

Health System Strengthening: Adopting WHO Building Blocks- Comparison between India and Indonesia

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ABSTRACT

Background: The objective of this review was to review and compare between Indian and Indonesian health systems. It attempted to understand the health system strengthening activities adopted by both the countries.

Subjects and Method: This was a systematic review using qualitative method. The internet-based search strategy extended the traditional approach of using bibliographic databases, journals, citations to include grey literature, abstracts, websites, reports and documents from WHO, World Bank, Ministry of Health Indonesia, and Ministry of Health and Family Welfare India.

Results: The concept of designating household meeting requisite health standards as a healthy home is something which can be successfully implemented in India as social recognition plays a vital part in encouraging people to move towards healthier lifestyles. India is in the process of upgrading 150,000 Sub Centres into health and wellness centers. Comprehensive health care will be provided in these centers, including for mother and child health and noninfectious diseases. Essential drugs and diagnostic services will be provided free of cost at these centers. Another notable feature from India is the concept of ASHA which is an acronym and stands for Accredited Social Health Activist. ASHAs are locally selected and trained women who performed the duties of health promoters and educators in communities. The ASHA is trained to work as an intermediary between the public health system and the community. Medical Insurance coverage for Primary Care and the concept of VVIP Rooms at differential pricing is something which can be tried in Indian context while, the latest Government funded medical insurance for Secondary and Tertiary care and Strategic purchase from Private sector is something Indonesia can emulate. For tackling the rural health care problems : schemes like National Rural Health Mission (NRHM) and mandatory service in rural areas by doctors if they want government job can be looked at by Indonesian Health care professionals. The concept of Posyandu (Maternity Hut) and the registered midwife clinics is a unique concept which can be tried in Indian Context.

Conclusion: The Indian and Indonesian health care systems have been compared and contrasted.

Keywords: health care system, India, Indonesia

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BACKGROUND

India and Indonesia are two of the most important emerging economies of Asia. As with most developing countries, both the countries are going through various transitions which include amongst others the 'dual burden' of disease wherein communicable diseases remain a major part of disease burden whilst the non-

communicable diseases are on the rise. The health care delivery system of both the countries face almost similar challenges as the level of economic development is almost the same and regional disparities are equally varied in both countries.

Health system strengthening is a way to achieve the stated goal of both the countries to provide Universal Health

Coverage (UHC) to all its citizens. The WHO formulated framework of building blocks is a very good tool to measure and

compare the health system performance of any country.

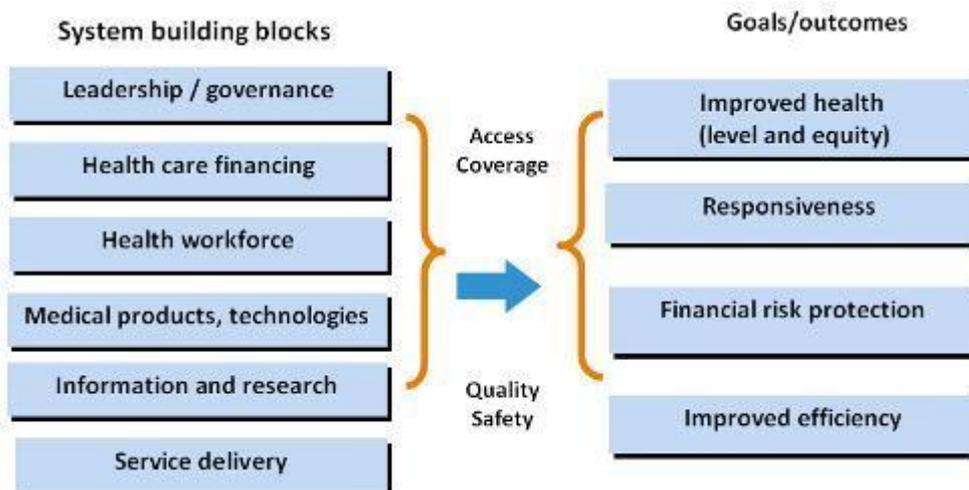


Figure 1. WHO health system building blocks and goals

A comparison of the health system strengthening of both the countries using the WHO framework of building blocks presents interesting finds and best practice which can be learnt and applied for the common good of citizens of both the countries.

The objective of this review is to:

- a) provide a brief overview of the health system based on the building blocks
- b) highlight few major initiatives carried out
- c) identify similarities, differences, and gaps between both the health systems.

SUBJECTS AND METHOD

This study is a review and comparison between Indian and Indonesian Health Systems. It attempted to understand the health system strengthening activities adopted by both the countries. This is a systematic review. The internet-based search strategy extended the traditional approach of using bibliographic databases, journals, citations to include grey literature, abstracts, websites, reports and documents

from WHO, World Bank, Ministry of Health Indonesia and Ministry of Health and Family Welfare India.

RESULTS

Health service delivery

Health care delivery mechanisms are almost similar in both the countries and organized pretty well, however regional disparities and a big rural urban divide exists in both the systems. In both the countries the delivery mechanism is divided into two major components - public and private. Infrastructure has been provided in rural and urban areas in the form of primary health care services. Primary health care services include maternal and child health care services and family welfare services. Specialized health care services are provided in both countries through hospitals in urban areas. The health indicators of both the countries are pretty similar, though Indonesia has been slightly ahead. The heartening thing to note here is that both the countries are making rapid progress in the field of universal health care and the mortality and morbidity

data is rapidly declining and both seem well

poised to meet the SDG targets.

Table 1. Comparison of the Distribution of Hospital and Primary Health Services between India and Indonesia

Indicator	India	Indonesia
Number and distribution of health facilities/ 100 000 population	<ul style="list-style-type: none"> • 19,817 hospitals having 6,28,708 beds. • Also there are 1,51,685 Sub centers, 24,448 Primary Health centers and 5,187 Community Health Centers. 	<ul style="list-style-type: none"> • 3.89/100,000 population • 725 RSU (General Hospitals) and Specialized Hospitals (RSK) • 503 RSK with
In patients bed per 10,000 population	<ul style="list-style-type: none"> • 9 beds per 10,000 population 	<ul style="list-style-type: none"> • 725 RSU with 245,340 beds • 503 RSK with 33,110 beds
Number and distribution.		<ul style="list-style-type: none"> • Total percentage of admitted patients per 10,000 population - 1.9%. • Average bed occupancy rate (BOR) - 65%. • 12.1 beds per 10,000 population.

Source: Directorate General of Health Services, Ministry of Health RI (2016)

Health Workforce

The scarcity of health workforce remains an omnipresent challenge in both countries. The addition of Health professionals each year is unable to keep up with the demands of rapidly increasing population. In addition the scarcity of Doctors especially in the rural areas is quite acute. Scarcity of doctors especially in Indonesia is well below the global and ASEAN average and is coming under increasing pressure by the burden of the increasing number of JKN patients. ASEAN Economic Community is likely to help mitigate the shortage of doctors in Indonesia as it will improve mobility of doctors from other ASEAN countries. Both the governments must rise up to this challenge and seriously address the rural sector. Profit maximization by the Private Sector also contributes to the woes of the poor people in both countries and hence strict regulations must be brought.

Health Information

Indonesia has operationalized a national information system (SIKNAS) that links to district-level health information systems

(SIKDA). The system though has been weakened due to decentralization and consequent gaps at various stages. Vital registration is incomplete, and hence there is a requirement of supplementing the same by carrying out national sample surveys at regular intervals. The SIKNAS intends to integrate the provincial health information systems and the district/ municipality health information system (Sistem Informasi Kesehatan Daerah/ SIKDA). However, due to decentralization, each hospital, district/municipality and province tends to build their own SIKDA which results in generating multiple datasets even within the same district/ municipality.

In India, Health Management Information System (HMIS) is at the heart of the monitoring and evaluation (M&E) effort and is focused on improving the collection and use of data related to various health programs. Health information system in India is structured vertically from ANM at village level to National level. Flow of information is as follows: At village level ANMs are given tablets to capture the

information and it automatically gets collected at health supervisor level. After which all the information is collected at district level where information from PHC, CHC and district hospital data also joins. It

then combines at district head quarter and then to state head quarter and finally making a huge database at centre level. India's "Digital India" campaign is helping India to achieve NHIS aims and objective.

Table 2. Comparison doctor and nurse per population ratios between India and Indonesia

Indicator	India	Indonesia
Doctors per 100,000	79.9 per 100,000 population. 40,000 allopathic doctors/ year from 335 medical colleges.	22 per 100000 population
Nurses per 100,000	216	120

Source: WHO country statistics 2015.

Essential Medicines

In India, number of essential drugs includes 652 commonly-used drugs under 27 therapeutic areas. There is a web based supply chain management system (e-Aushadhi). Decentralized procurement and decentralized distribution of medicines is being done to achieve low procurement

rates and establish a robust supply-chain management system. Online tendering and monitoring is linked to supply chain management. Healthcare Any Time Medicine (ATM) has been piloted in a few states to provide Tele-consultation supported with mobile phone and the generic drug vending machine.

Table 3. Essential medicine distribution between India and Indonesia

Indicator	India	Indonesia
Selected essential medicines in private and public health facilities	● Public 22.1 %	● Public 66.5 %
Median consumer price ratio of 14 selected medicines	● Private 76.8%	● Private: 57.8%

Sources: WHO (2016), Mendis et al. (2007)

In Indonesia, number of essential drugs for primary care is 484. Indonesia spends around US\$12 per capita per year on medicines alone. The Obat Generik Berlogo (OGB) initiative in its early days was designed to build doctor and patient confidence in cheap, unbranded generics and quality-assured generics. In puskesmas, the availability of vital drugs for communicable diseases and MCH (maternal and child health) at either minimal or free of cost is quite good, however district government performance variations affects access to crucial medicines for the poor and the needy. Indonesia must focus on improving performance of districts where

availability of essential medicines is poor and create stronger incentives for the district governments. There is also a need to strengthen competition in public procurement and reduce hidden costs of excessive inventory and stock-outs

Health Financing

Massive financing in India is being done in the recently launched National Health Protection Scheme under which a health coverage of up to 8000\$ per family is being offered for secondary and tertiary care hospitalization. This is now the world's largest government funded health care program.

The Indonesian budget on health is also very low, though as a percentage it is higher than India. Indonesian sources of

health financing are government allocation, private sector, direct out of pocket payment and aid from other countries.

Table 4. Comparison of health expenditure indices between India and Indonesia

Indicator	India	Indonesia
Total expenditure on health (as % of GDP)	3.89%	3.35%
Expenditure of government on health as a portion of general expenditure by government.	5.7%	5.5%
OOP % (out of pocket) expenditure, as % of the expenditure on health (2014).	47%	62.4%

Source: World Bank (2018)

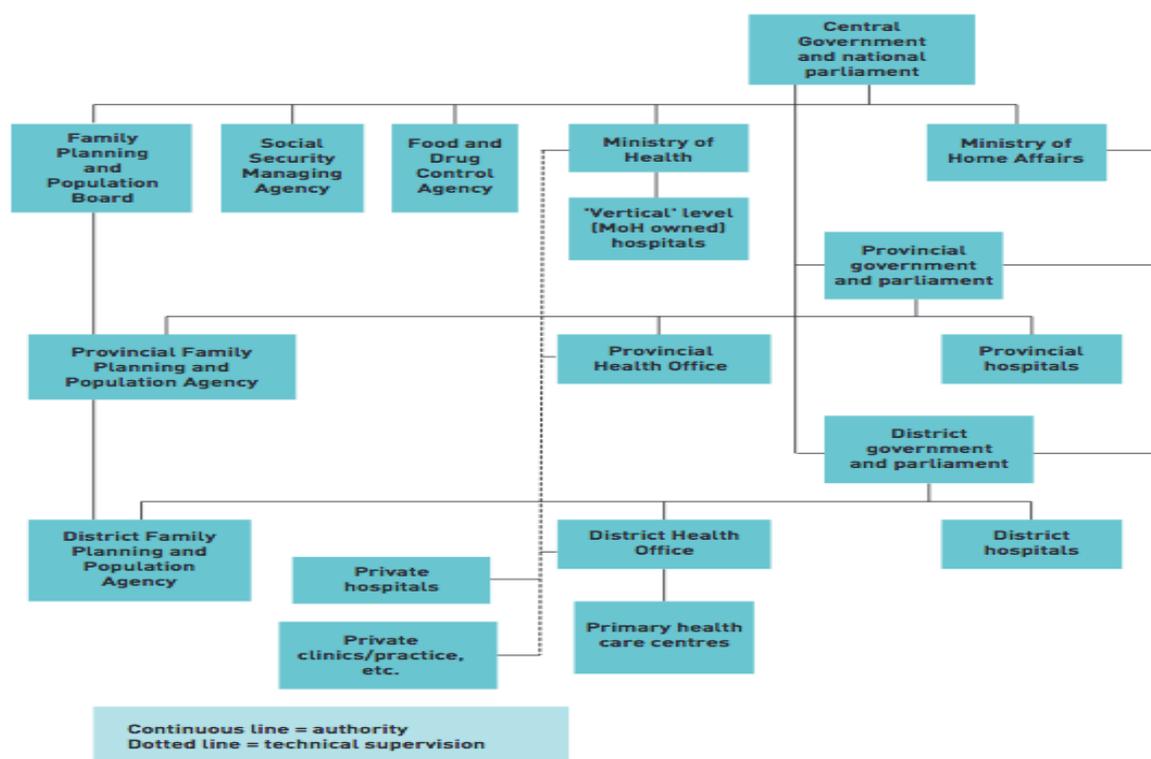


Figure 2. Organization of Health System in Indonesia, 2014

Source: Government organization, decentralization and health system (Government of Indonesia, 2007; House of Representatives, 2004g; House of Representatives, 2008; House of Representatives, 2014b; President of Indonesia, 2011a; President of Indonesia, 2011b).

Leadership and Governance

Recently, National Health Policy 2017 was released in India. This caters for revamping PHCs to Health and Wellness Centers, making integrated efforts for taking care of NCDs with health facilities and digitization of Family Health Records, besides many other laudable initiatives. Health in All

Policies is being done in India. Great stress is being laid on Water and Sanitation (Swachh Bharat Abhiyan), Nutrition, prevention of deaths due to rail and road traffic accidents, action against gender violence, improving workplace safety and minimizing outdoor and indoor air pollution.

In Indonesia, JKN (Jaminan Kesehatan Nasional) coordinates policies and strategies to achieve national health system goals and ensures equitable distribution of the burden of funding the system. Under JKN, Indonesian citizens can access a variety of health services provided by both public and private facilities that have joined

as providers in the scheme. JKN is a comprehensive scheme which covers a wide range of treatment ranging from flu through to chemotherapy, dialysis and open-heart surgery. Services not included in JKN are provided by private insurance companies who play a role by charging for excess or additional coverage.

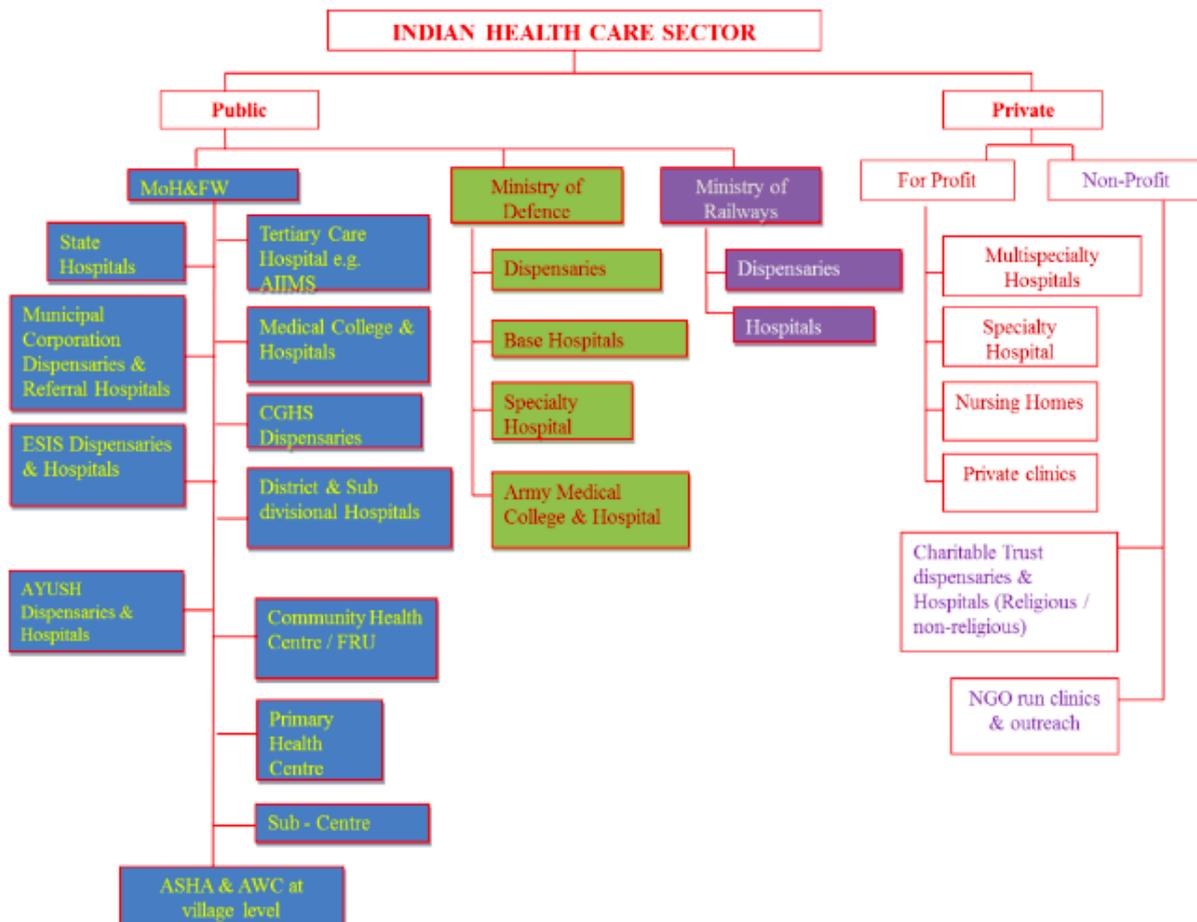


Figure 3. Indian health care system

There are lots of positive take a ways which both the countries can take from each other. The concept of designating household meeting requisite health standards as a healthy home is something which can be successfully implemented in India as social recognition plays a vital part in encouraging people to move towards healthier lifestyles. India is in the process of upgrading 150,000 Sub Centres into health

and wellness centers. Comprehensive health care will be provided in these centers, including for mother and child health and noninfectious diseases. Essential drugs and diagnostic services will be provided free of cost at these centers. Another notable feature from India is the concept of ASHA which is an acronym and stands for Accredited Social Health Activist. ASHAs are locally selected and trained women who

performed the duties of health promoters and educators in communities. The ASHA is trained to work as an intermediary between the public health system and the community.

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