Current Issues in Social Security Policy

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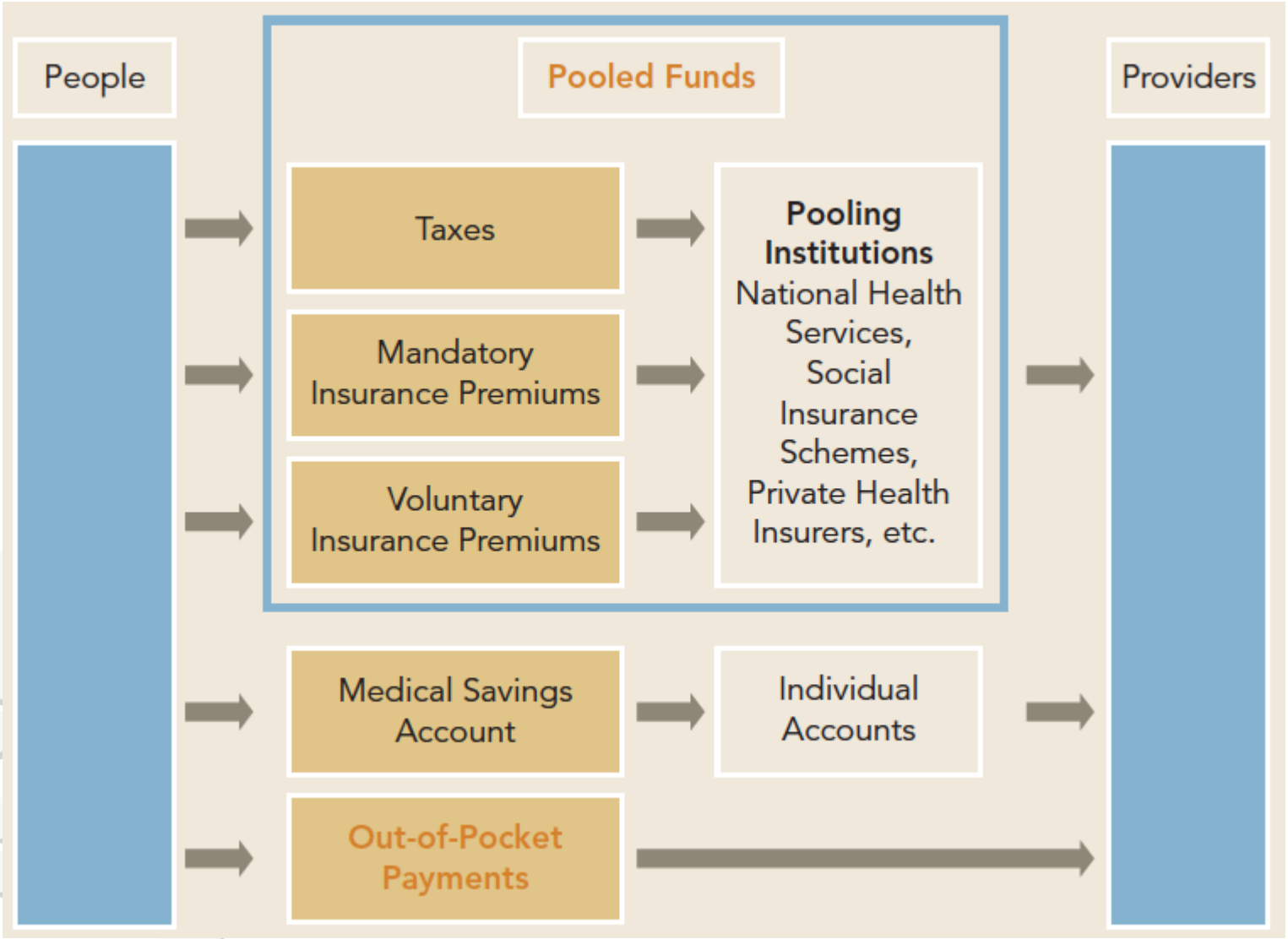
Pooled (Universal) Funds vs. OOP Health Services



Source: Savedoff et al, 2012

Health Finance Models

1. **Beveridge**: provided by government-financed health facilities, managed by government agencies. Examples: UK, Spain, Scandinavians, Cuba, New Zealand, Hongkong.
2. **Bismarck**: provided by private institutions; financed by non-profit insurance system, the premium is paid by employees, corporates, and the government; managed and controlled by the government. Examples: Germany, France, Switzerland, Belgium, Japan.
3. **National Health Insurance System:** provided by private institutions, financed by the government from the levied taxes. Examples: Canada, Taiwan, South Korea.
4. **Out-Of-Pocket (OOP)**: provided by private health facilities, financed by the patients through direct payments, no institutional management. Examples: most developing countries in Sub-Saharan Africa, India, China (before 1990s), Latin American countries.

International Experience

- USA: allocated 17.9% of its GDP for health, but 15.4% of its citizens are uncovered by health insurance → shifting toward UHC policy with the Obamacare. What's next under Donald Trump?
- Western Europeans (Germany, France, UK, Netherlands, Switzerland) have been adopting UHC since WW II.
- The BRICS (Brazil, Russia, India, China, South Africa) are moving towards the UHC policy.
- In Asia: Kyrgystan, Malaysia & Thailand have been successfully adopting the UHC policy in the last two decades.
- A strong commitment is fundamental for UHC policy. Example: The government in Turkey stated clearly that it is illegal for clinics and hospitals to hold patients who are unable to pay for health services.

COMPONENTS OF SOCIAL SECURITY SYSTEM

1. Health Insurance
2. Accident insurance
3. Old age pension
4. Public pension
5. Life insurance

Lack of Budget Commitment in Indonesia

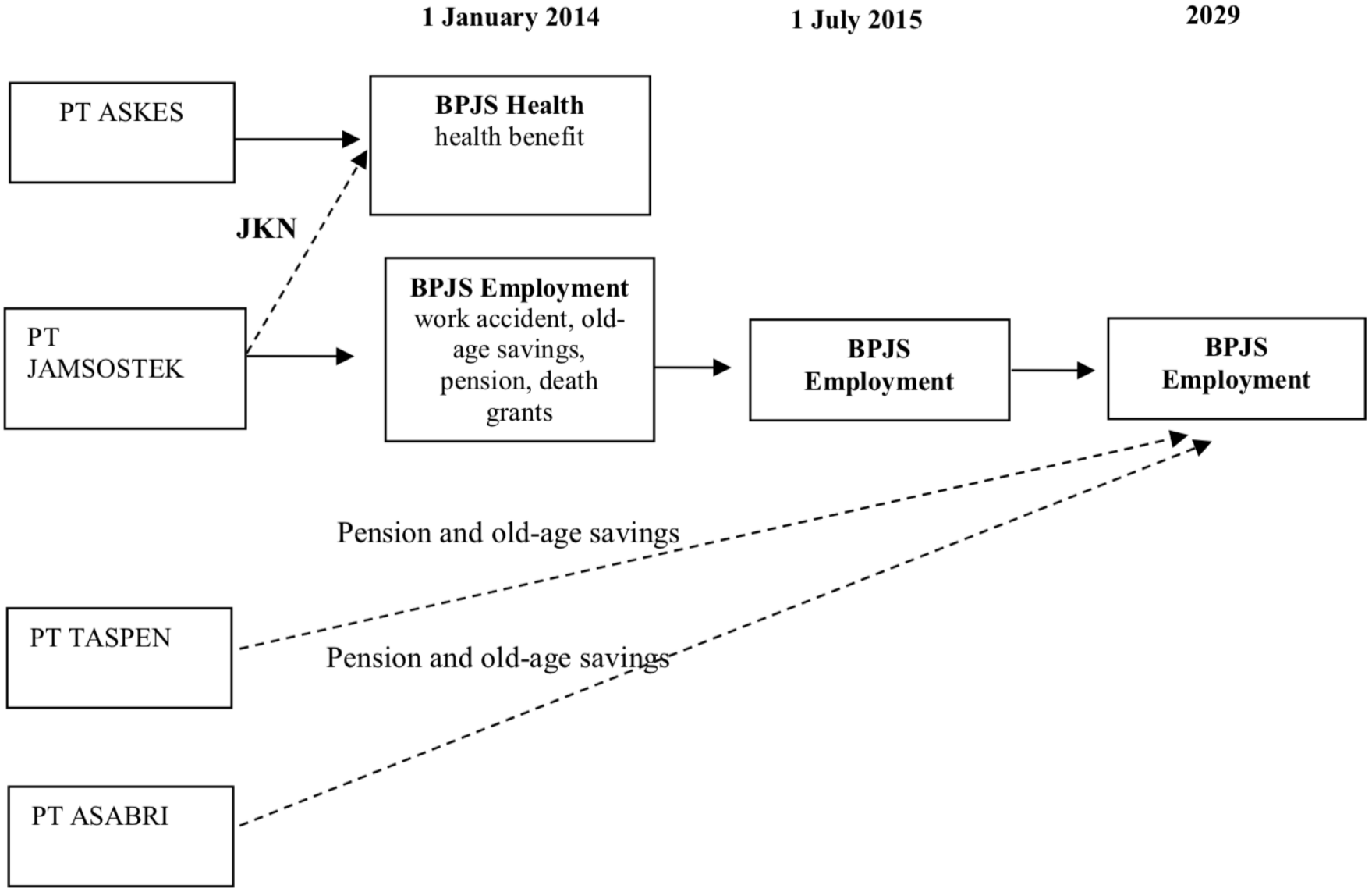
Country	Per Capita GDP (US$)	Health Expenditure to GDP (%)	Doctors		Nurses and Midwives	
			N	Density per 10,000	N	Density per 10,000
Indonesia	4,700	3.0	65,722	2.9	465,662	20.4
Cambodia	1,006	5.4	3,393	2.3	11,736	7.9
Viet Nam	1,910	6.6	107,131	12.2	88,025	10.1
India	1,498	4.1	757,377	6.5	1,146,915	10
Malaysia	10,538	4.0	25,021	9.4	72,847	27.3

Source: WHO, 2013; World Bank, 2014

2014 Budget: Rp 44.9 trillion committed for the JKN (86.6 mil PBI) of the Rp 602.3 trillion total MoH budget.

2015 Budget: Rp 47.8 trillion from the total Rp 647.3 trillion MoH budget → need for premium increase?

Transforming The Social Security System



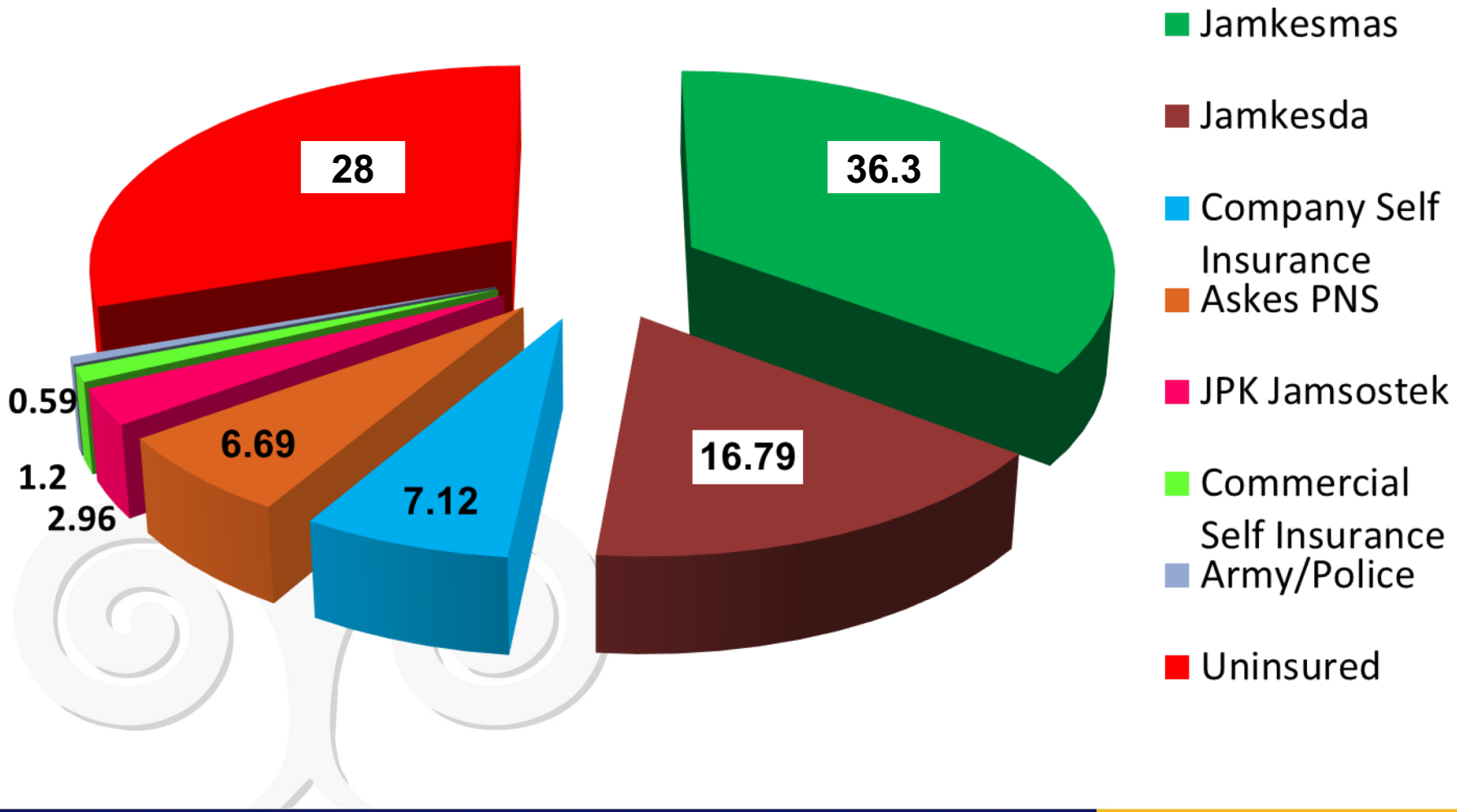
Social Security Finance in Indonesia: General Issues

1. Lack of integration in implementation and coverage.
2. Fragmented fund-pooling & management
3. Different benefit packages and inadequate schemes
4. Variations in management systems of different providers
5. Insufficient government control, lack of policy coordination.

INDONESIAN HEALTH FINANCE

- GDP per capita US$ 4,700
- Total Health Expenditure → Rp 214,9 Trillion,
  → 2.9% of GDP
- Per capita Health Expenditure → US$ 101.10
- 37.5% from public spending,
  61.4% from private spending
- 72% of population → now covered by insurance (various schemes),
- 28% of population → uninsured

HEALTH INSURANCE COVERAGE (PRIOR TO THE JKN, 2014)



ROADMAP TO UHC

86,4 mio PBI

Coverage of various existing schemes **148,2mio**

Uninsured people 90,4 mio

121,6 mio covered by BPJS Keesehatan

50,07 mio covered by other schemes

73,8 mio uninsured people

Activities:
Transformation, Integration, Expansion

257,5 mio (all Indonesian people) covered by BPJS Kesehatan

Level of satisfaction 85%

`Enterprises	2014	2015	2016	2017	2018	2019
Big	20%	50%	75%	100%		
Middle	20%	50%	75%	100%		
Small	10%	30%	50%	70%	100%	
Micro	10%	25%	40%	60%	80%	100%

2012 → 2013 → 2014 → 2015 → 2016 → 2017 → 2018 → 2019

Transformation from 4 existing schemes to BPJS Kesehatan (JPK Jamsostek, Jamkesmas, Askes PNS, TNI Polri)

Integration of Jamkesda into BPJS Kesehatan and regulation of commercial insurance industry

Presidential decree on operational support for Army/Police

Pengalihan Kepesertaan TNI/POLRI ke BPJS Kesehatan

Procedure setting on membership and contribution

Company mapping and socialization

Membership expansion to big, middle, small and micro enterprises

	20%	50%	75%	100%		
B						
S	20%	50%	75%	100%		
K	10%	30%	50%	70%	100%	100%

Synchronization membership data: JPK Jamsostek, Jamkesmas dan Askes PNS/Sosial – single identity number

Consumer satisfaction measurement every 6 month

Benefit package and sevices review annually

LEGAL FOUNDATION FOR INDONESIA'S NATIONAL HEALTH INSURANCE

- **Constitution of** 1945
- Act No 40/ 2004 on **National Social Security System** (**UU SJSN**)
- Act No 24/2011 on **Social Security Agency** (**BPJS**)
- Governmental Decree No 101/2012 **on Beneficiaries of Governmental Subsidy** (**PBI**)
- Pres Decree No 12/2013 **on Social Health Insurance**
- Other ancillary regulations

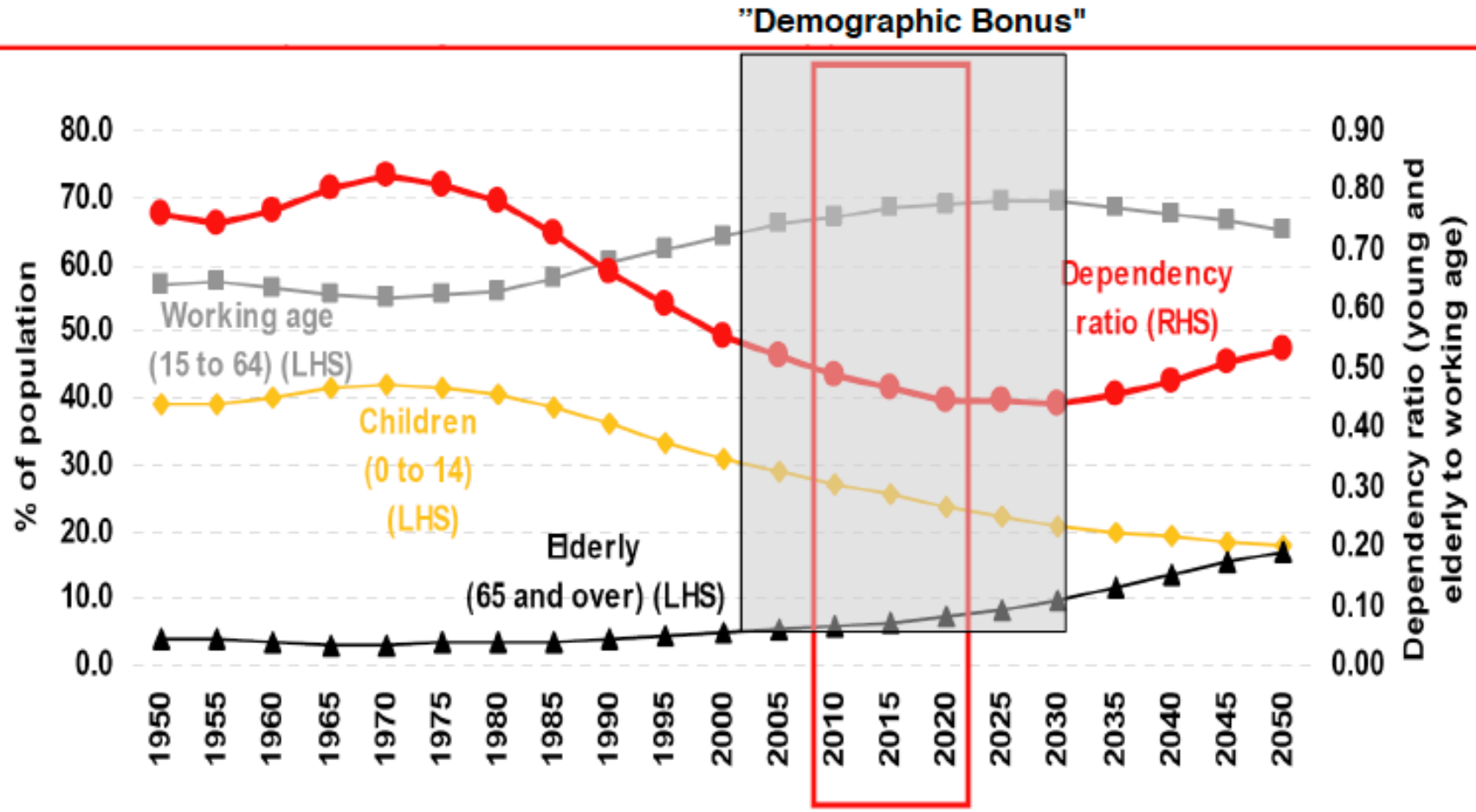
ADMINISTRATION & MANAGEMENT

- **Administered by BPJS** Kesehatan (single payer)
- **BPJS Kesehatan: managing** members, healthcare providers, claims, complaints, etc
- **Government:** (MoH, MoF, DJSN), regulates, monitors and evaluate implementation
- **MoH:** sets regulations on delivery of health services, drug and medical devices, tariffs, etc

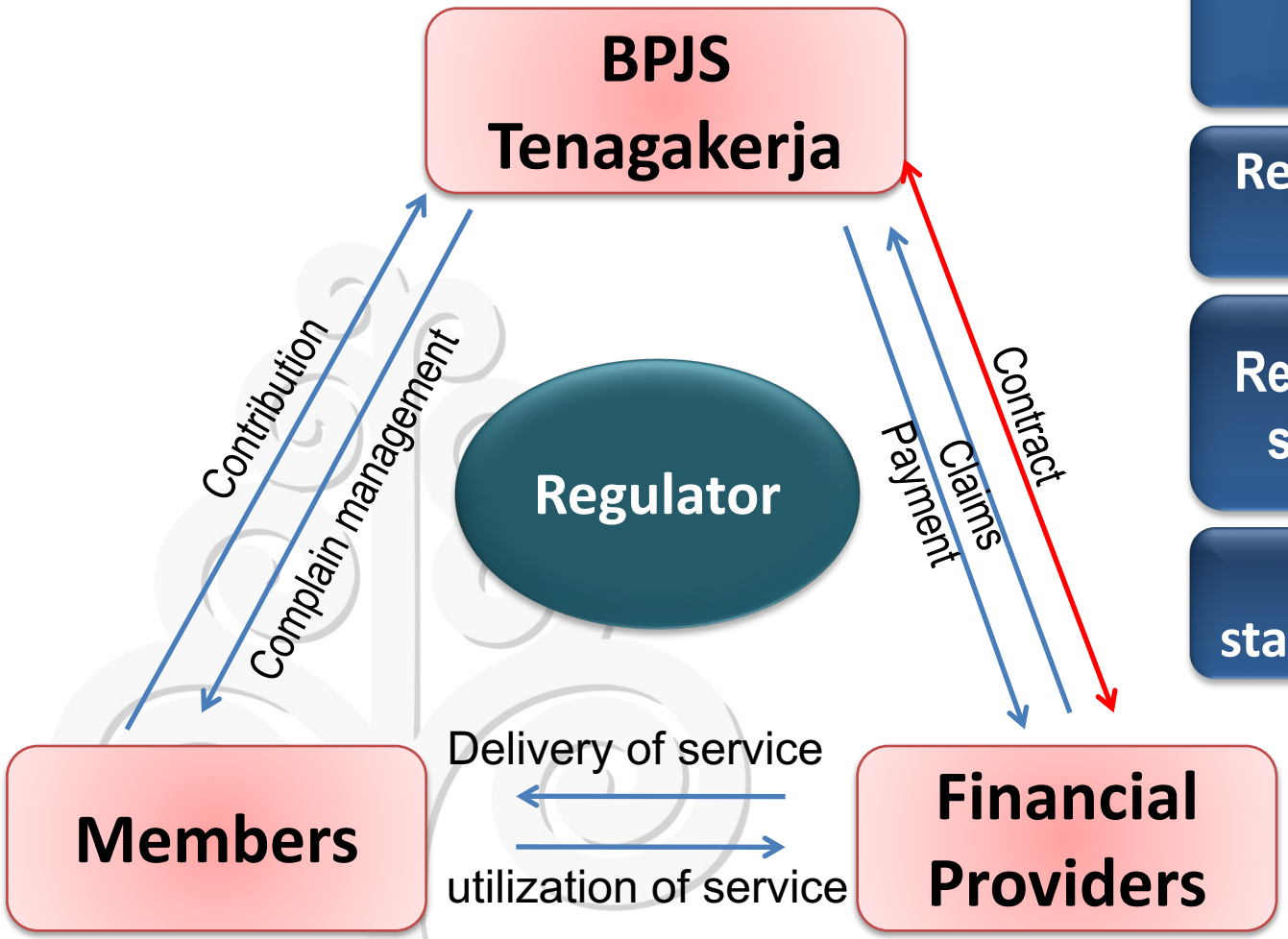
Indonesian Public Pension System

1. The provision of SSP for all current employees is intended to reduce their potential poverty and to have have optimum benefit from the demographic-dividend in 2020-2030.
2. The SSP is typically a FLAT benefit as the characteristic of social security.
3. Weighted data related to wage, year of contribution, age and inflation etc based on a coverage are in use of the benefit-contribution calculation.
4. The mechanism of paying benefits shall be based on a pay-as-you-go or cross-subsidy among the members except for the provident fund.
5. Sources of fund mainly derive from the members' contributions.
6. The withdrawal of pension benefit shall refer to retirement age at 55.
7. The requirement for pension withdrawal is at least 15 years of contribution which need to be met by the employees.
8. The pension contribution in the first stage in 2015 is 8% which refers to the case of Philippines, Trinidad and Tobago with 8.4%, then it is subject to increase according to the economic progress.

Indonesian Demographic Bonus: 2019 – 2030



SOCIAL SECURITY POLICY



- Government
- Regulation on delivery of services
- Regulation on quality of services, claims, etc.
- Regulation on standardization of tariff

Are all the schemes sustainable..?

Program	*Cost as % of Covered Wages*
Health	4.0% - 6.0%
Worker Accident	0.25% - 0.50%
Pension	5.0% - 6%
Old-Age Savings	3.0% - 4%
Death Benefits	0.25% - 0.50%
Total for SJSN Benefits	**12.5% - 17.0%**

Key Provident and Pension Fund Organizations and Indicators in Southeast Asia

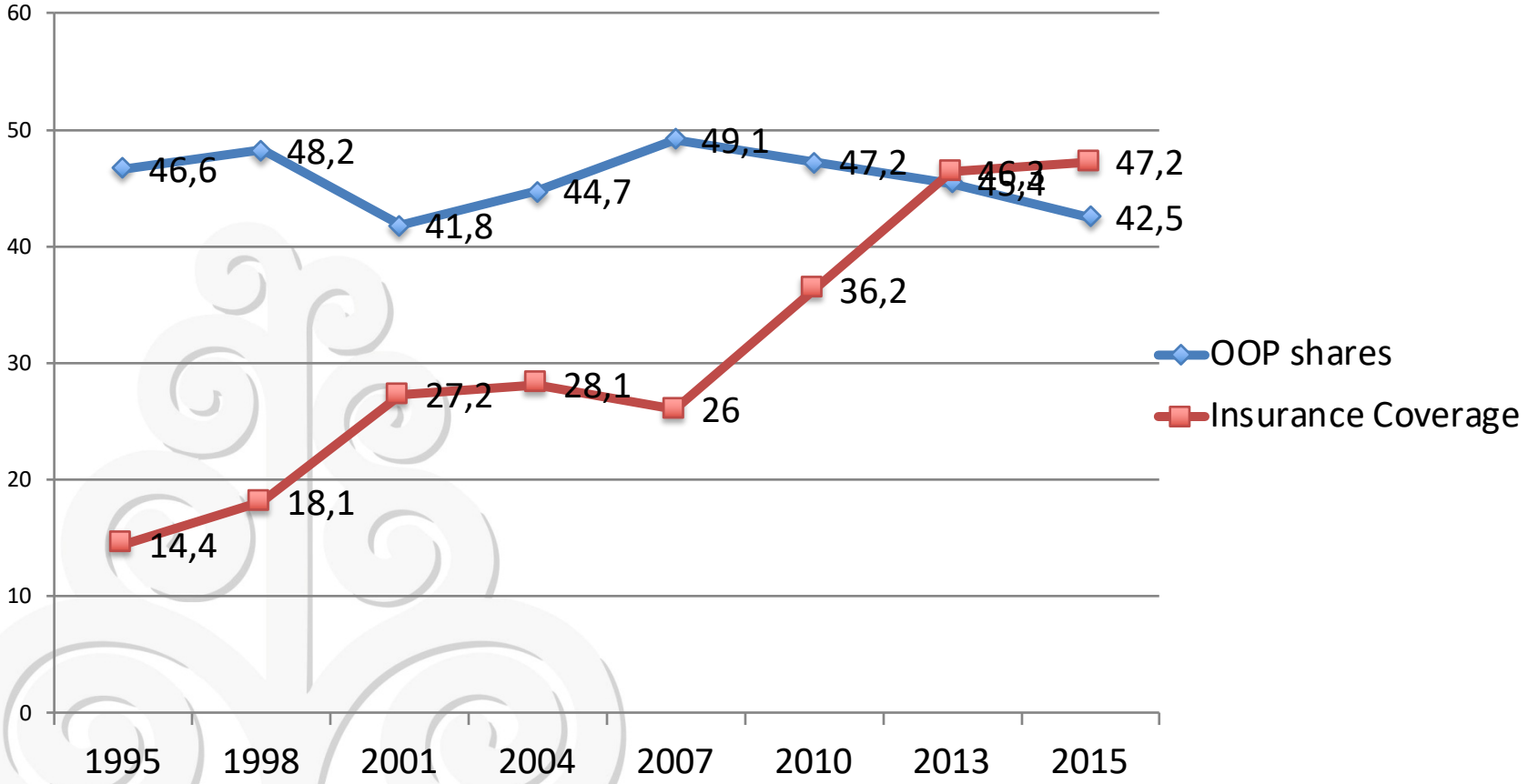
Country	Organizations	Contributors as Percent of Labor Force[a]	Contribution Rate	Wage Ceiling	Member Balances/Assets (USD Billion), Percent of GDP
Malaysia	Employees Provident Fund (EPF) Government Pension (GPF)	49.1 (2008)[b] NA	20.0 (employer 8, employee 12) NA	No No	98.9 , 65.5
Philippines	Social Security System (SSS) Government Service Insurance System (GSIS)	20-25[c] (2007) 4.5 (2007)	8.4 (5.07/3.33) 21.0 (12/9)	P 15,000 per month No wage ceiling	3.3, 3.8 8.3, 5.8 (mid-2008)
Singapore	Central Provident Fund (CPF) Government Pension (GPF)	84.0[d] (2008) NA	34.5[f] NA	S$4,500 per month from January 2006	107.7 60.6 (March 2009) NA
Thailand	Social Security Organization (SSO) Government Pension (GPF)	22.0[e] (2008) 3.0(2008)	6.0 6.0	B15,000 month	20.0, 11 (early 2005) 11.3, 4.6 (June 2008)

See Notes Page

The Premium of National Health Insurance

MEMBER	PREMIUM	Monthly membership fee (IDR)	REMARK
SUBSIDIZED MEMBER	NOMINAL (per member)	19.225,-	Class 3 IP care
CIVIL SERVANT/ARMY/POLICE/ RETIRED	5% (per household)	2% from employee 3% from employer	Class 1 & 2 IP care
OTHER WORKERS WHO RECEIVE MONTHLY SALARY/WAGE	4,5 % (per household) And 5% (per household)	**Until 30 June 2015:** 0,5% from employee 4% from employer **Start from 1 July2015:** 1% from employee 4% from employer	Class 1 & 2 IP care
NON WAGE EARNERS/ INDEPENDENT MEMBERS	NOMINAL (per member)	1. 25,500,- 2. 42,500,- 3. 59,500,-	1. Class 3 IP care 2. Class 2 IP care 3. Class 1 IP care

Reducing the OOP



Source: WHO, Susenas, 2014. The 2015 figure is an estimate.

Catastrophic Disease Treatment: How to Prevent "Adverse Selection"?

Components	General Hospital Class A (N=6)			General Hospital Class B (N=2)			Special Hospital (N=3)		
	CD	C	S	CD	C	S	CD	C	S
Accommodation	9.86	12.84	13.47	11.74	7.61	13.89	26.69	9.71	11.23
Ward treatment	15.7	9.87	14.79	26.17	9.75	25.15	28.36	8.38	32.12
Laboratory	19.19	11.17	23.01	14.94	6.63	11.87	10.85	11.25	12.35
Radiology	2.55	3.05	12.17	5.33	1.55	12.91	3.45	2.98	8.33
Surgery	2.44	21.74	5.29	1.46	12.53	2.61	0.00	32.77	0.00
Non-surgery	10.45	0.05	0.13	0.00	0.00	0.00	0.00	0.00	0.00
Medical rehab	3.12	0.09	1.27	0.00	0.00	0.00	0.00	0.00	2.21
Other treatment	4.74	3.47	2.12	4.69	1.04	5.34	8.78	14.83	2.23
Medicine	28.09	37.53	26.46	26.61	11.78	19.96	21.87	20.07	31.42
Medical consumables	3.86	0.18	1.30	9.06	49.12	8.27	0.00	0.00	0.00
Total	100	100	100	100	100	100	100	100	100
Average Costs (Million Rp)	410.00	236.24	228.68	396.13	136.48	305.97	38.22	86.71	62.13

Note:
CD: Cardiac Disease
C : Cancer
S : Stroke

Sumber: Budiarto & Sugiharto, 2012

The Evolving Components of Capitation

No.	Elements	INA-DRG (2008)	INA-CBG (2012)	INA-CBG (JKN, 2014)
1	Data coding	127,554 records	1,048,475 records	6,000,000 records
2	Costing benchmark	15 hospitals	100 hospitals	137 hospitals
3	Contributors	Class A & B	Class A, B, C, D and Special Class	All classes in public and private hospitals
4	Case distribution	Non-normal	Non-normal	Normal
5	Trimming method	L3H3	IQR	IQR
6	Tariff reference	Mean	Median	Mean
7	Number of case-base group	1077	1077	1077 + 6 Special CMG
8	Tariff grouping	12	12	6
9	Proportion of implemented tariff	75%	75%	100%
10	Clustering	-	4 regions	5 scales
11	Medical care class	3	3	3, 2, 1

Source: Wibowo, 2014

Benefit Size of Public Pensions
(solidarity vs. justice principles)

Reference of 5 x Earnings Not as Tax Object (ENTO), Upper and Lower Limits of Earnings and Benefit Size of Public Pension

No (0)	ENTO in place of Wages (x) (1)	Variety of Earning (Rp Million) (2)=(1)(2)	Increasing Replacement Rate due to dereasing earnings (%) (3)	Monthly benefit of Public Pension (IDR million) (4)=(2)(3)
1	5.0	10.0	33.34	3.34
2	4.5	9.0	37.00	3.33
3	4.0	8.0	37.34	2.98
4	3.5	7.0	38.00	2.66
5	3.0	6.0	39.00	2.34
6	2.5	5.0	40.00	2.00
7	***2.0***	***4.0***	*41.67*	*1.67*
8	1.5	3.0	44.67	1.34
9	1.0	2.0	50.00	1.00

Earning not as tax object (PTKP) for the lowest wage is IDR 2 million in place of provincial minimum wage (PMW), because of inconsistent PMW in respective provices.

Conjectures on Indonesian Incomes

Table 5 Roughly Projection of ENTO by Upper and Lower Limits of Earnings on Annually Average Inflation of 5% (IDR Million)

No	2015	2020	2025	2030
1	10.0	12.76	16.28	20.78
2	9.0	11.48	14.66	18.70
3	8.0	10.21	13.03	16.62
4	7.0	8.93	11.40	14.55
5	6.0	7.66	9.77	12.47
6	5.0	6.38	8.14	10.39
7	***4.0***	5.10	6.51	8.31
8	3.0	3.83	4.88	6.23
9	2.0	2.55	3.26	4.15

Variations in Local Policy

- **Membership system**: in some regions, poor patients are automatically registered when admitted to BPJS and entitled to Class-III insurance; in others, registration is based on ability-to-pay and PBI categorie; and in certain regions patients are required to have the poor-family cards (SKTM) from the Local Social Agencies.
- **The insurance coverage**: four provinces provide free-of-charge services, majority (25 provinces) provide subsidy below the BPJS rate (Rp 19.225), and three provinces provide subsidy above the BPJS rate.
- **Benefit packages**: 18 provinces follow national JKN policy (preventive & curative, rehabilitative, in-patient treatment); 16 provinces determine the package with Local Regulation (under considerations that the JKN standard is either too high or too low).

Conclusions

1. The elderly-poverty cannot be resolved by providing more cash-transfer (BLT). So the solution is your solidarity to participate directly in public pension under NSSS Law No 40 of 2004.

2. Universal Statement of ILO Secretary General : The World does not lack resources to abolish poverty, but it only lacks a right priority. As a matter of fact, Social Security is also not as a priority in certain countries.

3. The only thing we can do regarding the pension problem irrespective of whether there is fiscal burden or not: it is better late (to start right now) than never.

4. The consequences of the GOI in implementing compulsory pension are so many, among others: the need for the preparation of a good governance in social protection by doing more employment creation and its security which include remuneration for the protection of employees including their social security as well.

THANK YOU

Mengakar Kuat
Menjulang
Tinggi