Managing the medical workforce

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About this policy brief
This Policy Brief presents findings from research funded by the Australia Indonesia Governance Research Partnership (AIGRP).

AIGRP is a facility for sponsoring and promoting collaborative research between Australian and Indonesian researchers, focussing analytical expertise on policy-relevant issues in Indonesia, and strengthening the intellectual foundations of public and scholarly debate.

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1. Introduction

Medical workforce governance reform in Indonesia is vital and timely for several reasons. In June 2007, in a Constitutional Court of Indonesia hearing, the Indonesian Medical Doctors Association admitted the absence of ‘standards for the medical doctor profession’. Getting the fundamentals of health systems right (not least human resource issues) so they can function more effectively is a key priority for the Australian aid program as outlined in the 2006 White Paper. The National Health System, Sistem Kesehatan Nasional (SKN), establishes the right to health as realisation of the reference to general welfare contained in the preamble of the 1945 Constitution.

Improving outcomes in the Indonesian health sector will require addressing two major challenges related to personnel: quality and distribution. The quality of service provided by healthcare professionals depends greatly on the quality of the institutions that train and certify them. Accreditation requirements for educational institutions and professional certification, and position requirements within the dynamic context of health care system decentralisation, are the responsibility of the Ministry of Health. The problem of distribution is one of matching supply (medical practitioners) and demand (people’s needs and expectations), to remedy the unevenness that presently disadvantages rural and remote regions in particular (Joint Learning Initiative, 2004; Ilyas, 2006).

This project was undertaken as part of the work of the International Consortium for Research on Governance of the Health Workforce (ICR-GHW), a collaboration of governments, regulators, professional associations and researchers established with the assistance of the World Health Organisation, it was funded by the Australia Indonesia Governance Research Partnership. This work has implications for a range of governmental, professional, private and community organisations, especially the Indonesian Ministry of Health, the Indonesian Medical Council, the Indonesian Medical Association, and consumer organisations.

The project aimed to contribute to the development of a robust policy framework for medical workforce governance featuring:

(i) professional and ethical standards to govern the admission of medical practitioners into the profession

(ii) regulatory systems to ensure and improve the performance of doctors and to protect the safety of patients

(iii) the funding arrangements and human resource policies necessary to ensure an equitable distribution of doctors that fulfils all citizens’ right to healthcare.
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The table below lists the functions of the relevant laws and regulations governing the health sector in Indonesia.

**Table 1: The regulatory context, Acts and Regulations**

<table>
<thead>
<tr>
<th>No</th>
<th>Year</th>
<th>Name</th>
<th>Main Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1945</td>
<td>National Constitution</td>
<td>Guarantees ‘the right to health’ as a realisation of the general welfare</td>
</tr>
<tr>
<td>2</td>
<td>1974</td>
<td>Presidential Instruction (Inpres)</td>
<td>Mandates that all new medical graduates serve in under-served rural districts for 1–3 years.</td>
</tr>
<tr>
<td>3</td>
<td>1991</td>
<td>Presidential Regulation No. 37</td>
<td>Regulates the recruitment of doctors as temporary employees.</td>
</tr>
<tr>
<td>4</td>
<td>1992</td>
<td>Health Act No. 23</td>
<td>Regulates health personnel education and training as conducted by government and private sector institutions.</td>
</tr>
<tr>
<td>5</td>
<td>1996</td>
<td>Government Rule No. 32</td>
<td>Regulates types of health personnel.</td>
</tr>
<tr>
<td>6</td>
<td>1997</td>
<td>Ministry of Health Regulation No. 916</td>
<td>Regulates licensing of Medical Practitioners.</td>
</tr>
<tr>
<td>7</td>
<td>2002</td>
<td>Ministry of Health Regulation No. 1540</td>
<td>Regulates the placement of doctors during service period.</td>
</tr>
<tr>
<td>8</td>
<td>2004</td>
<td>Ministry of Health Regulation No. 1199</td>
<td>Guidance for recruitment of health personnel who will be posted in the government health facility.</td>
</tr>
<tr>
<td>9</td>
<td>2004</td>
<td>Medical Practitioner Act No. 29</td>
<td>Regulates that every doctor and dentist has to ensure quality services and cost containment.</td>
</tr>
<tr>
<td>10</td>
<td>2004</td>
<td>Local Government Authority Act No. 32</td>
<td>With decentralisation each local government has authority to recruit their own medical personnel as local government employees.</td>
</tr>
<tr>
<td>11</td>
<td>2005</td>
<td>Ministry of Health Regulation No. 1419</td>
<td>Regulates the conduct of medical and dental practice.</td>
</tr>
</tbody>
</table>

**2. Key findings**

The majority of informants agreed that existing acts and regulations for the governance of the medical profession in Indonesia were sufficient. However, implementation was not consistent, with significant arbitrariness in the application of regulations by governments at all levels. The biggest constraint in devising and implementing measures to address the weaknesses discussed below is that the Government of Indonesia, in the last three decades, has allocated less than two per cent of its national budget for health care. This funding shortfall reflects the low status and importance with which the government views the role played by the medical profession in national development.

The issues that emerged most frequently during discussions with health sector stakeholders included:
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Distribution

- The need for a new policy on the distribution of doctors that is both clearer and able to be more consistently applied. This is seen as essential to address the maldistribution of doctors between rural and urban areas.
- Related to this was the lack of a clear planning process to determine the number of medical doctors needed by every district each year. In addition, there is inadequate recruitment of doctors as government employees due to financial constraints.
- A lack of effective leadership in medical institutions was leading to poor governance of currently available medical resources.

Quality

- There is no national standard for medical education, which leads to highly variable quality among medical graduates. Often there is no synchronisation between medicine degree courses and the competencies required to be a doctor. There are now 67 medical schools in Indonesia, but they vary greatly in the quality of their medical training. There was a perceived need for greater cooperation between stakeholders to improve the quality of medical education.
- The Medical Council, Medical Schools Association, Ministry of Education and Ministry of Health need to take action to determine the national competency standards required by medical graduates, and to monitor and control the process of medical education properly.
- There is no comprehensive career planning system for doctors. It was felt that a new regulation was needed, to cater for three career options: civil employment, military and police employment, and private sector employment. The private sector (hospitals and medical schools) needed to take more responsibility in workforce planning for medical professionals.

3. Improving the distribution of medical care

Former policy

From 1974, Indonesia began distributing doctors to all sub-districts with the aim of ensuring all people have access to medical care. The program was popularly known as Inpres (Instruction of the President) and mandated that all new graduates of medical schools be deployed to serve sub-districts with a population of 10-30 thousand, for between one and three years. Initially the program applied only for general practitioners but it was later expanded to include specialists, in particular, internists, paediatricians, surgeons and obstetricians/gynaecologists, who were deployed to district-level hospitals. The program achieved a wider distribution of doctors and significantly reduced infant mortality.

However, after the Indonesia crisis of 1997 this policy of mandatory service was challenged as violating the rights of doctors to choose their jobs. Most doctors who finished their period of mandatory service sought to become civil servants to ensure lifetime job security. Eventually, the mandatory service program was replaced by a voluntary contract arrangement in which doctors volunteered to be deployed to remote areas with salary supplements used as inducements to entice doctors to remote areas: the more remote the deployment, the higher the wages.
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Thirty years after Inpres the demand for medical care, and the ability of some sections of the community to pay for it, has increased, especially in urban areas. The lure of better financial opportunities, combined with the discontinuation of the mandatory Inpres system, has created a concentration of medical doctors in large cities, where competition among doctors has been becoming ever-more intense. The high cost of medical education coupled with the nature of the 'asymmetry of information' of medical services — especially expensive procedures, has created many moral hazards. Increasing demand for medical care and ability of some patients to pay has influenced the behaviour of doctors and hospitals, which is increasingly oriented towards maximising profit.

Whether as a corollary or not, the incidence of malpractice also escalated in the late 1990s. In the mean time, disciplinary actions imposed by the Indonesian Medical Association (IMA) are not effective due to lack of legal action, financial punishment or penalty. Concern about increasing malpractices pushed the IMA to lobby Parliament members to pass the Medical Practice Law in the late 1990s. Currently, efforts are being made to improve quality and reduce medical errors by promoting a policy of 'put patients first'. But, the current trend that sees medical practitioners running multiple practices is likely to undermine efforts to achieve high quality public medical services.

Complaints about insufficient remuneration for doctors employed by the government are universal. The low government salary drives many doctors working in health centres, medical schools, public hospitals and other health offices to seek supplementary income through private practices in several offices/private hospitals (now limited by law to a maximum of three locations). Dividing their time between so many different places means that doctors necessarily neglect some patients. Ideally, a doctor should work fulltime in the one venue to maximise their availability for patients. Naturally, such private practices are concentrated in urban areas where they are most profitable, a situation that contributes to the unequal distribution of doctors between urban and rural/remote areas. The mushrooming of private hospitals in Indonesia and an insufficient pool of specialists are other barriers to ensuring an adequate patient-centred public healthcare system.

Current policy initiatives to address distribution

Recognising that provinces with fewer resources are unable to attract doctors, the Ministry of Health is developing initiatives to provide placement-related fellowships for young doctors to pursue specialist training. Under this program, a doctor can apply for a fellowship (covering educational costs and living allowances during 4-5 years of specialist training), conditional on the doctor signing a contract that commits him or her to a given number of years service in a smaller district after graduation. The more remote and less developed the district, the shorter the period of mandatory service. Past evidence from the placement of general practitioners shows that doctors are more likely to consider remote postings when an adequate incentive system is in place, indicating that financial incentives can be an effective mechanism for achieving a more even distribution of health workers.

Inequity in the distribution of doctors, due to the imbalance of economic incentives and public facilities, is leading to the development of local initiatives by Provincial and District Health Offices. The concept of 'Family Physician', a rational approach to structuring provision of health services (meaning specialists will only be used when necessary), is being introduced through a pilot project in East Kalimantan and West Sumatra under the Health Work Force Project. In addition, several other initiatives have been implemented in Bali and South Sulawesi. Such local initiatives designed to anticipate difficulties in managing the supply and distribution of doctors are a significant contribution to the development of effective health sector governance.
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4. Improving the quality of medical care

Medical Practice Law and the Indonesian Medical Council

In 2004, the Medical Practitioner Act was passed (Law No. 29/2004) and the Indonesian Medical Council was established (subsequently called the Council) as the policy making and quality control body governing medical and dental professionals. The Council has two chambers: medical and dental. The Council registers and stipulates competency levels for doctors and dentists. Although the Council is very new, road maps for governing medical and dental professionals, equivalent with what exists in more industrialised countries, have been developed. Procedures for screening the quality of inputs, process of education, accreditation, licensing and continuing medical education (CME), have been laid out. The ‘Swiss Cheese’ model, of continuous screening to ensure consistent quality assurance at various levels of training and licensing has been adopted by the Council. The challenge is enforcing legal sanctions for those who violate standard procedures.

Globalisation and the opening up of trade in services in ASEAN

Globalisation, in general, and the ASEAN Framework Agreement on Services (AFAS) under which Indonesia must open its door for foreign doctors by 2010, both pose huge challenges. Current flows of medical tourists, including Indonesians travelling overseas for medical treatment, have some negative implications for the public health sector in Indonesia. According to the Indonesian Medical Association of North Sumatra, North Sumatran people spend more than one trillion Rupiah each year on health care in Malaysia. Many high income earners in Indonesia trust doctors in Malaysia and Singapore more than they do Indonesian doctors, and are willing to pay higher fees for doctors overseas.

The salaries of Indonesian doctors employed in the public sector are much lower than those in Malaysia and Singapore. As a result, most doctors in Indonesia have to supplement their government incomes by working from private clinics or hospitals. As a result, they have little time to improve their knowledge and skills, which further undermines attempts to raise the quality of medical services and encourages those who are able to continue to seek health care overseas.

Continuing medical education (CME)

Indonesian authorities must pay more attention to the task of ensuring adequate CME for all practising doctors. Although the current licensing mechanism requires a degree and the accumulation of credits for CME, accreditation mechanisms for ensuring that specific medical competencies are acquired and updated by doctors have not been implemented. Without rigorous quality improvement, medical doctors in Indonesia will not be able to compete with incoming foreign doctors and will also be prone to malpractice suits. Data indicate that the incidence and prevalence of malpractice suits in Indonesia are increasing. Law enforcement of the implementation of the Medical Practice Act must be ensured. Indonesia has been known for its high level of corruption and legal violations due to poor law enforcement, despite the regulations that have been produced.

Training of educators

One of the important elements in enforcing high standards is the adequacy of medical equipment and the professional competence of academics in medical schools. The recent mushrooming of new medical schools, public and private, has raised concerns by experts that the quality of medical education is being sacrificed. Almost all informants
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acknowledge that the quality of medical graduates in Indonesia varies widely due to weak accreditation, lack of modern equipment in teaching hospitals, variability in the quality of teaching staff and sometimes high ratios of students to lecturers/professors. Many medical schools lack appropriate and up-to-date medical equipment for teaching.

Accreditation of training institutions and hospitals

Another challenge that the medical profession is facing in Indonesia is the lack of strict accreditation processes for institutions. Although a system of CME credits exists, structural accreditation and medical audits in hospitals have not been implemented. This lack of effective quality assurance in overall medical practice, especially in hospitals, might be one factor in the increased prevalence of malpractice cases. It is acknowledged that the Indonesian health care system is facing the difficult task of balancing strict quality control with inadequate financing.

5. Recommendations

Recommendation 1: Develop comprehensive and integrated medical governance

(i) That the Ministry of Health establish a Medical Governance Task Force (MGTF) at the national level to develop a comprehensive and solid medical governance scheme in Indonesia.

(ii) This Task Force should be initiated and chaired by the Minister of Health as ex-officio and involve all key stakeholders in medical care such as Indonesian Medical Association, Indonesian Public Health Association, Medical Council, Medical School Association, Legislative, Consumer Foundation, Hospital Association, Health Insurance Association etc.

(iii) Appointment of the members of this Task Force should be based on their knowledge and expertise in medical and health care and should be appointed by a Letter of Decree of the President.

(iv) The MGTF be designed to work closely with the newly established Indonesian Medical Council, with a focus on medical professional governance rather than policy-making which is the jurisdiction of the Medical Council.

Recommendation 2: Develop a National Plan of Action

(i) The main task of the Medical Governance Task Force would be to develop a National Action Plan for the Medical Care System, covering medical practitioners, and addressing health care financing considerations.

(ii) This National Action Plan should clearly stipulate the role and functions of the government, private sector and medical practitioners. This system should cover public and private sectors.

(iii) This Action Plan should be developed with reference to all existing medical and health laws and regulations.

(iv) If necessary, new laws and regulations should be developed during the course of the system development.

Recommendation 3: Define and clearly delineate the role and responsibilities of each institution

(i) The Plan should clearly define and delineate the roles and responsibilities of the relevant institutions in medical governance (including training, qualifying, certifying, licensing, monitoring & sanctioning) in order to define where the authority of one
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Institution or organisation starts and ends, as well as in cases of overlapping authority. These institutions include the Ministry of Health, Local Health Offices, Medical Council, Indonesian Medical Associations, and Medical Collegiums on Specialty etc. at the national and local level.

(ii) Special attention should be given to the District level due to the decentralisation policy for practical reasons.

(iii) The system should be based on experiences and lessons learned in medical governance from other countries, especially in Southeast Asia, as well as the experience of regions within Indonesia.¹

Recommendation 4: Conduct special seminars, workshops and applied studies

(i) Seminars and workshops should be conducted by the Task Force during the development of the Plan of Action to obtain input from experts and practitioners from relevant institutions. International experts should also be invited to contribute.

(ii) Small applied or operations research could be conducted where necessary, to support the development of the Plan.

Recommendation 5: Implementation of the Plan

(i) Implementation of the Plan of Action should be executed with flexibility, in stages and with careful monitoring and evaluation of the progress.

(ii) Implementation should start in regions that are more ready to implement the Plan, and then replicated in other regions.
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References


Notes

1 Some districts have developed ‘Medical Care Systems’, including some aspects of medical governance, in their respective districts by their own initiative.