Knowledge Development About The History And Basic Principles Of Health Insurance Business In Indonesia

Desi Aprianti[1], Qurotul 'Aini[2], Erlina Puspitaloka Mahadewi[3*]

[1,2,3] Master of Public Health, Faculty of Public Health, Respati University Indonesia
[3]Universitas Esa Unggul, Jakarta Indonesia
[*]Corresponding Author:
Email: erlina.puspitaloka@esaunggul.ac.id

Abstract.

The health insurance in Indonesia is something new for most Indonesians because the term health insurance itself, until now after the pandemic, has not become a word that is commonly understood. The understanding of what is called health insurance is still very varied so it is not surprising, for example, in the past, many people said that the Community Health Maintenance Guarantee (JPKM) in Indonesia was not health insurance but only the name was used without using the word insurance. The Indonesian population is generally a risk taker in terms of health and death. The economic condition of the Indonesian population from independence until now has been able to have a per capita income per year, which has not allowed the Indonesian population to set aside funds to buy health insurance or life insurance. Meanwhile, from the supply side, not many insurance companies offer health insurance products. The Indonesian government has been relatively slow in introducing the concept of insurance to the public through ease of licensing and legal certainty in the insurance business or developing social health insurance for the wider community. This study uses a qualitative method that aims to analyze the relationship between the development of knowledge about the basic history of health insurance related to the basic principles of health insurance in Indonesia which is expected to increase knowledge about the history of health insurance and the basic principles of health insurance. The goal of this research is to find out things that can provide compensation for losses originating from ignorance of health insurance knowledge.

Keywords: *Basic principles of health insurance, history of Indonesian health insurance and knowledge of health insurance.*

I. INTRODUCTION

In the past thousand years before Christ, ancient peoples have known the basic principle of insurance, which is known as the "Law of the Sea". This concept in ancient times at night made it difficult for ancient boats to land or see in the dark it was also difficult and it was agreed that something thrown into the sea to be able to illuminate the sea which can be enjoyed with fishermen, then the lighting effort is shared. This ancient law is the basis of the principle of insurance, not just health insurance, but all kinds of insurance "a common contribution for the common good". (Bagian, n.d.) The development of health insurance in Indonesia has been slow compared to other ASEAN countries. Several factors contributed to the slow growth of health insurance in Indonesia. On the demand side, in general, the Indonesian population is a risk taker in terms of health and death. Indonesian people think that sickness and death are God's destiny, so buying health insurance is against God's destiny. The economic condition of the Indonesian population since independence until now is still around US$1,000 per-year per-capita, so that it has not allowed the Indonesian population to set aside funds to buy health and life insurance. The supply side is strongly influenced by demand where insurance companies do not offer many of their products. In addition, health facilities that support the implementation of health insurance are not well developed and evenly distributed. On the regulatory side, the Government of Indonesia has been slow to introduce the concept of insurance to the public in terms of ease of licensing and legal certainty in the insurance business or developing social health insurance for the community. (Bagian, n.d.)

The concept of social insurance, namely mandatory insurance which of course is regulated by the government or authorities, began to develop in Europe in 1883 when Chancellor Otto van Bismark required all workers to join the sickness fund (zieken fond). This has also happened in various parts of the world, where traditional voluntary fundraising by friendly societies, such as health fund efforts or cooperatives in Indonesia, cannot develop adequately. Van Bismark argues that residents must get their rights during difficult times, when sick, not from donations but must be from their own contributions. The state must guarantee that this right is fulfilled by obliging the worker to contribute for himself, in the face of no wages when he is sick. (Bagian, n.d.) The Indonesian government began to introduce insurance principles since

1947 after Indonesia's independence. Likewise in developed countries, developing health insurance begins with social insurance in the field of accidents and occupational diseases. At that time, the Indonesian government required all companies to be able to pay insurance for accidents and occupational diseases for their employees, but the internal security situation was still a rebellion after independence and the Dutch wanted to retake Indonesia, so it had not been implemented properly. After Indonesia's political stability was good enough, in 1960 the Government of Indonesia tried to reintroduce the concept of health insurance where the 1960 Basic Health Law asked the Government to develop a 'sick fund' with the aim of providing access to health services for all people (Ministry of Health of Indonesia, 1985).

In 1967, the Minister of Manpower issued a Decree to establish a murip fund with the concept of Health Maintenance Organization (HMO) or Community Health Maintenance Guarantee (JPKM) which is used to realize the mandate of the health law. Determination by the Minister of contributions of 6% of wages consisting of 5% dependent on the employer and 1% being borne by the employees. However, the ministerial decree was apparently not strong enough to oblige companies to pay these fees. (Bagian, n.d.) In 1968, large companies and the government provided self-insured health insurance by reimbursing employees for health costs. Efforts to develop a more systematic social health insurance began to materialize in 1968 when the Minister of Manpower, Awaludin Djanin, made efforts to provide health insurance for civil servants. This effort to provide health insurance for civil servants and their families is the first social health insurance scheme in Indonesia. This civil servant health insurance program was originally managed by an agency within the Ministry of Health known as BPDPK (Health Maintenance Fund Organizing Agency).Financial administration in the Department is generally slow and bureaucratic so that it does not encourage good and satisfactory management. Therefore, Askes was then managed corporately by converting the BPDPK into a Public Company (Perum) known as Perum Husada Bakti (PHB) in 1984, with the change to PHB, the management of Askes became known as the Yellow Card, the management of Askes can be managed flexible. (Bagian, n.d.) There are several preconditions needed for the insurance concept to work, namely the uncertainty of loss, the insured can be measured in terms of money (measurability of loss), the number of participants is large enough (many insured), losses that are If the potential occurs the amount is quite large (a significant size of potential loss), there is an event to bear the risk together (an equitable method of sharing the risk). (Bagian, n.d.)

II. METHODS

This research is a qualitative research by conducting a literature review related to the research subject. This research is descriptive of the phenomenon in health insurance in Indonesia. The purpose of this study is to find out things that can provide compensation for losses originating from health insurance.The data collection technique used by researchers in collecting data and information is to take secondary data that comes from government regulations, the internet and the latest scientific journals or related data that supports this research. The method used in this study is a literature review journal, which aims to view and describe the history and basic business principles of the development of healthcare insurance in several countries and compared to Indonesia.

III. RESULT AND DISCUSSION

The principle of insurance functions to restore the financial position of the policyholder in the event of a risk, to the position before the risk occurred. The principle of insurance is also based on mutual trust and very good faith between the insurance company and the policyholder. The insurance principle also regulates the transfer of rights from the policyholder to the insurance company after payment of claims, five insurance principles, namely: utomost good faith, insurable interest, indemnity, contribution and proxima cause (Mosnier, 2015; Hiron, 1954; Williams, 1984).

1. Principles of Utnost Good Faith

It is the principle of insurance that states that both the insured and the insurer have entered into an insurance contract based on the best intentions (Hiron, 1954; Gaur et al., 2011; Williams, 1984). As an insured, have you declared information about the insured object in a transparent manner (Shi et al., 2016;

Hiron, 1954). For example information about medical history, information about the use of drugs and the like (Gaur et al., 2011). Likewise with the insurer, have you transparently informed the insured about the process of obtaining a policy, the process of dealing with claims, and payment of claims to the insured in a timely manner with the right amount. Transparency based on the principle of utmost good faith will generate trust from the insured to the insurance company through its marketers, so that the insured is confident and has no doubts in establishing relationships with insurance marketers (Hiron, 1954).

2. The principle of Insurable Interest

The principle of insurable interest is the basis for someone who has the right to insure a certain object (Hiron, 1954; Yu and Tung, 2013). Someone sometimes because of certain ties has the right to insure an insurance object, for example a husband has the right to insure his wife based on a husband and wife bond. That is the right of insurable interest arises because of marital ties. Another example is a mother being allowed to insure her child by taking a certain sum insured. As a result of the emergence of the principle of insurable interest, a person has the legal right to insure and may receive compensation from the offender (Williams, 1984, Yu and Tung, 2013).This principle also applies to the business sector, such as a building tenant having an insurable interest based on a rental contract that has been made with the building owner. For this reason, it is mandatory to communicate

by marketers is the foundation upon which good relationship marketing is established with customers.

3. The Principle of Indemnity

The principle of indemnity guarantees the insured to receive fair claim payments based on the correct insurance rules (Mosnier, 2015; Hiron, 1954; Williams, 1984). In general loss insurance, the principle of indemnity is translated as a fair payment because the insured is restored to his financial condition as it was before the loss occurred (Mosnier, 2015). A marketer must be able to show that the insurance company has fairly paid claims based on the principle of indemnity. The ability of a marketer in establishing relationship marketing with customers based on the principle of indemnity will be a guarantee of long-term trust. The customer believes that his rights to get reimbursement are guaranteed by both the marketers and the practice of the insurance company. However, in this type of life insurance, indemnity is interpreted as a fair compensation even if an insured has more than one number of policies because life cannot be measured by an amount of money (Hiron, 1954).

4. Principle of Contribution

The implementation of the principle of contribution to life insurance is different from general types of loss insurance, where contributions to life insurance allow all policies purchased by customers to operate when a claim occurs (Williams, 1984, Mosnier, 2015). So that the principle of mutual demands on general loss insurance does not apply to this type of life insurance policy (Hiron, 1954).Services based on the principle of contribution that are given to customers properly and correctly will be the basis for long relationship marketing with customers.The customer can at the same time buy more than one life insurance product, then when a claim occurs all the benefits of the policy can be withdrawn in terms of providing compensation based on the amount insured. An insurance agent is required to be able to master the principle of contribution in providing services to customers (Mosnier, 2015; Williams, 1984).

5. Proxima cause principle

The principle of proxima cause prioritizes the proximate cause in resolving a claim that occurs (Okura, 2013; Hiron, 1954; Alhasa-Williams, 1984). Claims demanded by a customer sometimes involve various causes, because it is possible for more than one cause. For example, an heir who files a claim for the death of an insured due to

Insurance Purpose:

a. Risk Transfer

The insured holds insurance with the aim of transferring risks that threaten his assets or life. By paying a certain amount of premium to the insurance company (guarantor), since then the risk has shifted to the insurer.

b. Compensation Payment

If at any time an event occurs which causes a loss (risk turns into a loss), then the insured will be paid compensation in the amount of which is proportional to the amount of insurance. In practice the losses that arise can be partial (partial loss), not all of which are total losses (total loss). Thus, the insured holds insurance with the aim of obtaining compensation payments for losses that have been suffered. In the payment of compensation by insurance companies the principle of subrogation applies (stipulated in Article 1400 of the Civil Code) in which the replacement of the rights of the debtor (the insured) by the third party (guarantor/insurance party) who pays the creditor (the value of the insurance claim) occurs either because of approval or because of the law.

Principles and History of Healthcare Insurance in Indonesia

Developing health insurance begins with mutual solidarity, which is a small collection, such as health funds, sick funds, and so on. These small businesses are generally not sufficient to grow because they are voluntary and the number of premiums or contributions is not calculated using sound actuarial principles. To overcome the failure of the small and local insurance system, there are two major modes, namely commercial management with a high professional level and management of social insurance which is mandatory for all people in a group. The social insurance model developed rapidly in Europe, starting in Germany, and spreading widely around the world. Meanwhile, the commercial health insurance system is more developed in the United States because America limits the growth of social insurance for work accidents and health insurance for parents only. The development of commercial insurance is supported by social insurance.

In Indonesia, the development of health insurance began with social insurance, namely health insurance for civil servants, followed by work accident social insurance for private employees, and continued with health social insurance for private employees in the Jamsostek program. Due to laws that allow private workers to opt out, social health insurance for private workers in Indonesia is not developing. The National Social Security System, which lays the foundation for National Health Insurance, is expected to be implemented consistently so that social health insurance coverage in Indonesia can be expanded. However, with the Law on the Additional State Budget which provides guarantees for treatment at community health centers and class three at hospitals starting in July 2005, AKN has begun to be realized in Indonesia. The AKN design in the SJSN does not cover commercial health insurance efforts as supplemental insurance or additional coverage for residents who have high incomes or want more satisfactory coverage. Financial losses caused by an incident can be reduced through the insurance system. Insurance is basically a risk management system, in which participants are offered the opportunity to jointly bear economic losses that may arise, by paying a premium to the insurance company.

Healthcare Insurance in Australia

Research shows that the health care system in Australia is a complex mix of public and private financing, and public and private service delivery. It consists of the Medicare universal public health insurance scheme and the voluntary private health insurance system. Under medicare, all Australians are entitled to taxpayer funds, free access to public hospitals, subsidized medical services provided by private medical practitioners, and subsidized prescription drugs. Medical practitioners are free to set their fees, but under Medicare, patients are only reimbursed part of the cost of the government's schedule (medicare benefits schedule, or MBS) which covers costs for all services and procedures. This subsidy is equivalent to 85% MBS for medical services outside the hospital, and 75% MBS for medical services in hospitals provided to patients. (Duckett & Nemet, 2019) Private health insurance in Australia (PHI) has been a contested policy zone for more than 70 years. In the 1940s, the Federal Labor government tried but failed to introduce a publicly funded health care system. The chaos of Australia's private and public health systems can only be understood by tracing the politically contested paths that led to the current arrangement. Australian voluntary health insurance dominated health care from the early 1950s to the mid-1970s, reflecting the then government's ideology of private enterprise and the 'independence' of the individual. During that period the Australian coalition government introduced subsidies for hospital care and medical services obtained under voluntary insurance, and free access to selected medicines.

Government support for access to hospital care has been tested, with free access to public hospitals restricted to retirees. ‘Safety net’ services are provided only for people who cannot access health care and health insurance. The dominant rhetoric and funding during this period, particularly from Commonwealth governments, favored subsidized voluntary health insurance systems, particularly those described as 'public-supported private practice'. (Duckett & Nemet, 2019) Australia passed its National Insurance Act in 1973 by providing comprehensive service guarantees to all Australian residents, both those in Australia and those in Australia and those in several neighboring countries such as New Zealand and citizens of several European countries living in Australia. Insurance which is also called Medicare is administered by the Health Insurance Commissioner at the Federal country level. All Australians never have to think about the cost of treatment when they are sick and therefore illness will not make them poor. The management of this insurance is so good that in order to stimulate the population who want to buy private health insurance, incentives are given to reduce the contribution of compulsory insurance. (Duckett & Nemet, 2019).

Healthcare Insurance of United States of America

To understand the pro-competitive movement and the idea of managed competition, we must understand the history of non-competitive systems. One of the highlights of the US healthcare economy until recently was how little value for money competition there was. Where Charles Weller describes the traditional system of fees for services, independent practice, free choice of provider, and payment by remote third parties as "union free choice". The principles of the system and its economic consequences are: (1) The choice of a doctor is free by the patient, so that the insurer has no bargaining power with the doctor; (2) Choice of free prescription by doctors, preventing the insurer from implementing quality assurance; (3) direct negotiation of costs by physician and patient, except for third payers who may have informed bargaining power and incentives to negotiate withholding costs; (4) Fee-for-service payments that allow doctors to maximize control over their income by improving services; (5) Single exercise. (Affairs et al., 2012) These principles dominated the US health care system well into the 1980s, and their influence is still important today.

This is enforced by law (e.g., the union principle was built into all state insurance codes until the 1980s and became title XVIII of the Social Security Act), boycotts (e.g., by doctors against hospital contracts with Health Care Organizations (HMO), professional exclusion (e.g., regional medical societies and hospital staff), denial of medical staff privileges, and harassment. commercial insurance companies offer coverage based on the accident insurance model. They accept union principles with some exceptions remaining financial intermediaries with expertise in risk underwriting not in organizing, managing, or purchasing medical care. This pattern of insurance coverage is almost 100% paid by employers, and it is spreading fast. Because health insurance is an attractive, inexpensive, tax-deductible benefit for employers and tax-free for employees, work groups can purchase coverage for much less than it costs individual coverage and paid for by the employer. (Affairs et al., 2012) Health benefits are a great source of bargain gifts for workers. In the minds of employees, coverage of service fees paid in full by the employer being normal is a right. Employment-based insurance spreads to small entrepreneurs.

When HMOs came into vogue in the 1970s and employers were required to offer them, employers usually agreed to pay the HMO's premium in full if it did not exceed the cost of traditional coverage. (Affairs et al., 2012). Flagships of the Free-union Choice Movement include Ross Loos in Los Angeles (1929), Group Health Association in the District of Columbia (1935), Puget Sound Group Health Cooperative (1945) with roots in the 1930s. In 1960 the federal government adopted health insurance for its employees. The blues and commercial insurance companies sought a non-competitive guild model. The Federal Employee Health Benefits Program (FEHBP) has both good and bad sides. The upside is the choice of a price-conscious individual; about bad benefits, non-standards, and a lack of design to manage biased risk selection. Paul Ellwood, Walter McClure, and colleagues proposed a national "health care strategy" in the 1970s that would address the crisis in health care costs and distribution by promoting a "largely self-regulated health care industry"(Affairs et al., 2012)

Healthcare Insurance in Germany

The german compulsory health insurance system is recognized as one of the prototypes of the modern health system configuration. The compulsory Health insurance system was established with the Health Insurance Act (Krankenversicherungsgesetz) of 1883. Since its introduction in 1883 by German Chancellor Otto Bismarck, the German Health principle has been solidarity among the insured. Although often called the originator of compulsory Health insurance, Bismarch built on traditions and structures that existed before, particularly regarding the five types of solidarity-based grants (for daily labourers, artisans, factory workers, workers or tradesmen and the community). Solidarity manifests itself on both the income side and the supply side of compulsory health insurance: all insured persons, regardless of health risk, contribute a percentage of their income, and this contribution entitles individuals to benefits according to need regardless of socioeconomic situation, ability to pay, or their geographic location. In this case, high-income people support low-income people, young people support older people, healthy people support sick people, and childless people support people who have children. The G20 Summit by Germany in July 2017, and ahead of the 135th anniversary of Germany's compulsory Health insurance in 2018 provided impetus to consider the German Health insurance system and its developments, trends, performance, and opportunities for change. (Busse et al., 2017) The development of the compulsory health insurance system through the prism of its 135-years history, its extraordinary resilience to survive with the main principles intact, various forms of government (kingdom, republic, and dictatorship), two world wars, hyperinflation, division, and further reunification of Germany.

Delegated regulation of the health insurance system through self-governance between both provider and payer associations. Self-management is very difficult to appreciate because payers and providers are together given the mandate to ensure equal access and provision of healthcare, limit costs, and maintain quality, on the other hand, the same actors are increasingly facing a regulated environment where they compete for patients and insured individual. (Busse et al., 2017)The Act of 1883 defined the basic principles of today's compulsory Health insurance. First, according to the principle of togetherness, the amount of insurance contributes to the ability to pay; in turn, the insured individual is entitled to benefits as needed. Second, compulsory health insurance is mandatory insurance where the employer participates in the payment. Finally, compulsory health insurance is based on a self-governing structure, meaning that competence is delegated to membership-based, self-governing sick fund organizations and health service providers.Health insurance coverage was initially limited to blue collar workers. In 1885, only 10% of the population was insured in one of 18,776 sick funds. Between 1885 and 1914, the number of contributing members tripled from 4.3 million members to 16.3 million members. Including dependents, the number of individuals insured fivefold from 4.8 million to 23 million individuals, which makes up 37% of the population. This increase was due to the rapid growth of the German industry, which has always been accompanied by the expansion of compulsory healthcare insurance industry. (Busse et al., 2017)

Healthcare Insurance in Kenya

Universal Health Coverage (UHC) currently dominates the global policy agenda. The government and policy makers are considering how to review the health financing system to make progress to UHC. Health systems in many Low and Middle Income Countries (LMIC) are mostly funded through out-of-pocket (OOP) payments. OOP payments are a major barrier to access; they promote inequality and contribute to household poverty. This concern has led to a shift in the policy debate, from OOP payments as the primary source of health care funding, towards prepayment mechanisms, including tax funding and/or health insurance contributions.Health insurance has gained popularity over tax funding, especially in Africa because tax-driven health systems in developing countries face challenges from a small formal sector, low institutional capacity to collect taxes, and lack of tax compliance. Health insurance protects individuals who incur high costs in times of illness, thereby promoting access to health care, especially where the government subsidizes premiums for the poorest population. As a result, health insurance has the potential to be seen as a mechanism to address structural inequalities that exist in Africa. (Abuya et al., 2015).Kenya is one of the few African countries to have had a national hospital insurance scheme since the 1960s. National Hospital

Insurance Fund (NHIF) membership is mandatory for all Kenyans in formal employment and voluntary for those in the informal sector.

The NHIF has been criticized for the poor quality of care in accredited facilities, complicated claims processes and the location of offices in urban areas where a small percentage of the population live.Some way to tackle this problem is to consider introducing the National Health Insurance Scheme (NHIS), which would cover the NHIF of all Kenyans, both outpatient and inpatient services regardless of their ability to pay. The country continues to search for UHC solutions, the main concern being whether NHIS is the most appropriate financing mechanism for Kenya, how the system should be designed and make it acceptable to stakeholders. Because stakeholders are key in any policy change; their preferences and interests can hinder policy formulation and implementation. Stakeholder views on the design are documented and lessons learned to inform the development of healthcare financing policies in Kenya for the future. (Abuya et al., 2015).The way insurance works is to spread the risk to several participants, so that most people in the group of participants who do not experience losses (although they have risks) can help the losses experienced by a small number of participants who experience losses. People who wish to be protected against such losses can purchase insurance from an insurance company. They pay an amount of money to the insurance company which is called the premium. By using the funds collected through the premium, the insurance company pays all or part of the financial losses experienced by the participants, who happen to experience events according to what the insurance company bears. Based on this, several preconditions are needed so that the insurance concept can function, as follows:

- There is uncertainty of loss
- What is insured can be measured in terms of money (measurability of loss)
- The number of participants is quite large (large nuber of insureds)
- Potential losses are quite large (a significant size of potential loss)
- There is a way to bear the risk together (an equitable method of sharing the risk)

Uncertainty of Loss

The basic principle of insurance is that there is uncertainty where a loss that will occur is beyond one's control. Someone who is sick certainly cannot buy hospital care insurance while he is in an ambulance heading to a hospital. In such cases, the insurance company will certainly set a price according to the amount of hospital fees that will be required, plus the service fee of the insurance company concerned. So, insurance may only be applied if an event contains uncertainty.

Losses must be measurable (Measurability of Loss)

The insurer must be able to calculate the loss that will be borne in terms of money, for example the cost of surgery, hospital care costs, or the cost of damage to a car due to a collision, and so on. If the loss cannot be calculated precisely, there must be a way to estimate how much the insurer should compensate for the loss that occurs. For example, when someone dies, it is sometimes difficult to calculate how much that person would have earned had he not died. In this case estimates are made before death occurs. For example, the insured buys a premium to get compensation of Rp. 25,000,000 or Rp. 100,000,000, which will be paid by the insurer if the insured dies.

The number of participants must be large enough (Large Number of Insureds)

Insurance is based on the concept of sharing risk among many participants. The insurer certainly does not want to provide health insurance to only one participant, because it is difficult to know whether that person will experience serious illness at a high cost. However, if the number of participants is in the thousands, then an estimate can be made of how many of them might experience an incident. For example, according to statistical calculations, out of 100,000 people of a certain age group, it can be estimated how many will be hospitalized.

The losses that may arise are quite large (Significant Size of Potential Loss)

The potential losses that may arise must be quite large and the impact on one's finances is also quite large. For example, no one wants to buy insurance to protect themselves from losing a ballpoint pen. If the ballpoint is lost or damaged, the person concerned can replace it immediately without causing a major impact on his finances. However, thousands of dollars in maintenance costs can bankrupt many people. Likewise,

many people would be bankrupt forever if they lost something of value they owned, such as a home or the ability to earn a living. Therefore, insurance is needed only for big losses (catastrophes) that might happen to someone more about this.

An Equitable Method of Sharing the Risk

Risk sharing or risk sharing. This method implements a problem-sharing system by bearing the problem together. This insurance concept consists of several people as members, each member collects funds within the agreed time and amount in the pool of fun (place to collect funds).

IV. CONCLUSION

In conclusion, based on the results and review of the literature, it can be concluded that in Indonesia, the development of health insurance began with social insurance, namely health insurance for civil servants, followed by social insurance for work accidents for private employees, and continued with social insurance for health for private employees in the Jamsostek program in Indonesia. Due to laws and regulations that allow private workers to opt out, social health insurance for private workers in Indonesia has not developed. The National Social Security System (SJSN), which lays the foundation for National Health Insurance, is expected to be implemented consistently so that social health insurance coverage in Indonesia can be expanded. However, with the Law on the Additional State Budget in Indonesia, which provides guarantees for treatment at community health centers and class three of hospitals starting in July 2005.The National Health Insurance (AKN) has begun to be realized in Indonesia. The National Health Insurance (AKN) design in the national social security system (SJSN) does not cover commercial health insurance efforts as supplemental insurance or additional coverage for residents who have high incomes or want more satisfactory coverage.

Financial losses caused by an incident can be reduced through the insurance system. Insurance is basically a risk management system, in which participants are offered the opportunity to jointly bear economic losses that may arise, by paying a premium to the insurance company. The way insurance works is to spread the risk to several participants, so that most people in the group of participants who do not experience losses (although they have risks) can help the losses experienced by a small number of participants who experience losses. People who wish to be protected against such losses can purchase insurance from an insurance company. They pay an amount of money to the insurance company which is called the premium. By using the funds collected through the premium, the insurance company pays all or part of the financial losses experienced by the participants, who happen to experience events according to what the insurance company bears. In avoiding risks and losses in health insurance, it is necessary to have principles underlying the insurance contract agreement between the insurance company and the policyholder. The principle of insurance functions to restore the financial position of the policyholder in the event of a risk, to the position before the risk occurred. The principle of insurance is also based on mutual trust and very good faith between the insurance company and the policyholder. The principle of insurance also regulates the transfer of rights from the policyholder to the insurance company after payment of a claim.

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