Women's World Banking

Unpaid, Underserved, Unprotected: Fixing The Healthcare Financing Gap For Indonesian Women

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Executive summary

Under the Indonesia Emas 2045 Vision, Indonesia is striving to become a high-income nation, emphasizing economic growth and social inclusion. Despite this earnest intent, women's ability to contribute fully to the economy remains constrained by financial and healthcare barriers. With a low labor force participation rate (53.5%), many women face challenges in balancing work and healthcare costs, especially in maternal and reproductive care and chronic disease management.

Awareness and accessibility barriers may be preventing women—particularly those in low-income and informal employment—from fully utilizing their BPJS Kesehatan benefits. As of June 2024, BPJS Kesehatan recorded a dormancy rate of 19.9%, with 55.4 million inactive participants out of 278.1 million enrolled (covering 98.45% of Indonesia's population). This high rate of inactivity suggests that coverage does not always translate to effective usage. For women, this gap may be compounded by financial constraints and high out-of-pocket (OOPE) healthcare expenses, often leading to delayed treatment or increased financial stress.

Indonesia's healthcare system remains fragmented, with limited integration between public and private insurance, namely Coordination of Benefits[1], forcing women to choose between restricted BPJS Kesehatan coverage or expensive private care. Women require more flexible, tailored and accessible financing solutions, such as installment-based health savings, micro-health insurance and employer-supported schemes to bridge the affordability gap. Addressing these matters is not only essential for improving healthcare outcomes, but goes toward empowering women to participate more fully in Indonesia's economic growth.

Golden Indonesia 2045 Vision

Goal

Become a high-income nation by 2045, with economic growth and social inclusion

Women's economic participation is key, but also a challenge

- Only **53.5%** of women are in the workforce
- Health costs make it even harder for women to stay employed

National Health Coverage (BPJS)

278.1M	55.4M (19.9%)
People enrolled	Inactive

Causes of inactivity

- Financial constraints
- Low awareness
- Accessibility issue

1 The Coordination of Benefits scheme, under Permenkes No. 3 of 2023, was introduced to enable individuals with both BPJS Kesehatan and inclusive insurance to combine their benefits, reducing out-of-pocket medical expenses and expanding access to healthcare

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Government bodies	Ministry of Health, Ministry of Women Empowerment and Child Protection, Otoritas Jasa Keuangan, Bank Indonesia, BPJS Kesehatan, Bappenas, Digital Transformative Office-Ministry of Health
Industry associations and professional organization	Asosiasi Asuransi Jiwa Indonesia (AAJI), Asosiasi Asuransi Umum Indonesia (AAUI), Perkumpulan Ahli Manajemen Jaminan dan Asuransi Kesehatan Indonesia (PAMJAKI), Ikatan Bidan Indonesia (IBI), Pengurus Pusat Ikatan Bidan Indonesia (PPIBI)
Civil society organizations	Yayasan Alzheimer Indonesia (ALZI), Komunitas Peduli Skizo (KPSI), Perkumpulan Penyandang Disabilitas Indonesia (PPDI), Gerakan Kesehatan Ibu dan Anak (GKIA), Gerakan Ibu Menyusui (AIMI ASI), Yayasan Kanker Indonesia (YKI)
Health advocacy and research institutions	Health Advocacy and Research Institutions: Thinkwell, Center for Indonesia's Strategic Development Initiatives (CISDI), World Health Organization (WHO), United Nations Population Fund (UNFPA), UN Women, Pusat Studi Kesehatan Perempuan UI, Global Reporting Initiatives (GRI)
Private sector and financial institutions	B. Braun Medical, BNI, BRI, Maybank, AFTECH, GoJek and CareNow

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Introduction

Indonesia aims to become a high-income nation with a strong and inclusive economy by 2045 under the Golden Indonesia (Indonesia Emas) 2045 Vision. Unlocking the full productive potential of women aged 15–64 is essential to this goal. However, persistent health and financial barriers—such as limited access to affordable care, underutilization of BPJS Kesehatan, and the high burden of out-of-pocket health costs—constrain women's ability to participate fully in the workforce. Women's World Banking recognizes that these are not just individual challenges, but symptoms of systemic market failures in both the healthcare and financial ecosystems.

The Healthy Indonesia 5.0 program focuses on improving the use of technology and innovation for disease prevention, building health resilience, and healthcare modernization, but must also tackle the health and financial challenges faced by working-aged women. This offers a pivotal moment to embed gender-intentional solutions—including tailored health financing products and digital savings tools for women.

Our research highlights how misalignment in the system that impacts women in the workforce. Issues such as inactive BPJS coverage affecting 19.9% members (~55.4 million people), predominately from non-subsidized members, unaffordable care and a lack of financial protection highlight the challenges many face in accessing or fully utilizing their benefits due to financial constraints, lack of awareness, or service accessibility issues.

Working-age women are particularly vulnerable, balancing economic roles with caregiving responsibilities, and facing heightened risk when health and financial systems fall short.[2] Women's World Banking addresses these systemic failures by designing and advocating for gender-intentional solutions that meet the needs of both women and men, thereby unlocking economic opportunities and enabling job creation. Through gender-intentional approaches—like tailored financial health products—our work strengthens women's ability to stay healthy, financially resilient, and economically active.

Understanding BPJS

BPJS (Badan Penyelenggara Jaminan Sosial) is Indonesia's national social security agency, split into two entities:

- **BPJS Kesehatan** – manages universal health coverage (JKN).
- **BPJS Ketenagakerjaan** – provides employment-related protections like pensions, work accident, and death benefits.

While institutionally separate, both aim to deliver comprehensive social protection across health and employment needs.

Aligning with *the Healthy Indonesia 5.0* agenda, a comprehensive, inclusive healthcare strategy that centers on women's realities is not just necessary—it is fundamental to achieving Indonesia Emas 2045. By addressing the root causes of exclusion, we can drive inclusive growth and ensure women's full participation in the economy and society.

2 Laksono, A.D., Nugraheni, W.P., Rohmah, N. et al. Health insurance ownership among female workers in Indonesia: does socioeconomic status matter?. BMC Public Health 22, 1798 (2022). https://doi.org/10.1186/s12889-022-14189-3

Infographic: Unpaid, underserved, unprotected: Where women fall through the cracks

Women population

136.3 million → **50% of population**

Women working age population

94.5 million → **69% of women population**

Unpaid: Health costs push women toward financial strain

71% of women's monthly non-food spending is needed for public hospital care; **112%** for private care.[3]

16.7% of mothers spend over **5%** of household income for childbirth; **8.4%** spend over **10%.**[4]

Fertility care remains largely uncovered by BPJS or insurance despite **11%** of couples experiencing infertility.[5]

Underserved: Few financial tools fit women's health

Insurance penetration is low (**2.72**% of GDP). Of the **151** insurers, **78** offer non-life insurance—including health coverage—but only a few provide individual or standalone health plans, as most are distributed through employer-based group policies or bundled with life insurance.

No dedicated health savings products exist; current ones only support auto-deductions to facilitate BPJS payment contributions.

Health loans are niche and unscalable—e.g., only **0.2**% of chronic patients use digital loans and **1.4**% use pawnshops

3 https://www.ceicdata.com/en/indonesia/average-monthly-expenditure-per-capita/average-monthly-expenditure-per-capita-goods-and-services-health-private-hospital?utm_source=chatgpt.com

4 https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0235176&type=printable

5 https://pubmed.ncbi.nlm.nih.gov/23661416/

Unprotected: Enrolled, but not effectively covered

278.1 million Indonesians are enrolled in BPJS Kesehatan (**98.45**% coverage), with women making up **49.46**%.[6]

55.4 million BPJS Kesehatan participants (19.9%) are inactive—pointing to usage gaps, not just enrollment.

Only **2**% of dormant participants reactivated their BPJS via REHAB program (Rencana Pembayaran Bertahap) as as of Dec 2024. The reactivation target for dormancy is at **4.71**% by 2024 and **18**% by 2025.[7] REHAB is a BPJS Kesehatan's initiative allows members with 4 to 24 months of unpaid premiums to repay their dues in instalments.

6 https://kesehatan.djsn.go.id/kesehatan/

7 https://kesehatan.djsn.go.id/kesehatan/uploads/penetapanck/Salinan_KepDJSN_Nomor_3_Tahun_2024_Penetapan_ICK_BPJS_Kesehatan_Tahun_2025.pdf

Approach

Research objectives

This research examines the health needs of working-age Indonesian women, key barriers they face in accessing healthcare, and how interventions from both government and financial service providers can bridge gaps in women's healthcare financing and enhance access to essential health services. In particular:

For policymakers

The research highlights key areas in women's healthcare financing and financial capability that require government intervention to improve affordability and accessibility. It identifies opportunities for policy-driven solutions, such as expanding insurance coverage, enhancing financial capability and introducing more inclusive healthcare financing mechanisms by strengthening coordination between BPJS and private insurance.

For Financial Service Providers (FSPs)

The research uncovers women's financial challenges related to healthcare expenses and identifies market white spaces where tailored financial solutions are needed. It points to opportunities for innovation, including embedded inclusive insurance solutions through livelihood platforms, and revolving health credit limits that cater to women's unique economic circumstances.

Research methodology

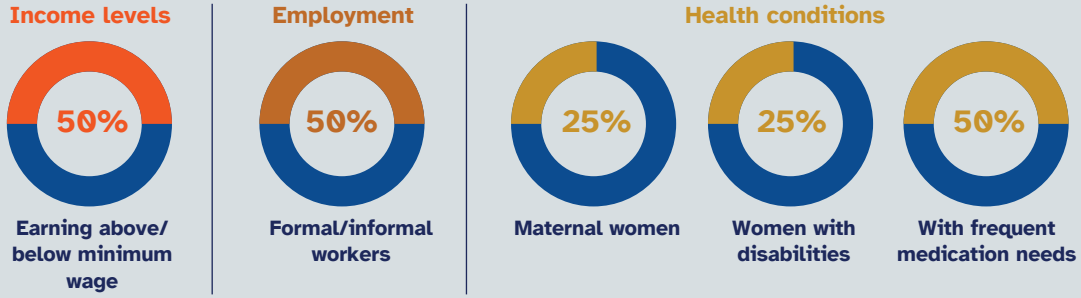
The research employs a mixed-method approach, combining qualitative and quantitative methods to gather comprehensive data on women's healthcare needs and financial challenges. The research team utilized the following methods:

Stakeholder workshops and interviews

Conducted 35 interviews with policymakers, regulators, health experts and financial service providers (FSPs) to assess women's health needs, existing financial products and collaboration opportunities. Workshops included patient associations, hospitals, BPJS and health insurance providers.

In-depth interviews and focus group discussion[8]

Engaged 35 working-age women across different income levels, employment types and health conditions:



Healthcare workers were also interviewed to understand barriers in accessing health financing services.

Consultative feedback

- Focused on cost-effective, scalable solutions rather than a broad list of interventions.
- Engaged nine key informants from various organizations including representatives from BPJS, Digital Transformative Office, Thinkwell, CISDI, AAJI, PAMJAKI and CareNow to refine policy frameworks and financial access strategies.

Secondary desk research

- Analyzed 2023 Susenas and Survei Kesehatan Indonesia (SKI) datasets to assess socioeconomic and health outcomes for women.
- Attended the Indonesian Health Economics Association Symposium and reviewed academic and policy reports on barriers to healthcare access and financial protection for Indonesian women.

8 Urban areas were chosen for sampling due to greater access to fintech and banking services. To ensure diverse insights, six provinces with varying healthcare access levels—Aceh, Kepulauan Riau, Jayapura (difficult) and DKI Jakarta, DI Yogyakarta, Nusa Tenggara Barat (easier)—were included, considering BPJS dormancy rates across regions.

Women's current healthcare needs: Maternal, reproductive and chronic healthcare

Key insights

Our research reveals that women struggle with maternal health complications and limited access to reproductive healthcare, on top of chronic disease influenced by biological, hormonal and lifestyle factors. Women's health needs extend beyond general medical care, requiring specialized services that increase their out-of-pocket expenses

Ensuring affordable and accessible healthcare financing solutions is essential to meeting these unique, lifelong needs.

Global trends show that while women live longer, they also face a heavier burden of chronic disease—a pattern mirrored in Indonesia. The 2024 Hologic Global Women's Health Index with Gallup measurement and Survey Kesehatan Indonesia (SKI) 2023 reveal that women experience higher rates of hypertension, diabetes, and cancer than men. These conditions also heighten pregnancy risks, contributing to complications such as gestational diabetes and hypertensive disorders.

Women's Health Global vs Indonesia Snapshot Table[9]

Indicator	Global	Indonesia
Women's health span	Women live longer but spend 25% more time in poor health than men (source: WEF)	SKI 2023 shows higher prevalence of chronic illness among women compared to men
Top chronic conditions	Cardiovascular disease, diabetes, cervical cancer, maternal health issues (source: WHO/WEF)	Prevalence by condition (SKI 2023): Hypertension (≥15 years): Female 10.5%, Male 5.5% Diabetes (≥15 years): Female 2.7%, Male 1.8% Cancer: Female 2.0%, Male 0.5% Heart disease: Female 0.91%, Male 0.8% Maternal conditions with risk factors (e.g. preeclampsia, GDM- a type of diabetes that develops during pregnancy): 15.6%
Health limitations	26% of women (~750M) report conditions limiting daily activities (source: Hologic Index)	No direct SKI measure, but high burden from untreated NCDs and financial barriers to care
Health index score	Global average: 53 (source: Hologic Index)	Indonesia: 57– ranks 52nd globally (source: Hologic Index)
Medical trend rate (% increase in healthcare costs)	2024 Global: 11.3% Asia: 12% 2025 Global: 10.8% Asia: 13% (Source: Mercer Marsh Benefits 2025)	2024 17.9% 2025 19% *Indonesia rate far exceeds global & regional trend rates. 2025 rate is nearly double global average (Source: Mercer Marsh Benefits 2025)

9 Global data is sourced from the McKinsey Health Institute, The Global Women's Health Index, The Mercer Marsh Benefits 2025 report. Indonesian data is primarily drawn from SKI 2023 survey, with medical cost trend rates for both Indonesia and global benchmarks taken from the Mercer Marsh Benefits 2025 Report.

In Indonesia, women face unique health challenges linked to pregnancy, childbirth, and chronic conditions rooted in biological, hormonal, and lifestyle factors. Access to quality maternal and reproductive healthcare remains uneven—particularly in poorer regions—pushing many women to pay out-of-pocket for private care not fully covered by BPJS Kesehatan.[10] These gaps create both health and financial strain.

> *Women's health is uniquely impacted by biological and hormonal factors, with fluctuations in estrogen and progesterone during menstruation, pregnancy and menopause increasing their risk of certain cancers. Additionally, caregiving responsibilities and limited healthcare access further restrict their ability to seek timely medical care.*
>
> *FGD with health experts, Jakarta*

> *During pregnancy, I paid for ultrasounds because the Puskesmas did not provide them. I went to an obstetrician at a pharmacy. Each ultrasound costs IDR300,000 (~USD17.8), and I had three scans as recommended by the doctor: at 4, 6 and 8 months. In 2022, I experienced bleeding from a contraceptive implant received during a government-organized birth control program. After a year, I requested removal at the Puskesmas and hospital but was denied and told to wait for three years. During the bleeding, I had to spend out-of-pocket (OOPE) to buy sanitary pads. Eventually, I had my contraceptive removed at a private clinic in Biak while visiting my sister, paying IDR250,000 (~USD14.8).*
>
> *A 22-year-old woman, post-maternal patient, BPJS Kesehatan PBI Beneficiary, Papua*

10 The list of BPJS Kesehatan coverage is regulated under Permenkes No. 28/2014.across regions.

Women—especially those in informal or low-income jobs—face income loss from maternity-related leave, childcare responsibilities, or illness. Without adequate coverage or support, they often return to work early at the expense of their health. Chronic conditions require long-term, specialized treatment, making affordable and continuous care critical for women's well-being and economic security.

> *Obesity and diabetes are affecting women more than men. Hormones and low physical mobility, including a lack of proper exercise, cause obesity in women (i.e. housewives who stay at home most of the time). The obesity condition generates rheumatic and muscular pain.*
>
> *A general practitioner, Jakarta*

> *Emergency funds for vulnerable women to access healthcare services can improve utilization rates, ensuring that chronic disease management is not delayed due to financial constraints.*
>
> *Health expert*

While there is no exact data on out-of-pocket expenses (OOPE) for lost wages due to health complications, childcare responsibilities and maternity leave policies in Indonesia,[11] our interviews reveal that women face a high risk of income loss from these factors. This financial strain is especially severe for those in low-income and informal employment, further exacerbating their economic vulnerability.

> ***Most of the women who visit Puskesmas are informal workers.*** *If they stop working due to pregnancy or other health complications, they don't get paid, making it harder to afford medical care. For low-income women, taking unpaid leave for maternity care or postpartum recovery isn't an option.* ***They return to work quickly, risking their health because they cannot afford to lose income.*** *Women must manage childcare expenses while also setting aside money for medical costs, often relying on informal borrowing when unexpected health issues arise.*
>
> *FGD with health workers in Jakarta*

11 Even though Indonesia has improved maternity leave policies by extending the duration to one-year, paternity leave remains minimal, preventing men from taking on a caregiving role. While women remain the primary caregivers for children, household duties and elderly family members, many of them face job insecurity, wage cuts, or slower career advancement after taking extended leave.

Indonesia women's financial challenges in healthcare

Key insights

Women in Indonesia face persistent financial barriers to healthcare—particularly for maternal, reproductive, and chronic conditions. Many struggle to afford non-covered services such as fertility treatments or pregnancy complications, often resorting to saving, borrowing, or selling assets. 19.9% of BPJS Kesehatan accounts are inactive, with women—especially those with irregular income or limited digital access—disproportionately affected. BPJS Kesehatan plays a critical role in providing coverage to 97% of the population, but challenges remain in ensuring continuous access—particularly for women with irregular income or limited digital access.

Without affordable, flexible financing options, many women delay or forgo care, increasing their long-term health risks.

> *Many informal workers, especially women, do not have access to stable digital connectivity for accessing BPJS payments, making it harder for them to keep their accounts active.*
>
> *Health policy expert, Jakarta*

1 Participation challenges in BPJS Kesehatan coverage

BPJS Kesehatan provides health protection for 273.5 million people (97.27%), including 46.9% subsidized (Penerima Bantuan Iuran, PBI). However, maintaining active participation—especially among informal workers—remains a key challenge. As of December 2024, 19.9% of members (55.4 million) were inactive, with dormancy particularly prevalent among non-subsidized members who face irregular income, limited financial flexibility, or digital access barriers.

To address this, BPJS launched the BPJS REHAB program, which allows installment-based repayment for 4–24 months of unpaid premiums via MobileJKN, Call Center 165, or BPJS offices. Yet as of December 2024, only 1.73 million had enrolled and 910,660 reactivated—just under 2% of dormant accounts, below the government's 4.71% target for the year and 18% by 2025.

Although BPJS offers broad coverage, the system's tiered referral pathway—starting from Puskesmas and involving wait periods—can further complicate access for those who re-enter the system after a lapse.[12]

12 See Appendix 1. Health Infrastructure, Appendix 2. Indonesia's healthcare financing flows, and Appendix 3. BPJS Kesehatan Health Facilities and referral system.

> *BPJS Kesehatan requires a long referral process and only covers generic medications, leading me to pay extra for non-generic drugs as I don't have time to wait that long.*
>
> *Single mother, Jakarta*

While no sex-disaggregated data is publicly available on BPJS dormancy and membership reactivation, health professionals note that dormancy disproportionately affects women in informal employment who are enrolled under their spouse's formal coverage. When these contributions lapse, women become more vulnerable—especially during periods when they need maternal or chronic care services the most.

2 Healthcare costs exceed household budgets

(Source: Susenas 2023 data)

Public hospital care for women-led households averages 71% of their monthly non-food expenditure, or approximately IDR2,882,500 (USD171.65). For private hospital care, the cost exceeds 112% of monthly non-food expenses—around IDR4,563,393 (USD271.75)—often forcing families to cut back on essentials or resort to debt.

Notably, across both public and private hospital types, women-led households consistently spend less on healthcare than men-led households. This spending gap—IDR2,882,500 versus IDR3,230,825 (USD171.65 vs. USD192.38) for public hospitals, and IDR4,563,393 versus IDR5,175,723 (USD271.75 vs. USD308.19) for private hospitals—suggests that women-led households may be delaying or avoiding needed care due to financial constraints, increasing the risk of long-term health complications.

3 High cost of maternal, fertility and non-covered care

(Source: various study)

Childbirth can impose a significant financial burden on families, with 16.7% of mothers facing costs that exceed 5% of their total annual household spending, and 8.4% spending over 10%.

For high-risk pregnancies, out-of-pocket expenses average around IDR41 million (USD2,639), while even mild complications can cost IDR19.5 million (USD1,131).[13] In contrast, the average reported ability to pay for a C-section is just IDR2.8 million (USD169), underscoring a major affordability gap.

Fertility care presents similar challenges: 11% of Indonesia's 150 million couples experience fertility problems, yet a separate study found that 40% of women surveyed could not easily pay for treatment from their regular income, 19% struggled financially, and 26% had to save in advance to afford care.[14]

Women frequently resort to paying out-of-pocket for health services that fall outside BPJS or private insurance coverage, further exacerbating financial stress.

> *Although BPJS Kesehatan covered most costs, I still had to spend IDR300,000 (~USD17.8) on transportation and IDR500,000 (~USD29.7) on non-BPJS medication. This might be manageable for me, but many women with lower income struggle significantly.*
>
> *Woman with disability and a chronic disease, Aceh*

13 https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0235176&type=printable

14 https://pmc.ncbi.nlm.nih.gov/articles/PMC3546836/

4 Low insurance adoption and awareness

Many women rely solely on BPJS Kesehatan, mistakenly believing it covers all medical needs. This over-reliance stems from low financial and health literacy, which limits their ability to plan for out-of-pocket costs or consider other options. Awareness of alternatives—like inclusive insurance, health savings, or health loans—is still low.

While insurance literacy[15] in Indonesia stands at 31.72%, actual inclusion remains much lower—rising from 13.15% in 2019 to just 16.63% in 2022. According to OJK, adoption is especially low among informal workers, factory workers, domestic workers, and microentrepreneurs, who represent 9.35% of the potential market. This suggests that awareness is not the main barrier. Instead, the gap between knowledge and usage points to deeper challenges such as affordability, trust, product relevance, and accessibility—particularly for women and in the informal sector are the main challenges. As one public health expert noted:

> *In the context of health insurance, people tend to understand its importance only after they or a family member suffer from an illness that forces them to pay high medical costs. At that point, they can compare the expenses they incur without insurance versus with insurance, as they become more aware of the risks involved. Meanwhile, those who have never experienced a serious illness themselves or within their family often do not fully grasp the concept of insurance, making them less interested. Interest in insurance is largely driven by personal experience, with financial literacy following afterwards.*
>
> *A public health expert*

5 Limited use of formal financial tools

While BPJS provides broad coverage, many women experience financial strain when seeking specialized maternal, reproductive, or chronic care services—which are often not fully covered:

> *Many women perceive BPJS as the only viable option, even when it does not cover specialized care or catastrophic health expenses, leading to out-of-pocket spending and financial strain.*
>
> *FGD with insurance association, Jakarta*

Without sufficient inclusive coverage and structured financial tools, women rely on personal savings, selling of bullion, or informal borrowing, which are often unreliable or sustainable. Individuals with chronic healthcare needs show low access to financial services, with only 1.55% using personal loans, 0.2% using digital loans and 1.4% turning to pawnshops, indicating limited financial access and a preference for asset-backed solutions.

> *If you asked me how women should prepare to maintain their health expenses? Sufficient savings to cover the OOP costs for catastrophic disease or other severe illness.*
>
> *A public health expert*

15 Insurance literacy, as defined by OJK, refers Insurance literacy is the knowledge, skills, and confidence that influence attitudes and behaviours in making better decisions and managing insurance products effectively to enhance individuals' financial well-being and protection.

Persona analysis[16]: Understanding women's financing needs

Three personas, spanning income levels and employment types, capture the diverse healthcare financing needs of Indonesian women—from low-income informal workers to financially stable professionals. Using Susenas data, we estimate each group's monthly healthcare allocation[17], focusing on women aged 18–59. Persona A includes those with education up to senior high school, while Personas B and C have at least senior high school education. Details are in appendix 4.

	Persona A Low-income women with limited financial stability	Persona B Moderate-income women with growing needs	Persona C Financially stable but selective users
Profile	Informal or gig worker earning less than the regional minimum wage, in expenditure deciles 3–4, mostly covered by fully subsidized BPJS.	Formal and informal workers with regular income above the regional minimum wage, in deciles 4–5, with BPJS non-subsidy and sometimes private/employer insurance.	Entrepreneur or salaried worker with BPJS and private insurance, in deciles 5–6. Prioritizes convenience and quality, and willing to pay for premium care.
Challenges	Irregular income and limited financial stability. Relies on subsidized BPJS but still faces OOPE—mainly for transportation and income loss when seeking care.	BPJS is insufficient for specialized or chronic care. Still incurs OOPE and lacks awareness of Coordination of Benefits scheme.	Limited provider networks and service gaps for specialized care (e.g., dental, maternity). Incurs additional costs at non-partner facilities and lacks awareness of Coordination of Benefits scheme.
Healthcare allocation capacity	IDR16,149 (~USD0.96)/month	IDR26,421 (~USD1.57)/month	IDR39,649 (~USD2.36)/month
Solution needs	Instalment-based BPJS payments (e.g., REHAB-style), inclusive insurance such as simple microinsurance or hospital cash plans, savings tools via trusted offline agents such as Midwives, health financial education tailored to low literacy levels	Inclusive insurance such as employer-linked insurance or Coordination of Benefits bundles to reduce OOPE for specialized or chronic treatments not covered by BPJS, digitally linked health savings (auto-deduction via salary or e-wallet) with optional top-ups for unexpected costs.	Integrated premium plans combining BPJS and private insurance with seamless Coordination of Benefits mechanisms for high-cost services (e.g., maternity, dental, chronic care), Health loan with upfront provider transparency on what's covered, preferably with cashless digital solution, Greater provider network options and premium service packages across both public and private systems, tailored to convenience and service quality.
Women market size estimate	43.04% (678,171)	51.09% (804,991)	5.87% (92,530)

Note: The estimated market size of ~1.5 million women (across Personas A–C) reflects a targeted subset of the broader population—those most aligned with the healthcare financing challenges and solution needs identified in this research. These personas were drawn from a filtered base population, using criteria such as income deciles, employment type, and current healthcare coverage, to illustrate solution-relevant segments, not the total addressable market.

16 Personas are representative profiles of individuals that can help us to explore the barriers, motivations and goals that real people are likely to face. Based on interviews and workshops across four regions, we developed profiles outlining key characteristics, pain points and healthcare financing needs.

17 This analysis builds on insights from the Indonesia-Ability to Pay study

Systemic barriers for women to affordable and accessible health financing

Key insights

Women face persistent barriers to affordable healthcare financing, shaped by regulatory gaps, financial hardship, and low awareness:

1. Health financing literacy, as a component of preventive care, is largely overlooked in public health programs.
2. Limited Coordination of Benefits: unclear regulations and limited hospital adoption keep it out of reach for most.
3. Lack of alternatives: existing financial tools tend to prioritize convenience over true affordability.

To strengthen women's health resilience, financial solutions must go beyond ease of payment to address affordability. This means offering flexible, low-barrier products that align with women's income patterns and reduce the long-term financial strain of healthcare.

Our analysis identifies three major systemic barriers that limit women's access to affordable and accessible healthcare financing in Indonesia. These barriers are deeply embedded in policies, regulations, institutional frameworks and financial practices—often disproportionately affecting women. They stem from governance gaps, economic structures and entrenched social norms, making them difficult to dismantle without intentional policy reforms and market-driven innovation.

1 Health financing literacy, as a component of preventive care, is largely overlooked in public health programs

Though BPJS guarantees "all medically necessary treatments,"[18] the lack of public clarity around what counts as medically indicated leads to unmet expectations and surprise OOPE.

> *BPJS guarantees coverages for all medical needs of its participants as stated in the law. However, there are exceptions for certain conditions or illnesses, particularly those that are self-inflicted. Any treatment deemed medically necessary, known as a medical indication, will be covered by BPJS. However, the definition of 'necessary' remains unclear, as medical needs can vary significantly. This ambiguity often leads to misperceptions in practice, resulting in out-of-pocket expenses (OOPE) for patients.*
>
> *Association of Health Insurance Management Experts of Indonesia (PAMJAKI) official*

18 See Appendix 3. BPJS Kesehatan Health Facilities and referral system for list of health coverage

In our interviews, most women across regions identified only BPJS or basic health insurance when asked about financial tools for managing healthcare costs. Few were aware of other inclusive financing options like microinsurance, installment-based health savings, or health loans—though interest grew once these were explained. This underscores that demand is not the issue—awareness and understanding are areas that could be addressed through targeted education and outreach.

Health financing literacy should be recognized as a core part of Indonesia's preventive health agenda. Empowering women to plan and save—particularly for maternity and chronic care—can reduce out-of-pocket costs, prevent delayed treatment, and improve health outcomes. Yet, Indonesia still lacks large-scale, integrated programs to promote this kind of financial preparedness.

While initiatives like the Ministry of Health's "Free Birthday Health Check" [19] are a positive step, these remain stand-alone programs and are not yet systematically embedded within broader health financing strategies for women. A comprehensive strategy would link these checks to follow-up treatments, preventive care, and potential health financing for services not covered by programs like BPJS Kesehatan.

> *Women with low literacy, especially those from lower-middle economic backgrounds, often do not use mobile phones to seek health information. This highlights the need for a more inclusive and educational approach to improve digital and health literacy among women.*
>
> *Center for Indonesia's Strategic Development Initiatives (CISDI) representative*

2 Limited coordination of benefits implementation: Unclear regulations and limited hospital adoption keep it out of reach for most

Although Permenkes No. 3 of 2023 allows the Coordination of Benefits, the absence of clear cost-sharing guidelines between BPJS and private insurers creates confusion among hospitals, insurers, and patients. Coordination of Benefits access is largely limited to employer-sponsored insurance, leaving out informal workers, freelancers, and the self-employed. Even of the 26.78 million private sector workers, only around 482,000 workers benefit from Coordination of Benefits—highlighting its limited reach. This indicates that a significant portion of the workforce is not benefiting from integrated insurance coverage.

> *In principle, the Coordination of Benefits scheme could be offered to individuals with a higher level of education, as they are better able to assess medical information and distinguish between which services should be covered by BPJS and which should be handled through commercial insurance.*
>
> *A public health expert*

19 The Ministry of Health's "Free Birthday Health Check" is a preventive care initiative launched in 2024, offering free basic screenings—including blood pressure, blood sugar, and cholesterol checks—for Indonesians aged 15 and above during their birthday month at Puskesmas and participating health facilities. The program aims to encourage early detection and increase public awareness of preventive care—especially among those who rarely visit health facilities unless seriously ill.

Our interviews indicate that hospitals often avoid implementing Coordination of Benefits due to reimbursement concerns, forcing patients to choose between BPJS or private insurance, rather than using both. Women and their families are typically unaware of Coordination of Benefits as an option, as hospitals rarely inform them. When seeking hospital care, they are typically asked whether they will use BPJS Kesehatan or private financing (self-payment or private insurance), but none of our respondents reported being informed about Coordination of Benefits scheme.

> *Most patients rely solely on BPJS or use it as a backup when private insurance reaches its limit. They cannot use both simultaneously to reduce out-of-pocket expenses because hospitals do not recognize a co-payment system.*
>
> *Insurance expert, Jakarta*

Also, for Coordination of Benefits to work effectively, there must be a clear system to determine the primary and secondary payer among multiple insurers. This ensures that the total reimbursement does not exceed 100% of the medical costs. However, in Indonesia, data-sharing between BPJS and private insurers is not yet well developed.

3 Lack of alternatives: Existing financial tools tend to prioritize convenience over true affordability

While many financial service provider (FSP) partnerships with BPJS Kesehatan have expanded payment channels—from Delima midwives, BRILink and Alfamart to Shopee and regional banks—they often fail to address the core issue: affordability.[20] Programs like BPJS REHAB help users repay overdue BPJS Kesehatan premiums in installments, but they do not prevent lapses in coverage, especially among informal workers facing income instability.

20 Delima Midwives is a network in Indonesia offering maternal and child healthcare, often helping with payments and savings. BRILink, run by Bank Rakyat Indonesia, provides agent banking services. Alfamart, a convenience store, offers services like bill payments and mobile top-ups. Shopee, an e-commerce platform, allows online shopping and digital payments.

> *Participants who diligently follow the BPJS Rehab program are generally those with health issues who rely on JKN facilities for their treatment, motivating them to continue paying off their overdue contributions in installments. However, some participants still fall behind on payments while enrolled in the BPJS Rehab program. To address this, BPJS actively sends reminders to encourage them to stay committed to the. installment plan.*
>
> *BPJS official*

Most FSPs continue to offer conventional financial products, with little innovation in inclusive health financing—such as microinsurance, structured health savings, or health loan tailored to women's realities. Even when piloted, health-linked financial products often get discontinued in favor of broader offerings.

> *The problem is not just about making payments easier, but about making healthcare more affordable in the first place. Many women do not have the financial flexibility to sustain their coverage.*
>
> *Financial Services Provider representative*

> *Most of the private insurance in Indonesia seems to put more focus on corporate clients rather than individuals.*
>
> *B. Braun Medical Indonesia representative*

Although FSPs do not deliver healthcare, they play a critical role in enabling health planning and resilience. But efforts remain stalled by regulatory ambiguity and risk concerns. Many institutions hesitate to enter the market without clear rules on how to integrate with BPJS or co-develop inclusive products. A lack of government-led frameworks has further slowed innovation in health-related financial solutions.

> *There is a potential for collaboration, considering that discussions are currently underway regarding additional services that could complement BPJS coverage. However, the details of this collaboration have not yet been determined, as the industry players are still unclear about what will be included on-top of BPJS services and how the mechanism will work.*
>
> *Association of Health Insurance Management Experts of Indonesia (PAMJAKI) official*

At the same time, gender-sensitive design is largely missing. Current health financing options do not reflect women's irregular income patterns—especially for informal workers who need low-barrier, flexible products. Women's demand is also underestimated, leaving many women underserved.

> *If Indonesians are broadly asked whether they need insurance, they will certainly say they do—especially since BPJS still has out-of-pocket expenses (OOPE). However, when the details of health insurance products are explained, not many would be willing to commit.*
>
> *A public health expert*

Unpaid, underserved, unprotected: Fixing the healthcare financing gap for Indonesian women

Ensuring that women have access to affordable and sustainable healthcare financing requires targeted improvements in payment flexibility, inclusive insurance and financial capability. Many women, particularly those in the informal employment sector, face financial constraints that make it difficult to maintain BPJS premium payments or access private insurance. Additionally, the lack of clear Coordination of Benefits implementation guideline and limited enrolment options create further barriers to dual coverage.

To bridge these gaps, a multi-pronged approach is needed from both policymakers and financial service providers. The following recommendations outline key strategies to improve health financing access for women across income levels.

For policymakers

Embedding financial preparedness into national preventive health strategies

One of the biggest challenges in healthcare financing is not just how people pay, but whether they recognize the need to prepare financially for medical costs. Many individuals only realize the importance of financial planning for healthcare when they face unexpected expenses. Expanding payment options alone is not enough; a more structured national approach to health-related financial resilience is essential.

Key strategies

- Integrate financial planning for health into national programs, encouraging individuals to save for medical expenses that BPJS does not cover.
- Leverage trusted community networks. Many women—especially those in informal work or with caregiving duties—have limited time for financial education. To address this, health financing education should be delivered through trusted community spaces like Puskesmas, midwife clinics. These touchpoints allow women to learn during routine visits, making education more accessible without adding extra time burden beyond their caregiving responsibilities or limited mobility.
- Use flexible learning options like WhatsApp messages, social media content and voice-based education to help women learn at their own pace, especially those with low digital capability. Religious gatherings and market-based networks can serve as alternative channels to reach women without digital access.

Policy actors involved

Efforts to strengthen financial preparedness for healthcare expenses would require collaboration among multiple stakeholders:

- The **Ministry of Health** could partner with **BPJS Kesehatan** and the **Indonesian Midwives Association (IBI)** to integrate health financing literacy into maternal health services, using midwives as trusted frontline educators. This approach leverages existing touchpoints to promote savings and financial planning before medical emergencies arise.
- In parallel, **OJK** (the Financial Services Authority) and **Bank Indonesia** can support financial service providers in developing simplified, low-barrier savings and insurance products tailored to informal workers—ensuring regulatory flexibility and consumer protection.
- The **Ministry of Finance** could play a key role by embedding health savings incentives into public programs and offering subsidies or matching schemes for preventive savings contributions.

Relevant business case:

Empowering Indonesian midwives to bridge maternal health and financial resilience for women and their families

In Indonesia, many expectant mothers face financial challenges in covering childbirth and related medical expenses, especially for services not fully covered by universal health insurance, including social expenses. Indonesia's lack of large-scale, integrated health financing literacy and preventive incentive programs leaves many low-income women unprepared for healthcare costs. Yet, targeted, community-driven models show promise in filling this gap. One such model is the BNI Midwives Health Savings Program—a partnership between Women's World Banking, Bank Negara Indonesia (BNI), and the Indonesian Midwives Association (IBI).

This initiative trains midwives—trusted figures in maternal care—as banking agents who help expectant mothers open savings accounts at midwife clinics. These accounts support gradual saving for delivery and non-covered medical costs, easing the financial burden on families. Midwives clinics also serve as convenient cash-in/cash-out points, increasing access to financial services. By embedding financial literacy and savings within maternal care, the program promotes preventive preparedness, not just for health but also financial stability.

This model shows how integrating financial education into maternal health services can help shift Indonesia's healthcare system from reactive to preventive, financially empowered care. Cross-sector collaboration can support a national framework that builds women's financial resilience by embedding literacy and affordable health tools within community services.

Lessons for scaling outreach and partnerships

1. Multi-stakeholder partnerships between healthcare providers, financial institutions, and associations like IBI can address systemic gaps in both financial literacy and preventive health financing.
2. Engaging midwives, who are deeply trusted within their communities, as financial intermediaries fosters higher acceptance and participation rates among target beneficiaries.

Enhancing coordination of benefits to strengthen BPJS and inclusive insurance integration

Expanding access to Coordination of Benefits is critical for improving healthcare financing as it allows BPJS Kesehatan members to combine their BPJS coverage with inclusive insurance. However, the absence of clear technical regulations and standardized cost-sharing mechanisms has led to inconsistent implementation, with many hospitals and insurers still hesitant to participate. Without well-defined guidelines, healthcare providers, insurers and patients face uncertainty, preventing Coordination of Benefits from functioning effectively.

Key strategies

- Develop comprehensive technical guidelines for Coordination of Benefits, incorporating input from inclusive health insurance providers, health financing institutions and healthcare practitioners to define a clear cost-sharing structure between BPJS Kesehatan and private insurers and/or other health financing providers.
- Establish operational guidelines aligned with the Ministry of Health's framework to ensure clarity and feasibility in implementation.
- Conduct pilot programs to refine Coordination of Benefits mechanisms before nationwide rollout:
  - In urban areas (e.g. Java and Sumatra), pilot programs should focus on employer-based insurance schemes, leveraging private sector partnerships and strengthening data-sharing systems.
  - In rural and underserved regions (e.g. Eastern Indonesia), pilots should explore inclusive insurance solution such as microinsurance tailored to informal workers and unwaged persons, ensuring Coordination of Benefits reach populations with limited financial protection.
- Encourage collaboration between BPJS Kesehatan, private insurers and healthcare facilities to develop standardized agreements and interoperable digital infrastructure for claims processing and seamless data exchange.

Policy actors involved

- **Ministry of Health** – Develops technical guidelines for Coordination of Benefits, defining clear cost-sharing rules in collaboration with inclusive heatlh insurers, healthcare providers and financial institutions.
- **BPJS Kesehatan** – Establishes implementation frameworks based on the Ministry of Health's regulations, ensuring smooth operational execution in hospitals and insurance networks.
- **OJK** – As BPJS Kesehatan operates under the regulatory framework for Non-Bank Financial Institutions, OJK is responsible for overseeing the implementation of Coordination of Benefits. This includes ensuring that BPJS Kesehatan's Coordination of Benefits framework aligns with financial sector policies and that private insurers comply with the established regulations, promoting transparency and integration within the healthcare financing system.
- **Ministry of Finance** – Assesses potential incentives for private insurers and healthcare providers to participate in Coordination of Benefits and ensures financial sustainability.
- **Healthcare and healthcare financing providers** – Offer insights into cost-sharing models and operational challenges to help refine Coordination of Benefits implementation for effective service delivery while also implementing internal policies to support integration.

For Financial Service Providers (FSPs)

Bridging healthcare costs and income loss for women caregivers

For many women, the financial burden of healthcare extends beyond direct medical costs—it also includes lost income due to taking time off work for treatments or recovery and hospital/ health facilities visits related to referrals. This is particularly critical for women in informal or low-income employment, who often do not have access to paid leave and face additional challenges in managing healthcare expenses.

To address this, financial service providers should consider designing hospital cash plans that offer flexible coverage options, specifically for women in caregiving roles, informal workers, and to cover relevant costs that are not currently covered by BPJS Kesehatan.

Relevant business case:

The caregiver insurance product

Women, especially those in low-income and informal employment, are often most concerned about healthcare and education—key areas where they play a significant caregiving role. With rising healthcare costs and limited financial protection, women in these sectors are at a heightened risk of financial instability when faced with health-related challenges. Caregiver insurance provides financial support to women and their families in times of medical emergencies, illness, or recovery. It offers two key features:

- **Hospital cash coverage:** A daily cash benefit during hospitalization or recovery, aimed at replacing lost income or additional expenses for the insured woman. This is particularly vital for informal workers, who may not have access to paid sick leave.
- **Family coverage:** Expands beyond the insured woman to include her spouse and children, offering additional cash benefits for maternity, illness, or healthcare needs within the family. This ensures a comprehensive safety net for caregiving women.

The target market for Caregiver insurance includes women in informal employment and those with irregular income sources, freelancers, gig economy workers, and small-scale entrepreneurs, mothers and primary caregivers who often delay or forgo medical treatment due to financial concerns.

Caregiver insurance is also appealing to women-led microfinance institutions (MFIs) and commercial banks, as it can be bundled with loans thus providing a holistic financial solution for underserved women.

Lessons for scaling outreach and partnerships

Bundling Caregiver insurance with loans, or other financial services such as remittances can boost customer engagement and retention. Women with insurance coverage tend to demonstrate better financial behaviors, such as higher loan repayment and savings rates, leading to increased customer loyalty and satisfaction—benefiting both clients and financial service providers.

Embedding digital inclusive solutions for informal workers

For gig workers and informal sector employees, affordable healthcare financing must be both accessible and integrated into the financial tools they already use. Rather than creating entirely new products, financial institutions should focus on embedding flexible health savings and payment options in widely used platforms, such as digital wallets, cooperative savings schemes and livelihood-based financial services.

One way to bridge affordability gaps is through installment-based healthcare payments, micro health savings and structured subscription models. These options can help individuals manage healthcare expenses in a way that aligns with their irregular income flows, reducing the risk of financial strain during medical emergencies.

To ensure these solutions remain viable and sustainable, financial providers must prioritize cost efficiency by minimizing administrative fees, improving transparency and implementing risk-sharing models that absorb excessive costs. Strengthening collaboration between financial institutions, healthcare providers and insurers can also standardize pricing and enhance accessibility. By making health financing solutions affordable, flexible and easily accessible, women—especially those with unpredictable incomes—can better plan for and manage their medical expenses.

Relevant business case:

Subscription-based insurance with auto-deduction from e-wallet for gig workers

Gig workers, including ride-hailing drivers, couriers and freelancers, often lack access to traditional insurance, leaving them financially vulnerable to accidents and unexpected expenses. GoRide GoProteksi, a collaboration between Gojek and PasarPolis, provides an affordable accident insurance plan for IDR15,000 (~USD0.89) per month, offering financial protection for ride-hailing drivers. This includes compensation of up to IDR30 million (~USD1,786) for disability or death, hospitalization benefits of IDR100,000 (~USD5.95) per day and coverage for damaged personal items such as helmets, jackets and mobile phones. Additionally, it provides motorcycle damage compensation of up to IDR2 million (~USD119), ensuring drivers are financially protected in the event of unexpected incidents.

The subscription-based model enables seamless adoption, with automatic deductions from users' Gojek Wallet balances, making the process hassle free. This mechanism demonstrates how inclusive insurance solutions can effectively target underserved populations, particularly gig workers, who may not prioritize insurance without easy accessibility.

Lessons for scaling outreach and partnerships

1. GoProteksi is seamlessly integrated into the Gojek app, making sign-up easy and hassle free. Its low-cost subscription model ensures affordability for low-income drivers and riders.
2. Through its partnership with PasarPolis, GoProteksi efficiently reaches Gojek's existing user base, showcasing how insurance providers can scale through platform partnerships.

Expand group scheme healthcare financing models to informal sector workers

Group healthcare financing models have traditionally been structured around formal employment, where employer-sponsored insurance provides coverage for workers. However, informal sector workers—who make up nearly 60% of Indonesia's workforce—are often excluded from these benefits, leaving them financially vulnerable to healthcare costs.

Given that informal workers often lack a single employer, alternative models leveraging cooperatives, professional associations and digital work platforms can serve as entry points for group healthcare financing. Worker cooperatives, trade unions and informal labor groups can negotiate collective health financing solutions, securing lower premium rates and broader coverage options than individual plans.

Expanding group-based healthcare financing models to the informal sector presents a significant opportunity to improve affordability, accessibility and risk sharing for uninsured and underinsured workers.

AXA Financial Indonesia and Induk Koperasi Kredit (Inkopdit), launched a microinsurance program to provide financial protection for cooperative members, informal workers and MSMEs. The initiative helps those who lack access to traditional insurance by leveraging cooperatives as a platform to distribute affordable insurance products.

The program offers three key products tailored to cooperative members: AXA Credit Life (covering loan repayments in case of death or disability), Asmik Sahabat Jiwa (a life and accident insurance plan with a lump sum payout of IDR5 million or ~USD297.7) and Asmik Sahabat Sehat (providing hospitalization benefits for critical illness). With premiums starting as low as IDR12,500 (~USD0.74) per year, this group scheme makes insurance affordable and accessible for low-income workers.

Beyond financial protection, the initiative includes financial literacy training to educate cooperative members on managing health and life risks. This group-based insurance model ensures lower costs, wider coverage and improved financial security for informal workers, who are often excluded from traditional insurance schemes. By integrating insurance into cooperatives, this program demonstrates how group financing models can bridge the protection gap, including for non-salaried workers.

Lessons for scaling outreach and partnerships

1. Leverage Existing Networks for Distribution: expanding group healthcare financing requires partnerships with established community organizations, such as cooperatives, labor unions and trade associations. These networks provide a trusted entry point for informal workers, ensuring higher adoption rates compared to standalone insurance offerings.
2. Embedding financial education into cooperative training programs and digital financial services can increase trust, awareness and long-term engagement with health financing solutions.
3. Offering installment-based contributions, seasonal payment options and bundled benefits can make financial protection more accessible and sustainable.

Expanding access to flexible health financing for individuals and families

Collaborations between BPJS Kesehatan, fintech, and health tech platforms can enhance healthcare affordability—particularly for women in informal work, freelancing, or caregiving roles. By enabling installment-based payment options, these platforms help manage medical expenses without disrupting essential household needs.

When insurance or savings fall short, health loans can serve as a responsible fallback for those with the ability to repay. Based on global benchmarking, similar platforms assess this using digital credit scores, income patterns, and alternative data such as e-wallet or utility payments. To manage risk, they apply tiered credit limits and offer short-tenor, 0% interest plans.

To scale these solutions effectively and protect women from turning to predatory or high-interest consumptive loans, healthcare financing must include clear terms, strong consumer protections, and risk-sharing mechanisms—ensuring they complement, not replace, existing coverage.

Relevant business case:

Health financing with a revolving credit limit for individuals and families

CareNow is a digital financing platform focused on healthcare, providing health financing that allows users to split medical expenses into 2–12-month installments, with 0% interest for short tenors. Users can access a revolving credit limit of up to IDR10 million (~USD595.5), enabling flexibility for multiple healthcare expenses. The platform prioritizes women's health needs, covering maternity care, vaccinations, dental procedures, specialist consultations, and elective treatments—not only for the women themselves but also for their family members. With an app-based application process, CareNow ensures fast approvals and seamless, cashless payments at over 500 partner healthcare providers.

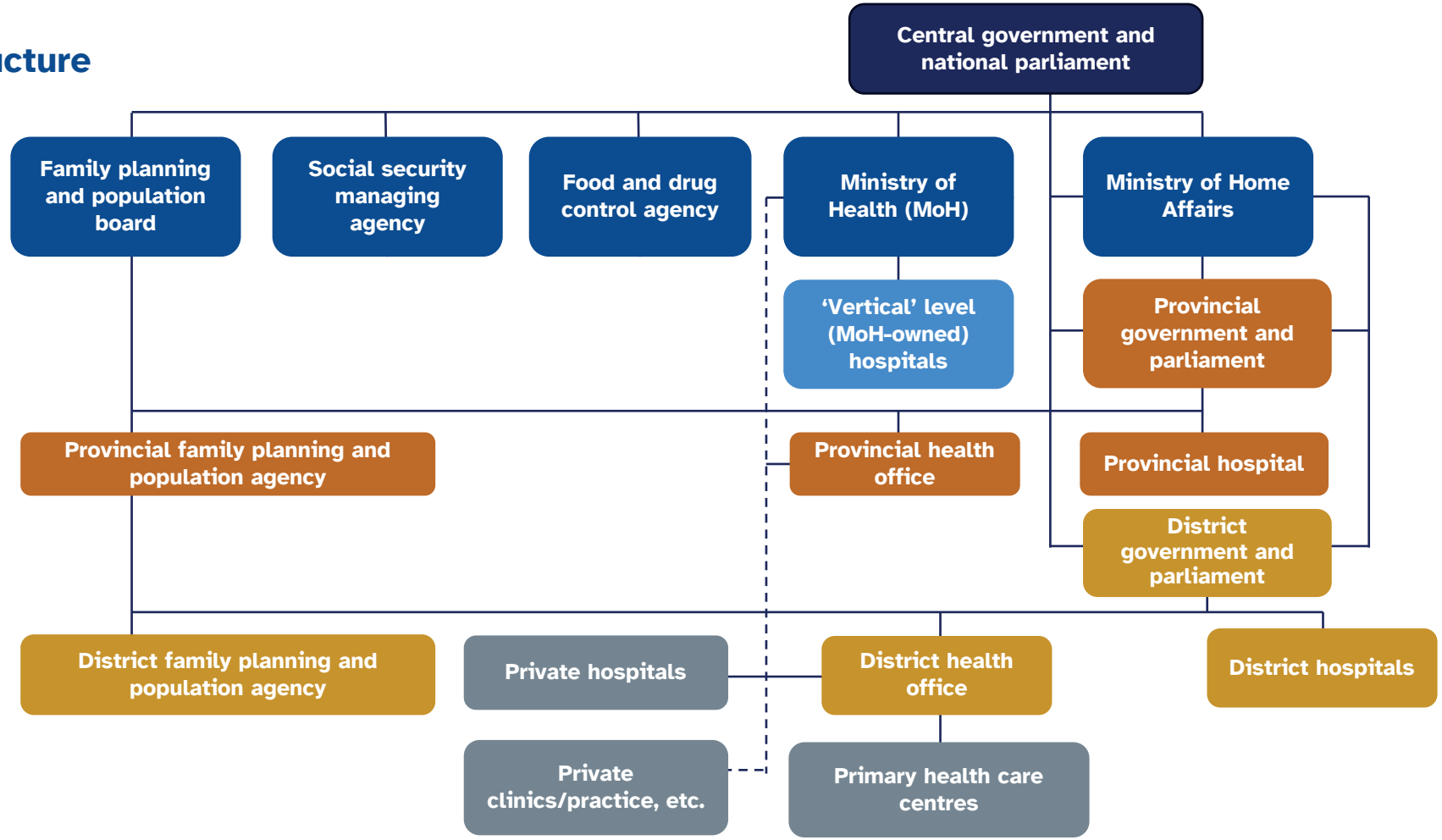
CareNow collaborates with hospitals and clinics, offering white-labeled in-clinic financing solutions under the "CareNow Installment Plan." Seventy percent of its users are women, who prefer installment-based payments, particularly for children's healthcare and reproductive services. The platform addresses a critical gap for freelancers and housewives who lack employer-sponsored insurance and rely on BPJS and personal savings. By providing no-interest, Sharia-compliant short-term loans, CareNow ensures more women can afford quality healthcare without financial strain.

Lessons for scaling outreach and partnerships

1. CareNow initially approached healthcare facilities through personal networks, but scaling partnerships and outreach will require more structured collaborations and trust-building.
2. Banks currently perceive P2P non-secured health loans as high-risk, highlighting an opportunity to develop risk-sharing models or blended finance approaches.

Appendix

Appendix 1:
Health infrastructure



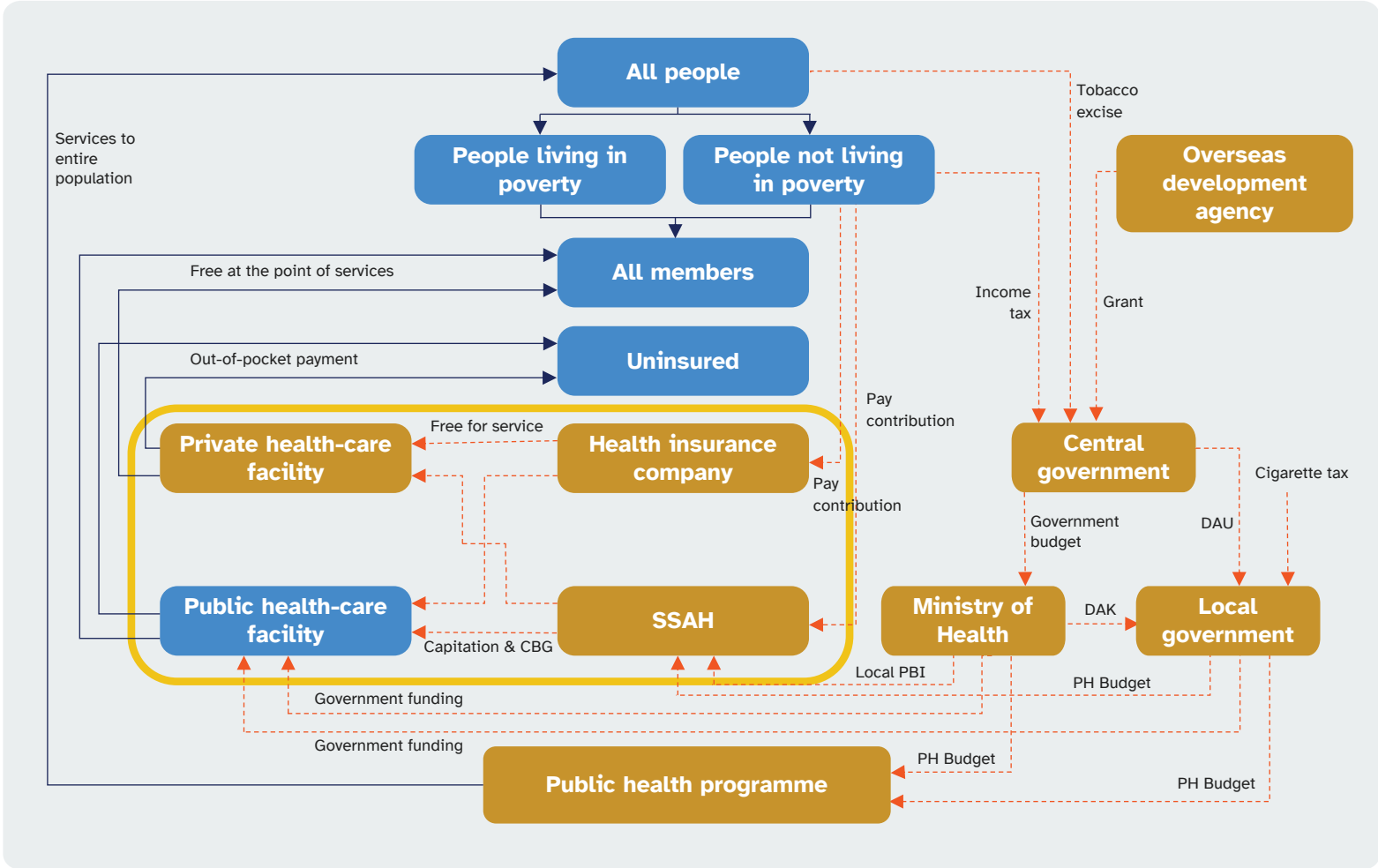
Source: Mahendradhata et al. 2017, Thinkwell 2022. Solid lines indicate authority, while broken lines represent technical supervision.

Appendix 2:
Indonesia's healthcare financing flows

Indonesia's healthcare financing system operates through a multi-tiered structure It is primarily driven by BPJS Kesehatan, the national health insurance program, funded by:

- Government funding or subsidies: generated from national and local budgets, tax revenues (income. tax, cigarette tax) and grants from overseas development agencies.
- Employer-employee contributions (5% of wages) and individual premiums (IDR42,000–IDR150,000, or around USD2.8–USD10 for informal workers). Low-income members are eligible for full government subsidies under BPJS Kesehatan PBI, covering 46.9% or nearly half of the population through subsidized health insurance (Susenas 2023 data).

The following diagram provides a detailed overview of Indonesia's healthcare financing flows.



Source: Agustina et al. 2019, Thinkwell 2022.

CBG: Case-based group
CBG+: CBG payment plus budget allocation from the local or national government
DAK: Special Allocation Fund
DAU: General Allocation Fund

GP: General practitioner
PBI: Subsidy for non-contributing members (poor or near-poor populations)
PH: Public health
SSAH: Social Security Agency of Health (which is also referred to as BPJS Kesehatan)

Appendix 3:
BPJS Kesehatan health facilities and referral system

Healthcare level	Health facilities included	Services provided	Referral to
Primary healthcare (FTKP)	Puskesmas, clinics, GPs	General care, preventive services, chronic disease management	Type C hospital
Type C hospital (FTKL)	Basic specialist services: District-level hospitals that provide basic specialist services, typically government or private hospitals, and serve as first referral centers for primary healthcare facilities	Minor surgeries, inpatient specialist care	Type B hospital
Type B hospital (FTKL)	Intermediate specialist services: Provincial or large regional hospitals that provide specialist and some sub-specialist services and usually serve as referral hospitals for Type C and D hospitals.	Specialized care (neurology, cardiology, orthopedic)	Type A hospital
Type A hospital (FTKL)	The highest level of hospital classification in Indonesia, serving as national referral centers. Equipped with sub-specialist doctors and advanced medical technology. Often affiliated with teaching hospitals or research institutions.	Advanced treatments (transplants, cancer, neurosurgery)	Final level
Emergency cases	Any hospital	Immediate critical care	Type C, B, or A hospital

BPJS Kesehatan coverage summary (based on Permenkes No. 3/2023)

Service category	Coverage description
Primary care (FKTP)	• Medical consultations and treatment (non-specialist) • Basic dental care • Routine immunization • Family planning (pills, condoms, IUD, implants, injections, sterilization) • Chronic disease management (e.g., hypertension, diabetes) • Maternal and child health (ANC, PNC, deliveries) • Screening (cancer, TB, anemia, hepatitis, etc.) • Ambulance services (for referrals/emergencies)
Maternity & neonatal care	• Antenatal care (USG & checkups) • Normal & C-section deliveries • Postnatal visits for mother & baby • Emergency obstetric services • Hypothyroid screening in newborns
Preventive & promotive care	• Health screening (cancer, diabetes, thalassemia, hepatitis) • Visual inspection (IVA), Pap smear • Health education & teleconsultation
Medications	• Drugs listed in the Formularium Nasional (Fornas) for chronic & acute illnesses • Chemotherapy & chronic meds (e.g., for TB, cancer, HIV, lupus)
Hospital care (INA-CBG)	• Emergency & inpatient treatment (non-ICU & ICU) • Specialist services • Surgeries & advanced diagnostics • Rehabilitation & mental health care • Dialysis (including CAPD)
Special services (Non INA-CBG)	• Cancer diagnostics (e.g., EGFR, PET Scan) • Blood transfusions • Prosthetics (glasses, hearing aids, dental, limbs) • Alteplase for stroke
Ambulance & referrals	• Ground/water ambulance for emergency/referral cases based on regional tariff guidelines
Dental prosthetics	• Max. IDR1.1 million per two years (with conditions)
Optional upgrade	• Patients can opt to upgrade inpatient class (to Class 1 or executive), paying the cost difference

Appendix 2:
Persona

Persona A
Low-income women with limited financial stability

Sari, a 37-year-old freelancer in Yogyakarta, works as field staff at a small architectural consulting firm, earning around the regional minimum wage (UMR), IDR2.4 million (~USD155). She is a BPJS Kesehatan PBI (government-subsidized BPJS) beneficiary and has a history of spinal scoliosis and chronic anemia. Despite having BPJS coverage, she still struggles with out-of-pocket expenses (OOPE) for preventive screenings, transportation costs and accessing specialized care, due to BPJS limitations.

Her awareness on health-related financial products

Sari has limited awareness of health financing beyond BPJS, believing it to be sufficient and not using private insurance or structured health savings plans. Her distrust of private insurance stems from past issues with an education insurance provider, where her family faced difficulties in claiming benefits. She primarily relies on cash savings, preferring conventional savings accounts

Her challenges when accessing healthcare

Sari travels 12 kilometers to Yogyakarta for BPJS Kesehatan-covered services, despite living in Bantul, as she believes that seeking care in the same area as her registered ID provides better access and reduces the risk of uncovered medication costs. She preferred the previous Jamkesmas system, which allowed cross-provincial healthcare access, reducing financial and logistical burdens.

Medical and non-medical expenses make healthcare access more expensive. Sari undergoes routine anemia check-ups every 2–3 months, requiring self-funded Hb (hemoglobin) level tests, since BPJS does not always cover preventive diagnostics. Additionally, she paid IDR75,000 (~USD4.47) for blood pressure, cholesterol and blood sugar tests, which were ineligible for BPJS coverage as they were self-initiated rather than doctor recommended. Transportation and parking costs for medical visits also add to her overall financial burden.

What she needs

Sari believes BPJS Kesehatan should collaborate with financial institutions to offer affordable health savings accounts.

Profile

Informal/gig worker earning ≤ UMR, expenditure deciles 3–4, fully subsidized BPJS

Key challenges

Irregular income, limited tools, high OOPE (transport, income loss)

Allocation capacity

IDR16,149/month (~USD0.96)

Solution needs

- Installment BPJS (e.g., REHAB)
- Microinsurance or hospital cash plans
- Trusted savings agents (e.g., midwives)
- Low-literacy health finance education

Market size

≈678,171 women (43.04%)

Persona B

Moderate-income women with growing needs

Fey, a 37-year-old teacher in Mataram, has been working for four years and was recently appointed as a P3K ASN (government contract public servant). With a steady income slightly above the regional minimum wage (UMR), she relies on BPJS Kesehatan and BPJS Ketenagakerjaan for her healthcare financing. She also uses BNI, BCA and NTB bank accounts for managing her salary. Although BPJS covers most of her healthcare needs, she still incurs out-of-pocket expenses (OOPE) for specialized care and non-covered treatments.

Her awareness on health-related financial products

Fey relies on BPJS as her primary health insurance, covering her mental health treatment, pregnancy and anemia care. She is unaware of alternative health financing options and does not use private insurance or health savings plans despite having the ability to set aside the money. Influenced by cultural norms, she follows her parents' approach of depending solely on BPJS Kesehatan.

Her challenges when accessing healthcare

She suffers from Polycystic Ovarian Syndrome (PCOS), anemia and mental health conditions, requiring regular hospital visits and specialized care, which BPJS Kesehatan does not cover if the treatment is outside its approved medical procedures or requires specific diagnostic tests and medications not listed under its coverage.

Fey had to pay for 15 out of 18 ultrasounds (IDR250,000–500,000 or ~USD14.8 – USD29.7 each) as BPJS only covered three. She also needed biweekly anemia injections, since oral medication was ineffective. Transportation and hospital visits added financial strain, though manageable with her stable income.

What she needs

She manages finances through salary-based planning, allocating minimal income to healthcare due to BPJS coverage, but open to any potential digital payment platforms for better management of medical costs if the initiative comes from BPJS Kesehatan or is employer driven. She also wants to know better Coordination of Benefits to reduce out-of-pocket expenses (OOPE) on specialized treatment.

Profile

Formal/informal workers with regular income > UMR, deciles 4–5, BPJS non-subsidy + occasional private/employer insurance

Key challenges

BPJS limited for chronic/specialized care, OOPE persists, low CoB awareness

Allocation capacity

IDR26,421/month (~USD1.57)

Solution needs

- Employer-linked or CoB bundled insurance
- Digitally linked health savings (salary/e-wallet auto-deduct) with top-up options for unexpected costs, clear information on Coordination of Benefits

Market size

≈678,171 women (43.04%)

Persona C

Financially stable but selective users

Eka is a bank employee in Mataram, earning more than IDR7 million and managing multiple financial products, including accounts at Bank Mandiri, BNI and BSI, as well as ShopeePay, OVO and QRIS. She has three children, including a four-month-old baby. To manage healthcare expenses, she relies on BPJS Kesehatan and private insurance, favoring cashless payments over reimbursement-based services.

Her awareness on health-related financial products

Eka values health insurance and actively uses both BPJS and her private health insurance. However, she cannot use them simultaneously for a single treatment, as the private hospitals she visits only offer either BPJS or private insurance, without a combination of both. Aware of healthcare costs, she also maintains emergency savings for unexpected expenses.

Her challenges when accessing healthcare

BPJS covered her childbirth hospitalization in Class 2, but she had to pay the cost difference for a VIP upgrade as per her request, which her private insurance covered. Despite having insurance, she spent IDR300,000 on uncovered medication, IDR1.2 million on pregnancy supplements and paid for a 4D ultrasound at a non-network facility due to better service quality. Accessing dental services was also difficult, with only three clinics in Mataram partnered with her private insurance providers.

What she needs

She sets aside income for healthcare and emergencies, using savings for unexpected costs, a lesson from her first pregnancy without insurance. She wants BPJS and private insurance to work together to be able to provide a Coordination of Benefits mechanism seamlessly and seeks more provider options for dental and maternity care to reduce out-of-pocket expenses. Being a banker she also curious whether there is an accessible health loan product in her city.

Profile

Entrepreneur or salaried worker with BPJS + private insurance, deciles 5–6. Prioritizes convenience, quality, and premium care.

Key challenges

Service gaps (e.g., dental, maternity), limited provider networks, low Coordination of Benefit awareness

Allocation capacity

IDR39,649/month (~USD2.36)

Solution needs

- Cashless health loans with clear coverage terms
- Broader provider options and premium care packages

Market size

≈804,991 women (51.09%)

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