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ARTICLE

Healthcare expansion in Indonesia and Thailand: a causal mechanism and its implications for welfare regimes

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Abstract

This article provides an overview of the scholarship on healthcare reform in democratic middle-income countries through comparative cases from Indonesia and Thailand. This study identifies the reasons why Thailand has achieved universal healthcare faster than Indonesia and analyses the policy outputs towards universalism resulting from unfolding reforms. Taking a closer look at the causal mechanisms underpinning healthcare developments (clientelistic-based mechanism and limited vertical alliance-based mechanism), we discuss how changes in political economy have enhanced the state's intervention in the healthcare sector while reproducing the fragmented and stratified nature of the system. Based on coverage, generosity and financial risk protection, Thailand has a higher degree of universalism in comparison with Indonesia. The article suggests that the welfare regime now governing healthcare can be conceptualised as a developmental-universalist state, while noting a less-effective model for Indonesia and a more effective model for Thailand.

Keywords: Democratic middle-income countries; healthcare reform; welfare regimes; Southeast Asia; Indonesia; Thailand

Introduction

In the last two decades, there has been a strong intention of government in the democratic middle-income countries (DMIC) to place social policy, especially healthcare, at the core of development goals (Barrientos & Hulme, 2009; Isabekova & Pleines, 2021; Kaminska et al., 2021; Ramirez-Rubio et al., 2019; Schmitt, 2020; Watt et al., 2019; Yazbeck et al., 2020). Many studies have discussed the variations in the character of the welfare system in the DMIC (Böger & Leisering, 2020; Dorlach, 2021; Schmitt, 2020; Seekings, 2019; Weyland, Madrid, & Hunter, 2010), suggesting that their depiction fits institutionally bound typology with the productivist type, whereas selective policies and rationing of its distribution are targeted to civil servants, military, and private employees (Abu Sharkh & Gough, 2010; Gough et al., 2004; Holliday, 2000; Takegawa, 2009). Recent expansion shows that healthcare coverage has introduced a more universalism model, which enhances financial risk protection and equity of healthcare utilisation (Böger & Leisering, 2020; Mkandawire, 2005; Pisani, Olivier Kok, & Nugroho, 2017). Such an expansion has encouraged many scholars to turn their research focus to social policy dynamics in the Global South (Kuhlmann & Nullmeier, 2021).

Influenced by "Three Worlds"-centred standpoints, research on social policy expansion is often associated with industrialisation and, particularly, the breakdown of core familial relations and traditional social security (Armingeon & Bonoli, 2006; Bonoli, 2007; Esping-Andersen, 1990; Skorge & Rasmussen, 2022). One of the impacts of the new societal changes at the time was increased population with less protection and greater social risk. Because access to formal social and health security was becoming a salient issue (mainly in the post-World War II era), organised labour unions and cross-class

alliances saw an opportunity to solidify their voices in the parliament, compelling the government to introduce a social policy that minimises social risks (Korpi, 1983).

The literature on comparative social policy is often criticised for focusing on Western-centred theoretical approaches for analysing policy developments in the DMIC. They did not envisage expansion without industrialisation and perfect democratic institutions. As pointed out by many studies (Haggard & Kaufman, 2008; Lavers & Hickey, 2016; Mares & Carnes, 2009), welfare programs in DMIC began or were expanded under nondemocratic regimes and as a result of economic crisis and political transition. This contrasted with the European welfare state experience, in which economic recession led to welfare retrenchment and reduced social expenditures.

Consider the experiences of Thailand and Indonesia, which achieved healthcare policy reforms in 2001 and 2014, respectively. These reforms occurred when the economic performance of both had declined compared with that in the pre-millennium and was significantly less than that in the advanced welfare state (Erlangga & Shi, 2013; London, 2018; Pholpark, 2018; Ramesh, 2000; Ramesh & Wu, 2008, 2009; Wu & Ramesh, 2009; Yuda, 2021a). Both also represented newly DMIC that were gradually transforming their welfare institutional landscapes from the segmented welfare types that have been operating since the 1970s. Nonetheless, the governance of both countries remained subject to the enduring "clientelistic and patrimonial elitism" of domination (London, 2018; Yuda, 2019, 2021a). This allowed the clientelistic motives to play a significant role that drove healthcare expansion. The anomaly leaves us with an important clue that the dominant approach is insufficient to explain how healthcare coverage expanded in Indonesia and Thailand. Notably, while the change was gradual in both countries, it occurred faster in Thailand, indicating how institutional structure variously affects the speed of policy universalisation.

With the aim of conceptualising the expansion of the health insurance coverage in Indonesia and Thailand, this article particularly highlights the causal mechanisms of universal healthcare institutionalisation following the Asian financial crisis (AFC). The contribution of this attempt lies in the fact that several approaches have been proposed to explain the differences in welfare expansion across countries. However, these approaches are biased towards established welfare states owing to their epistemological roots in functionalist approaches or power resource approaches (Kuhlmann & Nullmeier, 2021). Thus, critical evaluation of existing approaches is needed to understand social policy developments in the DMIC and determine whether adjustments need to be made.

In this article, the causal mechanism is understood as processes through which welfare actors (ie politicians, bureaucrats and international organisations) with the capacity to change the national health system, in specific contexts, transfer political influence to other entities that engenders the health reform (Beach & Pedersen, 2019; Collier, 2011; Kuhlmann & Nullmeier, 2021; Trampusch & Palier, 2016). In so doing, as Kuhlmann and Ten Brink (2021) put it, "particular attention needs to be paid to the detailed understanding of the crucial elements of the process that occurred between the cause and the outcome, and the causal relationship between these elements, as well as the contexts within which the mechanisms unfold" (p. 4). To unfold the contexts underlying mechanisms, this article also highlighted the role of the legislators and incentive of the political parties according to the parliament and electoral rules.

To provide an understanding of the causal mechanisms behind health reform, our article starts with a question as to why Thailand achieved universal healthcare faster than Indonesia. In this study, universal healthcare refers to universalism principle, covering three dimensions: coverage, generosity and financial risk protection (Bernales-Baksai, 2020). These three dimensions will be discussed in the analysis. This study includes provisions resulting from the unfolding healthcare reforms in both countries. The article uses an extensive review of secondary literature, policy reports and national documents in its attempt to answer the question.

Our analysis revealed that Thailand's ability to produce reforms more rapidly and comprehensively than Indonesia is primarily attributable to its strategy of not integrating all fragmented healthcare programs into one single administrative system. Rather, they are focused on universalism

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of healthcare expansion, ensuring the old player is not dismantled over control and the benefits associated with it, thereby reducing the tug of war of vested interests between political elites. Indonesia, on the other hand, concentrated on both the universalism of expansion and integration of all fragmented programs under a single administrative body. This causation has led to a long tug of war over political negotiations and also explains why reform legislation was passed in 2004 but has not yet been implemented. A successful reform was only achieved in 2014, shortly before the general election.

Furthermore, two possible mechanisms for understanding healthcare developments in Indonesia and Thailand are formulated. First, a *clientelistic-based mechanism* describes how policies are developed and expanded when there is a tug of war between political elites seeking to reorganise their clientele network within the healthcare sector. Second, the *limited vertical alliance-based mechanism* illustrates how healthcare reform has been made possible through an alliance of progressive politicians, bureaucrats, and nongovernment organisations (NGOs), even though it is temporary, limited, and abrupt in nature. These two features are characteristic of the political forces in DMIC, where ideology-based political forces in the western sense are absent or very limited. These two causal mechanisms are intertwined in the cases outlined (see section "The causal mechanisms of healthcare reform").

Also, discussing the healthcare dynamics allows us to conceptualise the sort of welfare regime approach that arose regarding healthcare governance in Indonesia and Thailand. Such an explanation is important as existing characterizations of both welfare regimes have yet to provide the central room for healthcare in the debates of social policy literatures. Our analysis revealed that in Indonesia and Thailand, the expansion of healthcare has not necessarily involved significant changes in welfare regimes beyond the traditional notions of productivism. However, our analysis revealed that a greater variety of productivist models are prevalent within the two countries, which is consistent with the developmental-universalist perspective while noting a less-effective model for Indonesia and a more effective model for Thailand.

We concluded that although health policy outputs and healthcare regime change have resulted in different reform outcomes in Indonesia and Thailand, the causal mechanisms responsible for the expansion of universalism in healthcare and healthcare regimes in the two countries are similar in most respects. These results offer the possibility of extrapolating them to other countries with similar political and economic contexts to Indonesia and Thailand.

Welfare regimes and healthcare

Conceptualising the welfare regime in DMIC

The discussion of welfare regimes has often relied on the ground-breaking publication of Esping-Andersen in 1990, which based its analysis on cases found in OECD countries in general and Western Europe in particular. Following "The Three Worlds of Welfare Capitalism," these countries were largely classified based on the degree of decommodification as social democratic (eg the Nordic countries), conservative (eg Continental Europe) and liberal (eg the United State, the United Kingdom). However, this welfare regimes classification is insufficient to explain the DMIC, which highly fragmented welfare provision with internal polarisation and clientelism are dominant traits (Papadopoulos & Roumpakis, 2019).

Concerning this, Gough et al. (2004) in their influential work on global welfare regimes, "Insecurity and Welfare Regimes in Asia, Africa and Latin America," attempted to engage with the scattered cases beyond "Three World" countries. From the analysis presented, they proposed three systems of "global welfare regime," namely, *welfare state*, *informal security*, and *insecurity* (Gough et al., 2004). The typology serves as a valuable tool to understand the complexity of the welfare regime covering the entire world.

Gough et al. (2004) classifies DMICs as informal security regimes essentially conditioning welfare provisions under informal arrangements, whereby a patron–client relationship has been determined for

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social policy expansion. The emphasis on informal security regimes echoes arguments about Asian familialism, where welfare responsibilities are assigned to families and communities (Murphy, 2019).

Despite that, the ambitious work of Gough et al.(2004) at covering the Global South countries lacked depth. For this reason, recent studies (Amoah, 2020; Roumpakis, 2020; Roumpakis & Sumarto, 2020; Sumarto, 2020; Velázquez Leyer, 2020; Yang & Kühner, 2020) have updated the Global South classification by using a range of methodologies, reaching out to detail recent developments in Africa, Latin America and Southeast Asia, based on selected studies of Ghana and Mexico, and comparative cases of Indonesia, Malaysia and Thailand. Cross-cutting studies of the Global North and Global South were also followed (Papadopoulos & Roumpakis, 2019; Roumpakis, 2020). They determined the cause of regime failure in the Global South as stemming from a transition into a welfare-type state and concluded that such causation arises due to the continuation of the family for welfare provision, in effect substituting for the ineffectiveness of social policy.

In a recent update, Sumarto (2020) considered Indonesia and Thailand as a part of an informal security regime. His analysis suggested that Thailand has achieved a higher security level than Indonesia in the last decade. This is mainly because Thailand's overall social protection expenditure experienced a significant increase, which proved sufficient for it to move beyond informal security, or what he calls an informal-inclusive regime, towards post-productivist model.

Looking at the causal mechanism and health policy outputs of the reform, comparative analysis of the healthcare development in Thailand and Indonesia has helped lead these countries onto a clear depiction of welfare regimes in the contemporary era. Healthcare policies have been largely modernised, and their coverage has been expanded, but this has not caused a radical departure from the productivist configuration (Yuda & Kim, forthcoming). A shift can be achieved by changing the membership of subgroup models within its productivism. Thailand represents a developmental-universalist regime, whereas Indonesia is considered to be a less-effective developmental-universalist as universal health insurance excludes the large informal sector (Yuda & Kim, forthcoming), in particular, those whose circumstances do not qualify them for government assistance and those who do not have sufficient means to access private services or pay monthly social insurance premiums (Yuda, 2021a).

Furthermore, Thailand emphasises its commitment to development-universalism by providing substantial social assistance and health services to the informal sector, both in an effort to quell activism and mobilise political support. The healthcare regimes in Thailand are also characterised by semi-corporatist welfare systems that were implemented during the post-war period and expanded during the neoliberal era (Yörük, Öker, & Tafoya, 2022). The results of this study contrast with those of previous studies (eg Sumarto, 2020), which attribute Indonesia and Thailand to post-productivism.

Bifurcated path of welfare productivism adoption

Before the introduction of greater redistributive policies, the social policy in Indonesia and Thailand reflected the dual nature of its distinctive distributive function, namely, as an economic growth booster and client state protector (Croissant, 2004; Gough et al., 2004; Kwon, 2009; London, 2018). Many argued that these two causations represent historical Asian products, which have different historical and political roots to the experiences of "*Three Worlds*" countries, where capitalism and liberal democracy are innately attached to social policy formation (Powell & Kim, 2014). Given the distinction, Holliday (2000) called this configuration "productivist welfare regimes," a type that represents a single unified categorisation of informal security regimes (Gough et al., 2004).

Under the productivist order, the extension of social policy was exchanged for productivity, thereby sending generous benefits only to particular populations, such as civil servants, military personnel and workers in large firms (Abrahamson, 2017). In the meantime, public support to "outsiders" – children,

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elderly, and disabled – was limited, forcing families to take on greater burdens of welfare responsibilities (Aspalter, 2006).

Productivist arguments centred on East Asia were soon overtaking further classification, culminating in three variants, which were fine-tuned closer to the Southeast Asian context, that is, facilitative, developmental-particularist and developmental-universalist (Holliday, 2000). Within the facilitative model, limited social rights are granted, which is a compensator of last resort when the family and market fails in providing welfare. The second model is named "developmental-particularist." In this variant, welfare provision is designed for the particular group regarded as politically important for preserving the status quo (eg, civil servants and military), or those who make financial contributions (eg formal employees in large firms).

The interesting last variant of the productivist model is developmental-universalist. A salient characteristic of this type is that the policy decision by the state has been made with greater emphasis on contributory welfare and noncontributory welfare for expansion to almost the entire population. The expansion is not aimed at ensuring social rights but at maintaining productivity and purchasing power parity at the required levels. Nevertheless, the expansion does not subdue market healthcare power and informal provisions. Instead, they remain persistent, performing a complementary role in welfare provision (Yuda, 2021a).

Indonesia

Within this welfare regime debate, Indonesia constituted a developmental-particularist mode in the 1970s until the 2000s, when healthcare was distributed to particular groups, such as civil servants and armed forces, through Civil Service Health Insurance (ASKES) and Indonesian Armed Forces Social Insurance (ASABRI). These two agencies, founded in 1968 and1971, respectively, provided comprehensive medical benefits to groups that were considered politically significant for the preservation of the Suharto authoritarian regime (Ramesh & Wu, 2008). To access the benefits, the employees and their dependents were required to contribute 2 percent of their basic monthly salaries, with the shortfall met by their institutions. While these two schemes included only a small share of the population, other groups benefited from Puskesmas, a local clinic providing "basic medical services" at a low cost (Aspinall, 2014).

A major healthcare restructuring took place in 1992 when the government extended healthcare through a noncontributory health insurance to low-income families affected by the oil price decline in the 1980s (Bazyar et al., 2021). This first healthcare expansion was a milestone for Indonesian government by delivering noncontributory health protection for the poor in Indonesia. According to Fossati (2017, p. 301), "the coverage of this program, however, was very limited, including a mere 1.87 percent of the population in 1998."

On the heels of the AFC, ASKES continued to manage the healthcare services program – from Social Safety Net in Health Sector (JPS-BK) in the 2000s, to Health Insurance for the Poor (ASKESKIN) in 2005, to Community Health Insurance (JAMKESMAS) in 2007 – under different labels, with no substantial change. The most common reasons for such re-labelling were political (Fossati, 2017; Pisani, Olivier Kok, & Nugroho, 2017; Rosser, Van Diermen, & Choi, 2016; Yuda, 2019; Yuda, Pratiyudha, & Kafaa, 2021) which will be discussed in greater detail in the subsequent section.

In 1992, private employees in large firms and state-owned companies were granted certain health coverage regulated under the *Healthcare Insurance* (JPK) scheme. The medical package provided by JPK was in-kind, offering services at the required levels through either public or private healthcare providers in cooperation with JAMSOSTEK, a state-owned agency that administered JPK and other employment-related protection (Bazyar et al., 2021). Although there was a shift in the regime's approach to Indonesian healthcare, it is undeniable that its productivist model continues to stand out as particularly significant up until 2014, when universal coverage was implemented.

Thailand

The reflection of the developmental-particularistic approach to healthcare in Thailand took a shorter period. As documented in numerous articles, the road to health universalisation in Thailand began in

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1975 through the introduction of low-income cards, later knows as the Medical Welfare Scheme (MWS) (Kuhonta, 2017), which applied a means-test for free healthcare in the public facilities. The scheme was later extended to unproductive groups, such as the elderly (1992), disabled individuals, children under 12 years old (1993), and, lastly, veterans (1994). In 1997, MWS succeeded in covering 41 per cent of the total population (Bazyar et al., 2021).

Taking a different route to the Indonesian experience, healthcare insurance for government employees and their dependants was introduced in 1978 and named Civil Servant Medical Benefit Scheme (CSMBS) (Gough et al., 2004). The developed scheme adopted a tax-based financing model previously applied in a European welfare state and acknowledged as the most generous insurance scheme in Thailand (London, 2018; Noda et al., 2021).

Five years after the CSMBS implementation, the government, through the Ministry of Public Health (MOPH), continued to expand healthcare coverage to nonpoor households and informal workers, largely concentrating on rural areas through the introduction of the Voluntary Health Card Scheme (VHCS) in 1983. VHCS covered four family members and was financed by household contribution (500 bath/year) and government subsidy (1,000 bath/year) (Sakunphanit, 2006).

Similar to Indonesia, healthcare covering private sector employees was first introduced in the early 1990s and named the Social Security Scheme (SSS). Firms with more than 10 employees were required to register their workers to SSS and benefited from direct/nonwork-related benefits (at the end reduced to one). Interestingly, the source of financing was tri-partite contributions: employee, employers, and government.

The successful extension in the 1990s marked the critical juncture for Thailand to begin its welfare regime episode with a more inclusive configuration, breaking out of the conservative productive path earlier than Indonesia.

Background to healthcare reform in Indonesia and Thailand

Before the healthcare reform in Indonesia (2014) and Thailand (2001), both countries had gradually developed healthcare systems: infrastructure, workforces, and health insurance systems (Evans et al., 2012; Mahendradhata et al., 2017). Despite the different models of financing and health supply systems, both countries had fragmented insurance programs and divided schemes based on occupation status, whereas the scheme for the poor and vulnerable was separately managed. Their health insurance coverage encountered unequal distribution to lower socioeconomic populations, particularly informal sector workers. The populations of both countries were also burdened with high out-of-pocket (OOP) payment expenditures; the poor were likely to pay more than the rich for healthcare calculated in percentage of their income (National Team for the Acceleration of Poverty Reduction, 2015; Pannarunothai & Mills, 1997). Persistent inequity in access to essential health services eventually led to health reform in the two countries.

As aforementioned, Indonesia, with a public–private mixed health system, limited investments in public health facilities while supporting investment in private health facilities through state-owned companies (Mahendradhata et al., 2017). Such highly fragmented systems resulted from public and private health insurance schemes based on employment status and region, which were financed and operated separately, resulting in unequal health benefit packages and limited access to healthcare for poor and vulnerable groups, particularly in remote areas (National Team for the Acceleration of Poverty Reduction, 2015).

Meanwhile, the Thai government directly invested in public health facilities, mainly through the MOPH, to expand public health services throughout the country, particularly in rural areas (Sakunphanit, 2006). However, its employment-based public health insurance schemes, financed mainly by general taxation yet operated separately, resulted in unequal health benefit packages, different payment methods and expenditure levels, and varying quality of care. In 2001, approximately 30 per

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cent of the Thai population, mostly informal sector workers with lower socioeconomic status, remained uncovered (Evans et al., 2012).

The causal mechanisms of healthcare reform

This section discusses some potential mechanisms at work in explaining the course of Indonesian and Thai healthcare reform. We argue that although these countries have different health policy outputs, they share similar causal mechanisms regarding health coverage expansion. We identified two causal mechanisms, as discussed in section "Introduction," for understanding the major characteristics of the healthcare trajectory, namely, the clientelistic-based mechanism and the limited vertical alliance-based mechanism. The former explains how policies and strategies are developed and implemented during a tug of war between the political elites of the healthcare sector to reorganise their clientele network. The latter shows how healthcare reform has been made possible through the partnership of progressive politicians, bureaucrats, and NGOs, despite being temporary, limited, and abrupt.

Indonesia

The AFC in 1997 started Indonesia on a process of gradual democratic reforms. However, it appeared that democracy was only devised to facilitate the reforms, the outcomes of which the conservative elite could attempt to control (Aspinall, 2014; Fossati, 2017; Yuda, 2019). As exemplified in the healthcare universalisation process, groups that had been associated with the stability of the Suharto administration were enthusiastic supporters of the policy legislation of JKN, as it allowed them greater control over material resources (Rosser, Van Diermen, & Choi, 2016). A study by Van Diermen (2018) demonstrated that a former operational director of ASKES (1986–2000) and two retired, high-ranking officials at Workers Social Security Program (BPJS Ketenagakerjaan) who had been introduced during the Suharto administration were key architects for the legalisation of JKN under the National Social Security System (NSSS).

However, until the NSSS law was legislated in 2004 and received financial and technical support from international organisations (WHO, ILO, the government of Germany through GIZ, the government of Australia and the government of Japan), the JKN was not automatically implemented and, instead, was long-delayed up until 2014. The result of our review indicated that the delay occurred as a consequence of a tug of war between elite interests at both the central and local levels.

At the central level, contestation of interest was taking place between two major groups of elites, the centre-left versus the centre-right. Yet, the attributions of such ideological standpoints seem to have had no direct link to the social policy preferences they supported.

The Indonesian Democratic Party for Struggle (PDI-P), which represents the centre-left group and hosts a range of former Suharto authoritarian administration stalwarts, has taken inconsistent political stands regarding support for healthcare. In the initial phase, PDI-P positioned itself as a major supporter of NSS legislation. Numerous studies have considered what seemed to be happening in PDI-P during 2000s as only the political efforts of their leader, Megawati, to attract the heart of the poor and informal sector to win the election in 2004. Unfortunately, her considerable election efforts reaped next to no benefit as the election was won handily by Susilo Bambang Yudhoyono (SBY) from the Democratic Party, a centre-right political party founded in 2001, that manifested itself as a home for old and new oligarchic power consolidation.

However, as asserted in some studies, SBY set his policy priorities more on noncontributory healthcare, which was politically beneficial for his party's popularity. The measures taken by SBY were thus criticised by Megawati and her party, which considered SBY's decision to have violated the mandate of the NSSS law (Yuda, 2021b). Nevertheless, for most people, the policy was considered reasonable, as those years were an important period for Indonesia to recover from the economic crisis (Van Diermen, 2018). This made the noncontributory scheme, ASKESKIN (renamed Jamkesmas), more preferable, as it aided the vulnerable population, which at that time had reached 17.8 per cent.

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Yet, ahead of the general election of 2009, PDI-P's support for JKN diminished. They were no longer following up on the immediate implementation of universal healthcare. Deliberately turning around, PDI-P's political support now poured out for a noncontributory scheme. This new political stance could be attributed to Megawati's strategy to win the election. Unfortunately, SBY won the presidential election yet again, obviously benefiting from his popular programs.

Similar depictions were captured nationally; all local governments had gradually instituted healthcare during the long delay of the JKN implementation. As presented in Figure 1, there was a rapid growth of noncontributory and contributory healthcare programs, from approximately 60 in 2008 to 514 in 2013 (Pisani, Olivier Kok, & Nugroho, 2017). Consulting range studies and reports, this expansion was attributed to a sensible strategy of reconsolidating the conservative elite's power in the local administrations.

In 2010, sudden pressure emerged from *Komite Aksi Jaminan Sosial* (KAJS), a civil movement union consisting of civil society organisations, student organisations, labour unions and farmers. They urged the SBY government to immediately implement the JKN. Unfortunately, their considerable efforts to propel the ruling government for the immediate JKN implementation failed to obtain a fruitful result, as the ruling party sat on it for 3 years before ultimately implementing the popular program in January 2014, 4 months before that year's presidential election.

Another story behind the process represents a range of political interests that were well entrenched during the Suharto period. For those who had previously enjoyed the lucrative resources of ASKES, ASABRI, and JPK, the integration of separate institutions into one single administrative body was considered a threat (Aspinall, 2014).The reason was that the integration would diminish the conservatives' continuing power to control the enormous insurance funds while arguing that the new system would disrupt the existing one (Rosser, Van Diermen, & Choi, 2016). Local governments in 155 districts and municipalities also weighed in, objecting to taking part in the merger (Sumarto & Kaasch, 2018). The complicated interests were finally mediated through working meetings of the committee of social security law. However, surprisingly, it was not run as expected due to the poorly prepared debate that had overlooked the funding mechanism, equality, coverage, provision, disease risk, and other essential issues. Instead, the meeting revolved more around the questioning of who would be appointed as high official for the current system (Pisani, Olivier Kok, & Nugroho, 2017). After the positions were assigned and distributed to conservative elites, JKN was finally implemented.

For all that, such rushed and haphazard considerations resulted in JKN provisions that did little to reduce the OOP rate, internal market practices, and patron–client pitfalls when accessing healthcare. Further explanation of this is provided in the next section.

The explanation implies that we should not dismiss clientelism and patronage as extraordinary determinants in taming the brutal world of healthcare commodification. The fact remains that welfare state expansion in other newly democratic countries owes much to this causation.

Thailand

Thailand, by contrast, has had a significant health insurance coverage expansion in the democratic transition in the late 1980s. However, it still cannot reach the entire Thai population. The reform initiative has started from the progressive health bureaucrats in the MOPH that had close links to the Rural Doctors' Society (Harris, 2015).

Although Dr. Sanguan Nitayarumphong and other progressive health bureaucrats have made several attempts to push forward health reform policy through various channels, including the parliament, the bureaucracy, and the civil society, they have yet failed to enact a national agenda (Nitayarumphong, 2012). The window of opportunity for progressive health bureaucrats came during the wake of the crisis.

The AFC accelerated the adoption of the 1997 Constitution, or the People's Constitution, addressing the right to healthcare access for all citizens, which later on facilitated the legislation of the National Health Security Act in 2002.

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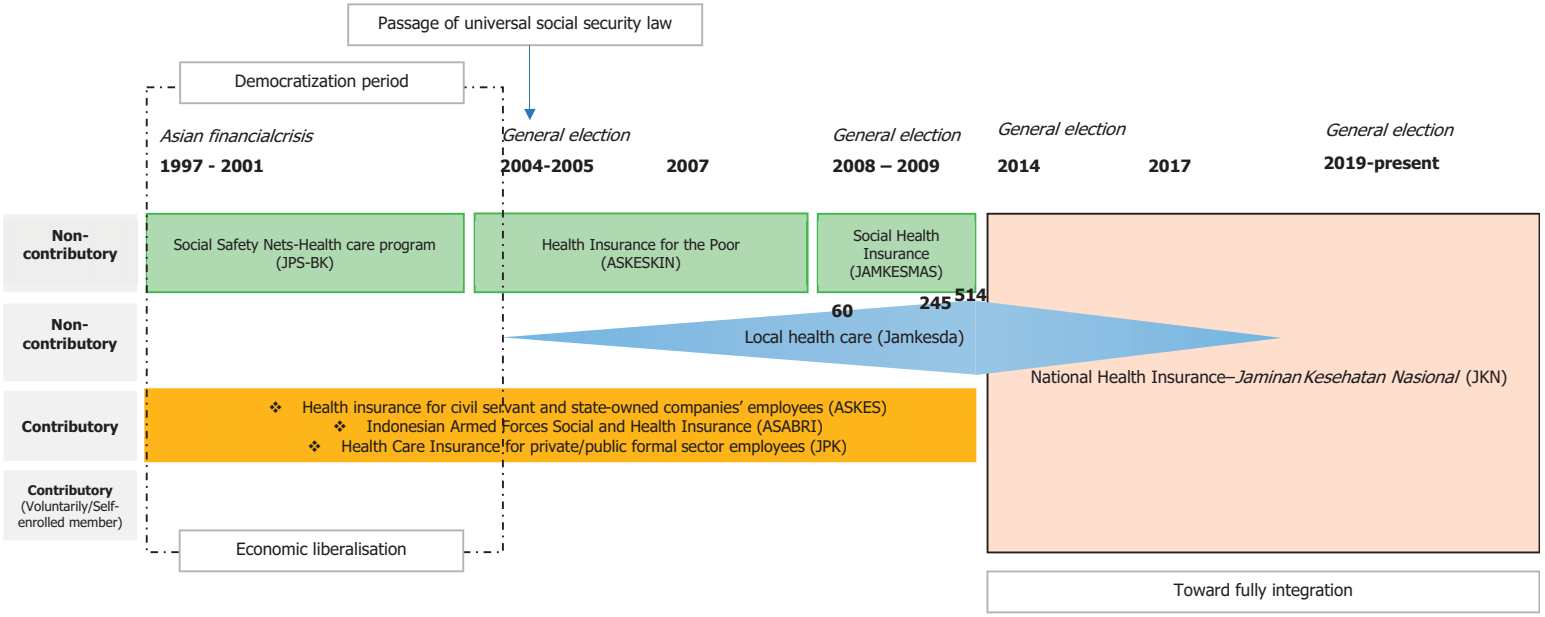

Figure 1. The evolution of the healthcare system in Indonesia in the post-Asian financial crisis.

The 1997 Constitution brought significant change to electoral rules that needed larger proportions of constituencies to win the majority vote by adopting a two-tier system: (1) the single-member district and (2) a single-national district by the closed party lists. As majoritarianism at the national level had become important, the parties had incentive to attract majority of voters (Selway, 2015). At the same time, there was no incentive to compete among members of the same parties. This led to institutionalisation of political parties and national policy competitions during the election (Hicken, 2006; Kuhonta, 2020; Selway, 2011). Importantly, the power is centralised around the office of prime minister through the parliament and built up the attachment between political parties and voters (Hicken & Selway, 2012).

Meanwhile, the crisis brought opportunity for a new political leader, Thaksin Shinawatra, from a new political party, Thai Rak Thai (TRT), established in 1998, to rise in the political competition. Through the network of rural doctors, Dr. Sanguan Nitayarumphong informally reached Thaksin Shinawatra and presented the universal coverage policy supported by research evidence that the policy was feasible for both financing and implementation (Evans et al., 2012). The TRT initially targeted poor and rural voters, thus offering healthcare as a national public good that added to the party's appeal (Hicken, 2006). TRT decided to adopt the Universal Coverage Scheme (UCS) policy known as "30 baht treat all diseases" as its principal political campaign. Meanwhile, the vertical alliance between progressive health bureaucrats and NGOs has together actively advocated to push health policy reform into the national agenda (Nam, 2015).

The UCS policy received great support from the public, especially the rural poor. Towards this end, TRT mobilised the majority of voters who had suffered from the economic recession and were disappointed with the previous government (Pitayarangsarit, 2010). Finally, TRT won the 2001 national election and became a dominance party in the parliament, which allowed the TRT government to deploy the policy reform to make a change on healthcare bureaucracy (Kuhonta, 2020).

To maintain a new social contract and popularity for reelection, the TRT government provided full support to the UCS policy and legislation of the National Health Security Act in 2002 to benefit the popular sector. In addition, the TRT government planned to strengthen the UCS by merging with the SSS. This led to the rally among workers who feared that their healthcare benefits would be reduced if fund mergers occurred (Hewison, 2004). Finally, only the MWS and VHCS were merged under the new noncontributory scheme with a comprehensive health benefit package, including high-cost care or the UCS, accounting for 75 percent of the total population. The CSMBS and SSS, however, retained their separate status (see Figure 2). Despite the unmerged existing schemes, the policy decisions taken have

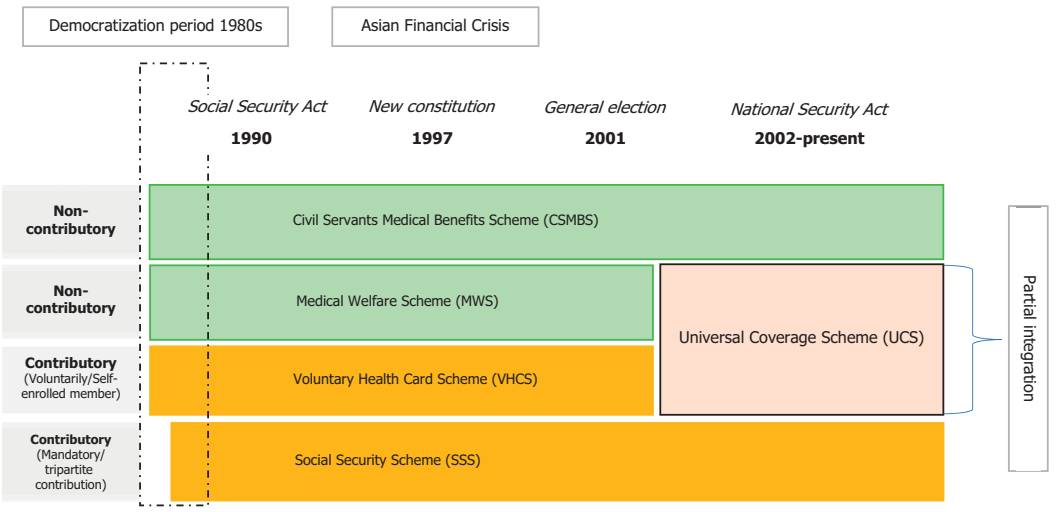

Figure 2. The evolution of the healthcare system in Thailand in the post-Asian financial crisis.

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changed the characteristics of the productivism model from developmental-particularist to developmental-universalist, given the reformed setup of the healthcare system that mainly relied on the tax-financed model with the universal provision and comprehensive benefit package.

Nonetheless, the UCS implementation cannot be achieved without the support from the bureaucracy and professional movement. Dr. Mongkol Na Songkhla, Permanent Secretary of MOPH, the highest-ranking civil service official, who had close links with the network rural doctors, committed to the rapid implementation of the UCS policy and expected to enact this program before his retirement due to the uncertainty of political commitment and stability (Harris, 2017). With the strong leadership of Permanent Secretary and progressive executives of the MOPH, starting in April 2001, the UCS policy has been rapidly implemented through a pilot project that expanded nationally within 1 year even before the legislation of the National Security Act in November 2002 (Harris, 2015; Harris & Selway, 2020).

Due to vertical alliance of political and bureaucracy, opposition and resistance from conservative health bureaucrats and medical professionals in Thai society could not fail the reform (Hewison, 2004), although some delays and difficulties emerged during its implementation (Evans et al., 2012).

As a result, the MOPH has become the major provider under the UCS policy. This has created conflicts between the MOPH and the new organisation that was established to play the role of purchaser for the National Health Security Office (Pitayarangsarit, 2004).

Unlike the case in Indonesia, progressive health bureaucrats have been comprehensively involved in the policy process and design, as well as the implementation of the UCS (Pitayarangsarit, 2004). The implementation of the UCS was not only achieved in terms of population coverage but also deepened the structural reform of the health system to ensure equity and financial risk protection.

Overall, both clientelistic and limited vertical alliance mechanisms may explain how democratisation and economic shocks have contributed to the health system expansion in Indonesia and Thailand. The next section discusses the potential impact of healthcare expansion, as well as the causal mechanisms underlying it, on welfare regimes in Indonesia and Thailand.

A quest for healthcare regime type

A degree of universalism

The development of healthcare represents the evolution of welfare regimes in Indonesia and Thailand. As described in the previous section, intertwined democratisation and AFC have shaped the political terrain within which subsequent welfare regimes have developed, resulting in a new trajectory diverging from previous approaches but converging to be more inclusive, placing the greater role of the state in welfare provision (Pholpark, 2018; Tangcharoensathien et al., 2019; Yuda, 2021b). In the context of healthcare, the new trajectory, as reflected in the social health insurance system, was selected by policymakers to consolidate all populations under a state-driven welfare system, as the National Health Insurance Program (JKN) (2014) in Indonesia and the UCS (2001) in Thailand (Bazyar et al., 2021).

As presented in Table 1, the healthcare universalism in Indonesia and Thailand has been proven by the massive coverage, accounting for 83.4 and 99.8 per cent of the total population, respectively. Regarding generosity, the government health expenditures have been increased after the reform in both countries, but the allocation of government health expenditures was higher in Thailand. In addition, The JKN and UCS, at their core, were designed to provide quality of care with comprehensive health benefit packages, covering both inpatients and outpatients, to the beneficiaries. Their systems designed the primary care unit to be the first contact under the referral system. Importantly, the emergence of the two programs has improved the financial risk protection of the family by reducing the OOP payment to 38.96 per cent in Indonesia and 11.25 per cent in Thailand. This led to the improvement in equity in healthcare utilisation in both countries.

Furthermore, the different levels of OOP in both countries are determined by the demographic characteristics and policy architectures that include coverage of health insurance, level of co-payment/cost sharing, generosity of benefit packages and labour market compositions (Erlangga & Shi, 2013).

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Table 1. Comparison of the health care regimes of Indonesia and Thailand before and after reform.

	Government health expenditures (%GDP)		Coverage (Public health services coverage, %)		Financial risk protection (Out-of-pocket expenses, %)		Healthcare access and quality (HAQ) (0–100)	
Country	**Pre-reform**	**After reform**	**Pre-reform**	**After reform**	**Pre-reform**	**After reform**	**Pre-reform**	**After reform**
Indonesia	0.78* (Spending averages between 2000 and 2013)	1.28* (Spending averages between 2014 and 2019)	51.2** (2013)	83.4*** (2019)	50.15* (Spending averages between 2000 and 2013)	38.96* (Spending averages between 2014 and 2019)	43.96 (HAQ averages in 2000, 2005 and 2010)	49.2 (2015)
Thailand	1.69* (Spending averages between 2000 and 2001)	2.51* (Spending averages between 2002 and 2019)	69.2 (2001)	99.8 (2019)	37.14 (Spending averages between 1995 and 2001)	11.25* (Spending averages between 2014 and 2019)	59.3 (2000)	68 (HAQ averages in 2005, 2010 and 2015)

Notes. *World Bank (2022); **Murphy (2019); ***Yuda (2019); Our world data, 2022, https://ourworldindata.org/. Two-first constitutive aspects of healthcare services (spending and universality) are adapted from Yang and Kühner (2020).

Another paramount factor is the expansion pace of healthcare insurance, either contributory or noncontributory (Tangcharoensathien et al., 2018). These policy architectures lead to low OOP and catastrophic expenditures in Thailand, as its government provides UCS, based on a noncontributory scheme and financed with tax revenues, while healthcare co-payments and cost sharing have been removed.

Despite the modernization and expansion of healthcare, the role of family has been persistently influencing Indonesia. Contrarily, in Thailand, the role of family has been significantly reduced after the reform. As presented in Table 1, the reliance on direct health payments from users demonstrates the continuing vigour of families with varying intensities in Indonesia, whereas a major noncontributory scheme with minimal cost sharing, which mainly relied on healthcare provided by the public sector, could significantly reduce the reliance on family and informal networks for healthcare in Thailand. Yet despite their differences, the institutional features of Indonesia and Thailand's healthcare and patterns of informality, clientelism, and fragmented policy trends distinguish them from other countries considered in this article.

Informality, clientelism and fragmented policy trends

Important evidence supporting the characterisation of the welfare regime in Indonesia and Thailand can be explored through the prevailing provision of universal healthcare.

In Indonesia, occupation and income status remain integral to the receipt of healthcare benefits, implying that the JKN does not always lead to effective decommodification, as is observed in many welfare state countries. This argument is exemplified in the provision specified in the updated law of 2020, in which inpatient room facilities received are dependent on the selected monthly contribution package, ranging from $10.46 USD (first-class room), $6.97 USD (middle-class room), to $2.93 USD (low-budget room). Despite this, the institutionalisation of the internal market in publicly funded healthcare systems, commonly for additional medical equipment and medications, has also pressured patients to make additional payments when accessing their entitlements (Yuda, 2021b). This causation has generated unexposed inequality among individuals in receiving healthcare. The determinants of occupation and income in accessing the JKN are more visible for the informal sector, which currently accounts for 55–57 per cent of the overall workers. With fluctuating income, their membership in the informal labour market remains important if they decide to participate in the JKN.

It is important to note that limited coverage and unresponsive bureaucracies have exposed uninsured, near-poor individuals unaccustomed to dealing with bureaucracies to the deeper patron–client relationship (London, 2018). Berenschot, Hanani, and Sambodho (2018) found that intermediaries or brokers attached to informal relationships with high officials or influential politicians often acting as "heroes" for the aforementioned individuals in accessing healthcare. In exchange, the brokers could mobilise their ex-clients to vote for particular candidate(s) upon their patron's requests (Fossati, 2017).

Thailand has achieved universal health coverage under three public health insurance schemes, namely, CSMBS, SSS, and UCS. Unlike Indonesia, CSMBS and SSS were left untouched in the health reforms, thus leaving an inequity of health benefit packages and levels of expenditures across the schemes. The schemes for formal and informal sectors still operate separately, which re-emphasises the developmental-particularist typology and clientelism for Thailand.

Following the National Health Security Act, NHSO has become established as a national purchaser, whereas the MOPH has become a major provider. This led to the new institutional arrangement that changed the health supply system in Thailand. The National Health Security Board was established to oversee the NHSO, which comprises various stakeholder groups: government officials, local governments, NGOs, health professionals, private hospitals, and experts in insurance, medical and public health, traditional and alternative medicines, financing, law and social sciences. It can be observed here

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that the NGOs involved in the UCS policy process were included in the policy circle following the reform to support the UCS implementation.

After the implementation, Thai health financing and the health supply system have been shifted from the urban hospitals to primary care through referrals and registered contracted providers to ensure equitable access, particularly for the poor and rural populations (Towse, Mills, & Tangcharoensathien, 2004). The incidence of catastrophic spending has significantly dropped (Tangcharoensathien et al., 2020) due to the small co-payment of 30 baht (US$ 0.70) per visit. Later, in 2006, the co-payment at the point of service was abolished altogether. In addition, service utilisation increased for outpatients and inpatients after the UCS implementation (Evans et al., 2012). The main achievements of the UCS were financial risk protection and access to essential health services. Thus, decommodification of healthcare was relatively successful in the case of Thailand, despite the still-intact characteristics of an informal and familial system (London, 2018).

Overall, the proliferation of attached informality, market-conforming provision, and clientelism within universal healthcare provision demonstrates the development of healthcare regimes in the context of productivism with a specific emphasis on the notions of developmental-universalist states.

The effective and less-effective dimensions of developmental-universalist states

In previous sections, we have demonstrated that similar causal mechanisms in the contexts of healthcare universalization have resulted in different policy outcomes. Consistent with many facets of the literature, it is suggested that a developmental-universalist state could be the most precise characterisation of the situation now prevailing in Indonesia and Thailand. One model is less effective in Indonesia, whereas another model is more effective in Thailand.

The explanation is that the policy architectures of universal healthcare in Thailand are more inclusive than in Indonesia. In Thailand, health insurance is mandated to cover all citizens, including informal sector, as a social right. The UCS is funded through tax revenues while offering comprehensive benefit package mainly provided by the public sector. Conversely, the health insurance in Indonesia is also mandated to cover the entire population but not yet to reach the entire informal sector due to contributory conditions. Despite the comprehensive benefit package, to certain extent, the provision of healthcare needs to be relied on the for-profit private sector, which could lead to OOP from inducing uncovered services. This suggests that relying on the funding from the contributions and health provision of private sector could limit the coverage and financial risk protection of the population.

The less-effective model reflects the development and implementation of comprehensive healthcare for all, but the entitlement of services is granted upon pragmatic consideration, not social rights. It results in stratified and fragmented healthcare. The less-effective argument can also be seen from the inability of universal healthcare to prevent individuals from accessing healthcare independently of the market, and/or its informal relationships, which works more predictably to meet the needs of individuals. In the effective model, both good healthcare outcomes and low levels of OOP expenses are achieved. The combination of these two factors suggests a successful productivist regime, such as that in South Korea (Yuda, Pratiyudha, & Kafaa, 2021).

Under the global welfare regime debates proposed by Gough et al. (2004), such attributions also describe the current position of both countries located between informal security and welfare state models. Indonesia is closer to the first type. Despite its position, Thailand's welfare regime points to a steady, more secure shift as OOP expenditures have continued to significantly decline. Moreover, there is a high level of state commitment to the provision of healthcare and a relatively effective provision of services, as well as moderately extensive coverage. Accordingly, both Indonesia and Thailand appear to demonstrate characteristics of proto-welfare states (eg Argentina, Brazil and Uruguay).

Nonetheless, the causal mechanisms underlying social policy development, as they do in welfare state regimes, do not fully emerge and rather rely on a highly clientelistic political environment. At the same time, public health expenditures are less than 5 per cent (compared with examples of proto-welfare state

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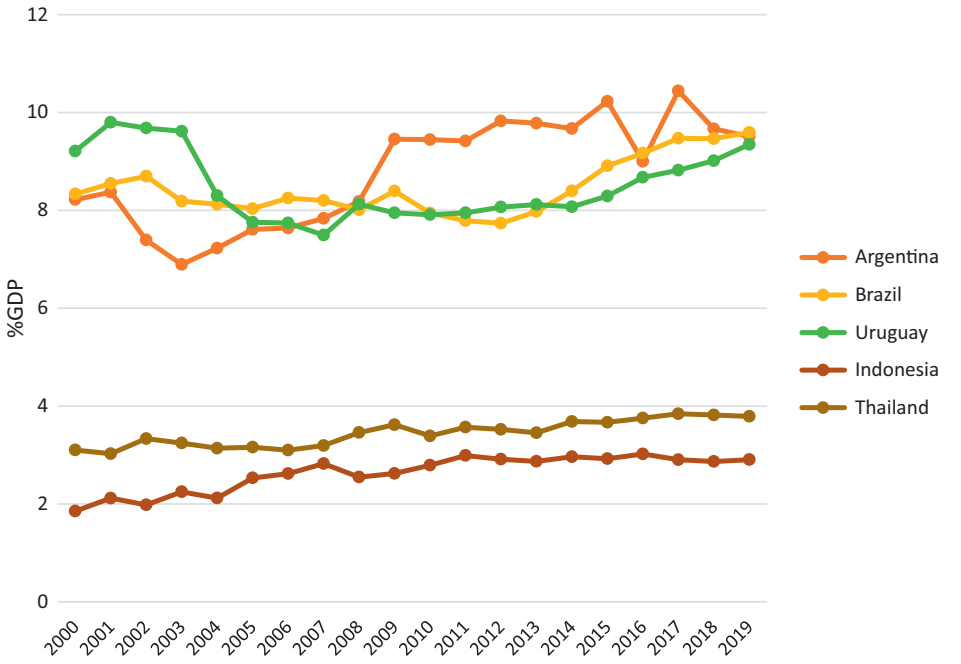

Figure 3. Current health expenditure (per cent of GDP) – Argentina, Brazil, Indonesia, Thailand and Uruguay. *Source:* World Bank (2022).

countries, such as those presented in Figure 3). Gough's description of meta-welfare regimes does not seem fully applicable in the current context, because there is too much bias if we are to classify Indonesia and Thailand under Gough's classifications.

Alternatively, we maintain the developmental-universalist model, a subset of the productivist model, as a more representative approach. Developmental-universalists prioritise industrialisation over redistribution, and family ties and informal social networks remain vital to ensuring social and health securities, especially in Indonesia, though healthcare has significantly extended to the informal sector. We contribute to the discussion here by comparing the effectiveness of the Indonesian developmental-universalist regime with that of Thailand, which we deem to be more successful.

Concluding remarks

With the observed healthcare expansion, Thailand as a country is relatively isolated from class directives, and international intervention has expanded their scheme much more rapidly than Indonesia in terms of coverage, generosity, and financial risk protection. Indonesia, by contrast, has used a liberal democratic system and is receiving support from international organisations for welfare policy installation. That said, it actually faced a 10-year-long expansion delay since it was first promulgated in 2004. Concerning this, we take note that the different trajectories of the respective healthcare systems during the 1970s to 1990s in Indonesia and Thailand could be argued as influencing causation for the recent reform outcome. However, the prevailing provision in the past is not due to a single causation. The political mechanism that emerges after reform has played a more significant role in defining the outcome and shaping healthcare regimes in Indonesia and Thailand.

The establishment of the JKN merging all fragmented schemes under one umbrella has led to a long tug of war between former authoritarian administration stalwarts (spreading in the centre-left and centre-right parties, both local and national) and those reorganising their power in a newly emerging

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health system. The complicated interests were successfully mediated through the appointment of old players as high-ranking officials, whereas the JKN implementation preceded the 2014 election. Being implemented does not mean the implementation process necessarily proceeded smoothly, given the objections raised by local governments about the merger policy. The attitude of "objection" among local governments, as our examination proceeded, was closely associated with the importance of local healthcare as a promising asset for electoral competition.

Unlike in Indonesia, it could be argued that faster reforms in Thailand emerged as a progressive bureaucrat and political-institutional product. The vertical alliance between progressive bureaucrats and NGOs operated within an institutional context of rudimentary democracy to push for the greater agenda of healthcare reform without merging together all of the fragmented schemes. Thus, the emergence of the UCS policy did not make the "old player" lose their control and benefits. Such mediation, thereby, allows the government and bureaucrat to quickly undergo substantial healthcare reform.

Drawing from the cases of Indonesia and Thailand, this study suggests that consolidation of fragmented public health insurance systems might not be the best option for achieving universal health coverage for DMIC, which possess strong patron–client relationships, because it might delay or fail the reform. Instead of merging the harmonisation of health benefit packages across different schemes to ensure access to essential healthcare without financial burden would be the more appealing and feasible option, one that would allow for decommodification of healthcare as a national public good.

Overall, while recent political economy changes have enhanced the state's intervention in healthcare, both countries have reproduced the fragmented and stratified nature of the scheme. Compared with that in Thailand, the health insurance in Indonesia relies more on contributory schemes with some degree of cost sharing and healthcare provision from the private sector. Thus, it has not significantly reduced activities of the family, informal network, or private sector within the healthcare provision.

Taken together, we suggest a developmental-universalist as a term of reference to improve our understanding of DMIC welfare regimes in wider comparative social policy scholarship. It is noteworthy that the conforming role of the state in industrialisation persists, whereas causal mechanisms underlying the reform, for example, clientelism-reform mechanisms, and limited vertical alliance-reform mechanisms, are emerging, making it distinct from the Three Worlds of Welfare Capitalism.

We conclude that despite differences in health policy outputs and healthcare regime change in Indonesia and Thailand, the underlying causal mechanisms for the expansion of both outcomes and regimes in both countries are similar. Our findings allow us to extrapolate the results to other countries that face similar political and economic challenges as Indonesia and Thailand.

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Ethical standards. This article does not contain any studies with human participants or animals performed by any of the authors. Thus, for this type of study, formal consent is not required.

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