ASM Sc. J., 13, Special Issue 5, 2020 for APRU2018, 183-187

Health Inequality in Wealth Disparity: A Narrative Review of Indonesia's Health Coverage Protection Against Poverty

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The ill-fated relationship between health and poverty might create a broader gap in health inequality between poor and rich. Universal Health Coverage (UHC) intends to alleviate this problem by providing financial protection for all. This article aims to uncover the development of Indonesia's Health Coverage protection against poverty throughout the implementation of UHC in Indonesia. This article utilises a narrative review in favour of its strength in constructing a critical analysis of a complex problem from the theoretical and contextual point of view. The searching process obtained nine journals articles that consist of country data analysis and commentaries, and twelve grey literature for the organisation of this paper. This article tries to analyse the global standard for country economic classification and its impact to the health disparity; the coverage of national health insurance; national health budget allocation and wealth disparity; and health services inequity that caused by wealth disparity regarding the ethical consideration. The wealth disparity in Indonesia is decreasing steadily, along with the increasing national budget allocation for health after the implementation of National Health Insurance (NHI) or Jaminan Kesehatan Nasional (JKN) in 2014.

Keywords: universal health coverage; poverty; Indonesia

I. INTRODUCTION

Universal Health Coverage (UHC) aims to provide financial protection for the public (World Health Organization/WHO, 2017). WHO also notes that all United Nation (UN) Members have agreed to achieve UHC by 2030. UHC ensures health equities for all individuals while protecting their financial status. UHC includes all essential and quality health services, including health promotion, prevention, treatment, rehabilitation, and also palliative care to improve public health status.

Based on world population review, currently, Indonesia ranks as the global fourth most populous country after China, India, and the United States. Indonesia's population estimated to contributes to the 3.5% total world population. Along with the population growth over the years, data by Indonesia's Central Bureau of Statistics (Badan Pusat Statistik/BPS, 2018b), the number of the poor citizen in Indonesia declines.

Over the decades, Indonesia has been through changes in its social security programs (Kementerian Kesehatan RI, 2014). In its development process, UHC became an electoral issue to move up the political agenda (Pisani *et al.*, 2017). Despite the involved political conflicts, in 2013, Indonesia targeted to achieve UHC by 2019. The commencement of this target began through the implementation of National Health Insurance (NHI) or Jaminan Kesehatan Nasional (JKN) that managed by BPJS-Kesehatan on 1 January 2014.

Global poverty prevalence primarily caused by the unfair resources distribution and various forms of structural deviance that produce wealth and power for one group and result in poverty and disempowerment for the other group (McCoy, 2017). Poverty and health intersect in various ways and results in the whole range of possibilities and opportunities (Murray, 2006). In the early period of life, childhood poverty and hunger will lead to poor school performance and later, to an inability to find decent work to support the family and causes less access to health — this

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vulnerability caused by their inability to provide their own basic living needs. In developing countries, poverty contributes to higher risks of injury, such as unsafe working conditions, uncovered wells that lead to drowning, use of open fires for cooking, and use of kerosene lamps that can easily knock over and ignited (Gostin *et al*., 2010).

This article aims to discuss the development of Indonesia's health coverage protection against poverty throughout the implementation of UHC in Indonesia through a narrative review of various journal articles and grey literature that focus to its protection against poverty.

II. MATERIALS AND METHOD

This article utilises a narrative review in favour to its strength in constructing a critical analysis of a complex problem from the theoretical and contextual point of view (Grant and Booth, 2009; Rother, 2007). The authors conducted a purposive search of the literature through online science databases, such as Google Scholar, Scopus, and PubMed using Universitas Indonesia Library and Curtin University Library provided access. 'Universal health coverage' in combination with 'poverty' and 'Indonesia' were used as keywords of the literature search. Websites of key health organisations and bureau of statistics, including https://www.bps.go.id; http://www.anggaran.depkeu.go.id; http://www.depkes.go.id; https://data.worldbank.org; and http://www.who.int were also searched.

III. RESULT

The literature search retrieved nine journals articles and twelve grey literature for the organisation of this article. The obtained journal articles consist of briefing paper (n = 1), commentaries (n = 3), editorial (n = 1), qualitative case study (n = 1), and secondary data analysis (n = 3). Four of these articles explain about UHC in Indonesia, its coverage, and its impact on poor people. One of these articles explains the global responsibilities for health. Three of them explain the health and poverty relationship. One article explains about challenges in NHI coverage. Moreover, the other one covers the representation of the Gini index as wealth inequality. From the grey literature, the authors obtained global health profile (1), Indonesia's health profile (6), population data (3), and countries economic classification (2).

A. Countries' Income Classification

Globally, instead of using Gini ratio as the basis for country income classification, the World Bank uses Gross National Income (GNI) per capita that only measures the nation's income without consideration to the economic disparity within the country (Ultsch and Lotsch, 2017). It includes all the income earned by a nation's residents and businesses, including those earned abroad (World Bank, 2018a). It will cover the fact of wealth inequality within a nation, hence biases the global perception of a nation's economic condition.

World Bank (2018b) categorises Indonesia as Lower-Middle-Income Country with GNI per capita ranged from $1,006 to $3,955 together with other countries such as Bangladesh, India, Philippines, and Vietnam. This classification influences the World Bank's lending decision that used for the countries development needs.

From the Gini ratio data of some Lower-Middle-Income Countries (LMICs) including Indonesia (0.391 in 2017), Bangladesh (0.321 in 2010), India (0.352 in 2011), Philippines (0.401 in 2015), and Vietnam (0.357 in 2012) (BPS, 2018a; World Bank, 2018a), the range of Gini ratio in LMICs ranged around 0.3 to 0.4. Brazil, one of the Upper-Middle-Income Countries has a higher Gini ratio (0.513). It means that even Brazil has a higher GNI per capita than LMICs, the economic inequality gap within the country is more extensive than these LMICs.

B. The Participation of National Health Insurance in Indonesia

Based on the payment sources, there are two categories of participants of BPJS Kesehatan, which are beneficiaries or Penerima Bantuan Iuran (PBI) and non-PBI. PBI participants are financially incapable citizens; hence, the government for their insurance.

The number of BPJS Kesehatan participants in total, as well in both participants category gives a positive trend. It increased every year since the commencement of BPJS Kesehatan (Table 1).

Table1. Increasing of BPJS Kesehatan participants (Kementerian Kesehatan RI, 2015, 2016, 2017, 2018)

BPJS Participants	2014	2015	2016	2017
% Participant in Indonesia's citizen	52.5	52.5	66.46	71.59
Total participants	132365340	156790287	171939254	187982949
Number of PBI participants	86400000	87828613	91099279	92380352
Number of non-PBI participants	38256424	57791059	65424687	75297324

Despite the increasing trend of participants nationally, the number of participants varies across the nation. Reich *et al.* (2016) study about UHC implementation in eleven countries, including Indonesia, shows that although Indonesia already made substantial progress toward UHC, it still has substantial coverage gaps. Geographical disparities in health workers distribution are the major problem of health care services in those eleven countries. This disparity will potentially result in the unequal quality of health services. Reich *et al.* (2016) study also note that although economic growth was essential to support in coverage expansion, the most crucial premise for UHC implementation is a national shared commitment to countermeasure health and poverty.

There is an increasing trend of the national budget for health in Indonesia that represents the increasing government concern towards health (Figure 1). Despite the increasing national budget for health, the wealth disparity in the urban and rural area is still high as ever. Based on data from BPS (2018c) from 2002 to 2018, the Gini ratio in the urban area is about 1.5 times higher than in rural area (Figure 2).

C. Health Care Services Classification

The classification of health care services received by the patients based on the paid amount of money for insurance is unavoidable due to the different monetary capability of NHI participants. This classification is often interchangeable with the social class categorization. The fifth core principle of JKN is "equal medical service is for all JKN participants; however, participants can choose to pay for a higher level of in-patient service"(Mboi, 2015).

IV. DISCUSSION

A. Does the Countries Income Classification Represent Wealth Disparity?

A zero Gini ratio represents perfect equality, where everyone in the country has the same income. A Gini ratio of 1 represents a maximal inequality of income among people within a country (BPS, 2018a). The steep curve of wealth inequality is captured in the global fact, as currently, the wealth combination of eight wealthiest people in the world is equal to the wealth of half of the world's population (Gibson, 2017).

Gibson (2017) explains that in the past fifteen years, the ultra-rich people in Indonesia have gained their privileged status through various Indonesia economic resources and commodities, such as oil palm, coal and other minerals, or through other businesses such as communications technology, multimedia, and finance businesses. The number of billionaires in Indonesia is also grown rapidly, from just one in 2002 to 20 in 2016. All the 20 Indonesian billionaires combined wealth was approximately US$49.8 billion. While in contrast, 84% of the Indonesians only possess less than $10,000 in wealth.

Rather than depending on the external funding and loan to develop health system and to eradicate poverty in a nation, it is a better option to let the wealthier and willing citizens invest in their development as the wealth inequality is quite striking in the global picture. By investing in their own country, those billionaires are expected to possess more sense of belonging as a part of the country and its development, not merely focus on their business goals.

B. National Health Budget Allocation and Wealth Disparity

Based on the BPS (2018c) reports, from 2002 to 2018, the Gini ratio in the urban area is about 1.5 times higher than in rural area. It means that wealth inequality is higher in urban areas rather than in rural areas. It potentially caused by the variation in the number of health care providers in impoverished areas of the country and their willingness to treat people with public insurance coverage (Swartz, 2009).

The extrapolation data of national health budget allocation and Gini ratio in Indonesia shows a positive result (Figure 3). Especially after the implementation of JKN in 2014, the wealth disparity in Indonesia is decreasing steadily, along with the increasing national budget allocation for health. It means that the implementation of UHC in Indonesia potentially has a protective effect against poverty.

C. Health Services Inequity in Wealth Disparity

One of JKN core principle, “equal medical service is for all JKN participants; however, participants can choose to pay for a higher level of in-patient service” (Mboi, 2015), is ambiguous. People could interpret the "higher level of in-patient services" differently. Regarding the ethical values, the difference of services supposed to only includes the facility or medication types. However, the way the health care providers treat the patients is also differ based on the social class. The higher the patient class level, the better health care provider serves the patient. On the contrary, they often despise or give less concern for patients in the lower class. It contradicts with UHC principle to provide equal access to health services for all residents in the entire nation.

Related to the ethical value of health care providers, in his study, Rosser (2012) highlights that the persistent of illegal fees in public health facilities in Indonesia reflects the political dominance of a coalition of political interests. It consists of the state government and primary business groups interests. The government considers that their health funding provision is proper and adequate, and on the other hand, the healthcare providers consider that the government funding for health care is not enough. Hence, they recommend other healthcare options to the patients that are suggested by the healthcare business. The healthcare providers introduce these options as more effective but more expensive options that are not covered by the government to the patients. Hence, they must pay more by themselves. Abolishing illegal fees practice in Indonesia’s public health system requires not only better funding of public health facilities and better management, but also efforts to empower the poor and their political allies in the government.

Ministry of Health Indonesia (Kementerian Kesehatan RI, 2018) reports that the most health budget in Indonesia is allocated for JKN programs, while the second and third highest health budget is allocated for the health service development program and human health resources development and program. This significant amount of money supposed to use for not only the scientific development of health services but also the ethical development of the healthcare workers. Health care providers are the core of health care services, which directly involved with the patients. The way they treat them will also potentially affect their health outcomes. If the core of health care services does not implement the UHC principle of health equity and equality, who will do?

V. CONCLUSION

The dual causalities between poor health and poverty might create a broader gap in health inequality between poor and rich. Universal Health Coverage (UHC) aims to provide financial protection for all people. The implementation of UHC in Indonesia potentially has a protective effect against poverty. Data trends of national health budget allocation and Gini ratio in Indonesia shows a positive result. The wealth disparity in Indonesia is decreasing steadily, along with the increasing national budget allocation for health after the implementation of JKN in 2014.

VI. ACKNOWLEDGEMENT

Indonesia One Health University Network (INDOHUN) supported this study for the 12th annual APRU Global Health Conference participation sponsorship.

VII. REFERENCES

Badan Pusat Statistik 2018a, Gini Ratio Provinsi 2002-2017, viewed 6 May 2018, <https://www.bps.go.id/linkTableDinamis/view/id/1116>.

Badan Pusat Statistik 2018b, Gini Ratio September 2017 tercatat sebesar 0,391, viewed 6 May 2018, <https://www.bps.go.id/pressrelease/2018/01/02/1410/gini-ratio-september-2017-tercatat-sebesar-0- 391.html>

Badan Pusat Statistik 2018c, Jumlah Penduduk Miskin Menurut Provinsi, 2007-2017. viewed 6 May 2018, <https://www.bps.go.id/linkTableDinamis/view/id/1119>.

Departemen Keuangan Republik Indonesia 2015, Anggaran Kesehatan 2010-2015, Departemen Keuangan Republik Indonesia, Jakarta.

Gibson, L. 2017, Towards a More Equal Indonesia. Oxfam Briefing Paper, Oxfam, Jakarta.

Gostin, L. O., Ooms, G., Heywood, M., Ha, J., Møgedal, S., Røttingen, J., … Siem, H. 2010, The Joint Action and Learning Initiative on National and Global Responsibilities for Health. World Health Organization, Oslo.

Grant, M. J., & Booth, A. 2009, A typology of reviews: an analysis of 14 review types and. Health Information and Libraries Journal, vol. 26, pp.91–108.

Kementerian Kesehatan Republik Indonesia 2014, Buku pegangan sosialisasi Jaminan Kesehatan Nasional (JKN) dalam Sistem Jaminan Sosial Nasional, Kementerian Kesehatan Republik Indonesia, Jakarta.

Kementerian Kesehatan Republik Indonesia 2015, Profil Kesehatan Indonesia Tahun 2014. Kementerian Kesehatan Republik Indonesia, Jakarta.

Kementerian Kesehatan Republik Indonesia 2016, Profil Kesehatan Indonesia Tahun 2015. Kementerian Kesehatan Republik Indonesia, Jakarta.

Kementerian Kesehatan Republik Indonesia 2017, Profil Kesehatan Indonesia Tahun 2016. Kementerian Kesehatan Republik Indonesia, Jakarta.

Kementerian Kesehatan Republik Indonesia 2018, Data dan Informasi: Profil Kesehatan Indonesia 2017. Kementerian Kesehatan Republik Indonesia, Jakarta.

Kementerian Keuangan Republik Indonesia 2018, APBN 2018. Kementerian Keuangan Republik Indonesia, Jakarta.

Mboi, N. 2015, Indonesia: On the Way to Universal Health Care Indonesia: On the Way to Universal Health Care. Health Systems & Reform vol. 1, no. 2, pp. 91–97.

McCoy, D. 2017, Critical Global Health: Responding to Poverty, Inequality and Climate Change Comment on "Politics, Power, Poverty and Global Health: Systems and Frames." Kerman University of Medical Sciences, vol. 6, no. 9, pp. 539–541.

Murray, S. 2006, Poverty and health. CMAJ, vol. 174, no. 7, pp. 923.

Pisani, E., Kok, M. O., & Nugroho, K. 2017, Indonesia's road to universal health coverage: a political journey. Health Policy and Planning, vol. 32, no. 2017, pp. 267–276.

Reich, M. R., Harris, J., Ikegami, N., Maeda, A., Cashin, C., Araujo, E. C., … Evans, T. G. 2016, Moving towards universal health coverage: lessons from 11 country studies. The Lancet, vol. 387, no.10020, pp. 811–816.

Rosser, A. 2012, Realising Free Health Care for the Poor in Indonesia: The Politics of Illegal Fees Realising Free Health Care for the Poor in Indonesia: The Politics of Illegal Fees. Journal of Contemporary Asia, vol. 42, no. 2, pp. 255–275.

Rother, E. 2007, Editorial: Systematic Review X Narrative Review. Acta Paulista de Enfermagem, vol. 20, no. 2, pp. 7–8.

Swartz, K. 2009, Health care for the poor: For whom, what care , and whose responsibility ? Focus, vol. 26, no. 2, pp. 69–74.

Ultsch, A., & Lotsch, J. 2017. A data science based standardized Gini index as a Lorenz dominance preserving measure of the inequality of distributions. PLoS ONE, vol. 12, no. 8, pp. 1–15.

World Bank 2018a, GINI Index (World Bank Estimate). viewed 6 May 2018, https://data.worldbank.org/indicator/SI.POV.GINI?locations=BD-IN-PH-VN-ID

World Bank 2018b, World Bank Country and Lending Groups. viewed 6 May 2018, https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and- lending-groups

World Health Organization. (2017). Universal health coverage (UHC). viewed 6 May 2018, <http://www.who.int/entity/mediacentre/factsheets/fs395/en/index.html>