

Factors Analysis Influencing on Demand for Private Health Insurance in Indonesia After Pandemic

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Abstract.

The study focused on the purpose of this writing is to find out the importance of today's health insurance such as protection for yourself and your family, by having health insurance you and your family will get health protection. If at any time you need treatment and medication, insurance will cover these needs. Sickness is an unexpected event that can happen to anyone, including yourself and your family. Therefore, with the protection you get from insurance, you will be calmer in living your life and not confused if you must spend large funds for medical needs. This study uses qualitative research methods, which are related to the subject and research informants. Private health insurance in Indonesia still has an important role to play in protecting individuals and families from the financial risks associated with health care costs. The demand for private health insurance is influenced by several complex and varied factors. An analysis of the factors affecting the demand for private health insurance in Indonesia will be important after the pandemic is over. Through a better understanding of these factors, the government and the private sector can make policy decisions in designing appropriate strategies to improve the accessibility, sustainability, and quality, of private health insurance.

Keywords: Insurance concept, private health insurance, private insurance and request for health insurance .

I. INTRODUCTION

According to the World Health Organization [1], coverage in UHC consists of two elements, namely access to fair and quality services for every citizen, and financial risk protection when citizens use health services. Universal Health Coverage demands optimal health service efforts for the community and has a direct impact on the health and welfare of the community. Having access to health services for the whole community allows a person to be more productive and active. At the same time, financial risk protection can prevent someone from falling into poverty when they must pay for health services [2]. To realize UHC coverage for every citizen, an effective and efficient health financing system is needed. The 58th World Health Assemble (WHA) resolution of 2005 in Geneva stated that every country needs to develop UHC through a social health insurance mechanism to guarantee sustainable health financing. On this basis, to achieve UHC, various countries formed National Health Insurance, including Indonesia, England, Germany, France, Australia, Korea, Taiwan, the Philippines, Thailand, Vietnam, and others. The form of implementation from the Indonesian government in the context of realizing the UHC program is the establishment of the National Health Insurance (NHI) program or what is known as the National Health Insurance (JKN) in Indonesia. The insurance is defined as an agreement between two parties, namely the insurance company and the policyholder.

The policy which is the basis for receiving premiums by insurance companies with various rewards to provide reimbursement to the insured or policyholder due to loss, damage, costs incurred, loss of profits, or legal liability to third parties that may be suffered by the insured or policyholder due to an event. which is uncertain. And or provide payments based on the death of the insured or payments based on the life of the insured with benefits whose amount has been determined and/or based on the results of fund management. Having health insurance from a young age is important. This is because besides being able to provide protection for the body's health in the future, insurance can also reduce medical expenses when we or our beloved family are attacked by certain diseases or health problems. The first reason for the importance of private health insurance is protection or protection for yourself and your family. By having health insurance, we and our beloved family will get health protection. If at any time you need care and treatment, insurance will cover these needs. Sickness is an unexpected event that can happen to anyone, including

yourself and your family. Therefore, with the protection you get from insurance, you will be calmer in living your life and not confused if you must spend large funds for medical needs [3]. The right to health is a fundamental right that every human being has. In Indonesia, based on the 1945 Constitution of the Republic of Indonesia, it has been determined that the government is fully responsible in terms of optimally regulating and protecting the right to public health.

One form of implementation of the Indonesian government's responsibility for fulfilling the right to health is by participating in one of the World Health Organization programs, namely establishing a Universal Health Coverage (UHC) system which is a health system to ensure that every citizen in the population has access to health services both promotive, preventive, curative, and rehabilitative, in a fair and equitable manner. Health Insurance is a guarantee in the form of health protection so that participants get the benefits of health care and protection in meeting basic health needs that are given to everyone who has paid Health Insurance Contributions or whose Health Insurance Contributions are paid by the Central Government or Regional Governments [3]. In its implementation, one of the principles of JKN is the principle of mandatory participation, which means that all Indonesian residents are required to become JKN participants managed by BPJS. The implementation of the National Health Insurance program in Indonesia integrates the functions of financing health services and providing health services. The function of financing health services is carried out by BPJS Health, Participants, and the Government, while the function of providing health services is carried out by health facilities, BPJS Health, and the Government [4]. Someone's request to use insurance services is usually based on a person's possibility of experiencing a risk of loss in the future. So, it requires financial support to deal with it. For this reason, people finally choose to invest in insurance. The insurance that is generally chosen is general insurance such as home or property insurance, vehicle asset insurance, life insurance, death insurance, work accident insurance, and so on.

Aside from being a form of risk control (financially), insurance also has various benefits which are classified into: main functions, secondary functions, and additional functions. The main function of insurance is to transfer risk, collect funds and a balanced premium. The secondary function of insurance is to stimulate business growth, prevent losses, control losses, have social benefits and as savings. While the additional function of insurance is as investment fund and invisible earnings. Private health insurance has an important role to play in protecting individuals and families from the financial risks associated with health care costs. The demand for private health insurance is influenced by several complex and varied factors. Analysis of the factors influencing the demand for private health insurance is important. Through a better understanding of these factors, policy makers can design appropriate strategies to improve the accessibility, sustainability, and quality of private health insurance [3].

II. METHODS

This study is a literature review that is part of a qualitative research, related to the research subject. Research is descriptive the social phenomena in detail. Based on this research, the research objective is to describe the factors influencing development of private health insurance 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 Indonesian Ministry of Health (MOH) website, government regulation, internet, and 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.

The method used in this research is a literature review of journals, which aims to describe the factors that influence the demand for private health insurance. Literature review is writing on a particular topic or issue based on a literature search or research according to research topics originating from reading books, journals, and other published publications. The data collection technique used by researchers in collecting data and information is to take secondary data where the information comes from government regulations, the internet, online books, and the latest scientific journals. The sources also used are journals and books published at home and abroad and are original. Research sources are published on the internet through open access channels such as Google Scholar, Pubmed and Science Direct.

III. RESULT AND DISCUSSION

Health funding is one of the keys to the health system in many countries. A fair and equitable health funding system (equity) means that the burden of health financing is issued from individual pockets and does not burden the community. Most developed countries have implemented the concept of fairness and equality to all their population based on the national health service system (National Health Service, NHS), the national or social health insurance system, or through the social security system [5]. The fact that cash is often unavailable when someone becomes ill is serious food for thought. Facing this problem, developed countries use an insurance system so that every citizen or even every resident is covered by insurance for the needs of their medical services. Most countries in Europe currently have adopted an insurance system, although in different ways.

The United States also adheres to the insurance system, but according to their life principle that every individual can choose their own insurance company and everyone, if they can afford it, can start an insurance company. Japan and Singapore also adopt an insurance system that is different from other countries. South Korea and Thailand have also adopted the insurance system. Indonesia has also embraced insurance, but only a small portion of its citizens. The government contributes around 20% - 30% for overall health funding. Meanwhile, funding by the private sector, which is generally out of pocket expenses paid directly (Out of Pocket/OOP) to Health Service Providers (PPK), reaches 60% -70%. The high spending on OOP is felt to be even more difficult for the poor compared to people belonging to the upper middle class because it can have an uneven effect or disparities in obtaining health services between the poor and the middle and upper class. Overcoming this, the portion of public funding or public health insurance needs to be reviewed [6]. Insurance is an agreement between two parties, namely the insurance company and the policyholder, which forms the basis or reference for premium receipts by the insurance company in return for:

- a. Provide reimbursement to the insured or policyholder due to losses suffered, damage, costs incurred, loss of profit or legal responsibility to third parties that may be suffered by the insured/policyholder due to an uncertain event.
- b. Providing payments with reference to the death of the insured or payments based on the life of the insured with benefits of a predetermined amount and/or based on the results of fund management.

Theoretically, several important factors can be put forward as factors that influence the slow growth of private health insurance in Indonesia. From a regulatory perspective, the Government of Indonesia has been relatively slow in disseminating the concept of insurance to the public through the ease of licensing and legal capacity in the insurance business or the development of social health insurance for the general public. According to Basuki in the Health System, health insurance is a form of insurance designed to ease the financial burden due to changes in health [7]. According to Thabrany and Mayanda in the health system, health insurance is a social instrument to ensure that a person (member) can meet health care needs without considering the person's economic situation when the need for health services arises [8].

From the definition above, it can be concluded that health insurance is a tool that can help people to continue to carry out health care without having to be burdened with economic or financial problems. Health insurance can act as a financing instrument that can achieve the goal of universal health coverage. The World Health Organization (WHO) encourages countries in the world to provide health insurance to their people, either in the form of commercial or social health insurance. The concept of insurance is to transfer all or part of the risk (risk) of loss into a form of premium payment. Consumers pay insurance premiums to cover medical expenses in the coming year. For each consumer, the premium will be higher or lower than medical expenses, but insurance companies can collect or share risk among many participants (risk pooling), so that the total premium will exceed the participant's medical expenses. Or in other words the law applies "the law of the large number" health insurance can be divided into seven types, namely:[8]

1. In terms of fund management

- a. Government health insurance
Called government health insurance (government health insurance), if the management of funds is carried out by the government. With the participation of the health government, several advantages will be obtained, for example health costs can be monitored, health services can be standardized. But besides

that, there were also several deficiencies which generally revolved around the dissatisfaction of the participants, all of which were related to the less than perfect quality of service.

b. Private health insurance

Called private health insurance, if the management of funds is carried out by a private body. The advantage of health insurance is that the quality of service is relatively better, while the disadvantage is that it is difficult to monitor health costs which in the end can burden the users of health services.

2. In terms of member participation

a. Mandatory health insurance

In compulsory health insurance (compulsory health insurance) participant participation is mandatory. Can apply to every resident (national health insurance) and or for certain groups only, for example in a company. In general, compulsory health insurance applies if the health insurance is managed by the government.

b. Voluntary health insurance

In voluntary health insurance (compulsory health insurance), the participation of participants is not mandatory, but up to the will of each. This form applies if the health insurance is managed by the private sector.

3. Viewed from the type of service covered

a. Covers all types of health services in a health insurance system where the fund manager also acts as a service provider, the types of health services covered usually cover all types of health services (comprehensive plans). So, it is limited only to curative services, but also preventive services. The main goal is to maintain and improve the health of participants. Participants will rarely get sick, the use of services will decrease, so that the health insurance agency will get a better profit.

b. Cover only part of the health service, what is covered is only part of the health service (partial plans). For example, for certain types of health services that generally require a large amount of money.

4. In terms of the amount of funds covered

a. Cover all necessary health costs:

In this system all health costs are borne (first dollar principle) by health insurance. It is easy to predict, if participants' awareness is lacking, it can encourage over-utilization, making it difficult for insurance agencies and or health service providers.

b. Cover only health services with high costs: To overcome excessive use, another form was introduced, in which health insurance only covers health services that require large costs (large loss principle). If the fee is still below the standard set, participants must pay for it themselves.

5. Viewed from the number of participants covered

a. Participants are individuals (individual health insurance)

b. Participants are one family (family health insurance)

c. Participants are a group (group health insurance)

6. Viewed from the role of the insurance agency

a. Only act as fund manager. This form is a classic form of health insurance which, when combined with a reimbursement payment system to health facilities, can lead to high health costs. However, when combined with a prepayment system, health costs can be controlled.

b. Also acts as a health service provider. The form of HMO is one example where the insurance agency also plays a role in providing health services. In this form, several advantages will be obtained, namely that health costs can be monitored, but it can also bring disadvantages, namely the incompatibility of health services with the needs of the community.

7. Viewed from the method of payment to health service providers

a. Payment based on the number of visits by participants. Here, payments are made based on the number of visits by participants (reimbursement) who use health services. The more the number of visits, the greater the money received by health service providers.

b. Payment is made in advance. In this system, payments to service providers are made in advance (prepayment), in the sense that after the health service has been completed.

Private health insurance is a private company that guarantees and bears the cost consequences of a risk that occurs in the health sector. In the insurance policy there is an agreement regarding which hospitals work with the insurer, and what diseases are included in the handling of the insurance. So, if the insured is sick or needs treatment, the costs will be borne by the insurer in accordance with the existing policy agreement. Private health insurance is a product from private health insurance companies that is most in demand by the people of Indonesia, with a percentage of nearly 80%. This is because private health insurance is considered to have good service, and has more complete facilities, including not requiring a referral letter, easy to submit multiple claims and can be used abroad. The advantage of this private health insurance in the end makes people interested. This is because the cost of the premium paid is commensurate with the services obtained, according to what is written in the insurance policy. Private health insurance in Indonesia has existed since 1970, but its development was very slow until 1992 due to unclear legal basis [9]. At that time, health insurance was sold as a rider product by general insurance companies. Meanwhile, it is not clear whether life insurance companies can sell these products or not. With the issuance of Law Number 2 of 1992 concerning insurance [10], both general insurance and life insurance may sell health insurance products.

Another factor that causes insurance growth is economic growth in Indonesia [11]. The development of health insurance in Indonesia accelerated when the issuance of PP No. 14 of 1993 concerning Asustek [12], in which it was explained that companies were given the choice whether to participate in the PT Asustek program. It turns out that many companies prefer to buy health insurance from the private sector rather than from PT Asustek [9]. Commercial health insurance companies can meet the wishes of a wide variety of individuals. Consequently, the company will design various products according to the demands of society. Health insurance in this case includes social and commercial health insurance products [13]. One of the Non-Bank Financial Institutions that plays a role as one of the pillars of the national economy is the insurance industry [14]. Even the growth of the insurance industry has a positive effect on production factors, savings, and investment capital accumulation [15]. The results of other studies show that there is a significant causal relationship between economic growth and insurance growth [16]. In general, health expenditures for private insurance countries in the world are around 4.7% of health expenditures outside investment (CHE) in 2014 [17]. Total private insurance spending in 2015 was around 3.9% of Indonesia's health spending (excluding investment) [18].

Even though the proportion is not large, there is not much literature or publication on the development of private health insurance in Indonesia. In Indonesia, the number of insurance companies continues to increase every year. In 2012 there were around 140 insurance companies, while in 5 years it increased to 146 insurance & reinsurance companies in 2016. In addition, insurance support companies also experienced an increase from 205 companies in 2012 to 237 companies in 2016. Likewise, the gross premium growth has increased by an average of 19.8% per year in the last 5 years or in 2016 around IDR 361.78 trillion [19]. The definition of demand for health insurance is inseparable from the understanding of demand in Economics, namely the number of commodities in the form of goods or services that consumers are willing and able to consume in a certain period [20]. Feldstein researched the demand for health insurance, meaning that several insurance benefits are willing to buy (WTP) with various premiums/price, additional insurance benefits will be paid if the premium/insurance price falls [21].

Demand is the desire of consumers to buy an item at various price levels during a certain period. For example, when talking about the demand for clothes, we are talking about the amount of clothes that will be purchased at various price levels in a certain period, per month or year. Demand according to economists describes the overall state of the relationship between price and quantity demanded, while the quantity of goods demanded is meant as the number of requests at a certain price level, commodity prices and other commodity prices, income, tastes, etc. [22]. Then demand is the desire of consumers to buy an item at various price levels during a certain period [23]. The concept of demand explains the demand for goods or services in relation to the factors that influence it. the factors that determine demand namely; the price of the goods themselves, the prices of other goods (having the same type of goods as the main goods), per capita income and household income, practices and wants of society, population factors, and factors from the business of providing goods to improve services. The demand for health services is derived from the demand

for health itself, in this model it is assumed that everyone evaluates the benefits of spending on health which is analogous to spending on other commodities in the form of deciding on optimal health status [24].

As a subject of discussion in economics will always refer to the demand, supply, and distribution of commodities. The community's perspective on the demand to improve their health status so that people need health services to achieve a higher degree of health. Meanwhile, the main supply or production of health services is health and at the same time produces other outputs [22]. From the consumption aspect, analyzing patterns of use of health services and their differentiation according to facilities, income levels. Education level, demographics, age, and occupation. analyze how certain factors affect consumption patterns of health services; tariffs, subsidies, health insurance, income, opportunity costs, and others [25]. Expenditures for health are uncertain in terms of time and costs. Expenses for health costs can be in the form of direct or indirect expenses due to someone not being able to work. Health insurance helps to reduce the risk of uncertain health costs. Insurance can be interpreted as follows: [26]

1. The exchange of a large uncertain loss for a certain minor loss, namely paying an insurance premium;
2. Exchanging money now for money used to pay for uncertainties in the occurrence of events

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The concept of demand explains the demand for goods or services in relation to the factors that influence it. the factors that determine demand namely; the price of the goods themselves, the prices of other goods (having the same type of goods as the main goods), per capita income and household income, practices and wants of society, population factors, and factors from the business of providing goods to improve services. The demand for health services is derived from the demand for health itself, in this model it is assumed that everyone evaluates the benefits of spending on health which is analogous to spending on other commodities in the form of deciding on optimal health status [24]. In summarizing the theory of demand for health insurance, attention should be drawn to two areas:

1. Factors influencing the demand for health insurance
2. Welfare implications (the better the worse the person) which requires a person to buy health insurance against all kinds of medical ailments, routine as well as low-cost services.

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The following factors will affect the demand for health insurance: Variable rationale using Paul J. Feldstein where there are 5 factors that influence the demand for health insurance, namely [27]:

1. How a person avoids risk (How Risk Averse Is the Individual). If a person has a utility curve that continues to increase but decreases (such as decreasing marginal utility for an increase in income), the individual is willing to pay an amount that exceeds the premium price for insurance. (Someone's risk of turning down a larger request for insurance).

2. The possibility of an event occurring (The Probability of the event occurring). One is willing to pay less for a pure premium than for an event that has an intermediate probability. (The demand for health insurance is lower when the probability of the event occurring is either very high or very low).
3. The Magnitude of the loss. The greater the loss, will be the amount of pure premium that a person is willing to pay for insurance. (Demand for insurance will be greater than the size of the loss).
4. The Price of Insurance, (Also known as the loading fee). The higher the price of insurance (the amount above the pure premium), a person will insure against fewer events. (The higher the price, the lower the quantity demanded by insurance).
5. Income of a person (The Income of The Individual), a study conducted by Fabri and Mandarina [24] reported that the richer and healthier the individual will consume more private insurance. The higher a person's income level, the more they want wider insurance coverage.

Individuals who are risk takers (dare to take risks) have a lower WTP than individuals who are risk averse (do not dare to take risks). [29] This opportunity affects wealth. The higher a person's risk averse, the more concave the utility curve will be [30]. When an individual is sick, the individual will face health costs, this expenditure is assumed to fully restore losses due to illness. The greater the possibility of loss, the greater the premium that is willing to be paid. Each individual faces 2 possibilities in the same environment: namely the possibility of getting sick and possibility of staying healthy or not incurring health costs [31]. For this reason, more people buy health insurance for hospitalization than health insurance for teeth or eyes. Currently health costs are getting higher due to the many new technologies that have emerged [32]. The amount of money that individuals are willing to pay for insurance depends on the level of risk that can be avoided. Research results in Norway show that smokers have a higher demand than non-smokers [33]. 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). If the actual utility exceeds the expected utility, the consumer will buy the insurance, and conversely the higher the price of insurance, the less WTP for insurance will be. The size of people's income and wealth will affect the amount of premium they are willing to pay for health insurance. For both low and high incomes, the marginal utility of income is either relatively high or low so those people may prefer to be sure; the distance between the expected utility curve and the actual utility curve is less good for high and low incomes than for middle income levels. Low income will reduce the level of demand for insurance [34]. Limited evidence suggests that consumers with higher incomes are less price sensitive (inelastic) than those with lower incomes [36]. The results of the study 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, result in smaller percentage changes in (inelastic) demand, but the estimated elasticity has a wide range. In the individual market, estimates of the price elasticity of demand range from -0.2 to -0.6 [35]. But the few observational studies used to estimate the income elasticity of demand consistently show that the demand for health insurance is inelastic with respect to differences in income. consumer. Research shows that the income elasticity of demand for health insurance is < 0.1 [37].

IV. CONCLUSION

Based on the results of the discussion that has been described, it can be concluded that private health insurance has an important role in protecting individuals and families from the financial risks associated with health care costs. The demand for private health insurance is influenced by several complex and varied factors. An analysis of the factors influencing the demand for private health insurance is important. Through a better understanding of these factors, policy makers can design appropriate strategies to improve the accessibility, sustainability and quality of private health insurance including:

1. The higher a person's level of risk aversion, the higher the likelihood that someone will buy insurance, and the higher the probability of a premium being paid.
2. The higher the potential loss, the higher the possibility of someone buying insurance, and the higher the premium risk
3. The higher a person's income level, the more they want wider insurance coverage.

4. the possibility of being sick has a higher demand than being healthy.
5. The greater the possibility of loss, the greater the premium that is willing to pay

Then demand is the desire of consumers to buy an item at various price levels during a certain period.

The concept of demand explains the demand for goods or services in relation to the factors that influence it. the factors that determine demand namely; the price of the goods themselves, the prices of other goods (having the same type of goods as the main goods), per capita income and household income, practices and wants of society, population factors, and factors from the business of providing goods to improve services. The demand for health services is derived from the demand for health itself, in this model it is assumed that everyone evaluates the benefits of spending on health which is analogous to spending on other commodities in the form of deciding on optimal health status.

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