

**Press Release by the Civil Society Coalition for Just Access to Health:
(Koalisi Warga untuk Keadilan Akses Kesehatan)**

**REJECTING THE HEALTH BILL OMNIBUS LAW RESULTING FROM EVIL CONSPIRACY BETWEEN THE
GOVERNMENT AND THE HOUSE OF REPRESENTATIVES, VIOLATING HEALTH RIGHTS WHILE
THREATENING PUBLIC SAFETY AND NATIONAL SOVEREIGNTY**

Jakarta, June 27, 2023 — The government and the House of Representatives have agreed to bring the Health Bill Omnibus Law to a plenary session for it to be enacted as a Law, despite numerous requests from various community groups to halt the discussion of the Health Bill. This is because the drafting of the Health Bill violates the constitutional mandate and the Law on the Formation of Legislation, which require meaningful public participation in the drafting and discussion of laws, and the substance of the Bill potentially deprives the people of their access to healthcare.

In response to the government's and the House of Representatives' agreement to promptly pass the Bill, the Coalition of Citizens for Health Access Justice states its REJECTION of the Health Bill Omnibus Law as the result of an evil conspiracy between the government and the House of Representatives. The Health Bill not only potentially deprives people of their health rights but also threatens public safety and national sovereignty. Our assessment is based on the following indications:

1. **The government and the House of Representatives have created the Health Bill Omnibus Law by disregarding the law and the Constitution.** The government and the House of Representatives have formulated and discussed the Health Bill Omnibus Law by negating meaningful public participation as mandated by the law and Constitutional Court Decision No. 91/PUUXVIII/2020 regarding meaningful public participation. The government and the House of Representatives intend to force the enactment of the Bill when the public is still searching for the latest version of the Bill and therefore remains unaware of its contents. The latest version of the Bill is deliberately concealed and kept out of public reach. The government and the House of Representatives have only presented the February version of the Bill, which the government itself considers expired.

When various community groups criticize the contents of the outdated version of the Bill, the government responds by stating that the public does not understand and has not read the latest version of the Bill, which has undergone numerous changes. How can the public read, know, and understand the contents of the latest version of the Bill if the government and the House of Representatives deny access to it? Until the Bill is agreed upon for enactment, the latest version of the Health Bill has never been officially opened to the public by the government and the House of Representatives. The voices of the people calling for the government and the House of Representatives to halt the discussion of the Bill and improve the legislative process by involving meaningful participation from all segments of society are completely disregarded.

2. **The Health Bill Omnibus Law is merely an empty promise for the people.** With the Health Bill Omnibus Law, the government and the House of Representatives have made numerous promises to prioritize health budgeting, provide healthcare services to all citizens across Indonesia, including in remote areas (known as 3T areas), improve citizens' access to quality healthcare, address inequalities, and enhance the quality of healthcare services, including human resources, supporting facilities, and supplies. However, the promises outlined in the Bill are essentially empty promises made by the government and the House of

Representatives to the public. This is because, at the same time, the government and the House of Representatives have also agreed to eliminate the provision on mandatory spending in the Health Bill. Article 171, paragraphs 1 and 2 of Law No. 36 of 2009 on Health stipulate a minimum allocation of 5% of the State Budget (APBN) and 10% of the Regional Budget (APBD), excluding salaries, for public services. By removing the minimum health budget allocation, the determination of the budget allocation is entirely left to the discretion of the government. As a result, the health budget in the State Budget can vary each year according to the government's political priorities.

The government and the House of Representatives' removal of the minimum health budget allocation is accompanied by various misleading justifications, including:

- Mandatory spending does not follow the principles of performance-based budgeting and money follows the program.
- It is not in line with the stages of budget planning and national development budgeting.
- Too much mandatory spending narrows down the capacity of the State Budget/Regional Budget and limits fiscal flexibility.
- Health budget is a basic necessity.
- The basis for the percentage of mandatory spending has not been adequately researched.

These reasons demonstrate the government and the House of Representatives' lack of concern for the interests of the poor groups who cannot independently meet their basic needs. Moreover, these various justifications represent flawed thinking on the part of the government and the House of Representatives, as they consider that mandatory spending is not accompanied by proper program development or planning in line with the stages of national development planning. The government acknowledges that the health budget is a basic necessity, but paradoxically argues that mandatory spending limits fiscal space and flexibility. This once again highlights the government's lack of concern for the interests of the poor, vulnerable groups, persons with disabilities, and residents in 3T areas. The minimum health budget allocation is designed to uphold the government's commitment to fulfilling the people's right to healthcare and addressing inequalities. Without mandatory spending, the government is free to allocate less than 5% of the budget for healthcare in order to meet other political priorities, as demonstrated during the pandemic when subsidies for the healthcare of the poor were revoked, while the government allocated significant funds for tourism campaigns involving influencers.

With the removal of the minimum budget allocation or mandatory spending, the budget to fulfill the people's right to healthcare is at risk of being reduced or even left unfulfilled, as its fulfillment depends on the goodwill of the rulers. However, various studies have shown that many healthcare services in regions depend on this budget. This includes the provision of medication, nutritious food to prevent stunting, assistance with BPJS membership fees, incentives for healthcare workers, health education programs, subsidies for hospitals, and more. Even with the minimum health budget allocation, healthcare distribution is still far from satisfactory, let alone if the minimum budget is eliminated. Despite the existence of the minimum budget requirement, many local governments (37.08% in 2020) do not comply with

it, let alone if the requirement is abolished¹. CISDI has noted that with mandatory spending in place, the public still has to pay out of pocket up to 30-35% of the total costs to access better healthcare services. This leads to only the wealthy being able to afford quality healthcare services for themselves.

Based on the Abuja Declaration of 2001, it is recommended that every government in each country allocate 15% of the national budget to healthcare. This is stated in the World Health Organization's Health Financing Working Paper titled "Spending target for health: no magic number." Even in the WHO Health Financing Guidance No.9 in 2020, it mentions the target for healthcare budget allocation that should be equal to or greater than 15% of the national budget before revisions each year. This raises a significant question: What is the basis for the Parliamentary Special Committee on Health Bill (Panja RUU Kesehatan Komisi IX) to remove the specified amount of healthcare budget allocation in the Bill?

The government also argues that the basis for the percentage of mandatory spending has not been adequately researched. However, various studies have shown that mandatory spending has an impact on the health status of mothers and children.

CISDI notes that in 2010, WHO published a journal stating that people living in countries that allocate 5-6% of GDP to healthcare find it easier to access healthcare services. Similarly, Resilient and Responsive Health Systems (Resyst), an international research consortium in the field of health policy funded by the UK government, published a similar study in 2017. Resyst states that a healthcare budget allocation of more than 5% of GDP is needed to provide good services for mothers and children. World Bank data shows that countries that spend more on healthcare tend to have a higher average life expectancy, reaching around 80 years². This is consistent with a WHO study in 2014, which indicates that increased realization of healthcare budget allocation has a positive relationship with the health status of the population.³

- 3. The Health Omnibus Law punishes the poor, vulnerable groups - including women and children, people with disabilities, and those in remote, disadvantaged areas - for the crimes that the government and DPR have been committing.** The minimum health budget allocation was established to uphold the government's commitment to fulfilling the people's right to healthcare and addressing inequality. By removing the allocation of minimum budget (mandatory spending) for healthcare, the government and DPR are trying to wash their hands of the obligation to fulfill the people's right to health and burden the financing of healthcare services on the public, village governments, local governments, and the private sector through various schemes, including the use of BPJS funds, which primarily come from public contributions, the use of village funds, the liberalization of the healthcare sector, the expansion of commercialization of healthcare services, the increased role of private insurance, and others. Instead of alleviating the burden on the people, the government and DPR are actually increasing the burden on the people by depriving them of their rights to healthcare budget, village funds, subsidies for healthcare services, and more. The result is that the poor, vulnerable groups - including women and children, people with disabilities, and communities

¹ <https://ejurnal.dpr.go.id/index.php/jurnalbudget/article/download/124/114>

² <https://www.visualcapitalist.com/cp/healthcare-spending-versus-life-expectancy-by-country/>

³ World Health Organization. (2014). WHO Global Health Expenditure Atlas. Switzerland: WHO

in remote, disadvantaged areas - will face increasing difficulties in accessing healthcare services. Ultimately, it can be said that by eliminating/removing the provisions on the minimum budget allocation for healthcare, the government and DPR intend to punish the people for the crimes committed by the government and DPR themselves, namely poor governance resulting in the accumulation of unproductive debt, and the rampant corruption that occurs in all sectors, including the healthcare sector.

4. **The Health Omnibus Law is a tool of the government and DPR for the liberalization of the healthcare sector and the expansion of privatization/commercialization of healthcare services.** This can be seen from the articles related to the utilization of foreign doctors and provisions regarding the issuance of business licenses for healthcare facilities. With the Health Omnibus Law, the entry of investment and foreign doctors is facilitated, including for Special Economic Zones, under the pretext of accelerating the production of doctors. The law will transform healthcare into the health industry. As a result, healthcare services become more expensive and further marginalize the poor, vulnerable groups, people with disabilities, and communities in remote, disadvantaged areas. These groups will increasingly lose access to affordable and quality healthcare services. Socioeconomic inequality will also worsen.
5. **The Health Omnibus Law provides room for ethical violations by medical and healthcare professionals, thereby potentially increasing malpractice in healthcare services in Indonesia.** The law (Article 304) regulates the enforcement of professional discipline for medical and healthcare professionals. However, it does not address the enforcement of professional ethics. In this case, the government (Ministry of Health) equates professional discipline with professional ethics. However, professional ethics and professional discipline are two different things. Professional discipline pertains to the regulations regarding the practices of medical/healthcare professionals (usually in the form of service standards), while professional ethics pertains to the standards of right and wrong in the execution of a profession, which applies to specific professions (usually in the form of a code of ethics). The absence of professional ethics in healthcare services will clearly impact the decline in the quality standards of healthcare services. Violations of professional ethics can lead to violations of professional discipline and even legal violations.⁴ This will lower the standards of healthcare services and may even worsen the situation, resulting in an increase in malpractice in healthcare services in Indonesia.

In addition to the potential ethical violations and the increase in malpractice in healthcare services in Indonesia, there are several other issues related to the healthcare profession, including:

- a. The utilization of foreign medical and healthcare professionals is exempted from competency evaluations solely based on possessing a competency certificate and having practiced for a minimum of 5 years abroad. This has the potential for foreign medical or healthcare professionals to possess competencies that may not meet the domestic standards. This also poses a potential threat to patient safety.
- b. The provision of lifelong registration certificates (*Surat Tanda Registrasi/STR*) is stipulated in Article 260 of the law. If we refer to regulations in other countries, such

⁴ <https://ugm.ac.id/id/berita/9955-langgar-etika-kedokteran-picu-dokter-melanggar-disiplin-dan-hukum/>

as Singapore or Malaysia, there are no provisions for lifelong registration. This also poses a potential threat to patient safety.

- c. The absence of regulations related to the Hospital Supervisory Body (*Badan Pengawas Rumah Sakit/BPRS*), while in Law No. 44 of 2009, the existence of the BPRS is crucial for overseeing and safeguarding the rights and obligations of patients as well as the implementation of ethical standards in hospitals.
 - d. The role of professional organizations. The regulation concerning healthcare professional organizations is multilayered in Article 311, whereas in the draft law prepared by the DPR's Special Committee (Panja), it was mentioned that there should be a single professional organization. The Constitutional Court Decision No. 82/PUU-XIII/2015 states, among other considerations in the decision, that "With only one professional organization for one type of healthcare professional, it will be easier for the government to supervise the respective healthcare professions." MHKI (Indonesian Medical Association) considers that the Panja has mistakenly prioritized the right to associate under Article 28 of the 1945 Constitution, which can only be exercised by a group of individuals, while the right to receive quality healthcare under Article 34, paragraph (3) is a fundamental right of the entire population. The existence of more than one professional organization can potentially lead to multiple standards in healthcare services, which poses a potential threat to patient safety. The 1945 Constitution of the Republic of Indonesia, as amended, explicitly states in Article 1, paragraph (3) that Indonesia is a legal state. The concept of a legal state (*rechtsstaat*) is closely related to the concepts of "the rule of law" and "*rechtsstaat*." According to Julius Stahl, the concept of a legal state encompasses four important elements: the protection of human rights, the separation of powers, governance based on the rule of law, and administrative justice. The distribution of power, which is the spirit of reform, means that power is not absolute and solely vested in the government. Therefore, some governmental authorities are delegated to various institutions and bodies to jointly maintain order. The existence of professional organizations has always synergized with the government, as evidenced during the pandemic. This law clearly eliminates the roles of healthcare professional organizations that have been carried out based on the mandate of the specialized laws.
6. **The Health Omnibus Law opens up the possibility of collecting genetic data (genomes) of the Indonesian population, which is vulnerable to misuse.** Article 346 (7) of the Health Omnibus Law provides room for Health Information System Providers to process health data and information outside the territory of Indonesia. This provision opens the possibility of collecting genetic data (genomes) of the Indonesian population, which is vulnerable to misuse. The explanatory section of the article states that the transfer of health data and information is for the purpose of managing outbreaks, epidemics, the Hajj pilgrimage, material transfer agreements, and international cooperation in the health sector. This data transfer conflicts with Law No. 27 of 2022 concerning Personal Data Protection. The misuse of genetic data of the Indonesian population clearly endangers the future sovereignty and security of the nation. Moreover, with the opening of investments and the presence of foreign medical and healthcare professionals in Indonesia, the collection of genetic data (genomes) will be facilitated. If the government can trade National Identification Numbers (NIK), it is even more concerning when it comes to genetic data of its citizens. Looking back at past incidents, data

breaches in the healthcare sector in Indonesia are not new. In May 2021, it was suspected that leaked BPJS Kesehatan (Health Insurance) data being sold on online forums originated from the BPJS Kesehatan itself. This was followed by the leakage of 3.2 billion data of PeduliLindungi application users in November 2022, indicating the weak supervision and commitment of the government to protect citizens' data.

Article 339 mentions that the storage and management of clinical specimens, biological materials, information content, and long-term data must be carried out by biobanks and/or biorepositories established by healthcare facilities, educational institutions, and/or health research and development institutions, whether owned by the central government, local governments, or the private sector. The involvement of the private sector in regulating this article has the potential for the industrialization and commercialization of data management, biological materials, and even genetic engineering in the future. Article 349 states that data and information can be transferred outside the territory of Indonesia for specific purposes. Once again, considering the fact that there have been cases of healthcare data breaches, including incidents within the Ministry of Health and BPJS Kesehatan, the lack of clarity regarding data security raises doubts among many parties about the protection of their personal data. Article 342 mentions that anyone who discriminates against the results of genetic examination and analysis of an individual will only face administrative sanctions. In Constitutional Court Decision No. 17/PUU-XIX/2021, in Consideration [3.16], it is stated that criminalization under Article 32 in conjunction with Article 48 of the Information and Electronic Transactions Law (UU ITE) is the protection of a person's right to their own information or electronic documents. The Constitutional Court considers the guarantee of personal data security and the guarantee of the valid and honest exchange of information as a precondition for fulfilling the constitutional rights of all citizens.

7. **The Health Omnibus Law is hastily and carelessly drafted.** The substance of the Health Omnibus Law, which was prepared in a rush and secretly, demonstrates the hasty and careless work of the government and the DPR. This can be seen, among other things, from the following aspects:
- It contains an incorrect definition of individuals. In Article 1 (38), it is stated: "Every individual is an individual, including corporations." In this article, corporations, which are legal entities, are equated with individuals. This is clearly incorrect.
 - The provisions in the Health Omnibus Law contradict, are not aligned with, or are inconsistent with the principles of the healthcare law itself, such as equitable distribution, ethics and professionalism, protection and safety, respect for rights and obligations, justice, non-discrimination, participatory approach, public interest, legal awareness, state sovereignty, order, and legal certainty.
 - There are crucial matters regulated in the Health Omnibus Law without proper definitions, such as assemblies, healthcare support personnel, healthcare auxiliary personnel, and others.
 - The law includes articles that obligate individuals to carry out responsibilities that are the duty of the state. Article 5 (1) states: "Every individual has the obligation to achieve, maintain, and improve the highest possible degree of public health." Article 5 (2) states: "The implementation of the obligations referred to in paragraph (1) letter a includes: a. Individual healthcare efforts; b. Public health efforts; and c. Health-oriented development."

- Article 314 (6) states: "In emergency situations, the Central Government and Regional Governments may establish and implement special policies for the procurement and utilization of pharmaceutical preparations, medical devices, and other health supplies." This could be interpreted as granting the government the discretion to determine the use of pharmaceutical preparations or medical devices that have not been clinically tested for safe application in humans.

Considering the aforementioned points, there are only two choices that the government and the DPR can make regarding the Health Omnibus Law: (1) Halt the enactment of the law that threatens the safety of the nation and its people and review the entire substance of the law with the involvement of all stakeholders as mandated by the law, or (2) Cancel the law as it poses more harm than benefit to the people and the nation. (ends)

Civil Society Coalition for Health Access Justice

1. Yayasan Lembaga Bantuan Hukum Indonesia (YLBHI)
2. The Institute for Ecosoc Rights (Ecosoc Institute)
3. IM57+ Institute
4. Pusat Kajian Hukum dan Keadilan Sosial (LSJ) FH UGM
5. Indonesia Corruption Watch (ICW)
6. Transparency International Indonesia
7. LaporanCovid-19
8. The PRAKARSA
9. Yayasan Penguatan Partisipasi, Inisiatif, dan Kemitraaan Masyarakat Indonesia (YAPPIKA)
10. Pusat Studi Hukum dan Kebijakan Indonesia (PSHK)
11. Pusat Studi Hukum HAM (HRLS) FH UNAIR
12. Pusat Studi HAM (PUSHAM) UII
13. Yayasan Peduli Sindroma Down Indonesia (YAPESDI)
14. Lembaga Bantuan Hukum Masyarakat (LBHM)
15. SIGAB Indonesia
16. Forum Masyarakat Pemantau untuk Indonesia Inklusif Disabilitas (FORMASI Disabilitas)
17. Komunitas Spinal Muscular Atrophy Indonesia.
18. Pergerakan Difabel Indonesia untuk Kesetaraan (PerDIK)
19. Lembaga Studi dan Advokasi Masyarakat (ELSAM)
20. Trade Union Rights Centre (TURC)
21. Yayasan Kurawal
22. Gerakan untuk Kesejahteraan Tunarungu Indonesia (GERKATIN)
23. Yayasan Peduli Distrofi Muskular Indonesia (YPDMI)
24. Yayasan Revolusi dan Edukasi untuk Inklusi Sosial Indonesia (REMISI)
25. KASIH RUMALA Group
26. Ohana Indonesia
27. TERALA
28. SAPDA
29. CIQAL
30. Perhimpunan Jiwa Sehat (PJS)

31. Himpunan Wanita Disabilitas Indonesia (HWDI)
32. Lembaga Penelitian, Pendidikan dan Penerangan Ekonomi dan Sosial (LP3ES)
33. Pemberdayaan Tuli Buta (PELITA) Indonesia
34. PPDI Padang
35. Persatuan Tuna Netra Indonesia (Pertuni)
36. Lentera Anak
37. Indonesian Youth Council for Tactical Changes (IYCTC)
38. Komite Nasional Pengendalian Tembakau (Komnas PT)
39. Yayasan Lembaga Konsumen Indonesia (YLKI)
40. Perhimpunan Bantuan Hukum dan HAM Indonesia (PBHI)
41. Forum Warga Kota (FAKTA) Indonesia
42. Masyarakat Hukum Kesehatan Indonesia (MHKI)
43. Dompot Dhuafa
44. BEM Seluruh Indonesia (BEM SI)