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PRIVATE SECTOR HEALTH CARE IN INDONESIA

HEALTH SYSTEMS 20/20

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PSP-One
private sector partnerships for better health

Mission

The Health Systems 20/20 cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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PRIVATE SECTOR HEALTH CARE IN INDONESIA

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ABBREVIATIONS

ANC	Antenatal care
Askes	Indonesia Health Insurance *(Asuransi Kesehatan Indonesia)*
Askeskin	Indonesia Health Insurance for the Poor *(Asuransi Kesehatan untuk Keluarga Miskin)*
AusAID	Australian Agency for International Development
Badan POM	National Agency for Drug and Food Control *(Badan Pengawas Obat dan Makanan)*
Bappenas	National Development Planning Agency (*Badan Perencanaan Pembangunan Nasional*)
BCC	Behavior change communication
BD	*Bidan Delima* midwife
BinFar	General Directorate of Pharmacy and Medical Supplies (*Direktorat Jenderal Bina Kefarmasian dan Alat Kesehatan*)
BKKBN	National Family Planning Coordinating Board *(Badan Koordinasi Keluarga Berencana Nasional*
BMPK	Council for Quality in Health Care in Yogyakarta (*Badan Mutu Pelayanan Kesehatan*)
CCM	Country Coordinating Mechanism
CPD	Continuing professional development
DANIDA	Danish International Development Agency
DAU	General budget (*Dana Alokasi Umum*)
Depkes	Ministry of Health (*Departemen Kesehatan*)
DFID	Department for International Development (UK)
Dinkes	District Health Office (*Dinas Kesehatan*)
DOTS	Directly observed treatment, short-course
DRG	Diagnosis related grouping
GAKIN	Poor Family [Insurance Scheme] (*Keluarga Miskin*}
GDP	Gross domestic product
GFK	District Medicines Store (*Gudang Farmasi Kesehatan*)
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GP	General Practitioner
HSP	Health Services Program

IBI	Indonesian Midwives Association *(Ikatan Bidan Indonesia)*
IDHS	Indonesia Demographic Health Survey
IMA	Indonesian Medical Association *(Ikatan Dokter Indonesia)*
ISFI	Indonesian Pharmacist Association *(Ikatan Sarjana Farmasi Indonesia)*
Jamkesmas	Civil Health Insurance for the poor (*Jaminan Kesehatan Masyarakat*)
Jamkesda	District level Health Insurance for the poor
Jamkessos	Social Health Insurance *(Jaminan Kesehatan Sosial)*
Jamsostek	Workforce and Social Insurance *(Jaminan Sosial dan Tenaga Kerja)*
JPKM	Community Health Insurance Scheme (*Jaminan Pemeliharaan Kesehatan Masyarakat*)
KARS	Hospital Accreditation Commission (*Komisi Akreditasi Rumah Sakit*)
LPK	NU Health Institute (*Lembaga Pelayanan Kesehatan)*
MCH	Maternal child health
MDG	Millennium Development Goal
MIMS	Monthly Index of Medical Specialties
MMR	Maternal mortality rate
NGO	Nongovernmental organization
NHA	National Health Accounts
NTP	National Tuberculosis Program
NU	*Nahdlatul Ulama*
OGB	Generic Drug Program (*Obat Generik Berlogo*)
OTC	Over the counter (medicines)
PERDHAKI	Indonesian Catholic Voluntary Health Services Association (*perkumpulan dhrama bakti kesehatan Indonesia)*
PERSI	Indonesian Hospital Association
PHO	Provincial Health Office
PKBI	Indonesian Planned Parenthood Association (Perkumpulan Keluarga Berencana Indonesia)
PR	Principal Recipient
PTT	Central limited-term contract (Pegawai Tidak Tetap)
Puskesmas	Health Center at Sub-District level (Pusat Kesehatan Masyarakat)
RDU	Rational drug use
TATAP	No pharmacist, no service (*Tanpa Apoteker Todak Ada Pelayanan*)
TB	Tuberculosis
TBA	Traditional birth attendant

THE	Total health expenditure
USAID	U.S. Agency for International Development
VAT	Value-added tax
WHO	World Health Organization

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EXECUTIVE SUMMARY

As documented in Indonesia's 2007 Public Expenditure Review, the private sector's role in the Indonesian health care system has grown dramatically over the past decade. Development partners came to agreement in late 2008 that a review and assessment of the private health care sector in Indonesia would make a significant contribution by identifying key issues and options for discussion. In-depth understanding of key private health care sector issues would provide information that USAID, development partners, and the Government of Indonesia could use to plan future interventions that better engage private sector health providers to achieve health sector goals and objectives. As a first step, USAID's Health Systems 20/20 and Strengthening Pharmaceutical Systems projects conducted a desk review to summarize what is currently known about the private health sector in Indonesia and identify gaps in knowledge requiring further investigation. Based on the desk review findings, and feedback from USAID/Indonesia and other development partners, five priority questions were identified for the in-country assessment:

- How can services provided at private facilities be better integrated into District Health Office monitoring and supervision systems to ensure quality services?
- How can financial incentives (such as performance-based payments, payment mechanisms) be used to improve access to services or quality of services among private providers (i.e., midwives, physicians, faith-based NGOs, etc.)?
- What can be done to rationalize the use of medications, as part of an integrated provider quality improvement approach?
- Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?
- What role can professional associations play in monitoring and improving quality of care among private providers?

This report presents the consolidated findings from the desk review and the in-country assessment, as well as recommendations for interventions that could strengthen the role private health care providers can play in achieving health sector objectives.

There is an overall wide acceptance among Indonesian consumers to use private sector providers for a range of health services and products – even among the poorest socio-economic groups. Out-of-pocket spending accounts for more than a third of all health spending. Over the long term, demand is increasing for private sector services and products, although this trend has reversed since 2004, primarily due to the implementation of government funded insurance for the poor, which only allows use of public facilities for primary care.[1] There is a trend away from seeking care in outpatient facilities toward self-medication using private drugsellers – with 45 percent of Indonesians self-treating their last illness episode. Women are increasingly giving birth in a facility – and more than two-thirds of institutional deliveries take place in private facilities across income groups.

[1] Although patients are only permitted to receive primary care at government health clinics, the situation for inpatient care is quite different. Nearly one-quarter of government contracted providers are private hospitals.

More than 40 percent of all women and 60 percent of women in urban areas rely on private sector providers for family planning services.

Many of Indonesia's health indicators are improving; however, other indicators remain a concern. Three indicators remain a cause for concern: i) high child mortality; ii) high maternal mortality rates (MMR); and iii) child malnutrition rates. Despite increases in the number of deliveries attended by a health professional (from 66 percent in 2002-03 to 73 percent in 2007) and the number of deliveries taking place in a health facility (40 percent to 46 percent) (IDHS, 2008), the MMR remains high. Only 9.7 percent of deliveries take place in public facilities – all other deliveries are in private facilities, or at home assisted by a private midwife or traditional birth attendant (TBA). It is unlikely that maternal mortality objectives can be met without fully engaging the private sector.

Indonesia ranks third on the list of 22 high-burden tuberculosis (TB) countries in the world. TB is responsible for 6.3 percent of the total disease burden in Indonesia, compared with 3.2 percent in the Southeast Asian region. After achieving a case detection rate of 73 percent in 2006, Indonesia slipped out of the target zone in 2007, more recently reporting case detection of 68 percent. The performance decline is in part attributed to the temporary cessation of support from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for nine months, resulting from GFATM audits and assessments that identified "weaknesses…in managing a conflict of interest between the Principal Recipient and one of its SRs [sub-recipients]."[2] This situation also highlighted weak oversight by the Country Coordination Mechanism (CCM) over the Principal Recipient (PR) and weak programmatic financial and management capacities of the PR. Although the conflict was resolved, and disbursements resumed, activity was extremely low throughout 2007.

In the current environment, there is significant scope to work with private providers to improve access to health services and quality of health services. Many private providers have not traditionally been partners in public health programs, but represent important channels for reaching large numbers of consumers. Two groups that are seldom even considered health providers are pharmacists and drugsellers – however, they must be engaged because for half of all Indonesians who choose to self-medicate, this is their first contact at the onset of illness. Also increasingly important partners are the faith-based NGOs that are new recipients of GFATM grants. These potential partners have central-level coordinating boards, and varying degrees of organizational structure at province and district level. While central-level government officials and other partners are critical to ensuring support and providing avenues for expansion, initial implementation should be based at district and province level in order to ensure operational feasibility. Working through all levels of partner organizations, along with engaging other organizations such as the Association of District Health Offices (*Asosiasi Dinas Kesehatan/Adinkes*), would maximize the likelihood of dissemination when appropriate.

There have been several important changes in health financing over the last five years. Public funding for health has increased substantially, primarily from central budget, but also from district budgets. Much of this new funding is channeled through insurance schemes for the poor. Jamkesmas, the central government financing scheme for the poor represents 25 percent of the Ministry of Health budget and covers 76.4 million Indonesians. At least 60 districts, and as many as 100, have supplemental financing schemes for the poor or near-poor. Insurance payers have advantages over individuals in ensuring quality and enforcing adherence to clinical standards – they can more easily access technical knowledge regarding appropriate treatment (employ physicians to review treatment protocols) and have more leverage over providers as they represent thousands of patients.

[2] http://www.theglobalfund.org/grantdocuments/5INDT_1084_493_gpr.pdf

By using their power to select which providers to contract with, and enforcing treatment protocols with their payment policies, Jamkesmas and other financing mechanisms have potential to provide incentives for providers (public or private) to improve care and adhere to quality standards. Changes may include paying providers who refer patients when necessary, or not paying for branded drugs when generic is available. Payment policies can also be used to target interventions that promote public health (such as providing higher reimbursement for the fourth antenatal care (ANC) visit, or completion of directly observed treatment, short-course (DOTS)) Making small changes to Jamkesmas reimbursement policies could significantly improve the quality of care, and improve health outcomes.

Interventions that incorporate financial incentives to drive provider quality have high potential for replicability, as Jamkesmas is fully implemented in all districts. Models at district level that demonstrate operational feasibility and document positive health outcomes could easily be adopted by other districts, as the Jamkesmas administrative systems are already in place. Investments in technical assistance to the unit managing Jamkesmas within the Ministry of Health may also create potential for changes to be adopted as national recommendations.

There is little coordination between district health officials and central public health programs, or between the district health officials and private providers. While district health offices have greater authority over health services within their districts, they do not always have the capacity and resources to provide effective planning and oversight. There is little coordination with private providers to involve them in critical public health programs, such as TB or malaria, or to include them as referral points. District officials do not have a good understanding of how to interact with private providers, and mostly focus on their role as licensor. In some districts, independent organizations are also active in reviewing service quality and consumer protection. While these groups are relatively nascent, and would benefit from external technical assistance, they are potentially effective models for external oversight of public and private providers. Improving capacity of district and provincial health officials to engage with private providers and consumers is critical to improving health services.

In order to demonstrate the effectiveness of a coordinated effort that includes changing provider incentives, partnership with private providers, and support to district and provincial health officials, initial efforts should focus on a limited set of critical health priorities. Officials at all levels identify maternal child health (MCH) and TB treatment and control as among their health priorities, there is information on appropriate treatment standards, and enforcing effective treatments does not require significant additional funding.

If Indonesia is to achieve its priority health objectives, more attention must be paid to engage private sector providers. To improve the quality of private providers and to ensure that they contribute to priority health objectives, general recommendations are:

- Improve district and province capacity to manage an integrated public-private health system;
- Through existing financing schemes, adjust payment policies to provide financial incentives for providers to improve quality and adhere to standards;
- Create partnerships with private sector to address public health priorities such as MCH, TB, and malaria;
- Support independent oversight boards and consumer education initiatives;

- Support the NGOs that are new recipients of Global Fund grants; and
- Revitalize and support promotion of high quality branded generics.

In line with USAID/Indonesia's current health strategy, the assessment team offers three options for potential programs to strengthen MCH services and control of infectious diseases:

1) INTEGRATED APPROACH TO IMPROVE MCH SERVICES

There is significant potential to improve the quality of MCH services, and thereby reduce maternal mortality, with a multi-component approach including creating financial incentives through Jamkesmas and Jamkesda to follow treatment protocols, strengthening districts to engage with private midwives and hospitals to improve MCH, supporting independent oversight boards, and working with the Indonesian Midwives Association (IBI) to ensure the quality of Bidan Delima.

The assessment team found many examples of systemic disincentives under the current financing schemes for providers to follow treatment protocols. Removing these disincentives and creating positive incentives for providers to perform to set standards would drive quality improvements. Some potential changes include:

- Reimbursing TBAs for referring patients to midwives;
- Restructuring the groupings for reimbursable services so that midwives are reimbursed for services provided prior to referral for a complicated delivery or for post-partum complications; and
- Adjusting reimbursement rates for emergency hospital deliveries to rates that would allow hospitals to maintain high quality emergency obstetrics units.

Working to strengthen district capacity to manage an integrated public-private health system to address MCH challenges would complement changes in financial incentives. Interventions may include: 1) supporting the district to lead development and dissemination of treatment and referral norms for MCH services with input from the Indonesian Medical Association (IMA)[3] and IBI, supported by Jamkesmas reimbursements to enforce the treatment norms; 2) supporting the mapping of all facilities to create an appropriate referral network integrating public and private providers; and 3) improving reporting from private midwives as they provide the vast majority of MCH services.

Additionally, providing assistance to independent oversight boards and consumer advocacy groups that are established at district level would help to institutionalize monitoring and to create more educated consumers. Lastly, working closely with IBI to ensure the quality of Bidan Delima, coupled with higher reimbursement rates, would promote the value of the Bidan Delima certification for midwives and consumers.

In wealthier districts with more fiscal space, further changes could be considered, such as adding a supplemental maternity benefit to Jamkesmas or Jamkesda. Some rudimentary calculations suggest that a good maternity health benefit could be put in place for under Rp 5000 per capita per month. This level of funding would allow reimbursement for delivery at closer to the market rate (Rp 500,000), and

[3] Often referred to using the abbreviation IDI which stands for the Indonesian *Ikatan Dokter Indonesia.*

higher reimbursement for complex deliveries and Caeserian section. These higher rates would attract for-profit hospitals to serve Jamkesmas patients, thereby increasing access in the event of emergency, and possibly improving quality (if the contracted hospitals are of higher quality).

2) COLLABORATION WITH THE PRIVATE SECTOR IN TB CONTROL

Given the data on health-seeking behavior, the first health professional in contact with TB patients may well be the local pharmacist or drugseller. A three-pronged intervention that includes training for private pharmacists and drugsellers to improve quality of case detection and treatment, creating incentives for these providers to follow standard protocols, complemented by stronger coordination between district health officials and the national TB program could significantly strengthen the TB program.

Training pharmacists and drugsellers to screen for TB symptoms, provide appropriate information on the illness, and refer patients for further investigation could significantly improve case detection. This training would be coupled with financial incentives in the form of reimbursement for detection, diagnosis, and treatment based on accepted clinical protocols. Reimbursing the pharmacist for case detection based on protocol would encourage the pharmacist to refer the patient for investigation, rather than sell him medicines. Reimbursement for following diagnostic protocols would encourage the hospital to conduct a sputum smear, rather than take an x-ray. Lastly, reimbursement at completion of treatment would encourage the provider conducting DOTS to follow up with the patient in the event of treatment lapse.

3) SUPPORT NEW GFATM RECIPIENTS TO CONTROL INFECTIOUS DISEASES

Muhammadiyah, NU, and PERDHAKI are all due to become new GFATM recipients for TB, HIV/AIDS, and malaria, respectively. While these organizations have significant reach, they have limited management and monitoring capacity. Supporting these organizations to successfully manage their GFATM grants would represent big improvements in these programs. Improvements in management capacity would not only benefit the GFATM funded programs, but would have benefits for the overall organization bringing improved efficiency in service delivery.

These three organizations also would need support to develop program monitoring systems. Support to ensure that data is reliable and timely, and meet GFATM requirements, represents good use of partner funding that leverages the GFATM grant to achieve disease control objectives. It also would be useful to help these NGOs develop an appropriate and feasible evaluation plan, ensuring that appropriate data is or can be collected to evaluate whether activities achieved their initial objectives.

1. INTRODUCTION

As documented in Indonesia's 2007 Public Expenditure Review, the private sector's role in the Indonesian health care system has grown dramatically over the past decade. Today, the majority of health care professionals engage in the delivery of both public and private services. Notwithstanding the progress made in expanding the public health care system, access to and the quality of services remain low and the poor in particular rely heavily on private-sector provision. Almost 40 percent of the poor who seek health care treatment do so from private providers. In most areas of Indonesia, the private sector now accounts for more than two-thirds of ambulatory care, more than half of hospital contacts, and 30-50 percent of all deliveries (compared with only approximately 10 percent a decade ago). Despite the importance of private providers, little is known about who they are, where they are and what services they provide. In addition, little analysis has been conducted to understand how the private sector is contributing to the public health priorities that have been identified by the government and development partners.

Development partners came to agreement in late 2008 that a review and assessment of the private health care sector in Indonesia would make a significant contribution by identifying key issues and options for discussion. In-depth understanding of key private health care sector issues would provide information that USAID, development partners, and the Government of Indonesia could use to plan future interventions that better engage private sector health providers to achieve health sector goals and objectives. USAID/Indonesia is particularly interested in using the private sector assessment to inform the Mission's future strategic planning to improve MCH services and to prevent and control infectious diseases in Indonesia.

As a first step, USAID's Health Systems 20/20 and Strengthening Pharmaceutical Systems projects conducted a desk review to summarize what is currently known about the private health sector in Indonesia and identify gaps in knowledge that may require further investigation. Based on the desk review findings, and feedback from USAID/Indonesia and other development partners, priority questions were identified for the in-country assessment. In-country work was used to validate findings from the desk review, as well as to focus on selected questions. This report presents the consolidated findings from the desk review and the in-country assessment, as well as recommendations for interventions that could strengthen the role private health care providers can play in increasing access to priority health services, and improving the quality of health services in Indonesia.

2. BACKGROUND

2.1 GENERAL BACKGROUND

Indonesia is a populous and diverse country. In addition to the capital city of Jakarta, Indonesia has 30 provinces and two special regions (Aceh and Jogjakarta). The Indonesian government is a highly decentralized, democratic Republic. The country is the fourth most populous country in the world with approximately 237 million people consisting of nearly 300 native ethnicities and 742 different languages and dialects. The largest segment of the population is the Javanese, making up 42 percent of the population, followed by the Sundanese, ethnic Malays, and Maduranese groups.

Prior to the recent global financial downturn, Indonesia's economy had largely recovered from the Asian financial crisis of the late 1990s. Indonesia is a lower-middle-income country with a nominal gross national income per capita of US$ 1,650 (US$ 3,580 purchasing power parity) in 2007. Indonesia has undergone significant economic reforms under President Susilo Bambang Yudhoyono. The economy has grown approximately 6 percent per year since 2005. The country has extensive natural resources, including crude oil, natural gas, tin, copper, and gold. Prudent macroeconomic policies have contributed to a decline in Indonesia's debt-to-gross domestic product (GDP) ratio and an increasing availability of government revenue. However, the recent global financial turmoil has led to sharp declines in demand and prices for key exports such as crude palm oil and coffee. The government is taking steps to try to mitigate the effects of the economic crisis. Experts predict that the growth of Indonesia's economy is expected to slow, but continue to estimate that it will grow by 4-6 percent in 2009.

Despite progress in stabilizing the economy, Indonesia continues to struggle with a number of complex issues. Nearly 18 percent of the population continues to live below the poverty line, while 49 percent of the population lives on less than US$ 2 per day (World Bank, 2006b). The unemployment rate has held steady at approximately 10 percent over the past several years, but may increase as the decline in demand for exports negatively impacts manufacturing and production. Distribution of resources across provinces remains highly unequal with provinces in the East of the country receiving substantially less than those in the West. Rapid decentralization, a key part of democratization efforts that began in 1999, has further complicated an already complex regulatory environment. Both a lack of accountability and corruption remain key concerns at all levels of government and continue to deter both foreign and domestic investment. The current administration has had to deal with a string of natural disasters including the devastating December 2004 tsunami and a number of terrorist attacks that also have affected domestic and international tourism and investment.

2.2 HEALTH SITUATION IN INDONESIA

A relatively small list of health conditions make up the majority of the burden of disease, particularly among the poor, and contribute to high levels of avoidable death. Data from the Ministry of Health's Basic Health Research collected in 2007-08 indicate that the main causes of child deaths are diarrheal disease (25.2 percent) and pneumonia (15.5 percent). Dengue hemorrhagic fever is the main cause of death among children between the ages of five and 15 in urban areas, responsible for 30.4 percent of deaths in this age group, while diarrhea at 11.3 percent is the main cause of death among

the same age group in rural areas. The main causes of death across all ages of the population over five years old are stroke (15.4 percent), TB (7.5 percent), and injuries (6.5 percent).[4] According to the World Health Organization (WHO), ischaemic heart disease, lower respiratory infections, malaria, HIV/AIDS, and nutritional deficiencies also contribute to mortality rates (WHO, 2007).

Many of Indonesia's health indicators are improving; however, other indicators remain a concern. Key health indicators, such as infant and child mortality, have improved steadily over the past several decades. Despite these general trends, improvements in some indicators seem to have slowed in recent years. The infant mortality rate decreased from 36 deaths per 1,000 live births in 2002-03 to 34 in 2007, while the under-five mortality rate decreased from 46 deaths per 1,000 live births to 44 (Statistics Indonesia et al., 2008, henceforth referred to as the Indonesia Demographic and Health Survey [IDHS], 2008). Life expectancy at birth is 66 for men and 70 for women (World Bank, 2009c). Between 2002-03 and 2007, the fertility rate remained at 2.6 births per woman. Contraceptive use among currently married women is high and has held steady at 61 percent (IDHS, 2008). Three indicators remain a cause for concern: i) high child mortality; ii) high MMR; and iii) child malnutrition rates, which remain high at 25 percent for children under five and have largely stagnated since 2000 (World Bank, 2008). Despite increases in the number of deliveries attended by a health professional (from 66 percent in 2002-03 to 79 percent in 2007) and the number of deliveries taking place in a health facility (40 percent to 46 percent) (IDHS, 2008), the MMR remains high. One study estimates MMR at 420 deaths per 100,000 live births (Hill et al., 2007), while the IDHS estimates MMR at 228 deaths (IDHS, 2008). Irrespective of the wide discrepancy in these two estimates, Indonesia's MMR is relatively high compared to similar countries in the region.

Comparing these indicators to the Millennium Development Goals (MDG), Indonesia appears on-track to meet its child health targets. However, progress in maternal mortality is less clear (see Table 1).

TABLE 1: STATUS OF PROGRESS TOWARD MDGS[5]

Indicator	1990	2007	Target (2015)	Status
Under-five mortality rate per 1,000	97	40	32	Likely to be achieved
Infant mortality rate per 1,000	57	32	19	Likely to be achieved
Maternal mortality rate per 100,000	390	307	110	Needs improvement

Source: Target MDGs Project (a joint initiative of BAPPENAS and UNDP), December 2007.

National health indicators mask significant disparities by region and socioeconomic status. Significant geographic disparities exist in health indicators such as life expectancy, infant and child mortality rates, and under-five malnutrition rates. For example, life expectancy in West Nusa Tenggara is 59 years compared with 72 years in Jogjakarta (World Bank, 2008). Infant mortality rates in West Sulawesi and West Nusa Tenggara are nearly three times greater than those in Jakarta and Central Java (IDHS, 2008). Significant variance in health indicators exists across socioeconomic quintiles. Despite improving overall trends in delivery care, most poor pregnant women deliver at home and 35 percent of women in the lowest income quintile deliver without the benefit of a skilled birth attendant. Infant and child mortality rates are more than four times higher among the poorest quintile (World Bank, 2006b).

[4] Results of the Basic Health Research were synthesized online in the article "Indonesia: Stroke and TB are Lead Killers," published December 9, 2008, IRIN humanitarian news and analysis, UN Office for the Coordination of Humanitarian Affairs, available online at www.irinnews.org/Report.aspx?ReportId=81883.

[5] It should be noted that the National Statistics Bureau's estimates for these indicators in 2007 included in this report differ from the 2007 estimates published in the IDHS in 2008.

While decentralization of the health sector provides opportunities in districts with capacity to take advantage of their additional authority, it has also created new challenges. Funding for health is much more fragmented, with multiple sources at central, provincial, and district levels. Decentralization has created more confusion around who has ultimate responsibility for provider licensing and oversight, or provision of essential medicines. The health sector is still working out the details to support effective decentralized district management and health financing. More complex issues, such as the dual sector workforce (providers who hold both public and private sector jobs), are not being addressed.

Due to longer life expectancy and fewer childhood deaths from communicable diseases, the demographic and epidemiological profile of Indonesia is transitioning. In the decades to come, Indonesia will face a "double burden of disease" from both communicable and non-communicable diseases. Already, the number of people with diabetes, heart disease, and cancer is increasing as the population ages, diets change, and lifestyles become more sedentary (World Bank, 2008). These changes have the potential to greatly increase both demand for and the cost of health care.

2.3 HEALTH SECTOR PRIORITIES AND HEALTH SPENDING

The Government's Annual Plan for 2007 describes the health sector's key policy directions and priority diseases. The main policy directions stated in the Annual Plan include increasing access to and quality of basic services for the poor, increasing the quantity and quality of health personnel, focusing on preventing and eradicating infectious and transmittable diseases (including diarrhea), improving nutritional status for mothers and children, increasing use of essential generic drugs, and revitalizing the family planning program. Priority diseases mentioned in the Annual Plan include TB, dengue fever, malaria, and HIV/AIDS. The Plan also outlines objectives for the health sector to increase immunization coverage and rates and to improve nutritional status through iron supplementation in pregnant women, exclusive breastfeeding in infants, and Vitamin A supplementation in children. There is no explicit statement regarding engaging the private sector in the Annual Plan.

Spending on health is relatively low in Indonesia. The World Bank estimates that Indonesia spends less than 3 percent of GDP on health (of which less than 1 percent is public spending) (Table 2). This is less than the average for countries in the East Asia and Pacific region (6.1 percent) and the lower-middle-income group of countries (5.9 percent). Despite the government's recent increases in health spending, public health expenditure remains low. Indonesia's health infrastructure is relatively less developed, with fewer hospital beds per 10,000 population than its neighbors in the region. Many public health facilities reportedly suffer from weak infrastructure and a lack of equipment. The country as a whole suffers from a lack of doctors, nurses, and to some extent midwives, particularly in rural and remote areas. Neighboring countries such as Vietnam, Philippines, and Malaysia spend more and have better health outcomes, including child and maternal mortality rates (World Bank, 2008).

TABLE 2: REGIONAL COMPARISON OF HEALTH PERFORMANCE INDICATORS, 2006 (UNLESS NOTED)

Indicator	Indonesia	Philippines	Thailand	Malaysia	China	Cambodia	Viet Nam
Health Financing							
Total health expenditure (THE) as % of GDP	2.2	3.3	3.5	4.3	4.5	6	6.6
General government expenditure on health as % of THE	50	40	64	45	42	26	32

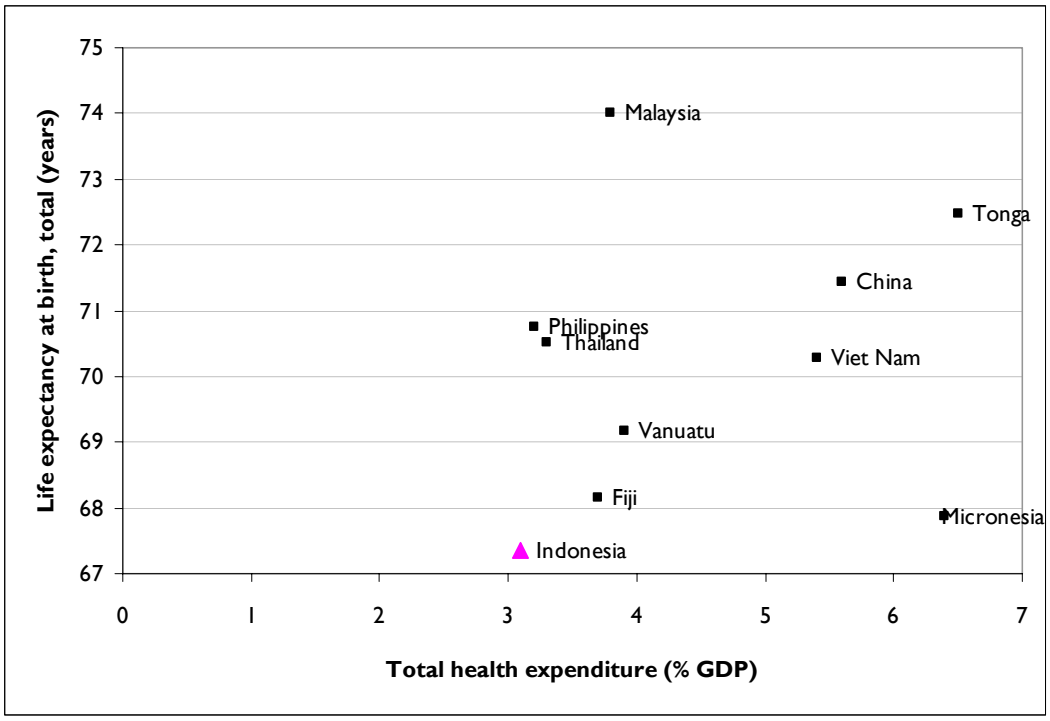
Indicator	Indonesia	Philippines	Thailand	Malaysia	China	Cambodia	Viet Nam
Private expenditure on health as % of THE	50	60	36	55	58	74	68
Out-of-pocket expenditure as % of private expenditure on health	66	80	77	73	93	84	90
Health Status							
Life expectancy at birth (years)	68	68	72	72	73	62	72
Infant mortality rate (per 1,000 live births)	26	24	7	10	20	65	15
Under-5 mortality rate (per 1,000 live births)	34	32	8	12	24	82	17
Maternal mortality ratio (per 100,000 live births)	420[f]	230[f]	110[f]	62[f]	45[f]	540[f]	150[f]
Births attended by skilled personnel (%)	66[d]	60[d]	97	100[f]	98	44[f]	88
Contraceptive prevalence (%)	61	49[d]	72	--	90[e]	40[f]	79[c]
Health Systems							
Hospital beds (per 10,000 population)	2.5[f]	13	22[a]	19	22	6[b]	26[f]
Physician density (per 100,000 population)	13[d]	58[a]	37[a]	70[a]	106[b]	16[a]	53[b]
Nursing density (per 100,000 population)	62[d]	169[a]	28[a]	135[a]	105[b]	61[a]	56[b]
Midwife density (per 100,000)	20[d]	45[a]	1[a]	34[a]	3[b]	23[a]	19[b]

Key: a) 2000; b) 2001; c) 2002; d) 2003; e) 2004; f) 2005.

Sources: WHO (2006c) and WHOSIS accessed at http://www.who.int/whosis/en/index.html.

Figure 1 shows that Indonesia spends less on health than its neighbors and has a lower life expectancy at birth. Philippines and Thailand spend only slightly more on health as a percentage of GDP than Indonesia but perform better on this outcome measure.

FIGURE 1: TOTAL EXPENDITURES ON HEALTH AS % OF GDP AND LIFE EXPECTANCY AT BIRTH (IN YEARS), 2006



Sources: Based on data from WHO (2006c) and World Bank (2006b).

3. DESK REVIEW FINDINGS AND IN-COUNTRY ASSESSMENT QUESTIONS

The desk review summarized information on the policy environment related to the private health care sector in Indonesia, demand for private sector services and products, private sector supply of health services, private sector supply of pharmaceuticals and health products, and private sector financing. It primarily drew on published and grey literature, and was further informed by information received from in-country sources and via key informant interviews. Research was conducted on the Internet, identifying publications, journal articles, and project reports from Indonesian institutions as well as multiple development partners and researchers working in the health sector in Indonesia. This included reports from the World Bank, USAID, WHO, the Australian Agency for International Development (AusAID), and Danish International Development Agency (DANIDA). Additional documents were collected and analyzed from a variety of in-country sources, including the World Bank Jakarta office, the Indonesia Business Coalition on AIDS, and the Indonesian Medical Council. A limited number of key informants were interviewed to obtain an overview of the regulatory environment and key policy issues.

3.1 POLICY ENVIRONMENT FOR PRIVATE HEALTH CARE

Indonesia's private health sector is large, diverse, and growing. Unlike many countries around the world, Indonesia has long supported the development of the private health sector, beginning with encouraging private sector participation in the delivery of family planning services. However, the distinction between public and private provision of health care services and products in Indonesia is not clear. The vast majority of publicly employed health personnel have second jobs in their own private practices or other private facilities. Some public facilities deliver private services and some state-owned enterprises are incorporated as private firms even though the sole or majority shareholder is the government. This lack of clarity may make defining the scope of the private sector more difficult, but it also points to a policy environment that acknowledges the private sector's contribution to health in Indonesia and is conducive to private sector participation in health care delivery.

3.2 DEMAND FOR PRIVATE SECTOR HEALTH CARE SERVICES AND PRODUCTS

There is an overall wide acceptance among Indonesian consumers to use private sector providers for a range of health services and products – even among the poorest socio-economic groups. Out-of-pocket spending accounts for more than a third of all health spending. Over the long term, demand is increasing for private sector services and products, although this trend has reversed since 2004, primarily due to the implementation of government-funded insurance for the

poor, which only allows use of public facilities for primary care.[6] There is a trend away from seeking care in outpatient facilities toward self-medication using private drugsellers – with 45 percent of Indonesians self-treating their last illness episode. Women are increasingly giving birth in a facility – and more than two-thirds of institutional deliveries take place in private facilities across all income groups. More than 40 percent of all women, and 60 percent of women in urban areas, rely on private sector providers for family planning services. Current demand for pharmaceuticals is estimated at around US$ 12 per capita with around 10 percent by value provided by the public sector.

Additional information and analysis are needed to fully understand care-seeking behavior in Indonesia, as consumers often lack information about quality and price. Often consumer-perceived quality is gauged by convenience and comfort (wait time, condition of the facilities), which are not necessarily linked to provider skills or ability to provide quality care. Further, patients are seldom in a position to compare or negotiate prices, partly because they require immediate treatment, and partly because health care pricing is extremely complicated and varies based on many factors (facility costs, treatment prescribed).

3.3 PRIVATE SECTOR SUPPLY OF HEALTH CARE SERVICES

There is no reliable data on the number of health service providers working in a private capacity in Indonesia. Decentralization, the government-sanctioned practice of dual employment, and incomplete registers among the professional associations are some of the main reasons it is difficult to tease out this figure. Experts estimate that at least 60-70 percent of the health sector workforce holds jobs in both the public and private sectors. Distribution of health service providers, including private sector providers, is inequitable and favors urban areas. This unequal distribution occurs across all types of providers. The number of private sector hospitals and hospital beds is continuing to increase – the Ministry of Health reports that there were a total of 626 private hospitals in 2006 with about 52,300 beds. Even so, the total number of hospital beds in Indonesia per 10,000 population remains low compared to its neighbors in the region. While private hospitals tend to focus on providing narrow specialty services and maternity care, taken together private health facilities and private service providers offer a wide range of preventative and curative services. Supply of private sector medical and nursing education has exploded in recent years with little regulation, raising concerns about the quality of pre-service education. Overall, quality of care remains an issue throughout the Indonesian health care system, in both public and private sectors. While small-scale efforts exist, there is no institutional and systematic commitment to quality assurance and monitoring, and little enforcement if institutions or practitioners are found to be providing sub-standard quality of care.

For the most part, the legislative and regulatory environment does not hinder the development of the private sector. Current regulations allow physicians and midwives to establish private practices, but not nurses. The government does have a system of registration and licensing of health care providers at province and district levels, however providers must only fulfill a series of administrative criteria rather than demonstrate the minimum competence required to perform professional work. As of 2007, physicians are required to take a mandatory competency test in order to get their license. There is an accreditation commission for public and private hospitals, but the commission does not regulate the many solo private practices run by physicians and midwives. There are many professional organizational bodies in Indonesia but for the most part they do not certify standards, monitor quality, or enforce compliance to minimum standards.

[6] Although patients are only permitted to receive primary care at government health clinics, the situation for inpatient care is quite different. Nearly one-quarter of government contracted providers are private hospitals.

3.4 PRIVATE SECTOR SUPPLY OF PHARMACEUTICALS AND HEALTH PRODUCTS

Supply of medicines to the private sector is considered to be straight-forward following a simple pyramid structure from manufacturer to wholesale distributor to dispensing unit, but with many players at each level. Privately purchased medicines supplied through private pharmacies and drugsellers dominate the supply of medicines in Indonesia. When sick, around half of the population relies on self-treatment, most commonly from a private seller of pharmaceuticals. Medicine prices in Indonesia are generally considered to be high – with innovator brand names around 20 times the international indicator price and generic medicines costing nearly 75 percent higher than the international price indicator guide. All medicines in the private sector are subject to a variety of taxes ranging from import duties on raw materials through to the value added tax (VAT). It has been estimated that the tax burden adds around 22 percent to the retail cost of drugs.

There is a National Drug Policy, a number of essential drug lists, a series of regulatory controls and statutory functions of various agencies, and a large number of Ministerial decrees that govern both public and private pharmaceutical sectors. Overall, Indonesia has reasonable and improving regulatory controls – through the national agency for drug and food control (Badan POM) – for product quality with a reported relatively moderate rate of counterfeit and fake medicines at around 25 percent by value of the market (approximately 5 percent by volume). However, more recent reports suggest that this could now be as high as 40 percent by value (approximately 8 percent by volume). These reports tend to be produced by pharmaceutical manufacturers, and do not disclose the basis of their calculations nor their definition of 'counterfeit' products. Some reports include as 'counterfeit' genuine, brand-name products manufactured and packaged in regional countries (where they retail at a much lower price than in Indonesia) and illegally imported into Indonesia. It is believed that high-cost 'lifestyle drugs' such as sildenafil (Viagra) dominate the counterfeit market (thus a much higher portion of the market by value than by volume). However, recently there are worrying suggestions that some of the newer, and hence higher cost antibiotics, which are also used for second-line TB treatment, are now being counterfeited.

This situation warrants further investigation and possible action to strengthen regulatory functions if confidence in the quality of all medicines in the country is to be maintained. Licensing and monitoring of retail pharmacy outlets and drugstores, and for enforcing regulations governing proscribing and dispensing, was decentralized in 2001, resulting in a somewhat variable and confused enforcement environment.

3.5 PRIVATE HEALTH CARE FINANCING AND EXPENDITURES

Total health expenditure in 2006 was 2.2 percent of GDP, with general government expenditure comprising 50.4 percent of the total and private spending comprising 49.6 percent (WHO, 2008). There has been a dramatic increase in government investment in health since 2000, from Rp 8.4 trillion to Rp 35.6 trillion in 2006, a more-than fourfold increase during this six-year period. Even with increased public spending on health, the private health sector plays an important role in supplying health services to all populations in Indonesia, including the poor. Currently, half of total health expenditure in Indonesia comes from private sources, primarily out-of-pocket payments including user fees (66.3 percent), with a small proportion from private prepaid health care plans (9.7 percent), and the rest spent by NGOs and private firms (WHO, 2008). Out-of-pocket expenditure is the main source of financing for pharmaceuticals on either volume or value estimates. Pharmaceuticals account for approximately 50 percent of medical insurance costs.

Lack of overall investment in health limits the development of the health sector including the private health sector. Many people prefer to use private health services, even over highly subsidized public services, and even people without insurance coverage. In 2001, more than two-thirds of total household health expenditures were on services provided at private facilities. The private sector is more attractive to many patients compared with public health providers, even when they must pay much higher fees out of pocket, which imply there are differences in perceived quality, cost, and availability between public and private providers.

There is little information on the amount of public funding that the private sector obtains from either national or local level governments. A comprehensive analysis of health care financing should include the flow of funds from financing sources to financing agents (managers or programmers of health funds), to health care facilities, and to the beneficiaries. In particular, little information is available to estimate the flow from institutional payers (including those that are publicly funded, such as Jamkesmas) to health care facilities. More comprehensive resource tracking and data analysis efforts are needed to understand the development and functioning of the private sector in the overall Indonesian health care system.

3.6 DEVELOPMENT OF IN-COUNTRY ASSESSMENT QUESTIONS

Given the findings of the desk review, the assessment team proposed three priority areas of focus for the in-country work, subject to feedback from USAID and other development partners:

- *Strengthening insurance options*. Insurance providers are increasingly important health payers in Indonesia, with approximately 80 million people covered by commercial or government funded insurance programs. Insurance payers already contract with private providers, and have greater capacity to determine quality, and more leverage to enforce quality standards than individuals.

- *Addressing pharmaceutical pricing and affordability*. Pharmaceutical prices are very high compared to international standards, and account for a significant portion of health expenditures. Reducing pharmaceutical prices and ensuring rational use (the bulk of which are distributed through private retailers and health facilities) would significantly reduce health care costs and improve health outcomes.

- *Improving quality of and expanding access to private providers*. Despite a consumer preference for private providers, studies show that quality is inconsistent both among public and private providers. Access to providers remains an issue in several respects. In more remote areas, the number of providers is limited. Even in urban areas, consumer access can be limited by referral practices and the higher cost of private providers.

The team disseminated a report of its desk review findings and priority areas for in-country work for discussion with USAID/Indonesia and other development partners. Discussions with USAID/Indonesia narrowed the focus to areas that would result in improving access to, and quality of, private providers. Consistent with the health sector priorities identified in the USAID draft Country Program Strategy 2009-14, the assessment focused on issues related to the Mission's intermediate results: lower maternal, neonatal, and child mortality rates; and lower infectious disease incidence and mortality.

There are many components for ensuring quality including setting standards, training providers, certifying providers, and monitoring compliance. In addition, it is important that

there are incentives that motivate the provider to maintain quality standards. This assessment evaluates the role of the District Health Office (*Dinas Kesehatan* or Dinkes) in monitoring and supervision to ensure quality, as well as the role professional associations can play to enforce norms of practice for their members. Given the ongoing shift toward insurers as payers of health expenditures, we also examine whether they could be effective in ensuring provider quality by linking quality to financial incentives, or using payment mechanisms to ensure appropriate treatment protocols.

While the most recent data shows increased utilization by the poor (likely attributable to Jamkesmas), it does not necessarily address all the issues that hinder access to health care. For primary care, Jamkesmas is generally only accepted at public facilities, so patients must travel to public health centers. In areas with both public and private providers, consumers covered by Jamkesmas are limited to public providers or must continue to pay out of pocket for services. Facilitating access to private providers for primary care for consumers enrolled in Jamkesmas can significantly improve access for the population of 76 million covered by Jamkesmas.

The high reliance on self-treatment and high cost of medications also requires attention. Without confronting high profile and political pharmaceutical sector issues, there is room to improve drug use as part of an integrated approach to quality improvement, by facilitating distribution of appropriate drugs to private providers. Although there has been little experience collaborating with pharmacists or drugsellers to-date, strengthening the skills of pharmacists and drugsellers potentially impacts treatment of nearly 50 percent of cases of illness.

With these considerations, the assessment team and USAID/Indonesia agreed on five core assessment questions for the in-country work:

- How can services provided at private facilities be better integrated into the Dinkes monitoring and supervision system to ensure quality services?
- How can financial incentives (such as performance-based payments, payment mechanisms) be used to improve access to services or quality of services among private providers (i.e., midwives, general practitioners (GPs), Asyiyah, etc.)?
- What can be done to rationalize the use of medications, as part of an integrated provider quality improvement approach?
- Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?
- What role can professional associations play in monitoring and improving quality of care among private providers?

It also was agreed to focus on four types of providers. These providers were chosen because of their relevance in support of USAID's focus on MCH and infectious diseases.

- Midwives – Midwives are responsible for a large portion of MCH services, have a relatively organized professional association, and are legally authorized to operate private practices.
- Service delivery NGOs – NGOs such as Muhammadiyah and Nuhdlatul Ulama (NU) operate clinics and hospitals throughout Indonesia. In some areas, they are the most convenient health provider; however, government insurance schemes for the poor may or may not authorize services at their facilities. It was later learned that Muhammadiyah is a principal recipient for a GFATM grant for tuberculosis TB, and NU is a principal recipient for an HIV/AIDS grant.

- Pharmacists and drugsellers – Approximately half of all Indonesians self-medicate with products purchased through pharmacists, drugsellers, and other retail outlets. These actors can play an important role in rationalizing drug use, and providing referrals to health facilities.
- Physicians (GPs) – It is estimated that 80 percent of all GPs, including those employed by the government, also have private practices. They have been underutilized as partners in improving MCH services, and controlling infectious diseases.

4. METHODOLOGY

The in-country work was designed to answer the priority questions agreed upon with USAID/Indonesia:

- How can services provided at private facilities be better integrated into the Dinkes monitoring and supervision system to ensure quality services?
- How can financial incentives (such as performance-based payments, payment mechanisms) be used to improve access to services or quality of services among private providers (i.e., midwives, GPs, Aisyiyah, etc.)?
- What can be done to rationalize the use of medications, as part of an integrated provider quality improvement approach?
- Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?
- What role can professional associations play in monitoring and improving quality of care among private providers?

4.1 DISTRICT SELECTION

The following criteria were considered in district selection:

- Existence of long-standing Bidan Delima program (network of high quality midwives);
- Existence of district financing scheme (district commitment to health for the poor);
- Existence of Muhammadiyah health facilities (network of non-governmental facilities); and
- Experience in the district under USAID's Health Services Program (HSP) project (availability of pre-assessment data).

These characteristics would allow more concrete options for improving quality by working with strong provider networks, and using financial incentives to improve and ensure provider quality. Using these characteristics, we also aimed to select four districts that were representative of different types of districts in Indonesia. With input from USAID/Indonesia to focus on high population density urban and peri-urban areas, the four districts selected for field work were:

- West Jakarta – very large urban district;
- Kabupaten Bandung – peri-urban district;
- Daerah Istimewa Yogyakarta (DIY) – smaller urban district; and
- Cianjur – rural district.

Findings from each of these districts are integrated into this consolidated report.

4.2 ASSESSMENT APPROACH

Data collection consisted of semi-structured key informant interviews at central and district level. Key informants included government health officials at central, province, and district level, representatives of professional associations at various levels, NGOs with affiliated health facilities, government and commercial health insurance organizations, public and private hospitals, private providers, and staff at pharmacies and drugsellers. The team also met with donor organizations working in the health sector, as well as representatives of selected national programs that were of particular interest to USAID/Indonesia (e.g., National Tuberculosis Program, National Family Planning Coordination Board).

An assessment guide was developed that outlined the approach for examining each of the five assessment questions. The team also developed an interview guide specifying a few key questions for each type of interviewee. Given the range of questions to be addressed within a limited time frame, it was understood that not all areas would be thoroughly addressed in every district. The assessment guide is provided as Annex A.

Four team members visited Yogyakarta district from May 13-16. Yogyakarta was used as a pilot district to test the feasibility of the approach and usefulness of the interview guide. In general, the experience in Yogyakarta was positive, and no revisions were made to the approach. However, it was noted that there was an informant who was particularly uncomfortable speaking with researchers without advance notice from official channels. As a result, the team provided advance notice of their pending visit to district health officials and other informants in the three remaining districts. Detailed information on findings from Yogyakarta are reported in Annex B.

Data collection at central level, and in West Jakarta, Kabupaten Bandung, and Cianjur districts occurred between May 26 – June 8, 2009. The seven member team was separated into two groups – with one group traveling to Bandung and Cianjur, and the other group focusing on West Jakarta and the central level. Detailed information from these districts is available in reports of findings from West Jakarta, and a combined Kabupaten Bandung and Cianjur report attached as Annex B.

5. INTEGRATING PRIVATE PROVIDERS INTO THE HEALTH SYSTEM

5.1 SCOPE OF PRIVATE ACTORS IN THE HEALTH SECTOR

Private providers represent a significant force in the Indonesia health care system. The scope of private health care provision ranges from pharmacists (apotek) and drugsellers (toko obat) to individual physicians and midwives practices to large networks of faith-based hospitals and clinics.

The data on private providers at district and province levels likely underestimates the actual numbers. Further, under the decentralized health system, there is no central source of data on providers as it is only compiled at the district level. There is evidence that the size of the private sector is likely larger than official estimates:

- The Indonesian Pharmacists Association (ISFI) estimates there are 27,000 pharmacists in Indonesia. Given that each pharmacist is usually affiliated with several pharmacies, the estimate of 8,300 pharmacies in Indonesia is likely grossly underestimated.
- Official data from West Jakarta district show 405 pharmacies, but ISFI estimates there are 800 pharmacies in the district.
- There are 69 hospitals and 200 health clinics affiliated with Mudammadiyah; PERDHAKI, the Catholic Hospital Association, reports 85 affiliated hospitals and clinics; there are 70 hospitals and maternity clinics affiliated with NU.
- In West Java province, there are 22 public hospitals and 120 private hospitals.

Private providers are perceived to be higher quality, although actual clinical quality is inconsistent among both public and private providers. Approximately half of all Indonesians self-treat their illnesses, primarily through private pharmacists and drugsellers. Across all income groups, more institutional deliveries occur in private facilities than in public facilities. Small improvements in access and quality among private provider groups would have significant impact.

5.2 SUPERVISING AND MONITORING PRIVATE PROVIDERS

Under Indonesia's decentralized health system, the district health office (Dinkes) largely holds responsibility for supervising and monitoring the public and private providers in the district. There are also various central level regulations and legislation related to private hospitals, individual practices, and drug retailers that are implemented somewhat differently from district to district.

Oversight by the Dinkes begins with its role in licensing providers and practices. The districts visited all recognized their role in licensing and supervising both public and private practices. In

practice, however, limited resources make it difficult for district authorities to maintain oversight over private providers. Some professions have been more pro-active in ensuring that members are meeting set competency standards.

For physicians, the Medical Practitioners Act of 2004 makes it clear that the Indonesian Medical Association (IMA) is responsible for ensuring the quality of the profession and setting practice standards. IMA, at branch level[7], provides a recommendation for licensing, which all districts require before a doctor can be licensed. IMA introduced a competency exam in 2007 for all new doctors. Upon passing the competency exam, physicians are licensed for five years. At renewal, the physician must document at least 250 continuing professional development (CPD) credits or re-take the competency exam. Licensing requirements, however, are only a first step in ensuring quality. IMA admits that it is still working to define how to fulfill its responsibilities for ensuring quality more fully. Currently, neither IMA nor Dinkes has the resources to conduct supervision visits or to monitor private practices in other ways.

The Indonesian Midwives Association (IBI) follows a similar practice to IMA for its members. IBI has just introduced a competency test for its members, required for licensing. Unlike other professional associations, IBI is more active in supervision of its members. In all four assessment districts, private midwives reported supervision visits by the District Midwife Coordinator or another IBI leader in the district. In Yogyakarta, midwives reported receiving visits from the head of the Puskesmas.

The situation on licensing of pharmacists and pharmacy outlets is more confused. The districts have responsibility for licensing pharmacists, and issue licenses for a period of five years. Generally, the local branch of ISFI (Pharmacists Association) provides a recommendation letter to the district. However, ISFI reported that not all districts consider this letter a requirement for licensing. The licenses for pharmacy shops/outlets are issued at province level, but with the bulk of the applications being received and processed at district level and a final recommendation made to province level. Again, given resource constraints, it is not possible for districts or ISFI to monitor pharmacy operations once licensed.

The process for licensing new hospitals is first to receive a temporary operating license. Once the hospital is operational, they would request Hospital Accreditation Commission (KARS) accreditation, and upon successful accreditation, a standard operating license would be issued. KARS is an independent institution that accredits hospitals on 16 service standards, such as operating theater, pharmacy, emergency unit, etc. Regulations require that hospitals be accredited every three years. KARS reported that of the 1300 hospitals in Indonesia, 560 are accredited for all 16 standards. Clearly, the accreditation requirement is not enforced, and there appears to be minimal oversight of private hospitals once they are licensed.

Once private hospitals, individual practices or pharmacies are licensed, there is generally little further interaction with public health officials. Although there are some exceptions, private health providers, pharmacies, and hospitals generally do not provide any regular reports to the district health officials. Some hospitals and private practices that receive medicines and supplies from vertical programs such as TB medicines, vaccines, and malaria medication provide reports to the Dinkes, but only related to those programs for which they have received free medicines.

[7] There are currently 343 IMA branches, nearly one in every district in Indonesia.

Midwives, as a profession, generally do report on their services provided through the local Puskesmas and to their local IBI chapter. This practice was confirmed in all the assessment districts and by an HSP study on midwives reporting practices in Pasuruan and Malang districts in East Java. The HSP study nonetheless found many deficiencies in the manner of reporting, including lack of standard written reports (reports by SMS and telephone), inconsistencies in how population not in the official catchment area were treated, and lack of follow up from IBI or district officials. By contrast, midwives in West Jakarta and Yogyakarta use a standard form for reporting, but these are both urban districts with easy transportation and access.

While there is a perceived need to regulate and monitor private providers, the reasons for regulation are varied. There is some degree of mistrust from both sides, with public officials wary of unethical private providers driven by profit and private providers wary of corrupt public officials. District officials want to maintain authority and have some control, but they do not have sufficient resources to carry out this function. The providers themselves want to regulate their profession in order to reduce potential competition – IMA suggested that it is important they control both the quality and quantity of providers, while pharmacies in Yogyakarta complained that district officials allowed new large pharmacies to open in close proximity to smaller pharmacies, negatively impacting revenues of smaller pharmacies.

Aside from resource constraints, there are other factors that make it difficult to monitor private practices. Licensing occurs at the district health office, and this information is not shared across districts or with central level. As such, in a large urban area such as Jakarta, officials are finding it difficult to enforce a national regulation limiting physicians to operating no more than three private practices – doctors are setting up additional practices in neighboring districts without detection. The West Jakarta team by coincidence found a midwife who was operating even though her license had expired several months ago. Aside from having district health officials inspecting the streets regularly, it is very difficult to prevent unlicensed private practices.

5.3 NEW INITIATIVES TO MONITOR QUALITY

In two of the four districts visited, the assessment team found independent agencies or organizations that were active in reviewing service quality and consumer protection. Some of these groups are relatively nascent, and would benefit from external technical assistance. Nonetheless, they are still potentially effective models for external oversight of public and private providers.

Yogyakarta district established an independent monitoring agency, Badan Mutu Pelayanan Kesehatan (BMPK), to oversee health care quality. Its creation was originally supported as part of a World Bank loan. Its mission is to help health care providers and authorities deliver comprehensive, continuous, professional, and high quality services. They provide a link between licensing, health worker monitoring and health facility management. Three examples of their work include:

- BMPK adopted ISFI's proposal to require two pharmacists at each pharmacy, in order to have 24 hour counseling on drug interaction, effectiveness and dosage. Although 53 percent of the Yogyakarta pharmacies officially have two pharmacists on duty, in practice this is proving very hard to enforce.
- BMPK commissioned an assessment of a private hospital that had an unacceptably high case fatality rate in the treatment of Dengue Hemorrhagic Fever. This resulted in a letter from

Dinas to the hospital detailing the necessary improvements required to be undertaken in order to avoid further sanctions, including potentially closing the hospital.

- BMPK assessed 10 hospitals that were each considered referral hospitals of choice for emergency obstetric treatment. This assessment found standard operating procedures (SOP) not in use, key staff such as anesthetists not in place, midwives not present in the emergency room, and non-functioning blood banks among other key findings.

In both Yogyakarta and Bandung, the team found groups that were active in consumer advocacy related to health care. The consumer group in Yogyakarta concerned itself with issues such as discrimination towards Jamkesmas patients, lack of physicians in the emergency room, and Puskesmas becoming increasingly profit-focused. The consumer group in Bandung was more focused on individual malpractice cases, and less on systemic issues in the district. Nonetheless, independent groups that have the technical skills to monitor quality related issues may contribute effectively to quality improvement.

5.4 COLLABORATION WITH PRIVATE PROVIDERS

As the licensor for health providers, district officials in principle have a full map of the health care system including private providers, but in practice they limit their focus almost exclusively to the public sector. As important as the lack of supervision of private facilities is the lost opportunity from not including private facilities in public health programs. Further, given the supply constraints in the health system, not making full use of all health care investments, whether public or private, is inefficient.

The extent of collaboration between public health officials and private providers tends to be limited. Nearly all the experiences of private sector collaboration provided were in the area of TB control. In West Jakarta, the district had a program to provide private doctors with TB drugs, but very few doctors participated, and the GFATM funding disruption effectively ended the program. St. Carolus Hospital in West Jakarta has operated a TB control program for 26 years, training community members to administer DOTS and supplying treatment kits. They sometimes received free TB drugs, and sometimes procured them independently. In Bandung, district health officials trained 50 pharmacists to identify TB symptoms and provide referral information. Under the direction of ISFI, these pharmacists were to train other pharmacists. However, there was little follow through by ISFI, and no monitoring by health officials, so results were limited. Kabupaten Bandung also provides TB drugs to the Muhammadiyah affiliated hospital.

The Bandung Provincial Health Office (PHO) seemed to seek broader collaboration with private providers, primarily through the professional associations. The PHO meets regularly with representatives of IMA, IBI, ISFI, and GP Farmasi at province level. One of the areas of discussion is provider training and the number of participant slots allocated for private providers. While this is a positive step, it would seem that assistance to facilitate discussions of more concrete collaborative efforts would be helpful.

One potential area for more concrete collaboration is developing referral protocols for both public and private providers linked to specific referral facilities, including public and private facilities. As a rule, staff in Puskesmas generally do not refer patients to private hospitals. Thus, even in emergencies patients would not necessarily travel to the nearest hospital. It is unclear whether there was a thoughtful decision only to refer to public facilities because of potentially higher costs at private facilities or loyalty to the public health system, or merely habit. St. Carolus Hospital in

Jakarta worked with nearby midwives to agree on a discounted rate for delivery for patients referred by the midwife because of complications. Such an agreement between Puskesmas and nearby hospitals with high quality emergency obstetric care could improve maternity outcomes. Working with professional associations to develop protocols for referral, training public and private providers on conditions for referral, and setting appropriate fees for treatment of important public health conditions would make use of investments in private health facilities to help achieve public health goals.

5.5 ROLE OF PRIVATE PROVIDER NETWORKS

One of the challenges of working with private providers is finding ways to bring activities to a significant scale. This assessment found many different types of networks that may be helpful to overcome this challenge. For the most part, however, these networks are only loose affiliations with limited management capacity, particularly at central level, and much technical assistance will be required for large scale project implementation. Nonetheless, they do represent a mechanism for coordination at district and province that could be effective. A few larger networks of providers that should be considered high potential partners are:

- Muhammadiyah, and its sister organization Aisyiyah;
- Nahdlatul Ulama (NU), and its sister organization Muslimat;
- PERDHAKI, Association of Voluntary Health Services (Catholic Hospital Association); and
- Bidan Delima, a network of quality-certified midwives.

Muhammadiyah and Aisyiyah together represent a network of 69 hospitals and 200 clinics, mostly concentrated on Java. All hospitals operate independently although some hospitals have affiliated health centers, which are managed through the hospital. There are currently no uniform treatment protocols, fee schedule, common procurement system. However, they represent a particularly interesting partner for two reasons: 1) they are undertaking efforts to improve management of their health facilities, aiming to set standards and improve service quality; and, 2) they are a PR for TB funding under Round 8 of GFATM grants, which will include community-based case detection and DOTS. Supporting Muhammadiyah to strengthen management, improve quality, and implement the GFATM grant would leverage on existing investments, with potentially high returns.

There are 70 NU and Muslimat affiliated hospitals and maternity clinics. Like Muhammadiyah, all operate independently for the most part, but there is some coordination in a few provinces. For example, in East Java, there is a provincial board that oversees affiliated facilities in the province, operated out of the NU affiliated hospital in Surabaya. Also affiliated with NU is the Health Sciences Institute (LPK). It has been a recipient of donor funding to conduct community mobilization, behavior change communication (BCC) and advocacy activities related to health. LPK is a GFATM sub-recipient for HIV/AIDS related activities.

PERDHAKI is an association of 85 Catholic-affiliated hospitals and clinics. All the health facilities are independently operated and self financing. However, PERDHAKI conducts activities at central level to support its members, and in some districts, there is some coordination between the health facilities. It organizes training for its members, maintains a program to provide free medicines for poor patients in its member facilities, and operates a drug procurement and distribution system for its members. It maintains a well organized central store of primarily generic medicines. PERDHAKI is one of the GFATM PRs for malaria. A PERDHAKI affiliated hospital, Panti Rapih, in Yogyakarta, coordinates the activities in four smaller health facilities, including procurement of drug and supplies.

Unlike Muhammadiyah and NU facilities, which tend to target the middle class but still serve a significant number of poor and near-poor patients, the perception in many areas is that the Catholic hospital is more expensive and so does not tend to attract the poor or near-poor. The observations of the assessment team tend to confirm this perception. For example, St. Carolus Hospital in Jakarta estimates that 15 percent of its patients are GAKIN patients, much lower than other hospitals visited in Jakarta. Panti Rapih Hospital in Yogyakarta reportedly treats 10 charity patients per month, generates operating surpluses, and cites orthopedic care and knee replacement as among their niches in the market.

There are many ways that these provider networks can be effective partners. They can participate as implementers of public health programs, such as TB or malaria control. Just as the vertical programs now provide drugs and supplies to public facilities, they also can supply private facilities more systematically. Supporting these networks to develop and enforce quality standards, an area in which at least Muhammadiyah has already shown interest, could have large scale effects – Muhammadiyah includes 69 hospitals out of 1300 in Indonesia, so the scale is not insignificant. Lastly, those facilities that may serve higher income clients also tend to have more advanced specialty wards not found in other hospitals, so ensuring that they are used effectively for complicated referrals increases the efficiency of the entire health system.

Bidan Delima (BD) is the only large scale network of individual practitioners identified. There are approximately 7,500 BD operating in over 200 districts in Indonesia. The BD program was established through a USAID program, and is operated by IBI. BD must undergo a certification process that aims to promote higher quality standards. While there is some evidence that the BD certification improves quality, continued vigilance is required to ensure that standards are maintained. Establishing financial incentives for BD to maintain high quality, such as access to contracting opportunities, or higher reimbursement rates, would promote compliance with quality standards.

6. USING FINANCIAL INCENTIVES TO IMPROVE ACCESS AND QUALITY

6.1 GROWTH OF THIRD PARTY PAYERS

Indonesia has historically spent relatively little on health, both from public and private sources, compared to other countries of similar income and compared to countries in East Asia. Because of the low level of public spending, the vast majority of public health personnel also work in private practice, and there is a large and flourishing private sector in health care provision including hospitals, clinics, and private drugsellers. Indonesians tend to pay a large percentage of health expenditures out-of-pocket, and often treat themselves, and this private spending is generally paid directly from the patient to provider. In a system relying on direct out-of-pocket provider payments, individuals have little leverage or knowledge to assess or enforce provider quality.

Despite a long history of health insurance in Indonesia, the growth of coverage has been relatively slow until recent years. The civil servants scheme managed by PT Askes was established in 1968, and currently covers 4 million government employees plus 11 million of their family members. The scheme for formal sector workers, which was established in 1993 and is managed by PT Jamsostek, has stagnated, and currently covers around 2.9 million workers. In addition, military personnel and their family members were covered by government funding, while other formal sector workers were covered by voluntary private health insurance.

In 2004, the situation changed significantly. First, the Government of Indonesia passed Law 40, which committed itself to achieving universal health insurance coverage. The Government also established a health insurance program for the poor, Jamkesmas (initially called Askeskin), and this now covers 76.4 million people. Many district governments have followed the lead of Jamkesmas and established district-based insurance schemes (often called Jamkesda) that cover the near poor. These schemes take different forms. Some schemes are designed as extensions of Jamkesmas, with the goal of covering an additional population of near-poor, on top of those covered by Jamkesmas. Other schemes focus on specific services, such as in Yogyakarta, where the assessment team found a scheme covering MCH services for 104,000 children and pregnant women. There are also a number of very small local initiatives with various different models in terms of their source of funding, benefit packages and fund management institutions. Lastly, there are a few districts that have announced free health services for all, but the details of funding and benefits are unclear.

With the establishment of the Jamkesmas scheme and the district-funded schemes that followed, nearly half of all Indonesians (109 million out of 237 million) are now covered by some form of health insurance, as shown in Table 3.

TABLE 3: POPULATION COVERAGE BY HEALTH INSURANCE IN INDONESIA, 2008, IN MILLIONS

Insurance Scheme	Total Coverage
1. Civil Servants (government funded)	15.0
2. Military Personnel (government funded)	5.0
3. Formal Workers in Jamsostek	2.9
4. Informal Sector (Self-insured)	0.1
5.Voluntary Private Health Insurance	7.0
6. Jamkesmas (poor and near-poor)	76.4
7. Sub-national Health Insurance Schemes	2.3
Total Known Coverage (millions)	108.7
Share of Total Population	47.3%

Source: Center for Health Financing and Health Security (Insurance) (PPJK, MOH)

Although universal coverage has yet to be implemented, Law 40 was the beginning of a broader trend toward increasing insurance coverage. Indonesia is transitioning from a publicly funded health system towards an insurance-based system, where the government pays the health insurance contributions of the poor.

The growth of third party payers, such as Jamkesmas and Askes, represent a major change in the health sector. These groups have much more leverage compared with individuals to exert pressure on provider behavior. Working through Jamkesmas and/or Askes to change payment rates and policies can help control costs[8] (reimbursement only for generic drugs), improve quality (reimbursement only if provider adheres to standard treatment protocols), and increase access (reimbursement at higher rates in remote areas).

6.2 FLOW OF PUBLIC FUNDING TO PRIVATE PROVIDERS

Of particular interest in this assessment is that these new publicly funded insurance schemes, which represent a significant portion of public health spending (Jamkesmas is 25 percent of the Depkes budget) and cover a large portion of the population (more than 30 percent) are being used at private health facilities. Less than 25 percent of Jamkesmas funding (Rp 1.0 trillion of Rp 4.6 trillion) is allocated to Puskesmas, which means the large majority of Jamkesmas funding can be used at public and private providers. Although services considered public health priorities, such as maternal health services, family planning, etc. have long been provided by private providers, the establishment of Jamkesmas meant that government funding was now being used to pay these private providers.

These changes in funding flows create new opportunities, as well as responsibilities, for public health officials related to private providers. Public health officials have not taken advantage of opportunities to use Jamkesmas (entirely publically funded) or Askes payment policies to support its public health objectives. Nor have public health officials acted upon their additional responsibilities to provide better oversight of private providers that are receiving public funding. While challenging traditional notions of the public health system, both public health officials and private

[8] Askes has realized significant reduction in its drug costs through improved management and enforcement of its drug formulary.

providers need to recognize that there are benefits to both sides in transitioning to a more integrated public-private health system.

Jamkesmas contracts with 926 hospitals to provide services, including 220 private hospitals. Staff at district level select the hospitals to contract with, and ensure that the facilities are licensed and perform satisfactorily. While the benefits package is the same nationally, districts set the reimbursement rates for various services based on local conditions. The civil servants scheme, which is equally funded by government and individual contributions, and managed by PT Askes, contracts with 312 private hospitals. It uses standard reimbursement rates for all hospitals, and negotiates a set cost sharing fee for its members (co-payment) with hospitals if the hospital will not accept the Askes rates. Askes maintains staff at district level, and also has established service centers within contracted hospitals to assist with claim verification and other administrative issues. In East Java, Askes is conducting a pilot to contract with individual family physicians, which represents its first foray into contracting with private providers for primary care. Previously Askes only contracted with Puskesmas for primary care.

PT Askes also has contracts with approximately 60 districts to manage district-funded insurance schemes covering 1.5 million people. Askes advises the local government on the financial soundness of its plans, and helps the government to adjust its benefit package based on the limited government budget, but takes no risk for the financial results of the plan. Askes contracts with public and private hospitals to provide services, just as it does with the civil servants scheme. In total, it is estimated that as many as 100 districts have this form of district-funded insurance.

While there has been broad experience with contracting public and private providers through these publicly-funded schemes, the contract mechanisms have not used reimbursement or payment policies strategically to drive improvements in quality or efficiency. There are many examples in maternal health, where the current reimbursement system by Jamkesmas sets the wrong incentives for providers, such as not reimbursing midwives for pre-delivery care if there is post-partum hemorrhage. Once the patient is referred to the hospital, the hospital receives the full reimbursement for delivery, while the midwife receives no fee, thereby discouraging midwives from referring patients to hospitals for complications as they would lose income. There is great potential in using the new insurance schemes to drive improvements in access, efficiency and quality. These insurance schemes create a new opportunity in Indonesia to drive quality improvement for priority services like MCH and TB by adjusting the payment methods to incentivize changes in clinical practice that promote public health priorities.

Under the decentralized health system, districts have the autonomy to set payment rates under Jamkesmas, and to design the benefits and payments of the district-funded schemes. District and provincial health offices are interested to work with the private sector, and would welcome technical support to pilot changes in payment methods/benefits packages to make progress in priority areas like MCH and TB.

Lastly, while the assessment found some complaints from private providers regarding these schemes, the fact that a variety of providers continue to accept them is very telling. While providers would always prefer higher reimbursement rates and faster payment, there appears to be generally sufficient financial incentive for providers to accept Jamkesmas and Askes. For example, midwives in Bandung reported that they accepted Jamkesmas because of their social responsibility, even though the reimbursement of Rp 300,000 to Rp 350,000 was at the low end of their normal fees of Rp 300,000 to Rp 500,000. On the other hand, in West Jakarta, where the GAKIN scheme reimburses at a rate of Rp 150,000 for delivery, none of the private midwives accepted GAKIN. Private providers are willing to accept some of the hassles of third party payers, if reimbursement rates are within the

customary fees. At the same time, it is unlikely that social responsibility or even mandates would be sufficient to encourage providers to accept reimbursements that are far below their normal fees.

6.3 IMPROVING ACCESS AND QUALITY THROUGH ASKES AND JAMKESMAS REIMBURSEMENTS

Both Askes and Jamkesmas offer comprehensive benefits packages, including inpatient and outpatient care, and prescription drug benefits. Both schemes reimburse based on services provided, although there are maximum reimbursement rates by type of service. Jamkesmas is reportedly in the process of transitioning its reimbursement system from fee-for-service to one based on diagnosis related grouping (DRG) beginning in 2009.[9] There is some period of roll-out, as the hospitals visited generally did not confirm this change.

Changes in reimbursement systems can drive provider behavior in many ways, including enforcing that providers adhere to treatment protocols, promoting specific health services, and removing existing disincentives to adhere to protocol. While there is no dearth of standards in Indonesia (clinical treatment standards, hospital standards, standard drug formularies, etc.) the problem lies in the lack of enforcement. Neither government officials nor professional associations have really taken on the task of ensuring that providers comply with the accepted standards. Askes and Jamkesmas have greater ability to enforce these standards than do the government or professional associations because as the financial intermediary, they control the money. We would expect changes to treatment practices if these payers did not reimburse for treatments or medicines outside the standard protocol, or did not contract with hospitals who do not meet standards. Askes has reduced its drug costs by enforcing use of its drug formulary, so there is a history of success in this area.

Another type of change that can be promoted through reimbursement systems is the use of targeted services. The current health system is very provider driven, so by adjusting the reimbursement rates for various services, we can encourage providers to target certain services. One potential application of this is in the area of family planning, a service which is increasingly dependent on private providers. Family planning methods have also increasingly become concentrated in two short-term methods – oral contraceptives and injectables. These two trends may not necessarily be independent of each other –private midwives tend to prefer these methods that are easy to administer and generate regular income (monthly injections), and patients increasingly have used private midwives. If for example, Jamkesmas or Askes increased its reimbursement rate for IUD, to a level that motivates midwives to provide the service, they may more actively offer it as an alternative method to clients. A similar example in the area of MCH would be increasing the reimbursement rate for the third or fourth antenatal visit. This may result in midwives more actively educating their clients on the importance of those visits to detect potential risk factors for delivery.

Throughout this assessment, there were many examples identified of disincentives in the current reimbursement policies. The most glaring was in the area of midwife referrals to hospital during or after delivery in the event of complications. In the event of a referral, the current policies only allow the hospital to be reimbursed for delivery. Not only is a midwife not reimbursed for her services (during many hours of labor) but she is not reimbursed for direct costs, such as IVs administered. While we have no evidence of purposeful unethical behavior, certainly all the incentives are for the

[9] DRG is a classification system used by health insurers to determine reimbursement rates based on diagnosis, differing from Indonesia's current reimbursement system based on goods and services provided. DRGs oblige hospital administrators to eliminate physician over-treatment, as the reimbursement rate is pre-set by diagnosis.

midwife to try to manage the complication herself. The same is true in the event of post-partum hemorrhage – once the patient is transferred to the hospital, the hospital would claim for both the delivery and the management of the hemorrhage. To add insult to injury, at least in Yogyakarta, the hospital might even transfer the patient back to the midwife for post-partum care – all for which she is completely not reimbursed. Although not intending to endanger the mother or child, the midwife has every incentive not to refer a woman to the hospital. By changing the reimbursement categories to include a fee for managing labor with referral to hospital, we may see a significant increase in earlier referrals.

From the standpoint of public health programs, Askes and Jamkesmas may be very useful tools for improving health outcomes, but these tools are not being used. Public health officials view these schemes primarily in financial terms and do not see their potential to drive forward public health priorities. The case of maternal health illustrates why it is important to complement interventions to change and strengthen clinical practice with financial incentives. Minor changes in payment policy could have important consequences for maternal health services. Jamkesmas, and its cousins Jamkesda, Gakin, Askes, and Jamsostek should adopt a more coordinated public health perspective to important health problems in Indonesia such as the high maternal death rate and the high rate of TB.

7. RATIONALIZING USE OF MEDICATIONS

7.1 OVERALL SITUATION ON RATIONAL DRUG USE

There is little evidence of rational drug use (RDU) being implemented in systematic ways among private sector providers, but RDU could be significantly improved with only minor changes to reimbursement schemes. The RDU situation is highly variable between the many different health care providers. There is a generally good knowledge of the many benefits of RDU among a wide range of active players, but little evidence of effective RDU being implemented in systematic ways. Rather, there are factors and powerful income motivations working against the rational use of drugs.

A recent World Bank Policy Note[10] concluded: "Financial incentives – the profit/income motivation – are currently driving irrational use of drugs and use of high cost medicines in cases where a cheaper alternative is available. The way that doctors, pharmacists, clinics and hospitals are organized, paid and held accountable needs to be reformed to encourage more ethical, efficient practices in relation to medicines." This finding was confirmed by the information collected during this assessment – current insurance reimbursement schemes discourage RDU, but the situation is not universally bad. The Askes scheme has already implemented a restricted formulary and gained major cost benefits and there are high levels of generic medicines use within the faith-based hospital networks.

Full implementation of effective RDU systems will probably require major policy reforms, and massive enforcement strengthening. However, many financial motivations which currently distort and discourage effective RDU could be reformed relatively easily to bring significant impacts, with only minor changes to reimbursement mechanisms within the existing health financing schemes for the poor. More widespread use of the RDU systems which Askes is already using would bring a significant impact in cost efficiencies.

7.2 SOURCES OF MEDICATION FOR PRIVATE SECTOR PROVIDERS

Most private sector providers are obtaining their medicines from the national pharmaceutical distributors. By far the main source of medicines for private hospitals is through the national pharmaceutical distributors, with most hospitals reporting using six to eight main distributors, and the ready availability of all medicines required.

Faith-based hospitals are using a high proportion of generic medicines. The private hospitals reported using a combination of generic and brand name products, but at the pharmacy sections visited,

[10] World Bank: Indonesia Health Sector Review: Policy Notes Series: Policy Note Pharmaceuticals; March 2009

an average of over 60 percent of the products were generics, and nearly 80 percent of the generics were Berlogo medicines (OGB).

Midwives are not obtaining drugs from secure sources raising product quality issues. Private midwives report using the 'informal market' – largely unlicensed sellers of pharmaceuticals – because of lower prices for very small scale purchases, and ease of access and response. The IBI branch in Jakarta tried to act as a distributor, but there was not much interest because the commercial sector is more efficient. In Bandung midwives are buying a proportion of their medicines through IBI during their monthly meetings, but it is uncertain how those medicines are sourced. Even so, midwives do not hold much stock and so may well buy from the informal sector mid-month as well. Providing secure supply sources for midwives by facilitating a relationship with a good distributor would likely not have any significant impact on price because volumes are too low, but could ensure that quality medicines are available. The majority of the medicines examined at midwife practices were generics.

None of the private sector health providers are operating a significant volume medicine supply alternative to the commercial distributors. PERDHAKI, the Catholic hospital association, operates both an internal medicines procurement, storage and distribution system (which deals largely with externally donated/funded medicines) for low-income patients in its affiliated hospitals, as well as a commercial procurement and distribution service, KDU. Both are very small scale. Muhammadiyah and NU have fully decentralized systems, with each hospital self-procuring medicines. None of the central or district financing schemes are operating direct supply medicine schemes.

7.3 POTENTIAL ROLE OF DISTRICT AS SUPPLY POINT FOR MEDICINES

There is very limited supply of public sector medicines available in the private sector. Nearly all private sector hospital respondents reported that they receive almost no medicines from the public sector, except for small quantities of TB medicines. However, the observed situations in the pharmacy sections of hospitals showed a generally reasonable supply of clearly public program TB medicines available at most hospital pharmacies/pharmacy stores. At some private hospital sites, small quantities of Oralit, Vitamin A capsules, and vaccines from the public sector were also found. Although public sector TB medicine kits are reaching the private sector, quantities need to be increased. Except for PKBI, the Indonesian affiliate of the International Planned Parenthood Federation, we found no public sector-funded contraceptives/FP commodities in any of the private sector sites visited. Midwives reported that they received some public sector medicines, including vaccines and Vitamin A, but these were never in sufficient quantities to meet the demand, and they generally purchased almost all of their needed supplies.

The potential for public/private cooperation in the area of drug supply is highly variable between districts.

> **Yogyakarta:** There is only a limited role for the district to serve as a supply point for private providers. Currently, vaccines, the drug regimen for TB and some malaria drugs are received by private providers from the district. In some cases, these drugs are intended to be passed on to the consumer at no cost but various different midwives stated that they charge fees, particularly for immunizations and contraceptives.
>
> **West Jakarta:** West Jakarta district reported that although in theory it can supply the private sector with program medicines, this practice is very limited for several reasons: 1) it receives

too few medicines to meet the public sector need fully; 2) there is little interest from the private sector with less than 10 percent uptake; and 3) the district has decentralized medicine procurement to Puskemas level. The system of decentralizing medicines procurement to Puskesmas level appears unique to Jakarta and would be unusual outside large urban areas, where there may be greater scope for the district to act as a resource for the supply of public medicines to the private sector.

West Java: Currently, vaccines, TB drugs, and some malaria drugs are received by qualified private providers from the District Health Office in Bandung. These drugs are intended to be passed on to the consumer at no cost.

There does appear to be potential to engage those districts who recognize the importance of inclusion of the private sector in developing mechanisms for effective supply. Districts have the potential to act as a medicine supply point for private providers in three ways:

- As a gateway for the supply of public sector, vertical program medicines from central level;
- As a source of provincial and district funded medicines (probably for specific priority medicines rather than a generalized supply); and
- As a secure source for very low volume users – individual midwives, small private clinics, and for 'orphan' medicines to all private sector users.

All districts can receive medicines from the 13 central level vertical programs: Acute Respiratory Infection (ARI) {includes Avian Flu and now Swine flu}, Contraceptives/Family Planning Supplies, Diarrhea control, EPI, HIV/AIDS, Iodine, Iron, Leprosy, Malaria, Oral Rehydration Salts (ORS), TB, Vitamin A, and Yaws. Although nearly all of the 13 public sector, vertical programs, claim they supply medicines to the private sector, in practice, for other than TB medicines, only very small quantities of public sector medicines are reaching private providers, and even that supply is highly erratic.

If medicines from the public sector vertical programs could be supplied into the private sector in significant quantities (as is already the policy of most of the public sector vertical programs) it could have a significant impact in two ways:

- It would help to drive rational drug use by ensuring that all sites used the same medicines, and treatment profiles – thereby reducing the potential for anti-microbial resistance; and
- It would help to make payments from Jamkesmas and district financing schemes more attractive to private providers (by effectively subsidizing the cost of drugs), possibly reducing potential resistance to the imposition of RDU conditions tied to these reimbursements.

7.4 ROLE OF PROFESSIONAL ASSOCIATIONS IN IMPROVING PRACTICE NORMS

There are a number of professional associations that could contribute to improving practice norms, however, they do not appear to be strong enough to lead major activities. While both of the national pharmaceutical professional organizations visited expressed interest in improving practice norms, it is clear that the information provided is sometimes confused and contradictory. They both appear weak in terms of clinical/technical practice development and have a highly decentralized structure. It would be advantageous to involve these associations in activities to

improve professional skills development and practice norms, but it would be difficult to envision how they could lead such a process, without substantial strengthening.

ISFI is the main professional body for pharmacists, while GP Farmasia serves as the main body for pharmaceutical manufacturers, distributors, pharmacies and licensed drugsellers. Both organizations recognize that there is a degree of overlap in their membership and activities. ISFI has approximately 5,400 members from an estimated 27,000 registered pharmacists, with 33 branches, mainly at province level. ISFI has tried to promote the concept of TATAP (Tanpa Apoteker Tidak Ada Pelayanan) or "no pharmacist, no service" as part of its national recommendations, as well as develop 'ethics committees' at branch level.

Based on the assessment team's visits to pharmacies, however, there is still a long way to go before there is general adherence to the TATAP rule. In Yogyakarta district, ISFI supports continuing education seminars in an effort to improve practice norms. At the most recent 2008 meeting, they offered a seminar on "Optimizing Pharmaceutical Services by Using Medical Records." In 2007, they offered a course on "Patient Safety and Drug Information" in conjunction with the Bethesda Hospital, a local business and Gadjah Mada University. In West Java, ISFI and local health officials are focusing on implementation of the "no pharmacist, no service" policy.

GP Farmasi, the association representing the pharmaceutical industry, has branch offices at province level, and a number of districts offices as well. They have tried to pioneer the concept of Apotek Sehat or "simple pharmacy service," meaning pharmacies would sell only ready finished products (no compounding or 'wet' dispensing) and be subject to less regulations, although a pharmacist is still required to be present at the time of dispensing.

Both of these organizations have membership data but only a small percentage of licensed pharmacists or drugsellers are actually dues paying members. The decentralized nature of both organizations means that meetings most often occur at district and province level. While both organizations could contribute to developing practice norms, because of the decentralized nature of operation, collaboration at district, and perhaps province level, would likely be more effective.

Major changes to practices in retail pharmacies will take some time. However, changes in targeted areas, with input from physicians and hospitals, may still be feasible to improve RDU. For example, working through the faith-based hospital associations to conduct training for pharmacists at their affiliated hospitals and pharmacies, related to labeling and counseling may be effective, as these are the only pharmacies that appear to have pharmacists on site. Similarly, working with IMA to develop standardized drug regimens for common conditions, if reinforced by recommendations from Askes or Jamkesmas also may be effective.

Further, interventions to improve consumer knowledge around drug use also would be important. Faculty at Gadjah Mada University implemented a program designed to help mothers with limited education make better consumer decisions about over-the-counter (OTC) medicines. The training is intended to empower mothers to seek and critically assess information on the drugs that they commonly use, and to increase drug procurement efficiency in households. This program is conducted via the students at the University.

8. PHARMACISTS AND DRUGSELLERS AS PARTNERS

8.1 LICENSING AND OVERSIGHT OF PHARMACIES AND DRUGSTORES

The requirements for licensing pharmacists seem to vary from district to district. Some districts require ISFI to provide a reference letter to Dinkes for the licensing process. It is unclear the basis of this reference, as ISFI reports to issue the reference for both members and non-members. Pharmacist licenses are issued for five years, with renewal requiring presentation of a portfolio of CPD or undertaking a competence test, but compliance varies widely. Because licensing is at district level, no records of licensed pharmacists are available at central level.

Beyond an initial licensing review it is clear that there is virtually no effective oversight and monitoring of pharmacies and drugs stores. District Health Offices say they simply do not have adequate staffing to undertake such tasks and there is little interest at central or other levels to enforce the required monitoring. ISFI does not currently undertake any effective monitoring of its members and activities.

There is no compliance with the basic regulations related to pharmacy practices. Ethical medicines are dispensed without prescription, no pharmacist is present at the time of dispensing, and there is no counseling or information provided to patients. Yogyakarta district is trying to enforce the standard of two pharmacists for every pharmacy, and currently 53 percent of pharmacies in Yogyakarta city have two pharmacists registered with the pharmacy. However in a random on-the-spot cross check conducted by the assessment team, a pharmacist was present in only one of many pharmacies visited. In West Java, a hospital pharmacist mentioned that the regulation of two pharmacists per pharmacy is not enforced in reality. The district ISFI branch is supposed to monitor the policy, but it has no power, as no recommendation is needed from ISFI for renewal of licenses, nor are licenses revoked if pharmacies fail to comply. In West Jakarta, all but one of the pharmacies and drugsellers visited, including a central level Depkes hospital, readily sold cephalosporin antibiotics without a prescription in clear breach of regulation and even the packet labeling. Pharmacists were not available at any of the commercial shops, nor the Depkes hospital visited.

8.2 STAFF OF PHARMACIES AND DRUGSTORES

Pharmacists were available at the faith-based and not-for-profit hospitals visited. They were knowledgeable and were able to locate their supplies by generic name and therapeutic requirement. Reference material in the form of formularies and the Monthly Index of Medical Specialties (MIMS) were available. A pharmacist was available at one GP practice visited in West Jakarta, who could correctly identify medicines and refused to sell antibiotics without a prescription.

No pharmacists were available at any of the retail sites visited. Staff claiming to be assistant pharmacists at the retail outlets had little demonstrable pharmaceutical knowledge, could not identify

medicine by generic name or therapeutic requirement, nor could provide dosage advice. All were willing to sell clearly marked 'prescription only' medicines without a prescription.

Medicines prescriptions at all sites visited indicated extensive poly-pharmacy, with typically over six items per prescription. Labeling of medicines was very poor at all sites. Labels were hand written in cursive script with no supplemental instructions or cautionary statements. Labels did not include important information such as the patient's name, name of medicine, or date dispensed.

ISFI has encouraged the requirement of two registered pharmacists per retail store in line with its vision that a pharmacy should be a place for professional services where pharmacists provide information on drug efficacy, drug interaction, drug allergies, etc. ISFI has been pushing the local and national governments to adopt regulations that recognize pharmacies as places for pharmacists' professional services, not business units. Under current practice, investors (sometimes doctors) own pharmacies and pharmacists are paid very low wages (about Rp.1-2 million a month). Under this model, a pharmacist comes in only one hour a day, or even only 2-3 times a week, undermining the professional consultation role. ISFI believes that limiting ownership of pharmacies to pharmacists would improve professional standards.

8.3 EXPERIENCES WORKING WITH PHARMACIES AND DRUGSTORES

The Ministry of Health had devised a potentially useful program for ensuring the availability of low-cost, good-quality generic medicines in the private sector. In the 1990s, Depkes developed a generic drug program (OGB) to promote affordable unbranded generics in the private sector. These quality-assured, unbranded generics carry a logo that was promoted to the public as a symbol of quality in the initial stages of the program. Around half of the drugs on the National Essential Drug List are included in this program.

Revitalization of the OGB scheme and the active promotion of the value of generic medicines have the potential for significant impacts. Ineffective promotion of the OGB scheme to the public, non-transparent pricing structures, and the loss of the former central-level mass procurement of public sector medicines (now procured by individual districts) have weakened the scheme. But the findings from this assessment are that the majority of basic medicines found in the not-for-profit private health hospitals are OGB medicines. Among the genuine pharmacy professionals employed in the private sector it is clear that OGB medicines are valued for their assured quality and low price. OGB medicines were also found at all the retail outlets visited – although it sometimes took a little pushing for the outlet to admit they had such items, and at the government approved prices. In recent years, the Askes civil servants scheme has achieved huge reductions in medicines cost at least partly due to regulatory requirements to use generic medicines.

Working at public health sector central level to revitalize the OGB scheme is likely to be challenging and would require many new inputs. Effective revitalization would need to include development of effective marketing strategies, dissemination of public health messages targeting providers and consumers, and transparent tendering and contracting mechanisms. The potential for major health impacts are however correspondingly high and the matter is worthy of serious consideration.

The efforts to collaborate with private pharmacists so far have centered around the national TB program, and are inconclusive because of funding interruptions. West Jakarta

district provides TB drugs to private providers, but the uptake has been low. Several faith-based hospitals visited reported having received TB medicines. Kabupaten Bandung had trained 50 pharmacists, organized through ISFI, to identify TB symptoms and refer for investigation. This program was not very successful because of lack of follow-up by ISFI or the District Health Office. Nonetheless, it is clear that in some districts, reasonable cooperation exists between the public and private sector, and both the drugsellers and pharmacies have been willing to undertake public health activities without the need for external financial incentives.

8.4 POTENTIAL AREAS OF COOPERATION

The data show that 45 percent of Indonesians first consult with a pharmacy or drugseller for medication at the onset of illness. The potential for pharmacy providers to make a significant impact through providing professional public health advice is therefore significant.

The national TB control program is considered one of the stronger public health programs operating in Indonesia and has already undertaken some work with private sector providers. Indonesia ranks third on the list of 22 high-burden TB countries in the world. According to the WHO's *Global Tuberculosis Control Report 2008*, there was an estimated 535,000 new TB cases and an estimated incidence rate of 105 new sputum smear-positive (SS+) cases per 100,000 people in 2006. Based on WHO disability-adjusted life-year calculations, TB is responsible for 6.3 percent of the total disease burden in Indonesia, compared with 3.2 percent in the Southeast Asian region.[11] After achieving a case detection rate of 73 percent in 2006, Indonesia slipped out of the target zone in 2007, reporting a case detection of 68 percent.

The national TB program faces many challenges[12]:

- Problems of access and geographic terrain in the eastern part of the country;
- Low commitment from local governments in terms of financial contribution;
- Temporary cessation of GF support in 2007 disrupting operational activities;
- Suboptimal quality of DOTS implementation in hospitals, private clinics and practitioners;
- Emergence of TB/HIV in high HIV prevalence provinces;
- Inadequate human resources due to high turnover and zero recruitment policy; and
- Repeated emergency procurements of drugs due to lack of sustained government funding.

If the TB program wishes to regain ground and make progress, it must make more systematic efforts to involve the private sector in case detection and treatment. Muhammadiyah will become a new PR for the GFATM funded activities in TB this September. While primarily a hospital-based operation, within its overall health activities Muhammadiyah also operates a small number of drugsellers and pharmacies. Muhammadiyah could serve as a pilot to design and implement a program of referral from drugsellers and pharmacies to private hospital level of symptomatic potential TB patients. Muhammadiyah-affiliated hospitals already have contracts with Askes and Jamkesmas, and so have the capacity to seek reimbursements for services provided – extending

[11] http://www.usaid.gov/our_work/global_health/id/tuberculosis/countries/asia/indonesia_profile.html
[12] http://www.searo.who.int/en/Section10/Section2097/Section2100_14798.htm

reimbursement to pharmacy level for referrals and perhaps eventually DOTS administration/follow-up could provide the needed incentive for more active participation by private providers.

9. ROLE OF PROFESSIONAL ASSOCIATIONS IN MONITORING AND IMPROVING QUALITY

9.1 RELATIONSHIP BETWEEN PUBLIC HEALTH OFFICIALS AND PROFESSIONAL ASSOCIATIONS

There is a proliferation of associations in Indonesia. The health professions all have their own association, and some have sub-associations. For example, all physicians are members of the IMA, but there are also associations for each of the medical specialties (obstetrics, pediatrics, etc.). Some associations admit there is overlap in issues of interest – for example ISFI, which represents pharmacists, and GP Farmasi, which represents the pharmaceutical industry, including distributors and pharmacies. Except for the IMA, which is legislatively mandated to oversee the quality of the profession, the official role of various associations in quality assurance is unclear. Generally, the associations have not played a significant role in enforcing practice norms or quality standards.

It is difficult for associations to collect dues – the Hospital Association (PERSI) estimates that only 10 percent of its members pay dues. Even IMA reports difficulty collecting membership fees of Rp 10,000 per month, even though physicians are required to be IMA members, and they do not have income constraints. Health professionals do not always see value from membership in their professional association, and the associations have limited budgets to undertake activities. Most rely exclusively on volunteers to manage operations and have limited capacity to take on large-scale projects. In this environment, it is difficult to define who its members are and to maintain membership lists.

Health officials generally realize the importance of involving the professional associations in discussions of new activities. While there is mutual respect, there is less understanding of concrete ways to work together. Lastly, there may be some degree of mutual interest among public health officials and professional associations in maintaining some of the ambiguity around the responsibility for provider quality, as no one wants to be fully responsible for provider quality.

9.2 INDONESIAN MIDWIVES ASSOCIATION (IBI)

IBI is making the slow transition from being a volunteer organization to being a professional organization. They currently have 13 salaried staff at headquarters, while all other staff are volunteers. Members pay membership fees of approximately US$ 6 a year. Additional funds are raised through training fees, sales of technical manuals, and donations from pharmaceutical and product groups.

IBI is piloting a competency exam for midwives. It is under review by the Ministries of Health and Education who are considering national implementation. Included in the discussion is how to train assessors at province or district level. It appears that some districts are independently requiring the competency exam, even though it is not yet a national standard. In Yogyakarta district, midwives do not

get the necessary recommendation from IBI to practice if they do not pass the exam. In a change of policy, new graduates who pass the exam are able to set up independent practices immediately, without the previously required experience at either a Puskesmas or hospital.

Of all the professional associations, IBI is the most active in monitoring and supervision of private practices. IBI chapter leaders were involved in joint monitoring in all of the assessment districts. Generally, respondents reported monitoring visits twice a year. Perhaps as a result of the history of efforts to strengthen MCH, most districts have a Midwife Coordinator. Based on this assessment and other studies, midwives seem to provide regular reports to district health officials, unlike other types of providers (despite significant scope to improve the accuracy and completeness of these reports).

Two important issues in discussions of midwives include institutionalizing the practice of referral and the quality of midwifery education. In both Bandung and Yogyakarta districts, one of the issues of concern to midwives was the lack of reimbursement from Askes or Jamkesmas for patients who are referred to hospitals for delivery because of complications. Midwives in Yogyakarta noted that not only are they not reimbursed for their time and direct costs (such as IVs used) up to the time of referral, but sometimes the patient is then discharged back to her care after having a Caesarean section. In Bandung, midwives reported that if there is hemorrhage after delivery has occurred, once the patient is referred to hospital, she receives no reimbursement. In order to institutionalize appropriate referral, setting a clearer standard for referral, as well as providing reimbursement for services prior to referral are critical elements. IBI also is concerned with the quality of private education, as there are many new midwifery academies in recent years. There is a World Bank project with the Ministry of Education to develop education standards and a system for accrediting training institutes.

There is great potential in working with IBI to improve the quality of MCH services. Their members are the main providers of prenatal care, delivery, and newborn care. In three of the four assessment districts, private midwives accepted Jamkesmas or a district financing scheme for payment. Working through IBI to develop and disseminate standard clinical protocols, and working with Jamkesmas and district financing schemes to provide financial incentives to follow those protocols could provide significant improvements in MCH outcomes, specifically benefitting the poor and near poor.

9.3 INDONESIAN MEDICAL ASSOCIATION (IMA)

IMA was legislatively given the responsibility of overseeing the quality of physicians. IMA has been working to fulfill this responsibility with the introduction of a competency exam prior to licensing, and requirements for CPD credits prior to re-licensing. Districts require an IMA recommendation before a doctor can be officially licensed, allowing IMA to control both the quality and quantity of physicians. IMA also maintains and updates a set of clinical practice guidelines, but has not been active in enforcing these clinical guidelines. There are currently 74,000 licensed doctors, approximately 30 percent of whom are specialists.

IMA at all levels is entirely operated by volunteers, with the exception of a few support staff. There are 343 IMA branches, with a branch in most districts. Its branch offices are not involved in monitoring or supervision of doctors, but often organize CPD training for its members, which are paid by the doctors attending and corporate sponsorship. All levels (headquarters, province, and district) hold regular meetings for its members. Provinces also meet regularly with their district branches – monthly in Yogyakarta. Membership fees are Rp 10,000 per month, but the payment rate is very low, although improving.

IMA is involved in any allegations of malpractice or patient dissatisfaction. IMA investigates the claims and often mediates the disputes. It is unclear who else is involved in settlement of such disputes, as IMA may arguably favor the physician.

One of the primary issues at district level discussions is physicians' income. The issues include setting customary fees (often with younger specialists seeking higher fees) and appropriate split between physician and hospital for fees reimbursed through insurance plans. The IMA branch in West Java Province reported that of the 1,100 Puskesmas in the province, 500 do not have physicians, primarily because the salary offered at Puskesmas is too low.

One of the concerns of IMA at headquarters level is the role of GPs in a system that is becoming increasingly specialist-centered. IMA wants to improve the quality of primary care, and the image of the primary care doctor. IMA is a partner in a World Bank funded program in Bontang, East Kalimantan to establish a district health system centered around nine family practice clinics, each staffed by three GPs. All curative care should be centered around these clinics, leaving the Puskesmas free to focus on public health activities.

IMA could be a good partner for improving quality of care, as it views this responsibility as an important part of its mandate. It has a broad branch network, and has more legal authority to monitor and supervise its members than do the other professional associations. Working with IMA to disseminate treatment protocols as part of its CPD offerings would be one potential intervention. IMA is also looking for ways to be more pro-active in quality assurance, so may be willing to take on responsibilities such as monitoring practice patterns, particularly if done in a supportive manner.

9.4 INDONESIAN PHARMACISTS ASSOCIATION (ISFI)

ISFI estimates that it has approximately 5,400 members from an estimated 27,000 registered pharmacists in Indonesia. ISFI has been trying to promote the TATAP concept or "no pharmacist, no service" as part of its national recommendations. ISFI considers the current regulations around pharmacy ownership, which allows non-pharmacists to own pharmacies, a major impediment to promoting professional operations.

ISFI participated in a pilot program with the National TB Control Program (NTP) in cooperation with Depkes. This project was implemented with the General Directorate of Pharmacy and Medical Supplies (Binfar) in three provinces included developing a pharmacy medical record to refer patients for early detection. The motivation for the pharmacists was the possibility of added sales through increased status in the community for undertaking public health works and increased shop visits. The program largely collapsed when GFATM funding to NTP was suspended.

While ISFI involvement would be critical in any projects with pharmacists, their role in improving the quality of the pharmacist profession is less clear. Given little local or central government interest in enforcing the regulations related to the profession, and the relatively weak organizational capacity within ISFI, it is unlikely they could lead major improvements.

9.5 GP FARMASI

GP Farmasi represents all the parts of the pharmaceutical industry, from the manufacturer through the distribution chain to the end providers. Its members include 210 manufacturers, wholesalers or distributors, apoteks, and toko obat. While the pharmacist is a member

of ISFI, the apotek would be a member of GP Farmasi. GP Farmasi estimates that large chain pharmacies currently represent less than five percent of the pharmacy market. While the drugseller (toko obat) in principle has no specialized education (unlike pharmacists who have specialized training), they are nonetheless potentially good partners since the shop owner is more reliably in the shop. The owners of toko obat tend to feel more responsible for providing recommendations, and must maintain his reputation within the community. Pharmacy owners and pharmacists, on the other hand, are seldom in the pharmacy.

While GP Farmasi should be involved in programs involving pharmacists and drugsellers, they do not appear interested in a role enforcing pharmacy standards.

9.6 INDONESIAN HOSPITAL ASSOCIATION (PERSI)

PERSI represents all public and private hospitals in Indonesia. There are 1300 members of PERSI, but only about 10 percent are fee-paying. PERSI has a branch office in each province, which independently runs seminars, courses, and other programs. At central level, there is an annual seminar and hospital exposition (primarily hospital equipment and pharmaceuticals) which generates the bulk of the central level funding. It is not officially involved in licensing, but in some districts, the PERSI branch is asked to provide a recommendation before a license is issued.

Some recent PERSI initiatives aimed at improving hospital quality include:

- Establishing a national Patient Safety Committee that includes representatives from consumer groups, legislative bodies, universities, professional associations, etc.
- Conducting a pilot program with KARS for PERSI and PHO to conduct regular monitoring of hospitals after the KARS accreditation is issued.

PERSI does provide input to policy discussions that affect hospitals, but its level of influence is unclear. It participates in discussions with Askes regarding fee setting, but does not play a role as a negotiator. It tries to mediate complaints to Depkes, but it has no power to influence the final decisions. It also has been involved in discussions regarding RDU, but is not involved in any specific program. PERSI realizes that cost of medicines in hospitals is increasing, and is happy to support use of generic drugs but reports that sometimes distribution is a problem. It also believes that the distribution chain is "too long" and that adds to the cost.

Although PERSI appears relatively organized, it is unclear the extent to which it wants a role in actively monitoring hospitals. Nonetheless, it could be an important partner in developing and disseminating standards to its members, and facilitating discussions with Jamkesmas on reimbursement policies.

10. CONCLUSIONS AND RECOMMENDATIONS

In the current environment, there is significant scope to work with private providers to improve access to health services and quality of health services. Private providers are varied, and provide critical public health services. There is potential to develop programs with different cadres of providers and provider networks, including new groups that have not traditionally been development partners. While concurrently engaging central-level stakeholders in policy dialogue, interventions targeted toward district and province level would have the greatest potential for more immediate impact. Further, the type of engagement proposed does not involve drastic changes in policy direction, rather small adjustments to implementation procedures can significantly improve potential health outcomes.

There have been several important changes in the health financing scenario over the last five years. Public funding for health has increased substantially, primarily from central budget, but also from district budgets. Jamkesmas, the government financing scheme for the poor represents 25 percent of Depkes' budget. At least 60 districts, and as many as 100, have supplemental financing schemes for the poor or near-poor. Nearly all NGO hospitals accept Jamkesmas, and in some areas, individual providers (such as private midwives) also accept Jamkesmas. Less than 25 percent of Jamkesmas funding (Rp 1.0 trillion of Rp 4.6 trillion) is allocated to Puskesmas, which means the large majority of Jamkesmas funding can be used at public and private providers. The civil servants health insurance scheme, although not new, is funded at approximately Rp 3.0 trillion per year, and contracts with public and private providers. Significant public funding is being used to pay private providers using payment policies that do not necessarily promote public health priorities or high quality care. For example, there is little control over drug use at hospital level, which represents a significant portion of total costs.

While Jamkesmas and other district-level financing schemes are referred to as insurance schemes, they bear little resemblance to true insurance policies. The premiums are not set to match the benefits package, there are no measures to manage demand, and no measures to manage treatment standards. Insurance payers have advantages over individuals in ensuring quality and enforcing adherence to clinical standards – they have greater access to technical skills and more leverage over providers as they represent thousands of patients.

By using their power to select which providers to contract with, and enforcing treatment protocols with their payment policies, Jamkesmas and other financing mechanisms have potential to provide incentives for providers to improve care and adhere to quality standards. Simple changes include paying providers who refer patients when necessary, or not paying for branded drugs when generic is available. Payment policies can also be used to target interventions that promote public health (such as providing higher reimbursement for the fourth ANC visit, or completion of DOTS treatment). Making small changes to Jamkesmas reimbursement policies could significantly improve the quality of care, and improve health outcomes.

There is little coordination between district health officials and central public health programs, or between the district health officials and private providers. While district health offices have greater authority over health services within their districts, they do not always have the

capacity and resources to provide effective planning and oversight. There is little coordination with private providers to involve them in critical public health programs, such as TB or malaria, or to include them as referral points. District officials do not have a good understanding of how to interact with private providers, and mostly focus on their role as licensor. Improving capacity of district and provincial health officials to engage with the private sector is critical to improving health services. Using the area of maternal health as an example, the data shows that only 9.7 percent of deliveries take place in public facilities – all other deliveries are in private facilities, or at home assisted by a private midwife or TBA. It is unlikely that maternal mortality objectives can be met without fully engaging the private sector.

There are a variety of potential private sector partners including professional associations and private provider networks. Many have not traditionally been partners in public health programs, but represent important channels for reaching large numbers of consumers. Two groups that are seldom even considered health providers are pharmacists and drugsellers – however, they must be engaged because for half of all Indonesians who choose to self-medicate, this is their first contact at the onset of illness. Also increasingly important partners are the faith-based NGOs that are new recipients of GFATM grants. These NGOs recognize their increasing responsibilities and have taken small steps to strengthen management, but will require additional support to implement their grants and to meet GF reporting requirements.

These potential partners have central level coordinating boards, and varying degrees of organizational structure at province and district level. In addition, government counterparts such as Depkes and Bappenas have staff at central level committed to improving health services. While central-level government officials and other partners are critical to ensuring support and providing avenues for expansion, initial implementation should be based at district and province level in order to ensure operational feasibility. The proposed interventions do not represent major policy changes, but rather fine-tuning of implementation details that must be carefully designed and evaluated at an operational level. Working through all levels of partner organizations, along with engaging other organizations such as the Association of District Health Offices (*Asosiasi Dinas Kesehatan/Adinkes*), would maximize the likelihood of dissemination when appropriate.

Interventions that incorporate financial incentives to drive provider quality have high potential for replicability, as Jamkesmas is fully implemented in all districts. Models at district level that demonstrate operational feasibility and document positive health outcomes could easily be adopted by other districts, as the Jamkesmas administrative systems are already in place. Investments in technical assistance to Jamkesmas within Depkes also may create potential for changes to be adopted as national recommendations.

In order to demonstrate the effectiveness of a coordinated effort that includes changing provider incentives, partnership with private providers, and support to district and provincial health officials, initial efforts should focus on a limited set of critical health priorities. Officials at all levels identify MCH and TB treatment and control as among their health priorities, there is information on appropriate treatment standards, and enforcing effective treatments do not require significant additional funding.

If Indonesia is to achieve its priority health objectives, more attention must be paid to engage private sector providers. To improve the quality of private providers and to ensure that they contribute to priority health objectives, general recommendations are:

- Improve district and province capacity to manage an integrated public-private health system;
- Through existing financing schemes, adjust payment policies to provide financial incentives for providers to improve quality and adhere to standards;
- Create partnerships with private sector to address public health priorities such as MCH, TB, and malaria;
- Support independent oversight boards and consumer education initiatives;
- Support the new NGOs that are recipients of GFATM grants; and
- Revitalize and support promotion of high quality branded generics.

11. USAID PROGRAM OPTIONS

In line with USAID/Indonesia's current health strategy, the assessment team offers three options for potential programs to strengthen MCH services and control of infectious diseases.

11.1 INTEGRATED APPROACH TO IMPROVE MCH SERVICES

There is significant potential to improve the quality of MCH services, and thereby reduce maternal mortality, with a multi-component approach including creating financial incentives through Jamkesmas and Jamkesda to follow treatment protocols, strengthening districts to engage with private midwives and hospitals to improve MCH, supporting independent oversight boards, and working with IBI to ensure the quality of Bidan Delima.

The assessment team found many examples of systemic disincentives under the current financing schemes for providers to follow treatment protocols. Removing these disincentives and creating positive incentives for providers to perform to set standards would drive quality improvements. Some potential changes include:

- Reimbursing TBAs for referring patients to midwives – this practice occurs in some areas with the midwife directly paying the TBA.
- Restructuring the groupings for reimbursable services so that midwives are reimbursed for services provided prior to referral for a complicated delivery or for post-partum complications.
- Adjusting reimbursement rates for emergency hospital deliveries to rates that would allow hospitals to maintain high quality emergency obstetrics units.
- Reimbursing midwives with Bidan Delima or D4 certification at a higher rate than other midwives, reinforcing the value of quality, and the value of the certification.
- Adjusting reimbursement rates for long term family planning methods so that providers are more motivated to provide these methods.

Working to strengthen district capacity to manage an integrated public-private health system to address MCH challenges would complement changes in financial incentives. The district and provincial health offices are interested to work with the private sector. They would welcome new ideas and support to implement changes in payment methods and benefits package to make progress in priority areas (MCH, but also infectious diseases), however, they need technical and political support. USAID could play a catalytic role by supporting provinces and districts in using innovative approaches to paying the private sector to improve access and quality to priority services. Interventions may include:

- Supporting the district to lead development and dissemination of treatment and referral norms for MCH services with input from IMA and IBI, supported by Jamkesmas reimbursements to enforce the treatment norms.

- Supporting the mapping of all facilities to create an appropriate referral network integrating public and private providers.

- Improving reporting from private midwives as they provide the vast majority of MCH services. Specific activities may include developing simple standard reporting formats, training health officials to analyze data reported, and developing systems for feedback to midwives.

Additionally, providing assistance to independent oversight boards and consumer advocacy groups would help to institutionalize monitoring and to create more educated consumers. Lastly, working closely with IBI to ensure the quality of Bidan Delima, coupled with higher reimbursement rates, would promote the value of the Bidan Delima certification for midwives and consumers.

In wealthier districts with more fiscal space, further changes could be considered, such as adding a supplemental maternity benefit to Jamkesmas or Jamkesda. Some rudimentary calculations suggest that a good maternity health benefit could be put in place for under Rp 5,000 per capita per month. This level of funding would allow reimbursement for delivery at closer to the market rate (Rp 500,000), and higher reimbursement for complex deliveries and Caeserian section. These higher rates would attract for-profit hospitals to serve Jamkesmas patients, thereby increasing access in the event of emergency, and possibly improving quality (if the contracted hospitals are of higher quality).

11.2 COLLABORATION WITH PRIVATE SECTOR IN TB CONTROL

Given the data on health-seeking behavior, the first health professional in contact with TB patients may well be the local pharmacist or drugseller. Training pharmacists and drugsellers to screen for TB symptoms, provide appropriate information on the illness, and refer patients for further investigation could significantly improve case detection. In addition to working directly with the pharmacists, engaging with GP Farmasi to reach the pharmacy owners would further strengthen commitment to the program. Lastly, collaboration with IMA to develop appropriate treatment and referral protocols and to provide training would alleviate potential concerns with professional encroachment.

This training would be coupled with financial incentives in the form of reimbursement for detection, diagnosis, and treatment based on accepted clinical protocols. Reimbursing the pharmacist for case detection based on protocol would encourage the pharmacist to refer the patient for investigation, rather than sell him medicines. Reimbursement for following diagnostic protocols would encourage the hospital to conduct a sputum smear, rather than take an x-ray. Lastly, reimbursement at completion of treatment would encourage the provider conducting DOTS to follow up with the patient in the event of treatment lapse.

A three-pronged intervention that includes training for private pharmacists and drugsellers to improve quality of case detection and treatment, creating incentives for these providers to follow standard protocols, complemented by stronger coordination between district health officials and the national TB program could significantly strengthen the TB program.

11.3 SUPPORT NEW GF RECIPIENTS TO CONTROL INFECTIOUS DISEASES

Muhammadiyah, NU, and PERDHAKI are all due to become new GFATM recipients for TB, HIV/AIDS, and malaria, respectively. While these organizations have significant reach, they have weak management and monitoring capacity. Supporting these organizations to successfully manage their GFATM grants would represent big improvements in these programs.

In order to minimize the potential for any disruptions to these important programs, donor support to strengthen the internal accounting and management systems of these organizations to ensure they meet GFATM standards is critical. Improvements in management capacity would not only benefit the GFATM funded programs, but would have benefits for the overall organization bringing improved efficiency in service delivery. Interventions would include improving financial systems, as well as developing management skills to analyze and act on financial data. The level of support could range from ensuring reliability of basic financial data, like expenditures by program (specifically for GFATM supported activities), to developing systems than allow tracking of drug use by diagnosis or by physician.

These three organizations also would need support to develop program monitoring systems. Support to ensure that data is reliable and timely, and meet GFATM requirements, represents good use of partner funding that leverages the GFATM grant to achieve disease control objectives. It would also be useful to help these NGOs develop an appropriate and feasible evaluation plan, ensuring that appropriate data is or can be collected to evaluate whether the activities achieved the initial objectives.

ANNEX A: ASSESSMENT GUIDE

Indonesia Private Sector Assessment – Assessment Guide
HS 20/20, May 2009
Key Informants at Central Level

Key Informants	Illustrative Questions for Key Informants
o **Professional assns** o IBI o Indonesia Doctors Assn o Indonesia Hospital Assn o Pharmacists Assn o Assn of Drugstore Owners (does one exist) o o	o Do you have up-to-date membership records? o What is the management and communication structure of the organization – how can you access your members? o Is there regular supervision of your members? o Are there regular meetings at district level? o Are there standard norms of practice recognized by the association? o What is your current role in ensuring quality of private and public health providers? o What role **could** you play in monitoring and improving quality? o How are members currently licensed or certified? o
o **NGOs** o Asyiyah/Muhammadiyah o Muslimat/NU o Indonesian Planned Parenthood Assn o other	o What types of health facilities do you operate (what services are available)? o What is the management structure of the health facilities? o What is the fee structure, compared with public facilities? o What types of contracting experiences have you had? What were the challenges and outcomes? o What are your sources of medications? o Do your facilities accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o Have you participated in any PPPs targeting priority services? o
o **Insurers, Third Party Payers** o Askes management o Jamkesmas management o Private insurers	o Under your benefits plan, what is covered, and what types of providers can patients see? o What do you do to ensure provider quality? o What types of contracting experiences have you had? What were the challenges and outcomes? o How do you select who you contract with? How do you negotiate the type of payment mechanism or payment rates? o Are all medications covered? o Do you have treatment protocols that providers must abide by, or risk nonpayment of claims? o How long does it take for providers to get reimbursement? o Do you have problems with fraudulent claims? How do you minimize these? o Have you participated in any PPPs targeting priority services (MCH, infectious diseases)?
o **Donor partners** o Claudia Rokx o Franz von Roenne o David Dunlop	o Claudia – update on program to improve accreditation and regulation of providers, with details for each type of provider, work in insurance and costing o Franz – update on SHI o David – update of district insurance plans and where USAID might add value, additional info on contracting work

Key Informants	Illustrative Questions for Key Informants
o **Other Informants/Experts** o KNCV – Jon Voskens o HSP – Reg Gipson o Dr Sulastomo o UI – Phamacy school?	o KNCV – private providers and TB o HSP – midwives reporting practices
o **In Jogya** o Pak Laksono o Pak Yodi, Adi Utarini o Other experts at Gadjah Madah (is there a pharmacist school)	o Laksono – contracting experiences o Yodi/Adi – private providers and TB

Also visits will be made to:

- BAPPENAS (present approach and key questions)
- BKKBN
- DEPKES Maternal Health, Child Health, TB program

Key Informants at Provincial Level

Key Informants	Illustrative Questions for Key Informants
o Provincial health officials	o What is the province role in regulation, licensing, supervision of private practice physicians and midwives? o What role could the professional assns (IBI, IMA, etc) play in monitoring and improving quality? o What have been the experiences of PPPs targeting priority services? o Could Districts act as supply points for medicines to outreach workers, such as bidans? o What is your role in regulation, licensing, supervision of pharmacies and drugsellers? o Have you had any experience contracting with public or private providers? What were the challenges and outcomes? Pls get details. o Have you had any experience implementating an insurance scheme? What were the challenges and outcomes? Pls get details. o What is your role in managing Jamkesmas? o
o Provincial hospital – senior finance and admin staff, pharmacy	o Do you ever supply medications to private providers? o How are you reimbursed for services under Jamkesmas (what documentation is required, for what types of services)? How long does reimbursement take? o Have you had experience with contracts for services (by private insurers, for example)? Pls get some details of the type of contract – solely reimbursement, any capitation mechanism, negotiated rates, etc. What were the challenges and outcomes?
o IBI province	o What is the relationship between province and district level IBI offices – what are the responsibilities of each? o Are there standard norms of practice recognized by the association? o Does the province IBI play a role in supervision of midwives? o How can coordination with Provincial or District health officials be improved? o
o IMA province	o What is the relationship between province and district level IMA offices – what are the responsibilities of each? o Are there standard norms of practice recognized by the association? o Does the province IMA play a role in supervision of doctors? o How can coordination with Provincial or District health officials be improved? o
o NGOs – Asyiyah, Muhammadiyah, other NGO facilities (is there a provincial administrative level?)	o What types of contracting experiences have you had? What were the challenges and outcomes? o Have you had experience as part of PPPs targeting priority services?

Key Informants at District Level

Key Informants	Illustrative Questions for Key Informants
o District health officials (Q1, Q2, Q3, Q4, Q5) o	**Coordination of Services, Accredition, Supervision** o Are there DINKES records of private practice physicians and midwives? o Is there regular supervision of these practices? o What are the regular reporting practices from private providers (data on deliveries, immunizations, infectious diseases)? o Do you have data on referral practices from private providers? o What is your role in ensuring quality of private and public health providers? o What role could the professional assns (IBI, IDAI, etc) play in monitoring and improving quality? **PPPs** o What have been the experiences of PPPs targeting priority services? **Phamacies, Drugstores, and Improving Drug Use** o Could Districts act as supply points for medicines to outreach workers, such as bidans? o How are pharmacies and drugsellers licensed? What is the DINKES' role? o Are there records of private pharmacies and drugsellers? o Is there regular supervision of pharmacies and drugsellers? o What is typically sold at pharmacies and drugsellers? o How do other retail outlets obtain medications for sale? **Improving Quality with Financial Incentives through Contracting and Insurance Payments** o Have you had any experience contracting with public or private providers? What were the challenges and outcomes? Pls get details. o Has the district had any experience implementing a district-based insurance scheme? What were the challenges and outcomes? Pls get details. o What is your role in managing Jamkesmas? o Is Jamkesmas only accepted at public health facilities? o Are capitation payments under Jamkesmas tied to performance measures? Would that be feasible?
o District hospital – senior finance and admin staff, pharmacy	o What are the normal referral practices from private providers? o What are your sources of medications? o Do you ever supply medications to private providers? o How are you reimbursed for services under Jamkesmas (what documentation is required, for what types of services)? How long does reimbursement take? o Have you had experience with contracts for services (by private insurers, for example)? Pls get some details of the type of contract – solely reimbursement, any capitation mechanism, negotiated rates, etc. What were the challenges and outcomes?

Key Informants	Illustrative Questions for Key Informants
o IBI, and member representatives (Q1, Q2, Q4, Q5)	o Are there district records of private practice midwives? o Is there regular supervision of these practices? o Are there regular IBI meetings at district level? o What are the sources of medications for private providers? o Are there up-to-date membership records? o Are there standard norms of practice recognized by the association? o Do you accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o
o IMA, and member representatives (Q1, Q2, Q4, Q5)	o Are there district records of private practice physicians? o Is there regular supervision of these practices? o Are there regular IMA meetings at district level? o What are the sources of medications for private providers? o Are there up-to-date membership records? o Are there standard norms of practice recognized by the association? o Do you accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o
o NGOs – Asyiyah, Muhammadiyah, other NGO facilities (Q1, Q2, Q4)	o What types of contracting experiences have you had? What were the challenges and outcomes? o What are your sources of medications? o Do you accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o Have you participated in any PPPs targeting priority services? o
o Private hospitals – management and health staff (Q1, Q2, Q4)	o What are the sources of medications? o What types of contracting experiences have you had? What were the challenges and outcomes? o Do you accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o Have you participated in any PPPs targeting priority services?
o Private clinics (including employer-based clinics) – management and health staff, and sole practitioners (Q1, Q2, Q4)	o What are your sources of medications? o What types of contracting experiences have you had? What were the challenges and outcomes? o Do you accept Jamkesmas payments? If not, why not? o If so, how are you reimbursed for services under Jamkesmas? o Have you participated in any PPPs targeting priority services?
o Pharmacies and drugsellers (Q3)	o What typically is sold at pharmacies and drugstores? o What is the background of staff in these outlets?
o Large employers	o What type of health benefits/services are provided for workers (on-site facilities, and insurance coverage)? o What types of contracting experiences have you had? What were the challenges and outcomes? o Have you participated in any PPPs targeting priority services?
o Consumers	o Why did you choose to see this provider? Do you always choose this provider? o For what problems do you go directly to the apotek? What do you buy there?

Assessment Questions and Assessment Framework

Assessment Question	Approach/Background	Key Informants	Illustrative Questions for Key Informants
1) How can services provided at private facilities be better integrated into the health system to ensure better delivery and monitoring of priority health services (ie, TB, ANC)?	o Assess current interactions between public health system and private providers (planning, reporting, supervision) o Assess referrals from private to public facilities and vice versa o Identify deficiencies in linkages and referrals o HSP study of reporting practices of private bidans	o HSP staff o District health officials o IBI, and member representatives o NGOs – Asyiyah, Muhammadiyah o Indonesia Medical Assn o KNCV/TBCAP for private sector interactions on TB	o Are there district records of private practice physicians and midwives? o Is there regular supervision of these practices? o What have been the experiences of PPPs targeting priority services?
2) What can be done to rationalize the use of medications, as part of an integrated provider quality improvement approach?	o Assess sources and presentations of medicines for priority health services o Identify factors driving current dispensing and dosing practices	o District health officials o District hospitals and private hospitals o IBI, and member representatives o Indonesia Medical Assn, and member representatives o NGOs – Asyiyah, Muhammadiyah o Pharmacists Association o Licensed drugsellers	o Are there regular IBI/IMA meetings at district level? o What are the sources of medications for private providers? o Could Districts act as supply points for medicines to outreach workers, such as bidans?
3) Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?	o Assess the organizational structure of pharmacies and drugstores o Assess staff of pharmacists and drugstores o Understand the sources of income for pharmacists o Assess the supervision and regulation of pharmacies and drugstores (on paper and in practice)	o DEPKES o Pharmacists Association o Licensed drugsellers o Leaders at pharmacy schools o District health officials o Provincial health officials	o Does the pharmacists association maintain membership records? o Are there district level officials of pharmacies or drugstores? o Who licenses pharmacies or drugstores? o What typically is sold at pharmacies and drugstores? o What is the background of staff in these outlets?

Assessment Question	Approach/Background	Key Informants	Illustrative Questions for Key Informants
4) How can financial incentives (such as performance-based payments, payment mechanisms) be used to improve access to services or quality of services at private providers (ie, midwives, GPs, Asyiyah, etc)?	o Assess ability of districts to manage and enforce contracts with providers that include performance specifications o Assess ability of insurers to manage and enforce contracts with providers that include performance specifications o Assess the reimbursement process for Jamkesmas, Askes to see identify potential obstacles for private providers o Assess prior related experiences or best practices o AusAID sponsored survey of subnational insurance schemes	o Franz von Roenne o David Dunlop o Pak Laksono o DEPKES officials administering Jamkesmas o Officials at Askes o District health officials o District hospitals and private hospitals o IBI, and member representatives o Indonesia Medical Assn, and member representatives o NGOs – Asyiyah, Muhammadiyah	o What types of contracting experiences have you had? What were the challenges and outcomes? o How are you reimbursed for services under Jamkesmas? o Do private providers accept Jamkesmas payments? o Are capitation payments under Jamkesmas tied to performance measures?
5) What role can professional associations play in monitoring and improving quality of care among private providers?	o Assess the current role of each professional association in accreditation and monitoring o Assess the organizational structure of the professional associations, particularly subnational capacity	o Claudia Rokx o IBI o Indonesia Medical Assn o Pharmacists Association o	o Are there regular meetings at district level? o Are there up-to-date membership records? o Are there standard norms of practice recognized by the association?

ANNEX B: FIELD ASSESSMENT REPORTS

1. YOGYAKARTA

The purpose of this assessment was to provide field data as a supplement to the desk top review which was completed in early March 2009. The team of four people, Dr. Firman Lubis, Lucy Mize, Damaryanti Suryaningsih, and Dr. Hasbullah Thabrany were in the field for four days (May 13 to May 16, 2009). Information was gathered from the professional organizations present in Yogyakarta, counterparts at the District and Provincial Health office, private providers and consumers.

1.1 Provincial Information

Yogyakarta Province is called a Daerah Istimewa or Special Area and is the second smallest province after Jakarta. It consists of five districts: Yogyakarta City, Sleman, Bantul, Kulonprogo and Gunungkidul. The 2000 census indicates that there is an approximate 3,120,500 population. Sleman is the largest district with a little over 900,000 inhabitants. 19.4 percent of the province population lives below the national poverty line, and the provincial health office reports that 942,129 people are enrolled in Jamkesmas (Kompas, September 2, 2008). There were 39 cases of maternal death in the province in 2008 and of those, 18 were in Bantul. There are 583 specialist physicians in the province out of a total of 2093 doctors, 73 are obstetricians and 77 are pediatricians.

1.2 District Information

The Dinas Kesehatan office in Yogyakarta is computerized and has reliable records on health information and statistics. From their records, the following is noted:

Indicator	Number	Data Source and Notes
Population	392,000	2000 Census, district records
Delivery by Health Worker	95.8% (province) 90.83% (district)	2007 DHS, Kepala Dinas Yogyakarta Kota, Dr. Choirul
DTP3 Coverage	97% (province)	2007 DHS
DPT 3 and Hepatitis Combination as used in Yogyakarta City	92.4%	Kepala Dinas Yogyakarta Kota, Dr. Choirul
Number of Physicians	154	DI Kota Yogyakarta Web Page. In conversation, Dinas estimated there were at least 500 doctors practicing in Yogyakarta, although they live in neighboring districts.
Number of Midwives	410-432	There is a data discrepancy between IBI Pusat and IBI Cabang
Number of Puskesmas (Community Health Centers)	18	DIY Government Website
Number of Apotek	115	DI Kota Yogyakarta Data
Balai Pengobatan	28	Small treatment centers, usually headed by nurse or midwife

Indicator	Number	Data Source and Notes
Number of Group Practices (including dental care)	9	
Number of Hospitals, Private and Public	18	Nine are general private hospitals and eight are specialist hospitals. One of the hospitals is the National Hospital, owned and managed by Depkes and serving as a referral source for two provinces.
Number of "Rumah Bersalinan"	12	These are small clinics that focus on maternal health care
Physicians Practicing at Esthetic Clinics	12	Dermatology cum beauty centers but regulated by Dinkes because of physician presence
Women and Children Treatment Centers	2	These centers would not cover labor and delivery.
Persons covered by Jamkesmas	68,456	Kepala Dinas Kesehatan DIY dr Bondan Agus Suryanto di Yogyakarta, quoted in Kompas, September 2008
District Health Insurance Scheme (Not strictly insurance as it is funded under APBD and is a social service)	Yes	JamKesDa, JamKesSos are district and provincial health insurance plans for low income. The district plan covers an estimated 20,545 people who fall out of the Jamkesmas quota. JamKesSos also covers non-health (such as some cash transfers) and uses an expanded criteria to define its target population

How can services provided at private facilities be better integrated into the health system to ensure better delivery and monitoring of private health services (e.g. TB, ANC)?

1.3.1 Reliability of Records on Providers at Dinkes

Dinkes Yogyakarta is computerized and keeps records on all the providers who are licensed to practice within the district. However, they do not track case load of providers or service treatment outcomes or quality indicators. AsKes and hospitals maintain good patient records because of the need to verify claims and charges for health care but these data are not part of the provincial health statistic service data.

1.3.2 Role of DinKes in supervision and monitoring of private providers and ensuring their overall quality

At the provincial level, a decision letter was published in 2005 that instructed all health personnel to take and pass a competency exam before receiving their license to practice. While this is in line with the national policy for physicians as of 2007, it is forward thinking in terms of regulating midwives. The midwives interviewed say they receive supervisory visits from the head of their local Puskesmas but not on a fixed schedule. The Head of the IBI for the province states that it is her responsibility to monitor midwives who have a private practice and that she does so at least twice a year.

Some of the professional organizations have protested that district government officials don't have a full map of the health care system and that they concentrate almost exclusively on the public sector, which limits their responsiveness to monitoring needs within the private sector. ISFI complained for example

that there was no management of the geographical location where pharmacies could open, so that some large pharmacies opened very close to smaller pharmacies, which had a negative impact on the revenue generation of the smaller pharmacy.

In terms of quality, Yogyakarta is examining some different options. They have established an independent monitoring agency, entitled Badan Mutu Pelayanan Kesehatan, which is contributing significantly to the evaluation of quality issues. This Council for Quality in Health Care has as a mission to help health care providers and authorities offer comprehensive, continuous, professional, and high quality services. They are also providing a link between licensing, health worker monitoring and health facility management. They do customer satisfaction surveys and report back to health authorities on licensing and management. Three examples of their work include:

- The Pharmacists Association made a proposal to BMPK that it was necessary to have two apothecaries at each pharmacy. This is in order to have 24 hour coverage and professional services that could offer counseling on drug interaction, effectiveness and dosage. As a result of this, 53 percent of the Yogyakarta apothecaries now have two pharmacists on duty.
- An assessment of a private hospital that had an unacceptably high case fatality rate in the treatment of Dengue Hemorrhagic Fever. This resulted in a letter from Dinas to the hospital detailing what were the necessary improvements[13] that needed to be undertaken or there would be sanctions forthcoming, including the potential to close the hospital.
- An assessment of 10 hospitals that were considered the referral hospital of choice for emergency obstetric treatment. This assessment found SOP not in use, key staff such as anesthetists not in place, midwives not present in the emergency room, and non-functioning blood banks among other key findings (BMPK, March 2009 Evaluation of PONEK).

1.3.3 Reporting Practices of Private Providers

Private providers fill in data information sheets and send them up to the Dinkes level. However, they feel that reporting is a one-way street and that they do not receive sufficient feedback from Dinkes as to the aggregate analysis of the reports. They use established Dinas formats to capture their service delivery data. The midwives interviewed say they send data to three different places: their local community health center, with carbon copies to Dinas and IBI. The BMPK found in its review of emergency obstetric systems of 10 hospitals that there were no reporting systems in place for the hospital to send information to Dinas.

In doing interviews with midwives, the team heard of other reporting practices. One informant who is a Bidan Delima, a D4[14] prepared midwife, and a Maternal Child Health Program Analyst with the Bantul District Office, shared her recent experience. She compiles data from all providers and then does trend analysis. In the 2006 and 2007 there were declining trends in maternal mortality, with only 6-8 cases being reported a year. In 2008, 18 cases of maternal death were reported and in the first quarter of 2009, they have already had seven maternal deaths. The majority of the deaths were attributable to eclampsia. Of the 25 deaths that have occurred most recently, only three were attributable to poor management by midwives. The other 22 deaths were in the hospital and resulted from either late referral or poor adherence to standard protocols.

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[13] The results of this inquiry will be presented at a workshop in Jakarta on June 4th. The workshop is focusing on decentralization and district governance process.

[14] Similar to Bidan Delima, D4 is a certification process that was previously supported to improve midwife quality.

1.3.4 DinKes Experience with Private Provider Practice

Overall the general sentiment appeared to be that private providers were integrated into the District health system. In terms of referrals, private providers made referrals to both private hospitals and to the National level hospital, RS Sardjito. In addition, none of the private providers interviewed excluded clients from receiving care, even if they were covered under Jamkesmas.

However, Gadjah Mada University researchers are concerned that there does not seem to be enough monitoring of the private sector by Dinas and an overly loose regulatory framework that is allowing the establishment of some sub-standard sites. The Dinas head was pleased by the explosive growth of hospitals and service delivery sites in Yogyakarta city and stated that it was becoming a "business like medical tourism." He said that patients from Semarang, Surabaya and even Jakarta are coming to receive care at various private sector hospitals. Community activists from both PKBI and Yayasan Lembaga Konsumen Yogyakarta (YLKY) on the other hand, have determined that there are ethical lapses among some of the providers. One case sited was the continued use of dangerous whitening creams that were being dispensed at private dermatological clinics.

What can be done to rationalize the use of medications as part of an integrated provider quality improvement approach?

1.4 Sources of Medications for Private Providers

In Indonesia, there are 204 pharmaceutical manufacturers, 49 sole/first layer distributors, 2,560 second layer distributors or Perusaahaan Besar Farmasi (distributing drugs to hospitals, pharmacies, and drug stores). The sole distributors manage distribution of one manufacturer to various PBF. In Indonesia, there are 5,695 pharmacies (which must have a pharmacist and are the only approved venue outside of a hospital or clinic to sell prescription drugs) and 5,513 drug stores (which sell over the counter medications and have an assistant pharmacist).[15]

There are 25 representative PBF in Yogyakarta city and 46 within the entire province. All of the service providers interviewed stated they purchased their medications locally from these distributors. One Bidan Delima, stated she had gotten other midwives together to form a cooperative and buy medications at a discounted price. However, she was recently told by IBI to stop doing this as it competed with an effort of IBI to use its foundation, Yayasan Buah Delima, as a supplier of drugs to private midwifery practices. During the field visits, the team observed that the Schering Pharmaceuticals agent was making field visits to the various private practices and discussing the purchase of medication.

The hospitals that were visited have very different procurement mechanisms. Panti Rapih, a Catholic hospital, does group purchasing for it and four other clinical sites throughout the province. It orders drugs on a quarterly basis and keeps them on-site at a drug depot. Muhammadiyah on the other hand had a more chaotic system, ordering drugs both daily and on a monthly basis. Despite being part of a large network of providers, the hospital only did ordering for its own drug needs and was not responsible for managing the supply chain for other clinics in the network. Muhammadiyah stocked three different classes of drugs for use with the different classes of patients. Class Three patients (usually JamkesMas) received the generic drug. Other classes received the off patent or the branded drug. For uncommon

[15] Richard Panjaitan. Prospek Dunia Farmasi Indonesia, 2020. In Wanandi, B. Pergumulan Kompleks Bagi Kesehatan Rakyat. Anugra Pharma. Jakarta, 2009

illnesses, such as advanced cancers, the hospital only kept on hand a few vials or boxes of the necessary medications.

1.5 Potential Role of District as supply point for private providers

There is only a limited role for the district to serve as a supply point for private providers. Currently, vaccines, the drug regimen for tuberculosis and some malaria drugs are received by private providers from the District. In some cases, these drugs are intended to be passed on to the consumer at no cost but various different midwives stated that they charge fees, particularly for immunizations and contraceptives.

1.6 Potential role of professional associations in improving practice norms (including drug use)

Faculty at Gadjah Mada University implemented a program designed to help mothers with limited education make better consumer decisions about purchased OTCs. Dr. Sri Suryawati states "The training is intended to empower mothers to seek and critically assess information on the drugs that they commonly use, and to increase drug procurement efficiency in households." This program is conducted via the students at the University.

ISFI has begun an effort to improve the pharmaceutical services at the Puskesmas level in Yogyakarta, as there are currently only two community health centers that comply with the code of ethics and have a pharmacist on staff. ISFI Yogyakarta supports continuing education seminars in an effort to improve practice norms, at the most recent 2008 meeting, they offered "Optimizing pharmaceutical services by using medical records." In 2007, they offered continuing education on Patient Safety and Drug Information in conjunction with the private hospital Bethesda, a local business and Gadjah Mada university.

Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?

1.7 Organization and Management of Pharmacists Associations

ISFI is a national professional association with branches locally. In Yogyakarta, they have 931 members. They have developed a code of ethics and a national competency exam. A second group, Persatuan Ahli Farmasi Indonesia, which was started in Yogyakarta in 1946, serves as an association for assistant pharmacists. They too have developed a national competency exam.

1.8 Licensing and Oversight of Pharmacies and Drugstores

In conversations with the provincial branch of ISFI, a number of regulatory and quality issues were raised. In Yogyakarta, under pressure from ISFI Yogya, the Provincial Health Office and Badan Mutu are enforcing the standard of two pharmacists for every pharmacy. Currently 53 percent of pharmacies in Yogyakarta city have two pharmacists. However in a random on-the-spot cross check conducted by the team, no pharmacists were present in the pharmacies the team visited. The team found only assistant pharmacists present, they stated they consulted by phone to the responsible pharmacist when patients asked about problems of prescriptions drugs (for example overdose or contraindications).

ISFI criticized a Yogyakarta-based pharmaceutical franchise, K-24. This is a private initiative of chain pharmacies (with 160 pharmacy outlets nationwide). The K-24 use the franchise model and takes on investors to open new branches. These standardized pharmacies are open 24 hours a day, seven days a week and also offer home delivery drugs.

The team interviewed a manager[16] at one of the K-24 franchises. The manager said because there is no strict regulation or enforcement by the government on price, some pharmacies charge higher prices on holidays or nights. This has led K-24 to develop a marketing strategy to guarantee their prices will be the same, night or day. Similarly, as there is little quality control enforced by the local government, K-24 is positioning itself as vendor of guaranteed good quality drugs.

The regional Food and Drug Administration (Balai POM) is responsible for conducting regulatory visits two to three times a year. However, informants to the team have stated that it is easy to subvert this regulatory process, they have either been asked for an in-kind or cash contribution by the inspector or they have offered it themselves and that results in positive findings.

1.9 Stock of Pharmacies and Drugstores

None of the informants questioned stated that stock-outs were a problem. The current supply chain consists of manufacturers to sole distributors and then further to the PBF. These secondary distributors supply the pharmacies and hospitals in Yogyakarta and clients take approximately one month to pay for drugs.

In theory, the PBF distribute prescription medication and OTC (over the counter) drugs to pharmacies and hospitals, while drug stores are only intended to receive over the counter medication. However, this is also loosely regulated and spot checks found prescription drugs available in drug stores in Yogyakarta.

Prices for drugs vary widely and are equally expensive in the public sector as the private sector. The Ministry of Health has a drug pricing policy called HET (Harga Eceran Tertinggi) which established the highest prices allowable to charge patients. Most pharmacies, hospital pharmacy departments, and drugs stores sell drugs with a margin of 20-50 percent of the net pharmacy prices.

1.10 Staff of Pharmacy and Drugstores

The requirement of two registered pharmacists per store is in line with the vision of ISFI that a pharmacy should be a place for professional services where pharmacists provide information on drug efficacy, drug interaction, drug allergies, etc. ISFI has been pushing the local and national government to adopt a regulation that pharmacies are a place for pharmacists' professional services, not business unit. Under current practice, investors own pharmacies and pharmacists are paid very low wages (about Rp 1-2 million a month).[17] Under this model, a pharmacist comes in only one hour a day – or even only 2-3 times a week – undermining the professional consultation role desired by ISFI.

1.11 Dinkes Experience with Private Providers

There are limited formal public private partnerships in Yogyakarta. In the cases where private physicians are treating clients for tuberculosis, they often refer to the public sector for confirmation and observation. Local social health initiatives cover the costs of private providers and midwives stated they did not have a problem receiving reimbursement from the Dinkes level.

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[16] Personal interview to Ms Ryan, Franchise Department, Head office of K-24 Chain Company.
[17] Drs, Nunut, ISFI Yogya, Interview

How can financial incentives be used to improve access to services or quality of services among private providers?

1.12 Experience Contracting through Dinkes or Insurance Schemes

All providers are eligible for receiving contracts, in Yogyakarta both private and public sector held contracts. Payment mechanisms are fee for service at pre-set rates or capitation. Despite strong encouragement from the Ministry of Health, Askes has not utilized the DRG system for cost reimbursement.

Quality of service among private providers remains unregulated. Askes credentialing of private providers in Yogyakarta rests on determining whether they are licensed, their geographic proximity to the client base and a visual inspection of the service site. This inspection is not codified against an established checklist of quality standards.

1.13 Implementation of Askes

Askes is the Social Health Insurance which has been covering civil servants and their family members up to two children since 1968. In addition, Askes covers retired military personnel and their immediate family members. Funding comes from a mandatory contribution of 2 percent of monthly basic salary (excluding benefits), matched with an additional 2 percent of salary by the government as an employer. The total number of members nationwide was 14,576,900 insured.[18] The benefit package is comprehensive health care, including open heart surgery, hemodialysis, and cancer treatment. However, members often have to pay cost-sharing for price differences. 982 drugs are covered under the plan.

In the Askes network nationally, there are 11,704 health care providers, including 1,333 private primary care doctors (who serve as gate keepers) and 811 hospitals, of which 622 are public hospitals and 189 are private hospitals. In Yogyakarta, Askes covers 376,543 members served by public and private health care providers. Askes contracts with all public providers, five private hospitals, all health centers, midwives, and about 400 private primary care physicians (PCP) in Yogyakarta and Central Java. Commercial Askes has about 100,000 members of 245 companies, including members of local parliaments (DPRD). Monthly capitation payment per member per month (PMPM) vary from Rp 1,000 to Rp 3,250. Some cancer treatments are excluded or covered in very limited amounts, such as payment only for a small range of the normal medication used to treat. Reimbursement for a normal labor is 480,000 rupiah, which is more than under Jamkesmas. Reimbursement for dialysis is 450,000 rupiah per episode, although Bethesda hospital claims that it receives 600,000 rupiah per episode from Askes and that the total is capped at 15 million per year.

In 1993, PT Askes was asked to expand coverage to non-civil servants such as employees in state-run companies and private corporations. The Yogyakarta Askes office suggested that the team visit PT Daya Manunggal (Damatex), an Integrated Textile Industry, which was just over the border in Salatiga, Central Java, as a good example of private contracting with Askes.[19] This company has been in operation since 1961 and has 6,000 employees, approximately half of which are women. It covers not only employees but their dependents, including spouse and two children for an approximate cohort of 16,000.

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[18] Askes Annual Report of 2007

[19] This coverage is called commercial insurance (Askes Komersial). Premium varies by regions and by benefit packages. Accordingly, the benefits vary from limited comprehensive to coverage at international facilities. This commercial insurance product covers 2,133,269 members of 2,417 corporations nationally.

They have used many different health coverage practices in the past, including interest-free lending up to 100 percent of an employee's salary to cover catastrophic illness. They maintain their own clinic (with a pulmonologist because of the textiles), but it is primarily for first aid and for social medicine, such as providing the circumcision ceremony to employee sons. Their primary avenue for providing health coverage to their employees has been via Askes since 1995. Labor costs of the company are about 8 to 10 percent of overall costs per year and the annual premium is approximately 1.8 billion rupiah a year. In the event that an employee should need medical care beyond that which is contracted for under Askes, the company still has a policy of issuing interest-free loans up to 200 percent of an employee salary to cover heavy out of pocket expenditures. They sited breast cancer and other cancers that had created employee demand for the loans.

One of their incentives for using PT Askes is that their employees live in a dispersed geographic area and Askes provided a very broad provider network. Their overall network coverage includes private hospitals, private doctors (dokter keluarga) and private midwives in the entire province. The team visited one of the contracted midwives, who usually treats between four to five Damatex clients per week. Although she was certified as a Bidan Delima, she was not keeping up her practice standards and there were a number of sub-standard clinic practices noted, particularly in the area of infection prevention and asset management.

In discussing costs and reimbursement issues, Askes staff raised the following issues as pertinent to the implementation of the program in Yogyakarta:

- Many of their clients prefer to use public providers because services are grouped together in one physical location and there are longer service hours. Clients complain that if they use the Primary Care Physician, they need to go to multiple venues to receive the care. In response to this, Askes is negotiating with a private, comprehensive, 24 hour clinic to enter its provider network.
- Private hospital providers are being reimbursed within 30 days while public hospital providers complain of lengthy delays in receiving reimbursement. In addition, at public hospitals, the doctor medical fee is not clear so some physicians are transferring clients from public hospitals to private hospitals in order to receive reimbursement sooner and at a higher rate. The team verified this point when doing hospital visits.
- Askes has established service centers within the hospitals to assist with claim verification and other administrative details. This center also provides client support by visiting hospitalized clients.
- Fees for out-of-plan expenses, such as unauthorized medication, have to be covered by the patients themselves. In some cases, this can be equal to 200 percent of a civil servant's monthly salary. In other cases, Askes has asked the physician to bear the costs of using out-of-plan medications.

1.14 Implementation of Jamkesmas

Jamkesmas covers the following standard package for maternal care: family planning methods (including the pill, injections, IUDs, and surgical contraception), antenatal care, delivery care for both normal delivery care and complications and post-natal care. Blood transfusions are also covered if necessary, as would be the case in the treatment of hemorrhage. Unlike research from other parts of Java, the majority of private providers, including midwives, said they accepted Jamkesmas insurance. They were paid approximately 350,000 rupiah for a normal delivery and it takes approximately one month to be

reimbursed after claim verification (which in itself can take up to one month). Claims are often reimbursed in cash. Ibu Istri said she preferred the previous contracting mechanism under AsKesKin, which used a voucher system. She thought having a tangible coupon for each part of care, such as eight vouchers for antenatal care and two vouchers for post-partum care, helped women receive more appropriate care. One drawback is that if a midwife referred a client, she was not reimbursed for her services up until the time of referral. While this did not prevent midwives from referring, it did appear to be inequitable and one of the system flaws they would appreciate being resolved.

Panti Rapih (a Catholic hospital) said that 160 out of 360 beds were dedicated to Class III patients. They accept Jamkesmas patients and usually receive their claims within one month, considerably slower than the two weeks it takes for Askes. Panti Rapih also has a system when an indigent patient comes who could be eligible for Jamkesmas, they help them navigate the bureaucracy under their "Pastoral Sosial" program. A complaint echoed by all the hospital administrators was that the rules for claims and reimbursements kept changing under Jamkesmas, leading to confusion and inefficiencies. They hoped that the current regulations would stay in force for at least two years so they would have time to adequately understand what they needed to do. Bethesda hospital accepts approximately 25 Jamkesmas patients per month, out of an allotted total of 138 Class III beds.

A study done at the national referral hospital in Yogyakarta in June 2008 looked at Jamkesmas patient satisfaction during their treatment. The researchers were looking at the quality of health services for Jamkesmas patients on multiple dimensions, including empathy, responsiveness, reliability, and assurance. Among the 89 respondents, a common finding was that the staff at the hospital were found not to be caring or kind in their treatment of Jamkesmas patients (Dr. Sri Susan Suciati, May 2009, www.skripsistikes.wordpress.com)

What role can professional associations and Non-Governmental Organizations play in monitoring and improving quality of care among private providers?

1.15 Overall relationship between professional associations and the district health office

IBI and the local district carry a joint responsibility for monitoring practices, scheduling a joint monitoring visit every six months. In addition four times a year, midwives who are IBI members receive an invitation to participate in the Maternal Audits that are done.

Midwifery providers do not have to be pre-approved by Dinas to take Jamkesmas or Askes insurance. They are not contracted with to deliver a certain amount of care but rather receive reimbursement on a case-by-case basis. They do not discount their rates nor do they beg reimbursement for non-Jamkesmas clients to what they receive under the Jamkesmas program. IBI has a Memorandum of Understanding with Dinas to establish what their expected roles are in terms of monitoring, reporting and supervising staff.

1.16 The Indonesia Midwife Association

The Indonesian Midwife Association is making the slow transition from being a volunteer organization to being a professional organization. They currently have 13 salaried staff at the headquarter national level, all other staff are volunteers. Members (and all midwives must be members) pay approximately $6 USD a year in membership dues. Additional funds are raised through training fees, sales of technical manuals and donations from pharmaceutical and product groups.

In Yogyakarta Province, there are 1,398 midwives and in Yogyakarta town, there are 423, of which 55 have independent practices. Yogyakarta is one of the provinces where the Bidan Delima program has flourished, there are 213 midwives who have received the Delima certification. There are many different clinic models throughout the province and district:

- Sole providers, no assistant
- Group practice, with a senior midwife (usually the owner) and 1-3 staff midwives
- Group practice with midwives who also have nurses on staff
- Group practice with physicians, including second-year residents and new graduates
- Group practice with obstetricians

In addition to these models, a number of the midwives who were interviewed also had students in their practices and working under their supervision.

Yogyakarta has implemented a competency exam for the midwives who wish to work in the region. It is based on the national standards. Without passing the exam, the midwives are not able to get the necessary recommendation from IBI to practice. In the event that a candidate should fail three times, the midwife is set up with a mentor from IBI to continue practicing skills. In a change of policy, new graduates who pass the exam are able to set up independent practices immediately without having to have experience at either a community health center or hospital.

As is common in Indonesia, most of the midwives interviewed also had government jobs or worked with the academic setting, teaching nursing and midwifery students. However, the Bupati in Bantul has recently issued a local regulation that would sanction any government employee who is not present for the established government working hours of 7:30 to 14:30. This decree has resulted in some midwives changing their practice hours and reducing their private practice in order not to jeopardize their government position.

Some of the current issues and concerns that IBI is focusing on in Yogyakarta are:

- A practice in which clients are referred to doctors because of obstetrical complications and then immediately after having a Caesarean operation are discharged back to the care of the midwife. They refer to this as “one-day care” and don’t feel that it is an ethical practice and that it puts too large a clinical burden on the midwife.
- Institutionalizing the practice of early referral. IBI Yogyakarta has a policy to make early referrals because they don’t want to patients dying in midwife practices but currently the system does not work on a routine basis.
- Establishing Bidan Delima as the minimum standard practices for midwives who wish to work in Yogyakarta province.
- Making the IBI foundation, Yayasan Buah Delima, operative to serve as distribution point for drug supplies for midwives.
- Concern over the quality of private education. There are ten midwifery academies in Yogyakarta. The concerns include teachers not being well prepared and thus unable to prepare students, insufficient case load for student practice, and a perceived disinterest in midwifery as a profession versus an opportunity to make money.

Another concern on IBI's part is the encroachment of nurses into the historical practice domains of IBI. There are approximately 2900 nurses in DIY, of which 300 are in Yogyakarta town. In a 2002 study, 50 of these were operating private practices and overall 10 percent of the nurses in the province were operating private practices illegally. 70 percent of these were providing pre-natal care and an unknown percent were also helping with labor and delivery (Widyawati, 2002). One of IBI's solutions is to promote the joint practice model and midwives use nurses as auxiliary partners.

In a focus group discussion with midwives, a number of findings came out. These include:

- Most of the 12 midwives interviewed did not have a desire to be a "bidan swasta murni" or pure private provider. The platform of a base guaranteed salary, while low, was an important factor in their security as were the benefits.
- At the same time, all the midwives said it was imperative to continue their practice because it not only contributed to their incomes but it added significant social value to the community. They felt as a whole they served an important community function.
- The group stressed that the benefits of private practice included location (embedded within the community), flexibility in hours, and sliding fee scales. Even in the case of bidans that were practicing in small communities, they established cooperation and collaboration rather than competition.

The midwife providers interviewed all took Jamkesmas and also reported that they had difficulty in getting reimbursed, being told that budget funds had not yet been issued out of Jakarta. They have an informal sliding fee scale that they use with indigent patients although the benchmark charge for a normal delivery is 450,000[20], the same they receive under Jamkesmas. They cited that one of the problems with referral is that there is no system for cost-sharing so that if they refer for an obstetrical complication, they will receive no partial payment for any of the care they delivered up until referral. Since they sometimes use IVs and Magnesium Sulfate, they can incur serious out-of-pocket expenses for which they have no reimbursement.

1.17 The Indonesian Doctor Association

At the local level, the Indonesian Doctors Association is run as a volunteer group, with a greater focus on organizing social gathering and professional meetings than as a monitoring group for quality and standards. Nonetheless, they make the recommendation to Dinas as to who should receive permission to practice. This is made based on the results of the national competency exam, which was instituted in 2007. They must have 200 credit hours from attending or presenting a paper in seminars, conferences, trainings, or other scientific meetings, in addition to passing the national exam. This same amount of contact hours is needed to renew their license. While they do not have a current strategy for addressing quality, IMA members sit on the BMPK and have been active in the case reviews of some issues.

The IMA province office updates their list of memberships in coordination with Dinas, only two of the district lists were available during the visit. They do not keep a list themselves of complete membership. They sort the membership list by specialty and by area of practice, making it transparent whether a doctor is practicing in one, two or three sites as allowed by law. As of January 2009, Kulon Progo and Gunungkidul had 105 IMA members. They do not know how many practice privately but assume that most of their members have dual practices. They believe there is trend among the recent medical school

[20] The legislated amount of reimbursement for a normal delivery is 450,000 but some midwives assume that it is the lower figure of 350,000 that it was under a previous health insurance scheme.

graduates to work immediately in 24 hour clinics. The Head of the IMA Yogyakarta branch is not only on staff at Gadjah Mada but also has bought his own hospital, which is the private hospital specializing in anesthesiology and urology.

They do not have routine meetings with Dinas but meet on an ad hoc basis as needed. For example, Dinas drew on them for the response to the earthquake in Bantul. They are also included in meetings when a patient has expressed dissatisfaction with services. The IMA branch meets monthly with the provincial branch.

Several of the issues that IMA Yogyakarta is focusing on include:

- Quality of education and length of education; and
- Cost structures – Younger specialists think the fee structure set in place by senior physicians is not sufficient and a barrier. There is also a lack of transparency among the public insurance plans as to what percentage of overall fees charged accrue to the physicians for services rendered.

1.18 NGOs

Yogyakarta has long had a history of community activism and strong local NGOs. The team met with representatives from three groups, Aisyiyah, The Indonesian Family Planning Group (PKBI), and the consumer protection group, YLKY.

Aisyiyah is part of the overall religious network Muhammadiyah. Aisyiyah provides a benefit to its members by running a private insurance scheme, in which members contributes 10,000 rupiah a year and they received limited inpatient and outpatient care. In Yogyakarta, they run a midwifery training school and five clinics in Sleman (2), Muntilan, Mojudah and Panggeran. They also have one Rumah Bersalin in Karangkajen. Their clinic sites are not certified for Askes but they do receive Jamkesmas patients. As with many of the other informants, they raised the concern that the reimbursement mechanisms used by Jamkesmas are lengthy and cause delays in receiving the funds. To supply their clinics with drugs, they rely on the local distribution networks.

Aisyiyah works closely with IBI on developing the selection criteria for candidates admitted to the school and they participate in the quality improvement efforts done by IBI. Students work in private practices, particularly with midwives who have been certified by the Bidan Delima program.

PKBI serves as an advocacy agent for many clients from disadvantaged backgrounds. One of its seminal roles is the provision of affordable family planning contraceptives at its clinic in Yogyakarta. They engage with both Dinas and private providers on the behalf of patients who feel they have been misused although they have no formal legal role. PKBI is also in the forefront of providing counseling and testing for HIV/AIDs clients and supporting high-risk populations to gain access to primary health care.

YLKY is also an advocate for clients and they are tracking several client-provider issues. These include:

- Discrimination towards Jamkesmas patients by hospital nurses when they are seeking to obtain services.
- Inability to access a doctor at the emergency room because they are not physically present.
- Paying two tariffs at the Puskesmas, in addition to other out-of-pocket payments.

- Consumers complaining that the community health centers are being converted to revenue generating service points and increasing the barriers to care.[21]
- Lack of monitoring of physicians for quality of care, including the belief that IMA will not sanction its own members because of professional loyalty.

1.19 District Initiatives to Increase Access to Care

Jamkesmas does not cover all the people in need in the district. Some are excluded because of inaccurate estimations of their household incomes, others because of quotas. In order to respond and provide access to health services for the remaining population that are poor and near poor, Yogyakarta has developed a number of local initiatives that draw on the private sector. One is Gerakan untuk Kesejahteraan Balita (GARBA), which began in August 2008. This targets the poor and near poor who are not covered under any existing social insurance plans. As of February, 2009 there were approximately 104,000 children under the age of five and pregnant women who were receiving these services. Private midwives verify with their local community health center to determine if the clients are entitled to the services and then deliver care without any charges, getting reimbursed later from the province. They use the established fees under Jamkesmas as the reimbursement levels for services and get approximately 350,000 to 450,000 for a delivery.

1.20 Hospital and Consumer Information

The team went to four hospitals in Yogyakarta town. The hospitals were Panti Rapih, a long established Catholic Hospital, Bethesda Hospital, which is a Protestant hospital, Muhammadiyah, the Islamic hospital and the national referral hospital, RS Sardjito. Although RS Sardjito is a public hospital, it does receive referrals from the private sector. It has 750 beds and over 2300 staff, and serves as the teaching hospital for medical and nursing students at Gadja Mada University. The team conducted an informal client satisfaction survey there.

Bethesda is a 420 bed Protestant hospital established in 1889. It reserves 33 percent of its beds for low-income clients. The clients who are low-income can be covered by Jamkesmas or Jamkessos. In the event they are not enrolled in either, the hospital uses its own charity fund to pay for the costs. They have approximately 50-60 Askes patients, 25 Jamkesmas and 40 Jamkessos patients monthly.

The hospital uses a number of fee schedules. They have contracts with private insurers and large companies such as Pertamina, banks and automobile companies. For these they charge a straight fee for service. Then for the clients covered under the social insurance programs, they bill the negotiated amounts. However, with the tacit approval of Dinas, they also bill Askes patients at a higher rate, so that patients will pay out of pocket for procedures and drugs not normally covered. For clients who have limited resources, they allow 33 percent of the incurred costs to be paid for over time and they provide a running total to the client so they are able to find the resources for the bill. Last, they keep a fund available, which is sourced by charity contributions, to cover the cost of indigent patients. They think that the advent of Jamkesmas and Jamkessos has contributed to their increased ability to serve greater numbers of indigent populations, because their charity contributions can stretch further.

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[21] A Gadjah Mada University study done in 2005 in four districts in DIY came to the same conclusions as consumers, they found that local administration of health centers is without transparency and accountability, health centers are being turned into profit centers and the greater role of the private sector is reducing concerns over preventative care and health for the poor (Stein and Santoso, Surviving Decentralization? Impacts of regional autonomy on health service provision in Indonesia, August 2005).

Muhammadiyah is a 226 bed hospital that is part of the greater network of Muhammadiyah hospitals, even though it managed independently. They accept clients with different social health insurances, including Jamkessos, JPKM from Sleman and Jamkesda from Yogyakarta town. In 2008, their billing to Jamkesmas was 500,000,000 rupiah, much of which took longer than six weeks to get reimbursed. On average, they have 80 Jamkesmas patients in a month. They have an internal charity fund derived from alms giving (Bazais) that they use to cover the costs of caring for the indigent who have no other insurance or for costs that are not covered by Jamkesmas. This was just formalized in a May 1st decision by the director of the hospital.

In addition to negotiated contracts with Jamkesmas, they have contracts with many other private insurance agencies, such as Allianz Life, Global Assistance and Health Care and Madukismo.pg (a sugar factory). They have a differentiated service system, Class III patients get generic drugs while Class I clients get branded drugs. They run their pharmacy formulary based on the approved drug list for Jamkesmas, but 33 percent of their operating costs are still for medications.[22]

Panti Rapih hospital is a Catholic-run hospital with 360 beds, of which 160 are reserved for Class III patients. Like the other hospitals, they have a fund based on charitable giving that covers the care for indigent patients. They usually have 10 charity cases a month. Up until now the hospital has been managed well enough that they have had a surplus each year. They are turning their surplus into infrastructure development, adding two new patient care wings. They have an operating business plan for the next three years which calls on them to develop their market niche in orthopedic care, urology and non-invasive surgery. They already are a referral center for total knee replacement. They are part of regional chain that has four other smaller centers and they manage the supplies and drugs for all those centers. They are a member of Perdhaki, the Catholic hospital association and also the Indonesia Hospital Association but they stated that there are only informal meetings and no routine networking meetings to tackle joint problems such as late payment from Jamkesmas.

1.21 Potential Interventions

Among the recommendations from the field visit are the following:

- Build on the quality assurance efforts being done by BMPK and seek to develop systems in which findings can be linked to either regulatory or policy change.
- Work with IBI to rationalize their investment in Bidan Delima and develop a plan for sustained monitoring and evaluation to ensure that midwives are continuing to practice to the established norms.
- Review how the regulatory environment could be strengthened to provide improved monitoring of private providers.
- Establish strong linkages with Gadjah Mada University and some of the IBI sponsored midwife academies. In particular, Gadjah Mada is doing significant research in the area that provides a constant stream of new data on utilization, barriers to access, and client satisfaction.
- Reach out to the established NGOs and capitalize on their advocacy efforts to engage consumers in more appropriate service utilization.

[22] At this point, the interview was ended by the Public Relations Director of the hospital who was not pleased that there had not been more formal advanced notice of our visit.

1.22 List of persons contacted

Aisyiyah

1. Ibu Nurjanah, BPH Aisyiyah (Badan Pengurus Harian)
2. Ibu Hikmah, Wakil Ketua II
3. Ibu Umu Hani, Wakil Ketua I/ IBI
4. Ibu Suratini, BP3M Aisyiyah (Badan Penelitian, Pengembangan dan Pengabdian Masyarakat)

PKBI

5. Dr. Budi Wahyuni
6. Rini Handayani
7. Sri Murtini
8. Masmar
9. Fita P
10. Dewi Julianti
11. Anggarista

Lembaga Konsumen Yogyakarta

12. Nanag Ismuarto

Ikatan Bidan Indonesia (Central Level)

13. Dra Harni Koesno, MKM, Head

Ikatan Bidan Indonesia Yogyakarta

14. Darmawanti Burham (Ibu Ning), Ketua Cabang DIY
15. Bidan Istri Utami
16. Bidan Bodro Purnomowati
17. Bidan Karjiyem, S.Si, T, Spd
18. Tri Wahyuning, S.Si.T
19. Witri Suhartanti,AmdKeb
20. Eny Purwati, AMdKeb
21. Tutik Purwani, AmdKeb
22. Fathiyatur Rohmah, AmdKeb

Ikatan Doktor Indonesia

23. Dr. Bambang, Head of the Yogyakarta IMA branch

Askes

24. Dr. Endang (Head of Regional Office for Yogya and Central Java)
25. Dr. Sri Ponco (head of Branch Office in Yoyga)
26. Dr. Lenny Soetikno, MM, AAK (Marketing Managers of In Health, a brand name of AJI, Asuransi Jiwa InHealth, a division of commercial health insurance owned by Askes)
27. HS Rumondang P, Kepala Seksi Pelayanan
28. Sukarjo, Assistant Area Manager, Askes

Pharmacists

29. Drs. Nunut, ISFI Yogyakarta
30. Ms Ryan, Franchise Department, Head office of K-24 Chain Company

Dinas Yogyakarta

31. Mardiningsih, Seksi Regulasi Kesehatan
32. Kusminatun, Seksi Keuangan
33. Dr. Choirul Anwar, Kepala Dinas

Hospital Informants

34. Mrs Widi Astuti, Head of Socio-Medic Department, Bethesda Hospital
35. Sister Valentina CB, Head of Administration, PantiRapih
36. Mr. Mateus Sujarwa, Administration, PantiRapih
37. Heru Prasetyo, Unit SDP RS PKU Muhammadiyah
38. Ahmad Mukhlis, SE Unit Keuangan, Muhammadiyah
39. Susi Astuti, Manager Akunting dan Keuangan, Muhammadiyah
40. Arwan, Patient Admissions, Muhammadiyah
41. Ika Widayati, Muhammadiyah
42. PT Damatex
43. Ma Dian L Meilisa, Head Human Resources Department
44. Kadiyoto, Kepala Bagian Kesra

Gadjah Mada University

45. Professor Laksono

2. KABUPATEN BANDUNG AND CIANJUR

The purpose of this assessment was to provide field data as a supplement to the desk review which was completed in early March 2009. The team of four people, Dr. Firman Lubis, Ms. Damaryanti Suryaningsih, Dr. Andre Villanueva, and Dr. Michael Borowitz were in the field for five days (June 1 – 5, 2009). Information was gathered from the professional organizations present in Kabupaten Bandung and Cianjur, counterparts at the District and Provincial Health office, private providers and consumers.

Summary

West Java is the most populous province in Indonesia with high rates of maternal mortality and tuberculosis, which are the top priorities for the Provincial Health Department along with Desa Siaga. The province and district public health offices realize that they cannot improve performance in these areas without engaging more with the private sector. Currently, there are 142 hospitals in the province and only 22 are public. The vast majority of deliveries occur in private practice. People buy their drugs directly from private pharmacies. Engaging with the private sector is a priority.

To date, there has been little successful collaboration with the private sector although they dominate service delivery. The rise of social insurance through Jamkesmas (social insurance for the poor) and Gakin (social insurance for the near poor through district financing) is changing the engagement with private sector. These social insurance schemes provide payments to private providers unlike previous social insurance mechanisms like Askes (insurance for civil servants) which previously contracted only the public sector. Not only are there national schemes like Jamkesmas, but the provinces and districts are providing additional insurance coverage for the near poor (Gakin) and these are even more active in engaging with the private sector. In Bandung District, the Gakin scheme has contracts with 22 private hospitals.

There is great potential in using the new insurance schemes to drive improvements in access and quality. This potential has yet to be realized since these social programs to help the poor have yet to use payment methods to incentivize changes in clinical practice. At the moment, Jamkesmas/Gakin are little more than insurance in name only. They do not make full use of the potential to drive quality improvements. Furthermore, given decentralization, the districts are at liberty to experiment with different benefits packages and payment methods. This creates a new opportunity in Indonesia to drive quality improvement for priority services like MCH and TB by providing incentives to private providers to treat the poor with public funds.

The district and provincial health offices are interested to work with the private sector. They would welcome new ideas and support to experiment with changes in payment methods/benefits package to make progress in priority areas like MCH and TB. However, they need technical and political support. Currently, the promise of decentralization has yet to be realized. In looking at the insurance schemes in the districts, one is struck by their uniformity, even though districts have the ability to do things differently, they do not. This is partially because they do not know what to do differently and how to do it. They need political support to help deal with other important players outside the health sector like government auditors, who may ask them why they are doing things differently. USAID could play a catalytic role by supporting provinces and districts in using new innovative approaches to paying the private sector to improve access and quality to priority services for MCH and TB.

2.1 Provincial Information

The population of West Java is 42 million with 26 districts. The three highest priorities for the province are:

- Maternal, neonatal, and child health
- Tuberculosis
- Desa Siaga (Alert Village)

HEALTH PROFILE (Data 2007 – 2008)

Indicator	West Java Province	Bandung District	Cianjur District
Population	42,194,869	3,038,036	2,212,078
Maternal Mortality Rate	321,15/100,000 (data 2003)	205/100,000	364,1/100,000
Infant Mortality	39 (IDHS2007) 19 neonatal 19 postnatal 49 under5		46
Exclusive Breastfeeding	53.57%		
TB Case	30,072	7,742	
Delivery attended by health worker (only physician and midwife) • % delivery by physician • % delivery by midwife • % of deliveries performed by non-physician, non-midwife (traditional birth attendant, nurse, etc)	72.85% (physicians and midwives) 11.97% <u>IDHS West Java</u> Doctor 4.8% Midwife 50% TBA 43.4% <u>Place of Delivery</u> Public facility 6.0% Private facility 38.6% Home 54.5%	76.1% (physicians and midwives) 23.9% (majority TBA)	58% (physicians and midwives) 42%
Immunization Program coverage • DTP - HB3 coverage • BCG • Polio • Measles	82.57% IDHS DPT3 77.4% 90.45% IDHS 89.4% 78.33% 81.58% IDHS 79.7%	89.3% 81.2%	
Number of physicians	3,724 (GP, specialist, dentist)	90	191 (25 are full private practice)

Indicator	West Java Province	Bandung District	Cianjur District
Number of midwives and nurses	22,645 (51.45%)	672 (midwives only) (30 – 50% stayed in the village)	445 (midwives only)
Number of Pharmacies	2,421	44	65
Number of Drugstores (Toko Obat)	1,058		5
Number of Puskesmas	1,017	92	45
Number of Balai Pengobatan (small treatment centers, usually headed by a nurse or midwife), if any	1,362	621	57
Number of Rumah Bersalin (small clinics that focus on maternal health), if any	204	108	
Persons covered by Jamkesmas		791,664	600,000 National 80% District 20% (Inclusive of district scheme)
Total number of hospitals			
• Public	22	2	2
• Private	120	5	0
Total number of private practice midwives	6,508		300 (16 are full private practice)
Total number of Bidan Delima	1,668	58	32
District insurance scheme (Y/N)	Yes	Yes	Yes
• What is covered by the scheme?	Comprehensive	Comprehensive	Comprehensive
• How many are covered?		360,000	(They do not differentiate from Jamkesmas)
• How many % of the remaining population NOT covered by any health scheme?		0	0
% of total district budget allocated for Health AND nominal amount		7.3% Rp131 Million (Rp45 Million for salary), 20% for MCH	4.3% (including salary)

Data from the Indonesia Demographic Health Survey (IDHS) shows that West Java does not perform as well as other provinces in Java, particularly Yogyakarta – the best performing province. Across all key performance indicators, West Java is behind such as infant and child mortality, but also intermediate process indicators such as percentage of births attended by skilled birth attendant.

How can services provided at private facilities be better integrated into the health system to ensure better delivery and monitoring of private health services (e.g. TB, ANC)?

2.2 Reporting on private providers to the District Health Office

The District Health Office keeps records of all private providers by category. There are 26 categories including private hospitals, clinics, midwives, pharmacies. There are a total of 3,603 private providers including 458 private midwives. They update private providers every year and private providers need to renew their license every 5 years. In Bandung district, they had data from 2003. In Cianjur district, they had less information at the district level because they have fewer private providers. For example, there are no private hospitals. However, the Provincial Health Office has data on all private providers in the province, since they are ultimately responsible for licensing.

It is unlikely that official data is reliable due to non-compliance by private providers to submit updated information. There is currently no real incentive to comply. For example, many of the private hospitals do not report data on the treatment of tuberculosis and yet they provide treatment. Only those hospitals that receive drugs from the health office submit data on TB. To the end of 2008, the Provincial Health Office Head reported that only 10 percent of private hospitals submitted their reports despite the fact that there is an existing regulation for hospital compliance with regards to submission of reports.

In terms of MCH services, there is regular reporting to the District Health Office from private midwives. There is much better compliance from Bidan Delima compared to other midwives. However, there is virtually no reporting from private hospitals.

Private providers are not required to provide any information on their fees to the Provincial or District Health Office. The government health offices only know whether the private providers are licensed.

2.3 Role of DinKes in supervision and monitoring of private providers and ensuring their overall quality

The primary role of the District Health Office regarding the private sector is to license private providers. For midwives, the initial license is issued by the District Health Office upon recommendation by IBI. The renewal license after 5 years is issued by the District Health Office upon recommendation by IBI. According to IBI Province, there is no competency test conducted for midwives prior to initial or renewal of license. They plan to conduct it this year.

Beyond this, they see their role as very limited. Even in Bandung District, which is more active than Cianjur and has more private providers, they play a limited role in monitoring the quality of providers. They check the clinic facilities such as equipment rather than the quality of care. They also have a limited role in supervision because of limited budgets. Given the large number of private providers in Bandung District, they have limited staffing and therefore cannot visit private providers regularly.

As an example, private pharmacies are supposed to have a pharmacist present. The District Health Office also conducts inspection of the various pharmacies. Pharmacists should only have one practice. It is, however, a known fact that pharmacists practice in multiple sites making their license available to pharmacy owners for their facilities to comply with business permit requirements. The Balai POM at the provincial level coordinates closely with the District Health Office. Inspections are supposed to be conducted twice a year. However, this is difficult to enforce, as per the Bandung District Health Office. In fact, in Cianjur district, a pharmacy owner

admitted that her pharmacist only comes once a month to take her salary. Another pharmacy in Cianjur was reported to sell narcotics without prescription.

It is important to realize that few of the private providers are only "private." The vast majority of health personnel working in the private sector are, in fact, government employees who work in public facilities during the morning and private facilities in the afternoon. For example over 80 percent of public midwives are in private practice. In theory, some of the supervision and regulation of the private sector occurs through public sector supervision, since it is the same person. Most of the "pure" private providers are retired from the public sector or newly graduated.

There is some supervision and monitoring through IBI. For example, IBI representatives provide training in the district training center for midwives. After the training, the District Health Office staff follows up the training to ensure it is being implemented. Also, the Midwife Coordinator in the District Health Office provides supportive supervision using a self-assessment tool. This system exists in both Bandung and Cianjur districts due to support from the USAID Health Service Program. There is also widespread supervision of midwives through the Bidan Delima program. The Representatives from IBI regularly visit all Bidan Delima as part of their supervisory program.

District government officials may have a full map of the health care system but they concentrate almost exclusively on the public sector, which limits their responsiveness to monitoring needs within the private sector. Unlike Yogyakarta, Bandung District does not have an independent monitoring agency (Badan Mutu Pelayanan Kesehatan), which is contributing significantly to the evaluation of quality issues in Yogyakarta.

2.4 DinKes Experience with Public-Private Partnership

The District Health Office in Bandung claims that it has a good relationship with individual private health sector partners (e.g., IBI, ISFI, etc). However, there is no regular meeting where the District Health Office meets with the various private sector partners in health care to discuss collaboration. The Head of the Provincial Health Office claimed that there is no collaboration at all between government and private hospitals. One gets the overall impression that the government health offices do not regard the private sector as part of their responsibility except for licensing and issues on malpractice.

A priority activity of the newly installed Head of the Provincial Health Office is to establish a good working relationship with the Districts by working with them as a team rather than the traditional hierarchical manner. She wants to move forward as a community with common interests. However, when she invited officials from the District Health Offices to get together, only 50 percent attended. She is determined to make progress and she is convinced that there can be closer collaboration between public and private health sectors. She is currently communicating with IMA, IBI, ISFI, GP Farmasi, and other stakeholders to strengthen links among all the players in the health care arena.

There are regular meetings between the government and professional associations. The Provincial IMA met quarterly with the Provincial Health Office on government health programs to discuss areas of collaboration. They describe their relationship with the Provincial Health Office as close. The Provincial Health Office is providing IMA Province an office space at the former's new office building free of rental charges. This move will likewise ensure more interaction and collaboration between IMA and the Provincial Health Office. Currently, the officers of IMA are volunteers and IMA sustains its Secretariat Offices.

The Provincial Health Office meets with the hospital group every three months. Muhammadiyah suggested to the City Health Office in Bandung that there should be more collaboration with private sector health providers and they should be involved in all the various training programs. They believe that at least 25 percent of training slots should be reserved for private sector participants.

One example of private-public partnership is between midwives and traditional birth attendants. In Cianjur, there are 348 villages and 17 of these have no midwife. Twenty five villages have midwives but these midwives are not residents of these villages. The District Health Office encouraged partnership between the traditional birth attendants and the midwives. There are 2,000 traditional birth attendants in Cianjur. In 2007, there were 85 maternal deaths and 84 of these were handled by traditional birth attendants. In 2008, 42 percent of deliveries were handled by traditional birth attendants. Currently, there is a partnership between a midwife and traditional birth attendants whereby all deliveries are referred to midwives. Traditional birth attendants handle the post-partum care and care of the infant. Rp 50-100,000 is paid to the traditional birth attendant and the midwife is paid Rp 200-250,000. There are three obstetrician/gynecologists in Cianjur, one of whom is retired.

An example of an unsuccessful public-private partnership is in the area of TB. Two years ago, the City Health Office in Bandung initiated and conducted a DOTS Training involving 50 pharmacists representing ISFI, the hospital, industrial, community pharmacies. It was, in reality, only a seminar where attendees were expected to cascade the learning to their constituents. The expected outcome was for pharmacists to identify TB symptomatics and refer them to the Puskesmas for proper diagnosis and treatment, if found to be a TB case. However, the intervention was not successful and this was attributed to the following reasons:

- Lack of follow-through on the part of the City Health Office in Bandung in terms of monitoring and evaluation;
- The need to have involved the drugstore owners (GP Farmasi Group) to ensure buy-in;
- Lack of follow-through on the part of ISFI to ensure dissemination and implementation of the intervention to its constituents and colleagues in the pharmacy – the assistant pharmacist and store clerks;
- No integration of the pharmacy sector with the DOTS system and lack of links to other players (e.g. physicians). There was no formal system for referral, nor a feedback system.

Recently, there has been renewed interest in public-private partnerships for TB. The Provincial Health Office has had discussions with Muhammadiyah about involving them in their TB Program. Muhammadiyah has submitted a request to the City Health Office in Bandung to be part of the TB DOTS Program. After having submitted statistics required by the District Health Office, Muhammadiyah is now part of the DOTS system and receives free TB drugs. However, the hospital's pharmacy said the supply of TB drugs from the District Health Office was insufficient. They only provided drugs for the poor, but they were supposed to provide drugs for all confirmed cases. There have been stock-out problems leading to patients not coming back for their treatment.

What can be done to rationalize the use of medications as part of an integrated provider quality improvement approach?

2.5 Sources of Medications for Private Providers

In Indonesia, there are 204 pharmaceutical manufacturers, 49 sole/first layer distributors, 2,560 second layer distributors or Perusaahaan Besar Farmasi (PBF) responsible for distributing drugs to hospitals, pharmacies, and drug stores. The sole distributors manage distribution of one manufacturer to various PBF. In Indonesia, there are 5,695 pharmacies (which must have a pharmacist and are the only approved venue outside of a hospital or clinic to sell prescription drugs) and 5,513 drug stores (which sell over-the-counter medications and have an assistant pharmacist).

Hospitals and stand-alone pharmacies purchased their medications locally from these distributors. Individual midwives would purchase drugs either from a local pharmacy or through pharmaceutical representatives. IBI has initiated a move similar to Yogyakarta where the IBI uses its resources to buy medications at a discounted price and sell them to its members. This system works reasonably well. However, the drugs are only distributed at IBI meetings, and these meetings are not held often enough. Midwives do not have spare money to hold stocks. Therefore, midwives, particularly those in rural areas, often have to buy drugs from the private market when they need them.

There was wide variation in how the different hospitals procured medications. The Borromeus Group, a Catholic group of hospitals and clinics, does group-purchasing for specific drugs. Most of the time, each member group procures its own drugs and supplies from PERDHAKI. The Borromeus Group, along with other Catholic health facilities, is a member of PERDHAKI, and as a member they get to procure their drugs and supplies from PERDHAKI at relatively reduced cost. Delivery of these drugs and supplies by the supplier are free of charge regardless of destination within the country. PERDHAKI conducts an annual membership meeting for synergy. It also provides training opportunities for its members (e.g. financial management) for free. There are scheduled trainings during the year.

Adventist Hospital in Bandung is a part of the Adventist group which has various health care facilities including 60 clinics nationwide. The various hospitals within the Adventist group are each separate Foundations, and each facility is autonomous. There is no pooling of resources for joint procurement of drugs and supplies. The idea of a central framework procurement for the whole group has never been discussed.

Muhammadiyah Hospital, which despite being part of a large network of providers, also procures its drugs and supplies only for itself. There is no joint supply chain for the network.

In general, procurement of drugs by private providers is currently not a problem. Drugs are readily available from various sources.

2.6 Potential Role of District as supply point for private providers

Currently, vaccines, the drug regimen for tuberculosis and some malaria drugs, which are part of vertical programs from the Ministry of Health, are received by qualified private providers from the District Health Office in Bandung. These drugs are intended to be passed on to the consumer at no cost to the patient.

There is a problem specifically with TB drugs. The head of the Provincial Health Office reported that TB drugs coming from the Central Health Department had been delayed by two months, and that interrupted supply has been common. Currently, there is no problem with TB drugs. The budget for TB drugs comes

from multiple sources: 40 percent from the Ministry of Health; 30 percent from the Provincial Health Office; and 30 percent from the District Health Office. As per the District Health Office, supply points are limited to public providers (hospitals and Puskesmas). However, Aisyiyah through Muhammadiyah, is a supply point of TB drugs.

IBI Province stated that it did not charge service fees to patients under Jamkesmas and Gakin for contraceptives coming from BKKBN. The stock is taken from the Puskesmas. However, the problem was the availability of these free contraceptives. Often, there were none available. Midwives would usually get these during big events sponsored by BKKBN.

2.7 Potential role of professional associations in improving practice norms (including drug use)

IBI Province stated that they did not meet regularly, but the IBI District and sub district met with their constituents regularly on a monthly basis. The gathering was mainly to share practice updates and discuss issues relating to their association.

IBI is also involved as a trainer in the district training center as a team member for strengthening system of supportive supervision. Supportive supervision is done once or twice a year by the Midwife Coordinator to Puskesmas, Pustu, Polindes and private midwives, using self-assessment tools. The health facilities focus on improving midwives' performance based on problem identified from the self-assessment tools.

IMA has a program for all its members to collect credit units by attending workshops and seminars to improve their skills and update their knowledge. In the renewal of their license, they must have accumulated at least 200 credit units within 5 years.

IMA also has a program whereby complaints received from patients are relayed and discussed with the concerned provider. IMA serves as a mediator in most of these cases.

The implementation of the "No Pharmacist, No Service" policy or Tanpa Apoteker Tidak Ada Pelayanan (TATAP) is critical. This is currently being piloted in West Java in close coordination with ISFI.

There is a scope for the private hospital association to play a more active role in the emerging new social insurance environment. Advent Hospital, for example, intends to become part of the National TB DOTS program.

Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?

2.8 Organization and Management of Pharmacists Associations.

ISFI is a national professional association with branches locally. ISFI has subdivided its group into three major divisions: The Hospital Pharmacy Group (HISFARSI); The Community Pharmacy Group (HISFARMA), and the Industrial Pharmacy Group (HISFARIN). ISFI Province has its counterparts in the districts. The system for tracking down and updating of members is relatively poor. ISFI officers meet every two months and there is usually a general membership meeting twice a year at the District levels. A national gathering is done once a year. IMA Province claims that it considers ISFI a partner is health care and will have coordination meetings with them, when needed.

As a professional organization, the main activities are through its sub-divisions because they have more common interests. For example, HISFARSI has been in existence for two years and has a member base of 150 and meets regularly. They see their main role as provider of continuing education of its members. HISFARMA appears to be the most active and has developed a program, TATAP ("No Pharmacist, No Service"), to ensure that all pharmacies have a pharmacist during operational hours.

In West Java, where the TATAP policy is being piloted, a hospital pharmacist mentioned that the regulation of two pharmacists per pharmacy is not enforced in reality. ISFI in the district is supposed to monitor the policy, but this is not routine. Also, ISFI has no power. There is no recommendation needed from ISFI for licenses to be renewed or revoked when a pharmacy is found not to comply.

Despite the opportunities to attend seminars, the Head of Pharmacy for Advent Hospital voiced concerns about the lack of continuing professional education. She mentioned that there was a lack of technical updates relating to the science, a lack of available journals to serve as source of information and reference, and a lack of information to ensure patient safety. This lack of continuing professional education contributes to the lack of confidence on the part of the pharmacist to conduct himself/herself appropriately during a patient-pharmacist interaction.

In the hospital setting, the Head Pharmacist is a member of the Hospital's Therapeutic Committee. Physicians always have the right to choose their own drugs particularly the guest doctors who bring patients to the hospital. The Hospital Formulary is regularly revisited and revised at least every two years for Advent Hospital. If there is one particular drug that is needed and not part of the Formulary, exceptions are made by the Committee if there is a good case. Good and open communication between the Hospital Pharmacy and the doctors lessens cases when the formulary is not followed especially on generic substitution of prescribed drugs.

Currently, only 10 percent of the pharmacies are owned by pharmacists. Ninety percent are owned by non-pharmacist. Owners of pharmacies have their own association – the GP Farmasi Group. ISFI Province has a plan for pharmacists to increase the ownership of pharmacies through a franchise scheme – "Pharmakita." Through this, the profession can duly be performed, and pharmacists can actually stay in the facility during work hours since the pharmacist owns the pharmacy. ISFI argues that if pharmacists own pharmacies, there will be greater control of the quality of drugs available for use by the public. ISFI Central is also planning to initiate a similar scheme, "Pharma Nusantara."

2.9 Licensing and Oversight of Pharmacies and Drugstores

The District Health Office is responsible for the issuing and renewing of licenses for pharmacies and drugstores. They are also supposed to enforce the standard of two pharmacists for every pharmacy. The regional Food and Drug Administration (Balai POM) is responsible for conducting regulatory visits two to three times a year in close coordination with the District Health Office.

Pharmacists are supposed to only have one practice. It is, however, well known that pharmacists practice in multiple sites, and that they make their license available to pharmacy owners for their facilities to comply with business permit requirements. Inspections by Balai POM are supposed to be conducted at least twice a year. However, the regulation is not enforced. In Cianjur district, a pharmacy owner reported that the pharmacist only comes once a month to collect her salary of Rp 800,000.

2.10 Stock of Pharmacies and Drugstores

None of the informants questioned stated that stock-outs were a problem. The current supply chain consists of manufacturers to sole distributors and then further to the PBF. These secondary distributors supply the pharmacies and hospitals in West Java.

In theory, the PBF distribute prescription medication and OTC (over the counter) drugs to pharmacies and hospitals, while drug stores are only intended to receive over the counter medication. However, this is also loosely regulated and spot checks found prescription drugs available in drugstores in West Java. In fact, the Head of the Provincial Health Office reported a recent scandal where one of the major drug distributors was caught selling methamphetamine ("ecstasy") to private drugstores. The Provincial Health Office blacklisted this distributor but the company changed its business name and continued to distribute drugs. The Provincial Health Office stated it was very difficult to enforce bans on companies.

2.11 Staff of Pharmacy and Drugstores

The requirement of having two registered pharmacists per store is in line with the vision of ISFI that a pharmacy should be a venue for professional services where pharmacists provide information on drug efficacy, drug interaction, drug allergies, counseling and referral, when needed. ISFI has been pushing the local and national government to adopt a regulation that a pharmacy is a professional service unit and not merely a business unit. Under current practice, investors own pharmacies and pharmacists are paid very low wages (about Rp 1-2M a month). Under this model, a pharmacist comes in only one hour a day-or even only 2-3 times a week, undermining the professional function and role desired by ISFI.

How can financial incentives be used to improve access to services or quality of services among private providers?

2.12 Experience Contracting through Dinkes or Insurance Schemes

The quality of service among private providers remains unregulated. Askes credentialing of private providers in West Java rests on determining whether they are licensed, their geographic proximity to the client base, and a visual inspection of the service site. This inspection is not codified against an established checklist of quality standards.

IMA and IBI Province stated that they accept and service Jamkesmas and Gakin patients as mandated by law and as mentioned in their professional by laws. Also, they felt it was their social obligation to serve the underprivileged.

2.13 Implementation of Askes

Askes is a government insurance program covering civil servants and their families (up to two children). Funding comes from a mandatory contribution of 2 percent of the monthly basic salary matched by the government as an employer. The total number of members nationwide was 14,576,900 insured. The benefit package is not basic care, but full, comprehensive health care including open heart surgery, hemodialysis, and cancer treatment. Members must register with a Puskesmas and cannot receive any secondary care without a referral letter from the Puskesmas. Many civil servants, particularly the upper tier, do not make full use of the benefit because few civil servants would want to go to the Puskesmas.

PT Askes (Persero) Cabang Utama Bandung covers four Districts including Bandung District. It covers 540,000 lives that are served by public and private health care providers. They have 13,000 different drugs on their formulary that are covered by Askes.

Out of a population of 40M in West Java, 178,786 are covered by Askes – Commercial. The capitation offered by Askes – Commercial for outpatient coverage is Rp 2,500 per capita with no inclusion of medicines. Through member mapping, the average number of lives per contracted physician is 150. The physician may opt to be capitated at the rate of Rp 7,500 per capita which includes medicines. Askes has contracts with the following providers: 16 clinical specialists, 280 GPs, 60 clinic facilities, 87 pharmacies, and 69 dentists.

Askes – Commercial focuses primarily on company accounts. It currently serves 152 companies. One of its major accounts is a railway company with 111,500 members. Based on information taken from PT Askes Central Office, all Commercial businesses will be handled by PT InHealth.

Under the Askes Sosial Plan currently administered by PT Askes (Persero) Cabang Utama Bandung, Askes affiliated with 24 hospitals, 5 of which are private hospitals, and 22 GPs. The criteria is based on mapping of where their members reside. The target is to have 60 GPs. GPs are capitated at Rp 2,500 per capita not inclusive of medicines and Rp 1,000 to Puskesmas. Another capitated fee option is Rp 7,500 which includes medicine.

Askes allows providers to charge in excess of the standard reimbursable amount; however, it negotiates with the provider acceptable rate. Currently, Askes does not use IMA's manual on clinical practice guidelines which could be the basis for sound and acceptable quality medical practice in the actual process of claims adjudication.

As per IMA Propinsi, they meet with Askes once a year. There is usually no discussion on utilization review, physician practice patterns, or the like.

As per Askes, reimbursement from Askes takes at least one month. As per IMA, the capitation fees are regularly received by them every month. However, payment to the hospitals takes up to two to six months.

For those pharmacies contracted by Askes, a 40 percent discount is afforded to each pharmacy when drugs are purchased from any of the 84 drug manufacturers accredited by Askes. These pharmacies are allowed to load their acquisition cost by 20 percent.

Accredited pharmacies are provided a special software by Askes to administer that portion of the member benefit. Pharmacies claim directly from Askes based on the agreed pricing and benefit allocation.

Adventist Hospital, one of the top hospitals in Bandung City, reported that they do not receive Askes and Jamkesmas patients in their hospital. They, however, accept Gakin patients. Adventist has applied to Askes but was informed by the latter that Askes had enough providers. The Gakin reimbursement process takes three months.

2.14 Implementation of Jamkesmas

Jamkesmas is a national program and is being implemented in West Java. Depkes contributes a "premium" of Rp 5,000 per capita per month for a complete benefit package following the national guidelines. They contract with public and private providers. Private providers are not allowed to charge above the set fee. Originally, Askes administered the claims but now they are being administered through Depkes.

In Bandung district, 791,664 people are covered by central Jamkesmas. An additional 361,000 are covered by Gakin. In four Districts, there are 40 private hospitals in the region and 22 hospitals have an MOU with the District Health Office for Gakin services, whereas only three have MOUs for Jamkesmas.

Jamkesmas is paying midwives Rp 300,000-350,000 for delivery and hospitals Rp 500,000 for a normal delivery. The fee includes both antenatal and postnatal care. The payment generally takes a month. Gakin pays the same amount; however, payment is more unreliable. The payment is inclusive of ante and postnatal care. In Cianjur, a midwife has to share the fee with the traditional birth attendants. In some areas, the midwife also has to pay the Puskesmas and tax. The midwives said that of the Rp 350,000 fee, they ended up with only Rp 200,000 net for delivery, far below the market price of 500,000 for a private delivery.

The majority of private providers in Bandung District, including midwives, said they accepted Jamkesmas and Gakin not just because it is mandated by law but also as part of their social responsibility.

There are a wide range of payments in the private sector for delivery. In a private hospital, for example Advent hospital, reported a charity package for Rp 2M for a normal delivery including a three-day stay.

Payment for Delivery: Advent Hospital

Provider Type	Payment for Delivery
Specialist	2,000,000
General Practitioner	800,000
Midwife	460,000

Askes reimburse midwives Rp 250,000 if delivered by a midwife in the Puskesmas; Rp 400,000 if delivered in the hospital; and Rp 480,000 if delivered by a private midwife.

The standard payment for a normal delivery for a private midwife is Rp 500,000 with variations between Rp 300-500,000. Most midwives reported that they would be satisfied with payment of Rp 500,000 per delivery. In private practice, midwives' monthly income would be approximately Rp 5M. On the average, a midwife will perform 5-10 deliveries per month.

Payment for Post-Partum Hemorrhage
Currently under Jamkesmas/Gakin, a delivery in the private sector is reimbursed Rp 300,000 which is below the market rate of Rp 500,000. If a mother has a post-partum hemorrhage and is referred to the hospital, the midwife is not reimbursed. This is because post-partum hemorrhage is considered a high-risk delivery and midwives are only reimbursed for normal delivery. The reimbursement mechanism creates a disincentive for midwives to do the right thing.
Recommendation: The reimbursement mechanisms for maternal services should be refined and include more categories. For example, there could be a category of delivery with post-partum hemorrhage. If a midwife would be paid for the delivery, she could also be reimbursed more than a normal delivery for providing additional services beyond standard practice (e.g. IV infusion). The addition of such an additional reimbursement code would also allow for improved monitoring of key clinical indicators such as post-partum hemorrhage.

A Cesarean Section is being reimbursed for Rp 5M by Jamkesmas compared to a private rate of Rp 7-8M. Despite this, providers are not allowed to charge the patients beyond Jamkesmas and/or Gakin rates. This was confirmed by IBI and Aisyiyah/Muhammadiyah. The concern here is the issue of social responsibility vis-à-vis quality of service.

The claims for hospital services (curative care) for Jamkesmas patients are processed using the budget from the Ministry of Health. The claims for PHC services (curative, preventive, promotive) are processed using the budget from Depkes with recommendation from the District Health Office. Administration of the claims is done by staff at the District Health Office. The claims for hospital and PHC services for Gakin (APBD) patients are processed using the budget of the District Health Office by its staff.

The midwives accept Jamkesmas and Gakin. They do not charge anything in excess of the schemes' benefit limit. Turnaround time for reimbursement for Jamkesmas can take from 1-2 months while that from Gakin is relatively faster, 20-30 days. Funds for Jamkesmas are issued out of the Ministry of Health in Jakarta.

The District Health Office has contracted, through MOUs, with a total of 22 public and private hospitals to serve the Gakin patients in Bandung District and nearby Districts: Bandung City, Cimahi District, and Bandung Barat.

It was mentioned that the budget for health is insufficient and there is a need to be more cost-effective and cost-efficient in the use of the allocation. According to the Cianjur District Health Office, the budget of health should be 15 percent of the overall district budget, but in reality they only receive 7 percent. The packaging of health services is an option being looked into. Meanwhile, the administration of Jamkesmas is done at the hospital level through a claims verifier using resources from the Ministry of Health and Gakin is done by staff at the Dinkes using resources of the Dinkes. There is no case management in the adjudication of claims of both schemes. As long as the claims where within the benefit limit, these were being processed for payment.

With regards to the limits set for reimbursement (e.g. Rp 300,000 for normal delivery by midwife), the Provincial Health Office said these cannot be adjusted to incentivize the providers as auditors of the Ministry of Health in Jakarta prohibits this. This limitation extends to restructuring the overall benefits (e.g. limiting benefits to priority services with higher coverage) as well. The District Health Office at the same time opts to continue on current practices to avoid conflict with Ministry of Health officials.

There was also no direct contracting arrangement with individual provider. There was no utilization review conducted nor a review of provider practice patterns.

Private providers working in three practice sites and midwives working in two sites, pose a threat whereby when the patient is referred to a practice site, the provider might be off to another location.

The monthly income of a private midwife is Rp 5-10M while that of an obstetrician/ gynecologist could be up to Rp 100M. A guaranteed income of said amounts may, in theory, ensure the presence of professional care in one facility at any one point in time.

As of 2008, there are 8,537 midwives in West Java, 1,668 of who are members of Bidan Delima. Six thousand are private midwives. There has been an increasing trend of Bidan Delima since 2004 (annual increase was 373). Reimbursing a higher fee for Bidan Delima may serve as an incentive to gain membership while at the same time increasing the quality of care.

Another concern cited by midwives is the issue on referral due to an obstetric emergency. There is no system for cost-sharing whereby midwives receive no partial payment for any of the care they delivered nor payment for drugs used up until referral. In some cases, midwives will offer the use of their personal transportation to ensure transfer is expedited without being reimbursed for gasoline usage. There is no system to allow for a referral fee nor a profit sharing scheme between the hospital (and the specialist) and the referring midwife.

In Surabaya, a physician contracted by Askes enjoys a reward system whereby if the budget allocation for health expenditure is not consumed by the population assigned to him at the end of the contract year, the surplus is awarded to him. Such scheme is being thought about by PT Askes (Persero) Cabang Utama Bandung for possible implementation in its four Districts.

What role can professional associations and Non-Governmental Organizations play in monitoring and improving quality of care among private providers?

2.15 Overall relationship between professional associations and the district health office

IBI and the local district carry a joint responsibility for monitoring practices, scheduling a joint monitoring visit every six months. In addition four times a year, midwives who are IBI members receive an invitation to participate in the maternal audits that are done.

Midwifery providers do not have to be pre-approved by the government health offices to take Jamkesmas or Askes insurance. They are not contracted with to deliver a certain amount of care but rather receive reimbursement on a case-by-case basis. They do not discount their rates nor do they insist reimbursement based on private practice rates when they attend to patients under the Jamkesmas program. IBI has a Memorandum of Understanding with the District Health Office to establish each of their expected roles in terms of monitoring, reporting and supervision.

2.16 The Indonesia Midwife Association

The Indonesian Midwife Association plays an important role as a professional organization for midwives. It is particularly important in West Java, where the Bidan Delima program has flourished.

There are 1,668 midwives who have received the Delima certification. In West Java, there are 8,537 midwives of which 6,000 are private midwives. There is still scope for growth for the Bidan Delima program. There are many different clinic models throughout the province and district – midwives working with other midwives as a group practice and midwives working with physicians (GP) as a practice entity. However, most midwives are in dual practice, where they work in both the public and private sector.

Some of the current issues and concerns of IBI in Bandung District are:

- Institutionalizing the practice of early referral. IBI has a policy to make early referrals because they don't want to patients dying in midwife practices but currently the system doesn't work on a routine basis.
- Establishing Bidan Delima as the minimum standard practices for midwives who wish to work in West Java.
- Midwives receive Jamkesmas and Gakin patients which are then filed for reimbursement in the Puskesmas. For Jamkesmas, the turnaround time for reimbursement is one month, and for Gakin, for some, reimbursement for 2009 patients has not been received as of yet.
- Reimbursement for a delivery is Rp 300,000 regardless if management included emergency services prior to transfer to a hospital facility. Midwives are reminded that they are only allowed to manage normal deliveries. Their regular charge is Rp 500,000 inclusive of services, drugs, and birth certificate.
- There is no incentive from the hospital when midwives refer obstetric emergencies. There are 1-2 hospitals that would reimburse a referring midwife Rp 20,000 for transportation expense.

- Private midwives are willing to receive Jamkesmas or Gakin patients even if they don't have a written contract or MOU with the District Health Office. They are made aware of the drive through socialization meetings with IBI and the District Health Office.
- Using the regular meetings as a distribution point for quality-assured drugs and supplies for midwives at a relatively cheaper cost.

2.17 The Indonesian Doctor Association

There are 11,000 IMA members in West Java. The 25 Districts in West Java has been divided by IMA Province into five zones. Each zone conducts regular meetings with its members. It is difficult for IMA Province to ascertain the total number of IMA members in each of the 25 districts. Kota Bandung had a membership of 2,000.

Membership to IMA will cost Rp 120,000 per year. This fee is paid to the IMA District. 75 percent is retained by the District, 15 percent is remitted to IMA Province, and 10 percent to IMA Central.

The primary role of IMA Province is to coordinate with the various IMA Districts especially on issues relating to physician practice. It also renders regular supervision to them. It is in the forefront as it investigates and mediates cases of malpractice. IMA Province has no authority over individual practicing physicians.

IMA District's role is more on operational activities. There is collaboration and cooperation between IMA Districts. It is the IMA Districts that get to elect their IMA Chairman for both Province and Central levels.

IMA updates its clinical practice guidelines regularly, yearly for specialty cases, and every 5 years for general cases.

Currently, the main concern of IMA physicians is practice income. On the average, the monthly income of a GP is Rp 3-6M. Specialists' income varies and may reach up to Rp100M per month. An anesthesiologist fee is usually 1/3 of the surgeon's fee.

Per IMA, there are 1,100 Health Centers in West Java (25 Districts) and 500 of these Health Centers DO NOT have physicians. It is the hope of IMA that physicians assigned in Health Centers be offered higher salaries. An acceptable monthly income for a GP is Rp 5M. A promise of a better career through a scholarship grant for further education overseas after serving government for at least three years is also seen as a good incentive.

As per the Chairman of IMA Province, physicians would accept poor patients as part of their social responsibility. However, government has not contracted with them regarding Jamkesmas and Gakin specifically.

Physicians are not allowed by law to dispense medication. They prescribe and pharmacies dispense. The IMA Province Chairman stressed that the pharmacies are the sole distributors of drugs to the public except in the very rural places where special permission is granted to physicians (or even other allied specialties) due to lack of pharmacists in the area.

IMA considers IBI, ISFI, and the Nurses Association as partners in the health delivery system. There is no regular meeting with them but coordination meetings, if needed, are done.

The license to practice medicine is issued by District Health Office. It coordinates with the Medical Council in Jakarta, with IMA District and Province, prior to the issuance and/or renewal of licenses. It also monitors compliance of the three practice sites regulation for physicians.

2.18 Civil Society and NGOs

2.18.1 AISYIYAH

Aisyiyah is part of the overall religious network, Muhammadiyah. In West Java, they have two hospitals and five maternity clinics. The focus at this time is improving on hospital services.

Aisyiyah and Muhammadiyah accept Askes, Jamkesmas, and Gakin patients. These partnerships have been formalized through an MOU with the District Health Office. Reimbursement turnaround is 20-30 days. Less than 10 percent of the patient load, however, is from Jamkesmas and Gakin. They do not charge the patient anything in excess of the benefit. They have allocated 11 beds for the poor.

The Muhammadiyah hospital is a secondary non-profit hospital. It caters to the public.

Physician specialists take 85-90 percent of the hospital income. There are 10 GPs employed as hospital staff. Specialists are favored because of the lack of such in the roster of physicians. To-date, there is very limited credentialing being done since specialists are considered a rare commodity.

There is no Quality Office to monitor patient care, physician practices and patterns, statistical review, etc.

Drugs are procured from their local distribution network through a bidding scheme. Physicians would usually submit their list of preferred drugs to the hospital and the hospital negotiates with the distributor.

Aisyiyah works closely with other association groups like IMA and IBI.

2.18.2 PKBI

PKBI Province is an NGO for Family Planning. It was established in 1957 and is part of the International Planned Parenthood Federation. It is present in all provinces and almost all districts within Indonesia. The Teratai clinic staff in West Java Province consists of: two GPs, two midwives, one Administrator, one Technical Consultant, one Medical Consultant, and three Counselors. It has been training for PMTCT. Another clinic, Mawar clinic, focuses in HIV/AIDS. This clinic receives funding and assistance from Impact.

Teratai clinic provides maternal neonatal health services such as ANC and immunization but their focus is in family planning services. Majority of its client is for IUD insertion (around 100/ month). According to the clinic staff, the option to use IUD (75 percent), is not because from the counseling of PKBI staff but from recommendation from friends and/or relatives. The lowest service availed of is vasectomy (once a year on the average). They also provide Pap smear. Most of their clients are from the low to middle income groups. Pap smear services are mostly used by middle to higher income groups.

BKKBN supplies PKBI Province with contraceptives. To-date, there has been no problem of supply.

There is a good relationship between the District Health Office and PKBI. They have been invited in District Health Office coordination meeting; however, there has been no long-term work relationship

between PKBI and the District Health Office. In 2000-2002, PKBI was involved with the District Health Office in monitoring activities for JPSBK (Jaminan Pengaman Sosial Bidang Kesehatan) funded by UNFPA. The PKBI had funding from the British Council to be involved in these activities.

There is a working relationship between PKBI and Askes-Private but none with Jamkesmas and Gakin.

The following are the cost and service fees for the following:

1. IUD insertion: Rp 150,000
2. Vasectomy: Rp 300,000
3. Implant: Rp 250,000
4. Pill: Rp 5,000
5. Injection: Rp 20,000

There has been a decline in the use of contraceptives. This is being attributed to the low number and/or absence of a cadre.

PKBI conducts outreach activities. It has 10 staff who visit villages every month to do IEC activities to motivate community to use contraceptive. However, it feels that they need more staff to reach out to the community. It used to work with FP field staff/ Petugas Lapangan Keluarga Berencana (PLKB) from BKKBN but now the number of FP field staff decreased since there is no BKKBN representative in the district.

2.19 Hospital and Consumer Information

The Team visited two hospitals in Bandung City. The hospitals were Advent Hospital and Cahya Kawaluyan Hospital:

The Adventist Group in Indonesia comprises of hospitals and clinics all across the archipelago. There are 60 clinics nationwide.

The Adventist Hospital in Bandung is a 220 bed secondary hospital which is considered by the public as one of the top hospitals in West Java. It accepts Gakin patients. It does not, however, receive Askes and Jamkesmas patients because Askes said it had enough providers already. Gakin reimbursement from District Health Office takes three months.

Sixty percent of patients of Adventist Hospital in Bandung are paying out-of-pocket. Forty percent are from companies on self-insurance and private insurance companies (e.g. Allianz, Manulife, AIA, AEA).

The income of Adventist Hospital in Bandung on Saturdays is pooled for charity and is used for their charity clinic. During Thursdays at their charity clinic, patients pay Rp 10,000 to include consultation and medicines.

Full-time physician staff of Adventist Hospital in Bandung includes an Internist, Surgeon, Obstetrician/Gynecologist, Pediatrician, and GP.

For a normal delivery, the physician fees at Adventist Hospital are: Rp 2M for a specialist, Rp 800,000 for a GP, and 460,000 for a midwife. These are just professional fees and do not include medicines and room and board accommodation which would be approximately Rp 200,000-500,000. A Charity Delivery

Package is Rp 2M which includes expenses incurred for and by the infant, professional fees, medicines and room accommodation for three days.

There is a monthly meeting conducted by the Adventist Hospital Management in Bandung, through its Medical Director, and the physician staff: specialists, subspecialists, GPs, and full time medical staff. The manner of split in income generated is agreed upon. Guest or visiting physicians may practice in three facilities. This is strictly followed because of peer control and monitoring by the District Health Office.

Adventist Hospital in Bandung has a Quality Assurance Office under the Medical Director. It follows a set of agreed quality standards of practice. It is believed that the hospital is legally responsible for any untoward incident happening in the hospital; therefore, the hospital carefully chooses the roster of physicians they have. There are 160 visiting physicians, half are specialists. There are 24 GP on full-time basis.

Cahya Kawaluyan Hospital, a member of the Borromeus Group, is relatively new operating on a 70-bed capacity. It offers a 24-hour Emergency Room service, Inpatient and Outpatient Services including facilities like laboratory, radiology (CT scan, ultrasound, general x-ray), and physiotherapy. It is one of the 5 hospitals of the Borromeus Group in West Java.

The hospital has two full-time GPs, 30 full-time specialists, and 29 guest specialists. For Borromeus Hospital, it has 10 full-time GPs, 35 full-time specialists, and 150 guest specialists. Full-time medical staff are pure private practitioners. Majority of the visiting physicians are also government employees from government hospitals. The fixed monthly salary for full-time GPs and specialists is Rp 2-3M for seven hours of service per day. Aside from the fixed fee, they are also eligible for a visiting fee. The hospital clarified that the fixed fee was to ensure that the physician was available at all times during the assigned work hours. Patients are free to choose their attending physician. Borreomeus Hospital is ISO certified.

All fees are divided as per hospital bylaw: 60 percent for the physician regardless of specialty and 40 percent for the hospital. Depending on case, the split can be 70 percent for the physician and 30 percent for the hospital. On the average and regardless of affiliation, a GP on private practice would earn Rp 3-5M per month and a specialist may earn up to Rp 100M per month.

Aside from hospitals, the Borromeus Group also has several Balai Pengobatan, a Rumah Sakit Bersalin, several Rumah Bersalin, dental clinics, JPKM insurance scheme, rehabilitation facility, schools (one of which is a nursing school), and a radio station. The quality of standard practices is universal to the Borromeus Group; however, each member is autonomous in the management of the facility including procurement procedures. Procurement may be done separately or by pooling depending on the item. Drugs are usually procured through the PERDHAKI. All the financials are consolidated as one Group.

The hospital has a Therapeutic Committee. The list of drugs to be included in the formulary is also done in consultation with the clinical staff. The formulary is revised every two years. The hospital advocates the use of generic drugs. There is cooperation from their clinical staff. Guest physicians are bound to abide with the hospital formulary as stated in the MOU which each and every physician agrees and sign upon inclusion in the roster of practicing physicians. Full-time clinical staff have formal contracts with the hospital.

Credentialing is also conducted prior to acceptance of any physician to practice in to Cahya Kawaluyan Hospital. Aside from having to have the license to practice medicine, one will have to pass the Psycho Test, an IQ Test, and an MPI Test.

Cahya Kawaluyan Hospital has adapted the government DRG system but modified it to suit their needs. Various hospital packages including hospital service tariffs are readily available for patients to have informed decisions. It also helps insurance companies in their premium setting based on realistic projections.

Cahya Kawaluyan Hospital accepts Jamkesmas and Gakin patients. Per regulation, they also reserve 25-30 percent of their beds for charity cases. Most of their patient load occupies the Class III section of the hospital. Twenty-five percent of the hospital's business is from private insurers. Less than 10 percent of their patients are Jamkesmas and Gakin combined. Based on their experience, administration of the Jamkesmas is faster as there is a hospital verifier who adjudicates the claim and readily approves the amount to be paid. Jamkesmas, however, is less preferred than Gakin because Jamkesmas often approves only 30 percent of the claim. The hospital cannot charge the remaining 70 percent to the patient. The experience with Gakin is that reimbursement of benefit takes four to five months upon receipt of claim by the District Health Office. Gakin is still preferred over Jamkesmas because the hospital is only required to cover on its account 20 percent of the charges and bills the balance to the District Health Office. The patient is requested to pay the excess before resorting to the District Health Office. It is unclear on whether or not the District Health Office pays the hospital regardless of how much is claimed in excess of the 20 percent of total charges incurred by the patient.

There was information received that there are several Consumer Groups in West Java but none was focused on health at this time. Yayasan Bina Konsumen (Indonesia) is one group focusing on agrarian issues. The group has an extensive network all over the country. Although focus was not on health, certain cases on health were elevated to the group's Office of the Chairman. Clearly, it can be surmised that there is lack of communication between patient and providers in terms of health outcomes and informed decisions. A facilitator role of the Consumer Group may help mediate as patients usually are afraid to complain or seek further information. Bina Kosumen has a national directory of the various offices located nationwide. It distributes IEC materials on health and other issues to its constituents.

2.20 General Observations

- **Lack of government stewardship over the whole health system.**

  Currently, the government seems its main role in running public sector facilities. The private health sector still remains an after-thought. The District Health Offices only see their role as licensing private facilities and they only take an interest if there is a case of malpractice in the private sector. All of the data points to the fact that the private sector delivery is dominate. For example, only six percent of births in West Java occur in public facilities, so if maternal health is a priority for the province, then working with the private sector is key to success.

- **Understanding the private sector requires understanding dual practice.**

  Although the private sector is dominate, it is not a "pure" private sector since most of the physicians and midwives practicing in the private sector are, in fact, government employees who work in the public sector in the morning and private sector in the afternoon. Almost 90 percent of the midwives in West Java are in dual practice and there are very few in "pure" private practice; generally the pure private providers are retired public employees. The most striking examples of dual practice were in the top hospitals in Bandung, where only a small percentage of the doctors in the hospital were employed by the hospital; the vast majority are "guest" doctors who work in the public sector.

Understanding the interaction between the public and private sector is key to regulating the private sector. There is also an inherent conflict of interest, since health professionals have an interest in ensuring that quality of care in the public sector is low in order to attract patients to their private practice.

- **Health insurance exists in name only; Askes, Jamkesmas and Gakin are public programs that do not really use insurance principles.**

  Jamkesmas is supposed to provide a comprehensive benefit package to the poor for a mere Rp 5,000 per month. This small amount of money can only, in fact, pay for a very restricted benefit package if the insurance program had to pay the true costs/prices for the provision of care. There is little attention to actual insurance principles such as estimated utilization to set the premiums. There is also little attention to demand management such as deductibles and co-payments. If these programs are to function as insurance, then they need to based on more actuarially sound principles.

- **Professional and hospital associations are not playing a sufficient role in assuring the quality standard services.**

- **Civil society organizations particularly faith-based groups, such as Muhammadiyah and catholic Perdhaki) could play a much greater role in public health.**

  Faith-based organizations have an extensive network of health care providers. They also have great social assets because of community involvement. They are an ideal venue for Directly Observed Treatment Short-course (DOTS) for tuberculosis, since this depends on community involvement. Given that the current system depends almost exclusively on the Puskesmas and a few patients want to go to the Puskesmas on a regular basis, there is wide scope for greater involvement of faith-based organizations in implementing DOTS and other priority public health interventions including HIV/AIDS and maternal and child health.

2.21 Recommendations

2.21.1 Assist Districts and Provinces to use the payment methods of the new social insurance schemes (Jamkesmas + Gakin) to improve maternal and child health

Currently, the government is not harnessing the power of these new social insurance schemes to drive improvements in the quality of care for services particularly MCH services. Unlike the insurance schemes of the past like Askes which only paid for services in the public sector, these new schemes pay both public and private providers. However, the current reimbursement rates are much lower than the private sector prices and this creates a strong dis-incentive to not participate.

In the case of maternal health services, the payment rates are below market rates, but not so far below market rates that reform is infeasible. With small increases in the payment rates, they could create a thriving market for maternal health services that could drive significant improvements in the quality of care in the public and private sector and also align incentives with clinical practice. As discussed earlier, a good example is the current payment for post-partum hemorrhage, one of the major causes of maternal death. Currently, once a midwife refers the case to the hospital, she no longer receives payment. This problem could easily be solved by created a separate code for post-partum hemorrhage. This could allow

the midwife to charge a slightly higher fee than a normal delivery and also could be used to monitor the quality of services and referral patterns for this important condition. This could be done with only small changes to the current system, and yet a minor reform could lead to a significant improvement in care.

In discussions with providers of maternal health care, there were a wide variety of small changes that could be made in the insurance payment method that could lead to significant improvements:

- Increase payment to Bidan Delima members to create incentive for others to become members at the same time ensuring quality of services to patients.
- Reimbursement of gasoline consumption by District health office to midwives who transport obstetric emergencies to the hospital.
- Profit sharing between hospital (and obstetrician/gynecologist) and referring midwife to incentivize midwives to refer early and when needed.
- Reimbursement of expenses incurred at midwife facility before transfer of obstetric case to hospital (e.g. pay for obstetric emergency).
- Create separate payment for antenatal care including higher payment for managing high-risk patients such as eclampsia.
- Move towards a mixed capitation/fee for service system for midwives to ensure adequate income in any one geographical location to ensure income/payment.
- District health office to offer capitation to midwives to ensure pre-payment of services.
- Inclusion of contraceptives in Jamkesmas and Gakin schemes.

In addition to these changes in insurance payment methods, there are some other complementary interventions in maternal health services that could also make a difference. For example, IBI could serve as “distributors” of drugs to midwives on much lower costs. Midwives can send text messages to IBI for drug needs. IBI can have special rates with the distributors. IBI could establish a broad framework contract with pharmacies/distributors for their members. This scheme would work much better if midwives had some money available to hold stocks of needed drugs and supplies rather than depending on purchasing them when they need them on the spot market. This requires shifting to partial capitation method of payment, so that midwives would have a guaranteed income that could be used to purchase supplies.

Some other recommendations include:

- Build on the quality assurance efforts being done by BMPK and seek to develop systems in which findings can be linked to either regulatory or policy change
- Work with IBI to rationalize their investment in Bidan Delima and develop a plan for sustained monitoring and evaluation to ensure that midwives are continuing to practice to the established norms.
- Strengthening the supportive supervision system for midwives

2.21.2 Engage with the private sector on Tuberculosis

To ensure widespread case detection and treatment of TB patients, effective organization and provision of services are needed. Numerous studies have shown that a large percentage of people with symptoms of TB first seek care in the private sector. Since TB is a disease of the poor, and the Indonesian poor seek care in the private sector, this means that engaging with the private sector is key to improving the performance for TB in Indonesia. Engaging with the private sector would help the TB program reach out a larger number of potential cases of TB, increase the case detection rate. Also, engaging with private providers like faith-based groups for implementing community DOTS could also increase the cure rate. It is recommended that government adopt the Public-Private Mix DOTS or PPMD Strategy in its expansion of the DOTS through the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

Establishing a Public-Private Mix DOTS. The Philippines has taken an innovative approach to address the TB problem by harnessing the participation of the private sector and integrating their services in the National Tuberculosis Program (NTP). The NTP under the stewardship of the Ministry of Health has adopted the PPMD Strategy to increase TB case detection, improve cure rate and synchronize the management of TB in the public and private sectors. This is done in partnership with the various private organizations.

Involving pharmacies and drugstores in DOTS. There is a trend away from seeking care in outpatient facilities toward self-medication and using private drugsellers or the pharmacy as the first source of care in an illness episode. Indonesians have increasingly changed their treatment-seeking behavior away from the outpatient facility-based services. In 2007, 45 percent of people reported that they relied on self-treatment during their last illness, obtaining medication at pharmacies or drugstores. This trend is consistent with reported widespread growth in the private pharmaceutical/drug market in Indonesia.

There are approximately 8,300 licensed retail pharmacies and approximately 6,600 licensed drugstores in Indonesia. Licensed drugstores are not required to have a pharmacist on staff (unlike pharmacies) and are supposed to sell OTC medications only. However, many also sell prescription drugs. Both pharmacies and drugstores are known to sell prescription drugs without a physician's prescription.

Pharmacies and drugstores as a venue for DOTS have singular strengths. They are numerous, widely dispersed, strategically located, accessible, and convenient to those who may be seeking information or medication about TB. As the first point of contact for information on TB drugs, pharmacies offer the unique advantage in detecting TB symptomatics or at least reaching out to TB symptomatics through their surrogate buyers of TB drugs. Moreover, pharmacies and drugstores, which tend to be trusted by clients, may also provide a venue for private and confidential advising and medical advice on TB.

These advantages provide a strong basis for developing pharmacies and drugstores as crucial disseminators of information and sources of educational messages on TB and referral to the health centers for appropriate diagnosis and free treatment. Aside from ISFI, it is also essential to get buy-in from the GP Farmasi Group, or pharmacy owner's association, since it is the owners who really determine whether the pharmacy will engage with the program. This is one of the lessons from the earlier failed attempt in West Java to set up a public-private partnership for TB.

Involving Faith-based Organizations in DOTS. Through the extensive network and followers of the various faith-based organizations, proper information on TB may be disseminated to TB symptomatics and TB patients. The DOTS protocol may be handled by faith-based organizations to ensure patients comply with their medication schedule.

Involving Physicians in DOTS. A significant number of sputum positive cases seek treatment from private physicians each year. On the other hand, there are gaps in getting accurate information on the actual TB caseload managed by the private sector and efficacy of the treatment approaches taken by private practitioners. Physicians appear to manage TB in various ways. An intervention to convince and incentivize physicians to practice DOTS is needed.

Involving Business Organizations in DOTS. Company clinics especially of large industrial/ manufacturing firms handle TB cases. It is important that the HR and clinic staff are engaged in the proper management of TB. A link to the DOTS matrix of stakeholders is critical.

2.21.3 Strengthen the role of consumer organizations to provide information on price and quality in the private sector to make the current market function better

As mentioned earlier, there is very limited information available on the price or quality of services in either the public or private sector. Consumers have very limited information to go on in choosing providers nor do they know the cost of services. At the heart of this market failure is information asymmetry where the providers have all the information and power. This could be remedied by making more information available to consumers through trusted intermediaries.

Currently, consumer organizations play a limited role in the private sector in West Java. The Provincial Health Office is interested to have them more involved as a counterweight to the power of providers particularly the powerful hospital sector. However, currently the consumer organizations do not have the funding or technical know how to engage in the complexities of the health sector. The experience of Yogyakarta shows that an active consumer group could play an important role in monitoring the quality of care. This would be a natural fit for USAID program which provides technical support to consumer organizations.

2.21.4 Strengthen the role of the Provincial and District Health Office in using the private sector to achieve public health outcomes and to become the steward of the health system

The government needs to harness the power of the private sector to achieve joint public health outcomes. Maternal health and tuberculosis offer two powerful cases where the government is unlikely to meet its objectives unless it engages with the private sector. If USAID was to provide support focused on these specific areas, it would serve as an example for other initiatives on the private sector. It could also be used as an entry point to strengthen the government's coordinating role in using the health sector. If complemented with support to consumer organizations and improved regulatory environment with greater transparency on pricing, then the government could move towards a greater stewardship role.

2.22 List of Persons Contacted

PT Asuransi Kesehatan (Askes)

1. Siswandi, SE (Senior Manager PT ASKES Cabang Utama Bandung)

Dinas Kesehatan Bandung District

2. Dr. Achmadi Kustijadi, KMep (Kepala Dinas Kesehatan)
3. Drg. Ratna MH (Kepala Seksi Sumber Daya Kesehatan)
4. Dr. Herminingsih (Kepala Bidang Bina Kesehatan)

Dinas Kesehatan Cianjur District

5. Dr. Hj. Trini Handayani, MH (Kepala Dinas Kesehatan Kabupaten Cianjur)

Dinas Kesehatan Jawa Barat Province

6. Dr. Alma Lucyati (Kepala Dinas Kesehatan Prov Jabar)
7. Dr. Lukman (Staff Sie Kesga dan Gizi)
8. Sita Pebriati, SKM (Staff Sie Kesga dan Gizi)
9. Mien Hasanah, SKM (Pengelola Program TBC)
10. Dr. RR. Endang ND, MPH (Ka Sie Kesga dan Gizi)
11. Neni Nurjanah (Staff Perencanaan Program)
12. Wayan, SKM, MPH (Ka Sie LKK)

Muhammadyah/ Aisyiyah

13. Dr. Rahman Ma'as (Wakil Ketua Majelis Kesehatan dan Kesejahteraan Masyarakat)
14. Tya (Majelis Kesehatan dan Lingkungan)
15. Euis (Wakil Ketua)
16. Rasmita (Bendahara)
17. Nien
18. Ni'mah
19. Sri
20. Nia

Persatuan Dharma Karya Indonesia (PERDHAKI)

21. Dr. Odilia (RS Santo Yusuf)
22. Dr. Retno Dewi (RS St Borromeus)
23. Widyanti (RS Cahya Kawaluyan)
24. Dr. Widjajanti (RS Cahya Kawaluyan)
25. Dr. Fransiska (RS Santo Yusuf)
26. Sr. Tibere (RS Santo Yusuf)
27. Rosita (RS Santo Yusuf)
28. Lisda (RS Cahya Kawaluyan)
29. Dr. Miriam (RS Santo Borromeus)
30. Dr. Ratna (RS Cahya Kawaluyan)

Perkumpulan Keluarga Berencana Indonesia (PKBI)

31. Dr. Siti Hannifah
32. Titeu Herawati, S Sos
33. Ita Kumaratihm SE, MM

Ikatan Bidan Indonesia (IBI) West Java Province

34. Bidan Iyet Ratnasih
35. Bidan Suasa
36. Bidan Mimin K
37. Bidan Sri Purwani
38. Bidan Taskini
39. Bidan Jutini
40. Bidan Enung Hasanah
41. Bidan Tati Herawati

Ikatan Bidan Indonesia (IBI) Bandung District

42. Bidan Eva Mantini (Ketua IBI)
43. Bidan Upen Supenti (Private midwife, Bidan Delima)
44. Bidan Ana Rukmanah (Private midwife, Bidan Delima, Fully private)
45. Bidan Tri Jeni Fitriani (Private midwife, Bidan Delima, work in Puskesmas Soreang)
46. Bidan Dedeh Helpizani (Private midwife, Bidan Delima, work in Puskesmas Rancaekek)

Ikatan Bidan Indonesia (IBI) Cianjur District

47. Bidan Tien Suprihatini (Head of IBI Kab. Cianjur)
48. Bidan Euis (Private midwife, Bidan Delima, work in Puskesmas Cibeber, Kecamatan Cibeber)
49. Bidan Yati (Private midwife, Bidan Delima)
50. Bidan Yanti Rohaeni (Private midwife, Bidan Delima, work in Puskesmas Cipendawa, Kecamatan Pacet)
51. Bidan Silvy (Private midwife, Bidan Delima
52. Bidan Yuni Wahyuni, SKM (Dinas Kesehatan MCH)

Ikatan Dokter Indonesia (IMA) Province

53. Dr. Wawang Sukarya, SpOG (ketua IMA)
54. Dr. H. Sulaiman Ratman, MPH (Sekretaris IMA)

Ikatan Sarjana Farmasi Indonesia (ISFI)

54. Bruce Sumendap (Public Relation Advent Hospital)
55. Dini Trisnawati (RS Muhammadyah)
56. Ida Ismi (RS Muhammadyah)
57. Ester M (Advent Hospital)
58. Deden Indra Dinata (PD ISFI Jabar)

Yayasan Bina Konsumen (YBK)

55. Ir. Hermina Suyono Hadi
56. Evi
57. Ujang (Client)

3. WEST JAKARTA

A team of three people, Andy Barraclough, Grace Chee and Dr. Hasbullah Thabrany were in the field for six days (May 30 to June 5, 2009) for assessment in this area. Information was gathered from the professional organizations working in West Jakarta, counterparts at the city and Provincial Health office, private providers and consumers to provide field data as a supplement to the desk review which was completed in early March 2009.

3.1 Provincial Information

DKI Jakarta Province is called as Daerah Khusus Ibukota – a region with special status as the capital of Indonesia. It consists of five cities and one district/kabupaten as follows:

City/Regency	Population		
	Male	Female	Total
Jakarta Pusat (Central Jakarta)	506,154	420,577	926,731
Jakarta Utara (North Jakarta)	777,257	644,621	1,421,878
Jakarta Barat (West Jakarta)	869,470	764,739	1,634,209
Jakarta Selatan (South Jakarta)	1,062,617	829,883	1,892,500
Jakarta Timur (East Jakarta)	1,419,794	1,192,244	2,612,038
Kep. Seribu (Thousand Islands) – kabupaten	11,215	10,237	21,452
TOTAL	**4,646,507**	**3,862,301**	**8,508,808**

Source: *Suku Dinas Kependudukan dan Catatan Sipil Kotamadya, January 2009*

3.2 District Information

Indicator	DKI	West Jakarta	Data Source and Notes
Population	8,508,808	1,634,209	Dinas Kependudukan website (data per Jan'09)
Delivery attended by health worker	173,599	33,379	
DTP3 coverage	188,383	45,426	
Number of physicians	1,533	340	
Number of midwives	2,521	446	
Number of Apotek	1,162	405 apotek 800 apotek 158 toko obat	(district estimate) (ISFI estimate)
Number of registered pharmacists	1,498	135	(estimate from ISFI)
Number of Puskesmas	52 PKM with bed 289 without bed 2 mobile PKM	8 PKM Kecamatan 66 PKM Kelurahan	Sudin Pelayanan Kesehatan Jakarta Barat 2008
Persons covered by **GAKIN**	424,687	37,194	
Number of private hospitals	119	20	
Number of private clinics	422	—	
District insurance scheme (Y/N)	GAKIN	GAKIN	

Indicator	DKI	West Jakarta	Data Source and Notes
APBD budget for health	Rp 1.74 trillion	Est Rp 253 billion	www.berita8.com website
APBN budget for health (Note: No DAK, DAU allocation for DKI Jakarta)	Rp16.9 trillion (2008)	—	Speech of President RI on 08/15/08, and
	Rp 20.27 trillion (2009)		NK APBN 2009, Pg-97

How can services provided at private facilities be better integrated into the health system to ensure better delivery and monitoring of priority health services (ie, TB, ANC)?

3.3 Reliability of Records on Providers at suDinKes (Suku Dinas, for city level IN JAKARTA)

The Sudinkes maintains records on health providers in the district, as they are responsible for licensing them. However, some of the figures are distorted because of the way practices are registered. For example, there are 2,010 registered GP practices, and 1,454 specialist doctors, but they may include doctors that have several registered practice sites. District records also show 408 registered apotek and 158 toko obat. The district has no capacity to ensure that everyone is licensed, or that licenses are up to date, as the first private midwife the team visited was a midwife whose license had expired.

3.4 Role of SuDinKes in supervision and monitoring OF private providers and ensuring their overall quality

The Sudinkes believes that it is their role to license and supervise all doctors and midwives, including ones in private practice. While they do issue the licenses, given the limited manpower however, the Sudinkes claims that it is not possible for them to visit or monitor these practices to ensure quality. But they do make sure that other required licenses are in place and the number of doctors and other staff meet the requirements, but they do not have time to monitor clinical quality.

IBI, and midwives, were the one group of informants that felt there was sufficient coordination with Sudinkes. Private hospitals seem to have little interaction with Sudinkes, although they are occasionally asked to participate in district health programs, or invited to selected discussions.

The situation on licensing of pharmacists and pharmacy outlets is confused. Sudinkes accepts that it is their role to license pharmacists, and issues licenses for a period of five years. The local branch of ISFI (Pharmacists Association) provides a recommendation letter which in West Jakarta is considered a necessary requirement. The licenses for pharmacy shops/outlets are issued at Province level, but with the bulk of the application being received and processed at Sudinkes level and a final recommendation made to Province level. The Sudinkes states that with manpower restrictions it is not possible for them to monitor pharmacy operations once licensed.

3.5 Reporting practices of private providers

The information on reporting practices was inconsistent. Sudinkes officials reported that they do not receive reports from private individual providers, but do get information from hospitals and clinics. However, private practice midwives assured us that they report to the Puskesmas every month. Staff at a Puskesmas also reported that they distribute TB drugs to eight private practice doctors and they provide reports to the Puskesmas. One hospital visited also reported that it provided monthly reports of TB

clients to Dinkes. The private providers only reported activities related to drugs or funding they received from the local government.

The consistency of reporting depends on the type of private provider. A discussion with private practice midwives found that all were reporting information on services provided to both the peskesmas and to the IBI district chapter. They all used a standard form for reporting, and as a rule, there are few lapses in reporting. However, it is not clear whether Sudinkes uses this information for planning or decision making. The midwives report that they never receive any feedback related to these reports. The team also visited a private practice midwife and small group practice of General Physicians. The midwife stated that she was seeing less than 10 clients per month for contraceptive injection, but her license had expired and she was not reporting to Sudinkes. The doctor who was interviewed in a small group practice did not know whether service reports were sent to Sudinkes.

At present pharmacies do not undertake any reporting for most medicines and are only required to provide reports for narcotics and psychotropic preparations which few shops handle.

3.6 Dinkes experience with PUBLIC-PRIVATE PARTNERSHIPS

Dinkes (?) has a program supported by the GFATM and USAID to conduct DOTS treatment, which includes private doctors, but very few doctors participate in this scheme. The doctors are also required to provide reports to Dinkes, if they participated. Further, this program is closing down as they are no longer receiving TB medicine and funding from GFATM. Although there were programs in the past to provide TB medications, vaccines, and contraceptives through private providers, they are no longer operating.

St Carolus Hospital, a not for profit Catholic hospital, has been active in TB control and treatment for 26 years. Its activities include training for community members in DOTS, distribution of treatment kits, and public health promotion. It treatment success rate is over 90 percent. If there is a shortage of drugs, the hospital procures from its own funds. St Carolus also provides public health services including immunization, and school-based health programs through its health center, with little support from government, except for medicines. Depkes had also provided rice to supplement the nutrition of low income patients, but that program has also ended.

The not-for-profit hospitals we visited believed it is unfair for the government to treat not-for-profit hospitals the same as for-profit hospitals, particularly with regard to tax treatment and utilities rates. These hospitals believed they have contributed to public health, and provide a high proportion of their services for low-income clients which should be government responsibility, often with limited government support.

What can be done to rationalize the use of medications, as part of an integrated provider quality improvement approach?

3.7 Sources of medications for private providers

By far the main source of medicines for private hospitals is through national pharmaceutical distributors. Most hospitals report using six to eight main distributors and report the ready availability of all medicines required. Private hospitals report that they can obtain significant price discounts from the distributers with a general 10 percent reduction on brand name medicines and 30 percent reduction on generic medicines, and under ASKES schemes a general 20 percent discount from the distributers. Private hospitals reported using a combination of generic and brand name products, but at the pharmacy sections

visited an average of over 60 percent of the products were generics, and nearly 80 percent of the generics were Berlogo medicines (OBG), which are government certified to be of high quality.

Of greater concern is that private midwives report using the informal market for medicine supply, largely unlicensed sellers of pharmaceuticals, because of lower prices and ease of access and response. Midwives report that they visit the informal market, receive deliveries from phone orders, and also sometimes have drugsellers visit bidan meetings with products. All the midwives expressed potential concerns on the quality of the medicines they were procuring. All of the medicines examined at midwife practices during the site visits were from established (national) manufacturers of reputable quality. Storage conditions of the medicines obtained from the informal sector however are unknown and remain a cause for concern. The midwives also reported that they have tried pooled procurement mechanisms in the past but that they much prefer the flexibility and convenience of the informal market suppliers, which are readily available in urban Jakarta.

The team visited two private midwife practices. At one busy midwife practice, magnesium sulphate, IV solutions, vaccines, contraceptives, and Vitamin 'A' were all available. At another individual midwife visited, who reported that she was providing only a contraceptive service, only injectable contraceptive manufacturer's promotional information was evident, and this rather misleadingly implied WHO approval for the product.

PERDHAKI, the Catholic health services association, operates both an internal procurement storage and distribution system (which deals largely with donated medicines) and a commercial procurement service/distributor, KDU. The small central internal pharmacy store was very well organized and had over 90 percent Berlogo generics (OBG) with non-generic items arising from overseas donations. Reported procurement volumes on the internal operation are low at around Rp 300 million per year and modest even on the commercial PT KDU at around Rp 5 billion per year. The main purpose of the supply operation appears to be to obtain a secure supply of quality assured medicines (especially for the low volume use clinics) rather than price factors. There is no centralized formulary. Each hospital operates largely independently and determines its own formulary.

The team also met with Muhammadiyah and NU, two Islamic associations that also have affiliated hospitals and clinics. Neither organization provides any medications or procures for its member facilities.

No public sector medicines are received at central level of any of these three associations. The level of public sector medicines received by individual facilities is said to depend on the willingness for cooperation between both parties, with some Dinkes being unwilling to supply and some hospitals being unwilling to accept public sector product.

The team also investigated whether medicines from public health programs were distributed to private facilities. There is some confusion between the situation respondents reported on medicines and the observed physical stock situation in pharmacy sections. Nearly all hospital respondents reported that they receive almost no medicines from the public sector, except for small quantities of TB medicines. The observed situations in pharmacy sections of hospitals was rather different with quite reasonable supplies of clearly public supply TB medicines being available, and in some cases, Oralit, Vitamin A capsules and vaccines. No contraceptives/FP commodities from the public sector were found at any of the private sector sites visited.

Midwives also reported that they received some public sector medicines, including vaccines and Vitamin A, but these were not in sufficient quantities to meet the demand and they generally purchased most of their needed supplies.

Overall, it is clear that even though some public sector medicines are reaching the private sector and nearly all of the 13 public sector vertical programs claim they supply medicines into the private sector, in practice, other than for TB medicines, only very small quantities of public sector medicines are reaching private providers and the supply is highly erratic.

This finding may be especially important in light of the difference between puskemas and private providers. Puskesmas, and to some extent public hospitals, receive free medicines and direct budget subsidies from public funds, but are reimbursed by Jamkesmas and GAKIN at the same rate as the private providers, who generally do not receive free medicines or other funding subsidies.

3.8 Potential role of District as supply point for private providers

West Jakarta district reported that although in theory it can supply the private sector with program medicines, in practice there is little supply because:

- It receives too few medicines from the vertical programs to be able to supply the private sector and will shortly be forced to start buying all of its own medicines, including TB medicines. Vaccines in particular were considered to be in short supply and not sufficient to cover the public sector demand.
- There is little uptake from the private sector – less than 10 percent of private sector GPs have requested to receive TB medicines
- The District funded supply of medicines is decentralized to Puskesmas level – Dinkes level does not buy any medicines. Each individual hospital and Puskesmas now procures its own medicine requirements.

This system appears unique to West Jakarta and may not be usual outside large urban areas, where there may be greater scope for District to act as a resource for the supply of public medicines to the private sector.

3.9 Potential role of professional associations in improving practice norms (including drug use)

The Ikatan Sarjana Farmasi Indonesia (ISFI) is the main professional body for pharmacists, while GP Farmasi serves as the main body for pharmaceutical manufacturers, distributors, pharmacies and Toko Obat (licensed drugsellers). Both organizations recognize that there is a degree of overlap in their membership and activities.

ISFI has been endeavoring to focus on human resources and especially pharmacy qualifications. There are 63 University Faculties offering pharmacy qualification with 24 at degree level, graduating around 3,000 to 3,500 new pharmacists per year. Almost none of these courses teach any public health perspectives, functions, or approaches. Before the year 2000, no patient consulting skills were taught, and even now this is recognized as a weak area, which the association is trying to address through continuing professional development (CPD). There is also a long running confusion on accreditation of pharmacy schools, resulting in no formally accredited training institution for pharmacists at present time.

ISFI has also been trying to promote the concept of TATAP – no pharmacist, no service as part of its national recommendations and developing 'ethics committees' at branch level. ISFI believes that 70 to 80 percent of pharmacy shops are not owned by pharmacists, which it considers a major impediment to promoting professional operations. ISFI reported that in West Jakarta there are 135 registered pharmacists and 800 pharmacy shops, clearly demonstrating the impossibility of a pharmacist being present on the premises for dispensing.

Pharmacist licenses are issued for five years, with renewal requiring presentation of a portfolio of CPD or undertaking a competence test, but compliance varies widely. Some branches are reported as being active in providing CPD courses, and recently the MoE has provided funding of Rp 200 million for educational activities to ISFI. Binfar (department of pharmacy at Depkes) also provides some CPD activities.

It is recognized that there is no system of integration of public and private sector operations and that the public sector guidelines are widely ignored. ISFI estimates that nearly 100 percent of the pharmacists employed in the public sector were also working in the private sector. The association reports that it has had some involvement with Askes but almost none with Jamkesmas and other health funding schemes.

ISFI did undertake a pilot linkage with the National TB Control Program (NTP) in cooperation with Binfar, in three provinces developing a pharmacy medical record to refer patients for early detection. The motivation for the pharmacists was the possibility of added sales through increased status in the community for undertaking public health works and increased shop visits. The program largely collapsed when GFATM funding to NTP was suspended.

The association has concerns on how to improve competence, how to have pharmacists in the public sector (currently many unfilled positions), integration of public and private sector; and feels that this is best addressed through improving the initial training for pharmacists.

In West Jakarta, a letter of recommendation is required from the local branch of ISFI for registration/re-registration of pharmacies.

GP Pharmasia has a branch office in each Province, and a number of Districts also have offices. They have tried to pioneer the Apoteket Sehat – simple pharmacy service, concept which would sell only ready finished products (no compounding or 'wet' dispensing) and be subject to less regulations but would still require a pharmacist to be present to undertake patient dispensing.

It reports that it has regular contact with BPOM, and has been invited to participate in activities funded by GFATM and Gates Foundation. GP Farmasia believed that one of the many attractions of the Toko Obat is that they can offer a wide selection of products to customers, and that the status and allowed activities of the Toko Obat should be upgraded.

Whilst both of the pharmaceutical professional organizations visited expressed interest in improving practice norms, it is clear that the information provided is sometimes confused and contradictory. They both appear weak in terms of clinical/technical practice development and have a highly decentralized structure. It would be advantageous to involve these associations in activities related to professional skills development and practice norms, but it would be difficult to envision how they could lead, or even be major players, in such a process at central level, without massive strengthening and probably re-structuring. There appears to be greater scope for effective cooperation at Provincial and District level in those branches which are active.

PERSI, the Indonesia Hospital Association does not play an active role in management or standards setting related to drugs. There are aware of complaints to ASKES over its formulary, in particularly in relation to TB medications. They have reports that Berlogo (OBG) medicines can sometimes be hard to find and there are distribution problems in various parts of the country. They consider that the distribution chain is too long and gives rise to mark-ups of 30 to 40 percent, and that tax on drugs is both a cost problem and causes hospitals undue complications. There is no TPN (sales tax) payable on drugs dispensed to inpatients, but TPN at 10 percent is chargeable on all out patient dispensing. This is not merely an accounting problem. Tax regulations often effectively force two separate pharmacists to operate in hospital – one paying tax, one not paying tax, and prevent transfer of medicines between the two units to meet stock shortages or oversupply.

Can pharmacists and drugsellers be good partners for improving health services and rationalizing drug use?

3.10 Licensing and Oversight of Pharmacies and Drugstores

Beyond an initial licensing review it is clear that there is virtually no effective oversight and monitoring of pharmacies and drugs stores. West Jakarta District Dinkes say they simply do not have adequate staffing to undertake such tasks and there appears little interest at central or other levels for the required monitoring.

In principle, the Association of Pharmacists (ISFI) provides a reference letter to Dinkes for the licensing process, but this is issued at ISFI District branch office level and no records are available at central level. Further, it is issued to both members and non-members of ISFI, and not all Districts require such a reference letter, or do not effectively incorporate it into the licensing process. ISFI does not currently undertake any effective monitoring of its members and activities.

All but one of the pharmacies and drugsellers visited, including in a central level Depkes hospital, readily sold cephalosporin antibiotics without a prescription. Pharmacists were available at pharmacies within the faith-based hospitals visited, but not at any of the commercial shops nor the Depkes hospital visited.

3.11 Organization and Management of ISFI and GP Farmasi

Both of the main pharmaceutical organizations have membership data but there are relatively few members as a percentage of the total number of licensed pharmacists and pharmacies, and even fewer

members who pay membership fees. The decentralized nature of both organizations means that meetings most often occur at District and Provincial level.

While both organizations could probably contribute to practice norms developments it is considered that because of the decentralized nature of operation, cooperation at local level – District, and perhaps Province, would be more likely to be effective.

3.12 Stock of Pharmacies and Drugstores

In general good stocks of all common medicines were observed at all sites visited and no serious shortages were reported at private sector sites. Similarly midwives reported no difficulty in obtaining the medicines they required.

Private hospitals were running quite small stock levels and replenishing with very regular deliveries – two or three times per week – from commercial pharmaceutical distributors. Midwives reported replenishing on an 'as used' basis, with many local sources willing to supply them with small quantities very quickly. The faith based hospitals had formularies available in the pharmacies.

The public sector Jakarta Barat GFK was a large, reasonable quality store, but largely empty except for TB medicines and Oralit, which probably reflects the change by West Jakarta to decentralize medicines procurement to Puskesmas level.

3.13 Staff of Pharmacies and Drugstores

Pharmacists were available at all the faith-based and not-for-profit hospitals visited. The pharmacists were clearly knowledgeable and were able to locate their supplies by generic name, and therapeutic requirement. Reference material in the form of formularies and MIMS were available.

A pharmacist was available at the GP practice visited, who could correctly identify medicines and refused to sell antibiotics without a prescription.

No pharmacists were available at any of the retail sites visited. Staff claiming to be assistant pharmacists at the retail outlets had little demonstrable pharmaceutical knowledge, and could not identify medicine by generic name or therapeutic requirement, nor provide dosage advice. All were willing to sell clearly marked 'prescription only' medicines without a prescription.

Medicines prescriptions at all sites visited indicated extensive poly-pharmacy, with typically 6+ items per prescription. Labeling of medicines was very poor at all sites. Labels were hand written in cursive script with no supplemental instructions or cautionary statements. Neither the patient's name, name of the medicine, nor date were written on the label.

How can financial incentives (such as performance-based payments, payment mechanisms) be used to improve access to services or quality of services at private providers (ie, midwives, GPs, AIsyiyah, etc)?

3.14 Experiences with contracting through Dinkes (GAKIN scheme)

DKI Jakarta has operated a financing scheme for the poor since 2003, prior to the establishment of a national scheme (Askeskin later Jamkesmas). GAKIN covers a population of 37,000 out of 1.56 million

in West Jakarta district, or approximately 2.4 percent of the population, a much lower share of the population than Jamkesmas. However, GAKIN regulations allows 85 public and private hospitals to claim for reimbursement when providing services to low income Jakarta residents without a GAKIN card, if the patient submits a statement of incapacity to pay from village/lurah office. Because of this rule, there is not a clear restriction on total beneficiaries. The total budget allocated for GAKIN for DKI Jakarta in 2009 is Rp 350 billion, increased from Rp 280 Billion in 2008.

The GAKIN scheme contracts with public and private hospitals for health services. Approved reimbursement rates under GAKIN are generally lower than other insurance schemes. Private sector experience with the GAKIN scheme was only at the hospital level as GAKIN had not contracted with private providers for primary health care.

The GAKIN scheme contracts with 18 public and private hospitals in West Jakarta, including one district hospital, and three Depkes hospitals. They also contract with Puskesmas on a capitated basis for a package of services, but have no contract with private providers for primary care. There are set maximum reimbursement rates for hospitals by package (i.e., outpatient specialist consultation, normal delivery, non-complicated C-Section, complicated C-section). Patients must first visit the Puskesmas to get a referral letter before going to the hospital. The Sudinkes, which verifies and approves the claims for payment, estimates that almost 40 percent of the claims are problematic (e.g. generally over the maximum package rate for the treatment).

Sumber Waras is a Class B, 276 bed, not-for-profit hospital. It serves the general population, including the poor. In addition, it holds contracts with various commercial insurance companies to serve their members. It serves approximately 500 outpatient and 50 inpatient clients per month that are reimbursed under GAKIN, Askes, or Jamsostek. Prior to GAKIN, it was always the hospital's policy never to turn away patients, and fees from patients unable to pay are written off. Its doctors are paid by a fixed salary plus a fee based on services. Most doctors have been with Sumber Waras for a long time, but some are contracted on a temporary basis.

The Cengkareng District Hospital is a 200 bed public hospital, with an annual budget of approximately Rp 80 billion, approximately Rp 60 billion of which is generated from revenues, with the remainder being funding from APBD budget. It reported that nearly all of its revenues are from third-party payers – GAKIN (48 percent), Askes (10 percent), Jamsostek (18 percent), corporate/employer contracts (21 percent) – with few patients paying directly. Its bed occupancy rate is 92 percent, and there are no more than 30 Jamkesmas patients per month. It did verify that Jamkesmas had paid them an advance in the first quarter of 2009. It had expanded from 110 beds one year ago (20 Class III) to 200 beds currently, with 115 Class III beds.

The Cengkareng District Hospital was managed quite differently than other hospitals visited. The hospital director was very serious in managing drug use, developing a formulary for the hospital that met the requirements of all its insurance schemes. Doctors are not allowed to prescribe outside of that formulary without the consent of the general director. Of its 48 specialist doctors, 85 percent were full-time doctors, with combined salaries plus service fees ranging from Rp 12.5 million to Rp 40 million per month. There are four full-time anesthesiologists, but at night they are on-call, not on-duty at the hospital.

Rumah Sakit Islam Jakarta (RSIJ) Cempaka Putih, a non-profit hospital affiliated with Muhammadiyah also contracted with GAKIN. Cempaka Putih is a 411 bed hospital, of which 35 percent is reserved for Class III patients. It serves 20,000 inpatient clients and 200,000 outpatient clients per year. It is affiliated with a group of three other hospitals and one clinic. It estimates that GAKIN patients represent 15-25 percent of all patients. Approximately half its patients are covered by some insurance scheme, with the

remainder paying out of pocket. Revenue from GAKIN patients is approximately Rp 1.2 billion per month, compared with support from Dinas of approximately Rp 25 – 50 million per month prior to GAKIN. Implementation of GAKIN has resulted in an overall higher budget for the hospital.

The team visited St Carolus Hospital, a 366 bed Catholic-affiliated hospital, with 35 percent Class III beds. It estimates that approximately 15 percent of its patents are GAKIN patients, another 30 percent are covered by commercial insurance, and 10-15 percent are covered under direct employer contracts. The remainder of patients (40-45 percent) pay directly out of pocket. The hospital is generally recognized for high quality MCH services, and has a special package fee for referrals from private midwives. However, Puskesmas would not refer GAKIN or Jamkesmas patients to St Carolus.

Providers report that it takes a long time to be reimbursed through GAKIN – during our visit the first week of June, Sumber Waras Hospital and RSIJ Cempaka Putih Hospital reported the GAKIN had not paid claims since November 2008. Both hospitals also reported that Askes and Jamsostek reimburses in approximately one month. St Carolus Hospital reported that 3-4 month delay in payment from GAKIN is normal. However, the Cengkareng District Hospital had been paid through March 2009. Both Cempaka Putih and St Carolus believed that reimbursements by GAKIN are below hospital cost, with St Carolus estimating that they only 50-60 percent of actual costs.

3.15 Implementation of Askes and Jamsostek

Both Askes and Jamsostek are important payers for health services. They are both considered to reimburse at rates above GAKIN and Jamkesmas, and are more reliable for timely reimbursement, generally within one month.

Three of the four hospitals visited had contracts with Askes and Jamsostek to serve their members, with the exception being St Carolus, who implied that they expected to have such contracts in the future. Cengkareng Hospital received 10 percent of its revenues from Askes, and 18% from Jamsostek. Cempaka Putih estimated that approximately 30 percent of its revenues are from Askes and Jamsostek.

Puskesmas Cengkarang reported that the capitation payment from Jamsostek is Rp 1,750 per capita, which includes consultation, MCH, FP, and drugs. There is a reimbursement schedule for other services that are not part of the capitation package. They also reported that approximately 25 percent of the Askes patients come solely to get a referral letter, and do not want any treatment.

3.16 Implementation of Jamkesmas

In DKI Jakarta, ensuring access for the poor and near poor is implemented through the GAKIN scheme. Jakarta province chose to implement its own scheme, rather than relying on Jamkesmas. GAKIN benefits are only provided to low income population, who are official residents of Jakarta. People who are not official residents would access the Jamkesmas card in order to get access to health services.

The reach of Jamkesmas in covering the population that lives in Jakarta, but are not official residents, is unclear. Three of the hospitals visited reported that Jamkesmas represented a small share of its patients, while St Carolus Hospital had no agreement to provide services for Jamkesmas patients.

The private midwives in West Jakarta do not accept Jamkesmas or GAKIN through their private practices. The reason given by the district IBI leaders were that there is no contract between the government and private providers, and they have never received notice that they could be reimbursed by Jamkesmas in their private facilities. During a group discussion with midwives, they also responded that the reimbursement by

GAKIN is too low – Rp 150,000 to 200,000 for delivery. Some thought that an increase to Rp 300,000 or Rp 400,000 may be acceptable, or some subsidy for drugs and supplies.

Since the implementation of the GAKIN scheme, deliveries in the midwives' private practices have decreased significantly – many estimating a decrease of as much as 50 percent. One midwife estimated that she had 60 deliveries per month at one point, but now only has 40 deliveries per month. The fee for normal delivery by a private midwife is Rp 700,000 – 800,000, with some small room for negotiation if the client cannot pay.

The midwives also reported that Jamkesmas patients receive contraceptives for free at the Puskesmas – they would only have to pay for the registration fee of Rp 2,000. One midwife reported that there is a separate stock of free contraceptives from BKKBN at the Puskesmas reserved for Jamkesmas patients. However, this could not be verified at the Cengkareng Puskesmas.

What role can professional associations play in monitoring and improving quality of care among private providers?

3.17 Relationship between professional associations and Sudinkes

There is generally little coordination between Sudinkes and private providers. There is generally more coordination of midwives, with the Puskesmas as the key spoke in the wheel – midwives tend to be employed at Puskesmas and provide regular reports to Puskesmas. While both physicians and pharmacists require a letter of recommendation from the professional association for licensing, there is little coordination between the associations and Sudinkes related to service delivery or quality assurance.

3.18 Indonesian Midwives Association (IBI)

The IBI chapter in West Jakarta is active organizing midwives in the district, and acting as a liaison between midwives and district health officials. It was a district where the Bidan Delima program was established early on, and currently has 485 BD, and 61 candidates for BD. IBI collaborates with the Puskesmas in oversight and supervision of midwives. IBI is also included in Sudinkes discussions of MCH services – for example, most recently IBI and Sudinkes discussed how to conduct maternal audits to investigate an increase in maternal death in 2008, to nine deaths, compared with five to six in previous years.

Midwives meet regularly at district and sub-district level to discuss a variety of issues. For example, midwives regularly discuss fees, and decide on what is appropriate as a group. At sub-district level, some groups of midwives have established savings schemes. IBI has tried pooled purchases of medicines, but there was little interest, as drugs are so readily available in Jakarta. The association has up to date membership data, and is in regular contact with members. Although the management capacity is limited, IBI has a clear organizational structure in place, and could readily access its members.

3.19 Indonesian Medical Association (IMA or IMA)

The team did not meet with anyone from the Jakarta chapter of the Indonesian Doctors Association. By law, all physicians must be members of IMA, with provides recommendations required for practice. We learned from central level that there is an annual meeting of all members at the branch level. Branch office operation is mainly on a voluntary basis. There are regular branch meetings and branch representatives attend national meetings.

3.20 Indonesian Pharmacists Association (ISFI)

The ISFI has 33 branches nationally, at the province level. The branches provide recommendations to the pharmacists for issuing and renewing licenses. Licenses are good for five years. In West Jakarta, there are 135 pharmacists and 800 apotek (which differs from Sudinkes data of 408 apotek). Although Decree 284 of 2007 provides ISFI the authority to control the profession, including licensing pharmacies, some districts do not follow this Decree. Although ISFI would like to play a larger role in setting practice standards, including simply enforcing the regulation that a pharmacist be present in pharmacies, it has not been very successful in this regard.

3.21 Conclusions – Potential Interventions and Issues to Consider

Below are main conclusions and recommendations for West Jakarta:

- **GAKIN covers less than 3 percent of the population. Based on data from hospitals, a relatively small share of their patients are Jamkesmas patients**. Compared with other parts of Java, a very small percent of the population are covered for health services by central or local government funding. More efforts should be made to address health services for the poor and near-poor, and for migrants to Jakarta who do not have official resident status.
- **None of the private midwives accepted GAKIN because the reimbursement rate is too low (Rp 150,000 for delivery),** so the poor in Jakarta have much more limited access to midwives. The rates are set based on what is charged at Puskesmas, which penalizes private providers as they do not receive other implicit government subsidies. Poor patients have no choice but to pay out of pocket or use only public facilities.
- **Askes is a significant payer for all hospitals**. Besides commercial insurance (which is estimated to cover less than 5 percent of the population), hospitals consider Askes to be a better payer (on time, reasonable rates). Because of Askes' leverage, there may be good potential in working with them to pilot reimbursement practices that promote public health priorities.
- **There is easy access to medications at competitive prices, although it is difficult to assess the quality of medicines received**. It seems unlikely that a new procurement or distribution system would add much to improve supply or pricing. However, there may be gains in the area of ensuring quality by working with existing distributors.
- **The practices observed in retail pharmacies were not to professional standard** – no pharmacist was present, ethical medicines were dispensed without prescriptions.
- **It may be useful to work with GP Farmasi as well as ISFI on programs targeting pharmacies and drugsellers**. GP Farmasi represents the apotek establishment, so any protential program should include the pharmacy owners and not only the staff. Further, GP Farmasi would also represent toko obat, which are generally owner-operated, so the operator has greater interest in the reputation of the shop.
- **Cengkareng District Hospital used approaches that appeared to be effective in managing drug use and physician practices**. This hospital may have more flexibility than other public hospitals because it is a relatively new hospital and its staff are not civil servants. Nonetheless, there may be potential to collaborate with them to transfer some of these practices to other hospitals.

3.22 List of Persons Contacted

Sumber Waras Hospital
General Director, Dr. Hasan, MARSDr. Hasan, MARS, Dr. Hasan, MARS
Medical Director, Dr. Ateng, SpOG, MARS, Dr. Ateng, SpOG, MARS

West Jakarta Dinas Kesehatan
Dr Yuni
Gedung Farmasia Kesehatan (GFK) West Jakarta

PERDHAKI (Association of Voluntary Health Services Indonesia)
(Catholic Hospital Association)
Dr. Felix H. Gunawan

GP Farmasi (Indonesian Pharmaceutical Manufacturer Association)
Kai Arief Iman Selomulya

PERSI (Persatuan Rumah Sakit Indonesia/Indonesia Hospital Assocation)
M Natsir Nugroho, Adib A Yahya, Robert Imam Sutedja

Puskesmas Kacamatan Cengkareng
Ms, Head of Public Health Program and Cashier

Rumah Sakit Cengkareng
Director, Dr. Nur Abadi, Dr. Nur Abadi

Rumah Sakit Islam Jakarta Cempaka Putih
Dr Jusuf Saleh Bazed, General Director

Peralatan Kesehatan St Carolus
Dr Markus Waseso Suharyono, General Director

ISFI, West Jakarta Chapter
Chapter Chairman, Drs. Wahyudi and
Secretary of the National ISFI, Fauzi Kasim

IBI West Jakarta Chapter
Bidan Ideh, Chapter Chairman
Bidan Riyana, Vice Chairman

Indonesia Medical Association (IMA)
Dr. Gatot Soetono

JAMKESMAS
Center for Health Financing and Security, Depkes
Dr. Gatot Soetono
Donald Pardede

Other
Apotek Gitamara, Jl. Kemanggisan Utama Raya No. 37, Jakarta Barat
Apotek Berkait Sehat, Jl. Litan Panjang Baray No. 143
Klinik Anggrek
RS Harapan Kita, Depkes, Mother Child Hospital

Bidans in practice sites
Unlicensed bidan
Bidan Puji Rodana, Cengkareng sub-district, Jakarta Barat

Group practice of GPs
Klinik Anggrek

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