The Development of Health Insurance and Services in Indonesia

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Abstract.
The study focus on the development and review of health insurance in Indonesia that is relatively new for most Indonesians because the term health insurance is not sufficient in the general vocabulary. Social health insurance is insurance that must be followed by all or part of the population (an example employees), to involved and contributions are not a nominal value but a percentage of the salary to be paid, and insurance benefits. Commercial health insurance is insurance sold by other insurance companies or institutions. The development of health insurance in Indonesia is very slow compared to the development of health insurance in several neighboring Asean countries (Associaton of South East Asian Nations). Careful research on the slow development of health insurance in Indonesia is still lacking. However, in theory, several important factors can be put forward as factors that influence the slow growth of health insurance in Indonesia. In this case, there are health services which, in the process of health services, there will be variations in the implementation of activities from time to time which will produce varying results. One of the efforts to reduce process variation is standardization. The normalization process includes the elaboration, implementation, follow-up, control, evaluation and revision of norms (Indonesia Government Regulations or PP number:102/2000). The development of public health services in Indonesia has succeeded in improving health services more evenly. Advances in science and technology have resulted in more and more educated and informed community groups so that they can choose and demand quality health services especially with health insurances coverage.

Keywords: *Benefits, health insurance, health services, pandemic, public health service*

I. INTRODUCTION

The national goal state is to protect the entire Indonesian nation and the entire homeland of Indonesia, promote public welfare, educate the nation's life, and participate in carrying out world order based on independence, eternal peace, and social justice. The ideals of the Indonesian people are clearly stated in the Indonesia preamble to the 1945 constitution which is also the national goal of the Indonesian nation.[1] Health insurance in Indonesia is relatively new for most Indonesians because the term health insurance is not sufficient in the general vocabulary. Understanding of what health insurance is still so diverse that it is not surprising, for example, in the past many people claimed that community health insurance (JPKM) is not health insurance, just because its name was deliberately chosen not to be used[2][3]. When discussing the history of health insurance, you should first agree on what is meant by health insurance. In many insurance textbooks, health insurance includes social and commercial health insurance product. Social health insurance is insurance that must be followed by all or part of the population (i.e.: employees), contributions or contributions are not a nominal value but a percentage of the salary to be paid, and insurance benefits (benefits). determined by law and the same for all participants[4]. Although commercial health insurance is insurance sold by companies or other insurance institutions, therefore the nature of participation is voluntary, depending on whether the person (or company) wants to buy or not, the premium is determined according to the insurance benefits offered, and therefore both insurance premiums and benefits vary widely, not the same for every participant[5][6].AKN (National Health Insurance) is now increasingly being used internationally. The UK was the first country to introduce AKN in 1911 (HIAA, 1997).

Although the health system in the UK is now better known as the NHS (National Health Service), in fact the system is also AKN, which is financed with mandatory contributions from national health workers. employment and job suppliers. Because the disbursement of funds through the APBN which is financed is greater than the general tax fund (financed by taxes) which is not set aside specifically for health as was the case before, the UK system is better known as the NHS than the AKN[7]. Many other European countries also have universal coverage with NHS systems following the UK pattern. Both the NHS and AKN have the same goal of ensuring that all residents receive health services according to the medical needs of the population, regardless of the economy, situation and capacity of the population[8]. The difference is that AKN funding is based more on special contributions that are mandatory (equivalent to taxes) and are managed separately from the APBN, either managed directly by the government or by an independent

energy agency[9][10].The development of health insurance, especially commercial insurance in the United States, grew rapidly after the federal government passed the mandatory workers' compensation law in 1908, followed by the state of Wisconsin in 1911. Health insurance efforts are considered the forerunner to the success of corporate health insurance in the United States. Union. In 1910, the Montfomery Ward Joint Fund for employees, which provided death and disability income benefits of $5 to $10 per week, was revised (feasibility study) for subcontracting to insurance companies[11][12]. The study was driven by low participation (only about 15% of employees), infrequent program reviews, and inadequate benefits. Finally, after many complicated negotiations, this compensation guarantee was finally contracted to the London Guarantee and Accident Company, in New York in 1911[13]. However, this insurance was offered only to workers who had high wages. In this case, there are health services which, in the process of health services, there will be variations in the implementation of activities from time to time which will produce varying results[14]. One of the efforts to reduce process variation is standardization. The normalization process includes the elaboration, implementation, follow-up, control, evaluation and revision of norms (PP 102/2000).

The existence of standards in health services will provide benefits, including reducing process variation, is a professional requirement and a basis for measuring quality[15]. Setting standards will also ensure the safety of patients and healthcare providers. Reducing the variety of services will increase the consistency of health services, reduce patient morbidity and mortality, increase service efficiency, and make it easier for officers to provide services[16][17]. According to Indonesia Ministry of Health decree number 128 of 2004, community health center is a technical implementing unit of the district/city health office which is responsible for organizing health development in a work area[18]. Community health center has a function as a driving force for health-oriented development, a community empowerment center, a first-level health service center that includes individual health services (private goods) and public health services (public goods). The results of health services in the form of clinical results, the benefits obtained by the client and the client's experience in the form of satisfaction or disappointment. Customer experience is highly dependent on service processes at the forefront or on service microsystems, service systems that are in direct contact with customers[19][20].In Indonesian society, there are two treatment techniques, namely conventional medicine and traditional medicine. Conventional medicine is a modern medical technique performed by doctors. Meanwhile, traditional medicine is treatment and/or treatment through medicines and their treatment which refers to experience, hereditary abilities and/or education/training, and is applied in accordance with the prevailing norms in society based on Article 1 Paragraph 1 decree of the Indonesia Minister of Health number: 1076/Menkes/SK/VII/2003 concerning the Implementation of Traditional Medicine[21][22].

II. METHODS

This study is a literature review that is part of a qualitative research, related to the research subject. Research is descriptive the social phenomena in detail. Based on this research, the research objective is to describe the development of health insurance and health services in Indonesia. The data collection technique used by researchers in carrying out data and information collection is by taking secondary data where the information comes from the official Indonesian Ministry of Health (MOH) website, government regulation, internet and scientific journals, also where the data obtained in in-depth interviews with the experts to confirmed the completeness of the policy or related data involved in this research.

III. RESULT AND DISCUSSION

Theoretically, several important factors can be put forward as factors that influence the slow growth of health insurance in Indonesia. On the demand side, Indonesians generally take risks in terms of health and mortality. Sickness and death in the life of the Indonesian religious community is God's destiny and because of that there are many assumptions that develop among Indonesian people that buying insurance is related to the opposite destiny[3][23]. First, the development of health insurance in Indonesia is very slow compared to the development of health insurance in several neighboring ASEAN countries (Associaton of South East Asian Nations). Careful research on the slow development of health insurance in Indonesia is still lacking. However, second, the economic condition of the Indonesian population, which since independence until now has a per capita income of around $1,000 USD per year, has not allowed Indonesians to set aside funds to purchase health and life insurance[11]. From the supply side which is also strongly influenced by demand, not many insurance companies offer health insurance products. In addition, health facilities that support the

implementation of health insurance are also not well developed or evenly distributed. From a regulatory perspective, the Government of Indonesia has been relatively slow in disseminating the concept of insurance to the public through the ease of licensing and legal capacity in the insurance business or the development of social health insurance for the general public. In social insurance, the Indonesian government has been trying to introduce insurance principles since 1947, two years after Indonesia's independence. As developed in developed countries, health insurance evolved from social insurance in the field of accidents and occupational diseases. At that time, the Government required all companies to insure their employees against accidents and occupational diseases. However, due to the post-independence internal security situation, which still contained various rebellions, and the Dutch efforts to reclaim Indonesia, it was impossible for these efforts to be carried out properly[24].

After Indonesia achieved good political stability, in 1960 the government tried to re-introduce the concept of health insurance where the 1960 Basic Health Law asked the government to develop a “sick fund” with the aim of providing access to health services for all people. However, because the various socio-economic conditions mentioned above are not yet conducive, the law and order cannot be implemented at all. In 1967, the Minister of Manpower issued a Decree to establish a Fund similar to the concept of the Health Maintenance Administration (HMO) or Community Health Care Insurance (JPKM), which was later developed to fulfill the mandate of the health law. The Minister stipulates a contribution of 6% of wages consisting of 5% dependents of employers and 1% of workers.Efforts to develop social health insurance or the provision of more systematic health insurance began in 1968 when the Minister of Manpower, Awaludin Djanin, sought health insurance for civil servants. This effort to provide health insurance for civil servants and their families is the first social health insurance scheme in Indonesia. Social health insurance is health insurance that must be followed by a group of residents (eg public officials), benefits or health care packages are stipulated by regulations and are the same for all participants, and contributions/premiums are determined as a percentage of wages or salaries. Initially, the health insurance for civil servants, which is now better known as Askes, required a contribution of 5% of wages[25][26].

In 1971, social security efforts in the field of work accidents were also initiated with the establishment of the Workers' Social Security Company (Astek). Astek initially only handled workers' compensation insurance. Efforts to expand the social security program to a more comprehensive social security program began with a pilot program of the Manpower Health Insurance Program in five provinces covering around 70,000 workers in 1985. The five-year trial was intended to assess the feasibility of extending social health insurance to the private sector, which has different characteristics from the public sector. Commercial health insurance was offered in major cities in the early 1970s by multinational insurance companies with branches or business units in Indonesia. The development of commercial insurance sales sold by insurance companies before 1992 did not experience significant growth because the legal basis was not very clear. Commercial health insurance at that time was usually sold as a travel product (rider) sold by insurance companies, because health insurance is loss insurance. Life insurance companies are not clear whether they can sell health insurance or not (such as like: Jamsostek in Indonesia)[27] In Indonesia, the number of insurance companies continues to increase every year. Since 2012 there were around 140 insurance companies, while in five years it increased to 146 insurance and reinsurance companies in 2016. In addition, insurance supporting companies also increased from 205 companies in 2012 to 237 companies in 2016. Likewise, gross premium growth increased by an average of 19.8% per year in the last five years or in 2016 of around Rp361.78 billion. The contribution of the insurance sector to Indonesia's Gross Domestic Product as reflected in the ratio of gross premiums to GDP increased by 0.36%, from 2.56% in 2015 to 2.92% in 2016. The largest increase in gross premiums in 2016 was obtained by the insurance sector. social security insurance, 30.4% which includes health insurance, all data is on the table below.

Description	**2012**	**2013**	**2014**	**2015**	**2016**
General Loss Insurance	**180**	**166**	**186**	**164**	**162**
Limited company	38	34	38	32	42
Reinsurance	8	8	10	12	10

National Private	134	124	138	120	110
Sharia Loss Insurance	**50**	**58**	**56**	**62**	**62**
Limited company	6	6	4	6	6
Reinsurance	6	6	6	6	6
National Private	38	46	46	50	50
General Life Insurance	**44**	**45**	**50**	**50**	**49**
Limited company	19	19	19	22	23
National Private	25	26	31	28	26
Sharia Life Insurance	**20**	**20**	**21**	**24**	**27**
Limited company	10	10	10	10	14
National Private	10	10	11	14	13
Grand Total	**294**	**289**	**313**	**300**	**300**

Fig 1. Table the Number of Health and Accident Insurance Companies

Meanwhile, the number of gross claims in the insurance industry in 2016 increased by 15% compared to the previous year, from Rp 197.75 trillion, while in 2015 it became Rs 227.35 trillion in 2016. Overall, the ratio of gross claims to gross premiums in 2016 was 62.8%. This index is lower than the previous year's accident rate of 66.9%. This decrease was due to lower claims growth compared to gross premium growth (Financial Services Authority, 2016).The development of the number of health also accident insurance companies in Indonesia based on this, insurance companies have fluctuating branches of health and or accident insurance. However, when reviewed through the trend pattern from year to year in general loss insurance companies have a downward trend, while loss insurance companies that adhere to sharia principles are increasingly emerging and developing. The decrease in the number of general loss insurance companies from 180 in 2012 to 162 companies in 2016. Meanwhile, based on property, general loss insurance is dominated by national private companies (between 67-80% of each category of general loss insurance companies). While in life insurance, this proportion is balanced between national private companies and mixed companies.

Description	2012	2013	2014	2015	2016
General Life Insurance	**263,716**	**111,245**	**115,874**	**181,565**	**261,970**
Limited Company	48,068	6,709	11,216	12,214	205,995
National Private	215,648	104,536	104,658	169,351	55,975
Sharia Life Insurance	**6,796,499**	**10,728,438**	**8,010,540**	**9,236,712**	**8,533,639**
Limited Company	3,252,773	4,719,894	3,341,906	4,340,412	4,027,085
National Private	3,543,726	6,008,544	4,668,634	4,896,300	4,506,554
Total	**7,060,215**	**10,839,683**	**8,126,414**	**9,418,277**	**8,795,609**

Fig 2. Table the number of health insurance policies issued by company ownership

The number of participants in health insurance tends to fluctuate every year. Although related to life insurance, it is known that the number of participations in general life insurance is much higher than that of sharia life insurance, which reached 33 times in 2016. One of indicator to determine the development of the insurance industry is to look at the number of participants as reflected in the number of policies issued by insurance companies[23]. The most interesting thing to observe is the increase in the number of participants. which jumped sharply from 12 thousand people. (2015) to 261,000 people (2016) in sharia life insurance in

joint ventures. Meanwhile, national private companies experienced a sharp decline in participation in 2016. It is possible that there are companies that do not report the number of policies to the Indonesia Financial Services Authority (OJK), so they are not recorded in the OJK report. The number of private insurance companies did not grow much during the period 2012 to 2016, even domestic private insurance companies tended to decline after the National Health Insurance (JKN). Based on the number of health insurance policies issued according to company ownership, it decreased until 2014 there was an increase again in sharia life insurance. It is undeniable that the government's program to realize universal health insurance with a social security program poses a threat to private insurance companies. The development of public health services in Indonesia has succeeded in improving health services more evenly. Advances in science and technology have resulted in more and more educated and informed community groups so that they can choose and demand quality health services (Sabarguna, 2004). Puskesmas as one of the public health services has the main task of organizing community health development and basic health services. Currently, the distribution of health centers and sub-health centers as the spearhead of basic health services is more evenly distributed. Each puskesmas serves 30,000 - 50,000 residents or at least one sub-district has a puskesmas. For the coverage of health services, each puskesmas is assisted by 3-4 sub-health centers and mobile health centers (Department of Health of the Republic of Indonesia)[18].

The government has tried to increase the distribution of health centers, but the appearance and quality of health services are not optimal. Weak management, lack of constant referrals, and lack of logistical support and operational costs largely determine the quality of services provided. The results of the 2000 national economic survey showed that of the population who had complaints of illness, only 36.76% went to health facilities and 63.24% treated themselves. Of the total population receiving outpatient treatment at health facilities, only 27.8% went to Puskesmas and Sub Health Centers, 30.55% to practicing doctors, 14.54% to hospitals, 14.37% to health workers, and 3, 50% to shaman/physician (Ministry of Health of the Republic of Indonesia, 2021)[28].Way back in 1967 health services were held by holding seminars to discuss and formulate integrated public health programs in accordance with the conditions and abilities of the Indonesian people. In 1968 a working meeting was held at the national level, it was proposed that the puskesmas be an integrated health service system, which was later developed by the government in a community health service center (Puskesmas). Since the introduction of the puskesmas concept in 1968, many results have been achieved, including a reduction in maternal and infant mortality, while the average life expectancy of Indonesians has increased. If in 1995 the maternal mortality rate was 375/100,000 live births and the infant mortality rate was 60/1000 live births, then in 1997 the maternal mortality rate fell to 334/100,000 live births and the infant mortality rate until 2001 fell to 51/1000 live births life. Meanwhile, the average life expectancy increased, namely in 1970 to 45 years and in 2000 to 65 years. In 2002 the number of health center was 21,587 units, and mobile health center was 5,084 units. In health services there are efforts in the success of health services in Indonesia. Primary health efforts are part of the beginning of primary individual health services and primary public health services. Primary health services are health services that occur because the first contact individually is referred to as the initial process of health services. There are main facilities for primary individual health services which consist of:

1. Health Center
2. Primary clinic
3. Practice doctor/dentist
4. Home nursing practice
5. Midwife practice
6. Physiotherapist practice
7. Traditional medicine and
8. Mobile service facilities (ambulatory)

In addition, there are supporting facilities for primary individual health services consisting of:

1. Pharmacy unit
2. Clinical laboratory
3. Radiology
4. Pharmacy
5. Medical rehabilitation
6. Optical, etc.

These health services will experience changes in methods and tools as they are adapted to the latest technology also the pandemic. The need for primary individual health services is an important need in the 22st century.

IV. CONCLUSION

The health insurance in Indonesia is considered slow to be introduced to the general public or into society when compared to several Asean neighboring countries in the 22th century. There are several factors or reasons why health insurance is slow to come to Indonesia due to the lack of demand from the Indonesian people themselves. Then, health facilities and infrastructure are also a factor in the delay in health insurance entering Indonesia. Health insurance itself has been introduced through insurance principles since 1947. Meanwhile, in the 21st century the number of private insurance companies has begun to grow a lot if you look at the data that has been taken from 2012 to 2016 as well as developments up to now 2022. The development of health insurance in Indonesia is very slow compared to the development of health insurance in several neighboring ASEAN countries (Associaton of Southeast Asian Nations). Careful research on the slow development of health insurance in Indonesia is still lacking.

However, theoretically, several important factors can be put forward as factors that influence the slow growth of health insurance in Indonesia. On the demand side, Indonesians generally take risks in terms of health and mortality. Sickness and death in the life of the Indonesian religious community is God's destiny and because of that there are many assumptions that develop among Indonesian people that buying insurance is related to the opposite destiny.The development of public health services in Indonesia has succeeded in improving health services more evenly. Advances in science and technology have resulted in more and more educated and informed community groups so that they can choose and demand quality health services. In the next 22 century, the development of health services is in line with technological advances, as can be seen in the main facilities and support for primary individual health services. Then this will be able to increase its profits and the insurance company can survive in the midst of the covid-19 pandemic.

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