The Government of Indonesia (GOI) has taken significant steps towards universal health coverage through the development of an integrated national health scheme. However, covering the non-poor informal sector workers still poses a major challenge. Derived from an Informal Economy Study (IES) conducted in 2011/2012, this policy brief explores different challenges and options to expand social health protection for non-poor informal workers in Indonesia.

In 2012, 60.14% of all Indonesian jobs were in the informal sector. Although this number has decreased over the past decade, many Indonesians still remain in unstable and highly vulnerable work conditions. Internationally it is known that informal workers, due to lack of social protection schemes for them, can often be impoverished from catastrophic health expenditures. This can increase numbers of poor households in any population as well as reduce productivity.

In 2014, the social health insurance administrative body, BPJS Health, will begin its operations with the aim of reaching universal health coverage (UHC) by the end of 2019. All Indonesians, both informal and formal workers, should by then be covered with health insurance. Currently, the GOI pays the contribution for parts of the population based on their poverty status, covering 86.4 million people – 35.6% of the total population.

A substantial number of informal workers will remain without health insurance. The IES estimated that 32.5 million (paid) informal workers will not be covered by any health insurance scheme in 2014. This coverage gap needs to be addressed in order to achieve the goal of UHC and most importantly to protect this vulnerable group from further impoverishment due to health care costs.

Extending Contribution Assistance to the Non-poor Informal Workers?

Achieving the goal of UHC by the end of 2019 as stated in the Government Regulation No. 12/2013 on Health Insurance is a big challenge. Yet, no formula to ensure a mandatory policy to request contributions from informal workers exists. Some countries, like Thailand, have therefore decided to substantially extend contribution assistance and pay premiums not only for the poorest, but for the whole informal sector. Other countries like the Philippines try to collect contributions from informal workers. Both policy options (requesting contributions from at least part of the informal sector versus funding coverage for the whole informal sector from general government revenues) imply trade-offs, as follows:

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1. Law 40/2004 on the National Social Security System (Sistem Jaminan Sosial Nasional or SJSN) and Law 24/2011 on Social Security Administrative Bodies (Badan Penyelenggara Jaminan Sosial or BPJS).
2. Badan Pusat Statistik, August 2012.
4. Data from PPLS 2011
First, collecting contributions from informal workers is extremely challenging, can hamper progress toward universal health coverage and is potentially costly, particularly where a high proportion of this sector are in rural areas. There is a risk, however, that paying contributions from government sources for all informal workers could lead to formalisation and undermine the contribution-based system for formal workers in the long run. The small evidence on this to date, however, is mixed and evaluation over longer time periods is necessary.

Second, various equity concerns arise from the different options. For informal workers whose income is near a cutoff point for contribution assistance, a slight increase of per capita household expenditure would require them to pay the full contribution. Where informal workers are already susceptible to impoverishment, the burden associated with contributions could then be greater for this group relative to others such as formal workers whose contribution will be partly paid by the employer. If, however, all informal workers were to be covered by government funds, another equity issue emerges. People with the same ability to pay would be treated differently; having to pay the contributions at least partly themselves or getting their contribution completely subsidized by the government depending on their respective status of their work relationship (formal versus informal).

Due to the aforementioned trade-offs from the different options, this policy brief suggests to further elaborate the policy of the Indonesian Government to collect contributions from non-poor informal workers for the upcoming BPJS Health.

Social Health Protection for Non-poor Informal Workers: Challenges

Briefly informed about the potential health risks and social health protection benefits, uninsured respondents to the IES explicitly stated that their willingness to enrol for health insurance would increase if they had more access to information and could develop confidence in the benefits.

International experience shows that health is particularly suitable for a multi-tiered socialization effort. The findings above imply the need for BPJS Health to initiate additional social marketing efforts communicating the expansion strategy.

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<th>Socialising Health Scheme Arrangements</th>
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<td>• About a quarter of the informal workers have never heard of any of the Indonesian health protection programmes.</td>
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<td>• About 38% of the informal workers do not know how to enrol in a health protection programme.</td>
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<td>• Even members of health protection programmes showed significant knowledge gaps regarding the benefit packages (outpatient services, inpatient care) they were entitled to.</td>
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Contribution collection

In addition to the importance of available information on health protection, the IES identified the nature of payment modalities as a core factor on the road to increased coverage of the non-poor informal sector. The study revealed that Indonesian informal workers would prefer direct payments to BPJS Health (55%), either at branch offices, to field officers of BPJS Health or - a small share - via bank transfer. Unfortunately, only 16% of the informal workers have their own bank accounts and 86% receive their income in cash. It is currently unclear if a substantial increase of bank account usage or payment using mobile phones is feasible over a mid-term range although an increased financial inclusion is for many reasons desirable. Secondly, if contributions were collected, monthly payments appear to be preferred by more than two-thirds of IES respondents (Figure 1). The remaining third would, however, prefer other payment frequencies, which might reflect the diversity of income patterns for the informal sector.

![Figure 1: Preferred frequency of contribution payment among informal sector workers according to the IES 2012.](image)

Administrative costs for collecting premiums from the informal sector and monitoring are usually quite high, especially in remote areas. Therefore innovative ways of contribution collection should be considered, for example working with intermediary institutions (e.g. LPA; see Box 3).
or organisations which might charge a fee for collecting the premium from workers.

A first evaluation on impact and implementation of the Askesos New Initiative has shown that the intermediaries might act as a Third Party Administration (TPA), enabling money flows between the local level and the professional insurance business. The evaluation indicates a considerable potential for coverage extension although only a handful of local governments allocate specific budgets at the moment to complement the Ministry of Social Affairs (KemenSos) budget on the Askesos New Initiative.

Similar to the abovementioned intermediaries, professional organisations such as associations of fishermen or ojek drivers might act as intermediaries by collecting the premiums. Therefore, this policy brief recommends that BPJS Health establishes a limited number of flexible contribution payment options (e.g. monthly, seasonal, annual, or per harvest payments). Note however that this will also have greater cost implications. These need to be clearly stated in the guidelines or standard operating procedures developed by BPJS Health. More information on organisations and/or associations that could act as intermediaries should also be generated.

As this policy brief discusses challenges towards an increased health protection coverage among informal sector workers, it also needs to be stressed that the respective supply side, meaning the availability of quality care and medical services in Indonesia, needs to be further improved. Government financed contributions are not a substitute for the necessary substantial increase in allocation of funds to establish the readiness of the supply side. International evidence, e.g. from Thailand, underlines the importance of investing in health infrastructure, human resources and suitable provider payment mechanisms for covering informal workers and reaching UHC.

**Box 3. Potential use of LPA Askesos as a TPA**

The Askesos New Initiative, commenced in 2012, provides work accident and death benefit to around 750,000 informal workers. It involves intermediary organisations (Lembaga Pengelola Askesos/LPA) which mostly consist of charity foundations, religious-based institutions and various other social organisations which act mainly as membership administrators and social marketers.

LPA can act as an intermediary organisation to extend Jamsostek memberships to informal workers. The LPA, as a compensation, receive 12.5% of the total premium collected from PT Jamsostek. This initiative should be taken into account by BPJS Health. Note that PT Jamsostek (Persero) will be transformed into BPJS Labour in order to start managing the non-health insurance programme in 2015.

**Recommendations**

The social health protection reform in Indonesia already unfolds and tremendous institutional changes are under way. While the broad picture for the coming years is depicted in the Road Map towards National Health Security, 2012 - 2019 (Peta Jalan Menuju Jaminan Kesehatan Nasional 2012-2019), a number of details still have to be decided. This policy brief takes into account that several follow-up activities such as pilots on contribution collection will be carried out or initiated soon and therefore it presents only a selection of recommendations with potential to feed into these.

- Many Indonesians are not aware of social protection options. A lack of information is considered to be the greatest challenge towards increased health coverage. Therefore, it requires a comprehensive social marketing strategy and continuous efforts on developing communication, information, and education techniques which takes into account preferred information channels for non-members of the health schemes. These are counseling by insurance company officers and (to a lesser extent) conventional mass media (newspapers, magazines, publications), electronic and social media as well as advocating stakeholders.

- Current experience on Jamsostek and the Askesos New Initiative in outreaching to participants by using intermediary organisations should be reflected thoroughly, replicated and extended, preferably by offering a limited number of flexible payment schemes (monthly, annually, seasonal, per harvest) for the purpose of contribution collection.

- Besides making use of intermediary institutions such as religion-based and occupational organisations for collecting contributions or distributing information, stakeholders shall select pilot regions according to their level of supply side readiness because a lack of medical facilities would strongly bias results from the pilot. Also, pilots should run at least 12 months.

- A randomized evaluation of a pilot project to implement social health protection for informal sector workers is recommended. The pilot should be carried out in collaboration with various partners under the auspices of GOI. It should focus on how to expand coverage to non-poor informal workers who have only very limited coverage so far (Figure 2). The pilot should also make use of several potential intermediaries for collecting premiums, ensuring optimal take-up in the scheme, disseminating information and providing space for members’ grievances and appeals, etc.
Conduct an assessment to clearly determine trade-offs between revenue collection possibilities of a contributory scheme and the costs of implementing it under various scenarios.

BPJS Health and BPJS Labour might harmonise their efforts in expanding membership. Also, harmonisation is needed between BPJS Health and the different social assistance programmes which cover those people with an insufficient capacity to pay contributions on a regular basis.

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