Indonesia Towards Universal Health Coverage: Lessons From Asean Countries

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INDONESIA TOWARDS UNIVERSAL HEALTH COVERAGE: LESSONS FROM ASEAN COUNTRIES

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Abstract

Background: WHO has recommended that all countries apply the concept of Universal Health Coverage (UHC) in their commitment to ensure the health of their people. Although most ASEAN countries have implemented UHC, only 30% of them are considered successful. UHC considers three pillars for its implementation; all groups of people should be covered, at least the basic healthcare services are delivered, and that people could afford to access healthcare when in need. National health insurance had been set up by many countries as the approach to ensure that all citizens could obtain healthcare. However, in Indonesia, after several years of implementation, 33% of the population has yet to register while the 100% target was overdue in 2019.

Objective: To describe the progress towards UHC in Indonesia and determine the strategies used by other countries in ASEAN in achieving UHC.

Methods: Articles on UHC in ASEAN countries between the years 2014-2019 were searched according to PRISMA and reviewed. The articles were compiled using a series keyword in ResearchGate, ScientDirect, ProQuest, SAGE, and EmeraldInsight database. The studies included qualitative studies and written in English.

Results: There are various healthcare financial mechanisms that a country can implement. In 2014, Indonesia had developed a national health insurance known as JKM as its mechanism of financing healthcare towards achieving UHC. However, till date only 54% of her population had registered for JKM. There is no automatic registration via the national identity card and registration for NHIS is only done when there is a need to use the healthcare services.

Conclusion: The review demonstrates that policy implementation still needs to be monitored and evaluated. Recommendations are made for the medical professional association and the government.

Keywords: *Health insurance, Indonesia health systems, Literature review, Universal health coverage*

Introduction

Universal Health Coverage (UHC) has become a subject matter of concern for both the developed and the developing countries. In 1948, WHO stated that health is a fundamental human's right. Since 2012, the World Bank and WHO have urged all countries in the world to prioritize the achievement of Universal Health Coverage (UHC). UHC considers three pillars for its implementation; all groups of people should be covered, at least the basic healthcare services are delivered, and that people could afford to access healthcare when in need. Through the attainment of UHC, equality will be created in receiving quality health services for all humans regardless of economic status.

Indonesia is one of the developing countries located in the Southeast Asia region. The total population of Indonesia is more than 262 million people spread over more than 17,744 islands. Since 1968, social health insurance (ASKES) had been introduced to the Indonesians but it covered only those in the formal sectors like civil servants, military and police under the name although in 2004, ASKES was expanded to cover the poor so that they could access the health services (1). The government of Indonesia had implemented the National Health Insurance System programme (NHIS or National Health Insurance) in 2014 with the aim to achieve UHC. The NHIS programme was carried out by the Social Security Agency for Health (SSAH or BPJS), a public-owned legal entity under the responsibility of the Indonesian president. With the implementation of NHIS, more and more Indonesians are able to access the healthcare services. The number of Indonesians who had registered with NHIS were 133,423,653 (52.29% of the total population) in 2014 and extended to 187,982,949 (71%) in 2017.

As in November 2018, the total population of Indonesia registered with NHIS was 77%. The increase in the number of population registered with NHIS has been averaged to 6.17% per year which had never reached the target of 9% per year needed for the country to achieve 100% population coverage by 2019 (6,7). This achievement is very low compared to Thailand, which managed to increase her population coverage for the national health insurance from 70% in 2001 to 100% in the next year. Thus, this review aimed to look at the status of UHC and analyse the UHC Policy in the ASEAN countries.

Methods

Articles with the set titles were searched in Emerald Insight, SAGE, ProQuest, and ScienceDirect. Only articles published in English between January 1st, 2009 through February 28th, 2019 were included. The terms used were "Universal Health Coverage", "health system", combination of both terms, and the word "Singapore", "Thailand", "Malaysia", and "Brunei Darussalam". Both quantitative and qualitative data from academic studies were reviewed.

Inclusion and Exclusion Criteria

Only articles written in English were included. The terms "Singapore", "Thailand", "Malaysia", and "Brunei Darussalam" were used on the basis that these countries had implemented the national health insurance as their means of healthcare financing to achieve full population coverage for healthcare services and thus UHC.

Screening and review process

Reviewers independently reviewed the titles, abstracts, and keywords of electronic records for eligibility according to the stated inclusion criteria. The results of the initial screening were compared and discussed among all the reviewers. Full texts of screened titles and abstracts were obtained and each reviewer had independently reviewed the texts according to the Preferred Reporting Items for Systematic Reviews and Meta- Analyses (PRISMA) methods of screening. Figure 1 illustrated the process of data collected.

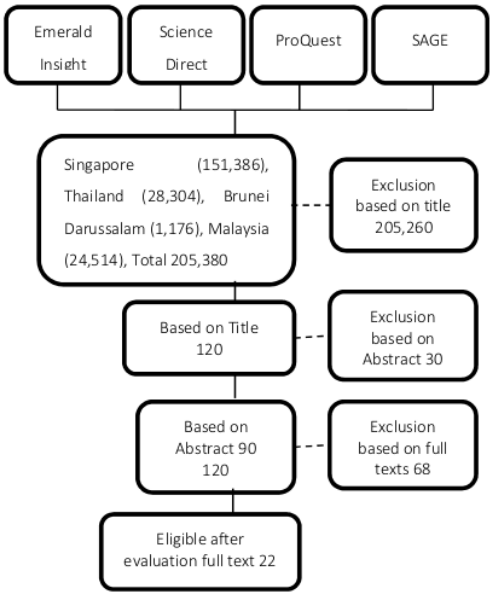

Figure 1: Process of Data Collected

Results

The search revealed 205,358 titles with at least one of the determined words. However, articles with the full theme as their title were only 120 of which only 90 had published abstracts and 22 with full articles were found. Therefore, only 22 articles should be reviewed by the authors. However, the authors were able to get access and obtain only 5 full articles for eview. Both the authors had read the five articles, reviewed and summarized, while the third author had reviewed, summarized and edited the manuscript.

Lesson from ASEAN

Single identity number

In most countries that implemented national insurance, in order to obtain the healthcare services, the citizens just needed to provide their national identification card (citizenship document) to the healthcare provider to check whether they are covered by the health insurance. However, for Indonesians, they need to register with BPJS before they can be given a special card that states that they are covered by NHIS and thus can present the card to the healthcare facilities to receive treatment. The card includes a complete serial number along with the name and date of birth of the card owner. This practice was similar with the previous health insurance scheme of Indonesia, since 1968.

The problem with this practice is that people especially those from the informal sector will only register with BPJS when they need to obtain the healthcare services using NHIS for the first time, and only then starts paying for the premium. The government and the BPJS would need to spend a huge amount to promote to the people to do their registration early and encouraged people to pay their premiums regularly. Otherwise, the NHIS fund to finance for the healthcare services would be small relative to the total population and payment to the healthcare providers would be jeopardized.

It is recommended that a single identity number be implemented whereby the national identity card can be automatically used to register people with NHIS and invoices sent to them for premium payment, even before they star utilizing the NHI to obtain the healthcare services. Countries such as Thailand and Brunei Darussalam have been using their national identity card to check for eligibility of obtaining healthcare services under the national health insurance. In fact, the citizens of Malaysia, one of the few countries that does not implement the national health insurance are using their national identity card to obtain healthcare services which are almost free at all the public healthcare facilities.

Financing UHC

There is no one ideal, one type fit for all financing healthcare systems. It is because each system has its own strengths and weaknesses depending on the financial condition of a country. Out-of-package payments (OOP) is a major problem in the national health system. Poor residents living in the rural areas tend to be having low incomes so they cannot afford to pay the premiums for their health insurance (4). Taxes in several ASEAN countries are the main source for healthcare financing systems.

The Indonesian government has a policy of full coverage for their very poor population and helps in paying a portion of the premiums for the civil servants, military and police. Meanwhile, for the employees in the formal sector, a portion of the premiums is borne by the company and the rest is borne by the employees. However, residents who work in the informal sector must bear the full cost of their insurance premiums themselves or pay the treatment cost directly to the healthcare providers from their OOP. The International Labour Office (ILO defines the informal sector) as well as the informal employees as workers who were not recorded, protected and regulated by the public authorities.

The resources for healthcare from tax and health insurance can be combined in different ways. The relationship between to refinance MediFund and insurance financed MediShield in Singapore can be an example of the above design. Enforcing NHI enrollment for the informal sector is difficult, so it tends to be voluntary in many low income countries. However, voluntary enrollment results in an adverse selection; for example, households with sick members are more likely to join the health insurance but after they had obtained the health service, they tend to stop paying the premium. In a bid to subsidize demand rather than supply of health services through a system of (universal pre-payment), the world band and other multilatered and donor organizations are advocating for single payer systems as more efficient ways to publicly finance health care (2).

The definition of single payer is comprehensive universal coverage where everyone in a given region is covered by the same health insurance plan with the same core set of services, and funding for that core set of services comes from a single public fund, generated through taxation. Providers are then reimbursed for healthcare service from that single public fund. The percentage of GDP spent on health care and health score spend per capita is said to be the lowest in the single payer system, as can be seen in Singapore (8.5% of GDP and $3,763 per capita). In Indonesia, the healthcare providers are mixed between the public and private sectors and the scheme covered by the NHIS varies according to the premiums paid. The proportion of GDP spent per capita for healthcare is low (about 4%) and is mainly to provide coverage for the poor so that they could access the healthcare services. This group of population has a high prevalence of chronic non-communicable as well as infectious diseases and given the big population of this group, the amount collected in the NHIS fund is not sufficient to be maintained. In fact, the quality of healthcare services provided is at stake; less types of services covered with a long waiting time for some procedures.

Thailand has made a strong commitment to UHC by spending 10.2% of its budget on health care. In 2013, Thailand implemented pay for performance (3). Along with the Civil Servant Medical Benefit Scheme (CSBMS) that covers government employees and their dependents, and the social Security Scheme (SSS) that covers the formal-sector employees as before the UC policy implementation, the UCS fulfills coverage for the rest of the population by combining those previously covered by the government-subsidized health insurance schemes (i.e, the Medical Welfare Scheme and the Voluntary Health Insurance Scheme), and incorporating the uninsured (~30% of population). Thus, Thailand had managed to cover approximately 97% of their population through the three health insurance schemes (5).

Subsequently, a universal health-care scheme was implemented by the Thai Government, with the financing from the government's tax revenues. Thailand's Universal Health Coverage is also known as the 30-Baht Health Care Scheme, reflecting a patient's 30 baht (-$1 USD) co-payment for an outpatient hospital visit, hospital admission, annual routine physical exam, or for other services. Tangcharoensathien et al. (2013) argued that the Thai universal coverage system has improved the health financing equity and provided financial risk protection to its citizens, especially in the case of a serious illness. Thai

Universal Health Coverage has been focusing on promoting primary health care as well as disease prevention and health promotion. Nevertheless, the authors concluded that in order to continue its success in the future, the system must extend its coverage area to include effective interventions for improved health promotion to combat non-communicable diseases (e.g., tobacco and alcohol control, obesity prevention, and support of physical activities).

In Indonesia, the NHIS's premium and the type of services covered under the NHIS are similar for all insurers. On the contrary, in Thailand, the Article 40 of the Social Security Act promulgates two insurance schemes.38,40 The first one is the 100-baht monthly payment scheme which is supplemented by a 30-baht government subsidy. The insured receives benefits for injuries, sickness, disability, and death. Another scheme is the 150-baht monthly payment scheme supplemented by a 50-baht government subsidy; the insured receives the same benefits as the beneficiaries in the first scheme plus an old-age pension, which becomes accessible at the age of 60.

While the Universal Pension Scheme provides the elderly Thai persons (i.e., 60 years of age or older) 500 baht a month in cash; however, it does not apply to the elderly in the public facilities and to those who receive other governance benefits. This progressive mode of premium payment would be a good way to motivate the population of Indonesia to register for the NHIS and to pay the premium without fail; provided the quality of healthcare service delivery in both the public and private healthcare facilities are improved and maintained.

Conclusion

The National health insurance system has been implemented in Indonesia since 2014 but at the end of 2018, only 77% of the population had registered and they are among those in the informal sectors who could also be among those from the low income population. The government of Indonesia has to strategise on increasing the NHIS coverage by creating more awareness and promotional activities, improving the registration mechanism and allocate more budgets for healthcare by utilizing the tax to cover the low income population.

This review has several limitations. First, there maybe some missed articles. The review only includes literature published in English, while there maybe non-English articles that discuss other systems in the ASEAN countries. Lastly, we did not confirm the results of the review to the related stakeholders about the latest system developments and development plans about the NHIS in Indonesia.

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