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An Inclusive Social Health Insurance for People with Disabilities in Three Southeast Asia Countries: A Systematic Review

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Abstract

This article examines how inclusiveness is implemented for People with Disabilities (PWDs) in social health insurance programs in Southeast Asia by focusing on the National Health Insurance (NHI) in Indonesia, the National Health Insurance Program (NHIP) in the Philippines, and Social Health Insurance (SHI) in Vietnam. The concept of inclusive social insurance for PWDs is used as an analytical tool to explore inclusivity criteria, such as target specifications, service benefits, multi-stakeholder involvement, service functions, and the program's impact. Drawing on the qualitative systematic review method, which refers to Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA), PRISMA Protocols 2015, and evidence-based guidelines, this article analyzes 25 selected pieces of literature. The results of the study show that: First, there are no special schemes and mechanisms in those programs that target PWDs directly and specifically. Second, those programs have not been able to meet the specific health needs of PWDs. Third, the implementation of those programs has involved three stakeholder actors: the state, the private sector, and NGOs. Fourth, those programs have not shown a significant impact on improving the health quality of PWDs. Finally, it can be concluded that the three programs are not yet truly inclusive in covering PWDs in social health insurance programs.

Keywords:
inclusive social insurance; people with disabilities; social health insurance; Southeast Asia

Introduction

Disability is a term that refers to a weak body condition and having limited ability to do activities due to the negative aspects of an individual's internal condition (body condition or health) and other external factors of the individual (surrounding environment) (Leonardi et al., 2006; WHO, 2011). Poverty and disability are generally understood and accepted as vicious circles (Elwan, 1999; DFID, 2000; Yeo, R., & Moore, 2003). People with disabilities (PWDs) are among the most vulnerable groups globally and the most marginalized from a social and economic perspective (WHO, 2011) Also, PWDs have often experienced social exclusion, receive a negative stigma, and are not given social support, education, and legal and political rights to access existing institutions' functions and services (House of Commons, 2019). The state, therefore, must formulate and implement an accurate strategy to overcome the problems faced by PWDs.

The United Nations (UN) has called for all UN member countries to address various problems related to PWDs through the Convention on the Rights of Persons with Disabilities (CRPD). Several articles in the CRPD specifically discuss the urgency of reducing poverty and creating equitable and inclusive conditions for PWDs in all aspects of development activities and all matters

relating to global health issues (UN, 2006). In this regard, the social insurance program that is more targeted at the health aspect (known as social health insurance) can be a tangible solution, considering that PWDs experience direct impairment in the health aspect, which causes PWDs' limited engagement in social and economic activities (House of Commons, 2019). Thus, "it can protect PWDs against financial and health burdens and is a relatively fair method of financing healthcare" (WHO, 2003: p. 1). Also, various social insurance and social health insurance programs have emerged and been implemented as "important instruments in social policy to address vulnerability, poverty, and social exclusion in these low and middle-income countries" (Palmer, 2013: p. 139).

However, in practice, various social insurance and social health insurance programs have not covered PWDs more inclusively due to the absence of explicit schemes and mechanisms and, instead, lead to social discrimination (ILO, 2012). For example, special barriers prevent PWDs from accessing and receiving benefits from social insurance programs, such as the inaccessibility of the program services due to discriminatory acts committed by program implementers (Gooding & Marriot, 2009). Therefore, the existing social insurance program needs to adjust the eligibility criteria and benefits packages, specifically for PWDs (Gooding & Marriot, 2009; Kafaa, 2021). Moreover, the failure to identify PWDs can complicate access and may reduce the program's positive impact as an essential development tool to encourage and improve socio-economic conditions, especially for vulnerable groups such as PWDs.

In this study, PWDs' social health insurance programs originate from several countries in Southeast Asia, i.e., Indonesia, the Philippines, and Vietnam. There are four interrelated reasons for the selection. First, the three countries are included in lower-middle-income countries in Southeast Asia (World Bank, 2019). Second, PWDs' presence in these countries has a relatively high number and percentage among other lower-middle-income countries in Southeast Asia (see Figure 1). Third, even though the three countries are included in the lower-middle-income, the social health insurance program for PWDs is still implemented. Also, credible data and literature are available. Finally, although there has been a lot of literature on social insurance programs for PWDs in low- and middle-income countries, the Southeast Asia regional boundaries and the concept of inclusive social insurance for PWDs have not been used in those studies.

For example, a study by Banks et al. (2016) explains how PWDs are included in social protection programs in lower-middle-income countries, which mainly refer to countries in South Africa. Another study by Walsham et al. (2018) describes how the condition of social protection programs for PWDs in lower-middle-income countries by focusing on countries in Africa and Asia. However, these two studies have not incorporated the concept of inclusive social insurance as their analytical tool. Therefore, they are unable to explain how these programs can effectively address the needs of PWDs, particularly their specific health requirements. In addition, the regional boundaries of Southeast Asia have not been used explicitly in the two studies, even though the level of lower-middle-income status of countries in Southeast Asia is the lowest in the Asia region (World Bank, 2022). Therefore, this study employs the concept of inclusive social insurance PWDs as the primary analytical tool for assessing social health insurance programs in lower-middle-income countries in Southeast Asia.

Thus, this study aims to examine how inclusiveness is implemented in the social health insurance program for PWDs in Indonesia, the Philippines, and Vietnam. We build two main arguments at the initial stage of this study. First, the social health insurance

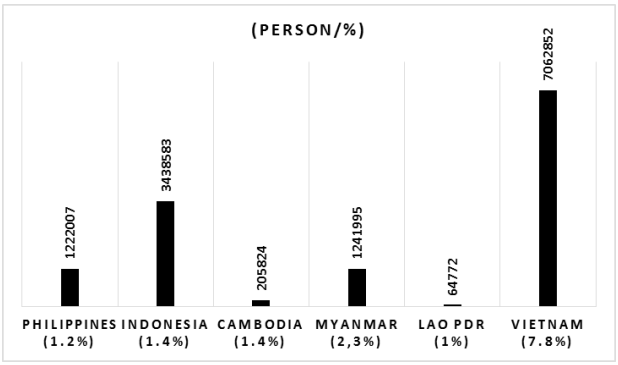

Figure 1. Data on PWDs in Lower-Middle-Income Countries in Southeast Asia
Source: Data modified from UNESCAP (2011)

programs for PWDs are implemented to reduce the number of PWDs and improve their health quality and overcome various socio-economic problems it entails (Banks et al., 2018; OECD, 2019; Palmer, 2013). Second, even though there are social health insurance programs in the three countries, the inclusiveness aspect of the program for PWDs remains unknown.

Inclusive Social Insurance for People with Disabilities

Social insurance is a set of specific schemes and mechanisms that usually become instruments of social policies implemented by the government to overcome life risks, reduce poverty, and improve living conditions (Barrientos, 2011). The social insurance program emerged as a response from the state to various community problems, especially social and economic risks. For example, people who live in poverty or face other forms of marginalized action, certainly face a high potential for many life risks that can cause or exacerbate poverty and vulnerability. Unfortunately, those experiencing this often have few means to prevent, mitigate, and/or address these risks (World Bank, 2001). As such, the social insurance program emerged as a social protection component to help the community by targeting individuals or groups considered vulnerable to such risks.

Furthermore, the urgency to implement the social insurance program has also been strengthened since the inclusion of a specific target under the Poverty Alleviation Goal on SDGs, which contains "the need to implement a system and mechanism of protection or social insurance that is appropriate and can cover everyone, especially for those who are poor and vulnerable," including PWDs (UN, 2015: p. 15). This would be reasonable, given that disability can lead to poverty and vice versa.

In the context of lower-middle-income countries, social insurance programs focus more on "poverty alleviation and socio-economic development by promoting risk management mechanisms combined with direct cash transfers and various other forms of benefits from social services" (Walsham et al., 2018: p. 2). This is because disability is a "very important component in the poverty reduction process" (Banks et al., 2016; Walsham et al., 2018). Furthermore, the emergence of many social insurance programs targeting PWDs in various countries is because "the situations they (PWDs) face can create multiple vulnerabilities" (Schneider, *et al.*, 2011: p. 43).

The World Report on Disability (2011) shows that "the implementation of social insurance programs in many countries is often still hampered by various problems that PWDs face in accessing various health services, transportation, education, employment, and others" (WHO, 2011: p. 70). Therefore, various ideas emerged regarding designing an inclusive social insurance program that could more specifically cover PWDs. However, in this study, this inclusive social insurance program is contextualized with the social health insurance program. This is important because the social insurance program itself has many types, such as social-employment insurance targeted to social and economic benefits. Thus, this study defines social health insurance as a social insurance program focusing on health aspects. According to WHO (2003), "social health

insurance is a form of financing and managing healthcare based on risk pooling both the health risks of the people on the one hand, and the contributions of individuals, households, enterprises, and the government on the other". While social insurance is more economically concerned and based on the recognition that economic insecurity arises largely from interruptions to income from work caused by unemployment, retirement in old age, death of the family breadwinner, or disability, either short-term or long-term (Ball, 1961).

We compiled several criteria from various studies to identify the inclusiveness of social health insurance programs for PWDs. First, the program is specifically aimed at PWDs and service benefits tailored to the conditions or types of disabilities (Palmer, 2013). This is important considering that PWDs often do not obtain an appropriate membership from existing social health insurance programs because of their disability condition. They also face access constraints to be a member or even after becoming a member of the social health insurance program. Their need for health services varies according to the type and severity of the respective disability conditions. Second, the program can include factors related to disability conditions that can create vulnerability for PWDs and their families (for example, social exclusion, discrimination, health needs, etc.) as integral service benefits (Schneider et al., 2011). Thus, the roles, functions, and advantages of social health insurance program services are important to help PWDs and their families deal with these factors. Third, the implementation of the program that involves the roles of multi-stakeholders, such as the government, the private sector, community organizations, and families (Cecchini & Martinez, 2012), as the inclusive concept itself in which every related party may be involved. This is also aimed at making the social health insurance program an integrated and multi-sectoral policy to reduce the risk of disability and prevent PWDs and their families from becoming multi-dimensionally poor (Pinilla-Roncancio, 2015). Fourth, the program aims to improve health quality by meeting health needs and overcoming all socio-economic risks to PWDs (Rohwerder, 2014: p. 2), given that PWDs are an "essential component in the poverty reduction process" (Banks et al., 2016; Walsham et al., 2018). This makes the social health insurance program one of the most important social policy instruments to alleviate poverty and improve community welfare.

To conclude, the logical reasons to study this issue are the program targets and service benefits, program functions, multi-stakeholder involvement, and the program's impact to identify the inclusiveness of the program. Thus, we also offer those logical reasons as a conceptual framework that may contribute to scientific enrichment, especially in terms of formulating and assessing the inclusiveness of social health insurance programs for PWDs.

Methods

This study uses a qualitative approach to examine social health insurance programs in three countries, i.e., Indonesia, the Philippines, and Vietnam, through a systematic literature review. It seeks to produce a comprehensive and objective review of existing research. The systematic review method used in this study is also in line with and complies with standard research procedures as described in Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA), Preferred Reporting Items for Systematic Reviews and Meta-Analysis Protocols 2015 (PRISMA-P 2015), and evidence-based guidelines supported by experts for systematic review methods (see, Cronin, Ryan and Coughlan, 2008; Moher *et al.*, 2009, 2015). Studies on the related issues of disability and inclusive social health insurance were also used during the research process as conceptual boundaries.

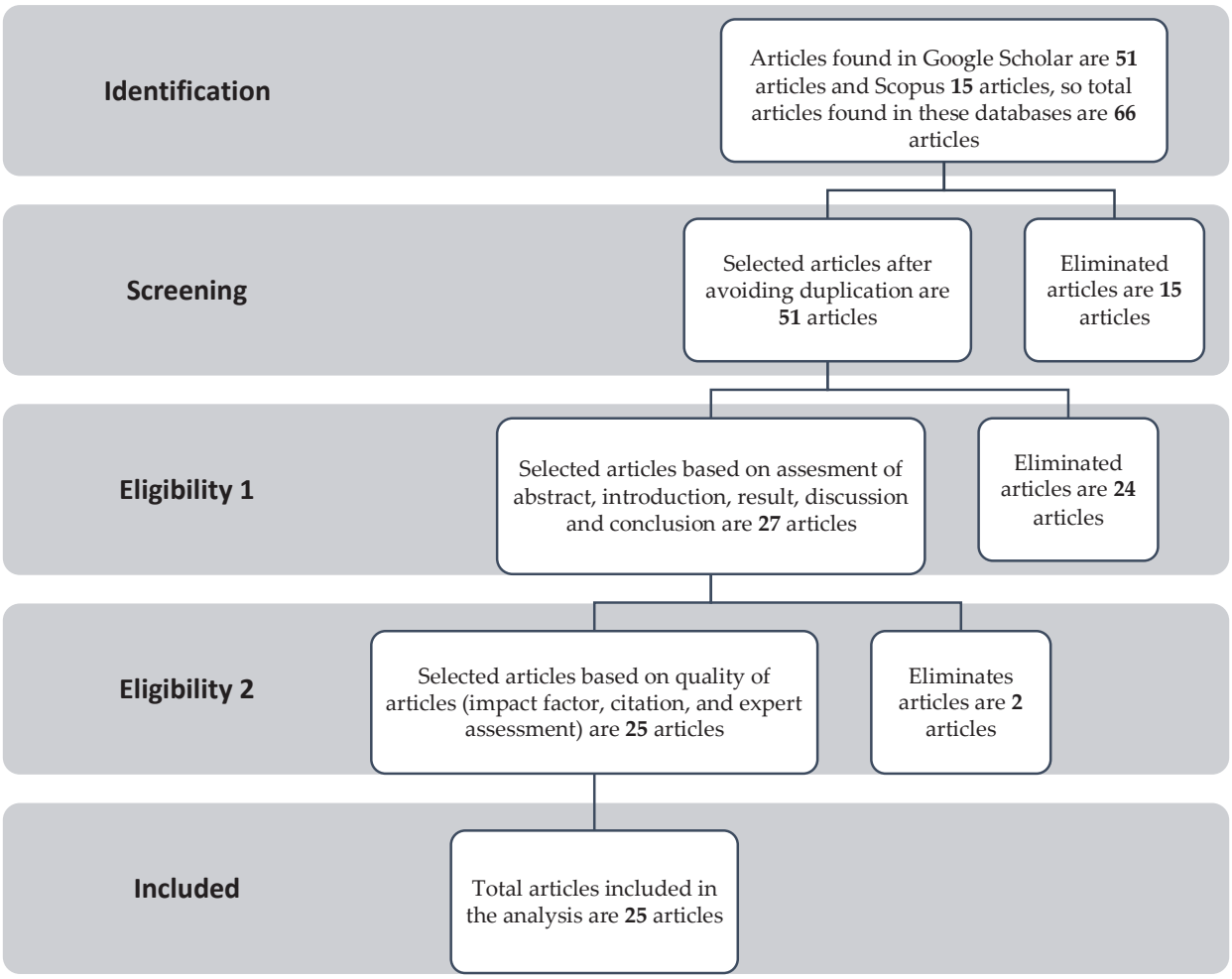

Figure 2.
The Systematic Literature Review Process
Source: Created by authors based on the SLR process

The research topics that have been chosen are related to the social health insurance program for PWDs in the three countries studied. We initiated the literature selection process by entering an electronic database and then selecting a journal or literature publisher with a focus on social issues, such as public policy, social policy, social welfare, social development, social protection systems, social health insurance programs, and vulnerable groups; and by using keywords that include social protection, social insurance, social health insurance, people with disabilities, inclusive, Indonesia, the Philippines, and Vietnam.

The two electronic accessible and relevant databases for this research are Google Scholar and Scopus. The literature works chosen are those published in the last ten years in English and Indonesian language. We did not include literature in other local languages, i.e., the national languages of the Philippines and Vietnamese, due to the language barrier. Most articles are in English, and three articles are in the Indonesian language. It should be noted that the inclusion of literature in those national languages may result in different conclusions. In this process, we found 66 academic studies in the format of journal articles, research reports published by reputable institutions, and policy briefs.

Table 1.
Criteria for Inclusion and Exclusion of Literature

Criteria	Inclusion	Exclusion
Country	Indonesia, the Philippines, Vietnam	-
Time of publication	The last ten years	More than ten years
Concept	Social health insurance	Social assistance
Citation (Google Scholar)	Minimum 10	Less than ten
Impact factor (Scopus)	Minimum 1,000	Less than 1,000
Type of publication	Journal, research report, official report, and policy brief	Proceeding
Availability	Full document	Abstract only
Language	English and Indonesian	-

Source: Created by authors based on the SLR process

We then screened the literature by examining the titles, abstracts, introductions, discussions, and conclusions and assessing the quality of literature involving two academics with scientific qualifications in social policy. At this stage, the initial 66 literature works were reduced to 25 (consisting of 11 works covering Indonesia, eight the Philippines, five Vietnam, and one both Indonesia and the Philippines) feasible for review in this study (see Appendix 1). This process was carried out in April-May 2020.

This study uses meta-synthesis and framework analysis techniques by "tabulating non-statistical data to integrate, evaluate, and interpret research findings" (Cronin, Ryan, and Coughlan, 2008: p. 39). These techniques aim to discover new concepts and theories and new understandings or interpretations (Polit & Beck, 2019). These techniques were chosen based on the similarity of the objectives of this study with the meta-synthesis and framework analysis techniques, which aim to examine social health insurance programs for PWDs in the three countries analyzed.

Results

Specifications for Target and Suitability of Social Health Insurance Program Benefits

Based on the program target criteria, PWDs in Indonesia, the Philippines, and Vietnam are only included in the universal health insurance system in general. There is no specification for PWDs to become the program's targeted audience in that system. Five studies explain that PWDs in Indonesia are included in the National Health Insurance (NHI) program, in this case, through the Health Social Security Administering Body (known as BPJS Kesehatan) as a recipient of contribution assistance (known as PBI-JK). This is also confirmed by three literature works that explain why PWDs are part of PBI-JK because they are included in the category of the poor and needy people who have been registered in the Integrated Social Welfare Data (known as DTKS). These results show the absence of a special mechanism that specifically targets PWDs because the DTKS data includes accumulatively the People with Social Welfare Problems (known as PMKS). Moreover, four studies state that the coverage of PWDs in Indonesia's social insurance programs is still relatively small. As data in 2017 shows, the coverage is only 1.2 million people out of a total of 4.4 million people (Larasati et al., 2019).

Seven studies state that PWDs in the Philippines insured by the National Health Insurance Program (NHIP) through Philippine Health (PhilHealth) are also categorized as poor and near-poor based on accumulative data in the National Household Targeting System for Poverty (NHTS-PR). Therefore, there is no specific mechanism for PWDs in PhilHealth. Moreover, the seven studies also confirm qualitatively that the coverage of PWDs in PhilHealth is still relatively small, although there is no single study that mentions quantitative data with certainty. In Vietnam, based on the six studies, PWDs in the Social Health Insurance (SHI) program

run by Viet Nam Social Security (VSS) are categorized as part of the poor, near-poor, and vulnerable groups, so there is no special mechanism specifically aimed at PWDs. Like the Philippines, the six studies also confirm that the coverage of PWDs in the SHI program is still relatively small. However, no study mentions quantitative data with certainty.

Based on the benefit suitability criteria explained in the six studies, the lack of knowledge to identify PWDs and their needs has led to unclear eligibility criteria in Indonesia's social insurance programs. In line with the evaluation result, the last research shows that "the lack of knowledge of PWDs' needs has led to ineffective PWD identification systems in social insurance programs" (Mleinek & Davis, 2012: p. 41). The three studies also explain that PWDs' benefits are almost the same as PBI-JK in general. Still, the difference lies in the benefits of providing assistance services for PWDs and the lack of knowledge of PWDs' needs and limited funding (Rohwerder, 2014: p. 1).

In the Philippine context, the PhilHealth program is needed to adjust an adaptive and dynamic system (Mont et al., 2016; Palmer, 2014b). The five studies explain that the PhilHealth program only provided service to other contribution assistance recipients, including Z benefit packages that provide relevant financial risk protection against medically and economically catastrophic illnesses, including specific health needs

Table 2.
Target and Suitability of Social Health Insurance Program Benefits

Aspects	Indonesia	Filipina	Vietnam
Scheme	Included in the NHI through the BPJS Kesehatan as PBI-JK	Included in the NHIP through PhilHealth as a recipient of contribution assistance	Included in SHI through VSS as recipients of contribution assistance
Targets	Categorized as part of the poor and needy people who are registered in the DTKS, so there is no specific mechanism for PWDs specifically	Categorized as part of the poor as recorded in the NHTS-PR, so there is no specific mechanism for PWDs specifically	Categorized as part of the poor, near-poor, and vulnerable groups, so there is no specific mechanism for PWDs specifically
Coverage	Relatively small, only 1.2 million people when compared to the total data for PWDs, which is 4.4 million people (data in 2017)	There is no literature that clearly mentions the number of PWDs covered by the PhilHealth	There is no literature that clearly mentions the number of PWDs covered by the SHI
Suitability Criteria	Lack of knowledge from the program's implementer and the existence of unclear suitability criteria in identifying PWDs and their health needs	There are eligibility criteria to identify PWDs, but it still requires certain adjustments in its determination	Eligibility criteria in identifying PWDs and their health needs are still unclear and not suitable
Categorization of Service Benefits	Almost similar to other recipients of contribution assistance, but PWDs have the benefits from the provision of assistive devices	Almost similar to other recipients of contribution assistance, but PWDs have the benefits from the provision of tools and Z packages	Almost similar to other recipients of contribution assistance, but PWDs have the benefits from the provision of assistive devices
Service Benefit Accuracy	Limited knowledge about the needs of People with Disabilities (PWDs), and insufficient funding has resulted in services that do not adequately address their health requirements.	Even though there are Z benefit packages, they are still not fully appropriate and in accordance with the health needs of PWDs.	The unclear eligibility criteria for PWDs and limited funding have led to a lack of appropriateness of service benefits in meeting PWDs' health needs.
Source code number on Appendix 1	1, 2, 3, 4, 5, 6, 7	12, 13, 14, 16, 17, 18, 19	20, 21, 22, 23, 24, 25

Source: Created by authors based on data analysis

for PWDs, and still limited funding in the program. Like Indonesia and the Philippines, the five studies in the Vietnam context state that the eligibility criteria for social insurance programs are not yet appropriate. Therefore, the lack of clarity in these criteria has made the existing social insurance programs unfair in covering PWDs with unclear eligibility criteria and limited program funding (Palmer, 2014a; Palmer et al., 2011).

Social Health Insurance Program Service Functions

In Indonesia, as stated by Rohwerder (2014: p. 2), "the lack of knowledge of PWDs (health needs) and limited implementation costs are separate obstacles in the effort to realize a truly inclusive social insurance program for PWDs." The six studies show that social health insurance programs are sufficient to increase the accessibility of PWDs to health service institutions. Increased accessibility is mainly concentrated in urban areas, while it is still quite low in rural areas. This is due to the lack of adequate health facilities in rural areas and the degree of social awareness of the PWDs (Kusumastuti et al., 2014).

The accessibility of PWDs living in rural areas to health service institutions is relatively low due to the lack of adequate health facilities and geographical conditions requiring high transportation costs, especially for those who live in remote areas (Cobley, 2015). This is also due to the same causes as Indonesia and the Philippines, namely the lack of adequate health facilities and the high cost of transportation to access adequate health facilities in cities (Banks, 2019; Banks et al., 2019). However, PWDs covered by social health insurance programs can help to reduce costs in their primary health needs.

Similar to the Indonesian case, six studies state that, due to the limited program funding, the program's service benefits have not fully met PWDs' health needs even though there are Z benefit packages. Z benefit packages have a limited quota and are therefore prioritized for PWDs with severe disabilities and children under six (PhilHealth, 2019). There are still many PWDs experiencing low and medium levels of disability and age range over six years who have not received the benefits of specific services (Reyes et al., 2018).

Multi-Stakeholders Involvement in the Implementation of Social Health Insurance Program

The social health insurance programs in three countries have involved three actors with their respective roles and functions: the state, the private sector, and Non-Governmental Organizations (NGOs). In the Indonesian

Table 3.
Social Health Insurance Program Service Functions

Aspects	Indonesia	Filipina	Vietnam
Health Needs	The lack of understanding of PWDs' needs and limited funding to provide service benefits have led to the lack of fulfillment of PWDs' health needs	The health needs of PWDs are still not fully met through Z benefit packages	The lack of understanding and awareness of the needs of PWDs as well as limited funding in providing service benefits have led to the lack of fulfillment of PWDs' health needs.
Health Access	The program is sufficient to increase the accessibility of PWDs to healthcare institutions, especially for PWDs living in urban areas, but not for their counterpart living in rural areas.		
Health Financing	The service benefits help the PWDs to reduce the costs of meeting their health needs.		
Source code number on Appendix 1	1, 2, 3, 4, 5, 6, 7, 8, 10	12, 13, 14, 16, 17, 18, 19	20, 21, 22, 23, 24, 25

Source: Created by authors based on data analysis

context, three studies state that the social health insurance program, primarily BPJS Kesehatan, involves those three actors: the state is represented by public hospitals, primary clinics, main clinics, Community Health Centers (known as *Puskesmas*), and BPJS Kesehatan; the private sector is represented by individual doctors, private opticians, and pharmacies owned by individuals; and the NGOs are represented by the Christian Foundation Rehabilitation Center for Public Health (YAKKUM). YAKKUM acts as a rehabilitation institution for PWDs, covering social, physical, and mental conditions, as well as being a provider and distributor of assistive tools for PWDs (YAKKUM Rehabilitation Center, 2020a, 2020b).

The three studies also explain that actors from the state play a pivotal role as health service institutions for the PWDs' health needs, including preventive, curative, promotive, and rehabilitative. At the same time, BPJS Kesehatan acts as the program manager and implementing agency of the NHI program. As of July 1, 2020, BPJS Kesehatan had 2,296 public hospital partners, 6,630 primary clinics, 254 main clinics, and 10,086 *Puskesmas* units spread across Indonesia (BPJS Kesehatan, 2020a). Moreover, the NHI program has a total of 221,021,174 participants (data as of 30 June 2020) (BPJS Kesehatan, 2020b) from the projected total population of Indonesia in 2020 of 269,603.4 (Central Bureau of Statistics, 2018: P. 42). To date, individual practicing doctors partnering with BPJS Kesehatan have reached 4,978 units, 1,100 units of optics, and 485 units of pharmacies. As of July 1, 2020, BPJS Kesehatan has partnered with health facilities with a total of 27,055 units (BPJS Kesehatan, 2020a).

Turning to the Philippines, the five studies show that the NHIP program's implementation also involves several actors, namely the state, the private sector, and NGOs. Moreover, the five studies also state that the involvement of the three actors is represented at least by government-owned hospitals, government-owned primary care facilities, PhilHealth Corporation (state), private hospitals, private primary care facilities, private clinics or doctors, opticians, and pharmacies (private), and Philippine School of Prosthetics and Orthotics (PSPO) (NGO). Two studies explain that institutions in each type of actor have their respective roles and functions.

PhilHealth, as a program manager, has been implementing the program by covering 410 government-owned hospital partners and 307 government-owned primary care facilities (PhilHealth, 2020), and the total number of participants has reached 97,750,573 out of a total population of 108,099,455 (data on 2019) (Philippine Health Insurance Corporation, 2019). In-private actors also provide drug distribution for PWDs. To date, private hospitals that have partnered in the NHIP have reached 839 units, 296 private primary health facilities, 565 private clinics or doctors (PhilHealth, 2020), and 36 central optics and pharmacies (PhilHealth, 2020b). Also, the NGO actor, namely, the Philippine School of Prosthetics and Orthotics, has a role as a rehabilitation institution that rehabilitates PWDs, both socially and mentally, and a provider and distributor of assistive devices for PWDs (Palmer, 2014b; PhilHealth, 2014).

In Vietnam, similar to Indonesia and the Philippines, the two studies state that the implementation of SHI also involves three types of actors. The SHI program currently has 47 public hospital partners at the central level, 419 units at the provincial level, and 684 units at the district level (WHO, 2020). The cumulative coverage of health insurance participants in the SHI program has reached 83.6 million people (VSS, 2019) from a total population of 94.7 million in 2018 (General Statistics Office of Viet Nam, 2019). It is also necessary to convey that, to date, private hospitals, private health clinics, optics, and pharmacies that have partnered

in the SHI program have reached 182 units (WHO, 2020).

The two studies also mention that several institutions can represent each of these actors, including public hospitals (central, provincial, and district levels) and VSS as state actors; private hospitals, private health clinics, optics, and pharmacies as the private sector, and Viet Nam Assistance for the Handicapped (VNAH) as an NGO actor. The rehabilitation activities carried out by VNAH about the SHI program include intensive psychological and social assistance (main activities), provision of prosthetic and orthotic aids, and even providing vocational training to increase the capacity of PWDs who are still in existence at vulnerable productive age (VNAH, 2020).

The Impact of the Social Health Insurance Program on Health Quality Improvement

In general, social health insurance programs have not shown a significant impact on improving health quality, especially in the provision of the health needs of PWDs. The problem is following the accessibility of PWDs, data management, and limited information. As happened in Indonesia, 12 studies state that the social health insurance program's service benefits are still not for PWDs' health needs. This is partly due to the absence of a

Table 4.
Multi-Stakeholder Involvement in the Implementation of Social Health Insurance Program

Aspect	Indonesia	Philippines	Vietnam
Actors		State, Private, and NGO	
Institutional	Various institutions, such as hospitals, clinics, and BPJS Kesehatan (State); private practice doctors, opticians, and pharmacies (Private); and social rehabilitation institutions, namely YAKKUM (NGO)	Various institutions, such as government hospitals, government primary health facilities, and PhilHealth Corporation (State); private hospitals, private primary health facilities, clinics or private practice doctors, opticians, and pharmacies (Private); and social rehabilitation institutions, namely PSPO (NGO)	Various institutions, such as public hospitals (central, provincial, and district levels) and VSS (State); private hospitals, private health clinics, opticians, and pharmacies (Private); and social rehabilitation institutions, namely VNAH (NGO)
Roles	1. Hospitals and clinics acting as the frontline in providing health care benefits for PWDs, while BPJS Kesehatan acting as both manager and service provider of the NHI program in Indonesia (State) 2. Individual practicing doctors acting as the front line of health services; optics acting as a provider of PWD aids, and pharmacies acting as providers of medicines needed by PWDs (Private). 3. The YAKKUM acting as a social rehabilitation institution as well as a distributor of aids for PWDs (NGO)	1. Government hospitals acting as the frontline in providing health care benefits for PWDs, while PhilHealth Corporation acting as both manager and service provider of the NHIP program in the Philippines (State) 2. Private hospitals and clinics or individual practicing doctors acting as the frontline health services; optics acting as a provider of PWD aids, and pharmacies act as providers of medicines needed by PWDs (Private) 3. The PSPO acting as a social rehabilitation institution as well as a distributor of aids for PWDs (NGO)	1. Public hospitals (central, provincial, and district levels) acting as the frontline in providing health care benefits for PWDs, while VSS acting as both the manager and service provider of the SHI program in Vietnam (State) 2. Private hospitals and clinics acting as the frontline health services for PWDs; optic acting as a provider of PWDs aids, and; pharmacies acting as providers of medicines needed by PWDs (Private) 3. The VNAH institution acting as a social and mental rehabilitation institution for PWDs
Source code number on Appendix 1	6, 11, 12	12, 13, 14, 17, 19	20, 24

Source: Created by authors based on data analysis

special program for PWDs so that the service benefits for PWDs tend to be the same as those categorized as poor and near-poor in general (Oddsdottir, 2014). Furthermore, the five studies state that the accessibility of PWDs to programs is still low due to lack of data, inaccurate data, and overlapping data. This is also an obstacle to social health insurance programs in Indonesia in general, as "data problems cause program targets to be unreliable" (Mleinek & Davis, 2012: p. 15). The following three studies also explain the transportation costs for accessing benefit claims so that "the benefits of their services are sometimes worthless" (Mleinek & Davis, 2012: p. 15). This is because PWDs tend to have additional needs and face other socio-economic constraints, which are not always accommodated by the service system in the social insurance program (Mont et al., 2016; Palmer, 2014a).

In the Philippines, the six studies show that the program's service benefits are not sufficient to match PWDs' health needs. Even though there are Z benefit packages that focus on providing relevant financial risk protection against medically and economically catastrophic illnesses, including specific health needs for PWDs, it is still not entirely accurate and facilitates what is needed by PWDs due to limited funding for the program (Lu et al., 2017; Villar, 2013). In this case, many PWDs often lack awareness of the accessibility of the program (Faculty of Social Sciences and Cultural Studies, 2016). Similar to Indonesia, the five studies state that, in some cases, the cost of transportation is more expensive than the benefits, especially for PWDs living in remote areas. The reason is mainly the lack of adequate health facilities in partnership with the program (Reyes et al., 2011). However, the program has sufficiently guaranteed primary health for registered PWDs. However, specifically, it is still not guaranteed by Z benefit packages because of the limited quota. Finally, similar to Indonesia and the Philippines, in Vietnam, the six studies show that the program's service benefits do

Table 5.
The Impact of the Social Health Insurance Program on Health Quality Improvement

Aspects	Indonesia	Filipina	Vietnam
Health services	The health needs of PWDs have not been fulfilled by program benefits		
Program Accessibility	Access for PWDs to become program participants tends to be low due to insufficient, inaccurate, and overlapping data	Limited information and data shortages have caused PWDs' access to programs to remain low	
Accessibility Service Benefits	The cost of transportation to claim service benefits is not commensurate with the amount of benefits, especially for those who live in remote areas		The cost of transportation to claim for service benefits is not commensurate with the amount of benefits, especially for those who live in remote areas, even though there has been transportation subsidy
Health Insurance	The basic health benefits of PWDs have been fulfilled, but it has not been able to fulfill their specific health needs	The basic health benefits of PWDs have been fulfilled, but it has not been able to fulfill their specific health needs due to the limited quota for the availability of Z packages	The basic health benefits of PWDs have been fulfilled, but it has not been able to fulfill their specific health needs
Source code number on Appendix 1	1, 2, 3, 4, 5, 6, 7, 9, 10, 12	12, 13, 15, 16, 17, 19	20, 21, 22, 23, 24, 25

Source: Created by authors based on data analysis

not cover the PWDs' needs due to the lack of accessibility of participants and information.

Discussion

The systematic review shows that PWDs are generally included in the Universal Health Coverage (UHC) system-based social health insurance program in three countries studied. The UHC system does not always provide free health insurance for citizens. However, it is still implemented in at least two ways: the contributory payment scheme for participants and government subsidies to non-contributory beneficiaries (WHO, 2019). In the context of PWDs, of course, PWDs are more dominant in subsidy recipients from the government. This is reasonable, considering that PWDs the world's poorest vulnerable, and most marginalized groups from a social and economic perspective (WHO, 2011).

However, UHC also requires adjustments to certain specifications that must be more contextualized to local conditions. For example, when PWDs are generally categorized as part of the poor and near-poor in social health insurance programs, PWD coverage is still relatively small because the database used to absorb program participants is based on general public data of poverty (for example, NHTS-PR in the Philippines), which tends to be incomplete, inaccurate and overlapping (Palmer, 2014a), and PWDs do not benefit from services that specifically target them (Oddsdottir, 2014; Rohwerder, 2014). Even though the health needs of PWDs are different from non-PWDs and even PWDs tend to have additional needs and face other socio-economic constraints, which are sometimes not accommodated by the service in the social health insurance program (Mont et al., 2016; Palmer, 2014a).

It is necessary to completely update the PWD data and increase the understanding of program implementers about PWDs' needs, including the socio-economic constraints faced by PWDs. Moreover, social health insurance programs covering PWDs should have specific eligibility criteria for identifying PWDs and their needs. Later, the categorization of service benefits should cover all types and severities of disabilities.

The funding for social health insurance programs also needs to be increased so they can cover all PWDs and meet their health needs. Given that the cost of health services for PWDs is more expensive than others ranging from "identification, assessment, monitoring, to rehabilitation" (Mleinek & Davis, 2012, p. 15). For example, the case in the Philippines shows that even though there have been Z benefit packages as a special service benefit for PWDs, due to limited funding, the package quota has become very limited and prioritized for PWDs with severe disabilities and children under age six years (PhilHealth, 2019).

As universal social health insurance programs, NHI, NHIP, and SHI are sufficient to help fulfill PWDs' primary health needs and reduce PWDs' health costs. This primary health refers to general health needs required by patients, PWDs, or non-PWDs, such as non-specialized health care services, non-specialized health care, and non-specialty health treatments. However, PWDs' specific health needs, such as specialist diagnosis and intensive expert assistance for mentally challenged people, are not sufficiently fulfilled.

These programs have also been able to increase the accessibility of PWDs to health service institutions, especially for PWDs living in urban areas, while PWDs living in rural areas are still constrained by the lack of adequate health facilities (Banks, 2019). So, they still have to pay excessive transportation costs to reach adequate health facilities, which are sometimes more expensive than the number of benefits they receive (Mleinek & Davis, 2012). Likewise, it applies not only to PWDs but also to the public who live in rural areas, especially those who live in remote areas.

The involvement of multi-stakeholders in social health insurance programs still does not involve the family's role as an important actor in helping PWDs, when, in fact, family members can monitor and assist PWDs, both mentally and socially (Vanegas & Abdelrahim, 2016; Yusuf et al., 2020). The family's role can also help reduce the costs incurred by program implementers to carry out intensive monitoring and assistance to PWDs. One of the obstacles to implementing an inclusive social health insurance program for PWDs is "the cost of intensive health monitoring and assistance which is quite expensive" (Rohwerder, 2014: p. 2).

In this case, a family can periodically report to program implementers regarding the health improvement progress. Thus, program implementers can also determine PWDs' current condition and the effectiveness of the benefits of the services provided. Likewise, a family can become actors in assisting PWDs with their mental and social rehabilitation (Canary, 2008; Vanegas & Abdelrahim, 2016; Yusuf et al., 2020), given that the family is also the first and foremost institution that is close and coexists with PWDs. Therefore, PWDs who have received the benefits of rehabilitation services can continue to be sustainable with family assistance in their daily personal and social life.

Conclusion

A social health insurance program certainly helps PWDs as a vulnerable group in improving or building their living conditions, especially in terms of improving the quality of health. As discussed in this study, the social health insurance programs, namely NHI in Indonesia, NHIP in the Philippines, and SHI in Vietnam, have also included PWDs as their beneficiaries. However, these programs also need to be reviewed in terms of inclusiveness, ranging from program schemes to insurance for PWDs' health needs, by using the concept of inclusive social health insurance for PWDs.

The categorization of PWDs as poor and near-poor communities included in the NHI, NHIP, and SHI, in general, has caused PWDs to experience many obstacles. This is because PWDs are not targeted more inclusively through the specific schemes and mechanisms of existing programs. This leads to the coverage of PWDs in these programs being relatively small due to a lack of data, limited information, and other obstacles in accessing the program. Also, the program's eligibility criteria to identify PWDs and their needs are still unclear and unsuitable, leading to a mismatch of service benefits with PWDs' health needs. Thus, special schemes and mechanisms are needed to directly target PWDs specifically, accompanied by appropriate and adaptive eligibility criteria to develop a service benefits package that can meet the health needs of PWDs for each type and severity of the disability.

Furthermore, the NHI, NHIP, and SHI programs have not met PWDs' specific health needs. This is due to the lack of knowledge from program implementers regarding the specifications of PWDs needs and limited program funding, which also makes the availability of special service benefit packages for PWDs very limited, such as the provision of tools and limited quota for Z benefit packages in the Philippines. However, even so, the program's existence has been sufficient to help reduce health costs that PWDs must spend independently and increase the accessibility of PWDs to health service institutions, especially for PWDs, who live in urban areas. Meanwhile, for PWDs, who live in rural areas, especially in remote areas, their accessibility is still low due to the lack of adequate health facilities in their area. Thus, an adequate transportation cost assistance scheme is needed so that PWDs are no longer financially constrained when going to health facilities to claim service benefits. These assistance schemes can be classified based on social, economic, and geographical conditions

that are adapted to the local context in each country.

Moreover, the implementation of the NHI, NHIP, and SHI programs still involves three stakeholder actors, namely the state, the private sector, and non-governmental organizations (NGOs). Thus, it is necessary to involve the family (household) role as an important actor to assist PWDs in implementing the program. For example, families can be involved in health monitoring and PWD assistance, both mentally and socially. The family's role can also help reduce the costs incurred by program administrators to carry out intensive monitoring and assistance to PWDs.

Finally, the impact of the NHI, NHIP, and SHI programs on improving the quality of health, especially in terms of meeting the health needs of PWDs, has not been positive. This is because the program's service benefits cannot meet PWDs' specific health needs yet, even though primary health has been sufficiently fulfilled. The accessibility of PWDs to become program participants is still low due to the lack of data, the presence of non-actual data, overlapping data from program implementers, and the limited information obtainable by PWDs. Moreover, many cases show that the transportation costs incurred by PWDs to access program service benefits are higher than the value of the benefits they receive. This is especially true for PWDs, who live in rural areas, especially in remote areas that are still constrained by geographic conditions and limited health facilities that are adequate and partnering with the program. Although there is a transportation cost assistance scheme for PWDs in Vietnam, this assistance cannot cover PWD's transportation costs.

In closing, we recognize this study has its limitations. This study does not include literature using the national languages of the Philippines and Vietnam and is limited to literature published in the last ten years, so it might be more comprehensive if using literature published longer than that. In addition, reports from the government and other related institutions, which are still limited to be used as data, maybe more comprehensive if they are used more. Also, this study uses a literature database that may not be able to capture the context of social and political dynamics in the three countries studied when compared to field research. Hopefully, the limitations of this study can be overcome by further studies.

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Appendix 1
List of Selected Literature

Code No.	Database	Publication Information
		Literature focusing on Indonesia
1.	Google Scholar	Dewi, R. (2019). *The challenge of realizing inclusive development for people with disabilities in Indonesia*. Jakarta.
2.	Google Scholar	Rohwerder, B. (2014). *Disability inclusion in social protection (Research report No. 1069)*. Retrieved from https://gsdrc.org/docs/open/HDQ1069.PwDf
3.	Google Scholar	World Health Organization. (2013). *Disability in the South-East Asia Region*. New Delhi.
4.	Google Scholar	Larasati, D., Huda, K., Cote, A., Rahayu, S., & Siyaranamual, M. (2019). Policy brief: Inclusive social protection for persons with disability in Indonesia. In *Policy Brief Edition January*. Jakarta.
5.	Google Scholar	The National Team for the Acceleration of Poverty Reduction (TNP2K). (2018). *The future of the social protection system in Indonesia: Social protection for all*. Jakarta: The National Team for the Acceleration of Poverty Reduction (TNP2K).
6.	Google Scholar	Deputy for the Coordination of Poverty Reduction and Social Protection. (2019). *The efforts to achieve an inclusive policy for people with disabilities.* Jakarta.
7.	Google Scholar	Mleinek, H., & Davis, M. (2012). *Disability and social protection in Indonesia: Projects outside the priority areas*. Jakarta.
8.	Google Scholar	Inclusion Center and the Advocacy Movement for Disabilities. (2013). *The policy of guaranteeing the fulfillment and protection of the rights of people with disabilities to health in the Special Region of Yogyakarta: Governor Regulation No. 51/2013 concerning the special health insurance and its implementation*. Yogyakarta.
9.	Google Scholar	Oddsdottir, F. (2014). *Social protection programs for people with disabilities*. Retrieved from https://gsdrc.org/docs/open/HDQ
10.	Scopus	Kusumastuti, P., Pradanasari, R., & Ratnawati, A. (2014). The problems of people with disability in Indonesia and what is being learned from the world report on disability. *American Journal of Physical Medicine & Rehabilitation*, *93*(1), S63–S67.
11.	Scopus	Nugraha, B., Setyono, G., Defi, I., & Guttenbrunner, C. (2018). Strengthening rehabilitation services in Indonesia: A brief situation analysis. *Journal of Rehabilitation Medicine*, *50*(0), 377–383.
		Literature focusing on Indonesia and the Philippines
12.	Google Scholar	Lu, Y., Yean, G., Mansor, N., Awang, H., Shahabudin, S., & Osman, A. (2017). *An exploratory study on social protection in selected ASEAN countries: Malaysia, Singapore, Thailand, Philippines, Brunei, and Indonesia* (No. 2017–6).
		Literature focusing on the Philippines
13.	Google Scholar	Reyes, C., Tabuga, A., & Asis, R. (2018). *Social protection for men and women in the Philippines: Some insights for improving program design of social insurance schemes* (No. 2018–35). Retrieved from http://hdl.handle.net/10419/211055.
14.	Google Scholar	Cobley, D. (2015). Typhoon Haiyan one year on Disability, poverty, and participation in the Philippines. *Disability and the Global South*, *2*(3), 686–707.
15.	Google Scholar	Mont, D., Palmer, M., Mitra, S., & Groce, N. (2016). *Disability identification cards: Issues in effective design* (No. 29). Retrieved from http://www.ucl.ac.uk/lc-ccr/centrepublications/workingpapers.
16.	Google Scholar	Faculty of Social Sciences and Cultural Studies. (2016). *Report of the Philippine disabled people's organization in the implementation of the covenant on economic, social, and cultural rights*. Dusseldorf.
17.	Google Scholar	Orbeta, C. (2011). *Social protection in the Philippines: Current state and challenges* (No. 2011–02). Retrieved from http://hdl.handle.net/10419/126838%0A.
18.	Google Scholar	Palmer, M. (2014). *The PWDs ID card: An options paper for the Philippines*. Manila.
19	Google Scholar	Philippine Health Insurance Corporation. (2019). *Stats and charts*. Retrieved from https://www.philhealth.gov.ph/about_us/statsncharts/snc2019_r1.PwDf.
		Literature focusing on Vietnam
20.	Google Scholar	Banks, M. (2019). *Investigating disability-inclusion in social protection programs in low- and middle-income countries, with case-studies from Vietnam and Nepal* (London School of Hygiene and Tropical Medicine). Retrieved from http://researchonline.lshtm.ac.uk/id/eprint/4655981/%0A.
21.	Google Scholar	Long, G. (2012). Delivering social protection to the poor and vulnerable groups in Vietnam: Challenges and the role of the government. *ASEAN Economic Bulletin*, *29*(3), 245–258.

Code No.	Database	Publication Information
22.	Scopus	Banks, M., Walsham, M., Minh, H., Duong, D., Ngan, T., Mai, V., Blanchet, K., & Kuper, H. (2019). Access to social protection among people with disabilities: Evidence from Viet Nam. *International Social Insurance Review*, *72*(1), 59–82.
23.	Scopus	Palmer, M., & Thuy, N. (2012). Mainstreaming health insurance for people with disabilities. *Journal of Asian Economics*, *23*(0), 600–613.
24.	Scopus	Palmer, M. (2014). Inequalities in universal coverage: Evidence from Vietnam. *World Development*, *64*(0), 384–394.
25.	Scopus	Banks, M., Mearkle, R., Mactaggart, I., Walsham, M., Kuper, H., & Blanchet, K. (2016). Disability and social protection programs in low- and middle-income countries: a systematic review. *Oxford Development Studies*, *45*(3), 223–239.

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