

2006 | ASIAN DECENT  
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International  
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SERIES:

SOCIAL SECURITY EXTENSION  
INITIATIVES IN SOUTH EAST ASIA

An abstract graphic with a vibrant orange border. Inside, there are swirling, concentric patterns in shades of green, blue, and purple, creating a sense of movement and depth.

## INDONESIA: PROVIDING HEALTH INSURANCE FOR THE POOR

ILO Subregional Office for South East Asia



*Decent Work for All*

Asian Decent Work Decade

## 1. Labour force and social security coverage

There are the following four existing social security schemes in Indonesia.

- **Jamsostek** is the social insurance fund for private sector employers and their employees. It provides four programmes: Employment Injury, Death, Health Insurance, and a provident fund type Old Age Benefit.
- **Taspen** is the fund for civil servants. It provides a retirement lump-sum, and a pension programme.
- **Askes** provides Health Insurance cover for public sector employees and some others.
- **Asabri** is the counterpart fund for the armed forces and police. It provides similar lump-sum retirement benefits and pensions. The Armed forces also have some hospitals of their own.

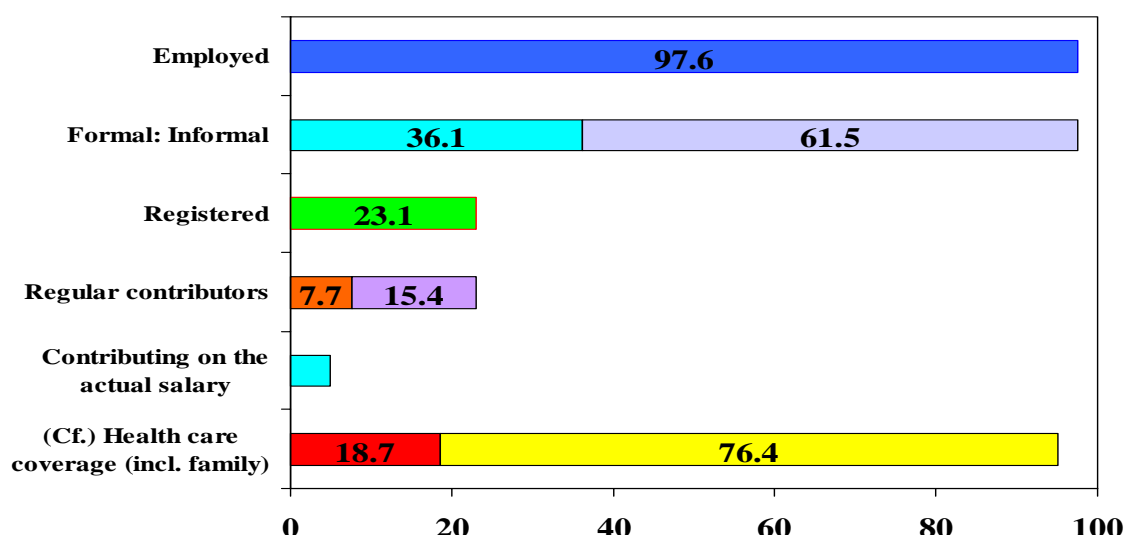
The following Table 1 and Figure 1 present the current status of labour force and social security coverage.

**Table 1. Labour force and social security coverage in Indonesia, 2007**

	Population in 2007 (in thousands)	As % of employed population
Population 15 years of age and over	162,352	
Labour force (economically active)	108,131	
Employed population	97,583	100%
By status:		
Own account worker	18,667	19%
Self-employed assisted by temporary/unpaid workers	20,849	21%
Employer with permanent workers	2,848	3%
Employee	26,869	28%
Casual employee in agriculture	6,278	6%
Casual employee not in agriculture	4,267	4%
Unpaid worker	17,805	18%
By formal/informal		
Formal economy	36,048	37%
Informal economy	61,535	63%
- Urban informal economy	16,144	17%
- Rural informal economy	45,391	47%
Unemployed population	10,548	
Jamsostek total members records held	28,814	30%
Jamsostek members	10,492	11%
Active members	7,720	8%
Voluntary programme	91	0%
Construction programme	2,682	3%
Civil service (Taspen, Askes, Asabri)	6,300	6%
Total (Jamsostek, Taspen, Askes, Asabri)	16,792	17%

Jamsostek health care program (including family)	3,128
Askes members (including family)	15,600
Health for the poor (target)	76,400
Total health insurance coverage	95,128

**Figure 1. Gaps in coverage, compliance, and collection  
The case of Jamsostek, Indonesia (in millions)**



From the above table, the following observations are made:

- In 2007, out of 162 million population aged 15 years and over, 108 million (or 66.6%) are estimated to be in the labour force. The employed population is 97.6 million. Unemployment rate is 9.75 per cent and under employment is 31.0% of those employed.
- Only 37 per cent of the employed are in the formal economy, and 67 per cent of those employed are involved in various forms of rural and urban informal employment, including agriculture which still employs over 40 per cent of the employed workforce.
- In substance therefore, formal social insurance fund membership is concentrated mainly amongst employees of larger private sector enterprises, plus public sector employees. Labour shedding by large enterprises following the Asian economic crisis, and a shift in economic activity towards smaller enterprises and the informal economy depressed social insurance membership statistics. And even within the formal economy at best under half of the employed workers are actually active members of social insurance funds<sup>1</sup>.

<sup>1</sup> The inactive members comprise:

- Members now unemployed and with less than five years of contributions;
- Members who have changed employment to an ineligible employer or self employment and do not exercise their rights to continue to contribute to the fund;
- Unemployed members who have chosen to retain their investment in the fund;
- Members who have discontinued contributions for reasons of employer bankruptcy;
- Members deceased and where family have not claimed their entitlement; and

- It can be seen that out of 36 million formal sector workers, only 16.8 million workers or 47% are actually contributing to Jamsostek, Taspen and Asabri schemes. This means that only about 17% of the employed population are currently covered by formal social security schemes. This percentage has been declining as employment shifted towards the informal economy or non-complying small business enterprises.
- Health insurance by Askes and Jamsostek has more extensive coverage including family members. The number of persons covered by the Jamsostek health care programme is 3.1 million (of whom 1.4 million are workers and 1.7 million are dependent family members). The coverage of Askes is 15.6 million (of whom 5.6 million workers, 8.4 million dependent family members, plus 1.6 million 'commercial' members). Thus about 18.7 million people in Indonesia are covered by the formal health insurance schemes.
- Recently there has been a progress in the provision of primary health care and health insurance cover for poor households in the framework of social assistance. The target number of this programme was initially 36.1 million persons, but later expanded to 60 million. In 2007, the coverage increased to 76.4 million. Adding this target number to the formal social health insurance coverage, a total of 95.1 million persons are estimated to have health insurance cover, which is 43.2 per cent of the total population of 220 million.

Reasons for the low penetration of social insurance in the private formal sector include the following.

- Legally only enterprises with 10 or more workers, or a payroll of over one million rupiah a month are required to enrol their workers in Jamsostek, the social insurance fund for the private sector. If the legislation is interpreted as its original intent, then the potential capture group for Jamsostek could be as high as 70% of the formal sector workers.
- Moreover, there are some evidences of contribution evasion by means of underdeclaration of contributory wages. A common type of underdeclaration is to report the basic wage only that excludes various allowances and bonuses. This is common practice for Jamsostek health care programme.
- There is an opting out clause for employment injury and health insurance of Jamsostek. Although the coverage is compulsory for the old-age and death benefits, an employer is allowed to "opt out" to a private insurance that provides higher level of benefits. This clause inevitably results in the evasion of large enterprises from the scheme and thus limits the redistributive effect.
- Jamsostek has no inspectors under its own control to enforce compliance, and relies on the activities of Labour inspectors currently deployed into regional government.
- Jamsostek has an unfavourable image amongst many workers, and some are reluctant to contribute to it.

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• Members who are now contributing through another employer and the previous record(s) are inactive.

Women are particularly disadvantaged in relation to formal social security coverage. The labour force participation rate for women is about 50 per cent which is significantly lower than men (more than 80 per cent), while the unemployment rate (11.8 per cent) and underemployment rate (41.3 per cent) are higher than men (8.5 per cent and 25.1 per cent, respectively). In addition, women workers are more likely to find themselves in the informal economy and in unpaid work. Heavy reliance on employment in the informal economy results in them being less likely to be protected by social security systems. Yet they are more vulnerable to risks related to their life cycle and their role in the family.

## **2. Health insurance for the poor**

In 2005 Indonesia instituted a new health card system for the poor to replace the former Kartu Sehat which had been issued to poor people as part of the Social Safety Net Programme.

The distinctive feature of the new system was the issue of health cards by Askes, the existing health insurance provider for many formal sector workers, with the Government paying premiums on behalf of the card holders. The health insurance programme for the poor is called Askeskin.

The contribution rate was set initially at Rp. 5,000 (about US\$ 0.55) per month per card holder. A simple estimate of the annual contribution would result in Rp. 3.6 trillion for 60 million members. The government allocated Rp. 3.9 trillion in 2005 for basic health care and health insurance.

Two distinct phases characterise the new health card programme.

- In the first Semester covering the period January to May 2005, a target of 36.1 million covered individuals was set. This was equivalent to the estimated number of poor people in Indonesia, at just under 17 per cent of the population. Districts were allocated quotas on the basis of the estimated number of poor people resident in the district, with the local authorities providing the lists of qualifying individuals to the local branch of Askes. The cards then issued covered both free outpatient primary care in the local health centres (Puskesmas), and free treatment at hospitals, generally 3<sup>rd</sup> class public hospitals. Askes received funds to cover both areas, and in turn reimbursed hospitals and health centres on a fee for service basis for health services provided to card holders.
- For the second semester covering June to December 2005, a higher target of 60 million was set, to include the estimated number of poor and near-poor. However, a major change in coverage was made. Direct funding of the health centres was resumed, with funding going from the Ministry of Finance via the BRI Bank to the District Health Office. Fund holding by Askes was limited to the amount allocated to pay for use of hospital services. Health card holders continued to get free treatment in the health centres. Under the revised system funding for services delivered by Puskesmas is thus allocated directly to each district, as previously, with an allocation also to the provincial government to fund support services. Askes receives the funding for hospital health services for the poor who hold their issued cards.

- As of mid-2007, the coverage of this programme was estimated at 76.4 million. It should be noted that the funding arrangement was changed again in 2006 where the funds for both primary out-patient care through health centres and in-patient care at hospitals are channelled through Askes. In the second-half of 2007, the funding arrangement was once again changed to a separate system for direct funding to local health centres and for social health insurance through Askes covering in-patient care. One reason for the frequent policy changes would be the insufficient budgetary allocation by the government. In 2007, the Department of Health initially allocated only Rp. 1.7 trillion for this programme, while the estimated premium for Askes was Rp. 4.3 trillion.

As with the earlier Kartu Sehat, the biggest difficulty experienced in card issue has been in actual identification of the poor. Statistics Indonesia (BPS) data which was used as the basis for financial allocations to districts and in estimating “quotas” of poor people until recently had simply been a sample survey of under 1 per cent of the population. Hence, other methods had to be used to decide who are the poor at the local level. Districts set up sub-district teams to do this. Some used the local Family Planning (BKKBN) estimates of household economic level. Others applied Statistics Indonesia (BPS) criteria, or their own methods. In effect there has been no uniform assessment system.

Problems experienced so far with the new system in terms of coverage include:

- Problems in reaching all the poor. In the first phases only an estimated 80 per cent of the quota numbers were actually achieved. People without local residence cards tended to be particularly disadvantaged.
- Targeting accuracy is problematic, with some poor households missing out on card allocation, and some non-poor people receiving cards.
- Regarding poverty assessment there is no effective integration with the parallel BPS (Statistics Indonesia) poverty assessment for the cash transfer scheme, nor with the older BKKBN (Family Planning) assessment of household poverty.
- Socialisation problems in getting some card holders to believe that they will actually receive the services covered by the cards
- Excess allocation of cards by some districts. Askes can ask these districts to pay for the excess. Some districts in oil-rich East Kalimantan have done so, as their local policy is to widen coverage.
- The “temporary letter” from village heads giving people the equivalent of Health Card free services in Puskesmas still seems to be operating.

In effect, a number of the problems which characterised the earlier allocation of the Kartu Sehat have recurred with the new system. However, discussions are going on about possible use of the new BPS household poverty assessments for the health card. This is intended to be the long-term allocation system, but was not up and running in time for the 2005 issue of health cards.

There are also some administrative issues in the interface between Askes and the government, and Askes and the hospitals.

- The costing basis for bulk funding Askes is still in evolution, with limited information available so far to assess premium and benefit setting. The initial allocation of Rp. 5,000 per month per card holder was reduced to Rp. 3,000 once the shift back to direct funding of district health centres was made.
- It has not yet been possible to replace fee-for-service funding to hospitals by capitation payments, although this is the intent of the policy direction. Cost estimates are Rp. 150,000 a day for 5-6 days for inpatient care.
- Excess claims are investigated by monitoring teams. However, there is a fund to cover some catastrophic care cases.
- Hospitals have complained about late reimbursement by Askes.
- Reimbursement of hospitals on a fee-for-service basis is likely to create long-term problems of cost control.
- The return to direct government funding of the health centres removes any funding pressure for efficiency improvement in these centres. Currently, the Puskesmas are of highly variable quality.

The involvement of Askes in the issue of health cards and the reimbursement of hospital providers now means that there is a degree of integration between health insurance cover for formal sector workers, and social assistance health cover for the poor.

#### Reference

ILO, *Social Security in Indonesia : Advancing the Development Agenda*, 2008