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THE EVOLUTION OF NATIONAL HEALTH INSURANCE IN INDONESIA: POLICIES, PROGRESS, AND CHALLENGES

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Abstract

This research aims to analyze the development of National Health Insurance (NHI) in Indonesia, with every progress and challenges in its evolution. Using a longitudinal case study that enables a nuanced examination of policy processes, shifts, and complexities within their evolving socio-political contexts, this research will explore the dynamics of health insurance policy development over an extended period. Before the establishment of BPJS Kesehatan in 2014, Indonesia's health insurance landscape was shaped by various schemes targeting different population groups, such as Askes for civil servants, Jamsostek for formal workers, and Jamkesmas for the poor. While these programs expanded access to healthcare, their fragmentation posed challenges to achieving a more inclusive and integrated system. In response, the government initiated a major reform through the establishment of BPJS Kesehatan as part of its commitment to realizing Universal Health Coverage for all citizen. While challenges in resource efficiency and service delivery remain—particularly as BPJS Kesehatan manages far broader coverage than its predecessors—the ongoing reforms reflect Indonesia's continued commitment to strengthening its health insurance system, improving service quality, and advancing toward Universal Health Coverage through more integrated, accessible, and trusted care.

Keywords: Social Protection; Health Policy; National Health Insurance.

Abstrak

Penelitian ini bertujuan untuk menganalisis perkembangan jaminan kesehatan nasional (JKN) di Indonesia, dengan melihat segala kemajuan dan tantangan yang ada. Menggunakan metode *longitudinal case study* penelitian ini melihat seluruh proses, pergeseran, sampai dengan kompleksitas kebijakan dalam perkembangan konteks sosial politik, dengan harapan memperlihatkan dinamika perkembangan kebijakan jaminan kesehatan pada setiap periode. Sebelum pembentukan BPJS Kesehatan pada tahun 2014, lanskap asuransi kesehatan Indonesia dibentuk oleh berbagai skema yang menargetkan berbagai kelompok populasi, seperti Askes untuk pegawai negeri sipil, Jamsostek untuk pekerja formal, dan Jamkesmas untuk masyarakat miskin. Sementara program-program ini memperluas akses ke layanan kesehatan, fragmentasi mereka menimbulkan tantangan untuk mencapai sistem yang lebih inklusif dan terintegrasi. Sebagai tanggapan, pemerintah memulai reformasi besar melalui pembentukan BPJS Kesehatan sebagai bagian dari komitmennya untuk mewujudkan *universal health coverage* (UHC) untuk semua warga negara. Sementara tantangan dalam efisiensi sumber daya dan pemberian layanan tetap ada, terutama karena BPJS Kesehatan mengelola cakupan yang jauh lebih luas daripada pendahulunya. Reformasi yang sedang berlangsung kemudian mencerminkan komitmen berkelanjutan Indonesia untuk memperkuat sistem asuransi kesehatannya, meningkatkan kualitas layanan, dan maju menuju UHC melalui perawatan yang lebih terintegrasi, mudah diakses, dan tepercaya.

Kata Kunci: Jaminan Sosial, Kebijakan Kesehatan, Jaminan Kesehatan Nasional.

I. INTRODUCTION

Research on health protection policy in various countries continues to develop, along with the emergence of the Universal Health Coverage idea, which requires all countries to provide adequate health protection for every society (Bárcena, 2020; Ooms et al., 2021). Health protection is crucial for providing equal access to all levels of society. National health insurance schemes that regulated through public policy, are a concrete manifestation of government involvement in meeting community needs (Oraro-Lawrence & Wyss, 2020). Prior to the idea proposed by the World Health Organization (WHO), several countries already had well-established health insurance arrangements in place. Several Western countries, in particular, have mandated health insurance for all citizens to facilitate equal access to healthcare (Naicker et al., 2021). The types of health protection offered also vary considerably, with some countries employing direct government-sponsored health insurance schemes, while others employ collaborative schemes with non-governmental and private organizations (Bode, 2019; Jaber et al., 2021).

However, not all countries have achieved success in implementing health insurance. Some developing countries still face complex challenges in providing health insurance to all their citizens (Castro et al., 2016; Ako et al., 2020). Geographical disparities, particularly between western and developing countries, as well as limited infrastructure and health workers in remote areas also impact the effectiveness of its implementation. Indonesia is one example of a country that continues to develop its national health insurance scheme to achieve equality in providing access to health services. Various challenges also continue to develop along with shifts in health insurance policies, which are also changing in Indonesia. Previous studies have also shown that the implementation of health insurance policies in Indonesia faces multiple challenges, ranging from the integration of implementing organizations to the service system problems (Helmi et al., 2021; Rasyada et al., 2020). Most recently, Indonesia has taken major steps towards UHC through the implementation of the National Health Insurance (JKN) since 2014. Although coverage has exceeded 90% of the population, challenges in financing, unequal distribution of services, and quality of health services remain major issues (Janah & Rahayu, 2019; Schaefers et al., 2022).

Research that comprehensively discusses the development of health insurance policies in Indonesia is crucial to provide a true condition of the current situation. This paper aims to demonstrate this by explaining the development of various policies that have been developed previously and the challenges in their implementation. This issue is interesting to examine, as previous research has not been able to provide a comprehensive problem of the formation of health protection implementing institutions over time in Indonesia, including the challenges of policy implementation within each policy. It is hoped that the author can provide a comprehensive landscape of Indonesia's progress in supporting the UHC concept and what aspects the government and other stakeholders should consider to improve and develop this achievement.

LITERATURE REVIEW

Universal Health Coverage

Universal Health Coverage (UHC) has become a global priority in efforts to improve national health systems. UHC aims to ensure that every individual has access to quality health services without facing a heavy financial burden. The World Health Organization (WHO) conceptualizes Universal Health Coverage (UHC) as comprising three core dimensions: the extent of health service coverage, protection against financial hardship, and inclusivity in population reach. Achieving UHC, however, involves more than merely expanding health insurance schemes. A growing body of research underscores the critical role of effective health system governance, sustained political will, and the strategic allocation of available resources in realizing the goals of UHC (Engels & Zhou, 2020; Zha et al., 2021).

Experiences from different national contexts illustrate the diversity of pathways toward UHC. In Thailand, for instance, the introduction of the Universal Coverage Scheme in 2002 marked a significant step toward inclusive health care. Funded through general taxation, this initiative succeeded in extending access to health services to nearly the entire population, including low-income groups. Evidence suggests that the program not only reduced the incidence of poverty linked to out-of-pocket health expenditures but also led to increased utilization of primary health care services (Tangcharoensathien et al., 2018).

In contrast, Rwanda presents a compelling example of how a low-income country can effectively pursue UHC. Through the implementation of a community-based health insurance model, known locally as *mutuelles de santé*, Rwanda has managed to provide broad health coverage. This success has been attributed to strong government leadership and consistent support from international development partners (Binagwaho et al., 2020). Notably, Rwanda's experience highlights the critical role of community engagement in ensuring the long-term sustainability and responsiveness of health insurance systems.

Meanwhile, middle-income countries like Vietnam have also made significant progress. Vietnam implemented a phased approach by expanding national health insurance coverage integrated into the public health system. Other studies have highlighted Vietnam's success in increasing population coverage and reducing out-of-pocket expenditures, although challenges remain in terms of service quality at primary health care facilities (Van Nguyen et al., 2020). In Latin America, Colombia also serves as a benchmark with its contributory and subsidy-based health insurance system, covering almost the entire population through an integrated dual scheme (Botero-Tovar et al., 2020; Ortiz-Barrios & Alfaro-Saiz, 2020).

Nevertheless, based on the experiences of these countries, it is clear that there is no single approach to achieving UHC. Key success factors lie in system design that is appropriate to the local context, sustainable funding, and cross-sectoral policy support. Furthermore, community engagement, technological innovation, and strengthening primary health care services are essential components in ensuring that UHC is not only achieved numerically but also provides real and equitable health protection for the entire population. (Bigdeli et al., 2020; Engels & Zhou, 2020).

Health Protection Policy

The efforts of governments and health institutions to protect the public from the risks of disease, injury, and other health threats through regulation, preventive interventions, and responses to health crises constitute the fundamental meaning of health protection policy (Bárcena, 2020; Flores & Asuncion, 2020). Unlike the health promotion, protection policy is more of a structural intervention, such as infection control, food and beverage regulation, and environmental hazard monitoring (Baum, 2008). This approach positions the state as the primary actor in ensuring public health security, particularly in the face of infectious diseases and global health disasters. A significant example of a health protection policy is South Korea's response to the COVID-19 pandemic. The South Korean government quickly implemented digital contact tracing, mass testing, and information transparency policies. Kim et al. (2021) found that collaboration between the technology and health sectors, supported by a clear legal system regarding personal data in emergencies, enabled the government to control the spread of the virus without having to implement a total lockdown. This underscores the importance of health system preparedness and cross-sector coordination capacity in health protection.

Furthermore, national health insurance also falls under the category of health protection policies, as it aims to protect the public from the financial risks associated with high healthcare expenditures. This system not only expands access to healthcare services but also provides social protection for vulnerable groups prone to poverty due to healthcare costs. For example, Germany has long implemented a statutory health insurance system that requires workers and employers to contribute to a common fund to finance

comprehensive healthcare services. This system allows all citizens, including low-income groups, to access healthcare services without the burden of large upfront costs (Bode, 2019).

In Canada tax-funded Medicare system offers a well-established model of universal basic healthcare, providing coverage to all citizens and permanent residents without requiring out-of-pocket payments at the point of care. This approach has played a significant role in reducing disparities in access across socio-economic groups and in shielding individuals from the financial risks typically associated with health expenditures. As such, Canada's system is often cited as a leading example of a healthcare policy rooted in principles of public solidarity (Lochmüller et al., 2021; Marshall et al., 2023). A similarly instructive case can be found in Thailand, where the Universal Coverage Scheme (UCS), introduced in 2002, has dramatically expanded healthcare access, particularly for populations previously excluded from formal health insurance, including the poor. Funded through general taxation, the UCS has not only curtailed out-of-pocket spending but also contributed to greater public confidence in the health system as a whole (Tangcharoensathien et al., 2018).

Beyond financing models, the effective implementation of health protection policies also hinges on factors such as strong local leadership and the capacity for data-driven decision-making. Studies emphasize the value of institutional structures that are not only resilient but also adaptable—traits that are underpinned by evidence-informed policymaking, technological integration, and active community participation (Lurie & Experton, 2021; Robert et al., 2022; Zulaika et al., 2024). Moreover, transparent and responsive governance emerges as a critical component in building and maintaining public trust. Taken together, the literature suggests that the success of national health protection policies relies on a multi-sectoral and systems-oriented approach. Such policies do more than improve access to care; they also serve as buffers against the socio-economic shocks of health crises. Consequently, prioritizing the development and reinforcement of these frameworks should be a central concern for health system planners and policymakers worldwide.

II. METHOD

This research adopts a longitudinal case study approach to explore, in depth, the dynamics of health insurance policy development over an extended period (Millner & Meyer, 2022; Peek et al., 2021). This methodological choice enables a nuanced examination of policy processes, shifts, and complexities within their evolving socio-political contexts. Unlike conventional case studies, which often provide a static snapshot of a phenomenon at a single point in time, longitudinal case studies are designed to trace changes and transitions as they unfold. By observing a particular case or phenomenon over time, researchers can better understand the underlying drivers of policy development, institutional change, or shifts in social practices (Mättö et al., 2020; Ongaro & Ferlie, 2020).

This approach is particularly valuable in policy research, as it allows for the identification of both continuity and disruption in governance processes. Longitudinal case studies typically incorporate multiple data collection methods, including repeated interviews conducted across different phases, periodic field observations, and the analysis of historical records, policy documents, and archival materials. Such a design supports a rich, contextualized understanding of the phenomenon under investigation. Moreover, qualitative longitudinal research facilitates direct engagement with stakeholders and provides insight into the lived experiences and interpretations of those involved in or affected by policy changes (Ponterotto & Park-Taylor, 2021). By integrating multiple sources of evidence over time, this method offers a comprehensive and dynamic perspective on how health insurance policies evolve and are shaped by broader institutional and societal forces.

With its longitudinal nature, this research not only captures static conditions at one point in time, but also observes developments, shifts

in actors, and policy responses over time (Bracci et al., 2021). Data were obtained through in-depth interviews with various stakeholders, such as policymakers, program implementers, health workers, and beneficiary communities, conducted in stages over several years. Additionally, analysis of policy documents, official reports, meeting minutes, and media archives was used to complement and verify field findings. This approach strengthened the validity of the data through triangulation of sources and time, and enabled a more nuanced understanding of the factors influencing the success or obstacles in implementing health protection policies. This study sought to capture structural changes and actors within the policy context while simultaneously addressing national dynamics.

III. RESULTS AND DISCUSSION

The Beginning of Health Insurance in Indonesia

Before the establishment of the Social Security Administration for Health (BPJS Kesehatan) in 2014, the Indonesian health insurance system had undergone a long process that began during the New Order era. The origins of health insurance in Indonesia can be traced back to 1968, when the government established the Health Maintenance Fund Administration Agency (BPDPK) to provide healthcare services for civil servants and their families. Initially, BPDPK was a unit under the auspices of the Indonesian Ministry of Health. Following Government Regulations No. 22 and 23 of 1984, it was transformed into Perum Husada Bakti (PHB), a separate state-owned enterprise. Prior to its most recent change to BPJS Kesehatan, PHB also changed its name to PT Askes (Persero) in 1992. Askes provides healthcare coverage for civil servants, retirees, and active members of the Indonesian National Armed Forces (TNI) and the Indonesian National Police (POLRI).

In addition to Askes, the government also established a social security program for workers through PT Jamsostek (Persero), which was established under Law No. 3 of 1992. In this scheme, health insurance is one of four social security programs for workers in the formal sector outside the civil service. Meanwhile, for the poor and disadvantaged, the government began developing social assistance schemes in the early 2000s. One of these is the Community Health Insurance Program (Jamkesmas), which was launched in 2005, and was previously known as JPK Gakin (Health Care Guarantee for Poor Families).

Jamkesmas is a significant milestone, marking the government's efforts to expand national healthcare coverage to the poor without paying premiums. The program is fully funded by the State Budget (APBN) and managed by the Ministry of Health. In some regions, local initiatives known as Jamkesda (Regional Health Insurance) have also emerged, aiming to reach residents not yet covered by Jamkesmas or Askes. The fragmentation of these various insurance schemes has become a challenge, leading to overlapping services, differences in benefits, and disparities in funding. This situation has prompted reform of the social security system through the enactment of Law No. 40 of 2004 concerning the National Social Security System (SJSN) and Law No. 24 of 2011 concerning the BPJS (Social Security Agency), which serves as the legal basis for transforming the various scattered schemes into a single national system. Through this policy, the government consolidated all health insurance programs into a single entity, BPJS Kesehatan (Healthcare), which began full operations on January 1, 2014, as the sole implementer of the National Health Insurance (JKN) program.

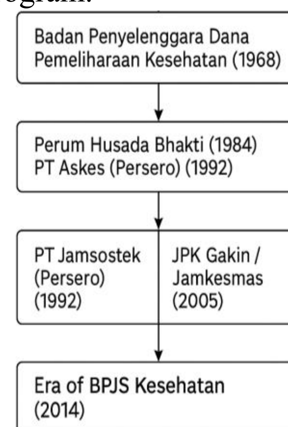

Figure 1. The Development of National Health Insurance in Indonesia

Several studies have explored the evolution of health insurance in Indonesia prior to the establishment of the National Health Insurance Agency (BPJS), with particular attention to the challenges of policy fragmentation and its implications for the effectiveness of social protection. Thabrany (2008), for instance, documented how Indonesia's health insurance landscape was historically divided along occupational and socio-economic lines, with distinct schemes such as *Askes* for civil servants, *Jamsostek* for formal private sector employees, and *Jamkesmas* targeting low-income populations. This fragmented system was widely viewed as contributing to disparities in access, inefficiencies in resource allocation, and the duplication of services. Although the introduction of *Jamkesmas* marked a significant step toward expanding coverage for the poor, Thabrany noted that the program continued to face structural challenges, particularly with regard to funding sustainability and the quality of healthcare services provided. The absence of a unified health insurance framework not only limited the system's equity and efficiency but also hindered the development of a coherent national strategy for health financing. These early experiences underscored the need for integration, eventually leading to the formation of BPJS as a centralized mechanism aimed at achieving more equitable and comprehensive health coverage across all population groups.

Another study by Rokx et al. (2010), in a World Bank report, analyzed the financing and institutional dynamics of the health insurance system before the BPJS. The report emphasized that although Indonesia had demonstrated a commitment to expanding health coverage, the existing system still faced various structural problems. These included weak coordination between institutions, overlapping central and regional authorities, and the absence of an integrated financing mechanism that guaranteed continuity of services for all citizens. The study recommended the creation of a single institution capable of integrating all health insurance schemes into a single national system—a recommendation that was later realized through the establishment of BPJS Kesehatan.

Furthermore, a study by Kristiansen and Santoso (2006) also illustrates how the implementation of the JPK Gakin scheme in various regions shows significant variation in implementation and outcomes. Their findings indicate that the main obstacle in implementing the health insurance scheme for the poor lies not only in financing, but also in regional institutional capacity, the availability of health facilities, and the community's understanding of their rights as beneficiaries. These studies strengthen the argument that the transition to BPJS is a response to the systemic need to unify various schemes into a more inclusive, efficient, and equitable health protection system.

BPJS Kesehatan Era

Since the implementation of the National Health Insurance (JKN) in 2014, BPJS Kesehatan (Social Security Agency for Health) has undergone a major transformation in the provision of universal healthcare services in Indonesia. This program aims to provide equitable and affordable access to healthcare services for all citizens. With a membership coverage of over 279 million people, or approximately 98% of the population, BPJS Kesehatan is one of the largest healthcare insurance systems in the world. However, this successful expansion of membership has been accompanied by serious challenges that test the program's overall sustainability and effectiveness. The most fundamental problem lies in the financial deficit. The claims-to-contributions ratio continues to show an imbalance—in 2024, the claims ratio was recorded at 107.93%, meaning that healthcare expenditures exceed contribution revenues. This situation is exacerbated by the high number of inactive participants, particularly in the independent (PBPU) segment, which reaches tens of millions of people with significant contribution arrears. Furthermore, delays in claims payments to hospitals are also a structural problem. Several regions recorded arrears reaching tens of billions of rupiah, which impacted the operation of health

services and even endangered the continuity of services for patients.

Another equally significant challenge is the problematic claims processing at several healthcare facilities. According to several healthcare workers at several facilities, the claims process often faces issues, with differing perspectives between BPJS Kesehatan and the healthcare facilities. Most utilize a reimbursement system, and if claims are not promptly processed, healthcare services face challenges. However, fraud in the claims system is also undeniable. Audits by various parties, including the Corruption Eradication Commission (KPK), have found fictitious claims or improper billing in several hospitals, which has harmed state finances and undermined public trust in the system. Suboptimal enforcement of sanctions has also been highlighted, resulting in a lack of deterrent effect for violators. BPJS Kesehatan must continue to develop an efficient claims system without disrupting healthcare services. Furthermore, unequal access to services remains an issue, particularly in remote areas such as Papua and other regions, where healthcare facilities are significantly limited compared to Java.

In an effort to address these various issues, the BPJS Kesehatan (Social Security Agency for Health) has begun implementing a number of innovations and policy reforms. One important step is optimizing alternative funding sources, such as donations through the JKN Care Fund program and utilizing regional cigarette excise funds. On the technology side, BPJS Kesehatan has also begun implementing a digital system based on big data and artificial intelligence to detect problematic claims and is encouraging the implementation of electronic medical records in various healthcare facilities. The government has also initiated a transformation of the service class system through the Standard Inpatient Class (KRIS) policy, which is expected to improve the efficiency and equity of healthcare services. However, it cannot be denied that several of these planned activities have not yet been implemented properly or are still under evaluation.

Despite facing various obstacles, BPJS Kesehatan's progress reflects a strong determination to realize equitable and sustainable healthcare coverage in Indonesia. However, more holistic strategic steps are needed, ranging from increasing transparency, strengthening regulations, to equitable distribution of healthcare infrastructure and information technology. The sustainability of the JKN program depends not only on financial management but also on the commitment of all stakeholders to ensure quality, efficient services that support the public interest.

To strengthen a more sustainable financing system, BPJS Kesehatan (Healthcare Social Security Agency) is also developing collaborative schemes between the government, the private sector, and civil society. One such scheme is mandating regional governments to allocate a portion of cigarette excise funds (37.5%) to support the implementation of the National Health Insurance (JKN) in the regions. This policy successfully raised more than IDR 10 trillion by 2024 and played a significant role in covering part of the deficit. Furthermore, CSR programs and public donations through the JKN Care Fund are also showing positive trends, with more than IDR 12 billion collected by early 2025 to assist informal participants struggling to pay their premiums. This scheme demonstrates that social participation can be part of the solution to the challenges of national health insurance. Despite various policies, BPJS Kesehatan still needs to address governance and transparency issues. Data discrepancies between hospitals and BPJS, as well as slow claims verification processes, often trigger administrative conflicts. To address this, BPJS has begun developing a cloud-based digitalization system and artificial intelligence (AI) that can expedite the verification process and detect potential irregularities in real time. However, the successful implementation of this technology depends heavily on the readiness of digital infrastructure and human resources at the regional level, which still varies greatly between regions.

Given these dynamics, the future success of BPJS Kesehatan (Indonesian Health Insurance) will be determined not only by technical innovation and fiscal policy, but also

by consistent efforts to build public trust and strengthen governance. Cross-sector collaboration, regular policy evaluations, and a data-driven approach based on local needs will be key to addressing the challenges of universal health coverage in Indonesia. If this reform momentum is maintained and strengthened, BPJS Kesehatan has a significant opportunity to become a model for an inclusive, resilient, and socially just social security system for all Indonesians.

Discussion

BPJS Kesehatan (Indonesian Health Insurance) is the newest health insurance scheme currently in Indonesia. Despite the challenges in its implementation, it is undeniable that BPJS Kesehatan has made positive efforts to support UHC, particularly in Indonesia. Reinforcing statements from previous research, BPJS Kesehatan demonstrates the government's political commitment to the health care system by increasing the reach of health insurance to all levels of society. The increase in membership in the BPJS Kesehatan era, which covers approximately 97% of the Indonesian population, is certainly a positive trend in the development of health insurance policies in Indonesia. Unlike previous eras that had limitations in service recipients, BPJS Kesehatan is more holistic and in line with the UHC goal of providing access to health services to all parties. Simply put, BPJS Kesehatan is close to achieving comprehensive population coverage in accordance with the UHC goals.

However, it cannot be denied that several evaluations still need to be conducted. BPJS Kesehatan (Indonesian Health Insurance) still struggles to achieve efficient resource use, a key aspect of previous research that health insurance must have to achieve UHC. BPJS Kesehatan continues to face challenges in efficient resource use, as several issues persist, such as the claims issues described in the findings section. This contrasts with Askes (the previous scheme), which, according to several informants from healthcare facilities, did not experience similar issues. However, these issues are certainly different, as BPJS Kesehatan offers far broader coverage than the NHI schemes before BPJS Kesehatan. Consequently, an efficient management model still needs to be developed and discovered. This is expected to improve the quality of health insurance services and build user and provider trust in healthcare services.

Despite this dilemma, Indonesia's health insurance system has also been able to optimally strengthen primary healthcare facilities (community health centers/clinics). The tiered referral system then strengthens healthcare services at the lowest level, effectively mitigating the congestion of healthcare services at the highest level. Despite several evaluations that need to be conducted, the implementation of this system is consistent with previous research and has been proven to increase the effectiveness of healthcare services in Indonesia. However, supporting regulations and user outreach are certainly needed to more clearly demonstrate the differences and limitations of each level of healthcare service, thus facilitating the delivery of services by healthcare facilities.

In order to achieve UHC comprehensively, sustainable funding and cross-sectoral policy support are essential. This aspect remains a challenge in the implementation of national health insurance in Indonesia to date, where health insurance funding in Indonesia certainly relies on a cross-subsidy system between each participant and some participants who have not been disciplined in fulfilling their responsibilities. Nevertheless, the current Indonesian health insurance has at least slowly managed to anticipate these problems and pay off the previously very high health insurance debt. Despite these positive aspects, several things also still need to be addressed. One of them is strengthening public trust in the National Health Insurance (NHI) in the BPJS Kesehatan era. Problems at the community level still frequently occur due to weak public trust in the services provided by BPJS Kesehatan. This has also caused conflicts between providers (health care providers) and users (the public). Furthermore, BPJS Kesehatan employees who use health insurance other than BPJS Kesehatan, or private health insurance, have also become a topic of discussion, leading the

public to question the commitment of the NHI services provided by BPJS Kesehatan. These matters then need to be considered and evaluated.

IV. Conclusion

This research has traced the complex evolution of Indonesia's health insurance landscape, highlighting how historical fragmentation and policy experimentation eventually led to the formation of BPJS Kesehatan as a unified national system. While the integration under BPJS marked a significant milestone in Indonesia's pursuit of UHC, the findings suggest that the journey is far from complete. Persistent challenges—particularly in the efficient use of resources, claims management, and public understanding of the tiered healthcare system—indicate that structural and operational improvements are still needed. However, the system has also demonstrated clear progress, especially in strengthening primary healthcare and expanding coverage to previously underserved populations. Moving forward, refining the management model, improving communication between stakeholders, and reinforcing supporting regulations will be key to ensuring that BPJS Kesehatan not only expands access but also delivers high-quality, equitable, and sustainable healthcare for all Indonesians.

While this study provides valuable insights into the evolution and implementation of Indonesia's health insurance system, it is not without limitations. The research focuses primarily on policy dynamics and stakeholder perspectives, which may not fully capture the on-the-ground experiences of patients across diverse regions. Additionally, the longitudinal case study method, while rich in contextual detail, is limited in its generalizability. Data availability and access to key informants were also constrained in some instances, potentially influencing the depth of analysis in certain areas. Future research would benefit from incorporating more quantitative data, particularly on service utilization and outcomes, to complement the qualitative findings and provide a more comprehensive evaluation of NHI's performance.

Based on the findings, several key recommendations can be proposed. First, there is an urgent need to improve the efficiency of claims processing and fund management within Indonesian NHI to ensure timely reimbursements and build trust among healthcare providers. Second, clearer communication and public education about the tiered healthcare system could help users better navigate services and reduce misunderstandings about access and referral procedures. Third, ongoing training and capacity building for health workers and administrators at all levels can strengthen service delivery and policy implementation. Finally, the government should continue to support regulatory reforms that enhance transparency, accountability, and responsiveness within the health insurance system, ensuring that Indonesia remains on track toward achieving equitable and sustainable UHC.

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