

Comparative study of UHC implementation in Indonesia and Malaysia: Literature review

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ARTICLEINFO

Article history:

Received Sep 29, 2025

Revised Sep 3, 2025

Accepted Oct 9, 2025

Keywords:

Implementation

Indonesia

Malaysia

National Health Insurance

Universal Health Coverage

ABSTRACT

Universal Health Coverage Universal Health Coverage (UHC) is a key principle of an equitable health system, ensuring access to healthcare services without financial burden. Indonesia, with its National Health Insurance (JKN), and Malaysia, with its tax-based public healthcare system, have different approaches to implementation. This study compares the implementation of UHC in Indonesia and Malaysia, including the financing system, resource distribution, service coverage, and service quality. The study used a literature review with the PRISMA approach. From the total number of articles found in various databases, titles, abstracts, and inclusion-exclusion criteria were screened, leaving 15 relevant articles for analysis. Indonesia, through JKN, has covered a large portion of the population, but faces disparities in access, unequal distribution of healthcare workers, and high out-of-pocket costs for specialist services. Malaysia has near-universal coverage with subsidized public services and financial protection for poor households, although there is inequality between the public and private sectors. Indonesia needs to improve infrastructure, equitable distribution of healthcare workers, public education regarding active participation, and strengthened program management. Malaysia is advised to strengthen the integration of the public and private sectors and maintain progressive financing to reduce financial risks for poor households.

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INTRODUCTION

The Indonesian government has implemented the National Health Insurance (JKN) system as a commitment to Universal Health Coverage (UHC), ensuring access to healthcare services for all. Since its launch in 2014 and managed by BPJS Kesehatan, JKN has covered approximately 85% of the population, or 229.5 million people, by 2021 (Erlangga et al., 2019; Wahdi et al., 2023). However, in its implementation, various obstacles are still encountered, especially in eastern Indonesia, such as East Nusa Tenggara, Maluku, and Papuan (Anjelina & Dompok, 2023; Pratiwi et al., 2021). These challenges include limited infrastructure, unequal distribution of health workers,

low community participation, and weak monitoring and evaluation mechanisms. This indicates that despite regulatory guarantees, the reality on the ground does not fully reflect the principles of justice and equity in health services (Herawati et al., 2020; Pradana et al., 2022; Zhafarin et al., 2023).

Meanwhile, Malaysia implements a public healthcare system funded through general taxes. This system allows healthcare coverage to reach nearly 90% of the population, at affordable costs in public facilities (Anjelina & Dompok, 2023; Jauhar & Nadjib, 2024; Pratiwi et al., 2021). However, the country also faces challenges in maintaining quality service between the public and private sectors. Public facilities are often overloaded and budget-constrained, while private facilities, financed independently or through insurance, are more attractive to high-income earners because they offer faster and better-quality service (Balqis-Ali et al., 2021; Khor et al., 2021; Thomas et al., 2011).

Globally, UHC is a key agenda item in the Sustainable Development Goals. The WHO defines UHC as access for all individuals to the health services they need without financial burden (Perdana et al., 2022). UHC includes promotive, preventive, curative, rehabilitative, and palliative services throughout the life cycle (Plianbangchang, 2018). However, global outcomes still show significant gaps. Between 2000 and 2021, the proportion of the world's population without coverage for essential services decreased by 15%, but in 2021, approximately 4.5 billion people still lacked adequate access. Approximately 2 billion people experienced financial burden due to healthcare costs, and the COVID-19 pandemic exacerbated this situation in 92% of countries in 2021 and 84% of countries in 2022 (World Health Organization, 2025).

In Indonesia, JKN participants reached 248.77 million people by the end of 2022, with an active participation rate of 82.2% (Ministry of Health of the Republic of Indonesia, 2023). On the other hand, Malaysia exhibits a disparity between the public and private sectors in primary healthcare services. Approximately 64% of outpatients access public facilities, although only 28% of primary healthcare facilities are government-run. This situation is exacerbated by the migration of medical personnel to the private sector due to the high workload in the public sector. Malaysia's financing system is mixed, with major contributions from taxes (49% or MYR 38.6 billion in 2021), as well as from direct payments, insurance, and the corporate sector (Khor et al., 2021).

Universal Health Coverage (UHC) is an important pillar in realizing a fair health system, with guaranteed access to services without financial burden (Perdana et al., 2022). Indonesia and Malaysia are both committed to achieving UHC, but differ in their system structure, financing mechanisms, and service quality. Indonesia, through its National Health Insurance (JKN), faces challenges such as sustainable financing, uneven service distribution, and low participant satisfaction (Kosasih et al., 2022). In contrast, Malaysia, with its tax-based healthcare system, faces a gap between the public and private sectors and a high burden on public facilities (Risyanda, 2025).

These differences have implications for access and quality of services, particularly in remote areas. This research focuses on comparing the financing systems and structure of health insurance programs in the two countries, as well as examining service quality, including waiting times, accessibility, and patient satisfaction. Using a qualitative approach, the research explores in more depth the perceptions, experiences, and social contexts that influence UHC implementation.

Prior to the comparative analysis, a literature review was conducted to examine the current situation, identify empirical evidence, and identify gaps in previous research. This process ensures accurate, data-driven research, allowing for objective and comprehensive comparisons (Lim et al., 2022). Based on this, the purpose of this study is to compare the implementation of UHC in Indonesia and Malaysia through a literature review.

RESEARCH METHOD

The research method used in this study is a literature review. Literature reviews are useful for providing an overview of a particular research problem or issue, evaluating the development of

knowledge, establishing a research agenda, identifying research gaps, discussing specific issues, or developing theories (Lim et al., 2022; Sammon et al., 2024). In this study, the PRISMA (Preferred Reporting Items for Systematic Review and Meta-Analysis) approach was used (Page et al., 2021) to conduct a systematic review and search for articles related to the comparison between the implementation of UHC in Indonesia and Malaysia.

A literature search was conducted in Google Scholar, PubMed, and ProQuest using keywords related to UHC, Indonesia, Malaysia, implementation, comparison, healthcare financing, and access to healthcare. Initial results identified 3,160 articles from Google Scholar, 98 from PubMed, and 386 from ProQuest. After screening for title relevance, 25 articles were obtained. Abstract review and application of inclusion-exclusion criteria resulted in 20 articles, and a thorough evaluation of abstracts and research findings ultimately yielded 15 relevant articles.

Inclusion criteria included qualitative, quantitative, mixed-method research articles, or literature reviews focusing on the implementation or comparison of UHC in Indonesia, Malaysia, or ASEAN, published between 2020 and 2025, with Indonesian articles indexed in SINTA, Intercopunicus, or Scopus. Exclusion criteria included articles in proceedings or those not fully accessible. The selection of these 15 articles was used to compile a comparative discussion on service coverage, financing systems, resource distribution, efficiency, and challenges of UHC implementation in Indonesia and Malaysia. The following is a picture: *Screening Flow Diagram*:

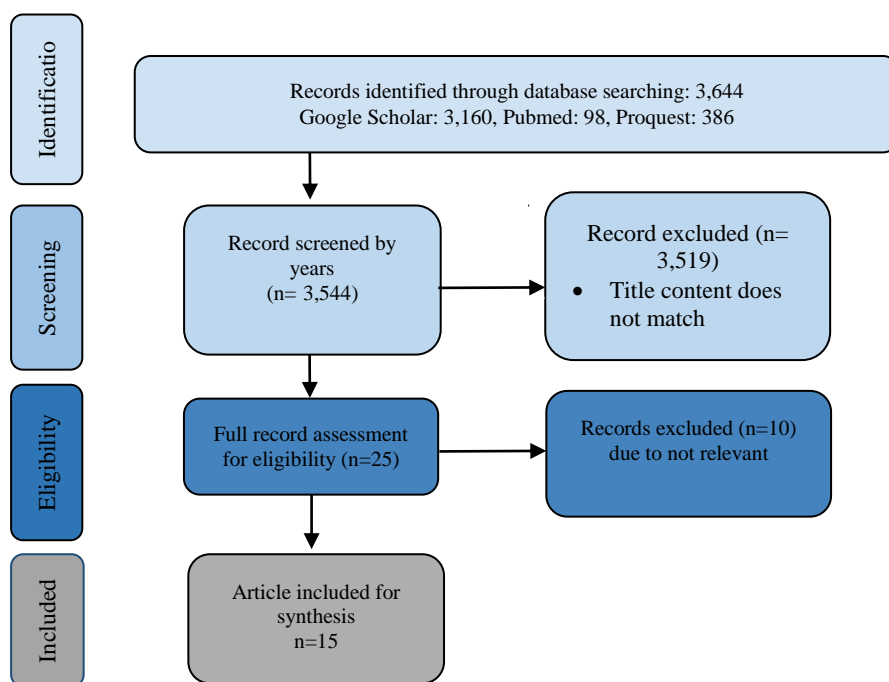


Figure 1. Screening flow diagram

RESULTS AND DISCUSSIONS

The following table presents a summary of the results of studies related to the implementation of Universal Health Coverage (UHC) in Indonesia and Malaysia from 2020 to 2024.

Table 1. UHC research results in Indonesia and Malaysia

No	Author (Year)	Article Title	Method	Results
1	Kanna et al. (2020)	Health service utilization by a semi-urban community in	Descriptive cross-sectional, April-May 2019, 112	The majority of respondents (80.3%) came from low-income households (B40). The majority (85.7%) used government

No	Author (Year)	Article Title	Method	Results
		Kedah, Malaysia	respondents, face-to-face interviews, Epiinfo 7.2 analysis	health services. The most common services were child health (52.6%) and maternal health (47.1%). The most common medical examinations included x-rays, electrocardiograms, and ultrasounds. The most frequent payments were for hospitalization, medications, and medical services. Satisfaction levels were quite high (80.4%).
2	Ramadhan et al. (2020)	Indonesia Universal Health Coverage Implementation on University Students	Questionnaire survey, 366 students of Bengkulu University, inductive approach	58.2% of students participate in JKN; parents play a crucial role. Some experienced "pseudo-UHC" due to delayed premium payments. 1.96% considered the program usurious and therefore did not participate. Implication: There is a need to improve student and parent understanding of active participation.
3	Ekawati & Claramita (2021)	Indonesian General Practitioners' Experience of Practicing in Primary Care under the Implementation of Universal Health Coverage Scheme (JKN)	Semi-structured interviews, phenomenological approach	JKN improves patient access to primary care, but general practitioners feel limited in resources, burdened by administration, and under-empowered. Systemic improvements are needed to optimize physician practice.
4	Hassan et al. (2022)	The Inequalities and Determinants of Households' Distress Financing on Out-of-Pocket Health Expenditure in Malaysia	Secondary analysis of NHMS 2019, 5,146 households, two-stage stratified random sampling, modified Poisson regression	Distress financing is low, most often interest-free loans (13.86%). It is higher in rural areas and poorer groups. The risk decreases with increasing economic status. Risk factors include the presence of elderly people and hospitalization.
5	Baharin et al. (2022)	Equity in Out-of-Pocket Payments for Healthcare Services: Evidence from Malaysia	Analysis of Household Expenditure Survey 2014-2015 data, 14,473 households, concentration curve and Kakwani Progressivity Index	OOP averaged 1.65% of household consumption. OOP increased from 1.03% in the poorest quintile to 1.86% in the richest quintile. OOP was progressive, with the highest expenditures for hospital services, followed by medical products, pharmaceuticals, and outpatient care. Progressiveness decreased compared to previous studies.
6	Nugraheni et al. (2022)	Factors Associated with Willingness to Pay for Cost-Sharing under Universal Health Coverage Scheme in Yogyakarta, Indonesia	Cross-sectional survey, direct interviews, bivariate analysis and logistic regression	Only 41.2% of participants were willing to pay for cost-sharing. Factors influencing this were gender, education, family size, occupation, individual and household income, service location, insurance coverage, and inpatient/outpatient status. The majority were unwilling to pay, influenced by socioeconomic factors and healthcare services.
7	Perdana et al. (2022)	Challenges And Implementation Of Universal Health Coverage Program In Indonesia	Qualitative research, literature review	Indonesia has been working towards achieving UHC through the National Health Insurance (JKN-KIS) since 2014. More than 40 million people remain unregistered. Challenges include

No	Author (Year)	Article Title	Method	Results
				disparities between provinces, uneven distribution of healthcare workers, and inadequate healthcare facilities. Recommendations include improving infrastructure, equalizing healthcare workers, and a commitment to reducing service disparities to accelerate the achievement of UHC.
8	Fairy Tale (2022)	Impact of Health Financing on Healthcare Quality and Affordability in Malaysia: A Conceptual Review	Conceptual study and literature review	Malaysia's healthcare system is supported by general taxes, SOCSO, the EPF (Employee Professional Facility), private insurance, and out-of-pocket payments (OOP). Public services are subsidized, while private services are expensive. There is no National Health Insurance, so public-private integration is lacking. Financial risks remain high for poor households paying out-of-pocket payments.
9	Zhafarin et al. (2023)	Analysis of the Effectiveness of UHC Implementation in Improving the Quality of Health Services in Indonesia	Literature review, 6 journals 2019-2023	UHC through the National Health Insurance (JKN) improves access, service quality, and financial protection. Barriers include limited infrastructure, uneven distribution of healthcare workers, and high premiums and drug prices.
10	Kaiser et al. (2023)	Extending universal health coverage to informal workers: A systematic review of health financing schemes in low- and middle-income countries in Southeast Asia	PRISMA systematic review, 156 publications (67 peer-reviewed, 89 grey literature), thematic analysis of the McIntyre & Kutzin framework	Many Southeast Asian countries face challenges with UHC due to high levels of informal workers. Fully subsidized tax-based schemes with mandatory coverage offer greater promise, reducing out-of-pocket costs, catastrophic expenditure, and increasing service utilization. Indonesia: Contribution-based National Health Insurance (JKN) challenges compliance and financial sustainability. Malaysia: A fully subsidized tax system is more effective in protecting informal workers because public services are affordable, equitable, and not dependent on contribution compliance.
11	Soraya et al. (2023)	Impact of the National Health Insurance Program (JKN) on Access to Public Health Services: A Comprehensive Analysis	Structured survey, interviews, FGD, 800 JKN respondents	Length of JKN membership influences service utilization; participants with more than 2 years are more likely to participate. Barriers to access include long waiting times and distance to facilities. Satisfaction levels are quite high, requiring quality improvement. Implications: Encourage long-term membership, reduce access barriers, and maintain service quality.
12	Liu et al. (2024)	Health system efficiency and equity in ASEAN: an empirical investigation	Empirical analysis, two-stage DEA, WHO and World Bank data 2011-2019	Malaysia is efficient and consistent in allocating resources due to stable economic growth and sustained investment. Indonesia has seen initial improvements in efficiency, but resource distribution remains uneven, with some regions over-concentrated and others underserved.
13	Manita & Afrita (2024)	Financing Accessibility in the	Normative legal literature	The right to health is guaranteed by law. JKN financing is divided into PBI (Public

No	Author (Year)	Article Title	Method	Results
		National Health Insurance Program		Health Insurance) and non-PBI (Non-PBI) programs. Implementation is limited in remote areas, with limited public awareness, and local governments bear part of the cost.
14	Suyanti et al. (2024)	Implementation of the Universal Health Coverage (UHC) Program in Indonesia	Normative research: statute & case approach; primary and secondary legal data	UHC, through BPJS Kesehatan, improves equitable access, service quality, and financial protection. Obstacles include limited funding, inadequate infrastructure, and program management. Effectiveness is influenced by inhibiting factors that need to be addressed.
15	Jauhar & Nadjib (2024)	The Role of Social Health Insurance in Achieving Universal Health Coverage in Asia: A Systematic Review	PRISMA systematic review, 768 articles were analyzed into 37 studies	Indonesia: JKN covers approximately 85%, with a target of 100% coverage by 2025. Challenges: infrastructure gaps, limited healthcare workforce, high OOP for specialist services. Malaysia: nearly universal primary care, limited specialist access, high OOP for private services.

Based on a literature review of 15 articles, the implementation of Universal Health Coverage (UHC) shows differences in characteristics and challenges between Indonesia and Malaysia.

Service Coverage and Utilization

In Malaysia, public healthcare is nearly universal and largely subsidized, with high utilization for child and maternal health and relatively high levels of satisfaction (Dongen, 2022; Kanna et al., 2020). This system allows B40 communities to access services equally, although integration with the private sector is still limited (Kanna et al., 2020). Meanwhile, Indonesia, through the National Health Insurance (JKN), has covered approximately 85% of the population with a target of 100% coverage by 2025. However, it still faces gaps in access, limited healthcare workers, and geographical and administrative barriers that affect service utilization, including among students and existing JKN participants (Ekawati & Claramita, 2021; Jauhar & Nadjib, 2024; Ramadhan et al., 2020; Soraya et al., 2023; Suyanti et al., 2024).

UHC is inclusive and emphasizes the provision of quality health services throughout the life course, including reproductive, newborn, maternal, and child health, communicable and non-communicable diseases, and service capacity and access. The UHC Service Coverage Index (SCI) measures this coverage through 14 tracking indicators for each country (World Health Organization, 2023). In Indonesia, the National Health Insurance (JKN) strives to provide comprehensive services covering promotive, preventive, curative, and rehabilitative care for all citizens. Participants can access services at Primary Health Facilities (FKTP) such as community health centers (Puskesmas), clinics, private practice physicians, and primary hospitals, and are referred to Advanced Referral Health Facilities (FKRTL) if needed (Wiasa, 2022). This system ensures equitable access, although geographical challenges, distribution of health workers, and gaps in facilities remain obstacles.

Malaysia has a dual healthcare system: public, private, and NGOs (Merican & bin Yon, 2002; Sebastian et al., 2016). The Ministry of Health (MOH) is responsible for public services, which are heavily subsidized, with outpatient costs ranging from RM1–RM5 and inpatient costs ranging from RM3–RM80 per day, applicable to all citizens (Chua & Cheah, 2012; Yu et al., 2008). The private sector serves high-income populations, offering primary, specialty, and complementary services. NGOs play a role in specific patient education and support. This system has enabled Malaysia to achieve universal health coverage (UHC) since the 1980s (Noor & Mudaris, 2021).

Financing System

In Malaysia, household distress financing is low and OOP averages only 1.65% of household consumption, increasing progressively with the highest income quintile, and is highest for hospital services (Baharin et al., 2022; Hassan et al., 2022). Tax-based and fully subsidy schemes have been proven to protect informal workers and reduce financial risks (Kaiser et al., 2023). In contrast, in Indonesia, the majority of JKN participants are unwilling to pay for cost-sharing, while OOP costs remain high for specialist services. Contribution-based schemes face challenges in compliance and financial sustainability (Jauhar & Nadjib, 2024; Kaiser et al., 2023; Nugraheni et al., 2022).

UHC financing is designed to be affordable, protect people from financial burden, and support the availability of essential medicines and technologies (World Health Organization, 2020). In Indonesia, the National Health Insurance (JKN) uses a contribution-based social insurance system managed by the BPJS Kesehatan (Social Security Agency for Health) based on the principle of mutual cooperation (Saputro & Fathiyah, 2022; Wiasa, 2022). Participants consist of several groups, including Contribution Assistance Recipients (PBI) whose contributions are covered by the government, wage-earning workers whose contributions are shared between their employers and participants, and non-worker participants whose contributions are differentiated by service class. This scheme ensures financial protection for all participants, including those with disabilities, and supports the sustainability of national health services (Minister of Finance of the Republic of Indonesia, 2018; Wiasa, 2022).

In Malaysia, healthcare funding comes from a combination of public and private sources. Public sources include taxes paid to the central and local governments, social security funds, and other public institutions. Meanwhile, private sources include out-of-pocket (OOP) payments by individuals, private health insurance premiums, contributions from employers, and non-profit organizations and other entities. Of this total funding, the Malaysian Ministry of Health (MOH) is the largest contributor, accounting for 49% of total healthcare expenditure (Total Expenditure on Health/TEH), or approximately MYR 38.6 billion in 2021 (Khor et al., 2021).

Resource Distribution and Efficiency

Malaysia's health system is relatively efficient in resource allocation and its distribution is quite equitable due to stable economic growth and continuous investment (Liu et al., 2024). On the other hand, in Indonesia, the distribution of healthcare workers is uneven, with some areas underserved and others over-concentrated. General practitioners also face a high administrative burden, sometimes limiting the effectiveness of primary care (Ekawati & Claramita, 2021; Liu et al., 2024; Perdana et al., 2022).

An effective health system requires sufficient, trained and motivated health workers, adequate service capacity, early detection, education and rehabilitation of patients, and cross-sectoral support such as transportation, education and urban planning (World Health Organization, 2020). In Indonesia, BPJS Kesehatan (Social Security Agency for Health) collectively manages participant contributions to support the distribution of services across regions. Primary health care (FKTP) serves as the frontline of services, while primary health care (FKRTL) handles complex referral cases. Service efficiency is maintained through quality control, cost control, and payment systems, but the distribution of healthcare workers and facilities remains uneven, resulting in some areas being underserved (Saputro & Fathiyah, 2022; Wiasa, 2022).

Malaysia's public sector excels in comprehensive services compared to the private sector, providing specialized services such as prenatal checkups, immunizations, child development monitoring, palliative care, and access to a more comprehensive laboratory. Public clinics typically operate as multidisciplinary teams, with healthcare professionals being the patient's first point of contact and responsible for treatment and follow-up of primary health issues, while the private sector focuses more on curative services. However, doctors in the private sector are more active in

providing health education due to the lighter patient load, although fewer than half of primary care clinics have their own X-ray facilities (Ong et al., 2022).

Implementation and Policy Challenges

Indonesia still faces more than 40 million unregistered residents, limited infrastructure, low outreach in remote areas, and program management that needs strengthening. Participants' and families' understanding also affects active participation in the National Health Insurance (JKN) (Manita & Afrita, 2024; Perdana et al., 2022; Ramadhan et al., 2020; Suyanti et al., 2024). In Malaysia, although the fully subsidized tax system has successfully protected informal workers, the progressivity of OOP has declined and integration between the private and public sectors remains a challenge (Dongen, 2022; Kaiser et al., 2023).

To achieve UHC, countries need to ensure a strong health system, affordable financing, availability of medicines and technology, adequate health workers, and cross-sectoral support (World Health Organization, 2020). Indonesia still faces significant challenges: more than 40 million people are not yet registered for the National Health Insurance (JKN), the distribution of healthcare workers and facilities is uneven, and program outreach in remote areas is low. Participants' understanding of their rights and obligations also impacts active participation. Some services continue to use cost-sharing, while a penalty system is in place for unpaid contributions, with a maximum limit of IDR 30,000,000 (Ministry of Health, 2022; Wiasa, 2022).

High out-of-pocket payments, a growing elderly population, low health literacy, and rising drug prices are key challenges (Hassali et al., 2015; Khor et al., 2021). Barriers to access in the public sector arise from waiting times, transportation, and patient dissatisfaction. The private sector is flexible, but services are not always coordinated, necessitating policy strengthening to ensure equitable and high-quality UHC (Khor et al., 2021; Ong et al., 2022).

CONCLUSION

In general, Malaysia's UHC system demonstrates near-universal coverage with subsidized public services, high utilization of maternal and child health, efficient resource allocation, and strong financial protection for poor households and informal workers. In contrast, Indonesia, through the National Health Insurance (JKN), has covered a large portion of the population, but still faces disparities in access, uneven distribution of healthcare workers, high out-of-pocket costs for specialist services, and challenges in contribution compliance and program management. Indonesia needs to improve infrastructure, ensure equitable distribution of healthcare workers, promote public awareness and education regarding active participation, and strengthen program management to optimize UHC coverage. Malaysia is recommended to strengthen integration between the public and private sectors and maintain progressive financing to reduce financial risks for poor households.

ACKNOWLEDGEMENTS

I would like to thank my family for their continued support and prayers. I also extend my gratitude to my friends and everyone who has helped and encouraged me throughout this research, ensuring its successful completion.

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