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## New directions in social policy evidence from the Indonesian Health Insurance Programme

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# UNRISD

United Nations Research Institute for Social Development

Working Paper 2018-9

## **New Directions in Social Policy**

*Evidence from the Indonesian Health Insurance Programme*

*Mulyadi Sumarto and Alexandra Kaasch*

prepared for the UNRISD project  
New Directions in Social Policy:  
Alternatives from and for the Global South

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# **Introduction to Working Papers for New Directions in Social Policy: Alternatives from and for the Global South**

This paper is part of a series of outputs from the research project New Directions in Social Policy: Alternatives from and for the Global South.

The project examines the emergence, nature and effectiveness of recent developments in social policy in emerging economies and developing countries. The purpose is to understand whether these are fundamentally new approaches to social policy or welfare systems which could offer alternative solutions to the critical development challenges facing low- and middle-income countries in the twenty-first century. This research aims to shed light on the policy options and choices of emerging/developing countries; how economic, social, political and institutional arrangements can be designed to achieve better social outcomes given the challenges of the contemporary development context; how the values and norms of human rights, equity, sustainability and social justice can be operationalized through “new” social policies; and how experiences, knowledge and learning about innovative approaches can be shared among countries in the South. For further information on the project visit [www.unrisd.org/ndsp](http://www.unrisd.org/ndsp).

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## Contents

1. Introduction .....	1
2. Context of Indonesian Social Policy Development.....	1
3. A History of Social Policy Development in Indonesia.....	3
4. Health Care Development in Indonesia.....	5
5. Global Actors and Ideas in Indonesian Health Care System Development .....	10
6. Conclusions and Discussion .....	12
References .....	14

## List of Figures

Figure 1: Government Health, Education and Final Consumption Expenditures in Indonesia .....	10
Figure 2: Government Health Expenditure in ASEAN Countries, 1995-2014.....	10

## Acronyms

Asabri	Asuransi Angkatan Bersenjata Republik Indonesia (armed forces social insurance)
ASEAN	Association of Southeast Asian Nations
Askes	Asuransi Kesehatan (public sector health insurance)
AusAID	Australian Aid
BPJS	Badan Penyelenggara Jaminan Sosial
DJSN	Dewan Jaminan Sosial Nasional
GDP	Gross Domestic Product
IMF	International Monetary Fund
Jamsostek	Jaminan Sosial Tenaga Kerja
JKN	Jaminan Kesehatan Nasional (Social Security for Workers)
JPS	Jaring Pengaman Sosial
OPK	Operasi Pasar Khusus (Special Market Operations)
PDM-DKE	Programme Pemberdayaan Daerah dalam Mengatasi Dampak Krisis Ekonomi (community grant programme)
PKSPU-CK	Padat Karya Sektor Pekerjaan Umum Cipta Karya (work programme)
PPLS	Survey for the Social Protection Programme
PSE	Pendataan Sosial Ekonomi (Social-Economic Survey)
SAP	Structural adjustment programme
SEA	Southeast Asian
SJSN	Sistem Jaminan Sosial Nasional
SSN	Social safety net
Taspen	Tabungan Asuransi Pensiun (public sector pension insurance)
UHC	Universal health coverage
UN	United Nations
UNRISD	United Nations Research Institute for Social Development
WHO	World Health Organization

## Abstract

This paper discusses the development of Indonesia's health insurance programme as a lens through which to understand Indonesian social policy development. The Indonesian health insurance programme has experienced considerable development despite fluctuating economic growth and political upheaval. Indonesia initiated its health insurance programme during the Soekarno period (1945-1966) by providing health insurance to formal workers. However, this period of economic austerity saw the programme poorly implemented. As the economy improved under Soeharto (1966-1998), the health insurance programme steadily improved until 1997, when the Asian financial crisis hit Indonesia. The crisis forced the Indonesian government to take a loan from the World Bank, which required the establishment a social safety net for the poor. The safety net programme led to massive development of social protection programmes, which encouraged the government to implement a universal health coverage programme. This paper describes the characteristics of Indonesia's social policy development, analyses its relationship with economic policy, highlights its key drivers and identifies the interests and alliances that shaped Indonesia's social policy.

**Keywords:** social policy, health insurance, economic growth, the World Bank, Asian economic crisis, Indonesia

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# 1. Introduction

At times of economic crisis, social policy institutions are at risk of retrenchment. During such times, the focus shifts from social policy to economic development and the responsibility for the provision of social protection falls to family and community (Gough 2004; Holliday 2000). Since the Asian financial crisis in 1997, there have been important changes in the social policies of East and Southeast Asian (SEA) countries (Abrahamson 2017; Gough 2004). We can observe significant, expansionary moves—or “new directions”—in social policy making in the region, particularly in the field of health systems. Thailand, for instance, initiated a national health insurance scheme soon after the crisis in 2001, which intends to cover the entire population, the Philippines followed in 2004, and Indonesia has shown impressive developments since 2014.

In this paper, we study the development of social policy in Indonesia, with a particular focus on health insurance programmes. By looking at the characteristics, the changes to programmes and schemes, and the influential actors driving this process, we highlight critical steps in advancing social protection in an emerging economy. More concretely, we discuss patterns of social policy development, looking at the link between economic performance and social policy, the impact of the Asian crisis, and the influence of transnational actors in social policy development. On that basis, we contextualize the Indonesian case as part of the SEA region, as well as discussing the continued classification as a “residual” social policy regime, despite significant expansionary steps in the past few years. The residual regime is a welfare model in which the state plays a minimal role in welfare provision (Powell and Barrientos 2011). This can be seen from the magnitude of the welfare expenditure in the percentage of national GDP.

This paper brings together primary data, government documents and previous studies. Primary data was gathered through in-depth interviews with high-level government officers, including the Minister of Health, a former minister in Soeharto administration, a former adjutant of President Soekarno, and officers of the government implementing agency. Interviews with former ministers of the Soeharto administration and the former adjutant of President Soekarno provide valuable insights into the social protection programmes developed during their administrations. To date, there has been limited documentation or studies about the Soekarno period of social policy development.

The structure of this paper is as follows: first, we describe the context within which Indonesian social policy development has taken place. In section 3, we illustrate how Indonesian social policy has evolved since the 1950s. In section 4, we provide an overview and analysis of health care development in Indonesia, followed in section 5, by a discussion of the global actors involved. The final section, section 6, discusses our findings and concludes with some key messages.

## 2. Context of Indonesian Social Policy Development

One of the recurring factors influencing social policy development in Indonesia is the fluctuating economy. This was evident during the Soekarno period (1945-1966) as the economic and political situation was particularly challenging. The country struggled with the impact of Dutch and Japanese colonialization, which did not support economic development. From the 1950s onwards, after the end of colonialization, the Soekarno administration restored the devastated infrastructure (a consequence of the war with the Netherlands), through a policy of intensified industrialization (Booth 1998; Dick 2002). This resulted in economic growth of per capita GDP with an average rate of 3.4 percent



(Suryahadi et al. 2017, Booth 1998). In the 1960s, Soekarno attempted to transform the political-economic system radically towards a socialist system, which took place during the guided democracy period (1959-1965). This, however, accompanied serious inflation and public deficit due to continued military struggles with the Dutch colonial government that was still holding West Papua. Inflation escalated under the austerity policy that followed and the anti-Western measures instituted by Soekarno in the mid-1960s. Eventually, Soekarno withdrew from the United Nations (UN), the International Monetary Fund (IMF) and the World Bank (Thee 2002, Dick 2002), which resulted in the withdrawal of foreign direct investment in Indonesia and raised inflation even further (Grenville 1981).

The change in government in 1966 from Soekarno to Soeharto (1966-1998) heralded a shift in the political economy of Indonesia. Between 1966 and 1970, economic stabilization took priority, with Soeharto opening the Indonesian economy and re-joining the UN, World Bank and IMF (Thee 2002). This resulted in increasing international financial aid, the rescheduling of Indonesia's debt and a World Bank loan in 1968 (Engel 2010). Furthermore, in order to tackle inflation, the Soeharto government tightened its monetary policies (Dick 2002).

Economic growth waxed and waned under Soeharto. Between 1971 and 1981, the Indonesian economy grew prolifically, reaching 7.7 percent GDP growth. Between 1982 and 1986, GDP growth declined to 4 percent, but grew again between 1987 and 1993, reaching 6.7 percent (Hill 2000). The main driving force of GDP growth was the price of oil and industrialization.<sup>1</sup> When the oil price fell in the early 1980s, Indonesian economic performance declined, leading to structural adjustment (supported by the World Bank (Engel 2010)). After the adjustment, Soeharto successfully expanded export-oriented industrialization leading to sustained economic growth. This high economic achievement was accompanied by a success on demographic control policy employing family planning programmes (Utomo and McDonald 2014).

When the Asian financial crisis hit in 1997, both the economic performance and the political situation changed dramatically. The Indonesian economy collapsed and economic indicators declined. Urban workers lost their jobs and the food price soared (Thee 2004, World Bank 2003). Demonstrations in many big cities caused the resignation of Soeharto. A structural adjustment programme (SAP) ensued as a condition of financial bailout package from the World Bank, which reformed Indonesia's political economy. Administrative governance became increasingly decentralized and via price liberalization and privatization, the economy became increasingly market oriented (Sumarto 2017).

The Soeharto government worked from the principle that the economy came first. However, in tackling the serious economic breakdown because of the Asian crisis, social policy development became more important. The conditionality attached to the World Bank loan and aid from the Australian government required the Indonesian government to substantially increase the budget for social protection and establish an extensive social safety net (SSN) for the poor. This stands in stark contrast to the notion of "economy first". The roll out of SSN also does not match the literature on social policy responses to economic crisis, which observes countries reducing social policy programmes under automatic austerity. Other literature evidences a shift in international ideas as to appropriate crisis reaction and the protection of vulnerable people in situations of economic downturns that have taken place between the early 1990s and 2007 (Kaasch 2014; Starke et al. 2014).

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<sup>1</sup> Booth 1998; Thee 2002; Hill 2000

### **3. A History of Social Policy Development in Indonesia**

Although Indonesia has a long history of social policy development, it is only in recent years that there has been a genuine effort to protect major segments of the population against social risks. The universalization of health care is an even more recent development and marks a significant expansion of Indonesian social policy from targeting the upper and lower ends of the income spectrum to a more inclusive approach. In this section, we discuss the historical development of Indonesian social policy in the post-colonial era, distinguishing between different periods of government.

Before independence, the colonizers had introduced a Dutch colonial pension scheme that provided pensions only to the colonial government's military personnel and government officers. From 1956, the Soekarno government abolished this scheme and took on responsibility for providing pensions to government officers (including former ones). In addition to pensions, there was a so-called "saving and insurance" programme, paid as a lump sum upon retirement (or to the family upon death of the government officer). At the same time, a "welfare funds" programme was initiated for special circumstances, such as the officer's wife giving birth, which was paid monthly. Both the "saving and insurance" programme and the "welfare funds" programme were funded by taking seven and three percent of the officer's monthly salary, respectively, as a contribution to the programme.

Weak political will meant that the programmes introduced by Soekarno were never comprehensively rolled out. Other issues took precedence, such as military spending (Booth 2010) and the general economic situation, which was fragile due to persistent financial deficit and hyperinflation. According to an interview with a former adjutant of President Soekarno,

There were, indeed, some regulations enacted by Soekarno administration ruling social protection programmes but the programmes could not be implemented because the government dealt with problematic financial difficulties. Perhaps, the enactments of the regulations were mainly due to the 1955 election, in which left-wing political parties fairly dominated the election. Some politicians of these parties in the parliament might express their concern on social protection programme through the enactments although the government did not have any budget for the programme (Former adjutant of President Soekarno 2015, interview 29 September).

The social protection programme introduced by Soekarno was expanded successfully by Soeharto. The Soeharto administration provided social protection for public sector workers covering health insurance (Asuransi Kesehatan (Askes)), pension insurance (Tabungan Asuransi Pensiun (Taspen)) and armed forces social insurance (Asuransi Angkatan Bersenjata Republik Indonesia (Asabri)). Public sector pension insurance was initially introduced in 1963 to serve as an endowment insurance fund. It was expanded in 1981 to include life insurance for public servants and their family members (Ramesh 2000). The pension insurance for public servants and military forces were managed by PT Taspen and PT Asabri, which provided a lump sum benefit at retirement age.

Social protection in the formal private sector, which was known as Social Security for Workers (Jaminan Sosial Tenaga Kerja (Jamsostek)), was initiated in 1992 as a response to industrial relations issues due to massive industrialization. It included four kinds of insurance: accident, health, death and old age benefits for workers and their family members. The employer paid the first three benefits and the fourth required contributions from the employer and employee (Jung 2016; Pisani et al. 2016).

The social protection programme for formal workers, however, was not accompanied by a programme for informal sector workers, and there have been very limited studies examining why Soeharto did not provide social protection for the informal workers. A notable result of an interview with an important key person, who served as minister for three periods of the Soeharto presidency, provides valuable details on Soeharto reasons on this issue. When the minister was asked whether Soeharto would have provided social protection for the informal worker, had he completed his presidency in 2002, he stated:

Soeharto had high concern for rural economic development to alleviate poverty in rural areas. He would spend a higher amount of the budget to build and provide clean drinking water, healthy sanitation, irrigation systems, paved roads and other physical infrastructure in poor peripheral villages. He believed that the rural development could increase living standard and lessen rural-urban economic inequality. This was much more important than the social protection programme, as the rural poverty issue was considerably problematic. It was thus less likely that Soeharto would develop social protection programmes for informal sector workers. (former minister of Soeharto administration 2015, interview 1 October).

In 1998-2004, soon after Soeharto stepped down, a broader social protection programme was implemented under the SSN programme, which was the result of pressure by the World Bank, to provide social protection specifically targeted to the poor, most of whom were informal sector workers. The SSN programme covered health insurance, special market operations (Operasi Pasar Khusus (OPK)),<sup>2</sup> a crisis programme for the provision of grants to selected community groups (Program Pemberdayaan Daerah dalam Mengatasi Dampak Krisis Ekonomi (PDM-DKE)), a labour-intensive work programme (Padat Karya Sektor Pekerjaan Umum Cipta Karya (PKSPU-CK)),<sup>3</sup> and a school scholarship and block grant programme.<sup>4</sup> The SSN was mainly financed by a loan from the World Bank, the SSNAL, which was ruled by a loan agreement signed by the Indonesian government and the Bank (World Bank 1999). Besides the SSNAL, other foreign aid supporting the SSN came from the Asian Development Bank and the Australian government's aid programme, AusAID. AusAID started providing financial support for social protection programmes in Indonesia in 2003 (Wilmsen et al. 2017).

During the SSN period, there were two fundamental institutional reforms in the Indonesian social policy. In 2002, the Indonesian government amended the country's constitution to include a clear statement on social protection provision (article 34, clause 2), stating that "the state shall develop a system of social security for all citizens and shall empower the poor and disadvantaged in society".<sup>5</sup> The other reform took place in 2004, when the government enacted National Social Security System (Sistem Jaminan Sosial Nasional (SJSN)) law. During the legal drafting process of the law, the government received technical assistance from the European Union, the Asian Development Bank, the International Labour Organization and the Australian government (Tim SJSN 2004). The SJSN law gave a fundamental mandate to the Indonesian government to establish a social

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1 OPK was the former name of subsidized rice for the poor programme (*beras untuk rumah tangga miskin* (Raskin)). OPK was changed to Raskin in 2002. OPK was introduced to ensure the availability of a staple food at an affordable price. PDM-DKE was a "provision of grants to selected community groups for (i) creating opportunities for employment and business, and (ii) developing social and economic infrastructure" (World Bank 1999: n.p).

3 PKSPU-CK aimed at distributing cash benefits to poor people after they took part in labour intensive projects. Both PDM-DKE and PKSPU-CK were mainly intended to create employment to respond to the threat of growing unemployment.

4 The school scholarship and block grant programme aimed "to provide (i) cash scholarships to poor students at the primary and secondary school level and (ii) grants to primary and secondary schools in poor districts for use in covering essential maintenance costs, obtaining essential office and classroom supplies, fee relief and teacher transport for KKG (teacher training)" (World Bank 1999: n.p).

5 Aspinal 2014, Fossati 2016, Jung 2016, Pisani et al. 2016

security system. In general, the SJSN law covers health insurance and four other types of social security: pensions, old age benefits, accident compensation and death benefits.

Entering 2005, the official SSN programme was discontinued after Indonesia repaid the structural adjustment loan and the SSNAL. The SSN programme was then shifted to what is called the poverty reduction programme, which continues to provide social protection for the poor today. The poverty reduction programme is now divided into four clusters: social assistance and protection, the national programme for community empowerment, microcredit and entrepreneurship and affordable housing and transportation programmes. The cluster of social assistance and protection covers Raskin, an unconditional cash transfer (*Bantuan Langsung Tunai*), cash transfers for poor students (*Bantuan Siswa Miskin*), and conditional cash transfer (*Program Keluarga Harapan*) programmes (Wilmsen et al. 2017).

To secure all these programmes, the Yudhoyono administration (2004-2014), after re-election in 2009, carried out two important actions. First, in 2009, the government approached the Australian government for financial assistance. AusAid was increasing its aid budget at that time, so it was good timing (Wilmsen et al. 2017). This provided a necessary boost in the finances for the poverty reduction programme. However, the magnitude of spending was still relatively low—on average it accounted for less than one percent of Indonesia's GDP. In fact, social expenditure after the financial crisis was much higher than during the crisis period. From 1994 to 1997, for instance, the government spent on average around 0.3 percent of GDP on poverty reduction programmes (Daly and Fane 2002). Second, in 2010, the Yudhoyono administration embarked on a process to consolidate the entire poverty reduction programme. The “consolidation” of the programme came under the control of the national team for poverty reduction acceleration (*Tim Nasional Percepatan Penanggulangan Kemiskinan (TNP2K)*) and was governed by Presidential regulations (*Peraturan Presiden (Perpres)*) No. 15/2010. TNP2K is an ad hoc governmental agency led by the Vice-President of Indonesia (*Perpres* No. 15/2010, article 10). It is responsible for developing, synchronizing, harmonizing, integrating, monitoring and evaluating poverty reduction programmes.

## **4. Health Care Development in Indonesia**

The first health insurance programme in Indonesia was introduced by the Soekarno administration in 1947. The insurance was for formal workers, which required corporations to provide financial support for work-related accident and sickness benefits for their employees. These benefits covered the cost of moving a sick person, the costs of medical examinations and treatments and a cash benefit for income losses suffered during recovery. In 1960, the government engaged in developing a broader health insurance programme (including private sector workers and civil servants) (Sumarto 2017). This programme was Indonesia's first step towards providing health services to all citizens. Building hospitals and other health services also took place during that period. The focus in both initiatives was on the alleviation of communicable diseases, particularly malaria, tuberculosis, yaws, leprosy and trachoma.

Under the Soeharto government, *Askes*, which provided health insurance for civil servants, the armed forces, retired public servants, military employees and their family members underwent progressive changes. When this programme was initiated, the Administering Agency for the Health Care Fund (*Badan Penyelenggara Dana Pemeliharaan Kesehatan*) was established. In 1984, it became a state owned enterprise called *Perum Husada Bhakti*, and in 1992, *Perum Husada Bhakti* shifted into *PT Asuramsi*

Kesehatan (PT Askes). Askes was compulsory for civil servants, personnel of the armed force and retired public servants. The contribution paid by members was two percent of the monthly salary (Ramesh 2000). Under the programme, members received health care services (medical doctor, health clinic and hospital), medicine, health aids (such as glasses), maternity and delivery care (midwife, medical doctor and hospital). Members were also entitled to reimbursement for medical expenses. Unlike public sector employees, people working in the private sector received health insurance from the Jamsostek programme. Members of the programme were entitled to health care services, such as outpatient and inpatient services, maternity and delivery care, medical diagnosis and emergency services.

In contrast to the reforms that occurred from the 1950s until the mid-1990s that prioritized health insurance for the formal sector, from 1998 onwards, the focus of social policy reform changed remarkably. Informal workers and targeted, pro-poor social policies became the major concern of the development of social policy programmes. While in previous decades, health policy had been just one element in a broader canon of social security schemes developed, in the early 2000s health became the centre of social policy development.

The Indonesian government provided health insurance for the poor under the SSN and poverty reduction programmes. During the SSN period, the programme saw three important changes. In 1998-2001, the Indonesian government introduced health insurance for the poor through the programme Jaring Pengaman Sosial Bidang Kesehatan (JPS-BK), which aimed at helping poor households to access health services and provide nutritious food for children during the economic crisis (TKPP-JPS 1999). Under the JPS-BK, a health care card was provided to every poor household to access free health services at local hospital and local health centres, known as pusat kesehatan masyarakat (puskesmas). In 2001, the JPS-BK programme was replaced by the Reduced Energy Subsidy Impact Alleviation Programme in Health Sector (Program Dampak Pengurangan Subsidi Energi Bidang Kesehatan (PDPSE-BK)). When the PDPSE-BK programme was implemented, the health care card distributed by JPS-BK programme was retained and could be used in addition to this new health subsidy. In 2002, the PDPSE-BK programme was changed with Compensation Programme for Reduced Subsidies on Fuel Oil in Health Sector (Program Kompensasi Bahan Bakar Minyak-Bidang Kesehatan (PKPSBBM-BK)). Under this programme, the health care card was still provided, but the funding came from the savings generated by the reduction of fuel subsidy under PKPSBBM.

After having repaid the structural adjustment loan and the SSNAL, health care schemes for the informal sector became part of the poverty reduction programme. From 2005-2013, the PKPSBBM-BK programme changed twice. From 2005 until 2007, the government developed a health insurance programme for the poor (Asuransi Kesehatan untuk Masyarakat Miskin (Askeskin)) and in 2008, it was replaced by Jamkesmas, which ran until 2013. Both Askeskin and Jamkesmas provided a health care card to targeted individuals to access free health services either at puskesmas or at local public hospital. In addition, the cardholder could access inpatient services at private hospitals. The main difference between the Askeskin programme and Jamkesmas was the separation of responsibilities for disbursing the funds and managing the membership. Under Jamkesmas, the Ministry of Health took on the role of disbursing the funds, while membership management remained the responsibility of PT Askes. Funds were disbursed directly to the puskesmas for the provision of health care services and to the Ministry of Health for hospitals.

The health insurance both under the SSN and poverty reduction programmes dealt with mistargeted distribution mainly because of a problem in the accuracy of the population data used for the insurance distribution. When the SSN programme was initiated, the Indonesian government did not have any poor household data designed for social protection. The only available poor household data were the data collected by family planning cadres, managed by the National Family Planning Board (Badan Kependudukan dan Keluarga Berencana Nasional) to support family planning programmes, so the SSN programme inevitably used the data. In 2005, a few months after the government changed the SSN with the poverty reduction programme, the government mandated the National Statistical Board (Badan Pusat Statistik) to conduct a Social-Economic Survey (Pendataan Sosial Ekonomi (PSE)), intended to collect poor household data specifically for social protection programmes. The PSE was updated every three years. In 2008, when the PSE was firstly updated, the name was changed to Survey for the Social Protection Programme (Pendataan Program Perlindungan Sosial (PPLS)). The PPLS was conducted twice, in 2008 and 2011. In 2015, the government changed the name once again, this time to Integrated Database Update (Pemutakhiran Basis Data Terpadu), which has been managed by Ministry of Social Affairs. These have been done to improve the accuracy of the poor household data, but these have not worked effectively, thus the health insurance still copes with mistargeted distribution.

The “universalization” of the health insurance programme, labelled as the Jaminan Kesehatan Nasional (JKN), was initiated in January 2014 by the Yudhoyono administration, under the SJSN. The JKN aims at providing health insurance for all populations, covering all workers in the formal and informal sectors. It is a result of welfare reform, which puts all health insurance schemes of all workers under Askes, Jamsostek and Jamkesmas in one health insurance scheme. The Indonesian government considers JKN to be a manifestation of universal health coverage (UHC), promoted intensively by global actors, mainly the World Health Organization.

To execute the health insurance programme under the SJSN, the government founded a social security organizing body, the Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-Kesehatan). The BPJS-Kesehatan is a legally independent entity controlled directly by the President of Indonesia. To make sure that the BPJS effectively contributes to the SJSN mission, it is monitored and evaluated by the National Social Security Council (Dewan Jaminan Sosial Nasional (DJSN)). The role of the DJSN is policy formulation, monitoring and evaluation and synchronization of the implementation of national system of social security.

The SJSN law stipulated that by 2009, the Indonesian government should have established the JKN. However, five years after the enactment of the law, Yudhoyono had not acted on the mandate. As a result, in 2010 Yudhoyono, along with Vice-President, Head of Parliament and eight related ministers, faced a lawsuit from the trade union association and several civil society organizations. Yudhoyono lost the lawsuit in 2011, forcing his administration to abide by the law.<sup>6</sup> In 2014, the JKN was finally established. This programme identifies four groups: public sector workers (for example, civil servants and military personnel), private sector workers, poor people (mostly working in the informal sector), and individual members (mostly non-poor informal workers, freelancers, investors and employers). In the past, public sector workers, under the Askes and Asabri programmes, had their premiums paid from the public budget. The amount of the contribution equals five percent of their monthly salary, of which three percent is paid

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6 Aspinall 2014; Jung 2016; Pisani et al. 2016; Sumarto 2017

by the government and two percent is paid by the workers, deducted from their salary. Private sector workers used to be included in the Jamsostek programme. Under the JKN, the contribute for private sector workers also equals five percent of their salary, but corporations hiring workers are required to contribute four percent, while the workers themselves pay only one percent. Poor people have their contributions paid from the public budget.<sup>7</sup> Individual members pay the premium from their own pocket for their own health insurance and that of their family members.

The JKN programme provides health insurance for all members along with their spouses and dependent children under 25 years old. They receive a health card to access several kinds of health services at puskesmas and at both public and private hospitals that collaborate with the BPJS-Kesehatan. The health services provided by the JKN include inpatient, outpatient and emergency health services, along with coverage of chronic conditions. The JKN also provides health aids, such as hearing aids, glasses, and dental prosthesis.

The JKN programme has successfully boosted the JKN membership but the programme has also dealt with a number of problems. In 2015 for instance, the members of the JKN increased by about 17.5 percent from 133,423,653 members in January 2015 to 156,790,287 in December 2015 (BPK 2017). The service quality provided by the JKN, however, has been very poor, causing some members to express their dissatisfaction on the service (Pisani et al. 2016). This has happened alongside mistargeted distribution of the access to the programme, mainly because of the weak capacity of the welfare bureaucracy (Jung 2016).

The JKN programme also has been coping with a complicated financial deficit. The deficit occurs mainly because the amount of the members' premium contribution was not sufficient to cover health care provided for them. The amount of the premium for the poor members, for instance, should be IDR 36,000<sup>8</sup> per person per month, but due to government's limited financial capacity, the government contributed IDR 19,225.00 in 2014-2015, which increased to IDR 23,000 in 2016. The other major factor causing the deficit was the registration of individual members for the JKN membership when they are sick in order to claim health care services provided by the JKN programme. Individual members perceive JKN membership as an alternative to affordable health care. They will pay the initial premium and access the health services, but then refuse to pay any further premiums and withdraw from the programme. This trend generated a deficit IDR 18.7 trillion between 2014 and 2016.

Another problem in the JKN is fraud. The fraud takes place at four levels the JKN system: the BPJS-Kesehatan officer, health care providers, medicine and medical device providers, and BPJS-Kesehatan members. To minimize the likelihood of fraud, in 2015, the Minister of Health issued a Minister Decree on restriction of fraud in the JKN programme. The Decree defined the type and culprit of the fraud, the restriction of the fraud, and the sanction for the fraud. The Decree gives a mandate to BPJS-Kesehatan to establish a fraud minimization team. As part of this initiative, the JKN programme now has verification officers that oversee the expenditure of each individual health care service.

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7 The mandate of the government to provide a contribution for the poor is established by PP 101/2012 on government support of premium contributions for the poor.

8 Equivalent to about USD 2.40 at the time of writing.

Furthermore, the integration of the JKN with local health care insurance (Jaminan Kesehatan Daerah (Jamkesda)) is a major challenge. Integration is mandated under article No. 6 of the BPJS law, which states that the government's health insurance programme is to be managed by BPJS-Kesehatan. Local government started developing the Jamkesda programme in response to the 2004 decentralization law,<sup>9</sup> which requires local government to develop local social security, including Jamkesda. The local government budget is the source of financing for the Jamkesda. Under Jamkesda, the local government provides supplementary health insurance. However, the premium contribution per person per month and service quality is variable across Jamkesda.<sup>10</sup>

The Jamkesda programme so far has undergone progressive development. In 2010, about 71 percent of the 498 districts and municipalities implemented the Jamkesda programme. This is quite surprising as some local governments have been coping with limited local revenue, but they are committed to implement Jamkesda. Some regents and mayors developed the programme because they believe that people need better access to health care services, while others have been more concerned with gaining political support from voters by introducing this largely popular programme. Since 2004, the appointment of local leaders has involved a public election and social programmes are often a means to garner votes (Sumarto 2014). Under such circumstances, some regents and mayors are reluctant to integrate Jamkesda into the JKN. Among 514 districts/municipalities, 155 of them have not integrated the programmes and some have outright refused to take part in the integration (BPK 2017). For the regents and mayors, if the Jamkesda is recentralized into JKN, they cannot claim that they have contributed to boosting people's access to health care services when running for re-election. Taking credit for the Jamkesda programme remains an important re-election platform.

In conclusion, Indonesian social policy has historical roots in its development. We observe a pattern of dynamic change from exclusivity to more inclusive social protection programmes. It began with selected, formally employed groups, but eventually extended to the informal sector—among poorer segments of society the focus was on poverty alleviation. The development of health insurance programmes demonstrates the path and patterns of Indonesian social policy development more broadly. Despite improvements, expenditure on health still lags spending in other sectors (see figure 1) and health expenditures in other SEA countries (see figure 2).

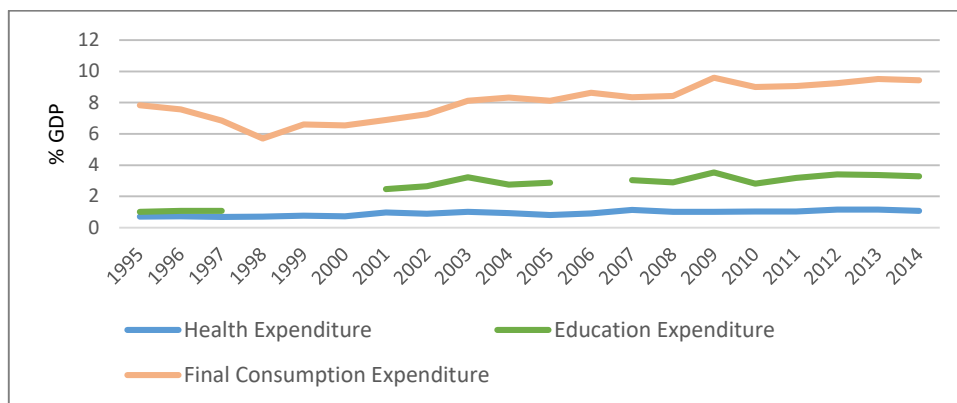
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9 The decentralization is established under the decentralization law that was enacted in 1999. The law was amended in 2004 and in 2014, mainly to adjust for policy reform. In the health sector, for instance, the 1999-decentralization law stated that local government had to implement local health policy. In the 2004-decentralization law, the local government had to provide health services and build local social security systems. The 2014 law simply states that the local administration has to ensure the access basic health services for local people.

10 Aspinall 2014; Fossati 2016; Jung 2016

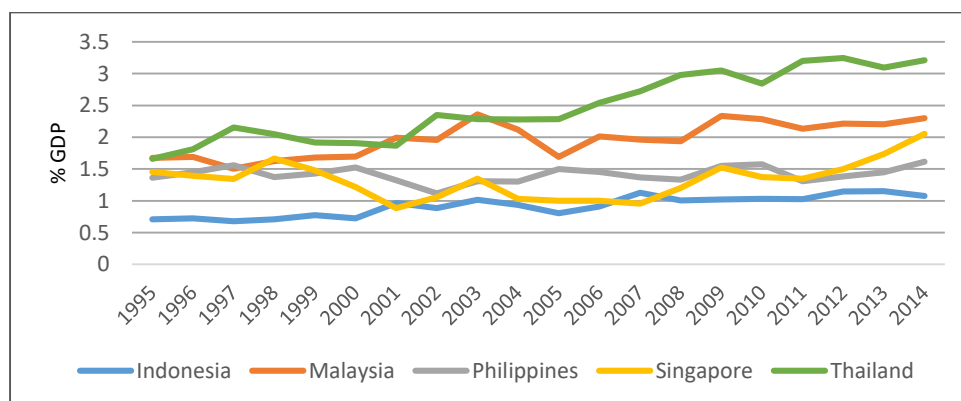


Figure 1: Government Health, Education and Final Consumption Expenditures in Indonesia



Source: World Development Indicators

Figure 2: Government Health Expenditure in ASEAN Countries, 1995-2014



Source: World Development Indicators

From a regional perspective, social policy development in SEA countries is subordinate to government efforts to boost economic growth.<sup>11</sup> Prioritizing health care and education in economic development is, however, considered to be a social investment intended to amplify productivity and contribute to economic growth (Mkandawire 2005).

## 5. Global Actors and Ideas in Indonesian Health Care System Development

The Indonesian central government has been and continues to be a key actor driving Indonesian social policy development. During the Soekarno and Soeharto periods, Indonesia was under a centralized political-economic system that saw the central government dominate the development of social policy and limited participation from local government and trade unions, and The decentralization that began post-Soeharto in 1999 has not improved the standing of local government and trade unions in the social policy domain. Moreover, beyond the trade unions’ involvement in the development of the health insurance policy, which required a lawsuit to be filed for this to be achieved,

<sup>11</sup> Abrahamson 2017; Gough 2004; Holliday 2000; Mok et al. 2017

there were few other contributors to social policy other than the central government under Yudhoyono.

The World Bank is another key actor in social policy development in Indonesia. Its importance grew significantly during the Asian financial crisis via the SAP. Prior to this, the World Bank's loans had been directed towards industrialization and infrastructure development to support economic growth (Kaasch et al. 2018). Under the SAP, the Bank provided the SSNAL, a special loan for SSN programme. To distribute the SSN, the World Bank provided not only the loan but also technical assistance. The SSN provision marked the beginning of social policy reform, as this is the first social protection provided by the Indonesian government for the poor. Currently, health insurance for the poor is combined with Askes and Jamsostek, resulting in the JKN programme (Sumarto 2017). Kaasch et al. (2018) discusses the position and interest of international donor agencies and their role in Indonesian social policy development.

The World Bank also had social and political motivations for its involvement in Indonesian social policy development. From a social perspective, the World Bank used the SSN to mitigate the economic difficulties caused by the Asian financial crisis for the poor. During the crisis, poverty and unemployment increased and food prices soared. However, its motivation was also political. The political-economic reform instituted under the World Bank's SAP in Indonesia produced economic shocks, which had social ramifications, such as unemployment and poverty. The Bank's insistence on the SSN was partly, at least, to soften the social effects of the SAP so as to enable its uncontested progression. Unsurprisingly, the World Bank's approach to social policy at that time was targeted rather than inclusive. It was concerned with providing goods and benefits to the poor. After repayment of the loans, the Indonesian government decided not to continue with the SSN in the form it initiated under the World Bank loan. Instead, it was transformed into current poverty reduction programme.

The World Bank's role was gradually reduced as Indonesia's debt from the Asian crisis was paid. At this juncture, the Australian government, via AusAID, stepped in to finance Indonesia's social protection programme. Australia's motivation for ramping up its involvement in Indonesia's social policy space was largely political. Indonesia is a strategic political priority for Australia as its location is crucial to Australian security and trade. The strength of Australia's political leadership is wedded to perceptions of secure borders and its lucrative trade in resources. Thus, it is essential for Australia to build cooperative bilateral relations with Indonesia. Wilmsen et al. (2017) provides a detailed discussion of the Australian government's involvement in Indonesian social protection programmes.

Other global ideas have also influenced the development of social policy in Indonesia, and particularly health care development. The notion of universalism resonates strongly in Indonesia, particularly the concepts of "primary health care" and "health for all" (Cheng et al. 2015). WHO and the World Bank define UHC as "the desired outcome of health system performance whereby all people who need health services (promotion, prevention, treatment, rehabilitation, and palliation) receive them, without undue financial hardship" (WHO and World Bank 2014: 1). Both WHO and the World Bank believe that UHC covers two important components, "the full spectrum of good-quality essential health services according to need, and protection from financial hardship, including possible impoverishment, due to out-of-pocket payments for health services. Both components should benefit the entire population" (WHO and World Bank 2014: 1). UHC is a normative concept (MacGregor 2017) in which the government has an

obligation to look after the health of the whole population (Yi et al. 2017). In practice, however, the spectrum of the obligation is relatively diverse, as the term UHC attracts complicated contestation of idea within that term, particularly in the concept of universalism (MacGregor 2017). Even so, UHC has been carried out in numerous developing countries in Latin America (Titelman 2015), Africa (Surender 2017) and Asia (Cheng et al. 2015; Hsiao et al. 2017).

UHC is not a key focus in Indonesia (Kaasch et al. 2018; Suryahadi et al. 2017). Beginning in Indonesia in 2014 after the financial crisis, the Indonesian government responded to a global call for UHC. The JKN became the vehicle for the Indonesian UHC project and has been supported by the World Bank and the Australian government. The Indonesian government aims to achieve “universal coverage” within its first five years, from 2014–2019. Unfortunately, it is less likely for the government to achieve this goal (BPK 2017) due to issues concerning financial deficit, fraud and JKN integration.

Since 2014, JKN programme has also been coping with complicated problems in programme governance, mainly because the DJSN is under subordination of Coordinating Ministry of Human Development and Culture, as one of the parties involved in the JKN. To perform its roles successfully, particularly in monitoring and evaluation of the JKN programme, the DJSN should be independent from any interference of other parties. However, the head of the DJSN is held by a high-level officer of the coordinating ministry, the Secretariat of the DJSN is under the office of the ministry, and the financial source of the DJSN budget comes from that ministry. The first problem arises because it was stipulated in the SJSN law, and the last two problems arise because of Perpres No. 44/2008, which administers the organizational structure of DJSN. Under this subordination, the DJSN has not been able to monitor and evaluate the achievement of the JKN effectively. This implies that there is a crucial need to review and amend the regulations, which rule the JKN.

## 6. Conclusions and Discussion

The above illustrations of the social policy development process in Indonesia mark a clear connection between economic and social policy development. This is particularly evident in our review of health care development. It clearly supports Wilensky’s (1975) *The Welfare State and Equality*, where he argued—for industrialized countries in this case—that economic growth and demographic outcomes are influential causes of the development of social policy. The economic-social policy development interconnection is particularly evident in the Soekarno and Soeharto periods. During the Soekarno administration, social policy stagnated. In fact, the government enacted several welfare laws as the legal basis for welfare provision, but did not distribute the welfare, mainly because it lacked sufficient financial resources. In that period, the government dealt with a problematic deficit and hyperinflation. Indonesian social policy was considerably different after Soeharto entered office. Building on high economic growth, Soeharto provided several social security schemes for formal workers, representing a sizeable increase of government spending for social security.

This logic however, is not sufficient to understand the social policy reform during the Asian financial crisis. Here, the Indonesian case is in line with part of the literature on social policy reform following global and regional economic crises (Starke et al. 2014). When the country was hit by the Asian financial crisis, the Indonesian economy was devastated. This provided the impetus for the Indonesian government to establish a SSN for the poor and therefore expand its budget for social protection and social assistance,

partly stemmed from the financial assistance from World Bank and the Australian government (Wilmsen et al. 2017).

As we have also argued in Kaasch et al. (2018), the involvement of global social policy actors had an impact on financing social policy programmes in particular times of hardship, and the “global social policy climate” (Starke et al. 2014; Kaasch, 2014). With discourses focused on topics like universal health coverage, this climate provided a context within which Indonesian policy makers formulated aims and developed their social policy programmes further. The concrete designs of programmes and policies were in the hands of national policy makers. Other social actors, such as national trade unions, have not gained significant importance in this process.

This is not to say that international agencies were the central actor in Indonesian social policy development and their work is not without any weakness. Both national government and global actors co-produced social policy (Yeates 2018). The statement of the former minister—remarking that in the Soeharto period, the government would not distribute social protection for the poor—provides evidence that the national initiative to develop a comprehensive social policy system was very limited. It was likely that without the external pressure from global actors in 1998, the initiation of social protection programmes for the poor would have gone through a complicated deferral. The involvement of external actors in the Indonesian social protection policies, therefore, was critical to this development (Mok et al. 2017). However, the SSN programme advised by the World Bank was loaded with problematic issues, such as complicated layering with community-based social protection (see Sumarto 2017) and mistargeted distribution. Similar programmes in other developing countries in Africa, Asia and Latin America were not able to mitigate from the effects of economic austerity on the poor (SAPRIN 2004).

In a regional context, we can speak of Indonesia as a typical case for social policy development in SEA. Usually, economic concerns take precedence over social policy development, except for during times of economic crisis when external funding is available. Focusing on the health sector in developing systems of social protection is not uncommon in SEA countries. However, health sector reform since the late 1990s was sluggish and incoherent. While the Asian crisis certainly pushed Indonesia to take social protection more seriously, it was not the ultimate driving force behind health system development. Policy reform accelerated when the World Bank advised the Indonesian government to provide a SSN specifically for the poor. The SSN programme encouraged the government to develop massive social protection system under the poverty reduction programme, which led to the introduction of “universal” health insurance in 2014.

Despite this positive development, it ought to be noted that, compared to other sectors in Indonesia and comparatively within SEA, health care spending is rather modest. Government expenditure for the health sector augmented steadily, but in relation to national GDP, it is still very low. This is much lower than the ratio recommended by WHO, which is 5 percent of GDP (Svedoff 2007). Public spending on health in Indonesia is also lower than in Malaysia, the Philippines, Singapore and Thailand. Therefore, the health care system in Indonesia can still be considered as residual, despite the laudable aims of the Indonesian government to realize “universal” health insurance. As yet, the UHC concept has not changed the residual characteristic of Indonesian social policy.

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