Analysis Of Demand For Health Insurance Business During The Indonesian Covid Pandemic

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Abstract.
The implementation of BPJS in Indonesia nine years ago, seems to have had an impact on a number of insurance companies also demand of the health insurance during pandemic in Indonesia. This mandatory program from the government inevitably affects the competitive landscape of the insurance industry in Indonesia, especially private insurance companies that serve health and other private insurance companies. Healthcare insurance competition is expected to become a mechanism capable of creating efficiency that functions as a tool to protect consumers and business actors. The Indonesia government policy is one of the state-owned insurance companies, PT. Askes (Persero) changed its name to BPJS which applies to all people. Currently PT. Askes (Persero) changed to BPJS which serves all Indonesian citizens without any difference. This study uses a qualitative method, aiming to analyze the development of demand trend in health insurance in Indonesia, its developments and implications, especially in the world of healthcare insurance business in Indonesia. From demand of health insurance business and competition, it is hoped that efficient, effective, and high-quality production will be achieved. The goal of this research is to highlight what are the things that benefit consumers because they are given the opportunity to have a choice of quality products and can buy at competitive prices which tend to be relatively cheap. This study also aims to analyze the demand for health insurance included: utilization of inpatient, utilization of health insurance and comparison literature review of inpatient and outpatient costs based on the type of social health insurance in Indonesia, public and private health facilities.

Keywords: *Health insurance, health law, Indonesia demand, insurance business, insurance demand*

I. INTRODUCTION

The existence of a pandemic in Indonesia has made people vulnerable to disease and even death. This has an impact on health and financial losses due to the high cost of hospitalization[1]. Therefore, using insurance will protect the family from financial losses with the compensation or sum assured that will be provided by the insurance company. In the concept of health economics, we know the term demand or supply. Demand is a desire accompanied by a willingness and ability to buy the goods and services in question and within a certain period of time[2][3]. The existence of this demand must be supported by the ability and willingness to buy, and the desire is not accompanied by the willingness and ability to pay, then the demand for goods has not occurred, so it has no effect on prices[4]. Demand or supply in the healthcare system included health insurance is one of theory in health economics. The theory of demand contributes a lot to the analysis of public and private decision-making. Demand analysis can explain that human wants or desires are rarely absolute[5]. For this reason, in the concept of health economic demand, it is important to do a forecasting (forecasting) about demand of health insurance. In health economics, there are several factors that influence the demand for goods or products in healthcare, including: intensity of needs, consumer tastes, income as the purchasing power, prices of substitute and complementary goods, consumer expectations of these goods or products[6].The keywords in the concept of demand or demand are ability and willingness.

As is the case in the demand for health products or health services. In general, the state of demand and need for health services can be described in a concept called the iceberg phenomenon. This concept refers to the notion that true demand should be part of need. Conceptually, the need for health services can be in the form of an iceberg with only a few peaks seen as demand "a little" is varied[7]. In developed countries, the tip of the iceberg may appear relatively large when compared to countries that are still in poor condition.

As an example of demand / demand for health insurance[8]. In developed countries, health insurance is an important factor in terms of demand for health services. In the United States people do not pay directly to health services, but through the health insurance system[9]. In addition, there are government programs in the form of health insurance for the poor and the elderly. This government program is often referred to as social insurance. The existence of health insurance and health insurance can increase the demand for health services[10]. Thus, the relationship between health insurance and the demand for health services is positive. Health insurance is to reduce the effect of the tariff factor as an obstacle to getting health services when you are sick[11]. Thus, the more people who are covered by health insurance, the higher the demand for health services, including hospitals and other health providers[12].The definition of demand for health insurance is inseparable from the notion of demand in Economics, namely the number of commodities in the form of goods or services that consumers are willing and able to consume within a certain period of time. According to the demand for health insurance means a number of insurance benefits that are willing to be purchased (WTP) with various premiums/prices, additional insurance benefits will be paid if the insurance premiums or prices fall[13].

The concept of insurance is to transfer all or part of the risk of loss into a form of premium payment. Consumers pay insurance premiums to cover medical expenses in the coming year[14]. For each consumer, the premium will be higher or lower than the cost of treatment, but the insurance company can collect or share the risk among many participants (risk pooling), so that the premium amount will exceed the total medical expenses of the participants. Or in other words, the law of the large number applies[15].The purpose of studying the relationship between health insurance and demand, the important point is that insurance is like a subsidy to purchase medical care; that is, lowering the price per unit of care. Although there is an income effect caused by premiums or taxes paid to finance insurance benefits, this income effect can be shown to be empirically negligible in its effect on care demand. According to this theory, the insurance financing mechanism is negligible because the effect of premiums on demand for medical care - the income effect - is empirically negligible [16]. The central implication of this theory is that any additional health care consumed as a result of being insured that is, any moral hazard reduces well-being. The demand for health insurance is motivated by the existence of conditions related to the expenditure of health costs that are uncertain both in time and in the amount of costs. Expenditures on health costs can be in the form of direct or indirect expenses due to not being able to someone's work[17]. Health insurance helps to reduce the risk of these uncertain health costs. Based on these matters, health insurance can be defined as follows:

1. The exchange of large uncertain losses for small definite losses, i.e. paying insurance premiums;
2. Current exchange of money for money used to pay for uncertainties in the occurrence of events.

Based on the type of management, health insurance is divided into two groups, namely:

Social Insurance this type of insurance is managed by the government or Indonesia state owned enterprises company (BUMN) with the aim of providing a certain level of guarantee to a person or group who is able or unable to make the said guarantee for himself[18]. According to Law No. 2 of 1992, in Indonesia law it is stated that the social insurance program is an insurance program that is held obligatory based on a law with the aim of providing basic protection for the welfare of the community. This law states that social insurance programs can only be implemented by state-owned enterprises (BUMN), for example the Social Security Administering Body (BPJS)[19].In the other side Commercial Insurance is based on voluntary participation and is usually managed by a private business entity that aims to seek profit. In commercial insurance, the insurer acts as a trader who offers insurance packages to the public as potential buyers[20]. If the package offered is in accordance with what the community needs, then the package will be purchased in large quantities so that the merchant will earn a large profit as well. On the other hand, if the package is not in demand by the public, it will not sell itself and will cause losses for the insurance/traders. The purpose of this commercial insurance is to meet the relatively different demands of individuals. Demand for health insurance is an example of that demand/demand is based on forecasting, for example forecasting the probability of illness that will be experienced and forecasting the utility that will be received.

The difference in health insurance coverage of the two provinces above is not in line with utilization health services, especially utilization with insurance on inpatient products (the difference is ± 2.3%-2.4%).

Height health insurance coverage does not always increase access and utilization of health services if it is not balanced with the availability of manpower and adequate health facilities. Other evidence of the result some of research in Indonesia before year 2022 found that there is a gap in in terms of knowledge about the existence of health facilities for the community. Home knowledge level stairs about the existence of a government hospital the highest in Bali (88.6%) and the lowest in NTT (39.6%). For knowledge about private hospitals the highest in DI Yogyakarta (82.4%) and the lowest in West Sulawesi (15.1%). These facts emphasize the inequity of health services in Indonesia, especially if we comparing between Java-Bali and outside Java-Bali or West Indonesia and East Indonesia[21]. If access information or knowledge alone is different, especially the availability of health resources. In addition to ensuring access and utilization of services, health insurance, social security is expected to protect participants from the disaster of Out of Pocket (OOP) expenses that must be borne by individuals and families. Because the bad impact of this large expenditure can have implications for catastrophic expenditures which ultimately lead to poverty. OOP expenses in health care are common in many countries, including most Asian countries. The existence of these expenditures absorbs a large proportion of household resources, and has an impact on future poverty in Indonesia[12]. This study aims to analyze the demand for health insurance such as: utilization of inpatient, utilization of health insurance and comparison of inpatient and outpatient costs based on the type of social health insurance in Indonesia, public and private health facilities. A person in making a decision on the demand/demand for insurance products will definitely consider the following factors[22]:

1. Health Insurance Prices

Avoiding the risk of costs due to illness can be delegated to the insurer, by paying a premium. The amount of the premium is related to the level of utility (satisfaction). Utility or satisfaction generates desire and eventually generates demand. If the actual utility exceeds the expected utility, consumers will buy the insurance, and conversely, the higher the insurance price, the less WTP for health insurance. Insurance prices are often known as health insurance premiums. Health insurance premiums are installments paid to insurance companies as a consequence of using a type of insurance product that covers the health or treatment costs of insurance participants if they are sick or have an accident.The results show that the demand for health insurance is generally price-inelastic. Percentage changes in insurance prices, for employees, employers, and individuals in non-group markets, lead to a smaller percentage change in demand (inelastic), but the expected elasticity is wide. Health insurance is to reduce the effect of the tariff factor as an obstacle to getting health services when you are sick. Thus, the more people who are covered by health insurance, the higher the demand for health services (including hospitals). This condition is like what happened in our country with the JKN (Social Health Insurance) program. The difference in the amount of premium that must be paid between Social Health Insurance in this case BPJS and commercial or private health insurance is very different. Social health insurance premiums are usually proportional to wages and relatively cheaper than commercial health insurance premiums which are known to be quite expensive at a certain price for the type of benefit provided. With the government's policy that all Indonesians are required to participate in the social insurance program implemented by BPJS starting in 2014, and it is hoped that by 2019 all Indonesians have become JKN participants.

The number of JKN participants is increasing every year, from 133 million participants (2014) to 156 million participants in 2015, and to 171 million in 2016, and increased again to 174 million participants in mid-March 2017. For information, the benefit package offered by JKN is comprehensive, all services are covered and there is no cost limit as long as it is according to procedures. Meanwhile, the health insurance benefit packages offered by private insurance companies are more limited, both in terms of benefit packages or even claim costs. However, over time, many complaints about services in the JKN program, prompted people to start looking back at product offerings from private health insurance.The calculation of the premium for the health care program in the future implementation of BPJS Kesehatan is based on the calculation of social insurance. According to the calculation of social insurance contributions is not based on the level of morbidity but on the basis of a percentage of wages. The calculation of the amounts of premium contributions based on the percentage of income/wages is a form of equity and social solidarity as well as the function of regulating and protecting the government for people with low incomes. The results of research

conducted by show how important a premium/contribution is by taking into account several aspects related to real premiums, normative utilization premiums and benefit packages by considering the ability and willingness to pay of the community[23].

2. Level of Wealth Income

According to a person's income is determined by the number of factors of production that he has sourced from the results of his savings in past years and inheritance (gifts), and the price per unit of each factor of production. Income has a strong relationship. positively with insurance demand. Low income will reduce the level of demand for health insurance. Limited evidence suggests that higher-income consumers are less price sensitive (inelastic) than lower-income consumers. However, several observational studies used to estimate the income elasticity of demand have consistently shown that the demand for health insurance is inelastic with respect to differences in consumer income. The study shows that the income elasticity of demand for health insurance is < 0.1. A WHO study reported that the wealthier and healthier individuals will consume more private insurance. The higher a person's income level, the more they want wider insurance coverage[24].The implementation of health insurance in Indonesia is carried out socially by the government and commercially by private insurance. The implementation of social insurance is carried out singly and or monopoly by the Indonesian government through a Social Security Administering Body (BPJS). Although legally, this is legal to do because it is based on the mandate of the Act, but the BPJS monopoly is feared not to be in line with the principle of business competition because it has the potential to create monopolistic practices, hinder business competition and kill existing commercial insurance business actors. The obligation to participate in BPJS also encourages people who like it or not to become BPJS participants, this can lead to anti-competitive behavior. Health insurance other than BPJS can be disrupted by this obligation. Health insurance that should be able to compete fairly and healthily has been hindered since the existence of the BPJS membership obligation.

However, if we look at the provisions of Article 50 of Law Number 5 of 1999, there are provisions that regulate agreements and actions that are excluded from the Anti-Monopoly Law, among others, namely acts and/or agreements aimed at implementing laws and regulations that one of them is the formation of this BPJS which is regulated based on the applicable laws and regulations. The state has a goal to protect the public interest, therefore, the state has a role in transforming the understanding of healthy competition among business actors. The state plays an important role in creating “the right tool” to promote more effective business competition law policies[5][25]. The role of the state in regulating fair competition can be identified where the state is an institution that has the right to make laws to regulate competition. Furthermore, the role of the state itself must also be monitored because based on experience, monopolistic practices can occur because of the government's own approval (government consent)[26]. Several past actions, some facts show that the state plays a significant role in actions that are monopoly practices and do not cultivate fair competition, such as: the facilities provided by the government by several business actors where the facilities have never been controlled again even though the business actors have clearly practiced monopolistic practices and unfair business competition, the role of the government is so large in providing facilities for conducting monopolies to business actors from state-owned enterprises, likewise, there is no clarity regarding natural monopolies that are allowed to be carried out by the government. This act always hides behind the sacredness of Article 33 of the 1945 Constitution where monopolistic actions carried out by state-owned companies result in a high cost and inefficient economy[27].

II. METHODS

The study in this research is descriptive the social phenomena in Indonesia healthcare insurance demand. Based on the research objective is to describe the demand of health insurance and health services in Indonesia. The data collection technique used by researchers in carrying out data and information collection is by taking secondary data where the information comes from the official Indonesia health insurance website, government regulation, internet and the latest scientific journals, also where the data obtained in in-depth interviews with the experts to confirmed the completeness of the policy or related data involved in this research[28].The method used in this study with journals literature reviews, which aims to describe the

impact of the existence of health insurance also private insurance companies in Indonesia. The data collection technique used is to collect data and information, namely by secondary data collection techniques where the information comes from internet, government officially websites, and also related latest scientific journals[29].

III. RESULT AND DISCUSSION

The presence of BPJS, must be a momentum for private insurance companies to be able to work on sectors that cannot be reached by BPJS. The sector in question is the upper middle class that cannot be touched by BPJS. BPJS is mandatory, it covers a lot. Then insurance can come along, for example, if the life insurance sector has not been explored, you can use BPJS data to work on the potential that is above the BPJS coverage.According to a person's expenditure can be used as a proxy for his income or economic status. The higher the expenditure, the higher the income, which means the higher the economic status. The higher the income, the better their health status. This is consistent both for residents who have health insurance and those who do not have health insurance. In the population with health insurance, the number who experience health problems in the lowest expenditure group (decile 1) is 293 per 1,000 people, much higher than the highest income group (decile 10), which is 259 per 1,000 people.

Thus, the difference between the lowest expenditure group (decile 1) and the highest expenditure group (decile 10) was 34 per 1,000 people (or 3.4 percent). The magnitude of the difference is the same, both for residents who have funds/health cards (298 per 1,000 people in the decile 1 group and 264 per 1,000 people in the decile 10 group) and those who do not have health insurance (297 per 1,000 people in the decile 1 group). and 263 per 1,000 people in the 10 group). A study in the USA concluded that overall families with all members in better health spend 4% of their income on premium contributions and self-medicating costs compared to 7% in households with at least one member in good or poor health. A study conducted in Spain (2008-2014) concluded that the effect of income and wealth on VPHI (Voluntary private health insurance) is non-linear. Only the top 40% of households show a greater propensity to purchase insurance, especially the top quintile. Wealth is relevant for explaining insurance decisions, but its effect is smaller than income[22].

Possible illness

In terms of health conditions or conditions, every person in the course of his life will face 2 (two) possibilities in the same environment: the possibility of getting sick and the possibility of staying healthy or not incurring health costs. The amount of money that individuals are willing to pay (WTP) for insurance depends on the level of risk that can be avoided. As we know, the cost of medical treatment in Indonesia is not cheap. For certain types of diseases, medical expenses can even drain the wallet until it is not left. That is why, it is important to have financial protection from these risks. One option is to have health insurance, both social and commercial, both of which can ease the burden of the mind (financially) when someone is sick. You can imagine if you experience stress because you think about medical expenses when you are physically weak. What exists is that the healing process will be longer and the cost of treatment will actually swell. The results of research in Norwegian show that smokers have a higher demand than non-smokers. In the National Library of Medicine put forward about the effect of health insurance on health. Several study committee reviews discussed the relationship of health insurance to various health-related outcomes, including[30]:

- Uninsured cancer patients generally have worse outcomes and are more likely to die prematurely than those with insurance, largely due to late diagnosis. These findings are supported by population-based studies of breast, cervical, colorectal, and prostate cancers and melanoma.
- Uninsured adults with chronic illnesses are less likely to receive appropriate care to manage their health conditions than those with health insurance. For the five conditions examined by the Committee (diabetes, cardiovascular disease, end-stage renal disease, HIV infection, and mental illness), uninsured patients had worse clinical outcomes than insured patients.
- Uninsured adults with hypertension or high blood cholesterol have reduced access to care, are less likely to be screened, are less likely to take prescription medication if diagnosed, and experience poorer health.

- People with uninsured diabetes are less likely to receive the recommended services. Without health insurance for a longer time increases the risk of inadequate treatment for this condition and can lead to uncontrolled blood sugar levels, which, over time, puts people with diabetes at risk for additional chronic disease and disability.
- Uninsured patients with end-stage renal disease starting on dialysis with more severe disease than those who have this insurance before starting dialysis.
- Uninsured adults with HIV infection are less likely to receive highly effective drugs that have been shown to improve survival and consequently die more quickly.
- Adults with health insurance that covers any mental health treatment are more likely to receive mental health services and care that comply with clinical practice guidelines than those without health insurance or insurance that does not cover mental health conditions.
- Uninsured patients who are hospitalized for a variety of conditions experience higher hospital mortality rates, tend to receive fewer services, and are more likely to experience substandard care and resulting injury than insured patients.
- Uninsured persons with traumatic injuries are less likely to be hospitalized, tend to receive fewer services while being treated, and are more likely to die than insured trauma victims.
- Uninsured patients with acute cardiovascular disease are less likely to be hospitalized for angiography or revascularization procedures, less likely to receive these diagnostic and treatment procedures, and more likely to die in the short term.

Health care costs when sick

Recently, a new awareness has emerged which proves that health social security is increasingly needed considering that economic conditions have an impact on the inability of the community to access health services when sick and even become poor after illness. The Indonesia Financial Services Authority (OJK) stated that public awareness of health insurance has increased during the covid-19 pandemic. The current pandemic condition is a momentum where people are increasingly aware of the importance of insurance as a product that provides protection against risks, especially health risks[31].When an individual is sick, the individual will face health costs, these expenses are assumed to fully recover losses due to illness. The greater the possibility of loss, the greater the premium that you are willing to pay. For this reason, more people buy health insurance for hospitalization than health insurance for teeth or eyes. Currently the cost of healthcare is becoming increasingly high due to the many new technologies that have emerged. As reported by the Central Statistics Agency (BPS), 68.36% of Indonesia's population has health insurance in 2021, down 0.93 points from 2020. If you look at the trend, the population who have health insurance has experienced an increase. A total of 59.41% of the population had health insurance in 2017. This percentage increased to 64.1% in 2018 and continues to increase to 65.88% in 2019. Then, during a pandemic, it increases along with increasing public awareness of health. The percentage of the population with health insurance increased by 3.41 points to 69.29% in 2020. Thus, it can be concluded that the increasingly expensive health care costs with the support of good technology can increase the demand for health insurance[32].

The level of individual risk averse (risk averse)

For most people, illness is an uncertain, irregular, and perhaps infrequent event. However, when these events do occur, the implications of medical expenses can be enormous and burden the household economy. Health insurance covered by a health insurance company through a health care guarantee program is a way to overcome the risk and uncertainty of illness and the implications of the costs that result. According to the principle of risk, that health insurance is a way of overcoming the risk of uncertainty to certainty. This is supported by a person's willingness to avoid health risks (risk averse). Individuals who are risk takers (dare to take risks) have a lower WTP than individuals who are risk averse (don't dare to take risks). The level of risk taker is closely related to one's awareness[33]. According to the awareness is defined as the possession of knowledge or being aware of someone, a situation or something. Awareness usually arises from oneself or an external impulse. Public awareness in insurance is a condition of individuals who understand about an insurance product. Understanding insurance products means knowing and understanding

insurance products and the benefits of insurance products insured.Indonesia health insurance association AAJI's reviews that the covid 19 pandemic disaster was a blessing in disguise for the insurance industry because it actually built the urgency of the community to use insurance services to protect themselves and their families from health risks and bad health conditions[34].

IV. CONCLUSION

During the covid-19 pandemic in Indonesia, there was a significant increase in the demand for health insurance for family and individual clusters. Data from the Central Statistics Agency (BPS) in Indonesia, the Financial Services Authority (OJK) and also the Insurance Association in Indonesia show this for the past two years. In accordance with the principles of Health Economics, it is necessary to have a market mechanism controlled by the government in the provision of private health insurance products in Indonesia in the future. BPJS Insurance can go hand in hand with the development of demand for private insurance to comply with the basic platform of the Government Law related to insurance.There are so many gaps and shortcomings of BPJS that can be covered by private insurance companies demands. As in terms of speed in service, hospitality, the facilities provided are more complete, the claim process does not make it difficult for participants, and other facilities that BPJS cannot afford. The various advantages of these facilities and services are certainly not all owned by the BPJS program, in that aspect private insurance companies will be able to compete with BPJS which seems to monopolize business competition in the insurance sector. Considering that there are already many private insurance companies and the creation of a perfectly competitive market in the insurance services sector, Law No. 24 of 2011 should be facultative or suggestive.

The development of health insurance in Indonesia is very slow compared to the development of health insurance in several neighboring ASEAN countries (Associaton of Southeast Asian Nations). Careful research on the slow development of health insurance in Indonesia is still lacking. However, theoretically, several important factors can be put forward as factors that influence the slow growth of health insurance in Indonesia. On the demand side, Indonesians generally take risks in terms of health and mortality. Sickness and death in the life of the Indonesian religious community is God's destiny and because of that there are many assumptions that develop among Indonesian people that buying insurance is related to the opposite destiny. The development of public health services in Indonesia has succeeded in improving health services more evenly. Advances in science and technology have resulted in more and more educated and informed community groups so that they can choose and demand quality health services. In the next 22 century, the development of health services is in line with technological advances, as can be seen in the main facilities and support for primary individual health services. Then this will be able to increase its profits and the insurance company can survive in the midst of the covid-19 pandemic[35].The future competition after pandemic is expected to become a mechanism capable of creating efficiency that functions as a tool to protect consumers and business actors. From healthy competition, it is hoped that efficient, effective, and high-quality production will be achieved. So that the ultimate goal is to benefit consumers because they are given the opportunity to have a choice of quality products and can buy at competitive prices which tend to be relatively cheap.

The expense of inpatient out of pocket (OOP) costs that occur to insurance users is actually inseparable from the payment system based on fee for services. This system provides opportunities for supply induced demand (providers provide services exceeds what is required) due to incentives larger, or insurance users request services that exceed the insurance package. This situation can lead to the assumption that health insurance cannot always protect participants from financial risk. For that it is necessary to consider a change in the payment system, such as the capitation system (services are calculated based on the number of participants, not based on the type of service). The capitation payment system has proven to be able to protect the risk of financial expenditure compared to the fee for services system in Indonesia[11].Although this research can prove that there are differences in the ability to protect financial risk among several types of existing private health insurance, there are limitations to research that have not studied in depth such as the type or type of health insurance, hospital class, and the type of service or treatment provided by the provider. In addition to data limitations, it is indeed very difficult to obtain more

comprehensive data or information related to with inpatient OOP expenses with wider area or sample coverage of future demand and types of private health insurance products in Indonesia[33].

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