INDONESIA: ESTABLISHING AN HRH COORDINATION PROCESS AND STRUCTURES

Key facts

- Population: 227,345,000
- Infant mortality rate: 31/1000 live birth
- Maternal mortality rate: 240/100,000 live birth
- Physicians in country: 1.3/1000
- Nurses and midwives in country: 8.2/ per 10,000 population
- Health care workforce (physicians, nurses and midwives): 9.3/10,000 population

The national health system in Indonesia is marked with the decrease of infant and maternal mortality rates and the increase of life expectancy. However, the achievement of the community health status is still below target and need continuous improvement. In the Strategic Plan of the Ministry of Health (MoH) 2010-2014, human resources for health (HRH) development is one of the top eight priorities in health development, including HRH planning and management, trainings, registration and certification, and technical support for an HRH development program.

Challenges

Coordination was identified as a key constraint to achieving progress in HRH, and collaboration is needed among critical stakeholders such as central-local government, related ministries, government and civil society organizations including health professional organization, universities and others. The President of Indonesia instructed that beginning in 2010, a stronger emphasis be placed on improving HRH information through HRH mapping and increasing the number of health workers in underserved areas. The formulation of national policies and plans in pursuit of HRH development objectives requires sound information and evidence. Coordination among key stakeholders was also cited as essential for provision of health services, capacity building in information systems, health financing and management of HRH.

The main challenges related to HRH policy prior to CCF included:

- Large gaps remained to fulfilling HRH requirements to support health development nationwide.
- HRH planning was not supported by an accurate and timely HRH information system.
- Adequate career development, training, supervision and compensation systems for health personnel had not been implemented.
- Resources were limited resources for HRH development and empowerment.
- After government decentralization, most local health authorities felt no obligation to report or provide data to the national level.
• Coordination was needed between central and local authorities to maintain a strong commitment among key stakeholders and to build capacity of health personnel.
• New health professions emerged and the MoH needed to establish updated regulations and guidelines for HRH types, responsibilities, rights, institutions and trainings.
• Globalization impacted HRH management in Indonesia, as demand increased for HRH from neighbouring countries, especially for nurses.

Key success factors related to HRH production that should be employed in the future are:

• Strong leadership from government bodies, including MoH and MoNE will play critical role to face future dynamics. Resources, administrative and political ownership within their hands are adequate to bring civil societies including universities, professional organization and others to develop fundamentals for a competitive and high quality HRH production.
• Empowered civil society including association of similar schools can be an excellent supervisory body to maintain high quality schools. Some of the associations such as medical schools association, have shown practices to regulate the quality of education, including careful selection for opening new schools/study programs.
• Role of central government is very critical as it was shown in recruitment policy shifting from civil servant recruitment to contractual mode brought chronic ineffective and inefficient problems. No adequate support and capacity development from the central at local governments is major cause.
• Role of local government is important in providing adequate facilities for productive working. Fiscal capacity limitation at several local governments is a major cause and need strong support from the central government.

HRH Coordination structures
Indonesia launched the country coordination and facilitation process, establishing three structures and a Secretariat to implement the collaboration efforts.

The Oversee Body is tasked to coordinate & facilitate:

• Resource mobilisation and consolidation to HRH production, management & utilization, and HRH control & supervision to the benefit of health system achievement
• HRH priorities as components of health system
• HRH database and plan initiatives
• Establishment of sectoral commitment to implement the plan
• Inter-sectoral link for M&E
• Training plan endorsement to related stakeholders
• Establishment of knowledge brokering

CCF Executive Board is responsible to assure the execution of:

• Resource mobilisation and consolidation to HRH production, management & utilization, and HRH control & supervision to the benefit of health system achievement
• HRH priorities as components of health system
• HRH database and plan initiatives
• Establishment of sectoral commitment to implement the plan
• Inter-sectoral link for M&E
• Training plan endorsement to related stakeholders
• Establishment of knowledge brokering including documenting best practices
HRH Production Working Group is responsible for:

- Resource mobilisation and consolidation to HRH production to the benefit of health system achievement
- HRH production priorities as components of health system
- HRH database and plan initiatives within the area of HRH production
- Establishment of sectoral commitment to implement the HRH production plan
- Inter-sectoral link for M&E in the area HRH
- Training plan endorsement to related stakeholders
- Establishment of knowledge brokering including documenting best practices

The CCF Secretariate has responsibility to:

- Plan and organize activities for CCF as a whole, either for Oversee Body, Executive Board, and Working Groups
- Plan and organize supported activities (coordination with and supported by line Ministries), such as situation analysis, policy analysis/evaluation, supervision visits, benchmarking, inviting resource persons from abroad and local, etc to the benefit of CCF as a whole.
- Publish reports, periodicals etc (coordination with and supported by line Ministries) to the benefit of CCF positions and understanding of HRH importancy.

Next steps and strategies for CCF in Indonesia:

- Development of action plans for each structures, including CCF oversee-body, CCF executive board, and the working groups (by the end 2010)
- Development of HRH national plan, including HRH Director General's action plan (by the end 2010)
- Political advocacies to critical stakeholders including: Vice President-Legislative Body-Coordinator Minister for Welfare-MoH and other line ministries related to HRH development-Donor agencies-NGO and Health Professional Organizations
- Formalize the structure of CCF
- Develop an HRH plan which includes:
  - Production projections and scenarios
  - Costing and budgeting
  - Health professional competencies development and its regulation
  - Distribution of HRH strategically
  - Health professional credentials
  - Build managerial capacity of critical stakeholders
  - Socialization of the established HRH plan to province levels

Lessons learned

In the CCF process in Indonesia include: high level political process is needed, that HRH involves everyone, including civil society; decentralization must be a factor; and international support and political direction are key for effectiveness.