Decisions on the allocation of scarce resources for health are rarely made by governments - or their development partners - purely on the basis of technical criteria. Political and other factors also shape decision-makers’ choices. This is particularly apparent in Indonesia, a country which previously achieved important outcomes in reproductive, maternal, newborn and child health (RMNCH) under a centralised authoritarian system, and has continued to do so since a dramatic and rapid process of decentralisation.

**Strategic context**
Indonesia has recorded many RMNCH achievements. It is “on track” to achieve the Millennium Development Goal (MDG) 4 target of reducing under-five and infant mortality by two thirds between 1990 and 2015. It has increased the percentage of trained health worker attendants at birth delivery from 40.7% in 1992 to 81.2% in 2011. Government reports indicate an “improved contraceptive prevalence rate for married women using modern methods, lowered teenage pregnancy rates for females aged 15-19 years, and increased coverage of antenatal services for both first and fourth pregnancy visits” (1). There is virtually no difference between the richest and the poorest quintiles in Indonesia in use of family planning and oral rehydration solution, continued feeding or care-seeking for children with pneumonia (2). Indonesia has already embarked on an ambitious program of universal health coverage (UHC).

Despite such progress, one child dies every 3 minutes (150,000 per year) and one mother every hour in Indonesia (3). The maternal mortality ratio, recently estimated at 220 per 100,000 live births, appears to have plateaued at a level higher than that of comparator countries, and much higher than what would be expected for the nation’s income level. There are large inequalities in the coverage of DTP3 immunisation, ranging from nearly 90% of children in the wealthiest quintile to 50% in the poorest, as well as large inequalities in skilled birth attendance (2).

**Key messages**
Indonesia faces several challenges, all of which have political economy dimensions.

Directly affecting the health sector and RMNCH is the **low level of health expenditure**. Total health expenditure is low in absolute terms: an estimated $99 per capita per
year. Of that amount, Government expenditure on health is just $38 per capita per year. Government expenditure on health was just 6.2% of total government expenditure in 2011 (4) compared to 18% on fuel and energy subsidies that primarily benefit the middle class and elite. One of the most senior people interviewed in Indonesia said that the key to elevating health within the Indonesian political system was to “understand the language of finance.” This would involve giving greater analytical attention to the costs, affordability, and cost-effectiveness of health programs implemented by governments.

Another challenge is the nation's multiple health burdens, including variable RMNCH outcomes; persisting under-nutrition; communicable diseases and the rapid rise in non-communicable diseases (NCDs) and injuries. The rapidly increasing NCDs and traffic injuries can divert resources away from the unfinished agenda of communicable disease control, under-nutrition and RMNCH. Indonesia has high rates of tobacco use, a driver of NCDs and otherwise preventable health costs for households and government. Raising tobacco taxation, as undertaken in the Philippines, is sound public health and public finance policy. It would simultaneously reduce consumption and raise additional revenue to potentially fund health insurance, but has significant political economy implications.

The Indonesian Government is implementing an ambitious program of expanding UHC. This will require additional public financing, especially to cover the large “missing middle” of those in the population who are not in formal employment but above the poverty line and currently ineligible for government support. Expanding UHC also requires strengthening policy and regulation to improve quality, safety and outcomes. The situation is made more challenging by the large - and largely unregulated - private health sector in Indonesia. All of this has political economy dimensions. The roll out of UHC, targeted for completion by 2019, is a major strategic opportunity for UNICEF and development partners to help shape the access, coverage, quality and incentives, of essential health services that can benefit women and children, and the poor.

A related challenge in Indonesia is the need to strengthen the process of planning, prioritisation and resource allocation in a highly decentralised system. There are many potential benefits to the health sector and to RMNCH in the nation’s devolution of power and resources. However, poorer provinces and districts may well have less financial – and managerial – resources to respond to local health needs. Decentralised planning also raises challenges for national coordination of priorities and programs to confront communicable diseases. Evidence based planning (EBP) can identify where, why and how to reallocate resources to their most productive use (“allocative efficiency”) but rigidities in top down budget line items then prevent resource reallocations. It is also clear that democracy and decentralisation are combining to make “free” health services a vote-catcher, but this risks generation of financially unsustainable commitments and unfunded mandates.

Strengthening implementation is key to raising quality of services but also to increasing the resources reaching front line health services. World Bank reports find “the low level of public spending is, however, not the only or even the main problem. Capacity to spend and the efficiency of spending, especially at the local level, are arguably even more serious problems. Fragmentation, allocative and technical inefficiencies, low productivity and poor quality have resulted in low utilization rates of both public and private facilities and high rates of self-treatment.”(5)

Achieving health goals, including UHC will also require improving the quantity and quality of health workers, especially in the public sector. Recent analysis finds that 30 of the 33 provinces in Indonesia do not have the WHO recommended ratio of 1 physician per 1,000 population (6). A World Bank study (7) estimated that Indonesia would need to increase the stock of health workers by 78 percent from current levels if it was to reach the WHO recommended target of 2.28 trained health workers per 1,000 by 2035. Political economy factors and the lack of incentives means it is particularly difficult to draw, train, or retain health workers in remote rural or island situations including Eastern Indonesia. Even less is known about service quality in the private sector which is largely unregulated (6). In 2010, one third (23 of 69) undergraduate medical schools in the public and the private sectors were not accredited, and only 17 out of 69 received the highest accreditation level (6). Once again, political economy factors will need to be taken into account when addressing these issues.

References


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1 Taking into account the lower cost of goods and services in Indonesia raises this to an estimated 50 “international dollars” per person per year in notional purchasing power parity terms.