

Universal Health Coverage 2019 in Indonesia: The Integration of Family Planning Services in Current Functioning Health System

Irma Ardiana^{1*}, Mario Ekoriano¹ and Siti Fathonah¹

Abstract

Indonesia is currently on track to achieve Universal Health Coverage (UHC) by 2019. The country's health insurance program aims to address issues of disintegration in the implementation and coverage of various health insurance schemes that used fragmented fund pooling for financing them. Under the UHC, family planning services is one of the benefit packages. However, little has been done to examine how family planning programs are appropriately managed across levels of governments and how family planning services are delivered to the end user. This study has been conducted through focus group discussions with related policy makers and selected programmers at the central and district levels. The study also benefits from related studies on family planning in the UHC scheme and other supporting data. The study carefully investigates some programmatic implications of the integration of family planning into the UHC program. An improvement in the regulatory frameworks and management considering the construction of the relationship between the central and district governments and across related institutions is noteworthy. Periodic studies highlighting the progress of program implementation is recommended. This would create opportunities for quick notification and problem-solving discussions in the case of improper planning and implementation.

Keywords

Beneficiary; family planning services; National population and family planning board; universal health coverage

Background

Moving closer towards UHC is relevant to all countries as reflected in the 2012 United Nation General Assembly (UNGA) resolution 2. All countries without exception are to make favorable progress on UHC, expanding the population covered along with the services available and the extent of financial protection provided. The construction of a strong health financing system stands on the basis of three common pillars (WHO, 2019). The first pillar suggests the health financing policy objective as an instrument to evaluate attainment and performance in the health financing system and the effect of health reform. The second pillar embraces a wide-range of effective and efficient mechanisms of funds sourcing. Countries might have different agreements and experiences on how to successfully manage resource allocation to fully meet the highest standard of health services. The third pillar puts its emphasis on fiscal constraints and other contextual factors. The fiscal context refers to a

¹ National Population and Family Planning Board, Jakarta, Indonesia

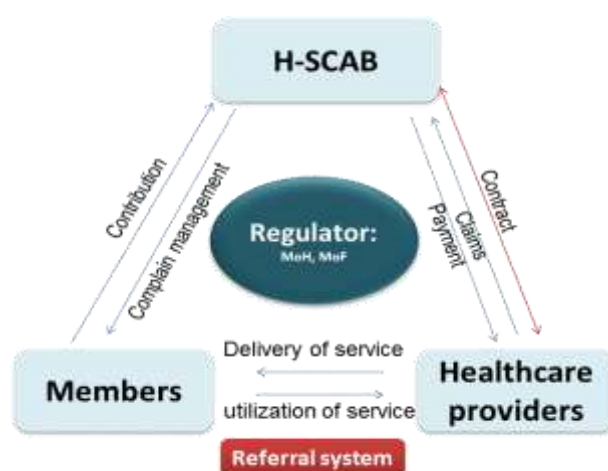
* Irma Ardiana, corresponding author. Email: irma_ardiana@yahoo.com

government's current and expected future capacity to spend. A good measure of the current fiscal context is the ratio of public expenditure (or revenue) to GDP.

In 2004, Indonesia enacted a substantial policy on social security for all citizens to enable each individual to fulfil the basic needs of decent living and improving their dignity towards the creation of a prosperous and just Indonesian society. The Social security programs initiated by the Government of Indonesia includes health insurance; accident insurance; pension plans; pension insurance and life insurance. In terms of health insurance, it is organized nationwide on the principle of social insurance and equity. The membership is compulsory for everybody and the Government pays the fees for the poor. Insurance management is no longer segregated by various schemes or residence but is integrated under one body nationally, the Health-Social Security Administrator Board (H-SCAB). All government health facilities and eligible private health facilities are registered as UHC providers to ensure the accessibility of participants to the services. The fund pooling system is separated into two major mechanisms. Either the source derives from a central and local government tax-funded system for people below the poverty line or from contributions from members paying their own premiums. A capitation payment system has been established for primary health facilities and case-based payment is applied for secondary and tertiary health facilities. Individual services are guaranteed, including promotive, preventive, curative, and rehabilitative. In addition to personal counseling, basic immunization provision, and medical screening, family planning services are integrated into health insurance benefits as part of promotive and preventive care.

It took a decade for the program to be implemented nationwide in 2014. A detailed road map to universal health coverage by 2019 has been agreed by related government institutions, civil society and the private sector. The road map covers, among other aspects, the regulatory framework, membership, benefits and premiums, the supply side, institutional arrangements and the implementation framework. To ensure the accountability of the program, the government has established a set of measurable targets to be achieved by 2019. Those targets encompass the operation of the H-SCAB, the coverage of the program, medical and non-medical benefit packages, adequate numbers and equal distribution of health facilities, adaptable regulations to ensure quality at a decent price, client satisfaction, health provider and health facilities satisfaction, and open, efficient and accountable management of the H-SCAB.

Figure 1: The triangle interrelationships of institutions/bodies in the UHC program



Source: President Decree No. 12/2013 on Social Health Insurance

Figure 1 shows the triangle of interrelationships among the H-SCAB, healthcare providers and members in the UHC program. The Ministry of Health lies in the middle of this triangle and functions as a regulator to ensure the established interrelations are in place. It formulates regulations, among others, on health service delivery, quality of care, and standardization of health service tariffs. The H-SCAB has authorization to collect premiums from members and provide access to health services by contracting certified healthcare providers. The payment system is organized by the government between the H-SCAB and healthcare providers. The contracted healthcare providers are required to be accountable to members by delivering qualified services.

Indonesia is struggling to sustain the UHC program for reasons of fiscal capacity. Despite showing strong growth of 8% in the Total Health Expenditure (THE) during the period of 1995-2013, out-of-pocket payments still remain at 45.3%, which constitutes 1.6% of GDP. Public insurance program contributions constitute 41.4% or 1.5% of GDP while social health insurance contributions are at 13% or 0.5% of GDP (World Bank Group, 2017). The increase in public health spending is mainly driven by subsidized health insurance for the poor from central and local government.

During the first four years of the program's implementation, abundant research by scholars has focused on total program coverage and mostly on the facets of equity and sustainability. However, little is known concerning how effective family planning care has been covered as part of the benefits package and how well it is integrated into the current functioning health system. This study investigates how family planning programs are managed across different levels of governments and how family planning services are delivered to the end user. The second focus of the study aims to explore the constellation of family planning provisions in health facilities and contraceptive supply-chain management, including an analysis of total government expenditure for contraceptive procurement and family planning utilization.

Methods

In analyzing institutional arrangements, the study is based primarily on reviewing the present regulatory structure on the division of authorities among levels of government and the implementation of the regulation platform in the current government system. In the realm of family planning integration in the UHC scheme, the study compares existing related academic research and updated progress. For a greater understanding of each context, the study is enriched with qualitative as well as quantitative data collection and involves consultations with related policy makers and selected programmers at central and district levels.

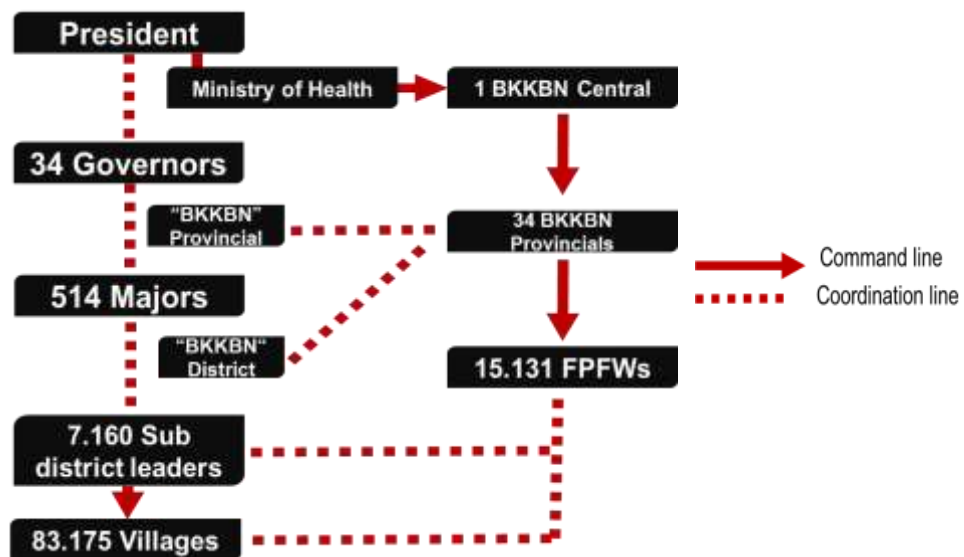
Results

Institutional arrangement

The implementation of family planning in Indonesia is unique in the sense that it is carried out under the authority of both the Ministry of Health (MoH or *Kementerian Kesehatan*) and the National Population and Family Planning Board (NPFPPB or *Badan Kependudukan dan Keluarga Berencana Nasional/BKKBN*), and the separation of authorities between these two government agencies in safeguarding the provision of family planning services is somewhat

ambiguous. As a result, it is difficult to determine a clear-cut disaggregation of supply-side arrangements under the MoH and demand generation for family planning organized by the BKKBN. This is due to BKKBN being responsible for some family planning supply-side services including ensuring the provision of required medical equipment, contraceptives and capacity fulfillment of health facilities to provide family planning services (Ministry of National Development Planning, 2015). In the context of BKKBN's connectivity with the president, it works under the coordination of MoH as shown in figure 2.

Figure 2: Institutional and Resource Arrangement for Population and Family Planning Affairs



The implementation of the UHC scheme since 2014 has demanded rapid adaptation in the overall functioning of the health system of which family planning is an integral part. The system recognizes the existence of the H-SCAB, and the H-SCAB is partly responsible for administrative duties. It also plays a role in providing and removing contracts for health facilities based on their eligibility to provide services.

In terms of family planning provision, BKKBN is formally assigned to design advocacy, communication, information, and education related to population, family planning and family welfare where family planning plays a significant role, to manage Family Planning Field Workers, to administer the contraceptive supply chain, to provide contraceptives for all eligible couples, to empower and engage civil society in providing and maintaining family planning participation as well as to establish family planning standards. These affairs are concurrently disbursed to the Province and District Population and Family Planning Offices. The Province Population and Family Planning Offices in this regard do not refer to provincial offices as the extension of the central BKKBN office. Furthermore, the Province Population and Family Planning Office has two job descriptions. 1) to design and develop advocacy, communication, information and education materials and activities acknowledging local information sources and ensuring cultural appropriateness; and 2) to empower and to engage civil society in providing and maintaining family planning participation at the provincial level. The authority given to the District Population and Family Planning Office is wider compared to that given to the provinces, with additional tasks including to empower Family

Planning Field Workers, and to control and distribute contraceptives and conduct family planning services.

Since 2008, the District Population and Family Planning Office has had access to fiscal equalization transfer from the Indonesian budget to, for example, provide the required medical equipment for family planning services, to provide mobile family planning services, and, starting from 2016, to support the distribution costs for the contraceptives from the district warehouses to the health facilities.

Family planning services are considered as promotive and preventive care assured by the Government through the UHC program. Benefits include services at the primary and referral health system. At the primary health care level, services include counselling, the provision of short term methods, i.e. the pill, injectables, and condom provision, as well as long-acting and permanent methods, i.e. insertion/removal of intra-uterine devices/2-rod implant and vasectomy. Counseling and provision of pills and condoms are considered under the capitation system. The payment system for the rest services is through a non-capitation system, where tariffs for each service have been determined by the government. The referral health system provides services that could not be delivered at the primary health care level, i.e. either cases with medical complications or female sterilization. The payment arrangements for these services follow Indonesia's Case Based Groups (INA-CBGs) regulations as laid out by the MoH.

Even though some service aspects are under the BKKBN's coordination, the national health system remains formally organized by the MoH and District Health Offices. Meeting demand and supply for family planning therefore requires close collaboration between these two bodies at every level of government. The BKKBN concentrates heavily on pre and post services in the community to create demand and maintain the sustainability of family planning participation. Family Planning Field Workers play an important role in the grass roots movement while the MoH assumes an important role in setting regulation platforms to ensure that the services are easily accessible and qualified.

Health facilities for family planning provision

The implementation of the UHC program recognizes the legal authority of the H-SCAB in the national health system. Following the minimal standard of health facilities determined by the Ministry of Health, the H-SCAB is responsible for mapping and contracting eligible health facilities under its service networks. The Government already set a 6-year road map to ensure an ideal ratio between doctor and UHC beneficiaries (Coordinator Ministry of People Welfare, Health-National Social Security Board, Ministry of Health & Ministry of National Development Planning, 2012). It is expected that by 2019, 51,498 primary health facilities and 2,439 secondary/tertiary health facilities will be contracted and participating in the scheme which amounts to a ratio of one doctor for every 4,000 beneficiaries (Table 1). Primary health facilities in this regards refers to those of the government (community health centers or *pusat kesehatan masyarakat/puskesmas*) and private sector, including private doctors, primary clinics and dentists. Hospitals (general and specialized hospital) and advanced clinics represent secondary and tertiary health care. In terms of family planning, dental clinics are excluded from the service network, as are special advanced hospitals. Therefore, health facilities competent to provide family planning services have been proportionally adjusted by the BKKBN to ensure the accessibility of family planning services through the UHC program. By 2019, the BKKBN assumes that 85% of total contracted health facilities, (approximately 45,000) will be able to deliver services (National Population and Family Planning Board, 2016).

Table 1: Numbers of Targeted Health Facilities by 2019

Health Facilities / BKKBN target	2014	2015	2016	2017	2018	2019
Primary health provider	24,318	31,048	36,850	43,884	51,156	51,498
Secondary/Tertiary health provider*	1.681	1.781	2.072	2.230	2.351	2.439
BKKBN's target for primary and secondary/tertiary health providers	24.8%	29.4%	43.3%	57.2%	71.1%	85%

Source: National Population and Family Planning Board, 2016a

The updated data confirms that the H-SCAB and the BKKBN are lagging far behind the target. In 2017, the program intended to have 46,114 and 26,284 contracted and registered health facilities under the H-SCAB and the BKKBN system, respectively. Their progress indicates that only 23,250 health facilities were contracted by the H-SCAB after 1,200 dentists were omitted. The BKKBN reached only 34% of the corresponding target or 44% from health facilities under the H-SCAB program (National Population and Family Planning Board, 2017a).

In addition, the credential system enforced to select qualified health facilities remains insensitive to family planning services. A study conducted in 2015 in 9 districts and 4 health facilities representing the western and eastern parts of Indonesia confirmed that not all contracted health facilities were equipped with the recommended medical equipment for family planning services (National Population and Family Planning Board, UNFPA & Gadjah Mada University (GMU), 2015) i.e. decision-making tools counselling for family planning services were not available in 7 health facilities; implant-removal kits were not available in 9 health facilities and 14 health facilities did not have a vasectomy kit.

The credential system is intended to prequalify health facilities for family planning services among others. However this does not guarantee the readiness of health facilities to provide family planning services. This unfavorable policy is officially addressed by the BKKBN, which has developed an alternative mode of channeling funds to the district government in the form of a specific allocation fund (*Dana Alokasi Khusus/DAK*). This scheme is part of the 5% of the total Indonesian health budget that is transferred to the District Population and Family Planning Offices to support national priority programs. One aspect of the scheme involves the provision of medical services for family planning services i.e. an intra-uterine device kit, an implant removal kit, a family planning bus for mobile services, a family planning bus for family planning propaganda purposes, and a contraceptive storage cabinet (National Population and Family Planning Board, 2017b).

Supply chain management for contraceptives

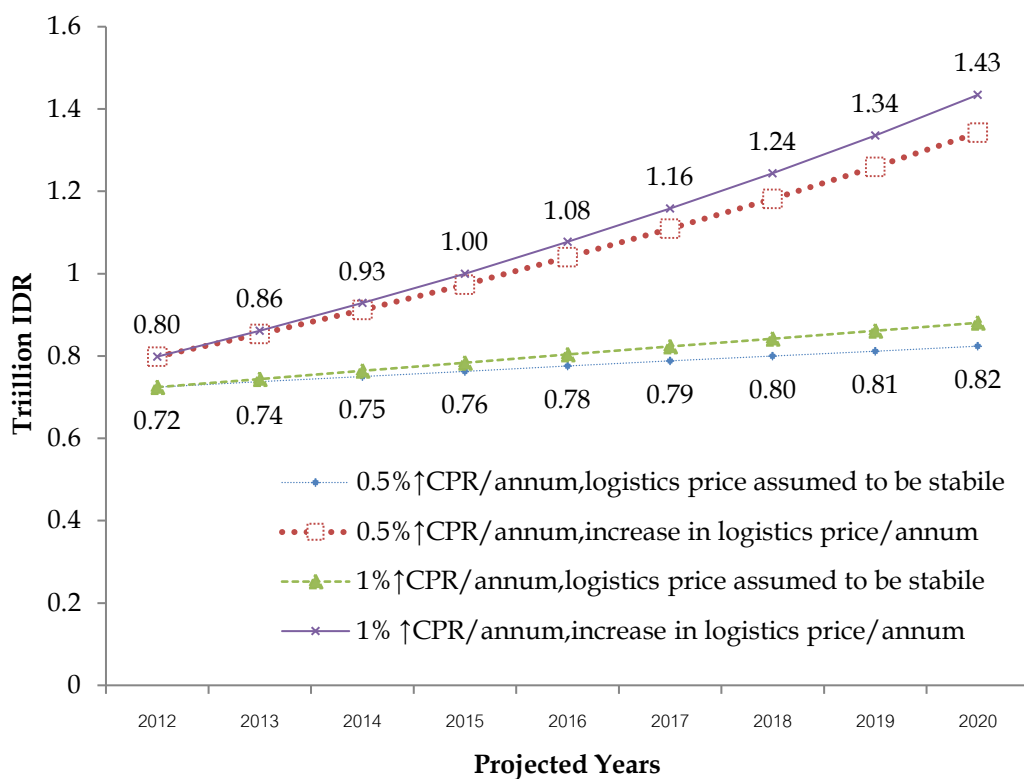
As mentioned earlier, the BKKBN is responsible for supplying contraceptive commodities for all program beneficiaries. The program commodities are listed in the national medicine list stipulated by Ministry of Health regulations every two years. The commodities consist of five essential contraceptives, the combined pill (*Levonorgestrel 150mcg & Etinilestradiol 30mcg*), an injectable (*Medroksi progesteron asetat 150 mcg*), copper T IUD and 2-rod implants (*Levonorgestrel 75 mg*) (Ministry of Health, 2015) and the male condom. Once a commodity is listed in the national medicine list, the BKKBN is responsible for quantifying and procuring it. Commodity needs are forecasted in annual consultation with the MoH and procurement is coordinated by the National Public Procurement Agency (*Lembaga Kebijakan Pengadaan Barang/Jasa Pemerintah/LKPP*). Unlike the MoH forecasting system, which applies bottom-up commodity planning from health facilities to the central office, contraceptive planning adopts

the opposite mechanism. Driven by a certain demographic target, contraceptive chain policy administers a combination of pull and push systems in the distribution pattern.

Contraceptives displayed by the supplier in the e-catalogue provided by the LKPP are ordered periodically by the BKKBN (for the central and each provincial office). The commodities are meant either to be stored at the warehouse or distributed to District Population and Family Planning Offices according to resupply planning procedures. This office is afterwards responsible for delivering the contraceptives to the entitled health facilities in coordination with the District Health Office (National Population and Family Planning Board, 2011). The cost of distribution from the District Population and Family Planning Office to determine health facilities derives from a Specific Allocation Fund for operational funding purposes.

Responding to the UHC road map and the need to meet the demand for contraceptives for eligible couples, the BKKBN conducted a study to identify the amount of funding needs for contraceptive commodities up to 2019. Figure 3 demonstrates an increasing trend of funding needs for contraceptives with the projected modern Contraceptive Prevalence Rate (mCPR) set to increase at 0.5% and 1% (National Population & Family Planning Board & GMU, 2014). This indicates a wide variation among the scenarios generating a significant escalation of the budget by between 14 to 82% depending on the assumptions held. Where the mCPR is expected to increase by 0.5% and the unit price for each contraceptive is not expected to fluctuate, the Government of Indonesia is required to allocate 797 billion IDR (approximately US \$56 million) by 2017. An increase in the mCPR of 1% will require an allocation of 1.16 trillion IDR in 2017 (US\$ 77 million).

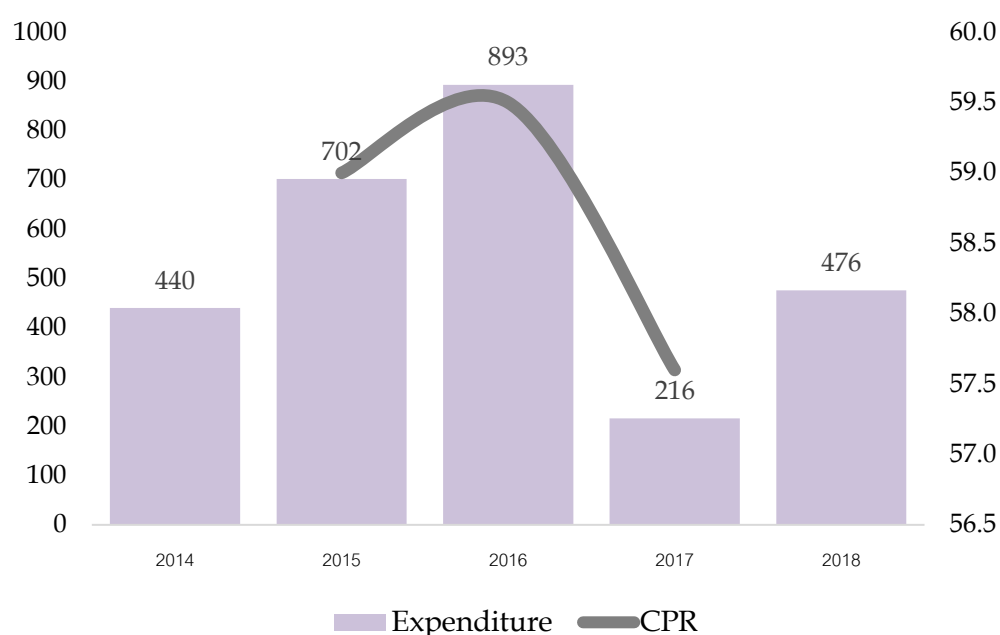
Figure 3: National Projection on Contraceptive Expenditure, 2012-2020



Source: National Population and Family Planning Board & GMU, 2014

National contraceptive expenditure for fiscal years 2014-2018 reveals a unique pattern, considering the annual trend of the mCPR (National Population and Family Planning Board, 2014a; 2015a; 2016a; 2017c; 2018a). Figure 4 envisages that a consistent increase of budget for contraceptive procurement occurred only between 2014 and 2016 along with an increase of the mCPR by 0.5% from 2015-2016. Afterwards, the Government's spending for national contraceptives appeared to decline notably. In 2017, it provided only a quarter of the previous year's budget spending.

Figure 4: National Contraceptives Expenditure, Fiscal Year 2014-2018 in billion IDR Vs CPR



Source: National Population and Family Planning Board, 2014a; 2015a; 2016a; 2017c; 2018a

With an understanding that contraceptive supply is not merely meant to ensure a set of contraceptives are procured in an adequate quantity but also that the commodities are available whenever or wherever clients ask for them, the government has attempted to strengthen supply chain management. The project put emphasis on the distribution of contraceptives at the district level. In collaboration with UNFPA, an initial assessment was conducted to gain a better understanding of the performance of the contraceptive supply chain nationwide. It revealed that the stockout rate for short term methods, the pill, injectables and condoms, was intolerably high at 26%, 31%, and 41% respectively (National Population and Family Planning Board & UNFPA, 2013). The assessment also carefully observed the stockout rate in 497 District Population and FP District Offices during June 2012 and January 2013. It was found that no less than 80 District Population Control and FP District Offices suffered from the unavailability of one or more commodities. There were a range of possible explanations of this unexpected situation mirroring every step of the logistic cycle. The issues arose from managerial incapacity, geographic obstacles, limited physical infrastructure (the absence of warehouses in 80 District Population Control and FP District Offices) and poor quality assurance.

In 2014, the BKKBN with UNFPA technical assistance developed and formulated three models of supply chain management to be piloted in some selected districts. The first model (Model A) emphasized improvement of the existing system under the auspices of the District Population and Family Planning Office. This model focused heavily on strengthening the

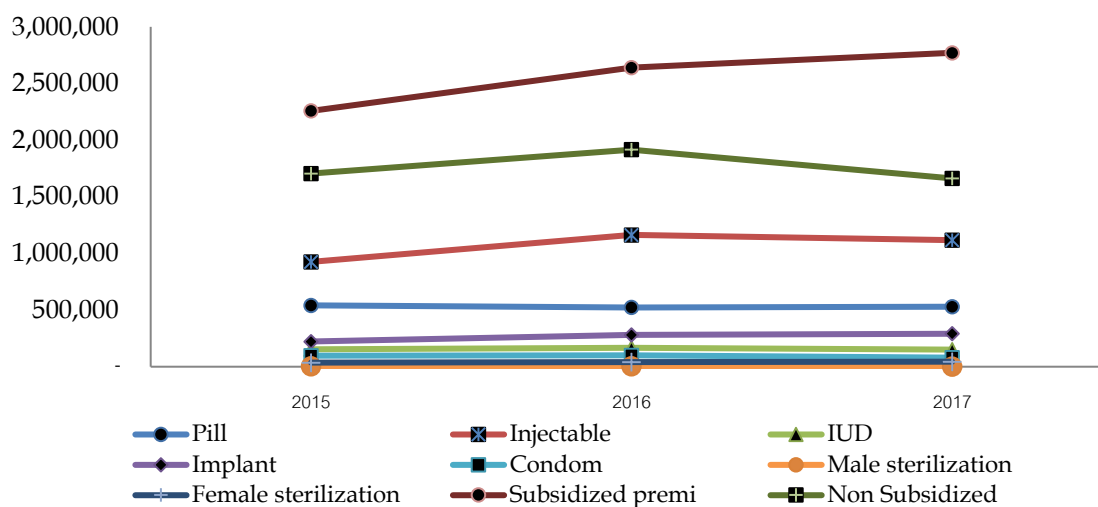
capacity of human resources and the availability of the required infrastructure. The second model (Model B) offered strong collaboration with the District Health Office (DHO) to store and to monitor the flow of contraceptive supplies to community health centers. The model applies in areas where there is not yet proper infrastructure available in the District Population Control and Family Planning Office. Considering the needs of contraceptive provision in remote areas and a huge shortage of Family Planning Field Workers (FPFWs), the third model (Model C) embraces partnership with state-owned companies and experts in the field of shipping to deliver logistics and to provide assistance in managing the Logistic Management and Information System. At the end of the study, all piloted districts succeeded in reducing stockout for all commodities by almost 100%.

Family planning services

For the last three years studied, family planning services were integrated into the benefits package of the UHC, but utilization continued to be stagnant (Figure 5). Family planning services covered in the program encompass the provision of the pill, injectables, insertion/removal of two-rod implants, insertion/ removal of Intra Uterine Devices (IUDs) and male/ female sterilization. The new FP clients who utilized the scheme mostly used it for the pill and injectables. Comparing the retention of family planning services between the subsidized and non-subsidized population (Figure 5), it can be seen that the program steadily succeeded in reaching more of the poor than the better off for the last three years of its implementation. However, a declining trend in access to family planning services under the program among non-subsidized beneficiaries was initially captured.

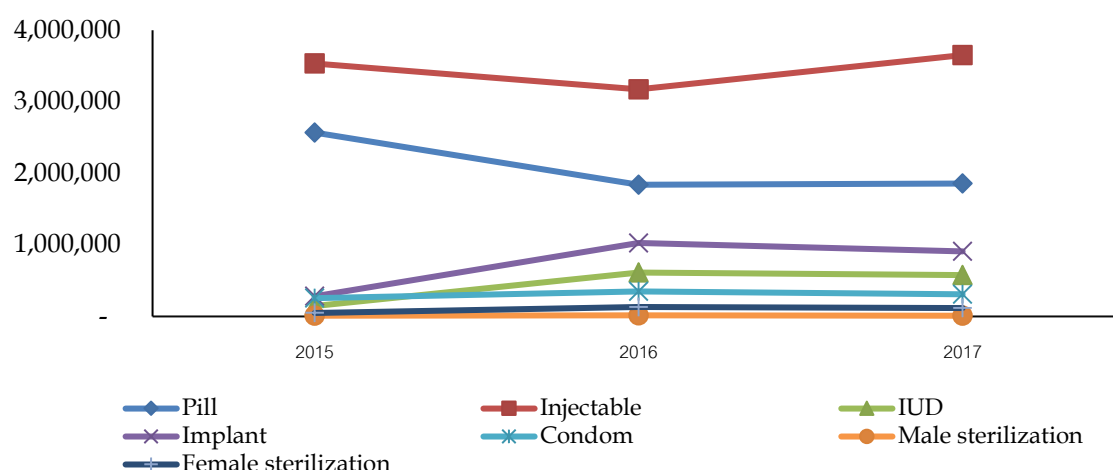
The BKKBN conducts an annual projection for new potential users of each method in accordance with a nationally agreed method mix to meet demographic targets, i.e. the Total Fertility Rate (TFR) and the Contraceptive Prevalence Rate (CPR) (Figure 6). Comparing new family planning users and the projected potential new family planning acceptors for each method, it is more likely that family planning services are underutilized, particularly for injectable and pill provision. With regard to long term methods, the 2-rod implant demonstrated the highest performance in 2015 and later decreased while the demand for this method in fact grew. A similar pattern was also experienced for IUD insertion and male and female sterilization, in which case supply was less likely to meet the demand.

Figure 5: Family planning services under the UHC program (new clients), 2015-2017



Source: National Population and Family Planning Board, 2016c; 2017d; 2018b

Figure 6: Potential family planning new users, 2015-2017



Source: National Population and Family Planning Board, 2015b; 2016d; 2017d

Discussion

Indonesia's family planning program, the BKKBN, which was established in the 1970s, not only serves the contraceptive needs of couples but also has a socialization aspect to it in that it promotes norms and activities beyond family planning. It is notable that total fertility has declined for the last two decades from 2.5 to 2 children on average (National Family Planning Coordinating Board, Ministry of Health, Central Bureau of Statistics, & Macro International Inc, 1992; 1995; 1998; National Family Planning Coordinating Board, Ministry of Health, Statistics Indonesia, & Macro International Inc., 2003; 2008; National Population and Family Planning Board, Ministry of Health, Statistics Indonesia, & Measure DHS 2013). This profile might partly explain the reduction of total fertility rate during this time from 3.02 to 2.6 and the increase uptake of modern contraception from 47% to 57.9%. This is considered to have resulted from a massive and continuous campaign on family planning. Political commitment in this regard was achieved through the collective agreement of government and NGOs as well as religious leaders (National Family Planning Coordinating Board, 1996).

There have been some critical adjustments to the BKKBN's structures. Since 2001, for example, the BKKBN is no longer vertically centralized but maintains its representative offices in all capital cities of the province. In the context of current government structures from central to district levels, a division of authority among the level is already determined yet it remains difficult to translate it into a more detailed form. The Head of the Planning Bureau at the BKKBN Central Office has stated that in order to understand better each authority in their respective territories, the Government needs to enact clear and specific regulations. However, the main focus of the BKKBN regarding the family planning program in the current health system continues to be the strengthening of small family norms. Consistent commitment from local and, particularly, religious leaders is necessary to ensure the sustainability of the program. Communication, information, and education on family planning need to be collaboratively provided by the government's representatives, civil society organizations, and other related elements.

In terms of family planning services, the mandate is placed at the level of the District Population Control and FP Office. Its position in the health system is crucial as this office is required to map and synchronize health facilities under management and information systems coordinated by the H-SCAB (National Population and Family Planning Board, 2014). Once health facilities are recognized under H-SCAB networks, this District Office is immediately requested to register those health facilities under the BKKBN's management information system, with the exception mentioned earlier (dental clinics and specialized hospitals). By having the registration number from the FP District Office, health facilities consequently have access to contraceptive commodities and the necessary medical devices for family planning services. Notably, a gap in the numbers of health facilities demonstrates that this divergence system is unable to unite information applicable to both sides. As stated by one BKKBN officials:

'BKKBN has to establish its own information system, separated from what H-SCAB develops. It enables us controlling our family planning performance including logistic purposes. Socialization to district family planning offices has been initiated since the beginning of program implementation. We required them to have updated information concerning the numbers and the target of health facilities to be integrated under District Population Control and FP Office management information system. They should have regular coordination with District Health Office and local H-SCAB office.....'

The need to pursue family planning objectives while implementing health sector reforms poses a major challenge for health managers. One might argue that health system management plays a significant role in maintaining the accessibility of family planning services. Having two different entities at the district level (District Population Control and FP as well as the District Health Office) with the introduction of H-SCAB is challenging. A lack of information/coordination as confirmed by staff from the District Population Control and Family Planning Office at Serang District may be a contributing factor to this challenge.

This situation, however, did not occur when Indonesia implemented a national scheme of health financing called birth insurance (*jaminan persalinan/jampersal*) in 2012. The goal of this scheme was to further accelerate the reduction of maternal mortality by ensuring safe pregnancy and childbearing. In addition to primary/secondary and tertiary health facilities, private midwives were also acknowledged in the health system network. Qualified private midwives were directly contracted by the District Health Office (Ministry of Health, 2011) to provide comprehensive maternal healthcare including family planning. With similar health management platforms between the District Family Planning Office (the name of local institution at that time) and the District Health Office, the District Family Planning Office could exceed the target of 23,500 and reach 27,330 health care providers (National Population and Family Planning Board, 2010) under their management information systems from 2010-2014 (National Population and Family Planning Board, 2014c).

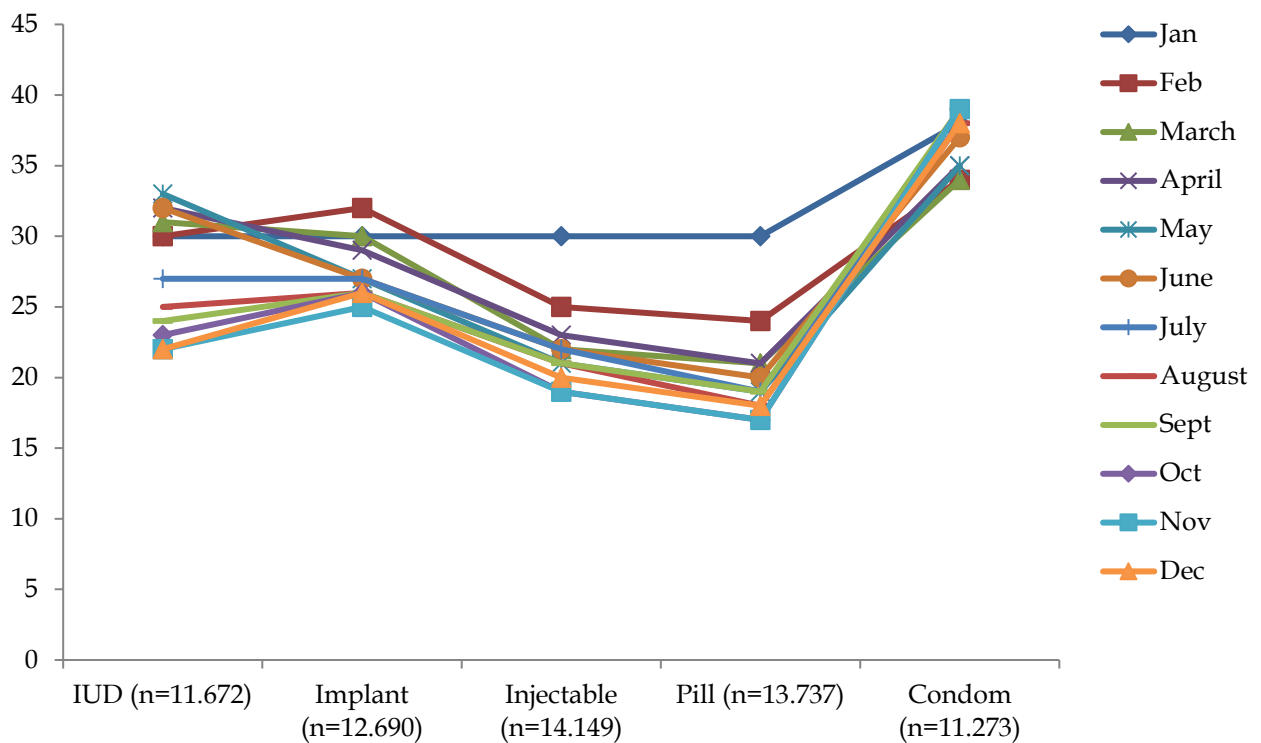
Contrasting the above situation and reflecting on the family planning and decentralization analytical framework (Williamson, Duvall, Goldsmith, Hardee & Myuba-Brown, 2014), the gap is preferably rooted on a formal framework rather than institutional capacity. Health reform in terms of health insurance coverage determines the essence of family planning in the broader health system. The integration of family planning into the UHC program might to some extent reduce family planning to a mere part of other components of promotive and preventive initiatives. The lack of ability to fully understand this relatively new system and the contribution of the District Population and Family Planning Offices in that system has

adversely affected family planning service delivery. The nuance was rather different when family planning was incorporated under the childbirth insurance program as part of a continuum of care. The legal structure in that case successfully defined interactions and relationships among different governmental institutions. This is understandable because the situation concerning the benefits package and the number of beneficiaries was far less complicated compared to that of the UHC program.

Good contraceptive forecasting requires inclusive consideration to prevent either overstocking or stockout at the service delivery points. Best practice identified by the USAID Deliver Project (2011), emphasized the need of at least three data sources for quantification contraceptives quantification. These are consumption, service, and demographic data. Analysis of these data enables project managers to be aware of resupply planning assumptions and the availability of funding BKKBN. Program planner adapted their contraceptive quantification starting in 2017 to include these new variable. The current method no longer merely considers demographic data as a basic assumption to quantify contraceptives, but also takes into account services and consumption data in addition to stock status in warehouses (National Population and Family Planning Board & JSI, 2017a).

The contraceptive procurement in 2016 only considered demographic data, which was likely to yield overestimates and is definitely affected by the amount of money invested in 2017. In the process of revising the quantification method in 2017 a new assumption was added, potential community demand. As a measure of national accountability to achieve the annual targeted modern contraceptive prevalence rate and long-acting and permanent methods, this target is converted into potential community demand. This included new and active acceptors at the national level which is then disaggregated by province. This new source of data is distinct from demographic data as it translates the defined target. This valuable process in an attempt to have better quantification methodology should be able to adjust periodically the baseline expenditure for national contraceptive.

The BKKBN initiative in developing models in the contraceptive supply chain management has shown significant results in decreasing the stockout rate. The model takes into account diversity in terms of human capacity, geographic landscape, the availability of district warehouses under the District Population Control and FP Offices, recognition of the role of the H-SCAB and quality assurance at the level of districts. With that uneven situation, a single supply chain system can hardly be expected to address barriers that may occur in the logistic cycle and cause persistent stockout. The performance of the District Population Control and FP District Office to maintain an ideal quantity of each contraceptive stock in health facilities is assumed to have been improved since central Government provided the Specific Allocation Fund in 2016. This financial access was designed from the central Government Budget to be allocated to districts to fund essential operational expenses which include, among others, the financing of contraceptive handling costs from the District Population Control and FP Offices to health facilities. However, health facilities have continued to experience a relatively high percentage of stockout for each commodity during 2017 at approximately between 18% and almost 40% (See Figure 7). Figure 7 represents the national scale.

Figure 7: Percentage of national stock out at the health facilities for each contraceptive, 2017

Source: National Population and Family Planning & JSI, 2017b

In order to be accountable to end beneficiaries in the provision of a full range of contraceptive choices, the BKKBN should reorient the relevancy of its operational mechanism to meet current conditions. The operational management of the contraceptive supply chain from central office to health care facilities has yet to conform to the guidelines published in 2011 (National Population and Family Planning Board, 2011). The distribution system which follows a 'one size fits all' approach should be re-examined considering the variety of contexts it is applied to. Building capacity is another aspect which needs to be fully addressed as program managers suffer from a serious lack of knowledge in managing the operational supply chain. Organizational capacity in the aspect of division of responsibility accompanied with accountable measures among the District Population and Family Planning Office, District Health Office, the local H-SCAB and the engagement of FP field providers needs to be clearly defined. Having different modes of budget transfer from central to district offices for financing supply chain management operation, in particular, could open up more opportunities for central government to improve logistic management.

The condition is more acute when the MoH does not consider the interests required family planning medical devices in the credentials guidelines. Some health facilities are able to show the availability of particular medical devices necessary for family planning services and some are not. It has been documented that since far before the implementation of the UHC, the BKKBN set targets to meet the required medical devices for family planning services at health facilities (National Population and Family Planning Board, 2010). Later, the financing scheme was transformed to place the authority to provide medical devices at the local government level through the fiscal equalization scheme (National Population and Family Planning Board, 2008). Those health facilities contracted by the H-SCAB have failed to provide family planning

as one of the benefit packages, and those contracted by the health facility have not always been equipped with the required medical instruments.

Health sector reform is a complex situation when it is faced with the issues of government institutional structure, organizational capacity, and system disruption. For example, after commencing a new phase of decentralization in 2010, Kenya's health system experienced some critical challenges concerning procurement mechanisms, fiscal transfer, and health sector capacity in defining the effect of devolution in their daily work (Williamson & Mulaki, 2015). Establishing a road map to devolution including formulas for budget allocation, assignment of health sector functions between national and country government, and alignment of two related ministries under Kenya's Health Sector Strategic and Investment Plan have laid an important political foundation for better public service delivery. This is very important when abundant research reveals that family planning and reproductive health are often overlooked and excluded from decentralization plans. The most plausible reason for this issue is ambiguity in the division of responsibilities between the national and sub-national government along with poor resource allocation. The required level of technical competency of health providers to provide a set of family planning services at the level of primary health care is also in doubt. Primary health facilities either at community health centers, or private clinics, or private doctors, have to be able to provide, according to regulations, among other services, 2-rod implant insertion and removal. However, the Competency Standard for Indonesian Doctors designates implant insertion and removal as a class 3 procedure (Indonesian Medical Council, 2012). This indicates that health providers at the primary health care level should refer the case to secondary health care. And this to a degree contradicts the application of the H-SCAB cost containment system (in addition to quality control) as the rate for implant insertion or removal is more expensive when it is conducted in hospitals than at primary health cares.

According to the Indonesian Demographic and Health Survey, the contraceptive method mix in Indonesia is dominated by short term methods, i.e. injectables and the pill. This pattern is also reflected among new users covered under the UHC program. In contrast, a study conducted in 50 states and districts of Colombia in 2017 (Wood et al., 2018) demonstrates that in areas where family planning financing systems have been established, health centers are more likely to offer more effective family planning methods and higher quality care. Indonesian women favor injectable most as it is more likely to be accessible and promoted by providers. The underlying causes of this are partly due to the impact of the Blue Circle and Gold Circle Campaigns of the 1980s and 1990s. The campaign goals were to shift family planning access from the public to the private sectors (mainly among village midwives in rural areas). The adverse implication of this initiative has led to private providers who are purposefully encouraging the use of injections and the pill regardless of clients' reproductive goals (Hull & Mosley, 2009). The other issue is rooted in the fact that sensitive policies, strategies, and programs to maintain private doctors or midwives' competencies, resources and incentives to provide high-quality family planning services have yet to be collaboratively formulated by the BKKBN and the MoH.

The UHC program deserves high appreciation for allowing more lower income people to enjoy the benefits of the program. Pooling revenue is a fundamental concept in sustaining the health financing policy. The policy shares financial risks across populations in order to prevent individuals carrying the full burden of health care costs (WHO, 2019). Figure 4 shows wider access to the poorer economic segment in acquiring family planning services at the national scale compared to those at a higher economic segment. In comparison, globally, UHC

has been more beneficial to the richest 60-80% as opposed to the poorer 20-40%. (WHO & The World Bank, 2014).

It is understandable that the Government puts more attention on the lower economic segment, which generally resides in rural areas, and they tend to have higher total fertility rate compared to their counterparts in urban areas. The government empowers them with the provision of transportation costs 'to and from' health facilities to obtain family planning services, preferably using long acting and permanent methods (National Population and Family Planning Board, 2013; 2017f). This is a form of subsidy targeting the less well off in an attempt to remove unnecessary financial barriers to access health facilities.

Demand for family planning also indicates that Indonesian women largely rely on short term methods (injectables and the pill) for family planning. According to the Indonesia Demographic and Health Survey 2012, 99% of currently married women are able to mention any modern method. Among all modern methods, they are best able to identify injectables (98%) and the pill (97.3%), less so other methods, particularly sterilization. For long term methods, implants and IUDs are preferable to sterilization. Social barriers to sterilization, particularly for males, are noticeable, but the government has promoted male sterilization with a message of raising men's participation in the reproductive function of the family and sharing women's burden in reproductive goals.

Contrasting supply and demand figures for each method of family planning, it is suggested that the supply side fails to fully meet the demand. A remarkable gap was found among those wanting the injectable and the pill as their means to exercise family planning. A high percentage in Indonesian women's knowledge relating to injectables and the pill and a heavy bias from health providers to promote short-term methods demonstrate a reciprocal interrelationship impeding the Government's effort to improve the current method mix. Even so, the Government is not concerned about this as Indonesia has a long history of having a larger share of the private sector fulfilling short-term family planning methods.

A remaining concern lies in the declining trend of long-term method usage over the last two years. The Indonesian Demographic and Health Surveys (IDHSs) consistently show that the public sector plays a more dominant role in providing IUD and implants insertion as well as sterilization methods compared to the private sector. People might assume a higher cost needs to be invested in having these services in contrast to short-term methods. Poor utilization of long acting and permanent methods entails either a bottleneck in the supply side or shifting demand due to changes in the reproductive goal of couples.

From a supply side point of view, there is a wide range of possible explanations to explain the underutilization of family planning services in the UHC scheme. Limited access to eligible health facilities, unavailability of contraceptives and certain medical apparatus, preference to access family planning services from private providers as well as unskilled health providers, particularly for long acting and permanent methods are plausible explanations as discussed earlier. More intensive discussion with the BKKBN staff in the family planning department reveals that in addition to that, the present health system also discourages the integration of family planning in the UHC system. Female sterilization faces an ambiguous position when established regulations collide with implementation due to delays in establishing technical guidelines. Shifting perception from 'fee for service' to an insurance-based payment generates reluctance among health workers in providing services who may assume that their professional competencies are not appreciated. This issue occurs mainly in hospitals when the payment utilizes a case-based group approach. The other crucial issue here is the referral

system in which the definition of vertical vs horizontal referral has yet to be clarified. The draft for this regulation is still in an ongoing process for approval.

Conclusion

Family planning is a cross-cutting issue when it is incorporated under the UHC system. The Ministry of Health and the District Health Office cannot unilaterally ensure the provision of family services without the collective commitment of the BKKBN and the District Population and FP District Office and vice versa. These efforts need also acknowledge the role of the H-SCAB within the health system. The demand that regulations designate more specific job descriptions at the BKKBN central-provincial and district offices needs to be immediately agreed upon. This would help set better defined interrelationships and interactions among different layers of government structures. With this formal approach, each institution can achieve a better understanding of their role and responsibility in the broader health system arena. In this way, this platform provides guidance to utilize more efficient resources.

The entry point for health facilities and family planning services under the H-SCAB's networks is through registration through the District Population and FP Office. Unless an integrated information system on health facilities is jointly developed, discrepancies in terms of numbers of qualified health facilities will remain. Those health facilities yet to be registered by the District Population and the FP Office will not be able to access contraceptives and medical instruments. This condition sacrifices the right of beneficiaries to obtain the family planning services are entitled to. In term of the overall program perspective, it is a huge loss of opportunity.

The BKKBN as a government institution with the authority to manage and provide contraceptives has to be more sensitive to uneven situations at the district level. The 'One size fits all' policy should be re-visited by contemplating the 2017 success story of three models in reducing the stockout rate and persistent high stockout nationwide. Periodic monitoring on the status of commodities at health facilities needs to be optimized through the use of information and communication technology. This could also be made a key performance indicator for the central and District Population and FP office. Projections for budget allocations for contraceptives need to be updated by considering a conclusive methodology and demographic target.

This study confirms a defect in regards to the formulation of regulations in the health system. The selection of health facilities, their accessibility, requirements of health provider competence, heavy provider bias to short term methods, and the coverage of female sterilization in hospitals are some of the issues possibly originating from unresponsive regulations. Systematic and periodic reviews on program implementation are thus essential. Formal frameworks need to be renegotiated periodically to allow for a fruitful policy dialogue. Potential misalignment of existing organization with policy objectives needs to be carefully analyzed. This argument rests on new information, shifting political realities, and lessons learned from a previous study. Corrective supply-side action might improve demand. A cost-benefit analysis of family planning as part of maternal and child health probably needs to be considered in an attempt to support a cost-containment policy under the UHC scheme. Preventive intervention, including family planning, deserves more attention as it is more cost-efficient.

References

- Coordinator Ministry of People Welfare, Health-National Social Security Board, Ministry of Health, & Ministry of National Development Planning. (2012). *Peta Jalan Menuju Jaminan Kesehatan Nasional 2012-2019* [Road Map to National Health Coverage 2012-2019]. Jakarta: Health-National Social Security Board.
- Hull, T. H., & Mosley, H. (2009). *Revitalization of Family Planning in Indonesia*. Jakarta: Ministry of National Development Planning & National Population & Family Planning Board.
- Indonesian Medical Council. (2012). *Standar Kompetensi Dokter Indonesia* [Competency Standard for Indonesian Doctor]. Jakarta: Indonesian Medical Council.
- Ministry of Health. (2011). *Petunjuk Teknis Jaminan Persalinan* [Technical Guideline on Childbirth Insurance]. Jakarta: Ministry of Health.
- Ministry of Health. (2015). *Daftar Obat Esensial Nasional 2015* [National Essential Medicine List 2015]. Jakarta: Ministry of Health.
- Ministry of National Development Planning. (2015). *Buku I: Rencana Pembangunan Jangka Menengah Nasional 2015-2019 dalam Peraturan Presiden Nomor 12 Tahun 2015* [Book I: National Medium Term Development Plan 2015-2019 in President Decree Number 12 Year 2015]. Jakarta: Ministry of National Development Planning.
- National Family Planning Coordinating Board. (1996). *Informasi Umum: Pembangunan Keluarga Berencana dan Keluarga Sejahtera* [Basic Information: Family Planning Movement and Prosperous Family Development]. Jakarta: Office of State Minister for Population/National Family Planning Coordinating Board.
- National Family Planning Coordinating Board, Ministry of Health, Central Bureau of Statistics, & Macro International Inc. (1992). *Survei Demografi dan Kesehatan Indonesia 1991* [Indonesia Demographic & Health Survey 1991]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/1991IDHS.pdf>
- National Family Planning Coordinating Board, Ministry of Health, Central Bureau of Statistics, & Macro International Inc. (1995). *Survei Demografi dan Kesehatan Indonesia* [Indonesia Demographic & Health Survey 1994]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/1994IDHS.pdf>
- National Family Planning Coordinating Board, Ministry of Health, Central Bureau of Statistics, & Macro International Inc. (1998). *Survei Demografi dan Kesehatan Indonesia 1997* [Indonesia Demographic & Health Survey 1997]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/1997IDHS.pdf>
- National Family Planning Coordinating Board, Ministry of Health, Statistics Indonesia, & Macro International Inc. (2003). *Survei Demografi dan Kesehatan Indonesia 2002-2003* [Indonesia Demographic & Health Survey 2002-2003]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/2002IDHS.pdf>
- National Family Planning Coordinating Board, Ministry of Health, Statistics Indonesia, & Macro International Inc. (2008). *Survei Demografi dan Kesehatan Indonesia 2007* [Indonesia Demographic and Health Survey 2007]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/2007IDHS.pdf>
- National Population and Family Planning Board. (2008). *Petunjuk Operasional Penggunaan Dana Alokasi Khusus Sub Bidang Keluarga Berencana Tahun 2009* [Operational Guideline on The Use of Specific Allocation Fund for Sub Component Family Planning 2009]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2010). *Rencana Strategis Badan Kependudukan dan Keluarga Berencana Nasional 2010-2014* [National Population & Family Planning Board Strategic Plan Year 2010-2014]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2011). *Petunjuk Teknis Penerimaan, Penyimpanan dan Penyaluran Kontrasepsi serta Non Kontrasepsi* [Guideline on Acceptance, Distribution and Storage of Contraceptive and Non Contraceptives]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2013). *Pedoman Penggerakan Pelayan Kontrasepsi dan Ayoman Komplikasi serta Kegagalan Penggunaan Kontrasepsi* [Family Planning Demand Creation &

- Management on Contraceptive Complication and Failure]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2014a). *Alokasi Anggaran untuk Pemenuhan Kebutuhan Alat dan Obat Kontrasepsi Nasional Tahun Anggaran 2014* [Government Expenditure for National Contraceptive Procurement Fiscal Years 2014]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2014b). *Penyelenggaraan Pelayanan Keluarga Berencanaan dalam Jaminan Kesehatan Nasional* [Family Planning Services in Universal Health Coverage]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2014c). *Potensi Data Fasilitas Kesehatan KB: Semester II 2014* [Potential Family Planning Health Facilities: Semester II 2014]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2015a). *Alokasi Anggaran untuk Pemenuhan Kebutuhan Alat dan Obat Kontrasepsi Nasional Tahun Anggaran 2015* [Government Expenditure for National Contraceptive Procurement Fiscal Years 2015]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2015b). *Perkiraan Permintaan Masyarakat untuk Peserta KB Baru 2015* [Community Demand Projection For New Family Planning Acceptor 2015]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2016a). *Rencana Strategis Badan Kependudukan dan Keluarga Berencana Nasional 2015-2019* [National Population & Family Planning Board Strategic Plan Year 2015-2019]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2016b). *Alokasi Anggaran untuk Pemenuhan Kebutuhan Alat dan Obat Kontrasepsi Nasional Tahun Anggaran 2016* [Government Expenditure for National Contraceptive Procurement Fiscal Years 2016]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2016c). *Laporan Pelayanan Kontrasepsi 2015* [Report on Family Planning Services 2015]. Jakarta: National Population & Family Planning Board.
- National Population and Family Planning Board. (2016d). *Perkiraan Permintaan Masyarakat untuk Peserta KB Baru 2016* [Community Demand Projection For New Family Planning Acceptor 2016]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017a). *Potensi Data Fasilitas Kesehatan KB: Semester II 2017* [Potential Family Planning Health Facilities: Semester II 2017]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017b). *Petunjuk Operasional Penggunaan Dana Alokasi Khusus Sub Bidang KB 2016* [Operational Guideline on The Use of Specific Allocation Fund Sub Component Family Planning 2016]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017c). *Alokasi Anggaran untuk Pemenuhan Kebutuhan Alat dan Obat Kontrasepsi Nasional Tahun Anggaran 2017* [Government Expenditure for National Contraceptive Procurement Fiscal Years 2017]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017d). *Laporan Pelayanan Kontrasepsi 2016* [Report on Family Planning Services 2016]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017e). *Perkiraan Permintaan Masyarakat untuk Peserta KB Baru 2017* [Community Demand Projection For New Family Planning Acceptors 2017]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2017f). *Pedoman Penggerakan Pelayanan Kontrasepsi dan Ayoman Komplikasi serta Kegagalan Penggunaan Kontrasepsi* [Guideline on Family Planning Demand Creation & Management on Contraceptive Complication and Failure]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2018a). *Alokasi Anggaran untuk Pemenuhan Kebutuhan Alat dan Obat Kontrasepsi Nasional Tahun Anggaran 2018* [Government Expenditure for National Contraceptive Procurement Fiscal Years 2018]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board. (2018b). *Laporan Pelayanan Kontrasepsi 2017* [Report on Family Planning Services 2017]. Jakarta: National Population and Family Planning Board.

- National Population and Family Planning Board & Gadjah Mada University (GMU). (2014). *Pelayanan Keluarga Berencanaan di era Badan Penyelenggara Jaminan Sosial Kesehatan* [Family Planning Services in Health Care System in The Era of Health-Social Security Administrator Board (H-SCAB): Cost Utilization]. Jakarta: National Population and Family Planning Board.
- National Population and Family Planning Board, Ministry of Health, Statistics Indonesia, & Measure DHS. (2013). *Survei Demografi dan Kesehatan Indonesia 2012* [Indonesia Demographic & Health Survey 2012]. Retrieved from <http://sdki.bkkbn.go.id/files/buku/2012IDHS.pdf>
- National Population and Family Planning Board & United Nations Population Fund (UNFPA). (2013). *Final Report of The Contraceptive Supply Chain Management Assessment*. Jakarta: National Population and Family Planning Board & UNFPA.
- National Population and Family Planning Board, United Nations Population Fund (UNFPA), & Gadjah Mada University (GMU). (2015). *Kajian Sistem Kredensialing Pelayanan Keluarga Berencana dalam Jaminan Kesehatan Nasional* [Study on Family Planning Credentialing System in Universal Health Coverage]. Jakarta: National Population and Family Planning Board & UNFPA.
- National Population and Family Planning Board, & John Snow Incorporated (JSI). (2017a). *Buku Referensi Kuantifikasi Alat dan Obat Kontrasepsi* [Reference Book for Contraceptive Quantification]. Jakarta: National Population and Family Planning Board and John Snow Incorporated (JSI).
- National Population and Family Planning Board & John Snow Incorporated (JSI). (2017b). *Stock out status for contraceptives*. Retrieved from https://jsirxtmy.sharepoint.com/:x:/r/personal/omar_jsirxt_onmicrosoft_com/_layouts/15/WopiFrame.aspx?docid=023645069ad1d4b06b935f5eaa984d67a&authkey=Abxd3tYjdHdcMQDtePAMx2k&action=view
- President Decree, Number 12 (2013). Jakarta: Ministry of Law and Human Right. Retrieved from <http://www.jkn.kemkes.go.id/attachment/unduh/Perpres%20No.%2012%20Th%202013%20ttg%20Jaminan%20Kesehatan.pdf>
- United States Agency for International Development (USAID) | Deliver Project, Task Order 4. (2011). *Quantification of Health Commodities: Contraceptive Companion Guide. Forecasting Consumption of Contraceptive Supplies*. John Snow Incorporated.
- Williamson, R.T., Duvall, S., Goldsmith, A.A., Hardee, K., & Myuba-Brown, R. (2014). *The effect of Decentralization on Family Planning: A framework for Analysis*. Washington, DC: Future Group, Health Policy Project.
- Williamson, T., & Mulaki, A. (2015). *Devolution of Kenya's Health System: The Role of HPP*. Washington, DC, Health Policy Project.
- Wood, S.F., Strasser, J., Sharac, J., Wylie, J., Tran, C., & Taho, R. (2018). *Community Health centres and Family Planning in An Era of Policy Uncertainty*. George Washington University and Kaiser Family Foundation.
- World Bank Group. (2017). *Improving the Quality of Indonesia's Health Spending in The Context of The Health Financing Transition: Health Sector Public Expenditure Review*. Retrieved from http://www.anggaran.depkeu.go.id/content/Publikasi/seminar%20bidang%20kesehatan/WBGHealth%20PER%20Update%20Phase2%20MOF%20Seminar_121417.pdf
- World Health Organization (WHO). (2019). *Health Financing for Universal Coverage*. Retrieved from https://www.who.int/health_financing/topics/pooling/en/
- World Health Organization (WHO), & The World Bank. (2014). *Monitoring a Progress Towards Universal Health Coverage at Country and Global Levels: Framework, measure and targets*. Geneve, Switzerland: WHO Document Production Services.