

**CASE-STUDY  
INDONESIA**

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**Indonesia**



## 4

**CASE-STUDY: INDONESIA**  
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Indonesia is one of the largest archipelagos in the world. It consists of 17 508 islands – of which about 6000 are inhabited. The five main islands are Sumatra (473 606 sq km), Java/Madura (132 107 sq km), Kalimantan (539 460 sq km), Sulawesi (189 216 sq km), and Irian (421 981 sq km).

The country is divided into 27 provinces, 336 districts/municipalities, 4 904 sub districts and 68 988 villages. There are 300 ethnic groups (tribes), five major religions, 583 local languages, and one national language – ‘Bahasa Indonesia’.

Approximately 64% of the population lives on the island of Java, where density is nearly 700 persons per sq km. In 2000, about 41% of the population lived in urban areas. Economic growth has led to rapid urbanization. In 1980, 22% of the population was living in urban areas.

With a national history that consists of hundreds of years of Buddhist and Hindu cultural influx, 350 years under Portuguese, Dutch, British and Japanese occupation, the average Indonesian today has a very rich yet complex cultural heritage. The years under European occupation, however, produced a community with limited education and little expectation from life, as well as a paternalistic culture.

Although there is a common national language, given the overall number of languages, tribes, and religions, there is, of course, great diversity in the customs and belief systems of Indonesians. During the last few years of reformation, in which freedoms have been introduced, it is apparent that the effects of long-term disintegration in the country have been significant. These factors may significantly influence the development of long-term care services in the future.

## LONG-TERM CARE

Sociopolitics are also a factor to be weighed in future policy development. The development of the sociopolitical system of Indonesia over the last years can be described as follows:

- Pre-1966: multi-party system, parliamentary and presidential systems.
- 1966–1997: three parties ('Golkar', 'PPP', and 'PD'), presidential system.
- 1998–2001: multi-party system, presidential system and decentralization.

The current political system is considerably more egalitarian and has promoted more freedom and equality. It has also enabled a move towards decentralization, granting more authority to the district governments. This shift has influenced, and will continue to affect, health service provision throughout the country.

In order to improve health care provision in Indonesia, the Ministry of Health established a Special Task Force on Health Development Reform in July 1998 to examine the ongoing economic crisis and reform issues and to subsequently recommend necessary reform policies and strategies. This Special Task Force recommended that the reform of the health sector must address the issues of equity, quality and efficiency.

Furthermore, it is of vital importance that steps be taken to ensure that services reach the poor as quickly as possible. In selected areas, the full implementation of health cards for the poor has already been proposed. Based on the recommendation of the Task Force, the Ministry of Health has instituted a new and more progressive policy for health development – the Healthy Paradigm.

In March 1999, the President signed a declaration proclaiming the start of the new development policy, a Health-Oriented National Development Approach envisioned as 'Healthy Indonesia 2010'.

## CASE-STUDY: INDONESIA

The main goal of this vision is not only to deal with current weaknesses, but also to look ahead to future challenges. This policy focuses more on health promotion and disease prevention rather than on curative services.

The new goals of the National Health Development Programme are:

- to initiate health-oriented national development;
- to maintain and enhance the health of individuals, families and the community, along with their respective environments;
- to maintain and enhance quality, equitable and affordable health services; and
- to promote public self-reliance in achieving good health.

In order to achieve these aims, the following will serve as the foundation for formulating a strategy for National Health Development:

- the Healthy Paradigm, emphasizing health promotion;
- professionalism;
- the Community Managed Health Care Programme ('JKPM'); and
- decentralization.

The main focus of the new approach and the key to health sector reform is decentralization. The Government is putting a tremendous amount of energy into such efforts, which can be seen in all aspects of the programme, including the budget.

## LONG-TERM CARE

This decentralized model involves the following areas:

- integrated health planning and budgeting;
- capacity-building at the district level;
- block grants for district health services;
- stronger community involvement in health services; and
- an increased role of provincial and district governments in health programmes.

Second, the new approach will emphasize disease prevention and health promotion. Third, an effective human resources development programme, that can support decentralization, will be given a high priority. And finally, access to quality basic health services will be strengthened through the 'JPKM' managed care approach.

The main objective of this case study is to provide insight into the development of long-term care policies in Indonesia by learning from what already exists in the country and identifying bases for further development that build on the existing health and social infrastructure in Indonesia. The methods used for this case study are as follows: secondary data, literature and policy review, consultation, case studies, and field observation.

Presented on the following four pages are background data on Indonesia, derived from international data bases<sup>1</sup>. These data involve demography, vital statistics and epidemiology, economic data, and health expenditure.

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<sup>1</sup> For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); US Bureau of the Census, International Data Base; WHO, World Health Report 2001; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

## 1.2 Background data from International data bases

<b>Demography (year 2000)</b>	
<b>Population</b> (thousands)	212 092
<b>Land area</b> (sq km)	1 826 440
<b>Population density</b> (per sq km)	111
<b>Population growth rate</b> (% 2000–2005)	1
<b>Urban population</b> (%)	41
<b>Ethnic groups</b> (%)	
Javanese	45
Sundanese	14
Madurese	7.5
Coastal Malays	7.5
Other	26
<b>Religions</b> (%)	
Muslim	88
Others	12
<b>Total adult literacy rate</b> (% in 1997)	86
<b>Age Structure</b> (%):	
0–14	30.8
15–24	19.9
60+	7.6
65+	4.8
80+	0.5
<b>Projections 65+</b> (%)	
2025	8.4
2050	16.4
<b>Sex ratio</b> (males per female):	
Total population	1.00
15–64	0.78
65+	
<b>Dependency Ratio:</b>	
Elderly dependency ratio in 2000 <sup>2</sup>	8.9
Elderly dependency ratio in 2025	13.7
Parent support ratio in 2000 <sup>3</sup>	5.3
Parent support ratio in 2005	7.1

<sup>2</sup> Elderly dependency ratio: the ratio of those age 65 and over per 100 persons age 20–64.

<sup>3</sup> Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.

## LONG-TERM CARE

### ***Vital statistics and epidemiology***

<b><i>Crude birth rate</i></b> (per 1000 population) (2000)	20.0
<b><i>Crude death rate</i></b> (per 1000 population) (2000)	7.1
<b><i>Mortality under age 5</i></b> (per 1000 births) (2001)	
males	50
females	40
<b><i>Probability of dying between 15–59 years</i></b> (per 1000) (2001)	
males	246
females	213
<b><i>Maternal mortality rate</i></b> (per 100 000 live births) (1995)	470
<b><i>Total fertility rate</i></b> (children born/woman) (2001)	2.4
<b><i>Estimated number of adults living with HIV/AIDS</i></b> (2001)	120 000
<b><i>HIV/AIDS adult prevalence rate</i></b> (%)	0.1
<b><i>Estimated number of children living with HIV/AIDS</i></b> (2001)	1 300
<b><i>Estimated number of deaths due to AIDS</i></b> (2001)	4 600

***Life expectancy at birth*** (years) (2001)

Total Population	65.9
Male	64.4
Female	67.4

***Life expectancy at60*** (years) (2001)

Total Population	17
Male	16
Female	18

***Healthy life expectancy (HALE) at birth*** (years) (2001)

Total population	56.7
Male	56.1
Female	57.2

***Healthy life expectancy (HALE) at 60*** (years) (2001)

Total population	10.9
Male	10.6
Female	11.1

Indonesia's Constitution of 1945 identified health – as a means to the promotion of public welfare and the development of human capital – as a national priority. Over the years, the Government has taken various steps in this direction and has greatly improved the public health of the country. The steady decrease in infant and child mortality and the increase in life expectancy illustrate the efficacy of such efforts.

The population pyramid is increasing towards the older population; there is a life expectancy at birth of 65 years for males and 69 years for females. The Infant Mortality Rate (IMR), furthermore, is gradually declining, most likely due to socioeconomic development and improved preventive and curative health services. The IMR was 142 per 1000 in 1968, 70 per 1000 in 1986, and 39 per 1000 in 2000.

## LONG-TERM CARE

Despite these figures, public health in Indonesia today still lags behind when compared to that of neighbouring countries. Moreover, there are regional and provincial disparities in health indicators. For example, in 1998 the IMR in West Nusa Tenggara was more than three times higher than the IMR in Jakarta. It is important to note these differences in order to more effectively target health services.

<b><i>Economic Data (Year 2000)</i></b>	
<b><i>GDP – composition by sector (%)</i></b>	
Agriculture	21
Industry	35
Services	44
<b><i>Gross national income (GNI) (\$PPP)<sup>4</sup></i></b>	596 billion
<b><i>GNI – per capita (\$PPP)</i></b>	2830
<b><i>GNI – per capita (US\$)</i></b>	570
<b><i>GDP growth (annual %) (1999–2000)</i></b>	4.8
<b><i>Labour force participation ( % in 2000)</i></b>	
Male	57.4
Female	39.4

In the more than 30 years under the New Order Government, Indonesia has made substantial progress, particularly in stabilizing political and economic conditions in the country. There was a period of economic growth from 1968 to 1986, when per capita income increased from about US\$50 to US\$385. This was primarily the result of an oil boom. However, after the drop in oil prices, the Government began to look for alternative sources of income. By 2000, the per capita income was US\$570.

Despite these achievements, the country experienced a severe setback in mid-1997 when the Indonesian economy collapsed. The value of the currency plummeted, prices increased, and unemployment rose dramatically. In addition, parts of the country suffered from relatively long droughts and extensive forest fires. These sudden crises resulted in political turmoil and a change of government. Although the health status of Indonesians may not have been affected drastically in the short term, the economic crisis undoubtedly slowed the development of the health system. Furthermore, the current political instability has also had a direct impact on economic recovery.

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<sup>4</sup> PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries

It is feared that the effects of the political and economic crises will be felt for several more years. Even though Indonesia is taking deliberate steps to protect the health of its population, particularly through modification of policies and strategies of health development (e.g. “Healthy Indonesia 2010”), it is widely believed that the pace of progress in solving many of the health problems in the country will be slow.

With shifting politics, the economic picture continues to oscillate. The percentage of the population living in poverty dropped from 60% in 1970 to an estimated 11–13% in 1996. Most of the poor today live in rural areas, typically in the remote islands or upland areas of Indonesia. However, since July 1997, as a result of the crises that hit Indonesia, the country has faced difficult, fundamental changes that have greatly affected people’s lives.

Examples of such changes include a steep decline in buying power, an increase in prices, a deterioration in industrial productivity, and a wave of lay-offs in various industries. The economic crises have caused a drop in the Indonesian per capita income (PCI) and put Indonesia back on the list of poor countries. According to the World Bank, the national poverty level, which was successfully reduced in 1996 to 22.5 million people (11.3% of the population), bounced back to 29 million (14.1% of the population) in 1999.

The Central Board of Statistics (“BPS”) estimated this figure at 79.4 million – 39% of the population in July 1998; while the Asian Development Bank’s estimation – 80 to 100 million people, nearly 50% of the population – was even higher. It is important to note, particularly for policy development purposes, that the people who are most vulnerable to change are the marginal members of society. In urban areas, they live in slums and work as maids, construction workers, etc. In rural areas, they do not have a steady income.

<i>Health expenditure (year 2000)</i>	
<i>% of GDP</i>	2.7
<i>Health expenditure per capita (\$PPP)</i>	84
<i>Health expenditure per capita (US\$)</i>	19

## LONG-TERM CARE

Although the Government is committed to making health a top priority, despite the economic crisis, preliminary analysis of public expenditures shows a decreasing health budget in real terms. Intersectoral cooperation has also been inadequate and the quality of human resources is poor.

Per capita health spending dropped from US\$11.4 in 1984/1985 to US\$10.2 in 1986/87, increased to US\$17.2 in 1994/95. In the last couple of years, due to the economic crisis, spending on health decreased dramatically. The level of per capita spending on health is significantly lower in comparison to other Asian countries with comparable per capita incomes, and in 1998 per capita public expenditure on health was US\$3.00 .

Experts estimate that approximately 17.5 million school-age children will have to leave school to help their parents at work, and four hundred thousand students will be unable to continue their studies, due to the economic crisis. In various large cities, the number of street children has increased. In several places, cases of child starvation are a common occurrence.

The literacy rate in 1997 for those age 10 years and older was 89.07%. Elementary school enrolment of children age 7–12 years for this same year was 95.4%.

## ***2 General health, social and LTC system***

### ***2.1 Basic income maintenance programmes***

There is no basic income maintenance programme for the elderly, except for those individuals who were career civil servants or military personnel. Some private companies have basic income maintenance programmes for their employees, although the number of such companies is very small.

### ***2.2 Organizational structure of decision-making***

In the Indonesian cabinet, according to changes as of September 2000, a decision was made to merge the Ministry of Health with the former Ministry of Social Affairs and the Ministry of Community Problems and Crisis. This merge created the new Ministry of Health and Social Welfare (MOHSW).

The new Ministry is responsible for the formulation and implementation of national health and social welfare policy and overall administration, and the coordination and management of the country's health and welfare system.

Current roles of MOHSW include:

- developing general policy;
- providing advice, facilitation and consultation; and
- implementing monitoring schemes and supervision.

It is divided into the following seven departments:

- Community Health;
- Medical Services;
- Centre for Disease Control (CDC);
- Pharmaceutical Services;
- Social welfare Services;
- Social Welfare Development; and
- Social Welfare Problems and Crises.

The MOHSW is headed by the Minister, and its staff includes the Secretary-General, the Inspectorate-General and seven Directorates-General (one for each department mentioned above). The Bureau of Planning, under the Secretary-General of the MOHSW, is responsible for planning and budgeting health development programmes and for coordinating activities for LTC. Overall, there is a high degree of centralization in health services with control by the central government, and frequently by vertical programmes.

The Ministries of Health and Social Welfare, Education, Religion, Population Affairs and Women's Roles are all coordinated by the Coordinating Minister for Politics, Social Affairs and Defence. The House of People's Representatives ('DPR') is divided into 11 committees responsible for producing legislation. Public Health, Social Welfare and Family Planning fall under one of these committees (Committee VII).

## LONG-TERM CARE

The political institution at the highest level in Indonesia is the People's Consultative Assembly or 'MPR'. There are also two national institutes in the country. The National Institute of Health Research and Development – which since June 2001 has become the National Institute of Health and Social Welfare – is responsible for health and social welfare research.

As mentioned, at the ministry level the Bureau of Planning for Health, under the Secretary-General of the MOHSW, is responsible for planning and budgeting the health development programs. This body is responsible for coordinating activities for the development of long-, medium-, and short-term health plans. It is also in charge of channeling all foreign assistance through the Bureau and coordinates its efforts with the Central Planning Board ('BAPPENAS').

At the provincial level, the MOHSW shares responsibility with the provincial government, under the Ministry of Home Affairs, for administering Government health services. The dual management system comprises the MOHSW Provincial Health Office ('Kanwil') that is technically and administratively accountable to the MOHSW, and the Provincial Health Service ('Dinas Kesehatan Provinsi') that is technically accountable to the provincial administration. Specific programmes and projects are the responsibility of the project officer. The 'Dinas Kesehatan Provinsi' is also expected to maintain an integrated view of all provincial health services.

At the district level, the District Health Office ('Kandep') is a unit of the MOHSW, while the District Health Service ('Dinas Kesehatan Kabupaten/Kota') is technically a unit of the district administration, and is administratively responsible to the head of the district. In general, there is only one office, the 'Dinas Kesehatan Kabupaten/Kota', which is responsible for the implementation of all health services at the district ('Kabupaten/Kota'), sub-district ('Kecamatan') and village levels. The head of this administration, the District Health Officer ('Dokabu'), is again the focal point of the dual lines of control. The district health administration plays an important role in primary health care in supervising the district health network, organizing the distribution of drugs, and executing CDC programmes.

At the village level, the Integrated Health Posts ('Posyandu') provide preventive and health promotion services. These health posts are established and managed by the local community, and assisted by staff and volunteers from the health centres. In order to improve maternal and child health, midwives/nurses are now being deployed in the villages.

Since 1958, the spirit of the decentralization of health services has been acknowledged, yet efforts have not included the resources necessary for implementation. Using donor assistance (USAID, World Bank, etc.), many studies and pilot projects on health reform have been conducted since 1979.

## CASE-STUDY: INDONESIA

Under the World Bank's Health Project III (1994), reforms in the budgeting process have been initiated. Because the budget has been tightly controlled by the central government and frequently by vertical programmes, local health services have been fragmented. In response, and in line with 1995 Government reorganization and decentralization regulations, an effort was made to integrate the budgets for public and basic health services into one project at the district level.

The Ministry of Home Affairs delegated more authority to district health offices for planning, implementing and managing resources. Although this was a good idea, vertical programmes resisted this attempt to combine and simplify the district budget. More recently, a new initiative has been developed – Integrated Health Planning and Budgeting – where district planners are offering the technical skills needed to analyse their particular situation and develop interventions to solve the problems with the necessary resources.

It is also the district planners' job to identify potential sources for resource mobilization particularly district funds, revenues from user fees, and private funds through partnerships. Responsibility for planning and budgeting of district hospitals has also now been granted to district health officers (WHO Health System Profiles Database, 2000). This new decentralized approach is considered to be one of the essential elements in building the capacity at the district level. This initiative has not been implemented extensively, but several districts have adopted the new approach to prepare for decentralization.

Decentralization has picked up more momentum in this 'Reformasi' era and is considered one of the main policies of the new Government. Two new decentralization laws have recently been enacted: Law no. 22/1999 that deals with provincial and local governments, and Law no. 25/1999 on fiscal equalization between central and local governments. These two laws, which impact health provision in important ways, will bring fundamental changes in the basic roles and responsibilities of the central, provincial and district governments.

Prior to the decentralization policy in January 2001, the top-down structure was clearly evident. In this structure, the Ministry of Health and Social Welfare had a very dominant role. However, after January 2001, the major decision-making roles – including health development programming – were taken over by the Governor and the District Administrator/Regent or by the City Mayor with their local health officers.

## LONG-TERM CARE

### **2.2.1 Budget allocation**

The national budget system in Indonesia is divided into two main components: the regular budget and the development budget. Regular budgets cover operational and maintenance costs (salaries, plant maintenance, etc.), while the development budget is for investment purposes (pre-investment activities, programme development, etc.). There are several schemes under the development budget including: 'INPRES' (President's Special Funds); 'BANPRES' (President's Funds); Development Projects; Foreign Aid Projects; 'SBBO' (Operations Subsidy); and 'OPRS' (Hospital Operations and Maintenance). Regional and local administrative levels provide additional funds, however, and at least 90% of the public budgets come directly or indirectly from the central government.

Based on the best available data, it is estimated that the total health development budget increased from 2.4% of the annual national development budget in fiscal year (FY) 1996/97 to 3.0% in FY 1999/2000. This amounts to a growth of 0.4% of GDP in FY 1996/97 to 1% in FY 1999/2000.

Unfortunately, the available budget fails to meet current health needs. According to a significant change in the 1999–2000 budget, however, approximately 60% of the Government budget will be allocated directly to the provinces. Regional allocations will take on two forms: general subsidies and specific block grants for sectors such as health (WHO Health System Profiles Database, 2000). Although the Government is committed to making health a top priority despite the economic crisis, preliminary analysis of public expenditures shows a decreasing overall health budget in real terms, particularly for FY 1998/99. Intersectoral cooperation has also been inadequate and the quality of human resources is poor.

## **2.3 Financing of health services**

### **2.3.1 Sources of finance and approximate share**

Funds flow into the health sector from a variety of sources: the major sources include Government revenues (both central and local); payments by households (fees for services, drug purchases); employer contributions to health care; limited support from NGOs; and foreign loans and grants. In the period 1985–1995, an average of 30% of all health care expenditures came from government sources. The remaining 70% came from nongovernmental sources, including the organized private sector (employers and insurance companies) and out-of-pocket health expenditures by households. Table 1 presents health expenditure (in local currency, converted into US dollars according to the mean of the annual exchange rate).

CASE-STUDY: INDONESIA

Per capita health spending dropped from US\$11.40 in 1984/1985 to US\$10.20 in 1986/87, but increased to US\$17.20 in 1994/95. This level of per capita spending on health is significantly lower in comparison to other ASEAN countries with comparable per capita incomes.

**Table 1. National Health Expenditures in Indonesia  
(billion rupiah & US\$ where indicated)  
1984/85, 1989/90 and 1994/95**

	1984/1985	1989/1990	1994/1995
<b>Public sector</b>	544 600.0	852 723.4	2 206 803.3
Central	305 700.0	701 286.1	1 821 087.7
Province	57 500.0	70 619.9	161 376.7
District	22,100.0	80 817.4	224 338.7
(%)	28.7	26.4	31.3
<b>Private sector</b>	1316 600.0	2 201 670.1	4 448 613.2
Out-of-pocket	1 020 700.0	1 661 786.0	3 346 644.0
Private company	72 800.0	194 300.0	433 824.6
Parastatal	132 700.0	241 600.0	471 574.8
Insurance/ managed care	90 400.0	103 984.1	198 569.2
(%)	69.6	68.3	60.3
<b>Foreign Aid</b>	30 300.0	167 271.2	373 271.0
(%)	1.6	5.1	5.3
<b>Total</b>	1 891 500.0	3 221,664.7	7 028 687.5
Population (million)	161.6	179.1	195.3
Per capita/GDP	Rp11 704.8	Rp17 988.1	Rp35 989.2
Percapita/GDP	US\$11.4	US\$10.2	US\$17.1
Per capita/GDP (at constant price 1983)	Rp10,669.0	Rp11,289.0	Rp15,190.0
Health Expenditure as % of GDP	2.06	1.85	1.94

Source: Suwandono & Malik (1995)

## LONG-TERM CARE

To analyse the flow of funds, Government funds can be grouped by administrative level (central, provincial and district), or by type of budget (development and routine). The principal source of funds for development expenditures at the central government level is provided from the 'APBN', or national development budget.

The regular or operating expenditures are allocated from the 'APBN', or national regular budget. Funds are also provided from the 'INPRES' (President's Special Funds) budget. These funds come from the central government to the provincial and district governments for health services provision, purchase of drugs, supplements to the budgets of Puskesmases, outreach programmes, clean water and environment programs, etc.

An additional source of funds is provided by the 'SBBO' (operation cost subsidy fund) and 'OPRS' (hospital operation and maintenance costs). Both of these sources provide funds from the central government (through the Ministry of Finance) to the provincial and district governments. This budget is a special fund intended to augment hospital resources for routine costs and maintenance. Salaries for health personnel in provincial and district governments are budgeted under the Autonomous Regional Subsidy routine budget.

Aside from central government funding, there are funds provided by the 'APBD Provinsi', the provincial-level government budget, which consists of a general development budget that complements that of the central government development budget, and the provincial regular budget which includes 'SDO' (regional autonomy subsidy) for salaries and incentives for MOH manpower. Funds provided by the 'APBD Kabupaten/Kota' (district-level government budget) consist of funds from the central government budget and district/city regular budget.

Additionally, there are many other public departments outside the Department of Health and Social Welfare that allocate funds for health and provide health services for military personnel (e.g. 'Hankam' - the Department for Defence and Security). The Department of Education and Culture supports medical education and the Department of Religion provides funds for Hajj Health Services. The Departments of Transmigration, General Works, Agriculture, Mining and Energy, and Social Affairs also provide funds for health and related activities.

The largest contribution of private funds comes from direct payments for inpatient and outpatient care. This is estimated at Rp 4.6 trillion ('Susenas 1998') and amounts to approximately 75% of the total, beyond insurance and Government expenses. Private investments in the health sector are growing rapidly – from 251 hospitals in 1989 to 464 in 1995.

## CASE-STUDY: INDONESIA

These hospitals are fully equipped with the latest technology. Foreign investors are also very attracted to private health insurance. Additionally, medical doctors are expanding their private practices into group practices and private hospitals.

As mentioned, due to economic development the insurance sector is growing at a remarkable pace. However, the development of health insurance is still slow. Only 15% of the 200 million inhabitants of Indonesia are covered by some type of health insurance. The following are important points in this area:

- Since the fiscal year 1982/1983, financial aid for health from foreign countries has been extensive. While there were at least 13 sources of funds from foreign agencies, the majority was for investment (infrastructure) and not enough was provided for system improvements. The emphasis on infrastructure development is a matter of concern as it may cause operational and maintenance costs to rise in the future.
- The national development budget for fiscal year 1999/2000 was 83.6 trillion rupiah. Of this, 30 trillion was from foreign assistance, as direct project support. Indirect support of 47.7 trillion came from foreign assistance such as general and sector loans from the IMF, World Bank, ADB and OECF. Only 6.2 trillion was from the government's own revenues. Thus, over 90% of development expenditures was funded (directly or indirectly) through foreign assistance.
- The Government of Indonesia directly uses most of the foreign aid, and, therefore, the burden of development and sustainability will be in its hands in the future. There is a growing recognition that this responsibility should be shared between the Government and the private sector. The Government must reduce its involvement in service delivery and be more involved in public policy, regulation and in ensuring that the poor have adequate health care.
- From the perspective of decentralization, there have been significant changes in the Government's 1999/2000 budget. Around 60% of the Government's sectoral development budget was allocated directly to the provinces, districts, and communities, leaving only about 39% for sectoral departments.

## LONG-TERM CARE

These regional allocations consist of two types of budgets: general subsidies to local areas and specific block grants for sectors such as health. In order to protect national priorities, the block grants have specific guidelines. However, much more autonomy will be given to local staff in implementing programmes. Block grants (totaling Rp 363 billion) will be given to health centres, allocating 40% for operational costs and 60% for maintenance.

- Decentralized procurement of drugs was originally proposed, but because of concerns about quality and rational drug use, it was decided to maintain the current system while expanding the local capacity for future decentralization. A total of Rp 475 billion has been budgeted for health centre drugs. Twenty percent of this amount will be procured at the provincial level and the remainder at the centre. In the next fiscal year, only very essential drugs will be procured centrally, and provinces will procure other essential drugs. This means that, in the future, less than 50% of the total budget for drugs will remain at the central level.

As a result of budget constraints, public hospitals suffer from a scarcity of resources. This condition is aggravated by the inflexibility of the budget system. The concept of autonomous hospitals or 'swadana' was launched in 1988. This allows hospital managers to retain hospital revenues as an additional source of operational costs.

Thus, this concept provides additional funding and, at the same time, it increases the hospital management's responsibility for improving the quality of services. At present, 44 public hospitals have been granted autonomous hospital - 'swadana' status.

However, although there is some evidence that this initiative improves the quality of services, it has not achieved the objective of lowering public subsidies for these hospitals. Also, as out of pocket fees have continued to increase, access for the poor is likely to be even more difficult. In addition, during the period of high economic growth, Indonesia opened its market to foreign investment and encouraged domestic investors in health care. As a result, the private sector grew substantially. This also fostered cooperation between public facilities and private companies, and the out-sourcing of some services.

### ***2.3.2 Pooled health care programmes, general taxation for health care provision, purchasing strategies utilized***

Although in 1993 the Government attempted to promote access to health care for poor and vulnerable populations through the 'Health Card' programme, it unfortunately did not achieve its goals. Health Card holders are eligible for free health care at public facilities and can receive primary as well as secondary care.

One of the main problems has been the reluctance on the part of local (district) governments to provide free services, especially in poor districts. This issue became more conspicuous as the economic crisis hit the country and boosted the number of poor to approximately 20% of the total population. To resolve this and other problems, the Government launched the Social Safety Net Programme for Health funded by the IMF and ADB. Some evidence has shown that this programme has reached the target population and promotes essential services to the poor.

However, there are concerns regarding programme leakages and their impact on the sociocultural conditions of the community. These problems have led to questions about the programme's sustainability and it will most likely be phased out in the coming year.

Government funds, however, are not adequate to pay for all of the health services required by the Indonesian public. While public funds will be used for priority public health initiatives and to ensure that the poor have access to services, more resources must be mobilized from the community. Overall, the non-poor will have to pay more for health services. Additionally, the establishment of effective managed care programmes (like 'JPKM', discussed below) will facilitate resource mobilization and ensure universal access to health services.

There are currently two voluntary health insurance programmes – 'Dana Sehat' and 'JPKM', and two statutory programmes – 'Pt. Askes' and 'Jamosek', in Indonesia. Unfortunately, the political climate of the 'Reformasi' era has also made compulsory schemes less attractive, and many of them have collapsed. The number of those with private health insurance, on the other hand, is still low but growing (WHO Health System Profiles Database, 2000).

Since the early 1970s the Government has promoted the 'Dana Sehat' village health programme. It had its origins in small NGO schemes. In 1990, the MOH issued a development strategy for this community health care insurance programme.

## LONG-TERM CARE

Community organizations, such as village cooperatives or religious organizations, organize and own the funds. Some village providers organize monthly pre-finance collections from local community members (Rp1000 or US\$0.10 per month) and they contract with the local health centres for certain basic health services for the villagers. Others involve external funds and are sponsored by NGOs or religious organizations.

The packages of services vary, although most cover the monthly costs of the services at the local government health centres, basic medications for emergencies, and some of the more developed care includes hospital care. There are no co-payments (WHO health system profiles database). This programme attempts to increase the coverage of health services in Indonesia by encouraging community participation in financing and in health promotion.

However, the limited funds that can be collected from villagers barely enable the village to reimburse high-cost services. This is especially true with regard to hospitalization. Limited benefits make the community less willing to participate in the scheme. However in some districts it has been successful under the management of the district head. By 1994, approximately 13% of all villages had some type of health fund (WHO Health System Profiles Database, 2000).

'JPKM' ('Jaminan Pemeliharaan Kesehatan Masyarakat') – the Indonesian version of Managed Care, was launched in 1992 under Health Law number 23/1992. This programme is focused on basic primary care (promotion, prevention, curative and rehabilitation services), as well as quality assurance, reliance on a prepaid capitation payment method, risk profit sharing and mandatory basic benefits.

It is a voluntary program that represents an attempt to unify the scattered and very different insurance programmes that operate throughout the country and integrate the insurance function, as well as health care management (similar to HMOs). Although the concept has been developed for more than 25 years, progress to date has been limited.

'JPKM' principles for maintaining efficiency, effectiveness and equity are summarized below and on the following page:

- prepaid capitation payment;
- risk profit sharing among the members, the 'JPKM' management unit and the health services institution;

- contract-based agreement in 'JPKM' ;
- clear mechanism and follow-up for complaints ;
- quality assurance;
- monitoring of procedures and structure of health services;
- basic compulsory package that contains promotion, prevention, and curative and rehabilitation services (including coverage for health education, immunization, maternal and child health care, treatment of diseases, outpatient, inpatient, diagnostic support, and emergency care).

The first and second principles, on the previous page, attempt to ensure budget efficiency. The third, fourth, fifth and sixth principles, above, ensure the effectiveness and quality of the services, and the last principle provides equity and basic health services for the community.

The 'Pt. Askes' scheme is a compulsory social security programme for public sector employees and retirees, which also has a health benefit (covering about 15 million people – 7 to 8% of the population). Due to budget deficits, efforts to contain costs include the introduction in some districts of capitation payments to health centres.

However, hospital services are reimbursed through fee-for-service. There is an extensive package of services including treatment for catastrophic to minor illnesses. A referral system was implemented to prevent over-utilization of secondary and tertiary care. This scheme is financed by a 2% payroll deduction and is additionally subsidized by the Government.

In 1993, it was expanded to include voluntary members and in five years this voluntary programme has grown to 600 000 persons, and is projected to expand rapidly (WHO Health System Profiles Database, 2000).

'Jamsostek' emerged in 1992 through a national law that established compulsory enrolment in the core benefits of social security, including a health component for all workers in companies of more than ten employees. (If a company can show better or at least equivalent coverage for its workers, it can opt out of this coverage).

## LONG-TERM CARE

The initial aim was to include the informal sector although this never materialized. It covers only two million workers out of the 25 million workers who are formally employed. It contracts with providers and was the first to pay hospitals on a capitation basis (although it has not been consistently followed). More recently, it has established a licensed 'JPKM' organization that manages health benefits on behalf of 'Jamsostek' (WHO Health System Profiles Database, 2000).

Until 1998, only 15% of the population was covered by some sort of insurance scheme. Civil servants - 7.8% of the total population – are the largest insured group (under 'Pt Askes'). Workers in the formal sector, 2.4% of the population, are insured by the 'Jamsostek' scheme, and another 2.7% of the population receives reimbursement from their employers.

These figures demonstrate that insurance coverage in the formal sector is still very low and that both employers and employees are unaware of its importance for health. Several other factors have been identified as obstacles to the implementation of the 'JPKM' insurance scheme, including in particular:

- poverty;
- highly subsidized user fees at public facilities;
- low community awareness;
- bureaucratic procedures;
- low technical capacity for implementation;  
and, most noteworthy,
- the low level of confidence in insurance providers.

Between 1992 and 1995, the initial steps of 'JPKM' policy development (e.g. regulation enforcement, policy application) were carried out. From 1995 to 1997 an integrated trial-and-error field study was carried out in the Klaten District that examined organizational development, local planning, unit cost, and various other related areas.

The results of this study led to programme implementation in several districts in Indonesia. In 1998, approximately 15.1% of the community was covered by 'JPKM' pre-paid payments. Hopefully, this will be the impetus for implementation of all 'JPKM' principles in the future.

**Table 2. Comparative Total Number of Members of Managed Care and Health Insurance  
(Comparative Data on 'JPKM' Members)**

*By Managed Care Organisation/Insurance Company and Insured/Groups 1988, 1994 and 1998*

Managed Care Organisation Insurance Company	Insured/Groups	Total Members		
		1988*	1994*	1998**
'PT. ASKES IND' (Parastatal, MOH)	Government employees & pensioners (Civil and Army)	11 127 093	14 684 761	15 600 000
'PT. ASTEK' (Parastatal, Ministry of Manpower) or "JAMSOSTEK"	Private companies employees	84 711	498 600	1 600 000
'Dana Sehat' (Village Health Fund)	Farmers, fishers and students	6 334 320	12 306 692	20 800 000
'Dana Sehat' w/'JPKM' Principles	Farmers, fishers and students	—	—	1 131 765
Co-operation Unit	Members of Credit Union Unit	—	945 239	700 000
Private Health insurance Companies	Middle-high income urban residents	20 000	71 579	90 643
<b>Total</b>		17 556 124	28 470 921	39 922 408 (or 19 122 408 without 'Dana Sehat')

\* 1994 NIHIRD Study, Suwandono, A and Ridwan, M. (1995)

\*\* Estimate by the Directorate General of Community Health Development, Depkes (1999)

## LONG-TERM CARE

Based on the 1994 NIHRD Study, it was estimated that in 1988, 17 566 124 people - 10.6% of those who were eligible – were covered by health insurance or the village health fund – ‘Dana Sehat’. This coverage increased to about 28 470 921 in 1994 (14.8%).

However, according to the report of the Directorate General of Community Health Development in the 1999 National Health Development Workshop, the population covered by managed care or health insurance was about 15.1% or approximately 19.1 million people out of 180 million eligible ‘JPKM’ members.

Table 2 shows that the estimation of total members of ‘JPKM’ or ‘Dana Sehat’, with or without applying ‘JPKM’ principles and health insurance, numbered approximately 39 922 408. Close to 20.8 million people are ‘Dana Sehat’ members, without applying ‘JPKM’ principles.

Therefore, it is estimated that ‘JPKM’ covers only about 19.1 million people. The current enrolment in ‘JPKM’ programmes depicted in Table 3 indicates that the largest market penetrated by the ‘JPKM’ programmes is that of civil servants, retired government officials, and army personnel. Interestingly, in the formal, informal and private sectors, the market is still wide open.

**Table 3. Enrolment in ‘JPKM’ and total market (1998)**

	<i>Number of enrollees</i>	<i>Total market</i>	<i>% Market still open</i>
Government	15 600 000	16 000 000	2.5
Formal Sector	1 600 000	40 000 000	96.0
Informal Sector	1 131 765	107 000 00	98.9
Private Sector	90 643	16 800 000	99.4

Source: Directorate General of Community Health Development (1999).

## CASE-STUDY: INDONESIA

In order to increase the coverage of 'JPKM' consumers ('PESERTA'), several activities were carried out at the district level. These included:

- analysis of actual and potential health problems in the district to map disease patterns; projection of district health service accessibility and ability to pay the local community; performance of health service units; managed care organization; etc.;
- promotion of 'JPKM' in local district administration offices, in health service units, and among candidates of managed care organizations;
- formation of advocacy and supervisory bodies at the district level;
- encouragement of managed care development; and
- education of the community about 'JPKM'.

The following efforts will help to improve the quality of health services provided by the health service units ('PPK'):

- family doctor training by the Indonesian Medical Association in collaboration with the local School of Medicine;
- training in 'JPKM' and business management, as well as quality assurance for HC's and public hospital staff;
- comparative study in Singapore on several HCs and public hospital doctors and staff;
- development of medical service standards for 'JPKM' at HC's and public hospitals; and
- improvement of medical facilities and equipment at HCs and public hospitals.

## LONG-TERM CARE

The development of more 'BAPELs' (managed care organizations) is crucial because, until recently, there were only 20 licensed organizations and 20 others in the process of being licensed. It appears that the strategic unit for 'JPKM' development is the district. The reasons are as follows:

- There is a complete infrastructure of health services (basic and referral) that can be used as a 'PPK' network.
- The number of eligible inhabitants at this level is manageable under 'JPKM'.
- There are government, private and community organizations that can be developed as the 'BADAN PEMBINA' and 'BAPEL' for 'JPKM'.
- The district is the smallest possible unit with a sufficient number of qualified personnel.
- The district is the smallest autonomous area in which full decentralization will be permitted by the central government

The following key efforts have been carried out to accelerate the establishment of 'BAPEL' and to strengthen those that already exist at the district level:

- development of financing standards (capital and reserve) for 'BAPEL';
- development of reporting and recording systems for 'JPKM';
- development of finance management systems for 'JPKM'.

The revitalization of 'JPKM' is one of the most important steps towards achieving the goals of Healthy Indonesia 2010. Additionally, the MOH has proposed that 'JPKM' will be one of several strategies used to reduce the public's dependence on the Social Safety Net for the Health Sector ('JPS-BK') and offer an alternative form of health care support to the community. However, under 'JPKM' the premiums of the poor will be paid by the Government.

CASE-STUDY: INDONESIA

The MOH is now preparing 337 'BAPEL' throughout Indonesia in order to hasten the enrolment of the poor in the 'JPKM' programme. The majority of 'BAPEL' are managed by Credit Unions (44.0%) and Foundations (33.8%).

Table 4 illustrates the distribution of 'BAPEL' which are being developed to support the integrated 'JPS-BK'-'JPKM' programme.

**Table 4. 'BAPEL' development for the integrated 'JPS-BK'-'JPKM'**

<b>'BAPEL' of 'JPKM'</b>	<b>Total number</b>	<b>Number of provinces</b>
Parastatal	19	5
Credit Union	147	22
Foundation	113	17
Company	7	3
Pt. Askes (Insurance company)	25	6
Others	26	10
<b>Totals</b>	<b>334</b>	<b>63</b>

The integrated 'JPS-BK'-'JPKM' programme will cover the population that falls below the official poverty line, and the Government will pay for the premiums. The 'BAPEL' and the 'PPK' must work intensively to overcome the existing obstacles in order to achieve the objective of integrating 'JPS-BK' - 'JPKM'.

## LONG-TERM CARE

The following is a list of priority issues to be dealt with:

- Inadequate management capability in health financing among health providers.
- Insufficient regularity and sustainability of the 'JPKM' and the 'Dana Sehat'.
- Lack of quality in monitoring and supervision.
- Lack of a widespread 'JPKM' financing system that includes pre-payment and capitation.
- 'JPKM' package concentrated on curative services.
- Insufficient knowledge about the concept of 'JPKM' by many health providers at various levels.
- Low tariff at rural health centres.
- Increasing number of poor people due to Indonesia's economic crisis.
- Inadequate education and training for implementation of 'JPS-BK' – 'JPKM'.

To revitalize reforms in the health sector, in the opening ceremony of the 1999 National Health Development Workshop, the President of Indonesia, BJ Habibie, launched "Healthy Indonesia 2010". The strategies for achieving this vision are:

- the application of the health paradigm;
- the improvement of professionalism;
- the application of decentralization; and
- the revitalization of 'JPKM' (the community health maintenance insurance).

## CASE-STUDY: INDONESIA

Among these strategies, the revitalization of 'JPKM' must be carried out immediately. This is necessary in order to keep it in line with the implementation of the Social Safety Net in Health Sector ('JPS-BK') in an effort to sustain the community-based health development in Indonesia.

The following parties should be involved in the implementation of the 'JPKM' programme:

- Defined communities as consumers ('PESERTA'). They are members of a family, a group, or a unit of an organization who pay a certain amount to maintain their health conditions.
- Health service units ('PPK') as an organized health service network which can provide effective and efficient health services as packages of comprehensive health maintenance assurance (health promotion, prevention, and curative and rehabilitation services).
- Formal Managed Care Organizations ('BAPEL'), which are responsible for the daily application of 'JPKM'.
- Government and local professional organisations ('BADAN PEMBINA'), which supervise, develop, encourage and support the implementation of 'JPKM'.

The relationship between these parties can be seen in the following diagram:



## LONG-TERM CARE

### **2.4 Services delivery system**

In the last 30 years, the Government has expanded public health care across the country by developing a system of health centres. There are about 7500 health centres in 314 districts and 21 000 sub-centres. In addition, almost every district has at least one district hospital. Each sub-district in Indonesia has at least one health centre headed by a medical doctor and it is supported by two or three sub-centres mostly headed by senior nurses. Health Centres provide 12–16 basic health services. Most are equipped with four-wheel drive vehicles or motorboats that serve as mobile health centres to provide services to under-served populations in urban and remote rural areas.

Newly-graduated medical doctors and dentists are deployed by the central administration and must serve in these public facilities. However, since 1992 the central government issued a 'zero growth policy' for civil servants.<sup>5</sup> This restricts the availability of doctors and dentists, especially in remote areas. In response, the MOH has implemented the Contract Doctor Programme in which new graduates must serve in health centres on a contractual basis for three years before becoming civil servants. Upon completion of the service, they are free to work in the private sector or to pursue specialty training. This initiative means, however, that young doctors are uncertain about their future work status and are therefore less motivated.

At the village level, the Integrated Health Posts ('Posyandu') provide preventive and health promotion services. These health posts are established and managed by the local community, use a cadre of volunteers ('kaders'), and are assisted by staff from health centres and village maternity centres. Unfortunately, due to the economic crisis, posts in some of the villages have been closed and volunteers dismissed, leaving villagers without access to this care. Those that are still in operation offer basic health care services for children under five, pregnant and lactating women, and eligible couples. They often offer spiritual support and health education as well. The services include weighing children, recording and reporting health information, distributing oral rehydration solutions, vitamin A, basic medicine for fever and influenza, and iron tablets; and providing health education for children and pregnant women. In order to improve maternal and child health and in conjunction with efforts to lower the maternal mortality rate, midwife nurses are being deployed in the villages.

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<sup>5</sup> Due to the decentralization policy, now if a local government (district or province) has the need and the resources to hire new personnel, they can, as long as they do not ask for additional budget money from the central government. Zero growth means the total of government officials cannot be added as before, new civil servants can replace them if they are pensioned or if it is really needed due to extreme conditions. In the past, the growth of civil servants was high; however it was not efficient, due to the low quality of the new civil servants.

## CASE-STUDY: INDONESIA

Since 1995, under a similar contractual scheme as the Contract Doctor Programme, the Government has deployed these village midwives across the country. At present, about 52 000 midwives have been deployed. However, questions have been raised regarding the efficacy of this initiative and its long-term sustainability. Additionally, traditional healers are numerous in Indonesia and are an integral part of the health system.

Many people in Indonesia seek care from traditional healers who use various forms of treatment including herbal medicine, water, and forms of magic. Sometimes the healers also provide health education on such things as which foods to avoid or to consume, places to visit that may have healing usage, or body positions that may be pain alleviating. In some cases healers are paid in trade, for example with a kilogram of rice or fruit from the patient's garden, or there is always the option to pay on subsequent visits or whenever able.

Accreditation and standardization of health services, particularly in hospitals, has been conducted since the late 1980s. In addition, several groups have been working on quality issues using various approaches. The World Bank Health Project IV provides health centres with technical assistance and systems development for quality insurance in five provinces. Several public and private hospitals have also begun quality assurance processes. In general, however, the quality of health services is still substandard, reflecting a combination of low quality health personnel and poor equipment.

At present, 44 public hospitals have been granted autonomous hospital – 'swadana' – status. However, although there is some evidence that this initiative improves the quality of services, it has not achieved the objective of lowering public subsidies for these hospitals. Also, as out-of-pocket fees have continued to increase, access for the poor is likely to be even more difficult. In addition to the issue of cost of care is the problem of access due to the lack of adequate transportation as well as variable proximity to health facilities particularly in rural areas.

Because of the large market for drug companies and the increasing availability of drugs, there is a tendency for health providers to over-prescribe. Anticipating this problem, in the early 1980s the MOH developed the List of Essential Drugs that is revised every three years. In addition, the MOH campaigns for more affordable generic drugs by providing facilities for Government-owned and selected private manufacturer drug production.

This reform is still problematic and there is reluctance on the part of both providers and consumers to use drugs rationally. However, the decreasing ability of consumers to pay out-of-pocket prices during this current economic crisis makes generic drugs an attractive alternative.

## LONG-TERM CARE

### ***2.4.1 Auspices of service providers***

During the period of high economic growth, Indonesia opened its market to foreign investment and encouraged domestic investors in health care. As a result, the private sector grew substantially. This also fostered cooperation between public facilities and private companies, and the out-sourcing of some services.

Despite a relatively large government health infrastructure, low utilization rates of health centres for primary care have continued to be a problem. Use of private sector practitioners (or public health workers who work also privately) tends to dominate the health care delivery system (WHO Health System Profiles Database, 2000).

Private clinics, hospitals and pharmacists are mostly located in urban areas. Rural areas utilize the private services of publicly employed health professionals in the 'off-hours'. Private sector hospitals are concentrated in only a few cities (WHO Health System Profiles Database, 2000).

A number of religious missions, mostly from the Netherlands, operate small hospitals and dispensaries, and mobilize funds to support urban and rural hospitals. Many charge patients for their services, and some are subsidized by the MOH. NGOs are active in caring for specific groups such as the elderly, mentally and physically handicapped, as well as specific disease groups (WHO Health System Profiles Database, 2000).

## ***2.5 Human resources and training***

The total number of health providers in Indonesia is approximately 380 000. About 17% work at the national level and the remainder are employed as local health providers (at the provincial, district/city, sub-district and village levels).

There are more than 150 000 Government doctors, nurses, midwives, paramedics employed as salaried staff by the Government (and comprise 60% of the total health budget). Fifteen percent of health workers are employed in private settings (WHO Health System Profiles Database, 2000).

Health providers can be categorized into the following nine groups:

<i>Category</i>	<i>Percentage</i>
■ Nurses and midwives	41.4%
■ Nurse assistants	12.7%
■ Non-paramedic health workers	25.5%
■ Other paramedic health workers	10.3%
■ Medical doctors (GPs)	4.7%
■ Medical doctors (Specialists)	1.9%
■ Dentists	1.8%
■ Pharmacists	1.0%
■ Others	0.6%

In 1995, there were 37 000 doctors throughout the country; one doctor for every 52 000 persons. No information is available on the number of nurses. Most nurses receive education at the junior high school level plus an additional three years of nurses training (WHO Health System Profiles Database, 2000). Nurses are also paid to make home visits.

In order to improve maternal and child health and in conjunction with efforts to lower the maternal mortality rate, midwife nurses are being deployed in the villages. Since 1995, under a similar contractual scheme as the Contract Doctor Programme described in above, the Government has deployed these village midwives across the country. At present, about 52 000 midwives have been deployed.

## LONG-TERM CARE

There are also about 500 000 traditional healers throughout Indonesia. They can be divided into four categories, based on the different techniques they employ:

- healers who use traditional herbs (such as 'jamu', food, water, oil and others);
- healers who use traditional instruments (acupuncture, 'coin', glass, and other instruments);
- healers who use traditional methods (traditional birth attendance, massage, acupuncture, etc.);
- healers who use supernatural powers.

The population uses these healers extensively.

Indonesia also has 39 000 social workers, who operate social welfare programmes at the provincial, district/city, sub-district, and village levels. In addition, there are around 4000 social organizations and roughly 14 000 village volunteer social workers who operate social welfare programmes throughout the country. The volunteer social workers have been trained by local social workers to assist with work at the village level. No information is available on training requirements for social workers.

Assisting the health providers, there are about 1 million village volunteer health workers ('kaders') in various fields and programmes. They are trained by local health centres, district hospitals and provincial hospitals to assist village maternity health workers, drug post health workers, integrated health post workers, and others. About 14 000 village volunteer social workers are trained by local social workers to assist in the villages. Most home visits in Indonesia are made by volunteers.

### 3 Summary of LTC provision

Long-term care in Indonesia has not yet been formally institutionalized, but has been carried out by players in various sectors with limited coverage. LTC services currently include:

- home care for the elderly;
- services for the mentally retarded;
- services for those needing traditional bone repositioning;
- care for disabled children; orthopaedic rehabilitation services;
- care for mental illnesses; and
- cancer treatment.

Generally, LTC in Indonesia can be divided into four categories:

- **LTC in institutions by age group:**  
geriatric homes ('Panti Wredha' – homes generally for the healthy elderly and those able to pay for care); vocational rehabilitation camps for disabled youth; disabled childrens' homes, and other services.
- **LTC for those with chronic disease in hospitals:**  
including mental illness, leprosy, heart disease, cancer, chronic lung disease, kidney disease, etc., and those needing orthopaedic rehabilitation services.
- **Community-based LTC:**  
activities for cancer patients (including those organized by a district 'family welfare movement'), and geriatric clubs (including a village geriatric group organized by local village health providers trained by a religious foundation).
- **Home-based LTC:**  
mainly, home care for the elderly and care for people with chronic diseases, disabilities, mental disorders, and others who are cared for by family members.

## LONG-TERM CARE

Home care is also provided for traditional bone reposition by healers who have 2–20 rooms for LTC in their homes. In addition there are paid nurses, neighbours, etc., who make home visits. Most home care (including personal care), however, is provided by family members and sometimes neighbours. Few home care programmes have been developed at the local level, and those that exist are based mainly on volunteers trained by health professionals.

LTC services provided by both institutions and individual providers vary by geographic area. Factors influencing LTC provision depend on:

- type of service;
- cultural background of patient and provider;
- socioeconomic background of patient;
- degree of seriousness of illness; and
- traditional vs. modern methods.

Another classification of LTC services is based on the type of institutions that provide the care:

- government;
- non-government;
- private; or
- community-based organizations.

Rehabilitation services can be divided into three types:

- institutional care;
- outreach; and
- community-based care.

## CASE-STUDY: INDONESIA

Aside from the financial considerations, a major reason for not developing a broader package of LTC services is that traditionally people have tended to take care of the elderly, and those who suffer from chronic illness, at home. Among the LTC facilities that currently exist, geriatric institutions are the only ones that have become more popular in recent years (particularly in big cities). This is due to the fact that increasing numbers of family members who live in big cities have to work, especially women who are the traditional caregivers. Today, programmes of public health nursing, developed by the Ministry of Health and Social Welfare, assist families in caring for the elderly and chronically ill.

As mentioned previously, traditional healers provide a great deal of care in Indonesia, including long-term care. The main profession of traditional healers in Cimande Village in the Bogor District of West Java Province is bone repositioning as a result of fracture, dislocation, or injury. There are more than 100 traditional healers doing bone reposition in this village. They also provide LTC for their patients in their own (the healer's) homes. Every traditional healer has two to twenty rooms for LTC. The average length of stay for LTC patients ranges from one month to several years. The healers use their bone reposition expertise as well as various types of oils to treat their patients. Patients for this type of treatment are from all socioeconomic backgrounds.

Current exceptional efforts in Indonesia, that may be used as successful examples for initiating further development of LTC services in the country, include:

- Public health nursing programmes developed by the Ministry of Health and Social Welfare that encourage and assist families in caregiving for elderly relatives, or family members with disabilities or chronic illnesses.
- Village geriatric groups organized by local village health care providers trained by a religious foundation. In a village of the North Sulawesi Province there exists a primary health programme, developed by a religious foundation ('Yayasan GMIM'), that is part of the Integrated Village Health Development Project and offers such services as:
  - weighing children under-five;
  - antenatal care;
  - clean water provision;
  - village health insurance;
  - fundraising; and
  - geriatric group activities.

## LONG-TERM CARE

The geriatric group has been organized by local village providers who are trained health providers from the 'Yayasan GMIM'. There are about 30 elderly people in the group ranging in age from 58 to 74. Some of them are disabled as a result of strokes, diabetes, cancer, chronic disease or injury, and suffer from various symptoms. Others are still very healthy. They have been divided into several small groups with five to six members in each. Most of the activities carried out by them are related to LTC. The activities include the following:

- Daily morning (except Sunday) walk around the village for approximately 30–40 minutes with additional light exercise.
- Communal breakfast in the village hall following the exercise. The menu consists of healthy food such as fruits, porridge, soy bean cake, etc., which is brought by members of the group.
- After breakfast, health providers usually lead a discussion about health or other topics. If the providers are absent, the discussion is led by the elderly themselves.
- The disabled and those with health problems are then examined by the health providers or by the elderly who have been trained by them to check blood pressure, reflexes, etc.
- Those who are sick at home or cannot participate in these daily activities, as well as those who are hospitalized, receive visits by other members of this geriatric group. Members also accompany those elderly who need assistance or request help from the families.
- Health fund programme within those elderly families are conducted.
- Fundraising activities are offered, including gardening, traditional medicine preparation, horticulture, etc.

- Community participation in LTC offering activities for cancer patients through the Family Welfare Movement ('PKK') in Sidoarjo District, East Java Province.

The 'PKK' is a family movement with women in key roles. This movement has ten basic activities, including health, social welfare, education, fundraising, housing, religion, environment, and others.

One of the activities of the 'PKK' in Sidoarjo is LTC for cancer patients. The 'PKK' volunteer workers ('kader') are trained by local health centres, district hospitals, provincial hospitals, private foundations, and research institutions in caregiving for this population.

They learn how to provide care, palliative treatment, health education, morale boosting, spiritual care, as well as to create a favourable environment, and how to avoid secondary infections and other dangerous complications. Traditional herbs, acupuncture and other traditional techniques are also used by the 'PKK' for palliative treatments.

'PKK' members encourage families of cancer patients to provide care for them at home. The 'PKK' also manages the village health insurance with the local hospital, and provides escorts (by the 'kader') for routine medical examinations and laboratory tests.

- Volunteers trained by local health centres, district hospitals and provincial hospitals.
- Integrated health posts ('posyandu') at the village level, assisted by staff from health centres, village maternity centres, and a cadre of volunteers.

## **4 General questions pertinent to LTC development**

### **4.1 Present and future needs for long-term care and gaps between needs and provision of services**

Currently in Indonesia, the following issues need to be addressed in order to improve long-term care provision in the country:

- Lack of institutionalized programmes for LTC.
- Lack of regulation of LTC.
- Lack of decentralization of health services at the district level, so that each district does not have a specific programme for LTC.
- Low initiative of NGOs and the private sector.
- Health care programmes at the health centres and hospitals still do not function as expected.
- The integration of the Ministries of Health and Social Welfare, and Community Problems/Crises is in progress but still lacks an integrated conceptual framework.
- Health and social welfare are not perceived as investments, but rather as social and humanitarian activities with low productivity and low overall development
- Community and private sectors are not partners in development, nor are they proactive. They still operate as the objects of development.
- Geriatric home care and other LTC services provide minimal coverage and are still not very popular. They are mainly for the very poor (government) and the rich (private) and operate without any standardization.
- Lack of clear guidance, supervision and advocacy for LTC practised by traditional healers.
- Facilities for pregnant women at high risk employ traditional birth attendants or midwife assistants, as well as midwives at the village level, and are not well standardized. There are no facilities for high-risk children under five with serious malnutrition.

#### **4.1.1 Greatest unmet needs:**

- Nursing home care for high-risk pregnant women.
- Nursing home care for high-risk children under five with severe malnourishment.
- Nursing home care for the elderly.
- Nursing home care for heart and cancer patients.

#### **4.1.2 Major education/training needs for LTC:**

##### ***For health personnel***

- Additional training in LTC, home care, high-risk pregnancies, and child nutrition for midwives, traditional birth attendants, traditional healers, and nurses.
- Training of family doctors.
- Training of general practitioners in LTC, home care for patients with various diseases, care for the disabled, geriatric care, and recognition of risk factors.
- Special education for geriatric nurses.
- Additional training for health providers in treatment of heart disease, chronic illness, mental illness, cancer, and injuries.
- Community involvement in LTC.
- Management and insurance for LTC.
- Medical and social rehabilitation.

## LONG-TERM CARE

### *For community health workers ('kader')*

- How to motivate the local community to participate in LTC.
- How to organize LTC.
- LTC, health care and social welfare.
- Financing of local insurance for LTC.
- Medication and equipment.
- Home care.

### *For the community (especially mothers and families)*

- Home care for babies and children under-five.
- Home care for pregnant, lactating, and high-risk women.
- Home care for the elderly.
- Management of heart disease, cancer, injuries, disabilities, mental disorders, and other chronic diseases within the family and neighbourhood
- LTC, health care and social welfare.
- Health care and social insurance.

**4.1.3 Major health concerns that lead to LTC needs:**

***Projected disease transition in Indonesia: (1990-2020).  
Disease, injury, or cause of death – year 1990 scenario  
based on the 1986 National Health Household Survey  
(NHHS)***

- Lower respiratory infections
- Diarrhoea-related diseases
- Conditions arising during the perinatal period
- Unipolar major depression
- Ischaemic heart disease
- Cerebro-vascular disease
- Tuberculosis
- Measles
- Road traffic accidents
- Congenital anomalies
- Malaria
- Chronic obstructive pulmonary disease
- Falls
- Iron deficiency anemia
- Protein energy malnutrition

## LONG-TERM CARE

### *Year 2020 scenario, based on the 1992 and 1996 NHHS*

- Ischaemic heart disease
- Unipolar major depression
- Road traffic accidents
- Cerebro-vascular disease
- Chronic obstructive pulmonary disease
- Lower respiratory infections
- Tuberculosis
- War
- Diarrhoea-related diseases
- HIV
- Conditions arising during the perinatal period
- Violence
- Congenital anomalies
- Injuries
- Tracheal, bronchial, and lung cancer

#### ***4.2 What resources (structures, manpower, organizations) at the national and local levels may be utilized to promote LTC provision?***

Several laws, regulations, decrees, and guidelines for disabled community and rehabilitation programmes related to LTC have been developed in Indonesia during the last decade. They are as follows:

- Law No. 6/1974: principles of social welfare.
- Law No. 23/1992: health and the health system.
- Law No. 4/1997: the disabled community.
- Government Regulation No. 43 /1998: improvement of social welfare for the disabled community.
- Presidential Decree, No. 83/1999 regarding National Coordination Committee on Disability (NCCD).
- National Principle Guideline for Development ('GBHN') 1999–2004: social welfare, community problems, crises, and health.
- National Programme for Development ('PROPENAS') 2000–2004: social welfare and health.
- Minister of Health Decree, No. 109/1999 regarding medical rehabilitation.
- Minister of Public Work Decree, No. 468/1998 regarding technical guideline of accessibility for public building and its surroundings.
- Minister of Transportation Decree, No. KM71 / 1999 regarding accessibility for people with disabilities and sick people, their vehicles and infrastructure of transportation.
- Other related Ministerial Decrees.
- Various technical guidelines related to disabled community and rehabilitation programmes.

## LONG-TERM CARE

According to the National Plan of Action for Elderly Welfare (2000), there are various policies and programmes formulated by the government related to the older population. They are as follows:

- Policy and Programme of Former Coordinating Ministry of People Welfare and Alleviation of Poverty, which contains general guidelines and standard services to institutionalize elderly in national development.
- Policy and Programme of the National Social Welfare Board by State Ministry of Community Issues/National Social Welfare Body and recently the Ministry of Health and Social Welfare, which concentrated on the management of the elderly through nursing home care and outside of nursing home care.
- Policy and Programme of Ministry of Health that focused on health services to maintain the health status and productivity of the elderly. Elderly health services that are part of family health through primary health care and referral system.
- Policy and Programmes of the State Ministry of Population/National Family Planning Coordinating Body, which basically focused on increasing elderly welfare through improvement of attention and the role of family in religious activities, healthy activities, productive life and independence.
- Policy and Programme of Other Ministries such as Ministries of Manpower, Education and Culture, Transportation, Religious Affairs, and so forth.
- Programme and activities of NGO/Private/Social and Community organizations.

### 4.3 Developments that will impact on LTC

As a result of the economic crisis and the political changes now taking place, Indonesia is in the midst of a transition. With steps being taken to mitigate the impact of the crisis on public health, many new developments are taking place both in public and private spheres. A new health policy and innovative approaches are being established to provide health care in an equitable and efficient manner.

Priority issues in LTC development include:

- **Equity in health care services:** This issue is growing in importance due to the economic crisis. Health care cards need to be distributed more widely. Voluntary managed care plans ('JPKM') have been introduced and people are strongly encouraged to join the plans for better coverage of health services and protection for all.
- **Decentralization:** This is the key to total development of the health sector. In Indonesia, the current movement involves all sectors. However, necessary precautions should be taken from the beginning to prevent any adverse effects of decentralization.
- **Deregulation in drug trade:** The production of generic drugs should be encouraged to increase accessibility to those of low income. In addition, rational use of drugs must be promoted.
- **The geographic distribution of health and health-related professionals.** Major obstacles in this area include the reluctance of health personnel to work in rural areas and difficulty in placing female health workers in the periphery. One way to combat these problems would be to improve incentives for career development in remote areas. It should also be noted that, in the decentralization era, it is likely that hiring of personnel can be conducted at lower administrative levels. This policy could increase the distribution of human resources dedicated to health care and has the potential for improving performance.

## LONG-TERM CARE

- ***Self-financing hospitals:*** 'Autonomous' hospitals are needed to improve efficiency in the use of funds and facilities through devolution of health programme management. There is a need to take appropriate steps to sustain the *private health sector*, in order to save it from collapsing in the wake of the economic crisis.
- A new policy aimed at supporting and improving health services permits the employment of physicians and medical specialists as *temporary contract workers*.
- Deployment of *village-based midwives* could reduce maternal and infant mortality through improved prenatal, delivery and postnatal care.
- Development of a *population-based health information system* at the district level to support managerial decision-making.
- Improvement of the quality of care in *public facilities* to promote higher utilization and contact rates.
- *High quality governance.*

The general election of June 1999 restored legitimacy to the Indonesian Government, introduced new members to the Parliament, and ushered in a new Minister of Health. While the new Health Minister has not made drastic changes in policy, the commitment for Healthy Indonesia 2010 still remains.

However, until mid-2000 the political sector was still reluctant to do anything that might slow economic recovery. The Government still needs to exert major efforts to solve the economic crisis and return the country to economic growth.

The Minister of Health has emphasized specific target areas for present efforts to be used to guide health priorities:

- *Exit policies after Social Safety Net programs.*  
During the economic crisis, the Social Safety Net ('JPS') for Health has been a major initiative to protect the poor from the adverse effects of the crisis. Nonetheless, these programmes are not sustainable and must be phased out over the coming year. This will have to be planned and implemented in an efficient manner.
- *Resource mobilization and health financing.*  
Government funds are not adequate to pay for health services required by the Indonesian public. While public funds will be used for priority public health initiatives and to ensure that the poor have access to services, more resources must be mobilized from the community. Overall, the non-poor will have to pay more for health services. Additionally, the establishment of effective managed care programmes ('JPKM') will facilitate resource mobilization and ensure universal access to health services.
- *Health delivery reforms.* More complete coverage and quality health services will require significant reform of the current health delivery system. Incentive systems must be established that reward efficient and effective health services, both at primary care ('Puskesmas' and clinics) and secondary care levels, and that take action against ineffective and inefficient practices.
- *Human resource development.* Reforms and financial changes need to be supported by improvements in human resources. Quality training programmes are needed for all health personnel and identification of new categories of health personnel is essential for meeting the future challenges in the health care system. In addition, pre-service training must be supported by effective career development and in-service or continuing education programmes. The science of health care is developing rapidly and health personnel must keep up with the latest developments and techniques.
- *Decentralization.* This approach, as mentioned above, will be the overriding strategy for all changes in the health sector.

## LONG-TERM CARE

The Government of Indonesia uses directly most of the foreign aid, and therefore, the burden of development and sustainability will be in its hands in the future. There is a growing recognition that this responsibility should be shared between the government and the private sector. The government must reduce its involvement in service delivery and be more involved in public policy, regulation and in ensuring that the poor have adequate health care.

Several laws and regulations have been passed during the last decade providing the legal basis for the improvement of social welfare for the disabled in the community, indicating a developing awareness of the needs of the disabled in Indonesia. Furthermore, the current political system during this reformation period is considerably more egalitarian and has promoted more freedom and equality. It has also enabled a move towards decentralization, granting more authority to the district governments. This shift has influenced, and will continue to affect, health service provision throughout the country. Nevertheless, for the future development of LTC, there are also several areas of conflict that should be considered:

- Signs of social and political disintegration
- Political in-fighting
- Ethnic conflict
- Religious conflict
- Misconception of democracy throughout the population
- Misconception of decentralization throughout the population.

Additionally, as a result of the economic crisis in Indonesia, there are several economic factors which must be addressed in order to develop effective LTC policy:

- Uncertain growth of economic sector in Indonesia
- Indonesian currency recently fell from Rp. 2200 to Rp. 10 500
- High international debt
- Capital outflow
- Industries moving out of Indonesia due to increasing crimes and conflicts.

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