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Policy and Decision Making in Indonesia

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Vice Minister of Health

"Developing Influential Think Tanks: What Does It Take To Be One?"

Jakarta, 3 October 2012

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PRESENTATION OUTLINE

1. Introduction
2. Policy process
3. Policy making Model
4. The role of evidence in policy making
5. A case study of policy making in Indonesia
6. Conclusion

1. INTRODUCTION

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- What is health policy?
- Two dimensions of policy:
  - Content: Policy is a guidance (guideline) of actions

    For example: Acts, Goverment Regulations, Minister's Decree
  - Process: Policy is a course of actions which involve actors, powers, meanings, and interests

    For example:

    (1) the process of creating BOK policy

    (2) the process of creating "Jamu Scientification" policy

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Policy levels and policy types

- Policy levels in terms of contents
  - Strategic policy
  - Managerial policy
  - Technical / operational policy
- Policy levels in terms of administration
  - International policy
  - National / state policy
  - Ministerial policy
  - Local goverment policy
- Policy types
  - Distributive policy
  - Redistributive policy
  - Regulatory policy

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Two types of policy analysis

1. Analysis for policy (prescriptive)
   - Policy advocacy
   - Information for policy
   - Policy evaluation
2. Analysis of policy (analytical and descriptive)
   - Analysis of policy process
   - Analysis of policy content

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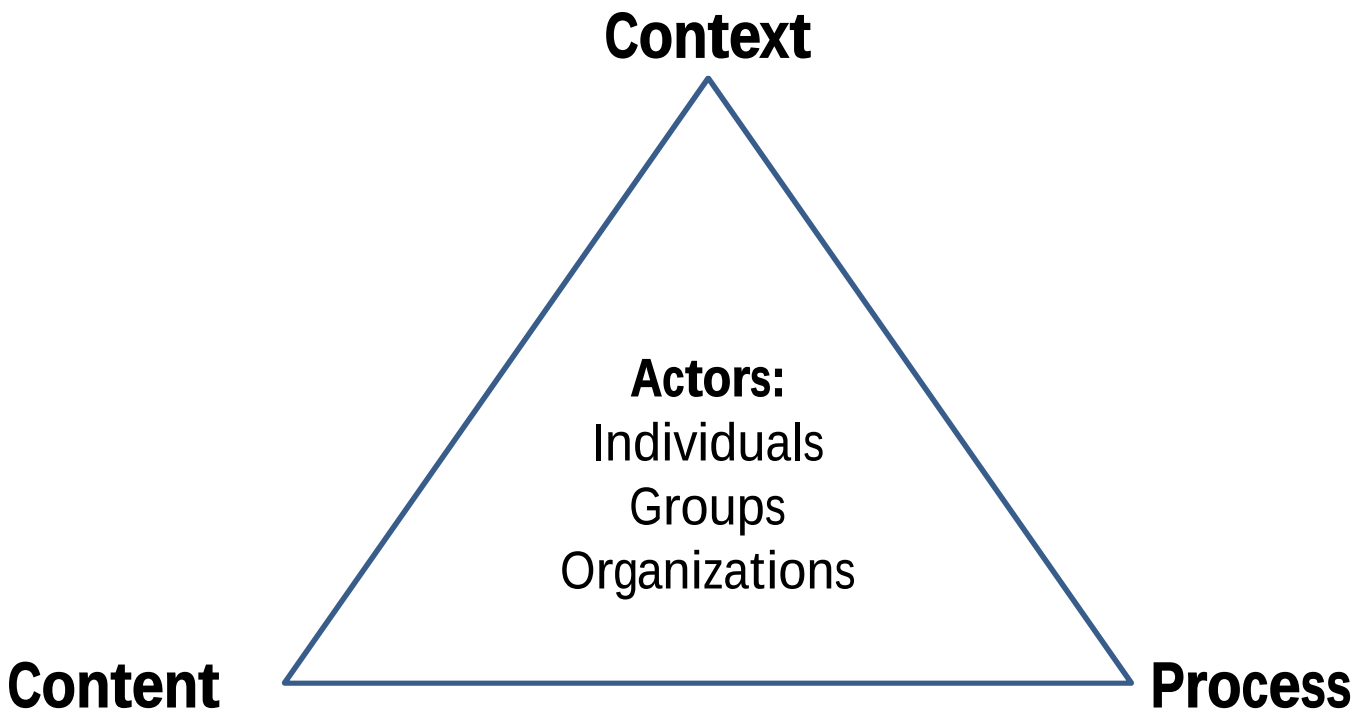
THE TRIANGLE OF POLICY ANALYSIS



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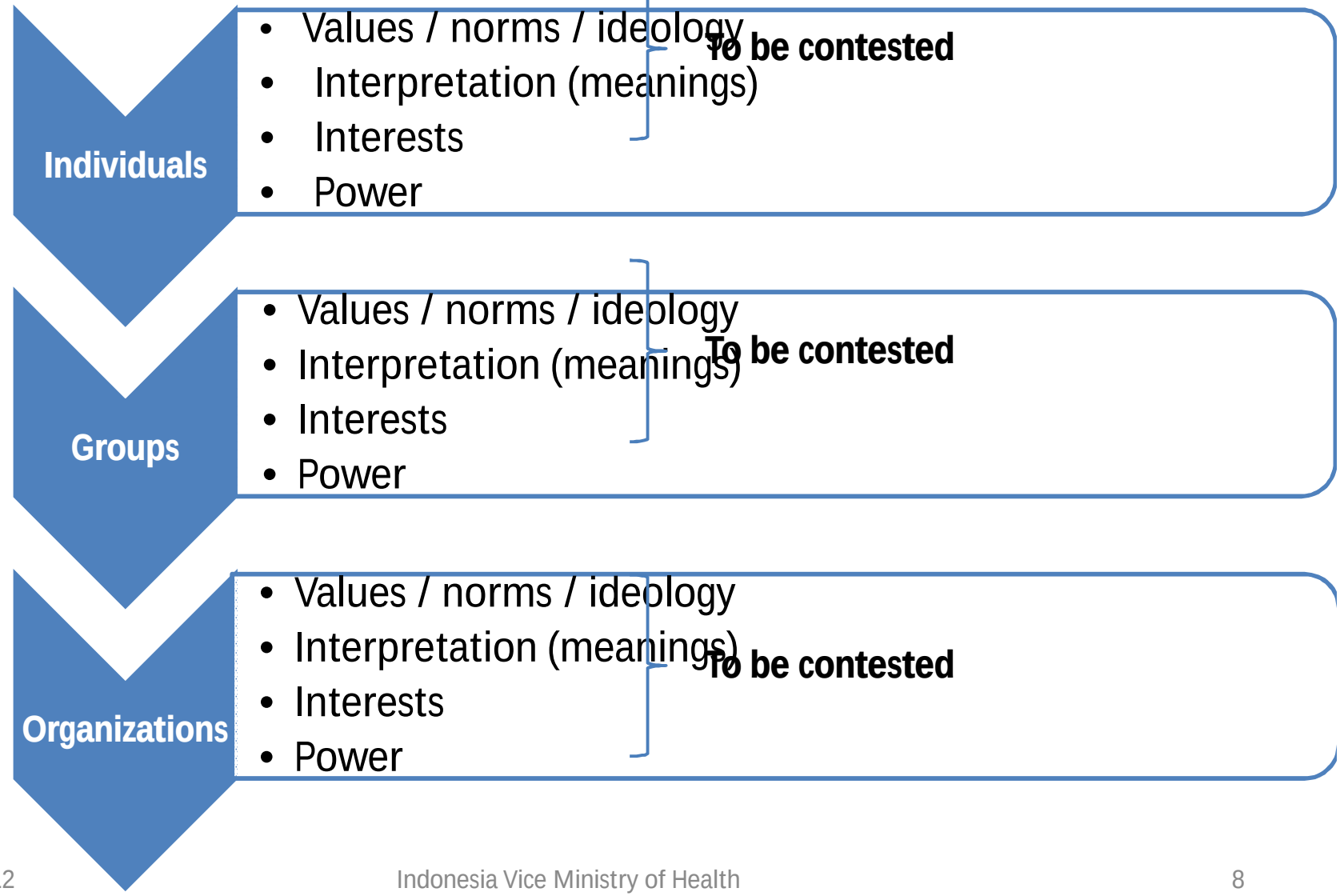
Policy actors



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Policy contexts

- Environmental factors: the environments that policy process take place, e.g. Decentralized systen, democratization, urgency (emergency), political interests, etc
- Structural factors: social structure that influence policy process, e.g. Education levels, economic status, health system structure (formal health system, indigenous health system)
- Cultural factors: cultural factors that influence policy process, e.g. Paternalistic culture, ideology, religious norms and values, community values and norms
- International factors: global commitment (MDGs), WHO (WHA) declaration and commitment, UN commitment, etc

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2. POLICY PROCESS

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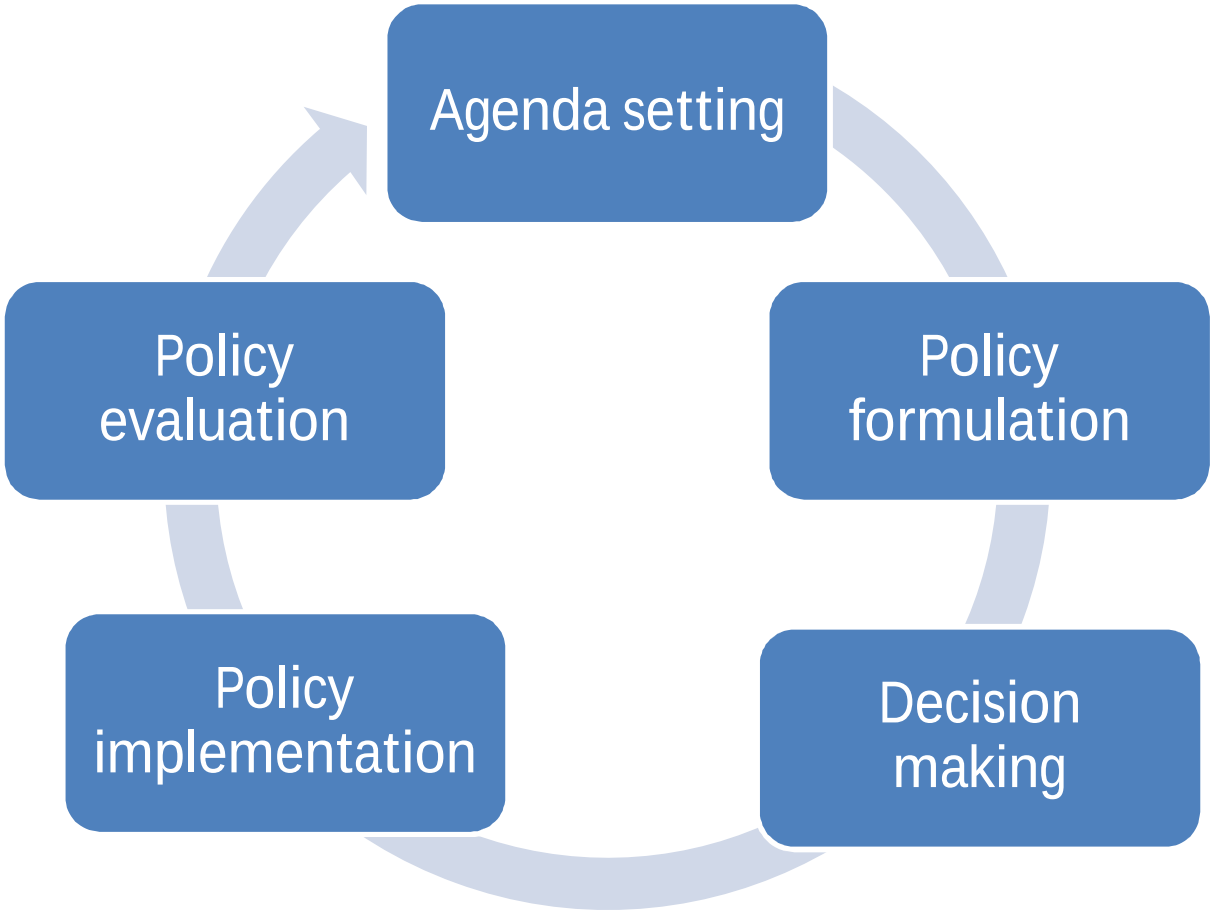
Policy process



In each step inherent with political process: negotiation, bargaining, collaborating, compromising

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Policy Contents

The policy content is the result of resultante from:

- Policy actors (different values, norms, meanings, interests)
- Policy context (environmental pressure)
- Policy processes (complicated process)

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2. POLICY MAKING MODELS

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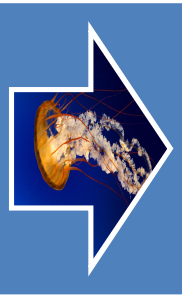
Policy Making Models

Example:



Rational model

Incrementalist model

Networking model

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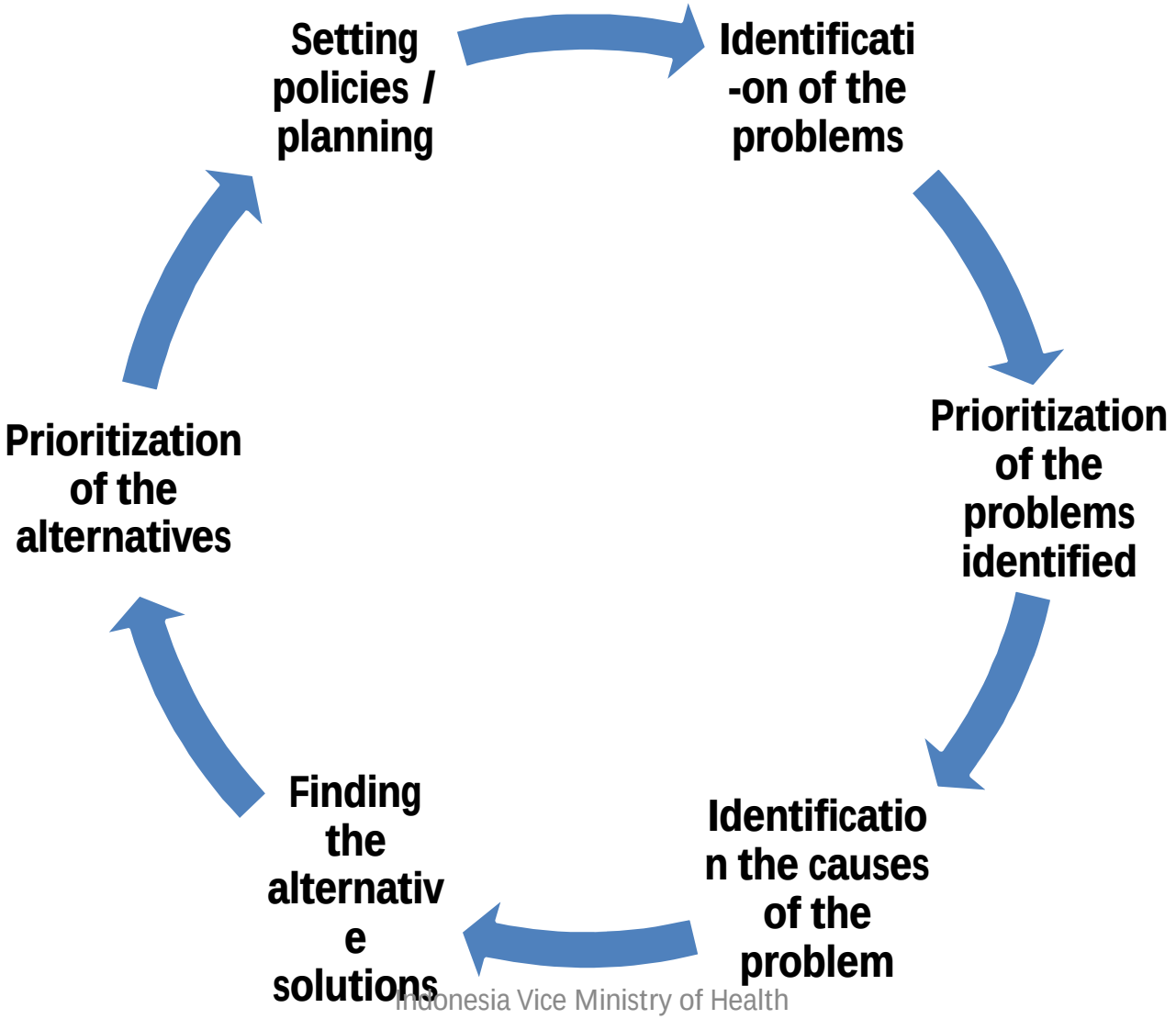
Rational model of policy making (Simon)



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Incrementalist model (Lindblom)

- The science of muddling through (gradualism)
- Why muddling through?
  - Limited rationality (decision made not in vacum situation → many actors, existing policies, ect)
  - Action made from branch (method of successive limited comparisons)
  - Pluralist system of organization
  - Limited budget
  - Goal of policy → satisficing rather than maximizing
  - In simple word: *think big, start small, act now*

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Networking model

- Decision is made by “social network’ amongst the actors
- Why networking model?
  - Decision making in policy process basically politic process
  - It is about actors, what are their interests, motives, norms, values, etc.
  - The process of politics: influencing, negotiating, compromising, bargaining, etc.
  - The process could be informal discourse (lobby, etc) as well as formal meeting

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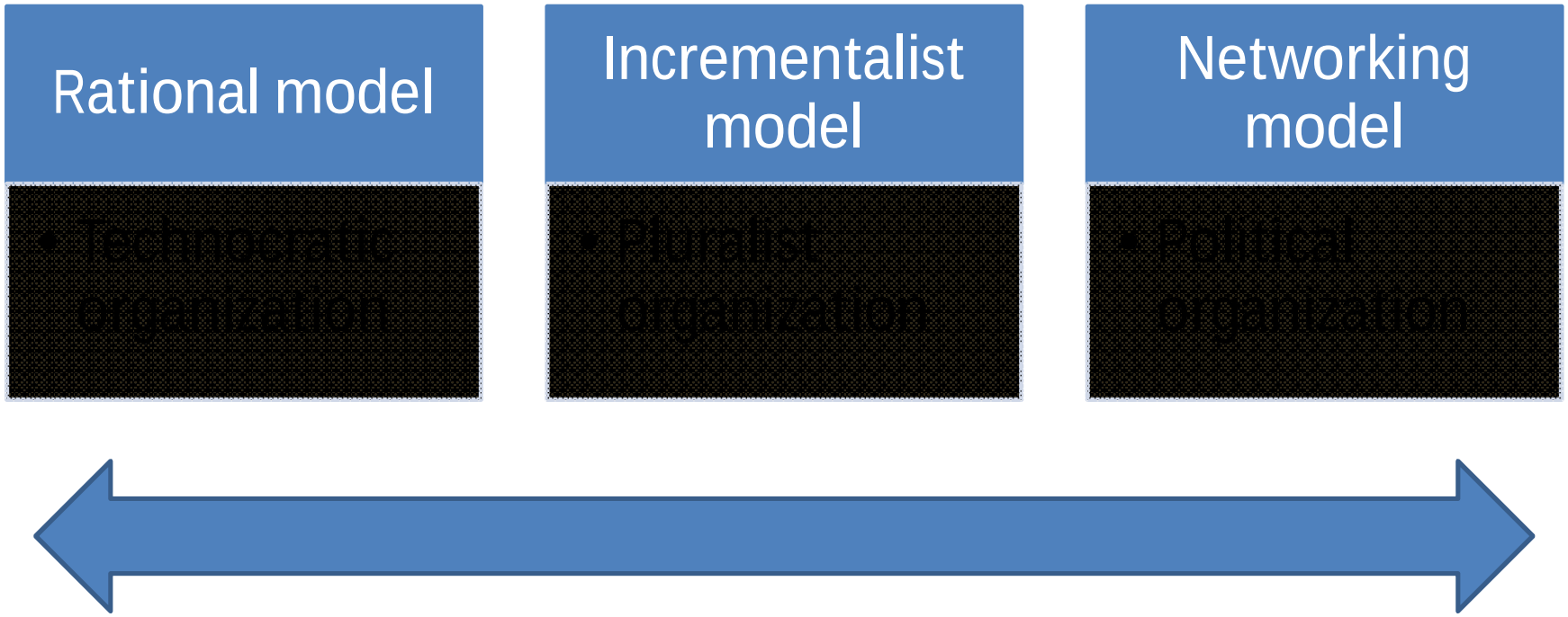
Contingency model of policy making



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4.THE ROLE OF EVIDENCE IN POLICY MAKING

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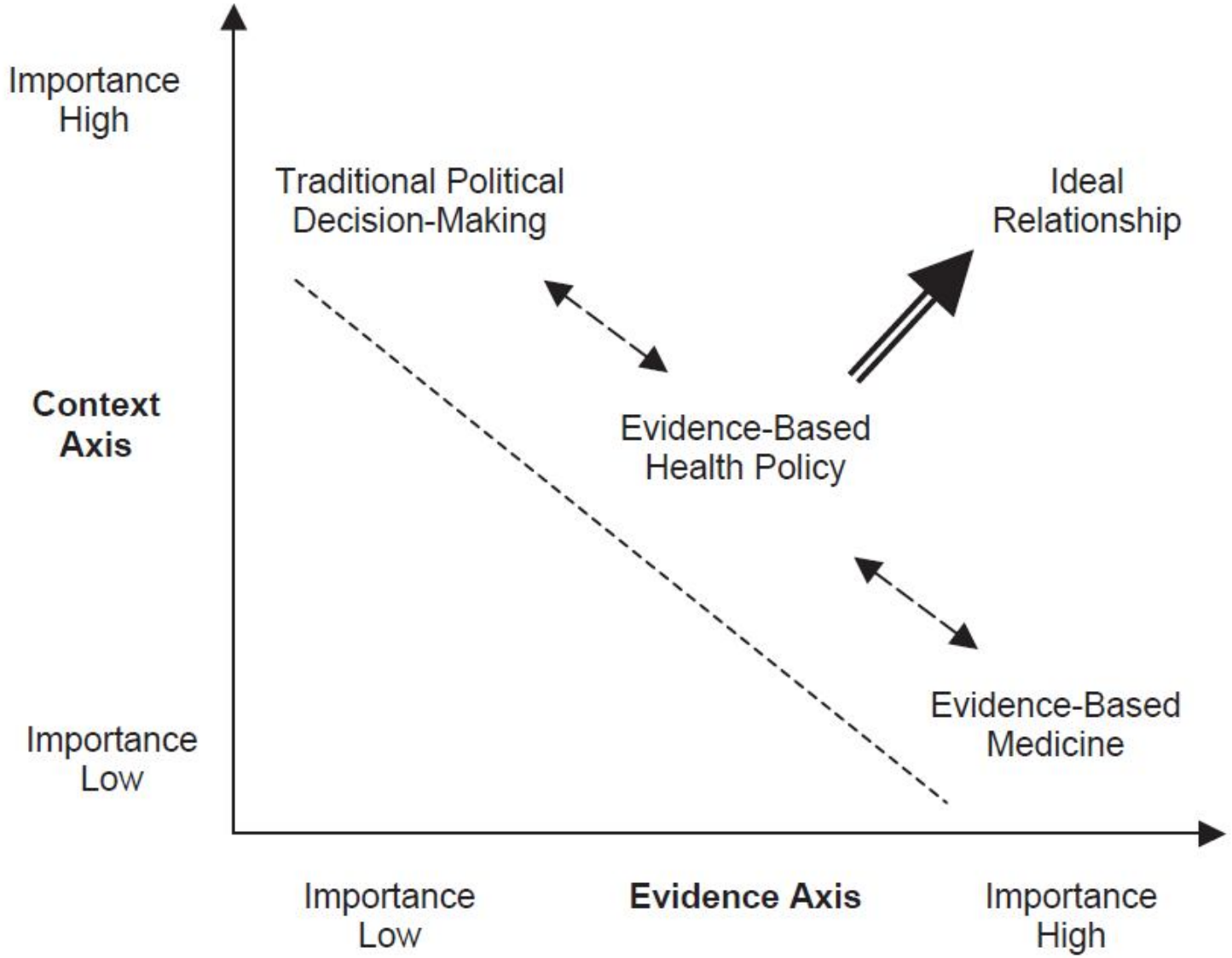

Fig. 1. Axes of evidence-based decision-making.

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Research Utilisation Models (Hanney, S.R.)

- Classic/knowledge driven model: Research → action (Researchers → Users)
- Problem solving / policy driven model: Customer → Problem → Research → action (Users → Researchers)
- Social interaction model: Researchers ↔ Users
- Enlightment model: gradual sedimentation of insight, theories, and concepts.
- Political model: research findings used as "ammunition".

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BOX 2.1 THE 'TWO COMMUNITIES' MODEL OF RESEARCHERS AND POLICY-MAKERS

	University researchers	Government officials
Work	Discrete, planned research projects using explicit, scientific methods designed to produce unambiguous, generalizable results	Continuous flow of many different tasks involving compromise between interests and goals
Attitudes to research	Research justified by its contribution to knowledge base	Research only one of many inputs; justified by its relevance
Accountability	To scientific peers primarily, but also to research sponsors	To politicians primarily, but also the public, indirectly
Priorities	Expansion of research opportunities and influence of experts in the world	Maintaining a system of 'good governance'
Rewards	Built largely on publication in peer reviewed journals	Built on successful management of complex political processes
Training and knowledge base	High level of training, usually specialized within a single discipline	Often, though not always, generalists; expected to be flexible
Organizational constraints	Relatively few (except resources); high level of discretion e.g. in choice of research focus	Embedded in large, inter-dependent bureaucracies and working within political limits
Values	Independence of thought and action highly valued; belief in unbiased search for generalizable knowledge	Oriented to providing high quality advice, but attuned to a particular context

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Figure 3.3 The HPSR and health policy world as perceived 20 years ago

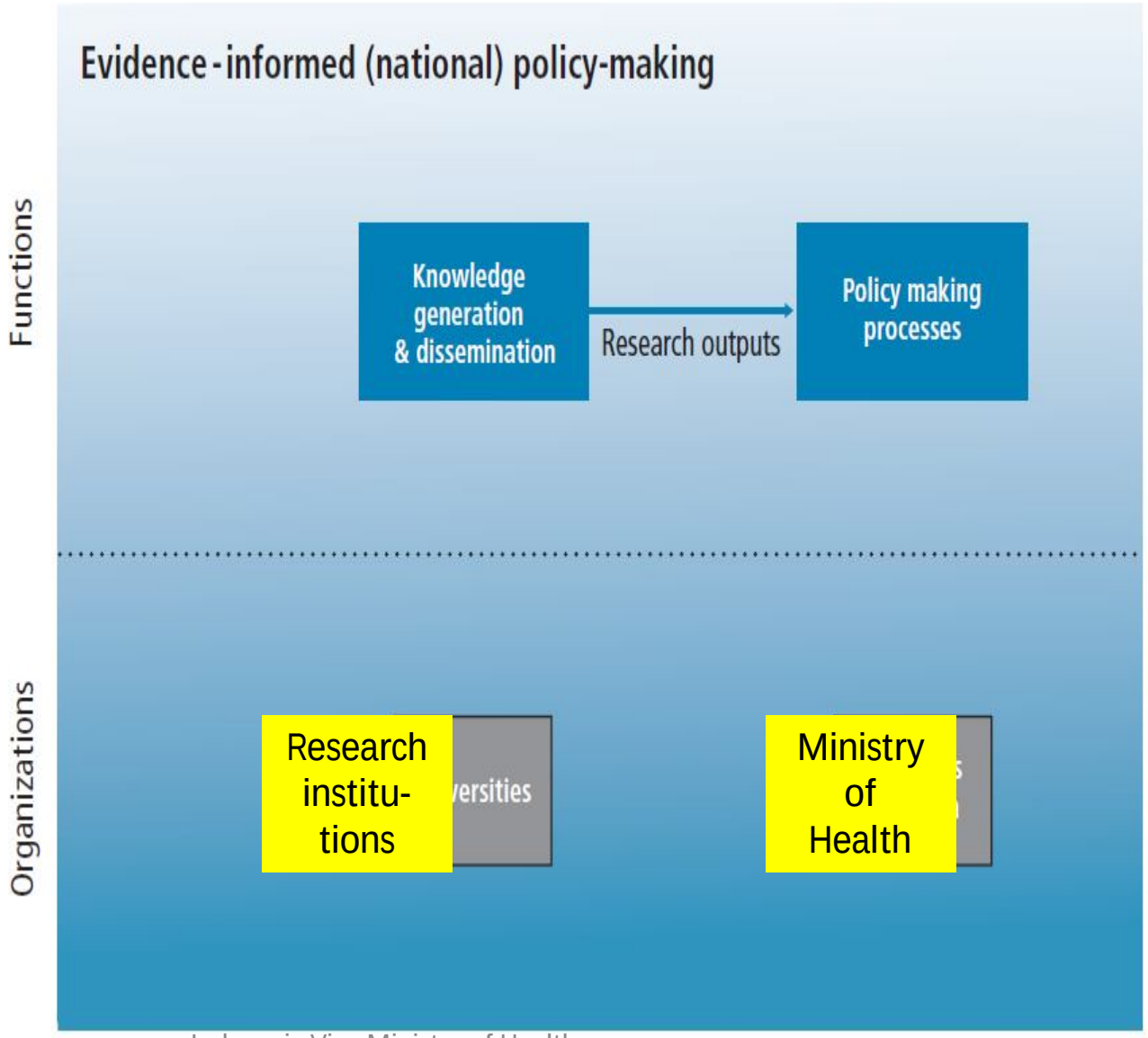

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Figure 3.4 Influences on health policy processes

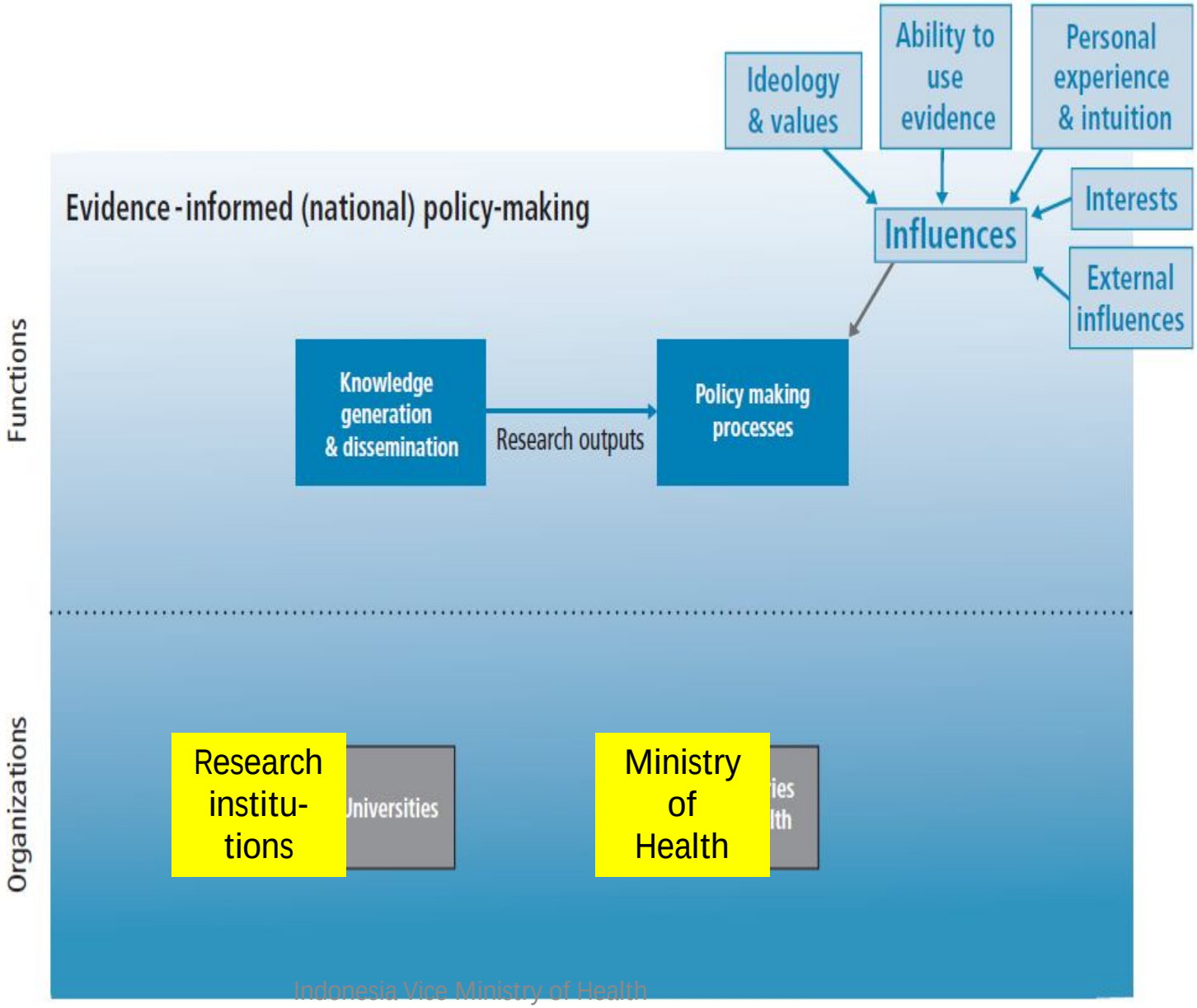

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Figure 3.5 The critical functions for evidence-informed policy-making

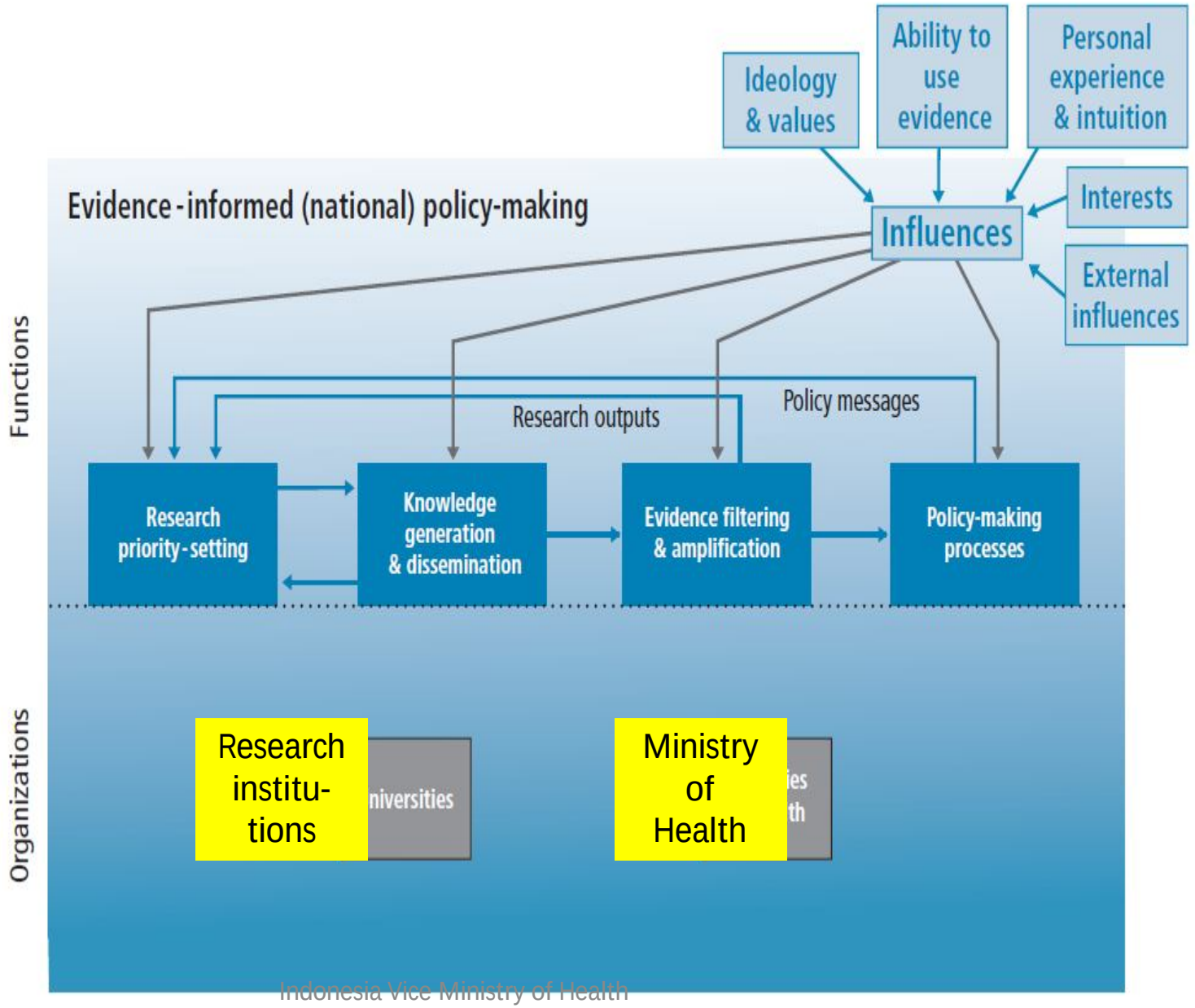

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Figure 3.6 Capacity for evidence-informed policy-making: The organizational level

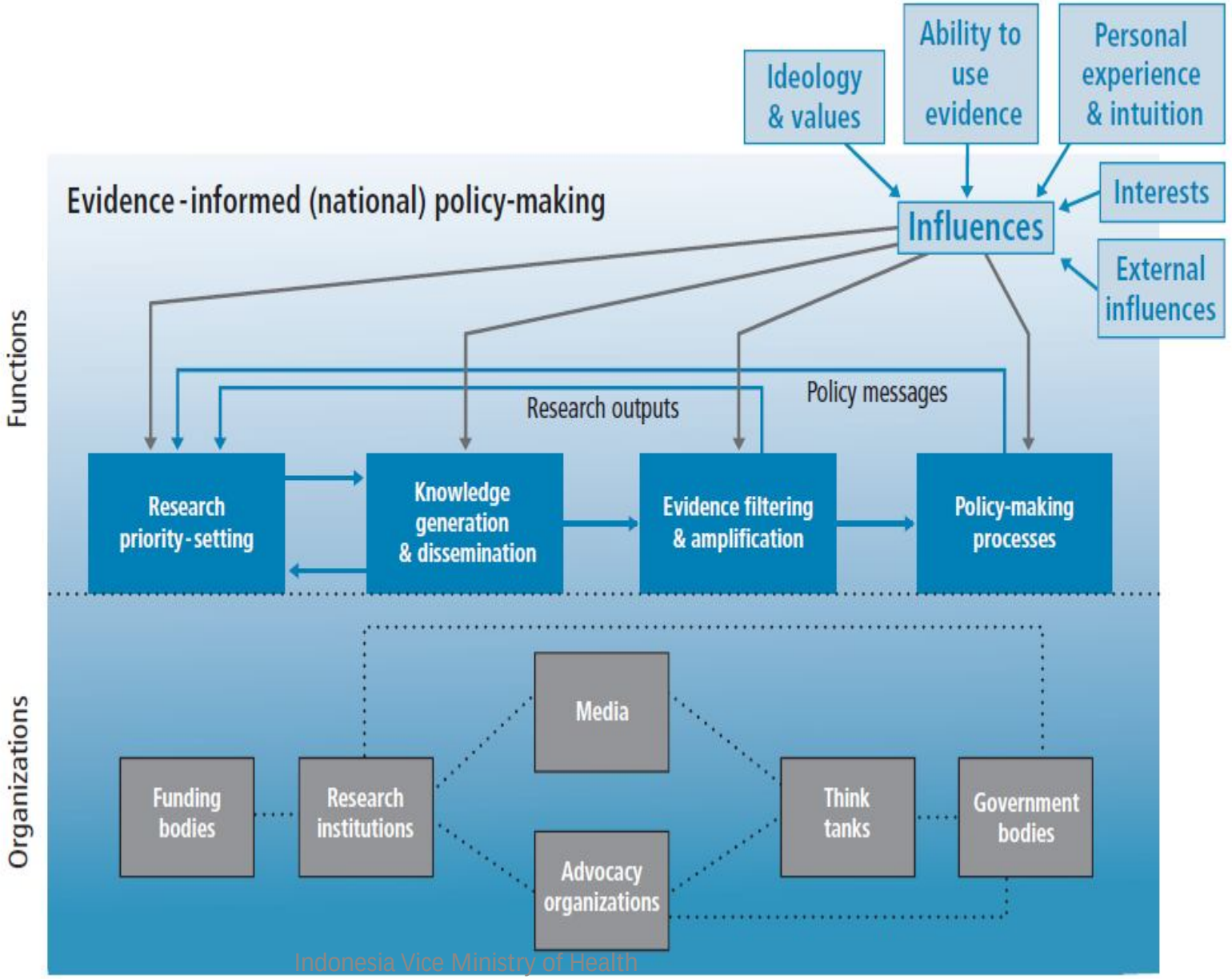

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Figure 3.7 Organizational capacity

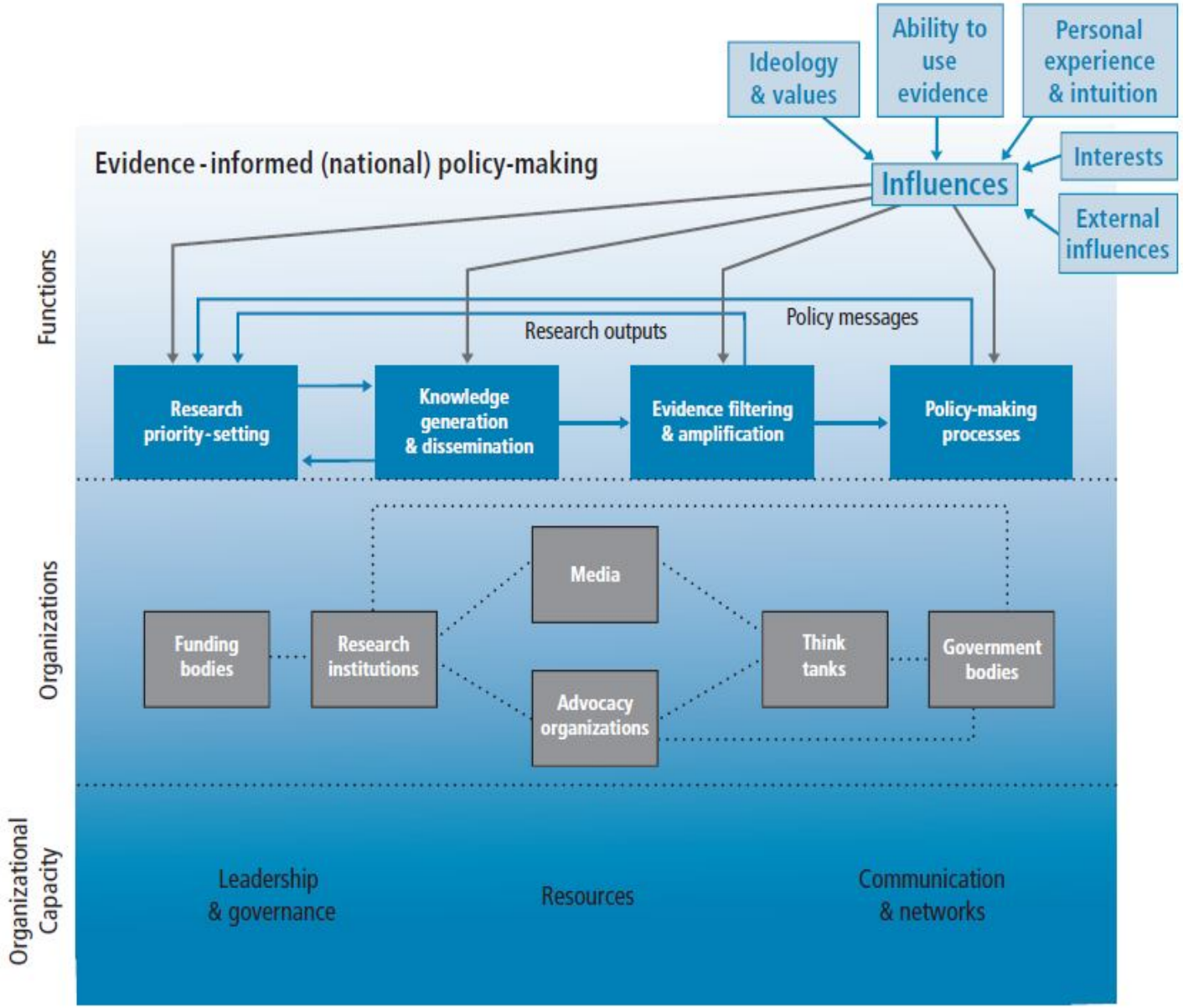

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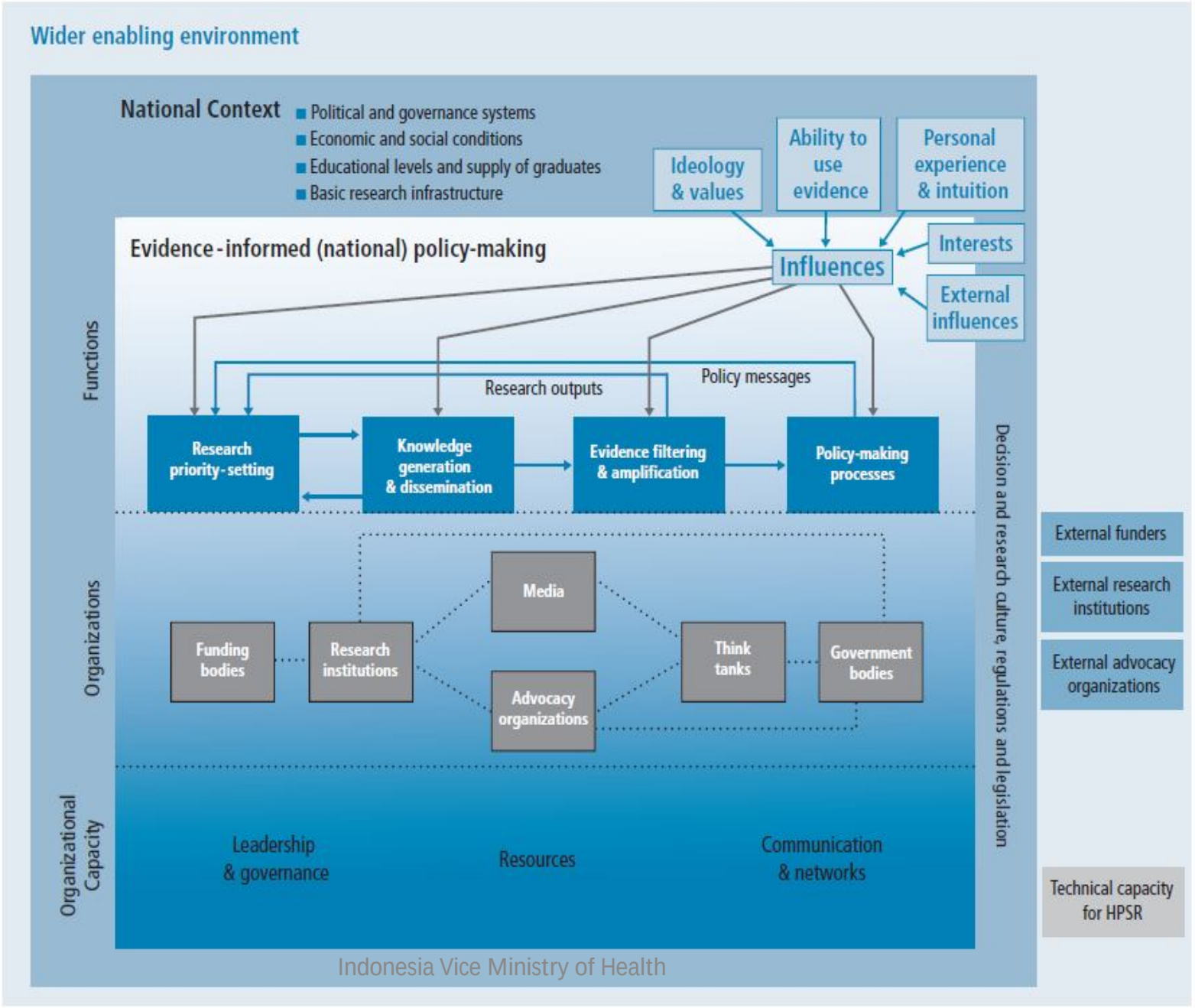
Figure 3.8 Final conceptual framework of evidence-informed health policy-making



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5. A CASE STUDY OF POLICY MAKING IN INDONESIA

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5A. A CASE STUDY OF BPJS ACT

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A case study, Act No 40 Year 2004 about BPJS (1)

- Who were the actors involved?
  - Legislative (DPR RI): Pansus BPJS
  - Executive: Kemkes, Kemkeu, Bappenas, Menko Kesra, Kemensos, Kemenakertrans, BUMN, Kumhan, Kemenhan, TNI, POLRI
  - Asuransi : Askes, Jamsostek, Asabri, Taspen
  - Consultants: Universities
  - NGO: KAJS,stc
  - Etc

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A case study, Act No 40 Year 2004 about BPJS (2)

- How was the context?
  - Ruling party: Demokrat
  - Decentralization euphoria?
  - Socialism paradigm vs free market paradigm?
  - Consultants: Universities

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Process of Act No 40 Year 2004 about BPJS

National legislation agenda (Prolegnas)

↓

Act draft (Naskah akademik UU) (initiative from Legislative)

↓

Discuss and debate in Legislative (DPR) (long period 15 months)

↓

Determination by Legislative and Executive; 25 Nov 2011

↓

Implementation?? 1 January 2014

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Content of Act No 40 Year 2004 about BPJS

What are to regulate??

- BPJS as an Executing Agency d to implement SJSN
  - BPJS Kesehatan (Health)
  - BPJS Ketenagakerjaan (Old Age, Accident coverage; Life ; Pension)

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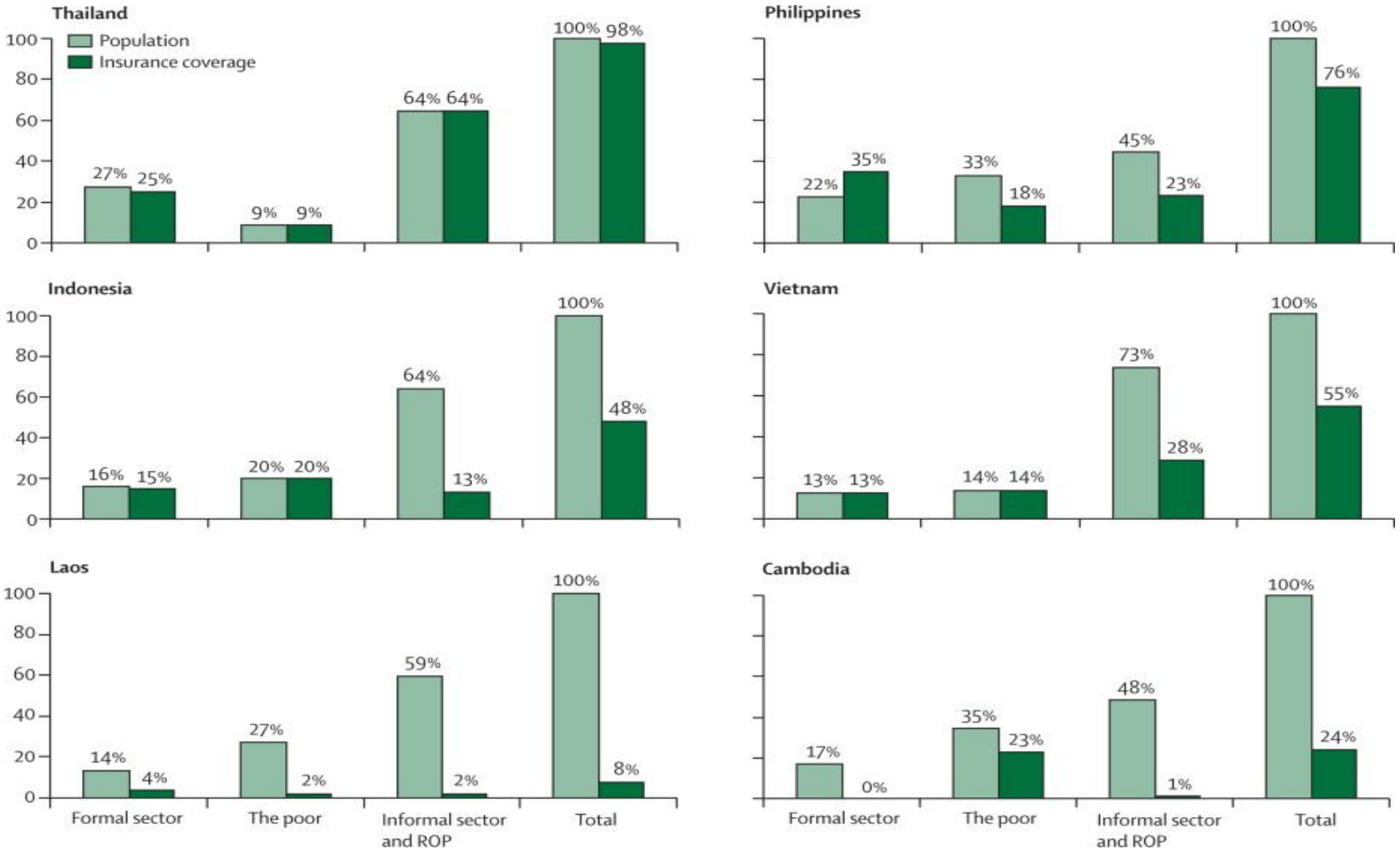
A case of Act No 40 Year 2004 about BPJS

- How was the characteristic of the actors?
- How was the context of policy process?
- How was the process of policy making?
  - Rational model?
  - Incrementalist?
  - Networking model?



Insurance coverage for three population groups in 2009
Malaysia is not included because it has 100% coverage. In the Philippines, the formal sector covered by PhilHealth (35%) includes public and private employees and their spouse and dependants, whereas the target population (22%) from the International Labour Office statistics covers only the public and private sector employees. Data from webappendix pp 2–3. ROP=rest of population.

Source:
http://www.thelancet.com/journals/lancet/article/PIIS0140673610618909/images?imageId=gr1&sectionType=green&hasDownloadImagesLink=true

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International Comparison on Health Expenditure

	THE (% GDP)	GGHE (% THE)*	Private health expenditure (% of THE)*	GGHE (% government expenditure)	External (% of THE)	SHI (% THE)	Out-of-pocket (% THE)	THE (per capita US$)	THE (per capita PPP int$)
Malaysia	4·4	44·4	55·6	6·9	0·0	0·4	40·7	307·2	604·4
Thailand	3·7	73·2	26·8	13·1	0·3	7·1	19·2	136·5	285·7
Philippines	3·9	34·7	65·3	6·7	1·3	7·7	54·7	62·6	130·2
Indonesia	2·2	54·5	45·5	6·2	1·7	8·7	30·1	41·8	81·0
Vietnam	7·1	39·3	60·7	8·7	1·6	12·7	54·8	58·3	182·7
Laos	4·0	18·9	81·1	3·7	14·5	2·3	61·7	26·9	83·9
Cambodia	5·9	29·0	71·0	11·2	16·4	0·0	60·1	36·8	108·1
Low income	5·3	41·9	58·1	8·7	17·5	4·6	48·3	26·8	67·0
Lower middle income	4·3	42·4	57·6	7·9	1·0	15·8	52·1	80·2	181·0
Upper middle income	6·4	55·2	44·8	9·4	0·2	21·0	30·9	487·9	757·0
High income	11·2	61·3	38·7	17·2	0·0	25·6	14·0	4405·2	4145·0
Global	9·7	59·6	40·4	15·4	0·2	24·6	17·7	802·3	862·5

Data from the World Health Statistics, 2010.13 In accordance with National Health Accounts conventions, external finance is included within government and private shares (which sum to 100%). Private health expenditure includes out-of-pocket payments, private social insurance, and other private insurance. International dollars are used when comparing across countries. US dollars are used when looking specifically in one country. THE=total health expenditure. GGHE=general government health expenditure. SHI=social health insurance. PPP=purchasing power parity. int$=international dollar. NA=not available.

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5B. A CASE STUDY OF DBK POLICY

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A case study:
Daerah Bermasalah Kesehatan (DBK) Policy (1)

- Who are the actors involved?
  - Kepala Badan Litbangkes
  - Peneliti Badan Litbangkes
  - Eselon I Kemkes RI (Ditjen)
  - Eselon II Kemkes RI (Direktur)
  - Ka Dinkes Provinsi
  - Ka Bappeda Provinsi

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A case study: Daerah Bermasalah Kesehatan (DBK) Policy (2)

- What is the context?
  - Momen pengembangan “evidence based public policy making”
  - Dukungan pimpinan puncak di Kemkes (the Ministers was a researcher?)

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A case study: Daerah Bermasalah Kesehatan (DBK) Policy (3)

- How is the process?
  - Basic Health Research (Riskesdas) → composite indicators → IPKM (public health development indicators) → disparity across districts / municipals in Indonesia
  - Setting "cut-off value" for districts / municipals with health problems
  - Districts / municipals below cut-off values be advocated to get DBK project
  - Transfer of money goes directly to health centers

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A case study: Daerah Bermasalah Kesehatan (DBK) Policy (4)

- What is the content?
  - Funding is channeled directly to Health Centers (earmarked) for primary health care services in Districts / municipals with Public Health Development Index (IPKM) under cut-off point.

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A case of DBK Policy

- How was the characteristic of the actors?
- How was the context of policy process?
- How was the process of policy making?
  - Rational model?
  - Incrementalist?
  - Networking model?
  - Garbage can model?

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6. CONCLUSION

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Conclusion

- Policy process is a complicated process which needs understanding the disciplines of management, economy, social, and political sciences
- The appropriate model is situational, dependent on the contexts and actors
- Evidence from research results should be advocated in policy process, with the recognition of the spectrum of the process from “rational “to “garbage can” model
- To improve the utilization of research results into policy, bridging researchers and policy makers is crucial (working together for both parties)

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Vice Ministry of Indonesia MoH
"Developing Influential Think Tanks: What Does It Take To Be One?"

Thank you
Terima Kasih

Indikator Bobot 5 (MDGs)

Variabel	Bobot
Prev. balita gizi buruk dan kurang	5
Prev. balita sangat pendek & pendek	5
Prev. balita sangat kurus dan kurus	5
Akses air bersih	5
Akses sanitasi	5
Cakupan persalinan oleh nakes	5
Cakupan pemeriksaan neonatal-1	5
Cakupan imunisasi lengkap	5
Cakupan penimbangan balita	5

Indikator Yang Masuk

Variabel	Bobot
Prev. balita gizi buruk dan kurang	5
Prev. balita sangat pendek & pendek	5
Prev. balita sangat kurus dan kurus	5
Prevalensi balita gemuk	4
Prevalensi diare	4
Prevalensi pnemonia	4
Prevalensi hipertensi	4
Prevalensi gangguan mental	3
Prevalensi asma	3
Prevalensi penyakit gigi dan mulut	3