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

Governance for Health: Beyond Policy, into Impactful Delivery

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List of Abbreviations

Abbreviation	Description
ADD	*Anggaran Dana Desa (Village Fund Allocation)*
ASN	Aparatur Sipil Negara (Civil Servants or Government Employees)
Bappeda	*Badan Perencana Pembangunan Daerah (Regional Development Planning Agency in Indonesia)*
Bappenas	*Badan Perencana Pembangunan Nasional (National Development Planning Agency in Indonesia)*
BGN	Badan Gizi Nasional (National Nutrition Agency)
BKKBN	Badan Kependudukan dan Keluarga Berencana Nasional (National Population and Family Planning Agency)
BOK	*Bantuan Operasional Kesehatan (Health Operational Assistance Fund in Indonesia)*
BPJS-K	Badan Penyelenggara Jaminan Sosial Kesehatan (Health Social Security Management Body)
BPOM	Badan Pengawas Obat dan Makanan (Indonesian Food and Drug Authority)
CDH	Commercial Determinants of Health
DPR-RI	Dewan Perwakilan Rakyat Republik Indonesia (House of Representatives of the Republic of Indonesia)
DTO	*Digital Transformation Office*
FCTC	Framework Convention on Tobacco Control
FENSA	Framework of Engagement with Non-State Actors
GDP	Gross Domestic Product
GERD	Gross Domestic Expenditure on Research and Development
GERMAS	*Gerakan Masyarakat Sehat (Healthy Society Movement)*
HiAP	Health in All Policies
IFRC	International Federation of Red Cross
ILP	Integrasi Pelayanan Kesehatan Primer (Integration of Primary Health Care)
JKN	*Jaminan Kesehatan Nasional (National Health Insurance)*
Kemenkes	*Kementerian Kesehatan (Ministry of Health in Indonesia)*
LKD	Lembaga Kesehatan Desa (Village Health Institution)
Musrenbang	Musyawarah Perencanaan Pembangunan (Development Planning Deliberation)
NCD	Non-Communicable Disease
NDA	National Designated Authorities
PIS-PK	*Program Indonesia Sehat Pendekatan Keluarga (Healthy Indonesia with a Family Approach Program)*
Poltekkes	Politeknik Kesehatan (Politeknik Kesehatan)
Posyandu	Integrated Service Post in Indonesian Villages
Puskesmas	Primary Health Care Center in Indonesia

RAK	Rencana Aksi Kerja (Work Action Plan)
Rakerkesnas	*Rapat Kerja Kesehatan Nasional (National Health Meeting in Indonesia)*
RAPBD	Rancangan Anggaran Pendapatan dan Belanja Daerah (Draft Regional Budget)
RAPBN	Rancangan Anggaran Pendapatan dan Belanja Negara (Draft State Budget)
RDPU	Rapat Dengar Pendapat Umum (Public Hearings)
Renstra	Rencana Strategis (Strategic Plan)
RIBK	Rencana Induk Bidang Kesehatan (Master Plan for the Health Sector)
Riskesdas	*Riset Kesehatan Dasar (Basic Health Research)*
RKP	*Rencana Kerja Pemerintah (Government Work Plan)*
RPJM	Rencana Pembangunan Jangka Menengah (Medium-Term Development Plan)
RPJP	*Rencana Pembangunan Jangka Panjang (Long-Term Development Plan)*
SKI	*Survei Kesehatan Indonesia (Indonesian Health Survey)*
SKPD	Satuan Kerja Perangkat Daerah (Regional Apparatus Work Units)
SPM	Standar Pelayanan Minimal (Minimum Service Standards)
SPPN	Sistem Perencanaan Pembangunan Nasional (National Development Planning System)
SRH	Sexual and Reproductive Health
SRMNCAH+N	Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health
Susenas	National Socioeconomic Survey
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan (National Team for the Acceleration of Poverty Reduction)
UKBM	Upaya Kesehatan Bersumberdaya Masyarakat (Community-Based Health Efforts)
UKP4	*Unit Kerja Presiden Bidang Pengawasan dan Pengendalian Pembangunan (Presidential Working Unit for Supervision and Management of Development)*
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Glossaries

Term	Description
Accountability	The obligation of decision-makers in government, the private sector, and civil society organisations to be answerable to the public and institutional stakeholders.
Commercial Determinants of Health	Influences on health governance and policy-making by commercial entities like the tobacco and food industries.
Consensus Orientation	Mediating differing interests to reach a broad consensus on health policies and procedures.
Digital Health Transformation	The process of integrating digital technologies into healthcare systems.
Digital Healthcare	The use of digital technologies and platforms in the delivery and management of healthcare.
Epistemic Community	A network of professionals with recognized expertise and authoritative claim to policy-relevant knowledge in a particular domain or issue-area.
Equity	Providing equal opportunities for all to improve or maintain their health and well-being.
Fragmentation in Approach	The lack of a unified and coherent strategy in health sector governance, leading to inefficiencies and inconsistencies.
Governance	Rules or tools, both formal and informal, shaping social and economic interactions among actors.
Grand Corruption	High-level corruption involving manipulation of procurement processes for profit.
Health in All Policies	An approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity.
Health Security	Protection of public health, considering a wide range of socio-economic factors.
Institutional Capacity	The abilities and resources of health sector institutions to effectively implement policies and deliver services.
Intersectionality & Inclusivity	Approaches in health governance that consider multiple overlapping social factors and aim to include diverse population segments.
Maternal and Neonatal Care	Healthcare services focused on mothers and newborns.
Meaningful Public Engagement	Involvement of the public in health governance, ensuring that policies and programs reflect their needs and expectations.
Merit-Based System	A system of governance or administration where appointments and responsibilities are assigned based on merit, such as skills and performance, rather than political connections or other non-performance related factors.
National Health Meeting (Rakerkesnas)	An annual planning meeting for heads of provincial and district health offices in Indonesia, focusing on policy dissemination and alignment.
Omnibus Law	A comprehensive law that covers multiple diverse or unrelated topics. In this context, it refers to a law used to create a national regulatory framework in Indonesia.

Policy Formulation	The process of developing policies, often involving multiple actors including the government.
Policy Synchronisation	The process of aligning health policies and plans with broader government strategies and budgeting, typically involving agencies like Bappenas and the formulation of documents like the RKP.
Posbindu	Integrated healthcare posts in Indonesian villages.
Public-Private Partnership	Collaborative arrangements between public and private sectors to achieve specific goals.
Risk Communication	The process of communicating potential risks to public health and safety.
Scenario Analysis	A process of evaluating possible future events by considering various plausible outcomes or paths of development.
State Accountability	The responsibility of government and health sector officials to act in the public's best interest and be answerable for their actions.
Strategic Vision	A long-term perspective on health and human development, with an understanding of historical, cultural, and social complexities.
Sustainable Development	Development that meets the needs of the present without compromising the ability of future generations to meet their own needs, involving environmental, social, and economic dimensions.
Transparency	The free flow of information ensures accessibility and understanding.
Village Fund Allocation (ADD)	Funds allocated to villages for local development and initiatives.

Chapter 1: Introduction

Overview: Why do we need to talk about governance?

When 1998 'reform' took place, a decentralised governance mechanism was introduced for Indonesia; the health system shifted its system accordingly. This shift gave a disruption in the existing health system which should have given more power and provided wider space for the public to be involved in health policy making processes and the governance mechanisms required. In the wake of the latest Presidential election, Indonesia will welcome a new government by the end of October 2024. It is expected that a new government will come with new sets of development priorities, where changes might further impact overall governance mechanisms at national and sub-national levels. The authors will take this momentum to unpack health governance in Indonesia that cannot be separated from the broader governance of the country itself.

In the area of development studies, strengthening good governance is considered as the panacea of all development problems, including the issue of public health. Although it may seem to oversimplify the solution for a very complex problem, the statement is supported by a body of literature that discusses the contribution of good governance for development problems. One explanation is that many of the root causes of these problems are related to the lack of government capability to solve the issues themselves. As an example, to improve healthcare access in remote areas, individuals who can manage the health system in that area effectively are needed. They require knowledge and skills to deliver health service to the community in the area. Without the sufficient capacity, the solution imported from the outside such as medical appliances and treatments would not be delivered properly to the public who need the service.

Furthermore, governance also implies the availability of rules or mechanisms that can allow the improvement of the situations. The concept of governance as a rule or institution, is arguably the most appropriate conceptualization of health governance in the low-middle income setting.[1] For example, the high incidence of non-communicable disease has several determinants including the lack of policies that regulate the food supply in the country. Without sufficient regulation, the public will end up consuming too much unregulated unhealthy food that is sold by the industry. Therefore, the focus on governance, both the actor's capacity and the rules, is essential. Improving the quality of governance will affect the quality of service delivery in the health system. One of the first priorities in national development is to improve governance as a whole.[1] For policy makers to achieve their

intended development targets and outcomes, governance is the essential lever to place priorities on.

The objective of this paper is twofold. First, the authors would like to evaluate the existing situation of health governance in Indonesia. How does the existing situation fit into the principles of good governance and is it sufficient as the foundation for health sector development. Second, we aim to provide operational recommendations to be taken by the next government taking place from 2024 to 2029 to further improve health governance to contribute to the improvement of the overall health status in Indonesia. This book combines and synthesises governance-related findings from all thematic books in this White Paper series.

Methodology

This report, is one part of the White Paper series where the authors use foresight as the primary method, utilising the Miles[2] framework, which has been modified to suit the study's specific needs. This approach 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 effectively informs policy-making, builds networks, and enhances the capacity to address long-term challenges.[3]

The process was conducted in two phases (see Figure 1): 1) **Phase One** (February-November 2023) included pre-foresight, recruitment, horizon scanning, synthesis, and a Delphi exercise, which resulted in the initial draft of the paper; 2) **Phase Two** (March-July 2024) involved internal workshops, an expert panel review, and additional expert consultations 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).

This research was conducted as a CISDI initiative, with all funding independently sourced by CISDI without support from donors or external parties.

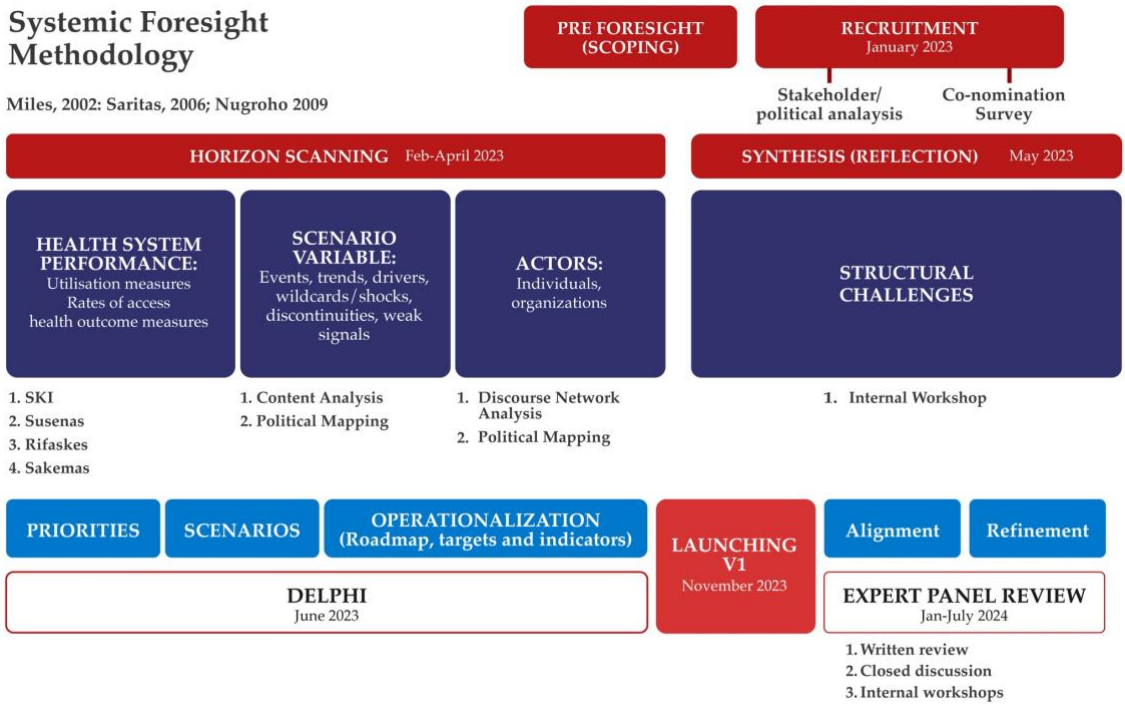


Figure 1. Stages of Foresight Methodology used in the paper (Source: Popper[3])

During the horizon scanning, a combination of literature reviews, desk research, content and discourse network analysis from Twitter conversations, and online news media feeds were analysed and mapped to capture events, trends, and drivers of the issue. As a part of foresight methodology, particularly in the horizon scanning phase, we use Google Search and News to automatically look up topics related to health governance. Specific keywords were identified for each topic and news were collected from January 2017 to May 2023. We found a total of 16,725 news articles on the topics in this White Paper. Certainly, there is some 'noise' — the repetitive and low-quality news stories that publishers often use to get clicks. To reduce noise, we have filtered our analysis to focus only on news articles that are labelled as opinion pieces.

The results were further synthesised to identify structural challenges. Concurrently, during Delphi workshops, we gathered scientific knowledge and opinions from various stakeholders on strategic issues in health governance. Specifically, during the Delphi consultations, stakeholders were asked to identify priorities, build possible scenarios and define key targets and indicators. The analysis was conducted based on themes that emerged from the literature and desk research, as well as Delphi consultations, and was then integrated into the framework proposed in this paper.

Scope of Study

Governance has become a catchphrase in the development sector and can be interpreted differently by different groups. Governance, without additional adjectives like 'good-governance' or 'smart-governance', is defined as "the rules or tools to govern, both formal

and informal, that shape the social and economic interactions among actors".[4,5] The governance that will be discussed in this paper will imply the broad sense of governance, not limited to the rules that are imposed by the government at all levels, and includes collective governance and operational governance.

Multiple governance mechanisms are available and utilised in alignment with the context in which it is applied. Corporate governance often applies what is known as the four pillars of good governance: accountability, transparency, fairness and responsibility.[6] In the broader area of development with a focus on sustainable development, the authors outline governance to include positioning of key national bodies, organisational structures, coordination and reporting mechanisms at the national and subnational level, decision-making and regulatory processes, as well as the actors and contexts involved and influenced.[7] We examined those aspects through the lens of good governance principles, including accountability, transparency, efficiency and effectiveness, and sustained public participation.

Specific to the health system, there are several definitions and framework of governance that have been reviewed and summarised comprehensively by several authors.[3,5,9] Abimbola et al identified three different approaches in analysing health governance in the existing literature: (1) the government-centred approach; (2) the building-block approach; and (3) the institutional approach[4] (see Table 1 for the details).

Table 1. Approaching Health Governance Analysis According to Abimbola et al[4]

GOVERNMENT-CENTRED	BUILDING-BLOCKS	INSTITUTIONAL
focuses on the role of governments, above or to the exclusion of non-government health system actors	*focuses on the internal workings of healthcare organisations, and treats governance as one of the several building blocks of organisations*	*focuses on how rules governing social and economic interactions are made, changed, monitored and enforced*

We put emphasis on governance within the context of the public sector; focusing more on how the government operates and makes decisions, the influencing factors, the stakeholders involved, and the resulting health outcomes.

The paper is structured to ensure readability for both the general audience and policy makers. We have avoided the use of excessive technical and scientific terms. Through horizon scanning, the identified events, trends, and drivers are grouped and presented in Chapter 1 as the context for outlining the challenges.

Health Governance Challenges in Indonesia

To scan the horizon on public conversations, we input keywords to an algorithm which then generates a network graph to be analysed. The network graph (see Figure 2) presents a complex interrelation of topics surrounding health governance from January 2017 until May 2023. The graph is structured with nodes representing individual topics and the edges indicating the connections between them. Central to the graph is the node labelled "COVID-19" appears to be a significant focus given its prominence and the number of connections due to the pandemic's impact on health policies. This node is heavily linked to "*Kementerian Kesehatan*" (Ministry of Health), "BPJS Kesehatan" (Health Social Security Administration), and "*Pemerintah Daerah*" (Local Government), suggesting intensive discourse on the role these entities played in pandemic response and management.

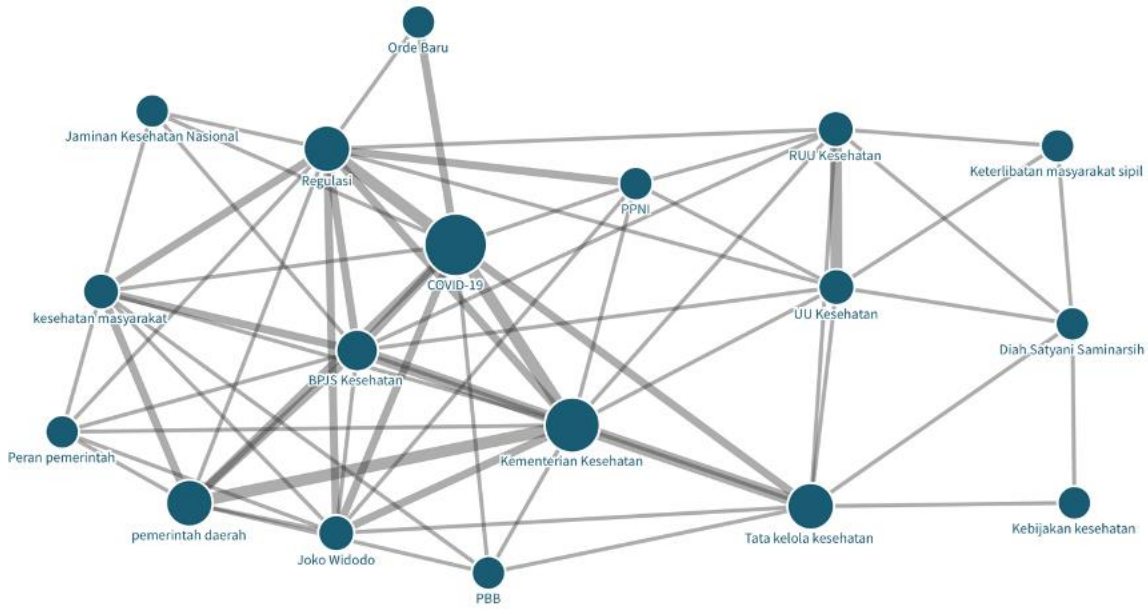


Figure 2. Graph Network from Published Opinion on Health Governance (January 2017 until May 2023)

Adjacent to these are nodes like "*Jaminan Kesehatan Nasional*" (National Health Insurance), "*Peran pemerintah*" (Role of Government), and "*Kesehatan Masyarakat*" (Public Health), indicating a broader discussion on the structural and policy-based facets of health governance. The presence of the President of Indonesia "Joko Widodo," was found to be connected to many nodes implying significant analysis of political leadership in health governance. The node "*Regulasi*" (Regulation) also suggests ongoing discussions about legal frameworks, possibly related to health policy reforms or implementations.

Some nodes, such as "*Kebijakan Kesehatan*" (Health Policy), "*Tata Kelola Kesehatan*" (Health Governance), and "*UU Kesehatan*" (Health Law), underline the legal and policy-oriented nature of the discourse. Meanwhile, "*Keterlibatan Masyarakat Sipil*" (Civil Society Involvement)

and "Diah Satyani Saminarsih," Founder & CEO of CISDI, suggest the recognized importance of civic engagement and individual contributions to the debates.

The graph's structure with dense interconnections, suggests a multifaceted dialogue with multiple stakeholders and issues that are tightly interwoven, reflecting the complexity of health governance, especially during and following a global health crisis like COVID-19. The varying node sizes represent the volume or intensity of discussions around each topic, indicating areas that have been most emphasised in public and policy discourse.

Through horizon scanning, we identified several issues that have become governance challenges in achieving optimal public health outcomes. We also identified governance challenges in various themes of White Paper series (see Table 2).

Table 2. Findings Related to Governance from 10 Thematic Books

Book's theme	Findings
Health System	• **Cross-sector Collaboration:** Inefficiencies and implicitness in collaboration, particularly outside stunting programs, hinder integrated efforts. • **Local Planning Branding:** Participative collaboration at various administrative levels often devolves into a branding exercise rather than effective planning, underutilizing the potential of Bappeda. • **Organisational Overlap**: Overlapping health organisations, such as BKKBN and Kemenkes, lack synergy, leading to operational redundancies. • **Governance Data Disconnection:** There is a significant disconnect and lack of coordination between health and non-health sector data governance. • **Service Synchronisation:** Service delivery, health research, and community needs lack alignment, often skewed by donor-driven agendas. • **Quality Assurance:** The healthcare quality assurance mechanisms for providers are inadequate. • **Partnerships:** Public-private and government-community partnerships are not optimised, creating readiness gaps in the health system.

Digital Health	• **Blueprint Sustainability:** The Digital Health Transformation blueprint is short-term, necessitating a longer-term, government-spanning strategy. • **Data Regulation:** Single Health Data regulations are restricted to the ministerial level and lack interoperability with broader data governance systems. • **Agency Establishment:** A dedicated digital health agency with cross-sectoral connections is required for sustainable, independent, and agile operation.
Risk Communication	• **Inconsistent Subnational Risk Communication Structure:** The lack of dedicated roles or structures tailored to manage health risks specific to each region's context and the absence of standardised risk communication frameworks at subnational levels results in varied approaches across regions. • **Limited Impact of Health Promotion Unit:** The current positioning of Health Promotion unit within the Directorate General of Public Health limits their ability to coordinate effectively across various health domains and diminishes the potential for comprehensive risk communication campaigns. • **Cross-Departmental Coordination Gaps:** The lack of a cohesive approach across different government departments and technical areas leads to disjointed efforts in risk communication and community engagement. • **Inadequate Funding and Resource Allocation:** There is a historical trend of limited and often inaccessible funding for pandemic and outbreak responses, which hinders the ability to adequately address public health challenges. • **Central-Regional Government Coordination Friction:** A lack of effective coordination and communication between central and regional governments leads to conflicting approaches and delayed responses, particularly evident during crisis situations like the pandemic. • **Limited Frontline Health Workers Influence on Policies:** Frontline health workers, crucial in the implementation of health policies and guidelines, often have limited channels to influence decision-making processes or communicate their on-ground experiences to higher authorities.
Health Security and Infectious Diseases	• **Governance Deficiencies:** Issues like data accountability lapses, outdated regulations, inter-agency poor coordination, and inadequate knowledge management from prior pandemics are pervasive. • **Decentralisation Complications:** The pandemic highlighted the difficulties of centralised decision-making with decentralised implementation, varying by regional capacities and needs.

	• **Coordination and Communication:** Weak mechanisms among central agencies and the involvement of non-health entities like military units in health matters necessitate stronger governance and accountability measures.
Non-Communicable Diseases	• **Fragmented Government Approach:** Disconnected policies and oversight due to a lack of cohesion among agencies addressing non-communicable diseases and its related risk factors. • **Political Disruption:** Electoral changes threaten program continuity with shifting agendas impacting funding and priorities. • **Industry Influence:** The policymaking process is swayed by the tobacco and food industries.
SMRNCAH+N	• **Coordinating Mechanisms:** Despite various initiatives, there's unclear leadership and coordination across data and programs, impacting maternal mortality reduction efforts. • **Adolescent Health Neglect:** Programs for adolescent health face discontinuation, access issues, and implementation inconsistencies. • **Stunting Initiatives:** The Stunting Acceleration Roadmap needs clear leadership, coordination, and dedicated budgets. • **Planning Inadequacies:** Traditional planning and coordination fail to address the complexities of SRMNCAH+N, leading to data and effort duplication
Health financing	• **Decentralisation Issues:** Accountability and monitoring challenges arise from decentralisation, affecting **results-oriented budgeting.** • **Coordination Problems:** Joint local and central government responsibilities suffer from exacerbated coordination issues. • **Performance Incentives:** Limited use of institutional and fiscal levers fails to incentivize better performance. • **Purchasing Functions Overlap:** BPJS-Kesehatan's role is diluted with MOH and other agencies performing similar healthcare purchasing functions. • **Misalignment in Planning and Budgeting:** There's a disconnect between the government's strategic plans and the actual budget allocation. This misalignment affects the effectiveness of policy implementation and financial resource allocation. • **Data and System Integration Issues:** There's a lack of consistent, reliable data and a poorly integrated financial management system, especially at local levels. This hinders accurate tracking of

	spending and assessment of financial efficiency in key sectors like health and education.
Human Resource for Health (HRH)	• **Inter-ministerial Coordination:** Lack of alignment between health and education ministries in health worker production. • **Civil Society Role:** The involvement of civil society in the health workforce council is ambiguous and needs clarification.
Global Health	• **Strategic Absence:** A comprehensive, holistic cross-sectoral strategy for global health cooperation units is missing. • **Coordination Mechanism:** There's a lack of a multi-actor coordination mechanism for global health diplomacy. • **Capacity and Skills:** Human resources display limited capacity in executing health diplomacy and global cooperation.
Research & Development	• **National Research Master Plan Focus:** The current plan emphasises pharmaceutical technology without addressing vital health needs such as maternal and child health. • **Communication Platforms:** Systematic platforms for policymakers, providers, and researchers are lacking, as seen in delayed COVID-19 preventive measures. • **Research Funding and Prioritization:** Low research funding and prioritisation issues, combined with isolated work environments, impede policy-informing research and practice translation.

We categorised the events, trends, and drivers into four key areas: governance among the different national bodies, health governance, Ministry of Health structure, national-subnational coordinating mechanism, regulatory and decision-making processes. Chapter 2 focuses on these topics, discussing how health governance impacts health outcomes in Indonesia. Within the four key areas, there are seven overarching themes that need to be addressed to improve the quality of health system governance in Indonesia. The themes are strategic direction, information & data governance, fragmentation in approach, institutional capacity, meaningful public engagement, intersectionality & inclusivity, and state accountability. Each of these themes will be explored more thoroughly in the following section.

Chapter 2:
Norms & Nodal Points

2.1 Perspective Change

Governance for Health

In the context of health development, the traditional view that health governance is solely the responsibility of the Ministry of Health and its directly related agencies is shifting towards a 'Governance for Health' approach.[8] This new paradigm recognizes that health programs, policies, and outcomes are shared responsibilities that extend beyond the health sector. It aims to integrate a wide range of fields that influence health determinants, including the environment, education, economy, culture, and legal norms. The central idea of this concept is to adopt a Health in All Policies (HiAP) approach and to establish collaborative governance, including whole-of-governance and whole-of-society approach, in policy-making processes.

Whole-of-Governance Approach

A whole-of-governance approach emphasises the necessity of cross-sector collaboration to address complex health determinants. Establishing formalised frameworks that promote collaboration among many domains is necessary to guarantee that public policy transcends mere implementation and turns into an instrument for addressing issues and redistributing authority. In order to supplement conventional hierarchical approaches, governance has grown more multilayered and flexible, depending on soft power mechanisms including networks, alliances, and self-regulation.[8] In order to effectively address complex health issues resulting from global variables, such as antimicrobial resistance, infectious disease outbreaks, and social determinants of health, these processes are essential.[10]

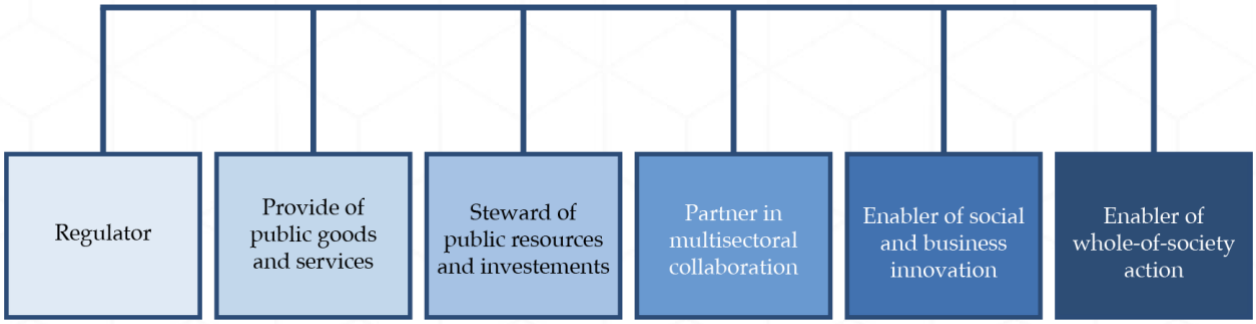


Figure 3. The Many Roles of Policy Development (Source: Dube et al[11])

Governments are expected to take on several responsibilities in order to effectively administer the health sector, including enforcing laws, supplying public goods, and collaborating with private entities (see Figure 3.).[11] In order to effectively address health

challenges, governments must become a shared duty spanning all societal levels and sectors. This calls for adaptable, inclusive, and flexible systems. The objective is to make sure that health policies support sustainable development by tackling the underlying causes of health issues and switching from reactive to proactive governance.

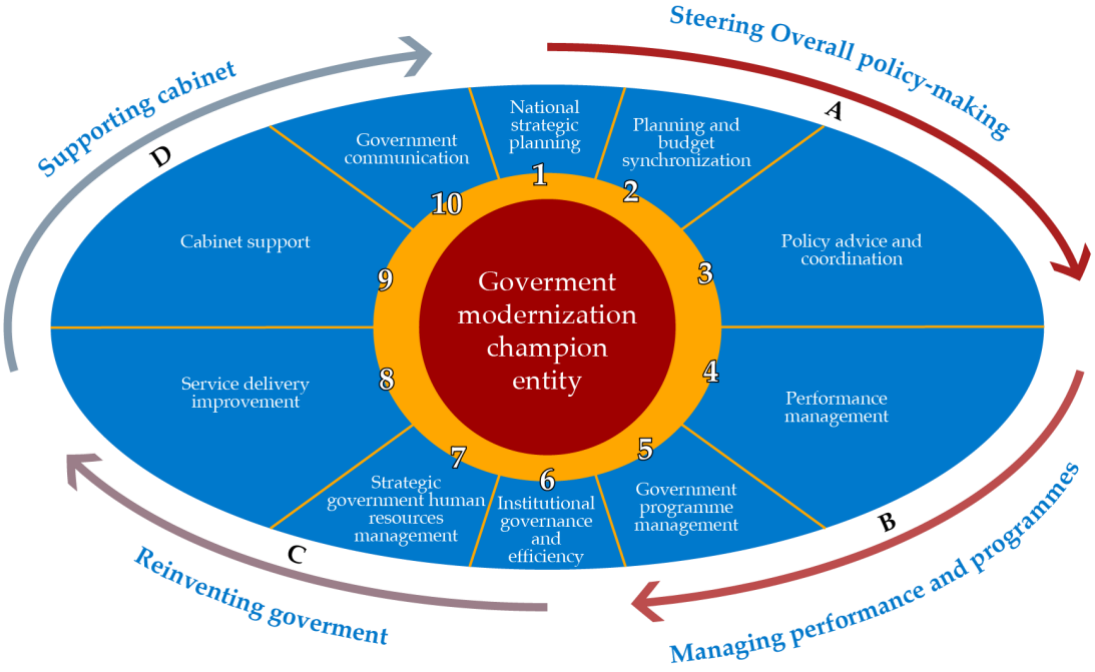


Figure 4. Government modernisation (Source: Adapted from World Economic Forum[12])

Governments need to adopt a more comprehensive viewpoint, acknowledging the complex nature of health and modifying their systems of governance appropriately. Figure 4 provides an illustration of the minimum four basic components of sustainable governance, each of which consists of multiple necessary inputs. First, procedures for consultation and coordination, inter-sectoral budget planning and synchronisation, and participatory strategy planning are all part of the policy-making process. The second component is performance management, which highlights responsibility in the administration of public programs. Thirdly, the emphasis is on improving service delivery, managing resources more effectively, and fortifying the institution. The interconnectedness of government agencies and the requirement for efficient communication round out the fourth and last point.[12] This approach reflects the complexity of 21st-century health governance by positioning health as both an outcome and an asset related to social and economic development.[13]

Whole-of-society approach

The whole-of-society approach goes beyond government action, incorporating the involvement of a wide range of social stakeholders, including citizens, civil society, and the private sector. This strategy is particularly crucial for dealing with "wicked problems," or intricate, multidimensional issues like pandemic preparedness[14] or tackling NCDs.[15]

Intersectoral collaboration improves problem-solving abilities, and platforms and communication tools are essential for maintaining openness and coordination. Communities are more resilient and able to tolerate risks to their health and well-being when they participate in these inclusive measures.

The whole-of-society approach encourages collaborative governance that is less prescriptive and centralised by promoting trust and matching normative ideals.[8] Together with governments, the corporate sector and civil society provide resources, innovations, and skills. The strategy recognizes the necessity for adaptable, networked governance to encourage group efforts toward common social objectives and guarantee that the health sector keeps pace with broader societal advancements.

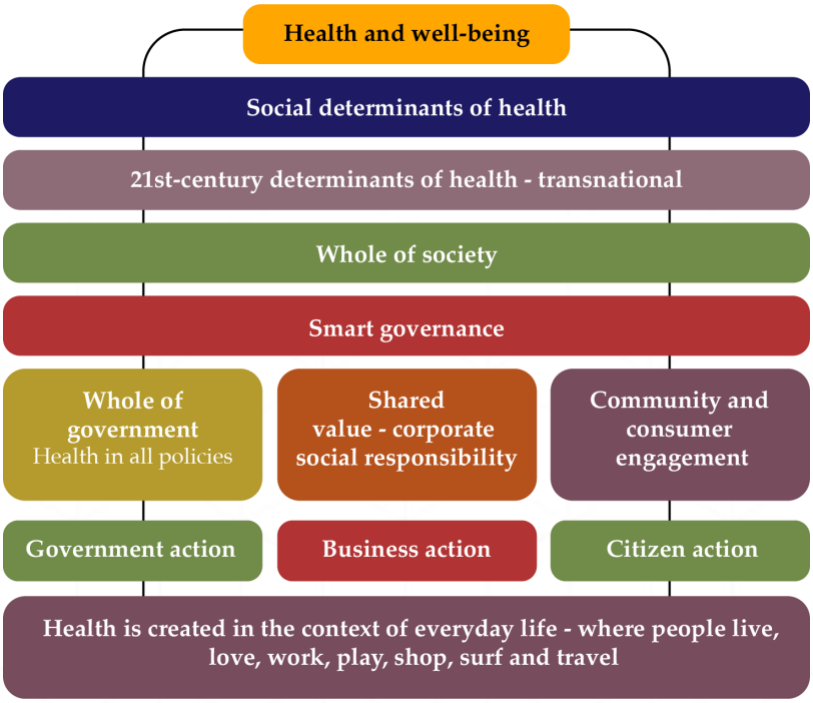


Figure 5. Governance for Health in the 21st century (Source: Kickbusch & Gleicher[8])

The concept of 'governance for health' expands upon the conventional definition of health governance by incorporating political, social, and economic determinants that impact health outcomes.[8] It links health to the capacities and assets of people as well as communities, placing health as a crucial component of a society's overall resilience. With this method, the emphasis is shifted from healthcare systems to a more comprehensive view of health as a social, political, and economic resource.

The 'governance for health' approach has the potential to be developed through Omnibus Law 17/2023 on Health, particularly in Articles 413-416 regarding the Coordination and Synchronisation of Health System Strengthening.[16] These articles emphasise the need for coordination and synchronisation of health policies and programmes across relevant ministries and institutions for health system development.[16] They also cover the use of

pertinent data and information in the health system development, the formulation of strategies and priorities, as well as the establishment of criteria and indicators for evaluating the implementation of health programs and initiatives.[16]

Effective governance requires a continuous effort to overcome political and societal barriers, ensuring the full integration of civil society's role in the operational framework of the health system.

There should be clear guidelines and regulations to manage and minimise conflicts of interest between the government and non-state actors, particularly with the private sector, which often has evident commercial vested interests. As a point of reference, the WHO has FENSA (Framework of Engagement with Non-State Actors), a guideline translated into a protocol that their staff must follow.[17] The framework, for instance, clearly prohibits engagement with tobacco industry, alcohol industry, arm industry, and more.[17] While private sector participation in health system governance in Indonesia offers potential benefits, it also presents significant challenges that need to be addressed. Harmonising private sector initiatives with public health objectives requires careful management to ensure that private investments and innovations align with and address the actual health needs of the population.

Civil society's role in health system governance in Indonesia is multifaceted and increasingly essential, particularly within the framework of decentralised health systems. These organisations are integral not only in policy formulation but also in implementing and overseeing health initiatives at both national and sub-national levels.

The role of national CSOs becomes critical in ensuring the continuity and effectiveness of essential health services. The decreasing international health development aid, as Indonesia transitions from a low-middle-income country, further elevates the importance of CSOs in service delivery. With donor funding diminishing, particularly for programs like TB, HIV, and immunisation, the responsibility shifts towards domestic sources. Civil society has also played a pivotal role in areas such as combating misinformation and shaping the risk communication landscape during the COVID-19 pandemic. The establishment of a Risk Communication and Community Engagement working group by the Health Ministry in July 2023, incorporating members from civil society, reflects the growing recognition of the importance of these collaborative efforts for future disease responses.

Overall, a paradigm shift in health governance towards a strategic, long-term, and holistic approach, must take place. This shift should synchronise service delivery with community needs and health research while ensuring continuity across electoral cycles and aligning strategic planning with actual budget allocation. Building state capacity in the health sector, reducing dependence on external consultancies, and prioritising a cross-sectoral strategy that encompasses a broad spectrum of health needs are crucial steps. Establishing such a

framework is key to developing resilient, responsive, and comprehensive health systems capable of meeting the diverse health needs of the population.

2.2 Change in Organisational Governance

Main priority of governance reform is to create an effective, robust, clean, and participative health governance. Main change recommended is not to add a new agency, but instead reframing the existing institutions, reorienting their governance mechanisms, and as such repositioning current ministries/agencies.[1] In the version of the President's Delivery Unit foresight document, some of the main recommendations are to reform bureaucracy governance, to ensure wide and effective public political participation supported by an ethical democratic political system.

Overall bureaucratic reform is needed to improve the management and development of Civil Servants (ASN). Capacity building for ASN is essential to enhance the effectiveness and efficiency of human resources in ministries and agencies (K/L), based on merit and track record. In this context, the Law on ASN needs to be updated to reflect current relevance and needs. Additionally, continuous professional development training for Civil Servants (PNS) is necessary to ensure ASN's capacity is always up to required standard. Moreover, to ensure knowledge sharing within and across K/Ls, which can help break the silo mentality. Increase and build ASN capacity as the key to increasing resource effectiveness and efficiency. Capacity building for ASN must be a sustained and enhanced effort conducted by each corresponding public or state institution, with inclusion of academia, private sector and civil society as experts and collaborators.

Conduct a review and analysis of the effectiveness of ministries/institutions or ad hoc institutions to determine further actions needed for a comprehensive restructure. There is a need for a study/review of the effectiveness of K/L or ad hoc institutions and the preparation of the necessary legislation and policies to restructure state institutions. In this regard, the focus of the first period of government is to prepare, establish, and implement laws to reorganise state institutions, including to prepare restructuring strategies that focus on the different requirements of each institution involved in the restructuring and reform, and to install and enact additional regulatory apparatus that will shift bureaucratic fragmentation into integration.

However, uncertainty surrounds further measures pertaining to the synchronisation and coordination of the health system, which are anticipated to be governed by a presidential regulation. To date, the Health Sector Coordination and Synchronisation Committee (KKSK) has been interpreted merely as a coordination platform between the MoH, BPJS Kesehatan, BPOM, and BKKBN.[18] It is probable that the National Nutrition Agency (BGN) will be included in this coordination framework following the issue of Presidential Regulation

83/2024 on the BGN.[19] This coordinating platform ought to reach beyond the ministries and organisations that are directly involved in health, in keeping with the governance for health approach. This larger viewpoint should be maximised within the governance framework in light of the fact that health systems are impacted by intricate social determinants of health and the critical role that the private sector and civil society play in influencing health outcomes.

2.3 Change in Coordination

In the context of governance for health, coordination entails such a process taking place between health and other development sectors and it may also mean coordination between institutions governing the health sector itself. The COVID-19 pandemic has taught us the much needed coordination between health and economic sectors. Triggered by the continued debate between health and economic priorities, the WHO set up WHO Council on the Economics of Health for All.[20] Going further back before the pandemic, since 2017 the G-20 has also set up the Joint Task Force for Health and Finance that convene Ministers of Health and Ministers of Finance in one coordination platform.[21] The most recent Lancet Commentary continues to push for the advancement of economics for health as a reorientation of seeing the health sector as a long term investment which governments and societies must embrace and act upon.[22]

In addition to coordination with the economic sector, health remains closely interconnected with other development sectors. The WHO has been advocating for development in general to embrace health as the epicentre of development, laid out very clearly in the Health in All Policies framework. The Main Book of the White Paper series dedicated a chapter to address this very strategic viewpoint.

At national level, coordination within and between the different institutions and/or agencies and between levels of government are the crucial points that will determine a successful outcome. Although the Law of Regional Autonomy no. 23/1999 has stipulated decentralisation as the governing mechanism for Indonesia after the fall of the New Order; several Presidents and governments proved to have their own way of interpreting decentralisation. As written in the Main Book of this White Paper series, the authors take note that the decline in democracy, weakening of anti corruption law, indicating higher appetite for political as opposed to technocratic approaches, and doubts surrounding national as well as sub-national leaderships; are the variables which push decentralisation away and brings back centralisation as the preferred approach in governing.

On the other hand, strengthening sub-national authority requires performance indicators that include supervision and oversight mechanisms. The indicators must be robust enough to measure the way they facilitate alignment of processes for target achievement at district/city level, including inter agencies coordination.

More robust and participatory planning/coordinating mechanisms remains imperative. To strengthen the existing mechanism, Musrenbang, to be more transparent, accountable, inclusive, and participatory. This also strengthens the agency and ensures the meaningful participation of the most affected vulnerable groups.

2.4 Change in Regulatory Approaches

Deliberative decision-making processes provide chances for better inclusivity and pushes for social accountability. This process aims to gather public aspirations, then ensure that the process that runs inclusively has recognized and considered the voices of affected groups as subjects of every regulation/policy product. This also considers the existence of local level parliaments, along with the tools and mechanisms that can be optimised such as special commissions in the health sector, consultation forums through Public Hearings (RDPU), and the recess mechanism to deliberate decision-making processes. However, with a note that industries enabling health risk factors, such as tobacco, packaged beverages, and ultra-processed foods, need to be controlled through mechanisms of reporting and public accountability as stipulated in the FCTC.[23,24]

Beyond regulatory harmonisation and synchronisation, the new provisions in the Omnibus Health Law must be accompanied by updates to other relevant laws.

Enhancing state accountability and transparency is essential for improving health system governance in Indonesia. Addressing the deeply ingrained issues of corruption requires a multifaceted approach that includes strengthening accountability mechanisms, ensuring transparency in service delivery and procurement processes, and fostering a culture of ethical governance. By tackling these issues, the health system can become more equitable, efficient, and trustworthy, ultimately leading to better health outcomes and increased public trust. Accountability in the health system involves formal mechanisms allowing patients and the broader population to hold key actors responsible for achieving objectives like access to quality services, satisfaction, and fair financing.

Developing more efficient, accessible, and responsive channels for public involvement is crucial. Inefficiencies in formal mechanisms for public participation in development planning significantly limit the health sector's capacity to integrate public perspectives into policy-making. Policies shaped by public input are more likely to be technically sound, socially acceptable, and in line with public expectations.

2.5 Change in Monitoring and Evaluation Provision

The new Health Law is filled with a variety of tools, prepared by the state (executive and legislative arms) to ensure achievement of the national health targets. One of the

instruments embedded in this law is known as the Master Plan for Health Sector/*RIBK*. This tool aims to assist the government in planning, allocating, and incentivizing both local and central governments based on their performance. For example, efficient budget allocation with strong outcomes should not solely be measured by the amount of budget absorbed. Moderate budget absorption, combined with good performance, should also be considered a positive achievement. In such cases, leftover funds could either be carried forward to the next year, allocated to a reserve fund, or used for other purposes.

RIBK is meant to also function as a coordination mechanism between national and central government, especially in light of the deletion of mandatory spending for health in the new health law. Mechanism within RIBK was set up to ensure sub-national governments continue to keep health as a development priority, while ensuring there is a healthy competition between provinces and regions/cities to design health programs that can be impactful.

However, the authors need to underline that immediate deletion and reduction of mandatory spending presents its own hazards on ensuring health remains on the top of the agenda of provinces, regions and cities. It is the position of authors in this White Paper series to continue to push towards policy makers' commitment to public financing mechanisms for health, while continuing to open partnerships with development partners and the private sector in health service delivery and other areas within health policy.

Acknowledging the need for the health sector to welcome other sources of financing, a transition phase can be implemented. A budget tagging mechanism that can track each budget line down to the subnational level, specifying which items or activities the funds are used for. This will help the government monitor resource allocation and assess policy implementation effectively. The possibility of other alternative financing mechanisms such as debt swap, has started to be implemented by the current government. This is an avenue worth pursuing, considering that Indonesia will have approximately IDR 800 trillion of debt due in 2025.[25]

Additionally, as written in the Main Book of this White Paper series, the authors agree that a governance or bureaucracy index should be established to measure the performance of provincial and local governments. This could help identify which sub-national governments require technical assistance or other forms of support to improve their capacity, including human resources. Finally, there should be flexibility in local planning and budgeting to ensure responsiveness to local and evolving needs.

Chapter 3:
The Process

3.1 Regulations and Decision-Making Process

There are several key health laws that serve as references for health governance and regulations in Indonesia. Over the years, hundreds of regulations at various levels have been enacted, many of which tend to overlap or even contradict one another. Some regulations are also outdated, and the policy-making process has struggled to keep pace with technological advancements, innovation, and the evolving needs of the community. Decision-making processes are an essential aspect of governance discussions, including in the context of health sector development. How a decision is made is crucial to ensure that health impacts are considered and that the decision will help people achieve the best possible health outcomes. This subchapter delves into the factors and actors involved in decision-making processes and their impact on health outcomes.

This subchapter outlines the challenges surrounding the regulatory and decision-making process in Indonesia.

The formulation of the new Health Law marked the beginning of the health transformation in Indonesia. The omnibus method was chosen to synchronise regulations while addressing the issue of fragmentation and over-regulation of health development at the national and regional levels.[26,27] Notably, the new Health Law consolidates and repeals 11 other health development-related laws.

In other words, the utilisation of the omnibus method changes the paradigm of health development regulation, which was previously covered by many regulations, into just a single regulation.[28,29] It is intended to redesign the hierarchical structure of health development regulations in Indonesia (see Figure 6).

The Health Ministry stated that the Omnibus Health Law will be the highest hierarchy and will be derived into 1 Government Regulation (*Peraturan Pemerintah*), 5 Presidential Decree (*Peraturan Presiden*), 1 Presidential Decree (*Keputusan Presiden*), and 14 Ministerial Decree (*Peraturan Menteri*). The drafting of all derivative regulations will also use the omnibus method. For example, the drafting and ratification of a Government Regulation (PP) on Health that revokes and combines 31 other health-related PPs.[30]

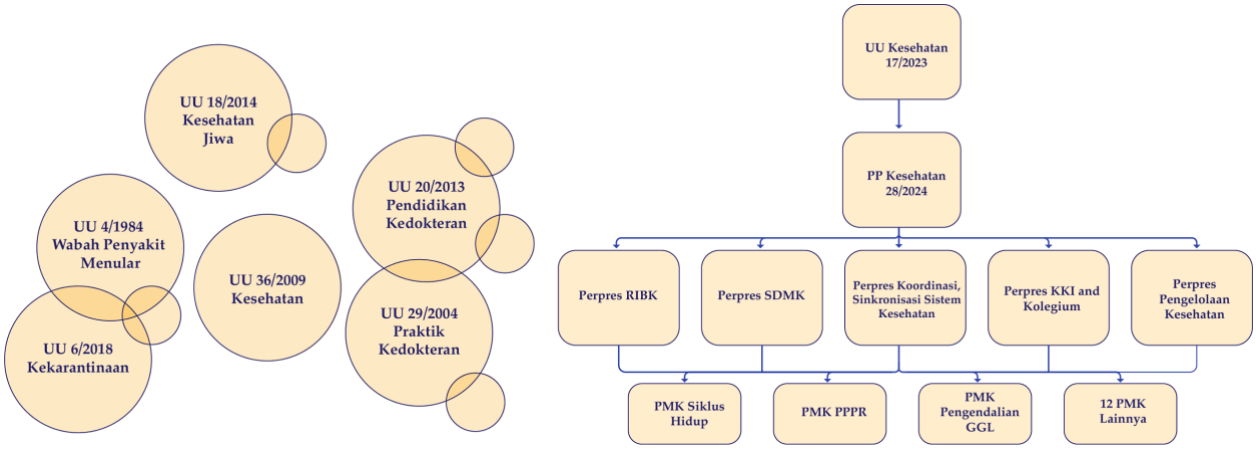


Figure 6. Structure Change of Health Development Regulation

Through horizon scanning and experts consultation, under regulatory and policy making area, we have identified four main challenges in the policy-making and regulatory restructuring of the health sector in Indonesia: **(1) transparency, social accountability, and meaningful public participation; (2) regulatory synchronisation; (3) decentralisation, as well as (4) evidence based policy making and data governance**. Moreover, **political commitment, and institutional capacity** were also the most discussed aspects as determinants of the policy direction and health regulation development in Indonesia. The following section discusses the key challenges in more detail.

3.2 Transparency, Social Accountability, and Meaningful Public Participation

Article 96 of Law 13/2022 has emphasised the need to include more meaningful public participation in the legislation processes as a manifestation of the constitutional mandate in Article 22A of the *Undang-Undang Dasar 1945*. This regulation has also adopted the Constitutional Court Decision No.91/PUU-XVIII/2020 page 393 regarding the operational definition of meaningful participation, including: *right to be heard*; *right to be considered*; and *right to be explained*.

Participation process in the formulation of the Omnibus Health Law tends to be one-directional, hindering meaningful dialogue and reducing the involvement of the public, particularly those directly affected by the policies.[31] Bivitri Susanti (2023)[31] explained, the formulation of the Omnibus Health Law mirrors the challenges encountered during the formulation of Job Creation Law. These challenges include the lack of access to the latest draft and limited opportunities for public participation.

A democratic system places the three main functions of governance—legislative, executive, and judicial— but does not always guarantee interconnected interactions or effective checks and balances. Agencies often compromise to secure support for their proposals or policies. Therefore, social accountability provided by civil society becomes crucial.

Meaningful public engagement and strategic partnerships may strengthen the monitoring function and capacity of the governance system.

Lack of inclusive participation limits potential impacts and increases the risk of more groups becoming vulnerable and left behind. Involving diverse stakeholders can help ensure that policies are more contextual and aligned with community needs. Additionally, academics and research institutions can play a crucial role in ensuring that the decision-making process is evidence-based and scientifically sound.

Our examination of current health policymaking reveals a tendency to focus primarily on health outputs, such as the availability, affordability, and acceptability of health services, while neglecting meaningful public participation.[31] This approach widens the gap between the public and the government in decision-making and policy evaluation. In a democratic system, however, the public should have a role in overseeing and ensuring the accountability of the government (see Figure 7).

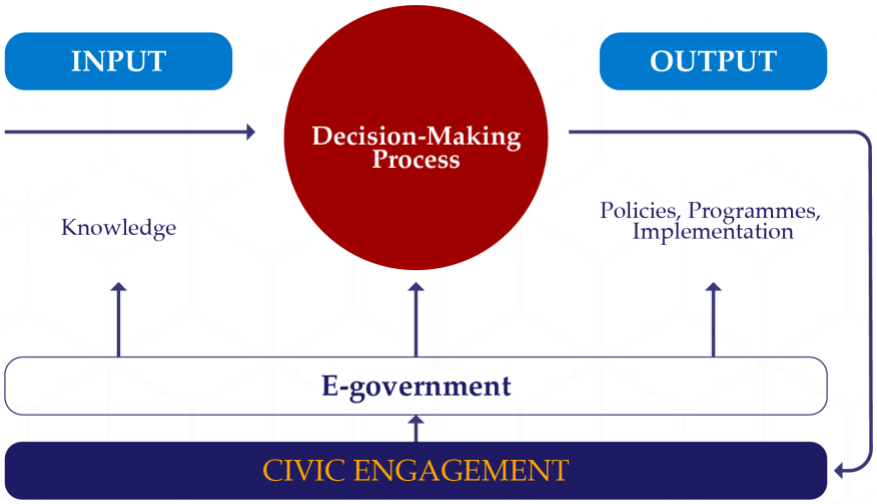


Figure 7. Civic Engagement in Decision-Making Process

During the formulation of the Omnibus Health Law, the Ministry of Health actually tried to minimise the trade-off in the quality of public participation through the establishment of the *Partisipasi Sehat* (Healthy Participation Platform).[32] *Partisipasi Sehat* is expected to become a platform for gathering aspirations, both online consultation and written form, as well as documenting the process through the cloud.[33] However, the implementation of *Partisipasi Sehat* is still not necessarily optimal with the following notes: (1) The lack of a public socialisation, (2) Limited public consultation process only for invited parties, and (3) The absence of a feedback mechanism that allows the public to know the follow-up to the input provided.

Limited feedback mechanism in the existing public participation platforms. *Partisipasi Sehat* still implements the partial meaningful participation because it fails to include a feedback

mechanism to the community. As a result, it is difficult for the community to monitor the development of the Health Law through formal mechanisms.

Who should be invited in the policy making process?

Power; government and the state; and interest groups are the main elements whose interplay determines the dynamics of governance for health. While the government holds the most power in policy making, interest groups such as civil society organisations, academia, patient advocacy groups and others must be accounted into the process.[33]

However, in many cases, policymakers only invite certain groups they are familiar with or those that favour their policies. This was also evident during the formulation of the Omnibus Health Law, where, in addition to the rapid discussions, there were limited efforts to involve and reach out to a broader audience. Our observation in the process of the Public Hearing Meeting (RDPU) by the House of Representatives (DPR RI) also shows that there was still a lack of representation because the process only involves professional associations. As a result, many issues in the omnibus health law were not properly addressed.

The term "directly affected" above did not explain the specific context of the impact. I**mpact may be interpreted as beneficial or detrimental, so this nomenclature opens up a space of misinterpretation**.[33] This potentially creates legal uncertainty, because the provision of "directly affected" must be clarified in order to protect the rights of disadvantaged communities.[34]

The quality of community participation in *Partisipasi Sehat* was also affected by limited access to information and the tight schedule of public consultations. These obstacles affected the depth of discussions and the ability of communities to engage effectively and provide through inputs in the consultation process.

Though Article 96 paragraph 3 of Law 13/2022 does not limit who is eligible to provide input in the formulation of laws and regulations, it emphasises on the definition such as follows:

"The community that has rights to provide input is emphasised as those who are directly affected and/or have an interest." Article 13/2022 Clause 3

The limitations were also driven by the lack of transparency and access to the completeness of legislation that should be made available for the public, such as Academic Scripts and the health bill's draft. The discussion process was also carried out in a rush and ignored the required Law. As a result, the decision-making process occurs without the function of social accountability that is supposed to be owned by the public.

What we have learned during the formulation of the Omnibus Health Law and other derivative health regulations is the involvement of the commercial sector, which is adding another layer of complexity to health governance. Its commercial interests significantly swayed and affected the policy making process.[35,36] Certain government ministries and institutions may have clashing interests, with one side aiming to control the consumption of unhealthy products, while the other side is willing to push the production further in the name of economic benefits.[35]

The fragmented nature of government agencies' approaches allows these commercial entities to exert undue influence, often at the expense of public health objectives. Therefore, it is important to have political will as well as creating transparency and social accountability mechanisms that can reinforce public over commercial interests. Information disclosure and meaningful involvement of civil society is one way to overcome the strong commercial intervention in policy making.

Box 1. The Omnibus Trend

Over the past five years, some anecdotal momentum indicates non-ideal conditions in the legislative and decision-making processes related to the formulation of national-level bills/legislation. It refers to political practices that trigger malfunctions of *checks & balances* in the government institutions.

Started with the Job Creation Law (Ciptaker Law) in October 2020. Although not strictly a health policy product, the process of passing the Ciptaker Law is considered to violate public rights because the ratification was carried out in the midst of the COVID-19 pandemic and will also contribute to influencing the dimensions of workforce in the health sector. The expansion of investment as stipulated in this law also opens up the risk of commercialization of health services. The imbalance of legislative and executive authority that triggers a discussion process that tends to be silent and minimal public involvement is also a polemic point behind the massive rejection of the Ciptaker Law.

This pattern of rushed policy formulation and the lack of public participation is repeated in various other legislative products, for example in the ratification of the Law on the Capital City in February 2022. Similarly, the process of formulating policies that have a direct impact on the health sector has also occurred, for example in the Draft Criminal Code (RKUHP) which ignores the fulfilment of Sexual and Reproductive Health Rights, as well as the ratification of the Revised Health Law on July 11, 2024 which was carried out in a rushed and non-transparent manner.

The misalignment of government institutions is also illustrated in the discourse to revise the

Regional Head Election Law, which was carried out by the House of Representatives to override the Constitutional Court Decision on the minimum age limit for regional head candidates. The DPR later aborted the revision plan after triggering polemics and public protests.

The policy formulation process also has another challenge, which is the declining public trust in institutions. It is compounded by widespread recognition of corrupt practices within the health sector, as none of the experts involved in a Delphi session denied the existence of corruption or noted any significant improvement in this regard.

Concerns about weakened anti-corruption measures further highlight the negative impact on health service delivery. Aspinall has starkly characterised the Indonesian health system as a major site of corruption, manifesting in various forms like illegal fees and inadequate service delivery, which limit access for the poor and drive the wealthy to seek healthcare abroad.[19]

Corruption in Indonesia is widely perceived as 'normal', even among government officials, as noted by Syarif and Faisal.[37] Juwita's study categorises corruption in the Indonesian health sector into three types: Grand Corruption, Corruption of Justice, and Corruption related to Decentralization.[38]

Grand Corruption involves influential individuals manipulating procurement processes for profit. Corruption of Justice describes efforts to evade formal prosecution, including bribing judicial officers. The third type covers corruption involving subnational government actors, where decentralisation has inadvertently provided opportunities for local officials to engage in illegal revenue generation. The root cause of corruption in the public service area, including health, can be traced back to a lack of accountability and transparency.

Therefore, social accountability, transparency, and public participation plays a crucial role in shaping Indonesia’s health system governance where public trust in the government is notably low. We highlighted a major challenge in current health governance is the absence of formal mechanisms to incorporate civil society's input into health planning. This gap highlights a lack of inclusivity, which is crucial for ensuring that health policies and programs are responsive to the diverse needs of the population. Civil society organisations often represent the interests and concerns of marginalised groups, and their exclusion from planning processes leads to policies that may not fully address these groups' unique health challenges. The authors acknowledge that the move towards inclusion of civil society has started in the public consultation process in the design of Health Minister’s Decrees for the implementation of Government Regulation/*PP* no. 28/2024. However, civil society and other development actors were notably absent from the consultations of the Government

Regulation Plan/*RPP*, conducted over a period of almost one year prior to the public consultations of the Ministerial Decrees.

3.3 Synchronisation of Cross-Sector Regulations

The issue of cross-sectoral harmonisation and synchronisation poses a significant challenge in drafting derivative regulations, given that the Health Law is a multisectoral Omnibus Law. As a lesson learned, the Constitutional Court declared the Job Creation Law "conditionally unconstitutional" due to the lack of participation and harmonisation in regulations containing cross-sectoral elements.[39] This situation created a legal vacuum and uncertainty due to delays in implementing the law and drafting its derivative regulations. Learning from this situation, the DPR (House of Representatives) and the Government decided that the drafting of derivative regulations (Government Regulations) must be completed within one year after the Omnibus Health Law is enacted. The legal vacuum should be anticipated including the repeal of 11 other health-related laws, which will also affect the implementation of its derivative regulations.[40]

Rushed process may compromise the quality of legal drafting, the substance, and the harmonisation of regulations with other laws. A one-year timeframe is, in fact, too short for drafting Government Regulations, which are more operational and cross-sectorally binding. Moreover, the derivative regulations will also be drafted using the Omnibus method.

In the context of the Health Government Regulation, we identified two articles/provisions that are not well-harmonised with other regulations.

1. **Article 116 regulates the proof of pregnancy as a result of sexual violence, requiring a doctor's certificate and investigator's statement.** The addition of the investigator's statement, with all its risks of discrimination and stigma, could significantly hinder a sexual violence victim from accessing safe abortion services, which is her rights.

   In contrast, referring to Article 24 of Law 12/2022 on Sexual Violence Crimes, proof can be established through: (1) A clinical psychologist's certificate, and/or a psychiatrist/medical doctor specializing in psychiatry; (2) Medical records; (3) Forensic examination results and/or; (4) Bank account examination results. **The use of the phrase "and/or" can be interpreted as an optional provision, meaning that not all evidence needs to be presented, but only one of them.**

   The substance of Article 24 is further emphasized in Article 25 of the Sexual Violence Crimes Law, which states that a witness/victim's testimony is sufficient to prove the defendant's guilt, with at least one other valid piece of evidence, provided

the judge is convinced. Therefore, proving pregnancy as a result of sexual violence should adhere to the evidentiary standards set by the Sexual Violence Crimes Law.

2. **Article 512 paragraph 3 of the Health Government Regulation still defines Posyandu (Integrated Service Post) as a Community-Based Health Effort (UKBM), whereas, according to the Village Law, Posyandu is clearly defined as a Village Health Institution (LKD).** The term UKBM should no longer be used. Moreover, the 2023 Joint Guidelines for Posyandu Management in the Health Sector, agreed upon by the Ministry of Villages and the Ministry of Home Affairs, already emphasise the clear distinction between UKBM and LKD.[41] This could lead to ambiguity in policy implementation in the field, from funding scenarios to coordination flows, especially since Posyandu operations involve both district/city and village governments.

These two articles in the Health Government Regulation highlight the issues of harmonisation and synchronisation of cross-sectoral policies between the Ministry of Health and other health-related ministries/agencies as implementers. A particularly compelling case is the Ministry of Health Regulation on Electronic Medical Records. When this regulation was enacted, the Personal Data Protection Law, which is intended to serve as the cornerstone for data protection and the restoration of rights, had not yet been passed.[42] This regulation's new content not only exceeds the scope of the Personal Data Protection Law but also goes beyond the provisions of the One Data Indonesia Presidential Regulation, which has yet to designate the Ministry of Health as the central authority for health data supervision.

Synchronisation and harmonisation are crucial not only at the policy level but also in program implementation, which often outpaces the availability of regulations and policies. A pertinent case study is the piloting of ILP (previously known as Posyandu Prima). This base of PHC reform provides a starting point to push for overall reform in the primary health care space, including its governance mechanism. Progress to date shows that while significant, successful realisation of ILP requires better understanding of policy barriers, public's demands and their barriers to access primary health care facilities. Demand-side analysis within a people-centred health system is discussed in detail in the Health System book of this White Paper series.

In one of our analyses conducted in 2023, we note that the absence of regulations hindered local governments' efforts to effectively implement this PHC reform agenda.[42] Consequently, the piloting districts lack clarity regarding available resources and budget schemes. Additionally, the responsibility for replication policies is left entirely to regional authorities, without a proper regulatory framework to ensure efficient bureaucracy and cross-sectoral collaboration. If there are no significant changes, there is a concern that another program implementation may become imprudent and also could affect the quality of monitoring and evaluation processes.

3.4 Decentralisation of Health Policy in Indonesia

Actions towards translating the Omnibus Health Law into actions will continue to be implemented at the sub-national levels. This translation process will manifest in various forms, including drafting regulations, development plans, implementation, and monitoring and evaluation of policies. Additionally, the Omnibus Health Law will influence the dynamics of policy formulation at the regional level, particularly with the establishment of the National Health Master Plan (RIBK). RIBK will be one of the key regulations that regulate planning and budgeting at the subnational level. The adoption of RIBK aims to replace the previous mandatory 5% spending policy, focusing instead on performance- and program-based planning and budgeting at the regional level (money follows program).

Within the framework of the Omnibus Health Law, the National Health Master Plan (RIBK) emerges as a new policy not yet addressed in Law 25/2004, which governs the National Development Planning System (SPPN). The SPPN Law ensures the integration, synchronisation, and synergy of development plans at both the central and regional levels. Key instruments included under this law are the RPJP (Long-Term Development Plan), RPJM (Medium-Term Development Plan), Renstra (Strategic Plan), RAK (Work Action Plan), and RAPBN/RAPBD (National/Regional Budget Plan). The responsibilities and coordination mechanisms related to these planning instruments.

However, the technical details regarding the drafting process and its synchronisation with the preparation of RPJM, Renstra, and RKP (Government Work Plan) have not been regulated in the Health Government Regulation. The Omnibus Health Law actually mandates the formulation of a specific Presidential Regulation regarding the technical provisions of RIBK. However, the government also needs to revise the SPPN Law to achieve cross-sectoral planning synchronisation. This aims to ensure alignment in the planning process, including authority arrangements and incentive mechanisms in the drafting of RIBK amidst the formulation of other planning products.

Limited participation of subnational governments in the formulation of RIBK. According to the regulation, the central government holds full authority over the process of drafting and synchronising the RIBK. Regional governments, on the other hand, are only required to refer to the RIBK when designing their health budgets. Neither the Omnibus Health Law nor the Health Government Regulation has provided a detailed explanation of the roles, functions, or implementation and monitoring schemes of RIBK by regional governments.

Box 2: Key Facts on the National Health Master Plan (RIBK)

1. The RIBK is a national document for health planning and budgeting, developed based on health development priorities in alignment with the RPJPN (National Long-Term Development Plan) and RPJMN (National Medium-Term Development Plan).
2. The RIBK is formulated through a consultation process with the DPR (House of Representatives) before being approved by the President.
3. The RIBK can be evaluated annually.
4. The RIBK serves as a reference for ministries, agencies, regional governments, and the public in preparing five-year health plans.
5. Regional health budget allocations must consider sufficient funding to meet Minimum Service Standards (SPM) and other national priority health programs.
6. In drafting regional health budgets, the central government has the authority to synchronise the needs for budget allocation.
7. The RIBK is established by the President.
8. The RIBK's formulation is coordinated by the Minister of Health, involving the Minister of Finance, Minister of National Development Planning/Bappenas, Minister of Home Affairs, and other ministries/agencies that support health programs.
9. Further details regarding the RIBK will be regulated in a Presidential Regulation.
10. Regional governments allocate health budgets from regional revenue and expenditure budgets according to local health needs, referencing the national health programs outlined in the RIBK, while also considering performance-based budgeting.

However, it is crucial for the government to be cautious not to reinforce hierarchical coordination lines between the central and regional levels, as this could limit the regions' flexibility in adapting, planning, and implementing policies 4).[1] Although centralization is seen as a way to enhance program effectiveness, it also risks creating power imbalances between the central and regional governments.[1] The implementation of RIBK by regional governments in the long term requires improvement in the quality of planning, implementation, coordination, and monitoring-evaluation is essential.

Regional health development planning instruments are often symbolic rather than substantive. Formal mechanisms such as the Musrenbang (development planning meetings) tend to be seen as formal requirements rather than as a productive format for two-way interaction between the community and the government in setting agendas. Several fundamental issues in the implementation of musrenbang at the regional level, including:

a. **Representation in Musrenbang:** Various studies highlight that participant selection often does not adequately represent diverse community groups, leading to a lack of reflection of the community's varied interests in the musrenbang process.
b. **Community ownership of Musrenbang**: The lack of a sense of ownership in the *Musrenbang* process is due to the absence of incentive and disincentive mechanisms and the limited follow-up actions that would allow for meaningful community participation.

c. **Musrenbang as a formality**: Tresiana(2016)[43] research indicate the musrenbang is often conducted merely as a checklist exercise, with the agenda setting process already determined by local elites such as secretary and head of village for rural area as well as head of sub district and the members of regional parliament (DPRD) for urban area.

4. Evidence-based policy making in Indonesia

One of the challenges in drafting the Omnibus Health Law is the limited public access to academic manuscripts. Whereas, Article 96, Paragraph 1 of UU 13/2022 mandates meaningful public participation at every stage of lawmaking, including planning, drafting, discussion, approval, and enactment. Hidayat R.[44] argues that article 96 of UU 13/2022 underscores the obligation of the DPR and the Government to actively involve the public in the preparation of academic manuscript.

The Ministry of Law and Human Rights further asserts that the preparation of these academic manuscripts must be conducted through an open, transparent, and inclusive process that considers the impact on affected groups. The involved parties should include academics, practitioners, researchers, policy formulators, stakeholders, and implementers, engaging in public discussions, focused discussions, and e-consultations.[45]

The problem in the formulation of regulations in Indonesia is not only limited to access to the formulation of academic papers, but also the utilisation of quality data and information. Currently, the handling and management of health data in Indonesia has poor quality. Health information systems are limited and sector-specific, primarily within the Ministry of Health. Health status data (e.g., mortality, morbidity) and health system data (e.g., insurance, healthcare personnel, and service coverage have not been integrated with health determinants data as outlined in the WHO's 2008 Health Metrics Network framework.[46] There is a disintegration of databases between ministries and government institutions and inadequate reporting at the district level. At the technical level, the reporting level is very minimal, with recurring issues with data quality.

Additionally, research governance is not well regulated, as evidenced by the lack of correspondence between surveys conducted by the different government agencies. For

example, data from the national basic health research (Riskesdas) conducted by the Ministry of Health are not linked to the national socioeconomic survey (Susenas) from the National Statistics Agency. This represents a missed opportunity to capture comprehensive health information on the population.

Even smaller surveys under the Ministry of Health, such as the Indonesian nutritional status survey (SSGI), are not interlinked with other surveys conducted under the same ministry. More importantly, the only commonly-used longitudinal data is the RAND's Indonesian Family Life Survey, funded by multiple international organisations, with its latest data available only for 2017.[47] Adding to these challenges is the reliance on national-wide cross-sectional surveys like Susenas (National Socioeconomic Survey) and Riskesdas (Basic Health Research), now known as SKI (Indonesian Health Survey), for health analytics.

The disparity in data collection frequency and methodological differences between these surveys have caused confusion and mistrust, **evident in conflicting data reports that complicate policy-making**.

Chapter 4:
The Actors

4.1 Health Governance: Understanding the Concept

Governance involves how different actors interact, communicate, and coordinate to achieve a decision. This subchapter discusses the issues around Indonesia's current governance structure and process that allows or impedes various sectors and actors within and across public sectors in health related policy making processes.

In Indonesia, the public health sector is primarily mandated to be the responsibilities of the Ministry of Health. There are other agencies working or supporting on specific health issues, such as BPJS, BKKBN, and BPOM that work in coordination with the MoH and report directly to the President. However, in many cases, public health goes beyond the health sector and requires multi sectoral collaborations. Several regulations and programs have emerged to use multi-sectoral approaches, whether in a comprehensive or partial manner. Examples include Presidential Regulation No. 72/2021 on the Acceleration of Stunting Reduction (Perpres Stunting)[48] and the Presidential Instruction No. 1/2017 on the Healthy Living Community Movement (Inpres GERMAS).[49]

Ineffective coordinating structure

The implementation of development programs and policies sometimes faces challenges in achieving optimal synchronisation and coordination. In the current state institutional structure, the coordination function is held by four ministries (see Figure 9), namely the Coordinating Ministry for Political, Legal, and Security Affairs (*Kemenko Polhukam*)[50]; the Coordinating Ministry for Human Development and Cultural Affairs (*Kemenko PMK*)[51]; the Coordinating Ministry for Maritime Affairs and Investment (*Kemenko Marves*)[52]; and the Coordinating Ministry for Economic Affairs (*Kemenko Perekonomian*).[53]

Each of these coordinating ministries is in charge of setting up the synchronisation, control, and coordination of affairs within their respective domains and is subject to several different Presidential Regulations. For example, Kemenko PMK coordinates performance, programmes, and policies within the Ministry of Health, Ministry of Social Affairs, Ministry of Villages, Development of Disadvantaged Regions and Transmigration (Kemendes PDTT), Ministry of Religious Affairs, Ministry of Women's Empowerment and Child Protection (KemenPPPA), Ministry of Education and Culture (Kemendikbud), and Ministry of Youth

and Sports (Kemenpora). The complexity of development issues can occasionally be beyond the scope of the coordinating ministries' authority.

The multi-layered bureaucracy across ministries and agencies may affect the delivery of programs and the implementation of policies, which potentially result in outcomes that fall short of expectations. As shown by Figure 8, these governance and structural challenges become more intricate when coordination and synchronisation are required not only at the horizontal level between ministries and agencies, but also at the vertical level, extending to district and village administrations.

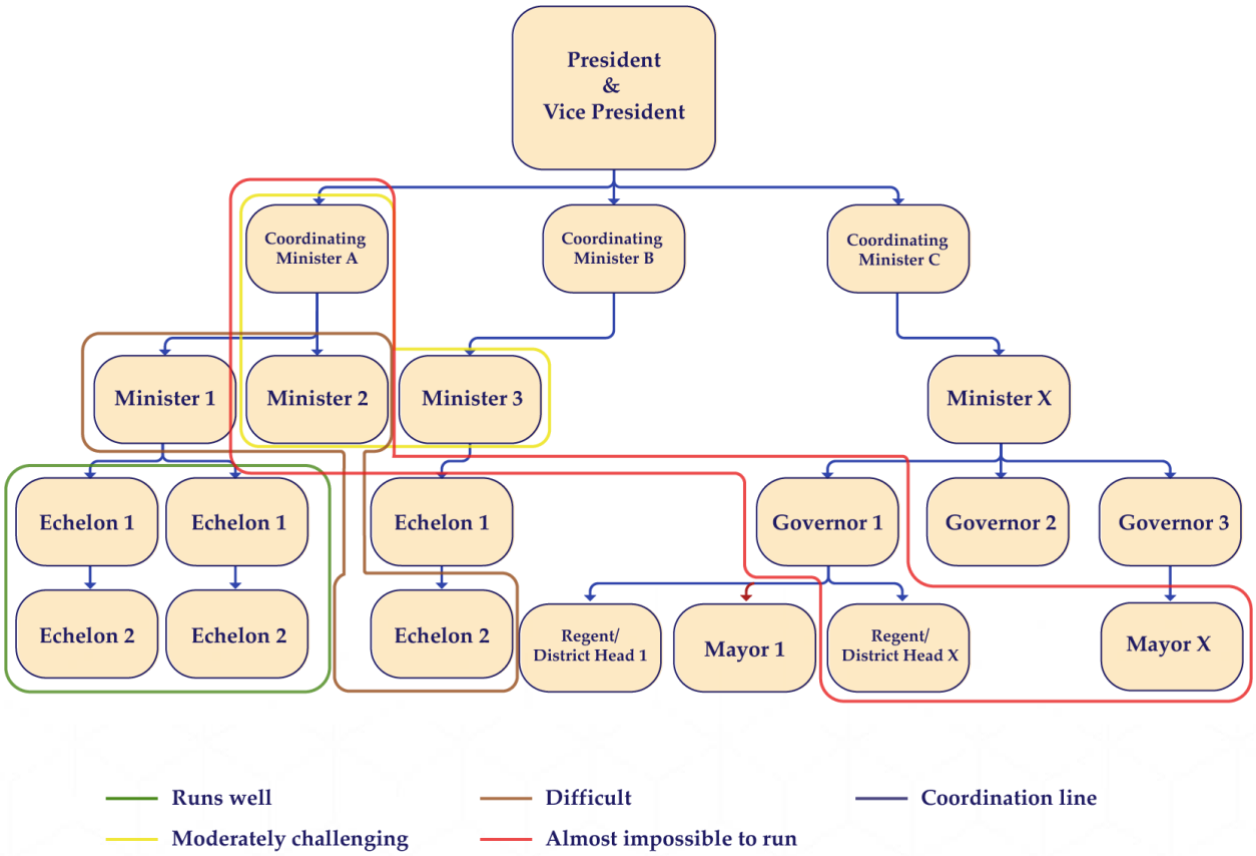


Figure 8. The Different Possible Situations in Implementation of Development Programs (source: UKP4, 2014, recreated by author).[1]

Coordination and synchronisation within the health sector or a single coordinating ministry already has its own challenges.[1] For example, managing the collaboration between the Ministry of Women's Empowerment and Child Protection, Ministry of Education and Culture, Ministry of Social Affairs, and the MoH to address issues such as child marriage, maternal and infant mortality, gender-based violence, and stunting can be complex. Similarly, it is unclear to define the roles that the MoH and agencies led by officials at the Echelon 1 level, such as BKKBN, should play in issues pertaining to adolescent health, reproductive health, and nutrition.

When policies or programs require coordination amongst agencies under various coordinating ministries, the problem gets even more complicated at program level. Because each technical and coordinating ministry has different interests, it can be more difficult in these situations to coordinate and synchronise development agendas. This intricacy is demonstrated, for instance, by the way in which the village's health service units (VHSU) and Community Health Workers (CHWs) functions are managed. The MoH supports CHWs and Pustu/VHSU through its Integration of Primary Health Care (ILP) programs,[54] while the Ministry of Villages and Village Head are in charge of enforcing regulations pertaining to village infrastructure and its resources.[55] At the same time, the MoHA plays a role in coordinating the performance of Governors and Mayors/Regents in carrying out national priority programs regarding to basic public services, in addition to their own regional priorities.[56]

Current Health Governance Structure

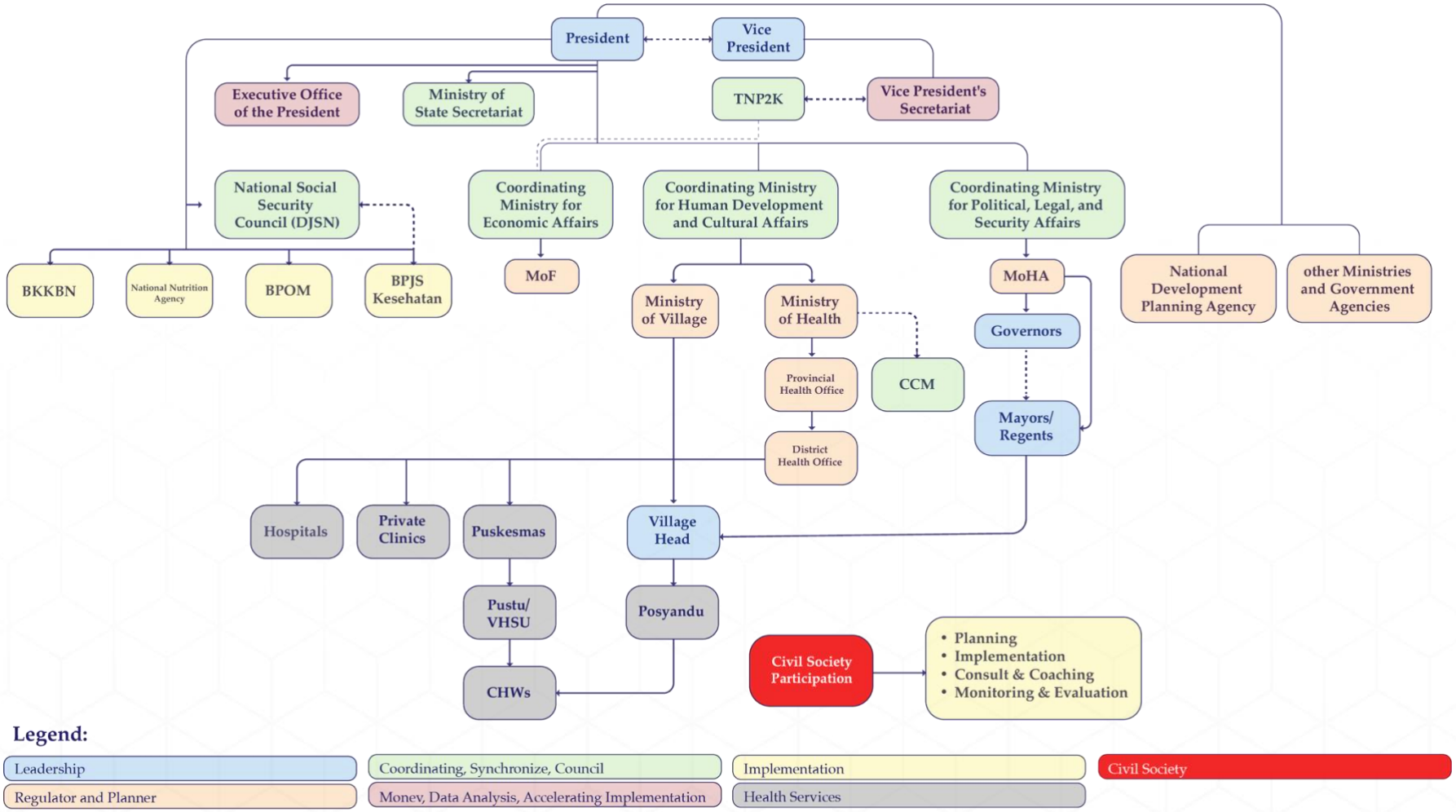


Figure 9. Current Health Governance Structure in Indonesia (Source: CISDI)

In some cases, regulations do involve similar stakeholder structures, however not interconnected and do not reference each other. The National Team for the Acceleration of Poverty Reduction (TNP2K) handles overarching concerns including poverty alleviation in addition to the coordinating ministries. The purpose of TNP2K is to support cross-sectoral coordination in order to improve the efficacy and efficiency of several policies and programs aimed at reducing poverty, such as the prevention of stunting and social protection system reforms.[57] The Vice President chairs TNP2K, similar to Presidential Regulation No. 72/2021 on the Acceleration of Stunting Reduction, with the Vice President's Secretariat acting as the Executive Secretary.

4.2 Fragmented Visions of Governance for Health in Public Health

Another example shows challenges in ensuring substantial commitments of other sectors in achieving public health. GERMAS Program through a Presidential Instruction states how each ministry/government agency may contribute in attaining a healthy community. The term "movement" in GERMAS, which usually connotes an all-encompassing endeavour, would have less of an effect because a Presidential Instruction has limitations regarding the involvement of entities outside the government. While this regulation encompasses nearly all ministries and agencies, as well as local governments, it relies on input indicators (programs/activities) rather than shared outcome indicators. The efficacy of GERMAS is constrained by the incompatibility between its programs and activities and the desired health outcomes. The Coordinating Ministry for Human Development and Cultural Affairs, which is responsible for coordinating GERMAS activities across technical ministries and agencies, faces limitations as not all ministries and government agencies fall under its coordination pathway. Moreover, those ministries are mandated with different development priorities, which sometimes are contradictory with public health outcomes, for example the ministry of industry with its KPI of tobacco industry growth/revenue.

Interplay between executive, legislative and judicative components in government influences health governance. Political parties typically play an important role in determining policy direction and as such imposes heavy influence on the bureaucratic system in the day-to-day process of policy making. On occasions where the legislative and executive mechanisms meet to find a common ground for development priorities, the pressure is often on the executive side to provide sound reasoning for a set of development priorities. This is where it is crucial for both groups to reach a consensus based solely on data and facts. Evidence, by which data and facts are compiled into, is the product of research. A strong and sustained epistemic community for research will also ensure that policies get delivered in a timely and efficient way.

The key challenge in health governance today is the lack of strategic alignment and continuity across various components of the healthcare system particularly in the significant

misalignment in planning and budgeting. This disconnect is evident in several aspects, such as the misalignment between service delivery, health research, community needs, and the actual allocation of financial resources. This inconsistency not only leads to inefficient interventions that fail to effectively address critical health issues within communities but also hampers the effectiveness of policy implementation due to the disconnect between government's strategic plans and budget allocation.

The influence of donor-driven initiatives often prioritises external agendas over local health needs, exacerbating this misalignment.[58] Additionally, the structural problems of contemporary capitalism, including financialization, short-termism, and the weakening of the public sector, further complicate the health industry. In times of crisis, like the COVID-19 pandemic, heavy investments in consulting contracts have shown outcomes that are not always proportional to the investment made. Scholars such as Mazzucato and Collington[59] advocate for investing in state capacity and expertise, revitalising the public sector, and reducing reliance on expensive consulting intermediaries.

Electoral changes also contribute to this inconsistency, particularly in non-communicable disease (NCD) programs. New administrations often shift agendas and budget allocations, disrupting the continuity and effectiveness of health initiatives that require long-term commitment. The absence of a holistic, cross-sectoral strategy in global health governance is further evident in the overemphasis of the National Research Master Plan on pharmaceuticals, neglecting broader health needs such as maternal and child health, nutrition, and NCDs. The marginalisation of adolescent health in the SRMNCAH+N framework is another example of this myopic approach.

Furthermore, the short-term focus of the current Digital Health Transformation blueprint reflects a broader trend of short-termism in health sector planning. This approach, often constrained by the tenure of a single government administration, fails to establish a sustainable vision for health governance, neglecting long-term digital health strategies and hindering the development of robust health systems.

4.3 Civil Society: Ensuring Sustained Inclusion and Meaningful Engagement

It must be acknowledged that the government and the state play a central role in health governance.[60] Bearing in mind that the health system is the product of the state's governing dynamics. However, this "state-heavy" mechanism has its drawback.

Dependence on government dynamics often means a tendency towards relying on bureaucracy and bureaucratic ways of doing business. These procedures imprisoned the actors involved, keeping them away from innovative and future-oriented thinking and trapped in the "what is possible today" frame of mind. Policy makers therefore do not

consider the possibility of having a wide range of policy options. They fall short of exercising their autonomy and capacity as a government who are expected to be forward looking, accommodative to new ideas and sensitive towards the public's variation of needs.

Reliance on state and government in policy formulation often excludes other development actors from the process. To guarantee good governance principles is achieved, it is the responsibility of policy makers to accommodate all inputs from all actors. In addition to ensuring continuity of inputs from different expertise and background; diversity of experiences and inputs from different actors. For example, community leaders, civil society leaders and scientists/academia present significant contributions to the strength and robust policy making processes.

The role of the private sector in health system governance in Indonesia is crucial yet complex. On health service delivery, the private sector provides a significant portion of health services in Indonesia. Private and philanthropic clinics have emerged as important players, offering services like sexual and reproductive health counselling, particularly for marginalised groups. The rise of digital health providers like HaloDoc, YesDoc, and Alodokter is also significant, addressing limited access to primary healthcare services. However, challenges include a lack of a clearly articulated strategy for private sector engagement by the government, restrictive establishment rules for foreign players, and unclear e-health regulations.

There is a lack of mechanisms to regulate conflicts of interest between the government and non-state actors, including private entities and civil society, in their interactions during the policy-making process. This issue is significant because there should be clear boundaries and platforms defining how, where, and when non-state actors may interact with the government and influence policy-making. In tobacco control, for instance, previous experience has shown how tobacco industries donated money to political parties and engaged in behind-the-scenes negotiations with the government to influence policy-making to support their interests.[61]

4.4 The Ministry of Health: main actor, leading sector

As the leading national institution, the Ministry of Health is expected to be the standard holder for health policies and resolve issues from policy to health service delivery. The authors proposed to approach this from the role of MoH and how the organisational structure reframes quite significantly in the last nine years.

In constructing this Governance book and proposing the recommendations, the authors compared the structure of governance for health in Indonesia to other countries, namely the United Kingdom and Thailand. The Department of Health and Social Care in the UK explicitly

states that their role is to shape and deliver policy that delivers the government objectives. It also states that it is mandated to act as the guardian of the health and care framework. This specific objective is carried out through legislative, financial, administrative and policy frameworks that are fit for purpose.[62]

This chapter will discuss the challenges faced by Indonesia's MoH and how resolving these fundamental issues will ensure good governance for health is achieved.

4.4.1 Regulator or Operator?

Among the top dilemmas faced by the MoH is attributed to its role as either a regulator or operator. According to the Presidential Decree No 68/2019 on State Ministry Organization, the MoH is mandated to formulate regulations, manage and allocate resources, provide supervision, and also implement regulation, technical guidance and supervision, and other national technical activities. In practice, the MoH conducts both functions, not only as a regulator, but also a healthcare provider (operator). For example, the MoH owns and provides health care services at hospitals, known as vertical hospitals, as well as health educational institutions (Poltekkes), in addition to its regulatory function. It is a problem that has been criticised in the context of health financing governance, where the MoH as a regulator and a provider might have conflict of interest and tendency towards its own hospitals. This situation persists and has been happening for the past decades given how development at the subnational level had a huge gap with the national level. Within the last ten years, the MoH has demonstrated its preference to take a more centralised positioning and as a consequence, it expands its authority and control by taking up more roles over the quality and implementation as opposed to only setting norms and guidelines.

4.4.2 Organisation Structure Transitioning from Pre- to Post-Pandemic

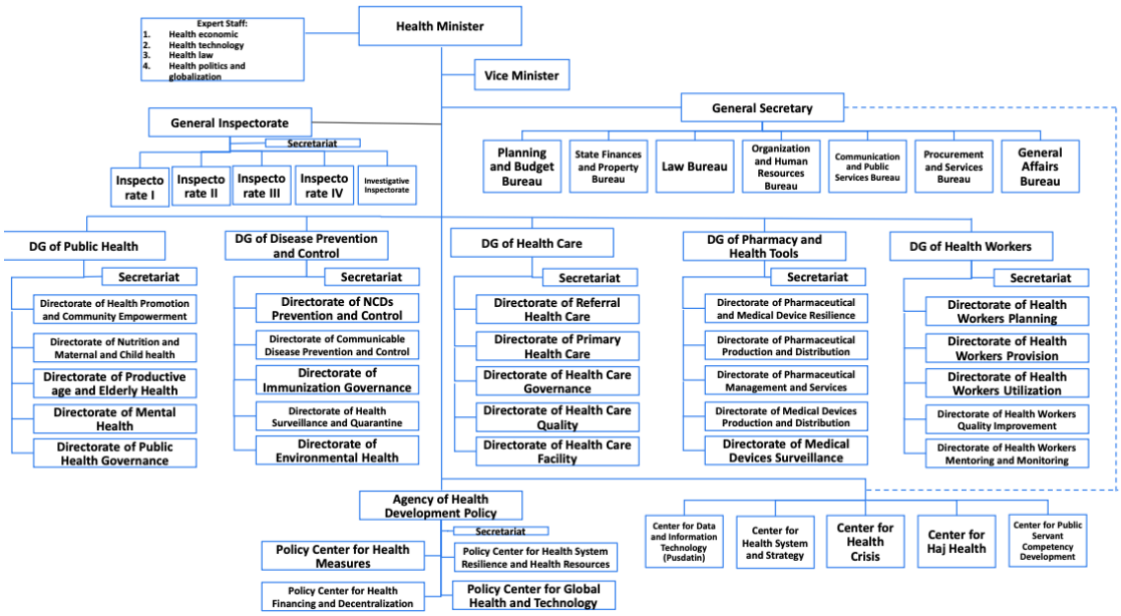


Figure 10. Current Organisational Structure of the MoH (source: Permenkes No 5/2022; recreated by author)[63]

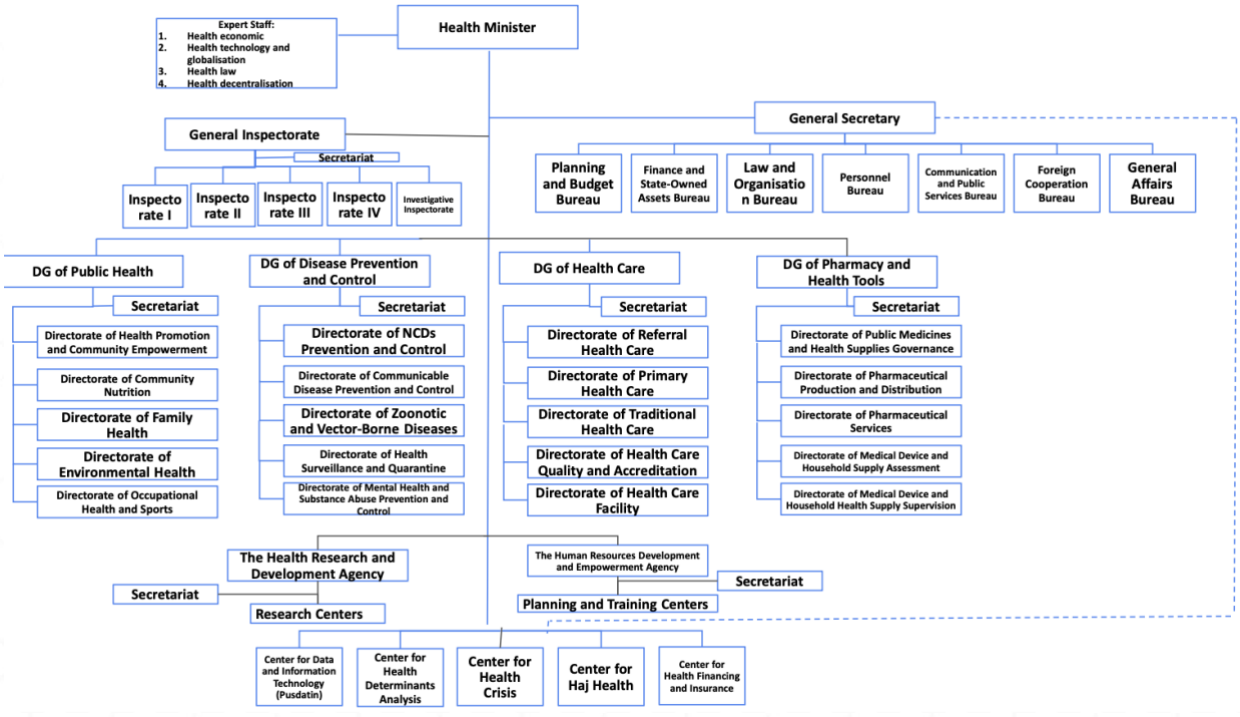


Figure 11. Previous Organisational Structure of the MoH (source: Permenkes No 64/2015, recreated by author)[64]

The pandemic marked a significant change in the country's MoH structure. After one and a half years in office, Dr. Terawan was replaced by Budi Gunadi Sadikin.[65] The new minister began rapidly reorienting the ministry, and changes are clearly reflected in the current organisation structure as well as the publication of the six transformative pillars as main

priorities of the Ministry of Health. Given the limited time he has, he brought in additional abled non civil servant professionals known as Paskass into the organisation to supplement the capacity gap within the ministry.

This is a significantly different approach than that taken by Minister Nila Moeloek (Minister of Health, 2014-2019) who relied fully on the bureaucratic capacity of the ministry when she took office. This stark difference affects not only the ministry, but also influences the change of dynamics in the health sector in general. By making the decision to add ad-hoc units and deploy non civil servants inside the ministry, it made him able to push for realising his top priorities but at the same time created tension within the organisation.

4.4.3 Challenges faced by actors: ineffective bureaucracy and structure

The MoH organisation structure and its governance has become quite extensive. The MoH organisational structure typically changes with each new minister. It has undergone several amendments usually when a new minister takes office. The last significant change occurred when the Minister Nila Moeloek assumed her role in 2015 (see Figure 11). Another restructuring was implemented in 2022 when Budi Gunadi Sadikin was appointed as the Health Minister (see Figure 10). Figure 10 illustrates that the current structure consists of 7 echelon 1 positions: 1 General Inspectorate, 1 General Secretary, and 6 Directorate Generals, each overseeing specific issues.

Each echelon 1 position supervises at least 5 directorates, which address various topics. In addition to the directorates, there are five different centres specialising in specific areas. One of the most significant changes in the current structure compared to the previous structure (in 2015) was the merging of Balitbangkes and several centres into BKPK, and the integration of BKLN into Pusjak KGTK. Moreover, due to the change to life course approach and shift in Puskesmas role to be heavier in health promotion and prevention, there are two directorates working on primary health care level, Direktorat Takelmas and PKP.

The MoH structure has been criticised for its fragmented functions and departments. Despite the reform, within the MoH structure, the focus is still highly specialised and siloed, which limits the ability to work across directorates. The limited capacity of staff is further exacerbated by the lack of opportunities for continuous professional development within the institution. Additionally, the rotation that occurs every 2-3 years hinders staff from specialising in a particular issue and forces them to learn from the beginning.

4.4.4 Adhoc Agencies and Functions

Temporary units/agencies may face difficulties in sustaining capacities and delivering outcomes. Another significant change was the addition of new directorates, such as the Digital Transformation Office (DTO) and Center for Health System and Strategy (PASSKAS) as the Strategic Delivery Unit, which are not formally embedded in the structure, and are ad hoc in nature. The Strategic Delivery Unit assists the Vice Minister and the Minister by overseeing different directorates and ensuring tasks are completed.[66] The DTO is tasked with achieving digital transformation in the health system, with one of the main goals being the integration of hundreds of information systems into one, called Satu Sehat (more details, see Digital Health Book). The Strategic Delivery Unit performs tasks related to carry out analysis, harmonisation, and synergy of strategies and health systems, and has overlapping functions with other directorates.

If it is discontinued under the next minister, the corresponding directorate should be strengthened to allow it to assume these roles. The DTO also handles tasks that should fall under The Center of Data and Information (Pusdatin). Both the DU and DTO are staffed by contract-based professionals who may or may not have strong experience in health, but possess strong academic backgrounds and degrees from abroad. Pusdatin and Project Management Officer (PMO) have been under capacity and unable to fulfil the tasks expected by the Minister. Similarly, when a new administration takes place, the functions of the DTO should be integrated into Pusdatin. There has been criticism and reluctance within the MoH regarding the introduction of new personnel into the bureaucracy who are considered an outsider and lack knowledge of bureaucratic processes.

This disjointed approach extends to the formulation and implementation of policies, particularly in addressing NCDs. Agencies working in isolation develop strategies and guidelines without sufficient consideration of efforts by other entities. This lack of coordinated action leaves significant gaps in both prevention and treatment strategies for NCDs, weakening the overall impact of health interventions. Health organisation overlaps, as seen between BKKBN and the Ministry of Health (Kemenkes), exist without synergy, indicating weaknesses in organisational structure and coordination. This issue reflects a broader challenge of fragmented institutional frameworks within the health sector.

Adolescent health and NCD programs are particularly susceptible to the adverse effects of fragmented governance. The absence of a unified, long-term vision for these programs leads to inconsistencies and disruptions in healthcare provision for adolescents, a demographic requiring sustained and specialised attention. This situation is exacerbated by shifting political landscapes, which often result in the discontinuation or drastic alteration of these programs. Meanwhile, 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.

The current approach to NCDs and SRMNCAH+N are characterised by fragmentation, with different government agencies operating in silos. This disjointed approach fails to take an intersectional view of health issues, that is vital for addressing the complex and varied needs of diverse populations. An intersectional approach would facilitate a more coordinated and comprehensive response to these health challenges.

4.5 National-Subnational Coordinating Mechanisms

This subchapter explores the challenges encountered by the government at various levels in coordinating efforts and effectively communicating to attain desired public health outcomes. It delves into the complexities of national-subnational collaboration and the difficulties in aligning local and national policies.

With the transfer of authority since decentralisation, coordination and communication between the central government and regional governments have become significant challenges. In the era of decentralisation, the institutional framework at the provincial and regency/city levels has been adjusted according to the authorities delegated to the regions. Technical ministries, which previously had 'extensions' down to the regency/city level, have seen their authority at the provincial and regency/city levels transferred and carried out by the Regional Apparatus Work Units (SKPD) since the decentralisation era began. Central government programs that are supposed to be implemented in sync by provincial and regency/city governments may encounter obstacles due to differences in perception between regional needs and central government interests. Therefore, the pattern of coordination and communication between the central and regional governments have been inadequate.

According to Law No 23/2014 on Local Government, health is classified as a basic service and is the primary responsibility of the local governments within their respective areas. However, responsibility is shared between the provincial and district governments if the scope extends across different districts or cities. Similarly, when issues span multiple provinces, it becomes the responsibility of the central government. Additionally, the provincial government is tasked with coordinating and overseeing districts and cities within their jurisdiction, ensuring alignment with national priorities.

Having a unified response from 38 provinces and 514 districts/cities across Indonesia is challenging. Varied capacities of governments remain a problem, it is difficult to ensure that every region and government can deliver the same standard and quality.[67] The very diverse social, cultural and demographic situation also makes it more difficult to have one policy that fits all. Since decentralisation started in 2003, limited mechanisms remain to ensure all local

governments can deliver the expected standards and to ensure to certain extent they can still comply with guidelines or policies issued by the central government.

4.5.1. Institutional Structure and Framework

The institutional structure at the central level has a significant impact on the governance structure at the Provincial and Regency/City levels. Therefore, a fragile institutional framework at the central level impacts the achievement of national priorities and the effective implementation of development actions at the sub-national level which are typically based on the interpretation of various policies issued at the central level.

The difficulty in synchronising policies and coordinating program implementation to meet determined targets is evident. The Ministry of Health, which has the primary responsibility for formulating policies and coordinating the implementation of health programs, often faces challenges in aligning its policies with other ministries as well as with sub-national governments. As a result, the programs implemented often fail to achieve the expected outcomes.

The existing institutional framework and structure of the state still present issues related to the ineffectiveness of coordination and communication, both among ministries/agencies (K/L) and between the Central Government and Regional Governments. This condition often leads to the failure to achieve development targets as expected. UKP4 identified challenges in coordinating different ministries under one coordinating ministry due to the limited authority and role of the coordinating ministry to enforce and intervene in a program. However, this coordination was still considered manageable, allowing programs to run relatively well. Coordination becomes much more challenging when a program involves two or more ministries under different coordinating ministries, especially when one of the coordinating ministries is also the implementer. In such cases, the coordinating ministries often have their own priorities. For example, during the national COVID-19 response, the lead coordinator was the Economic Coordinating Ministry, which led to debates and miscoordination regarding whether to prioritise the health response or sustain economic growth.

The most difficult coordination, and the most common issue, occurs when a program must be implemented and involves more than one, or even all, provincial and district/city governments (see Figure 9). The lack of structural authority of ministries at the provincial and regency/city levels makes coordination very difficult to achieve. The success or failure of a program depends on the efforts made by the Regional Apparatus Work Units (SKPD) at the provincial and district/city levels.

The varied capacities of local governments create challenges for the central government in advancing national priorities and create a tendency towards centralisation. Programs are implemented at different standards due to these varying capacities and differing levels of political commitments. Aware of this situation, the central government tends to centralise health authorities and policies to maintain control over implementation at the subnational level. A clear example of this is Health Law No 17/2023, where the central government strengthened its mandate towards planning and budgeting through the RIBK. This approach has been criticised for its "One Size Fits All" tendency. As a result, the guidelines tend to be prescriptive and directive, limiting local governments' ability to innovate and adapt based on local needs and context.

4.5.2. Oversight and Authority at Sub-National Level

Provinces have limited authority and resources to perform these tasks effectively and to ensure alignment and coordination between the central and district governments.[68] According to the law, provinces are tasked with acting as the extensions of the central government and are responsible for providing oversight and supervision to district governments. Specifically, the Governor is considered the representative of the central government, tasked with mentoring, supervising and evaluating local governance. For example, provincial health offices should provide technical guidelines to District Health Offices and coordinate interventions and programs across districts and cities.[69] Although the law authorises provinces to impose sanctions and grant approvals to some extent - such as to the heads of districts or cities - in practice, province's role remain limited. Provinces are allocated only around 10% of the national budget, while districts/cities receive approximately 30%.[67] Moreover, the role of provinces is becoming increasingly weakened due to the continuous expansion of new districts.

4.5.3. Limited Planning and Coordinating Mechanism

Available national to subnational coordinating mechanisms are still insufficient. There are several mechanisms for planning and coordination between central, provincial, and district-level governments. In the context of health, there is the National Health Meeting, held annually by the Ministry of Health, which brings together all PHOs and DHOs to discuss annual priorities and to align and harmonise plans. This mechanism tends to follow a top-down approach. The Figure 8 below is referenced from a Ministerial Decree to govern a mechanism called *Rakerkesnas*.[70] This is an annual planning meeting of Head of Province Health Offices and Head of District Health Offices.[71]

However, the outcome of this Rakerkesnas, often 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).[14] The purpose of the National Health Meeting (*Rakerkesnas*) here is limited to serving as a platform for the dissemination and national/subnational alignment of policy plans, program objectives, health development indicators, as well as decentralisation policies and supporting tasks that tend to be top-down in nature. The outcomes of *Rakerkesnas* are not bidirectional in terms of providing input for the Initial Draft of The Government Work Plan (RKP), as the synchronisation process with Bappenas has already been carried out beforehand.[71] As seen in the figure below, Rakerkesnas is a relatively top-down process where it convenes local DHOs (and PHOs) to socialise the MoH's priority, so they can each translate it further for local planning and budgeting.

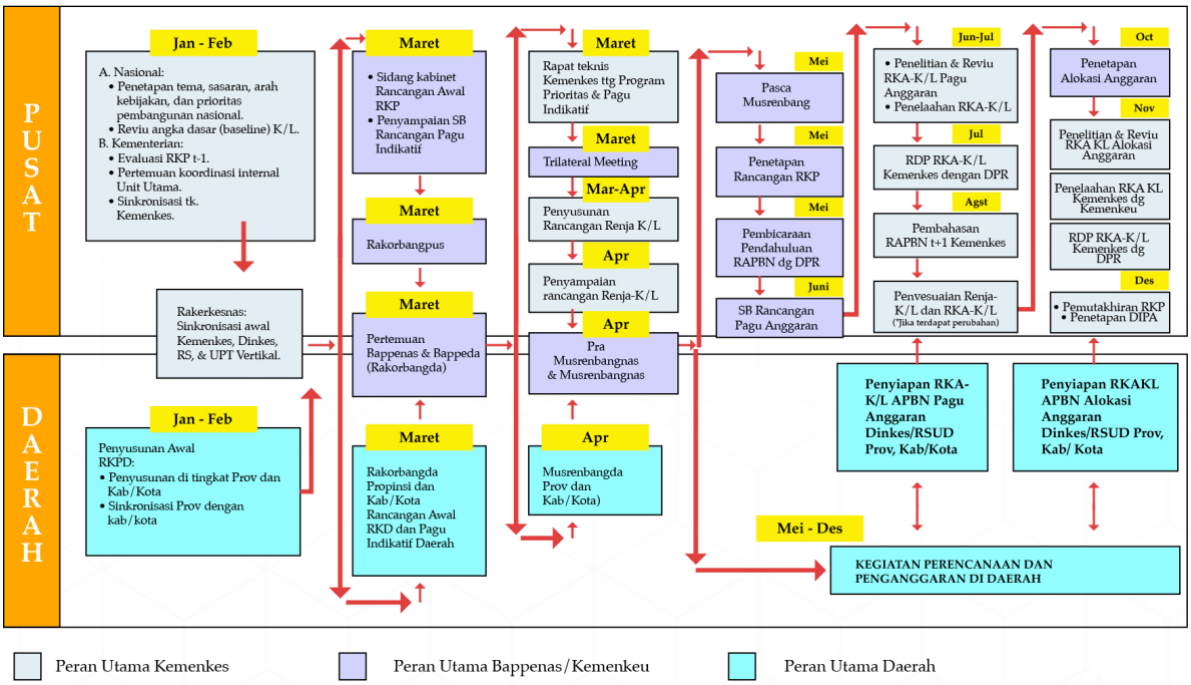


Figure 12. Schematic of Current Health Planning for *Rakerkesnas*[71]

Furthermore, bottom-up approaches such as Musrenbang (Musyawarah Perencanaan Pembangunan) are unable to facilitate effective and robust coordination among different stakeholders. Musrenbang is an annual planning process that moves from the subnational to the national level, typically starting at the village level, progressing through subdistrict, district, and provincial levels, and culminating at the national level. However, this method faces several challenges, including limited planning capacity among human resources, insufficient meaningful community participation, and difficulties in ensuring the inclusion of diverse and vulnerable groups.[72]

In some cases, this process becomes more of a formality, with limited transparency and accountability at higher levels, as the central government ultimately decides what will be prioritised. The process is not necessarily participatory; it also involves technocratic and political considerations. The budget must be discussed with legislative members to secure

approval from both the executive and legislative branches, which typically involves negotiations about what should be included, among other details.

Limited mechanisms available to distribute resources and ensure regional planning and coordinating capacity. Local governments are heavily dependent on the mechanism of central transfers to local levels. One such mechanism is the balancing fund (*dana perimbangan*), which consists of DBH[1], DAU[2], and DAK[3]. These schemes enable the central government to distribute funds to all provinces, and districts/cities based on predetermined criteria, including regional disparities, fiscal capacity, and more. However, these schemes have been criticised for their inability to distribute funds evenly across all provinces and districts/cities.[73] As an example, many regions in Indonesia remain underdeveloped, and the development gap continues to widen, along with regional capacities for planning and implementation.

4.5.4. Limited Monitoring and Evaluation Tools

Existing monitoring and evaluation tools fail to reflect the real situation and needs. The primary performance indicator used at all government levels is budget absorption. Consequently, our financing system has been structured around this metric. This focus creates challenges for implementing performance-based budgeting and supervision, further hindering the alignment and coordination between subnational to national levels. Performance is mainly assessed through the Minimum Standard of Services (MSS), a set of indicators provided by the Ministry of Home Affairs to monitor the performance of provincial and district governments across various topics. In the health sector, district and city governments are required to meet certain standards across 12 types of services. However, these indicators have been criticised for not accurately reflecting the real situation or performance, and for failing to measure what actually needs to be done. They are inadequate for effectively monitoring and determining performance. There is also misalignment between provincial and district targets. For example, PHOs are only required to meet two indicators, while DHOs must meet 12 indicators of the minimum standard of services. If they fail to meet

[1] Dana Bagi Hasil (DBH), also known as Revenue Sharing Fund, is a fiscal mechanism in Indonesia where the central government shares a portion of its revenue with regional or local governments. The revenue typically comes from natural resources, taxes, and other sources. The amount a region receives is usually calculated based on a formula that considers factors such as the region's contribution to the revenue source, the level of local development, and other criteria.

[2] Dana Alokasi Umum (DAU), or the General Allocation Fund, is a financial transfer from the central government to regional or local governments in Indonesia, aiming to reduce fiscal disparities among regions to provide basic public services to their populations. DAU is distributed based on a formula that considers fiscal gap, basic allocation, poverty rates, geographical conditions, and others

[3] Dana Alokasi Khusus (DAK), or the Special Allocation Fund, is a type of financial transfer allocated for funding particular projects or programs that are considered national priorities. DAK is determined by several criteria including regional needs and disparities, geographical conditions, proposals from regional governments, performance and capacity, and others.

these standards, the consequences are guidance and the imposition of disincentives, which in practice are also less than optimal. While more stringent sanctions are applied to regional heads who completely fail to implement the SPM, such as withholding financial entitlements for 3-6 months.[74] In practice, the mechanism for granting incentives and disincentives remains suboptimal due to the limited capacity of local government officials to plan and deliver programmes, and the inadequacy of the indicators used to accurately reflect the diverse situations within local communities.

Moreover, the limited capacity to provide oversight and control in measuring effectiveness and impact exacerbates the situation. The UKP4 report found that, in many cases, budget targets were selected without focusing on activities with high impact, and rigid procedures left little room for contingency plans if implementation did not proceed as planned.

4.5.5. Poor Institutional Capacity

The institutional capacity of the health sector is a cornerstone for its development and effective functioning. This capacity spans coordination across various sectors, health systems readiness, human resource development, and the implementation of health diplomacy. However, current challenges in these areas highlight significant gaps, underscoring the need for comprehensive reforms and strategic initiatives to enhance governance and service delivery within the health sector.

A fundamental deficiency lies in the capacity to generate participative collaboration, notably the underutilisation of Bapedda's functions, indicating a lack of institutional capacity for effective coordination. This deficiency prevents different sectors from working together harmoniously, leading to disjointed efforts and missed opportunities in health sector development. The readiness of the health system is further compromised by gaps in public-private and government-community partnerships, reflecting an institutional incapacity to effectively leverage diverse resources and expertise.

The misalignment between the health and education sectors in producing healthcare workers exemplifies a lack of coordinated strategy and understanding between these crucial sectors, resulting in inefficiencies in developing a skilled healthcare workforce. Similarly, the limited capacity and skills in implementing health diplomacy and global health cooperation highlight the need for institutional strengthening to enable effective international collaboration and engagement in global health initiatives.

Another glaring gap is the absence of a dedicated digital health agency, which is pivotal for fostering innovation and agility in health systems strengthening. The establishment of such an agency, ideally in tandem with a cross-sectoral digital transformation entity, would greatly enhance independent operation and agility in innovation.

The government's efforts, such as the Stunting Acceleration Roadmap with dedicated committees and funding, illustrate the necessity of clear leadership capacity and coordination. Specific budget allocation for these efforts underscores the importance of focused and strategic institutional responses. However, limited funding in research, as indicated by a low gross domestic expenditure on research and development (GERD) per GDP, inadequate infrastructure, and researchers' capacity, pose significant challenges. The need for prioritising research topics and fields, and translating health research into practice, is hindered by separate work environments among stakeholders.

Indonesia's decentralised system introduced complications in decision-making and implementation at the subnational level. This was particularly evident during the pandemic. Inadequate socialisation, communication, and varying capacities across different levels of government, along with differing local needs, highlight systemic capacity insufficiency in the health sector. Furthermore, decentralisation brings additional challenges for central line agencies in terms of accountability and monitoring, which are crucial for the successful implementation of result-oriented budgeting. This decentralised structure often leads to fragmented oversight and inconsistent implementation of health policies and programs.

Moreover, the institutional arrangement for purchasing health services, particularly in the era of the JKN (National Health Insurance), illustrates this fragmentation. BPJS-Kesehatan, primarily responsible for purchasing health services, operates alongside similar functions carried out by the Ministry of Health and other agencies, creating redundancy and confusion in service delivery.

Chapter 5:
Designing Plausible Scenarios

As discussed in the main book of this White Paper series, governance represents one axis by which health sector development depends upon (see Figure 13). The analysis and refinement of expert input and scenario development exercises highlight governance as a crucial factor influencing the development of the health sector. While the effectiveness of health system governance varies, it is a key indicator of the success of reforms. In scenarios where governance capabilities are moderately strong, there is sufficient influence to shift the focus from wealth accumulation to more value-based principles. Conversely, weak governance lacks the necessary drive to emphasise value-based principles. Given that governance is typically state or government-focused, its effectiveness relies heavily on leadership commitment. A major obstacle in health reform is the need to match reform promises with strong governance, including proficient planning, implementation, monitoring, evaluation, and impact assessments.

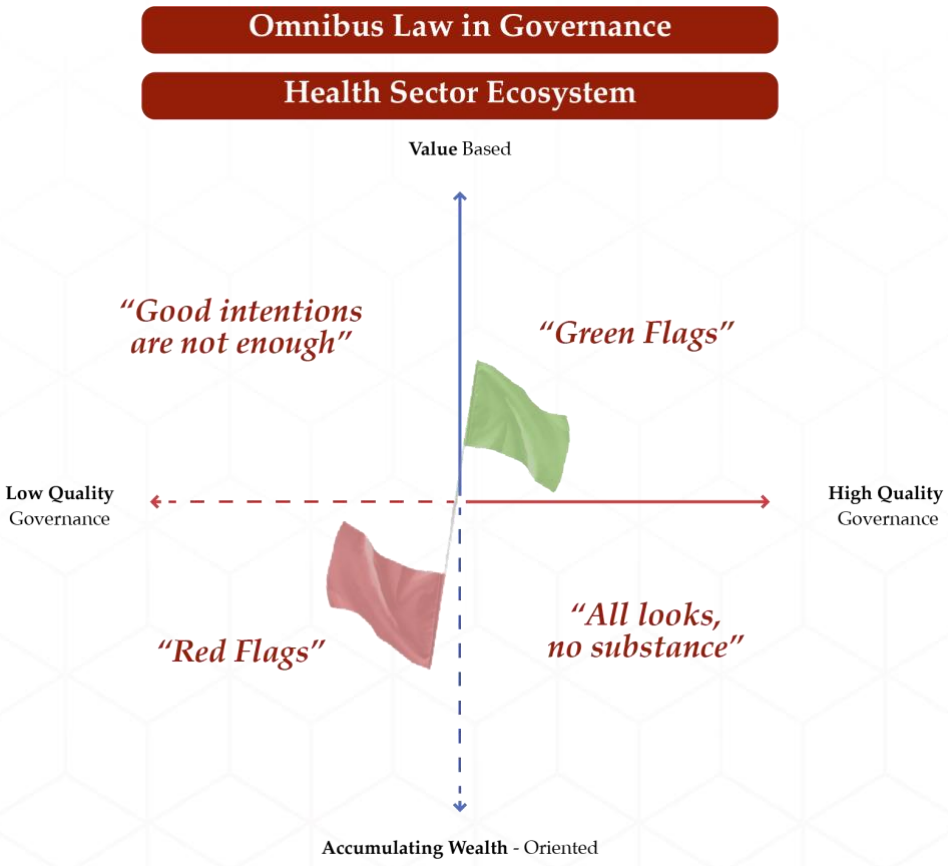


Figure 13. Proposed Plausible Scenarios

Meanwhile, the other axis represents a spectrum in which the health sector is oriented. The value axis on the graph delineates the orientation spectrum of the health sector. The upper end symbolises the intrinsic values of the health sector, prioritising health outcomes and social welfare. In contrast, the lower end denotes a shift towards treating health as an economic commodity, with policies that favour the health sector's commercialization and privatisation, ultimately intensifying health inequities. Amidst this, the Omnibus Law has been consistently used in the past two years to craft a national regulatory framework, raising questions about its efficacy in resolving sectoral fragmentation and fostering integration among different development sectors. The axis suggests that the health sector's future could be influenced significantly by the way the Omnibus Law shapes governance, potentially unifying diverse development areas.

Table 3. The Four Plausible Scenarios for Health Governance

Scenario 1 **Good Intentions are not Enough** 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	**Scenario 2** **Green Flags** Solid and long-term regulatory framework, all development actors engaged meaningfully, implementing the merit system to arrange consequence-based governance management
Scenario 4 **Red Flags** 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	**Scenario 3** **All Looks, No Substance** Awareness and bureaucracy change is still reactive without a long-term systemic approach, the change stalls halfway before transformation actually takes place

Scenario 1. ***Good Intentions are not Enough***

In this scenario, the country finds itself in a state of stagnation, with noble intentions failing to translate into effective action. The health sector's development hovers indecisively between poor governance and noble, value-based ideals, perpetually embroiled in a struggle to decide whether radical health system reform or economic enhancement should steer the country's salvation. This deadlock was evident during the COVID-19 pandemic, when inconsistent

policies across ministries and sub-national levels became apparent. Bureaucratic efficiency suffered, further eroded by the cyclic political changes every five years. Post-pandemic efforts seemed to lose momentum and public discussion, labelled as half-hearted attempts that did not genuinely contribute to saving lives. Budget adjustments within technical ministries did not result in a meaningful overhaul of the health budget, leaving a transformation of primary health services without clear direction. Not just during the pandemic, the lack of governance process has only acknowledged the surface of the problem, rather than exploring and resolving its causes. Policymakers will be very prone to not understanding public feelings, making decisions that are viewed negatively as seen in the practice of implementing various laws that ignore meaningful public participation and engagement. Despite showing a less than ideal process, in this scenario there remains a public belief in the potential for a revitalised health sector. Nonetheless, under the prevailing "*status quo*", influential policies outside the health sector are shaped by short-term financial calculations, prioritising immediate economic gains over long-term health investments. Furthermore, the strengthening of government institutions is also an area of expectation to ensure the functioning of checks and balances.

Scenario 2. ***Green Flags***

In the most optimistic scenario for Indonesia's health sector development, structural reforms are envisioned to create an ideal health governance ecosystem where all elements are aligned, development actors are engaged, and interactions between health and other sectors are maximised. In this scenario, the change of government administration that took place in 2024 bringing positive changes in governance, it is successfully learning from the pandemic and previous administration to implement an inclusive policy approach in the health sector. This scenario is characterised by a shift in investment views, seeing health as a long-term investment and introducing a merit-based system in governance to manage the delicate balance between political and technocratic elements of national health policy. The success of this scenario hinges on a robust regulatory framework, with reforms focusing on strengthening primary health services to create a patient-centric health system.

The realisation of this ideal scenario depends on active public participation in health system reform, demanding better services, and overseeing system performance. Sustained involvement in policy making and development, particularly through meaningful engagement of civil society and communities, is crucial. This engagement is expected to foster policies that are attuned to the public's needs. The question posed is whether Indonesia can achieve this "Green Flags" scenario, a vision of the desired world.

Scenario 3. ***All Looks, No Substance***

In the third scenario, reform efforts are depicted as tepid and inadequate, teetering between maintaining the status quo and attempting decisive, though difficult, actions. Despite appearances of progress influenced by public pressure, the absence of a strategic, long-term approach causes these reforms to falter before true transformation occurs. This scenario is marked by a failure to deliver substantial outcomes, with policy implementation confined to the bureaucratic sphere, failing to engage the wider public or achieve broader support. Despite superficial gestures towards inclusive health policies, the reality is dominated by wealth accumulation, commercialization, and privatisation of health services. The public voices and participation mechanisms will only be formal completions that are never considered for their quality. Ultimately, the principle of 'health in all policies' remains just a catchphrase, never fully realised in practice.

Scenario 4. ***Red Flags***

The fourth scenario paints a bleak picture where poor governance and a strong inclination towards wealth generation through the health sector prevail. Policymakers are swayed by economic and political interests, steering them towards maximising profits by privatising and commercialising healthcare services and industries. This results in a health system focused on profit-making, with an upsurge in hospitals designed for systematic financial extraction and private clinics boosting local government revenues. Despite a trend towards digitising healthcare, this move isn't supported by efforts to improve health and digital literacy among communities with limited technological access. Consequently, vulnerable and nearly poor populations are marginalised or excluded from the health system altogether, leading to reduced access to affordable, quality health services and a national regression in healthcare and public health outcomes, rendering health a luxury for many.

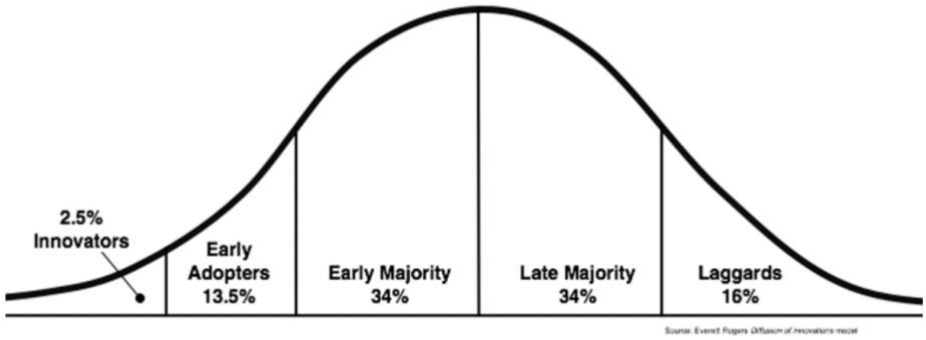
The lack of integration of health in cross-sectoral policies at the national and local levels also risks non-adaptive governance. The health issue, which becomes an intersectional dimension with climate and development issues in general, will remain a clichéd. With the big picture that health only belongs to a few people, the level of public trust in the government system will also be limited. The medium of participation will only be filled by supportive groups, while the gap in various aspects is expanding to marginalised groups.

Chapter 6:
Institutional Reframing, Restructuring, and Repositioning

One common denominator when we discuss governance is the beneficiaries of impact: the people. Policy makers, health sector not excluded, often overlook this people factor, and end up designing policies which do not account for the diversity of people's needs, their behaviours towards change itself and their adaptation and acceptance to implementing change. People in this particular context in governance for health, also include people who are exercising their role as policy makers. It is this combination of role plays that make policy making a unique skill which should have produced policies that speak to people's or general public's needs.

This variety or spectrum of people's acceptance towards change is explained in the diffusion of innovation theory.[75] This theory states that there are different stages where people adopt innovation or change or new ideas. Appealing to the different categories of people requires understanding of each of the types and as such, calls for different approaches to actions.

Figure 14 illustrates these different stages and the approximate percentage of people who are innovators, early adopters, early majority, late majority and laggards.



Source: http://blog.leanmonitor.com/early-adopters-allies-launching-product/

Figure 14. Different Types of Adopters of Innovation (Source: adapted from E. M. Rogers[75], Wayne W. Lamorte[76])

Although diffusion of innovation theory does not originate from the health sector and it was not adopted specifically to highlight adoption of innovation in the health sector; this theory is one that is commonly used in combination with the practice of organisational change management. The underlying reason for this adaptation and combination is that organisations that are expected to produce policies for the people, have to understand how people think.

People within the policy-making organisations and people outside or who are beneficiaries of policies.

The terms reframing, restructuring and repositioning are widely used in organisational change management exercises, by scholars and practitioners. The authors use the frames of thinking from practitioners, Gouilart and Kelly from Gemini Consulting[77] and Michael Porter from Harvard University. This chapter proposes combining their different approaches for more effective and efficient organisations. Whether it is in a private or business setting or whether it is in a government or bureaucratic setting, both require a well-functioning organisation with highly capable individuals.

This chapter argues how understanding of people's behaviour towards change and change management theories can be adapted into a bureaucratic setting to ensure inclusion of multiple development actors and ultimately, achievement of institutional reform. The authors would like to underline the importance of leadership, in political, managerial and technical elements, as the one that sealed the deal for successful achievement of good governance.

6.1. Trend in Governance: Siloed Approach

Of all the health programs currently being implemented, the majority of those are implemented by a single institution and/or ministry. It is important to state here that efforts to conduct collaborative programs that cut across different institutions and ministries are in a volatile trend. Sustainability and successful implementations of these programs remain to be tested throughout systems and administrations. Gaps in ensuring continuity in intersectoral and inter organisation programs often originate from failure to maintain across institutions tracing of problems. Difficulty to synchronise policies and coordinate program implementation to achieve specified targets remain a palpable barrier which hinder progress.

Fragmentation happens within and between ministries/institutions. An example that can be given is on the issue of stunting. Previously, nutrition was its own directorate under the Ministry of Health. The issue of stunting, a component of nutrition, was set as a national priority by the President's instruction.[78] Therefore the strategic leadership was placed at the Vice President Office to enable cross coordination between coordinating ministries. This is due to scientific evidence and reasoning which positioned stunting as a national problem beyond only health issues.

However, stunting was then moved to the National Population and Family Planning Agency (BKKBN) in the last four years. This move was done despite the fact that BKKBN has its own strategic mandate on addressing demographic/population challenges which then feed into intersectionality in health, such as adolescent health, maternal mortality rates (MMR), and sexual and reproductive health. As a consequence of this move, nutrition as a barrier to

achieving health targets was reduced to only stunting. While progress on stunting is on the right track, other burdens in nutrition such as underweight and overweight are simplified as health challenges to be solved through clinical interventions - losing their interconnection and intersection lens to public health problems, requiring public health intervention. Meanwhile progress in MMR adolescent health and its relation with access to sexual and reproductive health have plateaued. The SRMNCAH+N book in this White Paper series provides detailed analysis of challenges in this theme.

Siloed approach is not only isolated in the national level institutions. It extends to sub-national level as well, since policies are translated into programs and actions at sub-national level. The GERMAS program can be made as a case on point. The intent to insert health as key priorities in other sectors is a commendable effort. However, full application of the Health in All Policies principles calls for seamless coordination between state institutions and for each of those institutions to engage other stakeholders.

Detailed analysis of HiAP can be found in Chapter 5 of the main book in this White Paper series.

6.2 Challenges in Institutional Reform and Restructuring

Harvard Business School argued there are two types of organisational changes, as presented in figure 15.[79] The first one is adaptive changes and the second is transformational changes. Adaptive changes require only incremental changes, conducted over time where organisations can evolve and adapt over time. Transformational changes on the other hand, are larger in scale and scope and involve major shifts in structure, mission, strategy and process.

Figure 15. Types of Organisational Change[79]

For the purpose of this study, the authors proposed to consider the following points as key challenges of public sector reform: (i). mandate and role of the state institutions; (ii). unbundling of functions within each state institution; (iii). merging of duplicative functions between state institutions; and (iv). administration's appetite or tolerance for the intended and unintended consequences of reform.

Considering the situations above, it must first be guaranteed that the government can continue to run smoothly while transition is in process. This must take into account the duration by which a comprehensive change might exceed the government's budget cycle of one year. Hence, a separation between the restructuring's work plan and budget plan, while ensuring the budget plan for the coming years remains aligned with the work plans and their targets. Required laws and/or regulations must be put in place as one of the regulatory consequences for this decision. Institutional restructuring without understanding and in-depth analysis about the transition process and its operationalization may result in further ineffectiveness of these institutions.

Studies on organisation unbundling of functions have been conducted numerous times by different experts in the field. Michael Porter argued that private as well as public institutions can employ similar actions when they choose to restructure. However, the objective of restructuring and reform must be set to increase strategic value and obtain competitive advantage of organisations.[25] Seeing organisations as a collection of functions, unbundling those functions and moving those functions into other location within or external of the organisation are the key steps that must be done in this reform

Reform and restructuring do not always mean dissolving or creating new organisations. While further and more detailed analysis must be conducted should public sector reform become a priority of the incoming administration; conceptual understanding of the policy options can be owned now. Duplications of functions or categorisation of identical functions in multiple public sector organisations happen as manifestations of system failure and siloed approach. Therefore, appropriate reorientation of approach from siloed to a comprehensive one is taken as a fundamental consideration.

6.3. Why Restructure?

This study has generated findings to be mapped in the structural challenges as described in the main book of this White Paper series. These challenges were then structured into proposed priorities, targets and health development indicators. Achievement of priorities, targets and This development indicator assumes the existence of adequate institutional arrangements to respond to those structural challenges. It is important to note that various structural challenges such as governance, system, people and financing will not be possible to resolve sectorally or centralised at one particular level of government. A new institutional governance approach is needed so an enabling environment of policies can be generated. As detailed in the main book of this White Paper series, health is interrelated with other sectors. Full realisation and comprehension of this concept will ensure achievement of priorities, targets and indicators.

A study conducted by the Brookings Institution stated there are four underlying reasons why public sector reform is done. The reasons are: enhancement of transparency, improvement of leadership, boosting public servants confidence and performance measurement.[80] However, it must be established that prior to conducting any public institution reform and/or restructure, there needs to be a comprehensive understanding of its dynamics.

In the case of Indonesia where health is decentralised, it is worth noting that institutional reform and restructure at the national level of government will have consequences at their corresponding sub national levels counterpart institutions. Therefore, institutional arrangements and a solid line of thinking in the design of national level institutions are very important to ensure the achievement of national priorities and delivery of actions at the sub-national level.

The proposed institutional reorganisation and restructuring is carried out using a deductive process, after observing and conducting in depth studies regarding the results/recommendations resulting from the foresight process. In the view of the research team, and based on input from experts in various fields, institutional restructuring needs to be carried out systematically and in parallel to bureaucratic reform. This means not only

changes in organisational forms but also includes reform of the selection and recruitment system for Ministers, Heads of ministerial level agencies, Deputy Ministers, Director Generals or Deputies, up to Echelon 1 State Officials. It is hoped that this will be one of the main keys in changing the mindsets of bureaucracy, from a fragmented and politically oriented approach – to an approach based on results and performance achievements.

Furthermore, institutional restructuring at the central level is expected to bring changes on a wider scale, not only to improve the performance of Ministries/Institutions and their leaders. Successful institutional reform will bring clarity to national identity as reflected in better public civility. It will also bring coherence to Indonesia's position and direction in global health diplomacy, including guiding external aid to correspond with the priority in the people-centred health system. Detailed analysis on health system reform can be found in the Health System book of this White Paper series.

6.4. Budget and Institutions Capacity as a Challenge for Restructuring

Compared with the education sector's budget of 20% and positioned as part of the constitution, the health sector is still very low at 5.6%.[81] In addition to funding for the Ministry of Health programs, this allocation covers among others, JKN payment for the poor and near poor, budget for the Food and Drug National Body (BPOM) and budget for the National Population and Family Planning Body (BKKBN).

The current health system reform has to be done amid financial constraints, in the aftermath of the pandemic. The Government of Indonesia submitted an application for a concessional loan from the World Bank in early 2023.[82] This request was approved in December 2023, securing a loan valued at US$ 4,3 billion (EUR 3,732 billion).[83] It is co-financed with Asian Infrastructure Investment Bank (AIIB), Asian Development Bank, and Islamic Development Bank, with the details described in table 6.[84-,85]

Indonesia's recent loan from the World Bank is expected to significantly raise the proportion of External Health Expenditure (EXT) in the country's total Current Health Expenditure (CHE). In 2021, EXT accounted for 2% of CHE, a notable increase from the 0.5% (on average) baseline recorded between 2015 and 2020.[86] This rise was largely driven by the use of foreign aid to enhance health surveillance and accelerate the COVID-19 vaccination rollout.[87]

Table 4. ADB, AIIB, and IDB Loans for Modernization of the Health System in Indonesia[84]

Project Component	Project Cost (EUR million)	Financing (EUR million)			
		AIIB	WB	IsDB (parallel)	ADB
Component A SOPHI (PHC)	1,488	487	667	0	334
Component B SIHREN (Hospitals)	1,691	449	449	793	0
Component C InPULS (Lab)	552	0	276	0	276
Grand Total	**3,731**	**936**	**1,392**	**793**	**610**

As the utilisation on EXT (including foreign aid and concessional loans) continues to grow, it is essential that these funds be managed with accountability and caution to ensure they are effectively utilised. Robust accountability mechanisms will help ensure that these resources are directed towards strengthening the national health system and improving health governance.

An added layer of complexity faced by the health sector is the deletion of mandatory spending as enacted in the Health Law no 17/2023; which puts overall state's allocation for health in a volatile situation. There is no guarantee that the following years' budget for health sector development will increase or even remain the same, while health targets are still falling behind. This condition can be regarded as a barrier to the sector's reform and restructuring, since it adds further pressure to a sector that is expected to reform and perform at the same time.

Distribution of state budget through several mechanisms for example DAU and DAK needs to be safeguarded in its implementation. As reform is made, it is critical to ensure alignment not only in programmatic areas but also in how to ensure those programs remain well-resourced as restructuring takes place. Entering the next leadership with a new government by the last quarter of 2024, governance for health continues to be challenged with resolving the issue of balancing of resources for health sector development.

Chapter 7:
Delivering Good Governance for Health: Renew, Rebuild, Reform

This chapter offers both conceptual and operational recommendations on how to put the most ideal scenario into realisation.

7.1. The Platform of Approach: National Health Assembly

This book proposes that in addition to creating new institutions or agencies at different levels of government, there needs to be a set up of new approaches as well, to function as the vehicle for delivery. Figure 20 on the proposed health governance structure, highlighted the merging of the National Health Assembly (NHA) into the existing national mechanism, called Musrenbang. This NHA is going to be a multi stakeholder platform with a loop or circular approach where different entities are at an equal footing and opportunity to provide checks and balances.

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

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 (see Figure 16). 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 institution and other development actors including civil society, academia and private sector are meaningfully engaged and involved. The National Health Assembly (NHA) will be the landing spot by which all inputs are accommodated, processed and synthesised into a set of key priorities or agenda for health development. This set of priorities ensures alignment between three key ministries in health sector development (Ministry of Health, the National Planning Agency/*Bappenas*, and the Ministry of Finance). As for alignment of content, the existence of NHA ensures that key priorities agreed in this assembly are aligned with the

National Medium Term Plan issued by Bappenas every five years. On the technical ministry side, this process ensures two key points are achieved. 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 to be 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. Bringing the global context to national policy making dynamics is of utmost importance, especially in light of foreign aid. The concept of donor driven development or aid dependency is widely understood by development practitioners as a long standing challenge.[87] In this context, development partners often drive national priority setting to areas that do not correspond to national context when countries do not have clear direction of their global health priorities.[87]

The Global Health book of this White Paper series discussed this topic in more detail.

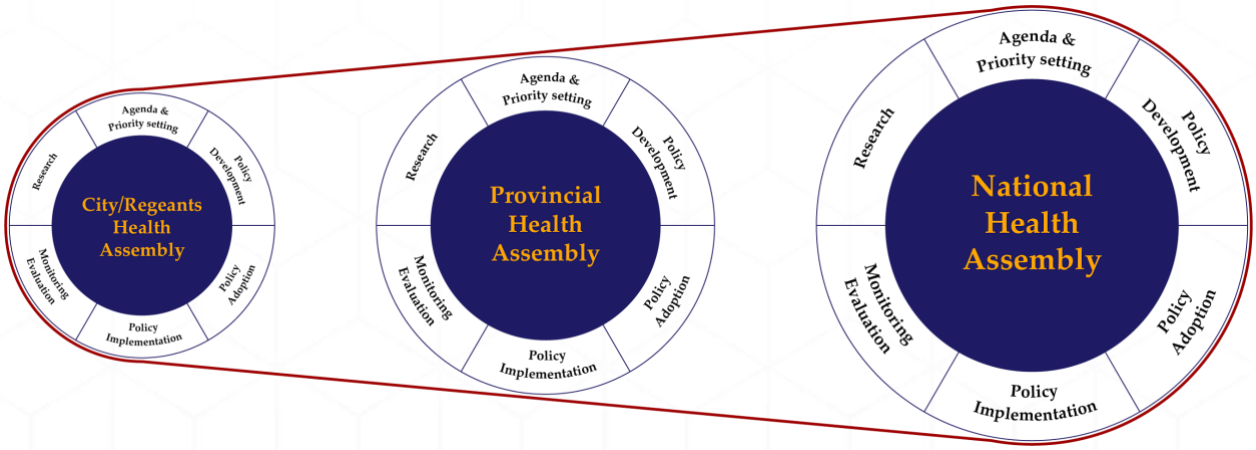


Figure 16. Governance for Health Framework: A Looping Approach for Inclusion and Coherence

Box 3. Lessons from Thailand: The Concept of National Health Assembly

The National Health Assembly (NHA) concept of the triangle consists of: Knowledge sector, People's sector, and Government sector to represent each other and create synergy through the constant interaction between the three groups. NHA governance mandated the formulation of several bodies, including the National Health Commission Office (NHCO). Thus, the NHA meant to be an instrument to put in practice the public participation in policy formulation and implementation. NHA resolutions are passed on consensus and are not binding for policy-makers and service providers. Rather, the NHA aims to achieve influence and compliance through the legitimacy its broad stakeholder base lends to its resolutions.

After several years of implementation, NHA shows some lessons of result such as bringing a wide and inclusive range of stakeholder representation, creating meaningful engagement in the policy-making process, and becoming a key vehicle for bringing strong evidence into policy discussion.[88] It emphasises how countries can strengthen health system governance to ensure accessible, equitable, and affordable health care. Key issues include transparent policy-making, accountability, and stakeholder participation in decision-making processes, aiming to achieve the Sustainable Development Goals (SDGs), particularly SDG 3.8, which focuses on UHC and financial protection.

Some of enabling factors of success highlighted from the practices of NHA in Thailand, including:[88]

1. **High-level political support**: The NHA is embedded in Thailand's National Health Act, which ensures its long-term sustainability and political position in health governance.
2. **Capacity building to Meaningful Civic Engagement**: The NHCO's focus on building the skills and knowledge of civil society and other stakeholders has contributed to the increasing maturity and quality of discussions at the NHA.
3. **Expanding Partnerships and Funding Opportunity**: A strong cooperation between stakeholders within NHA widens the opportunity of continuous funding and partnership. For example, the Thai Health Promotion Fund (which is supported by taxes on tobacco and alcohol), has strengthened civil society's ability to engage in the NHA process.
4. **Institutionalisation of the NHA process**: The integration of the NHA into Thailand's broader health system reform efforts has helped ensure its relevance and continuity across different political administrations

Will it be possible to implement the NHA in Indonesia?

The position of the National Health Assembly with a concept similar to that of Thailand can be illustrated through the two charts below. The actors within the NHA can represent the three axes of development actors, including representatives from the executive at the central and local levels, as well as representatives of non-state actors. The interaction among actors through their representation processes will maintain the quality of decision-making deliberation while also ensuring the prioritization of the health sector in development planning.

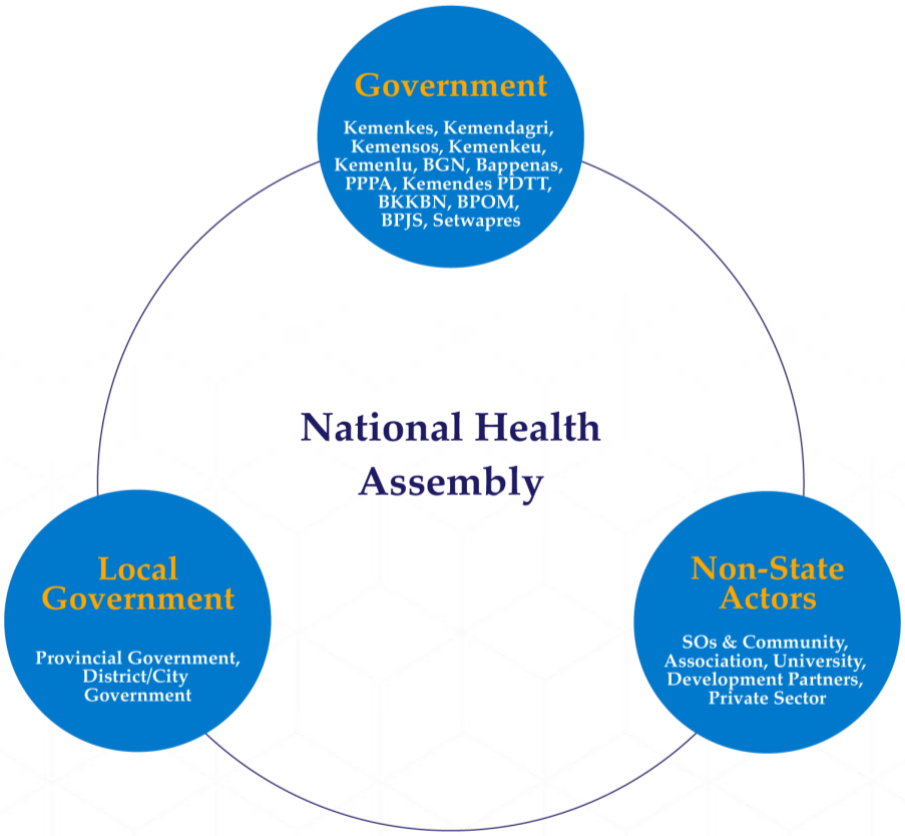


Figure 17. Proposed Structure of the National Health Assembly

As shown in Figure 18, the presence of the NHA in the flow and mechanism of development planning can align with the Musrenbang process and stand at the intersection of central-local interaction, with the aim of ensuring synchronisation between central and regional governments. The NHA does not replace the role of Musrenbang or the existing deliberation forums. Instead, the NHA will serve as a platform to maintain alignment of priorities between the needs and health development programs to be implemented.

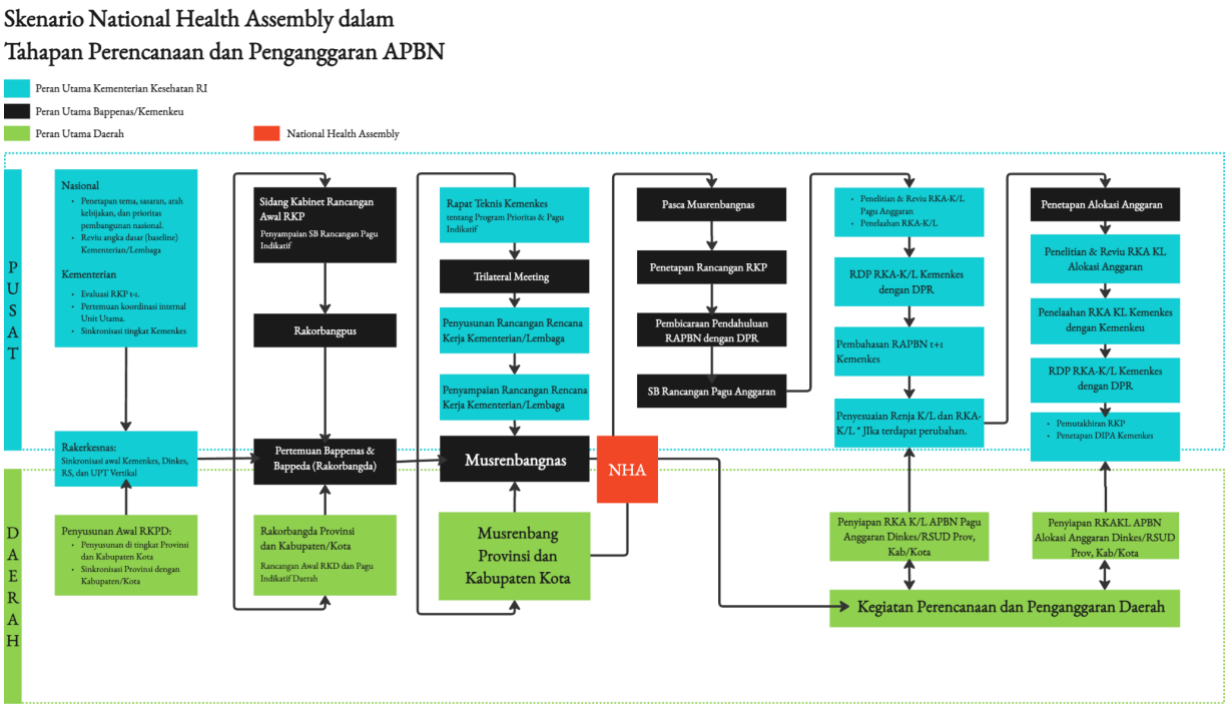


Figure 18. Scenario of NHA Implementation in Indonesia

Box 4. Learning from Climate Action:
Establishment of NDA for Multi-stakeholder Initiatives Hub

National Designated Authorities (NDA) in Indonesia are mandated entities to be the liaison between the government and development partners in the implementation and funding of projects responding to the climate crisis. Badan Kebijakan Fiskal (BKF), Ministry of Finance of the Republic of Indonesia is appointed as the Secretariat of NDA in Indonesia as per the Minister of Finance Decree No. 756/KMK.020/2017.[89]

The establishment of the NDA in Indonesia was driven by a response to the need of developing countries to mitigate the impacts of the climate crisis. In 2010, through the Copenhagen Accord, an international agreement was reached to establish the Green Climate Fund (GCF), a funding mechanism focused on assisting developing countries in strengthening initiatives to adapt to and mitigate the climate crisis.[89]

NDA plays a central role in ensuring that funded initiatives or projects are aligned with national priorities and meet sustainable development. The NDA also supports transparency and accountability in the governance of project financing, including strengthening the technical and institutional capacity of government and non-government entities.

The NDA becomes a strategic modality to strengthen Indonesia's role in climate crisis adaptation and mitigation. With a wider range of funding opportunities and a more strategic coordination function, the NDA can become a hub and catalyst for climate-responsive innovations.[89]

Institutional capacity challenges require strengthening cross-sector coordination, enhancing health system readiness through partnerships, aligning workforce development strategies, strategic leadership, focused budget allocation, prioritising research, effective decentralisation management, and improved accountability. These steps are essential for a resilient and responsive health sector.

Addressing the fragmentation in Indonesia's health governance requires a strategic shift towards greater coordination and integration among various health organisations and government agencies. This shift should aim to eliminate redundant operations, align policies and strategies across agencies, and ensure a continuous and coherent approach to health programs, especially for critical areas like NCDs and adolescent health. Establishing a more collaborative and unified health governance structure is vital for efficient resource utilisation, effective implementation.

National-Subnational Dynamics

The restructuring of the institutional framework to regulate working relationships and synchronise the implementation of central and regional government policies is a major task that must be addressed to ensure that development programs in the upcoming administration are successful and beneficial to the public.

In addition to Musrenbang, another cross-sector policy forum that needs to be optimised is the National Health Work Meeting (Rakerkesnas).[90] The Rakerkesnas often operates in a one-way manner, where regional governments primarily listen to the directives of the central government. As a strategic platform, the Rakerkesnas should provide a space for two-way interaction, involving more meaningful engagement of the government through problem-solving sessions and sharing of good practices by regional governments. The Rakerkesnas 2024 serves as a good benchmark, showing how regional governments were given space and opportunity to present their problems and best practices.[90]

The authors envision Rakerkesnas as an annual national meeting or assembly to enhance and strengthen national and sub-national dynamics. This meeting should aim to achieve concrete national consensus and resolution while in parallel strengthening multi sectors and multi actors commitment on health. However, the involvement of regional governments would be more effective if the Rakerkesnas forum offered more intensive, specific thematic discussion sessions on regional development issues, led by local governments. In this context, BKPK (Health Policy and Development Agency) could also optimise its role in facilitating the mapping of regional issues, which could be categorised into specific clusters. The resulting products could serve as the foundation for policy as well as a review of the evaluation of the Rakerkesnas implementation in the following year.

7.2 Organisation Reframing and Repositioning: Governance for Health for the Next Ten Years

Recent development of institutionalising campaign promise into national development priorities began with the establishment of the National Nutrition Agency and the appointment of the Head of this national body. Based on the information available in the public space, details of this new national body are described in the below box.

Box 5. The Establishment of the National Nutrition Agency: Starting Point of the Free Nutritious Meals Program

Presidential and Vice Presidential candidates Prabowo Subianto and Gibran Rakabuming Raka championed a program to provide free nutritious meals for all students as their campaign highlight. Now that they have been officially elected, preparations to fulfil this campaign promise through a national program have begun. A National Budget (APBN) of IDR 71 trillion has been allocated for the next fiscal year, confirming the government's commitment to this initiative.[91]

The inauguration of the Head of the National Nutrition Agency (BGN) by the President on August 19, 2024, marked the initial step in the implementation of this program. Previously, on August 15, 2024, the National Nutrition Agency was established through Presidential Regulation (Perpres) No. 83 of 2024. This agency has a broad role, ranging from coordination to the implementation of technical policies and supervision across various sectors, including governance, provision, promotion, and monitoring.[19]

The main target of BGN is to ensure the fulfilment of nutritional needs for (i) students in early childhood education (PAUD), primary, secondary, and special education, (ii) toddlers, and (iii) pregnant and breastfeeding mothers. Responsibilities related to nutritional vulnerability, which were previously handled by the Deputy for Food and Nutrition Vulnerability at the National Food Agency (BPN), have now been transferred to BGN. BGN's organisational structure consists of a Steering Council (chair, vice-chair, and members) and an Executive Body (head, vice-head, main secretariat, and deputies).[19] During the first five years, the President can directly appoint senior officials to BGN. The President also has the authority to assign additional functions to BGN in the future.

Although it has already begun to operate, BGN's governance mechanism does not explicitly mention the involvement of development actors, including meaningful and sustainable engagement with civil society. The existence of a Steering Council composed of community figures and/or academics has not yet guaranteed meaningful public and civil society participation in BGN's governance.[19]

Regarding the budget, BGN's funding comes from the APBN and other lawful and non-binding sources in accordance with the prevailing laws and regulations.[19] Although the budget allocated to BGN is larger than that of the Ministry of Health and other health-related institutions, to date, no publicly accessible action plan exists to ensure that the free nutritious meals program aligns with other national health priorities.

As proposed throughout this White Paper series, the authors reiterate the critical interlinkage and interconnectedness of health with other development sectors. In this subchapter, the authors take the approach to design a set of key governance for health for reform while keeping the connection to strategic governance for development at the same time.

Public institutions need strengthened approach, alignment of functions that allow for inter-sector collaboration and if necessary, combined or merged with new institutions that will ensure robust and air-tight delivery of programs. From the results of the analysis, several elements that contributed to the governance are: (a) insufficient oversight and control of programs to concretely measure their effectiveness and impact in achieving overall health targets; (b) budget targets that do not focus on activities with high impact; and (c) implementation guidelines do not allow for externalities and variations - something inevitable when programs are implemented on the ground

7.2.1. Beyond Health Sector: Governing the Interlinkage between Health and Other Development Priorities

To improve health governance across sectors and actors, we propose the following structure as shown by Figure 19 below. Some key points of the proposed health governance structure:

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.[1]
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. Establishing a formal and sustained engagement mechanism for meaningful civil society participation, such as NHA (National Health Assembly), is imperative for improving governance. As civil society plays a key role in health development, their diverse involvement should be mandatory in various stages of the policy making process, while ensuring clear boundaries are maintained to prevent any conflicts of interest.

5. Stronger coordination between the Ministry of Health and other health agencies, such as BPJS, BKKBN, BPOM, CDC, and BGN, which may report directly to the President but should be coordinated under the Ministry of Health

Proposed Structure for Governance for Health

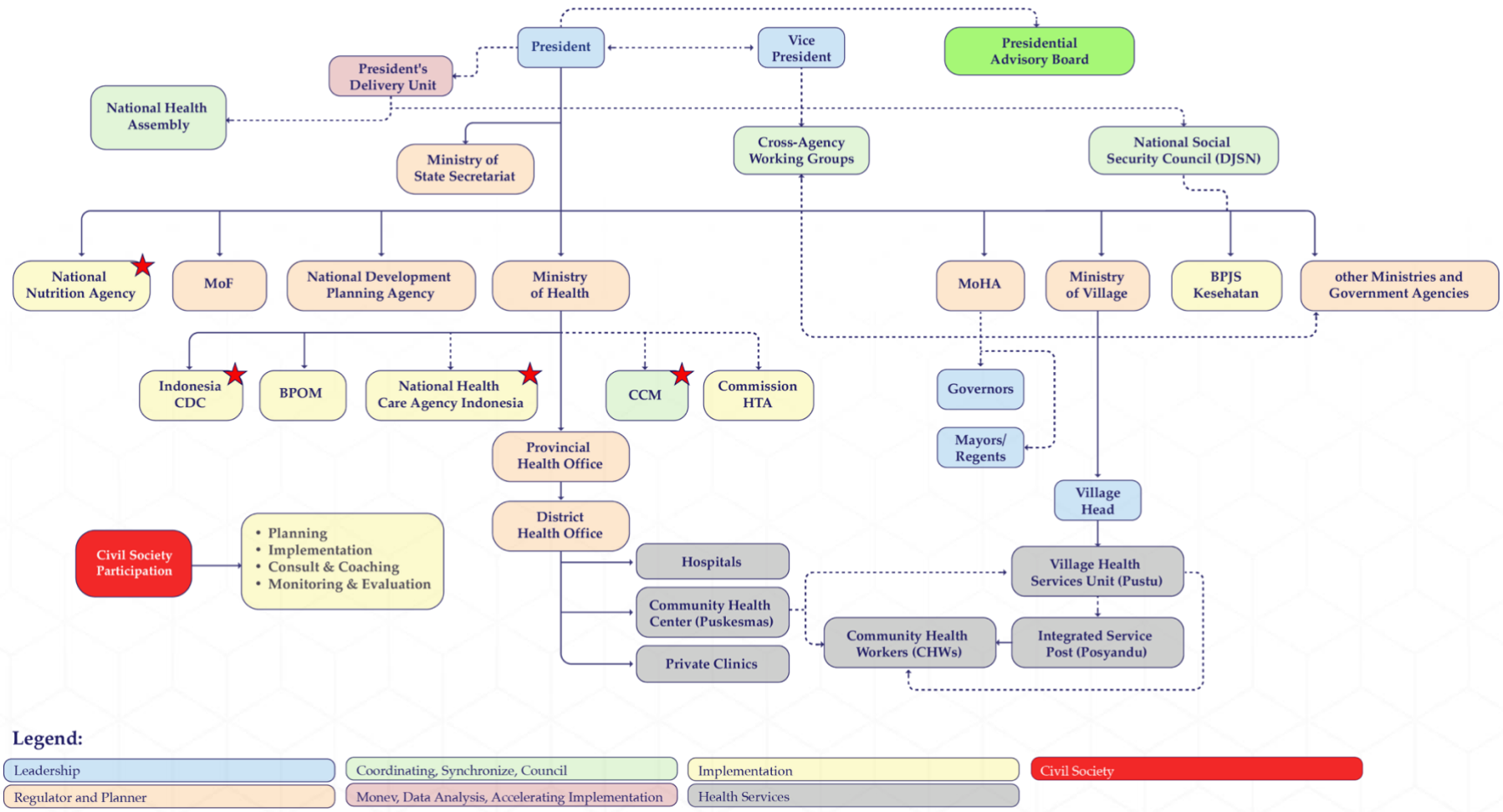


Figure 19. Proposed Health Governance Structure (source: author)

As in any newly elected government, this year's change in Indonesia comes with public speculation and anticipation, stemming from the declining trend in leadership and democracy as detailed in the Main Book of this White Paper series. The authors take note from information available in the public space of the promise or plan to build a professional cabinet, albeit large in size. Other news surrounding this issue is the possibility of up to twenty one additional new national bodies, to undertake different development issues.

Box 6. "*Zaken* Cabinet: Is it Possible?"

On September 9, 2024, the Legislative Body (Baleg) of the House of Representatives (DPR RI) and the Government concluded their deliberations on the proposed revision of Law 39/2009 (the ministries law). This revision is scheduled for approval at the *paripurna* session on September 13, 2024.[92] According to the Legislative Body DPR RI, the primary aim of this revision is to address global challenges and offer greater flexibility for the President-elect in forming a cabinet, establishing ministries, and determining the number of ministers.[93]

Several key changes in the revision of the Ministry of State Law include the following:

1. The removal of the explanation in Article 10 of Law No. 39/2009, which defined deputy ministers as career officials and not part of the cabinet;
2. Reformulate the Article 15 to eliminate the provision that limits the president to forming a maximum of 34 ministries;
3. Adding new article 6A that allows the establishment of ministries based on sub-affairs or specific governmental functions;
4. Adding new article 9A that grants the president an authority to modify the organisational structure of ministries according to the needs of government.

As the revision of the Ministries Law advances, discussions surrounding the increase in the number of ministers and the creation of new ministries and agencies are gaining traction. In addition to the BGN, which was established under Presidential Regulation 83/2024, other new bodies are expected to be formed, including the State Revenue Agency. Several leaders of the KIM+ coalition parties have suggested that the Prabowo-Gibran cabinet could include up to 44 ministers.[94] This cabinet is said to be composed of professionals rather than political operators. However, the Gerindra Party has clarified that no final decision has been made regarding the number of ministers in the forthcoming Prabowo-Gibran cabinet.[95]

The revision of the Ministries Law has raised concerns among civil society groups. Bivitri Susanti[92] argues that removing the limit on the number of ministries could promote the practice

of accommodative politics rather than fostering a technocratic or *zaken* cabinet. Additionally, the establishment of more ministries and agencies would require a significant portion of the national budget, which poses a challenge given the current fiscal constraints.[92]

The revision of the Ministries Law is expected to have a significant impact on governance, including in the area of health development. In response, CISDI has highlighted the need to prioritise prudence and good governance to ensure that the cabinet is formed with a strong focus on technocratic expertise and professionalism. Additionally, resource planning for the new cabinet structure must be allocatively efficient, taking into account fiscal constraints and the country's previously established strategic spending projections.

Specifically to the health sector, the authors identified key underlying reasons for reform as follows:

1. Existence of key public institutions at national level whose functions can be unbundled and transferred to other institutions.
2. Potential room for enhancement of delivery capacity, in alignment with the potential of linking institutions' title with added policy deliverables

These proposed items of institutional changes will require further change management studies to be conducted on all and each of the institutions involved.

Table 6 outlines specific proposals for institutional reform. The authors identified these national level institutions are the strategic levers to push for governance in health. However, further reframing of the directorates within the Ministry of Health is still required. In addition to the repositionings proposed below, this paper offers plausible organisational scenarios that might be applied towards the Ministry of Health as the leading technical organisation in national health sector development.

Table 5. Proposed Key Reframing and Repositioning of National-Level Organisations for Institutional Reform

Name of Ministry/ Institution/National Body	**Description of reform/change**	**Interlinkage with other ministries/institutions/national body**
National Nutrition Agency/*BGN*	• Conduct alignment of priorities between Free Nutritious School Meal Program and National Nutrition Health Targets	• MoH • Bappenas
National Body of Family Planning/ *BKKBN*	• Transfer demographic function to National Statistic Bureau	• MoH • BPS

	• Transfer mandate on equity, rights and sexual reproductive functions to State Ministry of Women Empowerment and Child Protection • Enhance the capacity of Family Planning function • Reorient *Kependudukan* or demographic mandate with family planning perspective	• Institute for Demographics, Universitas Indonesia
State Ministry of Women Empowerment and Child Protection	• Enhance gender, equity and rights functions to accommodate intersectionality perspective in health development • Enhance sexual reproductive rights issue with special focus on addressing adolescent/teen pregnancies, single parenting issues and other non-family based intersections. • Enhance gender based violence function • Enhance vulnerable populations issues, especially women, children, and adolescents	• BKKBN • MoH
Bureau of Statistics/*BPS*	• Enhance demography function • Enhance analysis function as key collaborator with research institutions	• BKKBN • MoH • Coordinating Ministry of Human Development
Indonesia CDC	• Accommodate Epidemiological Surveillance and PPPR functions • Enhance with functions from Directorate of Prevention and Disease Control • Benchmark with US CDC and Africa CDC	• New organisation set up • Process can begin with working group/task force • Main counterpart: President/Vice President office, MoH, Bappenas, MoF, MoFA, civil society networks,

		development partners, International Organisations (i.e: WHO, Unicef, World Bank) • Corresponding legislative commissions
National Health Assembly	• Benchmarking to Thailand Health Commission • Multi actor and multi sector platform set up at national level, with corresponding teams at provincial and districts levels	• New set up • MoH • PHO • DHO • Bappenas • MoF • Corresponding legislative commissions
Ministry of Health, Directorate of Health System	• Benchmarking to WHO's Health System Directorate	• Additional directorate
National Health Services Agency (NHSA)	• Benchmarking with NHS UK • Oversees health services delivery on the MoH's vertical hospitals • Ensuring excellence in quality of care	• MoH • PHO • DHO • BPJS Kesehatan - Bappenas
Ministry of Health, Foreign Relations Coordination/*Pusjak KGTK*	• Transfer back into MoH Secretariat General from National Health Policy Body to global health bureau, to ensure executing power in global health • Benchmark to Finland's and/or Norway's Secretariat of Foreign Relations	- Reassertion of internal ministry function
Ministry of Health, Health Promotion Directorate	• Merged and enhanced with the Public Communication Bureau to include risk communication function	• Reassertion of internal ministry function

Health Technology Assessment Commission	• Accommodate affordable care and clinical pathways requirement • Benchmarking to NHS Innovation Commission	• New set up • MoH • BPJS • Development Partners • International Organisations (i.e: World Bank)
President's Delivery Unit	• Benchmarking to the previous administration's UKP4 • Benchmarking to the UK Prime Minister Delivery Unit	• Reassertion of technocracy approach in the President's office • Vice President's office • A list of ministries with strategic levers align with national priorities to be determine during transition period
Omnibus Law for Governance Reform	• Defragmenting sectoral OBL into a comprehensive Law for integration of different development sectors	• Bappenas • Parliament • (Once confirmed to be set up) the President's Delivery Unit • The Vice President's Office • Infrastructure and institutional set up for additional ministries
Country Coordinating Mechanisms	• Unifying CCM across health issues in development • Involving civil society from the planning, implementation, to monitoring and evaluation processes.	• MoH • MoHA • Bappenas • MoF • MoFA • CSOs

7.2.2 Ministry of Health as Leading National Institution on Health Sector Development: Exercising Plausible Scenarios for Organisational Reframe

Radical institutional changes within the Ministry of Health should be minimised to reduce gaps in activities resulting from such changes.[1] However, certain adjustments are necessary to ensure the Ministry can fulfil its mandate as the health regulator in Indonesia effectively.

The incoming government's main priority on providing free school meals, opens the possibility of realignment of programs between the National Nutrition Agency/*BGN* and the Ministry of Health. As detailed in the SRMNCAH+N book of this White Paper series, Indonesia is facing a triple burden of malnutrition. A multiple-pronged approach is required to get ahead of this continued health issue which hinders achievement of *"Indonesia Emas 2045"* or Golden Indonesia 2045. Despite the considerably high public push back on this campaign promise, free school meals program presents an opportunity for both agencies (BGN and MoH) to support each other's targets, achievable only if both agree to approach with a governance in health perspective in mind.

In this Governance book of the White Paper series, the authors offer further thinking on how to optimally ensure this new national priority can also be a new lever to achieve health development targets. The Ministry of Health as the leading national agency for health development, should be reframed, repositioned and reaffirmed as the national regulator. Some functions within it must be strengthened, while other functions, specifically ones related with nutrition, can be enhanced and realigned with the new BGN. To reassert its primary role as the national regulator, functions on health service delivery where the Ministry of Health is also accountable for vertical hospitals; can be unbundled from the whole organisation into a National Body for Health Service Delivery, led by a Chief Medical Officer who reports to the Minister of Health. As shown by Figure 20 and Figure 21, several key changes include:

- The unbundling of the Health Service Directorate General into a separate agency, while still under the coordination of the Ministry of Health. This will allow the Ministry to better focus on its regulatory role.
- The Health Promotion Directorate to be merged and enhanced with the Public Communication Bureau to include risk communication function
- The National Health Policy Agency/*BKPK* must be reframed as a Directorate General and led by a Director General.
- The Country Cooperation Mechanisms should be positioned under the Secretary General to ensure that health-related development assistance is coordinated by the Ministry of Health and allows for diverse representation of Non-State Actors, including the most affected communities.
- The Foreign Partnership Bureau should be reframed as Global Health Bureau and incorporated under the General Secretary to take on more strategic functions in global health diplomacy.

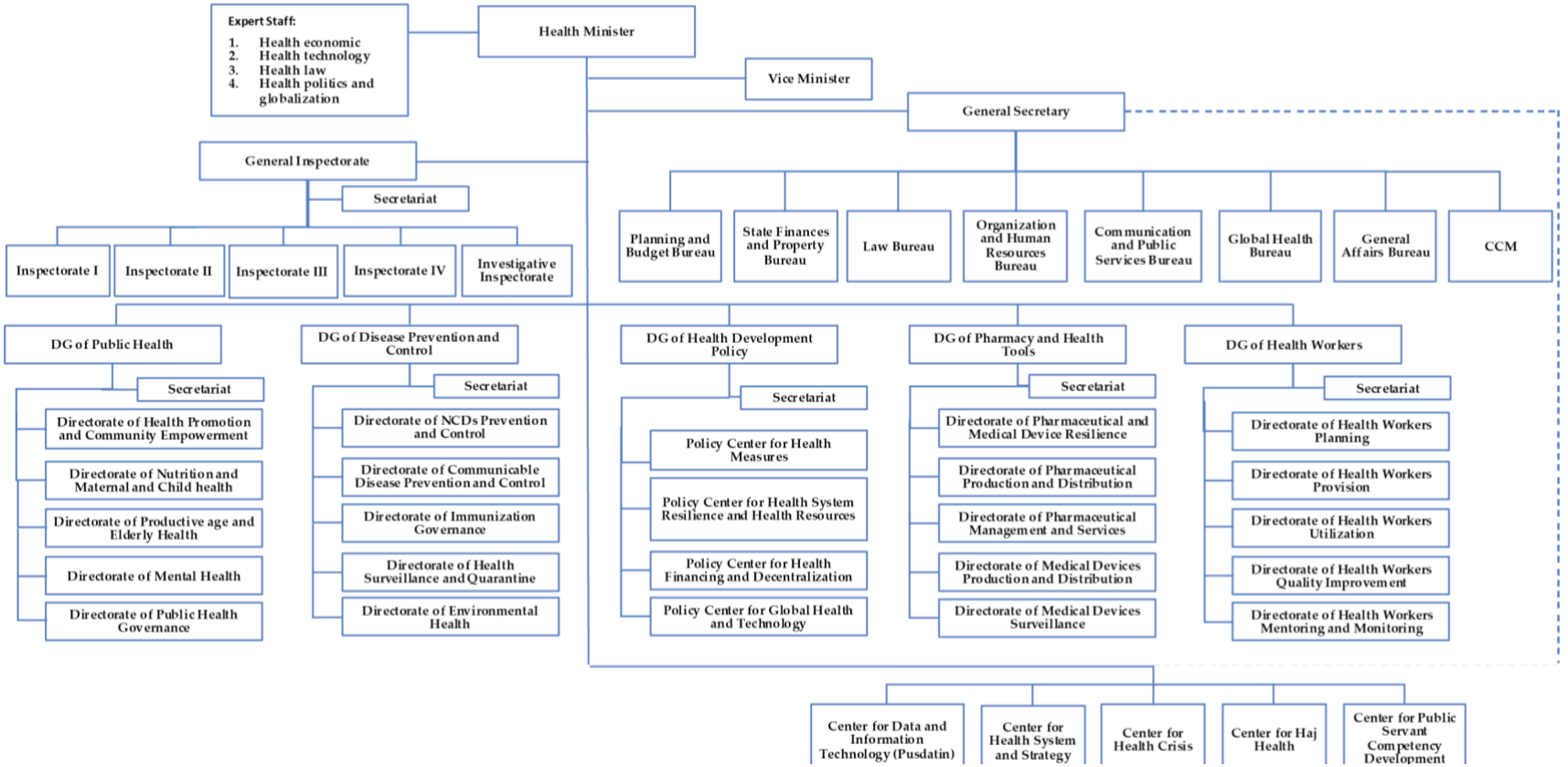


Figure 20. Proposed Organisational Structure of the MoH (source: author)

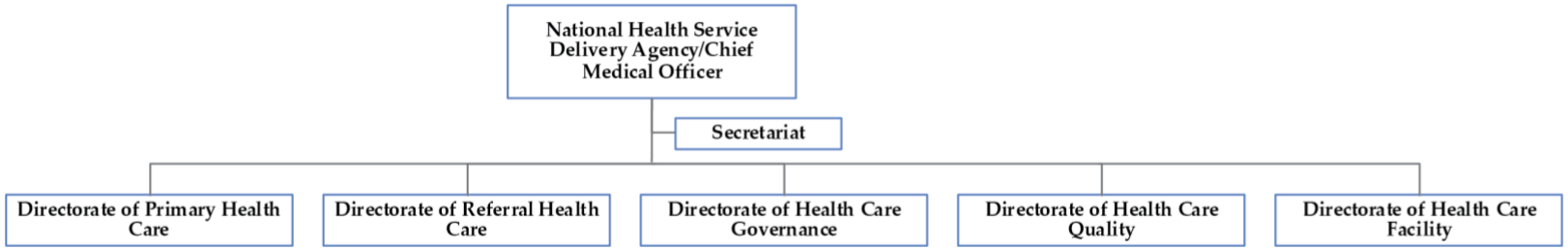


Figure 21. Unbundling the Organisation: National Health Service Delivery Agency (source: author)

Delivery of the proposed changes in this book will require significant alterations and revisions of regulatory mechanisms. The authors propose tracer indicators highlighted in the Main Book of this White Paper series, including detailed goals, targets and indicators in the annex. These prescriptive measures are taken to ensure that policy makers are well-equipped to deliver the recommended actions.

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Appendices

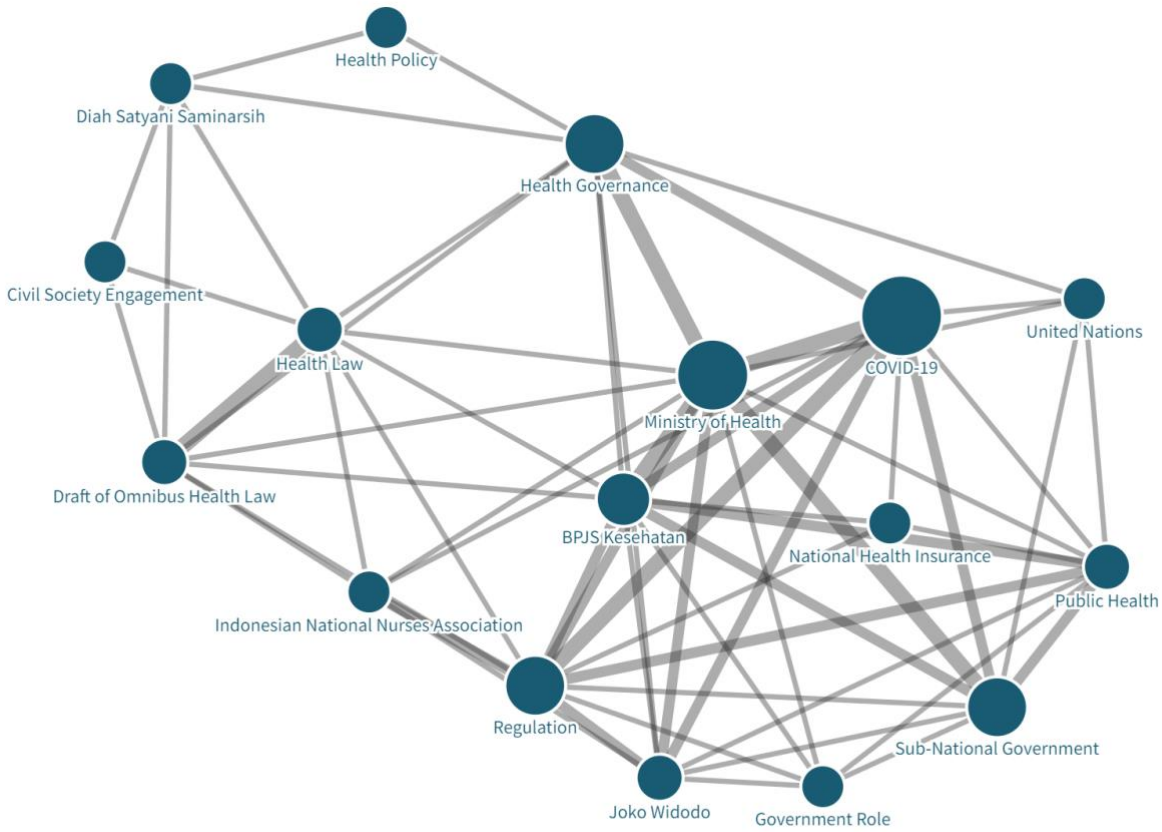

Figure 22. The Results of Media Monitoring on Indonesia's Health Governance Landscape

Table 6. Proposed Goal, Target, and Indicator

Goal		Target		Indicator	
1	Establish a strategic vision for Indonesia's health development to address complex health determinants and long-term societal well-being	1.1	The availability of a strategic vision for Indonesia's health development plan that include HiAP approach and GEDSI lens	1.1.1	By end of 2029, ensure all sectors–government ministries, private entities, civil society, and local communities–are aligned under a short-term, medium-term, and long-term unified strategic vision for governance for health, guided by the Health in All Policies (HiAP) framework and GEDSI lens
				1.1.2	Increased rank in the global gender gap sub-index 3 from 2024 baseline (From current rank of 100 to 60 by 2034)
		1.2	Integrated HiAP and GEDSI frameworks into national and local health policies	1.2.1	Percentage of sectors actively participating in intersectoral health governance platforms
				1.2.2	Number of health-related policies in place by end of 2026 (law, government regulation, president regulation, ministerial law, regional law) that incorporates HiAP and GEDSI principles
				1.2.3	Number of health-related norms, standard, procedure, criteria, and strategies that implements HiAP and GEDSI principles
2	Strengthen health governance by ensuring accountability,	2.1	Formalise the National health Assembly as an	2.1.1	The enactment of Presidential Regulation on the establishment of National Health Assembly by 2025

	meaningful participation, and promoting evidence-based decision-making of national health policies and programs		institutionalised platform for multi sectoral dialogue and decision-making.	2.1.2	The National Health Assembly (NHA) mechanism is established with active representation across all ministries and national bodies by the end of 2025, with clear terms of reference and operational guidelines
				2.1.3	A high percentage of diverse representatives (CSOs, academia, private sector, government) that actively participate under the NHA mechanism
				2.1.4	By 2026, the NHA conducts an annual review of priority program determinations and budgeting within the National Health Master Plan (RIBK), providing evidence-based recommendations and decisions to guide national health priorities, as documented in annual NHA reports and government responses
		2.2	Implement Health Impact Assessment (HIA) as a mandatory tool for all government sectors and private entities, ensuring health considerations are integrated into the planning, implementation, and monitoring of every development program and policy	2.2.1	By 2027, Bappenas develop and deploy context-specific HIA tools tailored to the needs of different entities (e.g., ministries, local governments) with the involvement of experts in HIA
				2.2.2	By 2027, 75% of relevant ministries and sub-national planning agencies (Bappeda) have completed capacity building programs on the application of HIA in development planning, measured by training records and HIA integration reports
				2.2.3	By 2029, at least 60% of multi sectoral development projects (e.g., infrastructure, education, environmental) integrate HIA findings into their project designs, as documented through project evaluation reports

				2.2.4	By 2029, 100% of key development planning documents (RPJP, RPJM, RKP) include mandatory Health Impact Assessments (HIA) as a standard procedure in policy planning and program implementation, verified through annual audits
		2.3	Establish robust, transparent, and participatory mechanisms that hold institutions accountable for health governance decisions, ensuring public trust and involvement.	2.3.1	By 2025, co-creation and participatory mechanism is incorporated in the Rakerkesnas guideline
				2.3.2	By 2025, regional government are meaningfully involved in policy discussions and formulation processes within Rakerkesnas, with monitoring through participation records and feedback mechanism
				2.3.3	By 2025, regional governments contribute to at least 30% of health-related policy products and program formulation processes within Rakerkesnas
				2.3.4	By 2025, regional governments contribute to at least 30% of health-related policy products and program formulation processes within Musrenbang at the subnational level
				2.3.5	By 2025, civil society meaningfully involved in discussions and formulation processes of derivative regulations of the omnibus health law, with monitoring through participation records and feedback mechanisms.
		2.4	Establish a robust system for monitoring and evaluating health policies and programs that includes public participation and ensures	2.4.1	By 2026, ministries and sub-national health offices sustainably include the public in the creation and monitoring of the budget in the sub-national development plan
				2.4.2	By 2027, achieve 75% public satisfaction rate on complaints

			transparency throughout the process		handling, with a 10% annual increase in satisfaction, as measured by citizen feedback surveys and public service satisfaction indices
				2.4.3	By 2029, 100% of sub-national regulations are available and easily accessible through government websites, with warning systems and in simple, easily understandable language, as monitored by online accessibility audits
				2.4.4	By 2029, increases Indonesia's e-participation and e-information index scores to above 0.7 tracked through the global e-Government Index
		2.5	Ensure the use of high-quality evidence to support the implementation of national health programs and policies	2.5.1	Investment for HTA research and health-related research, prioritising the vulnerable groups
				2.5.2	Starting in 2025, increase of 10% annually, percentage of newly adopted policies in the last five years that have been informed by evidence, assessed by the process being undertaken
				2.5.3	By 2026, establish a mechanism for translating evidence into policy that ensures evidence is streamlined to Ministries and institutions other than health to achieve HiAP
				2.5.4	Establishment of clear evidence-advisory role within health-related government institutions
3	Establish a cohesive and robust institution where all actors collaborate transparently and equitably, ensuring that decision-making is data-driven and aligned with the diverse needs of society to	3.1	National Institutions set up for governance for health	3.1.1	By the end of 2024, the President's Delivery Unit has been formed
				3.1.2	By the end of 2025, the National Health Services Agency (NHSA) has been set up
				3.1.3	By 2025, a Global Health Bureau has been established under the

	achieve sustainable outcomes				General Secretary of the Ministry of Health
				3.1.4	By the second quarter of 2025, the Country Coordinating Mechanism (CCM) have been established
				3.1.5	By the end of 2028, the of Indonesia Centers for Disease Control and Prevention (Indonesia CDC) has been established
		3.2	Regulatory set up for Governance for Health	3.2.1	By the end of 2024, revision of Ministerial Law (*Undang-Undang Kementerian*) to establish organisational reform
				3.2.2	By the end of 2025, the enactment of Omnibus Law for Governance Reform
		3.3	Multi sectoral governance set up for Governance for Health	3.3.1	By 2025, the working group mechanism for health-related program priorities determined through NHA is established
				3.3.2	Beginning in 2025, the working groups submitted regular progress reports to the VP secretariat every 6 months and annually to the NHA