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ARTICLE

# Social Policy Development Revisited: The Interplay between Push and Pull Factors in the Indonesian Healthcare Expansion

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Established theories of social policy development, such as industrialisation and power resources, have been extensively used to explain the expansion of social policy, predominantly in developed economies. We argue that they may not always be applicable in the Global South. Our article examines multiple factors at play in Indonesia's healthcare policy expansion using qualitative content analysis of historical sources, literature, and nine interviews with key policy architects. Using the pull-and-push factor model, we examined the interactions between policy entrepreneurs and centre-right political parties in creating national healthcare policy architecture and expansion. Our findings confirm that the window of opportunity for expansion was augmented when the political party of the ruling government experienced a decline in public trust, while clientelistic motives among elites facilitated the reform process. Drawing the lesson from Indonesia, we contend push prevails over the pull factors (labour movement and cross-class alliances) in social policy development.

**Keywords:** Policy entrepreneurs; healthcare reform; Global South; welfare state development

## Introduction

Over the past few decades, many countries in the Global South have undergone substantial health care reforms (Weyland, 1995; Wu and Ramesh, 2009; Carbone, 2011; Sparrow *et al.*, 2017; Isabekova and Pleines, 2021). Social policy literature characteristically contrasts two main drivers of this expansion in the Global South: industrialisation and interest group theory (Myles and Quadagno, 2002; Pierson, 2005; Haggard and Kaufman, 2008; Fleckenstein and Lee, 2017; Yuda and Pholpark, 2022). However, in examining the healthcare expansion, we argue that it is not adequate to only focus on those two factors. Despite the fact that industrialisation could effectively explain the Global North welfare states, it fails to acknowledge the rapid expansion of state-driven social policies across nations in the Global South during the late 1980s and 1990s in the transition to de-industrialisation and democratisation (Kim and Shi, 2020). In South Korea, Taiwan, and the Philippines, this period marked a critical juncture for a massive adaptation of the welfare state ideas (London, 2018). Other countries, including Indonesia, took the same step, driven by the Asian Financial Crisis as the catalyst (cf. Yuda *et al.*, 2022).

The political determinant is another area to look further into. As an example, while formal unions have played a lesser role in the South, the informal labour movement has had a significant impact on welfare reform, albeit with a limited impact (Dorlach, 2021). However, the interests of the conservative elite coalition, which previously controlled government assets, such as social security funds, continue to influence policy (cf. Yuda, 2021). Given this background, we argue

that the expansion of healthcare is driven by the interrelatedness of the demand and supply forces. This article discusses how the political, economic, and social institutions are part of those driving forces of the expansion of the Indonesian health care regime.

Healthcare access is a vehemently debated political issue in developing countries, especially Indonesia; the provision of healthcare services has been a source of political benefit for a number of prominent Indonesian politicians, including the current president, Joko Widodo (Fossati, 2016). In view of this, bringing Indonesia into social policy debates would provide a representative example that deepens our understanding of the welfare regime dynamics in the Global South.

As an overview, the Indonesian government has reformed its fragmented health care system to provide universal health care to more than 260 million people throughout the country (Murphy, 2019). It was initiated in 2004 when the government, through National Social Security Law, introduced universal health insurance and other schemes (old-age pensions and retirement savings and occupational benefits). However, the utilisation remained low until 2014, when legislation established it (Pisani *et al.*, 2017). Having achieved this milestone, Indonesia now has the most extensive single-payer health care system in the world (Yuda and Pholpark, 2022), correcting a prior initiative that had created an underdeveloped and partial system.

In our article, we examine the established factors of health and welfare expansion through the push and pull factors model. The push factor refers to significant factors stimulating the expansion of public health and social policies. In this case, the factors include industrialisation, international organisation influence, and the interaction between policy entrepreneurs and the centre-right political parties. This latter element reflects the new approach we are putting forth as a major driver of Indonesian healthcare expansion over other push and pull elements (see Jarvis and He, 2020 for details on policy entrepreneurship debates and reviews). Yet, it was possible that this pattern could change only if the dominant force at the time, the centre-right party, was not in favour of the circumstances, which threatened its existence and reputation in the election if it did not pursue policies that were popular among the public (further explanation can be found in the findings and discussion section). This rare occurrence can be viewed as an opportunity for reform.

On the other hand, the pull side dimension mechanism, such as labour union and movement and cross-class alliances, as theorised in the Western discourse, played an essential role in making policy reforms possible within institutional constraints. They aim to convey the messages of equality and insecurity through discrete networks, which reveal how institutional considerations and goals are translated into policy initiatives. In this article, we look further how they had lesser influence to exert pressure on the government to push forward the healthcare reform.

Overall, our study found that the national health insurance reform was possible in part because academics from public universities negotiated with centre-right groups serving as the centre of power from 1992 to 2004. They leveraged the declining public trust towards centre-right parties, especially during the period 2009–2014, to persuade the administration to fulfil the public demand. However, policy entrepreneurship strategies could not act alone; clientelism trends among Indonesian politicians following democratisation have facilitated policy entrepreneurs' efforts to champion their objectives.

Based on the above explanation, we argue that health care expansion has a myriad of factors influencing each other, which we classified as pull (demand) and push elements. Our article demonstrates that the push factor, which emphasises the interaction between policy entrepreneurs and centre-right parties, prevails over the pull factor (labour movement and unions and cross-class alliances), which is subordinated and fragmented, rendering them ineffective for achieving substantial reforms.

The next section of the article reviews understanding of healthcare expansion in the social policy studies literature.

## Theorising health care expansion

Social policy literature has identified two major strands of stimuli that engender health and social policy expansion: industrialism or structuralism and interest group theories. Industrialisation theories suggest that welfare state expansion is bound up with economic growth and urbanisation. Under this perspective, the state-led role of welfare expands as a natural response to the breakdown of core kinship relationship; health care policy, in particular, is necessary to address numerous social risks attached to modernisation (Bonoli, 2005, 2007; Jordan, 2011). However, the relevance of industrialisation studies was called into question during the deindustrialisation period, as a result of the economic crisis in the 1990s (Iversen and Cusack, 2000; Rodrik, 2016; Islami and Hastiadi, 2020; Schindler *et al.*, 2020).

In response to the industrialisation theories, interest-oriented theorists offer alternative frameworks by putting more emphasis on the role of interest groups (labour union, working-class power mobilisation, and centre-left strength), which constantly conduct vigorous advocacies for health care expansion (Edlund and Lindh, 2015). In the long-term view, the social policy accommodation of interest group theory is, in practice, more elastic than the (leftist) power-resource thought. The epistemological underpinning of the theory can also stem from the constructivist idea asserting that welfare policy expansion is constructed on the basis of ideas and cultural projects (Selway, 2015). Furthermore, with the presence of globalisation, consciousness about social rights, state-building, the spread of welfare rights and norms, and ideas for democracy are massively propagated and drive the civil society to push the government for health care reform (Huber and Niedzwiecki, 2015). Yet, conspicuous features of these interest-oriented prepositions, in turn, elicit criticism; questioning to what extent is the theory applicable to the health care reform in the Global South.

Indeed, some new democratic and low- and middle-income countries, such as Argentina, Brazil, Mexico, South Korea, Taiwan, and Uruguay, may reflect similarly on the causes of welfare state expansion in the Global North (Weyland, 1995; Fleckenstein and Lee, 2017; Flynn, 2019; Seekings, 2019; Kim and Shi, 2020; Dorlach, 2021). However, this argument has been recently called into question and has sparked a debate among scholars (cf. Yuda, 2021). The reason is that traditional assumption underpinning interest theory has failed to reckon with a weak effect on social policy outcomes compared with influences of bureaucracies and political elites (Yang, 2017). This argument can be elucidated through the historically bound explanation. Restrictions and even the abolition of the political and economic rights of local aristocrats, middle-class, and trade unions that were imposed in the past-colonial time have made the modern welfare state edifice, as such developed autonomously from class directives (Yuda, 2021). The development of welfare states in South and East Asia from the 1970s to the 1990s can be an illustration (Huber and Niedzwiecki, 2015).

Given this deficiency, a new stream of welfare politics literature suggests the inclusion of international influence into interest group theory. Its focus is on the phenomenon of the increasing new development trajectory of Global South countries that is recently reliant on bilateral or multilateral cooperation and international organisations on drivers' avenues (Holden, 2018; Seekings, 2019; Kuhlmann *et al.*, 2020). The extensive permeability of international organisations and donors is argued as a cause of social policy universalisation and replication in the Global South, especially in the low- and middle-income nations (Kaasch *et al.,* 2019).

Although the analysis of international influence provides another alternative explanation, many cases showcase that the adopted policies do not perfectly comply with the suggested prescriptions of international organisations (Kuhlmann and Nullmeier, 2021). A possible explanation may rest on the evasion mechanism assumption asserting that social policy adoption has generally been negotiated between international organisations and national and local political actors (Schmitt, 2020). A more common case is that of international organisations offering much social assistance to developing countries and implementing their programmes massively but rarely

reaching the target unless their schemes appeal to or fit actors of interest (Hickey *et al.*, 2020). Given this explanation, international influence does not seem to explain much of the extension of social policy among developing countries. This was due to the persistence of established political power that has been consolidated and concentrated in the national and local arenas together with heightened electoral competition (Kuhlmann and Nullmeier, 2021).

Although contested interest theory generally seems to fit as an alternative framework over the first one, we suggest looking into another cause that is more grounded on the appraisal of clientelist motives, which are found more prevalent as the driving force of healthcare expansion in the Global South. Examining the clientelistic motives unravels the pattern of the political elites, both conservative and left elites, using healthcare as a transactional political tool for vote buying. According to this logic, the choice of health care expansion is driven by the motives of political elites to solidify their power in public institutions. Instead of empowering, democratic institutions turn into levers for elites to pursue their goals.

However, the role of policy entrepreneurs is often overlooked in the policy cycle, especially in social policy research. Policy entrepreneurs are (individual or collective) political actors who attempt to change the status quo in public policy spaces by negotiating, persuading, and compromising as ways to garner political support of key policy players (Cohen, 2012; Mintrom, 2015). Policy entrepreneurs could be part of government agencies (politicians or civil servants), private entities (businesses, interest groups), epistemic communities (research organisations, scholars), or international organisations (Gunn, 2017). In our article, we had a closer look into policy entrepreneurs who were part of academic communities. Some of them were affiliated with political parties and government bureaucracy. All of these invested their time, energy, and resources to achieve health care reform.

Through examining both the demand and pull sides of healthcare expansion, we argue that although all factors could have contributed to drive changes, policy entrepreneur and clientelism are the most prominent factors at play which provided greater influence in expanding healthcare policy in the country, especially in the case of Indonesia.

In this article, we examine the potential causes of health care expansion in turn. We begin our review on the interplay of two major strands of the stimuli.

## Methods

The causes of welfare state expansion in Democratic Middle-Income Countries (DMIC) have been studied (see Dorlach, 2021 for an overview of these debates). One strand of the literature reveals that recent welfare state expansion in DMIC across the Global South has generally been driven by a broadly similar set of factors as post-war welfare state expansion in the Global North. It includes factors, such as economic development, democratic competition, and strong social and labour movements.

In this article, we further examine the developed arguments regarding healthcare expansion through a case study from Indonesia. We contend that the healthcare expansion in Indonesia is worth further investigation because, although the adherence to democratic values remains rudimentary after its transition to democracy post 1998 reform, Indonesia managed to experience massive healthcare expansion as illustrated in Table 1.

We began our study by reviewing literature and multifaceted datasets on Indonesian health care and social policies, including government reports and published and unpublished research papers. We complemented our study by conducting semi-structured interviews of approximately one hour duration on average with nine key policy makers who played a key role or had a profound knowledge of the policy and decision-making process in Indonesia from the 1990s through 2014.

The interviews served the purpose as a method to reconstruct events after the reform, corroborate our understanding of and information we acquired from literature and other sources, and

**Table 1** The performance of Indonesian healthcare development

| Government Health Expenditures (%GDP) | | Coverage (Public health services coverage, %) | | Financial risk protection (Out-of-pocket expenses, %) | | Healthcare Access and Quality (HAQ) (0-100) | |
|---|---|---|---|---|---|---|---|
| Pre-reform | After reform | Pre-reform | After reform | Pre-reform | After reform | Pre-reform | After reform |
| 0.78 (Spending averages between 2000–2013) | 1.28 (Spending averages between 2014–2019) | 51.2 (2013) | 83.4 (2019) | 50.15 (Spending averages between 2000–2013) | 38.96 (Spending averages between 2014–2019) | 43.96 (HAQ averages in 2000, 2005, and 2010) | 49.2 (2015) |

*Source*. Adapted and modified from Yuda and Pholpark, 2022

explore the perspectives of different decision-makers on the reform process. The key informants were: (1) former members of the National Social Security Council; (2) former Indonesian member of the National Social Security Council who designed Universal Health Coverage (3) former high level officials of the Ministry of Health in the 1990s; (4) an influential academic in the reform of the Indonesian health care and social insurance system in 2004; (5) prominent and influential members of parliament who were involved in the preparation of the social security bill; (6) representatives of the International Labour Organization; (7) the International NGO Forum on Indonesian Development; (8) Trade Union Rights Centre who were involved in the technical assistance process for the reform of the Indonesian social policy (health and employment-related insurances); (9) one of the key figures in the Social Security Action Group (*Komite Aksi Jaminan Sosial*, KAJS).

The composition of key policymakers warrants further exploration as most of them have served as academics in public and private universities, demonstrating the dominance of academics in policy-making in Indonesia. Wicaksono (2018) presents a very useful guide that invites others to explore and research the role that academics-turned-senior bureaucrats play in Indonesian public affairs, and our research, as we argued, takes into account this trend by examining how they interact with binding political structures. Due to this reason, we should be cautious not to glorify the structuralism and power resources model because the significant impact they had on social policy development was limited to the Indonesian case.

This study seeks to identify potential drivers of the expansion of health care in Indonesia and examine the implications of this expansion for social policy in the country. A cross-case analysis of sources was conducted to identify patterns among the different periods of policy implementations. Based on pattern matching and explanation building, we developed a logic model that could explain the cases based on consistency between periods of health care development. For analytical generalisability, within-case analyses were conducted to determine the operative mechanisms in examined policy (George and Bennett, 2005).

## Examining the push and pull factors of healthcare expansion in Indonesia

This section elaborates different possible causes of healthcare expansion in Indonesia. Each possible factor is examined through the historial lenses of healthcare development and how each factor from the push and pull sides interacts to influence and shape the healthcare expansion. The explanation contributes to the current perspectives of social policy development beyond the Western capitalist core.

## Push factors

### Industrialisation

Classical explanations of the origins of social policy begin with a structuralist logic standpoint, which links economic development factors, such as the industrialisation and fiscal capacity of the state, as the pre-eminence factors to state-regulated health care and welfare systems (Myles and Quadagno, 2002; Haggard and Kaufman, 2008). This view specifically asserts that health care policy is the prerequisite to attain sound inclusive economic development and hence propels the government to create or expand the policy (Barrientos and Hulme, 2009). The Indonesian experience under the authoritarian government of Suharto (1968–1998) can prove this argument, given that social policy, especially health care, is aimed at enhancing the capabilities of productive elements in society (Yuda *et al.,* 2022). It is one of the strategies to accelerate industrialisation, which follows the 'Rostow development approach,' suggesting the intense diversification of industry and investment with an international outlook.

During this period, health care schemes were altered and expanded at various stages. To be sure, only professional categories were privileged enough to enjoy the benefits. As observed in the early stages of industrialisation, health care was manifested in the form of Public Agency for Healthcare Funds (*Badan Penyelenggara Dana Pemeliharaan Kesehatan*, BPDPK), founded in 1968, and was only channelled to civil servants and the military. Meanwhile, other elements of society, such as informal workers, benefited from community-health centres (PUSKESMAS). Community-based health care provision was first supported by local volunteers, mostly women, who organised themselves into groups called the Family Welfare Movement (*Pembinaan Kesejahteraan Keluarga*) (Berenschot *et al*., 2018). It offered basic health services.

About a decade later, health care benefits expanded for industrial and retired public sector workers, urban formal workers, and even their families, for which their health care was managed under different administrations and integrated with other social security benefits, such as work accident insurance, pension scheme, and old-aged benefits. For example, Military personnel were granted with the Indonesian Armed Forces Social Insurance (*Asuransi Sosial Angkatan Bersenjata Republik Indonesia*), civil servants with pension insurance and comprehensive health insurance (ASKES), and industrial workers or urban formal workers with employee social insurance (*Asuransi Sosial Tenaga Kerja* henceforth known as ASTEK renamed as JAMSOSTEK) (Yuda and Pholpark, 2022).

Considerable evidence proved that its expansion coincided with the increase in economic growth, which reached 7.7 per cent per annum. It was made as a response to the rise in the number of poor people due to the adoption of neoliberal economic reforms (Aspinall, 2014; Fossati, 2016; Pisani *et al*., 2017). Surprisingly, as the industry rose on export-led manufacturing in 1992 and Indonesia's crude oil production remained steady, the government initiated a further extension of the health care for the poor under the Community Health Fund and Community Health Maintenance (JPKM) scheme. It was designed to 'mitigate the adverse effects of declining oil revenues on social spending, and it allocated funds to help indigent citizens to cover health care costs' (Fossati, 2016: 310). Despite the expansion, 'health inequality manifested itself in the form of significant differences among government employees and 'outsiders' in terms of their health care benefit' (Yuda, 2019: 352).

Nevertheless, the exploration of direct links between industrialisation and health care expansion, as we demonstrated here, was biased on European welfare state literature. They were often emphasised exclusively on economic development and inequality. In the context of the Global South, mainly in the Asian nations, the issue was of course not about economic performance per se, but to what extent the intertwining of economic and political purposes of the welfare state plays a decisive role in expansion. The strands of social policy literature showed that the social policy expansion during the industrialisation period was not caused by industrialisation itself or social needs, rather political motives to boost the legitimation of the authoritarian regime

(Murphy, 2019; Yuda, 2021). It clarifies enough why industrialisation in the Global South produces limited welfare state features, which contrast European experience (Powell and Kim, 2014).

In 1997, Indonesia, together with other East Asian countries, experienced stagnation in industrialisation, owing to the devastating Asian Economic Crisis. The crisis ended the once unprecedented prosperity experienced by many Indonesians and caused 36.5 million (17.86 per cent) people to be exposed to economic shocks. This number was an increase of approximately 14 million compared with 1996. Only 18 per cent of the Indonesian people were registered in health insurance; the rest of the population heavily relied on informal networks to internalise their health risk. In a nutshell, all these multiple factors eventually contributed to the abrupt fall of Suharto's regime in 1998. Since then, Indonesia began to enter the democratic era. This new development path created the critical juncture for social policy reforms and paved the way for health care expansion.

Based on the case presented above, an explanation that located the causes of health care expansion solely from industrialisation expansion and its consequences might be relevant before 1997. The reason might primarily have to do with the inability of the industrialisation assumption to explain a profound reform that was conditioned under the situation where the economic performance had declined and the wave of democratisation had taken place. To this point, other premises as drivers of policy expansion could be examined with caution; enabling us to work beyond structurally bound views.

### *The interplay between policy entrepreneurs and centre-right political parties*

The second element of the push factors to elucidate the expansion of healthcare reform is through policy diffusions. We contend that there are two policy diffusion mechanisms that contributed to the propagation of ideas of health care expansion in Indonesia: exchange of information between government officials and epistemic communities with their policy expertise.

Following the paradigmatic pathways of policy diffusion developed by Blatter *et al.* (2022), the first mechanism asserts that policy diffusion may take place through the exchange of information between government officials engendered primarily by external events, such as global or humanitarian crises. Government along with regulatory agencies deliberately search for and collect best practices from cross-border actors. This is also a learning avenue for the governments to understand and formulate crisis-fit policy responses. The emphasis of the second policy diffusion mechanism is driven by the policy expertise of epistemic communities. They may not directly intervene in the policy making process, but they have a pivotal role as a source of knowledge and scholastic perspectives. According to Blatter, policy diffusion especially takes place when the government's capacity to make decisions and sort the best practices for policy adoption are confined by time and they incorporate the suggestions from the epistemic communities into the policy formulation.

According to our interview with one of the key decision makers in health care policy in Indonesia, the first policy diffusion could be classified into two waves. The first wave was in the 1990s when a group of key decision makers of JPKM, including PT. Askes (a state-owned healthcare insurance company) and PT. Jamsostek (a state-owned healthcare insurance company for workers) were commissioned to attend an executive short course to learn and collect best practices in health care policy and management hosted by the University of California, Los Angeles (UCLA). The delegation was largely sponsored by the Health Project Four (HP-4) from the World Bank and the Project Health Sector Financing from the World Health Organization (WHO). The short course programme reinforced key decision makers about the managed care principles that are based on the market mechanism. The government officials learned that the key to establish the JPKM was to reform the first healthcare insurance implemented in the country from one that was exclusively for public officials and military apparatus, to expand the coverage to be more inclusive to all layers of society. The involved stakeholders were also introduced on the mandatory social insurance concept.

However, the early implementation of JPKM was rife with criticisms, mostly from the epistemic communities. The opposition views were mostly from healthcare policy scholars from Universitas Indonesia (UI) and Universitas Gadjah Mada (UGM). They argued that JPKM relied on the market-based mechanism in distributing the healthcare and it was equivalent to commodification of healthcare services, which they opposed. They asserted that because the healthcare distribution system was controlled by the market mechanism, JPKM would not be able to be implemented comprehensively. Furthermore, it was not fit for the Indonesian healthcare system that aims to redistribute healthcare for a larger segment of the population.

The surging criticisms from scholarly communities engendered the involved stakeholders to search for alternative frameworks that were fit with the Indonesian healthcare system and objectives. This also marked the beginning of the second wave of social policy diffusion on healthcare reform in the country. The government representatives and scholars pursued a short course in Germany which exposed them to social insurance. The concept exposed the stakeholders to the idea that social insurance is a mandatory membership governed by the government to cover the national population with more defined benefits than JPKM.

While the policy learning took place, the Asian Financial Crisis hit the country and affected the early implementation of JPKM that covered almost twenty-seven cities or regencies and five provinces. This engendered more criticisms from epistemic communities. They argued that the failure of the JPKM implementation was contributed by several factors. First, the involvement of private sectors that lead to the insufficient quality control of healthcare services. Second, as JPKM was based on market-mechanism, it only offered comprehensive healthcare assistance. Third, JPKM did not necessarily increase the healthcare coverage significantly across the nation because the nature of its membership was on a voluntary basis. In 1997, health care coverage reached to around 25 million or 10 per cent of total population, yet only 17 million of the population were enrolled in the programme.

Fourth, the lack of support from other government officials. Most of them perceived that the underlying principles of the JPKM was solely for economic growth purposes as part of Soeharto's New Order industrialisation agenda, not for redistribution. Fifth, managed care as the guiding practice for JPKM was not a successful use case either because of the inflation in the USA, exacerbated by the fact that the scheme was only limited to health model organization (HMO).

These lines of reasoning provided a cogent justification for the government to suspend JPKM. With the absence of healthcare insurance, the repercussions of the 1997 financial crisis left a large number of the population without insurance. This caused a higher demand for affordable healthcare because more people were hit by extreme poverty. The situation emboldened the government to revisit and further pursue social insurance to be implemented nationwide. This allowed a new healthcare insurance project sponsored by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). A group of key decision makers including representatives from epistemic communities were sent back to Germany to delve into the social insurance concept. The increasing demand for affordable healthcare became the basis for the epistemic communities to advocate for the inclusion of the welfare state concept in the constitution which was later manifested in the introduction of Law No. 40 on the National Insurance System (UU SJSN).

As explained above, the expansion of healthcare policy in Indonesia was predominantly driven by the influence of policy entrepreneurs consisting of epistemic communities that were not only from universities or scholarly organisations, but also those who were affiliated with political parties. This further pushed forward the healthcare policy reform agenda to the key policy makers. The mechanisms of which epistemic communities propagated the ideas and advocated for healthcare reform could be divided into several manoeuvres:

***The first manoeuvre.*** The first wave of the advocacy movement for healthcare reform and expansion from epistemic communities began when scholars from the University of Indonesia negotiated with the government to include the concept of welfare state into the constitution. The reform was expected to be implemented under Megawati's term but failed after the new

administration under SBY's leadership was elected. However, SBY decided not to implement the aforementioned principles because most resources and the state budget were allocated for crisis management, which was exacerbated by the increase of oil prices.

> When we went through a reform, we were also hit by the crisis in 1997/1998. I and a friend of mine, who was the head of the planning bureau of the Ministry of Health, had a discussion about our country's healthcare system . . . Our healthcare system is not good at all. We should propose the conception of a welfare state to our constitution to ensure the rights of access to healthcare services. *(*Anonymous, an academic who is also a key player in the health insurance reform process*)*

Another impediment to reforming the healthcare policy came from business entities. The International Chamber of Commerce explicitly opposed implementing healthcare reform in the country as it perceived potentially increased labour costs. They averred if the new element of healthcare was incorporated into the constitution and a new law were passed, investors would withdraw from Indonesia, leading to massive layoffs. They conveyed their disagreement to the minister of economic affairs as well.

> . . . from consultants in America, they provoked business entities to disagree with the SJSN idea. In response to this, I delivered my answer in 2003 through the Ministry of Economic Affairs and Secretary of State . . . because there are growing threats from the International Chamber of Commerce on the possibility of massive layoffs if SJSN passed and the collapse of the national economy (returning to the pre-crisis period). My answer for them was simple. Prove me which countries went bankrupt because of the comprehensive healthcare and social policy they give for their people . . . (Anonymous, an academic who is also a key player in the health insurance reform process)

The strong anti-leftists and anti-socialist sentiments exacerbated the process of passing SJSN, primarily because one of the key healthcare policy scholars who pushed the agenda was accused of having an affiliation with the Communist Party. Regardless of the obstacles, these policy entrepreneurs persisted in continuing their negotiation with the government by providing the facts of European welfare capitalism's success, particularly the example of the German Bismarckian social insurance model. In addition, the policy entrepreneur persuaded the Indonesian Chamber of Commerce to continue to support the healthcare reform initiative as investing in social insurance contributions increases the productivity of the labour force.

***The second manoeuvre*** began when a physician, who was also a politician from the Democratic Party, attempted rounds of negotiation with the finance minister to pass SJSN. He argued how low-income communities are vulnerable and the social assistance scheme implemented was not sufficient for them to access healthcare. The negotiation continued with another academician who was also a politician from the Indonesian Democratic Party of Struggle (PDI-P). The discussion resulted in an argument that, in all scenarios, the Democratic Party would not gain much from passing the BPJS law but could further exacerbate their political image in public. For PDIP, passing the BPJS law would benefit them in the 2014 election, whereas the Democratic Party might capitalise on this to improve their declined public trust due to the surging corruption cases among its members. However, failure in passing and implementing BPJS law would further demoralise the public which leads to more members not being seen as credible and trustworthy. The party would be considered pro-business and a corrupt political party. Therefore, it is necessary that the law no longer be politicised. This argument convinced SBY, which previously overlooked the welfare state initiatives, to support the implementation of BPJS law.

> The politicians in PDIP have one main principle: the implementation of this law [BPJS law] would benefit them. Failure to do so, it would further destroy the Democratic Party's public perception, not them. Democratic Party would not gain much from this law. However, it is essential to emphasise that my modality is I work for the people. (Anonymous, one of key player in designing health care insurance model)

From the explanation above, policy entrepreneurs played a pivotal role in influencing the key policy makers in implementing the healthcare reform agenda. When one representative of the Democratic Party was appointed as the chairman of BPJS law task force, members from epistemic communities tenaciously conveyed their scholarly ideas on designing the healthcare reform to the chairman. Although Democratic Party was not in favour of the implementation of the law and the chairman received a lot of resistance from different entities, the strong influence from representatives of the epistemic community pushed him to take a neutral stance in leading the group. Furthermore, despite being part of the Democratic Party, the chairman himself was also an experienced physician and scholar, further influencing his standpoint to bring forward the healthcare reform agenda to implementation. This section demonstrates that the interplay between policy entrepreneurs and political parties was dominant in healthcare reform. The scholarly ideas from epistemic communities had greater influence over interests from political parties in the implementation of BPJS law.

### *International organisation influences*

In 1998, the economic crisis followed by political instability created the need for essential macroeconomic reform initiatives in Indonesia. The International Monetary Fund (IMF) was at the forefront of this initiative contrary to the other international agencies that had oppositional views (Kwon *et al*., 2015; Holden, 2018; Kaasch *et al.,* 2019). This section further investigates how the influence of international organisations through their policy prescriptions broke the long-term equilibrium of health care system development in the previous path followed in Indonesia.

The financial deficit reached 2.3 per cent of the gross domestic product during the early months of the crisis and had brought Indonesia into the IMF conditional debt trap. The term 'conditional debt trap' was given because some unfavourable requirements, such as privatisation, a loose market policy, and free access to raw material and market, should be met before receiving loans.

Concerning the marketisation effect that caused such an increasing inequality, the World Bank (WB) offered loans of US$600 million for social protection expansion, among other things, such as education, subsidised rice for the poor, scholarships, and labour-intensive public work programmes. Specifically on health, 'WB also provided technical and financial support for the introduction of non-contributory health insurance programs for the poor' (Dorlach, 2021: 777). Targeted health insurance for the poor (Jamkesmas/Askesin) was claimed as part of WB's success in defining an essential stepping stone of Indonesian health care trajectory in the moving process toward universal coverage (Harimurti *et al*., 2014).

A similar endeavour was done by other international organisations. For example, WHO continuously supported the government of Indonesia in developing regulations during the initiation of the JKN legislation process. Some other forms of support were also provided; for example, agenda priorities were set, and an effective resource allocation for supporting the sustained Universal Health Insurance was ensured (Wisnu, 2012). While the main focus of WHO was on the regulation development area, the Deutsche Gesellschaft für Internationale Zusammenarbeit somewhat took a broad scope of intervention, such as the basic content, features, design transfer, and especially detailed technical expertise (Thabrany, 2008)

In addition, the role of the International Labour Organization (ILO) in policy models for health systems in Indonesia, as its core task, paid further attention to the issues of workers. Moreover, ILO supported the government in the collection of data regarding uncovered individuals under

health insurance and their accessibility problem toward health care. Such an intensified effort was claimed as a measure for stocktaking exercises to promote the extension of health benefits for those inside and outside the formal labour market. In Vietnam, the latter was pursued through the introduction of voluntary-based insurance (Kuhlmann and Nullmeier, 2021).

After the debt to WB was successfully paid off in 2006, the influence of WB on Indonesia gradually weakened. Instead, country-based international development actors, such as the governments of Australia and Japan, started to intensify their engagement in the development of Indonesia's health care system (Sumarto and Kaasch, 2018). Their involvement was particularly related to bilateral relationships that were politically lucrative for both countries, given that Indonesia was seen as a huge and strategic potential market for their industrial production.

From the succinct explanation above, this section demonstrates that political instability and the Asian Financial Crisis in 1998 have provided huge incentives for international organisations to intervene in the health care policy in Indonesia and have moved the country in the direction of a social rights-based universal scheme. Nonetheless, Indonesia's experiences contain some serious gaps between the idea of universal health care and the outcomes because the implementation is contingent upon the political interests of politicians.

Indonesia in the post-democratisation has a distinct characteristic in policy implementation, as it puts emphasis on decentralisation, and municipalities have their own regional autonomy. Hence, any external pressure from an external entity or civil society cannot substantially affect the local policy-making process (Savirani, 2018). The JKN implementation illustrates how the pressure from international organisations was unable to interfere the central government's decision. A further explanation of this issue is covered in the next section.

At the local level, the delaying implementation of JKN was acclaimed by local politicians. The transition to democracy was the momentum for political candidates at the local level because as the public celebrated the democracy, creating selective health care schemes was perceived as an effective political strategy to attract voters (Fossati, 2017). Therefore, international influence is not the determining factor of health care expansion in Indonesia. Drawing from the explanation above, clientelism is the factor that influences the health care reform in the country, and we take a closer look at the role of clientelism in the next section.

### *Clientelism*

The idea of creating a universal health care plan dates back to 1997, where the creation process involved dominant politicians from Golkar, political parties established by the authoritarian government of Suharto. It was set up as a strategy for restoring the legitimacy of the Golkar Party, as it responded to the political instability and public distrust throughout the country (Thabrany, 2008). Yet, it could not be realised as the collapse of Suharto in 1998.

Although the Suharto regime unravelled, it did not necessarily bring out the country from long-sustained authoritarian pitfalls. Instead, the political change had precisely placed the country in an unfavourable position. The reason was because the group regarded as most closely related to the stability of the Suharto administration remained in place while resurrecting the predatory state mode in a different fashion. The lack of interest representation by assertive civil society and trade unions during the political reform was the most common reason. The dominance of elite bureaucrats at the core of the social policy-making process during the post-democratisation period can support this argument.

The newly established parliament in 1999 amended the Indonesian constitution to include the right to receive social services for all citizens through the National Social Security System. Some prominent figures associated with Suharto were included in the list of architects who designed the system, among them were 'Sulastomo, a former operational director of PT ASKES (1986–2000) and a medical doctor; Hattri, a retired high-ranking official of PT JAMSOSTEK [Worker Social Security Program introduced during the Suharto administration]; and Sri Muwardjo, also a retired

high-ranking official of PT JAMSOSTEK. These three were to become the founders of the National Social Security System' (van Diermen, 2017: 162).

In 2002, over sixty people, including advisors representing international organisations, labour unions, and employees, drafted the National Social Security Law (Joedadibrata, 2012). At the early stages, this plan received objections from private-sector employers, as they had concerns about increasing production costs. Surprisingly, some labour unions also showed the same attitudes due to the law stipulating that workers would have to partly pay a premium of health insurance and other related social security, which were formerly fully borne by employers (Wisnu, 2007; 2012). 'Moreover, they worried that the premiums paid by workers and employers would be used to subsidise services for the poor and unwaged, leading to a cut in benefits for workers (Pisani *et al.*, 2017: 270). Despite the emerging controversy, President Megawati and her party, Indonesian Democratic Party of Struggle (PDI-P) – which represents the centre-left group – took considerable attention to intensify the support toward the creation of the National Social Security System Law from the very beginning of the process. However, many observers saw their support only as an 'investing measure' to pool popular support from the poor and the informal sector, which was essential for winning the presidential election in 2004, Indonesia's first direct presidential election. Unfortunately, despite the intensified efforts made, Megawati benefited next to nothing because the election was won by Susilo Bambang Yudhoyono (SBY) from the Democrat Party, a centre-right political group.

Although JKN under the National Social Security Law No. 40 of 2004 was enacted, it took ten years before JKN was implemented in 2014. Two reasons could explain the delay. First, JKN was not perceived as the by-product of the 'ruling' Democrat Party, but PDI-P legacies as the formal opposition during that period; hence, JKN was not lucrative to be politically leveraged (Yuda and Pholpark, 2022). Second, the implementation of universal health coverage with more emphasis on contributory schemes was considered unpopular among low-income individuals, which at that time reached 17.8 per cent. In 2005–2009, international oil prices also increased dramatically, making contributory health insurance have the tendency to no longer be an effective tool for vote mobilisation in the upcoming election. Instead, the ruling government decided to create a few non-contributory health care schemes for the poor and near-poor, such as Askeskin (renamed as Jamkesmas), which was considerably more favourable to legitimate his reign and boost his popularity in the election for a second term (2009–2014). Jamkesmas was also politically framed in such a way as a stopgap measure until JKN could be implemented.

Due to the delaying national plans, local governments were eventually initiated to fill the policy vacuum through many experiments to implement non-contributory health care (Jamkesda) (Thabrany, 2008; Tan, 2019). Pisani *et al.* (2017) noted that during the SBY reign (2004–2014), the Jamkesda 'swelled from approximately sixty in 2008 to at least 245 in 2012' (p. 6) and continued to increase in number to 514 in 2013, a year before JKN was implemented (Sumarto and Kaasch, 2018). Of districts that had already been running Jamkesda, some succeeded in achieving universal health coverage, such as Jembrana (Bali), Musi Banyuasin (South Sumatra), Universal Health Insurance of Aceh (Aceh), Yogyakarta Health Insurance (Yogyakarta), Social Security Program (Purbalingga), Solo Health Care and Education Subsidy (Solo), and Jakarta Health Card (Jakarta), which are frequently cited in many studies on Indonesian social policy development (Mas'udi and Hanif, 2011; Mas'udi and Lay, 2018).

Most notably, Bali's Jembrana district, one of its poorest areas, has a local scheme. A study conducted by Pisani *et al.* (2017) found that Gede Winasa earned the position of bupati there in 2000 through a political entrepreneurship strategy: he quietly convinced them that serving the local population would be more beneficial than pampering party elites. In his experience working at the local health department, he gained a deep understanding of the way health care should be delivered, such as the fact that the poor should be able to receive outpatient services from all registered hospitals. Despite being financially unsustainable, it improved health services for the population; infant mortality fell by almost half, and Winasa won 90 per cent of the popular vote

in the first direct election for bupati, making him Tempo's year-end 'Man of the Year' (Pisani *et al.*, 2017). The success of Winasa has led other political candidates to become obsessed with the concept of a state-funded district health scheme.

However, many untold stories about Jamkesda revealed that it was 'full of distortions, inefficiencies, rent-seeking, and outright corruption in government offices, private hospitals, [and] pharmaceutical company warehouses [alike]' (Aspinall, 2014: 816). Despite the dysfunction and being tainted by corruption and rent-seeking, Jamkesda was maintained because it had important stabilising functions for maintaining the power of predatory and their medical corporate allies (Fossati, 2016, 2017; Yuda, 2021).

We can observe convergent attitudes toward delaying the JKN implementation and targeted social policy between the incumbent and the opposition. PDI-P, a strong supporter of JKN, did not plead ruling the Democrat Party as a follow-up on the JKN implementation. Deliberately turning around, PDI-P was, instead, aggressively supporting targeted social protection that was introduced by the incumbent, including Jamkesmas/Askeskin, which they criticised before. A larger support to the programme of the incumbent was even expressed with confidence by Megawati ahead of the presidential election in 2009. Observers revealed that the changing attitude of PDI-P was the political strategy to combat the less development of support for them. Unfortunately, despite the considerable efforts of PDI-P to win the hearts of the poor and the informal sector, it did not mean Megawati and PDI-P were winning the then general election. SBY was surprisingly re-elected. Literature strands of welfare politics in Indonesia (Aspinall, 2014; Fossati, 2016, 2017; Yuda, 2021) attribute his electoral success in 2009 to the massive social welfare programmes introduced.

## Pull factors

### *Limited vertical alliances*

The decision to implement JKN in 2014 came about rather suddenly after a long delay. This decision was possible because a cross-group consisting of farmers, labour unions, fishermen, and university students incorporated in the KAJS had persistently compelled the government to immediately implement the delayed universal health coverage plans for two years long from 2009 to 2011. Despite receiving pressure, it failed to necessarily push the government to make an immediate decision. The expansion of health care was implemented in January 2014, four months before the presidential election. This case showcases that 'the underlying patron–client relationships are then reinforced and can prove extremely resistant to civil society pressures and social policy reforms along welfare state lines' (Sharkh and Gough, 2010: 29).

Additionally, our findings from an in-depth interview with a few key informants suggested that the emergence of KAJS has not yet been revealed and that the social movement was not a significant cause of reform. There are a few factors of the limitation of the civil society movement in pressing the government to implement JKN. First, the KAJS' agenda was unclear. The organisation was newly established and their sole agenda was not on healthcare reform. KAJS leveraged the heated discourse on social security reform to insert their agenda to put pressure on SBY administration in its second term which was considered to have many multidimensional problems. During the second term of SBY's administration, news media reported the number of Democratic Party cadres who abuse their positions have not only intensified public distrust to ruling government; they have also resulted in a politics of social security reform and other social welfare issues, with diversified views from civil society and labour union, undermining the authority of rulers.

Second, KAJS' movement focused more on the urban areas. Their movements did not reach people living outside Jakarta. We contend that in order for a civic movement to be successful in pushing their agenda to the government, gathering a larger mass from outside urban areas is crucial. Third, KAJS' agenda for healthcare reform was not quite aligned with the cause that most

civic organisations advocated for. Most civic organisations mobilised their resources to urge the government to decrease the fuel prices, not to reform healthcare.

> The KAJS voice didn't reach the [non-Jakarta] area . . . At that time, the student movement and civic organisations were more concerned with increasing fuel prices . . . the point was that political consolidation was only happening in Jakarta. No one outside Jakarta knows what KAJS is . . . Who cares . . . This is only an issue in Jakarta. KAJS's hidden agenda is simply to politicise [fragmented] labour [union] . . . [as well as] . . . taking advantage of anti-SBY administration sentiment, which was at that time rife with corruption in his party. (Anonymous, an observer, and expert from one of influential non-governmental organisation).

Civic organisations, indeed, have the power to exert influence on the government and shape the policy making process. However, with the unclear agenda, mass, and alignment of issues with other civil society organisations, relying on KAJS' move to influence the government to reform and expand healthcare plans for Indonesians across the country was not sufficient. Interestingly, the political debate about the implementation of health and social security laws barely discussed funding mechanisms, coverage, provisions, actuarial needs, disease risks, and other essential and technical issues. Instead, the discussed topic was on governing the details of the management structure of BPJS-Kesehatan, a mandated public agency for managing health care funds (Aspinall, 2014; Tan, 2019). The JKN implementation plans suddenly turned as a battle ground for elites, politicians, and bureaucrats 'who [previously] benefited from the [ASKES] funds they had been controlling' (Pisani *et al*., 2017: 276) since the 1990s.

Despite the JKN implementation, local governments did not simply wind back the local health care that had been implemented. A working paper by Sumarto and Kaasch (2018) notes that 155 districts/municipalities 'had outright refused to take part in the integration' (p. 9). This refusal is plausibly due to the health care-giving political incentives for politicians to boost their popularity when running for election; hence, many local governments consider persisting with it. Such an experience corroborates the arguments stressing the importance of 'clientelism and interests' in social policy proliferation in Indonesian democracy.

This case reflects that social policy after democratisation remains subject to operation under clientelism and was used for political legitimation over previous decades.

## Push and pull factors of health care expansion

The historical sequences-based explanation above has highlighted several determinants that help us appreciate different mechanisms of healthcare expansion in Indonesia. In this section, we extrapolate our analysis leveraging the push and pull factors to understand the interplay between each factor.

Our analysis began with industrialism theory. Our study found little evidence that long economic growth periods during the 1970s–1990s had an advantageous impact on this country's health care and overall welfare expansion. In this context, the social policy helped stabilise the political regimes of authoritarian Suharto by providing favourable treatment to those military and government officials deemed politically necessary. In contrast, social citizenship and redistribution received little attention and political support, with an apparent aversion to welfare states.

Maintaining autonomous state order is also characteristic of Indonesian welfare regimes during industrialisation. Organisations such as unions, except business entities, were effectively excluded from political decision-making, allowing ruling elites to maintain complete levels of autonomy (cf. Weber, 2006). To optimise this order, left-affiliated groups were undermined as part of the

communist depoliticisation policy which was prevalent during the Cold War while setting the stage for regime order with significant separation from class interests (Hadiz, 2003).

Unfortunately, this isolated mode of decision-making continues despite adopting liberal democratic governance. The underlying cause for this can be explained by the fall of Suharto and cannot entirely be attributed to the economic crisis. Instead, defection from the regime elite is viewed as an essential endogenous dynamic highlighted in the explanation of Indonesian political system transitions. The political transition took place against this backdrop when insiders – namely, Suharto and his close associates – were removed from the commanding heights of government, allowing former outsiders to regain access to patronage (cf. Fukuoka, 2013). In this context, the political transition was accomplished by decentralising previously centralised patronage networks and redistributing spoils. Health care has proven to be a perfect and lucrative sector to mobilise support for legitimising old players (Aspinall, 2014). This explanation finally also calls into question the role left-centred governments or interest groups play in welfare state reforms with a social democratic character.

It is undeniable that democracy, as theorised by many scholars, has created favourable conditions for mobilising welfare state demands, but it is insufficient to explain the case in Indonesia. Additional effects have been observed, such as competition between centre-left and centre-right parties that have facilitated the inclusion of the marginalised group (e.g. poor, disabled, and informal sector) into the healthcare system. For Indonesia, we should also recognise the role played by the centre-right parties of SBY in this expansion. Another study found that when centre-right parties were strong (2005–2014), large numbers of outsiders were included, and benefit levels were relatively generous through social protection services, even though these services were conditioned under patronage and clientelism permeability. This finding contradicts the major theories of welfare expansion, which assert that centre-right parties will obstruct the implementation of policies that support the development of the generous welfare state.

Even though abrupt social and labour movements emerged during the 2010s, these movements did not necessarily influence policymaking, as welfare reform decisions were subject to the political considerations of ruling regimes and their allies, even their rivals. The tug of war between parties, which was inextricably linked to clientelistic motives, in policy making also explicitly challenged international organisations' prescription of immediate reform, causing healthcare reform to stall for almost ten years.

Despite all of the above factors, the adjustment of institutionalised inclusive healthcare was first transformed by the policy diffusion process in 1992 as a result of the accumulation of new information related to managed care, which was promoted by international organisations and US institutions, and to the social insurance system which was promoted by the German government. The latter option was finally chosen because it met Indonesian constitutional requirements. However, institutional inertia reinforced by clientelism motives – such as the development of means-tested health care on both the national and local levels that sought to gain popularity among elites – prevent deliberate and reformist attempts to change health care and its institutional foundations in 2004, despite institutional routines for making ad hoc changes having been implemented. However, the reform plan gained momentum in 2011 when the limited vertical alliance emerged, pushing the government to execute the reform by integrating all fragmented health care on a national and local scale and expanding coverage to all segments of the population.

The findings we suggest in our article challenge the dominant Western perspectives in analysing healthcare reform. Most Western perspectives emphasise the successful health care reforms on the power resource mode. The results of our interviews and reviews indicate, however, that the interplay between factors which were illustrated by the push and pull factors is what drove the healthcare reform in Indonesia. Furthermore, we demonstrate that the interplay is superior within the push over pull factors. A group of key actors behind the interplay are the policy entrepreneurs, consisting of academicians, either those who were part of universities or affiliated with the parliament as consistently advocating for healthcare as public issues since the 1990s (see Table 2).

**Table 2** Different mechanism of interaction of causes of healthcare expansion evolution in Indonesia

| *Waves of reform* | First (1992) | Second (1998-2004) | Third (2005 – 2008) | Fourth (2010-2014) |
|---|---|---|---|---|
| ***Major events underlying or accompanying the reform*** | • Global economic crisis | • Asian Financial Crisis | • Rising national oil prices | • The formation of KAJS (2010)<br>• Citizen lawsuit for healthcare reform (2011)<br>• The declining reputation of the center-right ruling party |
| ***Policy outcome*** | • The emergence of JPKM | • The emergence of JPS-Healthcare<br>• National Social Security (NSS) Law no 40/2004 | • Failure implementation of NSS (2004)<br>• Askeskin replaced Jamkeskin (2008)<br>• Deadline term to implement BPJS *Kesehatan* (2009) | • The successful implementation of Universal Healthcare Insurance (JKN) |
| ***Significant actors at play*** | • Policy entrepreneurs | • Policy entrepreneurs | • Policy entrepreneurs<br>• Political parties | • Policy entrepreneurs<br>• Political parties<br>• Civil Society Organizations (in limited movement) |
| ***Push Factors*** | • Policy diffusion<br>• Industrialization (individual idea or ideology of policy makers that emphasizes on economic growth)<br>• Influence from international organization | • Policy diffusion<br>• The logic of social risk and insecurity<br>• Influence from international organization | • Policy diffusion<br>• Clientelistic motives<br>• Influence from international organization | • Policy diffusion<br>• Clientelistic motives |
| *Pull Factors* | • N/A | • N/A | • N/A | • Limited vertical alliances |

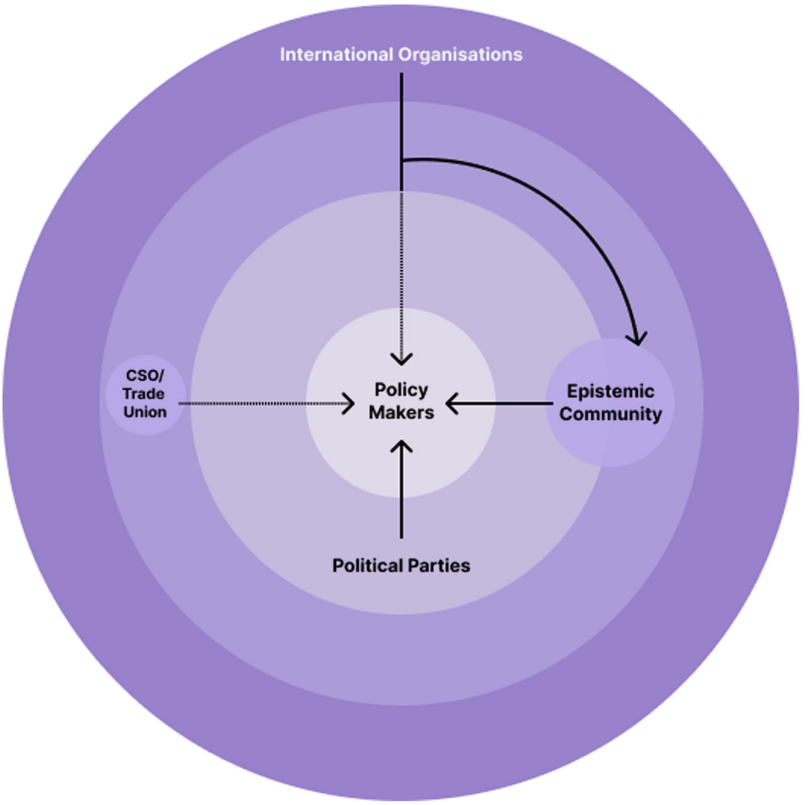


**Figure 1.** Ring of influences

Also, the political interests of the centre-right party to improve their public perception amid declining trust from the public, and the push factor from centre-left party who mobilised support for the 2014 election, have been crucial elements in expediting the approval for reform advocated by policy entrepreneurs. A consensus on reform was finally reached despite opposition from business groups on the spike, whose aspirations were previously facilitated by the centre-right party in 2004 - 2009. This finding, to some extent, contributes to revising recent findings (Yuda and Pholpark, 2022) that place limited-vertical alliances together with clientelism motives as political mechanisms underpinning healthcare reform.

### *Rings of influence*

In summary, we illustrate in figure 1 the rings of influence of healthcare policy reform in Indonesia to assess the push and pull factors that contribute to policy reform. Each ring represents the proximity of their influence. The closer the factors to the core ring, the greater the influence they could contribute to. Policymakers are placed in the central ring not only because they have the authority to formulate policies, but they are also subject to influence from other rings. Meanwhile, political parties fall within the second ring of influence because they were within the immediate environment of policymakers since many policy makers are affiliated with political parties. The third ring of influence consists of various organisations, including epistemic communities, academic institutions, and civil society organisations that advocate for healthcare reform.

Unlike other stakeholders, epistemic communities sit between the second and third rings of influence because some members of the scholarly organisation, based on our findings, were affiliated with political parties. This way, they had more power to influence and direct the decision-making process to determine healthcare reform. However, in contrast to this, the civil society organisations, in the context of healthcare reform, fell on the third ring; and oftentimes they were not able to pass through the second ring to directly influence the government.

Last but not least is the role of international organisations, such as the World Health Organization or the World Bank. They had pivotal roles in driving the policy agenda and disseminating ideas about healthcare practices, as explained in the previous sections. In some cases, they had the power to influence policy makers. For instance, the World Bank through its structural adjustment was able to demand the Indonesian government to change various policies to fit in their policy prescriptions. However, in many cases, their influence is contingent upon the political willingness of the policy makers to uptake their policy suggestions into account. Under this scenario, policy entrepreneurs become the intermediaries for these international organisations to propagate ideas for healthcare policy prescriptions that the government should adopt.

Our findings and analysis enable us to argue that significant reform of healthcare, which diverges from the original fragmented path, takes place when 'ideas' promoted by the international organisations are advocated by policy entrepreneurs (who in this instance are academics and political figures at the same time) and are more relevant in the case of Indonesia. This was demonstrated by how the policy entrepreneurs were able to influence and change the attitude of centre-right political parties toward an inclusive welfare regime. A part of the explanation lies in the exceptional circumstances among the centre-right political party from 2009 to 2011. The government was under heavy criticism for corruption because of a stagnant economy, rising unemployment, and increasing budget deficits due to the increased fuel price. Consequently, the structural healthcare reform has received significant attention from centre-right politicians, allowing centralisation to return to the agenda while challenging their institutional nature and preferences, supporting means-tested social protection while facilitating business interests. It is essential to emphasise that reform would not have been possible had the centre-right party opposed it.

Our findings on the interplay between policy entrepreneurs and centre-right political parties in driving the expansion of national healthcare policy landscape are echoed by the recent scholarly work, arguing that the process of healthcare policy-making and implementation is inextricably linked to elite bargain and political interaction among policy entrepreneurs and political parties to push forward the healthcare agenda in policy making (Campos and Reich, 2019; Dercon, 2022).

## Conclusion

Healthcare represents one of the most dominant social policies of recent decades in the Global South. Examining qualitative and historical data regarding health care evolution and expansion in Indonesia, this study assesses the recent findings and suggests important new directions, addressing several shortcomings in the existing research.

Our article demonstrates that significant healthcare reform occurred when policy entrepreneurs (in this case academics and political figures at the same time) exerted their knowledge to influence the centre-right party to change its previously means-tested and residual welfare policies. However, policy entrepreneurs were only able to reform healthcare under 'exceptional conditions' when the ruling government of the dominant centre-right party was accused of corruption: this situation is exacerbated by stagnant economic conditions, rising unemployment, and increasing budget deficits. These conditions facilitated the implementation of a new policy direction and made major change politically acceptable by SBY. In sum, we wish to emphasise that reform would not have been possible without the support of the centre-right party.

This argument is supported by our data showing that although the gradual changes, especially in the 1990s, had essential contributions to the early development of healthcare in Indonesia, successful healthcare reform has not been achieved as of 2004 when centre-left parties began the reform process. A significant reason for the failure of reform was the enormous influence of business in politics, facilitated by centre-right parties committed to social assistance as a source of legitimacy, and the lack of civil society and labour unions' involvement in politics. Furthermore, local governments' clientelism motives, which view means-tested health care primarily as a means of commodity to mobilise voters, contributed to the difficulty in implementing a comprehensive health care reform.

The failure of reform prompted academics who were a set of groups of scholars, progressive bureaucrats, and politicians to consolidate their political networks to revive the reform agenda. Others sought support from governments, while others focused on vertical alliances consisting of civil society, students, and fragmented labour unions. However, as shown in our analysis, the vertical alliance's movement and other driving entities have lesser influence on political lobbying. Corroborated by our interviews with key decision makers in Indonesia's healthcare agenda, we found that the movement focused more on issues related to fuel prices and SBY's administration in general, not on healthcare reform agenda. There was a sudden change in decision-making when the centre-right political attitude became supportive towards inclusive social policies. We identify the motivation for the convergence of political attitudes between these two groups. First, the centre-right party was in its efforts to improve its damaged reputation in light of increased corruption among its members. Second, the centre-left party attempted to garner support for the 2014 election. A consensus on reform was finally reached despite the rising opposition from business groups whose interests were usually catered to by the centre-right parties.

Our study significantly contributes to the emerging discourse of social policy dynamics in developing countries whereby social policy change is engendered when the political attitude of the centre-right parties is converging to the left-centre party. The driving force behind this change was the role of policy entrepreneurs within the body of the centre-right party. Policy entrepreneurs are capable of separating and balancing public aspiration and rational ideas resulting from social learning, while the latter represents the political interests of constituents, such as business unions and oligarchs. Right-centre parties, however, were the only sources of power capable of breaking the established institutions that had multiple political and institutional anchors. Drawing the lesson from Indonesia, our article demonstrates that the push factor, which emphasises the interaction between policy entrepreneurs and centre-right parties, prevails over the pull factor, which is subordinated and fragmented, which impeded their movement in delivering a significant impact on reform.

A comparison of existing studies reveals that there is no account of the pattern of social policy reform mechanisms derived from the intertwined relationship between the policy entrepreneur and the centre-right groups, as was the case in Indonesia. As this line of study continues to develop, it promises to offer insights into new cases as well as enhance our understanding of important aspects of social policy in developing economies.

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## References

**Aspinall, E.** (2014) 'Health care and democratization in Indonesia', *Democratization*, **21**, 5, 803–23.

**Barrientos, A. and Hulme, D.** (2009) 'Social protection for the poor and poorest in developing countries: reflections on a quiet revolution', *Oxford Development Studies*, **37**, 4, 439–56.

**Berenschot, W., Hanani, R. and Sambodho, P.** (2018) 'Brokers and citizenship: access to health care in Indonesia', *Citizenship Studies*, **22**, 2, 129–44.
**Blatter, J., Portmann, L. and Rausis, F.** (2022) 'Theorizing policy diffusion: from a patchy set of mechanisms to a paradigmatic typology', *Journal of European Public Policy*, **29**, 6, 805–25.
**Bonoli, G.** (2005) 'The politics of the new social policies: providing coverage against new social risks in mature welfare states', *Policy and Politics*, **33**, 3, 431–49.
**Bonoli, G.** (2007) 'Time matters: postindustrialization, new social risks, and welfare state adaptation in advanced industrial democracies', *Comparative Political Studies*, **40**, 5, 495–520.
**Campos, P. A. and Reich, M. R.** (2019) 'Political analysis for health policy implementation', *Health Systems and Reform*, **5**, 3, 224–35.
**Carbone, G.** (2011) 'Democratic demands and social policies: the politics of health reform in Ghana', *Journal of Modern African Studies*, **49**, 3, 381–408.
**Cohen, N.** (2012) 'Policy entrepreneurs and the design of public policy: the case of the national health insurance law in Israel', *Journal of Social Research and Policy*, **3**, 1, 1–22.
**Dercon, S.** (2022) *Gambling on Development: Why Some Countries Win and Others Lose*, London: Hurst Publishers.
**Dorlach, T.** (2021) 'The causes of welfare state expansion in democratic middle-income countries: a literature review', *Social Policy and Administration*, **55**, 5, 767–83.
**Edlund, J. and Lindh, A.** (2015) 'The democratic class struggle revisited', *Acta Sociologica*, **58**, 4, 311–28.
**Fleckenstein, T. and Lee, S. C.** (2017) 'Democratization, post-industrialization, and East Asian welfare capitalism: the politics of welfare state reform in Japan, South Korea, and Taiwan', *Journal of International and Comparative Social Policy*, **33**, 1, 1–19.
**Flynn, M. B.** (2019) 'Movement-driven development: the politics of health and democracy in Brazil', *Social Forces*, **98**, 2, 1–3.
**Fossati, D.** (2016) 'Is Indonesian local government accountable to the poor? Evidence from health policy implementation', *Journal of East Asian Studies*, **16**, 3, 307–30.
**Fossati, D.** (2017) 'From periphery to centre: local government and the emergence of universal healthcare in Indonesia', *Contemporary Southeast Asia*, **39**, 1, 178–203.
**Fukuoka, Y.** (2013) 'Indonesia's 'democratic transition' revisited: a clientelist model of political transition', *Democratization*, **20**, 6, 991–1013.
**George, A. L. and Bennett, A.** (2005) *Case Studies and Theory Development in the Social Sciences*, Cambridge, MA: MIT Press.
**Gunn, A.** (2017) 'Policy entrepreneurs and policy formulation', in M. Howlett and I. Mukherjee (eds.), *Handbook of Policy Formulation*, Cheltenham: Edward Elgar, 265–82.
**Hadiz, V.** (2003) 'Reorganizing political power in Indonesia: a reconsideration of so-called 'democratic transitions'', *The Pacific Review*, **16**, 4, 591–611.
**Haggard, S. and Kaufman, R. R.** (2008) *Development, Democracy, and Welfare States: Latin America, East Asia, and Eastern Europe*, Princeton, NJ: Princeton University Press.
**Harimurti, P., Pambudi, E. S., Pigazzini, A. L. and Tandon, A.** (2014) 'The nuts and bolts of Jamkesmas - Indonesia's government-financed health coverage program for the poor and near-poor (English)', Universal Health Coverage (UNICO) Studies Series No. 8, Washington, D.C.: World Bank Group, http://documents.worldbank.org/curated/en/430821468044119982/The-nuts-and-bolts-of-Jamkesmas-Indonesias-government-financed-health-coverage-program-for-the-poor-and-near-poor [accessed 01.12.2022].
**Hickey, S., Lavers, T., Niño-Zarazúa, M. and Seekings, J.** (2020) 'The negotiated politics of social protection in East and Southern Africa', in S. Hickey, T. Lavers, M. Niño-Zarazúa and J. Seekings (eds.), *The Politics of Social Protection in Eastern and Southern Africa*, Oxford: Oxford University Press, 1–41.
**Holden, C.** (2018) 'Global social policy: an application of welfare state theory', *Journal of International and Comparative Social Policy*, **34**, 1, 40–57.
**Huber, E. and Niedzwiecki, S.** (2015) 'Emerging welfare states in Latin America and East Asia', in S. Leibfried, E. Huber, M. Lange, J. D. Levy, F. Nullmeier and J. D. Stephens (eds.), *The Oxford Handbook of Transformations of the State*, Oxford: Oxford University Press, 796–812.
**Isabekova, G. and Pleines, H.** (2021) 'Integrating development aid into social policy: lessons on cooperation and its challenges learned from the example of health care in Kyrgyzstan', *Social Policy and Administration*, **55**, 6, 1082–97.
**Islami, M. I. and Hastiadi, F. F.** (2020) 'Nature of Indonesia's deindustrialization', *Economics Development Analysis Journal*, **9**, 2, 220–32.
**Iversen, T. and Cusack, T. R.** (2000) 'The causes of welfare state expansion: deindustrialization or globalization?', *World Politics*, **52**, 3, 313–49.
**Jarvis, D. S. L. and He, A. J.** (2020) 'Policy entrepreneurship and intuitional institutional change: who, how, and why?', *Public Administration and Development*, **40**, 1, 3–10.
**Joedadibrata, D.** (2012) 'A study of the shift towards universal social policy in Indonesia', Master thesis, International Institute of Social Studies, https://thesis.eur.nl/pub/13046 [accessed 01.12.2022].
**Jordan, J.** (2011) 'Health care politics in the age of retrenchment', *Journal of Social Policy*, **40**, 1, 113–34.

**Kaasch, A., Koch, M. and Martens, K.** (2019) 'Exploring theoretical approaches to global social policy research: learning from international relations and inter-organisational theory', *Global Social Policy*, **19**, 1–2, 87–104.
**Kim, W. S. and Shi, S. J.** (2020) 'East Asian approaches of activation: the politics of labor market policies in South Korea and Taiwan', *Policy and Society*, **39**, 2, 226–46.
**Kuhlmann, J., González de Reufels, D., Schlichte, K. and Nullmeier, F.** (2020) 'How social policy travels: a refined model of diffusion', *Global Social Policy*, **20**, 1, 80–96.
**Kuhlmann, J. and Nullmeier, F.** (2021) 'A mechanism-based approach to the comparison of national pension systems in Vietnam and Sri Lanka', *Social Policy and Administration*, **55**, 6, 1036–49.
**Kwon, H. J., Cook, S. and Kim, Y.** (2015) 'Shaping the national social protection strategy in Cambodia: global influence and national ownership', *Global Social Policy*, **15**, 2, 125–45.
**London, J. D.** (ed.) (2018) *Welfare and Inequality in Marketizing East Asia*, London: Palgrave Macmillan.
**Mas'udi, W. and Hanif, H.** (2011) 'Welfare politics in contemporary Indonesia: examining welfare vision of law 11/2009', *Power, Conflict, and Democracy*, **3**, 1–2, 95–124.
**Mas'udi, W. and Lay, C.** (2018) *The Politics of Welfare: Contested Welfare Regimes in Indonesia*, Jakarta: Yayasan Obor Indonesia.
**Mintrom, M.** (2015) 'Policy entrepreneurs and morality politics: learning from failure and success', in I. Narbutaité Aflaki, E. Petridou and L. Miles (eds.), *Entrepreneurship in the Polis: Understanding Political Entrepreneurship*, Aldershot: Ashgate, 103–17.
**Murphy, J.** (2019) 'The historical development of Indonesian social security', *Asian Journal of Social Science*, **47**, 2, 255–79.
**Myles, J. and Quadagno, J.** (2002) 'Political theories of the welfare state', *Social Service Review*, **76**, 1, 34–57.
**Pierson, C.** (2005) '"Late Industrializers" and the development of welfare regimes', *Acta Politica*, **40**, 4, 395–418.
**Pisani, E., Olivier Kok, M. and Nugroho, K.** (2017) 'Indonesia's road to universal health coverage: a political journey', *Health Policy and Planning*, **32**, 2, 267–76.
**Powell, M. and Kim, K. T.** (2014) 'The 'chameleon' Korean welfare regime', *Social Policy and Administration*, **48**, 6, 626–46.
**Rodrik, D.** (2016) 'Premature deindustrialization', *Journal of Economic Growth*, **21**, 1, 1–33.
**Savirani, A.** (2018) *Pengantar: Demokrasi dan Rezim Kesejahteraan di Tingkat Lokal di Indonesia*, Yogyakarta: POLGOV.
**Schindler, S., Gillespie, T., Banks, N., Bayırbağ, M. K., Burte, H., Kanai, J. M. and Sami, N.** (2020) 'Deindustrialization in cities of the Global South', *Area Development and Policy*, **5**, 3, 283–304.
**Schmitt, C.** (2020) 'The coverage of social protection in the Global South', *International Journal of Social Welfare*, **29**, 1, 6–19.
**Seekings, J.** (2019) 'The limits to 'global' social policy: the ILO, the social protection floor and the politics of welfare in East and Southern Africa', *Global Social Policy*, **19**, 1–2, 139–58.
**Selway, J. S.** (2015) *Coalitions of the Well-Being: How Electoral Rules and Ethnic Politics Shape Health Policy in Developing Countries*, New York, NY: Cambridge University Press.
**Sharkh, M. A. and Gough, I.** (2010) 'Global welfare regimes: a cluster analysis', *Global Social Policy*, **10**, 1, 27–58.
**Sparrow, R., Budiyati, S., Yumna, A., Warda, N., Suryahadi, A. and Bedi, A. S.** (2017) 'Sub-national health care financing reforms in Indonesia', *Health Policy and Planning*, **32**, 1, 91–101.
**Sumarto, M. and Kaasch, A.** (2018) *New Directions in Social Policy: Evidence from the Indonesian Health Insurance Programme*, Geneva: United Nations Research Institute for Social Development.
**Tan, S. Y.** (2019) 'Bureaucratic autonomy and policy capacity in the implementation of capitation payment systems in primary healthcare: comparative case studies of three districts in Central Java, Indonesia', *Journal of Asian Public Policy*, **12**, 3, 330–50.
**Thabrany, H.** (2008) 'Politics of national health insurance of Indonesia: a new era of universal coverage', presented at the 7th European Conference on Health Economics, Rome, 23–26 July.
**van Diermen, M.** (2017) 'Welfare in transition: the political economy of social protection reform in Indonesia', PhD thesis, University of Adelaide, Adelaide.
**Weber, D.** (2006) 'A consolidated patrimonial democracy? Democratization in post-Suharto Indonesia', *Democratization*,**13**, 3, 396–420.
**Weyland, K.** (1995) 'Social movements and the state: the politics of health reform in Brazil', *World Development*, **23**, 10, 1699–712.
**Wicaksono, A.** (2018) 'The role of policy transfer in Indonesian governance: the case of academic administrative entrepreneurs', *Policy Studies*, **39**, 6, 622–37.
**Wisnu, D.** (2007) 'Governing social security: economic crisis and reform in Indonesia, the Philippines and Singapore', Dissertation, Ohio State University, https://etd.ohiolink.edu/apexprod/rws_etd/send_file/send?accession=osu1179867530&disposition=inline [accessed 01.12.2022].
**Wisnu, D.** (2012) *Politik Sistem Jaminan Sosial*, PT Gramedia Pustaka Utama: Jakarta.
**World Bank** (2014) *Key Lessons Learned from Jamkesmas to Achieve Universal Health Care in Indonesia*, World Bank Report, https://www.worldbank.org/en/news/feature/2014/01/30/improving-jamkesmas-to-achieve-universal-health-care-in-indonesia [accessed 01.12.2022].

**Wu, X. and Ramesh, M.** (2009) 'Health care reforms in developing Asia: propositions and realities', *Development and Change*, **40**, 3, 531–49.

**Yang, J.** (2017) *The Political Economy of the Small Welfare State in South Korea*, Cambridge: Cambridge University Press.

**Yuda, T. K.** (2019) 'Welfare regime and the patrimonial state in contemporary Asia: visiting Indonesian cases', *Journal of Asian Public Policy*, **12**, 3, 351–65.

**Yuda, T. K.** (2021) 'The complementary roles of familism and clientelism in social policy development', *Social Policy and Administration*, **55**, 7, 1370–92.

**Yuda, T. K., Kim, M., Pholpark, A. and Bin Aedy Rahman, H. N.** (2022) 'Unmasking the social policy responses of COVID-19 in four Southeast Asian Nations: institutional patterns and policy adjustment', *Asia Pacific Journal of Social Work and Development*, DOI: doi.org/10.1080/02185385.2022.2136234.

**Yuda, T. K. and Pholpark, A.** (2022) 'Healthcare expansion in Indonesia and Thailand: a causal mechanism and its implications for welfare regimes', *Journal of International and Comparative Social Policy*, **38**, 2, 111–29.

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