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The Comparison of Health Insurance between Indonesia and other Middle-Income Countries

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Abstract*. Health insurance is a form of financial protection that allows a person to obtain financial protection when they need health care. In middle-income countries, health insurance schemes are divided into three types: community-based health insurance, voluntary health insurance, and compulsory health insurance. Implementation varies from country to country depending on conditions and policies. The purpose of this study is to compare Indonesia's health insurance system with other middle-income countries in terms of coverage, services, and financial sustainability. By conducting this comparison, it is hoped that the most effective and efficient health insurance model can be found. This research uses the literature review method with search engines used in literature searches including Google Scholar and PubMed with the keywords Health, Health insurance, Indonesia, middle-income countries, Health system, Health services, and Health policy. The resulting articles were selected based on publications published between 2018 and 2023. The results show that the comparison of the health insurance system in Indonesia with other middle-income countries is not much different, because the aspects of financing, membership, availability, accessibility, and quality of health services are still challenges that need to be addressed by the government and society. However, each country has different policies and programs.*

Keywords*: Health, Health insurance, Indonesia, Health system, Health services and health policy, Middle-income country.*

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INTRODUCTION

The definition of Insurance according to Indonesian Law Number 2 of 1992 is an agreement between two or more parties, by which the insurer binds himself to the insured, by receiving an insurance premium, to provide compensation to the insured due to loss, damage or loss of expected profits, or legal liability to third parties that may be suffered by the insured, arising from an uncertain event, or to provide a payment based on the death or life of an insured person. While health insurance is insurance that specifically addresses the risk of health, health insurance will cover all the costs required if you fall ill, including if the illness is caused by an accident (Fabiana *et al*, 2019). The functions of health insurance are: to help individuals stay healthy and improve their health when they fall ill, financial protection for individuals with catastrophic health events, assisting access to free or low-cost health services, negotiating health services by setting payment rates through fee schedules, improving and ensuring the quality of doctors and hospitals (Dey and Bach, 2019).

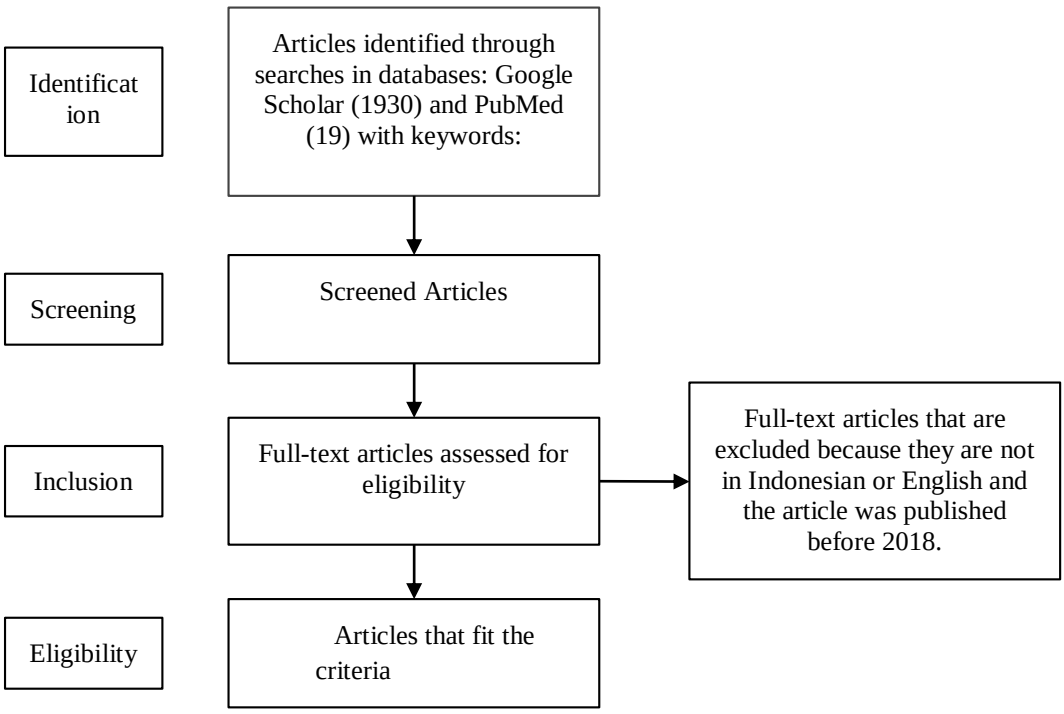
Since 1970, commercial health insurance has been present in Indonesia, but at that time health insurance was marketed as a rider product by insurance companies loss. The development of health insurance in Indonesia was relatively slow until 2010-1992 because there was no clear legal basis and life insurance companies at that time were unable to market health insurance products. The development of commercial health insurance in Indonesia started since its issuance of the Insurance Act, through the law health insurance products have a clear legal basis and can be marketed through life insurance as well as general insurance. Furthermore, the development of health insurance was not spared of GDP growth in Indonesia and the issuance of PP No. 14 of 1993 concerning Jamsostek (PP Jamsostek) in which it is explained that the company is given the freedom to choose to join the Jamsostek program or use the service commercial insurance, and in fact many of the companies that prefer commercial insurance products because they can be tailored to the needs of the company (Susetyo, 2019).

The role of good health in socioeconomic development and its essential human wellbeing is recognised by every country. The United Nations (UN) has identified the Universal Health Coverage (UHC) as one of the most effective ways for achieving the health-related sustainable development goals (SDGs) to better health and protection for developing countries (Baubacar, 2021). Low-and middle-income countries (LMICs) face particular challenges in achieving UHC due to particularly limited public resources for health care, inefficient allocation, over-reliance on out-of-pocket payments, and often large population size

(Erlangga *et al.*, 2019). As a result, access to healthcare and the burden of financial cost in LMICs tend to be worse. In Middle-Income countries these are classified by three types of insurance scheme: community-based health insurance, voluntary health insurance (non-CBHI), and compulsory health insurance. The implementation in every country varies depending on the conditions and policies that exist in the country.

METHODOLOGY

This research uses the literature review method to compare health insurance in Indonesia with other middle-income countries. We conducted electronic searches from 2018 to 2023 in PubMed and Google Scholar with English or Indonesian languages. The search strategy relied on keywords from a combination of medical subject headings and free text including terms such as "health", "health insurance", "Indonesia", "middle income country", "health system", "health service", and "health policy". The inclusion criteria were as follows:(i) articles that discuss health insurance in middle income countries (ii) the articles in English or Indonesian. The exclusion criteria were: (i) the article structure is incomplete (ii) the article does not match the criteria (iii) the article was duplicated (iv) the article was published before 2018. This led to a final sample of 8 articles that were reviewed in this study.



Picture 1. PRISMA flow

RESULTS AND DISCUSSION

Author	Location	Title	Method	Result
Myint, C. Y., Pavlova, M. and Groot, W. 2019	Myanmar	Health insurance in Myanmar: Knowledge, perceptions, and preferences of Social Security Scheme members and general adult population	Cross-sectional	The results show that the current health insurance in Myanmar needs to take action to update the premium calculation because the contribution must be proportional to the current salary scale to ensure the sustainability of social security.
Bazyar M, Yazdi-Feyzabadi V, Rashidian A, and Behzadi A. 2021	Iran	The experiences of merging health insurance funds in South Korea, Turkey, Thailand, and Indonesia: a cross-country comparative study	Cross-sectional	Improving equity in health financing and access to health care services among different groups of population was one of the main triggers to merge health insurance funds.
Han SM, Rahman MM, Rahman MS, Swe KT, Palmer M, Sakamoto H, et al. 2018	Myanmar	Progress towards universal health coverage in Myanmar: a national and subnational assessment.	Logistic regression	Attainment of universal health coverage in Myanmar in the immediate future will be very challenging as a result of the low health service. coverage, high financial risk, and inequalities in access to care.
Okuzu, O. *et al.* 2022	Nigeria	Role of digital health insurance management systems in scaling health insurance coverage in low- and Middle-Income Countries: A case study from Nigeria	Cross-sectional	The results show that digital health technologies in Nigeria can play a role in achieving UHC in LMICs. Successful expansion of digital health insurance schemes include: ease of use, existing digital infrastructure to support e-insurance systems, and trust manifested through data encryption, maintaining audit trails for all data, and fraud

				prevention processes in place.
Boubacar, Amadou. 2021	Indonesia, Ghana, Nigeria, Niger, Thailand	Healthcare Financing in Low and Middle-Income Countries and Achieving Universal Health Coverage	Health system analysis	The article finds that traditional channels of financing the health sector in these countries include the government's budget, donor aid, national health insurance, and out-of-pocket model. Moreover, the paper explores other alternative mechanisms for raising resources for the health sector including tax on demerit goods, remittances, and sovereign wealth funds' revenues.
Thuong, Nguyen Thi Thu. *et al*. 2020	Vietnam	Impact of Health Insurance on Health Care Utilisation and Out-of-Pocket Health Expenditure in Vietnam	Surveys method	The study offers evidence that the Vietnamese HI scheme increased health care service utilisation and decreased OOP for the participants of the VHI and HSHI programmes. Therefore, the government should continue to consider improving the HI system as a strategy to achieve universal health coverage.
Preker, A. S., Cotlear, D., Kwon, S., Atun, R., & Avila, C. 2021	Mexico, Turkey, The Republic of Korea, and Ukraine	**Universal health care in middle-income countries: Lessons from four countries**	Cross-sectional and longitudinal reviews	Based on the research, reaching UHC is achievable in middle-income and upper-middle-income countries. It is not an unattainable goal reserved for upper income countries. Also, successes and failures are evident both in the case of countries

				that pursue a contributory health insurance path to UHC and those that pursue a core government funding path.
Perehudoff, K., Demchenko, I., Alexandrov, N. V., Brutsaert, D., Ackon, A., Durán, C. E., El-Dahiyat, F., Hafidz, F., Haque, R., Hussain, R., Salenga, R., Suleman, F., & Babar, Z. U. 2020	Ecuador, Ghana, Philippines, South Africa, and Ukraine	Essential Medicines in Universal Health Coverage: A Scoping Review of Public Health Law Interventions and How They Are Measured in Five Middle-Income Countries	Comparative case study	This shows us five objectives of public health law were identified in national law for medicines financing and affordability in our five middle-income countries. Empirical evaluations of national law were mostly designed to evaluate economic policies and regulation, while scarcely evaluating the other four objectives of public health law (public health infrastructure, information, health equity, remedies and sanctions). Although laws for access to medicines are frequently adopted by law makers, the full range of their intentional and unintentional effects on medicines access in health systems is under studied. Adopting laws for all components of public health law and understanding their effectiveness at promoting universal access to medicines, is important to enforce UHC reforms.

UHC (Universal Health Coverage) means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation, and palliative care (WHO, 2022). The purpose of UHC is to protect people from the financial consequences of paying for hea

lth services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children. UHC has three main objectives. The first objective is to ensure equity in access to health services. The second objective is to ensure that the quality of health services is adequate to improve the health of people receiving them. The third objective is to protect people against financial-risk by ensuring that health expenditures do not put people into poverty (Boubacar, 2021). Achieving UHC is one of the targets the nations of the world set when they adopted the 2030 Sustainable Development Goals (SDGs) in 2015. In reality, the implementation of UHC in each country varies in terms of programs, coverage, implementation, and constraints.

Indonesia is one of the middle-income countries that implement Universal Health Coverage (UHC). Universal Health Coverage (UHC) in Indonesia, called JKN (Jaminan Kesehatan Nasional), has been implemented since 2014. JKN is a health insurance program organized by the National Social Security Agency (Badan Penyelenggara Jaminan Sosial-BPJS) and has coverage for all people in Indonesia. This program provides coverage on comprehensive basic benefit packages, outpatient and inpatient care at primary level up to tertiary hospital level (Bazyar et al., 2021). According to the Roadmap of National Health Insurance, it is supposed that all Indonesian citizens will be covered by the BPJS Health by January 2019. The total coverage of the JKN Program as of February 2023 is 248.77 million people or 90.34% of the total population (BPJS, 2023). The percentage of the population with JKN insurance varies by region. The largest percentage of the population is in Aceh with 95.15% of the total population, Jakarta with 85.56% of the population, Yogyakarta with 78.07% of the population, and West Java with 56.3% of the total population (Statistics Indonesia, 2021). The high percentage is closely related to the population density in each region. The higher the population density, the more difficult it is to ensure that the entire population has JKN. The JKN program has funding sourced from 5% of workers' salaries and their family members (Employer, with contribution contribution from the employee); 5% of the monthly salary monthly pension for retirees, 5% of 45% of the basic salary of civil servants for Veterans or their widows; and Public budget for the poor people (Bazyar et al., 2021). Factors affecting the application of the system health insurance in Indonesia are: 1) aspects of program participation, such as, the unsynchronized data and indicators of the poor population which caused many poor people to be removed from the public budget (Penerima Bantuan Iuran - PBI), having different definitions of poor and disadvantaged people, and weak law

enforcement of independent participants who are in arrears of BPJS Health contributions have not run optimally. 2) service aspects, access to the JKN benefit package has not been evenly enjoyed by residents in various regions of Indonesia and the implementation of hospital referrals that have not been optimized. 3) the financing aspect, where the value of JKN program contributions set by the government is still underpriced (Tri Aktariyani, Elva Noor Endah, 2021).

The Government of Ghana, West Africa, authorized a health insurance policy known as The National Health Insurance Law, otherwise known as The National Health Insurance Policy. The policy was created to alleviate the suffering of the citizens of the country of Ghana, especially the poor and vulnerable in accessing and utilizing health services, the policy tends to protect social health through risk sharing, cross-subsidy, solidarity, equity, and quality care. In addition, there is the National Health Insurance Scheme (NHIS) established by the government of Ghana in 2003. This program is a form of national health insurance established to provide equitable financial access and coverage for basic health care services to citizens of Ghana. Factors affecting the application of the system health insurance in Ghana, are: 1) the implementation of a cash and carry system (health care costs are paid in advance before the patient receives health care), 2) there is an inequality occur between urban areas and deep countryside health service delivery, 3) resource distribution unequal health including personnel affect health outcomes throughout the country of Ghana, 4) the majority of Ghana are economically active work in informal sector, 5) there are limitations funds on collection district and level national, 6) inadequate staff, management skills limited. In Ghana membership has stagnated between 30% and 40% of the population for several years, both those who can afford it, and even those who are exempt from paying a premium, not included in the National Health Insurance Scheme (N-Yaaba and A, 2014).

Thailand started a guaranteed health system in the country in the 1990s which at the time only covered 16% of the population (civil servants and formal workers), in the year of 2002, already covers the entire population (National Health Security) which is estimated to cover 75% of the entire population. Thailand in reaching the system UHC health, the population is 99% protected by 3 schemes, namely Universal Health Coverage (75% universal coverage), Social Health Insurance for the formal private sector (health insurance scheme for employees private sector 20%), and Civil Servant Medical Benefit Scheme (health insurance scheme for civil servants 5%) (Putri, 2019). Thailand is also experiencing serious problems in implementing the health system. Some of these problems are: 1) inequity in the allocation of

resources, 2) differences in services between regions, 3) lack of number and level of health care, and shortage of health workers practitioners, 4) lack of health protection adequate, especially among the poor, 5) found residents who do not get access to health care, especially for people living in rural areas. Despite the funding constraints still faced by Thailand government in running health care programs Universal Health Coverage, Thailand has provided examples of service programs effective health services for other countries, especially countries that are still developing because of this program (Kanti, 2020).

Indonesia	**Ghana**	**Thailand**
Program's name		
JKN (Jaminan Kesehatan Nasional)	National Health Insurance Scheme (NHIS)	Universal Health Coverage, Social Health Insurance, Civil Servant Medical Benefit Scheme
Implemented since		
2014	2003	2002
Memberships (covering)		
According to the Roadmap of National Health Insurance, it is supposed that all Indonesian citizens will be covered by the BPJS Health by January 2019.	Membership has stagnated between 30% and 40% of the population for several years, both those who can afford it, and even those who are exempt from paying a premium, not included in the National Health Insurance Scheme.	Universal Health Coverage (75% universal coverage), Social Health Insurance for the formal private sector (health insurance scheme for employees private sector 20%), and Civil Servant Medical Benefit Scheme (health insurance scheme for civil servants 5%).
Program's constraint		
Unsynchronized data and indicators of the poor population which caused many poor people to be removed from the public budget, weak law enforcement of independent participants who are in arrears of BPJS Health contributions have not run	The implementation of a cash and carry system (health care costs are paid in advance before the patient receives health care), there is an inequality occur between urban areas and deep countryside health service delivery, resource distribution	Inequity in the allocation of resources, differences in services between regions, lack of number and level of health care, and shortage of health workers practitioners, lack of health protection adequate, especially among the poor, and

optimally, access to the JKN benefit package has not been evenly enjoyed by residents in various regions of Indonesia, the implementation of hospital referrals that have not been optimized.	unequal health including personnel affect health outcomes throughout the country of Ghana, the majority of Ghana are economically active work in informal sector, there are limitations funds on collection district and level national, and inadequate staff, management skills limited.	there are found residents who do not get access to health care.

Tabel 1. Point Compare

CONCLUSION

The results of the systematic review can be concluded that UHC is an important concept that guarantees access to quality health services without causing financial hardship for individuals and communities. A comparison of health insurance coverage between Indonesia and other middle-income countries shows that aspects of financing, membership, availability, accessibility, and quality of health services are still challenges that need to be addressed by the government and the community. However, each country has different policies and programs.

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