Redesigning Government's Role in Health: Lessons for Indonesia from Neighboring Countries

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SUMMARY

REDESIGNING GOVERNMENT’S ROLE IN HEALTH: LESSONS FOR INDONESIA FROM NEIGHBORING COUNTRIES

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Performance in Indonesia's health sector has been disappointing, despite extensive government involvement.

To improve health care, Indonesia will need to examine the role of government in improving the efficient delivery of health care services. To do this, Indonesia can take a look at the experiences of other countries.

In this regard, there is much Indonesia can learn from Malaysia, Thailand and the Philippines, which have encountered and, for the most part, addressed similar health problems.

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Redesigning Government’s Role in Health: Lessons for Indonesia from Neighboring Countries

By Samuel S. Lieberman, Acting Division Chief, EA3PH

There are a number of questions currently on the agenda in Indonesia, where despite extensive state involvement, the performance of the health sector has been disappointing: What should be the government’s role in improving health outcomes, and what instruments should public authorities employ? How can government health interventions be implemented more effectively and expeditiously? What policies should be used to foster private provision of health-related services?

These questions have also been faced by neighboring Malaysia, Thailand, and the Philippines, which have also invested in publicly financed, government-operated health delivery systems similar to the one established relatively recently in Indonesia. Their varying degrees of success in dealing with these challenges provide valuable lessons for Indonesia.

The Government of Indonesia began to play a major role in health care after 1973, drawing on sharply increasing oil export revenues to finance this effort. The government’s broad aim was to improve the standard of living of the entire population, especially in rural areas, as a way to help disseminate the benefits of a rapidly growing economy. To this end, the government greatly expanded and reconfigured the public health delivery network, increased spending on drugs and related materials, enhanced the capacity for health training and medical education, and hired many new health workers as civil servants.

These initiatives had favorable results, at least initially. By 1980, the infant mortality rate (IMR), a useful broad-gauge indicator of health outcomes, had fallen to roughly 86 deaths per thousand from a 1970 level of more than 100 deaths per thousand. During the 1980s, however, the IMR showed little downward movement, and it took a decade for health to improve again. New surveys indicate that the IMR for the early 1990s was 57 deaths per thousand live births, which is substantially lower than the rate of 75 calculated for 1980-84 and 1985-90. Yet despite these gains, infant survival remains much lower in Indonesia than in Malaysia (IMR= 14 in 1992), the Philippines (IMR= 40 in 1992), or Thailand (IMR= 26 in 1992). Indonesia is now at the stage of health development that these other countries reached or transcended 15-30 years ago.

The government is aware of the slow pace of health advance. Indeed, its five-year development plan (Repelita VI 1994-1999) offers a candid account of the challenges facing the health sector. That discussion is noteworthy for its rounded and nuanced view of health development. Compared to previous planning documents, Repelita VI pays more attention to the efficiency and quality of services in the government-run health system, which has been funded largely from general revenues. It also makes explicit reference to the potential role of private and NGO providers and private financing; and mentions the importance of

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1 These estimates are drawn from the 1994 World Development Report. The rate cited for the Philippines falls between the figure cited by the 1993 National Demographic Survey (33.6) and a figure derived from indirect estimation techniques (48) by World Bank staff (World Bank, 1994a and 1995).
decentralized service planning and management, of household level decisionmaking (with adequate information), and of environmental factors, including clean water and sanitation.

The implementation of Repelita VI has been marked by a number of departures from past health policies. For example, the rate of growth of the government health work force has been reduced greatly, and newly graduating doctors, instead of being offered lifetime tenure as civil servants under the direction of the Ministry of Health (MOH), receive three-year contracts, with no guarantee of renewal. Other health workers are also now hired by contract. A second initiative has been to deploy a new type of field worker, the village midwife (bidan di desa), to give more rural women access to maternal and child care from a trained provider.

The government has also taken steps to sponsor and subsidize community-based water and sanitation investments, to give provincial officials more leeway in health budgeting and spending, to take steps to improve service quality in peripheral facilities, to require public hospitals to improve their efficiency and service standards and give them more autonomy in using retained earnings, and to deregulate aspects of pharmaceuticals production. In addition, government health spending, which had fallen in per capita terms during the final year of Repelita III (1983/84) and during Repelita IV (1984/85-1988/89) but had recovered somewhat during Repelita V (1989/90-1993/94), is projected to rise significantly during Repelita VI. And some potentially important legislation has been passed concerning health insurance coverage.

To date, however, these initiatives have been pursued on an ad hoc basis, and have not coalesced into a revised health strategy. For instance, the promising contract doctor initiative has not been followed up with a broad overhaul of work force allocation or, of management and supervision mechanisms in the public sector; or with a needed review of the quality of medical education and employment opportunities available to private providers. The village midwife scheme has also engendered concerns that have yet to be addressed about the economic viability of this new professional category, as well as the quality of training and the degree of acceptance in rural communities. At the same time, health spending has not risen and decentralized planning has proceeded at the pace envisaged. Central policy guidelines and instructions, conveyed through kanwils, the province-level offices of MOH, still largely determine local health strategies, which are implemented by the dinas, the provincial government health department. Similarly, the hospital reform initiatives have not moved beyond a limited pilot effort, and the regulatory framework and rules of the game regarding public government-mandated health insurance remain unclear.

Moreover, despite the laudable objectives of Repelita VI, the development plan does not offer a compelling analysis of sector problems and challenges. It contains a lengthy discussion of the goals of individual government programs, e.g., family health care, hospital services, health information, and so forth. But despite a preoccupation with public interventions, it offers no persuasive view of how government initiatives can influence health, of the key mechanisms in the sector, or of what public policies and programs—and private roles and incentives—are necessary to secure further advances in the health arena. In short, Indonesian health planners seem to lack a clear vision of what problems and opportunities lie ahead, what solutions are most promising, and how the government, private providers, and other stakeholders can contribute to health development.

THE EAST ASIAN CONTEXT

What can Indonesia learn from health development patterns in Thailand, Malaysia, and the Philippines? Specifically, what can be inferred about the design and efficacy of public interventions, including the possible separation of funding and service provision functions within public programs? What risks and opportunities lie ahead? And what lessons have emerged about the potential role of private health suppliers, the division of labor between public and private providers, and the mechanisms that can be used to improve health system performance?

One justification for looking to Thailand, Malaysia, and the Philippines for lessons is their physical
contiguity to Indonesia and their similar cultural and linguistic contexts. But geographic and social proximity may be confounded by strong differentiating factors. For example, income levels have been higher in these countries than in Indonesia (Table 1), while all four countries differ in their ethnic mix, political systems, and colonial heritage.

A more compelling rationale for using these countries for comparative purposes is the common approach that has been adopted towards health development. All four countries have experienced similar phases of health systems development: initially, a publicly managed, government-financed, multi-tier delivery system was parachuted into an existing setting in which patients had been served by traditional healers and some private practitioners. Subsequently, the public system was more heavily staffed and bolstered in other ways. Later, in response to observed performance problems and resource constraints, government services were fine tuned, often decentralized, and reconfigured in other ways, including differentiating between financing and service provision responsibilities of public agencies. At the same time, private health care surged in importance. This stage has been reached only recently in Indonesia.

Indonesia is the last of the Southeast Asian countries to proceed through this sequence of health system changes. After its creation, the government system expanded substantially during the late 1970s and the 1980s, with the number of health workers employed in public facilities rising from less than 50,000 in 1974 to roughly 190,000 in 1992 (World Bank, 1994). Government staff were divided almost equally between the network of peripheral health centers and subcenters and the country’s public hospitals. By 1993, Indonesia had more than 6500 health centers, each responsible for delivering curative care on an outpatient basis, and preventive services through outreach activities. The latter included support to monthly village gatherings or posyandus, organized by local volunteers to promote child health and nutrition. Health centers had a complement of 13-15 employees, including a doctor, 4-6 nurses and midwives, and various technical and paramedical workers. On average, each health center had three subcenters, each staffed by a midwife and an auxiliary worker, attached to it. Health center staff were also responsible for supervising the newly deployed village midwives. Accessibility to health centers also improved throughout the 1980s, with the average health center servicing 30,608 people by 1992 compared to 32,000 in 1985.

Employment in government hospitals and bed capacity also grew quickly during the phase of health system development. The number of first-line referral (class C and D) hospitals increased from 260 in 1978 to 300 by 1993, and total bed capacity rose by 25 percent. These facilities, plus the country’s 37 referral and teaching facilities, now employ about 78,000 health workers, with another 10,000 serving in mental and other specialized government hospitals.

Comparable public delivery systems were established in Thailand and Malaysia in the 1960s and early 1970s, and somewhat later in the Philippines. The Thai system was organized around district-level community hospitals, each with about 10 beds at least initially. Staff working in such facilities provided curative, preventive, health education and rehabilitative services, and also had responsibility for supervision of and technical support for workers and programs in the rural health centers. These centers, analogous to the Indonesian subcenters, were set up in centrally located villages and served tambons, or subdistricts of 7-10 villages. These facilities which were staffed by a midwife and a paramedic, provided prenatal, postnatal, and delivery care; immunization; family planning and nutrition services; water supply and sanitation advice and supervision; and limited emergency treatment. By the mid 1970s, more than 70 percent of the rural population had access to fully staffed and equipped health centers, while the cover-
Table 1: A Comparison of Indicators

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Indonesia 1992</th>
<th>Malaysia 1964</th>
<th>Thailand 1975</th>
<th>Philippines 1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality Rate (per thousand live births)</td>
<td>56</td>
<td>58</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (as % of married women age 15-59) a/</td>
<td>55</td>
<td>9</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td>Modern prevalence rate (as % of married women age 15-49) a/</td>
<td>52</td>
<td>n.a.</td>
<td>34</td>
<td>16</td>
</tr>
<tr>
<td>Total Fertility Rate, interpolated (no. of births per woman)</td>
<td>2.9</td>
<td>6.4</td>
<td>4.6</td>
<td>4.9</td>
</tr>
<tr>
<td>Daily calorie intake</td>
<td>2631 e/</td>
<td>2395</td>
<td>2288</td>
<td>2113</td>
</tr>
<tr>
<td>Access to safe water (as % of population) b/</td>
<td>42</td>
<td>29</td>
<td>25</td>
<td>43</td>
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Demographic

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<tbody>
<tr>
<td>Total population (in millions)</td>
<td>184.1</td>
<td>9.2</td>
<td>41.4</td>
<td>46.2</td>
</tr>
<tr>
<td>Urban population, interpolated (as % of total)</td>
<td>32.5</td>
<td>29.2</td>
<td>15.1</td>
<td>36.7</td>
</tr>
<tr>
<td>GNP per capita (in constant 1992 prices, US dollars)</td>
<td>665</td>
<td>951</td>
<td>738</td>
<td>873</td>
</tr>
<tr>
<td>Population density (no. of people per sq. km land area)</td>
<td>97</td>
<td>28</td>
<td>81</td>
<td>155</td>
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</table>

Investment in Human Capital

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<tbody>
<tr>
<td>Expenditure on health (as % of GDP) c/</td>
<td>1.8%</td>
<td>3.3%</td>
<td>3.8%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Per capita expenditure on health (constant 1992 prices, US dollars) c/</td>
<td>12.5</td>
<td>48.5</td>
<td>35.1</td>
<td>24.3</td>
</tr>
<tr>
<td>Public (constant 1992 prices, US dollars)</td>
<td>4.4</td>
<td>31.4</td>
<td>8.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Private (constant 1992 prices, US dollars)</td>
<td>8.1</td>
<td>17.1</td>
<td>26.9</td>
<td>17.8</td>
</tr>
<tr>
<td>Public (% of total expenditure on health)</td>
<td>35%</td>
<td>65%</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td>Private (% of total expenditure on health)</td>
<td>65%</td>
<td>35%</td>
<td>77%</td>
<td>73%</td>
</tr>
<tr>
<td>Health expenditure as a share of central government expenditure (%)</td>
<td>2.4% f/</td>
<td>9.0% g/</td>
<td>3.0% j/</td>
<td>4.3% l/</td>
</tr>
<tr>
<td>Population per physician</td>
<td>6200</td>
<td>6202 b/</td>
<td>8394</td>
<td>3150 m/</td>
</tr>
<tr>
<td>Population per nurse d/</td>
<td>1682</td>
<td>1316 b/</td>
<td>1167 k/</td>
<td>1050</td>
</tr>
<tr>
<td>Population per hospital bed</td>
<td>1502</td>
<td>277 l/</td>
<td>899</td>
<td>606</td>
</tr>
<tr>
<td>Gross enrollment ratio, primary, female (% of school age population)</td>
<td>113</td>
<td>84</td>
<td>80</td>
<td>110</td>
</tr>
<tr>
<td>Gross enrollment ratio, primary, total (% of school age population)</td>
<td>115</td>
<td>90</td>
<td>83</td>
<td>110</td>
</tr>
<tr>
<td>Illiterate population (% of pop. age 15 and over)</td>
<td>23</td>
<td>41.5</td>
<td>21</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Notes:

- Figures are from World Bank's Economic and Social Database unless otherwise specified.
- "n.a." means data not available.
- a/ Data from Malaysia from 1964-66 (Family Survey 1966-67); Thailand and Philippines from World Fertility Survey for respective years.
- b/ Figures for Malaysia from 1970; Philippines from 1975 and Indonesia from 1991.
- c/ Figure for Indonesia from 1991 (WDR 1993); Malaysia from 1966 (Heller 1975); Philippines and Thailand from 1976 (Over 1991).
- d/ Include auxiliary nurses and paraprofessional personnel such as traditional birth attendants.
- e/ 1990 data
- f/ 1991 figures (WDR 1993)
- g/ Data is from 1966 and for current expenditure only (Heller 1975).
- h/ 1965 figures
- i/ Interpolated from data available (WHO 1983).
- k/ 1973 data
- l/ World Bank, 1987
- m/ World Bank, 1984
- Data from Indonesia from World Bank, 1994; Malaysia from 1965 (Heller 1975) and Thailand from 1975.

Sources:

In Malaysia, a government health system was introduced in the mid 1950s, and by the early 1970s, nearly 90 percent of the population was living within five kilometers of a public primary facility (Government of Malaysia, 1978). In each district or subdistrict, the health center supervised delivery of services to a rural population of roughly 50,000. There were four subcenters (village clinics) associated with each health center, each serving a client population of 10,000. Health centers and subcenters had the same core staff of hospital assistants, assistant nurses, midwives, and public health inspectors; in addition, the main center had a doctor (when available), a nursing sister, and a health inspector who managed the activities of all health units in the service area. Some health centers also had a number of beds for emergency cases. Finally, attached to each center and subcenter were five midwife clinics, each staffed by a trainee midwife (bidan) who provided antenatal and postnatal services.

The Philippines, by the early 1950s, was already well endowed with public hospitals in cities and towns. The government then began setting up rural health units (RHUs) to provide general outpatient, maternal, and preventive care to the rural population. More than 1200 RHUs were in place by 1974. When the system was restructured in the mid 1970s, more RHUs were constructed, and these units were given responsibility for barangay health stations (BHS) set up to serve surrounding villages. By 1981, there were about 2000 RHUs, each serving 20-30 thousand people, and 8,000 BHSs, each covering 3-4 barangays and up to 5000 people. Each RHU was headed by a municipal health officer and staffed by a public health nurse, a sanitary inspector, and 4-5 public health midwives (World Bank, 1984). Each BHS was staffed by a trained midwife and several volunteer health workers from the barangay. The services available through the RHUs and BHSs resembled those delivered by the Malaysian and Indonesian health centers and subcenters and the Thai community hospitals and health centers: maternal and child care, family planning and nutrition advice, control of specific diseases, some dental care, environmental sanitation supervision and assistance, and health education.

DIFFERENTIAL OUTCOMES

Despite their similar histories, the government-run delivery systems in the four countries have had differing results. Although child survival prospects are now much higher in Thailand, Malaysia, and the Philippines, the IMR and other health outcome indicators have remained at unsatisfactory levels in Indonesia. Some cities, e.g., Jakarta and Yogyakarta, and some districts in Central and East Java, Bali, and Sumatra have achieved IMRs of less than 50 per thousand, but elsewhere, especially in the Outer Islands and in economically undeveloped areas in Java and Sumatra, health advances have been more circumscribed. Moreover, utilization rates and other measures of service performance in Indonesia have been well below expectations. For example, only about a quarter of those interviewed in 1992 said they visited a government facility when ill — fewer than reported in the 1987 round of the same household expenditure survey. Other surveys suggest that rural and urban residents visited a health center or subcenter once or twice a year, while still other sources say that in the early 1990s, health centers had fewer than 50 visitors a day, many coming for only minor complaints or follow-up matters. This figure was much lower for facilities located outside Java and Bali. In both Java and Bali and the Outer Islands, then, actual demand for health services in public facilities has been less than anticipated in the government's ambitious service delivery plan (World Bank, 1994).

On the other hand, the proportion of those who were ill and consulted private providers has continued to rise, and at over 34 percent in 1992, exceeded the government facility visit rate by a substantial margin. Use of private health care suppliers has been observed even in low-income households — in urban Java, nearly a third of those in the lowest four income deciles consulted private providers when ill. And by all accounts, the scope and importance of private health provision have risen sharply in Indonesia in the last decade. There are now many part-time as well as full-time private sector jobs available for doctors and other health workers in urban centers and also in prosperous
rural settings in Java, Bali, and Sumatra. Additional opportunities would emerge if an appropriate policy framework and procedures were worked out governing coverage and delivery of health services under prepaid health insurance schemes. Private participation in such schemes could suffer if the health insurance component of the 1992 Social Security Law (JAMSOTEK) were to be implemented in such a way that it limited provision of health care to government facilities. But the insurance framework (JPKM) included within the 1992 National Health Law would promote private involvement through its envisioned system of competing managed care programs (Sutopo, 1995).

Why has the utilization of government facilities remained so low? Factors such as distance or difficulty in reaching health centers and subcenters, travel and user fees, absences of key staff, and lack of medication may all deter people from using the government system. Even though the significant expansion of the system in the 1980s diminished these factors by improving access to facilities and increasing trained staff, the quality of care has been slow to improve. Quality pertains not only to the availability of skilled staff, drugs, and equipment, but to the nature of client-provider interactions, and the effectiveness of examinations, diagnoses, and the use of staff time. Various studies suggest that local residents typically do not have a high regard for the quality of services provided in government facilities (see Sciortino, 1992).

As noted, the child survival rate is now much higher in Malaysia and Thailand, and somewhat higher in the Philippines, than in Indonesia. However, infant mortality in these three countries was once as high as it is in Indonesia. Moreover, the public delivery systems in these countries has faced the same problems that Indonesia is now confronting. For instance, the use of Thai community hospitals and health centers was quite low in the early 1970s — in 1970, these facilities attracted only 16 percent of those who were ill, while 30 percent went to private providers and traditional healers and the rest treated themselves (Roemer, 1981). The low utilization was attributed to many of the same factors that are now affecting the public health system in Indonesia — physical and sociocultural distance between patients and government personnel, ineffective community participation, poor quality of services, high informal charges for care in public centers, and the divided loyalties of the staff, who typically maintain remunerative private practices in the afternoons and evenings.

In Malaysia, too, surveys in the late 1960s and early 1970s found that up to a quarter of all villages did not have easy access to primary health services, and that a significant number of women and children were not making appropriate use of available antenatal, delivery, family planning, and immunization services (Government of Malaysia, 1978). Likewise in the Philippines, a 1978 survey found that only 16 percent of respondents went to public facilities when ill, while 30 percent went to private providers and the rest treated themselves (World Bank, 1984). Low utilization was attributed to the limited credibility of the public system due to poor maintenance of health centers, frequent breakdowns in the supply chain for drugs and materials, skill shortages, inadequate staff supervision, and poor prioritization of field workers’ tasks.

But these difficulties have been resolved or circumvented in Malaysia, Thailand, and to a lesser extent, the Philippines. For example, by 1979, Thai public facilities attracted 27 percent of people who were ill, and by 1985, they attracted 47 percent (Baum and Strenski, 1989), while in the late 1980s Malaysians were visiting health units, on average, nearly five times a year. During the same period, as noted, Indonesians contacted such facilities only once or twice a year on average often for minor or follow-up requests. Health outcomes also showed striking gains in the three comparator countries, especially in Malaysia and Thailand. Malaysia’s IMR had fallen below 55—roughly the current Indonesian level—by 1965, and continued falling, to 45 in 1970, 37 in 1975, and 17 in 1980. Thailand and the Philippines each attained IMRs in the mid 50s by the late 1970s. Thai rates continued their rapid decline, while child survival improved much more slowly in the Philippines, with little noticeable change during the early and mid 1980s.
ENHANCING THE IMPACT OF PUBLICLY PROVIDED SERVICES

How did these three Southeast Asian countries overcome their health delivery problems? Undoubtedly, this achievement was due in part to factors that are not applicable or transferable to Indonesia. For example, Indonesia is much larger in area and population, and far more diverse culturally and ethnically. Moreover, per capita income in Malaysia in the mid 1960s and in Thailand and the Philippines in the mid and late 1970s, respectively, was higher than mean income is now in Indonesia. As a result, these countries were able to spend more public- and private-funds per capita on health, including on hospital beds and nursing personnel (Table 1). On the other hand, Indonesia had several advantages over these countries during those decades, including higher literacy, primary school enrollment, and contraceptive rates, and higher average levels of caloric intake.

Yet despite these differences in income and spending, some of the initiatives pursued in these countries may be adaptable to the Indonesian setting. Of special interest are the policies used to refashion public service delivery systems that had not elicited sufficient public interest. All three countries attempted to make publicly provided services more accessible and attractive, particularly for the poor and others facing higher than above average health risks. Each country pursued a somewhat different approach.

In Malaysia, in the late 1960s and early 1970s, planners altered service delivery policies after determining that despite improvements in vital rates, all regions and groups had not shared equally in health gains. Subsequently, during the Second (1971-75) and Third (1976-80) Malaysia plans, real per capita government health spending was sustained at high levels while authorities made a variety of policy adjustments. Intensive efforts were made to identify areas with limited access to health facilities and also to document and understand, through household surveys and group discussions, the reasons that some population groups did not like to use the health centers and subcenters (Pathmanathan and Bin Sahan, 1988).

In light of such findings, the delivery system was reduced from three to two tiers; subcenters were enlarged and upgraded to centers (one for every 15,000-20,000 people), and midwife units became village clinics. And pending the construction or upgrading of facilities, mobile clinics made fortnightly visits to underserved target groups. At the same time, many community water supply and sanitation projects were implemented using local volunteer workers (gotong royong) and nominal household sewer contributions for household connections and toilet bowls.

Malaysia overcame its critical shortage of doctors by introducing compulsory two-year service in the public health system for newly graduating doctors, recruiting physicians from abroad, and building more staff housing in rural areas. At the same time, well prepared mid-level personnel were assigned a critical role in health service delivery. Hospital assistants with eleven years of general education and two years of specialized clinical training emerged as the main suppliers of curative care in health centers and in hospital outpatient wards. Preventive services, especially those pertaining to reproductive health and child survival, were assigned to a new category of village nurses (jururawat desa). The professionalism and focus of the workforce were bolstered by strictly forbidding public employees to moonlight and requiring them to work a full day (8 hours) and a full week (5.5 days). Training activities were intensified, existing facilities were consolidated into regional centers and expanded, medical school and nursing entrance and graduation standards were raised and made uniform, and retraining of existing workers was vigorously pursued.

The training emphasized staff productivity and the quality of health services, and the intensified supervision included the innovative step of investigating each death during childbirth. A related measure was the introduction of a systematic quality assurance program for facilities, which involved measuring appropriate indicators and developing remedial strategies for problem facilities. Service quality also benefitted indirectly from the strong accreditation and malpractice review powers accorded to the statutory Medical Council.
The above measures were facilitated by the steps taken to strengthen middle-level health management, which were consolidated during the Fourth Plan (1981-85). This effort strengthened the problem-solving and decisionmaking skills of management teams at the facility, district, and state (provincial) levels through training and the use of health systems research as a management tool.

A final factor in Malaysia's success was that states were encouraged to pursue their own health initiatives. (Under the country's federal system, states have broad powers to implement such initiatives.) Another useful institutional vehicle were action committees at the district, state, and national levels, which provided a mechanism to achieve intersectoral coordination and to closely monitor agreed upon benchmarks.

Thai and Philippine health planners also went through stocktaking exercises during the mid and late 1970s, based on analyses of service utilization information and household surveys, and adopted policies similar to those in Malaysia.

In Thailand, real per capita government health spending was sustained at high levels, and many new district hospitals and health centers were constructed during the Fourth (1977-81) and Fifth (1982-86) plans. In addition, preservice and in-service training of doctors and other health workers was intensified, and many new staff (including mid-level nurse practitioners and midwives) were hired, with three years of service required after 1974 for all new medical graduates. (Part-time private practice was permitted to induce "conscripted" doctors to establish themselves in rural settings.) The poorest districts were targeted for enhanced service provision, and the poor in all regions were exempted from fees for facility use and prescriptions (Nittayaramphong, 1990; Mills, 1991). Also, the semi-independent Medical Council, established in 1968, was strengthened and given broader powers to register, certify, and regulate doctors and evaluate their performance. Finally, authority for various nationally orchestrated vertical programs, as well as ongoing hospital and health center-based and outreach activities, was devolved to new operational units.

Provincial Health Offices, leaving the central Ministry of Public Health free to concentrate on planning, coordination and technical support activities.

In the Philippines, health authorities turned, in the late 1970s and early 1980s, to training and staff recruitment measures and facility construction and repair to extend and intensify health services. In its 1980-85 plan, the government targeted about 20 percent of the country's 53,000 villages for stepped up primary health services, including water supply and sanitation interventions. But perhaps the most significant initiative of this period was the reorganization and deconcentration of government health activities. A 1979 functional analysis had found the public system to be excessively centralized, with fragmentation and duplication between central and field units, and with weak linkages between rural health and vertical programs, e.g., centrally run, disease-specific campaigns, and between central and field units (World Bank, 1984).

Under a follow-up executive order in 1982, the centrally run, vertical programs were eliminated, and their field personnel were integrated into provincial health services; special (central) programs offices became bureaus without their own operational staff; long-autonomous provincial hospitals and rural health services were combined; and financial and administrative responsibility for all delivery of public services was delegated to the provincial level. During the ensuing period, provincial health offices were given expanded authority over budgetary actions, personnel actions, and operational decisionmaking. These offices demonstrated that they were capable of generating and using health status and management information, formulating local plans consistent with national policies, and transforming strategies and targets into budgeted programs. The central health ministry, for its part, took on the role of providing national-level leadership and coordination through its specialized bureaus and program offices, inter-sectoral committees and task forces, and collaboration with NGOs (World Bank, 1984).²

In contrast to the Malaysian approach, Thailand and the Philippines made major efforts to engender sustained

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² Extensive health system deconcentration in the 1980s has been followed in the 1990s by far-reaching decentralization of authority and resources to elected barangays and municipal and provincial governments. Under the 1991 Local Government Code, elected authorities assume full responsibility for financing and delivering public health services. The implications of the 1991 Code for health service delivery are still being analyzed (World Bank, May 1994).
community involvement in health care. Malaysia has taken some steps in this direction by including health activities in the government-sponsored community development movement (Gerekan Pembaharuan, or Operation Renewal). But the Thai strategy went much further, probably reflecting tighter constraints on government health spending and the larger population and geographical area to be served. The key steps, tested in several carefully monitored pilot projects in rural Thailand in the 1970s, involved training and deploying thousands of village health volunteers (VHVs) and village health communicators (VHCs) who were chosen from the ranks of the VHVs. VHVs disseminated health and hygiene information and education to groups of 8-15 households within villages, while the VHCs (one per village) were taught how to respond to common diseases, accidents, and injuries. These volunteers worked closely with staff from nearby government facilities, obtaining supplies and technical support and supervision from public personnel, and benefitted from several incentives including free medical care and local recognition (Nittayaramphong, 1990; Roemer, 1981). The VHVs and VHCs brought the public system into closer contact with households, particularly in underserved or low utilization areas. A final feature of the Thai approach was the extensive involvement of community organizations and NGOs in health education and service provision. Government field staff were able to mobilize and work constructively with village committees, the tambon councils; with sanitation cooperatives; and with youth and women’s groups in the pursuit of common health objectives.

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The Philippines also relied on community volunteers to supplement and support government service delivery efforts, although the results were less impressive. That effort centered on barangay health workers (BHWs), part-time village volunteers who assisted government midwives with curative care in clinics and with some preventive and outreach tasks, e.g., weighing and deworming children and surveying communities. BHWs, who received limited training when recruited and were supervised informally by the midwives, were not on the public payroll but received some compensation, i.e., fees for service or a stipend, from their villages.

In a 1980 survey, doctors and nurses in the Philippines credited the BHWs with extending health services to previously inaccessible areas. However, they expressed concern about the high annual turnover rate of over 20 percent in this cadre. Government health staff wanted to try to sustain the motivation and commitment of the BHWs by paying them salaries and offering various non-monetary rewards, strengthening the rather weak supervision and in-service training and recruiting hilots, trained indigenous practitioners (World Bank, 1984). But this view was challenged by those who felt that the BHWs should operate not as part of the government health services but as local organizers and facilitators who could tackle a variety of problems (Bautista, 1989). They wanted these barangay development workers to get some publicly funded training to improve their organizational and technical skills, but to be managed by and responsible to individual communities. Unfortunately, this vital debate over the role and responsibilities of volunteer workers was overshadowed by the economic and fiscal crisis of the mid 1980s, which led to a sharp decline in both government and private health expenditures. These spending reductions, which made it difficult to sustain the oversight and close supervision needed to deliver high quality primary health care, may account for the lower rate of decline of the IMR during this period.

**FOSTERING PRIVATE HEALTH SERVICE PROVISION**

A second distinctive aspect of the health environment in the countries adjacent to Indonesia has been the extensive involvement of private suppliers of health care and related services. This has been especially significant in Thailand and the Philippines, where large

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3 Nittayaramphong (1990) credits the VHVs and VHCs with the large improvement in villages’ access to clean drinking water, immunization coverage, and children’s nutritional status.
and diverse private health networks were already in place when the publicly run delivery systems were enlarged. Private care capacity then continued to grow, at times very rapidly.

In the Philippines, value-added in private medical services increased by 16 percent a year during the 1970s and early 1980s. By 1985, private hospitals, which were typically small and widely dispersed, accounted for more than half of all facility beds, and private health outlays made up more than 70 percent of total health spending, with more than 70 percent of doctors and half of all trained health workers employed in this sector (Griffin and Paqueo, 1987). In Thailand, the number of doctors working full time in private hospitals grew four-fold in the 1980s, and private hospital bed capacity doubled. Significant private health sector expansion occurred somewhat later in Malaysia, in the 1980s, continuing into the 1990s. Private doctors, whose numbers grew by 300 percent between 1980 and 1993, accounted for more than half of all physicians by the early 1990s. Private hospital beds, most of which were in small facilities and nursing homes, grew by 400 percent during the 1980s and accounted for 20 percent of the national total by the early 1990s (Suluman, 1995).

Private providers, including physicians trained in medical schools as well as paramedical workers, pharmacists, and traditional healers and midwives, increased the scope and variety of service alternatives that were available in these countries, and therefore made it more likely that potential patients would seek some form of care, from either government or private suppliers. The presence of private practitioners also gave government planners more latitude to target health initiatives to areas that had the most critical need. For example, with the increase in private health care, Thai authorities were able to step up health delivery and promotion efforts in rural areas, particularly those with low vital indicators.

Several policy decisions and background factors contributed to the private sector assuming such a significant role in the health system, particularly in Thailand and the Philippines. First, health authorities typically endeavored to work with rather than exclude and disenfranchise indigenous healers and midwives. In Thailand, traditional practitioners were recognized and registered, covered in surveys of medical care, and included in the training and health promotion efforts sponsored by district hospitals and health centers. In the Philippines, 40 percent of all midwives had been trained to assist in primary health care by 1985 (Bautista, 1989). In Malaysia, trained government midwives initially encountered only limited community interest, in part because of local loyalty to the traditional bidan kampong. This resistance was overcome by asking government staff to be more respectful and encouraging individual states to develop complementary roles for the two types of midwives (Laderman, 1983). In Kalantan, for example, bidans were registered, trained, integrated into the health team, and paid fees to act as health and family planning motivators and to take up other tasks (Chen, 1981).

Second, private health provision was stimulated by the pro-growth policies and rapid income gains in these countries. The rapid growth of the Thai private health sector in the 1980s was fueled by rapid income gains and subsequent rising demand - an income elasticity for health care of 1.6 was estimated using Thai data for the mid 1980s (cited in Bennett and Tangcharoenathien, 1994). The strong private health supply response was encouraged by the government's stable and supportive macroeconomic and fiscal policies. Private health investors also responded to incentives, e.g., import duty waivers and exemptions on medical equipment, as well as tax holidays and rebates provided by the Board of Investment through its hotels and hospitals division. Private health suppliers also benefitted from a relatively open market environment in the Philippines — private and secondary private hospitals were exempted from duties on medical equipment and drugs, had access to loan financing, and were treated for tax purposes like any other private business. In addition, facility licensing requirements and procedures were straightforward and transparent (Griffin, 1993).

Third, private health care suppliers benefitted from changes in government health investment and financing strategies and other sector-specific policy adjustments. An example was the Thai health
ministry’s decision not to invest in additional urban health facilities, leaving the field open for the private sector; later this decision was modified to cover hospitals in rural areas as well. Similarly, public outlays on hospitals in the Philippines in the 1970s appeared to largely complement rather than compete with private investment — the government seemed to take advantage of the private sector’s presence by financing hospital construction, for the most part, outside Manila. Unfortunately, this pattern was reversed in the 1980s.

Another significant example was the decision to allow the Philippine public sector insurance scheme, Medicare, to pay providers of inpatient services in private as well as public facilities. This decision, which introduced a clear distinction between the government’s health financing and service provision roles, created powerful incentives for private health service supply (Griffin, et al., 1992).

In retrospect, much can be learned, especially from Thailand and the Philippines, about the challenges and risks associated with private health sector development. Three issues needed particular attention: private spending on medical equipment, the scope and design of health financing and service payment, and the regulation of private health suppliers. First, in regard to private spending on medical equipment: in Thailand, there appears to have been considerable, very likely excessive investment during the 1980s in high technology devices — in 1988, there were 108 CT scanners in the country, most of which were in privately owned facilities in Bangkok (Bennett and Tangcharoensathien, 1994). This capital spending was encouraged by import duty exemptions and by efforts to attract patients through non-monetary incentives. The risk is that such outlays will lead to rapidly rising health care costs and to supplier-induced demand for services.

Second, the scope and design of health financing and service payment arrangements also influenced the private health sector response. In the Philippines, the payroll-based, publicly run Medicare scheme covered more than 40 percent of the population by the mid 1980s and had become an important source of private health revenues. Still, observers noted several program flaws which conditioned and distorted the private supply response (Griffin, et al., 1992). For example, reimbursement procedures fixed repayment rates for a list of services and also set benefit ceilings. These arrangements favored smaller, less sophisticated hospitals, which were consequently able to recover a larger share of their costs from Medicare. Such arrangements, including the limits on hospital inpatient care, led to a proliferation of small-scale, less efficient hospitals and rewarded the provision of ineffective or unnecessary treatment. The way Medicare was organized also increased processing costs. Moreover, its designation as the primary risk-sharing mechanism, and the labor regulations requiring direct service provision in large companies, have slowed development of the private health insurance industry, including managed care. Finally, the scheme’s design as a form of protection against catastrophic losses was undermined by persistent consumer and producer behavior, specifically claims for reimbursement for non-life threatening medical problems. (Griffin, et al., 1992)

On the other hand, health insurance options emerged less rapidly in Thailand where until 1990, when the Thai Social Security Act (SSA) was adopted, the largest scheme in place covered only six million government workers and dependents. The health card facility, which promoted primary care in participating villages, benefitted another 2.7-3 million people, while the Workmen’s Compensation Fund insured employees in large firms against work-related illnesses. Another 200,000 people were insured through private arrangements. The SSA, which was implemented beginning in 1991, mandated coverage for those working in firms with more than 20 employees, thereby adding another three million beneficiaries to those with health insurance (Nittayaramphong and Tancharoensathien, 1994).
SSA permits private hospitals to compete with public facilities in treating patients. Payments to providers under this scheme are fixed at B700 (roughly US$28) per patient per year, in order to contain costs and prevent oversupply of service — less than a full commitment to funding private health care. Another issue that has emerged in Thailand is the sharply increasing number of claims under Workmen’s Compensation, which covers the same employees and reimburses providers on a fee for service basis. Providers have an incentive to shift the costs of treatment for many ailments to Workmen’s Compensation because it is not capped. The SSA intended to open up coverage to voluntary participants by 1994.

In short, the coverage of largely publicly managed health insurance arrangements in Thailand has widened in successive steps, although much of the population remains without protection. The embryonic and fragmented state of health insurance in Thailand may not have inhibited private health services in the 1980s since the country was testing approaches. However, at this point in time, the lack of a health insurance framework with broad coverage and attractive payment features may be an obstacle to further private health development, particularly since questions about the institutional capacity of the social security office to extend coverage into rural areas, and about how SSA-authorized coverage will be aligned and/or merged with other insurance schemes, remain unresolved.

In Malaysia, health planners became aware of the need for a comprehensive health financing framework during the 1980s, when the private health sector expanded and a fledgling private insurance market emerged. The impact of private sector growth was detected when the public facilities began to have difficulty maintaining staffing levels. The government’s near-term response was to raise the salaries of public personnel. Understandably, questions arose about the feasibility of matching private sector earnings levels, and about possible declines in quality that could follow further departure of professional staff. Accordingly, the government’s approach to health finance and insurance, which was reflected in a major study issued in 1987, also encompassed efforts to help the public system sustain high quality and equitable service delivery. The study recommended that a universal package of curative services be delivered by public and private care providers, who would be reimbursed by a National Health Security Fund. This fund would be financed by mandatory premiums paid by employers and the self-employed, and by the government on behalf of the poor. Various options for paying private providers, and for avoiding the escalation of costs observed in countries such as South Korea, have been explored. Despite continuing debate, no decision has been made on the crucial features of this proposed program, and government-financed, publicly delivered services continue to dominate the health system.

Finally, in hindsight it is possible to identify ways in which policymakers in each of the three countries could have improved the complementarity between public and private health initiatives. For example, greater efforts could have been made to purchase private inputs and services. In Malaysia, a brief attempt was made to enlist private doctors to provide hepatitis B immunizations; and private doctors are being used on a trial basis to supply specialist services in three districts (Bennett, et al., 1994). Except for pharmaceuticals (especially in the Philippines), however, there has been little contracting for private services to support and extend government-run facilities, even though this mechanism could be used to obtain specialized professional skills, as well as training, management, laboratory, food, custodial, computer, and other services. Large-scale contracting for such services would have boosted private health care delivery.

Insufficient coordination between the public and private health care systems has been seen in the low utilization of government hospitals and staff in some areas and neighborhoods in which there was active private competition. For example, it appears that Philippine health authorities could have been more successful in the late 1970s and 1980s in targeting public service provision and subsidies to localities that had the greatest need. Instead, in the face of an increased presence of private hospitals in all regions, the government continued to maintain and even expand its hospital network, despite indications that many
public facilities were poorly used and inefficient (Griffin, et al., 1992). More could have been done, to reduce the large share of the budget allocated to hospitals and to shift funds to communicable disease and preventive health activities, for which the government was largely responsible.

It is worth noting that further devolution of health service responsibilities in the Philippines to local governments, which began in 1991, could improve the public-private division of labor in health. Under the new system, fiscal pressures will likely compel the now municipally owned hospitals to compete more extensively with private facilities, which could lead to changes in the number and characteristics of service providers. The coordination problems that may arise in this setting will likely fall primarily within the public sector. Thus, there is a risk that efforts to control communicable diseases may suffer in this new environment because of the weakening of vertical programs run by central or provincial offices (World Bank, 1994a).

A third matter that needed more sustained public attention was regulation of private health suppliers, particularly their service quality standards and the minimum qualifications of personnel. All three countries have established statutory and regulatory frameworks regarding registration of private practitioners, training and harmful or unethical medical practices. For example, Thailand’s Health Ministry is responsible for annual registration of all private facilities, and for ensuring that private clinics satisfy specified standards. Malaysia has established similar requirements. In addition, medical councils and professional associations play a quasi-regulatory role, including accrediting training programs and examinations, disciplining members, and setting guidelines for fees for specific services. Consumer groups have also begun to focus on health care. In Malaysia, NGOs have drawn up a charter covering patients’ rights for both public and private services (Bennett, et al., 1994).

However, these efforts have been hampered by lack of information about cases treated by the private sector. In Thailand, the response rate to the annual survey of private practitioners has been very low, and professional associations have been unable to provide current information on their members or on the number and type of cases they handle. Regulatory activities by government agencies and professional bodies in all three countries have also been hampered by funding, staffing, and skill constraints. In this setting, there has been a passive approach to regulation, with watchdog entities responding to complaints and to blatant instances of negligence and unethical conduct, but not taking initiatives to actively enforce medical standards.

The regulatory framework governing private health care delivery is still taking shape in Thailand, Malaysia and the Philippines, facing challenges in a number of areas, including:

- Resolving competing health interests and priorities among different government agencies;
- Using incentives more effectively to encourage private providers to modify some practices and to become involved in specific activities and/or geographic areas;
- Enabling and inducing parastatal regulatory bodies and professional associations to be more proactive in meeting their responsibilities;
- Ensuring that medical education and training programs for health workers include material on professional ethics, clinical standards, the rationale for regulation, and business and auditing practices; and
- Ensuring that consumers, community representatives, and local authorities provide significant inputs to regulatory processes.

IMPLICATIONS AND CONCLUSIONS

Beginning in the mid 1970s, Indonesia invested in government-run health delivery arrangements similar to these already in place in Malaysia, Thailand, and the Philippines. This system currently operates through some 6500 health centers and 18,000 subcenters, staffed by a sizable health work force trained through publicly supported programs. This work force includes a significant number of recently deployed village
midwives. The extension of this network of facilities and staff has been associated with a gradual improvement in health outcome indicators, e.g., the infant mortality rate. However, direct measures of performance, such as facility utilization rates, remain low, and it is not clear that the government system has established itself as a credible and reliable service provider among low and middle-income Indonesians.

To some extent, performance problems within Indonesia’s public system are attributable to persistently low levels of health spending. All three of the country’s neighbors allocated considerably more public as well as private resources to health on a per capita basis (Table 1), and Indonesia usually rates poorly in cross-country analyses of government health outlays (Griffin, 1990). As mentioned above, health spending in the country plunged during the economic adjustment of the mid 1980s, but then returned in the early 1990s to the modest funding levels established a decade earlier. Health outlays remain low despite large number of facilities and the huge work force supported by public funds. This is due largely to the low civil service salaries and wages of health staff, who have been encouraged to supplement their income with earnings from private practice.

But chronically low spending levels provide only a limited, proximate explanation for disappointing health performance. Even within tight overall fiscal constraints, expenditure levels can be raised over time by reallocating resources in the substantial government budget, especially if health officials can make a strong case for spending increases. In the short run, international loans and grants can also be used to secure additional resources. Indeed, a number of donor-supported health projects were initiated in the early 1990s, and Indonesian borrowing for health could rise further thanks to the enhanced availability of Japanese aid funds.

However, health policymakers thus far have not been successful in securing a significantly larger share of the government budget. Moreover, authorities seem uncertain on how to make a convincing case for increased funding, or what measures they should pursue to achieve rapid, substantial, and sustainable health gains. Many promising policy initiatives adopted during the last three years, in response to concerns about performance, have not been followed up, while others have languished as pilot efforts or are proceeding without clear outcomes. In general, the adjustments that have been introduced have not been brought together into a coherent strategy for health sector development.

It is in this context that the health policy lessons from Malaysia, Thailand, and the Philippines are instructive. Important adjustments were made in these countries when the IMRs plateaued at roughly 55 deaths per thousand births after which decisionmakers determined that new initiatives and approaches, coupled with sustained levels of public spending, were needed to secure further health advances. Following these adjustments, health status indicators in Malaysia and Thailand improved substantially, while those for the Philippines increased at a modest rate. This is not definitive proof of a cause-effect relationship between specific policy interventions and health outcomes. It is notable, however, that changes in the health systems in these countries were accompanied by favorable impact indicators, including increased utilization rates and lower IMRs. Trends in the Philippines were the exception that proved the rule. Philippine reforms initiated in the late 1970s brought only marginal health gains in the 1980s, with this “stall” attributable to the sharp fall in public health spending in the mid 1980s during a period of both national economic crisis and decreasing private health outlays.

The Malaysian model? Within our Southeast Asian sample, the Malaysian example seems, at first sight, to be the most promising in terms of lessons for Indonesia. Malaysia’s rapid health advances—IMR fell from 55 in 1964 to 17 in 1980—occurred within the framework of a public delivery system that achieved substantial gains in coverage and utilization. These gains were the result of investments in fixed and mobile facilities and water and sanitation projects, and of skillful management and supervision of a well-trained, highly motivated government work force, which improved the quality of service.
Malaysia's health accomplishments have not gone unnoticed by Indonesian planners. Indeed, several recent initiatives in Indonesia, e.g., deployment of trained village midwives, are reminiscent of elements of the Malaysian program in the 1970s. However, Indonesian health authorities have been unable to emulate the management, supervision, and service quality dimensions of the Malaysian approach, and may not be able to do so because budgetary constraints have made the system dependent on a low wage, low skill work force. Although extensive in-service training has been used to remedy these deficiencies, pay restrictions remain a bottleneck. While the low wage policy continues, it will be virtually impossible to introduce Malaysian standards of professionalism and job commitment, or to ban private practice. A related disadvantage is Indonesia's decision to rely exclusively on doctors as facility and health district managers. As mentioned, Malaysia was forced, due to the scarcity of doctors, to build its system around experienced but lower paid senior paramedics. These well-trained senior staff have provided a resourceful and flexible presence in the sorts of facilities and field assignments that newly graduating Indonesian doctors still do their best to avoid.

Indonesian health officials at all levels are further constrained by their institutional mandate and by the limited instruments available to them to supervise health workers. This limitation would persist even if pay scales were suddenly and dramatically increased. The problem stems from the huge diseconomies of scale involved in its highly centralized health strategy, particularly since Indonesia is almost ten times the size of Malaysia. The Malaysian approach has been marked by flexibility and quick adjustments to performance indicators, as well as reliance on close and supportive supervision, systematic quality assurance mechanisms, state and district-level initiatives, and problem solving and decisionmaking by facility managers.

In Indonesia, by contrast, middle level managers lack the authority and policy tools needed to improve the quality of health services. Facility managers and their district-level supervisors have only circumscribed responsibility for work processes and outcomes, and for the activities and productivity of staff. Constructive managerial interventions are inhibited by a checklist approach to supervision; by the requirement that workers, who handle dozens of tasks, report to several supervisors; by a general lack of awareness of clients' needs and concerns; by the related practice of allocating fixed numbers of staff to facilities irrespective of utilization levels; by the absence of usable monitoring and evaluation data; over-reliance on quantitative targets at the expense of qualitative objectives; by the distractions introduced by opportunities to engage in private practice in the afternoons and evenings; and by a performance review system that gives little weight to output indicators, service costs, or impacts. Another problem is that middle level managers receive little encouragement from decisionmakers at the provincial and central levels. In fact, initiatives in planning, budgeting, and implementation are carefully controlled at each stage in the monolithic Indonesian health hierarchy, which extends from the facility level all the way to the central MOH units. Jakarta-based policymakers do not appear to view their role as one of enabling communities to respond to local health problems. Rather, they see themselves as promulgating and enforcing national policies and guidelines and implementing uniform service delivery packages. (In a sense, this task has been made easier by the lack of in-depth information and analysis on disease and facility use patterns.) The policy instruments that are in place, e.g., the sharp separation between planning and budgeting functions and implementation activities; provision of funds through different channels, each with its own procedures; and blunt and ineffective supervision, monitoring, and performance assessment arrangements, all serve this objective.
An alternative approach. In short, Indonesia's management and budgetary practices, and other institutional features of its public health system, are quite different from those that emerged in Malaysia in the 1960s and 1970s. It would, therefore, be difficult and very costly to build the same type of comprehensive, high quality public system throughout Indonesia although Indonesian authorities could selectively introduce key aspects of the Malaysian approach, as Thai and Philippine planners did in the 1970s and 1980s. For example, Indonesia could introduce a package of “Malaysian” measures aimed at enhancing service access and quality in the six to eight provinces or regions with the highest IMRs. Alternatively or simultaneously, Malaysian management principles might be used to improve certain indispensable activities such as control of communicable diseases.

Although the Malaysian model commands attention, there is a closer fit between Indonesian circumstances and those in Thailand and the Philippines, including tight spending constraints and the use of community-based workers to create health awareness and deliver services. In this context, private health care providers, who were instrumental in the health gains achieved in Thailand and the Philippines, could play a larger role in service delivery in Indonesia.

Indonesian health planners could also learn better lessons from the health development policies in Thailand and the Philippines. These lessons can be grouped into a broad agenda for developing policy and improving service delivery in Indonesia:

- **Deconcentrate to the provincial level most major health responsibilities**, including planning and budgeting, procurement, service delivery in government facilities, accreditation and other quality assurance mechanisms, and manpower-related matters. This initiative, which was implemented in Thailand and the Philippines during the late 1970s and early 1980s, respectively, is needed to improve program design and management. Expected outcomes include heightened commitment and accountability of field staff, increased responsiveness to local needs and target groups, and innovative departures from conventional delivery strategies. Expanded health responsibilities could begin with provinces in Java and Bali, and then be extended to other regions over a two to five-year period. Resources could be transferred through block grants, with the size of the grant dependent on a province’s plans and capabilities and its progress in regard to agreed indicators. Provincial grant requests could describe the planned coverage and quality of curative and preventive services; the approach toward communicable diseases; the mix of public and private service providers, supervision, and regulatory practices; and arrangements for contracting manpower and assessing performance. Initially, provincial staff may need training and technical assistance support. Capacity-building activities would need to address local health priorities, existing service delivery arrangements, health expenditure and revenue trends, and various manpower options and performance issues.

- **Take steps to convert the MOH into an agency that performs tasks such as technical support, program review, policy analysis, and advocacy.** First, MOH needs to become a powerful voice for health within the central government that draws attention to disease trends, funding needs, provincial-level inequalities in health spending, and ways of transferring funds to aid poor provinces. Second, MOH should be involved in assessing provincial health plans and performance and advising on the level of resources to be transferred for health. Third, MOH should retain broad responsibility for controlling communicable diseases, reviewing and supporting provincial programs and possibly playing a direct role, through its regional offices, in programs in the smaller, poorer provinces. Fourth, MOH should develop national health objectives and policy guidelines; provide technical support, when requested, to professional associations and to high-priority provincial initiatives (such as making greater use of private providers); advise on medical education and training programs; act as a clearing house for information on program successes; and fund research on health policy issues in different settings. As MOH shifts to these new tasks, some downsizing may be indicated.
• Use a range of instruments to guide and encourage private provision of health services. The central MOH and provincial governments can foster private health care delivery by withdrawing government providers from certain markets, e.g., urban and periurban hospitals and clinics; by raising fees in public facilities for all patients except the poor; by making loans available to help doctors, nurses, and midwives start their own practices; by using contracts and other means to purchase drugs, supplies, materials, equipment, training, security, catering and other inputs required in public facilities; by hiring private medical firms or NGOs to take over health center and/or hospital operations according to agreed terms of reference; by selecting private manpower, i.e., “headhunter” agencies to contract health staff for remote locations; by strengthening parastatal bodies and enlisting consumer groups and professional associations to take on important regulatory and accreditation functions, to enhance the quality of private providers; and by ensuring that medical education and health training programs prepare participants for possible careers in the private sector. Finally, the scope and design of publicly managed health insurance and related payment arrangements have enormous implications for private service provision. As mentioned above, private health spending and service provision could rise sharply if the health insurance framework included in the 1992 National Health Law wins acceptance. Under this Act, MOH is authorized to license prepaid managed care schemes that meet various criteria. But this approach needs to be aligned with the 1992 Social Security Act, which requires firms with ten or more workers to obtain health care coverage for all employees and their families from a public insurance agency (Pt. ASTEK). The latter legislation is flawed, however, in part because it would prevent private firms from purchasing insurance from competing private companies. Another problem with this Act is that it requires health services to be provided exclusively in government facilities.

• Rethink and reinvigorate community-based activities. The time has come to look beyond the posyandu as the main entry point at the community level. Posyandus occur too infrequently (once a month) and are attended too irregularly by mothers and children, village volunteers, and health staff to deliver significant health benefits. MOH has long seen the posyandu primarily as a convenient platform through which to provide immunization and other services, and sees village midwives as an alternative contact point in villages. Midwives proved more effective in Malaysia once a modus vivendi was worked out with traditional birth attendants. In Indonesia, an additional challenge for village midwives is to attain financial viability as private practitioners. In Thailand and the Philippines, however, local participation in health has been achieved by other means. For instance, following their example, village health committees in Indonesia could be asked to monitor service delivery in health centers, convey local health priorities, provide feedback on individual facility workers and on the effectiveness of different programs, discuss how to best use village midwives, advise on user fee levels, and participate in various resource and staff allocation decisions. In time, review boards in health centers, districts and hospitals could be established to provide an institutional forum for community views. In addition, more could be done with the volunteers (kaders) who currently staff the posyandus. They could be trained and paid to visit poor families, organize community health campaigns, work with youth groups, monitor high risk pregnancies, and so forth.

• Secure the increased public funding needed to bring about rapid health gains. A large part of these funds would go to personnel expenses in core central and provincial activities, which have been tightly controlled due to budgetary constraints. In addition to overall restrictions on civil service pay scales, health care wages have been controlled by requiring new doctors to accept health center assignments at below market rates, especially in outlying rural areas and in the Eastern Islands. The cost of services has been limited by not replacing doctors absent because of liberal leave, settling in

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and training provisions. Some expenditure increases could be offset by rationalizing staffing levels. For example, the kanwil and dinas units could be merged, allowing for staff reductions at the provincial level. Staffing in health centers should reflect actual rather than normative utilization levels. Higher personnel costs could also be offset by increasing cost recovery in public facilities, by subcontracting service delivery for hospitals and health centers in designated areas, and by generally improving the targeting of government programs to areas of highest need and withdrawing most other services. Provincial governments, when they assume more health responsibilities, will also need to persuade decisionmakers and the public of the need for increased cost recovery and for spending reallocations and increases. To that end, they will need to carefully estimate the staffing mix and the outlays needed to sustain essential communicable disease control programs and provide basic curative and preventive health services that are attractive to the poor.
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