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# Women and universal health care

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The Indonesian government started 2014 with the much-hailed rollout of its national health insurance (JKN) and the promise that by 2019, all the country's 250 million people will be covered by universal health care (UHC).

Concerns are rife about the complexity of implementing such a large insurance scheme and sustaining it over time, but few would dispute its lofty goals.

If successful, JKN could significantly enhance people's welfare and social protection. Costs will no longer be a barrier to health care or be a cause of impoverishment, with the gap in treatment for privileged and less privileged groups expected to narrow.

Greater fairness in society may not be too far-fetched, UNC having been proved to be an effective redistribution mechanism in many other countries.

Among those who have a stake in a well-functioning UHC program are women. They are the majority of the population, they are generally in more underprivileged positions, their health needs are many and they are also held responsible for the health of their children and family.

They are therefore highly dependent on health systems and are most affected by income-related barriers and inequities that reduce their access to health care.

UHC schemes that address these conditions can have great impact on women's health. Quick, Jay and Langer conclude in a recent article that "UHC has proven a powerful driver of women's health in low- and middle-income countries, including Afghanistan, Mexico, Rwanda and Thailand."

Indonesia clearly falls among the countries where women's health is in dire need of improvement and where UHC could make a difference if properly designed and implemented. Irrespective of the recent controversy on whether maternal mortality has increased or stagnated, it is clear that the 2012 Indonesia Demographic and Health Survey, which reported a mortality rate of 359 deaths per 100,000 live births, is high by all standards.

While the use of midwives' services has increased in recent years, for many women quality maternal health services are not available, if not at significant financial cost. Unmet needs for

effective contraceptives remain great and the occurrence of unsafe abortions is too sensitive to be dealt with.

Breast, ovarian and cervical cancer is growing, but prevention, screening and treatment services are lacking or are unaffordable. The feminization of the AIDS epidemic is ongoing, but still, HIV testing is not provided as part of government-subsidized antenatal services.

In view of the potential gains, it seems surprising that women's voices have not been heard in public discussions leading to the launching of JKN and continue to be missed in this early phase of implementation.

Planning and socialization efforts do not specifically engage women and women's groups and NGOs have devoted little attention to JKN, leaving the policy arena to health professionals, government officials and private lobbyists.

A review of the first two months of JKN has mainly focused on problems with payment to hospitals and complaints by patients who have encountered difficulties in accessing the promised services. As systems become more established, however, it may be time to pay more attention to JKN's degree of gender-responsiveness as a crucial element in improving women's health.

JKN includes a comprehensive package of sexual and reproductive health services. However, many questions remain on how comprehensive it is and how exactly it will be implemented. For instance, universal delivery care or Jampersal is now integrated into JKN so it is important for pregnant women to be aware and register as members to be able to access services.

As many parents are already finding out, newborns will not be covered if they are not registered first. Contraceptive services will also be provided under JKN.

The Social Security Management Agency (BPJS) that administers JKN will fund the provision of services and contraceptive methods will be procured and provided by the National Family Planning Agency (BKKBN).

How is this going to function in practice? Most importantly, how will women (and men) be sure that their choices will be respected and that the complete contraceptive spectrum from condom and pills to sterilization and vasectomy is chargeable (the recommended "cafeteria approach") and not, for instance, only selected long-term contraceptives decided according to population control priorities?

In addition, will poor women continue to be "compelled" to use intrauterine devices (IUDs) or implants after delivery as was the case in Jampersal, even if it is not their choice and actually disregards their rights? For girls, what package will be available, considering the increasing number of early pregnancies in the 15-19 age group?

UHC covers all types of cancer, but monitoring will be needed to ensure treatment is timely and of quality for affected women. Pap tests and mammography are foreseen in JKN, however their integration into basic health services will require an effort as they presently are not routinely

offered.

These and other issues require the attention of women and women's groups in the framing of packages and their implementation, as well as in the monitoring of women's health services.

For a start, they may demand sex-disaggregated data for JKN and the gathering of data on priority women's health services, health outcomes and equity indicators.

All information is invaluable to assess and ensure JKN is women-friendly and that no quality of care disparities emerge for women, irrespective of whether they pay the insurance fee or is it paid for them by the government.

Only with the engagement of women, will JKN deliver on its potential to improve women's health for all.

*The writer is a health and social development adviser and writer of Menuju Kesehatan Madani (Towards Civic Health, Gadjah Mada University, 2007).* - See more at: http://www.thejakartapost.com/news/2014/03/08/women-and-universal-health-care.html#sthash.kjHdz5Qh.dpuf