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Navigating the Politics of Business

Value-Based Assessment in Indonesia's Healthcare System

PREPARED FOR ASIA PACIFIC MEDICAL TECHNOLOGY ASSOCIATION (APACMED)

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EXECUTIVE SUMMARY

Although there exists a framework for value-based assessment within Indonesia's universal healthcare scheme (JKN), priority still lies on reducing cost. Challenges to implementation include a gap in knowledge among policymakers, a lack of financial and human resources, more pressing priorities amid widening JKN deficits, and little political will from high-ranking officials to drive improvements in value-based healthcare. **However, there is growing appetite among key stakeholders to learn more about developing value-based healthcare in Indonesia, creating opportunities for APACMed to explore avenues to support improvements.**

The most systematic and applied value-based assessment method in Indonesia is the Health Technology Assessment (HTA). **In theory, a HTA study should be conducted on each product considered for listing in the national formulary for drugs (FORNAS) and the compendium for medical devices. In practice, HTA in Indonesia is still heavily focused on minimizing cost and has rarely been used to influence the listing of drugs and medical devices.** The Indonesian government is aware that the number of HTA studies conducted is too few, especially for medical devices. Cited barriers include financial limitations, human resource capacity, and a lack of localized data.

Nevertheless, the Ministry of Health remains committed to HTA. Ideally, policymakers aim for the application of HTA to always be conducted in developing the list of drugs and medical devices for JKN coverage. **However, it will take some time before a fully functioning relationship between the HTA and drug and medical device listing exists, with a projected timeline only starting in 2026.**

Meanwhile, to better reflect the Indonesian healthcare needs and demographics in JKN reimbursements, the Ministry of Health is developing a new grouper for the Indonesian Case Based Groups (INA-CBGs). **The priority on lowering cost is consequently reflected in the ongoing reform to the INA-CBGs grouper, which does not prioritize value-based indicators such as quality of life.** While policymakers are aware that value-based indicators should be tied to JKN reimbursements, challenges persist, including a lack of clear authority within the Ministry of Health, minimal inter-agency collaboration, pressing priorities amid COVID-19, and budgetary and human resource limitations.

Lastly, the public procurement system—the e-catalogue—remains separate from the HTA. **Although there is a theoretical framework for HTA to influence the listing of medical products in the e-catalogue, this relationship is practically non-existent, especially for medical devices**. The Ministry of Health's priorities for recommending drugs and medical devices to the National Procurement Agency (LKPP) for listing in the e-catalogue remains focused on local content and alignment with the Ministry's priority programs, such as maternal mortality and COVID-19.

The findings in this report were obtained following in-depth desk research, conversations with APACMed members, and discreet interviews with numerous stakeholders, including from the Ministry of Health, the Center for Financing and Health Insurance (PPJK), National Case Mix Center (INA-CBGs Technical Team), and the E-Catalogue Assessment Team. Vriens & Partners also spoke with representatives from Commission IX overseeing health, labor, and population; as well as academics, members of the medical profession, and the Indonesian Doctors Association (IDI).

INTRODUCTION

Since 2014, Indonesia has been building on, and often grappling with, the ambitious rollout of its Universal Healthcare Scheme, Jaminan Kesehatan Nasional (JKN). The rollout of JKN at the beginning of President Joko Widodo's first term marked the start of Indonesia's journey towards a more accessible public health system, in line with the Ministry of Health's priority to improve and widen access to quality health services.[1] **However, concerns remain around its sustainability and implementation.** Structural challenges for patients persist, including readiness of hospitals, complex procedures, and high out-of-pocket (OOP) payments for specialized care. Meanwhile, the cost to healthcare providers remains high, with reimbursements under JKN from the Social Security Administrator for Health – BPJS Kesehatan – to hospitals often delayed. **With widening deficits, the government is discussing making JKN more sustainable through better financing and lowering expenditures.**

The architects of the JKN understood the need for value-based healthcare during its creation. At its core, value-based healthcare was introduced to drive improved patient and budgetary outcomes while challenging ineffective and inefficient medical practice, including costly interventions with few benefits. The Health Technology Assessment (HTA) Committee was created in 2013 as part of the JKN to conduct all HTA-related activities that would ultimately support universal healthcare scheme. However, a lack of political will among high-level officials has impeded the robust implementation of the HTA, with *value* still defined as minimizing up-front spending.

Numerous stakeholders are involved in the HTA, but the Center for Financing and Health Insurance (PPJK) under the Ministry of Health is its main overseer (as outlined in the figure below). The PPJK supervises the HTA Committee — which does HTA assessments — and hosts the National Case Mix Center, which looks after the treatment reimbursement system through the Indonesia Case Based Groups (INA-CBGs).

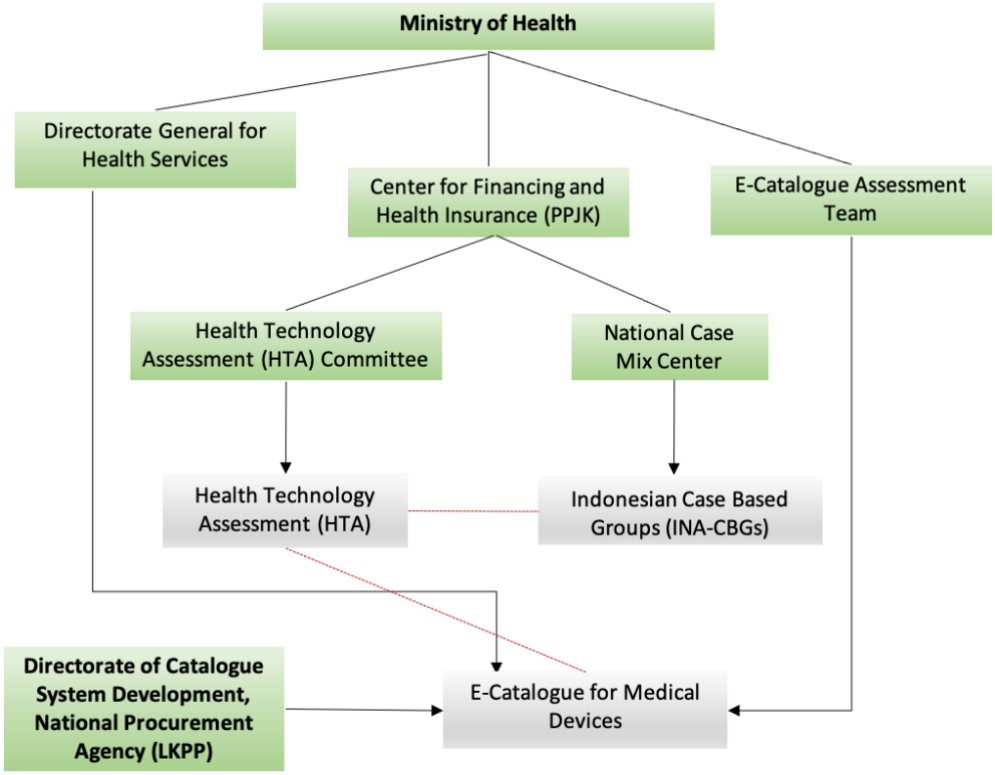

Figure 1: Relationship between key stakeholders in Indonesia's value-based healthcare ecosystem

[1] According to the Ministry of Health's 2020-2024 Strategic Plan

In-depth desk research coupled with discreet interviews with policymakers and regulators show that despite the Ministry of Health's existing framework for value-based assessment in the JKN, priority still lies on reducing cost. Uncertainty remains around several supporting elements, including how the HTA interacts with the INA-CBGs reimbursement process and the e-catalogue. This relationship proves more unclear for medical devices. The reform to the INA-CBGs grouper remains focused on price with no consideration for value-based indicators. The e-catalogue listing process theoretically involves the HTA. In practice, however, it is largely sidelined.

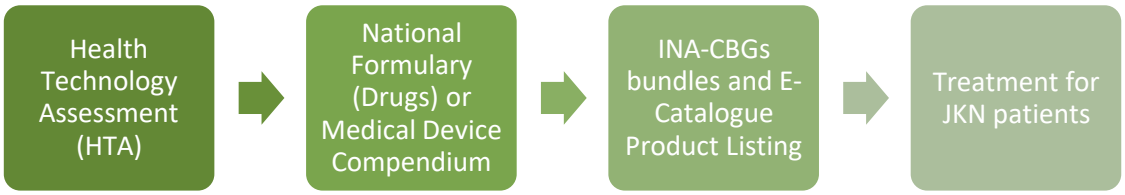

Figure 2: The existing theoretical framework for value-based assessment within Indonesia's universal healthcare scheme

The Ministry of Health and BPJS Kesehatan have expressed a wish to improve the landscape for value-based assessment, including through strengthening the HTA and integrating value indicators into the INA-CBGs. However, challenges to this vision persist. These include insufficient data; a lack of human resource capacity; little incentives and political will; and limited budget—especially as priorities shift due to the COVID-19 pandemic. Nevertheless, these challenges present opportunities for the private sector to investigate pathways for engaging the government to explore opportunities to support the improvement of value-based healthcare in Indonesia.

This landscape assessment focuses on the Indonesian government's perspective and policy direction on value-based assessment in healthcare policy in the context of JKN.

Health Technology Assessment (HTA)

Indonesia formally introduced the Health Technology Assessment (HTA) in 2013 as a tool for priority-setting on coverage under the universal healthcare scheme (JKN). Having considered different approaches to assessing value and allocating resources, including Managed Entry Agreements (MEA) and Most Economically Advantageous Tender (MEAT), the Ministry of Health settled on implementing HTA—now the only value-based assessment method in the country. This was due to the availability of more data and studies for HTA as it is a more commonplace approach. **Stakeholders within the Ministry of Health also recognized HTA's main advantage to provide scientific evidence in assessing the value of treatment tools**. In the context of JKN, the implementation of HTA is hoped to reduce out-of-pocket (OOP) payments and provide cost-effective treatment options. These efforts are deemed critical to ensuring JKN's long-term financial sustainability.

The implementation of HTA under the JKN is regulated through Presidential Regulation No.12 of 2013, which mandates the Ministry of Health to implement and consider the HTA, clinical advisory, benefits, standard tariff, and monitoring and evaluation for drugs and medical devices covered by the JKN. The use of HTA is developed and performed by the HTA committee under the Ministry of Health, who receives proposals from different stakeholders and recommends its findings to the Minister of Health. Each year, the HTA Committee creates an annual study plan laying out the treatments it plans to assess over the following 12 months. During the planning process, input can be provided by the private sector, patient groups, professionals, and government officials.

According to Indonesia's national health insurance guidelines, a HTA approach should be used to select a health technology or intervention, including drugs, medical devices, and diagnostics, which will be covered by the JKN. Therefore, a HTA study should be conducted on each product considered

for listing in the national formulary for drugs (FORNAS) and the compendium for medical devices, which eventually will inform the development of the e-catalogue. **Yet although the HTA guideline was published in 2013 and the HTA Committee installed in 2014, HTA has not been systematically implemented in the development of the FORNAS, medical device compendium, and the e-catalogue.**

There also exists a disproportionate use of HTA on drugs. This is mainly due to the perception within the Ministry of Health that there is a lack of internal knowledge, resources, and capabilities to assess the complexities of medical devices.

Finally, according to the HTA guidelines, HTA studies should consider safety, efficacy, cost-efficiency, social, ethical, legal, political, and religious effects, egalitarian equity, affordability, and budget impact analysis. **However, HTA in Indonesia is still heavily focused on minimizing cost.** This stands amid the government's worries around JKN's financial sustainability due to increasing deficits. Meanwhile, different ministers, especially from the Ministry of Health and Ministry of Finance, are debating the basic needs to be covered by JKN, with lowering deficits as priority.

Challenges and Opportunities

The Indonesian government is aware that the number of HTA studies conducted is too few, especially for medical devices. It considers 2016 to 2025 a "transitional learning period" until HTA's full implementation by 2026. **Policymakers under the Ministry of Health's Center for Financing and Health Insurance (PPJK), which houses the HTA committee, have identified various barriers impeding the planning and implementation of HTA.**

The first challenge is financial. Little resources, particularly following budget cuts due to the COVID-19 pandemic, are available for paying HTA experts, hosting HTA seminars, and performing HTA research—resulting in very few studies conducted. The HTA Committee, in its wish to remain independent, is wary of conducting HTA studies financed by sources other than state entities. **There is also a lack of capacity of local human resources**. As HTA is a new science in Indonesia, there is a lack of HTA academics, training, and associations in the country. Both challenges culminate into the broader lack of a clear framework of how HTA results can be implemented in healthcare policy under the JKN.

Ministry of Health officials also identified the lack of localized data for conducting HTA studies. Meanwhile, there are difficulties to access existing data on the national scale, which is managed by JKN administrator BPJS Kesehatan. BPJS Kesehatan has explained that the insufficient data is caused by unclear indicators on the types of data needed for conducting HTA studies.[2] Further, healthcare data, such as registry and individual patient data, have not been integrated nationally.

Nevertheless, the Ministry of Health remains committed to HTA. Policymakers are aware that the use of HTA is mandated in the regulation for implementing the JKN and that HTA will ensure the treatment tools listed for the coverage offer better patient outcomes. Ideally, they aim for the application of HTA to always be conducted in developing the list of drugs and medical devices for JKN coverage through the National Drug Formulary (FORNAS) and medical device compendium. The Ministry of Health also wants to increase the number of HTA studies on medical devices. **However, given that the deadline goal for full implementation is 2026, it will take some time before a fully functioning relationship between the HTA and drug and medical device listing exists, especially amid the government's priority in reducing JKN deficits.**

The Ministry of Health is also developing a HTA Roadmap with a plan to integrate HTA with all policies and regulations governing health services. Officials within PPJK did not give further

[2] Under the HTA guidelines, such data include real world clinical data and cost for economic analysis, consensus development, technical studies (functionality, validation), expert and user opinion, epidemiological and observational studies, and clinical trials, among others.

information nor is the timeline for completion clear at this stage, due to the disruptions caused by COVID-19.

Indonesian Case Based Groups (INA-CBGs)

Following the inception of the universal healthcare scheme (JKN), the government started implementing the Indonesian Case Based Groups (INA-CBGs) tariff rates for healthcare payment. Intended to promote efficiency and cost-saving among healthcare providers, the INA-CBGs force hospitals to administer treatment according to need and hopefully reduce unnecessary services.

The Ministry of Health leads the process to set INA-CBG and capitation tariff policies and rates, while BPJS Kesehatan handles claims processing and payments. The National Case Mix Center (INA-CBGs technical team) under the Ministry of Health's Center for Financing and Health Insurance (PPJK) is responsible for developing, implementing, and monitoring the INA-CBGs payment system. This includes coding, grouping, and tariff-setting. The BPJS Kesehatan reimburses hospitals according to the INA-CBGs with rates based on illness type, severity, and hospital class—while taking into account the varying levels of cost inflation in different regions.

The Ministry of Health's priority in implementing INA-CBGs is reducing cost and redundancy in reimbursements. INA-CBGs tariffs do not cover the full cost of treatment and health services as the Ministry of Health continues to heavily subsidize public healthcare facilities such as infrastructure and maintenance, equipment, and personnel. Other stakeholders concerned with INA-CBGs implementation, such as the BPJS Kesehatan and parliament, are similarly focused on maximizing INA-CBGs efficiency while addressing JKN budget deficits.

Currently, hospitals can request for "top-ups" for special conditions (e.g. special procedures, drugs, prosthesis), particularly for cases where the hospital's expenses for that treatment are large compared to the set INA-CBG tariff. **Health technology assessments (HTAs) have been performed to determine eligibility for "top-up" payments for certain expensive drugs, although the same cannot be said for medical devices**. However, implementation of 'top-ups' has been extremely scarce and will remain challenging, given the very few numbers of HTA studies and the rarity of cases eligible for "top-up" (e.g. chemotherapy).

Reform to INA-CBGs

The priority on lowering costs is reflected in the ongoing reform to INA-CBGs. In 2018, the National Case Mix Center under the Ministry of Health started a review of the INA-CBGs grouper following feedback from healthcare providers, academics, the medical profession, and parliament around the INA-CBGs' efficiency and applicability to the Indonesian health context.[3] Based on the Malaysian grouper, the current INA-CBGs has been criticized for not reflecting Indonesia's healthcare context and costs. The development of a truly Indonesian grouper is thus hoped to minimize cost, address the Indonesian healthcare needs, and better reflect the country's demographics and disease profile. Trials of the newly developed grouper started in April 2020 but have been impeded by budget cuts and shifting priorities amid the COVID-19 pandemic. Around 36 central government or vertical hospitals are currently testing the new grouper, with evaluation and many improvements still underway. Previously targeted for 2021, the revision's completion deadline is now unclear.

The new grouper does not prioritize the inclusion of value-based indicators. For example, rather than evaluating the cost of the treatment in regard to patient outcomes and longer-term health projections, it looks at the immediate expenses over a set timeframe.

[3] The INA-CBGs current grouper was created by United Nations University Japan based on the Malaysian healthcare system, disease profile, and cost distribution.

In the meantime, the Costing Team of the National Case Mix Center responsible for setting the tariff will continue assessing the average costs. In determining the final cost for each grouping, JKN administrator BPJS Kesehatan and the Ministry of Health will discuss with the National Case Mix Center.

SINGLE-TARIFF POLICY

In a bid to improve healthcare delivery and ensure JKN sustainability, the government has reportedly been discussing the implementation of a single-tariff policy for JKN coverage which will standardize basic needs and hospital class for JKN patients. While INA-CBG tariffs are currently adjustable according to factors including the regional classification of the hospital and special medical cases, a single-tariff policy will entail a blanket tariff across hospitals and services for the same treatments. **However**, **discussions around single-tariff policy of the JKN are still in the nascent stage**, **and the single-tariff policy remains a long-term plan.**

In the meantime, different ministries including the Ministry of Finance and Ministry of Health, as well as professional associations, are still debating the definition of basic needs and the standardized hospital class to be covered under the JKN. **Discussions on the single-tariff policy cannot proceed unless this debate has concluded**. The National Case Mix Center remains focused on first reforming the INA-CBGs grouper without considerations for the single-tariff policy.

Nevertheless, advocacy opportunities exist for industry players seeking to discuss single-tariff policy under the JKN as policy discussions are still in the ideation stage.

CHALLENGES AND OPPORTUNITIES

In the long term, Ministry of Health officials hope that the INA-CBGs will move beyond concerns around up-front costs. **The Ministry of Health's PPJK – which regulates health financing and the JKN and are deeply involved with the HTA and INA-CBGs – point to the lack of multi-stakeholder collaboration in implementing value-based assessments in INA-CBGs and thus payments under the JKN.** PPJK's leadership regrets that the burden of evaluating and implementing value-based assessment in JKN policy rests on them, suggesting that BPJS Kesehatan and the Directorate General for Health Services should take more responsibility for the implementation and development of the HTA and INA-CBGs.

Another barrier to implementing value-based assessment in JKN payments through the INA-CBGs lies in the unclear division of authority among relevant stakeholders. For instance, the Ministry of Health leads the process to set INA-CBGs and capitation tariff policies and rates, while BPJS Kesehatan handles claims processing and payments. At present, however, a framework for inter-agency cooperation on value-based assessment in the INA-CBGs and e-catalogue does not exist. Additionally, both institutions collect and maintain different sets of data without established mechanisms for sharing and collaboration.

The National Case Mix Center, PPJK, and the parliament attest to the challenge of financial and human resource capacity. There is a lack of knowledge of value-based indicators amongst policymakers and the technical team, including how such indicators have been applied in other countries' universal healthcare schemes and how they can potentially be integrated with the INA-CBGs system. In pushing for INA-CBGs reform in the past, the parliament's now disbanded working committee (*Pandja*) on INA-CBGs only discussed problems relating to cost, partly due to their inability to conceptualize value-based indicators and suggest value-based considerations for the new grouper to the Ministry of Health. Lastly, the COVID-19 pandemic has shifted the National Case Mix Center's priorities towards COVID-19 reimbursement, giving little urgency to discussions around value-based assessment.

However, there is growing appetite amongst policymakers to learn about how to apply value-based assessment in the INA-CBGs system. Ministry of Health officials have pointed to other countries which

consider quality indicators beyond pricing in their universal healthcare payment systems, such as the United Kingdom and Thailand, as ideal examples. The PPJK has also considered a reward system in the future whereby hospitals are recognized for reaching targets related to value indicators, which the BPJS Kesehatan will determine. However, this idea is at its early stages and it remains unclear whether the idea is supported by other stakeholders within the Ministry of Health.

VALUE-BASED PROCUREMENT: THE E-CATALOGUE

Ideally, were the Health Technology Assessment (HTA) system fully operational, it should influence the choice of pharmaceuticals and medical devices listed in the online public procurement system, the e-catalogue, as illustrated in Figure 3. **In reality, HTA is not part of the e-catalogue decision-making process, either by the Ministry of Health's e-catalogue assessment team or the National Procurement Agency (LKPP), as shown in Figure 4.**

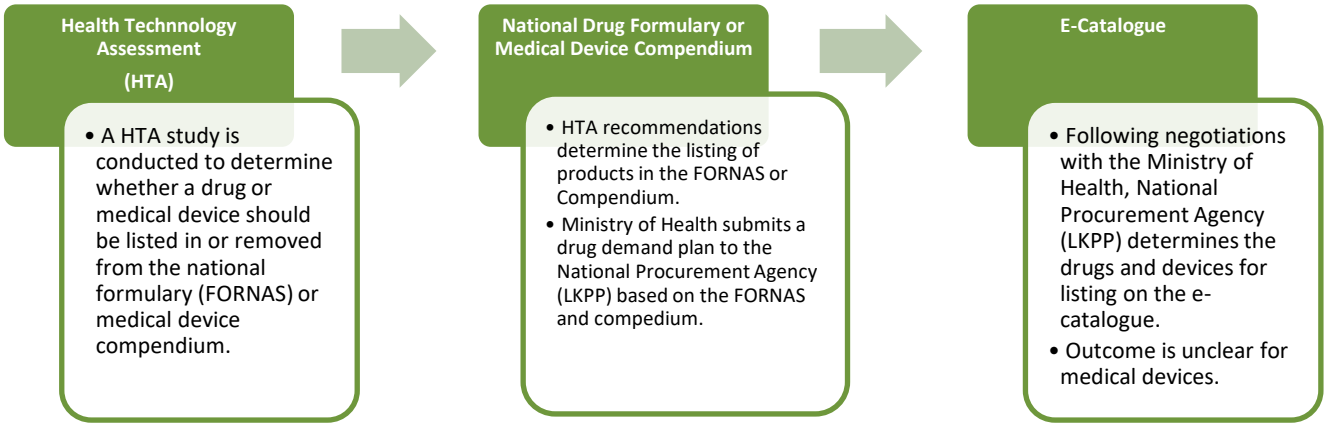

Figure 3: The Ideal Application of Value Based Assessment in E-Catalogue Listing Process

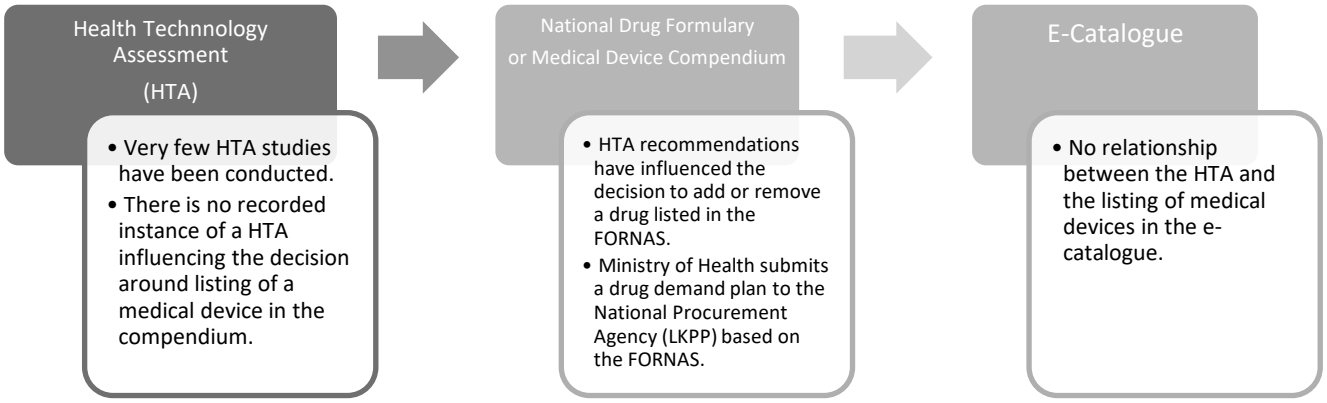

Figure 4: The Actual Application of Value Based Assessment in E-Catalogue Listing Process

There already exists a theoretical framework for the HTA and the listing of drugs in the e-catalogue—although the same does not hold true for medical devices. The Indonesian government has been trying to better integrate its national drug formulary (FORNAS) with the e-catalogue in a bid to improve quality while maintaining fair pricing. The e-catalogue listing process for drugs starts with the development of a Drug Demand Plan (RKO) by the Ministry of Health and based on the FORNAS. Following pricing negotiations with LKPP, the approved drugs for listing will be listed for procurement through the e-catalogue. **HTA-recommended drugs will be listed on the FORNAS, while a drug which**

is not recommended by the corresponding HTA will never be listed on FORNAS, and in extension, the e-catalogue. However, there have been so few HTA studies conducted that this relationship is practically non-existent.

In its decision-making on the e-catalogue, particularly to assess the cost-efficiency of a product, the Ministry of Health's e-catalogue assessment team can request for a HTA study on a drug or medical device. Yet such request has never been submitted, and the HTA has remained separate from the Ministry of Health's assessment throughout the e-catalogue listing process.

The Ministry of Health's priorities for recommending drugs or medical devices to the LKPP remain the following:

1. Local content
2. Alignment with Ministry of Health's priorities (e.g. COVID-19, maternal mortality)
3. Specifications and features
4. For medical devices, demand of medical personnel
5. Urgency (e.g. COVID-19 procurement falls outside of e-catalogue)

In line with the above priorities, the upcoming e-catalogue listing for medical device will be conducted in the following stages:

1. Domestically produced medical devices – currently ongoing and awaiting review before listing
2. Medical devices and equipment for COVID-19 treatment
3. Imported medical devices and teaching devices – currently waiting for budget and personnel, will be conducted together with the opening for pharmaceuticals
4. Consumables products and devices for teaching

According to the Director General for Health Services at the Ministry of Health, a renewed priority is the expansion plan of medical facilities to the outer parts of Indonesia (East and Central) as an effort to improve access to care. For its assessment on medical device procurement in the "new normal" era, the Ministry of Health will consider the disease pattern in the dedicated area and the capacity of healthcare providers in treating a disease. The renewed framework for the development and expansion of medical device infrastructure and facilities (SPA) include factors such as healthcare service delivery programs; environmental, building and land conditions; medical device planning; technological capacity; maintenance; and price.

CHALLENGES AND OPPORTUNITIES

Policymakers attribute the lack of value-based consideration in the e-catalogue to limited financial and human resources. Given the Ministry of Health's main concerns on the widening JKN deficits and price affordability, there remains little political incentive for incorporating value-based assessment in the e-catalogue.

There is consistent personnel change within the National Procurement Agency (LKPP), which directly impacts the institutional knowledge and capacity of the catalogue team. Echelon III- and II-level officials point to the challenges in understanding how a medical device works due to the lack of technical training on a particular product. This gap in knowledge is further exacerbated by the lack of knowledge transfer from trained to untrained officials. This rings especially true following recent reshuffles of officials in the Ministry of Health and the National Procurement Agency (LKPP).

In the past, the Ministry of Health's e-catalogue assessment has received technical training on new medical technology, but not any specialized training on conducting assessments for the e-catalogue. There is hence a weak foundation upon which technical knowledge and understanding on value-based indicators can inform their assessment for the e-catalogue.

Nevertheless, officials expressed hope that HTA can eventually be used for every assessment conducted for the e-catalogue, including medical devices through the national compendium. There is growing appetite to learn about best practices on the role of value-based assessment and procurement in healthcare around the world, as well as innovative funding mechanisms which can be applied in Indonesia. The Ministry of Health's catalogue assessment team remains open to receiving technical training by the private sector as a well-rounded understanding of a medical device will improve understanding of the product's value beyond cost. The technical training can cover device management, specifications, regulations, performance indicators, and cost-efficiency.

Relevant Stakeholders

Ministry of Health

Institution	Roles and Positioning
Center for Health Financing and Insurance (PPJK)	**Roles:** • A unit within the Ministry of Health which regulates health financing and the JKN at large. • Houses the Health Technology Assessment (HTA) Committee and the National Case Mix Center as the INA-CBGs Technical Team. • Comprises three main departments: health financing, economic evaluation, and health insurance. • Some research members lead or are involved in HTA studies.
Health Technology Assessment (HTA) Committee	**Roles:** • Appointed by the Ministry of Health to conduct assessments of health technology and interventions, including drugs, medicines, methods and diagnostic tools. • Coordinates all HTA activities in Indonesia. • Proposes, collects, and analyzes data for recommendations to the Ministry of Health.
National Case Mix Center (INA-CBGs Technical Team)	**Roles:** • Develops, implements, and monitors the INA-CBGs payment system. ○ This includes coding, tariff-setting, and maintenance. • Currently reforming the INA-CBGs grouper to reflect the Indonesian disease profile and true costs to healthcare providers.
E-Catalogue Assessment Team	**Roles:** • Conducts reviews for the assessment of drugs and medical devices to be recommended by the Ministry of Health for listing on the e-catalogue.

Directorate General of Health Services	**Roles:** • Formulates and implements policy on health services, such as the improvement and accessibility of health services, facilities, primary healthcare quality, and referral system. • Develops a list of *types* of medical products and interventions needed to be included in the e-catalogue. • Has knowledge of the on-the-ground conditions of healthcare facilities across Indonesia in the context of JKN.

Other Government Stakeholders

Institution	Role and Positioning
BPJS Kesehatan	**Roles:** • National JKN administrator and funder of payments. • Has authority to determine health benefits package and what goes inside the national drug formulary (FORNAS) and medical device compendium. • Commissions HTA studies on priority topics.
Directorate for Catalogue System Development at National Procurement Agency (LKPP)	**Roles:** • Develops strategy, policies, and standard operating procedures for the government's procurement of goods and services. • Regulates and monitors procurement through the e-catalogue. • Receives recommendations from the Ministry of Health and negotiates the list of drugs and medical device products for the e-catalogue. • Determines prices for health products on the e-catalogue, limited by the Ministry of Health's set maximum price.
Commission IX of the Parliament (DPR)	**Roles:** • Supervises health, manpower, and population affairs. • Drafts legislation, monitors and provides input to the Ministry of Health and BPJS Kesehatan on JKN implementation. • Pushed for INA-CBGs reform to improve cost-efficiency.

Academics and Practitioners

Institution	Role and Positioning
Center of Health Economics and Policy Studies (CHEPS) at University of Indonesia	**Roles:** • A premier institution for research and evidence to support policy implementation in Indonesia. • Consulted by the Ministry of Health in the creation and implementation of the JKN and HTA. • Some academics from the Center have been involved in HTA research. • Has received capacity-building capacities and exchanges from international organizations and government agencies on the HTA.

Health Financing and JKN Division at the Indonesian Doctors Association (IDI)	**Roles:** • As a professional organization, helps the governments by providing guidelines, monitoring, sanctioning, and improving the quality of doctors. • Involved in and consulted by the Ministry of Health for JKN policy, including INA-CBGs reform.