

Viewing Decentralization as an Opportunity: In Improving Availability of Health Workers in Underserved Areas

¹Anna Kurniati, ²Ferry Efendi

¹Center of Planning and Management of Human Resources for Health
Ministry of Health, The Republic of Indonesia
Jl. Hang Jebat Raya F3, Kebayoran Baru Jakarta, 12120
²Faculty of Nursing Airlangga University Indonesia
Jl. Mulyorejo Kampus C Unair Surabaya 60115
E-mail: annakurniati@gmail.com, fefendi@gmail.com

Abstract

Providing health care to underserved communities in Indonesia has long been a major concern. Lack of health workers particularly in rural remote and very remote areas has hampered community access to good quality of health services, which in turn leads to a poor health status of the people.

Implementation of the decentralization policy in health has affected human resources for health. Employment of health workers in public facilities has been transferred to the responsibility of the local government, especially at the district level. To some districts with shortage of certain type of health professional, difficulties in recruiting health workers have been answered through opening of new health workforce education institutions, provision of scholarship, and provision of financial incentives in return to serve in the underserved areas for certain period. However, disparity in financial capacity and geographical condition among districts creates favorable and non favorable areas to health workers.

Another consequence of this decentralization policy is the break-down of health personnel information system as the local level thinks there is no more obligations in sending data to the upper level.

This paper aims to assess the impacts of decentralization policy in Indonesia and what opportunities can be taken by each government level to improve the health workforce situation particularly in underserved areas. A desk study was performed from relevant published materials. Literature was reviewed from databases of the Ministry of Health. A clear understanding of the implementation of this policy and its impact is critical to face tomorrow challenges to improve health workforce distribution in the underserved areas.

Keywords: *underserved area, decentralization, health worker*

1. The background

Indonesia's 2001 decentralization is rapidly moving the country from one of the most centralized systems in the world to one of the most decentralized. The country has embarked on a program of fiscal, administrative, and political decentralization at the same time.¹ The radical and rapid change in intergovernmental relations in Indonesia was expected to lead to many changes at the district level, especially to improve public sector performance. These expectations were based on the view that although districts would remain heavily dependent on transfers of funds from central government for their revenue, the tight specification of the way in which funds would be used should be clearly defined. The increased autonomy at the local level was then expected to result in decisions more suited to the local setting and improved outcomes.

Prior to decentralization, the central Ministry of Health had complete responsibility for the health sector, including human resources, and decided how resources were to be allocated in the districts. According to Heywood², in principle the districts now have control of their public sector health workforce, but in reality the central government still controls all permanent civil servants or PNS (Pegawai Negeri Sipil) working at the district level; these staff are paid directly from the centre and the centre effectively controls hiring, firing and the conditions of employment of this category of staff. The centre also controls hiring, firing and the conditions of employment of a category of contract staff known as PTT (Pegawai Tidak Tetap). The PTT scheme is applied to medical doctors, dentist and midwives, with duration of the contract ranging from 6 months to 3 years depending on the location criteria. The contract can be prolonged twice. The PTT staffs have the same level in authority, medical practices and the same training as PNS.

Indonesia has made progress in health development after nearly a decade of the decentralization, as shown in the table 1.

Table1. The progress of health development³

No	Indicator	1997	2007
1	Infant Mortality Rate (per 1.000 live births)	46	34
2	Maternal Mortality Rate (per 100.000 live births)	334	228
3	Malnutrition of Children Under Five Years (%)	29.5	22.5
4	Life Expectancy (year)	68.4 (2004)	70.5

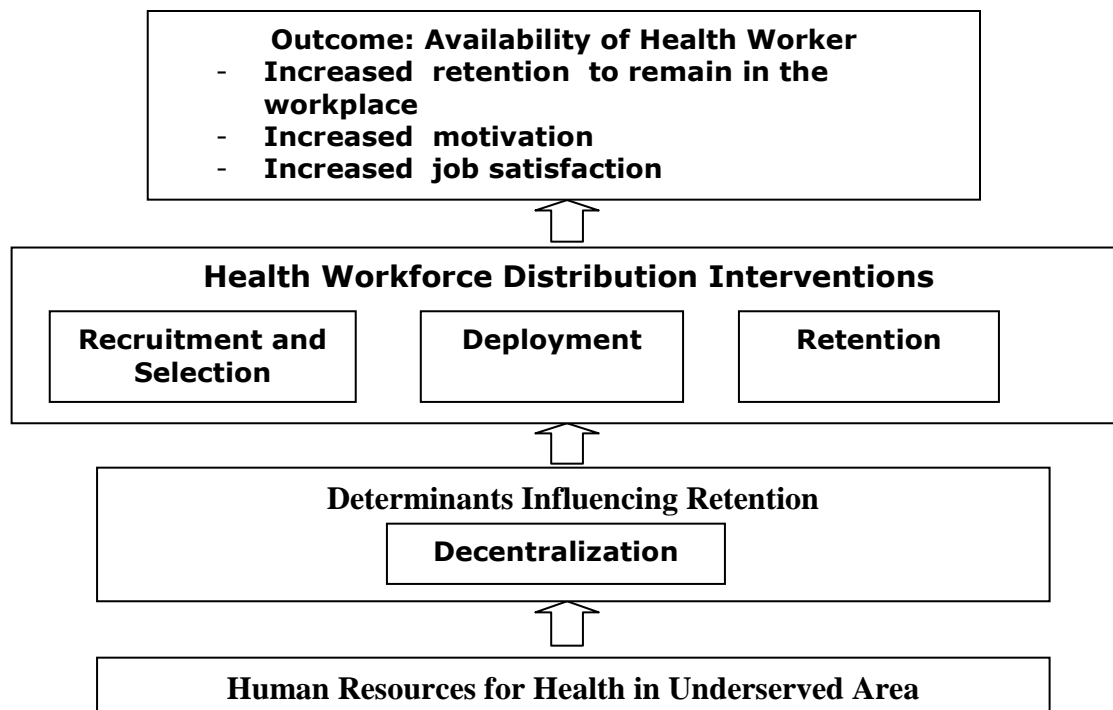
Although those health indicators shown good progress, the performance of the current health system needs further improvement to

achieve the Millennium Development Goals (MDGs) targets. Acceleration of health development toward MDGs will require adequate number of qualified health workers and equally distributed to support the functioning of health system. However lack of health workforce and maldistribution has been noted as one of the common problems in Indonesia situation.⁴

Decentralization has been seen as a challenge in the development of human resources for health. There are still many overlapping tasks and functions between central and local government. Some existing regulations especially in personnel management set up and controlled by the central level do not accommodate the districts innovation to suit the local needs. Therefore, this paper try to look at the impacts of decentralization on health workforce and what interventions to tackle the deployment and retention issues in the underserved areas. The author use "underserved" term, which mean a geographic location which has insufficient health resources (manpower and/or facilities) to meet the health needs of the resident population.⁵

2. The conceptual framework

Many factors influence the willingness of health workers to stay working in underserved areas such as communication, transport, security, social facilities, etc. To address this complicated field, the authors modify a framework that simplifies the concept of retention as follow:



There are several determinants factors affecting retention i.e macro health system level, micro health system level, factors at individual level or living circumstances. This paper will only focus on decentralization that is one of determinant factors under the macro level, and its impacts on health workforce. To some extent, shifting from centralized to decentralized system has affected health workforce distribution policy on recruitment and selection, deployment and retention of health personnel in various level of administration. Appropriate strategies in implementing this policy will improve availability of health workers in underserved areas. Finally community in underserved areas will be benefited by easy access to qualified health workforce.

Methodology

A desk study was performed of published and grey material. Literature was searched by means of the databases of the Ministry of Health of the Republic of Indonesia.

3. The Case of Indonesia

3.1. Impacts of Decentralization on Health Workforce

Enactment of the law on local autonomy in 1999 marked the beginning of the decentralization system in Indonesia. Implementation of this system was translated differently by each level of government. Transferring the autonomy was perceived by the districts to have more independent in regulating and managing their own affairs including health sector, thus ignoring the line coordination to the upper level as it was considered merely as a mandatory rather than a command line. On the other hand the central level still wants to take control over the local level.

An effort to clearly define the roles and responsibilities of national and sub-national levels was supported by the Law number 32/2004 on Regional Governance which was further regulated by Government Regulation (PP) number 38/2007. However, further clarifications of the PP are still needed.

Implementation of the decentralization has given some impacts on health workforce issues:

- a) *Transferring the employment status of civil servant from the central to the local level.* Approximately 70% of central PNS who worked in the local facilities were administratively transferred to the management of the local government. Up to year 2007, the proportion of civil servant is 71% at district level, 8% at province level and 21% at the central level.⁹
- b) *The local government has more autonomy in providing and managing public facilities.* The rapid formation of new provinces and

districts/municipals has been followed by the increased number of health facilities particularly district hospitals and community health centres. The number of community health centres annually increases by 3% within the last five years. However, this development is not adequately followed by deploying sufficient health personnel in accordance with the national standard (DSP or Daftar Susunan Pegawai).

- c) *The central level still maintain the power in contracting strategic health workers.* Under PTT scheme, recruitment and deployment of medical staffs and midwives are controlled by the MoH, the districts have responsibility to propose the required number of personnel. The districts still have authority to contract health workers using local budget, however many districts lack for fiscal capacity.
- d) *The break-down of information system including the health workforce information.* The districts do not feel obliged to send the health workforce data to the upper level. Health workforce planning thus is not supported by adequate and accurate data.
- e) *Rotation of health workers among the different administration regions.* Although the central level controls the system, mobility of health personnel among different regions is more restricted during the decentralization. The process of staff transfer from one region to other region requires approval from both side local governments before agreement from the central level involving complicated bureaucracy on administration and financing.
- f) *Problems on Excess vs shortage of health workers.* Restriction on mobility of civil servants and the abolition of Wajib Kerja Sarjana (a compulsory service for university fresh graduates) have caused difficulty in distribution of health personnel from health facilities with excess number of health workers to the health facilities with shortage number of health workers. Shortage of health workers is usually simply answered through proposing recruitment of new civil servants to the central level, although the vacancy quota is very much limited. On the contrary, districts or health facilities with excess number of health workers must struggle to find innovations to increase utilization of their staffs.
- g) *The growing number of health workforce education institution (pre service training).* To improve recruitment and retention, many local governments open new health workforce education institutions. Two new medical schools will be opened in two provinces in the eastern Indonesia. The private sector also plays significant role, as 84% of the midwifery schools and 52% of nursing schools managed by the private. However distribution also remains the issue, as more than 50% of the schools concentrated in Java. Another issue is quality, as

most of the schools also use resources (lecturers, clinical instructors and practical field) from public institution.⁸

3.2 Health Workforce Distribution

As stated in the WHO report year 2006, Indonesia was among 57 countries that critically suffer shortage of health workers (doctors, nurses and midwives), with health workforce ratio per 1000 population was below 2,5.⁶ A study conducted by the Ministry of Health in year 2006 found that more than 50% community health centers in underserved areas without medical doctors while in non remote areas the vacant post is only about 10%. The pattern is also similar to other type of health personnel.⁷ According to the estimation made by the MOH year 2008, the shortage number of medical doctors in community health centers is about 15% of the total need, while the hospitals (class B, C, D) suffer shortage of medical doctors approximately 18% of the total need. This problem is further exacerbated by imbalance distribution among regions.⁴

The most recent review conducted by the World Bank on health workforce found that in Java-Bali, the most populous region in Indonesia, in urban areas there is a doctor for every 3000 people, while in rural areas there is only 1 doctor for every 22,0000 people. Outside Java-Bali there are more doctors per population, but still only 1 doctor for every 12,000 people in rural areas, 1 for every 15,000 people in remote while there is 1 doctor for every 2,430 people in urban areas.⁸ Midwives are more equally distributed. It may be due to the nation wide Desa Siaga (Alert Village) program. This program requires at least one health worker to be deployed in a village, so that more contract midwives are recruited and assigned to work in village health post (Poskesdes) or village maternity ward (Polindes).

3.3 Health personnel recruitment and selection policies

The role of planning health workforce has also been transferred to the local level. The province and district levels are encouraged to plan the required number of health personnel according to the local need. The MoH provides guidelines and assistantship on the planning process and methods. This planning policy is acknowledged by the local level as an opportunity to obtain health personnel in accordance to the local specific and need. However, in fact only few districts follow on the guidelines. The time consuming process in planning and the least authority possessed by the District Health Office have demotivated the district managers to conduct health workforce planning. The local civil servant agency (BKD) has more power over other institutions to allocate the vacancy quota of PNS given by the central level and to conduct recruitment and selection. As a result, the

type and number of health personnel often mismatch with the real requirement proposed by the health facilities.

Recruitment and selection is a chain of process in searching for personnel to enter a particular job or position to increase the number of personnel or to substitute the loss of personnel (as part of the zero growth formation policy). The following methods are for recruitment and selection of health personnel:

a) Permanent Civil Servant (PNS)

There are various actors in recruitment and selection of PNS. The vacancy quota for PNS, or known as "formasi PNS" is determined by State Ministry for State Apparatus (MENPAN) in relation to the availability of the state budget allocated by the Ministry of Finance (MoF). The overall process of recruitment and selection is conducted at each central units (for central PNS) and at each local government levels coordinated by BKD. The result of selection will be then finalized for administration purpose by the National Civil Servant Agency (BKN).

b) Local contract.

The local governments (province and district level) could use their own resources to contract more local personnel. Nevertheless, since year 2005 the central government had prohibited local governments to contract new personnel. All contract personnel who were recruited before year 2005 and met the criteria are gradually employed as PNS.

c) Central Contract (PTT/Pegawai tidak Tetap).

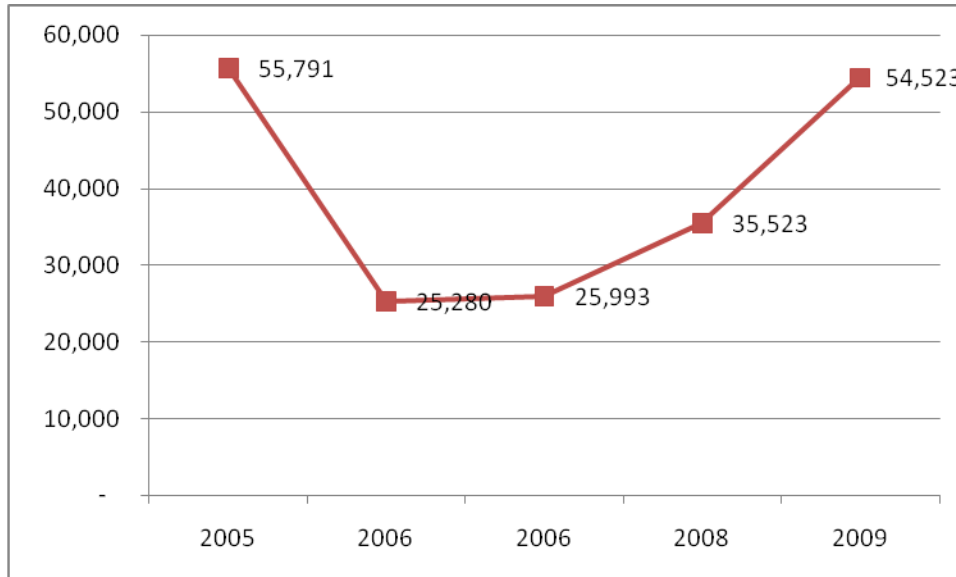
Exception was given to contract medical staffs and midwives under PTT scheme. Recruitment and selection is conducted centrally by the MOH. The vacancy quota is also determined by The MoH based on the proposal from province health offices.

d) Special assignment

Recently MOH introduced another contract mechanism to obtain other category of strategic health personnel who can not be recruited under PTT scheme, such as senior residents (medical doctors who are in the final stage of specialist training), nurses, sanitarians, nutritionist and other urgently required health professionals. The duration of the contract ranges from 3 to 6 months. Priority placement was located in very remote, borderline areas and the outer small islands that are considered as severe underserved areas. This is particularly to help districts with less financial capacity or do not produce certain type of health professional, to fill in the vacant post of health personnel in the underserved areas.

The number of formasi PNS for health personnel fluctuated from year 2005 to year 2009, as shown in the chart 1 below:

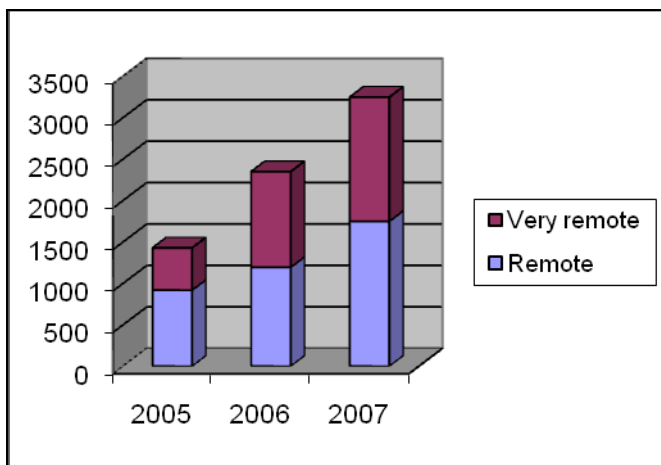
Chart 1: Trend of the number of Formasi PNS Year 2005-2009⁹



The high number of formasi PNS in year 2005 and year 2009 is due to provision of additional allocation for converting the employment status of contract personnel to PNS.

The number of medical doctors recruited under PTT scheme is increasing for the last 3 years (2005-2007), as shown the chart 2 below:

Chart 2: Trend of the number of PTT doctors in remote and very remote areas year 2005 – 2007.⁴



In year 2008, 11,432 new midwives were recruited as PTT and posted in villages. Yet, approximately more than 5000 midwives are still required. Under special assignment scheme, this year, 119 health personnel consisting of mixed nurses, sanitarians and nutritionist have been recruited and placed by MoH to 34 very remote health centers in 12 provinces. However, 5 of them have resigned before completing the assignment. Also in this year, MoH have recruited 54 senior residents for 13 district hospitals, fulfilling only 18% of the required number by 50 districts. Recruitment of senior residents were conducted through collaboration with the medical schools. However, it is not a compulsory for senior residents to join this program.

3.4 Deployment and Retention Policies

Some factors influence the willingness of health workforce to work in underserved areas, such as:

- Compulsory service for certain period as a prerequisite to obtain practice license
- Financial incentives and other support facilities (housing, transportation, electricity, water, telecommunications, other social facilities).
- Opportunity to have private practice or to work in other private health facilities while maintaining their job as civil servants in public facilities (dual practice).
- Safety and security guarantee (law protection)
- Opportunity for career development.
- For PTT and other contract workers, opportunity to be recruited as civil servants.

The compulsory service policy was ended by the implementation of the Law number 13/2003 on manpower. This policy was considered against the rights of health workers. The absence of this policy affected the most at rural and remote areas. As stated by Thabrany¹⁰, in the past, when compulsory service by new medical graduates, dentists, pharmacists and other health professionals was enforced by the central government, there was no problem in equitable deployment of health personnel to the poor and remote districts.

To improve distribution particularly in rural remote regions, the central government has encouraged the local governments to prioritize the deployment policy for remote and very remote areas and to provide additional financial and non financial incentives for health workers. Variation in provision of incentives among districts depends on several factors such as fiscal capacity, attention to health sector and the availability of local

resources. The big variation in fiscal capacity of local governments to finance health services and to hire health professionals had created competition among districts. For example, the amount of financial incentive for medical specialist ranges from Rp. 3,5 million to Rp. 12 million (approximately USD 385 to USD 1319) per month. Additionally, some local governments provide meal allowance, housing and vehicles or means of transportation. Health professional may choose working in health facilities in the districts which can provide adequate and standardized medical equipment, higher salary and incentives, wider career opportunity, better social facilities and so on. Finally rural and less fortunate districts were left underserved.

To attract willingness of health workers to be deployed in remote and very remote areas, since 2006 the MoH RI have implemented new policies for PTT:

- a. Offer vacancies only for remote and very remote posts.
- b. Shortening period of service

Previously, the length of service for PTT was ranging from 3 years in non remote areas to 2 years in remote and very remote areas. The length of service was then shortened, 1 year for remote areas and 6 months for very remote areas.

- c. Higher financial incentive for service in very remote areas (7,5% income tax included):
 - Medical Specialist : Rp 7. 500.000,00/month (USD 824)
 - Doctor/dentist : Rp 5. 000.000,00/month (USD 549)
 - Midwife : Rp 2. 500.000,00/month (USD 275)

In relation to implementation of those policies, individual performance of medical doctors was not evaluated and the payment of incentives was not linked to performance.

Those policies caused a creation of other location categories i.e. favorable and less favorable areas. The favorable areas were marked by the higher number of applicants, the waiting list of PTT, prolongation of the working contract, and the low turn over of staff in one place. Although most of favorable areas were in urban location, there were also some remote areas that included in this category. It seemed that those areas were economically attractive to PTT, such as having logging or oil plantation companies, that provided more opportunities to generate income from dual practice i.e. as the public employee and as private practitioner.

In response to this issue, MoH developed criteria for remote and very remote areas to guide the local government in determining the location

criteria of health facilities. For PTT, MoH also further altered the policy on the service period in very remote areas. In some very remote but favorable areas, the length of service increased to one year compare to 6 month in other less favorable areas. So far, MoH determined all districts in 4 provinces at eastern Indonesia as less favorable areas together with other 18 remote districts in 8 provinces.

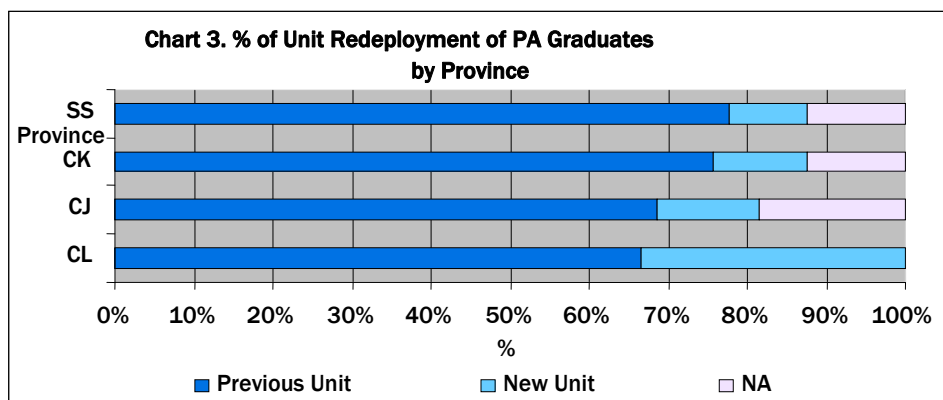
For retention, the MoH applied several policies:

1. Scholarship to upgrade education level (trainings in medical specialists, community health midwives, and nurse specialist/medical specialist assistants).
2. Influence the district governments to use the Special Allocation Funds (Dana Alokasi Khusus/DAK) from the central level to improve health facilities (including equipment and vehicles) and housing for health personnel in remote areas.
3. Career opportunities

After completion of the PTT service, they had basically 3 choices: (i) continue with their education to become a specialist; (ii) become a PNS by taking the PNS examination¹; or (iii) or go into the private sector. General Practitioners in very remote areas supposedly had a 90 % chance of getting into the PNS after completion of their service; General Practitioners in remote areas had a 50 % chance while those serving in ordinary areas had only 10%.⁸

In year 2008, the MoH gave scholarships for 134 nurses, 80 midwives and 700 medical doctors. Scholarships were made available for health workers who are willing to return to their rural post for maximum 2n (n=length of study) years or those who are willing to be posted to the rural and remote areas. Preference for selection of applicants is given to health personnel with PNS or post PTT status, having minimum 2 years working experience and working at health facilities outside Java-Bali. Administrative selection was conducted at two stages, at the provincial level and then at the central level. Candidates who passed the administrative selection might undertake academic selection in education institutions.

In addition, some local governments now offer scholarship for the local people to attend medical trainings and midwifery schools (Diploma 3 level or 3 years schooling after high school). This policy has been seen as more effective to retain health workers. A tracer study on fellowship participants conducting by Fifth Health Project, MoH in year 2004, found that 99,4% of 1578 alumni in MoH, Central Java, Central Kalimantan and South Sulawesi returned to their original provinces after completion of their studies. About 74% returned to their original working place (Chart3). The minimum length of this service was twice of the length of study or minimum of 3 years.¹¹



According to various studies and report on monitoring retention of health personnel, becoming a civil servant was one of the main reasons for many contract health workers to stay working.^{12, 13} MENPAN stated that the number of contract personnel awaiting to be transferred to PNS was 78.576 persons, mostly contracted at the local level.⁹ Employment as PNS was still attractive to many. This year, 26.490 applicants compete to win 1.745 post as health personnel at various health services managed by MoH. During our monitoring visit last month in two districts, most of contract health workers (nurses and sanitarians) expressed their career expectation to be employed as PNS. There was no good documentation on **how many PTT doctors were converted to PNS status during that period and whether in fact this attracted graduates.**⁸

3.5 RECOMMENDATIONS

Comprehensive changes in development of human resources for health are hindered by the unavailability of clear regulation and the amount of control transferred from the central level. Moreover, the local level has limited capacity and dependent to the support from the central level. This constraint, however, should not prevent any efforts to improve equal distribution of health workers between favorable and non favorable underserved areas. The followings are some recommendations:

1. Partnership with the private sector. The growing number of private health care facilities and the health professional education institution should benefit to expanding access community to health service. Contracting out the service to the private sector must be developed and regulated.
2. Improving the health information system including the health workforce information system. A good planning on human resources

for health will reduce the inefficient and ineffective use of limited fund in health services.

3. Provision of technical guidance on management, deployment and utilization of health personnel for each administration level. It refers to guidelines on defining roles between the central, provincial and the district level in health sector.
4. Development of a policy scheme on deployment strategic health workforce for various areas with different financial abilities. This policy should include retention strategies of intervention. This development is currently in ongoing process at the MoH. This policy is developed in response to the new health act which also mentions about health workforce.
5. Development of privileging policy for nurses and midwives working in less favorable and remote/very remote areas to ensure the availability of competent health workers.
6. The incentive system should be clearly linked to performance, not merely based on the remoteness of the location. Implementation of the system must be followed by effective monitoring and evaluation.
7. Coordination with other stakeholder (other departments/ministries) to improve infrastructure and social facilities in underserved areas.

4. A lesson learnt from Belu District, East Nusa Tenggara Province

Based on MoH study¹⁵, Belu district is one of the less favorable and underserved areas in Indonesia. It is located on East Nusa Tenggara province sharing borderline with Timor Leste. In the period of year 2005-2007, to improve access of the community to health services, the number of health centers had been increased from 16 to 19 and the number of hospitals increased from 3 to 5. The increased number of these facilities had been followed by recruitment of new nurses and midwives as PNS. However, it was very difficult for the district to retain or to recruit new medical doctors. During the same period, the number of medical doctors in health centres continuously decreased from 23 (2005) to 20 (2006) and then to 17 (2007).

To improve retention of medical doctors, from year 2008 the local government introduced the following policies:

1. Financial incentives. Apart of their regular salaries, medical doctors received a monthly allowance as follow:
 - a. Very remote area : Rp 2.500.000,-
 - b. Remote area : Rp 1.500.000,-
 - c. Ordinary area : Rp 500.000,-

Medical specialists received incentive at amount of Rp. 7.500.000,- /month.

2. Housing and transportation facilities
3. Telecommunication facilities such as radiomedic, handy talky and mobile phone.
4. Employee award priority.

Belu district also introduced an innovative approach to conduct outreach services in remote and country borderline areas, maximizing the utilization of the existing health personnel. The services were focused at 78 locations spreading in 9 community health centre. An outreach service was conducted by a team of 5 health personnels consisting of a medical doctor, a nurse, a midwife, a health promotion staff and a driver. This program was to provide immunization, iodine salt, soaps and drugs for the community.

Other retention policies for health workers included fellowship program for paramedics (from high school level) to attend undergraduate training, scholarships for bright students to undertake health training, and to provide in-service training for health staffs.

5. Proposal for regional or global actions

- a) Improve collaboration on health human resources research policy, education and training and build a strong networking for the development of health human resources plan based on evidence. This is necessary to support the efforts of advocacy or coordination between relevant department conducted with local government and for the provision of health human resources as needed.
- b) Develop a country specific health workforce policy framework and planning method.
- c) Coordination with all relevant professional organizations to approve on the authority that can be given to health personnel who served in less favorable areas.
- d) Conduct a study to explore any possibility of enhancing the performance of the health workers in that area through task shifting with additional training appropriate to the needs and characteristics of the local area.
- e) Develop guidelines for effective and supportive supervision to underserved areas with limited support resources.
- f) Develop a fair incentive system.

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