OSH concerns have been raised in all types of establishments and agencies, resulting in the offering of more OSH programmes in establishments.

4) Other agencies, too, have been providing OSH services and programmes. These definitely contribute to a better OSH situation in Thailand.

The purpose of this article was to provide a rough cost analysis of introducing the national agenda "Safe and Healthy Workforce" into the OSH strategic framework in Thailand. The results indicate that the introduction of the national agenda strategic framework into the OSH work plan of the DLPW was cost-effective in terms of avoiding preventable work-related accidents and deaths. In addition, the programmes had also promised potential long-term effects on the sustained development of OSH in Thailand. Nevertheless, after the implementation of OSH programmes under the national agenda implementation strategic framework, a long-term OSH surveillance system is needed in order to confirm the findings. Furthermore, a systemic evaluation should be done in order comprehensively to evaluate the economic impacts of such programmes as well as to determine effects owing merely to projects under the supervision of the DLPW. This would contribute to evaluating the efficiency of the DLPW's expenditure on OSH projects.

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Shifting Health Finance Policy towards a Better Occupational Health and Safety Program in Indonesia

Shifting health finance policy

In Indonesia, the health service programme mainly focuses on curative action. Unfortunately the majority (approximately 70% of 241 million) of the Indonesian population pay for health services by the out of pocket method or fee for service method. As a consequence, the majority of people have not been sufficiently covered by quality health care services. Since the prevention approach has not been prioritized, the implementation of occupational health and safety protection, which is an active part of health promotion and disease prevention, is far from satisfactory. Nevertheless, Indonesia has been approaching a new era since Act No 40 of 2004 concerning national social insurance was launched. The implementation of the programme has not been significantly developed, but the providers have already been appointed to start up the programmes. On the basis of Act No 24 of 2011 concerning the national social insurance provider, the two state-owned companies of Askes (Limited) and Jamsotek (Limited) will become the health social insurance provider and social insurance provider respectively. Askes (Limited) was established in 1968 and has acted as health insurance provider to serve civil servants and their family members in particular. Jamsostek (Limited) was established in 1977 and has provided worker social insurance, although this is still limited to the workers of formal sectors. Act No.24 of 2011 regarding employment social security providers required Askes (Limited) to become the health social security providers that provide health security to all Indonesian people from 1 January 2014, whereas Jamsostek (Limited) will become Employment Social Security Providers, fully operating from 1 July 2015. (1)

The regulation also stipulates that it is mandatory for both Indonesians and foreigners who have been in Indonesia for at least six months to participate in the social security programme, and to pay the membership fee in order to obtain the benefits. The Ministry of Health plans to cover the membership fee of those who are economically categorized as below the poverty line, through the membership fee aid programme. Compulsory membership aims to ensure that all people are totally protected. The implementation of the membership programme will be adjusted to the economic capacities of the government and the people, which is a prominent factor of the feasibility of the programme implementation.

The initial recruitment of social insurance members, in order to achieve universal coverage, focuses on all formal sector workers and extends their existing membership of the worker social insurance programme with Jamsostek. This will then be extended to those who work in informal sectors before the further step to finally cover all In-

Photo by Muchtaruddin Mansyur

Clove plantation workers do their work with limited personal protection equipment. They are not covered by health and social insurance.

donesian citizens.

As with the health insurance policy, the funding source of social insurance comes from membership fees, which are collected and managed by the providers. The providers will also develop a financial management programme, and manage the collected funds in order to maximize the benefits to the members. However, the policy of the funding source for those who have no ability to pay to join the social insurance programme is not yet regulated.

Existing social security system

Indonesia has been moving towards universal health coverage. The government provides primary health services in the Public Health Centre *(Pusat Kesehatan Masyarakat=Puskesmas)* and secondary health services in state-owned hospitals. People can also visit either physicians' private practices or private clinics and hospitals which are accessible throughout the country. However, people have to pay the user charge for the services they receive at puskesmas, and are fully charged if they visit private primary clinics and physicians' private practices. The majority of people can only afford the services to a limited extent, especially those who have no health insurance. People have to pay in full (full cost) for any service at the hospital, including diagnostics and specialists' procedures, surgery, and medicines. As a consequence, the majority of Indonesians have faced catastrophic risks to obtain secondary health services, and being sick exacerbates poverty. (2)

The above-mentioned are challenges, although some population groups have still been enjoying the advantages of health service facilities and social insurance. One of these groups is formal sector workers, who have some social insurance advantages. Social insurance consists of Provident Fund Benefit, Accident Benefit, Pension Benefit and Death Benefit, as well as Health Benefit, all of which are managed by Jamsostek (Limited), a state-owned company. However, the Health Benefit is not a compulsory part of this. The company is allowed to provide its own health services to its workers, but this should fulfil the recommended standards. Many medium-sized and large enterprises prefer to provide the health benefits in their own way rather than rely on the health services offered by Jamsostek. Only around 5.9 million workers joined the Jamsostek's Health Benefit Programme in 2011, only a slight increase from 5.0 million workers in 2010. (3) This means that only 22% of around 27 million participants join the Health Benefit Programme. From the worker's perspective, reluctance to participate is based on

Photo by Muchtaruddin Mansyur

A worker of personal coal mining collects coal from a river on Sumatera Island.

having easy access to health facilities and good quality services. Instead of using clinics provided by Jamsostek, workers more easily find the health facilities they need by using the health service fee reimbursement method offered by their company. If workers do not live in certain concentrated areas, the Jamsostek clinics cannot easily be visited. The clinics are located far away from many workers' living areas. By using the reimbursement method, the company allows the workers to choose the facility they prefer, which makes it easier for them to obtain better quality and more accessible health care facilities.

As well as the formal sector worker groups, Indonesia has some other groups consisting of civil servants and pensioners, the military, veterans and their family members, who enjoy advantages of social protection. The latter group also has pension benefits and provident fund benefits which are covered by the health insurance provided by Askes (Limited), the state-owned enterprise. As an insurance company, Askes has been specially assigned by the government to manage health care insurance for these groups for over 40 years, with the total number of recorded participants at 16.5 million people in 2011. In addition, since 2011, Askes (Limited) has been managing health insurance for poor people through the *Program Jaminan Kesehatan Masyarakat (Jamkesmas)* – literally meaning Public Health Care Insurance Programme – covering 76.4 million people through a membership fee aid programme. (4)

Askes has been aware that due to increasing chronic diseases they will face high-cost health care. In 2008, they started to shift the curative only health service to the disease prevention programme. The prevention programme consists of early detection by performing health screening such as Pap smear tests and diabetes mellitus screening, and annual medical check-ups for civil servants. They also provide the Hepatitis B vaccine as a complementary programme.

Although the three main population clusters described above – formal sector workers; civil servants, and the military and their families; and poor people – have been covered by existing health insurance, the majority of Indonesians who do not belong to the poor population category are still not covered by health insurance. In all, 63% (approximate 151 million) of Indonesian citizens are covered by the many methods of health insurance described above, but currently 37% (app. 89 million) of citizens still have no access to health insurance. Moreover, health care insurance is not the population's only factor for fulfilling basic life needs. They also need other social benefits, those that the formal sector workers and civil servants have. Both health insurance and the other social insurances are necessary for all.

The necessity of the universal coverage of social insurance is based on the fact that all people face unwanted life situations, including work accidents and work-related diseases. The high risk of unwanted situations can be seen clearly among the Jamsostek member workers. There were 98 711 accident cases in 2010 and 99 491 cases in 2011. The data also showed that on average 17 workers/day are functionally disabled, 10 workers/day are partially disabled, 0.2 workers/day are totally disabled, and 8 workers/day die due to work accidents. (5) Occupational diseases are also frequent in Indonesia, since many workers are exposed to potential health hazards at the workplace. Unfortunately, the data of occupational and work-related diseases has not yet been available, due to the limited ability and effort in making diagnoses. Misdiagnosis prevent workers from receiving compensation, even though they are suffering from an occupational disease.

Impacts of the policy for the occupational health and safety programme

The act concerning national social insurance states that the health care service does not contain only a curative approach, but also consists of health promotion and a disease prevention programme. This prevention programme includes health education, immunization, and family planning services. The curative approach is not only limited to the health services at the clinic or the public health centre but also includes hospitalization services, medical emergency assistance, and advanced medical services such as surgical intervention, hemodialysis, and chemotherapy. These services are standardized for better quality and options to ensure customer satisfaction.

The target of making the comprehensive health care approach into a universal coverage programme is not only to improve health care services, but also to solve public health problem issues, including the equity and efficiency of the health services. The equity and efficiency of health care services have a strong correlation with health promotion and disease prevention. (6)

Equity

The implementation of universal health coverage will help eliminate inequity in health care. Inequity due to limited funding for health care services for the majority of In-

donesians will be minimized. Accordingly, all people will have equal access to the same quality of health care facilities.

In 2009, the International Labour Organization survey found that informal sector workers strongly preferred to have social insurance with prioritized health insurance. This differed among those who work in urban areas and those who work in rural areas. The former preferred accident protection benefits, whereas the latter preferred pension benefits. Furthermore, this study found that the workers were willing to pay membership although their payment capacities were very limited. (7)

This means that without a cost sharing and subsidy scheme provided by the government, it will be difficult for informal sector workers to obtain health and social insurance. Approximately 37% (87 million) of people are not covered by health insurance, including around 64 million workers in the formal sector who have not joined the health benefit programme.

Efficiency

Financial management and its implications should not be separated from providing health services as a whole. As clearly stated in Act No 24 of 2011 concerning social insurance providers, the providers are not only to collect the membership fee, but also to manage and develop the financial management programme to ensure that the collected funds are sufficient to provide appropriate quality health services. As the social insurance providers are not profit-oriented companies, efficiency is essential in leading health and social insurance towards universal coverage. Building an efficient programme of health service, health promotion, health education, and disease prevention should be integrated into the health care services of the health and social insurances.

Occupational health and safety protection

The health promotion and disease prevention programmes should not only be limited to general health problems, but should consider health hazards related to problems specific to the work environment. These occupational health and accident hazards should be managed and controlled by reducing exposures, and minimizing risks in order to mitigate adverse health effects. This should be part of the integrated programmes of health promotion and disease prevention, aimed at both preventing work-related health problems and controlling the common diseases found among workers. Furthermore, health and safety education as a part of workplace health promotion should also identify and educate the workers at high risk of either general health disorders or specific occupational and work-related diseases. (6)

As described previously, national regulation stated that health insurance and accident benefits are managed by separate companies. The accident benefits consisted of work accident compensation and also occupational diseases compensation, including first aid, primary health care services, and necessary hospitalization services. This means that both social insurance providers are responsible for health promotion and disease prevention in the context of workers and specific occupations. Regardless of parties' responsibility, the providers offered an inefficient programme with no consideration of conducting promotive and preventive programmes. Health promotion, and disease and accident prevention through occupational health and safety programmes should be priority activities of integrated health service programmes and targeted towards both formal and informal workers. Occupational health and safety programmes are conducted by implementing the strategies of workers' education, health service improvements, and advocacy activities. The implications of integrated health promotion and disease prevention enable the workers of both the formal and the informal sectors to obtain better protection against any health hazards which may arise in their work or working conditions. This will also contribute towards the workers' physical and mental adjustment, in particular though the adaptation of work to the workers and their assignment to a job for which they are suited. These all are objectives of occupational health and safety protection, which leads to reducing health cost expenditures, preventing work time loss, increasing worker motivation, and above all, to increasing companies' productivity. (6)

Summary

The shifting health finance policy will have an impact on the occupational health and safety programme in Indonesia. The health paradigm which is oriented towards health promotion and disease prevention will more efficiently and effectively lead health financing towards improving the health status of the community. Occupational health and safety programmes will be a way of conducting the health promotion and disease prevention programmes of workplaces, which will shift the paradigm that is now only concerned with work accident and disease compensation towards more efforts in workplace health promotion through occupational health and safety programmes.

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