Universal healthcare coverage in Indonesia
One year on

January 2015

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Universal healthcare coverage in Indonesia—One year on

Foreword

Ivy Teh, Managing Director at Clearstate, an Economist Intelligence Unit business.

2014 marked a watershed year for Indonesia, the world’s fourth populous country, with the election of the popular reformist politician, Mr. Joko Widodo, as its president. The year also saw the rollout of the long-delayed universal healthcare scheme (UHC). Indonesia intends to phase-in the world’s largest single player health care insurance program from 2014 to 2019, reaching universal coverage for all Indonesians in 6 years.

After a much anticipated 9 years wait since the initial law was passed, the actual UHC rollout in Jan 2014 has led many to raise concerns about Indonesia’s ability and commitment to implement such a large-scale undertaking. Important issues such as the readiness of infrastructure, the chronic shortage of medical professionals, the sufficient and proper funding of the program, remain unresolved and their solutions unclear.

One year on, while teething problems exists, some progress have been made as Indonesia grapples with the enormous tasks to achieve universal coverage. This current paper provides our perspective one year on, offering the reader with some level of clarity on where progresses are being made and more importantly, highlighting the potential opportunities that the reader can look out for in the short to medium term.

Clearstate, an Economist Intelligence Unit business, is a healthcare market insight and intelligence consultancy that specialises on discovering
opportunities in emerging economies for pharma, medtech and health services clients. Indonesia is one of the most exciting emerging economy for healthcare providers, both for services and products, in recent years. It has the potential to be the next “powerhouse” and has plenty to offer in the long-term. We hope that through this whitepaper, we are able to provide not just an update on Indonesia’s UHC progress but also some new perspectives to think about in terms of risks and opportunities.

We do look forward to your feedback and will be happy to generate continuing conversation with you on this topic.
Executive summary

With the fourth-largest population in the world and a growing economy, along with rising incomes, Indonesia presents many opportunities to healthcare providers and suppliers looking for markets to expand in. Recent public reforms aimed at bringing universal healthcare coverage (UHC) to all Indonesians by 2019 are likely to bring significant changes to the healthcare landscape as we currently know it.

This market brief presents an introductory overview of the ongoing developments within the Indonesian healthcare landscape as the UHC scheme is being implemented, and highlights the challenges and opportunities for market participants—specifically in the healthcare service provision, pharmaceutical and medical device industries.

The previous paper within Clearstate’s series on Indonesia’s UHC scheme discussed the potential implications of the reform before the scheme’s rollout in 2014. Since then, the potential implications have become clearer as the country’s healthcare policies began to take on a more definite shape. Yet various issues remain, and in the second of this series addressing UHC implementation in Indonesia, we will be outlining the progress the Indonesian government has made since the rollout of the National Health Insurance Programme (JKN) at the beginning of 2014, as well as the trends further moulding the government’s policies to improve healthcare service provision in the country.
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description (Indonesian)</th>
<th>Description (English)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Askes</td>
<td>Asuransi Kesehatan</td>
<td>Social insurance scheme for civil servants and the military</td>
</tr>
<tr>
<td>BOR</td>
<td>Bed occupancy rate</td>
<td>Percentage of hospital beds occupied at a given point of time</td>
</tr>
<tr>
<td>BPJS Kesehatan</td>
<td>Badan Penyelenggara Jaminan Sosial Kesehatan</td>
<td>Social Security Management Agency for the Health Sector</td>
</tr>
<tr>
<td>INA-CBG</td>
<td>Indonesia Case Based Groups</td>
<td>Schedule for determining the amount of reimbursement for a given diagnosis</td>
</tr>
<tr>
<td>Jamkesda</td>
<td>Jaminan Kesehatan Daerah</td>
<td>Social insurance scheme provided by district and provincial governments</td>
</tr>
<tr>
<td>Jamkesmas</td>
<td>Jaminan Kesehatan Masyarakat</td>
<td>Social insurance scheme for the poor and near poor</td>
</tr>
<tr>
<td>Jamsostek</td>
<td>Jaminan Sosial Tenaga Kerja</td>
<td>Social insurance scheme for formal sector employees</td>
</tr>
<tr>
<td>JKN</td>
<td>Jaminan Kesehatan Nasional</td>
<td>National Health Insurance Programme</td>
</tr>
<tr>
<td>KIP</td>
<td>Kartu Indonesia Pintar</td>
<td>Indonesian Smart Card</td>
</tr>
<tr>
<td>KIS</td>
<td>Kartu Indonesia Sehat</td>
<td>Indonesian Health Card</td>
</tr>
<tr>
<td>KJP</td>
<td>Kartu Jakarta Pintar</td>
<td>Jakarta Smart Card</td>
</tr>
<tr>
<td>KJS</td>
<td>Kartu Jakarta Sehat</td>
<td>Jakarta Health Card</td>
</tr>
<tr>
<td>KKS</td>
<td>Kartu Keluarga Sejahtera</td>
<td>Family Welfare Card</td>
</tr>
<tr>
<td>SJSN</td>
<td>Sistem Jaminan Sosial Nasional</td>
<td>National Social Security System</td>
</tr>
<tr>
<td>TNP2K</td>
<td>Tim Nasional Percepatan Penanggulangan Kemiskinan</td>
<td>National Team for the Acceleration of Poverty Reduction</td>
</tr>
<tr>
<td>UHC</td>
<td></td>
<td>Universal healthcare coverage</td>
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</table>
On January 1st 2014 Indonesia took a large step forward in its attempt to achieve universal healthcare coverage (UHC) by unifying various public insurance schemes under a single social security agency—the Social Security Management Agency for the Health Sector (BPJS Kesehatan), tasked with the implementation of the National Health Insurance Programme (JKN). The JKN was conceived to provide better health coverage for all Indonesians, by extending insurance to the entire population, including large swathes of the population previously not covered by any public insurance schemes.

The country has put forward this social security net at a time when the economy seems to be faltering—economic growth figures have fallen short of analyst estimates in the past few quarters because exports are being weakened by a slowdown in the global commodities market that was previously fuelled by faster-growing economies such as China and India. In addition, the Indonesian rupiah has come under further pressure in 2014, leading to an increase in the cost of imports, and ultimately continuing the pattern of a growing fiscal deficit fuelled by large and rising government expenditure on fuel subsidies.

Despite the disappointing economic news, investor sentiment has remained positive, reflecting optimism following the election of the former mayor of Jakarta, Joko Widodo, as president in 2014. Jokowi, as he is commonly known, brings with him a positive reformist attitude that bodes well for Indonesia’s economy, long thought to be ripe for reforms such as the scrapping of fuel subsidies and an overhaul of the tax system.

Especially important to all stakeholders within the healthcare industry, Jokowi is a strong supporter of providing UHC to the masses, having piloted the Jakarta Health Card (KJS) in Jakarta, widely seen as one of the country’s major testing grounds for UHC. Not only has Jokowi put his weight behind the continuous
reform of the JKN, but since unveiling his cabinet of ministers, he has held close to his election promises to implement a wider social security net system via three new cards to be distributed to the poor, including the Indonesian Health Card (KIS).

Second in the series on UHC in Indonesia, this paper aims to shed more light on the details of the national health insurance schemes that have so far been implemented, including the immediate challenges faced by healthcare service providers. In addition, we will also discuss the potential trends that may affect future healthcare policy choices for the Indonesian government, which in turn will affect how healthcare service providers, and ultimately pharma and med-tech players, position themselves for success in the Indonesian market.
Indonesia’s version of universal healthcare: What is the JKN? What about the KIS?

The single-payer UHC model was officially rolled out within Indonesia by the BPJS in the form of the JKN which has been implemented since January 1st 2014, and aims to provide health insurance to the entire country’s population of 250m people within five years (by 2019). In particular, the JKN is expected to improve health insurance coverage for the poor and near poor, the self-employed, as well as those employed in the informal sector, consequently allowing for better access to healthcare.

Although premiums differ according to the ability and willingness of individuals to pay for social health insurance, the JKN is positioned as a national health insurance scheme that provides a comprehensive package of healthcare services to all Indonesians, differing only in the “quality” (in terms of ward class). All members of the JKN would be able to access a wide range of health services provided by public facilities, as well as some private facilities that have opted to join the JKN scheme as providers. Private insurance is expected to play its role in the system by providing for excess or additional coverage of services not included in the JKN.

As observed from other countries with more mature UHC programmes (eg, Taiwan and Japan), having a single-payer model is a large step forward in achieving true UHC in terms of being able to provide access to healthcare services to the masses. This is in contrast to having individual social security schemes for particular population groups (eg, civil servants, the employed, the poor), which ultimately leave out various sections of the population owing to the mis-targeting
Universal healthcare coverage in Indonesia—One year on

Figure 2: Social health insurance schemes before and after JKN

<table>
<thead>
<tr>
<th>Poor/near poor</th>
<th>Civil servants/retired civil servants, military, veterans</th>
<th>Formal sector employees</th>
<th>Informal sector workers/self-employed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jamkesmas</strong> (~87m persons)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Fixed premiums of Rp6,500 per member per month (PMPM) contributed by the central government from general taxation</td>
<td></td>
<td>No specific scheme</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Comprehensive; drugs within formulary covered, no cost-sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility type</strong></td>
<td>All puskesmas and public hospitals, and selected private hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider payment mechanisms</strong></td>
<td>Puskesmas: capitation hospitals; case-mix (INA-CBG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Askes/Asabri</strong> (~17m persons)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Employees pay 2% of basic pay, government pays 1% of basic pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Comprehensive; drugs within formulary covered; cost-sharing available when services fall outside basic benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility type</strong></td>
<td>Mostly contracted public health centres and public hospitals</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Provider payment mechanisms</strong></td>
<td>Special fee schedules for civil servants; extra billing depending on negotiated fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Jamsostek</strong> (~7m persons)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Employers pay 3-6% of salary depending on employee’s marital status; ceiling of Rp1m/month</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Comprehensive; drugs within formulary covered; cost-sharing available when services fall outside basic benefits</td>
<td></td>
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</tr>
<tr>
<td><strong>Facility type</strong></td>
<td>Mostly contracted public health centres and public hospitals</td>
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<td>Special fee schedules for civil servants; extra billing depending on negotiated fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Jamkesda</strong> (~11m persons)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding</strong></td>
<td>Provincially/district-level government units from provincial/district-level budgets</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Typically provide supplementary and complementary coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Benefits, facility coverage, and provider payment mechanisms vary by province/district</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After January 1st 2014

<table>
<thead>
<tr>
<th>Poor/near poor</th>
<th>Civil servants/retired civil servants, military, veterans</th>
<th>Formal sector employees</th>
<th>Informal sector workers/self-employed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed premiums</strong> (Rp19,225 = US$1.75 PMPM)† contributed by the central government from general taxation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Class III hospital beds</strong> in public hospitals and selected private hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Salary-based contributions</strong> of 5% of monthly salary to be paid by employers (4%) and employees (1%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>May be entitled to Class II and Class III hospital beds</strong> in public hospitals and selected private hospitals depending on premium levels paid</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

† Lower than the initial proposed premium of Rp27,000 PMPM, but higher than under Jamkesmas (Rp6,500 PMPM)

- Benefits under the JKN are supposed to be comprehensive, covering treatment for infectious disease such as influenza as well as expensive medical interventions such as open-heart surgery, dialysis and cancer therapies
- In a similar way to Jamkesmas, the provider-payer mechanisms under the JKN are to follow a case-mix system (INA-CBG) for hospitals and a capitation model for primary care providers

Sources: Australia Indonesia Partnership for Health Systems Strengthening; EIU databases; World Bank, East Asia and Pacific HNP Brief Series; EIU-Clearstate analysis.
UNIVERSAL HEALTHCARE COVERAGE IN INDONESIA—
One year on

of recipients and leakage of funds. In addition, different population groups have varying levels of access to healthcare services when social health insurance schemes are nested under different payers, as is currently evident as the JKN continues to be implemented. Yet, even as the JKN continues to be rolled out, gaps in the scheme have been identified—for instance, the current scheme does not provide coverage for some of the neediest population groups (e.g., orphans and the homeless) and does not include coverage of some essential health services (e.g., laboratory diagnostic tests).

Figure 3: JKN coverage of health services

✓ Health services covered under the JKN

- Medical examination, treatment and medical consultancy
- Medical treatment that is not included in the field of specialist competency
- Blood transfusions in accordance with medical requirement
- First-level laboratory diagnostic supporting examination
- In-patient care according to medical indications

If a patient requires further treatment, the primary healthcare facility will refer the patient to a higher-level facility—i.e., a hospital that has a collaboration arrangement with the BPJS

- Medical examination, treatment and medical consultancy with a specialist doctor
- Medical treatment from a specialist in accordance with medical indication
- Medical rehabilitation and blood transfusion
- In-patient care in either a non-intensive or an intensive room

✗ Health services not covered under the JKN

- Health services that do not follow the procedure set
- Health services in health facilities that do not co-operate with the BPJS
- Health services abroad
- Health services to conceive a child
- Health services for beauty purposes
- Health disorders or diseases caused by addiction to drugs and/or alcohol
- Alternative medicine

Sources: Australia Indonesia Partnership for Health Systems Strengthening; EIU-Clearstate analysis.

As a presidential candidate, Jokowi proposed various pro-poor programmes, including the Indonesian Smart Card¹ (KIP) and the Indonesian Health Card² (KIS), schemes similar to the Jakarta Smart Card (KJP) and Jakarta Health Card (KJS) that Jokowi had overseen as mayor of Jakarta. Consequently, after being appointed in October 2014, the cabinet quickly announced the KIS scheme in conjunction with two other social programmes (see Figure 3)—collectively named the Productive Family Programme. In particular, the KIS aims to extend insurance

¹ Also called the Smart Indonesia Card (KIP) – See Figure 4
² Also called the Healthy Indonesia Card (KIH) – See Figure 4
coverage, both to include the population groups currently not covered and to include those services currently excluded under the JKN scheme. The government has already started to distribute these three cards (KIS, KIP, and the KKS) to the disadvantaged since October 2014, a process that will proceed gradually over five years. Eligibility for the KIS is determined through an integrated database containing the names of poor and near poor households and individuals nationwide, compiled by the vice-president’s National Team for the Acceleration of Poverty Reduction (TNP2K); the KIS could potentially target 4.5m people by October 2015.

The implementation of the Productive Family Programme and the KIS has raised a number of questions, including whether the KIS could be in conflict with the National Social Security System (SJSN) law and whether the JKN and the KIS should be combined into one scheme. However, the schemes’ quick implementation coupled with the required co-ordination among eight different ministries is proof of the president’s strong support for the more efficient distribution of government aid, with healthcare being a priority.

Figure 4: Jokowi’s cards: KIH/KIS, KIP, KKS

**Healthy Indonesia Card (KIH)**
Provides free healthcare for Indonesia’s poor; the president, Joko “Jokowi” Widodo, promised during his presidential campaign to launch the KIH; this later posed a problem as the government already runs the National Health Insurance Programme (JKN), which includes coverage for the poor; Jokowi’s ministers have said that the KIH may take over the JKN but as yet there has been no clear plan on its delivery from the government.

**Smart Indonesia Card (KIP)**
Aimed at poor families that want to send their children, aged seven to 18 years of age, to school for free; also aimed at street children and teenagers within this age bracket who are currently not attending school.

**Prosperous Family Card (KKS)**
Jokowi has set up this cash-aid programme for poor families for the last two months of 2014 in anticipation of the plan to raise subsidised fuel prices in the first months of his term of office; Each family will receive Rp200,000 (US$16.5) per month.

86.4m people in the low-income bracket, with a plan to extend coverage to new-born babies.

1.7m homeless and internally displaced people; at the first stage, the government intends to cover 432,000 homeless and internally displaced people.

15.5m poor families that had previously received various kinds of social assistance under the Social Protection Card (KPS) scheme set up by the former president, Susilo Bambang Yudhoyono.

Source: The Jakarta Post.
Although the rollout of the JKN on January 1st 2014 was a significant step towards UHC, several issues with the JKN have immediately become evident. Some of these issues may present unique opportunities to various stakeholders in the healthcare industry; however, some issues could potentially cripple the long-term success of the national health insurance scheme.

Teething problems—A short-term affair?

When large changes in publicly-led policies are implemented, teething problems are to be expected and are not unique to Indonesia. Although the US is credited with having some of the most advanced technical capabilities globally, the confusion and technical issues among providers, payers and patients resulting from information asymmetry upon the recent implementation of the Affordable Health Care Act in the US is a good example of such teething problems occurring even in the most developed economies and healthcare systems in the world.

Similarly, many Indonesians were confused about their eligibility to receive JKN premium subsidies from the government, and Indonesian healthcare service providers were unsure about the inclusion of certain patient groups in the JKN scheme upon implementation. Add the KIS scheme into the picture and things get even more complicated, with various state and local governments being confused over the difference between the two schemes. Such confusion is expected, especially given the speed at which the Jokowi administration implemented the KIS scheme, probably for political effect; however, we expect these issues to be resolved over time provided the relevant authorities manage the situation and disseminate information appropriately.

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Balancing the budget—Fiscal sustainability

A recurring topic and a cause for concern is the fiscal sustainability of the JKN scheme. Total expenditure on health in Indonesia has already grown significantly over the past decade, at an annual average rate of 15.3% between 2007 and 2012 (see Figure 5). Over this period, government expenditure on health has also risen faster, at an annual average rate of 17.3%, than total expenditure on health. Yet, despite these impressive numbers in absolute terms, both total health expenditure and government health expenditure as a percentage of GDP have stayed roughly constant at around 3% and 1% respectively.

What sits uneasily with observers and market participants is that the source of additional funding for the much higher JKN premium subsidies (Rp19,225 per person per month compared with Rp6,250 under the Jamkesmas scheme) is unclear—with neither the BPJS nor the central government giving a clear indication of how the additional funds would be provided. Based on the assumption that the number of people eligible for JKN premium subsidies would be the same as the 87m covered by the Jamkesmas scheme, the central government would have to fork out an estimated Rp20trn a year, about three times the amount it paid out in 2013 under the Jamkesmas scheme (about Rp7.1trn*). This would result in BPJS expenditure accounting for close to half of the central government’s health budget of Rp44.9trn in 2014. Add in the KIS scheme, which will provide broader service coverage (implying higher expenditure per beneficiary) as well as targeting a wider population (implying more beneficiaries), and it is not difficult to see why critics are sceptical of the central government’s ability to fund Indonesia’s social insurance scheme in the short term.

Figure 5: Indonesia’s health expenditure from 2007-2012

- General government expenditure on health (IDR m): left scale
- Private expenditure on health (IDR m): left scale
- Total expenditure on health (% of GDP): right scale
- Government expenditure on health (% of GDP): right scale

Source: World Bank, National Health Accounts; EIU-Clearstate analysis.

* World Bank estimates consolidated from Askes and P2JK reports.
In addition, a study by the World Bank, concluded in August 2014, shows that even though the Jamkesmas scheme appeared to balance fiscally in 2006-11, with premiums of Rp6,500 per person per month in 2011, actuarial studies and estimates of public and private expenditure put the true cost of providing healthcare services at roughly three to five times the Jamkesmas premium. At Rp19,225 per person per month, the JKN premium is just under three times the Jamkesmas premium, just short of the lower end of the range suggested by actuarial estimates. The study also notes that these estimates do not take into account the fact that the undersupply of healthcare services and the underutilisation of the programme were indirectly acting as cost-management mechanisms for the Jamkesmas scheme. Utilisation rates are expected to be higher once supply-side constraints are eased, and population awareness and education is increased upon full implementation. This implies that current premium rates assigned to the JKN scheme for the poor and near poor do not seem to be fiscally sustainable for the scheme as it continues to grow in size and include larger population groups. Health officials are aware of this and have therefore emphasized the need to balance the allocated budget to the JKN, consequently setting low reimbursement rates for healthcare service providers.

Cracks in the system started to show even before the implementation of the JKN in 2014—the INA-CBG reimbursement rates were piloted in 2013 under the KJS before the official implementation of the JKN, leading to financial losses for several hospitals due to the low reimbursement rates set by state insurers. Despite the government committing to raising reimbursement rates in April 2014, private hospitals understandably remain reluctant to participate in the JKN scheme, resulting in low retention rates of private hospital and primary care provider participation.

Again, the issue of funding is not unique to Indonesia—health policymakers in established UHC markets such as South Korea and Taiwan have long grappled with ballooning healthcare expenditures, and are still looking for various means to resolve this issue without jeopardising the stability of the ecosystem. However, given such uncertainties, we do not expect the BPJS to be able to extend coverage of social health insurance under the JKN scheme to all Indonesians by 2019 unless significant effort is made by the central government to reprioritise its spending towards healthcare. In addition, not only the fiscal sustainability of the social health insurance schemes but also the comprehensiveness of health service provision under these schemes is in question, partly because of low reimbursement rates that “dis-incentivise” private providers from accepting patients under national health insurance schemes.
Chronic undersupply—Another barrier to providing truly comprehensive services

In addition to low reimbursement rates, another issue that threatens to cripple and slacken the pace of UHC implementation is the chronic undersupply of healthcare services within Indonesia. There are several key causes of this undersupply, including a general lack of human resources and infrastructure, which leads to a highly unequal distribution of healthcare services across the archipelago.

Figure 6: Regional comparisons for healthcare infrastructure and healthcare expenditure per capita

Despite the number of hospitals and hospital beds in Indonesia having increased by annual averages of 15% and 12% respectively between 2007-2012, the number of hospital beds per 1,000 Indonesians was still at a low 0.94 in 2012, compared with the OECD average of 4 beds per 1,000 people. In addition, the country also lacks trained personnel, with only 0.2 physicians per 1,000 people, one of the lowest rates in the region despite the country’s rapidly rising affluence levels (see Figure 6).

As anticipated by various market participants, the implementation of the social health insurance schemes has placed enormous strain on the Indonesian healthcare service provision infrastructure as previously uninsured pockets of the population begin to make use of healthcare services. This acute supply constraint has resulted in long waiting times and poor quality of care for patients. Noticeably, this phenomenon has happened even within Jakarta, home to the largest and most-
developed cluster of healthcare infrastructure in the country. Hence, healthcare services are undoubtedly also experiencing acute supply shortages in the other regions of Indonesia, especially in the other cities on the islands of Java and Sumatra where populations are denser, more affluent and better informed.

Consequently, not only has there been criticism from international observers about the lack of readiness of local infrastructure to handle larger patient volumes, local interest groups have also begun criticising the system. As employees gripe about the longer waiting times and poorer quality of care at hospitals participating in the JKN, a result of healthcare infrastructure being spread too thin, businesses are demanding an extension in the time required to fulfil their legal obligations to contribute to employee JKN schemes. Many employees in the private sector were previously covered under private insurance schemes where they were able to enjoy healthcare services at a mid-tier level. However, under the JKN, private-sector employees now have to wait alongside other JKN participants and are no longer enjoying better “benefits”. In order to provide their employees with the standard of healthcare that they have had in the past, employers would need to pay double premiums to both the JKN and a private insurance scheme. Understandably, employers are balking at this prospect and are thus demanding that they be allowed to wait until the JKN is running smoothly before being obliged to contribute to the employee JKN schemes.10

Although not unexpected, such examples of resistance by key stakeholders (formal sector employers and employees in this case) are likely to impede progress on implementing the national insurance scheme. This is likely to further impede the implementation of the JKN scheme, making the 2019 deadline appear more unfeasible. Even if legislation has mandated that the entire population be covered by social health insurance, it remains highly likely that healthcare service provision will struggle to provide the promised benefits to all Indonesians. Rural regions are likely to be more prone to issues such as low reimbursement rates, and lower population densities would probably discourage investment in the required facilities or equipment, as well as deter private providers.

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lthough the actual reprioritisation of central government expenditure towards healthcare has yet to be observed, indicating that the national health insurance scheme (JKN) as planned is unlikely to be fiscally feasible by 2019, more significant efforts have been made since Jokowi’s successful presidential bid. Despite the negativity currently surrounding the implementation of the social health insurance scheme, the controversial announcement of the cutting of fuel subsidies mid-November 2014 and 1 Jan 2015\(^1\) is a good example of the president’s strong commitment to building more infrastructure and improving implementation of social security nets such as the JKN and KIS (although the funds have yet to be reallocated). Thus, despite the difficulties, the market for healthcare in Indonesia remains attractive because of its large potential—much of it remains untapped even as the government continues to try to achieve UHC.

Healthcare service providers: Pockets of opportunity

As previously mentioned, the low reimbursement rates set by the BPJS according to the INA-CBG are inhibiting interest in the healthcare service provision market. The frantic rush of private investors into this industry, riding the UHC wave, may slow as investors respond to lower than expected returns flowing from low reimbursement rates. However, we still see pockets of opportunity for the healthcare service provision market in specific areas.

The frustrations shown by private-sector employers and employees at the mandatory switch to the JKN scheme continues to point towards higher future demand for private healthcare service providers. Ministry of Health data show that Jakarta and East Java have very high hospital bed occupancy rates (BORs) of 132.3% and 111.8% respectively (see Figure 7), indicating that despite these

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\(^1\) Estimates from the Ministry of Energy and Mineral Resources put savings from the cut in fuel subsidies at about Rp100trn (US$8.24m) in next year’s budget, which could be used more productively in areas such as infrastructure development, social programmes such as the JKN/KIS, and education.
regions possessing the densest and most-developed clusters of healthcare infrastructure, the demand for healthcare services in these regions far exceeds the supply. As private-sector employees continue to demand higher quality healthcare benefits or additional value-added services, some of the more affluent are expected to turn to private insurers and private healthcare service providers, boosting the market for higher-end private providers.

In addition, data from the Ministry of Health show that other than in Jakarta and East Java, average BORs are low, mostly within a 50% to 75% range. This compares with an over 80% BOR in the South-east Asian region, yet patients still experience long waiting times for treatment in hospitals across Indonesia, possibly indicating some opportunity for improvements in hospital efficiency. In particular, Figure 7 shows that regions such as Central Java, West Java, Banten and Yogyakarta may potentially benefit highly from greater hospital efficiency, as these regions have relatively higher population densities but lower BORs.
than is considered optimal (around 80%). Therefore, we believe that the market for healthcare service providers will continue to be attractive provided efficiencies can be achieved, alongside various other factors (eg, population wealth levels).

As such, despite profitability concerns due to the low reimbursement rates for facilities participating in JKN schemes, pockets of opportunity still seem to be present within the healthcare service provision market. Specifically, opportunities appear to exist in two areas: high-end service provision, and hospital efficiency, where improvements could raise revenue flows.

Med-tech and pharma: Spotting opportunities and tailoring product offerings

In the first series on UHC in Indonesia, we presented the outlook for med-tech and pharma as largely positive owing to the high potential of the market. Recent developments have continued to support our view that if healthcare manages to be successfully pushed up the government’s ladder of funding priorities, increased healthcare infrastructure spending is likely to present opportunities for both med-tech and pharma players.

However, med-tech and pharma players would need to tailor their products to the types of facilities they are selling them to. For example, promoting the cost-efficiency of products is likely to resonate more with the majority of healthcare service providers that are expecting to generate the bulk of their revenue by participating in the JKN schemes (eg, public hospitals). A case in point would be the sale of pharmaceuticals, where local generic suppliers are likely to benefit the most from the recent developments: currently BPJS INA-CBG reimbursement schedules endorse the use of generics, with more than 70% of drugs on the approved reimbursement list being generics. Med-tech players are likely to face similar concerns with regards to cost and profitability, especially in rural areas if the healthcare service provision market receives support from the central government to fulfil demand where supply is most scarce. Therefore, we see an opportunity for the strategic positioning of products for the value segment by emphasising cost-effectiveness.

On the other hand, within the higher-end market that is expected to develop out of patient frustrations with the undersupply and overcrowding in hospitals participating in JKN schemes, med-tech players in particular should target such customers differently. In contrast to cost-effectiveness, patient comfort and wellbeing should be emphasized as these are attributes higher-end healthcare service providers would be looking to associate themselves with in order to differentiate themselves from the bulk of the market.

In all, the med-tech industry does seem to be in a better position than the pharma industry in terms of value growth in the next few years, largely because of the strong price suppression tactics targeted at pharma—all of which are intended to keep costs down in order to maintain fiscal sustainability
for the social health insurance schemes. These include continuing to create a protectionist business climate, such as the enduring limit of a maximum of 85% foreign ownership of pharma companies. The Indonesian med-tech industry is currently shielded from such issues as the bulk of the market is still being supplied by imports. Nevertheless, the med-tech industry should not be complacent—cost concerns are likely to continue to afflict the healthcare service provision market as the government continues to try to find ways to contain rising healthcare expenditure. As such, frequent assessment of customer segments will be crucial for successful commercialisation in Indonesia.
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