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Samuel S. Lieberman, Puti Marzoeki

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Health Strategy in a Post-Crisis, Decentralized Indonesia

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Paper prepared by the World Bank's Jakarta Office to chronicle and analyze the health policy implications of the extraordinary events and steps taken in Indonesia in the 1998-2000 interval. These paradigm-altering developments included the fall of President Suharto and the undermining of his New Order regime, the economic crisis, and the decision to proceed with rapid and full devolution of major responsibilities and resources to the country's districts.

Abstract: This strategy note looks at prospects for health advance in what is likely to be a difficult near to medium term in Indonesia. A major government reorganization based on devolution of many central responsibilities occurred in January 2001, and will likely be the defining social process during the forthcoming period. The backdrop for the discussion below are the achievements and disappointments of health policy since the late 1970s. These mixed results are analyzed and policy implications derived. The note argues that health development will depend on establishing more effective provider-client interactions than what has been the pattern to date. Decentralization can lead to this desired outcome provided that the roles and functions of the districts, provinces or cross district bodies, and MOH (Ministry of Health) itself are defined and agreed by different stakeholders, and supported by introduction of appropriate policy instruments and mechanisms. Special attention is given in the note to ways of addressing the health of the poor and communicable disease control within a decentralized system.

Keywords: decentralization; Indonesia; health policy.

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Table of Contents

FOREWORD

Experiments with decentralization in the health sector began in the 1970s in Western Europe and have since spread to many developing countries. This discussion paper looks at some of the unique dimensions of decentralization in the Indonesian health sector. It identifies some political, managerial, technical, and structural issues that must be addressed before decentralization can be successfully introduced in a developing-country setting.

The historical origins of decentralization go back a long way. Decentralization fundamentally changes property rights by shifting power from one level of government to another. A unique feature of ancient Greek civilization was the absence of a central ruler—no king, no emperor. Instead, hundreds of fully independent *poleis*, city-states, flourished in Greece and in its colonies around the Mediterranean and the Black Sea between 800 B.C. and 300 B.C. Each city-state became a testing ground for small innovations in laws, economic policies, and political organization. A central tenet of Plato's Republic related to diluting the excessive power gained by the emerging aristocracy through a form of decentralization of the city-state.

The 1950s to 1970s witnessed significant centralization in the way medicine and health care was organized in Western Europe. This shift of power toward centralized responsibility for the health sector had some noteworthy advantages. It led to a greater engagement of the State in the financing of health care. And it allowed closer coordination of strategic public health activities where private markets had failed.

But centralized structures are "bureaucratic" in nature and often unresponsive to the population or patients that they are supposed to serve. Decentralization—keeping ownership public but passing control over decision rights, responsibility, and accountability to lower levels of government—was seen as a possible middle road between heavy-handed centralized control and a return to the laissez-faire approach of the "invisible hand" that had dominated health care for centuries.

In the early 1980s, many developing countries began to follow a similar path. Decentralization in the health sector was part of a broad agenda for reforming the State. Used by many stakeholders, each with its own special vested interest, decentralization was a powerful political tool.

Indonesia's current decentralization of its health sector is a fascinating case study of the intersection between such political processes and attempts at reform. Reverberations from Indonesia's January 2001 government reorganization are still being felt. Devolution in responsibility from the central government to the country's more than 350 districts is at the heart of a "big bang" restructuring of the role of the State itself. It is a process driven by broad political imperatives. The health sector with its government-run delivery system is one of the sectors most affected by this reform.

This discussion paper looks at the near- and medium-term implications of the current health care reform trends in Indonesia. Reform in the health sector is of particular concern to national policymakers because previous policy efforts, despite some achievements, have not brought about desired reductions in key mortality and morbidity indicators. And if current trends continue, Indonesia will not reach the 2015 Millennium Development Goals for infant and maternal mortality set by the United Nations. Moreover, decentralization in Indonesia provides a reference point for the East Asia and Pacific Region where the Philippines, Vietnam, and several other countries are actively undertaking reforms that involve decentralization (the Philippines, and Vietnam), preparing for such reforms (Thailand), or considering ways of improving previously devolved systems (China and Malaysia).

The discussion paper begins with an assessment of Indonesia's government-run health system at the start of the decentralization process. During the 1980s and 1990s, centrally planned primary health care became accessible to much of the population, and health outcomes showed some improvements during the initial period (up until 1997 when the economic crisis began). Nevertheless, the centrally planned delivery system was beset by problems. These included poor quality, lack of engagement and responsiveness to patients, a mismatch between available resources and the running costs of essential services, a lack of information about health services that patients could use to make informed choices, and multiple staffing problems, all discussed in this report.

The discussion paper links prospects for rapid health gains in Indonesia to improvements in human resource issues and the provider-client interface. Effective reforms would have to address long-standing problems with staff motivation, service quality, and lack of effective accountability structures. Decentralization, the author argues, can lead to conditions in which providers have the incentives, skills, supervision, material support, and discretionary authority needed to offer high-quality services, as well as conditions in which clients have the necessary information, financial means, and bargaining power to ensure appropriate responses to their preferences.

However, the author also emphasizes that the health gains that might accompany such decentralization may not materialize for several reasons. This is based on the experience of other countries in the region such as the Philippines that have tried similar reforms. Problems that might emerge include a breakdown in the deployment of staff, withdrawal of support from the poor, and lapses in reporting, accountability, and quality-control procedures at the local level. Such trends could result in further deterioration of the service delivery system and quality, rather than the expected improvements.

The author also highlights some medium-term risks linked to decentralization. "Downsizing" of administrative units could result in a loss of economies of scale and weak local management capacity. Scale reductions could raise unit costs and threaten the sustainability of a wide range of other programs and activities. The resulting smaller delivery units may have less capacity to develop and finance initiatives that would target the poor. Finally, decentralized units may try to save by skimping on public health investments that have large externalities but which provide seemingly little immediate benefit to local providers who face pressures for immediate curative care from their clientele. Decentralized units may also try to economize on labor costs by hiring untrained staff.

The author describes ways policymakers can mitigate many of these risks while securing some of the positive benefits of decentralization. He emphasizes that decentralization means a different—not lesser—engagement by the central government in financing and delivering health care. Instead of its traditional role as an employer of civil servants and producer of public services, the central Ministry of Health under a decentralized model must focus on providing leadership, advocating intersectoral action in areas that have an impact on health, securing a sustained commitment to the health agenda, and supporting coalitions that pursue such agendas. To achieve such objectives, the reformed central ministry must build a new capacity in policymaking, regulation, monitoring and evaluation, and supporting research and knowledge generation. It must play a special role in addressing the needs of the poor and ensuring that conditions with large externalities such as communicable diseases and other public health programs are not neglected under the new decentralized system.

Finally, the author draws lessons from experiences in various countries in addition to Indonesia. He highlights the need for policymakers to take a systematic approach to policy formulation and implementation of decentralization in the health sector, rather than importing—uncritically—structural models developed abroad. Political considerations should inform every decision made during decentralization reforms because they reveal both opportunities and limits to what can be achieved.

The most serious mistake any reformer can make is to assume that decentralization is a managerial exercise devoid of political cause and consequences. Lower levels of government may lack the resources or capacity to make politically intricate decisions on, for example, sustainable financing and improved access to services for the poor. "Passing the buck" down the line through decentralization on such issues that require both commitment and engagement at the national level is a sure recipe for failure.

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ACRONYMS AND ABBREVIATIONS

ABRI	The Armed Forces of Indonesia
ARI	Acute Respiratory Infection
Askes	Parastatal providing health insurance to civil servants and their families
Bapel	JPKM management agency
Bappenas	National Development Planning Agency
BKKBN	National Family Planning Coordinating Board
BKSN	Agency for National Social Welfare
BOR	Bed Occupancy Rate
BPK	Agency for Financial Audit
CDC	Centers for Disease Control
CHI	Coalition for Healthy Indonesia
DCC	District Coordination Committee
DG	Directorate General
DHB	District Health Board
Dokabu	Head of District Health Office
DPR	National legislative body
DPRDII	Elected district level assembly
EPI	Expanded Program on Immunization
FDA	Food and Drug Administration
GMP	Good Manufacturing Process
GOI	Government of Indonesia
HC	Health center
HFA	Health for All
HMO	Health Maintenance Organization
IDI	Indonesian Medical Association
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
Inpres	Central grants for specific development purposes
Jamsostek	Health insurance agency for formal sector workers
JPKM	Community Health Maintenance Program
JPS-BK	Health component of Social Safety Net
Kal Bar	Province of Kalimantan Barat
Kandepkes	Ministry of Health district office
Kanwil Depkes	Ministry of Health provincial office
KAP	Knowledge, Attitudes, and Practice
KB	Family Planning
Kris Mon	Media/colloquial term for the late 1990s economic crisis
LKMD	Village Resilience Body
MA	Medical Assistant
MENEGPAN	State Minister for Utilization of State Apparatus
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOHSW	Ministry of Health and Social Welfare
MOM	Ministry of Manpower
MPR	People's Consultative Assembly
NGO	Non Governmental Organization
NHC	National Health Council
NHIC	National Health Insurance Council
NTB	Province of Nusa Tenggara Barat (West)
NTT	Province of Nusa Tenggara Timur (East)
ORS	Oral dehydration salts
PAK	Practice, Attitudes, and Knowledge
PERSI	Indonesian Hospital Association

PHN	Public Health Nursing
PKK	Family Welfare Movement
Polindes	Village maternity room
POM	Food and Drug Control Directorate General
Posyandu	Integrated service post
PPNI	Indonesian Nurses Association
Pra-Bapel	Transitional Bapel funded by JPS-BK
PSRL	Policy Reform Support Loan
PTT	Non permanent staff
Puskesmas	Public Health Center
Pustu	Health Sub-Center
QA	Quality Assurance
RAAC	Regional Autonomy Advisory Council
Repelita	Five Year Plan document prepared by Bappenas
SAL	Structural Adjustment Loan
SMERU	Social Monitoring and Early Response Unit
SPSDP	ADB funded Social Protection Sector Development Program
SSN	Social Safety Net
SSNAL	Social Safety Net Adjustment Loan
Susenas	National household expenditure survey
WDR	World Development Report

CURRENCY EQUIVALENTS

Exchange rate as of November 2, 2000: US$1.00 = Rp 9,140

FISCAL YEAR

Until 2000	April 1 – March 31
FY2000	April 1 – December 31
FY2001 and later	January 1 – December 31

EXECUTIVE SUMMARY

HEALTH STRATEGY IN A POST-CRISIS, DECENTRALIZING INDONESIA

i. **The Indonesian health system**. This strategy note looks at prospects for health advance in what is likely to be a challenging near to medium term in Indonesia. A major government reorganization based on devolution of many central responsibilities took effect in January 2001, and is likely to become the country's defining social process during the next decade. This restructuring of the state apparatus, consisting of decentralization of spending authority, enhanced access to resources at the local government level, downsizing of central ministries, civil service reform, and related reform initiatives, is being driven by broad political imperatives. Nevertheless, it is appropriate to examine what this process implies, i.e., what opportunities and risks are entailed, for the health sector. This is because decentralization and other reforms are responding among other things to heightened popular expectations and impatience with the quality of government services including health care.

ii. The literature points to potential health system benefits associated with decentralization, notably enabling citizens to become involved systematically in decisions regarding health policy goals, design, and financing, and in monitoring and influencing service provision and performance of other functions. These and other improvements are within reach in Indonesia where decentralization offers an unusual opportunity to rethink health sector institutions and operating mechanisms which are no longer adequate.

iii. The public sector component of Indonesia's health system was essentially put into place in the 1980s using a design influenced by primary health care concepts. Indeed, Indonesia was one of the first countries to embrace an approach to health policy whose principles and features were endorsed at the landmark UN Health for All (HFA) conference in Alma Ata in 1979. What distinguished this paradigm from earlier thinking was the focus on getting basic health services to the poor, relying on providers with modest training and operating in peripheral locations. The Government of Indonesia (GOI) took on HFA in a determined and distinctive fashion, building and staffing over 7,100 health centers, 19,000 subcenters, and 285 district and 50 special referral hospitals. In addition, health center and hospital employees, numbering more than 200,000 and nearly all civil servants, support more than a quarter million posyandus, monthly village gatherings in which community volunteers promote maternal and child health and nutrition.

iv. Indonesia's large private health sector also owes much to the country's primary care based strategy, especially the decision to allow public sector staff to work part-time on private account. GOI, and specifically the Ministry of Health (MOH) saw this step as a way of supplementing low public service salaries and allowances. By letting staff provide medical care in their off duty hours, GOI in effect expanded private practice opportunities and facilitated the emergence of a dispersed private health sector. Related GOI policies encouraged investment in private hospitals, laboratories, medical schools, and health insurance schemes.

v. **Results**. At first glance, Indonesia's approach to HFA appears to have paid handsome dividends. Modern health services became more accessible for most of the population, with health outcomes showing marked improvement during the 1980s and 1990s (until 1997 when the economic crisis began). For example, the infant mortality rate (IMR) fell from over 80 deaths per thousand births in the late 1970s to under 50 in the mid 1990s. Contraceptive use in this period rose by over 60%, while the total fertility rate fell from 4.7 births to 2.8. And the public responded to improved access to public services. By the early 1990s, government facilities were attracting nearly a third of those who had

sought outpatient care (including self-treatment) during the previous month. Contacts with private providers also rose in the late 1980s and pre-crisis 1990s.

vi. However, several other low income countries achieved even faster IMR reductions--the current IMR of roughly 46 infant deaths per thousand births is roughly 40% below the 1985 level but still well above rates in nearby East Asian countries. Moreover, trends in malnutrition and maternal mortality in Indonesia have shown moderate improvement (i.e., reductions) at best, despite systematic primary care interventions. Utilization of public services also faltered. By 1995, the share of public providers had fallen below 30%, and by 1998, it had slipped below 20% before rising somewhat in 1999. By comparison, contact rates for privately supplied outpatient care appear to have stabilized, before falling marginally in 1998 and 1999. Inpatient days in publicly-run general hospitals increased by less than 1% annually between 1989 and 1997 compared to the 5% growth rate recorded in privately owned facilities.

vii. In the mid 1990s, low income families lagged well behind other groups in terms of various health indicators. Despite greater need, the poor relied on self treatment, with their use of government facilities especially hospitals well below average rates. Households in the top 20% of the expenditure distribution were far more likely than the poor to use public facilities on an inpatient basis and nearly as likely on an outpatient basis.

viii. The picture that emerges from these and other findings is of a primary health care-based system which registered significant first phase achievements which were not easily extended or in some dimensions even sustained. It appears that that the widely endorsed HFA design was unable, despite considerable outlays on facilities and staff, to engender the persistent client interest and utilization of government services needed to bring about rapid health advance.

ix. **Accounting for health system performance**. Two factors need to be kept in view while trying to explain the health outcomes of the last two decades. First, though the funding picture improved through 1997, the government health system remained under-resourced relative to other countries and in terms of the staff intensive design which had been adopted. In response, GOI tolerated informal user's fees, and as mentioned, permitted government health workers to provide health care on a private basis. MOH's compensation strategy created systematic and perverse incentives within government health centers and hospitals. Specifically, it was in the financial interest of health center staff to advise puskesmas patients who were able to pay to visit their private offices or residences.

x. In principle, MOH could have sought higher budget allocations or taken steps to contain spending. Instead, MOH opted to establish the primary health care system as intended on a country-wide basis. Here, the second performance factor is salient. This is the preoccupation of decision makers with human resource constraints which were seen as possibly delaying efforts to broaden access to primary care and referral services. A specific concern was the limited training and experience of a health work force made up of newly recruited graduates and those assigned to disease specific programs who then became multi-purpose workers. In response, GOI sought to impose strong guidance and control mechanisms. This seemed to make sense given the low salaries and seemingly limited capacity of a work force hastily assembled to work in the facilities built in the 1980s and early 1990s. The intention was to ensure continuity in service delivery of predictable quality by specifying objectives, preparing for likely contingencies, and of course, reducing limiting the choices available to government health staff if discretionary occasions arose.

xi. **Predictable impacts**. This note suggests that these compensation and guidance measures had a profound influence on health worker effectiveness, and help explain unsatisfactory health system performance in the 1990s, especially the inability of government's health services to attract clients on a sustained, high volume basis. Micro level studies provide the clearest sense of consequences stemming

from the way staff were paid and managed. Field interviews and observations reveal a passive labor force preoccupied with private earnings opportunities. These health workers often have only limited, routinized contact with clients who are generally poorly informed, resistant to user fees, and lack means of pressing for better services

xii. In short, the disappointing Indonesian experience with primary health care is attributed to the interplay of provider and consumer level incentives, perceptions, and behavior. Low visit and occupancy rates were linked first to responses by providers to monetary incentives and highly directive management against the backdrop of the disengaged worldview which developed within the health labor force. Indifferent service and informal fees within health centers and other facilities prompted clients and potential beneficiaries to resort to other alternatives, i.e., consulting private providers or self-treatment, when health problems arose.

xiii. **Micro level changes**. This note also points to ways of creating the kind of provider-client interactions which can bring sustained health gains. Improvements depend first on ensuring that clients and patients have access to service suppliers who are motivated, proactive, and technically proficient. Provider behavior can be altered by revamping compensation and employment arrangements so that government health staff are paid adequately for a required full day's work with little leeway for supplementing income by taking second jobs or seeing patients privately. Also required are changes in work culture and oversight practices. Health staff need to be encouraged to use their judgements, and assisted and evaluated through supervision arrangements which focus on improving front-line technical and inter-personal skills. Staff also need considerable technical training including upgrading capacity to respond to priority disease and health problems.

xiv. Such supply-side adjustments have to be underpinned and steered by demand-side changes. For one thing, providers need to be exposed to clients' questions and concerns and reminded continuously of their obligations to the recipients of services, while consumers must become better informed. And strong accountability mechanisms, opportunities to exert market power, and access to affordable, high quality care are also required to reinforce desirable provider performance and make sure that the poor make use of health services. Community education and mobilization activities, locally grounded decision making, feedback and resource mobilization arrangements all have a place in delivering high quality, highly valued services.

xv. Various elements in the provider-client relationship may take months or years to change. Nevertheless, the required adjustments in the Indonesian health service scene will be easier to set in motion than might first appear. For one thing, the country has "assets" which are already affecting some dimensions of the picture and which can be used more effectively. One example is JPS-BK, the health component of GOI's emergency crisis period policy package. JPS-BK is having some success in changing incentives and energizing providers, resulting in increased contacts with poor clients. Another instrument is the still emerging health promotion alliance. NGOs and other partners in this association could develop high impact, regionally grounded health education programs focused on the poor. Provincial health promotion boards are a possible platform for such activities.

xvi. **Decentralization as entry point**. Government reorganization represents a good opportunity to improve health services in Indonesia. Specifically, decentralization and related steps can lead to conditions in which providers have the incentives, skills, supervision, material support, and discretionary authority needed to offer high quality services, and clients have the information, financial means, and bargaining power required to elicit appropriate responses. In this respect, decentralization provides a context in which to build on initiatives such as JPS-BK, providing an opening for MOH to carve out a new leadership role, and improve its public image while jettisoning impractical obligations.

xvii. Decentralization can lead to this outcome provided there is sufficient consensus among stakeholders on the roles and functions of the districts, provinces or cross district bodies, and MOH. These roles need to be supported by appropriate policy instruments and mechanisms. What still needs to be resolved though are the actual health responsibilities of districts, and the division of the remaining roles and functions between the central MOH and province-level entities. Laws 22 and 25, which provide statutory underpinning for decentralization, make the district as a key level for policy implementation as well as formulation; and make available greatly increased resources. These steps have a strong rationale. Districts already own and operate health centers and most public hospitals, and have responsibilities as regards most health staff. Moreover districts provide the context in which care is delivered (or not), quality standards are achieved (or not), and generally in which providers and actual and/or potential clients interact.

xviii. Indonesia's districts have inherited numerous health facilities and staff, along with a large policy and program agenda. In principle, local assemblies (DPRDs) and district chief executives, Bupatis, have assumed responsibility not just for managing health centers, public hospitals, and training and regulatory functions, but also priority setting and resource allocation, together with some quality assurance and personnel management functions. All this requires decisions about the scope and content of health service provision, including choosing whether to keep or even add to the puskesmas menu, opt for smaller service packages, or withdraw from direct care provision. And districts face choices concerning resource mobilization.

xix. In the near term, some of these tasks and functions will be beyond the capacity of districts. Accordingly, MOH's efforts in 2000 centered on clarifying what districts need to do and designing support arrangements. Concerned that essential services may be disrupted, MOH has been in the forefront of government agencies preparing for decentralization. MOH identified 24 tasks and provided detailed descriptions statements of these responsibilities which it hopes districts will assume. This work included defining recommended input and achievement standards for various health center level activities. In addition, MOH has invoked its deconcentration powers to specify provincial responsibilities additional to the devolved functions enumerated in the operational guidelines for Law 22.

xx. However, MOH's approach comes with some risks. Its decrees and circulars incorporate broad, not clearly delineated powers for itself, which overlap with responsibilities it has in mind for province and district-level governments. For instance, MOH's "standard setting" role seems similar to functions allocated to sub-national governments. Over determination of tasks is seen as a means of safeguarding health in the short run. But such language could confuse and possibly arouse suspicion that MOH is not ready to relinquish its traditionally dominant role in the health sector.

xxi. This ambiguity, which could stymie district-level adjustments, can be reduced by focusing on activity costs as a way of allocating health roles and responsibilities. For example, districts will have difficulty carrying out essential public health, health education, and information functions. This is because no matter how competently they are managed, districts are too small to capture scale and scope advantages and enough of the gains from activities which yield externalities. For this reason, smaller political units worldwide typically underinvest in these classic public goods. Another function which districts will have difficulty managing is health care provision by government staff whether it is the standard puskesmas menu or smaller service packages. The solution adopted in different circumstances worldwide is to withdraw from such activities and to rely on payments to providers to subsidize care to the poor.

xxii. The same principles would help in deciding on the responsibilities provinces can carry out most effectively and those more appropriate for the central MOH. Communicable disease control provides a good example. Indonesia is too vast and diverse for disease control and surveillance tasks to be centrally managed, while as just mentioned, districts will always be tempted to "free ride" when other

areas develop such programs. Most disease control responsibilities should be entrusted to provinces which are usually of appropriate size. Province-level health education and promotion also makes sense in terms of scale and scope, while provinces typically provide an appropriate market size for health finance, regulatory, and related functions. For instance, districts represent too small a population and economic base to hire staff with the expert skills and to accumulate the operational and financial reserves needed for health insurance operations. Procurement of drugs and training services, operating personnel systems, and negotiating with labor unions are also "natural" responsibilities for provinces.

xxiii. In short, scale, scope and externality considerations suggest that some previously central responsibilities be assigned to provincial health units. Nevertheless, the central MOH would continue to have a crucial role though its mix of activities would change drastically. As regards communicable diseases, for example, MOH must monitor national and regional trends, alert provinces about outbreaks elsewhere, press for emergency funding to deal with epidemics, and so forth. But MOH would not focus on the details of health budget allocation. Nor would it be directly involved in designing and implementing health education activities, or deploying doctors and other staff, and it would relinquish its longstanding role of "guiding" service delivery, which left such an impression on provider incentives and behavior, and client perceptions.

xxiv. Instead of its traditional tasks, the functions of a reformed MOH center on leadership, meaning getting health the attention it deserves, developing and sustaining commitment to a national agenda, and building powerful coalitions to pursue this agenda. Overall, MOH needs to establish itself as a technically credible authority and voice on health matters; ensure that health status differentials figure prominently among the criteria used to determine central transfers to provinces and districts and monitor impacts; facilitate emergence of effective and sustainable financing and regulatory mechanisms; build consensus among different stakeholders in the sector; maintain an overview of national and regional trends and patterns in health status (especially among the poor), and financing and policy responses; serve as a clearing house for policy lessons and innovations from different parts of the country and abroad; take note of the quality of medical and other health worker education and its determinants; advance a limited number of high impact themes; and provide technical support in selected areas to district and province governments.

xxv. **Developing policy instruments: the district level**. Along with defining responsibilities appropriately, there are ways of enhancing district level capacity to formulate and implement health policy. As mentioned, an important decision would be to withdraw local governments from direct service provision responsibilities which make heavy demands on management capacity. District Health Boards (DHBs) can be helpful in finding a satisfactory exit route from delivery of care tasks, and in tackling other local health issues. DHBs would be expected to sensitize and consult health stakeholders on institutional and budgeting changes, options, and related policy matters, and assist in brokering sustainable solutions. Participants could include selected DPRD members, NGO and professional group representatives, consumer advocates, religious leaders, public and private hospital directors, Askes and Bapel staff, media specialists, and the Dokabu and his section heads.

xxvi. DHBs need to juxtapose health concerns and indispensable expenditures with likely resources, and then arrive at positions with respect to possible obligations. Having defined the setting in this fashion, the principal task for DHBs would be to address local planning and implementation constraints. This would entail reaching out to existing and fostering new local institutions to share management burdens. For example, DHBs could take advantage of the local oversight teams and other coordination and accountability mechanisms which JPS-BK is adding to the local setting. DHBs can work to simplify the functions and tasks left to DPRDs and their district teams. An option here is for DHBs to join together to fund cross-district bodies to carry out tasks for which there may not be sufficient local level management capacity and which promise significant economies of scale. Districts could also contract with other entities, e.g., universities, to handle specific functions.

xxvii. **Cross-district mechanisms**. The institutional issue at the province level is less a matter of capacity than agreement on how responsibilities are to be handled. Law 22 has eliminated the province-district hierarchy. Therefore, new policy mechanisms are required to ensure that cross-district health concerns are addressed. One of these is the Health Council which could include representatives of professional organizations, NGOs, and the private sector. The core members would be Bupatis or other district-level representatives, making decisions together on agreed agenda items in a transparent manner. The Council provides a forum in which to raise health issues, share management burdens, formulate common policies, and organize advocacy efforts. The Council is expected to take responsibility jointly for decisions and actions in respect of those activities, e.g., finance and insurance, health education and advocacy, disease control, special assistance to poorer districts, and regulatory tasks and other services and activities which would be costly for individual districts to tackle on their own. Technical support for the Council would be provided by functional groups attached to the provincial health office.

xxviii. **A new MOH**. MOH's emerging responsibilities also require appropriate supporting policy instruments. Internal capacity will need to be strengthened in respect of the leadership, analytical, consensus building, monitoring, and advocacy roles which MOH must assume. And there are near term challenges as regards health funding, redeploying and downsizing the government work force, and altering the public's image of government health interventions. To this end, a unit is required, empowered to facilitate health decentralization and reform. This team would have the tasks of articulating and getting agreement to a pattern of health decentralization which is at once acceptable in terms of likely health outcomes and sustainable financially and administratively. This would entail intensive discussions with MOF and other core ministries and with key stakeholders. One crucial constituency who must be approached thoughtfully is the government health work force. The MOH unit can sponsor a phased, regionally differentiated approach to health decentralization. But this will require close partnership, at least with a handful of provinces. Such an approach could also serve as the basis for stepped up donor coordination and a more coherent focus in health assistance--this would be another priority task of the health reform team.

xxix. The MOH decentralization team could also recommend strategies for transforming MOH internally, including calling attention to changes required in organizational personality. Meanwhile, the skills mix within MOH would likely shift towards those with social science and management expertise. As this happens, the mode of operations should become less formal and hierarchical, more outward looking and experience-based, and far more responsive to customer perceptions and preferences.

xxx. MOH needs mechanisms to carry out its leadership role within the government and in Indonesian society overall. Efforts to shape opinion and change behavior would benefit from easy access to high powered media expertise, possibly contracted from the private sector. And new institutions are needed to draw attention to health concerns, build consensus among the sector's important stakeholders, and pursue behavior change and other initiatives. Here, a National Health Council or Commission (NHC) with advisory powers could make a contribution. Such entities have proved effective elsewhere in taking on attention getting and agenda-defining functions, e.g., what approach to health decentralization makes sense, as well as in synthesizing and distilling the thinking of technical experts. MOH could serve as the secretariat for such an overarching body whose members would represent key stakeholder groups such as provinces and districts, and Indonesian society overall.

xxxi. There is a place as well for specialized entities. For example, a National Health Insurance Council could facilitate interaction and make recommendations on a range of health financing issues. This body could be tasked with improving regulatory arrangements in the health financing sphere. An essential focus for this Council would be the sort of national commitment to health insurance which was appropriate, i.e., what benefits should be included, on what basis should such a commitment be extended, with what sort of timing and phasing, and so forth.

xxxii. Finally, MOH's leadership role, especially its ability to shape and advance the health agenda, requires resource transfer instruments. Specifically, MOH needs a funding facility through which it can reinforce local government commitment to key national policies, e.g., improving the health of the poor. This instrument should operate along with the general block grants which will be the main conduit for resource transfers to districts starting in January 2001. As noted, MOH needs to ensure that health concerns are taken seriously in the formula used to allocate untied block grants.

xxxiii. An MOH-managed grant mechanism should be relatively small initially and used for two or three purposes only. Initially, a decentralization support facility, with funding for up to seven years, would help MOH to respond to district and province-specific transition problems. This might be accompanied by grant mechanisms, each starting small and expanding according to effectiveness, focused on improving the health of the poor and communicable disease control.

xxxiv. **Poverty-health and communicable disease challenges**. The note recommends that MOH manage a poverty and health fund. Initially, the size of this fund should be limited to what would be needed to finance an enhanced version of JPS-BK in ten kabupatens. Depending on effectiveness and resource availability, the fund might be expanded to cover up to a quarter of the country's districts, starting with the most disadvantaged ones. In the poorest areas, grants from this facility could finance a significant share, i.e., 50% or more, of program costs. In other regions, health care for the poor, possibly including payment of insurance premiums, would be funded from district resources, and from cross-subsidization within province-wide health insurance arrangements. (MOH would use other policy instruments, e.g., a possible National Health Corps, health promotion efforts, and so forth, to intensify the health-poverty effort.)

xxxv. To gain access to grant resources, district officials would prepare proposals which would be expected to describe the size and health needs of the poor and suggested responses. Current JPS-BK features would provide an entry point, but districts would be encouraged to concentrate on the health needs of their own poor households, and to set priorities which fit the local scene. Proposals should lay out how provider effectiveness and beneficiary health awareness and bargaining powers would each be enhanced. Proposals could depart from inherited delivery structures, and would be able to introduce management, staffing, incentive and compensation arrangements which make sense locally. Pra-Bapels, NGOs, private service providers small and large, and other stakeholders and actors, organized as District Health Boards, could all be brought in as program participants, as could local health promotion alliances.

xxxvi. A grant instrument would also be invaluable for communicable disease control, though center-province-district interrelationships would work differently. Compared to poverty-health concerns, what distinguishes this agenda is the necessity of investing in surveillance and prevention activities characterized by scale economies and externalities. In the near term, MOH should remain closely involved in maintaining disease control arrangements, while transiting to a decentralized approach based on a sustainable partnership between MOH and province level communicable disease units and other interested agencies. Grants from a disease control fund would be a key instrument. The fund would managed by MOH under the oversight of a group which would include outstanding technical experts.

xxxvii. Provinces and more rarely districts could submit proposals for grants from this fund. At first, this facility could finance start-up activities, e.g., enhancing MOH's quick-response capacity, developing terms of reference for province level communicable disease units, and intensive training of staff in disease surveillance and prevention. Later grants could be made available to fund work on disease-specific and other topics suggested by MOH and for unsolicited proposals.

xxxviii. **International assistance and health decentralization**. Donors can play a role in facilitating decentralization and related health system reforms in Indonesia. Multilateral and bilateral agencies can advise different audiences, i.e., Indonesian stakeholders and constituencies in their own headquarters and home-countries, about the health sector's distinctive needs at the moment and the unusual opening for a policy paradigm shift. And donors can build on current arrangements for working together. The "Partners for Health" alliance formed by the World Bank, ADB, WHO, and UNICEF in 1999 can help to reaffirm decentralization and system reform as MOH priorities while financing some of the costs of devolution. This will require an understanding that each donor would abstain as much as possible from traditional disease or problem-specific advocacy efforts vis a vis MOH. Doing this will make it easier for decision makers in MOH to focus on tough, reform-related issues and concentrate on developing effective partnerships with provinces, districts, and NGOs. Donors can also lighten the burden on MOH while improving investment performance by supporting efforts to strengthen MOH's leadership functions. This would likely mean cooperating to fund the decentralization and reform unit suggested above, and then working with this unit to develop a medium term expenditure plan which could be jointly financed.

HEALTH STRATEGY IN A POST-CRISIS, DECENTRALIZING INDONESIA

I. INTRODUCTION

The Kris Mon and health. Indonesia's economic crisis has been a health crisis as well. Economic troubles have brought heightened vulnerability, especially in low income households, to life-threatening diseases, malnutrition and micronutrient deficiencies, and maternal morbidity and mortality. The poor as well as many non-poor are also less able to cope with the financial burdens that typically accompany death, serious disease or injury within families.

1.1 The Government of Indonesia's (GOI's) response to these and other health sector issues has evolved since the crisis began in 1997. Linked to the steep devaluation of the Rupiah, the prices of imported pharmaceutical raw materials, medical consumables, spare parts, and imported and domestically produced medicines all rose significantly. Accordingly, policy makers were concerned initially to assure the availability and affordability of essential drugs and reagents in health facilities. Several steps, i.e., earmarking subsidized foreign exchange for pharmaceutical raw materials and lowering essential drug prices in government-run facilities, were taken during the first quarter of 1998. These measures undoubtedly helped to restrain drug price increases, and contributed to restoring real outlays on essential generic medicines to pre-crisis levels after a 15% drop in 1998.

1.2 Ministry of Health (MOH) officials hoped that by stabilizing pharmaceutical prices and supplies they would be able to sustain health care provision in public hospitals and health centers. Meanwhile, reports of student transfers from private to public schools led health policy makers to expect analogous increases in visits to publicly run facilities. In any event, a second set of crisis policies was developed aimed at making it easier for the poor to afford and obtain health care. These measures comprised the health component of the overall Social Safety Net (SSN) program. In a related initiative, MOH piloted a form of health insurance coverage for the poor.

1.3 It is still difficult though to get a complete and consistent picture of the health impact of the crisis and the effectiveness of policy responses. Some standard barometers suggest that catastrophic results were averted. For example, infant mortality rates (IMRs) seemed to have continued a downward trend, a rising proportion of women gave birth with the assistance of trained health workers, and the contraceptive prevalence rate remained at the level reached in 1995/96. However, other indicators pointed to deterioration in the health scene. The 1998 National Household Expenditure Survey (Susenas) found a 16.5% increase over the previous year in morbidity rates for illnesses considered to be "disruptive" by respondents. Sickness rates rose overall relative to 1997, and for the poor, children and the elderly, the increase in morbidity in the first crisis year, 1998, reversed gains made since 1995 (Saadah, et.al., 2000). These patterns are consistent with indications of upward trends in malaria and several other deadly diseases, and in health problems due to micro-nutrient deficiencies (Helen Keller International, 1998; Lahad, 2000).

1.4 Although illness rates rose during the crisis, outpatient visits to health service providers fell by 23% in 1998; contacts with public facilities fell most sharply, by 28% (Table 1). Visits to private providers fell as well, reversing strong gains in the 1995-1997 interval. The decline in utilization rates for public facilities was larger in rural areas than in cities, and seems to have extended a shift in visits from public to private providers which was underway before the crisis (Saadah, et. al., 2000). Meanwhile,

recourse to self care increased, with the share of households receiving no medical treatment when sick highest amongst the poor, i.e., those in the lowest four deciles of the expenditure distribution. [1]

1.5 The 1999 Susenas found modest increases in outpatient contact rates after the sharp decline in the first crisis year (Table 1). Visits to private providers declined slightly while those to public facilities rose by roughly 10%. Nevertheless, use of modern medical practitioners remained almost a fifth less than in 1997 (Figure 1).

1.6 **Indonesia and the Alma Ata vision**. It appears then that a health disaster was averted. However, health system performance was far less resilient and responsive than policy makers had hoped and anticipated. In fact, outcomes during the economic crisis showed that health authorities had counted on too much from the health system and supporting policies. This mismatch between expectations and results deserves further attention. Such a disconnect between objectives and outcomes existed long before the crisis, and can be traced back to the approach which has guided GOI's health policies since the 1970s.

1.7 This policy framework was based on the poverty-oriented, Health for All (HFA) vision endorsed at the landmark 1979 UN conference in Alma Ata. Indonesia was one of the first countries to put this path breaking, primary-care oriented health design into place. HFA goals were pursued in a serious fashion, and at first glance, the approach appears to have paid dividends. For example, the IMR fell from over 80 deaths per thousand births in the late 1970s to under 50 in the mid 1990s. Contraceptive use rose during this period from roughly 35% to 57% of couples of reproductive age while the total fertility rate fell from 4.7 to 2.8 births per woman.

1.8 But such trends were not the full story. Several other low income countries achieved even faster IMR reductions--the current IMR of roughly 46 infant deaths per thousand births is roughly 40% below the 1985 level but still 40% above the rate in Viet Nam, and Thailand (Bos and Saadah, 1999). Moreover, trends in malnutrition and maternal mortality in Indonesia have shown moderate improvement (i.e., reductions) at best, despite HFA-related interventions. The 1998 Susenas round found that undernutrition for all family members within the lowest two deciles had fallen to 34% compared to 42% in 1992. But undernutrition rates of 30% or more for the lowest six consumption deciles in 1998 were still very high, in light of recorded gains in per capita income during this period. Moreover, the nutritional status of infants was lower in 1998 than what was reported for 1992 (Saadah, et.al., 1999). A follow-up study suggested that most of the gains for children under age 5 reported in 1998 were attained in the 1989-1995 interval. The proportion of children severely underweight actually increased, from 6% in 1989/92 to 10.5% in 1995/98, while the proportions classified as moderately and mildly malnourished children fell (Jahari, et.al., 1999).

1.9 Other considerations also need to be reflected when assessing HFA impacts in Indonesia. In particular, public perceptions and expectations, especially the views of poor families, need to be kept in view. On this point, outpatient visit rates, a proxy for consumer "market share," reached at best moderate proportions before the crisis. This suggests that despite the considerable resources invested in facilities and staff, HFA has been unable to establish the sort of sustained client interest and utilization of government services needed to bring about rapid health advance. [2]

[1] In 1997, these families accounted for 43% of reported morbidity and 71% of all untreated cases (Marzolf, 2000).

2 Moreover, no statistically significant HFA impact is detected once the country's substantial income growth, poverty reduction and overall health status of the poor are factored into the analysis.

1.10 On the other hand, the "scorecard" on HFA improves substantially when utilization of private providers is taken into account. The country's approach to primary health care greatly expanded private practice opportunities for doctors and other health workers, and added substantially to the services available to the individual households, poor and non-poor. Related GOI policies encouraged investment in private hospitals, laboratories, medical schools, and insurance schemes. And the public responded, with visit rates to private providers generally rising in the late 1980s and pre-crisis 1990s, and stabilizing during the crisis. In fact, the buoyancy of the private sector helps explain the apparent inconsistency between improving life expectancy and child survival and low use of public facilities.

1.11 **Plan of the paper**. This strategy note looks at prospects for health advance in what is likely to be a difficult near to medium term in Indonesia. A major government reorganization based on devolution of many central responsibilities came into effect on January 1, 2001, and will likely be the defining social process during the forthcoming period. The backdrop for the discussion below are the achievements and disappointments of health policy since the late 1970s. These mixed results are analyzed and policy implications derived. The note argues that health development will depend on establishing more effective provider-client interactions than what has been the pattern to date. Decentralization can lead to this desired outcome provided that the roles and functions of the districts, provinces or cross district bodies, and MOH itself are defined and agreed by different stakeholders, and supported by introduction of appropriate policy instruments and mechanisms. Special attention is given in the note to ways of addressing the health of the poor and communicable disease control within a decentralized system.

1.12 The next section (Section II) analyzes Indonesia's approach to primary health care in terms of different benefits, costs and performance issues. Section III assesses the different policy measures introduced in response to health system problems before and during the crisis. Health policy options and scenarios as Indonesia proceeds with decentralization are discussed in Section IV.

II. HEALTH SYSTEM PERFORMANCE AND COSTS

2.1 **An East Asian interpretation of Alma Ata**. Indonesia's approach to HFA retained key dimensions of a perspective which broke decisively with the health development approach of the time. i.e., the late 1970s. One feature of this still influential paradigm was integrated service provision at the primary care level. This was seen as more effective than the then conventional reliance on hospital-based curative care coupled with stand-alone "vertical" public health measures. Other HFA elements included reliance on field workers, not doctors, trained to handle numerous tasks; attention to preventive health activities including efforts to reach the poor in peripheral areas; and significant community participation in planning, delivering and monitoring service provision.

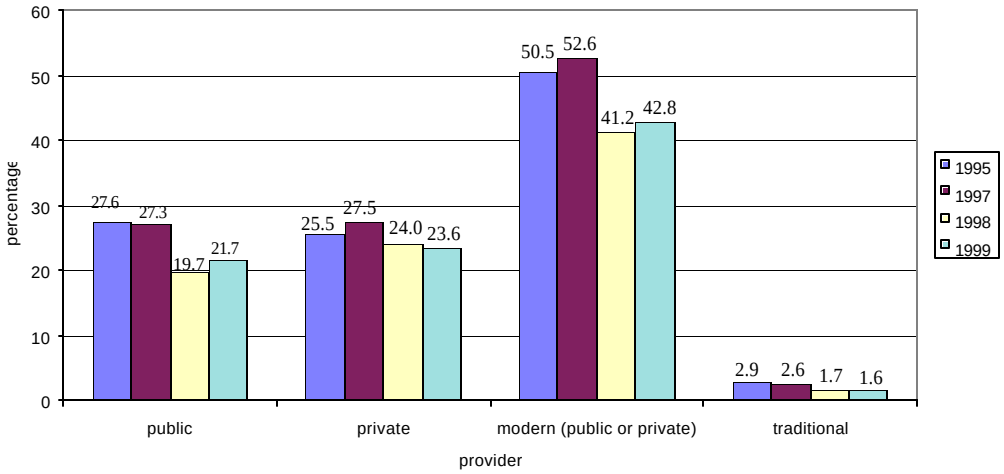
2.2 The Indonesian adaptation of HFA aimed at wide coverage from the outset. The mandate was to reach the poor as well as the non-poor whether they lived in remote areas in Outer Island provinces or in urban and periurban areas in Java and Sumatra. To this end, a service delivery network was established, which was jointly managed by MOH and the Ministry of Home Affairs (MOHA). By the mid 1990s, this self-contained system consisted of 7,100 health centers (puskesmas) which provided primary health care through outpatient clinics and through roughly 23,000 subcenters, over 4,000 mobile clinics, and 19,000 village maternity rooms (polindes). Health centers operated as referral points for 285 district hospitals. Patients were directed as well to the more than 50 centers of excellence and specialized facilities run by MOH. Health centers also served as the hub for surveillance and other communicable disease control activities. And puskesmas staff were tasked with supporting more than 240,000 posyandus, the monthly village gatherings in which community volunteers promoted maternal and child health and nutrition.

2.3 The puskesmas, an Indonesian acronym for public health center, is where the country's distinctive approach to HFA was and still is assembled and "retailed." The diverse services (see Annex 1) organized through the country's health centers are delivered mainly by salaried public service workers. A typical health center in Java and Bali employs about 28 people, including one or more doctors, a dentist, 4-6 nurses and midwives and a similar number of paramedics with various technical responsibilities, and 4-6 clerical workers, based in the health center itself. Each of the three subcenters and the mobile health unit attached to most health centers is staffed by a midwife and an auxiliary worker. In remote areas outside Java and Bali, the number of health center staff can be in the 5-10 range. In the 1990s, a new government-paid field worker, the bidan di desa (village midwife) was assigned to specified rural communities. Over 50,000 of these field workers were trained and hired on three year contracts which were renewed for three additional years. The overall puskesmas team now includes 5-10 of these village-based workers.

2.4 **Performance before the crisis.** As mentioned above, implementation of HFA in Indonesia has brought mixed results. Achievements included much greater reliance by Indonesians on trained health providers who supplied services on public and private account. In the 1980s, it was the public sector segment of Indonesia's form of HFA which got attention as access to government-run health centers and hospital increased. By the early 1990s, government facilities were attracting nearly a third of those who had sought outpatient care (including self-treatment) during the previous month. However, this trend was not sustained. By 1995, the share of public providers had fallen below 30%, and by 1998, it had slipped below 20% before rising somewhat in 1999. By comparison, overall contact rates for "modern" privately supplied outpatient care appear to have stabilized, before falling marginally in 1998 and 1999 (Saadah, et. al, 2000; Pradhan, M. and R. Sparrow, work in progress). Within the government system, the fall in patient contacts, at least during the 1995-98 interval, was concentrated in health centers and subcenters (Figure 1, Table 1). Hospital inpatient occupancy rates tell an analogous story. Bed days in publicly-run general hospitals increased by less than 1% annually between 1989 and 1997 compared to the 5% growth rate recorded in privately owned facilities.

2.5 In the mid 1990s, low income families lagged behind other quintiles in terms of infant and child mortality rates and prevalence of specific diseases and nutrition problems (Gwatkin, et. al., 2000). Yet despite greater need, the poor relied more heavily on self treatment, while their use of government facilities especially hospitals was below average rates. On the other hand, households in the top 20% of the expenditure distribution in 1995 were three times more likely to use public facilities on an inpatient basis and nearly as likely on an outpatient basis than those in the bottom two deciles (Saadah, et.al., 2000). In fact, the top expenditure decile gets nearly a third of its health services from public providers. This imbalance was greater in rural areas. Also of concern before the crisis, especially as regards poor mothers and young children, was low posyandu participation. Posyandu attendance by children under age five was, at 57% in 1997, already well below complete coverage. It fell further in 1998 to just 42% (Frankenberg, et.al., 1999). Susenas rounds for 1995, 1997 and 1998 detected similar trends, while province-specific surveys during the crisis revealed low contact rates for public facilities and a large share of posyandus as "inactive" (Indrajaya, 1999; Chalker, et.al., 1999).

Figure 1
Proportion of ill people who consulted a health care supplier, on an outpatient basis, in 1995, 1997, 1998 and 1999, by type of provider (percent)



Source: Susenas (Saadah, et. al., 2000; Pradhan and Sparrow, work in progress)

Table 1: Contact Rates by Type of Provider 1995-1999

	Contact Rate			
Provider	**1995**	**1997**	**1998**	**1999**
Public hospital	0.64	0.60	0.64	0.59
Private hospital	0.40	0.41	0.40	0.39
Private doctor	3.01	3.14	2.84	2.63
Primary health center	4.66	4.31	3.25	3.46
Subsidiary health center	1.69	1.66	1.01	1.01
Clinic	0.42	0.39	0.34	0.31
Posyandu	0.19	0.20	0.12	0.10
Paramedical practitioner	2.82	2.93	2.80	2.70
Traditional healer	0.73	0.63	0.43	0.40

Source: Susenas (Saadah, et. al., 2000; Pradhan and Sparrow, work in progress)

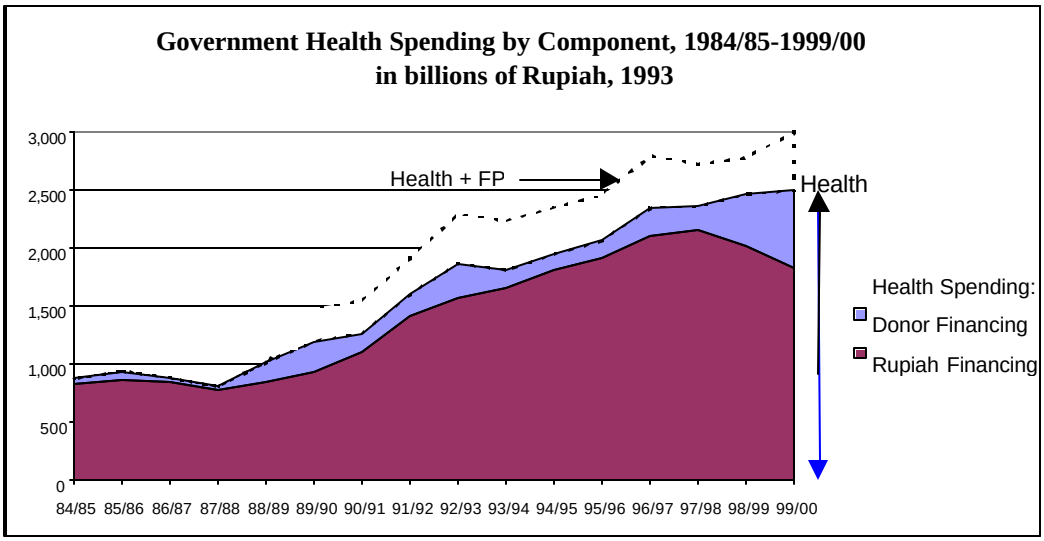
2.6 **Public sector performance--the funding picture**. Available data then point to what was a generally indifferent response, by the poor and the public overall, to the services provided through the expanded network of government-run facilities. Although there were and are high volume units, on the whole the public has never visited government health centers and hospitals in large numbers. But why haven't the Alma Ata-inspired, government-run services become the health care suppliers of choice? And what policy lessons can be gleaned from these results? Some explanations are developed in the following paragraphs, while implications for policy design within a decentralized system are explored further in Sections III and IV.

2.7 One often cited factor is low government spending, seen typically as handicapping efforts to upgrade publicly provided services. In other words, MOH could not obtain the domestic and international funding, on a sustained basis, needed to set up and operate the system as designed, with a corollary implication that many potential clients turned to alternative providers. In this regard, it is correct that Indonesia has for decades spent less on health than China and the neighboring South East Asian countries. For example, with per capita public and private spending of $7 each private spending of $7, Indonesia allocated roughly 1.5% of GDP (0.8 private and 0.7% public) to health in the early and mid 1990s, less than China (3.8%, public spending $9), Malaysia (3%, public spending $49), Thailand (5.3%,

public spending $27) and the Philippines (2.4%, public spending $10). Moreover, Indonesian public outlays and private spending were considerably lower in this period than expenditures in the adjacent South East Asian countries 15-25 years earlier when they recorded similar health outcomes, i.e., infant mortality rates (IMR) of roughly 50 deaths per thousand births (Lieberman, 1996).

2.8 Nevertheless, government health outlays increased substantially between the mid 1980s and the mid 1990s (Figure 2; Annex 2, Tables 1 and 2). Excluding family-planning-related outlays, real public spending per capita in 1996/7, the year preceding the crisis, was over twice the 1985/6 figure, and almost three times that in 1987/8, the low point in the mid 1980s economic downturn. Real per capita outlays rebounded quickly in the late 1980s and then grew at a 9.2% annual rate (8.6% including family planning program spending) during the 1989/90-1996/7 interval. Real per capita spending, which increased in bursts followed by years of modest advance, actually grew at an 11% rate if 1987/8 is used as the starting point.

Figure 2



Source: Ministrv of Finance

2.9 **Health financing at risk**. But increased outlays were not accompanied by reduced dependence on the current budget. This left the health sector susceptible to economic crises and other shocks. During the mid 1980s downturn, real per capita government health spending fell by 7.6% (1986/76) and 10.2% (1987/88). GOI was more successful in protecting overall government health spending during the crisis which started in 1997. Real per capita outlays in 1997/98 fell by 4.2% and then made a modest recovery, increasing by 0.8% in 1989/90 and 6.3% in 1999/2000 (Annex 2, Table 2). Further uncertainty is in store for health funding starting in January 2001 when spending responsibilities are to be devolved to districts and provinces.

2.10 The vulnerability of health financing in Indonesia has been due in part to the multiplicity of funding sources and channels (Annex 2, Table 3). Direct, central government outlays have dominated the funding picture. GOI has financed its extensive network of facilities and services through allocations under development, donor assistance and routine budget headings and grants to provinces and districts. Central level spending has accounted for roughly 80% of public outlays, with the rest derived from provincial and district level allocations. Health financing is also at risk because of the importance of cash payments by clients. Private outlays account for roughly two thirds of overall health spending, with an estimated 75% of this coming through cash payments at the time of service in public and private facilities, and the rest collected through prepaid arrangements.

2.11 Outlays on drugs are a sizable component of private health expenditures, with cash payments accounting for almost 80% of spending on pharmaceuticals. Real outlays on drugs in 1999 were 25% less than those in 1996, reflecting a 170% price increase in the September 1997-September 1998 interval. As mentioned, GOI succeeded in stabilizing prices of essential generic drugs, with real outlays falling by "only"15% in 1998 but then recovering in 1999, reaching a level 11% higher than 1996 spending. It was non-generic drugs which proved to be the most vulnerable component with real 1999 expenditures one third less than the 1997 figure (CREDES, 2000).

2.12 Of course, facility visits are often costly, even when charges for some components, e.g., generic drugs, are controlled. In 1998, average expenditures reported in Susenas for outpatient services ranged from roughly Rp 2,300 per health center and sub-center visit to Rp 6,300 and Rp 20,000 for consultations with private nurses and doctors respectively, and Rp 25,000 and Rp 42,000 for public and private hospital visits (Saadah, et. al., 2000). However the figures cited for health center and sub-center visits may exclude some or all of the additional fees collected informally in many facilities. For example, staff in two health centers serving periurban areas in Karo district in North Sumatra indicated that the official fee of Rp 1100 was "topped up" with extra payments of Rp. 7500-15,000 per patient per visit. Interviews with patients corroborated this finding, while staff and clients in three other facilities pointed to an average "willingness to pay" of Rp. 5000 per visit (Gani, 2000). These extra charges are, of course, a disincentive for the poor.

2.13 During the crisis, the largest rise in mean outpatient outlays (in constant prices) occurred at the hospital level, e.g., over 50% for public and almost 20% in private facilities compared to reductions in outlays for those visiting health centers, subcenters, and private providers. Of course, average inpatient outlays were much higher. Mean "hotel" fees for a bed in the Class III ward were between Rp 4,500 and Rp 8,000, but reached Rp 240,000 for Super VIP and Rp 66,000 for Class I care. User fees have been a significant source of operational funds for health centers, and in some districts became a key source of local government revenue.

2.14 Finally, insurance and related financing arrangements include private and parastatal-run schemes aimed at middle and higher income households; contributory programs run for civil servants and their families by the parastatal PT Askes and military retirees; private company financed health coverage for employees and usually their families; a social insurance facility, Jamsostek, for those formal sector workers whose employers have not set up company-specific health plans; and the small number of JPKM entities which began offering prepaid, managed-care like services in the mid 1990s. Prepaid premiums fall in the 300,000-600,000 rupiah per year range. User charges including service payments negotiated with insurance companies and JPKM plans typically make up only a small part--an estimated 10%--of GOI's health outlays.

2.15 **Donor financing**. GOI turned to increased donor assistance in health during each of the two crises since 1985 (Annex 2, Tables 1-2). This explains the counter-cyclical pattern in such funding. Donor aid accounted for roughly 6% of government health spending (excluding family planning program outlays) in the early and mid 1980s, rose to 21% in 1988/89 and 25% in1989/90 before slipping to 13% in

the early 1990s and roughly 7% in the mid 1990s. As noted, the sharp rise in the late 1980s responded to a mid-decade budget crisis. During 1997/98, the first year of the current crisis, the share of donor spending actually fell relative to 1996/97. The contribution of donor assistance then rose sharply, from 9% to 20% (from US$67 million to US$166 million) in 1998/99, and 27% (US$301 million) in 1999/2000.

2.16 **Resource misallocation**. Adding to the impact of low and erratic health spending is what appears to be inefficient use of funds within the public system. Indonesia spent an estimated Rp 1.48 trillion (US$164 million at an exchange rate of US$1= Rp 9,000) on its network of around 7,000 health centers in 1996/1997, or roughly Rp 206 million (US$23,000) per health center. Financing was made available through the national development budget and transfers from MOF covering salaries of civil servant staff. Such funds accounted for 85% of the resources reaching health centers, with the remainder coming from provincial and district development budgets. Outlays per health center varied by region and by type of facility, e.g., whether some inpatient services were available. Health center operational funds are allocated at the district level according to criteria such as total population numbers in the "catchment" area, the number of villages, posyandus, schools, and remote communities; and the number of subcenters and staff including village midwives.

2.17 There are 18 programs and activities carried out, at least nominally, in or through health centers (Annex 1). Two approaches were pursued in order to quantify the efficiency losses associated with pre-crisis service provision and utilization in an average health center. First, actual spending attributable to specified health center functions and programs was calculated. Four of the 18 programs, i.e., occupational health, sports, traditional medicine, and the well being of the aged, have very limited puskesmas activities and were ignored in this exercise. Profiles were developed of actual "outputs" for each activity, based on information on use of drugs, staff time and other inputs obtained in interviews with MOH technical staff. This approach yielded estimates of actual outlays for each activity in a typical health center (Annex 3, Table 1).

2.18 The exercise determined that outlays attributable to actual activities in an average health center amounted to Rp 165 million (US$18,300), or Rp 1.1 trillion (US$132 million) for the system overall. Compared to the estimates of 1996/1997 spending, the discrepancy was around Rp 41 million (US$4,700) per health center. What this method showed is that 25% of health center expenditures could not be attributed to identifiable activities. The exercise also indicated that unused staff time was the main source of the gap. Only about 40% of staff time could be accounted for using task and program-wise estimates. If those unused staff resources had been applied more fully to ongoing program activities, almost twice as much time could have been spent per patient, and/or more patients could have been seen, and/or more outreach activities conducted.

2.19 The second measure of system efficacy compared what was actually achieved using available funds with program activity levels needed to make a substantial impact on key health indicators. In this exercise, the standard health center program, but with its 18 activities implemented at "ideal" intensity as defined by technical staff, served as the comparator. This more demanding test reveals a substantial disparity, i.e. nearly five fold, between actual spending and levels needed to bring rapid health improvements. Estimates for several other high impact but lower cost scenarios were developed as well (Annex 3, Tables 2-4). Each of these would entail expenditures ranging from a 50% to a more than 400% increase over 1996/97 outlays.

2.20 Thus, the country's network of health centers and associated programs under performed in "normal" pre-crisis times in two senses, i.e., in using the inputs assigned to facilities and associated activities, and in the gap between what the system was providing and what would be needed to make significant health advances. The shortfall between actual activities and potential outputs, in the two senses just defined, was even larger during the crisis period.

2.21 A partial explanation. In short, Indonesia's government health system was subject to persistent underfinancing. And along with low budgetary commitments, government services were deprived of the funds tied up in underutilization of facilities and staff.[3] Meanwhile, erratic and unpredictable public funding levels had a further adverse impact on system performance. For example, the sharp fall in the operational budget in 1987/8 coincided with the crucial period when the public was testing the services being offered on an expanding basis in health centers. These initial and subsequent encounters with an inadequately resourced system may have shaped client perceptions for years to come, and explains why utilization rose only modestly during the 1990s when real per capita public spending increased.

2.22 The "missing" (including misallocated) resources needed by the health system could have been replaced in several ways. For example, money might have been diverted from other sectors to top up the operational funds so important for enabling puskesmas staff to visit local communities. Alternatively, MOH could have lobbied for greater access to multilateral and bilateral grants and loans. Lastly there was scope for reallocation within the resources assigned to MOH. In the face of what were seen as inadequate allocations, MOH could have considered adapting the program and lowering its sights at least during the near term. For instance, it could have taken on fewer than 18 programs and activities in each puskesmas. And instead of trying to apply a uniform standard, i.e., one health center with the same personnel, for every 30,000 people, across the country, it could have expanded coverage less rapidly and made sure that services performed well initially in poorer areas.

2.23 It is not known whether these options were reviewed, and if so, why they were rejected. MOH's position has always been that it responded to a commitment, endorsed at the highest political levels, to aim for extensive health care coverage for reasons of national integration and equity. To this end, MOH undertook to make a modicum of services available throughout what is a very large, and socially and epidemiologically diverse country. In other words, decision makers felt they could not offer fewer services in some areas or to some groups without violating an equity principle. MOH also underestimated the magnitude of the task of setting up an effective primary health care program. This would not have been surprising since most countries have encountered unanticipated HFA start-up problems. In cabinet meetings and other decision making opportunities, MOH may have presented the multi-tiered and staff intensive system it put into place in the 1980s as cheaper than the conventional approach which relied on "vertical," i.e., centrally run, single purpose public health campaigns, and hospitals. Health decision makers may then have been reluctant to ask for the additional funds needed, preferring instead to introduce improvements gradually while relying on various shortcuts and selected adjustments to ensure that services of some sort got to the public.

2.24 **Coping with less**. In any event, health decision makers had to make do with allocations well below what it estimated was needed. In this context, MOH took little notice of the informal fees often charged in health centers, sub-centers, and hospitals. Typically, such funds are spent to restock drug supplies and sometimes are divided among facility staff using agreed allocation rules. But MOH's main response to underfunding involved design and procedural adjustments which it expected to phase out once the budgetary picture improved. These measures, including ignoring user charges, have contributed in no small part to the country's indifferent experience with HFA. Moreover, these "compromises" have

[3] It was the low spending explanation not resource misallocation which was cited in planning documents from this period.

shaped provider incentives and behavior, as well as client perceptions and actions. Remedial policies or alternative approaches to service provision will need to take these influences into account.

2.25 The most important of these adjustments was a policy permitting civil servant doctors to supply services privately during duty hours. Allowing public employees to engage in income earning activities "on the side" has a long history in Indonesia. On the other hand, this decision could be seen as simply responding to reality. MOH recognized that government salaries were not sufficient for full time employment, and it would have been difficult to prevent public sector staff from engaging in private practice. In any event, by the early 1990s, an estimated 80% or more of publicly employed doctors, and high proportions of nurses and midwives, also worked privately on a part time basis (World Bank, 1994). Moreover, visits to these private care suppliers were not confined to middle and higher income households--surveys show consistently that private providers treat many poor patients, often adjusting their fees according to ability to pay.

2.26 The approach adopted to rewarding staff brought some benefits in the health sector. For one thing, MOH was able, due in effect to the resources it could generate in this fashion, to provide access to some modern curative and preventive health services even in the most remote and backward areas of the country. This was a remarkable achievement considering the scale and complexity of the task. In fact, the health benefits attributable to this approach are underestimated substantially by looking only at visits to public facilities. Service volume estimates also should include the significant amounts of care dispensed by government staff in their private practices, and HFA in Indonesia should be seen as an initiative which used public and private means to open new "markets" and make health care more widely available.

2.27 The impacts of MOH's compensation strategy then went beyond leveraging limited payroll allocations. The emergence of a geographically dispersed private health sector can be counted as a direct policy outcome--salary support (and implicit subsidies for use of buildings, electricity, and some "leakage" of drugs) in effect subsidized the placement of trained private staff, as civil servants or on time-bound contracts in locations, many quite remote, all over the country. Thanks to this "infant industry" type support, there is now a recognizable private medical sector in Indonesia with associated and distinctive policy issues.

2.28 But the consequences were not all constructive. MOH's compensation strategy created systematic and perverse incentives within government health centers and hospitals. Specifically, it was in the financial interest of health center staff to advise puskesmas patients who were able to pay fees to visit their private offices or premises. Various other attitudes and actions may also have been encouraged, in some settings and on some occasions, by the strong but conflicting incentives created by these distinctive approaches to remunerating health care providers. For instance, staff may have been tempted to use health center drugs when treating patients privately or even to handle such cases during official business hours or to advise those requiring care that they would face long delays in waiting for services on public account. At times, the right to see clients on private account may be interpreted by staff as a mandate to collect fees for referring public patients to private hospitals or laboratories or prescribing non-generic medicines supplied by pharmaceutical salesmen.

2.29 **Management compromises**. Health officials also turned to administrative measures to facilitate HFA implementation. And like the decision to allow staff to pursue private income earning opportunities, some seemingly unexceptionable policy steps brought significant and unanticipated outcomes. In this regard, decision makers were preoccupied with human resource constraints which were seen as possibly delaying efforts to broaden access to primary care and referral services. A specific concern was the limited training and experience of a health work force made up of newly recruited graduates and those assigned to malaria, leprosy, and other vertical programs who were converted suddenly into multi-purpose workers.

2.30 Policy makers' reservations probably went well beyond the particular technical skills which each worker had acquired. In fact, inadequate skills seems to have served as a shorthand expression or code not only for shortcomings in technical capacity but limitations in respect of how employees understood and approached their assignments and program goals and priorities overall. This broader concept of skills would also have included the inter-personal qualities and the level of intensity and commitment which staff brought to their jobs.

2.31 Above all, policy makers doubted the readiness of health staff generally to exercise independent judgement or make appropriate decisions in the health sphere. Authorities would have been aware, of course, that it was not unusual for health workers to find themselves in situations which encouraged the use of judgement. Geographic isolation and limited oversight from supervisors who had to monitor staff dispersed over broad areas despite constrained travel budgets were enough to guarantee some degree of worker autonomy. And several program design characteristics worked in effect to widen the scope of staff discretion. Thus, staff were often assigned informally to more than one of the 18 health center programs and activities, and usually were involved in several different components within one, e.g., EPI, of the broader program categories, may well have had the option of working on an out-reach or in-facility basis, and because of the above considerations, would have had to report to several supervisors. Each of these job characteristics would have brought some scope for choice and initiative by health workers. Furthermore, staff exercised judgement over the intensity and quality of their initial and any subsequent interactions with individual cases or patients.

2.32 To illustrate, the responsibilities assigned to health center-based midwives range from examining pregnant women and following up risky cases to training traditional birth attendants. These clearly cannot all be done simultaneously. The doctor-in-charge of the health center and district-level supervisory staff would have views as to the activities the bidan (midwife) should focus on. But even then, the midwife will make decisions concerning the activities and clients to emphasize. She must decide, for instance, how often to visit the puskesmas pembantu (health subcenters), and how much time to spend on routine home visits, follow-up of risky cases, or supervision and support of village level workers. Similarly, the bidan di desa is assigned numerous tasks, and inevitably, even when given instructions by district and health center-based staff, chooses between competing activities and/or "customers."

2.33 Skill levels and staff capacities overall were expected to improve as the products of strengthened and expanded training programs joined the health work force. But in the interim, MOH took strong and not easily reversed steps. Policy makers decided to rely (and still depend) on particular instruments and accountability principles to manage widely dispersed personnel, and to reduce deviations from standard practice. Specifically, health centers and associated subcenters and staff were directed to provide identical service packages throughout the country, following guidelines and handbooks describing standard procedures for different activities. Also, detailed norms were set as regards facility staffing, activity schedules, and work loads, and conscription and centrally controlled deployment of doctors and dentists were used to fill staff positions. Finally, supervision and assessment procedures were based mainly on seniority and compliance with guidelines not actual performance.

2.34 In this fashion, GOI sought to impose strong guidance and control mechanisms. The problem was seen as reducing scope for decision making rather than helping staff to make better decisions. This seemed to make sense given the low salaries and seemingly limited capacity of a work force hastily assembled to work in the facilities built in the 1980s and early 1990s. The intention was to ensure continuity in service delivery of predictable quality by specifying objectives, preparing for likely contingencies, and of course, limiting the choices available to government health staff if discretionary occasions arose.

2.35 **Predictable impacts**. Together these compensation and task assignment and guidance measures had a profound influence on the performance of the health labor force and the health delivery system itself. Indeed, these management adjustments were crucial features of Indonesia's interpretation of HFA. And the impacts of these steps were seen in the indifferent results registered and generally in the inability of the government-run health system to attract clients in large numbers on a sustained basis. As mentioned, the public system has never secured a sizable market share especially among the poor.

2.36 Micro-perspectives based on qualitative studies give a further sense of the consequences resulting from the way staff were paid and managed. Here, findings from interviews and field observation depict a passive and ineffective labor force, which seems disconnected from outcomes including the costs of their activities and distracted by the lure of private practice. In effect, an initially skeptical view of staff capacity on the part of policy makers became a self-fulfilling prophecy. A prescriptive management approach coupled with perverse incentives led to a system in which low patient loads, high unit costs, and questionable quality standards seemed to be acceptable. Moreover, the country's public sector-based approach was slow and inflexible in reacting to new challenges, such as the forest fires of 1997/98 or the economic crisis itself, and had problems dealing with complex problems like malnutrition, tuberculosis, reproductive risks and iodine deficiency.[4]

2.37 **A further sense of what was lost**. While not disagreeing with the above assessment, many MOH officials would attribute most problems to perennial budget shortfalls which have prevented remedial actions from being implemented on a large scale. Such a response, however, is not convincing. For one thing, this "gradual improvements" perspective underestimates, by several orders of magnitude, what is entailed in providing instructions to staff for every task and every eventuality. The major efforts made in this direction quickly ran into resource constraints--many handbooks and manuals remain to be prepared, while those which were drafted were not disseminated effectively. Nor were these documents helpful in many instances, i.e., how to choose between competing activities and how intensively to pursue individual tasks.

2.38 This approach then was a non-starter. But there is a more fundamental problem which is linked to the many opportunities which staff have to exercise judgement (see above). It is not only that the number of discretionary situations far exceeds capacity to prepare staff for these instances. It simply is not appropriate or desirable to try to micro-manage staff actions in this way. Indeed, the real benefits of a primary health care-based strategy lie in the opposite direction, i.e., capitalizing on the discretionary "space" of designated providers and empowering them to respond appropriately to local health needs. These benefits relate in part to the sort of health problems which stand out in most circumstances in Indonesia. The initial, relatively straightforward stage of the country's epidemiological transition is long past and the agenda now consists of the stubborn remnants or revivals, especially for the poor, of major diseases or health problems of poverty along with new challenges which depend on prevention efforts linked to behavioral change.

2.39 Addressing these challenges will require many inputs, but among these certainly are the thoughtful assessments and recommendations of providers who are expected to use their discretionary powers well. Appropriate staff judgement and behavior are critical not just in working out technically effective solutions but for sustaining receptivity and compliance on the part of clients. Accordingly, the competence as well as the orientation, motivation, and public persona of puskesmas staff are important since it is they who deal with actual and potential "customers." Health center staff are identified with the system in their clients' eyes by virtue of the incentives and signals they respond to and send out, the daily

[4] What looked like a sluggish public sector adjustment was likely the "dual" of a more vigorous private response with government providers "directing"patients to their own clinics.

routines and habits they develop, the interpretations of policies and instructions they arrive at, and finally, the decisions they make and the advice they tender.

2.40 **An illustration**. Making headway with the health problems of low income households will require smart, resourceful, and proactive providers. As mentioned, the poor are more vulnerable to infectious diseases, reproductive risks, environmental and certain behavioral threats, occupational hazards, and protein, calorie and micro-nutritient deficiencies, and more likely to experience disease-health problem interactions which can lower survival prospects and delay recovery. Moreover, the poor have less exposure to health messages because of their lower school enrollment and media exposure rates.

2.41 For these and related reasons, low income families are less likely to benefit from standard disease control, nutritional, and safe motherhood packages, and far more in need of customized diagnoses and advice. But poor people may perceive social barriers and economic hurdles and are typically less articulate and capable of explaining their health and related problems. These considerations may call for greater concentrations of government staff in poorer areas and for providers with the technical proficiency and discretionary authority to address the distinctive health circumstances and needs of low income individuals and families. And care suppliers should have the motivation and sensitivity needed to size up each patient's distinctive needs in depth and to work out appropriate solutions.

2.42 The poor also need some providers who can play a broader, essentially entrepreneurial role to engender local health improvements. Such opportunistic advisors and brokers would identify and implement ways, including creative interpretation of rules and conventions if necessary, of maximizing health benefits from existing programs and policies. The doctor-in-charge of a typical puskesmas provides a good place to begin. The doctor's overall task is to ensure that the 18 program areas are implemented as expected. As the designated "conductor" of the health center "band," i.e., the roughly 28 publicly paid staff assigned to each puskesmas, the doctor in principle must decide in effect on how to deploy available resources, i.e., staff as well as drugs, vehicles and operational funds, between in-clinic services and outreach activities all with the aim of implementing the standard 18 programs.

2.43 In this regard, the range of options a priori is quite large. Staff, i.e., doctors, dentists, nurses, midwives and other paramedics, can be used to intensify and enhance the quality of the services provided in the health center itself or in the network of attached subcenters. Alternatively, the puskesmas can serve as a "launching pad" for outreach activities in the surrounding area. This would involve assigning staff to routine or intensified posyandu and/or school health visits; training and supervision of voluntary workers; water and sanitation and other community development activities; helping village midwives to build a "market" and supporting them technically and symbolically; case finding and follow up of specially targeted diseases or health problems; and health promotion and education. In addition to tasks already mentioned, puskesmas doctors-in-charge can also use their time to assess staff skills and attitudes, and provide informal on-the-job coaching and advice on improving worker effectiveness.

2.44 Similarly, those responsible for health centers at the district level, i.e., the health officer (Dokabu) and staff, face a range of choices in respect of how they allocate their time and that of their team. They can remain in their kabupaten (district) offices, relying on section staff to interact with the health center teams. Or they and the district-level team can visit health centers and/or monitor outreach activities, relying on scheduled inspection rounds. Visits by the Dokabu and/or district team members could also focus on villages or areas with specific health-related problems, staff skills and work perspectives, or building community support and understanding for different health initiatives.

2.45 **Moving beyond HFA**. A micro level analysis has been used in this Section to account for the low utilization on a longstanding basis of government-run health services in Indonesia. Low visit and occupancy rates were attributed essentially to behavior by providers who were responding to monetary incentives and management guidelines and instructions within the "non-proactive" worldview which

developed within the health labor force. Indifferent service and informal fees within health centers and other facilities in turn prompted clients and potential beneficiaries to consider other alternatives, i.e., consulting private providers or self-treatment, when health problems arose.

2.46 In short, the Indonesian experience with HFA was ascribed to an interplay of provider and consumer level incentives, perceptions and expectations, and behavior. This perspective also points to ways of improving health system performance and outcomes, including specific roles providers need to play vis a vis the poor. What needs to be done to ensure that providers carry out such functions and responsibilities effectively? Clearly, the extensive preservice and in-service training initiatives and related manuals and handbooks have not prepared staff for such responsibilities. But the previous Section did identify one element which was available, i.e., worker time and especially their discretionary powers which are underutilized. As discussed, health staff have plenty of discretionary opportunities by virtue of the wide functions and activities assigned to them, coupled with the impossibility of carrying these out as specified and the superficiality of facility monitoring and assessment mechanisms. At present, much of this time is either used inefficiently, e.g., spending excessive tie on some tasks, or on private matters. This reflects not only the weakness of supervision arrangements, but a reluctance thus far to acknowledge that providers have discretionary resources and need to be encouraged to use these effectively.

2.47 This can and should change. Staff autonomy and the exercise of judgement ought to be recognized as resources which need to be used effectively. And health personnel at all levels should receive examples and guidance on using discretionary powers, bolstered by the incentives and remuneration practices, supervision, and peer pressures required to sustain appropriate provider behavior. Clearly these are not marginal changes--redesigning compensation arrangements and other elements is a medium term challenge. But a start can be made by calling attention to the effective use of judgement by staff. Many best practice examples can be cited, including ingenious interpretation or even bending of rules to improve outcomes (Box 1). In this regard, the system in Malaysia's state of Sarawak provides interesting contrasts with the Indonesian approach (Box 2). Creative solutions, which usually went unnoticed or may have brought reprimands in the past, should be captured, identified as appropriate behavior, and systematically recycled via training sessions, handbooks, task instructions, and guidelines. Supervision approaches need to change as well, while staff need to be rewarded for effective use of discretionary opportunities.

2.48 **Demand-side mechanisms**. Salary increases, training and other supply-side instruments may not be enough to promote shrewd and responsive provider decisions and behavior. Different demand-side factors need to be activated and institutionalized as well. Providers need to be exposed to clients' questions and concerns and reminded continuously of their obligations to the recipients of services and their families However, many customers, especially poor clients, lack adequate information, have little or no cash to pay user fees and informal charges, are subjects to peer and social status pressures, and because of these factors have limited bargaining power, in effect, in dealing with providers. Sophisticated, continuing communication efforts are needed to inform poor beneficiaries of current program goals and details, standards, means of registering complaints, and penalties for poor performance, and to seek regular feedback on what clients think and feel about services and what they prefer.

2.49 In this respect, the safeguarding mechanisms introduced in JPS-BK broke new ground in regard to consumer complaints and independent monitoring. But more needs to be done including developing valid and understandable quality indicators, facility-specific quality report cards, and use of surveys and focus groups to obtain timely feedback. And interaction with poor beneficiaries by way of surveys and receipt of complaints needs to be complemented with other means of eliciting and expressing demand. Expanded use of cash grants/vouchers by poor households seems warranted in light of the favorable experience of the crisis-period Scholarships and Grants Program (SGP) and other smaller initiatives. Alternatively or in a complementary fashion, greater command over program budgets should be given to

local community organizations. This could be the eventual outcome of the decentralization steps now underway.

2.50 These household and community level channels need to be informed and energized by advocacy groups or arrangements which work on behalf of the poor. Here there are many lessons from other countries worth noting and even piloting: For example, the New Zealand government is testing the use of private sector brokers who are contracted to help poor clients find and use the services they need (Salmond, 2000). A similar approach has been tried in several states in the USA except that the agents working on behalf of the poor are state government employees. Another approach which has been important in the USA context uses the political process to secure better services. The examples here include the patients' rights, consumers', women's health, and disability rights movements. Each of these organized causes has questioned current health arrangements from different perspectives, and proposed and lobbied for alternatives including budgetary reallocations, and improved quality assurance and delivery arrangements (Rodwin, 1996).

Box 1: How I Ran My Puskesmas

I was assigned to Puskesmas Tanjung Aru, East Kalimantan, 5 hours from the district capital by boat through river and sea. It was staffed by 2 nurses, 1 midwife, 1 immunization officer, and 1 sanitation overseer. Unexpected problems confronted me on arrival. The 52 year old senior nurse tried to persuade the other staff that I was unable to run the health center, and that I would rigidly control their day-to-day activities. He might have been correct. I was not at all confident about my management ability. Later, I learned he was worried my presence might disturb his private practice, which he had developed since the last doctor left 6 years before. Nobody knew about the budget except him. The health-center's workload and achievements were baffling. There were only 3 to 5 patients a day. The latest data, aside from the registers, were from 2 years before. Guidelines could not be found. They were taken by the last doctor when he left. Four months later we received photocopies of the guidelines from the District Health Office (DHO). They were not too helpful for managerial matters. There was no money left for operational tasks even though the year had 3 months to go. The doctor's house was dirty and unfurnished. The previous doctor took the furniture when he left. A request for replacement was sent to the DHO, but 6 years had passed with no response. Staff suggested I take a spare examination bed from the health center. I did this because I could not afford to buy a bed. The staff lacked initiative. No one came to work before 10 AM, and everyone left before 1 PM. They said that there was little to do.

What was my role? My acceptance by staff was a priority if I was to successfully manage this health center. My solution was to let the senior nurse continue his private practice providing he remained in the health center during office hours, donated 2.5% of his net practice income to the immunization officer and the sanitation overseer, and discussed cases with me. I would be his free medical consultant. The next step was enhancing commitment by conducting daily informal staff meetings from 12 PM to 1 PM, exploring our tasks, i.e., what we liked and didn't like. After a week, all agreed on the *team oath of conduct* focusing on working hours, team work, and action plans. Everyone, including me, signed the commitment. We framed and hung them on everyone's wall. By the second month, no one looked jobless during office hours. The commitment "exercise" had led to higher staff motivation and initiative. I worked to increase my capacity as a manager, through reading and discussion with colleagues. I passed on what I learned to my staff, for whom I became a mentor and facilitator.

We were over burdened. We had to achieve unreasonable targets with few resources. Luckily I became friends with the Camat (chief of the sub-district) and learned from him about priority setting. And *I decided that we would not be good in everything, but we had to be the best in at least one or two programs* to attract attention. At a staff meeting, we decided to prioritize recording & reporting, and MCH. We also provided outpatient care, *immunization, health education, and school health.* Together, the Camat, the PKK and I invented various ways to improve program implementation. Six months later, almost everyone in the sub-district was aware of immunization; after a year our facility was honored as the third best puskesmas (of 19) for immunization, and the best for management. Since we did not have enough resources for a complete school program, we concentrated on 2 primary and 1 junior high schools, which became models.

Community participation. The pre-service briefing told me that the kaders would be helpful. But the number of active kaders had dropped 40% in 2 years. The kaders were bored and got nothing from their activities except some health knowledge and a little bit of social status. Discussion with staff, Camat and PKK committee members led us to decide that Posyandu schedules were to be matched with village schedules, and should include non health related activities, e.g., handicrafts, and cooking, involving the PKK intensively. All kaders including TBAs could obtain free service in the health center. Although this policy was against the District regulation, with support from the Camat, the district authority adopted it. To be known by the community, I tried to accompany the Camat on his village visits and introduced myself as his assistant for health which he enjoyed. I kept him informed of any health programs and problems, and as the result he always raised health issues during community meetings. Health activities were never absent from his development proposals to the District government.

Staff categories and competence. We felt that 6 staff were enough for our 6 priority programs, as long as we did fewer outreach activities. I would have exchanged the sanitation worker for a midwife since his functions could be delivered by almost anyone. And I would have liked a cleaning attendant. When 2 Pekarya Kesehatans (auxiliary nurse) unexpectedly arrived with assignment letters in hand, their accommodation was an immediate problem. The Dokabu provided no funds, but the staff agreed to let the new people occupy a room in the health center, as long as they kept the building clean. I ignored the letters and assigned them to assist with immunization, and handle recording and reporting. I was also dissatisfied with my staff's competence. They always treated diarrhea with antibiotics, while the guidelines indicated ORS. After many discussions, it was apparent that limited competence was due not only to training and supervision flaws, but poor incentives and a lack of clear goals. - A. Sasmito

Box 2: Health for All in Adjacent Provinces in Two Countries

In March 1999, a team which included Indonesian and Malaysian experts and an expatriate medical anthropologist visited health facilities and assessed service delivery in Sarawak (Malaysia) and the adjacent West Kalimantan (Kalbar) province of Indonesia, which share some language, ethnicity and religious characteristics. Indonesia and Malaysia are committed to the Health for All vision. However, discussions with staff, patients, community leaders and others, revealed differences in the approach taken to implement the approach. These differences probably account for much of the strikingly different results observed in these directly adjacent provinces. For example, the estimated IMR in Sarawak, 9 deaths per thousand live births, is roughly one fifth of the rate thought to prevail in Kalbar. After a month in the field, the team's observations include:

Facilities. In Sarawak, clinics are spacious and clean, and provide a healthy environment in a well-maintained setting. Local attendants are hired to maintain each facility. Every clinic has a delivery room. Standards are higher than in Indonesia (clean water supply, better latrines, and furniture). In Kalbar, the team encountered contrasts from filthy unused rooms with equipment in disrepair, and patients who required referral still present, to a pristine clinic with healing herb garden, and an excellent associated Polindes and Posyandu, and every area clean and functioning, happy with services, and staff whose only complaint was salary levels.

Uniformity vs Innovation. Condition and services of the same level in Sarawak are standardized and predictable regardless of where facilities are located. Only three staff are posted in each rural clinic, with consistency of effort and skill maintained. The health care provided may not stray from that guaranteed by the system. The Medical Assistant (MA) may follow-up a complex case only after the doctor receiving the referral has established the treatment regimen. However, the State Health Department (SHD) encourages personnel to be innovative. A prestigious award goes every year to staff who develop something new.

Program activities. Unlike the case in Indonesia, Sarawak's clinic provide only outpatient and MCH services. Health education is integrated into every activity. Outreach activities are done by Village Health Teams and the Flying Doctor Service, each based in the Divisional Health Office. The only outreach handled by clinics is to update the village health survey every two years. This census identifies villages with low health status, a key step in Sarawak's way of decentralizing priority setting to clinic level.

Quality issues. Quality-related words and pictures appear on office walls in facilities throughout Sarawak. Almost everyone, from the Director in Kuching to MAs at Klinik Desa talk about quality very fluently. Quality is their culture, and influences the way they think and deliver services. Starting with top level managers, everyone in the system is trained on quality, unlike in Indonesia, which has started at the grass roots without preparing managers. SHD's vision, mission, and client's charter were displayed to staff and the public. Every service and support unit must develop and exhibit its own client's charter.

Competence of staff. The MAs, who perform the same tasks as nurses in Indonesia's Puskesmas, were trained to diagnose and treat certain diseases. Their training, senior high school plus 3 years of a nursing school is equivalent to Akademi Perawat in Indonesia. There is also 'induction' training on Quality Assurance and Corporate Culture of SHD for new staff before they are deployed. They receive briefs from 'programs' about field activities, and the obstacles they might encounter. There are yearly motivational and corporate culture courses as well. SHD also provides staff with technical guidelines. All staff concerned use the guideline, unlike Kalbar, where most staff said that they had never read or referred to the guidelines. Sarawak's technical and administrative guidelines are readable, clear, well structured, and comprehensive. Furthermore, implementation of the guidelines is closely monitored through quarterly quality control checks. Staff performance is linked to salary increments, and is assessed yearly.

Team Work and Management. Team-work is demonstrated at all level. Two key-elements observed are dedication to quality and customer value, and an environment of cooperation with rewards for the success of team rather than individuals. An informal and professional atmosphere exist with staff throughout the state having met each other or even worked together. In Kalbar, there is poor interpersonal and inter organizational communication, limited community acceptance of services, and limited effort and imagination in training of personnel. - L. Cargill, A. Sasmito, F. Zainal Ehsan, S.H. Nainggolan.

2.51 The private sector. As discussed the health system inspired by HFA also includes a significant de facto role for private providers This component, which resulted in large part from the compensation strategy adopted by MOH, sank local roots. By the late 1980s a small private sector with full time staff

working in clinics and hospitals had appeared. The pre-crisis 1990s brought rapid growth of private health services. Investment in private hospitals and clinics expanded rapidly, and probably outstripped spending on government facilities. Between 1989 and 1998, the number of private hospitals increased from 325 to 510, the number of private hospital beds rose by 4% yearly. As capacity rose, utilization increased as well--the number of patient days in private hospitals grew by 5% a year between 1989 and 1997. Private hospitals accounted for 42% of patient bed days in general hospitals, and the majority of beds in Jakarta and several other major cities. The economic crisis was damaging for private pharmaceutical manufacturers, wholesalers and retailers, and to a lesser extent for private hospitals and clinics. But apart from the private drug industry where the full impact is not yet clear, the crisis seems to have been more a pause than a sharp reversal for private providers after years of expansion.

2.52 The private health sector also benefited from the continuing outflow of doctors and other health workers from training institutions. The number of graduating doctors rose from 460 a year in the 1960s to roughly 2,000 a year in the 1990s. A crucial change was the decision in 1992 requiring doctors and dentists to enter national service for at most three years on a contractual basis instead of becoming career civil servants. By January 1999, 12 PTT cohorts, varying from 591 to 924 doctors and numbering almost 9,200 cumulatively, had completed their service obligations. Roughly a quarter of these doctors were offered permanent civil service jobs, while the remaining 6,700 or so, were employed or looking for work in the private health sector, or had made other occupational choices. Another 2353 completed their PTT contracts in 1999, with another 2411 due to follow in 2000. Because of spending constraints and other aspects of the country's decentralization initiative, it is likely that these and other young doctors will be looking for jobs outside government service. A similar trend applies to dentists. So in less than a decade, Indonesia's physician (and dentist) work force has changed from a publicly employed occupational group with important but still part-time, own account activities, to one which is becoming predominantly self supporting through individual or group practice or jobs in private hospitals, clinics and so forth.

2.53 The growth of private health services was facilitated as well by expanding private health insurance coverage. The 1992 Law (number 2) on health allowed general insurance companies to operate in the health market. By 1997, 49 companies were selling health insurance, and an estimated 1.6 million persons were covered by commercial indemnity health policies in 1998, up from 450,000 in 1993. Also in 1993, PT Askes, the parastatal company which insures civil servants and their families, began marketing health insurance to government and privately owned companies.

2.54 Mechanisms are in place to license newly trained staff and to certify that specialist skills have been attained. Those intending to become specialists study at a designated teaching hospital using a curriculum prepared by the Consortium of Health Sciences, and must then pass an examination set by a national board. Based on job openings in public hospitals and personal preferences, newly trained specialists are assigned to a province by the Central MOH, and to a district-level vacancy by the provincial health office. The Head of the Kanwil is responsible for licensing new specialists who want to practice privately, based on recommendations from IDI.

2.55 GOI also uses licensing at entry and other regulatory tools to ensure that facility standards are met. Licensing of new hospitals and clinics has been the responsibility of local government officials and the Kanwil who provide temporary and then "operational" licenses for a two year period. Applicants then assemble the material required to obtain a permanent license from the Directorate General of Medical Services in the Central MOH. MOH also initiated a program to accredit existing hospitals. Facilities are being assessed in stages in this slow moving process and according to different service dimensions.

2.56 Existing legislation gives MOF the role of licensing health insurance providers, while MOH is responsible for vetting JPKM proposals. The process involves review of specified documents and site visits and interviews with key staff. For JPKM applicants, the needed documentation includes business permits, tax registration numbers, bank statements, a feasibility study, proposed benefit plans, and

preliminary agreements with a provider network. GOI is also tasked with protecting the safety, quality, and efficacy of drugs, medical devices and other products consumed by the public. Quality standards are to be upheld through inspection of manufacturing and distribution facilities, sampling of products, laboratory testing, and investigation of counterfeit products.

2.57 Despite their availability, little use has been made of licensing and other regulatory tools, with limited funds allocated over the years for review and enforcement of facility, personnel, and pharmaceutical-related requirements. Meanwhile, relying on professional associations, e.g., specialists' associations, to advise on the qualifications of candidates may conflict with the public interest. Furthermore, certification and licensing at entry cannot ensure appropriate work practices, and it seems wasteful for MOH to operate separate licensing and accreditation procedures. And in light of complaints from enrollees, much stronger supervision appears to be needed as regards Jamsostek and Askes, the private and "voluntary" parastatal-run health insurance schemes, and the embryonic JPKM entities which entered the market in the 1990s.

III. POLICY RESPONSES BEFORE AND DURING THE CRISIS

3.1 **Pre-crisis initiatives**. Policy makers were aware of health system performance problems well before the fall-out due to economic crisis. This is seen in the candid assessment of health challenges included in the Sixth Development Plan (Repelita VI, 1994/5-1999/2000). Meanwhile, several policy adjustments were introduced during the early and mid 1990s. These included hiring doctors and a new cadre of village midwives on fixed term contracts (the PTT scheme); piloting health cards (Kartu Sehat) for the poor; government investment in water and sanitation facilities in low income rural communities; some decentralization of budgeting and spending responsibilities; testing quality assurance mechanisms; efforts to improve MOH's health information system; and increasing the number of autonomous public hospitals. As mentioned, public spending on health rose in real, per capita terms during this period.

3.2 This Section examines these pre-crisis policy departures as well as several crisis-period initiatives in terms of the approach suggested in Section II, i.e., impacts on the provider-client equation. In this regard, little was accomplished in the pre-crisis period even though several initiatives embodied promising policy content. For instance, the Kartu Sehat, which is aimed at exempting low income households from puskesmas-levied user fees, combined significant potential benefits for the poor together with demand-side pressures and incentives. However, this measure was not effectively publicized and may not have been introduced in some areas. Because of the limited reimbursement provided, health centers had little incentive to distribute or honor these cards, while the households which received cards had to bear the costs of getting to health facilities.

3.3 Other measures also yielded results far below potential impact. Increased resources were allocated to streamline existing facility reporting arrangements, and to add new management information options. But the system remains dysfunctional and has hardly been heard from during the crisis. The number of hospitals designated as swadana, i.e., autonomous, increased from five in 1992 to 61 in 1997. But despite the "autonomous" label, public investment in these hospitals has continued, sparing these facilities from encountering and transmitting market pressures and making it more difficult for private hospitals to remain viable. Thus, the swadana approach did not yield much as regards coherent accountability principles.

3.4 Meanwhile, the PTT scheme sustained a flow of doctors and later village midwives to remote health centers. But one of the original justifications for this approach, i.e., encouraging doctors to remain

in full time private practice in the localities where they were assigned as government doctors, was lost from view.

3.5 Quality assurance (QA) provides another example of a promising approach not accompanied by the other measures needed to yield strong and sustainable results. A QA approach being tested in a number of provinces works through phased activities. e.g., establishing care standards, using peer review to assess compliance, and subsequent reassessments (M. Bernhart, 1998 a and b). This facility-level intervention has been effective in altering provider behaviour (Box 3). But unlike the Sarawak example, it has not been integrated into a creed, and statement of principles and responsibilities in which QA is a key promise to the public and mechanism (Box 2). Nor have

Box 3: Quality Assurance

After a twenty year period of improving access to health services, the Indonesian government turned in the mid 1990s to ways of improving health service quality. Provinces like East Java, East and West Kalimantan, NTB, and West Sumatra, with support from the Bank-funded Fourth Health Project (HPIV), are testing ways of raising quality of basic health services through interventions to change work processes and improve the skills and behavior of health providers.

QA program seeks to improve technical competence, client satisfaction, efficiency, coverage and access, through: (i) compliance with protocols and check-lists; (ii) in service training; (iii) supervision; (iv) team work; (v) problem solving techniques; and (vi) patient information dissemination. The program is an evolutionary one, beginning with frontline health staff learning to analyze and resolve simple problems of non-compliance with clinical standards and progressing to more complex issues pertaining to priority-setting and health outcome problems. Four checklists were developed initially covering ante natal care, acute respiratory infection, vaccination, and diarrhea. Checklists for child and maternal nutrition, malaria, dengue, tuberculosis, and cataracts and eye refraction were added later.

The QA program started in 1994 with 10 health centers in East Java and NTB Provinces and rapidly expanded within all five HPIV provinces. By 1999 end, 1,558 health centers in 72 districts were implementing the program and 933 has reached the final "team-based" phase, in which complex quality issues are addressed. Compliance has steadily improved—the average compliance rate was 83% during 1998/99 as compared to an average rate at the project start of 62%.

The QA program impact is highly beneficial for patients and staff. Patients are better diagnosed and treated. QA-trained health staff are reassured in their daily practice by complying with checklists and standards. Training covers trainers and staff in province, district, and in-facility sessions, and through distance learning. A follow-up project (HPV) is introducing the QA program in three other provinces, integrating the concept with a program of competency based pre-service training, and expanding the program to include the district hospital and new categories of service providers.

Like all behavioral change programs, QA is difficult to supervise. The next steps to be undertaken by MOH are to improve evaluation and link QA with accreditation to certify health facilities which implement the QA program successfully. QA programs depend on effective and timely supervision. To strengthen supervision, HPIV is monitoring patient attendance and satisfaction by measuring the four indicators of quality, i.e., compliance with best practices and standards, and patient assessments, knowledge and continuation rates. Measuring these indicators periodically would provide a broad picture of the quality of service within a facility. – V. Turbat

ongoing QA efforts been linked to broader strategies which bring health education, worker and consumer incentives, performance assessment mechanisms and other elements into play simultaneously to get high quality services to clients.

3.6 Missed chances. In addition, there were other policy matters which got too little attention in the 1990s. The posyandu movement was drawn into the formal service delivery system as its lowest level outpost, losing its intended role as a potentially powerful demand-side vehicle for community mobilization. No new ground was broken in the health education arena as MOH continued to rely on ineffective vertical interventions using broad-gauged, one-off and one-way messages. And as discussed above, much more could have been accomplished as regards GOI's regulatory responsibilities, including

oversight functions as regards private service delivery, the quality and use of pharmaceuticals, and private and parastatal insurance companies.5

3.7 Another missed opportunity related to strengthening supervisory control over Askes and Jamsostek, and other health insurance scheme (Institute for Health System Development, 1999). Established under Law number 3, 1992, Jamsostek was intended to provide some health coverage for low income formal sector workers. Enrolment in the core program, which consists of social security benefits as well, was mandatory, though companies could (and did) opt out if they could demonstrate they provided at least equivalent health coverage. So far only two million or so formal sector employees have been signed up. Closer regulatory oversight appears to be needed in view of observations often made about Jamsostek: a lack of clear standards to assess proposals from companies to opt out of mandatory coverage; limited technical expertise as regards health insurance, demonstrated in a failure thus far to implement capitation arrangements with hospitals; a tendency to delay or "forget" to make payments to providers which has repercussions on the quality of services provided to enrollees; exclusion of retirees from health benefits; limited attention to benefits on the part of healthy workers, who do not contribute to the scheme, until they need health care; and reliance on inconveniently located providers with badly timed service sessions who must be consulted to for referrals to specialists or hospital services.

3.8 Robust oversight was lacking as well for Askes, the mandatory health care scheme for civil servants (including government and military retirees), their spouses and dependants. Under Askes, employees pay the entire premium themselves via a 2% monthly gross salary deduction (plus further contributions for other family members), with a basic service package provided through government-run clinics and hospitals. Concerns often voiced about Askes include: a requirement that members go to government facilities before receiving specialist or inpatient treatment; the low fees, accounting for less than half of treatment costs for most illnesses, that Askes, according to Law 2, can set for care; and the scheme's reputation for delayed reimbursements to providers and pharmacists. Law 2, 1992 also allowed Askes to provide health coverage to private and government-owned companies. This program, with over 500,000 members, also needs more regulatory oversight—private health insurance companies contend that this voluntary program is benefiting unfairly from lower management and operations costs because it shares facilities and overhead costs with the Askes civil servants scheme.

3.9 **Crisis responses**. Compared to the precrisis 1990s, the period since late 1997 has seen more active policy development with new and revised measures being pursued. One important intervention has been the health component, JPS-BK, of GOI's emergency Social Safety Net (SSN) program. Starting in 1998, this initiative financed various reproductive and child health services, supplementary feeding for young children and pregnant and post-partum women, other basic health services, and outpatient and inpatient care for poor patients referred to hospitals. During the second year of implementation, some JPS-BK funds were directed to communicable disease control and strengthening of posyandu-based services. Support was also provided for food and nutrition surveillance, staff and kader training, and specified pro-poor activities of pra-Bapels, forerunners of the district level bodies expected to play a key role in JPKM (see below). Another feature of JPS-BK was its use of postal accounts to channel funds to health centers and village midwives.6 Finally, central, district, sub-district, and village teams were

[5] For instance, stronger policies and enforcement are needed as regards distribution of sub-standard medication and growing resistance to certain antibiotics and other drugs.

[6] The initial JPS-BK package consisted of:

- Rp 10,000 annually to each health center to cover basic health services for every poor family in its area of responsibility;
- Funds for maternal health services covering 4 antenatal visits at Rp 8000/visit; 3 post partum visits at the same rate; normal and high risk deliveries at Rp 90,000/child; and transport for high risk pregnant women at Rp 16,000 for two people;

involved in decisions over important management and operational matters—these "coordination" units opened the way to wider discussion, within GOI at different levels and within communities, of health program directions. Also part of the management of JPS-BK is a client complaints and grievance resolution process. This is one element in a package of safeguarding measures which includes oversight by NGOs or other independent bodies and public information campaigns.

3.10 JPS-BK has been monitored on the basis of routine service statistics, movement of funds through postal accounts and conventional channels, oversight by line supervisors, scheduled Susenas rounds, and surveys and site visits organized by an independent team working with a coalition of NGOs, universities, and media participants. Unfortunately, this eclectic approach has not provided timely and accurate information on program progress and effectiveness by region and nationally. In fact, there is no broad understanding of what base line data to use, which events and activities to include as program benefits, and what comprise the costs of JPS-BK. And because of the lack of consensus on performance and impact, and the program's unusual and complex management arrangements, JPS-BK remains a poorly understood and still controversial initiative.

3.11 Actually, JPS-BK started on the wrong foot--the program took longer to become operational than the better known education component of SSN and then kept encountering implementation hurdles. And concerns have continued to be heard, especially from province and district level health staff and some NGOs. These have centered on eligibility criteria and accountability checks relating to funds transferred through postal accounts; delays in funds received through conventional channels; an unfavorable public image in part due to inadequate dissemination of information on the program to intended beneficiaries, opinion leaders, and other constituencies; overly rigid guidelines; weak coordination between government units; cumbersome referral and reimbursement procedures for patients sent to hospitals; and weaknesses in targeting recipient of food supplements. Local health officials have also drawn attention to the inequities inherent in providing grants of identical amounts throughout the country. For example, the standard puskesmas allocation of Rp 10,000 per family per year was insensitive to variations in family size, disease prevalence, unit costs of delivering services, and visit rates. Lastly, health officials have been highly critical of the lack of performance findings which has made it difficult to develop remedial steps.

3.12 But what about actual program outputs and outcomes? As noted, data limitations have made it difficult to arrive at balanced assessments of JPS-BK's impacts. For example, province-level indicators, e.g., for West and North Sumatra, relating to facility visits and program coverage [immunization of pregnant women and young children, and distribution of vitamin A capsules] do not reveal a distinct JPS-BK effect when 1998/99 and 1999/2000 figures are compared with pre-crisis coverage data. Program performance looks stronger, however, when the first crisis year, 1997/98, is used as the baseline for comparison.

3.13 Program consequences also seem more substantial when reference is made to postal account disbursements and information from surveys and field visits. For example, the Central Independent Monitoring Unit found that in July 2000, in the 5 provinces being followed, 89% of poor families had received Kartu Sehat (with selection of ineligible families occurring in 10% or less of all cases), and over 70% of pregnant women in such households had received ante-natal care and assistance during delivery

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- Funds for supplementary feeding at Rp 180,000 per child aged 6-12 months, Rp 90,000 per child aged 12-24 months; and Rp 90,000 per malnourished pregnant woman; and
- Rp 10,000 to be transferred annually to district level pra-Bapels, precursors of the funds-collecting, holding and purchasing entities which play a key role in health financing efforts envisaged via JPKM (see next section). Of this allocation, the pra-Bapel is to keep Rp 800 per family for administrative costs, and to use the remaining Rp 9,200 per poor household to reimburse health centers and through them village midwives and others for specific services, defined in contracts for specified periods.

from responsible health staff. Over 15 % of poor families in the vicinity of health centers reported visiting a facility during the previous month. It was also reported that village midwives had provided supplementary food to roughly 50-75% of targeted women and children. These results are generally in line with information obtained in field interviews with different program stakeholders. Finally, these findings are consistent with the increase in facility utilization reported in the 1999 Susenas. As noted in Section I, visit rates fell sharply in 1998. But probably assisted by JPS-BK, client contacts recovered somewhat during 1999 (Figure 1, Table 1).

3.14 Province, district, and facility visits have highlighted different impacts and mechanisms associated with JPS-BK. First, there was evidently a substantial "program" effect associated with sizable disbursements in 1998/99 after spending was interrupted with the onset of the crisis. This effect is seen in the case of North Sumatra. JPS-BK accounted for 12% of overall health outlays in that province in 1998/99 and even higher proportions of puskesmas-level and within that operational, i.e., non-salary, expenditures. In fact, JPS-BK seems to have brought an infusion of cash resources and revived not just staff morale but a health system which had been operating under informal but severe rationing starting in the second quarter of 1997/98 due to drug and operational funds shortages. The relevant baseline periods for measuring the JPS-BK program effect would seem to be the initial 6-12 months of the crisis when funds were very scarce and prices soaring, as well as 1996/97 and the first quarter (still pre-crisis) of 1997/98.

3.15 Facility visits and various anecdotal accounts have highlighted a second set of consequences linked to JPS-BK and the mechanisms through which such "allocation" effects have operated. What is referred to here are shifts in spending from hospital to primary level services, and within health center operations from facility-based to outreach activities. In this regard, JPS-BK introduced incentives and accountability arrangements which seem to have enhanced demand and community oversight as well as provider responsiveness. Demand for services also seems to have been bolstered by procedures pertaining to obtaining a Kartu Sehat. Before the crisis, it was the village or neighborhood head who decided which families would receive this document. Under JPS-BK, the task of selecting beneficiaries has been handled by local teams who must operate within program guidelines but still have substantial discretion in defining eligibility criteria. The recommendations by the local team have to be endorsed by both the village head and the puskesmas chief. And fee waivers for puskesmas and referral services have made health center and hospital care more affordable for the poor, while supplementary feeding for children under age two and pregnant women has increased posyandu attendance.

3.16 Providers seem to have responded to different JPS-BK impulses. Under this scheme, public hospitals have been admitting referred Kartu Sehat holders and others in part because they get reimbursed eventually for such cases and can get required drugs and other supplies. At the village level, the bidan di desa was always supposed to waive fees when treating poor women, but may have done this only on an exceptional basis because of the lack of robust reimbursement arrangement. Under JPS-BK, village midwives are paid for assisting deliveries by poor women and to cover drugs and transport costs. Field impressions suggest that this has increased the number of clients who turn to these midwives; this has enhanced their status in the community. Finally, the requirement that JPS-BK funds for basic health services and food supplementation be deposited in a banking account and related procedures in respect of withdrawing, allocating, and reporting on the use of funds seems to have brought greater teamwork and transparency to health center operations (Magrath, 2000).

3.17 **What next for JPS-BK?** What is noteworthy about this policy initiative is the improvement, albeit still modest, seen in the provider-client balance, referred to in Section II. Altered funds channeling and reimbursement procedures seem to have begun, during a period of falling private incomes, to redirect provider incentives towards care of patients on public account, while embryonic

local selection and oversight arrangements may already be strengthening provider accountability and enhancing program credibility. JPS-BK has brought the resources and enough operational discretion and flexibility for positive facility level responses to occur. Indeed, JPS-BK has opened the door to more significant community level inputs and oversight, and in this way anticipates a very different, decentralized, accountability-enriched approach.

3.18 These developments need to be extended. But this will require attention to information deficiencies and other program weaknesses. JPS-BK is still encumbered with more than enough guidelines/instructions to intimidate cautious bureaucrats and passive staff. In contrast to its incentives and accountability improvements, the program still includes traditional administrative tools and guidelines, i.e., the same management compromises which have created an unpopular and underutilized publicly run service delivery system. Similarly, the approach being taken to resuscitating the posyandu relies on traditional instruments, e.g., directives on the functions and composition of village-level motivational and technical teams, guidelines on "reorientation" of kaders and others, and decrees delineating key responsibilities within villages (UNICEF, 1999).

3.19 Looking ahead, these various aspects of JPS-BK need to be evaluated further with a view to extracting useful future policy designs. On this point, MOH staff based in Jakarta and at the province level do not currently have strong incentives, opportunities, or mandates to think through possible improvements and reforms. In this setting, the best outcome would be to give provinces and districts the responsibility for adapting JPS-BK to their own needs and goals. For example, local authorities are best placed to work out how to bring NGOs into JPS-BK more effectively both as service providers and in client mobilization and oversight roles. And these policy makers should be responsible for recommendations as well with respect to the coverage of JPS-BK. For instance, this poverty initiative provides only limited hospital benefits even though the costs of in-patient care can be devastating to poor and non-poor households (Marzolf, 2000). Decentralization of health responsibilities, provides an opening to introduce these and other changes in design and scope.

3.20 **A revived JPKM**. A second element in MOH's crisis response was a renewed commitment to JPKM, the distinctively Indonesian approach to managing the health market. This policy framework was developed after the "Kris Mon" in the late 1980s to address low and unpredictable health financing, and address concerns about service inefficiency, quality and equity. MOH's aim of moving JPKM beyond the pilot phase may have seemed foolhardy to some given conditions during the latest crisis. But this decision was not that surprising. As in the 1986/87-1988/89 downturn, government development and routine outlays on health fell, while recourse by the sick to potentially risky self-treatment rose, probably due to the increased household spending needed to cover fees and other outpatient expenses. As mentioned above, inpatient fees rose to levels which are, after only a few days in hospital, beyond the means of the large majority of Indonesians who have no alternative to out-of-pocket or other ad hoc funding.

3.21 MOH's plan to move ahead with JPKM took note of crisis realities by phasing in various responsibilities assigned to Bapels, an acronym for Badan Penyelenggara (Executing Agency) which have been established formally in all 314 of the country's districts.[7] The 1992 enabling Law 23 defined roles, functions, licensing requirements, and operational rules for Bapels which are the critical institutions in the JPKM vision of the health market. Like HMOs, Bapels are private companies which can enroll members who make payments in advance of service needs, and are then eligible for outpatient, inpatient, promotive and preventive services. Unlike HMOs, Bapels negotiate purchase of services from outside providers, i.e., government-run health centers, private provider networks or other suppliers.

[7] Bapels were originally referred to as the Badan Pengumpul dan Pengelola Dana or BPP-JPKM, i.e., the JPKM Project Management Agency.

Payments to such service suppliers by Bapels will be "capitated," i.e., at a flat rate per enrolled client. This method puts providers at risk since agreed payments may not cover the actual costs of care in specific instances. Bapels are expected to use marketing and various inducements, e.g., guaranteeing ready access to care and/or services of high quality, the availability of grievance procedures, the right to switch to other Bapels or to change to another provider network, to recruit customers in groups or on an individual basis.

3.22 As collectors and managers of funds, Bapels are meant to drive the JPKM vision of health development in Indonesia. Key principle and goals for JPKM include:

- consumer empowerment through health information, education, and grievance procedures, and by enhancing competition, widening options as regards service access, benefits and quality, and lowering pre-paid premiums through control of costs;

- service packages and capitation-based payment mechanisms which emphasize preventive and public health functions;

use of quality assurance mechanisms to achieve acceptable standards of care;

- provider performance improvements by requiring health care suppliers, including public sector facilities, to compete for funds and bear financial risks previously assumed by patients or insurance plans through fee for service-based payment arrangements; and

- achieving universal coverage while narrowing disparities in health outcomes by moving funds across risk pools to subsidize enrollment and service provision, i.e., using premium payments by the healthy and non-poor to cross-subsidize the less healthy and less affluent.

3.23 Bapels are to employ fulltime staff with management, finance, auditing, marketing, actuarial, contracting, health service delivery, quality assurance, and money management skills. To obtain a license, prospective Bapels must demonstrate to MOH that their organizational structure, management systems and financial reserves meet requirements spelled out in Law 23. Once licensed, Bapels are then expected to compete to enroll clients. It was envisaged that local branches of Askes would operate as the Bapels for civil servants and retired military staff, and units of Jamsostek would operate in the same fashion on behalf of those presently or previously employed in the formal sector. Other organizational platforms, e.g., insurance companies, hospitals, cooperatives and so forth could also provide institutional bases for the establishment of Bapels. In this scenario, new Bapels would be required primarily for those dependent on income generated from informal sector jobs or income.

3.24 GOI acknowledged it was not an appropriate time to move ahead with full JPKM implementation. Its strategy was to set up "pra-Bapels," with temporary, province-level licenses to enroll the poor using SSN-funded subsidies. There were 18 million poor households who were to be registered--they would become eligible for free curative and preventive services in government facilities. The pra-Bapels were expected to recruit non-poor members, for whom the benefits consisted of curative and preventive outpatient services at no expense along with five days of inpatient care, emergency surgery, and laboratory and X-ray fees. Pra-Bapels were given two years to develop the capacity needed to be fully licensed. MOH wanted to follow the establishment of pra-Bapels with compulsory registration. To this end, new legislation was drafted but this was not agreed to by MOF and other concerned ministries.

3.25 **JPKM Issues** JPKM'S re-emergence aroused much interest in the health policy community. Observers seem to fall into two camps (Torrens, 1997; Hotchkiss, et.al.,1998; Johnson, et.al., 1998;

WHO, 1998; Institute for Health System Development, 1999). The first sees JPKM as another of the costly, one-size-fits-all initiatives which have landed the health system in difficulty. Others agree with the critical reviews, pointing out that JPKM was expected to spread as regions became more affluent, and was always expected to compete with private insurance options. This group sees merit in phased, locally managed implementation of JPKM-like programs.

3.26 Those concerned with an execution plan based on compulsory registration and "roll-out" throughout the country make the following points:

- many countries have stumbled while trying to introduce universal health insurance coverage. It is the self-employed farmers, stall and shop keepers, and other small scale service and manufacturing enterprise owners, and their family members and employees who are the hardest to reach for premium or tax payments, and to bring into a health insurance net. In East Asia, South Korea succeeded but in a costly fashion, while Thailand and the Philippines are still experimenting with fiscally sustainable solutions which also meet democratically established health service obligations and standards.

- trust in government and other corporate entities remains low and it will be difficult, at least initially, to create interest in the JPKM "product."

- funding constraints will inhibit JPKM coverage—funds for Bapel start-ups are substantial as operational and financial reserves need to be accumulated, and training, marketing and other costs incurred.

- Bapels must purchase high quality services if JPKM is to avoid the image problems associated with the public delivery system. To do this, Bapels require strong quality control skills. Trialing is needed on how to assure service quality from private providers--offering the opportunity to supply large volumes of services may induce suppliers to adhere to specified quality standards.

- pilot efforts have been largely discouraging. The longest running JPKM trial, Klaten in Central Java showed that few groups would join a JPKM-like scheme voluntarily. Klaten, Magetan and the other pilots have shown that skills are missing in respect of assessing risk, determining premiums, marketing products, registering populations, designing and managing service delivery contracts, assuring quality, record keeping, and financial management.

- the public will not use designated services if cheaper options exist--non-poor households will resist registering with a Bapel if they can get affordable private care or subsidized services at government facilities. So health centers and hospitals need to raise not only service quality but also their fees, especially for those who can pay. In fact, what is needed is full autonomy or the equivalent for public hospitals as envisaged in the swadana initiative of the 1990s. And use of private providers by JPKM clients needs to be made a core design feature.

- Bapels have much to do, including not only costing and marketing service packages, estimating needed financial reserves, managing funds, and performing audit functions, but also designing and negotiating cost-effective service contracts which meet quality standards. Competition will be costly if it induces each Bapel to take on all these functions and more.

- JPS-BK was expected to overburden existing and newly created Bapels--the small amount allocated for enrolling poor households and "negotiating" service packages may result in sub-standard performance and medium term financial problems for fledgling Bapels. This will make it harder to

recruit non-poor customers and recoup losses incurred in subsidizing poor enrollees when SSN funds have been spent.

- Law 23 and subsequent regulations do not provide for cross-subsidization or other risk adjustment mechanisms. This is despite JPKM's stated rationale of avoiding adverse selection and other predictable insurance outcomes which widen health care disparities. Without compulsory inclusion of all individuals through different group arrangements, adverse selection remains a risk and cross-subsidization cannot be achieved. However, MOH may not be able to make a sufficiently strong case on readiness grounds for mandatory involvement.

- Improved regulatory capacity and strong and timely supervision and enforcement are needed to eliminate the numerous unlicensed insurance-like products which are being marketed but which do not meet reasonable fiduciary management or operational standards. Also needed is oversight of the quality of services provided to JPKM clients. There is concern that MOH has moved too slowly to establish appropriate regulatory mechanisms, insulated from marketing and implementation functions.

- MOH underestimated the administrative and regulatory costs and tasks of introducing and then monitoring JPKM. Besides strengthening current service delivery, MOH or its provincial or district-level successors, will need to review the benefits packages, business plans, and actuarial calculations built into JPKM license applications. It will also have to monitor performance and carry out financial audits. The latter will require not only careful assessments of individual JPKM entities but maintaining an overview of the distribution of financial risk system wide.

- It would be important for MOH to take account of the incentives which influence different JPKM participants--consumers care about cost and value for money; Bapels will push to increase contributions and restrict outlays; care providers will want to maximize their revenue flows; and GOI will want to contain costs, for several reasons including its commitment to subsidize the poor. MOH may also need to intervene regularly to assure that the equity enhancing, quality improving and other key aspects of JPKM are actually realized.

- There are cheaper and more realistic alternatives. Some see Indonesia's best option as continuing to improve the performance of government-run services which are a health insurance mechanism in their own right, while encouraging parastatal and private health insurance schemes to target additional, lower income markets.

3.27 **A phased, differentiated approach**. For the second group, the above assessment of JPKM to be too harsh, while the solutions proposed, especially salvaging the publicly run delivery system, are even more impractical. They suggest that JPKM be seen as framework within which there are near and medium term options health, financial, and other characteristics of different provinces and regions. Their responses to specific points follow.

3.28 First, despite a lack of full success, other countries continue to widen the coverage of health insurance schemes, including piloting ways including the poor (Reisman, 1995; Government of Thailand, 1989; Solon, et. al., 1992; Solon, et. al., 1999; Ron, et. al., 1999; Yu, 1993). For example, the National Health Insurance Program set up in the Philippines in 1995 has consolidated and extended previous efforts and is moving ahead with an innovative option for the poor. In this scheme, low income households are eligible for specified benefits, with premiums financed by Central and local governments.

3.29 The proposed strengthening of the existing government delivery system as an alternative to JPKM underestimates current incentives, accountability and quality problems and the public's distaste for

government-run services. Proponents of moving ahead with compulsory JPKM make the same mistake. Over time, skills and other capacity limitations can be overcome. But such steps will fall short unless health care in the government sector is improved qualitatively and in ways the public finds credible. Alternatively, JPKM would have to contract with private health. A providers, many of whom supply low quality services.

3.30 **A JPKM-related option**. One possible approach involves assigning poverty-related functions to the district level Bapels. Specifically, Bapels could be asked to take on significant responsibilities as regards the health and nutritional status of the poor. Bapels would not be the only actors. The poor need to organize themselves and involve NGOs and others so that their health needs are heard in what hopefully will become a pluralistic institutional environment. Assigning a poverty function to Bapels would give them a chance to establish credibility, particularly amongst the poor, while also providing the demand-side pressures needed to improve the performance of health service suppliers. The task for Bapels would be to assist the poor by acting as their advisors, champions and protectors in health matters. During an initial 12-18 months, Bapels would get familiar with poor communities and localities, meeting their leaders, visiting and registering individual households, learning about their life styles and health problems, looking out for high risk cases and distinctive health concerns, hearing their views about health services, and starting to build a data base by sponsoring studies of health seeking behavior as well as provider knowledge and attitudes.

3.31 Bapel staff would also need to develop a picture of the services the poor need the most, analyze what is being provided, and design contracting and monitoring instruments to insure the acceptable services will be provided. This will require observation of health center performance, visits to the Dokabu, hospital director, attendance at posyandus, observation within the puskesmas, regular interactions with the Bupati and his staff, and assuming responsibility for distribution of the kartu sehat. The Bapel would also need to assess private and NGO service provision and monitoring interest and capacity. Clearly, Bapels would want to make sure the poor were well aware of available services and escort them to health centers and remain with them until they are cared for. This may require help with transport, as well as monitoring outcomes and service quality, and efforts to improve health awareness, and provide feedback to puskesmas staff and other providers. The Bapel would also press for service improvements including quality gains, while lobbying (if needed) for alternative service arrangements including hiring private specialists and escorting the poor to private providers.

3.32 The logic to this approach is straightforward. It would help fill a demand-side void, building on agreed grievance and qualitative monitoring mechanisms which safeguard SSN service provision. The Bapel's clout would be based on its contracting powers and the opportunity to provide pressure from within the government-run system. In short, the Bapel would help the poor apply countervailing force, much like trade unions within labor markets, to offset the strong position of the publicly run service system. There would also be benefits for the Bapel itself, through connections established with prospective clients. Once these responsibilities had been fulfilled, the Bapel could move on to the conventional tasks of establishing viable premium levels and collecting payments from the non-poor, managing funds, and contracting for service packages and quality standards. This second stage of Bapel activities could begin fairly quickly in relatively well off places such as Bali and Yogyakarta although there would still be an important Bapel-assisted role to be played by NGOs and other institutions on behalf of the poor even in these provinces. Bapels would need to recruit staff with community development and public health skills. To do all this will require additional funds for Bapels, especially those in high poverty districts--the Rp 800 assigned to Bapels to manage each enrollee is clearly inadequate.

3.33 What next for JPKM? The second of the two perspectives would encourage JPKM to development according to conditions and needs at the province level. Compulsory JPKM coverage throughout the country would not be required during the next decade. Instead, provinces could be

encouraged through technical and possibly financial instruments to improve regulatory and enforcement capacity and devise strategies for widening coverage. This might involve working closely with Askes and/or private insurers to bring additional clients within their systems. It might also include political decisions by provinces and districts, possibly working together voluntarily, to opt for compulsory and comprehensive coverage.

3.34 Healthy Indonesia 2010. Lastly, then Health Minister F.A. Moeloek's 1999 Vision Statement brought a fresh perspective to crisis-period policy discussions. This document enunciated a promotion and prevention-based approach, proposed corresponding revisions in public sector priorities, and defined MOH's new mission as leading health-oriented national development, and promoting self-reliance in health matters. The Minister saw health as a responsibility shared with individuals and families, community groups, other ministries, and the private sector; he suggested that this approach, Healthy Indonesia 2010, would work only as an inclusive national movement which relied on a well prepared communications strategy. Lastly, the health promotion thrust would need to be underpinned, in the Minister's thinking, by professionalization of the health work force, rapid advance in establishing JPKM, and locally grounded service planning and delivery.

3.35 Issues and next steps. Healthy Indonesia 2010 was a departure from previous MOH thinking on health challenges and economic constraints. As discussed, consumer views and preferences, and the health program's overall image had been neglected in policy formulation. Past health education efforts consisted largely of project-supported attempts to communicate with target groups, e.g., mothers of young children, or purchasers and providers of commercial sexual services. The standard, one-way and one-time messages used were generally developed within MOH, with at best superficial pretesting but rarely any checking for consistency with local values and behavior. They were then delivered through mass media barrages or brief village-level campaigns using posters and flipcharts either imported directly from Jakarta or adapted slightly by the provincial team.

3.36 No doubt it would have been difficult to move from top down approaches to interactive methods known to be effective in sustaining changed behavior (Box 4). Making healthier life styles seem attractive requires compelling messages as well as changes in the context in which people live, work and play--formal and informal social and institutional settings are all important. In such favorable contexts, single issue, blitz type IEC efforts can be effective in guiding responses. But shaping settings and devising effective messages will not be straightforward, especially if the public questions the quality of services provided in government facilities. Unfortunately, little is known in depth on knowledge and attitudes about health and health service providers within the population. A round of health-seeking-behavior studies would fill this void. Also required are high caliber professional communications and marketing skills along with local government commitment and involvement of NGOs, consumer groups, and those who represent the poor. In a word, health promotion is an inherently local matter in which government agencies are inherently awkward and inept, especially those operating from a distance. the poor is indispensable.

3.37 In 2000, important steps were taken to translate Healthy Indonesia 2010's orientation to promotion and prevention into an operational communications strategy. Specifically, an independent body, the Coalition for Healthy Indonesia (CHI), was established with 29 founding members drawn largely from the NGO and private sectors and professional associations. MOH, BBKBN, and the State Ministry for Administrative Reform were included in the first group of members. CHI is seen as serving as a network and conduit to ideas and lessons together with technical and financial resources. For example, CHI may provide access to effective program messages and content, and promising techniques, while also facilitating interaction between member and other organizations and even designing and delivering information and advice to the public.

3.38 Although CHI was created recently, it clearly represents the sort of institutional innovation needed to make Healthy Indonesia 2010 a reality. In the near term, CHI's agenda is to increase the number of members and work out its operational style and procedures while also beginning to set up province and district level affiliates, and gaining experience in different aspects of health advocacy and lobbying. Looking beyond the next 12-18 months, CHI's medium term agenda is to establish the Healthy Indonesia paradigm within a decentralized health system. This planned linkage to the forthcoming reorganization of government roles and responsibilities represents an important step beyond the 1999 Vision Statement. The broad intention is to help establish and energize numerous local level health-oriented coalitions, including drawing in community-based and other groups and helping sub-national coalitions to operate effectively in local arenas.

3.39 In this regard, one promising approach is to formally transfer to local coalitions responsibility for the focus and modalities of health promotion work. The vehicle for this could be autonomous, legally constituted Health Promotion Boards with the authority and resources to carry out a variety of activities. Boards might choose to contract high quality professionals to assist in defining local health challenges, appropriate behavioral responses, and associated implications for health communications and promotion. Funds might be directed as well to "market research," i.e., learning about health seeking behavior and clients' reactions to services, and also about provider attitudes and motivations. Boards could have a role as well in helping health NGOs to strengthen their activities, and to target beneficiaries better. In addition, Boards would likely lobby government officials at different levels to strengthen allocations to health promotion and prevention, to enforce existing laws and regulations bearing on health, and to introduce new legislation as needed. And, of course, they would fund and design health promotion priorities and operational programs, and social marketing campaigns. Boards would be recipients of grant and even loan money, which would be spent on soliciting and evaluating operational research proposals submitted for reimbursement. Yogyakarta province has begun piloting its own version of the health promotion board concept.

Box 4: Two Health Promotion Case Studies

Indonesia's experience with health promotion includes a comparative success and a case in which such an approach failed to take shape though it was needed.

The family planning program. The comparative success story is the national family planning program launched in 1970 with the formation of the National Family Planning Coordinating Board (BKKBN). Along with strong political commitment, this initiative was supported by an innovative health promotion strategy. The Bureau for Information and Motivation within BKKBN handles promotion of family planning, targeting audiences such as government officials at every level, public and private providers, journalists, NGOs, schools, universities, religious leaders, and the public at large. Conventional printed and mass media, contests, speeches by public figures, workshops, seminars, billboards and social marketing all have been used, but the most important channel is intensive, sustained interpersonal communication which brings to bear strong peer and community pressures on individuals and couples.

In promoting family planning BKKBN was taking on a task with clear and measurable goals. Its marketing was in step with the general movement of Indonesian society and culture towards a 'modern' consumer orientation. BKKBN had institutional support at all levels and considerable resources from GOI and NGOs. Its concept of community involvement was top-down, involving mobilization but not community control. The strategy reversed the conventional KAP (knowledge, attitudes, and practice) framework, replacing it with PAK (practice, attitudes, and knowledge) principles. The PAK approach focuses on changing people's practices, using community mechanisms to establish and "enforce" a small family ideal. This low fertility norm was crucial in promoting uniform acceptance of contraception, leading to favorable attitudes, and then gradually introducing information and knowledge once the acceptance of family planning had been secured. BKKBN's independent agency status enabled it to secure a greater than normal degree of cross-departmental involvement.

Posyandus. Community posyandu sessions are supposed to occur monthly, targeting children under five and their mothers, with advice and services provided by volunteer health kaders and personnel from the nearest puskesmas. The main posyandu goals are to reduce infant mortality and improve the health and nutritional status of young children and pregnant and lactating women. The five service areas are maternal health (with a focus on antenatal care), immunization, diarrhea control, family planning, and nutrition. In the 1980s, GOI increased the number of posyandus to approximately 200,000 with support from UNICEF and the World Bank. Despite this increase, the program had mixed success in reducing infant and maternal mortality. Behavior change was limited by low attendance, reflecting a lack of community interest in posyandu activities. Recent surveys found that fewer than 50% of mothers with children under five participate in posyandu.

The goals of the posyandu "movement" were more diverse and harder to monitor than family planning (and thus less suited to a top-down command structure). The initiative combined a number of interventions into a single access point. Government support included expansion into every district in Indonesia, even where this involved moving ahead with insufficient resources, little training, and limited community involvement, and this has contributed to its difficulties. Posyandus were in general under-resourced in comparison to family planning services. Marketing for posyandus was formulated in terms of national goals rather than the particular wishes of mothers and therefore have had limited impact. Messages were directed towards mothers alone, and therefore were not taken on by the wider society. No marketing effort, however, could have been expected to persuade all mothers to patronize posyandus in the face of the many deficiencies in the system, including poorly trained kaders, cultural and social differences, and over centralized production of materials. Many of these problems sprang from a lack of genuine community participation other than through governmental and quasi governmental channels.

Future development of the family planning program and posyandus requires decentralization measures that will permit local ownership and targeting of services, paying more heed to the wishes of clients, and integrating poverty alleviation and community capacity building. - R. Galbally

IV. POLICY OPTIONS

4.1 **Opportunities through decentralization**. During 2000 the attention of the health community turned increasingly to the government reorganization which began in January 2001. Legislative underpinning for this major step is provided in Law 22 on "Regional Government" and Law 25 concerning "the Fiscal Balance Between the Central Government and the Regions." (The MPR issued its Broad Guidelines for State Policy and amended the constitution in August 2000, in each instance incorporating the principles set out in Laws 22 and 25.) These statutes, each passed by the DPR in April 1999, are part of a package of restructuring measures including new laws on civil service management, procurement by public agencies, the governance of elections, and the functions of central ministries and agencies. Other important framework documents include the required Operational Guidelines for Law 22 (Peraturan Pemerintah 25, May 2000) and Law 25 (submitted to the Cabinet Secretary, September 2000); guidelines on the composition of regional administrations (issued in September 2000); MENEGPAN decrees on and the size and make-up of individual ministries; and various other ministerial, governor-level, and Bupati level decrees relating to the implementation of Laws 22 and 25. Additional regulations are due to be issued. Some new institutions have been introduced as well. For example, a Regional Autonomy Advisory Council (RAAC) was established including representatives from the Associations of Mayors and Bupatis.

4.2 Together these measures establish a governmental system anchored in the more than 350 districts (and municipalities) to which is devolved considerable autonomy in policy making and implementation in respect of most dimensions of life which matter to individuals. What drives the process is the statutory transfer to sub-national governments of a sizable share, 25%, of total central government revenue, of which 90% is earmarked for districts and 10% for provinces. Local governments will also receive specified proportions of the property tax (and greater retention by producing areas of revenues from mineral wealth and fishing and forestry activities). Transfers, largely in the form of untied block grants, are due to rise dramatically in 2001 with district level spending expected to double its share of overall government outlays. Meanwhile, central ministries like MOH have been downsized, with some Jakarta-based staff asked to transfer to the regions or elsewhere; regional offices and staff of MOH subsumed into district units under the authority of local governments.[8]

4.3 The literature points to potential health system advantages associated with decentralization, notably enabling beneficiaries to become involved systematically in affecting both the goals and design, and the performance and financing of health interventions (Castenada, 1997; Perez, 1998; Kolehmainen-Aitken, 1997). These and other improvements are within reach in Indonesia where decentralization offers an unusual opportunity to rethink health sector institutions and operating principles and mechanisms. Although government reorganization and related reform initiatives are responding to broader political imperatives, it is fully consistent to include health in this process. This is because decentralization and other changes are being driven in part by heightened consumer expectations and impatience with the quality of government services including health care.

4.4 In the Indonesian setting then, decentralization offers a way to redesign health arrangements which are no longer adequate. The goal is to engender the sort of micro-level provider-client interactions which can bring sustained health gains. As discussed, the country's distinctive interpretation of the Alma Ata, primary health care vision was daring and brought results in the 1980s. Over time, however, this approach brought fewer gains, probably as a result of design and management compromises which MOH felt it had to make in order to sustain widespread coverage. By the mid 1990s, relatively low and

[8] The number of Directorates General (DGs) in MOH will fall from 5 to 3 with each having no more than 5 component Directorates—previously there were 5-6 Directorates per DG. In addition, POM, the Food and Drug Control Agency, will become an independent body reporting to the President.

possibly declining utilization rates pointed to an unsatisfactory equilibrium between providers and actual or possible clients. At the facility level and during outreach activities, there were limited interactions between a protected and distracted government health work force and potential beneficiaries who had little information and were without means of pressing for better services.

4.5 Decentralization can help in finding a route out of this cul de sac. It provides a way of creating conditions in which providers have the incentives, skills, supervision, material support, and discretionary authority needed to offer high quality services, and clients have the information, financial means, and bargaining power required to ensure that their preferences elicit appropriate responses. In this respect, decentralization provides a context in which to build on initiatives such as JPS-BK, JPKM, and Healthy Indonesia 2010, while for MOH itself, it is an opportunity to carve out a new leadership role, and improve its public image while jettisoning impractical obligations.

4.6 **The Philippines and elsewhere**. Nevertheless, the health gains associated with decentralization will not materialize automatically. The experience of the Philippines and that of several Latin American countries points to possible hurdles and unwanted outcomes. Features of Law 22 and the accompanying operational guidelines and implementation arrangements make it likely that health decentralization in Indonesia will face some of the same obstacles.

4.7 In the Philippines, significant health sector powers and resources were handed over to districts and municipalities in 1993.[9] However, weak administrative capacity, and problems connected to the absorption of devolved staff, especially the generous compensation package agreed with central government health workers, 80% of whom were devolved, resulted in a turbulent initial three to four year period. For their part, district and municipal officials opted not only to spend less but to focus on hospitals and clinics, while what was left of the central health department could do very little to persuade local authorities to rethink their health activities (Solon,1999). Communicable disease control, health education, routine monitoring of health status and performance, and referrals from primary care centers to hospitals were all affected.

4.8 Nevertheless, the Philippines experiences should not be written off as a failure. Some encouraging advances occurred fairly quickly, e.g., improved coverage of maternal and child health and family planning services (Hume, et. al., 1996). Important institutional innovations have been developed as well. These include the local government assistance unit within the central department; comprehensive health care agreements negotiated with sub-national governments, a matching grants facility, and partnerships between local governments and with NGOs to facilitate surveillance and control of infectious diseases. Also noteworthy is the "indigent program" within the National Health Insurance Program, which is being implemented on a widening scale in close cooperation with local governments. And province and local level reports suggest that participatory planning and needs-based budgeting are bringing local priorities to bear on health funding and services with encouraging results (Ramiro, et. al.,n.d.; Philippines Department of Health, 1997a and 1997b; Hume, et.al., 1996).

4.9 Finally, sectoral ups and downs since 1992 have brought recognition that the central department itself has been part of the problem. The health department has acknowledged that national policy "lapses" occurred, e.g., devolving unfunded mandates (Department of Health, 1997a). The latter comprised the several compensation packages which were negotiated and agreed to by Manila and then simply passed on to local authorities. Overly restrictive access to various funding alternatives meant for local governments were among the other errors cite. An internal department review recommended adoption of a more decentralization-friendly stance. To this end, since 1998, the department streamlined and reoriented its central and regional offices and strengthened its local government assistance unit and

[9] Some 75% of the country's government health workers, 92% of its hospitals, and all 12,580 of its Rural Health Units were devolved to local governments.

developed other means to serve local health initiatives. It has also advised donors that they should work in a complementary fashion to make a success of the locally based health system which is emerging. Recently, the Philippine national assembly opted to re-centralize certain health functions while also reorganizing and streamlining the central department. The department will focus on formulation of national policy, strengthening funding of public health services and shifting financing of curative care to insurance mechanisms, technical assistance to local health programs, response to disasters an epidemics, health information infrastructure, standard setting, regulation and licensing, and assessment of new technologies (Perez, 2000).

4.10 Other countries took a more gradual route with greater initial consensus building and opportunities for local input and variation. A phased approach to decentralization and related reforms was adopted in Brazil, Colombia and several other South American countries, with provinces required to be certified that they had the capacity to handle increasingly complex challenges. But this approach came with risks as well--the process, which was drawn out over five or more years and made overly complicated, was not popular with polit icians and typically lost its way within the bureaucracy. In Colombia, a failure to define responsibilities clearly and to provide for the full costs of restructuring led to staff resistance and affected the pace and depth of health sector decentralization. The government, which was forced to grandfather all current staff, relied on consultants for crucial planning and implementation tasks. But these decisions effectively undermined the central health ministry's pro-reform leadership and consensus building credentials, allowing central staff to retain control of local level operations and making it more difficult to re-invent the ministry's orientation and work culture. In the late 1990s, the government drew on donor support to strengthen the reform process. The problem of rapid senior staff turnover was addressed, and steps were taken to improve internal management, and staff professionalism and incentives (Castenada, 1997; Bossert, et.al., 2000).

4.11 **Muddling through--risks and advantages**. In short, mistakes have been made and opportunities missed which have affected health decentralization in several other countries comparable to Indonesia. One miscalculation which proved damaging in the Philippines was the assignment of unfunded expenditure obligations to local governments. This was coupled with hesitation in addressing the work culture and mission of devolved central staff--the same issues arose in Colombia and have been seen elsewhere. There were delays as well in defining and following through on a distinctive role and mission for central ministries-- these were at once a cause and an outcome of a reluctance to challenge staff work habits and expectations. Such delays carried over to ineffective communications with regional and local health decision makers, and with other stakeholders and the general public including their elected representatives. In a word, the central ministries did not make systematic efforts to interact with internal and external constituencies regarding health decentralization and reform and missed opportunities to articulate and follow through on strategies which reflected shared positions.

4.12 So there are specific challenges as regards health decentralization. And adding further complexity and unpredictability to the process are the many aspects of Indonesian decentralization yet to be decided. There are gaps in key documents and inconsistencies within the ever growing volume of official communications on the reorganization. For example, no guidance has been provided on resolving inter-district and other conflicts or on the extent to which the central GOI can overrule decisions made by districts or provinces (Van Zorge Report, September 2000). Also not resolved is the role of the province. Law 22 and the accompanying Operational Guidelines assign a large role to districts. For example, health is the first item mentioned in Article 11 of Law 22 among the "functions which must be performed by regions and municipalities." Only a limited role is envisaged for provinces, but subsequent decrees have bolstered provincial responsibilities. Other matters which need to be clarified are the guidelines for Law 25 and specifically the formula to be used in allocating general block grants; the fit between existing sectoral laws and Laws 22 and 25; and regulations pertaining to transfers of civil servants.

4.13 This confusing picture reflects pressures and counter pressures being brought to bear on policy makers. Nevertheless, the policy package including downsizing of ministries and staff transfers is moving ahead. The strategy seems to be a not unfamiliar one of "muddling" through and improvising as issues arise.[10] This was the approach adopted when introducing the primary health care approach in Indonesia. As discussed, this brought positive results early on, but over time performance faltered due to the incentives and management compromises resorted to in the face of implementation problems. So muddling through may prove to be very expensive, with the costs of such an approach apparent in the Philippines case. There is another reason for working out at least a rough game plan for health decentralization—the overall process is still in its early days. Because of this, there remains considerable scope for sectoral ministries like MOH and other stakeholders, e.g., important provinces, to shape events and results.

4.14 **MOH's response**. Concerned that essential services may be disrupted, MOH has been in the forefront of government agencies preparing for decentralization. MOH has made clear what it sees as the health responsibilities which districts and provinces must assume, and has explored ways of guaranteeing that these will be handled. MOH staff have conducted workshops for central level employees, members of legislative bodies at all levels, Bupatis, and mayors; prepared guidelines for future health offices and facilities; sent letters, circulars and even compact discs to Governors and Bupatis on the suggested roles and responsibilities of provinces and districts; and secured donor assistance in piloting decentralization in Yogyakarta, Lampung, and several other provinces. In addition, the Minister issued a number of decrees in a bid to influence the course of devolution, including one establishing a high level advisory group within MOH. Meanwhile, West Java, Yogyakarta and several other provinces have elaborated their own visions of health decentralization.

4.15 MOH's many activities are part of a strategy of informing local officials and politicians about the importance of health, and securing their commitment, while specifying functions of government at different levels. First, a Ministerial circular (July 27, 2000) delineated 24 district-level health responsibilities. These fall into four groups:

- Sustaining service delivery through available facilities as well as health, nutrition, and environmental surveillance, communicable disease control, food safety and health education activities. Districts are also to be accountable for planning and supervising these activities including utilizing available health workers, as well as recording and reporting on progress, and carrying out other health information tasks.

- Procuring required stocks of essential drugs for the network of facilities, and controlling misuse of drugs including drug abuse.

- Regulation of service fees within facilities as part of the task of using JPKM or other means to develop local health financing capacity; and

- Using licensing powers to protect the public in respect of their dealings with service delivery, training, and retail pharmaceutical enterprises.

[10] This is the sense that emerges from the overview of decentralization policy prepared by the Minister of Home Affairs and Regional Autonomy, Surjadi Soedirdja, for the October 2000 Consultative Group on Indonesia meeting in Tokyo. After acknowledging the risks involved, the Minister outlined a four phase implementation plan starting in 2001 with the transfer of functions, staff, and assets. During 2002-2003, the emphasis would be on completing this transfer in all regions and upgrading management functions and staff skills. During 2004-2007, the process would be consolidated and made "irreversible," and after 2007, decentralization would be "stabilized" and "developed further" (Soedirdja, 2000).

4.16 MOH took parallel steps to define the content and thrust of district level tasks set out in the circular. One of these was a formal meeting in Jakarta which concluded with the Bupatis and Mayors present signing a compact committing local governments to specified actions. MOH placed special emphasis on securing district agreement to 1) maintain existing facilities and support 12 priority programs (JPKM, nutrition improvement, disease control including immunization, family health, provision of essential drugs, health information system, and so forth), 2) reorganize health institutions in line with structural and functional positions, and 3) ensure that health receives at least 15% of development spending, in part by returning all fees received at hospitals, health center and other government health facilities.[11]

4.17 The second of these steps is to specify standards, both minimally acceptable and desirable, for various health services to be transferred to the districts. MOH experts have defined relevant indicators for each activity. The intention is to submit these as a package as recommendations which Governors would then consult in discussions with Bupatis and mayors concerning health sector performance targets.

4.18 MOH has also specified deconcentrated functions which should be conducted by provinces. These would be in addition to the devolved responsibilities listed in the Operational Guidelines for Law 22. The latter cover determining guidelines for health information campaigns, epidemiological surveillance, deployment of strategic staff, training and education of health workers, certifying health technology, and licensing special health facilities. Included among the suggested additional, deconcentrated responsibilities were: planning provincial health development, along with supervision and control of implementation of policies, standards (see previous paragraph), and guidelines; carrying out health activities and managing health facilities which are beyond the scope of districts; conducting province wide nutritional surveillance; sustaining a health information system; planning and procuring essential drugs for basic health services; and licensing and accrediting provincial scale health facilities along with registering and certifying health personnel. In this fashion, MOH was trying to convince Governors of the importance of a single, separate government health institution (Dinas Kesehatan) as opposed to a sub-unit placed in a broader provincial services agency. MOH has outlined three options for the structure and staffing of province-level units.

4.19 Finally, MOH has defined its own functions namely, developing general strategies as well as implementation, technical and monitoring policies; supervising and coordinating functions such as planning and utilization of resources, and interacting with other institutions; handling research and development, some education and training, and standard setting; and exercising functional control (Ministerial Decree #130, 2000).

4.20 MOH continues to question the readiness of different administrative levels for decentralization. And it recognizes that there are issues which it must still grapple with to bring about effective devolution of health powers and responsibilities. For instance, there is concern over funding in the medium to long term, management of the workforce and facilities, health prevention efforts, and impacts on the poor. (For these and other reasons, there is continuing support for initiatives, i.e., JPKM, JPS-BK, and HI2010, pursued during the crisis.) MOH officials also acknowledge that the financing and service delivery roles of NGOs and the private sector including insurance firms along with the possible responsibilities of professional associations have not been addressed yet, and appreciate that accountability and quality control mechanisms will need to be revisited in the context of decentralization.

[11] The other tasks listed were to mobilize local resources through JPKM or other health insurance methods; ensure availability, equity in distribution, and quality of health manpower by conducting some recommended steps the districts/cities need to follow in making manpower decisions; sustain education and training to maintain manpower quality; and provide incentives to improve staff performance, including execution of a career development system.

4.21 **Trade-offs for MOH**. In short, MOH has made a strong effort to respond to the upcoming government reorganization, including communicating with those whose decision making powers and resources will be enhanced. Still, health policy makers recognize that more preparatory work is required. One matter which MOH could give more attention to is the thinking underlying the allocation of block grants which decentralized districts and provinces will receive. The proposed formula is flawed in several respects (World Bank, 2000). From the health stand point, weaknesses include the absence of any social indicators, along with modest equalizing effects because of the way the formula accounts for expenditure needs and revenue capacity.

4.22 An immediate issue for MOH is that of focus. It has relied on different means to convince future decision makers that health is important and that its suggested sectoral priorities deserve consideration and funding. But consciousness raising and opinion shaping work need to be complemented by other approaches. This is because it is unclear how much of MOH's message will be internalized by local government authorities and for how long. For one thing, other sectors are using similar tactics, suggesting that MOH will have to rebroadcast its point of view fairly often.

4.23 But asking stakeholders repeatedly to reaffirm their intentions as regards health could become an expensive, time consuming, irritating, and low payoff process. Moreover, MOH has assumed that districts will have sufficient funds from their block grants and that what is needed are decisions to allocate adequate amounts to suitable health programs. A related process will rely on the minimum and desirable service standards which MOH expert staff have defined. To its credit, MOH has presented the standards as recommendations and left their application to Governors who are expected to take responsibility for coming to agreement with district level officials on health objectives and targets. There is some expectation that the standards will be attached to a future directions from MOHA defining standards across sectors and linking the size of block grant allocations to performance.

4.24 These matters remain to be negotiated and resolved, no doubt after several iterations. In the mean time, MOH's directives and suggestions including the numerous "recommended" standards districts would be expected to implement may be seen unfavorably by Bupatis and local politicians. For one thing, the sheer costs of attaining specified standards have not be addressed yet by policy makers (see Marzolf, 2000). However, the basic package estimates reported in Section II above indicate that a nearly five fold increase in public outlays would be needed to establish programs on an appropriate basis. Then there are many questions about how to organize the task of implementing standards. In effect, the compact initialed by Governors and Bupatis in July 2000 and the application of health standards would commit local governments to doing what the central government never fully accomplished. This is to fund health programs at adequate levels on a sustained basis. It would not be surprising if local politicians and officials see these steps as intrusive attempts to burden them with unfunded mandates including obligations towards existing staff and facilities. MOH may be caught in the middle, between the districts and MOHA and MOF, especially if it relies on its assumed standard setting responsibilities to induce local governments to implement various initiatives. But for reasons just stated, such tactics risk causing resentment and mistrust at the district and province levels, may encourage passivity on the part of health staff and supervisors, and result in partial and/or low quality performance. This approach could mean that MOH would focus its energies on enforcement, i.e., "policing" standards, detracting from its capacity to lead.

4.25 What alternative course could MOH follow? The medium term challenge relates to establishing a sustained, appropriately focused commitment to health at the district and municipality level. And this will depend on i) attaining greater clarity and consensus on government health responsibilities at different levels, and ii) development of new policy mechanisms and instruments. Here, MOH's short term and medium term goals may be at odds. The decrees and circulars it has issued incorporate broad powers for itself, a number of which seem to overlap with responsibilities it has had in mind for province and district-level governments. For example, MOH reserved for itself the tasks of "exercising functional

control and supervising the planning and use of resources" while at the same time indicating that districts were accountable for the planning, implementation, and supervision of health services, and provinces responsible for supervising policy implementation and handling activities "beyond the scope of districts."

4.26 MOH's "standard setting" role also seems similar to functions allocated to sub-national governments. This over determination in task assignment is intended clearly as one way of safeguarding health in the short run. But such language has caused confusion and possibly suspicion that MOH is not ready to relinquish its traditionally dominant role in the health sector. In fact, the standard setting responsibility puts MOH in a "no win" position. Setting strict standards could impose unfunded mandates on districts and put provinces and MOH in an inappropriate policing role. Of course, standards should not then be ignored. But they should be presented as goals with MOH using its advocacy and grant making powers (see below) to get societal commitment.

4.27 **Roles and responsibilities**. What still needs to be resolved are the actual health responsibilities of districts, and how the remaining roles and functions will be handled between the central MOH and province-level entities. By making local governments accountable for health, Law 22 projects the district as a key arena for policy implementation as well as formulation; meanwhile, Law 25 makes available greatly increased resources. These steps have a strong rationale. Districts own and operate health centers and most public hospitals, and are responsible for supervising most health staff. Districts already provide the context in which care is delivered (or not), quality standards are achieved (or not), and generally in which providers and actual and/or potential clients interact. Districts are where the benefits of decentralization can be captured.

4.28 But Indonesia's districts have inherited numerous health facilities and staff, along with the large policy and program agenda discussed above. In principle, local assemblies (DPRDs) and Bupatis have assumed responsibility not just for managing health centers and their 18 standard activities, public hospitals, and training and regulatory functions, but also priority setting and resource allocation, together with some quality assurance and personnel functions. This requires decisions about the scope and content of health service provision, including choosing whether to keep or even add to the puskesmas menu, opt for smaller service packages, or step back from direct care provision. And districts may face choices about resource mobilization.

Box 5: Role of a Reformed Central MOH--Work Force Issues

Health work force matters represent one useful focal point for a reoriented and reconfigured central MOH. An immediate concern would be to devolve central staff, including the large numbers already based outside Jakarta, without the disruptions and financing consequences see in other countries. This task, mandated by a MENPAN decree, may require extraordinary measures, e.g., a temporary lowering of retirement age, elimination of the PTT scheme, establishment of a retraining fund and procedure, and so forth. Once Law 22 is in force, MOH could put aside its previous mandate to eliminate apparent worker imbalances (derived from staffing norms calculated without references to actual demand). Jakarta-based officials would no longer intervene to influence staffing patterns in different areas, or the tasks and responsibilities handled by health workers—market forces would be recognized as a key mechanism relating to the availability and performance of different worker categories. Instead, the agenda for the central MOH could include:

- Serving as an information clearing house and analytical body covering performance issues, incentives effects, determinants of entry into health professions and success in private practice, and so forth;
- Supporting district and province-level health authorities as they strengthen the regulatory responsibilities they will handle as regards the health work force;
- Helping to establish statutory authorities responsible for the qualification, roles, and conduct of different worker categories;
- Working with professional associations to strengthen quality improvement activities, and consulting with consumer groups and hospital and other bodies on work force issues;
- Monitoring medical education to ensure that graduates meet public needs and standards and that funds are available for individuals from poor and/or Outer Island backgrounds;
- And establishing a small, prestigious National Health Corps which provides high caliber health workers selectively and on a matching grant basis to poor and remote districts.

4.29 In the near term, some of these tasks and functions may be beyond available capacity, and many districts nay require assistance in some form, e.g., through interim arrangements with the relevant province or MOH itself. But even in medium term, important elements in this agenda will be costly for districts to take on considering their small populations and lack of specialized staff. Health care provision by government staff whether seen as the standard puskesmas menu or possibly smaller service packages, is a function which most districts will have trouble managing. The solution adopted in different circumstances worldwide is to withdraw from such activities and to rely on payments to providers to subsidize care to the poor. As noted, Indonesia's version of the Alma Ata approach was instrumental in establishing private service capacities in most areas of the country. JPS-BK's payments to village midwives represents an important step in this direction.

4.30 Districts will also have difficulty carrying out essential public health, health education, and information functions. This is because no matter how competently they are managed, districts are generally too small to avail of scale and scope advantages and to capture enough of the gains from activities which yield externalities. For this reason, smaller political units worldwide typically under invest in these classic public goods—the Philippines example is relevant here.

4.31 Accordingly, the recommendation here is that central and provincial level health functions be determined by the extent of the scale and scope economies and the externalities which are entailed. The same principles would help in deciding on what responsibilities provinces can carry out more effectively

than the central MOH. Communicable disease control provides a good example. Indonesia is too vast and diverse for disease control and surveillance tasks to be centrally managed. On the other hand, districts are generally too small to carry out such functions efficiently, and will always be tempted to "free ride" when other areas develop such programs. Most communicable disease control responsibilities should be entrusted to provinces which are usually appropriately sized and organized. Health education raises analogous issues. Province-level health promotion makes sense in terms of scale and scope, e.g., cultural and epidemiological homogeneity and audience size, and on free rider grounds.

4.32 Provinces also typically provide an appropriate market size for health finance, regulatory, and related functions and initiatives Districts usually represent too small a population and economic base to build the skills base and accumulate the operational and financial reserves needed for health insurance operations. These costs and obligations can be spread, in effect, over larger work volumes when provinces take on the functions. There are other tasks, e.g., procurement of drugs and training services, operating personnel systems, and negotiating with labor unions, for which there may be scale and scope economies.

4.33 In short, scale, scope and externality considerations suggest that some previously central responsibilities be assigned to provincial health units. Nevertheless, the central MOH would continue to have a crucial role though its mix of activities would change drastically. In the communicable diseases example, MOH must monitor national and regional trends, alert provinces about outbreaks elsewhere, press for emergency funding to deal with epidemics, and so forth. In light of observed scale and scope diseconomies, MOH would not focus on the details of health budget allocation and deploying doctors and other staff . Nor would it be directly involved in designing and implementing health education activities, and it would relinquish its longstanding role of "guiding" service delivery, which left such an impression on provider incentives and behavior and client perceptions.

4.34 Instead of these tasks, the indispensable functions of a reformed MOH center on leadership, meaning getting health the attention it deserves, developing and sustaining commitment to a national agenda, and building powerful coalitions to pursue and update this agenda. To carry out this role, MOH should assume a proactive stance in terms on some matters and adopt a facilitative approach on other aspects of the health picture. Overall, MOH needs to establish itself as a technically credible authority on health matters; ensure that health status differentials figure prominently among the criteria used to determine central transfers to provinces and districts and monitor impacts; facilitate emergence of effective and sustainable financing and regulatory mechanisms; build consensus among different stakeholders in the sector; maintain an overview of national and regional trends and patterns in health status (especially among the poor), and financing and policy responses; serve as a clearing house for policy lessons and innovations from different parts of the country and abroad; take note of the quality of medical and other health worker education and its determinants; advance a limited number of high impact themes; and provide technical support in selected areas to district and province governments.

4.35 **Finding effective policy instruments: the district level.** Effective implementation of government health responsibilities, whether handled by districts or provinces and central units, will depend on the use of suitable policy tools. Districts are disadvantaged, lacking ready policy mechanisms and individuals with decision making experience. This is not surprising in that even after 20 years of operation, the centrally guided system had transferred only limited planning, managerial and regulatory tasks to the district health officer (Dokabu) and his team. The continuing Philippine experience with health decentralization suggests that the required capacity begins to develop within three years.

4.36 In fact, several steps can be taken to enhance district level capacity to formulate and implement health policy. As mentioned, an important course of action would be for local governments to steer clear of direct service provision tasks which invariably make heavy demands on available management capacity. District Health Boards (DHBs) can be helpful in finding a satisfactory way to withdraw from

current delivery of care responsibilities, and in tackling other local health issues. DHBs would be expected to sensitize and consult health stakeholders on institutional and budgeting changes, options, and related policy matters, and to assist in brokering sustainable solutions. Favorable experiences have been reported with DHBs in several countries where they serve as priority setting and accountability mechanisms (Hanson, 1999). Experience with DHBs in the Philippines suggests that they are most effective when local authorities are fully involved and appreciative of recommendations arrived at through this mechanism (Department of Health, 1997a; Ramiro, et. al., n.d.). Participants in an Indonesian form of DHBs could include selected DPRD members, NGO and professional group representatives, consumer advocates, religious leaders, public and private hospital directors, Askes and Bapel staff, media specialists, and the Dokabu and his section heads.

4.37 The first task for DHBs would be to become aware of the context, especially the significant spending expectations, obligations from the perspective of some stakeholders, which are being inherited. These "mandates" relate to transferred staff and strong guidance on the part of MOH that current programs would be continued. DHBs need to juxtapose health concerns and indispensable expenditures with likely resource trends, and to then arrive at positions with respect to possible obligations. Having defined the setting in this fashion, the principal task for DHBs would be to address local planning and implementation constraints. This would entail reaching out to existing and fostering new local institutions to share management burdens. For example, the Bapels set up in anticipation of JPKM can be mobilized and given assignments--some thoughts on what Bapels might due were discussed in section III. DHBs could also take advantage of coordination and accountability mechanisms which JPS-BK is adding to the local setting. Of relevance in this regard are the local teams involved in selecting beneficiaries and similar groups at the district and sub-district levels with the responsibility of responding to grievances. Other reservoirs of local management capacity are sure to emerge as well.

4.38 Thus, DHBs can contribute to local capacity by nurturing the "thickening" of the institutional setting that is already underway. They can work simultaneously to simplify the functions and tasks left to DPRDs and their district teams. An option here is for DHBs to join together to fund cross-district bodies to carry out tasks for which there may not be sufficient local level management capacity and which promise significant economies of scale. Districts could also contract with other entities, e.g., universities, to handle specific functions.

4.39 In the medium term then, service delivery responsibilities would rest with private firms or private-sector-like service and financing units, operating according to acceptable accountability principles. Publicly supplied services would be restricted to communicable disease and related interventions provided by well paid professionals who are not allowed to treat patients on private account. A way forward would be to convert public facilities into self-managed and self-financed enterprises, with complete control over personnel functions, and which receive public funds on a contractual or capitation basis, for example, for services to be provided to the poor. Private firms could be invited to take over some local hospitals and health centers. In time, districts could hive off service delivery entirely to private companies. The same principle applies to health financing. DHBs and local government decision makers should look for ways of involving all possible players, e.g., Bapels, private insurance companies, and so forth. This would draw in additional resources for health, stimulate service delivery competition, and add new players to the institutional picture, all desirable goals.

4.40 The district's primary role would then be that of oversight, comprising: i) monitoring health trends and assuring that the poor were getting services at required quality standards; and ii) managing the first tier of grievance procedures, regulatory requirements and guidelines for health finance entities and service providers operating in the district.

4.41 **Cross-district mechanisms**. The institutional issue at the province level is less a matter of capacity than agreement on how responsibilities are to be handled. Law 22 has eliminated the hierarchical relationship between districts and province and central level authorities; currently, many local politicians seem eager to defend their autonomous status and prerogatives and resent what are considered to be intrusive instructions from province level authorities. In this sometimes charged setting, new policy mechanisms are required to ensure that cross-district health concerns are addressed. One of these is the Health Council as it is called in Yogyakarta and Lampung where the approach is being piloted. The Council provides a forum in which to raise health issues, share management burdens, formulate common policies, and organize advocacy efforts. The Council is expected to take responsibility jointly for decisions and actions in respect of those activities, e.g., finance and insurance, health education and advocacy, disease control, special assistance to poorer districts, and regulatory tasks and other services and activities which would be costly for individual districts to tackle on their own. Technical support for the Council would be provided by functional groups working within the district government.[12]

4.42 But wouldn't the Councils be seen in the districts as a new version of the top-down institutions which Law 22 was supposed to have eliminated? This is not impossible at least at first, but membership composition and operational style can promote understanding and acceptance of decisions and actions by these bodies. Councils could include representatives of professional organizations, NGOs, and the private sector. But the core members would be Bupatis or other district-level representatives, making decisions together on agreed agenda items in a transparent manner. The goal of this cross kabupaten alliance would be to deliver tangible benefits by taking on health functions too costly for individual districts to afford. If these objectives were not met, then Council members would have authority and incentives to suggest better approaches.

4.43 The province-level Health Promotion Boards recommended in Section III have much in common with the Health Councils. Their task would be to set health education priorities and fund high quality initiatives proposed by NGOs, university-based teams or others. Board members would be drawn from the NGO world, the private sector, and local government. Councils and Boards need to be fleshed out and tested in real world situations. This is why GOI has drawn on donor assistance to implement province level projects in Lampung and Yogyakarta. Experiences with Health Councils (and their supporting technical teams), and the Health Promotion Board which Yogyakarta is introducing are being watched closely by other provinces.

4.44 **A new MOH**. Lastly, MOH's emerging responsibilities require appropriate supporting policy instruments. Internal capacity will need to be strengthened in respect of the leadership, analytical, consensus building, monitoring, and advocacy roles which MOH must assume. Such improvements in capability should not be postponed. The decentralization process is still in its early days, and there is still much scope for MOH to contribute to the re-design of the sector. And there are near term challenges as regards health funding, redeploying and downsizing the government work force, and altering the public's image of government health interventions. To this end, a unit empowered to facilitate health decentralization and reform is required. This team, which could grow into a larger entity, would have to articulate and gain agreement to a pattern of health decentralization which is at once acceptable in terms of likely health outcomes and sustainable financially and administratively. This would entail intensive discussions with MOF and other core ministries and with key stakeholders. One crucial constituency who must be approached thoughtfully is the government health work force. The Philippines and Colombia experiences provide reminders of how staff unhappiness can side-track reforms. Provincial authorities and the donors need also be included among the stakeholders needing attention. The MOH decentralization unit can sponsor a phased, regionally differentiated approach to health

[12] As mentioned, cooperation across local government lines is a feature of the health reforms in the Philippines (Perez, 2000), although not something which the central department is promoting.

decentralization. But this will require close partnership, at least with a handful of provinces. Such an approach could also serve as the basis for stepped up donor coordination and a more coherent focus in health assistance--this would be another priority task of the health reform team.

4.45 The MOH decentralization team would have other tasks. It could recommend strategies for transforming MOH internally, including calling attention to changes required in organizational personality. This would include planning transitions for distinctive components of MOH. POM, the directorate general for food and drugs, needs to be transformed into an agency something like the Food and Drug Administration (FDA) in the USA, while the communicable disease directorate could evolve into an institution similar to the Centers for Disease Control (CDC) in the USA or similar institutions elsewhere. Meanwhile, the skills mix within MOH would likely shift towards those with social science and management expertise. As this happens, the mode of operations should become less formal and hierarchical, more outward looking and experience-based, and far more responsive to customer perceptions and preferences. The health decentralization and reform unit must lead the way in this respect as well.

4.46 MOH also needs mechanisms to carry out its leadership role within the government and in Indonesian society overall. Efforts to shape opinion and change behavior would benefit from easy access to high powered media expertise, possibly contracted from the private sector. And new institutions are needed to draw attention to health concerns, build consensus among the sector's important stakeholders, and pursue behavior change and other initiatives. Here, a National Health Council or Commission (NHC) with advisory powers could make a contribution. Such entities have proved effective elsewhere in taking on attention getting and agenda-defining functions, e.g., what approach to health decentralization makes sense, as well as in synthesizing and distilling the thinking of technical experts. MOH could serve as the secretariat for such an overarching body whose members would represent key stakeholder groups such as provinces and districts, and Indonesian society overall.

4.47 There is a place as well for other specialized entities which would also have review, consensus forming, advisory, and possibly over some matters, decision making responsibilities. One of these could be a National Health Insurance Council, which would facilitate interaction and make recommendations on a range of health financing issues. For instance, this body could suggest ways of improving regulatory arrangements in the health financing sphere. An essential focus for this Council would be the sort of national commitment to health insurance which was appropriate, i.e., what benefits should be included, on what basis should such a commitment be extended, with what sort of timing and phasing, and so forth.

4.48 Finally, MOH's leadership role, especially its ability to shape and advance the health agenda, requires resource transfer instruments. In the USA, grants from the Federal level CDC to the states are an important mechanism for channeling national funding to communicable disease control. The Matching Grants Program in the Philippines is a second example of such a policy tool. The grants, which are used to reinforce local government commitment to maternal and child health and family planning services, are administered by the central health department. Indonesia's MOH needs a comparable funding facility to help it pursue national policies, e.g., a commitment to improve the health of the poor, by contributing to provincial and district health programs. This instrument, called a specific allocation in Law 25, would operate along with the general block grants which will be the main conduit for resource transfers to districts starting in January 2001. (As noted, MOH needs to ensure that health concerns are taken seriously in the formula and process used to allocate untied block grants.)

4.49 How large a fund should MOH have at its disposal? How should it be allocated? As in the Philippines, an MOH-managed grant mechanism should be relatively small at least during a three year trial period. And initially it should be used for two or three purposes only—provinces and districts will not have the capacity currently to review and react to an extensive menu of grants and related funding options with differing mixes of incentives and conditionalities, e.g., matching grants. Analogous to the

local government assistance unit in the Philippines, a decentralization support facility, with funding for up to seven years, would help MOH to respond to district and province-specific transition problems. This might be accompanied through grant mechanisms, each starting small and expanding according to effectiveness, focused on improving the health of the poor and communicable disease control (please see below).

4.50 **Benefiting from decentralization—poverty and health**. A sense of how these suggested mechanisms and instruments would work in practice can be derived by referring to two policy issues facing Indonesia's soon to be decentralized health system. Addressing the health needs of the poor is discussed first, followed by comments on the second policy concern, sustainable arrangements for communicable disease control.

4.51 As regards health and poverty, Section III suggested that advances would depend on establishing effective provider-client interactions. Improving this micro level "equation" was linked in turn to making it possible for patients and other beneficiaries to consult service suppliers who were motivated, proactive, and technically proficient. Here, Section III pointed to ways of bringing about appropriate provider behavior. These include revamping compensation and employment arrangements so that government health staff are paid adequately for a required full day's work with little leeway for supplementing income by taking second jobs or seeing patients privately. Also required are changes in work culture and oversight practices. Health staff need to be encouraged to use their judgement, and assisted and evaluated through supervision arrangements which focus on improving front-line technical, decision making, and inter-personal skills. Of course, staff likely need considerable in-service training along with assistance in upgrading capacity to respond to specific disease and health problems.

4.52 Section III also noted that such supply-side adjustments will need to be underpinned and steered by demand-side changes. In a word, health service consumers must become better informed. And strong accountability mechanisms, opportunities to exert market power, and access to affordable, high quality care are also required to reinforce desirable provider performance and make sure that the poor make use of health services.

4.53 These recommended adjustments in the Indonesian health scene will be easier to set in motion than might first appear. For one thing, the country has "assets" which are already focused on key elements in the picture and which can be used more effectively. One example is JPS-BK, which as discussed in Section III, is having some success in energizing providers and increasing contacts with poor clients. Also available, are the pra-Bapels set up, with funding through JPS-BK, to prepare the ground for full fledged JPKM service delivery and financing arrangements. As mentioned in Section III, pra-Bapels could be instructed and funded to become advocates of the poor within the health system. This role would actually help these entities gain credibility locally. Another instrument which can be brought to bear is the still emerging health promotion alliance (CHI). NGOs and other partners in this loose coalition could develop high impact health education programs focused on particular regions or localities. Provincial health promotion boards are a possible platform for such activities. Finally, decentralization itself is an asset and opportunity vis a vis the health of the poor since it, in principle, allows for a fresh start. But the overall government reorganization package is a mixed blessing since it may place health at a disadvantage financially and imposes the risks and costs that come with devolving staff and building a new work culture.

4.54 **Building on JPS-BK**. Putting these elements together, JPS-BK is the logical starting point for a policy focus in a decentralized system on the health of the poor. This program's micro-successes and accountability potential need to be recognized, and reinforced and elaborated while alternative funding mechanisms and targeting features are developed. To date, GOI has drawn on donor assistance in financing JPS-BK on a national scale. This approach is not sustainable. Districts and provinces should provide at least some of the needed resources in the future, especially in relatively prosperous regions.

The latter would be the areas where the population is better off and funding for the remaining low income households could come from cross-subsidization within province-wide health insurance arrangements. The indigent program within the national health insurance program in the Philippines provides an interesting model. Household premiums due for the poor in such a scheme could also come from district and provincial government budget allocations. But this would add a competitive, stochastic element--with adverse effects like those seen nationally in the last 20 years--to the funding scene.

4.55 The main challenge arises in poorer regions in which low income families account for a large share of the population, and localities lack substantial mineral, forestry, or fishing resources and thus are treated as beneficiary rather than producer areas under Law 25. These are the regions in which an enhanced JPS-BK should be implemented drawing on resources made available nationally. Some of these funds would have to come from the untied block grants which each district will get. The size of these grants should be linked to poverty and health characteristics, enabling financing to be available to serve as the counterpart contributions, with shares varying according to need, for allocations from a special national poverty and health fund which MOH would manage. Districts would have the option of not using this facility. Meanwhile, MOH would be able to draw on, not only the attractions of grants of different sizes, but leadership and communications powers get the attention of district and provincial legislators and opinion makers and their commitment to building locally grounded health improvement programs.

4.56 Initially, the size of this poverty-health fund should be limited to what would be needed to finance an enhanced version of JPS-BK, assuming some district contributions, in ten kabupatens. Depending on effectiveness and the availability of resources and based on guidance from the National Health Council, the fund might be enlarged to cover up to a quarter of the country's districts, starting with the most disadvantaged ones. And MOH might make use of other policy instruments, e.g., a possible National Health Corps, health promotion efforts, and so forth, to intensify the health-poverty effort. Current JPS-BK implementation features would provide a convenient jumping off point, but districts would be encouraged to concentrate on the health needs of their own poor households, and thus to introduce priorities which match the local scene. To gain access to these health resources, district officials would be asked to prepare proposals which would be expected to describe the size and health needs of the poor population and suggested policy responses.

4.57 These proposals would become the mechanism for enriching provider-client interactions, and should lay out directions through which the effectiveness of providers and the health awareness and bargaining powers of beneficiaries would each be enhanced. Proposals could build on or move quickly away from inherited delivery structures. That is, district systems would be also no longer need to rely on the standard public sector puskesmas and referral set-up, with its prescriptive guidelines and narrow parameters for decision making and discretionary judgement. Instead, district authorities, operating through joint health councils on some matters, would be able to introduce management, staffing, incentive and compensation arrangements which make sense locally. Pra-Bapels, NGOs, private service providers small and large, and other stakeholders and actors, organized as DHBs, could all be brought in as program participants, as could local health promotion alliances.

4.58 As mentioned, eligibility for poverty-health fund allocations might be restricted to a limited number of most seriously vulnerable districts. The same JPS-BK based approach to improving health services would make sense in other districts, where health financing will depend on allocations by local legislatures. MOH's leadership and persuasion powers could make a difference in building political commitment to health. As discussed, DHBs have an important role to play in building influential local health coalitions. MOH may want to take a special interest in facilitating the work of DHBs, including recommending ways for organized groups of health consumers, especially the poor, to make their concerns and needs known.

4.59 This approach, i.e., building on JPS-BK and moving ahead as appropriate, should yield results relatively quickly. JPS-BK has already begun to gain a foothold with clients, and the reaction to further program improvements should be positive. In fact, a favorable direction of change could set in motion a virtuous cycle in which increasing client interest and utilization provide the motivation and means for service improvements. Health promotion activities can be instrumental in sustaining such a process.

4.60 This discussion of health policy towards the poor has also touched on financing issues, health education programs, and the distinctive roles of districts, provinces, and the central MOH. Another feature of the current health scene which is referred to is regional differentiation. There already are sharp contrasts in health risks and outcomes between provinces and among districts within provinces. These differentials could become even more pronounced, unless corrective interventions are introduced.

4.61 As discussed, national health subsidies will need to shift sharply towards poorer provinces and groups. For example, central support is less essential in resource rich Riau and East Kalimantan or high income Bali. These provinces have the resources to support salary increases, extensive retraining, management and supervision reforms, full time work obligations, and quality assurance systems. MOH might provide technical suggestions, monitor trends and fund interesting pilots, but little or no net national subsidy would be allocated. (This is why this paper is not recommending negotiation of service agreements between MOH or GOI and all districts or provinces—such an approach, like that in the Philippines may make sense five years from now.) On the other hand, continuing national support would be needed in provinces with limited natural and human resources. In poor Outer Islands, decentralization would give districts the authority to revise inherited facility and staffing norms and standard service packages and introduce sustainable delivery arrangements. In such areas, central subsidies on equity grounds would be an essential component of health funding--some of this backing could come in kind, specifically by making available members of a suggested, prestigious National Health Corps. Finally, public subsidies mobilized within Java and Sumatra may be best spent to secure health insurance coverage for low income households, whom would need to benefit as well from persistent health promotion and assistance in bringing to bear market power on providers. Demand-side intervention on behalf of the poor, backed by regulatory measures, would make sense in light of the private health sector which has emerged in these areas.

4.62 **Decentralization and communicable diseases**. The operational response to decentralization would look somewhat different as regards communicable disease control. What distinguishes this agenda compared to poverty-health concerns is the necessity of investing in surveillance and prevention activities which are characterized typically by scale economies and externalities--it is likely that districts will underspend on establishing and then running response and control mechanisms. For these reasons, the discussion above suggested that province-level councils, supported technically by the central MOH, could fill an institutional gap in helping districts to take joint action.

4.63 But how would these arrangements work in practice? Here, it is worth drawing attention to some often overlooked elements in the infectious disease control system in the USA. What is most striking about that system is the partnership between the central CDC, and states, counties, and NGOs. When there is a disease outbreak, states contact CDC which sends a team at its own cost to investigate and recommend solutions.[13] CDC often takes the initiative, within this decentralized health system, using funds allocated for cooperative purposes. Recent challenges like lyme disease and the West Nile virus or longstanding problems like HIV provide good examples. The CDC-managed HIV prevention community planning project is actually the main mechanism through which state and local HIV programs in the U.S. receive Federal support.[14] State units make proposals in light of eligibility and review criteria

[13] A similar process occurs when the epidemiology of diseases needs looking into, except that it is a council of state experts which must contact CDC.

[14] The program is currently funded at about $300 million with every state and

disseminated by CDC—the states and NGOs were involved, as with other disease-specific grant programs, in setting performance goals and reviewing actual progress. Financial management controls introduced by CDC also shape the process. If a state is not making suitable progress, CDC can "condition" funding until the problem has been effectively addressed, or it can restrict spending until the state has shown that the issue has been addressed. Assignment of CDC staff to state or local jurisdictions is another useful means of support. This has created an informal network of contacts which has facilitated communication and other aspects of this partnership approach.

4.64 In short, the way complicated infectious disease control issues are handled in the USA, or in other large, diverse, and decentralized countries, may be instructive for Indonesia. The key mechanism is the partnership between a specialized central agency and states with their own budgetary powers. The partnership operates through the CDC's emergency response capacity and through grant-based, cooperative programs each aimed at particular health concerns. More importantly, what these and other mechanisms have created is close professional interactions which transcend bureaucratic lines and often allow issues to be addressed very effectively.

4.65 Of course, arrangements such as these are not immediately within reach in Indonesia. Indeed, some might argue that communicable disease threats linked to continuing economic and social troubles require central MOH authority and capacity to be enhanced not devolved. This view has merit at least in the near term--MOH should remain closely involved in maintaining disease control arrangements during the next three years while preparing for a transition to a decentralized approach. This period could be used to establish a sustainable partnership between MOH and province level communicable disease units and other interested agencies. The mechanism for this effort would be a disease control fund, managed by MOH under the oversight of a group which would include outstanding technical experts. Initially this facility could finance various start-up activities. These could include enhancing MOH's quick-response capacity; developing terms of reference for notional province level communicable disease unit and programs; assessments and ratings of disease control capacities by region; intensive training of relevant staff in disease surveillance and prevention; piloting a grants facility which supports local level activities while also laying the basis for a strong partnership with MOH; and testing ways of seconding MOH staff to regional offices and vice versa. This special fund could begin supporting province or district-based initiatives once agreement had been reached on a grants-based process.

4.66 **International assistance and health decentralization and reform**. Donors can play a significant near and medium term role in facilitating decentralization and related health reforms in Indonesia. Multilateral and bilateral agencies can give informative and supportive reports to Indonesian stakeholders as well as constituencies in their own headquarters and home-countries. The latter should include sector experts, those with macro economic and financial sector concerns, and NGOs with limited or even single-issue mandates. These audiences need to be advised of the health sector's distinctive needs at the moment and the unusual opening at present for a policy paradigm shift.

4.67 Current circumstances also put a large premium on meaningful coordination of donor health spending an other assistance. Fortunately, the major health donors are already working together. In 1999, the World Bank, ADB, WHO, and UNICEF formed a "Partners for Health" alliance as a vehicle for joint activities. This step was assisted by the convergence which had taken place in views of sector problems and remedies.[15] There were favorable precedents as well, e.g., the joint crisis initiative which led to the Scholarships and Grants Program.

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seven of the largest cities as grantees --it is a large, decentralized program on a critical national public health issue.

[15] See, for example, recent program or strategy papers prepared by WHO (1998), ADB (1999), Unicef (1999), AUSAID (1999), and USAID (2000).

4.68 The Partners alliance can be most helpful by reaffirming decentralization and system reform as high priorities on MOH's agenda and by pooling resources to underwrite some of the costs of devolution in the sector. This will require cohesion and discipline. Each donor needs to abstain as much as possible from traditional disease or problem-specific advocacy efforts vis a vis MOH. Doing this will make it easier for decision makers in MOH to focus on tough, reform-related issues and concentrate on developing effective partnerships with provinces, districts, and NGOs. Donors can also lighten the burden on MOH while improving investment performance by supporting efforts to strengthen MOH's leadership functions. This would likely mean cooperating to fund the decentralization and reform unit suggested above, and then working with this unit to develop a medium term expenditure plan which would be jointly financed.

Annex 1. Table 1: The 18 Health Programs and Activities Carried Out by Health Centers

No.	Programs	Characteristic	Responsible Staff	Budget
1.	Maternal and Child Health	Service Delivery	Do, N, M	Available at HC level
2.	Family Planning	Service Delivery	Do, M	Available at HC level
3.	Nutrition	Service Delivery	Na, N	Available at HC level
4.	Environmental Sanitation	Service Delivery	S	Available at HC level
5.	Communicable Disease Control	Service Delivery	N	Available at HC level
6.	Curative Care	Service Delivery	Do, N, M	Available at HC level
7.	Health Education	Service Delivery	Do, M, De, N	Available at HC level
8.	School Health	Service Delivery	De, N, M	Available at HC level
9.	Sports Health	Service Delivery	-	Negligible
10.	Public Health Nursing	Service Delivery	N, M, De	Available at HC level
11.	Occupational Health	Service Delivery	N	Negligible
12.	Mouth and Dental Hygiene	Service Delivery	De	Available at HC level
13.	Mental Health	Service Delivery	-	Part of curative care
14.	Eye Health	Service Delivery	Do, N	Part of curative care
15.	Simple Laboratory	Service Delivery	L	Available at HC level
16.	Recording Reporting	Administration	N, S, H	Available at HC level
17.	Services for Aged Clients	Service Delivery	N, De	Negligible
18.	Traditional Medicine	Capacity Building	-	Negligible

Worker Categories:

Do : Doctor
M : Midwife
De : Dentist
N : Nurse
S : Sanitarian
Na : Nutrition assistant
L : Laboratory assistant
A : Administrative worker

Annex 2. Table 1

Public Sector Health Expenditure by Level of Government 1984/85 - 1999/00

In Billion Rupiah

	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
MoH																
- DIP	101.7	94.7	58.3	27.7	79.6	76.6	149.3	229.7	314.3	376.3	371.9	420.1	485.0	593.0	1,210.0	1,033.1
- OPRS								49.0	49.0	53.9	50.8	52.7	50.9			
- DIK	97.3	122.6	134.4	143.9	161.0	177.5	236.9	290.4	368.7	475.5	582.7	764.0	806.0	1,048.1	1,127.0	1,461.7
- DIK-S											58.8	81.5	80.6	142.9	61.9	110.2
-INPRES	98.5	94.4	109.1	76.3	90.9	101.4	174.4	267.4	315.7	340.4	412.0	338.7	564.1	592.2	1,222.5	1,305.7
Foreign exchange subsidy for drug raw materials															559.0	199.0
BKKBN																
- DIP						101.8	134.3	159.2	207.6	220.4	215.0	225.1	309.6	236.0	109.7	171.1
- DIK						62.1	73.7	88.1	116.5	156.3	177.2	207.6	238.6	297.0	327.3	425.8
MORA (DIP)											0.2	0.2	0.2	0.2	0.2	0.2
SDO	117.3	160.6	174.8	187.7	171.1	255.5	255.6	295.5	334.6	385.0	443.0	532.6	624.7	738.8	871.7	1,320.7
SBBO	8.2	9.5	7.0	7.2	7.8	17.2	15.3	14.3	21.1	21.8	23.8	38.0	31.6	24.8	48.8	73.0
Total GOI	423.0	481.8	483.6	442.8	510.4	792.1	1,039.5	1,393.6	1,727.5	2,029.6	2,335.4	2,660.5	3,191.3	3,673.0	5,538.1	6,100.5
BLN-MOH	30.3	41.0	24.4	25.3	133.6	218.2	136.3	164.4	271.6	155.6	137.4	166.0	297.1	308.4	1,257.7	2,099.9
BLN-INPRES																63.7
BLN-BKKBN						49.5	19.8	12.2	64.3	52.3	47.7	17.1	13.2	4.1	362.3	91.0
Total BLN	30.3	41.0	24.4	25.3	133.6	267.7	156.1	176.6	335.9	207.9	185.1	183.1	310.3	312.5	1,620.0	2,254.6
Total BLN in million $	29.4	36.8	19.0	15.4	77.8	149.8	82.9	89.4	163.9	98.7	84.8	80.3	131.0	67.4	165.6	301.1
% Annual change		25.0%	-48.3%	-19.0%	405.3%	92.5%	-44.6%	7.8%	83.4%	-39.8%	-14.1%	-5.3%	63.2%	-48.6%	145.7%	81.8%
Total GOI+BLN w/o BKKBN	453.3	522.8	508.0	468.1	644.0	860.0	966.4	1,310.7	1,675.0	1,808.5	2,080.6	2,393.8	2,940.2	3,448.4	6,358.8	7,667.2
% Annual change		15.3%	-2.8%	-7.9%	37.6%	33.5%	12.4%	35.6%	27.8%	8.0%	15.0%	15.1%	22.8%	17.3%	84.4%	20.6%
Total GOI+BLN	453.3	522.8	508.0	468.1	644.0	1,059.8	1,195.6	1,570.2	2,063.4	2,237.5	2,520.5	2,843.6	3,501.6	3,985.5	7,158.1	8,355.1
% Annual change		15.3%	-2.8%	-7.9%	37.6%	64.6%	12.8%	31.3%	31.4%	8.4%	12.6%	12.8%	23.1%	13.8%	79.6%	16.7%
Exchange Rate	1,030	1,115	1,283	1,643	1,717	1,787	1,882	1,976	2,049	2,106	2,184	2,281	2,368	4,638	9,784	7,489
Population in million	161.6	164.0	166.5	169.2	172.0	175.6	179.2	182.9	186.0	189.1	192.2	194.8	198.3	201.4	204.0	207.4
Spending per capita in thousands w/o BKKBN	2.8	3.2	3.1	2.8	3.7	4.9	5.4	7.2	9.0	9.6	10.8	12.3	14.8	17.1	31.2	37.0
% Annual change		13.6%	-4.3%	-9.3%	35.3%	30.8%	10.1%	32.9%	25.7%	6.2%	13.2%	13.5%	20.7%	15.5%	82.0%	18.6%
Spending per capita in thousands	2.8	3.2	3.1	2.8	3.7	6.0	6.7	8.6	11.1	11.8	13.1	14.6	17.7	19.8	35.1	40.3
% Annual change		13.6%	-4.3%	-9.3%	35.3%	61.2%	10.5%	28.7%	29.2%	6.7%	10.8%	11.3%	21.0%	12.1%	77.3%	14.8%

Annex 2. Table 2

Public Sector Health Expenditure by Level of Government 1984/85 - 1999/00

In Billion Rupiah, Constant 1993 Prices

	84/85	85/86	86/87	87/88	88/89	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
GDP Deflators, 1993=100																
Government consumption	47.2	52.9	54.6	54.8	56.2	64.3	70.0	76.3	86.9	99.9	106.4	116.7	127.5	143.7	223.1	281.7
Gross fixed capital formation	58.5	60.6	64.8	71.7	74.8	80.9	85.9	87.1	92.1	100.7	108.4	115.1	123.3	150.6	280.4	326.9
MOH																
- DIP	173.8	156.2	89.9	38.7	106.4	94.7	173.9	263.8	341.2	373.5	343.2	364.9	393.4	393.7	431.6	316.0
- OPRS								56.3	53.2	53.5	46.8	45.8	41.3			
- DIK	206.3	231.8	246.0	262.4	286.4	276.3	338.5	380.4	424.2	475.8	547.9	654.5	632.3	729.4	505.1	518.9
- DIK-S											55.3	69.8	63.2	99.5	27.7	39.1
-INPRES	168.4	155.7	168.3	106.5	121.5	125.3	203.1	307.0	342.8	337.9	380.2	294.2	457.6	393.1	436.1	399.4
Foreign exchange subsidy for drug raw materials															199.4	60.9
BKKBN																
- DIP						125.8	156.4	182.8	225.4	218.8	198.4	195.5	251.1	156.7	39.1	52.3
- DIK						96.7	105.3	115.4	134.0	156.4	166.6	177.9	187.2	206.7	146.7	425.8
MORA (DIP)											0.2	0.2	0.2	0.1	0.1	0.1
SDO	248.7	303.6	319.9	342.3	304.4	397.7	365.2	387.0	385.0	385.2	416.5	456.3	490.1	514.2	390.7	468.8
SBBO	17.4	18.0	12.8	13.1	13.9	26.8	21.9	18.7	24.3	21.8	22.4	32.6	24.8	17.3	21.9	25.9
Total GOI	814.6	865.2	837.0	762.9	832.6	1,143.2	1,364.3	1,711.4	1,930.1	2,022.8	2,177.6	2,291.7	2,541.1	2,510.7	2,198.3	2,307.2
% Annual change		6.2%	-3.3%	-8.8%	9.1%	37.3%	19.3%	25.4%	12.8%	4.8%	7.6%	5.2%	10.9%	-1.2%	-12.4%	5.0%
Total GOI w/o BKKBN	814.6	865.2	837.0	762.9	832.6	920.7	1,102.6	1,413.2	1,570.7	1,647.7	1,812.5	1,918.3	2,102.8	2,147.3	2,012.5	1,829.1
BLN-MOH	51.8	67.6	37.6	35.3	178.6	269.7	158.7	188.8	294.9	154.4	126.8	144.2	241.0	204.7	448.6	642.4
BLN-INPRES																19.5
BLN-BKKBN						61.2	23.1	14.0	69.8	51.9	44.0	14.9	10.7	2.7	129.2	27.8
Total BLN	51.8	67.6	37.6	35.3	178.6	330.9	181.8	202.8	364.7	206.4	170.8	159.1	251.7	207.5	577.8	689.7
% Annual change		30.6%	-44.3%	-6.2%	405.8%	85.3%	-45.1%	11.6%	79.8%	-43.4%	-17.2%	-6.9%	58.2%	-17.6%	178.5%	19.4%
Total BLN w/o BKKBN	51.8	67.6	37.6	35.3	178.6	269.7	158.7	188.8	294.9	154.4	126.8	144.2	241.0	204.7	448.6	661.9
BKKBN-GOI						222.5	261.7	298.2	359.4	375.2	365.0	373.4	438.3	363.4	185.8	478.1
Total BKKBN/Family Planning						283.7	284.8	312.2	429.2	427.1	409.0	388.3	449.0	366.1	315.0	506.0
Total GOI+BLN w/o BKKBN	866.4	932.8	874.6	798.2	1,011.1	1,190.4	1,261.3	1,602.0	1,865.6	1,802.1	1,939.3	2,062.5	2,343.8	2,352.0	2,461.1	2,491.0
% Annual change		7.7%	-6.2%	-8.7%	26.7%	17.7%	6.0%	27.0%	16.5%	-3.4%	7.6%	6.4%	13.6%	0.4%	4.6%	1.2%
Total GOI+BLN	866.4	932.8	874.6	798.2	1,011.1	1,474.0	1,546.1	1,914.2	2,294.8	2,229.2	2,348.4	2,450.8	2,792.8	2,718.1	2,776.2	2,997.0
% Annual change		7.7%	-6.2%	-8.7%	26.7%	45.8%	4.9%	23.8%	19.9%	-2.9%	5.3%	4.4%	14.0%	-2.7%	2.1%	8.0%
Exchange Rate	1,030	1,115	1,283	1,643	1,717	1,787	1,882	1,976	2,049	2,106	2,184	2,281	2,368	4,638	9,784	7,489
Population in million	161.6	164.0	166.5	169.2	172.0	175.6	179.2	182.9	186.0	189.1	192.2	194.8	198.3	201.4	204.0	207.4
Spending per capita in thousands w/o BKKBN	5.4	5.7	5.3	4.7	5.9	6.8	7.0	8.8	10.0	9.5	10.1	10.6	11.8	11.7	12.1	12.0
% Annual change		6.1%	-7.6%	-10.2%	24.6%	15.3%	3.8%	24.4%	14.5%	-5.0%	5.9%	4.9%	11.6%	-1.2%	3.3%	-0.4%
Spending per capita in thousands	5.4	5.7	5.3	4.7	5.9	8.4	8.6	10.5	12.3	11.8	12.2	12.6	14.1	13.5	13.6	14.5
Annual change		6.1%	-7.6%	-10.2%	24.6%	42.8%	2.8%	21.3%	17.9%	-4.5%	3.6%	3.0%	11.9%	-4.2%	0.8%	6.2%

Annex 2, Notes for Table 1 and 2

Figures underlined do not include BKKBN.
Total health outlays do not include expenditures by provincial or local governments.

	Source of data
DIP, DIK, BLN DIP, BLN-Inpres. BKKBN, MORA	MOF
	MOF
DIK, DIK-S, OPRS, SBBO	MOH-Bureau of Finance
DIK-S 99/00	MOF, allocation figures
Inpres, foreign exchange subsidy 98/99	Nota PAN
Inpres 99/00	estimated
Foreign exchange subsidy 99/00	POM
SDO (Subsidi Daerah Otonomi) 99/00	estimated
BKKBN: DIP94/95, DIK98/99, 99/00	BKKBN

	Definitions
NA	Not available.
Nota PAN	A book published yearly by MOF and BPK which includes all revenues and expenditures by GOI that has been audited by BPK.
MORA	Includes spending to assist in communicable disease control.
Routine funds	
DIK	Intended mainly for salaries, operation and maintenance, procurement of medicines and consumables, replacement equipment and expendable supplies.
DIKDA I	Provincial routine budget.
DIKDA II	District routine budget.
DIK-S	Non taxable income from hospitals, which is returned to finance routine expenditures.
OPRS	Building renovation, equipment maintenance, and additional consumables of medicines for public hospitals.
PNBP	Non-taxable income from hospitals.
SBBO	Sometimes called SDO-RSUD, this is a subsidy by central government for local hospital non-salary routine expenditure. As with SDO, funds are channeled directly to the local government.
Development funds	
BLN	Foreign assistance channeled through the development budget (Bantuan Luar Negeri).
DIP	Allocated to regions for public hospital equipment procurement, construction, training and other expenditures.
DIPDA I	Provincial development budget.
DIPDA II	District development budget.
INPRES	Grant financing for health center construction and some operating costs (drug purchases, clean water, and environmental health).

Annex 2. Table 3: Health Financing Sources and Their Characteristics

	Nature of Scheme	Financing Mechanism	Payment Mechanism	Choice of Provider	Groups Covered Households/ Population Coverage in millions	Regulator
Government health budgets	Geographically based coverage and access	General taxation	Budgets with central, provincial and district components;	Public providers	Total population (210m)	MOH
Kartu Sehat /Poor certificate	Social welfare	No supplementary budget	Exempt from user charges at point of delivery	Public providers	Poor households (pilot schemes)	MOHA
Military Health Services budgets	?compulsory medical prepayment	General taxation; user charges	Centrally allocated budgets	Military public providers	Military and dependents (2.5m)	ABRI
PT ASKES Civil Servant medical insurance	Compulsory civil servant insurance	General taxation; employee payroll contribution 2%	Capitation for primary care Reimbursement of fees paid	Public providers	Civil servants; Veterans (4.5m/4.5m)	MOF Parastatals DEPKES
JAMSOSTEK social insurance	'Optional' medical component of social insurance	Employer payroll contribution 3/6%	Reimbursement of fees paid	Public and private providers	Workers in firms > 10 employees (2m)	MOM
JPKM	Voluntary prepaid medical care	Employee-employer share negotiated premium	Negotiated contracts with registered providers	Public and Private providers	Workers (0.8m)	MOH
DANA SEHAT	Voluntary community health funds	Community members contribution	Reimbursement of fees paid	Public providers	Rural communities	Cooperatives
Private insurance (commercial)	Voluntary medical insurance	Employee-employer share negotiated premium	Reimbursement of fees paid	Private providers	Workers in firms >10 employees	MOF
Private insurance (PT ASKES)	Voluntary medical insurance	Employee-employer share negotiated premium	Negotiated contracts with registered providers	Private providers	Workers in firms >100 employees (0.6m/ 25m)	MOF
Personal incomes/ Company revenues	Voluntary payment at point of service delivery	Out of pocket expenditure	Fee for services rendered	Private providers Public providers Traditional healers Self treatment	Total population (210m)	MOH

Source: Institute for Health Sector Development, 1999.

Annex 3. Costs of high impact service delivery scenarios

An exercise was conducted to determine approximately what it would cost to "purchase" significant health advances and what increases in health spending would be entailed. Estimates were developed of the full costs of different service delivery scenarios, each constructed to have substantial health impacts. As discussed, expert staff in MOH were asked to define what inputs would be needed to make headway rapidly with respect to different health problems. The standard program of 18 activities, implemented at "ideal" intensity as defined by technical staff, serves as the "base-line" option (Annex 3, Table 2). The funding needed in this scenario is quite large, i.e., 4.8 times puskesmas outlays in 1996/97. Estimates for other high impact but lower cost scenarios were developed as well (Annex 3, Tables 3-4). Each of the alternatives assumes that staff conduct their activities "efficiently," meaning that every outreach foray contributes to the implementation of several puskesmas programs. The options were devised to determine to what extent it would be possible to scale back funding requirements without compromising achievements.

Results show concretely some of the service delivery choices available to policy makers. The ideal, status quo scenario involves substantial funding for communicable disease control, particularly malaria and dengue fever, and for supplementary feeding in school settings. Curative care absorbs a lot of resources as well in this "strategy," thanks to a four fold increase in curative visits (Annex Table 1). Other large expenditures under this scenario are for MCH and Public Health Nursing (PHN) activities, which cover all home visits to post partum mothers, free services for the poor, and visits to families at high risk from other health problems. The package recommended in the 1993 World Development Report (WDR) is cheaper than the status quo ideal due to the absence of general curative care activities, malaria and dengue control, school-based supplementary feeding in backward areas, and public health nursing. The largest expenditures in the WDR scenario are for the EPI (Expanded Program on Immunization) and the Integrated Management of Childhood Illnesses. The Sarawak and quasi-Sarawak options were constructed to examine the cost implications of an approach which replaces health centers and most outreach activities with more numerous village level service units, klinik kesehatan (health clinics). The klinik kesehatan has no doctor and fewer staff than an Indonesian Puskesmas. Klinik workers undertake far less outreach work and handle a relatively limited range of outpatient services (Annex 3, Table 3). A network of klinik kesehatan, at current Sarawak coverage intensity, would double the outlays being absorbed in existing health centers, but would cut the costs of the ideal status quo scenario virtually in half. However, establishing the full Sarawak option would require significant construction and vehicle purchase outlays, as 180 service units would have to be built and equipped per district.

The quasi-Sarawak scenario assumes that existing health subcenters would be changed into klinik kesehatans without new construction or hiring new staff (Annex 3, Table 4). Some major adjustments would be entailed in this approach. Some doctors would be reassigned to hospitals, but many would lose their jobs--compared to the Indonesian approach, doctors play a smaller role in service delivery in Sarawak. The contract doctor (PTT) scheme would not be needed, with its phased elimination providing a more socially acceptable option than firing civil servants. Health center-based nurses and midwives would be reassigned to the village clinics, as would village midwives. And nurses and midwives would need to upgrade their diagnostic and treatment skills so that they can identify which cases need to be referred to hospitals for treatment by doctors. Sanitation workers would get larger responsibilities, particularly in vector control, and would need to be trained accordingly. Nutrition, laboratory, and pharmacist assistants, pekarya kesehatan, special immunization workers and administrative staff would be made redundant or retrained, since their

functions would be taken over by nurses, midwives and sanitation staff. In short, the quasi-Sarawak approach provides essential services only, delivered at an ideal level to achieve a significant impact on health status improvement. The interventions cover: EPI (Expanded Program on Immunization), general curative care, maternal and child health, nutrition activities focusing on the under fives (Protein Energy Malnutrition, Iodine Deficiency, Vitamin A Deficiency and Iron Deficiency), student health screening, and water and sanitation including vector control. This scenario is appropriate for rural areas where private services are not too extensive and where communicable diseases such as malaria and dengue are still prevalent. Districts implementing the quasi Sarawak scenario will need to double actual expenditures.[16]

From the high impact scenarios, two alternatives are within the range of actual expenditure (Annex 3, Tables 3 and 4). They are the WDR scenario (Rp 5.5 billion or US$614,000 per district), and the quasi Sarawak scenario (Rp 7 billion or US$786,000 per district). These calculations illustrate the range of price tags for different service delivery packages, all consistent with the HFA model. In other words, MOH and with decentralization, local government officials have some flexibility budgetarily in determining how to pursue HFA goals for their constituents.

[16] Considering budget constraints, a modification to the quasi-Sarawak scenario was designed for more developed districts with extensive private sector involvement in service delivery. This scenario entails less public involvement in curative care. Public curative services are directed only to the very poor, about 20% of the population. Another difference is that deworming and micronutrient distribution are added to the school health program. The budget for vector control is only one third of that in the quasi-Sarawak calculation, making this scenario more suitable for areas with few malaria and dengue cases.

Annex 3. Table 1: Actual Expenditures and Outputs by Program

No	Program	Services Provided		Actual Expenditure	Actual Expenditure	Percentage From
		Indicator	Achievement	Per district (Rp)	per HC (Rp)	Total
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Immunization	Basic immunization	90% of infants	420,391,993	19,108,727	11.55%
		Hepatitis vaccination	30% of infants			
		Pregnant women vaccination	78% of pregnant women			
		Elementary School (Grade I)	50% of students (Gr. I)			
		Elementary School (Grade VI)	50% of female st. (Gr. VI)			
2.	Lung Tuberculosis	Case Finding	35/100,000 pop	70,578,953	3,208,135	1.94%
		Cure rate	91%			
3.	Malaria (Java-Bali)	Case finding	220/100,000 pop	349,016,759	15,864,399	9.59%
		Larva control	5% of target			
		Mosquito control	40% of target			
4.	Dengue	Case finding	4/100,000 pop.	260,386,784	11,835,763	7.15%
	(sporadic cases)	Fogging	50% of target			
		Use of Abate	10% of target			
		Environment manipulation	10% of target			
5.	Diarrhea	Case finding	22.4/1,000 pop	117,156,259	5,325,285	3.22%
6.	ARI	Case finding	6/1,000 pop	32,082,475	1,458,294	0.88%
7.	Sexually Transmitted Diseases	Case finding	4/1,000 pop	9,193,521	417,887	0.25%
8.	Curative care	Visit/HC	43/HC/day	958,457,903	43,566,268	26.33%
9.	Maternal and Child Health	Four time ante natal visit (K4)	68% of pregnant women	621,571,553	28,253,252	17.08%
		Birth delivery by health staff	60% of pregnant women			
		Post partum care	60% of neonates			
10.	Nutrition					
	- Iron	Pregnant women coverage	60%	146,504,368	6,659,289	4.03%
		Child coverage	16%			
	- Vitamin A	Child coverage	80%	35,019,856	1,591,811	0.96%
		Lactating mother coverage	72%			
	- Iodine	Iodine capsule coverage	90%	50,479,474	2,294,521	1.39%
		Salt monitoring coverage	30% of schools			
11.	School health	School feeding in backward villages	33%	301,687,157	13,713,053	8.29%
		Deworming	11%			
		Student health screening	40%			
12.	Public Health Nursing	Coverage of home visit	30%	9,670,737	439,579	0.27%
13.	Family planning	Active participants	60%	98,039,651	4,456,347	2.69%
14.	Water and Sanitation			159,551,194	7,252,327	4.38%
	TOTAL			**3,639,788,637**	**165,444,937**	**100%**

Source: Marzoeki and Lieberman, 1999.

Annex 3. Table 2: Ideal Expenditures and Services by Current Program

No	Program	Services Provided		Ideal	Ideal	Percentage
		Indicator	Achievement	Expenditure per district (Rp)	Expenditure Per HC	from total
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.	Immunization	Basic immunization	90% of infants	2,037,612,273	92,618,740	10.70%
		Hepatitis vaccination	90% of infants			
		Pregnant women vaccination	90% of pregnant women			
		Elementary school (Grade I)	100% of students (Gr. I)			
		Elementary school Grade VI)	100% of female st. (Gr. VI)			
2.	Lung Tuberculosis	Case Finding	70/100,000 pop	181,384,197	8,244,736	0.95%
		Cure rate	91%			
3.	Malaria (Java-Bali)	Case finding	300/100,000 pop	1,884,934,739	85,678,852	9.90%
		Larva control	100% of targeted vill.			
		Mosquito control	100% of targeted vill.			
4.	Dengue	Case finding	10/100,000 pop.	1,506,839,673	68,492,713	7.91%
	(sporadic cases)	Fogging	50% of target			
		Use of Abate	10% of target			
		Environment manipulation	10% of target			
5.	Diarrhea	Case finding	28/1,000 pop	636,068,986	28,912,227	3.34%
6.	Acute Respiratory-tract Infection	Case finding	11/1,000 pop	364,590,535	16,572,297	1.91%
7.	Sexually Transmitted Diseases	Case finding	12/1,000 pop	284,207,374	12,918,517	1.49%
8.	Curative care	Visit/HC	160/HC/day	2,211,589,579	100,526,799	11.61%
9.	Maternal and Child Health	Four time ante natal visit (K4)	85% of pregnant women	1,312,960,713	59,680,032	6.89%
		Birth delivery by health staff	80% of pregnant women			
		Post partum care	80% of neonates			
10.	Nutrition					
	- Iron	Pregnant women coverage	80%	752,993,107	34,226,959	3.95%
		Child coverage	100%			
	- Vitamin A	Child coverage	80%	33,064,675	1,502,940	0.17%
		Lactating mother coverage	100%			
	- Iodine	Iodine capsule coverage	100%	112,686,152	5,122,098	0.59%
		Salt monitoring coverage	100% of schools			
11.	School health	School feeding in backward villages	100%	6,275,926,164	285,269,371	32.95%
		Deworming	100%			
		Student screening	100%			
12.	Public Health Nursing	Coverage of home visit	100%	1,192,186,319	54,190,286	6.26%
13.	Family planning	Active participants	60%	98,039,651	4,456,347	0.51%
14.	Water and Sanitation			159,551,194	7,252,327	0.84%
	TOTAL			**19,044,635,331**	**865,665,241**	**100%**

Source: Marzoeki and Lieberman, 1999.

Annex 3. Table 3: Cost Comparison of Actual and High Impact Scenarios

Programs	Actual	Cost/District Ideal	1993 World Development Report	Sarawak Model
(1)	(2)	(3)	(4)	(5)
Immunization	420,391,993	2,037,612,280	2,037,612,280	1,248,317,975
Communicable Disease Control				
- Lung Tuberculosis	70,578,953	181,384,192	181,384,192	
- Malaria	349,016,759	1,884,934,744		
- Dengue	260,386,784	1,506,839,686		
- Diarrhea	117,156,259	636,068,994		
- Acute Respiratory-tract Infection	32,182,475	364,590,534		
- Sexually Transmitted Diseases	9,193,521	284,207,374	284,207,374	
Curative Care	958,457,903	2,211,589,578		1,350,000,000
Maternal and Child Health	621,571,553	1,312,960,704	1,312,960,704	816,000,000
Nutrition	232,003,698	898,743,934	894,884,400	570,164,400
School Health	301,687,157	6,275,926,162	168,000,000	23,500,000
Public Health Nursing	9,670,737	1,192,186,292		
Family Planning	98,039,651	98,939,651	98,939,651	
Water & Sanitation	159,551,194	159,551,194		2,784,512,400
Integrated Management of Childhood Illnesses			2,010,388,292	
Salary (Sarawak model)				3,745,920,000
Preliminary Total		19,045,535,319	6,988,376,893	10,538,414,775
Adjustment to reflect cost savings from integrated service provision-		1,461,975,000	1,461,975,000	
Grand Total	**3,639,888,637**	**17,583,560,319**	**5,526,401,893**	**10,538,414,775**

Source: Marzoeki and Lieberman, 1999.

Annex 3. Table 4: Cost of High Impact Scenarios

Programs	Cost/District Ideal	1993 WDR	20% Curative	Sarawak Model	Quasi Sarawak
(1)	(3)	(4)	(5)	(6)	(7)
Immunization	2,037,612,280	2,037,612,280	2,037,612,280	1,248,317,975	990,965,735
Communicable Disease Control					
- Lung Tuberculosis	181,384,192	181,384,192	36,276,838		
- Malaria	1,884,934,744		1,373,602,309		
- Dengue	1,506,839,686		1,404,721,537		
- Diarrhea	636,068,994		127,213,799		
- Acute Respiratory tract Infection	364,590,534		72,918,107		
- Sexually Transmitted Diseases	284,207,374	284,207,374	73,832,075		
Curative Care	2,211,589,578		442,317,916	1,350,000,000	835,200,000
Maternal and Child Health	1,312,960,704	1,312,960,704	1,312,960,704	816,000,000	816,000,000
Nutrition	898,743,934	894,884,400	898,743,934	570,164,400	570,164,400
School Health	6,275,926,162	168,000,000	6,275,926,162	23,500,000	23,500,000
Public Health Nursing	1,192,186,292		1,192,186,292		
Family Planning	98,939,651	98,939,651	98,939,651		
Water & Sanitation	159,551,194		159,551,194	2,784,512,400	2,784,512,400
Integrated Management of Childhood Illnesses		2,010,388,292			
Salary (Sarawak models)				3,745,920,000	1,051,248,000
Preliminary Total	19,045,535,319	6,988,376,893	15,506,802,798	10,538,414,775	7,071,590,535
Adjustment to reflect cost Savings from integrated service provision	1,461,975,000	1,461,975,000	1,461,975,000		
Grand Total	**17,583,560,319**	**5,526,401,893**	**14,044,827,798**	**10,538,414,775**	**7,071,590,535**

Source: World Bank staff calculations.

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