Ensuring the Sustainability of JKN-KIS for the Indonesian People

Intended to cover the health costs of all Indonesians, the JKN-KIS national insurance program is now on the brink.

How can this program survive?
BPJS Kesehatan (Healthcare BPJS), Current Plans and Problems

When the Ministry of Health of the Republic of Indonesia was led by Minister Dr. Nafsiah Mboi, Sp.A, MPH in 2013, and began planning the birth of a national insurance program, quite possibly she did not imagine that, six years after the national health insurance program was inaugurated by President Susilo Bambang Yudoyono on December 31st, 2013 at the Bogor Presidential Palace, it would experience very challenging financial circumstances as is currently the case.

As of May 2019, the number of people who have enrolled in Healthcare BPJS had risen to about 221.6 million of which 36 million are independent-segment members. However, collectability within this segment is only 53% (which means only around 19 million members are paying their monthly premiums). The shortfall in monthly premium payments by independent segment members is one of the factors which has contributed to Healthcare BPJS’s deficit, which in July 2019 is estimated to be Rp 28 trillion, following continuous deficits incurred by this public legal entity since 2014.

The national health insurance program actually began to be initially planned many years ago, dating back to 2004, starting with the drafting of Law No. 40 of 2004 concerning the National Social Security System (SJSN) and Law No. 24 of 2011 on the Social Security Management Agency (BPJS), with inputs from various relevant stakeholders. The Ministry of Health, PT. Askes Indonesia and PT. Jamsostek, with assistance from various other parties, compiled a roadmap to prepare the national insurance scheme, with one goal, namely the achievement of National Health Insurance (INA-Medicare) for the entire population of Indonesia by 2019.

The idea of establishing a national health insurance program is based on sound principles. If you look at neighboring countries, some of them have implemented national health insurance programs using different coverage and financing schemes. In the Philippines, the National Health Insurance Act has been implemented since 1995, by adopting single hospital and doctor rates that apply nationally. The insurance scheme is similar to the JKN-KIS program, with contributions of 2.5 percent of monthly income shared by workers and employers. Meanwhile, contributions by workers in the informal sector are set at 120 Pesos (around Rp 20 thousand). It is different in Malaysia, as health insurance in that country relies on state budget funds that are sourced from taxes. For the cost of hospitalization, insurance members pay 3 Ringgit (or Rp 10,100) per day for all costs. Insurance participants do not need to pay any fees if they go to the hospital, although they still need to be prepared to face long queues. In Thailand, since 2002 the government has provided several different health insurance schemes, namely for civil servants and all their family members, including parents and in-laws, private employees and informal workers. Premium contributions are funded out of the state budget, except for family members of private sector employees, which are also guaranteed by the government. For the purposes of this national health insurance scheme, the Thai government allocates no less than 13.1 percent of the state budget. The amount turns out to be very useful, as evidenced by the drastic decline in the poverty rate since this national insurance program became available.

Indonesia, based on a National Development Planning Agency (Bappenas) projection in 2018, has a population of around 265 million, which is the equivalent of 8.2 times the population of Malaysia, 2.5 times the population of the Philippines, 10 times the population of Taiwan and about twice the population of Japan. Indonesians live on 5,000 of the 17,504 islands that make up Indonesia, which consists of 33 provinces, 497 districts/cities, 6,652 sub-districts and 77,012 villages/kelurahan. With its large population, uneven population distribution and diverse geographical conditions, the implementation of national health insurance in Indonesia is a very difficult challenge, especially if the insurance is primarily social and non-commercial in nature and aims to benefit all Indonesians. In Kompas Daily, November 12th, 2018, Prof. DR. Dr. Nila Moeloek, Sp.M, who is Minister of Health in the government of President Joko Widodo and Vice-President Yusuf Kalla, stated that the country’s wide and heterogeneous geographic area was a challenge for the delivery of evenly distributed healthcare services in Indonesia. The same thing was stated by Laksono Trisnantoro, Professor of Health Policy and Administration from Gadjah Mada University. According to him, people who live in remote areas often do not get the same services. Often in remote areas residents do not get adequate healthcare services because of the lack of suitable healthcare facilities and qualified personnel that are available in large cities.

But no matter how large the challenges are and while there are still many shortcomings in its implementation, the existence of the national insurance program, which was originally called Kartu Indonesia Sehat (KIS), and subsequently has become known as the JKN-KIS program (National Health Network-Healthy Indonesia Card), represents a new chapter in the history of healthcare of Indonesia, with the participation of the state in supporting the lives of its people dominant in helping to manage the health problems they face.
Understanding how the JKJ-KIS program of Healthcare BPJS works

The JKJ-KIS program is an insurance program with tiered, quality and cost-controlled services (managed care), consisting of primary care and progressive/advanced care. Primary care is available at community health centers (Puskesmas) and private clinics, which there are presently thousands. In addition, according to drs. Angger P. Yuwono, FSAI, / ChFC, member of the Republic of Indonesia National Social Security Council (DJSN), there are also more than 2,900 hospitals. There are also laboratories and pharmacies that serve in the provider network for JKJ-KIS services. In the first instance patients are required to visit a primary care service facility and consult a doctor at that particular healthcare facility. Efforts will be made to treat all health problems at this service level. If these cannot be resolved, the patient will be referred to an advanced service facility, such as a Type D hospital and then if required a Type C hospital. If the problem still cannot be resolved, for example due to limited human resources, or the lack of needed facilities and infrastructure, the patient can be referred to a Type B hospital and so on. Each type of disease can be handled by JKJ-KIS insurance, with the exception of certain diseases according to the prevailing laws and regulations.

After experiencing various changes, the latest Healthcare BPJS regulation, namely Presidential Regulation (Perpres) No. 82/2018 article 52, presently stipulates which services are not covered by Healthcare BPJS. Thus, it is quite clear that, in addition to the services mentioned in the article, all other needed services can be covered. In level 1 Healthcare Facilities (Faskes), all healthcare services are covered. Does this model of service therefore impair hospitals or health facilities? In fact, it is not quite like that. According to Muhammad Iqbal Anas Malruf, Chief Assistant Secretary, Public Communication and Public Relations, Healthcare BPJS, with the current system, i.e. the capitation system model, hospitals or health facilities can make a profit. In the first level facilities, all services are covered. Doctors receive a certain amount of capitation costs per patient, based on a statistical assumption that usually such visits represent only around 20% of the total population. This means that doctors or health facilities regularly receive a capitation fee every month. Moreover, any delay on the part of Healthcare BPJS will attract a fine or penalty. "It makes sense. In the old days of PT Askes (Asuransi Kesehatan), doctors or health facilities received Rp 2,500 per person, and they were happy; today doctors or health facilities receive Rp 8,000 per person, and so they would certainly be happier. Furthermore, based on statistics, the number of consultation visits is generally around 20% of the total population," said Iqbal. With this kind of scheme, Healthcare BPJS must prepare funds of at least around Rp 1 trillion every month to meet the costs of this capitation scheme. This is the amount of fixed costs that need to be met by Healthcare BPJS, excluding the costs of drugs, services and other expenses. It can therefore be imagined that the expenditure of this public legal entity is very significant. The largest expenditure is to cover critical diseases, which cost no less than Rp 250 trillion over 4 years. Then, how does Healthcare BPJS cover these costs?

Presidental Regulation and Minister of Health Regulation on Healthcare BPJS, which has been effective since 2019: Participants Take Part in Paying for Healthcare Services

There are two regulations related to Healthcare BPJS that have been implemented since the beginning of 2019, namely Presidential Regulation (Perpres) No. 82/2018 and also the Minister of Health Regulation (Permenkes) No. 51/2018. Both regulate healthcare services and participation. What are their contents?

Perpres No. 82/2018 is a presidential regulation that governs 21 healthcare services that are not guaranteed by JKJ, including illnesses/injuries due to workplace/work-related accidents, accidents covered by traffic accident insurance programs, sicknesses/injuries due to disasters during emergency response, extraordinary events/outbreaks, unexpected events that can be prevented, criminal acts of abuse, sexual violence, victims of terrorism & criminal acts of people's trafficking and services funded by other programs. In addition, other important issues include participation (PBI/Contribution Assistance Recipients, and non-PBI), as well as membership administration, the importance of a system to facilitate registration, as well as participants who experience layoffs, i.e. such participants are entitled to class III services for 6 months from termination date without paying contributions.

Permenkes No. 51/2018 stipulates that JKJ members who are wage recipients and independent participants should be charged an additional contribution fee of Rp 20,000 to pay the costs of minor illness health services in class A and class B hospitals. The provisions also apply to class D hospitals and primary clinics with a fee of Rp 10,000. These provisions for cost contributions do not apply to JKJ-KIS participants from the PBI segment and residents registered by Local Governments.
The Indonesian Government required all residents, including foreigners living in Indonesia, to enroll in the JKN-KIS national health insurance by no later than January 1st, 2019. In terms of business, this strategy was expected to ensure good financial incomes. However, instead of making progress via this strategy, in reality Healthcare BPJS has continued to incur severe deficits. Angger explained that, based on a simple actuarial formula, contributions received should equal benefits (payment of claims to participants) plus BPJS' operational costs. So, if there is then a deficit, this means that existing contribution receipts are less than claims paid plus operational costs. The amount of contributions received depends on the number of participants; if the number of participants is small, the income obtained is therefore also small. The membership segment of the JKN-KIS program is currently very diverse in character. There are Contribution Assistance Recipients (PBI) whose contribution installments are paid by the central and local governments; there are also civil servants, TNI (Indonesian Armed Forces), POLRI (Police) members and retirees whose JKN-KIS contributions are paid via the Directorate General of Budget in the Ministry of Finance. In addition, there are also two types of private employees: wage earners (PPU) and non-wage earners (PBPU).

When viewed in terms of the description of health system financing in the Universal Health Coverage (UHC) 3-dimensional Cube, which was first introduced at the launch of the World Health Report 2010 under the theme: "Health Funding System Towards UHC", as presented above, it can be seen on the population axis that the population coverage target in the JKN program is 100%. Therefore, the current coverage of participants at around 200 million needs to be expanded. It is estimated that there are still 60 million people who have not enrolled in the program - participants that will get access to equitable healthcare services. So, the 60 million target is expected to be achieved in 2019 as a Universal Coverage target in Indonesia. If we look deeper, there are many factors that cause people to not yet want to join the JKN-KIS program. Some examples include employees and retirees of state-owned enterprises (BUMN) whose offices already have good health facilities. They are still reluctant to join the JKN-KIS program because they feel they do not need membership in the program; this is because so far, they have been quite satisfied with the healthcare services in their own offices. Meanwhile, within low income communities, a lack of understanding and information has been one of the common obstacles. A study conducted by the Faculty of Public Health of Airlangga University and published in the Indonesian Journal of Health Administration volume 6 Number 1, January - June 2018, shows that the reluctance of people in the lower classes to join the program is due to low knowledge about the program, lack of socialization, shortage of health promotion media, family heads do not understand about the need for the program and the level of education is still low. Research conducted in Payaman village, Bojonegoro Regency, shows that only 56.85% of families in the area had JKN-KIS cards. The results of this study can certainly be an input for Healthcare BPJS.

Less than targeted contributions can also be attributable to the small number of people who are willing to pay their monthly premiums even though they are already members of the JKN-KIS program. Angger notes that, because the PBI (Contribution Assistance Recipients) are...
paid for by the government, then assuming 100 percent payment, claims from class III are around 70 percent, whereas class II, which is generally taken by civil servants, records approximately 95 percent in contribution payments and around 105 percent in claims. Meanwhile, in terms of PPU (Wage Recipient Workers) the assumption is 100 percent contribution payment, with claims at around 70-90 percent. Furthermore, in class I for the PBPU group (Workers Who are Non-Wage Recipients), it turns out the payment collectability rate is 50 percent, with their health claims being more than 300 percent, even reaching 400 percent. Given these factors, it is certainly difficult for Healthcare BPJS to achieve financial stability.

To What Extent is the Program Beneficial to Citizens and the State?

Undoubtedly, the JKN-KIS program provides great benefits to the community. Based on Indonesia Health Financing Assessment System: Spend More, Right & Better, 2016, the life expectancy of Indonesians increased to 69 years in 2014 since the JKN-KIS program began to be implemented, after being just 49 years in 1960. The under-five mortality rate dropped from 222 per 1,000 births in 1960 to 85 in 1990, and it fell further to 27 in 2015. The infant mortality rate also declined from 1/6 in 1960, to 23 per 1,000 births in 2015.

One of the benefits of the JKN-KIS program that has been felt directly by residents relates to the government’s responsibility for its citizens’ health issues. According to Angger, residents who previously did not have access to medical treatment at any healthcare facilities can now enjoy healthcare services in large hospitals. “Prior to the availability of Healthcare BPJS, there used to be many sayings such as: poor people should not be sick, then also, with private employees, if they got sick five times their salary would be lost to cover the hospital treatment costs, and so on. In addition, in the pharmaceutical industry, medicines and prices were determined arbitrarily; doctors and hospitals also took advantage of the ignorance of the people by commercializing their services. With the existence of BPJS, such things do not happen anymore,” Angger said, criticizing the condition of the healthcare industry in the past.

What Angger said is based on fact. Muhammad Samsudin (47 years), a resident of Sumber Lawang, Sragen Regency, Central Java, felt it. He was happy to be able to use the Kartu Indonesia Sehat (KIS) insurance, which benefits he was initially not aware of, because he got it for free from the RT (neighborhood association head). “The service at the Puskesmas is good, I took a number and was given the medicine; the medicine was effective too,” said the man who for the past two years has been trying his luck as a bajaj (tricycle taxi) driver in Jakarta. He also used his KIS card to seek treatment at a Puskesmas in the Pulo Gadung area, and this was accepted, even though he was asked to replace the card. His wife consulted about her pregnancy for her third child using the service, although later, due to ignorance, he had to pay Rp 1.2 million for the cost of giving birth with the help of a family midwife. He only learned that the actual cost of giving birth could be borne by the JKN-KIS program after his wife gave birth. “I am happy to have this KIS card. Satisfied indeed,” Samsudin said.

Various groups have benefited from the JKN-KIS insurance program, including the upper middle class. Ismi Farahnassy is one of them. A contract employee in a national NGO, she is married to an employee of the DKI Jaya Provincial Government who was a participant in the insurance program of PT. Askes – now the JKN-KIS program. When giving birth to her second child, Ismi used the Healthcare BPJS facility, although when consulting with her doctor she used personal money because there was no special insurance for pregnancy from her office, and only a month before giving birth she consulted the Puskesmas to give birth by cesarean delivery. She found it was straightforward to explain to the doctor at the Puskesmas regarding the condition of her pregnancy and her related medical history. She could also give birth with the help of the same doctor as the one who helped her prepare for her first pregnancy and childbirth in a private hospital. The five-day delivery fee of approximately Rp 16 million could also be covered [by the insurance program]. She believed that the drugs she was prescribed were quite good. Of the total costs, she only paid Rp 100,000 from her own pocket for buying breast milk pills. “Our family uses JKN-KIS cards, both for the costs of my younger sibling giving birth and treatment for my mother, who is diabetic and had to be hospitalized. So far, I am very satisfied with the services, although now it appears that the covered period of hospitalization has been rather limited,” Ismi said.

One of the benefits of the JKN-KIS program that has been felt directly by residents relates to the government's responsibility for its citizens' health issues.
Patients with critical diseases also enjoy JKN-KIS healthcare services. Ovarian cancer that subsequently spread to other limbs made Ria Gunawan dependent on the JKN-KIS program (see box). “This JKN-KIS insurance is very necessary; (this insurance) greatly reduces the financial burden. I see many cancer patients from Tangerang, Bogor, Bekasi, Sumatra, even Papua, come to hospitals in Jakarta, because in their areas there are no facilities for cancer, and they use the JKN-KIS cards,” said Ria. According to Angger, who serves as member of the DJSN that also conducts program evaluation, he has seen an increase in drug use. “Nowadays, people have greater access to health care. It used to be that villagers in remote regions, if they were sick, they had kerikan [having their backs scraped - a traditional healing method], they drank jamu (traditional herbal medicine) or bought medicine at the local stalls. Today, they come to the Puskesmas or other healthcare facilities. This observation was also affirmed by Muhammad Iqbal. According to him, the emergence of the JKN-KIS program has also encouraged people who used to be afraid to look for treatment, to seek formal medical care. Generally, when hearing from neighbors about the benefits of the program, people become interested and they seek treatment.

In addition to direct benefits for community members, this program from Healthcare BPJS also has very broad benefits. A study carried out within the framework of collaboration between Healthcare BPJS and the University of Indonesia’s Institute of Research and Development (LPEM UI) in 2016 shows that the JKN program is not just a cost, but it is also an investment. In the short term, the program can increase output and workforce in other sectors, while in the long term the JKN program can improve human capital through extending life expectancy, which, in turn, will increase economic growth.

The results of the JKN-KIS Program based on this study are as follows:
1. Increasing access to healthcare services. The increase in the number of JKN members will increase the utilization of outpatient care and hospitalization, as well as the duration of care by 0.86 days.
2. Achieving Universal Health Coverage (UHC) will increase life expectancy (AHH) by 2.9 years.
3. An increase of 1% in JKN membership will increase the GDP per capita by Rp 1 million.
4. The achievement of UHC in 2019 will generate output of Rp 269 trillion and contribute to the creation of employment for 2.3 million jobseekers.

Seeing the above, the JKN-KIS program has enormous benefits, and this is a huge homework for this country to strive for the sustainability of BPJS,” Angger said.

**Contribution of the JKN Program to Economic Sectors in Indonesia**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Output (trillions of Rupiah)</th>
<th>Labor (thousands of people)</th>
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<tbody>
<tr>
<td></td>
<td>2016</td>
<td>2021</td>
</tr>
<tr>
<td>TOTAL CONTRIBUTION</td>
<td>152.2</td>
<td>289</td>
</tr>
<tr>
<td>Government Health Services</td>
<td>57.9</td>
<td>110</td>
</tr>
<tr>
<td>Pharmaceutical Products Industry</td>
<td>10.1</td>
<td>19.1</td>
</tr>
<tr>
<td>Medical Equipment Industry</td>
<td>0.20</td>
<td>0.39</td>
</tr>
<tr>
<td>Healthcare Services and Private Social Activities</td>
<td>14.6</td>
<td>27.8</td>
</tr>
<tr>
<td>National health insurance</td>
<td>6.8</td>
<td>12.9</td>
</tr>
</tbody>
</table>

Source: Impact of JKN-KIS Program on the Indonesian Economy, Poverty Assessment & Social Protection LPEM FEB UI, 2017
Getting Ready to Face Evolution in the Healthcare Industry

The existence of a national health insurance program for hundreds of millions of community members not only makes the JKN-KIS program one of the largest programs in the world, but also it encourages an evolution in healthcare in this country. Before this national insurance program became available, medical services, both in terms of drug use, price and also quality of healthcare services, were always questioned by consumers who felt they were treated unfairly. In the early years of the program’s implementation, the community could feel the changes that had begun to occur, although most of them feel the difference in service between big cities and remote areas has persisted until now. Underlining Professor Laksono’s previous statement, it is evident that residents of remote areas do not get the same services as residents in big cities due to a lack of facilities and qualified health personnel, which are available in large cities.

Other concerns included the uncontrolled use of drugs at the discretion of doctors, which led to manipulation of drug prices. Control of treatment management by reference to the INA CBGs (Indonesian Case Base Groups - a reference for health service payment systems at advanced healthcare facilities in the form of a package system in accordance with patients’ illness) has succeeded in encouraging doctors and hospital management to provide efficient and effective services for JKN-KIS program patients, including giving medicines only according to the National Formulary list (the list of medicines used in the Healthcare BPJS scheme). This encourages hospital management to be more disciplined in the use of drugs and thereby force a reduction in the level of manipulation of drug prices which happened previously. Angger Yuwono argues that, “With the presence of BPJS, drugs are regulated, brand use is regulated and prices are set in the National Formulary list. To order drugs, it is no longer possible to use an auction system as before; orders are made online so as not to allow business concessions; this does disrupt the pharmaceutical industry. “The presence of BPJS also increases drug use and increases access to healthcare services.”

According to Angger, all these factors amount to an important joint homework to be able to strengthen Healthcare BPJS. “This might be called an evolution in the healthcare industry in Indonesia,” he said. The field of medicine is also undergoing an evolution. In the past, doctors, who were also university professors, did not feel pride if they had to handle BPJS, but today they receive smaller honorariums but from a larger number of patients. So, the payment remains the same. “All healthcare practices have been impacted by the presence of Healthcare BPJS,” Angger said.

“This might be called an evolution in the healthcare industry in Indonesia. All of healthcare practices have been impacted by the presence of Healthcare BPJS.”

drs. Angger P. Yuwono, FSAI, /ChFC
Member of the Republic of Indonesia National Security Council (DJSN)
Reaping the Storm of the JKN-KIS Program

Seeing the long list of benefits and also the expectations of the community for the program organized by Healthcare BPJS gives us enthusiasm and support for continuing this program. But we need to look deeper, what are the big problems faced by Healthcare BPJS besides the financial deficits that are clearly evident?

The high cost of the program is an unavoidable consequence, considering that the JKN-KIS national insurance program covers approximately 200 million Indonesian residents. In addition to the cost of capitation that must be paid to hospitals, doctors, or healthcare facilities that have cooperation with Healthcare BPJS, which amounts to Rp 1 trillion payable monthly, Healthcare BPJS also has to bear the high service costs for critical diseases. In 2015, the financing of critical diseases based on Healthcare BPJS data reached Rp 14.3 trillion, while in 2016 the figure rose to Rp 14.6 trillion, with the largest cost being financing for heart diseases at Rp 6.9 trillion (48.25%) in 2015, rising to Rp 7.4 trillion (50.7%) in 2016. The link between diseases and lifestyle also appeared from excessive consumption of fat, sodium and sugar based on the 2014 Indonesian food consumption (SKMI) survey data. During the last two years, the deficit suffered by Healthcare BPJS has been estimated at Rp 16.5 trillion.

In addition to issues associated with the monthly capitation payments of Rp 1 trillion and the major expenditures required to treat serious diseases as noted above, the high cost has also been triggered by the issue of abuse related to disease treatment services, which has later been regulated by Perdirijamelkes Numbers 2, 3, and 5 of 2018, for cataracts, for healthy babies and costs for medical rehabilitation. It is not without reason that

How Do Healthcare Facilities Benefit from the JKN-KIS Program?

There have been various complaints addressed to Healthcare BPJS, including those from hospitals that are on the frontline of this program. Do health facilities suffer losses in joining this program or vice versa? Presidential Regulation (Perpres) No. 82/2018 article 52 states what services are included in the program. All fees are guaranteed at the first-level healthcare facilities through the capitation model. Mohammad Iqbal Anas Ma’ruf, Chief Assistant Secretary, Public Community and Public Relations, Healthcare BPJS, explains that, with this capitation model, each participant service is valued at Rp 8,000, for example Doctor A has 5,000 participants, based on statistics. Thus he earns Rp 4 million per month, payable on the 15th of every month. Delay in payment will cause BPJS to be fined 1% every month. Based on the statistics of visits to doctors, being generally 20% of the total population, that number is still quite acceptable. There are almost no issues related to capitation matters. Issues exist in the optimization of city-level healthcare facilities. The doctors who serve in healthcare facilities are required to master 144 or 155 disease diagnoses, although often there are excuses given pertaining to TACC (time, age, complication, communication) - which are related to facilities and infrastructure.

8 Chronic Diseases among Indonesians that have become a Burden to Healthcare BPJS During January-August 2018

Healthcare BPJS suffered a financial deficit in the last two years of up to Rp 16.5 trillion. This is due to the high incidence of chronic diseases among Indonesians.

Source: CNBC Indonesia, based on presentation material of Prof. dr. Iwan Dwiprahasto, MMedSc, Ph.D

<table>
<thead>
<tr>
<th>Disease</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Kidney Failure</td>
<td>11.72%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>51.99%</td>
</tr>
<tr>
<td>Stroke</td>
<td>12.65%</td>
</tr>
<tr>
<td>Cancer</td>
<td>12.65%</td>
</tr>
<tr>
<td>Thalassemia</td>
<td>1.55%</td>
</tr>
<tr>
<td>Leukemia</td>
<td>1.67%</td>
</tr>
<tr>
<td>Haemophilia</td>
<td>1.83%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Chronic Diseases among Indonesians that have become a Burden to Healthcare BPJS During January-August 2018

Healthcare BPJS suffered a financial deficit in the last two years of up to Rp 16.5 trillion. This is due to the high incidence of chronic diseases among Indonesians.
With this kind of scheme, Healthcare BPJS must prepare funds of at least around Rp 1 trillion every month to meet the costs of this capitation scheme. This is the amount of fixed costs that need to be met by Healthcare BPJS, excluding the costs of drugs, services and other expenses. It can therefore be imagined that the expenditure of this public legal entity is very significant.

Muhammad Iqbal Anas Ma’ruf
Chief Assistant Secretary, Public Communication and Public Relations, Healthcare BPJS

these three issues have been included in the special regulations. The cost of treating cataracts is said to be higher than treatment for kidney failure, which is classified as life-saving. Based on historical data, various related cases were found, such as the scheme by hospitals to mobilize patients to receive cataract surgery treatments by their doctors, packages for mothers and babies born healthy, which have now been split into two different packages, and also the discovery of fraud in medical rehabilitation practices. From the historical data, suspicion of abuse has emerged, such as the same person undergoing medical rehabilitation up to 28 times a month. Unfortunately in July 2018 the regulations, which aimed to make treatment more cost effective, was revoked by the Supreme Court, following objections from the community represented by Indonesia Bersatu Doctors Association (PDIB).

In addition to the three issues above, errors in calculating service costs have also been frequently found in the delivery of program services; for example at the hospital referral level, such as the case of a mother who had a heart disease problem; she received treatment for three days as a class 1 patient, but based on family preferences, the mother was accommodated in a VVIP room; and when leaving the hospital, the family did not pay a penny. When examined further, it turned out that the ceiling cost for heart disease at the hospital was Rp 6.8 million, and, by having the VVIP room, the cost spent was Rp 4.4 million. In fact, by raising the treatment class, there should be elements for augmenting facilities that should be paid by the patients themselves. Such matters, according to Angger, can be called fraud, mismanagement, or they can also be caused by miscommunication.
Currently (2018) the JKN-KIS program contribution scheme is as follows:

<table>
<thead>
<tr>
<th>Class</th>
<th>Current monthly premium</th>
<th>Ideal contribution amount according to BPJS</th>
<th>Deviation</th>
<th>Ideal contribution amount according to DJSN</th>
<th>Paying Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>Rp 80,000</td>
<td>Rp 80,000</td>
<td>0</td>
<td>Same as current level</td>
<td>Personal/Company</td>
</tr>
<tr>
<td>Second</td>
<td>Rp 51,000</td>
<td>Rp 63,000</td>
<td>Rp 12,000</td>
<td>Rp. 63,000</td>
<td>Ministry of Finance, State-Owned Enterprises (BUMN)</td>
</tr>
<tr>
<td>Third</td>
<td>Rp 25,500</td>
<td>Rp 27,000</td>
<td>Rp 1,500</td>
<td>Rp. 36,000</td>
<td>Local Governments/ Central Government</td>
</tr>
</tbody>
</table>

The premiums payable for the second-class category show an implied deficit of Rp 12,000, while in the third-class category, there is a deviation of Rp 1,500 from the ideal amount according to Healthcare BPJS as indicated in the table above. The issue of the need to increase premiums also appears to require a more serious discussion, considering that this is an important key to the sustainability of the program. If we look at the Universal Coverage 3-dimensional cube, it can be seen that the benefits package offered by the JKN-KIS program, which currently covers a very wide range of services, will have an impact on the amount of costs that arise from the services provided. Logically, the amount of costs to be funded will have an impact on the contributions made by the participants, but Healthcare BPJS to date prefers to rely on government support. “The contribution issue is a big problem, but as long as the government provides its support, there is no issue. For example, people ask, why aren’t the contributions fixed? The options set out in Government Regulation (PP) No. 87/2013 are clear, i.e. contribution adjustment, benefit adjustment and fund injection. If one of the three options is chosen, what is wrong?” Iqbal said, giving a rationalization of the steps taken. According to him, if one day the action needed is to increase contributions, it will be done. The issue of contributions has never been an easy matter. Moreover, it can be expected, political factors are very strongly at play behind the issue of contributions. An important recent development is that in August-September 2019 the Ministry of Finance proposed increases in BPJS membership premiums payable: for the first category to increase by 100 percent from Rp 80,000 to Rp 160,000; for the second category from Rp 59,000 to Rp110,000 and for the third category the proposed increase would be 65% from Rp 25,500 to Rp 42,000 per participant per month.

In September 2019 Kompas online media reported that Commissions IX and XI of the House of Representatives rejected

**How JKN-KIS Plays a Role in the Lives of Patients with Serious Diseases**

If in the past, there were many stories about Indonesians who fell ill because of suffering from diseases, such as cancer; now that kind of story has begun to be rarely heard. Ria Gunawan, a mother who suffered from uterine cancer, said that she was quite satisfied with Healthcare BPJS services in a private hospital that handled many cases of cancer in the Central Jakarta area. When she first developed cancer in 2015, she was not yet a participant of Healthcare BPJS, so she had to pay for the cost of her first medical procedure by herself, to get the results of anatomical pathology. After the results came out, she was told that she did have ovarian cancer. She then joined the Healthcare BPJS program; since then post-operative costs such as chemotherapy, consultation and others have been covered by Healthcare BPJS. Now she can feel the benefits of taking part in this program, because in addition to satisfactory hospital services, such as clean hospital conditions, good service by nurses and doctors, and even in terms of queuing there is now automation using numbers issued through a machine.

However, Ria complained about a new regulation to renew referrals every three months. According to her, “For chronic diseases like this, the treatment is certainly quite long; if every three months I have to renew the referral and come to the Puskesmas myself, it is rather a nuisance, too.” The requirement for arranging referral letters that must be undertaken every three months without being able to be represented (by someone else) is indeed not easy, especially for chronic disease patients who are treated in cities or even islands that are in different areas than their homes, so they must travel to their home town every three months. At the hospital where she was treated she saw many patients from various regions, such as Tangerang, Bogor, Bekasi, Sumatra and even Papua.

The cost of healthcare services for critical diseases (serious illnesses) that have been borne by Healthcare BPJS all this time is indeed unmitigated. For cancer in 2017, Healthcare BPJS had to absorb a cost of Rp 3 Trillion. Cancer is a serious disease with the second largest healthcare cost being assumed after the costs of heart disease treatment, which amounts to Rp 9.2 trillion. Meanwhile, the cost of treatment for kidney failure is ranked third at Rp 2.2 trillion.
this proposal. However, they accepted that the first and second categories’ premiums will be raised by 100% with effect from January 2020. For the moment, the proposal to increase the third category’s premium by 65% is being postponed.

Healthcare BPJS itself has taken various approaches to encourage program participants to pay, for example arrears are calculated at no more than 24 months (maximum amount), while education is also provided for participants, i.e., for those who have just joined the program, payments can only be made after 14 days, so that people would not act at will. For example someone who is 8 months pregnant, if she wants to register to receive the benefits of the JKN-KIS program, then the time to process the registration would be too tight.

In addition, Healthcare BPJS has a policy related to registration and payment that they must be tied to all the members of the KK (family card – i.e. the whole family), so that more people participate in the program and participants have a sense of belonging.

### Schematic Picture of Deficit Issues on Finance Related to the Sustainability of the JKN-KIS Program

<table>
<thead>
<tr>
<th>Issue</th>
<th>Details of Issue</th>
<th>Explanation/Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High Cost</td>
<td>a. Capitation cost per month is Rp 1 trillion (fixed cost)</td>
<td>Healthcare facilities need to receive capitation funds to be able to serve JKN-KIS patients well.</td>
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<td></td>
<td>b. Healthcare costs for critical or serious diseases during 2014-2017 amounted to Rp 250 trillion</td>
<td>Critical diseases entail high costs and require long-term treatment</td>
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<td></td>
<td>c. Issues of abuse pertaining to the high costs/expenses for:</td>
<td>Rules concerning these three topics were previously contained in Perdirjampelkes Number 2, Number 3, and Number 5, 2018. The three regulations were designed to manage the effectiveness of these three medical services. In 23 October 2018. Although these regulations were intended to promote cost effective treatment, but due to the refusal of the community represented by the Indonesia Bersatu Doctors Association (PDIB), they have been revoked by the Supreme Court.</td>
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<tr>
<td></td>
<td>i. Cataracts - suspected to have been abused by hospitals</td>
<td></td>
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<tr>
<td></td>
<td>ii. Babies born healthy - these are now treated using a different package from mothers giving birth to newborn and baby with health problem.</td>
<td></td>
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<tr>
<td></td>
<td>iii. Medical rehab - its utilization has been widely abused.</td>
<td></td>
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<tr>
<td></td>
<td>d. Abuse (fraud), both in reporting on the BPJS system, and in its implementation</td>
<td>Lack of understanding of the financial system properly</td>
</tr>
<tr>
<td>2. Membership issues that have led to lower than target income</td>
<td>As many as 60 million Indonesian citizens in 2018 have not yet participated in the JKN-KIS program</td>
<td>- Non-participants include BUMN employees who already have qualified healthcare facilities; - Lack of information and correct understanding of the importance of health insurance.</td>
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<td></td>
<td>The amount of contributions from the community is inadequate at this time</td>
<td>- political factors - there are many interests behind the contribution amount</td>
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<tr>
<td></td>
<td>PBPU collectability is only 50%</td>
<td>- whereas their filed claims reach up to 300%-400%</td>
</tr>
<tr>
<td>3. Service quality</td>
<td>Service quality is not the same between big cities and small cities/remote areas.</td>
<td>By stipulating prerequisites whereby doctors at first-level healthcare facilities need to master 144 - 155 health problems related to patients.</td>
</tr>
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<td>Using hospital type categorization of A, B, C, D, E to optimize services.</td>
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Apart from contributions, the issue of service is still overshadowing the Healthcare BPJS program. At the start of the program, services at first-level healthcare facilities were always full and tended to exceed the available capacity, with chaotic queuing arrangements, but in recent years the issue has ceased to exist, thanks to the many healthcare facilities joining the program. The issue of differences in service quality is still quite significant at this time, with the prerequisite for doctors or healthcare facilities to have mastery of 155 patient health problems being crucial.
The various problems mentioned above certainly still constitute a major challenge for Healthcare BPJS and the Government, the latter of which has allocated a large amount of funds to finance the deficits of this ideal program. In the book Executive Summary of Healthcare Management and Social Security Report, Healthcare BPJS also expresses its belief that it will take a long time to strengthen healthcare facility services in Indonesia. This requires a long process, strong support and involvement of stakeholders. On the internal side, Healthcare BPJS should continuously seek to optimize the quality of services by strengthening cost-control and quality-control strategies, including the detection of fraud and abuse at the primary and advanced service levels. In carrying out this function, Healthcare BPJS relies on Primary Healthcare Service Management verifiers in all its regional divisions and branch offices.

Strategic partnerships involving the healthcare offices of Local Governments (Dinas Kesehatan), professional organizations and associations of healthcare facilities in the regions to support increased commitment of the healthcare facilities and optimize the roles and functions of the TKMKB (Quality Control and Cost Control Team) in improving service quality and maintaining cost control at FKRTL are essential to maintain the continuity of this program, including the detection and prevention of fraud in the implementation of the JKN-KIS program.

**JKN - KIS Sustainability, is there still Hope?**

Looking at the various problems in the JKN-KIS program is like seeing tangled threads. It is useful to examine the existing problems further. The JKN-KIS program is currently assumed to have won the trust of approximately 200 million participants. This program is designed as an embodiment of Article 28H paragraph (3) of the 1945 Constitution, which states that everyone has the right to social security, and also Article 34 paragraph (2), that the state develops a social security system for all Indonesians, and Pancasila, the ideology of the Indonesian state, whose third principle calls for social justice for all Indonesian people. With this strong foundation, the government wants to guarantee healthcare for all citizens. For this reason, the continuity of the JKN-KIS program is considered essential to fulfill the state's obligations to the people.

With regards to the infrastructure of Healthcare BPJS, one very important factor is the availability of capacity for accommodating patients in hospitals. The problem of hospital capacity shortfall to accommodate patients has become a classic problem for the JKN-KIS program (see the table “Healthcare Service Coverage in Indonesia 2013” below), resulting in various complaints about uneven services. To overcome this fundamental problem, certainly the participation of the private sector is needed. One option that may become an alternative solution is to use foreign investment to help address these shortcomings.

Table of Healthcare Service Coverage in Indonesia

Another crucial point as a measure to save Healthcare BPJS is to increase contributions. The discussion above concluded that the level of contributions is still less than ideal at this time, because there have continued to be many obstacles to participants making their full contributions. Therefore, it can be assumed that raising contributions is a step that will certainly be unpopular. Various ideas, as stated by Angger in the discussion above, could be deemed as options that should be considered, such as making payment for the JKN-KIS program a part of the requirements for making/extending Family Cards, Identity Cards, or STNK extension, or even it becomes part of the requirements for purchasing a vehicle. The point is to force people to be disciplined about making the payments.

In order to attract the interest of community members who have yet to join, the JKN-KIS program also needs to have proper socialization of the Coordination of Benefits (CoB) pattern and more practical implementation of the managed care system for insurance industry players and the Healthcare BPJS’s members.

One problem that remains difficult in the JKN-KIS program pertains to the quality of professional healthcare workers; this not only involves the quality of doctors, but also nurses, and other medical personnel. To maintain the quality of professional healthcare workers, BPJS can work with KARS (Hospital Audit Committee) to conduct training and evaluations to improve the quality of professional healthcare workers in the JKN-KIS program, such as understanding among these healthcare workers of the national formulary system, INACBG’s, service level of each individual and doctor’s mastery of 155 patient health problems.

Apart from professional healthcare workers, doctors who are in charge of hospital management or even administrators also need to improve their cost management and leadership skills. (See Bali PPT regarding efficient and effective hospitals in the BPJS era - related to costs), in this sharing of knowledge it was noted that even doctors must also make unpopular decisions.

Another point that is of no less importance is to improve the use of technology in TPA (Third Party Administrator). TPA is an administrative system that is used to provide detailed information about the status of a person’s insurance calculation and also the calculation of costs spent on treatment. TPA is a third party outside of insurance that functions to assist with the insurance work system (usually private insurance); usually the function is owned by a company. An Indonesian company that functions as a third-party administrator is Admedika (PT. Administrasi Medika). This is the first insurance administrator company in Indonesia; it was acquired by Telkom (Telekomunikasi Indonesia) in 2010, and presently it collaborates with Telstra (an Australian telecommunications company) in carrying out its functions.

In the growing world of healthcare industry, the presence of the medicine business cannot be reduced. Nonetheless, in Indonesia, in line with the expanding social security in the field of healthcare, i.e. the JKN-KIS program, the pharmaceutical industry seems to be increasingly marginalized, because only certain drugs can enter the National Formulary, which is the list of standard medicines included in the Healthcare BPJS treatment system. This policy needs to be evaluated to help the pharmaceutical industry and allow it to flourish in Indonesia. The current prices of medicines need to be reviewed. The prices of medicines are listed in an e-catalog that contains lists, types, technical specifications and prices of certain goods/services from various Government Goods/Services Providers. Studies need to be conducted to determine whether the price of a particular drug is too expensive or still acceptable. All this time, the prices of drugs in the e-catalog are too low; this needs to be discussed again, because not all drugs can be sold at low prices, especially patented drugs, namely new drugs produced and marketed by a pharmaceutical company that holds the patent to make the drugs. A patent does not allow other companies to make the drugs except with the permission of the patent owner. The owner of a patented drug has conducted a series of clinical trials according to the internationally established rules. All costs for the drug research are then charged to the price of the drug. This causes patented drugs to be expensive compared to generic drugs. Patents usually have a validity period. After the expiration date, the drugs can be produced by other companies and become generic drugs.

The last option that allows for the continuation of the national health insurance program is by reviewing an option that was considered in 2015, namely merging between Healthcare BPJS and Manpower BPJS [BPJS Ketenagakerjaan], even though at that time it was not a company merger that was sought but instead merging the portals for participant registration into one door, or known as One-Stop Integrated Services (PTSP), so it would be possible to exchange membership data information. However, the idea to merge the two companies under BPJS needs to be considered; considering that Healthcare BPJS has difficulties in cost management, while Manpower BPJS has a significant amount of accumulated funds. By carrying out the merger, cross-subsidies are expected to be well coordinated.
## Ten Primary Sources of Inefficiency in the World’s Healthcare System

<table>
<thead>
<tr>
<th>Efficiency Challenge</th>
<th>Relevance for Indonesia</th>
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<tbody>
<tr>
<td>Minimal use of generic drugs and higher drug prices than appropriate.</td>
<td>The regulation requires the government and healthcare facilities that implement the JKN program to use generic drugs. Problems in terms of supply readiness and with some preferences for branded drugs that are not covered by the JKN program have resulted in high expenditures; the prices of patented and well-known drugs in Indonesia are even higher than prices on international markets.</td>
</tr>
</tbody>
</table>
| Use of substandard quality drugs and fake drugs                                       | • There is a significant financial burden (and health risks) that has to be borne by consumers due to the use of substandard quality drugs or counterfeit drugs, but the data related to this is very minimal. Counterfeit vaccines, including vaccines that are routinely used for childhood immunization, are found to be sold in private hospitals and public health-related facilities, which have prompted community concerns on the ability of the government and BPOM (Food and Drugs Supervisory Agency) to effectively administer vaccines and drugs in Indonesia. Fake drugs generally consist of antibiotics, anti-malaria, pain killer, anesthetic drugs, vaccines and erectile dysfunction drugs.  
• In 2016 a national scale operation succeeded in seizing substandard quality drugs and counterfeit drugs worth US$ 42 million, in 32 provinces throughout Indonesia. |
| Inappropriate and ineffective use of drugs                                            | • Inappropriate, ineffective use and self-medication using written prescriptions, especially antibiotics, have occurred freely in both public and private healthcare facilities, and pharmacies; these have burdened both the government budget and private expenses of the people.  
• It is found in the JKN - KIS program, several instances of the increase of drugs usage which are not in the national formulary list, and high number of the usage of prescribed generic drugs in the prescription of the BPJS's members comparing to non-BPJS's. |
<p>| Utilization and availability of devices, actions and excessive procedures              | Under the JKN scheme, there has been an increase in cesarean section surgery which has been observed from 15 million birth claims, where more than half (54 percent) were carried out by caesarean section. Although there is no baseline data available on this matter, this figure is higher than the WHO recommendation, namely an upper limit of 15%. |</p>
<table>
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<tr>
<th>The mix between staff is inaccurate or the staff are paid expensive fees, with healthcare workers lacking motivation.</th>
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<tbody>
<tr>
<td>The main issue in HRH (Health Human Resources) pertains to distribution errors, a small number of specialist doctors and less skilled healthcare workers. There are striking inequalities between regions and provinces geographically, and between urban and rural areas; these represent a contributing factor to health output variables.</td>
</tr>
<tr>
<td>Registration at the hospitals and the length of stay in the hospitals are out of line</td>
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<tr>
<td>For JKN participants, re-registration is recorded at about 10% for hospital care, and that is questionable; also, the re-registration rate for outpatient services is also high. The period of hospital stay increased from four days in 2009 to six days in 2015.</td>
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<tr>
<td>Inadequate hospital sizes (low infrastructure use)</td>
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<td>Despite the growth in the number of hospitals that has occurred over the last decade, the total number of hospital beds to population ratio has remained low (ranging from 1.07/1000 compared to the average number in the global setting of 2.5/1000).</td>
</tr>
<tr>
<td>Medical errors and less than optimal quality</td>
</tr>
<tr>
<td>A study of verbal autopsy of pregnant women found that nearly 40% of decisions were made late and in more than half of these cases, clinical decisions were made incorrectly.</td>
</tr>
<tr>
<td>Loss, corruption and abuse</td>
</tr>
<tr>
<td>The practice of abuse potentially occurs in JKN claims, including mistakes in writing billing codes (upcoding), entering bills randomly to maximize reimbursement of various tests and procedures, prescription writing outside the drug list catalog, and errors in claims compounded by a lack of supervision.</td>
</tr>
<tr>
<td>A mixture of health interventions that are inadequate (for example between preventive and care measures, high vs. low value).</td>
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<tr>
<td>The implementation of the JKN program has increased the attention that this system is more focused, spending more money on curative practices rather than preventive practices. The absence of a need certificate - a legal document issued in several states and federal jurisdictions of the United States to confirm community needs - to provide more advanced technology and more expensive services (for example diagnostic equipment), has led to supply-induced demand which ultimately will increase drug prices.</td>
</tr>
</tbody>
</table>

Source: WHO 2010c (left column) and World Bank staff (right column)
Sources:
3. Journal of Indonesian Health Administration Volume 6 Number 1, January - June 2018, Identification of the Causes of Low JKN Participation in Informal Sector Participants in Rural Areas (The Identification Causes JKN ' Low Membership at Informal Sector in Rural Areas), Wahyu Kurniawati, Riris Diana Rachmayanti, Faculty of Public Health, Airlangga University, Indonesia
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Predictions has been published annually since 2001. In the latest edition, Deloitte Southeast Asia’s TMT practice has once again included its “Southeast Asia perspectives” alongside with four of the global TMT predictions. Through a series of focus group discussions conducted by Deloitte Southeast Asia with 77 millennials across the three regional markets of Indonesia, Philippines and Singapore, we offer some insight into how global developments may take a different course or growth trajectory within the region due to its unique characteristics. This year's prediction theme is evolution rather than stasis. The high data speeds and low latency 5G provides could spur the evolution of mobility, health care, manufacturing, and nearly every industry that relies on connectivity. In the report, there is a discussion about eSport with big implications for media companies and advertisers. In this report predictions about 5G networks that will be launching in 2019. Please contact us if you are interested to receive a copy of this report.

Indonesia, the most populous country in Southeast Asia, has always been a core market of interest for retail business. In this fifth edition of the Deloitte Consumer Insights report, we reflect on some of the latest consumption patterns among Indonesian consumers that we identified from the results of a survey conducted in 2018. Our survey indicates that there are potential shifts in the Indonesian market as compared to previous years. A decline in personal spending has influenced products in the Basic Necessities cluster, particularly the Fresh Food and Packaged Food category. There are also signs that Chinese brands may be successfully positioning themselves across different income levels with certain Electronic Products. Please contact us if you are interested in obtaining a copy of this report.

This eHealth thought leadership paper aims to deliver an outlook and recommendations for Indonesian regulators, policy makers, academics, business owners and users about future trends in the Indonesian healthcare system. As a developing country, Indonesia continues to experiencing relatively rapid economic growth. However, rapid growth brings with it certain increasingly complex challenges. Currently, Indonesia is in the midst of several transitions; ranging from demographic, epidemiological, in information systems to technological changes. With all of these changes, stakeholders are required to review and renew existing policies and systems in order to be respond to the potential changes in macro-economic conditions which are likely to arise in the near future. Please contact us if you are interested in receiving a copy of this important report.
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