ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Elective Report: Puri Raharja Hospital, Indonesia

I carried out the second half of my elective period in Puri Raharja Hospital, Indonesia. It is a small private hospital located on the island of Bali. I worked in the emergency department (ED) which consisted of a few beds and a bay dedicated for procedures. This report will discuss the four objectives set for this elective.

Identify the prevailing health conditions within Bali, Indonesia, and discuss the relevance of these findings in the context of global health.

The life expectancy in Indonesia (2012) was 71-years-old. (WHO, 2015) This has been steadily improving over the decades, whereby the life expectancy in 1990 was 63-years-old. (Mahendradhata, et al., 2017) It is also amongst one of the best in the region- the average life expectancy for South-East Asia in 2012 was 67-years-old. (WHO, 2015)

Stroke is the leading cause of death amongst Indonesians. (WHO, 2015) Other non-communicable diseases such as ischaemic heart disease, diabetes mellitus, hypertensive heart disease, chronic obstructive pulmonary disease, kidney disease and road injury overwhelmingly accounted for the top ten causes of death in the country. (WHO, 2015) Lower respiratory infections and tuberculosis (TB) were top communicable causes of death. (WHO, 2015) Indonesia has one of the world's highest TB burdens due to a large population and underlying high prevalence rate. (Mahendradhata, et al., 2017) Furthermore, it also has one of the world's highest diabetes disease burdens.

While non-communicable diseases such as cardio- and cerebrovascular diseases, and cancers, playing an increasingly large role in the burden of disease in the country, infectious diseases are still significant. Neglected tropical diseases such as helminthes, lymphatic filariasis, yaws and leptospirosis are widespread. (Mahendradhata, et al., 2017) Additionally, Indonesia is the only South East-Asia Region (SEAR) country to have endemic schistosomiasis. (Mahendradhata, et al., 2017)

Explore and contrast the modes of healthcare provision offered between Nepal and Bali.

Current health expenditure (CHE) in 2015 in Indonesia (3.3%) was lower than Nepal (6.1%), as a percentage of GDP. (WHO, 2017) However, domestic government expenditure as a percentage of CHE in 2015 was higher in Indonesia at 38.2%, compared to Nepal's 18.1%. (WHO, 2017) Additionally, out-of-pocket spending was a less significant form of health financing in Indonesia (2015) at 48.3%, than in Nepal (2015) where it accounted for more than half the health expenditure at 60.4%. (WHO, 2017)

Health provision in Indonesia has a decentralised structure, with provincial and district governments providing services at differing levels. Local level health services are provided at the provincial and district/municipality level. Corresponding provincial governments organise services through health offices and manage provincial hospitals. Municipality/district governments manage hospitals and organise services through their municipality health offices. Furthermore, district offices also provide primary healthcare through centres called puskesmas and their associated networks. (Mahendradhata et al., 2017) Additionally, the Ministry of Health provides tertiary services by operating specialist

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centres. (Mahendradhata, 2017) Additionally, private health organisations also provide parallel services at these levels alongside public services.

Whereas in Nepal, primary healthcare services are provided through numerous forms at the district level, including health and sub-health posts, and primary health care centres. (WHO, 2007) Secondary and tertiary health services are provided through regional and zonal hospitals, and speciality tertiary centres. (WHO, 2007) A large proportion of Department of Health Services staff (60%) worked in rural areas in 2005-2006. (WHO, 2007) The private sector in rural areas largely consisted of traditional practitioners who provided outpatient services.

Identify and contrast public health measures in place to manage cardiovascular risk factors in Bali and the UK.

The Ministry of Health has the overarching responsibility for providing public health services in Indonesia. District and provincial services play a role in delivering and managing these services and programs. (Mahendradhata et al., 2017)

Puskesmas have a significant role in ensuring such awareness-raising campaigns reach the public at the local level, especially in villages. They have developed community-based strategies such as Posbindu- an integrated coaching post which enables community involvement in early detection, follow up and monitoring of individuals with noncommunicable risk factors. (Mahendradhata et al., 2017) Cardiovascular diseases that are managed using this strategy include hypertension, coronary artery disease, diabetes, stroke and obesity. They are crucial for forming an early warning system which allows puskesmas to identify and refer individuals needing further interventions.

The puskesmas also form a crucial part in encouraging grass-roots level health education through programs such as Desa Siaga (Vigilant Village) and Dokter Kecil (Little Doctor) which promote awareness of health conditions and encourage behaviors such as smoking cessation and healthy eating in communites and schools. (Mahendradhata et al., 2017)

While tobacco use is one of the leading causes of cardiovascular disease in Indonesia, it is the only South-East Asian country to not be a signatory of the WHO Framework Convention on Tobacco Control (FCTC). (Mahendradhata et al., 2017) However, the country has developed similar strategies, similar to that in the UK, to tackle this. Strategies include higher excise taxes on cigarettes, modified packaging with health warnings and mandating local governments to develop regulations on no-smoking areas in places such as hospitals, schools and public transportation. However, places such as hotels, restaurants and malls still have an overall say in implementing smoke-free zones. This is in contrast to the UK where centrally mandated regulations ensure virtually all public spaces, including restaurants, are smoke-free. (Public Health England, 2017) Furthermore, the UK is a signatory of the FCTC.

Furthermore, there are multiple public health campaigns in place in the UK to prevent and manage cardiovascular risk factors. (Public Health England, 2017) These include "Childhood Obesity: a plan for action" which aims to reduces salt, calories, saturated fats and sugars in everyday foods; the launch of Food smart App which provides dietary information on foods, screening programs such as the NHS Health check, NHS Diabetes Prevention Programme, and the NHS diabetic eye screening programme amongst many others.

To gain an insight into how healthcare is delivered while managing patient expectations in a low-resource setting.

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Observing delivery of healthcare, especially emergency healthcare, in the Puri Raharja hospital was rather difficult due to it being a very small department which largely remained empty, and sometimes served as a clinic or procedure room for other outpatient services. Additionally, there was a language barrier which prevented effective communication with patients. Of what I have observed during my entire elective period, a key difference between my experience in Nepal and in Bali stems from the differences in health financing. While the Nepal ED relied almost entirely on out-of-pocket payments to initiate treatment, Indonesia has a nationalised health insurance system which inhibited delay in getting care. Furthermore, the equipment needed for procedures, such as taking blood or giving fluids, can be found in the ED in Bali, whereas in Nepal relatives had to walk to a pharmacy to purchase such items.

The cost-sharing made possible through the pooling of funds using a single-payer national insurance service has helped counteract some of the inevitable restriction in resources seen in other lower-middle income country.

The style of consultation in the ED is similar to that seen in Nepal in that a paternalistic framework is followed. It is in contrast to the UK where patient input and a collaborative manner is utilised in patient-physician decision making. In combination with the difficulties I faced in communicating with patients it is difficult to identify what expectations the patients had, and comment on how this may have been met or been thwarted by the resources available within the hospital.

References

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