

**DIRECTORATE FOR FINANCIAL AND ENTERPRISE AFFAIRS
COMPETITION COMMITTEE****Working Party No. 2 on Competition and Regulation****Designing publicly funded healthcare markets – Note by Indonesia****26 November 2018**

This document reproduces a written contribution from Indonesia submitted for Item 4 of the 66th OECD Working Party 2 meeting on 26 November 2018.

More documents related to this discussion can be found at

<http://www.oecd.org/daf/competition/designing-publicly-funded-healthcare-markets.htm>

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Indonesia

1. Introduction

1. Commission for the Supervision of Business Competition (KPPU) is an independent institution founded to supervise the implementation of Law Number 5 Year 1999 regarding Prohibition of Monopolistic Practices and Unfair Business Competition. KPPU has the duties and authorities to give the policy recommendations to government policies relating to monopolistic practices and/or unfair business competition and to enforce law against business actors.
2. KPPU is not merely a law enforcement institution that just puts an emphasis on the multitude of the case handling but also on the prevention aspect. In terms of the prevention aspect, there are 5 (five) strategic sectors that prioritized by KPPU on its prevention and enforcement efforts, namely energy, food, finance, health and education, as well as transportation and infrastructure sectors.
3. KPPU has conducted four researches with regard to the health sector for the last two years (2016 -2017).

1.1. KPPU's Policy Recommendations in Health Sector

4. Based on Article 35 of Law No.5/1999 regarding Prohibition of Monopolistic Practices and Unfair Business Competition, KPPU has the duties to give policy recommendations to the government. KPPU has given policy recommendations to the Ministry of Health, namely:
 1. With regard to the Significant Role of Doctors (Monopoly by the Agent) that may distort the market and the recommendations given are among other things:
 - Improve the role of pharmacists: “Pharmacists shall be obligated to inform of patent medicines or generic medicines which have the same of the active components to any patient”;
 - Obligation to write the prescription of generic medicines and the procurement of drugs at the Private Hospitals Installations ;
 - The enforcement of Code of Ethics for Doctors.Such enhanced role of pharmacists may strengthen the role of pharmacists to minimize the role of doctors in prescribing certain medicines as well as to eliminate transactional relationships between doctors and pharmaceutical companies. The following is the output scheme for strengthening the role of pharmacists.
 2. In order to cope with the high cost of the medicine price forming components, KPPU recommends the following matters:
 - Avoid dominant import control by certain business actors;
 - Eliminate cost inefficiency such as promotion cost, seminar cost, and others;
 - There is a need for regulating double taxation in the medicine distribution channel;

- Synergy with other government regulations that have linkage to the setting of the medicine price which aimed to reduce increased production costs of the medicine.
3. For matters concerning the categorization of branded generic medicines which basically constitute generic medicines, KPPU recommends as the following:
 - Eliminate the terminology of generic medicines or branded;
 - The government also regulates the Highest Retail Price (HET) of branded generic medicines/generic medicines having a trade name;
 - Obligation to write the prescription for generic names and procurement of medicines at the Installations of Private Hospitals;
 - Mechanism for the procurement of medicines at the installations of private hospitals in line with the procurement of medicines at the installations of government hospitals that has been conducted through e-catalogue.
 4. For matters concerning the high cost of patent medicines, KPPU recommends to used policy on TRIPs Flexibility which may conducted through 3 methods, namely: Mandatory License, Use by the Government, and Parallel Import.
 5. Several policy recommendations of KPPU as mentioned above have been conveyed to the Chief of Staff of the Presidency and the Minister of Health of the Republic of Indonesia. Out of such KPPU's policy recommendations, only the strengthening of the role of doctors that has been immediately implemented by the Ministry of Health of the Republic of Indonesia by formulating a Health Minister Regulation, while other recommendations require a more-indepth assessment.
 6. Policy recommendations of KPPU with regard to the strengthening of the role of pharmacists are well accepted by the Ministry of Health of the Republic of Indonesia by stipulating and issuing Regulation of the Minister of Health No. 98 Year 2015 regarding the Provision of Information on the Highest Retail Price of Medicines, as indicated in Articles 8 and 9.

Article 8:

(1) Pharmacists at drugstores or pharmaceutical installations at hospitals/clinics when rendering doctor's prescription services should obligated to give information on the Highest Retail Price (HET) of medicines to patients or Families of the Patients;

(2) Other than information on the Highest Retail Price of medicines as intended in paragraph (1), Pharmacists must inform other medicines especially generic ones that have active components with the same efficacy as the prescribed medicines as available at drugstores or pharmaceutical installations of hospitals/clinics to patients or Families of the Patients.

Article 9:

Patients or families of the patients shall be entitled to determine the choice of medicines based on the information given by Pharmacists as intended in Article 8.

7. Therefore, the policy recommendations given by KPPU become effective for they have been provision by the related Ministry in this regard the Ministry of Health.

2. Demand and Supply

2.1. Demand

8. Indonesia is a country with the largest population in the Southeastern region. The number of its population reached 252 million people in 2014 and 254.9 million people in 2015. With such a huge number of population and a high rate of growth, health constitutes a fundamental human need where human beings struggle for their physical, spiritual, and social welfare so as to be continually capable of conducting activities in a productive manner and the need for medicines not just limited to certain ages, but as long as human beings live will be always in need of medicines to cope with various types of disease and to maintain the quality of health.

9. Based on the said matter, the government has placed the development of community health as an integral part of the national development aimed at promoting awareness, willingness, and capability to live a healthy life for every person so as to materialize the health status of the people to best possible extent. Law Number 36 Year 2009 regarding Health (Law No.36/2009) stipulates that the government guarantees quality, safe, efficient, and affordable health efforts as well as assures the availability, even distribution, and affordability of health stocks, including medicines since the needs for medicines are not merely limited to certain ages, but as long as human beings live will always need medicines to get rid of various sorts of illness and to keep the quality of health.

10. In health economics, in general demand for health is defined as goods or services that are truly purchased by patients. The term demand is differentiated from the term need and want. Need is goods or services that are deemed the best by health service providers to be used in the context of improving the health of patients, meanwhile want is goods or services that are desired (requested) by patients, for example inexpensive medicines, efficacious medicines, and others. Such classification by differences is considered necessary especially in the health economics and public health aimed at reducing the gap between need and want.

11. Generally, demand is measured on the basis of the bed occupancy, number of visitor, number of diagnostic tests, and so forth. Demand for health services dominantly is very much influenced by various factors, namely tariff (price), patient's income, patient's preferences, and alternatives goods (availability and price). The relationships of such factors to demand for health services very varied. The price of health services has a negative link to demand for health services, the higher the price, the the lower the demand for health services will be. A similar relationship also transpires between the availability of alternative goods and the demand for health services. In the meantime, the incomes and preferences of patients as well as the price of alternative goods do have a positive relationship with the demand for health services.

12. In the context of enhancing demand for the employing of professional medical personnel, the Government will bear health insurance premiums for poor communities and will obligate employers to co-bear health insurance premiums so that workers will have the capability to reach the price of the relevant health services. Basically, health care benefit for poor communities has been borne by the Central Government under a Jamkesmas program and by Regional Governments under a Jamkesda program.

2.2. Supply

13. In general, supply for health services is defined as the provision of health services rendered to patients by the combination between medical personnel and health facilities (hospitals, clinics, and clinical laboratories, etc.). Factors that affect supply for health services are Man, Money, Material, Method, Market, Machine, Technology, Time, and Information, known as 6M, 2T, and 1I.

Table 1. Supply Health Services

No.	Supply Factors	Explanations
1	Man	Human resources who provide health services, both directly and indirectly, for instance: doctors, nurses, pharmacists, administrators, etc.
2	Money	Costs that arise in any health services, for instance: operational cost, investment cost, etc.
3	Material	Materials that are related to logistics, for instance: medicines, syringes, stethoscopes, etc.
4	Method	Standard Operating Procedure for health services, for instance: procedures for medical actions.
5	Machine	Equipment used in health facilities, for instance: dental chairs, laboratory equipment, etc.
6	Market	Working Territory of Health Facilities
7	Technology	Technology in health facilities
8	Time	Time used in the provision of health services
9	Information	Information in the form of health services

14. In general, the condition or quality of the determinants of supply determines the quality of health services. Determinants of 'Man' constitute the most dominant determinants in determining the condition of other determinants. This can be understood since other determinants are provided and managed by determinants of 'Man'.

3. The Government

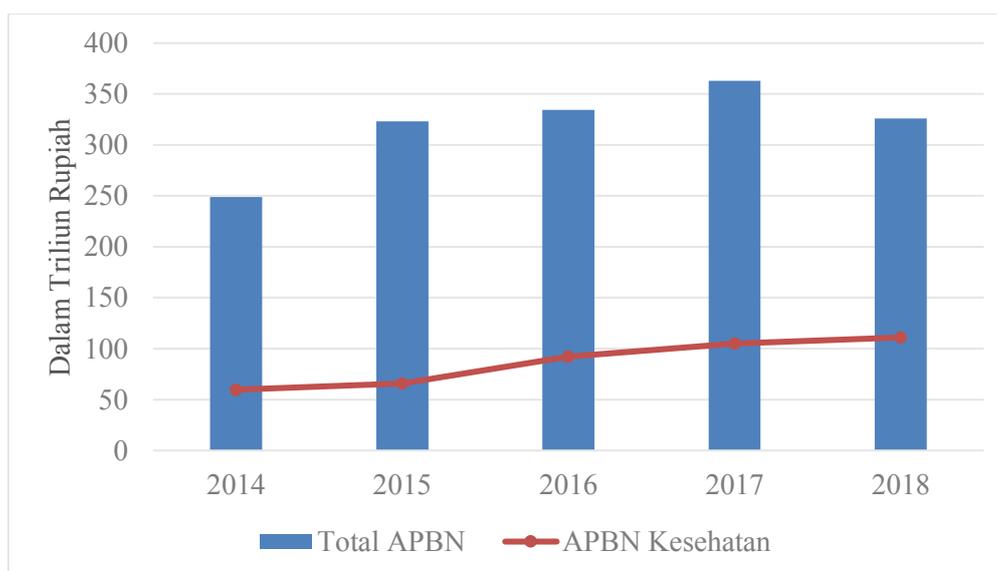
3.1. Vision, Mission, and Government Expenditure

15. Based on the Long-Term Development Plan 2005-2025 (RPJPN) in the field of human resources (HR) development, the Indonesian Government has a vision “To materialize healthy, smart, productive, and having a noble character Indonesians’ (National Development and Planning Agency, 2005). The quality of human resources dominantly is determined by Education and Health (Theodore W. Schultz, 1962). Moreover, according to the United Nations Development Program (UNDP), the Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living.

16. In health aspect, the Government endeavors to improve health services that are sustainable and having a good quality for the poor and the quality of community health through the improvement of healthy behavior of the community. Among other things, through the issuance of Law Number 40 Year 2004 regarding the **National Social Security System (SJSN)** (Republic of Indonesia, 2004) and Law Number 24 Year 2011 regarding **Social Insurance Administration Agency (BPJS)** (Republic of Indonesia, 2011) under the **National Health Security (JKN)** scheme.

17. Based on the data of the Ministry of Finance, the 2018 State Revenues and Expenditures Budget (State Budget/ APBN) is Rp 325.9 Trillion. In accordance with an Article 171 of Law No.36/ 2009 regarding Health states that “the Government shall allocate a health budget of 5% of the State Revenues and Expenditures Budget.” (Republic of Indonesia, 2009a). The 2018 State Budget in the field of health increases in the amount of Rp 0.8 Trillion. In aimed improving the supply side and services, promotive-preventive health efforts, and maintaining the sustainability of the JKN.

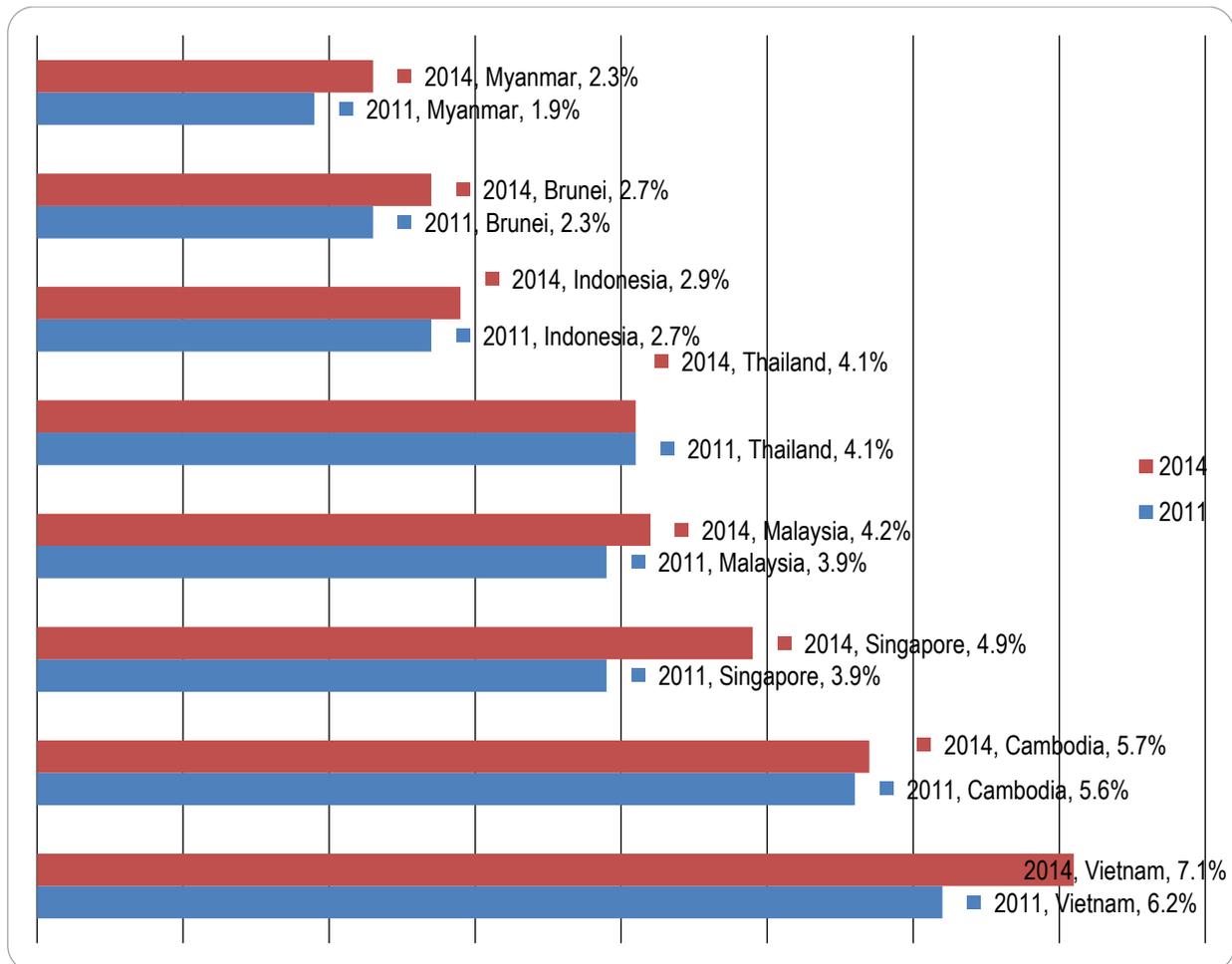
Figure 1. The Comparison of the Total State Budget with the Health Budget year 2018



Source: Ministry of Finance, 2018.(red: health budget, blue: state budget)

18. However, government expenditures in the field of health were very small, compared to those of other ASEAN countries, it is 2.9 % in the year 2014 which increased by only 0.2% for 3 (three) years as compared to Malaysia of 4.2% and Singapore of 4.9% with a per capita health expenditure per year in amount of US\$99.4 in 2014 compared to Malaysia of US\$455.8 and Thailand of US\$ 227.5.

Figure 2. Health Expenditure Ratio to GDP



Source: Processed by WHO, 2017.

19. This has resulted in lack of facilities and employees needed for public service and has spurred the growth of private health facilities. Therefore, the Government has a development target in the field of health in the year 2018, namely:

- Program Indonesia Sehat (Healthy Indonesia Program).
- Family Planning (KB) equality and quality of family planning and that of reproduction.
- Provide health facilities with best quality.
- Immunization for children of age 0-11 year

- Certification of drugs and food.
20. With the following policy directions, namely:
- Improve and enhance the distribution of health facilities and medical personnel.
 - Strengthen promotive and preventive programs aimed at noncommunicable diseases and program for pregnant and lactating mothers.
 - Promote the role of regional governments for the supply side and the improvement of the quality of services.
21. The challenges facing the Government in the field of health are broadening the JKN scheme in the year 2019 as well as coping with the regional gaps in the quality of services and accessibility, managing resources effectively, bearing the costs and minimizing frauds, engaging the private sector, and maintaining investments in health promotion and prevention program (WHO, 2017).

3.2. Regulation and Government Third Party Payers.

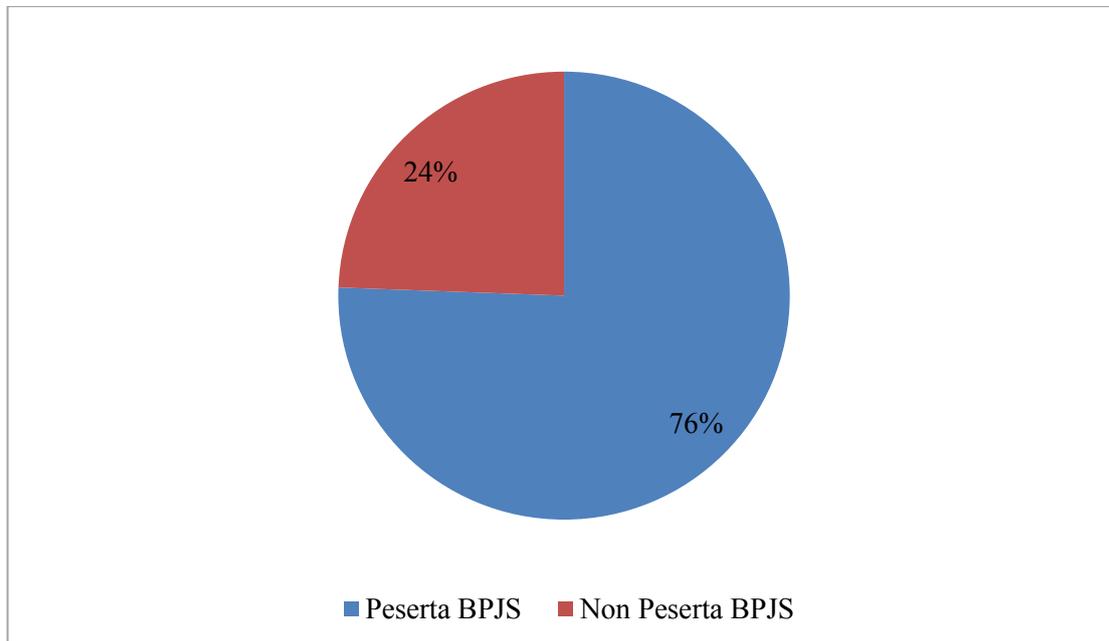
22. Based on SJSN Law and BPJS Law, the Social Insurance Administration Agency (BPJS) is a legal entity established to administering social security programs. In order to be able to administer a social security program, BPJS was divided into two, namely: BPJS Kesehatan (Health BPJS) and BPJS Ketenagakerjaan (Manpower BPJS). BPJS Kesehatan/Health BPJS administer health security programs and BPJS Ketenagakerjaan/ Manpower BPJS administers occupational accident, death, pension, and old age allowance security programs. Consequently, the Government begins to apply a Universal Health Coverage (UHC) policy, in terms of the rendering of health services to the community (Janis, 2014). The Indonesian health system adopts a mixed system, namely health facilities providers and health financing providers can be conducted by the public and the private sector.

23. Based on BPJS Law, BPJS shall have the following duties:
- conduct and/or accept the registration of Participants;
 - collect and gather Premiums from Participants and Employers;
 - receive Premium Assistance from the Government;
 - manage Social Security Funds for the interest of Participants;
 - gather and manage the data of the Participants of the Social Security Program;
 - pay for the Benefit and/or finance health services in accordance with the provisions on Social Security program; and
 - give information about the administration of the Social Security Program to Participants and the community.
24. Based on BPJS Law, BPJS shall have the following authorities:
- collect the payments of Premiums;
 - place Social Security Funds for short-term and long-term investments by taking the liquidity, solvability, prudence, fund security, and adequate proceeds aspects into account;

- supervise and examine the compliance of Participants and Employers with the fulfillment of their obligations in accordance with the provisions of laws and regulations regarding the national social security;
- enter into agreements with health facilities with regard to the payments of health facilities concerning the amount of the payments of health facilities by referring to the standard tariff as stipulated by the Government;
- draw up or terminate work contracts with health facilities;
- impose administrative sanctions on Participants or Employers not fulfilling their obligations;
- report Employers to the competent authority with regard to the noncompliance with the payments of Premiums or with the fulfillment of other obligations in accordance with the provisions of laws and regulations; and
- establish cooperation with other parties in the context of the administration of the Social Security Program.

25. Based on the data of BPJS Kesehatan, up to August 1, 2018, the number of participants of the JKN program reaches 200,286,632 people. This number is 76% of the number of the Indonesian Population in the Year 2018 which based on the 2013 projection of the National Development Planning Board (BAPPENAS) would reach 265 million people.

Figure 3. The Percentage of BPJS and Non BPJS Participants



Source: Processed by BPJS and Bappenas, 2018. (blue: BPJS member red: non BPJS member)

26. Based on the data of the Financial Services Authority (OJK) in the 2016 insurance statistics, the increase of the highest gross premiums in 2016 was obtained by BPJS in the amount of 30.4%. Claims paid by BPJS increased by 15.7%, from previously Rp75.00 trillion to Rp86.81 trillion. The amount of the assets of BPJS increased by 27.5% from

previously Rp 226.92 trillion in 2015 to Rp 289.42 trillion in 2016 or amounting to 28.7% and the investment fund by BPJS was 32.4% (Financial Services Authority, 2017).

4. Health Facilities in Indonesia

27. Article 1 paragraph 7 of Law No. 36/2009 regarding Health states that "Health facilities shall be an instrument and/or place used to administer health service efforts, both promotive, preventive, curative, and rehabilitative made by the Government, regional governments, and/or the community." (Republic of Indonesia, 2009). Furthermore, based on Article 30 paragraphs 1, 2, and 3, Health Facilities according to the type of services thereof shall consist of the following:

- Individual Health Services, and
- Community Health Services.

28. In the meantime, the level of health service facilities shall include:

- Level One Health Services,
- Level Two Health Services, and
- Level Three Health Services.

29. As well as, health services activities shall be conducted by the following:

- The Central Government,
- Regional Governments, and
- The Private Sector.

30. Based on Regulation of the Minister of Health Number 5 Year 2018 (Health Minister Regulation/ Permenkes No.5/ 2018) regarding the third amendment to Regulation of the Minister of Health Number 71 Year 2013 regarding Health Services at the National Health Security (Health Minister Regulation, 2018), level one Health Facilities in Article 2 paragraphs 2 and 3 can be in the form of the following:

- community health center or the equivalent;
- physician practice;
- dental practice;
- primary service physician practice;
- primary clinic or the equivalent; and
- primary D class hospital or the equivalent.

31. Further level referral Health Facilities can be in the form of the following:

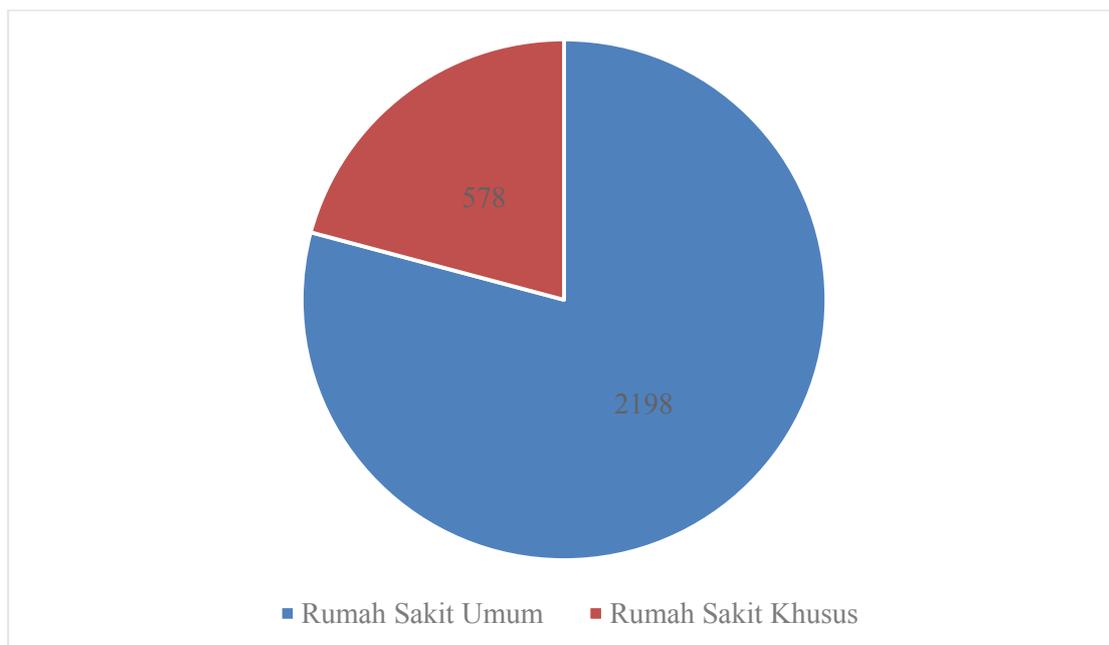
- principal clinic or the equivalent;
- general hospital; and
- special hospital.

32. Article 7 paragraph 2 of Law Number 44 Year 2009 (Law No. 44/ 2009) regarding Hospitals states that "Hospitals can be established by the Government, Regional

Governments, or the private sector.” Furthermore, Article 7 paragraph 3 states that “Hospitals established by the Government and Regional Governments as intended in paragraph (2) must be in the form of a Technical Implementing Unit of the Agency serving in the field of health, certain Agency, or Regional Technical Institution with the management of Public Service Agency or Regional Public Service Agency in accordance with the provisions of laws and regulations.” Furthermore, Article 7 paragraph 4 states that “Hospitals established by the private sector as intended in paragraph (2) must be in the form of legal entity the business activity of which only engages in the field of hospitals.” (Republic of Indonesia, 2009)

33. The number of private hospitals in Indonesia has grown since the implementation of the JKN, but is concentrated on Java and Sumatra. Based on the data of the Ministry of Health, the number of community health centers in Indonesia in 2017 was 9,825 community health centers and the number of hospitals in Indonesia in 2017 was 2,776 hospitals comprising among other things 2,198 general hospitals and 578 special hospitals or 79% constituting general hospitals as compared to 21% constituting special hospitals.

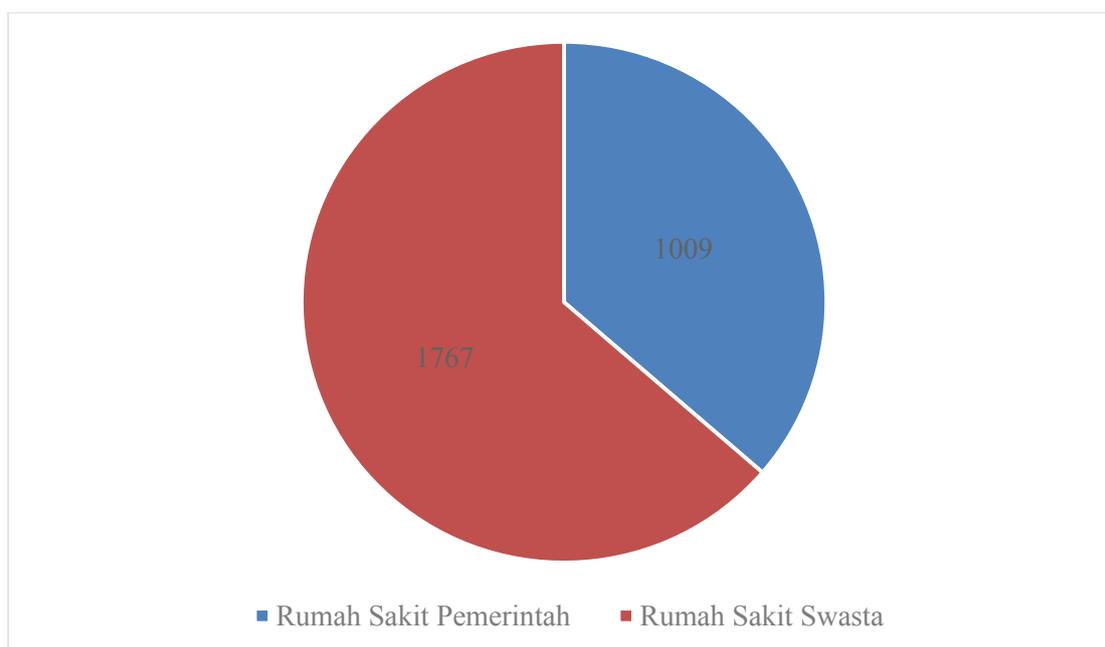
Figure 4. The Number of Hospitals in Indonesia



Note: (blue: public hospitals, red: private hospitals)

Source: (Ministry of Health of RI, 2018)

34. Furthermore, the number of hospitals based on the administrators is divided into two, namely government hospitals and private hospitals. The number of government hospitals is 1,009 hospitals and that of private hospitals is 1,767 hospitals or 36% is managed by Government Hospitals and 64% is managed by Private Hospitals.

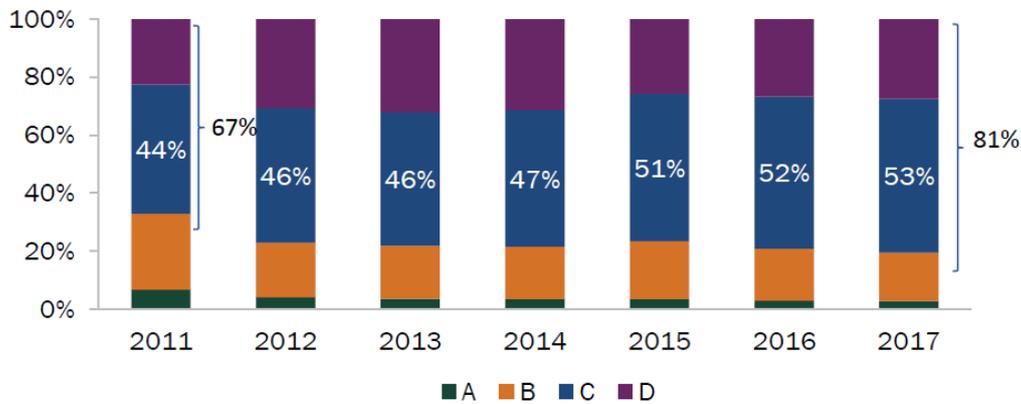
Figure 5. The Number of Hospitals based on Government and Private Administrators

Note: (red: government hospitals, blue: private hospitals)

Source: (Ministry of Health of RI, 2018)

35. Article 170 paragraph 3 of Law No.36/2009 states that “Sources of health financing shall come from the Government, regional governments, the community, the private sector, and other sources.” Furthermore, Article 171 paragraph 1 states that “The amount of the Government health budget shall be allocated in a minimum amount of 5% (five percent) of the state revenues and expenditures budget outside salaries.” Furthermore, Article 171 paragraph 2 states that “The amount of health budgets of provincial governments, regency/ city governments shall be allocated in a minimum amount of 10% (ten percent) of the regional revenues and expenditures budget outside of salaries,” and Article 173 paragraph 1 states that “The allocation of health financing coming from the private sector as intended in Article 170 paragraph (3) shall be mobilized through the national social security system and/or commercial health insurance.” (Republic of Indonesia, 2009).

36. Based on BPJS rule, patients must access the first services through primary care level and shall be referred to Class D and Class C hospitals. In the event that a further specialist care is needed, then it shall be further referred to Class B and Class A hospitals.

Figure 6. Class-Based Hospitals

Source: Ministry of Health, 2018

5. BPJS and Health Facilities

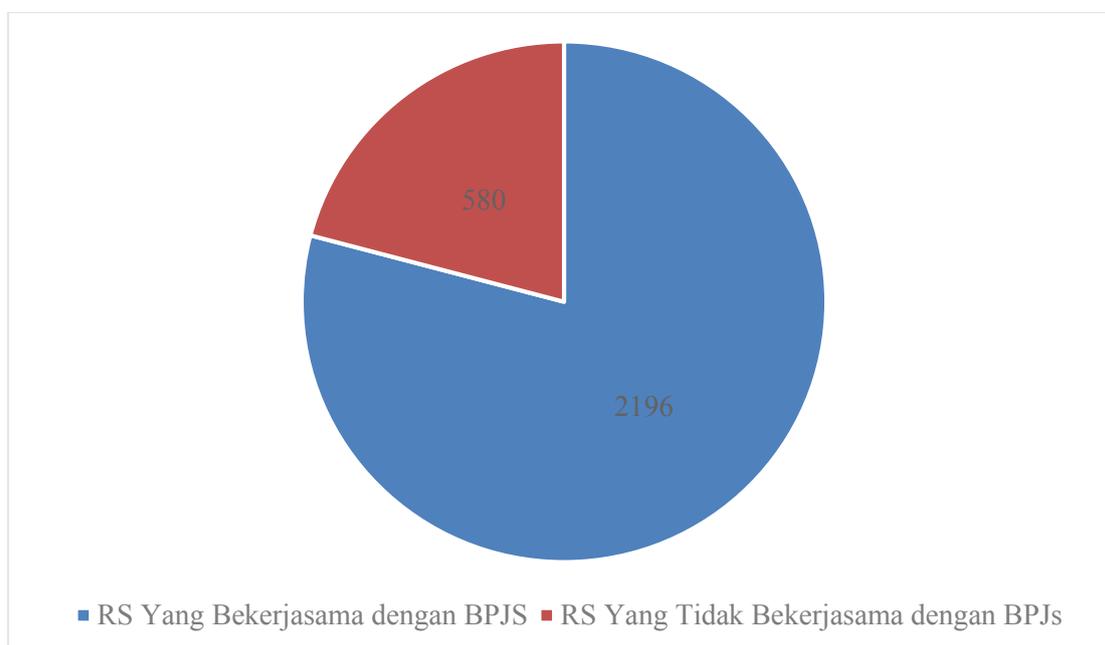
37. Government Decision for entering into a contract with private health facilities to offer the JKN benefit package has made insurance user market grow significantly overnight. BPJS has the authorities to make payments to health facilities based on the standard tariffs as stipulated by the government and/or in order to enter into or terminate a contract with health facilities as well as to establish cooperation with other parties in the context of the security program. In this regard, there is no agreement with regard to the amount of payments between BPJS and health facilities providers and it is only the Ministry of Health that has been given mandate to make a final decision.

5.1. Contract with Health Facilities

38. BPJS as health services must ensure that they enter into a contract with private health facilities that offer high quality, efficient, and effective services by enforcing a referral mechanism and granting investment incentives and expansion of services through interesting tariffs. In one case, an emergency service is provided by a health facility provider that has yet to sign a cooperation agreement with BPJS, the provider may still claim the cost to BPJS and is compensated in accordance with the local tariff by the health facility provider (WHO, 2017).

39. Based on the Data of BPJS as per August 2018, 2.196 hospitals have cooperated with BPJS. The total number of Hospitals in Indonesia is 2,776, thus, indicating that 580 hospitals have not yet been cooperate with BPJS.

Figure 7. The Comparison between Hospitals Already Cooperating with and not Cooperating with BPJS



Note: (blue: hospitals cooperate with BPJS, red: hospitals has not yet cooperate with BPJS)

Source: BPJS, 2018

40. JKN levels the playing field with its flat payment structures, motivating competition among providers and incentivizing investment in quality, service offerings, and efficiency. As noted earlier, JKN created a huge market for private providers. Such positive business prospects should increase the number of hospitals within a catchment population, increasing competition between the public and private sectors as well as among private providers. All private hospitals of the same class (A, B, C, or D) should receive the same reimbursement rate per type of hospital admission. Since patients have the ability to choose their hospital, private hospitals should be driving investments toward those that increase their competitiveness, including through improved quality or patient experience. Ultimately, such competition should lower cost of service for BPJS-K and improve the quality of services (Britton, Koseki, & Dutta, 2018).

5.2. Payment for Health Facilities

41. Based on Regulation of the Minister of Health Number 27 Year 2014 regarding Technical Guidelines for Indonesian Case Base Groups (INA-CBGs) System, health Financing constitutes the most important part in the implementation of the National Health Security (JKN). There are two hospital payment methods that have being used, namely retrospective payment method and prospective payment method. Restrospective payment method is a payment method made based on health services rendered to patients on the basis of each service activity given, the more the services rendered the larger the costs that must be paid. The example of retrospective payment system is Fee-For-Services (FFS). Prospective payment method is a payment method made based on health services the amount of which has been known prior to the rendering of the health services. The example of prospective payment is global budget, Per Diem, Capitation, and case-based payment.

42. BPJS has established coordination of benefits (COB) with some of the leading private health insurance providers to provide a top-up option for middle-and-high-income members of the JKN (BPJS Kesehatan, 2016).

43. BPJS has established a monopsony, so competition by price will not be possible. While that should incentivize competition by quality differentiation, our data indicates that the demand is higher than the (albeit increasing) supply of hospitals, so there is less need to try to differentiate by quality. On the other hand, many hospital owners see the immediate challenge of managing their cost against the tariff rates, which seems to compel them to focus on cutting costs rather than investing in service expansion and quality improvement (Britton et al., 2018).

6. Patients

6.1. Patient Information

44. In general, people have a little information about the quality of health services available for them both at general hospitals and private hospitals. The example is Not giving honest, ethical explanations and understanding to patients or their families in doing medical practices. When a patient enters a medical service system, their rights to information are guaranteed by the law.

6.2. Patient Choice

45. Indonesia has a double system in the use of health insurance. Any person is free to choose insurance publicly or privately. Users are only limited by the ability and willingness to pay for the use of private insurance, except in several provinces where the regional governments obligate private hospitals to admit patients under the regional government insurance scheme.

46. Based on Regulation of the Minister of Health Number 6 Year 2018 (Health Minister Regulation No.6/2018), patients intending to enhance health services and having additional health insurance, consequently, the difference of costs shall be paid in accordance with the agreement between the additional health insurance and the hospital. The difference of payments can be made by the participant, employer, and additional health insurance. Provisions concerning additional costs shall be stipulated by the director of the hospital. Furthermore, the hospital shall be obligated to inform the provisions concerning cost difference to patients (Social Security Administering Agency, 2018).

6.3. Patient Rights

47. Health Law, Hospital Law, and mandates of Medical Practice state that patients shall have the rights to health information. Patients shall have the rights to comprehensive information about medical procedures/ treatments that will be received by them, to ask for the second opinion, to receive accurate treatments in accordance with their medical needs, as well as to reject any medical treatments/ procedures whatsoever. Information must be given whether or not the patients ask for it and information about the disease, treatment, prognosis, and alternative treatment is made available without using complicated or complex medical terminology; patients shall also have the rights to be notified of the estimated costs.

48. Physicians might face sanction discipline if they do not give adequate information to patients and/or their families. Patients shall also have the rights to obtain copies of their medical records.

49. In order to ensure the rights of the disabled, there is a regulation regarding the accessibility to enable physical access to health facilities for the disabled applicable to any building owned by the government and that of the private sector/non-government, in addition to private houses, open to the public. This includes hospitals and facilities of other health services.

7. Pharmacy

7.1. Government Regulation

50. Supervision on Food and Drug in Indonesia is conducted by the National Agency of Drug and Food Control (BPOM). Although a large number of essential drugs are produced locally, 95% of the basic/ active ingredients are still imported (International Trade Centre, 2005a). To ensure quality and pharmacovigilance, pharmaceutical companies have to allow the requirements of good manufacturing practice (GMP) (Minister of Health, 2008c). The first GMP on drug manufacturing (CPOB) in Indonesia was published in 1989 (Minister of Health, 1988; National Agency of Drug and Food Control, 1989) and then revised in 2001, 2005 and 2012 (National Agency of Drug and Food Control, 2012b).

51. The BPOM is a member of the Pharmaceuticals Inspection Convention Scheme (PIC/S) and in order to comply with the PIC/S standard, the BPOM has issued the guidelines on bio-equivalence and bio-availability testing for generic drugs to ensure the high-quality substitutes for original brands (National Agency of Drug and Food Control, 2012a). The enforcement of good distribution practice (GDP/CDOB) by wholesalers and distributors is not comprehensive yet, but the BPOM makes an effort to disseminate and provide training on CDOB (National Agency of Drug and Food Control, 2013b).

7.2. Pharmaceutical Companies

52. Based on the data of the Minister of Health of the Republic of Indonesia in 2013, currently, there are 210 pharmaceutical companies in total spreading out throughout Indonesia, such as Banten, Yogyakarta, West Java, East Java, Sumatra and Jakarta. Several top players in this industry are Kalbe Farma, Sanbe, Soho, Dexa Medica, Tempo Scan Pacific and Pharos Indonesia, with a total market share of the six top players amounts to 27%.

Company	Sales (Million USD)	Market Share
Kalbe Farma	215	7.0
Sanbe	174	5.6
Soho	132	4.3

Dexa Medica	118	3.8
Tempo Scan Pasific	108	3.5
Pharos Indonesia	95	3.1
Dankos	84	2.7
Bayer Indonesia	84	2.7
Interbat	74	2.4
Pfizer	74	2.4

Source: IMS 2009-2013 Market Progress Report.

53. Furthermore, based on the data of the Ministry of Health in May 2018, the total number of pharmaceutical companies decreased from previously 210 pharmaceutical companies in 2016 to 174 pharmaceutical companies spreading out throughout the territory of Indonesia. The following is the table of the number of province-based pharmaceutical companies in Indonesia:

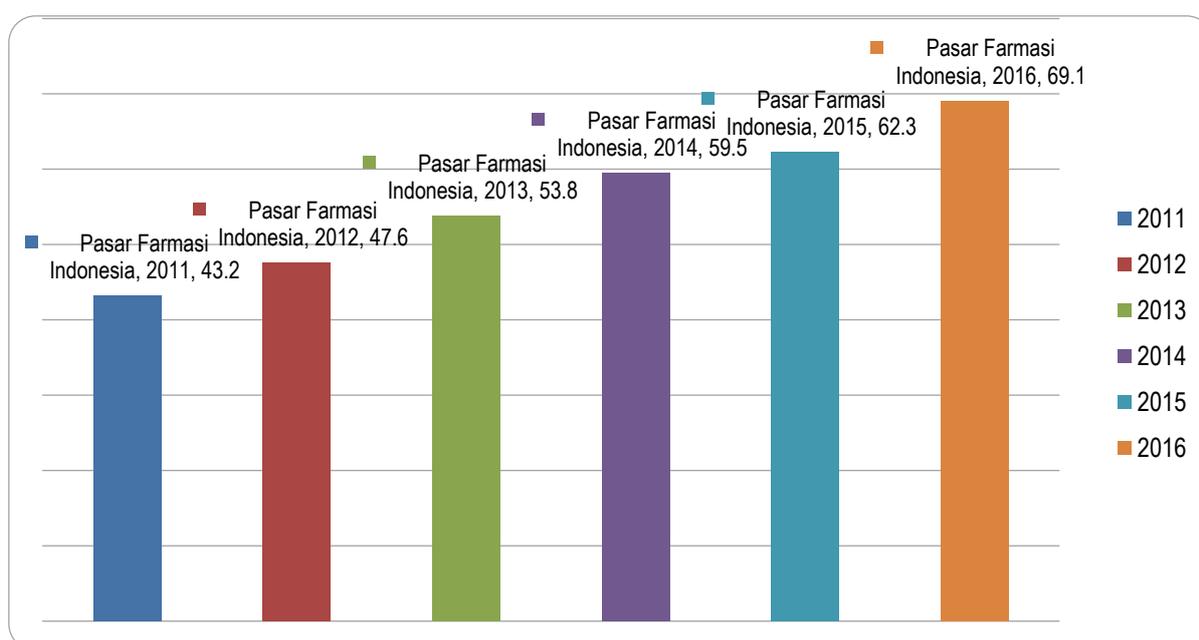
No	Region	Number of Industry
1	Banten	24
2	North Sumatra	3
3	South Sumatra	1
4	West Sumatra	1
5	East Java	34
6	West Java	63
7	Central Java	21
8	DKI Jakarta	26
9	DIY Yogyakarta	1
Total throughout Indonesia		174

Source: Ministry of Health, 2018

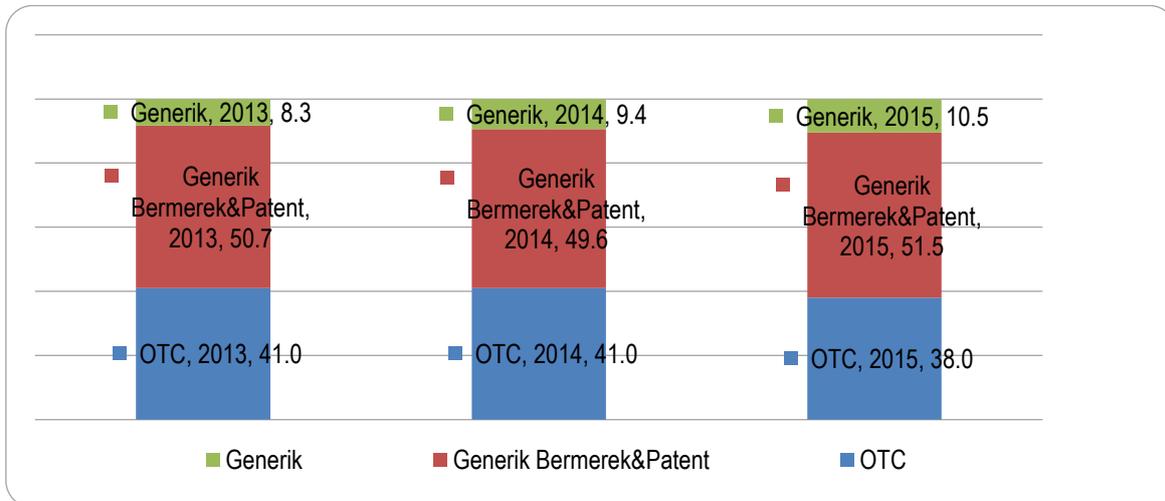
54. Domination of pharmaceutical companies is in the region of Java with a total number of 169 pharmaceutical companies, only 5 pharmaceutical companies are located in the region of Sumatra.

55. The national pharmaceutical market grew 10% on average per year in the 2010-2015 period. The amount of the national pharmaceutical market in year 2015 was approximately Rp62-65 trillion and would increase to Rp69 trillion in year 2016. In year 2015, prescription drugs (*ethical*) dominated approximately 62% of the national pharmaceutical market and the rest are over the counter/OTC drugs of approximately 38%. In addition to the above, prescription medicines are differentiated into patent medicines, branded generic medicines, and generic medicines with logo (OGB).

Figure 8. Indonesian Pharmaceutical Market



Source: IMS Health, 2016

Figure 9. The Composition of Pharmaceutical Market pursuant to the Type of Medicine

Source: IMS Health, 2016

56. The Government of Indonesia has introduced a new method to buy medicines together with the initiation of the National Health Security (JKN), by introducing the procurement of electronic catalogue (e-catalogue). Public sector facilities are obligated to buy medicines, medical devices, and consumables through e-catalogue at the portal of the National Public Procurement Agency (LKPP). All the medicines registered at the e-catalogue must first be inputted into the National Drug Formulary (FORNAS). There are two methods through which a pharmaceutical company may register its drugs at the e-catalogue, namely:

- There is a price limit as set by the Ministry of Health for generic drugs.
- There is a price negotiation for patented drugs.

57. The use of e-catalogue has promoted competition especially in terms of price, but it does affect the quality. Price is the only obvious indicator that stimulates choices at the e-catalogue. A lot of parties have regretted that decisions on pricing and coordination among government ministries/institutions are less transparent.

58. The Indonesian pharmaceutical market has grown absolutely since the commencement of the JKN in 2014. However, sales have slowed down in the last few years and are projected to decrease in 2018 and 2019 for patented and generic drugs. There were only several new companies that had entered the pharmaceutical market since 2014 and there is little evidence indicating that the variation of drugs has increased. However, the JKN has had an effect on the differentiation of market between multinational companies and local ones with the first focus on branded drugs meanwhile the latter focus on generic ones. Competition among domestic companies has increased although it is not clear that the quality of products has increased as a result of such competition. This may pose a concern for patients. The Indonesian health system depends on private pharmaceutical producers and importers for essential drugs and medical devices. A significant increase in the population with the ability to pay through the national health insurance scheme is a business opportunity.

8. Drugs

8.1. Generic Drugs

59. In Indonesia, the price of generic drugs, was followed with its ex-factory/manufacturer price, wholesaler (profit) margin or pharmacy margin (or profit) and any applicable taxes are regulated (Minister of Health, 2012a, Minister of Health, 2012b). To ensure the affordability, availability and distribution of the drugs to fulfill the needs of health care, there is rationalization of the highest retail price (HET) for generic drugs (Minister of Health, 2011c). The HET is valid throughout generic pharmacies, hospitals and pharmaceutical facilities in Indonesia. In other words, any sale of generic drugs can only be made at a maximum price equal to the HET. In general, ‘patent drugs’ (‘branded generic’ drugs or OGBs) are priced at around three times the price of generic drugs. The selling price from the drug manufacturer or pharmaceutical wholesaler to the pharmacy (drugstore net price/HNA) is subject to VAT. The final retail price, what the consumer pays, is also subject to VAT, but there is regulation of the ceiling price of these final highest retail prices (HET). In general, the highest retail price of drugs in Indonesia is higher than in other countries due to the heavy tax burden. It is estimated that in Indonesia, innovator brand names are priced around 20 times the international indicator price, while generic medicines cost nearly 75% more than the international price indicator guide (Chee et al., 2009a). Additionally, the Indonesian consumer is vulnerable to unnecessary medicines. People who buy drugs without a prescription usually pay out-of-pocket at private pharmacies, and any prescription by a private sector provider is usually also paid out-of-pocket. Thus, patients are not concerned about whether or not the drug is in the official formulary, and are not necessarily informed about the substitutability of unbranded generics with the branded generics and originator products (World Bank, 2009b). There is no policy of generic substitution at the point of sales. The government has decreed since 2006 that the generic name of each product should appear on the product label along with the trade name. In accordance with Ministerial Decree No. 068/Menkes/SK/II/2006, the font size of the generic name should be at least 80% of the trade name. This policy aims to familiarize providers and consumers with the generic names. Additionally, since 2010, the government has been encouraging the prescription of medicines by their generic names in all public facilities, and pharmacists are allowed to choose the generic substitution for the prescribed non generic medicines (Ministerial Decree No. PMK No. HK.02.02–068, of 2010). The Directorate General of Pharmaceutical Services is responsible for supervising and monitoring of the implementation of generic prescribing in public facilities.

8.2. National Essential Drug List

60. The national list of essential drugs is regulated to ensure more equal access to medicines for the public (Minister of Health, 2011a). The concept of essential medicines in Indonesia was introduced with the release of the national essential drugs list (DOEN) in 1980, and with the publication of the National Drug Policy in 1983. The DOEN is revised every two years (House of Representatives, 2009). With the DOEN, the availability of essential medicines and essential drugs will be improved because it will correlate with treatment guidelines and formularies in hospitals. The drugs listed in the DOEN are paid for by the government, so that people can easily obtain them. Essential drugs and vaccines are free of charge at puskesmas for the poor and near-poor (World Bank, 2009b).

8.3. Rational drug

61. Rational drug use is regulated in the National Drug Policy (Minister of Health, 2006), but there is a little evidence that it is being implemented in systematic ways among providers. The status of the rational drug use is highly variable among different health-care providers. In fact, there is an indication of wide spread irrational use of medicines, including overuse of antibiotics (World Bank, 2009b).

9. Conclusions

62. The implementation of the SJSN and BPJS policies will enhance the demand for health services especially from the community who all this time has been unable to buy health services, hence, this will result in the increase of fiscal burden. However, the increase of fiscal burden will be counterbalanced by the increase of the community productivity that will have impacts on the development of macroeconomy.

63. We hope that new comers will join in the private provider market, especially in the regions that lack health infrastructure. Prior to the existence of the JKN, people living in rural areas and eastern regions of Indonesia were not considered as a lucrative potential market for private providers due to lower ability to pay and higher service provision costs as compared to regions that are nearer to Jakarta due to longer distribution distance and lack of service providers interested in serving such regions. With the JKN, the poor and the near poor as well as those who live in the eastern regions of Indonesia obtain facilities to pay for health care that should make them a more interesting target market. It is expected that this trend will be stronger in the regions where providers are limited because competition is even lower.

64. Our assessment indicates that the JKN has developed several elements of the private industry, investment incentives, and improved competition, but has yet to holistically stimulate geographical diversity or larger products. JKN may have larger positive impacts on the private sector if the stakeholders do the following matters:

- Clarification of tariff level setting process, including pharmaceutical and commodity costs calculated in the calculation of tariffs so that private players may make decision based on the information about treatment options.
- Further use of health technology assessment to focus on beyond drugs currently paid to use top-up payment by the Health-Social Security Administering Agency (BPJS Kesehatan), in order to also help inform procedures related to the JKN, drugs and medical devices selection process.
- Improved registration of e-catalogue and bidding process of the LKPP (National Public Procurement Agency), especially to consider several possible bid winners for pharmacy, to develop criteria other than the price, and to enable access to private providers.
- Promote a more collaborative role of the private health insurance market so as to act together with the JKN through a method that is stronger than the current coordination of benefits or top-up to enable access to branded drugs and treatment procedures.

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