8 Conclusions

8.1 Key findings

Indonesia’s health status has improved significantly over recent decades. Life expectancy has increased to 71 years in 2012, from 63 years in 1990. The infant mortality rate has declined from 62 per 1000 live births in 1990 to 26 per 1000 live births in 2012. The under-five mortality rate has also decreased from 85 per 1000 live births in 1990 to 31 per 1000 live births in 2012. However, there has been less progress on other important health indicators, such as maternal mortality. Notably, in 2010 the maternal mortality ratio was 210 deaths per 100 000 live births, while the government has set a target of 102 maternal deaths in 2015.

The country is, notably, in the midst of large long-term social and economic transitions which are shaping its health and health system challenges, among which are the following: (1) the working-age population is increasing relative to the rest of the population, while the proportion of the elderly is also increasing; (2) economic growth is enabling Indonesia to emerge as a middle-income economy; (3) the political and social landscapes have been in transition from authoritarianism to democracy, along with decentralization reforms; and (4) disparities between the more rapidly developing central areas of Java–Bali and large cities, and the poorer areas of eastern Indonesia and rural and remote areas, have persisted and even increased.

As a result, Indonesia confronts the double burden of persistent problems of maternal and child health, undernutrition and communicable diseases, particularly in rural and remote areas, while the prevalence of noncommunicable disease and associated risk factors is increasing in urban and more wealthy areas.

Indonesia has a well-developed and extensive network of public health facilities, which reach from community level through to district, provincial and national level hospitals. However low levels of government spending over past decades have resulted in poor quality of health infrastructure, shortages of personnel and low levels of utilization. This has contributed
to the growing development of private sector facilities and increasing use of the private sector, and resulted in a complex and mixed public–private health system.

Following the economic downturns of the late 1990s, governments at all levels became more sensitive to the impacts of poor health and barriers to utilization of health services on social welfare, particularly for the poor. This has resulted in gradually increasing investment by government in health services, particularly through various programmes to provide financial protection to the poor, and culminating in the introduction of a universal health insurance scheme in 2014. While these investments have been associated with an increase in public financing for health, the focus on the health insurance mechanism has led to funding principally addressing curative services, and to relative neglect and underfunding of public health services, health promotion and preventive programmes.

Increased government and private funding has resulted in an increase in health infrastructure, including primary and referral health facilities, in the last two decades. However, the ratio of both hospital beds and puskesmas to population remains below WHO standards and lags behind neighbouring countries. In addition, there are varying conditions and quality of services found in facilities, resulting in geographical disparities between regions. Human resources for health have also grown in the last two decades, with increases in health worker to population ratios. However, the physician to population ratio is still lower than the internationally recommended figure and geographical disparities persist as well. There is also a pronounced shortage of nurses and midwives at both hospital and puskesmas level, despite the increase in absolute numbers.

The introduction of extensive devolution of powers and forms of authority from central government to provincial and district governments has created a complex and challenging operating environment for health service policy-makers and managers. On the one hand, the national government has created a strong and well-developed legislative and regulatory framework; on the other hand, this has resulted in a fragmented and complex management and financing system, with multiple specific funding streams, each with its own management requirements.

Within the health sector, regulations were in place to clarify the division of responsibilities between national and sub-national government
particularly to fulfil the minimum standard of services for health. Furthermore, budget from local or sub-national government are directed to be prioritized for health service provision and recently also to support the success of JKN or the national health insurance programme. The set of new regulations on power distribution implies that Indonesia’s decentralization process is still evolving.

The establishment of the national health insurance programme (JKN) in 2014 represents a new level of commitment by the government to the health sector, and creates new opportunities to address long-standing low levels of public funding. But it also brings new challenges in developing the organizational and administrative capacities to manage a scheme covering a population of 250 million.

8.2 Lessons learnt from health system changes

Indonesia has also introduced reforms to various aspects of the health system, while the health system has also been affected by reforms to government and public administration that are multisectoral. Key multisectoral reforms include the delegation of authority for certain government functions from central to local governments, including responsibility for the management and provision of public health services; and the progressive introduction of greater autonomy in management for public service organizations, which include hospitals. Reforms that focus specifically on the health sector include reforms to improve the quality of medical education, and the introduction of the national health insurance programme (JKN). Following nearly a decade of policy development, the JKN was introduced in 2014, with very significant implications for the management and delivery of health services.

An important lesson that is still being learnt is how to manage an integrated national health system in a decentralized environment. In particular, how to align priorities and plans at subnational level with national level priorities, when the subnational levels have autonomy to determine their own priorities, and when there is considerable variation in the health needs and system capacities among the different geographical regions of Indonesia. The vertical programmes and national level control established prior to decentralization achieved considerable success in addressing key population health issues through a focus on primary care (puskesmas) and priority vertical programmes (e.g. maternal and child health, family planning).
However, an unforeseen consequence of decentralization in 2001 was the creation of a fracture line between the central and local actors. Prior to decentralization, local actors were directly under the control of central actors for all aspects of the health system. However, after decentralization, the district/municipal health offices are responsible to local governments, with technical support and supervision from the central level agencies.

Issues of local governments’ capacity to undertake their new responsibilities and roles have also emerged. In earlier years, rapid decentralization was not supported by timely and appropriate capacity development at the local level to enable them to meet their new responsibilities, especially as regards the newly created districts/municipalities. Many heads of local government health offices, in particular, did not understand their role as regulators. Planning skills were also generally weak at the peripheral level in the early period of decentralization. When planning responsibilities were transferred to local managers without providing them with adequate skills, while at the same time databases frequently deteriorated, local (and national) planning suffered.

A particular issue for the maintenance of an integrated system was the breakdown of the integrated health information system, with lower levels of the system (district and provinces) no longer obliged to report regularly to the national level. Thus the central government has more difficulties in building a picture of the health system as a whole, and in comparing the performance and needs of different units within the system.

However, at the same time, decentralization has provided opportunities for local governments to demonstrate their commitment to the specific health needs of their communities, and encouraged and enabled them to use their own resources to increase health workforce numbers, improve facilities, and develop programmes specific to local needs. The popularity of local area specific insurance schemes (Jamkesda) is one example of local area initiatives. Furthermore, a variety of other local area innovations have arisen and subsequently been disseminated nationally, such as the Desa Siaga programme.

8.3 Remaining challenges
One major implementation challenge currently being addressed is to establish the institutions, systems and procedures necessary for
the effective and efficient operation of the national health insurance programme (JKN). In general, the supply side is still largely lagging behind the demand side, particularly in poorer and more distant regions, and the central government needs to ensure a better investment in the health workforce, facilities and equipment in less developed regions to ensure equity in access to services. Other necessary elements to support an effective and efficient JKN also present challenges. For example, HTAs, cost containment strategies and health information systems have become more crucial in JKN, and yet progress on these elements remains slow.

Furthermore, there is a risk of fraud. Indonesia is not free from fraud, and currently, there is no system for the prevention and prosecution of fraud. Use of BPJS-K funds through claims by hospitals can be aggravated by the phenomenon of fraud, which in turn will further reduce equity. Lack of fraud prevention mechanisms in the JKN is a justified concern. More to the point, an overall accountable JKN system is needed. The Indonesian people need to see measures to ensure public reporting on performance and avoid corruption, particularly now that the system is going to collect funding from the community.

The JKN also highlights some even more persistent challenges that are rooted in other components of the health system, namely health workforce availability and distribution, inequity of services, a fragmented system and fragmented financing, unintegrated health information systems, lack of coordination and lack of monitoring capacity, among others.

A second set of challenges is the need for the health system in Indonesia to re-orient towards the changing epidemiological landscape. The existing health facilities have been designed to address acute diseases/conditions. The increasing burden of noncommunicable diseases highlights the need to develop capacity to deliver care for chronic conditions that require long-term interactions between health providers and patients. There is thus an urgent need to build up capacity for patient-centred long-term and palliative care.

The central government needs to take into consideration the growing interregional disparities in terms of resources, services and health outcomes and develop a comprehensive strategy to address these disparities. The objective of equity in achievement of health indicators across districts has not yet been addressed properly in the
decentralization policy. With a large, widespread area and population, and with the commencement of a universal health coverage system, the need for a reliable and integrated information system to support the planning and decision-making process is becoming even more urgent.

With the existing limitation of public sector supply side, clearly the JKN will not succeed if it relies solely on the public sector. The JKN will more likely call for further collaboration with private health-care providers. The government needs a new set of skills to interact better with the private sector as well as an incentive to attract and keep them in the system. Competition for quality and costs will also drive the behaviour of providers including private providers, calling for close monitoring from the government, something that traditionally has been challenging for Indonesia.

8.4 Future prospects
Given the complexity of health challenges in Indonesia, health financing reform is not a panacea for its health system. The JKN alone will not and cannot be expected to solve the long list of health issues facing the country. Notwithstanding, the JKN provides a momentum to move towards more coordinated policies and strategies to achieve national health system goals, as well as towards a more equitable distribution of the burden of funding the system. Thus, the government needs to take stock of this momentum and make the necessary adjustments so that the health system can be more responsive to the ongoing epidemiological transition and function in a way that provides quality, efficient and equitable services while at the same time providing sustainable financial protection to the people.

In doing so, Indonesia has the opportunity to harness the prospects of continuing economic growth and the shift towards middle-income status, and the demographic dividend arising from the large proportion of relatively young people in the population, to obtain the resources needed to invest in health. The progressive transition to more stable and democratic government, and the development of a better aligned decentralized division of authority and responsibility, provides a basis for Indonesia to build the governance, regulatory and oversight systems which can ensure that investments benefit the whole community, and reduce waste and inefficiency.