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Healthcare Governance and Administration in Indonesia: A Narrative Review of Structures, Financing, Service Delivery, and Reform

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ABSTRACT: Indonesia's health system operates across roughly 17,000 inhabited islands and 34 provinces under a governance model that has shifted repeatedly between centralization and decentralization since 1999. This narrative review synthesizes evidence on the governance and administration of healthcare in Indonesia across four domains: the regulatory and institutional framework, health financing and insurance administration, health service delivery administration, and cross-cutting governance challenges including pandemic response and digital transformation. Decentralization devolved substantial authority for health planning, financing, and workforce deployment to district governments, producing gains in local responsiveness alongside persistent disparities in service readiness, medicine availability, and workforce distribution. The National Health Insurance Program (Jaminan Kesehatan Nasional), administered by BPJS Kesehatan, has expanded population coverage but continues to face challenges of financing equity and provider payment sustainability. The 2023 Omnibus Health Law consolidated eleven prior statutes into a single regulatory framework, introducing both opportunities for coherence and concerns regarding recentralization and reduced local participation. Governance of primary care, hospitals, and the health workforce remains uneven, while digital health platforms and pandemic-era coordination mechanisms illustrate both the promise and the fragmentation of multilevel stewardship. Strengthening accountability, financing equity, and institutional coordination across central and local government levels emerges as the central reform agenda for Indonesian healthcare governance.

KEYWORDS: Healthcare governance; health administration; decentralization; national health insurance; Indonesia; health policy

1. Introduction

Indonesia is the world's largest archipelagic state, comprising approximately 17,000 islands and a population exceeding 280 million. Its geographic dispersion, demographic diversity, and pronounced regional inequalities make healthcare governance and administration particularly complex. Effective health system management requires coordination across multiple levels of government, public and private healthcare providers, and regions with substantial differences

in infrastructure, fiscal capacity, workforce availability, accessibility, and epidemiological burden [1, 2]. In this context, healthcare governance encompasses the institutional structures, regulatory arrangements, and accountability mechanisms through which authority over health policy, financing, and service delivery is exercised, whereas healthcare administration concerns the operational processes through which these policies are translated into services at institutional and facility levels.

The contemporary Indonesian health system has been shaped by two major and partly competing reform trajectories. The first was decentralization, initiated through the Regional Autonomy Laws enacted in 1999 and implemented from 2001. These reforms transferred substantial responsibilities for health planning, budgeting, facility management, and workforce deployment from the central government to district and municipal governments. Decentralization was expected to improve local responsiveness, administrative flexibility, and community participation. However, it also generated institutional fragmentation, differences in local fiscal and administrative capacity, and persistent disparities in health system performance between regions [1, 2]. Consequently, the effectiveness of decentralized healthcare governance has remained highly dependent on local institutional capacity and coordination between national and subnational authorities.

The second trajectory has involved greater national integration and, in several areas, recentralization of health governance. A major milestone was the introduction of the National Health Insurance Program (*Jaminan Kesehatan Nasional*, JKN) in 2014, which sought to expand universal health coverage through nationally coordinated health financing. This trajectory was further reinforced by the enactment of Law No. 17 of 2023 on Health, which consolidated multiple health-related statutes within a unified regulatory framework [3]. These reforms have strengthened the central government's role in financing, regulation, standard setting, and health system transformation while simultaneously operating within administrative structures established through decentralization. The resulting coexistence of decentralized service responsibilities and increasingly centralized regulatory and financing mechanisms creates a distinctive governance architecture that requires critical examination.

A central problem is that major reforms have not fully resolved persistent weaknesses in coordination, equity, institutional capacity, and accountability across the Indonesian health system. These weaknesses are evident throughout healthcare administration. Primary healthcare centers (*Puskesmas*) demonstrate variable readiness and operate within complex administrative accountability arrangements [4]. District health authorities face persistent challenges in pharmaceutical procurement and supply-chain management [5, 6], while hospitals vary substantially in institutional capacity and accreditation performance. Health workforce shortages and geographical maldistribution further constrain equitable service provision, particularly in remote and underserved regions [7−10]. Although JKN has substantially expanded financial protection and access to healthcare, differences in service availability and administrative capacity mean that formal insurance coverage does not necessarily translate into equitable access to high-quality care.

These challenges expose a broader knowledge gap. Existing studies have frequently examined individual components of Indonesian healthcare governance, including decentralization, health insurance, primary care, hospital management, pharmaceutical systems, and workforce distribution. However, this evidence remains fragmented across governance levels and administrative domains. Consequently, there is limited integrated

understanding of how decentralization, national financing reforms, institutional accountability, service-delivery administration, workforce governance, and recent regulatory transformation interact to influence health system performance. This fragmentation is particularly important in the context of continuing health-system transformation following the 2023 Health Law and the lessons generated by the COVID-19 pandemic.

Therefore, this review aims to critically synthesize the available evidence on healthcare governance and administration in Indonesia and to examine how institutional arrangements, decentralization, financing mechanisms, service-delivery structures, and administrative capacity influence health system equity, quality, efficiency, accountability, and resilience. Particular attention is given to the interaction between national and subnational governance, the administrative consequences of JKN, primary and hospital care governance, pharmaceutical and workforce management, and emerging challenges associated with digital transformation and health-system resilience. By integrating these interconnected dimensions, the review seeks to identify persistent governance gaps, assess the implications of recent reforms, and establish priorities for strengthening a more equitable, accountable, and resilient Indonesian health system.

2. Governance Structure and Regulatory Framework of the Indonesian Health System

The governance architecture of the Indonesian health system reflects a multilayered interaction among central regulatory authority, provincial coordination, and district-level administration. As illustrated in Figure 1, healthcare governance can be conceptualized across five interconnected domains: regulatory and institutional governance, financing and insurance administration, primary healthcare governance, hospital and workforce governance, and digital and crisis-response governance. These domains demonstrate that health system performance depends not only on formal regulatory structures but also on coordination among institutions operating across different administrative levels.

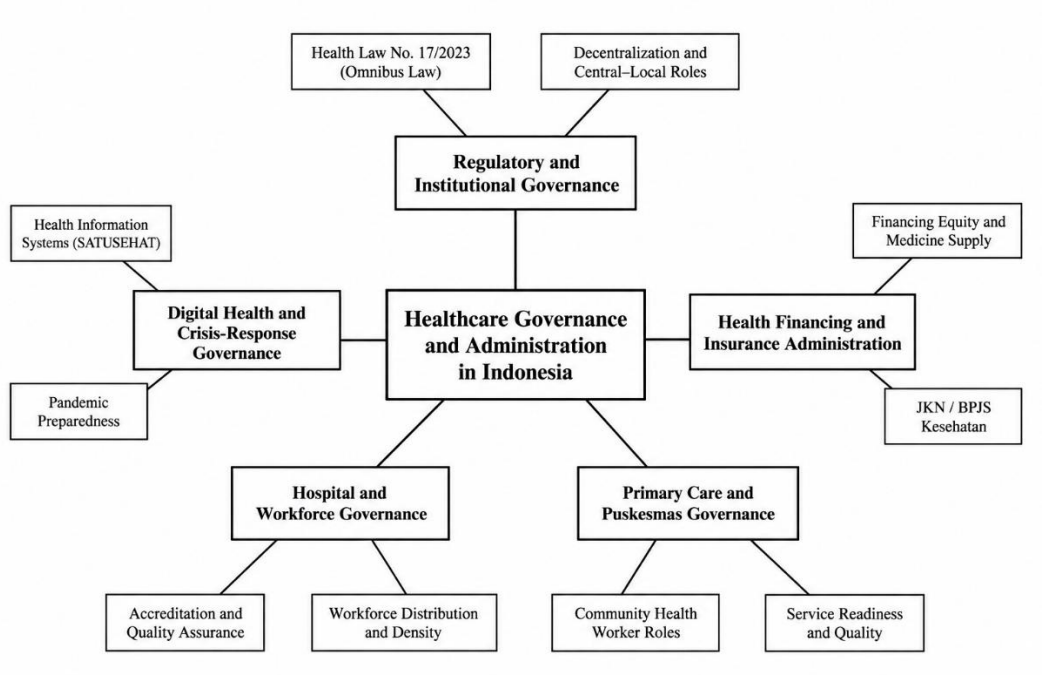


Figure 1. The Governance and Administration Domains of the Indonesian Healthcare System, Illustrating the Central Governance Framework and Five Interconnected Domains.

2.1. Central–Local Governance and Decentralization.

Indonesia's decentralization reforms, implemented in January 2001 under the Regional Autonomy Laws, devolved substantial authority for planning, budgeting, and managing publicly owned health facilities to district (*kabupaten/kota*) governments, while the Ministry of Health retained responsibility for national policy, standard-setting, stewardship, and strategic direction [1, 2]. This arrangement positioned district health offices as key administrative institutions responsible for translating national health policies into local implementation, including facility management, workforce deployment, and oversight of primary healthcare networks.

Empirical assessments of decentralization have demonstrated considerable variation in administrative and health-system outcomes. An evaluation of district hospitals following decentralization identified substantial differences in cost-recovery performance, indicating that local administrative capacity and governance quality influenced the effectiveness of devolved authority [1]. Similarly, a systematic review of district-level decentralization reported heterogeneous and context-dependent effects on health system performance. Although decentralization improved responsiveness and administrative flexibility in some settings, these benefits were frequently constrained by fragmented governance, unequal resources, limited institutional capacity, and coordination difficulties [2]. These findings indicate that decentralization alone does not guarantee improved health system performance; its effectiveness depends substantially on the institutional and fiscal capacities of subnational governments.

A persistent structural challenge concerns the division of administrative authority between institutions responsible for healthcare and local governance. The Ministry of Health oversees health service standards and the broader primary healthcare system, including *Puskesmas*, whereas the Ministry of Home Affairs has administrative authority over local government structures within which community-based health services, including *Posyandu*, operate [4]. This institutional bifurcation can complicate coordination, resource allocation, accountability, and integrated decision-making at the community level. Strengthening horizontal coordination between ministries and vertical coordination across national and subnational governments is therefore critical to improving primary healthcare governance.

2.2. Legal and Regulatory Foundations: The 2023 Omnibus Health Law.

The evolution of Indonesian healthcare governance has been accompanied by substantial changes in its legal and regulatory framework. Table 1 summarizes the principal legal and policy milestones that have shaped health governance since the introduction of decentralization, demonstrating a gradual transition from extensive devolution toward stronger national coordination in financing, regulation, digital health, and health-system transformation. The most consequential recent development was the enactment of Law No. 17 of 2023 on Health. Adopted in August 2023, this omnibus legislation repealed and consolidated eleven previous health-related statutes, including the 2009 Health Law, the 2009 Hospitals Law, and the 2014 Health Workers Law, into a single 458-article regulatory framework [3]. As reflected in Table 1, the legislation represents the latest stage of a broader transformation of Indonesian health governance following decentralization, the introduction of JKN, institutional

strengthening of hospital accreditation, the COVID-19 pandemic, and national digital health integration.

Table 1. Key Legal And Policy Milestones In Indonesian Healthcare Governance.

Period	Milestone	Governance Domain	Description	Ref.
1999–2001	Regional Autonomy Laws (Law No. 22/1999 and Law No. 25/1999)	Decentralization	Devolved responsibility for health service planning, budgeting, and facility management from the central government to district governments	[1, 2]
2014	Launch of *Jaminan Kesehatan Nasional* (JKN)	Financing/Insurance	Established a nationally coordinated health insurance system administered by BPJS Kesehatan	[7]
2019	Strengthening of national hospital accreditation (KARS)	Service Delivery/Quality	Strengthened institutional mechanisms for assessing hospital governance, quality, and performance	[10]
2020–2022	COVID-19 pandemic response	Crisis Governance	Required multilevel coordination between central and regional governments for containment, service continuity, and surge-capacity management	[11–13]
2022	Digital transformation through SATUSEHAT	Digital Health Governance	Advanced national integration of health information systems and electronic medical records across healthcare facilities	[16]
2023	Health Law No. 17/2023 (Omnibus Health Law)	Regulatory/Institutional	Consolidated eleven previous health-related statutes and strengthened central authority in selected areas of health planning and regulation	[3]

The Omnibus Health Law was introduced within the broader Indonesian Health Transformation agenda, which encompasses six major pillars: primary healthcare transformation, referral healthcare transformation, health resilience, health financing, health human resources, and health technology. By consolidating previously fragmented legislation, the law seeks to streamline regulation, facilitate licensing and workforce mobility, and strengthen national coordination across the health system. Nevertheless, analyses of the law's formulation and substantive provisions have identified several governance concerns. These include the compressed legislative process, limited opportunities for meaningful public participation, and provisions that strengthen central government authority over planning and licensing [3]. Such developments have generated concerns that greater administrative efficiency and regulatory consistency may be achieved at the expense of local autonomy and deliberative policymaking. These tensions reflect a longstanding governance dilemma in Indonesia: determining the appropriate balance between national standardization and coordination on the one hand and subnational autonomy and responsiveness on the other [1, 2]. The regulatory trajectory summarized in Table 1 therefore suggests that Indonesian healthcare governance has evolved not through a linear process of decentralization or recentralization, but through continuing adjustments in the distribution of authority across governmental levels.

2.3. Institutional Actors and Stewardship.

The Indonesian health system is governed through a network of institutions with distinct but overlapping responsibilities. The Ministry of Health provides national stewardship by

establishing policy directions, regulatory standards, and strategic priorities. BPJS Kesehatan administers JKN as a public legal entity responsible for national health insurance administration, while KARS performs an important role in evaluating hospital compliance with quality and patient-safety standards [10]. At the subnational level, provincial and district health authorities retain substantial responsibilities for health program implementation, facility administration, workforce management, and adaptation of national policies to local circumstances [1, 2].

The institutional arrangements presented in Figure 1, together with the regulatory evolution summarized in Table 1, demonstrate that Indonesian healthcare governance is characterized by interdependence rather than a simple hierarchy of authority. National institutions establish financing arrangements, standards, and strategic priorities, while subnational governments and healthcare facilities are responsible for translating these requirements into service delivery. Consequently, effective stewardship depends on clearly defined responsibilities, functional accountability mechanisms, interoperable information systems, and consistent coordination across institutional and governmental boundaries.

This coordination remains challenging because of Indonesia's geographic scale, regional diversity, uneven administrative capacity, and historical shifts between decentralization and stronger central coordination. The central governance challenge is therefore not simply whether authority should be centralized or decentralized, but how responsibilities, resources, information, and accountability can be aligned across levels of government. Strengthening these relationships is essential for reducing regional disparities and ensuring that national reforms translate into equitable and consistent improvements in healthcare delivery.

3. Health Financing and Insurance Administration

3.1. National Health Insurance (JKN) and BPJS Kesehatan.

Launched in January 2014, the Jaminan Kesehatan Nasional (JKN) program consolidated several pre-existing insurance schemes, including Askes for civil servants, Jamkesmas for low-income citizens, and Asabri for military personnel, into a single social health insurance scheme administered by BPJS Kesehatan [7]. As shown in Table 2, governance responsibility for JKN is distributed among the Ministry of Health, which sets service and financing policy; BPJS Kesehatan, which administers enrollment, contribution collection, provider contracting, and claims processing; and primary care providers, which function as gatekeepers responsible for first-contact care and referral management [7]. This institutional arrangement demonstrates that JKN operates through a multi-level governance structure in which financing, regulation, purchasing, and service delivery are institutionally distinct but operationally interdependent. BPJS Kesehatan functions as the principal purchaser and administrator of insurance funds, while national and subnational health authorities retain important regulatory, supervisory, and implementation responsibilities. Primary care providers occupy a particularly strategic position because their gatekeeping function influences patient access, referral pathways, continuity of care, and healthcare expenditure [4, 7]. Hospitals, meanwhile, operate within case-based reimbursement and accreditation requirements that connect financing with service quality [10, 14]. Consequently, effective JKN administration depends not merely on expanding population coverage, but also on provider capacity, efficient claims management, appropriate

reimbursement mechanisms, coordinated referral systems, and clearly defined accountability across administrative levels.

Table 2. Institutional Roles in the Administration of Indonesia's National Health Insurance Program (JKN).

Institution	Governance Role	Administrative Function	Ref.
Ministry of Health	Policy stewardship and regulation	Sets service standards, accreditation policy, and health financing regulation	[3, 10]
BPJS Kesehatan	Insurance fund administration	Member registration, contribution collection, provider contracting, and claims processing	[7, 15]
Primary care providers (Puskesmas / clinics)	Gatekeeping and referral management	First-contact care, capitation-based reimbursement, and referral coordination	[7, 4]
Hospitals	Secondary / tertiary service provision	Case-based claims processing (INA-CBGs) and accreditation compliance	[10]
District / provincial health offices	Local stewardship and oversight	Facility licensing, workforce deployment, and medicine procurement oversight	[1, 5]

The institutional distribution presented in Table 2 has important implications for service delivery and provider behavior. Research examining general practitioners' experiences under JKN found that the program substantially reinforced the gatekeeping role of primary care, while capitation-based reimbursement reshaped both clinical practice and administrative responsibilities [7]. This gatekeeping arrangement is intended to strengthen first-contact care and limit unnecessary hospital referrals, but its effectiveness depends on adequate staffing, diagnostic capacity, medicine availability, and referral coordination. At the financing level, BPJS Kesehatan's institutional position outside the conventional ministerial hierarchy gives it a distinct role in coordinating purchasing and insurance administration across a decentralized health system. However, this institutional separation also increases the importance of effective coordination among BPJS Kesehatan, the Ministry of Health, subnational governments, and healthcare providers to ensure that financing reforms are matched by sufficient supply-side capacity and consistent service quality..

3.2. Financing Equity and Sustainability.

A five-year financing incidence analysis covering 2015 to 2019 assessed the progressivity of Indonesia's overall health financing system, including direct taxes, indirect taxes, out-of-pocket payments, and social health insurance contributions. The analysis found that direct taxes and out-of-pocket payments were progressive sources of financing, while indirect taxes were regressive throughout the study period, and social health insurance contributions were regressive in most years. Critically, the overall health financing system, which had been progressive from 2015 to 2018, became mildly regressive by 2019, indicating a decline in financing equity that carries implications for the financial protection of lower-income households as JKN pursues universal coverage [15, 16]. These findings underscore those of Indonesian JKN research documenting the multisectoral and multilevel coordination required to sustain progress toward universal health coverage while safeguarding equity.

3.3. Pharmaceutical and Medicine Supply Governance.

The governance of medicine supply in Indonesia operates within a decentralized and multilayer structure in which the 514 district health offices are primarily responsible for medicine purchasing plans, procurement, and logistics for more than 10,000 primary health centers [5].

A qualitative study comparing national medicine policies with local procurement practices found substantial discrepancies between centrally issued regulations and the operational realities faced by district health offices, particularly in resource-constrained eastern regions of the archipelago [5]. A complementary national assessment covering all 9,831 primary health centers across 514 districts found that essential medicine availability varied considerably, was correlated with district poverty levels, and was influenced by access to alternative dispensing points such as private pharmacies [6]. Governance of the pharmacy workforce itself also presents administrative challenges: a national analysis found substantial geographic maldistribution of pharmacists, mirroring broader patterns of health workforce inequity documented elsewhere in the health system [16, 17].

4. Health Service Delivery Administration

4.1. Primary Health Care and Puskesmas Governance.

Community health centers (Puskesmas) form the backbone of Indonesia's primary health care network and are administratively responsible for both individual clinical services and population-based public health programs, including the community-based Posyandu network. Analysis of primary healthcare governance from the perspective of community health workers identified decision-making authority and resource management as the two central governance factors shaping Puskesmas and Posyandu performance, with governance quality varying considerably by district [4]. A readiness assessment of Puskesmas capacity to deliver cardiovascular disease services in Makassar city found that while health promotion, prevention, and basic treatment were widely available, long-term chronic disease management and rehabilitation services were far less consistently provided, reflecting gaps in administrative planning for non-communicable disease governance at the primary care level [14].

4.2. Hospital Governance and Accreditation.

Hospital accreditation functions as a central governance mechanism for promoting adherence to quality and safety standards in Indonesian hospitals, administered through the Hospital Accreditation Commission [10]. A national analysis of accreditation status found that larger hospitals and those managed directly by government were significantly more likely to be accredited, independent of specialty or the intensity of local market competition, indicating that organizational scale and ownership structure substantially shape hospital governance capacity. The same analysis noted that accredited hospitals exhibited both higher utilization and, notably, higher recorded mortality, a finding the authors attributed to case-mix and referral patterns warranting further investigation rather than a direct causal effect of accreditation itself [10]. These findings suggest that accreditation, while a valuable administrative lever for quality assurance, interacts closely with underlying disparities in hospital resourcing and governance capacity across the country.

4.3. Health Workforce Governance.

Human resources for health represent both a persistent quantity shortfall and a significant distributional challenge in Indonesia. A national analysis reported that Indonesia's health worker ratio of 3.84 per 1,000 population remains below the World Health Organization threshold of 4.45 needed to achieve 80 percent coverage toward universal health coverage, and

found continuing geographic maldistribution, with the inter-district Gini index for medical specialists remaining as high as 0.53 in 2022 despite improvement at the provincial level [8]. An earlier scoping review of the healthcare workforce likewise concluded that imbalanced distribution between urban and rural areas continues to challenge health service provision despite multiple government regulatory interventions, and called for further evaluation of the programs intended to address this imbalance [9]. Table 3 summarizes governance challenges and corresponding administrative responses across the primary care, medicine supply, hospital, and workforce domains discussed in this and the preceding sections.

Table 3. Governance Challenges And Administrative Responses Across Levels of Health Service Delivery.

Delivery Level	Key Governance Challenge	Administrative / Policy Response	Ref.
Primary care (Puskesmas)	Variable service readiness and dual administrative lines between the Ministry of Home Affairs (village level) and Ministry of Health	Strengthening community health worker governance and integration of Posyandu networks	[4, 14]
Medicine supply	Discrepancies between national policy and local procurement practice under decentralization	District Health Office capacity building for medicine planning and logistics	[5, 6]
Hospitals	Uneven accreditation uptake linked to hospital size, ownership, and market competition	Expansion of the independent hospital accreditation commission (KARS)	[10]
Health workforce	Persistent quantity shortfall and uneven geographic distribution, particularly of specialists and pharmacists	Workforce planning using inter-provincial and inter-district disparity indices (Gini index)	[8, 9, 17]

5. Governance Challenges, Digital Transformation, and Future Directions

5.1 Pandemic Preparedness and Crisis Governance.

The COVID-19 pandemic provided a major stress test of Indonesia's multilevel health governance system and exposed weaknesses in coordination between national policy formulation and subnational implementation. An assessment of the Indonesian healthcare system's capacity to respond to COVID-19 found that, despite numerous policy measures introduced by the central government, sustained expansion of healthcare surge capacity needed to be accompanied by more consistent implementation and enforcement of transmission-control measures at the regional level [11]. This finding illustrates a broader governance challenge in decentralized systems: nationally formulated policies may produce heterogeneous outcomes when implementation capacity and administrative priorities differ across jurisdictions.

A modified Delphi study involving medical and health academics identified health system resilience, cross-sector coordination, and clearer risk communication as priority areas for strengthening the government's pandemic response [12]. Complementing this national-level evidence, a qualitative study of regional preparedness in Bali and West Java, structured around the WHO health systems framework, identified leadership and policy clarity, cross-sector collaboration, and effective communication as key factors differentiating levels of regional preparedness [13]. Collectively, these findings demonstrate that crisis-response capacity depends not only on healthcare infrastructure but also on institutional coordination, clearly defined responsibilities, communication mechanisms, and the capacity of regional governments to translate national policies into timely local action.

5.2. Digital Health Governance and Information Systems.

Digital transformation has become an increasingly important component of Indonesian health governance, particularly through the development of SATUSEHAT as a national platform for integrating health information systems and electronic medical records. Digital integration has the potential to improve continuity of care, administrative efficiency, surveillance, planning, and evidence-based decision-making. However, achieving these benefits requires interoperability, adequate infrastructure, workforce capability, and consistent implementation across healthcare facilities. A national cross-sectional survey of health information system utilization among *Puskesmas* across all 34 provinces identified substantial fragmentation, with facilities operating different numbers and types of information systems developed by national and local governments as well as private vendors. The study also identified substantial disparities in infrastructure, system usability, and workforce digital capacity between urban and rural facilities. Differentiated implementation strategies were therefore recommended, including offline-compatible systems and fundamental digital literacy support for resource-constrained rural *Puskesmas*, alongside greater interoperability and advanced analytical capabilities in better-resourced facilities [16].

These findings demonstrate that digital transformation is not solely a technological challenge but also a governance and equity issue. National interoperability standards may promote integration, but their effectiveness ultimately depends on local infrastructure, human resources, financing, data quality, and institutional readiness. A uniform digitalization strategy may therefore reproduce existing geographical inequalities if facilities with limited connectivity and technical capacity cannot participate effectively. Digital health governance should consequently combine national standardization with implementation strategies adapted to differences in regional capacity.

5.3. Equity, Accountability, and the Reform Agenda.

Evidence across the major governance domains reveals a recurring pattern: Indonesia has achieved substantial institutional expansion, but implementation capacity and outcomes remain uneven across regions and levels of care. Decentralization increased subnational responsibility but generated heterogeneous administrative outcomes [1, 2], while subsequent reforms strengthened national coordination in financing, regulation, and digital health [3]. At the same time, financing equity, hospital quality, workforce distribution, pandemic preparedness, and information-system integration continue to demonstrate important geographical and institutional disparities [8, 10, 13, 15, 16]. Table 4 synthesizes the principal empirical evidence underpinning these governance challenges and highlights the recurring importance of institutional capacity, coordination, and regional inequality. The evidence summarized in Table 4 indicates that the principal challenge facing Indonesian healthcare governance is not simply the absence of institutions or policies, but the uneven capacity to translate national reforms into effective and equitable implementation. Decentralization has created opportunities for locally responsive governance, yet differences in fiscal resources, administrative capability, workforce availability, and infrastructure have contributed to heterogeneous outcomes [1, 2, 8].

Conversely, stronger national coordination may improve standardization in areas such as financing, accreditation, and digital health, but excessive centralization could reduce local flexibility and weaken participatory governance [3]. The policy challenge is therefore to establish an appropriate balance between national standards and subnational implementation capacity.

Table 4. Summary of Empirical Evidence On Healthcare Governance And Administration In Indonesia.

Focus	Setting/Method	Key Finding	Ref.
Decentralization and hospital financing	Cross-sectional analysis of district hospitals	Decentralization was associated with variable cost-recovery performance across district hospitals, indicating differences in local administrative capacity.	[1]
District-level decentralization impacts	Systematic review	Effects of decentralization on health system performance were mixed and strongly dependent on local context and implementation capacity.	[2]
Omnibus Health Law	Policy analysis/commentary	Centralizing elements of the new regulatory framework raised concerns regarding participation and the balance between national authority and decentralized governance.	[3]
Health financing equity	Financing incidence analysis, 2015–2019	The overall financing system became mildly regressive by 2019, reflecting continued dependence on out-of-pocket expenditure.	[15]
Hospital accreditation	National hospital dataset	Larger and government-managed hospitals were more likely to achieve accreditation, indicating institutional differences in quality-system readiness.	[10]
Health workforce adequacy and distribution	National workforce database	The health workforce remained insufficient in aggregate and unevenly distributed across districts.	[8]
Regional COVID-19 preparedness	Qualitative study in Bali and West Java	Leadership, cross-sector collaboration, policy clarity, and communication influenced regional preparedness.	[13]
Health information system utilization	National cross-sectional survey of *Puskesmas*	Health information systems remained fragmented, with substantial disparities in infrastructure and implementation capacity.	[16]

Equity should be central to this governance agenda. Expansion of insurance coverage does not necessarily ensure equitable access when financing remains partly dependent on out-of-pocket expenditure and healthcare resources are geographically concentrated [8, 15]. Similarly, accreditation standards and digital integration may improve system-wide quality, but facilities with weaker infrastructure and fewer skilled personnel may face greater difficulty meeting national requirements [10, 16]. Governance reforms should therefore incorporate explicit mechanisms for reducing regional disparities, including needs-based resource allocation, targeted workforce deployment, differentiated technical support, and monitoring systems capable of identifying implementation gaps.

Three priorities emerge from this evidence. First, district and provincial administrative capacity should be strengthened so that decentralized responsibilities are matched by adequate financial, technical, and human resources [1, 2]. Second, implementation of the 2023 Health Law should preserve effective national coordination while maintaining transparent accountability, meaningful stakeholder participation, and sufficient flexibility for local adaptation [3]. Third, universal health coverage should be supported by more equitable financing, improved workforce distribution, reliable pharmaceutical supply, and interoperable digital infrastructure [8, 9, 15–17]. Addressing these priorities simultaneously is essential because weaknesses in one governance domain can constrain progress in others. Indonesia's future health-system resilience will therefore depend less on isolated reforms than on the ability to align regulation, financing, information, institutional accountability, and subnational implementation within a coherent and equitable governance framework.

6. Conclusion

Healthcare governance and administration in Indonesia have undergone substantial transformation through decentralization, the expansion of JKN, regulatory consolidation, and increasing digital integration. These reforms have strengthened financial protection, institutionalized quality assurance, and expanded the capacity for nationally coordinated healthcare delivery. Nevertheless, significant governance challenges persist. Decentralized responsibilities are not always matched by adequate fiscal resources, administrative capacity, infrastructure, or workforce availability, contributing to substantial disparities across provinces and districts. At the same time, stronger central coordination through recent regulatory reforms creates an important challenge in balancing national standardization with local autonomy, responsiveness, and accountability. Persistent inequalities in health financing, workforce distribution, pharmaceutical availability, hospital capacity, and digital readiness further demonstrate that expanded coverage does not automatically ensure equitable access or quality of care. Future reforms should therefore prioritize stronger national–subnational coordination, needs-based resource allocation, equitable workforce deployment, sustainable financing, interoperable information systems, and transparent accountability mechanisms. Particular attention should be directed toward strengthening administrative capacity in underserved and geographically remote areas. Ultimately, Indonesia's progress toward universal health coverage and greater health-system resilience will depend on its ability to align regulation, financing, service delivery, human resources, and digital transformation within an integrated, equitable, and accountable governance framework.

Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this review.

Author Contributions

Both authors contributed equally to this work, including the conception and design of the review, literature search and synthesis, drafting of the manuscript, and critical revision of the manuscript for important intellectual content. Both authors read and approved the final manuscript.

Data Availability Statement

This is a narrative review article; no new primary data were generated or analyzed.

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