HSPI The Open Access Publisher

JCMHS ISSN 2833-5333 JOURNAL OF COMMUNITY MEDICINE AND HEALTH SOLUTIONS

Short Communication

Health challenges in Indonesia

Anne Booth*

Professor Emerita, SOAS University of London, England

Abstract

Indonesia is the fourth largest country in the world by population and has made considerable progress since the 1960s in terms of economic growth and structural transformation. But in recent years it has become apparent that the health of the nation is far from satisfactory. The purpose of this article is to review recent literature on health problems in Indonesia and to outline the policy challenges which face the government. Since 2001, the provision of primary health care has been decentralized to sub-provincial levels of government but they lack often lack the resources, and trained staff to provide adequate services to rural populations in particular. The literature suggests that while most health indicators have shown some improvement in recent years, there are still large variations by region and social class. The country is still far from achieving the goal of universal health coverage.

More Information

***Address for correspondence:** Anne Booth, Professor Emerita, SOAS University of London, England, Email: ab10@soas.ac.uk

Submitted: February 06, 2023
Approved: February 21, 2023
Published: February 22, 2023

How to cite this article: Booth A. Health challenges in Indonesia. J Community Med Health Solut. 2023; 4: 007-009.

DOI: 10.29328/journal.jcmhs.1001027

Indonesia is now the fourth largest country in the world, with a population estimated to be in the range of 280 million. It is also a country with a large Muslim population; what proportion of the 280 million people are in fact practicing Muslims can be debated, but it is probably over 200 million. Its long-serving president, Suharto, resigned almost 25 years ago, in May 1998, after serving for over three decades. Since then, the country's political and administrative systems have undergone substantial changes in the direction of becoming more open and democratic. An important part of these changes has been significant decentralization, with responsibilities for both primary healthcare and basic education devolved to provincial and sub-provincial levels of government. In spite of, or perhaps because of, these changes, the country's achievements in human capital development since 1998 have been rather disappointing. Indonesia has participated in several rounds of the PISA tests, carried out by the OECD to measure student attainment in maths, science and reading. It has performed rather badly compared with other middle-income countries. More recently, evaluations of the nation's health have shown serious failings in early child development, maternal mortality and nutritional standards among the entire population, among other measures. Although life expectancy has increased, and under-5 mortality has fallen, both in the Suharto era and more recently, a WHO Review claimed that 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 non-communicable diseases such as high blood pressure, high cholesterol, overweight, and smoking, are increasing [1].

In addition, a World Bank study on stunting found that around one-third of children under five in Indonesia were stunted (low height for their age), which was one of the highest rates in the world [2,3]. This was especially alarming as stunting is considered to be a reliable indicator of chronic malnutrition which in turn often affects brain development in early childhood. Other data from the survey of basic health indicators (RISKESDAS), published in 2018 and broken down by province show considerable variation across regions in a number of indicators. Failings at the national level have been attributed to low government spending on health care. The WHO Review found that public expenditures on health were just over one percent of GDP in 2014, a low ratio by Asian standards. Total spending on health was 2.8% of GDP; only Myanmar and Laos were lower. Total per capita health expenditures in PPP dollars in 2014 were lower than in several other Asian countries, including Vietnam and the Philippines, where per capita GDP is lower than in Indonesia. Nundy and Bhatt [4] reported that current expenditures on health in Indonesia in 2019 were 2.9% of GDP, about the same as in India but below Thailand and China. They also found that in 2020 35% of all expenditures were out-of-pocket expenditures, paid by patients at the point of delivery. This figure was lower than in 2010 but higher than in Thailand.

President Joko Widodo, in office since 2014, pledged a universal health system where poorer Indonesians would get free treatment and richer ones would pay into a national insurance scheme. But contributions to the insurance scheme have fallen well below government targets, necessitating additional government funding. In their analysis of the situation Pratiwi, et al. [5], found that while the public

insurance scheme had helped inpatients, especially the poorest, from crippling medical payments, there were many especially in Eastern Indonesia who could not benefit because they could not access facilities. A network of health clinics at the sub-district level (*Puskesmas*) was established in the 1970s, and after decentralization, it was expected that they would play a crucial role in delivering basic care in both urban and rural areas. The number of clinics has increased since 2010 [4]. These authors claimed that the increase was in part due to a desire on the part of the government to increase access to primary health care. But recent evidence shows that many lack trained staff and medicines and especially in more remote rural areas are often a considerable distance from where most people live.

The staff shortages reflect both a shortage of doctors at the national level and a general reluctance for doctors and other trained health workers to take up positions in rural clinics. Indonesia has a rather low ratio of qualified doctors to the population by Asian standards, and most are to be found in urban areas, often working in private facilities. The number of private hospitals has increased since 2000, although as Nundy and Bhatt [4] point out the distinction between public and private facilities in Indonesia is often blurred. Not all private hospitals are run for profit; many are operated by charities, often faith-based. Recent studies of the supply of nurses in Indonesia suggest that supply is actually exceeding demand, and Indonesia, like China and the Philippines, may actually have a surplus [6]. But there are serious imbalances between regions; Firdaus and Efendi [7] found that at least 60% of nurses did not want to work in rural areas. Even if they did, it appears that local governments do not always have the resources to employ them in rural clinics.

Another issue that has generated much controversy in Indonesian health policy has been the supply of medicines to both public and private facilities and the role of cheap generics versus expensive branded drugs. Elizabeth Pisani and a group of mainly Indonesian colleagues have tackled this question in several recent papers [2,8]. They conclude that the mixed market for medicines which has evolved in recent years does deliver medicines at prices that both rich and poor can afford, although it often means that similar drugs are sold to different patients in different facilities at very different prices. While this does not always fit with the government's promise of universal health care for all, it does mean that many people can access medicine at prices they can afford. Pisani and others point out that those advocating tighter regulation of the medicine market may end up creating further problems for consumers.

As in many other countries, the COVID pandemic placed the Indonesian health system under further strain. Mahendradhata, et al. [9], found that the pandemic confirmed that a system that had a limited capacity to deliver services to the whole population during normal times was unable to do so during the pandemic. In another paper, Marthias and Mahendradhata examined the impact of the pandemic on maternal, neonatal, and child health programs [2]. There were serious disruptions, but the levels of disruption varied across services. The pandemic also revealed ongoing problems in the health information system across the country which have resulted in estimates of death that many experts think are understated.

But in spite of the data problems, it seems clear that the provision of services varies greatly by region and is often weakest in those regions where the need is greatest, although these are not always the poorest regions in the country in terms of income. Skilled health professionals, especially specialist doctors, are mainly to be found in the richer urban areas, not because the need is greatest there, but because that is where they can earn higher incomes. For example, it has been estimated that there are 81 oncology surgeons in the Jakarta capital region, but none in the more remote province of West Kalimantan [2]. Decentralization has given more funding to provinces and districts across the country, but many lightly populated regions outside Java find it difficult to recruit and retain skilled professionals, including nurses and midwives. In several cases, the lagging provinces are not always the poorest in terms of per capita GDP. An analysis of births taking place in health facilities with trained nurses conducted by the Ministry of Health in 2021 found that the lowest percentages were in six provinces outside Java. Of these only East Nusatenggara and Maluku had lower per capita GDP than the national average. [2]. Although the decentralization policies have allowed resource-rich provinces outside Java to retain part of their resource revenues, it appears that they have difficulties in using these revenues to improve health services.

Studies carried out in other parts of Asia and Africa confirm that decentralization while sometimes important in empowering local populations has not always led to better results in terms of health care. Liwanag and Wyss [10] in their analysis of the Philippines, a country where decentralization of health services began rather earlier than in Indonesia, found that it was not an automatic solution to the problems in that country, especially in rural areas. Challenges in health delivery in the Philippines are compounded by the high proportion of skilled health workers who work overseas, a problem that is likely to worsen in Indonesia in the coming years. A comparative study of the decentralization of health services in Indonesia and Kenya found that while the policies in both countries did introduce new possibilities for citizen participation, the results for preventive health care were often disappointing. They argued that well-supported and empowered community health workers were potentially key actors to promote genuine community engagement, but they were not available in sufficient numbers in many regions [11,12].

In all the studies reviewed in this article, the authors agree

that more funding will be essential if the promise of universal coverage is to be met. What proportion of the required funds should come from the national budget, and the budgets of regional governments and what proportion from private contributions? Should both national and regional governments rely more on taxes (such as excises on tobacco) the funds from which could be devoted exclusively to health care? As in many other parts of the world, the answer to this question is still unclear in Indonesia. It seems likely that the urban middle classes in secure wage employment will continue to rely on health care funded by their employers, or by private insurance schemes, often supplemented by their own contributions. The rest of the population will have to rely on whatever care they can get from public clinics and from those hospitals which offer services either free or at prices that poorer people can afford. Indonesia is hardly alone among middle-income countries in Asia and elsewhere in struggling with these complex problems. The good news is that much more research is now being carried out in Indonesia on the health challenges facing the country than was the case a few decades ago. Anyone with a serious interest in health provision, not just in Indonesia but also in other large and diverse developing countries will benefit from reading these articles and books. They all provide comprehensive bibliographies which will guide further study and research.

Summary

Since the 1960s, Indonesia has made considerable progress in terms of economic growth and structural change, but there is growing evidence that there has been less progress in terms of human resource development. In recent years there has been considerable research on health policy issues in Indonesia, by international agencies as well as by Indonesian and foreign researchers. Comparative estimates show that total spending on health is low by Asia standards (around three percent of GDP). It also appears that at least one-third of all expenditures on health care, including medicines, are met by patients paying out of their own pockets at the point of delivery. Poor families who cannot meet these expenses often go without inpatient care and often cannot afford medicines, especially where cheaper generics are not available. While progress has been made in reducing infant and child mortality and in increasing life expectancies, recent research shows that Indonesia still has serious problems with stunting among children under five which reflect poor diet and other problems. The country also suffers from considerable regional disparities in many health indicators. Since 2001, primary health care has been decentralized to provinces and districts but it appears that many regional governments, especially outside Java, are not providing even basic health services to their populations. They lack trained doctors and nurses, and local health clinics are often poorly equipped, and too far away for many people living in remote areas to access. Tackling these problems will require not just increased funding, but also better coordination between levels of government as well as empowerment of local health workers.

References

1. Yodi M. The Republic of Indonesia Health System Review. Health Systems in Transition. New Delhi: World Health Organization Regional Office for South-East Asia. 2017; 7:292.
2. Claudia R, Subandoro A, Gallagher P. Aiming High: Indonesia's Ambition to Reduce Stunting, Washington, DC: World Bank. 2018; 12-103.
3. Firman W, Utomo A. In Sickness and in Health: Diagnosing Indonesia, Singapore: ISEAS Publishing. 2022; 18 + 252.
4. Nundy M, Bhatt P. Health System in the Republic of Indonesia: Reforms, Transformations, and Challenges. CSEP Working Paper 43, New Delhi: Centre for Social and Economic Progress. 2022.
5. Pratiwi AB, Setiyaningsih H, Kok MO, Hoekstra T, Mukti AG, Pisani E. Is Indonesia achieving universal health coverage? Secondary analysis of national data on insurance coverage, health spending and service availability. BMJ Open. 2021 Oct 4;11(10):e050565. doi: 10.1136/bmjopen-2021-050565. PMID: 34607864; PMCID: PMC8491299.
6. Ferry E, Aurizki GE. The Paradox of Surplus and Shortage: A Policy Analysis of Nursing Labour Markets in Indonesia. Journal of Multidisciplinary Healthcare. 2022; 15: 627-3.
7. Firdaus A, Efendi F, Hadisuyatmana S, Aurizki GE, Abdullah KL. Factors influencing the intention of Indonesian nursing students to work in rural areas. Fam Med Community Health. 2019 Jul 5;7(3):e000144. doi: 10.1136/fmch-2019-000144. PMID: 32148718; PMCID: PMC6910751.
8. Hasnida A, Kok MO, Pisani E. Challenges in maintaining medicine quality while aiming for universal health coverage: a qualitative analysis from Indonesia. BMJ Glob Health. 2021 May;6(Suppl 3):e003663. doi: 10.1136/bmjgh-2020-003663. PMID: 34049935; PMCID: PMC 8166595.
9. Mahendradhata Y, Andayani NLPE, Hasri ET, Arifi MD, Siahaan RGM, Solikha DA, Ali PB. The Capacity of the Indonesian Healthcare System to Respond to COVID-19. Front Public Health. 2021 Jul 7;9:649819. doi: 10.3389/fpubh.2021.649819. PMID: 34307272; PMCID: PMC 8292619.
10. Liwanag HJ, Wyss K. What conditions enable decentralization to improve the health system? Qualitative analysis of perspectives on decision space after 25 years of devolution in the Philippines. PLoS One. 2018 Nov 5;13(11):e0206809. doi: 10.1371/journal.pone. 0206809. PMID: 30395625; PMCID: PMC6218067.
11. McCollum R, Limato R, Otiso L, Theobald S, Taegtmeyer M. Health system governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia. BMJ Glob Health. 2018 Sep 28;3(5):e000939. doi: 10.1136/bmjgh-2018-000939. PMID: 30294460; PMCID: PMC6169670.
12. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Suparmi, Achadi EL, Taher A, Wirawan F, Sungkar S, Sudarmono P, Shankar AH, Thabrany H; Indonesian Health Systems Group. Universal health coverage in Indonesia: concept, progress, and challenges. Lancet. 2019 Jan 5;393(10166):75-102.doi:10.1016/S0140-6736(18)31647-7.Epub2018 Dec 19. PMID: 30579611.