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

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Regional Development: Fiscal Risks, Fiscal Space and the Sustainable Development Goals
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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 injuries from road traffic accident
  7. Universal access to reproductive health care services
  8. Universal Health Coverage
  9. Deaths and illness from hazardous chemicals
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)

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

Foundation of Social Workers (GOI)
- Private formal sector workers

Agency for Healthcare funds (GOI)
- Private formal sector workers

1957

1964

1971

1984

1992

1994

Health Card Program (GOI)
- Poor people

Perum Husada Bakti (State owned company)
- Civil servant

1998

JPS Health (GOI)
- Poor people

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

2001

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

2004

ASKESKIN (PT. ASKES)
- Poor and near poor people

2005

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

2008

2011

JAMPERASAL (Ministry of Health)
- Poor pregnant woman (Fie and post natal care)

2014

Jaminan Kesehatan Nasional
- 1 January 2014

2009

JAMKESDA (Local Government)
- Poor people

Member Contribution:

1. Low Income (ex-Jamkesmas) Non-Contributing Members
   - PBI

2. Workers in the formal Sector
   - (ex-ASKES, ASABRI, JKPK, JAMSOSTEK)
   - Wage Recipients

3. "Missing middle" (neither poor nor employed in the formal economy)
   - Non-Wage Recipients

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

Case: Philippines, Indonesia

1. Slower
2. More Sustainable
3. Costly Collection
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

Source: Author

<table>
<thead>
<tr>
<th>Population Coverage</th>
<th>Low Income Group</th>
<th>Middle Income Group</th>
<th>High Income Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Subsidized by Government (PBI Ex-Jamkesmas &amp; PBI-Ex-Jamkesda)</td>
<td>(Missing Middle)</td>
<td>Formal Sector Employment (Voluntary Registration) &amp; Contributrion</td>
</tr>
</tbody>
</table>

Source: Author Calculation based on Susenas 2014

Insurance Ownership by Income Level

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

Reasons not Join JKN yet but Want to Join JKN:

- Do not know how to register (19%)
- Do not have enough money (20%)
- The Cost for health insurance is larger than the benefit of insurance (6%)
- Do not how about health insurance (39%)
- Others (14%)
- Had already saved some money for health necessity (2%)

Source: Dartanto et al. (2016)
### 2.2 Utilization and Claim Ratio by Types of Membership

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


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

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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)
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

Fiscal Burden: Central Government

Fiscal Need
- Improving supply side (health services)

Fiscal Need (compulsory)
- Subsidy of premium for poor and near-poor (PBI)

Fiscal Incentive
- Incentive to non-poor informal sector to join BPJS Health

Fiscal Risk
- BPJS Health “Bailout”
3.2 Calculating Fiscal Risk (Deficit) of BPJS Kesehatan

Projection of JKN Member

Utilization Rate of Health Care (In & Outpatient)

Cases of Health Care (Utilization Rate x JKN Member)

Health Care Costs (# Cases x JKN Member) + Capitation

Revenue from Contribution (JKN Member x Average Premium)

Claim Ratio (Revenue/Cost)
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

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
<th>Target for the 2019 UHC</th>
</tr>
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<tbody>
<tr>
<td><strong>Business as Usual</strong></td>
<td><strong>Missing middle problem</strong>&lt;br&gt;- Low coverage</td>
<td><strong>Difficult to Achieve in 2019</strong>&lt;br&gt;- Informalization</td>
</tr>
<tr>
<td><strong>Fully Subsidy for the Informal (the General Taxation)</strong>&lt;br&gt;- Easy to implementation&lt;br&gt;- Political support</td>
<td><strong>Burdening Central Government Budget</strong>&lt;br&gt;- Sustainability Issue&lt;br&gt;- Informalization</td>
<td><strong>Guarantee Accomplished in 2019</strong>&lt;br&gt;- Tobacco Excise Tax for Financing UHC (Tobacco Tax should decrease)<strong>&lt;br&gt;- Incentive may not work</strong>&lt;br&gt;- Regulation issues&lt;br&gt;- Burdening SNGs Budget</td>
</tr>
<tr>
<td><strong>Earmarking of Tobacco Excise Tax</strong>&lt;br&gt;- Easy to implementation&lt;br&gt;- Political support</td>
<td></td>
<td><strong>Probable Accomplished in 2019</strong>&lt;br&gt;- Tobacco Excise Tax for Financing UHC (Tobacco Tax should decrease)<strong>&lt;br&gt;- Incentive may not work</strong>&lt;br&gt;- Regulation issues&lt;br&gt;- Burdening SNGs Budget</td>
</tr>
<tr>
<td><strong>Incentive for Informal Sector to join JKN</strong>&lt;br&gt;- Cost sharing between individual and Government</td>
<td><strong>Accomplished more than 2019</strong>&lt;br&gt;- Tobacco Excise Tax for Financing UHC (Tobacco Tax should decrease)<strong>&lt;br&gt;- Incentive may not work</strong>&lt;br&gt;- Regulation issues&lt;br&gt;- Burdening SNGs Budget</td>
<td><strong>Possibility to accomplished in 2019</strong></td>
</tr>
<tr>
<td><strong>Local Government Involvement</strong>&lt;br&gt;- Cost sharing between Central and Sub National Governments (SNGs)</td>
<td></td>
<td><strong>Source: Author’s calculation</strong></td>
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</table>
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