

## POLICY REPORT

# Health worker recruitment and deployment in remote areas of Indonesia

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## ABSTRACT

**Context:** Providing health care in remote and very remote areas has long been a major concern in Indonesia. In order to improve access to quality health care for residents in these areas, various policies on recruitment and deployment of health workers have been implemented, among them compulsory service, contracted staff and the Special Assignment of strategic health workers.

**Issue:** Indonesia's difficult geography presents great challenges to health service delivery and most health workers prefer to serve in urban areas, resulting in an uneven distribution of health workers and shortages in remote areas. Great efforts have been made to mobilize health human resources more equitably, including placement schemes for strategic health workers and contracted staff, combined with an incentive scheme. While these have partially addressed the severe shortage of health workers in remote areas, current government policies were reviewed in order to clarify the current situation in Indonesia.

**Lessons learned:** The Contracted Staff and Special Assignment of Strategic Health Workers programs show have made a significant contribution to improving the availability of health workers in Indonesia's remote areas. As these two programs used financial incentives as the main intervention, other non-financial interventions should also be trialed. For example, incentives such as the promise of a civil servant appointment or the provision of continuing professional education, as well as the recruitment of rural-background health workers may increase the willingness of health staff to serve in the remote and very remote areas of Indonesia.

**Key words:** health policy, health worker, Indonesia, very remote areas.

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## Context

The quality, composition, and distribution of a health workforce is widely recognized as a crucial determinant of health system performance<sup>1</sup>. Committed and qualified health workers are needed to deliver services to meet the needs of a community<sup>2</sup>. The most challenging element of health workforce provision internationally is ensuring that rural and remote populations have access to trained health workers<sup>3</sup>, and Indonesia is no exception, especially in regard to meeting the health needs of those who live in remote and very remote areas.

In 2006, WHO reported that Indonesia was among 57 countries suffering a critical shortage of health workers (doctors, nurses and midwives), with a health workforce ratio of less than 2.5 per 1000 population<sup>1</sup>. A study conducted by Indonesia's Ministry of Health (MOH) in 2006 found that more than 50% of community health centers in remote areas were without medical doctors, compared with approximately 10% in non-remote areas. This pattern is similar for other health personnel types<sup>4</sup>.

Indonesia's vast size and difficult geography presents a tremendous challenge to those concerned with health service delivery. For instance, it is difficult to place doctors on remote islands or in mountainous or forest locations<sup>5</sup>, and rural and remote areas suffer from a shortage of all essential health workers (ie doctors, midwives, nurses, nutritionists and sanitarians [tertiary educated environmental health officers]). Of those health workers willing to serve in such areas, generally their period of service is very short term. The reasons for this include communication difficulties, lack of basic and social facilities, low salary, low or no compensation, high living costs, lack of security and unclear career options<sup>6</sup>.

According to Indonesia's *Ministry of Health Decree No. 949 of 2007*, there are two degrees of remoteness, namely remote areas and very remote areas, and this division is based on

geographical position, access to transportation and the social economy (Table 1)<sup>7</sup>.

## Issues

The Indonesian Government has implemented policies to support the recruitment and deployment health workers in rural and remote. These include compulsory service, contracted staff and Special Assignment.

### *Compulsory service*

According to *Law No. 8 of 1961*, all university graduates including health workers are obliged to serve at least 3 years in government facilities<sup>8</sup>. This was followed by *Government Regulation No. 1 of 1988*, which required doctors and dentists to work in private or government health facilities, a university or the military for a minimum of 5 years to complete their compulsory service<sup>8</sup>. *President Instruction No. 5 of 1974* supported this policy by employing health workers to work compulsorily as civil servants<sup>9</sup>.

The MOH was given the authority to determine health workers' placement location and this program was controversial because it was considered an infringement of human rights as it offered an unattractive income, unattractive location and long waiting times for deployment, especially to more favored areas<sup>10</sup>, for example locations where remuneration was higher and there was a lower level of civil conflict. In addition, the number of civil service postings, popular with doctors and dentists were limited, and there was a long waiting time for placement.

With the proclamation of *Law No. 13 of 2003*, compulsory service no longer applied<sup>11</sup>. This meant greater freedom for health professionals to choose their career or work location, and few are willing to serve in remote districts. As a result, many less favored districts now suffer shortages of certain health professionals.



**Table 1: Differences between remote and very remote areas<sup>7</sup>**

Criteria	Remote areas	Very remote areas
Geographical position	<ul style="list-style-type: none"> <li>• Difficult to reach areas</li> <li>• Mountains, inland, and swamps</li> <li>• Prone to natural disasters such as earthquakes, landslides, and volcanoes</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to reach areas</li> <li>• Mountains, inland, and swamps</li> <li>• Small island, coastal areas</li> <li>• Border regions with other countries, such as land, small island or outermost island</li> </ul>
Access to transport	<ul style="list-style-type: none"> <li>• Public transport use (land/water/air) routinely, maximum twice a week</li> <li>• The travel time (round trip) &gt;6 hours</li> </ul>	<ul style="list-style-type: none"> <li>• Public transport use (land/water/air) routinely, maximum once a week</li> <li>• Travel time (round trip) &gt; 8 hours</li> <li>• Only air transport available to reach the site</li> <li>• Transport system hindered by climate or weather condition (eg wave height or typhoons)</li> <li>• No public transport</li> </ul>
Social economy	<ul style="list-style-type: none"> <li>• Difficult to meet basic needs</li> <li>• Security issue</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to meet basic needs</li> <li>• Security issue</li> </ul>

## Contracted staff

The ability of the government to recruit health workers as civil servants was limited, and an attempt to redress this resulted in *President Decree No. 37 of 1991*, which marked the implementation of a new policy 'Contracted staff' or *Pegawai Tidak Tetap* (PTT)<sup>12</sup>. Under this policy, doctors and dentists were obliged to work as temporary staff on a contract basis for a certain period. Coinciding with this was a similar scheme where the government assigned midwives to rural areas through the Village Midwife Program<sup>10</sup>.

Under the PTT policy, doctors, dentist and midwives served for a minimum 6 months and up to 3 years, depending on the location criteria. The contract could be renewed twice<sup>13</sup>. Under this program, PTTs who served in remote areas were rewarded with increased opportunities to be employed as a civil servant (PNS) and monetary incentives according to their length of service. For example, service in certain remote locations or disaster areas entitled the PTT who completes 1 year of service to be considered to have given 2 years. However doctors could terminate their contract early and many health centers in remote areas still lacked doctors<sup>4</sup>.

To motivate health workers to be deployed to remote and very remote areas willingly, since 2006 the MOH has implemented new policies for PTTs (Table 2)<sup>13</sup>:

1. Offer vacancies only in remote and very remote posts.
2. Shorten the period of service from 2 to 1 year for remote areas and 6 months for very remote areas.
3. Increase financial incentives.

These policies have been applied to all PTT workers in very remote areas, regardless of the level of geographic barriers, availability of support facilities and other factors.

A medical specialist who serves in a very remote area earns 10,350,000 IDR or approximately 1150 USD per month (~1 USD = 9000 IDR; Table 2). A study by the MoH Indonesia in 2007 found the incentive package was moderately satisfactory to PTTs; however, even this did not have a significant impact on their willingness to stay in very remote locations<sup>14</sup>.



**Table 2: Monthly salary and incentive for contracted staff<sup>†5</sup>**

Profession	Salary <sup>†</sup>			Incentive		
	Common <sup>§</sup>	Remote	Very remote	Common	Remote	Very remote
Doctor/dentist	2,050,000	2,050,000	2,050,000	-	3,350,000	5,800,000
Specialist (doctor/dentist)	2,050,000	2,050,000	2,050,000	-	7,850,000	8,300,000
Midwife	1,700,000	1,700,000	-	-	1,700,000	2,700,000

<sup>†</sup>In Indonesian rupiah (IDR; 1 USD = 9000 IDR); <sup>§</sup>'Common area' defined as significantly restricted accessibility to goods, services and opportunities for social interaction.

Data from the MOH in 2005 showed that 536 doctors applied the 55 posts in the West Java Province, resulting in a waiting lists of 481 doctors<sup>16</sup>.

In 2007, mandatory service for PTTs was formally changed by the MOH to voluntary service<sup>10</sup>. This meant that doctors could either join the service as a PTT or choose to have a career in the private sector. However the PTT scheme was still popular among new graduates and despite the voluntary nature of the program, there were still long waiting lists of doctors who had applied for particularly remote and very remote posts. By 2011, 32 978 health workers had actively served as contracted staff (Table 3).

Very remote areas are more popular than remote areas with doctors and dentists due to differing incentives and policies according to the district (Table 2). This has improved the availability of health workers in the health centers and villages particularly in remote areas. In 2010, only 17% of the 9000 very remote health centers were without a doctor, compared with 30% of 8000 health centers in 2006<sup>17</sup>.

However this policy has not addressed retention in these areas because the length of service is relatively short. As there is no bonding to retain doctors in remote areas, they naturally move to large urban areas for economic reasons<sup>17</sup>.

### *Special Assignment*

This need for health workforce in remote and very remote areas was a priority for the Indonesia Government's 2009

National Summit and for the MOH '100 Days' program, the Special Assignment Program for Strategic Health Workers (in addition to the PTT scheme). Those strategic health workers included nurses, sanitarians, nutritionists and other health cadres. The first phase was to ensure the availability of 300 health workers to health centers located in undesirable locations such as remote, underserved, borderlands, areas of conflict and disaster areas<sup>18</sup>.

Health workers who join the Special Assignment Program receive travel expenses and additional incentives<sup>19</sup> for a period of service of a minimum of 3 months and up to 1 year, renewable. The size of the incentive depends on remoteness or region (region I or region II). For instance, for service in region I the amount is 2,700,000 IDR per month and 1,700,000 IDR for region II<sup>18</sup>. The incentives were legislated in the *Ministry of Health Decree No. 1235 of 2007*<sup>20</sup> and *Ministry of Health Decree No. 156 of 2010*<sup>18</sup>.

This program is expected to increase the retention of health workers, because recruitment is conducted at the local level and priority is given to local health workers. However, to increase the attractiveness of the program, opportunities for civil service employment after serving in a Special Assignment area should be embedded in the program. And due to the short term of nature of the contracts (Table 4), recruitment should be continuous to overcome the rapid change in serving health workers.



**Table 3: Contracted staff year 2010<sup>12</sup>**

Profession	Location			Total
	Common <sup>†</sup>	Remote	Very remote	
Doctor	364	676	1980	3020
Dentist	126	119	659	904
Specialist (doctor/dentist)	6	60	20	86
Midwife	17 332	11 636	-	28 968
Total	17 828	12 491	2659	32 978

<sup>†</sup>'Common area' defined as significantly restricted accessibility to goods, services and opportunities for social interaction.

**Table 4: Summary of health workers recruitment and deployment in Indonesia year 2010<sup>15,16</sup>**

Program	Objective	N
Contracted staff	Distributed doctors, dentist and midwives in rural and remote areas Duration: 6 months–3 years	3020 doctors, 904 dentists, 86 specialists, 28 968 midwives
Special assignment	Distributed strategic health workers including nurses, sanitarians, nutritionist and other health cadres Duration: 3 months–1 year	15 doctors, 56 midwives, 210 nurses, 120 other health cadres

## Lessons learned

In conclusion, various policy options have succeeded in improving an unbalanced distribution and shortage of health workers in Indonesia's remote and very remote areas. Most of the targeted programs used financial incentives as the main intervention; however, non-financial interventions should also be included in one comprehensive incentive package to retain these health workers, such as the provision of continuing professional education and eventual opportunities for civil service employment. In addition, as has been found in many other countries, the recruitment of health workers of rural background is likely to increase willingness to serve in remote and very remote areas. Greater responsibility granted to local governments in a decentralized context would seem essential.

Finally, evidence-based data and other detailed information relating to the health workforce is urgently required, as is further research into the impact of Indonesian Government

policies on improving equity of access to health services and health care in rural, remote and very remote Indonesia.

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