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Challenges and Strategies for Training and Development of Health Workforce Improvement in Indonesia

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ABSTRACT

Nursing is an essential profession in health care services worldwide. The higher the quality of nurses, the better the patient care and other health care services they provide. Although health workforce competence comes in different definitions in different countries, however, in general, it is defined to be a comprehensive statement of proven quality. The aim of this study is to investigate some concerns over the challenges and strategies for health workforce improvement in Indonesia. The method in this study from the literature review to explore those challenges and strategies. The challenges include a shortage and inequitable distribution of medical workers, health workforce policy development and planning are not based on real need, growing and changing demand for health care due to demographic and epidemiological changes will increase the burden on the already ineffective health system. The strategies recommended are better information about the dynamics of the health workforce at the national and subnational levels, modernization of the planning methods for health workforce production and deployment to reflect real demand, to include the private sector in health workers recruitment and deployment, limit the recruitment of publicly funded medical doctors in urban areas, given the fact that more medical doctors settle in urban areas because of private practice opportunities. The public sector should emphasize the placement of medical doctors in rural under-serviced areas to increase the efficient use of public money, modernize health workforce policies based on an evidence-based evaluation of past policies and the quality assurance–certification, strengthen not only the clinical competence of nurses and midwives but also privilege them for providing clinical service in remote areas.

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Background and Significance of the Problem

Global Condition

Health state and healthcare service delivery is being threatened by a worldwide shortage of healthcare professionals. In a national survey conducted among hospitals in United States of America (USA), revealed that 82% of nurses reported staffing shortage which had negative impact on provision of health care services (Hunt, 2006). World Health Organization (WHO, 2006), also reported a staggering lack of healthcare workers worldwide for the past decade. According to Hiroko Minami (2009), President of the International Council for Nurses, Canada expects a shortfall of 113,000 nurses by 2016 due to the anticipated retirement of 50% of its presently employed nurses within the next 10 years. Similarly, USA also predicts a shortfall of 800,000 to one million nurses by 2012.

The fast growing young population due to high growth rate related to uncontrolled birth rate in developing countries and increasing ageing population in developed countries, coupled with the increasing severity of the health state in global communities due to proliferation of infectious, communicable and non-communicable diseases, acute and chronic diseases in both developing and developed countries resulted to the need for additional health care and additional healthcare providers, most especially nurses. Hence, the high demand for nurses.

Aside from the shortage of human resources for health and health development, a more serious concern exists is that, the present health workforce lacks the appropriate professional competency, leadership and managerial capacity to effectively and efficiently perform their functions (WHO Global Issues, 2009).

Indonesia's Condition

Indonesia is located on the equator and situated between Asia and Australia continent and between the Pacific and Indian Ocean. The country shares land borders with Papua New

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Guinea, East Timor, and Malaysia. Indonesia with an approximate area of 1.9 million square kilometers consisting of 17,508 islands, as the largest archipelago country in the world. With over 248 million people, it is the world's fourth most populous country. The nation's capital city is Jakarta. Per capita Income: $4810. Life expectancy at birth women 72 years and men 68 years and Infant mortality rate: 32/1000 births (UNO, 2008).

Indonesia is a country (UNO, 2008). The population is 232,516,771 and the sex ratio (men per hundred women) is 99 (UNO, 2009). The proportion of the population under the age of 18 years is 31% and the proportion above age 60 is 5% (UNO, 2009). The literacy rate is 97% for men and 96% for women (UN Statistics, 2008). The life expectancy at birth is 66 years for males and 69 years for females (UNO, 2005-2010). The healthy life expectancy at birth is 60 years for males and 69 years for females (UNPD, 2010). The country is in the lower middle income group (based on 2010 World Bank criteria).

After the Asian economic crisis in 1998, it was estimated that 80 million people were living below the World Bank poverty line (McCawley, 1998)). Internal conflict, together with economic problems, have contributed to a decline in health statistics, particularly in the ares of maternal and infant malnutrition (Jakarta Post, 1999), as well as an increased incidence of serious endemic diseases asuch as malaria, typhoid, cholera, TB (Shields & Hartati, 2003).

Health care and Service Delivery in Indonesia

At an operational level health care professionals in Indonesia have significant responsibility for managing the delivery of health care within a framework of limited provision and great environmental diversity. The health care system, widely accepted to be underfunded, with just 2% of the GNP being spent on health care, has created an obvious shortfall in

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equipment, supplies and health care personnel; moreover, it has affected their education and training (Hennesy, 2006a).

Poverty levels have contributed to a number of serious health problems in Indonesia. Not only do these problems pose serious risks for the population's health and the country' economic viability, they also present a significant challenge for the health service.

There is a serious shortfall (by international standards) of qualified nurses in Indonesia, with an estimated 50 nurses per 100,000 of the population. Many nurses do not have a formal job description, which means that professional and competence boundaries may be exceeded, especially where there is pressure on services and limited resources (Hennesy, 2006a).

Given that much of Indonesia's health care is delivered through an extensive primary care system which relies heavily on midwives and nurses for its efficacy and success, it seems self-evident to note that the preparation of these personnel is crucial to the effective functioning and delivery of clinical services. Moreover, because of the pressure on services and the wide variations in terrain and population levels, continual updating of health care professionals is required if they are to meet very specific local needs. Consequently, nurses must not only develop the clinical skills to manage serious diseases, but also must be sensitive to the cultural needs of the patient and family, while simultaneously operating in adverse environmental conditions with limited equipment and resources.

Nurse Training in Indonesia

Indonesia, the national organization for nurses (Indonesian National Nurses Association, INNA 2010) claimed 500,000 nurse members, and they comprise 60% of the health personnel in the country. Those considered nurse professionals in Indonesia are the graduates from a 1-year professional nursing course after a 4-year Bachelor of Science in

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Nursing (BSN) program, the Sajana Keperawatan (S.Kep). The Indonesian nursing curriculum starts with the 3-year Diploma III in Nursing, the graduate moves on to another year to earn the BSN or S.Kep degree, further enroll in a 1-year Professional Nursing (Ners) program. Only those who satisfactorily completed the 5-year basic nursing training are considered nurse professionals.

Indonesian Human Resources on Health (HRH, 2004), reported that there were 409 nursing schools in Indonesia and Ahmad Mufti (2009), claimed that at present, there are 770 nursing schools nationwide. Three hundred sixty one (361) nursing schools were added within 5 years. These schools produce 25,000 nursing graduates at an average every year. In 2010, there is an estimate of 390,000 nurses (Suwandono, et al., 2006) and 284,700 of them are unemployed. Suwandono (2006) stressed out that the rate of unemployment is related to the following reasons; "quality of nursing education, nursing teachers' capability, and lack of opportunities to work abroad". Suwandono (2006) also emphasized that nursing curriculum in Indonesia needs to be improved and quality of graduates upgraded. Nursing graduates lack the capacity to speak and write in English, so it is very hard for them to pass international employment qualifying examinations like the IELTS, TOEFL and NCLEX, which are given in English (Mufti, 2009). He further pointed out that nursing graduates have very limited clinical skills and their professional competency is weak due to the limited exposure to the clinical areas during the basic training years. "Nurses do not have enough experiences with modern hospital instrument and international nursing procedures" (Suwandono, 2006). Although there is a huge demand for nurses at the international marketplace, yet only very few Indonesian graduate nurses qualify for employment abroad.

Nurses are the product of three factors of training program: input, process and output. The input factor covers the highschool academic qualification and perception of the students

on the nursing profession. The process factor covers the academic programs that prepare the academic and skill qualifications of the students preparing them for the nursing profession. The output factor covers the actual nursing practice in their nursing profession in the clinical, hospital and community setting. The success of the nursing practice depends on the quality of these three factors.

The future of nursing is one of the chief common concerns of the Indonesian Health Ministry and the Association of Indonesian Nurse Education Center (AINEC) consisiting of The Association of Indonesian Baccalaureate Nursing Education Universities and Colleges: AIPNI), The Association of Indonesian Diploma Nursing Education Universities and Colleges (AIPDIKI) and the Indonesian Nurses Association (PPNI). These organisations set standards for nursing education and professional nursing practice to assure that competent nursing practice is made available to the public.

The increasing level of education in Indonesia, the current explosion of knowledge affecting health care, and the public demand for more health care have led to a critical analysis of nursing practice by these three organizations. These organisations also generally declare that there needs minimum preparation for beginning professional nursing practice should be baccalaureate degree education and Ners (certification for independent nursing practice) program, and that minimum preparation for beginning technical nursing practice should be associate degree education (diploma in nursing/D-3) in nursing. These two grades of nurses are expected to have different qualification and competence levels thus have influence on the enhancement of the standards of clinical provision. The third grade of nurse in the technical nurse (nurse aid) prepared at highschool level of education (SMK).

The majority of nurses (60%) are educated to high school level only, 39% have a diploma and 1% are graduates; these latter two groups typically move into education soon after

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completing their training (Hennesy et. al., 2006b). This means that not only do nurse educators have little clinical experience in the field, which could compromise the applicability of their teaching, but also that the majority of direct clinical care is delivered by the least qualified nurses. There appears to be little differentiation between clinical roles for the different levels of education.

Challenges and Strategies for Health Workforce Improvement

World Bank's View

The following are the challenges for the Indonesian health workforce improvement (World Bank, 2009):

1. There is a shortage and inequitable distribution of medical worker (doctors, nurses, midwifery, dentist, ect)
2. The education of health professionals is of poor quality and the accreditation and certification system is weak;
3. Health workforce policy development and planning are not based on evidence or demand, but rather on standard norms that do not reflect real need or take into account the contribution of the private health sector; nor have they adapted to a decentralized paradigm, and finally;
4. The growing and changing demand for health care due to demographic and epidemiological changes will increase the burden on the already ineffective health system

The following suggestions have been given to take the challenges (World Bank, 2009):

1. Provide better information about the dynamics of the health workforce at the national and subnational levels.
   a. A total of 5,500 medical doctors, 34,000 nurses and 10,000 midwives graduate each year.

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b. Better information is needed regarding allied and administrative health workers and this need should be given high priority in the future research agenda and Human Resource Information System development..

2. Modernize the planning methods for health workforce production and deployment to reflect real demand. At the same time as new challenges to the health workforce present themselves, Indonesia applies health workforce planning methods that are not transparent or responsive to actual need.
3. Include the private sector in health workers recruitment and deployment. Estimating the demand for future health workers needs to integrate an analysis of the demand for services and utilization patterns, from both the public and private sectors. There are large numbers of public facilities, especially in urban areas in Java/Bali, that are over staffed and where utilization rates declined with increased ratios of doctors. On the other hand, private facilities often resort to the public sector to fulfill their need for doctors. Worker shortages can be improved with better planning which includes the private sector.
4. Limit the recruitment of publicly funded medical doctors in urban areas. Given the fact that more medical doctors settle in urban areas because of private practice opportunitie. Public sector should emphasize the placement of medical doctors in rural underserviced areas to increase the efficient use of public money.
5. Limit the recruitment of public servants to those who have been certified according to national standards. In order to ensure the efficient use of public resources as well as to motivate health workers to obtain accreditation and certification, the public sector should apply clear criteria of nationally agreed upon accreditation and certification standards in their recruitment policies.

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6. Limit the reimbursement of services for patients with health insurance to those services that have been provided by certified health personnel in both the public and private sector. To ensure the quality of service provision, only those services rendered by qualified, that is certified, health personnel should be reimbursed under any insurance scheme.
7. Modernize health workforce policies based on an evidence-based evaluation of past policies. Allowing dual practice, the impact of decentralization, the PTT doctor scheme, the practice of contracting doctors on higher remuneration packages in remote areas and so forth are policies that may not have provided the impact foreseen for a variety of reasons. Of course, getting the provider to the remote area, even with a good salary, does not entice them to provide a quality service (unless altruism is sufficiently strong).
8. Modernize and improve the quality assurance–certification, accreditation and licensing–of health workers and health professional education. The regulatory and oversight system is weak in all aspects. The growth of private sector involvement in medical and paramedical education warrants strong public sector oversight to ensure quality of service provision.
9. Strengthen not only the clinical competence of nurses and midwives, but also privilege them for providing clinical service in remote areas. The importance of nurses and midwives for basic care at the community level in rural areas is evident. Studies clearly show that, in those areas, nurses and midwives are taking on many responsibilities beyond their skill level and without legal support. Improving the skills and legalizing the practice will improve the provision of health services in remote and rural areas.

Indonesian Government's Plan and Strategy

Currently there are 9.133 community health centers and 1765 hospitals in Indonesia. To access health service, approximately 59,07% Indonesian population have had health

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insurance. The available health workers are insufficient to meet the need of the health facilities, beside the distribution is still imbalance especially between urban and remote, country borderline areas and small islands (Indonesian Ministry of Health, 2010).

To improve the human resources on health (HRH) situation in Indonesia, the HRH plan has a vision that "all people have access to qualified health workers', which is supported by 4 missions as follow (Indonesian Ministry of Health, 2010):

1. Strengthening regulation and planning for HRH development.
2. Improving the production/ HRH education.
3. Assuring the equitable distribution, well utilized and well developed of HRH.
4. Improving supervision and quality control of HRH in health services.

There are 6 (six) strategies to achieve the target of the HRH plan as follow:

1. Strengthening the regulations on development and empowerment of HRH. This will be done through acceleration of implementation and collaboration among stakeholder at the national and local level.
2. Improving the HRH requirement planning. This will be conducted through planning of HRH requirement for the public sector, private sector, and anticipating the health emergency situation and liberalization on health service.
3. Improving and developing the HRH production. This will be conducted through rearrangement of HRH education framework including improvement of education standards, improving access and distribution of health education institution, resource management and development of quality control system of health education (accreditation of institutions and programs as well as certification of teachers/lecturers).
4. Improving the HRH management. This strategy will be conducted through recruitment and deployment of HRH as civil servants, contracted staffs (Pegawai Tidak Tetap/PTT), special

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assignment officers, private employee/practitioners, utilization of foreign HRH, and overseas placement. To improve retention in rural, remote and underserved areas, the Government provide financial and non financial incentives, scholarship with service bond, clear career development, continued professional development including inservice training, and improved health and safety of the working environment .

5. Strengthening supervision and quality control of HRH. Supervision is conducted to improve individual working performance and health profession service by coaching career, enforcement of discipline, and health professional development. Quality control of HRH is conducted through competency assessment, certification, registration and licensing of qualified HRH.
6. Enhancing resources for HRH development. This strategy will be conducted through capacity building of HRH, strengthening the HRH information system, increasing the financial resources and provision of other supporting facilities.

Conclusion

Indonesia is facing challenges in its pursuits to provide professional nurses in its human resources for health. There is a need for further assessment and evaluation program of Indonesian nurses is needed in order to determine the need for improvement in the form of orientation, improvement of curriculum, skill training and continuing education. New curriculum and new program for total global nursing competitiveness of Indonesian nurses, faculty and educational institution is urgently needed.

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