

Mapping Social Health Financing Mechanisms and Their Equity Implications in Indonesia: A Scoping Review

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ABSTRACT

Background: Health financing is central to universal health coverage (UHC), determining whether individuals can access healthcare without financial hardship. In Indonesia, the Jaminan Kesehatan Nasional (JKN) programme has substantially expanded population coverage, but registration does not necessarily ensure equitable healthcare utilization or financial protection. Poor and vulnerable populations, including informal workers and rural and remote communities, may continue to face barriers to healthcare access.

Aims: This scoping review aimed to map social health financing mechanisms implemented or studied in Indonesia and examine their implications for equitable healthcare access and financial protection among poor and vulnerable populations.

Methods: This review followed the Joanna Briggs Institute (JBI) methodology for scoping reviews and was reported according to the Preferred Reporting Items for Systematic Reviews and Meta Analyses extension for Scoping Reviews (PRISMA ScR). Searches were conducted in PubMed/MEDLINE, Scopus, Web of Science, Embase, Google Scholar, and Garuda, supplemented by grey literature from the World Health Organization, World Bank, Ministry of Health of Indonesia, BPJS Kesehatan, Dewan Jaminan Sosial Nasional, and Bappenas. Literature published between 2019 and 2026 was considered. Eligible sources addressed health financing mechanisms, healthcare access, equity, or financial protection among poor or vulnerable populations in Indonesia. Data were charted using a standardized extraction form and synthesized descriptively and thematically.

Results: A total of 235 records were identified, of which 30 sources, comprising 24 peer reviewed studies and 6 grey literature reports, met the inclusion criteria. Five broad categories of social health financing mechanisms were identified: national social health insurance through JKN and BPJS Kesehatan, government premium subsidies for poor populations through Penerima Bantuan Iuran (PBI), community and employment based contributory financing, non-contributory social assistance such as Program Keluarga Harapan (PKH), and faith based or philanthropic financing, including zakat based schemes. Although JKN registration reached 98.45% of the population by the end of 2024, active utilization was substantially lower at 78.83%. Equity implications differed across mechanisms: JKN and PBI extended nominal coverage and modestly reduced out-of-pocket payments for some vulnerable groups, community- and employment-based contributory financing showed unstable enrolment among informal workers, non-contributory social assistance influenced health-seeking behaviour only indirectly, and faith-based and philanthropic financing remained almost entirely unevaluated. Out-of-pocket and catastrophic health expenditure continued to affect poorer and informally employed households despite these gains, indicating that financial protection remained incomplete. Poor, informally employed, and geographically remote populations continued to experience greater financial and access barriers. Key challenges included administrative complexity, limited ability and willingness to pay among informal workers, geographic disparities in healthcare availability, and imperfect targeting of subsidy programmes.

Conclusion: Social health financing in Indonesia has expanded nominal coverage under JKN and PBI, but this nominal coverage has not consistently translated into effective, equitable healthcare access and financial protection: registration is not the same as effective coverage or genuine financial protection. Evidence on community based and faith-based financing remains limited. Future research should prioritize comparative equity evaluations, particularly among informal workers and populations in eastern Indonesia.

Keywords: *Health equity; Healthcare access; Indonesia; Scoping review; Social health financing; Social protection.*

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1. Introduction

Health financing is widely recognized as one of the core building blocks of a functioning health system and a decisive determinant of progress toward universal health coverage (UHC), which the World Health Organization defines as ensuring that all people obtain the health services they need without suffering financial hardship (Lim *et al.*, 2023). Adequate and equitably distributed health financing underpins three interlinked outcomes: financial protection from the impoverishing effects of medical costs, physical and administrative access to healthcare services, and the reduction of socioeconomic inequality in health outcomes. Across low- and middle-income countries, health financing systems reliant on high levels of out-of-pocket (OOP) payment have consistently been shown to exclude the poor from care or to push already vulnerable households into poverty when they do seek treatment (Jauhar, 2024). Understanding how a country structures and diversifies its health financing mechanisms is therefore inseparable from understanding who ultimately gains, and who continues to be left behind.

For the purposes of this review, social health financing is understood broadly as the set of mechanisms through which resources are mobilized, pooled, and allocated to fund and purchase healthcare for a population, whether through mandatory or voluntary insurance contributions, government-subsidized premiums, community or employer contributions, non-contributory social assistance, or philanthropic and faith-based instruments. Equity, in this context, refers to the absence of avoidable and unfair differences in health-financing outcomes between population groups defined by income, employment status, geography, or other markers of social disadvantage. Because a financing mechanism can succeed on one dimension while failing on another, this review distinguishes explicitly between three related but conceptually distinct outcomes: coverage (formal enrolment or registration in a scheme), utilization or access (whether enrolled individuals actually obtain needed services), and financial protection (the extent to which people are shielded from out-of-pocket and catastrophic health expenditure when they seek care). Equitable financing, as used here, requires progress on all three dimensions simultaneously, not on coverage alone.

Indonesia, the world's fourth most populous country and one of the largest archipelagic states, has pursued UHC principally through the Jaminan Kesehatan Nasional (JKN), a single-payer social health insurance scheme administered by BPJS Kesehatan since 2014 (World Bank, 2021). JKN consolidated a fragmented set of prior insurance schemes and combined contributory membership for formal-sector and informal-sector workers with a fully government-subsidized category, the *Penerima Bantuan Iuran (PBI)*, for the poor and near-poor (Adyas, 2021). By the end of 2024, JKN registration had reached approximately 278.1 million people, or 98.45% of the national population, positioning Indonesia among the countries closest to nominal universal coverage in Southeast Asia (Dewan Jaminan Sosial Nasional & BPJS Kesehatan, 2024). Yet registration figures alone conceal substantial variation in how different socioeconomic and geographic groups actually experience the financing system, including whether government subsidies reach their intended beneficiaries and whether coverage on paper translates into service use in practice (Kementerian Kesehatan Republik Indonesia, 2024).

Beyond JKN itself, the Indonesian health financing landscape encompasses a broader set of social health financing mechanisms. These include the government-subsidized PBI contribution scheme; community-based and employment-linked contributory arrangements for informal and formal workers; non-contributory social assistance programmes such as the conditional cash transfer Program Keluarga Harapan (PKH), which indirectly influences health-seeking behaviour among poor households (Erlianti *et al.*, 2025); and faith-based or philanthropic financing channelled through Islamic social-finance instruments such as *zakat*, which several community organizations have begun directing toward healthcare access for the poor. Each of these mechanisms differs in its funding source, eligibility criteria, administrative pathway, and the population segment it is designed to reach, meaning that their equity consequences cannot be assumed to be uniform simply because they all nominally serve “the poor and vulnerable.”

A single financing mechanism is unlikely to be experienced uniformly even within the population it nominally targets. Poor and near-poor households enrolled through the government-subsidized PBI category may still face indirect costs, such as transport, lost daily wages, or informal payments, that limit whether registration translates into

actual service use. Informal-sector workers, whose income is often irregular, may enrol and later lapse as premiums compete with immediate household needs, producing a pattern of unstable coverage that cross-sectional registration statistics do not capture. Rural and remote populations, particularly in eastern Indonesia, may be fully registered yet lack nearby facilities, referral pathways, or health workers, so that formal coverage cannot be converted into access regardless of the financing arrangement in place. Because these structural constraints operate independently of enrolment status, the same financing mechanism can appear to succeed in expanding coverage while simultaneously failing to deliver equitable access or financial protection for the specific subgroups it was designed to reach.

Whether these mechanisms deliver equitable access is an empirical question that has been examined from multiple angles, but rarely as a coherent whole. Socioeconomic equity studies have found that despite JKN's expansion, catastrophic and out-of-pocket health expenditure remain concentrated among poorer and informally employed households (Fattah *et al.*, 2023; Hafidz *et al.*, 2023), and that the distribution of financing benefits does not consistently favour those most in need (Asante *et al.*, 2024). Geographic equity studies have documented that healthcare benefit incidence, hospital utilization, and access to skilled birth attendance are systematically lower in rural and eastern Indonesian provinces compared with urban Java-centred regions (Laksono *et al.*, 2021; Sambodo *et al.*, 2021; Wulandari *et al.*, 2022), with patients in some districts bypassing nearer facilities altogether in search of adequate care (Putri *et al.*, 2021). Insurance-status equity research has further shown that formal enrolment in JKN does not guarantee actual utilization, particularly among informally employed and rural populations who report administrative, financial, and informational barriers to using their coverage (Muttaqien *et al.*, 2021; Roza & Sari, 2025; Sujarwoto *et al.*, 2026).

Although a substantial and growing number of studies have examined individual financing programmes, populations, or equity dimensions within the Indonesian health system, this evidence remains fragmented. Studies on JKN membership and utilization, PBI targeting, informal-sector enrolment behaviour, geographic benefit incidence, and community- or faith-based financing have largely been conducted and reported in isolation from one another, using different populations, outcome measures, and equity frameworks. No single synthesis has systematically mapped the full breadth of social health financing mechanisms operating in Indonesia alongside their documented equity implications, leaving policymakers, researchers, and civil-society actors without a consolidated evidence base from which to identify where financing arrangements are succeeding in promoting equitable access and where critical gaps persist.

Given this fragmentation, a scoping review rather than a systematic review or meta-analysis is the most appropriate methodology for the present inquiry. Systematic reviews and meta-analyses are best suited to answering narrowly defined effectiveness questions from a homogeneous body of evidence, whereas the Indonesian social health financing literature is heterogeneous in design, population, and outcome, spanning quantitative panel analyses, qualitative barrier studies, health-policy analyses, and grey-literature programme reports. A scoping review is explicitly designed to map the breadth, characteristics, and nature of such a heterogeneous evidence base, to clarify key concepts and definitions, and to identify gaps in the literature that warrant more focused future research or systematic review (Lim *et al.*, 2023).

This scoping review therefore aims to map the social health financing mechanisms that have been implemented or studied in Indonesia and to examine their implications for equitable access to healthcare among poor and vulnerable populations, following the Population–Concept–Context (PCC) framework recommended for scoping reviews. Specifically, this review sought to answer the following questions: (1) What social health financing mechanisms have been implemented or studied among poor and vulnerable populations in Indonesia? (2) Which target populations have these mechanisms addressed or been evaluated among? (3) What do the mechanisms imply for healthcare access and utilization among these populations? (4) What do they imply for financial protection, including out-of-pocket and catastrophic health expenditure? and (5) What gaps remain in the evidence base regarding these mechanisms and populations?

2. Methods

Study Setting

This scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews and is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist. A scoping review protocol outlining the review question, eligibility criteria, search strategy, and data-charting approach was developed prior to the search and used to guide the conduct of the review. Consistent with scoping review methodology, this review maps the breadth and nature of the available evidence and does not seek to determine the effectiveness of, or establish causal relationships between, specific financing mechanisms and equity outcomes. The protocol was developed and used internally by the review team to guide the conduct of the review but was not registered with or deposited in a public registry (e.g., the Open Science Framework); this is noted as a limitation of the review's methodological transparency.

Review Question

The review question was developed using the Population, Concept, and Context (PCC) framework recommended by the Joanna Briggs Institute (JBI) for scoping reviews. The Population comprised poor and vulnerable populations in Indonesia, including informally employed workers, rural and remote communities, women and children, older adults, and persons with disabilities. The Concept focused on social health financing mechanisms, including social health insurance, government premium subsidies, community-based financing, social assistance, and philanthropic or faith-based financing, with particular attention to their implications for health equity. The Context was Indonesia, encompassing evidence from both national and sub-national settings, including provincial and district levels. Based on this PCC framework, the review sought to identify and map the range of social health financing mechanisms that have been implemented or investigated among poor and vulnerable populations in Indonesia, as well as to examine how these mechanisms may influence equitable access to healthcare. Consistent with the review objective, both mechanisms formally implemented within Indonesia's health system (e.g., JKN, PBI) and mechanisms examined, piloted, or proposed in the research and policy literature but not necessarily implemented nationwide (e.g., localized community-based or faith-based schemes) were eligible for inclusion, provided they met the population and context criteria described below. Accordingly, the review question was formulated as follows: What social health financing mechanisms have been implemented or studied in Indonesia for poor and vulnerable populations, and what are their implications for equitable access to healthcare?

Search Strategy

Academic databases searched included PubMed/MEDLINE, Scopus-indexed journals, Web of Science-indexed journals, Embase, Google Scholar, and Garuda (Garba Rujukan Digital, the Indonesian national referencing portal). Grey literature sources included the World Health Organization (WHO), the World Bank, the Ministry of Health of the Republic of Indonesia (Kemenkes RI), BPJS Kesehatan and the Dewan Jaminan Sosial Nasional (DJSN), and Bappenas (the National Development Planning Agency). Reference lists of included studies and relevant systematic reviews were also hand-searched for additional eligible sources. The search strategy combined three core concepts: financing, equity, and Indonesia, connected with the Boolean operator AND, with synonyms and related terms within each concept combined using OR. The full strategy as applied to PubMed/MEDLINE is presented below; equivalent strategies, adapted to database-specific syntax and controlled vocabulary, were applied to the remaining databases.

Concept 1 — Financing: ("health financing" OR "social health financing" OR "health insurance" OR "national health insurance" OR "JKN" OR "BPJS Kesehatan" OR subsidy OR "social protection" OR "social assistance" OR "community-based financing" OR "philanthropic financing" OR zakat).

Concept 2 — Equity: (equity OR inequality OR inequity OR disparity OR "health inequity" OR "financial protection" OR "out-of-pocket" OR "catastrophic health expenditure" OR access OR utilization).

Concept 3 — Context: (Indonesia OR Indonesian).

Combined search: (Concept 1) AND (Concept 2) AND (Concept 3). Date limits of 2019–2026 were applied where database functionality allowed, and results were restricted to English- or Indonesian-language publications. All records identified through database and grey-literature searching were exported and de-duplicated. Two reviewers independently screened titles and abstracts against the eligibility criteria, and full texts of potentially eligible records were then retrieved and independently assessed for inclusion by both reviewers. Disagreements at either stage were resolved through discussion and, where necessary, consultation with a third reviewer. The results of this process are reported using a PRISMA-ScR flow diagram (Figure 1).

Grey literature was searched using a structured approach: the official websites of the World Health Organization, World Bank, Kemenkes RI, BPJS Kesehatan, DJSN, and Bappenas were searched using the same core search terms (financing, equity/access/utilization, and Indonesia), supplemented by a targeted web search using equivalent terms. Documents were eligible for inclusion as grey literature if they were substantive reports, technical briefs, or programme evaluations, rather than press releases or promotional material, published between January 2019 and August 2026 and addressing social health financing, access, equity, or financial protection in Indonesia. Grey-literature sources were screened for eligibility using the same criteria and process as peer-reviewed records, including independent assessment by both reviewers.

Data Charting

A standardized data-charting form was developed and piloted on a sample of included sources before being applied to the full set. Data charting was conducted independently by two reviewers; discrepancies between the two completed charting forms were identified through comparison and resolved through discussion, with a third reviewer consulted where consensus could not be reached. Extracted variables are summarized in Table 1.

Table 1. Data-charting variables

Variable	Description
Author/Year	Author(s) and year of publication
Study location	Province, region, or national scope
Study design	Quantitative, qualitative, mixed-methods, or policy/grey-literature report
Population	Target population studied
Financing mechanism	Type of social health financing mechanism examined
Funding source	Government, community, employer, or philanthropic/faith-based
Financing arrangement	Insurance, subsidy, cash transfer, or in-kind/service provision
Equity dimension	Socioeconomic, geographic, insurance-status, or gender/age-based
Healthcare access/utilization	Reported access or utilization outcomes
Financial protection	Out-of-pocket expenditure, catastrophic expenditure, or related indicators
Main findings	Key results relevant to the review question
Research gaps	Gaps or limitations identified by the source

For the purposes of data extraction and synthesis, equity was operationally defined as the presence or absence of systematic differences in coverage, utilization, or financial-protection outcomes across socioeconomic status, geography (urban/rural or regional), insurance status, or other markers of vulnerability; a source was coded as reporting an equity implication if it presented a comparison across such subgroups. Financial protection was operationally defined as any reported measure of out-of-pocket health expenditure, catastrophic health expenditure (commonly defined as out-of-pocket expenditure exceeding a specified threshold, e.g., 10% or 25% of household expenditure or capacity to pay), or related indicators of financial hardship associated with healthcare use.

Criteria for Inclusion and Exclusion

Inclusion criteria

Sources were included if they: (1) were conducted in or focused specifically on Indonesia; (2) addressed a social health financing mechanism (social health insurance, government subsidy, community-based or employer-based contributory financing, social assistance, or philanthropic/faith-based financing); (3) involved or discussed poor, near-poor, informally employed, rural/remote, or otherwise vulnerable populations; (4) reported outcomes related to healthcare access, utilization, equity, or financial protection (e.g., out-of-pocket expenditure, catastrophic health expenditure); (5) used a quantitative, qualitative, or mixed-methods design, or constituted policy analysis or relevant grey literature; and (6) were published between January 2019 and August 2026 in English or Indonesian.

Exclusion criteria

Sources were excluded if they: (1) were conducted outside Indonesia without an Indonesia-specific sub-analysis; (2) addressed health financing only tangentially or focused solely on macroeconomic or fiscal policy unrelated to health; (3) reported exclusively clinical or biomedical outcomes without reference to financing, access, or equity; (4) were editorials, commentaries, or conference abstracts without substantive original evidence; or (5) were duplicate publications or superseded preliminary reports of an already-included dataset..

Data Analysis

Consistent with JBI guidance for scoping reviews, no formal quality appraisal or risk-of-bias assessment was performed, as the objective was to map the breadth of available evidence rather than to appraise the strength of individual effect estimates. As a scoping review, this synthesis maps the extent, range, and nature of the available evidence; it does not determine the comparative effectiveness of, or establish causal relationships between, specific financing mechanisms and equity, access, or financial-protection outcomes. Data were analysed in two complementary ways. First, a descriptive numerical analysis summarized the number of included sources by publication year, geographic focus, study design, and financing mechanism. Second, a thematic analysis, informed by the data-charting categories, grouped findings into recurring themes: types of financing mechanisms, target populations, socioeconomic equity, geographic equity, insurance-status equity, financial protection, barriers and challenges, and evidence gaps. This review is reported in accordance with the PRISMA-ScR checklist. A completed PRISMA-ScR checklist is available on request from the corresponding author..

Ethical Considerations

This scoping review used data from previously published and publicly available sources and did not involve direct participation of human subjects. Therefore, ethical approval was not required. All included sources were appropriately cited and reported in accordance with established scoping review guidelines.

3. Results

Search Results

Database searching identified 214 records, and grey-literature searching identified a further 21 records, yielding 235 records in total. After removal of 43 duplicate records, 192 records were screened by title and abstract, of which 137 were excluded as clearly ineligible. The remaining 55 full-text sources were assessed for eligibility; 25 were excluded, most commonly because they addressed health financing only tangentially ($n = 9$), were not set in Indonesia or lacked an Indonesia-specific analysis ($n = 6$), reported exclusively clinical outcomes ($n = 5$), were editorials or commentaries without substantive evidence ($n = 3$), or were duplicate or superseded reports ($n = 2$). A total of 30 sources, comprising 24 peer reviewed studies and 6 grey literature reports, met the inclusion criteria and were included in the review.

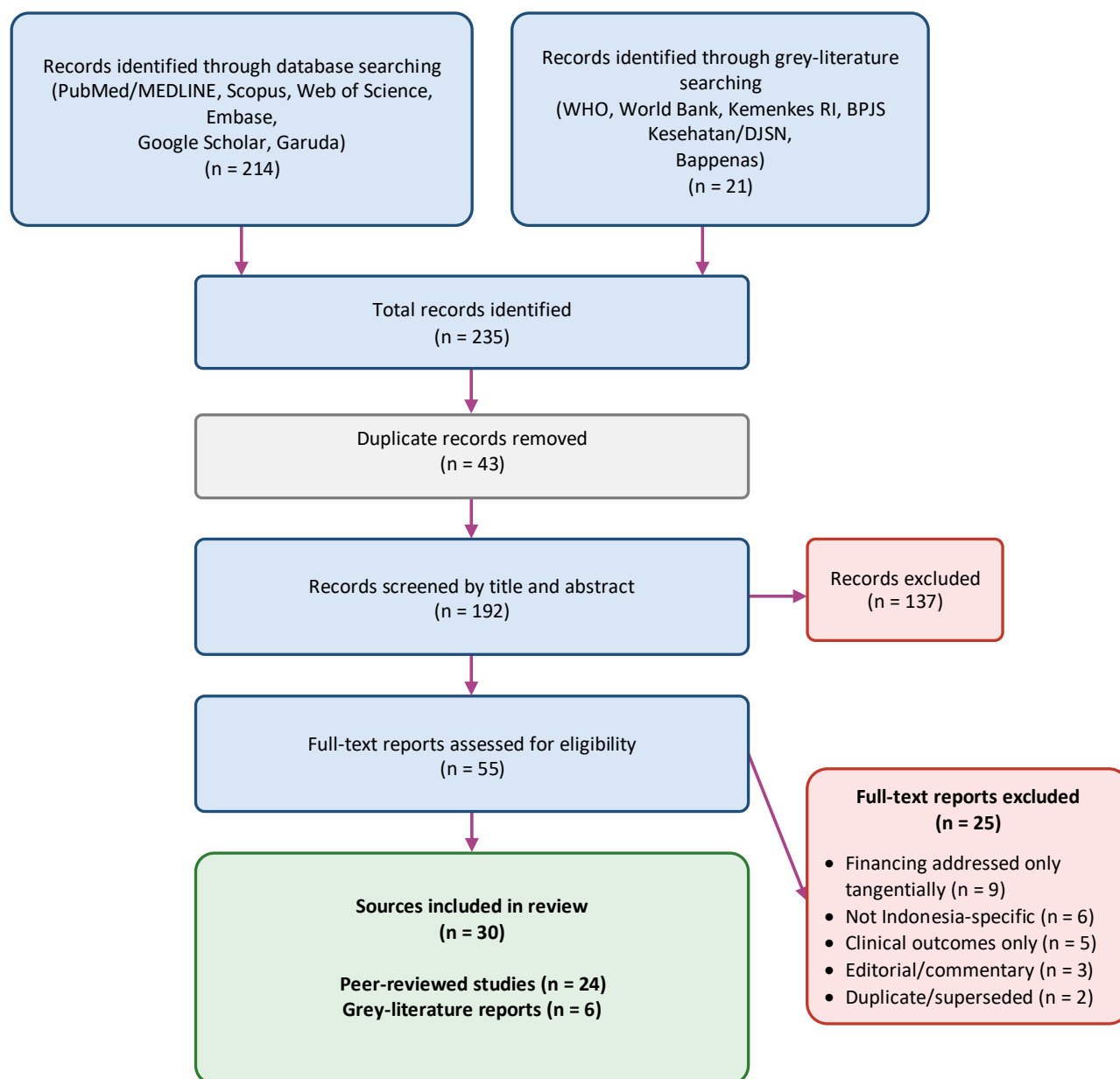


Figure 1. PRISMA-ScR flow diagram

Supplementary Characteristics of Included Studies

Included sources spanned publication years 2021–2026, reflecting the review’s focus on recent evidence generated since the maturation of JKN. Quantitative cross-sectional or panel-data designs predominated ($n = 18$), followed by policy analyses and grey-literature reports ($n = 6$), qualitative or mixed-methods studies ($n = 4$), and systematic reviews providing regional context ($n = 2$). Geographically, eleven studies analysed nationally representative data, while the remainder focused on specific provinces or regions, including Bali, West Sumatra, East Java, and eastern Indonesia (Papua, Maluku, and Nusa Tenggara). Table 2 summarizes the characteristics of the included peer-reviewed studies.

Table 2. Characteristics of included studies

Author (Year)	Location	Design	Financing mechanism	Main equity-related finding
(Maulana et al., 2022)	National	Quantitative	JKN social health insurance	JKN coverage reduced OOP payments for vulnerable groups but protection remained incomplete
(Fattah et al., 2023)	National	Quantitative (panel)	JKN / OOP	Catastrophic health spending persisted despite JKN, concentrated among poorer households
(Sambodo et al., 2021)	National	Quantitative (benefit incidence)	Public health spending	Geographic spending variation exacerbated healthcare benefit inequality favouring urban areas
(Asante et al., 2023)	National	Quantitative	JKN / general health financing	Benefits and burden of financing were unevenly distributed across socioeconomic groups
(Wenang et al., 2021)	National (remote/rural)	Mixed-methods	Primary care financing/provision	Remote, rural, and poor populations faced reduced availability and accessibility of primary care
(Pudji Nugraheni et al., 2026)	Remote areas	Quantitative	JKN	Identified priority groups for expanding insurance coverage in remote areas
(Muttaqien et al., 2021)	National	Qualitative	Informal-sector contributory JKN	Informal workers stopped paying due to low ability and willingness to pay
(Wulandari et al., 2022)	National	Quantitative	JKN / hospital financing	Urban–rural disparities in hospital utilization persisted under JKN
(Cheng et al., 2025)	National	Quantitative	JKN	Insurance status alone did not fully explain healthcare utilization patterns
(Hafidz et al., 2023)	National	Quantitative (survey)	OOP / JKN	COVID-19 increased OOP and catastrophic costs, disproportionately affecting poorer households
(Paramashanti et al., 2022)	National	Quantitative (decomposition)	Broader social protection	Wealth- and education-related inequalities persisted in child health outcomes
(Putri et al., 2021)	East Java	Quantitative	Facility-based access	Patients bypassed nearer facilities, reflecting geographic and quality-related access barriers
(Sujarwoto et al., 2026)	National	Quantitative	JKN	Hidden inequities in insurance underutilization despite formal coverage
(Lim et al., 2023)	Southeast Asia (incl. Indonesia)	Systematic review	Multiple mechanisms	Regional financing challenges included fragmentation, low pooling, and inequitable subsidy targeting
(Roza & Sari, 2025)	West Sumatra	Qualitative	Informal-sector JKN	Administrative and informational barriers limited informal workers' access
(Erlianti et al., 2025)	National	Policy analysis	PKH social assistance	Cash-transfer implementation gaps limited reach to the most vulnerable
(Jauhar, 2024)	Asia (incl. Indonesia)	Systematic review	Social health insurance	Social health insurance advanced UHC but equity outcomes varied by design
(Valentina & Marhaeni, 2025)	Bali	Quantitative	PBI government subsidy	Contribution assistance increased healthcare utilization among the poor
(Puspitasari et al., 2026)	National	Quantitative (multilevel)	JKN	Employment status shaped healthcare utilization across developed/underdeveloped districts

Table 2. Characteristics of included studies

Author (Year)	Location	Design	Financing mechanism	Main equity-related finding
(Banerjee et al., 2021)	National (RCT)	Quantitative (experimental)	Informal-sector JKN enrolment	Subsidized premiums and simplified enrolment increased informal-sector uptake
(Laksono et al., 2024)	National	Quantitative	Primary healthcare access	Education level shaped primary healthcare utilization among older people
(Laksono et al., 2021)	Eastern Indonesia	Quantitative	Insurance ownership	Disparities in insurance ownership shaped access to hospital-based birth delivery
(Ochoa-Moreno et al., 2026)	National (provincial)	Quantitative	Public health expenditure	Increased health expenditure did not uniformly reduce under-5 mortality inequality between provinces
(Adyas, 2021)	National	Policy analysis	JKN / UHC system	Human-resource constraints challenged equitable UHC implementation

Types of Social Health Financing Mechanisms

Five broad categories of social health financing mechanisms emerged from the included literature. The first and most extensively studied is national social health insurance, operationalized through JKN and administered by BPJS Kesehatan, which pools contributions from formal-sector employees, informal-sector voluntary members, and government-subsidized beneficiaries into a single national scheme (Maulana et al., 2022; World Bank, 2021). The second is government premium subsidy, principally the PBI category, through which national and regional governments pay JKN contributions on behalf of individuals classified as poor or near-poor (Valentina & Marhaeni, 2025). The third is community- and employment-based contributory financing, encompassing both formal employer-linked contributions and voluntary informal-sector membership, the latter characterized by considerable enrolment instability (Banerjee et al., 2021; Muttaqien et al., 2021). The fourth is non-contributory social assistance, exemplified by PKH, which does not finance healthcare directly but is understood to shape health-seeking behaviour and indirectly support access among poor households (Erlianti et al., 2025). The fifth and least-documented category is faith-based and philanthropic financing, comprising Islamic social-finance instruments such as zakat and community charitable initiatives that some organizations have begun channelling toward healthcare access, though this mechanism was represented by markedly fewer eligible sources than the other four.

Target Populations

Included studies addressed a range of poor and vulnerable population groups, most commonly low-income and near-poor households (targeted through PBI), informal-sector workers (a population characterized by irregular income and voluntary, unstable JKN enrolment), rural and remote-area residents (particularly in eastern Indonesia), women and children (in relation to maternal and child health service utilization), older adults, and, to a lesser extent, persons with disabilities. Several studies additionally examined cross-cutting vulnerability, such as informally employed women in rural districts, for whom multiple axes of disadvantage compounded financing-related barriers to access.

Overview of Included Evidence by Mechanism

Of the 24 included peer-reviewed studies, 12 concerned national social health insurance (JKN) as the primary financing mechanism examined, 1 concerned the PBI government premium subsidy specifically, 3 concerned community- or employment-based contributory financing (chiefly informal-sector enrolment), 2 concerned non-contributory social assistance (PKH or broader social protection), and 6 addressed public health financing or access more generally without attributing findings to a single named mechanism; no included peer-reviewed or grey-literature source evaluated faith-based or philanthropic financing (e.g., zakat-based schemes) as its primary object of analysis, which is itself a key

finding of this review. Classifying the main equity-related finding reported by each of the 24 peer-reviewed studies (Table 2) as improved, mixed, or adverse for equity yielded 2 studies reporting an improved equity implication (Valentina & Marhaeni, 2025; Banerjee *et al.*, 2021), 4 reporting a mixed implication (Cheng *et al.*, 2025; Jauhar, 2024; Maulana *et al.*, 2022; Pudji Nugraheni *et al.*, 2026), and 18 reporting an adverse or unresolved equity implication. Geographically, 17 of the 24 studies used nationally representative data not disaggregated to a specific province in the table; only 2 studies focused specifically on eastern Indonesia or remote areas (Laksono *et al.*, 2021; Pudji Nugraheni *et al.*, 2026), while single studies focused specifically on East Java (Putri *et al.*, 2021), West Sumatra (Roza & Sari, 2025), and Bali (Valentina & Marhaeni, 2025). Dedicated, province-specific evidence is therefore sparse for both Java and eastern Indonesia alike, although the large majority of nationally representative studies necessarily draw disproportionately on the more populous and better-resourced Java-centred population, and eastern Indonesia was repeatedly identified in the narrative synthesis as facing the most acute access barriers (see Research Gaps, below). Table 3 summarizes each mechanism against its typical target population, geographic setting, funding source, and its documented access/utilization and financial-protection outcomes.

Table 3. Financing mechanisms, target populations, and equity/financial-protection outcomes

Mechanism	k	Target population	Geographic setting	Funding source	Access/utilization outcome	Financial-protection outcome
National social health insurance (JKN)	1 2	General population; formal- and informal-sector members; near-universal registrants	National, Java-weighted samples	Payroll and voluntary premium contributions; government revenue	Registration near-universal (98.45%); active utilization markedly lower (78.83%) and uneven by income, education, employment	Reduced OOP for some vulnerable groups, but catastrophic expenditure persisted among poorer/informal households
Government premium subsidy (PBI)	1	Poor and near-poor PBI-eligible households	Bali (dedicated study); national programme	Government (national/regional budget)	Increased utilization among the poor where evaluated	Intended to reduce OOP burden; targeting/leakage concerns raised in narrative synthesis
Community-/employment-based contributory financing	3	Informal-sector workers	National	Member/employer contributions	Unstable enrolment; high disenrollment linked to irregular income	Low ability/willingness to pay limits sustained protection
Non-contributory social assistance (PKH/broader)	2	Poor households, esp. with children	National	Government (conditional cash transfer)	Indirect effects on health-seeking behaviour; no direct healthcare financing	Not a direct financial-protection mechanism; implementation gaps limited reach
Faith-based/philanthropic financing (e.g., zakat)	0	Not empirically defined in included evidence	Not reported	Religious/charitable donations	Not evaluated in included evidence	Not evaluated in included evidence
General/cross-cutting public financing and access studies	6	General population, by geography/socio economic status	National and sub-national (e.g., East Java, eastern Indonesia)	Public expenditure (general revenue)	Persistent urban-rural and inter-provincial disparities in benefit incidence and facility use	Not primary focus; expenditure increases did not reliably narrow outcome inequality

Equity Implications

Financial protection (socioeconomic dimension)

Despite the near-universal registration achieved through JKN, socioeconomic equity in financial protection remained incomplete. Fattah *et al.* (2023) found that catastrophic health spending continued to affect a meaningful share of Indonesian households in the period following JKN's introduction, with incidence concentrated among poorer and informally employed groups. Asante *et al.* (2024) similarly found that the benefits and burdens of health financing were not evenly distributed across socioeconomic strata, with wealthier groups disproportionately capturing certain categories of subsidized benefit. The COVID-19 pandemic further exposed socioeconomic fault lines in financial protection, with Hafidz *et al.* (2023) reporting elevated out-of-pocket and catastrophic costs that fell more heavily on households with limited savings and informal employment.

Access and utilization (geographic dimension)

Geographic disparities were among the most consistently documented equity concerns. Sambodo *et al.* (2021) demonstrated that variation in public health spending across provinces exacerbated, rather than reduced, inequality in the distribution of healthcare benefits, with urbanized and better-resourced provinces capturing a disproportionate share of subsidized care. Wulandari *et al.* (2022) found persistent urban–rural disparities in hospital utilization despite national insurance coverage, and Laksono *et al.* (2021) documented that disparities in health insurance ownership shaped unequal access to hospital-based birth delivery in eastern Indonesia specifically. Putri *et al.* (2021) added a further geographic dimension, showing that patients in East Java frequently bypassed their nearest health facility in search of adequate care, reflecting both distributional and quality-related inequities in the geographic allocation of services. Ochoa-Moreno *et al.* (2026) found that simply increasing aggregate health expenditure did not reliably narrow inter-provincial inequality in under-5 mortality, suggesting that the geographic allocation, not merely the volume, of financing is central to equity outcomes.

Access and utilization (insurance-status dimension)

A recurring and policy-relevant finding was that formal JKN enrolment did not guarantee equitable access in practice. Sujarwoto *et al.* (2026) described this as a form of “hidden inequity,” in which registered members, particularly those from lower income and less educated backgrounds, systematically underutilized their insurance benefits relative to higher income, better informed members. (Cheng *et al.*, 2025) similarly found that insurance status alone was an incomplete predictor of healthcare utilization once other socioeconomic and geographic factors were accounted for. Consistent with this pattern, national administrative data indicated that while 98.45% of the population was registered under JKN by the end of 2024, only 78.83% were actively contributing or utilizing their membership, revealing a substantial gap between nominal and functional coverage (Dewan Jaminan Sosial Nasional & BPJS Kesehatan, 2024) .

Financial protection (out-of-pocket and catastrophic expenditure)

Reduction of out-of-pocket and catastrophic health expenditure is a central equity objective of social health financing, and the evidence here was mixed. Maulana *et al.* (2022) found that JKN coverage was associated with reduced out-of-pocket payments among vulnerable populations, indicating a meaningful, if partial, protective effect. However, Fattah *et al.* (2023) and Hafidz *et al.* (2023) both documented continued exposure to catastrophic health expenditure among specific subgroups, particularly informally employed and rural households, suggesting that financial protection under JKN remains incomplete for the populations the scheme was designed to protect most.

Barriers underlying both access and financial-protection gaps cross the included literature

Administrative barriers, including complex enrolment and premium-payment procedures, were frequently cited as discouraging sustained participation among informal-sector workers (Muttaqien *et al.*, 2021; Roza & Sari, 2025). Limited information about entitlements and how to use JKN benefits compounded these administrative hurdles, particularly among lower-educated and rural respondents (Sujarwoto *et al.*, 2026; Laksono *et al.*, 2024). Geographic

barriers, including distance to facilities and uneven distribution of healthcare providers, constrained access in remote and eastern Indonesian regions (Pudji Nugraheni *et al.*, 2026; Wenang *et al.*, 2021). Informal employment itself was a structural barrier, as irregular income made consistent premium payment difficult and contributed to high disenrollment rates (Muttaqien *et al.*, 2021; Puspitasari *et al.*, 2026). Inadequate targeting of the PBI subsidy programme was also noted, with evidence suggesting both under-coverage of eligible poor households and, in some contexts, leakage of subsidies to non-poor beneficiaries (Valentina & Marhaeni, 2025; Erlianti *et al.*, 2025). Finally, human-resource constraints within the health system itself, including uneven distribution of health workers, were identified as a structural challenge to translating financing coverage into equitable service delivery (Adyas, 2021).

Research Gaps

Several evidence gaps emerged from this mapping exercise. First, few studies examined equity implications comparatively across different social health financing mechanisms; the large majority of the included evidence concerned JKN and its associated PBI subsidy, while community-based, employer-based, and especially faith-based and philanthropic financing mechanisms remained substantially under-investigated. Second, evidence specific to eastern Indonesia (Papua, Maluku, and parts of Nusa Tenggara) was comparatively limited relative to studies focused on Java and other more populous western regions, despite eastern Indonesia being repeatedly identified as facing the most acute geographic access barriers. Third, few studies disaggregated equity findings simultaneously by socioeconomic status, geography, and insurance status, limiting the ability to identify which populations experience compounding, intersecting disadvantage. Fourth, longitudinal evidence tracking whether the gap between JKN registration and active utilization narrows over time was sparse, despite its clear relevance to monitoring progress toward substantive, rather than nominal, universal coverage. These gaps are quantitatively reflected in the counts above: 18 of 24 peer-reviewed studies (75%) concerned JKN, PBI, or general/cross-cutting public financing, only 5 concerned community-, employment-, or social-assistance-based financing combined, and none evaluated faith-based or philanthropic financing directly; and only 2 of 24 studies focused specifically on eastern Indonesia or remote areas, underscoring both the mechanism-level and geographic concentration of the current evidence base.

4. Discussion

This scoping review mapped five categories of social health financing mechanisms operating in Indonesia: national social health insurance, government premium subsidies, community and employment based contributory financing, non-contributory social assistance, and faith based or philanthropic financing. The review found that their equity implications varied substantially by socioeconomic status, geography, and insurance status. The most striking finding was the gap between nominal and functional coverage: near universal JKN registration (98.45%) coexisted with markedly lower active utilization (78.83%), along with continued exposure to catastrophic and out of pocket expenditure among poorer, informally employed, and geographically remote populations.

Comparing the five mechanisms directly, rather than relying on JKN as a proxy for the whole system, clarifies where the evidence points to different types of progress. National social health insurance and the PBI subsidy have achieved the broadest and most consistently documented gains, extending nominal coverage to nearly the entire population and, in some studies, reducing out-of-pocket payments among the poor (Maulana *et al.*, 2022; Valentina & Marhaeni, 2025); yet the same evidence base shows that JKN/PBI coverage has not reliably translated into equitable utilization or financial protection. Community- and employment-based contributory financing, by contrast, was consistently associated with adverse or unstable outcomes in the studies that examined it, driven by irregular informal-sector income and low ability and willingness to pay (Hidayat *et al.*, 2025), although targeted interventions such as subsidized and simplified enrolment showed some ability to increase uptake (Banerjee *et al.*, 2021). Non-contributory social assistance, exemplified by PKH, does not finance healthcare directly and its evidence base is smaller and more indirect, pointing to implementation gaps that limited its reach to the most vulnerable households (Shah *et al.*, 2026) rather than to a financing-mechanism failure *per se*. Faith-based and philanthropic financing was not evaluated in any

dedicated source identified by this review; its equity implications therefore remain entirely unknown rather than negative, and this absence of evidence is itself a key finding. Read together, the five mechanisms occupy different positions on a continuum from well-documented but incompletely equitable (JKN/PBI) to plausible but under-evaluated (community-based and faith-based financing).

These findings resonate with the broader international literature on social health insurance in low- and middle-income settings, which has repeatedly shown that expanding nominal enrolment is necessary but insufficient for achieving equitable financial protection (Lim *et al.*, 2023; Jauhar, 2024). Similar patterns of “hidden inequity,” in which formally insured but under-informed or under-resourced populations fail to translate coverage into utilization, have been documented in other Southeast Asian UHC systems, suggesting that Indonesia’s experience reflects a regional, rather than uniquely national, challenge in the transition from coverage expansion to coverage effectiveness.

Several interlocking explanations help account for these patterns. Structurally, JKN’s reliance on voluntary and often unstable informal sector enrolment creates a persistent population at the margins of the system, registered when convenient but prone to lapse when premiums compete with immediate household needs (Muttaqien *et al.*, 2021; Banerjee *et al.*, 2021). Geographically, the concentration of healthcare infrastructure and human resources in Java and other western provinces means that even fully insured populations in eastern Indonesia face a supply side ceiling on the access their coverage can realistically translate into (Wenang *et al.*, 2021; Adyas, 2021). Informationally, low health financing literacy, including understanding what JKN covers, how to access it, and how referral pathways function, appears to disproportionately affect lower educated and rural populations, compounding the administrative complexity of the system itself (Mulyanto *et al.*, 2019).

For the Ministry of Health, BPJS Kesehatan, and subnational governments, these findings suggest that future policy attention should shift from coverage expansion, which is now approaching saturation, toward closing the utilization gap among registered but underserved members. This could include simplifying premium payment mechanisms for informal sector workers, strengthening outreach and health financing literacy programmes in lower education and rural communities, and improving the targeting accuracy of the PBI subsidy to reduce both undercoverage of the eligible poor and leakage to nonpoor beneficiaries. For local governments in eastern Indonesia specifically, the findings point toward the need for complementary investment in healthcare supply, including facilities and workforce, alongside financing reform, since demand side coverage cannot substitute for supply side availability.

The persistence of geographic inequality, concentrated in eastern Indonesia and remote areas, and of socioeconomic inequality, concentrated among informally employed and lower-income households, carries distinct policy implications. Geographic inequality signals a supply-side deficit that financing reform alone cannot resolve, and therefore requires complementary investment in health infrastructure and workforce distribution, whereas socioeconomic inequality signals more of a demand-side and administrative deficit that can be addressed more directly through simplified enrolment, improved subsidy targeting, and financial-literacy outreach. Treating these as a single, undifferentiated “equity gap” risks misdirecting policy responses that are effective for one dimension but not the other.

Because equity is the central concern of this review, it warrants explicit attention here. The evidence indicates that Indonesia’s social health financing system has been more successful at achieving formal, registration based equity, extending nominal membership across nearly the entire population, than at achieving substantive, outcome based equity in utilization and financial protection. This distinction can be summarized as a difference between nominal coverage (registration), effective coverage (registration combined with actual utilization of needed services), and financial protection (the extent to which utilization occurs without imposing catastrophic or impoverishing costs); the evidence assembled in this review indicates that Indonesia has made the most progress on the first of these three dimensions and comparatively less on the second and third. This distinction matters because policies and monitoring frameworks that track only registration rates risk overstating progress toward equitable UHC while masking persistent disadvantage among poor, informally employed, and geographically remote groups. A more equity sensitive monitoring approach would track utilization, out of pocket burden, and catastrophic expenditure disaggregated by socioeconomic and geographic subgroup, rather than registration coverage alone.

This review points to several priorities for future research. Comparative studies examining equity outcomes across financing mechanisms, including JKN/PBI, community based financing, and faith based financing, would help clarify which mechanisms most effectively reach the poorest and most geographically isolated populations. Research specifically situated in eastern Indonesia is needed to address the current geographic concentration of evidence in Java and other western regions. Longitudinal research tracking the trajectory of the registration utilization gap over time would help determine whether current policy efforts are narrowing this gap. Finally, mixed methods research combining quantitative equity metrics with qualitative accounts of why registered members do not utilize their coverage would help translate the “hidden inequity” finding into actionable programme design. This review drew on a comprehensive search strategy spanning six academic databases and five grey-literature sources, allowing it to capture both peer-reviewed and policy-relevant evidence that a database-only search would have missed. The inclusion of grey literature from the World Bank, WHO, Kemenkes RI, and BPJS Kesehatan/DJSN provided access to recent administrative and programmatic data, including national coverage statistics that substantially strengthen the currency and policy relevance of the synthesis.

Limitations

Several limitations should be noted. The review was restricted to sources published in English or Indonesian, which may have excluded relevant evidence published in other languages. As a scoping review, no formal quality or risk of bias appraisal was conducted, meaning that included studies varied in methodological rigor and that this synthesis should not be interpreted as an assessment of intervention effectiveness. Accordingly, the patterns described in this review, including the gap between registration and utilization and the concentration of adverse equity findings in specific mechanisms and regions, should be read as a synthesis of what has been reported and studied, not as a validated causal or comparative effectiveness assessment of which mechanism most improves equity. Findings corroborated across multiple independent sources, such as the registration utilization gap supported by both administrative data and several independent studies, warrant more confidence than findings drawn from a single source, such as the specific quantitative impact of the PBI subsidy, which was drawn primarily from one provincial study. The included evidence was heterogeneous in design, population, and outcome definition, precluding meta analytic pooling and necessitating a narrative, thematic synthesis instead. Definitions of “equity” varied across included studies, with some focusing on socioeconomic distribution, others on geographic distribution, and others on utilization gaps, which limits direct comparability of findings across sources. Finally, as with any literature based synthesis, the possibility of publication bias cannot be excluded, particularly given the comparative scarcity of published evidence on community based and faith based financing mechanisms relative to national insurance.

5. Conclusion

This scoping review mapped five categories of social health financing mechanisms in Indonesia: national social health insurance (JKN), government premium subsidies (PBI), community and employment based contributory financing, non-contributory social assistance, and faith based or philanthropic financing. The findings show that JKN and PBI have substantially expanded nominal coverage and provided some financial protection, but inequities in healthcare utilization and financial burden persist, particularly among poorer, informally employed, and geographically remote populations. The gap between near universal registration (98.45%) and lower active utilization (78.83%) further indicates that nominal coverage does not necessarily translate into equitable access to care. Community based and faith-based financing mechanisms remain comparatively under investigated, while evidence from eastern Indonesia is also limited. Because the available evidence is heavily concentrated on JKN and PBI, the findings should not be interpreted as an equally weighted assessment of all five financing mechanisms. Overall, this review highlights progress in coverage and financial protection alongside persistent inequities in effective access and financial burden. Further research is needed to strengthen evidence on less studied financing mechanisms and underserved populations, particularly in eastern Indonesia, to better inform efforts to achieve equitable access to healthcare.

6. Recommendations

Based on the findings of this review, recommendations are offered at three levels: policy, programmatic, and research.

Policy

JKN/BPJS Kesehatan monitoring should move beyond registration coverage to include active utilization and financial protection, disaggregated by socioeconomic status, employment, and region. PBI targeting should be strengthened using updated poverty data, while health-financing reforms should be accompanied by investment in health facilities, workforce, and referral systems, particularly in eastern Indonesia and other underserved areas.

Programmes

Enrolment and payment mechanisms for informal workers should be simplified, health-financing literacy should be strengthened among disadvantaged populations, and linkages between social assistance and healthcare utilization should be explored. Community and faith-based financing initiatives should also be documented and supported as complementary mechanisms

Future research

Comparative and longitudinal studies should evaluate equity across financing mechanisms, with greater attention to eastern Indonesia and other under-represented regions. Mixed-methods research should also examine the reasons behind gaps between insurance registration and actual utilization, particularly for community based and faith based financing mechanisms.

Conflict of Interest

There is no conflict of interest. Nothing to disclose.

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