Editorial

Universal health coverage in Indonesia – the forgotten prevention

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Universal health coverage (UHC) is described as an equity to access health services in terms of promotion, prevention, cure, and rehabilitation with reasonable cost.[1] Indonesia has engaged the UHC since January 2014. Although, it is no doubt that UHC should be implemented, until now the system still burdened with many problems in Indonesia. The problems occurred ranging from the administration system of the *Badan Penyelenggara Jaminan Sosial* (BPJS) *Kesehatan* to the health care services. It affects all stakeholders of the health care system, such as: health providers, medical industry, hospitals, and patients themselves. Nowadays, it focuses more on curative than preventive health services.

Until the mid of September 2014, the participants of this UHC have reached 127.7 million people, which is approximately half of the total population in Indonesia, served by 16,385 primary health care services and 1,582 hospitals.[2] Thus, the ratio of primary health care to patients is 1:7,794 and of hospitals is 1:80,702. The target is to cover all the population by 2019. When it happens, BPJS *Kesehatan* should be ready with good system.

Nowadays, BPJS *Kesehatan* is lack of payment methods that may ensure people to pay the contributions monthly on time, so there are participants that only pay the contributions when they have to go to health care services. It will be better if there is a website that people may login and track their payment bills.

There should be a scheme for people who do not have any illness to get benefit from UHC. The concept of UHC is not only for free service in term of treatment, but it should offer people to always be healthy by controlling the risk and screening the susceptible people. It will be realized when BPJS *Kesehatan* establishes the prevention and early detection program. Those programs' schedule can be also integrated with the previous mentioned website in order to inform people what prevention or early detection program covered during the period of time. For example, when people are scheduled to be immunized, they may know it by logging in to the website or may be further reminded by e-mail or short message service (SMS).

Next, the capitation for each participant in the primary health care is too small, even lesser when the health care need to do prevention or early detection. We should realize that the cost to build a continuous preventive services in the primary health care is neither free nor cheap. It will be better if BPJS *Kesehatan* calculates the cost to treat a disease compared with cost to prevent a disease, by considering the prevalence of a disease, so the decision to implement the preventive program can be done rationally within the limited budget. For example, Lotan, et al.[3] studied primary prevention of nephrolithiasis for a national health care system. They concluded that the model to prevent nephrolithiasis may save significant cost better than to cure the patients. Therefore, BPJS *Kesehatan* may analyze their current data and focus more on primary prevention in high-prevalence areas or even implement it to nationwide level. Health providers also need to be supported with the tools to do promotion services, such as disseminating information by distributing thousands of leaflets to educate people in primary health care.

Medicine always develops. As health is a basic requirement for everybody, there will be more researches, more drugs, more diagnostic tools, and more interventional technology, which in turn will result in more costs. Hence, the cost of medical care will never be enough for the best services.

There are some strategies to reduce the burden or at least to optimize the budget. I took an example from Sawada and Kawahara[4,5] who focused on

hemodialysis. They wrote two brief communications in two issues of Medical Journal of Indonesia. They showed that the cost of hemodialysis is increasing every year, even faster than gross domestic product in Japan.[4] In the second brief communication that was published in this issue, they showed that the expenditure on dialysis was gradually become higher, so they recommended to focus on prevention of metabolic diseases which may end with end-stage renal disease to reduce medical costs. Besides, they also showed that UHC would be beneficial in the development of medical industries, including health professionals. For that purpose, stimulus from the government is needed for local medical industries to grow. It would be great if Indonesia's local industries may provide the needs of health services. In this case, government and medical industries would be benefited as the medical expenditure given to the local medical industry will also indirectly develop the country's economy.[5]

Indonesian government should consider budget for medical care carefully. It is crucial not to allocate too low or too high budget on medical care. BPJS *Kesehatan* also needs to start preventive program using a scientific cost analysis, not by mere assumption, as those kind of researches are still rare here. When we entered search queries in PubMed, using word "cost" and "Japan" ((cost[Title]) AND Japan[Title]), we could find 157 documents, meanwhile using same keywords, except alternating "Japan" with "Indonesia", we could only find 20 documents, although there may be "hidden" articles that is published in journal, not indexed by PubMed. We need to give heed and learn from Japan which leads UHC in Asia.[6] As whether using good analysis, we can figure out how many people we can save with preventive versus curative method, using limited amount of money effectively.

Everyone should take part to succeed UHC. This journal also takes part in imparting knowledge to improve human health in basic science, clinical, and also community research field. Case reports, reviews, and brief communications also play roles in promoting human health. And now, what is your part?

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