

WORKING PAPER

# **Expanding Social Security in Indonesia: The Processes and Challenges**

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## **ABSTRACT**

### **Expanding Social Security in Indonesia: The Processes and Challenges\***

Asep Suryahadi, Vita Febriany, and Athia Yumna

This paper reviews the development of social security provision in Indonesia, which has evolved from very small in its early years to the privilege of formal sector workers during New Order period to universal coverage, at least in principle, in the current period. These changes were in line with and driven by the developments of the Indonesian economy in general, which has gone through various episodes marked by both booms and crises. There are two important milestones in the development of social security in Indonesia. First, after the change in government during the chaotic mid 1960s, the New Order government gradually developed various social security schemes, but limited only for formal sector workers. Second, after the Asian Financial Crisis at the end of 1990s exposed the weaknesses of the social security system in place, successive governments established a stronger social security system by adopting universal coverage. The challenges for implementing it, however, are formidable due to Indonesia's vast geography, huge population, and diverse availability and quality of infrastructure.

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# I. INTRODUCTION

In Indonesia, currently the right to social security is enshrined in the constitution. It forms the social contract between the state and society, aimed at guaranteeing that every Indonesian citizen can live a dignified life. Nevertheless, the road to achieving this objective has been long, difficult, and mired with uncertainties. Although most agree with this noble objective, the way to achieve it is controversial, marked by forceful and rigorous debate over how Indonesia should develop its social security system.

For a long time, social security was the privilege of a few. During the three decades of the New Order regime from the late 1960s to the late 1990s, social security schemes were reserved only for civil servants and formal private sector employees in medium and large enterprises. The large majority of the population, whose livelihoods were in the informal sector, had to rely on informal social protection from their families and the communities. When the Asian Financial Crisis struck in the late 1990s, a time when social security was expected to be most useful, the social security system that Indonesia had at that time proved to be meaningless. A large portion of the population who had escaped poverty by the virtue of three decades of economic miracle turned out to be still vulnerable and found themselves back in poverty.

Once the chaos of the crisis started to stabilize in 2000, a reform of the social security system was initiated, resulting in an amendment of the constitution which adds a clause on universal right for social security. After a controversial process, viewed as less than inclusive by some, the Law No. 40/2004 on National Social Security System (*Sistem Jaminan Sosial Nasional* or SJSN) was passed near the end of 2004. This new law provides a framework for integration of various social security schemes that already existed and new social security schemes, as well as the expansion of social security coverage to the whole population as mandated by the constitution.

However, for the law to be operational, various derivative laws and regulations needed to be issued as its implementation guidelines. The law provided a five year period for the issuance of the derivative laws and regulations. Unfortunately, the new social security law was signed into effect just a few months after a presidential election, but prior to the new president taking office. Hence, the issuance of the derivative laws and regulations became the responsibility of the new government. The new government never stated explicitly their objection to the social security law, but five years passed without a single derivative law or regulation issued.

The government was re-elected in 2009 for another five years without a clear prospect on the implementation of the social security law. Hence, the new parliament took an initiative to propose a law on the social security implementing agency. This is a crucial derivative law for the implementation of the social security law. After some protracted deliberations with the government, the parliament passed the Law No. 24/2011 on Social Security Implementing Agencies (*Badan Penyelenggara Jaminan Sosial* or BPJS) at the end of 2011. The new law created two social security implementing agencies: the BPJS Health, which would operate in January 2014, and BPJS Employment, which would operate in July 2015.

The establishment of these two social security implementing agencies marks a new era in the development of social security in Indonesia as these two agencies are responsible for providing social security benefits to the whole population. The BPJS Health is responsible for managing a universal social health insurance, while the BPJS Employment is responsible for managing the schemes on pension, old age benefit, death benefit, and work accident benefit.



The two social security implementing agencies will face great challenges in providing social security benefits to more than 250 million Indonesians. Discussing these challenges is the focus of this paper. The remaining of the paper is organized as follows. The second section discusses the development of social security in Indonesia. The third section discusses the nature of social security in Indonesia. The fourth section discusses the challenges faced in the expansion of social security in Indonesia. Finally, the fifth section concludes.

## **II. THE DEVELOPMENT OF SOCIAL SECURITY IN INDONESIA**

The development of social security in Indonesia is very much related with and driven by the development of the Indonesian economy in general. Therefore, the first part of this section discusses the ups and downs of economic growth that Indonesia has experienced and how these trends affect the socio-economic conditions. Their links to social security development is discussed in the second part of this section.

### **2.1 The Ups and Down of Indonesian Economic Growth**

In general, the trends of economic growth in Indonesia can be divided into several chronological periods: (i) the post-independence period (1945-mid 1960s), (ii) the New Order Government or pre-Asian Financial Crisis (pre-AFC) period (late 1960s-1996), (iii) the AFC period (1997-1999), (iv) the post-AFC period (2000-2007), (v) the Global Financial Crisis (GFC) period (2008-2009), and (vi) the recent and future prediction of growth (2010 onwards).

#### **2.1.1 The post-independence period (1945-mid 1960s)**

After proclaiming its independence in 1945, the war for independence continued until 1949 when the Dutch and international community finally formally acknowledged Indonesian sovereignty. The government's focus on ensuring political stability during this period took attention away from economic concerns, leaving the economy weak in the years immediately following independence. During 1949-1965, Indonesia recorded small economic growth, predominantly in the years from 1950 to 1957. The growth was fuelled by two main tradable commodities, oil and rubber, whose prices were rising in the world market. However, the growth shrunk in the period of 1958-1965, again due to political instability in the country.

An introduction of the first president Sukarno's 'Guided Economy' (*Ekonomi Terpimpin*) regime in 1959, which eliminated all foreign economic control in the private sector, compounded by other surging macroeconomic problems, made economic performance worse than the previous period (Lindblad 2010, Touwen 2008). Booth (1998) estimates a growth rate of per capita gross domestic product (GDP) of only 1.0 per cent annually on average during the years of 1950-1965. This growth rate was considered too low for the rapid population growth after the war, which reached 2.0 per cent annually.

### **2.1.2 The New Order Government (late 1960s-1996)**

After the New Order government took over in the mid 1960s, economic development in Indonesia underwent radical changes. The economy grew rapidly and Indonesia rose from being one of the poorest countries in the world to a middle-income country in 1993. The per capita income increased from US \$50 in 1967 to \$610 in 1991, which constitutes an annual GDP per capita growth of 4.6 per cent, making Indonesia one of the fastest growing economies in the world during the period (Suryahadi et al. 2012). The turn-around in the country's economic performance was mainly due to the change in economic policy from a closed to a more open policy.

Initially, the impressive growth also benefited significantly from two oil booms in 1973/1974 and 1978/1979, which raised the government's export earnings and revenues very significantly. The increased revenue enabled the public sector to play a greater role in the economy by undertaking substantial public investments in regional, social, and infrastructure developments. Increasing foreign exchange also enabled Indonesia to import capital goods and raw material, giving rise to a growing manufacturing sector.

As the oil boom came to an end in the early 1980s, the New Order government redirected the economy from one dependent on oil towards a promotion of the export-oriented manufacturing sector, while the large public investments in education, health, family planning, and infrastructure continued. Manufactured exports began to become the engine of the Indonesian economy. During the 1980s, the share of industrial output in the gross domestic product (GDP) was maintained at around 40 per cent. In addition to the industrial sector, the share of the services sector's output in total GDP has steadily increased, reaching 39 per cent in 1990 (Suryahadi et al. 2012).

The high economic growth during this period resulted in improvements in various social indicators. For example, life expectancy increased from 52 years in 1970 to 62 years in 1990, infant mortality rates fell from 100 per 1,000 in 1970 to 54 per 1,000 in 1990, school enrolment rates rose from 17 per cent in 1970 to 48 per cent in 1990 for secondary education, and the poverty rate fell from around 40.1 per cent in 1976 to 11.3 per cent in 1996. In addition, the provision of basic infrastructures, including health facilities, also rose substantially. For example, the number of health workers increased from 50,000 in 1974 to 190,000 in 1992, working in around 6,500 health centres. Furthermore, despite high economic growth sustained for a long period, inequality did not increase. Gini ratio was relatively stable at around 0.33.

### **2.1.3 The Asian Financial Crisis (AFC) (1997-1999)**

After nearly thirty years of uninterrupted rapid growth, low inflation, and a stable currency, the Asian Financial Crisis (AFC) in 1997 reversed the situation completely. The AFC, which first started in Thailand, weakened the Indonesian currency Rupiah from Rp 2,200 per US dollar in mid-1997 to Rp 12,000 in 1998. At about the same time inflation jumped to 78 per cent, driven by an increase in the prices of food by 118 per cent (Basri 2013, Suryahadi et al. 2012). To make matters worse, some areas of Indonesia suffered simultaneously from a severe drought which reduced the harvest of rice, the Indonesians' staple food, as well as other food crops.

The combination of these impacts caused the economy to contract by 13.7 per cent in 1998. The unemployment rate increased from 4.7 per cent in August 1997 to 5.5 per cent in August

1998 (Basri 2013, Suryahadi et al. 2012). The services sector suffered the most, with a contraction of -4.63 per cent annually, followed by the industrial sector with -2.97 per cent, while the agriculture sector still grew positively by 0.15 per cent annually. Due to this, Indonesia temporarily fell back to the low-income country status in 1998 (Suryahadi et al. 2012).

The severe crisis quickly eroded the confidence in the New Order government, as they were not able to solve the problems fast enough. Demonstrations and widespread calls for President Suharto to step down took place all over Indonesia, with some leading to riots and deaths. By May 1998 the country was already suffering from the combined effects of currency, financial, natural, economic, and political crises (Suryahadi et al. 2012). Finally, in May 1998, Soeharto agreed to step down from the presidency and transferred it to his vice-president B.J. Habibie.

The skyrocketing price of rice and other basic necessities due to the crisis increased the poverty rate from around 15 per cent in the mid-1997 to the highest point of around 33 per cent at the end of 1998. Around 36 million people fell into absolute poverty due to the crisis, albeit temporarily (Suryahadi et al. 2012). To cushion the impact of crisis for the poor, the Government with support from donors launched a social safety net programme called the JPS (*Jaring Pengaman Sosial*) programme, covering food, education, health, employment, and community empowerment supports.

### **2.1.3 The Post-AFC Period (2000-2007)**

During the post AFC periods, the Indonesian economy grew on average by 5 per cent annually, or around 70 per cent of the average growth rate during the pre-crisis period. The services sectors recorded the highest sectoral growth by around 6.5 per cent annually, while the industrial sector, which had been one of the drivers of economic growth before the AFC, grew at a slower pace of 3.9 per cent annually, and the agriculture sector grew much slower than it did before the AFC at 3.3 per cent annually (Suryahadi et al. 2012). Income per capita rebounded and surpassed the pre-crisis level, inflation decelerated, and the exchange rate became relatively stable. The debt-to-GDP ratio declined significantly from more than 100 to less than 40 per cent. Finally, Indonesia regained its middle income country status in 2003.

As Indonesia slowly recovered from the crisis, the poverty rate started to decline again. The poverty rate fell from 18.2 per cent in 2002 to 15.9 per cent in 2005. It increased again slightly to 17.8 per cent in 2006 due to the increase in fuel prices, but decreased again in 2007 to 16.6 per cent. In the post-AFC period, however, the average reduction in the poverty rate is about 0.61 percentage point annually, which constitutes only around 40 per cent of the pace of poverty reduction during the pre-crisis period (Suryahadi et al. 2012).

### **2.1.4 The Global Financial Crisis (2008-2009)**

Ten years after the AFC, Indonesia faced another crisis in the form of the Global Financial Crisis (GFC). The effects of the GFC were reflected in several indicators, such as the depreciation of the exchange rates and the decline in the stock market prices. The rupiah exchange rate fell by 30 per cent during 2008, while the stock market index dropped by 50 per cent during the year (Basri 2013). Nevertheless, the impact of the GFC on the Indonesian economy was relatively mild compared to other countries in the region, including Singapore, Malaysia, and Thailand.

The impact of GFC started to be felt in the fourth quarter of 2008 with a reduction in the demand for Indonesian exports. Export oriented industries contracted sharply, with an adverse effect on employment. The value of Indonesia's exports dropped by 17.9 per cent in a year from September 2008 to September 2009. The decrease in exports brought a decrease in Indonesia's economic growth. In the fourth quarter of 2008, economic growth slowed to 5.2 per cent year-on-year. Still, growth in the whole year reached 6.1 per cent, which was the highest in Asia after China and India (Basri and Rahardja 2011). In 2009, however, the economic growth did fell to 4.5 per cent, but it is still much higher than the global economy which contracted during the year.

The social impact of the GFC is concentrated in the regions supplying the export commodities. For example, the plantation sector which supplies the international market is concentrated in only five provinces, each of which depends on the revenue from a small range of crops, or even just one. This, combined with in place social protection programs, made it possible for the poverty rate to continue declining despite the crisis. The poverty rate continuously fell from 16.6 per cent in 2007, to 15.4 per cent in 2008, and 14.2 per cent in 2009.

### **2.1.5 The Recent Growth (2010 onwards)**

After successfully weathering the GFC in 2008-2009 as indicated by its ability to maintain relatively high economic growth and poverty reduction, Indonesia continued to post significant economic growth. In 2010, the economic growth rebounded to 6.1 per cent. This high economic growth is maintained in the following years. The Indonesian economy grew by 6.5, 6.2, and 5.8 percents in 2011, 2012 and 2013 respectively.

As a result of the continuing economic growth post AFC, the per capita income has steadily risen from \$2,200 in 2000 to \$3,563 in 2012. Nevertheless, more than 32 million Indonesians still live below the national poverty line, with about the same number of people are categorized as the near poor who live only slightly above the poverty line. Furthermore, different from the pre-AFC period where high economic growth was not accompanied by increasing inequality, the post-AFC growth is in tandem with increasing inequality. The Gini Ratio increased significantly from 0.32 in 2000 to 0.41 in 2011 and remained stable in 2012 and 2013.

## **2.2 The Development of Social Security in Indonesia**

After gaining independence in 1945, like in any other newly independent countries, Indonesia did not have the capacity to develop a social security system in its early years. In the context of instability and chaos, social security was neglected in favour of other critical problems, such as political reconstruction and government restructuring, even though the state had ensured all citizens had the rights for decent work and livelihood as well as social security for the poor and vulnerable as stated in the 1945 Constitution (Article 27 Subsection 2 and Article 34).

The situation changed considerably during the New Order period. Rapid economic growth and industrialization which started in the 1970s raised the need to develop the social security system. Labour market conditions at that time, in which increasing number of people worked in formal employment, led the government to enact more regulations and laws on statutory social security. However, the 1997 AFC revealed that the pre-crisis social security system did not cushion people from aggregate shocks, leaving a large part of the population

at risk of falling into poverty and providing only limited protection for those who were covered by the system.

Hence, one of the priorities of the successive governments post-AFC was to develop a stronger social protection system – consisting of both social assistance and social security – for the country. In terms of social assistance, Indonesia continues to maintain the social safety net (JPS) programs, which were introduced during the AFC, as well as introducing new programs such as the conditional and unconditional cash transfer programs. For social security, after a three-year deliberation with the parliament starting in 2001, the Law No. 40/2004 on National Social Security System (SJSN) was issued in 2004.

The remaining of this subsection will elaborate the development of social security in Indonesia from the early stage to the existing process towards universal coverage as mandated by current law.

### **2.2.1 Social Security during the Beginning of the State (1945-mid 1960s)**

Most of the modern social security scheme provided by the state did not exist in Indonesia in its early years of independence. The majority of resources were absorbed by the fight for independence and government reconciliations, resulting in low economic growth and high poverty levels. Nevertheless, as in many Asian countries, people had a strong reliance on the traditional support system of the extended family as well as community supports in times of shocks, such as loss of income because of work termination, sickness, old age, disability or death, or even in the process of entering labour force (Esmara and Tjiptoherijanto 1986).

However, actually the initial efforts to develop a social security system could be traced back to the basic laws that originated in the Old Dutch Civil and Commercial Laws of the 19<sup>th</sup> century. After independence, the first regulation on work accident compensation which covered medical care, invalidity, and death benefits was passed in 1947, then expanded in 1951. In 1963, the government established two social policy programmes for civil servants: ‘Civil Servant’s Welfare Fund’ (*Pembelanjaan Pegawai Negeri*) called DASPERI and ‘Civil Servant Insurance Savings’ (*Tabungan Asuransi Pegawai Negeri*) called TASPEN.

DASPERI is a social assistance programme for the family of civil servants, mainly compensating for natural disasters. It was supervised by the Ministry of Social Welfare. Meanwhile, TASPEN was a social insurance programme for the retired civil servants and their dependents, which aimed to provide retirement benefits for aged civil servants and military personnel and their dependents. A state-owned company, PN TASPEN, was established to manage the programme under the Ministry of Finance supervision.

The social security programme extended to the formal private sector in 1964 by the establishment of Social Security Funds (*Dana Jaminan Sosial*) following the formation of the Foundation of Social Workers in 1957. This program was voluntary for both employees and employers. This scheme firstly covered health-related benefits for the employees, such as medical care, maternity, and death benefits.

### **2.2.2 Social Security during the Rapidly Growing Economy (late 1960s-mid 1990s)**

Following the change of government in 1967, the New Order government altered the development priorities of the country. After first successfully managing the political instability, the New Order government then successfully boosted the economy, resulting in a rapid

economic growth starting in the beginning of the 1970s, averaging 7 per cent annually, until the 1997-1998 Asian Financial Crisis (AFC) grounded it to a halt. The period of high economic growth, gave a spacious room for the government to attempt more advanced public policies, including on social security provision. During the tenure of this regime, the government set economic growth as the fundamental goal and used social policy as an instrument for supporting that goal.

New laws and regulations were passed to improve or amend previous regulations. The Law No. 11/1969 on Principles of Employment for Civil Servants added up the previous regulation on civil servants and military personnel pension programme. This law regulates that retired civil servants receive a monthly pension benefit and a lump-sum old-age savings benefit at retirement age managed by PT TASPEN.

In 1971, the pension programme for military personnel was moved to a separate programme called the Armed Forces' Social Insurance (*Asuransi Angkatan Bersenjata* or ASABRI). The ASABRI was designed to accommodate different pension ages between military personnel and other civil servants. The programme was managed by the state-owned company, Perum (*Perusahaan Umum* or Public Enterprise) ASABRI, under the supervision of the Ministry of Defence.

The split has led the DASPERI programme at the crossroads since the programme was not an insurance scheme in the ordinary sense but more a social assistance programme. The government then made to decision to terminate DASPERI in 1975 and transferred the social assistance funds to TASPEN and ASABRI, while the natural disaster components of DASPERI was handed over to the Ministry of Social Welfare. The Government Regulation (PP) No. 25/1981 further merged all social security programmes for civil servants (the welfare programme, the old-age savings, and the pension) into a single programme under the administration of PT TASPEN (Esmara and Tjiptoherijanto 1986, ADB 2007). Meanwhile, the social insurance programmes for the Armed Forces were still managed by ASABRI.

A health component programme for civil servants and retired civil servants and military personnel was established in 1968. The programme employed a compulsory contribution managed by the Agency for Healthcare Funds (*Badan Penyelenggara Dana Pemeliharaan Kesehatan* or BPDPK) under the supervision of the Ministry of Health. The agency was changed to Perum Husada Bhakti in 1984. The target of this social health insurance programme was extended to civil servants, retired civil servants, retired military personnel, and their family members as instructed in 1991. Perum Husada Bhakti at this stage was permitted to run a private health insurance on voluntary basis to expand the memberships. The status of the company was also changed to a *Perseroan Terbatas* (PT Persero) ASKES in 1992 (ADB 2007).

The voluntary Social Security Fund (*Dana Jaminan Sosial*) programme for private sector employees was replaced by Employees' Social Insurance (*Asuransi Tenaga Kerja* or ASTEK), which was a compulsory programme. The legal endorsement of the ASTEK programme was the Government Regulation (PP) No. 33/1977 on the Implementation of the ASTEK Programme. The government also issued the Government Regulation (PP) No. 34/1977 on an establishment of Perum ASTEK to manage the programme.

The next substantial development of social insurance for private sector workers was the issuance of the Law No.3/1992 on Workers' Social Security (*Jaminan Sosial Tenaga Kerja* or JAMSOSTEK). The Government Regulation No. 36/1995 as a derivative of the Law assigned PT JAMSOSTEK to be the implementing agency of the JAMSOSTEK programme. The

programme benefits include health insurance, work accidents, old-age savings, and death benefit. The rate of contribution varies from 5.7 per cent of the salary for provident fund, made up of 3.7 per cent employer contribution and 2 per cent employee contribution, to 0.3 per cent of the salary for death benefit grant.

JAMSOSTEK was not designed to protect against the risk of unemployment, therefore it has limited ability to cushion the impact of the economic crisis to its participants. In addition, the Government Regulation No. 14/1993 regulated an 'opt out' mechanism for private sector workers for a better private health insurance. This mechanism partly caused a low effective coverage of JAMSOSTEK's health insurance programme. Membership of the programme in 1995, under Perum ASTEK administration, was about 9.1 million workers. It only increased slightly in 1997 when the programme had been managed by PT Jamsostek to 11.8 million workers, which was about one half of the formal sector employees.

### **2.2.3 Social Security in the Midst of the Crisis and Afterwards**

The Asian financial crisis in 1997 hit Indonesia hard and reversed the positive trends that had been achieved before. The currency fell to as low as 15 per cent of its pre-crisis value in less than a year, the economy contracted by 13.7 per cent in 1998, the inflation rate soared by 78 per cent, the unemployment rate increased from 4.7 per cent in August 1997 to 5.5 per cent in August 1998, and the poverty rate (using a new method) rose from 17.5 per cent in 1996 to 21.4 per cent and 23.4 per cent in 1998 and 1999 respectively.

In spite of the development of a modern social security system prior to the crisis, the system still left a large part of the population uncovered. The system limited its coverage to the formal sector workers, whereas about two-thirds of workers were in the informal sector. Even for those who were covered in the system, the scheme did not deliver a sufficient level of income protection or quality of services for the workers and let the workers who were hit by the shock fall into poverty.

The immediate response to the crisis by the government was the introduction of the social safety net (*Jaring Pengaman Sosial* or JPS) programme in 1998 and 1999. The introduction of JPS was triggered by the introduction of the Structural Adjustment Programme (SAP), which was heavily influenced by the International Monetary Fund (IMF) and the World Bank. The SAP has four objectives: (i) to stabilize the exchange rate and prices and stimulate domestic demand through fiscal and monetary policy, (ii) bank and corporate restructuring, (iii) improving governance and increasing transparency and efficiency, and (iv) protection for the poor and preservation of human assets, which was accomplished through Social Safety Net (SSN) programs (Mulyadi 2013).

The JPS programme aimed to prevent the poor from falling more deeply into poverty and reducing the exposure of vulnerable households to risk. The JPS programme, which was partly financed by a loan from the World Bank, covers five programs: rice subsidy, school scholarships and block grants, health card (providing the poor with free access to public health services), labour intensive work programme, and the provision of grants to selected community groups.

The JPS programme was an *ad hoc* response to the crisis. All of its component programmes were plagued by the problems of targeting. A large number of the poor were not covered by the programmes and there was substantial benefit leakage to the non-poor (ODI, 2006). There was an acknowledgment among policy makers (mainly in the Ministry of National

Development Planning (Bappenas) and Coordinating Ministry for People Welfare) for a need to develop a sustainable arrangement to be better prepared for future shocks. Based on this thinking, the then President Abdulrahman Wahid started the process of social security reform in 2000 by bringing up the concept of the development of a national social security system to the Annual Assembly of the People's Consultative Assembly (*Majelis Permusyawaratan Rakyat* or MPR), the highest representative body in the country.

In 2002, the MPR accepted the proposed reform by amending the Constitution to extend social security to cover the entire population. The amendment of Article 28H, Subsection 3, of the 1945 Constitution asserts that "Every person shall have the right to social security to develop oneself as a dignified human being" and Article 34, Subsection 2, states that "The state shall develop a social security system for all the people and shall empower the vulnerable and poor people in accordance with human dignity". In the original Constitution there was no article mentioned about social security explicitly. The closest related two articles were Article 27, Subsection 2, which stated that "Every citizen has the right to work and to live in human dignity" and Article 34, which stated that "The poor and destitute children shall be cared for by the State".

A draft concept of the Law on National Social Security System (*Sistem Jaminan Sosial Nasional* or SJSN) was completed in 2003 and submitted to the parliament in early 2004. The draft had been revised 56 times before it was enacted as the Law No. 40/2004 on SJSN in October 2004. One of the major debates in the deliberation process was on deciding the type of institution that would manage the national social security programmes, i.e. whether it should be in the form of a state-owned enterprise or a public and non-profit legal entity. The law had the consequence of covering all of the population, in both formal and informal sectors, and bringing them into the national social security system.

The first social health program that targeted poor households was started in 1994 with the health card (*kartu sehat*) programme and was fully institutionalized in 1998 through the JPS Health (*JPS Bidang Kesehatan*) programme. The programme ran from 1998 to 2001. During 2001-2005, it was replaced by the PKPS-BBM programme, which is a fuel price increase compensation scheme, which also used the JPS programme management. The fuel price compensation scheme changed its name in March 2005 into 'Health Insurance for Poor Households' (*Asuransi Kesehatan bagi Keluarga Miskin* or ASKESKIN) under the first term of President Yudhoyono.<sup>1</sup>

Although the name of the program was a health insurance, it was actually a health service fee waiver for the poor, which was tax financed. The ASKESKIN programme could be seen as a first phase introduction of universal health coverage as mandated by the Law No. 40/2004. Like the JPS, the PKPS-BBM and ASKESKIN programmes were also targeted to poor households. However, the scheme was evolved into the 'Health Security for Society' (*Jaminan Kesehatan Masyarakat* or JAMKESMAS) programme starting in 2008, with the same scope to cover the poor and vulnerable. The difference between the two programmes is the base of participation. While ASKESKIN is on household basis, JAMKESMAS is on individuals basis, although its targeting is still done at the household level. In this programme, the Ministry of Health (MoH) verified the beneficiary list (compiled by Statistics Indonesia, the BPS) and

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<sup>1</sup>While slowly recovering from the impact of the crisis, Indonesia had to deal with the increase in global fuel prices which had led the government to gradually slash its fuel subsidy starting in 2005. It resulted in an average of 30 and 114 per cent increased of fuel prices in March and October 2005 respectively. In this period, the social protection schemes were designed to compensate the poor from the impact of the fuel subsidy reduction.



processed the claims, while hospitals and community health centres provided the services and claimed the fees to the MoH.

## 2.2.4 The Law on National Social Security System

As mentioned earlier, the Law No. 40/2004 on the National Social Security System (SJSN) is a framework law.<sup>2</sup> It does not stipulate detailed benefits and contribution rates for each of the programme (ADB 2007). It rather outlines the basic structure of the reformed social security system, which are:

- (i) Universal coverage for all Indonesian, both for formal and informal workers and their dependents, and they would be required to make contributions to the programme.
- (ii) Five separate programmes would be created in the system.
- (iii) Four existing state-owned companies would be the administrator of the programme.
- (iv) A National Social Security Council would be established with 15 members representing the government, employers, workers, and experts.
- (v) Formal and informal workers make different contributions. Formal workers' contributions are a percentage of wages and split between workers and employers. For informal workers, meanwhile, the contributions are a nominal amount in Rupiah.
- (vi) The government pays the contributions of the poor.

The SJSN Law stipulates five social insurance programmes: (i) pension, (ii) old-age savings, (iii) health-related benefits, (iv) work accident compensation, and (v) death grants. The details regarding the benefit levels and costs are left to government regulations and presidential decrees. Regarding the institutional setting, the law mentions that the four existing state-owned social security companies – JAMSOSTEK, ASKES, TASPEN, and ASABRI – will form the Social Security Implementing Agencies (BPJS). Yet the exact role of each institution is to be determined in a separate law.

The SJSN law required that the regulation on implementing agencies to be created by October 2009, five years after the SJSN Law was passed. However, the timeline could not be achieved by the government and the draft of the law had not been submitted to the parliament by then.<sup>3</sup> The parliament then took the initiative to solve this problem by formulating the draft first and subsequently discussed it with the government in the end of 2010. Finally, it was passed as the Law No. 24/2011 on Social Security Implementing Agencies (*Badan Penyelenggara Jaminan Sosial* or BPJS) in November 2011.

The BPJS Law stipulates two administrative bodies responsible to implement the social security programmes: BPJS Health and BPJS Employment. BPJS Health will manage the health benefits, while BPJS Employment will administer the other four programmes (work accident, old-age savings, pensions, and death benefits). Furthermore, the BPJS Law specifies that PT ASKES which previously managed the health insurance of civil servants, would be transformed to become the BPJS Health and would start to operate on 1 January 2014. The road map of 'National Health System' (*Jaminan Kesehatan Nasional* or JKN) states that the first

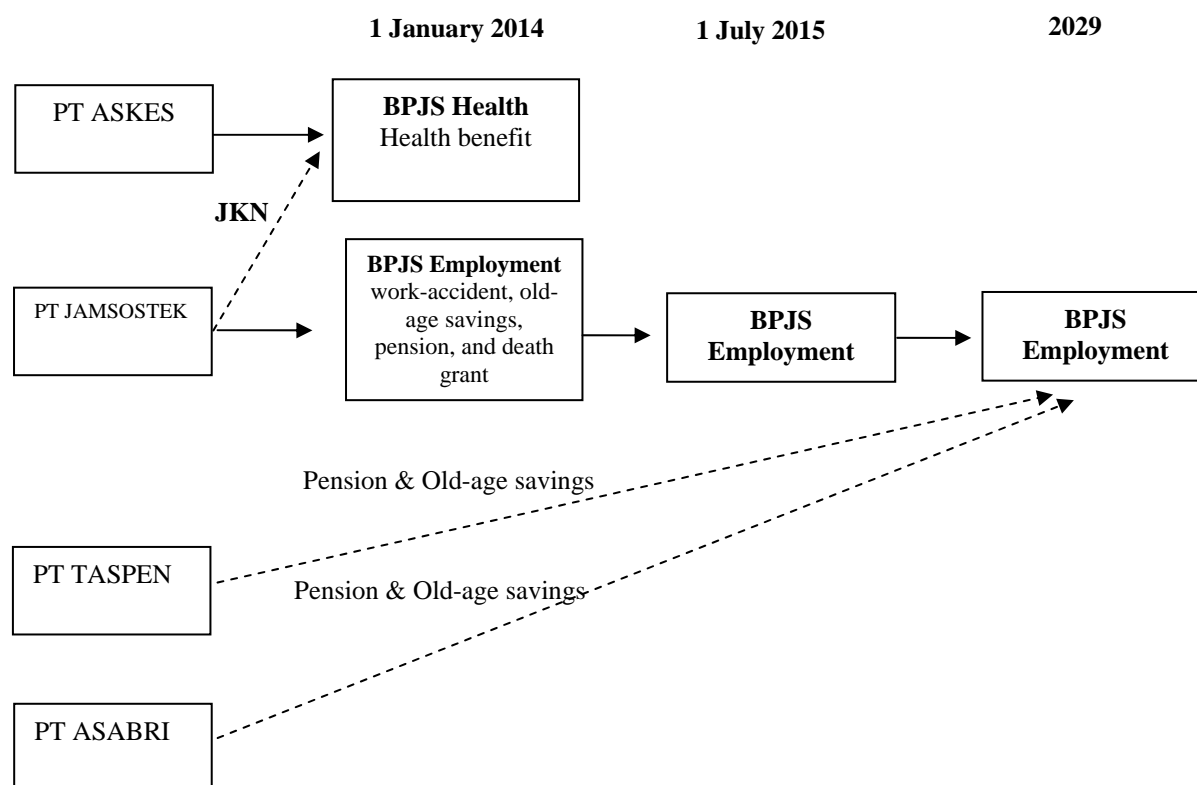
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<sup>2</sup>A law in Indonesia is followed by some implementation regulations which include: Government Regulations, Presidential Regulations, Presidential Instructions, Presidential Decrees, and Ministerial Decrees.

<sup>3</sup>The drafting of law requires parliament's approval, with no time limit for completion (Datta et al. 2011)

step of the JKN implementation would firstly include the ASKES, JAMSOSTEK, and JAMKESMAS beneficiaries as the participants of the BPJS Health.

The Law also stipulates that PT JAMSOSTEK would be transformed to become the BPJS Employment on 1 January 2014 and would start to operate on 1 July 2015 at the latest. The existing health component programme of PT JAMSOSTEK would be merged to the BPJS Health. Whereas the social insurance programmes, old-age savings, and pensions that are currently handled by PT TASPEN and PT ASABRI will be merged to the BPJS Employment by 2029 at the latest (see Figure 1).



**Figure 1. Transformation of BPJS Health and BPJS Employment**  
 Source: Government of Indonesia 2012

### III. THE NATURE OF SOCIAL SECURITY IN INDONESIA

#### 3.1 Social Security Provision

Shared responsibility between all stakeholders, which include the state, employers, individuals as workers, and families or communities, is a basic concept of social security provision (ADB 2007). In Indonesia, as mentioned in the previous section, informal or traditional support systems from extended families or communities still have a significant role in the provision of support for people (especially who are in informal sectors) in time of shocks. Meanwhile, for formal sectors, there is a strong reliance on the employer’s liability provisions and, to a lesser extent, on public and/or private social insurance programmes. Table 1 summarizes the existing social insurance programme for both formal and informal workers in Indonesia.

**Table 1. Existing Social Insurance Programmes in Indonesia**

Type of Benefit	Formal employment		Informal employment	
	Civil servants	Private sector	Non-poor	Poor
Health	√	√	√	√
Pension	√			
Old-age (lump sum)	√	√		
Work accident		√		
Death benefits	√	√		
Termination/endowment/ severance pay	√	√		

Source: ADB 2007

As of 2009, only 17 per cent of the Indonesian population benefited from formal employment-linked contributory social insurance, mostly formal sector employees, according to a study conducted by the International Labour Organisation (ILO) and PT JAMSOSTEK (ILO 2010). The social health insurance entitlement shows a better figure, as slightly more than 60 per cent of the population are covered in the health-benefit programme, of which half of them are included in the government's health insurance for the poor (JAMKESMAS) programme.

**Table 2. Health Insurance Coverage in Indonesia, 2012**

	Coverage (million people)	As % of population
Private formal sector (JAMSOSTEK and private health insurance)	23.8	9.83
Civil servants	17.3	7.14
Army and police	2.2	0.91
Informal Poor	76.4	31.54
Local health insurance (initiated by district or provincial governments)	32.0	13.21
<b>Total</b>	<b>151.6</b>	<b>62.59</b>

Source: Government of Indonesia 2012

Social security-related programs in Indonesia are managed by four social security administrators, which are all state-owned limited liability companies (PT Persero): PT JAMSOSTEK, PT TASPEN, PT ASKES, and PT ASABRI. These four companies are under supervision of several ministries as follows:

- (i) The Ministry of Manpower is responsible for the oversight of PT JAMSOSTEK and the enforcement of compliance of its related legislation.
- (ii) The Ministry of Finance is responsible for the supervision of PT TASPEN, private insurance companies, and private pension schemes. It has also some regulatory duties regarding the investment management activities of these limited liability companies.
- (iii) The Ministry of Health is responsible for the supervision of PT ASKES.

- (iv) The Ministry of Defense is responsible for the social security provisions of the armed forces, with PT ASABRI administering the scheme.

## 3.2 Health Services Provision

Health services provision is an important component in the implementation of a social security system. In Indonesia, the institutional setting of health service provision involved structural health management in the central, provincial, and district government. In addition, it also engages with communities as well as the private sectors (SMERU, Bappenas, and UNICEF 2012).

Decentralization in 2001 transferred the responsibility for managing health from the central government to the sub-national governments, particularly to the district governments. It did have a tremendous impact on the national health system, which was previously predominantly managed by the central government. The sub-national governments, particularly the district, now have the freedom to develop and plan their own health programme and activities with their own funds and the funds that they receive from the Ministry of Health. Nevertheless, the decentralization arrangements as mandated in the Law No. 32/2004 and its derivative regulations still create confusion regarding the role and responsibilities of each level of government, in particular the provincial level, in the health sector.

The central government's roles, through the Ministry of Health and the Provincial Health Office to a lesser extent, is more involved with facilitating managerial and cooperative mechanism among district governments through the provision of technical standards, guidelines, technical assistance, and training. For example, the Ministry of Health issued a decree outlining 26 types of minimum public health services with 54 indicators and targets which have to be performed by the district governments. This minimum service standard aimed to ensure that the district governments maintain public health standards and improve monitoring and evaluation processes.

On the other hand, in the decentralization arrangement, the districts are given full roles and authority to prioritize sectors in their development agenda. In some cases, health problems did not receive special attention or funding. Therefore, it is perceived that the decentralization has dwindled the unified national health system, such as disease surveillance system (WHO 2008, SMERU, Bappenas, and UNICEF 2012).

The health service provision in Indonesia, in fact, is a comprehensive structure from the lowest level of health post in the village to the referral hospital in the district. Furthermore, Indonesia has a combination of public and private health services systems. The public health services provide outpatient and inpatient care, as well as carry out promotive and preventive health activities. Meanwhile, the private health services perform ambulatory care provided by private practitioners and government medical staffs who work privately (World Bank 2008).

At the district level, there is at least one district public hospital which is responsible for providing health services for all of a district's population, with perhaps at least one more private hospital in almost every district in Indonesia. Public health services expanded significantly in the 1970s and 1980s and private services had a large expansion in the 2000s driven by the increase in population, higher disposable income, and changing lifestyle, which have opened opportunities for private providers to enter the business.

The total number of hospitals increased from 1,145 in 2000 to 1,721 in 2011, of which more than half (about 52 per cent) were provided by private health services. Hospital beds also increased considerably from 107,537 beds in 2000 to 148,125 in 2011 (Rokx 2009, Ministry of Health 2012). However, the beds to population ratio (beds per 1,000) in Indonesia is still the lowest among East Asia and Pacific countries, even compared to countries with much lower GDP per capita, such as Lao PDR and Cambodia (World Bank 2008, Rokx et al. 2009).

At the sub-district levels, there is at least one 'Community Health Centre' (*Pusat Kesehatan Masyarakat* or PUSKESMAS) headed by a doctor or public health specialist and supported by two or more supporting staffs such as nurse, midwives, or nutritionist. PUSKESMAS is the backbone of primary health care in Indonesia. The number of PUSKESMAS increased from 7,699 in 2005 to 9,321 in 2011 with an average growth of 3.5 per cent per year in that period.

A common indicator to measure the coverage of a PUSKESMAS is the size of population served by a PUSKESMAS (per 100,000 population). It increased slightly from 3.61 in 2007 to 3.86 in 2011. However, this indicator should be seen very cautiously as there could be greater ratio for remote areas and sparsely-populated areas in the eastern part of Indonesia, such as Papua and Maluku, compared to, for example, the most accessible region in Java. In the east of Indonesia, people have to travel miles away with limited and difficult transportation, as well as expensive cost to access the PUSKESMAS. This means that the coverage size of PUSKESMAS is one problem and access to PUSKESMAS is another problem.

The operational activities of PUSKESMAS are also supported by Sub-PUSKESMAS (*PUSKESMAS Pembantu* or PUSTU) in two or more villages in the sub-district and Mobile Health Centers (*PUSKESMAS Keliling* or PUSLING). The PUSTU are mostly headed by nurses or midwives. Services available at the PUSKESMAS include basic compulsory health services and community-based health services. The compulsory health services are comprised of 'six basics' covering: health promotion, environmental health, maternal and child health (including family planning), community nutrition improvement, prevention and eradication of communicable diseases, and basic medical treatment. Meanwhile, community based health services are varied by PUSKESMAS depending on the District Health Office's concerns in accordance with the local issues and local needs. Services are also dependent on the capabilities of the PUSKESMAS' facility and staffs.

At the community level down to the village and below, the health services are provided by Village Health Post (*Pos Kesehatan Desa* or POSKESDES) and Integrated Health Post (*Pos Pelayanan Terpadu* or POSYANDU). POSKESDES provides curative services at the village level, while POSYANDU provides more preventive and promotive health services. Midwives or nurses usually provide services in POSKESDES, while monthly gatherings in POSYANDU are established and managed by the community with assistance from PUSKESMAS or PUSTU health staffs. By 2011, there are 53,152 POSKESDES and 268,439 POSYANDU in the total of 77,465 villages in Indonesia.

Health workforce density per population in Indonesia is lower than most countries in the region. Table 3 shows that, on average, there are only about three public doctors per 10,000 population, implying that one doctor will need to provide health services for about 3,300 people. While the ratio of nurses and midwives per 10,000 populations is higher, about 20 nurses and midwives serve 10,000 inhabitants. This implies that most people will be served by a nurse or midwife, rather than a doctor, when seeking health care.

**Table 3. Health Workforce in Indonesia and Other Countries in the Region**

Country	Physician		Nurses and Midwives	
	Number	Density per 10,000 population	Number	Density per 10,000 population
Indonesia	65,722	2.9	465,662	20.4
Cambodia	3,393	2.3	11,736	7.9
Viet Nam	107,131	12.2	88,025	10.1
India	757,377	6.5	1,146,915	10
Malaysia	25,021	9.4	72,847	27.3

Source: World Health Report 2012

The nurses and midwives are much more distributed across Indonesia. They are often the only health worker available in the remote areas. The higher numbers of midwives are largely due to the ‘Village Midwives’ (*Bidan di Desa*) programme, which was introduced by the government in 1994, where every village was provided with a midwife, resulting in the distribution of this health workforce much better than other health staffs (World Bank 2008).

The lack of health workforce is not only the problem faced by the poor in rural and remote areas. High rates of absenteeism among health workers is a serious problem in Indonesia, as a survey in 2003 found that 40 per cent of health workers were absent in primary health centres. This rate was among the highest compared to other countries in the world (Chaudhury et al. 2006). PUSKESMAS are understaffed with insufficient doctors and midwives. In many remote rural areas, it is often found that the PUSKESMAS has no doctor available. There is also a question of whether the ‘legal dual practice’ between public and private work of health workers results in their reluctance to provide quality care in their obligatory public services.

## IV. THE CHALLENGES

While the central government has the obligation to implement the universal coverage of social security programmes for all Indonesian citizens as mandated by the SJSN Law, some political and technical challenges remain. This section explains the challenges in details and analyzes the causes of those challenges.

### 4.1 Slow Preparation of the Related Regulations

Based on the Law No. 24/2011 on BPJS, the government should have prepared about 16 derivative regulations (both for BPJS Health and BPJS Employment) before 25 November 2012. However, none of those regulations were issued by the deadline. The first derivative regulation issued is the Government Regulation (*Peraturan Pemerintah* or PP) No. 101/2012 on the beneficiaries for whom the premiums are paid by the government, i.e. the poor and near poor, which was issued in December 2012. Meanwhile, the second derivative regulation issued is the Presidential Regulation (*Peraturan Presiden* or PERPRES) No. 12/2013 on Health Insurance, which was issued in January 2013.

The slow process of preparing the derivative regulations has been criticized by parliament members, NGOs, as well as academics. This delay has posed some technical difficulties in setting up the institutions and other things related to the implementation of universal coverage, such as the decision on the contribution of participants, governance of BPJS, and initial capital of BPJS. PT Askes, which was a state-owned company and managed the health insurance of civil servants, complained that its preparation to transform itself into the BPJS Health, which is a non-profit agency tasked to manage the universal health coverage, had been hampered by the delayed regulations.

One of the main reasons for the delay, besides some technical difficulties such as how to appropriately calculate the premium and benefits, is that there are tough and on-going discussions and negotiations between the government, employees organization, and labour unions on various issues. For example, even within the labour unions there are two opposing positions on the implementation of the social security law. One side has been very active in supporting the law on the basis that it is expected to provide social security for all. Under the previous law (JAMSOSTEK), an employer was only required to register when employing at least ten staff with salary of minimum Rp 100,000. However, due to weak enforcement, many employers chose not to register, leaving many workers without social security.

On the other hand, the other side believes that the universalism of the law will actually be detrimental to workers' welfare. They argue that it is the responsibility of the government to provide social security for the people and not to take contributions. Under the law, workers are now required to contribute 2 per cent of their wage for health insurance scheme, whereas under the previous JAMSOSTEK programme, it was the responsibility of the employer (Joedadibrata 2012).

## 4.2 Budget Allocation

Government's political commitment to implement the universal social security programmes could also be measured by how much budget it allocates for the implementation of this policy. For example, currently only 2.2 per cent of total government budget is allocated to health. Recent newspaper headlines pointed out that the Ministry of Finance has agreed to allocate only Rp 15,500 (equivalent to USD 1.59) /month/beneficiary for the poor and near poor as the premium paid by the government instead of Rp 22,000 (2.3 USD) as proposed by the Ministry of Health. More over, this amount would be allocated for only 84.6 million poor and near-poor people instead of the proposed 96.4 million people (the poorest 40 per cent of the population).

Health experts have said that the premium would not be enough to cover all types of health problems, which could include catastrophic illnesses like cancer, diabetes, and thalassemia.<sup>4</sup> Furthermore, with premiums, it would be difficult for the government to force private hospitals to join the healthcare program because they would expect it to be difficult to get appropriate compensation for their services. Instead, these health experts have said that the government should just focus on state-run hospitals and community health centres to provide universal healthcare.<sup>5</sup>

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<sup>4</sup>The Indonesian Doctors Association (IDI) previously refused the government's proposed premium of Rp 22,000. They recommended the contributions to be set at Rp 27,000. They feared that the low premiums would have a detrimental impact on health care in Indonesia.

<sup>5</sup>The Jakarta Post, 26/03/2013.

For employment programmes, the government's role in covering poor employees, who are predominantly in the informal sector, is still hotly debated. The issue of the contribution of employer and employee as well as the contribution that should be paid by the government for poor informal employees have not been discussed yet.

### **4.3 Unclear Roles of Local Governments**

Indonesia is a decentralized country that consists of 34 provinces and around 500 districts. Health issues (including finance and infrastructure) comprise one of the sectors that have been set as the district government's affair, with the role of central government to steer rather than row. The local health insurance programmes have flourished since 2008. This is directly related to local electoral politics, as candidates promise free social services, like healthcare and education, in a bid to appeal to voters. These schemes were also initiated by many local governments as an effort to close the gap as some of the poor were not covered by the central government's JAMKESMAS programme.

By 2013, a year before the universal coverage scheme to be implemented, around 350 local governments (both provincial and district levels) have a local health insurance scheme in place. However, the role of local governments remains unclear in the grand design of universal health coverage (World Bank 2013). The BPJS Law, which was enacted in 2011, does not mention the role and responsibilities of ongoing local health insurances. These local health insurance schemes, which have variations in benefits packages and reflect partly the fiscal capacity and preferences of local governments, may pose a particular challenge with regard to harmonization and integration of the universal coverage efforts.

Until now, local governments feel that they have not been informed appropriately on the progress of the universal health coverage plan, what roles they would have after the universal coverage is implemented, and what they have to do with their ongoing local health insurance. Some local governments even sued the central government to the Constitutional Court just after the SJSN Law was enacted because they believed that the law violates the Decentralization Law, particularly on the roles of local government in the health sector (Wisnu 2013).

### **4.4 The Supply Side Readiness**

Improving access to social security programmes for more than 250 million people spread across more than 17,000 islands, divided into 33 provinces and 500 districts, surely would pose some supply challenges. This challenge has also been faced by the current ongoing government health insurance for the poor programme (JAMKESMAS). A study by the World Bank (2013) which evaluates the effectiveness of JAMKESMAS shows that there are significant deficiencies in the availability and quality of the basic benefits package, especially for those living in relatively remote and rural locations of the country, and this problem limits the effective availability of benefits for many JAMKESMAS beneficiaries.

The questions on supply side preparedness for the universal coverage scheme, particularly for the health programme, that need to be addressed include:



#### **4.4.1 Lack of Hospital Beds**

First and foremost, the implementation of universal health coverage may increase the demand for treatment. This phenomenon had happened recently when the Jakarta Province launched its universal coverage program in January 2013. Even for the Jakarta Province, which has more comprehensive health services than other provinces in Indonesia, the implementation of universal coverage was overwhelmed by the increased demand to seek for treatment.

According to the World Health Organization (WHO), the country has only six hospital beds per 10,000 people on average in the period 2005-2011, compared with 42 per 10,000 people in China and 30 per 10,000 in the U.S. A critical challenge is the availability of third class beds/rooms (low cost inpatient facilities) in hospitals. It is expected that this type of bed will be overwhelmed by the increase in demand from poor and near poor patients whose premiums have been paid by the government.

The World Health Organisation (WHO) regulates that the minimum ratio of third class beds is 1:1,000 of population. Indonesia currently has 148,125 beds, both in public and private hospitals (Ministry of Health 2012). With a population of 237 million in 2010, there should be an additional 89,000 beds in 2010, and increase over time as the population increases. Currently the third class beds occupancy rate is quite high at 60 to 80 per cent. Furthermore, there is also the issue of services distribution and disparities across regions in the country. The available hospital beds are concentrated in particular areas (mostly in Java), resulting in huge disparities across the country.

#### **4.4.2 Lack of Service Providers**

The issue of supply side also occurs in the availability and capacity of health service providers. It is apparent that Indonesia experiences a sharp shortage of doctors. The ratio of doctors in Indonesia is 2.9 per 10,000 inhabitants, compared to 14.2 per 10,000 in China and 24.2 per 10,000 in the US. Village of Potential Data Survey in 2011 reported that around 92 per cent of PUSKESMAS had at least one doctor (Statistics Indonesia 2011). However, more realistic estimates suggest that as many as 2,250 PUSKESMAS (around 25 per cent of the total number) are without doctors, most of these in the more remote areas of the country (World Bank, 2013). Similarly, the distribution of doctors is highly concentrated in the Java-Bali region, which accounts for around 65 per cent of all doctors. Fewer than six per cent of doctors practice in the eastern part of the country.

#### **4.4.3 Lower Quality of Community Health Centres (PUSKESMAS)**

As mentioned in the previous section, PUSKESMAS is the backbone of primary health care in Indonesia. Before the SJSN, people are obliged to pay for individual health benefit from PUSKESMAS and the amount is determined by each local government. The total of funds received by PUSKESMAS becomes part of Locally Derived Revenue (*Penerimaan Asli Daerah* or PAD) in the local governments' budget. In addition to fee collected from patients, PUSKESMAS also receives funds from a variety of other sources, including PT ASKES, PT JAMSOSTEK, JAMKESMAS, JAMPERSAL, and other government health programmes. With the commencement of the SJSN in January 2014, the PUSKESMAS financing for individual health efforts is supported by capitation payments from the BPJS Health.

As of 2011, the total number of PUSKESMAS was 9,321, comprising of 6,302 centres with outpatient facilities only and 3,019 centres equipped with inpatient facilities (Ministry of Health 2012). In principle, PUSKESMAS are meant to provide basic health services and

referrals to secondary and tertiary public hospitals. However, in practice many people prefer going to hospitals directly rather than via PUSKESMAS. It is mainly due to the low quality of human resources and facilities in PUSKESMAS. Besides, the gate-keeping and referral functions of PUSKESMAS are very weak. There are no penalties for self-referring to a higher-level facility as patients can go directly to secondary or tertiary hospitals and obtain its services without PUSKESMAS referrals (or simply obtain a referral letter from a PUSKESMAS without having the required procedure).

On average there are 3.86 PUSKESMAS per 100,000 populations in 2011. As discussed before, this ratio should be perceived with caution since it is found that the ratio of PUSKESMAS per 100,000 in remote provinces is much higher. For instance, in the eastern part of Indonesia, the ratios ranged from 8 to 12 per 100,000, but these facilities cover geographically remote, difficult, and sparsely populated areas (World Bank 2013).

## 4.5 Informal Sector Inclusion

In expanding coverage to achieve universalism in social security programmes, one of the most challenging issues is the expansion to cover the non-poor informal sector. Other countries, such as Brazil, China, Mexico, and Thailand have had difficulties covering this particular group. The challenges are around the level of premium contributions and collection mechanisms. The majority of the people in Indonesia (about two-thirds of the population) work in the informal sector and around 50 per cent of them work in the agriculture sector and live in rural areas (World Bank, 2013). Statistics Indonesia estimated informal employment to be about 68 per cent in 2009 and the share of small enterprises (that seem to be mostly informal) to the GDP output to be roughly 38 per cent.<sup>6</sup>

However, the current system has no coverage for them, unless they are considered poor. There are no official data on the informal non-poor in terms of the number, income, location, and type of occupation or business they run. Lack of data creates difficulties in deciding the size of the premium which should be paid by them and how to collect contribution from this informal non-poor.

Lessons to be learned may be based on the experiences of the Government's pilot project on the Social Welfare Insurance Programme (*Asuransi Kesejahteraan Sosial* or ASKESOS). The programme has been piloted since 2003, and managed by numerous civil society organizations (CSOs) under the Ministry of Social Affairs' supervision and targets the poor and near poor working in the informal economy. The main objective of the programme is to protect informal sector workers by providing insurance in the case of unwanted situation. The programme covers limited healthcare benefits and death benefits for a maximum of three years membership.

In this pilot, the workers are encouraged to save Rp 5,000 per month for three years and, while they are doing so, the Ministry of Social Affairs bears the cost of any hospitalization lasting at least five days (to the extent of Rp 1,000,000 per year) and provides a lump sum of up to Rp 600,000 in the event of their death. It is expected that after three years the awareness

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<sup>6</sup>Statistics Indonesia (*Badan Pusat Statistik* or BPS) adopted the definition from ILO's 1992 Surveys of Economically Active Population, which defines informality as 'traditional economic activity conducted by low level or unstructured organizations without transaction accounts, in a causal relationship, and based on personal relations rather than contract or formal agreement'. Informal economy constitutes activities that are outside the 'formal reach of law' (Joedadibrata 2012).

towards the importance of insurance will be built and the members would voluntarily join the insurance and pay full premiums. In 2012, there are around 125,000 members, consisting of mostly the self-employed informal workers, managed by 251 CSOs spread over 33 provinces. The lesson that can be drawn from this programme is how it employs the local CSOs in collecting the contribution and convincing the informal workers to participate in the program.

## V. CONCLUSION

Social security provision in Indonesia has evolved from very small during its early period to the privilege of formal sector workers during the New Order period to universal coverage, at least in principle, in the current period. These changes were in line with and driven by the developments of the Indonesian economy in general, which has gone through various episodes marked by both booms and crises. Nevertheless, over the long run, there is a clear pattern of expansion in social security provision both in terms of the schemes provided as well as the population coverage of the social security system.

There are two important milestones in the development of social security in Indonesia. The first is the change in government during the chaotic situation in the mid 1960s. The New Order government, after successfully stabilized the economy, embarked on economic development, which resulted in high economic growth during three decades it was in power. The high economic growth made it possible for the private sector to grow and expand, which created a demand for social security for the growing number of workers in the formal sector. Through gradual successive steps, the government developed various social security schemes, managed by four state owned enterprises: PT ASKES for managing health insurance for civil servants, PT TASPEN for managing pension for civil servants, PT ASABRI for managing social security schemes for military and police personnel, and PT JAMSOSTEK for managing social security schemes for workers in medium and large private enterprises.

The second milestone is the occurrence of the Asian Financial Crisis at the end of the 1990s, which brought down the New Order government. The crisis exposed the weaknesses of the social security system in place at a time it was needed most. Because it left out a large majority of the population, the social security system was ineffective in preventing a large number of people from falling into poverty, resulting in a significant increase in the poverty rate. This prompted efforts to establish a stronger social security system in the country, initiated by an amendment in the constitution guaranteeing the right to social security for every citizen. This was followed by the issuance of the Law on National Security System, which adopts a universal coverage for social security provision. After a considerable delay, another law was issued to establish two social security implementing agencies: BPJS Health and BPJS Employment.

However, the challenges for implementing the expansion of social security coverage to the whole population as mandated by the national social security law are formidable. Indonesia's vast geography, huge population, and diverse availability and quality of infrastructure implies that the implementation of the national social security system to cover the entire population should proceed very cautiously and involve all stakeholders including the local governments, employers, employees, the implementing agencies (BPJS Health and BPJS Employment), as well as service providers. For example, to avoid confusion, it is important to make sure that the roles of local governments in social security provision are clearly stipulated.

To anticipate the problem supply side availability, coordination between various levels of government and multiple agencies needs to be clearly designed. It is also critically important to assess the fiscal sustainability of the system, which requires a political commitment to ensure this. Since the universal coverage would also have an impact on the demand side, managing the demand shocks, especially at the first stage of implementation, will be very critical, particularly in the health programme. In this aspect, the government needs to develop a clear and strong referral system and make sure that the system works efficiently and effectively.

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