

Risk Privatization: COVID-19 and the Urgency of Health Reform in Indonesia

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Abstract

In the last twenty years after the political reform, health services in Indonesia have still been heavily reliant on the citizens' purchasing power. As a result, the health system and citizens' health have become unprepared in the face of the COVID-19 pandemic, as the system is stuttering and underfunded. This study examines how the economic and social costs of the COVID-19 pandemic are being shifted from the Indonesian government to the affected Indonesian citizens. This article provides a current review of the handling of COVID-19 and emphasizes the importance of health reform in Indonesia. In discussing these risk shifts, our study raises concerns about the privatization of risk in the wake of pandemics. In this study, data and information were prepared and obtained from various sources, namely, literature review, mass media analysis, and documents' analysis focusing on risk privatization, health sociology, and health politics in Indonesia.

Key words: COVID-19; Health Reform; Indonesia; Risk Privatization; Social Restrictions

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Introduction

Effective management of every disaster is inseparable from the quality of social institutions, (Clarke & Short, 1993) particularly the health system and health services. The unpreparedness of health services and system in handling the continuing COVID-19 outbreak, however, has been an infamous result of technical inability and also a result of past and present policy choices. The first task of science and public policy is to find the anti-virus or antibodies against Coronavirus immediately, where research and investment must be directed there. However, from the social science perspectives, the issue is not that simple; coronavirus has fundamentally changed the community ecosystem entirely (Kabadayi et al., 2020).

The economy has collapsed, and the socio-economic impact must be overcome. Not all people keep physical distance and wash their hands. Not all political leaders and elites prioritize health or health security more than the economy. Not surprisingly, the priority research agenda by WHO entitled *A Coordinated Global Research Roadmap*, which was launched in March 2020, has recognized the

critical role of social science. The document states the importance of social science in understanding contextual vulnerability; in understanding how decision-makers in the field weaken the objectives of handling a pandemic; and how the socioeconomic impact of the disease must be mitigated. Various studies on public health, social, and behavioral science can help generate not only new knowledge but also the knowledge that solves problems (Bavel et al., 2020).

In the context of Indonesia, there are critical questions raised that are not only important for the handling of the COVID-19 today but also for the medium term after the pandemic (4-5 years), among others: (a) whether the pandemic will harden divisions in society or it will strengthen solidarity and cooperation between those who work and those who do not work; (b) whether the COVID-19 crisis will enhance science and technology in both the health services and other fields such as education, social, and economics; and (c) whether this pandemic will strengthen the role of the State in the health service and system in general, leaving behind the old-fashioned approach which heavily relies on the market and people's purchasing power (out of pocket).

This study examines how the economic and social costs of the COVID-19 pandemics are being shifted from the Indonesian government to the affected Indonesian citizens. Those costs include loss of jobs and, most importantly, risks to personal health. However, it is difficult to predict and measure the health externalities of the COVID-19 when much uncertainty exists about the scale of the disease itself. This paper argues that risk has been shifted to the citizens as Indonesians have been encouraged to return to work that is highly risky to get exposed by the COVID-19. It also examines government agencies' efforts to shift the disaster's externalities through inadequate rapid testing, poor risk communication, limited social safety net, and other policies that hand over costs to citizens.

Literature Review

When the COVID-19 arrived, it was clear that all countries, institutions, and industries were not prepared for the subsequent health and socio-economic crisis (Laurencin & McClinton, 2020). Although the medical community has had experience in the past, the unprecedented nature of this crisis was a complete shock to the system. In particular, the health care system quickly realized that the rapid influx of citizens was out of balance with supplies for personal protective equipment and ventilators (Ranney et al., 2020). The number of mortality rates and rates of infection was further used to consider the debates of the COVID-19 and its risk (Zhou et al., 2020). However, it remains difficult to conclude and compare the likely death rates from infection rates since there are so many different testing approaches across countries (Brown, 2020; Li et al., 2020). While members of society have many reasons to distrust the public health system, the current pandemic also represents the growth of mistrust between science and politics (risk denial), which is often motivated by political ends (Erduran, 2020).

What does sociology have to say about pandemics and emerging infectious diseases? There is a shift beyond the classic sociological focus on societal reactions and the social construction of diseases and pandemics (Powers & Xiao, 2008). The spreading of infectious diseases has raised many other issues, including the interplay of public health and national security, as well as the dynamics of health governance. Instability, uncertainty and even socio-economic crises can break down the social order as everything we have taken for granted suddenly become different (Cell, 2020). For a moment, our world and routine can become sociologically strange. It raises provocative questions for policy and implementation worldwide, especially in understanding social structures and processes (Dingwall et al., 2013).

We need more studies on knowledge, attitude and practice regarding risk assessment and acceptance of public health measures for COVID-19 to help the general public address some issues such as anxiety, fear (Abdullah, 2020), and stigma associated with the COVID-19 (Gupta et al., 2020; Logie & Turan, 2020). There is also a need to understand the effect of government public-health policy and COVID-19 management: quarantine, isolation, lockdowns or targeted lockdown (Acemoglu et al., 2020), social distancing (Nicola et al., 2020), and new normal. The determinant factor of sustainable public health is measured not only by the psychosocial and physical well-being of individuals but also by the socio-economic status of the whole community. Data and information on the public health system

must have a strong capability and accountability to address issues based on the dynamics of COVID19 and the effectiveness of the control measures (Bedford et al., 2019). For these reasons, the most critical and tangible contribution of social sciences is to build strategies, narratives, and practices that are more inclusive while fostering trust, cooperation, and communication across social divisions.

The old paradigms relied on countries protecting their territories from the entry of infectious diseases by controls at borders. New paradigms have emerged in a context of globalization that needs new institutional flexibility in response to the increasing economic, political, and social interdependence of the modern world. This shift is motivated by the global interconnectedness and ideas to find ways to increase its efficiency in response to pandemics (Figuié, 2014). As such, new modern risks take the form of contested knowledge illustrated by the diversity of viewpoints and values from which their 'reality' and acceptability can be constructed and evaluated (Neely and Nading 2017).

A modern approach must be able to integrate tools and practices from a diverse range of fields including mental health and psychology, humanities, politics, and diplomacy and security (Holmes et al., 2020). We believe that such an approach needs to become the norm for the curriculums of schools of public health around the world. It will also train new generations of epidemiologists so that they have the skills, knowledge, and networks to recognize and make use of every tool available to help them do their work effectively. Only then will we be able to maintain the comprehensive and useful response needed to stop epidemics and protect people's lives, no matter the circumstances (Bedford et al., 2019).

The advanced approach brings its challenges into the governance of institutions, leadership, collaborations and interventions. It must be free from something that can undermine trust in the organizations that respond to an outbreak, including the abuse of power and misuse of funding (Khemani, 2020). Prevention, mitigation, and intervention plans must be as inclusive as possible (Petretto et al., 2020). A commitment to inclusion means responding to the COVID-19 in a way that is sensitive to our most vulnerable communities (Wenham et al., 2020), including poor people, those without adequate insurance or employment, women and elderly, people in prisons, indigenous communities, immigrant communities, people with disabilities, and the healthcare workers and emergency responders (Ahamed & Gutierrez-Romero, 2020).

The COVID-19 also represents shared risks that cross borders and societies. Health systems, routine care, trust in governments, travel, trade, and business are all disrupted during an epidemic (Peeri et al., 2020). With such broad risks, the preparation and response must be nationally owned and led, internationally supported, and undertaken with a whole-of-society approach. Since risk perceptions of the COVID-19 correlate strongly with socio-cultural factors across countries (Dryhurst et al., 2020), a focus must be building coordinated regional and country expertise, resources, and capacity through national and regional public health institutions.

Risk is privatized when organized institutions renegotiate social and economic contracts so that risk is shifted to individuals, who are made responsible for assuming costs (Nadesan, 2013). The privatization of risk is a global social trend occurring in a myriad of ways as risk is shifted from government and corporations to private citizens. Jacob Hacker, the US sociologist, described how economic risk was being displaced from government and corporations to individuals and their families with the reduction of education, health, and welfare benefits (Hacker, 2006). Naomi Klein also found the privatization of risk occurring in the response and aftermath of varied disasters ranging across the 2004 Asian Tsunami, 2005 Hurricane Katrina, and the Greek financial crisis of 2012 (Klein, 2007). Across financial and environmental crises, the resulting privatization of risk promoted personal autonomy and action over social interventions, mainly when powerful opposing interests were involved.

Understanding how social arrangements change when natural or biological environments disrupted is the core contribution of the sociological imagination to policy and practice (Armstrong et al., 2020; Simpson & Elias, 2011). With rapidly changing ecology, urbanization, climate change, increased travel, and fragile public health systems, pandemics will become more frequent, complex, and harder to prevent and contain (Harapan et al., 2020). Response to pandemics must evolve from crisis response during discrete outbreaks to an integrated cycle of mitigation, response, and recovery. This is an opportunity to combine knowledge and skills from all over the world (Buheji, 2020), but it requires a new approach to training tomorrow's leaders in epidemic prevention and response. We should consider pandemics not as discrete events, but rather as connected cycles. The challenges are real: future

pandemics will be fueled by conflict, poverty, climate change, urbanization, and the broader demographic transition.

Research Methodology

In this study, the authors used various public records, mass media, and other physical evidence related to handling COVID-19 in Indonesia. Authors also use audio-visual recording sources, webinar presentations, focus group discussions, and other official public speeches conducted by the government and experts as complementary materials for conducting analyzes related to this study. Visualization of the Indonesian population's mobility - includes places like restaurants, cafes, shopping centers, theme parks, museums, libraries, and movie theaters - during COVID-19 is obtained from Google's mobility trends (period February 17 – October 4, 2020). A systematic analysis was carried out on both printed and electronic documents to gain insight into how the Indonesian government manages COVID-19 in Indonesia using ATLAS.ti.

The authors coded various collected materials and then categorized the data and information into specific categories. Only sources associated with the handling of COVID-19 and releases from the government, media, and official institutions were analyzed (N=53). This document can discuss national and local developments in the Indonesian territory. The analysis not only looks at the framing used by the Indonesian government in controlling the pandemic but specifically also highlights the health sector's performance as the main backbone of the fight against COVID-19. Using this tool and method, we developed tables that show the frequencies of our codes and code groups. We were able to show how many times a specific code was used in a particular document (absolute frequencies) and relative frequencies while we can still refer to the quotations behind each frequency count. In the final steps of document analysis, we exported the code-document table and included it in this article (see table 1).

Table 1. Code-Document Table for Systematic Document Analysis (N=53)

No	Code Groups	Coded Document	Freq. (%)
1	Isolation & Hospitalization	positivity rate / recovery rate / type of hospital / hospital capacity / capacity of isolation room / death of healthcare worker / digital tombs / separation of patients / chaos/ independent isolation / quarantine/ peak of pandemic/ "wisma alit"	73.6
2	Safety net/Social Assistance	interest subsidies for micro businesses / targeted social assistance / social assistance corruption / social assistance benefits / cash assistance / village funds / social assistance evaluation / wage subsidies / universal healthcare / internet subsidies/hope family programs	56.6
3	Provision of Vaccines	vaccine production / vaccine collaboration / vaccine raw material / vaccine production / vaccine price / vaccine access / vaccine budget / free vaccination/ Covax	54.7
4	Government responses	COVID-19 control / government denial / health crisis / economic crisis / weak coordination / failed handling/ budget transparency/stimulus effect	28.3
5	Physical distancing protocols	physical distancing / PCR test / tracing ratio / face mask / body immunity / lack of discipline / sanctions for violators/ Large-Scale Social Restriction/DKI Jakarta	28.3
6	Sectoral impact of COVID-19	unemployment rate / impact on business / maternal and child health impact / impact on hotels and tourism / employment impact / impact on auto sector / impact on financial sector / workers affected by COVID-19	20.8

From the coding system that has been implemented, it appears that the discourse on COVID-19 in Indonesia that emerged from February to October 2020 was converging on six major topics; the chaos problem of handling COVID-19 patients in hospitals (73.6%), social assistance provided by the government (56.6%), debates on the provision of vaccines (54.7), to various criticisms of the denial and

slow response of the government (28.3%). Physical distancing protocols (28.3) - especially over social restriction policies in the capital city - were also a significant concern and controversy of both public and Indonesian governments. From this general description, it can be concluded that the fragility and unpreparedness of Indonesia's health system are the most worried by the Indonesian public. It means that there are public health risks at stake. Another big problem is the distribution of government aid, which has received a lot of criticism.

Results of the study

Managing Health System and Services During the Outbreak

In response to the COVID-19 pandemic, the Indonesian Government has taken several strategic steps, including, first, forming the Task Force chaired by the Head of the National Disaster Agency, which gathers various scientists from various fields including epidemiologists. The government has also conducted large-scale social restrictions in areas with high transmission rates, including DKI Jakarta, West Java, Central Java, and East Java. Second, the Ministry of Finance has reallocated and refocused the budget, where more than IDR 80 trillion was prepared for the health sector, social assistance, and economic recovery including tax incentives and loan delays. There are at least eight types of social assistance reported by the government: electricity subsidies; expansion of PKH beneficiaries; food assistance for Jakarta, Bogor, Depok, Tangerang, and Bekasi (Jabodetabek) residents; and IDR 600.000cash assistance per month for non-Jabodetabek residents.

Third, the government has allocated IDR 75 trillion to the health sector to strengthen health workers' capacity, as well as to the supply and procurement of medical devices and medicines related to the handling of the COVID-19. Fourth, the Ministry of Research and Technology has formed the COVID-19 Vaccine Development Team, in hope that Indonesia would not depend on vaccines produced by other countries. Fifth, through the Ministry of Foreign Affairs, Indonesia has collaborated with CEPI, an international network of hardware in Norway, to access the vaccine.

Table 2. List of Government fund allocation to mitigate the impact of the COVID-19¹

No	Programs/Sector	Total Budget	Target/Recipients
1.	Health Sector	75 trillion rupiahs	
	a) Medical equipment	65.8 Trillion rupiahs	Medical equipment, health facilities and human resources
	b) Incentives for health workers	5.9 trillion rupiahs	Incentives for specialist doctors 15 million rupiahs/month, general practitioners 10 million rupiahs/month, nurses 7.5 million rupiahs/month, other health workers and hospital administration personnel 5 million rupiahs/month which will be given for 6 months in 132 referral hospitals
	c) Death benefits	300 billion rupiahs	Death benefits for health workers: 300 million rupiahs/person
	d) Contribution for National Health Insurance (JKN) BPJS Healthcare	3 trillion rupiahs	30 million rupiahs/people (14 million people with class 3 PBPU and 16 million rupiahs/participants who have just shifted to class 3 PBPU)
2.	Tax incentives	70.1 trillion rupiahs.	
	a) Tax is borne by the government for PPH Art.21 and VAT	52 trillion	Expansion of taxes borne by the government
	b) DTP Import Duty	12 trillion	Expansion of import duty exemption
	c) KUR stimulus	6.1 trillion	Postponement of principal and interest payments for all KUR schemes affected by COVID-19 for 6 months
3.	National economic recovery	150 trillion rupiahs.	Distributed through financing policies, including stimulus for ultra-micro
4.	Social Assistance (Safety Net)	110 trillion rupiahs.	

a) Electricity subsidies	3.5 trillion rupiah.	Approximately 24 million customers (450 VA) and 7 million customers (900 VA). The exemption of 450 VA electricity rates and 50% discount on electricity rates for 900 VA. The validity period of this waiver is April-June 2020.
b) Additional distribution for PKH	8.3 trillion rupiah	The budget allocation for PKH in APBN 2020 was 29.1 trillion. Therefore the total allocation become 37.4 for 10 million Beneficiary Families (KPM)
c) Additional distribution for Pre-Employment Card	10 trillion rupiah	A total budget of 20 trillion rupiah for 5.6 million participants
d) Additional distribution for staple food card	10.9 trillion rupiah	A total budget of 43.6 trillion rupiah for 20 million recipient families.
e) Additional housing incentives for Low-Income Communities (MBR)	1.5 trillion rupiah	175000 units
f) Other Social Safety Network Programs	30.8 trillion rupiah.	(Still need to be coordinated)
g) Reserves to fulfill basic needs and market/logistics	25 trillion rupiah	(Still need to be coordinated)
h) Adjustments to the education budget for handling COVID-19	20 trillion rupiah	-

¹ Ministry of Finance, Republic of Indonesia (March 31, 2020)

However, observers assess that from the beginning of February 2020 to the end of February 2020, the government initially did not appraise the severity of the coronavirus and tended to lose momentum to begin preparations. It seems that the government has been more worried about the economic impact than the health impact on the public. Although Indonesia officially stated that the COVID-19 had been detected in the country since early March 2020, various mass media reports exposed actual health service unpreparedness, including in the cases of:(1) late allowance payment for nurses in Jakarta; (2) small number of mass tests to help detect a decrease in infection rates; (3) high number death of health workers due to the lack of personal protective equipment (PPE); (4) lack of procurement of goods and medical devices; and (e) late collaboration between the Ministry of Health (MoH) and non-MoH laboratories. Media monitoring also documented that the government was not transparent regarding data, including data on the death cases, where it tended to report lower numbers than the actual reality.

According to our data from the mass media reports, the costs of the COVID-19 tests vary across agencies. Although free tests are available, people are required to take independent tests if they are to travel or enter a city in Indonesia. For example, when people want to take the train, they will be required to do a rapid test, PCR test, or influenza test. In June 2020, when the relaxation of the PSBB was implemented, many workers were required to have COVID-19 test results, including pilots, drivers, and employees who planned to go in and out of Jakarta. Nevertheless, what happened was that the test costs were borne by those individuals and were relatively expensive, ranging from IDR 300.000 to 500.000 (the average wage in Indonesian is IDR 3-5 million per month).

Gaps in test ratios

The number of tests conducted in Indonesia is still far from WHO standards. Various parties including journalists and CSOs have repeatedly urged the government to undertake very serious efforts to increase the COVID-19 mass tests. INFID, for example, has urged that a mass test of 500.000 be held since the beginning of April 2020. In June, the Minister of National Development Planning Agency stated that the number of COVID-19 tests should be 30.000 according to WHO standard, while Indonesia had only reached 11.000 per week.

As shown in Figure 1, per July 6, West Java was the region with the lowest COVID-19 molecular-based tests (PCR) in Java (1,736 per one million citizens). It was then followed by Central Java (1.777

per million), East Java (1.877 per million), Banten (2.320 per million), Yogyakarta (5.119 per million), and Jakarta (26.527 per million). Based on this number, only Jakarta has met the minimum WHO test standard. Nine provinces are lacking the ability to analyze COVID-19 samples using PCR. With the high-test gap in Indonesia and the number of rapid test abuses, these regions need to focus on increasing PCR tests.

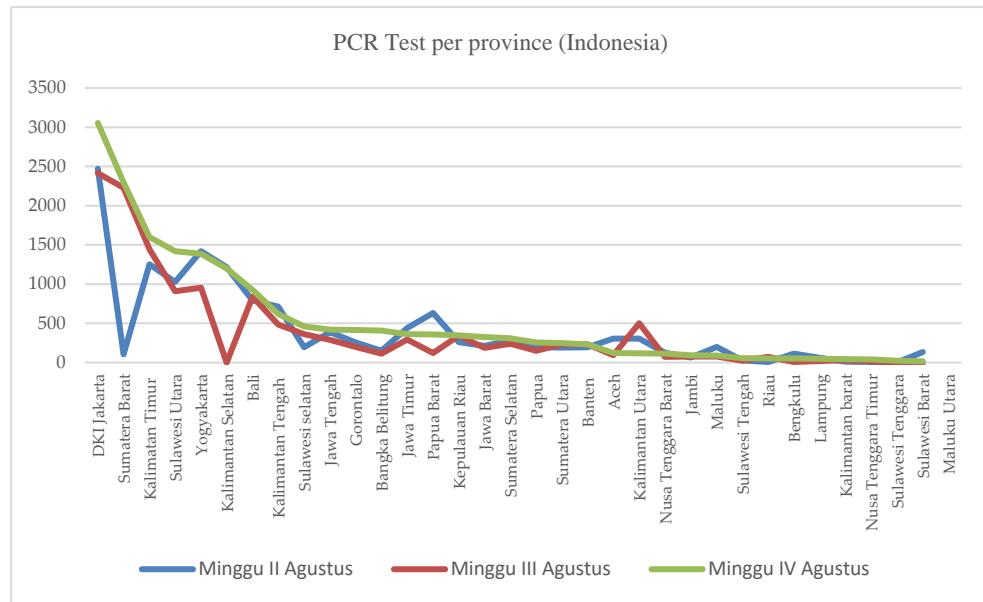


Figure 1. PCR Test Results per Province/per one million citizens (last updated: July 6, 2020)

On July, 20, the government announced 88,214 confirmed cases of COVID-19, with 4,239 deaths, from all over the country. The government also declared that 46,977 people had recovered from the illness, and over 1.2 million specimens had been tested since the beginning of the outbreak (OCHA, 2020). Indonesia has become one of the few developing countries with high mortality rate (Turista et al., 2020) and major socio-economic problems due to fundamental mistakes in the practice of the government. This mismanagement has created huge socio-economic risks.

On the other hand, experts still see the rapid test as inaccurate because it only detects antibodies and is, therefore, unable to support the strengthening of the surveillance system: Test, Track and Isolate. Many people are positive but then are detected negative because the antibodies have not yet formed. Also, Hydroxychloroquine (Malaria Medication) has been included in the guidelines for treatment procedures and bought in large quantities, making people who need it most have difficulty getting it. Some studies suggest that Hydroxychloroquine has proven ineffective in treating people with COVID-19.

Problems with Applying Social Restrictions

Large-scale Social Restrictions (PSBB) in Indonesia is considered ineffective because they are not well-coordinated, well-monitored, well-measured, and well-evaluated. Complicated by licensing rules and unreasonable requirements, the proportion of the population living at home nationally does not have an impact on suppressing COVID-19 transmission. Communication on Social Restrictions is also seen as incoherent and not understood, causing confusion among the community and regional officials. Also, PSBB has hurt the socio-economic life of the population and turned off the economy of low-income households. The government should adopt a policy of local or environmental-based social restrictions (PSBL), where these restrictions are more reliable and effective because the strength of social capital drives them. Community involvement is the front line in successful pandemic response.

The government's efforts to divide the COVID-19 vigilance level into black, red, yellow, blue and green zones for PSBB must also be reviewed. Zoning arrangement has the potential to use invalid data and weak methodologies. A regional-based risk approach can be misleading because the population's mobility strongly influences the spread of cases (Aldila et al., 2020). The virus will follow the movement of people, without limits, and through silent transmission. The term Zoning has caused stigma and vulnerability associated with political or engineered interests; there are areas that refuse to test because they want to maintain a low-risk status against COVID-19. The movement to curve towards the green zone has also become a political agenda. Some regional heads asked their staff to minimize the PCR test and simply use a rapid test. Until now, the government mentioned many green zone areas with zero cases but did not mention their data on the number of tests or inspections. After all, it is evident that if there are no tests, there are no cases.

The government's efforts to encourage people to travel even in the midst of high COVID-19 spread has also caused controversy. Although the central government started a campaign to safeguard public health protocols, the policies issued by Transportation Minister has actually contradicted and complicated its realization. Openings of offices simultaneously, easing transportation and flight requirements that do not require PCR tests are some of those contradictory policies. Although many people do not understand the risk or rather neglect it, the component of failure in handling is mainly from the asynchronous policies that put citizens in a more-risky situation.

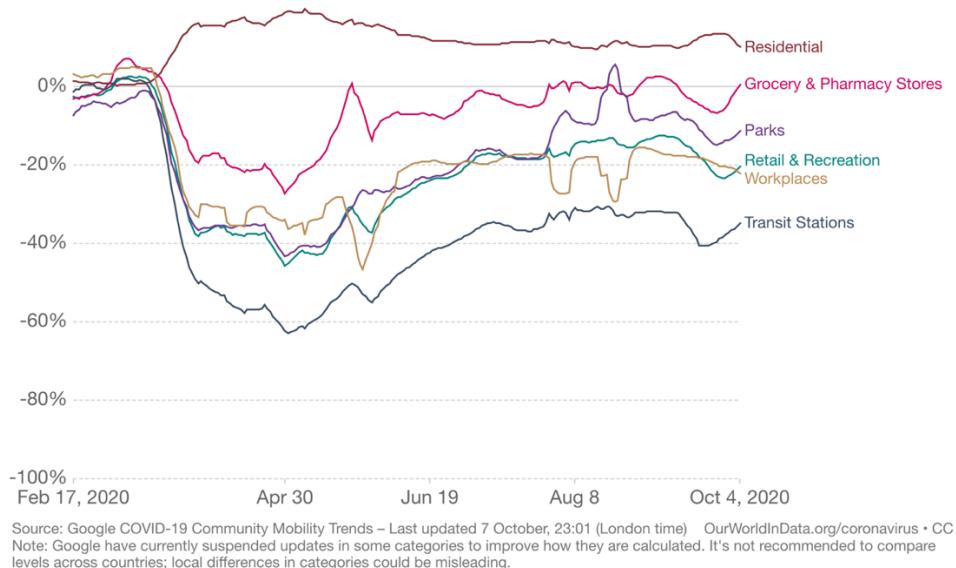


Figure 2. The data above shows how visitors to (or spent in) categorized places change compared to baseline days – the median value from the 5-week period from January 3rd to February 6th, 2020. Source: Google Community Mobility Report: <https://ourworldindata.org/covid-mobility-trends>

Conclusion & Recommendations

From the various evidence that has been collected, the government tends not to be present and shifts the burden of COVID-19 disease to its citizens. Although the number of infections is not as high as Brazil, the US and Mexico, victims among medical personnel in Indonesia rank high. This is not surprising because of the lack of PPE for health workers and the lack of preparation in the deployment of health workers. From the data of the COVID-19 victims in various countries, certain groups (elderly population and residents with congenital interpretations) have become the most victims of the COVID-19, but the number of victims among children is also significant in Indonesia.

The absence of the government is seen not only from the technical unpreparedness in handling the pandemic, but also from the neglect of health services outside the COVID-19, such as health services for women, immunization services, and services for tuberculosis (TB). The neglect of family planning services and maternal health is feared will drive an increase in birth rate. As a result, children prone to illness due to not getting immunized will also be widespread. As with the TB case, it will become more numerous and become a burden on society.

Social sciences and humanities seem to be less involved and utilized in helping manage the COVID-19 pandemic in Indonesia; in effect, to this day, we do not know for sure who and what groups of victims of the coronavirus are. Until July 2020, the COVID-19 Handling Task Force also did not have accurate data on this matter although they can be immediately used to reduce the number of infections. This may be interpreted as a technical imperfection but is also understood as a policy that consciously does not want to use data and science as a basis for policy making.

Shifting social risks to citizens is also apparent in the implementation of the social assistance programs. Although the government has planned and channeled their assistances, exclusion of many vulnerable groups, is still becoming an issue. As seen in a variety of reliable social surveys on the distribution of social assistance during the pandemic, it was found that the degree of mistargeting was quite high. As many as 60.3% of respondents in the Indonesian Political Indicators survey (June 7, 2020) assessed that the government's social assistance was not on target.

The most valuable lesson from the COVID-19 pandemic is that our health system, for the last 20 years, is still too dependent on the purchasing power of citizens. This can be seen from the data on Indonesia's health expenditure that is dominantly derived from OOP (Out of Pocket) compared to government spending. At the same time, the state's role is needed so that the health system produces micro and macro efficiency. Besides, the primary mission of health institutions is to become a superior, efficient, effective, and accountable health provider. Health institutions will be more efficient and effective if, and only if, health institutions develop governance and accountability, including social accountability in terms services to users and citizens.

Looking at Indonesia's conditions and the situation today, it appears that health institutions in Indonesia have not been monitored, evaluated, and improved for too long. The Ministry of Health and Social Protection management (BPJS) have not been designed to deal with large-scale disease transmission such as the COVID-19. Health services need to better design citizen-based services and internal reforms of the bureaucracy. Access, availability, and convenience of health services must be a long-term priority. In the 2020 National Budget, the Indonesian President has allocated IDR 75 trillion for the health sector, the highest amount in the history of the State Budget for the health sector. Seriousness and the right policy strategy are needed so that health reform can go hand in hand with the handling of pandemics. Without improved governance and accountability, we will never know whether the Ministry of Health and BPJS is part of the problem or whether the increase in National Budget funds will significantly impact the health of the Indonesian people.

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