

# WORKING PAPER

Number 04 Year 2009

## Toward Universal Health Insurance in Indonesia : The Role of Civil Society Organizations

Adenantera Dwicaksono  
October 2009



Institute for Innovation,  
Participatory Development, and Governance

# Toward Universal Health Insurance in Indonesia: The Role of Civil Society Organisations<sup>1</sup>

---

By: Adenantera Dwicaksono<sup>2</sup>

Jl. Guntur Sari IV/16, Bandung, Jawa Barat – Indonesia/Perkumpulan INISIATIF

## Introduction

The quality of health service in Indonesia is still a major problem faced by the Indonesians, particularly the poor people. Data from the latest Indonesia Demographic and Health Survey 2007 (IDHS 2007) indicates persisting disparity of health status between the poor and the better off. For instance, the infant mortality rate (IMR) for the lowest wealth quintile is 56 deaths per 1000 live births, which is almost double compared to 26 deaths per 1,000 live births for children of the highest wealth quintile (Statistics Indonesia and Macro International, 2008). In the area of maternal health, the maternal mortality ratio of Indonesia is 420 per 100.000 live birth deliveries, which is ranked in the 12<sup>th</sup> country of 18 countries of ASEAN and SEARO (*Departemen Kesehatan*, 2008). These figures confirm the most recent statement of the Coordinator Ministry of People Welfare, Aburizal Bakrie, who comments on Indonesia's achievement of the MDGs targets. He said that the periodic achievement of MDGs targets are still as

---

<sup>1</sup> This paper was submitted to 2009 AIGRP Essay Competition, organized by Crawford School of Government, The Australian National University

<sup>2</sup> He graduated from Master of Development Studies at The University of Melbourne in 2007. Currently, he works as the Chief of Division of Public Policy Reforms at Perkumpulan Inisiatif –an NGO dedicating for the improvement of the livelihood of marginalised people through policy reform. He is involved in national network of advocacy for National Social Security System (SJSN).

planned, so that the target will be fulfilled by 2015, except for the health sector (*Suara Pembaharuan*, 2009).

Health financing is one among the problems of Indonesia's health sector. Based on the IHDS 2002-2003, the main problem in accessing health care by woman is economic in nature (24%), which prevents women to access health facilities (Statistics Indonesia and ORC Macro, 2008). The rural women are found to have more economic difficulties compared to urban women (30% and 16% respectively). This illuminates the lessons learned from World Health Report 2000, which suggests that health care financing is the most important element of health system determining the health status of a country (WHO, 2000). Indonesia, like other developing countries, relies heavily on the *out-of-pocket* payment system. According to Rokx et al. (2009), there are at least 73,9% of Indonesian population that are uninsured. WHO(2000) recommends that health care financing systems should be able to maximally pool risks and share health care burdens across populations. The social health insurance is one option to choose and leaving the *out-of-pocket* payment system as minimal as possible (Ortiz, 2007).

In 2004, President Megawati Sukarnoputri signed the Law No. 40/2004 on the National Social Insurance Scheme. The law outlines the type of social insurance by which each citizen will be covered, including social health insurance. Many believe that this law will be the milestone that will pave the way to the realisation of universal health insurance in Indonesia. Unfortunately, almost five years have passed and no single operational regulations are produced, which makes this law crippled. The hope of universal health insurance coverage in Indonesia is started to fade away.

Despite the low progress of implementation at the national level, some provincial and district level governments are heading the other way around. Instead of waiting actions from central government, they initiate numerous policy innovations of universal health insurance in their localities at varying degrees. For instance, Sumatra Selatan and Yogyakarta Province introduce the social health insurance for their citizens. A number of districts and municipalities, like Bandung, Purbalingga, Jembrana and so on, also take initiatives to introduce similar policies. These innovations shed the lights that the dream of universal health insurance in Indonesia is possible, though it is still a long way to go.

This essay offers an alternative route to the realisation of the universal health insurance in Indonesia. Instead of pushing changes from above, the social health insurance system can be promoted from below, by exploiting opportunities provided by decentralization.

The essay focuses the concerted roles of civil society organisations working at local and national level to promote health care financing policy reform, particularly toward the realisation of universal health insurance.

## **Decentralisation: Fertile Soil for Policy Innovations**

Since the *Reformasi* era, Indonesia has undergone one of the most ambitious decentralization program among all developing countries (Budlender and Satriyo, 2008). Decentralisation has been rolled out since 2000 through the implementation of Law No. 22/1999 and further revised 22/1999 by Law No. 32/2004. The laws provide the normative basis for the transfer of authorities and financial management from central government to local governments, including health care matters. The article 14 paragraph (1) letter e of the Law states that the health sector management is one of the mandatory authorities of the local government. It is obliged to deal with the health sector including its sub-systems like health care financing. Furthermore, the law also provides opportunities for regions to develop their own social insurance systems (article 22 point h), one of them is the social health insurance (Law 40/2004 Article 18). These policy frameworks are further elaborated by the KepMenKes No. 004/Menkes/Sk/I/2003 on Decentralization Policies and Strategies of Health Sector.

Although the decentralisation framework has brought some opportunities for better local governance, it may impede the realisation of the universal access of health service nationally (Thabrany, 2008). According to Thabrany (2008) the pressures on local governments to generate more revenues have led to the commercialisation of public hospitals, and the significant cuts of subsidy for health services at local level to ease local budget expenditure burden. These trends eventually affect to the substantial decrease of health service equity.

This situation is partly true. However, the decentralisation can also be seen as a fertile soil for policy innovations development in health care financing at the provincial and local level. More and more provincial and local governments have adopted policy innovations for health care financing to ensure universal access for all their citizens. Based on a review of seven case studies, Dwicaksono and Nurman (Forthcoming) identify three typologies of policy innovations in health care financing adopted by local. The policy options are subsidising operational cost of basic health care services;

introducing subsidised health insurance; and establishing co-payment between government and community.

Subsidised operational cost of basic health care service is adopted by Sumedang District, Banjar Municipality, and Sukoharjo District. These governments eliminate the retribution of basic health services provided by *Puskesmas* (community health centre) and allocate subsidies to the operational cost of *Puskesmas*. This policy innovation has increased equity of the basic health care services disregards of social and economic status. However, this policy option also has several disadvantages. This scheme does not provide stable funding in the long run due to the nature of competitions with other sector priorities within the government (Drouin, 2007), is highly dependent on macro-economic conditions and by the composition of formal and informal sectors in the economy (WHO, 2000); and may be inefficient due to the lack of competitive incentives for health care providers and effective public oversight.

Another policy option is the subsidised health insurance scheme. Regions adopting this scheme are Yogyakarta Municipality, Purbalingga District, and Jembrana District. Jembrana adopts the most progressive social insurance scheme, which provides free primary healthcare to all population; and free secondary and tertiary care for poor members (Gaduh and Kuznezov, 2005). Purbalingga introduce a more moderate policy option by adopting partially subsidised insurance scheme (Marianti et al., 2005). The government only subsidises the premium for poor member group, and partially subsidise the premium of the near poor group member. Yogyakarta adopts similar policy options, but it acts as additional package to the insurance scheme provided by Yogyakarta Provincial government.

Kabupaten Sleman adopts a more conventional health care financing policy option, which is a mixture of *out-of-pocket* payment and government-based financing (Dwicaksono and Nurman, Forthcoming). The government is responsible to allocate adequate fund to ensure the highest standard of health services, while the community pay the service costs in accordance with the level of willingness-to-pay (WTP) for services received. The access of the poor is covered by the national program of JAMKESMAS, and other available schemes.

## **Pushing Forward: What Civil Society Organisations Do?**

The stagnant progress of the Law 40/2004 on National Social Security System indicates poor political commitment of central government to take progressive measures toward the realisation of national health insurance. This situation provides an impetus for civil society to take more progressive actions to promote reform agenda on universal health insurance. This proposal of actions are based on the view that sees civil society as a means to deepen democracy practice (Gaventa, 2006). 'A robust civil society can serve as an additional check and balance on government behaviour, through mobilising claims, advocating for special interests, playing a watchdog role, and generally exercising countervailing power against the state' (Gaventa, 2006, p. 14).

The role of civil society to promote the universalisation of health services has been cited in Brazil's experience of health system reform. Cornwall and Shankland (2008) assert that the health system reform in Brazil is the outcome of organised civil society movement, which successfully bring in the agenda of universalisation of health services into the formal agenda of health system reform. The civil society movement also put pressure on the government to make changes to the system and to expand the discourse about the model to wider audiences.

The realisation of universal health insurance system in Indonesia requires active and concerted roles of civil society both at region and national level. In doing so, there are at least two broad strategies for civil society organisations: (1) promoting extensive replication of health care financing policy innovation at the local level across the country; and (2) pushing forward health reform agenda at the national level.

Extensive replication of health care financing policy innovation at the local level aims to create demonstration effect to the central government that there is an immensely growing demand on health system reforms both at the national and local level. Civil society organisations can act as a catalyst for widespread extension of health care financing policy innovations at the provincial and local level. Based on a survey conducted by FITRA (*Forum Indonesia untuk Transparansi Anggaran*) and The Asia Foundation on an inventory of civil society organisations (CSOs) working in the area of budget advocacy, there are over 50 CSOs working in the area of budget advocacy (Budlender and Satriyo, 2008). Budlender and Satriyo (2008) also points out that the majority of the organisations' focus on local government budgets rather than national government budgets, which makes Indonesia different from many other countries.

Budget and pro-poor policy advocacy, which have been the key work areas of local CSOs in Indonesia, are the entry points to introduce health care financing policy innovations at local level. For instance, the advocacy program of the adoption of *Jaminan Pemeliharaan Kesehatan Masyarakat* (Social Health Insurance) in Bandung District by Perkumpulan INISIATIF, is the follow up action from the result of preceding budget analysis on health sectors (Nurman and Martiani, 2008). The policy proposal was developed with intention to abolish financial barrier of the poor people to access health care facilities. Similar action was taken by *Pusat Pengkajian dan Pengembangan Masyarakat Lokal* (P3ML), a local NGO located in Sumedang District. The policy proposal to eliminate retribution of Puskesmas services were designed to ensure that budget allocation in health sector contribute to the elimination of barrier of access to basic health care facilities, particularly for poor people in Sumedang District. Another CSO, *Jaringan Kajian dan Advokasi Kebijakan Publik* (*Jangkep*) –a coalition of NGOs in Yogyakarta, currently assists Yogyakarta Municipal Government to develop local regulation on Social Health Insurance.

The roles played by CSOs working at local level require very specific set of skills and capacities. Alongside with the capacities in policy advocacy, such as lobbying, negotiation, persuasive communication, and networking, CSOs are required to have additional technocratic capacities in policy research, understanding of health system financing, and institutional setting of different health care financing system. These skills are required to persuade local government to take initiatives toward social health insurance. This situation confirms the study conducted by Court and Young (2003), which shows how the capability of CSOs to establish legitimacy of evidence is influential to the outcome of policy advocacy.

At the national level, there are a number of CSOs working at the national level to safeguard the legislation of derivative national regulations. *PRAKARSA* and *GAPRI* (*Gerakan Anti-Pemiskinan Rakyat Indonesia*- Movement for Anti Impoverishment of Indonesian Life) are among the few CSOs, which focus their advocacy programs aiming the realisation of national health insurance in Indonesia. Currently, they are working together to safeguard the legislation process of the law draft on National Social Security Implementing Agency (*RUU Badan Penyelenggara Jaminan Sosial Nasional/ RUU PBJSN*), which is currently being proposed by the National Social Security Council (Dewan Jaminan Sosial Nasional – DJSN). *PRAKARSA* and *GAPRI* aim to ensure that the social security implementing agencies established at the local level are also

acknowledged and provided with substantial roles to deliver social security scheme, including social health insurance, at the provincial and local level aside to the traditional state-owned national insurance firms (PT. ASKES, PT. ASABRI, PT. TASPEN, and PT. Jamsostek). Thus, the ongoing local government policy innovations in health care financing can be sustained.

PRAKARSA and GAPRI play a number of roles to ensure that the views of civil society are reflected in the new law. They work as counterparts of the policy makers, by extending the discourse of the national health insurance scheme to a wider audience, mobilising circle of experts on of public health financing to enrich the ongoing debate, and facilitating the aspiration from below to policy makers. Recently, PRAKARSA and GAPRI submitted an alternative draft of the Law on National Social Security Implementing Agency, which is based on civil society perspective, to the parliament ([http://www.gapri.org/page.php?lang=id&menu=agenda\\_view&agenda\\_id=21](http://www.gapri.org/page.php?lang=id&menu=agenda_view&agenda_id=21)).

These concerted civil society initiatives both at local and national level depict the possibilities of an alternative route to the realisation of universal health insurance coverage in Indonesia. Instead of inducing changes from above, local initiatives on health financing policy innovation promise better leverage to achieve the goal more rapidly. These initiatives are heading toward the *integrated-decentralisation model* of universal health insurance system (Mukti, 2007, Mukti and Moertjahjo, 2008). The *integrated-decentralisation* model is a model of social health insurance institution that incorporates the subsidiarity principles by providing opportunities for local governments to develop and implement social health insurance scheme in accordance with local needs, but remains integrated with the national system. The model also reflects the decision of Constitutional Court of Indonesia on the judicial review of Law No. 40 In 2004 in particular Article 5 Paragraph 3 stating that the local governments can develop a health insurance system with the conditionality of inclusiveness principles, which means that the system ought not to be exclusive only for their own citizens but others too.

## Conclusion

This essay shows that an alternative route toward the realisation of universal health insurance is possible through concerted roles of civil society working at national and local levels. The massive replication of health care financing policy innovation in a number of regions justify the need for more comprehensive and yet integrated system



of social health insurance in Indonesia. The endurance of national CSOs to actively engage with policy makers in central government and parliament also plays important factor to keep the progress at the national level.

However, challenges toward universal health insurance in Indonesia still persist. Indonesia is still in the process seeking for the most suitable model of social health insurance. Therefore, the discussion of the model is still far from end. The debate should be extended to incorporate the perspective from local level as well as other regions, particularly outside Java. The endeavour to find the most ideal model of universal health insurance system is a long process of trial and errors. The experience of Brazil with the *Sistema U'nico de Sau'de (SUS)* (Cornwall and Shankland, 2008), and the Philippines with *PhilHealth* social health insurance (Obermann et al., 2006) show that the realisation of universal and equitable access for all citizens is a long journey of experiments and struggles.

### List of References

- Budlender, D. & Satriyo, H. A. (2008) *Budget Advocacy in Indonesia*, International Budget Partnership, Available from <http://www.internationalbudget.org/IndonesiaCountryReport.pdf> [Accessed 29 August 2009]
- Cornwall, A. & Shankland, A. (2008) Engaging citizens: lessons from building Brazil's national health system. *Social Science & Medicine*, 66 2173-2184.
- Court, J. & Young, J. (2003) *Bridging Research and Policy: Insights from 50 Case Studies*, ODI Working Paper No. 213, London, Overseas Development Institute-UK.
- Departemen Kesehatan (2008) *Profil Kesehatan Indonesia 2007*, Jakarta, Departemen Kesehatan Republik Indonesia.
- Drouin, A. (2007) Methods of financing health care: A rational use of financing mechanisms to achieve universal coverage. *ISSA Technical Report*, 5 1-15.
- Dwicaksono, A. & Nurman, A. (Forthcoming) Menuju Jaminan Akses Kesehatan Universal di Indonesia: Perbandingan Model dan Kelembagaan Sistem Jaminan Kesehatan di Daerah. *Jurnal Analisis Sosial*.
- Gaduh, A. B. & Kuznezov, L. (2005) *Making Services Work for the Poor in Indonesia - Case Study 6: Health Insurance Reform in Jembrana District, Bali Province*, Harvard University Kennedy School of Government, Available from <http://www.innovations.harvard.edu/showdoc.html?kpid=8638> [Accessed 29 August 2009]
- Gaventa, J. (2006) *Triumph, Deficit or Contestation? Deepening the 'Deepening Democracy' Debate*, IDS Working Paper No. 264, Brighton, Institute of Development Studies, University of Sussex.
- Marianti, R., Budiati, S. & Tan, E. (2005) *Making Service Work for the Poor in Indonesia: Financing Mechanisms in Kabupaten Purbalingga, East Sumba, and Tabanan*, Jakarta, SMERU.
- Mukti, A. G. (2007) *Masa Depan Sistem Pembiayaan dan Asuransi Kesehatan di Indonesia: Konsep Desentralisasi-Terintegrasi [Presentasi]*, Yogyakarta, Available from [http://www.desentralisasi-kesehatan.net/id/Materi\\_Seminar\\_Deskes/Hari\\_2\\_8\\_Agustus\\_2007/Sesi\\_2\\_2/Sesi\\_2\\_2a/%2810%29%20ALI%20GUFON%20MUKTI.pdf](http://www.desentralisasi-kesehatan.net/id/Materi_Seminar_Deskes/Hari_2_8_Agustus_2007/Sesi_2_2/Sesi_2_2a/%2810%29%20ALI%20GUFON%20MUKTI.pdf) [Accessed 29 August 2009]

- Mukti, A. G. & Moertjahjo (2008) *Sistem jaminan Kesehatan: konsep desentralisasi terintegrasi*, Yogyakarta, Magister Kebijakan Pembiayaan dan Manajemen Asuransi Kesehatan, Fakultas Kedokteran, Universitas Gadjah Mada - Asosiasi Jaminan Sosial Daerah.
- Nurman, A. & Martiani, A. W. (2008) *Merumuskan Skema Penyediaan Jaminan Pelayanan Kesehatan yang Sesuai untuk Daerah*, Seri Advokasi Universalisi Pelayanan Kesehatan, Bandung, Perkumpulan INISIATIF.
- Obermann, K., Jowett, M. R., Alcantara, M. O. O., Banzon, E. P. & Bodart, C. (2006) Social health insurance in a developing country: The case of the Philippines. *Social Science & Medicine*, 62 (12): 3177-3185.
- Ortiz, I. (2007) *UNDESA Policy Notes: Social Policy*, Washington, DC., UNDESA.
- Rokx, C., Schieber, G., Harimurti, P., Tandon, A. & Somanathan, A. (2009) *Health Financing in Indonesia: A Reform Road Map*, Jakarta, World Bank Indonesia Office.
- Statistics Indonesia & Macro International (2008) *Indonesia Demographic and Health Survey 2007*, Calverton, Maryland, USA: BPS and Macro International.
- Statistics Indonesia & ORC Macro (2008) *Indonesia Demographic and Health Survey 2002-2003*, Calverton, Maryland, USA: BPS and ORC Macro.
- Suara Pembaharuan (2009) Menko Kesra: Sektor Kesehatan Bermasalah [The Coordinator Ministry of People Welfare: Health Sector is in trouble]. *Suara Pembaharuan*, 26 August 2009,
- Thabrany, H. (2008) Politics of National Health Insurance of Indonesia: A New Era of Universal Coverage. *The 7th European Conference on Health Economics*, 23-26 July 2008 Rome, Italy. Rome, Italy: Available from: <http://www.un.org/ecosoc/newfunct/pdf/Thabrany-NHIP-Program%20and%20Politic-Indonesia.pdf> [Accessed 29 August 2009]
- WHO (2000) *The World Health Report 2000: Health Systems - Improving Performance*, Geneva, WHO.