White Paper: Indonesia's Health Sector Development (2024–2034)

Designing a Future for Policy and Delivery

Center for Indonesia's Strategic Development Initiatives (CISDI)

Study Report

White Paper on Indonesia's Health Sector Development

(2024-2034)

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For Kuntoro Mangkusubroto

A thinker who delivers

WHITE PAPER

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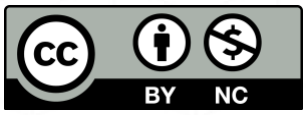

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Table of Contents

List of Figures

List of Tables

List of Boxes

List of Abbreviations

API	Application Programming Interface
ASEAN	Association of Southeast Asian Nations
CDH	Commercial Determinants of Health
COVAX	COVID-19 Vaccines Global Access Facility
CEA	Cost-Effectiveness Analysis
CPA	Corporate Political Activities
DNA	Discourse Network Analysis
FCTC	Framework Convention on Tobacco Control
FGD	Focus Group Discussion
G20	Group of Twenty
G7	Group of Seven
GDP	Gross Domestic Product
IDI	In-Depth Interview
IHME	Institute of Health Metrics and Evaluation
IKN	Ibu Kota Negara (New Capital City in Kalimantan Utara)
JKN	National Health Insurance (Indonesia)
KTP	Kartu Tanda Penduduk (National ID Card)
OECD	Organisation for Economic Cooperation and Development
PSN	Proyek Strategis Nasional (National Strategic Projects)
SSB	Sugar-Sweetened Beverages
STEEPV	Social, Technology, Economic, Environment, Politics, and Value
USD	United States Dollar
UU	Undang-Undang (State Law)
UU ITE	Undang-Undang Informasi dan Transaksi Elektronik (Electronic Information and Transactions Law)
WHO	World Health Organization

Glossaries

Terms	Description
BPJS Kesehatan	The Social Security Administering Body for Health in Indonesia, responsible for implementing the JKN program.
Commercial Determinants of Health (CDH)	Strategies used by companies or the private sector to promote unhealthy or harmful products and choices.
COVAX facilities	Global initiative aimed at equitable distribution of COVID-19 vaccines.
Delphi	Structured communication technique or method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts.
Democracy Index	An index that measures the state of democracy in countries based on various criteria.
Discourse Network Analysis (DNA)	A research method that analyses the relationships between concepts and actors in discourse or communication networks.
Disinformation	Deliberate spreading of false information with the intent to deceive or manipulate.
Foresight	A tool used for long-term planning that assists in policy making, encourages policy innovation, and opens up possibilities to experiment through innovative approaches.
Hierarchy	A system of ranking or organising individuals or groups based on status or authority.
Hoax	False information or rumour that is deliberately spread to deceive people.
Horizon Scanning	A technique to identify early warning signs of changes in policies and strategies, used in foresight to gather scientific knowledge and opinions from various stakeholders on strategic issues.
ID Card (KTP)	Kartu Tanda Penduduk, a National ID Card in Indonesia.
Indonesia Vision 2045	A vision for Indonesia's development and economic growth by the year 2045.
Intersectionality	The interconnected nature of social categorizations and their impact on individuals.
Kominfo	Ministry of Communication and Information in Indonesia.
Misinformation	False or inaccurate information that is spread, often leading to

	incorrect beliefs and actions.
Multidimensional Poverty Index	A measure of poverty that takes into account various dimensions of well-being.
Multilateral Health Diplomacy	Diplomacy involving multiple countries and international organisations in the health sector.
Named Entity Recognition	A natural language processing technique to identify and classify named entities (such as names of people, places, and organisations) in text.
National Health Insurance (JKN)	A national insurance program in Indonesia aimed at providing healthcare coverage to the population.
Negative Investment List	A list of sectors or activities that are restricted or prohibited for foreign investment.
Nepotism	Favouritism or bias shown to family members or close friends in various fields, including government and employment.
Pandemic Fund	A fund established to address global health emergencies.
Primary Health Care	Essential healthcare services that are accessible to all individuals and communities.
Return on Investment (ROI)	A measure of the profitability or efficiency of an investment.
Social Network Analysis (SNA)	A method to analyse social structures through the use of networks and graph theory, often used to study relationships on social media.
STEEPV	Social, Technology, Economic, Environment, Politics, and Value elements that influence and shape future possibilities in foresight.
Sugar-Sweetened Beverage (SSB) Taxes	Taxes imposed on sugary drinks to reduce consumption and combat health issues related to excessive sugar intake.
Universal Health Coverage	Ensuring that all individuals and communities have access to quality health services.

Foreword

Centre for Indonesia's Strategic Development Initiatives (CISDI) conducted a study and published a report titled **"White Paper for Indonesia Health Sector Development (2024-2034)".** The study was carried out with the aim of providing recommended policy directions for health policy makers, development actors, as well as material for adoption by the incoming new government who will step into national leadership in 2024. As part of the civil society communities in Indonesia, the team of researchers aspire for this paper to function as a public health compass for the greater public. This study examines the condition of Indonesia's health policies, particularly in the national health system and primary health care, from before the pandemic until it took place and the consequent policy improvements required in the future.

This study formulates recommendations for policy improvement as the world prepares itself for a changed development dynamics as we emerged from the pandemic. These recommendations are based on global and regional scientific evidence as well as explicit and implicit knowledge gained from experience working at national, sub-national and communities levels.

The research process for the first phase was conducted from February to October 2023, until it was finally disseminated in November 2023. From January to July 2024, the paper underwent alignment, refinement, and expert panel review, leading to the publication of this latest version. This research was carried out as a CISDI initiative, and the funding for this study was independently sourced by CISDI, without support from any donors or external parties.

Diah Satyani Saminarsih, CEO and Founder of the Centre of Indonesia's Strategic Development Initiatives (CISDI) is the Principal Investigator and corresponding author of this study.

Overall process of research, analysis and report writing were carried out by a team of CISDI researchers and thinkers consisting of Yurdhina Meilissa, Olivia Herlinda, Sadika Nuraini Hamid, Muhamad Fachrial Kautsar, Agatha Swasti Ayuning Tyas, Syailendra Persada, Aufia Espressivo, Yurdhinda Aprilia, Muhammad Iqbal Hafizon, Rayssa Anggraeni Putri, Nadhira Febianisari, Nico Gamalliel, Reyhan Alemmario, Clarissa Magdalena, Yovi Arista, Nidya Eka Putri and Rina Chomawati.

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In developing this paper, we utilised ChatGPT, an AI language model developed by OpenAI, to assist with proofreading. The analysis and conclusions were independently determined by the authors.

CISDI claims full ownership of this study and is fully responsible for its findings, conclusions, and recommendations. All authors declare no competing interests.

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Chapter 1.
Why Now, Why a White Paper

1.1 Contextualising Health in a Changed World

"If we look at countries with strong universal health systems, many of these countries build upon their strength through crises – crisis acts as the catalyst towards the start of a change." This statement was delivered by the Former Prime Minister of New Zealand, Helen Clark, at a recent event hosted by the London School of Hygiene and Tropical Medicine in London, United Kingdom,[2] where she referred to the resilient national health systems shown during and after the start of the pandemic in countries including New Zealand, Sweden, Thailand, the United Kingdom, China, and Japan.

The commemoration of World Health Day on the third year of the pandemic acts as a point for reflection for all: are we on the right trajectory to rise from the downturn of the pandemic? Departing from global panic and extraordinary confusion came to be glimpses of light and hope through breakthrough research and the global distribution of the COVID-19 vaccine in a matter of months; reviews and improvements of the International Health Regulation; to the launch of the Pandemic Fund as one of Indonesia's leadership contributions to the G20 summit.[3,4] The world is not only preparing for the next pandemic but preparing to act in solidarity to defend humanity.

Figure 1. COVID-19 Dashboard WHO[5] (captured on 8 November 2023)

For the past three years, the momentum and dynamics of multilateral health diplomacy have also continued to be moved toward meaningful actions to occur. The "Big Bang" devastation of impact as the result of the pandemic has uncovered the necessary impetus for significant changes and reshaping needs for national health systems resilience. This resulted in a policy climate suited to raise attention from isolated realms of health diplomacy into public conversations domain from communities to national, regional and global levels. Through various platforms, such as the WHO, G20, G7, ASEAN, African Union, and the European Union, many countries came together and contributed to the development of concrete solutions to end the pandemic once and for all toward a restored world.

1.1.1 Towards a Restored World

What must we do to achieve the collective aspiration for a restored world? Recognizing its strategic position in determining policy prioritisation and the mobilisation of global financial resources, the Hiroshima Global Health Task Force was established to provide guidance for the Government of Japan as a part of the G7 Presidency. Several key priorities were identified as the gateway toward the global development of the post-pandemic world.

One stated the vital need to prioritise a human and community development security approach. This approach will aid in facilitating governments and systems to see people as individuals as well as seeing them as a part of a wider society. Human well-being and security cannot be separated from national resiliency as it protects populations from health threats while increasing their capacity to face various public health challenges to tackle structural inequities. The task force also stated how a transformative and gender-equitable primary health care system is the cornerstone of achieving universal health coverage and health security. From a financial and budgetary perspective, the Government of Japan also recognizes how many low- and middle-income countries face financial burdens due to slow economic growth and global inflation.[6]

In 2017, the Government of Japan committed to providing 2.9 billion USD for Universal Health Coverage to underpin the strengths of the health systems through access to financial and quality health services for all.[7] Though in the aftermath of the pandemic, multiple collective concrete actions from all the countries in the world were needed to rebuild health systems devastated by the prolonged pandemic.

However, raising current global financial resources has become arduous. The world's economic conditions have significantly slowed due to the strained resources wiped out due to the pandemic. Not only in the business sector, global humanitarian activities saw a massive toll. The elimination of 1,500 job opportunities at the International Center of the Red Cross showcases the devastating impacts of economic deceleration on humanitarian actions.[8] Beyond aspirational alignments, fiscal instrument mechanisms such as debt swaps and

alternative/blended financing for health development are needed. If such mechanisms are successfully delivered as a key outcome within global health diplomacy, financial mobilisation for health development, particularly among low- to middle-income countries, will be realised.

1.1.2 Addressing Gaps and Intersectionalities in Health Sector Development

It must not be overlooked that addressing impacts of pandemic, rebuilding countries and the world, cannot be separated from the already widening health, social and economic inequities. Jobs and economic loss are two of the most tangible impacts, while consequences of other intangible losses are equally detrimental. Left unattended, increasing Multidimensional Poverty Index[9]; the gap between access to clean water in Jakarta (93.4%) and Bengkulu (41.1%)[10]; and inequality between and within countries in vaccination coverage; will be an insurmountable barrier for a thriving and reformed health sector development (see Figure 2).[11]

The Institute of Health Metrics and Evaluation (IHME) has reported on the global burden of diseases for more than a decade.[12] The growing burden of diseases presented an added layer of complications when added with the impacts of global pandemic. Morbidity and mortality rates alone cannot fully describe the magnitude of depth required when addressing gaps within this sector. Climate and environment issues, the various intersectionalities such as gender, vulnerable populations needs, called for structural shift in public health policy making in the next ten years.

While it is crucial to reform and rebuild within a particular sector, such as health, it is equally important to always consider the intersectionality and interconnected aspects of health. Democracy Index, Corruption Index, overall macroeconomic growth, access and availability of housing, availability of clean water, access to broadband internet both in households as well as health facilities and unemployment rate; are indicators which closely influenced successful attainment of health goals.[13]

Figure 2. Growing inequity in Indonesia

1.1.3 Determining Policy Prioritisation for Change and Impact

The highest responsibility in rebuilding health systems falls within each and every country. Across various forums, goals, and promises on the global and regional levels, the entire policy follow-ups and implementation are realised at the national and sub-national levels. National-level policies set the direction for sub-national policies and become the compass for various public actions spearheaded by civil society organisations. Recognizing these dynamics is required throughout the complete policy making and decision processes. Meaningful collaborations with civil society organisations, academia, the media, and the private sector, according to their capacity and expertise, have proven beneficial and saved public health through the most treacherous period of the pandemic.

The principle of evidence-informed policymaking is non-negotiable. Though the immediate challenges of the pandemic showcase how the evidence collected is not yet sufficient in numbers and is still anecdotal, resulting in policymakers with a dilemma. On the one hand, new and effective policies are needed. However, insufficient data points are available, nor is other evidence to ensure a successful implementation. This results in policies with a reactive characteristic while losing their sustainability aspects within it.

In three years, more than enough data have been collected to develop sharp policies that can be operationalized at the national down to the sub-national and community level. More than millions of lives have been lost due to the pandemic; there is no room to accommodate policies developed in an ad-hoc and hastened approach to serving short termed political deadlines.

During this critical juncture lasting for almost two years, much of the state's financial resources were absorbed for the pandemic response.[14] Due to the centralised nature of the

health sector to the successes of development at large, it is now time to set the health sector's fiscal space at the same level of urgency, commitment, and allocation seen in the education sector. This budgetary commitment, supported by political commitment, is what must be set in place if a health system reformation is to be truly realised in its complete form.

1.1.4 Measuring Success, Now, and in the Future

There is not one development sector that has the ability to stand alone. From a health perspective, this is known as Health in All Policies. Successes in the health sector are also often determined by policies originating from other sectors supporting the achievement of health targets.

A health system's resilience is not only seen through its capability to respond during a health emergency but also through its capacity to face external shocks. Recognizing the intersectoral nature of the health sector with other development sectors, success indicators informing the extent of health system reformation encompasses indicators within and outside of the health sector.
In the publication "Democracy Index 2021",[15] it is stated that a global public health crisis has become one of the causes of the decline in democracy in many countries of the world. Moreover, the pandemic has also resulted in deep segregation between those who favour the principle of security and expert-based policies and those who prefer an approach that is not prescriptive and allows room for more individual freedom. There are five democracy index measurement categories: pluralism and electoral processes, the extent of a functioning government, political participation, political climate, and societal freedom. Referring to the said democratic index, it is thus evident that the extent of quality of democracy has the potential to be used as one of the indicators originating from outside of the health sector to measure the success of the health system reform.

Meanwhile, based on a published study by the European Observatory on Health Systems and Policy, several measurement domains used to ensure health system performances are the population's health, individual health, quality and accuracy of clinical services, health system responsiveness, equity, and productivity.[16] It is equally important not to overlook in defining the most vulnerable populations, addressing the factors contributing to their vulnerability, and ensuring tailored treatment approaches for the entire population.

A complete shift in benchmark and thinking processes is needed to answer how best to rebuild a more resilient health system compared to pre-pandemic periods. It is evident that systems collapse in the event of an outbreak, even more so in a pandemic. Rebuilding back systems means a complete and comprehensive reformation. Rebuilding back systems does not mean rebuilding a system to the state it was once before—but rebuilding to produce much better

outcomes through evidence-based priority setting, inclusivity, transparency, economic prudence, and measurability.

1.2. Making Health a National Development Priority

As a country on the fast track to sustained economic growth and vision towards claiming a demographic bonus (Indonesia Vision 2045); the loss from pandemic might potentially be difficult to recover. On the other hand, one has to admit that had it not been to COVID-19, health would not have surfaced to the centre of public conversations. Various researches, community innovations, state or government initiatives and response, were thrust front and centre. Health, including its connection to policies and systems, became everyone's topic of discussion. Implications of not being able to achieve health goals and targets, became an imminent threat to nations.

However, as the emergency period slowly passed, so did people's attention and awareness. Health has shifted back into a business as usual issue for many. Political and budget commitments for health steadily declines.[17,18] At the global level, inequity has not only remained. It has grown. The COVAX facilities, who has received USD 12.5 billion until 2022 to ensure equitable global vaccines distribution faced difficulties in ensuring global south countries can increase their COVID-19 vaccines coverage.[19] Contrary to COVAX that can be considered as successful in their resource mobilisation, the Pandemic Fund[20] fell short in achieving its funding targets. A year into its operations, while pushing for good governance and meaningful inclusion of multiple actors in its Governing Board, the Pandemic Fund was able to gather only around 20% of USD 10.5 billion of the estimated annual gap needed for PPPR.[20,21]

This constant context of health being positioned as a second layer of development priority, even after facing such dire loss of lives during pandemic; triggered this White Paper. Rebuilding consists of comprehensive stock taking of past mistakes or failures, utilisation of tools that have not been used before, designing new mechanisms and reenforce policy strength towards ensuring delivery and impact. Identification of health development stakeholders and ensuring inclusivity, diversity and transparency is also key to ensuring wider ownership of policies produced.

At the onset of this White Paper study, the researchers designed a framework to build the compelling case for change to function as an overall foundation of approach. This compass enabled the team to employ the methodology while in parallel pushed for coherence in communicating the findings of this study to multiple development actors from different sectors. Figure 3 shows the framework of approach of this White Paper.

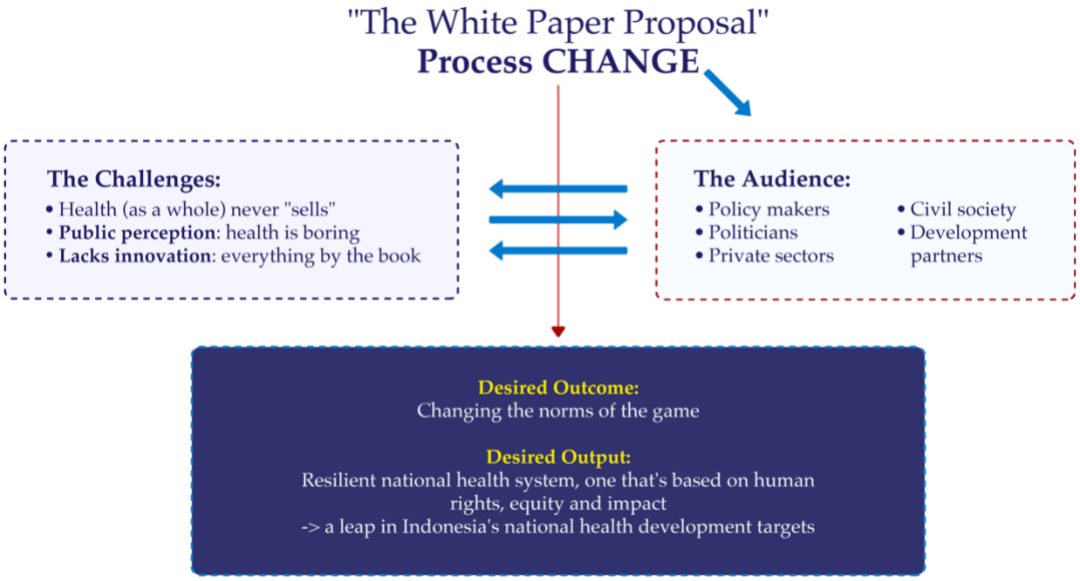


Figure 3. The Compelling Case for Health Sector Reform

1.2.1 National Health System Reform

Suppose the budgetary and political commitment of the health sector is brought upon. How does one determine priority in a sector almost annihilated by the COVID-19 virus? The policy paper "Making the Economic Case for Investing in Health Systems",[22] stated that beyond the benefits acquired for the population's well-being, investments in health systems improvements produce positive externalities on macroeconomic conditions as well as the sustainability of state's fiscal availability. In the event such health system reformation is seen as an investment step taken with the evidence-informed principle, which parts are to be prioritised? What policies should be in place to address the threats surrounding chronic diseases, the nutritional status of children under-5, and the growing number of smokers in Indonesia? Should that not also be a priority? Despite the long-term nature, why does much global and regional evidence suggest that investments in health systems are the most logical step to take due to their affordability and high returns?

Ideally, a range of activities should be conducted as a part of public policy making processes. Firstly, an impact evaluation needs to be done. Second is the measurement and reporting of Cost-Effectiveness Analyses; and third, particularly considering the immense magnitude and scale of the national health system reformation, a measurement of the Return on Investment is required. Beyond the need for an integrated data and management system at all levels of policymaking, these three activities require economic modelling as an output from various research in the field of health economics and health systems. Policymakers are positioned in such a strategic space to improve policy production processes, that on its own will enhance the quality of these policies. While awaiting national evidence and research results,

policymakers may refer to evidence uncovered and researched on the global and regional levels. Within the restructuring and reformation processes, this step is known as benchmarking.

On policy making processes, we appreciate some involving public in consultations, as seen from the policymaking processes on the Sexual Violence Law and the consultation process of the Health Revision Bill. However, it must be noted that end-to-end multi stakeholder meaningful engagement, involves inclusion from planning to confirmation and implementation in a continuous sustainable manner. Access and implementing a reporting infrastructure must be ensured to serve as a multi-stakeholder feedback forum to account for the diverse needs throughout the policymaking process. Consistency in carrying out these processes will help change the accuracy and sharpness of the policies produced.

With the current global and regional benchmarks, evidence has shown points in which the highest potential return on investment and budget effectiveness were found in primary health care, the provision of financial access for quality health care, and human resources for health. These are the three strategic elements within the health system. Of course, as seen with other investments, detail accuracy requirements must be met to ensure optimal return is realised.

Chapter 2.
Foresight and Policy Prioritisation Methodologies for Overall Reform of the National Health System

2.1 Foresight

Foresight is used by the Organization for Economic Cooperation and Development (OECD) as a tool for long-term planning.[23] Foresight can assist the government in policy making to develop policies that can anticipate possible changes and disruptions. In addition, foresight also encourages policy innovation that opens up the options or possibilities to experiment through and with innovative approaches.

It is very important to distinguish between Foresight and Forecast (prediction or prognosis of the future). Foresight is more of a process than a technique as pictured in Figure 4. Foresight is not intended to predict with certainty what will happen in the future. Foresight guides the process of thinking, debating and shaping the future in a participatory, open and action-oriented way, by defining and fulfilling a shared long-term vision and desired future conditions. In contrast to forecasts, foresight is not aimed at 'getting the future right', but to broaden and reframe reasonable developments that need to be considered.

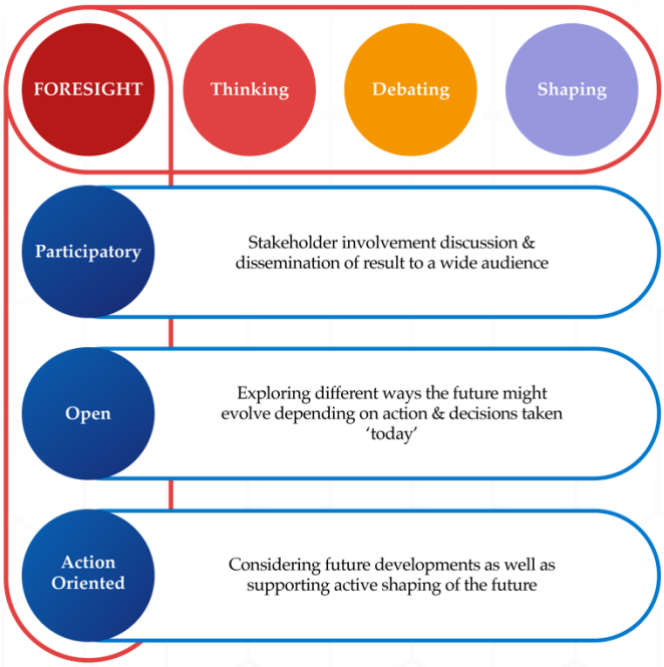


Figure 4. Concept of Foresight (Source: OECD[23] & CISDI[24])

Foresight brings together key change agents and various knowledge sources to develop strategic vision and anticipation. By emphasising stakeholder networking and participation

throughout the vision development and future-oriented policy-making process, *Foresight* can be carried out effectively to inform policy-making, build networks, and enhance the ability to address long-term problems.

Foresight can have different functions that support policy making[25], such as:

- **Informing policy**: generating insight into the dynamics of change, future challenges and options;
- **Facilitating policy implementation**: increasing capacity for change in specific policy areas by building shared awareness of current and future challenges such as building networks and new visions among stakeholders;
- **Empower participation** in policy-making and thereby increase transparency and legitimacy;
- **Support policy definition**: jointly translate the results of the collective process into specific options for policy definition and implementation;
- **Reconfiguring** policy systems to address long-term challenges;
- **Has a symbolic function** in showing the public that policies are based on rational information.

Foresight relies on a set of forward-looking approaches that aim to help decision makers explore and anticipate in a participatory manner what might happen, and prepare for future possibilities, influencing and shaping them. Foresight is usually carried out by systematic, participatory discussions, and the process of developing a medium to long-term vision to open up alternative possibilities that occur in the future. Foresight uses different methods and tools to consider different possible future developments and their integration into current decision-making, by thinking, debating and shaping the future.[26]

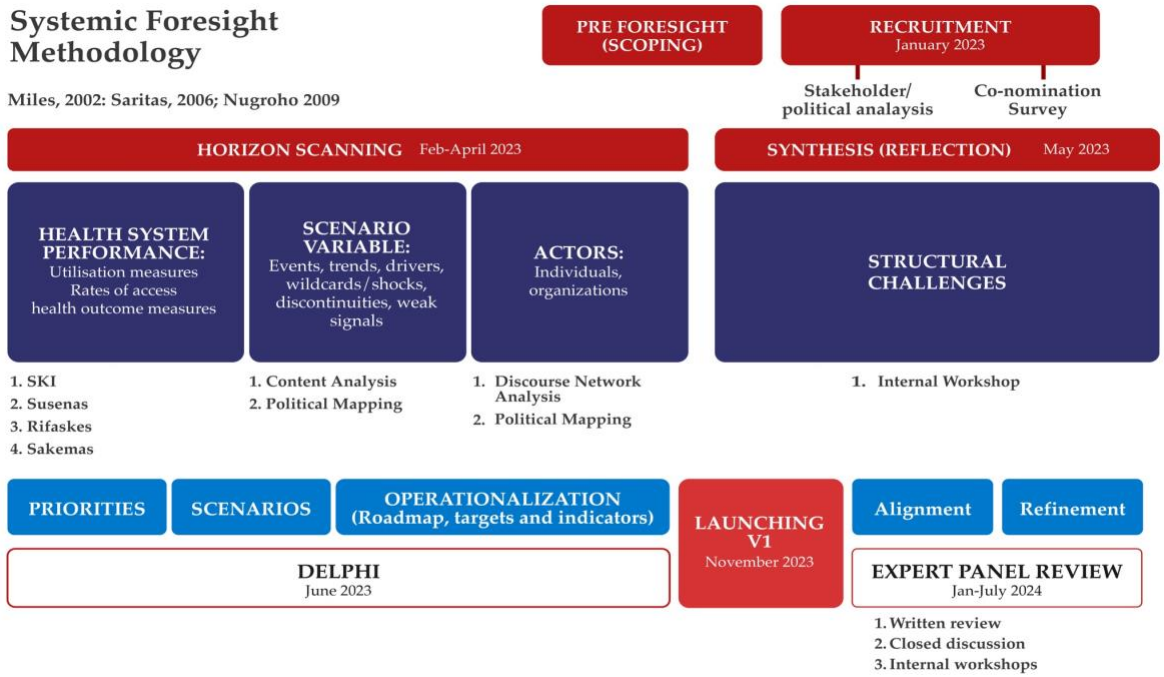


Figure 5. Research methodology used (Source: author)

This report employs a modified version of the Miles foresight framework, tailored to the study's specific needs. By integrating key change agents and diverse knowledge sources, this approach fosters strategic vision and anticipation. Our research process was conducted in two phases (see Figure 5): 1) **Phase One** (February-November 2023) included pre-foresight, recruitment, horizon scanning, synthesis, and 21 Delphi and 4 plenary sessions, which resulted in the initial draft of the paper; 2) **Phase Two** (March-July 2024) involved 8 internal workshops, 33 expert panel reviews, and an additional expert consultation session to further incorporate updated data and refine the paper. This step was taken to ensure its relevance as a reference for the new administration (2024-2029).

Theoretically there are five stages of the Foresight methodology[27], namely (i) pre-Foresight; (ii) recruitment; (iii) implementation of Foresight (generation); (iv) take action based on foresighting (action); and (v) evaluate and update the cycle (renewal). This process is a standard process and has been practised in many contexts both in developing and developed countries.[28] In addition to carrying out the stages according to the methodology, the foresight applied in this study is designed to put more depth on the input of expert resource persons either through Delphi or in the process of exploring the linkages of issues in the thematic discussions of Social, Technology, Economics, Environment, Politics, and Values (STEEPV).

Pre-foresight (scoping)

The process begins with the pre-foresight phase, which involves a series of scoping that include making decisions about the reasons and objectives of the foresight, the research team that will be involved, and the methodology to be used.

Recruitment (participation)

This study brings together change agents (decision makers, business, and civil society) and knowledge sources (formal and informal) to develop a strategic vision and anticipate the future. We employ stakeholder analysis to identify policy makers. We brainstormed and conducted a co-nomination survey to recruit experts who understand the relationship between primary health care issues and expertise in their respective fields. The recruitment process was done in accordance with the ethical approval published by the University of Atma Jaya number 009X/III/PPPE.PM.10.05/10/2023.

Generation

In this phase the information that is already available is collected (horizon scanning) and new knowledge is synthesised to form a future vision and action plan.

Horizon scanning is a technique to look for early warning signs of changes in policies and strategies. A combination of literature searches, Twitter conversations and online news media feeds, as well as Delphi techniques are used to gather scientific knowledge and opinions from various stakeholders on strategic issues that need to be addressed in the area of primary health care policy and to highlight related agreements or conflicts. Specifically, stakeholders were asked to identify scenario variables: trends, drivers, surprises (wild cards), weak signals, and discontinuities, which may appear, disappear or change and so influence and shape the future (expected timing of events is 2024).

During this process, it is important to look beyond the current policy environment when identifying the drivers of change. Many of the driving factors will shape the development of primary health services that will emerge from outside the policy area, namely shifts in STEEPV. Therefore, a panel of STEEPV experts was consulted to identify strategic issues related to these factors. A more detailed explanation of the STEEPV framework is provided in the following subchapter. Chapter 5 further discusses the STEEPV factors and how we leverage multiple perspectives on health development through the Health in All Policies approach.

Action

The overall objective of foresight is to provide valuable input into strategy and policy planning, while also mobilising collective strategic action. This step involves exploring alternative ways of the external environment that might develop in the future, considering how each actor might behave differently, and identifying the key terms of policy under different conditions. Scenario planning helps policymakers anticipate how the future might be different, starting today, and how to develop policies that are resilient across a range of possible futures.

The process of vision development is then used to clarify expectations, establish common goals and objectives for improvement in the health system, highlight what is important in the short term and what can be "delayed", and identify the scale of change needed to successfully achieve them. When experts explain their vision, we encourage them to be aspirational and not be shackled by today's realities. The intent behind this design is to help remove practical barriers, policies or structural confines that might be restricting them from thinking beyond the norm. The potential danger of pushing this way of thinking is that discussion groups may push the conversation into unrealistic or impractical territories. When this occurs, reminders for experts to return to the present-day reality are conveyed and allow other experts to chime in. We argue that there is more benefit in building an ambitious – even unrealistic – vision and then adapting it than being overly cautious and unaspiring for future success.

Evaluation and Renewal

Evaluation is a method of systematically collecting information on the achievements of activities that can be used for other purposes such as socialisation and renewal of activities. This information is useful for those who participate in foresight. Evaluation provides a good opportunity for the participants involved to express their views on what worked and what did not. After the evaluation, renewal of foresight is an important step that aims to create a foresight, where it can continue to be used as a policy and strategy-making tool.[29] In this book, we conducted reviews after the first version, updated it with the latest developments, and further refined the content and recommendations, resulting in the current version.

2.2 STEEPV Framework

This section introduces the STEEPV framework, which is embedded in the analysis of this foresight study. In this white paper, we incorporate the analysis of multiple interconnected sectors using the STEEPV framework, as depicted in Table 1. STEEPV is a strategic tool used to assess and analyse external factors affecting an organisation or project and is a key component of the foresight methodology. This study applies the STEEPV framework to provide a structured approach for examining broader social, technological, economic, environmental, political, and value-based factors that may influence Indonesia's health sector development.

Table 1. Descriptions of Each STEEPV Elements

SOCIAL	TECHNOLOGY	ECONOMIC
The social element encompasses demographic factors, cultural norms, and societal trends. This includes a rapidly growing population, urbanisation, stigma and intersectionalities, and changing healthcare-seeking behaviour, which all impact healthcare access and utilisation.	Technology focuses on the role of innovation and advancements in healthcare. The discussions revolve around the adoption of telemedicine, electronic health records, and medical equipment, as well as the potential for digital health solutions to improve access and quality of healthcare services.	The economic element addresses the financial aspects affecting the health sector. This element includes the national budget allocation for healthcare, health insurance schemes, public-private partnerships, and economic disparities, all of which influence healthcare accessibility and affordability.
ENVIRONMENT	**POLITICAL**	**VALUE**
Environmental factors pertain to the natural surroundings and their impact on health. This entails discussions on environmental hazards, air and water quality, climate change-related health challenges, and the promotion of eco-friendly healthcare practices.	Political factors encompass government policies, regulations, and political stability. This includes healthcare policy reforms, regulatory frameworks, healthcare infrastructure development.	Value pertains to the ethical and moral considerations within the healthcare sector. This involves discussions on ethics in medical research, patient rights, healthcare quality standards.

A literature review and horizon scanning were conducted for each specific topic to establish a baseline foundation and triangulate or support data collected from various processes, including the Delphi sessions. From six separate Delphi sessions, we gathered insights from approximately 40 multidisciplinary experts regarding the influence of these six sectors on health development. The insights from the Delphi sessions were analysed, and from the transcripts, we identified the events, trends, and drivers related to health development mentioned by the experts. However, after the analysis, we found no clear boundaries between the six elements of STEEPV, as the events, trends, and drivers overlapped and were interconnected. Therefore, the authors believe that separate discussions of each STEEPV element would not be beneficial. Instead, we present the data and information based on the framework outlined in Chapter 7.

2.3 Structuring this White Paper Series

Realising the complexities of issues within the health sector; interconnectedness of health with other sectors; the breadth of data and expertise available; and the appetite for an in depth dissection of different topics in health; the research team categorised the White Paper Series into twelve books, as follows:

- Main Book: White Paper on Indonesia's Health Sector Development (2024-2034)
- White Paper on Governance
- White Paper on Health System
- White Paper on Human Resources for Health
- White Paper on Health Financing
- White Paper on Global Health
- White Paper on Sexual Reproductive Maternal, Newborn, Children, Adolescent Health and Nutrition
- White Paper on Health Security and Infectious Diseases
- White Paper on Non Communicable Diseases
- White Paper on Digital Health
- White Paper on Risk Communication
- White Paper on Research and Development

The main book focuses on the overall approach, research methodology, horizon scanning, overall structural challenges and the required shifts as a precondition for reform. The remaining eleven books also apply foresight methodology on each different theme for generation of plausible scenarios. It is through these different plausible scenarios that different and operationable recommendations are generated in detail for each theme.

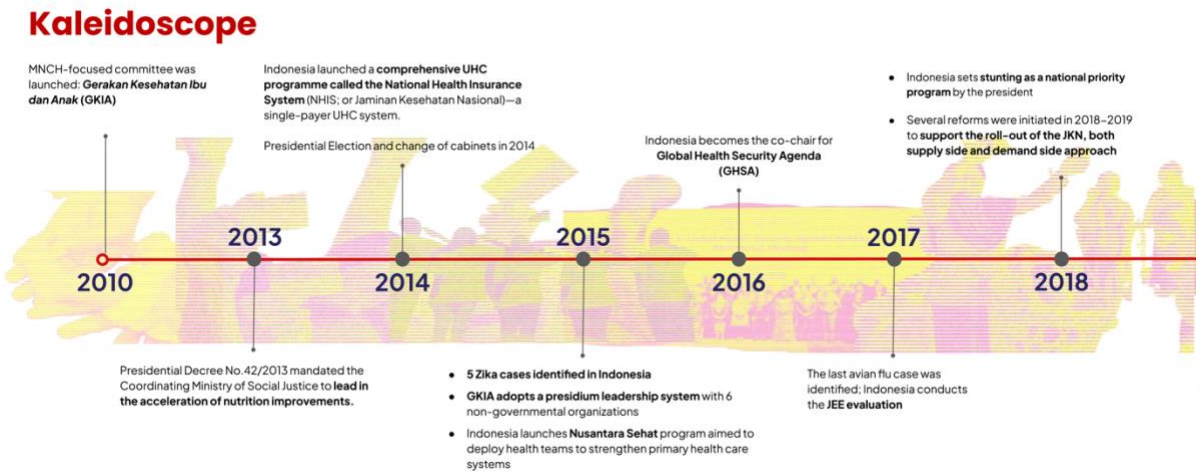
Chapter 3.
Looking Back, Addressing the Present, Planning Ahead

3.1 Kaleidoscope

No future can be structured without accounting the past. In this chapter, the researchers attempted to scan the widest health horizon possible to obtain the most complete picture of events, trends and drivers that collectively build the current landscape.

Inputs on the different events or series of events from 2010 to 2024 were extracted from expert resources persons during the Delphi consultations and expert panel review. The below kaleidoscope presents notable events by which trends and drivers were then formed. A few landmark events besides the COVID-19 pandemic occurred and were identified to originate from national as well as global levels.

It is also important to note that these events came from outside of the health sector, most notably from political angles such as the Presidential Election and also from an intersection of health and economics at global level, such as the G20.



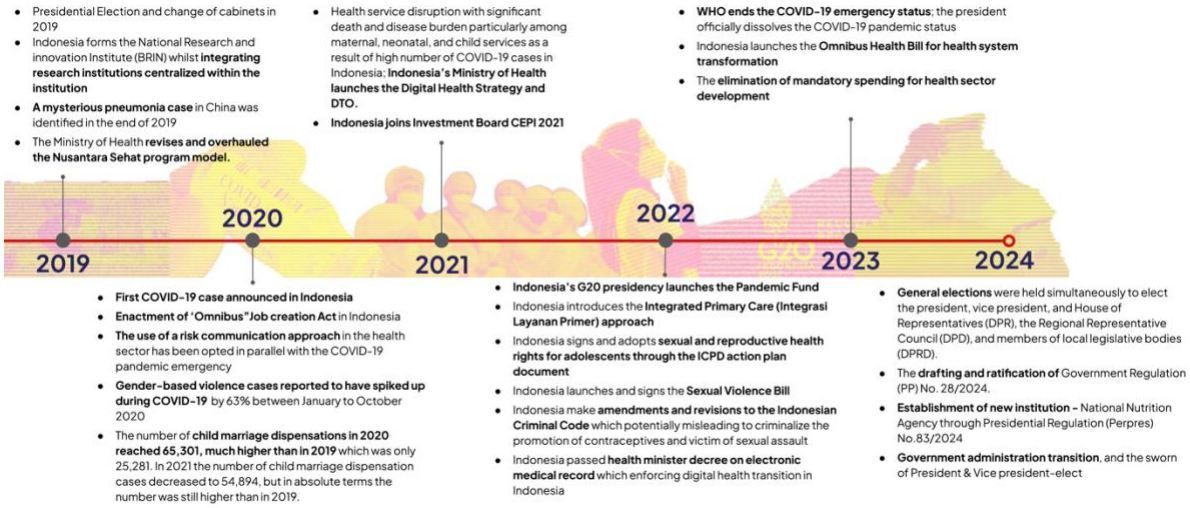


Figure 6. Kaleidoscope of Health-Related Events 2010-2024

3.2. Mapping and Structuring the Present Health Landscape

Pandemic has raised awareness of the importance of the national health system. It has also awakened leaders and policy makers on how the health system is the backbone of the overall continuity and sustainability of health service delivery. However, approaching health as a system was still a foreign concept to many, especially after years of perceiving health including its policies and regulations as merely a set of clinical interventions provided to eradicate diseases.

Immediately following the global pandemic announcement, numerous health-related initiatives were launched. While global ground-breaking progress on medical countermeasures were made in the production and roll out of vaccines, therapeutic and diagnostics; impact of national, sub-national and community initiatives must not be underestimated. Collaboration and critical roles of all actors in health and beyond were seen as extremely critical by WHO. This is the impetus of "whole of government" and "whole of society" approaches, coined in the WHO COVID-19 Strategy document.[30]

During COVID-19, many collaborations emerged. The Government of West Java took a leap in health leadership by collaborating with a civil society organisation and academia in a primary health care based initiative for pandemic response. Adopted and adapted from a civil-society led initiative to provide equal access to primary health care service in remote areas; a similar approach was conducted in 100 primary health care centres with highest sentinel risk. Initially planned to operate for a duration of six months, this collaboration lasted for three years and has since transformed into a sustained effort for health system reform with a focus on primary health care transformation.

Box 1. The Case of PUSPA West Java

Puskesmas Terpadu dan Juara (PUSPA) was established in 2021 through a collaborative effort between CISDI and the West Java Provincial Government. The primary objective of the PUSPA program was to strengthen the provision of West Java PHC pandemic response. Notably, the initiative extended critical support to healthcare workers, providing them with necessary resources such as personal protective equipment (PPE) and COVID-19 testing equipment. The program facilitated tiered training for health workers, including Community Health Workers (CHWs), and implemented innovative strategies at the puskesmas level. Due to its tangible impacts on the community, the PUSPA program has garnered annual recognition from the West Java provincial government, adapted each year to effectively address the region's evolving health challenges.

The PUSPA program was successfully implemented across 280 primary health care centres in 22 districts and cities between 2021 and 2023, with each intervention period spanning 7 months, annually. This comprehensive program notably trained 10,600 CHWs in the execution of Community Based Surveillance, reaching an impressive 17 million individuals and ensuring their access to crucial health services and information. Concurrently, the program significantly enhanced the primary healthcare services in 280 puskesmas within the West Java region, showcasing its instrumental role in promoting community well-being and resilience.

Through its effective integration of Community Based Surveillance cadres, the PUSPA program demonstrated its efficacy in containing the transmission of COVID-19 and reducing morbidity rates within the community. Recognizing the transformative potential of this approach, CISDI has actively championed the development of the *Pencerah Nusantara - Puskesmas Responsif Inklusif dan Masyarakat Aktif Bermakna* (PN-PRIMA program), building on the success of PUSPA. PN-PRIMA was designed to empower CHWs and extend critical healthcare services to vulnerable communities during the pandemic, emphasising inclusivity and meaningful community engagement.

In its initial phase, PN-PRIMA made significant strides in enhancing Covid-19 vaccination coverage among vulnerable groups and revitalising CDC-Nutrition services at Puskesmas with the assistance of well-trained CHWs. Notably, the program's success underscored the pivotal role of CHWs in providing mentorship and education based on competency mapping and performance-based incentives, thereby fortifying the primary healthcare services. Building on this success, the PN-PRIMA program expanded to 21 Puskesmas across 3 Regencies/Cities, with a rigorous focus on continuous training, competency mapping, and rigorous supervision processes for 392 PRIMA CHWs in Depok City and Bekasi Regency. PN-PRIMA cadres demonstrated commendable performance by

conducting home visits to 2,500 families with toddlers affected by malnutrition and conducting CDC screenings for more than 2,000 individuals of productive age within a condensed time frame of 5 months across 12 Puskesmas under the PN-PRIMA program.

Following suit, the central government took on transformative changes as well. The six pillars of transformation as shown in the figure below explains the transformative shift from disease-based perspective on health to system-based thinking, with focus on primary health care.[31]

Figure 7. Six Pillars of Indonesian Health Systems Transformation[31]

A notable occurrence on the health landscape is the public's reacquaintance with risk communications, at the early outbreak phase and throughout the critical time of response. Grappling in the beginning, Indonesia made an effort to employ principles of risk communications in its COVID-19 public communication. However the efforts were not well coordinated between ministries and public officials. Detailed and in depth discussion on risk communications is available in the **Risk Communication** book of this White Paper series.

As the world and the country eased out of the critical pandemic stage, the need to solidify reforms became apparent. After a relatively tumultuous formulation process, Health Law 17/2023 was passed. This team of researchers believes that, while this critical milestone in health sector development legislation brings progressiveness, it also introduces significant disruptions to the overall national health policy landscape. Among the many important points in the Health Law, the researchers of this White Paper identified several key disruptors, such as: the removal of mandatory health spending (previously, a minimum of 5% of national expenditure was earmarked for health), changes in the production mechanisms for specialised

medical doctors, shifts in the roles of professional organisations in health care worker management, the lack of a GEDSI (Gender Equality, Disability, and Social Inclusion) perspective, and major changes in the structure of integrated primary health care.

The following section outlines the findings on the current health landscape and discusses them in the context of factors beyond health, including its intersections with other sectors.

3.3. How do we position health in this society?

3.3.1 Health beyond curing the sickness

Some experts described the incorrect paradigm underlying the health program in Indonesia as the fundamental issues. Most Indonesians, including policymakers and healthcare providers, view health as equivalent to medicine or curative measures on clinical diseases. However, medicine is just a part of the broader public health sphere. The narrow focus on medicine in health development programs has obscured the importance of preventive programs that have been the core of public health.

However, in its true reality, our healthcare resources are still predominantly directed towards treatment rather than prevention. This is partly due to the difficulty in prioritising future concerns over current ones. The healthcare system is primarily structured to address existing diseases rather than preventing them. When there is a sudden surge in disease cases, such as COVID-19 pandemic, health authorities inevitably allocate resources to manage the immediate crisis leaving limited room for long-term prevention strategies.

Health beyond medicine is not limited to the curative and preventive program. Rather, a holistic approach to health highlights the relation between human health and ecological health. For example, the availability and quality of food are very much dependent on the quality of the environment. Ironically, the health and development programs still often fail to consider the impact of the health system on the environment.

3.3.2 Health as knowledge assets

The latest development of information technology has democratised access to information that previously was not available. Populations are now able to access a vast collection of health information and literature from various resources. However, this ease of access has created a fertile ground for misinformation, disinformation, and hoax production. According to the Indonesian Digital Literacy Status Survey 2022[32] , 47% of respondents admitted that they had never (or were unable to independently) search whether the information they found on the website was true or false. This elucidates how almost half of the population who have access

to the internet may be prone to believe in the false information without cross-checking such information with more reliable sources.

Health literacy in the population is generally low, increasing its vulnerability to misinformation. According to WHO, health literacy refers to the cognitive and social skills that enable individuals to access, understand, and use information to promote and maintain good health.[33] As a personal asset, it results from proper health education and access to accurate information. Without sufficient health literacy, people struggle to differentiate between valid and false information, leading to harmful reactions to misinformation. For example, during the COVID-19 pandemic, misinformation led to social unrest, the stigmatisation of those infected and at-risk groups like health workers.

The government should also create an enabling environment by providing accessible information to help people make informed health decisions. Moreover, with the abundance of information, there is a need for curation mechanisms to filter out hoaxes and ensure the public has access to accurate, reliable information.

3.3.3 Health as a luxury for the minority

Stigma, described as "deeply discrediting attribute"; "mark of shame"; "mark of oppression"; "devalued social identity",[34] is ubiquitous in many forms in our system. Stigma can be characterised with certain stigmatised conditions, such as mental illness, HIV/AIDS, substance-abuse, or in the time of the COVID-19 pandemic, infected by coronavirus also become the stigmatised condition. Moreover, social statuses including but not limited to economic status, racial minorities, sexual orientation and diverse gender expressions are other characteristics prone to stigmatisation. Health-related stigma has been known as one of the most studied types of stigma in the literature.[34] The negative effects of stigma have been proven to have negative consequences through the act of labelling, stereotyping, separation, status loss, and discrimination, which lead to exacerbation of health inequalities in the population.[34,35]

This paper discusses two types of stigma: provider-based and structural stigma. Provider-based stigma refers to discriminatory behaviour by healthcare providers, such as using stigmatising language, holding stereotypes, or refusing treatment.[34] This has been well-documented in Indonesia, particularly among people with HIV/AIDS, leprosy, and mental health issues.[36–39] Structural stigma involves prejudice and discrimination embedded in policies and laws, excluding certain groups or creating unintended barriers.[34] his institutionalised stigma often affects gender-diverse groups, religious minorities, low-income individuals, and specific age groups.

In Indonesia, minority groups' access to healthcare is often hindered by administrative issues, such as lacking a National ID Card (KTP), which limits access to health insurance services. Even when access is equal, healthcare services often fail to address the specific needs of marginalised groups. For example, transmen and transwomen have unique reproductive health needs that are frequently overlooked by providers. Beyond minority groups, stigma can affect individuals based on age, gender, or behaviour that falls outside societal norms, such as unmarried pregnant women, particularly if underage. This stigma is institutionalised in reproductive healthcare, reinforcing harmful stereotypes and limiting access to necessary services.

To create an inclusive and people-centred health system, understanding the intersecting vulnerabilities of the population is essential. Everyone's health is valuable including those who are stigmatised. Healthcare service delivery should aim for equitable access for everyone.

3.3.4 Health as an electoral investment

The inherent long-term nature of investments in health programs and policies focusing on prevention that does not produce instant and tangible impact has deterred government and policy makers from prioritising such an approach. Meanwhile, it is these same policy makers that are often political actors driven by a popular constituent's interest. Particularly for elected leaders, pressure to showcase quick wins to the public, such as programs dispersing free rice for the poor, free healthcare access, scholarships, are preferred.

Therefore, some health initiatives that appeal to the politicians are only those that provide instant benefit to their constituents and often disregard the sustainability of the impact itself. Early on in the decentralisation phase, local governments experimented with healthcare insurance schemes to attract public vote; later, the health financing program was re-centralised under the National Social Protection Scheme.[40] On a positive note, this political incentive pushed for policy shifts that expanded the coverage of national healthcare insurance.[41] Although the oligarchic power relation and corruption that persists might sabotage the quality of healthcare service delivery.[42]

Prevention policies need to be framed as revenue-generating tools to appeal to policymakers. For example, raising tobacco taxes is attractive as it increases government revenue, while banning tobacco advertising may seem less appealing due to potential losses in ad revenue. However, despite the government's acceptance of tobacco taxes, this hasn't led to a reduction in tobacco use. Revenue-focused policies limit the tax rate on cigarettes, maintaining affordability and reducing the policy's effectiveness. This highlights how short-term incentives can hinder the long-term impact of policies.

Another issue with the political value of health is the sustainability of policy implementation, often limited by the tenure of elected officials. Health-related policies are likely to change when the initiator leaves office or is reassigned, typically through implicit means such as lowering program priority, altering organisational structures, or reducing budgets. As a result, measuring the true impact of these policies is challenging, as programs frequently end before their effects can be realised.

The government and politicians should view health as a prerequisite for long-term national development, rather than merely a short-term electoral investment. As an electoral investment, the health program and policy might never be reliable and responsive enough to suffice the long term needs of the population.

3.3.5 Health after Presidential election and towards sub-national election

Although the debate on how to increase political currency of health continues, health is typically a favourite subject in political campaigns. A promise to make one's life healthier and easier is always a method of choice for politicians to gain popularity and votes. During the campaign period leading up to the Presidential election, each of the presidential candidates boasted their own promise to bring health and well-being for the people, once elected. The below table presents the highlight of health-related promises made by each candidate.

Table 2. Key Highlights of Health-related Campaign Promises of Each Presidential Candidate (Source: CISDI)[43]

Topics*	Anies-Muhaimin Official Candidate Number 1	Prabowo-Gibran Official Candidate Number 2	Ganjar-Mahfud Official Candidate Number 3
SRMNCAH+N	- Reducing the prevalence of stunting through assistance to pregnant women until the first 1000 days of a child's life - Reducing maternal and infant mortality through strengthening the role of posyandu and puskesmas, including the activation of midwives and health cadres from a young age to the provision of free balanced nutrition - Encouraging the fulfilment of balanced nutrition for every child and reducing the risk of obesity in children, including through regulating excess sugar, salt and fat (GGL) and providing facilities and infrastructure for physical activity for children	- Provide free lunch and milk (free lunch meals/Makan Siang Gratis) in schools and Islamic boarding schools, as well as nutrition assistance for children under five and pregnant women to 80 million beneficiaries with 100% coverage by 2029 *(after the election, this is known as the free nutritious meal program)* - Creating a Healthy Child Card (*Kartu Anak Sehat*) that is included in social protection and health programmes as a stunting intervention - Improving the quality of nutrition, clean water, and community sanitation in addressing the threat of stunting (malnutrition)	- Strengthening stunting prevention while ensuring the quality of child development with quality parenting during the first 1000 days of life with adequate nutrition for children and pregnant women at least until the age of 5 years old - Revolutionising healthy food menus based on local food with the nutritional content needed by children to prevent stunting - Education, parenting for brides-to-be and for adolescent girls by making mothers the guardians of family health

Topics*	Anies-Muhaimin Official Candidate Number 1	Prabowo-Gibran Official Candidate Number 2	Ganjar-Mahfud Official Candidate Number 3
NCD	- Regulate products with excessive levels of sugar, salt and fat to reduce obesity and degenerative diseases, including through clear labelling obligations related to sugar, salt and fat content, as well as risks - Encourage the presence of mental health counsellors (psychologists) at Puskesmas and provide free online counselling services in collaboration with institutions and communities - Elderly people can easily seek treatment through special queue lines, additional ambulance fleets, as well as pick-up ball examinations and treatment'	- Strengthen the Healthy Living Community Movement programme to prevent disease, both infectious diseases (TB, HIV, etc.) and non-communicable diseases (heart disease, stroke, etc.) - Improve mental health programmes that are more responsive, comprehensive, integrated, and sustainable - Releasing Healthy Indonesia Card (Kartu Indonesia Sehat) specifically for the elderly	- Establish counselling posts on all campuses, mental health services in all community health centres, and mental health service facilities in all public hospitals. - Providing education and counselling services and mental health assistance for all citizens. - Improving the social security of the more comprehensive Happy Elderly Programme for the elderly by providing financial support for the elderly who want to remain productive and serve.
Infectious Diseases	- Accelerate the elimination of infectious diseases, especially TB and malaria and expand the coverage of vaccination programmes to achieve Universal Child Immunisation (UCI) to villages - Preparing Indonesia to deal with security threats from the food, energy, environment, and health sectors that could arise from natural disasters, political dynamics, economic wars, pandemics, hybrid warfare, and others	- Strengthen the Healthy Living Community Movement programme to prevent diseases, both communicable diseases (TB, HIV, etc.) and non-communicable diseases (heart disease, stroke, etc.) - Organise free health check-ups, reduce TB cases by 50% in five years and build quality full hospitals in the districts	- Increasing the readiness of the health system in facing a pandemic, both health facilities and health workers through the formation of reserve personnel comes from active community participation, either directly or through institutions/organisations that can be activated at any time during a health crisis - Increased implementation of vaccinations, including routine immunisation, for free, especially for diseases that need immediate prevention such as the Covid-19 vaccine and HPV vaccine
Investment in Health System	- Realising an easier and patient safety-oriented service referral system for JKN participants. - Strengthen national health insurance services by evaluating the amount of advanced health facility payments (INA CBGs) in accordance with the provisions of the National Social Security System Law (SJSN)	- Improve the governance of the Health Social Security Agency (BPJS) to prevent deficits and improve quality health services by prioritising promotive and preventive efforts, and formulating BPJS policies that are more pro-people, pro-health workers, pro-health facilities, and pro-pharmaceutical procurement. - Ensure the availability of health services for all Indonesians: Improving BPJS Health and providing medicines for the people	- Increased standardisation of service time for BPJS patients, in addition to standardisation of treatment classes through SOPs for registration time and drug collection/redemption time, both at posyandu, puskesmas and hospitals - Ensure that the health budget allocation remains at least 5 (five) percent of the state budget outside of employee salaries, according to the needs of the community and the state to continue to improve the quality of public health even though it is no longer mandatory spending in Health Law No. 17 of 2023.
Health Service	- Revitalising and improving	- Strengthen community	- Encouraging 1 Village - 1

Topics*	Anies-Muhaimin Official Candidate Number 1	Prabowo-Gibran Official Candidate Number 2	Ganjar-Mahfud Official Candidate Number 3
Delivery including Human Resources for Health	Puskesmas, Puskesmas Pembantu and Posyandu throughout Indonesia, increase the role of Posyandu and CHWs for promotive and preventive health - Accelerate equitable distribution of health services that can be accessed by the entire community - Improve the national surveillance system by integrating data and information systems of health facilities and strengthening community-based surveillance - Promote the pharmaceutical and medical device industry as a national strategic industry with fiscal and non-fiscal incentives. - Strengthening research on drug development (including herbal and traditional), vaccines and domestic medical materials	empowerment programmes (gotong royong) for healthy living such as the revitalisation of Posyandu (integrated service post), revitalisation of Posbindu (integrated coaching post), UKS (School Health Effort), Poskesdes (village health post), and Poskestren (pesantren health post). - Ensuring drug availability and rational use of drugs in health facilities, both in health centres and hospitals - Improving quality, fair, and equitable health services through improving facilities and infrastructure - Improving the traditional medicine industry to realise affordable medicine prices for the community through local strengths - Striving for the independence of the national drug and vaccine industry in stages	Puskesmas / Pustu - 1 Doctor / Health Worker where people must easily get primary-level health services - Improvement of Puskesmas and Puskesmas Pembantu (Pustu) services in every village throughout Indonesia with the fulfilment of doctors / health workers (nakes) and essential drugs 100%, accompanied by the acceleration of digitalisation of health services (telemedicine) and supported by the revitalisation of posyandu at the hamlet / RT / RW level - Provision and expansion of mobile health centres (KOLING) and floating health centres, including ambulances in remote areas, small islands, and coastal areas - Gradually increasing the domestic production of raw materials for medicines, vaccines, and medical devices - Increasing mastery of technology and science for domestic vaccine production and expanding the types of vaccines in routine immunisation, especially for vaccines that have been included in the free program.
Human Resources for Health	- Ensure the availability of medical & health personnel in every health service facility, especially Puskesmas, including in coastal, island, and inland areas by providing special allowances, as well as the welfare and protection of medical and health workers - Easing the burden of health worker admin through the utilisation of technology and integrated systems - Cross-sector collaboration and strengthening support for village CHWs to ensure balanced food availability, infection prevention and environmental improvement - Encourage the structuring of health workers, including changing the status of the	Increase the number of health workers per population and hospital beds to match WHO standards Increase ASN salaries, especially teachers, lecturers, and health workers, TNI / Polri, and state officials - Improving the welfare of health workers - Quality hospitals will be established in all districts with attractive support and incentives for medical specialists who will serve there	- Increasing the quantity as well as the quality and competence of health workers, medical personnel and posyandu CHWs - Simplification of the specialist doctor education process through granting authority to hospitals to become the main organiser of specialist doctor education in collaboration with colleges and universities to accelerate the availability of specialist doctors in all regions of Indonesia and prioritise general practitioners who already work in the relevant district / city hospitals - Exemption of specialist doctor education fees organised by teaching hospitals in accordance with their respective capacities for doctors who will be placed in

Topics*	Anies-Muhaimin Official Candidate Number 1	Prabowo-Gibran Official Candidate Number 2	Ganjar-Mahfud Official Candidate Number 3
	Specialist Doctor Education Programme (PPDS) from students to health workers in training so that they get their rights as professionals		remote regions - Expand health polytechnic education and improve the competence of health workers, among others through health polytechnic education, in order to be able to provide excellent service through increased regular training up to the sub-district level

*The campaign promises in each candidate's key campaign documents were categorised into topics determined by CISDI team for analytical purpose

Upon confirmation of their victory, Prabowo and Gibran immediately prepared and made the necessary actions to realise their campaign promise into national development priority actions. Their free nutritious meal program/*MBG* remains a top priority. Starting with budget allocation of IDR 71 trillion, institutionalising the National Nutrition Agency/*BGN*, and appointing the Head of Agency; the authors can summarise that the free meal program will be put in motion as one of the new government's top priorities.

Now that the country is preparing for the sub-national election cycle to be done throughout Indonesia on 27 November 2024, health is once again made it into the campaign manifestos of candidates for governors, mayors and *bupati*. This is a window of opportunity for public health scholars, practitioners and advocates to inject a solid proposal for health as a development priority.

3.3.6 Health in the midst of power struggle

After over 20 years of democratisation and decentralisation, paternalistic and autocratic values remain embedded in Indonesian society, affecting health policy implementation. While the transfer of power from the central to local governments was expected to strengthen civil society's role in policymaking, nepotism persists, with power often favouring those connected to political leaders, sidelining broader public interests. Local development varies based on elected leaders who may prioritise supporters from past elections.

In the health system, tensions exist between the government and medical associations, exemplified by the Health Law 17/2023, which reduced the authority of professional associations over medical practice licences, sparking public debate. This is just one example of the power struggles in Indonesian health policy. Further, an institutionalised hierarchy exists within the health workforce, where specialists are seen as holding the highest status, overshadowing other healthcare professionals like nurses, midwives, and public health practitioners. This hierarchy extends into health governance, as most Health Ministers have

been specialists, even though the role doesn't require such qualifications. These elites have shaped Indonesia's healthcare system while maintaining their dominant position.

Meanwhile, other groups of actors in the health system governance perceived to have least power are the patient or general public. Asymmetric information between patients and the providers within the system places providers in a position of power and limits the ability of patients to exercise their rights in accessing health care.[44] Patients associations that are specific to certain conditions and diseases have emerged to fill in the gap and improve patients' literacy about their rights, facilitate access to the appropriate care and advocate for more affordable care.

3.4. How do we position health within the realm of economic development?

3.4.1 Space for health in growth-oriented development

Like many countries, Indonesia's development paradigm is centred on a growth-oriented focus, prioritising wealth accumulation and sidelining health as an afterthought. Economic development is narrowly measured by GDP, a focus criticised by economists like Easterly, who argue that high growth rates are often temporary and unsustainable.[45] This overemphasis on economic growth sacrifices social and environmental well-being, positioning health and the environment as obstacles to progress.

Extractive development, which has driven short-term economic growth, has severe consequences for both the environment and public health. These impacts can be direct, such as pollution from industrial projects, or indirect, contributing to the climate crisis and natural disasters like floods and droughts, which reduce food and water supplies and worsen public health. Despite growing evidence of the negative effects of extractive industries, growth-oriented policies continue to prioritise short-term benefits. For instance, despite Indonesia's abundant renewable energy resources, policies still favour fossil fuels, driven by the coal sector's contribution to economic growth. The health impacts of extractive industries and climate change are largely ignored.

Additionally, the National Strategic Projects (PSN) have been criticised for inadequate environmental and social impact assessments. A key example is the new capital city in Kalimantan Timur (IKN), where, according to experts, impact assessments were conducted only after political decisions were made, reducing the process to a formality. According to data from the Ministry of Finance, the total budget realised for the development of the new capital (IKN) between 2022 and 2024 amounts to 72.3 trillion rupiah. This is a significant figure, especially amidst the competing priorities for development agendas and the equitable distribution of access to basic services in various regions.[46]

3.4.2 Commercial Determinants of Health

Public behaviour is influenced by available choices, shaped by policy and the market. The consumption of unhealthy food, drinks, and tobacco is driven by industries that produce and promote these products. Uncontrolled production and marketing of these products increase public consumption, leading to a rise in non-communicable diseases. Scholars refer to this as the 'commercial determinants of health' (CDH), describing strategies used by companies to promote harmful products and choices.[47]

The strategies extend beyond traditional promotion activities like advertising. They include Corporate Political Activities (CPA) such as coalition building, shaping public narratives about their products, and direct involvement in policy making through lobbying. For instance, Indonesia has not ratified the Framework Convention on Tobacco Control (FCTC), reflecting the influence of such activities in tobacco control.[48]

As a result, the government is not obligated to implement control measures that align with global standards, allowing tobacco companies to continue promoting their products. Despite some restrictions, such as controlled air time on television and limits on outdoor advertising, companies find loopholes to target younger populations. Similarly, there is minimal regulation of packaged foods and drinks, particularly in terms of sugar, salt, and fat content, as well as distribution, promotion, and pricing. This regulatory gap has contributed to the rise in diabetes and other metabolic diseases. Efforts to introduce a sugar-sweetened beverage (SSB) tax are underway, but there is still much progress needed to implement health policies aimed at behaviour change.

Furthermore, the current situation in Indonesia is unfavourable for public health, as industries producing unhealthy products exert influence over policies. Tobacco companies and their affiliated groups are notorious for investing in politicians to block policies that limit their revenue. A notable example is the removal of a clause in the Health Law (UU No. 36/2009) that classified tobacco as an addictive product.[49] In other countries that ratified FCTC, they are obligated to have regulations that "protect public health policies from commercial and other vested interests of the tobacco industry in accordance with national law"[48] or mechanism to prevent conflict of interests.

Beyond tobacco and food, the concept of CDH includes industries like automobile, pharmaceuticals, and mining, all of which negatively impact health.[47] Indonesia still needs to establish many regulations and mechanisms to control CDH, especially for tobacco companies, which are more strictly regulated in other countries.

3.4.3 Unguided Industrialisation of Health

Some experts are concerned about the commercialization of healthcare, where providers prioritise revenue. This debate surfaced frequently during the Delphi sessions. Opponents argue that healthcare is a basic human right and should be the government's responsibility, not driven by market forces. They believe industrialising health undermines equitable access. Proponents, however, argue that the industrialization of healthcare is inevitable and doesn't negate the idea of healthcare as a human right. They see industrialization as increasing efficiency through division of labour, standardisation, and management structures.[50]
Experts argue that the industrialization of healthcare is inevitable, following trends in other sectors, but Indonesia lacks a strategic plan to guide this process. Unlike China, Indonesia's development plan doesn't set clear targets for building its pharmaceutical industry. The healthcare sector faces high entry barriers, especially for drugs and medical devices. First, the e-catalogue system limits available products in healthcare facilities, as producers must meet stringent criteria. Second, the pharmaceutical sector is on the negative investment list, discouraging investment. Third, overlapping regulations between ministries, particularly concerning export and import, hinder timely access to needed products. While these barriers aim to ensure safety, they raise questions about the efficiency and effectiveness of drug and device procurement.

3.5. How can we leap into the restructured future?

3.5.1 Health technology advancement into the precision healthcare

Many view technology as the solution to various health challenges. During the COVID-19 pandemic, digital health advanced rapidly to address limited physical access to care, with telemedicine enabling remote consultations. Beyond the pandemic, digital technology holds immense potential to enhance all dimensions of healthcare, from service delivery and workforce education to research.

Technological advancements will transform healthcare, and there is a need for authorities to shift from merely regulating to actively accelerating these changes. For example, big data and AI can enable predictive analysis, reducing the diagnostic burden on doctors—an advancement that might be restricted by current regulations requiring human doctors to handle all diagnoses. Health Law No. 17/2023 includes biomedical technologies aimed at precision medicine, and the Ministry of Health is developing the Biomedical and Genome Science Initiative (BGSi), which focuses on curative measures. However, genome sequencing also has preventive applications, such as nutrigenomics, which tailors nutrition interventions to individual patients.

Tech adoption needs to consider how impactful the tech is for the targeted users. As one author reminds us that any kind of technology "is a means to an end, and only one of available means".[51] While new shining tools will always emerge, we need to separate between "hype and substance" and choose technology options that best serve our purposes.

3.5.2 The Concern Behind Technological Advancement

Despite its promise, technological advancement also has a concerning side: the 'digital divide.[52-56] This gap results from unequal access to essential infrastructure, such as the internet, and differences in technological literacy.

Currently, Indonesia faces disparities in infrastructure, particularly electricity and internet access. According to the National Socioeconomic Survey (Susenas),[57] 66.48% of the population has internet access, with DKI Jakarta at 84.65% and Papua at only 26.32%, highlighting the disparity between western and eastern Indonesia.

Besides, the inequality is also perpetuated by the varied ability to access and utilise technology, both amongst healthcare providers and the general public. This gap is particularly salient among older generation population groups who tend to be *late majority* or *laggards* according to diffusion of innovation theory.[58] As new digital tools are introduced, those preferring traditional methods fall further behind.

In terms of digital literacy, a national survey showed a slight increase in the index from 3.49 in 2021 to 3.54 in 2022.[32] This index measures four pillars of digital literacy consisting of digital skill, digital ethics, digital safety, and digital culture. However, nearly 40% of respondents reported never using or being unable to independently interact with digital tools. While many have achieved functional digital literacy, a significant portion of the population remains excluded from the benefits of technological advancements, particularly in healthcare. This highlights the need for targeted approaches to reach populations with limited digital skills.

3.6. Utilising Public Discourse Algorithm for Analysis and Sentiments

Dynamics of policy making processes often escaped the public's eyes due to the state or government heavy tendencies of policy making.[59] Social media has provided the public, in particular researchers from academia and civil society, to utilise social media conversation as data. Discourse Network Analysis (DNA) and Social Network Analysis (SNA) are two outputs where, given enough data (social media conversations) is available, a sentiment analysis can be derived.

CISDI has utilised this wealth of data for several years and used various clustering algorithms and machine learning models to analyse social media conversations around health. The following are the different results from CISDI's DNA and SNA in three key studies that it has conducted. Variations of types of DNA and SNA came from the availability of social media conversations concerning certain topics. The more the public discusses a health topic in public space and social media, the better the discourse/sentiment analysis it can generate.

3.6.1 Discourse Network Analysis in Health Financing Study

In the prior study conducted by CISDI in 2019, titled "Reinvigorating the Future of the National Health Insurance: Incorporating Network Analysis in the Foresight for JKN to Understand Development Dynamics," horizon scanning was executed by analysing three key facets: health system performance, scenario variables, and actor analysis. The analysis of health system performance involved the measurement of service utilisation, rates of access, use-needs ratios, spending thresholds, as well as disaggregated health outcome measures. Data sources for this aspect were drawn from several primary documents, including the Basic Health Research (Riskesdas), the National Socio-Economic Survey (Susenas), the Health Facility Research (Rifaskes), and the National Labor Force Survey (Sakernas).

Concurrently, the aspect of scenario variables and actor analysis encompassed content analysis, policy analysis, as well as Discourse Network Analysis (DNA) and political mapping. Some of the outcomes included the structural dimensions of JKN, the discursive dimensions of JKN, and the mapping of future challenges viewed from various interconnected aspects of STEEPV.

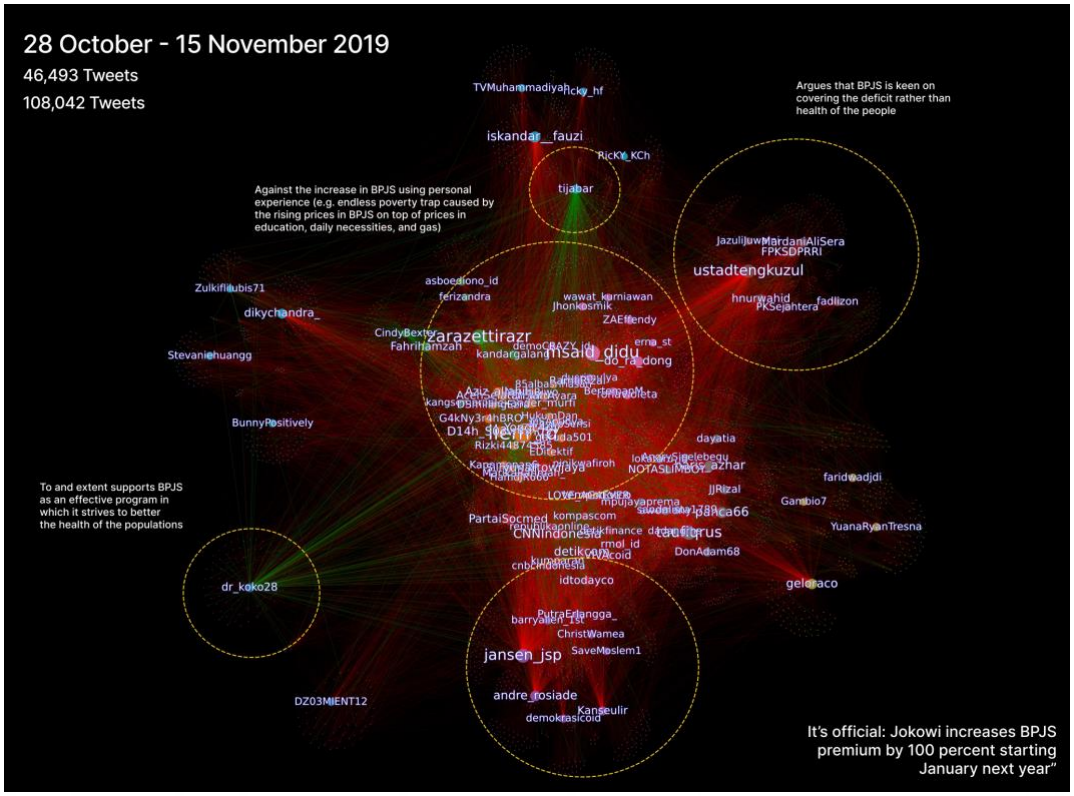


Figure 8. DNA of Health Financing Issue on Twitter

The findings show that nearly every regulation issued by the government related to JKN attracted public attention. While the JKN benefit package and BPJS financial deficits garnered interest, the increase in JKN contributions stirred the most controversy and became a polemic issue. As shown in Figure 8, the visualisation of cross-sectional clustering of DNA reveals the growing polarisation between government policy (focused on increasing revenue) and public demand (focused on managing expenditure growth). On Twitter, the government appeared to struggle in defending or presenting coherent arguments and narratives to justify their policy proposal.

3.6.2 Discourse Network Analysis in Food Policy Study

In the DNA study, we collected data from online media coverage and policy documents. This study used secondary data generated from Indonesian online newspapers and media to represent a diverse range of readership profiles and political orientations. We used online newspapers as the main data source to encompass a wide coverage of different actors, including members of the public involved in the policy discourse. We conducted manual searches for policy documents related to activities on the adoption of SSB taxes for secondary data. These documents included legislative bills, government regulations or statements, and advocacy strategies. A national policy public database. To perform the DNA, we used the coded media statements as discourse concepts and analysed its network using DNA to bring in statements that have been regarded by previous scholars to be consistent with the beliefs

of actors within the network. The network was constructed by using actors' public statements that have been coded, resulting in a network graph of visual representations of clusters. It is regarded as a congruence network, created by connecting multiple actors who refer to the same concept and have the same stance.

The DNA results for each timeframe show the existence of different coalitions in the SSB tax advocacy landscape. The analyses revealed the formation of pro-SSB tax (blue) and contra-SSB tax adoption (yellow). Organisations in respective clusters shared common concepts. The size of the nodes in the network represents the frequency of a particular organisation being mentioned in the media regarding SSB tax discussions. However, formal networks formed within each cluster could not be identified through the DNA. The findings indicate that the Ministry of Finance had the most significant influence on the discourse, while actors from civil society organisations (CSOs) and universities contributed to policy change through evidence-based recommendations. Meanwhile, economic actors engaged in the debate, raising concerns about the potential harm that tax adoption could cause to the industry.

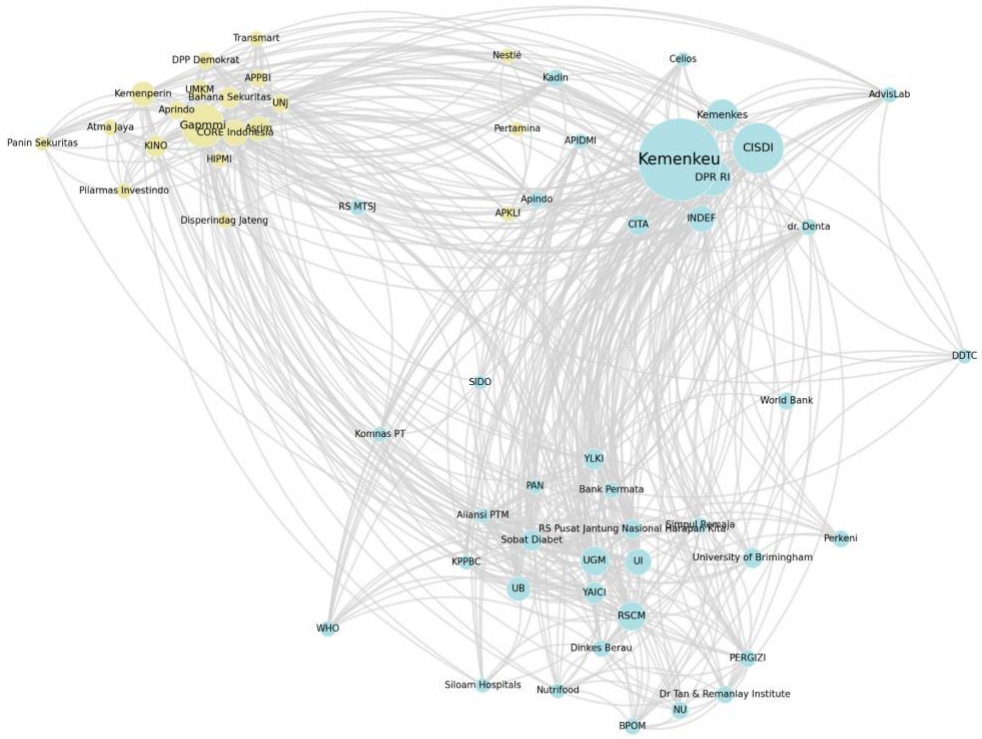
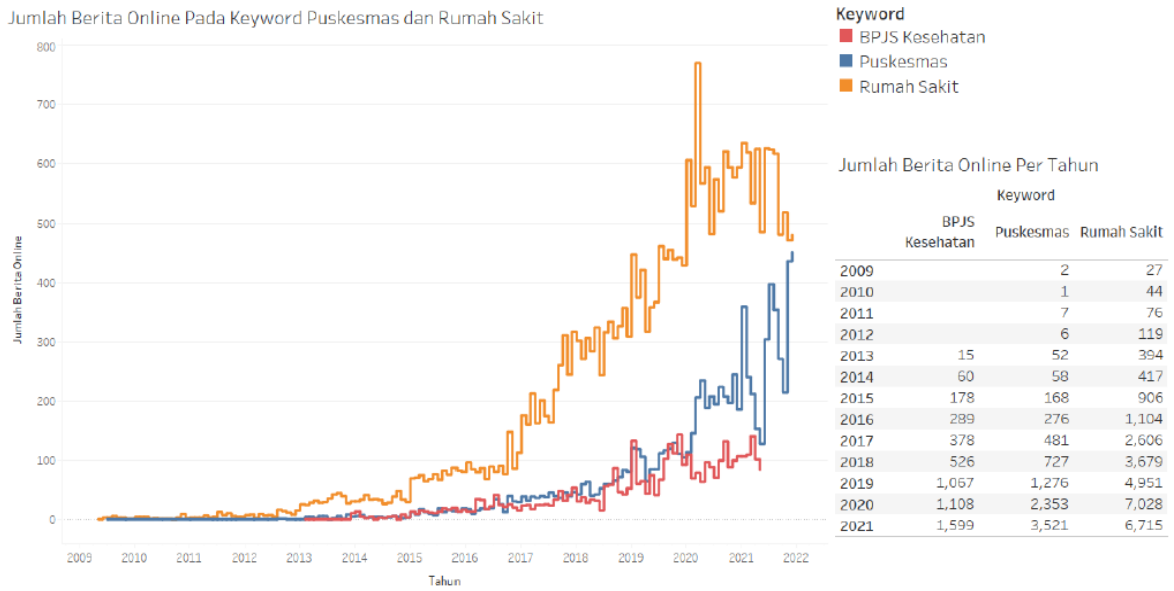


Figure 9. DNA of SSB Tax in Indonesia from Online Media Conversations

3.6.3 Employing Discourse Analysis Network approach in Primary Health Care

In the document "Foresight to Structuring the Future of Indonesia's Primary Health Care," horizon scanning is carried out by mapping a comprehensive range of events and trends that significantly shape the implementation of primary health care policies in Indonesia. This identification serves as a key element in comprehending the challenges encountered by the Indonesian government in delivering primary health care services. Furthermore, this identification acts as a means to detect early signs of developments that have the potential to either pose threats to or offer opportunities for the reform of primary health care services in Indonesia.



Jumlah Berita Online Per Tahun

	Keyword		
	BPJS Kesehatan	Puskesmas	Rumah Sakit
2009		2	27
2010		1	44
2011		7	76
2012		6	119
2013	15	52	394
2014	60	58	417
2015	178	168	906
2016	289	276	1,104
2017	378	481	2,606
2018	526	727	3,679
2019	1,067	1,276	4,951
2020	1,108	2,353	7,028
2021	1,599	3,521	6,715

Figure 10. Comparison of Several Keywords in Foresight PHC

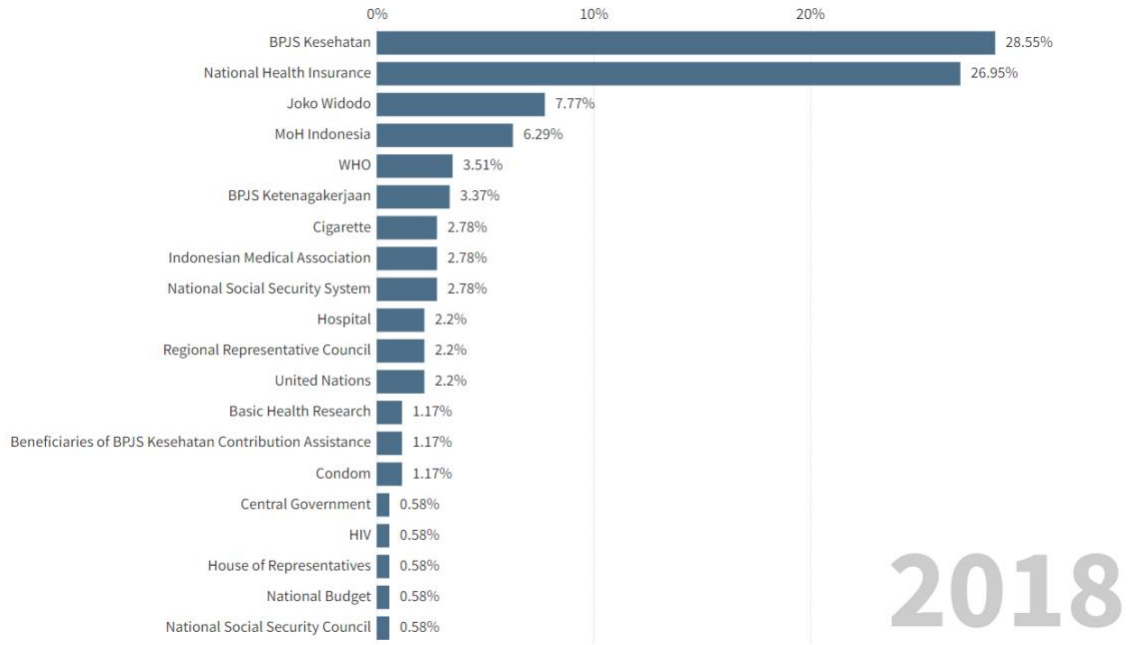
Foresight PHC utilises various information sources, including 'conventional' ones such as peer-reviewed research, quantitative data, and opinion columns, as well as more 'contemporary' sources like data crawling from social media and online news coverage. The outcomes of this horizon scanning are employed to capture public demands and supplement the opinions of experts obtained through the Delphi technique.

Online media provides three times more coverage of hospitals compared to primary healthcare services. This stark contrast in news value indicates a noticeable disparity in the coverage and utilisation of these two issues. The media's reporting trends have shown a faster increase in hospital-related news in comparison to primary healthcare news during the COVID-19 pandemic period in Indonesia, fluctuating with the waves of SARS-CoV-2 infections. A comparison of word clouds between years reveals a shift in reporting from everyday anecdotal events to key policy topics, including free services, operating hours, medication availability, healthcare personnel, National Health Insurance (JKN-KIS),

accreditation, capitation funding, examinations, and COVID-19 vaccination. Additionally, there is a noticeable increase in the number of actors posting tweets using keywords related to primary healthcare services.

3.6.4. Scanning the Horizon for Health Sector White Paper

In contrast to previous studies, this research encountered limitations in accessing conversations and public opinions on social media platform X (formerly Twitter), due to the revocation of API access for researchers in mid-2023 during the conduct of this analysis. Furthermore, several of the selected topics garnered relatively low public attention as they did not rise to the level of national issues, which resulted in a Social Network Analysis (SNA) that was not well-clustered. Despite some limitations, we've still managed to use Google Search and News to automatically look up topics mentioned in this research. We did this by setting up specific keywords for each topic and collected news from January 2017 all the way up until we started the Delphi interviews in May 2023.



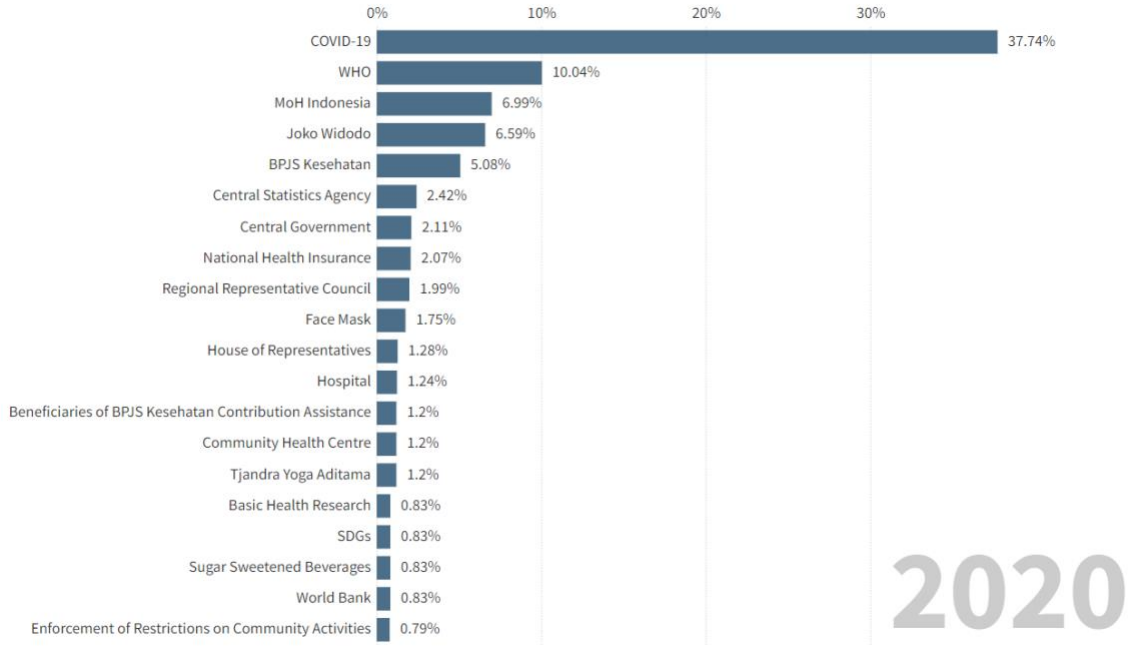


Figure 11. Popular Keywords from Published Opinion on Health News in 2018 & 2020

From the text of these articles, we have used a machine learning model to pull out key phrases using named entity recognition for the Indonesian language. By applying the same model to all the opinion pieces, we've come up with a bunch of important and recurring phrases that we can present in a word cloud and a bar chart (Figure 11) for each year in a form of frequency percentage to all phrases, based on when they were published. We've also mapped out how these phrases are related to each other based on how often they show up together in the same news piece, and we've displayed this in a network graph (Figure 12).

With these two analyses, we can look at news trends over time and see how closely related the phrases detected by the machine learning model are. Take, for example, the period before the COVID-19 pandemic struck. The most prominent issue that emerged was related to JKN, which is understandable given the escalating premium costs discourse for BPJS Kesehatan that began in 2018. The network graph also shows that terms associated with this issue, such as “National Health Insurance” and ”State Budget”, are positioned closely together. The results of this analysis were used as a reference in the Delphi interviews with experts and helped identify the main health topics that gained traction and were most discussed by the public.

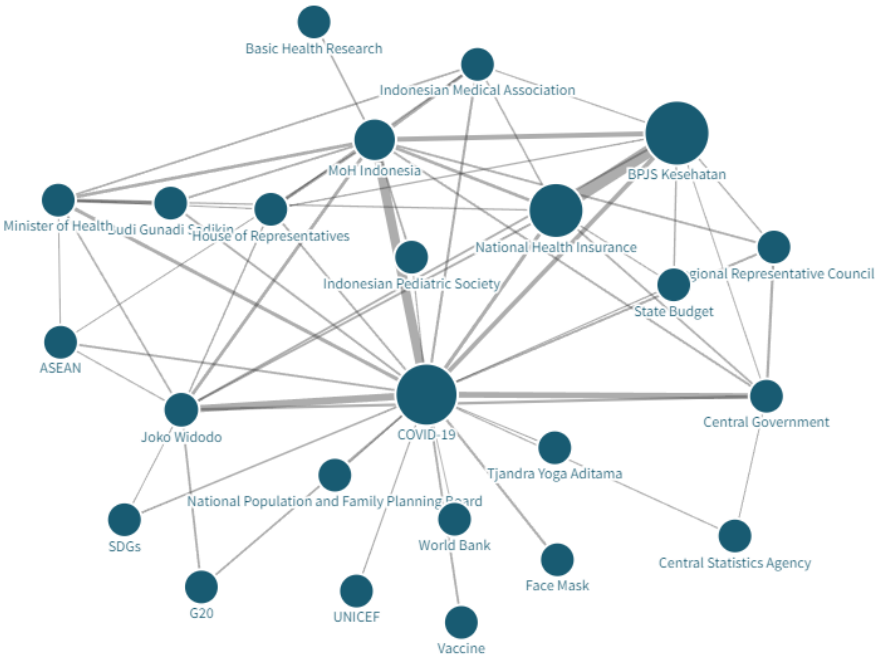


Figure 12. Graph Network from Published Opinion on Health News from January 2017 until May 2023

Chapter 4.
Addressing Structural Challenges

Through the horizon scanning process, each theme of the book identified its own structural challenges (see Table 3). We then utilised expert input from the Delphi methodology to guide the process of confirming and validating the horizon scanning findings (see list of Delphi resource persons). Across 22 Delphi sessions, we posed guiding questions regarding events, trends, drivers, short- and mid-term solutions, as well as inputs for designing the future and identifying wild cards or disruptors within each theme. The thematic Delphi discussions were followed by plenary consultations, which served as checkpoints for the researchers and experts. These consultations ensured that all identified trends were discussed in depth, refined, and summarised.

Each of the eleven themes in this White Paper series has mapped out the structural challenges faced. Table 3 outlines the barriers that have stalled progress or blocked potential breakthrough efforts within each theme.

Table 3. Structural Challenges Found in Each Thematic Books

Book's Theme	Structural Challenges
Health System	• Imbalanced investment with more resources going to referral hospitals, hindering access for low-income individuals. • Multiple barriers for vulnerable groups, including homeless people, households with children and elderly, persons with disabilities, and ethnic minorities. This is also perpetuated by the rigidity of the referral system. • The shift from mandatory health spending to a performance-based budgeting system raises concerns about sustainability. • Decentralisation challenges, with local governments focusing on physical infrastructure rather than human resources and prevention interventions, which is translated to lack of investment and stalled improvement of coverage and quality • Disconnection between donor-driven and private sector investment and public health needs.
Digital Health	• Indonesia continues to grapple with issues concerning data security, compliance related to data security, and the safeguarding of privacy • Digital health literacy and proficiency among both healthcare professionals and the general population remain inadequate • The digital health transformation agenda is giving rise to an increased reliance on digital devices • Disparities on accessibility, availability, and equitable distribution of services and digital healthcare infrastructure • Level of connectivity between primary care and referral services

Book's Theme	Structural Challenges
	remains a substantial challenge
Risk Communication	• Structures for risk communications are not uniformly in place at subnational level. • There is an observed lack of transparency, clarity, and consistency, with a preference for crafting a positive public image in communications, especially during the pandemic, leading to loss of trust. • An important aspect that is often forgotten when formulating a risk communication plan is to take into account strategy to reach vulnerable populations. • A pressing need to establish better two-way communication channels and feedback loops between the central government and other stakeholders such as the public, frontline health workers, communities, and subnational governments. • A lack of an integrated information system to manage and monitor community engagement activities effectively. • The capacity of communities to engage in risk communication differs widely. • Rampant misinformation and hoaxes on health issues.
Health Security and Infectious Diseases	• Weak surveillance system, leading to difficulties in early detection and containment of infectious disease outbreaks. • Challenges in integrating human, animal, and environmental health fields because of the fragmented governance approach to those 3 different fields. • Fragmented and non-interoperable health information systems cause delays in reporting, underreporting, and poor data quality. • Deficiencies in data accountability, regulatory framework, and coordination among government agencies in the context of managing outbreak • Disparities in the distribution of medical countermeasures, both globally and within Indonesia and lack of incentives for private sector innovation
Non Communicable Diseases	• The nature of NCD that has delayed onset of symptoms causes a lack of sense of urgency towards the disease. Meanwhile the health promotion and preventive programs also have no instant impact, which have limited political incentive for the policymaker. Therefore, generally, NCD programs are less likely to be prioritised. • Curative and rehabilitative measure for NCD needs long-term care which is more expensive and will continue to burden the healthcare system. • Lack of coordination mechanisms to control the risk factors of non communicable diseases, which cannot solely be controlled by the Ministry of Health or health institutions. • Clashing interest between government institutions, with one side aiming to control the consumption of unhealthy products, while

Book's Theme	Structural Challenges
	the other sides willing to push the production further in the name of economic benefits. • Commercial interests are shaping the consumption product availability,through all means of promotion and also lobbying activities to secure the enabling policy environment for them to continue accumulating profit.
SMRNCAH+N	• Scattered data could be considered classic and widespread challenges of SRMNCAH+N policy • Service standard tariffs of JKN for SRH remain to not respond to the demands of beneficiaries for a more comprehensive package • Inconsistent availability and a sustained referral system between puskesmas and secondary care facilities are also dependent on puskesmas' capacities that are often inequitable between districts • The complexities in obtaining appropriate, accessible, and quality SRMNCAH+N services, lies its dependency on health workforce that is gender-sensitive to the intricacies of societal norms and values • Adolescent health seemed to have been overlooked when compared with other SRMNCAH+N areas
Health Financing	• *Revenue Collection:* Low tax-to-GDP ratio and revenue-raising capabilities; challenges related to tax policy, informality, and taxation inefficiencies; and reliance on central government transfers by sub-national governments. • *Expenditure Management:* Inconsistency and misalignment between planning architecture, budget architecture, performance management framework, and organisation structure of the government; Fragmented and predominantly budget-absorption-focused monitoring, rather than impact measurement. • *Service Delivery*: Weak health information systems hindering informed decision making and claims verification which leads to challenges in assessing quality and holding providers accountable.
Human Resource for Health (HRH)	• The number of healthcare professionals remains insufficient to meet the population's needs • Disparities in healthcare workforce distribution continue to represent a significant challenge • Inadequate capacity among health workforce planners in both central and regional settings hinders healthcare workforce planning • The curriculum in medical education has not undergone necessary updates, rendering it incompatible with current demands and future needs • High educational costs serve as a notable barrier to the production of specialised medical practitioners.

Book's Theme	Structural Challenges
Global Health	• Disconnection between Indonesia's global health strategy with national health system strengthening • Limited meaningful participation of Global South countries has hindered the representation and perspectives of crucial stakeholders in decision-making processes • Inequitable global health governance is also supported by unequal knowledge/power relations between global north and global south countries • The utilisation of south-south cooperation in the area of global health issues is also still limited • Unreliable Development Assistance for Health (DAH) systems across the globe • ASEAN regional health governance are highly fragmented and poorly connected
Research & Development	• Health and medical researchers in Indonesia face challenges in receiving adequate training, funding, and infrastructure • The lack of correspondence between surveys conducted by the different government agencies • Most health research conducted in Indonesia shows the uneven distribution of geographical research, focusing more on Java island and less on exploring problems in situations outside of Java • The limited capacity of health workers and the government to collect and manage multiple datasets • The lack of monitoring of inclusive and meaningful community participation diverts the research from achieving the needs of the population. In the health program planning

All the mapped events, trends, drivers, and descriptive analyses were overlaid. From this exercise, the researchers identified key structural challenges, which later informed the plausible scenario-building process. The analysis of these structural challenges will also be used in Chapter 7 to strengthen strategic prioritisation for rebuilding national health reform. This chapter elaborates on the five elements identified as structural challenges in health sector development.

4.1 Fundamental and Structural Challenges

4.1.1. Governance

Governance for health extends to multiple actors, multiple varieties of organisations and cuts across different ministries and/or sectors. Most notable characteristic of governance is that it describes mechanisms of the state or government in policy making and their management consequences.[59] Complexities of health governance in Indonesia is added with the fact that

health is mandated to be decentralised[60] to 38 provinces, 514 regions/towns and 89 thousand villages.[61]

As consequences of decentralisation, fragmentation within and between levels of government is also decentralised. Instead of having silos only at national level, silos and fragmentation are apparent at all levels of government, even at village level. In addition to fragmentation, government institutions are large in size and each department is further siloed into smaller groups. This division of labour is a necessary step to overcome the overpopulated government offices at national and sub-national levels.

The combination between the high numbers of government staff and complexities of bureaucracy exacerbate challenges in governance. As seen in figure 13 below, the diagram of health governance structure is expected to help guide and navigate health governance mechanisms across levels of governments, three coordinating ministries and multiple numbers of state institutions. It is not clear, however, whether measurement on efficiency is ever taken into account and that an impact analysis is ever conducted to measure success of employing this mechanism to govern health.

The UKP4 Foresight Report found that coordination within the health sector, even within the same coordinating ministry, is challenging. Examples include efforts to address child marriage, maternal and infant mortality, gender-based violence, and stunting, which involve multiple institutions such as the Ministry of Women's Empowerment and Child Protection (PPPA), Ministry of Social Affairs, Ministry of Education, Ministry of Health, and the National Nutrition Agency. The complexity increases when programs require coordination across different ministries and sectors, each with competing priorities (see Figure 13). For instance, the Ministry of Villages, Ministry of Health, and Ministry of Home Affairs all regulate aspects of village health services: the Village Law covers infrastructure, the Health Law empowers health cadres, and the Local Government Law mandates local leaders to balance national and local priorities. The **Governance** book of this White Paper series discusses this in detail.

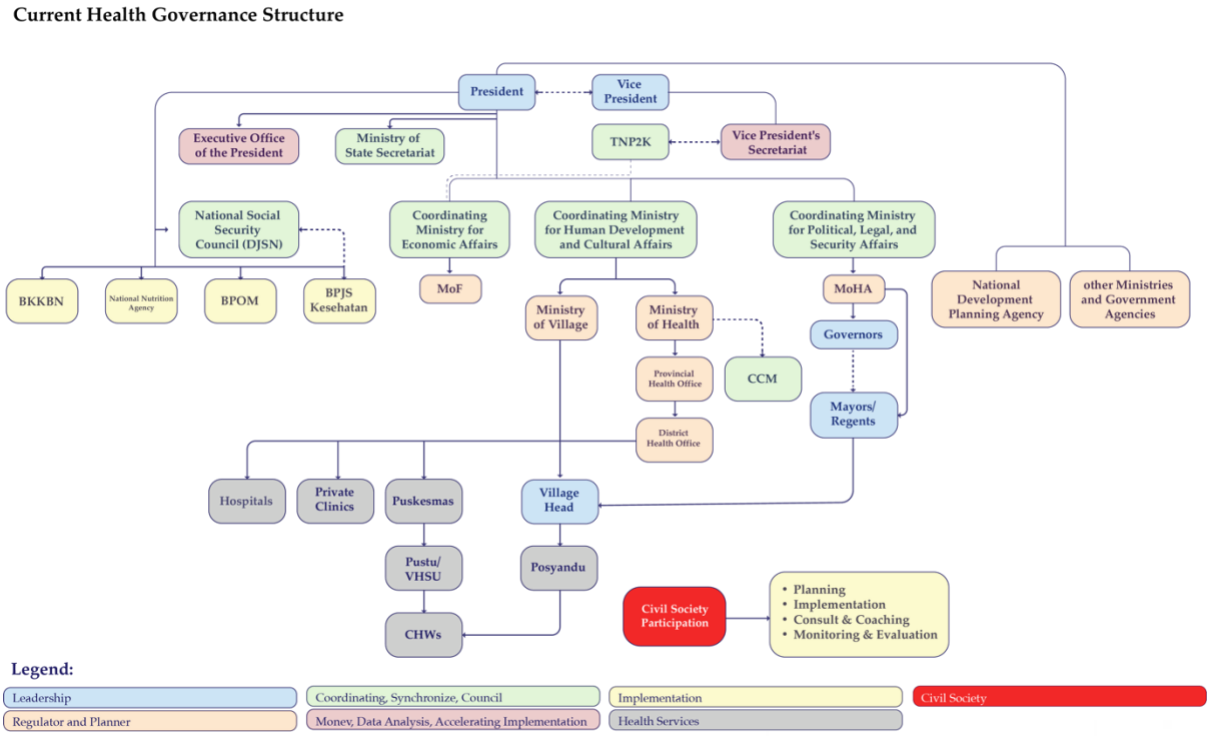


Figure 13. Existing Indonesian Health Governance Structure (Updated with the Existence of Presidential Decree 83/2024 on the National Nutrition Agency)

Fragmentation in coordination also reflects a lack of strategic vision in public health. Regulations and development targets often overlap or even contradict one another. The government continues to prioritise economic growth as its primary focus, sometimes at the expense of human development. Extractive industries that harm the environment—and ultimately human health—through deforestation, forest fires, zoonotic diseases, and more, are still prioritised. Harmful products like tobacco, despite existing control regulations, see increased production efforts each year, driven by the Ministry of Industry and Trade.

In Indonesia, the growing dependency on Big Three and the Big Four consulting firms are becoming more apparent. As Mazzucato stated in her book, although there is a place for consulting firms in countries' governance mechanism; the increasing trend of it moving towards the centre and replacing bureaucracy and technocracy is concerning as it weakens the overall countries' systems. It can be seen as a growing tendency since at least the last two decades; but in the first two years of COVID-19 pandemic governments have spent an unprecedented expense on consultants. A number of developed countries such as France, the United States, the United Kingdom and Italy have also collectively spent close to USD 4 billion from 2020-2021 alone.[62]

Dependency on consultants highlights limited institutional capacity to address public health challenges. Factors such as inadequate recruitment, insufficient training, weak performance-based mechanisms, and a lack of continuous professional development

contribute to this stagnation. As a result, public institutions in Indonesia struggle to build sustainable, long-term capacity to meet the nation's health needs independently.

Transparency and accountability issues in policy-making also limit the meaningful participation of CSOs. They are still perceived as beneficiaries and often lack the capacity to be involved in decision-making. On the other hand, business sectors with power and capital may influence the process, sometimes becoming the main stakeholders to be consulted, both formally and behind closed doors.[63] The absence of conflict-of-interest regulations in policy processes exacerbates challenges in governance.[64]

4.1.2. Leadership

Leadership remains a pivotal component in ensuring a robust health system. The constantly changing landscape of leadership at national and subnational levels presents challenges, particularly given the fragility of the current health system. Evidence shows that poor leadership contributes to ineffective and inefficient decision-making within the health system.[65]

A weak democratic system increases the risk of political processes prevailing over technocratic ones, which is also evident in leadership election systems in Indonesia. Having leaders with strategic vision, clear intentions, and competence is an ideal scenario, but without good governance and a balance between meritocracy and equity, this remains elusive.

In recent years, the quality of democracy in Indonesia has declined. For instance, Freedom House reported that Indonesia's democracy index dropped from 62 to 57 points between 2019 and 2024.[66] Several factors and events indicate this decline, including widespread violence against journalists and the media, repressive actions by the police, weakened Corruption Eradication Commission (KPK), interventions and conflicts of interest within key state institutions, and the rise of dynastic politics that undermine political ethics.[66,67]

National leadership both influences and is influenced by politics and power dynamics at regional and global levels. These factors play a significant role in shaping national health policies, and vice versa. A clear example is the struggle to access COVID-19 vaccines during the pandemic, which highlighted the lack of robust global health governance and the influence of wealthier, more powerful nations. Additionally, global instability, such as wars, affects national health governance and systems due to disruptions in global priorities and financing. Indonesia's unclear strategic vision and limited institutional capacity in foreign policy, including health, weaken its negotiating position at the global, regional, and national levels.

4.1.3 Systems

In most cases in different countries, there are two hubs within the government in which planning and delivery is governed. Systems, in this particular case, works well if it can ensure continuity and coherence of different inputs; monitor sound technical execution through norm, guidelines and regulations by different ministries and/or government offices at all levels; and guarantee delivery of those regulations into actions in communities.

However, a fragmented system is not uncommon. Often, one state institution designs and implements its own system, undermining the potential duplication or misalignment that can pose as a barrier to achieve the common goals. A system consists of one cycle of stages, from planning to evaluation. In multiple Delphi meetings, the researchers captured the experts' input of this notion of system failure. To strengthen this anecdotal example, the authors combined this input on structural system barriers with an illustration on the existence of multiple systems in health sector development planning.

The current planning mechanisms are unfortunately insufficient to facilitate collaborative governance and address the complex needs of public health. One example is the Rakerkesnas, an annual planning meeting of the Ministry of Health with the Head of Province Health Offices and Head of District Health Offices.[68] However, the outcome of this annual meeting, does not align in timing with the annual development plan of the National Planning Agency (Bappenas) and the subsequent process of budgeting which then lands on the Government Work Plan document (RKP).[69] While inclusivity is a concern, the mechanism remains top-down, and the outcomes of Rakerkesnas are not bidirectional in providing input for the Initial Draft of the Government Work Plan, as the synchronisation with Bappenas is completed beforehand.[67]

Fragmentation in Indonesia's health information system limits the government's ability to make informed policy decisions and hinders communities from receiving the care they need. Indonesia uses hundreds of different, non-interoperable information systems, creating inefficiencies and placing a greater burden on healthcare providers to input data. During the COVID-19 crisis, the subnational and national governments operated different health information systems (HIS), causing delays in tracking rising cases and taking necessary measures. This issue was further compounded by a lack of capacity to effectively utilise the available data.

The disconnection between public and private health systems creates further fragmentation in ensuring the continuity of healthcare. Due to issues of accessibility, quality, and availability in public health facilities, a significant proportion of people still opt for private, including informal and semi-formal, health services. The integration of these services has not yet occurred, contributing to different standards of care, delays and incomplete

treatment, inefficiencies in cost and time, and slow responses to health crises, among other challenges.

There is limited institutional capacity to manage knowledge and utilise data to drive evidence-based policies and programs. A disconnect exists between the government's programs and research—research is not always aligned with actual needs, and programs or policies are often implemented without a robust needs assessment. The current skill mix also lacks sufficient capacity in data and knowledge management, utilisation, and analysis, further limiting the ability to inform the policy-making process.

Furthermore, the capacity for providing supervision, monitoring, and evaluation as part of the policy process is often overlooked and neglected. This responsibility is mandated to central and provincial governments, which are not always equipped to fulfil it. District-level governments often report a lack of feedback on their reports, minimal mentoring, and insufficient guidance to effectively implement national programs.

Problems related to insufficient capacity of human resources for health often originate from issues in the education system, production and recruitment plans, distribution strategies, training programs, and the monitoring and evaluation system. Many of these challenges partly arise from the lack of capacity among healthcare workers to fulfil their responsibilities, which is further exacerbated by inadequate systems.

An unsupportive research ecosystem is limiting the emergence of research and innovation. The recent policy establishing a centralised research agency has created challenges in decentralising knowledge and evidence-based policymaking. The central agency tends to direct solely on national priorities, which are not necessarily aligned with subnational or community needs. Additionally, the minimal budget allocation for research and weak incentive mechanisms further hinder innovations in medical products and programs.

Ultimately, the system remains fragile without the support of basic infrastructure and necessities. Many public health facilities lack essential medicines, equipment, cold chain systems, and the infrastructure needed to fulfil their mandates and deliver high-quality services. Significant disparities exist across Indonesia, with the largest gaps found in the eastern regions. Additionally, poor physical infrastructure, such as inadequate roads and safety concerns, further exacerbates inaccessibility in many parts of the system.

4.1.4. Financing

Despite spending at least 5% of the national budget, the allocation has not yet met the WHO recommendation of allocating at least 5% of GDP to health. National budgeting mechanism: comparison of APBN pre-COVID, during covid and post covid (2023 or projected 2024) - National health budget was Rp 119.9 trillion in 2020, Rp 124.4 trillion in 2021, Rp 134.8 trillion in 2022, and Rp 172.5 trillion in 2023. It was proposed that in 2024 to be Rp 186.4 trillion.[70] Consecutively, from 2020 to 2024 as seen in figure below, health budget comprised 5.2%, 6.2%, 9.4%, 5.5%, and lastly will comprise 5.6% of the national budget (APBN).[71]

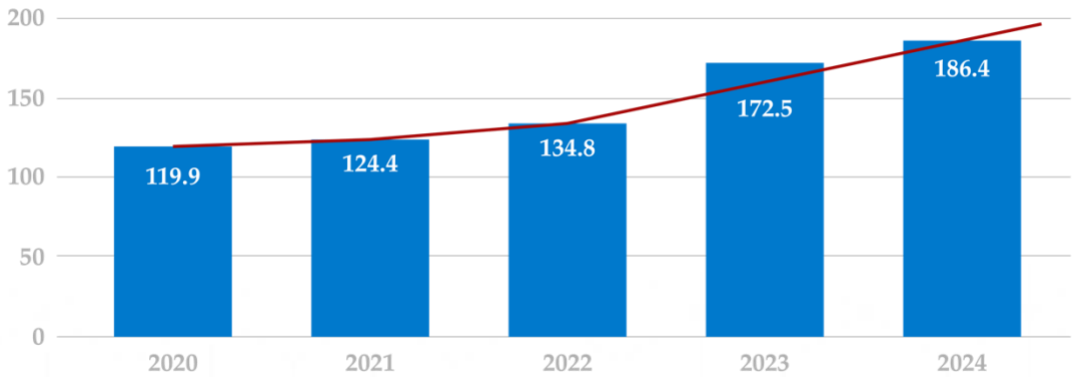


Figure 14. The Indonesia Government Budget for Health (*in trillion Rupiah*)

The trend above indicates a shift in priorities from the health sector to other development sectors as focus moves away from the health emergency.[72] In this current state of the world, investing in the health system becomes difficult. Domestic resources, especially originated from state funding, are becoming increasingly limited. Health, in the context of a health crisis or health emergency, has absorbed almost all of countries' funds. The declining trend also shows the challenge in maintaining sufficient investment for health.

Challenges in pooling and generating funds from a limited formal sector, along with weak financial management, hinder the government's ability to spend effectively and efficiently. The small size of Indonesia's formal sector complicates efforts to ensure tax compliance and revenue generation. Moreover, the limited institutional capacity to implement sound public financial management, ensuring both allocative and technical efficiency, further exacerbates these issues. Studies reveal that inefficiencies stem from the lack of performance-based mechanisms, inadequate planning, and unnecessary expenditures.

With the enactment of the new Health Law (UU No. 17/2023), there were changes in the health development planning and budgeting system. If in the previous regulation, the reference for medium-term development planning was only the RPJMN and the Strategic Plan of the MoH, now there is a Health Sector Master Plan (RIBK) which is an instrument for integrating health sector planning and budgeting that involves not only government actors, but also other resources such as the private sectors and the community. This instrument is also intended as

a measuring tool for performance-based budgeting and a mechanism for providing incentives or disincentives for government actors (both national and sub-national), and non-state actors.

To learn more about the potential implications of the RIBK document on the overall health planning and budgeting system, please refer to the **Governance** book in this White Paper series.

4.1.5. People

It is ironic that the very people who are the primary beneficiaries of a robust health sector are often excluded from the policy design and formulation process. They are frequently treated as objects within the health system, rather than as active participants. When they are involved, it is often merely a formality, meant to fulfil the public consultation requirement without meaningful engagement. Currently, there is no formal mechanism to meaningfully involve and engage the public in policy-making processes, let alone ensure inclusivity.

As a result, health policies in Indonesia are not yet moving toward health equity. The most vulnerable groups are often overlooked and not prioritised. Additionally, the definition of vulnerability remains too narrow. Current policies prioritise proportionality over equality, which exacerbates disparities for those with limited access to healthcare. One example is the prioritisation in the COVID-19 vaccination program. Another is the government's tendency toward a hospital-centric approach rather than shifting to transformative primary health care, which could benefit a broader segment of the population.[73]

The present condition shows that most vulnerable groups face multiple layers of barriers before accessing healthcare services. Only 16 percent of homeless people have access to health insurance, not including mental health services; and many of them face legal documentation as the prominent obstacle.[74,75] Households with children and elderly, and persons with disabilities struggled to recover during the recovery phase of the COVID-19 pandemic.[76] On a different note, ethnic minority people of Indonesia still identify physical infrastructure inadequacies as the reason for not accessing basic health services, such as saving labour;[77] and transfer use of their land together with modernisation of diet cause food insecurity that contributes to their children being undernourished.[78,79] From a national health insurance perspective, although technically 113 million of poor and near poor people own access to quality health services; vulnerable population groups without residence identification (KTP) still face barriers in obtaining their right to health. Data management system for this group is yet to be fully integrated and outreach remains scattered.

Chapter 5.
Health's Interconnectedness with Other Development Sectors

Health development never happens in isolation. The growth of healthcare will always be affected and affect other aspects of development. Healthcare revolves around human users, human providers, and human authorities, thus, sociocultural beliefs, norms, values, and political dynamics influence the way healthcare is being delivered and received. The development of the health sector also coexists within the clashing interests of economic growth and environment conservation. Meanwhile, technological disruption continues to change the way health and other sectors of development progress. This chapter explains the 'Health in All Policies' approach and GEDSI lens, which serves as the foundation for the recommendations in this book aimed at achieving health equity. These approaches acknowledge these multisector influences on health, and advocate for a multi sectoral approach in policy making related to health and equity.

5.1 Health in All Policies and GEDSI Lens

The world confronts distinctive challenges and emerging threats, distinct from previous circumstances, primarily underscored by the global COVID-19 pandemic and evolving trends across diverse sectors. The intricacy of these challenges underscores the imperative for a paradigm shift in our approach to health. Addressing today's health problems necessitates more than downstream interventions. Rather, it calls for a heightened focus on the drivers that shape the entire spectrum of health-related factors, from their origins to their ultimate effects.[80] Surprisingly, these drivers which hold the most sway, often lie outside the realm of the healthcare sector.[81]

WHO has identified these drivers as "poor social policies and programmes, unfair economic arrangements, and bad politics.".[82] Meanwhile, Krieger[83] has defined them as "how power–both power over and power to do, including constraints on and possibilities for exercising each type–structures people's engagement with the world and their exposures to material and psychosocial health hazards.".

The question arises as to what extent we are paying attention to and holding non-health sector policies accountable for their impact on health outcomes.[83] Since 1978, the Declaration of Alma Ata has firmly anchored equity and intersectoral action for health (IAH) at the core of the endeavour to attain health for all.[84] This commitment was further underscored by the 1986 Ottawa Charter, which stressed the importance of crafting a "healthy public policy".[85] Such a policy places health considerations on the agendas of policymakers across all sectors and at

all levels, prompting them to recognize the health consequences of their decisions and assume responsibility for health.

This narrative leads us to the imperative of adopting Health in All Policies (HiAP), is a systematic, cross-sector public policy approach that carefully considers the health system implications of decisions, aiming to identify synergies, prevent detrimental health impacts, and enhance population health and health equity.[86] The novelty offered by HiAP approach lies in its emphasis on how the goal of health for all can substantially contribute to broader societal objectives. HiAP places great importance on the idea that improved health outcomes can align harmoniously with economic growth, productivity, socio-economic development, and overall well-being. HiAP approach is characterised by its non-linearity and adaptability, capable of evolving to suit the ever-changing contextual dynamics (see Figure 15).

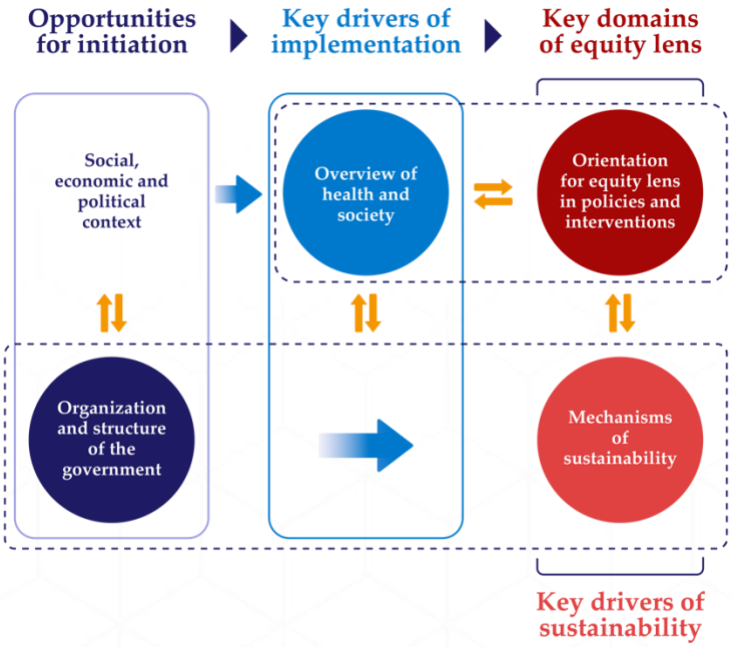


Figure 15. Areas for Learning in Health in All Policies Experiences[87]

To ensure the enduring viability of HiAP, a set of pivotal strategies is recommended. Foremost, the enactment of public health legislation stands as a cornerstone for the institutionalisation of HiAP, facilitating systemic transformation.[88] These legislative frameworks serve to legitimise multi-sectoral collaboration with the goal of addressing shared priorities and objectives. Furthermore, the monitoring system for health data needs to be expanded to encompass a more comprehensive range of health-related data in other policy sectors.[89]

Another key element of the HiAP approach is collaborative governance. In line with this, Kickbusch and Gleicher introduced the term 'governance for health,' which emphasises shared accountability and commitment to health and well-being. This approach facilitates a

whole-of-government and whole-of-society strategy aimed at preventing or mitigating adverse health impacts and enhancing positive health outcomes across all sectors.[90] The involvement of community voices and active engagement of civil society are essential in shaping actions related to health determinants.[91(p12)] This approach acknowledges the vital role of a broad spectrum of stakeholders and the public, recognizing their potential as agents for transformative change.

This implementation of the HiAP approach is often manifested through the inclusion of Health Impact Assessment (HIA) and Health Lens Analysis (HLA) in the policy development processes. HIA is centred on equity and focuses on population groups that may be disproportionately affected by the policy under consideration.[92] Through HIA, policymakers can assess health risks, broader health implications, and potential mitigation strategies for adverse impacts resulting from projects or policies. Typically, HIA is conducted through evidence gathering and analysis workshops involving community members, industries, and other professionals, and its outcomes inform the planning, monitoring, and evaluation of policies.[93,94]

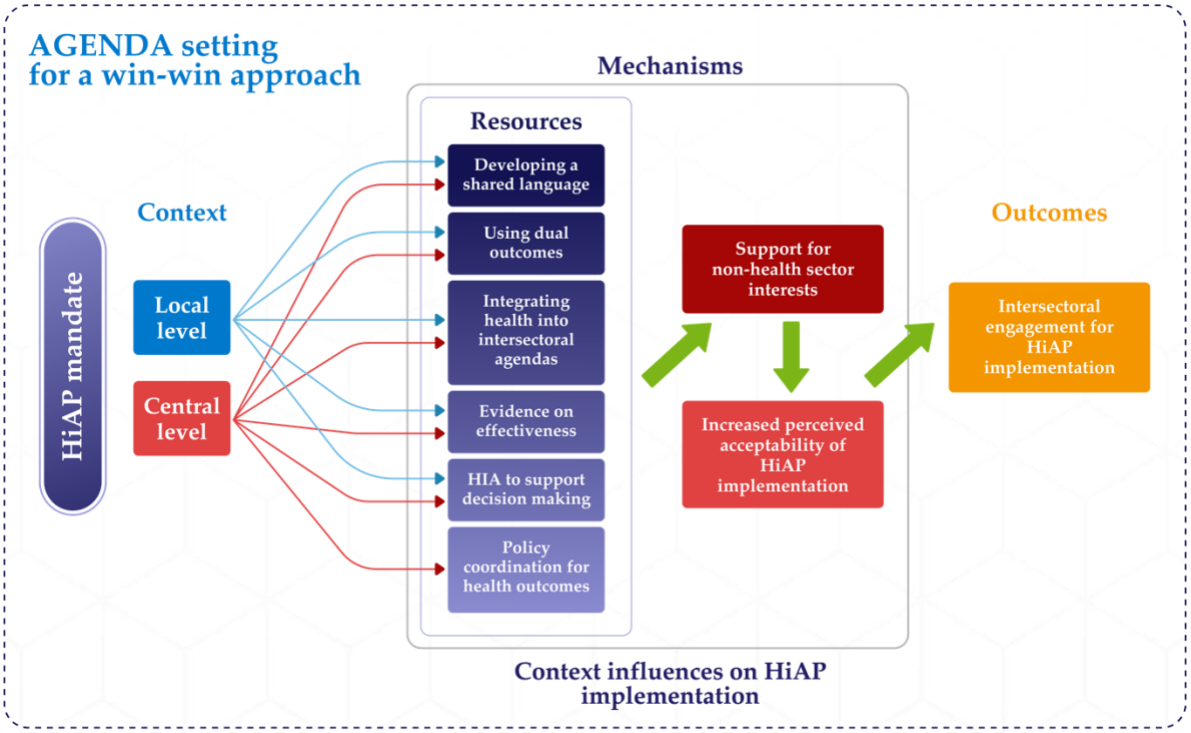


Figure 16. HiAP Implementation[95]

In contrast, Health Lens Analysis (HLA) comes into play at the agenda setting and policy development stages (see Figure 16). It aims to pinpoint critical interactions and synergies between the policy area and health, ultimately leading to policies that offer benefits to health as well as other outcomes.[96] The goal is to achieve co-benefits across systems or "win-wins" for all involved parties.[95] HLA seeks to establish relationships and connections that can lead to a unified policy focus shared between the health sector and other sectors. The results of HLA

are typically in the form of frameworks, roadmaps, or strategies that navigate and steer the implementation of recommendations through decision-making processes in an effective manner.[92]

Box 2. The Current HiAP Implementation

While principles for Health in All Policies still remains a noticeable gap to be filled, CISDI conducted a background study for the National Medium-Term Development Plan (RPJMN) 2024-2029 titled "Towards Health For All Through Health in All Policies" in 2022. This study employed foresight methodology and the framework of South Australia's Health in All Policies (HiAP) approach, involving expert opinions from five Delphi sessions explored how a strong authorising environment, cross-sectoral activities, and effective multi-sectoral coordination could create a conducive policy environment. This aims to achieve short-term cross-sectoral outcomes for NCD prevention and stunting reduction, with the long-term goal towards health for all.

The study findings indicate that Indonesia has already initiated a form of HiAP implementation at the national level, particularly in the context of addressing stunting. While not explicitly labelled as an HiAP approach, several principles related to multi-sectoral governance for health outcomes are discernible within this program. The Presidential Regulation on Accelerating Stunting Reduction has encompassed shared indicators, stakeholder mapping, role allocation, and financing schemes from the central to the local level. The Stunting Reduction Acceleration Team (TP2S) was also established to ensure cross-sectoral integration, both at the central and sub-national levels, under the direct leadership of the Vice President of the Republic of Indonesia.

Conversely, the study highlights that similar efforts have not been made regarding other multi-sectoral issues such as the prevention and control of non-communicable diseases (NCDs). The absence of a competent leading sector or delivery unit is evident in the lack of commitment to implementing the Healthy Living Community Movement (Germas). The Presidential Instruction on Germas does not include shared indicators among institutions or government levels and lacks financial schemes and community involvement. Efforts to address environmental and behavioural risk factors also face obstacles due to the limited scope of the Health Information System (HIS), which primarily still focuses on health system data and health status data (see the **Digital Health** book of this White Paper series).

As a result, this background study ultimately disseminates and recommends several key points to the National Development Planning Agency (Bappenas):

1. The establishment of a delivery unit and leading sector to manage coordination bottlenecks across government ministries, administrative levels, and various stakeholders
2. Integration of data and information systems to facilitate a continuum of care with seamless transitions
3. Digital-in-health financing, including funding mechanisms, budgeting processes, and an increase in healthcare allocation
4. Leveraging community representation platforms, such as Indonesia Health Assembly (IHA), to ensure diverse societal input into policy development
5. Strengthening local governments with a reward and punishment mechanism to enforce the achievement of strategic health objectives
6. Translating the roles of non-health stakeholders into tangible actions
7. Utilising tools such as Health Impact Assessment and Health Lens Analysis to assess the influence of each sector's activities on health outcomes.

Addressing multi sectoral health inequities requires recognising that health disparities cannot be solved by the healthcare sector alone. A **GEDSI** (Gender, Equity, Disability, and Social Inclusion) lens—integrating gender equality, disability equity, and social inclusion—is also essential for understanding the vulnerabilities of at-risk and marginalised populations. Expanding the definition of vulnerable groups to include those facing limited healthcare access, human rights violations, and systemic marginalisation enables health programs to better address these inequities. Just as the HiAP approach emphasises the importance of cross-sectoral collaboration, the GEDSI lens is equally crucial for ensuring inclusive, non-discriminatory health services that promote equity and better development outcomes for all.

Chapter 6.
Plausible Scenarios and Scenario Planning

6.1 Understanding the plausible scenarios in Health Sector Development

The COVID-19 pandemic revealed the central role and need for resilient health services at the community level. Considering the various uncertainties the health sector still faces as the result of the global disruption, to what extent has Indonesia measured the accuracy of its direction in its health development strategy remains a question. For this reason, future scenarios or narratives can guide development actors and policy makers as the basis of consideration for designing a sustained future for health.

Having scenarios also assists policy makers and development actors from various sectors to be acquainted with the complex system's dynamics through a more holistic perspective. Acknowledging the existing uncertainties and gaps, whilst challenging the assumptions on what should or should not be done.

Systematically, scenarios are developed with an understanding of trends. Mapping the trends over a certain period of time will provide an overview of the main factors that act as drivers towards the identified trends. To ensure future scenarios and narratives are developed, an understanding of the driving factors needs to be established.

There are nine stages of scenario development and analysis. The first step is to determine the objectives and time horizon scenarios, i.e., the timeframe in which the scenarios are expected to last. The next stage is to determine the main aspects in the STEEPV fields that will be the focus of the scenario development, particularly in terms of the subject ('who') and what might happen. Followed by determining the assumptions in each scenario and the development of a framework for the main trends in each scenario. The fifth stage comprises a detailed scenario writing process including the analysis of crisis situations in each scenario (sixth stage). The seventh stage ends with the development of the anticipated policies within each scenario by considering what can and cannot be controlled. Lastly, the eighth stage wraps the whole process by developing and evaluating the strategy-based action of the anticipated policies based on their importance and availability of resources.

For this White Paper, the research team acknowledged that the spectrum by which this study aims to cover is wide. As such, we viewed preparation for scenario building as an integral part of the entire process of structuring the future of health sector development. Scenario planning began from mapping trends that characterise development, identifying major challenges to setting development priorities. This approach of development integration and scenario analysis is important because it involves the results of each methodological phase in

foresight. In other contexts, should it be desirable, scenario developments can also be carried out to prepare a roadmap by considering reasonable alternatives in the future.

6.2. Plausible Scenarios

This report scrutinises the gaps hindering significant leap and/or progress of the health sector. It observes the health system's resilience through governance reform, the importance of primary care for prevention and behavioural change.

The immediate aftermath of the pandemic generated an instruction from the President to do an overall reform of the national health system.[97] In this directive, the President showed firm leadership to strengthen the national health development policy for improving health services towards universal health coverage. However, compared to other countries, the direction of the Indonesia health reform by overall transformation of primary health care still leaves a considerable gap and questions around the execution of overall systemic change as opposed to superficial level change. This is despite the fact that the impact of primary health care transformation is evident for health outcomes, health system efficiency, and health equity.

The STEEPV horizon scanning and dimensional investigation indicated two-way pull between overall governance mechanisms and its capacity including health system governance and the implementation of public health values versus wealth accumulation. These two factors correspond with the structural challenges and are significantly present in the trend mapping. These two factors will be used as the main reference in the scenario development.

6.2.1 Governance Axis - Indonesia and its capacity to govern the health sector

Further data processing and cleaning of the experts inputs and scenario building exercises, point towards governance as an axis by which health sector development depends upon. Although the capacity to execute good health system governance is a spectrum from low to high quality, it represents the determinants of success for reforms.

In situations where capacity to govern is moderately high, enough leverage to balance out the pull towards more value-based principle rather than wealth accumulation may be evident. On the other hand, when governance capacity is low, insufficient thrust power to bring in more tendency towards values-based principles will be apparent.

Considering governance is typically state or government oriented,[59p54] its performance (low or high quality) is dependent upon leadership commitment. The challenge facing health reform often hinges on the ability to complement reform commitments with effective governance and high capacity in planning, implementation, monitoring and evaluation and impact assesments.

6.2.2 Axis of Values: orientation of value-based principles versus wealth accumulation in public health

The COVID-19 pandemic has given rise to the devastating shocks that highlight the inequities and tug-of-war between sectors. In the economic sector, reports from various international institutions indicate an economic contraction that could trigger a global recession.[98] Many countries such as Singapore and the Philippines have even announced anticipated measures against recession.[99] On the other hand, the health sector still requires more resources even though the period of time of pandemic as global health emergency, has officially ended.[100]

Similar to other countries, Indonesia looks to build alliances in multiple platforms at national, regional and global levels. These networks and alliances are built with the objective to move resources to supplement or add to the limited fiscal space for health. This is a critical and difficult juncture for health policy makers, since as a global public good, the health sector typically absorbs resources with a longer period of return on investment. Regarding investing in the health system, WHO suggested that the tendency to reduce investment into the health system is not uncommon due to its high inefficiency.[22] However, they also suggested that investing in each or all of the health system components will generate macroeconomic growth. Perception of health as a source of revenue generation for the state, therefore positioned policies for health as consumer or for-profit goods.

At its extreme, the drive to accumulate wealth derived from the health sector, means commercialising health services and privatisation of the health sector.[101] This frame of thinking and policy direction will further exacerbate health inequity. In the case of Indonesia, direction towards this wealth principle goes against the principles of social justice and does not align with the National Health Insurance mechanisms which provide access to healthcare for everyone. Additionally, this study focuses on the value axis since it encompasses the strategic vision guiding the country's efforts to achieve health equity.

This study develops four scenarios to provide an approach and policy direction for health sector development (see Figure 17). The scenario development is carried out through a deductive exploratory method using data on the current situation (drivers, trends, challenges). Each scenario has its own characteristics and the same probability of occurring in 2024 onwards (see also Table 4).

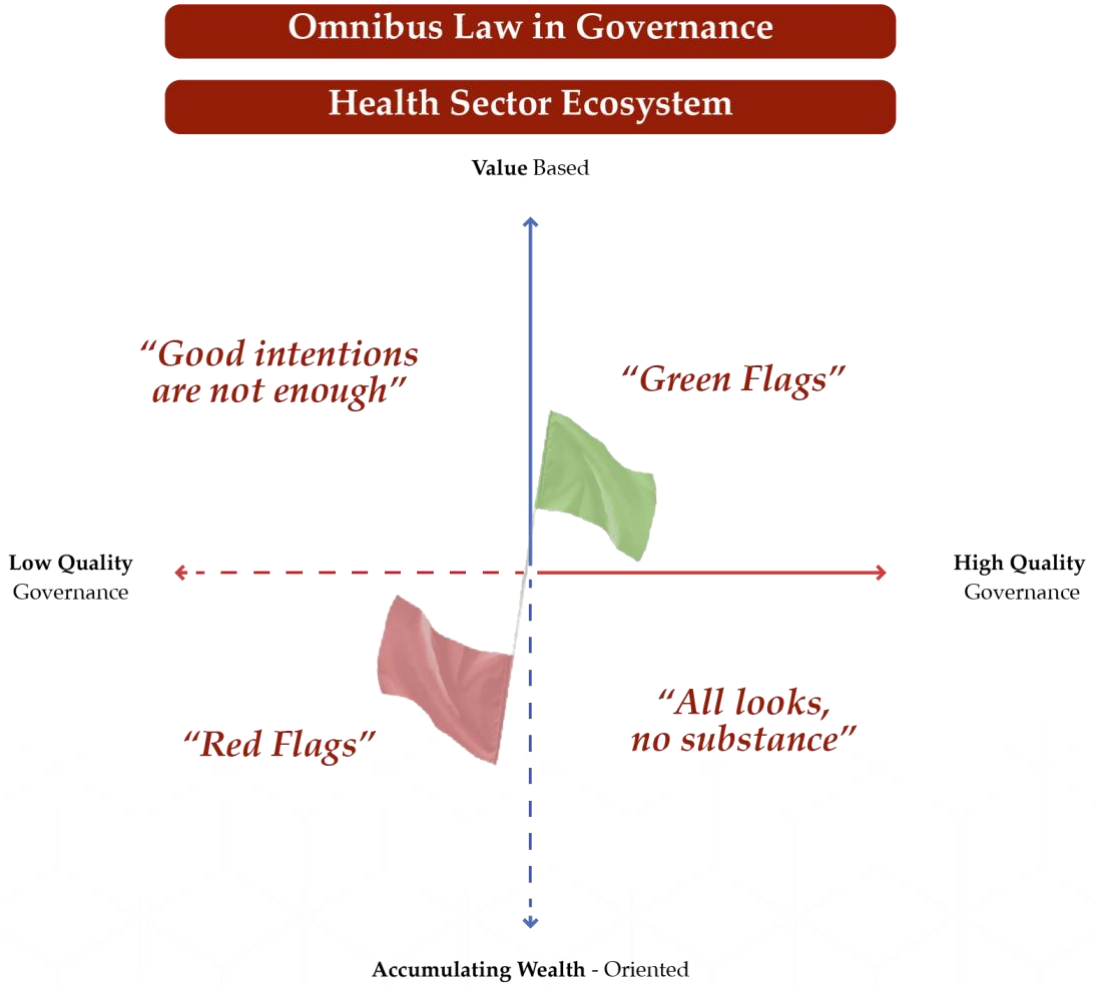


Figure 17. Proposed Plausible Scenarios

It is important to underline that the last two years have shown a consistent trend of utilising the Omnibus Law approach in developing the national regulatory framework. However, there remains a question of whether this sectoral Omnibus Law provides a suitable remedy to end fragmentation between sectors and actors. Both plausible scenarios axis vectored in Omnibus Law in governance as a potential element that will push for integration of all development sectors.

Scenario 1: Good intentions are not enough

This scenario is best described as a stagnant situation, within which the country is imprisoned by nothing but good intentions. The country's health sector development is caught floating in the spectrum between low quality governance and value-based principles. Within that spectrum, the tug-of-war continues between saving the country through total reform of the health system or through economic improvement. This condition is reflected during the COVID-19 pandemic and the policy inconsistencies between ministries, institutions and sub-national levels.

Bureaucratic capacity is already significantly affected by the dynamics of the five-year political routine. At the end of the pandemic, the COVID-19 response was almost forgotten and was discussed in the public space as a half-hearted effort without actual merit to save lives.

Changes in the budget structure within the technical ministries are not complemented by significant changes in the overall posture of the health budget and seem to be without clear priorities set towards the transformation of primary health services.

From a general development perspective, policy makers often take steps that hurt public feelings. Various examples, from the enactment of the Omnibus Employment Creation Law, the State Capital Law to the recent Health Law; show the failure of development policy makers to side with public health restoration.

Despite the destruction caused by the pandemic, people still believe a renewed health sector condition is possible although other development priorities continue. As such, this scenario also illustrates that under the "status quo" conditions, policies outside the health sector that are very influential in achieving development targets will rely more on short-term wealth and profit/loss calculations.

Success in breaking out from this spectrum towards the ideal spectrum will depend on the perseverance, ability and capacity to deliver policies into action.

Scenario 2: Green Flags

This scenario presents the most ideal spectrum within which Indonesia's health sector development can manoeuvre, from an optimistic perspective. Progress made is believed to lead to improvements towards an ideal national health ecosystem, where all key elements align, all development actors engaged meaningfully and every interconnection between health and other sectors explored and utilised. Operationalisation of all these components into clear development priorities, monitoring mechanisms are in place, and risk mitigation actions are prepared; ensure policies are delivered in precision.

The main condition being that structural improvements are carried out and governance, as the key structural barrier, is significantly overhauled to redirect its course for a people focused attainment of health outcomes.

This scenario optimistically sees the momentum of the leadership change in 2024 as bringing fresh air into overall governance for health. The good and bad practices during the pandemic all sorted out, with good subsequent implementations to ensure applications of health in all policies.

The main characteristic of this scenario is that it places structural changes as a way of changing perspectives. Thus, the investment perspective has begun to focus on seeing health as a long-term investment, not as a short-term cost burden.

An additional characteristic of this scenario is reflected in its governance. The government has drastically started implementing the merit system to arrange consequence-based governance management. From a national health policy perspective, this means managing the interaction between the political wing and the technocracy arm.

Availability of a solid regulatory framework is also one of the benchmarks for this scenario to be in play. However, it is important to note that current Health Law still requires proof and guarantee that the health system is accessible with quality services available to all.

The formulation of health reform prioritises investment in strong primary health services so as to enable the health system to side with the needs of patients or people-centred health systems. Therefore, in this scenario health services can be more effective in utilising resources, as well as able to increase public health literacy because of their active participation in their own care.

With the high level of public participation in creating demand and overseeing the current health system, Indonesia's position can also shift to this scenario if there is a mechanism for sustained public participation into the government system, especially in policy making and development implementation. Civil society and communities must be meaningfully engaged as a critical thinking partner to ensure production of policies that answer people's needs.

"Green Flags"-- the ideal world we desire. Is this where Indonesia will be?

Scenario 3: All looks, no substance

This scenario shows that a half-hearted reform is not a reform. The situation where the dynamics between doing "business as usual" and delivering "tough but right moves" makes this scenario very likely to happen. The dynamics of external elements to the bureaucracy, especially public pressure, can make changes seem to move towards the ideal scenario. However, because change is still reactive without a long-term systemic approach, the change stalls halfway before transformation actually takes place.

The main characteristic of this scenario is the failure to deliver. Policies produced cannot give birth to meaningful actions for impact. Movement for the policy implementation is limited only to the state apparatus; it always fails the wider public and never gains enough momentum for wider ownership beyond the health sector. From a public health perspective,

although it appears that there are measures taken towards health in all policies, accumulation of wealth, commercialisation and privatisation of health services are more prominent. In the end, health in all policies stops at being a slogan/rhetoric and is never really materialised

Scenario 4: Red Flags

Characteristically, this scenario describes a condition where there is low quality governance and high tendency towards wealth accumulation. The constant push and pull between economic and political interests dominates the policy makers' policy directions.

This scenario exists when the focus is leaning towards generating the highest revenue for the health sector through overall privatisation and commercialisation of health services and its industries. The health system is seen as a means to maximise profits, and hospitals with a more systematic profit withdrawal system are rapidly built. At the local government level, private clinics and hospitals are used as a source of regional income.

The push for digitalising health in the overall health sector is becoming more prominent. However, the steps towards truthfully embedding overall health digitalisation is not accompanied by strengthening the health and digital literacy of communities whose access to technology is precarious. Vulnerable groups and those in near poor condition will be further cornered to the brim of the system, if not entirely pushed outside of it. Access to affordable and quality health services become scarce. Overall, a nation-wide regress on health care and public health outcomes. Once again health becomes a luxury for many.

Table 4. Matrix of Plausible Scenarios

Health Sector Development	Scenario 1 Good Intentions are not Enough	Scenario 2 Green Flags	Scenario 3 All Looks, No Substance	Scenario 4 Red Flags
Systems	Efforts to strengthening the health system are currently fragmented and contingent upon specific figures, lacking institutionalisation to ensure sustained progress	Health system is oriented towards achieving health equity and improving health outcomes. There is interconnection between health and other sectors, ensure applications of health in all policies	Agenda-setting process is heavily influenced by the interests of parties solely focused on wealth accumulation, with public participation primarily dominated by industrial interests	The focus is leaning towards generating the highest revenue for the health sector through overall privatisation and commercialisation of health services and its industries
People	Public awareness of the need for fundamental changes clashes with the bureaucracy's reluctance to change, as many parties have benefited from the current "status quo"	The public, consisting of civil society, private sector, and academics, is meaningfully engaged in the transformation of the health system. The public feels optimistic due to a sense of ownership and shared-responsibility for achieving health for all.	Certain segments of the community are experiencing the benefits of the ongoing health system transformation, while others perceive a growing sense of exclusion. This is attributed to the fact that the changes lack sensitivity to distinct needs that vary among societal groups and regions	The public is unaware of their rights to health and well-being, allowing certain entities to continuously exploit their ignorance for profit and accumulating wealth
Governance	Acknowledging the imperative for fundamental changes in health governance, but the success of its transformation continues to rely on short-term visions limited to the tenure of the government	Solid and long-term regulatory framework, all development actors engaged meaningfully, implementing the merit system to arrange consequence-based governance management	Awareness and bureaucracy change is still reactive without a long-term systemic approach, the change stalls halfway before transformation actually takes place	Health governance and bureaucracy are predominantly steered by the self-interest of the actors, having limited capacity for ensure the implementation tailored to public needs
Financing	Awareness of the inadequacy in health budget allocation exists, but limited action can be taken as health financing constantly competes with interest in wealth accumulation	Commitment to budget allocation supporting health system and health outcomes has intensified, accompanied by a distinct priority for health system strengthening	There are no appropriate planning and financing according to needs, leading to a loss of momentum in strengthening the health system and creates gaps to exploited by opportunistic entities to accumulate their wealth	Lack of a clear direction in prioritising health financing, as all actors compete to reap profits and accumulate wealth from the health sector

Chapter 7.
Policy Recommendations: Operationalising and Answering the "How"

This research was triggered by a "patriotic call" as an appeal to development stakeholders, policy makers and the public to place health as a development priority. The extensive loss of lives because of the pandemic adds to many other counts of illnesses and deaths, due to prior neglect of health as key priority to development. Such devastation cannot be solved with incremental and superficial level triage. Recovery after a crisis of this magnitude will be an effort that requires almost a total overhaul of the system and reorientation of perspectives.

This is the right momentum to reaffirm commitments to build a robust and resilient health system. The WHO interim report on the "Fourth round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November 2022–January 2023"[102] indicates that countries' health systems have started showing recovery from pandemic, despite resource mobilisation remains an issue to be solved at the national as well global levels.

A strengthened health system must be achieved through an inclusive process. Evidence prior to the pandemic already referred to health system strengthening as a key priority action.[103] Pérez-Cuevas *et al* suggested that hearing and capturing public perceptions is one of the most important parts of structuring the future of health policies, in particular the primary health care system.[45] Studies conducted in several Latin American countries show that 85% of the population demand fundamental changes to occur in the health system.

Complexities of structuring the future of health sector development requires identification of fundamental levers that will systematically and structurally generate sustained public health impact. The four scenarios in chapter 6 explain why tensions between values and governance, two interlinkage components to health, directly affect policies in the health sector.

Based on the horizon scanning of public discourse, the experts' inputs and mapping of events, trends, drivers; **the ideal scenario for Indonesia is scenario 2: "Green Flags"**.

The following subchapter suggests how to operationalise strategies for achieving the ideal scenario.

7.1. Operationalising the Ideal Scenario: A Framework of Delivery

The ideal scenario aims to achieve the ultimate health development goal: **Healthy Population**. The authors identified these five SDGs health goals as the north star where health objectives

must ultimately land on. This White Paper contextualises the SDG goals with national context, bearing in mind other development priorities while still pushing for health to be the centre of national development efforts.

The below table presents the ultimate main goals to be achieved in health. With the SDGs only five years away from its final stage, it is wise to place all of Indonesia's national efforts towards achieving those goals.

Table 5. SDGs Health Goals (Source: The Global Goals 3 & OECD)[104]

Healthy Life Expectancy Expected number of remaining years of life spent in good health from a particular age, typically birth or age sixty-five, assuming current rates of mortality and morbidity disaggregated by sex, gender/gender identity				
By 2030, reduce the maternal mortality ratio to less than 70 per 100,000 live births	By 2030, end preventable deaths of newborns and children under 5 years of age, with the aim to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births, respectively	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	By 2030, substantially reduce the number of deaths and illnesses from road traffic accidents, substance abuse, hazardous chemicals and air, water and soil pollution and contamination

**Updated September 2024*

Upon completion of the expert panel review period, the authors conducted internal workshops sessions to synthesise the experts' comments into tracer indicators. These indicators were then grouped under each lever, detailed in the below tables. The authors propose for the tracer indicators from each level to be the anchors by which each detailed indicator can be based upon. Detailed Goals-Targets-Indicators can be found in the annex document of this White Paper series. Utilising the tracer indicators along with the GTI table will ensure operationalisation of all recommendations put forward by this White Paper.

The authors proposed an integrative framework which functions as a foundation for structuring the future of health sector development (see Figure 18). When made operational, this framework functions as an instrument to transition from disease-based frame to system-

based approaches for a healthy population. Detailed operational steps are provided in each thematic book of this White Paper series.

The authors reproduced the Olmen's Framework[105] by adding elements of interaction between the health system, global health and intersectionality. This integration positioned the population or people at the centre of health sector development. The population is an active component within this ecosystem, with the inclusion of multiple development actors, including the private sector, scientists, and civil society in the overall dynamics of policy making.

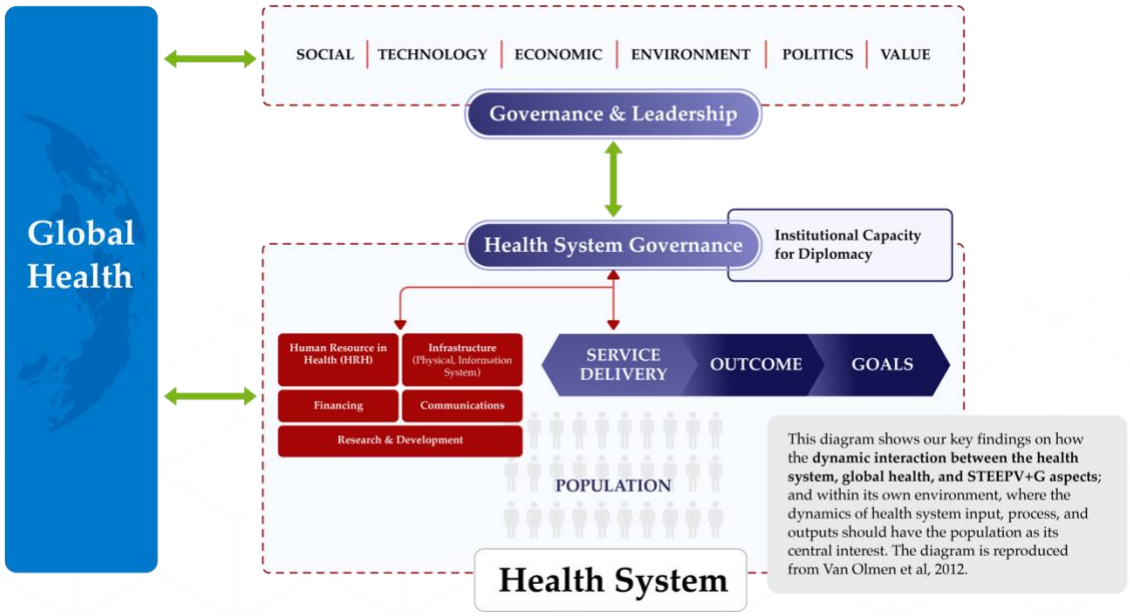


Figure 18. Framework of the Indonesia's Health Sector Development (2024-2034)[106]

This approach guarantees coherence of policy direction and positioning at national and global levels. In the current horizon of national health sector development, global health and the institutional capacity for global health diplomacy remains detached from the overall national policy making process. Contrary to that condition, the structured future of health policy making process there is constant and sustained dialogue between national and global processes. Once understanding of this concept of integration and interconnection between global, national, sub-national levels of policy making is achieved, subsequent delivery of policies will healthily influence and inform each other to the benefit of the population. This approach is consistent with Indonesia's current position with development actors who have brought in resources to support the national health agenda.

This framework implores to adopt a system thinking position. Governance and leadership is where interface between intersectoral components such as social, technology, economic, environment, politics and value, takes place. Whereas health system governance serves as a platform that manages the interrelationships between components or building blocks in the

health system. On its own, Human Resource for Health, Infrastructure, Financing, (Risk) Communications and Research and Development is not a system. It is the interplay between these different components that make them a system.

As such, Governance for Health ensures the elements are collaborating as an integrative system, in addition to ensuring each of these components is robust in itself. Only when the system works in a sustained manner, that goals and outcome of health policy and quality service delivery can be achieved.

Table 6. Tracer Indicators for Health System Reform

Code	Tracer Indicators
Governance	NHA publishes health impact assessments (HIAs) of projects, plans, programs, and policies undertaken by the government or the private sector as part of RIBK decision-making
Governance	The enactment of Omnibus Law for Governance Reform
Investing in Health System	% domestic general government expenditure on health as a percentage of total health expenditure
Investing in Health System	Benefit incidence of priority health programs to the poor, vulnerable, and aspiring middle-class women (% of total health program benefit to the poor. vulnerable, and aspiring middle-class women)
People-centred Health System	% increase in timely and high-quality health care utilisation rate in line with the standardised care pathways in the poor, vulnerable and aspiring middle-class women population segment
People-centred Health System	% increase of patient-reported outcome measures for 10 high-burden (high cost, high volume, and high risk) diseases
Human Resource for Health	Percentage of facilities that have the numbers and right skill mix of professionals according to population health needs.
Human Resource for Health	Ratio of active health workers leaving the public sector labour market to total stock of active health workers every year disaggregated by type of facilities, occupation and sex.
Global Health	The availability of Indonesia's Global Health Strategy blueprint
Global Health	Indonesia government appoints Ambassador for Global Health under Ministry of Health

In this version, we provide additional context to the proposed recommendations for health system reform proposals. After thorough alignment and refinement, incorporating recent policy updates, last year's data, and an expert panel review, we identified key tracer indicators for the proposed shifts. These indicators are presented in the table above (Table 6). For more details on technical recommendations and supporting indicators, please refer to the "**Goals, Targets, and Indicators**" book within this White Paper series.

7.2. Delivering Five Structural Shifts

Creating sound policy is only the beginning;

Successful leadership requires relentless focus on implementation.

Sir Michael Barber.

At the end of the day, the measurement of success of policies will be at its implementation, or as coined by Sir Michael Barber: delivery.[107] As much as policy making is science, delivery is science in itself, as argued by former World Bank Jim Yong Kim in his annual speech in 2012.[64] The UK Prime Minister Tony Blair, commissioned Sir Michael Barber to build a "Prime Minister Delivery Unit" during his tenure, beginning in 2001. A delivery mindset ensures clear priorities and targets are determined, routine mechanisms are in place to monitor progress, thus ensuring apparatus are positioned to keep implementations in track so problems can be solved methodically.

Ensuring delivery of a structured future in health sector development, means putting things in motion for the ideal scenario to be in play. Acting upon that will require five strategic and structural shifts to take place.

The authors proposed the following five structural shifts:

1. Execution of Governance for Health approach
2. Investing in Health System
3. Building a People-centred Health System
4. Achieving Decent Work for Human Resource for Health
5. Integrative Diplomacy on Global Health

7.2.1. Setting up governance mechanism and ensuring sustained delivery

Significant change in governance, in particular in governing for health policy formulation, must occur for this scenario to be in play. Operationalisation of the scenario requires a theory of change that is able to be implemented by the bureaucratic structure, considering that an agile bureaucracy is as important as an actively involved society. Considering the decentralised nature of health governance in accordance with the Regional Autonomy Law,

the recommendations given are only truly operational if they can be implemented by the central government or directly adopted/implemented by the local governments. This is true in particular with enactment of several Omnibus Laws for Health or the Health Law no 17/2023.

In the structured future, leaders in health and other development sectors with interlinkages to health are required to have a strategic vision and conceptual understanding of governance for health. This understanding will then have to be applied into Indonesia's socioeconomic, demographic and geographic contexts. This approach departs from the previous mechanism; where laws, regulations and technical procedures within the regulatory framework were successfully made but failed to be enforced to their full extent.

The governance structural shift requires the fulfilment of several preconditions: (i) meaningful participation, inclusion and diversity of all development actors in the full extent of policy making, from formulation to implementation; (ii) establishing collaborative governance through HiAP; (iii) applying principles of evidence-informed policy and GEDSI lens; (iv) utilising integrative or system thinking; (v) ensuring sustained political and budget commitments.

At technical operational level, an in-depth stock taking exercise of current initiatives and programs at national and sub-national levels, must take place immediately or during the transition period between the current to the incoming administration. Results of this exercise will be the seed of oversight and monitoring instruments whereby decisions to continue/discontinue, enhance and merge existing programs or initiatives can be made by the incoming administration and incoming key leader of the sector.

To push for collaborative governance across sectors and actors, including civil society, we propose a National Health Assembly (NHA) mechanism. This overhaul of perspective, shifts the health governance mechanism from central government to sub-national to global level in its entirety. Instead of seeing levels of government as hierarchical, the future health governance proposes to view different levels of state including the multiple actors, in a loop perspective. A looping approach needs only one system or platform that is commonly utilised by the corresponding organisations and actors. It ensures misalignment of timing is avoided so coherency in policies and implementation between subnational to national to global level can be achieved. The looping framework proposes a process whereby every health-related national institutions and other development actors including civil society, academia and private sector are meaningfully engaged and involved.

The National Health Assembly (NHA) is envisioned as the platform where all inputs are gathered, processed, and synthesised into a set of key priorities for health development. These priorities ensure alignment among the three key ministries involved in health sector

development: the Ministry of Health, the National Planning Agency (Bappenas), and the Ministry of Finance. In terms of content alignment, the NHA ensures that the agreed-upon priorities are consistent with the National Medium Term Plan, issued by Bappenas every five years. On the technical side, this process guarantees that two key objectives are met. First, the MoH can produce their Ministry Work Plan/*Rencana Kerja Pemerintah*; and second, the annual meeting of PHO and DHO/*Rapat Kerja Kesehatan Nasional* ensure leaders generate strategic plans that connect national and sub-national priorities areas in the health sector. In particular with the enactment of Health Law no.17/2023 where mandatory spending for health is no longer available, this mechanism ensures the central government's health sector priorities are still reflected in and remains the priorities of the sub-national governments.

NHA also ensures that at the global level, Indonesia's national position brought to the global health diplomacy fora is always clear and in coherence with national context. This is especially important due to the dynamics in global health where a baseline of "high call" or "red line" position is paramount. The **Governance** and **Global Health** books of this White Paper series details the required restructure and reorganisation of national institutions for this mechanism to be operational.

Additionally, collaborative governance will require changes in organisational structure to enhance agility. Some of the key changes include:

1. **Removing the function of Coordinating Ministries** to shorten bureaucracy and ensure more seamless coordination and communication. As described in Chapter 4, UKP4 report recommended the action due to the limited roles of the Coordinating Ministry to provide coordination and supervision to respective ministries.
2. **Installing inter-ministries working group or task force mechanisms within the President's or Vice President's office** with the main task as operator or implementer of the transition and institutional restructuring process. The task of this work unit is to work collaboratively with think tanks, academia and civil society to conduct studies/reviews, and evaluations of regulations/overlapping policies/legislations. The task force and working groups must work together with related state institutions and deliver their recommendations to the President's or Vice President's office. These working groups will ensure alignment between political and bureaucratic priorities. Oversight and monitoring of these priorities can be tasked to the President Delivery Unit.
3. **Establishing an oversight and delivery unit directly under the President is required**, with the primary task of acting as the operator or executor of the transition and reorganisation process of institutions and ensuring the President's priorities are delivered across K/L. The need to reassert the functions of monitoring and oversight into a delivery unit for monitoring of delivery and impact of health development targets that can be placed in the President's or Vice President Office.

4. **The MoH should separate its regulatory and operator function by establishing the Health Service Directorate General into an independent agency**, maintaining coordination with the Ministry to enhance its regulatory focus. The National Health Policy Agency (BKPK) should be reframed as a Directorate General led by a Director General, while the Foreign Partnership Bureau should be rebranded as the Global Health Bureau under the General Secretary to strengthen its role in global health diplomacy.
5. **Establishing Indonesia CDC as a national institutional instrument for Pandemic Preparedness and Response**, in coordination with the MoH. The CDC should focus on epidemiological surveillance and PPPR, incorporating functions from the Directorate of Prevention and Disease Control and benchmarking against US CDC and Africa CDC.
6. **Unbundling of the Ministry of Health to establish the National Health Service Delivery Agency.** This new national agency oversees health service delivery on the vertical hospitals currently owned by the Ministry of Health. This separation allows the ministry to function independently as the national regulator, while the NHSA will follow the norms and guidelines and service blueprints of care, to ensure there is excellence in quality of care.
7. **Establishing a semi-autonomous organisation to serve as a Health Technology Assessment (HTA) Committee** in coordination with the Ministry of Health (MOH), similar to NICE in the UK and Thailand. This entity would be responsible for providing guidance on navigating the innovation pathway, from idea generation through development, regulation, reimbursement, endorsement, commissioning, and adoption, for pharmaceuticals, medical devices, in vitro diagnostics, and digital health solutions.

8. **BPS (National Statistics Bureau) should strengthen its demographic and analytical functions** by collaborating more closely with research institutions. KemenPPPA needs to enhance its focus on gender, equity, and rights by adopting an intersectional perspective, particularly addressing sexual and reproductive rights, adolescent pregnancies, and single parenting. In this way, BKKBN should transfer its demographic functions to BPS, shift equity, rights, and sexual reproductive responsibilities to KemenPPPA, and focus on strengthening its Family Planning functions.

Reforming governance requires strong leadership, organisational restructuring, business process changes, and full stakeholder commitment. Institutional reform proposed by the authors encapsulates health-related institutions or agencies as well as other bodies beyond the health sector. The proposed governance for health structure can be seen in the below figure. For more detailed recommendations, please refer to the **Governance Book** of this White Paper Series.

7.2.2 Making the Case for Investing in the Health System

Indonesia's spending capacity is constrained by its relatively insufficient ability to generate revenues. The government should focus on improving the Debt Service Ratio (DSR) by addressing its main causes: the falling tax revenues. **In the short to medium term, the GoI should focus on expanding the tax base for unhealthy products, such as tobacco, alcohol, sugar-sweetened beverages, and high-fat, high-salt, and sugary foods.** Excise taxes on these items are effective policy tools with health, economic, and fiscal benefits. For income and corporate taxes, the GoI must be cautious, as raising tax rates will impose additional burdens on economic actors. The GoI should focus on improving tax administration to reduce the cost of compliance and encourage greater voluntary participation in the tax system. Additionally, a hypothetical scenario where energy subsidy reforms involve reducing spending by 0.7 percent of GDP annually, removing VAT exemptions for non-medical service, and increasing tobacco excise taxes to generate 1.1 percent more revenue each year. To counterbalance the effects of VAT exemptions and energy subsidy reforms on the bottom 40 percent of the population, targeted cash transfers costing 0.5 percent of GDP would be implemented. This entire plan would result in a net positive fiscal impact of 1.3 percent of GDP per year.[108]

The health sector is currently extremely inefficient. Indonesia should prioritise more effective programs and interventions by reallocating resources away from less productive ones. **RIBK must provide a robust intervention logic for programs applied to all government levels, clearly defining intermediate steps and establishing measurement criteria to track progress. Then this clear input – output – outcome framework can be aligned as a performance-based component in the fiscal transfer.** Three of the most important functions played by the Ministry of Health here: (1) establish a robust pre-implementation assessment of proposed interventions to create a compelling rationale for resource allocation.; (2) set up a robust monitoring and evaluation of whether key interventions are achieving their goals, as well as (3) conduct pending reviews and performance budgeting to allocate resources where they yield results.

Moving fiscal transfers to BPJS-K is essential for achieving the target of 70% pooling of public funding. A phased approach, beginning with capital investments, is both practical and manageable. Gradually transferring 10% of funds each year allows the system to make the necessary adjustments without overwhelming the existing infrastructure. The initial focus should be on capital investments, with funds moved to BPJS-K to support capital adjustments through the CBG (Case-Based Groups) tariffs. To ensure effective implementation, the Ministry of Health (MOH) and provincial governments should develop a Master Plan that outlines which regions or facilities receive these capital adjustments. Salary funding would be transferred last, given the political sensitivities involved. The roadmap for this transition

should be announced in 2025, with the shifts occurring over a five-year period, providing ample time for all stakeholders to align their efforts.

Unintended cross subsidisation needs to be managed. There are various approaches to adjustment to consider.[109] Redistribution can be achieved by providing budget transfers and gradually increasing these, with the aim of achieving equitable access to health services and harmonised benefit packages. Countries that have pursued this pooling reform option include for example Colombia,[110] Gabon,[111] Mexico,[112] Peru[113] and Thailand.[114] In these countries, reforms have substantially reduced the differences in per capita expenditure between different population groups, and thus helped to improve financial protection and equitable access to health services.

While awaiting the design of a new pooling mechanism, Indonesia must continue to invest in Primary Healthcare Centers (Puskesmas) and referral networks in remote and underserved areas by providing sufficient staffing, medical supplies, and equipment. Telemedicine should also be expanded to bridge gaps in specialist services, enabling rural populations to access high-quality consultations without the need for travel. Additionally, incentive programs for healthcare professionals, such as higher salaries or benefits, should be implemented to encourage medical personnel to work in rural areas. Furthermore, the allocation of JKN funds must be adjusted based on regional needs, with greater support directed toward areas facing significant healthcare access deficits.

Indonesia should focus on transforming BPJS-K into a strategic purchaser with full responsibility for the benefits package, contracting, provider payments, and quality assurance. The BPJS-K Board must function more effectively, with the CEO reporting to the Board rather than the reverse. The Board should also take responsibility for producing the organisation's annual report, which must include a thorough actuarial assessment. To strengthen its governance, the composition of the BPJS-K Board should be enhanced by including more experts in health financing, addressing the current gap in understanding these critical issues. Furthermore, it is recommended to reform the National Social Security Council (DJSN) to focus exclusively on health and to provide oversight and coordination among key stakeholders, including the Ministry of Health, BPJS-K, the Coordinating Ministry, the Ministry of Home Affairs, and others. The DJSN should be composed of 50 to 100 health experts to ensure effective governance and coordination across these entities

BPJS Healthcare is currently performing basic claims reviews and verification, but a more thorough analysis of claims could uncover additional opportunities for enhancing service delivery and fund management. Specifically, **analysis of JKN claims could help ensure compliance with care guidelines and protocols, which in turn could enhance service quality, such as by identifying and preventing adverse events, unnecessary or ineffective treatments.** Furthermore, claims data analysis could pinpoint items with high costs or usage

frequency, offering insights to devise policies that address the issue of open-ended hospital payments. Policy development could be informed by simulations and budget impact assessments reflecting actual service use. Nevertheless, the current quality of data presents a significant obstacle to such analyses, highlighting an urgent need to improve medical reporting quality and the skills of clinical coders

The current INA-CBGs tariff rates no longer align with the economic realities due to rising healthcare costs, inflation, increasing hospital operational expenses, layered taxation, and the rising minimum wage (UMR and UMK) and retributions. **This necessitates a revision of the INA-CBGs tariff structure alongside the ongoing development of the INA-Grouper system. Good quality data on costs and resource use at hospitals are vital to regularly updating DRG tariffs so that any unintended distortions can be corrected.** Currently the costing template is not detailed enough to get accurate estimates of unit cost. Filling out the templates is also not based on a representative sample of public and private hospitals. When the cost data are inaccurate or unfair, it may incentivize providers to under provide services or upcode. Tariffs also have several adjustments for hospital type, region, and JKN membership class, but none of these adjustments were cost and the tariffs do not reflect the cost of actually delivering care.

To improve equity in allocation, Indonesia could consider replacing the input-based formula for paying primary healthcare. One alternative is to adopt a budget-neutral formula where the base rate is determined by dividing the total funds in the JKN PHC pool by the total population. An adjustment coefficient could then be applied to ensure that the base rate for private FKTPs (Primary Healthcare Facilities) is higher than for public FKTPs, recognizing that public facilities have alternative sources of funding for operational costs. The potential for risk-based capitation should also be examined. A more complex formula, where the base rate depends on factors such as age, gender, and chronic disease status, could be justified if enrollee risk composition varies systematically across facilities.

The design of performance-based capitation can be improved by focusing on output indicators that are largely within the control of the facilities. This means giving less weight in the KBK (Capitation-Based on Performance) formula to indicators that most facilities are already comfortably meeting and instead linking penalties to progress over time rather than absolute targets. Rewarding facilities for their own improvements is more equitable than rewarding the achievement of fixed targets, particularly in a context where there is significant variation in service readiness across facilities.

Efforts to modify the scope of the healthcare benefit package have faced considerable opposition due to the lack of a clear and open method for determining what should be included or excluded. This has made it politically challenging to reduce benefits, especially when media coverage and public opinion frequently overturn evidence-based

recommendations from health technology assessments and cost-effectiveness studies. To navigate the complex political landscape of these decisions, it's crucial to leverage detailed data from JKN claims, budget impact analyses, and economic evaluations to provide policymakers with robust evidence to support their decisions. These resources exist but are not currently being utilised to shape policy. **Indonesia can consider creating a semi-autonomous organisation outside of MOH as in NICE in the UK and in Thailand. This entity is tasked to provide guidance for navigating the innovation pathway from idea generation, through development, regulation, reimbursement, endorsement, commissioning and adoption, for pharmaceutical, medical devices and in vitro diagnosis and digital health.**

7.2.3. Building a People-centred Health System

Putting people (i.e: patient or person) at the centre of the health system not only aims to improve their personal health outcomes through personalised care plans but also considers how their actions can influence the overall population health. This approach encourages patients to actively participate in their own care, promotes transparency and accessibility of information, and fosters a collaborative, coordinated healthcare environment tailored to individual needs, all of which can contribute positively to community health outcomes.

An effective people-centred health system should include: (1) continuity and comprehensiveness, (2) accessibility, (3) availability and readiness, (4) efficiency and sustainability, (5) appropriateness, and (6) quality. It's crucial to highlight how health system components like human resources, service delivery, information, supplies, and finances are interconnected. The success of the health system relies on these elements working together, guided by strong governance principles.

Strengthening the PHC system is vital for creating a people-centred health system in Indonesia that offers accessible and locally tailored services. Key steps include enhancing service delivery through puskesmas, pustu, and posyandu, and conducting a detailed task-sharing analysis to streamline care. Deploying family medicine specialists (SpKKLP) in each sub-district will further provide holistic care, with local governments responsible for their allocation.

Additionally, integrating private primary care services by enforcing quality and data governance standards will elevate service delivery across sectors. Tailored PHC models for rural and urban areas, supported by capacity-building policies for CHWs, will further enhance service delivery. Lastly, expanding healthcare coverage in DTPK areas by maintaining adequate general practitioners and extending essential services will ensure equitable access across the country. Developing tailored PHC models for rural and urban areas, along with capacity-building for CHWs, will improve overall service.

To build a resilient health system that improves service delivery and patient outcomes, several critical areas need attention. Ensuring the availability of essential medicines and medical devices in both public and private primary care settings is vital, particularly for patients with NCDs and psychiatric conditions. Implementing transparent procurement systems, such as the e-catalogue, and ensuring clear national to sub-national budget flows will strengthen supply chain readiness.

Expanding holistic health screenings across primary care and promoting task-sharing between puskesmas, pustu, and posyandu will boost early detection and treatment. Additionally, addressing accreditation gaps in private clinics and enhancing health data governance through a national research and data framework will support evidence-based decision-making and improve service quality.

Advancing digital health initiatives and integrating digital tools for research and personalised care are also essential. Strengthening human resources for health (HRH) by deploying staff based on needs, supported by centralised data and automated planning tools, will improve workforce efficiency. Finally, formalising CHWs with structured support and fair compensation will enhance their role in healthcare delivery and public health preparedness.

Achieving high-quality healthcare across Indonesia requires a transformative approach focused on implementing medical guidelines, fostering interprofessional collaboration, and ensuring readiness for health crises. Expanding the National Guidelines for Medical Services (PNPK) for diseases covered by BPJS is critical for standardising care. Strengthening collaboration between healthcare professionals through targeted training and regularly updated accreditation processes will improve service quality. Additionally, a national health crisis readiness plan, supported by digital tools to assist healthcare workers without replacing human expertise, is essential to maintain high-quality care during emergencies.

Addressing equity challenges, especially for vulnerable and marginalised populations, demands integrating an inclusivity framework within the healthcare system. This framework must guarantee access to quality services for all, irrespective of gender, disability, or socio-economic status. Prioritising socio-economic determinants in healthcare planning and promoting cross-sectoral collaborations between public, private, and community-based organisations will help bridge existing gaps. By focusing on patient-centred care, public participation, and innovative solutions, Indonesia can create a more inclusive health system. Mapping healthcare providers and aligning partnerships with the private sector, particularly in underserved areas such as preventive and mental health care, will further enhance inclusivity.

Leadership and governance in Indonesia's health system need strengthening to ensure effective planning, monitoring, and accountability at all levels. Local governments should promote cross-sectoral collaboration, align health services with population needs, and establish solid frameworks for regional health planning. We recommend forming the Indonesia Health Commission and Assembly, drawing on successful models like Thailand's National Health Assembly, to harmonise national health strategies, engage stakeholders, and address local health issues through decentralised assemblies. Moreover, refining the 2023 Health Law is necessary to ensure continuous professional development for healthcare professionals. A focus on HRH quality assurance and accountability in service delivery will ensure that healthcare services evolve to meet the changing needs of Indonesia's population.

7.2.4. Human Resource for Health: one who delivers service

Decent work, as defined by the International Labour Organization (ILO), ensures fair wages, job security, social protection, and opportunities for personal development, while fostering equality and inclusion in the workplace. In the health sector, providing decent work conditions strengthens the workforce by promoting professional growth, retaining skilled workers, and improving job satisfaction. By aligning with the principles of decent work, Indonesia can build a more resilient and effective health system, where healthcare workers are empowered to deliver higher quality care and contribute to better health outcomes.

Establishing enhanced inter-ministerial and cross-sectoral coordination is crucial to addressing the fragmentation of efforts and improving the availability of qualified health workers. This involves creating a robust and frequent information exchange mechanism among key stakeholders, including the Ministry of Education, the Ministry of Health, the Ministry of Labour, and the private sector.

An integrated data centre should be established to dynamically analyse HRH supply and demand, connecting these entities for better decision-making. Additionally, a streamlined assessment and planning mechanism should be developed to facilitate more efficient HRH evaluations at the district and healthcare facility levels.

Effective planning of healthcare workforce requirements must be based on actual conditions and workload rather than traditional population ratios. A needs-based approach tailored to specific regional or facility conditions is essential to determine the optimal number and type of health workers. Expanding the focus to include roles such as nutritionists and laboratory technicians, and increasing education budgets for diverse health worker training, will help meet future demands. Implementing tools like WISN from WHO can improve HRH planning by accounting for variations in service complexity and ensuring that workforce planning aligns with facility needs.

Human resources for health curricula must adapt to current and future healthcare needs, including integrating digital literacy and shifting from curative to preventive care. Improving the quality of healthcare services also necessitates reforms in education. Community-based education programs and interprofessional education (IPE) are essential to prepare health workers for effective collaboration and patient-centred care. Adopting the Academic Health System (AHS) approach can further enhance integration between medical education, research, and healthcare services, fostering a more cohesive healthcare system in Indonesia.

Adhering to the principles of decent work, as defined by the International Labour Organization (ILO), is essential to improving the recruitment and retention of healthcare professionals, particularly in rural and remote areas. This involves establishing fair wage standards applicable to all healthcare workers, including Community Health Workers (CHWs), to ensure their compensation meets or exceeds minimum regional wage levels. Additionally, regulations should be developed to address workplace risks such as violence and harassment, with clear sector-specific guidelines and training to manage these issues effectively. Ensuring adequate facilities and resources for healthcare workers, along with appropriate budget allocations, will support their well-being and enable them to provide high-quality care.

Improving the management of CHWs by formalising the system. This includes refining the recruitment process to make it more professional and less influenced by local politics. Clear technical guidelines should be developed and incorporated into regulations to ensure a transparent and accountable recruitment system. Furthermore, CHWs should receive ongoing training and professional development, with their competencies aligned with their responsibilities across various life stages. This structured approach will enhance the effectiveness of CHWs and support their role in delivering quality healthcare services.

Establishing systematic regulations for incentives to address the issue of fair compensation for CHWs. These regulations should include both financial incentives, such as salaries and bonuses, and non-financial rewards, like training opportunities and career development. Additionally, a specific budget should be allocated to support CHW financing, with clear guidelines for the distribution of incentives. This approach will address discrepancies in incentive amounts and sources, motivating CHWs and ensuring they are adequately compensated for their efforts, ultimately improving the quality of healthcare services they provide.

A Coordinating Committee should be established to oversee and standardise the process to implement task shifting effectively. Task shifting is a strategic approach to address the imbalance in Indonesia's healthcare workforce by redistributing tasks among a wider range of healthcare professionals, particularly in underserved areas. Collaboration between the

Ministry of Health, professional councils, and other stakeholders is crucial for alignment and coordination. Operational guidelines and competency matrices must be developed to define tasks and roles clearly, while maintaining supervision and allowing for some independent decision-making. Defining clear limits and conditions will ensure task shifting maintains quality of care. This approach aims to enhance service delivery by utilising a diverse workforce, improving healthcare access and addressing workforce shortages in critical areas.

In this current version, we provide additional context to the proposed human resources for health recommendations. After a thorough process of alignment and refinement based on policy updates and data from the past year, as well as an expert panel review, we have identified the following tracer indicators that serve as key tools for monitoring and evaluating the success of the proposed shifts, and are presented in table 6. For further details on the technical recommendations and supporting indicators, you can refer to the **Goals, Targets, and Indicators** book within this White Paper series.

7.2.5. Integrative Diplomacy in Global Health: Beyond Talk, More than Aid

These are all key recommendations for advancing Indonesia's global health strategy over the next 5 to 10 years, as outlined in this white paper. It aims to enhance Indonesia's global health diplomacy, strengthen domestic health systems, and contribute to global health, particularly within the global south.

The Ministry of Health's current blueprint for international health cooperation requires expansion to address cross-sectoral challenges. A comprehensive strategy is recommended, incorporating mechanisms for priority setting, diversified health funding, cross-sectoral coordination, and human resource mapping. This blueprint should adopt a "Whole of Government" framework, engaging ministries such as Finance, Foreign Affairs, and Agriculture, as well as a "Whole of Society" approach that involves civil society in shaping Indonesia's global health agenda. The aim is to ensure that national policies address the needs of vulnerable populations while enhancing health diplomacy efforts.

To support this, a Global Health Bureau should be established under the Secretary General of the Ministry of Health to coordinate Indonesia's global health diplomacy. This body would oversee legal drafting, policy development, international health initiatives, and stronger roles and authorities compared to being positioned as a Policy Center.

Strengthening the competency of health professionals in global health is crucial for Indonesia's global health diplomacy. This requires targeted recruitment, competency-based training, and continuous professional development for health workers. The government should introduce performance-based key indicators to enhance the skills of Ministry of Health staff, particularly in areas such as policy analysis, intelligence, and coordination.

Indonesia's global health leadership should focus on bolstering the national health system while advocating for the needs of global south countries. As part of this effort, a roadmap for achieving vaccine, therapeutic, and diagnostic independence within ASEAN is essential. In addition, appointing a Global Health Ambassador by 2030 would further elevate Indonesia's diplomatic presence in international health forums, promoting leadership in global health diplomacy.

Contributing to sustainable and equitable global health financing is critical as Indonesia wants to achieve its proactive role in global health. The government should leverage official development assistance (ODA) by allocating 1 trillion IDR (approximately $60 million USD)[1] through the Indonesia Aid (LDKPI) for Indonesia's global health agenda for global south countries. Moreover, Indonesia also could provides additional funds of 13 Million USD annually[2] to actively contribute to a number of global financing pools including but not limited to: CEPI, Pandemic Fund, Global Fund, ACPHEED Fund, and ASEAN Pandemic Fund for the fiscal year 2025-2030.

To strengthen its impact, we recommend the Indonesian government to appoint an Ambassador for Global Health by 2030. The Ambassador will work under the Ministry of Health, in coordination with the Global Health Bureau. It is important to realise this according to the successful story of Australia and Japan in maintaining its leadership in global health. The appointment of a Global Health Ambassador will enable the Indonesian government to engage more proactively in health diplomacy, leveraging both political and technocratic functions. Furthermore, if this role is bolstered by a well-resourced Global Health Bureau, Indonesia can assert its leadership in areas such as drafting legal frameworks for international cooperation, contributing to global health financing mechanisms, and expanding its Official Development Assistance (ODA) to strengthen south-south cooperation in health.

[1] The estimated amount of ODA funding for Health Cooperation is measured based on the historical state budget allocation for LDKPI (Indonesian Aid) for the period 2021-2024.

[2]The estimated additional funds for CEPI, Pandemic Fund, Global Fund, and ACHPHEED Fund were also developed based on Indonesia's historical budgeting for global health initiatives, such as Global Fund: US$15 M; Pandemic Fund US$50M;Achpeed Fund: US$ 10 M, during 2021-2025 fiscal years

Chapter 8.
Building A Structured Future for Health Sector Development

Structuring the future while in parallel accounting for its interconnectedness to other development sectors, requires thorough end-to-end thinking: from policy to governance to delivery and impact. In particular the health sector, where policies have direct impact on peoples' lives; there are a myriad of intersectionalities which have to be addressed; among others gender, climate, vulnerability, inclusivity and diversity. Indonesia, with 4.9% growth year on year and announced as potentially moving on into a high income country in 10 years[115] is seemingly set to achieve Indonesia Vision 2045.

However, there will not be an Indonesia Vision 2045 without a healthy and resilient population healthy and competitive enough to be classified as "capital". Demographic bonus will not be realised with stunting still at 21.6%, 2020 maternal mortality rate at 173 per 100,000 live births,[116,117] smokers at 71% of male population, and 8 out of 10 people dying from Non Communicable Diseases.[118] It takes more than good intentions and surface level touch up to claim true reform. Structuring the future of health requires in-depth, systematic planning and precision of delivery. Health is for everyone, health is a right. A well-structured future of health sector development saves generations and the future of this country.

This White Paper series provides in-depth recommendations on directions towards a future that is well-designed, utilising health as an entry point for an overall sustained and comprehensive reform. The authors presented an overall review of the trends that influence policy formulation and direction. Public discourse, scientific evidence and experts' opinions are positioned as integral variables to the policy making process, in addition to regulatory framework, leadership and budget commitments.

Within each of the thematic books in this White Paper series, all development actors including the public can be active participants in structuring a future we would like to live in, now, in the next ten years and for many more years to come.

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