Missing Middle and BPJS: A socio-cultural and economic analysis

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Content:

• Current Health Care Financing, BPJS deficit and wrong targeted subsidy
• The Middle Class and BPJS
• Future Analysis
  - GDP and problems of Tax Collection
  - 2-tier system health care
Policy Options
Current Health Financing (simplified)
Single Pool system in BPJS

- Tax Income
- Non-tax Income
- Foreign Donors
- APBN
- MoH
- Other Ministries
- LG
- Local Gov Income
- PBPU (Informal workers)
- PPU (Salaried workers)
- Private Commercial Insurance
- Out of pocket
Three Groups of Members Segments in BPJS

- APBN
  - Tax Income
  - Non-tax Income
  - Foreign Donors

- PBPU (Informal workers)
  - Non-PBI

- PPU (Salaried workers)
  - Non-PBI

- Other Ministries
  - Private Commercial Insurance

- Local Gov Income

Three segments: PBI, Non-PBI, and subsidized premi for the poor and nonpoor.
Member Coverage

Are they missing-middle?

△ 60.2 juta Jiwa

76.6% Populasi

Number of member

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>133,423,653</td>
<td>156,790,287</td>
<td>171,939,254</td>
<td>187,982,949</td>
<td>197,291,883</td>
<td>257,455,100</td>
</tr>
<tr>
<td>Target UHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Non PBI increased fast

Segment growth

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-PBI</td>
<td>133,42</td>
<td>156,80</td>
<td>171,94</td>
<td>187,9</td>
</tr>
<tr>
<td>PBI</td>
<td>86.40</td>
<td>87.83</td>
<td>91.10</td>
<td>92.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PBI APBN</th>
<th>PPU</th>
<th>BP</th>
<th>PBPU</th>
<th>PBI APBD</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.05</td>
<td>8.77</td>
<td>11.18</td>
<td>15.42</td>
<td>20.3</td>
</tr>
<tr>
<td>24.33</td>
<td>37.86</td>
<td>41.03</td>
<td>44.9</td>
<td></td>
</tr>
<tr>
<td>64.8%</td>
<td>49.1%</td>
<td>50.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Non PBI increased fast
BPJS is experiencing deficit

- Fixed income, with broad and unlimited benefit
- PBPU (informal workers segment) is making loss. Premium is too low

Mundiharno, BPJS. 2018
## What happened per segment

<table>
<thead>
<tr>
<th>Member Segment</th>
<th>Class</th>
<th>Premium per member/month</th>
<th>Cost per member/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPU Government</td>
<td></td>
<td>62,270</td>
<td>69,597</td>
</tr>
<tr>
<td>PBPU</td>
<td>1</td>
<td>80,000</td>
<td>257,706</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>51,000</td>
<td>172,958</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>25,500</td>
<td>136,452</td>
</tr>
<tr>
<td>PPU Enterprise</td>
<td></td>
<td>59,327</td>
<td>31,541</td>
</tr>
</tbody>
</table>

Making Loss:
- PPU G
- PBPU

**Adverse selection: the sick and high risk groups entered the system first**
Wrong Targeted Subsidy

PBI claim ratio is less than 100%
PBI is used for non-PBI

- APBN
- Tax Income
- Non-tax Income
- Foreign Donors
- MoH
- Other Ministries
- LG
- LG Income
- Local Gov Income
- PPU (Salaried workers)
- Non-PBI
- PBPU (Informal workers)
- Non-PBI
- Private Commercial Insurance
- Private Insurance

Worsening problems in Equity
Current research finding on Equity using Susenas data:

• Access to outpatient care at public primary facilities, mainly puskesmas, is pro-poor. Access to most other types of health care is pro-rich.

• Access to inpatient care at public hospitals is nearly universal at the national level but this masks significant variation according to geographical location.

• Inpatient care at public hospitals in urban areas is pro-poor whilst it is pro-rich in rural areas.

• Pro-rich access is driven by pro-rich non-health factors, mainly households’ economic status, geographical factors and non-targeted health insurance (SHI).

ACCESS INEQUITY, HEALTH INSURANCE AND THE ROLE OF SUPPLY FACTORS
Meliyanni Johar, Retno Pujisubekti, Prastuti Soewondo, Harsa Kunthara Satrio, Ardi Adji. TNP2K WORKING PAPER 1 - 2017 December 2017
The Middle Class
Who are the Middle Class

• One in every five Indonesians now belongs to the middle-class group.

• Another 45 percent are no longer poor or vulnerable to poverty.

World Bank 2017
Today’s

Middle class counts at least 52 million people whose consumption accounts for 43 percent of total household consumption.
Another data:

In 2016, Indonesia: the world’s fourth largest middle class with 19.6 million households.

expected to rise to 23.9 million in 2030

Euromonitor International’s Indonesia Income and Expenditure Country Briefing
Middle class

• They are wealthy and young
• Internet users
• Spend for healthy lifestyle products but not medical care

Why they do not buy BPJS premi?
- Are they risk taker
- Is BPJS regarded as inferior service (low price, low quality)

Unfortunately:
no behavioral economics research on the middle class in using their income in health care and insurance
Future Analysis

• How to handle middle class?
• The danger of relying on BPJS in the missing-middle
• Forecasting Health Revenues
Tax Situation

Problems in tax collection

Sumber: Indonesia dalam Angka
BPJS revenue depends on Tax (PBI) and small (making loss) premium

For sustainability; financial support for the universal health coverage is weak.

- Dominated by Corporate Tax
- Income Tax is not progressive
Strategic issue

- It is difficult to raise health revenue through taxation
- Should find ways to tap more resources from GDP.

Opportunity, using Thailand Benchmark. There is 1.5% GDP is available for health (GDP for health in Indonesia is around 3%, in Thailand 4.5%). It worths 180 trillion
The Future of Health Revenues

- APBN: Tax Income, Non-tax Income
- BPJS: PPU (Salaried workers), Non-PBI (Promising), PBPU (Informal workers), Non-PBI (Promising)
- MoH: Other Ministries
- LG: Local Gov Income (Depends)
- Foreign Donors
- Private Commercial Insurance

Primary Care: Out of pocket
- MoH
- LG
- Local Gov Income

Referral Care: Out of pocket
- MoH
- LG
- Local Gov Income

Not promising

Promising
Financing condition happened in current situation:

two-tier health care system
Upper Class

Middle Class

Poor people

Different demand and supply of health care
Upper Class

Different demand and supply of health care

Middle Class

Poor people
Upper Class

Middle Class

Tier: 1. Non-BPJS Hospital and Non-BPJS class

Tier: 2. BPJS Hospitals/Wards

Poor people
Future Policy

• Based on Single Pool problem, incl. the use of poor subsidy by the relatively richer BPJS members

• Two-tier system and health consumer preference

• The Opportunity for tapping health revenue from GDP
Policy Option 1:
- BPJS remains single pool
- The middle and upper premium of PBPU increased based on actuarial setting
- Tight compartment to prevent PBI budget used by the non-PBI members
Policy Option 1:
- Exploit the opportunity in GDP using BPJS as single pool
The big question:

Is BPJS capable for attracting middle-class to join the scheme?
Policy Option 2:
- Not a single pool system
- BPJS concentrates in Social Health Insurance only. The middle and upper premium of PBPU is spin-off from BPJS
- Commercial insurance group opens business for the middle-class and affluent ones
- Becomes safety valve for BPJS

Not promising
Tax Income
Non-tax Income
Foreign Donors

APBN
BPJS
PPU (Salaried workers)
Non-PBI
PBPU (Informal workers)
Non-PBI
Private Commercial Insurance

Primary Care
Referral Care
Out of pocket

MoH
Other Ministries
LG
Local Gov Income
Policy Option 2:
- Exploit the opportunity in GDP not using BPJS

Not promising

Tax Income → APBN → BPJS → PPU (Salaried workers) Non-PBI

Non-tax Income → Foreign Donors

MoH

Other Ministries

LG

Local Gov Income

Primary Care

Referral Care

Out of pocket

Miliar Rupiah

Private Commercial Insurance

PPU (Salaried workers) Non-PBI

PBPU (Informal workers) Non-PBI

Foreign Donors

Not promising

Exploit the opportunity in GDP not using BPJS
Challenge for commercial health insurance companies:

• Whether commercial health insurance company can attract middle-class?

• How their risk-taker and healthy lifestyle can be assessed and put in the health insurance scheme?

• Is it possible to mix medical insurance scheme with gym-club or other healthy lifestyle?
We need behavioral economics research on the middle class in using their income in health care and insurance in various regions.
Thank-you