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Indonesia Health Sector Review

Accelerating Improvement in Maternal Health: Why reform is needed

Introduction[1]

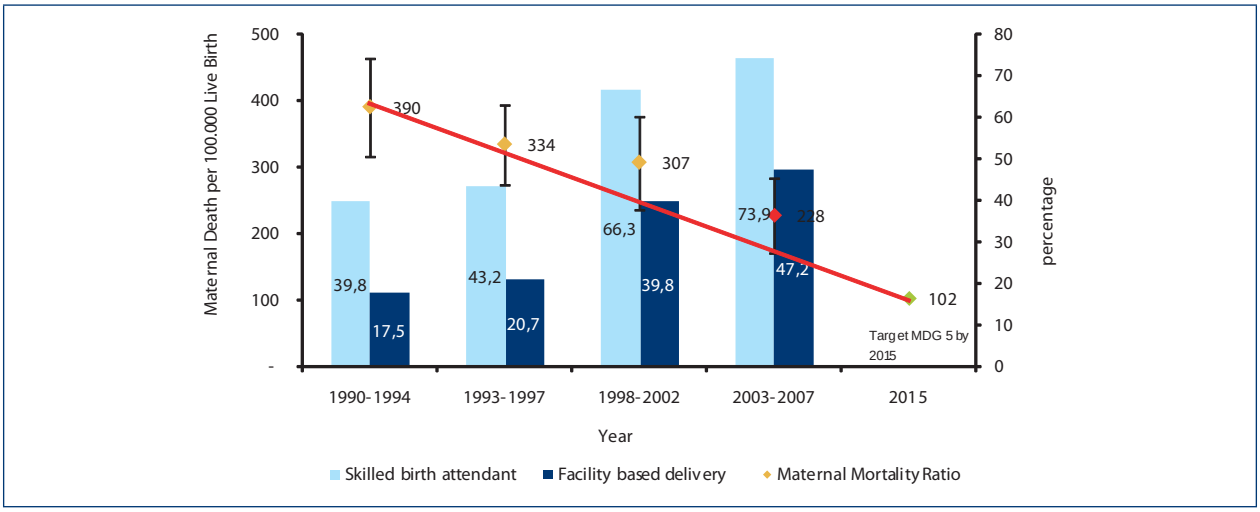
At least 10,000 women continue to die of childbirth-related causes every year in Indonesia. Even with the most recent estimate of 229 maternal deaths per 100,000 live births (Lancet 2010[2]), Indonesia's MMR remains among the highest in East Asia. At the same time, past efforts are not to be minimized (Figure 1): in the five years prior to the 2007 IDHS survey, more than 73 percent of births were attended by a professional health provider (doctor, nurse, or midwife) and facility-based deliveries increased to 47 percent, with over 90 percent of the recent increase due to the use of private sector facilities. Cesarean section rates, an important measure of comprehensiveness of care, increased from 0.8 percent in 1986-89 to 6.8 percent in 2003-07, again mostly provided in private sector facilities.

Main Challenges

Inequities between rich and poor women and those living in rural and urban areas generally decreased with the increased use of professional health providers[3] for deliveries. Yet the richest are still seven times more likely to access a facility than their poorest counterparts. Hence, a large number of poor women continue to give birth at home without professional help. A review of a sample of maternal death audits from West Java (n=210) in 2009 reveals a large share of women who died due to childbirth-related causes relied only on traditional birth attendants to deliver, were referred too late and even when referred did not get appropriate treatment (Figure 2, World Bank 2010[4]).

In addition, although prenatal and postnatal care increased to high levels, use of family planning services has stagnated. There are persistent high rates of unintended pregnancies among both married and unmarried women. Recent reviews of the national family planning program highlight the need to address contraceptive practices among high-risk groups, especially the growing group of unmarried women

Figure 1: Trends in MMR, Skilled Birth Attendance and Facility-based Delivery in Indonesia (1990-2007)



Source : IDHS 1994-2007 The latest Lancet series shows MMR Indonesia 229

Figure 2: Snapshot of Verbal Autopsies

No	Name	Age	Preg. History	ANC	Time of death	Cause of death	Provider				Procedure	Baby status	Note
							First	Second	Third	Fourth			
1	Ne	29	G2P1A0	6	30 minute post partum	Other causes	Private hospital				Vacuum Extraction	Stillbirth	
2	Tt	28	G4P3A0	3	1 day post partum	Eclampsia	Midwife	District hospital			SC	Well	
3	En	23	G3P2A0	2	8 hour post partum	Post partum bleeding	TBA	Midwife	District hospital			Well	
4	Asr	36	G3P2A0	3	2 hour post partum	Undiagnosed	TBA					Well (twin)	
5	Fat	25	G3P2A0	3	4 hour post partum	Post partum bleeding	TBA	Midwife	*Puskesmas*			Well	Midwife not available, died on the way to district hospital
6	Ph	20	G1P0A0	1	40 week pregnancy	Eclampsia	*Puskesmas*	Private hospital	Maternity hospital			IUFD	
7	Rd	21	G1P0A0	3	9 day post partum	Other causes	Midwife					Well	Midwife recommended referral, patient did not go
8	Ih	30	G3P2A0	6	4 hour post partum	Post partum bleeding	TBA	Midwife	District hospital			Well	Ob-gyn cannot be contacted at district hospital
9	IS	27	G2P1A0	5	12 hour post partum	Post partum bleeding	Private hospital				SC	Well	
10	Ul	16	G1P0A0	2	6 week pregnancy	Dehydration	District hospital					IUFD	
11	Mam	22	G1P0A0	3	6 day post partum	Eclampsia (post SC)	District hospital				SC	Well (twins)	
12	A	42	G7P6A0	6	3 hour post partum	Eclampsia, bleeding	TBA	Midwife	Private hospital		Vac Extr	Well	
13	Nan	42	?	?	2 hour post partum	Post partum bleeding						Stillbirth	No assistance during delivery
14	Suh	27	G1P0A0	3	33 hour post partum	Pre-eclampsia	Midwife	Private hospital	District hospital	Private hosp	SC	Stillbirth	Rejected at first - 2 hospitals because first hospital was full
15	Id 2	35	G3P2A0	3	3 hour post partum	Post partum bleeding	TBA	Midwife	*Puskesmas*			Well	
16	ES	20	G1P0A0	9	28 day post partum	Other causes	Midwife					Well	Died in hospital

Source: World Bank (2010).

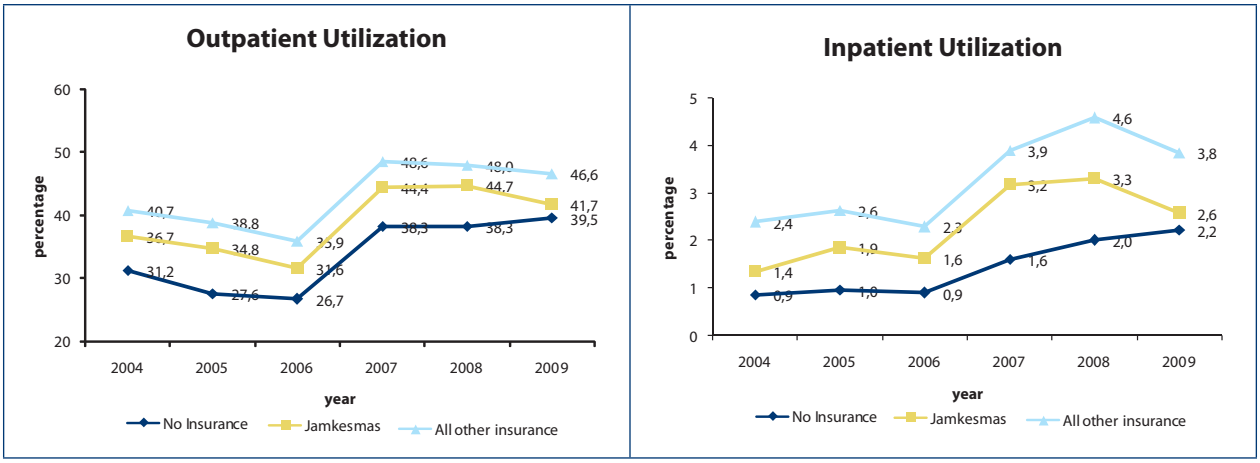
who are sexually active and whose needs are ignored by family planning programs. Unintended pregnancies among the 24 million women in this group are more likely to result in unsafe abortion and lead to more maternal deaths. Although little information is available about the incidence of abortion, estimates range between 700,000 and 3 million abortions each year, many of them performed in unsafe conditions with increased risks (Hull et al 2009)[5]. Family planning service delivery has shifted to the private sector over the last decade, with the subsequent risk that the poor may face financial barriers in accessing these services. Privatization without regulation has also meant a shift towards more temporary and profitable contraceptive methods, as seen with the shift towards short-term injectables as the primary contraceptive nationally.

The high cost of, and uncertainty about, medical expenses continue to discourage women from seeking care when needed. In order to provide better financial protection against catastrophic health expenditures and to increase access to care, the GoI in 2005 introduced the Health Insurance for the Poor Program *Askeskin*–now called *Jamkesmas*. *Jamkesmas* covers 76.4 million people with the aim of ensuring that poor women have access to all aspects of maternal care in the public sector. It is already influencing levels of demand for, and incentives to provide, maternal health services by both public and private providers. Despite the increased coverage of *Jamkesmas*, financial barriers to seeking timely care remain: women do not know about their eligibility for *Jamkesmas* coverage; they do not understand the benefits and remain unsure about the possible future costs of delivery at a facility. They often refuse referral of obstetric complication to a facility due to transport costs which are not included in the benefit package (Figure 3).

In the case of referral for women with obstetric complication, the quality of the emergency obstetric care is poor and still often results in unnecessary deaths. Village midwives do not always stabilize the cases before referral; health centers that provide Basic Emergency Obstetric and Newborn Care (BEONC) are often bypassed because of the perceived lack of ability to handle complications, while not all districts have a functioning hospital with Comprehensive Emergency Obstetric and Newborn Care (CEONC). Despite attention in past years and policies to promote facilities that are able to treat obstetric emergencies, few areas have reached UN standards and few facilities fulfill the required CEONC criteria, leaving women at risk of inadequate treatment once they are referred to a facility. Quality concerns apply to both public and private facilities.

Although Indonesia has given serious attention to increasing the number of midwives in all areas of Indonesia–especially in rural areas–there are inadequate numbers of specialists. There are particular shortages of obstetricians, with only 2,100 ob-gyns for 230 million people in Indonesia and the

Figure 3: Trend of Outpatient and Inpatient Utilization in the Last Four Weeks by Type of Insurance Among Women 10-49 years of age



Source : Susenas 2004-2009

distribution is highly inequitable (Figure 4). While government efforts have largely achieved the one midwife per village target, financial incentives have changed over time; many midwives have moved from rural to urban areas and prefer to provide private care, leaving the poor with less coverage. Hence, midwifery coverage is also highly variable. In addition, the quality of the services midwives provide could be improved; one study found that poor quality of care was a contributing factor in 60 percent of the 130 maternal deaths examined (Supratrikto 2002)[6]. A recent comprehensive review of Indonesia's health workforce draws attention to the fact that the quality of health workers, general practitioners, midwives and nurses, has improved only marginally over the past decade and that the regulatory framework governing the basic training of these providers is, at best, patchy (World Bank 2009, Rokx et al 2010)[7, 8].

Figure 4: Ratio of Ob-Gyns to 100,000 Population by Province

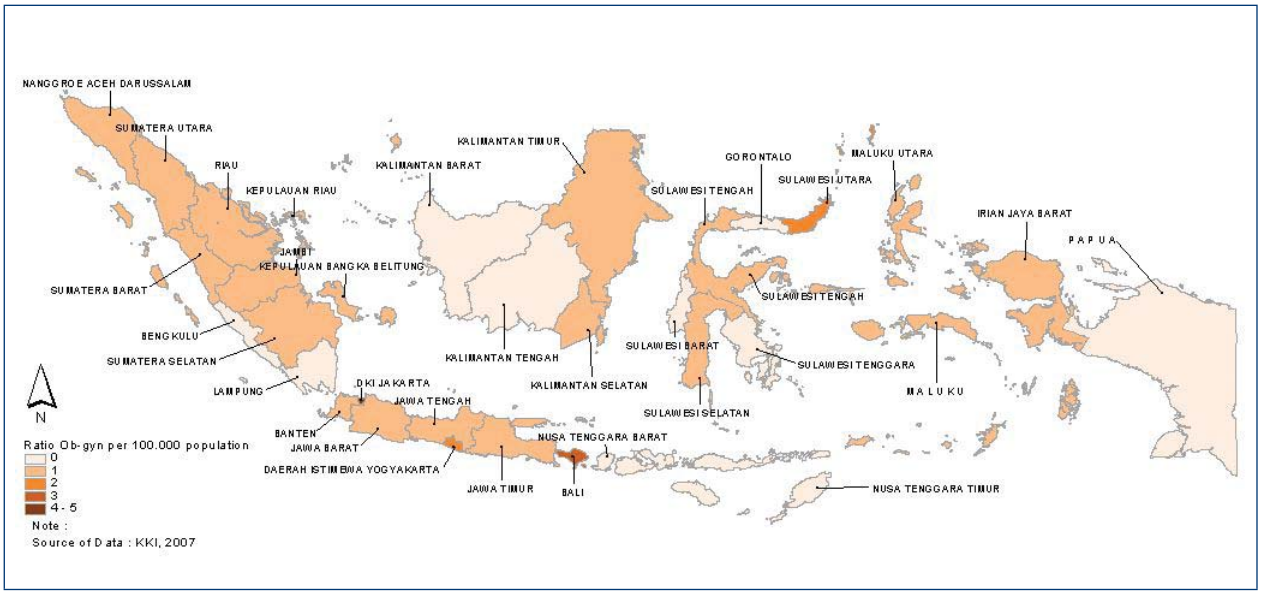
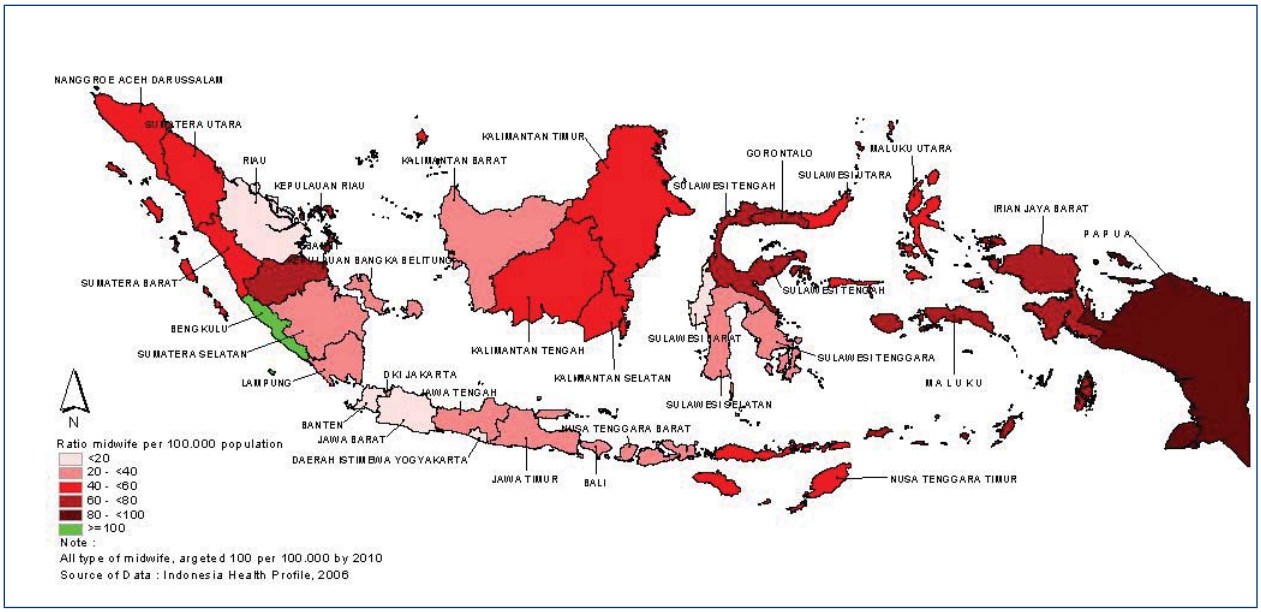


Figure 5: Ratio of Midwives to 100,000 Population by Province



In part, the lack of care at facilities can be explained by continuing low levels of health spending. Indonesia spends barely 2 percent of its GDP on health, of which half is public spending. This is one of the lowest health spending levels in East Asia and globally–despite a doubling of public spending since 2005 (Bappenas 2009)[9]. In addition, at the local government level, budgets are available only very late in the fiscal year resulting in already inadequate levels of resources not being spent at all.

The "Big Bang" decentralization of public sector management responsibilities to the district level, initiated in 2001, has created serious challenges to the capacity of central agencies, including the Ministry of Health (MoH) and the family planning coordination agency (BKKBN), to oversee and guide service delivery. Minimum service standards (MSS) for basic maternal health and for family planning services at district level have been established with the MoH and the Ministry of Home Affairs (MoHA) and a guidebook for managers lays out their responsibilities. However, the MSS remain ill-defined, complex to measure and few districts actually apply them[10]. The sense is that quality of family planning services and health care in general have deteriorated, and access remains a major issue with decentralization.

The Way Forward

Despite Indonesia's strong government and civic commitment and decades of investment in relevant interventions, maternal mortality in Indonesia remains stubbornly high at 229 maternal deaths per 100,000 live births. Even at its recent accelerated pace of 5 percent decline annually; Indonesia will need considerable extra efforts to meet the fifth Millennium Development Goal of 102 maternal deaths per 100,000 live births by 2015. As Indonesia works to accelerate the pace of change, major challenges as discussed above will need to be addressed. This policy note uses the findings of the Maternal Health Policy Assessment, the Review of Maternal Death Audits and results from a Stakeholder Consultation on Maternal Health held on December 17, 2009 in Jakarta to propose options for strengthening various areas of the Indonesian health system that will lead to better health outcomes.

Improving access to quality maternal care, increasing public spending for maternal care, removing financial barriers, creating better awareness, improving the skills of midwives, increasing the numbers of Ob-Gyns and ensuring quality emergency obstetric care as well as appropriate family planning for all are now the key priorities to accelerate the improvement in maternal health in Indonesia. In order to achieve these priorities, underlying health system issues such as increased health financing needs, lack of health insurance coverage and traditional provider payment methods which do not motivate quality care, as well as health workforce quality issues and a weak regulatory framework and inadequate information systems, need to be urgently addressed.

Improving Access to, and Demand for, Quality Maternal Health Services

Increased Health Spending

- *Increase overall funding for maternal health and ensure **timely** and **sufficient** availability of resources at the local government level for locality-specific maternal health interventions*. Overall levels of health spending are low and there are serious delays in resource availability at the local level, with funds sometimes available only in the last

three months of the fiscal year. The lengthy delays in funding availability appear specific to the health sector and a detailed tracking exercise of funding flows is recommended to shed more light on bottlenecks and ways to improve disbursements. A recent assessment of the fiscal space for health in Indonesia[11] concludes that there are various options that could be considered to raise resources for health, ranging from increased allocations to earmarking taxes and improved efficiency of current expenditures. In addition to more funding, there needs to be a greater devolution of decision-making powers to the district level to allow districts to allocate and use resources more efficiently and according to local needs.

Increased Health Insurance Coverage and Utilization for facility-based delivery

- *Increase the geographic coverage, enhance the benefits package, and improve community understanding of health insurance eligibility criteria and the benefit package to promote the utilization of facility-based deliveries and pre- and post-natal care with skilled health workers*. Despite an estimated coverage of 76.4 million poor and near-poor people under *Jamkesmas*, actual utilization of services included in the benefit package, such as facility-based delivery, remains low. In part, this can be explained by a lack of awareness of the benefits of *Jamkesmas* among those who are eligible and need such care. However, there are also important issues to consider on the supply side. Providers are still not widely available, especially those able to manage obstetric emergencies. For example, health centers (*Puskesmas)* may be too far away and lack a doctor when needed for obstetric emergencies. The private health sector provides almost one-half of all ambulatory care, and most women who use a facility for delivery go to the private sector. Private provision is not always taken into account when planning service delivery, however, and quality assurance is far from adequate. Furthermore, existing reimbursement policies do not always induce behavior towards equitable treatment. First, midwives do not, or at least are uncertain about, being reimbursed for services when the woman delivers in a facility after referral, which may negatively influence decisions for referral. Second, re-imbursement tariffs differ by insurance program and are considered too low to cover the costs of delivery, especially when there are complications.

- *Concrete actions are urgently needed to address these issues and improve access through reducing financial barriers.* Necessary actions include: (i) information campaigns to better inform the eligible population about the program; (ii) development and piloting of provider payment schemes aimed at reducing the equity gap but with fairness to providers to motivate them to assure quality health care for all; and (iii) appropriate payment schemes for midwives regarding re-imbursement for provision of long-term contraceptives. In order to facilitate these actions accelerate work on defining and costing benefit packages, including adequate maternal health services coverage (consider including transport costs) to increase coverage within the available resources envelope.

Improved Health Workforce Numbers and Quality

- *Increase the supply of Ob-Gyns and anesthesiologists in Indonesia, especially in underserved areas and improve the quality of midwifery services.* There are too few Ob-Gyns and anesthesiologists in Indonesia and producing more will take considerable time and effort. In the interim, it is recommended to consider exploring temporary licensing of, for example, other nationalities to practice in Indonesia at the same time as accelerating the training of Ob-Gyns and anesthesiologists. There is a need to not only improve the quality of the midwives currently practicing, but also to improve the quality of the educational institutions providing the training and those now in training. Over the past decade Indonesia has seen an explosion in the number of new private midwifery schools, which have not undergone an adequate accreditation process before producing graduates of widely varying quality. Improving the training institutions, the accreditation system for schools, and the certification and licensing for graduates and new professionals is vital to improving the quality of maternal health services. Other important health

system actions that would contribute to improving these services are the strengthening of the role (and skills) of the Midwife-Coordinator as well as ensuring an adequate supervision budget at district level to cover operational costs. The professional associations–IBI (midwives) and POGI (ob-gyns)–have important roles to play in these efforts and should be included in planning and developing new policies.

- *The review of the maternal death audits exercise highlighted issues and suggestions for improvements.* For example, the use of the maternal health audit results, which are very important for policy development and decision making, are seldom used for feedback and policy changes. Within the audit reporting, which should be done for every single death, attention should be given to understanding what went wrong without fault finding.

Strengthened Referral System

- *Revisit the current referral policies and create more CEONCS.* Many referred women do not receive needed care. Many hospitals do not have the required specialists nor equipment to provide what is needed when obstetric emergency cases arise. More women do use facilities for delivery and, since the introduction of *Askes/Jamkesmas* in 2005, utilization levels appear to have increased. There is an urgent need to increase the number of CEONCS in order to respond appropriately; given the number of private hospitals that can provide adequate care, they should also be included. This, in combination with creating a fairer re-imbursement policy, could contribute to better overall access.

- *The referral policy should be adapted to local circumstances.* For example, direct referrals to a CEONC should be allowed if the CEONC can be reached in a maximum of two hours from the location of the maternal emergency, instead of having to pass through a BEONC and lose valuable time. This would require revisiting the standard of providing one CEONC and four BEONC facilities for every 500,000 population and encouraging districts to adjust standards according to the local situation–including geographical realities.

- *Link the referral changes to payment schemes and ensure re-imbursements from health insurance schemes are limited to certified staff only.*

- *Explore social and cultural changes to reduce the demand for traditional birth attendants, starting with information campaigns to raise citizen awareness about, and utilization of, the referral system.*

Revitalized Family Planning and Unmet Needs Addressed

- *Unmet family planning needs among unmarried single women in particular is quickly becoming one of the very large challenges Indonesia faces.* Decisions to address this issue are politically and socially sensitive, but in urgent need of resolution. Indonesia's successful family planning program is centered on the family but does not adequately address the needs of unmarried women. Until these sensitive decisions are taken, it is difficult to propose more concrete actions other than ensuring payment incentives for midwives are better aligned with women's choice and ensuring quality oversight over private sector provision of family planning services.

Effective Health Information System

- *Improving the health information system is needed to provide current data, to ensure it is used to influence policy and program changes in a timely fashion and that it supports accountability in the overall health system*. Since decentralization, Indonesia's health information system has suffered from fragmentation, lack of updated reporting and an explosion in the number of districts from 250 in 1998 to almost 500 in 2009. In recent decades, Indonesia has developed an impressive array of surveys[12] which have all contributed to global knowledge of health system quality and performance, but have been less successful in developing workable, credible systems for routine reporting on public sector performance. Most reforms were designed to extract and pass up data from the local level rather than support improvements in decision making and accountability to the public at the local district level. Developing effective governance practices in

the sector therefore requires a sharpened effort to design information systems that enable greater use of reliable data and focus on population outcomes and resource use at the district and provincial levels. A major element of these efforts should include improving reporting and discussion among hospital and health center managers at the district level of population health outcomes including, in particular, maternal morbidity and mortality, and service use.

- *The cohort system registering all pregnant women could be strengthened by making better use of the information and involving the midwives in policy decision making.* There is an urgent need to assess the capacity and use of local hospitals (both public and private) in emergency obstetric care to form a better understanding of where changes are needed to improve the referral system, hasten the payment schemes and strengthen human resources.

In conclusion, considerable extra effort is needed for Indonesia to achieve the Maternal Mortality MDG in 2015. Strengthening all parts of the health system is one of those extra efforts needed. This note lays out a number of areas that were identified in the maternal health assessment, where these efforts could be directed.

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12 Regular Demographic and Health Surveys, the national statistics office conducts regular household surveys SUSENAS, the Governance and Decentralization Surveys and the panel survey of Indonesia Family Life Surveys.

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