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Expansion of Health Care Protection and Health Governance in Indonesia

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***Abstract*— The 1999 Asian economic crisis and political reform brought significant change in the sphere of health governance in Indonesia. One of the important landmarks is the expansion of health assistance for the poor (known as Askeskin). While Askeskin and later program such as Jamkesmas were created as ad hoc policies to mitigate the impact of economic crisis, these programs evolved to be a salient political issue both at national and local levels. The implementation of the National Social Security Law in 2011 further emphasises the defining role of health protection as a mean to achieve government's ambition of universal access to health care by 2019. Based on 10 months ethnographic research and interviews with various health insurance stakeholders, this paper examines how health care expansion shapes health governance in Indonesia. Inspired by Gough & Wood's informal welfare regime (2004), this paper argues that despite the ambition, government's lack of investment in health services remains to be the main factor inhibiting health care reform. As consequence, the current health governance is caught in the limbo between expanding access to health services and providing adequate health services.**

Keywords*— *health reform; social insurance; governance

I. INTRODUCTION

Indonesia is undergoing a massive expansion in its health system. The main driver of the expansion is through the expansion of health insurance and ambition to achieve Universal Health Coverage by 2019. Politically, the expansion proves that health care protection in Indonesia has been evolving from productivist welfare in the 90's, 'pro poor policy' during the Asian financial crisis, toward a more universal welfare provision.

This article seeks to explain in what ways the expansion of health care protection affects health governance. Inspired by Gough and Wood's informal security regime, I argue that health care reform may not lead to better health care protection. In this article I argue that the caveat of the current health care expansion lies in the governance and the institution where the reform takes place. The first factor is political process. As a political process, health care reform is inevitably affected by the established governance. In this case, the current health care reform is very much influenced by strong negative permeability of the Indonesia societal and political structures. Democratization indeed opens up possibilities for stronger popular representation; and yet, progressive popular representation remains weak. The dominant political sphere is still dominated by legacy of the authoritarian regime (politico-bureaucrat) as well as conservative view on social protection.

Secondly, institutionally Indonesia health care reform is built upon a dysfunctional health care system. Fragmentation and stratified norm of health system in Indonesia was deeply embedded in the current reform. The policy making process was also dominated by conservative view of health care. Health care protection is therefore an extension of the remaining stratified and privatized health care provision. The most devastating implication of the conservatism in health care expansion can also be seen by limited government investment in health provision. The unequal supply side and demand side creates governance limbo in many health institutions.

II. INSTITUTIONAL BASE OF HEALTH CARE REFORM

Analysis on the development of welfare regime, including health care, in advanced capitalist country is usually converged around the relationship between market, state, and family [1]. In this perspective, social class and social structure are fundamental features to explain the emergence of welfare regime variations (conservative, liberal, social democratic). According to Esping-Andersen, social class through the politics of class mobilization plays an important role as a political agent. Esping Andersen further demonstrates how variations in the politics of labor unions (and class alliances initiated by working class mobilizations) determine the shapes of the three welfare regimes.

However, not so much about working class mobilization, initial motivation of welfare policy in Indonesia was very much state centered and related to the International Monetary Fund and World Bank's structural adjustment policies [2]. Even though the initial objective of the policy was to contain the severity of the 1998 economic crisis, it represents a major step in the collectivization of social security arrangements in Indonesia.

In this article, I argue that expansion of health care expansion in Indonesia could be partly explained through Gough and Woods's informal security regime. Asian welfare regime according to Gough is characterized by tiny role of the state, the insignificant degree of decomodification, and the questionable salience of the concept of welfare in the society [3]. Moreover, the role of formal institution in shaping stratification outcomes and interest group formation is small.

The SEA welfare regime also heavily influence by external factors such as global economy and supranational institutions. Impact of the external factors is larger compared to the advanced capitalists countries/OECD where the welfare regime approach is derived.

Taking into account the need of reexamination and reformulation of welfare regime approach, Wood and Gough propose two welfare regimes to describe welfare regimes in South Asia (Bangladesh) and Africa: informal security regimes and insecurity regimes [4]. Both of welfare state regimes touch upon non state and state institutions in the reproduction of security and insecurity, and recognize the diversity of welfare trajectories in peripheral capitalism. Wood and Gough define informal security regimes as 'institutional arrangement where people rely heavily upon community and family relationships to meet their greater needs, to greatly varying degrees. The relationships among actors are usually 'hierarchical and asymmetrical' and often results in 'problematic inclusion or adverse incorporation'. In this informal security arrangement, the underlying connection between actors is patron-clients relation and to some extent this relationship can be extremely resistant to civil society pressure as well as welfare reform.

Before the introduction of health insurance for the poor, only 10% of Indonesian population was covered by formal health insurance. The formal health insurance is provided by Government and employers trough various schemes. Government is responsible to pay insurance premium of the civil servants as well as police and military personnel; while employers are responsible to provide health insurance for their workers. Besides the compulsory insurance, private insurance and other community based insurance are also available. The private health insurance scheme covered approximately 4 percent of the population. Low level informal workers who made up 60 percent of Indonesia labor force and the poor were excluded from any form of social health insurance.

III. EXPANSION OF HEALTH INSURANCES

The first social health insurance was intended to protect the poor under the name of Social Safety Net (SSN) health card scheme and was largely part of the International Monetary Fund and World Bank structural adjustment policy. During Asian Financial Crisis in 1997-1998, International Monetary Fund and World Bank play important role in initiating the 'pro poor policy' within the logic of Structural Adjustment Program. The Structural Adjustment Program has four objectives: (i) stabilizing the exchange rate and prices and stimulating domestic demand through fiscal and monetary policy; (ii) bank and corporate restructuring; (iii) improving governance and increasing transparency and efficiency; and (iv) protection for the poor and preservation of human assets, which was accomplished through the Social Safety Net (SSN) program [5]. In terms of program coverage, the SSN scheme was smaller than the latter programs. It provides fee waivers to the health card holders for inpatient care in third class wards at public hospitals. However, different from the latter health insurance schemes in which the reimbursement payment is based on treatment package, the SSN reimbursement's scheme was is in the form of block grant based on estimated number of poor household in the area. This method of reimbursement created implementation problems where hospitals often did not have enough funds to provide services for the SSN card holder patients.

In order to expand social security coverage to the informal sector, Askeskin program was introduced in 2005 to replace the SSN scheme. The objective of Askeskin was to reach the target population of 60 million people. Broader than the predecessor, Askeskin covered basic outpatient care, inpatient care in third class wards at public hospitals, an obstetric service package, mobile health services and special services for remote areas and islands, immunization programmes, and medicines. In terms of reimbursement policy, hospitals claims were based on fee for treatment package. At the primary health centres, compensations were given on capitation basis. As a broader policy, Askeskin was also intended to cover private health services. However, only few of the private health care providers voluntarily took part in Askeskin. Even though central government was responsible to fund the scheme, resources and risk were pooled at the district level. In order to cover a monthly premium of Rp5000, central government disbursed approximately Rp3.9 trillion, (approximately USD 400 million) in 2005.

Later on, Jamkesmas was introduced in 2008 as replacement of Askeskin. The significant difference of the policy compared to Askeskin is the role of PT Askes (the state owned insurance corporation) as the sole payer. In the Askeskin scheme, government transferred fund to PT Askes instead of to the local governments. Further, PT Askes distributed the fund to different hospitals based on claims made by the hospitals. During the implementation of Askeskin, government claimed that PT Askes has failed to distribute approximately Rp1.7 trillion. The incidence resulted in different financing method whereas in the current health insurance scheme government provides reimbursement directly to the hospital.

In addition to central government's efforts to expand health protection for the poor, the decentralization law (Law 32/2004) stipulates greater role of local governments to provide health care services. According to the law, national government is no longer the sole provider of public health services. Through decentralization of political and budgeting powers, local governments are also responsible to provide health services. Local governments respond to this new structure in various ways. Ninety percent of districts in Indonesia have been implementing different kind of local health financing scheme and 9 million of poor people are covered by local health insurance for the poor/Jamkesda [6]. The notable examples in which local governments provide (almost) universal (free) health care can be seen from Jembrana Health Insurance introduced by Gede Winasa, Alex Noerdin in Musi Banyuasin, and the most celebrated one is Jakarta Health Card. With few local governments provide universal and free health care, we can say that most of the

schemes are created to supplement the national scheme by extending coverage for the poor who are not covered by the national scheme.

Expansion of social health insurance can be seen further in the implementation of National Social Security Law (UU SJSN) and Social Security Agency Law (UU BPJS). The social security laws guarantee provision of health care, workplace accident, old age, and death benefits to all Indonesian citizens. Furthermore, as the program will be sustained financially by participants' contribution, the social security laws represent the shift from the social assistance perspective into a more universal social protection regime. For the proponent of the laws, the laws represent a constitutional shift in providing a universal and comprehensive protection for all citizens including the poor. In other words, it represents a major change in the collectivization of welfare in Indonesia.

IV. IMPLICATION TO HEALTH GOVERNANCE

Despite the constitutional guarantee, government expenditure on health care remains low, from 2 percent in 2005 to 2.9 percent of GDP in 2011 [7]. Government expenditure on health care is slightly increased from 4.1 percent in 2001 to 5.3 percent of the national government budget in 2013. The notable increased is the increased number of government expenditure for health insurance for the poor. This is certainly not a surprised given the fact that from 150.559.634 national health insurance members, 84 million members are funded by government budget through health insurance for the poor scheme. Moreover, public/government expenditure does not replace the dominant role of private expenditure (out of pocket payment) on health [8].

Furthermore, the expansion of health insurance is built upon what Pisani calls as 'logic of dysfunction. She argues that the system suffers chronic problems that only 'healthier politics' can cure. The system is highly decentralized to a point of fragmentation. Indonesia health care system is considered as one of the weakest in the world with key features among others are low budget allocation (2-3% of national and local budget), ineffective treatment, high out of pocket proportion of the medical expenses, and eventually low utilization of the formal health care system.

Under this 'logic of dysfunction', the introduction of social security laws does not necessarily lead to better health protection. The social security law itself contains several internal policy problems. The law was vaguely formulated and lack of details of how the social protection would look like. Deliberation process of the social security law occurred under the pressure to pass the law before the end of President Megawati's term. Many contentious and debatable clauses in the law were removed or replaced by vaguely formulated social security jargons; hence reducing its substantive clarity. The end result is an ambiguous law with language that can be diversely interpreted. In addition, stakeholders have low confidence on the quality of the laws. During the drafting and deliberation processes, there were no known actuarial calculations detailing contribution rates and benefits, nor any reliable economic analysis on the short and long term impacts of the scheme [9].

Besides low quality of policy making process, many observers on welfare policies in Indonesia, speculate on the unholy motive behind the social security law. Social assistance is arguably play important role in election campaign and vote buying [10]. In the same light with the role of social assistance during elections, social security law is regarded as a way for politicians to create a huge off budget slush fund rather than fulfilling citizen's rights [9]. The mismanagement and corruption of workers provident fund and pension fund during the New Order are examples of welfare institutions practices in the past and illustrate the fragility of state institutions.

Rosser & Wilson [11] argues that the current public health care system is under invested and this condition is a result of competing interests between the politico-bureaucrat. The competition among politico-bureaucrats makes budget allocation to public health care remains low compared to other government projects. Accordingly, public health facilities have to charge illegal fees simply to pay workers and provide services. Secondly, according to Rosser, current public health facilities is still part of the larger 'franchise structure' that characterized the New Order. As part of 'the franchise' public health facilities are also expected to generate funds for local government budgets. 'The franchise' also involves public officials' personal interests. Reflect from the widespread of bribery and illegal practices within the Indonesian public service, public health bureaucrats also take advantage of the facilities to generate additional incomes for themselves. And lastly, Rosser argues that poor people have no effective way of contesting illegal fees when they are charged to pay the illegal fees. Despite the Government attempts of bureaucratic reform, internal accountability and complaints mechanisms within government institutions, especially health care are still very weak.

In addition to Rosser's research on illegal fees, research also shows decentralization contributes to poorer quality of the available health care, especially health care services for the poor [12]. Decentralization of health care is marked by the growing number of private hospitals at the local level. Doctors are also seen to increasingly use their position in community health centers to attract patients to their own private and more expensive services [13]. In relation to local government's initiatives on health care card, Johar argues that the increased demand of health care for the health card holders does not correspond with the supply side [14]. Numbers of full time GPs working in public health facilities are decreasing. The study does not reveal the causes of the decreased, but it is widely known that doctors are reluctant to participate in the government scheme due to low compensation.

V. CONCLUSION

At the policy level, there are shortcomings that the government should address. The first is low budget allocation

for health allocation. The current health budget would not be sufficient to realize government promises of universal access to health care. At the same time, the current health insurance policy needs to be reformed. Health experts have stated that the current national health insurance premium would not be enough to cover all types of health problems, which would include catastrophic illnesses. Moreover, in the highly privatized health system, the current premium will not give incentive for private hospital to join the national health insurance program. Secondly, the government needs to improve supply side readiness. With the increased demand of health care, the current health care provision is far from sufficient. Indonesia has the lowest bed availability (6 bed per 10.000 people) compared to other countries in the region. With the introduction of health insurance for the poor, the availability of third class wards becoming more critical. Health providers, both hospitals and medical human resources, are highly concentrated in urban areas and centered on big islands. On the other hand, the government needs to invest more in improving community health facilities. Thirdly is the informal sector inclusion. More than 60 percent of Indonesia workforce is informal. In the current health insurance scheme, their involvement remains very low. And lastly, Indonesian to some extent is used to accept 'stratified health care' as the norm of health care provision. For a long time, stratified health care and notion of social protection as privileged have been reproduced through various welfare policies as well as political practices.

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