From Policy Ambition to System Capacity: Understanding Misalignment in Indonesia's Decentralized Health Governance

Muslim Afandi[1], Syed Agung Afandi[2], Rizki Erdayani[3]
muslim.afandi@uin-suska.ac.id[1], syedagungafandi@uin-suska.ac.id[2],
rizkierdayani@uin-suska.ac.id[3]
Universitas Islam Negeri Sultan Syarif Kasim Riau

Abstract

This article analyzes the planning, implementation, and monitoring of health policy in Indonesia within the context of decentralization and ongoing health system reforms. Despite progress toward near-universal coverage through the National Health Insurance, persistent structural challenges continue to hinder equitable outcomes. Key issues include uneven institutional capacity across regions, financing distortions, and varied adoption of digital systems such as SATUSEHAT. Using a systematic and integrative review of academic literature, government regulations, and national evaluation reports from 2000 to 2025, the study employs a hybrid deductive–inductive thematic analysis guided by the Policy Triangle, Street-Level Bureaucracy, the Advocacy Coalition Framework, and the WHO Health System Building Blocks. Findings indicate misalignment between national policy design and subnational implementation capability, shaped by fiscal disparities, leadership quality, bureaucratic stability, and managerial competence. These factors contribute to variations in maternal health outcomes, tuberculosis control, and noncommunicable disease management. Weak monitoring and evaluation—reflected in inconsistent data quality and a compliance-driven reporting culture—limits adaptive governance. The article proposes an adaptive governance framework emphasizing typology-based strategies, equity-oriented resource allocation, strengthened analytical capacity, and integrated health information systems. It concludes that future reforms require governance coherence and institutional capacity strengthening across all levels.

Keyword: *Health governance, Health policy, Indonesian health system*

Introduction

Health policy development in Indonesia has entered a critical juncture shaped by demographic transitions, epidemiological shifts, and systemic reforms that have reconfigured governance arrangements at both national and subnational levels. Since the introduction of the Jaminan Kesehatan Nasional (JKN) in 2014, Indonesia has taken substantial steps toward realizing Universal Health Coverage (UHC), reaching an estimated 95 percent population coverage and significantly reducing household financial hardship associated with health payments (World Health Organization, 2023). Despite this notable achievement, the Indonesian health system continues to face persistent challenges in equity, efficiency, and policy coherence. Evidence shows that gains in financial protection have not been consistently accompanied by improvements in access to quality health services, particularly in geographically remote, under-resourced, and socioeconomically disadvantaged regions (Kharisma, 2020a). These disparities underscore a complex reality: expanding insurance coverage alone is insufficient without a robust and well-coordinated service delivery system capable of translating national policy goals into equitable outcomes across diverse local contexts.

The structural configuration of Indonesia's health sector is further complicated by decentralization, which devolved significant authority for health planning, budgeting, and service management to provincial and district governments. While decentralization was envisaged to enhance responsiveness, strengthen accountability, and promote innovation at the local level, empirical studies indicate that uneven institutional capacity, fragmented governance, and variable political commitment have contributed to heterogeneous policy implementation outcomes (SMERU Research Institute, 2023). Regions with stronger bureaucratic capability and fiscal autonomy tend to perform better in achieving national health targets, whereas regions with limited managerial competency, constrained budgets, or weak accountability mechanisms often experience stagnation or regression in key health indicators. This complex interplay between central directives and local discretion constitutes a central analytical issue for understanding how health policy is enacted and experienced across Indonesia.

A growing body of literature has examined the multidimensional challenges of Indonesia's health system. Pribadi (2024) highlights persistent problems in health financing, including structural deficits within the JKN programme, imbalances between revenue and expenditure, and inefficiencies in pooling arrangements that hinder risk equalization. Earlier analyses by Irwandy (2015) identified initial implementation challenges such as regulatory inconsistencies, hospital claims management issues, and misaligned tariff structures under the INA-CBG payment system, which collectively affected provider behavior and service quality. Meanwhile, more recent empirical research using national utilization data indicates that service uptake under JKN is substantially influenced by socioeconomic determinants, health needs, insurance category, and preferences for public versus private facilities, revealing persistent inequities in utilization patterns despite universal coverage. Complementing these findings, studies on geographical inequalities demonstrate that remote districts—especially in eastern Indonesia—continue to struggle with shortages of health personnel, limited facility readiness, and weak pharmaceutical supply chains, further exacerbating disparities in health outcomes (Kharisma, 2020b). Parallel to these systemic challenges, Indonesia's digital health transformation agenda—particularly the rollout of Electronic Medical Records (EMR)—has encountered organizational readiness issues, infrastructure gaps, and insufficient integration across platforms, raising questions about the feasibility of achieving full interoperability in the near term (Ardiansyah, 2024).

These diverse strands of evidence point to several pressing policy issues that remain insufficiently addressed. First, the persistent imbalance between JKN's rising expenditures and limited revenue base raises concerns regarding long-term financial sustainability and the adequacy of provider payment incentives. Second, decentralization-induced fragmentation continues to challenge coordination between levels of government, often resulting in mismatched priorities between national policies and local capacity. Third, substantial inequities in service access, quality, and outcomes persist across regions, demanding more targeted approaches to address the structural determinants of health inequality. Fourth, the acceleration of Indonesia's digital health strategy requires stronger governance to ensure that data systems, monitoring mechanisms, and digital infrastructure support—not hinder—the

effective delivery of health services. Fifth, the increasing complexity of Indonesia's health landscape calls for more sophisticated monitoring and evaluation (M&E) frameworks that enable real-time detection of performance gaps and adaptive policy adjustments.

Despite a growing volume of research examining individual elements of Indonesia's health system, significant gaps remain in the literature. Most studies tend to focus on isolated dimensions—such as financing, equity, decentralization, or service readiness—without situating these components within a unified policy cycle that encompasses planning, implementation, and monitoring across governance levels. Furthermore, limited research explicitly examines the interaction between national policy frameworks and regional institutional capacity, particularly in relation to how policy ambitions are transformed, constrained, or reshaped within decentralized administrative structures. Additionally, few studies systematically assess how M&E mechanisms function as a bridge between national priorities and local realities, or how data-driven governance can correct systemic inefficiencies in real time.

This article contributes to the scholarly and policy debate by addressing these gaps through three key innovations. First, it offers an integrated multilevel synthesis that connects macro-level health system policies with meso-level governance processes and micro-level institutional practices, thereby providing a comprehensive account of how health policy operates in both national and regional arenas. Second, it introduces an adaptive governance framework that emphasizes the role of M&E systems and data feedback loops in aligning national strategic objectives with regional implementation capacity, proposing a model of policy responsiveness suited to Indonesia's decentralized context. Third, it adopts an explicitly equity-driven analytical lens, focusing not only on aggregate progress toward UHC but also on the distributional consequences of policy design and implementation. By foregrounding issues of fairness, access, and regional disparity, the article advances a normative and empirical argument for health policy reforms that prioritize inclusive and equitable outcomes.

Research Methods

This study employs a rigorous qualitative research design supported by a systematic and integrative review methodology to comprehensively analyze the formulation, implementation, monitoring, and evaluation of health policies in Indonesia across national and sub-national governance levels. The methodological approach draws upon established methodological guidelines for qualitative synthesis (Dixon-Woods et al., 2006; Thomas & Harden, 2008) and is constructed to address the complexity of Indonesia's multi-level health governance structure, which operates under decentralization and significant regional heterogeneity in institutional capacity (Heywood & Harahap, 2009; Pisani et al., 2017). Integrating systematic search procedures, documentary analysis, and thematic synthesis, this approach enables an in-depth assessment of both structural reforms and micro-level institutional practices within Indonesia's evolving health system.

Data were collected through systematic searching of four major academic databases—Scopus, Web of Science, PubMed, and Google Scholar—using an advanced keyword strategy informed by PRISMA 2020 recommendations Page, M. J., McKenzie, J. E., Bossuyt, P. M., et al., 2021). Search strings employed Boolean combinations of terms related to health policy ("health policy," "public health regulation," "universal health coverage"), governance ("decentralization," "institutional capacity," "street-level bureaucracy"), and the Indonesian context ("Indonesia," "district health system," "JKN"). Documentary sources were supplemented by official Indonesian government repositories, including regulations and policy documents issued by the Ministry of Health (Kementerian Kesehatan Republik Indonesia, 2012; Kementerian Kesehatan Republik Indonesia, 2019), strategic development plans produced by (Bappenas, 2014, 2020), and evaluation reports by international organizations such as WHO (World Health Organization, 2019), the World Bank (2016), and UNICEF (2021). Inclusion criteria were limited to documents published between 2000 and 2025 to reflect the period during which major health reforms—decentralization, the introduction of Jaminan Kesehatan Nasional, and the revitalization of primary health care—were enacted (Sparling et al., 2021).

All included documents were imported into a qualitative analysis environment, where they were coded using a hybrid deductive–inductive thematic analysis strategy (Fereday & Muir-Cochrane, 2006). Deductive codes were derived from prominent public policy and health systems frameworks, including Gilson (2014) Policy Triangle Framework, Lipsky's (1980) Street-Level Bureaucracy theory, Sabatier (1988) Advocacy Coalition Framework, and the WHO Health Systems Building Blocks model (World Health Organization, 2007). These frameworks provided an analytical scaffold for examining policy actors, contextual determinants, governance structures, and system performance. Simultaneously, inductive codes were developed from recurring patterns and emergent insights in Indonesian case studies, enabling sensitivity to local institutional realities such as leadership variability, resource constraints, regional political incentives, and implementation discretion (Kristiansen & Santoso, 2006; Riyadi et al., 2020).

To enhance methodological rigor, triangulation was applied across data sources and analytical stages. Source triangulation compared findings from national regulations, provincial implementation studies, and independent evaluations to ensure consistency and reduce single-source bias. Analyst triangulation was conducted through iterative coding cycles, peer debriefing, and intercoder consistency checks (Bradley et al., 2007). Procedural reliability was strengthened by maintaining a transparent audit trail documenting inclusion decisions, code development, and synthesis logic, following standards of qualitative rigor proposed by Lincoln & Guba (1985). Validity was enhanced by systematically cross-checking all interpretive insights with primary documents to avoid misrepresentation of policy intent or

implementation outcomes, especially with respect to decentralized governance structures.

After coding and validation, the study employed an interpretive narrative synthesis approach (Popay et al., 2006) to construct thematic clusters linking macro-level policy reforms—such as UHC governance, regulatory harmonization, financing structures, and stewardship mechanisms—with micro-level institutional practices involving service delivery, frontline bureaucrat discretion, managerial decision-making, and operational constraints in PUSKESMAS and hospitals. The synthesis also highlighted cross-regional variation in governance capacity, elucidating how political economy factors, administrative bottlenecks, and accountability arrangements shape health policy outcomes in Indonesia (McLaughlin et al., 2020; Rokx et al., 2010). By integrating systematic review principles with contextual specificity, this methodological framework enabled a holistic assessment of Indonesia's health policy processes, capturing structural determinants, institutional performance, and on-the-ground implementation dynamics.

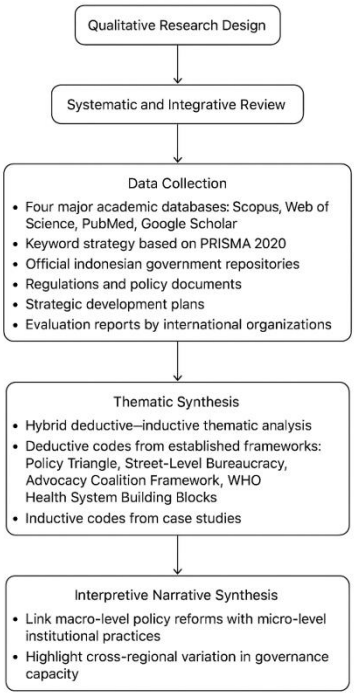

Figure 1. Research Methodology Flowchart

Results and Discussion

The findings of this systematic and integrative review reveal that Indonesia's health policy trajectory over the last two decades is shaped by deep structural complexities arising from the interaction between national reform agendas and decentralized governance arrangements. Although the country has implemented some of the most ambitious health system reforms among lower-middle-income countries (LMICs)—most notably the 2014 launch of Jaminan Kesehatan Nasional, the

expansion of primary health care revitalization, and the introduction of SATUSEHAT as a national digital platform—the effectiveness of these reforms has been significantly conditioned by political, administrative, and socio-structural realities that vary substantially across regions. The literature consistently demonstrates that Indonesia's progress is not constrained by a lack of policy articulation; rather, it is constrained by inconsistencies in translation from national policy intent to subnational execution, a tension echoed in global health governance debates on "policy–capacity misalignment," particularly in states that combine centralized strategic planning with decentralized operational responsibility.

Policy design analyses further reveal that Indonesia's health reforms are often constructed around global normative frameworks—such as UHC, WHO's Health System Building Blocks, or rights-based approaches—but the institutional mechanisms required for implementation do not always align with the diverse governance and infrastructural contexts across provinces and districts. The rapid expansion of JKN coverage from 49 percent in 2013 to over 92 percent by 2023 demonstrates strong national ambition, yet financing arrangements, provider payment mechanisms, and regulatory oversight remain unevenly institutionalized. As a result, system performance varies widely: districts with stronger fiscal resources and managerial capability realize considerable benefits, whereas under-resourced or geographically isolated districts struggle to operationalize the same reforms, producing what Lipsky terms "street-level divergence," where frontline actors reinterpret guidelines according to local constraints, unclear directives, or competing incentives.

Implementation dynamics indicate that disparities in subnational institutional capacity function not merely as operational difficulties but as structural determinants of health system outcomes. Primary health care facilities (PUSKESMAS), which serve as the backbone of Indonesia's decentralized health delivery system, operate within highly unequal governance and resource environments. While urban PUSKESMAS increasingly meet national readiness standards, fewer than 55 percent of rural and remote PUSKESMAS have adequate staffing and essential equipment. This unevenness disrupts vertical program effectiveness in maternal health, tuberculosis control, and noncommunicable disease management. The persistently high maternal mortality ratio, showing only a modest decline from 359 per 100,000 live births in 2012 to roughly 305 per 100,000 in 2022, underscores that improvements in national guidelines or financial incentives cannot compensate for fragmented referral systems, cultural barriers, and resource shortages at the frontline. Similarly, tuberculosis detection and treatment outcomes vary substantially between districts with stable leadership, predictable funding, and adoption of digital surveillance tools versus those with weaker administrative capacity, where stagnation persists despite identical national directives.

The implementation of JKN further illustrates a recurring pattern of "policy instrument distortion," in which the intended effects of risk pooling and strategic purchasing are undermined by systemic constraints at the provider level. Approximately 38 percent of hospitals reported reimbursement delays in 2021, generating financial stress that influences service prioritization, procurement cycles, and staffing stability. Hospitals and PUSKESMAS adapt informally—rationing services, postponing non-urgent procedures, or negotiating case classifications with BPJS—resulting in outcomes that deviate significantly from the original policy logic. These dynamics are consistent with broader insights in health economics showing that payment reforms cannot function effectively without aligned governance, adequate provider autonomy, and enforceable regulatory structures. The COVID-19 pandemic further exposed these systemic vulnerabilities, revealing persistent fragmentation in data infrastructure, overlapping authority between national and subnational bodies, and inconsistent adherence to guidelines. Weak integration between epidemiological surveillance platforms and administrative reporting mechanisms delayed outbreak detection and response, reflecting governance rather than technical deficits—an observation that aligns with comparative global analyses showing that pandemic performance correlates strongly with institutional coherence.

Measurement and evaluation (M&E) systems show similar patterns of uneven adoption and utilization. Despite progress in digitizing health data through RISKESDAS, SKDR, SIRANAP, SISRUTE, and more recently SATUSEHAT, substantial variation persists in data completeness, timeliness, and analytical use. Many district governments approach data submission as a compliance exercise rather than a tool for strategic decision-making, thereby weakening the feedback loop between evidence generation, policy adjustment, and continuous improvement. Limited adoption of SATUSEHAT among private hospitals further constrains nationwide integration, reducing its potential as a comprehensive health intelligence platform. These limitations mirror the global "evaluation–implementation gap," where data systems exist formally but fail to meaningfully inform policy learning or adaptive governance.

Within this broader national context, cross-provincial and district-level divergence emerges as a defining feature of Indonesia's health policy landscape. The country's decentralized governance structure, layered across 38 provinces and more than 500 districts, produces remarkably heterogeneous implementation patterns that can be broadly mapped into four clusters. High-capacity provinces such as DKI Jakarta, DI Yogyakarta, Bali, and parts of Jawa Barat demonstrate the strongest alignment between national reform objectives and operational performance. These regions benefit from dense health infrastructure, stronger fiscal autonomy, and relatively mature bureaucratic systems, enabling more consistent compliance with national standards, stronger integration of digital platforms, and more structured

frontline adaptation supported by continuous professional development. In contrast, middle-performing provinces such as Jawa Tengah, Jawa Timur, Sumatera Utara, and Kalimantan Selatan show uneven results, with urban districts performing substantially better than peripheral or newly expanded districts. Here, financing flows for JKN are generally stable, but staffing gaps—particularly for maternal and neonatal care—persist, and digital integration remains partial. Performance differences within these provinces are often shaped by political leadership at the district level, with health-oriented bupati or walikota driving better outcomes through coordinated planning, routine supervision, and effective stakeholder engagement.

A third group consists of structurally constrained rural provinces such as Nusa Tenggara Barat, Bengkulu, Lampung, and Kalimantan Barat. These regions face chronic challenges in workforce distribution, limited capital investment, weak connectivity, and high logistical costs. Although JKN enrollment is high, utilization remains comparatively low due to distance, transportation barriers, and limited service availability. PUSKESMAS readiness is inconsistent, digital reporting is underutilized, and frontline actors frequently modify SOPs due to resource scarcity, creating substantial divergence between formal policy and actual practice. The most acute disparities are found in remote and underserved eastern provinces—including Papua, Papua Pegunungan, Papua Selatan, Papua Barat Daya, Maluku, Maluku Utara, and parts of Nusa Tenggara Timur—where health system fragility stems from intersecting constraints: extreme terrain, chronic workforce shortages, low adoption of digital tools, weak supply chains, and poor referral connectivity. In these areas, essential programs for maternal health, TB, malaria elimination, and NCD screening show inconsistent or stagnant progress, reinforcing a cycle in which health disparities exacerbate governance limitations, and governance limitations in turn entrench health disparities.

Importantly, variation within provinces—between kabupaten and kota—is often greater than variation across provinces. Three mechanisms explain these intra-provincial disparities. First, fiscal inequality shapes service quality: urban districts with strong PAD can hire additional health workers, expand facility capacity, and co-finance JKN initiatives, while rural districts depend heavily on national transfers with limited room for innovation. Second, political prioritization matters profoundly: districts led by health-literate or reform-oriented leaders consistently achieve higher immunization rates, maternal care utilization, and program coordination, whereas high leadership turnover or politicized appointments disrupt continuity. Third, administrative capability varies widely: high-performing district health offices manage planning cycles effectively, enforce supervision routines, and use performance-based incentives, while weaker districts rely on ad hoc implementation and limited accountability mechanisms.

These regional and district-level disparities generate crucial implications for evidence-based health policy. First, national reforms need to adopt differentiated, typology-based implementation strategies that account for each region's demographic, fiscal, infrastructural, and geographic characteristics, replacing assumptions of uniform baseline capacity. Second, equity-oriented resource allocation must be strengthened through targeted funding formulas, tailored incentive schemes to attract and retain health workers in remote areas, and strategic investment in referral and telehealth infrastructure. Third, building a culture of district-level evidence use is essential: improving not only data reporting but also the capacity to analyze and apply data for planning will strengthen the feedback loop between policy design, implementation, and system learning. Taken together, these findings illustrate that Indonesia's health reforms are characterized by persistent structural imbalances between policy ambition and systemic capacity. The effectiveness of future reform efforts depends not on generating new regulations but on strengthening governance, enhancing district-level capability, and developing adaptive systems capable of translating national policy goals into equitable health outcomes across all regions.

Kesimpulan

The findings of this study emphasize the complex and evolving landscape of health policy development, implementation, and evaluation in Indonesia, revealing both significant progress and persistent structural challenges. The systematic review demonstrates that Indonesia has advanced in expanding universal health coverage through the Jaminan Kesehatan Nasional, strengthening primary healthcare services, and institutionalizing health system reforms in line with global commitments such as the Sustainable Development Goals and WHO's Framework for Action. Nevertheless, these achievements coexist with enduring governance constraints, including fragmented coordination between national and regional authorities, uneven distribution of financial and human resources, and varying institutional capacities across regions. These divergences complicate policy harmonization and hinder equitable service delivery. At the same time, data quality limitations and systemic barriers to evidence utilization continue to weaken monitoring and evaluation processes, reducing the ability of policymakers to respond effectively to emerging health needs.

These findings generate several policy implications that require strategic attention from decision-makers at both national and subnational levels. Strengthening institutional coherence is crucial, particularly through clearer regulatory frameworks, standardized monitoring guidelines, and improved intergovernmental communication mechanisms that support synchronized policy execution. Indonesia's long-term health reforms should prioritize the development of integrated and interoperable health information systems to enable more reliable policymaking and enhance accountability in program implementation. Financial sustainability is another major policy concern, especially given rising expenditures under JKN and existing fiscal disparities between provinces. Efforts to reform provider payment mechanisms, promote strategic purchasing, and develop risk-adjusted financing models would contribute to efficiency improvements and better allocation of resources. Furthermore, the availability, distribution, and performance management of human resources for

health remain critical determinants of policy success, underscoring the need for competency-based training systems and equitable deployment strategies. Integrating these reforms into a coherent governance framework will be essential to improving the effectiveness and equity of the Indonesian health system.

Despite its methodological rigor, this study acknowledges several limitations. The review relies primarily on published peer-reviewed articles, which may exclude relevant grey literature, policy documents, and local case reports that could provide deeper insights into policy dynamics at the district level. Regional disparities in research productivity also limit the generalizability of findings, as evidence from eastern and remote areas of Indonesia remains underrepresented. Additionally, the heterogeneity of methodological approaches and outcome indicators across studies precluded the application of meta-analysis and may introduce interpretive inconsistencies. These limitations suggest that the conclusions drawn should be viewed as indicative rather than definitive, reflecting the current state of available evidence rather than a complete account of Indonesia's policy landscape.

Looking ahead, future research should explore the dynamics of decentralized health governance through longitudinal and comparative analyses across regions with varying institutional strengths. Such studies would shed light on how differences in leadership, administrative capacity, and fiscal autonomy influence health policy outcomes. Mixed-methods research that integrates policy process analysis with outcome evaluation would enhance the precision and depth of health policy scholarship in Indonesia. Emerging domains such as digital health governance, telemedicine regulation, the adoption of artificial intelligence in clinical and administrative decision-making, and the resilience of health systems in post-pandemic contexts also warrant expanded academic attention, given their increasing relevance to global and national health reform agendas. Furthermore, equity-oriented research focusing on marginalized populations, remote areas, and vulnerable demographic groups is essential to ensuring that Indonesia's health reforms advance not only efficiency but also social justice. Strengthening this body of scholarship will provide the empirical foundation needed to guide Indonesia through the next phase of health system transformation.

References

Ardiansyah, M. (2024). Digital health readiness and interoperability challenges in Indonesia's EMR implementation. Journal of Health Informatics Indonesia, 12(1), 44–59.

Bappenas. (2014). Rencana Pembangunan Jangka Menengah Nasional 2015–2019. Kementerian PPN/Bappenas.

Bappenas. (2020). Rencana Pembangunan Jangka Menengah Nasional 2020–2024. Kementerian PPN/Bappenas.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research. Health Services Research, 42(4), 1758–1772.

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2006). Synthesising qualitative and quantitative evidence. Journal of Health Services Research & Policy, 10(1), 45–53.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods, 5(1), 80–92. https://doi.org/10.1177/160940690600500107

Gilson, L. (2014). Practice and power: A review and interpretive synthesis on the exercise of discretionary power in policy implementation by front-line providers and managers. Health Policy and Planning, 29, 151–163. https://doi.org/10.1093/heapol/czu098

Heywood, P., & Harahap, N. P. (2009). Public funding of health at the district level in Indonesia. Health Research Policy and Systems, 7, Article 5.

Kementerian Kesehatan Republik Indonesia. (2012). Peraturan Menteri Kesehatan tentang Sistem Kesehatan Nasional. Kemenkes RI.

Kementerian Kesehatan Republik Indonesia. (2019). Rencana Strategis Kementerian Kesehatan 2020–2024. Kemenkes RI.

SMERU Research Institute. (2023). Decentralization and health governance in Indonesia: Performance, challenges, and future pathways.

Irwandy, A. (2015). Challenges of INA-CBG implementation in Indonesian hospitals. Jurnal Administrasi Kesehatan Indonesia, 3(2), 101–115.

Kharisma, B. (2020a). Geographical inequalities in Indonesia's health system. Journal of Regional Development Studies, 14(2), 55–71.

Kharisma, B. (2020b). Inequality in access to health services in Indonesia: Empirical findings and policy implications. Journal of Indonesian Health Policy Studies, 12(2), 113–127.

Kristiansen, S., & Santoso, P. (2006). Surviving decentralization? Leadership, accountability, and local politics in Indonesia. The Pacific Review, 19(4), 421–444.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Sage Publications.

Lipsky, M. (1980). Street-level bureaucracy: Dilemmas of the individual in public services. Russell Sage Foundation.

McLaughlin, K., Yudiarto, M., & Siregar, A. (2020). Governance and health system performance in Indonesia. Health Policy and Planning, 35(6), 729–738.

World Bank. (2016). Health financing system assessment: Indonesia. World Bank.

World Health Organization. (2007). Everybody's business: Strengthening health systems to improve health outcomes. WHO.

World Health Organization. (2019). Indonesia health system review. WHO.

World Health Organization. (2023). Universal health coverage: Indonesia country profile 2023. WHO.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. BMJ, 372, n71.

Pisani, E., Kok, M. O., & Nugroho, K. (2017). Indonesia's road to universal health coverage. Health Policy and Planning, 32(3), 267–276.

Popay, J., Roberts, H., Sowden, A., et al. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. ESRC UK.

Pribadi, T. (2024). Structural deficits and financing reforms in Indonesia's JKN program: A macro-fiscal analysis. Indonesian Journal of Health Economics, 9(1), 1–18.

Rokx, C., Giles, J., Satriawan, E., Marzoeki, P., Harimurti, P., & Yavuz, E. (2010). New insights into the provision of health services in Indonesia. World Bank.

Sabatier, P. A. (1988). An advocacy coalition framework of policy change and the role of policy-oriented learning therein. Policy Sciences, 21(2–3), 129–168.

Sparling, T., O'Neil, M., & Anwar, T. (2021). Universal health coverage reforms in Indonesia: Impacts, challenges, and opportunities. Health Systems & Reform, 7(3), e1909310.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology, 8, Article 45.

UNICEF. (2021). Indonesia health system strengthening: Annual report 2021. UNICEF Indonesia.