A summary of the political economy factors that are shaping the way Indonesia uses evidence to plan, prioritise, and allocate resources in the health sector.

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POLITICAL ECONOMY ANALYSIS: COUNTRY REPORT ON INDONESIA

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Acronyms and glossary

AIPD  Australia Indonesia Partnership for Decentralisation
APBN  National Budget (Anggaran Pendapatan dan Belanja Nasional)
BAPPENAS  National Development Planning Agency (Badan Perencanaan Pembangunan Nasional)
BAPPEDA  Regional Development Planning Agency (Badan Perencanaan Pembangunan Daerah)
BOK  Bantuan Operasional Kesehatan (Operational funds for General Allocation Fund (Dana Alokasi Umum)). Provides untied block grants from central level to subnational level. In 2012, the DAU made up almost 60% of central government transfers to subnational governments.
DAK  Special Allocation Grants (Dana Alokasi Khusus), Disability Adjusted Life Years. A DALY is an estimate that combines premature death and disability. A DALY averted can be thought of as achieving a healthy year of life.
Jamkesmas  Public Health Insurance Program (Jaminan Kesehatan Masyarakat)
Musrenbang  Musyawarah Rencana Pembangunan: Multi Stakeholder Consultation for Development Planning
NHA  National Health Accounts
ODA  Official Development Assistance
Posyandu  Sub village / hamlet level integrated health service posts.
Puskesmas  Sub-district level community health centre. Pos pelayanan terpadu
PNPM Generasi  National Community Empowerment Program—Healthy and Smart Generation Program (Nasional Pemberdayaan Masyarakat Generasi Sehat dan Cerdas). A conditional cash transfer program directed to communities rather than individual households.
RMNCH  Reproductive, Maternal, Newborn and Child Health
THE  Total health expenditure
UHC  Universal Health Coverage

Currencies and exchange rates

All $ are current United States dollars
$1US = Indonesian Rupiah (Rp) 11,874 in August 2014.
Indonesian Rupiah (Rp) 100,000 = $8.40

1 Executive summary

Background and methodology

Decisions on the allocation of scarce resources are rarely made purely on the basis of technical criteria. Political and other factors also shape decision-makers’ choices. It is therefore important to understand how and why governments in developing countries prioritise and allocate their own resources (as well as those of development partners), if countries are to achieve outcomes that are financially, politically and institutionally sustainable.

Since 2011, the Australian Government has been providing development assistance to improve reproductive, maternal, newborn and child health (RMNCH) outcomes in Bangladesh, Indonesia, the Philippines and Nepal. The approach focuses on improved use of local data in the prioritisation, planning and allocation of resources at district level. The main objective has been to develop, through district-level pilots, an ‘investment case’ to encourage sub-national governments to fund RMNCH as a key area of human development. Australian aid funding was channelled through UNICEF and other partners working with governments at national and district level in the four countries.

To deepen its understanding of the political economy of health and RMNCH in those four countries, UNICEF undertook a literature review and field analysis during June-September 2014. A mixed methodology was used, drawing on expert recommendations from academia and development experts. A questionnaire was developed based on a review of the relevant peer-reviewed and grey literature. Local data was gathered and interviews conducted in-country. This report provides the findings for Indonesia.

Situation analysis

Progress – or the lack of it – in health outcomes in Indonesia is so significant that it has regional and global implications. Indonesia is the world’s fourth largest country with a population of over 246 million, and around 25 million children aged under five years (1). It may achieve the fourth Millennium Development Goal (MDG) targets on reducing infant and under-five mortality, but is unlikely to achieve the MDG5 target on maternal mortality. Despite such progress, one child dies in Indonesia every 3.5 minutes (150,000 per year) and one mother every hour (2). Nearly half (48%) of the deaths under five years occur in the first month of life (1). The maternal mortality ratio, recently estimated at 359/100,000 live births (3), is much higher than would be expected for Indonesia’s income level. The prevalence of HIV infection increased more than four-fold between 2005 and 2013. At 55 million (4), Indonesia has the world’s second highest number of people practising open defecation, and also the third highest rate of tuberculosis, third highest number of unimmunised children and fifth highest number of stunted children (2). Public health in Indonesia and the economy in general were adversely affected by SARS and zoonotic diseases including ‘bird flu’. There are significant inequities in access to and outcomes of health based on geography, wealth, and education.

Politically, over the last ~20 years, Indonesia has seen a historic transition from stable authoritarian rule to stable democracy. This also involved transition from a centralised political structure to one in which substantial power and resources were decentralised to districts and local areas. This was undertaken as a means of preserving national unity in the aftermath of the Asian financial crisis and the fall of President Suharto. Centralised, authoritarian rule did help Indonesia achieve some important public health outcomes, including eradication of smallpox and polio even in remote parts of the country, through the establishment of basic public and preventive health services at community level. However, the “big bang” decentralisation since 1999 saw fundamental changes to Indonesia’s political landscape, and the relationship between state and society, including in the health sector.

The political economy of the health sector and RMNCH in Indonesia

Indonesia faces three immediate strategic challenges that have political economy implications for its health sector. The first is to put in place a reform-minded administration; this is difficult when government involves multiple ‘parties’ and coalition politics and some deep rooted vested interests. This has direct implications for the management of the economy, national priorities, allocation of scarce resources, and measures to reduce inequities, all of which directly and indirectly affect the health sector, including RMNCH. The second immediate challenge is financial and economic: to expand the fiscal space for increased government investment and services. This has been heavily constrained by the politically driven commitment to fuel and energy subsidies which absorbed almost one third of the national budget; disproportionately benefiting the middle class and the rich; and left reduced resources for pro-poor services including RMNCH. The recent abolition of the fuel subsidy, saving $22bn from the national budget, should free up funds for social sector expenditure, if it is sustained. Overseas development assistance is a tiny proportion of total health expenditure. The third strategic challenge with political economy dimensions is reform of the bureaucracy, which is often influenced by patronage rather than performance.
There are also strategic challenges over the medium and longer term in Indonesia that have direct implications for the health sector. The rapid rise in non-communicable diseases (NCDs) and traffic injuries can drain health resources away from the unfinished agenda of communicable disease control, under-nutrition, and RMNCH. Another challenge is to lift public expenditure on health, which has been historically low in absolute and relative terms. A third medium-term challenge directly affecting the health sector and RMNCH is to achieve government objectives for Universal Health Coverage (UHC) in a manner which is effective (including quality and safety), efficient, equitable, and financially sustainable. The situation is made more challenging by the large and largely unregulated number of private providers of health care in Indonesia.

A particular challenge in Indonesia is the need to strengthen the process of planning, prioritisation and resource allocation in a highly decentralised system. There are many potential benefits to the health sector and RMNCH in Indonesia’s rapid and substantive devolution of power and resources, including down to the village level. Local communities have the potential to identify their own priorities and allocate resources accordingly. Monitoring and accountability can – in principle – be more direct and robust. On the other hand, decentralisation also raises challenges. Poorer provinces and districts may have less financial and managerial resources to respond to local health needs. National coordination of priorities and programs to control communicable diseases, for which such coordination is most important, is more difficult when planning is decentralised. Local resource allocation can be difficult when rigidity in top-down budget lines prevents local reallocation. It is also clear that democracy and decentralisation are combining to make “free” health a vote-catcher; but there is little evidence that politicians are committed to improving actual health outcomes. Instead, it appears that national and local politicians are using the promise of “free” health care – in effect, a boost to household incomes – to attract votes. This should not be a surprise: politicians in a country of over 250 million have many issues to consider and “improved health” is usually a long term outcome that does not align with the short term political cycles of direct and vital interest to politicians. During this analysis, many interviewees suggested that the election cycle affected budget allocations and disbursements in health and other sectors.

Implementation issues with political economy dimensions are also important to RMNCH and health more broadly. Hiring, deploying and supervising health workers are complex aspects of health service provision, influenced by factors such as financing, patronage and nepotism. Similarly, procurement is fundamental to health sector functioning, with opportunities and risks including incentives, corruption and interruptions to budget execution. Coordination between districts and national priorities is a challenge, especially for national surveillance and communicable disease control, but may have political implications. And implementation of health programs without due regard to the quality of services – with all that raises in terms of incentives, payment and other political economy factors – undermines the sustainability of gains in health. In 2010, one third of Indonesia’s 69 public and private medical schools were unaccredited, and only a quarter received the highest accreditation level (5).

Finally, there are other broader political economy challenges that Indonesia faces that have indirect implications for the health sector, including RMNCH. These challenges include consolidating democracy, citizens’ participation, and redesigning the decentralisation of government (a challenge apparently being taken up by the new government); avoiding the “middle income trap” of relatively low economic growth; population migration and urbanisation; exploiting the potential “demographic dividend” of a large working age cohort by providing productive formal sector employment opportunities, raising tax revenue to fund social health insurance premiums and UHC; reducing infrastructure bottlenecks; and reducing inequities in health service access and improving environmental sustainability. Each of these issues has the potential to improve – or undermine – health outcomes, including RMNCH.

Summary and recommendations for development partners

It is clear that the environment in which Indonesia’s government and development partners now operate has changed dramatically over recent decades. Analysis of RMNCH there provides an excellent example of how political economy developments both reflect and affect the evolution of that change and related outcomes. However, there remain opportunities for UNICEF and other development partners to have strategic impact in Indonesia, including the following:

• The establishment of UHC, targeted for 2019, is a major strategic opportunity for UNICEF and development partners to help shape the access, coverage and quality of essential health services that can benefit women and children, especially the poor.
• All stakeholders need to “understand the language of finance”: it is important that development partners use National Health Accounts to analyse and engage in policy dialogue about health financing as a whole. This provides the evidence for informed discussions about reallocating resources to priority health needs, including RMNCH.
• A new Village Law, which is likely to provide block grants of around $100,000 for locally-determined allocation in every village of Indonesia, is a strategic opportunity to influence increased commitments to children and the poor.
• UNICEF and development partners should also proactively advocate for tobacco control. Tobacco use is a major driver of expensive NCDs in Indonesia, draining money from government and households that could be spent on RMNCH, undernutrition and other essential needs. Raising taxes on tobacco – as undertaken successfully in the Philippines – is a “win-win” solution to reducing NCDs and generating financial resources to scaling up UHC.
• Finally, actively tracking “what works” in the fast changing political economy landscape of Indonesia is a sound investment for UNICEF and development partners.

Indonesia’s political and economic landscape is changing rapidly. There are new opportunities for development partners to assist this enormous nation as it progresses in democratisation and decentralisation. Being aware of the political economy factors that influence priority setting and resource allocation is an important complement to technical expertise and financing from development partners.
2. Background

What causes governments to give priority to the issue of safe motherhood, given that national political systems are burdened with thousands of issues to sort through each year? In marked contrast to our extensive knowledge about the medical interventions necessary to prevent maternal death, we know little about the political interventions necessary to increase the likelihood that national leaders pay meaningful attention to the issue… What ‘political will’ means… has been left as an unopened black box. (8)

2.1 Context

Social and economic development processes involve much more than technocratic approaches: ‘political economy’ factors usually determine the fate of reforms (7-18). More specifically, how and why governments make and implement decisions; prioritise the allocation of scarce financial and human resources; resolve trade-offs; regulate the private sector; achieve accountability; and interact with civil society and development partners is an essential key to understanding the process of international development. Understanding how governments use – or don’t use – evidence to shape policies and prioritise the use of their own scarce resources is increasingly important. That is particularly true as more and more countries achieve middle income status, with large burdens of poverty (19), and as with progressively diminishing international development assistance.

Development partners increasingly need to understand the political economy of social sector progress, decision making and resource allocation if they are to have impact. Traditional forms of Overseas Development Assistance (ODA) have become relatively less important in much of Asia as those economies expand and many development partners withdraw. For example, total ODA in all sectors (ODA) have become relatively less important in much of Asia in the last two decades (20). Understanding the political economy of RMNCH is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes have been successfully implemented at scale in some low income Asian countries decades ago (21). Yet if the scientific evidence base, cost-effectiveness and affordability for improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite the political commitments and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure going to health, and especially RMNCH? How can RMNCH be prioritised and resourced in countries which are rapidly decentralising political and economic decision making to sub-national districts and even to villages? Political economy analysis can help provide insights into these issues for the benefit of governments and their development partners.

This report builds on recent collaborative work between Australia and UNICEF aimed at improving the evidence base for investment decisions for RMNCH in Asia. More specifically, since June 2011 the Australian Government’s aid program has been funding the development of an Investment Case for RMNCH in Bangladesh, Indonesia, the Philippines and Nepal. Led by UNICEF and its partners, the goal has been to demonstrate a new and systematic way of producing evidence that enables policymakers and planners to: (1) assess the extent to which RMNCH services are equitably distributed, using locally gathered data; (2) identify the constraints hampering the scale-up of cost-effective interventions that affect RMNCH; (3) design realistic strategies to address those constraints; and (4) estimate the expected mortality and morbidity impact and costs associated with implementing the strategies proposed. The approach sought to influence national policymakers and decision makers, including development partners, by highlighting financing gaps within national health systems and in specific geographic areas, as well as gaps in governance of the health sector. It is also applicable to other social sectors such as education and even agriculture, and also focuses on improving the evidence base for sub-national planning and budgeting.

Understanding the political economy of Reproductive, Maternal, Newborn and Child Health (RMNCH) is a particularly important issue. This is partly because there remains a large but preventable RMNCH burden globally, including in Asia and the Pacific: 2.5 million children under five died in this region in 2013, 41% of the global burden (20). Understanding the political economy of RMNCH is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes have been successfully implemented at scale in some low income Asian countries decades ago (21). Yet if the scientific evidence base, cost-effectiveness and affordability for improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite the political commitments and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure going to health, and especially RMNCH? How can RMNCH be prioritised and resourced in countries which are rapidly decentralising political and economic decision making to sub-national districts and even to villages? Political economy analysis can help provide insights into these issues for the benefit of governments and their development partners.

UNICEF commissioned this report to better understand the political economy of decision making in Indonesia, with particular reference to RMNCH. It responds to UNICEF’s and DFAT’s wish to better understand the overarching strategic factors that drive priority setting and resource allocations for RMNCH and the health sector more broadly at both the national and sub-national levels in Indonesia. This should, in turn, inform UNICEF and other stakeholders on how they might need to recalibrate their approaches so as to increase their impact on RMNCH and the health sector more broadly. It may also inform approaches in other social sectors. Similar reports have been prepared for three other Investment Case countries. The original design and Terms of Reference for this work are available on request. The political economy reports are in addition to a separate exercise that evaluates the outputs and outcomes of the Investment Case approach.

This analysis came at a particularly opportune time in Indonesia. A newly elected President, Joko Widodo assumed duties on 20 October 2014 with a new political agenda and mandate. The Government, through the National Development Planning Agency (Bappenas) was preparing the 2015-2019 Medium Term Development Plan, and has committed to UHC by 2019. It has also abolished the fuel subsidies and is moving to re-empower the provinces. Each of these key developments will affect the political economy of RMNCH and health more broadly in Indonesia, in the medium term. Coincidentally, UNICEF was in the process of developing its country strategy for 2016-2020. It will be important to consider these developments and contextual factors in order to prioritize the use of dwindling resources.

The specific methodology used for each of the four countries was as follows. We first reviewed different approaches to political economy analysis, especially as it applies to the health and social sectors, in peer reviewed and or grey literature. We then reviewed the literature, and open access data bases to identify the main political economy characteristics of the country. The Inception Report also set out the proposed methodology and analytical approach, including ethical issues; a proposed standard questionnaire for interviews; and a recommended program of field level interviews. The Inception Report for Indonesia is appended as Annex 3. Once UNICEF had reviewed and approved the Inception Reports and methodology, field interviews were conducted during one or two week visits to each country over 7 weeks in July – September 2014. In Indonesia 37 individual stakeholders were interviewed from a wide range of government, development partner, and other organisations, in Jakarta and Jayapura, Papua (where UNICEF has been developing an investment
3 RMNCH situation in Indonesia, and relevant context

3.1 RMNCH achievements and challenges

Indonesia has made substantial progress in reducing under-five and infant mortality. The latest Government report (28) on Indonesia’s progress with respect to the Millennium Development Goals (MDGs) stated that the nation had “demonstrated meaningful progress” in several areas and at that time was “on track” to achieve the MDG 4 target of reducing under-five mortality by two thirds between 1990 and 2015. More specifically, the report states that the under-five mortality rate fell from 97/1000 live births in 1991 to 44/1000 in 2007. Furthermore, the infant mortality rate, and the neonatal mortality rate, are reported to have fallen from 68/1000 to 34/1000, and from 32/1000 to 19/1000 respectively over the same period (28). Neonatal deaths now account for 48% of all under five deaths (1), reflecting the success in reducing deaths among older children through immunisation and other interventions, and the different skills, facilities and investments now required to address newborn health. The rate of immunisation against measles increased from 44.5% to 87.3% over the same period as well. But challenges remain. Around 37% of children under five were stunted in 2012 (3), down from 48% in 1995 (1) but high nonetheless, and recent stagnation of under-five mortality rates have made achievement of the related MDG target uncertain.

Indonesia faces bigger challenges on reducing maternal mortality. The latest Government report on the MDGs stated that the maternal mortality ratio has decreased from 390/100,000 live births in 1992 to 228/100,000 in 2007 (28), but a more recent source puts the figure at 359 (3). The Government acknowledges that it is highly unlikely that the MDG 5 goal of reducing maternal mortality by three quarters over the period 1990-2015 will be met, confirmed by the independent Countdown to 2015 report (1) and shown in Chart 1 below. On the other hand the same Government MDG progress report notes an increased percentage of trained health attendants at delivery from 40.7% in 1992 to 81.2% in 2011. Furthermore, Indonesia has “improved the contraceptive prevalence rate for married women using modern methods, lowered teenage pregnancy rates for females aged 15-19 years, and increased coverage of antenatal services for both first and fourth pregnancy visits” (28).

This report is structured as follows. Section 3 provides a summary of the RMNCH situation of Indonesia, and related context. Section 4 summarises the structure and function of the health sector and RMNCH at the national and sub-national level, using the WHO health system building blocks as topic areas. Section 5 provides analysis and recommendations.

Chart 1: Progress in reducing under-five and maternal mortality (excludes DHS 2012 data)
Inequity in access to and outcomes of RMNCH remains a major challenge in Indonesia. Recent analysis shows that there is virtually no difference between the richest and the poorest quintiles in terms of family planning, use of oral rehydration solution and continued feeding for children with diarrhoeal disease, or care-seeking for children with pneumonia (1). On the other hand there are large inequalities in the coverage of DTP3 immunisation, with coverage of nearly 90% among the wealthiest quintile but below 60% among the poorest quintile (1). UNICEF notes that inequality of access to, and outcomes of, health are often driven by geography (rural/urban), including more remote and poorer provinces in Eastern Indonesia; wealth, education, or an overlap between all these factors (29). Not surprisingly, therefore, there is a noticeable inequality of outcomes in terms of infant mortality, and under-five mortality, based on both geography and wealth differences in Indonesia. This is apparent in Chart 2 below. UNICEF also notes that there has been rising income inequality in Indonesia at a national level, including as a result of the 2008 Global Financial Crisis (29).

The situation with respect to other MDGs that directly or indirectly affect RMNCH is mixed. Indonesia concedes that while there has been “demonstrated progress” in reducing poverty (MDG1) and curbing the spread of HIV/AIDS (MDG 6), achievement of the related targets “still requires a great deal of work” (28). Slow progress in reducing poverty – after dramatic improvements in earlier decades – and controlling HIV/AIDS related targets “still requires a great deal of work” (28). Slow progress in reducing poverty – after dramatic improvements in earlier decades – and controlling HIV/AIDS will obviously have direct and indirect adverse effects on RMNCH outcomes.

Indonesia has an unfinished agenda of communicable, nutrition, and RMNCH challenges, but like most developing countries, it is also experiencing a rapid and substantial epidemiological transition, with rising NCDs impacting resources and attention to RMNCH. Latest estimates from the Global Burden of Disease (30) suggest that four of the top ten leading causes of premature death in Indonesia were NCDs: stroke, ischaemic heart disease, diabetes, and cirrhosis. The number of premature deaths attributed to these conditions increase by at least 75% in Indonesia, since 1990. All four have also increased their rankings as causes of premature death, with stroke now the leading cause of premature death among all communicable and non-communicable diseases in Indonesia. Even more striking is the change in ill-health and disability rather than only premature death. As shown in chart 3, there has been a reduction in virtually all Disability Adjusted Life Years (DALYs) lost to communicable diseases. On the other hand, there has been a pronounced increase in DALY’s lost to NCDs and injuries. This includes a more than 100% increase in premature death and disability due to lung cancer, since 1990. Indonesia has very high rates of tobacco consumption, and low taxation rates on tobacco.

### Chart 2: Inequality of infant and child mortality outcomes based on geography and wealth

#### Infant mortality rate (IMR) by area, Indonesia 1997-2007

- **Urban**
  - 1997: 61.0
  - 2002: 43.0
  - 2007: 35.0

- **Rural**
  - 1997: 71.0
  - 2002: 56.0
  - 2007: 37.0


#### Infant mortality rate (IMR) by wealth quintile, Indonesia 2002-2007

- **Lowest**
  - 2002: 61
  - 2007: 35

- **Second**
  - 2002: 54
  - 2007: 37

- **Middle**
  - 2002: 50
  - 2007: 31

- **Fourth**
  - 2002: 44
  - 2007: 33

- **Highest**
  - 2002: 40
  - 2007: 29


#### Under-five mortality rate (USIMR) by area, Indonesia 1997-2007

- **Urban**
  - 1997: 77.5
  - 2002: 58.0
  - 2007: 51.0

- **Rural**
  - 1997: 89.0
  - 2002: 66.0
  - 2007: 60.0


#### Under-five mortality rate (USIMR) by wealth quintile, Indonesia 2002-2007

- **Lowest**
  - 2002: 77
  - 2007: 71

- **Second**
  - 2002: 64
  - 2007: 58

- **Middle**
  - 2002: 59
  - 2007: 52

- **Fourth**
  - 2002: 54
  - 2007: 48

- **Highest**
  - 2002: 46
  - 2007: 42


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A DALY is an estimate that combines premature death and disability. A DALY averted can be thought of as achieving a healthy year of life.

Source: IHME: Global Burden of Disease Profile - Indonesia 2013 (31)
3.2 Political, economic and development context

Major recent political and economic developments help to explain Indonesia’s current political institutions and processes. Since achieving political independence in 1945, Indonesia has experienced: “Guided democracy” under Sukarno; a bloody and military-backed takeover of power by Suharto in 1967 and a strong centralised authoritarian “New Order” period; rapid economic growth followed by major financial, economic and social upheaval during the Asian financial crisis of 1997/8, when poverty levels doubled to one third of the population; the removal of President Suharto after 33 years in power; secessionist movements in Aceh and Papua; the independence of Timor Leste; rapid decentralisation of political and economic power to districts, to preserve the nation state, and the introduction of direct elections for the President and Vice President since 2004. The World Bank notes that:

In little more than a decade, Indonesia has gone from a low-middle-income country in political, financial and economic crisis to a democratic, stable and confident member of the G-20. Between 2001 and 2012, total GDP almost doubled from US$580 billion to US$1.1 trillion (16th largest economy in the world). During the same period, GDP per capita jumped from US$2,737 to US$4,272 (all in constant 2005 US$, PPP). (32)

McKinsey estimates that by 2030 Indonesia could be the 7th largest economy in the world, overtaking Germany and the UK, and that an additional 90 million people would be added to Indonesia’s “consuming class” (i.e. have genuine discretionary expenditure) by 2030 if Indonesia achieved growth of 5-6% per year (33).

Centralised, authoritarian, rule helped Indonesia to achieve some important public health outcomes. A strong, centralised, hierarchical, command and control system of government facilitated the eradication of smallpox and polio even in remote parts of Indonesia during the Suharto “New Order” regime. As noted by Naysmith “participation in smallpox eradication was not optional and there was little space for individuals or local authorities to resist or avoid the program” (34). Political economy factors – and especially using the power and prestige of President Suharto’s office - were also central to explaining rapid reductions in the then high levels of maternal mortality (400/100,000 live births in 1990). As noted by Shiffman:

The existence of a severe maternal mortality problem was by itself insufficient to catalyze action. The generation of political will required the development of reliable indicators to mark the seriousness of the problem, the persistent and proactive cultivation of national-level policymakers, the creation of workable policy solutions and the organization of attention-generating focusing events. In this way a longstanding but hidden crisis came to receive meaningful priority. (6)

Similarly, community-based RMNCH-focused health posts (posyandu, especially focusing on child nutrition, and community health centre for bidan desa) were a legacy of the Suharto-era approach to centrally-designed and funded public health.

The “Big Bang” decentralisation since 1999 is seeing fundamental changes to the political landscape in Indonesia and the relationship between state and society. Indonesia has always been a varied and heterogeneous country. The Asian Financial Crisis and the abrupt removal of President Suharto unleashed centrifugal forces that could have, potentially, seen the break up the nation. Faced with such a crisis, political leaders responded by rapidly devolving political and financial power to around 300 districts, largely bypassing the provinces which were seen as potentially capable of secession given their relative size and the history of regional unrest. The size, speed, and significance of the decentralisation process from 1999 cannot be underestimated. As the World Bank notes, “within one year, the big bang decentralized much of the responsibility for public services to the local level, almost doubled the regional share in government spending, reassigned 2/3 of the central civil service to the regions, and handed over more than 16,000 service facilities to the regions” (35). A UNICEF report also notes that “Rule over the populace has shifted from ‘rule through the law’ that characterised Suharto’s New Order regime, to building the ‘rule of law’” (29). The World Bank notes that subnational governments manage nearly the same proportion of public spending as the central government, when central government spending on subsidies and interest payments are excluded (32).

Even more changes to decentralisation are being proposed or implemented since the election of a new government in 2014. A re-empowerment of the provinces, largely bypassed in the funding and regulation of the social sectors during the “big bang”, has been proposed. In addition, sub-division of districts has elevated their number above 500, and new and unassigned block grants amounting to ~US$100,000 will be allocated to each administrative village, per year, for usage according to priorities determined by local leaders and, presumably, the local community.

Finally, progress – or the lack of it – in improving health outcomes in Indonesia will have regional and global consequences. Indonesia is the world’s fourth most populous country with a population of over 246 million. Despite much progress, one child dies every 3.5 minutes (150,000 per year) and one mother every hour (2). The maternal mortality ratio, recently estimated at 369/100,000 live births (3), appears to have plateaued at a level higher than that of comparator countries, and much higher than what would be expected for Indonesia’s income level (32). There has been a more than fourfold increase in HIV prevalence between 2005 and 2013. Indonesia has the world’s second highest number of people practising open defecation (65 million) (6), the third highest rate of tuberculosis; the third highest number of unimmunised children and the 5th highest number of stunted children (2). Public health and the economy more generally were adversely affected by SARS and zoonotic diseases such as ‘bird flu’. In brief, the political economy factors that influence the priority setting and resource allocation decisions related to RMNCH in Indonesia will have substantive implications for achieving the MDG targets at sub-national, national, regional and global levels.
4 Structure and function of the health sector at national and sub-national levels

It is evident from the foregoing that many factors affect Indonesia’s performance in the social sectors, including its uneven performance in RMNCH. In this section we present the major influences on the political economy of health and RMNCH at national and sub-national levels in Indonesia, drawing on the WHO ‘building blocks’ approach as a framework for our analysis.

4.1 Health system structure, governance and context

Like many developing countries, Indonesia is facing multiple health challenges. There is an unfinished agenda of communicable diseases, under-nutrition, and RMNCH. Persisting high maternal mortality was described above. Other challenges include for example high rates of tuberculosis (TB) and diarrhoeal disease, recently estimated as, respectively, the second and fourth major causes of years of life lost in Indonesia (31). Earlier reports suggest that nearly 300 people die of tuberculosis (TB) every day in Indonesia, with over 450,000 new cases estimated to occur every year (38). On the other hand, Indonesia is also facing a major challenge in the growth of NCDs and injuries. Stroke is now estimated to be the leading cause of years of life lost in Indonesia - a 78% increase since 1990 – and road injuries are now the third leading cause (31). WHO notes that Indonesia has also had to respond to SARS in 2003; avian influenza in 2006; the reintroduction of poliomyelitis in 2005 after a decade of absence, as well as reconstructions and rehabilitation following the unprecedented tsunami disaster of 26 December 2004 (37). As the population ages, Indonesia must also expect to see a rise in the incidence of dementia and other illnesses related to ageing.

Indonesia’s health sector includes a public sector that penetrates all the way to village level, along with a private sector that, while growing rapidly, primarily services settled or urban areas. In general, the per capita number of qualified physicians is low, and heavily favours urban areas. Dual practice is allowed, impacting where physicians prefer to work (38) and resulting in fragmentation of physician services. By contrast, according to the most recent data, the number of midwives in rural areas is not lower than in urban areas; data on nurses is less reliable (39). Multiple stakeholders in health facilities management exist, with parallel lines of authority; for example, health centres and hospitals are managed by different directorates which makes uniformity and consistency of services across the continuum of care difficult.

4.2 Health financing

Financing for health is low in absolute and relative terms in Indonesia. Latest WHO statistics (41) show that total health expenditure (THE - public and private) was just 2.9% of GDP in 2011, lower than the 4.4% average for low and middle income countries globally. Almost two thirds (62%) of THE is private expenditure and more than three quarters (75%) of that is directly out of pocket without insurance reimbursement, a potential barrier to care and source of impoverishment for Indonesians. THE is also low in absolute terms, an estimated $99 per capita per year. Of that amount, Government expenditure on health is just $38 per person per year. Government expenditure on health was just 6.2% of total government expenditure in 2011 (42) compared to 18% going to fuel and energy subsidies primarily benefiting the middle class and elite. Moreover, government expenditure on health is increasing more slowly than other sources of health spending (Chart 4).

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In addition, the ‘pipes and plumbing’ of financial flows for health to districts, while being streamlined, is complex and fragmented, as seen in the financial flow Chart (Chart 5). As in many countries, not only those with low and middle income per capita, this has important implications for RMNCH and health financing at sub-national levels in Indonesia.

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5 The World Bank estimates health expenditure is lower at 0.9% GDP in 2013.
6 Taking into account the lower cost of goods and services in Indonesia raises this to an estimated 50 "international dollars" per person per year in notional purchasing power parity terms.
In Indonesia, the Ministry of Health is responsible for integrating and managing the Jamkesmas program for the poor and near-poor. However, the challenge lies in the multiple funding sources and their influence on the policy and prioritisation process. Unspent budgets, delays in budget fund release, weak accountability, and political influences on the policy and prioritisation process have a serious impact at each step of the financing process.

A detailed analysis of the financing of Indonesia's health system, as well as an examination of the political economy factors, reveals that the activities and coverage of private sector services are not included as part of the evidence base for planning and priority setting. This is surprising given that most health expenditure in Indonesia is private, dual or simultaneous practice of health workers in both the public and private sector, and the high levels of mis-targeting and leakages to the non-poor.

In addition to the amount of funding available for health, a major problem lies with the multiple funding sources and complex mechanisms by which funds move within the system, from the centre to the periphery, as well as within provinces and districts. Unspent budgets, delays in budget fund release, weak accountability, and political influences on the policy and prioritisation process have a serious impact at each step of the financing process. These difficulties are well recognised and apply to all government sectors, not just health. Improving the allocation, flow, prioritisation of and accountability for resources at the periphery is recognised to be a major challenge, but sits largely outside of the health sector.

A detailed analysis of the financing of Indonesia’s health sector is available in a baseline report for the DFAT-funded Investment Case work (43).

Indonesia is undertaking a major program aiming to establish UHC. A government-financed health insurance program for the poor and near-poor, Jamkesmas, has been managed and financed by the Ministry of Health since it became operational in 2005. It currently insures more than 76 million people in Indonesia, but is to be integrated and merged with all other social insurance programs under a single-payer umbrella in the short term. Jamkesmas has both strengths on which to build, and areas for improvement, as Indonesia moves to increase the breadth, depth, and height of UHC. A recent report summarised the situation:

"On the positive side, about 40% of poor and near-poor households are covered under the program, outpatient and inpatient utilization rates have increased among program cardholders, levels of catastrophic payments have declined, and there is generally a positive perception with regard to the program among those who are enrolled. There is increasing participation of the private providers under Jamkesmas, and more than 300 complementary local Jamkesmas-inspired programs have been initiated across the country. On the negative side, there is evidence of high levels of mis-targeting and leakages to the non-poor, low levels of socialization and awareness of benefits, low utilization and relatively low quality of care, regional inconsistencies in the availability of the basic benefits package, relatively shallow levels of financial protection, and poor accountability and feedback mechanisms” (44).

4.3 Health and MNCH planning and priority-setting at national and sub-national levels

4.3.1 Health planning and priority setting processes

A number of planning mechanisms are endorsed by the Government of Indonesia, for use at national and subnational level. Attempts to democratis planning have also been stepped up with introduction of the annual Musyawarah Rencana Pembangunan or multi-stakeholder Consultation Forum for Development Planning (43). Musrenbang is a deliberative multi-stakeholder forum that identifies and prioritizes community development policies. It aims to be a process for negotiating, reconciling and harmonising differences between government and nongovernmental stakeholders and reaching collective consensus on development priorities and budgets. There is a hierarchy of these forums for synchronizing between ‘bottom up’ and ‘top down’ planning. (45)

However, particularly at sub-national level, there is a lack of uniformity and consistency in the approaches and tools used in musrenbang and other planning processes. For example, for MNCH, the central government-endorsed planning approach is DTPS, but this is not used in all provinces, and when UNICEF initiated evidence-based planning in Papua, many senior officials were unaware of its existence. In practice, it is not uncommon for districts to resubmit plans from the previous year with minor adjustments to the budgets. The use of recent evidence and data in informing the formulation of plans and budgets in the health sector appears to be the exception and not widely practiced based on interviews conducted in this analysis.

4.3.2 Evidence in the context of health priority setting in Indonesia

The ability of evidence to influence decision making is very context specific in all countries. The demand for, and supply of, evidence for decision making is, itself, usually a reflection of political economy factors (8). Much depends upon the answers to the following questions: What evidence? Whose evidence? When is it presented? How is it presented? The following answers to these questions are based on the interviews conducted in Indonesia.

What evidence? Some of the most basic evidence about children is missing in Indonesia. For example, UNICEF notes that “birth registration in Indonesia in 2007 was just above 42 per cent, a marginal improvement from 40 per cent in 2001, and that the target of achieving a record of 100 per cent registration of children by 2011 is unlikely to be achieved…. There is a very strong association between wealth and birth registration, with the majority of children in the two poorest quintiles remaining without legal identity.” (29) Having said this, Indonesia benefits from regular government- and internationally-supported surveillance and surveys of health service coverage and indicators, including 5-yearly Demographic and Health Surveys; however, the latter are not representative at district or even province levels.

It is clear that the activities and coverage of private sector services are not included as part of the evidence base for planning and priority setting. This is surprising given that most health expenditure in Indonesia is private, dual or simultaneous practice of health workers in both the public and private sector is common (46); at least half of all hospitals in Indonesia are private, including not for profit facilities (47) and around 60% of the rapid increase in medical schools in Indonesia is in the private sector (5). Yet a consistent theme in all interviews was that the existing and planned services of the private sector were not systematically taken into account when prioritising, planning and allocating scarce public health resources. This was somewhat understandable in Papua province where the formal allopathic private sector is very small. However even there, traditional healers are a major source of health provision, whether it be helpful or harmful.

It is unclear why there is a ‘blind spot’ with respect to the private sector when it is such a significant part of the health system. Interviewees speculated that the private sector was amorphous and not well organised, so it was difficult to collect key data. Others speculated that organisational culture in government tended to focus on the public sector. Whatever the reason, it means that priority setting, planning and resource allocation decisions are made in the absence of fundamental data. One senior official suggested the private sector doctors were, in fact, very influential but only behind the scenes, including for example lobbying for fee increases.
There is also a lack of evidence on the costs of delivering services, and operational research. Indonesia’s low level of government expenditure on health might imply interest in the cost of basic services, to ensure value for money from what relatively little is spent. However interviews suggested that basic cost data is not being collected and analysed to help inform policy. Do unit costs of immunisation decrease because of economies of scale, or do they increase because they involve harder to reach locations? What is the true economic cost of a maternal delivery at a secondary hospital compared to a district level hospital? How does the cost of treating a diabetes patient compare with comparable interventions in neighbouring countries of similar incomes? Some interviewees also noted that development partners often collected, and sometimes analysed, good cost data of health interventions but that the evidence was “locked up and balkanised” in project files. Several interviewees also noted that, despite the plethora of “pilots”3 supported by development partners, there were very few robust or useful operational evaluations. One exception cited by several interviewees was the World Bank evaluation of the PNPM Generasi Program, considered to be the largest randomised control trial of a community level grant program in the world (48).

Whose evidence?

Who presents the evidence is important in terms of influencing local policymakers. There was a widespread consensus amongst interviewees that senior decision makers in Government looked to known academics from two Indonesian universities – Universitas Gadjah Mada and the University of Indonesia – as sources of trusted and credible evidence. As said by President Widodo and other senior leaders attended one of these two elite Universities was noted by interviewees. Some local think tanks, including SMERU, were seen as influential by interviewees because of the quality of the evidence produced and their local “Indonesian” voice.

One analysis noted that the World Bank was particularly influential in provision of evidence, not only because of its technical expertise but because it could cite the “evidence” if things went wrong (IB). How is evidence presented?

Interviewees confirmed that how evidence is presented is critical to its impact on priority-setting and resource allocations. Senior Government officials in Jakarta and Jayapura, Papua confirmed that for evidence to be useful, and able to be used and usable to busy decision makers, submission of short, informative, simply-presented and recent data was important. Interviews in Papua also confirmed that the integrated micro-planning tool, developed and used by UNICEF Papua in some sub-districts, met these criteria. It facilitates community-based, reasonably factual, micro-level planning at the puskesmas level and, if replicated beyond current pilots, has the potential to help shape district level priority setting in those situations where individual puskesmas level plans are “rolled up” into district level plans. A summary of the integrated micro-planning approach is appended as Annex 5, explaining the features that are feasible to implement in real-world settings. These include a more coherent integration of RMNCH interventions, including maternal and child health, immunisation and nutrition that have tended to be viewed in silos; active community participation and proactive “local area monitoring and tracking” of key local data, and clear presentation of evidence in simple spreadsheets to track progress and deviations from key targets. In Jayapura, interviewees confirmed that district and provincial decision makers were using, and sometimes insisting upon having evidence generated by this process.

When is evidence presented?

Interviews, and the international literature, confirm that the timing of evidence is critical to whether it will be used to influence priorities and budget allocations. Key decision makers in Jakarta and Papua emphasised that short, sharp, evidence needed to be presented at critical times in the budget and political cycle if it is to be used. Evidence, no matter how robust, that was published outside of those critical time periods, was unlikely to be used. A recent example of the political economy making in Indonesia also noted that one of the reasons why the World Bank was particularly influential was that Indonesian Ministers knew from experience that they could get very short, technically accurate, policy briefing notes within a week of asking the World Bank, in contrast to the exceedingly long delays in getting urgent policy advice from their own departments (IB).

4.3.3 Other factors that affect priority setting and resource allocation at national and sub-national levels in Indonesia

Obviously, priority setting and budget allocations in all countries, and at all times, reflect influences other than just the evidence base. The following summarises other key issues identified from the literature and during interviews in Indonesia.

The impact of bottom up, evidence based planning may be limited by rigid, top down budget allocations or line items. Decentralisation in Indonesia has given genuine autonomy to districts and significantly increased their resource base, but this has not been accompanied by increased capacity or authority to prioritise, plan, budget and implement all resources. Evidence based planning at local level can identify where, why and how to allocate resources most productively (“allocative efficiency”), but rigid budget line item priorities often prevents this. The fundamental purpose of local planning is to provide a rational basis for allocating scarce resources (money, human resources etc.). However, if it simply maintains the status quo because of limited flexibility, it is no better than budgeting based on previous year funding, also known as “grand-fathering”. Interviews in Papua confirmed that officials and communities were generally enthused by local level bottom up planning. However it was also clear that institutional rigidities and constraints can diminish the impact of local decisions. Some funds provided from the centre to the district, or from districts to villages, could not be reallocated except by applying to Parliament. Moreover, some line items themselves had varying local relevance. For example, the total health budget for Yaper district in Papua in 2013 was Rp 3,341,080,000, a per capita allocation of IDR77826 or $US37/person/year, a small amount in absolute terms, but with 14 separate line item headings (administration, training, medicines, public health etc). This level of detail limits the flexibility to reallocate resources quickly to meet changing demands or new evidence. It can also be argued that a relatively small population of around 83,000 does not need 14 separate line items.

Expenditure on health has traditionally been very low in Indonesia and the political economy is now making “free”5 health care a populist vote-catcher. As noted earlier, government expenditure on health has been very low in absolute and relative terms in Indonesia. And while the proportion allocated to health is still low, a reflection of its relatively low priority despite political rhetoric and commitment to UHC, this is now changing, at least in terms of the absolute financing on offer. Unfortunately, there remains little evidence that politicians are newly committed to, or even interested in, actually improving actual health outcomes. Instead, what appears to be happening is that national and local politicians are using the promise of “free” health care – in effect, free services for all, i.e. no health income tax, as a mechanism for attracting votes. One analyst describes the manipulation of the “health” vote in this way:

Local free healthcare schemes mostly have their origins in elections. Over the last five years or so, candidates competing for office right across the country have made promises of free healthcare and other services in a bid to mobilise support. The model is so widespread that most local politicians see it as a basic ingredient of a winning campaign nowadays. Some of the politicians offering these schemes … have reputations as reformers, but many are machine politicians and oligarchs of the traditional sort(49).

However the danger is that “free health” as a vote-catcher has initiated a financially unsustainable bidding war. For example, in East Java, where the government once agitated for regional administrations’ right to implement local programs, healthcare services are overwhelmed and under resourced. In 2010, the program was badly in debt, with a budget allocation of just Rp50 billion (a little over $US5 million) and costs totaling Rp112 billion. This kind of blow-out is not uncommon. Often it happens because poor health infrastructure cannot deal with the sudden increase in demand that comes once services are offered for free. Sometimes the problem comes when officials incorrectly (and often corruptly) identify residents as ‘poor’ and thus eligible for free services, leading to overcrowding of the system. (49).

Many interviewees suggested that the election cycle affected budget allocations and disbursements in the health and other sectors. Many believed that expenditure under the health budget increased in the months prior to an election, usually on the basis of hiring temporary staff. Interviewees speculated that this was either a form of direct political patronage in the lead up to an election, or a device to increase the visibility of health workers and service delivery to the broader community. Most interviewees were convinced the expenditure under employment surge prior to an election was quickly reversed afterwards.

The hiring, deployment and supervision of health workers is a key component of priority setting and resource allocation with political economy dimensions specific to Indonesia. Decisions about the training, recruitment, and deployment of health workers are often made by public and private institutions beyond the influence and control of the Ministry of Health (50). Moreover, salaries and allowances for health workers, while relatively low at the individual level, are often a fixed and major part of health budgets, leaving little money for operational expenses. Local governments are responsible for hiring personnel but do not bear the majority of the costs: the central government pays about 70% of civil servant salaries through the ‘general allocation fund’ or DAU block grant, which is largely based on the salary bill for civil servants. World Bank analysis notes that “the DAU block grant, which is largely based on the salary bill for civil servants in the district or province, implicitly incentivizes civil servants to demand higher salaries as a means to capitalise on the government’s ability to provide higher salaries” (50).

Currently, there is very little oversight of the hiring process and little tying of salaries to performance, quality or productivity, in some cases, even attendance.

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3 An economic cost takes into account the use of all resources, including human resources, rather than just money.

4 Referred to as ‘pilots’ by one interviewee given the spread of them.

5 “Free” is in inverted commas because it is never “free”. Someone, somewhere, at some time has to pay for the economic resources used, even if that person is not the health seeking patient.
4.4 Service delivery and quality

In a diverse country like Indonesia, access to services is understandably variable due to a combination of geography and health systems challenges in different parts of the country. However, there remain serious concerns regarding the quality of services across the country, and this partially explains why relatively high coverage of services, for example antenatal care and deliveries attended by skilled birth attendants, do not translate into a reduction of maternal mortality. A quality of care assessment in 2012, led by WHO and supported by the United Nations H4+ partners, showed quantitatively and qualitatively that major quality gaps exist across the country, even in the delivery of some basic maternal health services. Moreover, it was observed that the quality gaps are not limited to remote Eastern Indonesia and remain an issue even on the populous island of Java with no major geographical barriers.

4.5 Health workforce and service quality

Like many countries in Asia, Indonesia needs to increase the quantity, strengthen the quality and improve the distribution of its health workforce. Recent analysis finds that 30 of the 33 provinces in Indonesia do not have the WHO-recommended ratio of 1 physician per 1,000 population (8). Another study estimated that Indonesia would need to increase the stock of health workers by 78% from current levels if it was to reach the WHO-recommended target of 2.28 trained health workers per 1,000 by 2035 (52). Moreover, as suggested by the preceding section, the knowledge and quality of health workers is very mixed in the public sector, even less is known about the quality in the private sector which is largely unregulated (5). It is particularly difficult to deploy, train and retain health workers in remote rural or island situations, including Eastern Indonesia.

In addition to these numeric limitations, payment and oversight of local health personnel in Indonesia has political economy dimensions and influences their performance. As mentioned above, the majority of funding for social sector personnel (including the health workforce) comes from national resources by way of DAU funds, limiting district-level capacity to hire (or fire) staff on the basis of need or performance. District capacity in this regard is also limited by the ability to raise additional resources for the health sector, particularly in the context of “free” health care, plans for UHC, the limited capacity of district governments to levy taxes or raise other revenue, and the limited capacity of poorer communities’ ability to pay. As a result of these funding issues, poorly supervised training and issues related to the distribution and attendance of public sector health professionals (38, 53), RMNCH services in rural Indonesia are generally not well resourced with personnel.

4.6 Procurement

Procurement is a fundamental part of implementation in the health sector, with opportunities and risks from a political economy perspective. In principle, decentralisation should enable districts to purchase essential goods and services when they need them. In practice, procurement can be a major source of corruption (54). Management and development partner attention sometimes focuses on upstream planning and priority setting to the neglect of actual implementation through procurement (16). Mis-procurement and delayed procurement disrupts budget execution and priorities. Analysis by the World Bank found that over 2007-2011, real procurement expenditure (IDR Billion, 2011 price) declined in 65% of districts in Indonesia. Of particular concern, from the point of view of equity was the finding that “the clusters of districts that have experienced a decline in procurement expenditures over time point to growing disparities in procurement performance between rich and poor districts” (58). This may reflect less capacity to design and manage essential procurement of goods and services in poorer districts.

5. Analysis and recommendations

5.1 Analysis

Three immediate challenges have political economy dimensions for health and RMNCH in Indonesia.

The first challenge with political economy dimensions is to have in place a reform minded administration, which difficult when it involves multiple ‘parties’ and coalition politics. Newly elected President Joko “Jokowi” Widodo was elected largely on the basis of his reform agenda, including improved service delivery, and ‘clean’ image. However his Gotong Royong Coalition only secured a little over one third of 560 seats in the House of Representatives in the elections, so his coalition government may have to compromise on Ministerial appointments and policies. Despite his election promise not to engage in “transactional politics,” President Widodo had to concede that around half of his Ministry comprised coalition party leaders and politicians, with likely implications for the national economy and prioritisation of government resource allocations. This will have implications for RMNCH and the health sector more broadly.

Coalition building is difficult in Indonesia, as in most nations that newly adopt a multi-party system, as political parties tend to be personality-driven, rather than issue-driven. In fact one commentator on Indonesia says that “coalition-building has been random, ‘promiscuous’, opportunistic, and determined by division of the spoils of office rather than reflecting coalitions of interests committed to policy outcomes” (56). The need for coalition building (and political compromises) is also likely to be a feature of the Indonesian political system in future. A World Bank report notes “the fact that highly competitive parties are tied to coalitional politics at the national level and in many regions, and that greater voice in the political arena has been afforded to a wide range of non-state actors has made it difficult to task the policy formulation, of reaching consensus on critical policies and reforms that much more challenging” (57).

The second challenge with political economy dimensions is financial and economic to expand the fiscal space for increased government investment and services. Despite rapid economic growth, Indonesia has a relatively small tax base, partly due to a large part of the economy being informal and out of the reach of government. However several other factors narrow the fiscal space and room for manoeuvre of central government to reallocate budgets to new priorities. For example the central government is legally prevented from having a fiscal deficit of more than 3% of GDP, the education sector is mandated to receive 20% of the national budget, and around 11% of the budget is required to pay down debt. Government salaries – always difficult to reduce for political economy reasons – further narrow the fiscal space. Independent analysis (58) of the 2015 proposed budget notes the relatively large increases in budget allocations – a clear reflection of government priorities – to the Ministries of Defence and Religious Affairs “despite widespread allegations of graft,” and to local government.

However the biggest constraint on how the central government can reallocate resources to new priorities has been the politically driven commitment to fuel subsidies. Total spending on fuel, electricity and non-energy subsidies would have absorbed almost one third (31.5%) of the 2015 budget proposal submitted to Parliament in August by outgoing President Yudhoyono. At the time of this analysis, fuel subsidies alone were set to rise by around 18 percent, or Rp4.6 trillion ($3.81 billion), to Rp29.1 trillion in 2015 compared to 2014. This would have declined in absolute terms because of falls in the global price of oil since August 2014, but meanwhile fuel subsidies were dropped by incoming President Widodo. Fuel subsidies disproportionately benefit the middle class and the rich. The World Bank estimates that about 84% of all benefits go to the top half of households by consumption, and only 16% to the bottom half. Indeed, 40% of the benefits go to the richest 10% of households, and less than 1% to the poorest 10% (32). Removing or even reducing fuel subsidies has been a very sensitive political issue in Indonesia, generating mass protests and street demonstrations often led by students, purportedly on behalf of the poor. They reflected perceptions – partly managed by protest leaders – that removing the fuel subsidy would lead to rising prices for daily goods such as rice, cooking oil, and public transport. It remains to be seen whether abandonment of fuel subsidies can be sustained politically, particularly if oil prices rise. While ostensibly saving $22bn, the net effect of this decision on government fiscal space, especially for social sector spending, remains unclear.

The Economist Intelligence Unit observes that “Departments to do well out of the 2015 RAPBN included the Ministry of Defence, with Rp4.6 trillion: Tandon and Cashin 2010. It can do so without impairing fiscal solvency: ie the government’s present and future ability to cover its recurrent expenditures and service its debt” (59). Fiscal space exists “when a government has budgetary room to increase spending and can do so without impairing fiscal solvency: ie the government’s present and future ability to cover its recurrent expenditures and service its debt” (59). The need for coalition building (and political compromises) is also likely to be a feature of the Indonesian political system in future. A World Bank report notes “the fact that highly competitive parties are tied to coalitional politics at the national level and in many regions, and that greater voice in the political arena has been afforded to a wide range of non-state actors has made it difficult to task the policy formulation, of reaching consensus on critical policies and reforms that much more challenging” (57).

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Fiscal space is “the capacity of a government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its fiscal position” (60). Fiscal space exists “when a government has budgetary room to increase spending and can do so without impairing fiscal solvency: ie the government’s present and future ability to cover its recurrent expenditures and service its debt” (59). The Economist Intelligence Unit observes that “Departments to do well out of the 2015 RAPBN included the Ministry of Defence, with defence spending slated to increase by 14% to Rp9.99trn. Increasing tensions in the South China Sea have encouraged many other governments in the region to increase military expenditure. The Ministry of Religious Affairs was granted the fourth-largest allocation among
The third challenge with political economy dimensions is reform of the bureaucracy. Government officials are essential to the delivery of health services. The number of government officials at central and local level have been increasing significantly and can absorb around 60–80 per cent of local budgets, leaving little left for operational and other expenses (29). Less than half (47%) of civil servants at national and local level are considered to have professional skills. Institutional culture and organisational incentives means that productivity and performance is patchy at best; the civil service is “rich in structure but poor in function” (29). Public sector employment is a means of patronage, especially in Papua and eastern Indonesia where there are few alternative sources of employment. The “dual practice” of health workers in Indonesia can mean that private sector activities complement those undertaken in the public sector. But more often than not the lack of supervision and accountability means that doctors and other health workers are absent or not delivering essential health services at a standard expected or required (46, 59).

There are also five challenges that have political economy dimensions over the medium and longer term in Indonesia.

The rapid rise in NCDs and injuries is an important and far reaching challenge for Indonesia, and has several important political economy dimensions. For example, treatment of NCDs puts significant added but often preventable financial pressure on the health system, leaving less for communicable, nutritional and RMNCH challenges. This squeezing out is partly due to technical factors: treatments for cancer, diabetes and heart disease are often chronic and often occur in secondary and tertiary level hospitals and/or involve expensive diagnostic and drug regimes. NCDs can also displace expenditure on treatments, especially in urban areas. It will also put new pressures on the health system. Although the prevalence of NCDs is rising, the rising drug regimes. NCDs can also displace expenditure on treatments, especially in urban areas. It will also put new pressures on the health system. Although the prevalence of NCDs is rising, the rising

Government has recently committed to increasing social sector resource allocations. The low level of government support for health needs to be seen in the broader context of social sector spending. Indonesia has prioritised, and resourced, the education sector. As noted in one assessment “few countries in the world have increased public spending on education by over 60% in real terms over a five year period, as Indonesia did between 2005 and 2019” (51). And Indonesia is committed to building on its already rapid expansion of social health insurance so as to achieve UHC by 2019 (44). But political economy questions remain. The 20% budget allocation for education is an input-based target, and is not based on performance-related output targets (say, number of children graduating from secondary school) or outcome targets (e.g. literacy). Institutional incentives create unintended adverse consequences from the requirement to allocate 20% of the budget to education. For example, within-year sharp and rapid changes in the overall budget generates an automatic 20% change in the education budget which is inimical to longer term planning and provides an incentive to simply add staff that can absorb funds but locks in staff numbers for the future (51).

Expansion of UHC is intended to expand access and financial protection to all Indonesians. But still unclear are how coverage can be extended to the large informal sector just above the poverty line in an affordable and sustainable manner (the “missing middle”), the financing incentives for curative versus preventive care under UHC, and regulatory mechanisms to ensure quality. Importantly, how and from whom the Government of Indonesia generates additional revenue for expanded social sector investments is a fundamental political economy question with implications for equity. There is speculation that Government could elect a tax-based system without pre-paid premiums. Raising additional revenue through value added taxes and excise duties may seem the most feasible option given the large number of informal sector workers, but value added taxes and excise duties are generally regressive (involve a proportionately higher contribution from the poor). There is also speculation that the anticipated inability of eastern provinces to absorb UHC funding will result in money being returned to the central level and reallocated to expensive but inefficient health interventions (dialysis, cancer treatment etc.). Provider payment systems could, if not well regulated, encourage private practitioners to elect unnecessary (and therefore wasteful and potentially harmful) interventions such as Caesarean section over normal vaginal delivery.

The third strategic challenge with political economy dimensions is whether Indonesia will achieve a “demographic dividend” or face a “demographic disaster”. Like many developing countries in Asia, Indonesia has had a large ‘youth bulge’ reflecting, in part, historic fertility levels and reduced under-five mortality. Between 2013 and 2020, the working-age population in Indonesia will increase by 14.8 million, reaching 189 million from the current 174 million (32). If that youth bulge is well-educated, productive, and employed - especially in the formal sector, generating tax revenues for government - then there is a one-time “demographic dividend”. Government’s overall fiscal space is expanded and the new revenue can be used to fund social initiatives such as UHC and pensions. The alternative is a “demographic disaster” – a population bulge not productively employed and adding to fiscal pressures on government. The political economy dimensions of the two alternatives are profound. A productive and employed population bulge can support, through income and taxes, investments and social protection for the young and the aged. The age dependency ratio12 will be lowered. As can be seen in Chart 6 below, Indonesia’s critical window of opportunity to take account of the demographic dividend is from 2020 to 2030. **Chart 6: Historic and projected dependency ratios in Indonesia**

<table>
<thead>
<tr>
<th>Year of Census</th>
<th>Dependency ratio (14 years)</th>
<th>Dependency ratio (65 years)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>27.45</td>
<td>47.50</td>
<td>74.92</td>
</tr>
<tr>
<td>1971</td>
<td>28.25</td>
<td>48.81</td>
<td>76.06</td>
</tr>
<tr>
<td>1980</td>
<td>29.00</td>
<td>49.70</td>
<td>78.70</td>
</tr>
<tr>
<td>1990</td>
<td>30.11</td>
<td>51.72</td>
<td>81.83</td>
</tr>
<tr>
<td>2000</td>
<td>31.22</td>
<td>53.37</td>
<td>84.59</td>
</tr>
<tr>
<td>2005</td>
<td>32.37</td>
<td>55.07</td>
<td>87.44</td>
</tr>
<tr>
<td>2010</td>
<td>33.52</td>
<td>56.72</td>
<td>90.24</td>
</tr>
<tr>
<td>2025</td>
<td>34.72</td>
<td>58.42</td>
<td>93.14</td>
</tr>
<tr>
<td>2030</td>
<td>35.92</td>
<td>60.11</td>
<td>96.03</td>
</tr>
</tbody>
</table>

Source: UNICEF. The situation of children and women in Indonesia 2000-2010 (29)

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12 The dependency ratio is the ratio of the young (below aged 15 years) and the aged (people older than 64) to the working-age population (15 – 64 years).
Consolidating democracy is the fourth strategic challenge with political economy dimensions. In 1999 Indonesia held its first and competitive elections in 44 years. Since then it has successfully had direct elections and transfers of power for the President and other key positions of power. Political disputes are being managed through peaceful judicial review. On the other hand, the new political system is still beset by operational problems. The people who make institutions work have become very adept at manipulating the system for short-term and sectional gain, and the old autocratic players have ‘reorganised’ themselves (in Hadz and Robison’s words) to survive and prosper in the new democratic environment. Despite institutional reform, the informal rules of the political game as played out in Suharto’s time remain essentially unchanged. (56)

Consolidating the decentralisation process is the fifth strategic challenge for health and RMNCH with political economy dimensions. Still evolving, this involves several issues – legal, constitutional, financial, and economic – as well as several Ministries including the Ministry of Home Affairs. Several interviewees observed that the issue of complex financial flows is not just a substantive issue in its own right, but symptomatic of a larger problem of overall coordination and coherence, especially in terms of subnational decision making and accountability. This is important from a political economy perspective because fragmented and separate funding streams (i.e., the capacity for reallocating scarce resources to the great social needs, and complicates the process of accountability in expenditure).

Economic and financial incentives are also encouraging the creation of new – some would say ‘artificial’ – new provinces, districts and sub districts. For example, in the ten years after decentralisation began in 1999 the number of recognised districts in Indonesia increased from 268 to 399, the number of recognised municipalities increased from 73 to 98, and the number of villages increased from 69,065 to 77,012 (29). District municipalities increased from 73 to 98, and the number of recognised sub districts also increased from 268 to 399; thus creating incentives for each region to split up.(35)

Fragmentation and proliferation of administrative units may be most effective of Finance Ministers and personnel, and must be carefully assessed and presented. Financial leaders must decide the overall resource levels going to the health sector and RMNCH. Good quality evidence about costs (including the costs of doing nothing) is required to convince Ministries of Finance, and development partners, of the affordability and sustainability of any publicly financed approach. UNICEF has not yet been able to systematically capture the overall resource costs (finances, human resource and management) of the nutrition work discussed above. A move in this direction may be successful in yielding additional, longer term, multi-sectoral commitments to prevent undernutrition.

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are allocated. It will be impossible to judge if “enough” resources are going to RMNCH and other priority issues without more accurate and transparent sub-national accounts. It is also very important that such sub-national accounts are accessible to the public. This is a recommendation of the Commission on Information and Accountability for Women’s and Children’s Health (60) and critical to ensuring accountability. Making such information simply “accessible” to the public is, however, not enough. Few members of the general public in any country will have the skill and patience to search budget documents and to challenge unfairness or gross discrepancies. Support for media training in how to understand a budget is therefore a sensible investment with potentially high political payoffs in terms of public interest and increased accountability. (For the same reason it has risks: journalists in the Philippines and elsewhere have been threatened and even killed for exposing corruption.)

**Actively engage in the roll out of the Village Law.** The Government of Indonesia intends to provide around Rp1 billion per village per year (~$100,000) to every village in Indonesia, beginning in 2015. This will be provided as a block grant for community-based decision-makers to prioritise and allocate. The proposal builds on the earlier and successful PNPM Generasi program and its predecessor community driven development program (48). The World Bank is supporting the government of Indonesia to introduce coordination of 27,000 facilitators who are being trained to assist villages to prioritise, plan and budget the use of these funds. Given the scale of the Village Law program it would be important for UNICEF and other development partners to work with the World Bank and government in this regard. UNICEF Papua’s example of integrated micro-planning demonstrates the use of evidence to improve the capacity of local leaders to prioritise health, nutrition and related interventions at village level. A specific example could be promotion of villages free of open defecation. UNICEF’s experience in supporting the training of Mayors in the Philippines about local level planning for health could be a good model to follow.

**Actively engage in the further roll out of UHC.** Indonesia has already made substantial and rapid progress in scaling up UHC but much more is needed in terms of policy and financing before the goal of UHC in 2019 can be achieved (44). Indonesia’s aspirations for UHC provide both policy and financing before the goal of UHC in 2019 can be achieved (44). Indonesia’s aspirations for UHC provide both

**Unresolved questions about UHC have political economy dimensions and implications.** UNICEF should actively follow through on its plans. In Indonesia, the UNICEF think tank to assist in the design of and assess the roll out of UHC, and compare it to previous schemes. This will enable UNICEF to advocate for UHC to meet the essential health needs of the poor, rather than being captured by the rich. Discussions in Jakarta suggest that following policy and programming areas where UNICEF could be particularly helpful:

- Participating at policy and technical levels in designing the RMNCH and nutrition benefit package and its implementation (as undertaken effectively by UNICEF in the Philippines);
- Designing and piloting strategies to increase access to health services (public or private);
- Designing systems to monitor whether new care packages are reaching the most vulnerable, are of adequate quality and are acceptable to communities, and
- Evaluating how local schemes are dovetailing with UHC.

**Proactively advocating for increased tobacco control is sensitive but strategically essential given the alarming health and social burden of tobacco use in Indonesia.** Tobacco use kills more people globally than HIV AIDS, malaria, and TB combined. Tobacco use exacerbates and accelerates the progression of all major NCDs: cancer, heart disease, diabetes and respiratory disease (61-63). The recent Global Burden of Disease study found that lung cancer is now the fastest growing cause of premature death and disability in Indonesia. World Bank studies found that expenditure on tobacco was the second highest item of expenditure in lowest quintile in Indonesia, absorbing more than expenditure on health and education combined (42). All of these factors adversely affect RMNCH outcomes either directly or indirectly. There is speculation in Indonesia that tobacco companies, a powerful lobby group (64), may pay the insurance premiums of smokers under UHC: clearly a “moral hazard” that is likely to encourage the poor to take up tobacco use.

UNICEF could use its focus on equity to advocate for genuine limits on the marketing and sale of tobacco products to children, drawing on its experience on marketing of breast milk substitutes; join with other international agencies such as WHO and World Bank to increase tobacco taxes, highlighting the example of the Philippines; and include behaviour change communication about tobacco, drugs and alcohol as a part of adolescent health and education programs. According to the World Bank:

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For Indonesia, tobacco tax is the most cost-effective way of reducing the incidence of death from tobacco use while reducing poverty. In Indonesia, implementing the maximum legally allowable tobacco tax rates could prevent between 1.7 and 4.0 million tobacco-related deaths among smokers, and increase fiscal space by generating additional revenues of US$3.2 to US$6.8 billion. While a doubling of the tobacco tax may negatively impact six economic sectors, one research simulation suggests that growth in 60 other sectors would be stimulated. (2)
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**Proactively track and document “what works” in terms of priority setting and resource allocation in the complex and fast moving environment of Indonesia.** Interviews with senior decision makers of the field visits suggested that a proposal in the health sector is likely to get priority and budget allocations if it combines five key elements simultaneously:

- The intervention addresses a serious issue that affects a large population;
- There is low technical / political risk in scaling up the intervention;
- There is low financial cost or human resource / management burden on the health system;
- There are quick and identifiable results, and
- There is media support.

While this set of criteria is unlikely to address some of the more pressing health burdens in Indonesia (including the rise of NCDs or issues of direct interest to UNICEF (such as neonatal care, adolescent health)) it is informative about decision makers’ perceptions. Moreover, it is also reflected in academic analysis specifically related to a key RMNCH priority in Indonesia:

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Four factors that heighten the likelihood that an issue will rise to national-level attention: the existence of clear indicators showing that a problem exists; the presence of effective political entrepreneurs to push the cause; the organization of attention-generating focusing events that promote widespread concern for the issue; and the availability of politically palatable policy alternatives that enable national leaders to understand that the problem is surmountable. (6)
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Finally, the engagement of political entrepreneurs can be an effective means of promoting orphan issues in which there has been poor progress and attracting limited attention and funding. Engagement of such individuals can make or break the uptake of and political and financial support for various social causes. Lobbyists are a familiar part of the political landscape in developed countries. In the same analysis on Indonesia’s high rate of maternal mortality, Shiffman describes the characteristics of political entrepreneurs:

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... effective political entrepreneurs possess certain distinct features: they are knowledgeable about the issue, they are persistent, they have excellent coalition-building skills, they articulate vision amid complexity, they have a credibility that facilitates the generation of resources, they generate commitment by appealing to important social values, they are aware of the critical challenges in their environments, they infuse colleagues and subordinates with a sense of mission, and they are strong in rhetorical skills. (6)
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REFERENCES

29. UNICEF. The situation of children and women in Indonesia 2000-2010: working towards progress with equity under decentralisation. 2011.
Annex one: definitions of political economy

There is no single, agreed definition of the term “political economy.” The OECD concisely says that: “Political economy analysis is concerned with the interaction of political and economic processes in society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time.”(22) Bueuran says “In its modern form, political economy studies refer to the study of the relations between political and economic processes which involve several factors such as incentives, relationships, and the distribution of power between various interest groups in society, all of whom have an impact on development outcomes” (85).

DFID has a more expansive description, which highlights how political economy analysis can improve development effectiveness:

Political economy analysis is a powerful tool for improving the effectiveness of aid. Bridging the traditional concerns of politics and economics, it focuses on how power and resources are distributed and contested in different contexts, and the implications for development outcomes. It gets beneath the formal structures to reveal the underlying interests, incentives and institutions that enable or frustrate change. Such insights are important if we are to advance challenging agendas around governance, economic growth and service delivery, which experience has shown do not lend themselves to technical solutions alone…. It can also contribute to better results by identifying where the main opportunities and barriers for policy reform exist and how donors can use their programming and influencing tools to promote positive change. This understanding is particularly relevant in fragile and conflict-affected environments where the challenge of building peaceful states and societies is fundamentally political (22).

The World Bank (23) says:

What is political economy? Political economy (PE) is the study of both politics and economics, and specifically the interactions between them. It focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes. PE analysis involves more than a review of institutional and governance arrangements: it also considers the underlying interests, incentives, rents/rent distribution, historical legacies, prior experiences with reforms, social trends, and how all of these factors effect or impede change.

References

References for this Annex are included in the list of References at the end of the main report.

Annex two: approach and methodology

The following is an extract on initial thinking about methodology and approaches written by Dr Midori Sato. The full text is available on request.

There are numerous analytical tools and approaches that could be used to examine governance and political economy of priority setting, planning and budgeting in the social sectors of developing countries. According to DFID’s “how to note” on political economy analysis (PE), these tools are broadly divided into three types: (1) Macro-level country analysis (understanding how political and economic systems of a country enable or hold back overall development, and to identify strategic entry points for programming in a country); 2) Analysis focused on particular sectors (understanding the interests, incentives and institutions operating within a particular sector, to inform the design of a sector programme) (ii), and 3) Problem-focused analysis (understanding and resolving a specific problem that may be encountered in a particular donor programme) (iii).

For example, the analytical process proposed by DFID/ODI (Figure 1) broadly follows these three stages (including the above two levels of analysis at both country-level and sector/intra-sector level) and supports DFID’s “Drivers of Change” (iv).

Another option is a problem-driven framework for political economy analysis (Figure 2) which was informed by a review by Wild et al., (2012) on governance and political factors affecting weak service delivery in three social sectors (education, health and water and sanitation) in multiple countries.

Mcloughlin (2012) maps technical characteristics of service provision in particular sectors and sub-sectors and identifies the political and governance implications of these characteristics for provision.

These papers facilitate our understanding by providing an analytical toolkit to give shape to the complex web of incentive structures that affect sector performance. The problem-driven analysis framework (Figure 2) presents a way of thinking about governance and political economy and the interaction between the three sets of variables/factors and corresponding steps to analyse those variables:

(i) Identifying the problem, opportunity or vulnerability to be addressed,
(ii) Mapping out the institutional and governance arrangements and weaknesses, and
(iii) Drilling down to the political economy drivers, both to identify obstacles to successful and progressive change and to understand where a ‘drive’ for positive change could emerge from and likelihood is of stakeholder support for various change options.

The second and third layers are differentiated in order to emphasize that institutional and governance dimensions as well as stakeholders and their interests, motivations, power and behavior will be explicitly considered in the second layer. The framework is useful in framing the concrete, problem-focused analysis and for structuring the inquiry process, yet it has limitation, such as difficulty in understanding linkages between wider country-level dynamics and specific problem analyzed within specific sector (Fritz et al., 2009).

References

18 A conceptual model that seeks to explain how pro-poor change arises as a result of the interaction between structures, institutions and agents; useful to identify drivers for change, but less useful for understanding how political systems operate in practice.
Other tools and approaches that can also be applied for political economy analysis include: “Power Analysis” by SIDA (Swedish), which focuses on the nature of power relations, distribution of power, and incentives for pro-poor reforms; “Strategic Governance and Corruption Analysis (SGACA)” developed by the Netherlands’ Ministry of Foreign Affairs, which is very similar to “Drivers of Change” but with a more tightly structured process and heavily relying on secondary sources of data conducted within a short timeframe; other tools include, but are not limited to “Politics of Development” by DFID and “Addressing Governance in Sector Operations” by the European Commission (ECI).

All of the tools and approaches described above have strengths and weaknesses. Considering that there is a great variety between, and within, the four assessment

Figure 1: Stages in political economy analysis (taken from Moncrieffe and Luttrell, 2005)

Figure 2: Problem-driven framework for applied political economy analysis (taken from Harris, D. 2013)
Annex three: Inception report for Indonesia

Four key messages

The four key messages of this Inception Report are as follows:

- Indonesia is a large and populous country. With a population of around 237 million, progress – or the lack of it – in reducing maternal and child deaths and disability will therefore have regional and even global consequences.
- Despite much progress, Indonesia faces many health and socio-economic challenges: a double burden of disease; poverty, vulnerability and inequality; and the possibility of being caught in a "middle income trap".
- There are clear and substantive political economy challenges:
  - Politically: Indonesia has moved from a centrally controlled system under an effective but authoritarian President to a more decentralised system where political coalitions requiring compromises among competing factions is important. Personalities and patronage still tend to be more important than policies per se.
  - Economics and resource allocation: expenditure on health care continues to be very low in absolute and relative terms compared to other countries in Asia, lower middle income countries globally, and needs. The channels for disbursing budget resources under decentralisation are often clogged or leaking.
  - Institutional / bureaucratic constraints: Public sector health worker numbers are low, inequitably distributed, and of very variable effectiveness, efficiency and quality. The private sector is a key component of the health system but private sector medical schools often lack accreditation. Policies are often good, but are poorly implemented. Overall accountability and feedback loops are weak.
- But there are also strategic windows of opportunity to help Indonesia scale up pro-poor interventions that will benefit vulnerable women and their children in an affordable, effective, efficient, and sustainable manner. The National Health System (SKN) aims – at least on paper - to put primary health care at the centre of the health system. Government appears committed to scaling up Universal Health Coverage by 2019: a major but very challenging opportunity for better and more equitable health outcomes. Presidential elections in July 2014 provide an opportunity for a fresh mandate for reforms. The Government is currently developing the 2015-2019 Medium Term Development Plan: an opportunity to shape the level, effectiveness, efficiency and equity of resource allocation (including health personnel as well as financing)

The political environment

Indonesia’s political system has evolved in response to several challenges in the short 69 years since independence. Importantly, Indonesia has remained united and democratic. This is despite great cultural diversity; centripetal forces threatening breakaway regions especially during the turbulent Asian Financial Crisis; and the proximity of the armed forces to the centre of power. Much of Indonesia’s political culture and history was shaped under the strong, centralised, authoritarian regime of President Soeharto but this has been changing. The current political culture is characterised more by the need for a (still relatively powerful) President to build coalitions (and therefore compromises) with various parties and interest groups. More specifically, the Indonesian Democratic Party-Struggle (PDI-P) won the largest number of seats in the April 2014 legislative election, but has only 109 of the 560 seats in parliament. President Yudhoyono’s second-term government contains representatives of the Democratic Party (PD), Golkar, the National Mandate Party (PAN), the Prosperous Justice Party (PKS), the National Awakening Party (PKB) and the United Development Party (PPP) (66).

Indonesia is holding Presidential elections in July 2014 which will decide the shape and direction of national strategies for coming years. The Economist Intelligence Unit sees important differences between the two Presidential candidates:

Joko Widodo’s (‘Jokowi’) 41-page campaign manifesto prioritises welfare measures and emphasises a bottom-up reform process. Jokowi’s Indonesia would see a strengthening of anti-corruption institutions, a restructuring of oversized bureaucracies, the introduction of merit-based and performance evaluations in government, and investment in infrastructure, healthcare and education. This pro-poor approach is in contrast to Mr Subianto’s vision of top-down control and enhanced presidential powers.

Jokowi is therefore likely to communicate better how his programme would be of greater benefit to the average Indonesian.

The socio-economic environment

Indonesia has a Gross National Income21 (GNI per capita) of $3580 in 2013(67) making it a lower middle income country. Indonesia is ranked 121 on the latest UNDP Human Development Index, behind the Philippines (114) but above Bangladesh (146) and Nepal (157). The percentage of those living in absolute poverty (< $1.25 a day PPP) in Indonesia has fallen dramatically from 54% in 1990 to 16% in 2011, the latest year available. This is a remarkable achievement driven by deliberate government policies such as employment-intensive manufactured exporting and increased agricultural productivity. However many Indonesians are still close – and therefore vulnerable – to the absolute poverty line. An estimated 43% of the population - around 101 million – still lived below the $2 a day PPP line in 2011.

Despite progress, inequity of access and outcomes remains an important challenge in Indonesia. For example, latest WHO statistics (41) show that 90% of women with a secondary education or higher have births attended by skilled birth personnel compared to only 44% for women with no education. The under-five mortality rate is 77/1000 live births for the poorest quintile in Indonesia compared to 31/1000 in the richest quintile. Service coverage helps to explain such differences: less than half (46%) of one year olds in the poorest quintile had DPT 3 immunisation coverage compared to 82% in the richest quintile. A (still draft) report just submitted to the Government of Indonesia as it develops the next Medium Term Plan also notes that Indonesia lags behind comparable countries in the region on several key health outcome measures including maternal mortality and life expectancy. The report then makes the important political and public health point that: “If the health outcomes achieved in the best performing geographical areas and socio economic groups were achieved nationally, Indonesia would be one of the best performing countries in the region. Achieving equity in health outcomes and ensuring best practice is delivered evenly across the country to all socio economic groups is the single most important step that the health sector can take” (reference available on request).

Chart 1: GNI per capita growth.

Source: World Development Indicators 2014

A striking feature of Indonesia’s economic landscape is volatility. As the red line in Chart 1 below shows, GNI per capita growth in Indonesia has been much more volatile22 than other comparable countries. Note in particular the collapse of GNI per capita growth of – 16.9% in 1998 during the Asian Financial Crisis. GNI per capita growth was at a respectable 4.4% in 2011 (latest year available) which is above the LIC average but still below that of Philippines (6.1%) and Bangladesh (5.1%).

21 GNI is a better measure of economic wealth as, unlike Gross Domestic Product, GNI captures the effect of overseas remittances: key issues in Asia.
22 The peak of 15.2% per capita GNI growth in 1993 is correctly cited from the World Development Indicators, but seems implausible and even inapplicable. It will be checked during field visits.
23 Estimates are not available for Nepal for 2011.
The resource allocation environment: proxy evidence of political priorities and commitment.

Virtually all countries make bold political commitments to improving health outcomes for the poor and vulnerable, including especially women and children. But resources (money, health personnel, political capital) are always scarce, especially in developing countries. Where, why, and how the political / bureaucratic system allocates its scarce resources is therefore the true litmus test of what is actually a priority to the decision makers.

Unfortunately, “health” appears to get a lower priority – or at least is less competitive and successful in making its claims – than other sectors in Indonesia. This is true in both absolute and relative terms. More specifically, total health expenditure (public and private) is just 3.02% of GDP in Indonesia. This is a lower relative share going to health than Bangladesh (3.5%), Nepal (5.4%), Philippines (4.5%) and lower middle income countries globally (4.59%) (67). The absolute level of expenditure on health is also low compared to other comparable countries. This is clear from Chart 2 below. It can be seen from Chart 2 that real (adjusted for inflation) per capita expenditure in PPP terms24 has been rising in Indonesia. However at $I 150 per person in 2012 (the red line) Indonesia is still well below the Philippines $I 202 (purple line at top) and the LICs globally $I 177 per person (yellow line) for Lower Middle Income Countries (LMICs) globally.

Perhaps most significantly from a political economy perspective, the share of government expenditure going to the health sector is low in Indonesia compared to other comparable countries. This is an important, substantial, albeit proxy indicator of the “real” priorities of decision makers. That is because public resources are always scarce – especially in developing countries. As a result, the actual share that a particular sector attracts is a particularly good indication of either the “true” priority of that sector or the lobbying power of other sectors and vested interests. As Chart 3 below shows, Indonesia consistently allocates a lower share of its government expenditure to health than the other three countries, and LMICs globally. The 6.9% of total government expenditure that Indonesia allocated to the health sector in 2012 – while an increase over previous years - is also less than half the 15% level that some authorities recommend as being necessary to provide essential health services without high levels of impoverishing out of pocket payments (54).

Chart 2: Real health expenditure per capita

Source: World Development Indicators 2014

![Chart 2: Real health expenditure per capita](image)

Source World Development Indicators 2014

Chart 3: Government expenditure on health as a % of total government expenditure

Source: World Development Indicators 2014

The environment for RMNCH and the health sector more broadly:

Indonesia has achieved important health outcomes. For example, UNICEF statistics (68) show that life expectancy has increased from 52.8 years (both sexes) in 1970 to 70.6 years in 2012. Under 5 mortality has fallen from 84 /1000 live births in 1990 to 31/1000 in 2012. Partly as a result, Indonesia has progressed from having the 165 worst rate of under five mortality in the world in 1970 to 31st by 2012.

But previously announced targets have not been met; progress appears to have stalled in other areas; and new challenges have emerged. Taken individually, or together, these trends have political, bureaucratic, resource allocation and technical implications for Indonesia. For example, the national average Total Fertility Rate of 2.6 has barely moved over the last decade. The maternal mortality ratio in Indonesia – a now much disputed figure – appears to have reduced from 600 / 100,000 live births in 1990 (second line from the bottom in Chart 4) to 220 / 100,000 in 2010 but progress appears to have tapered and stalled. Nepal – a low income country - now has a lower MMR (170 /100,000) than Indonesia. There were an estimated 8000 maternal deaths in Indonesia in 2013. These are national averages: regional disparities are higher.

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24 Purchasing Power Parity (PPP) is an estimate that seeks to minimise exchange rate movements and takes into account that prices of goods and services may well be lower in developing countries. It expresses figures in notional “International dollars” or $I to distinguish the estimates from $US.
This report was prepared for BAPPENAS as it formulates its next Medium Term Plan. It is available on request.

least in principle – demands on the public health system.

43% of hospitalisations, thereby relieving – at

The private sector is also rapidly expanding the number of medical schools. In principle, decentralisation could give provinces and districts greater autonomy and flexibility to respond to local needs. Indonesia has many good policies (although implementation is then often lacking due to shortage of resources, incentives, and accountability / feedback mechanisms). Indonesia also clearly has the critical mass and capacity for generating good evidence-based policy development on the supply side: there is perhaps less evidence of a willingness to use such approaches on the demand side.

But there are clearly substantial and long-standing challenges in the organisation of the health system in Indonesia. These are not simply technocratic problems. They reflect instead deep seated and complex political economy factors. The policies, incentives, and resourcing for producing and distributing health workers is one such challenge in Indonesia, as it is in many countries of Asia (50, 53, 59, 69-73). This is particularly so in Indonesia where ‘dual practice’ with the private sector offers opportunities for complementarity but also competition with the public sector (53). A recent analysis of the production, distribution, effectiveness and efficiency of human resources for health in Indonesia illustrates the complexity of the challenges. For example:

Despite the growth in the number of health workers, this is still not sufficient to meet population growth and growing demands. The shortfall in health workers is particularly pronounced at the primary health care level (puskesmas): a critical gap if Indonesia is to achieve UHC and focus more on prevention and promotion. There is also a pronounced shortfall of nurses and midwives at hospitals: a critical gap if Indonesia is to reduce maternal and infant mortality, and respond to the growing burden of NCDs and injuries.

The geographical distribution of health workers has been a longstanding challenge in Indonesia: 30 of the 33 provinces in Indonesia do not have the WHO recommended ratio of 1 physician per 1,000 population. Indonesia’s dual practice system of allowing health personnel to work in both public and private relieves budgetary pressure on government, but is a contributing factor to mal-distribution of health personnel, especially specialist doctors. Indonesia does not have enough health workers so it needs to ensure it is getting maximum benefit from those that it has. The quality of the health workforce starts with the quality of schools where there is a great deal of variability: only half of schools are accredited

It is also clear that political economy factors help to explain the challenges of planning, allocating, disbursing, expending, procurement, monitoring and accounting for financial flows under a decentralised system in Indonesia. The challenges of fiscal decentralisation in Indonesia are by no means new (34). Recent analysis finds a mixed picture of the latest situation. One encouraging finding was that “relative to the politically stable communities, fiscal decentralisation promoted development mostly in communities which transitioned out from elite capture to embrace democracy and particularly where these processes defeated incumbent oligarchs” (75). Another study that analysed 271 districts in Indonesia concluded that “after the dramatic expenditure decentralization of 2001, districts with relatively lower levels of public infrastructure started to invest more in these sectors. In contrast to the marked budgeting changes following fiscal and administrative decentralization, we find no consistent effects of the democratization process on local public investments. Our results reflect initial improvements in local targeting but show no evidence of increasing electoral accountability” (76).

Conclusion and next steps

Indonesia is a large, varied, complex society. It is undergoing rapid social, economic and political change. Field visits and further literature reviews will identify how, when, where, why, and at what cost UNICEF and other development partners can best assist Indonesia address its challenges, particularly in addressing the needs of women and children.

References

References for this Annex are included in the list of References at the end of the main report

Decision makers will also have to make increasingly hard choices and trade-offs in the use of scarce resources because Indonesia is also facing a classic ‘double burden’ of disease. More specifically, there is an unfinished agenda of communicable diseases (including malaria and TB) and undernutrition. The burdens are highest in poorer provinces and districts. At the same time there is a rapid escalation in the incidence of non-communicable diseases (NCDs) such as heart disease and diabetes as well as their risk factors, especially rising incidence of overweight and tobacco use. Recent study prepared for Government as it develops its next five year plan found that the rising case load of NCDs is likely to lead to total health costs increasing from 2.6 trillion Rupiah in 2013 to 3.4 trillion in 2015 and 4.7 trillion Rupiah in 2019, an increase of 0.9 trillion (US$ 76.8 million) and 2.3 trillion (US$ 189.7 million respectively (reference available on request).

The institutional and bureaucratic environment

There are several positive political economy features of the institutional and bureaucratic environment. For example, an amendment to Indonesia’s constitution formally recognised the universal right to health care in 1999 and much political and bureaucratic effort has since gone into broadening and consolidating insurance schemes to pay for that expanded coverage (42, 44). The private sector now provides, on average, around 60% of outpatient services and 43% of hospitalisations, thereby relieving – at least in principle – demands on the public health system.

In principle, decentralisation could give provinces and districts greater autonomy and flexibility to respond to local needs. Indonesia has many good policies (although implementation is then often lacking due to shortage of resources, incentives, and accountability / feedback mechanisms). Indonesia also clearly has the critical mass and capacity for generating good evidence-based policy development on the supply side: there is perhaps less evidence of a willingness to use such approaches on the demand side.

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References

References for this Annex are included in the list of References at the end of the main report.
Annex four: List of organisations and people interviewed

The following is the list of those people interviewed in the Philippines during the period 14-25 July 2014. Organisations, and names of individuals, are listed in alphabetical order. Interviews were requested with the Department of Health, Manila; Department of Budget and Management; Australian Department of Foreign Affairs and Trade (DFAT) and the World Bank but could not be accommodated in the time available.

### Organisation/ individual’s name (in alphabetical order)

<table>
<thead>
<tr>
<th>Organisation/ individual’s name (in alphabetical order)</th>
<th>Title of individual</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DFAT Jakarta</strong></td>
<td></td>
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Annex five: Integrated Micro-planning in Papua

Integrated Micro-Planning Main Summary of Key Issues

Prepared by Tania Thenu Barendz

Background

In 2012, UNICEF initiated to support evidence based planning and budgeting in MNCH program of health sector in Papua in collaboration with Provincial Health office (PHOI) Papua, University of Gajah Mada (UGM) Yogyakarta, University of Cendrawasih (UNCEN), local polytechnic institute and provincial BAPPEDA. With a provincial team of 21 trained people (of which 6 from PHOI, 6 from provincial BAPPEDA, 2 from Polytechnic institute, 3 from UNCEN Faculty of Public health and 4 from UNCEN Medical School), support to evidence-based planning in selected districts (originally 3 districts: Yapen, Boven Digul and Jayawijaya) was provided in order for the districts to come up with their evidence-based strategies to accelerate MDGs. This team along with UNICEF team followed up with the districts and observed the following:

1. The districts had appropriate strategies incorporated in the planning document but this was not adequately translated into the plan of action (POA) of the Puskesams (Primary Health Care/PHC) with local context adaptation
2. Lack of capacity of the PHC to develop an evidence-based plan and to prioritize on the interventions based on available resources to reach the unreached populations
3. The effectiveness and efficiency of the funds were in question
4. No local participation of non-health stakeholders in the health planning and monitoring.

In order to strengthen management capacity and planning process at the PHC level, the UNICEF and the provincial teams reviewed various existing planning tools such as POA, Minimum Service Standard (SPMI), RED Microplan for EPI, and malaria micro-planning tool. Following the review, the team agreed to has an integrated micro planning on maternal child health, EPI, malaria and nutrition based on the lessons learnt from RED Micro-planning in EPI and Malaria color-coded micro-planning. Therefore, the integrated micro-planning is not a new planning tool or concept. Instead, it is an expansion of the EPI RED micro-planning and the malaria micro-planning to MCH program. The PHO Papua shared this concept with the Evidence-Based Planning (EBP) provincial team during a workshop in April 2013.

Components and Steps in Integrated Micro-Planning

Similar to RED micro-planning, the integrated micro-planning has five components, namely: outreach service strengthening, supportive supervision, community participation, data monitoring for follow up action, and planning and resource management. The planning process follow seven steps which are 1) data analysis, 2) problem mapping, 3) integrated activity planning, 4) meeting plan with community/religious/adapt leaders, 5) quarterly workplan development, 6) logistics management, and 7) use of monitoring charts (LAMAT = local area monitoring and tracking).

Priority Setting in Planning Process using Integrated Micro-Planning Approach

The stratification and integrated prioritization in step one is new to other programs except for EPI. The analysis is done based on indicators for access and utilization but also governed by other variables such as mortality figure, availability of health staff and geographical difficulty. Points are provided for meeting particular landmarks in the indicators and based on the points the prioritization is done and is tailored with the subjective experience of the local community and health staff. Example of weighing of health personnel and geographic conditions is presented below.

### Geographic Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Weight/point</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Difficult</td>
<td>3</td>
<td>Travel time of more than 60 minutes from PHC to village-level health post by using common local transport</td>
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<tr>
<td>Medium</td>
<td>2</td>
<td>Travel time between 31 to 60 minutes from PHC to village-level health post by using common local transport</td>
</tr>
<tr>
<td>Easy</td>
<td>1</td>
<td>Travel time of less than 30 minutes from PHC to village-level health post by using common local transport</td>
</tr>
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</table>

### Access Utilization

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>UTILIZATION</th>
<th>CATEGORY</th>
<th>WEIGHT/POINT</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Kn1</td>
<td></td>
<td>BUBA</td>
<td>1</td>
<td>Good access, good utilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BABA</td>
<td>2</td>
<td>Good access, bad utilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BABU</td>
<td>3</td>
<td>Bad access, good utilization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BUBU</td>
<td>4</td>
<td>Bad access, bad utilization</td>
</tr>
</tbody>
</table>

Note: Kn1 = first neonatal visit; HB-0 = Hepatitis B between the age of 0 - 7 days.
Priority setting per individual program

Example of prioritization based on above scoring for neonatal health program

<table>
<thead>
<tr>
<th>Issue</th>
<th>Problem Priority</th>
<th>Scoring</th>
<th>Geographic Coverage</th>
<th>Health Personnel</th>
<th>Other aspects for considerations</th>
<th>Absolute Score</th>
<th>Category Point</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
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- Such prioritization process will be done for each program (i.e., MCH (mother, neonates, under-fives), malaria, immunization). Once this is completed, the final score will be calculated as shown in below matrix. The computerized ranking (auto generated excel sheet) is tallied with the local experience of the staff and community and a manual ranking is also done to see if it is close to subjective perception.

**PRIORITY RANKING**

<table>
<thead>
<tr>
<th>No.</th>
<th>Village</th>
<th>MCH - Mother</th>
<th>MCH - Neonates</th>
<th>MCH - Under five children</th>
<th>Malaria</th>
<th>Immunization</th>
<th>TOTAL (the smaller the number the higher the priority)</th>
</tr>
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<tbody>
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**INTEGRATED MICRO-PLANNING**

Besides bringing all sections (at the PHO, DHO, and PHC) and health stakeholders together during the planning process, integrated micro-planning encourages community participation in the planning, monitoring and review of the programs, thus in the spirit of decentralization. It also aims to provide an objective tool in the monthly mini-workshop to review programs and make real-time review and take immediate corrective actions. The monitoring graphs for each program can easily detect any deviation in the program path and help to make immediate corrective actions.

At the PHC level, the integrated micro-planning process helps to sharpen the planning process and makes the POA more evidence-based. The integrated micro-planning does not replace the POA but is an annex to the POA on detailed planning and allocation of funds for more effective and efficient use of the local funds. It helps to micro-target and integrate programs at local level.

Being piloted in the districts of Jayapura, Jayawijaya and Biak of Papua province, and Fak of West Papua province, the integrated micro-planning has contributed to supporting the concerned PHCs to:

1. give an objective explanation to the budget allocation
2. see opportunities across programs to converge and integrate
3. reallocate or add or remove outreach clinics based on the data analysis
4. use the map with symbols for various program for better integration and identification of target population

Consequently, the integrated micro-planning reflects systematic, logical and transparent basis for decision-making, and it is appropriate and relevant to local level planning.

Jayapura, 30 August 2014