Comparing National Health Financing Strategies Amidst Increasing Mobility Within ASEAN: Lessons from the Philippines and Indonesia

Jaifred Christian F. Lopez[1], Ryan Rachmad Nugraha[2], Don Eliseo Lucero Prisno III [3]
[1]Associate, Office of Research and Innovation,
San Beda College, 638 Mendiola St. San Miguel, Manila, Philippines 1005
[2]Researcher, Center for Health Economics and Policy Studies, School of Public Health,
Universitas Indonesia, Depok City, West Java, Indonesia
[3]Associate Professor, Xi'an Jiao Tong-Liverpool University, Suzhou, China
jaifredlopez@gmail.com

Keywords: ASEAN integration, Health financing strategy, Migrant health, Philippines, Indonesia.

Abstract: Health needs within the Association of Southeast Asian Nations (ASEAN) are expected to become more mobile as a result of regional integration, thus highlighting the need for a regional consensus on providing health services to migrants, the need to equip health systems, and the need to harmonize national health financing strategies. We propose that this harmonization can be facilitated by a contextual comparison of national health financing strategies, guided by the framework promoted by the World Health Organization. Using an analysis matrix that synthesized insights generated from literature, we compared the health financing strategies of the Philippines and Indonesia, two countries with important political and socioeconomic similarities. Results show that the strategies are predominantly inward-looking, which focus more on providing various levels of health coverage depending on socioeconomic status and employment, while lacking mechanisms and a program framework to cover migrants. Thus, while considering the diversity of government structures and health system capacities within the region, there is a need to develop a common framework for universal health coverage for migrants, which has to be included in national health financing strategies within ASEAN.

1 INTRODUCTION

Mobility across the members of the Association of Southeast Asian Nations (ASEAN), specifically the free movement of migrant workers and people engaged in business, is now at its highest and is expected to rise further. In 2015, the number of international migrant workers coming from within the region amounted to 6.78 million, an increase from 6.5 million documented in 2013 (ILO, 2015). This development may be attributed to policy reforms liberalizing and harmonizing the conduct of business, trade, education, and employment in the region, amidst efforts among the ASEAN countries towards economic integration (ASEAN, 2016a).

Accompanying this development is the need to plan for emerging health concerns, and achieve universal health care (UHC), a goal that is consistent with a strategic measure to "promote strong health insurance systems in the region (ASEAN,. 2016b)." In view of the regional goal to facilitate mobility, this goal implies that ASEAN citizens can freely move between the member countries with assurance that their health needs are covered anywhere within ASEAN. Confirming this implied vision is the ASEAN Socio-Cultural Community Blueprint, which highlights regional strategies for socioeconomic development, and specifically mentions the need to "provide guidelines for quality care and support" for migrants (ASEAN, 2016b). Difficulty in developing such guidelines is expected, however, in view of the diversity existing among the ASEAN countries in terms of economic development, healthcare situation, and existing welfare systems for migrants as shown in Table 1, thus complicating regional efforts.

Lopez, J., Nugraha, R. and Prisno III, D.
Comparing National Health Financing Strategies Amidst Increasing Mobility Within ASEAN: Lessons from the Philippines and Indonesia.
In *Proceedings of the 4th Annual Meeting of the Indonesian Health Economics Association (INAHEA 2017)*, pages 222-227
ISBN: 978-989-758-335-3
Copyright © 2018 by SCITEPRESS – Science and Technology Publications, Lda. All rights reserved

Table 1: Socioeconomic and health indicators of ASEAN member countries (Minh et al., 2014; ILO, 2015)

	Population (000s), 2015	Gross National Income per capita, 2016*	Total government expenditure on health as % of general government expenditure, 2015	Out-of-pocket as % total expenditure on health, 2014^
Brunei	423	38 520	6.5	6.0
Cambodia	15 578	1 140	6.1	74.2
Indonesia	257 564	3 400	5.7	46.9
Lao PDR	6 802	2 150	3.4	39.0
Malaysia	30 331	9 850	6.4	35.3
Myanmar	53 897	1 190	3.6	50.7
Philippines	100 699	3 580	10.0	53.7
Singapore	5 604	51 880	14.1	54.8
Thailand	67 959	5 640	13.3	11.9
Vietnam	93 448	2 050	14.2	36.8

*Determined through Atlas method, World Bank

At the national level, plans for funding UHC are supposedly included in national health financing strategies, which are documents that propose policy directions and plans towards financing the health needs of the population while preventing widespread catastrophic health spending (Kutzin et al., 2017). In keeping with the regional thrust to "provide guidelines for quality care and support" for migrants, ideally, national health financing strategies should pave the way for providing health coverage for outbound citizens in other ASEAN countries, as well as addressing the health needs of incoming ASEAN citizens. Since priority for addressing the health needs of specific segments of the population is most clearly manifested by how these are considered in health policies, analyzing the national health financing strategies of individual ASEAN countries can provide valuable insights on socioeconomic and political contexts that affect the level of commitment of each member country to a common UHC regional framework, and thus facilitate consensus building and implementation. However, in view of challenges present in the region, among them the wide disparity of socioeconomic status and the state of health care services, this therefore leads to a hypothesis that policies governing health needs of migrants within the region only offer a semblance of protection within the jurisdiction of the home country, without considering the possibility of a region-wide scope of health coverage.

With the aim to gather evidence on whether national health financing strategies envisioned region-wide coverage for migrants within the ASEAN region in keeping with the shared goals of "promoting strong health insurance systems in the region," and "providing care and support for migrants," this study therefore compared the national health financing strategies of two ASEAN countries, the Philippines and Indonesia. These countries are the primary sources of migrants within the region, with the aim to identify aspects that can facilitate the implementation of a regional UHC framework for the benefit of migrant workers and persons engaged in business and trade. This study also reviewed published studies and grey literature documenting current efforts towards a regional UHC in both countries and in the region.

2 METHODS

In comparing the two countries, we retrieved the national health financing strategy documents published by the Philippine Department of Health (DOH) and the Government of Indonesia, and used the guide for developing national health financing strategies endorsed by the World Health Organization (WHO) as analytical framework, from which a comparison matrix was developed. The WHO guide focused on the following aspects: 1) strategic interventions, which included revenue raising, pooling revenues, purchasing services, benefit design, rationing and entitlement basis, and alignment issues; and 2) governance-related concerns, which included implementation arrangements, evaluation and monitoring plans and capacity building (Kutzin et al., 2017). Special attention was given to any provision that intended to cover migrants and other outbound citizens. Meanwhile, using PubMed and Google Scholar, we searched the literature for any supporting studies on the efforts of both countries in providing health

coverage to their outbound citizens, as well as similar efforts in other countries within the region. For the purposes of this review, only English documents were analyzed.

3 RESULTS

Generally, official documents, published data and supporting literature showed that the national health financing strategies of both countries confirmed the hypothesis that policies for health insurance among migrants are predominantly inward-looking, in that the strategies focus on expanding coverage for the uninsured, providing benefits for dependents of migrants, and improving the system of reimbursements and the implementation of benefit packages and case rates. These efforts have been spearheaded by the Philippine Health Insurance Corporation (Philhealth) and the *Badan Penyelenggara Jaminan Sosial* (BPJS Kesehatan), which manages the *Jaminan Kesehatan Nasional* (JKN, National Health Insurance). Membership categories exist in both countries as shown in Table 2. This is in addition to the various private health maintenance organizations (HMOs) in both countries that offer health services in private facilities.

Table 2: Public health insurance membership categories in the Philippines and Indonesia (DOH, 2010; JLN, 2017; Pisani, Kok and Nugroho, 2017)

Membership category	Eligibility criteria	Contribution	Benefits	Providers
Philippines				
Formal sector (casual and contractual)	Civil servants, private employees, military and police	Payroll contributions	Outpatient and maternal care benefit packages (availed primarily in accredited facilities) Inpatient case rates	Philhealth-accredited public and private facilities
Overseas Filipino workers	Registered migrant workers	Fixed premium		
Informal sector	Informal workers, independent professionals, foreign citizens	Voluntary payment of fixed premium		
Indigents (sponsored program)	Certified poor households based on social welfare data	Shared subsidy between local government unit and national government		
Indonesia				
Employees: government/ private sector	Civil servants, entrepreneurs, military, police	Salary deduction. Government employees: 3% paid by employer, 2% by employee Private sector: 4% paid by employer, 0.5% by employee	Comprehensive coverage of outpatient and inpatient services	Public and selected private facilities. Options vary according to premium paid
Self-employed members	Non-poor self-employed	Monthly premium paid by members Class 1: IDR 25 500 Class 2: IDR 51 500 Class 3: IDR 80 000		
Subsidized members	Poor and near-poor classified by Ministry of Social Affairs	Fully subsidized by national government		Public/select private facilities

An important difference between the two countries is how the Philippine national health financing strategy document specifically mentions the importance of covering the migrant worker population, and how the DOH acknowledges the need to expand benefits afforded them. Meanwhile, roadmap documents produced by the Government of Indonesia in partnership with third-party

development agencies show that while there is an effort in including the Ministry of Manpower and Transmigration in consultation meetings, there is no directly stated goal or aspiration to cover for the health needs of migrants (JLN, 2017). Thus, for the purposes of this study, information on covering Indonesian migrants was retrieved from other published studies.

In both countries, revenue raising has been carried out through collection of premiums, either deducted from regular salaries or voluntarily contributed, depending on status of employment. In all these efforts, migrants have been included through compulsory premium payments, as in the case of the Philhealth Overseas Filipino Program and the Indonesian Migrant Worker Insurance Program (Guinto et al., 2015). Moreover, risk pooling, which affects revenue raising and the ability of the health insurance system to purchase health services, is affected by the fragmentation of revenue schemes in the two countries, but strategies have been proposed in both countries to consolidate these schemes into a unified health insurance fund, thus reducing fragmentation (DOH, 2010; Pisani, Kok and Nugroho, 2017).

Additionally, in the Philippines, entitlements have been limited in a way that prevents the depletion of pooled funds, thus leading to the development of benefit packages. Unfortunately, such limitations have led to insufficient payment for health services rendered, thus requiring out-of-pocket payment to cover for the remaining cost. This is in contrast to a comprehensive coverage being offered in Indonesia, but provided in specific facilities depending on the amount of premium paid. In the case of migrant workers from the Philippines, while Philhealth provides a mechanism for revenue collection and health insurance coverage for dependents remaining in the country and even an expense reimbursement system for overseas health facilities, its coverage is mostly insufficient, thus pushing affected migrants towards catastrophic health spending, repatriation, and eventual impoverishment (DOH, 2010) Amidst these emerging problems, the governments of both countries have entered into agreements with selected destination countries to ensure that the health needs of migrant workers are addressed (Guinto et al., 2015).

In summary, a system for overseas health expense reimbursement exists for Philippine migrant workers enrolled in the national health insurance program while a similar program is being developed in Indonesia, but the reality of insufficient reimbursements highlights the need for a more effective health financing framework that is also funded sustainably and sufficiently.

4 DISCUSSION

Though limited by a lack of economic evaluation and modeling, which may be the topic of a future study, the study nonetheless presents two lessons for discussion: 1) that the development of an effective and sustainable regional UHC framework needs to consider how it should equitably cover all citizens, regardless of the economic status of their countries of origin; and 2) that such a framework may follow various health financing schemes adopted by similar international and regional organizations. These lessons lead to a common message: the need to develop a common framework to be integrated in national health financing strategies.

Designing a regional framework that covers both industrialized and economically disadvantaged countries must innovate ways to collect sufficient revenue, create an equitable risk pool, and purchase health services sufficiently, all while transcending national boundaries. This leads to asking the classic question on what kind of health financing system should be adopted at the regional level: a “socialized medicine” approach (Beveridge model) financed through tax payments; a health insurance scheme funded through salary deductions (Bismarck model); or the National Health Insurance (NHI) model, which combines elements of the two aforementioned models by instituting a single payer mechanism funded either by taxes or premiums (Wallace. As a supranational entity, the ASEAN does not have any authority to collect taxes, thus significantly limiting the prospects of a socialized regional health care financing system.

Another possibility is adopting models utilized by international organizations for field employees. Particularly, the United Nations offers its employees a medical insurance plan implemented by a private HMO through its network of accredited health care facilities (United Nations, 2017). The ASEAN Economic Community Blueprint seems to support this direction as it advocated the involvement of the private healthcare sector in efforts towards UHC and the brokering of public-private partnerships for health (ASEAN, 2016a).

Meanwhile, the European Union (EU), whose model of economic integration serves as a pattern for ASEAN, has developed a human rights-based regional health services framework for migrants,

guided by principles of "availability, accessibility, acceptability and quality," through the health-related provisions of the 2007 Lisbon Treaty and the EU Consolidated Treaty. These provisions encouraged EU states to implement policies that are in keeping with their respective interpretations of the rights enshrined in the aforementioned treaties, while preserving "complementarity of health services in cross-border areas." While these rights are upheld in laws in both countries that implement health insurance systems (DOH, 2010), at the regional level, the ASEAN itself has developed a strategic framework on health development where the health of migrants was stated as a priority, though regrettably this has not been translated to policy reforms in all of the ASEAN countries (ASEAN, 2016a; Guinto et al., 2015; Government of Indonesia, 2017; Fernando, 2011).

Given these considerations, it may thus be appropriate that an insurance scheme similar to the National Health Insurance model be considered as a platform for complementarity between the health systems of ASEAN countries, while agreeing on a rights-based framework. The possibility of rolling out a similar regional scheme may only be realized through harmonized policy interventions that may either establish a new system specifically for ASEAN citizens, or integrate flexibly within the existing system of the country of destination (Nodzenski, Phua and Bacolod, 2016).

5 CONCLUSION

Therefore, considering the significant percentage of migrant workers in ASEAN and the importance of health coverage in ensuring sustainable economic productivity, it is in the best interest of the region if a regional UHC framework can be developed and adopted, informed by a balance of economic evaluation, consideration of how health financing functions can be optimally implemented, and utmost regard for human rights. Because these considerations require substantial political will in each of the ASEAN countries, these factors must be made part of national-level policy discussions, integrated in national health financing strategies for further consideration of national level policy makers, and included in the agenda for ministerial meetings and in declarations being adopted in the ASEAN.

REFERENCES

Association of Southeast Asian Nations (ASEAN). 2016. *The ASEAN Economic Community Blueprint*. Available at: http://www.asean.org/storage/images/2015/November/aec-page/AEC-Blueprint-2025-FINAL.pdf [Accessed 30 Aug. 2017].

ASEAN. ASEAN Socio-Cultural Community Blueprint. 2016. Available at: http://asean.org/storage/2016/01/ASCC-Blueprint-2025.pdf [Accessed 30 Aug. 2017].

Department of Health, Philippines (DOH). 2010 Toward Financial Risk Protection:Health Care Financing Strategy of the Philippines 2010-2020. Health Sector Reform Agenda – Monographs. Manila, Republic of the Philippines - Department of Health..(DOH HSRA Monograph No. 10)[Accessed 30 August 2017].

Fernando F. 2011. *ASEAN Strategic Framework on Health Development* (2010-2015): Increase Access to Health Services for ASEAN People. Available at:http://www.searo.who.int/thailand/news/asean_health_cooperation_increasing_access_to_health_people_dr_ferdinal.pdf[cited 30 August 2017].

Government of Indonesia. 2017. *Roadmap toward the National Health Insurance of Indonesa* (Ina Medicare). Available at:http://www.health.bmz.de/events/In_focus/Indonesia_roadmap_to_universal_health_coverage/THE_BRIEF_EDITION_Roadmap_toward_INA_Medicare.pdf [Accessed 30 August 2017].

Guinto R, Curran U, Suphanchaimat R, Pocock N. 2015. Universal health coverage in 'One ASEAN': are migrants included?Glob Health Action8:25749. doi:10.3402/gha.v8.25749 [Accessed 30 August 2017].

International Labour Organization. 2015. *Migration in ASEAN in figures: the international labour statistics (ILMS) database in ASEAN* [online]. Available at: http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms_420203.pdf[cited 30 August 2017].

Joint Learning Network for Universal Health Coverage. 2017. *Indonesia: Approaches to covering poor, vulnerable, and informal populations to achieve universal health coverage*. Available at: http://www.jointlearningnetwork.org/resources/download/get_file/ZW50cnlfaWQ6MzU0M3xmaWVsZF9uYW1lOnJlc291cmNlX2ZpbGV8dHlwZTpmaWxl [Accessed 30 August 2017].

Kutzin J, Witter S, Jowett M, Bayarsikhan D. 2017. Developing a national health nancing strategy: a reference guide. Geneva: World Health Organization;. (Health Financing Guidance No 3) Available at:.http://apps.who.int/iris/bitstream/10665/254757/1/9789241512107-eng.pdf [Accessed 30 August 2017].

Minh H, Pocock N, Chaiyakunapruk N, Chhorvann C, Duc H, Hanyoravongchai P, Lim J, Lucero-Prisno D, Ng N, Phaholyothin N, Phonvisay A, Soe K,

Sychareum V. 2014. *Progress toward universal health coverage in ASEAN*. Glob Health Action [online], 7: 25856.doi: 10.3402/gha.v7.25856. [Accessed 30 August 2017].

Nodzenski M, Phua K, Bacolod N. 2016. New Prospects in Regional Health Governance: Migrant Workers' Health in the Association of Southeast Asian Nations. *Asia & the Pacific Policy Studies* [online];3(2): 336–350. doi:10.1002/app5.113 [Accessed 30 August 2017].

Pisani E, Kok M, Nugroho K. 2017. Indonesia's road to universal health coverage: a political journey. *Health Policy and Planning*; 32:267–276.doi: 10.1093/heapol/czw120 [Accessed 30 August 2017].

United Nations. 2017. The UN Worldwide Health Insurance Plan. [online]. Available at: http://www.un.org/insurance/plans/un-worldwide-health-insurance-plan[Accessed 30 August 2017].

Wallace L., 2013 .A view of health care around the world. *Ann Fam Med*.; 11(1): 84. doi: 10.1370/afm.1484 [Accessed 30 August 2017].

SCITEPRESS
SCIENCE AND TECHNOLOGY PUBLICATIONS