Community-based health coverage at the crossroad: the Muhammadiyah health fund in Indonesia[1]

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Abstract

This paper discusses the complexities of community-based health insurance (CBHI) coordinated by faith-based NGOs in Indonesia, and how government health care schemes threaten community-based health care plans. A qualitative approach with a deep interview followed by a field visit and using secondary data for analysis, this study particularly look inside into Muhammadiyah's history, one of the largest Islamic civil society organizations dealing with the health sector, as well as their struggle to facilitate community-based health care insurance. Muhammadiyah established Dana Sehat Muhammadiyah (Muhammadiyah

Health Fund) to provide internal insurance for students. It was growing rapidly during 2000-2016. However, after the new regulation applied in 2014 the progress was slowed down and became conflicting. The role of state-based universal health coverage (UHC) has markedly overshadowed civil society programs, including faith-based NGOs, in implementing and providing health care services in their circles or members. While the State faces a delicate situation in the management of its universal health care, both financially and operationally, civil society groups have sought to revive the limited health care scheme as a way to supplement and even contend with the state welfare regime. However, during this pandemic situation MHF can be an alternative solution to support UHC.

Tulisan ini membahas kompleksitas asuransi kesehatan berbasis komunitas (CBHI) yang dikoordinasikan oleh Ormas berbasis agama di Indonesia, dan bagaimana skema perawatan kesehatan pemerintah mengancam rencana perawatan kesehatan berbasis komunitas. Pendekatan kualitatif dengan wawancara mendalam disertai kunjungan lapangan serta data sekunder, secara khusus membahas tentang sejarah Muhammadiyah, salah satu organisasi masyarakat sipil Islam terbesar yang bergerak di bidang kesehatan, serta perjuangan mereka memfasilitasi jaminan kesehatan berbasis masyarakat. Muhammadiyah mendirikan Dana Sehat Muhammadiyah (DSM) yang berkembang dengan pesat di era 2000-2016. Akan tetapi dengan berlakunya aturan baru tahun 2014 perkembangannya terhambat dan menurun. Peran jaminan kesehatan universal (UHC) berbasis negara telah menghilangkan program asuransi kesehatan masyarakat sipil, termasuk Ormas berbasis agama, dalam melaksanakan dan menyediakan layanan perawatan kesehatan di lingkungan atau anggotanya. Sementara negara menghadapi situasi yang rumit dalam pengelolaan perawatan kesehatan universal, baik secara finansial maupun operasional, kelompok masyarakat sipil telah berusaha untuk menghidupkan kembali skema perawatan kesehatan yang terbatas sebagai cara untuk melengkapi dan bahkan bersaing dengan rezim kesejahteraan negara. Dalam situasi pandemi model DSM menjadi salah satu solusi alternatif dalam mendukung UHC.

Keywords: *universal health coverage, Muhammadiyah, welfare, civil society.*

Introduction

In 2019, Indonesia's major newspapers and social media reported lively discussions on the failures of Indonesian Health Care and Social Security Agency (BPJS) in raising funds, as well as the government's late payment to hospital partners, including state and private hospitals. Politicians, scholars and civil society organizations have criticized the management of health care and the capacity of the government to seize funds for BPJS. Private hospitals and civil society, including religious groups, were concerned about the ability of the government to reimburse the healthcare funds expended by the clinics to serve the patients.

Universal health coverage (UHC) in Indonesia, as elsewhere in many countries, has been one of the major healthcare projects that are not always effectively enforced. Implementation of UHC becomes increasingly complicated due to certain factors such as people's economic disparity, the shortage of health care services, people's awareness of health care coverage, as well as a sizeable geographic situation that causes unequal access to health care. With more than seventeen thousand islands and 260 million inhabitants, Indonesia has faced many difficulties in fairly distributing the limited facilities and scarcity of human resources (physicians, nurses, and midwives) in many regions.

It is not surprising that there are efforts coordinated by civil society groups, in general, and faith-based NGOs in particular, to engage actively in healthcare issues. Some groups have founded hospitals or clinics and provided some forms of community-based health care insurance. As the largest Muslim country in the world, Indonesia is a home to many Islamic organizations whose activities are as diverse as their religious orientation. Muhammadiyah, founded in 1912, is among the most prominent Islamic organizations which have played a profound role in the health sector. Until now, in many provinces of Indonesia, Muhammadiyah has operated

no fewer than 300 clinics, medium and large scale clinics/hospitals, to supplement the existing hospitals run by either private companies or state agencies.

Some scholars have been involved in researching the Muhammadiyah movement from many disciplines, such as anthropology[2], politics[3], women's leadership[4], health care[5], religion[6]), philanthropy[7] and disaster management[8]. This paper discusses how government-sponsored UHC intervenes and impacts the growth and decline of CBHI by analyzing Muhammadiyah. It discusses the idea of UHC, which Muhammadiyah proposed decades ago but then declined as soon as the existence of the government's health care insurance scheme. Civil society's role in delivering healthcare services is gradually being overshadowed in this respect. The government's growing role in providing and running universal health care coverage (UHC) has challenged the existence of community-based health insurance (CBHI) in Indonesia.

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[2]Mitsuo Nakamura, *the Crescent Arises over the Banyan Tree, a Study of Muhammadiyah Movement in a Central Javanese Town, c. 1910-2010*, 2nd Enlarged edition, Singapore: Institute of Southeast Asian Studies, 2012.

[3]Syamsuddin MS, "Religion and Politics in Islam: The case of Muhammadiyah in Indonesia's New Order", Dissertation, University of California, 1991; Eunsook Jung, "Islamic Organizations and Electoral Politics in Indonesia: The Case of Muhammadiyah", *South East Asia Research*, Vol. 22, No. 1 (2014), 73–86.

[4]H. Kurniawati Dewi, "Perspective versus Practice: Women's Leadership in Muhammadiyah", *Journal of Social Issues in Southeast Asia*, Vol. 23, No. 2 (2008), 161-185.

[5]Rosalia Sciortino, Ridarineni, Neni & Marjadi, Brahmaputra, "Caught between Social and Market Considerations: a Case Study of Muhammadiyah Charitable Health Services", *Reproductive Health Matters*, Vol. 18, No. 36 (2010), 25-34.

[6]Zakiyuddin Baidhawy, "The Role of Faith-Based Organization in Coping with Disaster Management and Mitigation: Muhammadiyah's Experience", *Journal of Indonesian Islam*, Volume 09, Number 02 (2015), 167-194.

[7]Hilman Latief, "Health Provision for the Poor: Islamic Aid and the Rise of Charitable Clinics in Indonesia," *Journal of Southeast Asia Research*, Vol. 18, No. 3 (2010), 503-553.

[8]Robin Bush, "Muhammadiyah and Disaster Response: Innovation and Change in Humanitarian Assistance" in C. Brassard et al. (eds.), *Natural Disaster Management in the Asia-Pacific: Policy and Governance, Disaster Risk Reduction*, Japan: Springer, 2015, 35.

Therefore, this paper would focus on the following questions: to what extent can community-based health coverage (not) function in society and how does it relate to the government scheme? How do community-based healthcare services, like what Muhammadiyah has proposed, survive and is it complementary to the health care systems of the current government?

UHC and social welfare: contesting the state and civil society

Many countries have introduced universal Health Coverage (UHC) as a means of providing a reliable healthcare scheme to cover the needs of society under the framework of mutual-heal and mutual-benefit. The state has played instrumental roles in utilizing UHC to replace, if not compete with, other schemes offered by either private companies or the communities. UHC is defined as equal access to health services in terms of promotion, prevention, treatment, and rehabilitation[9]. While the World Health Organization (2019) defines UHC as a condition when every individual and the communities receive the health service they need without suffering financial hardship. It includes the full spectrum of quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC becomes one of the Millennium Development Goals supported by the United Nations.

The UHC framework emerges and operates side by side with the private sector in many developed and even emerging countries. The chosen schemes would be used by people based on their preferences and financial ability. The private sector's growing role in providing health insurance is because the private sector is assumed to have "greater service capability, more administrative experience, better service efficiency, and technology and innovation, as well as expenditure and financing" [10](Clarck et al. 2019:

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[9]Thomas O'Connell, Kumanan Rasanathan, and Mickey Chopra, "What Does Universal Health Coverage Mean?", *The Lancet*, Vol. 383 (2014), 277–79.

[10]David Clarke et all., "The Private Sector and Universal Health Coverage", *Bull World*

434). Although health insurance provided by private businesses remains massive, the State's commitment to implementing UHC is growing as part of the restructuring of the social welfare system.

UHC's implementation model varies from country to country, depending on state capability, private sector participation, political climate (democratic or undemocratic country), as well as societal economic situation. Thus, UHC implementation studies have utilized various perspectives and discussed different points. Some scholars have paid attention to the political context of healthcare and social welfare policies by examining whether or not healthcare policies can be successfully enforced in a democratic country and whether the universal healthcare plan arises from politicians or civil society advocacy groups. Other scholars have addressed some key issues in health policy or social welfare reform in how state policy can properly support the poor: achieving their rights, obtaining opportunities, and enjoying health care privileges.

In some developing countries, however, civil society plays a significant role in encouraging the government to provide not only the best health care system but also an effective health insurance system that, in many cases, does not meet and satisfy people's expectations[11]. It is assumed that the liberal market interference in health care services without state control would not result in socially desirable health care quantity, efficiency, or delivery. However, the full participation of the state still does not guarantee that the state system and its resources are adequate to account for the whole segments of society. In the state-based and private health care system, there are always the "excluded groups," and thus "micro-insurance" is required[12].

Health Organ, Vol. 97 (2019), 434–435.

[11]Adila Hassim, "National Health Insurance: Legal and Civil Society Considerations: Perspectives on a National Health Insurance – Profile", *South African Health Review*, Volume 2010, Issue 1 (2010), 205 – 208.

[12]David M. Dror & Jacquier, Christian, "Micro-insurance: Extending Health Insurance

Micro insurance, or community-based health insurance, increased under a poor government and public policy and power.

The National Health Insurance Scheme (NHI) has been introduced in Ghana to modernize health care coverage as well as replace the Ghanaian 'cash and carry' system. Modernizing health care is implemented as a way to get more people out of their traditional medical practices, partially because more Ghanaians are using conventional medicine (TRM) rather than modern medicine[13]. While this strategy (NHI) has elevated the standard of health services, an ambitious state project renders many people in rural areas unattainable. The government supports community health insurance in Uganda is limited and many people are reluctant to participate due to issues of governance, such as poor quality of services[14].

Indonesia had relied on the market force for health care for several decades until it experienced a democratic transition that persisted in the period of democratization following the constitutional reforms of the late 1990s. A study by Eunsook Jung on the relationship between democratic reform and reform of social security in Indonesia indicates that democratization is not enough to underpin the implementation of welfare policy. He argues that inclusive social welfare reform can be strongly underpinned by "a broad-based advocacy coalition that represents cross-class interests"[15]. He continues that "a broad-based organization goes beyond its narrow interests, builds cross-class alliance and pressures the government. Without this prerequisite, democratization does not

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to the Excluded," *International Social Security Review*, Vol. 52, No. 1 (1999), 99.

[13]Kofi Bobi Barimah, "Traditional healers as service providers in Ghana's National Health Insurance Scheme: The wrong way forward?", *Global Public Health: An International Journal for Research, Policy and Practice*, vol. 8, No. 2 (2013), 202-208.

[14]Robert Basaza, Criel, Bart. Stuyft, Patrick Van der, "Community Health Insurance in Uganda: Why Does Enrolment Remain Low? A view from Beneath," *Health Policy*, Vol. 87 (2008), 172–184.

[15]Eunsook Jung, "Campaigning for All Indonesians: The Politics of Healthcare in Indonesia", *Contemporary Southeast Asia*, Vol. 38, No. 3 (2016), 480.

necessarily result in comprehensive social reforms"[16].

The Indonesian government has sought to implement various health insurance programs, referred to in this paper as Universal Health Coverage (UHC). While UHC's presence is prevalent in Indonesia, politically, this policy has been enforced "a top-down manner by the government without a broad societal consensus" [17]. On January 1, 2014, the Indonesian government committed to achieving UHC through the creation of the Jaminan Kesehatan Nasional (JKN) or NHI program. JKN became the embryo of the UHC implementation in Indonesia scheduled for 2019. Through the NHI, the government will manage the entire public health coverage.

The NHI is coordinated by a single organization, the Jaminan Sosial Badan Penyelenggara (BPJS). Since then, the number of NHI participants has risen, from 133 million in 2014 to 187 million in 2017. Based on data from BPJS Health (2018), 165 million people, (75 percent) of Indonesia's population, became NHI participants in January 2019 to meet the government's goal of 257.5 million (95 percent)[18]. As a result, the number of health-care facilities (medium-scale clinics) to work with BPJS increased (Minister of Health, 2019). First-level health facilities (FKTP) were about 18,437 in 2014, and by the end of 2017, they were 21,763—a rise of around 18%. At the same time, there were 1,681 FKTL for the Advanced Health Facilities (FKTL) or large-scale hospitals partnering with the National Health Insurance (NHI) program in 2016, an increase of 36 percent to 2,292 FKTL at the end of 2017.

The government-owned hospitals still control as much as 52.2 percent of the total participating FKTL, and the remainder belongs to private

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[16]Eunsook Jung, "Campaigning for All Indonesians..., 480.
[17]Eunsook Jung, "Campaigning for All Indonesians...,478.
[18]BPJS annual report, 2019.

hospitals as much as 47.8 percent. The NHI usage portrait can be seen from the number of visits, which rises each year. There were 62.3 million visits in 2014, and 219.6 million in 2017. The above data indicates that the National Health Care Insurance (NHI) policy meets the needs of the citizens of Indonesia in health services. In view of the reality of this reasonably large rise in JKN programs, it is assumed that the JKN program should be retained as a sustainable program[19].

The success of Indonesia's National Health Insurance (NHI) program has a distinctive character, as it is the product of government-owned combining programs. First, NHI operates through a single quasi-government body. Second, NHI pays primary care providers using a prospective capitation arrangement and depends on case-based associations for secondary providers to make the arrangement. Third, the Ministry of Health sets the quality of care, treatment, and referral to ensure the capacity and service of primary care providers is standardized. Fourth, the system designates the primary care provider as the UHC entry point and the advanced care referral portal. Finally, private sector providers are encouraged to involve themselves in expanding the provision of services[20].

It appears that private sector participation models in providing healthcare in Indonesia have certain parallels with what has been put into practice in other countries. Lam's (2018) findings of UHC's performance in Thailand indicate a very close partnership between the government and NGOs to achieve the goal. Rising private health care providers is one indicator of private sector participation. For example, the number of private hospitals rose from 500 hospitals to more than 1200 hospitals between 2014 and 2018[21]. Some private hospitals are part of religious

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[19]Rina Agustina et. al., "Universal Health Coverage in Indonesia: Concept, Progress, and Challenges", *The Lancet*, Vol. 393 (2019), 75-102.

[20]Rina Agustina et. al., "Universal Health...

[21]http://sehatnegeriku.kemkes.go.id/baca/rilis-media/20180502/4725818/upaya-

organizations (FBOs).

It should be remembered that the participation of faith-based organizations (FBOs) in the provision of both health care and community-based health insurance reflects the active role of civil society in complementing the duties of state agencies. FBOs refer to organizations whose beliefs are centered on faith and belief, whose mission is focused on the social principles of the particular religion, and whose members (leaders, workers, and volunteers) are most frequently drawn from a single community of faith. The faith to which it applies does not have to be officially identified as a religion.

The word "faith-based organization" is more inclusive than "religious organization," as it often applies to principles of faith that are not congregational[22]. These organizations play a vital role in development as a partner in strengthening and making health services easier to obtain, especially in developing countries[23]. In the area of health and economic development, the World Health Organization and the World Bank have made some reports pertaining to the roles of FBOs in health care provision.

Studies concerning FBOs and well-being were carried out not only by researchers but also by policymakers. In 2008, the WHO mentioned that FBOs were major health providers in developing countries, providing an average of about 40 percent of primary healthcare services in sub-Saharan Africa. That function includes HIV treatment in Africa[24]. A study carried out in 8 countries in Africa, Eastern E Europe and Asia, conclude that

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indonesia-capai-universal-health-coverage-tahun-2019/

[22]W. Bielefeld, & Cleveland, W. S., "Defining Faith-Based Organizations and Understanding Them Through Research", *Nonprofit and Voluntary Sector Quarterly*, Vol. 42, No. 3 (2013), 442–467.

[23]RC. Kagawa, Anglemyer A, Montagu D., "The Scale of Faith Based Organization Participation in Health Service Delivery in Developing Countries: Systemic Review and Meta-Analysis", *PLoS ONE, Vol.* 7, No. 11 (2012), e48457.

[24]Jon O'Brien, "Can faith and freedom co-exist? When Faith-Basedhealth providers and women's needs clash", *Gender & Development*, Vol. 25, No. 1 (2017), 37-51.

governments could effectively engage non-state providers, including FBOs, in strengthening health systems to achieve UHC through the use of appropriate contracts and proper regulation (Shroff at al 2018). Another WHO study on Indonesia's health system also mentions the functions of FBOs in encouraging, training, caring for, and treating various diseases such as tuberculosis, HIV/AIDs, and malaria[25].

Muhammadiyah can be described as an involved FBO, offering an important and clear inspiration for action and mobilizing workers and supporters in this organization. It plays a significant role in recognizing, supporting, or collaborating with beneficiaries and stakeholders, while non-believers are not discriminated against, and the organization encourages multi-faith cooperation. Muhammadiyah can also be labeled as a constitutive FBO, meaning that this organization is larger than NGOs. Therefore, Muhammadiyah can also be classified as a civil society organization[26]. Muhammadiyah was organized geographically, from the province to district level. In the health sector, it should be remembered that the relationship between a government program and FBOs lies in the context of helping to prioritize and care for the needy, disadvantaged and oppressed in their core values, which maintain physical and spiritual well-being.

It is worth stressing that religious philanthropic organizations may also partly serve FBOs employed in the health sector. Over the past thirty years, Indonesia has witnessed unparalleled growth of a religious charitable organization, whose duties include gathering public donations and distributing funds for health services to the poor, not just in spots

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[25]Y. Mahendradhata, et al., "The Republic of Indonesia Health System Review", *Health Systems in Transition*, Vol. 7 No.1 (2017).

[26]M. Clarke & Ware, V.A., "Understanding Faith-Based organizations: How FBO are contrasted with NGOs in international development literature", *Progress in Development Studies*, Vol. 15, No. 1 (2015.), 37–48.

impacted by disasters, but also in densely populated regions. Interestingly, several Islamic philanthropic organizations, including Muslim groups, are expanding their social welfare-oriented programs by creating poor-catering clinics[27].

Studies on the engagement of FBOs (Islam, Christianity, Hinduism, Buddhism, and Confucianism) in the health sector in the Indonesia concludes: (1) the roles of FBOs in addressing maternal and child health problems, HIV/AIDS, and family planning in Indonesia have been notable. The country is known internationally as the best example of the contributions from the FBOs in this regard. (2) FBOs are considered by the national government to be strategic partners. They also have control on legislative and democratic systems. (3) Gender inequalities continue to be an area of concern by patriarchal and conservative movements. Still, women-led FBOs have actively worked to reshape the debate, including setting up leadership for their own people. (4) FBOs are involved in the prevention of HIV/AIDS, maternal and neonatal health, sexual health and family planning. (5) Muslim voices emphasized the need for a greater focus on rights-based approaches to women's sexual and reproductive health[28].

Historically, the role of FBOs in Indonesia's healthcare began in the late 18th century. These organizations obtained Dutch Government subsidies[29]. The first non-profit hospital was Cikini Hospital, founded

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[27]Hilman Latief, "The Politics of Humanitarianism-based Welfare in Post Disaster Aceh," in Wawan Mas'udi and Cornelis Lay (eds.), *The Politics of Welfare: Contested Welfare Regimes in Indonesia*, Jakarta and Oslo: Yayasan Obor Indonesia in cooperation with PolGov Fisipol UGM and University of Oslo, 2018, 199-220.

[28]Emma Rachmawati, Dominika Jajkowicz, Lintang Purwara Dewanti, Mouhamad Bigwanto, "Mapping Faith-Based Responses to Sexual and Reproductive Health and Rights in Indonesia: A Snapshot from 10 Muslim, Christian, Hindu, Buddhist and Confucian Faith-Based Organizations", Proceedings The 1st UICIHSS (UHAMKA International Conference on Islamic Humanities and Social Sciences, 22-23 Maret 2017.

[29]L. Trisnantoro, Dewi, S, Meliala, A, Hort, K, *The non-state hospitals in Indonesia*, Yogyakarta: Gadjah Mada University Press, 2012.

in 1898, and then the Salvation Army belonged to the William Booth Semarang hospital of 1915. In 1918 Jakarta's St. Carolus Hospital was inaugurated, and HKBP Balige North Sumatra hospital was funded by the Christian congregation and. The first Indonesian-initiated hospital was Jang Seng Ie (Husada) in Jakarta, and was established in 1924 by Dr. Kwa Tjoan Sioe. Another organization involved in the health sector in that period was the Movement for Muhammadiyah, which founded its first clinic in 1923[30]. After becoming independent in 1945, the hospitals and clinics operated by FBOs became the backbone of health service along with government hospitals.

The rise and decline of the Muhammadiyah's health fund

Muhammadiyah is a social welfare organization whose primary aim is to enhance the understanding and practice of Islam among believers[31]. Muhammadiyah has also been identified as Calvinist Islam, Protestant Islam, Puritan Islam, and reformist Islam in addition to being categorized as Modernist Islam[32] (Burhani, 2019; Sukidi 2006). Muhammadiyah describes itself as "an Islamic movement that supports al-amr bi al-maūrūf wa al-nahy an al-munkar (enjoining the right and prohibiting the wrong), promotes tajdīd (reform) and is focused on the Qurān and sunnah"[33]. The organization was founded in Yogyakarta in 1912 and gained support from the middle class. Kyai Ahmad Dahlan (1868–1923), an educated and pious Muslim (santri) who was also an aristocrat of the Kingdom of

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[30]Hilman Latief, "Health Provision for the Poor: Islamic Aid and the Rise of Charitable Clinics in Indonesia," *Journal of Southeast Asia Research*, Vol. 18, No. 3 (2010), 503-553.

[31]Robin Bush, "Muhammadiyah and Disaster Response..., 38.

[32]Ahmad Najib Burhani, "Muhammadiyah", In Oxford Islamic Studies Online. Oxford Islamic Studies Online, http://www.oxfordislamicstudies.com/ article/opr/t343/e0296 (accessed August 15, 2019.

[33]Muhammadiyah, *Anggaran Dasar dan Anggaran Rumah Tangga Muhammadiyah*, Yogyakarta: Pimpinan Pusat Muhammadiyah, 2010.

Yogyakarta, is the key figure in the organization's establishment, shaping, and development.[34]

The Muhammadiyah mission has been successfully enforced by achieving considerable results in three areas: education, health care, and philanthropic activities. In education, by replicating Dutch school, Ahmad Dahlan set up its first elementary school and modernized the teaching-learning system. Muhammadiyah is today one of the largest faith-based organizations in Indonesia offering educational services. The organization currently runs more than 10,000 kindergartens and playgroups, 3,626 primary and secondary schools across Indonesia, with a total of over 53,000 teachers and 812,000 students. A total of 171 universities/colleges in higher education, with 43,5922 students in 2017 and 49,6629 in 2019 (Muhammadiyah database, 2019). The health education institutions funded by Muhammadiyah include 12 medical schools, 22 pharmacy schools, and 37 nursing schools.[35]

Muhammadiyah's desire to provide for society has also been reflected in the provision of health care. In 1920, Muhammadiyah founded Penolong Kesengsaraan Oemoem (Public Suffering Relief Assistance), a sort of special unit for serving and helping the needy. The first Muhammadiyah's clinic was built in the village of Jagang Notoprajan, Yogyakarta, on February 15, 1923, and became Muhammadiyah's first hospital in early 1970. The name PKO had changed to PKU (Community Welfare Builder) in the 1980s. PKU established the Center for Disaster Management to respond to increasing natural disasters in Indonesia in 2007 and founded the Muhammadiyah Disaster Management Center (MDMC) during 2010 during the National Congress. PKU hospitals remain the

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[34]Amelia Fauzia, *Faith and the State: A History of Islamic Philanthropy in Indonesia*. Leiden and Boston: Brill, 2013.

[35]Majelis Pendidikan Tinggi Penelitian dan Pengembangan, Direktori Perguruan Tinggi Muhammadiyah & Aisyiyah, 2019.

backbone of the medical teams. The term PKU was revitalized after the 2015 Muhammadiyah Congress to become Pembina Kesehatan Umum (Public Health Advisory) and concentrate on promoting health activities within the organization.

Muhammadiyah and 'Aisyiyah, a women's group within Muhammadiyah, currently have 103 hospitals and 256 clinics. Most of Muhammadiyah hospitals have been approved by the government. About 50 percent of hospitals are located in the provinces of East Java and Central Java. Many of those hospitals experienced the transition from maternal and child health maternity clinics to full hospitals. Muhammadiyah hospitals are actually in a position to serve people who do not have access to expensive private health care but who can afford to pay small fees[36]. This approach is in line with Muhammadiyah's principles, which support the vulnerable and provide access to people in need of aid.

Today, Muhammadiyah is not only Indonesia's largest but also Indonesia's oldest modernist movement. At the last national congress in 2015, Muhammadiyah proclaimed the ideology to be Islam Berkemajuan (Progressive Islam), meaning an Islam that accepts progressive ideas to create an enlightened society and become mercy for the universe[37] The organization has now begun spreading to many nations. Internationally, there are separate branches in the United States of America, Egypt, Singapore, Thailand, China, Taiwan, and Germany. The organization opened a school in Australia and Malaysia, and in Egypt in 2018 and 2019. In addition to developing its branches overseas, Muhammadiyah's participation in the humanitarian mission overseas through its philanthropy is gradually widening its understanding of the Islamic

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[36]Rosalia Sciortino, Ridarineni, Neni & Marjadi, Brahmaputra, "Caught between...
[37]Pimpinan Pusat Muhammadiyah, *Tanfidz Keputusan Muktamar Muhammadiyah ke 47*, 2015, 8.

definition of humanity[38].

The Movement of Muhammadiyah has gained support from its members and sympathizers, including employees employed in its thousands of institutions (hospitals, colleges, universities, banks, etc.) Muhammadiyah therefore tried to establish a kind of collective health insurance in 1987, called Dana Sehat Muhammadiyah (Muhammadiyah's health fund-MHF). This project aims to provide health care services to the Muhammadiyah community, particularly for kindergarten students through higher education. MHF has served as insurance in the group. Students pay a small sum of money via school administration (currently Rp 75,000 or USD 6 a year) to be able to receive benefits from Muhammadiyah's medical facilities and services. The benefits list contains the following: 1) regular doctor visits in the clinics, first-level ambulatory treatment at schools, health education, equipment and medicines; 2) advanced treatment in the ambulance, doctor's examination, radiology, ECG, EEG, MRI, drug reimbursement; 3) emergency response; 4) rehabilitation programs; 5) compensation against injuries.

Members and sympathizers of Muhammadiyah have been very positive about this health insurance initiative. From 2013 to 2015, MHF participants, mainly students studying at schools or universities in Muhammadiyah, grew to 55,000. According to Ms. Salimah, MHF chairperson, the program's popularity is because the installment is relatively inexpensive, and the procedure is easy[39] (Interview 2018). Two years after the introduction of National Health Insurance (NHI) in 2014, however, the number of members who participate in MHF dropped in 2016. The "predatory" character of NHI, which pressured all organizations in

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[38]Hilman Latief and Nashir, Haedar, "Local Dynamics and Global Engagements of the Islamic Modernist Movement in Indonesia: The Case of Muhammadiyah", *Journal of Current Southeast Asian Affairs*, Vol. 39, Issue 2 (2020), 290-309.

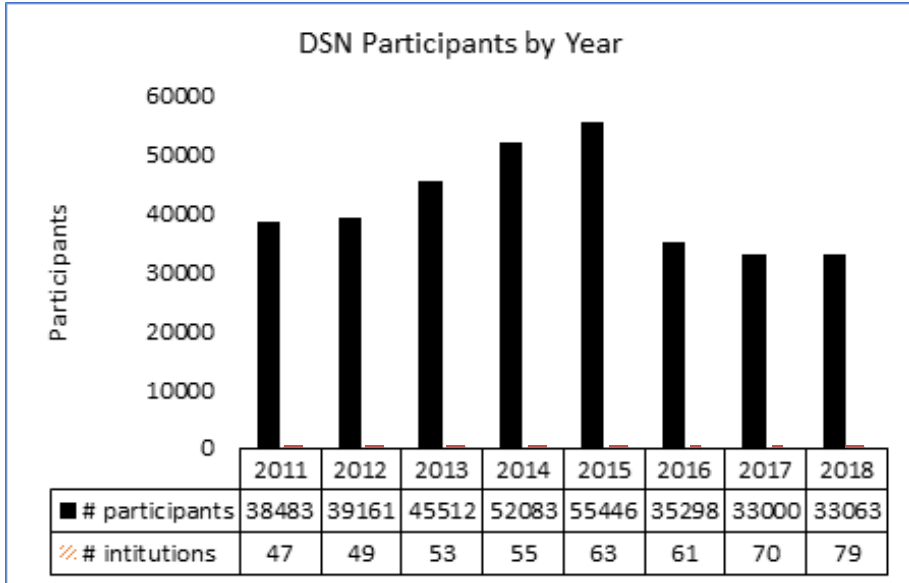[39]Siti Salimah, Director MGH interview, 2019.

Indonesia to become part of NHI, appears to have dramatically sidelined the positions of community-based health insurance.

The table below shows that when MHF was introduced to the Muhammadiyah communities through its institutions, such as schools, universities, and hospitals, the number of participants increased from 2011 until 2015. Three years after, the trend shows the decline of member participants, even though participating institutions increased. It should be noted that MHF membership mainly relies on the support of 'internal Muhammadiyah' institutions. Muhammadiyah schools and universities take initiatives or even urged by the organization to enroll the students in the MHF scheme. This effort aims to provide a more organized and affordable but precise health insurance scheme. Just like other people participating in the CHI/CBHI in many developing countries, the enrollment of Muhammadiyah institutional and individual in MHF is "to reduce the anxiety of falling sick when they may not have funds[40]. CBHI gain support from people in the communities because it can provide health coverage "to persons with limited protection from other sources, such as those who are not engaged in formal sector employment"[41] (Bennet 2004: 148). Nevertheless, in the case of MFH, the participation of lecturers, students, and other employers working in the Muhammadiyah institutions is not only "to reduce anxiety" but also to support the existing Muhammadiyah hospitals or clinics.

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[40]Robert Basaza, Criel, Bart. Stuyft, Patrick Van der, "Community Health...", 181.

[41]Sara Bennett, et al., "The future of health markets". *Global Health*, Vol. 10, No. 1 (2014), 51.

Table 1. The Number of Participants in Muhammadiyah Health Fund (DSM) 2011-2018

DSN Participants by Year

	2011	2012	2013	2014	2015	2016	2017	2018
■ # participants	38483	39161	45512	52083	55446	35298	33000	33063
⧄ # intitutions	47	49	53	55	63	61	70	79

The Muhammadiyah case in Cileungsi-West Java may be an example of how CBHI operates under the Muhammadiyah health coverage system. The leaders of Muhammadiyah in Cileungsi set up a kind of community-based health insurance, which shares some similarities with MHF. There is a clinic arranging such policies with various plans for the students and the employee plus the family. With such limited membership on a monthly basis, the clinic offers health education, a routine medical check-up every six months and it protects from injuries while workers and families pay benefits with the company subsidizing 40 percent. The insurance is going to be top of NHI insurance. The Cileungsi Group, a total member of 1,300, is able to continue this initiative from 2011.

Meanwhile, Muhammadiyah University of Yogyakarta (UMY), one of the largest universities affiliated to the Muhammadiyah movement, has

experienced a dynamic process of engaging MHF. For many years, this university (UMY) enrolled more than 15.000 people of their students, lecturers, and administrative staff in the Muhammadiyah Health Fund (MFH). However, the university should face "double burdens" as the government enforced NHI Law to all employers, including universities, to enroll their employees in the government scheme. Therefore, the chairman of the university decides to reduce its double payments by withdrawing its participation from MFH and fully register its employees to the National Healthcare Insurance (NHI). Suryo Pratolo[42], the Vice-Rector for Human Resource Development and Finance of Muhammadiyah University of Yogyakarta (2013-2017) confirms that the University's decision was reasonable at that time. The university should pay what he termed "sunk cost", meaning that they should pay (to MHF) for health insurance whose services were not used by the employers. As a second buffering health scheme, the university operates its internal micro health coverage for the employees and their three family members. He also said that "we participate in the NHI because of the mandatory regulation from the government" (Interview with Suryo Pratolo, 2019). Seen from the experience of Muhammadiyah University of Yogyakarta's experience and other Muhammadiyah institutions, it can be argued that the government scheme has significantly sidelined community-based health care. As the MFH faces a delicate situation, the Muhammadiyah movement attempted to preserve the presence of hospitals and clinics by making a partnership with the NHI scheme. Seen from the experience of Muhammadiyah University of Yogyakarta and other institutions of Muhammadiyah, it can be argued that the government scheme has considerably overshadowed community-based health care. As the MFH faces a delicate situation, the Muhammadiyah movement has tried to maintain the role of hospitals and clinics through cooperation with the NHI scheme.

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[42]Interview with Suryo Pratolo, 2019.

Uneven reconciliation with the National Health Insurance

The Muhammadiyah president signed a Memorandum of Understanding (MOU) with National Health Insurance (NHI) in 2018 and was renewed in 2021. The MOU[43] is a collective agreement on: (a) expanding coverage (Muhammadiyah membership in the JKN scheme and low-economy group donation payment); (b) expanding access / supply side (a special agency responsible for administering the National Health Insurance Fund / BPJS established or associated with Muhammadiyah hospitals and health clinics). This partnership provides Muhammadiyah members (a) a broader spectrum of benefits, including access to the network of providers not operated by Muhammadiyah and (b) a transition from equality to fairness (previously, DSM offered the same health benefits to all members regardless of needs). Muhammadiyah also obtains premium NHI coverage for any insurance issue. As a result, MOU's success was significant; Muhammadiyah-owned health facilities are one of BPJS Health Providers' biggest networks. Since 2014, NHI has leased 73 percent of hospitals. NHI is in the process of obtaining accreditation, licensing, and meeting terms and conditions set by the non-contracted facilities.

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[43]Memorandum of Understanding between BPJS and Muhammadiyah, 2021.

Figure 1. Number of Muhammadiyah Hospital and Clinics
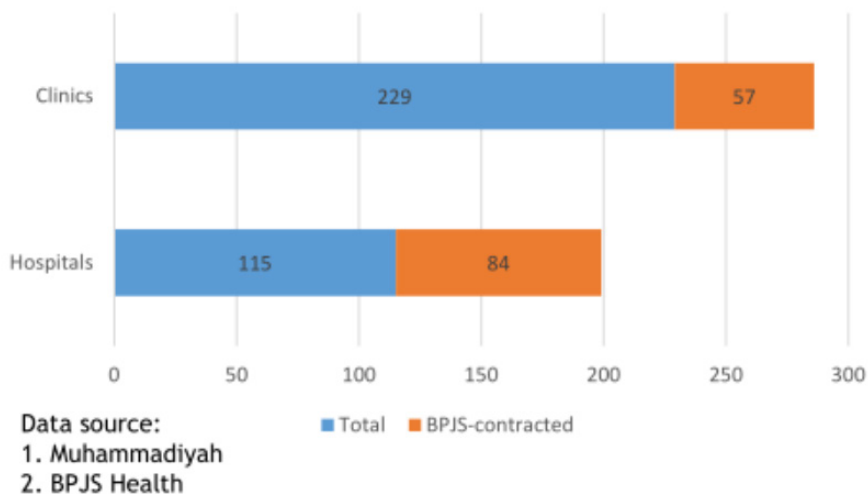
With this agreement Muhammadiyah became biggest group of hospitals in term of number of patients—more than 12 million annually and 2.5 trillion IDR (1.7 million USD) claims. Both parties share the same interest which is helping those in needs. Definitely create demand for hospitals, especially outside big city, cooperation with BPJS is compulsory in order to survive. Most of the Muhammadiyah hospitals serve 60 to 90% of its capacity to BPJS member.

The relationship between BPJS and Muhammadiyah creates financial burdens within Muhammadiyah hospitals. Some hospitals in Muhammadiyah face a delicate situation due to BPJS's reimbursement scheme. Unclear payment plan and denial of claims from hospitals are among the most common problems that the hospitals face. At the end of 2019, there was a dispute on social media over the financial pressure within Muhammadiyah hospitals. It was reported that a delayed payment from the BJPS, nearly one trillion rupiahs, shook the cash flow of some

Muhammadiyah hospitals that serve people in several regions. In this regard, it can be argued that community-based health insurance, such as MFH, was a "victim" of the coercive existence of NHI. At the same time, community-based health care such as Muhammadiyah hospitals and clinics sponsored the NHI program through its reimbursement system.

Covid19 pandemic effect

February 2020 covid19 virus was found in Indonesia; since then numerous impacts were experienced in Indonesia economic, education, social and health. The Indonesian economy in 2020 experienced a growth contraction of 2.07 percent (c-to-c) compared to 2019. From the production side, the deepest growth contraction occurred in the Transportation and Warehousing Business Field by 15.04 percent. Meanwhile, from the expenditure side, almost all components contracted, the Component of Exports of Goods and Services became the component with the deepest contraction of 7.70 percent. Meanwhile, imports of goods and services, which were a reducing factor, contracted by 14.71 percent. All schools went online while most of the company were working from home[44].

As per 1st April 2021 they were more than 1.5 million infected and 1.3 million recovered with more than 200 thousand fatality left. The number of patients dropped drastically as low as only 20% compared to normal period. According to Budi[45], MHF Director, the organization has faced big challenges during the Pandemic such as:

1. Visits to school are not optimal, due to study at home, so they are only for teachers and employees.
2. Many schools have not paid premiums, because schools are also faced financial burden.

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[44]Biro Pusat Statistic 2012.

[45]*Interview with Budi, new Director MHF, 2020.*

3. MHF is difficult to supervise and coordinate, due to pandemic.

Despite the challenges, all the impact of covid19 pandemic the MHF may exemplify an alternative solution of health insurance with lower costs and optimal benefits while having national insurance became expensive for lower economy class. MHF has the opportunity to communicate better to their customer, with 10% of national health insurance students may benefit certain medication treatment.

Conclusion

In a situation where low-income families are increasingly in need of stable financial help for health, the existence of the National Health Insurance (NHI) can play an important role in responding to people's concern over health care coverage. On the one hand, compulsory NHI membership to all workers will progressively increase awareness of universal health coverage among citizens. This legislation, on the other hand, has a significant effect on current community-heath policies. The rise and fall of the Muhammadiyah Health Fund (MHF) can reflect how civil society, including faith-based NGOs, copes with a delicate situation in managing their financial health coverage following NHI 's intervention.

MHF appears as a continuum of the welfare vision of Muhammadiyah. It was focused on mutual-help among community members. Interestingly, when NHI overshadowed MHF, the efforts to maintain MFH as an alternative way to provide health coverage remained strong, mainly sponsored by students studying at schools in Muhammadiyah. In a nutshell, MFH remains "like an ant walking alongside an elephant"— small but still alive. This paper also argues that other forms of community-based health coverage often exist within the Muhammadiyah in the form of "micro and self-management health insurance," such as what can be found in the Cileungsi-West Java branches of the Muhammadiyah University of

Yogyakarta and the Muhammadiyah. These two types of micro- and self-management health insurance depend on university and community-run clinics.

Under these conditions, it can be argued that community-based health insurance remains at the crossroads in Indonesia because they face significant challenges from the current welfare system implemented by the government under the NHI program. With millions of members, thousands of schools, and hundreds of hospitals under Muhammadiyah's umbrella, the Muhammadiyah Health Fund (MHF) will survive with difficulty. However, other community-based health insurance programs, which are not underpinned by adequate health services and their supporting structures, can be challenging to obtain trust and support from the communities. Last but not least, the kind of MHF by Muhammadiyah can be an alternative solution to gain UHC within low economic situations.

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