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Expanding social security in Indonesia: The processes and challenges

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Expanding Social Security in Indonesia

The Processes and Challenges

Asep Suryahadi, Vita Febriany and Athia Yumna

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Towards Universal Social Security in Emerging
Economies: Process, Institutions and Actors

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Acronyms

AFC	Asian Financial Crisis
ASABRI	Indonesian Armed Forces' Social Insurance (<i>Asuransi Angkatan Bersenjata Republik Indonesia</i>)
ASKESKIN	Health Insurance for Poor Households (<i>Asuransi Kesehatan bagi Keluarga Miskin</i>)
ASTEK	Employees' Social Insurance (<i>Asuransi Tenaga Kerja</i>)
BPDPK	Agency for Healthcare Funds (<i>Badan Penyelenggara Dana Pemeliharaan Kesehatan</i>)
BPJS	Social Security Implementing Agency (<i>Badan Penyelenggara Jaminan Sosial</i>)
BPS	Statistics Indonesia (<i>Badan Pusat Statistik</i>)
CSO	civil society organization
DASPERI	Civil Servant's Welfare Fund (<i>Pembelanjaan Pegawai Negeri</i>)
GDP	gross domestic product
GFC	Global Financial Crisis
ILO	International Labour Organization
JAMKESMAS	Health Security for Society (<i>Jaminan Kesehatan Masyarakat</i>)
JAMSOSTEK	Workers' Social Security (<i>Jaminan Sosial Tenaga Kerja</i>)
JKN	National Health System (<i>Jaminan Kesehatan Nasional</i>)
JPS	Social Safety Net Programme (<i>Jaring Pengaman Sosial</i>)
POSKEDES	Village Health Post (<i>Pos Kesehatan Desa</i>)
POSYANDU	Integrated Health Post (<i>Pos Pelayanan Terpadu</i>)
PT	private limited liability company (<i>Perseroan Terbatas</i>)
PT or PT <i>Persero</i>	state-owned limited liability company
PUSKESMAS	Community Health Centre (<i>Pusat Kesehatan Masyarakat</i>)
PUSTU	Sub-PUSKESMAS (<i>PUSKESMAS Pembantu</i>)
Rp	rupiah
SJSN	National Social Security System (<i>Sistem Jaminan Sosial Nasional</i>)
TASPEN	Civil Servant Insurance Savings (<i>Tabungan Asuransi Pegawai Negeri</i>)
WHO	World Health Organization

Abstract

This paper reviews the development of social security provision in Indonesia, which has evolved from very little in its early years 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. 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 to formal sector workers only. 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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1. Introduction

In Indonesia, the right to social security is currently enshrined in its 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 government 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. A large majority of the population, whose livelihoods were in the informal sector, had to rely on informal social protection from their families and communities. When the Asian Financial Crisis (AFC) 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 virtue of three decades of economic miracle turned out to be still vulnerable and found themselves back in poverty.

Once the chaos of the AFC started to stabilize in 2000, reform of the social security system was initiated, resulting in an amendment to the Constitution that adds a clause on the universal right for social security. After a controversial process, viewed as less than inclusive by some, Law No. 40/2004 on the National Social Security System (*Sistem Jaminan Sosial Nasional* or SJSN) was passed near the end of 2004. This new SJSN 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 entire 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 SJSN Law specified a five-year period for the issuance of the derivative laws and regulations. Unfortunately, it was signed into effect just a few months after the 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 and although it never explicitly stated any objection to the social security law, 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 for the implementation of the SJSN Law. Hence, the new Parliament took the initiative to propose a law on the social security implementing agency. This is a crucial derivative law for the implementation of the SJSN Law. After some protracted deliberations with the government, the Parliament passed Law No. 24/2011 on Social Security Implementing Agency (*Badan Penyelenggara Jaminan Sosial* or BPJS) at the end of 2011. The new law created two social security implementing agencies: BPJS Health, which began operation in January 2014; and BPJS Employment, which would begin operation in July 2015.

The establishment of these two social security implementing agencies marked a new era in the development of social security in Indonesia as they are responsible for providing social security benefits to the entire population. BPJS Health is responsible for

managing the universal social health insurance, while BPJS Employment is responsible for managing the schemes on pension, old-age, death and work accident benefits.

Both implementing agencies face great challenges in providing social security benefits to more than 250 million Indonesians. Discussing these challenges is the focus of this paper, which is organized as follows. Section 2 discusses the development of social security in Indonesia. Section 3 considers the nature of social security in Indonesia, while section 4 examines the challenges faced in the expansion of social security in Indonesia. Finally, the section 5 concludes.

2. Development of Social Security in Indonesia

The development of social security in Indonesia is very much related to 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 socioeconomic conditions. Their links to social security development is discussed in the second part of this section.

Ups and downs of Indonesian economic growth

In general, the trends of economic growth in Indonesia can be divided into several chronological periods: (i) the postindependence period (1945–mid-1960s); (ii) the New Order government or pre-AFC period (1967–1996); (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).

Post-independence period (1945–mid-1960s)

After proclaiming its independence in 1945, the war for independence continued until 1949 when the Dutch government and the 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. From 1949 to 1965, Indonesia recorded little economic growth, predominantly 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 from 1958 to 1965, again due to political instability in the country.

The introduction by Sukarno, Indonesia's first president, of the 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 (Touwen 2008; Lindblad 2010). Booth (1998) estimated a growth rate of per capita gross domestic product (GDP) of only 1 per cent annually on average from 1950 to 1965. This growth rate was considered too low for the rapid population growth after the war, which reached 2 per cent annually.

New Order government (1967–1996)

After the New Order government took over in 1967, economic development in Indonesia underwent radical changes. The economy grew rapidly and it rose from being one of the poorest countries in the world to a middle-income country in 1993. The per

capita income increased from \$50¹ 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 turnaround 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 significantly raised the government's export earnings and revenues. 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 toward the 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 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. The Gini ratio was relatively stable at around 0.33.

AFC (1997–1999)

After nearly 30 years of uninterrupted rapid growth, low inflation and a stable currency, the AFC in 1997 reversed the situation completely. The AFC, which first started in Thailand, weakened the Indonesian currency rupiah (Rp) from Rp 2,200 per \$1 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 (Suryahadi et al. 2012; Basri 2013). To make matters worse, some areas of Indonesia suffered simultaneously from a severe drought that 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 (Suryahadi et al. 2012; Basri 2013). 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

¹ All references to \$ are to United States (US) dollars.

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 Soeharto to step down took place all over Indonesia, with some leading to riots and deaths. By May 1998 the country was suffering from the combined effects of currency, financial, natural, economic and political crises, and Soeharto agreed to step down from the presidency and transferred it to Vice-president B. J. Habibie (Suryahadi et al. 2012).

The skyrocketing price of rice and other basic necessities due to the AFC increased the poverty rate from around 15 per cent in 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 the crisis for the poor, the government, with support from donors, launched the Social Safety Net Programme (JPS or *Jaring Pengaman Sosial*) programme, covering food, education, health, employment and community empowerment support.

Post-AFC period (2000–2007)

During the post-AFC period, 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 crisis 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 AFC, 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 points annually, which constitutes only around 40 per cent of the pace of poverty reduction during the pre-crisis period (Suryahadi et al. 2012).

GFC (2008–2009)

About 10 years after the AFC, Indonesia faced another crisis in the form of the GFC. The effects of the GFC were reflected by 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 and the stock market index dropped by 50 per cent in 2008 (Basri 2013). Nevertheless, the impact of the GFC on the Indonesian economy was relatively mild compared to other countries in the region, including Malaysia, Singapore and Thailand.

The impact of the 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 one 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 throughout 2008 reached 6.1 per cent, which was the highest in Asia after China and India (Basri and Rahardja 2011). In 2009, however, economic growth fell to 4.5 per cent, but it was 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 crop. This, combined with in-place social protection programmes, made it possible for the poverty rate to continue declining despite the crisis. The poverty rate continued to fall from 16.6 per cent in 2007 to 15.4 per cent in 2008 and 14.2 per cent in 2009.

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, economic growth rebounded to 6.1 per cent and this high economic growth was maintained in subsequent years. The Indonesian economy grew by 6.5, 6.2 and 5.8 per cent in 2011, 2012 and 2013, respectively.

As a result of the continuing economic growth post-AFC, the per capita income steadily rose from \$2,200 in 2000 to \$3,563 in 2012. Nevertheless, more than 32 million Indonesians still lived below the national poverty line, with about the same number of people categorized as the near-poor who lived 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 was 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.

Development of social security in Indonesia

After gaining independence in 1945, as in 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 that all citizens had the right to decent work and livelihood as well as social security for the poor and vulnerable as stipulated 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, increased the need to develop the social security system. Labour market conditions at that time, in which an 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 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 JPS programmes, which were introduced during the AFC, as well as introducing new programmes such as the conditional and unconditional cash transfer programmes. For social security, after a deliberation with the Parliament starting in 2003, Law No. 40/2004 on SJSN was issued in 2004.

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

Social security at 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 assistance in times of crises, such as loss of income because of work termination, illness, old age, disability or death, or even during the process of entering the labour force (Esmara and Tjiptoherijanto 1986).

However, 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 nineteenth century. After independence, the first regulation on work accident compensation that 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: the Civil Servant's Welfare Fund (*Pembelanaan Pegawai Negeri*) called DASPERI and the Civil Servant Insurance Savings (*Tabungan Asuransi Pegawai Negeri*) called TASPEN.

DASPERI was a social assistance programme for the families of civil servants, mainly compensating for natural disasters, supervised by the Ministry of Social Welfare. Meanwhile, TASPEN was a social insurance programme for 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 supervision of the Ministry of Finance.

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

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, it boosted the economy, resulting in a rapid economic growth starting at the beginning of the 1970s, averaging 7 per cent annually, until the 1997–1999 AFC grounded it to a halt. The period of high economic growth, gave spacious room for the government to attempt more advanced public policies, including for 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. Law No. 11/1969 on Principles of Employment for Civil Servants combined the previous regulation on civil servants and the 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 Indonesian Armed Forces' Social Insurance (*Asuransi Angkatan Bersenjata Republik Indonesia* or ASABRI). ASABRI was designed to accommodate different pension ages for 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 led the DASPERI programme to a crossroads since the programme was not an insurance scheme in the ordinary sense, but more a social assistance programme. The government then made the decision to terminate DASPERI in 1975 and transferred the social assistance funds to TASPEN and ASABRI, while the natural disaster components of DASPERI were handed over to the Ministry of Social Welfare. Government Regulation No. 25/1981 further merged all social security programmes for civil servants (welfare programme; old-age savings; 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. BPDPK 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 decreed in 1991. Perum Husada Bhakti at this stage was permitted to run a private health insurance on a voluntary basis to expand the membership. Its status was changed to a limited liability company (*Perseroan Terbatas* or PT *Persero*) and became PT ASKES in 1992 (ADB 2007).

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

The next substantial development of social insurance for private sector workers was the issuance of Law No. 3/1992 on Workers' Social Security (*Jaminan Sosial Tenaga Kerja* or JAMSOSTEK). Government Regulation No. 36/1995, as a derivative of Law No. 3/1992, assigned PT JAMSOSTEK as the implementing agency of JAMSOSTEK. The programme's benefits included health insurance, work accidents, old-age savings and death benefits. The rate of contribution varied from 5.7 per cent of the salary for a provident fund, consisting of 3.7 per cent employer contribution and 2 per cent employee contribution, to 0.3 per cent of the salary for a death benefit grant.

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

Social security in the midst of the AFC and afterwards

The AFC in 1997–1999 hit Indonesia hard and reversed the positive trends that previously had been achieved. The currency fell to as low as 15 per cent of its pre-crisis value in less than one 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 of measurement) 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 AFC, 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 by 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 crisis fall into poverty.

The government’s immediate response to the AFC was the introduction of the JPS in 1998 and 1999, which was triggered by the initiation of the Structural Adjustment Programme, in turn heavily influenced by the International Monetary Fund and the World Bank. The Structural Adjustment Programme has four objectives: (i) stabilizing the exchange rate and prices and stimulating 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 JPS programmes (Mulyadi 2013).

The JPS programme aimed to prevent the poor from falling more deeply into poverty and to reduce the exposure of vulnerable households to risk. The JPS programme, which was partly financed by a loan from the World Bank, covers five programmes: rice subsidy; school scholarships and block grants; health card (*kartu sehat*), providing the poor with free access to public health services; labour-intensive work programme; and the provision of grants to selected community groups (Sumarto et al. 2002).

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, 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*), the highest representative body in the country.

In 2002, the Consultative Assembly 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, no article mentioned social security explicitly. The two closest related 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 SJSN Law was completed in 2003 and submitted to the Parliament in early 2004. The draft had been revised 56 times before it was enacted as 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, that is, whether it should be in the form of a state-owned enterprise or a public and non-profit legal entity. The SJSN Law had the consequence of covering the entire population, in both the formal and informal sectors, and bringing them into the national social security system.

The first social health programme that targeted poor households was started in 1994 with the health card programme and was fully institutionalized in 1998 through the JPS Health (*JPS Bidang Kesehatan*) programme, which ran from 1998 to 2001. During 2001–2005, it was replaced by the *PKPS–BBM* programme, which was a fuel price increase compensation scheme that also used the JPS programme management system. The fuel price compensation scheme changed its name in March 2005 to Health Insurance for Poor Households (*Asuransi Kesehatan bagi Keluarga Miskin* or ASKESKIN) under the first term of President Yudhoyono.²

Although the name of the programme referred to a health insurance, it was actually a health service fee waiver for the poor that was tax financed. ASKESKIN was seen as a first-phase introduction of universal health coverage as mandated by Law No. 40/2004. Like the JPS, the *PKPS–BBM* and ASKESKIN programmes were also targeted to poor households. However, ASKESKIN 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 a household basis, JAMKESMAS is on an individual basis, although its targeting is still done at the household level. In this programme, the Ministry of Health verified the beneficiary list (compiled by Statistics Indonesia – *Badan Pusat Statistik* or BPS – and processed the claims, while hospitals and community health centres provided the services and claimed the fees to the Ministry of Health.

² 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. This resulted in an average of a 30 and 114 per cent increase in 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.

The SJSN Law

As mentioned above, Law No. 40/2004 on SJSN is a framework law.³ It does not stipulate detailed benefits and contribution rates for each of the programmes (ADB 2007); rather, it outlines the basic structure of the reformed social security system, which is:

- Universal coverage for all Indonesians, both for formal and informal workers and their dependents, who would be required to make contributions to the programme.
- Five separate programmes would be created within the system.
- Four existing state-owned social security companies – JAMSOSTEK, ASKES, TASPEN and ASABRI – would serve as the administrator of the programme.
- A National Social Security Council would be established with 15 members representing the government, employers, workers and experts.
- Formal and informal workers would make different contributions. Formal workers' contributions as a percentage of wages and split between workers and employers. For informal workers, the contributions as a nominal amount in rupiahs.
- The government would pay 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 SJSN Law specifies that the four existing state-owned social security companies would form BPJS. Yet, the exact role of each institution was to be determined in a separate law.

The SJSN Law required that the regulation on implementing agencies be created by October 2009, five years after it was passed. However, the timeline could not be achieved by the government and the draft of the derivative regulation was not submitted to the Parliament by that date.⁴ The Parliament then took the initiative to solve this problem by formulating the draft first and subsequently discussed it with the government at the end of 2010. Finally, it was passed as Law No. 24/2011 on BPJS in November 2011.

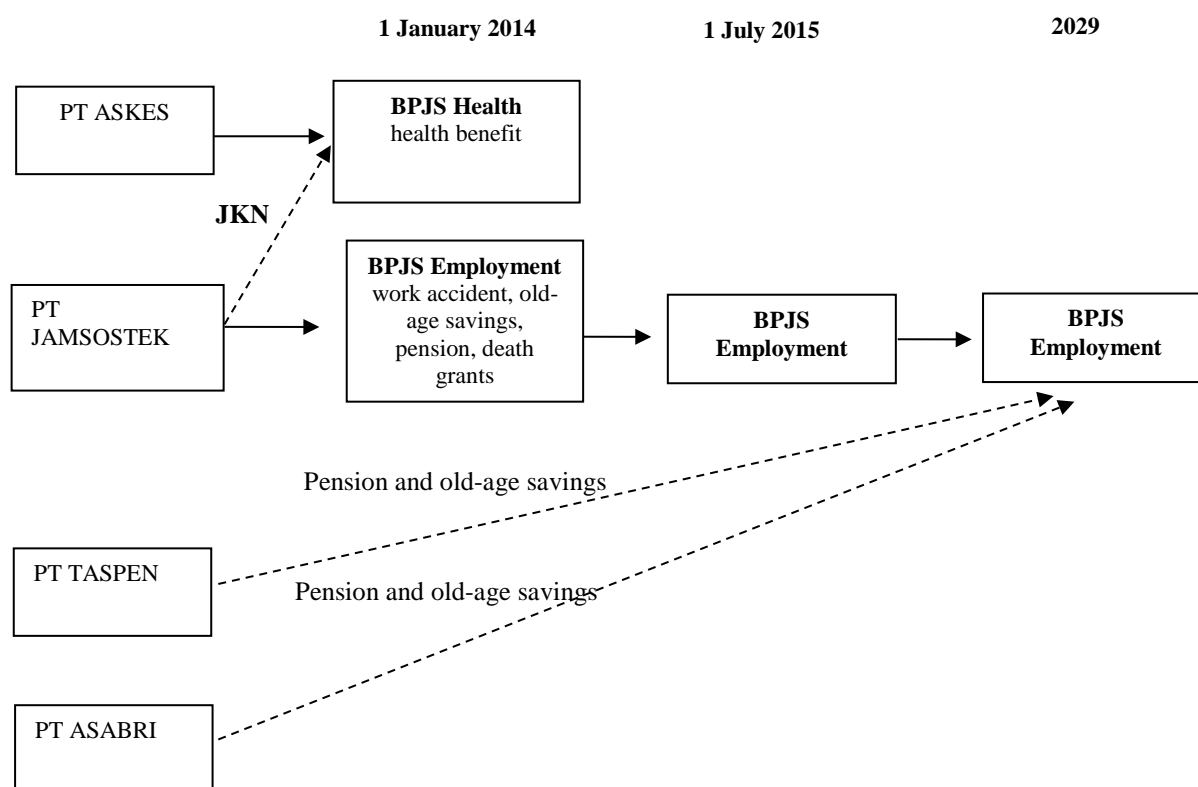
The BPJS Law stipulates two administrative bodies that are responsible for the implementation of the social security programmes: BPJS Health and BPJS Employment. BPJS Health manages the health benefits, while BPJS Employment administers the other four programmes (work accident, old-age savings, pensions 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 BPJS Health and would start to operate on 1 January 2014. The road map of the National Health System (*Jaminan Kesehatan Nasional* or JKN) states that the first step of the JKN implementation would initially include ASKES, JAMSOSTEK and JAMKESMAS beneficiaries as the participants of BPJS Health (Widowati 2013).

The BPJS Law also stipulates that PT JAMSOSTEK would be transformed to become 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 with BPJS Health; whereas, the social insurance programmes, old-age savings and pensions that are currently handled by PT TASPEN and PT ASABRI would be merged with BPJS Employment by 2029 at the latest (see figure 1).

³ A law in Indonesia is followed by implementation regulations that include: Government Regulations, Presidential Regulations, Presidential Instructions, Presidential Decrees and Ministerial Decrees.

⁴ The drafting of a law requires Parliament's approval, with no time limit for completion.

Figure 1: Transformation of BPJS Health and BPJS Employment



Source: Government of Indonesia (2012).

3. The Nature of Social Security in Indonesia

Social security provision

Shared responsibility between all stakeholders, which includes 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 times of crisis. 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 programmes 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 Organization (ILO) and PT JAMSOSTEK (ILO 2010). The social health insurance entitlement showed a better figure, as slightly more than 60 per cent of the population is covered by the health benefit programme, of which half is included in the government's health insurance for the poor (JAMKESMAS) programme (see table 2).

Table 2: Health insurance coverage in Indonesia, 2012

	Coverage (million people)	% 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
Total	151.7	62.63

Source: Government of Indonesia (2012).

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

- The Ministry of Manpower was responsible for the oversight of PT JAMSOSTEK and the enforcement of compliance of its related legislation.
- The Ministry of Finance was responsible for the supervision of PT TASPEN, private insurance companies and private pension schemes. It also had some regulatory duties regarding the investment management activities of these limited liability companies.
- The Ministry of Health was responsible for the supervision of PT ASKES.
- The Ministry of Defence was responsible for the social security provisions of the armed forces, with PT ASABRI administering the scheme.

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 at the central, provincial and district levels of government. In addition, the social security system also engages with communities as well as the private sectors (SMERU et al. 2012).

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

The central government's role, 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 that are 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 the disease surveillance system (WHO 2008; SMERU et al. 2012).

Health service provision in Indonesia, in fact, is a comprehensive structure from the lowest level of the 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 staff who work privately (World Bank 2008).

At the district level, there is at least one district public hospital that is responsible for providing health services for all of the 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 experienced considerable 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 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 Asian and Pacific countries, even compared to those with much lower GDP per capita, such as Cambodia and the Lao People's Democratic Republic (World Bank 2008; Rokx et al. 2009).

At the subdistrict level, 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 staff such as nurses, midwives or nutritionists. The 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 used to measure the coverage of a PUSKESMAS is the size of the population it serves (per 100,000 population). It increased slightly from 3.61 PUSKESMAS' in 2007 to 3.86 in 2011. However, this indicator should be cautiously viewed as there could be a 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 of Java. In eastern Indonesia, people have to travel many miles with limited and difficult transportation, as well as considerable cost to access to the PUSKESMAS. This means that the coverage size of a PUSKESMAS is one problem and access is another problem.

The operational activities of a PUSKESMAS are also supported by a Sub-PUSKESMAS (*PUSKESMAS Pembantu* or PUSTU) in two or more villages in subdistricts and by Mobile Health Centres (*PUSKESMAS Keliling* or PUSLING). PUSTUs are mostly headed by nurses or midwives and the services available include basic compulsory health services and community-based health services. The compulsory health services are comprised of “six basics” covering: (i) health promotion; (ii) environmental health; (iii) maternal and child health (including family planning); (iv) community nutrition improvement; (v) prevention and eradication of communicable diseases; and (vi) 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 needs. Services are also dependent on the capabilities of the PUSKESMAS’ facility and staff.

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

Health workforce density by population in Indonesia is lower than in most countries in the region. Table 3 shows that, on average, there are only about three public doctors per 10,000 people, implying that one doctor would need to provide health services for about 3,300 people; while the ratio of nurses and midwives is higher, with about 20 nurses and midwives per 10,000 people. This implies that most people will be seen 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	Doctors		Nurses and midwives	
	Number	Density per 10,000 people	Number	Density per 10,000 people
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: WHO (2012).

Nurses and midwives are much more distributed across Indonesia, and are often the only health workers available in 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, whereby every village was provided with a midwife, resulting in the distribution of this health workforce much better than other health staff (World Bank 2008).

The lack of a health workforce is not the only problem faced by the poor in rural and remote areas. High rates of absenteeism among health workers is a serious problem in Indonesia, with one survey in 2003 finding 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 an insufficient number of doctors and midwives. In many remote rural areas, it is often found that a 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.

4. The Challenges

While the central government has an obligation to implement 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 detail and analyses the causes of those challenges.

Slow preparation of the related regulations

Based on the BPJS Law, the government was expected to 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 was Government Regulation No. 101/2012 on the beneficiaries for whom the premiums are paid by the government, that is, the poor and near-poor, in December 2012. Meanwhile, the second derivative regulation issued was Presidential Regulation (*Peraturan Presiden* or PERPRES) No. 12/2013 on Health Insurance in January 2013.

The slow process of preparing the derivative regulations has been criticized by the members of Parliament and non-governmental organizations as well as academics. This delay has posed some technical difficulties in setting up the institutions and other necessary arrangements related to the implementation of universal coverage, such as the decision on the contributions of participants and governance of 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 BPJS Health, which is a non-profit agency tasked to manage universal health coverage, had been hampered by the delayed regulations.

One of the main reasons for the delay, besides several technical difficulties such as how to appropriately calculate the premium and benefits, is that there are tough and ongoing discussions and negotiations between the government, employees' organizations and labour unions on various issues. For example, even within the labour unions there are two opposing positions on the implementation of the SJSN Law. One side has been very active in supporting the SJSN 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 10 staff with total salaries of a minimum of 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 SJSN 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 collect contributions. Under the SJSN Law, workers are now required to contribute 2 per cent of their wages for the health insurance scheme, whereas under the previous JAMSOSTEK programme, it was the responsibility of the employer (Joedadibrata 2012).

Budget allocation

The government's political commitment to implement the universal social security programmes could also be measured by how much of the budget it allocates for the implementation of this policy. For example, currently only 2.2 per cent of the total government budget is allocated for health. Recent newspaper headlines pointed out that the Ministry of Finance has agreed to allocate only Rp 15,500/month/beneficiary (equivalent to around \$1.5) for the poor and near-poor as the premium paid by the government instead of Rp 22,000 (\$2.3) as proposed by the Ministry of Health. Moreover, 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) (*The Jakarta Post* 2013).

Health experts have stated that the premium would not be enough to cover all types of health problems, which would include catastrophic illnesses such as cancer, diabetes and thalassemia.⁵ Furthermore, with premiums, it would be difficult for the government to force private hospitals to join the health-care programme because they would expect it to be difficult to receive appropriate compensation for their services. Instead, these health experts have stated that the government should focus on state-run hospitals and community health centres to provide universal health care (*The Jakarta Post* 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 contributions of employers and employees as well as the contribution that should be paid by the government for poor informal employees has not yet been discussed.

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 designated as the district government's responsibility, with the role of the 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 such as health care and education in a bid to appeal to voters (Aspinall 2014). 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, one year before the universal coverage scheme was to be implemented, around 350 local governments (both provincial and district levels) had 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 partly reflect the fiscal capacity and preferences of local governments,

⁵ The Indonesian Doctors Association (IDI) previously refused the government's proposed premium of Rp 22,000, instead recommending that 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.

may pose a particular challenge with regard to harmonization and integration of the universal coverage efforts.

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

Supply side readiness

Improving access to social security programmes for more than 250 million people spread across more than 17,000 islands, divided into 34 provinces and around 500 districts, surely would pose some supply challenges. Additional challenges are the drawbacks of current ongoing government health insurance programme for the poor (JAMKESMAS). A study by the World Bank (2013), which evaluated the effectiveness of JAMKESMAS, showed 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 services for many JAMKESMAS beneficiaries.

The issues of supply side preparedness for the universal coverage scheme, particularly for the health programme, that need to be addressed include the following.

Lack of hospital beds

First and foremost, the implementation of universal health coverage may increase the demand for treatment. This phenomenon happened recently when the Jakarta Province launched its universal coverage programme 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 (Reuters 2013).

According to the World Health Organization (WHO 2012), Indonesia had 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 United States. 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 are paid by the government.

WHO recommends that the minimum ratio of third class beds is 1:1,000 of the 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 have been an additional 89,000 beds, with increases over time as the population increases. Currently, the third class bed occupancy rate is quite high at 60–80 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.

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 people, compared to 14.2 per 10,000 in China and 24.2 per 10,000 in the United States. The BPS' Village Potential Data Survey in 2011 reported that around 92 per cent of PUSKESMAS' had at least one doctor. 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 6 per cent of doctors practise in the eastern part of the country.

Lower quality of community health centre (PUSKESMAS)

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

As of 2011, the total number of PUSKESMAS' was 9,321, comprising 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 a PUSKESMAS. This is mainly due to the low quality of human resources and facilities in a PUSKESMAS. In addition, the gatekeeping and referral functions of a 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 following the required procedure).

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

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 also have had difficulties covering this particular group. The challenges centre on 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). The

BPS estimated informal employment to be about 68 per cent in 2009 and the share of small enterprises (that seem to be mostly informal) to GDP output to be roughly 38 per cent.⁶

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 that should be paid by them and how to collect contributions from the 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 supervision of the Ministry of Social Affairs 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 situations. The programme covers limited health-care benefits and death benefits for a maximum membership of three years.

In this pilot project, 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 (up to 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, awareness of the importance of insurance would be established and the members would voluntarily join the insurance programme and pay full premiums. In 2012, there were around 125,000 members, consisting mostly of self-employed informal workers and 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 contributions and convincing the informal workers to participate in the programme.

5. Conclusion

Social security provision in Indonesia has evolved from very little during its early period to a privilege for 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 covered by the social security system.

There are two important milestones in the development of social security in Indonesia. The first was the change in government during the chaotic situation in the mid-1960s. The New Order government, after successfully stabilizing the economy, embarked on economic development, which resulted in high economic growth during the 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

⁶ The BPS adopted the definition from the ILO 1992 Surveys of Economically Active Population, which define 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).

government developed various social security schemes, managed by four state-owned enterprises: (i) PT ASKES for managing health insurance for civil servants; (ii) PT TASPEN for managing pension for civil servants; (iii) PT ASABRI for managing social security schemes for military and police personnel; and (iv) PT JAMSOSTEK for managing social security schemes for workers in medium and large private enterprises.

The second milestone was the AFC 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 when it was needed most. Because it left out a large majority of the population, the social security system was ineffective in preventing a high 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 to the Constitution guaranteeing the right to social security for every citizen. This was followed by the issuance of the SJSN Law, which adopts 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 entire population as mandated by the SJSN 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 and 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 of 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 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. To achieve 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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