Indonesia's Health Sector Review

1

OVERVIEW

DATA, GRAPHS AND TABLES

UPDATED JUNE 2012

Background

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- The WB received requests for electronic copies of the various charts, tables and graphs included in the reports and papers produced for the Indonesia Health Sector Review
- In response, this synthesis report has been created. It includes the key charts, tables and graphs that can be downloaded
- This is a living document and updates will be inserted when new data become available
- This document does not summarize all the work that was carried out, rather it includes mainly the data and graphs. For summaries and details please refer to the documents listed in the annex. Each slide includes the source document for easy reference

This review was put together by the World Bank Jakarta-based health team including Claudia Rokx, Pandu Harimurti, Puti Marzoeki, Eko Pambudi, George Schieber, Ajay Tandon and John Giles. Elif Yavuz was involved in earlier versions.

Indonesia's Dynamic Environment

3

Indonesia's health system performance is challenged by a changing environment:

- Ongoing demographic and epidemiological transitions that are likely to increase demand and result in more costly and more diverse health care.
- Additional pressure will come from emerging diseases and epidemics such as HIV/AIDS, H5N1 (Avian Influenza) and H1N1 (Swine Influenza).
- The implementation of Law No. 40/2004 on Universal Health Insurance Coverage (UHIC) will further increase demand and utilization.

Indonesia's population is growing: by 2025 there will be 273 million people and the elderly population will almost double to 23 million.

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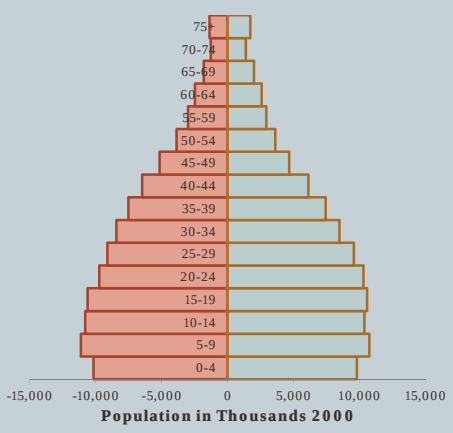

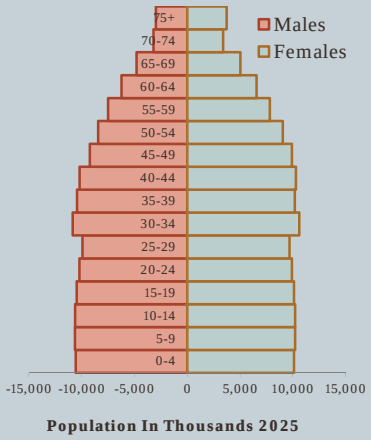

Source: BPS 2005.

The demographic transition may provide a 'demographic bonus' in the short term if those coming of working age are employed…

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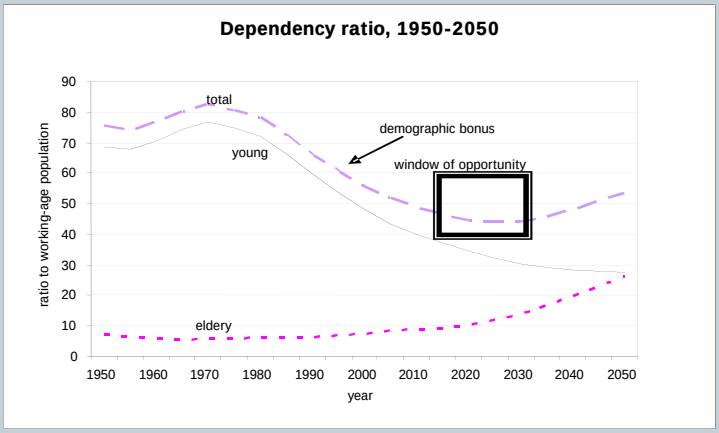

Source: Adioetomo 2007.

…but may also have serious implications for the delivery and financing of health care; doubling the need for care from aging alone.

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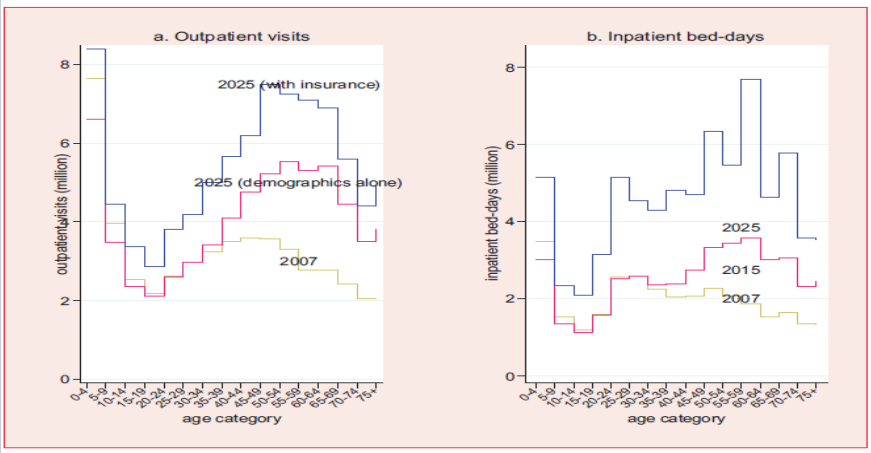

Source: Author's calculations.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Although communicable disease remains a large burden, with the changing age structure disease patterns will shift to noncommunicable disease and injuries, increasing and diversifying the demand for health care further.

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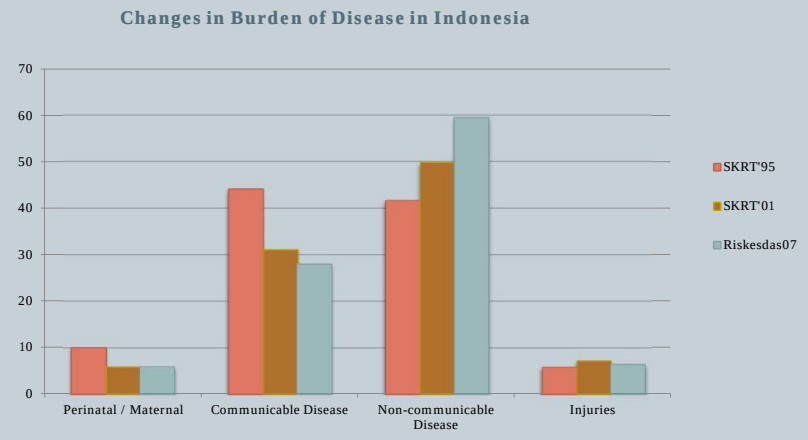

Source: Riskesdas Survey 2007.

The obesity rate is rising and increased prevalence of risk factors will change the burden of disease – increasing the need for preventive measures.

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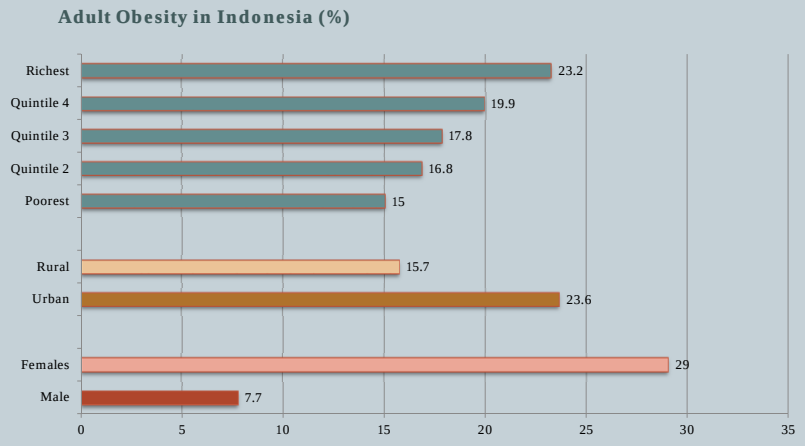

Source: Riskesdas Survey 2007.

Increased need will demand more resources for health. Fortunately, despite the global economic crisis, the macroeconomic picture is still favorable.

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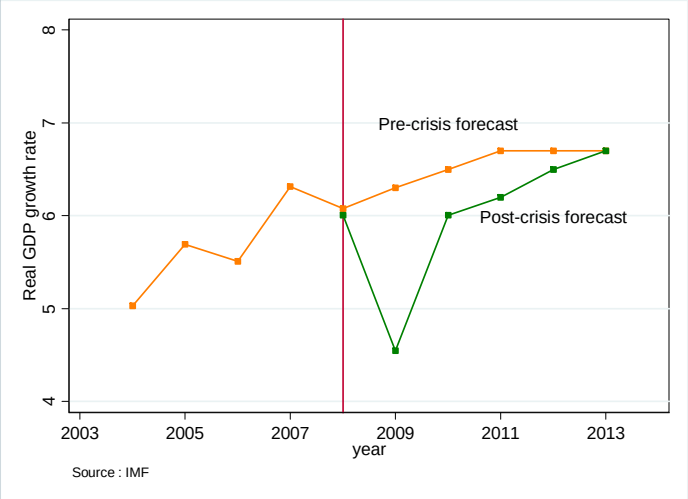

World Bank. 2009. Giving More Weight to Health in Indonesia.

Health System Performance

10

Indonesia's health system performance measured in terms of health outcomes, financial protection, consumer awareness and equity and efficiency is mixed:

- Indonesia scores highly on reducing child mortality but low on reducing maternal mortality.
- Inequities in health outcomes between income levels and geographic areas are very large and constitute a major problem for the health sector overall.

Indonesians live longer in 2010 and child mortality has fallen dramatically since the 1960s.

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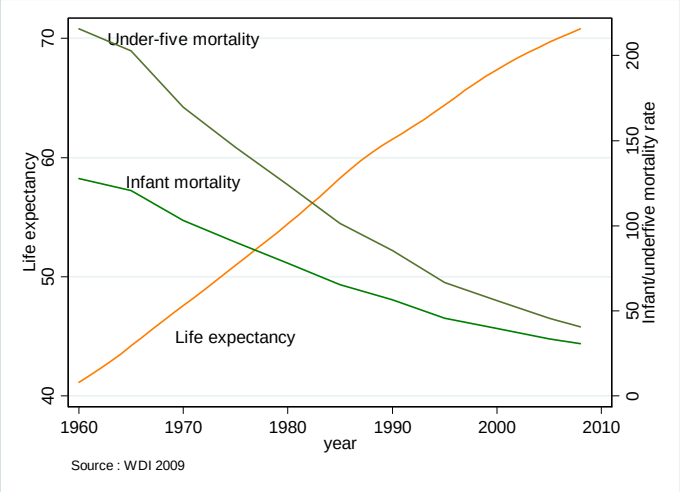
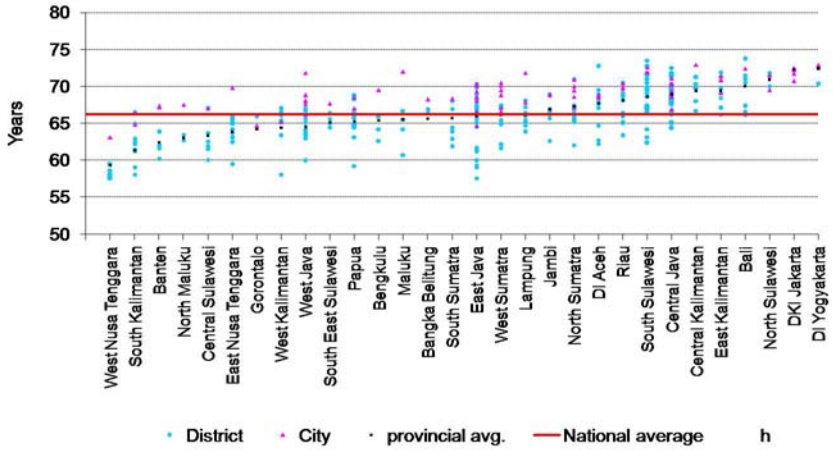


World Bank. 2008. Investing in Indonesia's Health: Health Expenditure Review 2008.

But geographic inequities remain large: life expectancy varies between 60 in West Nusa Tenggara and 75 in Yogyakarta.

12



World Bank. 2008. Investing in Indonesia's Health: Health Expenditure Review 2008.

Indonesia performs well in terms of infant mortality relative to other comparable health spending level countries but less well for its income.

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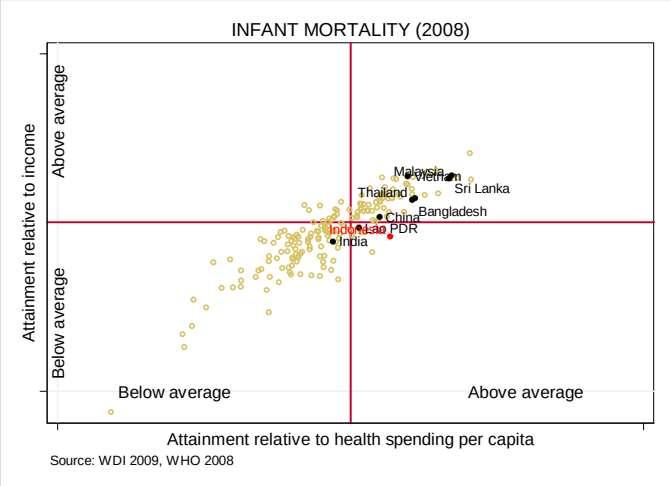
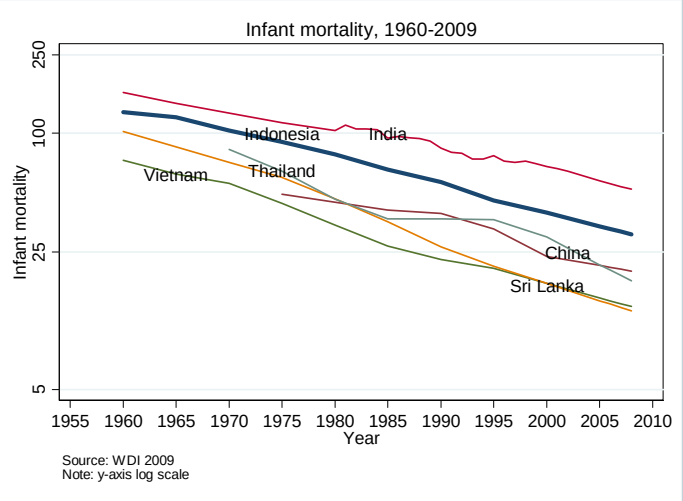


World Bank. 2009: Health Financing in Indonesia: A Reform Road Map.

Despite significant reduction in IMR over time, some neighboring countries have performed better.

14



World Bank. 2009: Health Financing in Indonesia: A Reform Road Map.

And there are large inequalities between provinces and income levels.

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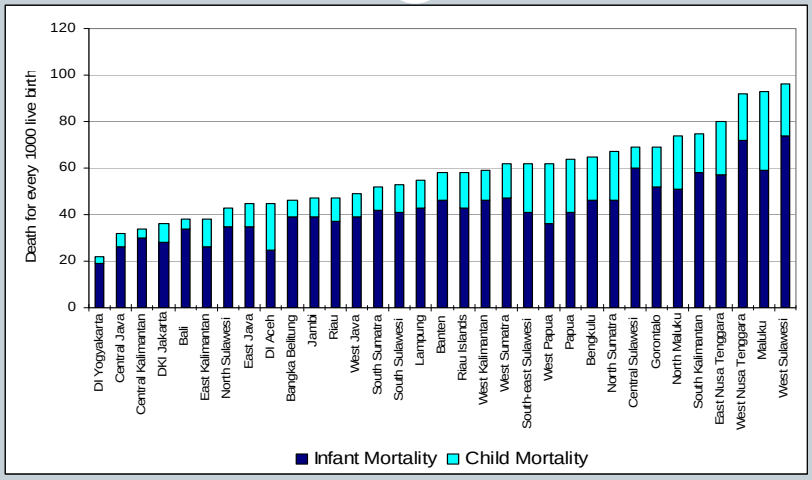

Source: DHS 2007.

In fact, some of Indonesia's provinces are at par with some of the best and worst performing countries.

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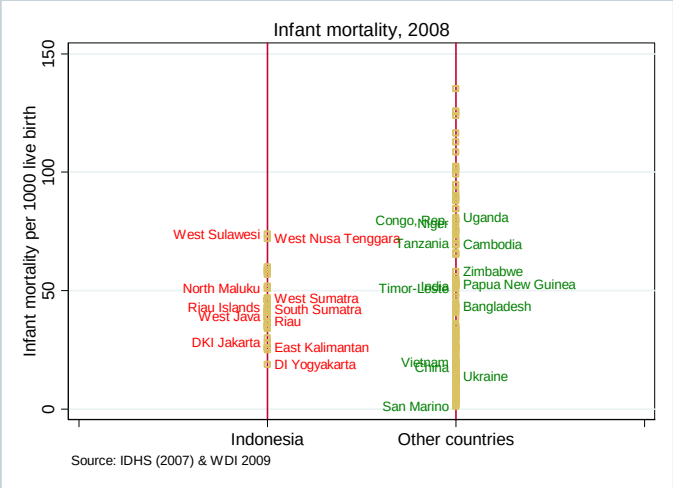
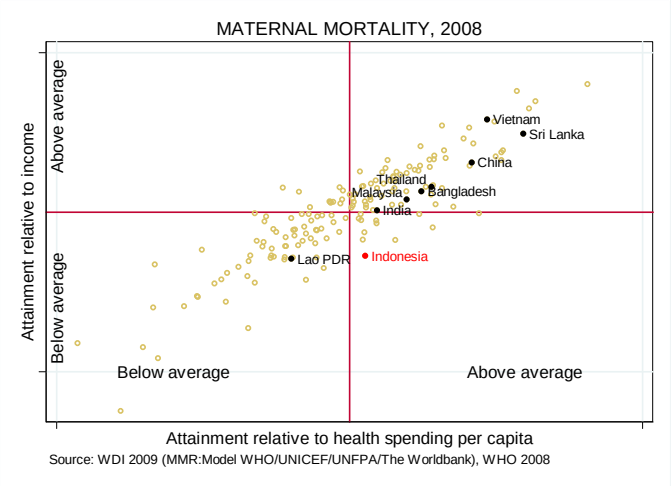


World Bank. 2009: Presentation on Health Financing in Indonesia: A Reform Road Map.

Indonesia also performs less well on maternal mortality for its income level in international comparisons.

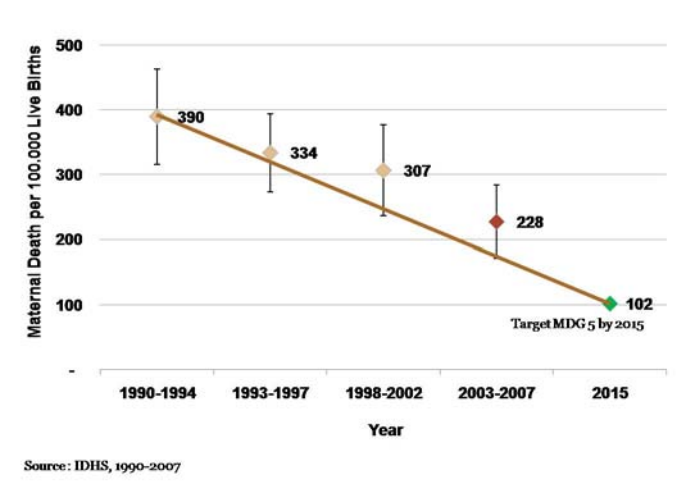
17



World Bank. 2009: Health Financing in Indonesia: A Reform Road Map.

And will need extra efforts to achieve the MDG of reducing maternal deaths by 75 percent by 2015.

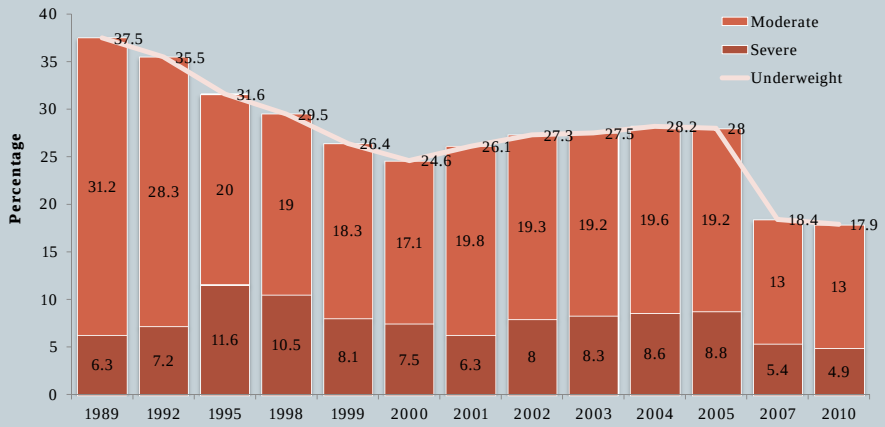
18



The World Bank 2010."...End Then She Died": Indonesia Maternal Health Assessment.

Underweight among children under five years of age has declined significantly…

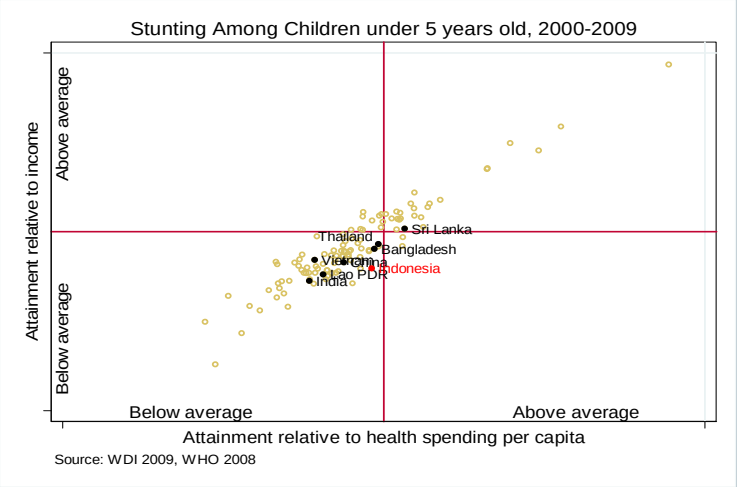
19



Source : Susenas 1989-2005, Riskesdas 2007-2010

…however, stunting rates, which are an indicator of chronic malnutrition, remain very high.

20



Source: WDI 2009, WHO 2008

Health Spending Trends

21

By any measure Indonesia's public spending on health is low and inequitably distributed:

- Indonesia's public health spending as a proportion of GDP has stagnated in recent years and compares unfavorably with other comparable income countries.
- Indonesia's Out-of-Pocket (OOP) spending is about average for its income level and has improved in recent years.
- Indonesia does reasonably well on reducing catastrophic spending incidence but less well on health insurance coverage and equity.
- Public spending on health is inequitably distributed across provinces and income quintiles.

Despite substantial increases in government health expenditures as a share of GDP over recent years, Indonesian governments barely spends 1 percent of GDP on health

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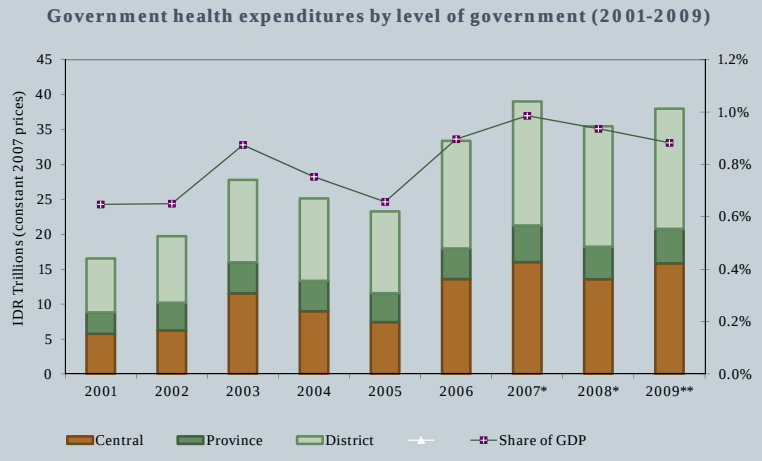
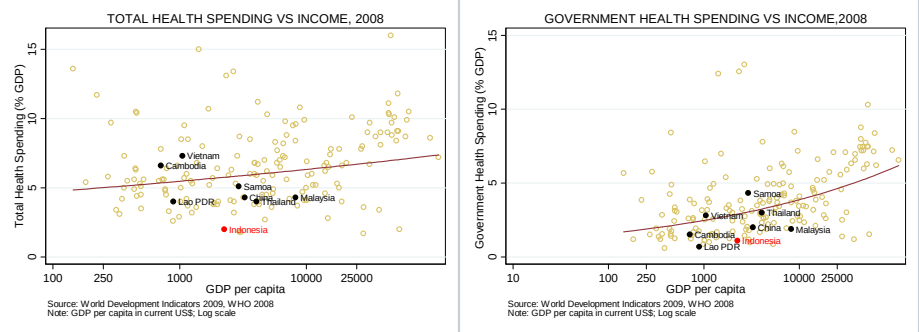


World Bank. 2008. Investing in Indonesia's Health: Health Public Expenditure Review 2008.

Total and public health spending in Indonesia is low relative to other comparable income countries.

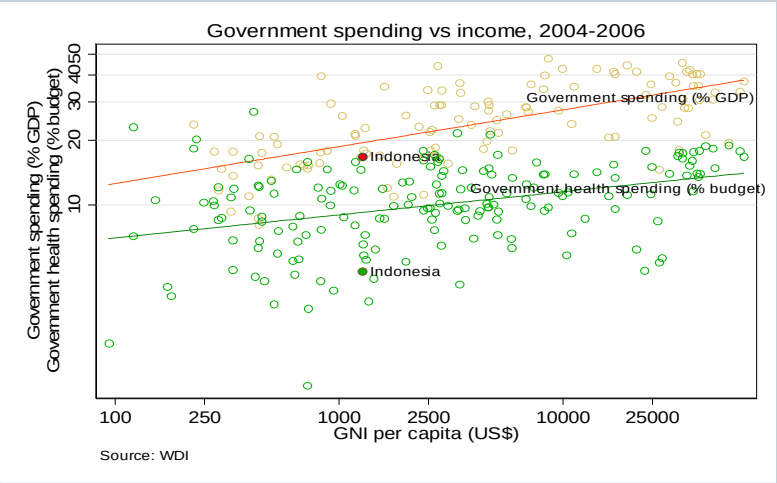
23



World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

And government health spending as a share of the budget is even lower than total government expenditures as a share of GDP.

24



World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

OOP spending, a measure of financial protection, is about average relative to comparators.

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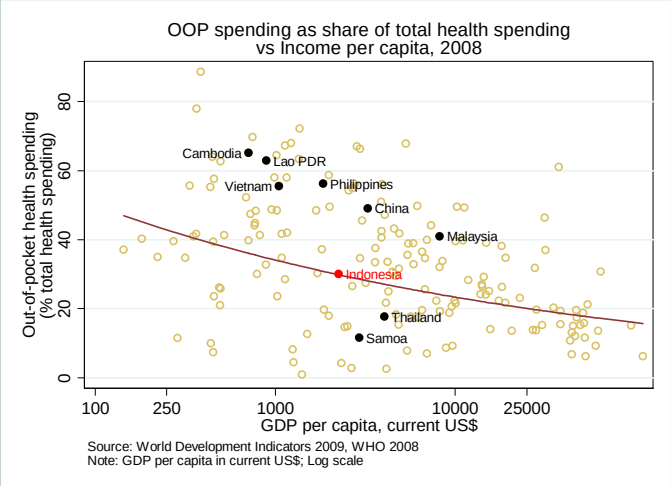

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Financial protection, measured as the OOP share of nonfood spending has improved.

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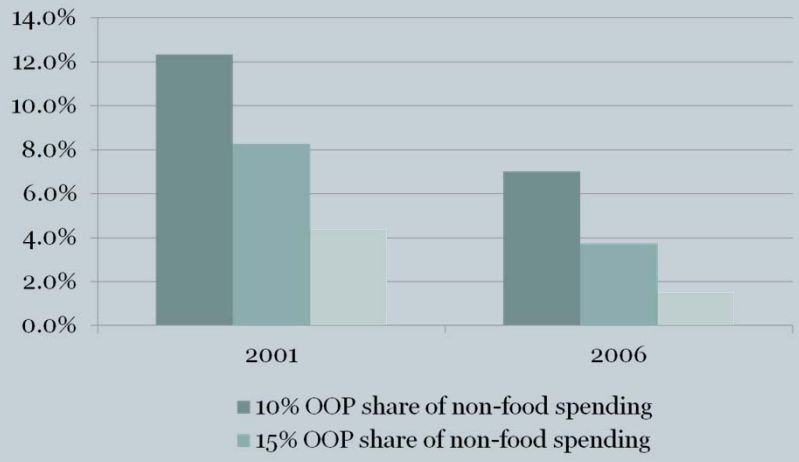
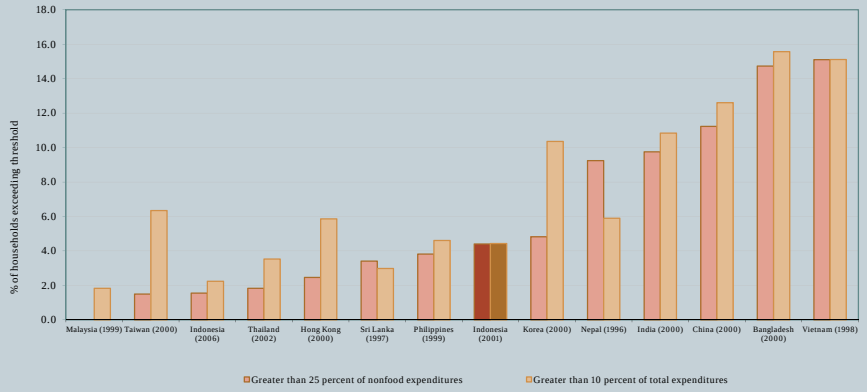


Source: Equitap Update 2009.

By regional standards, the incidence of catastrophic health spending is low in Indonesia.

27



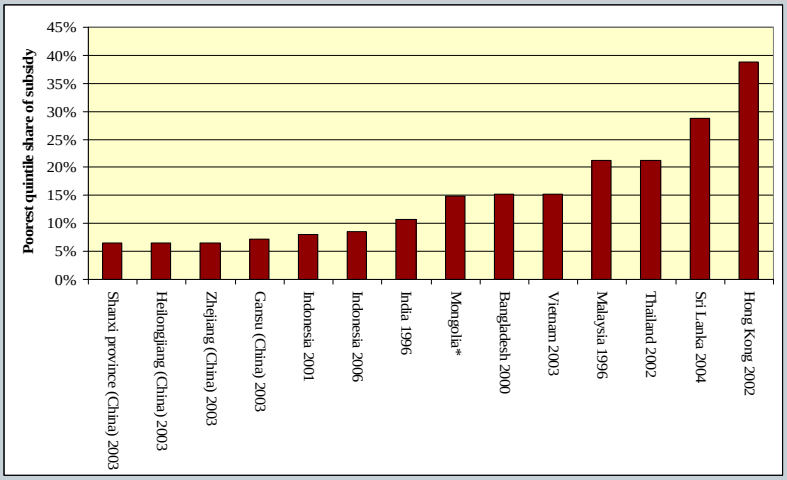
Catastrophic payments for health care are defined as OOP payments in excess of a substantial proportion of the household budget, usually 10-40 percent (Van Doorslaer et al. 2006; Xu et al, 2003)

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Equity of public spending on health could be improved; it is low in international comparisons and has not changed much since 2001.

28

Poorest Quintile Share of Public Hospital Inpatient Subsidies in EAP Region

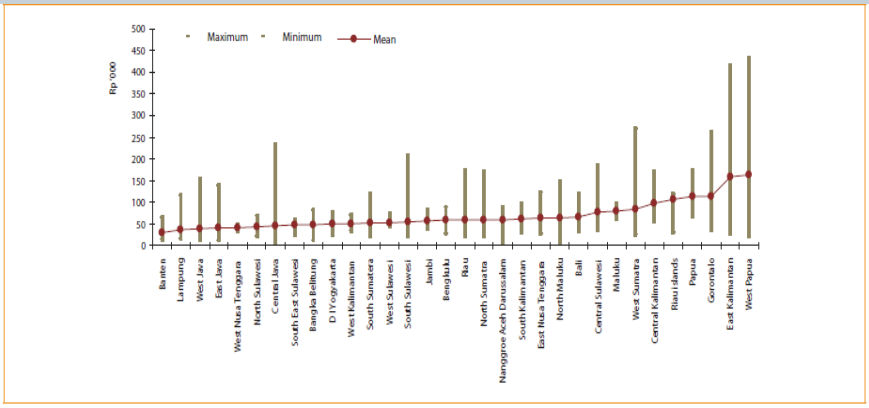


World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Inequities between provinces are also evident from differences in health expenditures.

29

District Public Health Expenditures by Province (2005)

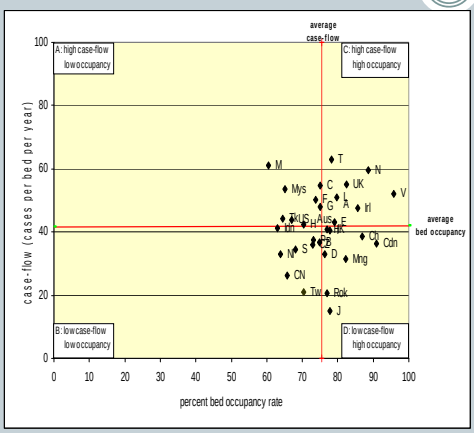


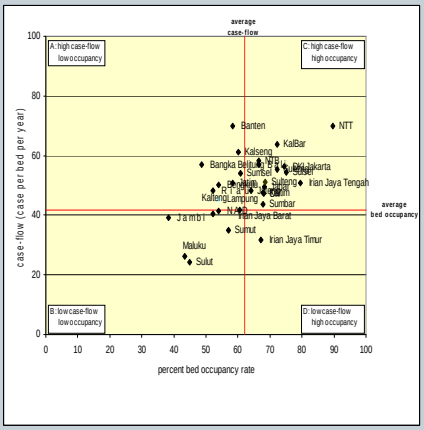
Source: World Bank, SIKD database, based on data from MoF.

World Bank. 2008. Investing in Indonesia's Health: Health Expenditure Review 2008.

Technical efficiency is low in Indonesia in global comparisons and there are large differences between provinces.

30





Technical efficiency is ideally measured using case-mix unit cost data, however these are not available in Indonesia. Instead case-flow and average bed occupancy are used.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Indonesia's Health Delivery System

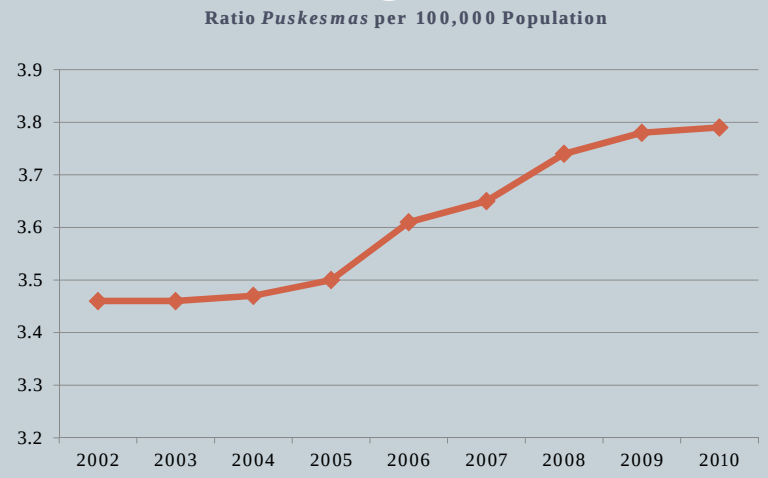
31

An already stretched health system will incur further pressure due to increased demand from ongoing demographic, nutrition and epidemiological transitions as well as the introduction of universal health insurance coverage.

- Indonesia's health infrastructure, although widely available for primary care, does not have sufficient beds or health workers to respond to these increased needs.
- Pharmaceutical supplies are reasonable but most Indonesian pay more than they need to and most expenditures are out of pocket.
- There is a pressing need to address human resources distribution inequities and quality.
- Satisfaction levels overall are good although there is a high level of dissatisfaction with various aspects of health care.

Indonesia's primary public health care system is extensive: more than 90 percent of the population has access to primary care facilities.

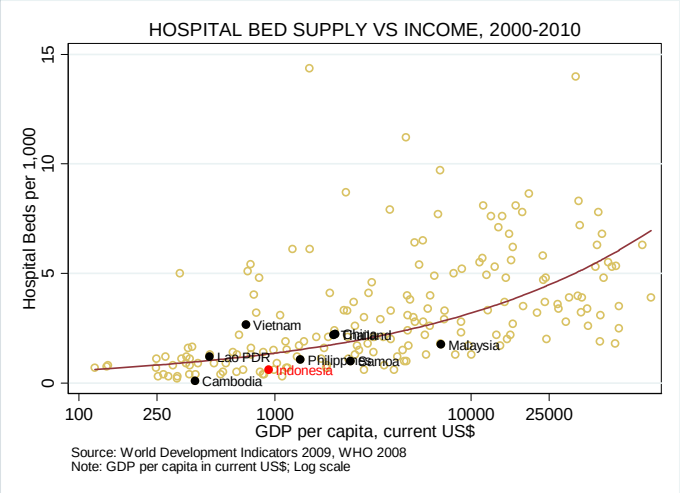
32



Source: MoH. 2010. Health Profile.

While Indonesia has a well-developed primary health system, it has fewer hospital beds than comparators.

33



World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

And Also Fewer Health Workers

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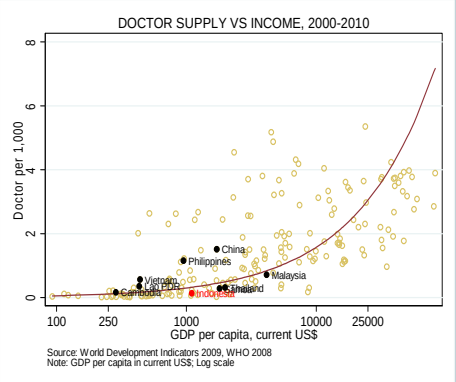
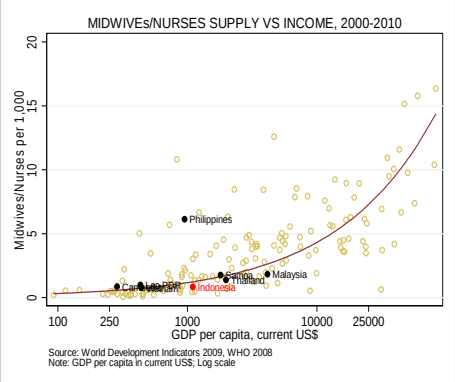




World Bank. 2010. New Insights into the Provision of Health Services in Indonesia: A Health Work Force Study.

At the *Puskesmas* level most basic services are available.

35

Structural Indicators and Quality Scores for Prenatal, Child Curative and Adult Curative Care (by Clinical Setting)(2007)

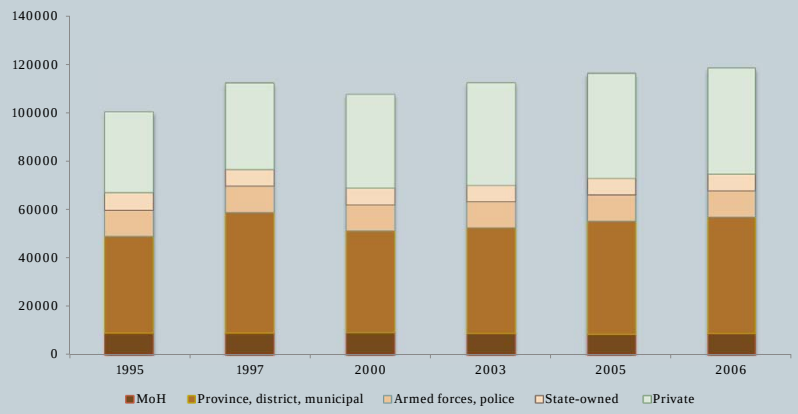
Quality Measures	Public Settings		Private Settings			
	Puskesmas	*Pustu*	Private Nurse	Private Midwife	Private MDs	All Settings
Structural quality						
Internal water source (%)	89	71	80	84	89	84
Inpatient beds (%)	28	3	3	28	3	18
Functioning microscope (%)	79	5	1	3	7	25
Tuberculosis service (%)	95	30	8	2	44	38
Measles vaccines in stock (%)	97	51	5	48	11	51
Tetanus toxoid vaccine in stock (%)	97	55	9	59	12	55
Hepatitis B vaccine in stock (%)	92	52	6	54	16	52

World Bank. 2010. New Insights into the Provision of Health Services in Indonesia: A Health Work Force Study.

Secondary and tertiary care have not progressed equally: the number of hospitals and hospital beds has grown slowly.

36

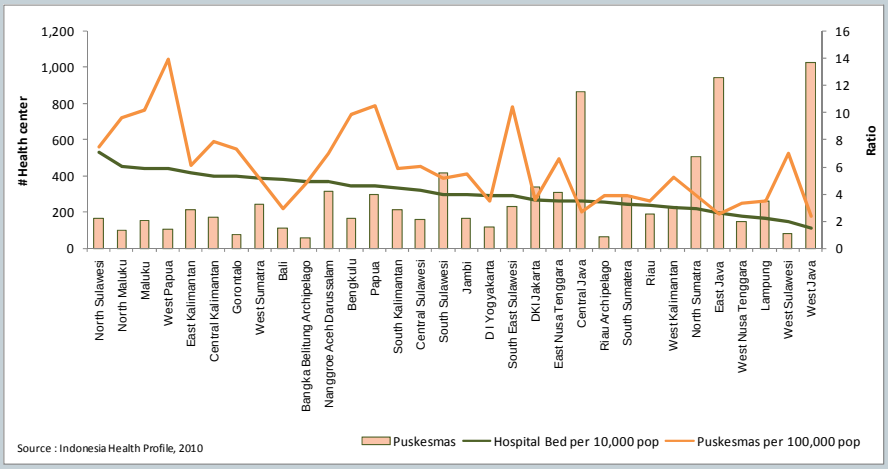
Increase in numbers of hospital beds between 1995 and 2006 by ownership



World Bank. 2008. Investing in Indonesia's Health: Health Expenditure Review 2008.

There are 3 beds per 10,000, 3.8 *Puskesmas* per 100,000 and 6.9 hospitals per 1,000,000 Indonesians, however, on average, there are serious inequities among provinces.

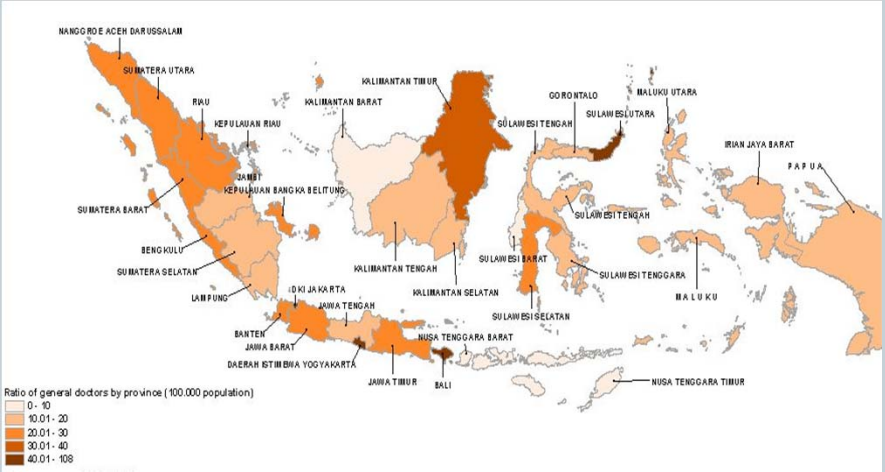
37



Source : Indonesia Health Profile, 2010

The ratio of physicians to population also masks significant inequities among urban and rural areas.

38



Source: KKI 2008.

DPT3 immunization, often considered a good indicator of health system coverage, is low for Indonesia's health expenditure level and may indicate low levels of efficiency.

39

Country	Total health expenditure pc (US$)	DPT3 immunization coverage
Indonesia	**26**	**70**
Uganda	22	84
Rwanda	19	95
Tajikistan	18	85
Tanzania	17	90
Nepal	16	75
Pakistan	15	80
Bangladesh	12	88

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Analysis of the number of staff per primary care facility illustrates inequalities at the facility level...

40

	National		Java-Bali		Sumatra		Other Provinces	
Facility	**1997**	**2007**	**1997**	**2007**	**1997**	**2007**	**1997**	**2007**
Puskesmas								
Number of Doctors	1.51	1.90	1.68	1.96	1.19	1.85	1.09	1.62
Number of Doctors (%)	3.4	7.0	1.5	5.9	2.0	6.8	15.9	11.3
Number of Midwives	5.85	3.69	5.76	3.44	6.33	5.28	5.62	3.18
Number of Nurses	5.05	6.14	4.58	5.60	6.16	7.16	5.84	7.61
Pustu								
Number of Midwives	0.98	0.81	1.06	0.76	1.13	1.17	0.44	0.21
Number of Nurses	1.08	1.06	1.02	1.09	1.16	1.08	1.16	0.89

Source: IFLS 1997; 2007.

...and quality, measured as diagnostic and treatment ability, varies between regions and geographic areas and has not improved much over time.

41

Quality of Public Health Services in Indonesia 1997-2007 (by Region)

Service	National			Java/Bali			Sumatra			Other Provinces		
	1997	2007	P=	1997	2007	P=	1997	2007	P=	1997	2007	P=
Prenatal Care												
Public	42	46	***	45	47	**	35	39	**	38	49	***
Private	40	44	***	43	46	***	34	37	**	39	46	***
Child Curative Care												
Public	56	64	***	58	66	***	48	56	***	55	65	***
Private	55	59	***	57	62	***	50	52		54	60	***
Adult Curative Care												
Public	49	56	***	52	59	***	43	48	***	44	53	***
Private	46	53	***	48	56	***	40	51	***	44	51	***

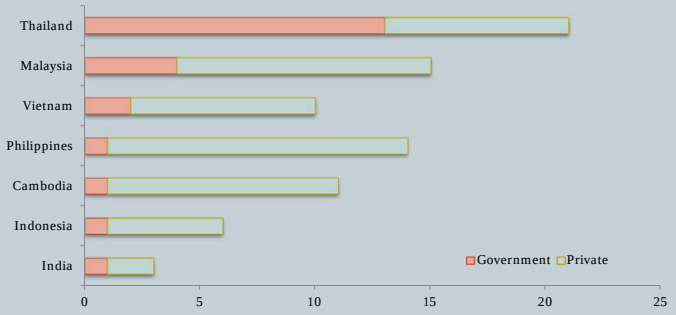
*** $p<0.01$, ** $p<0.05$

World Bank. 2010. New Insights into the Provision of Health Services in Indonesia: A Health Work Force Study.

In international comparisons Indonesia spends little on medicine per capita, and most expenses are out-of-pocket.

42

Spending on drugs per capita in US$



Over half of Indonesian districts spent less than US$0.55 per capita in 2007 and some spent less than US$0.10. Districts would need to spend around US$1.50 per capita or more on average (assuming the central government continues to provide around US$0.55 per capita for *Puskesmas* drugs) to provide all the primary care medicines recommended by WHO.

Source: WHO. 2004. The World Medicines Situation.

But most Indonesians pay more than they need to for their medicines when they buy from the private sector or from public hospitals.

43

Price ratio to median international indicator price	Originator brands	Most sold branded generic	Lowest price generic
Private pharmacies	22-26	6-7	2.6
Public hospitals	22	1.7-6	2.15

Source: National Institute for Health Research and Development (NIHRD) Survey 2004.

Provision of health services by private health providers has grown significantly over the past decade.

44

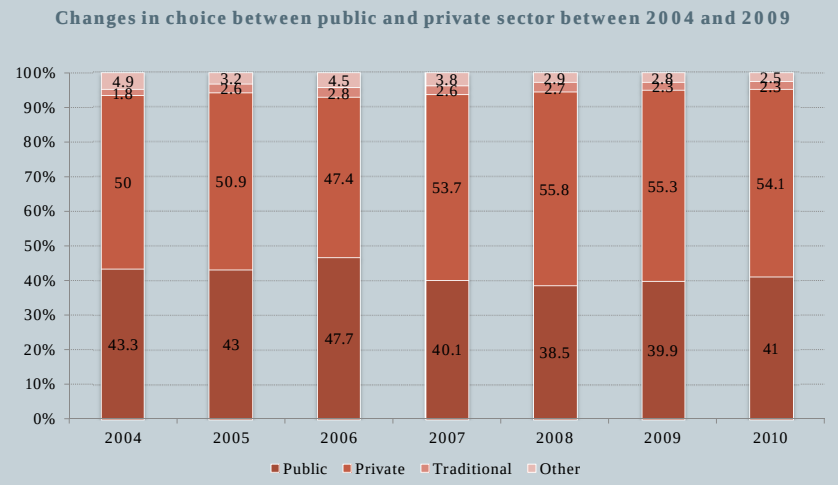
- At the national level, physician practices per 1,000 of population grew at 38.5 percent
- The number of midwife practices per 1,000 population increased by 4.64 percent.
- And the majority of physicians working in a *Puskesmas* supplement their income through private service provision

	% of *Puskesmas* physician w/ private practice	
	1997	2007
All sample	76.57	67.96
Urban	75.05	66.61
Rural	78.78	70.66
Sumatera	81.48	68.06
Urban	82.65	62.61
Rural	80.22	76.32
Java-Bali	77.23	70.03
Urban	74.19	69.00
Rural	82.91	72.90
Other provinces	68.52	61.02
Urban	69.33	60.44
Rural	67.82	61.63

World Bank. 2010. New Insights into the Provision of Health Services in Indonesia: A Health Work Force Study.

And utilization of private health providers fell after *Askeskin* was introduced and the utilization of *Puskesmas* increased.

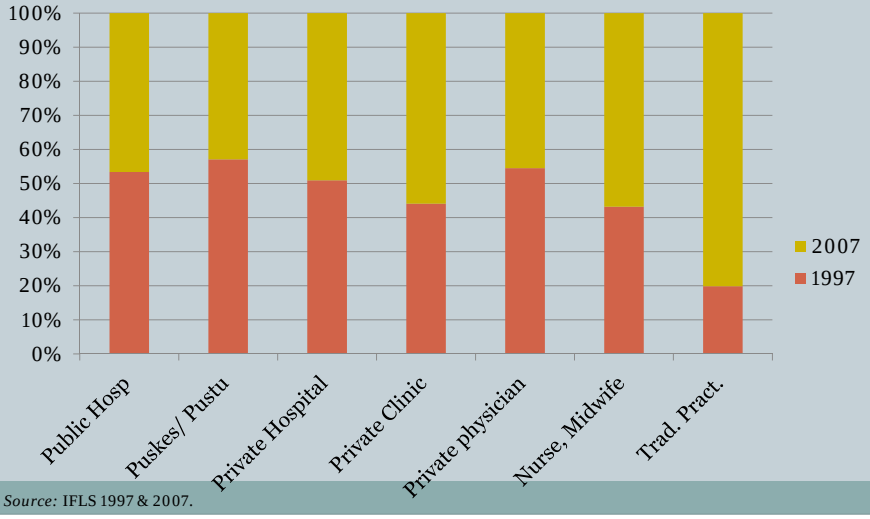
45



Various Susenas : Worldbank staff calculation

However, most Indonesians continue to seek ambulatory care from private providers when ill.

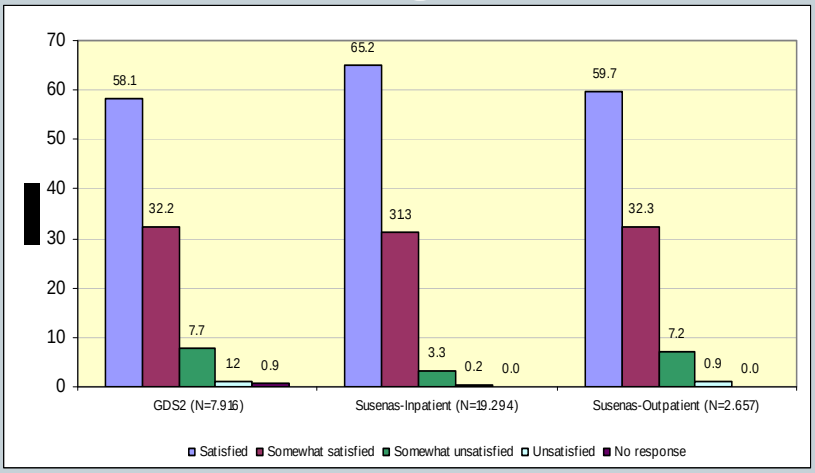
46



Source: IFLS 1997 & 2007.

Overall consumer satisfaction with inpatient and outpatient services appears good...

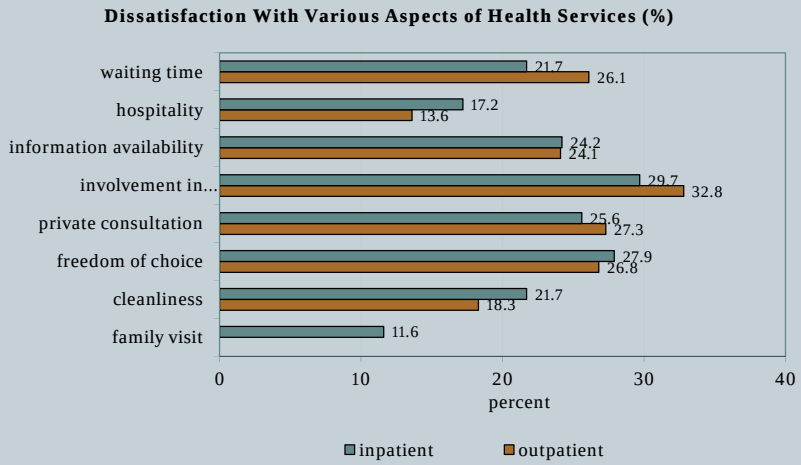
47



Source: GSD2 and *Susenas*.

...although there is a high level of dissatisfaction with various aspects of the provision of health care...

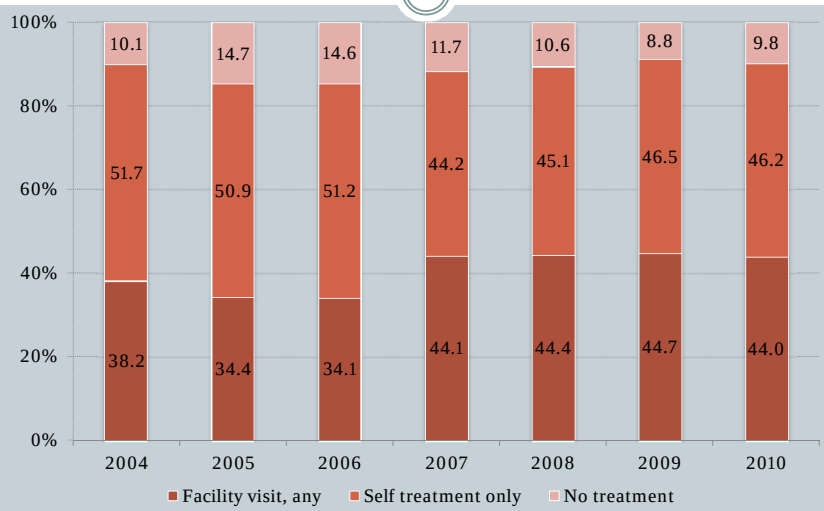
48



Source: Sakernas National Health Survey 2004.

...and many people continue to opt for self-treatment or forego treatment altogether.

49



Source: Susenas various years.

Health Financing Reform

50

The new government is committed to implementing the reform and assuring all Indonesian citizens access to quality health services and financial protection against the impoverishing effects of large unpredictable medical care costs.

Fulfilling this commitment will require the development, implementation, and monitoring of policies affecting all aspects of the health system – basic public health programs; delivery systems and logistical capacity; quality and distribution; organization, management, and accountability; pharmaceuticals; financing; public—private partnerships and all levels of government.

Background

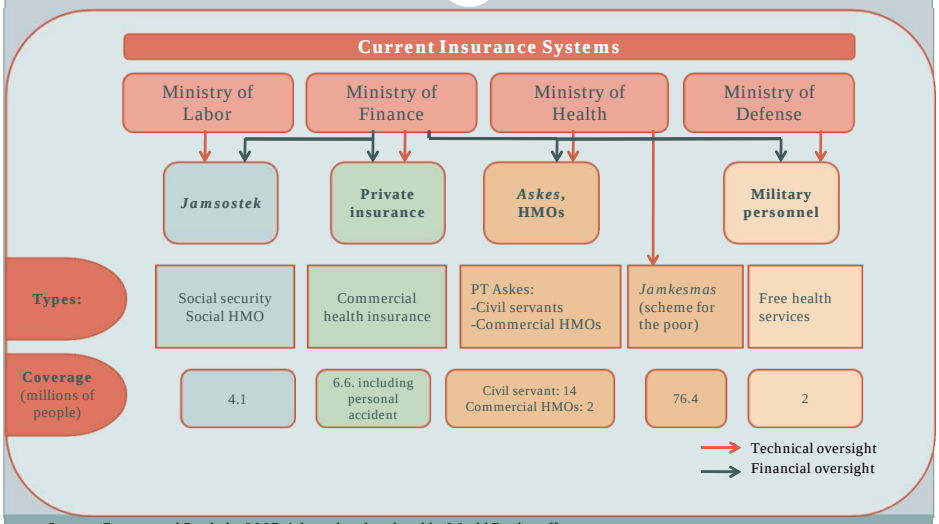
51

- The 2004 Social Security legislation (Law No. 40) envisages coverage of the entire population through a mandatory health insurance system evolving from the existing insurance programs.
- As of 2009 the government has covered some 76 million poor and near poor through the *Jamkesmas* program, funded through the central government budget.
- However, progress over the last five years has been slow in developing the final configuration of the health insurance system and the transition plan to provide health insurance to the remaining 50+ percent of the population who currently lack coverage remains to be developed.
- Many local governments have developed their own financing schemes, some for the uncovered non-poor.
- The health insurance reform is complicated by the big bang decentralization reform that took place in 2001 which transferred most of the authority and responsibility for assuring service delivery capacity to local governments.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Health insurance systems in Indonesia since 2008.

52



Source: Gotama and Pardede. 2007. Adapted and updated by World Bank staff.

The Current Health Policy Baseline for Health Financing Reform: **System Strengths.**

53

- The country has favorable demographic circumstances with dependency ratios falling over the next 30 years
- There are high educational and literacy levels
- The government is committed to reform
- Health spending levels are not excessive
- The country achieves reasonable health outcomes, financial protection and consumer satisfaction
- There is substantial experience with health insurance programs
- There is an extensive primary care delivery system
- Pharmaceuticals are generally available

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

The Current Health Policy Baseline for Health Financing Reform: **System Challenges.**

54

- Half the population lacks health insurance coverage
- Health financing and delivery systems are highly fragmented
- Human and physical infrastructures are limited and face quality and efficiency problems
- Salary and capital subsidies to public health providers preclude the development of a 'level playing field' for both public and private providers to compete on the basis of price
- Critical data for decision making are lacking, including national and subnational health accounts, detailed information on the numbers, risk profiles of the insured and the uninsured, and unit cost information
- Design features of the *Jamsostek* and *Askes* programs result in high OOP costs for program beneficiaries and limit operational effectiveness and sustainability
- Local contributions vary widely, current intergovernmental fiscal redistributions may not adequately reflect local fiscal capacity and need, and the fiscal capacity of districts vary widely.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Framework to Assess HI Financing Options.

55

- **What is the 'ultimate' HI system of Universal Coverage (UC) under Law No. 40:**
  - single unitary Social Health Insurance (SHI); or
  - multiple systems under a single set of rules; or
  - a unitary general revenue funded system (e.g., *Jamkesmas* for all)?
- **What are the specific details of this system with respect to:**
  - single or multiple funds;
  - eligibility of different groups including informal sector workers;
  - benefits covered including cost sharing and referral requirements;
  - financing including public subsidies and regional contributions;
  - provider payment and cost containment;
  - quality assurance;
  - Administration; and
  - the role of the private sector.
- **What are the transition policies to get to (UC)?**

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Future Vision 1: *Jamkesmas* for All: An Indonesian NHS.

56

- This approach approximates a National Health Service like that in Sri Lanka.
- It reflects the fact that more than half of the population is currently poor or near poor, and thus has a very limited ability to pay.
- It also recognizes the inherent difficulty of identifying the 61 percent of workers who are in the informal sector and having them pay premiums.
- By picking up formal sector workers through general revenues, firms might be more competitive as their 3-6 percent payroll contributions would be eliminated and/or could be replaced by more efficient and equitable broad-based taxes.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Future Vision 2: A Single Integrated SHI Fund.

57

- This approach approximates the 'new' national SHI model (now called Mandatory Health Insurance (MHI)) where the SHI is funded through both wage-based contributions for public and private sector workers (and retirees) and government general revenue contributions for the poor and other disadvantaged groups.
- Under this approach there would be a single standardized national HI fund (although one could also establish multiple funds as in Germany or Japan).
- The poor would be financed through the GoI budget, while government and private sector workers would be funded as now through wage-based contributions.
- The GoI would need to decide if informal sector workers would be covered by the GoI like the poor (as in Thailand) or whether mechanisms can be developed to make them contribute some share of their earnings.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Future Vision 3: MHI through a Single Set of Rules Applying to Multiple SHI and NHS Type Programs.

58

- This approach could be considered as a variant of Option 2 or a combination of Options 1 and 2.
- Existing programs would be scaled up to include the entire population.
- All the poor and other disadvantaged groups would be covered through *Jamkesmas*.
- All private sector workers would be covered through *Jamsostek* (possibly though elimination of the opt out, employer size, and wage ceiling restrictions and adding requirements to cover retirees).
- Civil servants and civil service retirees would be covered through *Askes* (or the *Askes* program could be folded into *Jamsostek*, or conversely).
- A decision would need to be made about how to handle informal sector workers.
- The three programs would have separate administrative structures but would operate under the same set of rules concerning issues such as benefits and contracting/provider payment.
- There might be cross-subsidies required across programs on the financing side.

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

No Matter Which Option is Chosen, The Devil Will Be in The Detail.

59

- Administrative and governance arrangements
- Defining the benefit package
- Determining eligible groups
- Determining purchasing/contracting arrangements and cost containment policies
- Estimating actuarially sound premium levels
- Determining financing sources
- Defining revenue collection mechanisms
- Defining transition steps to new system
- Developing and implementing monitoring and evaluation procedures

World Bank. 2009. Health Financing in Indonesia: A Reform Road Map.

Actuary Estimates

60

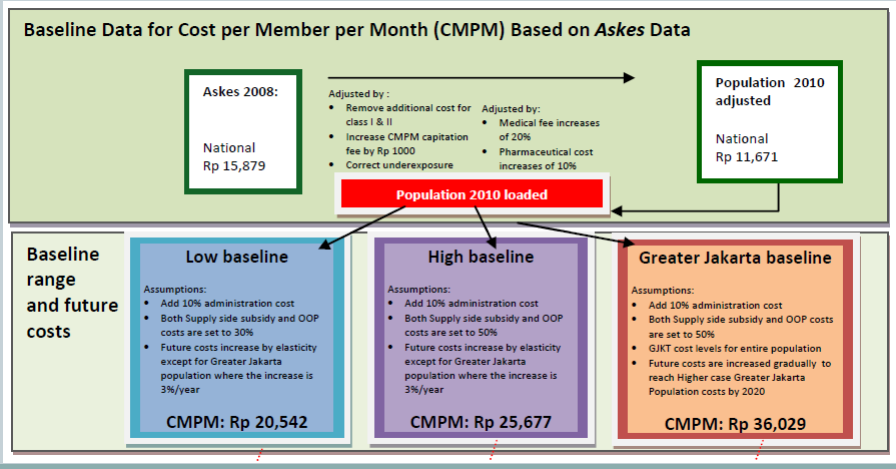
The purpose of the actuarial estimates was to respond to the GoI request to assist in developing baseline estimates for the cost of existing health insurance programs and to perform an actuarial analysis to cost different options for attaining UHIC.

It demonstrates the importance of the decisions to be taken regarding the detail as each decision influences the level of financing needed.

The exercise included the development of a baseline based on the 2008 *Askes* claims data, the creation of a range of baselines and the creation of various scenarios.

CMPM estimation which include out-of-pocket (OOP) expenses, subsidies to the public system and supply constraints assumption in various scenarios, provides a more realistic expenditure estimate ranging from Rp 20,542 CMPM to Rp 36,029.

61



Source : Actuarial costing of Universal Health Insurance Coverage in Indonesia : Options and Preliminary results, Worldbank 2011

Projecting costs forward to 2020 suggests that UC in Indonesia is likely to require an expenditure range between Rp 127 trillion (6.66 percent of total public expenditures and 1.17 percent of GDP) and Rp 221 trillion (11.58 percent and 2.03 percent).

62

- Same level of supply constraints as exists today. Excludes adverse selection and assumes a normal pooling of good and bad risks
- Amounts in Rupiah are expressed in real terms. There is no adjustment for inflation
- The amounts include only public expenditures on health insurance. Government budget spending and OOP costs are excluded

Estimated **Cost for Achieving Universal Coverage for All Indonesians Gradually (2010:50%, 2015:75%, 2020: 100%)**

Scenario	Low case			High case			Greater Jakarta case		
Year	2010	2015	2020	2010	2015	2020	2010	2015	2020
CMPM	20,542	28,442	39,835	25,677	35,553	49,793	36,029	56,705	9,222
Annual exp (trillions of Rp)	30	65	127	37	82	159	52	130	221

Source : Actuarial costing of Universal Health Insurance Coverage in Indonesia : Options and Preliminary results, Worldbank 2011

More Resources for Health; Assessing Fiscal Space

63

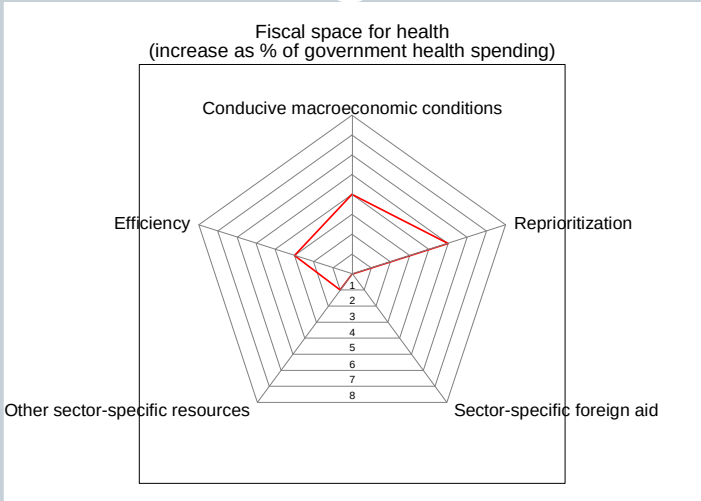
In all likelihood, and for a variety of reasons, Indonesia will need to boost health spending in the near future as it expands access to care through the expansion of *Jamkesmas*, the health insurance scheme for the poor and the near poor.

In addition, projections based on demographic and epidemiological changes in the country indicate there is likely to be a significant increase in the demand and need for health services and more sophisticated care.

Despite a tripling of the public budget for health over the past five years, this increased need, combined with the fact that Indonesia remains a comparatively low spender on health, indicates that there will continue to be upward pressure on resources for the health sector in the near future.

Visualizing fiscal space for Indonesia: different means by which government spending on health can increase.

64

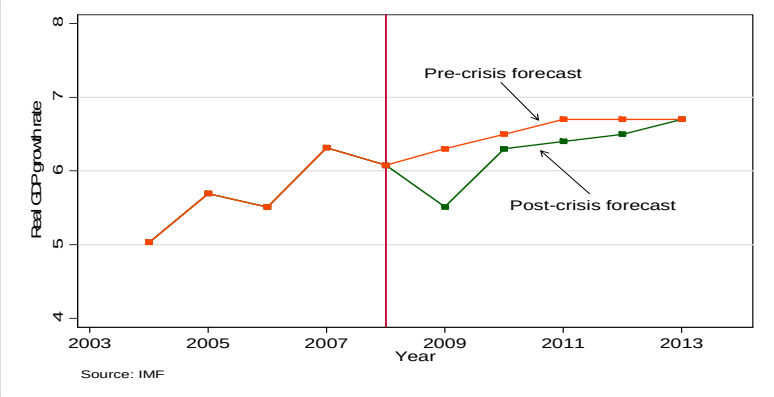


World Bank. 2009. Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia.

One of the most important determinants of fiscal space for health is economic growth which has a positive outlook in Indonesia.

65

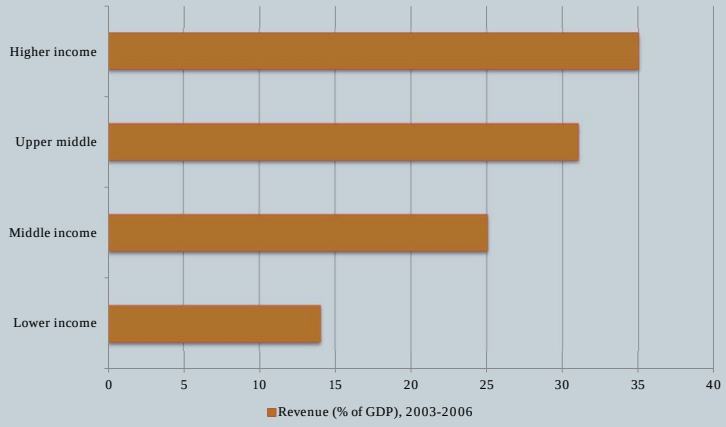
Since the outbreak of the crisis, the IMF has lowered its growth and inflation forecasts for the country, although growth remains in the 6-7 percent range per annum over the period 2008-2013.



World Bank. 2009. Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia.

Higher revenues provide extra resources, but Indonesia's revenues as a percentage of GDP (19 percent) are low in comparison with other lower-middle-income countries.

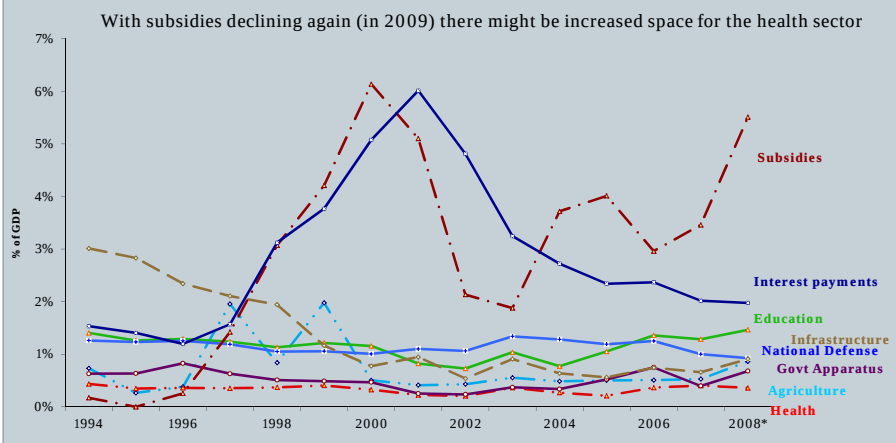
66



World Bank. 2009. Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia.

Given current low levels of spending for health compared to other sectors, a good case can be made for reprioritizing in favor of health.

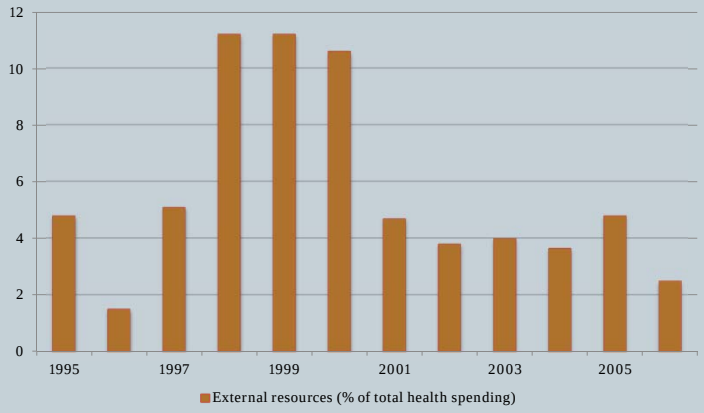
67



World Bank. 2009. Presentation on Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia.

Indonesia's has not depended significantly on external resources for health in recent years.

68

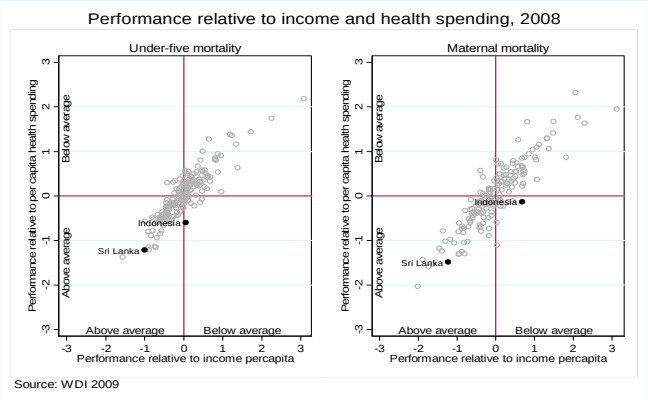


Source: WHO.

In addition to increasing budgets for health, effective fiscal space may be generated by increasing the efficiency of spending.

69

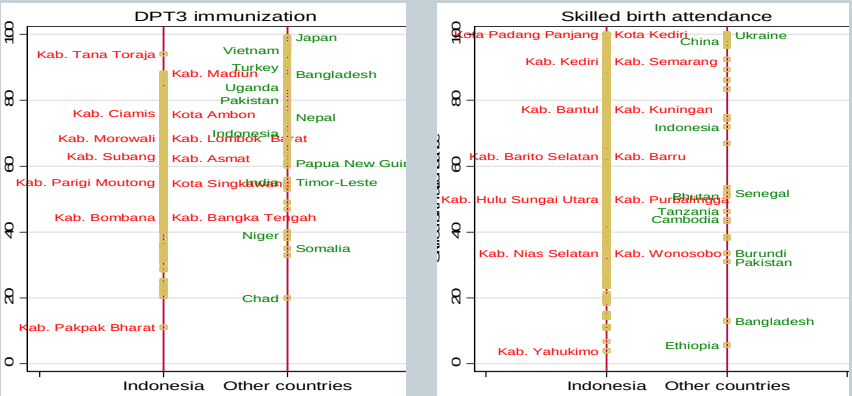
Sri Lanka is often presented as an example of a country that has been able to attain excellent health outcomes with relatively low levels of resources, in part because of the underlying efficiency of its health system.



World Bank. 2009. Giving More Weight to Health: Assessing Fiscal Space for Health in Indonesia.

Local variation in performance across districts further indicates potential efficiency gains.

70



Source: Susenas and WDI.

Focus on MDG 5: Reducing Maternal Death

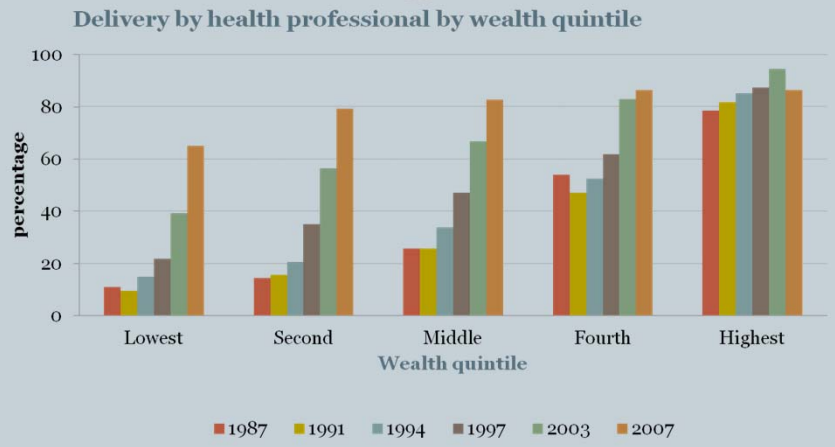
71

At least 10,000 women continue to die of childbirth-related causes every year in Indonesia.

- Even though skilled birth attendance has increased significantly, more needs to be done to accelerate a reduction in deaths and achieve MDG5.
- A large number of women continue to deliver at home without professional help.
- High levels of uncertainty about medical expenses continue to delay the decision to seek care at a facility.
- Even when women reach a facility on time, quality of management is poor and death rates at facilities remain high, especially, but not only, in poor areas.

There has been an impressive improvement in skilled birth attendance since 1987, but the poor continue to lag behind.

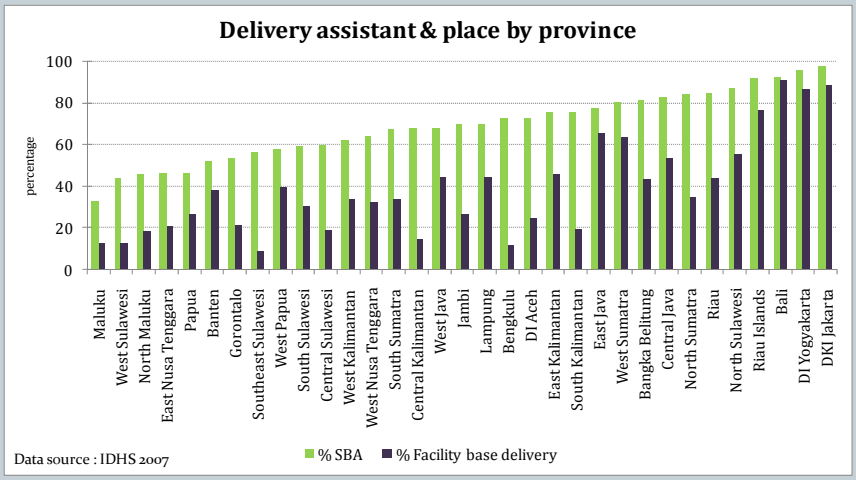
72



Data source : IDHS 1987-2007

Disparities exist between province, economic quintiles, and education levels.

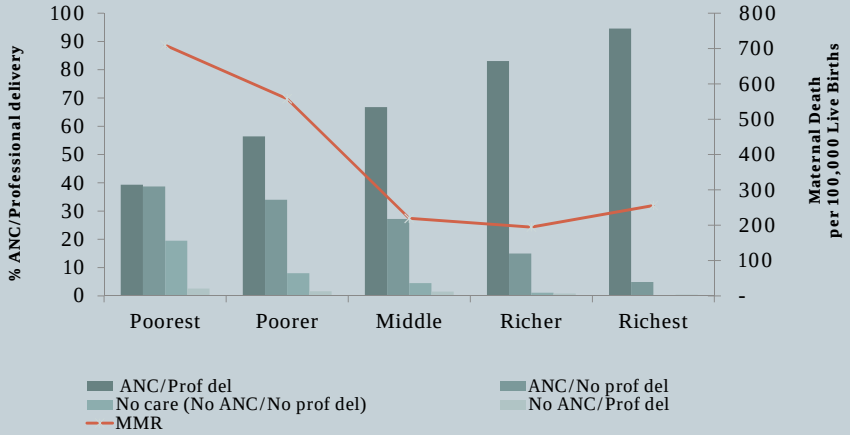
73



Data source : IDHS 2007

Most poor women continue to deliver their babies at home with traditional birth attendants (TBAs) where the risk of maternal death is highest...

74



Source: DHS 2007.

...even though midwives are almost everywhere and are equally distributed.

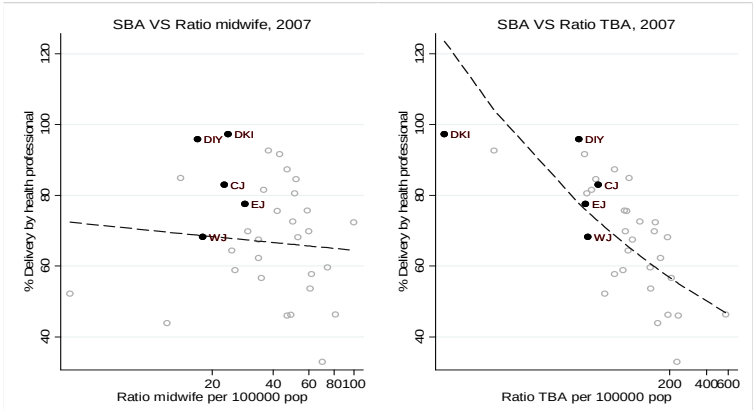
75

Government target is 100 midwives per 100,000 population by 2010.

Note: All types of midwives included. *Source:* Indonesia Health Profile 2008.

Midwife availability has increased significantly, however, TBA remains the preferred choice of provider for childbirth.

76

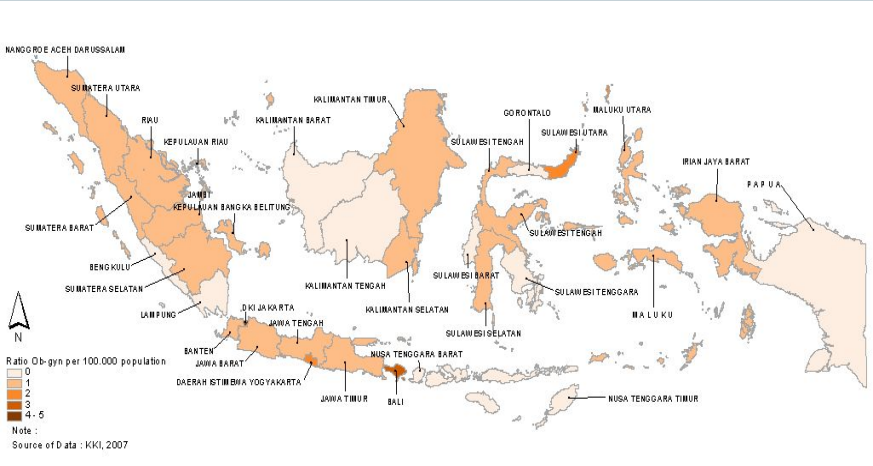


Source: Skilled Birth Attendant (SBA) (IDHS, 2007), Ratio midwife (Indonesia health Profile, 2007)
Ratio Traditional Birth Attendant (TBA) (PODES, 2008)
Note Abbreviation: DKI=DKI Jakarta, WJ=West java, CJ=Central Java, DIY=Yogyakarta, EJ=East Java

World Bank. 2010. Presentation on "...and then she died.." Indonesia Maternal Health Assessment.

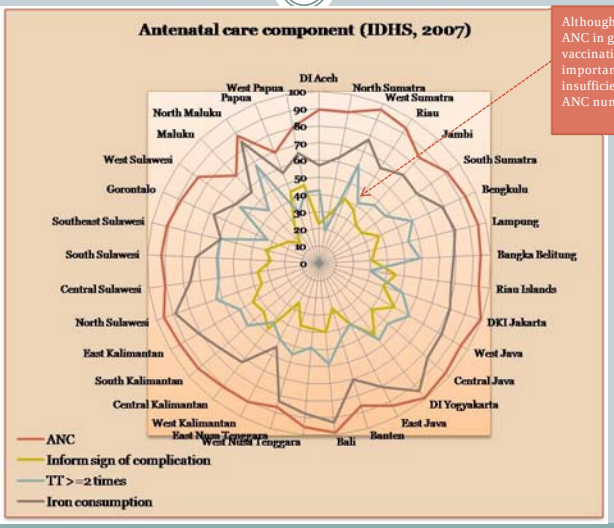
There is a serious shortage of Ob-Gyns in Indonesia and the few there are cluster in richer urban areas.

77



Although more than 70 percent of pregnant women receive antenatal care by skilled providers, the quality of care varies widely.

78

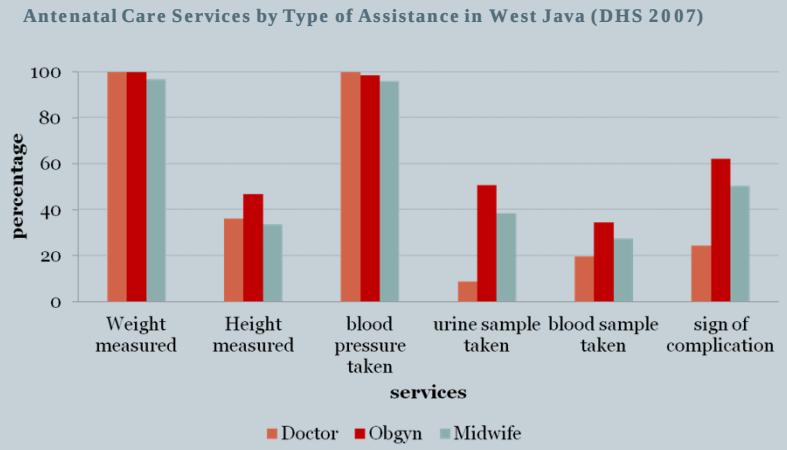


Although Riau scores high on ANC in general, tetanus vaccination is very low and an important part of ANC. It is insufficient to rely only on ANC numbers

World Bank. 2010. Presentation on "...and then she died..". Indonesia Maternal Health Assessment.

Ob-Gyns provide the most comprehensive services but reach only a limited population.

79



World Bank. 2010. "...and then she died..". Indonesia Maternal Health Assessment.

Four areas for priority action to improve the health status of Indonesian mothers: Being implemented in ongoing pilots.

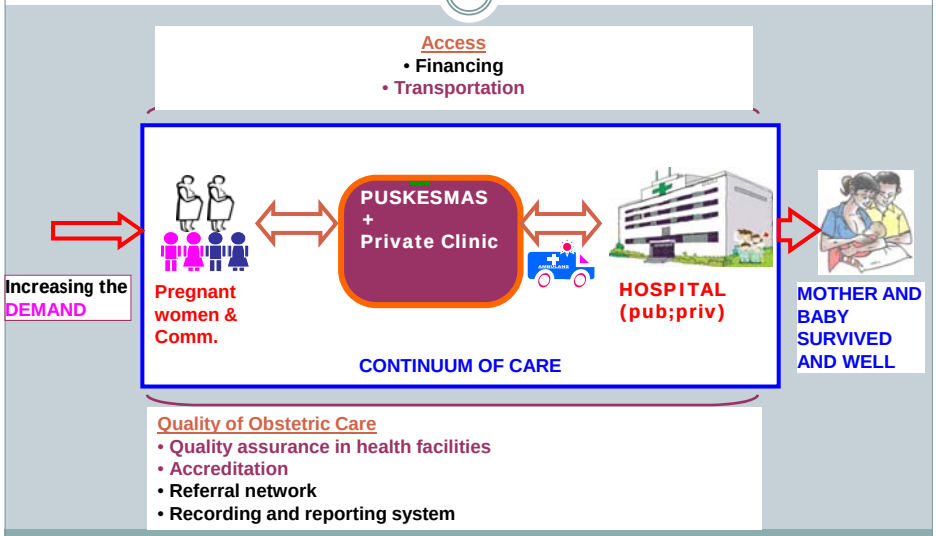
80

1. Improving coordination between public and private sector services at provincial and district levels	Increase research into near miss and maternal death for better understanding of the local contributing factors. Use this analysis to determine whether factors such as access to SHI, ANC, and place of delivery had an impact on outcomes
2. Strengthening coordination between community-based services and hospital services	•Improve vital statistics registration, particularly for deaths among women of reproductive age •Address the unmet need for access to emergency obstetric care among the large majority of the female population •Conduct a hospital assessment for maternal health to identify barriers to care within the facility context
3.Reducing financial barriers to utilization of maternal health services	•Review the social insurance coverage amounts to expand what is reimbursed and to cover the true cost of having a delivery with a skilled provider. •Review reimbursement mechanisms in the case of referral upwards to a hospital for complications.
4. Improving clinical skills and quality assuranc	•Improve the quality of the skilled provider, particularly the *Bidan di Desa* by building on existing initiatives (such as *Bidan Delima*) and linking quality of care to accreditation and certification. •Look at the implementation of the comprehensive emergency obstetric services to find areas of improvement.

World Bank. 2010. Presentation on "...and then she died..". Indonesia Maternal Health Assessment.

Logical Framework
(intervention model)

81



Focus on *Jamkesmas* Update in December 2011

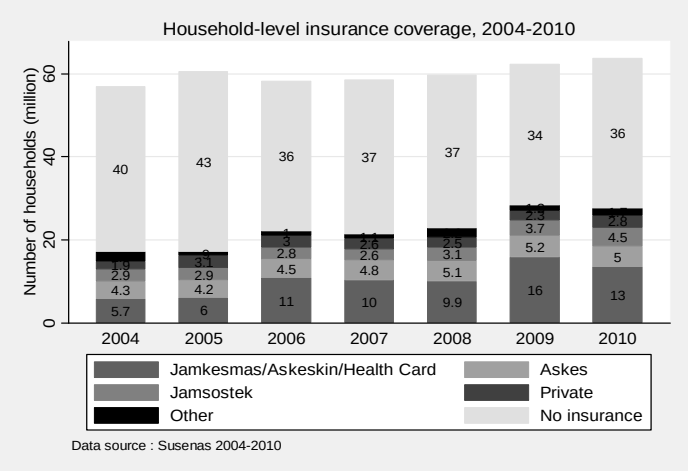
82

IMPACTS TO DATE:

- Coverage has effectively been increased and an estimated one-third of the population is currently being covered, according to official data (*Susenas* survey data indicates lower coverage rates).
- Forty-three percent of those covered are poor and near-poor households.
- Utilization of health services among *Jamkesmas* beneficiaries has increased, especially for inpatient services.
- *Jamkesmas* has a protective effect on the OOP health expenditures of the poor and near-poor; those with *Jamkesmas* coverage have lower OOP payments (a measure of financial protection) and *Jamkesmas* beneficiaries have a lower incidence of catastrophic medical expenditures when compared with those with no insurance or those with other forms of insurance.
- Geographic analysis shows significant increases in inpatient utilization in the poorest provinces (NTT, Papua, Maluku).

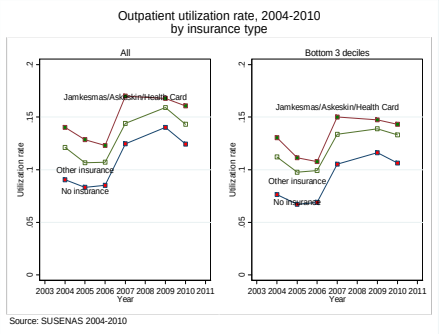
Almost half of population covered by health insurance, and nearly 30% of population covered by Jamkesmas

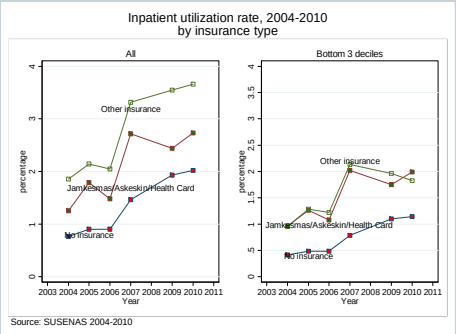
83



High utilization of outpatient care among those who covered by Jamkesmas, increase used of Jamkesmas for outpatient and inpatient care

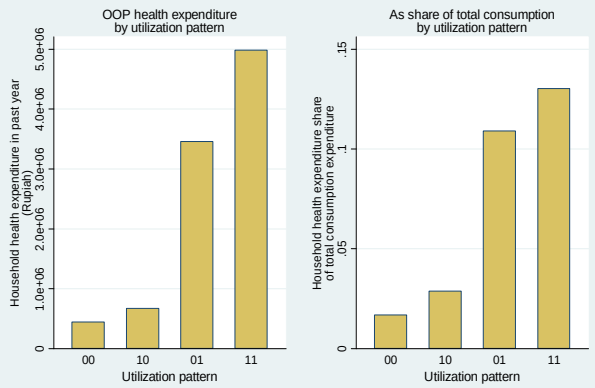
84





health spending is highest among households that had at least one inpatient utilization visit among any of the family members

85



Source: SUSENAS 2010
Utilization pattern: 00=0 outpatient and 0 inpatient visits; 10=1 or more outpatient and 0 inpatient visits
01=0 outpatient and 1 or more inpatient visits; 11=1 or more outpatient and 1 or more inpatient visits

the share of health in total consumption expenditures – when conditioned on those utilizing inpatient care – are generally lower among Jamkesmas/Askeskin/Kartu Sehat households across 2004-2010

86

Health expenditure and health share of household expenditure among those with at least one inpatient visit, 2004-2010

	All	No insurance	Jamkesmas/Askeskin/ Kartu Sehat	Other insurance
Year	Health expenditure (share of total expenditure %)	Health expenditure (share of total expenditure %)	Health expenditure (share of total expenditure %)	Health expenditure (share of total expenditure %)
2004	Rp 1,629,763 (10.9%)	Rp 1,626,499 (11.9%)	Rp 1,006,313 (9.5%)	Rp 1,898,414 (9.8%)
2005	Rp 1,881,057 (10.0%)	Rp 1,856,633 (11.3%)	Rp 1,155,444 (8.9%)	Rp 2,308,581 (8.3%)
2006	Rp 1,653,611 (8.3%)	Rp 1,867,575 (9.9%)	Rp 893,536 (6.7%)	Rp 1,944,168 (7.2%)
2007	Rp 1,738,784 (8.1%)	Rp 1,846,480 (9.1%)	Rp 1,104,266 (7.6%)	Rp 2,126,047 (6.9%)
2009	Rp 3,066,949 (10.3%)	Rp 3,171,209 (11.3%)	Rp 1,959,415 (9.2%)	Rp 4,054,062 (9.6%)
2010	4,151,826 (11.9%)	4,145,972 (13.2%)	1,955,121 (9.9%)	6,152,485 (11.5%)

Source: 2008 data not included due to problems with expenditure module

Annex: World Bank Studies for the HSR

87

- **Investing in Indonesia's Health:** Challenges and Opportunities for Future Public Spending. Health Public Expenditure Review – June 2008
- **Indonesia's Doctors, Midwives and Nurses:** Current Stock, Increasing Needs, Future Challenges and Options. Health Human Resources Review – January 2009
- **Giving More Weight to Health:** Assessing Fiscal Space for Health in Indonesia– January 2009
- **Health Financing in Indonesia:** a Reform Road Map – June 2009
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- Achieving Universal Coverage: Different Stages of Harmonization of Implementing Health Insurance Information Systems – August 2010
- Health Professional Education in Indonesia: Why Reform is Needed
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- Actuarial Estimates : What would Universal Health Insurance Coverage by 2020 Cost?

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