Executive summary

Indonesia is the largest archipelago in the world with an estimated total of 17,504 islands. The country is ranked fourth globally in terms of population, with a population of more than 240 million. This large population includes numerous ethnic, cultural and linguistic groups, speaking 724 distinct languages and dialects. The country is in the midst of a fundamental demographic shift as the working-age population increases relative to the rest of the population. Indonesia has also emerged as a middle-income economy, economically strong and politically stable. The political and social landscapes have also been evolving through transition from authoritarianism to democracy and decentralization reforms. These macro-transitions have concurrently influenced an epidemiologic transition in which noncommunicable diseases (NCDs) are increasingly important, while infectious diseases remain a significant part of the disease burden.

Indicators of overall health status in Indonesia have improved significantly over the last two and half decades, with life expectancy rising from 63 years in 1990 to 71 years in 2012, under-five mortality falling from 52 deaths per 1000 live births in 2000 to 31 deaths in 2012, and infant mortality falling from 41 deaths per 1000 live births in 2000, to 26 deaths in 2012. However, progress on maternal mortality and communicable diseases has been slower, with maternal mortality remaining high (210 deaths per 100,000 live births in 2010), and continuing high incidences of tuberculosis (TB) and malaria. At the same time, risk factors for NCDs, such as high blood pressure, high cholesterol, overweight and smoking, are increasing. Responding to this increasingly complex epidemiological pattern in the midst of multiple macro-transitions is one of the major challenges for the country’s health system. Indonesia has stepped up its leadership in global health; for example, the Minister of Health became Chair of the Board of the Global Fund in 2013, and the President was named by the United Nations Secretary-General to co-chair the high-level 27-person panel to draft the Sustainable Development Goals (SDGs). However, Indonesia
remains the only country in Asia and one of 9 worldwide not to have signed the WHO Framework Convention on Tobacco Control.

The Indonesian health system has a mixture of public and private providers and financing. The public system is administered in line with the decentralized government system in Indonesia, with central, provincial and district government responsibilities. The central Ministry of Health is responsible for management of some tertiary and specialist hospitals, provision of strategic direction, setting of standards, regulation, and ensuring availability of financial and human resources. Provincial governments are responsible for management of provincial-level hospitals, provide technical oversight and monitoring of district health services, and coordinate cross-district health issues within the province. District/municipal governments are responsible for management of district/city hospitals and the district public health network of community health centres (puskesmas) and associated subdistrict facilities. There are a range of private providers, including networks of hospitals and clinics managed by not-for-profit and charitable organizations, for-profit providers, and individual doctors and midwives who engage in dual practice (i.e. have a private clinic as well as a public facility role).

Indonesia has a hierarchy of interrelated long-term, medium-term and annual plans, from central to provincial and district level. The planning process combines top-down direction, with bottom-up participation from communities and local agencies. While Indonesia has established a national information system (SIKNAS) that links to district-level health information systems (SIKDA), communication between the systems has been weakened by decentralization, and by multiple separate reporting systems. Vital registration is not complete, and is supplemented by regular national sample surveys.

The function of regulation is divided between central, provincial and district governments. Regulations are arranged in a hierarchy from laws to different levels of regulation at different levels of government. Regulation of providers includes requirements for individual providers to be registered and gain a licence to practise, while hospitals require a licence to operate and must participate in the hospital accreditation scheme. There is also a variety of regulations relating to the production of pharmaceutical products, their advertising, distribution and sale. However, there remains a high rate of illegal sale of pharmaceuticals by unlicensed drug vendors, and self-medication is common. Patient rights are guaranteed by several laws,
including the right to confidentiality, to information about treatment and costs, to give consent to any procedures, and not to be treated negligently.

Indonesia faces the challenge of increasing health expenditures, as nominal health spending has been steadily increasing in the last eight years, by 222% overall. Although there has been a substantial increase in health spending at national level, health spending as a proportion of gross domestic product (GDP) remains below average among the low-to-middle-income countries (3.1% of GDP in 2012). The government share of total health expenditure also remains low, at only 39%, whereas private, primarily out-of-pocket (OOP) expenditure, is 60%.

In response to the high levels of OOP expenditure and its impact on access to health services by the poor, the Government of Indonesia has introduced various social insurance programmes for health, such as the Social Safety Net for Health-care, Askeskin, Jamkesmas and the most recent national health insurance scheme, the Jaminan Kesehatan Nasional (JKN). This programme, which commenced in January 2014, pools contributions from members and the government under a single health insurance implementing agency (BPJS Kesehatan). Population coverage is planned to expand progressively and the aim is to reach universal coverage by 2019, with a comprehensive benefit package and minimal user fees or co-payments. Payments to primary care providers are through capitations, and to hospital providers through DRG episodes of service payments (INA-CBGs). Salaries for public staff continue to be covered through budgetary allocations.

However, the focus of increased spending on health through the JKN is on curative care services and health infrastructure that supports medical care. Thus, the allocation for public health and prevention is relatively low, and the allocation for curative services is high. Challenges remain in the continuing high levels of OOP expenditure, the complex system of payments, expanding population coverage to include informal sector workers, and ensuring improvements in the supply of services to enable equitable access to services across regions of Indonesia.

Indonesia has experienced an increase in health infrastructure, including primary and referral health facilities, in the last two decades. Inpatient beds in both public and private hospitals and primary health centres have also increased. Puskesmas or primary health centres are important, particularly in the context of Indonesia’s Universal Health Coverage (UHC) or JKN programme, as the gatekeeper for medical cases as well as public
health efforts. However, the ratios of both hospital beds and *puskesmas* to population remain below WHO standards and lag behind other Asia-Pacific countries. In addition, there are varying conditions and quality of the facilities, resulting in geographical disparities between Indonesian regions.

Capital investment is financed by the government budget from various institutions and different levels of government. At the hospital level, a hospital with *Badan Layanan Umum* (BLU) status can finance its own capital investment. Other sources of funds include cooperation with private institutions. Foreign investments are welcomed, but limited to hospital-level investment only. There is wide use of mobile technology, with Indonesia currently the eighth-largest Internet user globally. The adoption and use of information technology in the health system is still limited and not well coordinated. This includes the limited growth in the use of electronic medical records.

Human resources for health have also grown in the last two decades, with increases in health worker to population ratios. However, the ratio of physician to population is still lower than the WHO-recommended figure, and ongoing geographical disparities exist. There is also a pronounced shortage of nurses and midwives at both hospital and *puskesmas* level, despite the increase in absolute numbers. Professional mobility of health workers has been modest, but with growing outmigration of nurses to the Middle East. Health training institutions have grown in number, with various changes in the curriculum aimed to improve the quality of the graduates; however, significant investment is needed to meet the population’s needs.

The Ministry is also responsible for management of programmes addressing public health issues, such as programmes to combat communicable disease, including TB, HIV/AIDS, malaria, dengue and avian influenza. These programmes are led by the Ministry of Health at national level, but are delivered by the network of public facilities at district level (hospitals and district health offices), and at community level (*puskesmas* and their networks). There is also an active surveillance and outbreak response system, and regular national surveys to measure and monitor key aspects of population health.

The *puskesmas* and their networks manage and deliver the basic immunization programme, although the programme can also be accessed through private providers. The immunization programme still faces significant challenges from both the supply and demand sides
e.g. geographical disparity, topographical situation, limited availability of outreach activities and cold chain maintenance, due to the decentralization and availability of funding, negative perception of immunization side-effects, and suspicion of haram ingredients, despite awareness campaigns.

The Ministry of Health also organizes and directs health promotion activities, which again are delivered through the network of facilities at district and community levels. Preventive efforts also focus on NCDs, including health promotion to raise public awareness, and community-based health awareness groups, early screening and early detection. For example, the Posbindu is a community engagement programme that addresses almost all NCD risk factors, and is integrated into other settings within the community, such as schools, workplaces and residences. Although Indonesia is not yet a party to the WHO FCTC, several policies on tobacco control have been implemented such as higher excise taxes on cigarettes, stricter regulation of tobacco advertising and of the promotion and sponsorship of tobacco products, introduction of smoke-free public places, and specific packaging and labelling of tobacco products.

The patient pathway commences from the primary care facilities, puskesmas and their networks, which act as gatekeepers for JKN patients before referral to hospitals for further treatment. Without a referral letter, a JKN patient is not allowed to seek treatment directly at a hospital or specialist clinic, except in an emergency situation. The puskesmas provides both curative and public health services, with a focus on six essential service areas: health promotion, communicable disease control, ambulatory care, maternal and child health, and family planning, community nutrition and environmental health including water and sanitation. Information and education on family planning is provided by the National Population and Family Planning Board (BKKBN) and its subnational-level agencies, while clinical family planning services are provided by Ministry of Health facilities.

Inpatient facilities include public hospitals at national, province and district levels, and a growing number of private hospitals, particularly in the central islands of Java–Bali. While patients attending hospital should be referred from primary health care level, in fact many patients come directly to hospitals and pay OOP. As a result, patients accumulate at hospitals and face long queues. Emergency care is provided by all levels of services. Since 1970, pre-hospital care radically improved when the Indonesia
Surgeons’ Association started to operate the 118 Emergency Ambulance Services in Jakarta with the support of the local government.

The provision of pharmaceuticals, and oversight of the quality of pharmaceutical production is managed by the Ministry of Health Food and Drug Supervisory Board. In ensuring access to pharmaceuticals, the MoH ensures the availability of 484 essential drugs for primary care as listed in the National List of Essential Medicines (the national health programme-related drugs and vaccines). The government also monitors production capacity in the country and regulates drug prices by imposing price ceilings for several essential drugs.

Indonesia has also introduced a number of reforms to different aspects of the health system, while the health system has also been affected by reforms of 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 the management of 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 a national health insurance scheme, the national health insurance programme (JKN). Following its introduction, JKN has significantly influenced management and delivery of health services.

Potential future reforms are likely in the use of telemedicine to address issues of geographical coverage; more innovative ways of addressing the challenge of distribution of the health workforce, including contracting in by local governments; and dealing with the implications of removal of restrictions on free movement of the health workforce within the member countries of the Association of Southeast Asian Nations.

Health is clearly stated as one of the important objectives in the Indonesian constitution and is also well defined in the Ministry of Health National Strategic Plan. In terms of financial protection and equity in health financing, Indonesia is still struggling. Even though JKN coverage is steadily increasing, OOP expenditure is above average. Catastrophic spending remains at a high level with many workers in the informal sector not yet insured. Implementation of the single risk pooling mechanism (JKN) poses several risks to equity in health-care financing and service utilization. As all funds and risks are collected in a single pool, provinces
or districts with limited health infrastructure and supply-side readiness, and lower health-care utilization, might receive less government subsidy compared to well-developed areas.

Information on user experience is limited in both the public and private sectors. Requirements for informed consent are regulated but there is no national charter to describe the rights of patients in choice of provider, privacy or information. The ratio of health workers to population has improved over time, but disparities between provinces remain large.

Both total and public spending on health as a proportion of GDP have been low and increasing only slowly, including for public health measures. There is a need to evaluate the current UHC programme regulation on payment or claim cap at the hospital level.

The health system in Indonesia needs to re-orient towards the changing epidemiological landscape. The increasing burden of noncommunicable diseases highlights the need to develop capacity to deliver care for chronic conditions, which require continuous long-term interactions between health providers and patients. The central government also 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 issues. 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 planning and decision-making is becoming even more urgent.

With the existing limitations of the public sector supply side, JKN provides an opportunity for further collaboration with private health-care providers. However, there is a risk of fraud, and currently there is no system of prevention and prosecution of fraud. An accountable JKN system is required, as people need to see measures in place to ensure public reporting on performance and avoid corruption. In any case, given the complexity of health challenges in Indonesia, health financing reform is not a panacea for its health system. Notwithstanding, JKN provides the momentum to move towards more coordinated policies and strategies to achieve national health system goals.