BPJS Kesehatan
Badan Penyelenggara Jaminan Sosial

EXPERIENCE SHARING

Tackling the Burden of Non-Communicable Diseases: BPJS Kesehatan's Policy and Program Responses

Mahlil Ruby

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SECURE WEBINAR 21

Jakarta, May 15th, 2025

Curriculum Vitae

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Education Experience :

- University of Syiah Kuala Banda Aceh, General Practitioner, Bachelor Degree (1992)
- University of Indonesia, Department of Health Administration and Policy, Master Degree (2000)
- University of Indonesia, Public Health (Public Health Policy, Health Economics & Insurance), Doctorate Degree (2007)

Work Experience :

- Head of Public Health Center in Aceh Province (more than 10 years)
- Health Expert for Commission IX of National Parliament (2009)
- Health Advisor for Public Services I RTI (2009-2013)
- National Advisor for Social Health Insurance GIZ - Social Protection Program (SPP)
- National Social Health Insurance (JKN) Specialist DAI – USAID Jalin (2018 – 2020)
- Director of Planning and Development of BPJS Kesehatan (2021 – present)
- Lecturer and Examiner of Doctoral Program, Faculty of Public Health, University of Indonesia

1. OVERVIEW NATIONAL SOCIAL HEALTH INSURANCE (JKN PROGRAM)
2. RESPONSE IN MANAGING NCD
3. KEY TAKEAWAYS

I. OVERVIEW
NATIONAL SOCIAL HEALTH INSURANCE (JKN PROGRAM)

1A. BPJS KESEHATAN BUSINESS MODEL IN JKN PROGRAM

Not-For-Profit Legal Entity, Single Payer, Directly under President of RI

Ina-CBGs and Non-InaCBGs, MAB, Q and CCT, AFS

According to Act no 40 year 2004 on National Social Insurance, health insurance is based on social insurance and equity principles (article 19 number 1)

Managed care

Run by ±8500 dedicated young personnels with Org. cultural values : INISIATIF Monitored by KPI

Government

3b Premium

Subsidize premium

Wages
1. Subsidized members (MOSA, MOF, MOH, MOHA and Local Gov)
2. Wages, 1%:4% (CS & Non-CS)
3. Contribution approx. $3, $6, $10

Contribution

*CS: civil servant

5 Regulator

All main activities are supported by Advanced IT System

Government Beneficiaries

Non Government Beneficiaries

Referral Health Care

- Hospitals
- Clinics

Contract 4a

4c Referr

4d Referr back

- Pharmacys
- Laboratory
- Optics

- Community Health Centers
- General Practioners
- Clinics
- Seconday Health Care (Hospital Type D)

Contract 4a

Primary Health Care

Capitation based payment and Non-Capitation

Stratgic Purchasing | Revenue Collection | Risk Pooling

BPJS

Premium 3a

Employers

MEMBERS

Payment Channels (PCs)

±950,000 PCs

5

Register 1

Providing identity, obtaining information on rights and obligations 2

4b Benefit of Services

- Promotional
- Preventive
- Curative
- Rehabilitative

Single Scheme, 98,9% Coverage (279 M), **Deficit (-)** → **Surplus (+)** , Down payment, increased tariff & satisfaction, OOP 49.7% → 25%

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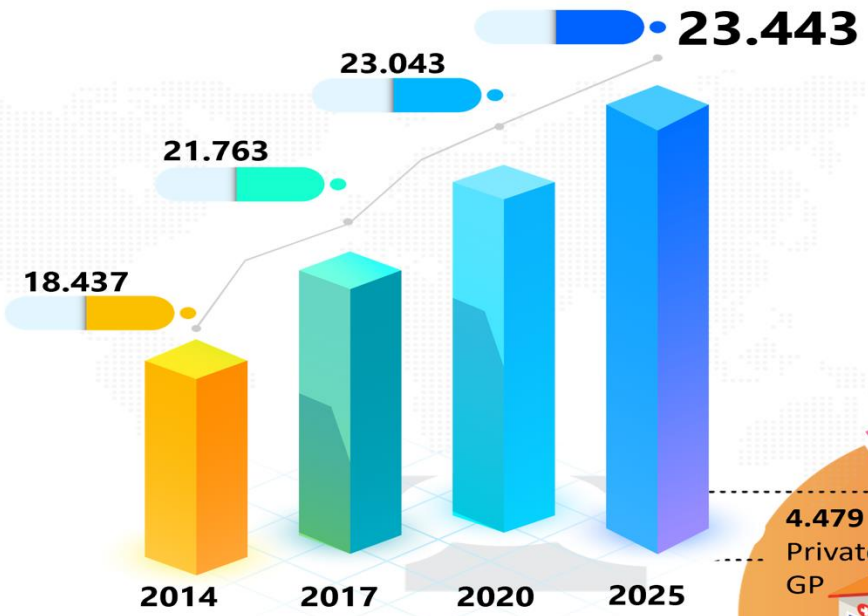
1B. JKN MEMBERSHIP COVERAGE AND EXPANDING ACCESS TO HEALTH SERVICES

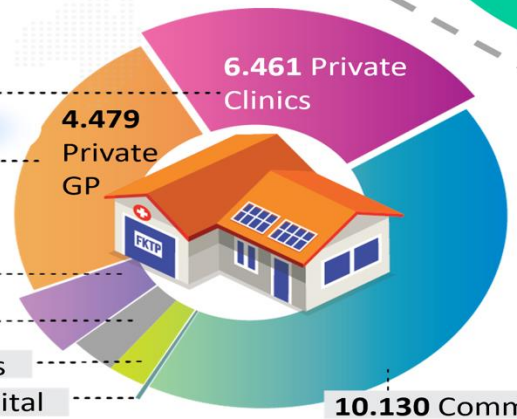
MEMBERSHIP COVERAGE PER MAY 1, 2025

279.836.564 members

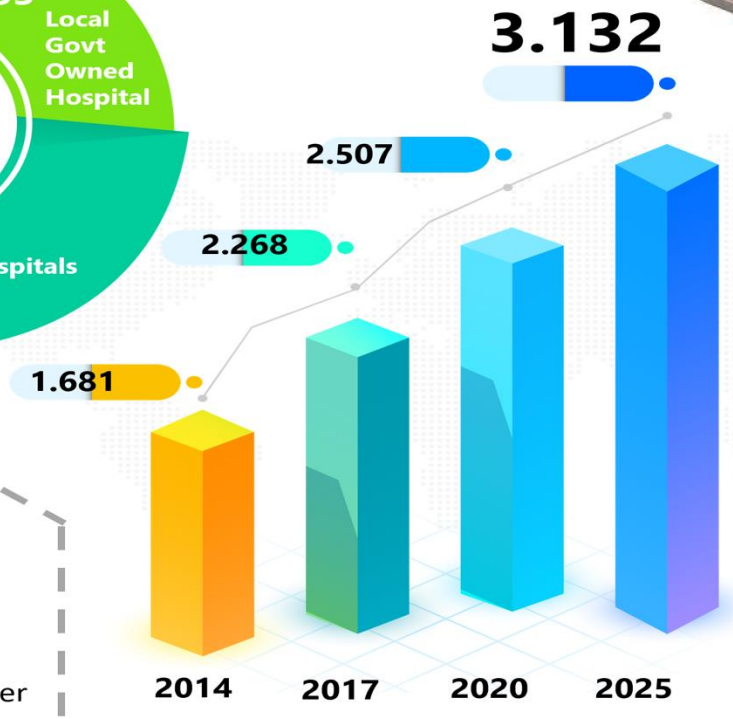
98,2%
OF 284.973.643
TOTAL POPULATION

Primary Health Care





Secondary Health Care (Hospital)



1C. NATIONAL HEALTH ACCOUNT (INDONESIA)

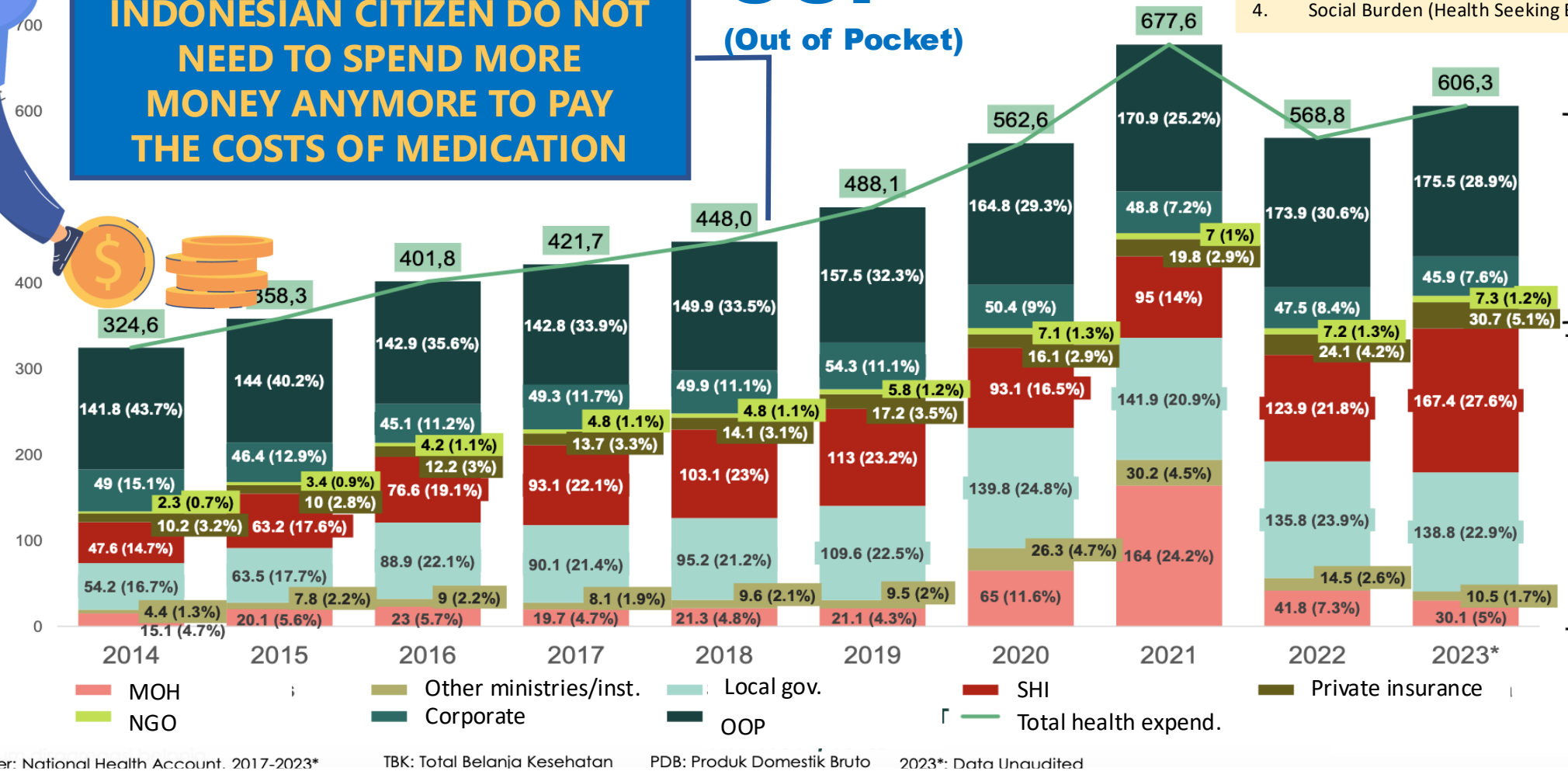
(in Trilion rupiah)

Public health spending on schemes has increased, especially on the Social Health Insurance scheme

INDONESIAN CITIZEN DO NOT NEED TO SPEND MORE MONEY ANYMORE TO PAY THE COSTS OF MEDICATION

OOP
(Out of Pocket)

Public Health Spending factors :
1. Double Burden (Infectious Disease, NCD,and malnutrition);
2. Geographic Burden (archipelago state and transportation)
3. Politic Burden (Decentralization and Government Commitment)
4. Social Burden (Health Seeking Behavior, and Local Culture)



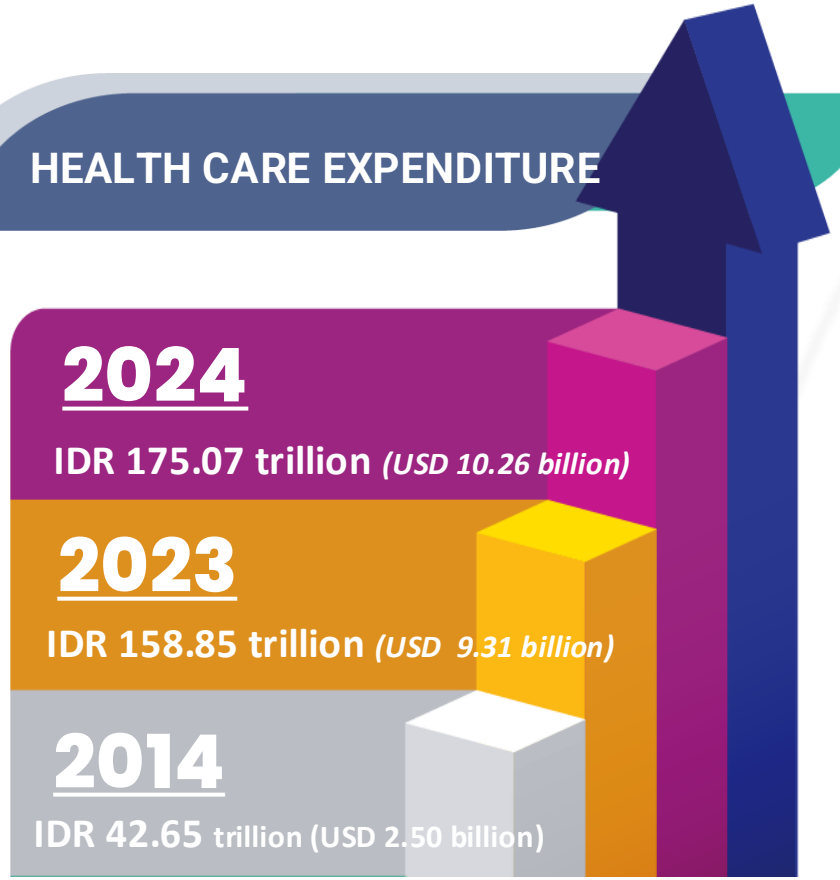
Private scheme spends 42.8% from Total *Health Expenditure* (259.46 B)

Public scheme spends 57.2% from Total *Health Expenditure* (346.84 B)

Sumber: National Health Account, 2017-2023* TBK: Total Belanja Kesehatan PDB: Produk Domestik Bruto 2023*: Data Unaudited

1D. HEALTH CARE SERVICE UTILIZATION

HEALTH CARE EXPENDITURE

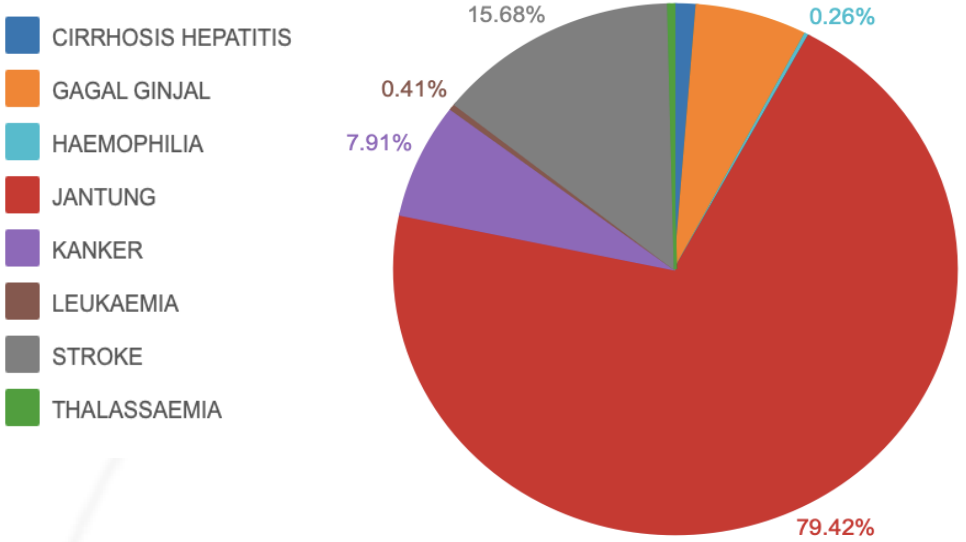


Total health care expenditure in 11 years of JKN implementation
IDR 1,087.4 Trillion (USD 63.77 billion)

Health care service utilization

2024
- 1.9 million visits/day
- 700.42 million visits/year

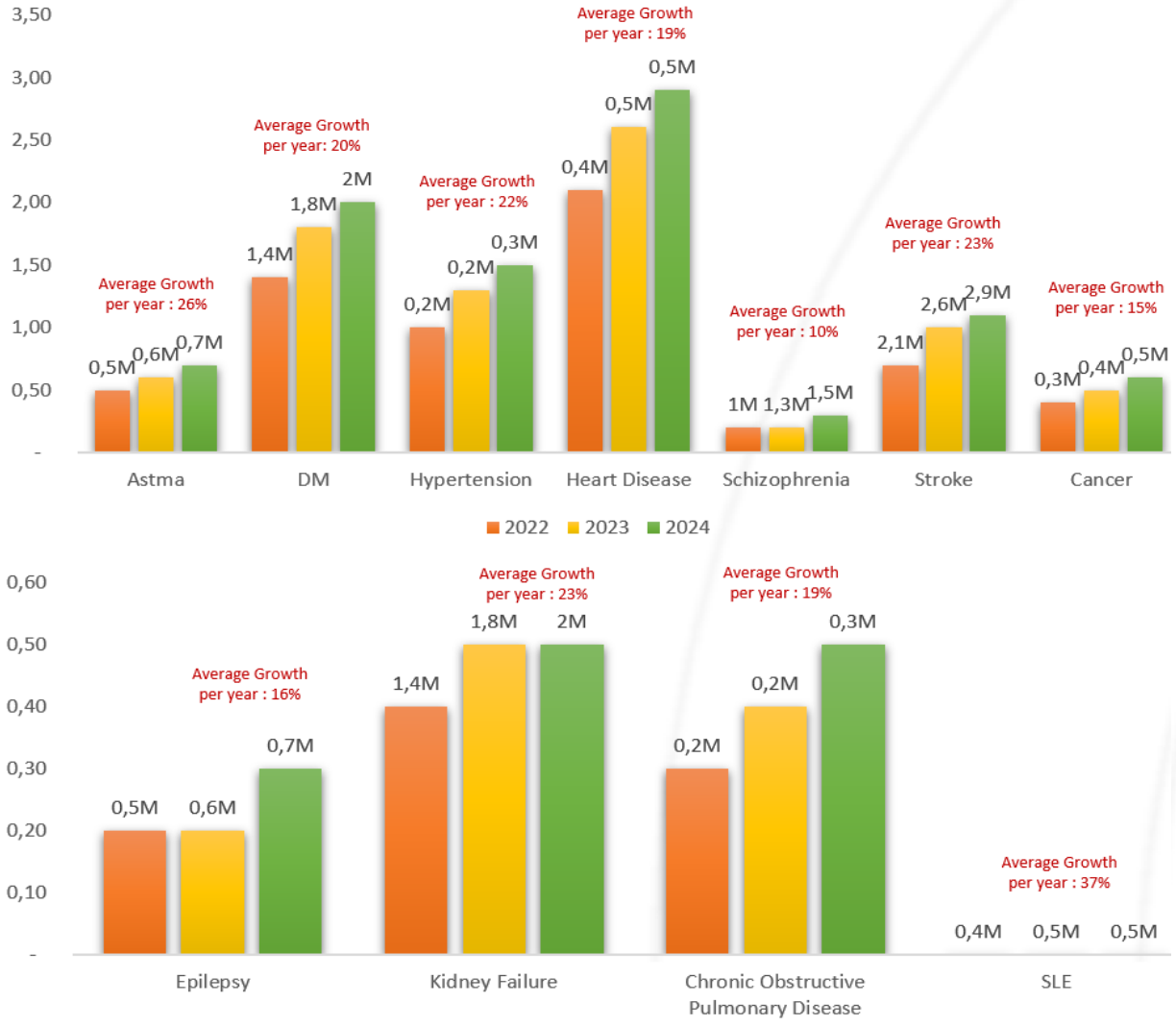
2014
- 252 thousand visits/day
- 92.3 million visits/year



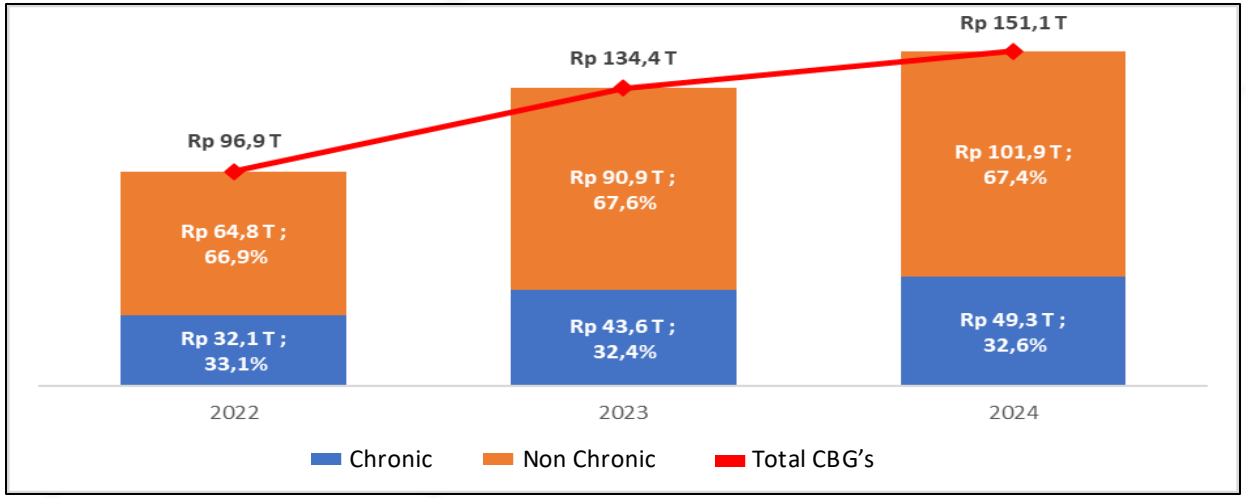
- ✓ **Catastrophic expenditure took part about 24-31%** of the total health care expenditure
- ✓ The total of catastrophic expenditure from 2014 to 2024 is no less than IDR 235 trillion (USD 13.78 billion)
- ✓ Catastrophic expenditure due to heart diseases is the largest proportion

1E. CHRONIC DISEASE PATIENT (JKN PARTICIPANTS)

Trend Total Chronic Disease Patient per Diagnosis 2002-2024 (in mio)



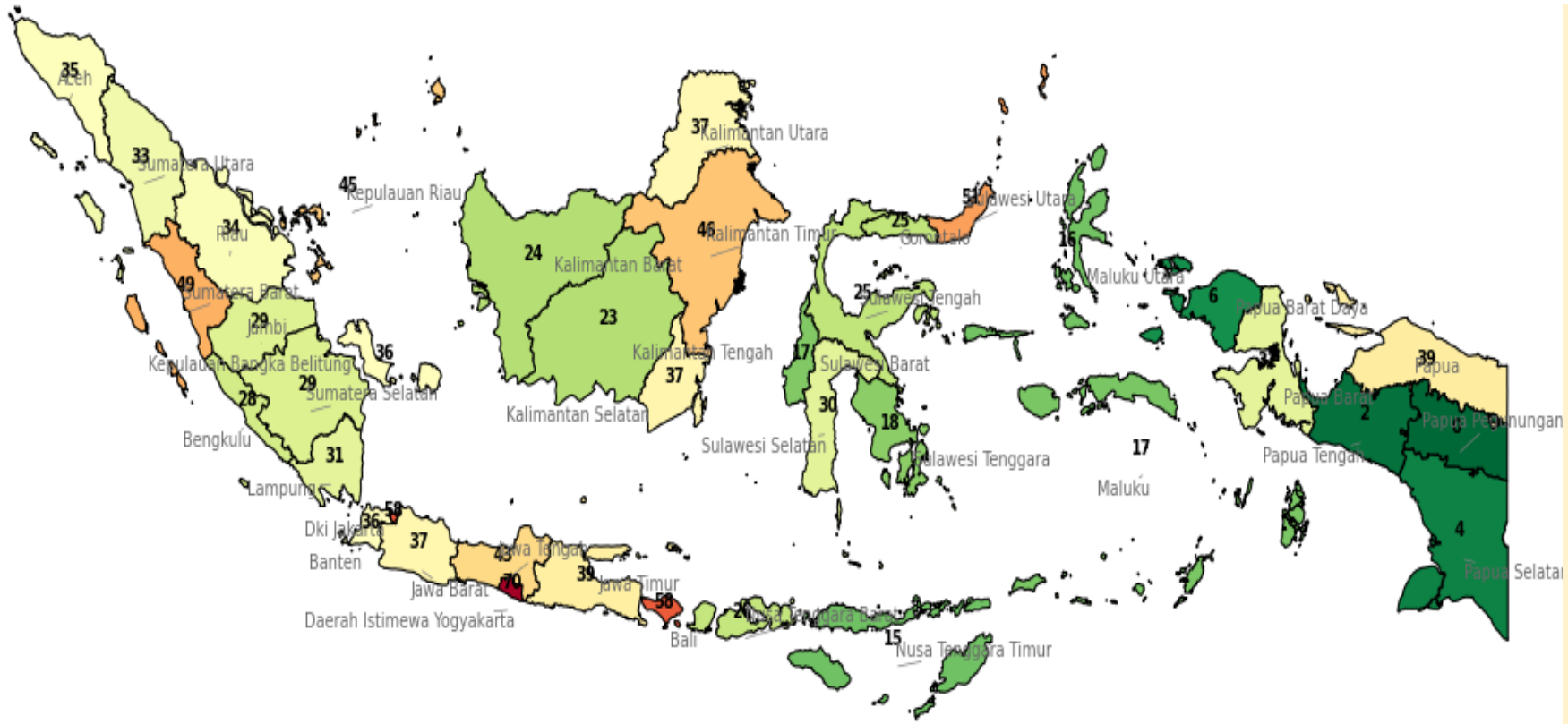
Trends in Health Care expenditure VS Chronic Disease Expenditure in Referral Care Facilities



- ✓ Chronic Disease Patient (JKN Participants) who receive services from JKN continue to increase every year.
- ✓ The highest average annual increase are Hypertension (average 0.9 million), Diabetes (average 0.6 million) and Heart Disease (average 0.4 million)
- ✓ If this condition is not managed optimally, it can lead to financial instability. In long term, it will have an impact on the deficit.

1F. CHRONIC DISEASE CASES (JKN PARTICIPANTS) AND RISK FACTORS

Total of Chronic Disease Cases per Province in 2024 (Per mil)



In terms of rate (permil of JKN participants) the highest are in the Province of DIY (70 permil), DKI Jakarta and Bali (58 permil)

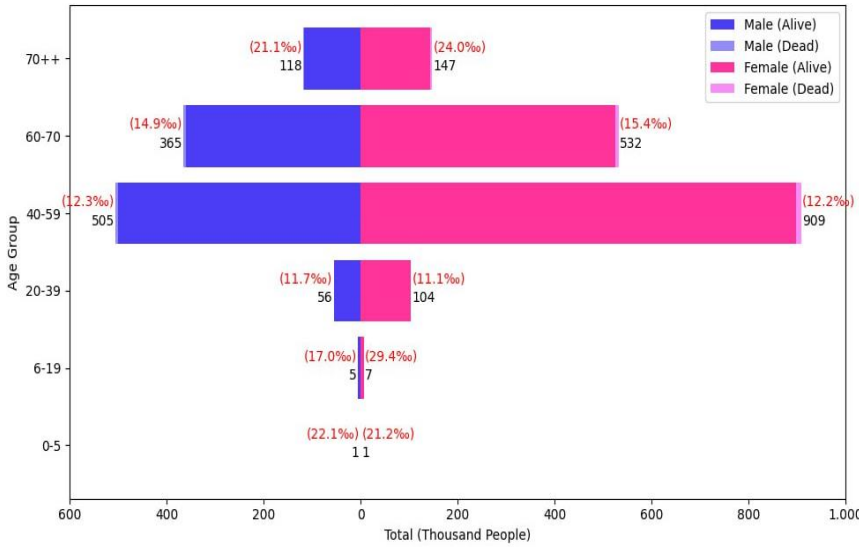
Chronic Disease Risk Factors :

1. Lack of physical activity (33,5% population ≥10 years old)
2. Unhealthy Diet (95,5% vegetables/fruits consumption <5 portion/day)
3. Smoking (28,8% population ≥10 years old)
4. Excessive alcohol consumption (~3,0% (estimation))
5. Overweight (21,8% population ≥18 years old (BMI ≥25)
6. Age (~26,3% population)
7. Sex (50,3% Female, 49,7% Male)
8. Genetic (10-30% depend on kind of disease)

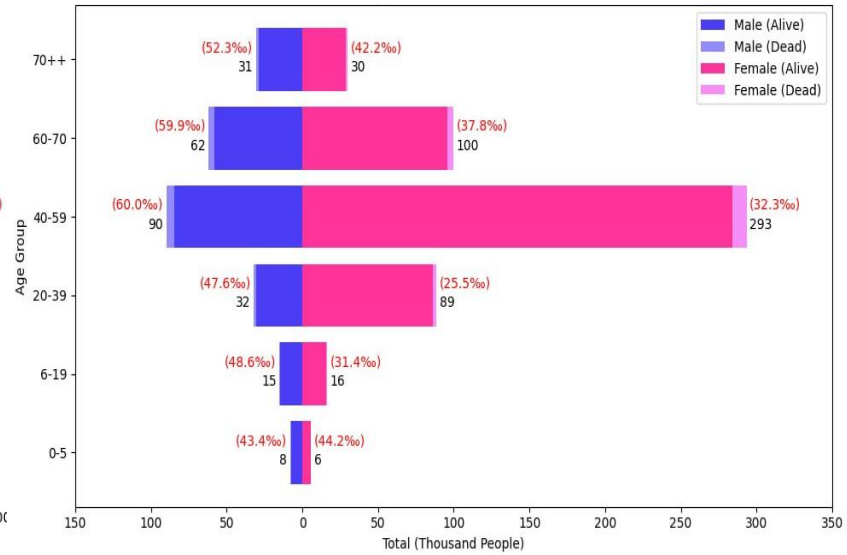
Source : Riskesdas 2018, BPS 2020, WHO 2018.

1G. CHRONIC DISEASE PYRAMID (2024)

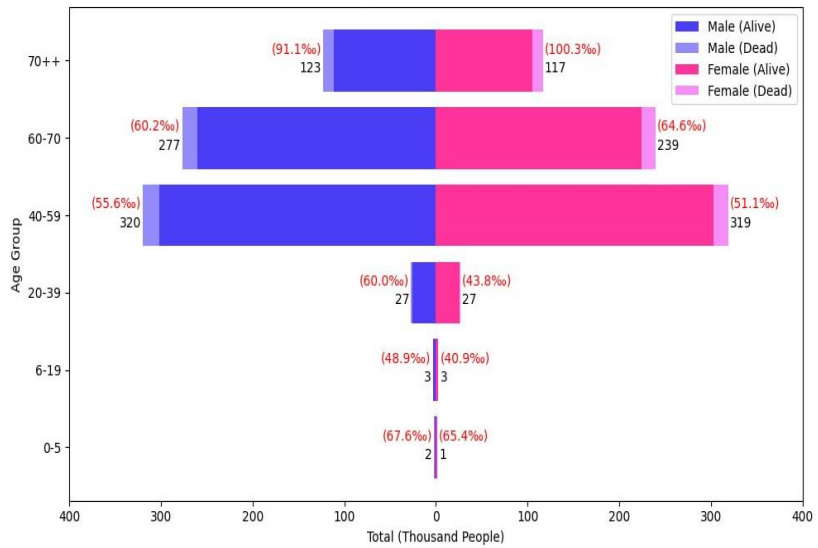
DM Patients (2024)



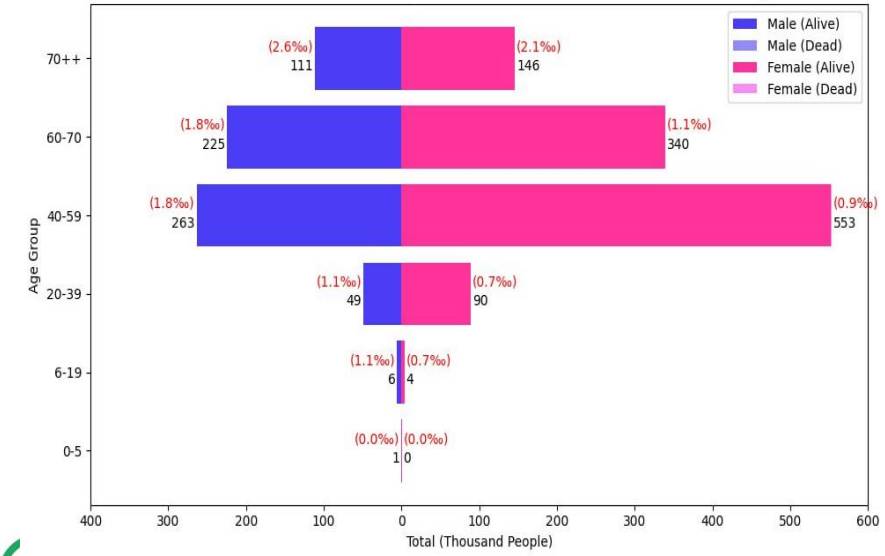
Cancer Patients (2024)



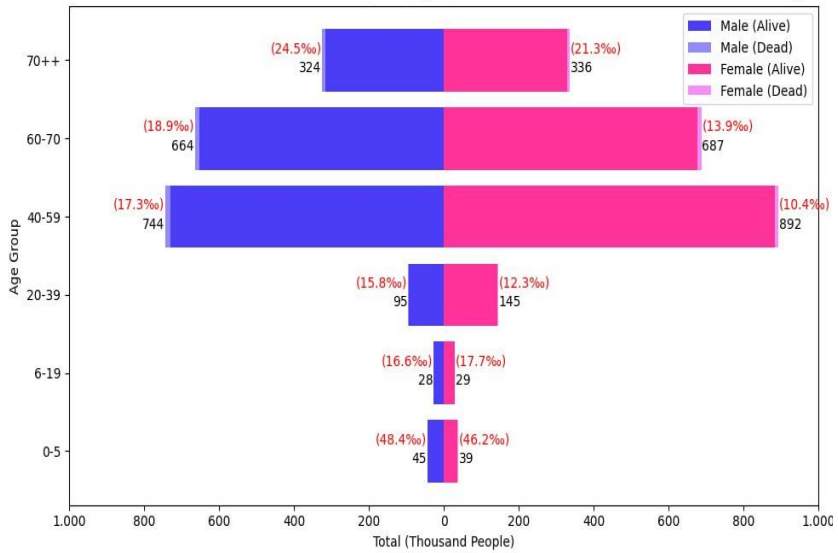
Stroke Patients (2024)



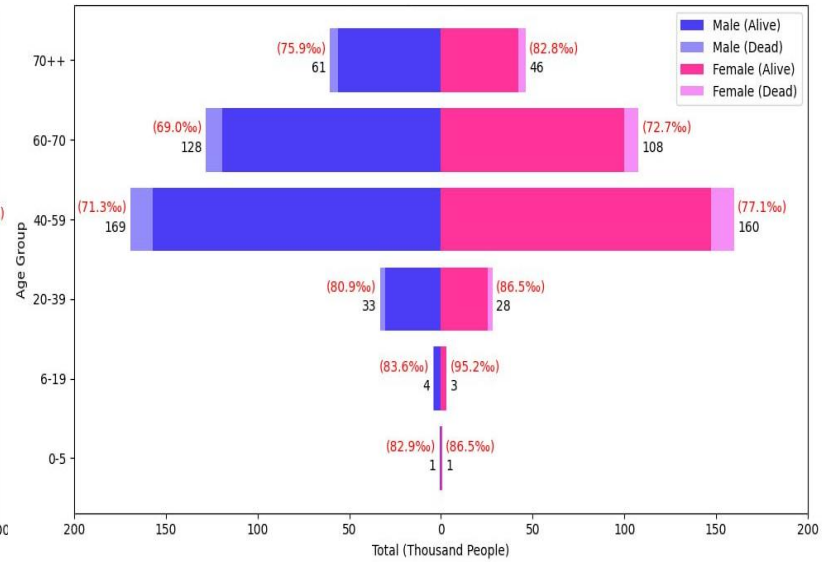
Hypertension Patients (2024)



Heart Disease Patients (2024)



Kidney Failure Patients (2024)



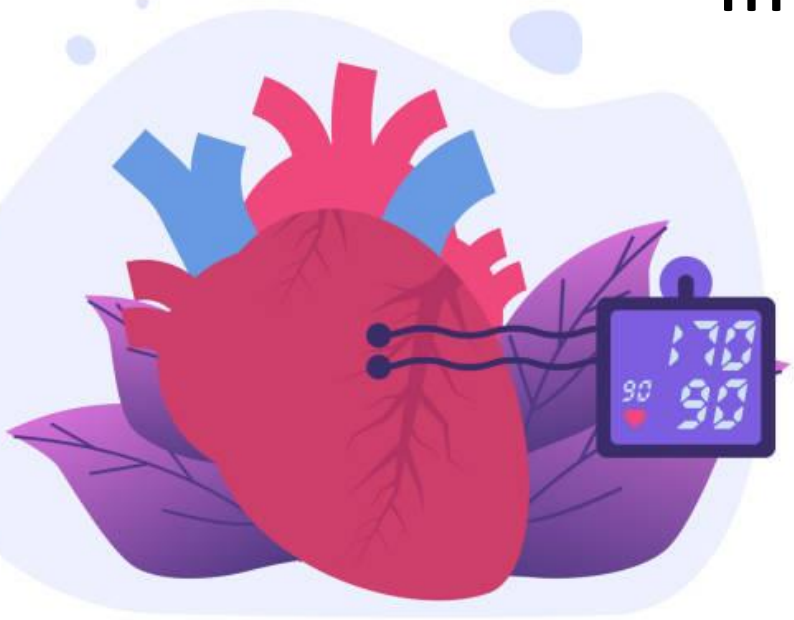
II. RESPONSE IN MANAGING NCD

2A. WHY CONTROLLING DM AND HT IS IMPORTANT

Hypertension and diabetes mellitus are **mother of diseases.**
Being a silent killer: often asymptomatic until severe complications arise.

Type of Complication	Increased Risk (compared to non-diabetics)	Prevalence in Diabetes Patients	Main Reference Sources
Heart Disease	2–4 times higher	±30%	Johns Hopkins Heart Foundation Australia
Hypertension	Very high (>2x)	±66%	Medical News Today Johns Hopkins
Stroke	2–5 times higher	±11.2%	BMJ Open BMC Public Health

Diabetes like **"gateways"** or contributes to other serious health problems.



More than **49,3 trillion rupiahs** were spent in 2024 to treat DM, HT, stroke, kidney failure, and heart disease.

HYPERTENSION AND DIABETES PREVENTION PROGRAM

Hypertension and diabetes must be controlled

Hypertension and diabetes mellitus reduces productivity and quality of life.

2B. DIABETES MELLITUS AND HYPERTENSION COVERAGE IN THE JKN PROGRAM

Presidential Decree Number 59 year 2024 on National Health Insurance

HEALTH PROMOTION

Education and monitoring for members who have not shown risks, at risk, or have been diagnosed

Includes treatmend for pre-diabetic and pre-hypertension patients

HEALTH SCREENING

Early detection for DM and Hypertension

- DM screening by blood glucose examination
- Hypertension screening by blood pressure examination
- Stroke and heart disease screening by blood pressure examination

CHRONIC DISEASE TREATMENT

DM and HT medication every month

Both in primary care and hospital care

REFER BACK PROGRAM (PRB)

Members with controlled condition for DM and HT in hospital care may proceed the medication in primary care

Prescription is made by doctors and the medicine is provided by the PRB Pharmaceutical center (*Apotek PRB*)

DISEASE MANAGEMENT PROGRAM (PROLANIS)

PROLANIS aims to stabilize DM and Hypertension members' clinical condition.

Blood glucose examination, HbA1C, cholesterol examination, physical activity, and personal health promotion is included in PROLANIS benefit

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2C.PROMOTIVE PREVENTIVE SERVICES IN JKN SCHEME

JKN PARTICIPANTS

HEALTHY

Primary Prevention

Health Promotion

1. Health Education
2. Health Promotion Media
3. Exercise

a. Health History Screening

1. Diabetes Mellitus
2. Hypertension
3. Chronic Kidney,
4. Coronary Heart

b. Routine Immunization
c. Family Planning Services

HEALTH BEHAVIOR

At RISK

Moderate/ High Risk

Low Risk

Secondary Prevention

Health Screening

Diseases	Screening Examination
DM	Glucose Test
Hypertention	Blood Pressure
Stroke	
Ischemic Heart	
Anemia	Hb Test
Breast Cancer	Clinical Breast Examination
Servical Cancer	IVA or Papsmear
Thalassemia	CBC and PBS
Colorectal Cancer	RT and FOBT
Tuberculosis	Chest Examination
Lung Cancer	
COPD	
Hepatitis	B and C Rapid Hepatitis Test
Congenital Hypothyroid	Congenital Hypothyroid Test

Healthy

Sick

SICK

Tertiary Prevention

Cryotherapy

Healthy

PROLANIS

1. Health Consultation
2. Supporting Examination
3. Medicine Services
4. Education and Exercise
5. Health Status Monitoring

Referred Back

Drug services for 9 diseases:

1. Diabetes Mellitus
2. Hypertension
3. Heart
4. Asthma
5. Chronic Obstructive Pulmonary Disease
6. Epilepsy
7. SLE
8. Schizophrenia
9. Strokre

PARTICIPANT HEALTH STATUS CONTROLLED

Health History Screening

43,9 mio Health History Screening (target 33 mio)

2,5 mio Risk Participant will receive WA Blast

Specific Health Screening

817 thousand DM Screening

160 thousand IVA Screening

1,6 mio Hypertension Screening

179 thousand Papsmear Screening

In the JKN program there are 14 screening programs, including screening for diabetes mellitus, hypertension, stroke, and ischemic heart diseases.

2D. CHRONIC DISEASE MANAGEMENT PROGRAM (PROLANIS)
Tertiary Prevention

What is PROLANIS?

A health service system with an integrated proactive approach, involving Participants, Health Facilities and Health BPJS in the framework of health care for participants with chronic diseases, especially **Type 2 DM and Hypertension** to achieve optimal quality of life with effective and efficient health care costs.

Goal: Encouraging participant independence, increasing participant health status, increasing participant satisfaction, and controlling health service costs in the long term.

PROLANIS EVALUATION Per Dec 2024

622.291 Members of **Prolanis DM**

1.001.124 members of **Prolanis Hypertension**

PROLANIS activity

Health Consultation
- Done through direct consultation / teleconsultation
- Performed as needed at any time.

Medicine Service
- Given every month to Prolanis participants
- For Prolanis-PRB participants: mechanism for administering PRB drugs.
- For pure Prolanis participants: Mechanism of capitation drug administration

Lab Tests
- Fasting blood sugar test: 1x/month
- HbA1C: 1x/6 months
- Blood chemistry tests (Total cholesterol, HDL, LDL, Triglycerides, Creatinine, Urea, Microalbuminuria): 1x/6 months

Education and physical activities
- Conducted every month
- Can be carried out ofline or virtually via Zoom, Whatsapp Video, Ms.Teams, etc

CHALLENGES:
- **Not all DM and HT patients are registered by their primary care providers as a Prolanis member.**
- **The insufficiency of drugs and medical devices.**
- **Awareness from Prolanis members of their own health status**

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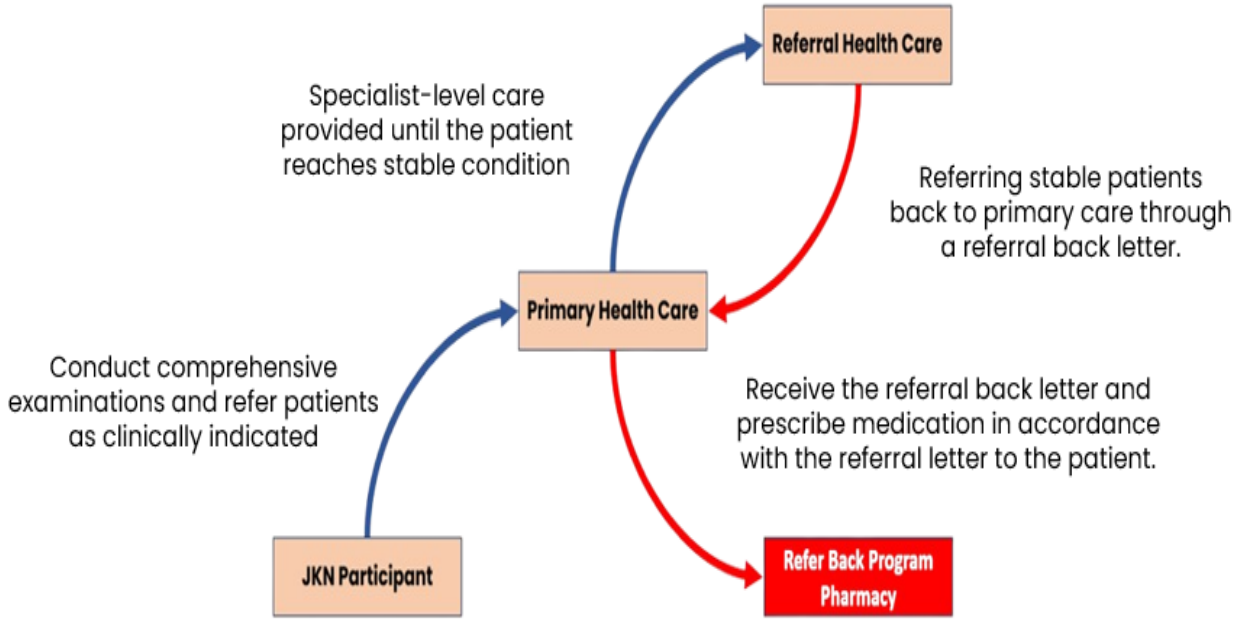
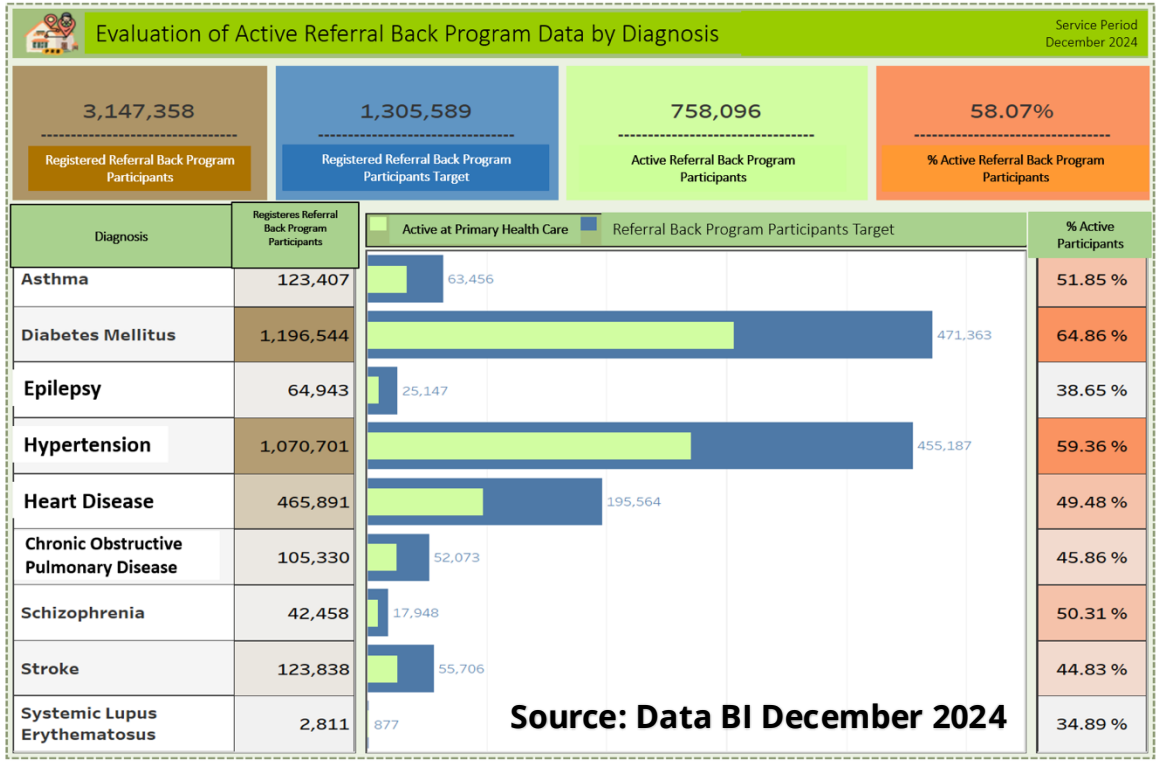
2E. REFERRAL BACK PROGRAM (PRB)

Referral Back Program (PRB)

refers to the transfer of responsibilities for healthcare services from specialist or subspecialist doctors at referral care facilities to primary care facilities for chronic patients in stable condition, through referral letter.



The Implementation of 4 Primary Health Care Pillars	1. First Contact 2. Comprehensive Care 3. Continuity of Care 4. Coordination of Care



Diagnosis	Registeres Referral Back Program Participants	Active at Primary Health Care	Referral Back Program Participants Target	% Active Participants
Asthma	123,407	63,456		51.85 %
Diabetes Mellitus	1,196,544		471,363	64.86 %
Epilepsy	64,943	25,147		38.65 %
Hypertension	1,070,701		455,187	59.36 %
Heart Disease	465,891		195,564	49.48 %
Chronic Obstructive Pulmonary Disease	105,330	52,073		45.86 %
Schizophrenia	42,458	17,948		50.31 %
Stroke	123,838	55,706		44.83 %
Systemic Lupus Erythematosus	2,811	877		34.89 %

Challenges in implementing Referral Back Program (PRB):

- ✓ Availability of medications at Referral Back Program pharmacies, including compliance with E-Monev and E-Purchasing accounts.
- ✓ Education and monitoring of treatment for participants by Primary Health Care Facilities
- ✓ Collaboration and synergy between Primary Health Care Facilities and Referral Care Facilities in managing Referral Back Program participants.

2F. PROLANIS INDICATOR IN THE PAY FOR PERFORMANCE (KBK) SCHEME

Hypertension and diabetes mellitus should have been prevented by the primary care providers.
As a response to the data of Diabetes and Hypertension cases, BPJS Kesehatan enacted a **pay for performance (KBK) scheme**.

- Primary care providers are assessed every month before the due for capitation payment.
- Capitation payment will be adjusted ranging from 15% of total capitation received by the primary care providers.
- One of the indicator is related to PROLANIS disease management program.

KBK PERFORMANCE INDICATORS

CONTACT RATE

How many JKN members can the primary care providers contact each month.

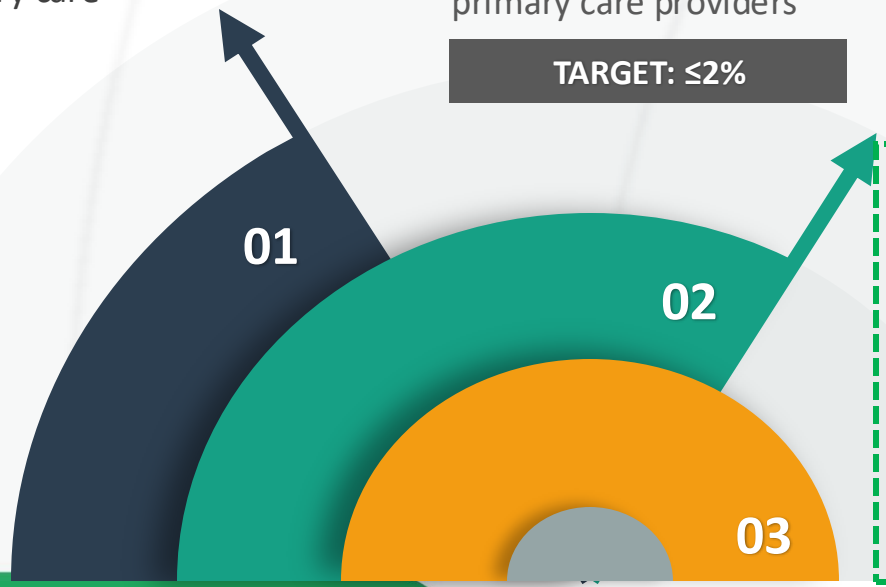
TARGET: ≥ 150‰

NON-SPECIALTY REFERRAL RATIO

How many unnecessary referrals are issued by primary care providers

TARGET: ≤2%

Data utilization is used to determine indicator, target, capitation adjustment, and further evaluation.



PROPORTION OF-DISEASE MANAGEMENT PROGRAM (DMP) MEMBERS WITH CONTROLLED CLINICAL OUTCOMES

How many JKN members enrolled in the Diabetes Mellitus and Hypertension DMP with controlled blood sugar and blood pressure level.

TARGET: ≥ 5%

2G. DIGITAL INNOVATION IN TACKLING NCD

1st Model, Telehealth : 23 Primary Health Care Facilities
2nd Model, Telemedicine : 124 Primary Health Care Facilities
3rd Model, Teleconsultation : 5 Primary Health Care Facilities

Telemedicine provides 3 models for health consultations with GP and Specialist through JKN Mobile

7.517 PCPs

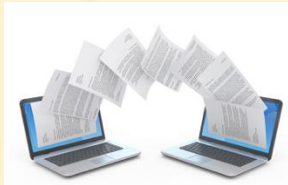
2.016 ref. care facilities

I-Care JKN makes it easy for doctors to find out the patient's health service history from other health facilities.

BUGAR helps participants to provide the information about blood pressure, glucose levels, and mineral levels for real time health monitoring.

3.054 Referral care facilities

Biometric validation for participant's eligibility through Finger Print at hospitals in order to obtained health care services



2.191 Referral care facilities

Electronic SEP by digital claim (no paper print) and signature by the participant. Validation via FP & QR Code

HEALTH HISTORY SCREENING in the form of filling out a self-assessment by the Participant and/or FKTP doctor once a year, to determine the participant's potential risk of disease.

III.KEY TAKEAWAYS

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KEY TAKEAWAYS

Strengthening the Role of Primary Care

- Reinforce the role of Primary Health Care Facilities as **gatekeepers**
- Enhance the use of primary teleconsultation as **the first patient contact**.

Improving PROLANIS & Referral Back Program

- Improve healthcare worker **competencies**
- Ensure **infrastructure, medicine** availability, and supporting facilities (including **digital innovation**)
- Consider performance-based **capitation incentives**

Participants Engagement

- Increase participant **awareness and compliance** with Referral Back Program–Prolanis disease management targets.
- Enhance participant's **health literacy**
- **Utilize digital health tools** to facilitate active participation

Cross Sector Collaboration

- Harmonize **policies** between multisectors
- **Integrate health programs** with local government initiatives
- **Leverage digital platforms** for multi-stakeholder coordination

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Inisiatif

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