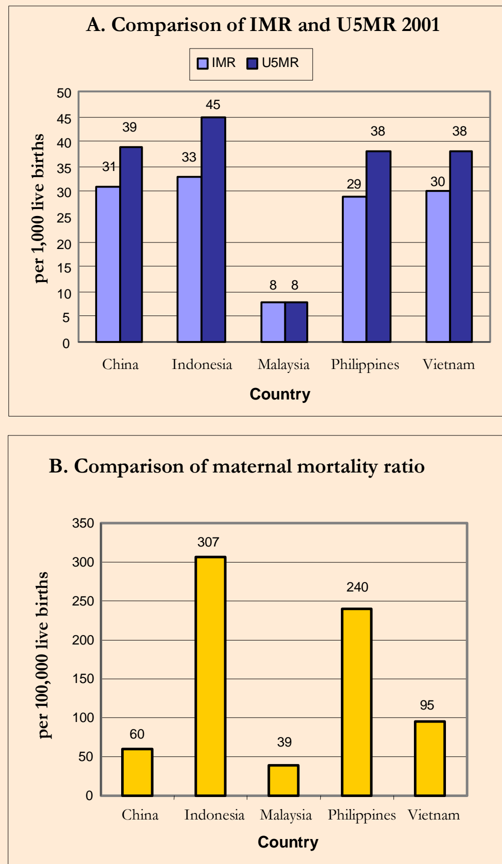
## An Unfinished Agenda

Indonesia has made significant progress in health outcomes over the last decades. For instance, infant mortality dropped from 118 deaths per thousand births in 1970 to 35 in 2003, and life expectancy increased from 48 years to 66 years over the same period. This progress owed much to the expansion of public health provision in the 1970s and 1980s, and programs in family planning. However, new challenges have emerged as a result of social and economic changes:

1. **Disease patterns have become more complex.** Indonesia is in the midst of an epidemiological transition in which non-communicable diseases (NCDs) are increasingly important while infectious diseases remain a significant part of the disease burden. Thus, cardiovascular diseases now account for almost 30 percent of deaths in Java and Bali. Indonesia is also among the ten countries in the world with the highest incidence of diabetes. At the same time, infectious and parasitic diseases account for 22 percent of deaths, and both maternal and infant mortality rates are higher in Indonesia than for most of the comparable countries in the region. One in twenty children die before the age of five, and one woman dies in child birth for every 325 live births. Responding to this changing and more complex pattern of diseases is a major challenge for Indonesia's health system;

2. **There are important regional and socioeconomic inequities in the health system.** In many provinces, the infant and child mortality rates compare unfavorably with some of the poorest countries in Asia. The poor suffer disproportionately from Indonesia's major health problems, and are less likely to be immunized, or have their births attended by skilled health personnel. Children from the poorest families are nearly four times more likely to die before their fifth birthday than children from the richest families. High levels of morbidity from both communicable and non-communicable diseases reduce the income earning capacity of the poor, contributing to the vicious cycle of poverty.

**Figure 1: Comparison of IMR, U5MR, and MMR 2001**




3. **Performance and utilization of public health services is declining and the private sector is now the major source of health care**. Immunization rates have dropped since the mid-1990s – with only half of all children immunized, Indonesia is lagging behind countries such as the Philippines and Bangladesh. The TB control program is detecting less than one-third of the expected annual number of new cases across the country. Overall, use of public facilities is dropping, and more and more Indonesians choose a private health service provider when sick. In most areas of Indonesia, the private sector is the dominant provider of health care and now accounts for more than two-thirds of ambulatory care, more than half of hospital contacts and 30-50 percent of all deliveries (compared with only approximately 10% a decade ago). The poor tend to make much greater use of non-medical health staff and have lower hospital utilization rates.

4. **Health financing is low and inequitable.** Health financing is overwhelmingly private, with individuals providing 75-80 percent of all health outlays, and most of this out-of-pocket, i.e. at the time they receive health services. Overall, total spending on health is much lower than in other countries in the region (USD 16 per person per year in 2001) due to low levels of both public and private spending. In addition, insurance coverage is extremely limited, with only formal sector workers and their families, or about one third of the population, covered by formal health insurance. Even those that are insured face high out-of pocket spending for many health services. The result is that the poor utilize less of the publicly funded services and, consequently, receive less public subsidies than the rich: the poorest 20 percent of the population captures less than 10 percent of total public health subsidies while the richest quintile captures almost 40 percent.

5. **Decentralization poses new challenges and presents new opportunities.** Local governments have become the focal point for health care provision: their share in total public health spending increased from 10 percent prior to decentralization, to 50 percent in 2001. This shift could make public spending more responsive to local conditions and variations in disease patterns. But it may also cause the loss of economies of scale, increasing regional disparities and a lack of critical health information.

6. **HIV/AIDS transmission rates are increasing but the epidemic remains largely localized.** An estimated 120,000 Indonesians are now infected with HIV/AIDS, with the highest concentrations in a small number of provinces (including Papua) and in towns and cities that service industry, mining, logging and fishing. The virus spread at a slower rate than expected during the 1990s, but transmission has recently increased in high risk groups, which do not widely practice preventive behavior, such as the use of condoms during commercial sex, or the use of clean needles in the case of Intravenous Drug Users (IDUs).

## Priority Actions to Improve Health Outcomes

The challenge for the incoming Government is to continue to improve health outcomes as it restructures and reforms the health system in a decentralized environment. The most important tasks are to focus on priority health outcomes,

improve equity in health outcomes and health system utilization, engage the private sector, reevaluate health financing mechanisms, and manage decentralization, including workforce issues.

1. **Focus on improving priority health outcomes and on managing the whole health system.** Despite the ongoing epidemiological transition, health services funded through the public budget continue to be focused primarily on the earlier, infectious-disease-dominated pattern. Changing the focus in a way that allows priority on the most important infectious diseases while controlling the emerging epidemic of NCDs is a major challenge for the health system.

2. **Concentrate the use of public funds on delivery of public goods and improving equity for priority health outcomes**. Public funding of health care in Indonesia is lower than in most other countries in the region. It is therefore critical that priority for these limited public funds is given to the provision of public goods (such as immunizations and surveillance/control of communicable diseases), for ensuring oversight and stewardship of the whole sector, for promoting and ensuring quality of services, and for the provision of services for which the market is inadequate (such as health education). Actual provision of health care is of secondary importance, except in areas where there are market failures, i.e. the private sector is unable or unwilling to provide certain services. Even then, the government can contract private sector parties to provide specific services, as they are often more efficient. For those functions performed by local governments, the central government can do three things to promote a more pro-poor distribution of resources: (i) *make the DAU distribution more equitable* by further strengthening the formula-based allocations, which – according to the recent revisions to Law 25/1999 – now take into account the local human development index; (ii) *expand the DAK for health*, focusing on the provision of primary health care, especially for poor districts; (iii) *empower the poor* through third party payments, information, and greater oversight of health providers.

3. **Recognize the role of the private sector.** The health system in Indonesia relies heavily on the private sector and efforts to improve priority health outcomes will fail if they do not take this into account. For example, more people seek care in the private sector for such critical services as birth delivery, child diarrhea, and acute respiratory infection than in the public sector, and this proportion is rising, even among the poor. Given the reliance of health delivery on the private sector, the Ministry of Health must safeguard health service users by ensuring quality and accountability through demand-side interventions (such as vouchers for the poor and health insurance) as well as through regulation and licensing.

4. **Reconsider health financing.** Indonesia is currently considering significant reforms of health financing through the phased introduction of national health insurance. Health insurance can be a powerful tool to increase resources for health care, increase access for the poor, and make providers more accountable. But the recently passed Social Security Law fails to provide a coherent framework for the reform of the health care financing and delivery system. The new government should set up a task force to develop a comprehensive strategy for health financing, of which social health insurance would form a part, and amend the legislation accordingly. Such a strategy should:
   - Determine the combination of health financing (public insurance, private insurance and out of pocket) that best meets the Governments goals of quality health care at affordable prices, and with access for the poor;
   - Analyze the impact on the budget of the proposed strategy;
   - Draw lessons from existing regional experiments with social health insurance and other forms of pre-paid health care;
   - Propose transition arrangements for existing private and state-owned insurance schemes;
   - Allow for a broader set of service providers, rather than just doctors, to be eligible for payments under the social insurance.

5. **Manage decentralization of public health functions.** The Government has already undertaken several initiatives to manage the new decentralized environment for health care provision. These include piloting a national health grants program to help upgrade health services in poor regions and increase access for the poor. Critical next steps in managing decentralization are to:
   - **Better define the various roles and responsibilities of the three levels of government** in managing the health system and in providing cross-district public health functions. Role differentiation and improved management capacity

should be the key design principles, with provinces and the center specializing in critical public health functions, while districts assume primary responsibility for health sector performance in their jurisdictions.

- **Enhance the role of the province**, by strengthening the legal position as well as the management responsibilities of the province to increase coordination among local governments and achieve greater efficiency in public health provision.
- **Restructure the central health ministry.** The Ministry today is structured to play the lead role in service delivery – a role which is now the responsibility of the regions under decentralization. It needs to restructure and refocus around the stewardship roles of core public health functions of most relevance to the new disease pattern. This should be a top priority of the new government.
- ***Urgently rebuild the health information system.*** The current disease reporting systems yield incomplete and incompatible health data, a situation which has worsened under decentralization to the point where epidemiological surveillance of infectious diseases has been curtailed throughout the country. As a result, less is known about health outcomes today than before 2001.
- **Address health workforce issues**. The most important budgetary item for the public health system is personnel – salaries account for more than half of public expenditures at the central and district levels, and approximately one-third at the provincial level. Nevertheless, districts and provinces have little or no discretion over workforce issues. The Ministry of Health faces some difficult choices on training, competence, right-sizing of the workforce and equitable deployment across regions. Actions on many of these issues are constrained by the existing civil service regulations. Addressing key health workforce issues, including the dual public sector/ private sector roles of many health staff, and ensuring better responsiveness to the health market needs, is key for the next stage of health system development.
- **Ensure availability of quality pharmaceuticals at competitive prices**. Responsibility for quality assurance should be clearly delineated between local governments, the Ministry of Health and the Food and Drugs Administration BPOM. There is also a pressing need to review other pharmaceutical policies and regulations with the objective of improving quality and increasing availability to consumers at internationally competitive prices.

6. **Control the spread of HIV/AIDS by focusing on prevention.** The single most important priority in this area is to decrease transmission of the virus. This requires that efforts concentrate on high-risk groups in the main urban areas, and in and around certain economic enclaves. The emphasis should be on increasing the use of condoms among high-risk groups, on treating and preventing other sexually transmitted diseases, on discouraging the frequent change of sexual partners, and on preventing the sharing of needles by IDUs.

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