The Scoping Visit to Indonesia to inform the iDSI Steering Committee

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Reported by
Yot Teerawattananon, Sripen Tantivess, and Nattha Tritasavit, HITAP

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Background

This country report is based on a scoping visit conducted in Jakarta, Indonesia on June 23-24, 2014. A two-day training workshop on health technology assessment was conducted at the Pullman Hotel. The majority of the participants were from the Ministry of Health (MoH), Jakarta. During the first day of the workshop, Professor Sudigdo Sastroasmoro gave a presentation on HTA in Indonesia, the National Evidence-based Healthcare Collaborating Agency (NECA) gave a presentation on HTA experiences in Korea, and HITAP gave a number of presentations on the introduction to HTA, experiences in Thailand, and the global movement on HTA as well as existing international sources. However, this report focuses on the second day of the workshop in which group discussions and ideas were exchanged about developing a roadmap and work plan for HTA in Indonesia. Professor Agus Purwadianto, who was assigned by the Minister of Health to be a focal point on HTA development in Indonesia, chaired this session.

During the group discussion session, the participants were divided into 3 groups to discuss:

i. the need for HTA in Indonesia
ii. the demand for HTA in Indonesia
iii. the supply of HTA in Indonesia

The following content is based on the presentations given by each group and related discussions.

1. Health systems context

Indonesia has a population of approximately 240 million with geographical and economic disparities. It has one of the fastest growing economies in the region and has had continuously increasing per capita health expenditure. However, inaccessibility to essential healthcare services remains as a significant obstacle. This may be due to a lack of priority setting processes.

The government of Indonesia has committed to introducing Universal Health Coverage (UHC) through a single National Health Insurance Program (NHIP) by the year 2019. If successful, the NHIP will become the largest public insurance scheme in the world. A national technical team has been established, which is chaired by the Minister of Health and overseen by the lead focal point, Professor Agus Purwadianto, who is also the Acting Director General of Disease Control and Environmental Health, and Senior Advisor to the Minister of Health. The National HTA Commission was established to carry out major activities related to HTA development in Indonesia. Professor Sudigdo Sastroasmoro, who is a senior academic staff from the Universitas Indonesia, chairs the HTA Commission. The Secretariat team serves the HTA Commission and was formed from the P2JK[1] (Center of Health Financing and Insurance); however, there is no Secretariat team member working full-time on HTA.

[1] Pusat Pembiayaan Jaminan Kesehatan (Center of Health Financing and Insurance)

2. Political will and support for HTA

It is worth noting that the Indonesian government introduced HTA in 2003, but due to confinements, including limited financial and human resources, undetermined organizational structure, restricted access to literature, and poor dissemination, the programs did not flourish. In addition, the past HTA studies were made without clear policy use, making it more of an academic exercise than policy research. Nevertheless, the experiences taken from the previous attempt between 2003 and 2008 can be used as a constructive lesson for new initiatives on HTA.

Strong commitment to achieve UHC in the year 2019 was evident during the group discussions and Indonesia may become the largest country in the world in terms of population to achieve UHC. The use of HTA is declared by law (presidential and ministerial decrees) to support the strategic movement toward UHC, and as such, HTA will be affirmed with good support from the government. Although the presidential election will occur on 9 July 2014, it is expected that the movement on UHC and HTA will not lose momentum. The MoH and academic participants confirmed this, stating that there should not be a change in direction of UHC and HTA in Indonesia regardless of the new government party.

As mentioned in section 1 and confirmed in the workshop, Professor Agus Purwadianto and a group of senior officers have been assigned by the Minister of Health to be a Secretariat team for HTA. The benefit is that he has strong leadership skills whereas the disadvantage is that he holds important positions within the MoH which is time-consuming. In the same vein, Professor Sudigdo Sastroasmoro, who chairs the national HTA Commission, also does not work full-time for the HTA Commission, nor does the whole Secretariat team, which poses another challenge for HTA development in Indonesia. In order to overcome this drawback, it would be very important to identify full-time committed staff with an adequate level of understanding of HTA to work for the Commission alongside Professors Sudigdo Sastroasmoro and Agus Purwadianto, who would be valuable mentors.

3. Potential to benefit from HTA

Based on the group discussion on the need for HTA in Indonesia, participants suggested multiple areas that HTA should inform. These areas include the national strategic plan of the MoH; policies on health promotion and disease prevention; and vertical programs such as HIV, TB, malaria and environmental health; use of medical devices; UHC related policies; maternal and child health programs or services; different types of technologies, including vaccines, reagents, drugs, and treatment methods for diagnosis or screening; management in terms of manpower, money, materials, and machines; quality assurance of medicines and medical devices or pre-market regulation; and

community-based interventions, such as the feasibility of mobile hospitals for communities and public health facilities.

At present, national HTA methodological guidelines are being developed and the participants requested for information regarding the process of developing such guidelines. A technical expert from NECA shared experiences on the guideline development process in Korea. From this, participants requested for the review, update, and finalization of the guidelines. In addition, questions regarding the process for topic selection, such as appropriate procedures for topic proposals from the National HTA Commission and professional organizations, and the establishment of ad hoc teams, were raised. These questions were followed by inquiries to the approach for prioritizing topics and selection of the prioritized list of topics. It is encouraging that there is recognition in Indonesia of the need for HTA process guidelines and a recommended starting point would be the development of the process guidelines for topic selection.

A significant emphasis was placed on the fact that a presidential decree[2] and a ministerial decree[3] have been issued for the use of HTA, which is under the decree for the concern of health care benefits. However, there was also counsel that any decrees on HTA need to be operationalized, caution that the law may not be sufficient, and stakeholders would need to endorse HTA.

4. Potential HTA programs and roles of different stakeholders

The group discussion on the demand for HTA in Indonesia brought forth suggestions for potential HTA users. These include different departments of the Ministry of Health (see appendix 1); industries, such as pharmaceutical or unhealthy foods and beverages; and universities/medical schools (expressed as training and education institutions by the participants). It is noteworthy that the participants placed a higher priority on disease prevention, health promotion, and public health programs over the assessment of pharmaceuticals and medical devices. This may be because there is a lack of clear policies regarding public health programs discussed as part of UHC development. This lack of discussion could potentially lead to the exclusion of public health programs as part of the benefit package. The types of studies required to inform policies include economic evaluation, budget impact analysis and feasibility study. Research for human resources planning and management was also mentioned as an important area.

Participants also recommended that HTA users need capacity building on HTA and using HTA results. It was suggested that a clear plan and capacity is needed to enforce the law to implement the HTA results in order for HTA to link to policy. Additionally, participants indicated that existing structures and functions of the National HTA

[2] Regulation of president of the Republic of Indonesia No. 12 Year 2013 concerning health care benefits
[3] Not currently available in English, but the HITAP team requested for the translation from P2JK

Commission for UHC would need to be extended to include assessment of interventions introduced in vertical programs, such as HIV, TB, and malaria, as well as the use of traditional, alternative and complementary medicines.

5. Local HTA capacity at individual, institutional, and network levels

The supply of HTA in Indonesia does not start at the grassroots level, as evidenced by the current National HTA Commission and commitment to HTA for UHC policy decisions. For example, it is clear that awareness of the importance of HTA exists among high-ranking authorities. In addition, experts responded enthusiastically to previous HTA studies. Currently, the Secretariat of the National HTA Commission is the P2JK, and it was suggested by participants that the P2JK will continue to be the Secretariat regardless of the outcome of the elections. However, the P2JK has a limited number of staff, none of whom are researchers and would only be able to function in an administrative capacity.

Other key institutions and stakeholders who would be involved in providing HTAs presented by the participants include the BPJS[4]; the MoH; hospitals; professional associations such as the IDI[5] (Indonesian Medical Association), health economic association, IAKMI[6] (Indonesian Public Health Association); and universities. Importantly, the group on the supply of HTA in Indonesia described LITBANG, or the National Institute of Health and Research Development (NIHRD), as a capable organization with more than 1000 staff/researchers, financial flexibility, and the ability to reach many provinces and districts. Although this organization does not conduct HTA studies, it conducts clinical and research studies that are relevant to HTA. For example, some clinical studies and policy research have been completed. The group on the needs for HTA in Indonesia also proposed that the Commission should be updated to include clinicians, experts, communities, academicians, professionals, and researchers.

Nevertheless, supply gaps and challenges remain and need to be addressed. Such gaps include economic assessments of technology, the capacity to advocate and inform decision makers, the leadership capacity for the decision process, and the ability to disseminate HTA results to other stakeholders. In one group, participants pointed out the need for effective approaches in 'socializing HTA' among decision makers, program managers, financing officers, health professionals, and other stakeholders. The challenges faced are the untimeliness of the HTA process, the need to operationalize the presidential decree on HTA, the lack of coordination between the HTA Commission and decision makers, the incompletion (to date) of the national HTA methodological

[4] Badan Penyelenggara Jaminan Sosial (Social Security Agency), which is managing the UHC scheme
[5] Ikatan Dokter Indonesia
[6] Ikatan Ahli Kesehatan Masyarakat Indonesia

guidelines, and the difficulty of reaching out to the 18,307 islands (although it was suggested that this could be done through distance or e- learning).

6. Discussion and Conclusion

The workshop clearly illustrates a significant need for HTA in supporting UHC development, moderate demand mainly from high-ranking decision makers and the law, and very limited HTA supply due to a shortage of experienced researchers and HTA organizations. Moreover, approximately 40 participants showed strong commitment, which was evidenced by their attendance for two days with a high level of engagement. Participants raised many good questions and provided fruitful discussions throughout the two days, making the workshop lively and interactive.

The level of commitment of PATH staff, including Ritu Kumar and Mutsumi Metzler who are leading objective 4 of the Access and Delivery Partnership project (which has 3 years remaining), would create a synergic working environment with the commitment shown by the Indonesians. They consider HITAP's involvement and iDSI as a significant contribution to the success of this objective. In addition, their work ethics and approaches, which include their good understanding of the need for and nature of capacity building and the necessity of responding to country demands, are in line with iDSI's approach.

In conclusion, institutionalizing HTA in Indonesia is promising. Despite the need for future development, there are many conducive factors:

(1) Political will and policy opportunity, especially the introduction of Universal Health Coverage.
(2) There are legislative measures, at different levels, to support the introduction of HTA in Indonesia. The area to be strengthened is on the connection between HTA research and policy.
(3) HTA capacity has existed to a certain extent. Capacity building is required in policy advocacy, management and technical aspects. The National HTA Commission should collaborate with MOH's directorates and vertical programs, research units (including the NIHRD), universities, professional associations and the UHC scheme. The formulation of HTA programs in this country should take into account the large population, geographical feature, and decentralization of government administrative authorities.
(4) Fundamental infrastructure for HTA: national HTA direction and guidelines on methods and process are necessary. Since HTA evidence is demanded in many policy areas, a transparent process for HTA topic prioritization, with stakeholder participation, should be developed.
(5) iDSI's efforts could be supplemental to PATH's current program. Given the limited resources for both sides, it would be difficult to achieve each respective objective; however, with both organizations working in Indonesia, the effect would be synergic.

At the end of the workshop, PATH, NECA, and HITAP discussed the future steps to be taken, if iDSI selects Indonesia as a pilot country, in order to keep up the momentum of this workshop. These include:

(1) Another country visit by HITAP and PATH, plus other iDSI partners, to interact with key players, including the National HTA Commission team members and its Secretariat, the director of LITBANG, the new Minister of Health, and others as appropriate. This visit would aim to inform key players about the workshop's outputs as well as to socialize HTA. This visit should be done as soon as possible once the new government has been formed, but it is not likely to be during Ramadan (June 29 to July 27, 2014). Therefore, it was agreed that this activity should take place in August.
(2) To share experiences with and assist the National HTA Commission on the process of the development of the national methodological guidelines, process guidelines, and HTA topic prioritization.
(3) To provide technical training on HTA to key organizations, such as LITBANG, universities, etc. This training will give a basic understanding of the methods and approaches of HTA to researchers and academic staff, with the hope that they can start forming a technical team to assess health interventions and technologies for the National HTA Commission. It was agreed that this workshop should take place by the end of 2014.
(4) External experts should provide technical support to local scholars for conducting prioritized HTA topics identified by the National HTA Commission. This process may take 6-9 months and relevant public health authorities should use the results.

Appendix 1: Suggestions on the different departments of the Ministry of Health that would use HTA

Unit/program	Theme
Sub-directorate HIV & AIDS – CDC	Access to anti retroviral
DG health services and medical devices	Acupuncture need to be addressed in the UHC scheme
Sub-directorate NTD – CDC	NTD drugs
Sub-directorate TB – CDC	Gene-X-pert Line 2 drug
Sub-directorate radiology	Reno grame Tele-medicine
Sub-directorate malaria	ACT & RDT assessment
BPSDM[7] –MoH HR	Capacity building for MoH HR

Source: presentation by Group 2 on demand for HTA in Indonesia

[7] Badan Pengembangan Sumber Daya Manusia, (Human Resource Development of Transportation Agency, Ministry of Transportation)

Appendix 2: Next steps for HTA in Indonesia, collated

Activities	Timeline	Key stakeholders
Policy / Guidelines/ TORs created to support Presidential Decree	September 2014	University, NIHRD, MoH, Professional Association
Set up national committee on HTA	August 2014	MoH
Conduct a policy relevant HTA under new committee	September 2014	MoH
Topic proposals by professional organizations, community, academicians, etc.	3-6 months	MoH, Experts, academician, professional, civil society
Review and select the priority list of topics	1 month	
Piloting project and inform HTA in universities, professional organizations, etc.	1 year	
Expanding the existing structure of HTA commission, eventually developing an independent HTA committee	Semester 2 – 2014 (3-5 years to develop an independent HTA committee)	HTA Commission, Secretary General
Update guideline of HTA	3-6 months	MoH and experts
Review guideline of HTA	1-3 months	Experts, academician, professional, civil society
Finalize guideline of HTA	1-3 months	MoH and experts
Dissemination of HTA Guidelines	October 2014	MoH, hospitals under BPJS
Enhance knowledge on HTA 1. Media (website, IEC information) 2. Workshop Inserted to the existing activities which will be organized	* Government budget: next year[8] * Donor: Q3, Q4 2014	MoH Officials Private health devices, drug, food and water companies

[8] A participant indicated that government budget is available this year

Appendix 3: Next steps to determine HTA in Indonesia, as presented by workshop participants

Presented by Group 1 – "Needs"

Activity	Timeline	Key stakeholders
Develop independent core team/task force of HTA	3-5 years	Secretary general
Udpate guideline of HTA	3-6 months	MoH and experts
Review guideline of HTA	1-3 months	Experts, academician, professional, civil society
Finalize guideline of HTA	1-3 bulan	MoH and experts
Piloting project and inform HTA in educational university, proffesional organization, etc	1 year	
Collect a list of topics from proffesional organization, community, academician etc	3-6 months	MoH, Experts, academician, professional, civil society
Review and select the priority list of topics	1 month	

Presented by Group 2 – "Demand"

Activity	Timeline	Key stakeholders
Expanding the existing structure of HTA commission	Semester 2 - 2014	HTA Commission
Enhance knowledge on HTA 3. Media (website, IEC information) 4. Workshop 5. Inserted to the existing activities which will be organized	* Government budget: next year * Donor: Q3, Q4 2014	MoH Officials Private health devices, drug, food and water companies

Presented by Group 3 – "Supply"

Activity	Timeline	Key stakeholders
Policy / Guidelines/ TORs created to support Presidential Decree	September 2014	University, NIHRD, MoH, Professional Association
Set up National committee on HTA	August 2014	MoH
Conduct a policy relevant HTA under new committee	September 2014	MoH
Dissemination of HTA Guidelines	October 2014	MoH, hospitals under BPJS