

The socioeconomic impacts of tuberculosis in Indonesia
by Dr Djunaedi Hadisumarto, Chairman of the National Development Planning Agency
Republic of Indonesia

Your Excellencies, distinguished guests, ladies and gentlemen:

Let me begin by expressing my appreciation for allowing me the opportunity to share a few thoughts on the situation in Indonesia and our efforts in the area of Tuberculosis (TB). I owe a special thanks to the Director General of the World Health Organization, and the Minister for Development Cooperation of the Netherlands for their kindness in inviting me. I am sure that I will better understand and convey the assembled wisdom of this distinguished group on my return.

You are all aware that Indonesia was hit badly by the crisis that struck much of Asia in mid-1997 and has been slow to recover since then. With the crisis Indonesia, one of "East Asian Miracle Countries" moved from rapid and sustained growth to a massive economic contraction and rapidly rising poverty. After two and a half years we believe that we have begun to turn the corner and are on our way to recovery. With a peaceful completion of the first democratic Parliamentary election in June 1999 and the free, fair and transparent election of the President and Vice President in October 1999 international confidence has begun to recover. GDP growth began to pick up in 1999 and is now forecast to grow 4 percent in 2000.

The impact and legacy of the crisis is the poverty it has left behind. Redressing this situation is now at the forefront of our development agenda in Indonesia.

To combat poverty in the longer term we are taking a two-track approach:

- First, and emphasis on broad-based, efficient growth in which the poor participate through their labor and skill;
- Second, a government focus on investment that "guarantees" the provision of health, education and other social services and allows the poor to capture/access the opportunities growth creates.

In very broad outline this is the kind of development that the new government would like to foster and implement in Indonesia.

In the immediate wake of the crisis the government has also put in place a social safety net programme designed to alleviate the most pressing problems. There are three pillars to this programme:

- Temporary income transfers for designated poor families, largely through subsidized rice prices
- Income support programmes designed to supplement the purchasing power of poor households by creating employment and supporting small and medium enterprises and cooperatives; and
- Preserving poor household's access to social services especially those related to health and education

Early in the crisis we identified keeping children in school as a critical crisis reaction programme. To do this, the government protected the overall education budget, increased the share of basic education, and implemented special programmes aimed at both children and schools in areas hardest hit. These programmes had many innovative features designed specifically to keep children in school and prevent deterioration in the quality of education being delivered.

In health the general strategy was similar. The budget allocation for procuring essential drugs and providing basic health services were protected.

In particular health services that targeted the poor were accorded priority. Our programmes were designed to make free health services available in government health's centres and hospitals to poor families. In addition, supplementary food was made available to young children and pregnant and lactating women in high poverty areas.

Distinguished guests, ladies and gentlemen,

That is the very broad outline of our strategy both longer term and during the crisis. Let me briefly discuss the Indonesian experience with Tuberculosis control.

First some background on our estimates of the problem we face. In the early 1990s there are estimates that each year 450 thousand Indonesian's were contracting new cases of TB with at least 175 thousand dying from the disease. In 1996, the World Bank estimates that TB caused 7.7% of the total disease burden in Indonesia, as measured as DALYs or Disability Adjusted Life Years a number significantly higher than the Asian average value of 4%.

An avoidable disease in any age group is to be deplored. However, TB may have particularly severe economic consequences as approximately 75% of the cases in Indonesia are also in the highly productive 15-45 age group. Sixty percent of cases occur amongst the poor and poorly educated contributing to Indonesia's relatively poor Human Development Index (HDI) rating.

TB has a particularly severe impact on women and is estimated to be among the highest causes of mortality in women of child-bearing age. This is particularly severe additional burden as Indonesia also has (according to the World Development Report 1999/2000) among the highest rates for maternal mortality in the world at 390 for 100 000 live births. The disability and death of mothers has an incalculable effect on the rest of the family, particularly the children. We believe that this problem is contributing to a difficult social situation and perhaps a rising number of street children.

A 1997 WHO report on Indonesia indicates that a death from TB results in an average of 12.8 years of productive life being lost, with an estimated total cost of US\$ 11 490 per person. Other estimates from this study indicate that the average costs resulting from morbidity due to TB ranged from US\$ 149 to US\$ 898 annually for patients who remained undiagnosed.

This clearly provides room for a TB control programme to significantly improve peoples' lives and the economy more generally. In fact, over 20 years a good TB programme is projected to be able to save as many as 12 million productive people years (a technically measured by DALYs) (range 2 to 20 million). This loss of productive time would, over same period result in a cumulative financial loss of 5-21 billion US\$. Conversely these would be the savings of a minimum TB control programme, and an improved programme would generate additional savings of US\$ 1-11 billion. Over 20 years, the average benefit-cost ratio of such a programme would be 55 (range 15-90). In other words, every US\$ invested in improved TB control results in an average social return of 55 US\$.

Distinguished guests, ladies and gentlemen,

The first serious Indonesian TB control programmes were launched by the government, in collaboration with a leading Dutch NGO (KNCV), in 1990. These innovative efforts were successful and the government commitment to this effort increased continuously. With the introduction of the DOTS programme (Directly Observed Treatment, Short-course) the budget in 1995 was raised ten times over the previous year.

Nevertheless we believe that only approximately 51% of the health clinics are currently implementing DOTS. Improving our controlling of TB is now a priority and our strategy aims for a coverage ratio of 70% for DOTS within five years. We expect that hitting this goal and maintaining it for 5 years would reduce TB incidence by 50%

Despite the economic challenges that we face Indonesia must control TB now to avoid an even more difficult and expensive problem in the future. To do this we need your help and assistance in creating an effective, good quality programme. Without an adequate programme (and the resources that make it possible), the incidence of TB, including multidrug-resistant versions, will inevitably increase and the economic and social impacts will rise with them. Inevitably diseases like TB know no boundaries and our problem will be your problem.

Conclusion

Mr Chairman, for the first time in the history of TB control, the elected governments of the 20 high burden countries have come together to form a consensus on the need for and direction of reform in TB the global control programme.

The government of Indonesia is equally committed to accelerate its action against tuberculosis. Thus we welcome the initiative of WHO and the World Bank in calling for a massive attack on tuberculosis and in mobilizing increased political and financial resources for improved tuberculosis control.

However, the most difficult task lies ahead. The primary responsibility for implementing the consensus rests with the government, private sector and civil society in each of our countries. Nevertheless, the assistance of external institutions—bilateral, multilateral and nongovernmental—remains indispensable to translating the consensus into results and improving people's health for current and future development.

Thank you.