

LETTER TO EDITOR

The Home-Care Paradox in Indonesia: Who Pays for Diabetic Foot Ulcer Care at Home?

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DEAR EDITOR

Diabetic foot ulcers (DFUs) require more than episodic clinical treatment. Patients frequently need repeated wound assessment, dressing changes, infection monitoring, education, and long-term follow-up. In Indonesia, these demands can make repeated visits to healthcare facilities burdensome, particularly for patients with mobility limitations or those dependent on family members for transportation. Home-based care, therefore, represents an attractive alternative. Indonesian evidence shows that self- and family-management support can improve the patients' ability to manage DFUs at home, including improvements in wound size and glycemic control.¹ A home-based nursing intervention involving community health nurses has also improved in diabetes self-management and wound healing among patients with recurrent DFUs.²

These findings reflect a broader opportunity for community nursing. Nurses are well positioned to provide wound assessment, dressing changes, diabetes education, monitoring, and early identification of complications in patients' homes. Evidence from community-based wound-care models suggests that nurse-led care can improve wound healing, reduce pain, achieve high patient satisfaction, and potentially provide cost-effective care.³ Thus, home-based DFU care appears to create an ideal convergence between patient preference and nursing practice; patients can receive care closer to their home, while nurses can extend professional services beyond facility walls.

Yet, in Indonesia, this convergence exposes a health-financing paradox. Indonesia's National Health Insurance, Jaminan Kesehatan Nasional (JKN), administered by Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan, has substantially expanded financial protection through a healthcare system organized around contracted health facilities and established referral and payment mechanisms.⁴ However, independently delivered home-based nursing services, including wound care provided directly in the patients' homes, are not routinely integrated in this formal reimbursement pathway. Consequently, when patients choose independent professional wound care at home, the financial burden may fall directly on them.. This creates a striking disconnect: patients may prefer care at home, and nurses may be willing to provide it, but the financing architecture does not yet consistently connect the two.

The first paradox concerns patients. Home-based DFU care may reduce repeated travel, waiting time, transportation difficulties, and dependence on family members while allowing care

to occur in a familiar environment. Yet, when access to this option depends on direct out-of-pocket payment, patient-centered choice risks devolving into an ability-to-pay-centered choice. This matters in Indonesia because JKN plays an important role in reducing out-of-pocket (OOP) expenditure. Evidence indicates that JKN members are less likely to incur OOP healthcare payments and, when they do, generally spend less than uninsured households.⁵ A parallel market for independently paid home care could, therefore, create an unintended equity divide: patients who can afford home visits gain convenience, whereas economically vulnerable patients may remain dependent on facility-based services.

The second paradox concerns the nurses. Home-based wound care offers opportunities for continuity, professional autonomy, closer engagement with families, and direct observation of the environment in which self-care actually occurs. Specialized nursing involvement in wound care has also been associated with improved efficiency, better wound outcomes, and potential cost reductions.⁶ At the same time, direct payment from patients may provide a simpler and more immediate remuneration pathway than navigating institutional reimbursement mechanisms.

This should not be interpreted as suggesting inappropriate financial motivation among nurses. Rather, it raises a structural question: why does a service demanded by patients and deliverable by qualified nurses remain insufficiently connected to formal health financing? When direct payment is easier than participation in a structured reimbursement pathway, the health system may inadvertently encourage home-based nursing to develop as a parallel OOP service rather than as an integrated component of community care.

However, simply extending JKN reimbursement to every home-care service would not be sufficient. Unregulated expansion could raise concerns about competency, documentation, referral, continuity, patient safety, and accountability. Indonesia could instead consider piloting a regulated reimbursement pathway for selected home-based wound-care services. Such a model could establish clinical eligibility criteria, nurse credentialing requirements, standardized wound assessment and documentation, defined service packages and reimbursement rates, referral pathways for deteriorating wounds, and measurable clinical outcomes. Digital documentation could further connect home-care nurses with primary healthcare facilities and support continuity when care must be escalated.

The issue extends beyond diabetic wounds. It illustrates a broader challenge as healthcare gradually moves from hospitals and clinics toward homes and communities. Community nurses can be central to this transition, but service innovation without financing innovation risks leaving patients and nurses outside the formal system.

Indonesia may already have two essential elements of home-based wound care: patient demand and nurses capable of providing it. The missing link is a financing architecture that connects them safely and equitably. Home-based diabetic wound care should not become a convenience reserved for those who can afford to pay out of pocket. Integrating appropriately regulated home nursing services into national health financing deserves serious consideration as Indonesia advances toward more accessible, equitable, and community-based healthcare.

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Authors' Contribution

H.S. developed the conceptualization and drafted the manuscript; Y.R. performed the document search and funding administration; L.L. contributed to the conceptualization and revised the manuscript;

E.N. contributed to the conceptualization and drafted the manuscript; and R.K. contributed to the conceptualization and revised the manuscript. All authors reviewed and approved the final draft and are responsible for the content of the letter. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Conflict of Interest

None declared.

Declaration on the Use of AI

The authors used OpenAI, GPT-4 to assist with language refinement. No AI tool was used for data generation, analysis, interpretation, or scientific decision-making. The authors take full responsibility for the integrity, accuracy, and originality of the manuscript.

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