paid as to whether the conditions exist in Indonesia for successful implementation of a national health insurance system. Reviews of global and Asian experience\textsuperscript{16} have concluded social health insurance requires: (i) a growing economy and level of income able to absorb new contributions; (ii) a large payroll contribution base and, thus, a small informal sector; (iii) concentrated beneficiary population and increasing urbanization; (iv) a competitive economy able to absorb increased effective wages arising from increased contributions; (v) administrative capacity to manage rather complex insurance funds and issues such as management of

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reserves, cost containment, contracting and others; (vi) supervisory capacity to overcome some of the market failures such as moral hazard and risk/(adverse) selection and other important matters of governance and sustainability: and (vii) political consensus and will. The GOI has evidenced a strong political will to insure the poor via the Askeskin program. It has provided impetus to SHI implementation by enacting Law No. 40/2004 and it has improved government contributions in health financing. Some countries in the region also did not have all of these preconditions in place when they initiated their efforts to implement SHI, for example South Korea and Taiwan, but they had the political will to begin to develop a long-term strategy for its eventual full implementation. Indonesia does not have all these underlying conditions in place. It is therefore important to develop a carefully crafted implementation plan based on clear evidence, much of which may be acquired from within the country, to craft the technical design of the program as described above so that it moves towards the goal over time.

Figure 14: Indonesia’s transition to universal health coverage

Indonesia’s Transition to Universal Coverage
(National Social Security Law No.40/2004)

Organization and Management

- Each single existing carrier follows its own regulation
- For profit entities

- Nat Soc Security Council directs main policy
- Nat Soc Security Carriers implement the program, not for profit
- Synchronization of multiple schemes

Source: MOH: Ida Bagus Indra Gotama, Donald Pardede
poor, utilization among the poor increasing, and ongoing work is analyzing the effects on out-of-pocket expenditures and substitution effects. And, although the Askeskin health insurance for the poor targeting scheme may be slightly pro-poor, due to lower utilization rates by the poor, the benefits of this program also appear to accrue to the richer quintiles as well (Askeskin evaluation). The Askeskin program is being implemented throughout the country and will serve as one of the key building blocks of the government’s proposed universal coverage scheme based on the new National Social Security Law that was passed in October 2004 to synchronize multiple health insurance schemes for achieving universal coverage.

Box 1: Brief overview of landmarks regarding social health insurance in Indonesia

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1968</td>
<td>Health Insurance for Civil Servants – Askes</td>
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<tr>
<td>1974-90</td>
<td>Promotion and Experiments of Community Health Insurance – Dana Sehat</td>
</tr>
<tr>
<td>1992</td>
<td>Social Security Private employees, JPKM (HMOs) and Community Health Insurance</td>
</tr>
<tr>
<td>1997</td>
<td>Financial Crisis</td>
</tr>
<tr>
<td>1998</td>
<td>MoH attempt to mandate HMOs fails</td>
</tr>
<tr>
<td>1999</td>
<td>Social Safety Net – financial assistance for the poor, ADB loan</td>
</tr>
<tr>
<td>2000</td>
<td>Comprehensive Review of Health Insurance and Amendment of Constitution to prescribe the rights to Healthcare</td>
</tr>
<tr>
<td>2001</td>
<td>Comprehensive Review of Social Security System</td>
</tr>
<tr>
<td>2002</td>
<td>Amendment Constitution on the Rights to Social Security. President establishes a Task Force on Social Security</td>
</tr>
<tr>
<td>2003</td>
<td>(June) Parliament initiates a Bill on National Social Health Insurance. (December) The Task Force finishes drafting the Bill on National Social Security; health, occupational health, provident fund and pension, death.</td>
</tr>
<tr>
<td>2004</td>
<td>(October 19) Bill on National Social Security enacted.</td>
</tr>
<tr>
<td>2005</td>
<td>Preparation for implementation 36.4 million poor people covered via the Askeskin program.</td>
</tr>
<tr>
<td>2007</td>
<td>Askeskin program expands to cover 76.4 million and encounters a significant financial deficit. The formal Council to implement Law No. 40/2004 will be established by February 29, 2008</td>
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</table>

Source: Adapted from Prof. Hasbullah Thabrany Presentation at Bandung Policy Seminar, April 2007

Sources of Public Spending on Health. In terms of the revenue sources of public spending, general revenues finance about 80 percent of government spending with contributory social security payments financing most of the remainder. Financing of health is through both demand-side financing of insurance and facilities as well as supply-side subsidies to public providers. Much of that is funneled in a very complex manner through the intergovernmental fiscal transfer procedures currently in place. In addition, the GoI has financed much of its extensive network of public facilities through allocations from central to provincial and district levels.

Health financing under decentralization is complicated as some funds are earmarked by central level government, while others are not, and formulas used for redistributing funds from central to local governments often do not reflect local need and fiscal capacity. Although conceptually the situation at first appears very simple, the responsibility for implementing health services resides at the district level. The complex flows of funds — some targeted to health, others not, some payments made through insurance

\[17\] The current fiscal decentralization picture is as follows: there are three main funding source from central level to district, two of which are direct funding of the district (DAU and DAK), and one via the provincial level (Decon). In addition, the district has its own funding, the PAD.
organizations, and others made directly to public providers (i.e., hospitals, Puskesmas, or personnel) — make for a very complex, inequitable, inefficient and fragmented set of financing flows (Figure 15).

The largest share of expenditures is now at the district level. These expenditures have, for the most part, become non-discretionary routine expenditures, as salary costs make up 70 percent of the expenditures which are still controlled by central level. This leaves very little room for districts to spend according to their needs. Furthermore, the center requires a share of local funds as matching funds to acquire the central flow of the DAK. As a result, local governments have very little discretion in managing their public health funds. In addition, the role of the province is vague and has led to a loss of a number of important tasks in which provinces had a comparative advantage: disease surveillance; training; coordinating policies and sharing experiences and equalizing inter-government fiscal transfers.

**Figure 15: Intergovernmental financing flows**
The government’s overall revenue-raising efforts could also be improved as Indonesia’s revenues (tax and non-tax) relative to its GDP are only about average for its income level. While Indonesia’s positive future growth prognosis (IMF/WB) suggests that increased revenue growth will occur, improvements in tax administration and the mix of taxes could also improve revenue efforts and the availability of future fiscal space.

In addition to serious issues regarding revenue-raising and risk-pooling, Indonesia’s arrangements for purchasing health services do not reflect modern contracting payment approaches and promote neither technical nor allocative efficiency or access for the poor. The convoluted mix of spending flows, coupled with the decentralized financing and ambiguous decision-making structures, precludes a uniform set of efficiency-based incentives from impacting on both public and private sector providers. Money does not generally follow patients, and facility managers have little autonomy and few incentives to be efficient. There is little control over quality and the vast private sector is largely unregulated. In addition, broad and imprecise benefit package design and funding decisions regarding public health programs, coupled with current funding flows and local decision-making regarding resource allocation across sectors, frustrate achievement of allocative efficiency (e.g., lack of focus on highly cost-effective anti-smoking and anti-obesity and road safety campaigns and a systemic focus on maternal mortality).

Moreover, provider payment systems have not been extensively documented or studied in Indonesia. Virtually all provider payments are input, not performance, based. While there are discussions ongoing about introducing performance-based budgeting, reform policies have yet to materialize. Private providers are paid on a fee-for-service basis for outpatient services and fee-for-service or hospital salary for in-patient services. Public health workers are paid a salary following the civil service scale for those with civil servant contracts (PNS) and PTT contractual agreements. Both categories also receive a number of allowances depending on their family situation and placement. The basic mechanisms for paying PNS-public service health providers (i.e., contract health workers) is through the budget mechanism and salaries are included in the direct funding to districts in the DAU formula. There is little discretion for health sector managers at the district level to recruit, redeploy or dismiss health workers. About 80 percent of public practitioners also provide private services, where they are paid on a fee-for-service basis. Earlier studies indicate that the major share of the total income of health workers comes from private practice.

Analyses of the efficiency of both public and private expenditures are hampered by a lack of data, particularly spending by function and by provider, as well as case mix-adjusted unit cost information. Budgets are organized by broad categories, making it difficult to analyze how funds are spent at the different levels of the health system. In addition, due to the complex flow of funds through the intergovernmental transfer system, it is often difficult to compile accurate public spending data at the district level. Private spending information is even more problematic. Current work being conducted via the public expenditure review process suggests important gains can be made to enhance allocative and technical efficiency.
2. Human Resources for Health (HRH)

Workforce issues are heavily influenced by government labor market policies, decentralization, and how key full HRH functions are impacted at both the macro and microeconomic levels. Norms and regulations, as well as underlying incentives, are critical determinants of workforce performance. Health workforce density in Indonesia is low relative to global standards for the provision of basic care and low relative to other countries in the region. Based on data from the 2000 national census and including public and privately practicing healthcare providers, health workforce density is 0.65 health providers per 1,000 population.\textsuperscript{18} Physician density is 0.16 per 1,000 population well below the numbers in other comparable income countries, resulting in one physician in Indonesia being responsible on average for the care of over 6,000 people (Figure 16). Combined nurses and midwives density is 0.49 nurse/midwife per 1,000 population and for dentists, 0.01 per 1,000.

**Figure 16: Global physician to population ratio trend line**

![Doctor Supply vs Income Chart](chart.png)

Source: World Development Indicators, WHO 2007

Note: GDP per capita in current US$; Log scale

Workforce shortages are exacerbated by large imbalances in public health workforce between provinces and districts, and urban and rural areas. In Puncak Jaya district where physician density was lowest in 2000, one doctor is responsible for the healthcare of over 60,000 persons, over 200 times the highest density district (Kabupaten Bireuen) (PHER, 2006). The ratio of nurses and midwives to population also varies significantly between districts (PHER, 2006).

In an effort to reduce public spending, in 1992 the GoI enacted a zero growth policy to stem the expansion of the civil service. For the health sector, this policy implied a major change in the incentives for deploying staff. Newly graduated medical doctors were no longer guaranteed a civil service post, thus eliminating a key incentive for voluntary

\textsuperscript{18} 2.5 staff per 1,000 people is considered by some the minimum threshold for basic service provision.
deployment to remote regions. Declines occurred immediately after the implementation of zero growth in the number of medical doctors in remote regions.\textsuperscript{19}

Insufficient work has been done investigating the appropriate combinations of incentives for deployment to and retention in remote and rural areas. These areas are characterized by few basic amenities, poor transportation and communication, 24-hour on-call responsibilities, and limited educational facilities for children. The MoH continues to rely on the incentive of a civil service contract. However, growing opportunities in the private hospital market may make civil service employment less attractive than before. Systematically testing alternative incentives for deployment could build on earlier experiences while also considering responsibility, workload and performance.

An estimated 70-80 percent of publicly employed health staff have second jobs, many in private solo practice or private facilities.\textsuperscript{20} Possible negative consequences of dual practice include resource misallocation, competition for public time, and diverting public patients to private practice. Given that private practice can provide substantial supplemental income, especially for medical doctors, the lack of private practice opportunities in remote and poor regions is a factor that deters deployment to these regions. There are benefits and costs of dual practice. A benefit arises when the government can only afford below-market wages. In this case, dual practice helps the public sector to retain a share of a doctor’s time despite public budget constraints. The major cost is the continuing balancing of where a civil servant allocates his/her time. However, no strong studies exist documenting either positive or negative impacts of dual practice; therefore, the debates remain theoretical and anecdotal. It is important to note that in Indonesia holding second jobs is tolerated across the entire civil service and not simply an issue within the health sector alone.

3. Physical Infrastructure

In recent decades, improvements have been seen in the physical infrastructure of the health sector in Indonesia. The number of beds has increased significantly, more than doubling in 25 years. Health centers (Puskesmas), sub-centers (Puskesmas Pembantu) and mobile health centers have also increased. However, in spite of these improvements, many Indonesians either remain underserved, or have opted to seek care for their health problems from providers acting on a private basis.

Indonesia responded to the “Health for All” by year 2000 commitment by establishing the earlier mentioned\textsuperscript{21} extensive public health network of Puskesmas and related outreach centers and programs and hospitals. The construction of Puskesmas and the primary care network was financed primarily through the central government budget, initially through the Inpres program (Presidential Instruction program), and later through the MoH (APBN) budget. Central level funding for Puskesmas construction continued post decentralization through the Special Allocation Fund (DAK) channeled directly to

\textsuperscript{19} Barber et al, 2007.
\textsuperscript{20} GDS, 2006.
\textsuperscript{21} See the section on health system coverage and utilization.
the district level. The Puskesmas and their network were equipped following a standard set by the MoH. They were funded by the central government and since decentralization district governments have continued the financing. Although in some districts the networks continue to be well equipped and financed, this is far from being the case in all 440 districts. In fact, there is considerable variation between districts, for example in terms of adequacy of equipment and quality of maintenance.

The number of general hospitals in the country by 2003 was 966, representing an increase of almost 14 percent since 1995. This improvement is primarily due to an increase in the number of private hospitals, as the government only constructed 13 new general hospitals, far fewer than the 103 constructed by the private sector. Of these newly constructed facilities 63 (54 percent) were concentrated in the five main provinces on Java and in North Sumatra. In 2003, there were 112,379 beds or one hospital bed per 1,000 people, of these almost 38 percent were private hospital beds. An additional 270 public and private hospitals provide special services such as psychiatric, eye and maternity care. More than 50 percent of these special hospitals belong to the private sector and of those 61 percent are maternity hospitals.

Similar to the Puskesmas network, the construction of public hospitals has been financed by the central government. After decentralization, a number of districts, particularly new districts, allocated resources to building their own hospitals, although there are no official records for verification. In general, procurement of hospital equipment is also financed by the central government and this financing was continued by the central level after decentralization. However, little analysis of the condition of public hospital facilities has been undertaken. Furthermore, little is known regarding how private facilities are financed, their current capacity of service delivery, or their state of maintenance.

4. Pharmaceuticals

Current Susenas data suggest that the largest share of the population’s first source of care given an illness episode is a private seller of pharmaceutical items. As pharmaceuticals comprise a significant share of total health spending (nearly 30 percent), it is essential for this health sector assessment to address the pharmaceutical sub-sector. A description of the pharmaceutical sub-sector is complex because it involves both a health sector input for treatment purposes, as well as encompassing issues regarding industrial policy. Pharmaceuticals can also become an important component of the design of a health insurance benefit package. As such, the sub-sector can have important implications for the cost and sustainability of health insurance schemes. In addition, the large out-of-pocket payments for pharmaceuticals, particularly by the poor, have important consequences in terms of impoverishment and financial protection embodied within the Indonesian health system. The cost-effectiveness of drug treatments vis-à-vis the disease burden also has important implications for health outcomes and allocative efficiency. Finally, the pharmaceutical industry is an important player in the industrial base of the economy and, as such, represents both a domestic employer and an export industry.
The pharmaceutical market in Indonesia is around US$2.4 billion in 2007 (includes OTC drugs) with a double digit growth rate mainly fueled by the private sector. The market is dominated by the domestic industry: four large companies so far remain state-owned enterprises (SOE’s), although privatization is being considered, whereas about 170 smaller companies are in private hands. Multinationals also have a significant manufacturing presence in Indonesia, some of them making drugs or active substances for export. Technical capacity to meet international quality standards exists in Indonesia, although several of the smaller companies may not have the capital base to afford investments needed to comply with good manufacturing practices (GMP) quality standards. ASEAN guidelines on GMP will come into effect in 2008, but compliance regulations to these standards have not yet been promulgated.

The market is dominated by branded generics despite availability of unbranded and relatively cheap generics. This means that consumers are willing to pay for the brand image or are persuaded by providers to choose the more expensive drugs. On the other hand, the government is trying to push price-regulated unbranded generics. There appears to be a protracted debate between government and industry regarding the branding issue, which may distract from the real issues of competition, price and quality in the generic sector. Generic drug treatment is affordable for most people in the public and private sector. However, a recent study found drug prices for a small number of frequently prescribed drugs to be relatively high compared with international tender prices, with no significant difference between public and private sector outlets.

Per capita drug expenditure is slightly above US$10 per year, although this figure does not reflect the inequality as most people purchase their drugs out-of-pocket. In such markets, spending is dominated by the wealthier parts of the population. Patent-protected brands — imported or made locally under license — are mostly consumed by the higher income urban population, whereas many poor people cannot access effective drugs. Most people buy their drugs in the private sector, while the share of government-provided drugs is low (15 percent of total drug expenditure). Public sector healthcare facilities are supplied with unbranded generic drugs, which are given to the patients free of charge or at a small fee. Little is known about the use of traditional medicine although it is expected to be of large magnitude.

The dominant private sector has different segments, from licensed pharmacies and drug stores to an unknown but presumably large number of unlicensed drug stores, including drug peddlers in villages or small markets. Many private physicians and other health professionals are self-dispensing. The size of the informal market is not well documented but may be as large as one third the size of the formal market. The fact that health institutions and professionals make part of their income from selling drugs creates incentives for over-prescribing or recommendation of more expensive brands. Limited available data suggest that over-prescribing may be widespread.

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22 HAI, June 2006.
23 HAI, June 2006.
Decentralization has led to a system in which districts are deciding on, planning for, and purchasing their own drugs. As a result, it appears that central data collection has ceased and it is no longer possible to review or assess parameters such as total public spending for drugs, availability, quality, etc. There is no common pattern of pharmaceutical procurement in the provinces or districts. Depending on the quality of provincial management and availability of resources for drug purchases, the supply situation can be satisfactory in one province, and plagued by widespread shortages in another. Similar patterns are found regarding quality inspections of pharmacies and drugstores.

Until 2000, regulation of the pharmaceutical sector was conducted by the MoH particularly the Directorate General for Drugs and Food Control. This situation changed with the release of Presidential Instruction No.166/2000 establishing the National Agency for Drugs and Food Control (NADFC) as a separate entity from the MoH. Under this new arrangement, the MoH maintains the responsibility as the coordinator of drug and food regulatory functions. In general, the MoH is responsible for drug availability (particularly within the public sector), accessibility and affordability, while the NADFC is responsible for controlling drug quality, safety and efficacy. The NADFC conducts inspections of drug production and distribution, while the authority to license and revoke the license of drug manufacturers and wholesalers/distributors lies with the MoH.  

The informal sector seems to largely escape regulation and enforcement. Penetration of sub-standard and counterfeit drugs in the informal market could be high, comprising perhaps as much as 25 percent of the market. This is a major public health issue affecting mostly the poor who buy from these informal sellers because they are the only ones accessible or because prices in the formal sector are too high.

In 1980, the MoH issued its first Essential Drug List (EDL), which specified drugs for use in facilities of each tier of the service delivery system. The EDLs appear to have grown and developed over time. Various versions of the list appear to be in circulation, often without clearly defined issue dates. Some include imported items that might not normally be considered essential.

EDL use in the Askeskin program is not specifically mentioned in the Askeskin implementation guidelines. Instead, the guidelines indicate that public health centers and hospitals have to use generic drugs listed and priced by the government. Use of drugs outside the generic list should be based on treatment protocols approved by the hospital.

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24 The roles and responsibilities of the NADFC in ensuring drug safety and quality encompass pre market as well as post market control. A drug that passes pre market evaluation process will get a marketing authorization and distribution from the Agency. Post market surveillance and control is conducted through sampling and testing of drugs sold in the formal market by NADFC central and regional offices.

25 MoH regulations defines three types of EDL: Very, very essential drugs (vvEDL), very essential drugs (vEDL), and essential drugs (EDL). The districts are responsible for acquisition, stockpiling, and distribution of EDL, while vEDL is the responsibility of the provinces, and vvEDL is the responsibility of the center. VvEDL comprise of a clearly defined list of products although the list is somewhat unusual for an EDL and appears to have grown overtime. It has not been possible to obtain clearly agreed splits between vEDL and EDL but there is general agreement on the combined list of vEDL and EDL products.
director. As yet there has not no review of the adequacy, relevance or affordability of drugs used in the Askeskin program.

5. Organization, Management, and Accountability

Weak vision, inefficient public sector management, lack of evidence-based policy making, and limited oversight concerning access, quality and costs with respect to the entire health system are among the main gaps in the current Indonesian health system. The gaps have serious consequences for the reform efforts currently underway. Governance is an important and politically charged issue. Governments everywhere are reassessing health sectors regarding where to intervene, when, how and how much to intervene, and where and when to leave things to the market (patient demand, health services, whether public or private supply). Providing oversight and an enabling environment for equitable, efficient and sustainable health system’s functioning is a clear public good that would benefit all Indonesians. Thus, it is a potential area for public action.

There is an oversight gap regarding the provision of all forms of private health services and how they are paid/financed. The private sector in Indonesia is not incorporated into the current health policies and plans, despite the fact that more than half of the population goes to private providers for a first visit to obtain treatment. Although the government performs regulation through registration and licensing, these processes are based on fulfillment of administrative criteria rather than on assessment of minimum competence to perform professional work. Recent policy changes have further reduced potential for oversight, such as the abolition of mandatory government service for medical graduates and the abolition of medical state exams for all graduates, including nurses and midwives.

Oversight is crucial to improving equity and quality of service delivery, but in order to perform this function, the system requires clear functional divisions. Current ambiguity about the relative roles of the centre and regions embodied in Law No. 22/1999 continues to create uncertainty about roles and responsibilities for financing and decision-making throughout the health system. Ministerial decrees, including the MoH’s minimum service standards for basic service delivery, lack legal force and are considered only as recommendations. The lack of clarity about the provinces’ legal obligations for health has led to a situation where the MoH remains closely involved in service delivery. In 2004, Law No. 32 was enacted to address these uncertainties but resulted in continued lack of clarity given that it called for a reversal of the shift in management responsibilities back to the central government.

The quality of services at public facilities has eroded and is linked to the absence of health personnel. Studies have found that doctors are frequently not present at health centers even when supposed to be and there is up to 40 percent absenteeism without valid reasons. Moreover, the lack of effective certification and licensure standards for health personnel and hospitals, limited monitoring and surveillance, and the lack of cost

26 Chaudhury, 2005.
Containment and private health insurance regulations do not augur well for a possible expansion of insurance coverage.

Decentralization has exacerbated all these issues. For example, many public health functions suffered a setback after decentralization in part due to the confusion in roles as well as the breakdown in the surveillance system and management of information. Districts have been given the mandate to implement health services, but no clear guidance was provided on how, which services and how to share information. As a result, many districts simply stopped reporting. Districts also applied in many instances a rather narrow view of the health services, limiting themselves to basic primary care and curative services, while largely neglecting public health interventions. There is no referral system that directs patients to the level of care that best meets their needs. Drug prescribing and dispensing is often irrational and over-prescribing results. There is no system of redress for medical errors and negligence, although a number of districts have started some initial experiments introducing public accountability mechanisms.

There is no comprehensive vital registration system, with the exception in several pilot areas of the country, and systems for tracking morbidity, mortality, and facility utilization are not reliable. The burden of important illnesses, such as malaria, is not known for certain. HIV/AIDS is an emerging disease and although given more attention recently, the infection rate of HIV-positive persons with TB is not yet adequately addressed and poses a growing problem. Unlike most other countries in the region and more developed countries, routine utilization data reported by facilities are not routinely used and are considered unreliable. There is a lack of regional capacity to take on important health information, management, and regulatory tasks and, in particular, regional capacities in health workforce administration and management. The health system’s assessment must address these deficiencies in the GoI’s organization, management, and stewardship functions, as these institutional realities affect all other health system components.

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27 AusAID is funding an ongoing pilot (under guidance from Alan Lopez) in five areas on burden of disease; including death certificates.
28 A recently completed GTZ survey in NTB and NTT documents large under-reporting in Puskesmas utilization.
D: PROPOSED BASIC POLICY QUESTIONS

1. Basic Policy Questions in Health Financing

A. What are the key issues and policy options available for implementing universal coverage, given enactment of Law No. 40/2004?
B. What are the key fiscal issues concerning funding the public health system and insurance programs such as Askeskin?
C. What are the key public and private provider payment/contracting reforms needed?
D. What are the institutional constraints to developing and implementing the universal coverage financing and payment systems?

2. Basic Policy Questions in Human Resources for Health (HRH)

A. How do current civil service rules and procedures associated with decentralization affect the ability to staff health facilities?
B. What are the key strengths and weaknesses in the current system for training, distributing, and motivating health personnel?
C. Are there any incentives built into compensation packages that enhance health facility staffing, especially in remote areas? If so what are they and how to they work?
D. How does the phenomenon of dual practice affect access to care for the poor and non-poor? Address both the impacts on the demand and supply side of the market.
E. What accreditation and regulatory procedures are being implemented to guarantee quality care through both the public and private sectors?
F. Is it more cost-effective for government to rely on other appropriately skilled health practitioners such as nurse practitioners rather than doctors in underserved communities?
G. What policies are needed to improve quality of service delivery especially in the private sector?

3. Basic Policy Questions in Physical Infrastructure

A. How should possible changes in physical infrastructure be financed in the future, and especially what role should the government of Indonesia play (include cost implications)?
B. What will be the role of the private sector (financing, managing maintaining, other)?
C. What aspects of the law would need to be changed to effectively meet such needs in terms of definitions of roles and responsibilities and financing?

4. Basic Policy Questions in Pharmaceuticals

A. What should the main focus of pharmaceutical policy be where the private sector is clearly dominant? i.e., how can the private sector be best regulated in order to have private sector providers contribute to public health outcomes and be more cost conscious?
B. Should there be a drug benefit component included in any health insurance program (public sector only or contractual partnership with private sector)?
C. How can the influx of (and trade in) fake and sub-standard drugs be curbed?
D. What are the costs and benefits associated with various strategies designed to eliminate the informal drug market (offer sellers a way into formal status, close down illegal shops)?
E. How will policy changes affect the domestic pharmaceutical manufacturing industry?
F. What is the role of traditional medicine in a market that embraces traditional practices?

5. Basic Policy Questions in Organization, Management, and Accountability

A. What should be the role of the private sector (e.g., private financial markets, private medical schools, direct service provision, etc.)?
B. What changes are needed to make decentralization work in the health sector?
C. What changes are needed to make provider payment reforms work?
D. What are the needed changes in the regulatory structure including the insurance industry?
E. What governance and accountability procedures need to be incorporated into the reform agenda?

6. Basic Policy Questions in Public Health

A. What fundamental changes are needed in the public health system to accommodate the three transitions in terms of policies, financing, personnel, and infrastructure?
B. How will the GoI ensure sustainable financing for public health interventions as well as curative care in the face of these transitions? What are the feasible options?
C. How can emerging diseases/conditions, including HIV/AIDS, obesity, diabetes and tobacco-related illnesses be tackled more effectively and efficiently?

7. Cross Cutting Policy Issues

A. How can the cross-cutting role of gender be incorporated within this review?
B. What additional decentralization policy issues should be woven into this assessment?
C. Legal framework issues, generally and sector specific?
Technical Questions Requiring Information to Answer Policy Questions

1. How effectively and efficiently is Askeskin being implemented?

2. How will the demographic and epidemiological transitions affect demand for health services and its financing?

3. What mix of skills will be needed to meet increasing demand for treatment of chronic diseases?

4. What changes are needed in the physical infrastructure – types of inputs and location – to meet current and evolving future health needs?

5. If a drug benefit component is desired within the health insurance program, what mandates, skills and capacity are required to implement a possible drug benefit program (selection of drugs, price negotiation, contracting, control instruments, communication and education)?

6. What are the needed changes in the organization, size, management, and roles of key government agencies?

7. How can accountability mechanisms be made more effective?
PROPOSED OUTLINE OF HEALTH SYSTEM ASSESSMENT

Executive Summary

1. Introduction

(A) Purpose, objectives, scope and methodologies of the assessment
(B) Overview of the chapters
(C) Governance Arrangements

2. Country Profile and Health of the People

(A) History, Geography, Governance Structure:
  Brief review of the evolvement of the health system since Alma Ata to decentralization implementation in 2001 to date (the basic Laws Nos. 22, 25 and modifications 32; additional devolution and increase in resources — 15 and 30 percent — to the districts occurred in 2006/7).

(B) Socio-economic Situation:
  Factual review of the socio-economic situation including: current and projected macroeconomic trends; government budget; MTEF, and MTFF; labor market; and poverty trends and current rates.

(C) Demographic Situation:
  Review of the underlying circumstances resulting from the demographic transition (epidemiological and nutrition transitions are included in next section) with details on the age distribution of population visualized with population pyramids, geographic distribution, migration (intra and external) and urbanization, life expectancy trends over time; literacy and educational attainment; and gender and household characteristics.

(D) Health of the People (Health Situation and Epidemiological and Nutritional Transitions):
  1. Major causes of death and disability and changes over time; international comparisons; epidemiological and nutrition transitions and implications; trends in mortality rates for infants, children, women and adults in general; morbidity and disease risk factors, emerging disease patterns (both re-emerging communicable and NCDs and injuries), and the burden of disease and implications for longer-term financing
  2. Discussion on the level of attainment of the MDGs in Indonesia; Indonesia’s national development goals for 2004-09; financial protection and consumer satisfaction.
3. Health System Assessment

The objective of this chapter is to assess the health system by building upon earlier reviews and updating the information using more recent data from the annual household surveys (Susenas), the MoH health survey (Sukesnas), the labor force survey (Sakernas), annual village infrastructure census (Podes), the Governance and Decentralization Survey (GDS), the Indonesia Demographic Health Survey (DHS) 2007\(^{29}\) and the GTZ-funded NTT-NTB district level health survey. International comparisons are included where relevant. No primary data collection is expected to be needed, except potentially for the human resources for health (HRH) section and the costing of health facilities.

This chapter will also assess progress made on recommendations that were made in the 2002 Decentralization Health Strategy by the World Bank and reforms that were introduced at the province and district levels under the Provincial Health Projects and district level projects implemented by the ADB and other Partners in Health, as is the case in NTT and NTB.

A case study on the parallel health system under the umbrella of the Muhammadiyah Foundation is foreseen and will describe service delivery, including ambulatory care, geographic locations, training facilities and to the extend possible quality. This case study would be informative for private sector provision of services, choice of consumer, provider payments and incentives, parallel training facilities and quality.

This chapter is divided in 7 main sections (A-G) and a final section in which the need for a comprehensive health systems reform is presented based on the strengths and weaknesses of the current system. In the last part the basic principles guiding this work would be addressed: which policies should be maintained and continued; which policies should be improved and which policies should be eliminated?

(A) Health Sector Organization and Management

1. Current institutional and organizational structure of the sector; the Ministry of Health and other relevant ministries, decentralized levels, parliamentary commissions, public and private health insurance organizations, private sector providers, professional organizations, the service delivery system and outreach structures.
2. Health information, disease surveillance systems and quality assurance mechanisms; implications of decentralization on functioning.
3. Basic regulatory and legal structures, the SKN (sistem kesehatan nasional, or national health system) on primary health care 1982 to date, changes after decentralization. Indonesia’s health law is being revised/amended by Commission IX of parliament during the same period as this assessment.

(B) Health Sector Physical Infrastructure

\(^{29}\) Fieldwork being conducted, preliminary results may be available by December 2007.
1. The purpose of this section is first to provide a background to the assessment of
the performance of the public and private health systems in terms of technical
efficiency. This review will be based on an analysis of the available public sector
infrastructure information contained in the Governance and Decentralization
Survey (GDS). That survey includes questions regarding the availability and use
of various standard pieces of medical equipment. The GDS and the most recent
Podes surveys provide updated information; the former includes questions on
maintenance and quality of the infrastructure. Anecdotal and supervision reports
estimate large numbers of idle equipment and low utilization of facilities. Without
having an overview of the existing facilities, equipment and the status that they
are in, this assessment cannot be conducted. Unfortunately, similar information
is currently lacking on the status of private health facilities. This may be rectified
over the next couple of years as a part of the NHA survey work required, but not
before the review has been completed in 2009.

2. Second, the assessment and eventual costing of a supply increase due to changes
in demand resulting from transitions and government policies such as extension of
ASKESKIN would be based on existing infrastructure. This section will therefore
review the numbers and distribution of the ambulatory care infrastructure, both
the public (Puskesmas, Puskesmas Pembantu, Pustu, Polindes and the outreach
programs Posyandu and Bidan di Desa) and private (doctors’ practices, nurses,
midwives, clinics) sector; in-patient infrastructure number and distribution of
beds. However, it will not be complete as the private sector information is more
limited than for the public sector, and policy aspects and cost assessments may
need to be revisited at a later date given this caveat regarding information.

(C) Human Resources

Work on this area started earlier with the background paper for the Health Workforce
concept note for which a review meeting was held in February 2007. An assessment of
regulatory responsibilities and management of the health workforce has been carried on
and a detailed description of the main human resources policy to date, the PTT
program was undertaken in the context of that assessment. This information will be fed into this
section and subsequent sections under the health sector reform strategy. Work is ongoing
in the area of education and pre- and in-service training, as well as in management
information systems for workforce with GTZ. Also earlier research conducted on HRH
will be used here.

1. Situation analysis of the size, composition and distribution of the health work
force in Indonesia; data by type of worker, type of care provided, skills levels,
gender distribution, education and training of workers, as employment status,
place of assignment, and dual practice. Health workers include specialists,
doctors, midwives and nurses. No details on administrative non-medical
personnel are included in this assessment.
2. Some information may be available from PT Askes and Jamsostek regarding human workforce requirements and employment required for the health insurance sector.
3. Medical education, pre-service and in-service training of the health workforce, registration and licensing.
5. Human resources and insurance programs, payment methods used and underlying economic incentives.
6. Overview of human resource policies and changes over time; employment laws, employment conditions, recruitment, deployment and remuneration.
7. Deployment, retention of health workers in more remote areas, management and quality.
8. Epidemiological, demographic and nutrition transition effects on demand for and skills mix of workforce.
9. Muhammadiyah Case Study.

(D) Health Services Utilization
1. In this section an updated analysis of the trends and current situation of the utilization of health services is provided, both for utilization of public and private services. Current status and changes in utilization are analyzed by province, income level, education, type of provider. Utilization rates have declined since 1997, especially in the public sector. Recently there appears to be an increase in utilization of public services. Analyses are being conducted to determine whether this is indeed an overall increase or a substitution between private and public utilization (or due to the expansion of health cards through Askeskin).
2. Discussion on allocative (in) efficiencies: preventive and promote health interventions such as information campaigns about communicable disease, tobacco control, as well as public health functions appear under-implemented and under-funded); technical efficiencies (e.g., ongoing data-collection by AUSAID and GTZ on costs for Puskesmas and utilization data) and quality of care; equity of utilization from benefit incidence studies. A special review of the linkages between primary schools and health promotion is needed during the conduct of this review to add more information regarding the potential for using this vehicle as a change point of entry.

(E) Healthcare Financing

This section includes the earlier work on the Indonesia PER and ongoing more extensive health PER work. Also included in this section are quantitative and qualitative data analyses on the fuel subsidy and Askeskin program (Arun 2006); ongoing analysis of the Askeskin implementation; and the issues concerning both equity and the implementation of universal insurance coverage as proposed in Law No. 40/2004. In particular attention will be given to a review of what Law No. 40/2004 mandates (every citizen becomes a participant in the NHS insurance scheme; single payer is state managed agency) and what the implications are for Indonesia in terms of sustainable financing. Alternative
implementation options will also reviewed, especially in light of the sub-national health insurance scheme review currently under contract.

1. Analysis of the available data on national and district healthcare spending (NHA and DHA), the sources of financing and revenues: public versus private financing; non-tax versus tax; and the different levels – national, provincial, and local – of financing sources;
2. Benefit, tax/revenue and net incidence of spending (Equitap, it will be determined whether an update of the Equitap studies is needed and feasible);
3. Impact of catastrophic medical spending on impoverishment (based on Equitap, recent PA (2006) and ongoing analysis which shows catastrophic health spending is second cause of falling into poverty);
4. Detailed description of the flows of funds and uses of funds;
5. Public expenditures by program and type of service;
6. Private expenditures by source of payment (i.e., OOP, private HI, etc.) and type of service (depending on data-availability);
7. Organization of healthcare financing (public and private): MoF, MoHA, MoH and other government ministries, including the police, military, and disaster preparedness; public health insurance programs (Askeskin, civil servants – PT Askes, Jamsostek) and private health insurance programs;
8. Public and private purchasing and provider payment arrangements (intergovernmental fiscal flows; MoH and other government providers; Askeskin; civil servants – PT Askes; Jamsostek; and private providers); and
9. In this section the basic issues regarding the transition to universal coverage will be addressed, subject to data availability. The current issues in Indonesia such as how providers are paid, the lack of a common set of incentives, the increased costs of Askeskin and the universal coverage law preparation, the lack of good efficiency incentives will be discussed. Also, international experiences and lessons will be provided. The section will include an assessment of as many of the following set of issues as possible:
   - role of private sector financing/insurance;
   - top down national system or bottoms-up local approach;
   - single versus multiple national programs;
   - single or multiple benefit packages;
   - treatment of informal sector workers;
   - provider payment mechanisms;
   - administrative systems;
   - sources of revenues;
   - needed changes in intergovernmental fiscal formulas, revenue sharing, and dedication of tax bases;
   - impacts on competitiveness;
   - sustainability and availability of fiscal space; and
   - need for capacity building.
(F) Pharmaceuticals

The pharmaceutical section will update existing information using secondary sources. A review of the pharmaceutical sector in Indonesia was carried out in 2003 by the World Bank. While industry issues will be assessed, the focus of the discussion on pharmaceuticals in this review is on the importance of pharmaceuticals in the benefit packages of the Askeskin and under the universal coverage policies of government.

1. Update of situation analysis of the pharmaceutical market in Indonesia; consumption and use of drugs, including generics; expenditures and financing; pharmaceuticals and public sector institutions; the Indonesian drug industry/manufacturers, importers, and trade; and pricing and distribution.
2. National drug policy and changes since decentralization; essential drug list; availability of drugs; affordability of drugs; quality of drugs and counterfeit drugs; rational use of drugs; and traditional medicine.

(G) Need for Comprehensive Health System Reform

This section summarizes the need for reform based on the strengths and weaknesses in the health system as laid out in the assessment above. The political, fiscal and other constraints to reform will be reviewed followed by an assessment that will lead into the next chapter: the health sector reform strategy.

4. Health Sector Reform Strategy

(A) Goals of Reform Strategy

The goals of the reform strategy would be those that are defined in the National Development Plan 2009-14. It is anticipated that the above assessment will be used by the GoI in its goal setting. Policy options are then proposed and estimates of the likely costs of implementation will be presented for each of the following reform areas to assist the GoI in achieving reform goals.

(B) Reform of Public Health and Nutrition Activities

Based on the results of the assessment options will be presented to improve the focus on public health activities and re-emerging diseases and public health problems (MCH, TB, HIV/AIDS, cancer, smoking, nutrition etc.) as well as assuring a balance in financing of these areas in the changing decentralized environment of demand for more curative and costly services. The reforms options will focus on cost-effective interventions, reaching vulnerable populations and will address coordination with the health insurance benefit package and appropriate demand side and consumer awareness measures.

(C) Reform of Organization, Management and Accountability of Health Sector
Based on the assessment, the need for reform would be discussed regarding: the functions, size and structure of MoH; need for administrative systems for health insurance (national, sub-national); capacity and roles of decentralized authorities; service delivery models; public health; regulatory changes regarding private sector oversight; and quality assurance mechanisms, HIS, disease surveillance, systems, etc.

(D) Reform of Health Care Financing

Based on the assessment the policy options for increased coverage and sustainable financing for Askeskin, as well as policy options for achieving universal coverage (the issues raised and reviewed under chapter 3, section E point 9) or possibly proposals for amendments to Law No. 40/2004 based on the findings of the implications in terms of costs of the law’s potential mandates, will be raised.

(E) Reform of Human Resources

Policy options and strategies to adjust the size and composition of the health workforce in line with deployment needs and future demand for services will be discussed, within the context of a large and potentially growing private sector. Skills improvement options, employment conditions and retention options, as well as addressing issues around dual practice and the legal environment regarding financial incentives, will be addressed.

(F) Reform of Health Sector Physical Infrastructure

A review of the potential options to address investment planning based on population health needs and affordability, taking into account both the public and private sector would be discussed. Also options for re-organization of physical infrastructure, changes in the DAK, facilities and equipment as appropriate given public health reforms and health insurance benefit packages would be raised.

(G) Reform of the Pharmaceutical Sector

A discussion around the role of the private sector, and assuring private sector implementation of public health functions may be discussed; options to influence behavior (demand and supply) for rational pre-scribing, dispensing and consumption of drugs; options for improvements in quality and efficiency of drug manufacturing; discussion of options to reform drug policies and essential drug lists and pharmacy practices.

5. Operationalizing the Reform Strategy

(A) Costs and Available Revenues
(B) Timing and Transition Steps
(C) Needed TA and Capacity Building
(D) Piloting Strategies and Related Operational Research Issues