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Campaigning for All Indonesians: The Politics of Healthcare in Indonesia

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Many scholars argue that democratization is conducive to the development of social welfare policies and that democracy brings about redistributive reform due to demands from the newly enfranchised poor. In reality, however, democratization does not necessarily bring about comprehensive social welfare reform. If not democratization, what explains social welfare expansion in developing countries? This article examines Indonesia, which began the process of democratization in 1998 following the fall of President Soeharto, and which has since become a stable democracy with a consistently growing economy. More than a decade after Soeharto's resignation, Indonesia started to implement a comprehensive healthcare policy. What explains the gap between the enactment and the implementation of this social policy reform? In answering this question, I argue that electoral competition alone does not shape social policy reform. Instead, social reform has institutional prerequisites, such as the broad-based organization of its advocates. A broad-based organization goes beyond its narrow interests, builds cross-class alliance and pressures the government. Without this prerequisite, democratization does not necessarily result in comprehensive social reforms.

Keywords: Indonesia, advocacy coalitions, healthcare, Social Security Administering Bodies (BPJS), National Social Security System Law (SJSN).

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Many scholars argue that democratization fosters redistribution through electoral competition and inclusiveness.[1] By extending the franchise to the poor, they argue, democracy provides electoral incentives that promise social protection for its citizens. In addition, voters can penalize governments when they fail to carry out their promises. However, regime type is not sufficient to explain social policy outcomes. Although democracy does provide incentives for politicians to promise social protections to the newly enfranchised poor, it does not guarantee the enactment or implementation of inclusive social reform policies. What then explains social policy expansion in developing countries? This article explores this question by examining Indonesia's implementation of universal healthcare reform in January 2014.

As a new democracy and emerging economy, Indonesia provides an interesting case study for analyzing what enabled the implementation of universal healthcare expansion. After thirty-two years of authoritarian rule, Indonesia started democratizing after the fall of President Soeharto in 1998. More than ten years later, in 2011 the Indonesian government passed the Social Security Administering Bodies bill (*Badan Perencanaan Pembangunan Nasional*, BPJS), which enabled the National Social Security System Law (*Sistem Jaminan Sosial Nasional*, SJSN) to be implemented. In 2004, the last year of Megawati Sukarnoputri's presidency (2001–04), parliament had enacted the SJSN law, which could have provided comprehensive reform of the existing social care system. This law covered four social security programmes — health insurance, employment injury, old-age pensions and death benefits — and seemed to provide a springboard for comprehensive social policy reform to include formal and informal sector workers, the unemployed and the poor.

However, the SJSN law was not put into effect immediately. Implementing this law required detailed provisions of social security programmes to be determined by presidential regulations, including policy options for benefits and benefit parameters. While government agencies and the House of Representatives had discussed the law, no progress was made until October 2011. Neither President Susilo Bambang Yudhoyono nor the existing social security agencies and ministries were enthusiastic about the reform.[2] Nevertheless, the House of Representatives passed the BPJS bill and Presidential Decree 111/2013 was subsequently issued. Both pieces of legislation enabled the Indonesian government to establish a comprehensive healthcare programme beginning on

1 January 2014. Other social security programmes were subsequently implemented on 1 July 2015. Under this social welfare reform, all Indonesian citizens — as well as residents of the country — are required to join the national healthcare insurance scheme, and the Indonesian government aims to achieve universal healthcare coverage by 2019.

Why did the implementation of universal healthcare take ten years after the initial enactment? I argue that social welfare reform has an institutional prerequisite, such as an advocacy coalition, which represents the broad interests of society. An advocacy coalition is a "group of actors from various public and private organizations who share a set of beliefs and who seek to realize their common goals over time".[3] Without such a coalition, electoral competition does not necessarily provide incentives for politicians to undertake inclusive social welfare reform. In concrete terms, the 2004 SJSN reform bill was introduced in a top-down manner by the government without a broad societal consensus. In contrast, the 2011 BPJS reform was a bottom-up initiative. The successful implementation of the BPJS law demonstrates that the coordinated efforts of an advocacy coalition going beyond their own narrow interests can pressure politicians into implementing inclusive social welfare reforms.

This article consists of four sections. First, it reviews the literature on social policy expansion to elucidate competing arguments and identifies what is missing in the literature to verify the causal mechanism linking democratization with social welfare. Second, I offer an historical overview of Indonesian healthcare policies and the reasons behind their slow expansion. Third, I examine pre-existing challenges to comprehensive social welfare reform in Indonesia. Finally, I explain how an advocacy coalition consisting of various organizations was able to press the government to implement social welfare reform despite pre-existing challenges.

Explaining Social Welfare Reform

The existing literature on social policy expansion focuses mainly on cases from Western countries or East Asia such as South Korea and Taiwan. Theoretical insights gained from Western case studies primarily concern countries that are economically developed,[4] have strong bureaucracies,[5] party institutionalization or strong left-wing political parties and trade unions.[6]

Scholarship focusing on Asia emphasizes that democratization has been a significant factor for social policy expansion.[7] Joseph Wong argues that the process of democratization shaped social policy reforms in South Korea and Taiwan. Democratic reform and the political incentives of electoral competition initiated universalization of healthcare when conservative parties turned to social policy reform as winning electoral platforms.[8] Furthermore, the degree of electoral competition helps shape the outcome of social policies: the high degree of electoral competition in South Korea obliged the government to implement a quick-fix reform while the ruling party in Taiwan adopted a more transformative policy due to the low degree of electoral competition. With respect to Indonesia, Edward Aspinall argues that the country's democratization has led to healthcare policy expansion because of an open policy-making process and an incentive structure that is sensitive to social pressures in a democratic environment.[9] Aspinall acknowledges that "in terms of policymaking dynamics, the Indonesian experience is reminiscent of the pattern of health care policy expansion identified by Wong in Korea".[10] Similarly, Andrew Rosser and Ian Wilson argue that democratic decentralization contributed to pro-poor policy reforms in Indonesia by examining two districts in Bali: Jembrana and Tabanan.[11] Jembrana has taken a much more pro-poor approach than Tabanan because of their respective district heads' political strategies. When the votes of politicians depend solely on the masses instead of the party machine or mafia networks, the district head is likely to produce pro-poor policies.

While the existing literature rightly highlights the importance of democratization in social policy expansion, the causal mechanisms linking democratization with social welfare reform is missing.[12] In particular, the literature falls short in not discussing the importance of social forces. Although an open policy-making process and an incentive structure that is sensitive to social pressures exist in Indonesia, these cannot explain why the 2004 SJSN law could not be implemented while the 2011 BPJS law was able to be put into effect. Therefore, it is vital to examine how social pressures are mobilized, and how the policy-making process and incentive structures are shaped by social forces. By paying attention to social forces, we can understand the causal mechanism linking democratization with social welfare reform. Furthermore, I argue that democratization is a necessary but not a sufficient condition for social welfare policy implementation. What is needed for an

inclusive social welfare reform is a broad-based advocacy coalition that represents cross-class interests.

Advocacy Coalitions

I use the term "advocacy coalition" to encapsulate a broad-based organization that represents cross-class interests. The concept of advocacy coalitions is not new. Many scholars argue that advocacy coalitions play a significant role in public policy-making.[13] While social movements do not always produce tangible policy outcomes, advocacy coalitions can increase the possibilities for achieving policy outcomes in three ways. First, advocacy coalitions can create political opportunities in both authoritarian and democratic states by effectively setting an agenda and bargaining with governments. Authoritarian states seeking to increase their legitimacy and social control can be susceptible to advocacy coalitions. For example, in the case of Singapore, where the role of civil society is circumscribed, civil society organizations like the Association of Women for Action and Research (AWARE) and Nature Society Singapore (NSS) have successfully engaged in advocacy politics vis-à-vis the state.[14] In democracies, competitive elections and the urge for bureaucratic accountability enables advocacy coalitions to take advantage of political institutions. Second, advocacy coalitions increase the chances of social movements attaining their goal by orchestrating various movement strategies, including protests and political alliances. Given that an advocacy coalition has a discernable leadership, it makes coordination feasible. Moreover, utilizing both protest and political alliances can produce a joint effect.[15] Lastly, advocacy coalitions with cross-class alliances can raise issue salience more effectively for their movements, as they appeal to broader constituencies. An advocacy coalition in Indonesia is able to set an agenda, utilize various means of protests while collaborating with sympathetic politicians, and gain a broader audience by reframing the issue to be of concern to all citizens.

Before I analyze how an advocacy coalition has influenced the implementation of heathcare policy in Indonesia, I will examine Indonesia's previous health policy provisions and how healthcare policies have evolved or expanded over time. Examining the piecemeal growth of healthcare policies in Indonesia demonstrates that there has been a political logic behind social policy formulation.

Indonesia's Social Policy Provisions Prior to the BPJS Reform

Prior to Indonesia's democratization, Indonesia's social policies favourably benefited civil servants, members of the security services such as the police and army, and formal sector workers only.[16] All of these systems were introduced during Soeharto's authoritarian regime (1967–98) as an instrument for legitimation. The Soeharto regime used social policies to maintain political control and reduce social pressures for political change. Therefore, Indonesia's social policies have gradually expanded whenever the regime has faced internal or external challenges or crises.[17]

With Presidential Decree no. 230 (*Keputusan Presiden*, Keppres) in 1968, the Soeharto regime started to provide healthcare benefits for current and retired public employees and military personnel as they were the regime's main power base.[18] In 1992, in the face of increasing industrial unrest organized by labour organizations, the government passed the Workers Social Security Law (*Jaminan Sosial Tenaga Kerja*, JAMSOSTEK) to provide social security for private formal sector workers.[19] It was implemented to ease friction between labour and the state. State-run companies ran these insurance schemes. TASPEN (*Tabungan dan Asuransi Pensiun*, Social Insurance and Pension) and AKSES (*Asuransi Kesehatan*, Health Insurance) covered voluntary social insurance or mandatory savings for civil servants while ASABRI (*Asuransi Angkatan Bersenjata Republik Indonesia*, Military Insurance) covered the armed forces. JAMSOSTEK covered formal sector employees.

The main weakness of these insurance schemes was low coverage. Under AKSES, civil servants contributed 2 per cent of their basic salary (matched by the government) to the publicly managed insurance fund. This scheme covered 7 per cent of the population in 2012 (about 17.2 million beneficiaries). JAMSOSTEK covered individuals working in private companies employing at least ten workers and with a turnover of over 1 million Rupiah. Employers paid 3 to 6 per cent of the salary depending on the employee's marital status. Only 5.6 million people were covered by health insurance in 2012. Out of 100 million workers, only about 23 million workers were covered by these schemes. Including the number of commercial health insurance participants, currently around 151.5 out of 240 million Indonesians are covered by some form of health insurance.[20]

Although the Soeharto regime provided some health services for the rural poor, they were extremely limited. *Puskesmas* (*Pusat*

Kesehatan Masyarakat, Community Health Centres) provided affordable healthcare services for people at the sub-district level after 1968 and expanded its coverage throughout the country over the next twenty years.[21] In addition to this, *Posyandu* (*Pos Pelayanan Terpadu*, Integrated Health Service Posts), run by community volunteers, provided services for basic maternal and child health after 1984.[22] Despite the importance of these schemes for the rural poor, the overall quality of these programmes were deficient and the numbers of health centres were far from sufficient. For instance, one *Puskesmas* was available per 30,000 people,[23] while one *Posyandu* was available for per 1,000 to 1,500 people.[24]

During the economic crisis of 1997–98, health services and social assistance programmes for the poor were introduced and expanded to mitigate the effects of economic hardship. This included the health card (*Kartu Sehat*), subsidized rice (*Raskin*), fuel subsidies and scholarship for poor children. In addition, the Ministry of Social Affairs provided social assistance programmes for abandoned children, disabled persons and the elderly. Since Indonesia's democratization, the budget of successive governments has increased for social assistance, and more governmental social welfare programmes have been added.

When Megawati Sukarnoputri became president in 2001, she established a Task Force to design a National Social Security System. One year later, the House of Representatives passed the fourth amendment to Constitution, which included the provision that "the state shall establish a national social security system for all citizens".[25] Megawati was personally interested in a national social security system as she and her party PDI-P (*Partai Demokrasi Indonesia-Perjuangan*, the Indonesian Democratic Party of Struggle) represented and relied on electoral support from workers and the urban poor. She was thus keen to pass the National Social Security System Law for re-election purposes. For that reason, the process of formulating and introducing the 2004 SJSN law was done in a top-down manner by the Megawati government without a broad societal consensus.

However, Megawati was not re-elected and in 2004 Susilo Bambang Yudhoyono became president. Although he did not prioritize a national social security system, he did adopt a populist approach by introducing pro-poor policies.[26] At the beginning of Yudhoyono's presidency, the Ministry of Health announced that it would provide social health insurance for the poor ignoring the fact that the National Social Security System had been passed.

As a result, *Askeskin* (*Asuransi Kesehatan Masyarakat Miskin* or Health Insurance for the Poor) was introduced in 2005. *Askeskin* allowed the poor to have free care at public health facilities and participating private facilities. The state-owned insurance company, P.T. Askes, was tasked with managing the programme. The Ministry of Health paid P.T. Askes a contribution per person every month and it reimbursed funds to public hospitals and participating health institutions. In 2008, it was replaced by *Jamkesmas* (*Jaminan Kesehatan Masyarakat* or People's Health Insurance). The main difference between these two programmes was that the Ministry of Health reimbursed hospitals directly rather than through P.T. Askes, as the company was criticized for poor management and corrupt practices.[27] The *Jamkesmas* health card was based on the recommendation of local officials and was relatively easy to obtain. About 75 million were enrolled in the scheme.[28] In addition to these programmes, other pro-poor policies, including both conditional and unconditional cash transfer programmes, were implemented. Hope for Family (*Program Keluarga Harapan*, PKH), which began in 2007, was the pilot programme for a conditional cash transfer policy. As long as the mother went for regular check-ups during pregnancy and the children (aged 7 to 15) stayed in school, the family received a set amount of cash from the government.[29] In 2005 and 2008 the government provided an unconditional cash transfer to poor families to compensate for the increase in the regulated gasoline prices. Under this programme, roughly 19.5 million households received unconditional cash transfers.[30]

Although various healthcare programmes have been introduced for the poor since Indonesia began the process of democratization, the reach to targeted populations has been limited. There is a discernable gap between the number of distributed healthcare cards and the actual number of impoverished families in the country.[31] Weak bureaucracy and administration in hospitals and local government, as well as the lack of public awareness of government insurance programmes, also limit their effectiveness.[32] Corruption is an entrenched problem and people often have to pay illegal fees — which are several times the value of the official fee — in order to use public healthcare facilities.[33] Moreover, these programmes are populist in nature so it is debatable whether the welfare of the people are genuinely improved. Instead, the government has been ostentatious by showing to the population that they care for the poor, especially in the run-up to elections.

The existing systems are far from sufficient to cover the entire population for social protection. People in informal sectors and the self-employed are excluded from any social protection. In fact, currently the lack of social protection is one of the nation's most pressing problems. According to the daily *KOMPAS* in March 2009, 77.8 per cent of the respondents mentioned social issues such as the price of basic goods, unemployment and poverty as the most pressing problem, while only 5.6 per cent believed corruption to be the most important problem.[34]

In filling the gap between government services and people in need, non-governmental organizations (NGOs) have played a significant role in providing services including healthcare, education and income-generating activities for people in need. As the most populous Muslim country in the world, local Muslim organizations have been providing social services to those in need for many decades. *Nahdlatul Ulama* (NU), a traditionalist Muslim organization, runs educational institutions in rural areas in Java such as *madrasah* (day school) and *pesantren* (boarding school) while *Muhammadiyah*, a modernist Muslim organization, runs both hundreds of clinics and hospitals and educational institutions. *Madrasah* and *pesantren* generally cost a third less than state schools and parents are expected to pay only a portion of this cost. Therefore, students who cannot afford to go to the state schools are likely to go to either *madrasah* or *pesantren*.[35] *Muhammadiyah's* healthcare services have traditionally catered to Indonesia's poorest people although the organization's hospitals currently serve both the wealthy middle class and low-income households.

Due to the economic crisis in 1997–98, Islamic welfare organizations proliferated and started implementing various programmes in both poor urban and rural areas. Community-based *zakat* (alms-giving) agencies which specialized in health provision for poorer families were also established.[36] Following the onset of democracy, political parties such as PKS (*Partai Keadilan Sejahtera*, the Prosperous Justice Party), an Islamist party, began providing social welfare services to attract voters, as the government was seen as ineffective in delivering basic services.[37] Social welfare services provided by the PKS included free healthcare, education and student training in marginalized areas.

Overall, Indonesia's social welfare system has gradually expanded over the years. Political logic has consistently been the driver behind social policy expansion. Under Soeharto, social policies were used to

legitimize his authoritarian control. After democratization, pro-poor policies were adopted by politicians to increase their electability. However, electoral competition and open policy processes alone cannot ensure the implementation of universal healthcare, as the failed implementation of the 2004 SJSN law illustrates. The next section will examine major challenges to social policy reform in Indonesia. These challenges have been consistently present both for the 2004 SJSN law and the 2011 BPJS law.

Challenges to the Indonesian Welfare State

In 2004, the Indonesian government enacted the SJSN law, which was supposed to be a comprehensive social welfare reform. However, progress in implementing comprehensive reform was slow until after the BPJS law was passed in 2011. Two factors posed challenges to the Indonesian government for implementing comprehensive reform measures: the lack of a cohesive state structure, and rent-seeking distribution coalitions centred on the beneficiaries of the existing social provision. Both factors have prevented the SJSN law from being implemented.

Lack of Cohesive State Structure

In Indonesia, inter-ministry rivalry makes it difficult for one ministry to take charge of social welfare programmes. None of the ministries are willing to give up the programmes they oversee. Oversight capacity means retaining power along with financial resources. The existing social insurance systems for civil servants, army and formal sector employees were introduced under the Soeharto regime, and were managed under various ministries and state enterprises. Social protection for workers came under the Ministry of Manpower, healthcare-related protections the Ministry of Health, health institutions run by religious institutions under the Ministry of Religion, and some insurance schemes for the socially marginalized administered by the Ministry of Social Affairs. In some cases, many primary actors are involved in the overall implementation of each social programme. For example, *Jamkesmas* is run by seven different institutions including the National Task Force for Acceleration of Poverty Alleviation, the Ministry of Finance, the Ministry of Health, the Ministry of National Development Planning, provincial and district governments, public and enlisted private healthcare providers and the insurer/third-party administrator.[38]

Given the inter-ministry rivalry and complex oversight arrangement, it was necessary for the government to reduce institutional redundancy and complexity, and to enhance coordination between the various programmes. Unfortunately, however, the government was unable to elicit cooperation and communication among different government ministries.

Decentralization adds another layer of complexity to social protection systems. Decentralization was introduced in 2001 and has not been conducive to curtailing the institutional complexity and redundancy. The central government delegated power to local governments, and allowed them to enact policies and regulations, except in several areas including security and defence, foreign policy, monetary and fiscal matters, and justice and religious affairs. In theory, local governments should be better able to determine what their communities need in terms of social protection than the central government, but in practice are not because of various factors including corruption, privatization, and low fiscal and bureaucratic capacity. Out of thousands of local regulations, only 5 per cent of regulations are categorized as pro-poor, while the rest of the regulations are for increasing local revenues.[39]

In general, local health insurance programmes (*Jamkesda, Jaminan Kesehatan Daerah*) have proliferated since 2005, as direct elections for the heads of regional governments were introduced. More and more district heads are adopting local healthcare schemes as a way of attracting voters. Approximately 60 district insurance schemes were implemented in 2008 rising to over 300 in 2010.[40] Local healthcare schemes will complicate the introduction of a comprehensive healthcare system, as the central government absorbs decentralized healthcare at the local level, and subsequently, re-centralizes the healthcare system.

Rent-Seeking Distributional Coalitions

The other challenge is rent-seeking distribution coalitions. Previously introduced state welfare programmes affect the size and orientation of various societal groups as well as patterns of interest-group formation.[41] Frequently, the existing beneficiaries of welfare programmes form rent-seeking distributional coalitions, while policy-makers depend on existing beneficiaries of welfare programmes for political support. Those who have received benefits for a long time do not want to lose them.[42] Given Indonesia's social welfare system that has benefited civil servants, military/police, and private formal

sector workers for decades, rent-seeking distributional coalitions in Indonesia consists of politico-bureaucrats, organizations representing business groups and private formal sector employees. Politico-bureaucrats refer to "the state apparatus who exercise authority over the allocation of resources and access by fusing political and bureaucratic power".[43] Business organizations include the Indonesian Chamber of Commerce (*Kamar Dagang dan Industri*, KADIN) and the Indonesian Employers' Association (*Asosiasi Pengusaha Indonesia*, APINDO) while unionized formal private sector workers were also part of the rent-seeking distributional coalitions.

Although a comprehensive social reform measure was enacted in 2004, there was no incentive for those who were already receiving benefits to push for implementation. Expanding the system could have jeopardized their benefits. Implementation of the 2004 reform required inter-agency integration, but this would have reduced rent-seeking opportunities for politico-bureaucrats. Both trade unions and employers' associations lobbied against the 2004 SJSN bill. Trade unions were afraid of losing their benefits despite wanting to expand the programme to everyone. At the same time, employers were not willing to share the burden of paying for social protection for everyone. It was a rare case that all three groups including government ministries and agencies, trade unions and employers' associations were opposed to implementing social reform.

The BPJS Reform: Campaigns for "All" Indonesians

If structural and institutional constraints remained the same in 2011, how then was the government able to implement universal healthcare? There has been a notable change since the 2004 SJSN law was passed. An advocacy coalition, called the Social Security Action Committee (*Komite Aksi Jaminan Sosial*, KAJS), was formed as a result of various seminars and workshops held by civil society organizations on the issue of healthcare and other social policies. KAJS embodies a collective leadership that includes both NGO and trade union leaders, although the latter were core participants of the coalition.[44] The advocacy coalition's primary players included Surya Tjandra, a lawyer and researcher at the Trade Union Rights Center, Said Iqbal, the chairman of the Confederation of Indonesian Workers Union and Timboel Siregar, the secretary general of the Indonesian Workers Organization.[45]

KAJS was innovative in utilizing citizen lawsuits against the Indonesian government. As many Indonesian civil society activists came from legal backgrounds, they decided to challenge the government legally. Although President Yudhoyono had a plan to implement the 2004 SJSN law within five years, his government was reluctant to implement it. During his second term, President Yudhoyono again did not show any commitment to implement the 2004 SJSN law. In order to pressure the government, KAJS decided to sue the government for negligence.

On 13 July 2011, KAJS, on behalf of 120 people, including trade union and NGO activists, lawyers, students, journalists and other professionals,[46] sued the government for negligence and lack of commitment to implementing the 2004 SJSN law within the time frame indicated.[47] KAJS won the lawsuit and the Indonesian National Court instructed the government to implement the law as soon as possible. This verdict generated the momentum for civil society organizations to pressure the government into initiating discussions about healthcare policy implementation. The whole legal process attracted a great deal of media attention, which helped the issue become more salient.

As the 2004 SJSN law aimed to provide social insurance for everyone, KAJS reframed its movement, and launched a national campaign "for all Indonesians". In 2004, the trade unions were reluctant to support a universal healthcare law as they were afraid of losing their benefits. KAJS struggled against rent-seeking distributional coalitions who attempted to block reforms so as to protect their own interests. State-owned enterprises that ran the funds did not support the BPJS bill and not all the trade unions supported it either. Large trade unions like the Confederation of All Indonesia Workers (*Serikat Pekerja Seluruh Indonesia*, SPSI) and the Confederation of the Indonesian Prosperous Workers Union (*Serikat Buruh Sejahtera Indonesia*, SBSI) were against any reform since they already had long-standing deals with *Jamsostek*, and the presidents of these union confederations were commissioners of *Jamsostek*.

Unlike the rent-seeking distribution coalitions, advocacy coalitions moved beyond narrow interests, and successfully reframed their campaign to represent all Indonesians. As a result, their membership grew. KAJS began with trade union initiatives but was later joined by many other organizations including those representing the interests of farmers and fishermen, the urban poor,

migrant workers, domestic workers and students. By 2011, the network had expanded to include sixty-seven organizations.

KAJS employed two key strategies. First, during the court sessions, KAJS members demonstrated inside and outside the courtroom. As their campaign motto was to protect the rights of the Indonesian people including informal sector and the self-employed, the campaign by KAJS gained wide public support as well as the support of other civil society organizations. Thousands of people joined the public protests. KAJS also formed a "*balconi* (balcony) faction", watching parliamentary discussions about the BPJS law from the public gallery. They also distributed the officially registered mobile phone numbers of legislators to the public and encouraged people to send text messages to those who opposed the BPJS law.[48]

Second, KAJS collaborated with a handful of politicians to pressure the parliament. Competitive electoral politics provided an opportunity for KAJS to strengthen its position by working with politicians, and also helped enhance KAJS's profile. For example, Rieke Dyah Pitaloka and Surya Chandra Surapati from PDI-P worked closely with KAJS.[49] In particular, Rieke represented the voices of KAJS within DPR (*Dewan Perwakilan Rakyat*, People's Representative Council) by actively arguing for the BPJS bill and criticizing the delays in passing it.[50] There are other legislators who promised to support the passing of the BJPS bill, including Marzuki Alie (the Speaker of Peoples' Representative Council, *Ketua DPR*), Nizar Achmad Shihab from the Democratic Party (*Partai Demokrat*, PD) and Zuber Zafawi from the Justice Prosperous Party (PKS).[51] The advocacy coalition enabled the reform to be implemented despite the challenges facing it. Even after the reform was implemented, KAJS continued to support BPJS by creating BPJS Watch which operates a hotline for people to report any difficulties and malpractices pertaining to BPJS.

Conclusion

This article examined the factors that have shaped the implementation of comprehensive healthcare policy reform in Indonesia. The government of President Yudhoyono enacted the Social Security Administering Bodies law in 2011, enabling the comprehensive healthcare reform to be implemented from 2014 onwards. Other social protections such as pension, occupational injury benefits, provident funds and death benefits were subsequently implemented in 2015.

Democratization is a necessary but not a sufficient condition for social welfare policy implementation to occur. Even after democratization ensued from 1998, Indonesia experienced various challenges to the introduction of comprehensive social policy reforms. Beginning with Soeharto, Indonesia operated a bifurcated system for decades which benefited members of the security services, civil servants and private formal sector workers. The existing system benefited these groups and created a rent-seeking distribution coalition that was opposed to social policy reforms which disadvantaged them. Neither trade unions nor employers' associations were in favour of comprehensive reform. Moreover, since various programmes were managed under different ministries and state enterprises, it was difficult for them to relinquish their programmes or merge them with others. Introducing a new system eradicating old ones required coordinated efforts from vested interests including ministries and state enterprises.

Despite these challenges, the Indonesian government was able to implement comprehensive healthcare reform in 2014. Formed in 2010, an advocacy coalition that consisted of trade unions, various NGOs and student organizations played a crucial role in pressuring the government to implement healthcare reform. The advocacy coalition moved beyond narrow interests, launched national campaigns for the social protection of all Indonesians, and stood up against rent-seeking coalitions. Moreover, the efforts to frame healthcare as an issue that affected all Indonesians regardless of their job status helped the advocacy coalition gain momentum. The coalition utilized various social movement protest strategies including legal suits and street protests. Moreover, electoral competition in Indonesia provided an incentive for politicians to work with the advocacy coalition, and media publicity made the issue more salient. An advocacy coalition, supported by a cross-class alliance, became a necessary and important factor in driving comprehensive healthcare reform in Indonesia.

NOTES

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[1] See for example: Stephen Haggard, "Political Economy of the Asian Welfare State", in *Asian States Beyond the Developmental Perspective*, edited by Richard Boyd and Tak-Wing Ngo (London and New York: RoutledgeCurzon, 2005), pp. 145–71; Evelyne Huber and John Stephens, *Development and Crisis of the Welfare State: Parties and Policies in Global Markets* (Chicago, Illinois: University of Chicago Press, 2001); Joseph Wong, *Healthy Democracies: Welfare Policies in Taiwan and South Korea* (Ithaca, New York: Cornell University Press, 2004); Carles Boix, *Democracy and Redistribution* (Cambridge, Massachusetts: Cambridge University Press, 2003).

[2] Edward Aspinall, "Health Care and Democratization in Indonesia", *Democratization* 21, no. 5 (July 2014): 8.

[3] Huck-Ju Kwon, "Advocacy Coalitions and the Politics of Welfare in Korea After the Economic Crisis", *Policy and Politics* 31, no. 1 (January 2003): 70.

[4] See, Philips Cutright, "Political Structure, Economic Development and National Social Security Programs", *American Journal of Sociology* 70, no. 5 (March 1965): 537–50; Harold Wilensky, *The Welfare State and Equality: Structural and Ideological Roots of Public Expenditures* (Berkeley, California: University of California Press, 1975).

[5] Hugh Helco, *Modern Social Politics in Britain and Sweden* (New Haven, Connecticut: Yale University Press, 1974).

[6] See for example, John Stephens, *The Transition from Capitalism to Socialism* (London: Macmillan, 1979); Walter Korpi, *The Democratic Class Struggle* (London: Routledge and Kegan Paul, 1989); Gosta Esping-Andersen, *Politics Against Markets* (Princeton, New Jersey: Princeton University Press, 1985).

[7] See Stephen Haggard and Kaufman, *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe* (Princeton, New Jersey: Princeton University Press, 2008); Katja Bender, "The Political Economy of Social Protection Reforms in Developing Countries: What is to be Explained and How?", in *Social Protection in Developing Countries: Reforming Systems*, edited by Katja Bender, Markus Kalternborn and Christian Pfleiderer (London & New York: Routledge, 2013), pp. 33–42.

[8] Wong, *Healthy Democracies,* op. cit., pp. 2–5.

[9] Aspinall, "Health Care and Democratization", op. cit., pp. 9–13.

[10] Ibid., p. 13.

[11] Andrew Rosser and Ian Wilson, "Democratic Decentralization and Pro-Poor Policy Reform in Indonesia: The Politics of Health Insurance for the Poor in Jembrana and Tabanan", *Asian Journal of Social Science* 40 (January 2012): 608–34.

[12] There is also a growing number of studies about social policy expansion in Southeast Asia that does not emphasize democratization. For example, by examining Thailand, Malaysia, the Philippines and Vietnam, Erik Kuhonta argues that institutionalized political parties and cohesive state structures contributed to equitable development regardless of regime types. Malaysia and Vietnam, both of which are authoritarian states, did better than two democratic states, Thailand and the Philippines, in terms of equitable development. See Erik Kuhonta, *The Institutional Imperative: The Politics of Equitable Development in Southeast Asia* (Stanford, California: Stanford University Press, 2011).

[13] See for example, Kwon, "Advocacy Coalitions and the Politics of Welfare in Korea After the Economic Crisis", op. cit., pp. 69–83; Kurt Weyland, *Democracy Without Equity: Failures of Reform in Brazil* (Pittsburgh, Pennsylvania: University of Pittsburgh Press, 1996); Paul Sabatier, "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein", *Policy Sciences* 21 (June 1988): 129–68; Suzaina Kadir, "Singapore: Engagement and Autonomy Within the Political Status Quo", in *Civil Society and Political Change in Asia: Expanding and Contracting Democratic Space*, edited by Muthiah Alagappa (Stanford, California: Stanford University Press, 2004), pp. 324–54.

[14] Kadir, "Singapore", op. cit., pp. 334–41.

[15] Marco Guini, *Social Protest and Policy Change: Ecology, Antinuclear, and Peace Movements in Comparative Perspective* (Lanham, Maryland: Rowman & Littlefield Publishers, 2004), p. 5.

[16] Mukul Ramesh and Mukul Asher, *Welfare Capitalism in Southeast Asia* (New York: St. Martin's Press, 2000), pp. 39–45 and 87–90.

[17] Incremental or "piecemeal" reforms are much more common than universal reforms when it comes to social policies. See Robert Kaufman and Joan Nelson, "Introduction: The Political Challenges of Social Sector Reform", in *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America,* edited by Robert Kaufman and Joan Nelson (Washington, D.C.: Woodrow Wilson Center Press, 2004), pp. 1–19.

[18] Ramesh and Asher, *Welfare Capitalism in Southeast Asia*, op. cit., pp. 39–45.

[19] In 1988, there were 39 strikes while in 1990 there were 61 strikes. In 1992, the number went up to 177 strikes. See Jonathan Rigg, *Southeast Asia: The Human Landscape of Modernization and Development* (Abingdon, Oxon.: Routledge, 2002), p. 228.

[20] Amanda Simmonds and Krishna Hort, "Institutional Analysis of Indonesia's Proposed Road Map to Universal Health Coverage", *The Nossal Institute for Global Health Working Paper* (2014), p. 3, available at <http://ni.unimelb.edu.au/__data/assets/pdf_file/0004/834457/WP_33.pdf>.

[21] Stein Kristiansen and Purwo Santoso, "Surviving Decentralization?: Impacts of Regional Autonomy on Health Service Provision in Indonesia", *Health Policy* 77 (August 2006): 248.

[22] B.C. Smith, "The Decentralization of Health Care in Developing Countries: Organizations Options", *Public Administration and Development* 17 (October 1997): 399–412.

[23] Kristiansen and Santoso, "Surviving Decentralization?", op. cit., p. 248.

[24] The numbers of *posyandu* were estimated based on the statement that "In 1990, about two to three *posyandu* were available per village." Each village has about 3,000 people. See Anke Niehof, *Food, Diversity and Social Change: Research Findings from Insular Southeast Asia* (Wageningen: Wageningen Academic Publishers, 2010), p. 103.

[25] Hasbullah Thabrany, "Politics of National Health Insurance of Indonesia: A New Era of Universal Coverage", paper presented at the 7th European Conference on Health Economics, Rome, 22–26 July 2008, p. 12, available at <http://www.un.org/en/ecosoc/newfunct/pdf/thabrany-nhip-program%20and%20politic-indonesia.pdf>.

[26] Aspinall "Health Care and Democratization", op. cit., p. 814; Thabrany, "Politics of National Health Insurance of Indonesia", op. cit., p. 16.

[27] Rosser and Wilson, "Democratic Decentralization and Pro-Poor Policy Reform in Indonesia", op. cit., pp. 608–34.

[28] Jacqueline Hicks, "The Missing Link: Explaining the Political Mobilization of Islam in Indonesia", *Journal of Contemporary Asia* 42, no. 1 (February 2012): 54.

[29] Muliadi Widjaja, "Indonesia: In Search of Placement-Support Social Protection", *ASEAN Economic Bulletin* 29, no. 3 (December 2012): 187.

[30] The second unconditional transfer occurred right before the election. It is believed that as a result of this, the incumbent Democratic Party and President Yudhoyono won the election in 2009. Ibid., p. 188.

[31] Evidence suggests that the leakages to non-eligible beneficiaries of *Jamkesmas* are noteworthy: 20 per cent of all *Jamkesmas* holders belonged to the top three economic deciles. World Bank, "The Nuts and Bolts of Jamkesmas: Indonesia's Government-Financed Health Coverage Program", *Universal Health Coverage Studies Series* 8 (Washington, D.C: World Bank, 2013), p. 12.

[32] Hilman Latief, "Health Provision for the Poor: Islamic Aid and the Rise of Charitable Clinics in Indonesia", *South East Asian Research* 18, no. 3 (September 2010): 514–15.

[33] Andrew Rosser, "Realizing Free Health Care for the Poor in Indonesia: The Politics of Illegal Fees", *Journal of Contemporary Asia* 42, no. 2 (May 2012): 255–75.

[34] Marcus Mietzner, "Indonesia's 2009 Elections: Populism, Dynasties and the Consolidation of the Party System", *Analysis*, Lowy Institute for International Policy (May 2009), pp. 3–22.

[35] Hicks, "The Missing Link", op. cit., p. 58.

[36] Latief, "Health Provision for the Poor", op. cit., pp. 507–12.

[37] Kikue Hamayostu, "The Political Rise of the Prosperous Justice Party in Post-Authoritarian Indonesia: Examining the Political Economy of Islamist Mobilization in a Muslim Democracy", *Asian Survey* 51, no. 5 (September 2011): 971–92.

[38] World Bank, "The Nuts and Bolts of Jamkesmas", op. cit., p. 9.

[39] Edie Suharto, "Development of Social Welfare in Indonesia: Situation Analysis and General Issues", paper presented at International Conference on Building Capacity and Policy Networking for Effective Welfare Development, Center for International Administration Studies, National Institute of Public Administration, Jakarta, 18–19 November 2009, p. 5, available at <http://www.policy.hu/suharto/Naskah%20PDF/Development%20of%20Social%20Welfare%20in%20Indonesia.pdf>.

[40] Edward Aspinall and Eva Warburton, "A Healthcare Revolution in the Regions", *Inside Indonesia* 111 (January–March 2013), available at <http://www.insideindonesia.org/a-healthcare-revolution-in-the-regions-2>.

[41] Theda Skocpol and Edwin Amenta, "States and Social Policies", *Annual Review of Sociology* 12 (August 1986): 131–57.

[42] See for example, Paul Pierson, "The New Politics of the Welfare State", *World Politics* 48, no. 2 (January 1996): 143–79; Kurt Weyland, *Democracy Without Equity: Failures of Reform in Brazil* (Pittsburgh, Pennsylvania: University of Pittsburgh Press, 1996).

[43] Richard Robinson, "The Middle Class and the Bourgeoisie in Indonesia", in *The New Rich in Asia: Mobile Phones, McDonalds and Middle Class Revolution*, edited by Richard Robinson and David Goodman (London: Routledge, 1996), p. 82.

[44] The importance of KAJS was noted elsewhere. See, for example, Rachelle Cole, "A New Tactical Toolkit", *Inside Indonesia* 110 (October–December 2012), available at <http://www.insideindonesia.org/a-new-tactical-toolkit>; Dinna Wisnu, *Politik Sistem Jaminan Sosial: Menciptakan Rasa Aman Dalam Ekonomi Pasar* (Jakarta: PT Gramedia Pustaka Utama, 2012), pp. 134–40.

[45] Author interview with Dr Dinna Wisnu, Jakarta, 2014.

[46] These were the activists who led the movement. They included R. Abdullah, Joko Hariyono, Achmad Munji, Indra Munaswar, Ali Akbar, Timbul Siregar, Abdullah Sani, Surya Tjandra and Said Iqbal.

[47] Surya Tjandra, "Sistem Jaminan Sosial Nasional: Langkah Besar Gerakan Buruh Meraih Kesejahteraan dan Keadilan Sosial" [National Social Security System: A Big Step by Labor Movements to Achieve Welfare and Social Justice], in *Kebangkitan Gerakan Buruh: Refleksi Era Reformasi* [Awakening Labor Movements: Reflection of the Reform Era], edited by Jafar Suryomenggolo (Serpong: Marjin Kiri, 2014), p. 25.

[48] Author interview with Surya Tjandra, Jakarta, 2014; Surya Tjandra "Sistem Jaminan Sosial Nasional", op. cit., p. 26.

[49] Aspinall, "Health Care and Democratization in Indonesia", op. cit., p. 11; Author interview with Surya Tjandra, Jakarta, 2014.

[50] Cole, "A New Tactical Toolkit", op. cit.

[51] "Janji Marzuki Alie Ikat DPR" [Marzuki Alie Promises to Bind The House of Representatives], *Kompas*, 22 July 2011, available at <http://nasional.kompas.com/read/2011/07/22/20303552/Janji.Marzuki.Alie.Ikat.DPR>.