INdonesian primary care through universal health coverage systems: A feeling in bones

Al Asyary*1,2
1Department of Public Health Science, the Graduate School, University of Muhammadiyah Prof. Dr. Hamka, Jakarta, Indonesia
2Problem-solving for Quality Hospitals Unit, Center for Educational and Community Services, Faculty of Public Health, University of Indonesia, Depok, Indonesia

Received: 31 May 2018 | Accepted: 4 September 2018
*Correspondence:
Dr. Al Asyary, SKM, MPH
Email: al_asyary@uhamka.ac.id

Abstract
Jaminan Kesehatan Nasional or JKN realized as the one of problem solving for equity of healthcare in Indonesian setting. At the same point, it has to compatible with all aspects in health financing issues by its newly adopted systems. This review aims to reveal JKN health financing policy since it implemented by 2014 in Indonesia. Several bibliographies databases were identified to conduct literature reviews that comprised of international and national/local journals. It founds that JKN principles focuses on mutual support, not-for-profit, good governance, and portability aspects. JKN enrollment consisted of two types polisholders including incapable polis insurance (PBI JKN) that bear by the Indonesian government, and capable polis insurance (none PBI JKN). JKN have to synergize with recent existing challenges including integration from previous regional health insurance (Jamkesda), healthcare facilities, package benefit, financing issue as well as the deficit issue which happened as lower dues that making by JKN polisholder than the high claim by the healthcare facilities particularly in hospitals. Although, JKN emerges to tackle the inequity of healthcare in all Indonesian regions, the existing settled Jamkesda in several regions, particularly regions with high regional income, made JKN integration as the setback health financing on its regions. Limited healthcare facilities that cooperated with BPJS-Kesehatan also challenged the JKN implementation as well as financial lose in affecting by mismatch between medical expenditures with JKN claimed as per package. It concludes that the political willing to choose several options including to prevent JKN deficit depend on the leader commitment to make JKN as not for another journey but it shall be the destination for health financing in Indonesia.

Keywords: health financing, universal health coverage, health insurance, national health insurance, Indonesia

Introduction
Health care is the most needed care by anyone that wants to healthy living that could not be negotiated. Sometime, it is no matter how much people have to pay for having healthcare, particularly in developing country setting such as Indonesia. Indonesian public health systems are currently providing an ideally social security assurance for health, namely Indonesian universal health coverage (Jaminan Kesehatan Nasional or JKN). In previous circumstances, Indonesian people tent to achieve standard healthcare by cost (out off pocket), but if they uncapable to afford it, they will resisted by healthcare providers as a formed of violation to both patient and human rights (Widjaja, 2014). In this case, a healthcare facility more likely neolib than where it depended on how much money they
can obtain from patient. Meanwhile, other developing countries have already successfully implemented their newly and reformed health systems almost in detail family medicine including new structure of primary care (Põlluste & Lember, 2016; Tkachenko, 2017). Otherwise, it also varied by fraud or inappropriate healthcare that included maximum drug or therapy referred while the same outcome but cheaper than out-off pocket were available (Aspinall, 2014).

In this era, JKN presents a health system that has enabled the health expenditure that is no longer burdening the patient. The financial bussiness of this system runs by an independent management agency for health namely national healthcare security committee (Badan Penyelenggara Jaminan Sosial Kesehatan or BPJS-Kesehatan) (Mboi, 2015).

METHODS

In this review, the literatures were search in both international and local bibliographic sources i.e. MEDLINE, EMBASE, CINAHL, Cochrane Library, Science Direct, ProQuest, WHO SEARO database, SCOPUS, Wiley Library, SAGE, Taylor & Francis, SpringerLink, Hindawi, and Directory of Open Access Journals (DOAJ). This study also search literature not listed in the above bibliographic resources using Indonesian Portal Indexing (IPI), and it examined the recent literature on the current issue and prospects for the current health insurance of Indonesia with JKN as a main outcome for the review discussion resulting from the government policy associated with update circumstance of Indonesian JKN in numerous studies.

PRINCIPLE

BPJS-Kesehatan system that underlined systematic step to ensure the JKN conservative fund for utilized efficiently (Indonesian Government, 2004). Healthcare provider is paid by prospectively such as capitation, casemix based group (CBG) or in specific budgeting. For example, Indonesian government is commited that there are only two ways to paid it that consisted of capitation and CBG (PerPres RI, 2013). BPJS-Kesehatan in health facilities discussed about standard cost of healthcare on both primary and secondary health facilities that determined by the claim of diagnose related system as well as in CBG (Indrani, Kusnanto, Ghuftron Mukti, & Kunto, 2013). CBG is not only utilizing by uncapable patient but also it uses by capable registrant. Capable registrant is meaning as polishanded of JKN who covered their health assurance by themselves. Meanwhile, uncapable registrant that unable to paid their health assurance, so the government has to pay it for them. CBG model applied the claim payment of JKN to the healthcare facilities based on healthcare packaging that formed by the group of disease diagnostics (Hadning, Ikawati, & Andayani, 2015; Hasanah, Mahawati, & Ernawati, 2013). CBG tariff was concluded and it issued by 10th International Code for Disease (ICD X). Periodically, this code shall be revised and analyzed for the appropriateness circumstance of healthcare facilities’s data and it also reviewed the previous JKN implementation in order to produce and fixing the cost method’s calculation (Mundiharno & Thabrany, 2012).

JKN principles are comprised of following: (a) Mutual support; as major core of JKN principle which is meaning spirit and practice when capable helps noncapable participant, low risk helps high risk, and the healthy supports the sick. These three components are not happened on comercial health insurance, so it shall be realized social equity for all society. (b) Not-for-profit; shall not be beneficiary on either of partial people or board executive, which also called shareholders. Legally, it collected as trust fund and utilised for healthcare payment. (c) Good governance; consisted of openness, caution, accountability, efficiency and efectivity. It included of policies, revenues, expenditures, investments, and any others transactions should be recorded and archived for surely. External audit board obligated to examine and verified it publicly. Otherwise,
chief of BPJS-Kesehatan have published the accountability and audit results publicly on official website. (d) Portability; meant participant to not only produce benefit, but also healthcare that became participant’s rights (Mboi, 2015). Portable also expressed mobility that is valid on all healthcare entities and it is following the dynamic of participant’s needs. BPJS-Kesehatan also cannot impose restriction of assurance in any region or area in any setting of populations.

ENROLLMENT

In the meaning of the participant is any person, including a foreigner who works for a minimum of 6 (six) months in Indonesia, who has paid the dues. While the worker is any person, who works by receiving the salary, wages, or other forms of remuneration. Participants include JKN incapable polis insurance (PBI) and none PBI JKN with details as follows:

Table 1. JKN enrollment procedures (Indonesian Government, 2004, 2011)

<table>
<thead>
<tr>
<th>JKN enrollment procedures</th>
<th>JKN mechanism of registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>JKN enrollment types</td>
<td>Registration requirement, terms of registration will be arranged later in BPJS-Kesehatan rules</td>
</tr>
<tr>
<td>PBI JKN participants consisted of people who categorized as poor and disadvantaged.</td>
<td>Registration location for Participant Registration have done at the nearest/local BPJS-Kesehatan office</td>
</tr>
<tr>
<td>Wage-earning workers and members of their families, namely: civil servants, members of the military (TNI); members of the police; state officials; non-government employee; government employee; private employees</td>
<td>Participant registration procedure</td>
</tr>
<tr>
<td>Non-beneficiary workers and their family members, namely: a. workers outside the employment relationship or self-employed b. workers who do not include letter a who are not wage earners. c. workers as referred to letters a and b, including foreign citizens countries working in Indonesia for a minimum period of 6 (six) months.</td>
<td>1) The government registered PBI JKN as a member to BPJS-Kesehatan. 2) Employers enrolled their workers or workers enrolled as members to BPJS-Kesehatan. 3) Not-workers and other participants are required to self-register their selves and their family as members to BPJS-Kesehatan.</td>
</tr>
<tr>
<td>Rights and obligations of the Participant</td>
<td>Every participant who has enrolled in BPJS-Kesehatan entitled to: a) the identity of the Participant and b) the benefits of health services at the Health Facility which had collaboration with BPJS-Kesehatan. Every participant who has registered with BPJS Kesehatan have obligatory to: a) pay dues and; b) report membership data to BPJS-Kesehatan by showing the identity of the participant when moving domicile/or transferring work.</td>
</tr>
<tr>
<td>Phasing of membership</td>
<td>JKN participation shall conduct in several stages. The first phase commencing on 1st January 2014, where its membership shall include at least the following: PBI JKN; members</td>
</tr>
</tbody>
</table>

The pension recipients consist of: civil servants who have retired with the right to retirement; members of the TNI and members of the

Public Health of Indonesia, Volume 4, Issue 3, July - September 2018
police who stopped with the right pension.

<table>
<thead>
<tr>
<th>JKN enrollment types</th>
<th>JKN mechanism of registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>of the TNI/civil servants within the Indonesian Ministry of Defense along with their families; members of police/civil servants within the Indonesian Police along with their families; health insurance participant of PT Askes along with their families, and participant of Jamsostek along with their families member. Furthermore, the second phase included all residents who have not entered as participants of BPJS-Kesehatan for enrolled no later than January 1, 2019.</td>
<td></td>
</tr>
</tbody>
</table>
Previously, all provinces in Indonesia have already a regional health insurance (Jamkesda) respectively with there were four provinces that have settled Jamkesda financing (Supriyantoro, Hendarwan, & Savithri, 2014). The number of provinces that only guarantee the participants of none Jamkesmas poor were 27 provinces (81.81%), while two provinces (6.06%) using uncappable recommendation that issued by incapability-confirmed recommendation (SKTM) (Supriyantoro & Hendarwan, 2014). It indicated that the understanding and ability of each regions in Jamkesda management were varied, especially to achieve settled Universal Health Coverage (UHC).

Based on the characteristics and feasibility analysis of Jamkesda policy in 6 provinces, there were several points to consider in the formulation of the integration policy formulation as follows: 1) The existing regulations and action plan at the provincial level which would determine the how far the Jamkesda integration process works well; 2) The political commitment of regional leaders, which was in general it should be visionary regarding to the preparation of JKN implementation after; 3) Field preparedness which was also a key that should well prepare during the Jamkesda integration process into the JKN, concerning limited access, availability of health services and BPJS-Kesehatan that distributed evenly and the quality of standards, as well as the level of knowledge/awareness of the community; 4) The ability of regions to adjust Jamkesda policies compiled with the regional middle development plan (RPJMD) performance indicators which was essential in the integration process, as it should synergy in each region respectively; 5) Economic and financial factors, particularly the readiness of local budgets with determination the readiness of regions to integrate; 6) Result basis financing that may bridging the existing system differences and improve performance both concerning to supply and demand from health systems in achieving Universal Health Coverage (Supriyantoro & Hendarwan, 2014; Supriyantoro et al., 2014).

Health Facility
Implementation of the JKN led to increased utilization of services in health facilities, especially hospitals (Nugraheni, 2015). Integration into JKN Jamkesda participants would also be escalated the number of service utilization (Ambarriani, 2014; Supriyantoro & Hendarwan, 2014). Several problems shown in relating to the limited healthcare facilities that caused people cannot take advantage of these health facilities despite having health insurance. For example, the case of patients who end up having to find another hospital after a very long wait for a treatment room, a patient rejected by the hospital, especially those needing the emergency care such as ICU (Sandhyaduhita et al., 2016). In relating with the rise of PBI JKN patient rejection by the hospitals, this issue triggered the moral hazard that harmed the community and the patient to declared theirselves as a general patient so it can be served faster and more secure than if admitted as a JKN patient whose responded by slowly and unfriendly from the hospitals.

Package Benefits
Concerning benefit package for PBI JKN, Presidential Act No.12 of 2013 has clearly stated details of benefits received by PBI (Pemerintah RI, 2013). However, in practice, the benefits package not entirely obtained by patients or due to poor hospital management that affected patients have to spend their money (out-off-pocket) to fulfill the needs of health care (Veruswati & Asyary, 2017b). Also, the benefits package in JKN does not adequately fulfill the needs of particular patients, for example, specified drugs according to the national formulary (Fornas) (H Thabrany & Abidin, 2017). In BPJS-Kesehatan perception, Fornas drugs has been fully met the standard needs of the treatment (Indonesian Government, 2011). In fact, several hospitals made patients to out-off-pocket for particular receipt in pharmacies outside the hospital (Veruswati & Asyary, 2017a). Furthermore, Fornas itself is a list of drugs that do not include the trading name of medicine and it only written as the active substance of the drug (Pemerintah RI, 2015). Thus, it led the hospitals to made patient that
have to pay for anonymous trading name of the drug as caused by unavailability of the *Formas* medication. On the implementation of JKN, it should be able to encourage hospitals to improve the management of services including providing the stock of medicines and medical supplies in considering the increased utilization of health facilities.

Besides, the hospitals complained about the difficulty of accessing e-catalog (Dwiagi, Sarmianto, Thabrany, & Syarifudin, 2016; Kusmini, Satibi, & Suryawati, 2016). It carried on as common event as e-catalogs run the mechanism for the tender of medicines and medical consumables needed in government health facilities (Hasbullah Thabrany, Sari, Tilden, Dunlop, & Hajaraeni, 2015). The hospital in collaboration with *BPJS-Kesehatan* should cooperate with pharmacies which appointed by *BPJS-Kesehatan* to provide medication for JKN participants. It indicated that the government still needs to educate and provide the explanation for the private sector that cooperates with *BPJS-Kesehatan* and prevent patient’s rejection by the hospitals.

**Deficit**

As a newly-innovate insurance, *JKN* is aimed to afford health equity access for all Indonesian mankind. *JKN* alongside with Health Indonesian Card (Kartu Indonesia Sehat or KIS) have succeeded to covering more than 178 millions (more than 60%) of Indonesian society (*BPJS Kesehatan*, 2017). Otherwise, *JKN-KIS* allowed increasing Indonesian people to have their health insurance in such a way (Andria & Kusnadi, 2017; Habibie, Hardjosoekarto, & Kasim, 2017). Based on enrolment distribution data of The National Healthcare Security Committee (*Badan Penyelenggaran Jaminan Sosial Kesehatan* or *BPJS-Kesehatan*) on March 2017, participant still enrolled dominantly by Recipient of Contribution Subsidy (Penerima Bantuan Iuran or PBI) with 52% rather than the other policyholders (24% employee, 12% non-employee/entrepreneur, 3% government shareholders, and 9% integration from previous local government health assurance or Jamkesda) (*BPJS Kesehatan*, 2017).

One of the basic huge problems is emerging as unequaly between total revenue that is coming through participant subscription received with total expenditure both for claimed payment (hospital) and capitation (health center) that called mismatch. It should be acknowledge that mismatch is hardly to avoid as caused by subscription structure that set by the government was below from real actuarial accounting. In fact, actuarial accounting has been calculating and set the cut-off point as ideally subscription for *BPJS-Kesehatan* anyway. However, it decided, always, by considering the political and economics policy. The government amended the subscription amount below actuarial accounting ideally. And automatically, the consequences of these policy felt as current situation (Lestari & Djamaludin, 2017).

In 2015, subscription average was IDR 27,000 per person per month, while its claiming expenditure was reached IDR 33,000 per person per month. Thus, deficit happens IDR 6,000 per person per month with 145 millions participants, so it achieved 10.4 trillions deficit (*BPJS Kesehatan*, 2017). This concludes that *JKN* revenue is still far away from its expenditure. On the other hand, this situation will also influence to quality and pattern of health care. Therefore, the government is essential to improve the fiscal capacity to accommodate health financial needs, including *JKN* financing.

Obviously, the Government Act No. 24 of 2011 about *BPJS-Kesehatan* had been amended the mechanism of *JKN* financing. Unfortunately, its financial regulation have not detailed as expected yet, while it hopes that it can be cover whether with government regulation No. 87 of 2013 about Management of Health Social Assurance Asset or the revised version as government regulation No. 84 of 2015, however, it seems that these latest regulations were only the repetition from the prior act without any particular meaningful in addition.

There are several options to avoid mismatch in future deadlock for further. According to the
Indeed, the mainly factor is changing the subscription participant at least equivalent to actuarial accounting which is by escalating the current subscription participant. However, it should consider the political issue. Meanwhile, investment program seems tantalizing but it is more difficult to regulate either for the profit (Fossati, 2016), investors requirement, and investment methods in such a way (Trisnantoro, Marthias, & Harbianto, 2014). Otherwise, in effort to interpreting the last option as seeking for other legitimately source is essential to earmarking the best benefit health care (Hashbullah Thabrany & Laborahima, 2016), as well as to reduce the morbidity and mortality, for further.

CONCLUSION

As the singular national health insurance, JKN showed by the powerful policy to adopt its scheme in all of the regions at this country. It indicates that the political commitment is the main venue to implement it beyond the rest factors including current challenges such as the Jamkesda integration and the deficit. These challenges should be the opportunities in making JKN for not only the one of the journeys but the destination of the health insurance in Indonesian.

Acknowledgement

I would like to thank to the contributors: Mrs. Meita Veruswati, Dr. Abdillah Ahsan and Mr. Nur Hadi Wiyono. The review discussions are those of the authors and any views expressed are not necessarily those of any affiliations’ opinion.

Conflict of Interest

The author has no conflict of interest to declare that related to this paper.

REFERENCES


