SMERU RESEARCH REPORT NO. 3/2024

POLITICAL ECONOMY ANALYSIS OF HEALTH FINANCING REFORMS IN TIMES OF CRISIS: IDENTIFYING WINDOWS OF OPPORTUNITY FOR COUNTRIES IN THE SEA REGION

INDONESIA CASE STUDY REPORT

Nurmala Selly Saputri, Arif Budi Darmawan, Nina Toyamah, Rizki Fillaili

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The SMERU Research Institute
August 2024

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Authors: Nurmala Selly Saputri, Arif Budi Darmawan, Nina Toyamah, Rizki Fillaili

Editor: Liza Hadiz

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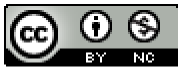

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Research Team

SMERU Researchers

Nurmala Selly Saputri

Arif Budi Darmawan

Nina Toyamah

Rizki Fillaili

Interns

Davyna Melvionita Nandini

Zaki Mubarok

Advisors

Asep Suryahadi

Athia Yumna

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Abstract

Political Economy Analysis of Health Financing Reforms in Times of Crisis: Identifying Windows of Opportunity for Countries in the SEA Region
Indonesia Case Study Report

Nurmala Selly Saputri, Arif Budi Darmawan, Nina Toyamah, Rizki Fillaili

Previous crises have opened a window of opportunity for countries to enact reforms and policies that dramatically expand health coverage and improve the health of their populations. Indonesia has gone through a multitude of crises, especially in the economic sector. This study aims to understand the influence of these crises on the political economy dynamics that facilitated changes in the health system and the various strategies pursued to move forward reforms. The study used retrospective assessments using a Political Economy Analysis framework. Data collection was carried out through literature reviews (including media tracking) and in-depth interviews with eight selected key informants from September to October 2023. This study found that the watershed moment in Indonesia's health financing history was the Asian Financial Crisis (AFC) of 1997/1998. The crisis not only caused an expansion of financial protection for the poor but also instigated the establishment of a legal framework for social security, including the National Health Insurance (JKN), that extended to the entire population. The launch of JKN involves various stages of law and policymaking processes. The deliberative process of the laws consisted of contested ideas and interests, including strategic actions and collaboration by key actors involved. One of the key successes of this reform was the presence of a change team comprising diverse stakeholders, including civil society organizations, academics, external organizations, parliamentary members, and the mass media. These stakeholders recognized the urgency of implementing health and security protection schemes for the general populace, the impoverished, and vulnerable groups, as a preemptive measure against potential future crises. Furthermore, throughout the reform process, the presence of technical assistance from international organizations also played a pivotal role.

Keywords: political economy analysis, health financing reform, Asian Financial Crisis, Jaminan Kesehatan Nasional

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List of Abbreviations

ADB		Asian Development Bank
AFC		Asian Financial Crisis
APBD	Anggaran Pendapatan dan Belanja Daerah	Regional Revenue and Expenditure Budget
ASEAN		the Association of Southeast Asian Nations
Askeskin	Asuransi Kesehatan Masyarakat Miskin	Health Insurance for the Poor
BPJS Kesehatan	Badan Penyelenggara Jaminan Sosial-Kesehatan	Social Security Implementing Agency on Health
CHE		current health expenditure
DALYs		disability adjusted life years
DJSN	Dewan Jaminan Sosial Nasional	National Social Security Council
FES		Friedrich-Ebert-Stiftung
FKKBN	Forum Konsultasi dan Komunikasi Bipartit Nasional	National Bipartite Consultation and Communication Forum
GDP		gross domestic product
GoI		Government of Indonesia
GIZ		Gesellschaft für Internationale Zusammenarbeit
GTZ		Deutsche Gesellschaft für Technische Zusammenarbeit
ILO		International Labour Organisation
IMF		International Monetary Fund
INA-CBGs		Indonesian case-based groups
Jamkesda	Jaminan Kesehatan Daerah	Regional Health Insurance
Jamkesmas	Jaminan Kesehatan Masyarakat	Community Health Insurance
JKN	Jaminan Kesehatan Nasional	National Health Insurance
JPK Gakin	Jaminan Pemeliharaan Kesehatan bagi Keluarga Miskin	Health Financing Mechanisms for Poor Families
JPKM	Jaminan Pemeliharaan Kesehatan Masyarakat	Community Health Insurance

JPS	Jaring Pengaman Sosial	Social Safety Net
JPS-BK	Jaring Pengaman Sosial-Bidang Kesehatan	Social Safety Net for the Health Sector
KAJS	Komite Aksi Jaminan Sosial	Social Security Action Committee
Kementerian PPN/Bappenas	Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan dan Pembangunan Nasional	Ministry of National Development Planning/National Development Planning Agency
KII		key informant interview
MPR	Majelis Permusyawarahan Rakyat	People's Consultative Assembly
NSSA		National Social Security Act
PDPSE-BK	Penanggulangan Dampak Pengurangan Subsidi Bahan Bakan Minyak-Bidang Kesehatan	Mitigating the Impact of Reduced Energy Subsidies in the Health Sector
PBI	penerima bantuan iuran	premium assistance beneficiaries
PEA		political economy analysis
PKPS-BBM	Program Kompensasi Pengurang Subsidi Bahan Bakar Minyak	Health Sector Fuel Subsidy Reduction Compensation Program
puskesmas	*pusat kesehatan masyarakat*	community health center
RPJMN	Rencana Pembangunan Jangka Menengah Nasional	Five-Year National Medium-Term Development Plan
RPJPN	Rencana Pembangunan Jangka Panjang Nasional	National Long-Term Development Plan
SSIA		Social Security Implementing Agency
UHC		Universal Health Coverage
WHO		World Health Organization

Executive Summary

As societies grapple with the health and economic fallout of COVID-19, questions are raised about the trajectories their health systems will take. Previous crises have opened a window of opportunity for countries to enact reforms and policies that dramatically expand health coverage and ultimately improve the health of their populations. In addition to health-related crises, such as the COVID-19 pandemic, Indonesia has gone through a multitude of crises, especially in the economic sector. There is a need to understand the influence of these crises on the political economy dynamics that facilitated changes in the health system and the various strategies pursued to move forward reforms. This research will analyze and discuss relationships between health financing reform, particularly JKN, and the crises that occurred in Indonesia, such as the 1997/1998 Asian Financial Crisis (AFC) and the 2008 Global Crisis. Understanding these reform dynamics, including the relevant stakeholders, and their power, position, and influence in the reform process, can help to inform current reform leaders. Furthermore, reflections can be made in terms of the strategic compromises made as a result of political dynamics and how they impacted reform outcomes.

The study employed two main data collection methods, namely literature reviews and in-depth interviews with selected key informants. As the reform was implemented before 2014, the study used a restrospective study design, using a political economy analysis framework. The literature review focused on published documentation and media tracking. This study also employed media tracking from online media. For the interviews, a total of eight interviews were conducted to capture perspective, as well as roles, interest, and power of each stakeholder. Stories, information, and views from informants are carefully triangulated through the document review and media tracking.

Asian Financial Crisis and Its Impact on Indonesia

Historically, Indonesia had been hit by economic crises several times, but the AFC was the biggest and had the most significant impact. Around the same period as the AFC, Indonesia was also facing a series of natural disasters in rapid succession. These included widespread rice harvest failures in numerous regions due to an extended and intense dry season, infestations of crop pests, and extensive forest fires in Kalimantan. Additionally, mid-May 1998 witnessed riots that swept through many cities, leading to the ousting of President Suharto. Subsequently, this tumultuous period saw the separation of East Timor Province from Indonesian territory. The crisis during 1997/1998 was characterized by the fall of gross domestic product (GDP) by 13.1%, the collapse of the exchange rate against the US dollar, high inflation, and the poverty rate soaring to 27.1%. The AFC also had a direct impact on health financing and health service utilization in Indonesia. As many households experienced a reduction in their purchasing power during the crisis, access to health facilities also became challenging. Waters, Saadah, and Pradhan (2003) identified a significant decrease of health care utilization in government and private health facilities.

The watershed moment in Indonesia's health financing reform was the 1997/1998 AFC. The crisis not only caused an expansion of financial protection for the poor but also

instigated the establishment of a legal framework for social security that extended to the entire population. For this reason, we decided to select the period of 1997 to 2014 as a focus of our case study.

Main Health System and Health Financing Reforms

Before delving into the impact of the crises on health financing reform, this study first looks at the reforms in Indonesia's health system, particularly the six following reforms.

a) Shift to Health Promotion and Disease Prevention (1993)

The Government of Indonesia (GoI), under the leadership of Dr. Adhyatma as minister for health from March 1988 to March 1993, underwent a strategic shift in its healthcare priorities, transitioning from a predominantly curative health orientation to a focus on preventive and promotive heath strategies. Previously, the GoI predominantly emphasized the curative aspect of healthcare. However, since Dr. Adhyatma served as minister for health, he prompted a shift toward increased investment in public health services. While the significance of health promotion and disease prevention had been well-established, according to the latest data, the allocation for preventive and promotive interventions remained low. Resources earmarked for promotive and preventive intervention were 26% of the total budget allocation (Ministry of Health, 2018).

b) Decentralization and Health Financing (2001)

In January 2001, Indonesia embarked on a policy shift that was considered quite radical, transitioning from a centralized governance system to a decentralized one. This transformation was driven by multiple compelling factors, including the 1997/1998 AFC. Literatures posit that international organizations, such as the World Bank and the International Monetary Fund (IMF), played a pivotal role in influencing the decisions of policymakers to adopt decentralization. However, over a span of more than two decades following its implementation, its efficacy in the health sector varied. Factors such as different fiscal capacities, competing policy priorities, and the different characteristics of the local leaders significantly influenced the degree of success in decentralization efforts.

c) Financial Protection for the Poor (1997–2014)

The GoI has implemented a series of social protection for the poor in the country, including to protect their access to health services. The social protection system for the poor in Indonesia began with the implementation of the Health Card Program in 1994. The program provided full subsidy for poor households to pay for medical expenses at the community health center (*puskesmas)*. However, its execution was halted because of regional disparities in delineation of eligible recipients (Johar, 2009). Subsequently, the GoI implemented the Social Safety Net (JPS) program that was designed to mitigate the impact of the 1997/1998 AFC. Under the JPS program, poor people received social security and assistance across diverse domains, encompassing nutrition, employment, education, and healthcare.

After the year 2000, as the crisis situation failed to improve and there was a surge in fuel prices, the government initiated a program called Mitigating the Impact of Reduced

Energy Subsidies in the Health Sector (PDPSE-BK). The benefits of this program were similar to those of Social Safety Net for the Health Sector (JPS-BK), except that it removed the food and supplements for pregnant women and replaced it with hepatitis B vaccines and eye care. Over the period from 2002 to 2004, this program underwent a transition, becoming known as the Health Sector Fuel Subsidy Reduction Compensation Program (PKPS-BBM). In addition, alongside the decentralization policy in 2001, there was a gradual increase in the number of regions offering Regional Health Insurance (Jamkesda) funded by local budgets. A survey conducted by The SMERU Research Institute in 2012 revealed that out of 262 *kabupaten* (districts) surveyed, 245 had instituted some form of local health financing scheme (Aspinall, 2014).

Concurrently, in 2003, the government undertook an experimental implementation of another health protection called Health Financing Mechanisms for Poor Families (JPK Gakin) in 15 *kabupaten*. Within the JPK Gakin model, health sector subsidies were not distributed directly to health service providers. Rather, these subsidies were administered through the Health Insurance Implementing Agency (Bapel JPK). Because of adaptation to the context of local demand, the JPK Gakin program was more responsive than the previous centrally administrated one. The local leaders showed their initiative in promoting universal health coverage in their *kabupaten*.

Following the enactment of Law No. 40 of 2004 on the National Social Security Act (NSSA), a significant change took place in the form of the transformation of the PKPS-BBM initiative to a healthcare insurance program named Health Insurance for the Poor (Askeskin) program, which was under the administration of PT[i] Askes. Additionally, commencing in the year 2008, the Community Health Insurance (Jamkesmas) program was introduced, signifying a further evolution from the JPS-BK and Askeskin. In implementing Jamkesmas, PT Askes no longer had a role in managing the finances and membership of the program. In 2014, Jamkesmas and Jamkesda were integrated into the National Health Insurance (JKN) program managed by the Social Security Implementing Agency (SSIA) on Health (BPJS Kesehatan).

d) The National Social Security Act (NSSA 2004)

In 2004, the GoI enacted Law No. 40 of 2004, which established the NSSA, marking an important step toward providing comprehensive social protection to its citizens. This law was designed to cover five types of social security programs, i.e., health insurance, work-related accident insurance, older persons' insurance, retirement savings with disability benefits, and death benefits. The implementation of this reform is widely acknowledged as a significant milestone in the realm of health financing. The development of NSSA concept adopted the participatory welfare state concept where the state cooperates with the people to provide a social security system (*Kompas*, 2004c).

e) Mandatory Spending in Law No. 36 of 2009 on Health

In 2009, the GoI introduced a new legislation, Law No. 36 of 2009 on Health, which brought a notable change in the government's commitment to allocating healthcare budgets within the country. Under Law No. 23 of 1992 on Health, it was stipulated that

[i]PT means limited liability company/for profit oriented.

"the implementation of health efforts would be funded by the government and/or the public." However, with Indonesia's embrace of the decentralization paradigm, Law No. 36 of 2009 mandated that the governments allocate a minimum of 5% of the state budget and 10% of regional budgets to the health sector. This compulsory allocation aimed to address issues of regional-level social and economic disparities. However, this policy became outdated following the introduction of a new legislation by the GoI, Law No. 17 of 2023. The new enacted Health Law of 2023 eliminates the necessity for budget allocation previously mandated.

f) The Establishment of SSIA on Health and JKN (2011–now)

The creation of the SSIA on Health was one of the mandates of NSSA in 2004. Preceding the inception of the SSIA on Health, Indonesia had at least three separate health insurance management entities. The first, PT Askes, primarily catered to civil servants, while PT Jamsostek oversaw health insurance for employees in the private sector, and ASABRI concentrated on providing and managing health insurance for military and police personnel. These fragmented health insurance schemes underwent a substantial consolidation, and were merged fundamentally into a single public entity known as BPJS (SSIA) in 2011. Different from its predecessors, the SSIA on Health is structured as a nonprofit institution, in compliance with the stipulations of the NSSA Law.

Political, Social, and Economic Contexts of the 2014 UHC Reform/JKN Creation

As previously noted, the 1997/1998 AFC became an inflection point of many transformations in Indonesia's government system. During this period, the government embarked on an unprecedented endeavor to expand healthcare coverage for individuals with low incomes (Pisani, Olivier Kok, and Nugroho, 2016). After Indonesia went through the crisis, policymakers initiated a contemplation of the imperative of establishing a social protection system. The government became more aware of the national social security system and was willing to protect all of its population from the potential of shock in the future (Sumodiningrat, 1999). The fourth president of Indonesia, Abdulrahman Wahid, and his vice president, Megawati Soekarnoputri, started the reform process (Pisani, Olivier Kok, and Nugroho, 2016; Suryahadi, Febriany, and Yumna, 2014). The initial step in the reform of Indonesia's social security system took the form of an amendment to Article 34 of the 1945 Constitution by the People's Consultative Assembly (MPR) in 2001. This constitutional amendment marked the inception of a legal foundation for social security in Indonesia.

The formation of the social security system in Indonesia was a continuous process. When Megawati succeeded Abdurrahman as the president, the social security reform became her priority (Pisani, Olivier Kok, and Nugroho, 2016). Megawati formed an NSSA task force, which consisted of 17 members from government institutions and universities/academics, to draft the NSSA concept. Subsequently, in 2002, through Presidential Decree No. 20 of 2002, President Megawati established a task force dedicated to draft the NSSA Law. This task force had the authority to prepare draft legislations and to support academic papers for the NSSA. It had received technical assistance and financial support from international

development partners. Comprising 60 members, the NSSA task force encompassed diverse stakeholders, including healthcare workers' associations, the Ministry of Finance, members of the parliament, and academics (Bazyar et al., 2021; Pisani, Olivier Kok, and Nugroho, 2016). Subsequently, the first version of NSSA conceptualized the establishment of a single-payer nonprofit insurance system that also implied a fusion of the previous four state-owned insurances (Pisani, Olivier Kok, and Nugroho, 2016). This draft legislation catalyzed extensive debate during the deliberation process. The first version of NSSA Law, legalized in 2004, had no details of contribution levels, copayment percentages, and benefits packages or sanctions. The details of NSSA had to be passed within five years (Pisani, Olivier Kok, and Nugroho, 2016).

After the NSSA Law passed, the creation of the SSIA encountered substantial delays. Wisnu (2012) documented that within the agenda of the incumbent government, there existed a deliberate effort to put aside discussions concerning the implementation of the NSSA Law. The formation of the National Social Security Council (DJSN), entrusted with the role of facilitating the president in crafting overarching policies and coordinating the execution of the national social security system, was only realized in September 2008. Concurrently, the legislation associated with the SSIA was not promulgated until November 2011. Consequently, the implementation of the social health insurance through SSIA was not carried out until January 2014.

The discussion on the conceptual formulation of the SSIA Law started in April 2006. The process involved various actors, from bureaucrats to civil society organizations. The Coordinating Ministry for People's Welfare took the lead in orchestrating a series of meetings that brought together multiple ministries, experts, academics, and health insurance administrators. These meetings resulted in the formulation of the SSIA Law in January 2008. Approaching the 2009 deadline for the enactment of supplementary implementing legislation, it appeared that Indonesia's aspirations for social security might have remained unrealized. In response to this deadline, both parliamentarians and civil society groups intensified their efforts (Pisani, Olivier Kok, and Nugroho, 2016). In July 2010, the parliament (DPR) convened a plenary session to endorse the draft bill on the SSIA. Subsequently, deliberations on the draft bill ensued, involving the parliament and representatives from other five ministries, including the Ministry of Finance, Ministry of State-Owned Enterprises, Ministry of Social Affairs, Ministry of Administrative and Bureaucratic Reform, as well as Ministry of Law and Human Rights.

The political dynamics in the deliberations over the SSIA bill between the parliament and other government representatives were characterized by significant challenges. The process was marked by protracted debates and difficulties to reach an agreement. Therefore, until March 2011, the discussion of the draft law was deadlocked. However, in October 2011, the demand from SSIA supporters became stronger, prompting the parliament and the government to make more serious, transparent, and rapid efforts to complete the SSIA bill. After being pressed by the representatives of the Social Security Action Committee (KAJS), an assembly of civil society actors, in October 2011, the chairperson of the parliament and the chairperson of the SSIA Special Committee made a pivotal commitment in October 2011 by endorsing a statement. In this statement, they pledged to immediately advance the ratification of the SSIA bill through a dedicated

forum designed to facilitate the finalization of the SSIA bill in collaboration with the government. Finally, the parliament and the government agreed to sign the SSIA bill which was then ratified and enacted as Law No. 24 of 2011 on 25th November 2011.

This study examines the strategies and approaches used by key actors to pursue health financing system reform, which consist of the following:

a) **Conduct comprehensive generation of evidence** lead by academics and international organizations to provide optimal recommendations for the health insurance framework.
b) **Seize political opportunities** to realize the UHC system.
c) **Facilitate strategic collaboration among the change team,** involving multiple sectors and partners.
d) **Invite key actors to dialogue** to find input and solution. This strategy has been sought by the GOI on various occasions, as the reluctance to embrace social health insurance often arises from a lack of understanding and ignorance.
e) **Persist in reform initiatives** despite the challenges posed by the 1997/1998 AFC, which significantly impacted the socioeconomic landscape of the country. This resilience underscores the strength of the country's political systems in navigating adversities.
f) **Pursue strategic leveraging of external support.** The roles of international organizations varied, ranging from the provision of technical assistance to the allocation of financial resources for the execution of health programs.
g) **Hold public engagements** to empower the community to articulate its needs and advocate for governmental intervention and the provision of a comprehensive social security across all strata of society.

Lessons Learned

By conducting a thorough review of the political economy dynamics surrounding the establishment of social health insurance in Indonesia, several key insights have been unearthed. These serve as valuable lessons for shaping future transformations within the healthcare system post-COVID-19 pandemic.

a) Institutionalizing the Reform in Law

The health financing reform in Indonesia was initiated by the leader's strong awareness of the importance of providing social security system in the country. The initiative came from former President Megawati, who then appointed around 60 people to formulize the design. Moreover, initiative and commitment came from the parliamentary members who took over the process of establishing the SSIA Law when it was delayed during the Yudhoyono presidential era.

b) Creation of Coalition of Supportive Actors (Change Team)

One of the key successes of the health financing reform in Indonesia was the presence of a change team comprising diverse stakeholders, including civil society organizations, academics, external organizations, parliamentary members, and the mass media. The role of this change team was more pronounced after the NSSA Law finished and the government was in charge of creating technical regulations. In this study, we found that the pivotal contribution of academics and international agencies in improving the interest groups' (formal and informal working groups) understanding of social health insurance helped to alter the interest groups' positions from opposing the idea to supporting the reform. Beyond the formation of the change team, an intriguing aspect for discussion is the multifaceted factors influencing the change team's consistent advocacy for the government's realization of social security, including social health insurance.

c) Internal and External Influence

This study shows the strategic role that academics have in providing evidence based on experience and international literature that is accurate and valid so that the transformation of health insurance receives strong support from various parties. Throughout the reform process, the presence of technical assistance played a pivotal role. International organizations, notably GIZ (previously known as GTZ), played a significant role by collaborating with the office of the coordinating minister for people's welfare in 2006 to produce a report on Social Security System Reform in Indonesia. Additional development partners such as ILO, the World Bank, and initiatives like PNPM, in conjunction with TNP2K, conducted public dialogues to identify government projects and programs that could be coordinated and synergized with the NSSA Law.

d) Decentralization

The implementation of decentralization and regional autonomy emerges as a formidable challenge in the establishment of a comprehensive social security framework, notably within the domain of social health insurance. In response to the request proffered by representatives of regional governments, the Constitutional Court undertook a judicial review of Law No. 40 of 2004 vis-à-vis the 1945 Constitution. The trial, characterized by its comprehensive nature, featured the testimonies of experts spanning diverse fields such as law, economics, insurance management, public health, and actuarial science whose insights were solicited to inform the ensuing decision-making process. The outcome of the judicial review delineated that the mandate for administering the national social security system resides jointly within the scope of both the central and regional governments. Consequently, local governments should continue providing regional health insurance in strict adherence to the principles of decentralization and regional autonomy.

I. Background to the Study

1.1 Introduction

As societies grapple with the health and economic fallout of COVID-19, questions are raised about the trajectories their health systems will take. Previous crises have opened a window of opportunity for countries to enact reforms and policies that dramatically expand health coverage and ultimately improve the health of their populations (e.g., Argentina, Turkey, Thailand, and South Korea) (Bazyar et al., 2021; Bertone, Pholpark, and Witter, 2022; Cavagnero, 2008; Lee, 2003; Yıldırım and Yıldırım, 2011). These crises can raise public awareness of a problem by changing perceptions around reforms or can shift the position of key stakeholders, but as theory tells us, the precise policies and politics will ultimately need to come together to move reform forward.

In addition to health-related crises, such as the COVID-19 pandemic, Indonesia has gone through a multitude of crises, especially in the economic sector. There is a need to understand the influence of these crises on the political economy dynamics that facilitated changes in the health system and the various strategies pursued to move forward reforms. The impact of the crisis to the health system reform is particularly relevant in the Southeast Asia Region, where some countries have made good progress toward Universal Health Coverage (UHC), but many countries' health financing systems still fail to ensure adequate financial protection to large shares of their populations (World Health Organization, 2023b). In conducting an analysis of this impact, lessons can be garnered for this current moment, with the objective of building a stronger and more resilient health system well into the future.

1.2 Political Economy of Health Financing

Over the past two decades, many governments have sought to promote equitable access to quality health services by reforming their health financing policies and expanding effective coverage policies. A broad international agreement on the importance of UHC has not translated easily into the implementation of related health financing reform. A health financing reform that focuses on expanding effective coverage involves complex interactions between a range of stakeholders in the health sector and beyond, who have varying power and influence. Added to this are dynamic economic factors that directly impact feasible reform options. This can make reform politically contentious and difficult to move forward to adoption and implementation.

Extensive literature has reported the significance of political economy factors in shaping the trajectories of health financing reform (Box 1). Political economy analysis (PEA) approach involves not only an examination of the distinctive contextual (structural) determinants specific to each country, but also an evaluation of relevant stakeholders, encompassing their power/influence, position, and interests in health financing reform, as well as the formal and informal institutions that facilitate their interactions (Sparkes et al., 2019). The objective of political economy analysis is to elucidate the interplay between

political and economic dynamics within a society. PEA aims to evaluate the influence and standing of key political actors (stakeholders) as a means to formulate strategies for altering the political viability of desired reforms (Sparkes et al., 2019). With this strategic and pragmatic objective in mind, this study aims to apply a political economy perspective to the analysis of the health financing reform process in Indonesia.

Health financing reform is not new to Indonesia. The introduction of the National Health Insurance (JKN) program in 2014 is an example of a large-scale reform that sought to expand coverage and completely overhaul the health financing landscape in Indonesia. This research will analyze and discuss relationships between health financing reform, particularly JKN, and the crises that occurred in Indonesia, such as the 1997/1998 Asian Financial Crisis (AFC) and the 2008 Global Crisis. Understanding these reform dynamics, including the relevant stakeholders, and their power, position, and influence in the reform process can help to inform current reform leaders. Lessons can also be learned from the reform strategies taken that either leveraged political support or overcame political challenges. Furthermore, reflections can be made in terms of the strategic compromises made as a result of political dynamics and how they impacted reform outcomes. In addition, analyzing the 2014 reform process from a political economy perspective, and the approaches it used to successfully create the largest single-payer in the world, can offer key lessons related to strategies to either overcome or take advantage of the political economy dynamics that can be synthesized and shared across countries.[1]

1.3 Study Objective

The main objective of the research is to equip the World Health Organization (WHO) and the Ministry of Health with retrospective assessment of the political economy dynamics involved in health financing reform plans in Indonesia. The focus on strengthening the primary care level of care in Indonesia's current reform agenda involves multiple directorates as well as multisectoral coordination, which is inherently political. The areas identified as key levers for health financing transformation toward strengthened primary care services—specifically Public Financial Management and strategic purchasing—will have implications for many stakeholders across the health sector and beyond. As part of the assessment processes, the political economy analysis will be embedded to understand the various stakeholders and their relative power and position on potential reform proposals, as well as the institutional processes that will need to be activated. This political economy dimension is particularly important given the Ministry of Health's goal of rebalancing public expenditures to have a greater weight on primary care as compared to secondary/tertiary care. Past reform experiences and related dynamics can be highly informative for this current reform process. Therefore, this political economy analysis will mostly focus on the 2004 to 2014 JKN reform process that can help inform strategies, policies, and potential compromises. We will also explain briefly about other health

[1]Such analysis would contribute to expanding the ongoing program of work by WHO/SEARO on health financing governance and reforms, and its political economy dynamics as it develops and applies a comparative case study methodology among a set of Member States. The overall focus will be to systematically analyze the political economy dimensions of health financing reforms in the past 20 years. Importantly, the analysis will need to go beyond agenda setting issues and will consider the strategies involved in adopting and implementing health financing reforms.

systems and health financing reform processes that have occurred in Indonesia before and during the reform of social health insurance.

1.4 Research Questions

Based on the aforementioned objectives, the proposed research questions for this study are as follows:

a) What were the main reforms in health system and health financing in Indonesia?

b) What were the political economy dynamics affecting the 2014 JKN reform process?

   (1) Who were the actors involved in the reform, including their roles, position, interests, power, and influence?

   (2) What was the timeline of the reform?

   (3) What were the enablers and constraints faced by the reform team during the process (including key crises, shocks, or turning points)?

   (4) What were the strategies taken by the reform team to manage the political dynamics? Were compromises made in order to continue the reform process?

   (5) What are the implications for governance-related issues and institutional dynamics?

c) What are the lessons learned for current strategic actors in implementing health financing transformation toward strengthened primary care services?

Box 1
What Is Political Economy Analysis[2]

Political economy analysis (PEA) aims to explain the interactions of political and economic processes in a society. PEA is used to assess the power and position of key political actors (stakeholders) as a way to develop strategies to change the political feasibility of desired reforms. In the context of health, PEA involves not only a review of the contextual (structural) factors unique to each country, but also a careful assessment of relevant stakeholders, including their power, position and interest in the health financing reform, as well as the formal and informal institutions through which they interact.

By using PEA as an integral component of the overall health financing reform process, policymakers can increase the likelihood that the intended health financing policies are adopted and implemented.

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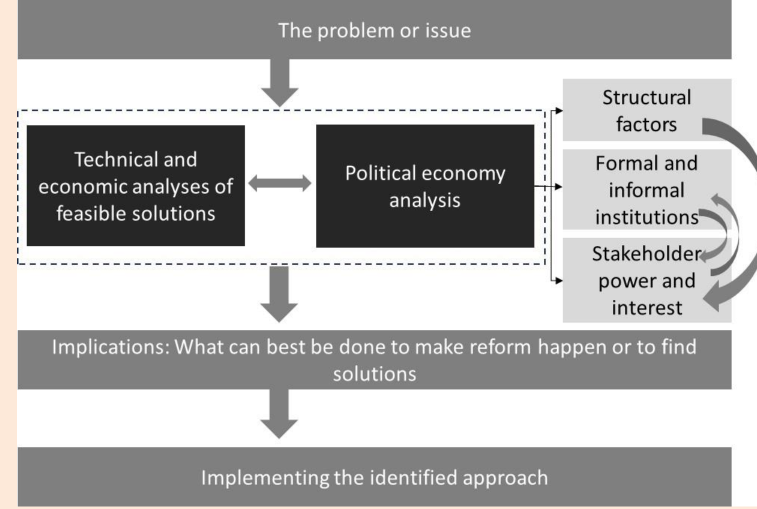
[2]Box and figure were adopted from Bertone, Pholpark, and Witter (2022) and Baral, Gautam, KC, and Witter (2023).

Figure 1. Problem-Driven Political Analysis Framework



II. Methodology

2.1 Study Design

As mentioned in Chapter I, this research will purposively adopt the current political economy of health financing reform approach developed by WHO/SEARO (Baral et al., 2023) to analyze the context in Indonesia. As the reform was implemented before 2014, we will do a restrospective study design, using PEA. The framework and tools of this study were developed from two similar studies in Thailand and Nepal (Baral et al., 2023; Bertone, Pholpark, and Witter, 2022).

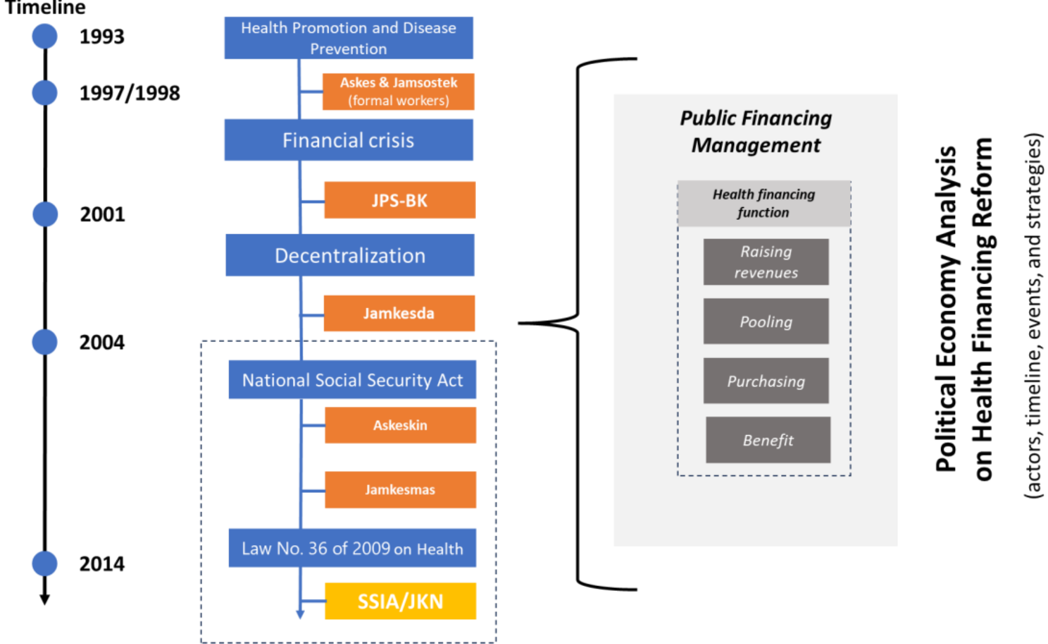
2.2 Research Scope

Based on Sparkes et al. (2019), the core functions of health financing focus on four areas, namely revenue raising, pooling of funds, benefit design, and purchasing. Due to the time constraints of this research, this study will mainly focus on the JKN reform that occurred before 2014. Aside from focusing on JKN, we analyzed some reforms that occurred around the provision of health insurance system for the poor, the influence of decentralization on the health financing system, and financing for health promotion and disease prevention in Indonesia.

We conducted two consultative meetings with the Center for Health Financing and Decentralization Policy, Ministry of Health, in early September 2023. The meetings discussed the information needed by the Ministry of Health from this study which could help to formulate the health financing transformation plan in the future. During the meetings, we rearranged the research questions, topics, as well as the approach that could be adopted to enrich the research. The importance of this process had been reviewed by Loffreda, et al. (2021). They found that research that utilizes PEA works often only involves stakeholders passively as key informants for interviews, rather than involving them in the whole process of the research. They also argued that limited involvement of stakeholders during the research process will lead to less successful research uptake.

Before the meetings with the Ministry of Health, the study planned to focus on the reform of social health insurance which covered the creation of the National Social Security Act (NSSA) to the implementation of JKN. However, during the discussion, the Ministry of Health’s representative asked the researchers to briefly include other health system reforms, especially the implementation of public financial management and other health financing reforms relating to social health insurance implemented before the JKN. Therefore, we added one more research question about the reforms in the health system to capture the story about other health financing reforms, aside from JKN. The meeting also resulted in the framework below (Figure 2).

Figure 2. Research Scope



The above figure shows the topics that will be covered in this research. In general, this research will cover health financing reforms that occurred from 1997/1998 to 2014 with specific focus on the creation of NSSA Law and SSIA Law as a case study. In addition, we also discussed earlier financing reform of Health Promotion and Disease Prevention in 1993, as it served as a important momentum of shifting awareness from curative to promotion and disease prevention. To accommodate the Ministry of Health's needs, this study will also discuss briefly the selected main health system reforms that occurred in Indonesia over the time. The information incorporated in this analysis will include how the health care system in Indonesia has shifted from a treatment/curative approach toward more preventive actions, and how these shifts have affected the allocation and spending of the overall health budget. Before 2014, Indonesia also began national and subnational health accounts to evaluate the efficiency of budget spending on health. We will have a special section that discusses in more detail about the political economy dynamics which influence the reform of social health insurance in Indonesia. In this section, the analysis will be more focused on the interplay of the roles of various actors, including their power and interests. Any important events, including shocks or new policies during that time, and strategies to address the PEA challenges will also be incorporated into the analysis.

2.3 Ethical Clearance

The procedures implemented in this study complied with the standard of ethics issued by the Commission of Ethics in the Social Humanities Affairs of the National Research and Innovation Agency (Komisi Etik Bidang Sosial Humaniora Badan Riset dan Inovasi Nasional) No. 567/KE.01/SK/08/2023.

2.4 Data Collection

The study employed two main data collection methods, namely literature reviews (including media tracking) and in-depth interviews with selected key informants.

2.4.1 Document Review and Media Tracking

The literature review focused on published documentation (peer-reviewed articles, book, published reports, and news available online). Beginning in September 2023, we looked for documents referring to (i) the health financing reform in Indonesia during the period from 1997/1998 to 2014, (ii) information on key socioeconomic, political, and other important turning points, crises, shocks, and relevant contextual information. We searched published documents available in English.

Scoping document search was conducted as follows:

a) Pubmed search with the keywords ((Indonesia) AND (UHC OR "Universal Health Coverage" OR "health financing" OR "insurance")) AND ("political" OR "politic*") [35 results]
b) Google Scholar search with the keywords "The Reform of Health Financing in Indonesia" [first 5 pages screened]
c) Google Scholar search with the keywords "Health promotion and prevention reform in Indonesia" [first 4 pages screened]
d) Google search with the keywords "Reformasi Jaminan Kesehatan Nasional" ("National Health Insurance Reform")
e) Google search with the keywords "Effectivity of mandatory health spending in Indonesia[3]"
f) Suggestions from WHO, advisors, and informants, with additional studies selected based on review of references of selected documents

For this review, around 55 documents were selected, in particular, articles that discussed universal health coverage and national health insurance in Indonesia as a single case or comparison with health insurance schemes in other countries. Other documents focused on decentralization process and progress, impact of financial crisis to the health reform, and political economy analysis of health financing in other countries.

This study also employed media tracking to understand the political and economic situation during the health financing reform. We limited the search for available online media covering news from the year 2003 to 2014. We initially planned to look at the news before year 2000, but nothing related to health financing reform was available. The media was searched using Indonesian language. Most of the news came from national media, such as Kompas.com, Detik.com, Tempo.co, and Hukumonline.com. We created an excel table where we extracted qualitative information, such as year published, title, and content of the news (e.g., who the actors were, their roles, timeline, and what

[3]This sentence was not specifically related to health financing reform, especially national health insurance; however, we still looked for documents for this issue, as it was specifically requested by the Ministry of Health.

information/statements were related to the reform process). In total, we collected more than 80 news items and categorized them into positive news, negative news, and neutral news on health financing reform in Indonesia. Positive news contains information about support to the formulation of reform laws. Negative news refers to critics and doubts of actors mentioned in the news about the benefit of social security system and its implementation. News is categorized as neutral if the written narrative consists of two perspectives (positive and negative) or it does not report any pro or cons about the reform, including discussing the reform process, as well as its progress and timeline.

2.4.2 Key Informant Interviews

In-depth interviews were conducted from September to early October 2023. Most of the interviews were conducted offline, but some of the informants preferred to have online interviews. The purpose of the interviews was to capture perspective, as well as roles, interests, and power of each stakeholder. Stories, information, and views from informants were carefully triangulated through the document review and media tracking.

A total of 8 interviews were conducted out of an initial sample frame of 13 respondents. These informants were identified based on document review and media tracking, recommendations from WHO, as well as recommendations from the informants themselves based on their knowledge of who else had a key role in health financing reform in Indonesia. The selection of informants were purposive with the aim to have at least one representative from each stakeholder. However, we could not interview representatives from the leadership group, as we had time constraint to conduct interviews and difficulties to contact the candidates for interview. A limited number of key informant interviews could potentially influence the richness of information obtained. Nevertheless, we tried to solve this problem by enriching information from other sources, such as document review and media tracking. Table 1 shows the summary of the informants based on their constituent group.

Table 1. Summary of Key Informant Interviews

No.	Organization	Stakeholder Group during Reform
1.	Think tank	Beneficiaries group
2.	SSIA on Health	Beneficiaries/bureaucracy group[a]
3.	Employer's association	Interest group
4.	Academics	Beneficiaries/bureaucracy group[a]
5	Health workers association	Interest group
6	Civil society	Beneficiaries group
7	Ministry of Finance	Budget group
8	International organization	External group

[a]Some actors hold various roles during the reform process.

2.5 Data Analysis and Synthesis

The documents and interview notes were analyzed based on the research questions. The notes were also grouped by type of agency (roles), timeline, and context that affect the policymaking process and content. The PEA approach and framework in Box 1 guided the overall analysis for this study.

Based on that process, we were able to produce a visual timeline to show the timing and content of the health financing reforms alongside political/economic events which influenced the reform. This timeline is briefly discussed in Chapter IV. This analysis is important to provide contextual information that influenced the reform in health financing, especially to identify key events/shocks that impacted the process of health reform. The analysis also includes stakeholder mapping to identify the power and interests of the related stakeholders. We adopted the map from Bertone et al. (2022) and Baral et al. (2023). Lastly, the analysis produces strategies that were used by the stakeholders to achieve their goals during the reform. This includes the narratives about negotiation, coalition building, compromises, and sequencing of reforms, which are discussed further in Chapter VI.

III. Historical, Political, and Societal Contexts and Changes

3.1 Overview of Socioeconomic and Political Changes in Indonesia

In 2022, Indonesia was the most populous country in the Southeast Asia Region with a population of 275 million people and ranked as the fourth most populous nation globally. Renowned as the world's largest archipelagic state, Indonesia is strategically positioned amidst two oceans—the Indian and the Pacific—and between two continents, namely Asia and Australia. The nation is celebrated for its rich natural resources and biodiversity. During the 15th century, Indonesia was colonized by European countries, particularly dominated by the Dutch. Other European countries, namely Spain, England, France, and Portugal, also asserted control over the region. Additionally, Japan colonized Indonesia from 1942 to 1945. Following World War II, Indonesia declared its independence in 1945. At the onset of its independence, the country adopted Pancasila[4] as the five foundational principles of the state, and the 1945 Constitution became the constitution and the primary source of state law. The 1945 Constitution then underwent several revisions, one of which included the state's obligation to provide social security for all its people.

At the onset of its independence, Indonesia grappled with formidable political and economic challenges. The political landscape was challenged by a poor communication system that hindered the widespread dissemination of information regarding Indonesia's independence. A lack of cohesion in central government leadership led to frequent changes in the government system. Moreover, tribal conflicts, and aggressive military actions by the Dutch hindered the country's development plan. Concurrently, Indonesia's micro- and macroeconomic conditions faced stagnation, characterized by soaring inflation rates, an economic blockade, and an empty state treasury. By 1950, political stability and a more consolidated Indonesian government emerged, particularly with the dissolution of the United Republic of Indonesia and the establishment of the Unitary State of the Republic of Indonesia.

Indonesia has a big role in supporting political and economic stability in the Southeast Asia Region and the world. In 1955, Indonesia organized the Bandung Conference, which was a meeting between Asian and African states. This conference aimed to discuss Africa-Asia economic and cultural cooperation that opposed any forms of colonialism. Furthermore, during the Cold War, when tensions were high between the Western and Eastern blocs, Indonesia took the lead in establishing the Non-Aligned Movement (NAM) in 1961, which has since grown to include 120 member countries. This is in accordance with the mandate of the 1945 Constitution, which stipulates that "Pursuant to which, in

[4]Pancasila are five principles that function as the nation's ideology, "*panca*" meaning five and "*sila*" meaning principle. The principles of Pancasila are (i) The belief in the one and only God; (ii) Just and civilized humanity; (iii) The unity of Indonesia; (iv) Democratic rule that is guided by the strength of wisdom resulting from deliberation/representation; and (v) Social justice for all the people of Indonesia.

order to form a Government of the State of Indonesia that shall protect the whole people of Indonesia and the entire homeland of Indonesia, and in order to advance general prosperity, to develop the nation's intellectual life, and to contribute to the implementation of a world order based on freedom, lasting peace and social justice, ..." Additionally, as one of the founding members of the Association of Southeast Asian Nations (ASEAN) in 1967, alongside Malaysia, the Philippines, Singapore, and Thailand, Indonesia plays a key role in shaping ASEAN's vision, direction, and objectives. Moreover, in the Group of Twenty (G20), formed in 1999, Indonesia plays a notably influential role. The country contributes significantly to realizing international financial stability and addressing global issues, both in the financial and nonfinancial sectors. Indonesia actively engages in fostering peaceful dialogues amid ongoing geopolitical disruptions.

The evolution of democracy in Indonesia has been quite complex and very dynamic. From independence to the present, the country has experienced at least four distinct forms of democracy, each marked by upheavals and conflicts of interest. Firstly, there was the parliamentary democracy (1945–1959), modeled after the Western concept, where the parliament played a fundamental role in the government. However, this form of democracy was deemed less suitable for Indonesia due to the nascent democratic culture. Secondly, the guided democracy (1959–1965) emerged, designating the first President Sukarno as the paramount leader in both democracy and revolution. During this period, the influence of communism and the military's role in politics led to numerous violations of the Pancasila and 1945 Constitution. The third phase was the Pancasila democracy during the New Order[5] era (1965–1998), following the events of the 30th September 1965 Movement[6]. This marked a leadership shift from President Sukarno to President Suharto, who then ruled for 32 years amid irregularities, such as unfair general elections; restricted political freedom for civil servants; limited freedom of expression; a constrained party system; and widespread instances of collusion, corruption, and nepotism. The last phase is the democratic reform, which began in 1998, triggered by the 1997/98 AFC. This era aimed to reinstate the fundamental principles of democracy, including direct general elections, freedom of the press, decentralization, regional autonomy, protection of the citizens' basic rights, and inclusive political recruitment. Notably, in 2004, Indonesia successfully held its first direct presidential and vice-presidential elections, electing President Susilo Bambang Yudhoyono and Vice President Jusuf Kalla. Despite the democratic elections reflecting the will of the people, the previously initiated health financing reform faced delays. Wisnu (2012) reported that frictions between the incumbent President Yudhoyono and his predecessor contributed to the postpone of diverse policies, particularly the execution of social security initiatives. For a more in-depth examination of this phenomenon, a comprehensive elucidation is available in Subchapter 5.2.2.

3.2 Macroeconomics and Fiscal Contexts

Before being hit by the AFC, Indonesia had achieved impressive gains in economic growth since 1970. In 1993, Indonesia, together with Malaysia and Thailand, was referred to as the

[5]The New Order is the regime of the second Indonesian president, Suharto, reigning from 1966 to 1998.

[6]This is an important part of Indonesian history, generally referred to by the government as the G30S/PKI (Indonesian Communist Party) Movement.

“newly industrializing economies” (NIEs) of Southeast Asia based on the sustained growth of manufactured exports (Basri, 2018; Hofman, Rodrick-Jones, and Thee, 2004; Karmeli and Fatimah, 2008). Until mid-1997, gross domestic product (GDP) grew an average of 7% a year, inflation was controlled, and the poverty rate fell to 11% (Basri, 2018; Karmeli and Fatimah, 2008). However, in mid-1997, Indonesia was hit by the AFC, which significantly affected its socioeconomic conditions.

Historically, Indonesia had been hit by economic crises several times, but the AFC was the biggest and had the most significant impact. Basri (2018) stated that there were at least two crises in Indonesia before the AFC, namely in 1960 (homegrown[7]) and 1980 (falling oil prices). These two crises had impacts on economic growth, but Indonesia recovered quickly. Meanwhile, during the AFC, Indonesia experienced a major setback. Around the same period as AFC, Indonesia was also facing a series of natural disasters in rapid succession. These included widespread rice harvest failures in numerous regions due to an extended and intense dry season, infestations of crop pests, and extensive forest fires in Kalimantan. Additionally, mid-May 1998 witnessed riots that swept through many cities, leading to the ousting of President Suharto. Subsequently, this tumultuous period saw the separation of East Timor Province from Indonesian territory. The crisis during 1997/1998 was characterized by the fall of GDP by 13.1%, the collapse of the exchange rate against the US dollar, high inflation, and the poverty rate soaring to 27.1% (Table 2 and Table 3) (Karmeli and Fatimah, 2008; Suryahadi, Sumarto, and Prichett, 2003).

Table 2. Indonesia Macroeconomic Indicators

Indonesia	1997	1998	2004	2008	2014	2020
GDP (current US$)	215.7 B	115.3 B	256.8 B	510.2 B	890.8 B	1,059 T
GDP per capita (PPP, current US$, thousand)	5.14	4.46	5.86	7.85	10.4	12.24
GDP growth (annual %)	4.7	-13.1	5	4.7	5	-2.1
Government expenditure (% of GDP)	15.25	15.08	17.83	19.39	18.61	18.58
Tax revenue to GDP	n.a.	n.a.	12.1	13.0	12.12	10.1
Gini Ratio	0.37	0.31	0.32	0.36	0.40	0.38
Unemployment rate (%)	4.86	5.46	7.30	7.21	4.05	4.25

Source: International Monetary Fund, 2021; Kementerian PPN/Bappenas, 2017

The AFC also had a direct impact on health financing and health service utilization in Indonesia. At the government level, the crisis reduced government expenditures for health care by 9% and 13% in 1996–1998 and 1998–1999, respectively (Waters, Saadah, and Pradhan, 2003). These declines resulted in shortages of pharmaceutical supplies, such as antibiotics and contraceptive pills (Frankenberg, 1999). As many households experienced a reduction in their purchasing power during the crisis, access to health facilities also

[7]This crisis was due to a loss of macroeconomic stability, imprudent economic strategies, and deep political impasse that impacted economic growth (Hill, 2012).

became challenging. Frankenberg (1999) reported that households were reducing the share of budget spent on health services and increased their spending on food. In addition, Waters, Saadah, and Pradhan (2003) identified a significant decrease of health care utilization in government and private health facilities.

After recovering from the AFC, there were another global crisis in 2008 and a market panic in 2013, but Basri and Rahardja (2010) argued that the impact of these crises on the economy was limited. Although the global crisis did not severely impact the economy, the government needed to shift its focus, creating strategies to maintain the economy. As a result, the effort to accelerate social health insurance during this time was delayed. Detailed political and economic issues related to this delay will be explained in Chapter V.

3.3 Trends in Demographic and Social Indicators

Indonesia is the 4th most populous country in the world, with 56.54% of its population living in urban areas (Table 3). Up to 2045, Indonesia will have a demographic bonus, where the composition of the productive age population is greater than the nonproductive one. This moment should be a window of opportunity where the working age group has potential to improve social security and economic growth in the country. However, Table 3 also shows that currently Indonesia is facing various burdens, as the rates of communicable and noncommunicable diseases, as well as malnutrition are very high. During the 1990s, the leading causes of disability adjusted life years (DALYs) were dominated by communicable diseases (diarrheal diseases, lower respiratory infections, tuberculosis) (Mboi et al., 2018). This pattern changed a decade later where noncommunicable diseases, such as ischemic heart diseases, cerebrovascular diseases, and diabetes became the main causes of DALYs. In addition, Table 3 shows the reduction of infant mortality rates. However, the maternal mortality rate continues to be among the highest in Southeast Asia. Failure to improve these conditions could reduce the quality of the workforce, which hinders the country's potential to reap the rewards provided by the window of opportunity.

Table 3. Population, Demographic, and Health Indicators

Indonesia	1990	1998	2000	2010	2020
Population, total (millions)	182.20	207.9	214.10	244	271.90
Population growth rate (annual %)	1.80	1.60	1.40	1.30	0.80
Urban population (% of total)	30.58	39.59	42.00	49.91	56.64
Poverty headcount ratio (national poverty line, % of population)	15.10	27.1[a]	19.14	13.33	9.78
Life expectancy at birth, total (years)	62.09	65.15	65.65	69.00	71.77
Fertility rate, total (births per woman)	3.20	2.55	2.54	2.48	2.28
Maternal mortality rate (per 100,000 live births)	n.a.	n.a.	299	219	173
Infant mortality rate (per 1000 live births)	62.95	45.48	42.19	28.24	17.71
School enrollment, primary (% gross)	114	111	109	109	90
Adjusted net enrollment rate, secondary (% of primary school age children)	47	n.a.	55	76	89[b]
Stunting prevalence (children aged under 5 years old)	48[c]	n.a.	42	36	26.6
Stroke (Death per 100,000 population)	n.a.	n.a.	97.18	112.89	131.8[d]
Tuberculosis (Death per 100,000 population)	n.a.	n.a.	55.69	44.82	33.24[d]

Source: World Health Organization, 2023a

[a]1999

[b]2018

[c]1995

[d]2019

The Government of Indonesia's (GoI's) commitment to provide financial protection for access to health can be seen in Table 4. In general, data show a slight increase in Current Health Expenditure (CHE) and share of government spending for health. After two decades from 2000, the CHE only increases by 1%, which was still considered low. Out-of-pocket spending also continues to decrease from 45% in 2000 to 32% in 2020 as more people joined the JKN program. The domestic general government health expenditure as percent of CHE rose sharply from 30% in 2000 to 55% in 2020, mostly for the COVID-19 prevention and care. Moreover, GoI also increased its spending to pay the subsidy for the poor in the JKN program. In 2023, more than 96 million of poor people in Indonesia was subsidized to participate in the JKN program (Sopiah, 2023).

Table 4. Health Financing Indicators in Indonesia

Indonesia	2000	2004	2010	2020
CHE per capita in US$	16	26	86	133
Current health expenditure as % of GDP	2	2	3	3
Domestic general government health expenditure (GGHE-D) as % CHE	30	35	24	55
Out-of-pocket spending % of health spending (OOPS%CHE)	45	46	61	32
Priority to health (GGHE-D%GGE)	4	4	4	10

Source: World Health Organization, n.d.

IV. Main Health System and Health Financing Reforms—A Timeline

4.1 A Shift to Health Promotion and Disease Prevention (1993)

The GoI, under the leadership of Dr. Adhyatma as minister for health from March 1988 to March 1993, underwent a strategic shift in its healthcare priorities, transitioning from a predominantly curative health orientation to a focus on preventive and promotive heath strategies. Historically, following the postindependence era in 1945, health development in Indonesia revolved around two primary objectives. The first objective aimed to enhance public acceptance of formal healthcare provision, while diminishing reliance on traditional healers. The second objective sought to increase healthcare accessibility through establishing community health centers (*puskesmas*) and its ancillary health facilities; building more hospitals and providing subsidies for their services; as well as the launching of doctors' services programs (Nugroho, Handayani, and Effendi, 2021). During this time, the GoI predominantly emphasized the curative aspect of healthcare. However, since Dr. Adhyatma served as minister for health, he prompted a shift toward increased investment in public health services. Moreover, the redirection of healthcare toward preventive intervention was influenced by the release of the World Development Report titled 'Investing in Health' in 1993, which described the importance of allocating more money to public health and essential healthcare services.

> Then, Soewardjono (previous minister for health) was replaced by Adhyatma. This change was an important moment because Adhyatma was a Master of Public Health graduate .... At that time, there began the thought that Indonesia had to shift from curative to promotional and preventive care. (KII 6)

While the significance of health promotion and disease prevention had been well established, the allocation for preventive and promotive interventions remained low compared to curative interventions. Data from 2015 to 2017 reveals that curative interventions were allocated with around 61% of the Ministry of Health's spending (including for social health insurance subsidies). In contrast, resources earmarked for promotive and preventive interventions were 26% of the total budget allocation (Ministry of Health, 2018). These budget allocations for promotive and preventive activities were utilized to finance various initiatives, including but not limited to community health development, disease prevention and control, and health services development.

4.2 Decentralization and Health Financing (2001)

In January 2001, Indonesia embarked on a policy shift that was considered quite radical, transitioning from a centralized governance system to a decentralized one. This transformation was driven by multiple compelling factors, including the 1997/1998 AFC, the ousting of the Suharto regime in 1998, the establishment of free elections and the

introduction of democratic governance in 1999, and the de facto secession of the former East Timor province in 2000 (Kristiansen and Santoso, 2006; World Bank, 2005). Furthermore, Kristiansen and Santoso (2006) posit that international organizations, such as the World Bank and the International Monetary Fund (IMF), played a pivotal role in influencing the decisions of policymakers to adopt decentralization. The division of tasks between the central government and regional governments in decentralization was initially written in Law No. 22 of 1999 concerning decentralization. Within this framework, the health sector emerged as one of the areas that must be managed by *kabupaten* (district)/*kota* (city) governments. The implementation of this transition involved the transfer of governmental functions to regional entities, accompanied by the allocation of financial resources, the transfer of assets and infrastructure, and the allocation of personnel.

Upon the initiation of decentralization, policymakers held the expectation that regions possessing higher fiscal capacity would be sufficiently equipped to finance the majority of healthcare needs, thereby necessitating only a marginal contribution from the central government. Early in the implementation of decentralization, local governments utilized this as a space for them to try various social health insurance models in the Regional Health Insurance (Jamkesda) scheme (Agustina et al., 2019; Pisani, Olivier Kok, and Nugroho, 2016). At that time, the provision of health services through Jamkesda became material for political campaigns for candidates vying for local and regional leadership positions. However, over a span of more than two decades following its implementation, the efficacy of decentralization in the health sector varied. Factors such as different fiscal capacities, competing policy priorities, and the different characteristics of the local leaders significantly influenced the degree of success in decentralization efforts (Bawono, Purbasari, and Mujiyati, 2018; Nikijuluw, 2021; Sutarsa and Paradissa, 2023). Erlangga and Shi (2014) found that regions characterized by substantial healthcare budgets were not necessarily those marked with high fiscal capacity, but rather those lead by leaders who have greater awareness and expertise in the health sector.

Funding sources for regional entities, commonly referred to as the Regional Revenue and Expenditure Budget (APBD), are subject to regulation, that is, with the provision of Law No. 25 of 1999 concerning fiscal decentralization, while the allocation of the health sector budget is governed by the stipulation articulated in Law No. 36 of 2009, specifically in the mandatory spending section. It is important to note that after two decades of decentralization, a substantial proportion of regions continue to depend on financial allocation from the central government to sustain their health sector. Consequently, some local governments still consider the Ministry of Health as the primary source of financial support for providing healthcare personnel, essential medical equipment, as well as pharmaceutical and vaccines (World Bank, 2005). Mboi (2015) argued that the decentralization process has resulted in a situation where the health financing and service delivery system in Indonesia suffer from inadequate coordination and standardization.

4.3 Financial Protection for the Poor (1997–2014)

The social protection system for the poor in Indonesia began with the implementation of the Health Card Program in 1994. The program provided full subsidy for poor households

to pay for medical expenses at *puskesmas*. However, its execution was halted because of regional disparities in delineation of eligible recipients (Johar, 2009). Subsequently, Indonesia experienced the AFC, leading to an increase in the number of impoverished households necessitating healthcare coverage. Prior to the AFC in 1996, the number of poor people in Indonesia was 22.5 million people (9.7%). Following the AFC, this figure surged substantially to 27.1% (Table 3) (Statistics Indonesia, 2018). Indonesia received loans from various international organizations, such as the Asian Development Bank (ADB), IMF, and the World Bank, to minimize the impact of the crisis (Kristiansen and Santoso, 2006; Suryahadi, Febriany, and Yumna, 2014). The Social Safety Net (JPS) program was then designed to mitigate the impact of the 1997/1998 AFC. Under the JPS program, poor people received social security and assistance across diverse domains, encompassing nutrition, employment, education, and healthcare. Specifically, within the health sector, the program name is the Social Safety Net for Health Sector (JPS-BK). This program provided governmental subsidies for pharmaceuticals, medical equipment, hospital operational support, and free health services (including inclusion in family planning program, and food and supplements for pregnant women and toddlers) (Kementerian Perencanaan Pembangunan Nasional/Badan Perencanaan Pembangunan Nasional, 2014). The assistance for the poor was distributed through *puskesmas* and village midwives.

After the year 2000, the crisis situation failed to improve. Furthermore, a surge in fuel prices compelled the government to develop a new program aimed at preserving individuals' access to healthcare services. Subsequently, in 2001, the government initiated a program called Mitigating the Impact of Reduced Energy Subsidies in the Health Sector (PDPSE-BK). The benefits of this program were similar to those of JPS-BK, except that it removed the food and supplements for pregnant women and replaced it with hepatitis B vaccines and eye care. Over the period from 2002 to 2004, this program underwent a transition, becoming known as the Health Sector Fuel Subsidy Reduction Compensation Program (PKPS-BBM). Concurrently, in 2003, the government undertook an experimental implementation of another health protection called Health Financing Mechanisms for Poor Families (JPK Gakin) in 15 *kabupaten*. Within the JPK Gakin model, health sector subsidies were not distributed directly to health service providers. Rather, these subsidies were administered through the Health Insurance Implementing Agency (Bapel JPK). Because of adaptation to the context of local demand, the JPK Gakin program was more responsive than the previous centrally administrated one. The local leaders showed their initiative in promoting universal health coverage in their *kabupaten*. In addition, alongside the decentralization policy in 2001, there was a gradual increase in the number of regions offering Jamkesda funded by local budgets. A survey conducted by The SMERU Research Institute in 2012 revealed that out of 262 *kabupaten* surveyed, 245 had instituted some form of local health financing scheme (Aspinall, 2014).

Following the enactment of Law No. 40 of 2004 on NSSA, a significant change took place in the form of the transformation of the PKPS-BBM initiative to a healthcare insurance program named Health Insurance for the Poor (Askeskin) program, which was under the administration of PT[8] Askes. The announcement of this initiative, made by the newly

[8]PT means limited liability company/for profit oriented.

appointed minister for health, generated significant attention and controversy. The minister for health appeared to be lacking awareness regarding the enactment of Law No. 40 of 2004 on NSSA and the decentralization policy, which had curtailed the central government's authority to issue directives to *kabupaten* (Pisani, Olivier Kok, and Nugroho, 2016). Upon receiving guidance from her advisors, she was encouraged to utilize the NSSA Law as the legal foundation for this program and to rebrand the JPK-Gakin pilot initiative, subsequently extending its implementation across the entire nation (Pisani, Olivier Kok, and Nugroho, 2016). Additionally, commencing in the year 2008, the Community Health Insurance (Jamkesmas) program was introduced, signifying a further evolution from the JPS-BK and Askeskin. In implementing Jamkesmas, PT Askes no longer had a role in managing the finances and membership of the program. Management of the Jamkesmas program fell under the purview of the Ministry of Health. In 2014, Jamkesmas and Jamkesda were integrated into the JKN program managed by the Social Security Implementing Agency (SSIA) on Health (BPJS Kesehatan). The details of each social health insurance can be found in Appendix 1.

4.4 The National Social Security Act (2004)

In 2004, the GoI enacted Law No. 40 of 2004 which established the NSSA, marking an important step toward providing comprehensive social protection to its citizens. This law was designed to cover five types of social security programs, i.e., health insurance, work-related accident insurance, older persons' insurance, retirement savings with disability benefits, and death benefits. The implementation of this reform was widely acknowledged as a significant milestone in the realm of health financing. Prior to this reform, during the New Order era, the social security landscape was characterized by fragmentation, extending the coverage primarily to specific groups, such as civil servants, military personnel, and private employees (Agustina et al., 2019). The number of poor people who were part of the social health insurance was very limited at that time. In 1998, for example, only 1.87% of the population was a member of the Community Health Fund (Dana Sehat[9]) and less than 100,000 people participated in the Community Health Insurance (JPKM[10]) plans (Arifianto, 2004). Rather than a social system, healthcare in Indonesia was identified as an entrepreneurial system based on gaining profit. Hence, the development of NSSA concept adopted the participatory welfare state concept where the state cooperates with the people to provide a social security system (*Kompas*, 2004c). Nevertheless, the establishment of NSSA received various forms of support and faced obstacles. The dynamics of the implementation of NSSA from 2004 to 2011 is explained in Chapter V.

[9]Dana Sehat was established in 1970 as part of the village community development program. Dana Sehat was implemented by community members and aimed to improve the health status of community members by the principle of mutual support *(gotong royong)*.

[10]JPKM was stipulated in Law No. 23 of 1992 on Health. The program was considered as a health financing strategy to increase accessibility to health providers and leverage private sectors involvement.

4.5 Mandatory Spending in Law No. 36 of 2009 on Health

In 2009, the GoI introduced a new legislation, Law No. 36 of 2009 on Health, which brought a notable change in the government's commitment to allocating healthcare budgets within the country. Under Law No. 23 of 1992 on Health, it was stipulated that "the implementation of health efforts would be funded by the government and/or the public." However, with Indonesia's embrace of the decentralization paradigm, Law No. 36 of 2009 mandated that the governments allocate a minimum of 5% of the state budget and 10% of regional budgets to the health sector. This compulsory allocation aimed to address issues of regional-level social and economic disparities. Nevertheless, the stipulated percentage of expenditure in the law fell short of the global benchmarks. The WHO reported that a minimum government expenditure of 5% to 6% of the GDP is required to ensure broader protection of households against financial constraints related to health expenses (Xu et al., 2010). During the implementation period, not only did the government allocate a relatively modest portion of the budget to healthcare, but the effectiveness of its implementation had also been less than optimal (Hafez et al., 2020).

Since the enactment of Law No. 36 of 2009, compliance with the obligatory minimum health budget allocation had been notably lacking, both at the central and regional levels. Nationally, the central government consistently allocated budgets for health that fell below the 5% threshold from 2010 to 2015 as depicted in Figure 3. In the years from 2020 to 2022, the budget increased dramatically due to the COVID-19 pandemic. Meanwhile, the allocation of funds by the central government for the health sector at the subnational level remained relatively substantial. This situation causes regional dependence on health budget and policy directives from the central government. Nasution (2022) reported that in 2018 only 43% of subnational governments managed to meet the mandated minimum expenditure requirements.

Figure 3. Health Budget Allocation % of State Budget

Source: Kementerian Keuangan, n.d.

Currently, Law No. 36 of 2009 is no longer in force, as it had been supplanted by Law No. 17 of 2023 on Health. In this latest legislation, the mandatory spending requirements for the health sector have been abolished. From a fiscal management standpoint, the removal of the mandatory spending could increase government flexibility in aligning the budget

based on development priorities. However, this change also carries the potential risk of diminishing the healthcare budget (Swasono, 2023).

4.6 The Establishment of BPJS Kesehatan/SSIA on Health and JKN (2011–now)

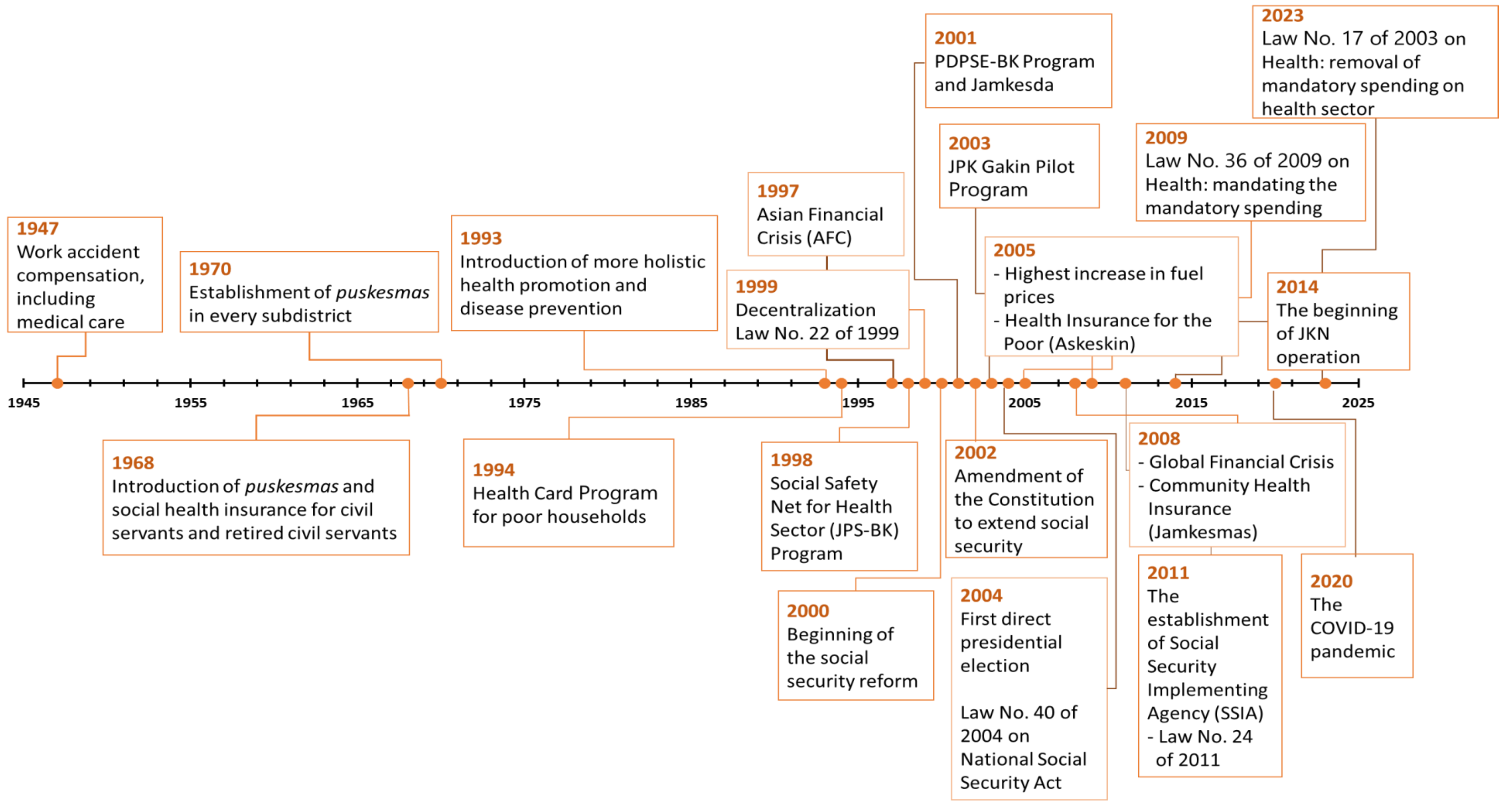
The creation of the SSIA on Health was one of the mandates of NSSA in 2004. Preceding the inception of the SSIA on Health, Indonesia had at least three separate health insurance management entities. The first, PT Askes, primarily catered to civil servants, while PT Jamsostek oversaw health insurance for employees in the private sector and ASABRI concentrated on providing and managing health insurance for military and police personnel. These fragmented health insurance schemes underwent a substantial consolidation, and were merged fundamentally into a single public entity known as BPJS (SSIA) in 2011. Different from its predecessors, the SSIA on Health is structured as a nonprofit institution, in compliance with the stipulations of the NSSA Law. There exist two distinct branches of SSIA: BPJS Kesehatan (for health insurance) and BPJS Ketenagakerjaan (for employment). Starting from 2014, the SSIA on Health commenced the implementation of the mandated JKN. Under the JKN program, the government tries to ensure healthcare coverage for the entire population. Chapter V will delve into the political economy dynamics surrounding the establishment of the SSIA on Health and the subsequent introduction of the JKN program.

4.7 Reflection on How the Health Financing Reform Process Maps against Broader Political, Economic, and Societal Changes

Figure 4 illustrates the health financing reform explained above alongside the political, societal, and economic changes. The figure unveils the GoI's longstanding efforts to provide health insurance, an initiative that commenced soon after the nation's independence in 1945. However, a notable observation is that the majority of these health insurance schemes did not encompass the marginal population. The watershed moment in Indonesia's health financing history was the 1997/1998 AFC. The crisis not only caused an expansion of financial protection for the poor but also instigated the establishment of a legal framework for social security that extended to the entire population.

For this reason, we decided to select the period from 1997 to 2014 as a focus of our case study. During the 1997 to 2014 timeframe, there were only several main events which we considered as a main reform process (i.e., during the creation of NSSA and SSIA). We found several points of delay in the reform which influenced the length of reform process in Indonesia. In the next chapter, we explain the broader impact of political, societal, and economic contexts in shaping the trajectory of health financing reform, as well as strategies that were used by the key stakeholders to achieve the goal.

Figure 4. Timeline of Main Historical, Political, and Societal Shifts and Health Financing Reforms



V. Case Study: The Creation of the JKN against the Backdrop of the Political, Social, and Economic Contexts

5.1 Overview of JKN

Indonesia has successfully integrated the fragmented health insurance system into a single-payer system. Historically, the country had an assortment of five *distinct* health insurance categories: (i) health insurance serving civil servants and military personnel, (ii) health insurance catering to private employees, (iii) health insurance for poor people provided by national government, (iv) health insurance for poor people provided by local governments, and (v) private health insurances. A study reported that fragmentation in health insurance schemes can lead to failure in the provision of financial protection as well as reduce access to health care services (Bazyar et al., 2021). Prior to the implementation of JKN, over 74% of the population lacked any form of health insurance coverage (Claudia Rokx et al., 2009). This subgroup was predominantly composed of informal workers, who constituted 53.6% of the population during that period (ILO, 2013).

As the Constitution was amended to ensure the provision of social security and the NSSA Law mandated the availability of national health insurance, in 2014 Indonesia initiated the UHC program called JKN. JKN operates as a nonprofit social health insurance program, with mandatory participation for the entire population, financed through participant contributions (Mukti, 2022). There are two types of participants in JKN scheme, the one who pays the premium (non-PBI) and the other whose premium are paid by the government (premium assistance beneficiaries/PBI). The non-PBI participants consist of formal and informal workers, and people who are not considered poor. Meanwhile, PBI participants are poor people whom the premiums are subsidized by the central or local governments. The non-PBI participants are obligated to pay the premiums monthly directly to the SSIA on Health, meanwhile for PBI participants, the payments are made by the governments. Central to JKN is the principle of *gotong royong* (mutual support), wherein individuals in good health support those in need of healthcare, the young support older persons, and the rich help the poor. In January 2014, 121.6 million participants transitioned to JKN. They were originally the members of previous schemes (civil servants, the poor, military personnel, and some part of formal workers) (National Team for the Acceleration of Poverty Reduction, 2015). Presently, JKN provides coverage to over 260 million participants, constituting approximately 96% of the population (DJSN, 2023).

Participants in the JKN program are bound by established procedures, commencing with an initial consultation at a public or private primary healthcare facility. Every JKN participant must be registered with one primary health care provider, either public or private. Hospitals may be accessed following a referral from the primary healthcare

facilities, unless the situation pertains to a medical emergency. The primary healthcare facilities, functioning as gatekeepers, are mandated to manage up to 144 primary diagnoses, thereby serving as a critical mechanism for ensuring quality assurance and cost control within the system. In general, JKN offers a comprehensive range of benefits, encompassing basic outpatient services and extending to catastrophic provisions, such as hemodialysis and cardiac surgeries.

The number of health facilities collaborating with the SSIA on Health has increased over the years. In 2014, there were a total of 15,861 primary healthcare facilities, comprising 9,598 *puskesmas*, and 6,263 private clinics, general practitioners, and dentists (National Team for the Acceleration of Poverty Reduction, 2015). Currently, the number of contracted primary care facilities has surged to 23,361 (DJSN, 2023). In the context of hospitals, the number has expanded from 1,701 in 2014 to 3,018 in 2023 (DJSN, 2023; National Team for the Acceleration of Poverty Reduction, 2015).

The implementation of the JKN program has also introduced a strategic purchasing approach aimed at improving the overall performance of the healthcare system. Within this framework, primary healthcare services are remunerated through a capitation scheme, which is calculated based on the number of registered participants at a given facility. In contrast, hospitals operate under the Indonesian case-based groups (INA-CBGs) payment model, wherein the amount of claim is disbursed by the SSIA on Health to hospitals for their services. As of December 2022, the cumulative disbursement made by the SSIA on Health to all health facilities in 2022 amounted to 113 trillion rupiah (US$ 7.5 billion) (DJSN, 2023). Notably, caesarean section procedures ranked at the top in terms of utilization within the JKN program, incurring a cost of nearly 5 trillion rupiah or the equivalent of US$ 333 million.

As previously mentioned, before the JKN program was implemented, there was a major reform in purchasing for the program. The old-fragmented schemes were hitherto administered by multiple entities, ranging from the health insurance company name PT Askes to the Ministry of Health. In 2011, the government enacted Law No. 24 of 2011 on Social Security Implementing Agency (SSIA) that changed the various insurance managements into a single public entity called BPJS Kesehatan (SSIA on Health). The SSIA on Health is an independent management agency that is responsible for recruiting new members, disbursing payments to service providers, and the collection of premiums (Mboi, 2015). In the JKN era, the Ministry of Health continues to play a significant role in supporting the implementation of JKN toward UHC. The Ministry of Health is responsible for the formulation of clinical guidelines, setting technical norms, and allocating funds for subsidizing the poor.

Numerous research studies have been conducted to evaluate the efficacy of the JKN program in increasing population health outcomes. The JKN program has been associated with improved accessibility to healthcare services, particularly inpatient and outpatient services; increased quality of care for maternal health services; and reduced healthcare inequality (Hartini, 2017; Pratiwi et al., 2021; Tiara Marthias et al., 2022). Studies also found that JKN has a positive impact on the reduction of out-of-pocket (OOP) payment. Maulana et al. (2022) reported a positive influence of JKN where poor households with JKN memberships were less likely to spend OOP payment compared to uninsured households.

It was also previously mentioned in Table 4 that the OOP health expenditure also decreased from 45% in 2000 to 32% in 2020. However, based on the latest UHC Global Monitoring Report (World Health Organization and World Bank, 2023b), the UHC service coverage index score in Indonesia was among the lowest compared to other Southeast Asian countries (Table 5). Indonesia was lacking in indicators such as hypertension treatment and health worker density. Furthermore, for JKN implementation, some improvements are still needed to leverage the benefits of JKN in Eastern Indonesia where the availability of healthcare service providers remains constrained (Pratiwi et al., 2021).

Table 5. UHC Service Coverage Index (UHC SCI), 2021

Countries	UHC Service Coverage Index
World	68
Southeast Asia	62
Indonesia	55
Thailand	82
Malaysia	76
Philippines	58
Singapore	89
Myanmar	52
Lao PDR	52

Source: World Health Organization and World Bank, 2023b

Note: The UHC SCI SDG 3.8.1 is calculated as the geometric mean of 14 indicators for each year from 2000 to 2021 for all Member States. There are four indicators for reproductive, maternal, newborn, and child health, four indicators for infectious diseases, three indicators for noncommunicable diseases, and three variables for service capacity and access.

5.2 Political, Social, and Economic Contexts of the 2014 UHC Reform/JKN Creation

5.2.1 The 1997–2004 Period: Setting the Stage for the Establishment of JKN and UHC Reform

The 1997/1998 AFC became an inflection point of many transformations in Indonesia's government system. During this period, the government embarked on an unprecedented endeavor to expand healthcare coverage for individuals with low incomes (Pisani, Olivier Kok, and Nugroho, 2016). That was also a first step forward in Indonesia's road to UHC; in many countries—such as Thailand, Turkey, and Brazil—a significant social, economic, or political change stimulated the reform in health financing. The conflict created upheavals, an opportunity for the reformist group to break the oligarchy in power (Reich et al., 2016). The reformists required innovative approaches to be advanced and adopted. In the context of Indonesia, Jakarta became the center of protest marches. During the crisis, the march mostly involved students from various universities in Indonesia. This was also called the rise of "the middle class of politics", with educated urban people who used criticism as

their political basis (Prasisko, 2016). The main demand of the reformists was to enforce the rule of law, which was biased toward President Suharto and his cronies. The reform brought new actors and amplified public pressure on the working of the state but did not completely eradicate the political-business elite during Suharto's rule (Robison and Hadiz, 2004).

Conflict also created a sense of national solidarity to promote significant reforms, especially for the population's health and social protection. Since the fall of the authoritarian regime of President Suharto, Indonesia had experienced an increase in the scale and reach of state-run social welfare programs. These programs were designed to blunt the impact of the AFC (Aspinall, 2014). As explained in the previous chapters, the 1997/1998 AFC caused an increase in the number of families living in poor conditions. During AFC, the price of rice and other necessities increased, and the poverty rate also increased from less than 10% in 1996 to more than 27% in 1998 (Statistics Indonesia, 2018). The crisis was exacerbated, as Indonesia did not yet have a social security framework that could protect all of its population from the shocks. In the health sector, health insurance was limited to formal workers (civil servants, private employees, military personnel, and police personnel) (Aspinall, 2014).

In response to those conditions, international organizations, such as IMF, advocated for the implementation of the JPS program to protect the poor and near-poor population. The JPS program covered the protection for education, health, and food security. JPS program gives improvement at the household and aggregate levels. Nonetheless, the program faced criticism due to poor targeting, where a large number of poor were not covered and substantial benefits were given to the nonpoor (Suryahadi, Febriany, and Yumna, 2014).

After Indonesia went through the economic crisis, policymakers initiated a contemplation of the imperative of establishing a social protection system. The government became more aware of the national social security system and was willing to protect all of its population from the potential of shocks in the future (Sumodiningrat, 1999). The Ministry of National Development Planning/National Development Planning Agency (Kementerian PPN/Bappenas) and Coordinating Ministry for People's Welfare embarked on a concerted effort to form a sustainable arrangement for future shocks. The fourth president of Indonesia, Abdulrahman Wahid, and his vice president, Megawati Soekarnoputri, started the reform process (Pisani, Olivier Kok, and Nugroho, 2016; Suryahadi, Febriany, and Yumna, 2014).

The initial step in the reform of Indonesia's social security system took the form of an amendment to Article 34 of the 1945 Constitution by the People's Consultative Assembly (MPR) in 2001. This constitutional amendment marked the inception of a legal foundation for social security in Indonesia. The Constitution asserts that "Each person is entitled to social security enabling them to develop their entire self-unimpaired as a dignified human being" and "The state develops a social security system for everybody and empowers the weak and underprivileged in society in accordance with their dignity as human beings".

> There is no right to health in our constitutions, so we started to demand amendment of our conditions, that everyone has right to health services. (KII 1)

The formation of the social security system in Indonesia was a continuous process. In 2001, Megawati, the then vice president of Abdurrahman Wahid administration, was approached by Sulastomo and Hattari to discuss the idea of establishing a social security system (Wisnu, 2012). When Megawati succeeded Abdurrahman as the president, the social security reform became her priority (Pisani, Olivier Kok, and Nugroho, 2016). On 21st March 2001, Megawati formed a NSSA task force which consisted of 17 members from government institutions and universities/academics. The task force was assigned to draft the NSSA concept which covered topics of contribution, implementation, implementing agency, and timeline (Wisnu, 2012) Subsequently, in 2002, through Presidential Decree No. 20 of 2002, President Megawati established a task force dedicated to draft the NSSA Law and that would report to the president. This task force had the authority to prepare draft legislations and to support academic papers for the NSSA. It had received technical assistance and financial support from international development partners, such as the Asian Development Bank, International Labour Organisation (ILO), and Australian Government. The task force had a deadline to present the concept of NSSA to the president in December of 2002. Comprising of 60 members, the NSSA task force encompassed diverse stakeholders, including healthcare workers' associations, the Ministry of Finance, members of the parliament, and academics (Bazyar et al., 2021; Pisani, Olivier Kok, and Nugroho, 2016). Subsequently, the first version of NSSA conceptualized the establishment of a single-payer nonprofit insurance system that also implied a fusion of the previous four state-owned insurances (Pisani, Olivier Kok, and Nugroho, 2016). This draft legislation catalyzed extensive debate during the deliberation process.

Many obstacles emerged during the formulation of the NSSA Law to convince stakeholders of the mid-term and long-term benefits of having a social security system in place, which was driven primarily by the competing interests of various stakeholders. Firstly, pre-existing insurance companies voiced concerns about merging into a single institution that may engender a clash of interests, given the shift in the orientation of the insurance entity from a for-profit to a nonprofit organization (*Kompas*, 2004d). Secondly, the employers' association resisted participation in mandatory health insurance, primarily due to (i) increased contributory rates relative to the preceding system, (ii) the elimination of the option to opt out from the scheme, and (iii) an unfavorable and noncompetitive investment climate (*Kompas*, 2004b). Concurrently, the employees' group also voiced strong opposition to the proposed bill, owing to the introduction of mandatory contributions. Additionally, the Ministry of Labor expressed concerns about relinquishing control over health insurance for private workers and the ensuing burden placed on the workforce (Bazyar et al., 2021). During the process of drafting the NSSA bill, the death of four key members of the task force also caused delays (Thabrany, 2008). The bill of social security reform was revised 56 times before the task force submitted it to the parliament (Bazyar et al., 2021; Suryahadi, Febriany, and Yumna, 2014). Ultimately, on 28th October 2004, the parliament granted approval to the draft bill following several revisions (ILO, 2008). President Megawati signed the draft bill in 2004.

> That was my first-time experience to watch a law signed ceremonially. So, the ministers and the NSSA team were, of course, also invited to the Palace on October 19th. On the last day at the Palace, Megawati signed the NSSA Law. Morally, she just said "This is what I can leave for the people." (KII 1)

The first version of NSSA Law, legalized in 2004, had no details of contribution levels, copayment percentages, and benefits packages or sanctions. The details of NSSA had to be passed within five years (Pisani, Olivier Kok, and Nugroho, 2016). Unfortunately, Megawati's struggle to implement NSSA in Indonesia was not enough to get her elected in the first direct election. The health reform in the President Yudhoyono era stalled for some years (Aspinall, 2014). The economic and political health reforms in the era of President Yudhoyono will be explained in the next section.

5.2.2 The 2005–2014 Period: Social, Political, and Economic Contexts during the Establishment of JKN

Law No. 40 of 2004 on NSSA mandates the compulsory nature of social security programs, particularly in the health sector, for the entire population through the establishment of the implementing body called BPJS Kesehatan or Social Security Implementing Agency (SSIA) on Health. The legislation explicitly decreed that all legal prerequisites governing SSIA had to be enacted no later than five years following its creation, i.e., by 2009. However, the actual implementation of the SSIA encountered substantial delays. The formation of the National Social Security Council (DJSN), entrusted with the role of facilitating the president in crafting overarching policies and coordinating the execution of the national social security system, was only realized in September 2008. Concurrently, the legislation associated with the SSIA was not promulgated until November 2011. Consequently, the implementation of the social health insurance through SSIA was not carried out until January 2014.

Many factors influenced the slow implementation of these reforms. A prominent determinant was the deviation from prioritizing the legislative mandate encapsulated in Law No. 40 of 2004 by President Yudhoyono (Pisani, Olivier Kok, and Nugroho, 2016). Wisnu (2012) documented that within the agenda of the incumbent government, there existed a deliberate effort to put aside discussions concerning the implementation of the NSSA Law, redirecting attention exclusively toward the prioritized goal of poverty reduction. Additionally, there was resistance coming from certain communities and stakeholders toward the overarching concept of the NSSA and the mandated social health insurance. There were contentious debates surrounding various facets of the social health insurance implementation. All these factors contributed to the delay in the implementation of NSSA Law.

> The implementation of the NSSA Law was also delayed because the government had other priorities at that time. (KII 1)
>
> When I was mandated to prepare for the SSIA and social health insurance, I had to face protest marches from employees' associations and various other things. There were those who agree and disagree, basically it was not easy. (KII 2)

The discussion in this section centers on the political, social, and economic contexts that characterized the social health insurance reform process, encompassing the period after Law No. 40 of 2004 and leading up to the commencement of JKN operations in 2014. This particular juncture unfolded during the tenure of President Yudhoyono's administration, which was divided into two terms of offices: November 2004 to October 2009 and November 2009 to October 2014, as illustrated in Figure 5.

Several months after the implementation of NSSA Law, there was resistance from the regional governments through the submission of a request for the right to judicial review. This legal challenge was predicated on the contention that the NSSA Law was perceived to be in conflict with the provisions of the 1945 Constitution (Mahkamah Konstitusi RI, 2005). The applicant for the judicial review considered that the implementation of NSSA had violated decentralization and regional autonomy policies so that regions no longer had the authority to provide health insurance in their regions. Wisnu (2012) further asserted that the impetus behind these demands was caused by the violation of constitutional norms committed by the Ministry of Health, which appointed PT Askes as the overseer of the Askeskin program. Based on the decision of the Constitutional Court of the Republic of Indonesia (MKRI) case No. 007/PUU-III/2005, the article governing SSIA was incongruous with the 1945 Constitution and lacking a robust legal foundation. Consequently, in the subsequent formulation of the SSIA Law, due consideration was given not only to Law No. 40 of 2004 but also to MKRI Decision No. 007/PUU-III/2005.

> Regions did not have the authority to create regional health insurance anymore. Meanwhile, [as I was working with the local governments], I really understand the struggles they faced when they tried to implement JPK Gakin. They [local leaders] were trying their best …. However, there was tension until a judicial review process was finally carried out. East Java was one of the regions that carried out the judicial review process. (KII 2)

President Yudhoyono, at the start of his administration (2004–2009), implemented various social assistance programs as one of his priorities. This strategic emphasis is distinctly articulated within the framework NSSA policy direction, as delineated in the 2005–2025 National Long-Term Development Plans (Rencana Pembangunan Jangka Panjang Nasional/RPJPN) document. The specifics of this policy orientation were also described in the Five-Year National Medium-Term Development Plans (Rencana Pembangunan Jangka Menengah Nasional/RPJMN) (Figure 5). During this period, a policy of reducing fuel subsidies was in progress, which caused the selling price of fuel in the country to increase rapidly, especially in 2005. The implementation of social assistance programs in the health sector was aimed at ensuring that people could continue to access health services even though the cost of services tended to become more expensive due to the increase in fuel prices. Furthermore, in the year 2008, the country grappled with a global financial crisis; however, it is noteworthy that this crisis did not exert a substantial or enduring impact on Indonesia.

Figure 5. Policy Direction and Goals of the National Social Security System in the 2005–2025 RPJPN

RPJMN 2005–2009:

Enhancing sector-specific social protection and welfare through the implementation of social assistance programs.

The program encompasses a wide range of issues, such as child and older person neglect, disability, social malaise, natural disasters, and social crises.

Goal: increasing the quality and access of the community to healthcare services.

RPJMN 2010–2014:

- Preparation, publication, and structuring of social security regulations.
- Structuring of social security administering bodies: transition process and formation of the legal basis for SSIA.
- Provision of social security benefits through actuarial analysis.
- Careful financial management and sustainable administration.
- Dissemination and education of social security programs.
- Increase in and integration of the role of the private sector.
- Expansion of social security participation and provision of subsidies for health insurance contributions for the poor and vulnerable.
- Goal: development of social security institutions.

RPJMN 2015–2019:

Goal: realization of social security institutions.

RPJMN 2020–2025:

Goal: compre-hensive social security coverage.

Source: Putri, 2014

The discussion on the conceptual formulation of the SSIA Law started in April 2006. The process involved various actors from bureaucrats to civil society organizations. The Coordinating Ministry for People's Welfare took the lead in orchestrating a series of meetings that brought together multiple ministries, experts, academics, and health insurance administrators. These meetings resulted in the formulation of the SSIA Law in January 2008. However, subsequently, the process of formulating the draft of SSIA Law encountered a hiatus. This was attributed to the necessity of awaiting the government's consensus on the legal status of the SSIA entity, a matter that remained subject to ongoing debate. During this interval, the DJSN, which was established in September 2008, did not take proactive measures to continue the development of the draft bill on the SSIA, despite its initial initiation by the Coordinating Ministry for People's Welfare. Even during discussions on the draft regulations of SSIA in 2010, the role of the DJSN was questioned (Wisnu, 2012).

Approaching the 2009 deadline for the enactment of supplementary implementing legislation, it appeared that Indonesia's aspirations for social security might have remained unrealized. In response to this deadline, both parliamentarians and civil society groups intensified their efforts (Pisani, Olivier Kok, and Nugroho, 2016). In July 2010, the parliament (DPR) convened a plenary session to endorse the draft bill on the SSIA. Subsequently, deliberations on the draft bill ensued, involving the parliament and representatives from other five ministries, including the Ministry of Finance, Ministry of State-Owned Enterprises, Ministry of Social Affairs, Ministry of Administrative and Bureaucratic Reform, as well as Ministry of Law and Human Rights. Pisani, et al. (2016) also reported that concurrently, academics, research organizations, and think tanks embarked on a comprehensive examination of existing social insurance endeavors, subsequently disseminating their findings. This period saw the concept of UHC gaining prominence, not only domestically but also among international development organizations. Some of these

entities, including Australian Agency for International Development (AusAID), United States Agency for International Development (USAID), and Gesellschaft für Internationale Zusammenarbeit (GIZ), provided funding to support these studies.

The political dynamics in the deliberations over the SSIA bill between the parliament and other government representatives were characterized by significant challenges. The process was marked by protracted debates and difficulties to reach an agreement. The main issues debated by the parliament and other government representatives included the nature of regulations, differences in views regarding NSSA, institutional concepts, and legal entity forms (Table 6). Therefore, until March 2011, the discussion of the draft law was deadlocked.

Table 6. Main Issues in the SSIA Bill Debated by the Parliament and the Government

No.	Issue	The Parliament	Other Governmental Institutions
1.	The nature of the regulations	**The bill is regulatory (*regeling*)—comprehensive**	The bill has the nature of determination—very simple, so the discussion time is faster
2.	Perceptions about NSSA	**Prioritize the fulfillment of citizens' rights**	Consider more on the financial aspects
3.	Institutional concept	Forming a single payer: merging the four existing social security administering bodies	**Forming two types of SSIA, to maintain existing organizing bodies:** **(1) SSIA on Health** **(2) SSIA on Employment**
4.	Organization legal entity	**In the form of a trustee legal entity**	Formed as a state-owned enterprise legal entity (profit oriented)

Source: Kementerian Hukum dan Hak Asasi Manusia, n.d.

The deadlock in discussing the SSIA bill occurred between April and early October 2011. The schedule for discussing the SSIA bill was deferred beyond the stipulated parliamentary session agenda. Originally slated for discussion on 19th October 2011, the intended finalization of the bill was subsequently impeded (Wisnu, 2012). In October 2011, the demand from SSIA supporters became stronger, prompting the parliament and the government to make more serious, transparent, and rapid efforts to complete the SSIA bill. After being pressed by the Social Security Action Committee (KAJS), an assembly of civil society actors, representatives in October 2011, the chairperson of the parliamentary, and the chairperson of the SSIA Special Committee made a pivotal commitment in October 2011 by endorsing a statement. In this statement, they pledged to immediately advance the ratification of the SSIA bill through a dedicated forum designed to facilitate the finalization of the SSIA bill in collaboration with the government. Finally, the parliament and the government agreed to sign the SSIA bill which was then ratified and enacted as Law No. 24 of 2011 on 25th November 2011. This law outlined the provisions concerning the establishment of the SSIA on Health, as outlined below:

a) SSIA on Health functions to administer the national health insurance program.
b) SSIA on Health is headquartered in the national capital and has the option to establish representative offices in the provinces, as well as branch offices in *kabupaten* and *kota*.
c) The transformation process involved converting the state-owned enterprises (Badan Usaha Milik Negara/BUMN) responsible for social security administration in the health sector, such as PT Askes, into nonprofit autonomous public legal entities, namely the SSIA on Health. This transformation encompassed substantial changes, including alterations to the legal foundation, legal entity structure, organizational components, operational protocols, institutional dynamics, responsibilities, interinstitutional associations, and oversight and accountability mechanisms.
d) The initial capital for the SSIA on Health was a maximum of 2 trillion rupiah (US$ 133 million), which came from the national budget.
e) The responsibilities and power of the SSIA on Health were specified.

In the meantime, the formulation of the social health insurance—spanning various health functional areas—was subject to extensive deliberations involving the Ministry of Finance, the Ministry of Health, the SSIA on Health, and DJSN, with the engagement of experts and academic professionals. The preparation and implementation stages of social health insurance from 2012 to 2014, including regulatory, membership, contribution, and institutional aspects, are outlined in Figure 6.

> The arrangements regarding the health fund in the NSSA Law were very good. The contribution of academics and experts who care about healthcare was great, including those who are experts in the field of health insurance. We were assisted to have better understanding about health insurance concepts, including for calculating the amount of premium/contributions, health service fee that will be paid by the SSIA on Health to providers as well as benefit design. (KII 5)

Figure 6. Preparation and Implementation Stages of SSIA on Health, 2012–2014

2012:

- Preparation of health insurance regulations and recipients of contribution assistance
- Benefit packages consensus

2012–2013:

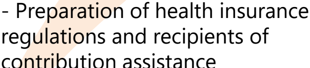
- Preparation of business process standardization
- Plans for developing health facilities, health workers, referral systems, and infrastructure
- Synchronization of membership data from Jamsostek, Jamkesmas, Askes, and ASABRI

2013

- Selection of SSIA on Health head
- Initial capital regulations
- Health insurance organizers prepare the handover of participants, assets, and human resources
- Determination of recipients of contribution assistance
- Determination of benefits packages and coordination of benefits management
- Preparation of standards, procedures, and payments for health facilities

2014

- SSIA on Health starts operating
- Transfer of health insurance participants: Jamsostek, Askes, ASABRI, Jamkesmas, Jamkesda to SSIA on Health
- SSIA on Health can accept new participants
- Development of all derivative implementing regulations
- The NSSA Law and the SSIA Law have been promulgated and published
- Implementation of the development of health facilities, health workers, referral systems, and infrastructure



Source: Ghufron, 2012

As of December 2014, almost one year after JKN had been implemented, the number of participants had reached 133 million, exceeding the government's target of 121.6 million people (Dewan Jaminan Sosial Nasional-BPJS Kesehatan, 2021). This showed that people's interest in accessing health services had increased sharply. However, the implementation of the SSIA on Health still faces fundamental problems including:

a) Disparities in the availability of health facilities and health personnel between regions. In terms of health service supply, the increase in the number of hospitals and hospital beds and medical personnel is faster on the island of Java than in other regions.

b) Many subsidized participants who are poor fail to take advantage of JKN due to various factors, including disparities in the availability of facilities and health personnel, especially outside Java.

c) SSIA on Health experienced several yearly budget deficits, mainly due to the large number of participants from the informal sector and nonworkers who were not paying contributions on an ongoing basis.

d) The low quality of services provided by health facilities, including cases where JKN participants are rejected or find it difficult to receive treatment for various reasons. The participants also complained that they receive different treatments compared to patients who are not in the program.

The discussion in the next section of the report is to understand the form of support and rejection, as well as the role of each key actor involved in the national health insurance

reform process. These roles include setting the agenda, designing, and starting the initial implementation process of the SSIA on Health.

5.3 Mapping of Key Stakeholders for the 2002–2014 Creation of JKN

The launch of JKN involves various stages of law and policymaking processes. As previously discussed, there were two stages and important periods of JKN creation. The early stage is the 1997–2004 period of reform where the foundation of JKN was first set up with the enactment of the NSSA Law, while the second stage of reform refers to a period from 2005–2014 where the SSIA Law was enacted in 2011. The JKN was then launched in 2014. The two periods comprise events and momentums which shaped how JKN was prepared and created, and eventually implemented. Both laws are considered as an achievement and a breakthrough for Indonesia in the area of health financing reform.

The process of law-making toward UHC is a political economy process in Indonesia and as experienced elsewhere (Chemouni, 2018). The deliberative process of the two laws consisted of contested ideas and interests, including strategic actions and collaborations by key actors involved. We found some noticeable differences in terms of leading key actors toward reform in the two periods, the involvement of nonstate actors in the law-making process, and the strategies taken to pursue reform agenda. In the two periods, the composition of the change team and their roles, albeit different, was successful in forcing the enactment of the two laws.

Literatures suggest that the success of having the NSSA Law in place was due to the leadership of President Megawati (Pisani, Olivier Kok, and Nugroho, 2016; Thabrany, 2008) and her strong influence though some inconsistencies toward the effort to establish the system was also observed. President Megawati played a key role as a political leader, categorized as leadership politics in this assessment, in the process of formulating the NSSA (Law No. 40 of 2004) and making it a success. President Megawati used her power and authority since she was still a vice president to establish a task force to promote social security issues both in government and in the public arena. With this task force, President Megawati had formed strategic alliances to prepare the draft legislation and academic papers for the NSSA. During this time, members of the task force worked hard not only to prepare the bill, but also to educate the public, the private sector, and even the government and line ministries about the importance and benefits of having a social security system in place. Some rejections came from the private sector and business associations, who think that the mandatory health contributions would put more burden on the business, thus reducing business profit. They suspected that the new health system required them to contribute more, while the money would not be used for their formal workers' benefits; instead it would be used to pay for the contributions of poor and vulnerable groups.

Conflicting interests also arose from within the line ministries, where some economic arguments were made against the universal health benefit, such as the potential of losing private investment if the social security law was enacted. There was also fear that the

implementation of the law would disrupt the state budget leading to bankruptcy. There were some disagreements within the line ministries themselves, i.e., between the Ministry of Labor, Ministry of Social Welfare, and Ministry of State-Owned Enterprises. This made the government's position toward the reform unclear, thus hampering the reform process. Meanwhile, support that came from international organizations, such as GIZ, Friedrich-Ebert-Stiftung (FES), the European Union, Asian Development Bank, and Australian Government, provided financial assistance and technical assistance to the government on the concept of social security system, as well as built people's knowledge and awareness.

In dealing with the groups that opposed the draft of NSSA Law, the task force team had to negotiate and make some compromises. For instance, compromises were made between the private sector and the government on the issue of premium contributions. To avoid constant rejection from the private sector, it was then agreed that the business owner would pay around 4% of the mandatory contribution, whilst workers would contribute around 1% of it. Although many technical issues were still part of the challenges to reach the goal of affordable health care (Pisani, Olivier Kok, and Nugroho, 2016), the law was successfully enacted.

> Finally, (we) have the law. Ibu Megawati may not understand much about the issue (of social security), but she cares about it. (Academic, in-depth interview, 19 September 2023)

Despite Megawati's interest and political commitment to achieving health coverage for all citizens, many debates and conflicting positions during the law-making process which were not noticed by the public were discussed by Pisani et al. (2016). Fairly limited media coverage on the issues may have caused it to be unnoticed, in addition to other issues, such as decentralization and direct election that attracted more of the public's attention. From our media tracking activity, we found at least 80 news articles on social security issues from 2003 to 2014. We counted that some 27 news articles reported on the interest group, more than 33 news articles reported on the bureaucratic group, 5 news articles reported on the budget group, 27 news articles reported on the leadership group, 15 news articles reported on the beneficiary group, and none reported on the external group.[12] The public started to pay attention to the bill once it was submitted to the parliament for discussion. During our media tracking, we found news covering some demonstrations by workers from the National Bipartite Consultation and Communication Forum (Forum Konsultasi dan Komunikasi Bipartit Nasional/FKKBN), who protested against the NSSA bill consultation process and called for a halt to the enactment of the bill, arguing that both the government and parliament had never consulted and sought the opinions of business and workers on the bill. Mass mobilization and workers' protest marches would occur if the parliament insisted on going ahead with the enactment (*Kompas*, 2004a). However, we also learned that the roles of beneficiary actors, such as civil society organizations and labor unions, in the formulation of the NSSA Law were less strong and dominant than in the formulation and stipulation of the SSIA Law. Labor unions have different positions and interests regarding the NSSA Law. Depending on the actors involved and their interests, unions can position themselves as opponents or supporters of the NSSA Law.

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[12]The total number is not 80 news articles because a news article could discuss the perspectives/opinions from multiple groups.

Regarding the role of bureaucratic politics, literature shows that the Ministry of Health displayed different standpoints toward the universal health scheme and its implementation (Mboi, 2015; Pisani, Olivier Kok, and Nugroho, 2016; Thabrany, 2008). Siti Fadilah Supari, the former health minister, promised to pay for inpatient services for all poor people in Indonesia, unaware of the presence of the NSSA Law (Pisani, Olivier Kok, and Nugroho, 2016). She paved the way for a pro-poor program called Askeskin to re-emerge. Yet, the program was seen as controversial for many, as it redirected power away from the local government to the central government, and the public was dissatisfied with its implementation. Some tensions between the Ministry of Health and other ministries, such as the Ministry of Finance and the Ministry of State-Owned Enterprises, also occurred concerning program administration, membership, and the roles of the local government in providing and administering health services (Thabrany, 2008). The controversies and tensions were apparent to the public through media coverage, which later led to continuous public attention to the matter.

Under the leadership of Nafsiah Mboi, the support of the Ministry of Health toward the social health insurance scheme was more apparent. She demonstrated strong attention toward the scheme and prioritized finalizing the conceptualization and planning for implementation of JKN while also aiming to expand healthcare facilities and strengthen the capacity of healthcare providers through continuous training (Mboi, 2015).

> For me, JKN is a great opportunity to improve access to care and public health in Indonesia, and I gratefully accepted to serve as a minister with priorities to finalize the conceptualization and planning for JKN; expand health care facilities across the country in various ways ... (Former Ministry of Health, Nafsiah Mboi, in Mboi, 2015).

Six working groups involving various people from the health sector and domestic and international experts were established to address key challenges in implementing the JKN. Members of the working groups came from, among others, the Indonesian Medical Association, health economists, representatives from the Ministry of Finance, the National Planning Board, and other organizations. The working groups were set up to ensure the timely and smooth launching of JKN in early 2014. The Ministry of Health also participated in proposing the design of social health insurance, together with the NSSA task force team and parliamentary members (Thabrany, 2008).

The literature further suggests that despite being mandated by the NSSA Law, the formulation and enactment of the SSIA Law continued to be a political process. NSSA was seen as Megawati's initiative and was controversial at the start (Pisani, Olivier Kok, and Nugroho, 2016). After Megawati stepped down, the SSIA Law formulation process was paused especially during the first period of Yudhoyono's presidency. During several key informant interviews, it was mentioned that President Yudhoyono had other issues of concern at that time, such as poverty issues and poverty reduction programs, which among other things, postponed the formulation of the JKN Law. The fiscal impact of the system, and the capacity of infrastructure—including institutions—to run the system were among the reasons for the postponement frequently mentioned. During some of our interviews, it was also revealed that a lack of knowledge among key policymakers regarding the roles of the insurance system, particularly health insurance, in promoting people's well-being also seemed to be the reason behind the delay. It was also reported

that there was a lot of pressure on the government from those who did not want the law to be implemented because they would lose direct access to the social security funds administered by the four state social security companies, as well as pressure from private insurance companies who were concerned about losing their market.

After more than ten years since the launch of the NSSA Law in 2004, the SSIA Law was successfully passed in January 2014. We learned that success of the launch was due to the involvement of quite a number of key stakeholders from various backgrounds in the process, from drafting the law, initiating the discussion in the parliament, and guarding the formulation process until it was finally enacted. Some of them had been participating since the formulation of the NSSA Law in 2004, while other actors happened to be dominant during the JKN law-making process. Table 7 summarizes the roles of each strategic actor in realizing this reform of health financing in Indonesia.

Academics were key stakeholders who were consistent in their position on UHC and the subsequent system since the beginning of the design of the NSSA Law. The academics come from several state-owned universities across Indonesia, some specializing in social and health insurance systems, having become strong supporters of UHC, and fully supporting the establishment of the system.

> There have been some conflicting arguments among the academics concerning the type of system that should be adopted and at what level government should run the health care system. The choice is either central government or local government. (KII 1)

We also identified the roles of international organizations in supporting the implementation of financial protection for people in Indonesia. During the 1997/1998 AFC, numerous international organizations allocated financial resources to improve the economic conditions in Indonesia, including to enhance impoverished individuals' accessibility to healthcare services. In addition, during the formulation of the NSSA Law, donor organizations, such as Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), have been actively involved in discussing the concept of a social security system for the country. Other international organizations also provided financial resources to support academics and research centers engaged in investigating the implication of implementing a social security system on diverse dimensions of livelihood. Another German-based organization, FES, was also actively involved in the law-making process, taking different roles than the GTZ. FES provided discussion materials and facilitated public dialogues to raise awareness and increase public knowledge about the UHC and social health insurance scheme. If GTZ particularly worked with the government, FES directed its assistance toward labor unions and civil society organizations.

The significance of parliamentarians in effecting health financing reform in Indonesia is pivotal. Since the inception of the NSSA Law, parliamentary members had demonstrated their endorsement for the establishment of a robust social security system designed to safeguard the populace during crises. Additionally, parliamentarians had contributed a conceptual framework of social health insurance which they deemed suitable for Indonesia. According to Thabrany (2008), the conceptualization of social health insurance proposed by the parliament closely resembled the notions advocated by the NSSA task force, showing the influence of task force on the framework. The parliament also benefited

from the support of Prakarsa, a local NGO who assisted in drafting the bill. The difference lay primarily in the design, as parliamentarians advocated for supplementary benefits for those opting for higher premium payments. The important role of parliamentarians became particularly evident during the formulation of the SSIA bill. Recognizing the potential repercussions of a delayed SSIA Law on the future viability of the social security system, parliamentarians assumed control of drafting the legislation.[13] Their proactive engagement extended to urging the government to expedite the enactment of the SSIA Law before the stipulated timeframe in the NSSA expired.

This assessment highlights the establishment of KAJS as a civil society response to the delay from the government, set up to push the social security reform. The committee comprised dozens of national labor unions, professional/employee unions, and various social movements, including representatives from farmers, fishers, students, and poor urban communities. KAJS serves as the overseeing body responsible for monitoring the implementation of Law No. 40 of 2004. The committee played a pivotal role in steering the formulation of the SSIA Law by actively engaging with the government during that period. Employing a multifaceted approach, KAJS actively advocates for the advancement of the SSIA agenda through channels such as dialogues, marches, deliberations, and public demonstrations, and in certain instances through legal actions taken against the government to expedite the implementation of social health insurance. Substantively, KAJS benefited from the support and guidance of academics and international organizations. During this period, the support for SSIA was far greater than those in opposition. Opposition primarily came from a minority faction of workers/employees and employers' associations.

> KAJS is suing the president, vice president, chairperson of the parliament, and eight other ministers for neglecting the implementation of the NSSA Law in the year of 2011. The lawsuit was accepted, and the government appealed to the high court. At that time the government had started to formulate the SSIA Law, but it was stopped. So, KAJS approached the parliament, especially the members in Commission IX on Health. The parliament supported the idea by initiating the drafting of the SSIA Law. Then a presidential instruction was issued assigning the coordinating minister for people's welfare as the team leader, who was then replaced by the minister for finance. This consistent change showed that the government has no desire to immediately implement NSSA through the creation of the SSIA Law. (KII 3)

[13]In Indonesia's legislation system, the parliament can propose a bill which then will be taken in a plenary session to pass the bill.

Table 7. Summary of Key Stakeholders, Their Interests and Power, and Strategies toward Reform

Stakeholder Category	Time Period	Stakeholder Group	Interest/ Position	Power/ Influence	Strategies toward Reform
Leadership politics	Enactment of NSSA Law	President	President Megawati was committed to the establishment of social security system and was in favor to pass the NSSA bill before the end of her presidentship.	The president utilized its power to form a special team consisting of academics specializing in social security issues (post-1998 crisis).	The president formed a special team to review existing security schemes and design the social security system.
		The parliament	The members of a political party (PDI-P) strongly supported the president as their party leader and her decision.	The parliament had a strong commitment and influence to push the government in passing the NSSA bill. They also proposed the social health insurance concept to the government.	To collaborate with academics and other experts in order to understand the concept of social health insurance.
	Enactment of SSIA Law	• President • Parliament-ary members (Commission IX/Health Commission)	The newly elected president did not have a strong interest in health issues. He delayed the stipulation of the SSIA Law, although it was mandated by NSSA Law. Parliamentary members had strong interests toward the stipulation of the SSIA bill, thus they	As the government seemed to lack interest in the social security issues, the parliamentary members then used their power to initiate the discussion of the bill in the parliament.	The parliamentary members-initiated discussion involved civil society organizations and academics to follow the discussion closely and monitor the issues.

Stakeholder Category	Time Period	Stakeholder Group	Interest/ Position	Power/ Influence	Strategies toward Reform
			initiated the discussion process in the parliament.		
Bureaucratic politics	Toward the implementa-tion of JKN	Ministry of Health	Support toward the universal health scheme and its implementation	Have limited power/influence outside the ministry	Established six working groups to address key challenges in implementing JKN; held a discussion/ negotiation with the Ministry of Finance to set up a premium contribution system; provided technical concept of social health insurance system (HMO concept)
	Enactment of NSSA Law	Ministry of Labor	Initially did not support the social insurance scheme due to competing interests (especially in ensuring the welfare of employees)	Suppressed the passing of the NSSA bill, especially when there was an option of equal share of contribution by employers and employee	In coordination with employers and employee association refused the passing of NSSA bill
	From 2004–2014	Other ministries (Bappenas, the Coordinating Ministry for People's Welfare, DJSN)	Supported the creation of social health insurance by providing required policy instruments	Provided policy instruments required to create SSIA and implement JKN	
Budget-related groups	From 2004-2014	Ministry of Finance	Strong Interest to keep the state contribution to a minimum	Ministry of Finance has influence over state budget. Some debates between the line ministries around the	Actively coordinate with other bureaucratic group politics, such as the Ministry of Health and DJSN, and other actors

Stakeholder Category	Time Period	Stakeholder Group	Interest/ Position	Power/ Influence	Strategies toward Reform
				amount of contribution fee from the government for poor group.	(academics, health workers associations)
Beneficiaries	From 2004–2014	Citizens, civil society organizations (KAJS)	Proponent of the SSIA Law: • KAJS: in favor of SSIA Law. Provided strong support toward the stipulation of the bill • Labor union Opponents of SSIA bill • Some labor unions • Business associations	Task force (comprising academics) had strong influence on Megawati in terms of designing the system and draft law.	Civil society (KAJS) mobilized people, workers' unions, urban poor consortium to fight for the SSIA bill to be passed and implemented by taking the matter to court for judicial review. Labor union protested against the draft bill which was seen as not inclusive in terms of process.
External actors		International organizations (GIZ, FES, EU)	Supported the establishment of the social security system	Each influenced different stakeholders. GIZ worked toward the government, while FES targeted public education and labor awareness.	Provided funds to conduct studies, facilitated discussions and public and social dialogues
Interest groups		• Health workers' associations • Employers' associations • Labor unions • Academics	Some labor unions and professional associations opposed the reform (reluctant to pay for workers' contribution).	Tried to influence and negotiate with the government, delayed the implementation of mandatory contribution by employers	Health workers' associations were invited to a discussion related to NSSA bill, SSIA bill, and JKN concept. They actively provided technical analysis to support the implementation of social health insurance, especially analysis related to the

Stakeholder Category	Time Period	Stakeholder Group	Interest/ Position	Power/ Influence	Strategies toward Reform
					distribution of health. Demonstrations were held by labor unions under the influence of professional associations. Academics became members of a task force that designed the system and raised public awareness.

5.4 Challenges

5.4.1 Decentralization

Decentralization presents a spectrum of opportunities and challenges in the realm of health financing transformation. The underlying principle of decentralization is to bring healthcare services into closer proximity to communities, fostering increased community participation in public decision-making processes. However, the practical implementation of decentralization has proven to be daunting, if not outright impeding, numerous transformative initiatives.

As previously discussed, within the decentralized system, the responsibility for implementing the health protection system was delegated to subnational governments, specifically *kabupaten* governments. However, with the establishment of JKN, health programs previously under local government jurisdiction needed to be integrated into the JKN managed by the implementing agency, the SSIA on Health. For some local governments, this mandatory integration was perceived as a form of intervention by the central government, resembling a trend toward recentralization. This perspective was notably prevalent in regions with well-established local health systems such as Jamkesda. In the case of East Java Province, there was even an appeal for a judicial review to contest the obligatory integration.

The mandatory requirement for program integration brought about persistent problems and challenges related to program harmonization. Research indicates that the diverse designs of regional health programs or Jamkesda, the fiscal capacity of local governments, and the political commitment of local leaders played pivotal roles in either supporting or impeding the integration process. Challenges arose from variations in the benefit packages offered by both central and regional governments, along with discrepancies in

the targets for premium assistance beneficiaries (PBI). Addressing these integration challenges involved making adjustments and adaptations to the system designs. Moreover, offering a more substantial role for regional governments in the decision-making process was proposed as a solution to facilitate smoother integration.

5.4.2 Negotiation and Interest Compromise of Each Actor

To ensure the success of health financing reform, collaboration among multiple key stakeholders is imperative. In the context of establishing JKN, key stakeholders engaged in continuous negotiations from the inception of the reform, addressing crucial aspects such as benefit packages, premium structures, program financing, benefit and claim coverage, and the implementing agency. These negotiations encompassed both technical considerations and the political interests of the involved stakeholders. A notable challenge emerged when the NSSA team had to persuade high-level government officials, including those from relevant ministries and other government bodies, to endorse the social security design proposed by the NSSA team. This persuasion centered on communicating the short- and medium-term benefits of the system, requiring a concerted effort by the NSSA team (Wisnu, 2012).

Wisnu (2012) emphasized that the NSSA implementation agency became a focal point of discussion among key stakeholders. Intense disagreements surfaced, even within government ministries, regarding the repercussions of abolishing existing institutions managing the insurance system, such as Jamsostek, Taspen, Askes, and ASABRI. The consolidation of all these managing institutions into a single implementation body, either DJSN or SSIA, raised concerns among some stakeholders who feared the potential loss of financial benefits typically derived from these individual institutions.

Negotiation points also arose from employee associations, which perceived the new health insurance system as an additional burden due to anticipated increased payments (Wisnu, 2012). Moreover, they harbored suspicions regarding the management of health funding, lacking trust in the current implementation bodies, such as Jamsostek. Concerns were raised about the possibility of their funds being utilized to finance or contribute to the coverage of the poor and vulnerable groups. The NSSA Law, once renowned as a political product, bears a heavy nuance of compromise among key stakeholders.

5.4.3 Political Commitment of Leaders

Political commitment of the president notably influenced the health financing reform process in Indonesia, specifically during the development of social health insurance. As elucidated in Subchapter 5.2, during President Yudhoyono's tenure, the execution of NSSA Law encountered substantial delays. Based on the law, it was scheduled that the technical regulation should be finalized in 2009; however, their ultimate completion was deferred until 2011. Literature and insights gleaned from in-depth interviews conducted in this study posit that discrepancies in program priorities and discordant relations between President Yudhoyono and his predecessor contributed to the protracted implementation delays (Pisani, Olivier Kok, and Nugroho, 2016; Wisnu, 2012). This finding aligns with the theoretical framework articulated by WHO (2018), asserting that the trajectory of reform initiatives is intricately linked to the commitment and priorities of political leaders,

including the head of state. In the Indonesian context, the roles of the change team, comprising diverse stakeholders, emerged as significant factors, as their collective efforts exerted pressure on the government to persevere with the reform agenda despite the prevailing political interest of the leader. Further insights into the strategic interventions of the change team are expounded upon in Subchapter 5.3.

5.4.4 Ensuring Provision of Quality Healthcare to Support the Implementation of JKN

To realize the goal of UHC, not only do people need to fully participate in the national health insurance system, but also the government needs to establish and maintain a well-functioning and adequately provisioned healthcare infrastructure. However, the situation of healthcare in Indonesia prior to the JKN era was inadequate, reflected by scarcity and uneven distribution of health personnels, and suboptimal level of healthcare services performance (Claudia Rokx et al., 2009; Heywood and Choi, 2010). Rokx et al. (2009) observed a notably deficient doctor-to-population ratio in Indonesia compared to its regional counterparts. As delineated in Table 8, Indonesia lagged behind other ASEAN countries in metrics such as the physician-to-population ratio, availability of nurses and midwives, and the provision of hospital beds. In 2011, 25% of *puskesmas*, predominantly located in rural and remote areas, operated without the presence of medical doctors (Harimurti et al., 2013). Disparities in healthcare quality, particularly in rural and remote areas, also contributed to the underutilization of previous health insurance programs, such as Askin and Jamkesmas (National Team for the Acceleration of Poverty Reduction, 2015). Furthermore, prevailing skepticism toward *puskesmas* and stigma that *puskesmas* is only for poor people created reluctance among the population to seek such facilities, consequently exacerbating queues at hospitals facilities (Erlangga and Shi, 2014; Mboi, 2015).

Table 8. Comparison of Availability of Health Staff and Hospital Beds per 1,000 People in the Region, 2010

	Physicians	Nurses and Midwives	Hospital Beds
Indonesia	0.1	1.3[a]	0.6
Cambodia	0.2	0.9	0.8
Lao PDR	0.3	0.8	1.5[b]
Malaysia	1.1	3.1	1.8
Philippines	1.3	5.6[c]	1.1
Thailand	0.4	2	2.1

Source: World Bank, 2021
[a]nurses and midwives in Indonesia, 2015 (data not available in 2010)
[b]hospital beds in Lao PDR, 2015
[c]nurses and midwives in the Philippines, 2009

Preceding the initiation of the JKN program, the government, especially the Ministry of Health, had intervened with the provision of health services providers nationwide. Mboi

(2015) reported that regulatory revisions and guidelines were enacted, with a specific focus on refining the operational scope of primary healthcare, such as strengthening the responsibilities of *puskesmas* on the functions of providing preventive care, health promotion, early diagnosis and treatment, and management of chronic care. To enhance overall healthcare accessibility, the shift to JKN involved the transition of the providers that previously collaborated with Jamkesmas, Askes, and Jamsostek. These providers were prepared to provide health services to at least 121.6 million participants (Dewan Perwakilan Rakyat Republik Indonesia, 2013). Concurrently, the government undertook capacity-building initiatives to elevate the proficiency of health professionals and to distribute the health workers to fulfill the minimum service standard.[14] Additionally, concerted efforts were directed toward enhancing healthcare infrastructure, accompanied by the provision of a national formulary and e-catalog to facilitate the procurement of medications by health providers (Mboi, 2015). The dispersion of healthcare providers and personnel was aligned with the objectives outlined in the JKN roadmap for the period of 2014–2019, with the following key performance indicators:

a) achieving the mandated bed ratio per 1,000 population in accordance with established standards;
b) increasing the number of hospitals, especially in regions where healthcare providers were limited;
c) increasing the development of medical services in government hospitals;
d) increasing ratio of doctors and medical specialists; and
e) equal distribution of doctors and medical specialists.

Despite the meticulous preparation for the implementation of JKN by the government, the execution process had encountered some problems. As mentioned in Table 4, the OOP expenditures in Indonesia had decreased significantly from 45% in 2000 to 32% in 2020. However, literature posits that disparities persist in the supply-side distribution of healthcare resources, resulting in inequitable access to health services. For example, six months after JKN was implemented, there were very long queues and a long waiting time to access outpatient services (National Team for the Acceleration of Poverty Reduction, 2015). Moreover, six years subsequent to the initiation of JKN, a scarcity of medical specialists persisted coupled with a slow expansion of healthcare facilities and beds compared to the growth of population (Candra et al., 2020).

5.5 Strategies to Move the Reform Forward

In this section, we analyze the strategies and approaches used by key actors to pursue the reform of the health financing system. These strategies can also be seen from Table 7.

5.5.1 Comprehensive Generation of Evidence

The process of evidence generation is undertaken by diverse stakeholders to provide optimal recommendations for the health insurance framework. Mboi (2015) reports that

[14]Minimum service standards are provisions of mandatory basic services at the regional level which the citizen has the right to obtain at a minimum.

preparation to "getting it (the health insurance system) right" during 2004–2014 was not only an exercise of health financing alone but an opportunity to comprehensively review the overall health system. Academics, drawing upon their educational expertise and experiences, proposed the amalgamation of previous social security schemes as a pre-eminent proposition. Moreover, as explained before, the evidence generation process was also supported by international institutions, for example, by sending academics to Germany to study the health insurance system.

The design of benefits and the overall structure of the JKN system in Indonesia did not transpire abruptly. The selection of the design for social health insurance, encompassing payment modalities for healthcare facilities, is a culmination of diverse models previously implemented. Also, preceding its nationwide implementation, the design of JKN had undergone extensive testing and garnered feedback from diverse stakeholders. Mboi (2015) additionally asserted that the JKN design had undergone thorough monitoring and evaluation, accompanied by significant adjustments.

One of the initial conceptualizations of the social health insurance framework divided the management of short-term insurance (encompassing health and workers' compensation) and long-term insurance administration (comprising pension and death funds). Subsequently, this model was utilized by the current social security system in Indonesia through SSIA on Health or Employment. The Indonesian government, however, did not adopt the Beveridge Model[15], due to low tax revenues at that time (Table 2).

> At that time, the debate was whether we wanted to use tax based like Malaysia or whether we wanted to use a contribution system. The debate took place around the year 2000. We finally tried to calculate. In 2001, only 2.5 million people had taxpayer numbers. Can you imagine ... how is it possible that 2.5 million people can cover or want to subsidize hundreds of millions of people? That's why we want to use a contribution system. (KII 2)

Meanwhile, the mandatory system that was also proposed encountered substantial opposition, notably from employers' association, business chambers, and government officials (Thabrany, 2008). This resistance came from the concerns that the mandatory system might violate human rights principles and cause poor management system. Thabrany (2008) argued that such opposition predominantly stems from a lack of understanding among stakeholders regarding the fundamental tenets of insurance concepts.

5.5.2 Seizing Political Opportunities

As previously discussed, the 1997/1998 AFC gave a new perspective for policymakers in government to provide a social security system that could protect people's finances when they were in an emergency situation. Apart from providing various forms of social assistance programs, the government also realized that at that time only a minority of people were covered by the health insurance system. This moment was utilized by the change team to realize the UHC system that had been promoted globally. Table 6 states that the formation of a task force involving various experts and academics was one of the

[15]The Beveridge Model funding and delivery are provided by the government, mainly using tax.

strategies used by President Megawati at that time to quickly review and conceptualize NSSA in accordance with the nation's ideology.

In the face of the aforementioned challenges within the health financing reform process, the active involvement and participation of civil society organizations at the grassroots level proved instrumental in propelling the reform forward. Ongoing discussions, publications, and public dialogues involving workers' unions, employers, and academics, supported by established think tanks, had sustained concerns and discussions on health reform and social security issues. The collaboration among nonstate actors had coalesced into a social movement, as evident by the formation of KAJS, which played a pivotal role in advancing the reform agenda. Additionally, at the parliamentary level, the establishment of a special committee (Pansus) for NSSA bill and SSIA bill, led by a workers' activist, emerged as a contributing factor to the success of the reform efforts.

5.5.3 Strategic Collaboration among the Change Team

The establishment of the comprehensive JKN system and its various subsystems was executed through multisectoral, multipartner, and multilevel endeavors. It is crucial to note that this undertaking was not confined solely to the health sector but encompassed a collaborative effort involving multiple sectors and partners. We identified two examples of the change team during the development of social health insurance in Indonesia. The first one was the task force team that was formed during the creation of NSSA bill. As mentioned above, this task force consisted of more than 60 stakeholders, among others, ministers, existing social security/insurance corporations, academics, and other organizations (Thabrany, 2008). These stakeholders worked together to finalize both academic papers and the NSSA bill. Although the process was lengthy and difficult, this strategic team could finalize the bill before the incumbent president finished her tenure.

The second change team was accidentally formed during the process of making regulations regarding SSIA. One of these team members was the KAJS. It is important to note that the strategies taken by the KAJS in pursuing its objectives were concepting, lobbying, and action.[16] During the law-making process, KAJS closely monitored the special session in the parliament, attended almost every meeting, had a special seat in the discussion room, and could comment and send feedback directly to parliamentary members who were present in the discussions. These strategies were made possible due to the closeness in the relationship between KAJS and its collective leadership with parliamentary members. These strategies were also useful and valuable since the parliamentary members felt that they were being watched and monitored by KAJS. The KAJS would instantly know if some issues being discussed were misled or went in a different direction than the reform objectives. Quoting one of our interviews, “This period was regarded as the time when the relationship between the parliament and civil society organizations reached the most harmonious relationship” (KII 3).

[16]Prior to holding a demonstration, KAJS engaged in a preliminary conceptualization of the issue, often involving internal deliberations to ascertain the nature of the problem and evaluate the feasibility of its resolution through policy advocacy, such as discussion or “lobbying” with relevant policymakers. Should diplomatic avenues prove unproductive in resolving the identified problem, KAJS proceeded by employing more assertive measures, exemplified by the organization’s recourse to organized demonstrations.

5.5.4 Initiating Policy Dialogue

From the NSSA bill conception process to the launch of JKN, the GoI held various opportunities to invite key actors to dialogue to find input and solutions.
The reluctance to embrace social health insurance often arose from a lack of understanding and ignorance about the benefits of having social insurance for the development and welfare of society. Some government officials saw healthcare as a commodity, not a basic social right. Meanwhile, employers tended to think that the existence of social security would increase the costs they had to bear. Thabrany (2008) reported that in making the NSSA bill, the task force and parliamentary teams invited various key actors, such as labor organizations, employers' associations, local governance, and international organizations, to discuss the NSSA concept. The government also held regional workshops to facilitate discussions with stakeholders in the regions. Even though they were facilitated, not all stakeholders felt included in or invited to the discussions. In previous discussions, FKKBN, for example, reported to the mass media that they felt they had never been included in discussions regarding the conception of NSSA. This of course created resistance from several parties to openly accept the implementation of the social security system.

5.5.5 Sustaining Resilience during Reform

Despite the challenges posed by the AFC, which significantly impacted the socioeconomic landscape of the country, the reform initiatives persisted, and the realization of the JKN system was achieved. This resilience underscored the strength of the political system in the country in navigating adversities. The evident factors contributing to this resilience included robust leadership from the president in the initial phases of the reform, unwavering support from the legislative body, and a concerted effort from civil society organizations and other nonstate actors. The later-phase involvement of civil society organizations in decision-making processes proved to be pivotal.

The political system's resilience during the reform process derived from a shared sense of values and awareness among members of the legislative body, academics, civil society organizations, and some leaders within government bodies and ministries. These stakeholders recognized the urgency of implementing health and security protection schemes, particularly for the general populace, the impoverished, and vulnerable groups, as a preemptive measure against potential future crises.

5.5.6 Strategic Leveraging of External Support

The roles of international organizations in facilitating the process of health financing reform in Indonesia are spread throughout various literature. Entities such as the World Bank, WHO, ADB, and GIZ have collaboratively worked with diverse governmental ministries, including the Ministry of Health, Bappenas, and the Ministry of Finance (Asian Development Bank, 2007; Hotchkiss and Jacobalis, 1999; Mboi, 2015; Simms and Rowson, 2003). The roles of international organizations varied, ranging from the provision of technical assistance to the allocation of financial resources for the execution of health programs.

International development entities have played a pivotal role in supporting the GoI since before the reform era. Noteworthy organizations, such as ADB, IMF, WHO, and the World Bank, in collaboration with the Ministry of Health, have sponsored and provided technical assistance for the implementation of health insurance programs, such as the managed care initiative[17] and JPS-BK. These initiatives were strategically implemented to mitigate the repercussions of the 1997/1998 AFC, especially in the health sector (Hotchkiss and Jacobalis, 1999; Simms and Rowson, 2003). External financial resources also have significantly contributed to funding various health programs in Indonesia, including those addressing HIV/AIDS, tuberculosis, and malaria (Claudia Rokx et al., 2009; Erlangga and Shi, 2014). Figure 7 shows the proportional allocation of external resources within the total health expenditure. It is discernible from the figure that Indonesia experienced an upsurge in funding post the 1997/1998 AFC, which was instrumental in bolstering the nation's social security program and ensuring provision of basic health services and interventions. As the country could navigate the crisis, the amount of external assistance witnessed a gradual decline. By 2006, donors accounted for a modest 2.3% of the total health expenditure (Claudia Rokx et al.).

Figure 7. External Resources as Share of Total Health Expenditure in Indonesia, 1995–2006

Source: Rokx et al., 2009

Throughout the health financing reforms, we found that the GoI showed receptivity toward international assistance proffered by various agencies. The roles of international organizations were emphasized in the provision of technical assistance and policy advice for policymakers, rather than providing direct funding for program implementation. The international organizations were included in a working group created by the minister for health, tasked with addressing challenges inherent to the social health insurance development, such as regulatory infrastructure, financial consideration, the transformative and integrative processes from preceding programs, supply-side provisions, and

[17]Managed care is a healthcare financing system that controls costs by managing the number of enrolled members and how care is provided. It involves prenegotiated contracts with healthcare providers to offer comprehensive services, including preventive care. Unlike traditional fee-for-service models, managed care pays providers a fixed amount for each member, regardless of the number of services used.

dissemination and advocacy endeavors (Mboi, 2015). In 2007, the Ministry of Finance specifically engaged with the ADB to conduct an initial fiscal analysis, delineating the short- and long-term costs associated with the implementation of social health insurance. Additionally, the ministry solicited ADB's assistance in formulating the design of social health insurance, providing capacity-building initiatives for the analysis of fiscal implications and broader economic effects associated with alternative social security reform options, and establishing an economic monitoring system to address potential shocks (Asian Development Bank, 2015; 2007). Furthermore, as previously noted, the FES undertook capacity-building endeavors for academics, labor unions, and civil society organizations. This involved convening discussions on health financing reform and facilitating visits to Germany, thereby affording firsthand insight into the implementation of social health insurance.

Other studies related to social health insurance and old pension scheme were also executed by GTZ and the World Bank. Through a collaboration with Bappenas, GTZ provided policy advice for Bappenas, while the World Bank formulated a comprehensive report delineating a reform roadmap. Concurrently, the World Bank and International Labour Organisation entailed research specifically focused on the pension payment system (Arifianto, 2004; Claudia Rokx et al., 2009). Some of the studies showed their support toward the implementation of a social security system; meanwhile, we also found a study stating its concern regarding potential impact of social security on Indonesia's future economic performance (Bazyar et al., 2021). Notably, despite extant literature acknowledging the roles of international development organizations in supporting reform initiatives within Indonesia, the interviews conducted for this study did not elicit discussion regarding their significance among the domestic stakeholders (except the interviews with international organizations). This result aligns with the findings of Pisani et al. (2016), who similarly reported that the views of international donors did not exert influence over the domestic discourse regarding the implementation of social health insurance in the country.

5.5.7 Mobilizing Public Support

Community mobilization is a form of community involvement in identifying their priority needs. In practice, this engagement empowers the community to articulate its needs, advocating for governmental intervention and the provision of comprehensive social security across all strata of society. It is imperative that all expressions of demand from the community be attentively considered. In response, the government may exhibit its responsiveness by adapting policy orientations and priorities. In this context, the community proactively urged the government to sustain deliberations pertaining to SSIA through demonstrations. The KAJS orchestrated multiple instances of mobilizing the community, drawing participation ranging from hundreds to thousands of individuals (Detik.com, 2011a). Additionally, a parliamentarian, advocating ardently for societal welfare, mobilized a cohort of 1,000 women to advocate for the enforcement of social health insurance (Detik.com, 2011b). Community mobilization, in this instance, operated through representative community entities. Demonstrations served as one of the strategies employed by KAJS, following antecedent phases of direct negotiations and advocacy. Demonstrations emerged as the ultimate recourse for KAJS when the organization perceived a lack of government responsiveness to their articulated concerns. Preceding the demonstration, KAJS had pursued legal action against the president, alleging intentional delays in implementing the NSSA Law (Wisnu, 2012).

VI. Lessons Learned

6.1 Reform Institutionalized through Law

The health financing reform in Indonesia was initiated by the leader's strong awareness about the importance of providing social security system in the country. This is in line with the literature that mentions that 'Health financing reforms are inherently political' (Odoch, Senkubuge, and Hongoro, 2021). Hence, without a serious commitment, a comprehensive reform toward a better system will be very difficult to pass due to pressure from interest groups (Harris, 1992). The strong social security system initiative was also considered a good practice as the leaders did not re-think about fiscal space or fund availability for policy adoption (Reich et al., 2016). As explained above, in Indonesia, the initiative came from former President Megawati who then appointed around 60 people to formulize the design. Moreover, initiative and commitment came from the parliamentary members who took over the process of establishing the SSIA Law when it was delayed during the Yudhoyono presidential era.

6.2 Creation of Coalition of Supportive Actors (Change Team)

One of the key successes of the health financing reform in Indonesia was the presence of a change team comprising diverse stakeholders, including civil society organizations, academics, external organizations, parliamentary members, and the mass media. The role of this change team was more pronounced after the NSSA Law was adopted and the government was in charge of creating technical regulations. In this study, we found that the pivotal contribution of academics and international agencies in improving the interest groups' (formal and informal working groups) understanding of social health insurance helped to alter the interest groups' positions from opposing the idea to supporting the reform. Beyond the formation of the change team, an intriguing aspect for discussion is the multifaceted factors influencing the change team's consistent advocacy for the government's realization of social security, including social health insurance.

Based on literature, a pivotal determinant driving the persistent advocacy of the change team for the establishment of social security, particularly social health insurance, lies in the mandates outlined by both the 1945 Constitution and Law No. 40 of 2004 concerning NSSA. The amended 1945 Constitution mandates the state to formulate and implement a comprehensive social security system, underscoring the entitlement of every citizen to social security. The 1945 Constitution encapsulates legal norms that constitute foundational pillars within the legal framework of Indonesia. The explicit statement about social security compels the government to fulfill this obligation without exception. Subsequently, the change team, with particular emphasis on parliamentary engagement, strategically harnessed this constitutional mandate to persistently advocate for the realization of a robust social security system (Antaranews.com, 2011).

Another influential factor shaping the efficacy of the change team in urging the government toward the realization of social security is the heightened awareness and knowledge of the need for social security for the community. This awareness is a result of numerous studies and publications conducted by scholars, which were disseminated through formal reports and mass media channels, as well as discussions facilitated by international institutions and nongovernmental organizations. As Wisnu (2012) articulated, these endeavors crystallized into a consensus underscoring the imperative to pursue subsequent actions following the enactment of NSSA Law. This realization spurred the change team, particularly involving civil society organizations and parliamentary representatives, to exert pressure on the government, compelling it to fulfill its responsibilities in formulating regulations concerning SSIA and instituting a comprehensive social security system.

6.3 Internal and External Influence

All key informants in this study, either explicitly or implicitly, stated the importance of evidence-based health planning. They need accurate evidence so that they are able to make decisions in accordance with the political role they play, including when the social community decides to move to oversee the implementation of social/health security. This study shows the strategic role that academics have in providing evidence based on experience and international literature that is accurate and valid, so that the transformation of health insurance receives strong support from various parties. Academics who are experienced and have expertise in the fields of public health, social security, and health financing are resource persons/consultants for the government, the parliament, and the general public.

Evidence and knowledge about health, including health financing, that are relevant locally and nationally have not been fully managed professionally, starting from their collection and presentation to their dissemination. This issue needs to be addressed to ensure that evidence is quickly available, with good quality, and easily accessible and as needed so that decision-making processes in the health sector can be carried out appropriately and the allocation of health resources is more effective and efficient.

Throughout the reform process, the presence of technical assistance played a pivotal role. International organizations, notably GIZ (previously known as GTZ), played a significant role by collaborating with the Office of the Coordinating Minister for People's Welfare in 2006 to produce a report on social security system reform in Indonesia. This collaboration involved Indonesian academics with expertise in public health, as outlined by Wisnu in 2012. The report delineated the subsequent agendas post the enactment of NSSA Law, including the formulation of DJSN and SSIA, and the preparation for the transformation of four institutions, namely PT Askes, PT Jamsostek, PT ASABRI, and PT Taspen.

Additional development partners, such as ILO, the World Bank, and initiatives like PNPM, in conjunction with TNP2K, conducted public dialogues to identify government projects

and programs that could be coordinated and synergized with NSSA Law. These collective efforts were aimed at facilitating the smooth implementation of NSSA Law.

6.4 Decentralization

As delineated in Subchapter 5.2, the implementation of decentralization and regional autonomy emerged as a formidable challenge in the establishment of a comprehensive social security framework, notably within the domain of social health insurance. The antecedent prerogative of regional governments to delineate health insurance structures within their jurisdictions was met with dissent upon the promulgation of Law No. 40 of 2004. In response to this contention, the government had undertaken a multifaceted approach, involving the utilization of legal mechanisms, specifically judicial review, and the rectification and alignment of regulatory frameworks governing the implementation of decentralization and national health insurance. This concerted effort was designed to facilitate a resolution to the debate, fostering a consensus on the distribution of authority between central and local governments within the health sector. The objective is to demarcate the delineation of authority comprehensively, mitigating potential overlaps in implementation through a clarified division of responsibilities between the central and local entities.

In response to the request proffered by representatives of regional governments, the Constitutional Court undertook a judicial review of Law No. 40 of 2004 vis-à-vis the 1945 Constitution. The trial, characterized by its comprehensive nature, featured the testimonies of experts spanning diverse fields such as law, economics, insurance management, public health, and actuarial science, whose insights were solicited to inform the ensuing decision-making process. The outcome of the judicial review delineated that the mandate for administering the national social security system resides jointly within the scope of both the central and regional governments. Consequently, regional governments should continue providing regional health insurance in strict adherence to the principles of decentralization and regional autonomy, albeit without contravening the provisions set forth in the NSSA Law. Concurrently, most experts generally advocated for the implementation of regional health insurance through a mechanism that may manifest in the form of complementary or supplementary services, strategically aligned with the services offered under the JKN program.

In addition, the government was engaged in policy amendments pertaining to the delineation of authority in decentralization between the central and regional governments within the health sector. Notably, Law No. 32 of 2014 omitted explicit delineations of authority concerning health financing matters between the central and regional governments. The allocation of authority within the health sector, designated as the purview of regional governments, is aimed at providing accessibility and enhancing the quality of health services within respective regions. This reallocation encompasses the provisioning of health infrastructure, deployment of health personnel, facilitation of pharmaceutical and medical equipment accessibility, and community empowerment initiatives within the health sector.

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Appendix

Appendix 1
Health Insurance Designs

Characteristics	PT Asuransi Sosial ABRI (PT ASABRI) for Military and Police Personnel	PT Asuransi Kesehatan (PT Askes) for Civil Servants	PT Jaminan Sosial Tenaga Kerja (PT Jamsostek) for Private Employees	Private Health Insurance	JPS-BK	PDPSE–BK	JPK-Gakin	Jamkesda	PKPS BBM-BK	Askeskin	Askeskin-Community	Jamkesmas	JKN
Implementation Timeline	**1971–2013**	**1992–2013**	**1992–2013**	**1970, Growing Rapidly in 1992–now**	**1998–1999**	**2001**	**2001**	**2001–2013**	**2002–2004**	**2005–2007**	**n.a.**	**2008–2013**	**2014–now**
Scheme													
Participation	Mandatory	Mandatory for civil servants	Mandatory, unless the company provides other insurance that is better than Jamsostek	Additional benefits (not mandatory)	Additional benefits (not mandatory)	Additional benefits (not mandatory)	Voluntary	Voluntary	Additional benefits (not mandatory)	Voluntary	Voluntary	Voluntary	Mandatory
Model	Social health insurance	Social health insurance	Social health insurance	Commercial insurance	Social assistance	Social assistance	Managed care model	Near the model of social health insurance	Social assistance	Managed care model	Various schemes in the community	Near the model of social health insurance	Social health insurance
Coverage	Military personnel, police personnel	Civil servants, retired civil servants, veterans, freedom pioneers, and their family members.	Private and family employees and informal workers (in reality, it is rare to find informal workers who participate in Jamsostek)	Private employees	The population is poor and vulnerable to poverty, including newborn babies and victims of acts of violence	Poor families	Poor people who are registered in the Integrated Social Welfare Data (DTKS) and vulnerable people who are not yet registered in the DTKS, but have the same poverty	Poor, near poor, and based on individual and household targets. There are also areas that cover the entire community.	Poor, near poor,	The informal sector, civil servants and military as well as those who cannot afford it but are not yet covered by other health insurance programs	Various communities in the informal sector	For those indicated to be poor, approaching poor, and based on individual and household targets	All Indonesian people, consisting of premium assistance beneficiaries (PBI) and non-PBI

Characteristics	PT Asuransi Sosial ABRI (PT ASABRI) for Military and Police Personnel	PT Asuransi Kesehatan (PT Askes) for Civil Servants	PT Jaminan Sosial Tenaga Kerja (PT Jamsostek) for Private Employees	Private Health Insurance	JPS-BK	PDPSE–BK	JPK-Gakin	Jamkesda	PKPS BBM-BK	Askeskin	Askeskin-Community	Jamkesmas	JKN
Implementation Timeline	**1971–2013**	**1992–2013**	**1992–2013**	**1970, Growing Rapidly in 1992–now**	**1998–1999**	**2001**	**2001**	**2001–2013**	**2002–2004**	**2005–2007**	**n.a.**	**2008–2013**	**2014–now**
							criteria as poor families						
Number of participants	n.a.	14 million people (Susenas, 2007)	4,1 million people (2009)	6.6 million people (Susesnas 2006)	n.a.	36,1 million people	n.a.		n.a.	Target 60 million people, more than 36 million poor people	440.000 people (Susenas, 2006)	75 million people	Entire population (target)
Choice of health service provider													
Outpatient	Government hospital or equivalent private hospitals	-First level: *puskesmas*, Clinics and GP -Advanced level: *kabupaten/ kota* hospital, provincial hospital, private hospital, and vertical hospital	-First level: *puskesmas*, Clinics and GP -Advanced level: *kabupaten/ kota* hospital, provincial hospital, and vertical hospital	Private, and in some areas where private hospitals are not available, government hospitals are used	*Puskesmas* and village midwife	Hospitals, *puskesmas* and their networks	*Puskesmas* and hospitals, both government and private	- First level: *puskesmas* -Advanced level: *kabupaten/kota* hospital, provincial hospital, and vertical hospital	*Puskesmas* and hospitals	*Puskesmas* and hospitals	Only public hospitals	-First level: *puskesmas*, village midwife, and *pondok bersalin desa* (*polindes*) -Advanced level: *kabupaten/ kota* hospital, provincial hospital & vertical hospital	Government hospitals, *puskesmas*, private hospitals or clinics that collaborate with BPJS
Inpatient	Class I inpatient government hospital, government hospital regional, or equivalent	-First level: *puskesmas* with beds -Advanced level: *kabupaten/ kota* hospital, provincial	-First level: *puskesmas* with beds -Advanced level: *kabupaten/ kota* hospital, provincial hospital, and vertical hospital							Only public hospitals	Not covered	-First level: *puskesmas* with beds -Advanced level: *kabupaten/ kota* hospital, provincial hospital, and	Government and private hospitals that collaborate with BPJS

Characteristics	PT Asuransi Sosial ABRI (PT ASABRI) for Military and Police Personnel	PT Asuransi Kesehatan (PT Askes) for Civil Servants	PT Jaminan Sosial Tenaga Kerja (PT Jamsostek) for Private Employees	Private Health Insurance	JPS-BK	PDPSE–BK	JPK-Gakin	Jamkesda	PKPS BBM-BK	Askeskin	Askeskin-Community	Jamkesmas	JKN
Implementation Timeline	**1971–2013**	**1992–2013**	**1992–2013**	**1970, Growing Rapidly in 1992–now**	**1998–1999**	**2001**	**2001**	**2001–2013**	**2002–2004**	**2005–2007**	**n.a.**	**2008–2013**	**2014–now**
	private hospitals	hospital, and vertical hospital										vertical hospital	
Benefits package													
Type of service provided	Comprehensive	Comprehensive	Comprehensive	Comprehen-sive	Basic health services and provision of additional food for toddlers	All health care as well as provision of additional food and hepatitis B vaccination at the *puskesmas*	Comprehen-sive	Comprehensive	All health care as well as provision hepatitis B vaccination and eye care	Comprehensive	Limited	Comprehen-sive	Comprehen-sive package according to basic needs and medical indications
Excluded conditions	No	No	Varies by plan	Varies by plan	n.a.	n.a.	n.a.	n.a.	n.a.	Varies by plan	n.a.	No	Yes
Benefits for childbirth	No	Yes, package for normal delivery	Yes, package for normal delivery	Yes	Yes, in village midwive	n.a.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Annual medical examination	No	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No	No
Disease prevention and health promotion	n.a.	Yes	Yes	Yes	Yes	n.a.	Yes	n.a.	Yes	Yes	Yes	Yes	Yes
Services not covered	n.a.	Plastic surgery, physical examination, dental prosthesis, fertility	General checkups, cancer treatment, heart surgery, dental dialysis, long-	Depends on the package selected	Follow-up care	n.a.	n.a.	General checkup, glasses, hearing aids, mobility aids (wheelchairs, crutches, corsets),	Provision of supplemental food	Cosmetic surgery, physical examination, alternative medicine, dental	Inpatient and specialist doctors	Cosmetic surgery, physical examination, alternative	There are types of services that are guaranteed

Characteristics	PT Asuransi Sosial ABRI (PT ASABRI) for Military and Police Personnel	PT Asuransi Kesehatan (PT Askes) for Civil Servants	PT Jaminan Sosial Tenaga Kerja (PT Jamsostek) for Private Employees	Private Health Insurance	JPS-BK	PDPSE–BK	JPK-Gakin	Jamkesda	PKPS BBM-BK	Askeskin	Askeskin-Community	Jamkesmas	JKN
Implementation Timeline	**1971–2013**	**1992–2013**	**1992–2013**	**1970, Growing Rapidly in 1992–now**	**1998–1999**	**2001**	**2001**	**2001–2013**	**2002–2004**	**2005–2007**	**n.a.**	**2008–2013**	**2014–now**
		treatment, and nonbasic immunizations	term treatment for congenital diseases, non-basic immunizations, surgery, and infertility treatment					Alternative medicine (acupuncture, traditional medicine), medication and procedures in an effort to conceive children including IVF and impotence treatment, dialysis for 7 and so on, due to traffic accidents, due to drugs/narcotics, and unprocedural services		prosthesis, fertility treatment		medicine, dental prosthesis, fertility treatment	limited, those that are subject to reduced fees and those that are not guaranteed
Finance													
Source of funds	Member fees	Member contributions are 2% of basic salary and 2% of state funding and there is no limit	Single: 3% basic salary; Members with dependent: 6% salary limit to IDR 1 million (US$ 100)	Payroll (company salary scheme), depends on the plan	Financed through loan funds from the Asian Develop-ment Bank (ADB)	State budget	State budget	Regional budget	State budget	Premium, depending on plan. For poor people, the government/state budget pays a premium of 5,000 rupiah per person	Community contribution	State budget/tax-based: allocated IDR 6,000/capita	Varied based on type of participants

Adapted from Claudia Rokx et al., 2009

Jl. Cikini Raya No. 10A
Jakarta 10330 Indonesia

+62 21 3193 6336

+62 21 3193 0850

smeru@smeru.or.id

smeru.or.id

The SMERU Research Institute

@SMERUInstitute

@smeru.institute