

**Potential for Expanded Private Sector Delivery
of Family Planning Services in Indonesia:**

Initial Findings and Recommendations



by
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The Futures Group International
OPTIONS II Project

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EXECUTIVE SUMMARY

Potential for Expanded Private Sector Delivery of Family Planning Services in Indonesia: Initial Findings and Recommendations

The Indonesian family planning program has a huge task to keep up with the growth in the numbers of new acceptors and improvements in the quality of care. Full participation of the private sector will be an important contribution. This is an initial review of issues in and constraints to expansion of private sector family planning service delivery to inform the development of an agenda for further USAID-funded activities in the area of policy reform.

The potential for expansion of private family planning service delivery in Indonesia appears to be constrained by three primary factors:

- the continuing perception among providers that consumers believe family planning services are an entitlement from the government;
- the perception that a relatively low number of Indonesians are able to pay for private sector physician services and commercial pharmaceutical products, which discourages potential private sector practitioners and therefore limits the sources of private sector family planning services;
- the public sector's apparent inability to segment the family planning market and confine its goods and services just to those who cannot be served by the private sector.

Other factors -- such as midwives' lack of training in basic business management skills, apparent provider bias toward certain contraceptive methods, and lack of promotion of tubal ligation as a safe, effective, long-term contraceptive method -- have notable impact on the effective delivery of family planning services in the private sector.

Key informants report that general practitioners are the private providers least favored by consumers of family planning services. They also report that women with the ability to pay for healthcare seek out ob/gyn specialists, while less financially-able women seek lower-cost, female midwife providers for family planning services.

The affordability of privately-delivered family planning and other healthcare services is being addressed through the development of JPKM managed care schemes. These will enable managed care providers to use "shared risk" client pools as a means of making private healthcare services affordable to a large percentage of the Indonesian population without the need for government subsidies. Family planning services are mandated to be part of the basic benefits packages that must be offered, although considerable efforts to encourage use of these services through JPKM providers is probably necessary. The potential return on current policy efforts aimed at convincing JPKM providers to promote and provide voluntary sterilization (VS) services could be enormous.

The willingness of Indonesian healthcare consumers to pay for preventive services such as family planning and the value that they assign to such services need to be improved through education and additional public promotion.

Furthermore, the costs and inefficiencies of distributing pharmaceutical products in Indonesia can perhaps be improved through regulatory reform. Commitment to a segmented market also implies important responsibilities for the public sector. For example, rural areas hold a higher concentration of poor people with low ability to pay for health services in general and family planning in particular. In more affluent areas, the public sector can pursue a strategy of targeting the poorer segments of the population while letting the private sector serve those who can pay commercial prices.

LIST OF RECOMMENDATIONS

The following list is a compilation of major recommendations made throughout the report. For the purpose of clarity, recommendations have been grouped into four categories: training; market segmentation; JPKM; and institutional sustainability. Please see the report page listed for each recommendation.

Training

1. Recommendation: Ascertain whether or not -- or the extent to which -- expansion of private service delivery and contraceptive sales through BKKBN channels accomplishes actual savings to the public sector. Also examine the extent to which public sector savings will be affected by releasing "contract" doctors into the private sector for employment. (Page 2)
2. Recommendation: Assess the economic incentives and motivations of midwives. Before the number of midwives is increased, examine the potential impacts on market segmentation- and private sector participation. (Page 5)

As more midwives enter the market as private providers, there may also be a need to: 1) strengthen their knowledge of standards of practice and limitations of authority; 2) strengthen their legal protection through such avenues as legal consultation within district-level offices of the Indonesian Midwives' Association (IBI); and 3) strengthen their business skills (and perhaps access to credit) so that they can compete more effectively as private providers.

3. Recommendation: Give continued attention to training and employing midwives for effective family planning service delivery. Explore the potential for expanding the role of female general practitioners in family planning service delivery. Identify the rate of enrollment and graduation of females from medical schools. If warranted, consider the possible need for a policy that encourages females to enroll in and complete medical school. (Page 8)
4. Recommendation: Explore possibilities for training of midwives in basic business practices (e.g., budgeting and management of revenues). Perhaps such training can be provided through continuing education programs sponsored by IBI and/or through collaboration with interested pharmaceutical companies. (Page 8)

Market Segmentation

1. Recommendation: Conduct studies to establish that buying power exists and identify ways to mobilize the buying power. Potential private providers should be made aware that purchasing power exists and should be trained in methods to attract clients (e.g., with amenity-based quality services). (Page 3)

Analyze the validity of using the Keluarga Sejahtera (KS) Family Welfare Classification System as a means test for fully-subsidized services.

2. Recommendation: Conduct further analysis of requirements (e.g., more public education/promotion, more stringent means tests for access to the public sector, improved targeting of appropriate public sector clients, economic growth) to shift family planning consumers from the public sector to the private sector. Research efforts such as market segmentation studies, analysis of the public's perceived value of preventive care services (e.g., family planning) and analysis of family expenditure priorities may be useful in providing program planners with further information. (Page 3)
3. Recommendation: Give considerable thought to development of a service delivery/market segmentation strategy recognizing that the private/commercial sector may not be able to sustain service delivery in hard-to-reach, lower-access, low-income areas that are currently targeted as areas of particular concern to BKKBN policymakers. Perhaps BKKBN and other government planners should accept that more rural, harder-to-reach and low-income areas are the special responsibility of the public sector alone rather than spending additional efforts on "helping" the private sector become involved in activities that it cannot do well and/or sustain. (Page 13)

JPKM

1. Recommendation: Undertake policy efforts to encourage adoption of any remaining, necessary regulations (e.g., the proposed JPKM Government Regulation), decrees and orders to create "shared risk" opportunities for potential private sector healthcare consumers. (Page 3)
2. Recommendation: It appears that family planning services are firmly included in the requirements for healthcare service delivery under the JPKM system. However, since this system may eventually have a large share of family planning service delivery, some mechanism should be developed or some responsible office/agency identified to: 1) monitor progress in the development of this scheme; and 2) note any changes in policy that may occur along the way. (BKKBN managers interviewed by the consultant currently appear to have little or no idea of what is happening in regard to JPKM.) Particularly, someone with relevant legal expertise should examine closely pertinent legislation and regulations to ensure that all aspects of family planning services -- counseling, clinical services and drugs -- are fully covered as it has been reported. (Page 17)

There is room for significant input from family planning policymakers in regard to the role of various types of providers in managed care service delivery. The role of midwives in the managed care system and the role of outreach workers in promoting, in the home, the benefits

of healthy behaviors are policy areas potentially rich in impact on family planning acceptance and contraceptive use.

Outreach and/or clinic-based workers promoting healthy "preventive" behaviors (e.g., contraceptive use) is a concept that should/could be sold to managed care companies on the basis of improved profitability.

While family planning service benefits may be available from JPKM providers, consumers may not be fully aware of their managed care provider as a source of these services. USAID recognizes the importance of social marketing/public relations in promoting the use of managed care programs for potential consumers and will be investing heavily under the PHR or another project. Available services that are not utilized have no positive impact. The way in which these family planning services are offered can also have a large impact on client use. Consequently, it may well be worth considerable policy effort to develop an information base on which such managed care family planning service delivery decisions can be made.

BKKBN must communicate to DEPKES and JPKM the standards of care associated with an effective family planning program.

Institutional Sustainability

1. Recommendation: Study the cost/benefit of concentrating public resources on services in less-populated, rural or more remote areas and leaving the burden of service provision in urban, more easily-accessible areas primarily to the private sector. Explore the feasibility of differentiating public sector provider salaries according to the difficulty of the work area. Such financial incentives could strengthen the public sector's ability to provide services to targeted consumers, while the "release" of more urban clients to the private sector could provide the savings necessary to fund these salary incentives. (Page 7)
2. Recommendation: Establishing private sector family planning-only practices/clinics is probably not an effective use of time and resources. Multi-service clinics and practices, however, offer an opportunity to promote and deliver family planning services to clients who present themselves for other reasons. "One-stop shopping" is usually attractive to private sector consumers. The multi-service clinics supported by PSFP, SDES and PKMI are an important step in this direction. A more effective market segmentation strategy will spur demand for private services that will induce the private sector to more aggressively promote family planning services in its practices. (Page 7)
3. Recommendation: Examine the reported regulatory constraints on provider cooperatives to ascertain the degree to which they actually inhibit effectiveness in making affordable, commercially-obtained products available to midwives. Pursue any necessary regulatory reform. (Page 9)
4. Recommendation: Policy efforts to secure funding for further promotion of VS services in the private sector seem critically important. Additionally, efforts to promote the acceptability of

government-promoted and -supplied VS services should be a major part of any family planning policy program. (Page 9)

5. Recommendation: Encourage BKKBN to develop a more rational strategy for product availability and distribution. (Page 14)

Provide assistance in projecting public sector contraceptive needs so that unnecessary amounts of public resources are not used for contraceptive procurement when these products are widely available in the commercial sector.

6. Recommendation: Study the risks/benefits of removing the prescription requirement for oral contraceptive sales. It would also be useful to consider the extent to which the prescription requirement is actually a factor in current sales of the method. (Page 14)

**Potential for Expanded Private Sector Delivery
of Family Planning Services in Indonesia:
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The purpose of this initial review of issues in and constraints to expansion of private sector family planning service delivery is to inform the development of an agenda for further USAID-funded activities in the area of policy reform. The review is based largely on information garnered through personal interviews with healthcare and family planning policymakers, private providers and USAID-related technical assistance contractors. It is also based on translations of relevant laws and regulations and other pertinent documents.

This report was commissioned as "initial findings" and does not claim comprehensiveness. Many of the findings and recommendations are based on a limited number of interviews. The sample of interviewees primarily includes people in leadership positions who are presumably knowledgeable about a range of issues.

I. DEFINITION OF PRIVATE SECTOR

1. Finding: The primary reason for expanding delivery of private family planning services is to relieve the public sector of some of its financial and other burdens and thus to enhance the potential for long-term sustainability of a growing family planning program. Continuing public sector subsidization of "private" sector providers -- whether intentional or not -- does not appear to contribute positively to such a shift. When unburdened, the public sector will be able to reach previously-unreached segments of the population, as well as keep up with the still rapidly increasing population.

One example of such subsidization is the government's willingness to support providers who supply both public and private services. Indeed, virtually all physician and midwife providers who operate a private practice in Indonesia also hold a public sector appointment. (This situation will begin to change as continuing classes of "contract" physicians are released from government employment at the end of their required three-year service period. 1995 was the first year in which young physicians were released from government employment. Approximately 17 percent of those completing their compulsory service in that year were retained as government employees. Midwives, who are the primary providers of family planning services in Indonesia, are included in a similar contract provider/limited government employment plan that will graduate its first class of providers into the private sector in 1998, according to DEPKES sources.)

Government appointment provides a regular (though low) salary, ASKES health insurance and a pension. These payments are made by the government despite the fact that the providers operate half-time private practices. Consequently, no savings to the government in personnel costs are achieved. Additionally, no savings in public sector infrastructure costs are realized through providers' split practices since the Department of Health (DEPKES) does not believe itself able to reduce the number of clinics and health centers it operates or the types of services it provides.

Lack of savings to the public sector is further compounded by the generally-reported use of publicly-procured contraceptive commodities by providers -- particularly midwives -- in their private practices. (Use of publicly-procured commodities in private sector practices does not represent a subsidy for the consumer but rather for the provider since most providers charge consumers for the product.) Even BKKBN-reported increases in KB Mandiri payments by users of the public sector system have not reduced BKKBN's budget requests for contraceptive procurement.¹

The blurred definition of public sector service provision as opposed to private sector service provision (i.e., services supported with nongovernmental funding) is illustrated by the 1994 Demographic and Health Survey (DHS) listing of posyandus as "other private" sources of contraceptives. These health posts, while located in the community, are served by public sector employees with publicly-procured commodities.²

Recommendation: Actual savings to the public sector that result from private family planning service delivery and contraceptive sales through BKKBN channels should be analyzed to ascertain whether or not -- or the extent to which -- expansion of such private services accomplishes the desired end.

The extent to which public sector savings will be affected by releasing "contract" doctors into the private sector for employment should also be examined.

II. ABILITY OF SERVICE PROVIDERS TO WORK IN THE PRIVATE SECTOR

1. Finding: No class of family planning service provider interviewed by the consultant -- physician, midwife or pharmacist -- reports any legal or regulatory difficulty in obtaining a license to practice in the private sector. (The steps required to obtain a license for private practice are described in Appendix A.1.)

Recommendation: There is no apparent need for reform of regulations governing provider licensing for private sector service delivery. This finding, however, should be validated by interviews with a larger sample of physicians and midwives in the regions, as well as Jakarta.

2. Finding: Popular opinion holds that the primary constraint to operation of a sustainable private sector healthcare practice is the limited "buying power" of Indonesian consumers. Widely-held opinion indicates that only 2-10 percent of the population currently is able to pay the full costs of required healthcare services. This perception of ability to pay is conditioned both by true ability to pay and the

¹ KB Mandiri payments are retained either in the service delivery system of DEPKES or by BKKBN volunteer field workers. Cost-recovery to defray system costs does not appear to be on the agenda of BKKBN.

² William Winfrey and Laura Heaton show that posyandus, polindes and family planning posts fill a niche that more closely resembles the public sector than the private sector. (See Winfrey, W. and L. Heaton. "Market Segmentation Analysis of the Indonesian Family Planning Market: Consumer, Provider and Product Market Segments." OPTIONS II Report, 1996.

history in Indonesia of available free services (e.g., family planning). Additionally, the group of better-off consumers is concentrated in the larger cities, not distributed evenly throughout the country.

BKKBN managers indicate that the current policy is to subsidize fully the family planning service needs of the 58 percent of Indonesian families that comprise Welfare Classes Pre-Prosperous and Prosperous 1 in the Keluarga Sejahtera (KS) Family Welfare Classification System. While the BKKBN projects that by the year 2000 this number will have decreased to 40 percent, the cause of this decrease is not clearly articulated.

Recommendation: Indonesia is a middle-income country with a rapidly expanding economy. Historically, countries at similar income levels have found the means to pay for medical care and family planning. Studies should be conducted to establish that buying power exists and identify ways to mobilize the buying power.³ Potential private providers should be made aware that purchasing power exists and should be trained in methods to attract clients (e.g., with amenity-based quality services).

Considerable policy efforts should be made to encourage adoption of any remaining, necessary regulations (e.g., the proposed JPKM Government Regulation), decrees and orders to create "shared risk" opportunities for potential private sector healthcare consumers. Such "shared risk" pools would likely increase the number of Indonesian consumers who can seek and pay for private sector services, thereby expanding the private sector share of family planning services delivery.

An analysis of the validity of using KS as a means test for fully-subsidized services is needed.

3. Finding: Despite the large number of clients who make at least small payments, physician providers interviewed nonetheless believe that a persistent constraint to private sector service delivery is the belief among the populace that the government is responsible for supplying family planning services. In their opinions, family planning services are generally seen by the people as an entitlement. Physicians believe that expansion of private service delivery is further constrained by the availability of free or nearly-free public family planning services to everyone who requests them.

Insufficiently-mobilized consumer demand for private family planning services dominates physician analysis of the private sector family planning market.

Recommendation: Further analysis of requirements (e.g., more public education/promotion, more stringent means tests for access to the public sector, improved targeting of appropriate public sector clients, economic growth) to shift family planning consumers from the public sector to the private sector should be made. Research efforts such as market segmentation studies, analysis of the public's perceived value of preventive care services (e.g., family planning) and analysis of family expenditure priorities may be useful in providing program planners with further information.

Many healthcare providers interviewed by the consultant appear to believe that implementation of "top down" legislation forcing consumers to seek services through the private sector (e.g., managed care companies with lists of clients who must seek services through them) is required. The overall

³ A first step in this direction is the market segmentation study mentioned above.

effectiveness of this strategy -- in terms of consumers' acceptance of selected services -- should be considered.

III. AVAILABILITY OF PRIVATE SECTOR PROVIDERS

1. Finding: Between 1,800 and 2,000 medical students are graduated each year in Indonesia. Immediately after graduation, every new physician must report for a compulsory term of government service. Beginning in 1995, each "class" of young physicians completing its three-year stint of government service is released from government employment -- with the exception of approximately 15 percent each year who are retained. (In the past, virtually all physicians retained a government post at the end of their compulsory service.) The physicians who are not retained in government service -- approximately 1,600 per year -- must seek employment in the private sector.

There currently appear to be too few opportunities for profitable practice in the private sector to support this yearly influx of new providers. Salient factors reported in interviews include the following:

- It is generally believed by influential physicians that it will be at least five years before opportunities for physician employment in private sector managed care facilities become a reality. (Other policy planners who believe that some JPKM managed care companies may begin to deliver services within the next two years also state that employment opportunities within this scheme for the full complement of available physicians will develop slowly.)
- Estimates by a variety of private sector healthcare providers indicate that currently no more than 2-10 percent of Indonesians can afford to pay the full costs of private sector healthcare (see section II.2 for comments on the probable difference between perceptions and reality on ability to pay).
- Specialist physicians in Indonesia are allowed to provide primary healthcare services. Young, unknown general practitioners cannot successfully compete against these specialist providers for clients who can afford to pay.

Young physicians who cannot support themselves and their families through the practice of medicine will likely turn to other areas for employment. This could represent a considerable loss of public sector investment in education and training.

Recommendation: Analysis of the national need for both public and private sector physicians should be undertaken. Analysis of viable private sector employment opportunities (including a trajectory of providers employable by JPKM clinics) for "contract" doctors being released from government employment should also be undertaken. Strategies for accommodating the results of these analyses -- such as adjusting the numbers of physicians graduated annually or postponement of reduction of public sector jobs until further development of private sector employment opportunities -- should be designed. Implementation of these strategies falls outside the scope of USAID's current objectives but could be taken up by other donors.

Ironically, Indonesia ranks rather low among countries in the region in its ratio of physicians per 1,000 people (0.14/1000), according to World Bank statistics. From this perspective, reducing the number of trained physicians does not appear to be in the best interests of public health. Those interviewed claim that viable employment opportunities do not currently exist in the private sector for accumulating numbers of recently-graduated physicians totally dependent on private sector income. This issue should be closely examined.

Any savings of public sector resources that might be "lost" through training a surplus of private sector physicians could be used to pay salaries of an increased number of public sector physicians in rural, hard-to-access areas or to improve training of more popularly-affordable private providers (e.g., midwives). An analysis of career change among young physicians over time could provide an indication of the degree to which, if any, the educational investment of medical training is "wasted."

2. Finding: According to DEPKES managers, there were 28,000 midwives in government service in 1992. It is generally agreed that most government service midwives also operate a private practice during the afternoon/evening of each day. The government has announced a service delivery goal of having at least one midwife in each of the 54,000 villages in Indonesia. To achieve this goal, the number of midwives currently available will need to be doubled. This effort is already well underway, and almost completed. The intent is to encourage midwives to go to rural areas where there are no midwives, and to encourage them to stay there.

Interviews indicated that most if not all midwives with a private sector practice desire concurrent employment in the public sector in order to receive ASKES insurance benefits (available only to government employees) and to be eligible for government pension payments during retirement.

The MOH has devised an employment scheme for midwives similar to the "contract" doctor scheme described above. For midwives, this policy went into effect in 1995. According to DEPKES managers, the first class of contract midwives that finishes its required government service will be "pushed" into the private sector for employment in 1998. The DEPKES officials interviewed by the consultant did not know the percentage of midwives that will be retained in government employment after the completion of required service.

Recommendation: The economic incentives and motivations of midwives need to be assessed. Before the number of midwives is increased, the potential impacts on market segmentation and private sector participation need to be examined. Extant research should be organized and examined, and, where necessary, further research should be conducted to fill gaps and answer the following questions: What is the possibility that some midwives will be able to develop sufficiently profitable private practices in their government service-assigned rural and hard-to-access areas? What steps can be taken to ensure employment opportunities for a greatly-increased number of midwives who no longer hold government positions? What role -- if any -- will midwives have in the managed care systems of the future? Will there be any role for outreach workers in the managed care system, and are midwives qualified/appropriate for such a role?

Will training of additional midwives have any impact on contraceptive prevalence due to the increase in number of providers? Will doubling the number of midwife providers create any unwanted bias in contraceptive method mix?

As more midwives enter the market as private providers, there may also be a need to: 1) strengthen their knowledge of standards of practice and limitations of authority; 2) strengthen their legal protection through such avenues as legal consultation within district-level offices of the Indonesian Midwives' Association (IBI); and 3) strengthen their business skills (and perhaps access to credit) so that they can compete more effectively as private providers.

3. Finding: At least one representative of a major pharmaceutical company in Indonesia believes that there is a shortage of pharmacists in the country. (Department of Education and Culture data indicate that in 1992 only about 250 pharmacy students were graduated with a "university degree-level health sciences education.") Other pharmaceutical sector professionals say that there is not a shortage of pharmacists in Indonesia. The problem, they say, may be that many pharmacists graduate from unaccredited pharmacy schools and, therefore, cannot practice until passing a government-sponsored examination. The waiting list for this exam is said to be quite long.

While Indonesian law requires that every apotik (pharmacy) operate "under the supervision" of a certified pharmacist, the regulatory language is sufficiently general so that most pharmacists are not present in the apotiks "under their supervision." Thus, clients are served by pharmacist assistants. (These assistants receive secondary school training. It is reported that apotik customers do not perceive them to be well trained and do not, therefore, seek medical advice at pharmacies, as happens in many other countries.)

The apparent shortage of apotiks in the country (one for every 44,000 people) is generally attributed to limited opportunities for operating a profitable apotik rather than to a shortage of pharmacists.

Recommendation: Some assessment might be made of any unmet need for pharmacists. If such a need exists, policy reform to speed up the examination of graduates from uncertified pharmacy schools might help resolve the shortage. Additionally, if a shortage of pharmacists exists, any policy that somehow constrains graduation from accredited pharmacy schools to 250 students per year (see above) should be reformed. These are issues that other donors may be able to effectively address.

4. Finding: The government requires a term of compulsory public sector service for physicians, midwives and pharmacists to ensure that there are healthcare providers operating in more rural, remote areas of the country. It is generally agreed that without such compulsory service, these providers would probably not locate in such areas primarily because of their inability to operate profitable private practices there. Of course, when the compulsory service period is completed, most providers leave these remote regions for areas where they are likely to be able to sustain a private practice or be near families and needed facilities.

Recommendation: A study should be conducted to examine the cost/benefit of concentrating public resources on services in less-populated, rural or more remote areas and leaving the burden of service provision in urban, more easily-accessible areas primarily to the private sector. The feasibility of differentiating public sector provider salaries according to the difficulty of the work area should be explored. Such financial incentives could strengthen the public sector's ability to provide services to targeted consumers, while the "release" of more urban clients to the private sector could provide the savings necessary to fund these salary incentives.

To support this possibility, it might be useful to explore through survey interviews with selected physicians what benefits or other job attributes would increase their willingness to work and live in more remote locations. Exploration could also be undertaken of: 1) the role that municipal governments in more remote areas might play in providing better and more attractive healthcare facilities to attract physicians; and 2) the possibility of municipal and national government entities sharing the costs of salary incentives for attracting physicians for longer-term work in more remote areas.

IV. PRIVATE SECTOR PROVIDERS OF FAMILY PLANNING SERVICES

1. Finding: As has been observed elsewhere, family planning service delivery alone does not offer a sufficient opportunity to support an increasing population of private sector physicians. All physician providers interviewed by the consultant expressed with certainty the belief that provision of family planning services alone will not provide a profitable practice. Many, but not all, interviewees believe that a range of maternity and family planning services is necessary to operate a profitable private practice.

Some healthcare policymakers believe that the lack of profitability of *family planning-only services* is due to "catchment area phenomena." This means that the number of potential family planning clients within an area conveniently serviced (i.e., with transportation and distance costs acceptable to potential clients) by any given service delivery outlet is insufficient to support the costs of maintaining the outlet.

Recommendation: Establishing private sector family planning-only practices/clinics is probably not an effective use of time and resources. Multi-service clinics and practices, on the other hand, offer an opportunity to promote and deliver family planning services to clients who present themselves for other reasons. "One-stop shopping" is usually attractive to private sector consumers. The multi-service clinics supported by PSFP, SDES and PKMI are an important step in this direction. A more effective market segmentation strategy will spur demand for private services that will induce the private sector to more aggressively promote family planning services in their practices.

2. Finding: Physician providers interviewed generally agreed that general practitioners are the class of private sector providers least favored by female clients for family planning services. They also reported that women who can afford truly private sector fees appear to choose ob/gyn specialists for services, while less-affluent female consumers much prefer female midwives as family planning service providers.

Midwives are authorized under Indonesian law and regulations to provide all family planning methods except tubal ligation and vasectomy. Only specially-trained and certified midwives are authorized to insert and remove Norplant[®], but this is also the case for physicians.

Recommendation: Continued attention should be given to training and employing midwives for effective family planning service delivery. The potential for expanding the role of female general practitioners in family planning service delivery should be explored. The rate of enrollment and graduation of females from medical schools should be identified. If warranted, consideration should be given to the possible need for a policy that encourages females to enroll in and complete medical school.

Under current circumstances, it appears that the decision to discontinue special training, loan programs and equipment provision for family planning service delivery by general practitioners may not provide sufficient impact to justify their costs.

3. Finding: A major constraint to expanding the role of midwives as truly private family planning service providers is their relatively low level of use of commercially-obtained contraceptive products. It is generally agreed that midwives often dispense publicly-procured contraceptives in their private practices. (Some midwives report that they are now purchasing more products, especially Depo-Provera, than before because BKKBN stores are out of these products.)

The inability of both the midwife and her private client to pay prevailing commercial prices for contraceptives is usually cited as the primary reason for midwives' continuing reliance on public sector products in their private practices. The limitations of commercial distribution companies in reaching midwives in more rural areas on a regular basis are also a factor. (P.T. Schering Indonesia reports that it now details midwives with its own staff because of its distributor's inability to do so.)

To make commercial prices and products more accessible to midwives, pharmaceutical companies have worked with BKKBN and the IBI to establish special contraceptive distribution schemes and pricing strategies. Sales of Blue and Gold Circle products to providers such as midwives, however, are reported by BKKBN managers to be disappointingly low. Additionally, commercial manufacturers and their distributors who have worked with IBI to establish higher-volume/lower-price purchasing cooperatives for midwives have experienced problems with their implementation. These problems center around two issues: 1) cooperatives are reported to have no legal authority to hold pharmaceutical products in store for distribution down the chain; and 2) midwives have not proved to be sufficiently good credit risks for consignment and other types of product sales for distribution companies.

Recommendation: Possibilities for training of midwives in basic business practices (e.g., budgeting and management of revenues) should be explored. Perhaps such training can be provided through continuing education programs sponsored by IBI and/or through collaboration with interested pharmaceutical companies.

The reported regulatory constraints on provider cooperatives should be examined to ascertain the degree to which they actually inhibit effectiveness in making affordable, commercially-obtained products available to midwives. Any necessary regulatory reform should be pursued.

The possibility for a "natural experiment" appears to exist in the case of increased commercial oral contraceptive sales during a period of decreased public sector availability of orals. An analysis of the cause and effect relationship between these two events should be pursued.

V. CONTRACEPTIVE METHODS AVAILABLE

1. Finding: Oral contraceptives, condoms, spermicides, IUDs, Norplant®, Depo-Provera and other injectables, tubal ligation and vasectomy are all legally available in the Indonesian private sector.

Recommendation: No regulatory reform appears necessary to ensure that a wide variety of contraceptive choices is available to consumers of private sector family planning. As outlined below, however, some regulations slow and partially limit the distribution process.

2. Finding: Tubal ligation is not promoted by the BKKBN as a long-term contraceptive method, although the procedure is available upon request at government hospitals. It is the government policy to leave the risk (i.e., fear of religious backlash) of promoting tubal ligation as a safe, effective, acceptable method of long-term contraception to the private sector under the aegis of an NGO, PKMI.

During a limited period of time, the USAID-funded Indonesia voluntary sterilization (VS) program actively promoted VS in Jakarta through IEC and public relations activities aimed both at consumers and providers. Considerable positive response was generated. In spite of the positive consumer response, policy reform to make VS a program method and to liberalize media promotion has not occurred. Without such support, VS cannot be a success. Funding for this program has now ended, and private sector promotion for tubal ligation and vasectomy has ceased. Policy dialogue on the issue continues.

The promotion of tubal ligation as a long-term method in Indonesia seems especially important since no other country has successfully achieved and sustained contraceptive prevalence above 60 percent without its substantial use. Additionally, the presence of tubal ligation as a significant part of the national contraceptive method mix has played a major role in the financial sustainability prospects for the family planning programs of many other countries.

Recommendation: Policy efforts to secure funding for further promotion of VS services in the private sector seem critically important. Additionally, efforts to promote the acceptability of government-promoted and -supplied VS services should be a major part of any family planning policy program.

3. Finding: Depo-Provera's increasing share of the contraceptive method mix is largely attributed by family planning program managers to the fact that midwives heavily promote this method because they are able to charge a recurring fee for method administration. (About 85 percent of injectables in Indonesia are provided by midwives either through private practice or at public clinics.)

According to MOH managers, the Indonesian government is now the largest single purchaser of Norplant® in the world (these sets are reportedly purchased for US\$30/set.). Thousands of family planning clients are having this method inserted each year. There are some anecdotal reports that women who wish to have the implant removed experience difficulty in finding a public sector provider who is willing to do so.

Recommendation: While the BKKBN operates officially under the "cafeteria policy" in regard to client's method selection, some additional provider education and policy promotion for both public and private providers appear to be needed to ensure: 1) that Indonesian women are counseled on the full range of contraceptive methods available; and 2) that women are counseled about methods that suit their reproductive health needs and fertility preferences. New, innovative methods of collecting and evaluating service statistics in terms of unmet and met need could be helpful.

4. Finding: At present, oral contraceptives cannot be sold without a prescription. Some physician providers of family planning services interviewed by the consultant report that other physicians, even some ob/gyn specialists, are reluctant to prescribe oral contraceptives to their clients because of perceived risks of cancer and because such hormonal preparations "interfere with the body's natural workings." The influence of these physicians is said to be a major factor in the reluctance of the government to consider the sale of oral contraceptives without prescription.

Recommendation: If there appears to be widespread truth to this report of physician misinformation, considerable effort should be made to correct the misinformation and biases against hormonal contraceptives held by some physicians, especially ob/gyn specialists. Efforts could include continuing education seminars led by internationally- or nationally-recognized medical experts, issuance of standards of practice guidelines by the Department of Health (DEPKES) and improved instruction in medical schools.

VI. SITES FOR PRIVATE SECTOR FAMILY PLANNING SERVICES DELIVERY

1. Finding: No owner of a medical clinic interviewed by the consultant expressed concern about the regulatory aspects of licensing and operating a clinic. (Steps for obtaining a license to operate a clinic are described in Appendix A.2.)

There are three categories of medical service delivery recognized by Indonesian law: hospitals, clinics, and private practice. There is reportedly no defining terminology beyond this categorization. There could be some confusion, therefore, about staff required for clinics with limited service objectives, such as maternal and child health-only or ob/gyn-only. According to the chairman of the Indonesian Medical Association (IMI) and other private clinic owners, however, there is in actual practice no particular regulatory problem in obtaining a license for such a limited-purpose clinic once the limited purpose is stated during application for a license to operate.

Recommendation: No regulatory reform appears necessary to facilitate the availability of medical clinics within the private sector.

2. Finding: Government employees are not well paid. Consequently, it is reported by many, they are often looking for ways to supplement their salaries in order to support themselves and their families. The payment of small "tips" to employees in gatekeeper positions within the licensing process is considered to be a normal part of the clinic application process. The amount of these "tips" is insignificant to the applicants, while failure to "tip" can result in delays in the process.

Recommendation: Policy and program planners should be aware of this "fact of life" in Indonesia.

3. Finding: The managing director of a major pharmaceutical manufacturer in Indonesia reports that considerable deregulation of the pharmaceutical sector occurred in 1989. Since that time, he states, there has been no particular regulatory problem in licensing an apotik for operation in Indonesia.

Recommendation: It appears that there is no need for regulatory reform in the process of licensing an apotik for operation in the private sector.

(One regulatory constraint to obtaining a license to operate an apotik is also relevant in establishing a private medical practice and in operating a medical clinic: a new practice, clinic or apotik must be at least a prescribed distance from an already-existing one. For example, a new private medical practice must be at least 200 meters from an existing private medical practice. This constraining factor is not reported to have any undue negative effect on the ability to operate these licensed services or their accessibility in the private sector. In fact, most providers probably see this "constraint" as protection of their future business. It does, however, reward those who "get there first" in particularly good commercial sites. In some municipalities, because of their size, this regulation might limit the total number of apotiks licensed; but it is not at all clear that such limitation would diminish easy consumer access to apotiks in such an instance.)

4. Finding: According to professionals in the trade, the primary constraint to operation of private sector apotiks is the law that prevents Indonesian apotiks from selling any products other than over-the-counter and prescription drugs. The government rationale for this restriction is said to be to protect drug products from possible contamination in storage by other types of products, such as pesticides, cleaners or other poisons.

Drug-only sales are generally considered to be too small for some apotiks to be able to sustain a profitable business, especially in view of the perceived limited buying power of Indonesian healthcare consumers. To maintain or enhance profitability, some apotiks now sell non-drug products even though this practice is against current law.

The problem of profitability through drug-only sales is particularly acute in less urban areas where the population of potential consumers able to pay is much less dense. Expanding the types of goods for sale (and therefore expanding the basis for potential sales revenue) within a single outlet is, therefore, especially important to maintaining private sector sources of pharmaceutical products in less urban areas of the country.

Apotiks are also at a competitive disadvantage with *toko obats* and kiosks, which are allowed to sell W List drugs. (These include such products as bronchial remedies, cough/cold preparations and treatments for skin disease.) Prices charged by apotiks must cover the costs of prime commercial location, air conditioning (usually), lighting and staff, for example. *Toko obats* and pushcart kiosks, on the other hand, do not have these costs and can consequently price their products at a lower level.

Recommendation: A risk/benefit study should be undertaken to ascertain the feasibility of reforming restrictions on apotik sales in view of the potential positive impact such reform could have on increased private sector availability of apotiks and thereby pharmaceutical products, including contraceptives. Other donors may be interested in pursuing this avenue of reform.

5. Finding: In 1992, there were approximately 3,500 apotiks in Indonesia. This represents a ratio of about 1 apotik per 44,000 people, which is considered by some representatives of the commercial pharmaceutical sector to be inadequate to serve the needs of the people. On the other hand, some pharmaceutical professionals say that the *distribution* of apotiks -- not their number -- is the problem. Of course, apotiks are concentrated in more densely-populated areas where more people are able to pay their prices.

To compensate for the lack of access to apotiks for affordable drugs, increasing numbers of people are seeking drugs at more easily-accessible *toko obat* locations (1 per 7,000 people) and kiosk/pushcarts. *Toko obats* and kiosks can be operated by anyone; no special training is required.

Indonesian law prohibits the sale of List G prescription drugs at *toko obats*. Consequently, the legitimate pharmaceutical sector does not supply them with these products. Unwilling to forego the profit potential of fulfilling the demand for these drugs at their locations, some *toko obat* and kiosk owners purchase smuggled or counterfeit pharmaceutical products for resale. (These products are attractive to *toko obats* for two main reasons: 1) traffic in them leaves no paper trail for future prosecution; and 2) the illegal goods may be cheaper than legally-available products.) Efficacy and safety of these products is questionable.

Representatives of international pharmaceutical manufacturers estimate that 25-30 percent of the total pharmaceutical market in Indonesia is currently represented by smuggled and counterfeit drugs. Effective monitoring of this problem and/or prosecution of illegal dealers by the government appears insufficient at this time.

Recommendation: Policy studies should be undertaken to examine the impact of regulatory reform that would allow the legal sale of additional selected pharmaceutical products in *toko obats* and/or kiosks. The study should also examine the possibility of allowing sale of certain drugs (e.g., oral contraceptives) at apotiks and *toko obats* without prescription.

A study of the impact of continued sale/use of counterfeit and smuggled drugs on the economic well-being of legitimate pharmaceutical companies (which influences their ability to continue operating in the private sector) and on the health of consumers might encourage the government to be more strict in monitoring and enforcing laws against this illegal activity.

6. Finding: The financial viability -- and therefore the availability -- of private sector sources/sites for family planning services is determined in large part by proximity to a sufficiently large population of potential clients with the ability to pay. In Indonesia, as in virtually all other countries in the world, this means that private sector service delivery will naturally occur and thrive in more densely-populated areas where money is more accessible to potential consumers and where the costs of service delivery/distribution can be recovered profitably through fees/prices affordable to the target market.

Recommendation: Considerable thought should be given to development of a service delivery/market segmentation strategy recognizing that the private/commercial sector may not be able to sustain service delivery in hard-to-reach, lower-access, low-income areas that are currently targeted as areas of particular concern to BKKBN policymakers. Perhaps BKKBN and other government planners should accept that more rural, harder-to-reach and low-income areas are the special responsibility of the public sector alone rather than spending additional efforts on "helping" the private sector become involved in activities that it cannot do well and/or sustain.

VII. PRIVATE SECTOR SALES OF CONTRACEPTIVES

1. Finding: The adverse impact on commercial sector contraceptive sales of public sector stocks relatively freely available to all providers and potential users has been discussed for at least a decade. Interviews for this review provide further support for this observation.

First, according to a representative of one oral contraceptive manufacturer in Indonesia, commercial sales of oral contraceptives have increased over the last year or two. During this same period, he reported, distribution of oral contraceptives within the public sector apparently has been more tightly controlled. While he is not willing to claim a complete cause and effect relationship between these two events, he does suggest that the less available publicly-procured oral contraceptives are, the greater commercial sales of oral contraceptives become.⁴

Second, according to at least one midwife interviewed, increasing numbers of midwives are now purchasing Depo-Provera from commercial distributors rather than obtaining injectable supplies from public sector stocks. This change is attributed to the fact that public sector/BKKBN stores are currently in short supply of Depo-Provera. (BKKBN is said by commercial sector sources to have devoted "most" of its procurement budget for the past year to the purchase of Norplant® sets. Consequently, BKKBN has reduced quantities of other contraceptive methods. Not only is Depo-Provera in relatively short supply, but one oral contraceptive manufacturer "advanced" BKKBN quantities of oral contraceptives prior to having a procurement contract just so that oral contraceptives remain available within the BKKBN system.)

Recommendation. Some continuing effort to encourage BKKBN to develop a more rational strategy for product availability and distribution should be made.

⁴ The influence of supply controls on contraceptive use can be followed up with analysis of successive years of SUSENAS and DHS data.

Assistance in projecting public sector contraceptive needs should be provided so that unnecessary amounts of public resources are not used for contraceptive procurement when these products are widely available in the commercial sector. (It is reported that even while KB Mandiri figures for the public sector are on the rise, the BKKBN budget request for contraceptive procurement is increasing. Of the total contraceptives "sold" by BKKBN, 75 percent comes from the publicly-procured government supply and only 25 percent from Blue and Gold Circle sales, according to a BKKBN manager.)

Segmentation of the market between public and private sectors could be done according to geographic (i.e., the public sector serving more remote, hard-to-reach areas) as well as consumer financial criteria. The commercial sector is not a very effective service delivery system for sparsely-populated, low-income, hard-to-access areas of the country. The commercial sector cannot itself sustain distribution in these areas without greatly-increased costs/prices, and the government's "help" in extending commercial distribution to these areas has not proved to be very effective. The experience with Blue and Gold Circle products has borne out this phenomenon.

A BKKBN commodity manager indicates that there is some discussion of, in the future, printing the words "just for the poor" on the outer packs of publicly-procured products. The extent to which this will limit private sector use of the products is not clear, especially since the outer package of Depo-Provera and IUDs is never seen by consumers and the outer pack of an oral contraceptive can be removed by the provider before giving the cycle to the consumer. BKKBN should also investigate other possibilities for slowing commodity leakage, such as inventory control methods and product differentiation.

2. Finding: Sales of oral contraceptives in Indonesia require a physician's prescription.

Recommendation: A study of the risks/benefits of removing the prescription requirement for oral contraceptive sales should be conducted. It would also be useful to consider the extent to which the prescription requirement is actually a factor in current sales of the method, the extent to which availability of oral contraceptives in toko obats might enhance the private sector as a source of the method, and the extent to which access to oral contraceptives -- especially in more rural areas -- would be increased. Other donors would probably be interested in pursuing policy reform in this area.

3. Finding: A major factor in the potential expansion of the private sector as a source of contraceptives for Indonesian consumers is the affordability of commercially-available products.

Currently, it is reported by a number of commercial sector sources that distribution costs constitute a higher-than-usual portion of the final retail price of pharmaceuticals, compared to other countries in the region. Ex factory costs of distribution (wholesale and retail level) may account for as much as 60 percent of the retail price. On average, distribution to the apotik level accounts for 17 percent (compared with an average of 12 percent in Thailand), and 30-50 percent is added at the apotik. Inefficiencies in the distribution system and the presence of too many distribution companies (1 wholesaler/7 apotiks) are often cited as reasons for higher costs.

Many of these wholesalers/distributors are thought to be "seasonal" companies. That is, when a particular hospital issues a tender for drugs, a company appears through which all sales under the tender must be made. The existence of this company adds a new level of cost to the drugs purchased by the hospital. This phenomenon of "seasonal" companies has been described by some as "another money collecting process."

All contraceptive manufacturers interviewed believe that if the Indonesian law prohibiting the operation of foreign distribution companies within the country were changed, distribution could be greatly improved. At least one manufacturer thinks that the distribution of his company's products by one of many multinational distributions firms would increase the effectiveness of distribution/volume of his sales. On the other hand, the manufacturer thinks the effect on costs of distribution would be relatively small.

Recommendation: A study of the price structure for pharmaceutical products, including contraceptives, would be helpful in devising appropriate strategies for promoting any needed policy change. It would also be useful to examine the potential positive impact (e.g., increased availability and affordability of contraceptives and other pharmaceuticals) of instituting regulatory reform to allow the operation of foreign distribution companies within Indonesia.

VIII. PERCEIVED ADVANTAGES OF PRIVATE SECTOR SERVICES OVER PUBLIC SECTOR SERVICES

1. Finding: In most countries, perceived advantages for consumers of private sector services over public sector services include: 1) better qualified providers; 2) less waiting time for services; 3) more attractive/hygienic service delivery sites; and 4) more privacy.

As already discussed, the same physicians and midwives providing services in the Indonesian public sector provide private sector services. Consequently, the training and quality of the providers do not differ between the public and private sectors. While women often have to wait considerable time before receiving treatment in the public sector, it is reported that many well-established, popular private sector physicians do not see their clients on an appointment basis. Many middle-class women seeking private sector healthcare plan on spending three to five hours to see a busy practitioner and may carry food and drink with them for the wait.

In Indonesia, therefore, the primary reasons given to explain why many women seek private health services for which they must pay are: 1) direct access to treatment provided by the physician him/herself; 2) more comfortable waiting conditions (e.g., air conditioning, better seating); and 3) immediate access to necessary drugs. It is also mentioned by some healthcare providers that consumer pride in obtaining services from a private provider, especially a prominent provider, plays a large role for some consumers in choosing the private over the public sector.

Recommendation: Some study/consideration should be given by healthcare planners as to: 1) whether or not service delivery through managed care systems will duplicate what are, for the consumer, the

least desirable attributes of public sector health services (i.e., no direct access to physicians or specialists, care provided by the nurse or midwife); and 2) whether or not this may have a negative impact on the private sector consumer's acceptance/use of particular services, such as family planning, as delivered by the managed care system.

On the other hand, it may be that women's reported desire for female providers of family planning services will overcome their consumer preference for direct access/treatment by the physician. Some consumer research on this issue may be worthwhile.

IX. FAMILY PLANNING SERVICES DELIVERY WITHIN HEALTHCARE FINANCING SCHEMES

1. Finding: Regulatory and implementation efforts are well underway in Indonesia to create, through managed care systems, "shared risk" pools for consumers of healthcare services. Such shared risk schemes will allow a significant percentage of the Indonesian population to afford/obtain services from private sector providers.

A summary of the health finance environment is provided in the Introduction and Background sections of "Development of Family Doctor Clinics by the Indonesian Medical Association to Promote Family Planning through JPKM," by Dr. James R. Marzolf. This document is attached as Appendix B.

In the development of managed care legislation/regulation, the Indonesian government has given advantages to JPKM managed care over traditional indemnity health insurance products. (The Ministry of Finance has authority over insurance; DEPKES has authority over JPKM managed care.)

A number of companies and agencies are already expressing interest in providing managed care services, and some have already begun the process of obtaining the required licenses to operate as managed care providers. Among the groups interested in working within the managed care scheme are foreign healthcare companies and the IDI. Under JPKM, the IDI plans a managed care system of franchised clinics where family doctors will be the primary healthcare "gatekeepers."

JPKM systems are authorized under the Health Law of 1992. A number of regulations that detail various aspects of managed care implementation have been passed. (A summary of the relevant regulations is available in Appendix C.) The authorizing Health Law and the accompanying regulations make it clear, according to the managed care advisor to DEPKES, that family planning services are part of the basic health benefits package that must be offered to all managed care consumers regardless of provider. While additional benefits may be offered, no package may contain less than the basic bundle of benefits, which includes family planning.

According to the rules of managed care developed for Indonesia, as explained by the DEPKES advisor, client participants in a managed care scheme may not be charged any additional amount for any of the services within the benefits package of their provider. This seems to mean that oral contraceptives, injectables, IUDs and other contraceptive products will be available at no extra charge

to the client acceptor. Managed care providers will cut their own volume discount deals with pharmaceutical companies for the drugs required for the services included in their benefits packages.

The roles of various types of healthcare providers within managed care (e.g., physicians, midwives, nurses, outreach workers) are not yet fully defined.

Recommendation: It appears that family planning services are firmly included in the requirements for healthcare service delivery under the JPKM system. However, since this system may eventually have a large share of family planning service delivery, some mechanism should be developed or some responsible office/agency identified to: 1) monitor progress in the development of this scheme; and 2) note any changes in policy that may occur along the way. (BKKBN managers interviewed by the consultant currently appear to have little or no idea of what is happening in regard to JPKM.) Particularly, someone with relevant legal expertise should examine closely pertinent legislation and regulations to ensure that all aspects of family planning services -- counseling, clinical services and drugs -- are fully covered as it has been reported.

There is room for significant input from family planning policymakers in regard to the role of various types of providers in managed care service delivery. The role of midwives in the managed care system and the role of outreach workers in promoting, in the home, the benefits of healthy behaviors are policy areas potentially rich in impact on family planning acceptance and contraceptive use.

Outreach and/or clinic-based workers promoting healthy "preventive" behaviors (e.g., contraceptive use) is a concept that should/could be sold to managed care companies on the basis of improved profitability. Actuarial tables have been prepared that demonstrate the profitability of promoting long-term family planning methods versus the costs of providing maternity and related services.⁵ The potential role of JPKM providers as promoters of VS services is extremely important. VS has clearly been shown to be the most cost effective of all contraceptive methods and could, therefore, enhance the profitability of JPKM clinic service provision. Furthermore, JPKM promotion/ provision of VS services could fill a striking gap in the national family planning effort.

While family planning service benefits may be available from JPKM providers, consumers may not be fully aware of their managed care provider as a source of these services. USAID recognizes the importance of social marketing/public relations in promoting the use of managed care programs for potential consumers and will be investing heavily under the PHR or another project. Available services that are not utilized have no positive impact. The way in which these family planning services are offered can also have a large impact on client use. Consequently, it may well be worth considerable policy effort to develop an information base on which such managed care family planning service delivery decisions can be made.

Finally, BKKBN must communicate to DEPKES and JPKM the standards of care associated with an effective family planning program. This would require at the least improved communication between DEPKES and BKKBN at the policy level. JPKM is a new initiative and the opportunity to build in

⁵ Marzolf, James. "Financing Long-term Family Planning Methods through JPKM Managed Care." Private Sector Family Planning Project, University Research Corporation, 1995.

effective family planning services right from the beginning is a powerful incentive for BKKBN to play an active role in the launch of the initiative.

**APPENDIX A.1:
STEPS REQUIRED FOR LICENSING A PHYSICIAN
TO PRACTICE IN THE PRIVATE SECTOR**

Following are the steps required for physicians who have obtained their medical degree from an Indonesian university to be licensed to practice medicine in the private sector:

1. Graduate from a recognized medical school;
2. Report to the Department of Health (DEPKES), Bureau of Personnel;
3. Receive from DEPKES one's assignment for required government service;
4. Receive from DEPKES the SP certificate (a letter of appointment to practice medicine in Indonesia);
5. Complete the required government service;
6. Go to the municipal health office of the locality where one desires to practice privately and obtain a set of the forms and list of documents that must be completed for licensing;
7. Complete forms/compile documents that include the following:
 - medical school diploma
 - SP (letter of appointment)
 - letter certifying that the required government service is either in process of being fulfilled or completed
 - address of proposed practice site at least 200 meters in any direction from an existing private practice
 - plan/layout of one's proposed office
8. Pay the required administrative fee (approximately Rp50,000);
9. Obtain the equipment and basic drugs required by regulations for a physician's private practice (approximate cost from US\$250-500, depending upon quality of equipment chosen). These absolutely required items (additional items are listed in the regulations as suggested) are as follows:

- one examination room, at least 3x3 meters square
- one waiting room
- one bathroom/WC
- one name board/sign between the sizes of 40x60cm and 60x90cm (style and information allowed regulated)
- one examination bed
- two flashlights
- washbasin
- medicine/instrument cabinet
- table and chair
- instrument table
- disinfectant
- drying cloth
- two waste baskets with lid
- waiting bench
- patient record cards
- prescription pad
- medical registration book
- periodic report forms
- informed consent forms
- tankard of Medical Practice Service Manual
- PDU Standard Manual
- stethoscope
- obstetrics stethoscope
- sphygmomanometer
- tongue depressors
- eight scale
- thermometer
- reflex hammer
- disposable syringes (1cc, 3cc, 5cc)
- needles (no.12, no.14, 22/23G)
- tweezers
- metal instrument bowl
- forceps, dressing 6"
- two forceps, hemostatic
- forceps, sponge
- gauze scissors
- needle holder
- three muscle needles
- three skin needles
- catgut and silk thread
- two scalpels
- infusion stand/infusion bottle hanger
- two infusion sets
- cotton, gauze, and tape

- physician kit for home visits
 - injection drugs: adrenaline bitartrate, corticosteroid, antihistamine, spasmolytic, antipyretic/analgesic, anti-asthma, anti-convulsant
 - infusion liquid: ringer lactate or NaCl 0.9%
10. Have inspection of proposed office by agent of the municipal health office (for soundness of structure and presence of required equipment and drugs); and
 11. Receive license to practice privately from prevailing municipal health office.

It is estimated that the licensing process for private practice of medicine by a physician trained in Indonesia requires two to four weeks for completion.

The administrative fee for obtaining the license is a minimal charge. Physicians interviewed by the consultant indicated that the US\$250-500 cost of required equipment and drugs is not prohibitive. Young physicians may have to borrow this money, but it is usually readily available through family loans or through a personal loan from a bank. (Banks are said to make personal loans to professionals at reduced interest rates (e.g., 10-12 percent instead of 20-22 percent.)

The cost of obtaining space for operating a private practice is not included in any of the items above. Many private practice physicians operate their businesses out of their private residences. Office space can be rented or purchased if desired.

**APPENDIX A.2:
STEPS REQUIRED FOR LICENSING
A PRIVATE SECTOR MEDICAL CLINIC**

Following are the steps required to license a medical clinic for operation in the private sector:

1. Identify location for clinic;
2. Ascertain that there are no objections to clinic location within neighborhood;
3. Obtain letter from the municipal government certifying that there are no objections to clinic within neighborhood;
4. Find building at location and renovate according to standards set forth in regulations;
5. Obtain medical and non-medical equipment according to standards set forth in regulations;
6. Hire staff (who must each have his/her own practice license);
7. Initiate formal application process for license by obtaining from municipal health office the forms and list of documents required. These documents include the following:
 - plan of clinic layout
 - staff organization and job descriptions
 - statement of type of service to be offered
 - statement of types of equipment provided (x-ray requires approval from atomic energy agency)
 - municipal government certification that there are no objections to clinic within neighborhood;
8. Submit documentation and pay administrative fee;
9. Arrange for inspection of site by agent of the municipal health office; and
10. Receive license.

On average, the licensing process (once site, building and staff are arranged) can take approximately three months. It is reported, however, that a temporary approval to begin clinic operation can often be obtained prior to the issuance of the formal license.

The administrative fee required for license application is minimal and not considered to be a constraint of any kind. The average cost of outfitting a clinic, however, is estimated by some clinic owners to be

at least US\$50,000. (The operating table is considered to be a major expense.) Therefore, the opening of a clinic is well beyond the reach of virtually all young physicians.

**APPENDIX A.3:
STEPS REQUIRED FOR LICENSING A PHARMACIST
TO WORK IN THE PRIVATE SECTOR**

Following are the steps required for a pharmacist who has obtained his degree from a government university or from an accredited private university to be licensed to work in the private sector:

1. Graduate from an accredited school of pharmacy;
2. Report to the Department of Health, Bureau of Personnel;
3. Receive from DEPKES one's assignment for required government service;
4. Receive from DEPKES the SP certificate (a letter of appointment as pharmacist in Indonesia);
5. Complete the required government service;
6. Go to the municipal health office of the locality where one desires to work in the private sector and obtain a set of the forms and list of documents that must be completed for the SIA license (license to run an apotik);
7. Complete forms/compile documents that include, among others, the following:
 - copy of the diploma from an accredited school of pharmacy
 - the SP certificate
 - administrative fee of approximately Rp50,000-100,000
8. Submit documents to the relevant municipal health office; and
9. Receive license.

The process for obtaining a license to run an apotik takes approximately two weeks to one month if all documents are presented as required.

**APPENDIX A.4:
DOCUMENTS AND CERTIFICATIONS REQUIRED FOR
OBTAINING PERMIT FOR INDIVIDUAL PRACTICE AS MIDWIFE**

The following documents and certifications are required in order to obtain a license to practice as a private sector midwife:

1. Home address and address of practice;
2. Photocopy of identity card;
3. Photocopy of Midwife Certificate;
4. Letter of appointment for required government service;
5. Letter of assignment from company for which midwife works;
6. Certificate of health from physician;
7. Passport-size photos;
8. Letter of recommendation from Head of the Public Health Center for the area where the midwife will practice; and
9. Letter of statement of approval to become supervising doctor for the midwife.

The license, or permit for practice, is valid forever within the district where the application was made as long as the midwife does not move.

APPENDIX B:
DEVELOPMENT OF FAMILY DOCTOR CLINICS BY THE INDONESIAN MEDICAL ASSOCIATION TO PROMOTE FAMILY PLANNING THROUGH JPKM

Dr. James R. Marzolf
December 1995

I. Introduction

In the last quarter of 1993, the concept of promoting KB Mandiri (self financed family planning) through the implementation of Jaminan Pemeliharaan Kesehatan Masyarakat (JPKM: Guaranteed Health Maintenance for the Public) was developed. This effort issued from the USAID Private Sector Family Planning Project (PSFP) conducted under the auspices of BKKBN and implemented by the University Research Corporation through an institutional contract agreement. The basic strategy was to develop multi-service health and family planning clinics manned by Family Doctors which worked on a contractual basis with JPKM programs.¹ The potential benefits of such a strategy were manifold and included; significant support for the growth of KB Mandiri, employment opportunities for the "Contract Doctors", and a substantial source of quality, primary care providers for the implementation of JPKM. A strategic plan to implement this concept was initiated in early 1994 and ended in December 1995 with the completion of the PSFP project. This report is an evaluation of the final results of this effort.

II. Background

The National Health Law (UU #23) ratified in 1992 and the subsequent Ministerial Regulations established the basis for Managed Care (JPKM) as the predominant strategy for financing Indonesian health care for the foreseeable future. One of the most significant features of this system for the KB Mandiri strategy is the "basic benefit package" (BBP). Inclusion of the benefits contained in the BBP is compulsory for all JPKM programs. Inclusion of benefit exceeding or not included in the BBP is voluntary. Among the basic benefits specified by the regulations are family planning services. Thus, family planning benefits are also mandatory. Also significant is that JPKM, the primary long term national health care financing strategy, features among its long-term objectives, universal coverage. This means that JPKM could serve as the vehicle to provide access to family planning services to a majority if not all Indonesians.²

The second "key" legislative initiative, which will act as a driving force, is the National Worker's Security Law (UU #3) also ratified in 1992 and the Government Regulation (PP #14)

¹ The Family Doctors are physicians who have undergone a special curriculum which prepares them for service as primary care "resource allocators" in managed care ambulatory clinics. This curriculum was originally developed to provide a venue for "Contract Doctors" to enter the private sector subsequent to their government service.

² One feature of JPKM which may lengthen the period required for universal coverage is that participation is voluntary. Estimates based on this condition project 75-76 percent coverage by 2005.

passed in early 1993. These regulations established a benefits program, known as Jamsostek, for workers which provides not only retirement, death, and accident benefits for workers, but also a health care benefit program for workers and their dependents. This health benefit is based on the JPKM principles of the Department of Health and is designed to provide a basic benefit package (not to be confused with the BBP of DEPKES) to the labor sector. Like the BBP specified in the health regulations, family planning benefits are included.

The big difference between the workers' security and the health laws is that enrollment in the Jamsostek program is compulsory. This is especially significant given that the labor sector, as defined in the National Law, includes the self employed, day labor, and seasonal labor. At present, this would include an estimated 72-85 million workers and dependents. As the economy of Indonesia develops, this number will grow. In the initial phase, the Manpower Regulation #14 specifies that enrollment is mandatory for businesses employing 10 or more employees or who have a monthly total payroll of 1,000,000 Rp. or more. Rough estimates of the population covered by this regulation are around 20 million workers. With an average of 2.1-2.2 individuals per member, the health care benefit should cover 41-42 million people in the first phase alone.

Concomitant with these developments, numerous strategies are being pursued in Indonesia to increase both the number of KB services provided by the private sector and those purchased with private or individual funds. If those with the "ability to pay" for KB do so, the limited government resources can be focused towards providing these services to those who cannot afford them. However, what is significant for this "KB Mandiri" strategy is that the 42+ million market segment, which must join Jamsostek, constitutes the very population with the greatest "ability to pay" for the KB Mandiri family planning services. This means that "KB Mandiri" implementation through the JPKM benefit of Jamsostek will increasingly replace other strategies during the coming decade. Indeed, the concept of establishing family planning service centers (KB Mandiri) will be profoundly effected (sic) by the Jamsostek legislation. Those who could afford to purchase KB services will have, already done so. It is unlikely that they will purchase significant quantities of these services directly from KB clinics since they have already paid for them through their Astek JPKM benefits program. It is conceivable that stand alone KB clinics could be established in areas where Jamsostek has not yet been implemented but this would mean that these facilities would suffer certain extinction as Jamsostek is implemented nationwide. In fact, the very sites most favorable for the establishment of these clinics are the very ones which will be targeted first for enrollment in Jamsostek. From this, it would seem that JPKM will erode the KB Mandiri market.

The alternative perspective is to use the Jamsostek program as a means of rapidly establishing KB Mandiri services. Aside from the compulsory nature of enrollment, several other advantages would be afforded, namely, the cost of KB to the user will be subsidized by the rest of the JPKM membership, as will the cost of any medical complications arising from KB services. This is a significant effect in view of the ratio of KB acceptors to the general population. Another aspect of KB's inclusion in a broader benefit package is that individuals who do not have the "willingness to pay" for KB services may become acceptors simply because of the inclusion of KB in their benefit and the resultant lack of financial barriers.

Specialized family planning centers could attempt to contract as JPK-KB service providers, however, it will be difficult for them to compete with facilities that offer the full range of JPK services. Not only would the overhead costs of delivering KB services (electricity, water, etc.) be subsidized by the other health services provided in the multi service facilities but also, the provision of maternal child health services would ensure that the KB target population would be visiting the facility. In addition, supplementary health care services provided to non-Jamsostek members on a fee-for-service basis could further subsidize the overhead costs of the KB services.

Thus again, the strategy which would seem to be most logical is to utilize the Jamsostek JPK program to facilitate provision of KB services through family health centers thereby underwriting, subsidizing, and defraying a significant portion of the costs of KB services.

**APPENDIX C:
SUMMARY OF RELEVANT REGULATIONS**

Dr. James R. Marzolf

Briefly, the JPKM managed care legislation was developed in response to the necessity for economic austerity measures in Indonesia during the 1980's due to dropping oil prices and the Yen/Dollar slide. As in most countries, the first public areas to feel the cut were health and education. The strategy adopted for health was to mobilize the public's funds and afford the private sector a greater role. The GOI reviewed the health care financing strategies of numerous countries before attempting to develop JPKM. The goal was to adopt and adapt that which was good will (sic) eschewing that which was not. The results appeared in legislation starting in 1992 and the process has continued until the present. The most important statutes are:

National Health Law # 23: expands private sector role, establishes managed care strategy (favored over indemnity insurance). Conduction of JPKM without a license is punishable by up to 15 years imprisonment and a \$272,000 fine. Also establishes, quality assurance and standards of care and malpractice guidelines.

National Workers Security Law # 3: mandates participation in workers security program for formal and informal labor sectors (est.: 72,000 workers & dependents). Includes participation in Managed Care Benefits (not indemnity insurance). Companies with equal or superior medical benefits may "opt out."

National Insurance Law # 2: limits delivery of health insurance to life insurance companies, establishes liquid reserve requirements. Does not pertain to managed care programs, (in fact insurance companies are prohibited from managing health care services).

National Labor Regulation # 14: establishes "temporary" monopoly over workers security benefits for parastatal of the Ministry of Labor, PT. Astek. Re-emphasizes that companies with superior health care benefits may not lower the level of benefits provided.

Ministerial Health Regulation # 330: establishes that managed care programs may only be conducted by legal entities possessing a JPKM license and defines the protocol for obtaining such a license.

Ministerial Health Regulation # 527: establishes programmatic and benefit requirements for JPKM companies. Stipulates that the basic benefit is mandatory but enhanced benefits may be offered at the discretion of the JPKM company. Also stipulates that standards of care and quality insurance are mandatory, accredited facilities are to be used, and that the capitation payment must be adjusted to reflect the risk characteristics of the membership.

Ministerial Health Regulation #571: establishes the organizational and financial requirements for JPKM companies. Most notably a 3 month liquid reserve deposited in a national bank, proof

of capitalization for 1 year of administrative costs, and adequate operational reserves. Also states that capitation is the method of payment and that risk/profit sharing withholds must be used (withhold 15-45% of capitation, %'s provider: MC sharing open to negotiation). Also addresses "truth in advertising" & fair disclosure requirements. Also, that the company conducting managed care must not commingle either business or funds with other company lines of business. (For this reason, hospitals desiring to conduct JPKM programs must establish a separate entity. There can be no staff model HMO's in Indonesia as providers are prohibited from engaging in underwriting practices or collection of prepayments for services).

Ministerial Health Regulation # 150: establishes the family doctor strategy to increase private sector physicians trained to operate in a managed care environment (as gate keepers).

Ministerial Health Regulation # 154: establishes the basic parameters for quality assurance, standards of care, and hospital accreditation in Indonesia.

National Insurance Regulation # 73: prohibits "social insurance" organizations (those with compulsory memberships) from engaging in the sale of voluntary products (benefits).

In summary, JPKM managed care has been afforded advantages over traditional indemnity health insurance products. Licensure for managed care must be obtained from the Ministry of Health, health insurance from the Ministry of Finance. TPA type activities can be conducted without either license. Licensure requirements fro JPKM programs are similar but have some differences from US HMO regulations.

**APPENDIX D:
KEY INFORMANTS**

USAID

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BKKBN

Dr. Kusnadi, Chief, Department of Research
Dr. Siti Fathonah, Department of Research
Dr. Kasmiyati, Department of Research
Mr. Kijam Ginting, Bureau of Logistics
Dr. Djoko Rusmoro, Bureau of Contraceptives

Ministry of Health

Mr. Arsil, Attorney, Bureau of Law and Public Relations
Dr. Hendarto, Chief, Ob/Gyn Section
Dr. Herkutanto, Faculty of Law and Medicine, University of Indonesia

Commercial Pharmaceutical Sector

Mr. Stephen A. Udy, President Director, P.T. Upjohn Indonesia
Mr. Robby Susatyo, Resident Advisor, The Futures Group/SOMARC
Mr. Parulian Simanjuntak, Managing Director, P.T. Schering Indonesia

Others

Dr. James Marzolf, Consultant

Physicians

Dr. Azrul Azwar, Chairman, Indonesian Medical Association (IMI); Director/Owner, PKMI Clinic
Dr. Agus Purwadianto, General Practitioner
Dr. Budi Sampurna, General Practitioner/Clinic Owner

Midwives

Bidan Farida Dano Djae

Pharmacists

Dra. Ratu Atu, Pharmacist
Dra. Lavinia, Pharmacist

**APPENDIX E:
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