The Indonesian welfare state system

With special reference to social security extension in the development context

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With a population of around 248.8 million (GOI, 2014a: 2), Indonesia is the fourth most populated country in the world after China, India and the US. The World Bank classifies Indonesia, with a gross national income (GNI) per capita of US$3,580 (2013), as a member of the lower-middle-income group.

The country's political history since its emergence from Dutch colonial rule in 1945 falls into the following main periods: (1) the post-independence period of Sukarno; (2) the transition to the authoritarian New Order Regime of Suharto since 1966, which included significant economic expansion; and (3) the exit of Suharto under the combined impact of the Asian Financial Crisis of 1997/1998 and a student-led democratization movement in 1998.

Following a democratic transition process, the country has been led by Abdurrahman Wahid (1999–2001), Megawati Sukarnoputri (former vice president who took over from Wahid for the second half of his statutory five-year presidential term), Susilo Bambang Yudhoyono (2004–2014, two terms, and the first president elected in a popular vote since 1945) and Joko Widodo (since 2014).

The history of Indonesia's welfare system can be briefly sketched as follows: (1) formal welfare state policies were largely absent until the early 1960s; (2) during the New Order regime, formal welfare policies were expanded to cover public employment sectors, and there was also some limited expansion of anti-poverty programs; (3) the Asian Financial Crisis nevertheless highlighted the general inadequacy of welfare policies in Indonesia; and (4) after transition to democracy, aspirations to significantly expand and transform the welfare system started to influence policy making.

In this larger context, Law No. 40/2004 on the National Social Security System or Sistem Jaminan Sosial Nasional (SJSN) was introduced. This significant framework law initiated for the first time a process to implement universal and compulsory social security for all citizens and residents of Indonesia, which is currently ongoing.

As already indicated, the establishment and development of social security systems in Indonesia after independence was slow. During the Sukarno period, formal social security was limited to provisions covering certain industrial accidents. During the New Order regime, the
The development of the welfare state system in Indonesia up to 2004

The enactment of Law No. 40/2004 on the SJSN, as deliberated and agreed in 2000 and 2002 by the country's highest legislative body, the DPR, provided a framework for social security reform. The new law transformed the existing three types of social security in Indonesia, namely social insurance schemes, social assistance programs and out-of-pocket or voluntary private social insurance (Joedahdrata, 2012: 13).

Prior to the enactment of the SJSN, the main types of social security in Indonesia covered civil servants and the formal private sector (Joedahdrata, 2012: 13). These social insurance programs were as follows: (1) Civil Servant Insurance Savings or Tabungan Asuransi Pegawai Negeri (TASPEIN); (2) Indonesian National Armed Forces Social Insurance or Asuransi Social Angkat Tertentu Republik Indonesia (ASABRI); (3) Civil Servant and Pensioner Health Insurance or Asuransi Kesehatan (ASKES); and (4) Social Insurance for Private Sector Workers or Jamkesocial (Table 22.1).

The implementation of social security programs was highly segmented, resulting in partial coverage of certain formal sector workers. Only the civil servants, military and police personnel enjoyed a certain degree of social security coverage.

On the other hand, workers in the formal private sector were often not covered. Larger companies were more likely to offer coverage to workers compared to smaller companies. Finally, the majority of Indonesian workers in the informal sector, heavily concentrated as an agricultural workforce in rural areas, were not covered by any kind of social insurance. Because of their low incomes close to subsistence levels, most informal sector workers had to prioritize their everyday basic needs or expand their home industries or businesses, rather than save income or contribute to social insurance schemes.

In reaction to the Asian Financial Crisis, Indonesia began to focus on social assistance programs and poverty relief. The initial consideration was to quickly respond to the suffering brought about by the crisis. However, the rise in the poverty rate could not be stopped by the proliferation of social assistance programs and problems with targeting questioned their relevance.

This experience resulted in President Wahid's initiation of social security reform, and the concept of the development of a national social security system was deliberated on in the Annual Meeting of the People's Consultative Assembly (Mahkota Permusyawaratan Rakjat or MPR), the highest representative body in the country, in 2000. The reform was in principle accepted by the same body in 2002, and the 1945 Indonesian Constitution was amended. In this amendment, a new Article 26A, Subsection 3 stated that "Every person shall have the right to social security to develop oneself as a dignified human being," while Article 34, Subsection 2 suggested that "The state shall develop a social security system for all the people and shall empower the vulnerable and poor people in accordance with human dignity." (Suryahadi et al., 2014: H-9).

Thus, the 2004 SJSN Law represents the most significant transformative effort to advance universal social security protection in Indonesia. Although implementation only started in 2014, the process, if successful, might overcome the traditional main feature of the Indonesian welfare system, namely dominance of informal and family-based welfare.

Before analyzing the SJSN in further detail, the next section first explains pre-2004 policies, programs and implementation of social security in Indonesia in order to highlight its fundamental characteristics.

The four social security programs were managed by four state-owned enterprises or Badan Usaha Milik Negara (BUMN), which represent a special feature of Indonesian social policy. Their management was categorized as limited liability or Perum, in which the economic orientation was supposed to be similar to private companies. In addition, there were also some social assistance programs that were specifically designed to target poor and near-poor people. In Indonesia, unconditional cash transfers (UCT) already existed prior to the Asian Financial Crisis, while conditional cash transfers (CCT) were implemented afterwards (Kwon and Kim, 2016).

The unconditional cash transfer programs are as follows: (1) the Social Safety Net Program or Jaminan Program Jaminan Sosial (JPS); (2) Health Insurance for the Poor or Asuransi Kesehatan Masyarakat (ASKEMAS); (3) Rice for the Poor or Beras untuk Rakyat Miskin (RASKIN); and (4) Direct Cash Transfers or Banjarmasin Langgar Tunai (BLT).

In 2007, conditional cash transfer programs were introduced in Indonesia for the first time through the Hope Family Program or Program Keluarga Harapan (PKH). In summary, social insurance is administered by four state-owned enterprises while social assistance is mostly administered by different ministries.
The early post-independence period (1945–1966)

After independence in 1945, the country did not provide any social security schemes with the exception of certain types of accident compensation (Suryadi et al., 2014: 6). In 1963, two social security programs were established for the first time, which can be characterized as social insurance and social assistance programs, respectively. These were TASPEN, covering Civil Servant Retirement Provisions, and the Civil Servant’s Welfare Fund or Dana Kesetiban Pensiun Negeri (DASPER). The former program provided retirement benefits for retired civil servants and the dependents of deceased civil servants (Binura and Tjoepoherijanto, 1986: 14). The latter program provided social assistance to civil servant families and in the case of natural disasters.

Thus, the two programs, TASPEN and DASPER, provided some degree of social security for civil servants. The subsequent development of social security and of more comprehensive schemes remained focused on civil servants and military and police personnel (Lindesthal, 2004: 18). Most Indonesian citizens therefore continued to rely on extended families and other informal support systems for their social security.


The rapid economic growth during the period from 1970 to 1996 transitioned Indonesia from a developing into a transition country. Between 1986 and 1996, average GDP growth amounted to around 7 percent per year (Sumarto et al., 2003: 4). High economic growth allowed for more comprehensive social security schemes and programs.

However, social security issues were not given priority in national development agendas (the five Five-Year Development Plans or Pembangunan Lima Tahun [PELITA] between 1969 and 1994). At this stage, the focus was placed on poverty alleviation and the expansion of basic education and basic health care. In this context, community development programs, such as the President’s Instruction on Left-behind Villages, or Inpari Desa Terisol, were put forward (GOI, 2014: 15).

In the early 1990s, laws on social security for formal sector workers were enacted for the first time covering civil servants, the military, police and formal private sector workers. The major reforms concerned the transformation of the existing TASPEN program, the abolition of the DASPER program, and the introduction of three additional new programs, namely ASKES, ASABRI, and JAMSOSTEK.

Post-reform, the system consisted of four state-owned enterprises managing health, pensions, and provident funds for different categories of employees. These four social insurance programs (TASPEN, ASKES, ASABRI, and JAMSOSTEK) focused in turn on civil servant pensions (TASPEN); civil service health insurance (ASKES); military, police and Ministry of Defense and Security personnel pensions (since 2013 also health insurance) (ASABRI); and provident funds, accident insurance, health care insurance and death benefits for formal private sector workers (JAMSOSTEK).

The reforms were expected to improve the implementation of social security in Indonesia. However, the focus on civil servants and the formal sector was maintained and workers in the informal sector were still not included. In addition, the gap in social security coverage between civil servants and other public sector employees, on the one hand, and formal private sector workers, on the other hand, stayed in place. The latter category of employees was only covered by a provident fund, rather than pension schemes, and the degree of coverage was very uneven.

In practice, JAMSOSTEK coverage was limited to large and medium enterprises while small enterprises did not participate, although the regulations assumed mandatory coverage.

As for social assistance policies, pre-1997 these were limited to targeted education and health policies. However, the dramatic impact of the Asian Financial Crisis of 1997/1998 on Indonesia triggered an 8 percent fall in the exchange value of the Indonesian rupiah against the US dollar. This currency devaluation had a significant impact on the tripling of domestic prices during this period (Sumarto and Basti, 2011).

In addition, the Asian Financial Crisis triggered a rapid increase in unemployment and poverty levels in Indonesia, revealing that social security programs failed to deliver adequate social protection. In particular, informal sector workers and rural areas were hit hard by the Asian Financial Crisis, although poverty in urban areas was also skyrocketing – poverty levels increased by 75 percent in rural areas and doubled in urban areas (Sumarto et al., 2003: 3). Thus, Indonesia’s poverty rate grew from 15 percent in mid-1997 to 33 percent at the end of 1998, and 36 million people fell into absolute poverty (Sumarto and Basti, 2011).

The Social Safety Net or Jaminan Program Sosial (JPS) was implemented as a quick response to the crisis. Its main purpose was to provide assistance in the areas of food security, employment creation, education and health. These four areas each had specific programs.

Households categorized in the lowest and second lowest category of poverty were included in the Special Market Operation or Operasi Pasar Khusus (OPK). This food security program provided subsidized rice for poor families at a third of the retail market price. Furthermore, employment creation programs, named Labor Intensive (Pekerjaan Intensif), block grants to selected primary and high schools, and Health Sector JP or JPS Pendidikan, provided some limited subsidies for poor people (Sumarto et al., 2003: 6–9).

The extensions of the Indonesia social security system after 2004

As already outlined, the concern to implement compulsory and universal social security to cover all Indonesian citizens resulted in the enactment of the SJSN Law in 2004.

The SJSN Law reorganized the four existing state-owned enterprises or Pers社aham Pensiun, that ran social security programs (TASPEN, ASKES, ASABRI and JAMSOSTEK) into one legal entity: Social Security Administrative Body or Badan Penanggung Jawab Jaminan Sosial (BPJS). This new BPJS is supposed to provide universal health coverage and universal social security for all citizens and for foreigners staying for more than six months in Indonesia.

Under the BPJS, existing social security programs are reorganized into two main programs, BPJS for Health or BPJS Kesehatan, and BPJS for Workers or BPJS Ketenagakerjaan. The main purpose of the integrated social security system is to reach all citizens and employees in Indonesia.

However, the SJSN implementation process has been lengthy starting only with the enact-ment of Law No. 24/2011 on Social Security Administering Bodies or BPJS. The 2011 law was in turn the result of a legal appeal filed by the Social Security Action Committee or Komite Aksi Jaminan Sosial (KAJS), an umbrella group of labor unions and civil society groups, which made the Indonesian Constitutional Court rule the government guilty of neglecting the implementa-tion of the national social security system (Joeladiharta, 2012: 12).

Pension programs

Prior to the SJSN Law, pension systems in Indonesia were organized according to employment sectors, with different laws regulating different pension institutions and programs. This section explains in turn public and private pension provisions.
Public sector pensions: TASPEN and ASABRI

All public sector employees categorized as civil servants at the national and regional level and in universities belong to the Pension Insurance Savings or PT. Tabungan dan Asuransi Pensiun (TASPEN) Pension.

The civil servants of the Ministry of Defense and Security of the Republic of Indonesia (prior Department of Defense and Security), the Indonesian Armed Forces and the Indonesian National Police belong to the Indonesian National Armed Forces Social Insurance or PT. Asuransi Angkatan Bersenjata Republik Indonesia (ASABRI) Pension.

These pension schemes for civil servants and military and police personnel follow the pay-as-you-earn model. However, current contributions are not sufficient to cover the pension payments of retired civil servants, and the state budget covers the annual deficit. (Public sector pensions are discussed further in the section "Welfare state system for the public sector: TASPEN, ASABRI and ASKES.")

Private sector pensions: Dana Pensiun

For private sector employees, the enactment of Law No.11/1992 on Pension Funds or Dana Pensiun has widened opportunities to voluntarily contribute to and qualify for monthly retirement pensions. Many employers might offer access to such schemes, although they are not mandatory.

Dana Pensiun is a non-banking financial institution that provides two types of pension funds: (1) Employer Pension Funds or Dana Pensiun Pegawai Kerja (DPKK) and (2) Financial Service Pension Funds or Dana Pensiun Lembaga Keuangan (DPLK). The latter are organizationally separate from other banking business.

First, the DPKK is a pension fund established, owned, and managed by either individuals or employers. Two programs are offered: (1) the Pension Program based on Defined Contributions (DC) or Program Pensiun Basis Pensiun (PPBP); and (2) the Pension Program based on Defined Benefits (DB) or Program Pensiun Manfaat Pasti (PPMP).

The PPBP is a program that collects contributions from workers in individual accounts and benefits derived from accumulated contributions. In the PPBP, the employer contributes and the final pension depends on a benefit formula based on working years. The employer decides which program is offered. Until mid-2012, there were 247 DPKKs overall. Out of these, 206 DPKKs or 83 percent applied PPBP, while the rest applied PPMP (GOI, 2012a: 5).

The second type of pension funds is the DPLK, which is offered by banks and life insurance companies. In this program, employees and the self-employed can voluntarily join. Recently, DPLKs were offered by private companies and self-employed from the other banking activities and 17 life insurance companies (ASOSIASI DPLK, 2015).

Most Dana Pensiun assets are invested in bank deposits and government bonds (GOI, 2008: 7). In 2011, the Dana Pensiun assets amounted to 2 percent of Indonesia's GDP. According to the latest available data from 2011/2012, 5.06 percent of private sector employees and self-employed workers (out of a total of 60,902,202) participated in Dana Pensiun.

Table 22.2 shows the number of workers covered by the provision of the law 11/1992 on pension funds.

The low participation rates are due to the voluntary character of the Dana Pensiun. Thus, many employers have not established their own Dana Pensiun for their employees (GOI, 2012a: 1-5).

Health programs

In order to deliver health care and services to around 248.8 million Indonesian citizens, the country relies on public and private institutions. In 2013, there were 1,562 public and 662 private hospitals, and the ratio of hospital beds was 11.2 per 10,000 people (GOI, 2014c: 35-37).

In Indonesia, the most accessible health care is provided by the basic care services, termed Puskesmas. These public health centers are under the responsibility of district governments. In December 2013, there were 9,655 Puskesmas units, consisting of 3,317 inpatient units and 6,338 outpatient units (GOI, 2014c: 27).

The function of Puskesmas is to provide basic health care and to provide referrals to access health care services that can only be provided by hospitals. However, this "gatekeeper" function of Puskesmas does not work in practice because patients can go directly to hospitals without Puskesmas referrals (Harimurti et al., 2013: 6).

By the end of 2013, 76.18 percent of the total population were covered by health insurance under several programs (GOI, 2014d: 81). Some of these schemes are classical insurance schemes in which workers pay their own contributions, such as in the case of private sector workers, civil servants, and military and police personnel. Others are targeted at poor and near-poor people in the informal sector and contributions are covered by the national or regional governments.

Thus, the programs JAMKESMAS and JAMKESDA are paid by the national and regional governments, respectively. One should note, however, that informal workers classified as "nonpoor" are excluded from access to these two programs. The various programs are implemented by public, private, and state-owned enterprise institutions (see Table 22.3).

Health insurance programs for poor people will be discussed further in the next section while those covering regular workers in the public and private sector will be discussed in subsequent sections.

JAMKESMAS and JAMKESDA: health insurance for poor people

Introduced in 2007, JAMKESMAS and JAMKESDA were health insurance programs for the poor and the near-poor people in Indonesia (the word "insurance" is used in Indonesian documents, although the two programs might be classified as social assistance from the point of view of comparative social policy research as they did not require contributions from those covered in the program).

The source of funding for the former program was from the central government state budget, and it was managed by the Ministry of Health of Indonesia. The source of funding for the latter program was from the local government health budget and managed by local health offices. The latter program provided coverage for some of those not covered by the former program.
Table 22.3 Share of total population covered by Indonesian health insurance programs

<table>
<thead>
<tr>
<th>No.</th>
<th>Programs</th>
<th>Number</th>
<th>Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>JAMKESMAS</td>
<td>36.3%</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>2</td>
<td>ASKES PNS</td>
<td>6.91%</td>
<td>BUMN Persero</td>
</tr>
<tr>
<td>3</td>
<td>JPJ JAMSOSTEK</td>
<td>2.93%</td>
<td>BUMN Persero</td>
</tr>
<tr>
<td>4</td>
<td>JAMKESDA</td>
<td>19.59%</td>
<td>Regional Government</td>
</tr>
<tr>
<td>5</td>
<td>Various Private Insurance</td>
<td>1.23%</td>
<td>Private Institutions</td>
</tr>
<tr>
<td>6</td>
<td>Armed Forces and Police Health Insurance (ASABRI)</td>
<td>0.97%</td>
<td>BUMN Persero</td>
</tr>
<tr>
<td>7</td>
<td>Jaminan Pernasahan (company-provided)</td>
<td>7.11%</td>
<td>Company</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>76.18%</td>
<td></td>
</tr>
</tbody>
</table>


Prior to the 2007 reform, JAMKESMAS was named ASKESKIN and managed by PT. ASKES Persero. The 2007 name and management changes were due to the earlier program's accumulation of a high debt of around IDR.1.17 trillion that had not been paid by PT. ASKES Persero to the health service providers of ASKESKIN. Because of the unfunding of the earlier program, ASKESKIN subscribers were rejected by the health service providers (Kementerian Kesehatan Republik Indonesia, 2015).

After the name and management changes, the role of PT. ASKES Persero was limited to the management of membership of JAMKESMAS while the funding of the new program JAMKESMAS was turned over to the central government.

Under the JAMKESMAS program, benefits were divided into four categories: (1) health care services of basic-care providers, such as Dr. Bapak Koesio; (2) health care services of primary-care providers, such as hospitals; (3) partially funded health care services; and (4) health care services excluded from coverage.

The JAMKESMAS program, funded by the central government, provided flexible access to various public and private health care services and institutions. Around two-thirds of the participating institutions affiliated to JAMKESMAS belonged to the public sector and one-third belonged to the private sector. The program covered slightly more than a third of the total population (see Table 22.4) and its comprehensive benefits and flexible access to health care made the program attractive for major sections of the population.

Many of those not covered by JAMKESMAS were covered by JAMKESDA, which provided health insurance programs funded by local governments. Their scope and coverage was determined by local government budgets and policies. Approximately 350 district governments (out of 500) provided JAMKESDA programs under various names (COI, 2012). In order to control expenses and to provide standard health care packages, the Ministry of Health developed a coding system to classify health problems and diseases, namely the Indonesian Diagnosis Related Group (INADRG) (Dwicaksono et al., 2012). To determine eligibility of both programs, the BPS, a national statistics bureau, assisted the Ministry of Health in identifying criteria for eligibility of the poor and near-poor households. The BPS conducted a National Poverty Census Survey (PSEOS) and used a "proxy means test" with 14 asset indicators to select beneficiaries in each district (Harimurti et al., 2013).
### Table 22.4 (Continued)

<table>
<thead>
<tr>
<th>Service and family planning program and side effect treatment (Contraception tools are provided by BKKBIN)</th>
<th>Normal childbirth and Basic Emergency Neonatal Obstetric Service (PONID)</th>
<th>Advanced service and family planning program (Contraception tools are provided by BKKBIN)</th>
<th>Medical rehabilitation service</th>
<th>Health care services during natural disaster relief, unless he/she is JAMKESMAS patient</th>
<th>Health care service given during social events, Fertility treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicine</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>Intensive treatment ICU, ICCU, PICU, NICU, and PACU</td>
<td>Formularium medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced pregnancy check-up</td>
<td>Blood transfusion</td>
<td>Disposal of medical tools</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High-risk pregnancy</td>
<td>Childhood Basic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neonatal Obstetric Service (PONID)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coverage or thalassemia patients, even though JAMKESMAS participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


### Current developments in social security extension

The two health consumption programs, JAMKESMAS and JAMKESDA, were included in the new types of health and BPJS Keluarga, together with the other health insurance programs since 2014. In 2007, the Hope Family Program or Program Keluarga Harapan (PKH) was launched in Indonesia for the first time as a conditional cash transfer program in Indonesia. The program targets the poorest families, those with children aged 18 years and below. The program was designed to reduce poverty among the poorest households by improving household consumption levels and breaking the cycle of poverty through school education and health services. The program is intended to reduce poverty by providing cash transfers to households below the poverty line. The program is implemented in partnership with local governments and non-governmental organizations. The program has been successful in reducing poverty rates among targeted households.
Table 22.5 Population aged 15+ based on working status

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>2004</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Citizen Aged 15+</td>
<td>157,941,169</td>
<td>168,870,483</td>
<td>181,169,972</td>
</tr>
<tr>
<td>2</td>
<td>Labor Force</td>
<td>197,076,750</td>
<td>115,231,039</td>
<td>125,316,991</td>
</tr>
<tr>
<td></td>
<td>a. Labor Force</td>
<td>67.80</td>
<td>68.24</td>
<td>69.17</td>
</tr>
<tr>
<td></td>
<td>b. Participation Rate (%)</td>
<td>96,950,954</td>
<td>106,093,755</td>
<td>118,169,922</td>
</tr>
<tr>
<td></td>
<td>c. Open Unemployment*</td>
<td>10,123,796</td>
<td>9,137,284</td>
<td>7,147,069</td>
</tr>
<tr>
<td></td>
<td>d. Open Unemployment Rate (%)</td>
<td>4.46</td>
<td>7.93</td>
<td>5.70</td>
</tr>
<tr>
<td>3</td>
<td>Non-labor Force</td>
<td>50,864,419</td>
<td>53,639,444</td>
<td>55,852,981</td>
</tr>
<tr>
<td></td>
<td>a. School Students</td>
<td>11,067,629</td>
<td>12,533,884</td>
<td>15,899,591</td>
</tr>
<tr>
<td></td>
<td>b. Housewife</td>
<td>31,683,615</td>
<td>32,693,645</td>
<td>32,853,393</td>
</tr>
<tr>
<td></td>
<td>c. Others</td>
<td>8,113,175</td>
<td>8,391,913</td>
<td>7,099,997</td>
</tr>
</tbody>
</table>

Note: * Definition of the category of Open Unemployment in the National Socioeconomic Survey: looking for a job, preparing their own business, hired but not starting yet.

Table 22.6 Population aged 15+ based on main job status

<table>
<thead>
<tr>
<th>No.</th>
<th>Main Job Status</th>
<th>2004</th>
<th>2009</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Employed</td>
<td>19,075,578</td>
<td>21,214,758</td>
<td>20,320,671</td>
</tr>
<tr>
<td>2</td>
<td>Self-Employed with Non-permanent Labor/Unpaid Labor</td>
<td>22,963,346</td>
<td>22,485,004</td>
<td>19,736,696</td>
</tr>
<tr>
<td>3</td>
<td>Self-Employed with Permanent Labor/Paid Labor</td>
<td>3,127,590</td>
<td>3,041,995</td>
<td>4,143,512</td>
</tr>
<tr>
<td>4</td>
<td>Labor/Employee</td>
<td>25,354,178</td>
<td>29,005,761</td>
<td>43,348,961</td>
</tr>
<tr>
<td>5</td>
<td>Informal Worker on Agriculture sector</td>
<td>4,721,777</td>
<td>6,471,042</td>
<td>4,739,310</td>
</tr>
<tr>
<td>6</td>
<td>Informal Worker on Non-agriculture sector</td>
<td>3,756,314</td>
<td>5,164,311</td>
<td>6,750,395</td>
</tr>
<tr>
<td>7</td>
<td>Family Worker/Unpaid</td>
<td>17,952,176</td>
<td>18,710,884</td>
<td>19,132,377</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>96,950,954</td>
<td>106,093,755</td>
<td>118,169,922</td>
</tr>
</tbody>
</table>


half of the population in Indonesia is employed in the formal public or private sector; the other half belongs to the informal sector. Those working in the informal sector are usually not covered by social security policies.
As shown in Table 22.5, the total workforce in Indonesia has grown steadily, while open unemployment has gradually decreased over time. Furthermore, Table 22.6 shows that the number of self-employed and informal workers amounts to more than half of the total labor force. Finally, Table 22.7 shows that the agricultural sector is still most significant numerically, although there has been a steady growth in public sector employment and in various service sectors.

Welfare state system for the public sector: TASPEN, ASABRI and ASKES

The TASPEN program (discussed earlier) provides pension benefits and old-age savings programs for all civil servants with the exception of those employed by the Ministry of Defense and Security. The recipients of TASPEN include retired civil servants and their dependents. In addition, the program provides pensions for veterans of the Indonesian national independence movement. Contribution rates of TASPEN amount to 8 percent of monthly salary. This contribution includes 4.75 percent for pensions and 3.25 percent for old-age savings (Indonesia, 2015).

Because Indonesia’s public pension system follows the pay-as-you-go formula, civil servants receive their monthly pensions out of current contributions. However, contributions are no longer sufficient to pay out pensions and the state budget funds the growing deficit each year. It is expected that the budget allocations for pensions will soon be made necessary to pay the wage bill of active personnel.

ASABRI was specifically established to manage pensions of military and police personnel and of civil servants employed by the Ministry of Defense and Security. The contribution rate of ASABRI is 3.25 percent of total salary including marriage benefits (10% of basic salary) and children benefits (2% per child).

In addition, the ASKES program covered health care of civil servants. It was financed by a 2 percent contribution from total salary. Before 2012, military and police personnel and civil servants in the Ministry of Defense and Security were also covered. Since then, they have been covered in a different scheme.
Welfare state system for the private sector: JAMSOSTEK

The JAMSOSTEK provided an umbrella for four social insurance programs for formal private sector workers, namely (1) Old-Age Savings or Jamuan Hari Tua (JHT) for a lump sum payment on retirement; (2) Health Insurance or Jamuan Pemeliharaan Kesehatan (JPK); (3) In-Work Accident Insurance or Jamuan Kekcoopan Kerja (JKK); and (4) death benefits or Jamuan Keramat (JK). JAMSOSTEK did not provide a pensions program offering monthly pensions in retirement. The contribution for JHT was shared between employers and employees in an asymmetric manner, while contributions for JPK, JKK, and JK were paid fully by employers.

In the JHT scheme, contributions were paid by the employer (3.75%) and the employee (2%). In the JPK scheme, the employer contributed 3 percent for unmarried workers and 6 percent for married workers, with a maximum premium of IDR 1,000,000. The employer-covered JKK contribution was between 0.24 and 1.74 percent of monthly or annual salary depending on the type of company or beknown as its activity. Finally, the employer-covered JK contribution was 0.3 percent of monthly salary.

On January 1, 2014, the total number of covered workers in JAMSOSTEK was 11.6 million. JAMSOSTEK ceased to exist as a program on January 1, 2014, when the program was turned over into the new BPJS Kesehatan.

Implementation of JAMSOSTEK

Although regarded as one of the main social security programs for the formal private sector, JAMSOSTEK was in fact unable to provide sufficient benefit levels to its subscribers. In terms of health insurance or JPK JAMSOSTEK, the program did not provide comprehensive benefits for the treatment of chronic diseases or other higher-cost treatments (GOI, 2012b:47). Some higher-cost treatments were for the first time covered since 2012, nearly two decades after the program had started. Because of the limited benefit levels and exclusion of many health conditions from coverage, private enterprises often preferred to provide private health insurance to their employees.

Another frequently criticized JAMSOSTEK program was the old-age savings program or JHT (i.e. the lump sum payment on retirement). The critics alleged that the benefits delivered at the end of the contribution period were very low, which made the public prefer to deposit their money as savings in banks or other financial institutions.

In addition, JAMSOSTEK had other features that made the program fall short in terms of effective social insurance: (1) in the old-age savings or JHT, apart from the fact that the lump sum payment did not provide sufficient income during retirement, members were allowed to withdraw the balances in the case of unemployment; (2) JAMSOSTEK as a state-owned enterprise was profit oriented and held a monopoly on state-managed social security contributions; and (3) finally, there were no tax incentives to contribute to social security systems (Tambunan and Purwoko, 2002:34).

Current trends of the Indonesian welfare state system: the 2011 BPJS law

After the enactment of the BPJS Law in 2011, the supposed universal social security coverage is implemented under two main programs, BPJS for Health or BPJS Kesehatan, and BPJS for Workers or BPJS Ketenagakerjaan. Among those two main programs, BPJS Kesehatan started first, on January 1, 2014, based on the transformation of the earlier PT. ASKES Persero (including its assets and employees).

Three programs were in turn abolished: (1) the JAMSUKESMAS health insurance for the poor; (2) the JPK JAMSOSTEK health insurance for the private sector; and (3) the various health insurance programs of the military (including the personnel of the Ministry of Defense and Security) and the police personnel. All beneficiaries and participants of these previous programs have been moved into the BPJS Kesehatan (Purni, 2014:14-15).

Thus, under BPJS Kesehatan, the contribution is determined as follows: (1) for poor people, the government covers contributions fully; (2) for civil servants and those who work for the military and police, the contribution is 5 percent of salary; (3) for private sector workers, the contribution is 5 percent of salary paid by employers; (4) for more than three children and for extended family members, such as parents or in-laws, the contribution is 7 percent of salary; (5) informal workers have their own scheme in which contributions are fixed, ranging from IDR 25,000 (class III benefits), IDR 42,500 (class II benefits), and IDR 59,500 (class I benefits) (these "class benefits" refers to health care services provided in hospital) (GOI, 2014e:22-23).

Because the new BPJS program is compulsory for all Indonesian citizens and foreigners who stay and work for at least 6 months in Indonesia, it means that people in the informal sector will be covered by social insurance for the first time if implementation proves to be successful. However, BPJS Ketenagakerjaan has only recently not yet included a pension program and the debate about contribution levels for pensions has been rather lengthy. Most stakeholders have agreed to an 8 percent of total salary contribution consisting of a 5 percent contribution by employers and a 3 percent contribution by employees. The new pensions program was launched in July 2015. Prior to July 2015, BPJS Ketenagakerjaan included three main programs, as follows: (1) Old-Age Savings or Jamuan Hari Tua (JHT); (2) In-Work Accident Insurance or Jamuan Kekcoopan Kerja (JKK); (3) Death Benefit or Program Jamuan Keramat (JK). In addition, there exists a special program for construction workers, termed Jasa Konstruksi.

The JHT is a provident fund for workers. The contribution will be paid by employers (3.75% of monthly salary) and employees (2% of monthly salary). The benefit received by the worker on retirement will be the total accumulation of contributions and returns on fund investments.

In turn, JKK contributions covering in-work accident insurance are fully paid by the employer and range from 0.4 to 1.7 percent of an employee's salary per month according to employment sectors. Finally, JK is a program that provides death benefits for families of current or former employee and is also funded by employers (0.3% of monthly salary).

Yet the focus on regulating pensions programs and schemes based on participants' working sectors ultimately fails to address the fact that many Indonesian workers still have no access to pensions. Public sector employees, especially civil servants, the military and police personnel enjoy pension security due to the TASPEN program. Conversely, most private sector employees face a more insecure situation because this sector includes many informal workers.

Hence, enactment of the SJSN Law has started to transform regulation and implementation of the Indonesian pension system. The new pension program is under the management of BPJS Ketenagakerjaan. The new Peraturan Pemerintah (PP) Law was established to be the fundamental reference for the ongoing operations of BPJS Ketenagakerjaan and was implemented in July 2015.
Summary and conclusion

In Indonesia, implementation of social security has proceeded slowly due to the country’s economic status as transition country and its political heritage of authoritarian rule. First steps to provide social security for civil servants were undertaken in 1963 with the TASPEN and ITASPERI programs. Since then, there were no significant changes until the enactment of the 1992 and 1993 Laws on the four main social security programs (i.e. TASPEN, ASKES, ASABRI and JAMSOSTEK).

The reform legislation of the early 1990s still focused on civil servants, the military and police personnel. In addition, the formal private sector and especially employees in mid-sized and larger enterprises were covered. Informal workers were not covered. Thus, the informal sector poses the biggest challenge in Indonesia for further expansion of social security and future implementation of universal coverage.

In addition to social insurance, poor and near-poor people have also been targeted by social assistance programs. Such programs were expanded in response to the Asian Financial Crisis of 1997/1998, which triggered a dramatic increase in poverty levels and undermined the vulnerability of the poor in Indonesia. In response to the crisis, several unconditional cash transfer programs were implemented. In 2007, conditional cash transfers were also introduced for the first time with the Hope Family Program.

The enactment of the 2004 SJSN Law and the implementation of universal health insurance coverage should be considered as significant transformations in the history of social security in Indonesia. It appears that the need of social security for all citizens is an ongoing concern and receives due attention. Yet, the question of whether or not ambitions will be matched by state capabilities at the implementation stage can only be answered at some future point.

First, as mentioned before, informal sector workers remain the biggest challenge for plans to introduce universal social security. The reason is that many informal workers are concentrated in rural areas in which informal labor is the norm. In addition, mutual solidarity in the family neighborhood and community remains very strong and is the primary source of welfare. Thus, individuals might not be socialized to consider social welfare as an individual right and might not place high significance on social insurance institutions.

Moreover, the complex geographical setting of Indonesia and high variation in the level of social development makes it difficult to gather up-to-date statistical data and distribute information on social security institutions. The socialization of actors to support such programs and to pay contributions can therefore not be taken for granted.

Second, the management of the four long-standing social insurance programs, TASPEN, ASKES, ASABRI and JAMSOSTEK, has been handled by state-owned enterprises – a particularity of Indonesian social insurance implementation – and the main purpose was to generate profits. The management was designed to be similar to private companies, which was supposed to result in a more professional, effective, and transparent mode of operation.

However, JAMSOSTEK was still unable to cover the entire formal private sector because the returns on investments – undertakers principally in Indonesian government debt and state-owned enterprises – lacked those offered by private insurance companies and transparency was missing due to limited reporting.

Nevertheless, the enactment of the 2014 SJSN Law shows that greater effort is placed on the realization of universal coverage. Just as in the case of other new policies where criticism is inevitable, the new system should be judged on whether or not it achieves its purpose. In this context, the relevant stakeholders have agreed to work on road maps on health (2012–2019) and on social security for workers (2014–2019).

First, the Roadmap towards National Health Security (2012–2019) has eight targets to be achieved until 2019: (1) BPJS will be able to gain public trust; (2) the entire population of Indonesia will be covered; (3) access to health and medical services will be made more generous to cover chronic diseases; (4) health care facilities will be improved; (5) a satisfaction rate of at least 85 percent from the beneficiaries of health care facilities and BPJS for Health will be achieved; (6) at least 80 percent of health care institutions will be satisfied with the management of BPJS for Health; (7) the BPJS management should be transparent, efficient and accountable; and (8) the BPJS legislation should be reviewed again in 2019 in the light of the experience gained (GOI, 2012b: executive summary).

Second, the Roadmap on the Implementation of Social Security for Workers (2014–2019) focuses on (1) covering all workers in the formal and informal sector; (2) providing equal access to benefits for all workers; (3) limiting administrative costs; (4) program resilience to crisis caused by demographic change and economy instability; (5) guaranteed transparency; (6) educating beneficiaries about the program; and (7) improving administration and service delivery. In addition, business processes and information systems should be integrated between BPJS for Workers and BPJS for Health (GOI, 2014f: 2).

In conclusion, the two roadmaps set medium-term targets for universal coverage of Indonesian workers in health and pension insurance. What is at the end of this road remains to be seen after gaining more insights from the implementation process.

Notes

1 This kind of management for social security program was not in accordance with the statement in the Basic Law of the Republic of Indonesia 1945 (Pasal, 2014: 12–15) but derived from Sukarno’s decision in the early 1960s to make social insurance serve economic development.

2 The regulation mentions a third category of pension, i.e. the Pension Based on Profit of Dana Penunjang Badan Usaha Keuangan (DPBB). However, this type of pension fund has not been implemented.

3 There is debate in Indonesia to shift from a PAYGO public pension system to a fully funded system.

References

BPS, Badan Pusat Statistik (2015), http://www.bps.go.id/LinkTabelStatis
— (2012b), Peta Peta Penyelidikan Pajak Perusahaan, Jakarta.
— (2012a), Pajak Dana Pensiun, Jakarta.
— Pajak Dana Pensiun, Jakarta.
— Pajak Dana Pensiun, Jakarta.
— Pajak Dana Pensiun, Jakarta.
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— Pajak Dana Pensiun, Jakarta.
— Pajak Dana Pensiun, Jakarta.
— Pajak Dana Pensiun, Jak
—— (2014c), Profil Keseluruhan Indonesia Tahun 2013, Kementerian Republik Indonesia: Jakarta.
—— (2014d), Laporan Kesehatan Kinerja Kementerian Keseluruhan Tahun 2013, Kementerian Republik
Indonesia: Jakarta.
Indonesia: Jakarta.
Government-Funded Health Coverage Program for the Poor and Non-Poor, World Bank, Washington, DC,
January.
Institute of Social Studies, a Research Paper, Erasmus University, The Hague, December.
ppjk.depkes.go.id.
Lindenthal, R. (2004), The Challenge of Social Security for All: Policy Options for Indonesia, IOM-UNESFR-
Recovery, Jakarta, November.
Transfer Programme, International Policy Centre for Inclusive Growth, Research Brief No. 42, United
Nations Development Programme, Brazil, October.
Parri, A.E. (2014), Sosial Batin Salas 2: Panduan BPJS Badan Pelayanan Jaminan Sosial, Friedrich-Ebert-
Stiftung Kantor Perwakilan Indonesia: Jakarta.
Sekretariat Kabinet Republik Indonesia (2014), obs.setkab.go.id.
Future, SMERU Research Institute, MERU Paper No. 7891, Jakarta, March.
Suryahadi, A.; Febriani, V. and Yaman, A. (2014), Expanding Social Security in Indonesia, United Nations
Research Institute for Social Development, Working Paper 2014–14, United Nations, Switzerland,
November.