

INDONESIA MISSION REPORT

2nd Visit: iDSI Country Pilot Work
22-26 September 2015

This document is for internal use only. This document reports on the 2nd country visit of the HITAP International Unit in Jakarta Indonesia for the purpose of the iDSI country pilot work in Indonesia on 22-26 September 2015

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Background and Objectives

Indonesia was selected as a pilot country for the international Decision Support Initiative (iDSI) demonstration work (see the meeting minutes of the first iDSI steering group meeting convened on June 5, 2014 and the report on The Scoping Visit to Indonesia to Inform the iDSI Steering Committee dated June 30, 2014). Objective 5 (the pilot country demonstration work) under the iDSI aims to provide policymakers with coordinated support in priority setting as a means to achieve Universal Health Coverage (UHC).

The Health Intervention and Technology Assessment Program (HITAP) team visited Jakarta, Indonesia between September 22 - 26, 2014 to learn in-depth about relevant stakeholders, stakeholders' Health Technology Assessment (HTA)-related activities and interests, and potential HTA projects for the demonstration work. Moreover, it is expected that an outcome of this visit would be an intermediate-term plan for the pilot country work.

In addition to the HITAP team, staff from PATH also joined the visit since the iDSI country work links well with the Access and Delivery Partnerships (ADP) project, funded by the government of Japan and managed by UNDP/PATH, in which one of the objectives is to institutionalize HTA agencies in Indonesia. As such, the iDSI and ADP objectives and target countries are the same, leading to synergic collaboration and expected greater impact. Each project will bring its own resources to work in the country.

Activities

- I. Conducted face-to-face interviews and focus group discussions with relevant stakeholders in Indonesia regarding the past and current HTA-related activities, the need for HTA evidence in supporting policy decisions, potential demonstration projects, and potential barriers and supportive factors for the establishment of HTA institutes to support UHC in Indonesia.
- II. Discussed with PATH partners who are working in Indonesia to support HTA institutionalization as part of the ADP project about possible collaborative activities
- III. Developed an intermediate-term plan for iDSI's objective 5 activities in order to obtain agreement from iDSI partners

Findings

National HTA committee

The national HTA committee includes members from multiple departments in the Ministry of Health (MoH) with Professor Sudigdo Sastroasmoro acting as the Chair and the P2JK¹ acting as the Secretariat (see Appendix 1 for the ministerial decree)². The members of the committee informed us that the national HTA committee is required to focus on curative interventions. As a result, its members are clinicians and researchers without participation of public health experts. This may be a limitation for leaders of the MoH because Indonesia is overpopulated and has very limited health resources, in particular health infrastructure and human resources. Therefore, it is unlikely that health problems in Indonesia will be solved by secondary and tertiary care.

Progression since June 2014

Progression by the national HTA committee since the last visit in June 2014 has been slow. Thus far, the activities that they had planned, such as the guidelines and the work which was targeted for the third quarter of this year, have not materialized. From the interviews with members of the committee, it was found that meetings for this committee are not regularly scheduled and thus far there has not been discussion about short- or long-term plans for conducting HTA to support the UHC movement.

With respect to the new government, the elected president will be inaugurated on October 20, 2014 and the appointment of the new cabinet will follow. It is expected that there will be a change of high- level decision makers under the MoH, including that of a government unit related to HTA, for example, the Directorate General of Disease Control and Environmental Health which is now the focal point for HTA under the MoH and the Directorate General of Pharmaceutical Care and Medical Devices (BINFAR) which is responsible for the development of the National Essential Drug List (NEDL).

Nevertheless, from interviews with all stakeholders, UHC policy remains a high priority for the new government because UHC is one of the two policy campaigns of the new president (the other is universal access to education). It is also expected that the government will put emphasis on health promotion and disease prevention because this

¹ Sometimes called PPJK; Center for Health Financing and Insurance

² Note: Professor Sudigdo is the only member in the committee that is not from the MoH

area is in line with the democratic economy (using health and education to drive the economy) policy of the government. Currently, UHC in Indonesia (under the national insurance scheme called JKN, administered by BPJS³), covers approximately 160 million people, which accounts for 67% of the total population and it aims to cover 100% by the year

2019. However, UHC was implemented in urgency due to the political situation at the beginning of 2014 without a clear process or adequate communication between the different organizations that are responsible for implementing UHC.

Potential topics for HTA projects

- Current priority health issues in Indonesia are related to non-communicable diseases (NCD) due to increased life expectancy (aging population) and poor health behaviors of Indonesians. It will be very challenging for the new government to cope with the NCD burden under the UHC policy. One of the potential solutions is integration of disease prevention and health promotion of NCDs at the primary healthcare level as opposed to high-cost treatments at secondary or tertiary hospitals that are geographically scattered and are not easily accessible by the majority of the people who are living in more than 18,000 islands.
 - We learned that there is a forthcoming evaluation on the implementation of a modified Package for Essential Non-communicable (PEN) diseases, which is currently implemented at the primary healthcare level in 34 provinces throughout the country. The original PEN is recommended by the World Health Organization, whereas Indonesia modified the PEN to integrate it with other services, such as thalassemia, at primary healthcare facilities since 2001. The evaluation will be conducted by the MoH, CDC, and WHO from October to December 2014. The plan for assessment will focus on process rather than outcome, impact, and value for money. From discussion with the organizations responsible for this evaluation, they are keen to learn more about the contribution of iDSI/ADP in providing technical support to local staff so that the evaluation can be more comprehensive for future development of the modified PEN project in Indonesia. The potential user of this report is Dr. Ekowati Rahajeng, Director of Non communicable Diseases Control under the Directorate General of Communicable Disease Control and Environmental Health.
- Another potential demonstration project is to provide technical support to develop the pharmaceutical formulary under the UHC. At present, around 30% of the total

government health expenditure is spent on drugs and vaccines. The price of patented drugs in particular is much higher in Indonesia than other countries in the region and generic products are also expensive because the government has policies to support local production.

Discussions with international organizations

The HITAP team also met with staff from the Department of Foreign Affairs and Trade, Australian Embassy Jakarta and the World Bank, Jakarta office. The objective of these discussions was to learn about existing initiatives and pieces of work that we could potentially build on for the pilot project as well as to determine the potential of collaborating with the Country Coordinating Mechanism (CCM). From our discussions, we learned that the CCM Indonesia is not functional and is reacting rather than proactive, and that the CCM is more active in some areas than others (e.g. HIV/AIDS).

The HITAP team visited the World Bank office and discussed with Darren Dorkin (senior health expert based in Jakarta) and Ajay Tandon (health economist based in Washington, D.C.) about the World Bank project in supporting the Indonesian government to develop a health benefit package for UHC. However, this work ended up as supply-side readiness for UHC: assessing the depth of coverage for NCDs in Indonesia. This is because when developing the project, they found very limited resources were available at the peripheral level and had the idea that it would not be possible to develop a comprehensive package without knowing the limitation of supply. The report on supply-side readiness informs that there is a large gap of supply-side capacity and available resources across different types of health facilities and geographical locations. For example, the availability of blood glucose and urine tests in one of the public programs (puskesmas) shows that in Gorontalo province the tests available are less than 10% of the facilities in that province compared to 100% in Yogyakarta. The World Bank team expressed interest in our work, especially on the development of health benefits package guidebook led by CGD. They believe that this can be useful for many LMICs that they are working with. They are also very supportive to our work in Indonesia given that they have very close links with NIHRD. They would be very happy if we could bring NIHRD into our program.

Next steps

In discussion with members of LITBANG (National Institute of Health Research and Development), which is a member of the HTA committee, Dr. Siswanto, the Director of the Center for Applied Health Technology and Clinical Epidemiology under LITBANG, expressed a

willingness to conduct an HTA pilot project with iDSI/ADP, but strongly advised that the selection of the topic must be made by P2JK. In addition, Dr. Siswanto suggested a structure for the next workshop in Indonesia: practical experiences of HTA on the first day and HTA methodology for the selected topic on the second day. He proposed that the workshop participants should be members of the HTA committee as well as researchers who would be involved in conducting the HTA. He recommended holding the workshop in the early weeks of January 2015³.

Nonetheless, discussion with the PATH team led to the agreement that primary HTA work should be conducted without delay. This primary HTA work aims to involve the HTA committee and empower them by demonstrating the scope and features of HTA work as well as potential applications of HTA in policy. Three options were discussed, with advantages and disadvantages for each:

1. Find a research project that is ongoing and introduce HTA within that project, then use the results of the project in the committee
2. PATH funds primary work as requested by the HTA commission, including hiring full-time staff for the committee who are good in technical aspects, while the policy aspects remain under the guidance of the committee - the disadvantage is the likely unsustainability of the technical staff
3. Convince and fund a unit like LITBANG to do technical work for the committee (must be staff of the MoH) who they will have no role in the selection of topics and this ensures that capacity will be retained, but the sustainability of the link between LITBANG and the committee cannot be guaranteed

iDSI has limitations in the case of options 2 and 3, rendering option 1 the most feasible; however, the involvement of PATH and the ADP opens up opportunities for the latter two options. The PATH and HITAP teams agreed that options would be explored for the best way forward while maintaining good relations with the HTA committee.

Discussion

If we are not proactive in conducting the demonstration project and we rely on the national HTA committee to make a move, we will most likely be unable to see an impact during the timeline of the iDSI. It is possible to work in parallel, providing support to the national HTA committee and technical support to alternate partners through hands-on support on

³ The HITAP team has blocked out the week beginning January 12, 2015 for the workshop and will propose this week to the committee

selected projects. The national HTA committee members still need to obtain a better understanding of policy implications of HTA in supporting UHC before making a move. The committee requested for another in-depth discussion with HITAP and other HTA agencies in the region in order to learn more about good practices and experiences of HTA processes in support of UHC.

Meanwhile, the national HTA committee has little potential to undertake primary HTA work because it is not the intention of the committee or its Secretariat (PPJK) and the members are all part-time. According to the decree, an ad hoc Panel Team (consisting of assigned clinical experts from various disciplines) will be appointed for each priority topic and it remains unclear who will conduct primary work and how it will be conducted if the Panel Team is neither full-time nor part-time.

Since we cannot expect the HTA committee to determine priority topics and develop a Panel Team in the near future, it is better for iDSI to work with partners that can provide technical support to the ad hoc Panel Team and HTA committee through a selective demonstration project. This project aims to develop technical capacity for local partners and also create a policy link so that it will be a good lesson learned for the partners as well as others to use HTA to support UHC.

At the end of the visit, it was agreed that we would consult with Professor Sudigdo and Dr. Donald

Pardede, the head of P2JK, the following week regarding the plan for the HTA workshop in January 2015 as well as the priority topics for conducting HTA. As of submission of this report, we have not received feedback from them.

Recommendations

- Maintain a working relationship and good collaboration with the national HTA committee with a plan for another 1-2 day meeting for in-depth discussions with its members who are keen to learn about good practices of HTA processes. This in-depth discussion will take place on the request of the national HTA committee, but is unlikely to occur during the first week of November because some key members are unavailable.
- The demonstration project will begin by the end of this year or at the latest by early next year.
 - HITAP recommends the evaluation of the modified PEN as the demonstration project, but this needs to be agreed on by the P2JK. PATH will consult with their partners about the aforementioned options and the feasibility of each option in implementation. The potential local partners that would work on the additional HTA components of the evaluation, which will be proposed in the future and conducted in collaboration with NICE International, PATH, and HITAP staff, is LITBANG (given that the P2JK agree). This work will start with close collaboration with the MoH and WHO evaluation team that will begin the work (development of the evaluation protocol) in October 2014. Meanwhile, HITAP would provide training to local partners about HTA on PEN by the end of this year or early next year. The HTA work will be carried out until September 2015. The plan of this HTA work should be endorsed by the HTA committee and regular progress reports will be submitted.
- UNDP/PATH has signed a formal agreement with the MoH and we suggest that NICE, on behalf of iDSI, signs a Memorandum of Understanding with the MoH in Indonesia (as well as Vietnam or any other countries in which we will support introduction of HTA institutionalization and capacity building).



Appendices

Appendix 1: Proposed Timeline

Activity ⁴	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	Mar. 2015	Apr. 2015	May 2015	Jun. 2015	Jul. 2015	Aug. 2015	Sep. 2015
In-depth discussion with national HTA committee	Upon request											
Development of the evaluation protocol with MoH and WHO consultants	X											
Technical training on HTA for PEN for local partners		X	X									
Primary data collection			X	X	X	X						
Analysis of data incl. economic model development if needed						X	X	X				
Writing up report									X	X	X	
Stakeholder consultation meeting												X
Reporting back to national HTA committee and other relevant decision makers												X onwards

⁴ Based on integrated PEN evaluation as a demonstration project

Appendix 2. MoH Decree translated by PATH staff

MINISTRY OF HEALTH DECREE NO.171/MENKES/SK/IV/2014 ON HEALTH TECHNOLOGY ASSESSMENT COMMITTEE

THE HTA COMMITTEE consists of The Chairman, Secretary, members, Secretariat Office

The Organization Structure of the Health Technology Assessment Committee

Responsible Officials:

1. Minister of Health
2. Vice of Minister of Health

Steering Committee:

1. General Secretary
2. Directorate General (DG) of Health Effort / Health Management?
3. DG of Pharmaceutical Care and Medical Devices
4. DG of Nutrition and Maternal and Child Health
5. DG of Diseases Control and Environmental Health
6. National Institute Research and Health Development
7. National Institute of Health Human Resources Empowerment and Development
8. Ministry's Expert Staff on Health Technology and Globalization

Chair: Professor Dr. dr. Sudigdo Sastroasmoro, SpA(K)

Secretary: Head of P2J

- Members**
1. Prof.Dr.Dra. Sri Suryawati, Apt
 2. Prof. Iwan Dwiprahasto, .Med,Sc., PhD
 3. Prof.Dr.dr.Rianto Setiabudi, Sp.FK
 4. dr. Santoso Soeroso, Sp.A, MARS
 5. Prof. Dr. dr. Edi R. Rahardjo, Ap.An., KIC
 6. Dr.drg. Mardiati Nadjib, MSc.
 7. Prof. Budi Hidayat, SKM, MPPM., PhD
 8. Director Health Referral Management
 9. Director BIFAR
 10. Director Production and Distribution of Health Devices
 11. Head of Center of Application of Health Technology and Clinical Epidemiology
 12. Head of P2JK

Secretariat

(The (long) list consists of many departments under MOH and some MOH staff – Ully’s department is listed among others)

Task of HTA Committee

- a) To develop concept and activity program of HTA Committee
- b) To develop guidelines book on HTA
- c) To develop guideline books on HTA implementation
- d) To receive ideas/suggestion from health facility association, health professional organization, and BPJS and other bodies for an assessment of the health technology
- e) To filter/assess incoming ideas / suggestions and determine priority topic before HTA
- f) To set up ad hoc Panel Team to implement an appropriate and comprehensive assessment of the health technology
- g) To advice Minister of Health of the assessment result for final decision.

The panel team (point –f-) consists of experts from various disciplines such as: professional organizations, universities, and relevant experts in relation to Health Technology Assessment.

Point 9.

This decree to replace the previous decree No.423/MenKes/SK/XII/2012 on Technical Team on Assessment and Appraisal of Health Care Technology.

Signed by Ministry of Health
21 April 2014

Prof.Dr.Dra. Sri Suryawati, Apt

Prof. Dr. Sri Suryawati, Clinical Pharmacology expert now sits as member of International Narcotics Control Board (NICB).

Prof. Iwan Dwiprahasto, .Med,Sc., PhD

Chair of Indonesian Pharmacology Association and Senior Lecturer Pharmacology – Medical Faculty University Gajah Mada Jogjakarta.

Prof.Dr.dr.Rianto Setiabudi, Sp.FK

Senior Lecturer – Pharmacology – Medical Faculty University of Indonesia – Jakarta

Dr. Santoso Soeroso, Sp.A, MARS

Direktor – Infective Disease Hospital - Sulianto Saroso, 2002-2007 Chief Operating Officer Puri Indah Hospital, 2008 –

Prof. Dr. dr. Edi R. Rahardjo, Ap.An., KIC

Senior Lecturer – Biomedic Engineering – Post Graduate Study – Airlangga University – Surabaya

Dr.drg. Mardiaty Nadjib, MSc.

Lecturer: Health Policy and Planning . Public Health University of Indonesia

Prof. Budi Hidayat, SKM, MPPM., PhD

Senior Lecturer – Economy and Health Insurance – Public Health University of Indonesia Jakarta.

Appendix 3. Schedule of Meetings

Date		Organization
Monday, 22 September 2014	A.M.	University of Indonesia (Interview with Dr. Mardiaty Nadjib, HTA committee member)
	P.M.	-
Tuesday, 23 September 2014	A.M.	Department of Foreign Affairs and Trade, Australian Embassy Jakarta (Meeting with John Leigh and Adrian Gilbert)
	P.M.	National HTA Committee (Attended by Prof. Sudigdo Sastroasmoro and Dr. Arman Syah ⁵)
Wednesday, 24 September 2014	A.M.	DG of Disease Control and Environmental Health (Focus group discussion with Prof. Agus Purwadianto, Dr. Slamet, and team)
	P.M.	BPOM ⁶ (Focus group discussion)
Thursday, 25 September 2014	A.M.	NIHRD (Meeting with Dr. Siswanto, Dr. Idaiani, and Uly Adhie) World Bank (Meeting with Darren Dorkin and Ajay Tandon)
	P.M.	BPJS (Focus group discussion)
Friday, 26 September 2014	A.M.	BPPSDM ⁷ (Meeting with center for planning)
	P.M.	-

⁵ As a representative of P2JK as Dr. Donald Pardede, the Head of P2JK, was unavailable due to illness

⁶ National Agency of Drug and Food Control

⁷ National Institute of Health Human Resources Empowerment and Development

Appendix 4: Notes of the Interviews, Meetings, and Focus Group Discussions

Interview Summary

Interview Date: September 22, 2014 at 9:30AM

Interviewee:

Dr. drg. Mardiaty Nadjib, Lecturer at Department of Health Policy and Administration, Universitas Indonesia

Interviewers:

Dr. Sripen Tantivess, Ms. Nattha Tritasavit, Ms. Mutsumi Metzler, Ms. Appolina Sidauruk

The interview began with Mutsumi providing an overview of the Access and Delivery Partnerships project and Nattha giving a brief overview of the international Decision Support Initiative.

Background

Dr. Mardiaty teaches health economics and economic evaluation, and only recently, pharmacoconomics. She conducts research and provides consultancy services as well as collaborates with UNAIDS and the World Bank on programs such as HIV/AIDS in which the World Bank is interested in supporting the assessment of introducing HIV/AIDS programs in UHC. She has also had collaboration under the Diseases of the Most Impoverished (DOMI) project to introduce new vaccines. She is involved in Monitoring and Evaluation of new schemes and the national health account. She has experience in conducting economic evaluation and cost-effectiveness of new vaccines, such as Haemophilus influenza type B vaccine (Hib). She explained that assessment of new drugs is a new area and pharmacoconomics is mostly understood in theory rather than practice.

Current Capacity

Currently, politicians are aware of health economics and support HTA. Other universities, such as Gadjah Mada University in Yogyakarta, also have good capacity and the intention to improve capacity is growing. The advantage that the University of Indonesia has is that it is located close to the Ministry of Health, making collaboration more convenient. Prof.

Iwan Dwiprahasto in the Department of Medicine is very knowledgeable on the process of registration for the FDA.

A proponent in support of increasing capacity is Professor Hasbullah, who is a leader on the social health insurance scheme in Indonesia (in 2014, a new single-payer scheme was introduced on a contribution- based system). At the University of Indonesia, health economics cannot be earned as a degree, but it plays a major role in the Master's of Public Health and Master's of Epidemiology programs. Dr. Mardiati's colleagues in her department are leading in mainstreaming health policy. The university produces data and submits it to the MoH, which uses the information to make policies.

She stated that she learns by attending international conferences, such as the recent ISPOR conference in Beijing, because there is no systematic process to improve in terms of development of HTA. Indonesia has a health economics association at a national level and an ISPOR chapter. Knowledge of pharmacoeconomics is still limited in Indonesia and the need for more systematic and institutionalized assessment and pharmacoeconomics is critical at this moment.

HTA Research

There has been some research on pharmacoeconomics, such as a study on self-monitoring blood glucose, in collaboration with professional specialists and pharmaceutical companies (e.g. Sanofi). Students have written theses about cost-effectiveness of interventions, such as surgery or peritoneal dialysis versus hemodialysis. Research has begun, but is not yet advanced.

Her colleagues did an exercise on premium setting of the new scheme and Prof. Hasbullah fought to bring the health insurance scheme to reality. Her senior colleagues have also collaborated with AUSAID, DFAT, and Tim Endorsor from York (at the time) on maternal and child health with support from DFID to conduct systematic studies and economic evaluation.

After attending an ISPOR conference, Prof. Hasbullah realized that they were behind on pharmacoeconomics so he and his colleagues initiated a training for participants from various institutions, including the MoH, hospitals, pharmaceutical industry, etc., which was supported by Novartis. Dr. Mardiati mentioned that lecturers from NICE⁹⁸ and universities in the U.S. and U.K. taught a 6-month certificate course to introduce pharmacoeconomics and the participants were expected to develop a simple study on pharmacoeconomics, which was not easy for them.

⁹⁸It has been clarified that the lecturer from NICE is actually a member of one of NICE's technology appraisal committees

ISPOR invited Indonesia to present about pharmacoeconomics guidelines so they developed guidelines for the sake of having guidelines, which have never been used. The MoH published the guidelines internally, but under the new HTA organization, they want to update the guidelines as part of the HTA guidelines. Understanding about good systematic review on economic evaluation is very important and still very limited.

Country Context

In Indonesia, certification/registration by the pharmaceutical industry is done with the FDA, which is different from the Ministry of Health. Under the MoH, there is a R&D department called LITBANG (similar to IHPP). LITBANG has done some research like the Hib and DOMI project. Previously, LITBANG was the institution that managed HTA, but it was more on clinical procedures and not on pharmacoeconomics and HTA. The new ministerial decree changed the institution responsible for HTA to the PPJK.

There is an insurance scheme dealing more with curative care, which is separate from public health. Their system is very fragmented so the funding is not clear and there needs to be a sufficient fund to support public health and priority programs, but most of the money of the MoH is spent on the new insurance scheme.

HTA Committee

The HTA committee was established in 2014 (August) and she has attended only one meeting. The MoH is very busy with social health insurance since the single payer scheme should be efficient and provide good quality of care, but they realize that HTA is important so they changed the focal point of HTA from LITBANG to PPJK. Prof. Sudigdo came from the old HTA team under LITBANG to the new HTA committee. She and her colleague who calculated the premium for the social health insurance scheme is part of the HTA committee. To her understanding, the plan is that the committee will have collaboration with ad hoc committees, e.g. if there is a need to produce pharmacoeconomic studies, the committee will have collaboration with centers that do the assessment. They want to have a full-time Secretariat and also want to involve various units in the MoH, but only a few people in the MoH know about pharmacoeconomics so they are still struggling with the best way to rationalize it. She suggested that it may be good to learn from HITAP.

She said that there is no established ToR for the committee and in the last meeting they were still discussing this with no conclusion. They will meet again to discuss the operationalization.

The HTA commission should have a role in coordinating different units and this is the plan for them. PPJK (under Secretary General) is echelon 2 and Secretary General and DG are echelon 1. If the Secretary General has interest in this area then it will work. At the moment, the members of the commission are representatives of units under the MoH and some of them are not familiar with HTA. Procedures and processes must be done credibly.

HTA committee will focus on HTA for curative care at this stage because it will be linked with the reimbursement list, social health insurance scheme, benefits package. The committee will be responsible for giving the recommendation to the minister.

Responsibilities of MoH Departments

PPJK is responsible for setting up DRG price and capitation. Now it's shifted to BPJS, but they still do not have good knowledge on HTA. There is a different DG under the MoH that is responsible for drugs and medical devices and this DG, BINFAR, has a unit responsible for the formulary, unit for pricing, unit for public drugs, etc. They are responsible for the efficacy part. Drugs for curative care and for public health programs are managed separately and a catalogue/formulary lists all the drugs, giving flexibility to hospitals, payer to decide. There is still confusion on who should do HTA on medical devices. Certification of new devices is usually under the MoH rather than FDA, which only approves drugs. There are different DGs for different areas of healthcare – very fragmented.

Collaboration for national insurance for PPJK is not difficult because the premium for the poor is set up by this unit so the budget is under the MoH. Ideally, there should be a unit like an inventory of information related to HTA and that is the plan for PPJK because after the implementation of the single payer scheme, the money will be managed by the health insurance carrier so they will focus on policy, focusing on national health account, HTA, etc.

External Support

AIDS, TB, malaria resource allocation from the MoH is very low: donor finance versus government finance is 60/40 and Global Fund contributes 50% (out?) of the 60%. Global Fund support cannot wait until everything (HTA) is set up so they have different assessments.

The priority programs of the DGs rely on external support but the scheme for curative care is politically more attractive (to provide free access and the people do not need to pay) so it is the primary focus.

Next Steps

She suggested providing training of trainers during the workshop in November.

Meeting with DFAT Summary

Meeting Date: September 23, 2014 at 9AM

Meeting Venue: Australian Embassy, Jakarta

Attendees:

1. Dr. John Leigh, Director (Health), Development Cooperation, Australian Embassy
2. Dr. Adrian Gilbert, First Secretary – Health, Development Cooperation, Australian Embassy
3. Dr. Yot Teerawattananon, HITAP
4. Dr. Sripen Tantivess, HITAP
5. Dr. Inthira Yamabhai, HITAP
6. Nattha Tritasavit, HITAP

AUSAID conducted a comprehensive review of the health sector in Indonesia on the request of the Ministry of Planning to do this every 5 years in order to develop the 5 year plan, which will be approved by the government. They reviewed 10 different aspects of the health sector, including a chapter on the pharmaceutical sector by Susan Hill. Indonesia pays above international prices for drugs because they manufacture locally, which is very expensive and inefficient. In this chapter, there was a recommendation to conduct HTA to prioritize medicines, but the issue with conducting HTA is that the government does not know how to begin or the process of HTA. AUSAID recommended to start step by step and to start with drugs before moving on to medical devices.

It is also unclear what the definition of Universal Health Coverage (UHC) is and there was a request by Prof. Ghufroon to move toward UHC. BPJS should be the purchaser, but at the moment they play a role as a clearinghouse and there are many unanswered issues regarding UHC.

Issues in the health sector include health services on the supply side, including quality of services and costs of technologies; the prices of drugs in Indonesia are significantly above international places and sophisticated medical devices must be imported so the prices are very high, which affects subsidy by the government and the service quality provided. UHC will be supported by the new President and government because President Jokowi is attempting to reform health (and education) and emphasized UHC during his campaign. He aims for free education and free healthcare, and the new government is concerned about equity across islands.

The implementation of UHC has not been clear and there have been problems with system set up in hospitals, DRG, etc. The government has a fiscal budget, but management is an issue.

AUSAID has a health systems strengthening (HSS) program, which has been implemented for 2 years and emphasizes the 3 building blocks of the WHO: health financing, human resources, and service delivery for primary care. However, Indonesia is highly decentralized (policy and finance are under the national government, but the service delivery is at the sub-national level) and there are about 520 provinces under 34 districts. Each district has a population of, on average, 500,000 people. The districts report directly to the President through the Ministry of Home Affairs and this results in an issue of accountability

Key Programs of DFAT:

- Australia-Indonesia Health Systems Strengthening – provides technical support to the national government and assists with the development of the DRG system, which is not on track, and supports development of district health accounts;
- MCH, HIV, emerging infectious diseases at the sub-national level;
- Health financing: some support to the DRG system;
- Human resources: analysis of health workers planning, 1st mapping because MoH doesn't know about HR nationwide because of decentralization;
- Trying to set up information system on HR;
- Distance learning for midwives and nurses so that midwives are not pulled from their districts;
- Formation of primary healthcare system so there is less fragmentation in primary care delivery;
- Initiative by Bloomberg to strengthen the health information system with Johns Hopkins, University of Melbourne.

The most difficult aspect to achieving UHC will be the HR component.

Partners

AUSAID works primarily with the MoH, but also Ministry of Foreign Affairs, Planning Ministry, etc. HSS has a steering committee chaired by the Secretary General (SG). SG primarily works with the Bureau of Planning. He works with Dr. Donald from PPJK and also Prof. Akmal, DG of health services.

CCM in Indonesia is not functional and are reactive rather than proactive. The CCM has smaller divisions in different areas that are more active than other areas, such as in HIV/AIDS. The Chair of the CCM is civil society and John Leigh sits on the CCM board. CCM focuses only on work of the Global Fund.

Other major players include USAID who work with partners such as the CDC, NCC and are very active in the CCM and provide full time international staff to support the CCM.

Potential Collaboration

He recommended collaborating closely with the SG because has full oversight on the health sector. SG will set up a committee for coordinating health issues and CCM is a part of this.

HR Issues

Problems lie in distribution and quality – half the population lives on Java Island and there is a lack of regulation of the private sector in Java. Outside Java, especially toward the east, there is no HR or specialists in some areas that are more complicated.

Recommendations for HTA

- The national formulary has 3 different systems - standardizing drugs to begin with
- HTA for medical devices
- Value for money and price
- Clear protocol for drug reimbursement
- Systematic program evaluation

Meeting with HTA Committee Summary

Meeting Date: September 23, 2014 at 1PM

Meeting Venue:

Jl H. R. Rasuna Said Blok X.5 Kav. 4-9, Jakarta Pusat, Ministry of Health, Prof.Dr. Sujudi Building, 14th Floor

Attendees:

1. Dr. Arman Syah, P2JK (aarmansyah@yahoo.com)
2. Ms. Appolina Sidauruk, Consultant, PATH Indonesia (ulina99@gmail.com)
3. Prof. Sudigdo Sastroasmoro, Chair, HTA Commission (s_sudigdo@yahoo.com)
4. Dr. Mardiaty Nadjib, member, HTA Commission
5. Dr. Kalsum Komaryani, MoH
6. Ms. Eva Herlivang, MoH (bergkamo@yahoo.com)
7. Ms. Erie Gusnellyanti, MoH (erie.gn@gmail.com)
8. Sadiyah Imran, BINFAR (Imran_sadiyah@yahoo.com)
9. Ms. Mutsumi Metzler, PATH
10. Dr. Yot Teerawattananon, HITAP
11. Dr. Sripen Tantivess, HITAP
12. Dr. Inthira Yamabhai, HITAP
13. Ms. Nattha Tritasavit, HITAP

Note: The meeting was conducted in both Bahasa Indonesia and English

Introductions were made by Dr. Yot and the Secretariat followed by a presentation by Prof. Sudigdo on the past, present, and future of HTA. The presentation was followed by opening for comments and recommendations by Dr. Yot and Mutsumi.

Dr. Yot began by asking about full-time staff to do HTA work and whether it is possible to hire full-time staff. The Secretariat stated that they have a plan for full-time staff, but in the first year of developing HTA they will only have part-time staff because they have a plan to train staff and then decide which staff will switch to full-time in the HTA committee. Dr. Mardiaty commented that the idea of the committee is more of a “clean kitchen”, i.e. the committee doesn’t do the dirty work, so the committee consists of experts, academia, MoH staff. The full-time staff is the Secretariat who will work on ad hoc committees to do the assessments.

There are staff who have a health or statistics background as well as pharmacists in the committee. Most of the MoH graduated from schools of public health, but do not conduct research because under the MoH there is NIHRD to do it. There is also a center for data and information. This unit under the MoH is responsible for financing and health insurance.

Dr. Yot proposed two options: 1) many staff have the potential to develop technical skills so 1 young staff in the committee will develop technical expertise, 2) convince other units who do technical work to do technical work for this committee. Dr. Mardiaty commented that the proposed is the ideal institutionalization of HTA, but the committee is still at the embryo stage. The intention of this committee is to link with the reimbursement list and it is mandated by law that HTA should be linked with inclusion in the BP.

The committee needs to serve the need/demand, but the committee also needs to be able to make recommendations, which needs support technically so how can the technical support be acquired?

Mutsumi suggested having a meeting in the future when more HTA committee members could attend to discuss in more detail about the organizational structure in the HTA process in Thailand.

The Secretariat said that they need support in capacity, especially for the Secretariat because right now the Secretariat has made an initial draft for the HTA report. First, they need support to improve capacity of the Secretariat members because the members have an important role in supporting experts to make HTA. Dr. Mardiaty mentioned the importance of the institutionalization of the unit such as the committee doing the dirty work or just coordinating and the need to decide about which option is the best for Indonesia. She also mentioned that the capacity of the technical aspect needs to be improved.

Indonesia has just started the implementation of its new health insurance scheme and there is a need to maintain and sustain the program. Where to start? Finish capacity building of the team and start research for selecting drugs, devices, procedures, etc.? The team also needs a 5-year plan. Dr. Yot suggested to start with both technical capacity and policy movement – think big, act small. Policy movement begins by requesting topics from various stakeholders and prioritizing the topics, choosing one that will have a big impact on the society at the end of the HTA. Importantly, a link must be made between HTA and policy. It begins with a full-time technical group and the committee to provide policy support, help, and protect the young staff.

Mutsumi raised the point of having one workshop to talk in detail about HTA committees, organization, function, where HTA in Indonesia could start, and then based on this to create a 5-year work plan.

Prof. Sudigdo asked about PATH's primary purpose. Mustumi stated that HITAP and PATH have a shared goal with the main difference being that HITAP is an expert in HTA whereas PATH introduces new technologies to developing countries; however, the goal of the ADP is

to establish a process to assess new technologies based on evidence to countries in need and then decide which technologies are appropriate to introduce to countries. What PATH can support is up for discussion, for example PATH supported the workshop in June, but if the committee needs support for training staff or additional workshops for decision making or discussion platforms for shared learning opportunities then PATH can support this as well. If the committee has a primary need to finance full-time staff, it may be possible for PATH to support it.

Dr. Yot mentioned the usefulness of having a technical training on how to do systematic review, meta- analysis, etc. For the workshop in November, the participants should be the committee and others who are relevant to policy and management issues. Mutsumi underlined the objective of developing a 5-year work plan at the end of the workshop. After determining who will technically support the committee, a training can be held. The workshop and training can be done in parallel. Mutsumi suggested that the training agenda could be developed collaboratively so that it would be catered to answering the committee's questions.

Meeting with P2PL Summary

Meeting Date: September 24, 2014 at 7AM

- Prof. Agus was senior adviser in health technology association, former chair of commission
- Preparing Dr. Slamet to be the next leader

What is going to be a priority for the MoH?

- Capacity building for coordinating methods of HTA among cross-sectoral and cross-discipline institutions;
- Committee has been established with many sectors, including Ministry of Law, Ministry of Education, MoH, etc. so the long-term project of the program is to institutionalize HTA;
- Priority for preventive technological aspect because the national health scheme is more on an individual effort and dealing with healthcare facility, individual approach, patients, etc. but HTA should also deal with promotive and preventive aspects;
 - Screening technology or early detection kits, FETP (under MoH);
- Preventive technology is an area that MoH will support during the next 5 years – breakthrough in HTA;
- Technology development will be a big issue for the new government to boost MDGs and economy;
- MoH services do not have capacity for producing HTA and need advice to develop capability and methods.

Direction of universal coverage for the new government?

- Target to achieve UHC is 2019, but ID is too big and some islands will not be included – supply side (infrastructure and HR) of healthcare facilities is also then a priority but the focus is on primary healthcare (facility should be equipped with standard equipment)

What policy questions are decision makers in MoH facing that make it challenging to make a decision?

- NCDs (cardiovascular disease);
- New president (people's economy, democratic economics) needs to think about promotive and preventive aspect compared with curative;

- The issues are also in line with national health service (BPJS).

Which department is responsible for developing new policy for the new government on promotive and preventive aspect of CVD?

- Non-communicable Diseases directorate headed by Ibu Ekowati.

UHC in Indonesia

- Total 240 million and right now cover 127 million but the budget until 2019;
- Communicable and NCDs will have the attn. of the Minister of Health.

Prevention and health promotion for CVD

- ID already has government regulation for smoking that is implemented but do not know the effectiveness;
- Sin tax on tobacco;
- Proportional allocated revenue for each district but people don't understand public health logic.

What is the direction of the HTA commission?

- Criticism of experts recruited who always ignore ethical/legal and effective/efficient aspects (HTA includes these);
- It is a multidisciplinary team so why using only available evidence rather than real beneficiaries?

Goal is always directly related to the people

- This is dealing with the curative aspect so at least we should also combine with the community/social aspect of specialization;
- ID is very big so need to be careful that commission is not Jakarta centric;
- Prof. Sudigdo's team does not include HTA on health programs because they only deal with HTA in UHC (individual curative aspects);
- Intention of establishing commission is to focus on curative because the members are clinicians rather than public health – not representing pharmacoconomics;
- Products of commission are mainly used to inform the public.

Full-time work on HTA

- Possible to be FT in the future, especially if following commissions of other countries;
- HTA will be implementable for program on HIV Implementation of HTA in programs.

Implementation of HTA in programs

- Major programs that involve many sectors usually have experts that give recommendations after which MoH follows the advice, but usually major programs have committee of experts;
- NCD experts are still being identified and committees are still being established;
- Opinion expert is used in curative aspect but not public health aspects.

PEN

- Adopted PEN and modified it (not only hypertension and diabetes but also diseases that are of focus in ID e.g. thalassemia, COBD, etc. and is implemented since 2011 in all of ID but the PENs may be different in different regions);
 - Policy is the same but implementation may not be;
- This year an evaluation will be conducted on PEN by primary health care (evaluated by the program in collaboration with WHO country office, Dr. Sarath, in December);
 - Funded by government budget.

Support from PATH in terms of further development of HTA

- Need is capacity building and experiences from other countries;
- Piloting project to show how evaluation and policy development could be done;
- Follow on from June workshop with hands on workshop with smaller group of people to discuss bringing in examples and how EE is done, how to transfer it to policy development;
- Connect to networks, experts and facilitators;
- Practice rather than theory.

Integrated NCD Program Evaluation

- In December, consultants from WHO and research institutes (Indonesian experts) will assist with evaluation for 4 provinces (about one month);
- 200 million Rupiah per one province x 35 from the Ministry for training – trainers come from Jakarta from MoH and professional experts.

Meeting with BPOM Summary

Interview Date: September 24, 2014 at 1PM

Background of BPOM

- BPOM was established in 2001 and before that FDA was under the MoH, but as an independent organization it is still under the coordination of the MoH (in ID there is MoH and Ministerial Institution);
- ID separates MoH and FDA and the insurance is handled by the MoH but FDA discusses what should be included in the list;
- Meeting includes FDA (registration unit) and MoH and the DG chairs it – as of 2 years ago it meets about twice a year;
- BPOM is mandated to protect people from products that risk population health so the commodities that are controlled include medicinal products, traditional medicine, cosmetics, food, health supplements, vaccines as part of therapeutic programs but not medical devices, which is still under the MoH;
- Procurement also because UHC scheme needs to know which products to renew (registered products have validity for 5 years and BPOM does renewal of products and facilities);
- BPOM has 31 regional offices out of 33 provinces in ID and there are increasingly more provinces so the number of BPOM offices may increase – the regional office has inspection, certification, laboratory, but not quality control;
- 4,000 staff in BPOM for the whole country but there is still a lack of resources because there are 240 million people and some are in remote areas in Papua, Moluccas, Borneo.

BINFAR

- Rational use of drugs and licensing are under BINFAR (pharmaceutical services under MoH), which has 4 directorates:
 1. Rational drug use
 2. Pharmacy services
 3. Public sector
 4. Production and distribution assistance
- National Essential Drug List (NEDL) – BINFAR is the Secretariat
- When BINFAR revises the essential drug list, BPOM is always involved because the knowledge is at BPOM such as safety, post-market information, etc.

When Indonesia develops a list of drugs to be covered, what is the decision making process?

All the procedures and criteria are developed by BINFAR. BINFAR invite BPOM because they want information, but the criteria, selection, and decision are by BINFAR. There is also has a government procurement institution (LKPP) that works with BINFAR. Relevant stakeholders are invited by BINFAR to select the products.

For imported products, e.g. patented drugs, do they need to report the number of imports or sales?

Information comes from scheme of national single window, issuance of import licenses.

Pricing data?

In the labelling of one product, a maximum price must be printed but the price is reported to the MoH. MoH decides the price and does price control. There is a regulation saying that a branded product should be not more than 3x of generic product and MoH sets up the price for generic products. The MoH (BINFAR) will negotiate with the companies and base it on the cost structure.

What about pharmaceutical companies?

BPOM will procedurally inspect pharma facilities and give the Good Manufacturing Practice certificate and do routine inspection every 2 years for each company. If they do not comply with GMP criteria, they will be sanctioned. All pre- and post-market control is under BINFAR. MoH will give licenses based on BPOM recommendations after inspection to state-owned, MNC, all pharmaceutical companies. For marketing authorization, there is Health Minister Regulation on pharmaceutical registration, but under the HMR, BPOM can make a health BPOM decree which is a more technical regulation. For example, HMR is about who can apply for registration in Indonesia, what kind of products can be registered in ID for MNCs, what kind of entity, etc. whereas under BPOM decree it is more detailed, what is the timeline for the new products, validity of the marketing authorization, etc.

What are the most serious challenges in Indonesia in terms of regulation, development, or use of drugs?

New government does not focus on pharmaceuticals at the moment but from previous experience, every ministry and government institution have to give something for first 100 days of the new cabinet. For example, the president will officially be inaugurated on Oct. 20th and the cabinet will be appointed on the 22nd 100 days after the 20th, there will be a program and they will have policy to promote the use of local products. Next year there will be AEC so now there are 216 local manufacturers. Now BPOM are PICS members and it is mentioned that only member countries that are PICS members or being assessed by experts can get the benefits of Mutual Recognition Agreement (MRA). This means that all GMP inspection done by regulatory authorities is recognized by all member countries.

What policy does the government need to do to promote local production?

UHC is now mandatory and covers 160 million people. In 2019, it aims to cover 100%, meaning that the demand for drugs will increase significantly. Now, Indonesian companies are eager to produce more because they know there is a market here.

Will this kind of policy inhibit the use of newly developed and patented products?

Both generic and patented products are included in the list. The idea is to help people gain access to healthcare services.

Traditional medicine?

Under a different deputy. Under BPOM there are 3 deputies:

1. Pharmaceuticals;
2. Traditional medicines, cosmetics, health supplements;
3. Food.

Meeting with LITBANG Summary

Interview Date: September 25, 2014 at 10AM

Attendees:

1. Dr. Siswanto
2. Dr. Idaiani
3. Uly Adhie
4. Dr. Sripin Tantivess
5. Nattha Tritasavit
6. Mutsumi Metzler

Uly was one of the moderators of the June 2014 workshop on introducing HTA which was held by PATH in collaboration with HITAP and NECA. Dr. Siswanto would like to find a way for PATH, NECA, and HITAP to contribute to the ID team in such a way that ID improves its capacity to do HTA in terms of primary research, systematic review from secondary data, methodology of HTA, etc. He proposed that the objective of this meeting would be to address this issue.

Structure of the next workshop

Dr. Siswanto expressed that the next workshop should be more practical and it would be better to discuss one topic, e.g. the use of high-tech in CVD, but in a multidisciplinary way to gain more skills and knowledge. He suggested that the topic of interest should be discussed with the DG of health services.

For the workshop, he proposed the first day should focus on process while the second day focuses on methodology of, for example, peritoneal dialysis; showing case study from Thailand as an example.

Objectives of the workshop would be:

1. Impart practical
2. Improve skills and knowledge for researchers

The deliverable of the workshop would be a proposal by the ID team.

Topic – Dr. Donald Pardede/P2JK should decide on this

Tools – methodology is about research so LITBANG should lead on how to master the tool to address the topic chosen by P2JK

Workshop Participants

- Participants should include HTA committee members and researchers that will be doing the research on particular topics
- LITBANG can be involved in the development of proposals and in the research

Priority policy issues

Criteria: high-cost, high burden, high-tech maybe because these types of tech will absorb a lot of money. HTA is to assist Dr. Donald to decide which technologies should be included in ID health coverage.

ID System

- AIDS/TB/malaria is already covered by MoH so patients go to primary healthcare and receive drugs freely
- JKN (national health security) addresses NCDs and does not include CDs, which are not priorities right now

LITBANG and HTA in ID

HTA in ID has two phases (before and after UHC)

- I. Before JKN – led by DG of medical care and members are from university (faculty of medicine); first led by Dr. Santoso, then by Prof. Sudigdo, and finally by Prof. Eddy R.
- II. The second phase has a new committee under the MoH

HTA committee prioritizes the topic and what topic should be assessed, LITBANG participates in the assessment and then provides the result to the HTA committee.

- Currently, the focus is on epidemiology research, which includes basic health research, health facility research (nationwide), food consumption, total life study and the results are communicated to the MoH with the aim to change or revise policy
- Research is not closely related to HTA result and there is some concern to put efforts in public health research so this is the new era
- Some concern to link epidemiology research with health policy, which is another step – maybe

- HTA for public health
- In terms of technical approaches, departments under the MoH will ask for LITBANG's help to conduct research, e.g. CDC on NCDs and CDs include LITBANG for brainstorming for topics and invite universities to develop the theme for research agenda programs
- Process of conducting research:
 - 1st year is preparation to identify research question to protocol
 - 2nd year is implementation
 - 3rd year is results and advocating results
- Due to decentralization, health district office or provincial offices have their own research units but LITBANG doesn't have an MOU or agreement with those units (those research units focus not only on health)

- Basic research and researchers at the district or provincial level are trained by the MoH.

Other requests from LITBANG

- Need some documentation on institutionalizing HTA in ID – there are some documents before the JKN era and would like to publish manuscripts in international journals;
- Good to document from now on the institutionalization of HTA in LITBANG.

Meeting with World Bank Summary

ONLY Date: 25 September 2014, 9.00-10.00

Attendees:

- Darren W. Dorkin, Senior Operations Officer
- Ajay Tandon, Senior Economist (Health)
- Yot Teerawattananon
- Inthira Yamabhai

Venue: The World Bank, Indonesia Stock Exchange Building, Jakarta, Indonesia

Darren and Ajay overviewed the current work that the WH country office has been involved in health system development in Indonesia, especially supply side assessment looking at the issues of supply side readiness from the perspective of introducing UHC in Indonesia. The survey at the availability of human resources as well as health technologies in both rural and remote areas across the country. The main finding was that the health care facilities were not ready to comply with the policy. This work was done in collaboration with Lit Bang and the report was recently published in June 2014. The report is also focusing on supply side readiness for NCDs in comparison with the WHO PEN recommendations. The Bank considers this work would be a good foundation for development of health benefit package under UHC in Indonesia because the development of benefit package should recognize health system infrastructure and the feasibility issue is critical here.

The WB also support together with other international agencies on health system review. For example, DFID took a lead as a focal point and the review includes the assessment of medical products system. The WB is working on the HIV/AIDS with Thai scholar who develops Asian Epidemic Model (AEM) for assessing epidemiological profile of HIV/AIDS in Indonesia. The Bank also did a biological and behavior survey in some islands, for example, Papua. This HIV/AIDS project is an on-going project and they are interested to have a list of cost-effective interventions to treat HIV/AIDS patients.

The Bank works in nutrition because one of its main local partner is interested in this issue and she is very strong in this area. Currently Indonesia has a problem with a large number of children are malnutrition while the significant proportion of adults are obese. The Bank just finished a survey that measured blood pressure level and urine sugar or blood sugar? of the samples. This work was done by Li Bang under the project namely Riskesdas. This work has not been published but the data is very valuable for HITAP work if we aim for the assessment of PEN. The focal point at Lit Bang organization is Kosin. The Bank also is interested in health

financing and this work has been involved with Ministry of Finance office. Lastly, the collaboration between the World Bank, NICE and HITAP are welcome to strengthen the current programs under the World Bank.

Meeting with BPJS Summary

Interview Date: September 25, 2014 at 2PM

Background

BPJS has 3 departments:

1. Primary care facilities
2. Research and development
3. Inter-institution relations

R&D research for utilization, review, advise regulators about benefits and premium settings (differ from R&D of MoH).

- BPJS means social security administering body – same level as MoH but different line of responsibility;
- P2JK focus on policy, BPJS administering office (government is regulator, BPJS is operator);
- Sometimes BPJS participate in some discussions to give input/advice to formulate the BP and premium setting but the decision is from the regulators;
- MoH asks for BPJS' opinion about the impact to the finance or not; if yes, they will adjust the tariff payment to the hospital and the premium e.g. the tariff of ID DRG was adjusted after consulting BPJS about the financing;
- BPJS budget is from the premium from private sector, informal sector, individuals.

Context

- 128 million are covered by JKN (social health insurance) and the target is Jan. 1, 2019 to cover all;
 - Single-payer to manage JKN but there is also commercial health insurance.
- Social health insurance – revenue collection purchaser, risk pooler;
 - Revenue collection purchaser about how to pay facilities, providers;
 - Risk pooler about benefits, HTA.
- BPJS is under the presidential decree and has a responsibility to give reports periodically, including premium and expenditure for the health services;
- Have a significant role to give advice to the regulator when they want to set the benefits and the premium e.g. giving warning to MoH about how including a new

benefit will affect the sufficiency of the funds and need to consider that giving more benefits means needing to increase the premium;

- Adjust benefit and premium every 2 years but every year either benefit or premium will be adjusted;

- All of data is at BPJS and collect data every month but required to give a report to president based on regulations twice a year but they also give a report every 3 months.
- Within 7 months, benefits increasing but premium is the same;
 - New benefits like acupuncture,
- Before HTA committee was formed, decision was made by P2JK;
- BPJS was established on Jan. 1, 2014 but it is a transformation from 46 years of national health insurance;
- NEDL includes only generic drugs and in DRG case-based group is paid by primary and secondary diagnosis, co-morbidity or complication, medical intervention;
- Tender from pharmacy to bid on the list of drugs and the most efficient will be listed in the e- catalogue (prices of national formulary drugs), consisting of several different prices and name of the drugs;
 - Most efficient drugs are included in the e-catalogue to make it efficient for the hospital – more efficient to use drugs in e-catalogue because the price is lower than branded names.
- Hospitals have no regulation about medical devices and BPJS pays the hospital;
- MoH and local government are responsible for providing government health facilities;
- Assistive devices are incl. in benefits package but have different mechanism to pay for it i.e. maximum payment (not in DRG).

Meeting with BPPSDM Summary

Interview Date: September 26, 2014 at 10AM

Note: Although we were supposed to meet with the Head of Center for Planning and Utilization for Human Resources in Health, she was unavailable at the last minute and we met with her staff instead

Background

- Head of BPPSDM is being promoted to Secretary General so the position is now empty

BPPSDM has 4 HR divisions (health related):

1. Planning
2. Training
3. Education
4. Standardization

This center is planning and empowerment (distribution).

Scope of Work

- Collaborate with P2JK on HR in primary HC and hospitals closely related with UHC
- Prepare training for doctors in primary care, preparing health workers in primary health services as well as send them to do further studies in specialized areas
- Every 5 years, departments will come together to make roadmap for next 5 years; this department makes roadmap based on needs/supply assessment and calculates distribution of HR in relation to new health scheme

HTA Committee

- Her staff were unaware of the ministerial decree and stated there is still confusion about what this department's role is in the committee
- Happy that HTA committee is set up but there is no clear step that has been taken and there has been no meeting to discuss which departments play what role

They do not know of an invitation to join the committee but suggested that the head at the national level (the center is the second level) may know about it