

## FACT SHEET



**THE WORLD BANK**

### *Health Financing in Indonesia: A Reform Road Map*

**Indonesia has made major improvements in health outcomes**

Health outcomes have improved significantly since 1980 when life expectancy was only 52 years compared to almost 70 today, and some 100 infants out of every 1000 died before their first birthday, compared to less than 30 today. The total fertility rate has declined from 4.7 children per woman to slightly above 2. Despite these impressive improvements, Indonesia's achievements have been less impressive than some of its neighbors, and for certain health outcomes, such as maternal mortality, the country does not perform as well as other comparable income and health spending level countries.

**Indonesia's health delivery capacity has expanded significantly**

Indonesia's health delivery system expanded significantly over the past 40 years. Virtually all Indonesian's have access to basic care through a network of 8000 Puskesmas and 22,200 Puskesmas Pembantu, and some 5,800 mobile health clinics. On the other hand, while Indonesia has far fewer hospital beds per capita compared to other comparable income countries, these beds are poorly utilized with occupancy rates on the order of 60 percent. In terms of human resources for health, while nurse mid-wives are readily available throughout the country, Indonesia's health workforce overall is small relative to other similar income countries and concerns over quality and efficiency persist. Its physician workforce is very small relative to comparators, and there are severe shortages of specialists, which are particularly problematic given the proposed expansions in health insurance coverage and the oncoming non-communicable disease burden. There are serious equity, quality, and efficiency problems underlying Indonesia's current health delivery system which, unless corrected, will result in major access, cost, and sustainability problems as the country moves to universal health insurance coverage.

**Indonesia's health spending is relatively low and the country gets reasonable 'value for money' in terms of some health outcomes as well as relatively good financial protection**

Indonesia spends only slightly more than 2 percent of its GDP on health, about half the level of other comparable income countries. Half of all health spending is public. About one-third of health spending comes directly from out of pocket payments by households. Health is a relatively small share of the government's budget, some 5 percent, although the share has been increasing since the implementation of the Askeskin program in 2004. Despite low spending health outcomes and financial protection are relatively good, although these latter results may be due to Indonesia's relatively high education levels and extended family social structure. On the other hand, some health outcomes such as maternal mortality, which is dependent on a well functioning health system, are worse than other comparators and analyses of technical efficiency suggest that there are some potentially serious problems.

**The reform needs to build on the system's strengths and address its weaknesses**

The report documents the health system's strengths and weaknesses based on empirical analyses of health spending, health outcomes, financial protection, consumer responsiveness, quality, equity, and efficiency.

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>▪ Favorable demographic circumstances</li> <li>▪ High educational and literacy levels</li> <li>▪ Government commitment for reform</li> <li>▪ Low levels of health spending</li> <li>▪ Reasonable financial protection and consumer satisfaction</li> <li>▪ Experience with health insurance programs</li> <li>▪ An extensive primary care delivery system</li> <li>▪ Generally good availability of pharmaceuticals.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Half the population lacks health insurance coverage</li> <li>▪ Government health subsidies disproportionately benefit the rich</li> <li>▪ Health financing and delivery systems are highly fragmented</li> <li>▪ Some health outcomes are poor</li> <li>▪ Demographic, epidemiological, and nutrition transitions will place significant pressures on future health care costs and delivery system needs</li> <li>▪ Significant geographic disparities in health outcomes, availability and use of services persist</li> <li>▪ Human and physical infrastructures are limited and face quality and efficiency problems</li> <li>▪ Significant improvements in the quality and costs of pharmaceuticals, which account for some one-third of health spending, are needed</li> <li>▪ Decentralization has confused the roles and responsibilities of the different levels of government and the intergovernmental transfer system does not yet fully recognize differences in need and fiscal capacity</li> </ul>

	<ul style="list-style-type: none"> <li>▪ Critical data for decision-making are lacking</li> <li>▪ Design features of the Jamsostek and Askes programs result in high out of pocket costs for program beneficiaries and preclude effective operation</li> <li>▪ No comprehensive studies of the health outcome and financial impacts, real costs, and future sustainability of the Askeskin/Jamkesmas programs.</li> </ul>
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**Indonesia's reform process needs to address both broad policy concerns such as the final system design and transition options as well as numerous 'devils in the details' including the design of the basic benefits package; groups eligible for public subsidies; identification and collection of premiums from informal sector workers; how medical care providers will be paid; how the reform will be financed; who will administer the program; and, how will better health outcomes, financial protection, consumer responsiveness, quality, efficiency, equity, and financial sustainability be assured.**

While the Government has made some important progress in developing draft laws to implement the Social Security Reform Law 40/2004, the report notes that much additional work needs to be done. It also highlights the need for the Government to specify its final vision for universal coverage and develop and cost the various transition options and timing to get there. It highlights several potential final visions including a single national mandatory health insurance system where the government subsidizes the poor and other disadvantaged groups as in Turkey, Thailand, Columbia, and Chile as well as a 'Jamkesmas for all' approach which is fully financed by the government and very much approximates the national health service systems in Sri Lanka and Malaysia. Development of the transition options and final reform impacts will require specification of key program details. The report develops a policy framework for addressing the key policy issues requiring resolution based on the system's strengths and weaknesses, Indonesia-specific and international experience, and underlying public health, health insurance, health economics and public finance principles.

The report also focuses heavily on the need for solid actuarial analyses of the costs and revenues of the various options and the challenge to the government to assure sustainability of the reform within its available future fiscal space. If upon achieving universal coverage Indonesia's spending jumps to the level in other comparable income countries and Indonesia faces the cost pressures of the industrialized countries, health spending in 2040 could reach almost 10 percent of GDP compared to just over 2 percent today. If the government can hold future cost pressures to their historic rates of increase, then spending will be on the order of 6 percent of GDP. The report highlights the importance of getting the key design elements of the reform 'right', a rather complex policy challenge given the interactions among reform components as well as Indonesia's socioeconomic situation which includes a large number of poor, much of the population living in rural areas, a high percentage of informal sector workers, and a large number of very small firms.