Ear to Asia podcast

Title: The political battle over health policy in Indonesia

Description: What's at stake and who are the stakeholders in steering health policy in Indonesia? While the right to health for all Indonesians has been embraced by progressive, populist and technocratic political forces in recent years, oligarchic elites with ties to business and the military are now reemerging to thwart further improvements in healthcare for ordinary people. Political economist Prof Andrew Rosser and public policy specialist Dr Luky Djani join presenter Peter Clarke to examine the politics of healthcare in Indonesia. An Asia Institute podcast. Produced and edited by profactual.com. Music by audionautix.com.

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Voiceover:

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Peter Clarke:

Hello. I'm Peter Clarke. This is Ear to Asia.

Luky Djani:

Before we have this national health insurance scheme, people are afraid to go to see doctors, afraid to go to hospitals because they don't have money to pay for the treatment. But since the government introduced the national health insurance system, more and more Indonesians access the health facilities.

Andrew Rosser:

The Indonesian government has increased health spending quite significantly during pandemic as one would expect. The big question is whether that signals a change that would stick in the future, or whether it would just prove to be a temporary thing, and once the crisis is abated, once concern about covid-19 has started to dissipate, will things return to their previous state.

Peter Clarke:

In this episode, the politics of health in Indonesia.

Ear to Asia is the podcast from Asia Institute, the Asia Research Specialists at the University of Melbourne.

Well before the COVID 19 pandemic took hold in Indonesia, the country's health policies were already keenly contested politically. The fall of Suharto's New Order Regime a little over two decades ago, galvanised a recognition of the need for reform in many sectors of Indonesia society, including the area of health policy in the world's fourth most populist country. The right to health for all Indonesians, and the healthcare resources needed to uphold that right gained real currency with the political ascendancy of more progressive, populist, and technocratic forces. And yet entrenched interests, including predatory elites with political and military ties, are now reasserting themselves to thwart changes being sought to further improve the health prospects of ordinary Indonesians. So what's at stake, and who are various stakeholders in Indonesia's health policy debate? Why can't Indonesia seem to shake off the older predatory elites undermining more equitable health provision? How has the COVID-19 pandemic changed

the dynamics? And to what degree do the politics of health in Indonesia reflect the vitality of the country's broader democracy.

Peter Clarke:

Joining me to discuss the politics of health in Indonesia are development economist Professor Andrew Rosser of Asia Institute and public policy expert Dr. Luky Djani of Univeritas Indonesia. Welcome back Andrew, and welcome Luky.

Andrew Rosser:

Nice to be here.

Luky Djani:

Nice meeting you, Peter.

Peter Clarke:

Now Luky and Andrew, we all know that a lot has changed since the end of the New Order Suharto regime back in around about 1998, a lot has changed in the health area as well in Indonesia. Luky, can we start our conversation just sketching in some of the broad contours of how it operates today. So could we start just by describing how big is it, and how many people are involved in terms of the health industries within Indonesia.

Luky Djani:

Yes. As we know after the fall of Suharto, health issue become more and more demanding, both by the public as well as by health practitioners. We know around 60% of Indonesian population are located in Java Island, and 40% located in the rest of islands like Sumatra, Kalimantan, Sulawesi, Maluku, and Papua of course. The health structure in Indonesia, we have roughly 10,000 puskesmas community health centres located at the sub-district level. Puskesmas serve more than two villages. And we know that almost 40% of the puskesmas are situated in Java Island, but the ratio, in fact Java Island is the lowest compared to other islands because of the density of the population.

In term of doctor and nurses, most of them are also located in Java, but again, the ratio of Java is far below other islands. This is the main challenge faced by Indonesian government, especially health ministry, how to deploy health practitioners, and also to establish a new health facilities more evenly, not only in Java, but also outer Java, and also in the very remote areas such as islands. But we do have interesting development recently. It started in 2011 where the Indonesian government at that time embraced the universal health coverage. The government tried to cover all the Indonesian population. It's supposed to be ended in 2019, two years ago, where 100% of population should be covered with this health insurance scheme, but due to certain condition or situation, it could not materialise. Based on data available in 2021, only around 83% of Indonesian population as this health insurance.

Peter Clarke:

Luky, if I was visiting you there in Jakarta, and I had to go to a big public hospital to perhaps the emergency outpatient's department to fix up my cut foot, what would I discover there compared perhaps with a big public hospital here in Australia? Very similar?

Luky Djani:

Yeah, if you are in Jakarta, I think it would not be a problem if you get injured, for example, or you have illness, then you can choose any hospital that you wanted to attend to. But the situation will be very much different if you are in outer Java, especially in a remote area, well at least you need to reach for this puskesmas at the kecamatan level at least you have to travel an hour to get medical attention.

Peter Clarke:

You mentioned health insurance. Just take us a bit further on that. If I do front up to an outpatient department in a big public hospital, is that all free? If I go to my GP? What is the health insurance system there like?

Luky Djani:

Basically the system works very much similar to the system used in Australia for example or in UK. In fact, our health insurance mimic what the UK system, the NHS system, so you can enter the public hospital for example, and you get treatment. But due to the financial restriction, now a few diseases cannot be treated using that health insurance. You have to pay out of pocket.

Peter Clarke:

How is it funded, Luky? Is it funded through the tax system I picked up from you a moment ago, perhaps not?

Luky Djani:

It depends. If you belong to the category of poor people or people who does not have monthly income. For example, you're are work in informal sectors, so you're entitled to be covered by the state. So the insurance payment will be covered by the state. But if you are wealthier, then you have to pay the monthly insurance premium by yourself.

Peter Clarke:

Andrew, that brings us to the private and public split in health systems. Thinking of the one here in Australia, we got a rather badly bolted together public/private system here. What's it like in Indonesia? What are the similarities and the difference between public and private healthcare in Indonesia.

Andrew Rosser:

Well look, Indonesia, I guess, historically has relied very heavily on private financing of healthcare and relied very heavily on private health providers. Out of pocket payments historically have been a really important source of health financing. And that is, of course, beginning to change now, and in particular it's changing as a result of the establishment of a national insurance system. But according to recent data, out of pocket payments still account for something in the vicinity of 37-38% of total health expenditure, government accounts for around about 45%, and the remainder is other forms of private financing. Even with the developments that we've seen the recent year, the government is only accounting a bit less than half of total health expenditure.

Probably one of the key difference between Indonesia's health system with regards to the public/private split and say a country like Australia is that doctors who in most cases civil servants and required to work in the public system are given permission to moonlight in the private system as a way of supplementing their income. It's very common for doctors who work in facilities like puskesmas or public hospitals to have private practises or alternatively to work in private hospitals where they can, of course, earn a lot more money than they do in the public system.

Peter Clarke:

When you and Luky talk about out of pocket expenses, is that in direct parallel to the way experience out of pocket experiences here in Australia, the gap payments, or are they total payments if someone goes to a particular doctor, is it a total payment with no component with bulk billing, for example? Luky, can you address that?

Luky Djani:

Yes. There are two components of out of pocket payment. First is related to immediate hospital coverage. For example if you're attending the hospital, then you wanted to get non-patent medicine, you do not have to pay anything. But if you wanted to get a better medicine, for example, which is not listed under the

insurance scheme, so you have to pay for that medicine. And also some treatment – surgery do not covered by this health insurance scheme. The second one is related to access through the health facilities. For example, you still have to pay a transportation fees to get you to the hospital, and you have to pay for other expenses. In Indonesia there is a common culture, for example, if you are being hospitalised, so your families, your sibling or your parents, will accompany you in the hospital at your bedside. Then they certainly need to pay for their meals, for the transportation, et cetera, et cetera. The second type of out of pocket money is very much related to Indonesian custom.

Peter Clarke:

Luky, I think it will help our discussions, since we're going to be focusing on the idea of the right to healthcare and the right equitable healthcare, just to compare what it was like before 1998 during Suharto's new order regime, and how that evolved after the fall of that regime. In particularly, I guess, in the later year, how the Asian financial crisis modulated the change in people's attitudes, and the practicalities of healthcare in Indonesia. Could you sketch that out for us?

Luky Djani:

Yes. Before we have this national health insurance scheme, people are afraid to go to the hospital or go to the puskesmas because they cannot afford to pay for the medication. We do have a saying here, sakit sedikit jatoh miskin. In English, it's, "If you get sick, then you get poor." Therefore, people are afraid to go to see doctors, afraid to go to hospital because they don't have money to pay for the treatment. But since the government introduced a national health insurance system, more and more people access the health facilities. And in fact, due to this euphoria in the early days of the enactment of this scheme back in 2014, 2015, people go to the hospital even though they don't have a serious illness, because they feel that they're covered anyway so there's no risk to go to hospital to meet the doctor. Because of that, in the early period of this scheme, many hospital become jam packed with patients, and it also create a burden especially for doctor and nurses, because they have to deal with many patients which they do not have before.

Andrew Rosser:

Peter, if I can just add one point here. I think it's important to understand that historically the health sector has been neglected by government. When the New Rrder fell in 1998, I think everyone, even the most conservative economists recognised that Indonesia had underspent on health. And part of the reform process in Indonesia since the fall of the new order has been simply to increase health spending. And that increase in health spending has helped to make things like the national health insurance scheme a possibility. But really health has been a neglected sector, and it's been, I mean, most obviously demonstrated by the relatively low amounts of money that the government has spent on health, but also it's reflected in the data with regards to the Indonesian health workforce. Even today, the size of the Indonesian health workforce has grown quite significantly in the last two to three decades. But even today, Indonesia only has .46 physicians per 1000 head of population. That's less than half what the WHO recommends. The WHO recommends one physician per 1000 head of population. Back in 1992, which was fairly late in the new order period, for instance, the country only had 0.15 physicians per 1000 population. As I understand it in the Australia today, we have over three physicians per 1000 population, just to put those figures in some sort of perspective.

So the sorts of issues that Luky is talking about, people's reluctance to go to the hospital, a sense that you would face catastrophic health expenditure if you did have to go to hospital, these are reflections of the neglected health system by government and an unwillingness to invest in health in general.

Peter Clarke:

Andrew, am I right in picking up from what Luky's described to us already, that it is rather uneven mosaic across vast archipelago of Indonesia. Now we understand remoteness and separation between islands, et cetera, must play a role. But is part of that mosaic also about class, about socioeconomic divisions, et cetera?

Andrew Rosser:

I think it would be fair to say that are some persistent inequities in access to healthcare across the country, notwithstanding the sorts of changes that we've seen in the Indonesia since the fall of the New Order. To provide you with one indication of that, if you look at the availability of doctors per 1000 population by region in Indonesia, it's actually relatively even with the exception of Maluku, East Nusa Tenggara, and Papua where doctors are really, really scarce. And the scarcity of doctors is even more pronounced if we're talking about specialist doctors. In that particular part of Indonesia, which is the most remote part of Indonesia, some of the poorest parts of the country are located in those particular areas, the availability of doctors is really quite scarce.

You also see some pronounced differences in terms of health outcomes. Indonesia's made really significant progress in recent decades in terms of improving the life expectancy. In 2012, Indonesians lived on average to 70 years of age. That's up from something in the 40s in the 1960s, so a really significant improvement. But in that year, 2012, that average hid some really quite significant differences across different parts of the country. Whereas people in Jogjakarta, which is a major city, and it's quite central. It's got good services, a relatively large middle class, people were living on average to 74 years of age, but West Sulawesi Province, they were only living to 62.8 years of age. I gather there's quite a bit of evidence to suggest that socioeconomic factors also shape the ability of people to access healthcare.

There's been a recent study published in BMJ Open, for instance, which has pointed to the influence of socioeconomic background on people's ability to access in particular secondary and preventive care. The establishment of the puskesmas system has put primary healthcare in the reach of most people, although in the more far flung parts of the country, people have to travel larger distances to get access to any sort of public health facility. But nevertheless, the puskesmas system has been reasonably successful at putting primary care in the reach of most people. But when it comes to secondary care and preventive care, it's a different story.

Peter Clarke:

Andrew, we're describing the fall of the Suharto regime, the end of that regime the new order period. As a major inflection point in Indonesian history, we've talked about technocratic forces, progressive forces, and populist forces. Who were these people? And was the education system before the end of the Suharto regime part of producing different cohorts of people that took up the reigns of moving the country forward more progressively.

Andrew Rosser:

I think the crucial thing about the Asian financial crisis and the fall of the New Order is that it led to a realignment in power relations between competing elements in Indonesia's political economy. Up until that point, people used to talk about the Indonesian political system as being dominated by predatory elites, by oligarchic forces, and the like. And poor people, the middle class, NGOs, even government technocrats being largely excluded from decision making. That changed to a significant extent following the Asian financial crisis and fall of the new order. And in a way that served to provide a bit of impetus to a process of health sector reform that we've started to outline in broad terms. I mean, a number of these elements that we're talking about were in existence during the new order period, but they just didn't have much say in policy making in general or in health policy in particular.

Andrew Rosser:

The Technocrats, a lot's been written the technocrats, and here what people are talking about is a group of economists were ideologically predisposed to favour free markets over government intervention. They played a really crucial role in the management of the economic crises of the mid 1960s and the mid 1980s, the time of the end of the oil boom. They were crucial actors in forging the establishment of the social safety net schemes at the time of the Asian financial crisis, and importantly they were,while predisposed towards fiscal conservatism, they could see that Indonesia under-invested in health, and that health spending had to go up, and they were amenable to that being achieved through targeted forms of

assistance aimed at helping the poor access health services, and even eventually the establishment of a system of universal health coverage.

The progressive elements, and here we're talking largely about NGO activists committed to human rights and in particular the right to health, but also progressive elements within professional organisations, like the Doctor's Association, the Nursing Association, and so on, and some academics – public health academics. These groups are all there under the new order, but they just didn't have much say. With the fall of the new order and the shift to a more democratic political system, they started to become more visible, more involved in policy making, policy spaces opened up that they could access, what we often refer to as populist figures. They were there during the new order period, but were relatively marginal to decision making. They, like progressive elements, were able to take advantage of democratisation, which created an incentive for them to promote redistributive policies as a way of trying to win votes at election time, and some of them, particularly at the local level and initially subsequently at the national level, latched on to health as an area of reform through which they thought they could win a few extra votes at election time. And health insurance especially was crucial in that respect.

Peter Clarke:

You're listening to Ear to Asia from Asia Institute at the University of Melbourne. And just a reminder to listen to us about Asia Institute's online publication on Asia and it's societies, politics, and cultures. It's called the Melbourne Asia Review. It's free to read, and it's open access at melbourneasiareview.edu.au. You'll find articles by some of our regular Ear to Asia guests and by many others. Plus you can catch recent episodes of Ear to Asia at the Melbourne Asia Review website, which again you can find at melbourneasiareview.edu.au. I'm Peter Clarke, and I'm joined by Dr. Luky Djani of Universitas Indonesia and Professor Andrew Rosser of Asia institute. We're talking about how competing political actors hold sway over Indonesia's approach to healthcare.

Peter Clarke:

Luky, in a paper that you and Andrew presented quite recently to a conference at the Australia National University, within that paper you describe, and just picking up on what Andrew just said then, you describe five broad groups of actors, Technocratic forces, progressive forces, and populist forces. What we haven't really dug into yet are we've already called the predatory elites. I want to know more about who they are, and I'm assuming some of them come from the large and established families. And also, what role do workers' groupings and farmers' groupings play in these interactions politically amongst the various actors?

Luky Djani:

Yeah, if we are talking about the predatory elites in Indonesia, we certainly have to take into account the conglomerates, the handful of very wealthy industrialist families, which they actually during the oil boom and the mid '80s, they enjoy the economic development and the economic policy pursued by the New Order regime. They established a quasi relationship with their regime. They have a privilege. They have political protection, and also a security protection that they can grow their businesses. But in the early '90s where the internal dynamics between Islamist groups and also Islamist groups within the bureaucracy and military against the nationalist element within the bureaucracy and military increased, so these conglomerates have to choose which side that they wanted to play with. And prior to the Asian financial crisis, there were several huge demonstration back in mid '90s in Jakarta in particular and also in other industrialise cities like Surabaya. This give a strong message to these conglomerates that the New Order era will come to end, so they need to realign themself. They see that the growing middle class, especially university students, angel activists, public academe become more and more prominent, they become directly criticising the New Order policy, and when the Asian financial crisis hit Indonesia, most people, especially the poor, become angry, and they took part in the demonstration.

The conglomerates see that the New Order regimes, especially Suharto at that time, cannot give protection for them as before, so this conglomerates some of them, of course, they try to support the demonstration and also progressive elements within the bureaucracy and the ministers at that the time. After the fall of Suharto, there was a major constitutional revolt, and much of Indonesian political system and political

configuration become liberalised. For example, governor, mayor, and district, and even president, should be popularly vote through the direct election. This changed the incentive of politician. The populist element within the polity, because they do not have to rely on a blessing of Suharto as before, or they don't have to establish a special relationship with the Cendana family to the elected as governor, for example, to be elected as mayor, but then they have to take votes from constituency, so this also changed how they see the issues, especially issues related to poor people or the vast majority of Indonesian voters, namely health, education, and other social issue. And this social issue become more and more gaining ground, because many politician use this as an instrument to attract votes. This combination of change in our political system and the realignment of these conglomerates led the way to the more progressive social policy.

Peter Clarke:

And Luky, organised labour and the farmers groupings, what roles have they been playing in improving health services in Indonesia?

Luky Djani:

Yeah, this is interesting element of reform. Initially the Labour Union wanted to reform the so called Jamsostek law. Jamsostek is like labour insurance specially designed for formal labour. But then several progressive individuals and organisations were able to convince the leadership of labour unions that the union can push forward broader and progressive social policy, such as these health insurance scheme. Then the leadership of labour union see this opportunity, and they abandon the idea to reform the Jamsostek Law, and they pursue discussion of this universal health coverage scheme. This is also because the labour union as we know in Indonesia is relatively small compared to in South Korea, for example, because it is not mandatory for workers to join a labour union. Therefore, the leadership of labour unions see this as an opportunity also to enlarge their membership, include the same semi-formal or informal workers if they're able to give them something that will cover their health problems.

Peter Clarke:

Andrew, as we try to get a clearer picture of the actual political dynamics around the health system in Indonesia, let's talk about health insurance, because that's been a very contentious and highly contended area, hasn't it? What do we learn about political dynamics and how the politics actually modulate the health system in Indonesia when we look at the health insurance history?

Andrew Rosser:

I think it's important to understand here that the establishment of a national health insurance scheme, which has been criticised on a lot of different grounds. It's a system that's got a lot of bugs in it, a whole lot of problems that need to be addressed, but it's very establishment is really quite a remarkable achievement, and particularly the fact that it is built on the principal of universal health coverage, and under the New Order, you simply didn't have a system of universal health coverage. What you had was a series of separate schemes providing some level of assistance, often involving government subsidies to particular groups of people. There was a scheme especially set up to provide health insurance to civil servants known as Askes. Asabri was a scheme that did the same thing for members of the military. Luky just mentioned Jamsostek which was, as he said, a labour insurance scheme. Those particular elements of society in Indonesia were provided with some sort of limited, some sort of basic coverage, whereas everybody else was really left to the vagaries of the marketplace.

The establishment of a national health insurance scheme built on the principal of universal health coverage really was quite a remarkable achievement once you consider the history here. And I think in terms of the politics, it's important to understand that these predatory elites that we've talked about have been really a key obstacle to precisely this sort of change and other sorts of change in Indonesian health policy that might serve to promote better fulfilment of the right to health, because they haven't really had significant interests in the establishment of such schemes, and in fact such schemes have, if anything, threatened their interests. When it comes to health spending, for instance, the interest of predatory elites really lie in minimal expenditure on the social sectors. They've got much greater interest in public money being spent

on things like infrastructure or subsidies for this or that product rather than on the social sectors. A key determinant, a key causal factor for Indonesia's low spending on health historically has been precisely the interest of these sorts of predatory elites.

At the same time, these elites, because they represent a nexus or a coming together of political bureaucratic and corporate elements. It's been these interests that have benefited most from the privatisation of the health sector, and in particular the relatively lucrative end of the health market in the form of private hospitals providing relatively high quality care to members of the middle class and the elites. Those sorts of operations have very often been owned by the major conglomerates which have very, very strong political connections and so on. And really the story of the politics of health policy in Indonesia since the fall of the New Order has to a significant extent been a story of progressive or technocratic elements confronting the interests and the agendas of predatory elites to try and achieve some sort of change.

Peter Clarke:

And if we discuss electoral democracy, electoral politics in Indonesia, is the health insurance area, because it lies at the service delivery sector I suppose of the whole picture, is that more important in terms of electoral politics and people using it electorally during campaigns?

Andrew Rosser:

It certainly was in the first decade, decade and a half of the post New Order period. A really key decision that had to be taken early on was whether Indonesia would go for more of a US style managed care-type model of health financing or one built more on a European model of social insurance. And in the end, that issue got settled in favour of the social insurance model. But you had all of these different initiatives emerge, and in part they did so because local politicians, sometimes who came from health backgrounds themselves, the probably primary example in this respect is the former party of Jembrana in Bali, Gede Winasa who's a dentist, a medical professional understood health systems had some insight into health financing, and he pioneered a local health insurance scheme for the poor that attracted an awful lot of attention and in typical Indonesian style, attracted visitors from local governments from other parts of the country interested to learn about this new system, and in some cases that resulted in similar initiatives being rolled out elsewhere in the country.

Later on some similar dynamics emerged at the national level, and most clearly perhaps when Joko Widodo ran for president in 2014, where he promoted his healthy Indonesia card which he touted as a mechanism for helping to ensure that Indonesians had better access to healthcare than had been the case in the past.

Luky Djani:

Andrew illustrate a very interesting dynamics within the elites in Indonesia, and we could understand this by looking at one, the Indonesian population because more and more middle class, or at least aspiring middle class who then are difficult to be mobilised using the traditional instrument such as vote buying, such as patronage. I think both the politician and their business counterparts understand this. They cannot simply win over the election – direct election by distributing money. They cannot only rely on small local strongmen to be able to mobilise votes for them, so they have to find another instrument which more populist that would then appeal to the broader voters. That's one element that push forward this progressive social policy.

And there are individual and groups like Andrew mentioned before, public health practitioners, academe, NGOs, who also see this opportunity to push forward a reform agenda because the electoral system opened the avenue for them to inject those progressive ideas. So even though as we've seen back in 2011, some of business association strongly object this universal health insurance scheme because they have to shoulder part of the premium. But then they also understand that if majority of Indonesians, especially the poor, do not have safety net, then what happened back in '97 and '98 when a huge demonstration occur against New Order regime, that would happen if the lower classes of Indonesia do not have social benefit in health and in education. So afraid of those kinds of demonstration reemerge and will shake their business interests, then they have to embrace progressive ideas.

Peter Clarke:

Luky, I've always thought of Indonesia as being made up of many avid smokers, but when I looked at the actual data around smoking in Indonesia, I was quite amazed really. Apparently 68% of men smoke in Indonesia, but only about 5% of women smoke. There's a lot of smoking going on in Indonesia, and I guess this fits the category within our discussion of an underlying health condition. How has the tobacco industry and smoking fitted into what we are discussing today, the political dynamics around health in Indonesia?

Luky Djani:

If we are talking about reform or controlling tobacco it's always become highly disputed and controversial issues. For example, just recently the ministry of finance wanted to increase the sales tax of tobacco, and immediately the Farmer Association reject the idea on the ground that it would shift the burden to the farmers because more and more production cost will be suppressed by the tobacco company, and they will pay tobacco farmers at the lowest price, and also there are alternative of tobacco, especially imported from elsewhere, for example, from Turkey, that also suppress the selling price of tobacco from the farmers to tobacco company. And therefore when the government tried to increase the sales tax of tobacco, the immediate response from the Farmer Association is to reject it. And I think the tobacco company also have played significant role in trying to mitigate the impact of the restriction of tobacco policy.

Peter Clarke:

Now as I understand it, there are health warnings on cigarette packaging in Indonesia. There have been some progressive moves made and with some success. But how did they actually get through the system? Luky?

Luky Djani:

This has become mandatory by law. In 2008, we have the health law which regulate further certain harmful substance, including tobacco. From that time, all tobacco boxes have to filled with the health information or even pictures. And also more media, especially TV station choose not to air tobacco advertisement, because they wanted to avoid being penalised by the media watchdog.

Peter Clarke:

Andrew, what has made the tobacco area, cigarettes and the tobacco industry, involvement in health politics in Indonesia so intractable? What's your analysis of what's made it so difficult?

Andrew Rosser:

I think the first point here is just to say Indonesia does have a real problem with tobacco addition. Public health scholars and commentators writing about tobacco issues in Indonesia talk about there being a tobacco epidemic. As you noted at the outset, the tobacco consumption rates are extremely high and very gendered. Indonesia also has a really significant problem with youth tobacco consumption, apparently something in the vicinity of 9% of 10 to 18 year olds smoke, and that number seems to be going up, not down. Something in the vicinity of 225,000 people die from tobacco-related diseases every year, and tobacco consumption's a key contributor in particular to a series of noncommunicable diseases that have become particularly or increasingly important as a cause of death in Indonesia, such as heart disease and stroke. But it also contributes to infectious disease prevalence and in particular tuberculosis. It's a really, really significant problem.

Despite that, there aren't many elements of Indonesian society who really have, and this sort of gets to your question about the politics, who have really mobilised to advocate for increased tobacco control. There are a number of NGO groups led by the Indonesian Consumer's Foundation and the National Tobacco Control Commission. There are some elements within the Indonesia Doctor's Association have also been quite outspoken on tobacco control issues. There are some academics as well, public health academics who've advocated publicly for improved tobacco-control measures. Figures in the Health Ministry, the Health Ministry actually been pretty consistent in its support for increased tobacco control measures as

well. But they're facing off against on the on hand the cigarette companies, and the big cigarette companies in Indonesia are really, really, really big. They are amongst the biggest companies in Indonesia. Every so often a magazine or a group like Forbes, or what have you will draw up a list of the largest companies in Indonesia and the wealthiest individuals, and the cigarette companies and their owners are typically featured very, very prominently in those lists. They're said to have incredibly good political connections. When Susilo Bambang Yudhoyono was president, tobacco-control activists used to point to the fact that one cigarette company's boss used to drive his Rolls Royce into the national palace and park it there presumably to make a visit to the president and, I don't know, talk about whatever they needed to talk about.

So you've got incredibly powerful corporate and political interests on the other side of this conflict. And they've been very, very successful, as Luky has already intimated, in mobilising support from key popular constituents, most prominently tobacco farmers groups. The tobacco control advocates, who are fairly few in number, reasonably well organised, have good access to the media, and some level of international support, particularly from international organisations like the WHO and to a certain extent the World bank, they're on the weaker side of the ledger when it comes to the politics around this issue.

Peter Clarke:

Luky, Indonesia has wide spread and very influential religious groupings. Are they part of the progressive side of the political dynamics around health, more communitarian, perhaps, or are they more conservative elements in terms of health?

Luky Djani:

Yeah, if we are looking at certain religious groups or networks in Indonesia, if we are discussing about universal health coverage for instance, most of them are in favour for scheme. They were also support discussion of the bill into 2010 and 2011, and some of them are quite outspoken at that time, mainly because they understand that this universal health coverage will also protect them from disease. But if we are talking about the tobacco, it's a different story. Some religious clerics benefit from the tobacco company. For example, several tobacco company has their headquarters either in central or the eastern part of Java, and they're often donate some of their CSR funds to this religious school or religious facilities. I think becomes a moral dilemma for the clerics who choose whether they have to take side in the anti-tobacco movement or on the tobacco company side.

Peter Clarke:

Andrew, before we finish our conversation, and we look to the future of health politics in Indonesia as we finish up this conversation, the elephant in the room, the SARS-CoV-2 pandemic. How has that altered politics around healthcare and health deliver in Indonesia? We know that there're have been very high infection rates, very high death rates. How has that affected politics? How has that affected the political standing of the current president with an election not too far away?

Andrew Rosser:

It is a question I would love to have a really clear answer to, but this is a matter of crystal ball gazing, and my crystal ball is rather cloudy. I think it's fairly clear that COVID-19 has served to highlight some of the weaknesses in Indonesia's health policies and in it's health system. I don't think it's exposed those problems. They were well known beforehand, but it's really shone a light on them. There have been some quite horrific scenes, particularly during this most recent Delta-driven outbreak, quite harrowing scenes of people queuing up outside hospitals seeking treatment and being treated in pickup trucks or in tents or what have you outside the hospitals, and the numbers we've been seeing in Indonesia in terms of infections and deaths from COVID-19, which were almost certainly an underestimate in both cases, have been quite alarming.

The big question really is what does all of this mean in terms of the future of health policy. The Indonesian government has increased health spending quite significantly during the pandemic as one would expect. One of the provisions of the 2009 health law was that the central government should spend at least 5% of

it's budget on health, excluding salaries and wages for medical staff. It took quite a long time for the Indonesian government to reach that point, but it's now projected to go up over 6%, so a reasonably significant increase as a result of COVID-19. The big question is really whether that signals a change that will stick in the future, or whether it will just prove to be a temporary thing, and once the crisis is abated, once concern about COVID-19 has started to dissipate, will things return to the previous state.

And I think the broad judgement that Luky and I have reached and which we articulated in the paper that we wrote together and presented at the ANU is that thus far there isn't really much sign that COVID-19 is proving to be a game changer in terms of the broad alignment of political and social forces in Indonesia. So COVID-19 is not proving to be a moment in time that is broadly comparable to the Asia financial crisis in the fall of the New Order. And that, unfortunately, suggests that maybe the future entails a reversion back to the state of affairs that was occurring prior to COVID-19, which there was some improvement happening unevenly, some signs of increased commitment to health on the part of the government, but baulking at really, really fundamental change.

Peter Clarke:

Luky, your views on this. How has President Widodo survived greater opprobrium with some of the terrible scenes we've seen in Indonesia and the high infection rates and high death rates? How has the president escaped greater opprobrium and how do you think it's going to play? If it's not a game changer, how is the pandemic going to play in future elections?

Luky Djani:

First of all, the Joko Widodo has in second term by constitution, he cannot run in the 2024, therefore there is little electoral incentive for the current administration to use COVID as political leverage. But we can see and compare with other countries. COVID-19 is certainly a different kind of disease that should be handled differently. We try harder, for example, to push forward a number of vaccine. Now at this point, we can only secure 100 millions of Indonesian to be vaccinated. We still have a long way to go, another 170 million people more or less. At least 120 million Indonesian need to be vaccinated in order to reach the herd immunity.

The second thing is that we see that the government is juggling between health and economics. We know that as we've seen elsewhere, also in Australia for example, mainly people suffer not only socially, because we have to maintain social distancing, but also suffer economically because many firms or companies have to re-scale their business operation have to reduce their labour. So the government also see this pandemic actually bring two front of battles at the same time, how to isolate this virus and how to protect the community. But on the other hand, how to at least make the business still going on. I don't see and I don't any leader in the world can able to solve this puzzle smoothly, but yesterday less than 2,000 new cases emerged in Indonesia out of 270 million population. This is good signs for us that the government and the community were able to work hand in hand to protect the society, try to protect the family, and try to be more productive at the same time.

Peter Clarke:

Luky, Andrew, thank you so much for being with us on Ear to Asia.

Luky Djani:

Thank you, Peter.

Andrew Rosser:

My pleasure.

Peter Clarke:

Our guests have been Professor Andrew Rosser of Asia Institute of the University of Melbourne, and Doctor Luky Djani of Universitas Indonesia. You can find more information about this and all our other episodes at

the Asia Institute website. Be sure to keep up with every episode of Ear to Asia by following us on the Apple Podcast App, Stitcher, Spotify, or SoundCloud. If you like the show, please rate and review it on Apple Podcasts. Every positive review helps new listeners find the show. And please help us by spreading the word on social media. This episode was recorded on the 21st of September, 2021. Producers were Erik van Bemmel and Kelvin Param of Profectual.com. Ear to Asia is licenced under Creative Commons, copyright 2021, the University of Melbourne. I'm Peter Clarke. Thanks for your company.