International Labour Organization

Social protection assessment based national dialogue:

Towards a nationally defined social protection floor in Indonesia

Description of existing social security and social protection schemes for each of the four social protection floor guarantees, identification of policy gaps and implementation issues, recommendations, rapid costing exercise to estimate the cost of completing the social protection floor

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In addition to the two authors, Tauvik Muhamad (ILO) supported the assessment process.

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Foreword

The social protection floor (SPF) is a basic set of social security guarantees that should be guaranteed to all the population. In line with the Social Protection Floors Recommendation, 2012 (No. 202), which was adopted by the International Labour Conference (ILC) at its 101st session in June 2012, Indonesia strives towards the extension of social security coverage and the establishment of at least a social protection floor for all. The right to social security for all is reflected in the Indonesian Constitution, in the National Social Security Law (Law No. 40/2004) and the recent Law on Social Security Providers (Law No 24/2011). Indonesia's commitment to social protection is also reflected in the tripartite Indonesian Jobs Pact 2011-2014, which was signed on 13 April 2011.

Over the past year the International Labour Organization (ILO) in close collaboration with Bappenas conducted an assessment of the social protection situation in Indonesia with an aim to know whether the social protection floor is a reality for the whole population. The assessment exercise was based on a number of consultations with all relevant ministries, institutions, workers' and employers' representatives at both the provincial and national levels, and United Nations (UN) agencies participating in Indonesia's UN sub-working group on the SPF. Despite the already advanced development of social protection in Indonesia, which includes both contributory and non-contributory schemes for workers and their families in the formal and informal sectors, a number of policy gaps and implementation issues were identified and some specific policy recommendations were formulated to complete the social protection floor. We also calculated and projected the cost of these policy recommendations and expressed this cost as a percentage of Gross Domestic Product (GDP) and government expenditures. These cost calculations provide preliminary indications of the affordability of the recommended social protection provisions.

We hope that the results of the assessment exercise and particularly the policy recommendations presented in this report will provide useful guidance in the development of a plan for completing the social protection floor in Indonesia and that some of these recommendations will be translated into action. We are confident that the participatory approach that was adopted throughout the exercise has contributed to raise awareness among line ministries, workers' and employers' representatives, civil society organizations (CSOs), and UN agencies on the social protection floor concept, its relevance for Indonesia, and the importance of a coordinated, holistic approach to social protection development.

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Executive Summary

Indonesia strives to extend social protection coverage to the entire population. Since its amendment in 2002, the Indonesian Constitution recognizes the right to social security for all, and the responsibility of the State in the development of social security. Though the existing social protection schemes tend to be fragmented and scattered, progress is taking place towards a more comprehensive provision of social protection coverage.

An important milestone is the progressive implementation of the National Social Security Law (Law No. 40/2004 regarding the National Social Security System). The law mandates the extension of social security coverage to the whole population in the categories of health, work injury, old age, and death of the breadwinner. The Law follows a staircase approach with non-contributory schemes for the poor, contributory schemes for the self-employed, and statutory social security schemes for formal sector workers. Universal health insurance under the Law on Health Social Security Providers (BPJS Kesehatan (BPJS I)) is expected to commence in 2014, while other schemes, under the Law on Workers' Social Security Providers (BPJS Ketenagakerjaan (BPJS II)), are anticipated to start in 2015. On the social assistance front, efforts to extend coverage to reach the poorest and most vulnerable populations and to better coordinate among various programmes are in progress.

The social protection floor concept was articulated in the ILO's Social Protection Floors Recommendation, 2012 (No. 202), which was adopted by an overwhelming majority of government, employer, and worker delegates of the ILO's 185 member States at the International Labour Conference in June 2012. Reaffirming that social security is a human right and a social and economic necessity, the Recommendation sets out that countries should establish and maintain national social protection floors. The Recommendation provides guidance to countries in establishing and maintaining national social protection floors as a fundamental element of comprehensive social security systems. In addition, the Recommendation offers direction in developing extension strategies that progressively ensure higher levels of social security to as many people as possible and as soon as possible, reflecting national objectives, economic and fiscal capacities, and guided by other ILO social security standards.

The social protection floor constitutes of a set of nationally-defined basic social security guarantees, that enable and empower all members of a society to access a minimum of goods and services at all times. The social protection floor aims to achieve a situation where: (1) all residents have access to affordable essential health care, including maternity care; (2) all children receive basic income security providing access to nutrition, education, care and any other necessary goods and services; (3) all persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability, receive basic income security and (4) all residents in old age receive basic income security through pensions or transfers in kind.

The components of the social protection floor are flexible to be aligned with the development of the national social protection system. The four guarantees set minimum performance standards with respect to the access, the scope and the level of income security and health care rather than prescribing a specific architecture of national social protection systems. While not all countries will be able to immediately put in place all components for the whole population, the social protection floor provides a framework to plan a progressive implementation that ensures a holistic vision of the social protection system and that exploits synergies and complementarities between different components.

The social protection floor framework can be used to describe existing social security, social protection, and poverty alleviation programmes, identify policy gaps and implementation issues, and draw recommendations for the further design and implementation of social protection provisions in order to guarantee at least the social protection floor to all the population. The cost of the proposed social protection provisions is then estimated and projected over a ten-year period. This costing exercise can serve as a basis for discussions on the fiscal space and government budget reallocations and in turn help to prioritize between possible social protection policy options.

Assessment process

From April 2011 to November 2012, the ILO, in close collaboration with relevant line ministries and the UN sub-working group on the social protection floor in Indonesia, engaged line ministries, UN agencies, social partners, civil society organizations, academia, and other relevant stakeholders to assess the social protection situation, identify policy gaps and implementation issues, and draw appropriate policy recommendations for the achievement of a comprehensive social protection floor in Indonesia.

This policy dialogue—called the assessment based national dialogue (ABND) exercise—consisted of the following steps:

STEP 1 – Development of the assessment matrix

The assessment matrix describes existing social security schemes that provide access to health care and guarantee income security for children, the working age, the elderly and people with disabilities. The inventory identifies policy gaps, implementation issues and potential policy recommendations for social protection provisions with a goal of closing gaps in the social protection floor.

STEP 2 – Costing using ILO Rapid Assessment Protocol (RAP)

Specific social protection provisions that need to be introduced or further expanded identified during the assessment process are then translated into "costable" scenarios. The costs of these provisions are calculated and projected over the 2012-2020 period. This cost is expressed as a percentage of Gross Domestic Product (GDP) and government expenditures in order to provide preliminary indications of the affordability of the proposed social protection provisions.

STEP 3 – Finalization and endorsement

The results of the costing exercise and the next steps, including the identification of possible measures to increase the fiscal space for social protection, are discussed with all stakeholders in the framework of workshops. A report detailing the costing results and policy recommendations is produced and shared with the Government of Indonesia.

Main results of the assessment

During the development of the assessment matrix we found some common gaps and issues across programmes: limitation of coverage, limited access to social services particularly in eastern parts of Indonesia, limited linkages between social protection programmes and employment services, almost no social security for workers in the informal sector, high social security evasion in the formal sector, data limitation and targeting issues, as well as issues of coordination and overlaps among programmes.

Based on this assessment, the main policy recommendations include:

- Design and pilot a Single Window Service (SWS) for social protection programmes at the local level, which would provide information to potential beneficiaries on guarantees and services, facilitate registration

processes, update beneficiaries' databases, facilitate the appeals mechanisms, and improve coordination among programmes;

- Ensure that the health care package has an adequate level of protection;
- Extend the coverage of Program Keluarga Harapan (PKH), a cash transfer programme that facilitates access to nutrition, education, and care for children from poor families;
- Support the implementation of BPJS Kesehatan (BPJS I) and BPJS Ketenagakerjaan (BPJS II);
- Conduct a feasibility study for unemployment insurance with links to employment and skills programmes;
- Extend the coverage of programmes for vulnerable elderly and for people with severe disabilities;
- Develop a comprehensive database of individuals in target groups such as people with disabilities.

For each of the SPF guarantees (access to health care and income security for children, the working age, people with disabilities, and the elderly), policy recommendations were translated into specific social protection policy options called "scenarios". We estimate that the additional SPF provisions identified that would complete the social protection floor in Indonesia and guarantee income security across the life cycle would cost between 0.74 per cent and 2.45 per cent of GDP by 2020.

HEALTH - Closing the SPF gap for health care is estimated to cost between 0.17 per cent of GDP ("low" scenario) and 0.98 per cent of GDP ("high" scenario) by 2020. Both low and high scenarios for health correspond with health care packages currently being developed within the implementation framework of the BPJS Kesehatan (BPJS I).

- The "low scenario" includes the extension of a third-class moderate level health insurance benefit package for the poor, near poor, and vulnerable (bottom 40th percentile by income), Human Immunodeficiency Virus (HIV) testing for the most-at-risk populations, regular check-ups for all people living with HIV (PLWHIV), antiretroviral (ARV) treatment for those who are eligible, and the introduction of a universal package to reduce mother to child transmission (MTCT) for HIV and Syphilis.
- The "high scenario" includes the extension of a first class-high level health insurance benefit package to the entire informal economy population, the inclusion of HIV testing for the general sexually active population (age 15-49), regular check-ups for all PLWHIV, ARV treatment for those who are eligible, and the introduction of a universal package to reduce mother to child transmission (MTCT) for HIV and Syphilis.

INCOME SECURITY FOR CHILDREN - Closing the SPF gap for children is estimated to cost between 0.03 per cent of GDP ("low" scenario) and 0.18 per cent of GDP ("high" scenario) by 2020.

- The "low scenario" includes the expansion of the current Program Keluarga Harapan (PKH) programme to cover all poor households.
- The "high scenario" includes a universal child allowance for all children. The proposed allowance is similar to the current PKH benefit for primary school students.

INCOME SECURITY FOR THE WORKING AGE POPULATION - Closing the SPF gap for working age population through the establishment of a public works programme linked with vocational training is estimated to cost around 0.47 per cent of GDP by 2020.

- More detailed feasibility studies of unemployment insurance schemes and of a Single Window Service need to be conducted. In addition, a roadmap for the implementation of BPJS Ketenagakerjaan (BPJS II) needs to be developed with all actors involved.

INCOME SECURITY FOR THE ELDERLY AND PEOPLE WITH SEVERE DISABILITIES - Closing the SPF gap for the elderly and people with severe disabilities is estimated to cost between 0.08 per cent of GDP ("low" scenario) and 0.82 per cent of GDP ("high" scenario) by 2020.

- The "low scenario" includes the extension of the existing non-contributory pension scheme for all persons with severe disabilities and all vulnerable elderly.
- The "high scenario" includes the extension of the existing non-contributory pension scheme for all persons with severe disabilities and the establishment of a universal pension for old age covering people 55 years of age (the legal retirement age in the formal sector) and older.

We hope that the policy recommendations entailed in this document will be further explored by the Government of Indonesia and support on-going policy reforms.

Abbreviations

ABND	Assessment Based National Dialogue
AIDS	Acquired Immunodeficiency Syndrome
APBN	Anggaran Pendapatan dan Belanja Negara (State Budget)
APINDO	Asosiasi Pengusaha Indonesia (the Employers' Association of Indonesia)
ART	Anti-Retroviral Treatment
ARV	Antiretroviral
ASKESOS	Program Asuransi Kesejakteraan Sosial (Social Welfare Insurance Programme)
BAPPENAS	Badan Perencanaan dan Pembangunan Nasional (Ministry of Planning and Development)
BLK	Balai Latihan Kerja (Vocational Training Centre)
BLT	Bantuan Langsusng Tunai (Unconditional Cash Transfer)
BOS	Bantuan Operasional Sekolah (School Operational Assistance)
BPJS	Badan Penyelenggara Jaminan Sosial (Law on Social Security Provider)
BPJS I	Badan Penyelenggara Jaminan Sosial Kesehatan (Health Insurance Provider)
BPJS II	Badan Penyelenggara Jaminan Sosial Ketenagakerjaan (Workers' Social Security Provider)
BPS	Badan Pusat Statistik (Central Bureau of Statistics)
BSM	Beasiswa untuk Siswa Minskin (Scholarship for Poor Students)
BULOG	Badan Urusan Logistik (Central Logistic Agency)
CBG	Case Based Group
CCT	Conditional Cash Transfer
CD4	Cluster of Differentiation 4
CSO	Civil Society Organization
CTC	Close to Client
DJSN	Dewan Jaminan Sosial Nasional (National Social Security Council)
DPLK	Dana Pensiun Lembaga Keuangan (Financial Institution for Pension Fund)
DPPK	Dana Pensiun Pencari Kerja (Job Seekers' Pension Fund)
DRG	Diagnosis Related Group
EAST	Education and Skills Training for Youth Employment
FAO	Food and Agriculture Organization of the United Nations
G20	Group of Twenty (G-20) Finance Ministers and Central Bank Governors
GDP	Gross Domestic Product
Gini coefficient	A measure of the inequality of a distribution, a value of 0 expressing total equality and a value of 1 maximal inequality
HIV	Human Immunodeficiency Virus
IDR	Indonesian Rupiah (1 US $ = approx. IDR 8,500)
ILC	International Labour Conference

ILO	International Labour Organization
IMF	International Monetary Fund
INA-CBG	Indonesia-Case Based Group
INA-DRG	Indonesia-Diagnosis Related Group
Jamkesda	Jaminan Kesehatan Daerah (Health Insurance for the Poor—provided by local governments)
Jamkesmas	Jaminan Kesehatan Masyarakat (Health Insurance for the Poor—provided by the national government)
Jampersal	Jaminan Persalinan (Delivery Guarantee/Benefit)
JHT	Jaminan Hari Tua (Jamsostek Old Age Benefits)
JK	Jaminan Kematian (Jamsostek Death Benefits)
JKA	Jaminan Kesehatan Aceh
JKK	Jaminan Kecelakaan Kerja (Jamsostek Occupational Injury Benefits)
JPS	Jaminan Pengaman Sosial (Social Safety Net Programme)
JSLU	Jaminan Sosial Lanjut Usia (Cash Transfer for Vulnerable Elderly)
JSPACA	Jaminan Sosial Penyandang Cacat (Cash Transfer for People with Severe Disability)
KPA	Komisi Penanggulangan AIDS
KSBSI	Indonesia Prosperity Labour Union Confederation
KSPI	All Indonesia Trade Union Confederation
KSPSI	Confederation of Indonesian Trade Unions
KUR	Kredit Usaha Rakyat (Credit for the People)
LHK	Jamsostek Luar Hubungan Kerja (Outside Working Relationship)
MARP	Most-at-risk Population
Menko Kesra	Coordinating Ministry of People's Welfare
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOMT	Ministry of Manpower and Transmigration
MOSA	Ministry of Social Affairs
MTCT	Mother To Child Transmission (of HIV)
NGO	Non-Governmental Organization
NTT	Nusa Tenggara Timur province
OHCHR	Office of the High Commissioner for Human Rights
P2KP	Program Penanggulangan Kemiskinan di Perkotaan (Rural Poverty Alleviation Programme)
PKH	Program Keluarga Harapan (Conditional Cash Transfer)
PPA-PKH	Pengurangan Pekerja Anak untuk Mendukung Program Keluarga Harapan (Child Labour Reduction Programme in Support to the PKH)
PKSA	Program Kesejahteraan Sosial Anak (Children Social Welfare Programme)
PLWHIV	People Living with HIV
PMTAS	Program Makanan Tambahan Anak Sekolah (School Feeding Programme)
PNPM	Program Nasional Pemberdayaan Masyarakat (Community Empowerment Programme)
PPK	Program Pengembangan Kecamatan (Sub-district Development Programme)

PPLS	Pendataan Program Perlindungan Sosial (Survey designed for Social Protection Programmes)
PPP	Purchasing Power Parity
PT	Perseroan Terbatas (Limited Liability Company)
PWP	Public Works Programmes
RAP	Rapid Assessment Protocol
Raskin	Beras untuk Orang Miskin (Rice for the Poor)
RPJM	Rencana Pembangunan Jangka Menengah (Medium Term Development Plan)
SD	Sekolah Dasar (Primary School / Grade 1-6)
SJSN	Sistem Jaminan Sosial Nasional (National Social Security System)
SME	Small and Medium Enterprise
SMERU	Independent Research Institute
SMP	Sekolah Menegah Pertama (Junior Secondary School/grade 7-9)
SPF	Social Protection Floor
SSM	Subsidi untuk Siswa Miskin (Subsidies for Poor Students)
SWS	Single Window Service
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team for the Acceleration of Poverty Alleviation)
TKPK	Tim Koordinasi Penanggulangan Kemiskinan (Coordinating Team for Poverty Reduction)
TVET	Technical and Vocational Education and Training
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	UN Refugee Agency
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNRWA	United Nations Relief and Works Agency
USD	United States Dollars
VCT	Voluntary Counseling and Testing
WFP	United Nations World Food Programme
WHO	World Health Organization
WMO	World Meteorological Organization

Introduction

I

Indonesia strives towards the extension of social protection coverage to the entire population. Since its amendment in 2002, the Indonesian Constitution recognizes the right to social security for all and the responsibility of the State in the development of social security policy.

Social protection is not only considered a right but also a precondition to sustainable economic development and growth with equity. Social protection plays a key role in developing a productive, educated, skillful, and healthy workforce in the country. Indonesia's Medium Term Development Plan (2010-2014) prioritizes the further development of existing programmes and schemes that will guarantee access to health care for the whole population, access to education and nutrition for families with children, job opportunities and progressively sustainable income for the working age population, and a minimum income security for vulnerable populations, such as the elderly and the disabled with no family support (Presidential Regulation No. 5/2010 Regarding the Medium Term Development Plan (RPJM) 2010-2014).

Today, there are several national and local level social protection programmes in place providing health and income security to various groups in Indonesia. For example, more than half of Indonesia's population has access to health care both through contributory and non-contributory social health protection schemes. The non-contributory health insurance scheme, Jamkesmas, covers 32 per cent of the population, including the poor and near poor. The school assistance programme, Bantuan Operasional Sekolah (BOS), provides block grants to schools with the aim of guaranteeing free basic education through grade nine. The PKH conditional cash transfer and Scholarship programme for the poor further facilitate access to education, nutrition, and health care for poor children.

In addition to the large-scale national programmes, there are also several smaller scale programmes targeting people with disabilities, abandoned children, and vulnerable elderly. The community empowerment programme, Program Nasional Pemberdayaan Masyarakat (PNPM), supports both rural and urban communities in the design and implementation of their own community-level development plans, which may include income generating activities, small scale infrastructure development, and social services for their populations. Additionally, microcredit programmes provide some micro-entrepreneurs access to credit.

The Government classifies existing anti-poverty programmes into three clusters. Cluster 1 contains cash and in kind transfer social assistance programmes. Cluster 2 includes community empowerment programmes. Cluster 3 contains programmes that support the creation and development of small and medium enterprises, such as microfinance programmes (Presidential Regulation No. 5/2010 regarding the Medium Term Development Plan (RPJM) 2010-2014).

The Government of Indonesia also prioritizes the further development of social security systems through the progressive implementation of the National Social Security Law (Law No. 40/2004 regarding National Social Security System). Law No. 40/2004 mandates the extension of social security coverage to the whole population in the areas of health, work injury, old age, and death of the breadwinner. The Law follows a staircase approach with non-contributory schemes for the poorest, contributory schemes (with nominal contributions) for the self-employed and informal economy workers, and statutory social security schemes (with contributions set as a percentage

of wages) for formal sector workers. Some of the necessary supporting regulations, including the Law on Social Security Providers (BPJS), have been enacted while other regulations are in the formulation process. For example, the universal health insurance under the Law on Health Social Security Providers (BPJS I) is expected to go into effect in 2014 while other schemes, under the Law on Workers' Social Security Providers (BPJS II) are to materialize in 2015. At the time of writing this report, the formulation of supporting regulations and roadmaps necessary for the implementation of the BPJS Law was under way.

Indonesia's commitment to social protection is also reflected in the tripartite Indonesian Jobs Pact 2011-2014, which was signed on 13 April 2011 (Indonesian Jobs Pact, 2011). The Indonesian Jobs Pact 2011-2014 prioritizes job creation and social protection in response to the recent global economic crisis and supports further socioeconomic development in general.

The social protection floor framework, promoted by the UN and the G20, is a relevant tool both to describe social security, social protection and poverty alleviation programmes and to identify priority programme options for future implementation in Indonesia. The framework also helps to identify ways to enhance policy coherence across programmes, reduce fragmentation and increase efficiency through better targeting mechanisms. Finally, the approach encourages stakeholders to search for synergies with other strategies, to reduce vulnerabilities of the poor, and to improve the welfare of the whole population.

Context

2

2.1. The national context

2.1.1. An increased priority for social protection

Prior to 1997, Indonesia was ranked as a high performing Asian economy (World Bank, 1993) with an average GDP growth rate of 7.4 per cent per year. Social protection was not a government priority and government social spending was concentrated on social services (Suryahadi and Sumarto, 2002).

The Asian financial crisis in 1997 revealed the vulnerability of the Indonesian economy and the importance of social protection for the whole population. Unemployment, dramatic declines in real wages, and other economic challenges, sent 25 per cent of the Indonesian non-poor population into poverty (World Bank, 2006). In response to the crisis, the government launched the first nationwide social safety net programme, Jaminan Pengaman Sosial (JPS), in 1998. The programme provided subsidized staple foods, basic education, basic health services, employment opportunities through public works projects, and revolving credit funds.

Following the recovery from the 1997 crisis, Indonesia experienced strong economic growth and a steadily declining poverty rate. The national poverty rate[1] fell from 24.23 per cent in 1998 to 11.96 in 2012 (BPS, 2012). On average, per capita consumption over the period 1996 to 2010 grew by 1.4 per cent. Unfortunately, this growth has not been equitable. While the richest ten per cent on average enjoyed more than 1.7 per cent growth in per capita consumption, the poorest ten per cent experienced only 0.6 per cent growth in consumption over the same period (World Bank, 2011a). To further support this point, inequality, as measured by the (national real) Gini coefficient, has increased from 0.32 in 1996, to 0.34 in 2007, and further to 0.41 in 2011.

At present, extreme poverty — defined as living on Purchasing Power Parity (PPP) of one US dollar (USD) per day or less — is relatively low in Indonesia. However, 43.3 per cent of the population is on the brink of poverty, living on PPP two USD or less per day (World Bank, 2011a). A recent analysis of income and consumption data indicates that Indonesian households face a significant risk of moving into poverty: 38 per cent of poor households in the study in 2004 were not considered poor in 2003 (World Bank, 2006).

Against this backdrop, Indonesia has seen major progress in the last decade towards the extension of social security for all through two important milestones: the amendment to the 1945 Constitution regarding the extension of social security to the entire population and the enactment of Law No. 40/2004 regarding National Social Security System, Sistem Jaminan Sosial Nasional (SJSN). The social security law is designed to create a social security system covering all Indonesian workers and their dependents in both the formal and informal economy.

1 The national poverty rate is calculated based on the proportion of people in the country who fall under the poverty line. The poverty line is defined by the *National Bureau of Statistics* as the "*value of per capita expenditure per month to provide basic food and non-food needs*." Given the size and diversity of the country, the poverty line is set at different levels for different provinces and for urban and rural areas in each province. The average national poverty line in 2011 is at IDR 211,000.

This showcases the government's commitment to social protection for all. The latest development towards the implementation of SJSN was the enactment of Law no. 24/2011, which mandates the transformation of the four existing social security providers (PT Askes, PT Jamsostek, PT Taspen, and PT Asabri) into two providers: BPJS Kesehatan (BPJS I) for health insurance and BPJS Ketenagakerjaan (BPJS II) for workers' social security. BPJS I will commence operations in early 2014 and implementation of BPJS II is planned for mid-2015.

2.1.2 Overview of existing schemes

The existing social protection system principally comprises of social security schemes and a tax-financed social assistance system (public welfare) as part of a broader set of antipoverty programmes and government subsidies.[2] Existing schemes and programmes tend to be fragmented and scattered under different ministries, including Health, Education, Manpower and Transmigration, Social Affairs, Home Affairs, among others.

2.1.2.1 Social security schemes

Social security schemes are primarily managed by four state-owned limited liability companies or Perseroan Terbatas (PT):[3]

1. PT Jamsostek is the social insurance fund for private sector employees. It provides four schemes: employment injury, death, health insurance, and an old age provident fund.
2. PT Taspen manages the civil servants' retirement lump sum and pension programme.
3. PT Askes provides health insurance coverage for civil servants and retired military personnel.
4. PT Asabri provides lump sum retirement benefits and pensions as well as death and occupational injury insurance for the armed forces and the police.

Table 1. Social security schemes

Target group	Types of benefits	Institution	Supervisory Ministries
Armed forces and police	Lump sum old age benefit, pension, death, work Injury, disability	PT Asabri	Ministry of Defense Ministry of State-Owned Enterprises
	Health Care	Armed forces hospitals PT Askes (for the retired)	Ministry of Defense
Civil servants	Lump sum old age benefit, pension, death, disability	PT Taspen	Ministry of Finance
	Health Care	PT Askes	Ministry of Health, Ministry of State-Owned Enterprises, Ministry of Finance
Private sector employees	Lump sum old age benefit, death, work injury	PT Jamsostek	Ministry of Manpower & Transmigration, Ministry of State-Owned Enterprises
	Health Care	PT Jamsostek (optional)	

2 In some literature government subsidies are not included in as part of a social protection system. Controversies exist over commodity subsidies, particularly those accruing mainly to non-poor groups (such as fuel and electricity).

3 The four State-owned limited liability companies will be transformed into two social security providers (BPJS), BPJS Kesehatan (health) on 1 January 2014 and BPJS Ketenagakerjaan (workers) on 1 July 2015 according to Law No. 24/2011.

The bulk of informal sector workers are left with almost no social protection. To a limited extent, Program Asuransi Kesejakteraan Sosial (Askesos), administered by the Ministry of Home Affairs, provides income replacement benefits to a few groups of informal workers such as street vendors and micro-entrepreneurs. There are also other small-scale pilot programmes such as the Jamsostek pilot programme for informal sector workers, Jamsostek **Luar Hubungan Kerja** (LHK), which provides work injury, old age, health care, and death insurance.

2.1.2.2 Social assistance and subsidies

Social assistance is provided through a number of social welfare programmes providing access to education, health care, food security, social infrastructure, and employment opportunities. The programmes are implemented by various line ministries.

Government subsidies, both universal and targeted, include universal energy subsidies (fuel and electricity) and non-energy subsidies (rice for the poor, fertilizer, seed, microcredit, soybean, cooking oil among other things), which are targeted to certain categories of the population.

The 2010-2014 Medium Term Development Plan (in Presidential regulation No. 5/2010) sharpens the policy focus on poverty alleviation, aided in part by the Government's shift from funding universal fuel subsidies to targeting social protection programmes. Presidential Regulation No. 15/2010 moved the coordinating authority for the management and practices of national poverty alleviation to the Vice President's Office in order to create multi-sector synergies and to synchronize poverty alleviation paradigms and agendas under the different ministries. With this transformation, the coordinating team for poverty reduction, Tim Koordinasi Penanggulangan Kemiskinan (TKPK), was changed into a national team for poverty reduction acceleration, Tim Nasional Percepatan Penanggulangan Kemiskinan (TNP2K).

Coordination of poverty alleviation programmes is organised in three clusters as follows:

1. The social assistance cluster aims to fulfil the basic needs of the poor and targets household units. Programmes included in this cluster are health insurance for the poor (Jamkesmas), rice subsidy for the poor (Raskin), conditional cash transfers (PKH), scholarships for the poor and social assistance for the disabled, the vulnerable elderly and abandoned children.
2. The community empowerment cluster is intended to improve income among the poor through community involvement in the development process. The Program Nasional Pemberdayaan Masyarakat (PNPM) is the main actor in this cluster.
3. The small and micro-enterprise empowerment cluster aims to support the development of small and micro-enterprises through access to credit. The main instrument of this cluster is the Kredit Usaha Rakyat (KUR) programme.

Table 2. Social assistance and subsidies

Target group	Types of benefits	Institution	Supervisory Ministries
Poor households	Free health care	Jamkesmas	Ministry of Health
	Subsidized rice	Raskin	Ministry of Welfare (coordinating ministry)
	Conditional cash transfer for households with children	PKH, PKSA	Ministry of Social Affairs
	Cash assistance (IDR 300,000 per month) for people with severe disabilities	JSPACA	Ministry of Social Affairs
	Cash assistance (IDR 300,000 per month) for vulnerable elderly	JSLU	Ministry of Social Affairs
	Scholarships for poor students	Scholarships for the poor	Ministry of Education
Poor communities	Block grants to communities to develop social and physical infrastructure at sub-district and village levels	PNPM	Ministry of Welfare (coordinating ministry), Ministry of Home Affairs (rural PNPM), Ministry of Public Works (urban PNPM)
Small and micro enterprise	Small and micro enterprise empowerment through micro-credit programme	KUR	Ministry of Economy (coordinating ministry)[4]
Universal	Free childbirth care	Jampersal	Ministry of Health
	Block grants to schools	BOS	Ministry of Education

2.1.3. The legal framework

Table 3. Legal framework

Scheme or programme (main benefits)	Legal Framework
PT JAMSOSTEK (Work injury, death, old age benefit for formal sector)	• Law No. 3/1992 on Workers' Social Security • Government Regulation No. 14/1993 on Workers' Social Security Programme
PT JAMSOSTEK (Health for formal sector)	
PT ASKES (Health for civil servants, retired civil servants, retired military and veterans)	• Government Regulation No. 69/1991 regarding Health Care for Civil Servants, Pensioners, Veterans, National Patriots and their Dependents • Government Regulation No. 28/2003 regarding Government Subsidy and Contribution to Civil Servants' Health Insurance
JAMKESMAS (Health Insurance for the	• Law No. 11/2009 on Social Welfare • Law No. 36/2009 on Health

4 In coordination with the Ministry of Cooperation and SMEs, Ministry of Agriculture, Ministry of Industry, Ministry of Forestry, and other relevant agencies (see information on KUR distribution mechanism in http://www.depkop.go.id/index.php?option=com_content&view=article&id=351)

Scheme or programme (main benefits)	Legal Framework
poor provided by the national government)	• Minister of Health Decree No. 686/2010 on Jamkesmas Implementation Guidelines
JAMPERSAL (Universal delivery care)	• Law No. 11/2009 on Social Welfare • Law No. 36/2009 on Health • Minister of Health Decree No. 2562 /2011 regarding the Technical Guidelines of Jaminan Persalinan (Jampersal) Programme
PT TASPEN (Pension and old age savings for civil servants)	• Law No. 11/1969 regarding Pension for Employees [Civil Servants] and Employees' Widow/Widower • Government Regulation No. 25/1981 regarding Social Insurance for Civil Servants
PT ASABRI (Pension and old age savings for military and armed forces)	• Government Regulation No. 67/1991 on Social Insurance for the Armed Forces
PT JAMSOSTEK (Health, work injury, death and old age for informal economy workers)	• Law No. 3/1992 on Workers' Social Security • Labour Law No. 13/2003 • MOMT Minister Regulation No. 24/2006 on the Implementation Guidance of Social Security Programme for workers outside working relationship
ASKESOS (Social welfare insurance for informal workers)	• Law No. 11/2009 on Social Welfare • Ministerial Decree No. 51/2003 regarding Social Security Programme for Poor and Vulnerable People through Social Welfare Insurance and Permanent Social Welfare Assistance Methods
BOS (School operational assistance for primary and lower secondary school)	• Law No. 20/2003 on National Education System • Government Regulation No. 47/2008 regarding Compulsory Basic Education • Government Regulation No. 48/2008 regarding Education Financing • Minister of National Education Regulation No. 37/2010 regarding the Technical Guidance of the Utilization of BOS Budget in the 2011 Budget Year.
(BSM)/(SSM) (Scholarships for poor students)	• Law No. 20/2003 on National Education System • Government Regulation No. 47/2008 regarding Compulsory Basic Education • Government Regulation No. 48/2008 on Education Financing
PKH (Conditional cash transfer)	• Law No. 11/2009 on Social Welfare • Presidential Instruction No. 3/2010 on Socially Just Development Programme
RASKIN (Rice subsidy for the poor)	• Law No. 11/2009 on Social Welfare • Decree of the Coordinating Minister for Social Welfare No. 35/2008 regarding Raskin Coordination Team
PNPM (Community empowerment programme)	• Law No. 11/2009 on Social Welfare • Presidential Instruction No. 3/2010 on Socially Just Development Programme • Decree of the Coordinating Minister for Social Welfare No. 25/2007 on Guideline of PNPM Mandiri
KUR (Microcredit, with	• Law No. 11/2009 on Social Welfare • Presidential Instruction No. 3/2010 on Socially Just Development

Scheme or programme (main benefits)	Legal Framework
government subsidized guarantee scheme)	Programme • Presidential Instruction No. 6/2007 on the Development of the Real Sector and SME Empowerment • Finance Minister Regulation No. 135/2008 on the Facilitation of the Guarantee for KUR
JSPACA (Assistance for people with severe disabilities)	• Law No. 11/2009 on Social Welfare • Law No. 4/1997 on Persons with Disabilities • Government Regulation No. 43/1998 on Efforts to Improve the Social Welfare of Persons with Disabilities • Regulation of the Ministry of Finance's Director General of Treasury No. 20/2006 on Cash Disbursement for Severely Disabled People and for Vulnerable Elderly • Presidential Instruction No. 3/2010 on Socially Just Development Programme • Law No. 19/2011 on the ratification of UN Convention on the Rights of People with Disabilities
JSLU (Assistance for vulnerable elderly)	• Law No. 11/2009 on Social Welfare • Law No. 13/1998 on Welfare for Elderly People • Government Regulation No. 43/2004 on Efforts to Improve the Social Welfare of Elderly People • Regulation of the Ministry of Finance's Director General of Treasury No. 20/2006 on Cash Disbursement for Severely Disabled People and for Vulnerable Elderly • Presidential Instruction No. 3/2010 on Socially Just Development Programme
PKSA (Children's Social Welfare Programme)	• Law No. 11/2009 on Social Welfare • Law No. 4/1979 on Child Welfare • Law No. 23/2002 on Child Protection • Decree of the Minister of Social Affairs No. 15/2005 on General Guidelines for PKSA Implementation • Presidential Instruction No. 3/2010 on Socially Just Development Programme

Note that the legal framework above covers programmes that are running at the time of the writing of this report and does not include the SJSN Law and its supporting regulations which are expected to be implemented at a later stage.

See annexure 2 for international conventions ratified by Indonesia, which are relevant to the four guarantees of the SPF. The table also lists national laws and policies that translate the conventions into national Law (Source: UNAIDS).

2.1.3.1 Workers' social security

The current Social Security Law is Law No. 3/1992 on Workers' Social Security.[5] It stipulates that every employee has the right to social security. Every enterprise is obliged to provide social security to its employees who perform work in an employment relationship, while the Government is responsible for a social security programme for workers outside employment relationships. Contributions for health, occupational injury, and death benefits are

5 Law No. 3/1992 will go through transformation based on Law No. 40/2004 and Law No. 24/2011.

borne by the employer, while contributions for old age benefits are shared between employers and employees. The Law covers the following social security contingencies: health, occupational injury, old age, and death benefits for workers as well as health benefits for workers and their dependents. Additionally, Law No. 13/2003 stipulates the provision of severance pay for workers.

2.1.3.2 Social security for private sector workers in the formal economy

Government Regulation No. 14/1993 on Workers' Social Security Programmes serves as an elaboration of Law No. 3/1992, particularly for formal private sector workers. This regulation stipulates that participation in Jamsostek's occupational injury, old age, and death benefits programmes is compulsory, while employers can opt out from Jamsostek's health insurance scheme as long as they provide higher benefits through an alternative system (i.e. private insurance or in-house health services).

2.1.3.3 Social security for civil servants and military personnel

Based on Government Regulation No. 69/1991, civil servants, retired civil servants, retired military and police personnel, veterans, and their dependents are entitled to health insurance managed by PT Askes. Contributions to PT Askes programme are borne jointly by workers and the government as stipulated in Government Regulation No. 28/2003. Active military and police personnel are provided with in-house health care through special military hospitals.

Civil servants, military, and police personnel are currently the only groups with access to a comprehensive defined-benefit pension system providing monthly pensions for retirees and survivors. Furthermore, they are entitled to an additional lump-sum old age savings payment received upon retirement. The pension and old age savings fund for civil servants is managed by PT Taspen as mandated by Government Regulation No. 25/1981). The pension, old age savings and social insurance programme for the military and police personnel is managed by PT Asabri as stipulated by Government Regulation No. 67/1991.

2.1.3.4 Social security for workers in the informal economy

Law No. 3/1992 has limited social security provisions for informal sector workers, stipulating that social security programmes for workers outside working relationships will be regulated further by government regulation (article 4, point 2). The Ministry of Manpower and Transmigration issued Ministerial Regulation No. 24/2006 on the Implementation Guidance of Social Security Programme for workers outside working relationship. Based on this regulation, a pilot project was established to expand social security coverage to informal economy workers through a voluntary scheme that is managed by Jamsostek. This scheme offers four benefits: health, work injury, death, and old age.

The progress in expanding coverage through the pilot project has been slow. Although there are 70 million workers in the informal sector, the total number of members only amounted to approximately 400,000 by 2010. The turnover of members in this programme is also very high. Members can sign up and leave the programme at any given time. Jamsostek concedes that the slow growth of the programme is due to issues in both supply and demand. Jamsostek's limited administrative and human resource capacities along with workers' lack of awareness and inability to pay contributions on a regular basis have kept participation rates at a low level (Jamsostek, 2010). Consultations at both the provincial and district levels show that most workers do not continue their membership once the subsidized pilot period is over.

The characteristics of jobs in the informal economy also make registration, compliance with payment of contributions and record keeping very challenging for Jamsostek. There is a need to further explore payment mechanisms and administrative methods that are more adapted to the constraints of informal economy workers as well as to design a benefit package that responds better to their needs.

The Ministry of Social Affairs, on the basis of Ministerial Decree No. 51/2003 regarding Social Security Programmes for Poor and Vulnerable People through Social Welfare Insurance and Permanent Social Welfare Assistance Methods, initiated the Askesos, a social welfare insurance programme. Askesos is an income replacement scheme for informal sector workers, providing modest one-off cash benefits to members in case of sickness, work injury or death. The Ministry selects local organizations to manage the funds of 150 or more members each (MoSA's Askesos implementation guideline, 2005). The Ministry provides IDR 30 million to the organization for 3 years and each member contributes IDR 5,000 per month to the organization. In case of sickness or injury, workers receive IDR 300,000 (maximum one claim per person per benefit per year). The death benefit amounts IDR 400,000 if the member dies in the first year of membership, IDR 600,000 if in the second year of membership or IDR 800,000 if death occurs in the third year of membership (MoSA, 2011). In 2011, the Askesos scheme covered 358,000 members and was administered through 1,790 social organizations in 33 provinces. Currently, the Askesos programme is working to be more in line with insurance principles, as mandated by regulations on social security. It is also attempting to improve the capacity of the implementing organizations through a partnership with PT Jamsostek.

2.1.3.5 Amendment of the 1945 Constitution and Law No. 40/2004 on social security

Efforts to reach a comprehensive and universal social protection system are marked by two important milestones in Indonesia: the amendment of the 1945 Constitution regarding the extension of social security to the entire population and the enactment of the National Social Security System Law (SJSN).

In 2002, the Government of Indonesia amended the Constitution regarding social security. Article 28 H, subsection 3, states, "Every person shall have the right to social security in order to develop oneself as a dignified human being," and article 34, subsection 2, states: "The State shall develop a social security system for all the people and shall empower the vulnerable and poor people in accordance with human dignity."

The National Social Security System Law (SJSN), enacted on 19 October 2004, is designed to create a social security system covering all Indonesian workers and their dependents in both the formal and informal economy with five separate programmes:

- **Health insurance** is provided to all people who pay contributions or, in the case of the poor, whose contributions are paid by the government. Participants who receive a wage (formal sector workers) will pay a contribution in percentage of wages, co-shared with their employers. Participants who do not receive a wage (informal sector and self-employed workers) will pay a nominal amount. Contributions for poor people will be paid by the government, also based on a nominal amount.
- **Work injury insurance** ensures that in case of work accidents or work-related illnesses, participants receive health services as well as lump sum cash compensation if the accidents or illnesses cause death or permanent disability. Contribution for wage workers is set at a percentage of wages and that of non-wage workers is a nominal amount.
- **Contributory old age savings benefits** are provided to workers who reach pension age or become disabled, and survivors of deceased workers or pensioners. The amount of benefit is determined by the total accumulated contributions plus the return on investment.
- **Contributory pension** provides fixed monthly benefits to workers who reach pension age or become permanently disabled, and survivors of deceased workers or pensioners. Participants are entitled to receive fixed monthly benefits after contributing for a minimum of 15 years. Should participants reach the age of retirement before having contributed for the minimum of 15 years, they would receive total accumulated contributions plus return on investment. This scheme is only available for wage workers and the contribution is set as a percentage of wages borne jointly by workers and their employers.
- **Life insurance** provides a lump sum benefit to the heirs of deceased workers. Contributions are made by employers in case of wage employment and are set as a nominal amount in case of non-wage employment.

The National Social Security Board (Dewan Jaminan Sosial Nasional (DJSN)) has the mandate to formulate general policies and synchronization of the implementation of the National Social Security System. The board is accountable to the President.

A recent development in the implementation of the social security system, as mandated by Law No. 40/2004, is the enactment of the Law on Social Security Providers (BPJS) in November 2011. The new law transforms the four State-owned insurance companies (PT Askes, PT Jamsostek, PT Taspen and PT Asabri) into two non-profit public entities—BPJS Kesehatan (Health) and BPJS Ketenagakerjaan (Employment)—working directly under the President's supervision. PT Askes will be transformed into BPJS Kesehatan (BPJS I), providing health insurance for all citizens and will start operations in January 2014. PT Jamsostek will be transformed into BPJS Ketenagakerjaan (BPJS II), providing employment injury insurance, old age savings, pension and death benefits, and will start operations by July 2015. The two other providers, PT Taspen and PT Asabri, are instructed by the BPJS Law to design a roadmap for their progressive transfer to BPJS II.

With a view to support the implementation of the Law on BPJS I, a working group of relevant stakeholders was established and came up with a roadmap for the achievement of universal health care coverage in Indonesia.

2.2 The global and regional contexts

In April 2009, the High Level Committee on Programmes of the UN Chief Executives Board adopted the social protection floor as one of its joint initiatives to face the global financial and economic crisis and to accelerate recovery, with the ILO and the WHO as lead agencies. This initiative supports countries to plan and to implement sustainable social protection schemes and essential social services. As this objective transcends the mandate of any single body or agency, the Initiative built a global coalition of UN agencies (FAO, OHCHR, UNAIDS, UNDESA, UNDP, UNESCO, UNFPA, UN-HABITAT, UNHCR, UNICEF, UNODC, UN Regional Commissions, UNRWA, WFP, WMO), the IMF and the World Bank, as well as development partners and leading NGOs.

At its 101st session (2012), the International Labour Conference adopted the Recommendation concerning National Floors of Social Protection, 2012 (No. 202) (Social Protection Floors Recommendation)[6] which reaffirms the role of social security as a human right and a social and economic necessity, and provides guidance to Members in building social protection floors within progressively comprehensive social security systems. The Recommendation was adopted almost unanimously (453 votes in favor and one abstention) after fruitful and constructive debate among constituents. Recognizing the crucial role of social protection in social and economic development, and notably in combating poverty, vulnerability, social exclusion and realizing decent work for all, the Conference also adopted the Resolution concerning efforts to make social protection floors a national reality worldwide,[7] which invites governments, employers and workers to jointly give full attention to implementing Recommendation No. 202 as soon as national circumstances permit.

Social protection floors are nationally defined sets of rights and transfers that enable and empowers all members of a society to access a minimum of goods and services at all times. By calling for both demand and supply side measures (transfers and services), the SPF takes on a holistic approach to social protection. The SPF calls for access to a minimum set of goods and services for all age groups, but with particular attention to the marginalized and vulnerable groups (such as ethnic minorities and people with disabilities). Once a social protection floor has been established, countries may then choose to progressively extend to their populations higher levels of social protection (e.g. by shifting from free primary education to free secondary and pre-primary education or by increasing levels of benefits through a mix of non-contributory and contributory schemes.)

6 www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_183326.pdf

7 ILO: "Resolution concerning efforts to make social protection floors a national reality worldwide", in Provisional Record No.14, International Labour Conference, 101st session (Geneva, 2012).

The SPF promotes income security through a basic set of guarantees that aim at a situation in which:

- all residents have access to a nationally defined set of essential health care services including maternity care that meets the criteria of availability, accessibility, acceptability, and quality;
- all children enjoy basic income security at least at the level of the nationally defined poverty line, ensuring access to nutrition, education, care, and any other necessary goods and services;
- all those in active age groups who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity, and disability, enjoy basic income security at least at the level of the nationally defined poverty line;
- all residents in old age enjoy basic income security at least at the level of the nationally defined poverty line.

Defining the components of the floor as guarantees creates the flexibility that makes the concept of a social protection floor compatible with all possible national social protection systems. The four guarantees set minimum performance or outcome standards with respect to the access, the scope and the level of income security and health care in national social protection systems rather than prescribing a specific architecture of national social protection systems. While not all countries will be able to immediately put in place all components for the whole population, the SPF provides a framework to plan a progressive implementation that ensures a holistic vision of the social protection system and that exploits synergies and complementarities between different components.

The SPF also serves as a tool for gender empowerment. Globally, women are disproportionately represented amongst the poor and the vulnerable. They face many legal and social constraints that limit their access to the labour market, productive assets, and better-remunerated work, or to equal remuneration with male counterparts. Women tend to be confined to more casual, insecure, and hazardous forms of work and self-employment, particularly in the informal economy, with no or only limited access to social protection. The SPF which aims at extending basic social protection to those who are currently excluded has great potential to redress existing gender imbalances. Social transfers are also found to be particularly important in supporting women's caring roles and responsibilities.

While the Asia-Pacific region, has made considerable economic progress in the last two decades and has lifted millions out of poverty, not all have benefitted from these gains. Millions of people are still poor, deprived of basic rights, and vulnerable to increased risks due to global economic crises and climate change. This threatens to reverse hard-won human development gains of the past decade. Given this context, it is not surprising that social protection, which refers to a range of policy instruments for ensuring that the rights of all people to income security and access to a minimum level of social services are realized, is high on the policy agenda in the region. Recently, at their 67th session in May 2011, member States of the UN Economic and Social Commission for Asia and the Pacific passed a resolution on "Strengthening social protection systems in Asia and the Pacific." The SPF is also a priority on the G20 agenda. In a preparatory meeting to the G20 Heads of State Summit, G20 Labour and Employment Ministers recommended in September 2011 to "strengthen social protection by establishing social protection floors adapted to each country." At the 15th Asia and the Pacific Regional Meeting held in Kyoto, Japan on 4-7 December 2011, governments, employers, and workers from the Asia and Pacific Region recognized that "building effective social protection floors, in line with national circumstances" was one of the key national policy priorities for the Asia and the Pacific Decent Work Decade.

Assessment based national dialogue in Indonesia: Objectives, process and methodology

3

3.1 Objectives

The SPF framework can be used to describe the social security, social protection, and poverty alleviation programmes in Indonesia and to identify priority options for the future. In addition, the SPF framework can be used to find ways to enhance policy coherence across programmes, reduce fragmentation, increase efficiency through better targeting mechanisms, and search for synergies with other strategies with an aim to reduce vulnerabilities of the poor.

The assessment based national dialogue exercise's main objectives were:

1. To trigger a national dialogue on social protection with all key stakeholders in the country, including line ministries, social partners, civil society organizations, academia, and the UN country team, while raising awareness on the social protection floor concept and increasing capacities in policy formulation and planning;
2. To identify priority areas for government intervention in the field of social protection and the necessary measures for the establishment of a more comprehensive, rights-based, and systemic social protection floor in Indonesia;
3. To support informed decision-making towards the future development of the national social protection floor while ensuring that the proposed new schemes and benefits do not put at stake the financial sustainability of the social security system as a whole;
4. To serve as a baseline against which the future and progressive realization of the SPF in Indonesia can be monitored.

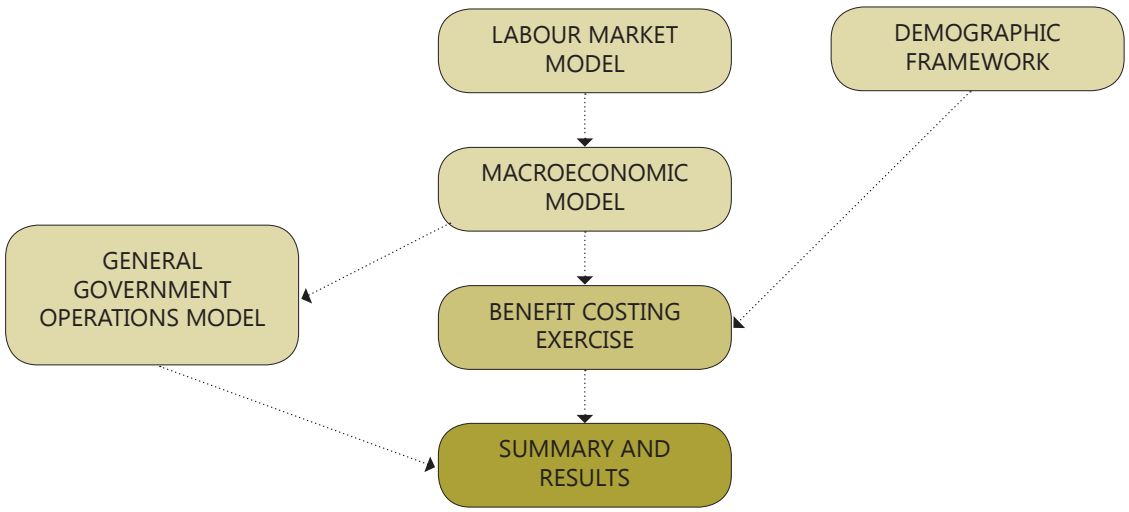
3.2 Process

For each of the four basic guarantees mentioned above, the assessment process described existing social security schemes and social protection programmes and identified policy gaps and implementation issues. The assessment helped to draw recommendations for the further design and implementation of social protection provisions to reach at least the social protection floor for the entire population. The subsequent rapid costing exercise estimated the cost of introducing these additional social protection provisions. The assessment based national dialogue (ABND) exercise consisted of the following steps:

STEP 1 – Development of the assessment matrix - An assessment matrix containing an inventory of existing social security, social protection, and poverty alleviation programmes for each of the four SPF guarantees was developed. The matrix helped to identify policy gaps, implementation issues, and a number of recommendations for the design and implementation of further social protection provisions with the aim of guaranteeing at a minimum the SPF to all the population.

STEP 2 – RAP Protocol - The cost of the proposed social protection provisions was then estimated and projected over a ten-year period using the ILO Rapid Assessment Protocol (RAP). This costing exercise can serve as a basis for discussions on available fiscal space, government budget reallocations, and the prioritization of different social protection policy options.

Figure 1. RAP model structure



STEP 3 – Finalization – The recommendations were shared with government representatives, workers and employers, and civil society organizations with a view to validate the assumptions and recommendations and to prepare for the next steps, which include feasibility studies for the design of new schemes, expansion of existing schemes, and establishment of coordination mechanisms.

3.3 Methodology

The assessment used diverse methods and tools:

1. Literature review of studies, reports, laws and regulations, and statistical reports;
2. Technical consultations (face-to-face and through workshops) on existing schemes and their implementation status;
3. National dialogue on priority policy development and priority measures to be taken;
4. Development of capacities through policy consultations and training workshops;
5. Establishment of a technical working group within the UN system, with key actors from ministries, the statistical office, and social security institutions;
6. Establishment of a validation mechanism for the exercise at each stage and particularly during step 3 to ensure the endorsement of the report by Bappenas and other line ministries.

In conducting the assessment, a series of individual and public consultations took place at provincial and national levels between May 2011 and November 2012. At the provincial level, workshops were organized to complete the assessment matrix in Ambon-Maluku, Kupang-NTT (Nusa Tenggara Timur), and Surabaya-East Java Province. Consultations included participants from relevant ministries and departments, social security schemes, anti-poverty programmes, and representatives from workers' and employers' confederations. Preliminary findings of the assessment were presented and validated at a national validation workshop held in Jakarta. Representatives from

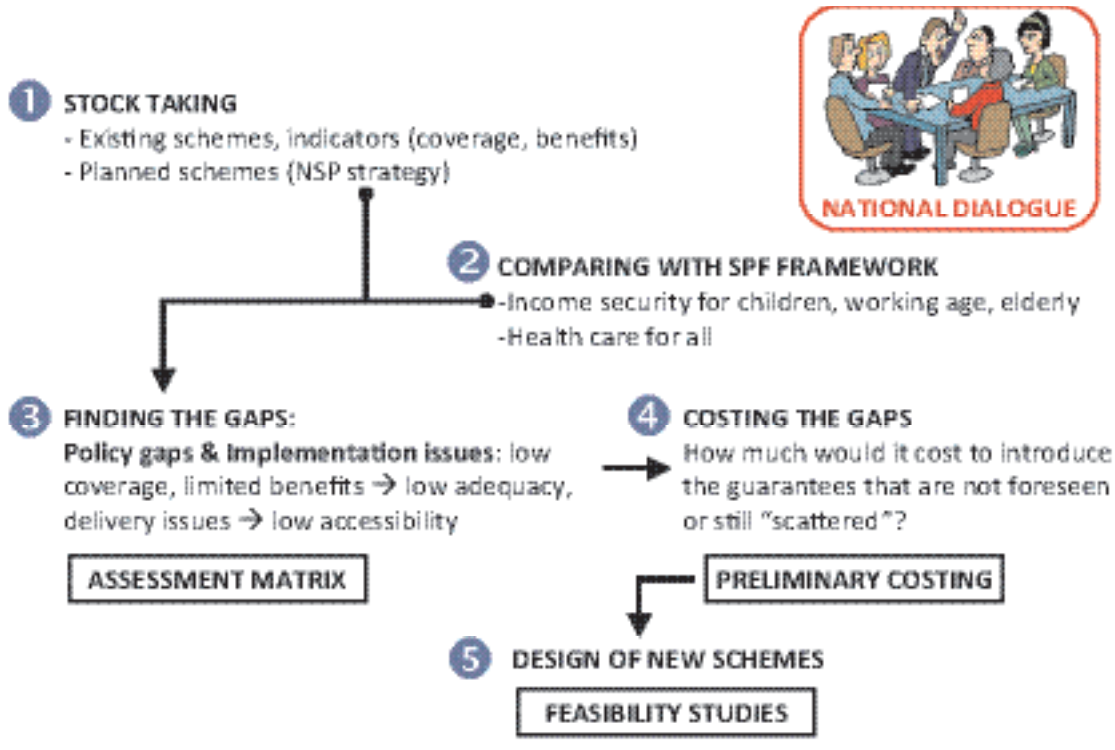
government and workers' and employers' organizations endorsed the preliminary findings and recommendations, including the need to have a unified social protection system and to pilot a "Single Window Service" for the implementation of the social protection floor in some districts. The assessment was also presented along with lessons learnt and best practices on the implementation of the SPF in other countries of the Asia-Pacific region at a four-day "Experts Meeting on Social Security and the Social Protection Floor" from 12 to 15 December 2011 in Jakarta and at an ASEAN training course on "Social Protection: Assessment, Costing and Beyond" organized by ILO DWT Bangkok, in close collaboration with the Faculty of Economics, Chulalongkorn University, from 15 to 19 October, 2012 in Bangkok, Thailand.

Capacity building activities for trade unions were also conducted at the provincial level. Seventy union leaders from existing national trade union confederations were invited to attend these trainings. The objective was to equip the unions so that they can contribute to policy formulation notably in the field of ongoing social security reforms.

The near-final draft of the assessment was presented in a workshop organized by Bappenas on 24 July 2012, for final inputs and endorsement. Representatives from relevant line ministries, the National Social Security Council (DJSN), international agencies, and national experts attended the workshop

The process of the ABND is described in the diagrams below:

Figure 2. Process of the assessment based national dialogue exercise



4

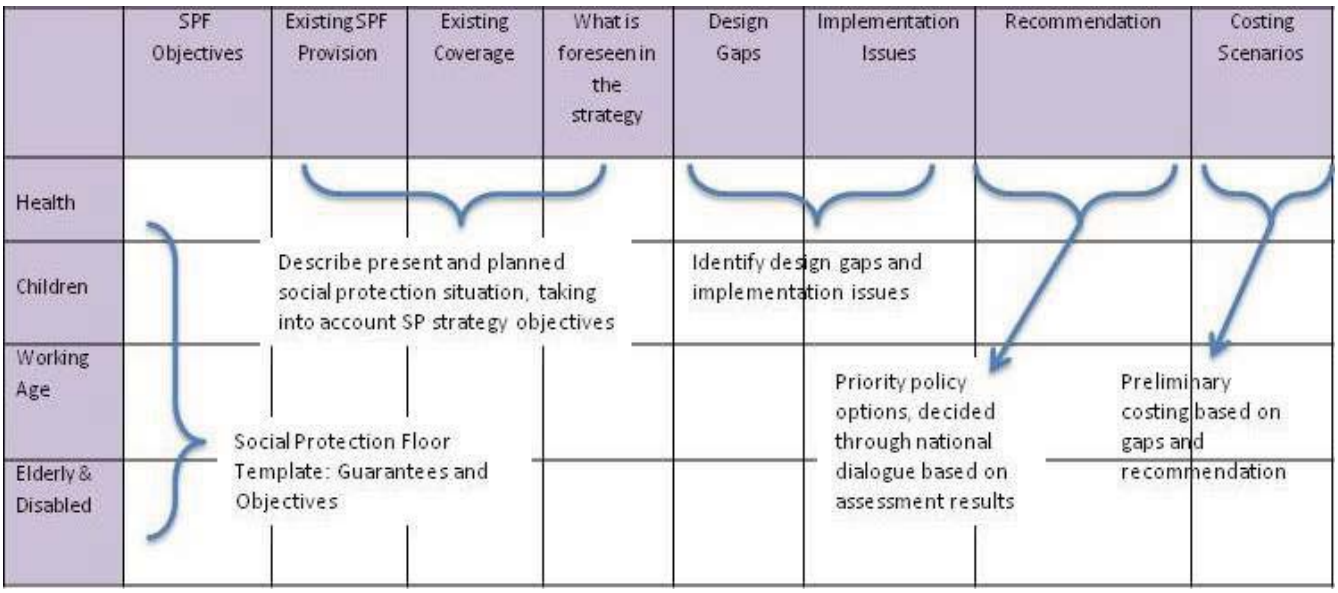
Presentation of final assessment matrix: Structure, existing provisions, policy gaps, implementation issues, and recommendations

The assessment matrix is a tool to analyze to what extent existing and planned social protection provisions match the benchmarks set by the four guarantees of the social protection floor framework and to support the identification of policy priorities to complete the floor. The matrix describes the social protection situation and identifies design gaps and implementation issues.

The assessment matrix underscores the relative strength of the Indonesian social protection system, as a number of social protection provisions are already available for a large share of the population. However, some opportunities for improvement have been identified.

4.1 Structure of the assessment matrix

Table 4. Assessment matrix



4.2 Existing provisions

4.2.1 Health care "all residents have access to a nationally defined set of affordable essential health care services"

With the enactment of the National Social Security System Act in 2004 and Social Security Providers Act in 2011, the government made a commitment to achieve universal health insurance coverage. The roadmap for implementing the Universal Coverage of Social Health Insurance in Indonesia specifies that BPJS I will commence on 1 January 2014 and indicates that universal health care will gradually be achieved by 2019.

However, before the National Social Security System is fully in place, a significant proportion of the population is still without health insurance. Though the coverage of existing health insurance programmes has had significant improvements in the last few years, there is currently still around 41 per cent of the population living without health insurance.[8]

Of those having access to social health protection, 32 per cent is covered under the Jamkesmas programme, a tax-funded health insurance scheme targeted at the poor and near poor population. Other types of insurance (including compulsory health insurance for civil servants, health insurance obtained by formal private sector employees, private insurance, and other smaller programmes) mostly cater to the richer population. Among households in the top three deciles in terms of expenditures, 33 per cent of households hold these forms of insurance, compared to only 4.4 per cent of households in the bottom three deciles and 12 per cent of households in the middle four deciles (World Bank, 2011b).

4.2.1.1 Health insurance for the poor

Jamkesmas

The public health insurance scheme, Jaminan Kesehatan Masyarakat (Jamkesmas), previously known as Askeskin, targets the poor and the near poor. Targeting is conducted through a survey designed for social protection programmes, Pendataan Program Perlindungan Sosial (PPLS), using a proxy means-testing targeting method. The scheme provides beneficiaries with free health care services in community health centres (Puskesmas) and third class (basic level) wards in government hospitals and some designated private hospitals. This scheme grew out of the former health card programme (1998-2001) and is funded by reallocated government budget from the fuel price compensation scheme (2001-2005).

Expenditure for Jamkesmas in 2012 amounts to IDR 7.3 trillion (roughly equivalent to 0.09 per cent of the GDP) covering 76.4 million beneficiaries (Indonesian Financial Note and Draft State Budget 2013). A fee-for-service claim system is applied to health centres, replacing the previous capitation system. For hospitals, the claim system uses the Case Based Group (CBG), which has recently replaced the Diagnosis Related Group (DRG) system.

Since the start of the Jamkesmas programme in 2005, health insurance coverage among households in the bottom three income deciles according to expenditures increased from 16.5 per cent in 2004 to more than 43 per cent in 2010 (World Bank, 2011b). However, even after accounting for the other 4.4 per cent of households in this population group covered by other insurance schemes, 52.6 per cent of the poor population remains without health insurance. On the other hand, 28 per cent of households from the middle deciles and 11.8 per cent of households in the top three deciles are covered by the Jamkesmas programme.

8 The Ministry of Health's data show that in 2010, a total of 59 per cent of the population had health insurance. Data on insurance schemes at the national level (including health insurance for the poor, formal private sector, civil servants, and the military) reveals that coverage stands at about 46 per cent. Provincial- and district-level government programmes provide additional health insurance to poor people who are not covered by the national scheme, or, in the case of three provinces, to all their residents. These provincial- and district-level programmes (using different schemes and levels of benefits) cover around 13 per cent of the total population..

Currently, Jamkesmas' cost estimates are not based on in-depth actuarial calculations. Jamkesmas has not yet developed a comprehensive dataset of beneficiaries, incidence rates, and utilization rates of health care services. The lack of data and absence of proper cost calculations threaten the viability of the scheme, which is fully funded by the government. Moreover, the programme has not yet designed a clear benefit package of guaranteed services. As a result, beneficiaries, who do not know what they are entitled to, cannot appeal when health care services are not available or when they are refused free access to treatment. Through the design and implementation of the BPJS Kesehatan (Health), these challenges are expected to be addressed.

Jamkesda

At the provincial and district levels, local governments allocate funds to the regional health insurance programme for the poor, Jaminan Kesehatan Daerah (Jamkesda). Jamkesda typically targets people who are identified by the local authorities as poor but are not covered by Jamkesmas because of inclusion errors or because they recently became poor. While Jamkesmas provides treatments all over the country, benefits of Jamkesda are often only provided through health care providers in their respective areas.

Under the Jamkesda programmes, the level and types of protection vary from one province or even one district to the other. Some provinces allocate local government funds to extend coverage to other groups in addition to those identified as poor or even to all residents. Bali province's Mandara Health Care Programme, which started in January 2010, provides free access to health care to all residents in the province. The pooling of funds is at the level of the province. Antiretroviral treatment for HIV and chemotherapy are to date among the services excluded from the benefit package (Bali Provincial Health Office, 2011). South Sumatra and Aceh have also implemented non-contributory social health protection schemes that cover all non-covered populations (informal economy, both poor and not poor). In South Sumatra, the pooling is at the level of the district, which limits the portability of benefits, whereas in Aceh, the implementation of the universal health care scheme, Jaminan Kesehatan Aceh (JKA) is managed by PT Askes. Yogyakarta's social health insurance programme (Jamkesos) currently provides free access to health care for the poor only, but has plans to extend coverage to formal and informal economy workers who are not covered by health insurance. For these groups, different contribution patterns will apply (Jogjakarta Provincial Health Office, 2011).

According to the Ministry of Health, provincial- and district-level insurance programmes cover approximately 13.5 per cent of the Indonesian population. These programmes are found in almost all provinces with the exception of Gorontalo, Papua and West Papua (Centre for Health Financing and Health Insurance, Ministry of Health, 2010 data). Though Jamkesda programmes are designed to complement Jamkesmas, the two programs generally use completely separate databases and targeting mechanisms. This has resulted in overlaps in targeted groups and has posed considerable challenges in crosschecking recipients.

4.2.1.2 Health insurance for civil servants and military personnel

Active and retired civil servants, retired military and police personnel, veterans and national patriots, and their dependents are covered by a compulsory health insurance scheme managed by PT Askes. The membership of this scheme in 2010 totaled 16,482,331 people (seven per cent of the population) including active civil servants and their dependents (11,661,743 beneficiaries), retired civil servants and their dependents (3,042,573 beneficiaries), retired military and police personnel and their dependents (1,148,666 beneficiaries), veterans and their dependents (582,790 beneficiaries), partner doctors and midwives and their dependents (41,313 beneficiaries), as well as ministers and special state officials and their dependents (5,246 beneficiaries) (PT Askes 2010 Annual report). Members obtain benefits through a structured health services mechanism, which is available throughout Indonesia. Contributions are shared between civil servants and the government in its role of employer. Civil servants contribute two per cent of their salaries and the government matches the contributions. In 2009, the total premium amounted to IDR 7.9 trillion. Active military and police personnel are provided with in-house health care through special military hospitals.

4.2.1.3 Health for formal sector workers

PT Jamsostek, the State-owned company designated to manage the social insurance fund for the private sector, provides health insurance for formal sector workers. Employers may opt out from the Jamsostek health insurance under the condition that they provide higher levels of benefits and protection through other channels to their employees. Some employers choose to purchase private insurance for their employees while others choose to establish in-house health services. However, many simply evade the law and do not provide any health protection to their employees.

In Jamsostek's 2011 annual report, the number of workers registered under PT Jamsostek's health insurance programme (JPK) reached 2,567,671 people (around six per cent of formal sector workers or two per cent of the total workforce), providing benefits to a total of 5,884,528 beneficiaries (around two per cent of the population).

Based on the Ministry of Health's database, Jamsostek health insurance, employer-provided health insurance and health care services, and private and other health insurance cover six per cent of the total population. This is a very small number given that one-third of the workforce is in the formal sector. This alludes to weak enforcement mechanisms for the Workers' Social Security Law (Law No. 3/1992).

Contribution to PT Jamsostek's health insurance is six per cent of wages for a worker and their dependents and three per cent of wages for workers with no dependents. Until 2011, some high-cost treatments such as heart surgery, hemodialysis, cancer treatment, and HIV/AIDS medication were excluded from this scheme. With the enactment of the Directors' Decision No. Kep/310/2011 in December 2011, Jamsostek now includes coverage for HIV treatment, heart surgery, and hemodialysis. The aforementioned treatments remain excluded from most private health insurance schemes.

4.2.1.4 Universal delivery care

Jampersal is a new Ministry of Health programme (started early 2011) that provides women universal free delivery care, including pre-natal and post-natal consultations. Consultation and delivery care are provided in health centres or third class wards in hospitals. The budget in 2011 was IDR 1.2 trillion, targeting 2.6 million deliveries or 60 per cent of the total estimated 4.8 million deliveries. The scheme uses a direct payment mechanism based on a flat rate capitation amount, which means the patients do not pay anything. The total delivery package cost is IDR 420,000, including IDR 350,000 for delivery, IDR 40,000 for four anti-natal care visits, and IDR 30,000 for three post-natal care visits. The costs for special delivery cases are determined by the Indonesia Case Base Group (INA-CBGs) costing guidelines (MOH Decree No. 631/2011 regarding the Technical Guidelines of Jampersal).

4.2.1.5 Jamsostek pilot programme for informal economy workers

The Jamsostek pilot programme for informal economy workers, launched in 2006, includes health care benefits. The total membership amounts to approximately 400,000 persons, but since members can enter and exit the programme at any time, the number of members at a given point in time varies widely. The programme targets informal economy workers earning at least the minimum wage, which amounts to approximately IDR 1 million, but is subject to variations across provinces. The contribution for health care benefits is set at three per cent of income for workers without dependents and six per cent of income for workers with dependents, where "income" is set at the minimum wage level of IDR 1 million per month.

4.2.1.6 Summary of health care coverage in Indonesia

Table 5. Recap of the coverage for health care

Scheme or programme	Contributions or funding	Number of persons covered
PT JAMSOSTEK	Employer 3 per cent of wages for workers without dependents 6 per cent of wages for workers with dependents (maximum of 5 family members)	2,180,825 contributors in 2010 (5.7 per cent of formal sector workers or 1.8 per cent of the total workforce) Covers 5,044,375 beneficiaries (2.1 per cent of the total population)
PT ASKES	Worker (civil servant) 2 per cent of salary Employer (government) 2 per cent of salary	16,559,025 insured individuals in 2010 (7 per cent of the total population)
JAMKESMAS	Central government budget IDR 5.1 trillion in 2010 (0.07 per cent of GDP and 20 per cent of the central government health budget)	76.4 million beneficiaries (32 per cent of the total population)
JAMPERSAL	Central government budget IDR 1.2 trillion (2011) (estimated 0.017 per cent of 2011 GDP)	2011 target: 2.6 million deliveries (60 per cent of estimated 4.8 million total deliveries)
JAMSOSTEK pilot programme	Worker 3 per cent of income for workers without dependents 6 per cent of income for workers with dependents (maximum of 5 family members) ("income" set at minimum wage level of IDR 1 million per month)	< 400,000 persons

4.2.2 Children "all children enjoy income security through transfers in cash or kind, at least at the level of the nationally defined poverty line level, ensuring access to nutrition, education and care."

4.2.2.1 Education programmes

Government social assistance programmes in education include school operational assistance programme, a scholarship programme for students from poor families, and a school construction and rehabilitation programme. The fourth amendment of the Constitution stipulates that the budget for education shall be at least 20 per cent of the total State budget. Based on this, the education budget in 2012 is IDR 308 trillion (Indonesian Financial Note and Revised Budget 2011) and expected to be IDR 331.8 trillion in 2013 (Indonesian Financial Note and Draft Budget 2011).

School operational assistance, Bantuan Operasional Sekolah (BOS)

The Bantuan Operasional Sekolah (BOS) programme is the main component of the government's social assistance programme in education. It transfers block grants to schools with the objectives of providing free basic education from grades one to grade nine to poor students and ensuring that all students attain quality basic education. Budget allocation for the BOS programme in the last five years has increased from IDR 4.8 trillion in 2005 to IDR 23.6 trillion in 2012. This translates into an increase in the number of beneficiaries as well as the level of per capita grant. The programme covered 34.5 million students in 2005, 41.9 million students in 2008, and 44.7 million students in 2012. The per capita grant accrued to primary schools students, Sekolah Dasar (SD), was IDR 235,000 per student per year in 2005 and IDR 254,000 per student per year in 2008. The per capita grant at the junior secondary level, Sekolah Menegah Pertama (SMP), increased from IDR 324,500 per student per year in 2005 to IDR 354,000 per student per year in 2008. Since 2010, the programme offers two different levels of per capita grants for schools in urban and in rural areas. Budget allocation for schools in urban areas amounts to IDR 400,000 per student per year for primary school students and IDR 575,000 per student per year for junior secondary school students, while schools in rural areas receive a per capita grant of IDR 397,000 per year for primary level and IDR 570,000 per year for junior secondary school students (Indonesian Financial Note and Revised Budget 2011).

Scholarships for poor, Beasiswa untuk Siswa Minskin (BSM) and Subsidi untuk Siswa Miskin (SSM)

The Government established the Scholarship for Poor Students programme (Beasiswa untuk Siswa Minskin (BSM)) in 2008, targeting poor students from primary to university levels. In 2008, the programme budget of IDR 2.2 trillion covered 2.7 million students. In 2012, the budget allocation increased to IDR 5.9 trillion, covering approximately 6.3 million students (Indonesian Financial Note and Revised Budget 2012). In 2012 the Government changed the programme name from Scholarship for Poor Students, Beasiswa untuk Siswa Minskin (BSM), to Subsidies for Poor Students, Subsidi untuk Siswa Miskin (SSM). Subsidies are transferred directly to students, mainly via post service, in several tranches a year.

Targeting for the SSM programme still lacks clarity. The number of beneficiaries is determined by the availability of funds received by provincial authorities from the Ministry of Education. Selection of beneficiaries is often left to local education offices or headmasters of the schools. At the national level, there is an agreement that the scholarship should prioritize children whose families are in the conditional cash transfer programme (PKH programme, described below) as they are from very poor families. However, in practice schools and local education offices may have different considerations, such as redistribution of resources to poor students who do not get any assistance from the PKH programme.

The scholarship programme has not yet established a proper monitoring system of its recipients. Hence, recipients in primary schools may or may not receive the scholarship when they move to secondary school even though their economic condition remains the same. Through an interview in NTT it has also been found that even during

a particular academic year a school may receive several transfers of various amounts covering different students. This situation shows the need to improve database management and targeting methods.

Some provincial government education programmes complement the national BOS and scholarship programmes. For example, East Java's provincial government extends the BOS programme to Islamic boarding schools, which are currently not benefiting from the central government's BOS programme. In Maluku, the provincial government extends the BOS programme to senior secondary schools (for students aged 15-18 years). The discussions that took place in Maluku in the framework of the assessment exercise led to the recommendation to expand the scholarship programme by using provincial budgets.

4.2.2.2 Conditional Cash Transfers

Conditional cash transfer programme, Program Keluarga Harapan (PKH)

The Program Keluarga Harapan (PKH) programme is primarily designed to improve maternal and neonatal health as well as children's education among poor households. In the framework of the assessment we have placed the PKH under the guarantee "income security for children", as children are seen as the group which benefits most from the programme in terms of the amount and the duration of transfers. However, one can see this programme as also providing income security for women in the working age in times of pregnancy and delivery.

PKH was first introduced in 2007 and piloted in seven provinces. In 2012, PKH covers 33 provinces and 1.5 million very poor households, with a budget allocation of IDR 1.8 trillion. The programme is expected to reach 3 million households in all districts by 2014 (Indonesian State budget 2012; Ministry of Social Affairs, 2010; consultation with staff of the Ministry of Social Affairs in 2011). Currently, priority is given to areas with high concentrations of very poor households, but where health care and education facilities are available. The areas currently targeted by PKH are seen to have an adequate supply of social services (health and education). A future challenge will be to expand the programme to new target areas, especially in eastern parts of Indonesia, where the availability of health and education still lags behind the rest of the country and improvements are required.

Beneficiaries consist of households with children younger than 15 years of age (also includes children 15-18 years who have not yet completed the ninth grade) and/or pregnant or lactating women. Depending on the family structure and their compliance with the programme's educational and health requirements, households receive IDR 600,000 to 2,200,000 per year. Programmed conditions include: (1) children are enrolled in school and attend at least 85 per cent of school days; (2) pregnant and lactating mothers as well as infants of 0-6 years of age regularly visit health facilities for health checks.

Table 6. Benefits under the PKH programme

Benefit scheme	Benefit per household (IDR per year)
Fixed benefit	200 000
Children under 6 years old, pregnant/lactating mother, Children in elementary school, Children in junior secondary school	800 000 400 000 800 000
Average benefit per poor household	1 390 000
Minimum benefit per poor household	600 000
Maximum benefit per poor household	2 200 000

Source: Ministry of Social Affairs, 2010

A study by Febriany, Toyamah and Sodo (2010) showed that PKH has motivated rural households to keep their children in school and contributed to increases enrolment rates. For pregnant and lactating mothers, the availability of funds and strict enforcement of visits to health care providers in rural areas have also improved prenatal and infant care. However, the study also revealed that the impact of the PKH programme was curbed by the limited supply of health care.

Child labour reduction programme in support to the PKH, Pengurangan Pekerja Anak untuk Mendukung Program Keluarga Harapan (PPA-PKH)

The Pengurangan Pekerja Anak untuk Mendukung Program Keluarga Harapan (PPA-PKH) programme aims to reduce child labour among PKH target households. The programme prepares children in PKH families, who have previously dropped out of school for the purpose of work, to return to school. The children receive motivational and academic training for one month at training shelters, as well as out of shelter consultations by social workers, in order to prepare them to return to school. PPA-PKH started in 2008 with 4,853 target children in 48 districts in seven provinces. In the programme's first year, the return to school rate for the target group was only 32 per cent (MoMT, 2012). In 2010, 3,000 children from 50 districts in 13 provinces were targeted, and the rate of return to school improved to 74 per cent (MoMT, 2012). In 2012 the programme targets 10,750 children from 84 districts in 21 provinces.

Children's social welfare programme, Program Kesejahteraan Sosial Anak (PKSA)

The Program Kesejahteraan Sosial Anak (PKSA) programme is a special conditional cash transfer for children with social problems. The programme targets five groups of children: abandoned infants/infants with special needs (five years or younger), abandoned children (6-18 years old), street children (6-18 years old), children with criminal charges (6-16 years old) and children with disabilities (0-18 years old) (MOSA's Decree No. 15A/2010 on PKSA Implementation Guideline). The programme provides a savings account (IDR 1.8 million per year in 2011) which can be withdrawn to purchase any necessities, with the approval of a dedicated social worker. Conditions vary across groups (staying in school, stop working on the street, not participating in criminal activity). The total budget for 2011 was IDR 287.1 billion. The table below indicates that this programme covers only a small fraction of the children in need.

Table 7. Target beneficiaries versus children in need of the PKSA programme

Target number of beneficiaries (according to Presidential Instruction No. 3/2010)	Estimated number of children in need of the PKSA programme (MOSA's PKSA Operational Guideline, 2010)
142,530 abandoned children	230,000 street children
6,925 abandoned children under five years old	over 10,000 children with criminal cases
4,200 street children	46,000 children with disabilities
930 children with criminal charges	180,000 children who are victims of violence
1,750 children with disabilities	

In addition to the coverage issue, this programme faces challenges in collecting and updating data on targeted children and currently does not have an updated database that would facilitate the targeting and monitoring of these children. The children enrolled under the programme are those who have been identified by NGOs and social organizations, likely leaving many children with social problems unidentified. An assessment on the implementation of PKSA was conducted by Bappenas in collaboration with Puska UI and the World Bank (2011). The assessment pointed out issues related to the targeting mechanism among PKSA's main shortcomings, as well as the lack of baseline information and integrated data of beneficiaries as a major constraint to effective monitoring.

4.2.2.3 Staple food programme, Raskin

In the late 1990s, the poor, who spend a quarter of their total expenditure on rice consumption, were the most affected by the large increase in rice prices (Suryahadi et al., 2010). Consequently, the economic crisis led to a drop in rice intake and a decline in the children's health status (World Bank, 2006). Coping mechanisms to smooth consumption included taking children out of school and sending them to work (Suryahadi et al., 2010). To ensure adequate staple food consumption, the government introduced the subsidized rice programme in 1998, supplying 1.05 million tonnes of rice to households during that fiscal year. Though the programme targets household units, we chose to include it under income guarantee for children, as children are seen as the major beneficiaries of the programme. In 2002, the programme was renamed Rice for the poor, Beras untuk Orang Miskin (Raskin). In 2012, the Government allocated a budget of IDR 15.7 trillion to subsidize 3.41 million tonnes of rice to be distributed to 17.5 million households (Indonesian Financial Note and Revised Budget, 2012).

A study by Sumarto, Suryahadi and Widiyanti (2005) reports that participation in the subsidized rice programme increases household consumption by 4.4 per cent and that recipient households are 3.83 per cent less likely to be poor compared to their counterparts. Several studies assessing Raskin pointed out that the programme faces major targeting and efficiency issues. Hastuti et al (2009), for instance, found that "many problems emerge in the distribution of the rice from the primary distribution point to the beneficiaries" and that there is "a lack of dissemination of information and transparency; inaccurate targeting, amount, and frequency of rice received by beneficiaries, as well as price of rice; high cost of programme management, ineffective monitoring and evaluation; and ineffective complaint mechanism."

4.2.2.4 School feeding programme, Program Makanan Tambahan Anak Sekolah (PMTAS)

The Ministry of Education, in coordination with six other ministries, launched the School feeding programme, Program Makanan Tambahan Anak Sekolah (PMTAS), in 2010. The programme provides additional food for kindergarten and elementary school students in 27 less developed districts in Indonesia. In 2011, the programme targeted around 1.4 million kindergarten and elementary students in general public schools (managed by the Ministry of Education) as well as Islamic schools (managed by the Ministry of Religious Affairs). Students receive three meals every week. The Government allocates a budget of IDR 250 billion. The cost estimate of one meal is IDR 2,600 in the eastern parts of Indonesia and IDR 2,250 in the western parts. The programme prescribes that the food provided to students must be obtained locally (Ministry of National Education's Policy Brief, 2011; Presidential Instruction No. 1/2010).

4.2.2.5 Universal basic vaccinations for children under five years old

Basic vaccinations are provided for free for all children of zero to five years of age. These vaccinations include BCG, DPT1-3, HepB3, Polio, and Measles. Coverage in some areas, however, is curbed by limited access to health centres or lack of awareness. UNICEF and WHO estimate that vaccination coverage in 2011 was 82 per cent for BCG, 86 per cent for DPT1, 63 per cent DPT3, 63 per cent for HepB3, 70 per cent for Polio3, and 89 per cent for measles (WHO and UNICEF, 2010). The estimates indicate that coverage trends over the last ten years for these immunizations have been relatively stable, though measles coverage has increased and DPT 3 shows a decrease since 2006.[9]

9 Report available at http://apps.who.int/immunization_monitoring/en/globalsummary/timeseries/tswucoveragebycountry.cfm?country=IDN and updated regularly.

4.2.2.6 Summary of protections for children in Indonesia

Table 8. Recap of income security policies and schemes for children

Scheme or programme	Contributions or funding	Number of persons covered
BOS	Central government budget IDR 23.6 trillion in 2012 (0.3 per cent of GDP (2012 estimates))	44.7 million students in 2012
BSM and SSM (Scholarships for the poor)	Central government budget IDR 5.9 trillion in 2012 (0.07 per cent of GDP (2012 estimates))	6.3 million students in 2012
PKH (CCT)	Central government budget IDR 1.8 trillion in 2012 (0.02 per cent of GDP (2012 estimates))	1.5 million very poor households in 2012
PKSA	Central government budget IDR 287 billion in 2011 (0.004 per cent of GDP (2011))	156,335 children in 2011
Raskin	Central government budget RP 15.7 trillion in 2012 (0.2 per cent of GDP (2012 estimates))	17.5 million households in 2012
PMTAS	Central government budget IDR 250 billion on 2011 (0.003 per cent of GDP (2011))	1.4 million students in 2011
Universal vaccination for children under five years old	Central government budget	BCG: 82%; DPT1: 86%; DPT3: 63%, HepB3: 63%; Polio3: 70%; Measles: 89% in 2011

4.2.3 Working age population "all those in active age groups who cannot (due to unemployment, underemployment or sickness) or should not (in case of maternity) earn sufficient income in the labour market enjoy a minimum income security through social transfer in cash or in kind schemes or employment guarantee schemes"

4.2.3.1 Income security in case of termination of employment

According to Labour Law No. 13/2003, all private formal sector employees, about one-third of the total workforce, are entitled to a termination pay once they have finished their probation period of four months. Upon termination of employment, regardless of the reason, the employer is obliged to provide lump-sum severance pay and long-service pay. The amount of severance pay varies depending on the length of employment. According to the law, the amount should be one month of wages for employment of less than one year, two months of wages for employment of between one and two years, three months of wages for employment of two to three years, and so on to a maximum of eight years of employment. Those employed for more than eight years will receive a severance pay of nine months of wages

4.2.3.2 Income security in case of sickness and maternity

According to Labour Law No. 13/2003, employers are obliged to pay full salary to their employees in case they are absent because of sickness. Employees cannot be terminated because of sickness unless they are absent for at least 12 months. Female employees should be given three months of paid leave during childbirth. Civil servants are entitled to similar provisions (up to 12 months of sickness leave) under Government Regulation No. 24/1976.

The Askesos (social welfare insurance) programme is an income replacement scheme for informal sector workers, providing modest one-off cash benefits to members in case of sickness, work injury, or death. In case of sickness or injury, workers receive IDR 300,000 (maximum one claim per person and per benefit per year).

A new initiative is being developed to transform the Askesos programme to be more in line with insurance principles, as mandated by regulations on social security. The initiative, currently in trial phase, will be conducted in partnership with PT Jamsostek.

4.2.3.3 Employment injury

Jamsostek occupational injury (JKK)

According to the Government Regulation No. 14/1993 on Workers' Social Security Programmes, participation in Jamsostek's occupational injury, old age, and death benefits programmes is compulsory for all formal private sector employees. Employment injury insurance covers accidents at work, occupational disease arising out of employment, and travel accidents that occur while traveling to and from work following the usual route. The contribution is fully paid by employers and ranges from 0.24 to 1.74 per cent of wages, depending on the level of risk and protection.

Jamsostek for construction workers

Jamsostek provides an occupational injury and death benefit package for construction workers. Based on MoMT decree No. 196/1999, all contractors and subcontractors providing construction services must underwrite all their workers into the Jamsostek special insurance for construction workers. This programme provides occupational injury and death insurance for the period of their work contract. In 2010, 4,330,383 workers were registered in this programme nationwide.

Jamsostek pilot programme for informal economy workers

The Jamsostek pilot programme for informal economy workers, piloted since 2006, includes occupational injury benefits. The contribution for the occupational injury benefit is set at one per cent of income, where "income" is set at the minimum wage level of IDR 1 million per month.

Askesos

Under the Askesos programme for informal sector workers, members receive IDR 300,000 (maximum one claim per person per benefit per year) in case of employment injury. The scheme was modified in 2012 (on a pilot basis) to provide lump sum and periodic payments in case of employment injury and disability due to work related accidents. The new pilot scheme is administered by Jamsostek.

4.2.3.4 Death benefit

Jamsostek death benefit for formal sector workers (JK)

Based on Government Regulation No. 14/1993, in case of death during active employment (whatever the cause), the dependents of the deceased employee are provided benefits which include a lump sum of IDR 10 million, a funeral grant of IDR 2 million, and monthly transfers of IDR 200,000 per month for 24 months. The contribution to the death grant is made only by the employer, amounting to 0.3 per cent of wages.

Askesos for informal sector workers

Under the Askesos programme for informal economy workers, the death benefit amounts IDR 400,000 if the member dies in the first year of the membership, IDR 600,000 if death occurs in the second year of membership, or IDR 800,000 if death occurs in the third year of membership. The scheme was modified in 2012 (on a pilot basis) to provide lump sum and periodic payments in case of death of the insured. The new pilot scheme is administered by Jamsostek.

Jamsostek pilot programme for informal economy workers

The Jamsostek pilot programme for informal economy workers, piloted since 2006, includes death benefits. The programme targets informal economy workers earning at least the minimum wage (approximately IDR 1 million per month, but subject to variations across provinces). The contribution for the death benefit is set at 0.3 per cent of the minimum wage.

4.2.3.5 Occupational injury and death benefits in the upcoming National Social Security System (SJSN)

As mentioned in earlier sections, the Law on Social Security Providers (BPJS) No 24/2011, as part of the implementation of the new National Social Security System, stipulates that occupational injury and death benefit schemes shall apply to all workers, including those in the informal sector. The schemes will be part of the workers' social security package under the domain of BPJS Ketenagakerjaan. BPJS Ketenagakerjaan is expected to start operation in July 2015. Based on previous experience (notably of the Jamsostek pilot programme) it is expected that expanding social security coverage through contributory schemes to informal sector workers will be particularly challenging.

4.2.3.6 Income security for working age populations who are underemployed: Community empowerment, job training, microcredit programmes

The national community empowerment programme, Program Nasional Pemberdayaan Masyarakat (PNPM)

Previously, Indonesia had various community empowerment programmes under the responsibilities of various ministries. In an effort to harmonize these programmes, the government launched the PNPM programme in 2007. It is a national programme for community empowerment in poor districts and sub-districts. Under the PNPM

programme, control over development project planning, design, implementation, and monitoring is given to local communities. The PNPM consists of two subprogrammes: PNPM Inti and the PNPM Penguatan. PNPM Inti is an area-based community empowerment programme. It includes PNPM-rural, PNPM-urban, PNPM for disadvantaged and specific regions, PNPM-rural infrastructure, and PNPM-social and economic infrastructure. PNPM Penguatan is a community empowerment programme for specific sectors. Included in this category are the PNPM-rural agribusiness development, PNPM-fishery, and PNPM-tourism.

In 2012, the budget allocation for PNPM amounted to IDR 13.4 trillion, with 10 billion allocated to each rural PNPM for distribution to 6,622 sub-districts. Each sub-district received between IDR 1.5 billion and IDR 3 billion. PNPM-urban had an allocated budget of IDR 1.5 trillion in 2010. Rural and urban PNPM budgets represent around 0.18 per cent of GDP (2012 State budget).

Vocational training programmes, Balai Latihan Kerja (BLK)

The Ministry of Manpower and Transmigration (MoMT) oversees Technical and Vocational Education and Training (TVET) centres known as Balai Latihan Kerja (BLK). The BLK centres provide vocational training and job placement services to formal and informal sector workers. Courses are provided free of charge, though a few BLK centres also provide non-subsidized courses. The BLK centres exist in all provinces and in some districts. Since the Government's decentralization in 2001, the majority of BLK centres was handed over to provincial and district governments. In 2011, the central government managed 11 BLK centres, provincial governments managed 33 centres, and district governments managed 141 centres.

According to the Ministry of Manpower and Transmigration (in State News Agency Antara, 2011), BLK graduates have high employability. In 2009, out of 107,051 graduates, 95,094 or 89 per cent were absorbed into the labour market. Unfortunately many BLK centres, especially those currently managed by local governments, are understaffed and underutilized. Most of the facilities are not functioning optimally and need serious revitalization. It is estimated that around six per cent of the training equipment in the district BLKs is in need of serious refurbishment (Minister of Manpower, 2011). However, comprehensive data regarding general BLK capacity, funding, and performance are difficult to acquire at the central level.

A survey conducted by the World Bank in a number of BLKs shows that the per capita cost of training differs widely. The average cost per graduate (about three months of training) of central BLKs is IDR 17 million, while it is IDR 9 million in provincial BLKs and IDR 4 million in district BLKs. The average number of graduates in 2009 for the three types of BLKs ranged from nearly 1,300 per BLK for centrally managed centres to 650 and 340 per centre at the provincial and district levels, respectively (World Bank, 2011C). Funding for the central BLKs comes entirely from the central government, while provincial and district BLKs are co-funded by the central and the respective provincial or district governments.

The Ministry of Manpower and Transmigration initiated a BLK revitalization programme to improve the performance of BLK centres. In support of this revitalization programme, the ILO EAST project works with BLK centres in some provinces. The Ministry estimates that at least IDR 2 trillion per year is required to help revitalize the existing BLKs. The government budget allocated for BLK operations amounted to IDR 540 billion in 2010 and IDR 786 billion in 2011. On an average, the central BLKs spend IDR 20.7 billion, provincial BLKs spend IDR 5.8 billion, and the district BLKs spend IDR 1.5 billion per year.

Microcredit programmes

The Government's microcredit programme is intended to provide the poor and micro-enterprises (who face credit constraints due to the lack of collateral) with access to affordable credit. The credit for the poor programme, Kredit Usaha Rakyat (KUR), is a programme in which six participating commercial banks provide loans to micro-enterprises and cooperatives with a guarantee scheme in which 70 per cent is subsidized by the Government (Central Bank of Indonesia, 2012). In 2011, a total of IDR 29 trillion was lent to approximately 6 million businesses (statement of the Coordinating Ministry of Economy quoted by Antara State News Agency, January 10th 2012)..

Employment creation programme, Padat Karya

The term Padat Karya, which means "labour intensive", has been used throughout Indonesia since at least the early 1970s to refer to village infrastructure activities that employ workers entirely from the local community (Perdana and Maxwell, 2004). Padat Karya became an umbrella name for a larger set of employment creation programmes carried out as safety net programmes in response to the Asian economic crisis in late 1990s (Sumarto, Suryahadi and Widyanti, 2002). In fiscal year 1998/1999, the Padat Karya consisted of 16 programmes under the employment creation category. However, in fiscal year 1999/2000, the Padat Karya was reduced to only two employment creation programmes (Sumarto, Suryahadi and Widyanti, 2002).

The Government continues to run small-scale but longer term Padat Karya programmes, which can be classified more broadly as social protection as opposed to safety net programmes. The aim of the Padat Karya is mainly "to provide income support to the unemployed and the poor while building local infrastructure" (OECD Employment Outlook, 2010). Issues around the targeting and efficiency of the Padat Karya programme are often the subject of criticism (e.g. Ausaid, 1998; URDI, 1999; EPWSP, 2007).

Infrastructure development programme

In line with the 2010-2014 Medium Term Development Plan, the National Planning Agency (Bappenas) launched an infrastructure development programme covering 23 provinces with a total budget of USD 47 billion. The infrastructure programme is "aimed at meeting basic needs and achieving competitiveness of Indonesian products" (Bappenas, 2011). The projects under the programme will be implemented by the private sector through public-private partnership arrangements. This programme can be seen as providing employment opportunities for the working age population. However, though it has a large potential for providing public employment, the programme does not fall into the public employment category as there is no specific stipulation regarding the type of the work to be performed (i.e. highly labour intensive or not).

Provincial programmes

Local governments have often established their own income security and community empowerment programmes for the poor. Different programmes are run by different provincial or district governments, generally targeting households or communities not covered by national programmes. In East Java, for instance, the provincial government provides cash and rice transfers for unproductive households and business start-up grants or microcredit programmes for productive groups. The Tabanan district in Bali province has an employment opportunity programme whereby community leaders assist unemployed people to find jobs. The East Nusa Tenggara (NTT) province has the Anggur Merah (Independent Village Programme) which allocated IDR 250 million in 2011 to each target village to support productive economic activities.

Livelihood programmes by various line ministries

Several line ministries have various livelihood and income generation programmes for rural communities (for example, in agriculture and plantation, fishery, animal husbandry, among others). These programmes comprise of trainings, grants, or credit for business capital (in cash or in kind such as seeds, livestock, or irrigation). These programmes are mostly conducted independent of one another and targeting is conducted separately. The number of programmes and beneficiaries also fluctuates by year, as they are conditional on the availability of budget. Local level information on these programmes is scattered.

4.2.3.7 Summary of protections for the working age population in Indonesia

Table 9. Recap of income security policies and schemes for the working age population

Scheme or programme	Contributions or funding	Number of persons covered
Severance pay (unemployment)	Employer	Theoretically all formal private sector employees
Sickness and maternity	Employer	Theoretically all formal private sector employees and civil servants
PNPM	Central government budget IDR 13.4 trillion (0.18 per cent of GDP in 2012)	6,622 rural sub-districts (2012)
KUR	Central government budget Banks: provide loans Government: 70 per cent subsidized guarantee scheme	6 million businesses in 2011
ASKESOS	Central government budget IDR 30 million per organization managing approximately 200 members each Under the new pilot scheme since 2012: IDR 10,400/member/month Members IDR 5,000/month	280,800 members (2010)
PT Jamsostek (work injury)	Employers 0.24 per cent - 1.74 per cent (depending on the level of protection)	10,311,669 persons covered (2011)
PT Jamsostek (death)	Employers 0.3 per cent of the wages	10,311,669 persons covered (2011)
Jamsostek pilot programme (work injury)	Worker 1 per cent of the income, where "income" is set at the minimum wage of IDR 1 million per month	Approximately 400,000 informal sector workers (as of 2011)
Jamsostek pilot programme (death)	Worker 0.3 per cent of the income, where "income" is set at the minimum wage of IDR 1 million per month	Approximately 400,000 informal sector workers (as of 2011)

4.2.4 Elderly and persons with disabilities "all residents in old age and all residents with disabilities have income security at least at the level of the nationally defined poverty line through pensions for old age and disability or transfers in kind"

Only around 13 per cent of all Indonesian citizens are currently covered by old age benefits, the vast majority of whom are in the formal sector. Civil servants (around four per cent of the workforce) and military and police personnel (around one per cent of the workforce) receive a comprehensive defined-benefit monthly pension as well as a lump sum old age savings payment. Around a quarter (10,311,669) of the private sector workers, or eight per cent of the economically active population, are covered by the Jamsostek provident fund programme, which is a compulsory defined-contribution savings scheme where the benefit is paid in a lump sum upon retirement (Jamsostek 2010 annual report). A small additional number of private sector workers voluntarily join private pension schemes. The voluntary programmes include both defined-benefit and defined-contribution types of schemes. In addition, two non-contributory schemes targeted at vulnerable elderly (without family support) and people with severe disabilities exist.

4.2.4.1 Pension and old age savings programme for civil servants and military personnel

Retired civil servants receive a monthly pension and a lump sum old age savings benefit at retirement age. The monthly pension benefit amounts to 2.5 per cent of the final month's pay multiplied by the number of years of civil service up to a maximum of 80 per cent, whereas the lump-sum old age savings benefit is based on a multiplication of the number of years of service, final monthly salary, and a factor determined by the Ministry of Finance (the factor is currently 0.6). The retirement age varies from 56 to 60 years, depending on the position. Early retirement is possible for those who are 50 years or older and have worked as civil servants for at least 20 years.

Employee contributions are set at 4.75 per cent of monthly salary for the pension fund and 3.25 per cent for the old age savings programme. Since both programmes are defined-benefit, the Government's contribution varies according to actual expenditure. PT Taspen is responsible for administering both programmes.

The monthly pension programme is a pay-as-you-go system. PT Taspen collects civil servants' contributions but is not entitled to manage the funds. PT Taspen acts only as the Government's collection and payment agent and is not legally responsible for the liabilities under that programme. The benefits are paid from the State budget. The total amount of benefits (pensions paid) was IDR 51.2 trillion in 2010 (around 0.7 per cent of the GDP).

In the old age savings programme, funds are managed and invested by PT Taspen. The State budget pays for unfunded liabilities such as those resulting from changes in the remuneration policies. The unfunded liability for the old age savings programme in 2011 reached IDR 1.6 trillion, as current employee contributions were less than the payout to current retirees (Kompas, 2011).

Pension expenditure is expected to rise considerably over the next 10 years due to increases in civil servants' salaries since 2003 and, of course, the issue of the aging population, resulting in an increasing dependency ratio. The current dependency ratio is of 20 per cent and is expected to reach 50 per cent by 2050 (ADB, 2007).

Similar benefits are provided to 1.16 million military personnel, representing around 0.5 per cent of workforce, under the management of PT Asabri (PT Asabri, 2011). Retirement age for military personnel is generally younger, at 50 years old. An assessment by the Asian Development Bank in 2007 mentioned that issues faced by programmes under PT Asabri are of similar nature with those faced by PT Taspen.

Civil servants are entitled to a pension and an old age savings benefits in case of permanent disability (Law No. 11/1969).

4.2.4.2 Old age benefits for formal private sector employees

The Jamsostek old age programme (JHT) for private sector employees is a provident fund, where members receive a lump-sum benefit corresponding to the accumulated contributions and declared interest refunded. The conditions for the withdrawal of the lump sum are (1) retirement at the age of 55 years, (2) total and permanent disability (3) death of the employee before retirement age, or (4) unemployment in case the employee has contributed for five years or more.

Workers contribute two per cent of their wages and employers contribute 3.7 per cent of wages to the provident fund. Unlike that of the civil servants, old age benefits for private sector employees are made based on a defined contribution method. In this case, the role of PT Jamsostek is to generate returns that accrue to individual members' accounts in accordance with members' investment goals and risk tolerances.

4.2.4.3 Voluntary private pension schemes

Voluntary private pension schemes are either managed by the employer (DPPK/Dana Pensiun Pemberi Kerja) or the financial institutions (DPLK/Dana Pensiun Lembaga Keuangan). Based on Law no. 11/1992 regarding pension funds, these can be a defined-benefit or a defined-contribution programme. The maximum benefit for a defined-benefit programme is 2.5 per cent of the salary per year of service and an overall maximum of 80 per cent. In the case of a defined-contribution programme, the contributions cannot be higher than 20 per cent of the employee's salary, with the employee's contribution not exceeding 7.5 per cent. Employer pension funds are mostly defined-benefit while financial institution pension funds are all defined-contribution.

4.2.4.4 Jamsostek pilot programme for informal economy workers

The Jamsostek pilot programme for informal economy workers includes an old age benefit scheme. The programme targets informal economy workers earning at least the minimum wage (approximately IDR 1 million, subject to variations across provinces). The contribution is set at a minimum of two per cent of income, where "income" is the minimum wage. The lump-sum benefit is composed of the accumulated contributions plus the return on the investment.

Among the schemes provided in the Jamsostek pilot programme, the old age benefit scheme was of least interest among workers. Since the old age benefit was not one of the subsidized schemes in the pilot programme, the number of informal workers joining this scheme was very low.

4.2.4.5 Benefits for vulnerable elderly

The Ministry of Social Affairs is managing a non-contributory minimum pension programme which provides cash transfers to vulnerable elderly (elderly who are unproductive and/or have no caregiver) called Jaminan Sosial Lanjut Usia (JSLU). The amount of the minimum pension is IDR 300,000 per month, which is on average above the poverty line. Under the programme, according to Presidential Instruction No. 3/2010, 13,250 vulnerable elderly were targeted in 2011. The number of beneficiaries is determined by the amount of funds available at the central level. This coverage is still very low compared to available estimates that suggest the actual number of vulnerable elderly to be around 1.7 million people. The Ministry of Social Affair's JSLU Guidelines (2008) state criteria for classifying individuals as vulnerable elderly (such as being 60 years and older, poor, non-recipient of other programmes), but the targeting strategy still needs to be improved.

The Ministry of Social Affairs also provides subsidies to old people's homes called Panti Sosial Tresna Wredha (MoSA's JSLU guideline, 2008). The programme transfers IDR 3,000 (around USD 0.35) per person per day to these homes (Directorate General of Social Rehabilitation, Ministry of Social Affairs, 2010). This subsidy amount is considered too low to even cover daily food expenditures. To address this issue, some provinces have initiated programmes to provide subsidies to pay the full cost of the old people's homes.

4.2.4.6 Benefits for persons with disabilities

Jaminan Sosial Penyandang Cacat (JSPACA) is a cash transfer programme targeting people with severe disabilities. The management and benefit of JSPACA are similar to those of the JSLU. Presidential Instruction No. 3/2010 specifies that 19,500 disabled persons were targeted in 2011. As with the JSLU, the number of beneficiaries of JSPACA is determined by the amount of funds available at the central level resulting in very low coverage. The total number of people with physical, mental, and multiple disabilities in the bottom 40 per cent poorest population was 1,105,675 persons in 2011 (PPLS data).

The Ministry of Social Affairs also provides subsidies to rehabilitation centres and homes for disabled people, with a standard amount of IDR 3,000 (around USD 0.35) per person per day (Directorate General of Social Rehabilitation, Ministry of Social Affairs, 2010). Again, this subsidy is considered too low even to cover daily food expenditures. Some provinces opt to fully subsidize the cost of the rehabilitation centres and homes for disabled people.

Disability caused by traffic accidents is covered by a general traffic accident insurance, Jasa Raharja, providing a small one-off benefit.

4.2.4.7 Summary of protections for the elderly and people with disabilities in Indonesia

Table 10. Recap of income security policies and schemes for the elderly and people with disabilities

Scheme or programme	Contributions or funding	Number of persons covered
PT Taspen (pension fund for civil servants)	Worker 4.75 per cent of monthly salary Central government budget Contribution varies according to actual expenditure (IDR 50 trillion or 0.7 per cent of 2011 GDP)	2,361,408 pensioners receiving pension (2011) 4,598,100 active civil servants making contributions (2011)
PT Taspen (old age savings for civil servants)	Worker 3.25 per cent of monthly salary Central government budget Contribution varies according to actual expenditure (IDR 1.6 trillion or 0.02 per cent of 2011 GDP)	4,598,100 active civil servants and approximately 120,000 state-owned enterprise employees (2011)
PT Asabri	Similar to Taspen	1,159,715 members (2010)
JHT	Worker 2 per cent of wages Employers 7.24–11.74 per cent of wages	10,311,669 active contributors (2011)
Jamsostek pilot programme for informal economy workers	Worker 2 per cent of the income, where "income" is set at the minimum wage of IDR 1 million per month	Approximately 400,000 members for at least one of the four programmes
JSLU	Central government budget	13,250 elderly (2011)
JSPACA	Central government budget	19,500 people with severe disabilities (2011)

4.3 Policy Gaps and Implementation Issues

4.3.1 Common gaps and issues

A number of policy gaps and implementation issues that are common across programmes, benefits, and implementing agencies have been identified. These issues will be listed in this section while issues specific to each of the four SPF guarantees will be described in the subsequent sections.

4.3.1.1 Almost no protection for non-poor workers in the informal sector

The group with the least social protection is workers in the informal sector. Until the new Social Security System Law reaches the implementation stage, existing social security programmes are targeted mainly to formal sector workers, including civil servants (Askes and Taspen), military and police personnel (Asabri and Askes), and formal private sector workers (Jamsostek). While informal economy workers account for around two-thirds of the workforce, programmes targeting this group consist of only small and scattered schemes such as Jamsostek LHK (for workers outside employment relationships) and Askesos. Both programmes have so far provided modest protection and low coverage.

The Jamsostek programme for workers outside employment relationships has not shown significant progress beyond its pilot stage. In most cases members do not continue their membership once the subsidized pilot phase is over. Workers lack information and guidance on how to individually enroll after the subsidized programme ends. Additionally, those who do have the knowledge often find it troublesome to register and to pay the contributions when the service is not easily accessible. Jamsostek has limited capacity to reach and to provide services to individual workers, especially those residing in remote areas of Indonesia. There are a few cases in which workers continue their membership after the pilot stage due to intermediation by a third party. For instance a workers' association in Kupang, NTT functions as an intermediary between Jamsostek and the enrolled members, facilitating the collection of contributions, new enrolments, and claim processes.

Askesos, a subsidized income replacement scheme for informal sector workers, has similar issues. The programme reaches only a very small fraction of informal economy workers and provides only a modest level of protection (a small one-off payment for a maximum one contingency per year). The continuation of the programme is also in question, as the programme is administered through local organizations that are contracted only for three years with low management capacity. The new Askesos programme which was launched on a pilot basis in 2012 aims at addressing these limitations.

The SJSN Law is a promising foundation for the provision of social security for all Indonesian workers and their dependents, including those in the informal economy. The new system, however, has not yet reached the implementation stage. The challenge awaiting the new system is to find effective ways to reach out to informal sector workers, the majority of whom have never been part of any social security scheme.

The latest development towards the implementation of the National Social Security System is the enactment of the Social Security Provider Law and the development of an implementation roadmap for the health social security provider, BPJS Kesehatan, and the workers social security provider, BPJS Ketenagakerjaan. Other implementation regulations are also in the making. Upcoming regulations will need to find adapted contribution collection mechanisms for informal sector workers, propose payment patterns that are in line with income patterns, and possibly propose a mix of funding sources. Past and existing experiences in Indonesia and from other countries need to be considered as lessons learnt when designing future programmes.

4.3.1.2 High evasion in the formal sector

In the private sector, the gap in coverage due to social evasion is of particular concern. Despite its obligatory nature, Jamsostek membership among formal sector workers is still low. In 2011 the number of workers registered under PT Jamsostek's health insurance programme (JPK) was 2,567,672 persons and the number of workers registered under PT Jamsostek's work injury, death, and old age programs was 10,311,669 people (Jamsostek's 2011 annual report). Based on the Ministry of Health's database, the combined coverage of Jamsostek health insurance, employer-provided health insurance and health care, and private and other health insurances cover only six per cent of the population.

According to the Ministry of Manpower, one of the reasons for widespread evasion of the current law is the lack of supervisory and inspection officers at both the central and regional levels. Unlike Jamsostek, the enactment of the BPJS Law provides both BPJS Kesehatan and BPJS Ketenagakerjaan enforcement authority. Innovative control and monitoring mechanisms should be further explored and become part of the implementation plan of BPJS.

4.3.1.3 Data limitations and targeting issues

A number of programmes face data limitations and targeting issues. Programmes that target certain groups within the population, such as disabled people, children with special needs, or the vulnerable elderly, require information about their target beneficiaries. To date, there is a lack of updated data that enumerates these target groups.

Moreover, in many cases the target groups also lack of clear definitions. For instance, for JSPACA and other programmes targeting people with disabilities, there is not yet a harmonized definition and uniform disabilities classification. Different ministries have different definitions. BPS's data on disabled people do not contain key parameters necessary for targeting, such as disability type, severity, existence of multiple disabilities, among others. Similarly, though some of JSLU's criteria for identifying the "vulnerable elderly" (such as being 60 years and older, poor, and not a recipient of other programmes) are mentioned in MoSA's JSLU Guidelines, the definition remains vague and a clear targeting strategy is lacking. The lack of appropriate data combined with vague definitions of target beneficiaries consequently force programmes such as JSPACA, JSLU, and PKSA to rely on district offices of social affairs and social workers, who have limited capacity to conduct systematic data collection, to identify beneficiaries.

Efforts to improve the database are ongoing, including efforts to establish a unified database for potential beneficiaries (the new Pendataan Program Perlindungan Sosial (PPLS) 2011 dataset managed by TNP2K), which has been finalized and made available since the beginning of 2012. The new database, containing information on the four bottom income deciles of the population, is designed to provide the necessary information to enable targeting for the different social assistance programmes. The adoption of the database by existing social assistance programmes is still in process, thus the database's impact on programmes' effectiveness and efficiency cannot be assessed at this time. It remains to be seen whether the database is detailed enough to be used by all social programmes and whether the frequency of updates will capture the dynamics of socioeconomic conditions in Indonesia.

4.3.1.4 Coordination issues and overlaps among programmes

Many social protection programmes are meant to complement one another. However, problems in coordination often curb the impact of these programmes. Jamkesda, which is designed to complement Jamkesmas, uses a completely separate database and targeting mechanism from that of Jamkesmas. Target overlaps have been found in some areas, such as TTS district, NTT, and crosschecking recipients faces a considerable challenge.

The BSM and PKH programmes are both cash transfer programmes with similar target recipients. They are, however, managed separately with different targeting methods. At the national level, there is an agreement that the scholarship should prioritize children from PKH families, but at the district level this is not the case.

Various programmes, though often targeting the same group of recipients, have different delivery channels: some are managed directly from the centre, some by provincial offices, and others by district offices. There is often a lack of information sharing both vertically (between different levels of the same ministry) and horizontally (between offices of different line ministries). For example, officials at a district social affairs office mentioned during interviews that they were frustrated at not being informed about various programmes run by the central government, the provincial office, and by other line ministries. This lack of coordination may contribute to inefficiencies in programme operations.

4.3.2 Gaps and Issues in the provision of health care for the whole population

4.3.2.1 Gaps in coverage

More than 40 per cent of the population in Indonesia is not covered by health insurance

Though significant progress has been achieved in recent years, a large proportion of the population is still without health insurance. A database at the Ministry of Health shows the following coverage (as of 2010):

- The poor: Jamkesmas (32 per cent of population), Jamkesda (13 per cent of population);
- Civil servants, pensioners, and their dependents : PT Askes (seven per cent of population);
- Private formal sector workers and their dependents: PT Jamsostek, private insurance, and in-house health care (six per cent of population);
- Non-poor informal sector workers and their dependents: Jamsostek LHK (less than one per cent of population)

These figures indicate a gap of around 41 per cent of the population who are not covered by existing health insurance schemes. This group is dominated by non-poor informal economy workers and their families, followed by formal sector workers and their dependents that are not covered due to social evasion.

Targeting errors and overlaps in beneficiaries

In addition to the official figures, further gaps in coverage are due to mistargeting. For example, inclusion and exclusion errors are still a major issue for Jamkesmas. Previous studies have found some benefits accruing to the richer population while a notable number of poor were still without health insurance (see for example World Bank, 2011b).

The database systems and targeting mechanisms of Jamkesmas and Jamkesda are separate, and therefore overlaps of targets are likely to happen. Crosschecking is difficult and has not been systematically conducted. In interviews at the district and sub-district levels, officials stated that they have found people with both Jamkesda and Jamkesmas membership, but the detailed figure is unknown since no systematic crosscheck has ever been conducted. There were even cases where a patient is found to have both Jamkesmas and Askes insurance, though these are considered exceptional cases (based on interviews with district level PT Askes staff in NTT).

Coordination, integration of databases, as well as frequent data updates are essential in dealing with these issues.

Geographic and financial access to health services

For those covered by Jamkesmas, other barriers to access may remain. In rural areas where most poor people live, especially those in small islands and remote places, health workers and facilities are very limited, if available at all (Sparrow, Suryahadi and Widyanti 2010; MoH, 2009). The recent Village Potential Statistics (PODES 2011) illustrates the disparity of access to health care among regions in Indonesia. Areas with limited access to primary care are prominent in eastern Indonesia while areas with limited access to secondary care are spread out outside Java Island. For many rural villagers, the nearest community health centres are usually located in the centre of their sub-district, which means beneficiaries face significant transportation costs and forego income during the time

used seeking health care. In addition, when they do access the services, beneficiaries are often requested to pay out-of-pocket to cover the medication or other costs despite their health insurance coverage. Although these out-of-pocket expenses have significantly decreased with the establishment of the Jamkesmas programme, they are still significant for the very poor (Sparrow, Suryahadi and Widyanti, 2010).

It is imperative to think of health care provision issues both in terms of supply and demand. In an assessment of the health card programme implemented in 1999-2002 (predessessor to the Jamkesmas programme), Pradhan, Saadah and Sparrow (2007) showed that a combination of health care cards distribution and additional budgetary support to health care infrastructure contributed to increased access and utilization of health care services five times more than the sole distribution of the health care cards alone. This demonstrates that demand side improvements need to be accompanied by supply side improvements.

Our consultations in the provinces raised concerns about discrimination when seeking treatment. Some Jamkesmas patients perceive that they receive lower quality treatment, experience longer wait time, and/or face more administrative requirements than other patients.

Challenges of BPJS Kesehatan in expanding coverage

The transformation of PT Askes to BPJS Kesehatan entails the expansion of coverage from only civil servants and pensioners to the entire population, hence a corresponding expansion of capacity for services.

Through consultations, PT Askes' provincial- and district-level staff expressed that their biggest challenges are to expand its capacity in order to reach and to provide services to the whole population and to synthesize different health insurance schemes that currently operate as separate programmes. The extension of coverage to the non-poor informal sector workers through a contributory scheme will be particularly challenging.

A change in the contribution mechanism will occur for formal private sector workers once they are transferred from the Jamsostek programme to the Askes programme. The Jamsostek health insurance contribution is currently paid fully by the employer. Under the new Askes health insurance programme the contribution will be shared by both workers and employers. This change will require awareness-raising in order to avoid workers' rejection of the new programme.

4.3.2.2 Gaps in the level of protection

Exclusion of some treatments and diseases in the current programmes

Some diseases such as HIV are currently excluded in most health insurance schemes. Though Jamsostek recently changed its policy to include heart surgery, hemodialysis, cancer treatment, and HIV antiretroviral treatment, other insurance providers have not yet done the same. The draft presidential regulation of the future health insurance scheme under BPJS Kesehatan includes coverage for these diseases. The BPJS Law prescribes that benefits in the new system should not be less than those previously provided.

HIV came up as a particular concern during our consultations. Since combating this disease is part of the millennium development goals, stakeholders expressed that its treatment should be part of the national health care strategy. Spending on HIV treatment is also seen as an investment to prevent higher spending on medical care in the future. Coverage for HIV also has economic implications since people living with HIV may be active contributors to the economy if properly treated.

Discussions and consultations conducted during the assessment also revealed the need to improve maternal and child health by providing tests and treatments for serious diseases that can be transmitted from mother to child, such as HIV and syphilis, to all pregnant women. Prevention of mother to child transmission (PMTCT) of HIV is crucial in reducing HIV prevalence among children. Syphilis, whose test and treatment are very inexpensive, has proven to 'result in adverse outcomes of pregnancy such as stillbirth and spontaneous abortion, prenatal death, and serious neonatal infections and low-birth weight babies' (WHO, 2005).

Lack of clear benefit package and in-depth actuarial data of the current Jamkesmas

Jamkesmas cost estimates are not currently based on in-depth actuarial calculations. The programme has not yet developed a comprehensive database that includes beneficiaries, incidence rates, and utilization rates of health care services. In addition, the programme also does not have a clear benefit package stipulating guaranteed health care services under the scheme.

The lack of data and absence of proper calculation of the cost of benefits threatens the viability of the scheme. Moreover, the situation may lead to unanticipated out-of-pocket payments and beneficiaries, who do not know what they are entitled to, cannot appeal when the health care services are not available or when they are refused free access to treatment.

Current efforts by the Ministry of Health and other relevant agencies in improving the database and designing specific benefits packages for the BPJS Kesehatan are a crucial step towards the development of a sustainable social health insurance system.

4.3.3 Gaps and Issues in the provision of income security for children

4.3.3.1 Gaps in coverage

Many programmes are still faced with the issue of limited coverage, both in terms of the number of recipients and geographical areas. This is the case with the children's social welfare programme, Program Kesejahteraan Sosial Anak (PKSA), a special conditional cash transfer scheme for children with social problems. Though this programme is still expanding, the number of targeted beneficiaries is far below the estimated number children in need of intervention. In the Program Keluarga Harapan (PKH) conditional cash transfer programme, barriers to health and education services in some regions—especially in eastern parts of Indonesia—curb the extension of the programme to additional households. Similarly, the school feeding programme has not yet been implemented in all kindergarten and primary schools in the target districts. Even when schools are covered, not all targeted students are reached.

4.3.3.2 The need for data improvement and clear targeting mechanisms

Under-coverage is often made worse by lack of reliable data and efficient targeting mechanisms. Some targeted programmes such as PKSA do not have comprehensive baseline data for their target groups. Consequently, identification of beneficiaries cannot be conducted in a systematic manner. Children enrolled under the programme are those who have been identified by NGOs or social organizations, which suggests many children remain out of the programme's reach.

4.3.3.3 The need for better coordination and programme synchronization

Lack of coordination and overlaps are found in some programmes. The scholarship for the poor programme, for instance, is targeted to students from very poor households. Targets are theoretically the same as for PKH. There is also an inter-ministerial agreement at the central level that students who receive scholarships should be the same as PKH recipients. However, targeting of both programmes is done in a separate manner: PKH targeting is based on national data while the selection of scholarship recipients is done by the school, based on the recommendation of the school committee and the community. In practice, schools or local education offices may have different considerations, such as redistribution of resources to poor students who do not get any assistance from the PKH programme. There is therefore a double targeting system that could be harmonized for the sake of economies of scale and efficiency. If the scholarship for the poor and PKH are combined, administration and monitoring costs could be reduced.

4.3.3.4 Issues in programme management and disbursement of benefits

Issues in programme implementation include tardy delivery and inefficient management. For example, the school feeding programme has encountered issues of late disbursement of funds, which led to low utilization of the programme. During interviews and consultations in one of the target districts in NTT, the district education office indicated that the 2011 funds had only been received in August. Unutilized funds need to be returned to the State budget by the end of the year, which means the number of days in which students receive school meals are fewer than expected.

Raskin faces major targeting and efficiency issues. According to several studies (e.g. see Hastuti et al, 2009) there is a lack of information and transparency regarding the distribution process and beneficiaries are often unaware of the amount of rice they are entitled to and the frequency of distribution. There is also "high cost of programme management, ineffective monitoring and evaluation; and ineffective complaint mechanism" (Hastuti et al, 2009).

4.3.4 Gaps and Issues in the provision of income security for the working age population

4.3.4.1 Lack of linkages between employment programmes and social security programmes

Linkages between employment programmes and social security programmes could be further developed. Income security benefits need to be connected with measures to increase employability, facilitate job creation or return to employment so that recipients can move up to better employment and participate in contributory social security schemes. Employment opportunity programmes also need to put workers' social security as one of their priorities. For instance the PNPM programme does not collect any information on workers' or contractors' enrolment in social security schemes and has no means to check nor to enforce their participation in social security. Relevant to this is the need to link trainings with public works programmes in order to increase the capacities of the workers as well as their productivity.

4.3.4.2 Trainings often provided in ad hoc manner

Trainings related to income-generating activities are provided by various agencies and line ministries (e.g. offices of agriculture and plantation, animal husbandry, fishery, women empowerment, among others). However, these trainings are usually provided on an ad-hoc basis, contingent to availability of funds. The trainings also lack follow-up consultations and refresher courses.

4.3.4.3 Severance pay provides insufficient protection compared to unemployment insurance

The one-off severance pay received upon termination of work provides lower protection to workers and makes hiring and firing more expensive for employers. It is therefore necessary to consider the possibility of setting up an unemployment insurance scheme. An in-depth feasibility study would need to be conducted. This may be the next stage after the SJSN implementation.

4.3.4.4 Challenges of BPJS Ketenagakerjaan (BPJS II) in expanding coverage

As in the case of BPJS Kesehatan (BPJS I) for health, BPJS Ketenagakerjaan (BPJS II) for workers' social security faces a notable challenge in extending the coverage of social security programmes to the informal sector. PT Jamsostek, which will be transformed into BPJS II, currently caters to formal sector workers. The transformation undoubtedly requires expanding its capacity to be able to reach all workers in all areas, particularly in the informal sector. It also requires offering social security provisions that would effectively suit the needs and characteristics of informal sector workers.

4.3.5 Gaps and Issues in the provision of income security for the elderly and for people with disability

4.3.5.1 Coverage gap

The Majority of Indonesian workers are currently without old age benefits

The most prominent gap in old age and disability benefits is in their coverage. Currently, only 13 per cent of Indonesians are covered by old age benefits and this group is dominated by workers in the formal sector. Among those with old age benefits, only civil servants, military, and police personnel receive monthly pensions (on top of the one-off old age savings benefits) upon reaching retirement age. The National Social Security System intends to close this gap by providing an old age savings scheme for all workers in both the formal and informal economies and a monthly pension scheme especially for workers in the formal sector. This will be done gradually under the management of the workers' social security programme, BPJS Ketenagakerjaan.

Under-coverage of social assistance for people with severe disabilities and the elderly

The cash transfer programmes for the vulnerable elderly (JSLU) and the severely disabled (JSPACA) target only a small number of people who are living in the most severe circumstances. Among the target group, only a small proportion is effectively covered. Under the leadership of TNP2K, the government is exploring the expansion of both the JSPACA and JSLU programmes.

4.3.5.2 Data limitations

Presently, there is no harmonized definition of disabled people and no comprehensive, disaggregated, and comparable database of disabled people across ministries, BPS, and other agencies. This makes targeting of the JSPACA programme particularly challenging. The BPS data on disabled people does not contain classifications (e.g. types, severity, and existence of multiple disabilities), which limits the capacity to do a proper targeting.[10] To a certain extent, JSLU faces similar issues.

4.3.5.3 Old age lump sum benefits provide insufficient protection compared to monthly pension

The lump sum benefits received by formal sector employees do not provide sufficient protection. The lump sum is generally small and retirees tend to spend the payout immediately on consumption goods rather than planning for an annuity. In 2009, the average lump sum paid by Jamsostek was less than IDR 6.5 million.[11] The current 5.7 per cent contribution is too small to result in sufficient benefits.

10 The available definition, in Law No. 4/1997 on persons with disabilities, is as follows: "A person with disabilities is every person who has a physical and/or mental impairment which can disturb or present a challenge for that person in functioning the way he or she should, who is (a) physically disabled; (b) mentally disabled; (c) physically and mentally disabled, where physically disabled means a disability which results in a disturbance to the way the body functions, among others, movement of the body, sight, hearing and the ability to speak; mentally disabled means a mental impairment and/or behavioral impairment, both inherent and as a result of disease/illness; physical and mental disability means a person who has both disabilities" (Nicola Colbran, 2010).

11 In 2009, there were 898,886 cash out cases in the old age benefit programme and Jamsostek paid a total of IDR 5,789.84 billion in benefits (PT Jamsostek 2009 annual report).

4.4 Recommendations

4.4.1 General recommendations

4.4.1.1 Law enforcement to reduce social evasion

Firm enforcement of the Labour Law and the Social Security Law is key in achieving social protection objectives. Many workers and employers, despite their obligation to join social security schemes, are currently out of the system. Unlike the current social security provider, Jamsostek, the BPJS Law gives both BPJS Kesehatan and BPJS Ketenagakerjaan the authority to enforce participation.

Supervision and inspection need to be strengthened extensively. The system also needs to design adapted and cost-efficient mechanisms to increase inspection capacity. International experiences can be explored for possible replication. One potential option is the TWIN system developed in China. In the TWIN system, a network of assistants visits all enterprises in urban and rural areas in order to collect information on the labour force and working conditions. This data is then entered into a common database, which is then compared with the information received from social security institutions. This process facilitates the identification of firms evading social contributions, such as through the under-registration of workers.

4.4.1.2 Support the development of regulations for the implementation of Law No. 40/2004

Extension of coverage to informal economy workers

The National Social Security System, according to Law No. 40/2004 and Law No. 24/2011, shall provide health insurance to the entire population and social security schemes to all workers through BPJS I and BPJS II. Workers in the informal economy, who are currently almost entirely uncovered by social security schemes, have specific characteristics that pose challenges to social security registration, contribution payment, and claims collection. There needs to be a thorough analysis in order to design adapted enrolment and contribution mechanisms that would suit these characteristics. The use of professional associations, area-based associations, and microinsurance schemes to facilitate enrolment, collect premiums, and serve as "agents" for social security providers may be considered. In addition, the development of a database containing detailed information on informal economy workers would facilitate the implementation process. Lessons learnt from previous programmes in Indonesia as well as experiences in other countries need to be incorporated into the design of the BPJS Law regulations and the BPJS Law implementation process.

Development of roadmaps for BPJS Kesehatan and BPJS Ketenagakerjaan

The National Social Security Council (DJSN) and other relevant agencies are in the process of developing roadmaps for the health social security provider (BPJS Kesehatan) and the workers social security provider (BPJS Ketenagakerjaan). A concerted effort and close cooperation between the agencies is crucial in the formulation of comprehensive and workable roadmaps.

4.4.1.3 Improve database and targeting mechanism

A sound database and a clear targeting mechanism are prerequisites for a successful social protection programme. As many programmes are still lacking these components, improvements in these areas should be prioritized. Targeted programmes, including PKSA, JSLU and JSPACA, will particularly benefit from such improvements. It is also important to have the database disaggregated by sex in order to monitor gender sensitivity of programmes. A concern was raised during the national consultation concerning a gender bias in the scholarship programme, where boys seem to benefit more than girls. The development of a database would facilitate proper monitoring of this and other issues.

Efforts to improve the database are ongoing, including the establishment of a unified database of the four bottom income deciles of the population (PPLS 11 dataset managed by TNP2K). The new database is intended to be used by all social protection programmes. Adoption of the database is still in process, thus its usability and impact on programmes' effectiveness cannot be assessed at this time. There are still questions on whether the information in the database is detailed enough to be used by all programmes, particularly those needing specific information (such as PKSA, JSLU), and on the method and frequency of data updates.

4.4.1.4 Design and pilot test a Single Window Service (SWS) for social protection programmes

The SWS would facilitate access to the social protection system

Barriers of access are a prominent issue, particularly among people in the informal economy. The current capacity of PT Askes and PT Jamsostek, the two enterprises that will be transformed into BPJS I and BPJS II, is limited to the provision of social security benefits to formal sector workers and their dependents. Their services are currently inaccessible to people in remote areas. Many social assistance programmes also face similar limitations where issues of accessibility restrain coverage. There is a need for institutions that have outreach capacities to the informal sector, the poor, and the vulnerable in both urban and rural areas to act as intermediate structures between social security providers and final beneficiaries. These institutions would act as a Single Window Service (SWS) and would provide information about existing programmes to potential beneficiaries, conduct vulnerability and skills assessments, facilitate registration to suitable social protection programmes and skills development or employment programmes, host and update beneficiaries' databases, use such data to facilitate monitoring and impact evaluation, and facilitate appeals mechanisms. The SWS mechanism needs to be designed and pilot-tested in some areas before we can come up with one or more suitable design options.

The SWS would facilitate coordination and prevent overlaps among programmes

A Single Window Service will host a database of various programmes and their respective beneficiaries in its area. This would allow for more coherent targeting, implementation, and monitoring of programmes. This would also enable the ability to crosscheck and to verify information on beneficiaries enrolled in different programmes, thus preventing overlaps. Information gathered at the decentralized level would then feed a national database, resulting in a consolidated coverage database including all provinces and districts within Indonesia. The mechanism would therefore support cross-ministry coordination and central-regional coordination. The database would need to use unique identification numbers for all beneficiaries in order to enable proper verification and monitoring systems.

The SWS would contribute to link social protection programmes with employment services

The integration of social protection and employment services under the Single Window Service would provide beneficiaries with opportunities to progressively graduate from being mere receivers of basic social protection to participating in trainings, finding (or creating) a decent job, and being able to contribute to social security.

*Note: Recommendation on the feasibility study of the Single Window Service was included as part of the key activities of a new ILO-Korea project, "Promoting income security and return to employment for workers in vulnerable employment and the formal sector in ASEAN".

4.4.2 Recommendations to guarantee access to essential health care

4.4.2.1 Develop and apply specific and clear benefits package

Learning from the experiences of Jamkesmas, the health insurance under the National Social Security System needs to develop a specific benefit package that can be guaranteed to all (or each of the group of beneficiaries, should there be groupings), to establish a checklist of services and interventions that should be available at the different levels of the health care pyramid (health clinics, centres, hospitals and so on) and to ensure that the health care staff is sufficiently trained and available to provide at least the services included under the benefit package. The

beneficiaries need to be informed about the guaranteed benefit package and provided with control, monitoring, and appeals mechanisms.

A benefit package for health care under the SJSN is currently being developed by various agencies, including DJSN, TNP2K, and the Ministry of Health.

4.4.2.2 Cover the treatments of some diseases currently excluded

Treatments of some diseases such as ARV for HIV and hemodialysis are currently excluded in most existing health insurance schemes, with the exception of Jamsostek health insurance, which recently included heart surgery, hemodialysis, cancer treatment, and HIV antiretroviral treatment in its coverage. It is important to highlight that the SJSN Law stipulates that benefits in the new system should not be less of those previously offered.

Antiretroviral treatment for PLWHIV

The exclusion of HIV was raised as a particular concern by stakeholders, as the reduction of such disease is part of the millennium development goals. Stakeholders also stressed that the treatment of such disease does not only improve the lives of those infected, but also helps to prevent virus transmission. Prevention and treatment should certainly go hand in hand and be part of the national health care strategy. Expenses for the treatment and prevention should be seen as an investment to prevent higher spending in the future.

Prevention of mother-to-child transmission of serious diseases such as HIV and Syphilis

Stakeholders, especially agencies whose work are related with health and HIV, including UNAIDS, KPA, WHO, and UNICEF, emphasized the need to improve maternal and child health by providing tests and treatment for serious diseases that can be transmitted from mother to child, such as HIV and syphilis, to all pregnant women. Prevention of mother to child transmission (PMTCT) of HIV is crucial in reducing HIV prevalence among children. Syphilis, whose test and treatment are very inexpensive, has proven to 'result in adverse outcomes of pregnancy such as stillbirth and spontaneous abortion, prenatal death, and serious neonatal infections and low-birth weight babies' (WHO, 2005).

4.4.3 Recommendations to guarantee income security for children

4.4.3.1 Expand CCT programme to more areas and more recipient households

The PKH currently targets around 1.5 million very poor households. Its coverage exists in all provinces but not all districts within the provinces. The programme is currently being expanded and the government intends to extend coverage to 3 million households in all districts by 2014. The programme needs to keep expanding in order to reach all very poor households in all areas within districts.

Referring to its initial plan, the PKH was originally designed for poor households (not only very poor households). The initial target of the programme as quoted in General Guideline of Program Keluarga Harapan (2010) was to reach 6.5 million households. The programme needs to keep growing and expanding in order to reach all of the households in need (both very poor and poor).

If the government budget allows, the growth of the programme needs to be accompanied with improvements in the supply of health and education services. Lack of education and health care supply in remote areas, more often found in the eastern parts of Indonesia, may curb the impact of the programme

.

4.4.3.2 Synchronize or explore the merging the scholarship programme with other relevant programmes

Provided that the BOS programme is well implemented and that the funds received by the schools are sufficient to provide free basic education, and provided that child benefit programmes are further developed, the scholarships for primary and junior secondary schools may become irrelevant. For better targeting and more efficient implementation of programmes, it is recommended to explore the possibility of merging the scholarship for the poor programme and the PKH.

4.4.3.3 Explore and calculate the cost of a universal child benefit programme

Universal programmes are often found to be easier to implement and to administer. The absence of targeting reduces enrolment costs. Exploring the design of a universal child allowance programme is therefore worthwhile.

4.4.3.4 Raskin needs to improve targeting and management efficiency

Concerns about the Raskin programme are related to its high cost and inefficient delivery. The programme is currently centrally managed by the logistics agency. Administrative costs can be substantially reduced by involving local markets for supplying rice.

4.4.4 Recommendations to guarantee income security for the working age

4.4.4.1 Conduct a feasibility study for an unemployment insurance scheme and linkages with employment services

Unemployment insurance can provide better protection for workers and can be more cost effective for employers than the existing severance pay system. As Indonesia moves toward higher levels of worker protection, it may be necessary to consider setting up an unemployment insurance scheme. A feasibility study is a necessary step to explore this possibility. This may be pursued after the SJSN implementation.

4.4.4.2 Develop a public employment programme linked with skills development for workers in the informal economy

In order to achieve better outcomes for beneficiaries, public employment programmes need to be linked with skills development programmes. Target beneficiaries, who come from the informal economy, should not only be provided with jobs that offer temporary income support, but also skills training and capacity development relevant to the public works programme and beyond.

4.4.4.3 Explore the possible introduction of maternity benefits for women in the informal economy

While women in the formal sector receive maternity benefits for times when they are unable to work due to childbirth, women in the informal economy do not enjoy such protection. This may impact the wellbeing not only of the women, but also of the new-borns and even entire families (either due to the reduction of household income when the mother cannot work or health detriments when she has to return to work too soon). It is necessary that income security during childbirth is provided to all women workers and not only those in the formal sector. For this, a feasibility study needs to be done to find the appropriate mechanism that suits the characteristics of female workers in the informal sector.

4.4.5 Recommendations to guarantee income security for the elderly and people with disability

4.4.5.1 Conduct a study on the design of a defined-benefit old age pension scheme for formal sector workers

The SJSN Law mandates that a pension scheme should be available for all formal sector workers. For this, there needs to be an in-depth study considering the design of the scheme. The DJSN, together with an implementing working group, is currently looking at this subject and is expected to develop an implementation plan for the defined-benefit pension scheme.

4.4.5.2 Explore the possible extension and calculate the cost of a non-contributory minimum pension scheme for the elderly and people with severe disabilities

The non-contributory minimum pension programme for vulnerable elderly, Jaminan Sosial untuk Lanjut Usia (JSLU), and the programme for the people with severe disabilities, Jaminan Sosial Penyandang Cacat (JSPACA), currently cover only a small share of those in need of such programmes. These programmes need to be extended to more beneficiaries and eventually to all vulnerable elderly and all people with severe disabilities.

4.4.5.3 Create a comprehensive database of people with disabilities and the elderly to facilitate targeting

To support the extension of JSPACA and JSLU, it is crucial to develop a database containing accurate population information about the two groups in order to facilitate effective targeting. The TNP2K is currently working on creation of comprehensive database.

4.4.5.4 Increase the amount of subsidies to nursing homes and other charitable homes

The current subsidy of IDR 3,000 (around USD 30 cents) received by residents of elderly nursing homes or homes for people with disabilities is clearly below the amount required to cover the cost of their daily needs. This amount needs to be increased.

5 Costing methodology, description of the policy options ("scenarios") to complete the social protection floor, and calculation of the costs

5.1 The costing methodology using the RAP protocol

The Rapid Assessment Protocol (RAP), a new costing tool developed by the ILO on the basis of an earlier UNICEF/ ILO costing tool, was used for this costing exercise.

The RAP uses a simple and easy methodology that builds on single age population projections, single age estimates of labour force participation rates, a relatively crude economic scenario as determined by assumptions of overall GDP growth rates, productivity rates, inflation and wage rates, interest rates, as well as poverty rates. The model uses these variables as drivers of expenditures and revenues starting from initial statistical values given for the last observation years. Detailed assumptions are all noted in the model and can be provided to all readers together with this report.

The costing exercise provides a rough estimate of the cost of providing additional social protection provisions that would lead toward a comprehensive social protection floor in Indonesia. The cost is expressed in Indonesian rupiah, as a percentage of GDP, and as a percentage of government expenditures. The results of this costing are then used to support discussions on social protection policy priorities and provide a basis for discussions on the fiscal space and budget reallocations with different government agencies.

This assessment exercise has resulted in recommendations to both provide additional SPF benefits and extend existing benefits. Using the RAP protocol, the following sections present cost estimates of introducing new schemes or extending existing schemes in the form of "scenarios" based on the respective recommendations. The costing exercise is intended to provide a description of some of the policy options in terms of expenditure, which can feed into discussions on social protection priorities. Note that the costing exercise focuses on the estimated cost of the proposed schemes and does not provide recommendations for financing of these additional benefits, which may be fully subsidized by the government, partially subsidized, or fully contributory.

5.2 Health care "all residents have access to a nationally defined set of affordable essential health care services"

Among the recommendations on health, the following are relevant to the costing exercise:

- Develop and apply specific and clear benefits package
- Cover the treatment of some diseases currently excluded, particularly, but not limited to:
    - Antiretroviral treatment for PLWHIV
    - Prevention of mother-to-child transmission of serious diseases such as HIV and syphilis

We translated these recommendations into the following scenarios:

- Scenario 1: Extension of health insurance to all very poor, poor, near poor, and vulnerable people at third class-moderate level (see below for an explanation of the "moderate level").
- Scenario 2: Extension of health insurance to all very poor, poor, near poor, and vulnerable people at third class-high level (see below for an explanation of the "high level").
- Scenario 3: Extension of health insurance to all informal economy population at third class-moderate level.
- Scenario 4: Extension of health insurance to all informal economy population at third class-high level.
- Scenario 5: Extension of health insurance to all informal economy population at first class - high level (highest level of cost estimates).
- Scenario 6: Inclusion of HIV testing for high-risk population, regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV who are eligible for treatment.
- Scenario 7: Inclusion of HIV testing for the general sexually active population (age 15-49), regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV who are eligible for treatment.
- Scenario 8: Introduction of a universal package to reduce mother-to-child transmission (MTCT) for HIV and syphilis.

We then calculated the cost of these scenarios using the RAP protocol.

As noted earlier, in the process towards the implementation of the National Social Security System Law, a number of agencies (TNP2K, MoH, Bappenas, and other relevant agencies) are developing possible health care packages for the new social health insurance. The Government has yet to decide which one of several package options to implement. For this costing exercise we use package options developed by TNP2K. The package options range from third class to first class services and for each class moderate cost estimates and high cost estimates were formulated. Cost estimates are made for 2014 and 2019. Scenarios 1 to 5 are based on these package options.

The assumptions and the results of the cost calculations are presented below.

5.2.1 Scenario 1: Extension of health insurance to all very poor, poor, near poor, and vulnerable people at third class-moderate level

5.2.1.1 Assumptions

- The moderate estimate for a third class service level has a cost per member per month of IDR 16,560 in 2014 and IDR 29,279 in 2019. These costs include loading factors such as administration costs, marketing, and utilization increase.
- The cost increase between 2014 and 2019, as well as between 2019 and 2020, is assumed to be constant.
- The target of very poor, poor, near poor, and vulnerable population is around forty per cent of the population (based on PPLS 2011 database) or around 96.14 million people in 2014, and assumed to increase with population growth in the following years.
- The scenario is to be effective in 2014, when the new BPJS I starts operation.

5.2.1.2 Results

The total cost per year for the extension of health insurance to the poor, near poor, and vulnerable at third class-moderate level is projected over the years 2014-2020 and then expressed as a percentage of GDP and of government expenditures. It is estimated that expanding a modest level health care package to the poor, near poor, and vulnerable would cost a total of 0.19 per cent of GDP or 1.12 per cent of government expenditures by 2020.

Compared to the current Jamkesmas spending projections, this entails an additional 0.14 per cent of GDP or 0.80 per cent of government expenditures.

5.2.2 Scenario 2: Extension of health insurance to all very poor, poor, near poor, and vulnerable people at third class-high level

5.2.2.1 Assumptions

- The high estimate for a third class service level has a cost per member per month of IDR 21,970 in 2014 and IDR 40,366 in 2019. These costs include loading factors such as administration costs, marketing, and utilization increase.
- The cost increase between 2014 and 2019, as well as between 2019 and 2020, is assumed to be constant.
- The target of very poor, poor, near poor, and vulnerable population is around forty per cent of the population (based on PPLS 2011 database) or around 96.14 million people in 2014, and assumed to increase with population growth in the following years until 2020.
- The scenario is to be effective in 2014, when the new BPJS I starts operation.

5.2.2.2 Results

The total cost per year for the extension of health insurance to the poor, near poor, and vulnerable at a third class-high level is projected over the years 2014-2020 and then expressed as a percentage of GDP and of government expenditures. It is estimated that providing the health care package to the poor, near poor, and vulnerable would cost a total of 0.27 per cent of GDP or 1.55 per cent of government expenditures by 2020. Compared to the current Jamkesmas spending projections, this alternative would cost an additional 0.21 per cent of GDP or 1.22 per cent of government expenditures.

5.2.3 Scenario 3: Provision of a third class-moderate level benefit for entire informal economy population

5.2.3.1 Assumptions

- The moderate estimate for a third class service level has a cost per member per month of IDR 16,560 in 2014 and IDR 29,279 in 2019. These costs include loading factors such as administration costs, marketing, and utilization increase.
- The cost increase between 2014 and 2019, as well as between 2019 and 2020, is assumed to be constant.
- The target coverage is 62.9 per cent of the population (which is the current proportion of the population in the informal economy based on BPS's recent definition of informal economy) and assumed to be stable until 2020.
- Take up rate increases from 40 per cent of population in 2014 to 62.9 per cent of population in 2016.

5.2.3.2 Results

The total cost per year for the provision of health insurance to the whole informal economy at a third class-moderate level is projected over the years 2014-2020. It is estimated that providing the health care package to the entire informal economy population would cost a total of 0.31 per cent of GDP or 1.79 per cent of government expenditures by 2020. Compared to the current Jamkesmas assumption, this alternative would cost an additional 0.25 per cent of GDP or 1.47 per cent of government expenditures.

5.2.4 Scenario 4: Provision of a third class-high level benefit for entire informal economy population

5.2.4.1 Assumptions

- The high estimate for a third class service level has a cost per member per month of IDR 21,970 in 2014 and IDR 40,366 in 2019. These costs include loading factors such as administration costs, marketing, and utilization increase.
- The cost increase between 2014 and 2019, as well as between 2019 and 2020, is assumed to be constant.
- The target coverage is 62.9 per cent of the population (which is the current proportion of the population in the informal economy based on BPS's recent definition of informal economy) and assumed to be stable until 2020.
- Take up rate increases from 40 per cent of population in 2014 to 62.9 per cent of population in 2016.

5.2.4.2 Results

The total cost per year for the provision of health insurance to the whole informal economy at a third class-high level is projected over the years 2014-2020. It is estimated that providing the health care package to all informal economy population would cost a total of 0.43 per cent of the GDP or 2.48 per cent of government expenditures by 2020. Compared to the current Jamkesmas spending projections, this alternative would cost an additional 0.37 per cent of GDP or 2.15 per cent of government expenditures.

5.2.5 Scenario 5: Provision of the highest levels of benefits (first class-high level) to entire informal economy population

5.2.5.1 Assumptions

- The high estimate for a first class service level has a cost per member per month of IDR 59,071 in 2014 and IDR 92,303 in 2019. These costs include loading factors such as administration costs, marketing, and utilization increase.
- The cost increase between 2014 and 2019, as well as between 2019 and 2020, is assumed to be constant.
- The target coverage is 62.9 per cent of the population (which is the current proportion of the population in the informal economy based on BPS's recent definition of informal economy) and assumed to be stable until 2020.
- Take up rate increases from 40 per cent of population in 2014 to 62.9 per cent of population in 2016.

5.2.5.2 Results

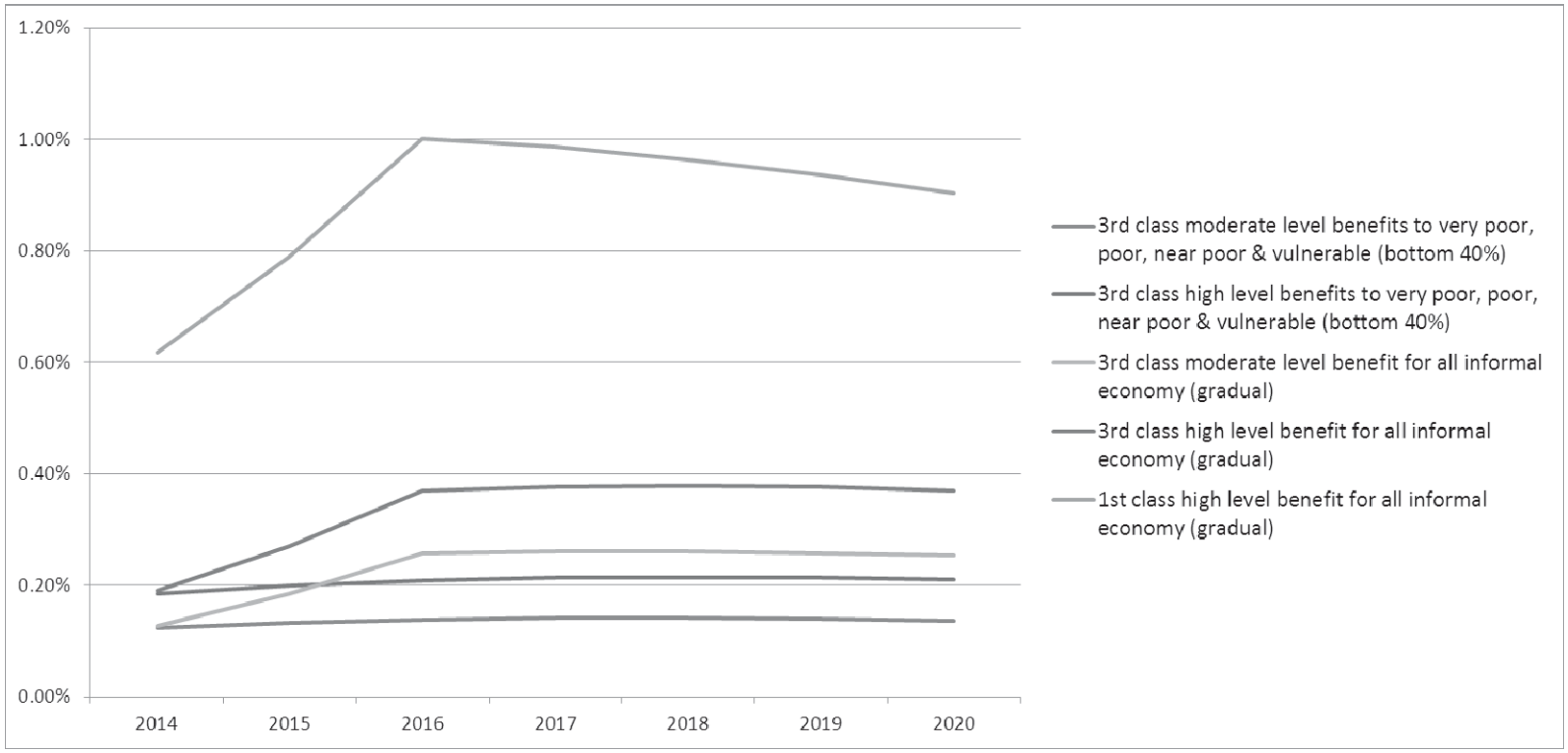
The total cost per year for the provision of the highest health insurance package to the whole informal economy is projected over the years 2014-2020. It is estimated that providing the health care package to the entire informal economy population would cost a total of 0.96 per cent of GDP or 5.57 per cent of government expenditures by 2020. Compared to the current Jamkesmas cost projections, this alternative would cost an additional 0.90 per cent of GDP or 5.25 per cent of government expenditures.

Table 11. Projection of the cost of the proposed health care scenarios

Scenario 1. Third class-moderate level benefits to very poor, poor, near poor, and vulnerable							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Cost per person per month	16 560	19 104	21 648	24 191	26 735	29 279	31 823
Coverage (40th percentile) in thousands	96 142	97 162	98 229	99 307	100 368	101 402	102 413
Total additional cost in million IDR	12 665 889	15 207 496	17 765 184	20 317 623	22 855 063	25 365 694	27 839 936
Total additional cost in % GDP	0.12%	0.13%	0.14%	0.14%	0.14%	0.14%	0.14%
Total additional cost in % govt. expenditure	0.66%	0.70%	0.74%	0.77%	0.79%	0.80%	0.80%
Scenario 2. Third class-high level benefits to very poor, poor, near poor, and vulnerable							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Cost per person per month	21 970	25 636	29 302	32 968	36 634	40 300	43 966
Coverage (40th percentile) in thousands	96 142	97 162	98 229	99 307	100 368	101 402	102 413
Total additional cost in million IDR	18 907 432	22 823 746	26 787 872	30 776 626	34 777 415	38 776 394	42 763 511
Total additional cost in % GDP	0.18%	0.20%	0.21%	0.21%	0.21%	0.21%	0.21%
Total additional cost in % govt. expenditure	0.98%	1.05%	1.12%	1.17%	1.20%	1.22%	1.22%
Scenario 3. Third class-moderate level benefit for all informal economy (gradual)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Cost per person per month	16 560	19 104	21 648	24 191	26 735	29 279	31 823
Coverage (% of total population)	40.0%	50.0%	62.9%	62.9%	62.9%	62.9%	62.9%
Total additional cost in million IDR	13 036 790	21 316 560	33 152 815	37 702 123	42 272 863	46 850 127	51 423 819
Total additional cost in % GDP	0.13%	0.19%	0.26%	0.26%	0.26%	0.26%	0.25%
Total additional cost in % govt. expenditure	0.67%	0.98%	1.39%	1.44%	1.46%	1.47%	1.47%
Scenario 4. Third class-high level benefit for all informal economy (gradual)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Cost per person per month	21 970	25 636	29 302	32 968	36 634	40 300	43 966
Coverage (% of total population)	40.0%	50.0%	62.9%	62.9%	62.9%	62.9%	62.9%
Total additional cost in million IDR	19 399 503	31 021 694	47 616 432	54 468 194	61 384 722	68 347 850	75 346 721
Total additional cost in % GDP	0.19%	0.27%	0.37%	0.38%	0.38%	0.38%	0.37%
Total additional cost in % govt. expenditure	1.00%	1.43%	1.99%	2.07%	2.12%	2.15%	2.15%

Scenario 5. First class-high level benefit for all informal economy (gradual)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Cost per person per month	59 071	65 717	72 364	79 010	85 657	92 303	98 949
Coverage (% of total population)	40.0%	50.0%	62.9%	62.9%	62.9%	62.9%	62.9%
Total additional cost in million IDR	63 034 072	90 572 129	128 985 242	142 423 300	156 033 872	169 785 658	183 667 634
Total additional cost in % GDP	0.62%	0.79%	1.00%	0.99%	0.96%	0.94%	0.90%
Total additional cost in % govt. expenditure	3.26%	4.17%	5.40%	5.42%	5.40%	5.34%	5.25%

Figure 3. Projection of the cost of the proposed health care scenarios (% GDP)



5.2.6 Scenario 6: Inclusion of HIV testing for high-risk population, regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV who are eligible for treatment

5.2.6.1 Assumptions

- The most-at-risk population comprised of more than 6 million people in 2011 (based on consultation with UNAIDS). This population is assumed to grow at the same rate as the general sexually active population. The number of people taking voluntary consultation and testing (VCT) in 2010 is 220,000 or around 3.7 per cent of the most-at-risk population.
- In 2010, 371,800 people were living with HIV (PLWHIV) and 55,700 were newly infected. All the PLWHIV need regular check-ups (viral loads and CD4 count). Among PLWHIV, 50,400 required ART (Anti-Retroviral Treatment). Figures from 2008 to 2014 are taken from MOH's "Mathematic Model of HIV Epidemic in Indonesia" (2008). Figures for 2015-2020 assume constant increase based on the average increase in the preceding years.
- Prevalence among the most-at-risk population is estimated at 2.5 per cent.[12]
- In 2011, only 44 per cent of PLWHIV adults in need of treatment had access to treatment (MoH, 2011). The government targets to cover 80 per cent by 2015.
- The cost of voluntary counseling and testing (VCT) in 2010 was IDR 171,044 if the result is positive, and IDR 57,015 if the result is negative. The number of the tests with positive results is estimated based on prevalence of 2.5 per cent.
- In 2010 the cost of CD4 counts was IDR 170,000 and the cost of viral load was IDR 850,000. The cost of first line ARV was IDR 350,000 per month per person and that of second line ARV was IDR 1,650,000 per month per person. Of the patients who needed treatment in 2010, three per cent needed second line ARV, and this percentage is increasing over time (MoH's HIV Mathematical Model, 2008).

The benefit package includes:

- Two free voluntary counseling and testing (VCT) per year for most-at-risk populations. The target population is assumed to increase from 3.3 per cent in 2011 to 20 per cent by 2012 and 100 per cent by 2020.
- Two viral loads and two CD4 counts per PLWHIV per year. Fifty per cent of PLWHIV would receive free medical check-ups in 2012 and the proportion would increase by ten per cent every year until reaching 100 per cent in 2017.
- ARV treatment for the PLWHIV in need of treatment (either first line or second line depending on the needs of the patient). Fifty per cent of the PLWHIV in need of treatment would receive ARV treatment in 2012 and the proportion would increase by ten per cent every year until it reaches 100 per cent in 2017.

The population is projected over the years 2012-2020 and the costs of testing and treatments are indexed on inflation.

5.2.6.2 Results

Inclusion of HIV testing for high-risk populations, regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV in need of treatment would cost 0.02 per cent of GDP and 0.14 per cent of government expenditures by 2020.

12 Based on MOH's most-at-risk population (MARP) size estimation, 2009—the median estimation of PLWHIV among key population is 158,708.

5.2.7 Scenario 7: Inclusion of HIV testing for the general sexually active population (age 15-49), regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV who are eligible for treatment

5.2.7.1 Assumptions

- The total "sexually active population" (15-49 years old) was 132,144,900 in 2010. The number of people taking voluntary consultation and testing (VCT) in 2011 is 220,000 or around 0.17 per cent of the active population. Among the general active age population, prevalence is estimated to be 0.3 per cent.[13]
- Other assumptions are the same as in scenario 6.

The benefit package includes:

- One free voluntary counseling and testing (VCT) per year for members of the active age group (15-49 years old). 20 per cent of the total active population would receive free testing in 2012 and the proportion would increase by ten per cent every year to 100 per cent by 2020.[14]
- Two viral loads and two CD4 counts per PLWA per year. Fifty per cent of PLWA would receive free medical check-ups in 2012 and the proportion would increase by ten per cent every year to 100 per cent by 2017.
- ARV treatment for the PLWA in need of treatment (either first line or second line depending on the needs of the patient). Fifty per cent of the PLWA in need of treatment would receive ART in 2012 and increase by ten per cent every year to 100 per cent by 2017.

The population is projected over the years 2012-2020 and the costs of testing and treatments are indexed on inflation.

5.2.7.2 Results

The provision of HIV testing for all sexually active population (age 15-49), regular check-ups for all PLWHIV, and ARV treatment for all PLWHIV in need of treatment would cost 0.08 per cent of GDP and 0.44 per cent of government expenditures by 2020.

5.2.8 Scenario 8: Introduction of a universal package to reduce mother-to-child transmission (MTCT) for HIV and syphilis

5.2.8.1 Assumptions

- The total number of births in 2010 was 4,485,000 and we assume that this represents the total number of mothers delivering in 2010.
- The number of births in need of MTCT prevention procedures is estimated to be 5,730 in 2010, 6,340 in 2011, 6,890 in 2012, 7,320 in 2013 and 8,170 in 2014 (based on the MOH's Mathematic Model of HIV Epidemic in Indonesia, 2008). Figures for 2015-2020 assume constant increase based on the average increase in the previous years.
- The per person cost of VCT for HIV in 2010 was IDR 171,044 if the result was positive, and IDR 57,015 if the result was negative. We assume that the estimated number of births in need of MTCT consists of those whose test result is positive (thus with higher test cost). The ART prophylaxis for a delivery in which the mother is found HIV positive cost IDR 6,512,833 in 2010.

13 Based on consultation with UNAIDS and UN PDF working group on HIV.

14 In line with the rights-based approach, this costing exercise envisions the availability of service for 100% of the targeted population though the actual number of people utilizing the service, as discussed with several stakeholders during the assessment, may be much lower.

- Estimated prevalence of syphilis among pregnant women is 1.7 per cent (WHO, 2009).[15] The cost of a syphilis test is IDR 25,000 if the result is positive and IDR 2,000 if the result is negative. The prevalence rate is used to estimate the number of positive test result.
- The cost of antibiotic treatment for syphilis in 2010 was approximately IDR 20,000.[16]

The benefit package includes:

- One free HIV VCT and one free syphilis test for all mothers who will deliver in the year. Twenty per cent of future mothers would receive free testing in 2012 and the proportion would increase by 10 per cent every year to 100 per cent by 2020.
- Those living with HIV will receive ART prophylaxis to reduce the mother to child HIV transmission, and those with syphilis will receive antibiotic treatment. Twenty per cent would receive the treatment in 2012 and the proportion would increase by 10 per cent every year to 100 per cent by 2020.

5.2.8.2 Results

The introduction of a universal package to reduce mother to child transmission of HIV and syphilis would cost 0.002 per cent of GDP and 0.014 per cent of government expenditures by 2020.

15 This figure is based on a two-month trial in 15 health centres and three hospitals of four districts in 2007, where 2,640 pregnant women were tested for syphilis and 52 (1.97%) were found to be positive. See WHO's 'Regional strategy for the elimination of congenital syphilis', 2009.

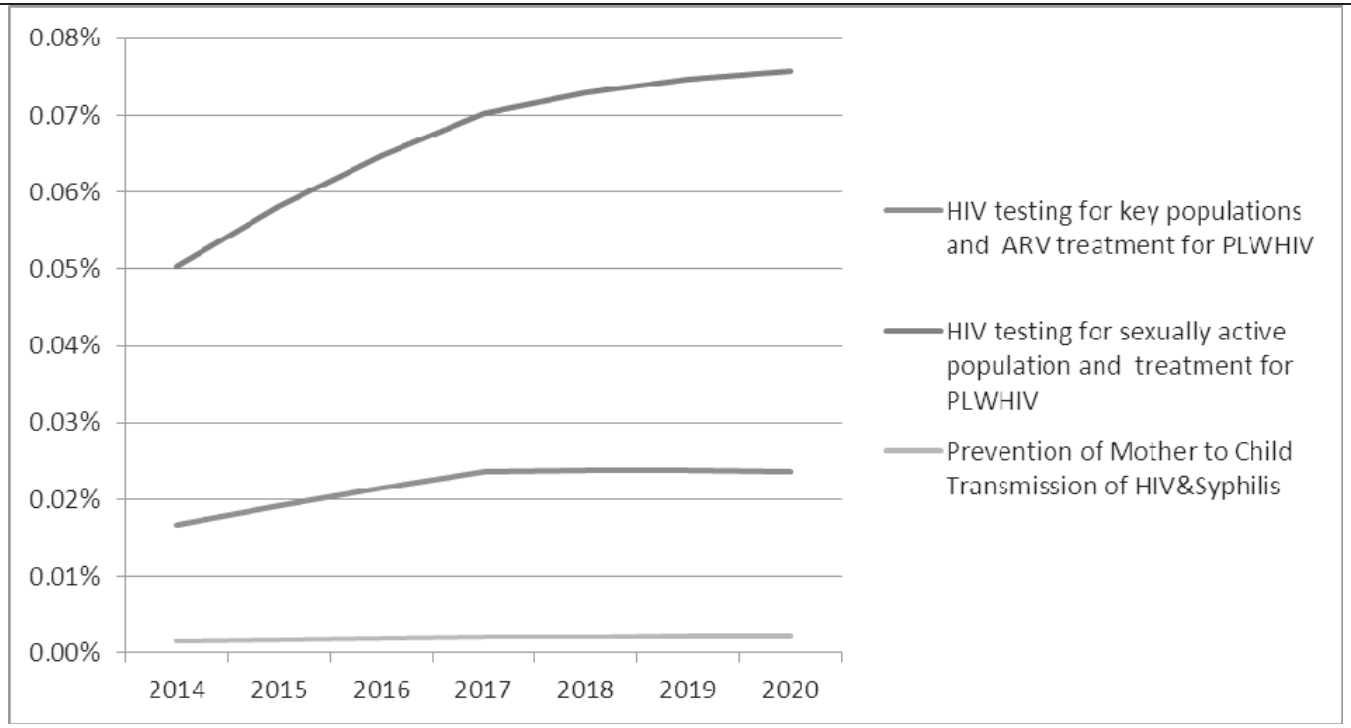
16 Based on consultation with members of UN-PDF working group on HIV.

Table 12. Projection of the cost of the proposed HIV-related benefits scenarios

Scenario 6. Inclusion of HIV testing for key populations and ARV treatment for PLWHIV							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Coverage of VCT for key populations	40%	50%	60%	70%	80%	90%	100%
Coverage of ART for PLWHIV	70%	80%	90%	100%	100%	100%	100%
Two free VCT per year for key populations	390 694	505 790	631 729	763 218	902 545	1 049 684	1 204 651
Two CD4 count per PLWA per year	158 625	201 505	250 361	305 946	335 128	365 785	397 980
Two viral loads per PLWA per year	793 127	1 007 524	1 251 807	1,529 728	1 675 638	1 828 925	1989 902
ARV line 1	272 218	350 468	439 616	540 711	594 669	650 360	707 811
ARV line 2	96 593	143 670	204 970	283 230	346 492	418 089	498 606
Total (in million IDR)	1 711 257	2 208 957	2 778 482	3 422 833	3 854 471	4 312 844	4 798 951
Total in % of GDP	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%
Total in % of Govt. Expenditure	0.09%	0.10%	0.12%	0.13%	0.13%	0.14%	0.14%
Scenario 7. Inclusion of HIV test for all productive age population and ARV treatment for PLWHIV							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Coverage of VCT all productive age population	40%	50%	60%	70%	80%	90%	100%
Coverage of ART for PLWHIV	70%	80%	90%	100%	100%	100%	100%
One free VCT per year for active age	3 831 616	4 960 391	6 195 498	7 485 046	8 851 448	10 294 478	11 814 270
Two CD4 count per PLWA per year	158 625	201 505	250 361	305 946	335 128	365 785	397 980
Two viral loads per PLWA per year	793 127	1 007 524	1 251 807	1 529 728	1 675 638	1 828 925	1 989 902
ARV line 1	272 218	350 468	439 616	540 711	594 669	650 360	707 811
ARV line 2	96 593	143 670	204 970	283 230	346 492	418 089	498 606
Total (in million IDR)	5 152 179	6 663 558	8 342 251	10 144 660	11 803 374	13 557 637	15 408 570
Total in % of GDP	0.05%	0.06%	0.06%	0.07%	0.07%	0.07%	0.08%
Total in % of Govt. expenditure	0.27%	0.31%	0.35%	0.39%	0.41%	0.43%	0.44%

Scenario 8. Introduction of a universal package to reduce mother-to-child transmission of HIV and Syphilis							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Take up rate	40%	50%	60%	70%	80%	90%	100%
One free VCT for all pregnant women	123 731	156 435	187 037	224 877	264 733	306 643	350 507
ART prophylaxis to reduce MTCT for HIV+ mothers	26 187	36 258	47 908	61 309	76 572	93 829	113 220
One free syphilis test for all pregnant women	5 304	6 703	8 011	9 629	11 333	13 123	14 996
Antibiotic treatment for syphilis	852	1 077	1 287	1 547	1 820	2 108	2 408
Total (in million IDR)	156 074	200 473	244 243	297 362	354 458	415 703	481 131
Total in % of GDP	0.002%	0.002%	0.002%	0.002%	0.002%	0.002%	0.002%
Total in % of Govt. exp.	0.008%	0.009%	0.010%	0.011%	0.012%	0.013%	0.014%

Figure 4. Projection of the cost of the proposed HIV-related benefits scenarios (% GDP)



5.3 Children "all children enjoy income security through transfers in cash or kind, at least at the level of the nationally defined poverty line level, ensuring access to nutrition, education and care"

Among the recommendations on income security for children, the following are relevant for the costing exercise:

- Expand the PKH programme to more areas and more recipient households;
- Explore and calculate the cost of a universal child allowance.

We translated these recommendations in the following scenarios:

- Scenario 1: Extending PKH to all poor households (and not only to the very poor households) in line with original government plan.
- Scenario 2: Scenario 1 + increased benefit package for children 13-15 years old. Since the target group for the primary and junior secondary school scholarships is the same as that of PKH, we propose to have only one programme.
- Scenario 3: Establishment of a universal child allowance for all children 0-15 years old.

We then calculated the cost of these scenarios using the RAP protocol. The assumptions and the results of the cost calculations are presented below.

5.3.1 Scenario 1: Extension of the PKH programme to all poor households (and not only to the very poor households)

5.3.1.1 Assumptions

- The number of poor households covered will increase (according to the initial government plan as stated in the general guideline of the PHK programme from the MoSA, 2010) to 6.5 million households, and then progressively decrease as some are expected to 'graduate' above the poverty line. According to the initial plan, the 6.5 million would be reached in 2010. However, given current trends, we assume that this target would be reached in 2016.
- The beneficiaries of the PKH include children under five (28.81 per cent of total beneficiaries), children of primary school age (50.85 per cent), children of junior secondary school age (18.64 per cent) and pregnant or lactating mothers (1.69 per cent). We assume that this composition, which is based on proportions of existing beneficiaries, will remain constant over time.
- The benefit package and administrative costs are the following in 2012 and we assume that the benefits and administrative costs will increase with inflation:

Table 13. Benefits provided by scenario 1

Beneficiary type	Annual amount (IDR)
Children under five	800 000
Primary school age	400 000
Junior secondary school age	800 000
Pregnant or lactating mother	800 000
Fixed per household	200 000
Admin costs/hh (estimates)	220 000

5.3.1.2 Results

The extension of the PKH programme to all poor households (and not only to the very poor households) will entail an additional cost of 0.03 per cent of GDP and 0.20 per cent of government expenditures by 2020, on top of the PKH expenditure for the current target. The total cost of the PKH programme will cost 0.05 per cent of GDP and 0.27 per cent of government expenditures by 2020.

5.3.2 Scenario 2: Scenario 1 + increased benefit package for children 13- 15 years old

5.3.2.1 Assumptions

- Same as scenario 1.
- The benefit package and administrative costs are the same as in scenario 1 except for the junior secondary school children. For this category, the benefit package is IDR 1,200,000 per year instead of IDR 800,000.

Table 14. Benefits provided by scenario 2

Beneficiary type	Annual amount (IDR)
Children under five	800 000
Primary school age	400 000
Junior secondary school age	1 200 000
Pregnant/lactating mother	800 000
Fixed per household	200 000
Admin costs (estimates)	220 000

5.3.2.2 Results

The extension of the PKH programme to all poor households (and not only to the very poor households) including an increased benefit package for junior secondary school children will cost an additional 0.04 per cent of GDP and 0.22 per cent of government expenditures by 2020. The total cost of the PKH programme will become 0.05 per cent of GDP and 0.28 per cent of government expenditures by 2020.

5.3.3 Scenario 3: Establishment of a universal child allowance for all children

5.3.3.1 Assumptions

- The child allowance is IDR 400,000 per person per year, based on the current PKH benefit for primary school children. The administrative costs are assumed to be similar to those of the previous BLT unconditional cash transfer programme, which was five per cent.
- The take up rate is 20 per cent in 2012 and increases by ten percent each year until participation reaches 100 per cent in 2020.
- The benefits and administrative costs increase with inflation

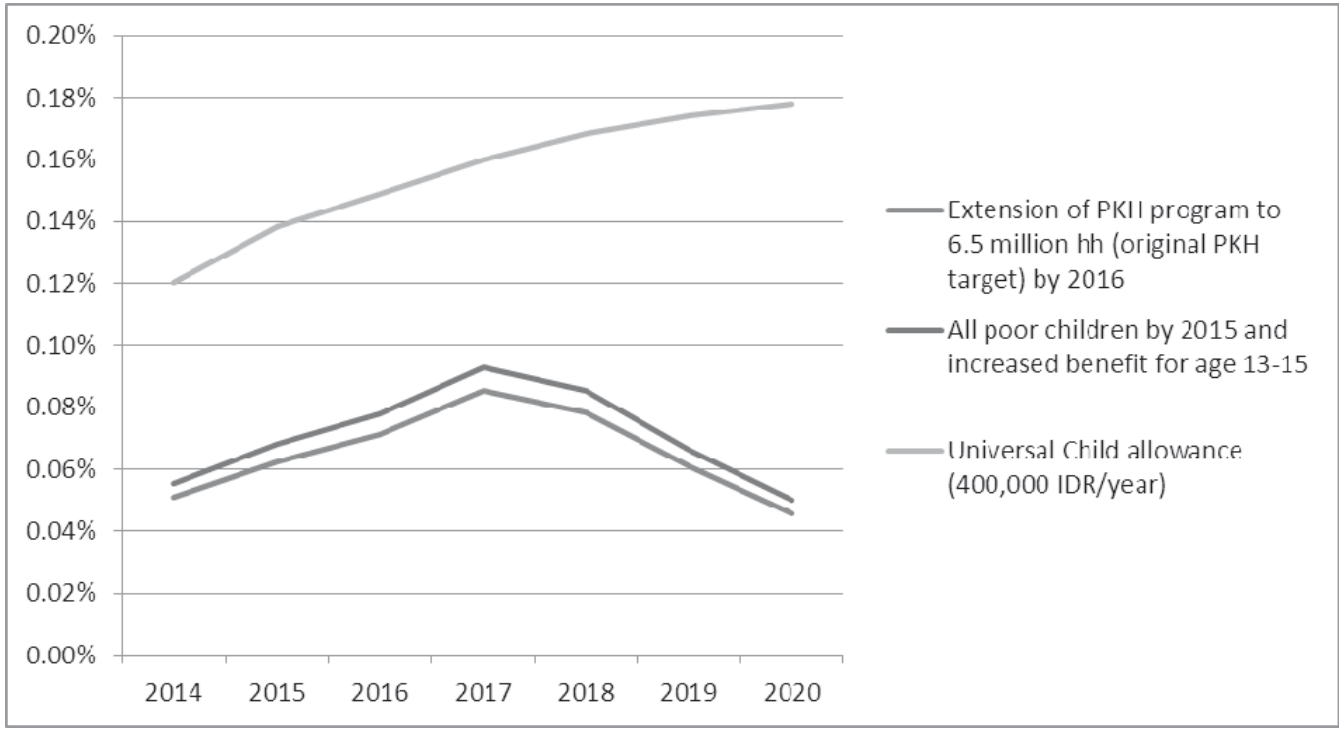
5.3.3.2 Results

The establishment of a universal child allowance for all children will cost 0.18 per cent of GDP and 1.04 per cent of government expenditures by 2020.

Table 15. Projection of the cost of the proposed child benefits

Scenario 1. Extension of the PKH programme to all poor households (and not only the very poor households)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Number of households covered in thousands	4 000	5 000	6 500	6 500	6 500	5 500	4 500
Average cost per HH (thousands IDR)	1 732	1 785	1 838	1 893	1 950	2 008	2 069
Total additional cost in million IDR	5 092 625	7 034 167	9 998 876	10 298 842	10 607 807	8 917 719	7 116 679
Total additional cost in % GDP	0.05%	0.06%	0.08%	0.07%	0.07%	0.05%	0.03%
Total additional cost in % Govt. expenditure	0.26%	0.32%	0.42%	0.39%	0.37%	0.28%	0.20%
Scenario 2. Scenario 1 + increased benefit package for children from 13 to 15 years old							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Number of households covered in thousands	4 000	5 000	6 500	6 500	6 500	5 500	4 500
Average cost per HH (thousands IDR)	1 891	1 949	2 007	2 067	2 129	2 193	2 193
Total additional cost in million IDR	5 730 214	7 855 629	11 098 333	11 431 283	11 774 221	9 934 294	7 677 299
Total additional cost in % GDP	0.06%	0.07%	0.09%	0.08%	0.07%	0.05%	0.04%
Total additional cost in % Govt. Expenditure	0.30%	0.36%	0.46%	0.44%	0.41%	0.31%	0.22%
Scenario 3. Universal child allowance							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Number of children covered in thousands	67 229	67 456	65 945	66 114	66 255	66 365	66 432
Take up rate	40%	50%	60%	70%	80%	90%	100%
Total cost in million IDR	12 274 777	15 868 069	19 165 347	23 089 339	27 237 323	31 613 933	36 216 506
Total cost in % GDP	0.12%	0.14%	0.15%	0.16%	0.17%	0.17%	0.18%
Total cost in % Govt. Expenditure	0.64%	0.73%	0.80%	0.88%	0.94%	0.99%	1.04%

Figure 5. Projection of the cost of the proposed child benefits (% GDP)



5.4 Working age population "all those in active age groups who cannot (due to unemployment, underemployment or sickness) or should not (in case of maternity) earn sufficient income on the labour market should enjoy a minimum income security through social transfer in cash or in kind schemes or employment guarantee schemes"

Among the recommendations on income security for the working age population, the following recommendation is relevant to the costing exercise:

- Develop a public employment programme linked with skills development for workers in the informal economy.

We translated the above recommendation into the following scenario:

5.4.1 Scenario 1 - Establishment of a public works guarantee linked with vocational training

5.4.1.1 Assumptions

- The coverage of the programme is progressively increased to 25 per cent of informal economy workers by 2020.
- The programme provides a guarantee of 30 days of work per person per year and is paid at the rate of the minimum wage per day (which we assume will increase with inflation).
- In addition, the beneficiaries of the programme are entitled to ten days of training every five years.
- The estimated training cost is IDR 1,700,000 per person per training (taken from a World Bank survey on BLK programs, 2011c).
- The administrative costs are assumed to be 15 per cent. .

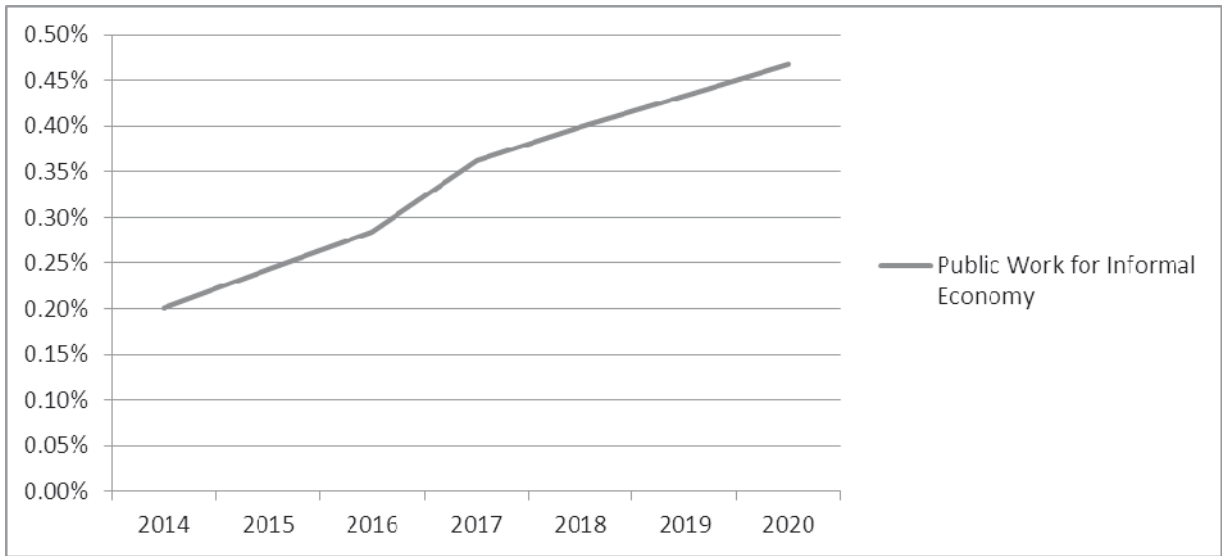
5.4.1.2 Results

The establishment of a public works programme will cost 0.47 per cent of GDP and 2.72 per cent of government expenditures by 2020.

Table 16. Projection of the cost of the proposed benefits for the working age group

Scenario 1. Establishment of a public works guarantee linked with vocational training							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Coverage	8.3%	11.1%	13.9%	16.7%	19.4%	22.2%	25%
Number of persons covered (thousands)	6 556	8 868	11 240	13 672	16 162	18 707	21 308
Number of days of work/person/year	30	30	30	30	30	30	30
Minimum wage per day (IDR)	66 927	72 674	78 857	85 638	93 039	101 122	109 951
Number of trainees per year	2 249	2 311	2 372	4 553	4 676	4 795	4 912
Cost of training/person (IDR)	2 091 635	2 155 869	2 219 575	2 286 162	2 354 747	2 425 389	2 498 151
Total Admin cost (15%)	2 680 257	3 647 547	4 778 404	6 830 219	8 418 253	10 257 085	12 382 977
Total cost (in million IDR)	20 548 636	27 964 527	36 634 430	52 365 013	64 539 939	78 637 654	94 936 160
Total in % GDP	0.20%	0.24%	0.28%	0.36%	0.40%	0.43%	0.47%
Total in % govt. expenditure	1.06%	1.29%	1.53%	1.99%	2.23%	2.47%	2.72%

Figure 6. Projection of the cost of the proposed benefits for the working age group (% GDP)



5.5 Elderly and disabled people "all residents in old age and residents with disabilities have income security at least at the level of the nationally defined poverty line through pensions for old age and disability or transfers in kind"

Among the recommendations on income security for the elderly and people with disabilities, the following recommendation is relevant to the costing exercise:

- Explore the possible extension and calculate the cost of a non-contributory minimum pension scheme for the elderly and people with severe disabilities.

We translated this recommendation in the following four scenarios:

- Scenario 1: Extension of the non-contributory pension to all severely disabled persons.
- Scenario 2: Extension of the non-contributory pension to all the vulnerable elderly.
- Scenario 3: Establishment of a non-contributory pension for all the 55+ elderly.
- Scenario 4: Establishment of a non-contributory pension for all the 65+ elderly.

5.5.1 Scenario 1: Extension of existing non-contributory pension scheme (JSPACA pilot programme) for all people with severe disabilities

5.5.1.1 Assumptions

- The estimated number of severely disabled people was 163,000 in 2010 and will increase at the same rate as the general population growth. This number is based on estimations expressed by officials as quoted in the media as well as through discussions. Accurate data and an official estimation are not yet available. The Ministry of Social Affairs recognizes that the actual number of severely disabled people may be much higher.
- The percentage of persons covered will progressively grow from 11.8 per cent in 2012 and increase to 100 per cent in 2020.
- The benefit amount is IDR 300,000 per month (based on the current JSPACA benefit) and increases with inflation.
- The administrative cost is 15 per cent.

5.5.1.2 Results

The extension of the existing non-contributory pension scheme for all severely disabled persons will cost an additional 0.005 per cent of GDP and 0.026 per cent of government expenditures by 2020, on top of the cost for the existing coverage. The total spending for the programme will cost 0.005 per cent of GDP and 0.029 per cent of government expenditures by 2020.

5.5.2 Scenario 2: Extension of a non-contributory pension (JSLU pilot programme) for all vulnerable elderly

5.5.2.1 Assumptions

- The percentage of the elderly in vulnerable situations is assumed to be 9.2 per cent of the total elderly population (60 years and above) and remains constant over time. The number is based on estimates of 1,700,000 vulnerable elderly in 2010.

- The percentage of the vulnerable elderly covered will progressively grow from 0.75 per cent in 2011 to 100 per cent in 2020.
- The benefit amount is IDR 300,000 per month (based on the current JSLU benefit) and increases with inflation.
- The administrative cost is 15 per cent.

5.5.2.2 Results

The extension of the existing non-contributory pension scheme will cost 0.074 per cent of GDP and 0.43 per cent of government expenditure by 2020. As the current spending on JSLU is very low, this additional cost is almost the same of the total amount of the programme.

5.5.3 Scenario 3: Establishment of a universal pension for elderly of 55+ (the legal retirement age in the formal sector)

5.5.3.1 Assumptions

- The percentage of the elderly 55 years of age and older covered by the universal pension will reach 100 per cent by 2020.
- The amount of benefits equals the average poverty line of IDR 226,335 per person per month in 2011 and increases with inflation.
- The administrative costs are 5 per cent.

5.5.3.2 Results

The establishment of a universal pension for elderly 55 years of age and older will cost 0.82 per cent of GDP and 4.75 per cent of government expenditures by 2020.

5.5.4 Scenario 4: Establishment of a universal pension for elderly of 65+

5.5.4.1 Assumptions:

- The percentage of the elderly 65 years of age and older covered by the universal pension will reach 100 per cent by 2020.
- The amount of benefits equals the average poverty line of IDR 226,335 per person per month in 2011 and increases with inflation.
- The administrative cost is 5 per cent.

5.5.4.2 Results

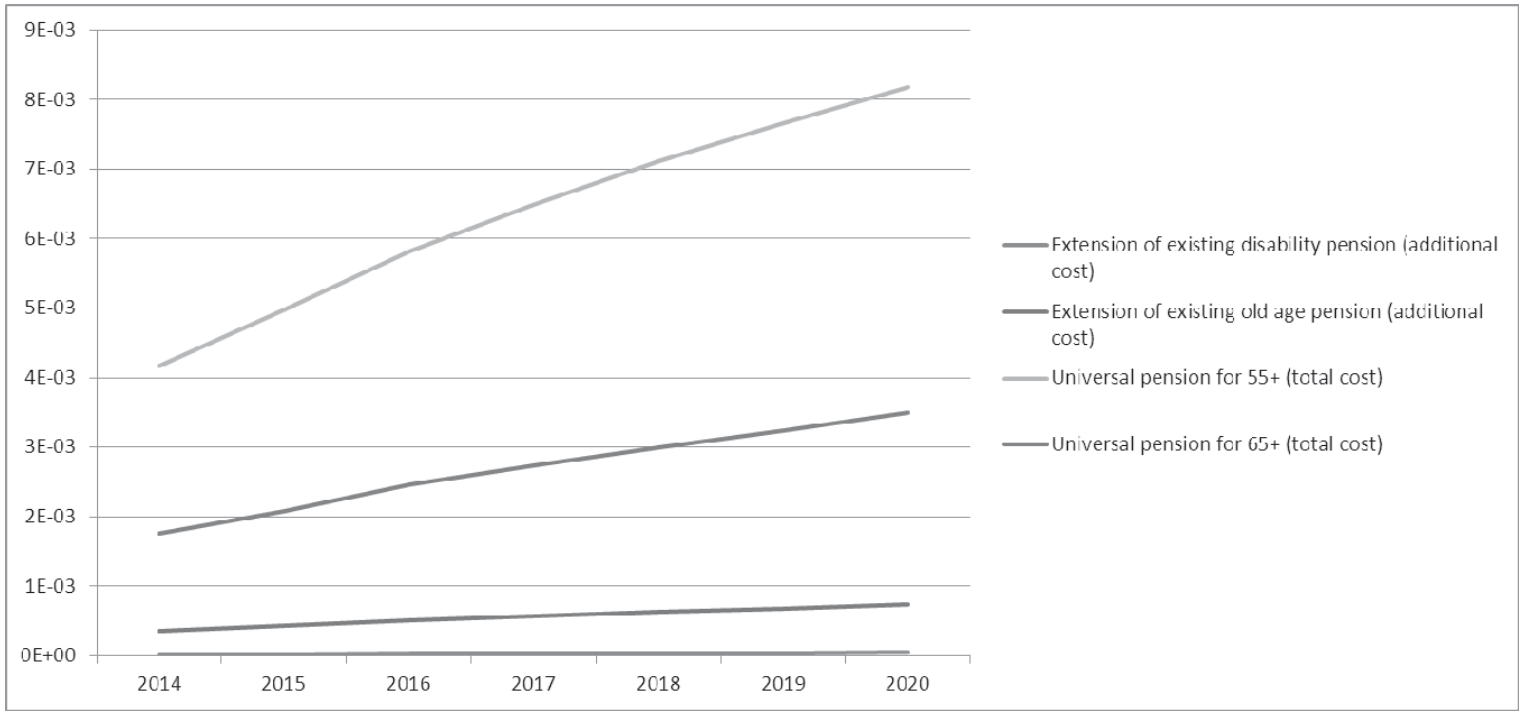
The establishment of a universal pension for elderly of 65 years of age and older will cost 0.35 per cent of GDP and 2.03 per cent of government expenditures by 2020.

Table 17. Projection of the cost of the proposed benefits for people with severe disabilities and the elderly

Scenario 1. Extension of existing non-contributory pension scheme for all severely disabled persons							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Estimated severely disabled population	170 545	172 356	174 249	176 161	178 043	179 877	181 671
Percentage of population covered	40%	50%	60%	70%	80%	90%	100%
Benefits/person/month (inflated)	344 103	354 670	365 151	376 105	387 388	399 010	410 980
Total additional cost (in million IDR)	231 344	326 352	428 570	538 813	657 201	784 043	919 755
Total additional cost In % of GDP	0.002%	0.003%	0.003%	0.004%	0.004%	0.004%	0.005%
Total additional cost In % of govt. expenditure	0.012%	0.015%	0.018%	0.021%	0.023%	0.025%	0.026%
Scenario 2. Extension of a non-contributory pension for all vulnerable elderly (without family support)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Estimated vulnerable elderly (thousands)	1 983	2 064	2 200	2 296	2 404	2 523	2 653
Percentage of population covered	40%	50%	60%	70%	80%	90%	100%
Benefits/person/month (inflated)	344 103	354 670	365 151	376 105	387 388	399 010	410 980
Total additional cost (in million IDR)	3 704 554	4 985 918	6 585	8 271 742	10 210 066	12 429	14 970
Total additional cost In % of GDP	0.036%	0.043%	0.051%	0.057%	0.063%	0.068%	0.074%
Total additional cost In % of govt. expenditure	0.19%	0.23%	0.28%	0.31%	0.35%	0.39%	0.43%
Scenario 3. Establishment of a universal pension for old age people of 55+ (the legal retirement age in the formal sector)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
55+ population (thousands)	32 533	33 867	35 986	37 470	39 064	40 751	42 543
Percentage of population covered	40%	50%	60%	70%	80%	90%	100%
Benefits/person/month (inflated)	259 609	267 581	275 488	283 753	292 266	301 034	310 065
Total cost (in million IDR)	42 567 618	57 092 225	74 947 136	93 775 735	115 082 536	139 111 519	166 208 369
Total cost in % of GDP	0.42%	0.50%	0.58%	0.65%	0.71%	0.77%	0.82%
Total cost in % of govt. expenditure	2.20%	2.63%	3.14%	3.57%	3.98%	4.38%	4.75%

Scenario 4. Establishment of a universal pension for old age people of 65+							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
65+ population (thousands)	13 691	14 162	15 225	15 797	16,453	17 231	18 188
Percentage of population covered	40%	50%	60%	70%	80%	90%	100%
Benefits/person/month (inflated)	259 609	267 581	275 488	283 753	292,266	301 034	310 065
Total cost (in million IDR)	17 913 167	23 874 106	31 708 364	39 534 179	48 469 977	58 821 143	71 056 352
Total cost in % of GDP	0.18%	0.21%	0.25%	0.27%	0.30%	0.32%	0.35%
Total cost in % of govt. expenditure	0.93%	1.10%	1.33%	1.50%	1.68%	1.85%	2.03%

Figure 7. Projection of the cost of the proposed benefits for people with severe disabilities and the elderly (5 GDP)



5.6 Consolidated package to close the social protection floor

To close the social protection floor gap in Indonesia, we propose two possible combinations of schemes, the "low scenario" and the "high scenario":

Table 18. Low and high combined scenarios to compare the social protection floor in Indonesia

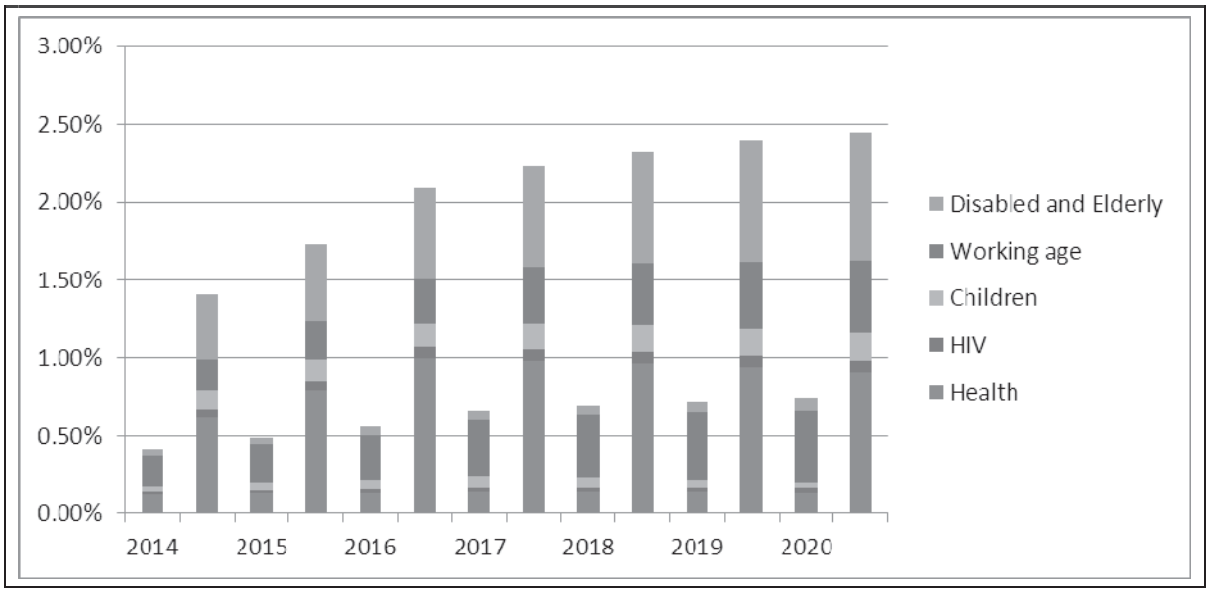
		Low	High
Health	Scenario 1: Extension of health insurance to poor, near poor, and vulnerable population at third class-moderate level benefits	X	
	Scenario 5: Provision of health insurance to all informal economy population at first class-high level benefits		X
	Scenario 6: Inclusion of HIV testing for high-risk population, regular check-ups for all PLWHIV and ARV treatment for all PLWHIV who are eligible for treatment	X	
	Scenario 7: Inclusion of HIV testing for the general sexually active population (age 15-49), regular check-ups for all PLWHIV and ARV treatment for all PLWHIV who are eligible for treatment		X
	Scenario 8: Introduction of a universal package to reduce mother-to- child transmission (MTCT) for HIV and Syphilis	X	X
Children	Scenario 1: Extension of the PKH programme to all poor households (and not only to the very poor households)	X	
	Scenario 3: Universal child allowance		X
Working age	Scenario 1: Establishment of a public works guarantee linked with vocational training	X	X
Disabled Elderly	Scenario 1: Extension of existing non-contributory pension scheme for all people with severe disabilities	X	X
	Scenario 2: Extension of a non-contributory pension for all the vulnerable elderly	X	
	Scenario 3: Establishment of a universal pension for old age people of 55+ (the legal retirement age in the formal sector)		X

Based on these two combinations, completing the SPF would cost between 0.74 per cent and 2.45 per cent of the GDP by 2020.

Table 19. Projection of the cost of proposed combined low and high scenarios to complete the social protection floor in Indonesia (%GDP)

Possible "Low Scenario" in order to close the SPF gap in Indonesia (% GDP)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Health- Scenario 1	0.12%	0.13%	0.14%	0.14%	0.14%	0.14%	0.14%
HIV- Scenarios 6 and 8	0.02%	0.02%	0.02%	0.03%	0.03%	0.03%	0.03%
Children- Scenario 1	0.05%	0.06%	0.08%	0.07%	0.07%	0.05%	0.03%
Working age- Scenario 1	0.20%	0.24%	0.28%	0.36%	0.40%	0.43%	0.47%
Disabled Elderly- Scenario 1 and 2	0.04%	0.05%	0.05%	0.06%	0.07%	0.07%	0.08%
Total	**0.43%**	**0.50%**	**0.58%**	**0.66%**	**0.70%**	**0.72%**	**0.74%**
Possible "High Scenario" in order to close the SPF gap in Indonesia (% GDP)							
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Health- Scenario 5	0.62%	0.79%	1.00%	0.99%	0.96%	0.94%	0.90%
HIV- Scenario 7 and 8	0.05%	0.06%	0.07%	0.07%	0.08%	0.08%	0.08%
Children- Scenario 3	0.12%	0.14%	0.15%	0.16%	0.17%	0.17%	0.18%
Working age- Scenario 1	0.20%	0.24%	0.28%	0.36%	0.40%	0.43%	0.47%
Disabled and Elderly- Scenario 1 & 3	0.42%	0.50%	0.59%	0.65%	0.71%	0.77%	0.82%
Total	**1.41%**	**1.73%**	**2.09%**	**2.23%**	**2.32%**	**2.39%**	**2.45%**

Figure 8. Projection of the cost of proposed combined low and high scenarios (% GDP)



Preliminary indications of the fiscal space

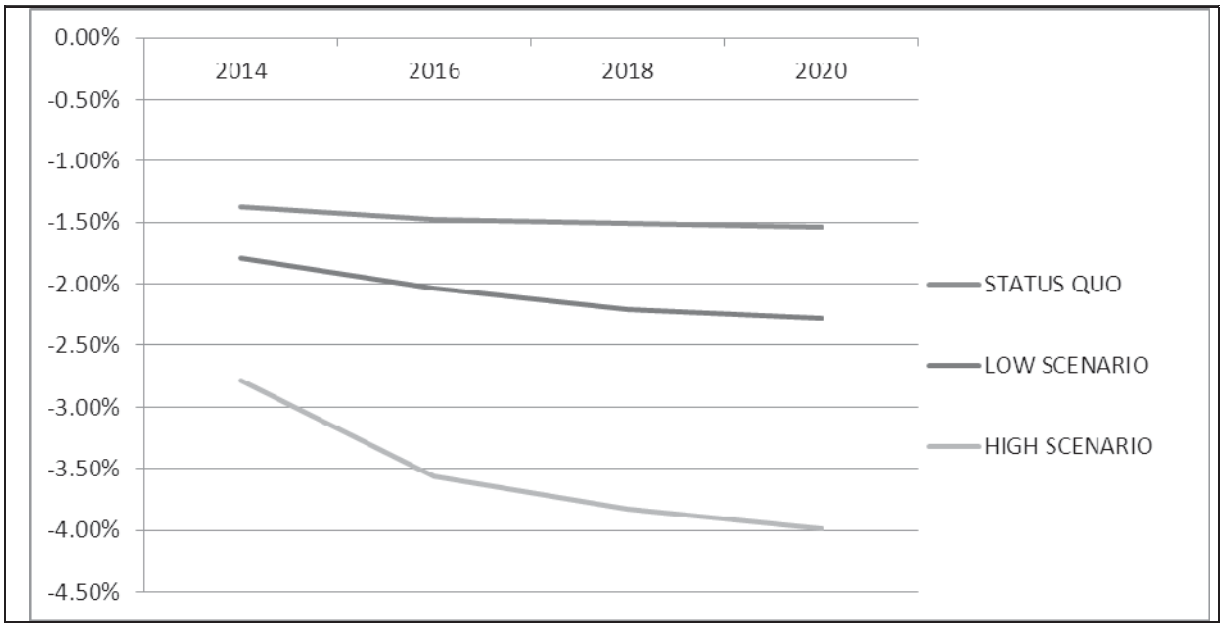
6

We added the estimated cost of the low and high scenarios to government budget projections and came up with the balance (government revenues and grants minus expenditures) in Indonesian rupiah and in percentage of GDP for the status quo, the low scenario, and the high scenario. This provides an indication of the fiscal space in case the proposed social provisions are financed entirely from the Government's budget.

Table 20. Fiscal space: Low and high scenarios entirely financed from the government's budget

Year	2014	2016	2018	2020
Balance in million rupiah – Status quo	(140 786 015)	(189 656 153)	(243 974 955)	(312 648 307)
Balance in million rupiah – Low scenario	(183 164 434)	(261 334 641)	(357 053 961)	(463 711 433)
Balance in million rupiah – High scenario	(284 750 716)	(458 403 373)	(619 683 659)	(810 486 432)
BALANCE (in % of GDP at current prices) - Status Quo	-1.38%	-1.47%	-1.51%	-1.54%
BALANCE (in % of GDP at current prices) - Low scenario	-1.79%	-2.03%	-2.20%	-2.28%
BALANCE (in % of GDP at current prices) - High scenario	-2.79%	-3.56%	-3.83%	-3.98%

FIgure 9. Fiscal space: Low and high scenarios entirely financed from the government's budget (% GDP)



The model shows that overall government expenditures under the status quo would create a negative fiscal space balance of around 1.38 per cent of GDP in 2014. The additional cost of new social protection floor initiatives under the low scenario and high scenario in 2014 will increase the negative fiscal space balance by an additional 0.4 per cent of GDP and 1.4 per cent of GDP, respectively. Both scenarios would entail a deficit in the government's budget beyond 2020. In both cases, budget reallocations, changes in the tax structure and/or the collection of social contributions from some segments of the population would be needed. Sequencing the implementation or further extension of the social protection floor components can also be considered, in line with the Social Protection Floors Recommendation, 2012 (No. 202).

Annexure 1: SPF Assessment matrix

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http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=26262

Annexure 2: Legal and human rights framework in Indonesia

8

Table 21. Legal and Human Rights Framework in Indonesia

No	4 SPF Guarantees	International conventions signed by Indonesia	National law and policy
1	All residents have access to essential health care	1. ICCPR, ratified in 2005 Art.25 2. ICESCR, ratified in 2005 Art.12 3. CRC, ratified in 1990 Art. 3 (3), Art. 23, Art.24 4. CEDAW, ratified in 1984 Art. 5 5. CERD, ratified in1999 Art. 5 6. UDHR 7. ILO Convention No. 19 on Equality of Treatment 8. ILO Convention No. 111 on Discrimination	1. Law No. 12/2005 on Ratification of ICCPR 2. Law No. 11/2005 on Ratification of ICESCR 3. Presidential Decree No. 36/1990 of Ratification of CRC 4. Law No. 7/1984 on Ratification of CEDAW 5. Law No. 29/1999 on Ratification of CERD 6. Law No.40/2008 on the elimination of Racial and Ethnic Discrimination 7. Law No.36/2009 on Health 8. Law No. 39/1999 on Human Rights 9. Law No. 40/2004 on National Social Security System 10. Law No. 17/2004 on the National Development Plan 11. Law No.35/2009 on Narcotics 12. Draft Presidential decree on the National Programme for children by 2005 (covering four areas namely Education, Health, HIV/AIDS, protection) 13. Presidential Instruction No.9/2009 on Gender Mainstreaming
	All Children enjoy income security through transfers in cash and in kind allowing access to nutrition, education, and care	1. ICESCR, Art 9, 10 2. CRC, Art.26, 28 3. ILO Convention No. 138 on Minimum Age 4. ILO Convention No. 182 on Worst Forms of Child Labour	1. Law No. 23/2002 on Child's Protection 2. Law No.40/2004 on National Social Security System 3. Law No. 20/2003 in National Education System 4. Government's Nine Year Compulsory Basic Education Programme United Nations Development Assistance Framework in Indonesia 2006-2010
	All those in active age group who cannot earn sufficient income enjoy a minimum income security	1. ICESCR, Art.9, 11 2. UDHR, Art. 23	1. Law No.13/2003 on Labour 2. Law No.40/2004 on National Social Security System 3. Law No. 11/2009 on Social Welfare
	All residents in old age and all residents with disabilities have income security through pension or transfers in kind	1. ICESCR, Art. 9, 11 2. CEDAW, Art. 11 3. UDHR, ART 23, 25 4. CRPD, Ratified in October 2011, Art. 28	1. Law No. 3/1992 on Workers Social Security 2. Law No. 40/2004 on National Social Security System 3. Law No. 11/1992 on Pension Fund 4. Law No. 4/1997 on Persons with Disabilities 5. Law No. 11/2009 on Social Welfare

Source: UNAIDS

Annexure 3: Laws and regulations

9

- Law of the Republic of Indonesia No. 3/1992 on Workers' Social Security
- Law of the Republic of Indonesia No. 4/1997 regarding Disabled Persons
- Law of the Republic of Indonesia No. 4/1979 regarding Child Welfare
- Law of the Republic of Indonesia No. 11/2009 regarding social Welfare
- Law of the Republic of Indonesia No. 11/1969 regarding Pension for Employees [Civil Servants] and Employees' Widow/Widower
- Law of the Republic of Indonesia No. 13/1998 regarding Welfare for Elderly People
- Law of the Republic of Indonesia No. 13/2009 regarding Poverty Alleviation Coordination
- Law of the Republic of Indonesia No. 13/2003 on Manpower
- Law of the Republic of Indonesia No. 20/2003 regarding National Education System
- Law of the Republic of Indonesia No. 23/2002 regarding Child Protection
- Law of the Republic of Indonesia No.24/2011 regarding Social Security Providers
- Law of the Republic of Indonesia No. 40/2004 regarding the National Social Security System
- Law of the Republic of Indonesia No. 36/2009 regarding Health
- Decree of the President of Indonesia No. 3/2010 on Socially Just Development Programme
- Regulation of the President of Indonesia No. 5/2010 Regarding the Medium Term Development Plan (RPJM) 2010-2014
- Decree of the President of Indonesia No. 6/2007 regarding the Development of the Real Sector and SME Empowerment
- Instruction of the President of Indonesia No. 1/2010 regarding the Acceleration of the Implementation of National Development Priorities of 2010
- Regulation of the Government of Indonesia No. 14/1993 on Workers' Social Security Programme
- Regulation of the Government of Indonesia No. 25/1981 regarding Social Insurance for Civil Servants
- Regulation of the Government of Indonesia No. 28/2003 regarding Government Subsidy and Contribution to Civil Servants' Health Insurance
- Regulation of the Government of Indonesia No. 43/1998 regarding Efforts to Improve the Social Welfare of Persons with Disabilities
- Regulation of the Government of Indonesia No. 43/2004 regarding Efforts to Improve the Social Welfare of Elderly People

- Regulation of the Government of Indonesia No. 47/2008 regarding Compulsory basic education
- Regulation of the Government of Indonesia No. 48/2008 regarding Education Financing
- Regulation of the Government of Indonesia No. 67/1991 regarding Social Insurance for the Arms Forces
- Regulation of the Government of Indonesia No. 69/1991 regarding Health Care for Civil Servants, Pensioners [retired civil servants and armed forces personnel], Veterans, National Patriots and their Dependents
- Decree of the Minister of Social Affairs No. 15A/2010 on General Guidelines of PKSA Implementation
- Decree of the Minister of Social Affairs of the Republic of Indonesia No. 51/2003 regarding Social Security Programme for Poor and Vulnerable People through Social Welfare and Insurance and Permanent Social Welfare Assistance Methods.
- Decree of the Minister of Health No.686/2010 regarding the Implementation Guidelines of Jamkesmas Programme
- Decree of the Minister of Health No.631/2011 regarding the Technical Guidelines of Jaminan Persalinan (Jampersal) Programme
- Decree of the Coordinating Minister for social Welfare No. 35/2008 regarding Raskin Coordination Team
- Decree of the Coordinating Minister for Social Welfare No. 25/2007 on Guideline of PNPM Mandiri
- Regulation of the Minister of Manpower and Transmigration of the Republic of Indonesia No. 24/2006 on the Implementation Guidance of Social Security Programme for workers outside working relationship
- Regulation of the Minister of National Education of the Republic of Indonesia No. 37/2010 regarding the Technical Guidance of the utilization of BOS budget in the 2011 Budget Year
- Regulation of the Minister of National Education No. 37/2010 regarding the Technical Guidance of the utilization of BOS budget in the 2011 Budget Year.
- Regulation of the Ministry of Finance No. 135/2008 on the facilitation of the guarantee for KUR
- Regulation of the Ministry of Finance's Director General of Treasury no 20/2006 on Cash Disbursement for Severely Disabled and Abandoned Elderly

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