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Does Indonesian National Health Insurance serve a potential for improving health equity in favour of workers in informal economy?

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MSc Development Studies dissertation (August 2015)

Abstract

This study examines whether Indonesian national health insurance system promotes health equity in favour of informal economy workers. It first lays out the theoretical justification on the need of social protection, particularly health protection for informal workers. The paper argues that the absence of health protection for vulnerable informal workers in Indonesia has reinforced health inequity between formal and informal workers, thus provides a justification on extending health protection to this segment. It then boils down its analysis on existing BPJS Health scheme, a government-run national health insurance, and to what extent this scheme serves the needs of informal workers in Indonesia. The finding suggests that several factors (contributory premium, access to healthcare services and politicisation of national healthcare) are responsible for adversely incorporating informal workers; hence fail to promote health equity in favour of vulnerable workers in informal economy.

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List of Acronyms

BPJS	Badan Penyelenggara Jaminan Sosial (National Social Security Agency)
BPS	Badan Pusat Statistik (Central Statistics Body)
ILO	International Labour Organization
JKN	Jaminan Kesehatan Nasional (National Health Insurance)
NHI	National Health Insurance
RSBY	Rashtriya Swasthya Bima Yojna
SEWA	Self Employed Women's Association
SJSN	Sistem Jaminan Sosial Nasional (National Social Security System)
UHC	Universal Health Coverage
WHO	World Health Organization
WIEGO	Women in Informal Employment Globalizing and Organizing

1. Introduction

Margaret Chan, WHO Director-General, once stated “no one in need of healthcare, whether curative or preventive, should risk financial ruin as a result”. This statement represents what WHO defines as universal health coverage (UHC). It is agreed that UHC is one of the ingredients for sustainable development; it is not only as development goal in itself –nobody wants to be sick –but also as a promoter to achieve other development goal, such as poverty eradication. Evans, et al. (2012) postulated that lack of access to healthcare reduces people’s ability to work, thus diminishes their productivity and income. Similarly, paying expensive medical bills through sale of individuals’ assets or taking excessive debt leads to impoverishment.

Recognising the importance of UHC, countries have put a great emphasis on reforming their healthcare system. In many developing countries, it is common that major challenge of sustaining healthcare system is ensuring its efficient and effective health financing strategy. If health is viewed as a right of individuals, health financing should ultimately come from government revenues, which in large is general taxation. Nonetheless, while this system might be viable in rich nations such as the U.K., this might not hold true in many developing countries, whereby informal economy makes up a large percentage of total employment. If informal economy is defined as economy operating outside formal regulation (including taxation), clearly, large informal sector would mean a missing source of financing for national healthcare.

At a broader level, health is often referred as one of most important form of social security. ILO defined social security as “protection that a society provides to individuals and households to ensure access to healthcare and to guarantee income security...” (ILO 2001). Furthermore, ILO’s Declaration of Philadelphia in 1944 has stipulated social protection as a basic human right, in which ironically, half of the world’s population (mostly the poor and informal workers) does not actually possess.

To ensure right of their citizens for social protection, health in particular, developing countries have come up with various strategies to expand their health coverage for the poor and informal workers with various initiatives, ranging from universal to targeting schemes. In many developing countries, social security system is heavily fragmented; consisting of different schemes for different classes of citizens i.e. formal vs. informal workers and the rich vs. the poor. Results have generally varied; from a rather 'successful' universal system such as Thailand which relied on general taxation to a problematic targeting scheme like India's Rashtriya Swasthya Bima Yojna (RSBY; a free care for population below poverty line).

Unanimous global agreement to put forward UHC has incentivised the author to analyse the issues facing healthcare system at narrower lens into national level, with a particular attention on workers in informal economy. Indonesian newly introduced national health insurance (NHI) system in early 2014 called Jaminan Kesehatan Nasional (JKN) managed by a Healthcare and Social Security Agency called Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan has been picked as a case study for this paper.

Indonesian case is particularly interesting as Indonesia has recently launched a single ambitious reform in the realm of NHI to explicitly include informal workers. Previous healthcare system had been heavily fragmented with the majority of workers enrolled were formal workers. Thus, the new system is believed to reduce health inequity among classes of citizens including formal vs. informal workers. On the other hand, Indonesian informal economy landscape is still characterised with high vulnerability in terms of the absence of social protection of any kind, including health (ILO 2009). Hence, following the global attention toward UHC, Indonesian government has passed two key laws (1) Law on the National Social Security System No. 40/2004 in 2004 and (2) Law to establish the Social Security Agency (BPJS) in October 2011, Law 24/2011. With Law 24/2011, the government has developed the Road Map toward National Health Insurance—Universal Coverage 2012-2019.

1.1. Research question

With informal economy landscape in mind, this paper will attempt to answer one main question which will be divided into two sub-questions as follow:

Does Indonesian national health insurance serve a potential for improving health equity in favour of workers in informal economy?

- a) Why is health protection needed for informal economy workers?
- b) Does the current system have a potential to serve the needs of informal workers when measured in terms of
 - i. Contributory premium
 - ii. Access to information and health services
 - iii. Health politics

1.2. Significance of the study

This study is important for several reasons. First, it identifies some trends in developing countries' adoption of UHC and how do they conform to a theory that health is a right of individuals. Second, the study fills the gap of literatures by approaching health equity from an alternative perspective of informal workers. Moreover, its originality comes from the fact that there has been very few academic research on Indonesian newly adopted health insurance with special attention to informal workers. Therefore, it hopes to provide inclusive portfolio of existing literatures. Third, it is expected that the study can add to broader implications in identifying factors that may contribute to health equity and/or reinforce health inequity in the adoption of UHC for other developing countries.

1.3. Research method and outline

This study is a qualitative research which may include some quantitative statistics to justify the arguments. It utilises existing academic and fieldwork research to gather the data and support its analysis. It also relies heavily on data and paper published by international organisations such as ILO and WHO, as well as government official publications. The case study also depends on media publications for some issues relating to current implementation of policy on Indonesian NHI.

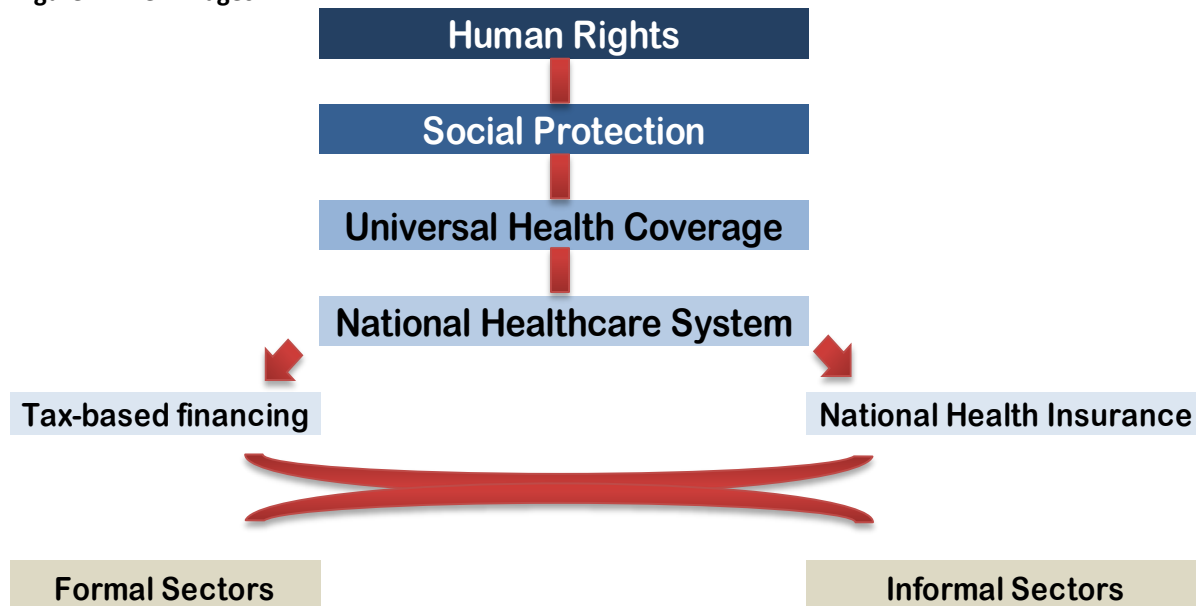
The major limitation of this study is in particular related to its case study as it is a fairly recent policy thus the data obtained might not be fully sufficient to support the argument. Also, there is no single definition on what is considered as informal economy thus there will be some inconsistency in its analysis. Nonetheless, the paper has attempted to acknowledge these limitations in its analysis to minimise the problem of over-generalisation.

The following sections are structured as follows. The second section provides a theoretical justification on the provision of social protection as well as relevant theory of UHC. It also covers global trend on the adoption of UHC with some issues facing informal workers. The third section, the case study, provides an in-depth perspective on Indonesian health insurance. It initially analyses the evolution of social protection in Indonesia with a focus on health insurance system. It then offers hindsight whether the current health insurance serves the needs of informal workers with some analysis on different parameters including health politics at broader level. The concluding part presents some reflections on NHI and summarised main findings based on the research questions as well as recommendations for further research.

2. Inclusive approach to social protection and health equity

Drawing from existing literatures (ILO 2001, 2009; WHO 2010, 2013; OXFAM 2013; Asante, et al. 2013), this paper attempts to layout the linkages between social protection, UHC and NHI in general.

Figure 1. The linkages



As Figure 1 depicts, the top level of ‘development’ goal lays the fulfilment of human rights; social protection is one of basic human rights. As the Universal Declaration of Human Rights 1948 states that “everyone, as a member of society, has the right to social security...”¹ (Article 22), “and (social security) refers specifically to the right to medical care and necessary social services, to security in the event of sickness, disability, widowhood, old age and unemployment, and to special care and assistance for motherhood and childhood (Article 25). Thus, this statement imply that UHC can be considered as a part of social protection; as equally implied in The World Health Assembly resolution 58.33 in 2005 “everyone should be able to access health services” (WHO 2010).

Member states of WHO have been committed to adopt UHC at the national level, which essentially seek to reform their healthcare system. This system can be financed either through general taxation or health insurance; or a mixture of both (OXFAM 2013). Health insurance can be defined as insurance to cover future medical sickness financed by contributory premium paid by the members, their employers or by

¹ Social security is often used interchangeably with social protection (ILO 2009)

the state. Health insurance can take many forms, public, private or community-based; nonetheless, this paper will focus on the former which generally defined as social/national health insurance.

2.1. Why do we need social protection?

There are two contending perspectives on the needs of social protection and ultimately its provision (Meagher 2015a). First, as mentioned previously, is right-based social protection and second is social risk management, as proposed by the World Bank. Viewing social protection from risk management perspective means that social protection is an investment on human capital (Hiroshi 2008 as cited in ILO 2010) that is needed to manage risks that may affect workers' productivity, efficiency and eventually economic growth. However, flawed social protection can backfire on economic growth. For instance, in Mexico where people in low-productive employment (informal workers) were given more social benefits than formal workers, formal workers would be motivated to move to informal sector (Levy 2008).

Social risk management perspective is often argued for reinforcing neo-liberal agenda in the realm of social protection. For instance, its provision needs to rely on the basis of efficiency, which market should be the first provider of social protection (e.g. private health insurance). The role of state is to facilitate the operation of market mechanisms within the social protection (Ridha 2014). Contrast to this, right-based social protection argued that it is ultimately global and national (state) responsibilities for the provision of social protection.

While these perspectives on social protection seem to be contradictory, there has been some convergence of ideas on the needs of social protection. From development perspective, social protection can be both understood as basic human right and managing risks to achieve other outcomes. Sen (1999) sees development as 'expansion of human freedom', believes that expansion of human freedom can be seen as the primary end (constitutive roles) and the principal means of development (instrumental roles of freedom). In light of social protection, it can be seen as the primary end (basic human right) and the

principal means for economic growth (e.g. healthy workers are more productive for economy than sick ones).

As for UHC, this paper believes that while UHC strongly sees health as human right, it also seems to converge toward looking at financial risks associated with expensive medical bills. A resolution of the United Nations General Assembly in 2012 which promotes UHC highlights the importance of UHC as 'principal means' in alleviating poverty and in achieving sustainable development (WHO 2010).

2.2. Health equity through UHC approach

Orem and Zikusooka (2010) defined health equity as 'fairness' in financial contribution towards healthcare and 'fairness' in benefiting from its services. Moreover, they stipulated that equitable health financing is thus a system that seeks financial contribution according to people's ability to pay (i.e. the poor pay less than the rich), while offering non-discriminatory healthcare according to their needs.

In promoting UHC and thus health equity for all, WHO (2010 as cited in Acharya, et al. 2012) has laid down requirements for successful UHC through NHI scheme. First, its contribution to the risk pool needs to be compulsory to prevent adverse selection to the scheme (i.e. rich and healthy will opt out). Second, the risk pool has to have large numbers of people to handle large health costs and spread risk sufficiently, as pools with a small number cannot spread risk sufficiently and are too small to handle large health costs. Third, in the presence of large number of poor, pooled funds needs to be subsidised from state revenue (this is often referred as demand-side subsidies²). More importantly, NHI scheme shall eventually reduce out-of-pocket payments by the individuals and maximise mandatory pre-payment (OXFAM 2013) to enable maximum cross-subsidies between the rich vs. the poor and the healthy vs. the sick. WHO stipulated that out-of-pocket payments above 15-20% of total health expenditure can lead to impoverishment (Lagomarsino, et al. 2012).

² Subsidies to support healthcare from healthcare demander/ patients

In the realm of health expenditure, attention should be on improving healthcare infrastructure such as human resources, medical supplies, distribution of health facilities, and the quality of healthcare (Thabrany 2008). This can be partly financed through insurance funds as well as supply-side subsidies³. The state also needs to pay attention on health service needs of population and match services to those needs as well as creates incentives for the providers to deliver better services and take action against poor performance (OXFAM 2013).

2.3. Informal economy: The concept and focus

The term 'informal sector' was first coined by the ILO to describe "activities of the working poor who were working very hard but who were not recognised, recorded, protected or regulated by the public authorities" (ILO 1972). In this sense, informal economy was characterised by low-productivity sector and seen as residual economy which might diminish as the economy grows. Thus, informal economy was considered unfavourable for economic growth and the attention should be focused on formalisation of informal sector. Nonetheless, this has not been the case whereby informal economy is growing over the past decade, even in some industrialised nations, with much greater complexity (ILO 2002).

There is no single definition of informal economy. Different organisations and nations often used their own definitions; however they shared one important characteristic –operated outside formal regulatory framework. Most often, informal economy is also characterised with high level of vulnerabilities which lacks of adequate social protection mainly at the bottom end. Thus, ILO attention has been focused on 'decent work deficits' in formal and informal enterprises and workers. Decent work deficits are best viewed as "poor-quality, unproductive and unremunerative jobs that are not recognised or protected by law, the absence of rights at work, inadequate social protection, and the lack of representation and voice" (ILO 2002).

³ Government directs subsidies into healthcare facilities

Ever since, there has been global pushes for research on extending social protection, which mainly exist in formal sector, to informal sector by international organisations such as ILO as well as global and national NGOs for informal economy (e.g. WIEGO, OXFAM, SEWA). However, one major challenge in informal economy research has been in terms of measuring its reliable statistics due to its paradox of inclusion (i.e. recording the unrecorded sector) (Meagher 2015b). Comparability among nations has been a major problem in measuring informality which led researchers to construct their own estimates which sometimes lead to different conclusions (The World Bank 2013). Nonetheless, ILO and the Delhi Group since 2006 have produced manuals on surveys for informal economy which has improved statistical comparability among nations significantly (The World Bank 2013).

WIEGO (n.d.) extends the definition of informal economy through segmenting it into different level. [Figure 1A](#) illustrates the level of informal employment, with the highest level is employer, and while at the lower end are mostly low-wage informal workers and unpaid family workers. Other things equal, the level of income is parallel to this structure by which those at the bottom end receive the least income as well as are exposed to highest level of vulnerability.

This dissertation mostly directs its focus on health equity for vulnerable informal workers, who are mainly at the bottom end. It is because these segments are often excluded in market provision of health insurance (i.e. too poor to purchase health insurance). This causes these workers to have high level of vulnerability including greater exposure of financial risks in the case of chronic illnesses. Furthermore, in the case of wage workers, lack of formal regulation and enforcement of code of conducts might also incentivise the employers to exploit the workers by forcing them to work long hours and being paid far below minimum wage. This will therefore expose them to a greater risk of being ill.

If we compare the level of vulnerability faced between formal and informal workers at the similar level of income, other things equal, informal workers possess greater vulnerability because of irregularity of

income and unstable jobs (Sciortino 2014). Formal workers are protected under labour regulation and often covered by social protection, thus even if they are at the low level of income range, they are still able to benefit from these regulatory framework.

2.4.NHI in the presence of substantial informal economy

In many developing countries, social protection system is heavily fragmented, which means there are different social protection schemes for different target groups. Perry, Maloney and Arias (2007) found that almost Latin American countries have 'truncated welfare system' which means that formal sector employees are covered in extensive social protection scheme, including health insurance, whereas informal workers often do not have access to such protection or other government benefits.

To fill this gap for informal sectors, some developing countries such as Rwanda, Ghana and Mali, have relied on fragmented and voluntary community-based health insurance schemes (Lagomarsino, et al. 2012). Unlike compulsory health insurance, these schemes tend to create moral hazard problems; those who were at high risks of chronic illnesses tend to enrol themselves while healthy people tend to opt-out (Lagomarsino, et al. 2012; Bitran 2014). In Vietnam, moral hazard problem tends to be associated with income level. Jowett, Deolalikar and Martinsson (2014) found that insured individuals are more likely to use outpatient facilities and public services with an effect that is "particularly strong at lower income levels". This moral hazard, thus, risks that such system would be unsustainable in the long run because health expenditure outweighs financing.

Apart from voluntary insurance, there is a similar pattern of developing countries' attempts on extending social protection, with initial enrolment by formal workers, followed by government-subsidised schemes for the poor (Bitran 2014). For example, India introduced RSBY scheme targeted for below the poverty line (BPL) families in informal sector (Gothoskar 2014). However, such scheme ran into difficulty in terms of identifying who is poor enough to qualify (Lagomarsino, et al. 2012) and it is found that many vulnerable

workers (migrants, street-children, deserted women) were excluded from this scheme (Gothoskar 2014). Henceforth, fragmented system often creates 'the missing middle problem', which refers to segments that are just little above the cut-off-point of poverty line (Bitran 2014).

Following the adoption of UHC, compulsory and single pool NHI looks appealing as it offers potential to promote health equity due to its mandatory pre-payment and pooling that can be distributed equitably across the population (OXFAM 2013). While this might be viable option in developed countries, the major challenge facing many developing countries is to include those working in informal economy. There are several reasons why extending health insurance to informal workers tends to be difficult.

In terms of contributory premium, employers often do not record informal workers, especially casual workers. Thus, it is difficult to administer and collecting contributions from these workers. In addition, since many informal workers (i.e. mostly seasonal and temporary workers) do not have binding contract, they are paid daily or weekly by their employers without fixed amount of income (Thabrany 2008). This irregularity has made determination and the collection of contributory premium to be problematic. Some countries have avoided this problem by relying on general taxation while some tried to seek fair amount of contributory premiums from informal workers. Results have been varied, whereby there is no strong evidence that countries with contributory-scheme offer better or worse protection compared to those which rely on general taxation (Xu K, et al. 2007 as cited in Tangcharoensathien, et al. 2011).

While relying on general taxation for public health services often caused informal workers to be 'free riders' of healthcare system, OXFAM (2013) argued that when health is considered as the right of citizens, successful countries, even in the presence of large informal economy, tend to finance their health expenditure by tax revenues. Malaysia has achieved universal coverage (i.e. 100% population is covered under financial protection scheme) because it relies on general taxation (Tangcharoensathien, et al. 2011). Thailand, before the introduction of UHC in 2002, 30% of the total population has no social protection in

2001, mostly in the informal sector (Tangcharoensathien, et al. 2011). When the government decided to rely on general revenues, there has been vast improvement in terms of health coverage and access to services (WHO 2010 as cited in OXFAM 2013). Furthermore, the proportion of poorest families facing catastrophic health expenditures went down dramatically from 4% in 2000 to 0.9% in 2006 (WHO 2010 as cited in OXFAM 2013).

Those in favour of general taxation system argued that contributory scheme for informal workers tend to be inefficient because costs of administering and collecting contributions will be much higher than collected contributions. In Ghana, premium paid by the informal sector is only below 5% of financing cost of NHI scheme (OXFAM 2013; NHI Authority 2010 as cited in Lagomarsino, et al. 2012). Also, there was a tendency of distrust with the scheme among informal workers which makes enrolment rates to be low especially among the poor population (Criel, et al. 2014).

South Korea, in contrast, offers a success story of contributory-based NHI scheme for those working in informal economy. NHI scheme of South Korea has improved health equity in favour of informal workers, particularly for self-employed population. This mainly has to do with more equitable contribution system. Jeong (2010) postulated that the success are due to three reasons, first, contribution rates from informal workers were set at affordable level; second, there were supports from national treasury and third, sustained economic growth has increased the capacity of nation to finance the system.

In terms of access of information and health services, national health insurance might actually reinforce health inequity between formal and informal workers. Alfors (2013) study on Ghana NHI scheme found that richer society can pay others to do the work for them than poorer ones. Also, NHI registration tends to be easier at wealthier district than poorer ones. On one hand, time wasted by informal workers to register and access the scheme caused them to be less productive at work thus fails to provide economic empowerment. On the other hand, formal workers, even at lower socio-economic status, may well have

been able to take a day's paid leave to do his or her NHIS registration. Single-pool NHI scheme also fails to address the problem of social exclusion which may affect informal workers' access to healthcare services. Social exclusion in the provision of healthcare may be due to discriminatory practices of medical professionals within the context of poor accessibility and quality of services (Criel, et al. 2014). Thus, while high enrolment rates of informal workers into NHI may indicate a success story, it does not explain the delivery of healthcare toward informal workers.

Health protection is undeniably important for every citizen, including informal workers. While offering single health package for all citizens can improve health equity, this might not be the best option in developing countries in the presence of lack of financial contributions and low government revenue. Thus, it is important to pay attention to priority needs of informal workers in order to avoid unsustainable health system. Informal economy is highly diverse in terms of sectors and levels, thus there exist different priorities among these workers. These priorities depend on, (1) demographic characteristics (women, children, men and old age); (2) Degree of hazards in different activities (e.g.: garbage collectors); (3) Locations (home-based, on the streets, in small allocated places); (4) Social intercourse (tendency in communities and not companies); (5) Capability to contribute a specified premium contributions (Suprobo, Tarigan and Weiss 2007; ILO 2009).

To illustrate, some workers may be in need of health protection than others. In contrast, other workers such as those in construction sectors may need occupational health and safety hazard (OSH) more than others. Alfors (2009) found that because of ambitious NHI goal, Ghanaian government tend to put more attention toward curative care while there has been lack of considerations for work-related injury for informal sectors. This paper theorises that lack of government consideration on informal workers' priorities may partly be due to politicisation of healthcare services, as illustrated in the following case study.

To sum up, while NHI addresses the lack of social protection in informal economy, it may paradoxically reinforce or worsen health inequity between formal and informal workers due to reasons mentioned above; contributory premium problem, access to information and services, as well as different priority and needs of workers in informal economy.

3. Health equity and NHI scheme: Indonesian case study

The following section tries to understand the dynamics of social protection, particularly health protection for informal workers in Indonesia. It first lays out current health statistics, followed by the evolution of social protection and informal economy. Lastly, it analyses current Indonesian NHI scheme with special focus of workers in informal sector.

3.1. Snapshot of Indonesian health system

Indonesia, located in South-East Asia region, in 2013 is considered as low-middle income country according to the World Bank classification. WHO (2015) has laid out the statistics of Indonesian current health situation. In terms of life expectancy at birth of 71 years of age, it performs above the World Bank income region average (66). In 2012, cardiovascular and diabetes constituted as highest burden of disease (measured by healthy-life years lost due to the disease). Tobacco use is regarded as the highest adult health-risks factor, especially among men. About 67% of men in Indonesia are smoking, which translates into 34% of world's men smokers.

According to WHO (n.d.), Indonesian health equity based on economic status, when measured in terms of reproductive, maternal, new-born and child health intervention (RMNCH), has improved over the past decade. However, 2012 data showed that while 80.4% population is covered by RMNCH, there is still a considerable gap between the poorest quintile (68.9%) and the richest quintile (85.5%). Furthermore, health inequity is significant in the case of child mortality rates, 21.8 vs. 69.7 deaths per 1000 births for richest and poorest quintiles respectively.

[Figure 2A](#) by the WHO laid out the current health financing system quite clear. In terms of health expenditure, share of government spending allocated to health is 7% which only accounts for 1% of GDP in 2013. Regionally and globally, its position is at the lowest-end of expenditure as a share of GDP, thus indicating that health system is still under-funded. While the government only contributed to 39% of country's health spending, out-of-pocket expenditure by the household is nearly half (46%) of total country's spending. This figure is alarmingly high considering WHO criteria of 20% out-of-pocket payments as a share of total health spending may lead to impoverishment (Lagomarsino, et al. 2012).

3.2. The evolution of social protection in Indonesia

The legislation of social protection in Indonesia was underlined in The 1945 Constitution of the Republic of Indonesia. Article 28H (3) stipulates that "every citizen has the right to social security and underlines the role of the state in providing universal social security coverage" and article 34 (2) states that the "state shall develop a system of social security for all people and shall empower the inadequate and underprivileged in society in accordance with human dignity" (ILO 2009). Thus, this legislation seems to fit into right-based perspective of social protection whereby it is the ultimate responsibility of the state to provide social security for its citizens, including informal workers.

In terms of national health insurance scheme, the government first introduced compulsory health insurance for civil servants in 1968, followed by a system for private sector workers in 1977 (ILO 2009). In 1992, the State Corporation PT Jamsostek (Social Security for Workers) was established as a body to manage social insurance for formal workers which include health, pensions, death and OSH benefits (ILO 2009). One important features of Jamsostek programme is that private firms were granted an option to provide their own insurance or medical protection for their workers, which subsequently reduce the enrolment rates; only 10% of formal sector workers and dependent enrolled (JLN n.d.), thus minimise potential of cross-subsidisation of the scheme.

Following 1998-99 financial crisis, the government has undergone extensive reform including decentralisation reform and granted most authorities, including healthcare services to subnational and regional authorities—except fiscal, national security, foreign policy, and religious affairs (Thabrany 2008). One major concern is that, any national health reform would be complicated by this decentralisation due to intricate and fragmented set of financing flows (JLN n.d.) that might reinforce unequitable health distributions among districts and regions (Thabrany 2008). For instance, poor districts would have insufficient funding for healthcare thus would focus on fee-for-service health delivery (e.g. privatising public hospitals) whereas rich districts might initiate free healthcare for the citizens.

While regional autonomy in healthcare still exists to date, following UHC commitment, the government passed the SJSN Act No.40 of 2004 on national social security system which basically re-instated government commitment to provide universal coverage in the realm of social protection. Following this decree, in the same year, the government developed a fully subsidised social security targeted for the poorest section of society (around 40 millions), called Askeskin (Sparrow, Suryahadi and Widyanti 2013; JLN n.d.). The scheme then was extended to covers the near poor (76.4 millions) in 2008 and was renamed as Jamkesmas (JLN n.d.; Bitran 2014).

Despite a substantial increase in coverage, Mukti (2013 as cited in Bitran 2014) stipulated that only 58% of Indonesians were covered under fragmented health insurance schemes (see [table 1](#)). Thus in 2011, the government passed another law in October 2011, Law 24/2011 to establish the Social Security Agency (BPJS). In terms of national healthcare system, this law called for an integration of the multiple insurance schemes into one single-pool scheme called JKN⁴ (Jaminan Kesehatan Nasional/ National Health Insurance) managed by BPJS Health organisation, creating largest single-pool system in the world (Bitran 2014).

⁴ Sometimes the term 'BPJS Health' is used interchangeably with JKN.

Under the new NHI scheme which started to operate in early 2014, the government has set an ambitious target for 100% enrolment rates of population Indonesia. To date, nearly 150 million people are enrolled in the system which accounted for roughly 58% of total population, which interestingly, reflects the same percentage under previous fragmented insurance schemes⁵. Broadly speaking, there are two different membership types of BPJS Health based on payments of contributory premiums; (1) the poor (PBI) whose contributions are paid fully by the government (2) non-poor (Non-PBI) whose contributions depended on the types of employments. Non-PBI members are divided into two, formal and informal workers. While formal workers' contributions are paid by the employers and the employees themselves based on certain percentage of their salaries, informal workers' contributions are set by fixed amount regardless of their income levels. However, informal workers have three sets of options of contribution amounts which will determine services that they receive (First, second and third class services). Nonetheless, the government is committed to abolish class-based healthcare delivery by 2019 (Mukti 2012). By then, BPJS Health will also operate double sanctions; for those who have not registered themselves and for late payments of those who are registered into the scheme.

3.3. Informal economy landscape in Indonesia

There are varieties of definition on what constitute informal economy in Indonesia according to different government and non-government institutions (Suprobo, Tarigan and Weiss 2007). However, the paper will focus on the definitions of informal economy based on the Central Statistics Body (BPS), as its definition is regarded as the most comprehensive one at the national level (Subropo, Tarigan and Weiss 2007; ILO 2010). BPS adopted the definition from ILO's 1992 Surveys of Economically Active Population, Employment, Unemployment and Underemployment to define informality as "traditional economic activity conducted by low level or unstructured organisations without transaction accounts, in a casual

⁵ As per July 24, 2015, enrolment rates of JKN are 149,172,165 (BPJS Kesehatan 2014a). Total population estimated 257,563,815 in 2015 (UN Population 2015).

relationship, and based on personal relations rather than contract or formal agreement” (Joedadibrata 2012).

[Table 2](#) reflects how BPS determines the level of informality based on employment status and main types of jobs. This is indeed an extensive feature of WIEGO’s classification (see [figure 1A](#)) which categorises informal economy based on types (level) of jobs. Prior to year 2006, BPS only categorised informal sector workers as workers ‘outside formal-working relationship’ thus, in the [table 2](#), informal economy referred to all employment status except (3) and (4) (Suprobo, Tarigan and Weiss 2007). However, it had masked the dynamics of informality that exist; hence, combining these two main features seemed to be more reflective of realities (ILO 2010).

[Table 3](#) shows that the old categorisation of informal sector had overstated the proportion of informal economy. However, one main important feature is that, although the size of informal sector had fluctuated over a decade, the number was consistently above two-thirds of total employment. The implication for social security provision is that, in order to achieve universal coverage, there is indeed a considerable justification why focus needs to be directed to informal workers. It is also interesting to note that there is more informal jobs in rural than urban areas (47% vs. 18% in 2009).

In terms of types of jobs, [table 4](#) shows strikingly that informal workers are over-represented in agricultural-based activities i.e. over 93%, while it is under-represented professional and administration works. In addition, informality has been growing in services and production sector. These trends are worth considering in order to understand the actual priority needs of informal workers as well as their ability to contribute to NHI.

3.4. Inequity in health facilities and informal coping mechanisms

Indonesian healthcare facilities consist of health centres and public and private hospitals. Health centres mainly provide primary healthcare normally at sub-district levels and headed by a newly-graduate general

practitioner (Thabrany 2008). Before the introduction of UHC, the patients have to pay small amount of user service fees, which vary between districts. The significance of health centres is that its close proximity to population, thus enabling easy access for healthcare. On the other hand, both public and private hospitals generally provide secondary and tertiary health services with different class treatments.

User fees of health centres and public hospitals are generally heavily subsidised through supply-side subsidies (Thabrany 2008) indicating that these subsidies have been regressive since hospitals receive larger subsidies than health centres. Unfortunately, the poor refrain from coming to hospitals fearing expensive bills which eventually create health inequity among the citizens (Thabrany 2008; Sparrow, Suryahadi and Widyanti 2013). Furthermore, doctors in health centres and public hospitals are allowed to conduct private practices in the evening and charge single payment for every visit as well as provide some medications which are unavailable in health centres or public hospitals. They attracted demand from the poor and informal workers to go to these private practices (Thabrany 2008; Suprobo, Weiss and Tarigan 2007).

As seen in [table 1](#), roughly 42% of Indonesian population is not covered under fragmented social protection, with mostly informal workers (Mukti 2013 as cited in Bitran 2014) relying on their own coping strategy in the case of illnesses. There have been different strategies adopted by informal workers which generally varied according to their level of income and types of jobs. It is not uncommon that many informal workers have negative perception on the effectiveness of health centres, thus they prefer to go to private practices. One major reason is because these health centres are severely underfunded due to the fact that government subsidies have been mostly directed to public hospitals (Sparrow, Suharyadi and Widyanti 2013). Decentralisation reform also worsens this condition because poor districts would normally have fewer budgets to subsidise health centres. As a result, patients receive poor services and/or pay high user fees.

Suprobo, Weiss and Tarigan (2007) conducted various micro case-studies to examine different coping strategies of informal workers. First, street traders Karang Ayu market in Semarang would prefer to go to practicing doctors for seeking medications due to negative perception of health centres. They also generally receive high income thus are able to rely on their income (varied from IDR600,000/month to couple of millions) to pay for the doctors (normally IDR25,000/visit). Majority of them are not covered under Jamsostek, partly because of age factors (old), the health centres referred by Jamsostek are too far from their houses, as well as lack of awareness about the scheme.

Second, at the other end, sidewalk traders in Klaten receive very small income (gross IDR15,000/day) and do not have enough saving for sudden or chronic illnesses. One trader stated that normally he would take care of himself if he was sick and if there is an emergency need, he can sell rice from his side job as a farmer. This, therefore, indicates high level of vulnerability in the absence of health insurance.

Third, informal workers also rely on their social capital through their relatives or friends as well as associations for large healthcare expenditure. The members of The Process-Farming Group Association-Group of Women in Jakarta, for instance, when encountered with financial difficulties, will seek helps from close friends, relatives or selling off their assets. They also sometimes rely on the pool-money under Arisan⁶ programme in the association.

From the above passage, it is clear that the absence of health insurance has regressive impacts on workers in informal economy, especially poor informal workers as urgent need of health costs will require them to sell off their assets. This effect is magnified where the presence of informality has been consistently above two-thirds of total employment. This condition therefore supports the need of UHC as proposed by WHO –no one should ruin financial risks related to expensive health costs. NHI might be one option, as

⁶ Arisan is a 'common activity conducted by Indonesian society in which a group of people gathered to submit certain amount of money and one or some of the group member would be randomly picked to get the money' (Suprobo, Tarigan and Weiss 2007).

chosen by Indonesian government; however, closer examination is needed to analyse the policy whether it might improve or otherwise worsen health equity for informal workers.

3.5. BPJS Health for informal workers

Fragmented health protection system has pushed Indonesian government to launch an ambitious single-pool NHI scheme JKN, commonly referred to as BPJS Health starting from January 2014 with an ambitious goal to cover all Indonesian by 2019. BPJS Health is a comprehensive scheme that covers almost all health services from primary to tertiary healthcare which include promotive, preventive and curative healthcare as well as medications according to individuals' needs. These services are provided by health centres, public hospitals as well as private hospitals that have opted to join the scheme as providers (Razavi 2015).

While BPJS Health scheme can be examined through various indicators, this paper, however, only tries to highlight several following parameters to analyse whether BPJS Health may improve or worsen health equity for informal workers.

3.5.1. Contributory premium

In terms of contributory premium to BPJS pool, Non-poor members (Non-PBI) contributions are as follows; civil servants and military personnels' contribution is 5% of their monthly income with 3% paid by the government and 2% paid by the employees; state-owned enterprises and private formal workers are obligated to pay a premium of 4.5% of their salary, 4% payable by employers and 0.5% payable by employees; non-salaried workers, which include informal workers, the self-employed and investors pay fixed monthly premiums of between IDR25,500 and IDR59,500 in a tiered system of first, second and third-class services depend on the amount of contribution paid. For the poor and near poor (PBI), the contribution of IDR19,225 is fully funded by the government.

As discussed in the previous section about UHC requirements that has been proposed by WHO, the current BPJS Health is believed to meet some UHC requirements. First, it is compulsory for all Indonesian citizens, thus has a potential in preventing adverse selection into the system. The large number of enrolment also leads to sufficient risk spreading. However, there is a concern with regard to the fairness in terms of government subsidies for the scheme. Mukti (2013 as cited in Bitran 2014) found that there are one-third of informal workers currently under PBI scheme. The remaining two-thirds are above cut-off point and are required to join the scheme under payable fixed-amount premium latest by 2019. The current scheme indeed is rather problematic. As mentioned earlier, PBI members received fully subsidised services while those with income just slightly above poverty-line would have to pay for their healthcare. Indonesia's poverty dynamics are fluid and there are a large number of the near poor live close to the

poverty line; about 40% and 60% of Indonesians live below 1.5 and 2 times of poverty line respectively (Sciortino 2014).

To deliver more equitable system particularly for those fall into near-poor category, the JKN road map has stated the possibility of government subsidies for the 'non-poor' in the informal sector (Sciortino 2014). Unfortunately, there is no clear definition on what constitutes informal workers under SJSN law; informal workers are only defined as non-salaried workers, thus exclude those under employers-employees jobs (Sibarani 2014). It clearly contrasts the dynamics of informal economy relationships as defined by the BPS statistical body (see [table 2](#)). As a consequence, this discrepancy in definition will make targeted subsidy for non-poor informal workers be more difficult and potentially exclude those in need of subsidies and reinforce health inequity among informal workers.

While the immediate solution would be to cover all informal workers under PBI membership, it might increase the prevalence of informality. Levy (2008) study on Mexico found that the dualistic social policy in which the government heavily subsidised social security for informal sectors has led formal employers and employees to shift to informal economy instead. Greater informality, in this case, would be unfavourable as it might lead to unsustainable scheme resulted from reduction of pooled funds.

Setting fixed contributory premium for informal workers may also reinforce inequity between employers and employees working in the informal economy because the employers can easily evade of not contributing to their informal workers contribution. Worse still, it may also reinforces gender inequity, since men are predominantly at the top end of informal structure, thus employers are much more likely to be men (see [figure 1A](#)). This informal structure is proven in the case of Indonesia since the average women's income in informal sector is only 75% of that of men in 2008, even when calculated in terms of wage per hour, women still earns 20% less than men (see [table 5](#)). The good news is, women are not tragically over-represented in informal sector compare to men, thus, the significance of gender inequity

could still be minimised (see [table 6](#)). However, one must be wary that, other things equal, women have more significant needs of healthcare, particularly maternal health, therefore, gender inequity may instead increase the vulnerability of women in healthcare services.

Compared to formal sector, whereby the employers are responsible for paying large proportion of contribution (4% by employers and 0.5% by employees), fixed contribution by informal workers may instead reinforce health inequity between formal and informal workers, especially those with low-income. According to various surveys, BPJS Health premiums are actually higher than the amount that informal workers are willing to contribute. Handayani, Gondodiputro and Saefullah (2013) study in district of Hulu Sungai Selatan, Borneo found that majority of informal workers (mostly farmers) are only willing to pay IDR5,000 per month, which is only a quarter of the lowest premium set by BPJS (IDR25,500). ILO (2010) study for informal workers on various districts in Indonesia also revealed that 26% of workers cannot afford to pay the premium, whereby 40% of the sample are only willing to pay less than IDR10,000. Furthermore, only 11% of informal workers are willing to pay above IDR20,000 who are mostly at the highest income quintile of informal workers. Joedadibrata (2002 as cited in Sibarani 2014) also affirms that rural informal workers had difficulty in paying the monthly premium of IDR25,000.

In terms of collecting the premium, one concern for this scheme is due to the nature of employment of informal workers in Indonesia. [Table 4](#) had revealed that informal workers are over-represented in agricultural sectors, mostly in rural area. Monthly premium makes it difficult for these workers to contribute, as farmers only harvest every 3 months which sometimes are affected with droughts or bad harvests (Suprobo, Weiss and Tarigan 2007), consequently raising a concern on the continuity of premium collection. Apart from rural informal workers, there might be difficulty of premium collection from urban informal workers, who are normally street traders. For instance, urban street vendors possessed significant vulnerability in terms of irregular income stream, mainly due to, ironically, violence conducted

by local government to remove them from public space (Forum Keprihatinan Akademisi 2003, UPLINK-Indonesia 2008 as cited in Gunadi 2009).

Referring back to Orem and Zikusooka (2010) which promotes health equity based on people's ability to pay (i.e. rich pay more than the poor), it is clear that current Indonesian scheme does not conform to this ideal. While it may be argued that this limitation occurs because of irregular income stream in informal economy, a success lesson from South Korea NHI is worth considering. When extending health insurance to informal workers, South Korea set the premium according to 'supposed' income of the workers, rather than fixed contribution. To illustrate, supposed income is estimated by allocating point scores for age and sex of the head of the household, property lease value as well as car tax payment (Jeong 2010). Thus, Indonesia could learn from this technique in order to set fair amount of contribution for informal workers.

3.5.2. Access to information and healthcare services

In terms of access to information and services, the government has implemented a significant step toward socialising the BPJS Health programme and easing the registration for the citizens, for instance, through building an interactive website which enables online registration and increase transparency by providing much information to the general public. The government also continuously socialise the programme through mass media, which comes with a fruitful outcome of high enrolment rates of the scheme just within one year i.e. achieving its target enrolment rates for 2014 by 102% (BPJS 2014). Nonetheless, high enrolment rates do not necessarily mean that there is improvement of health equity among the citizens. Lagomarsino, et al. (2012) debated that when the benefits of insurance scheme are not well understood or services are inaccessible, financial coverage is useless.

One major barrier for informal workers to access the information is low education level. For example, the highest education level of majority of informal workers in Surabaya city is primary education thus this may affect their understanding of the scheme (Triyono and Soewartoyo 2013). Their understanding is crucial

because without adequate information, informal workers may experience social exclusion in medical treatments. The problem of social exclusion in Indonesia seems to mirror Criel, et al. (2014) study on discriminatory practices by medical practitioners against poor in the case of Ghana NHI. In Indonesia, Putranto (2015) reported that poor people often received discriminatory practices, such as removal of patients, by medical professional although they are registered under BPJS Health.

Ruqoyah and Darmawan (2015) reported a case of one casual worker in Jakarta, was being overcharged by public hospital amounted to IDR150million for a medical treatment of his newly-born baby. The worker admitted that he even had followed all procedural requirements of BPJS Health to pay for first-class treatment of his baby; nonetheless the hospital denied his BPJS Health card. He could not do anything because the hospital insisted that he did not follow the procedure correctly. This clearly illustrated an extreme case of discriminatory and exploitative practices.

Healthcare services for informal workers under BPJS Health are currently tiered according to the payment of premium. This clearly contrasts the principle of health equity, so it rather reinforces health inequity between formal and informal sector, as well as among the rich and the poor. Besides, the recipient of PBI scheme often experienced stigma in self-identifying as poor, thus creating barrier in accessing health services (Rokx, Scheiber, et al. 2009 as cited in Simmonds and Hort 2013).

Paradoxically, BPJS health has also created 'insurance effect', particularly for informal workers, whereby healthy workers were rushing to come into health centres and hospitals to get the treatments because they 'have paid' the contribution premium (BPJS Kesehatan 2015b). Hence, this might be problematic for long run sustainability of the system, whereby the pooled funds would be insufficient to cover these unnecessary medical expenditures.

3.5.3. Health politics: Neoliberal healthcare?

This section highlights how politics plays an important role in influencing national health system, BPJS scheme and finally, workers in informal economy. Evaluating social protection through political lens requires wider understanding of the penetrating logic. Social risk management theory has been argued for reinforcing neoliberal agenda in healthcare realm, in which the government facilitated market operation in healthcare services. In the case of Indonesia, the paper argued, neoliberalism has indeed penetrated the construction and the implementation of BPJS Health insurance.

The current statistics has highlighted that national healthcare has been seriously underfunded compared to other government expenditures. At narrowest sense, increasing health expenditure as a percentage of government expenditure either through supply-side subsidies and/or demand-side subsidies would solve the problem. But instead, the government proposed BPJS Health which requires significant premium contributions by the citizens; with the massive new injection will come from informal workers since majority of them were previously not covered under old system. McGregor (2001 as cited in Ridha 2014) contends that the neoliberal agenda of healthcare reform consist of “cost-cutting for efficiency, decentralising to the local or regional level (removing responsibility from the national level) and setting up healthcare as a private good for sale rather than a public good paid for with taxpayer money”. Indonesian BPJS Health undeniably fits into all these criteria; accordingly it indeed reinforces neoliberal ideal in the realm of healthcare rather than leaning toward the original constitution 1945 (i.e. health as rights of the citizens). BPJS health also relies on the principle of ‘individualism’ which is at the core of neoliberal ideology i.e. citizens have to pay premium in order to gain the membership (Ridha 2014). This henceforth would affect health equity in particular for informal economy workers.

To understand how political force underpins the establishment of BPJS Health, there is a need to look closely on how SJSN law 2004 on social security came into the picture. While it is believed that the law

came as a result of crisis of social protection and pushes from international actors e.g. ILO and WHO (Thabrany 2008), it is also partly due to electoral reason. The law was designed in 2002, at the time when Megawati sat as the president of Indonesia. She specifically took interest on national social security due to her populist background, stemming from nationalism creed established by her father, Soekarno (Indonesian first president), as well as her PDI-P political party mission on social welfare (Aspinall 2014). The presidential election at that time was due in 2004, thus it would really have made sense when she proposed the formulation of the law to run for the second term. Unfortunately, she lost to Yudhoyono, whom immediately assumed the position in 2004. Nonetheless, Megawati signed for SJSN Act in 2004 during her last stay in presidential palace by saying “I produce this Act as a gift for you (Indonesians)” (Thabrany 2008). Yudhoyono, coming from Democrat party, had little interest in developing the Act, thus social security reform stalled for few years. Only in 2011 finally the law on establishment of social security agency, BPJS, was passed by the parliament which partly due to push by members of Megawati’s populist party (Aspinall 2014).

At regional level, the story is no less different. The power of regional leaders due to decentralisation reform has also been widely misused by the incumbents to promote populist policies in the realm of healthcare to increase their reputation. Aspinall (2014) noted that 2012 Jakarta gubernatorial election created a heavily politicised healthcare when two of the contenders, Joko Widodo and Alex Noerdin, had already run successful health schemes in their places of origins, assured to introduce the schemes to Jakarta whereas the incumbent, Fauzi Bowo, had actually implemented his own health programme.

Politicisation of healthcare is certainly not a new story; however, the extent in which it may adversely affect the citizens is a big concern for the sustainability of the system. In the case of Indonesia, healthcare system has been inefficient and full of rent-seeking activities by the government officials, hospitals and pharmaceutical agencies (Aspinall 2014). In addition, heavily politicised policy would fail to alter the

power structure that governs the society. BPJS Health, this paper argued, might only reinforce the existing power structure while at the same time, fail to address the vulnerability of informal workers.

The major concern of social protection in Indonesia is to extend the protection to informal sector, either through extending the existing schemes or designing targeted scheme specifically for informal workers. However, targeted scheme is not really attractive for populist purposes as it only creates narrow-based support from specific target population. Broad-based coalition is thus possible through the universal social policy, which in this case is national health insurance in the form of BPJS Health. However, it has been argued earlier that due to diverse nature of informal economy, there would be different priorities for informal workers across jobs and sectors. In Indonesia, ILO (2010) surveyed that on average, informal workers in various sectors and regions put highest priority for accidents at work (36%) while workers' health only comes at second place (29%). It also found gender disparity in terms of priority; female informal workers put much more priority for health insurance for themselves and family members (i.e. about 50% of workers put health as their first priority) compared to those of men (approximately 30% put health as their first priority). In terms of priority diseases, as mentioned previously, there has been a serious prevalence of tobacco smoking among Indonesians which might lead to specific health diseases, i.e. lung or mouth cancers.

BPJS Health irrefutably ignored this reality. Yet, it even extends the universality nature into recipients' health treatments by covering almost all treatments from primary to tertiary healthcare. There is no harm of proposing universal policy, however, in the case of fiscal crisis, it would be problematic and not address the real problem. In many countries, universalism has been blamed of "not being redistributive and of wasting scarce resources on the middle and upper income classes and the undeserving poor" (Mkandawire 2015). To demonstrate this fiscal crisis, in just over a year, BPJS Health has run into negative account balance of IDR1.9trillion (Praditya 2015). It is argued by some that the loss occurred because contributory premiums were set too low thus not enough to cover all benefits received (Praditya 2015;

Solidaritas.net 2015). Hence, the government has planned to increase the premiums by IDR10,000 for each class of treatment (Solidaritas.net 2015). However, informal workers have no strong channel to oppose such increase because the union that most often protests is the formal workers' union (Solidaritas.net 2013). Hence, BPJS Health fails to change the existing power structure thus only adversely incorporates informal workers into the system.

BPJS Health also fails to address the vulnerability of informal workers because it does not address the problem of underinvestment by the government in health sector (Ridha 2014). Because of its neoliberal creed, it instead leads to more underinvestment by the government at the same time, increasing the burden of the payers. Under BPJS Health, the government only subsidises the payment for the poor (PBI) and the civil servants while neglecting the fact that significant portion of paying informal workers are not able to pay for the premium. Worse still, the government operates cross-sanctioned policy for the late and nonpayers of BPJS Health (for informal workers and other fixed-premium payers) by excluding them from accessing other public services (BPJS Kesehatan 2015a). This sanction, hence, only reinforces the existing power structure and worsens health inequity particularly for informal workers.

4. Conclusions

The study has argued that there has been convergence on viewing social protection, health protection in particular, as both rights of individuals as well as the means in achieving other developmental goals. However, the absence of health protection in informal economy has been attributed for reinforcing health inequity between formal and informal workers. Substantial informality in most developing countries has pushed the government to find an effective way to extend health protection in informal sector. This study presents that while national health insurance is an option for promoting health equity between formal and informal workers, several problems which might reinforce health inequity have been highlighted; contributory premium issues, access to information and health services and different priorities of informal workers.

In Indonesia, fragmented social protection system had failed to incorporate large proportion of informal workers. Health protection is undeniably needed for these workers, as this paper argued, due to their high vulnerability in the case of large medical costs. The launching of BPJS Health, a government-run health insurance as pathway to achieve universal health coverage is hoped to protect informal workers from this problem. Nonetheless, like other developing countries, this scheme has a potential to adversely incorporate these workers, which ultimately, reinforce health inequity between formal and informal workers.

The finding suggests that fixed contributory premium set by the government is much higher than what informal workers are willing to pay. Where informal workers are mainly over-represented in agriculture, monthly payment method also makes it difficult for these workers to contribute due to seasonal harvest problem. Lack of clear definition of informal workers under social security law may also reinforce gender inequity as it opens the space for the male employers to evade from paying contributions of their female informal workers. In terms of access to healthcare services, on the one hand, it is also found that poorly informed informal workers often experienced social exclusion in the form of discriminatory practices by

the health practitioners. On the other hand, the scheme created moral hazard problem whereby many informal workers use health facilities more frequently when they enrol into the scheme. At broader level, the paper also adds to discussion on politicisation of healthcare, where neoliberalism indeed underpins the formulation and implementation of BPJS Health. The scheme merely strengthens power imbalance between the politicians and vulnerable informal workers i.e. repudiating these workers from other public services in the case of late or non-payments. Thus, it is concluded that, based on these parameters, the scheme only adversely incorporates informal workers into the system.

This paper, nevertheless, is far from suggesting the government to scrap BPJS Health scheme. It instead proposes that the government should address these issues in order to make the scheme be more favourable toward informal workers. Some suggestions are as follows; reconciling the term informal economy between BPS statistical body and SJSN law on social security for ensuring fairer contribution, followed by revising payment method for informal workers, for instance, following South Korea's method in setting contributory premium; improving quality controls of health facilities to avoid discriminatory treatments; and finally increasing government investment for healthcare infrastructure while at the same time, providing proper channel for informal workers to voice out their views on government policies to counterbalance unequal power structure in the society. The government also needs to address other health issues apart from its financing part, i.e. prevalence of tobacco smoking that might lead to substantial health costs. These recommendations therefore call for further in-depth and technical researches in these specific issues on national health insurance.

5. Appendices

Table 1. Indonesia: Health Insurance Coverage by Scheme, 2013

Scheme	Membership	Coverage	
		Millions of people	% of total population
Jamkesmas	Poor and near-poor (bottom 40%)	76.4	32
Askes	Civil servants (nonmilitary)	14	6
Jamsostek	Formal private sector workers + informal (to some extent)	4.8	3
Jamkesda	Subnational schemes (estimated)	36	15
Private	Voluntary insurance — household individual	6.6	3
Military	Military service employees	2	1
TOTAL		139.8	58

Source: Mukti (2013 as cited in Bitran 2014)

Table 2. Determining Informal Worker Group Based on Job Status and Type of Main Jobs in Indonesia

Employment Status	Main Occupation									
	Professional	Managerial	Clerical worker	Sales worker	Service provider	Agriculture worker	Production worker	Operator	Labourer	Other
1. Own account worker	F	F	F	INF	INF	INF	INF	INF	INF	INF
2. Employer assisted by temporary worker/unpaid worker	F	F	F	F	F	INF	F	F	F	INF
3. Employer assisted by permanent worker/paid worker	F	F	F	F	F	F	F	F	F	F
4. Regular employee	F	F	F	F	F	F	F	F	F	F
5. Casual employee in agriculture	F	F	F	INF	INF	INF	INF	INF	INF	INF
6. Casual employee not in agriculture	F	F	F	INF	INF	INF	INF	INF	INF	INF
7. Family worker/unpaid worker	INF	INF	INF	INF	INF	INF	INF	INF	INF	INF

Note: F -Formal INF- Informal

Source: BPS (2006 as cited in Suprobo, Tarigan and Weiss 2007)

Table 3. Informal sector in Indonesia (millions of workers), 2001-2009

	2001	2003	2006	2009
Informal - Urban	13.93	14.83	15.85	17.97
Informal - Rural	41.88	43.61	44.92	46.87
Informal - Men	33.07	37.05	38.48	38.56
Informal - Women	22.74	21.40	22.29	26.28
Total Informal	55.81	58.45	60.77	64.84
Total Employment	90.81	90.78	95.18	104.49
Informal employment as % of total employment -New definition	61.5	64.4	63.4	62.1
Informal employment as % of total employment -Old definition	67.7	70.8	69.8	69.5

Source: ILO (2010)

Table 4. The tendency of informality based on types of main jobs in Indonesia

	2006	2009
Professional	0.5	0.3
Managerial and Administrative	0.0	0.0
Clerical	0.7	0.9
Sales	59.1	58.1
Services	29.2	32.5
Agriculture, farming, forestry, fisheries and hunting	93.1	93.2
Production, operator, labourer	45.1	46.8

Source: BPS (2009 as cited in ILO 2010)

Table 5. Monthly wage, working hours and wage per hour in Indonesian informal economy, 2006-2008

	2006	2007	2008
Average monthly wage (IDR)			
Men	827,101	958,971	1,031,348
Women	612,131	715,414	773,979
Working hours			
Men	44	45	44
Women	41	42	41
Wage per hour (IDR per hour)			
Men	18,798	21,310	23,440
Women	14,930	17,034	18,878

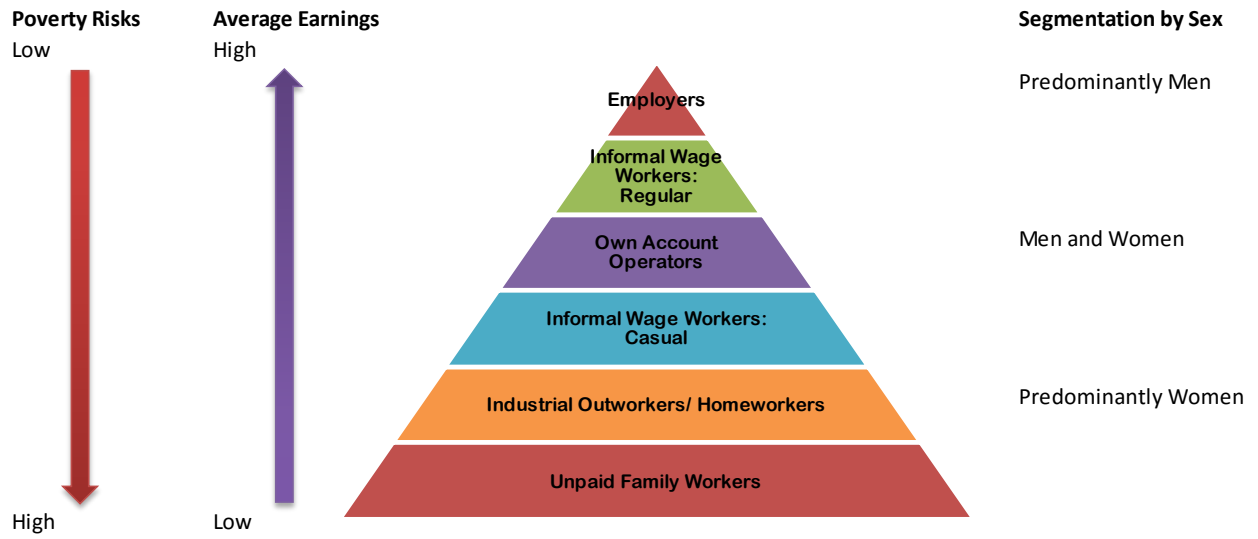
Source: BPS (2009 as cited in ILO 2010)

Table 6. Indonesian informal economy by gender, 2009

Sex	Informal employment		Employment in the informal sector		Informal employment outside informal sector	
	Thousands	% of non-agricultural employment	Thousands	% of non-agricultural employment	Thousands	% of non-agricultural employment
Women	1,180	72.9	1,034	63.9	227	14
Men	1,977	72.3	1,788	65.4	305	11.1

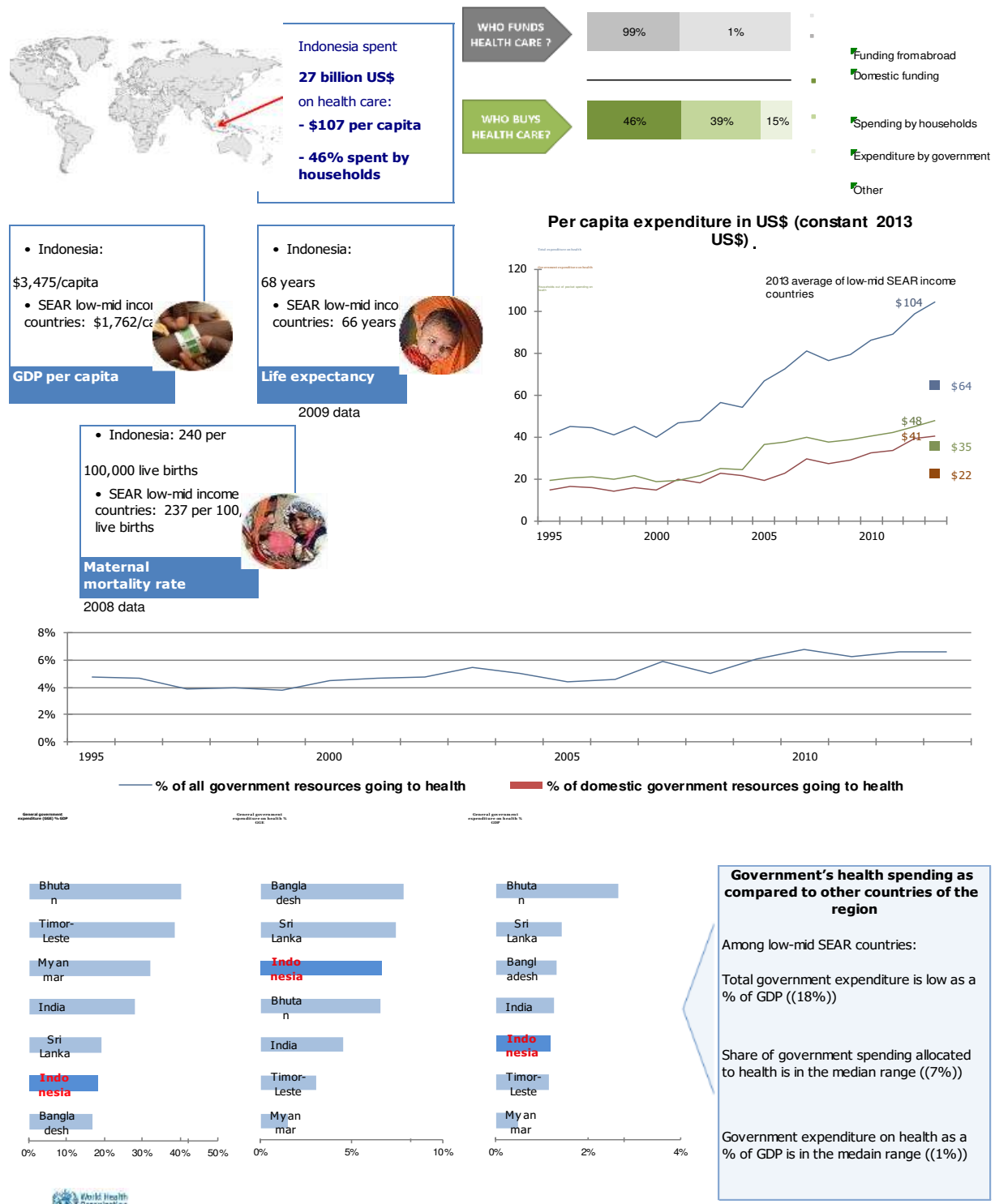
Source: ILO (2013)

Figure 1A. The structure of Informal Economy



Source: WIEGO (n.d.)

Figure 2A. Health Financing System Profile: Indonesia, 2013



Source: WHO (2015)

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