Universal Health Coverage in Indonesia:
Informality, Fiscal Risks and Fiscal Space for Financing UHC

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OUTLINE

SDGs: Goal 3

Good Health and Well-Being
& 9 Targets

Universal Health Coverage (Program Jaminan Kesehatan Nasional)

- Current progress
- Missing middle problem: Informality
- Challenges

Fiscal Space for UHC

- Fiscal Cost for UHC
- Financing UHC

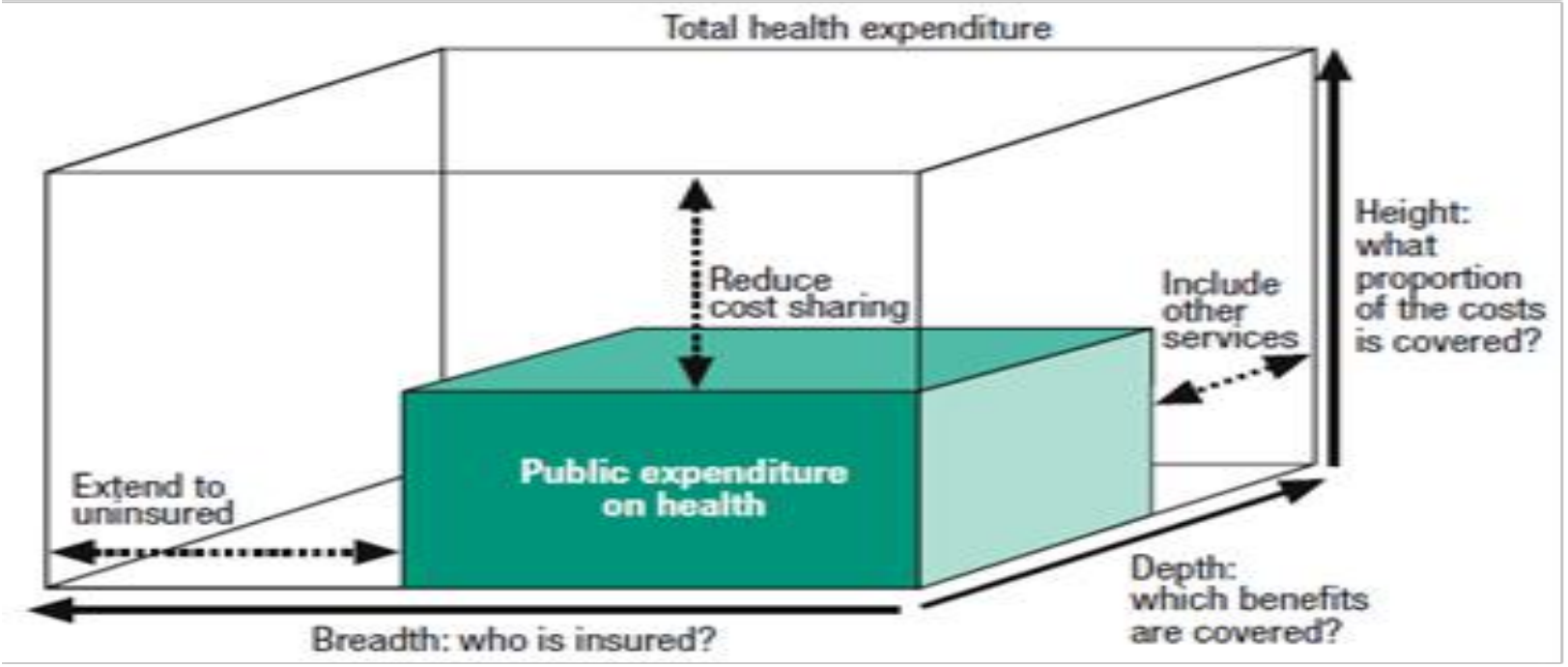
Way Forward

1.1 SDGs: Affordable Dream?

- SDGs: 17 Goals & 169 Targets
- Goal 3: Good Health and Well-Being & 9 Targets
  1. Maternal mortality
  2. Neonatal mortality
  3. End of communicable disease
  4. Premature mortality from non-communicable disease
  5. Preventing of substance abuse
  6. Global deaths and injures from road traffic accident
  7. Universal access to reproductive health care services
  8. Universal Health Coverage
  9. Deaths and illness from hazardous chemicals

1.2 Universal Health Coverage: Definition

Figure 1. Three ways of moving towards universal coverage



Source: WHO, 2008

WHO defined that Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

1.3 A Long Journey to *Jaminan Kesehatan Nasional (JKN)*

BPJS Kesehatan
Badan Penyelenggara Jaminan Sosial

Universal Health Coverage

Regulation:
- Social Security Law No. 40 Year 2004
- Social Security Agency No. 24 Year 2011

1957 — **Foundation of Social Workers (GOI)**
Private formal sector worker

1964 — Agency for Healthcare funds (GOI)
Private formal sector worker

1971 — ASABRI (Perum ASABRI under supervision of Ministry of Defense)
Military Personel

1984 — Perum Husada Bakti (State owned company)
Civil servant

1992 — **ASKES (PT. ASKES)**
Extended to civil servants, retired civil servants, retired military personnel, and their family members

1994 — Health Card Program (GOI)
Poor people

1998 — JPS Health (GOI)
Poor People

2001 — PKPKS (GOI)
Poor people as compensation of fuel price increase

2004 — ASKESKIN (PT ASKES)
Poor and near poor people

2005 — JAMKESDA (Local Government)
Poor people

2008 — JAMKESMAS (Ministry of Health)
Poor and vulnerable people (individual basis)

2009 — ASKESOS (Ministry of Social Affairs)
Informal Worker

2011 — JAMPERSAL (Ministry of Health)
Poor pregnant woman (Pre and post natal care)

2014 — Jaminan Kesehatan Nasional
1 January 2014

Member Contribution:

1. Low Income (ex-Jamkesmas) **Non-Contributing Members PBI**
2. Workers in the formal Sector (ex-ASKES, ASABRI, JPK-JAMSOSTEK) **Wage Recipents**
3. "Missing middle" (neither poor nor employed in the formal economy) **Non- Wage Recipents**
4. Retires & Veterans

1.4 Approach to Achieving UHC

THE INITIAL PHASE

Focusing on low & vulnerable goods paid by government

Workers in formal sector by contribution

THE SECOND PHASE
(Divergent Phase)

NON-CONTRIBUTORY

For all rest of families paid by government (general) tax

1. Faster
2. Less Sustainable (strong taxation)
3. Informalization

Case: Thailand

CONTRIBUTORY

For non-poor and non vulnerable families have to contribute

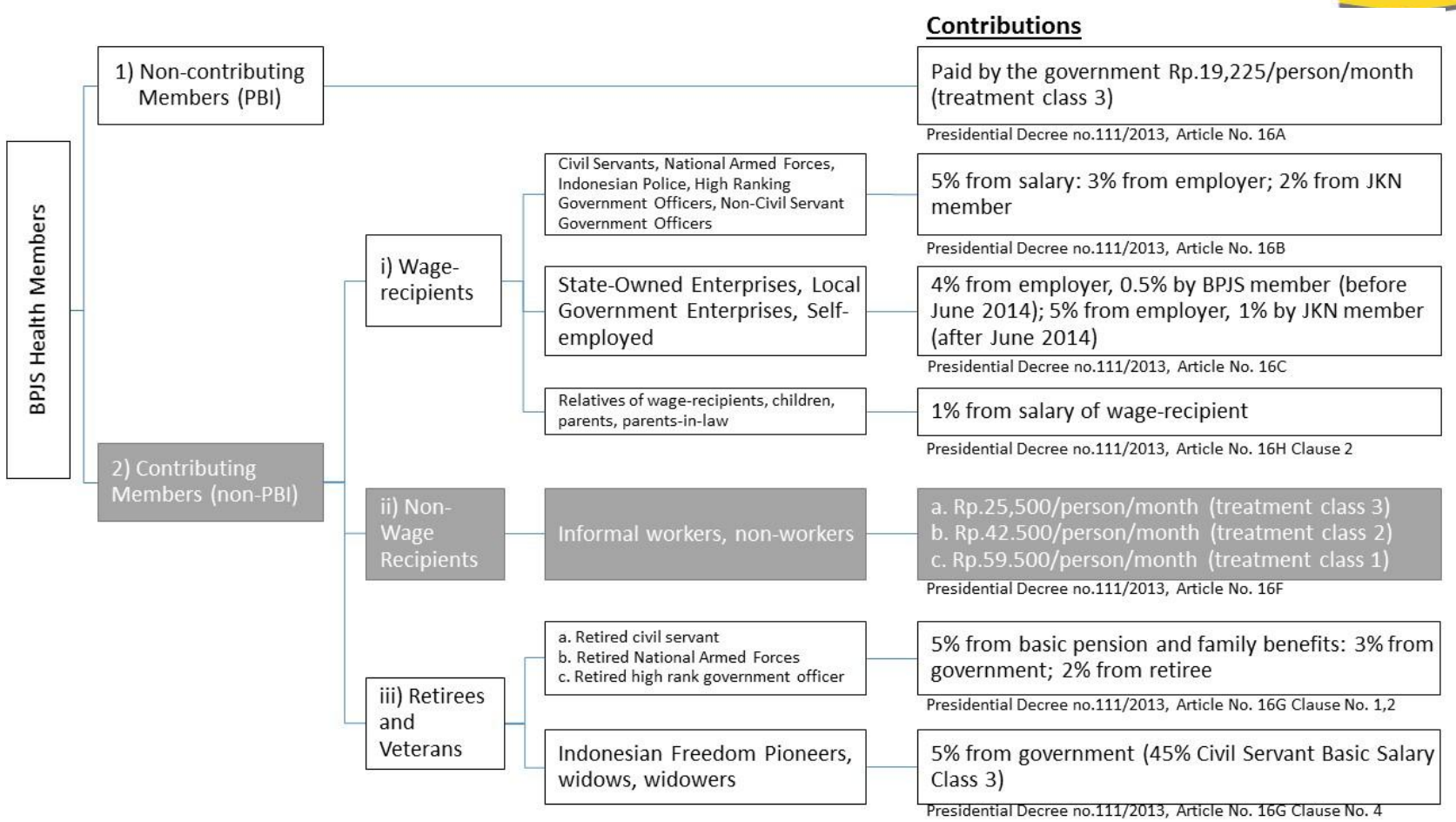
1.Slower
2.More Sustainable
3.Costly Collection

Case: Philippines, Indonesia

1.5 Briefly Overview of JKN System

Key features of JKN:

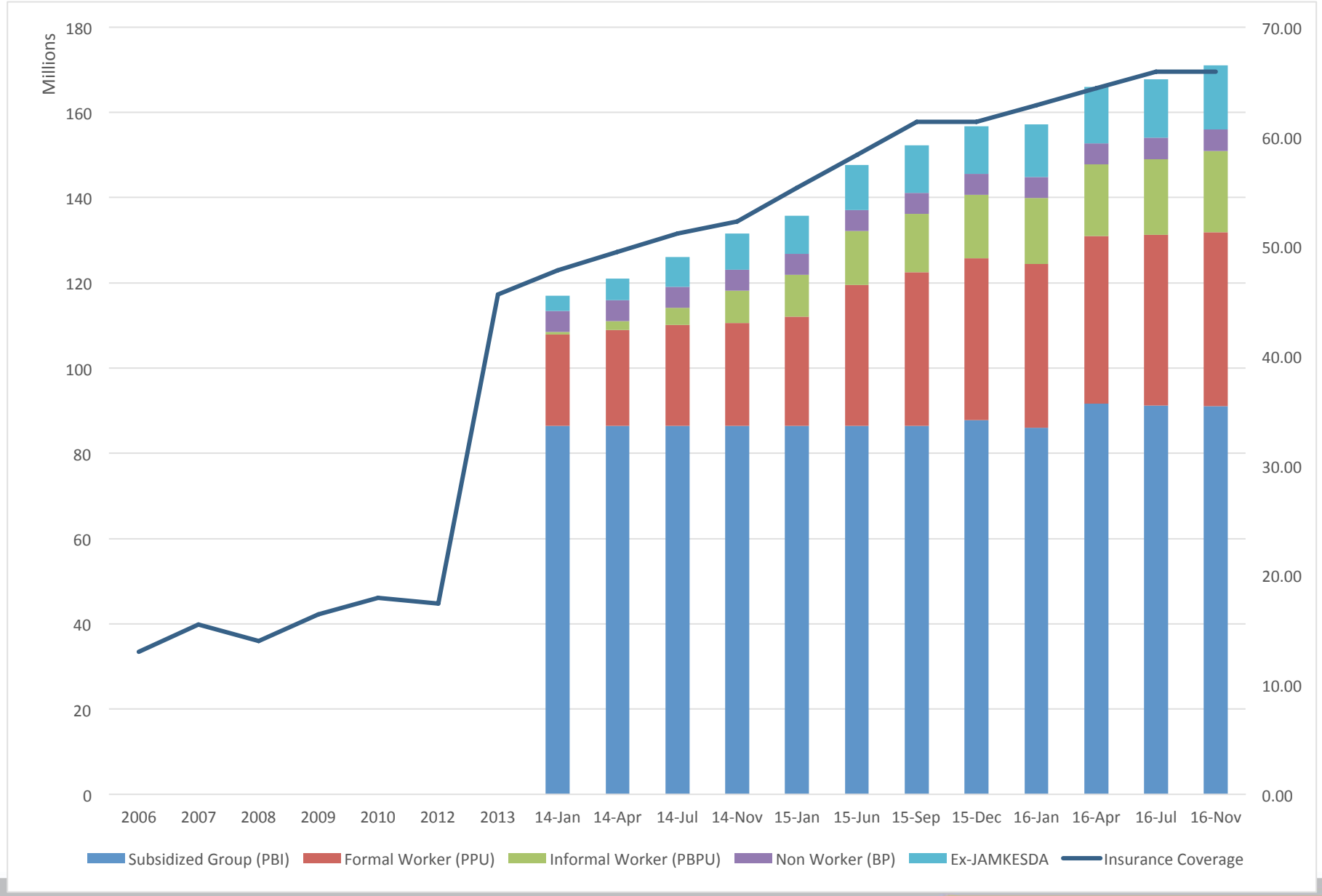
- A Single carrier of BPJS Kesehatan
- Compulsory for all residents (including foreigner living at minimum 6 months) to register in JKN
- Contribution system
- Self-enrolled for Informal Sectors
- Comprehensive package
- Referral system



Note: Any additional family members such as parents and parents in law may be registered with a contribution rate of 1 per cent per person per month.

Source: Authors compilation

1.6 Current Progress of JKN Coverage

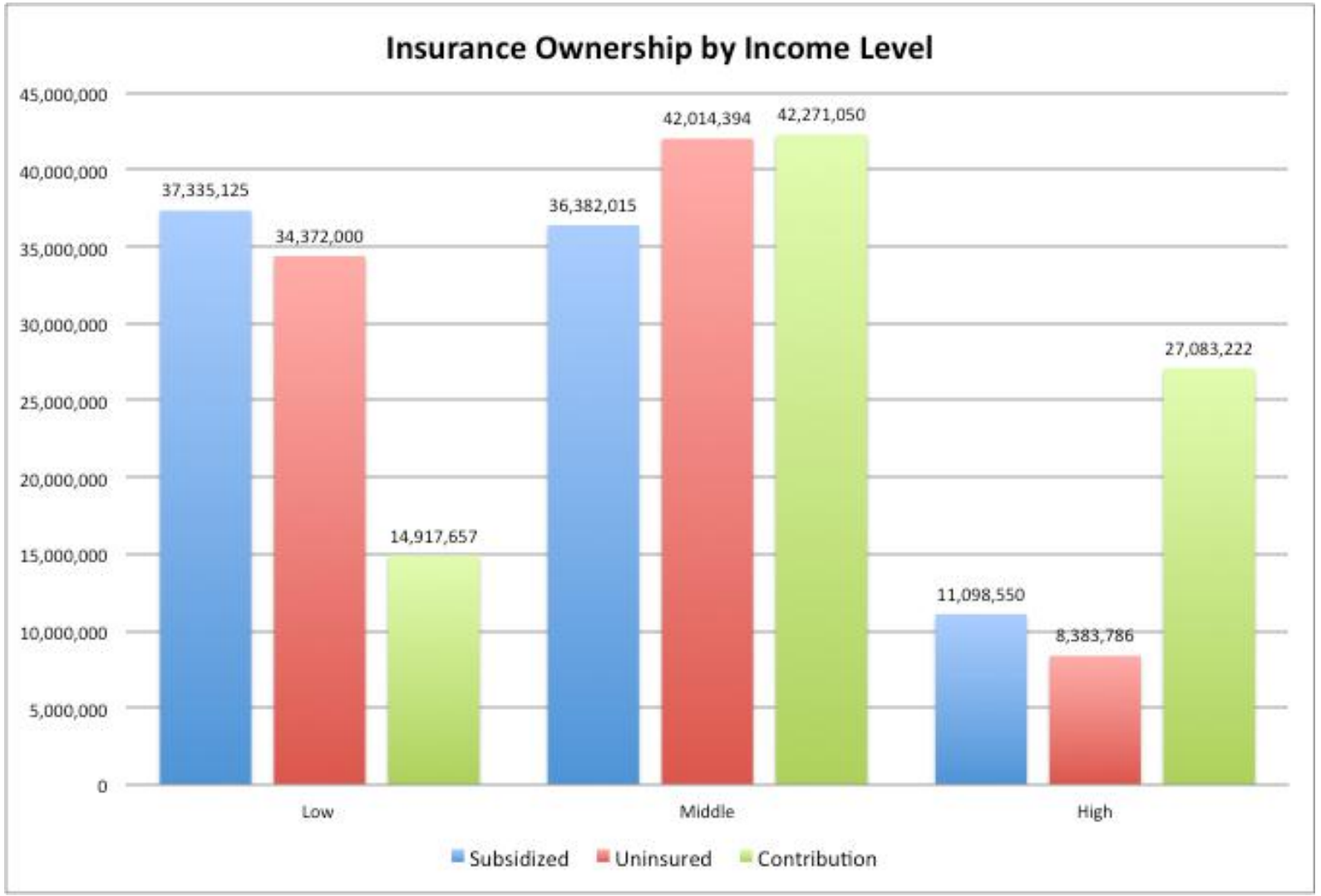


- **The membership growth of informal sector is 30.78%/ month →moral hazard**
- **The membership growth of this group is continuously slowing down from 6.55%/month (2015) then 2.17%/month (2016).**
- **34% is still uncovered by BPJS Kesehatan (mostly informal sector**

1.7 The Missing Middle Problem: The Current NHI System

Population Coverage	Low Income Group Subsidized by Government (PBI Ex-Jamkesmas & PBI-Ex-Jamkesda)	Middle Income Group (Missing Middle) Self-enrollment (Voluntary Registration) & Contributrion	High Income Group Formal Sector Employment (Contribution-Payroll System)
	Income Level		

Source: Author



Source: Author Calculation based on Susenas 2014

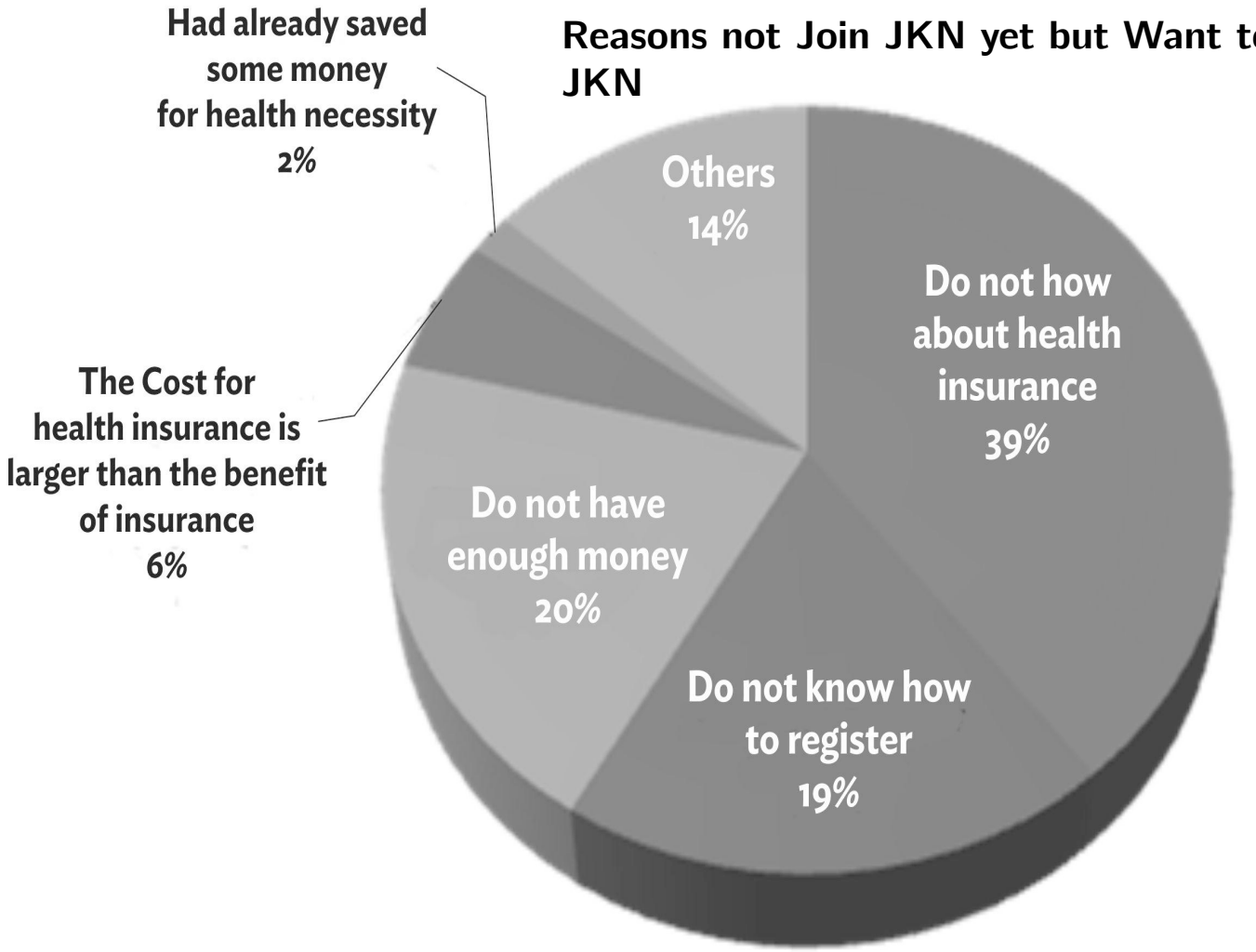
Problem of Informality in the New JKN Program

Expanding Coverage in the Presence of Informality

1. Before Joining JKN: How to mandate

2. After joining JKN: How to Sustain the Payment

2.1 Responses of Non-Poor working in informal Sector to the New JKN System (Survey in April 2014)



Dartanto et al. (2016) shows that Willingness to Pay (join) of workers in informal sector to JKN (econometric estimations):

- Necessary condition → increased availability of health services
- Sufficient condition →improving insurance literacy
- Income do not the main obstacle
- High risks people tends to join JKN

Source: Dartanto et al. (2016)

2.2 Utilization and Claim Ratio by Types of Membership

	Poor and Near Poor (Government Subsidy)*	Formal Sectors	Self-Enrolled Member (Informal Sector/PBPU)	Total Member
Total Member (person)	87,828,613	23,456,697	13,882,595	132,354,398
Utilized Member (person)	3,608,629	4,492,821	4,510,874	12,612,324
Utilization Rate (%)	**4.11**	**19.15**	**32.49**	**9.53**
Av. Premium (IDR/ Capita/Month)	18,668	62,349	**11,318**	25,638
Av. Medical Cost (IDR/ Capita/Month)	8,813	72,629	**73,036**	26,859
Avarage Claim Ratio (%)	**47.21**	**116.49**	**645.32**	**104.76**

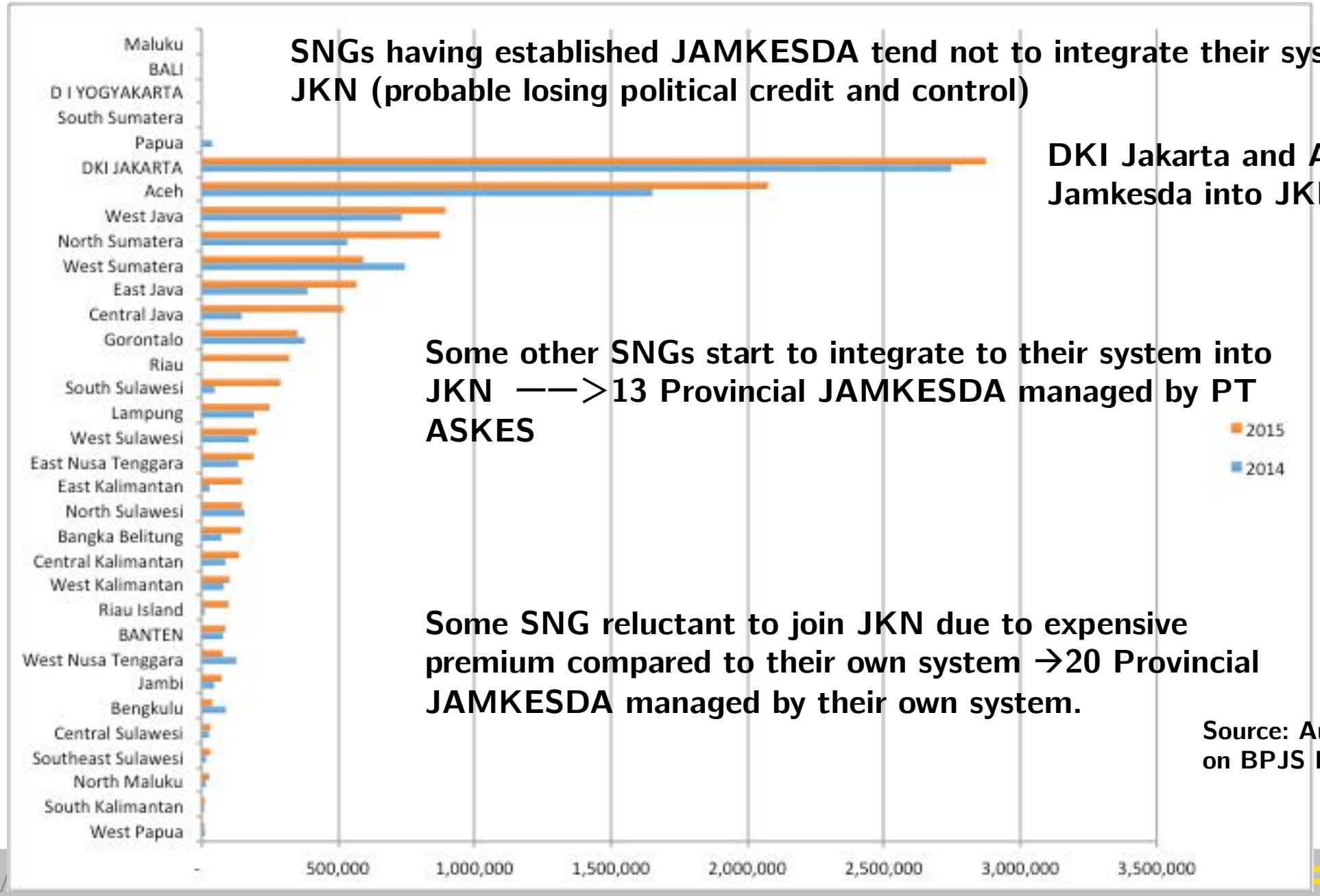
Deficit of BPJS Kesehatan:

- **2014: IDR 3.1T ($235M)**
- **2015: IDR 5.8T ($440M)**
- **2016 projected IDR 6.8T ($515M)**
- **2017 projected IDR 8.6T ($660M)**

Source: BPJS Kesehatan Desember 2014 in ADB-LPEM Report 2015

Note: the utilization rate and average claim ratio of Poor and Near Poor are the lowest due to (possibility) lack of access

2.3 Integrating Jamkesda into JKN System (2014-2015)



SNGs having established JAMKESDA tend not to integrate their system into JKN (probable losing political credit and control)

DKI Jakarta and Aceh integrate their Jamkesda into JKN since 2014

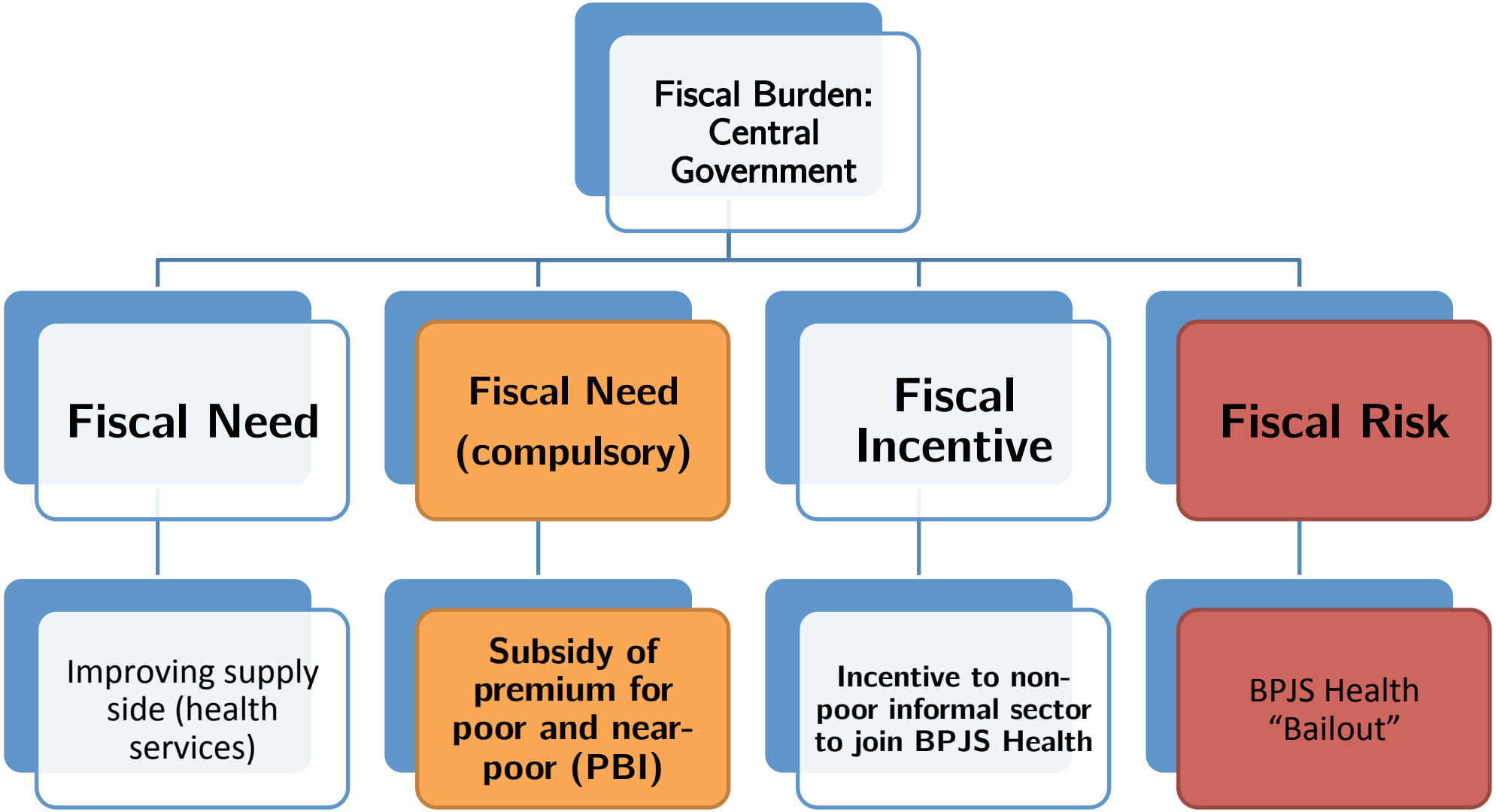
Some other SNGs start to integrate to their system into JKN ——>13 Provincial JAMKESDA managed by PT ASKES

Some SNG reluctant to join JKN due to expensive premium compared to their own system →20 Provincial JAMKESDA managed by their own system.

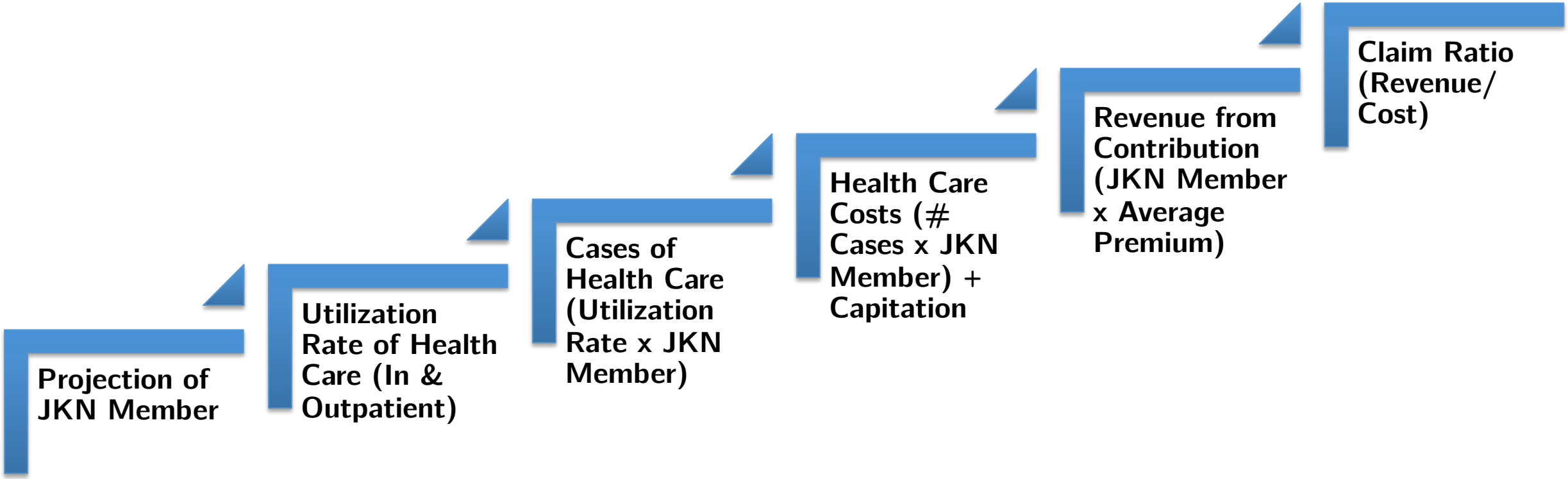
Source: Author's compilation based on BPJS Kesehatan database

Fiscal Cost and Fiscal Space for Financing UHC

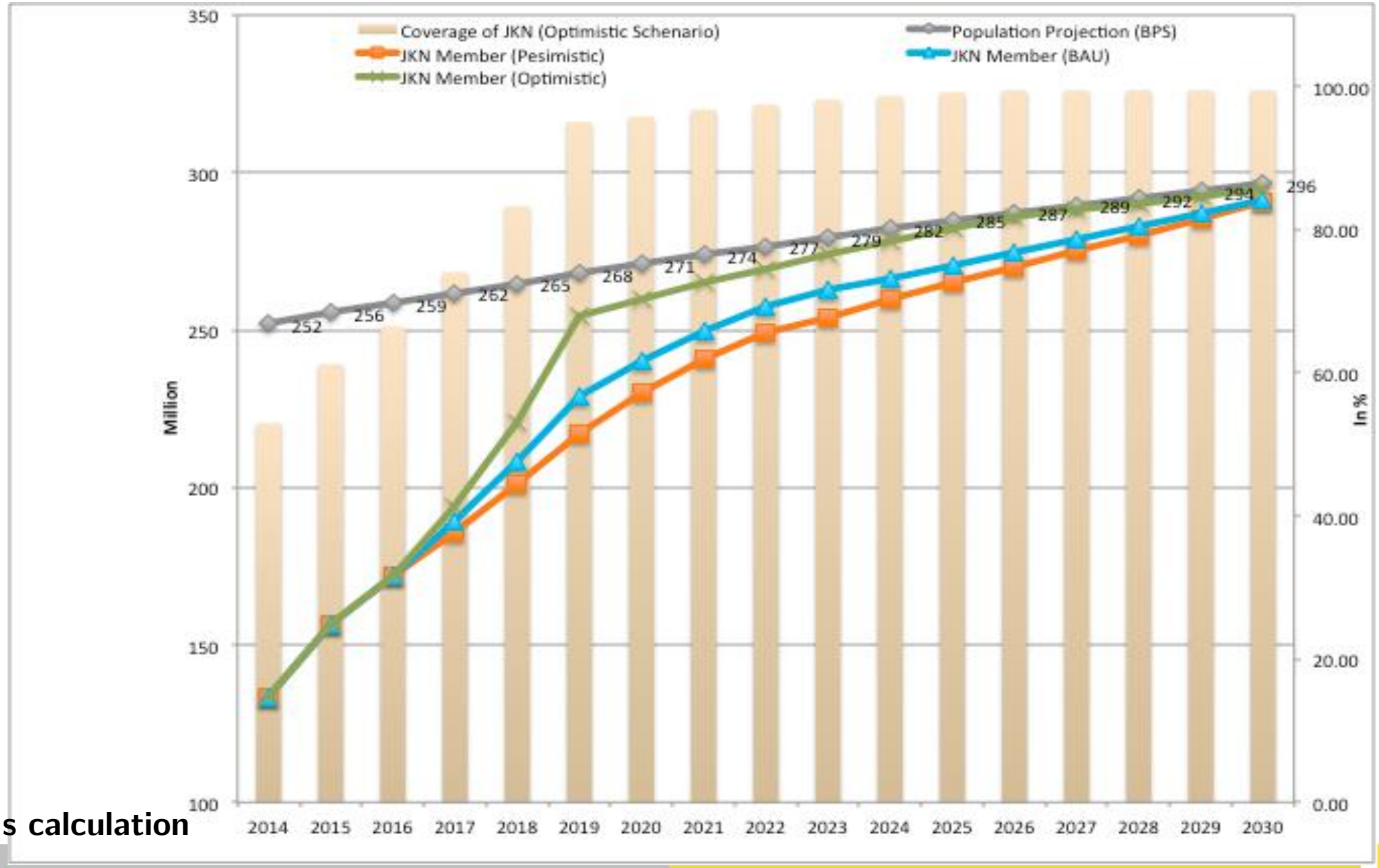
3.1 Fiscal Burden for Realizing UHC



3.2 Calculating Fiscal Risk (Deficit) of BPJS Kesehatan



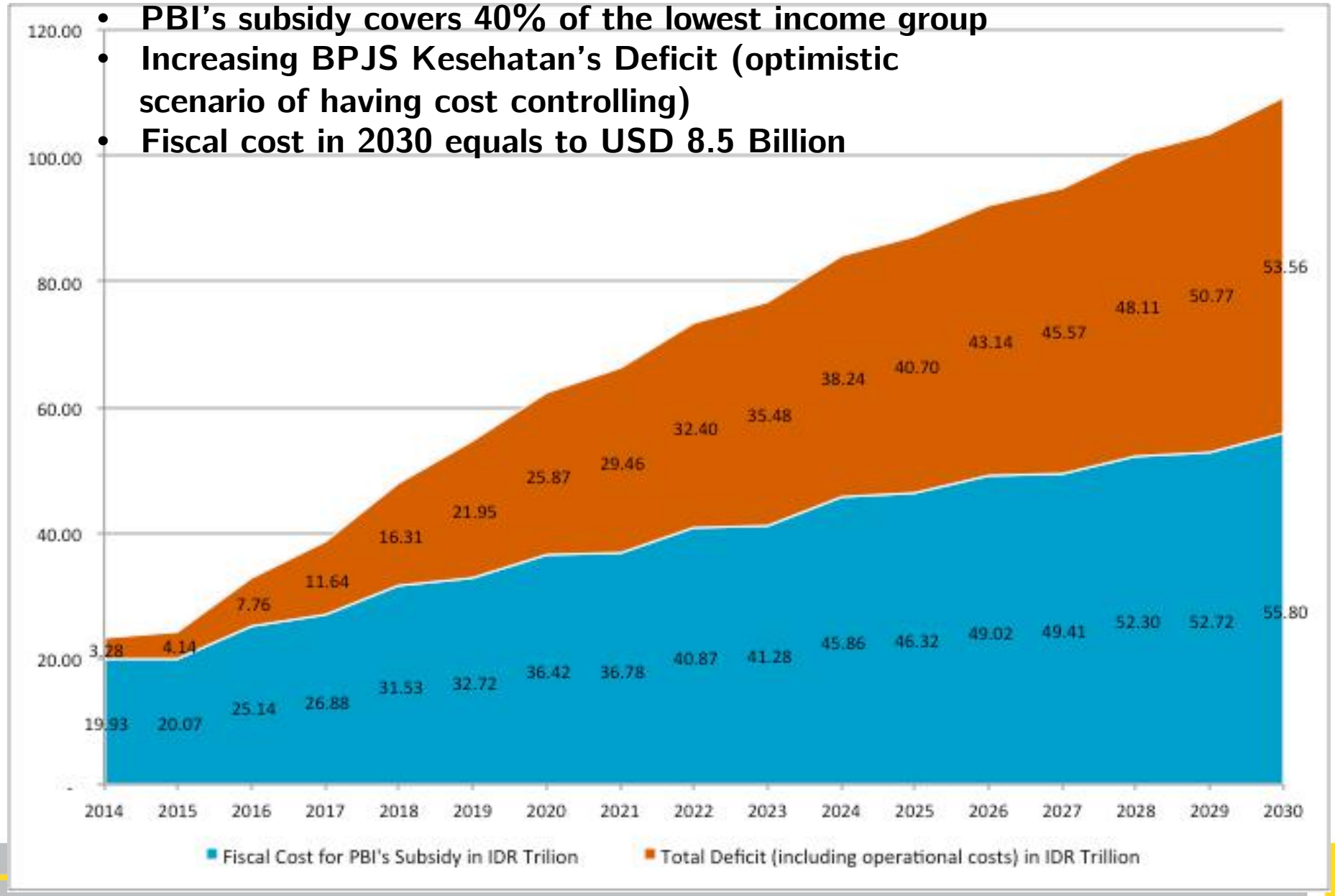
3.3 Projection of JKN Coverage



Source: Author's calculation

3.4 Estimated for Fiscal Needs for Premium Subsidy (PBI) and BPJS Kesehatan (Bailout)

- PBI's subsidy covers 40% of the lowest income group
- Increasing BPJS Kesehatan's Deficit (optimistic scenario of having cost controlling)
- Fiscal cost in 2030 equals to USD 8.5 Billion

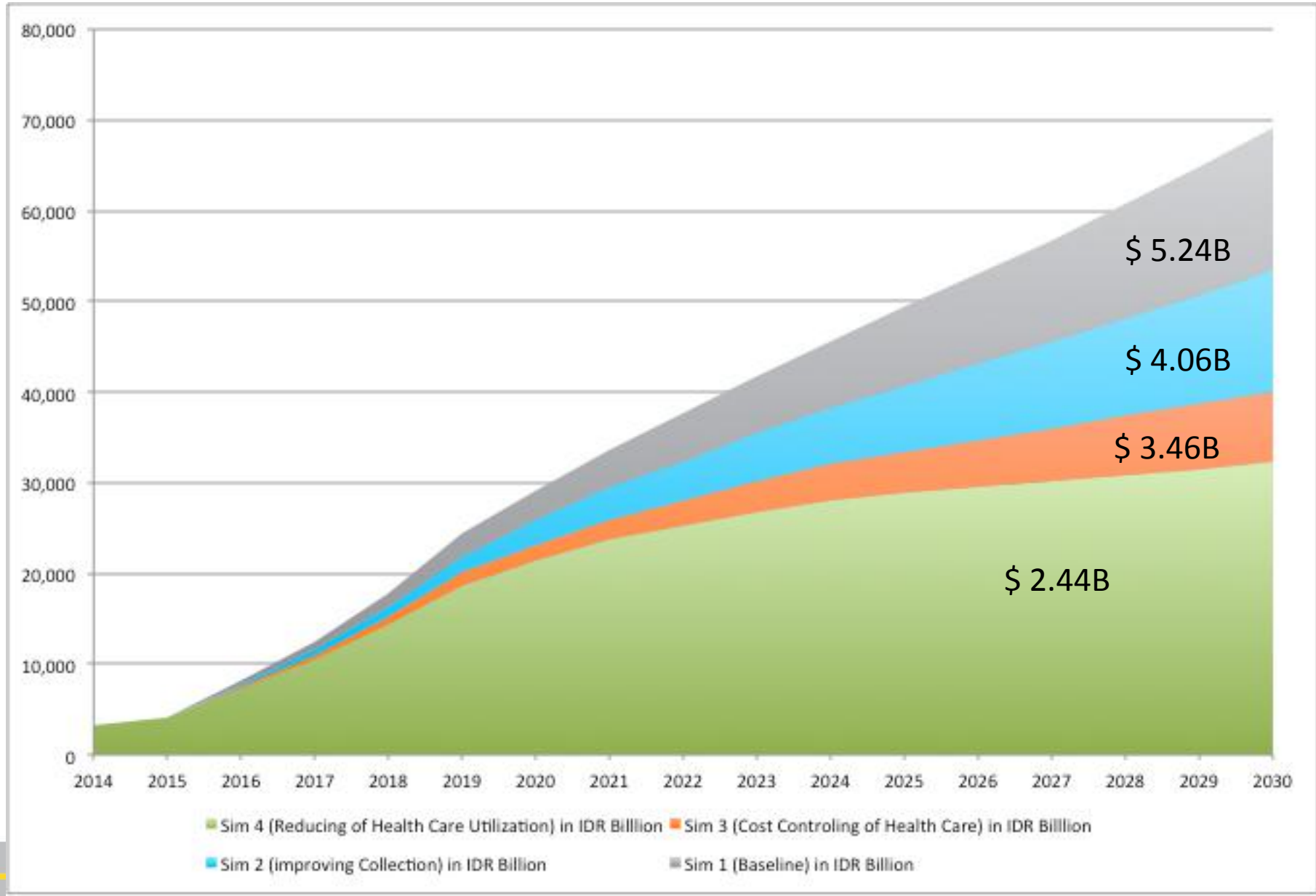


Source: Author's calculation

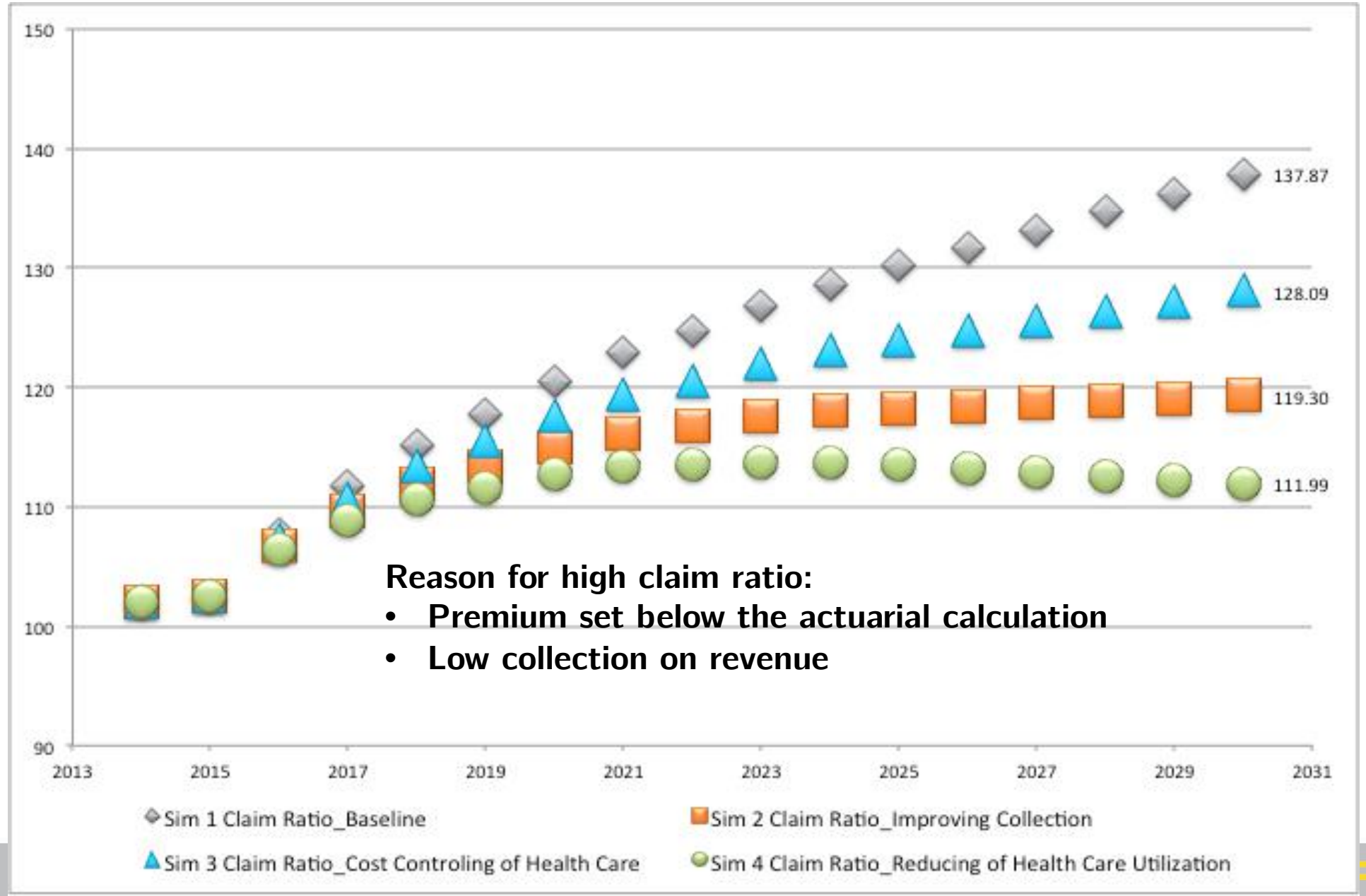
3.5 Improvement in Collection Rate, Cost Control, Reducing Morbidity (Health Care Utilization) and Deficit (Fiscal Cost)

Improving premium's collectability especially on self-enrolled member → reduce fiscal cost from IDR 69.2T → IDR 45.7T

Improving (better health condition) Health Care Utilization → significantly reduce fiscal cost from IDR 69.2T → IDR 32.2T



3.6 Claim Ratio (Cost/Revenue)

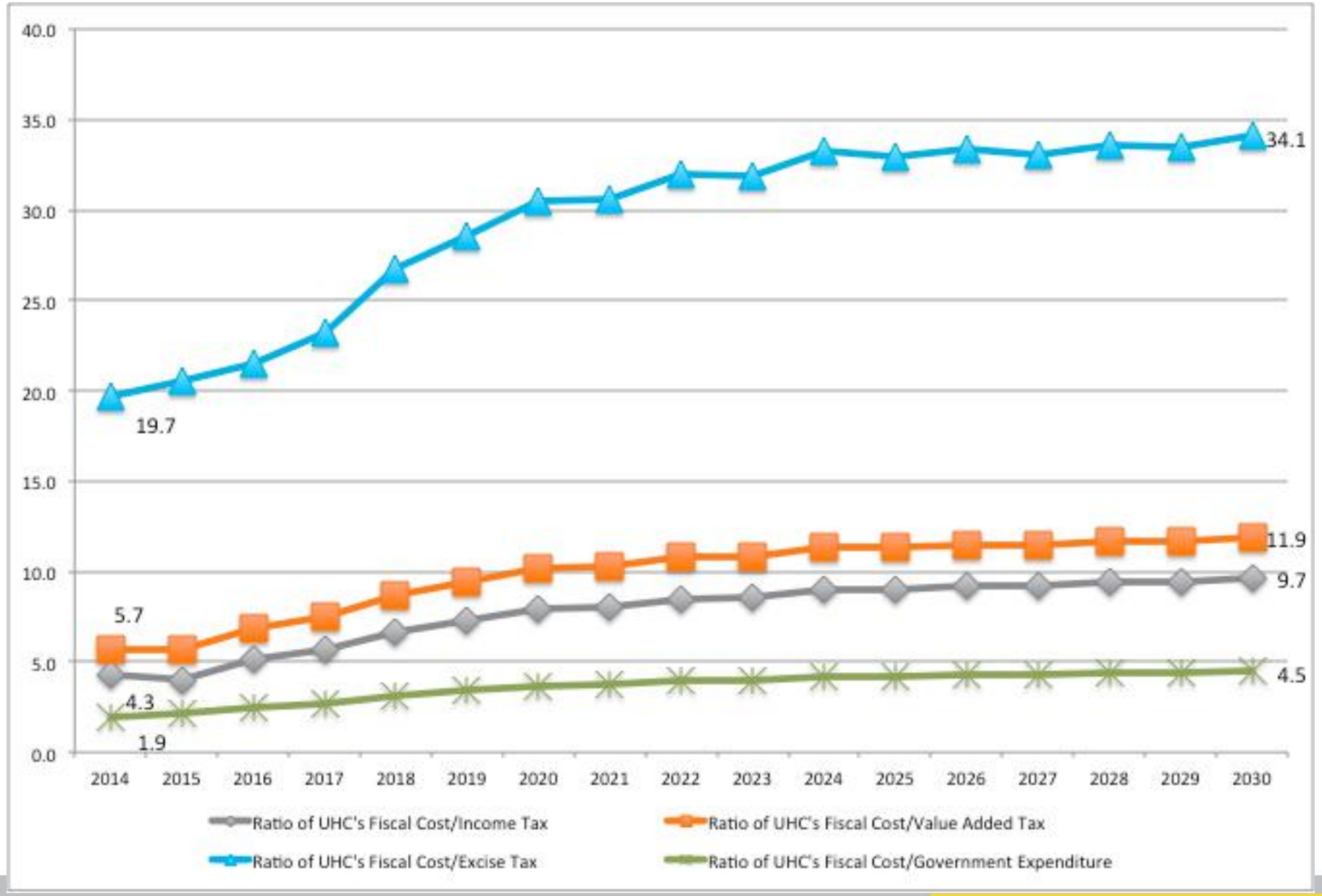


Reason for high claim ratio:

- **Premium set below the actuarial calculation**
- **Low collection on revenue**

Source: Author's calculation

3.7 Financing for UHC



Cost of UHC is increasing over year.

Cost of UHC would be almost double within 10 years from 1.9% (2014) of Gov. Exp. to 4.5% (2030)*

Significant efforts on improving collectability, cost controlling and reducing morbidity would reduce the cost of UHC.

Note:* Gov. Exp. not included Gov. Transfer to Local Government

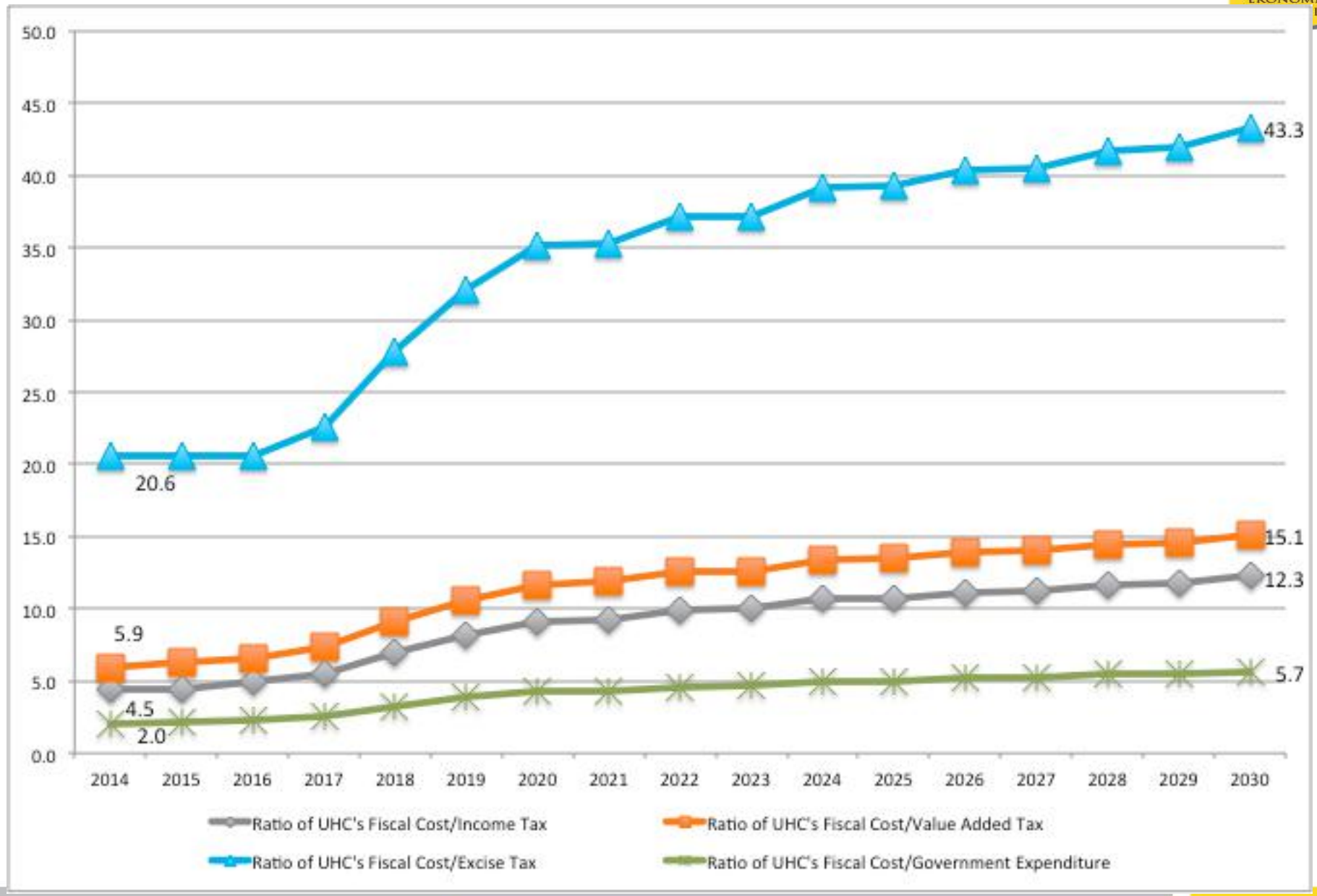
Source: Author's calculation

3.8 Financing for UHC with Fully Subsidy for Informal Sector

Fully subsidy for expanding the coverage of informal sector would increase the fiscal cost of UHC.

With the fully subsidy of informal sector then cost would be 15.1% of VAT Revenue

Note: Gov. Exp. not included transfer to local government.



Source: Author's calculation

4.1 Way Forward: Informality and Financing UHC

	Business as Usual	Fully Subsidy for the Informal (the General Taxation)	Earmarking of Tobacco Excise Tax	Incentive for Informal Sector to join JKN	Local Government Involvement
Pros	• Contribution based • Less cost for Central Government	• Easy to implementation • Political support	• Easy to implementation • Political support	• Cost sharing between individual and Government	• Cost sharing between Central and Sub National Governments (SNGs)
Cons	• Missing middle problem • Low coverage	• Burdening Central Government Budget • Sustainability Issue • Informalization	• Sustainability of Tobacco Excise Tax for Financing UHC (Tobacco Tax should decrease)	• Incentive may not work	• Regulation issues • Burdening SNGs Budget
Target for the 2019 UHC	Difficult to Achieve in 2019	Guarantee Accomplished in 2019	Probable Accomplished in 2019	Accomplished more than 2019	Possibility to accomplished in 2019

Source: Author's calculation

4.2 Concluding Remarks

- With the current path (without any massive intervention), UHC is difficult in 2019, but possible in 2030.
- Cost of achieving UHC is gradually increasing over time (double within 15 years) → possible burden for the government budget in the future.
- Covering all of those in informal sector to join JKN (for UHC) via fully subsidy of premium would be very costly for the government budget and create the possibility of "informalization" of formal sector.
- How to reduce cost of UHC: improving collection rate and cost controlling of health services, but promoting healthy behavior (reducing morbidity → role of public health) would be the most effective way.
- Accomplishing 1 target of 169 targets is cost around 4.5-5.7% of central government budget in 2030 (0.5% of GDP), every government should carefully assess their financing need (priority) for SDGs.

Thank You Very Much For Your Attention

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Note: Assumptions of Fiscal Calculation

- Population growth follows the BPS projection
- JKN Member Optimistic Scenario: FY2014-16(BPJS report), FY2017(12.75%), FY2018(13.75%), FY2019(15.50%), FY2020-21(2%), FY2022-23(1.75%), FY2024-25(1.5%), FY2026-30(99.5% of Population)
- Average Premium Contribution: FY2014-15 (BPJS Report), FY2016-20 (5% every year), FY2021-22 (4% every two years) FY2021-22 (4% & 3%/year), FY2023-30 (2%/year).
- Average treatment costs:
  - Inpatient: FY2014(BPJS Report), FY2015(2%), FY2016-2019(1%), FY2020-2030(2%)
  - Outpatient: FY2014(BPJS Report), FY2015(5%) FY2016-30(3%)
  - Capitation: FY2014(BPJS Report), FY2015-19(5%), FY2020(4%), FY2021-30(3%)
- Average Utilization Rate of Outpatient and Inpatient: on average 4%/ year