

## Institutional Arrangement on Welfare Regime in Indonesia: How Does Indonesia Maintain Its Health Care Policy

Pradhikna Yunik Nurhayati<sup>1,2</sup>

<sup>1</sup>Universitas Gadjah Mada, Indonesia

<sup>2</sup>National Cheng Kung University, Taiwan

(corresponding author: [pradhikna.yunik@ugm.ac.id](mailto:pradhikna.yunik@ugm.ac.id))

Received : July 2020; Accepted; October 2020 ; Published : November 2020

### Abstract

*In the last decade, Indonesia has successfully reduced the poverty rate from 11.96% in 2012 to 9.22% at the end of 2020. However, the rate of inequality in Indonesia is considered the highest within the region. Therefore, it is pivotal for Indonesia to strengthen and expand its welfare system in order to overcome the inequality. This paper aims to examine the institutional arrangement of welfare regime in Indonesia especially the health care policy. This paper implement qualitative method by examine secondary resource such as journals, articles and government report to gain understanding about institutional arrangement on welfare system in Indonesia. Result shows that population coverage of health care is shifting gradually from partial group of population to all of the citizens especially by the existence of national health insurance. The source of funding is risk-pooling rather than self-help. It indicates that government of Indonesia embrace inclusive productivist welfare as its institutional arrangement.*

*Keywords: welfare; institutional arrangement; health care policy; Indonesia*

### Abstrak

Dalam satu dekade terakhir, Indonesia telah berhasil menurunkan angka kemiskinan dari 11,96% pada 2012 menjadi 9,22% pada akhir 2020. Namun, tingkat ketimpangan di Indonesia dinilai tertinggi di kawasan. Oleh karena itu, penting bagi Indonesia untuk memperkuat dan memperluas sistem kesejahteraannya guna mengatasi ketimpangan. Tulisan ini bertujuan untuk mengkaji tatanan kelembagaan rezim kesejahteraan di Indonesia khususnya kebijakan pelayanan kesehatan. Makalah ini menggunakan metode kualitatif dengan mengkaji sumber-sumber sekunder seperti artikel jurnal, artikel dan laporan pemerintah untuk memperoleh pemahaman tentang pengaturan kelembagaan pada sistem kesejahteraan di Indonesia. Hasil penelitian menunjukkan bahwa cakupan penduduk terhadap pelayanan kesehatan bergeser secara bertahap dari sebagian kelompok penduduk menjadi seluruh penduduk terutama dengan adanya jaminan kesehatan nasional. Sumber pendanaan adalah pengumpulan risiko daripada swadaya. Hal ini menunjukkan bahwa pemerintah Indonesia menganut kesejahteraan produktif yang inklusif sebagai tatanan kelembagaannya.

Kata kunci: kesejahteraan; pengaturan kelembagaan; kebijakan perawatan kesehatan; Indonesia

## INTRODUCTION

Indonesia has successfully reduced the poverty rate in the last decade from 11.96% in the early 2012 to 9.22% at the end of 2019 (Statistical Yearbook of Indonesia, 2020). However, the level of poverty reduction in Indonesia has become slowed. Indonesian government still has to struggling with high level of income inequality that increasing every year. As mentioned by Samboh (2017), the level of inequality in Indonesia is one of the highest in the East Asian region. Therefore, Indonesia needs to strengthen its coverage expansion as well as assistance system in order to overcome the inequality.

As an effort to overcome the problems above, Indonesian government renewed its commitment to improve equality through various social assistance programs. According to World Bank Report (2017) about social system in Indonesia, the government needs to be more efficient in spending, finding new sources of income outside the state budget, as well as creating more effective programs. World Bank (2017) also noted that “recent improvements in fiscal management have also enabled higher overall budget allocations for social assistance” (p. III).

Nowadays, Indonesian welfare system is considered as mix regime model. The state, market and kinship relation play important role to provide welfare services. Most of the welfare services by government are targeted into poor people that not coverage by market system. Many of welfare services in Indonesia required formally poor status to obtain the aid from the government. The informal institution such as familial relation or kinship-based institution still play pivotal role in order to provide alternative services and go hand in hand with the market as well as state as the basis of welfare services provision. Yuda (2018) argued that this welfare service provision is an effort from government to “establish a sense of loyalty and gain legitimacy to govern a society” or patrimonialism (p. 3). The development of social policies are top-down, with greater emphasize public employees in order to gain the legitimacy for the important interest groups.

The aim of this paper is to examine the institutional arrangement of welfare services in Indonesia, especially in health care services. Adapting the concept of Productivist Welfare by Kim (2013), this paper will try to examine two main basis of welfare policy: who get the benefit and who funds the benefit. This paper will contribute on enhance of welfare study especially in Indonesia.

### ***Institutionalism on welfare regime***

The welfare state systems development cannot be separated by the historical background and political activities. According to Hall (1996), there

are three different approaches on understanding institutionalism. First is historical institutionalism. Historical institutionalism mainly relied on calculus and cultural approaches in order to understand how actors behave on the institution. On the other hand, cultural approach emphasize that behaviour of individual is not fully strategic but also relied on the worldview.

The second approach is rational choice institutionalism. This approach complement the weakness of historical institutionalism by developed more precise conception about the relation between institution and human behaviour. However, this approach is also belongs to some weakness by simplifying human motivation that leads into miss of many important dimensions.

The third is sociological approach. These approaches emphasize that many forms and procedures in institution is actually a result of culturally specific practices. Even the bureaucratic form can be seen in the cultural terms. This approach appropriately revealed the relation between institution and action which may not be measured by the rational approach through the highly instrumental or well-modelled theory. Understanding these three institutional approach will help us understand the rational and logic within the welfare regime system.

During this time, the study of the welfare regime in Asia was dominated by the idea that welfare is not merely protective like usually happened in western country. The welfare regime in Asia is considered as productive welfare policy. It means, the welfare program was mean to support the economic growth by protecting their labour force or any other formal position in order to protect productivism in the country. The welfare and social safety net are mostly provided by community and market. According to Abrahamson (2017), two most influential approaches on assessing East Asia welfare arrangement are productivist welfare state by Holliday (2000), or development welfare state by Kwon (2005).

On his paper, Holliday (2000) emphasized that the welfare arrangements in East Asia cannot be fitted into tripartite framework (conservative; liberal; and social democratic) by Esping Andersen. The social policy discourse in East Asia is different from Euro-American model. As mentioned by Abrahamson (2017), the welfare provision in East Asia mainly characterized by familial character, dominated by informal care regime where the informal care services are provided by the family especially female members. In the social virtues, filial piety, individual self-help, as well as family interdependence are robust. The provision of social safety net appears to the main role of traditional families.

However, in the modern world where the women began to enter the labour market, the role of welfare provision that previously hold by female member was interrupted. Women labour forces are also play pivotal role on

supporting economic development in the country. It leads into welfare expenditure growth. Therefore, welfare service provisions in East Asia were prone to be a tool for the regimes to support the healthy and qualified work forces (Hong, 2014).

By maintaining the health and quality of work forces, the productivity will increase. Hence, the welfare services aims to support economic development rather than to fulfil citizen universal social rights. This is what Holliday (2000) defined as productivist welfare capitalism (PWC). Holliday (2000) developed productivist welfare capitalism in order to complement the tripartite model by Andersen. According to Holliday (2000), the liberal – conservative – social democratic model is not compatible to analyze welfare regime in Asia. Therefore Holliday developed the fourth model called PWC. The aim of PWC state is mainly to support the economic policy in order to increase labour productivity.

There are two central aspects on PWC. First is the growth-oriented state and the other is subordination of social policy towards economic objectives. Therefore, the consideration toward social rights is minimal and the extensions of the benefit will link to the productive activity. The PWC will focus on the reinforcement of productive elements by maintaining relationship between state, market, and family in order to provide the services and safety net directed toward group.

The other approach to analyze welfare services in Asia developed by Kwon (2005) called developmental welfare state. Before the Asian crisis in 1998, the benefits coverage from social policy was mainly focused on certain population group that considered as strategic for economic development. In this era, the vulnerable people in society such as poor people were left behind the system. However, when the economic crisis arrived in 1997 – 1998, the most Asian country had to expand its welfare services in order to overcome the impact from the crisis. The significant reform of welfare state emerged by providing various welfare programs in order to protect the citizen and overcome the difficult situation.

There are two types of developmental welfare state: selective and inclusive. Selective developmental welfare state is characterized by social policy as an instrument for the economic policy. It favouring population that considered strategic for the economic development of the country. The vulnerable population is leaving outside the system that leads into inequality of income and social strata. There is no distributive mechanism between the rich and poor population. For example: Singapore and Hong Kong. On the other hand, there is the other type of developmental welfare state, the

inclusive one. On this type, the main rationale of welfare services provision is social right. Therefore, this system focuses on giving equal access to social protection for all the citizens. For example: Korea and Taiwan (Kwon, 2005).

The discourse about welfare system in Asia continued. In 2013, Kim wrote a dissertation that focus on institutional varieties of PWC in East Asia. The study by Kim challenged the concept of PWC by questioning “whether productivist welfare states are really homogenous and converging institutionally” (p. iv). Discussing social protection is not only discussing how to spend the money. It has to be complement by how to design the institutional arrangements. Therefore, the basis on welfare policy discussion can be done by analyzing who to fund and how to channel the fund (Kim, 2015).

On its dissertation, Kim (2013) categorized PWC into three different institutional formats such as: (1) Inclusive Productivist Welfare (IPW); (2) Market Productivist Welfare (MPW); and Dualist Productivist Welfare (DPW). What makes the institution different is because the IPW implement risk-pooling principle while MPW implement self-help principle. On the other hand, DPW implement both patterns simultaneously.

The IPW implement risk-pooling programs such as social insurance and public assistance as a tool to support socio and economic development. The MPW relies on self-help where establishment of social services are based on compulsory savings scheme. It means the citizen pay their own cost to obtain welfare services. Still, the welfare services provision aims to be a tool for economic growth. For DPW, the welfare services are funded by both risk-pooling as well as self-help (combination of inclusive and market oriented).

Another thing needs to be note is the level of spending on social welfare. Even though the social expenditures level in East Asian countries is increasing, the number is still not significant. The priority is still the national economic development where the social policy is a subordinate in order to increase quality and efficiency of the labour forces. The involvement of the family and private sector are larger compared to the public expenditure. East Asian is considered as late to provide social services compared to the Western countries (Hong, 2014; Kim, 2015).

## **RESEARCH METHODS**

This paper employ qualitative descriptive by examine secondary data such as journal, government report, news, and article related to the issue. The data was collected from multiple sources to ensure the validity of the data (triangulation) and result on similar conclusion. Data available were organized and analyzed in order the answer the research questions.

This paper will try to identify the institutional arrangement of health care services in Indonesia based on three subtypes of PWC by Kim (2013). Therefore, this paper will emphasize on two aspects: (1) population coverage

(eligibility level); and (2) source of funding (risk pooling or self-help) as independent variables.

Kim (2015) developed five levels in order to measure the eligibility such as: (1) government employees; (2) state firm employee and the above; (3) private firm employee and above; (4) self-employed and above; and (5) farmers and fishermen and above. The more population coverage means the more inclusive the health care services.

In order to examine the source of funding as second variable, this paper will identify the social protection financed-schemed. If on IPW the basis of funding is representing by total government spending on social security and health care services provision (risk-pooling), the funding of MPW is representing by private health expenditure (self-help). By identifying the main source of financial funding as well as population coverage, this paper will be able to identify the type of institutional arrangement of health care in Indonesia.

## **RESULTS AND DISCUSSION**

The journey of welfare programs in Indonesia started since the independent day in 1945. At that time, Soekarno (1945 – 1967) as the First President of Indonesia relied more on informal welfare where the state play a role as regulator. The strongest welfare services were provided by the family while the market still remained weak and government only able to provide very limited social protection. In Soeharto era (1967 – 1998) Indonesia began its productivist welfare period where the state still play a main role as regulator and provided limited social protection. The government started to encourage market and community to provide welfare protection (Yuda, 2018b).

The productivist welfare period continued on BJ. Habibie era (1999 – 2001) where the state still maintain to play its role as regulator and provided limited social protection. However, on that period the market is encouraged to be superior to community to provide social services. On the period of Abdurrahman Wahid (1999 – 2001), Megawati Soekarno Putri (2001 – 2004) and Susilo Bambang Yudhoyono or SBY (2004 – 2009), the state began to expand the welfare programs targeting individuals and community. The role of the market as social services provider has been institutionalized (Yuda, 2018b).

Started in 2009 in the second period of SBY administration, Indonesia began its universalism period, continued by Joko Widodo from 2014 to present. On this period, the role of state as regulator on social protection has been transformed into provider. The role of market and community are still

pivotal in order to provide social protection. The universalism period of social protection in Indonesia is the result of law of national social security system that passed the national legislature in 2004 and 2011 and began on 2014.

The transformation for Indonesia from productivist and universalist began by the enactment of the National Security System (SJSN) Act No. 40 in Year 2004. The aim of SJSN is to protect the right of Indonesian citizen to fulfil their basic needs. The enactment of SJSN was followed by the establishment of Social Security Administering Body (BPJS) under the Act No. 24 in Year 2011. Meanwhile, the implementation of the program was started in 2014 with goals of universal health coverage in 2019. BPJS is consists of four organizations such as: (1) Social Security for Labour Force – JAMSOSTEK; (2) Saving and Insurance for Civil Servants – TASPEN; (3) Social Insurance for National Armed Forces of Indonesia – ASABRI; and (4) Health Insurance of Indonesia (ASKES).

There are five social protection arranged under SJSN includes: (1) health protection; (2) work injuries; (3) elder protection; (4) pension benefit; and (5) life insurance. The health protection of Indonesia is organized under BPJS Health; while the protection of work injuries, elder protection, pension benefit, and life insurance are covered by BPJS Employment.

The health insurance under BPJS Health is held on national level based on social insurance and equity principles. It aims to ensure that every participant will be able to obtain health care and protection benefits in order to fulfil their basic health needs. The participants of health insurance are everyone who pays the contribution fee or participants that the contributions are paid by the government. The government will pay the contribution of poor people, people with permanent disabilities, and people who are after six months cannot obtain a job and have no ability to pay the contribution fee (SJSN, 2004; BPJS, 2011).

Previously, before the enactment of SJSN, the health insurance of Indonesia is only covering labour force (under the JAMSOSTEK), civil servants (under the TASPEN), and National Army (under the ASABRI). The program was only protected partial of Indonesian society. By introducing BPJS under SJSN Law, the JAMSOSTEK, TASPEN, and ASABRI are organized under BPJS. The eligibility level of the health insurance is also expanded by providing Health Insurance of Indonesia (ASKES) covering all citizens as the participant of BPJS. It is also covering foreigner that live in Indonesia for minimum six months (SJSN, 2004).

As the Law emphasized on the equity principles, the SJSN implemented mutual cooperation and distribution mechanism from the rich to the poor; from people with lower risk to the higher risk; and for healthy people to sick people in order to realize “social justice for all Indonesia society”. The BPJS is also established by non-profit orientation that emphasize on transparency, accountability, effectiveness and efficiency. The social security is intended to

provide a guarantee sustainable even if the participant changes their work or residence inside territory of Indonesia (SJSN, 2004).

The principle of participation on SJSN is mandatory. It is intended for the whole of population. Even though the membership is mandatory, however, the application is still depend on the economic capabilities of individual and government as well as the feasibility of the program. Therefore, for the implementation, the first stage will prioritize on formal worker and gradually will coverage the all of the population including informal worker. The phrase “gradually” in this provision is intended to pay attention to the conditions of participation as well as program implementation with regard of the state budget (SJSN, 2004).

As cited by Aspinall (2014), Indonesian national health system was considered as “the biggest ‘single-payer’ national health scheme in the world” by The Economist magazine. The single payer means the government collect all the contributions from the participant and pay all the bill results from the health care services. The BPJS Health on national level actually complemented by free health care provided by local governments as well especially for poor people. This health care provision indicates that “the state is becoming more responsive to the interests of poor citizens, and that policymaking processes are providing at least some avenues for input by groups representing their interests” (Aspinall, 2014, p. 804). Before the national health system was existed, some of local government in Indonesia successfully provided universal health coverage for their local citizen. One of the examples is Jembrana Health Insurance initiated by Gede Winasa, a politician from Jembrana Bali.

Discussing the health coverage for the population, the universal health coverage by BPJS Kesehatan transformed Indonesian health protection from selective into inclusive one. If referring to the level of eligibility by Kim (2015), Indonesia gradually moved to inclusive productivist welfare by expanding its coverage not only for formal workers but also non-formal workers. Previously, the health care protection for the formal workers are provided by employer/employees joint contributions while the government providing health care protection for the poor and near poor and private insurance is an option for people who can afford it (Wiseman et al., 2018). National Community Health Insurance was only covering about 32% of total population in 2011 while the Local Community Health Insurance was only covering 14% of population (Ministry of Health of Indonesia in Aspinall, 2015). Under the SJSN and BPJS Law, Indonesia gradually shifted into universal health coverage providing health protection for informal, self-employed as well as the other groups of population (Pisani et al., 2017).

The other variable to assess institutional arrangement is the source of funding, between risk-pooling or self-help. The Act of SJSN already emphasized the principle of social insurance that implemented distributive mechanism from the rich to the poor, from the health to the sick, from the lower risk to higher risk. The risk-pool enables government as a single payer for the health care services. It means Indonesia health care system embrace inclusive system as the government is not only the regulator but also the service provider.

In 2020, total number of participants of BPJS Health was 222.5 million people out of around 265 million Indonesian citizens (Katadata, 2021). However, the challenges emerged from the implementation of inclusive health care service. According to Sri Mulyani the Minister of Finance of Indonesia, there are factors causes the deficit of BPJS Health (Katadata, 2019).

First is the structure of contribution from the participants is consider as under actuarial or underpriced. The contribution or the payment from the participant is too small while there are too many benefits and health coverage. Therefore, the risk is too high because of many participants. The second problem is many participants from informal sector who only register and pay when they are sick and stop paying the contribution after receiving health services. This also called as adverse selection where the people with higher risk of being sick actively participated while people who considered themselves as healthy reluctant to join and contribute to the social insurance system. The third is the level of active participations is considered low while the level of utilization is very high. It compounded by the large financing on catastrophic diseases that cost more than 20% from total cost of benefit.

Indonesia still has to deal with the lack of willingness that leads into budget deficit for the health care services. The government uses the state budget to overcome the deficit of BPJS Health. Meanwhile, the formal workers contribute to the surplus followed by poor people and civil servants (Katadata, 2018). Formal workers contribute to the surplus is because many of them still rely on private insurance provided by the employer.

From discussion above, referring to two independent variables (population coverage and source of funding), Indonesia seems to adhere inclusive productivist welfare for its health care services. The population coverage of health care is shifting gradually from partial group of population to all of the citizens. The second variable is source of funding. As we can see from discussion above, the source of funding is risk-pooling rather than self-help. Moreover, government has to overcome the deficit by taking financial resources from the state budget. It indicates that government of Indonesia embrace inclusive productivist welfare as its institutional arrangement.

## **CONCLUSION**

From discussion above, this paper identifies that Indonesia implement

inclusive productivist welfare for its health care services. Inclusive productivist welfare is characterized by covering all population and implement risk-pooling financial scheme that emphasize on distributive mechanism. Even though the implementation of universal health coverage is not fully realized and Indonesian government is still gradually expanding their population coverage, it can be concluded that Indonesia has inclusive productivist welfare as its institutional arrangement.

## REFERENCES

- Abrahamson, Peter. 2017. "East Asian Welfare Regime: Obsolete Ideal-type or Diversified Reality." *Journal of Asian Public Policy*, 10 (1): 90-103.
- Act No. 40 Year 2004. National Security System of Indonesia. Republic of Indonesia.
- Act No. 24 Year 2011. Social Security Administering Body. Republic of Indonesia.
- Aspinall, Edward. 2014. Health care and democratization in Indonesia. *Democratization*, 21 (5): 803-823. DOI: 10.1080/13510347.2013.873791
- BPS-Statistics Indonesia. 2020. Statistical Yearbook of Indonesia 2020.
- Hall, Peter. 1996. "Political Science and the Three New Institutionalism". *Political Studies*, XLIV, 936-957.
- Holliday, Ian. 2000. "Productivist Welfare Capitalism: Social Policy in East Asia." *Political Studies*, 48: 706-723.
- Hong, Ijin. 2014. "Trends and Determinants of Social Expenditure in Korea, Japan and Taiwan." *Social Policy & Administration*, 48 (6): 647-665.
- Katadata. 2021. Number of BPJS Health Participants Reaches 222.5 Million People by 2020. Retrieved from <https://databoks.katadata.co.id/datapublish/2021/01/06/jumlah-peserta-bpjs-kesehatan-capai-2225-juta-orang-hingga-2020> Accessed on March 15, 2021.
- Katadata. 2019. Sri Mulyani Explains Four Causes of the BPJS Financial Deficit. Retrieved from <https://katadata.co.id/agustiyanti/finansial/5e9a5033ad096/sri-mulyani-beberkan-empat-penyebab-defisit-bpjs-keuangan> Accessed on March 15, 2021.
- Katadata. 2018. At the end of September 2018, BPJS Health Deficit 7.95 trillion rupiah. Retrieved from <https://databoks.katadata.co.id/datapublish/2018/10/31/akhir-september-2018-bpjs-kesehatan-defisit-rp-795-triliun> . Accessed on March 15, 2021
- Kim, M. S. Institutional Varieties of Productivist Welfare Capitalism in East Asia.

Dissertation on University of Pittsburgh.

- Kim, M. S. 2015. "Institutional Variation in Productive Capitalism." In Kim, Mason M. L. *Comparing Welfare Capitalism in East Asia: Productivist Models of Social Policy*. UK: Palgrave MacMillan, pp. 18-45.
- Kwon, Huck-ju. 2009. "The Reform of Developmental Welfare States in East Asia." *International Journal of Social Welfare*, 18: S12-S21.
- Pisani, E., Kok, M.O., Nugroho, K. 2017. Indonesia's road to universal health coverage: a political journey. *Health Policy and Planning*, 32 (2): 267-276.
- Samboh, Ester. 2017. High Noon for Jokowi's Social Welfare Ambitions. Retrieved from <https://www.thejakartapost.com/academia/2017/01/12/commentary-high-noon-for-jokowis-social-welfare-ambitions.html> . Accessed on March 15, 2021.
- Wiseman, V., Thabrany, H., Asante, A., Haemmerli, M., Kosen, S., Gilson, L., Mills, A., Hayen, A., Tangcharoensathien, V., Patcharanarumoi, W. 2018. An evaluation of health system equity in Indonesia: study protocol. *International Journal of Equity in Health*, 17 (138) : 1-9.
- World Bank. 2017. Towards a Comprehensive, Integrated, and Effective Social Assistance System in Indonesia.
- World Bank. 2018. The World Bank in Indonesia: Overview. Retrieved from <https://www.worldbank.org/en/country/indonesia/overview> . Accessed on January 10, 2019.
- Yang, Nan. 2017. "East Asia in transition: Re-examining the East Asian Welfare Model Using Fuzzy Sets." *Journal of Asian Public Policy*, 10 (1): 104-120.
- Yuda, T. K. 2018. Welfare regime and the patrimonial state in contemporary Asia: visiting Indonesian cases. *Journal of Asian Public Policy*. DOI: 10.1080/17516234.2018.1462685
- Yuda, T. K. 2018b. Welfare Regime Transformation in Indonesia: A Citizenship Debate. *Masyarakat Jurnal Sosiologi*, 23(2): 143-165.