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Primary Care-Led Health System in Indonesia

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INTRODUCTION

It is a general consensus that investing more in primary care will lead to better health outcomes overall, and therefore, primary care should be the focus of development for health services. A body of evidence that intervention in primary care is cost-effective and reduces health system burden and disparities[1–7] plus choice of meal replacements or weight loss medication. Making primary care the focus of health development is crucial for the sustainability of the health system, particularly amidst the changing demographic landscape and disease burden. Designing health service or needs to start at primary care at its heart. This is concurrent with WHO 2008 report on Primary Care[8]: *"... focus of reform that reorganizes health services as primary care, i.e., around people's needs and expectations so as to make them more socially relevant and more responsive to chancing world while produced better outcomes – service delivery reforms.*"

Indonesia has been championing primary care since the inception of its health system, although many system-related issues hinders its acceleration. It has been operating public-centered primary care centers which was named *Pusat Kesehatan Masyarakat* (*Puskesmas*) and community-based public health service (Posyandu) since the 1980s. Both Puskesmas and Posyandu is tasked with delivering essential health services and education to mothers and children under-five. For over 30 years, the presence of both spearhead Indonesia's primary care, followed by the growth of private-owned primary care centers, including private practices, clinics, and others. Despite the growth of public- and private primary care service in Indonesia, many still prefers secondary or hospital care, and therefore leaving primary care unattended[9] during its first year of implementation, recruitment of JKN members was slow, and the referral rates from primary to secondary care remained high. Little is known about how the public views the introduction of JKN or the factors that influence their decision to enroll in JKN. Aim: This research aimed to explore patients' views on the implementation of JKN and factors that influence a person's decision to enroll in the JKN scheme. Methods: This study was informed by interpretative phenomenological analysis (IPA. This impacts to ballooning out of secondary care services and over-visits at the secondary care, making hospital overcrowded, burned out hospital staffs, and increased hospital bills. Luckily, in 2021, the Ministry of Health announced the strategic agenda of transforming the health system, in which a plan for transforming primary care was set. At its core, primary care transformation is aimed at improving the supply level of primary care by revitalizing the network, primary care service, and laboratory facilities, as well as improving health prevention coverage[10].

DISCUSSION

I adopted the the WHO health system building blocks and look at ways primary care can lead the arrangement of health system, as depicted in **Figure 1.**

Primary care-led service delivery centers at gatekeeping and efficient arrangement between health providers. Gatekeeping is the act of provides the opportunity to filter patients based on their healthcare needs to make the use of health services efficient[11]. During patient-physician interaction, primary care physicians (PCP) explore the medical needs of patient and orient patient within the complex patient interaction. On the other hand, the efficient arrangement of health service centers at the interaction between health providers. PCPs help patients and primary care users navigate the complex healthcare realm. This concept is also referred to as integrated primary care. There are two streams of integrated primary care, both vertically and horizontally. Horizontal integration of primary care requires efficient integration within primary care providers, particularly among public and private clinics, primary care laboratories, nursing homes, and other primary care providers. Meanwhile, vertical integration refers to coordination from primary care service towards

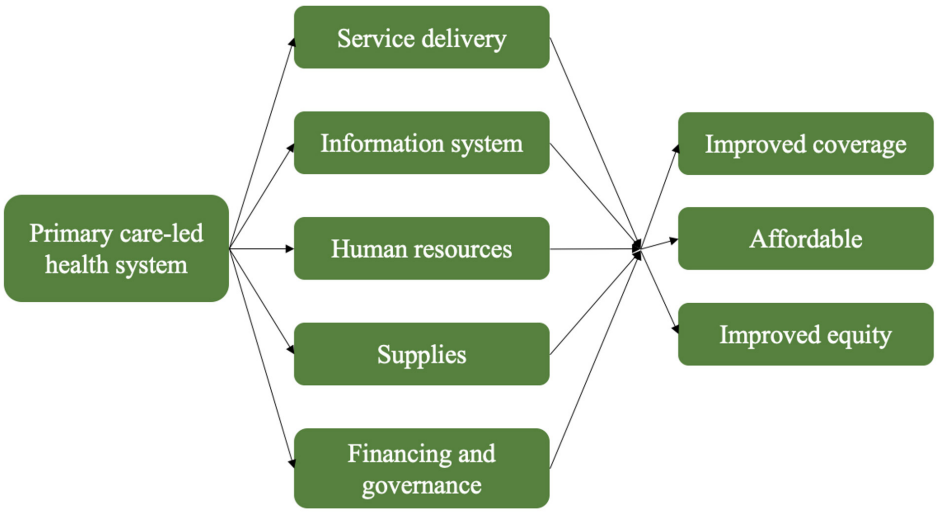

Figure 1. Primary care-led health system

advanced care, including secondary care (referral hospital) and tertiary care (specialized hospital).

Health information system becomes another critical part of realizing a health system that is primary-care led. An integrated information system in primary care keeps medical history integrated and therefore complete, which assists PCPs and practitioners when making clinical decision. Aside of integrated information system at its downstream, at the higher level, policymakers needs timely information to make a data-driven policy in primary care. Combining relevant clinical information in aggregate results in public health data that captures epidemic trend, which helps guide decision making at higher level.

Another important aspect of the primary care-led health system is human resources. In primary care, a nexus of diverse health practitioners carry out the work: PCP, nurse, laboratory assistant, physiotherapist, home nurse, administrative managers, and many more, including non-health workers such as community health workers. A primary care-led system also looks at how these elements interact, particularly how each healthcare worker works based on competency while emphasizing efficiency (maximum coverage and quality given the constraint). Moreover, a primary care-led system also thinks about leveraging the role of non-healthcare workers, particularly CHWs. Involving CHWs in community improves reachout to population, increases community's sense of belonging to providers, and proves to be cost-effective in tackling public health challenges[12–15].

Improving the primary care benefit package, including providing medical products, vaccines, and technologies that are appropriate in primary care, will leverage the primary care-led system effort. Primary care interventions are deemed cost-effective, meaning that investing in it provides value for money for the health system overall. Improving the coverage and modalities for secondary prevention in primary care facilities, such as screening and vaccination, is proven effective in alleviating disease burden.

Lastly, a primary care-led health system also pinpoints financing and governance that incentivizes primary care. Secondary care tends to be catastrophic, meaning that it imposes high cost of care that can impoverish individuals accessing care. When financing is directed towards primary care (primary care-led financing), it improves care coverage as well as equity. In a healthcare system that is managed and financed by public money (i.e., tax-based health insurance), making financing that puts more incentives at primary care will nudge PCPs into performing better and more efficient. One example is through modifying payment system that tailors to performance and coverage, such as performanced based financing or capitation.

At the end, primary-care led health system means prioritizing primary care in as front of health system. In the long term, investing in primary care reduces the health system's burden, particularly in secondary care, while cost-saving. However, investing in primary care requires coordination from multi-sector, particularly since primary care requires involvement from non health actors at the level of planning (high-level planners policymakers) up to implementation (i.e., CHWs in grassroots). Moreover, an ideal primary care-led health system will require political and financing commitment that can shift resources toward primary care, making health system "primary-care first."

A reflection of the state of primary care in Indonesia:

Yesterday, my colleague, 42 years old, was a lecturer at the engineering faculty, experienced stiffness at her neck after eating lunchShe was afraid of some stroke or else, considering that she had just eaten a lamb/ meat (this is the patient's perception). So, instead of consulting a primary care doctor, she ran to an emergency room in a big hospital. The doctor in the ER consulted both internal medicine and a neurologist, who then decided to do an MRI. For observations, she has to stay in the hospital for three days.

Now, it is day 5, and she is at home. I called her to ask how she was doing, and she told me that the diagnosis was torticollis, alias *'tending'* in the Javanese term - just like I predicted.

Imagine if this case was primary care led; we only need about 100 thousand rupiahs for an 'anti-pain and inflammation balm.' This illness is a self-limited disease, which will recover in a few days. Without primary care-led services, we all witness that the same problem can cost millions of rupiah, which will be covered by the national insurance BPJS, which is drawn from Indonesia's taxpayer money.

Stories from chronic illnesses tell us other perspectives. Without adequate primary care-led promotion and prevention, people of certain districts of Yogyakarta have a stigma that does not want to consume, for example, hypertension drugs because they are afraid of kidney damage from the drug. And instead of trying to have more knowledge on the illness and the medication, people tend to ignore the illness. So when it comes to complications of hypertension later in life, it becomes a catastrophic disease with all organ complications that need more medication and health care facilities, which ultimately will cost millions of times the original proper use of anti-hypertension and healthy lifestyle.

A primary care-led healthcare will reduce cost, increase health outcomes, and increase patient-provide satisfaction.

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