

Healthcare Access Inequity within a Social Health Insurance Setting: A Risk Faced by Indonesia's *Jaminan Kesehatan Nasional* (JKN) Program

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Abstract

This paper is a literature review laying out empirical evidence of healthcare access inequity within an implementation of social health insurance (SHI) programs. The research question of this paper is: in what way, and how, inequity in healthcare access potentially happens, even if a type of SHI covers the whole, or most, of a society. This paper is mainly motivated by the implementation of *Jaminan Kesehatan Nasional* (JKN), an SHI program in Indonesia. Even though the program aims to create better equity in healthcare access, the existing health system and the program's design may prevent the achievement of this goal. By laying out evidence on how healthcare access inequity in other countries remains within an SHI mechanism, this paper illuminates that JKN may face the same risk.

In reviewing the papers, this study applied Goddard and Smith's (2001) concept of healthcare access inequity in the area of availability, quality, cost, and information. The findings suggest that healthcare access inequity could happen despite the implementation of an SHI program. Four types of circumstances that might have led to healthcare access inequity include geographical disparities of health facilities; adequacy of insurance program's reimbursement and healthcare providers' financial motive; healthcare providers' prejudices toward patients; and unequal personal advantages of health treatment seekers. When applied to the context of JKN implementation in Indonesia, the risks of healthcare access inequity are imminent, mostly due to the uneven concentration of health facilities, the program's segmented tariff rates, and the socioeconomic diversity among JKN members.

The findings imply that JKN members might be at risk of healthcare access inequity. While the risks are plausible, this study is limited to predicting the potential inequity within JKN, mirroring from the empirical evidence. This study signifies the need for further empirical research on this area, which will potentially inform policymakers to improve the program.

Keywords: healthcare access; inequity; social health insurance; Indonesia; *Jaminan Kesehatan Nasional* (JKN)

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Healthcare Access Inequity Within a Social Health Insurance Setting: A Risk Faced by Indonesia's *Jaminan Kesehatan Nasional* (JKN) Program

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I. Background

This study is a literature review focusing on inequity in healthcare access. In the analysis, specific attention is given to the countries whose governments aim to cover their population through some prepaid health financing mechanisms, such as through social health insurance or general tax-funded healthcare. While not all of these mechanisms fit as social health insurance (SHI), they have the same goal to improve equity in healthcare access (World Health Organization, 2005). Thus, for the paper, the term SHI will be used to refer to all types of prepaid health financing programs.

The research question of this paper is: in what way, and how, inequity in healthcare access potentially happens, even if a type of SHI covers the whole, or most, of a society. This paper is mainly motivated by the implementation of *Jaminan Kesehatan Nasional* (JKN), an SHI program in Indonesia. JKN currently covers 223 million people, or about 85% of Indonesia's population, and is expected to cover all its population soon universally (BPJS Kesehatan, 2020; Tim Nasional Percepatan Penanggulangan Kemiskinan, n.d.). Even though one of the main aims of the program is to create better equity in healthcare access for all Indonesian people (Tim Nasional Percepatan Penanggulangan Kemiskinan, n.d.), some circumstances, including the existing health system and the JKN program's design, may hinder the plan to achieve this goal. By laying out empirical evidence on how healthcare access inequity in other countries remains, even within an SHI mechanism, this paper illuminates that the JKN program may face the same risk.

The study uses Goddard and Smith's (2001) category of healthcare access inequity in collecting the articles and analyzing the evidence. Goddard and Smith (2001) categorize healthcare access inequity into four forms: availability, quality, cost, and information. From the data analysis, this study finds four general circumstances that potentially contribute to maintaining the healthcare access inequity in an SHI setting. Those circumstances include (1) geographical disparities of health facilities, (2) insurance reimbursement level and healthcare providers' financial motive, (3) prejudices of healthcare providers toward patients, and (4) advantages of certain groups of the population. By applying these findings to an Indonesian context, this paper then argues that those circumstances also exist within the JKN implementation and Indonesia's health system, placing JKN beneficiaries in the risk of healthcare access inequity.

II. The Concept of Healthcare Access Inequity and Social Health Insurance

According to an egalitarian viewpoint, equity in healthcare means that healthcare is distributed based on need, but funded based on ability to pay. This implies that in a society, everybody should have equal access to healthcare when they need it, regardless of their income levels (Wagstaff and van Doorslaer, 2000). This concept of healthcare access equity focuses on the supply side of healthcare, which means that this theory limits its scope of discussion only to the way access to healthcare is provided and distributed (Wagstaff and van Doorslaer, 2000). Another concept of equity, which focuses on how access to healthcare is taken up by the population, deals more with the demand side of health care and will not be covered in this paper.

The concept of healthcare access inequity has been a subject of discussion among public health scholars, especially regarding the interpretation of access. Hall et al. (2008)

have offered the concept of a “physician-enabling component.” In a study on Medicaid implementation in Florida, they have proposed to measure healthcare accessibility through four components: the availability of physicians accepting Medicaid patients, easiness in contacting a physician, easiness in making an appointment with a physician, and proximity of physicians to the patients’ residences. Goddard and Smith (2001) argued that the definition of healthcare access is highly contextual. It could mean health insurance in one area, and it could include more components in others, such as a specific range of treatments and a level of service quality. As previously stated, Goddard and Smith (2001) proposed that variations in healthcare access could happen in four different areas: availability, quality, costs, and information. Availability refers to the physical existence of the health service, i.e., whether or not the doctor and medical staff are present. Quality covers the issue of appropriateness for both medical and non-medical aspects of the health service. Costs reflect personal expenses in seeking and obtaining healthcare, including both medical (the health treatment) and non-medical (transport and accommodation) related costs. Lastly, information means the understanding of healthcare seekers about the available services to cure their diseases or treat their illnesses. An access inequity happens when particular groups of people can find health services more easily, get more appropriate health treatment, spend less money or time in accessing healthcare, and know better about what is available, compared to other groups, even though they have similar health needs.

SHI is a policy based on egalitarian logic, to eliminate the said healthcare access inequity. The egalitarian stances advocate a dominant role of government in managing health care. The state is expected to distribute healthcare according to need and collect public money to fund the system (Wagstaff and van Doorslaer, 2000). SHI fits that expectation. The program is mandatory to cover all (or a large part of) the population in a particular jurisdiction (country/state/province) (Savedoff, 2004; McIntyre et al., 2008). The policy provides standardized health benefits to the beneficiaries and is funded through either an insurance premium or taxes paid by the members/citizens. Unlike private health insurance, SHI’s premium/tax contribution amount is determined by the ability to pay, usually as a portion of income (Wagstaff and van Doorslaer, 2000). In many countries, the government also provides premium subsidies for the poor population. This way, regardless of the amount of the contribution paid, within an SHI setting, everyone should be able to access healthcare when they need it.

III. Analytical Framework and Methods

SHI improves access equity by limiting health financial barriers, especially the cost of medical care. While medical cost is a significant aspect of the whole healthcare seeking process, there are other essential aspects as well (Goddard and Smith, 2001). This research aims to understand those other aspects that create healthcare access inequity, even after medical cost is controlled through SHI. In other words, this research studies what the types of healthcare access inequity are and how they form, within an implementation of SHI.

As indicated previously, the research question of this paper is: in what way, and how, inequity in healthcare access potentially happens, even if a type of SHI covers the whole, or most, of a society. This paper answered the questions through a literature study of empirical research on SHI and healthcare access inequity. The Goddard and Smith’s (2001) categorization was used mainly in grouping the empirical evidence, and in analyzing within the groups, the circumstances that lead to the inequity. The categorization was then also applied in an Indonesian context to predict the risk of access inequity faced by JKN beneficiaries. The study chose to use the Goddard and Smith (2001) theory because it has offered a more flexible concept of healthcare access inequity, making it fit better for comprehensive analysis, especially in an international context. As explained above, Goddard and Smith’s (2001) concept did not limit the definition of health access only to availability; instead, it applies a broader spectrum, covering the issues of quality, cost, and information.

This paper studied 18 empirical research on SHI and healthcare access inequity. The articles were mostly in English, with one exception of a *Bahasa Indonesia* article. The studies were collected gradually through both active journal searching and bibliography study from the previously acquired articles. The keywords used for the international journal searching included combinations of “healthcare inequity,” “healthcare access,” “social health insurance,” “universal health coverage,” “patient-physician communication,” “physician perception,” “patient stigmatization,” and “patient discrimination.” This study did not apply a systematic inclusion and exclusion criteria of the articles. However, the study focused on the articles discussing healthcare access inequity within Goddard and Smith’s (2001) concept. Of all the articles used in this paper, two articles were qualitative studies, fourteen articles were quantitative research, and two articles used mixed-methods. The qualitative and mixed-method studies conducted focused group discussions (FGD) and semi-structured interviews, while the quantitative studies mostly performed statistical analysis with survey data collected from random samples.

IV. Results: Empirical Evidence of Healthcare Access Inequity in a Social Health Insurance Setting

The empirical evidence laid out in this paper came from both developed (the United States, Australia, Canada, and Germany) and developing countries (Indonesia, Kenya, Malawi, Brazil, Colombia, and eastern European countries). Some of the reviewed programs were fully implemented SHI, such as those in Canada, Germany, and several continental European countries; some were tax-funded health care systems, including those in Australia and Malawi; and some others were SHI with limited population coverage in a fragmented health care system, such as those in the United States (Medicaid) and Indonesia (JKN). While some studies specifically discussed a particular category within Goddard and Smith’s healthcare access inequity concept, some were broader and covered multiple categories.

4.1. Inequity in Healthcare Availability

Inequity in healthcare availability within an SHI setting has happened in different forms and could be triggered by different reasons. In many cases, the inequity of healthcare availability was caused by geographical disparities in healthcare services. In Malawi, where free healthcare has been provided for all of the population through government-owned health facilities, public health facilities were not evenly distributed across geographical regions (Abiuro, Mbera, and De Allegri, 2014). Some communities were only in proximity to private health facilities that required out-of-pocket payment.² Despite the program’s universal coverage, people in remote regions, who needed healthcare, were forced to either access the private health facilities and pay the fees, travel the extra miles to the closest public health facility, or altogether forgo health treatment because the other two options were unaffordable. The problem of geographical disparities seemed to be a common source of healthcare access inequity among developing countries implementing a type of SHI. Studies in Kenya (Mwabu, Ainsworth, and Nyamete, 1993), Colombia (Garcia-Subirats et al., 2014), and some eastern European countries (Cylus and Papanicolas, 2015) reported the same problem.

In developed countries with more even distribution of healthcare facilities, inequity in availability could be caused by healthcare providers’ refusal to participate in the SHI programs. In the United States, the poor population covered by Medicaid faced inequity in healthcare availability because not all physicians were willing to participate in the program or accept new Medicaid patients. Thus, while Medicaid patients were theoretically covered by insurance, it might be more difficult for them to find healthcare when compared to other patients covered by non-Medicaid insurance. In Oregon, parents who were Oregon Health

² Direct payments by households/individuals to healthcare providers, which are not reimbursed by insurance (HealthCare, n.d.).

Plan beneficiaries (Oregon's state-funded Medicaid program) found it challenging to find physicians that would accept their children, and they had to travel long distances to do so (DeVoe et al., 2007). Hall, Lemak, Steingraber, and Schaffer (2008) conducted a study in Florida by calling Medicaid primary care providers pretending to be a new patient. While 87% of those providers were accepting new patients, only 68% were willing to accept new Medicaid patients, reducing Medicaid patients' probability of accessing necessary healthcare by around one-fifth.

Healthcare providers' refusal to admit Medicaid beneficiaries can be attributed to both Medicaid's reimbursement adequacy and the program's workload. On several supply-side studies with physicians, pediatricians, and other healthcare providers, Garner, Liao, and Harpe (1979); Berman, Wasserman, and Grimm (1991); and Berman, et al. (2002) found that Medicaid's low reimbursement level, reimbursement delays and rejections, as well as excessive paperwork, have contributed to the healthcare providers' low participation. Furthermore, Berman, Wasserman, and Grimm's (1991) study in Colorado predicted that a rise in Medicaid reimbursement levels would increase physicians' willingness to fully participate in the program.

4.2. Inequity in Healthcare Quality

Goddard and Smith (2001) have suggested that healthcare quality may include issues ranging from medical care appropriateness (i.e., whether medically appropriate treatments were given to the patients according to their needs) to non-medical aspects (i.e., the waiting time for the medical treatment, the respectfulness and empathy of the medical staffs, as well as the dynamic of doctor-patient communication). While the availability aspect focuses on whether the healthcare physically exists and is accessible, the quality aspect discusses more the properties of the treatment *when* the patients successfully accessed the healthcare. Thus, the discussion of inequity in healthcare quality is limited to patients who have acquired health services.

Many studies on the inequity of healthcare quality did not strictly discuss the issue within an SHI setting. Many of them conducted a broader comparison of healthcare quality obtained by SHI patients, private insurance patients, and other patients. In some articles focusing on stigmatization and racial disparities, sometimes, SHI did not appear at all in the discussion. Those articles were still included in the study because the findings may still be significantly relevant when applied to an SHI setting. Additionally, some of those studies were conducted in high-income countries where SHI programs have been available to a large proportion of the population. This implies that even though SHI was not an explicit research object, the inequity discussed in the studies potentially happened in an SHI setting.

More studies reported the inequity of the non-medical part of healthcare quality. This is probably because it is simpler to measure non-medical qualities compared to the medical ones. For example, it would be easier to measure if somebody had waited for too long, or a health worker was rude, rather than to define whether a doctor had given the appropriate medical care for a certain patient. Two studies that touched upon the issue of inequity in medical care quality were the Malawi (Abihiro, Mbera, and De Allegri, 2014) and Indonesia (Astuti, Murti, and Probandari, 2015) studies. The Malawi study compared medical care offered by the public (fully-subsidized healthcare) and private (not subsidized) health facilities (Abihiro, Mbera, and De Allegri, 2014). Based on the FGD they conducted with community members, the medical care offered by public facilities was worse compared to the one offered in private facilities. Regarding healthcare in public facilities, the community reported a shortage of health workers and medicines, as well as a poor prescribing practice, where patients were given the same kinds of drugs regardless of their illnesses (Abihiro, Mbera, and De Allegri, 2014).

Astuti, Murti, and Probandari (2015) studied Indonesia's SHI program JKN and compared the health treatments given by family doctors (primary care providers) to JKN members and other patients in Jember, Indonesia. They found that JKN patients were three times more likely to be referred to hospitals (secondary medical care providers) by family doctors. Astuti, Murti, and Probandari (2015) argued that this was due to the physicians' financial motive. The capitation system³ applied to JKN's primary care providers limited the physicians' ability to benefit from providing higher-level medical care. Rather than completing the treatment in their end, they would instead do the minimal work and let the hospitals do the rest. Other patients who paid out-of-pocket or were covered by private insurance which applied a more generous fee-for-service system⁴, were more likely to provide more significant financial benefits to the doctors, making them more profitable to be given more advanced care.⁵

Two articles studied the non-medical quality of healthcare within an SHI setting. Johar et al. (2012) study in Australia revealed that, despite the country's SHI that covered everyone with equal benefit, patients of lower socioeconomic status had to wait longer, by an average of four months, to get elective surgery in public hospitals. They found that the waiting time differences were not correlated with medical urgency and were entirely attributed to the patients' socioeconomic status. Another study in Cologne, Germany, focused on physician-patient communication. In Germany, all people were covered by mandatory SHI, while a small part of the population, mostly government employees and high-income people, were also able to obtain private insurance (Neumann et al., 2011). While both plans covered a similar range of health treatments, hospitals could charge more to private insurance. In this universal, but semi-fragmented, insurance coverage, Neumann et al. (2011) discovered that, among cancer patients, private insurance patients rated physician empathy higher. They argued that this was because physicians spent more time with private insurance patients so that they could charge the insurance more. This way, physicians and private insurance patients built a stronger bond, which then influenced the patients' subjective perception of the doctors' empathy.

Some studies, which did not focus on SHI, discussed the different treatments conducted by health workers toward particular population groups. In a qualitative study in Ohio, Subban, Terwoord, and Schuster (2008) explored discriminatory treatment experienced by African-American patients, including disrespectful treatment from health workers. Subban, Terwoord, and Schuster's (2008) study findings were consistent with some previous studies such as the one conducted in New York (van Ryn and Burke, 2000) and Texas (Street, Gordon, and Haidet, 2007). These studies found that doctors were more contentious and reported fewer affiliate feelings toward African-American patients.

Many of these studies tried to find the reasoning behind inequity in healthcare quality. Most of them concluded that a certain population group had advantages that enabled them to be treated better compared to other groups. The advantages could be in the form of financial benefit, which then interacted with the healthcare providers' financial motive. In the case of Indonesia and Germany, people with insurance who provided higher benefits for healthcare providers received better treatments, be it more appropriate health treatments or longer consultation time (Astuti, Murti, and Probandari, 2015; Neumann et al., 2011). The

³ The capitation system provides health facilities per person, rather per service, payments and usually is applied to pay primary care facilities. The amount of insurance reimbursement per person in a specified timeframe (usually per month) is fixed, regardless of how many times the person uses the service (American Medical Association, n.d.).

⁴ The fee-for-service system provides payment to health facilities for each service they conduct (Centers for Medicare & Medicaid Services, n.d.).

⁵ However, this study did not obtain more on the patients' information. This made it suffered from the risk of selection bias; e.g., JKN patients were probably sicker than other patients and actually might require more advanced health treatments and to be referred from higher-degree facilities.

effect appeared even if the expected benefit was not instant. In Australia's case, Johar et al. (2012) offered an explanation that favoritism toward high socio-economic patients happened because of an expectation of future financial benefits. Healthcare providers wanted to build close connections with high socio-economic patients and expected them to use private services (i.e., services that were not covered by public health insurance) in the future.

In non-financial-related aspects, Johar et al. (2012) argued that high socio-economic patients might have a bigger network of healthcare providers, which somehow enabled them to get better healthcare quality. In the case of racial disparities of healthcare access in the U.S., van Ryn and Burke (2000) disentangled the causes by asking physicians' perceptions of cardiac artery disease patients. Based on the survey, it was the physicians' own prejudices that caused them to believe that African-American patients were less intelligent, at risk for non-compliance with the rehabilitation process, at risk for substance abuse, and lack of social support. van Ryn and Burke (2000) then associated these physicians' prejudices with their assertiveness toward African-American patients.

4.3. Inequity in Healthcare Costs

Even when SHI covered medical costs, different population groups, or individuals, faced different personal costs in seeking health treatment, which then influenced their access to healthcare. Most of the healthcare cost inequity could be attributed to inequity in healthcare availability. With high geographical disparities of health facilities in Malawi (Abihiro, Mbera, and De Allegri, 2014), or limited participation of physicians in the U.S.'s Medicaid program (Garner, Liao, and Harpe, 1979; Berman, Wasserman, and Grimm, 1991; and Berman et al., 2002), people in need of health treatments would have to travel longer and spend more time and money to access healthcare. The cost of healthcare-seeking would even be more unequal if opportunity costs were to be included in the calculation. A self-employed person, for example, would not be able to work full time on the day she has to seek healthcare, which causes her to lose some potential income. This implies a relatively higher cost in healthcare seeking for self-employed people when compared to employees with paid sick leave.

Another aspect of this issue, even though not necessarily an inequity problem, was the level of copayments and benefits packages. Patients in some countries with more fragmented health insurance plans might experience healthcare cost inequity due to copayment levels and benefits packages of different operating insurance programs. In the universal SHI setting, where everybody has the same arrangement, the SHI's copayment level and benefits package define the program's equity impact. The larger the copayment and the more limited the coverage of the benefits package, the more likely that somebody's access to healthcare would be defined by their income, rather than health needs.

4.4. Inequity in healthcare information

Goddard and Smith's (2001) concept on equity in healthcare access information refers to the idea that information on available health treatment is equally understood by people, based on their health needs. This concept is more difficult to study directly, because it would have to involve the measurement of people's level of understanding of the healthcare system, the SHI program, as well as some degree of medical issues based on their health needs. In the context of SHI, this concept implies that all people in need of a certain type of healthcare should equally understand what health treatment is needed for their condition, which is available through the SHI program. If some people only knew what they need without knowing whether or not the treatments were offered by the SHI, or the opposite, if they knew what was covered by the SHI but they did not understand if those treatments would be beneficial for them, this already implies inequity in the information of healthcare access.

Some studies managed to explore the inequity of healthcare access information indirectly. Two studies in Canada by Dunlop, Coyte, and McIsaac (2000), as well as Veugelers and Yip (2003), found that, despite the universal SHI applied by the country, people with higher socioeconomic status (such as those with higher income or higher education level) were more likely to use specialized healthcare, even after controlling for health needs differences. Dunlop, Coyte, and McIsaac (2000) argued that this result could partially be attributed to the inequity in healthcare access information. The Canadian SHI program covered specialist care. However, it could only be accessed through referrals from family doctors. Langley et al. (1992), in a previous qualitative study, found that patients' requests were among the most prominent factors, other than medical reasons, for family doctors to issue referrals to access specialist care. Based on this finding, Dunlop, Coyte, and McIsaac (2000) then built an argument that it might be the case that patients with higher education and income had "different attitudes" about the benefit of attending a specialist's care, which then made them more motivated to ask for a referral from their family doctors. Even though they did not specify further what they meant by "different attitudes," their argument suggested that patients with higher socioeconomic status were more well-informed about at least two things, (1) the benefit of specialist care for their health needs and (2) the availability of such care upon their request to their family doctors. Based on this argument, patients with a lower socioeconomic status were lack of either one or both of those understandings, which then limited their access to specialists.

V. Discussion: the Risk of Healthcare Access Inequity within JKN Implementation

To summarize these studies, there are some circumstances triggering healthcare access inequity in an SHI setting. First, the uneven distribution of health facilities across the region. This creates geographic-based access inequity, primarily through uneven physical availability of health services and the barriers of travel/opportunity costs. Second, the adequacy of the insurance program's reimbursement and the financial motive of healthcare providers. Inadequate insurance reimbursement may limit access to healthcare for the program's members, often through healthcare providers' decision to restrict admission or differentiate treatment quality. The financial motive may influence healthcare providers to treat patients differently based on the potential benefits they bring. Third, the prejudices of healthcare providers toward different types of patients. Healthcare providers' prejudices influence the way they provide the treatments, both medical and non-medical, based on patients' socioeconomic or demographic characteristics. Lastly, the unequal advantages of different groups of people in need of healthcare. Some population groups, especially those with higher socioeconomic status, possess more advantages in terms of financial resources, social networks, and education. These advantages enable better healthcare access for them, even within the boundaries of the same program, such as a universal SHI program.

Unfortunately, all of those circumstances could potentially be found in Indonesia's health system and JKN program design, putting JKN at the same risk of failing to improve healthcare access inequity. First, health facilities were not evenly distributed across all Indonesian regions, with a disproportional concentration in Java, the nation's most developed island. While the median distance to a health facility was about 5 kilometers (about 3 miles), in the eastern part of the country, the median distance could reach 30 kilometers (about 19 miles) (Dorkin et al., 2014). Furthermore, at least 18% of the population, mostly outside Java, needed more than one hour to travel to the closest healthcare facility (Dorkin et al., 2014).

Second, JKN's reimbursement system might have allowed healthcare providers to treat patients based on their financial motives. While it was still highly subjective whether or not JKN reimbursement was adequate, the program applied a diagnosis related group (DRG) system which aimed for more efficient health spending (World Health Organization, 2007). This implies healthcare providers expected less financial benefits from JKN patients,

when compared to other patients who paid out-of-pocket or were covered by private insurance that mostly applied fee-for-service system and offered more generous reimbursements (“CoB Menarik,” 2014). Furthermore, JKN also differentiated its inpatient reimbursement tariff rates by patients’ accommodation class⁶ (Peraturan Menteri Kesehatan Republik Indonesia No. 59/2014). In this arrangement, healthcare providers received higher reimbursements when treating patients of a high-accommodation class, even for the same treatment.⁷

Third, negative prejudices might have existed within JKN’s healthcare providers. JKN low-accommodation class members were dominated by the poor population who were subsidized by the government (BPJS Kesehatan, 2016). For this population group, their socioeconomic status could easily be identifiable. Healthcare providers could probably guess based on their physical appearance. Their JKN numbers could also provide an exact confirmation about their subsidized membership status, allowing health care providers to assert their prejudices to people from this specific socioeconomic status. Lastly, JKN was projected to be a universal coverage program that would consist of members with different levels of advantages. For instance, government and private employees mostly had better advantages in terms of education, social network, and communication skill, when compared to the subsidized poor members. These advantages would allow them to obtain more benefits from JKN.

Based on Goddard and Smith’s (2001) framework, these circumstances might have created risks of access inequity in the sphere of healthcare availability, quality, cost, and information for JKN members. In terms of availability, based on their health needs, JKN members living outside Java might have had narrower options for healthcare access. JKN low-accommodation class members might also have faced difficulties in finding healthcare, if JKN healthcare providers, who mostly also accepted non-JKN patients, limited their admission and favor JKN high accommodation-class and non-JKN patients who guaranteed higher financial benefits. In terms of quality, depending on their degree of financial motive, healthcare providers might have differentiated their treatments, both medical and non-medical, based on the patients’ JKN status (JKN vs. non-JKN members or high-accommodation vs. low-accommodation class patients). The differentiation in treatment quality might have grown more severe if prejudices toward the poor population influenced the way healthcare providers treated them. Subsidized poor JKN members might have experienced improper medical care, disrespectful treatments, and less informative physician-patient communication.

In terms of costs, the uneven distribution of health facilities might have burdened JKN members outside Java with higher transport and opportunity costs. With the same health needs, JKN members in Java would have to spend fewer hours on traveling to health facilities and would potentially be able to have a more economically productive time. Finally, in terms of information, highly educated JKN members, including government and private employees, potentially would have a better understanding of the program. They would know their rights as JKN members, which would allow them to obtain better healthcare access within JKN setting, compared to other low-educated JKN members. They might also be more communicative and skillful in building a stronger connection with their healthcare providers. This network then would allow them to obtain even more information about what the healthcare providers could offer within the JKN benefits.

⁶ Poor people who were subsidized by the government were placed in the lowest accommodation class. Other members could choose classes based on their willingness to pay, but almost all government and private employees belong to the high-accommodation class.

⁷ The inpatient accommodation classes consisted of Class I, Class II, and Class III. The highest class, Class I, had typically 2-4 beds per room. The lower classes had more beds: Class II has 3-5 beds per room and Class III has 4-6 per room (Kuncoro, n.d.).

VI. Closing Remarks

In summary, this paper tries to conduct a literature review to lay out empirical evidence of healthcare access inequity within an implementation of social health insurance programs. The evidence is then analyzed following Goddard and Smith's (2001) categorization of healthcare access inequity in the area of availability, quality, cost, and information. The findings of 18 empirical articles in various SHI and economic development level settings reveal that healthcare access inequity based on Goddard and Smith's (2001) categories happened despite the implementation of an SHI program. Further studied from the articles, four type of circumstances might have led to healthcare access inequity, including (1) geographical disparities of health facilities; (2) adequacy of insurance program's reimbursement and healthcare providers' financial motive; (3) healthcare providers' prejudices toward patients; and (4) unequal personal advantages of health treatment seekers.

When applied to the context of Indonesia, within the implementation of JKN, the risks of healthcare access inequity are imminent in those four circumstances. Notably, some factors potentially trigger the risks of inequity, including the imperfect health system with a high concentration of health facilities in Java, the JKN's reimbursement schedule which was based on accommodation class, the socio-economic clusters in JKN membership setting (non-subsidized vs. subsidized members), and high diversity in JKN members' advantage level (i.e. education level). This situation implies that JKN members might face the risk of healthcare access inequity. Specifically, in equal condition of health needs, members living outside Java, members in the lowest accommodation class, as well as the poor, less educated members receiving government subsidy, might experience either more significant difficulties in finding healthcare, lower quality in health treatment, relatively higher cost in seeking care, or more limited information on JKN benefit.

While the risks are plausible, this literature review study is limited to predicting the potential healthcare access inequity within JKN implementation, mirroring from the existing empirical evidence. This study signifies the need for further empirical research on this area. Such a study would provide complete knowledge on the actual JKN implementation, including the inequity issues, therefore enabling policymakers to formulate a program improvement plans. Such improvements would allow JKN to function optimally in achieving its goal, to improve healthcare access equity among its members and the Indonesian population in general.

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