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# **Achieving Universal Health Coverage by 2019 in Indonesia**

**The Challenges of the Government of Indonesia,  
Informal Sector Workers and the Local Government**

인도네시아에서의 2019 년 국민의료보장제도  
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# **Achieving Universal Health Coverage by 2019 in Indonesia**

**The Challenges of the Government of Indonesia,  
Informal Sector Workers and the Local Government**

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# *Ad Maiorem Dei Gloriam*

*“Everything is for God’s greater glory”*

*Terima kasih kepada  
Mother Mary*

*Papa, Hari Udji Aswinto  
Mama, Rr. Rery Retno Indraswari  
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*Dan kepada*

*Dr. Jörg Michael Dostal  
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## **Abstract**

### **Achieving Universal Health Coverage by 2019 in Indonesia The Challenges of the Government of Indonesia, Informal Sector Workers and the Local Government**

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The purpose of this research is to identify potential challenges encountered by the Government of Indonesia (GOI), informal sector workers, and the local government due to a newly-adopted health care scheme “health for all” or Universal Health Coverage (UHC). The health care scheme aims to integrate the previously fragmented formal social protection programs, either the programs run by four state-owned enterprises or local governments into a single national health care program. The program is known as National Health Care Insurance or *Jaminan Kesehatan Nasional* (JKN). There is only one public entity called Social Security Administrative Body or *Badan Penyelenggara Jaminan Sosial* (BPJS Kesehatan) that has the sole authority on managing the implementation of JKN. JKN is already targeting to provide health care universalism for the entire Indonesian population via Social Health Insurance (SHI) within five years between 2014 and 2019, a very ambitious target considering

that Indonesia is the fourth most populous country and the largest archipelago country in the world, with a strong tendency toward decentralization and predominantly inhabited by informal sector workers.

Indonesia's decentralization policy has helped diversify and further mature the UHC scheme at the regional level prior to implementing JKN. This has become a source of tension between the central and local governments since some local governments have been reluctant to integrate their own version of regional health insurance known as *Jaminan Kesehatan Daerah* (JAMKESDA) into JKN. JKN adopts SHI as the health care funding mechanism to finance the program. It requires a compulsory membership for all people in Indonesia and a compulsory contribution based on the income level of each individual. This poses challenges for the informal sector workers who make up a predominant percentage of Indonesia's total labor force. Such workers are mostly involved in industries such as agriculture, fishery, hunting and forestry.

In order to identify the possible challenges, this research has conducted an analysis based on the "six facilitating factors" by Carrin and James (2005). They argue that the six facilitating factors are key to speeding up the transition toward UHC via SHI. By

analyzing the six facilitating factors in the context of Indonesia, it has been found that the “government stewardship” factor is most critical to solving issues such as the mounting deficit of BPJS *Kesehatan* which continues to rise each year. Hopefully, this research may be further developed in the future by focusing on the process of JAMKESDA’s integration into JKN.

**Keywords: Indonesia, Universal Health Coverage, Social Health Insurance, the Government of Indonesia, Informal Sector Workers, Local Government.**

**Student ID: 2014-23731**

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## LIST OF ACRONYMS

BPJS	<i>Badan Penyelenggara Jaminan Sosial</i>
SJSN	<i>Sistem Jaminan Sosial Nasional</i>
GOI	Government of Indonesia
SHI	Social Health Insurance
UHC	Universal Health Coverage
AFC	Asian Financial Crisis
BPS	<i>Badan Pusat Statistik</i>
JAMKESDA	<i>Jaminan Kesehatan Daerah</i>
JAMKESMAS	<i>Jaminan Kesehatan Masyarakat</i>
ASKES	<i>Asuransi Kesehatan</i>
ASABRI	<i>Asuransi Angkatan Bersenjata Republik Indonesia</i>
JAMSOSTEK	<i>Jaminan Sosial Tenaga Kerja</i>
JPS	<i>Jaring Pengaman Sosial</i>
RASKIN	<i>Beras untuk Rakyat Miskin</i>
TASPEN	<i>Tabungan dan Asuransi Pensiun</i>
PPK	<i>Program Pembangunan Kecamatan</i>
IDT	<i>Instruksi Desa Tertinggal</i>

## CHAPTER 1

### INTRODUCTION

The term ‘transformation’ has been strongly emphasized in the context of social protection development in Indonesia. It refers to a rapid change in the sets of social policy as a response to the political-economic situation post-the Asian Financial Crisis (AFC) in 1997-1998. This research begins with brief historical background of social welfare regime in Indonesia during the preceding years before National Social Security System or *Sistem Jaminan Sosial Nasional* (SJSN) in 2004.

Moreover, this research focuses on the latter years after SJSN to present specifically during the implementation of National Health Insurance or *Jaminan Kesehatan Nasional* (JKN). JKN replaced major health care programs run by the Government of Indonesia (GOI), either it is the central government or the regional government by establishing Social Security Administrative Body for Health or *Badan Penyelenggara Jaminan Sosial* (BPJS Kesehatan). At least for now, BPJS Kesehatan is the largest single-payer while JKN sets a pretty massive ambitious goal, achieving Universal Health Coverage (UHC) within the range of five years (2014-2019).

Meanwhile, by clustering the research questions into three parts, this research strives to posit the potential challenges encountered by the GOI,

the informal sector workers and the local government during this transition phase.

## **1.1 Historical Background**

When Indonesia declared its independence in 1945, The Preamble of The 1945 Constitutions of the Republic of Indonesia has been the fundamental structure to perceive the national aspirations of the citizen, as follows:

“Indonesia’s National Independence shall be enshrined in the Constitution of the State of the Republic of Indonesia, established within the structure of the State of the Republic of Indonesia with sovereignty of the people based upon Belief in the One and Only God, just and civilized Humanity, the Unity of Indonesia, and the Democracy guided by the inner wisdom of Deliberations amongst Representatives, and by creating social Justice for the entire people of Indonesia.” (GOI, Ministry of State Secretariat of the Republic of Indonesia).

The last sentence stipulates that the GOI is the prime mover in providing social justice for all Indonesian citizens, it took fifty-nine years later, in 2004, nonetheless. This implies that the concern of the GOI with social welfare development is *vis-à-vis* to current state of economy and political-economic at the time thus, there are three vital timeline: (1). Old Order regime (1945-1966); (2). New Order regime (1966-1998); (3). Post-AFC from 1997-1998 to the present (Sumarto, 2017). However, it is also important to highlight that the development of social protection programs in Indonesia has been heavily relaying on informal social protection

provisions, such as: family-based or community-based social protection. While the formal social protection programs usually set up for particular group of population and it covered only less than 10 per cent of total more than 250 million out of Indonesian population prior to 2014, that marked the first year of SJSN actualizes via BPJS *Kesehatan*.

Even after the Proclamation of the Indonesian Independence in 1945, Soekarno and Indonesian people had to continue struggling and surviving periods of warfare against the Dutch, the United Kingdom and Japan. Major government budget was spent for military-related affairs (Booth, 2010). At the same time, the GOI also had to rebuild the war-torn country from the scratch, with the large debt from the Netherland Indies. Thus, the government budget allocated mainly to military-related affairs and to rebuild the country as the aftermath of centuries of colonization that ended by revolutionary wars. It was a devastated period for all aspects of development in Indonesia, including a ruined health care system (Neelakantan, 2014). The provision of health care infrastructures was less than sufficient. On the one hand, Soekarno had put effort to initiate formal social protection programs though, the target exclusively aimed for formal workers, both in public and private sectors. By the end of Soekarno's administration, the economy of Indonesia was in severe turmoil due to the hyperinflation.



The beginning years of Soeharto's incumbent, known as New Order regime (1966-1998), labeled Indonesia as 'the East Asian Miracle' and 'newly industrializing economies' because Soeharto was able to turn the depressing hyperinflation from 636 percent in 1966 to 9 percent in 1970 (Sumarto, 2017). In order to boost the economic development in Indonesia, Soeharto opened the foreign investment for the first time. In fact, the injection of the new policy contributed to the rapid industrialization in Indonesia. The situation affected the increasing number of job opportunity. Since more people joined the active workforce, the GOI assessed the formal social protection programs that previously initiated during Soekarno's era. During the period of Soeharto's presidency, the only significant alternation was the establishment of four state-owned enterprises that managed social protection programs and the expansion of health care and pension coverage for civil servants, police and army members and private sector workers. For the civil servants, the health care insurance was Health Insurance or *Asuransi Kesehatan* (ASKES) while for the pension program was Savings and Insurance for Pension or *Tabungan dan Asuransi Pensiun* (TASPEN). The police and army members are registered for Social Insurance for Indonesian Armed Forces of the Republic of Indonesia or *Asuransi Sosial Angkatan Bersenjata Republik Indonesia*

(ASABRI). Due to enormous economic growth and economic development, this era introduced the generosity of fuel-subsidy. To present, the fuel-subsidy is widely enjoyed by almost all the Indonesian population. In other words, there have been no standardized-criteria to assess the eligibility of the recipients which then causes great burden to the government budget.

The New Order regime collapsed when the Asian Financial Crisis (AFC) hit Indonesia in 1998. The AFC might be illustrated as an emergency call to the inactive motion of social protection development in Indonesia. The AFC had triggered the evolution of Indonesia's social security system, shifting from a fragmented system into a single comprehensive system. The reason was, that in the aftermath of the AFC, was the increasing national poverty rate from 15 percent in mid-1997 to 33 percent by the end of 1998. The falling of real wages combined with the skyrocketing price of domestic necessities by 78 percent were the major causalities that pushed approximately 36 million people into absolute poverty (Sumarto and Bazzi, 2011). In the wake of the crisis, the GOI launched Social Safety Net Program or *Jaring Pengaman Sosial* (JPS) specifically to prevent more people fell into absolute poverty. Social Safety Net (SSN) programs started to dominate the social security system in Indonesia since then. Moreover, the AFC had been also deemed as a

trigger of political transition of Indonesia. The transition was set in motion after the collapse of 32 years of military-led authoritarianism. This transition period has been titled as *Era Reformasi*. *Era Reformasi* generates massive alteration on political system of Indonesia, including handing over some degrees of authority from the central government to local governments the so-called decentralization.

In summary, given the background on Indonesia's social security prior 2004 was fragmented and targeted only certain groups of the population, public sector workers, members of the military along with their dependents and the formal sector workers in large firms. The development of social security was also slow-paced. A critical juncture that triggered a pivotal advancement in social security in Indonesia was the AFC in 1997-1998. On a different note, as for the country in which the government allocated fuel subsidies over 20 percent of total government expenditure in mid-2000s, albeit it has been gradually cut-off ever since, this declares Indonesia as a generous subsidized-energy provider to its citizen (ADB, 2015). Thus it was not without reason that the concern about stagnant development on social protection kept experiencing delay especially anterior to the AFC.

## 1.2 Research Background

More than thirty countries, including Indonesia, have adopted the Universal Health Coverage (UHC) scheme. Countries like Thailand, Rwanda and Mexico prove that UHC is not a ‘pipedream’ for developing countries by demonstrating improving health outcomes and by providing health care access to their poorest population (Pablos-Mendez, et.al., 2016). Recently, this inclusive healthcare has been mainly enhancing in the Sustainable Development Goals (SDGs). UHC strives to provide accessible yet affordable healthcare provisions to all the citizens. Likewise, the concept of UHC is in accordance with one of the national aspirations of Indonesia. Since it is mandated in the aforementioned last paragraph of The Preamble of The 1945 Constitutions of the Republic of Indonesia

Dating back to October 19, 2004, under Megawati’s administration, the Law No.40/2004 on National Social Security System or *Sistem Jaminan Sosial Nasional* (SJSN) was enacted. The objective of SJSN is to establish a national system that guarantee all the population to be covered by an integrated social security scheme. As the follow-up of the SJSN Law, GOI regulated the establishment of a single public legal entity to implement social security programs for all the people in Indonesia, referred as Social Security Administrative Bodies or *Badan*

*Penyelenggaraan Jaminan Sosial* (BPJS). BPJS integrated four existing social security programs managed by state-owned enterprises and other social protection programs run by different ministries or institutions, either it is in the level of central or local governments. The legal basis of the establishment of BPJS is in accordance with the Law No.24/2011. BPJS functions within two programs, BPJS *Kesehatan* or BPJS for Health and BPJS *Ketenagakerjaan* or BPJS for Worker. However, the effectuation of BPJS *Kesehatan* is more crucial and critical. It is because BPJS *Kesehatan* has an obligation to support the objective of National Health Security or *Jaminan Kesehatan Nasional* (JKN), providing access to health care service while protecting the population from financial harm. This objective is in accordance with the concept of UHC. JKN mandates a compulsory enrollment and compulsory contribution for all the population. According to the Ministry of Health of the Republic of Indonesia, JKN scheme adopts the concept Social Health Insurance (SHI) as the health care financing tool. JKN aims for a comprehensive benefit package with affordable cost, assuring quality control and cost control, sustainability in health care provision and portability in delivering health care service (GOI, 2013). JKN sets a main goal to reach UHC by providing coverage for all the population by 2019 whereas the program launched in 2014. It means that Indonesia is having five years to

accomplish the goal. Does the goal is too ambitious? Considering several aspects in health care-related provisions that are still less than sufficient.

### **1.3 Problem Formulation and Research Questions**

Tracking Indonesia's total health expenditure over the last two years, after BPJS *Kesehatan* has been operated since 2014, is still far below the global standard, 11.5 percent. In 2016, Indonesia's total health expenditure was 5 percent even though, it was slightly increasing compared to the previous years (GOI, 2016). Hence, it might not overstate to describe that Indonesia is pretty ambitious towards achieving UHC by 2019. Nonetheless, Indonesia has implemented the largest national social insurance to date moving to become the largest single-payer of UHC.

The objective of aiming a target group of population for JKN program is to provide coverage for the non-poor informal sector workers who were the 'missing middle' (Dartanto, et al., 2016) or remain uncovered on the previous existing social insurance programs. Statistics Indonesia or *Badan Pusat Statistik* (BPS) reported that in February 2017, the number of informal sector worker accounted for 58,5 percent which is still higher than the share of formal sector workers, amounting to 41,5 percent. Based on vocation types, informal sectors are dominated by workers in agriculture, farm, forestry, hunting and fishery (GOI, 2017).

The average income of such workers is somehow considered low and unstable. In spite of that, the SHI scheme of JKN program also obliges the informal sector workers the mandatory enrollment by paying contribution on monthly basis. The insurance contribution is based on level of healthcare facility they choose to enroll.

Moreover, another challenge in achieving UHC in Indonesia is to merge the existing local healthcare schemes, known as Regional Health Insurance or *Jaminan Kesehatan Daerah* (JAMKESDA) into JKN since the SJSN Law mostly focus on the transformation of JAMSOSTEK, TASPEN, ASABRI and ASKES. The rapid growing number on JAMKESDA is the result of decentralization policy in 1999. Article 11 and paragraph 2 of the Law No. 22/1999 on Local Government regulated that healthcare is one of the “mandatory” functions of district/city government. However, the amendment of the Law on Local Government passed in 2004. Specifically the Law No. 32/2004, Article 13 and Article 14 defined that the provincial government has the function to design, establish and develop their own healthcare system, which was later reaffirmed by the issuance of Decision of the Constitutional Court or *Keputusan Mahkamah Konstitusi* No.007/PUU-III/2005. As the implication, in 2011, 479 districts and cities out of 491 had implemented

or in the progress to implement their own local healthcare schemes (Fossati, 2017).

This research attempts to analyze the future challenges in achieving UHC in Indonesia by 2019, given the specific objectives by putting forward the following research questions:

1. What kind of challenges does the Government of Indonesia encounter in the process of achieving Universal Health Care coverage by 2019?
2. What kind of challenges do informal sector workers face in the process of enrolling in BPJS *Kesehatan*?
3. What kind of challenges does the local governments, both in the provincial and district/city level, meet toward integrating their various JAMKESDA schemes into JKN?



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1. Demographic Profile**

Understanding Indonesia means noting some crucial physical facts of the country which affect the distribution of health service, human resources and healthcare infrastructure: 1). Indonesia is the largest archipelago country in the world, with 13,466 islands are registered with the valid coordinates on United Nations; 2). Those islands are scattered in 1,913,578,68 square kilometers; 3). Indonesia is the fourth most populous country, accounting the increase number of population in 2016: 258,7 million. During 2010-2016, the average growth rate of population accounted 1,36 percent (GOI, 2017).

The issues of demographic in Indonesia, projecting between the time span from 2010 to 2030, has been shifted to these demographic mega trend, first is Indonesia's large population will continue growing, accompanied with rapid urbanization. Second, Indonesia starts experiencing Demographic Dividend due to the positive outcome of the Family Planning Program. Thirdly, population situation will shift from mobility to non-permanent mobility (Salim, et. al, 2015). The drastic alteration in population structure will start post-2015.

Salim, et. al (2015) elaborates that working age population will be around 140 million with lower dependency ratio compared to decades ago, with 60 percent population living in urban areas. Recent data taken from Statistics Indonesia (GOI, 2017) shows, that the number labor force or economically active is 124,44 million. The average income for formal sector worker per August 2016 is IDR 2,552,962 (USD 192.2), while for informal sector worker is IDR 1,496,430 (USD 119.6).

Agriculture, Forestry, Hunting and Fisheries still dominates the main industry in which the largest labor force or economically active people work, while the largest main employment status is owner assisted by temporary worker/unpaid worker. Even though the largest number of labor force and economically active people work in agriculture, forestry, hunting and fisheries, the highest average of net wage/salary per month for formal worker is in mining and quarrying industries: IDR 4,197,869 (USD 316.1). As for informal worker, the highest salary per month is in services industry: IDR 1,825,984 (USD 137.5) (GOI, 2017).

## **2.2. The Evolution of Social Protection in Indonesia**

This part elaborates the relevant literature on the evolution of social protection in Indonesia, placing more focus on the period between the AFC and the present period. Thereafter, the focus shifts into more specific

on how the evolution of social protection affects the informal sector workers and local healthcare schemes, JAMKESDA, managed by local governments.

Since the Declaration of Independence in 1945, social protection schemes had no dynamic of expansion until the AFC weakened Indonesia. During the Dutch colonization, the social protection was one of the privileges owned only by public sector workers. A very minor amendment was passed in 1970, providing social protection program for a limited number of formal sector workers, mostly in large firms (Ramesh, 2014). Widjaja (2012) argues that the AFC in 1998 affected on how the concept of social protection evolves in Indonesia. Indonesia already adopted two concepts of social protection since then; social assistance and social security. He elaborates that although social security program was started earlier in 1960s, in fact, social protection scheme heavily relies on social assistance rather than social security in Indonesia. Social assistance was just first introduced in 1998, such as social safety nets and subsidies programs were widely implemented in the wake of the crisis. However most of social assistance programs are intended to smoothen consumption for the poor and the near-poor (Widjaja, 2012).

Social Safety Net Programs or *Jaring Pengaman Sosial* (JPS) was shortly introduced as an emergency tool to mitigate the negative impact of

the AFC. Referring to Sumarto and Bazzi (2011) and Widjaja (2012), the evolution of social protection is divided into two generations. The first generation of social protection programs were introduced during the period after the AFC, during Habibie's administration until before Megawati's administration enacted the SJSN Law in 2004. The social protection programs consisted of, as follows: 1). Food security. This was mostly in a form of targeted sales of subsidized rice, OPK and Rice for the Poor or *Beras untuk Rakyat Miskin* (RASKIN); 2). Health care subsidies, JPS health program; 3). School scholarships and block grants, JPS scholarship; 4). Work creation programs, JPS *Padat Karya*; 5). Community block grants, the programs focused to empower local communities, *Kecamatan* Development Program (PPK), Village Infrastructure Project or *Instruksi Desa Tertinggal* (IDT) and Regional Empowerment to Overcome the Impact of Economic Crisis (PDM-DKE) (Sumarto and Bazzi, 2011; Widjaja, 2012).

Furthermore, the second generation of social protection started in the late 2004 onward. In this generation, national social health insurance was introduced, as mandated by the SJSN Law. Nonetheless, social assistance programs were extended and comprehensively developed during Yudhoyono's administration. The objectives of social protection during this period were expanded, not only mitigating the negative impact of the

financial crisis and poverty alleviation tool but also mitigating the negative impact of economic policy due to massive cut-off fuel subsidy in 2005 (Katiman, 2012). In this second generation of social protection, Unconditional Cash Transfers (UCT) or *Bantuan Langsung Sementara Masyarakat* (BLSM) and Conditional Cash Transfers (CCT) such as, Hope for the Family or *Program Keluarga Harapan* (PKH) were introduced. While the other programs were Health Insurance for the Poor (ASKESKIN), school assistance programs such as, Poor Students Subsidy or *Subsidi Siswa Miskin* (SSM) and School Operational Subsidy or *Bantuan Operasional Sekolah* (BOS), also community program through National Program for Society Empowerment or *Program Nasional Pemberdayaan Masyarakat* (PNPM) (Widjaja, 2012).

#### **2.2.1. Informal Sector Worker**

Defining the target population of social protection programs in Indonesia, it either targets the poor and the near-poor or the formal sector workers, both from public sector and private sector (mostly in large firms), yet not to informal sector workers. Informal sector workers always account higher than formal sector workers on total number of labor workforce in Indonesia. Nevertheless, informal sector workers are mostly excluded from any social protection programs or also known as the

‘missing middle’. The term ‘missing middle’ refers to the non-poor informal sector workers who remain excluded from any social protection.

The structure of the Indonesian economy has changed since 1970s. With the primary agriculture share in Gross Domestic Product (GDP) has fallen from 45 percent in 1970 to approximately 14 percent in 2014, shifting from agriculture-based economy to be more on manufacturing and services oriented (Rothernberg, et.al., 2016). In between the period of 1990 and 1996, the labor market marked its rapid transformation: 1. It had more formal sector workers than informal sector workers; 2. It moved from rural to urban; 3. Construction, manufacturing and services served as the primary sectors, replacing agriculture-related sector. It was in 1998 due to the AFC, that brought the robust economic growth in a halt, resulted in a ‘sharp real wage contraction’, pushed the formal workers who got laid off to enter informal sectors and reversed the aforementioned rapid transformation (Feridhanusetyawan and Gaduh, 2000).

Even though the number of informal sector workers dominates the labor workforce in Indonesia, in fact, there was no comprehensive social protection program. The informal sector workers are not protected by workplace or company regulation and they do not pay income tax. In 1995, the GOI launched Social Welfare Insurance Program or *Asuransi*

*Kesejahteraan Sosial* (ASKESOS), managed by the Ministry of Social Affairs and community-based organizations (ILO, 2017). Sirojudin and Midgely (2011) state that ASKESOS was intended to provide social insurance for informal sector workers while accelerating poverty alleviation and promoting social development. The premium was 60 cents USD on a monthly basis. The amount was based on the requirement that the worker must earn a minimum salary of 30 USD per month (ILO, 2017). The premium was relatively smaller, considering that the majority worked in agriculture and urban informal sector without sustain salary system (Sirojudin and Midgely, 2011).

Non-poor informal groups should voluntarily self-enroll to the program because they are not eligible for premium subsidies. However due to several reasons, such as asymmetric information, lack of health services, lack of knowledge and income, they might not enthusiastically register to the JKN (Dartanto, et.al., 2016).

Albeit the steps have been taken towards UHC since 2014, data by January 2016 showed that 15,080,000 out of 160,900,000 households with employment in informal sector already registered with JKN through BPJS *Kesehatan*. Thus the enrolment rate status poses a major obstacle to achieve UHC in 2019 (Dartanto, et al., 2016).

### 2.2.2. Local Healthcare Schemes

During the New Order, local government had a limited resources and restricted contribution in health policy and healthcare provision. While local projects invested more focus on infrastructure development, there was low demand for healthcare service as well, with local people opted to traditional healing process (Achmad, 1999). It was until 1999, when decentralization, in granted substantial authority and allocated more power to the local government, districts in particular that encouraged policy experiment and innovation in health policy. The period after the enactment of decentralization law was signified by the emerging numbers of local healthcare schemes, known as Regional Health Insurance or *Jaminan Kesehatan Daerah* (JAMKESDA). Most of JAMKESDA schemes aim to provide free or highly-subsidized healthcare service to its residents, implying that the local governments already “laid out more ambitious plans to reach UHC within their jurisdiction” (Fossati, 2017). He argues that JAMKESDA had triggered the central government to implement UHC scheme on the national policy level by putting the issue of equity to access healthcare service.

Between the period from 2001 to 2012, the Ministry of Health recorded data of JAMKESDA schemes designed, funded and managed by the local governments in 352 municipalities/cities in 33 provinces.



The effort of the local governments had finally captured by the central government. In 2004, the newly appointed Minister of Health, Siti Fadilah Supari disclosed that the government would pay for inpatient services for all poor people in Indonesia, also known as Health Insurance for the Poor or *Asuransi Kesehatan Masyarakat Miskin* (ASKESKIN). When ASKESKIN finally launched in 2005 as the first large-scale of national health insurance program, the program highlighted the first milestone towards a comprehensive UHC scheme in Indonesia (Fossati, 2017; Sparrow, Suryahadi and Widyanti, 2013). While some local governments argued that the launching of ASKESKIN was the reaction of the existing JAMKESDA (Fossati, 2017), on the one hand, this issue shook the very core of the power relationship that just set up due to the decentralization policy. Insiders claimed that her movement was an attempt to cover a deliberate move to re-consolidate the power at the center (Pisani, et.al., 2016). Thus, it angered some districts that already successfully run their own health schemes (Arifianto, et.al., 2005).

The SJSN Law affirms the role of local government based on judicial review, granted by the Constitutional Court of the Republic of Indonesia. As the follow up, the Law No.32/2004 on Local Government: Article 22 Alphabet H and Article 167 regulate the local governments

are obliged to prioritize their regional expenditures to develop their own local health schemes. After the BPJS Law was legislated in 2011, the GOI formulated a national roadmap towards achieving UHC. The national roadmap signifies that the integration from JAMKESDA to JKN should be executed (Supriyantoro, 2014). He perceives that the integration process is a challenge due to huge diversity of JAMKESDA schemes, applied by the provincial governments and district/city governments. His research analyses the challenge of integration from JAMKESDA to JKN is to synchronize administrative management, benefit packages and target recipients of *Penerima Bantuan Iuran* (PBI) for the poor and non-poor people.

In Indonesia, decentralization law sharpens the inequity in health care funding and health provision, specifically in district/city government. Health care provision is more widely determined by district government's revenue than population needs thus, the inequity at district level affects inequity at the individual level. Even so the solution mandated by the Ministry of Health is that local governments must provide a minimum package of services or *Standar Pelayanan Minimal* (SPM) (Ensor, et. Al, 2012). SPM focuses to provide health care service on maternal and neonatal care, infant and child care, family planning and priority communicable disease

## **CHAPTER 3**

### **THEORITICAL FRAMEWORK AND RESEARCH METHODOLOGY**

#### **3.1 Theoretical Framework of Social Health Insurance (SHI)**

The development of permanent health system in which all the population is granted equal access to health service, heavily relies on health financing methods, but not limited to political commitment and cultural aspect as well (Garrett, Chowdhury and Pablos-Mendez, 2009). According to Normand and Weber (2009), the four main principles on health financing methods are direct payment or out-of-pocket payment, commercial health insurance or private for-profit health insurance, government financing by general tax revenues and SHI.

In fact, out-of-pocket payment accounts higher in low-income countries though, it limits certain group of population to access health service (Carrin, Xu and Evans, 2008) and risks people falling into further poverty and impoverishments (Garrett, Chowdhury and Pablos-Mendez, 2009). Thus, one of the objectives of UHC is to gradually minimize the use of out-of-pocket payment method by shifting it to prepayment method.

Carrin and James (2005) elaborate on how government financing by general taxation revenues and SHI as the two principal methods of health

financing towards achieving UHC. General tax revenue is considered as the main source of health financing, combining the role between public networks and private providers. Whilst SHI aims to implement compulsory enrollment by paying contribution, covering all the population. Normand and Weber (2009) explain that SHI combines prepayment method and risk pooling, with mutual support.

Nevertheless due to the growing adoption of a global health objective in achieving health care for all, many governments encounter difficulties to maintain financial sustainability only through general taxation revenues, specifically in low-income developing countries. Hence it is common for countries to apply mixed health financing method of general tax revenue and SHI (Carrin and James, 2005). As a further matter, the central focus of this research is resting upon the concept of SHI towards UHC.

A number on Member States posited a reform initiative on health financing methods during the fifty-eight World Health Assembly on Sustainable Health Financing, Universal Coverage and Social Health Insurance, by mixing of public and private approaches, including SHI method (WHO, 2005). WHO elaborates that there are seven main points of SHI method proposed by the Member States, such as the health-financing system should include prepayment for financial contribution.

Second, ensuring an adequate and equal distribution of a good-quality health care both for the infrastructures and human resources in reference to the benefit package. Third, external funds should be managed and organized accordingly to support sustainability of health-financing system. Fourth is planning on achieving the target of UHC is crucial, with the objectives of improving health care quality, alleviating poverty and attaining international development goals. The fifth one is the process of transitioning from incomplete to UHC needs to be fit to the macroeconomics, socio-cultural and political context of each country. Sixth, the collaboration of public and private providers, together with health-financing organizations is mutual and beneficial under a strong government stewardship. And last point is sharing experience is expected on the development of various health financing methods.

While Norman and Weber (2009) suggest that there are certain issues should be examined before a country decides to apply SHI as a financial tool to achieve UHC. This issues cover political aspect that lies on the idea on how the political situation affects the enrollment status of certain groups of the population in SHI, or if it is more feasible to have separate schemes for them. This issue is also related to different financial, territorial and ethnic considerations within one country. Second is the technical aspect. Unlike commercial insurances that apply risk-based

premium and qualifies the insured, SHI belongs to both groups of the population, consisting of ‘low-risk’ people and ‘high-risk’ people, by applying compulsory membership with premiums being based on wage-related contributions, flat rate contributions or the mix from both contribution schemes. Third is equity which is considered as the transitional process to gradually extend the coverage by focusing on the status and ability of each person. The fourth aspect is the feasibility of universal coverage. This aspect deals with an assessment of timely process needed to include all the groups of workforce into the SHI scheme. The Fifth aspect is how the membership enrolment scheme should be conducted: voluntary or compulsory. They list that voluntary has more disadvantage than compulsory membership. The sixth aspect is to suggest that solution is to cover dependents by charging contribution for each family member, free of charge membership or providing subsidies for the family members. This last aspect, covering the informal sector, will be given below section.

Norman and Weber (2009) elaborate several alternatives taken to include informal sector workers in a SHI scheme: 1. The preference is to choose more priority to compulsory contribution rather than voluntary contribution; 2. If the informal sector workers cannot afford to pay monthly contribution, SHI scheme should opt to apply flat-rate

contributions or even free membership; 3. At least the informal sector workers are able to access basic benefit package; 4. SHI scheme should be work together with the local communities and community-based organizations in order to have easier access to reach informal sector workers; 5. Combining a benefit package of SHI and other micro finance insurance; 6. Strengthening audit and control of small medium enterprises; 7. Conducting information-sharing across government agencies.

In the context of Indonesia, SHI has been chosen to speed up the transition process from incomplete coverage to universal coverage. The fact that Indonesia targets to accomplish registering all the population into BPJS *Kesehatan* by 2019, Carrin and James (2005) propose that there are six ‘facilitating factors’ involved in speeding up the transition process. Thus in order to answer the research questions, this research grounds on the six ‘facilitating factors’ mentioned below:

1. Level of income or general economic growth.

Carrin and James (2005) posit an argument in which the ability of enterprises and citizens to provide prepayment contribution for SHI is determined by the level of income per capita.

2. Structure of the economy.

This is related to the relative size of formal sector worker and informal sector worker. If the size of informal sector worker accounts larger than formal sector worker, the situation will affect the process of income assessment which is determined premiums or contributions. SHI is heavily relied on household contributions.

3. Distribution of the population.

The population in urban area has better access to acquire health care information, health care service and health care infrastructures.

4. The country's ability to administer.

The business process of SHI scheme requires trained and skilled labor force.

5. The level of solidarity within a society.

When a country is able to define the level of solidarity within its society, most likely the process of cross-subsidy from the rich people to the poor people easier to get done. Cross-subsidy is crucial to provide sustainability towards SHI.

6. Government's stewardship.

Government must provide legitimacy and transparency towards various stakeholders and population to have a voice in social



polycymaking. Hence the government will gain trust from its citizen.

### **3.2 Research Method and Data Collection**

Aiming to answer the research questions, this research combines both quantitative and qualitative methodology in the analysis. Descriptive analysis focuses on trend of provision health expenditure, health care service, human resources and health care infrastructure in 33 provinces in Indonesia. The data is taken from the first law of SJSN was enacted, 2004 to date. The qualitative method is heavily relied on theoretical and literature review of previous case study, institutional policies and objectives.

This research conducts grey literature, within the five main websites: 1. Ministry of Health of the Republic of Indonesia; 2. Statistics Indonesia; 3. ILO; 4. BPJS Kesehatan; 5. WHO. The secondary sources data is collected from statistics, reports on health and informal sector worker related policy, regulation, local healthcare schemes, and the road-map national healthcare scheme.

## CHAPTER 4

### ANALYSIS

This chapter aims to analyze that six ‘facilitating factors’ that contribute to speed up transition in attaining Universal Health Coverage (UHC) through Social Health Insurance (SHI) in the context of Indonesia. Carrin and James (2005) posit the six ‘facilitating factors’ based on their research in eight countries (Austria, Belgium, Costa Rica, Germany, Israel, Japan, Republic of Korea (ROK) and Luxembourg). Those six ‘facilitating factors’ are ranging from macro to micro indicators of a country, as follows: 1). Level of income and economic growth; 2). Structure of the economy; 3). Distribution of the population; 4). Ability to administer, 5). Solidarity and 6). Government stewardship.

By elaborating six ‘facilitating factors’ in the context of Indonesia, this research proposes to identify the challenges, encountered by the Government of Indonesia (GOI), the informal sector workers and the local government during the ongoing transition phase towards 2019. Carin and James (2005) define that the transition period as “the number of years between the first law related to health insurance and the final law voted to implement universal coverage”. However in the context of Indonesia, there is a slight difference. The reason for this that the first law was issued in 2004 (the law on National Social Security System or *Sistem Jaminan*

*Sosial Nasional*/SJSN Law) and the latest law in 2011 (the law on Social Security Administrative Body or *Badan Pelaksana Jaminan Sosial*/BPJS Law). However, the GOI did not implement any of those laws regulated. It was only on January 1, 2014 when BPJS *Kesehatan* started to operate to reach the goal of UHC in 2019.

#### **4.1. Level of Income and Economic Growth**

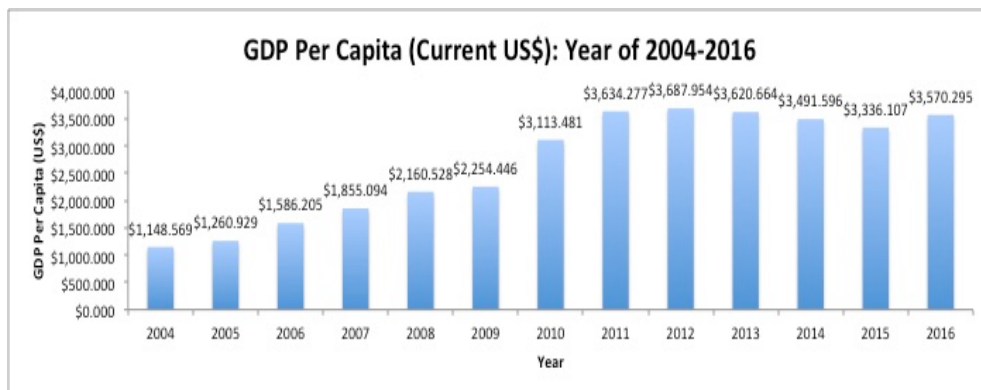
The financial capacity of enterprises and citizens determines financial sustainability of SHI since they must pay premiums; either it is self-funded by informal sector worker and their dependents or cost-sharing between the employer and employee. Any increase in per capita income is likely to affect the willingness of citizens to even prepay the SHI premium. Ideally the steady economic growth and tax revenue enables government to allocate more funding for subsidies to the targeted-population. In fact, macro economic growth is not a sole reference to reflect a comprehensive growth or development in a country.

At the time of the passing of the SJSN law passed in 2004, the economic growth of Indonesia started stabilizing in the aftermath of the Asia Financial Crisis (AFC). Even though the GDP per capita was USD 1,148.569 and the GDP growth rate was 3.5 percent during the first year of the enforcement of the initial law related to national health care, the

GDP per capita progressively improved between the years of 2004 to 2013. Meanwhile between the years of 2014 and 2015, the numbers slightly declined before it started to rise again in 2016.

Depicting the timeline of the internal economy situation in Indonesia, between 2004 and 2010 was fluctuated due to the issue of the phasing out of fuel subsidies in Indonesia (Pradipto and Sahadewo, 2012). It has a binding instant impact on the industries and household consumption in Indonesia. Consequently, the GOI has to allocate budget to mitigate the impact from the fuel subsidy cut-off, mostly in the form of social assistance schemes. As defined by the Asian Development Bank (2005), it is a ‘public service obligation’ for the GOI to provide subsidized energy to the citizens specifically for electricity and other petroleum fuels to the present.

**Figure 1. Indonesia’s GDP Per Capita (Current US\$): Year of 2004-2016**



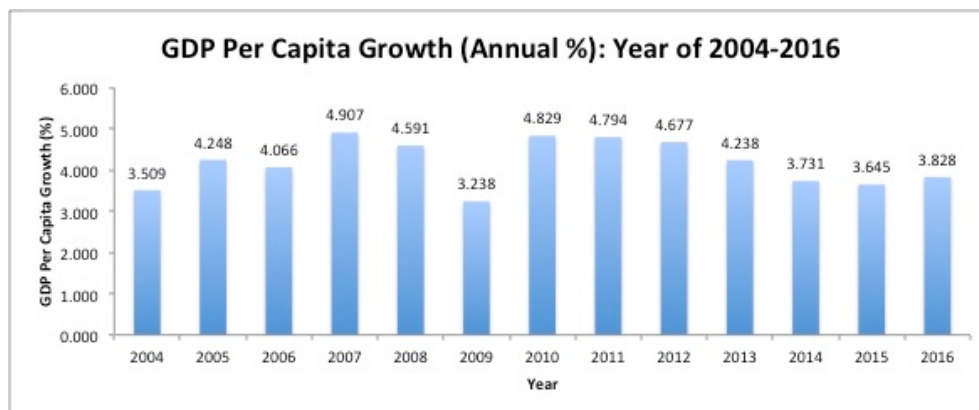
Source: The World Bank

<https://data.worldbank.org/indicator/NY.GDP.PCAP.KD?locations=ID>

Note: Author’s compilation

Figure 2 increasing GDP growth rates during the period from 2004 to 2016, with intermediate decline in 2009, 2014 and 2015. In 2008, the Global Financial Crisis occurred, inflicted economic crisis on Indonesia as well though the impact was not as bad as during the AFC.

**Figure 2. Indonesia's GDP Per Capita Growth (Annual %): Year of 2004-2016**



Source: The World Bank

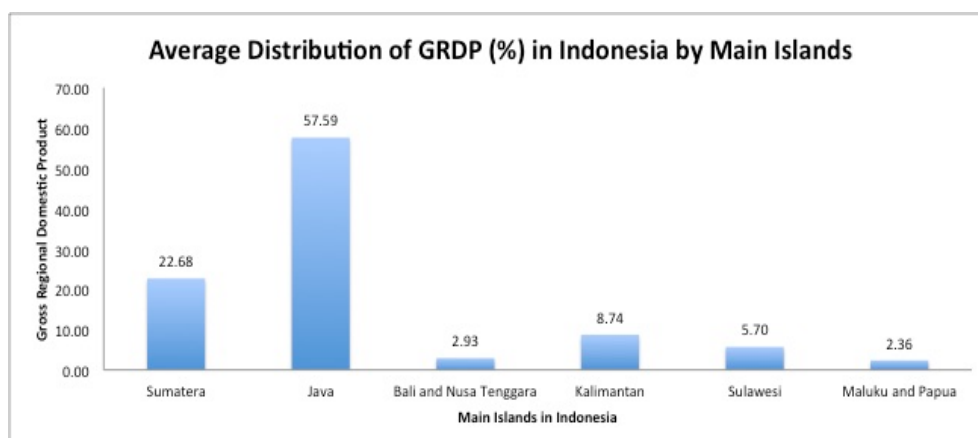
<https://data.worldbank.org/indicator/NY.GDP.PCAP.KD.ZG?end=2016&locations=ID&start=1967&view=chart>

Note: Author's compilation

Although Indonesia enjoyed a continuous positive trend on economic growth post-AFC, the fact that it does not represent an overall measurement of all regional regions of Indonesia, namely it ignores regional disparities, is inevitable. Assessing the annual Gross Regional Domestic Product (GRDP) divided by the main/main group islands: Sumatera, Java, Bali and Nusa Tenggara, Kalimantan, Sulawesi, Maluku and Papua, as seen in Figure 3, Java is still dominating, with 57.59

percent on average contribution of GRDP. It is followed by Sumatera (22.6 percent). As for the rest of the main islands, the annual contribution of GRDP to national GDP is less than 10 percent. This implies that the extreme gap of GRDP exists between Java and the other main/main group islands specifically the Eastern islands of Indonesia, such as Maluku and Papua (2.36 percent). The calculation of each presented main/main group islands is based on the annual contribution of GRDP to national GDP between 2011 and 2016 of the 34 provinces in Indonesia.

**Figure 3. Average Distribution of Gross Regional Domestic Product (%) in Indonesia by Main Islands**



Source: Statistics Indonesia (a)

(<https://www.bps.go.id/dynamictable/2015/10/07/959/-seri-2010-distribusi-pdrb-terhadap-jumlah-pdrb-34-provinsi-atas-dasar-harga-berlaku-menurut-provinsi-2010-2016-persen-.html>)

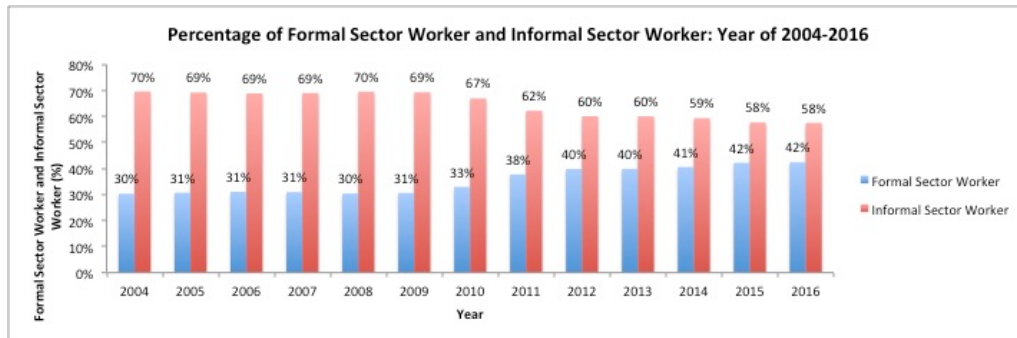
Note: Author's calculation and compilation

## 4.2. Structure of the Economy

The rising number of formal sector workers might be a positive indicator for the longevity of the SHI program specifically in a developing country, such as Indonesia. The situation facilitates the SHI management body, in this case BPJS *Kesehatan*, to perform better on controlling its membership administration and to get easier access to convey any updated information regarding the program. This is due to the fact that the institutions, companies or employers are considered to be the main pool in passing on information and to create a systematic and punctual payment flow.

Even though in terms of sectors, the structure of the economy in Indonesia has been shifted from a primarily-agriculture based economy to manufacturing and services, and more recently to communication and transportation (Rothernberg, 2016 ;Yasir, 2017), on the one hand, in terms of the labor force, informal sector workers have been dominating the annual total number of the workforce. During the recovery period after the AFC in 2004, the informal sector workers accounted for 70 percent of the total workforce. Even though the number was declined slightly a year later, and became 69 percent, the condition remained static until 2010. Starting in 2011, the wide gap between informal sector workers and formal sector workers has been narrowed rapidly. (Figure 4).

**Figure 4. Indonesia's Percentage of Formal and Informal Sector Workers: Year of 2004-2016**



Source: Statistics Indonesia (b) <https://www.bps.go.id/statictable/2016/04/05/1910/penduduk-berumur-15-tahun-keatas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-1997---2007.html> and <https://www.bps.go.id/statictable/2016/04/05/1911/penduduk-berumur-15-tahun-ke-atas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-2008---2017.html>  
 Note: Author's calculation and compilation

The head to head between Figure 6 and Figure 7 expounded that the biggest number of formal sector workers are in social services and individual proprietorship industries, while mostly informal sector workers still dominate agriculture, forestry, hunting and fishery industries. However, since the number of formal workers has been steadily escalating, this predicts the raising net income from informal sectors to formal sectors in which it had an effect on the premium scheme of the BPJS *Kesehatan*. This is because the calculation shows that BPJS *Kesehatan* benefits more from progressive premium rates (paid by formal workers) rather than flat premium rate (paid by informal workers and non-employees).



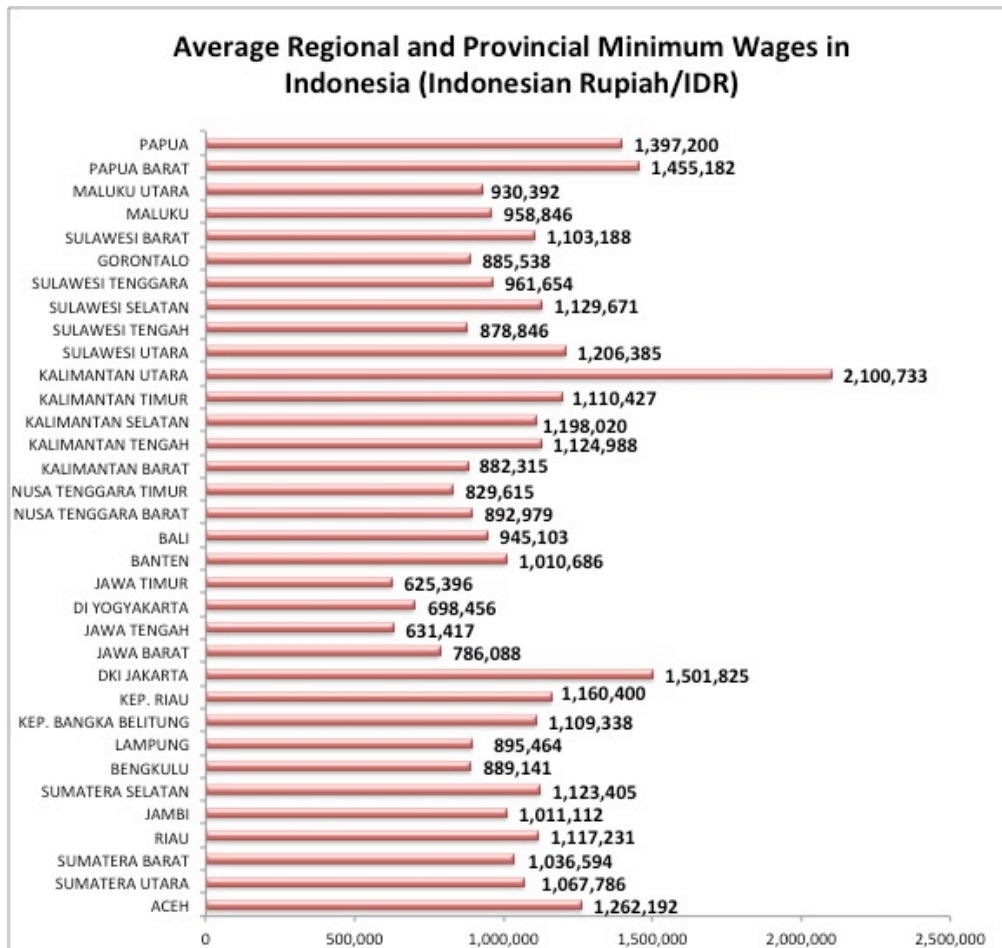
Regarding the minimum wages, Indonesia sets different minimum wages within regional and provincial levels, known as Provincial Minimum Wage or *Upah Minimum Provinsi* (UPM). The background of this policy is due to the decentralization in 2001, and also considering the regional economic growth is different from one to another. The governor has full authorization to decide the set amount of UPM and to adjust the amount every year. The regulation of UPM should be applied for formal and informal sector workers. In fact, the UPM is still leaving behind many informal sector workers who are still uncovered (Hohberg and Lay, 2015).

Referring to the data obtained from Statistics Indonesia per August 2016 (GOI, 2017), the average of net income per month for worker in formal sector is 2,552,962 IDR (USD 192.2) and for informal sector worker is 1,496,430 IDR (USD 119.6). Table 6 delineates mining and quarrying industries offer the higher amount of salary, compared to other main industries due to the fact that the some of the biggest mining and quarrying companies in Indonesia are multinational companies. They usually provide better benefits as well. It indicates that the highly skilled-workers are demanded to work in those companies.

As for figure 5 below, the average numbers are based on annual regional and provincial minimum wages in Indonesia for each province

issued by Statistics Indonesia(c). This research processed the data from 2004 to 2016. As it is presented, the highest average of minimum wages in Indonesia is in Kalimantan Utara (2,100,733 IDR or around 157.8 USD). By contrast, Kalimantan Utara sets up pretty much higher minimum wages than DKI Jakarta, as the capital city. Whereas in terms of the population, DKI Jakarta is about 13 times bigger than Kalimantan Utara.

**Figure 5. Average Regional and Provincial Minimum Wages in Indonesia (in Indonesian Rupiah/IDR)**

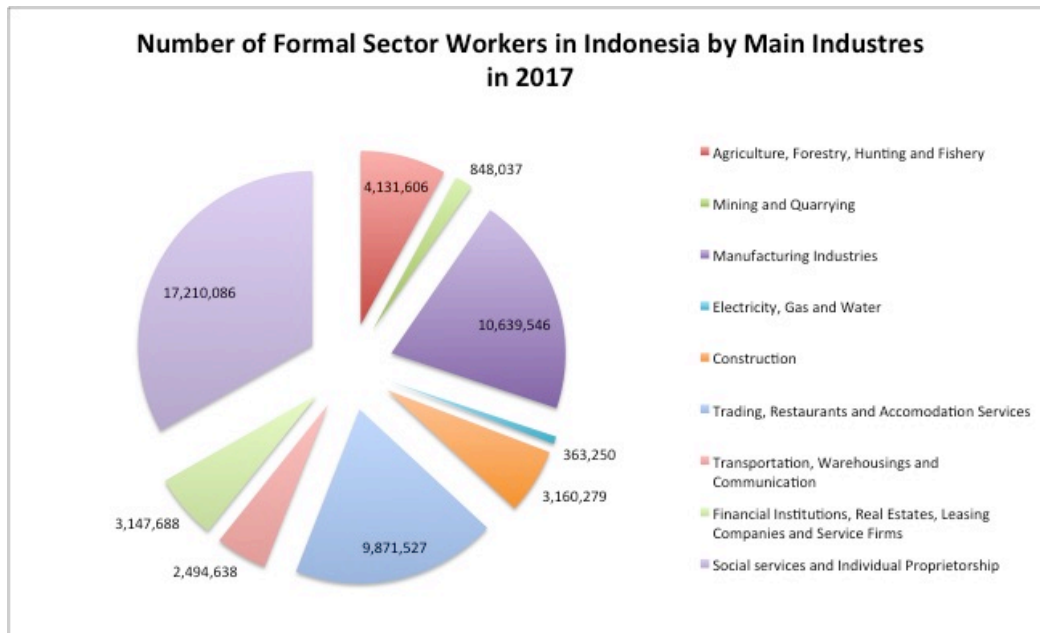


Source: Statistics Indonesia (c)

(<https://www.bps.go.id/linkTableDinamis/view/id/917>)

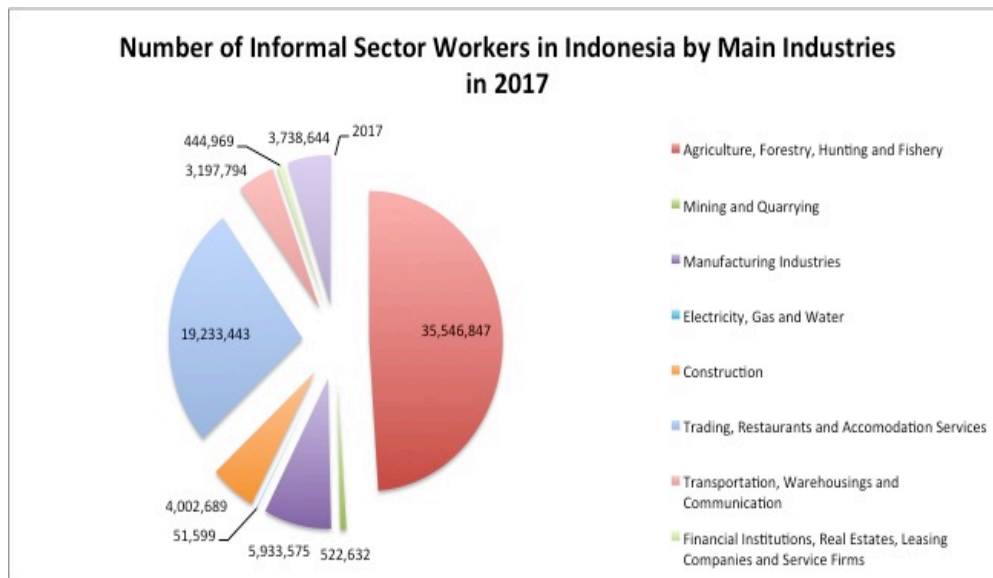
Note: Author's calculation and compilation

**Figure 6. Number of Formal Sector Workers in Indonesia by Main Industry:  
Year of 2017**



Source: Statistics Indonesia (b) <https://www.bps.go.id/statictable/2016/04/05/1910/penduduk-berumur-15-tahun-keatas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-1997---2007.html> and <https://www.bps.go.id/statictable/2016/04/05/1911/penduduk-berumur-15-tahun-ke-atas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-2008---2017.html>  
Note: Author's calculation and compilation

**Figure 7. Number of Informal Sector Workers in Indonesia by Main Industry: Year of 2017**



Source: Statistics Indonesia (b) <https://www.bps.go.id/statictable/2016/04/05/1910/penduduk-berumur-15-tahun-keatas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-1997---2007.html> and

<https://www.bps.go.id/statictable/2016/04/05/1911/penduduk-berumur-15-tahun-ke-atas-yang-bekerja-selama-seminggu-yang-lalu-menurut-status-pekerjaan-utama-dan-lapangan-pekerjaan-2008---2017.html>

Note: Author's calculation and compilation

**Table 1. Average of Net Salary per Month for the Formal Employee by Main Occupation and Main Industry: 2016**

Average of Net Wage/Salary per Month for Formal Employee by Main Occupation and Main Industry (Indonesian Rupiah/IDR), 2016

Main Occupation	Main Industry				
	Agriculture, Forestry, Hunting, Fishery	Mining and Quarrying	Manufacturing Industry	Electricity, Gas and Water	Construction
Professional/Technical Related Workers	3,680,086	11,611,892	4,812,360	3,698,625	3,773,788
Administrative and Managerial Workers	8,581,637	8,553,094	8,120,820	6,306,362	4,556,059
Clerical and Related Workers	3,257,989	5,658,796	3,633,610	3,440,814	4,196,769
Sales Workers	2,229,820	4,500,000	4,421,444	1,443,351	7,955,167
Service Workers	1,500,263	2,905,825	2,967,116	1,598,546	5,946,513
Agricultural, Forestry, Hunting and Fishermen Workers	1,537,052		5,868,647		
Production and Related Workers, Transport Equipment Operators, Aborers	2,036,368	3,788,951	2,087,631	3,174,029	2,035,026
Others	2,315,351	2,637,116	2,528,774	2,458,512	2,386,302

Source: *Statistik Indonesia* Statistical Yearbook of Indonesia (2017)

Note: Author's compilation

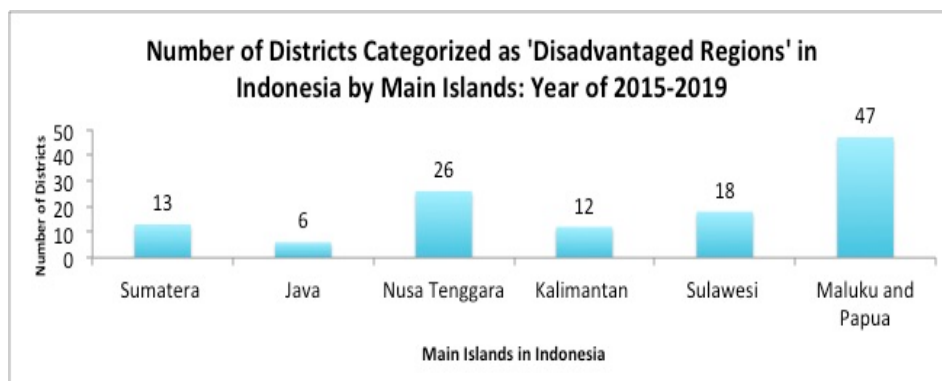
### **4.3. Distribution of the Population**

Urban areas are apt to provide better access and better service to health care. Urbanization with its vast development of infrastructure, the advancement of communication and population density produces more efficiency in administrative cost for SHI program compared to dispersed rural areas (Carrin and James, 2005). Although Indonesia's urban population is one of the highest in Asia, with more than 50 percent of the total population (Lewis, 2014), particular geographical features of some areas remain a challenge for the GOI. As for some areas with arduous access, the condition delays the improvement of infrastructure, hinders the distribution of essential goods (e.g. electricity) and provision of information (e.g. government's programs).

The GOI has projected the growth of the urban population in each province for every five year period the timespan of 2010 to 2035. Thus according to the 2010-2015 urbanization projection, as shown in Table 7, the average rate of the urban population is expected to reach 56.7 percent by 2020, a year after the target of UHC in 2019. However the Table 7 and Figure 7 suggests a typical yet critical issue in Indonesia: immense gap among provinces. Provinces such as Sulawesi Barat (23.0 percent), Nusa Tenggara Timur (26.3 percent), Maluku Utara (28.9 percent) are among the low-rate urbanization growth.

It is clearly relatable to Figure 6 that pronounces the number of districts categorized as '*Daerah Tertinggal*' or 'Disadvantaged Regions' by main islands in Indonesia. The term 'Disadvantaged Regions' derives from the Presidential Decree of the Republic of Indonesia No. 131/2015 on *Penetapan Daerah Tertinggal Tahun 2015-2019*. The definition of 'Disadvantaged Regions' refers to 122 districts that are still less developed or underdeveloped than other districts. The classification of 'Disadvantaged Regions' is appertained to the criteria of local economic activities, human resources, infrastructure, regional financial ability accessibility and characteristics of the districts. The list of districts is subject to change every five years. According to the Figure 6, mainly the Eastern regions of Indonesia appear on the list.

**Figure 8. Number of 'Disadvantaged Regions' in Indonesia by Main Islands: Year of 2015-2019**



Source: Ministry of State Secretariat of the Republic of Indonesia

Note: Author's calculation and compilatio

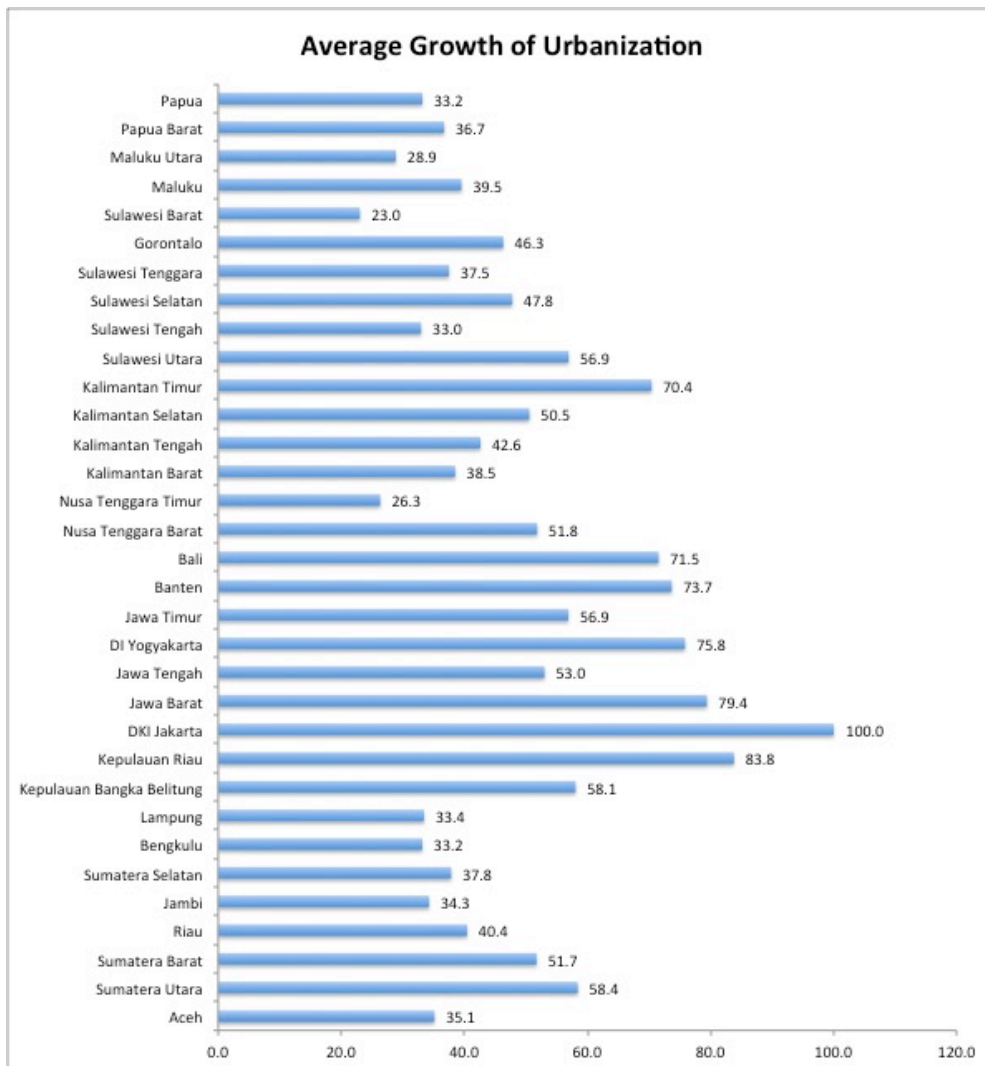


**Table 2. Urban Population (in %) in Indonesia by Provinces: 2010-2035**

<b>Province</b>	<b>2010</b>	<b>2015</b>	<b>2020</b>	<b>2025</b>	<b>2030</b>	<b>2035</b>
Aceh	28.1	30.5	33.2	36.2	39.5	43.2
Sumatera Utara	49.2	52.6	56.3	60.1	64.1	68.1
Sumatera Barat	38.7	44.2	49.6	54.6	59.4	63.8
Riau	39.2	39.6	40.1	40.7	41.2	41.8
Jambi	30.7	32.0	33.3	34.8	36.5	38.2
Sumatera Selatan	35.8	36.5	37.3	38.2	39.1	40.1
Bengkulu	31.0	31.7	32.6	33.5	34.5	35.6
Lampung	25.7	28.3	31.3	34.6	38.3	42.4
Kepulauan Bangka Belitung	49.2	52.5	56.0	59.7	63.5	67.4
Kepulauan Riau	82.8	83.0	83.3	83.8	84.5	85.3
DKI Jakarta	100.0	100.0	100.0	100.0	100.0	100.0
Jawa Barat	65.7	72.9	78.7	83.1	86.6	89.3
Jawa Tengah	45.7	48.4	51.3	54.3	57.5	60.8
DI Yogyakarta	66.4	70.5	74.6	78.0	81.3	84.1
Jawa Timur	47.6	51.1	54.7	58.6	62.6	66.7
Banten	67.0	67.7	69.9	73.7	78.8	84.9
Bali	60.2	65.5	70.2	74.3	77.8	81.2
Nusa Tenggara Barat	41.7	45.4	49.4	53.6	58.1	62.7
Nusa Tenggara Timur	19.3	21.6	24.3	27.3	30.7	34.6
Kalimantan Barat	30.2	33.1	36.2	39.8	43.7	47.9
Kalimantan Tengah	33.5	36.6	40.2	44.1	48.3	52.9
Kalimantan Selatan	42.1	45.1	48.4	52.0	55.8	59.8
Kalimantan Timur	63.2	66.0	68.9	71.8	74.8	77.7
Sulawesi Utara	45.2	49.8	54.7	59.2	63.9	68.7
Sulawesi Tengah	24.3	27.2	30.5	34.2	38.4	43.1
Sulawesi Selatan	36.7	40.6	45.0	49.8	54.9	59.6
Sulawesi Tenggara	27.4	31.2	35.0	39.4	43.6	48.3
Gorontalo	34.0	39.0	44.0	48.9	53.5	58.4
Sulawesi Barat	22.9	22.9	23.0	23.0	23.1	23.1
Maluku	37.1	38.0	38.9	39.9	41.0	42.1
Maluku Utara	27.1	27.8	28.5	29.2	29.9	30.6
Papua Barat	29.9	32.3	34.9	37.8	40.9	44.4
Papua	26.0	28.4	31.2	34.2	37.7	41.5
<b>INDONESIA</b>	<b>49.8</b>	<b>53.3</b>	<b>56.7</b>	<b>60.0</b>	<b>63.4</b>	<b>66.6</b>

Source: *Badan Perencanaan Pembangunan Nasional, Badan Pusat Statistik* and United Nations Population Fund

**Figure 9. Average Growth Rate of Urban Population (in %) in Indonesia by Provinces**



Source: *Badan Perencanaan Pembangunan Nasional, Badan Pusat Statistik* and United Nations Population Fund

Note: Author's calculation and compilation

#### 4.4. Ability to Administer

This factor evolves to an administrative aspect proposed by Carrin and James (2005) about the availability of skilled-manpower specifically

in bookkeeping, banking and information processing to manage the business process and strengthen the sustainability of the SHI program. Meanwhile, in the case of Indonesia, the aforementioned factor should be considered as secondary aspects rather than an aspect of building trust between the management of SHI program (BPJS *Kesehatan*) and its participants (Bärnighausen and Sauerborn, 2002). Thus they also elaborate German started from “small, informal, voluntary health insurance schemes may serve as learning models for fund administration and solidarity, both of which will make introduction of larger, more formal, compulsory schemes an easier task.” (Bärnighausen and Sauerborn, 2002). By contrast, the ability to administer in the case of Indonesia is broader from what Carrin and James (2005) proposed, not only the skilled-manpower but also the institution itself.

Formal social protection programs in Indonesia were run by four state-owned enterprises prior to BPJS *Kesehatan*. BPJS *Kesehatan* was introduced as a part of the main agenda of Indonesia’s social protection transformation. The transformation refers to the shifting assets, liabilities and management staffs from PT. ASKES Indonesia (Persero) to BPJS *Kesehatan*. PT. ASKES Indonesia (Persero) was one of the state-owned enterprises that managed health care funds only for the civil servants, i.e. about 7 percent of the total population by the end of 2013. This indicates

that the former state-owned enterprises managed very small population. Moreover the employee who worked for the former state-owned enterprises were categorized as public civil servants. It means that the recruitment process and the management of employee referred to the standard of public civil servant.

By contrast, BPJS *Kesehatan* is considered as the sole public entity who has authority to manage all the implementation of the health care system in Indonesia, nationally. Even though it is a centralized health care system, the fact that it is still fragmented in terms of the health care facility procedure because based on the area where the person lives has cause more complex.

Aside being transformed from PT. ASKES Indonesia (Persero), the Ministry of Health of the Republic of Indonesia already handed over the management of JAMKESMAS, the subsidized-health insurance for the poor and near-poor people to BPJS *Kesehatan*. It assumes that the scope of tasks has been broaden for the fund administration.

#### **4.5. Solidarity**

Solidarity refers to the concept of performing cross-subsidization between the poor and the rich and the high-risk and low-risk groups, as it is proposed by Carrin and James (2005) and WHO (2010). On another

note, the concept of solidarity here as applying cross-subsidization might create friction specifically between the high-risk and low-risk group. Due to the reason that high-risk group is the people who prone to catastrophic diseases hence, they most likely use the high-cost health care treatments in the regular basis.

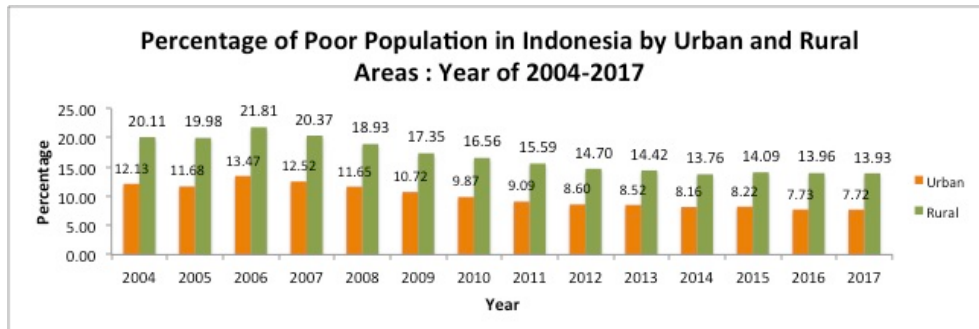
The concept of UHC should not be defined as one-size-fits-all on health care systems and health care provisions although the sole purpose is the equality to access health care service without risking them financially (WHO, 2010). It is because UHC should reflect and prioritize the needs of a nation despite its initiation and purpose led by the global health community (George, 2016). By responding to the needs of its population, a government initiates solidarity within the society.

The GOI bears the premium expense of BPJS *Kesehatan* for the poor and the near-poor population. On a different note, the premium for the poor and the near-poor people is considered too low, 1.7 USD. Since the amount is compared to the estimation of the standard of basic care service by the Commission on Macroeconomics and Health, 34 USD (WHO, 2010). Figure 9 displays a declining trend of the poor population in Indonesia, despite the fact exhibited by Figure 10, that the poor and the near-poor people dominate about 60 percent of recent total membership enrollment status for BPJS *Kesehatan*. This situation contributes to the

less income of BPJS *Kesehatan*. Whereas the GOI already raised the premium scheme for the informal sector workers or non-employees since April 2016.

JKN requires a referral system in using health care facilities. According to the regulation in which members must visit the first classification of health care facilities, consisting of *Pusat Kesehatan Masyarakat* (Puskemas), *Poliklinik*, dentists or 24 hour clinic/family clinics. Public hospitals, private hospitals and specialist doctors are classified as ‘referred health care facilities’. The numbers of *Puskesmas*, *Poliklinik* and clinic are sufficient to reach almost all the areas of Indonesia, unlike hospitals that are mostly located in the provincial capitals. Related to user fee, *Puskesmas*, *Poliklinik* and clinic are more affordable (about 1-2 USD), than hospitals or specialist doctor. Hence regardless the monthly premium of BPJS *Kesehatan*, the referral system in using health care facilities is considered as a form of solidarity.

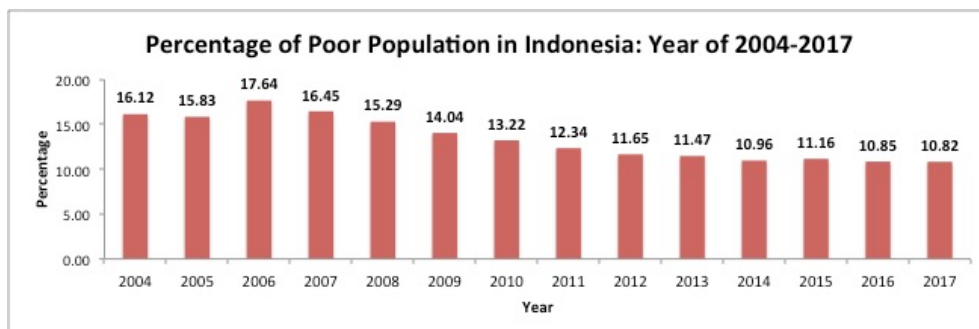
**Figure 10. Percentage of the Poor Population in Indonesia by Urban and Rural Areas**



Source: Statistic Indonesia (d) (<https://www.bps.go.id/linkTabelStatis/view/id/1494>)

Note: Author's calculation and compilation

**Figure 11. Percentage of Poor the Population in Indonesia by Years**



Source: Statistics Indonesia (d)

(<https://www.bps.go.id/linkTabelStatis/view/id/1494>)

Note: Author's calculation and compilation

#### 4.6. Government Stewardship

In the case of Indonesia, government stewardship possibly turns out to be a critical yet most crucial issue. Since the role of the government is to be the main actor to lead, to ensure and to secure social welfare programs for all the citizen, t This implies that the government's

transparency is often challenged in order to earn trust from the citizens. By paying premiums, citizen contributes to preserve the continuity of the SHI program.

Thus, the mutual interest between the GOI and the citizens determines the sustainability of BPJS *Kesehatan*. On a different note, Kusnali, Laksmiarti and Effendi (2017) cluster conflicts, involving BPJS *Kesehatan*, citizens and healthcare facilities, based on ‘complaints’ and ‘other than complaints’. ‘Complaints’ refer to conflict or disputes occurring within the scope of handling complaints division of BPJS *Kesehatan*. ‘Other than conflicts’ often occurs due to the contractual cases or illegal issues. Consequently, they strongly suggest the GOI to establish an independent institution that solely focuses yet remain neutral to any potential conflicts or disputes (Kusnali, Laksmiarti and Effendi, 2017).

The ongoing precarious issue is the growing budget deficit of BPJS *Kesehatan* since its first year implementation in 2014. The root of the problem is the imbalance between the low premiums option and broad medical coverage (Rachman, 2015). The latest update mentioned that BPJS *Kesehatan* has been suffering from a budget deficit which has already reached 9.7 trillion IDR (728.23 million USD) in 2016 (Jakarta Globe, 2017).



As for the current status of membership enrollment, 183,579,086 residents of Indonesia already registered by November 1, 2017. Figure 10 distributes the numbers for each group of the population. Therefore approximately 71 percent of the total population are already covered by JKN. Even so based on the data by the Ministry of Health of the Republic of Indonesia (2013), the population covered by health insurance in 2013, a year before BPJS *Kesehatan* was introduced in the beginning of 2014, was 76,18 percent of the total population 111,593,654.

**Figure 12. BPJS Membership Status per November 1, 2017**



Source: BPJS *Kesehatan*

Note: Author's compilation

## **CHAPTER 5**

### **CONCLUSION AND RECOMMENDATION**

#### **5.1. Summary of Findings**

The historical background of social protection development in Indonesia describes an inactive motion on formal social protection provisions and it was heavily relied on informal social protection arrangements prior to the National Social Security System (JKN) in 2004. One of the arguments is due to the ‘Indonesia’s welfare regime change’ correlates with the economy and political-economic reform that is described into three major period: (1) Old Order regime (1945-1966); (2) New Order regime (1966-1998); (3) Post-AFC from 1997-1998 to the present (Sumarto, 2017). This research also recounts the historical background of the social protection development with a particular form on health care during the aforementioned periods.

Formal social protection refers to social protection programs that exclusively target certain group of population, such as workers in public and private sectors. Formal social protection programs were introduced during the Old Order regime (1945-1967) and Soekarno was the president during the period. However the program did not well-developed because the GOI allocated most of the national budget to build and restore the country from the war-torn situation. Second big portion of the national

budget went to military-related purposes since after the Proclamation of Indonesian Independence in 1945, Indonesia was struggling from other countries invasions for few years after that (Sumarto, 2017; Booth, 2010). Indonesia entered its miraculous economic transformation from the late 1960s to the early 1970s under the presidency of Soeharto, known as the New Order regime (1966-1998). This is the period of 'Oil Boom' provided Indonesia with abundance of not only oil but also other minerals wealth. One of the crucial economic policies by Soeharto in the early years of his tenure was to open foreign investment to boost Indonesia's economic development and Indonesia's rapid industrialization. As the result, the job openings were expanded and labor force participation rate increased. The increasing rate of labor force participation affected the enhancement of formal social protection programs as well. Even though it was not significant. The period marked as the beginning of hefty oil subsidies that is enjoyed by most of the Indonesia population. The oil subsidies issue is always be the main focus and main concern of the nation, at least to the present day. Thus the issue on oil subsidies is one of the main factors why the formal social protection programs have been slow developed.

By contrast, informal social protection was and still usually initiated as part of family-based and community-based social protection programs

that strongly rooted in Indonesian society. The fundamental philosophy derives from the term of '*Gotong royong*', a Javanese phrase that means "several people carrying something together" (Bowen, 1986 in Sumarto, 2017). *Gotong royong* is widely acceptable and applicable social protection provision in Indonesia more than formal social protection provision. Sumarto (2017) also emphasizes that how the role of *Gotong royong* in providing social protection for its community members covers almost all the aspects, such as: (1). *Gotong royong* as multi-purpose insurance, also known as '*Arisan*'; (2). *Gotong royong* as sickness insurance; (3). *Gotong royong* as healthcare; (3). *Gotong royong* as death insurance; (4). *Gotong royong* as income maintenance; (4). *Gotong royong* for housing; (5). *Gotong royong* as food security; (6). *Gotong-royong* as neighborhood security. Even though the informal social protection has been dominantly occupying the coverage needs of Indonesian population, in fact, it was unable to protect them from the aftermath of major crisis, such the Asian Financial Crisis (AFC) in 1997-1998 and the Global Financial Crisis in 2007-2008. Those major financial crises specifically the AFC have been marked as a critical juncture in the transformation of social protection provision in Indonesia.

It was during Megawati Sukarnoputri's presidential term in 2004, the law on National Social Security System or *Sistem Jaminan Sosial*

*Nasional* (SJSN) was enacted. The law regulates that the fragmented social protection programs in health care and employment run by four state-owned enterprises: (1). PT. ASKES; (2). PT. JAMSOSTEK; (3). PT. TASPEN; (4). PT. ASABRI must be converted into a single public entity, named Social Security Administrative Body or *Badan Penyelenggara Jaminan Sosial* (BPJS). BPJS manages health care program (BPJS *Kesehatan*) and employment program (BPJS *Ketenagakerjaan*). The health care program run by BPJS *Kesehatan* is nationally known as National Health Insurance or *Jaminan Kesehatan Nasional* (JKN). The health care program is the sole focus of this research.

The background of this research derives from a very ambitious goal of the GOI to achieve a newly-adop‘health for all’ or UHC within five years, from 2014 to 2019. In fact, covering such large number of people does pose many challenges due to the strong decentralization and structure of economic diversity of Indonesia. At present, BPJS *Kesehatan* is the largest single health insurance payer.

Indonesia, the largest archipelago country in the world with more than 250 million inhabitants occupies different regional and time zones and has been actively adjusting to a newly-adopted health care scheme, ‘health for all’, via the compulsory membership and contribution of SHI since 2014. The program is nationally known as National Health

Insurance (JKN) with a single public entity body as the health care fund management, name Social Security Administrative Body (BPJS *Kesehatan*).

Decentralization policy has been moving authority from the central government to local governments to establish their own health care policy. This is supposed to reflect the its citizens' needs priority within the boundaries of their respective financial ability and budget allocation at the local government level. As a result, prior to the passing of the SJSN Law in 2004 and between the years from 2001 to 2012, more than 350 districts/cities already funded, designed, established and managed their own Regional Health Insurance (JAMKESDA) schemes. This indicates that the local government already was already aware of UHC scheme even before the central government initiated JKN as a national program.

Meanwhile, when the GOI finally enacted the SJSN Law, one of the main considerations was to provide social protection for employees who work in informal sector. By 2004, the gap between formal sector worker and informal sector workers was very large, with the informal sector workers constituting more than 65 percent of the total number of the labor force. However, the task of JKN, the centralized health care system, remains challenging to reach since the informal sector workers mostly work in the dispersed rural areas. In addition, most of them work in

traditional industries, such as agriculture, forestry, hunting and fishery, which poses various challenges to reaching them from an administrative point of view. Moreover, Indonesia has made efforts to establish an integrated single citizen database system, yet the e-KTP (national identification registration), as the pilot project, has been struggling with corruption case.

For theoretical framework and research methodology, this research was conducted to identify the potential challenges faced by the GOI, with regard to informal sector workers and regarding the activities of the local government in responding to the goal of UHC by 2019. This research uses the six ‘facilitating factors’ that are elaborated by Carrin and James (2005). They argue that the six ‘facilitating factors’ has been the key factors to speed up UHC through SHI, based on their comparative research of eight countries that already reached health care universalism (Carrin and James, 2005). This research is primarily applied grey literature and secondary source data.

## **5.2. The Challenges of the GOI, Informal Sector Workers and the Local Government**

During the nascent phase of health care reform in Indonesia, the mounting deficit of the BPJS *Kesehatan* was the biggest concern. The

implication is potentially creating a domino effect among all the stakeholders: (1) BPJS *Kesehatan*-health care facilities; (2) Health care facilities-BPJS *Kesehatan* beneficiaries; (3) BPJS *Kesehatan*-its beneficiaries. Tracing the root of the problem, about 60 percent of total membership is made up of poor and near-poor people who are fully subsidized by the GOI, with the low amount of monthly premium of 1.7 USD per person. Whereas the broad spectrum of medical services and treatment have been applied for all the members of BPJS *Kesehatan*.

This indicates that raising resource funding is indispensable yet challenging for the GOI, although since April 1, 2016, the premium of informal sector workers and non-employees already partially adjusted to be higher than the previous initial premium. It is challenging because the GOI should not impose more burden on the national budget. Otherwise the National Health Insurance or *Jaminan Kesehatan Nasional* (JKN) only performs similarity to the previous poverty alleviation programs, subsidized programs or social assistance programs rather than as SHI scheme.

Due to the new centralized health care system, the GOI should be more proactive to reach out to all sections of the population, including indigenous peoples. Reaching out to the informal sector workers in dispersed rural areas is still the major challenge because the high number



of informal sector workers in industries such as agriculture, forestry, hunting and fishery remaining a major challenge. The challenges can be addressed by strengthening and improving coordination and corporation with the local governments

The growing numbers of membership enrollment should be accompanied by expansion of health care facilities. Thus, the ideal ratio between beneficiaries and health care facilities are fulfilled.

### **5.3 Recommendations**

Despite the ongoing discussion between the GOI and the related Ministries/Institutions regarding the mounting deficit of BPJS *Kesehatan*, raising the premium of BPJS *Kesehatan* should be the most crucial solution to be considered. The situation is pretty urgent in order to sustain the program for the long run. Otherwise JKN program will only impose burden to the government budget specifically to the central government, similarly to the ongoing issue of oil and subsidies. Furthermore, the objective of implementing health insurance should be exposed to the citizen of Indonesia. Considering that almost all the Indonesian population is more familiar with the informal social protection provision rather than formal social protection provision. Thus building the trust between the GOI along with all the related stakeholders of this national

program and the citizen is the essential key. For another proposed-solution, allocating budget from tobacco taxation is supplementary.

Moreover the referral system of BPJS *Kesehatan* does not really reflect how the national health care system should be applied. It indicates that the system should be nationally integrated so that all the population is able to access all the health care facilities regardless their residential region or area and without complex bureaucracy as well. Universalism in health care also means equal development and distribution of health care facilities, health care infrastructures and health care practitioners such as doctors, nurses etc.

Taking the definition that UHC is not a one-size-fits-all scheme is closer to describing the diversity of existing regional health care schemes and programs (JAMKESDA) in Indonesia. Due to this reason, a centralized health care program should consider adjusting the needs of local governments and the population within the area of jurisdiction. This is not only going to support the efficiency of national budgets but also the effectiveness of the JKN.

As for the immediate integration process from diverse regional health care schemes and programs of provincial and district/city level to JKN, it should be an incremental process, since some JAMKESDA schemes are already more mature than JKN. Once the integrated database of the

population is already well-established, centralized health care systems will be a lot easier to implement. Decentralized health care systems under centralized health care management might then be one of the policy-making options.

The goal of the UHC should not be limited to how fast all the population is covered by the program or the scheme, but, should also the readiness of health care infrastructures and human resources to provide health care equality. Most importantly is to raise the resource funding and this supposedly be done by the central government and the local government or by cross-subsidization between public and private sectors. After that the central government and local government should divide clear authority and clear tasks regarding the program, the integration of JAMKESDA to JKN is possibly done partially.

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## 국문초록

인도네시아에서의 2019 년 국민의료보장제도 실현:  
중앙정부, 지방정부 및 비공식 노동자들이 직면한 과제들

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본 연구의 목적은 “모두에게 건강을” 의료제도, 즉 국민의료보장제도 (Universal Health Coverage)를 새로이 도입함에 있어 인도네시아 중앙정부, 지방정부와 비공식 노동자들이 직면한 잠재적 과제들을 파악하기 위함에 있다. 해당 의료제도는 네 개의 공기업 및 지방 정부들 사이에 분산 운영되던 기존의 공식 사회보호 프로그램들을 통합한 단일 전국민의료제도이다. 전국민의료보험 또는 JKN (Jaminan Kesehatan Nasional)이라 명명된 이 제도의 도입은 사회건강보험공단인 BPJS Kesehatan (Badan Penyelenggara Jaminan Sosial)이라는 공공기관에서 단독 주관하게 되었다. JKN 이 이미 세운 목표는 2014 년부터 2019 년까지 5 년 이내에 인도네시아 인구 전체를 대상으로 사회의료보험(Social Health Insurance)를 통해 의료 보편주의를 실현하겠다는 것이다. 인도네시아가 세계에서 네번째로 인구가 많은 나라이자 가장 큰 섬나라이며 분권화 성향이 뚜렷한 가운데 비공식 노동자들이 압도적 다수를 차지하는 나라라는 점을 감안하면 상당히 야심찬 목표이다.

JKN 이 도입되기 이전부터 인도네시아가 실시해온 지방분권화 정책은 지역 차원에서 의료보장제도를 다양하게 보완해왔다. 따라서 지방정부들이 각자 발전시켜온 JAMKESDA (Jaminan Kesehatan Daerah), 즉 지역건강보험을 JKN 에 마지못해 통합시키는 과정에서 몇몇 지방 정부들은 인도네시아 중앙정부와 갈등을 겪게 되었다. JKN 은 사회의료보험을 통해 자금을 충당하는데 이는 인도네시아의 모든 국민이 개개인의 소득수준에 기초해 의무적으로 가입하고 분담금을 납부하도록 되어있다. 이는 인도네시아의 전체노동인구 중 압도적 비중을 차지하는 비공식 노동자들, 즉 농업, 어업, 수렵, 임업에

주로 종사하는 비공식 노동자들로 하여금 난제에 봉착하게끔 만들고 있다.

이러한 잠재적 난제들을 파악하기 위해 본 연구는 카렝과 제임스 (2005)가 제시한 여섯 가지 촉진요인들에 기반해 분석을 실시했다. 카렝과 제임스의 주장에 따르면 이 여섯 가지 촉진요인들은 사회의료보험을 통해 JKN 의 이행을 가속화 시키는데 있어 핵심적이다. 이 요인들을 인도네시아의 상황에 적용해 분석한 결과, 매년 증가하는 인도네시아 건강보험공단의 적자와 같은 문제들을 해결하기 위해 가장 중요한 요인은 정부의 책임의식 (government stewardship)임이 밝혀졌다. 따라서 본 연구를 발전시켜 JAMKESDA 가 JKN 에 통합되는 과정에 초점을 맞춘 연구가 향후 이뤄지기를 기대해 본다.

**주제어:** 인도네시아 (Indonesia), 국민의료보장제도 (Universal Health Coverage), 사회건강보험 (Social Health Insurance), 인도네시아 중앙정부 (the Government of Indonesia), 비공식 노동자 (Informal Sector Workers), 지방 정부 (Local Government).

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