

To What Extent Can Value-Based Healthcare Governance Be Applied In Value-Based Hospitals? Lessons from MENA for Indonesia

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Abstract

The Value-Based Healthcare (VBHC) paradigm shifts the focus of care from quantity to quality and the efficiency of patient outcomes, a transformational shift in healthcare management that is now widely adopted in the MENA region (Middle East and North Africa). In Indonesia, despite rapid growth in the private sector, value-based hospitals operated by foundation-based legal entities still face stagnation in service delivery due to high operational costs, low profitability, and weak professional governance. This research aims to study the extent to which value-based healthcare governance can be implemented in Indonesia by drawing valuable lessons from the transformation in the MENA region. Using a descriptive approach with qualitative methods supplemented by quantitative field data, this study evaluates operational readiness and formulates

a value-based governance framework. The findings indicate that the implementation of VBHC is highly dependent on an integrated governance ecosystem involving regulation, procurement, accreditation, digital infrastructure, leadership, and outcome measurement. Drawing lessons from Saudi Arabia and Egypt, coordination among regulators, payers, and accreditation bodies is an absolute pre-condition. In Indonesia, foundation hospitals require a contextual approach that takes into account their financial sustainability, organizational capacity, and specific nonprofit characteristics. Policy implications call for the Ministry of Health and BPJS Kesehatan to strengthen cross-institutional coordination in order to integrate VBHC principles into financing governance, outcome indicators, and value-based service delivery mechanisms.

KEYWORDS *Value Based Healthcare; Faith-based Hospitals; Healthcare Governance; MENA; Indonesia Hospitals.*

Introduction

Value-Based Healthcare (VBHC) is an approach to hospital healthcare services that emphasizes measuring the value of services provided in terms of clinical outcomes and patient satisfaction.¹ The National Health Service (NHS) in the United Kingdom defines VBHC as the equitable, sustainable, and transparent use of the available resources to achieve better outcomes and experiences for every individual. VBHC aims to incorporate an individual perspective on value by highlighting qualitative elements while simultaneously emphasizing cost by linking values with resource utilization.²

VBHC is a paradigm that emphasizes delivering high-quality healthcare at comparatively lower costs, shifting the focus from the quantity of care to the quality and affordability of care. VBHC incentivizes healthcare providers to deliver efficient and effective care by enhancing patient health, mitigating the risk and prevalence of chronic diseases, and educating patients on healthy lifestyles tailored to their specific health situations (based on evidence). This

¹ Zanotto, Bruna Stella, Ana Paula Beck da Silva Etges, Miriam Allein Zago Marcolino, and Carisi Anne Polanczyk. "Value-based healthcare initiatives in practice: a systematic review." *Journal of Healthcare Management* 66, no. 5 (2021): 340-365. <https://doi.org/10.1097/JHM-D-20-00283>

² Moberg, Kristoffer Dahl, and Margit Malmlose. "A value-based healthcare approach: Patchy institutionalized logics infusing managers' VBHC perceptions." *Financial Accountability & Management* 41, no. 1 (2025): 19-41. <https://doi.org/10.1111/faam.12402>

concept shifts the paradigm from the traditional fee-for-service system, which is based on the volume of services provided. According to Teisberg, the objective of value-based care transformation is to enable healthcare systems to create more value for patients.³ Value in healthcare is generated only when an individual's health outcomes improve; thus, definitions of value-based healthcare that emphasize cost reduction are insufficient. Cost reduction is essential but inadequate: If the primary objective of value-based health care were cost reduction, analgesics and compassion would suffice.⁴

Corporate governance is "a system of laws, rules, and factors that control operations."⁵ As a system, corporate governance, where laws, regulations, guidelines, best practices, and ethical values form the basis for guiding the board of directors/commissioners/supervisors/management in running, controlling, and directing the company properly to achieve the welfare of shareholders and other stakeholders, including workers.⁶

The implementation of VBHC governance has become imperative for countries globally due to escalating healthcare expenditures and heightened public expectations for accountability and quality. Traditional healthcare systems have become unsustainable, resulting in inefficiency and stagnation. VBHC transforms this paradigm by aligning financing, data, and clinical practices with measurable health outcomes in relation to costs, ensuring that each dollar spent delivers real value to patients and society.⁷ VBHC improves population health and stabilizes national health budgets by promoting transparency, facilitating multidisciplinary collaboration, and advocating for preventive and efficient care. Countries that delay this transition risk escalating costs, persistent inequities, and declining trust in their healthcare systems, while those that adopt VBHC can secure sustainable, high-quality care for their populations.⁸

³ Teisberg E, Wallace S, O'Hara S. Defining and Implementing Value-Based Health Care: A Strategic Framework. *Acad Med.* 2020 May;95(5):682-685. <https://doi.org/10.1097/ACM.0000000000003122>.

⁴ Moberg et. al.. "A value-based healthcare approach: Patchy institutionalized logics infusing managers' <https://doi.org/10.1111/faam.12402>

⁵ Jonathan R. Macey, *Corporate Governance, Promises Kept, Promises Broken*, Princeton University Press, New Jersey, 2010, 2. <https://doi.org/10.1515/9781400829781>

⁶ Macey, *Corporate Governance*, 3.

⁷ Macey, *Corporate Governance*, 4.

⁸ Van Staalduijn, Dorine J., Petra van den Bekerom, Sandra Groeneveld, Martha Kidanemariam, Anne M. Stiggelbout, and M. Elske van den Akker-van Marle. "The implementation of value-based healthcare: a scoping review." *BMC Health Services Research* 22, no. 1 (2022): 270. <https://doi.org/10.1186/s12913-022-07489-2>

Countries in the Middle East and North Africa (MENA) region are currently undergoing a major transformation of their healthcare systems. Several countries in the region, such as Saudi Arabia and Egypt, have implemented definitive measures to transition to a value-based care model, acknowledging its potential to reduce healthcare costs, improve the quality of medical services, and promote healthier lifestyles among their populations.⁹ This transformation not only signifies the government's intent to streamline healthcare financing but also demonstrates the awareness that the old volume-oriented model is no longer sufficient to meet the needs of a growing and increasingly complex population. By shifting the focus from the number of medical procedures to the actual outcomes experienced by patients, MENA countries seek to create healthcare systems that are more sustainable, equitable, and responsive to community needs.¹⁰ This change also requires improvements in governance, the integration of digital technology to monitor health outcomes, and strong collaboration with the private sector especially Foundations¹¹, ensuring that the success of value-based care is realized not only at the policy level but also in the actual practices of hospitals serving patients daily.

This dynamic parallels the challenges encountered by Indonesia. According to the Indonesian Central Bureau of Statistics (BPS) 2025, the number of general and specialized hospitals increased to 2,710 general hospitals in 2024, up from 2,636 in 2023, and 525 specialized hospitals in 2024, an increase from 519 in 2023.¹² Out of 2,636 general hospitals, 242 are managed by the central government (9.2%), 849 are managed by local governments (32.2%), and 1,545 are privately managed (58.6%). Figure 1 presents data on hospital ownership in 2021, indicating a total of 3,042 hospitals, comprising 1,546 government-owned hospitals (Central/Regional, Ministries, Military/Police) and 1,496 privately owned hospitals. In 2022, the total comprised 1,569 government hospitals and 1,503 privately owned hospitals. According to data from sirs.kemkes.go.id, obtained on August 24, 2025, Indonesia was expected to

⁹ Batran, Radwa Ahmed, Mohab Kamel, Ayman Bahr, Ahmed Khalil, and Mohamed Elsokary. "Value-based healthcare in oncology: Can it drive transformative shifts in the Middle East and North Africa region?." *Health Policy and Technology* 13, no. 6 (2024): 100939. <https://doi.org/10.1016/j.hlpt.2024.100939>

¹⁰ Batran et al.

¹¹ Republic of Indonesia, Law No. 16 of 2001 on Foundations (Yayasan), State Gazette of the Republic of Indonesia 2001 No. 112; and Law No. 28 of 2004 on Amendment to Law No. 16 of 2001 on Foundations (Yayasan), State Gazette of the Republic of Indonesia 2004 No. 115.

¹² Badan Pusat Statistik, *Statistik Indonesia 2025* (Jakarta: Badan Pusat Statistik, 2025), 790, <https://www.bps.go.id/id/publication/2025/02/8/8cfe1a589ad3693396d3db9f/statistik-indonesia-2025.html>

have 1,253 (38.34%) government hospitals and 2,015 (61.66%) private hospitals, totaling 3,268 hospitals in 2025. Among these private hospitals, 243 (12.06%) are religious-based institutions founded as foundations, the majority of which are Islamic hospitals, totaling 143. Islamic hospitals operate under a management structure established by MUKISI (All-Indonesia Health Council), grounded in the principles of Maqashid al-Syariah al-Islamiyah.¹³ Data indicates that the number of private hospitals consistently rises annually. In 2021, the number of private hospitals reached 1,496, reflecting an increase of 83.55% from 2012.¹⁴ Private hospitals recorded a growth rate of 11.9%, surpassing the 5.95% growth of government hospitals.¹⁵

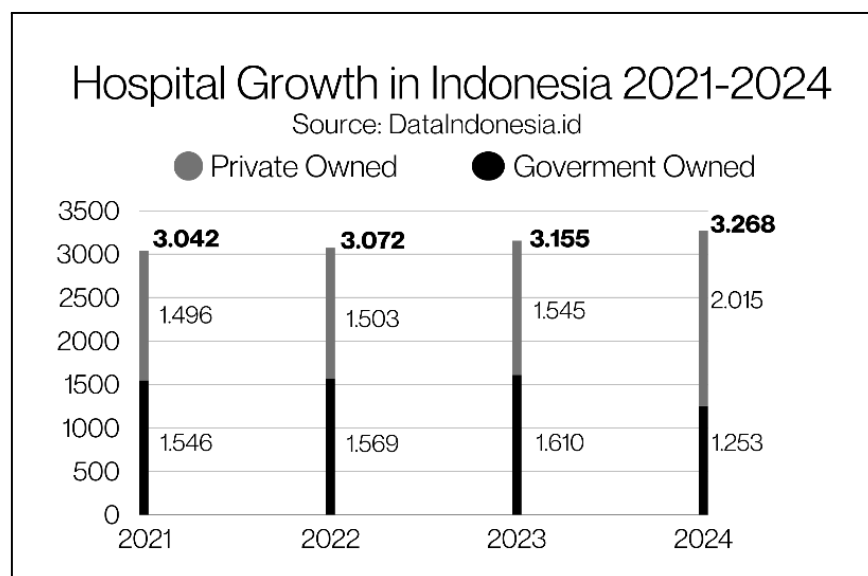


Figure 1. Hospital Growth Rate

¹³ Mahmudah, Zustika Nada, and Diska Arliena Hafni. "Penerapan standar rumah sakit syariah di bidang akuntansi dan keuangan pada RS. Muhammadiyah Lamongan." In *Proceeding of National Conference on Accounting & Finance*, pp. 536-542. 2022. <https://doi.org/10.20885/ncaf.vol4.art67>

¹⁴ "Jumlah Rumah Sakit di Indonesia Meningkatkan tapi Masih Belum Merata," *Lestari Kompas*, 18 Maret 2024, <https://lestari.kompas.com/read/2024/03/18/140000686/jumlah-rumah-sakit-di-indonesia-meningkat-tapi-masih-belum-merata>

¹⁵ PEA, "Kemana Arah RS NonProfit?," *Manajemen Rumah Sakit* (1 July 2024), <https://manajemenrumahsakit.net/2024/07/kemana-arah-rs-nonprofit/>.



Figure 2. Private Hospital Level of Services Rate

Figure 1 illustrates the growth of hospitals in Indonesia from 2021 to 2023, whereas Figure 2 indicates the services provided by private hospitals in Indonesia. The superior service in private hospitals has not corresponded with satisfactory performance. Despite the COVID-19 pandemic, which resulted in 155,000 fatalities, private hospitals have emerged as an essential service. A 2020 survey conducted by PELKESI revealed that, among 73 private Foundation hospitals, only 20 possessed sufficient financial resources. This indicates that 53 hospitals (73%) had poor financial performance. Regarding service provision, only seven hospitals achieved inpatient occupancy exceeding 70%, while four hospitals attained outpatient occupancy surpassing 74%. An article on Hospital Management Patterns indicates that the highest Bed Occupancy Rates averaged 66% in type B hospitals, 70% in type C hospitals, and 51% in type D hospitals. Meanwhile, type C private hospitals provided BPJS services with an average of 66% for outpatient care and 65% for inpatient care. The classification of hospitals A, B, C, and D is predicated on their capabilities and the medical facilities they offer. Type A hospitals are the foremost referral institutions, offering extensive specializations and subspecializations. Type B hospitals provide a broad range of specialist services, but with limited subspecialty options. Type C hospitals offer restricted specialist services, including internal

medicine, surgery, pediatrics, and obstetrics and gynecology. Lastly, Type D hospitals deliver general and dental services (Ministry of Health Regulation No. 3 of 2020 concerning Hospital Classification and Licensing).

In terms of cost management, merely 30% of hospitals compute unit costs, and only 15% do it consistently. Private Foundation hospitals confront the challenge of inadequate quality and performance, while simultaneously managing significant cost pressure in their operations. Private Foundations hospitals encounter challenges in governance, encompassing both institutional and financial aspects. Financial incapacity (inability to generate profits) partially results from the inadequate implementation of accountability principles and accounting systems, which influence internal monitoring and financial transparency.¹⁶ Additionally, service professionalism, including hospital complaint management and the level of satisfaction among health workers, remains a critical issue that significantly contributes to improving service quality, patient satisfaction, and hospital performance.¹⁷ If these challenges remain unaddressed, private foundation hospitals may ultimately face stagnation in healthcare services.¹⁸

The problems experienced by foundation hospitals are systemic and interrelated, not only internally but also in relation to regulations such as BPJS/JKN rules, while internal problems relate to human resource capacity and organizational culture. Research on sustainable hospital management indicates that the VBHC model has been effectively implemented in various countries to achieve efficiency, enduring sustainability, and enhanced hospital capacity.¹⁹ VBHC integrates multiple elements, including outcome measurement, financial accountability, interdisciplinary teamwork, and patient-centered care, to encourage professional behavior and continuous quality improvement throughout the hospital systems.²⁰

¹⁶ Haryani, Endang, Rini Darmastuti, and Sri Winarso Martyas Edi. "Model of Financial Communication to Reinforce Financial Literacy for Indonesian Society." *Ultimacomm: Jurnal Ilmu Komunikasi* 16, no. 1 (2024): 186-207. <https://doi.org/10.31937/ultimacomm.v16i1.3891>

¹⁷ Utomo, Achmad Yoga Setyo, Bagoes Widjanarko, and Zahroh Shaluhiah. "Mutu Pelayanan dengan Kepuasan Pasien Rawat Inap di Rumah Sakit: Literature Review." *Media Publikasi Promosi Kesehatan Indonesia (MPPKI)* 6, no. 9 (2023): 1708-1714. DOI : <https://doi.org/10.56338/mppki.v6i9.3720>

¹⁸ Prananingrum, Dyah Hapsari, Abigail Prasetyo, Oliviani Yanto, and Kezia Annabel RP. "Telemedisin Rumah Sakit Berbadan Hukum Yayasan Menurut Prinsip Kepastian Hukum erlawanan P." *Yuridika* 7: 3. <https://doi.org/10.31328/wy.v7i3.5232>

¹⁹ Michael Porter, "What is value in health care?," *New England Journal of Medicine* (2010). <https://doi.org/10.1056/nejmp1011024> Porter, "What Is Value in Health Care?"

²⁰ Porter, "What Is Value in Health Care?"

The implementation of VBHC in Indonesia remains limited and challenging. Most hospitals, whether foundation-owned or corporate-owned, largely evaluate service quality primarily through the accreditation process, rather than through value-based outcomes.²¹ There is a heightened demand for continuous improvement in hospital governance to examine how VBHC principles can be integrated into existing hospital management systems. Such an approach may provide a framework for considering operational objectives alongside long-term sustainability, particularly for private hospitals that currently encounter financial pressures and challenges in professional service delivery. However, the applicability of VBHC to the governance and sustainability challenges of private foundation hospitals in Indonesia remains insufficiently examined.

Based on existing research gaps and the challenges encountered by private hospitals in Indonesia especially in value-based hospitals under foundations²², this study seeks to identify the feasibility of implementing VBHC in Indonesia, the influencing ecosystems, and the applicable VBHC model. To that end, this study will examine the feasibility of implementing VBHC in Indonesia by analyzing its implementation in the MENA region, hospital governance in Indonesia, the necessary preconditions, and the governance environments that affect VBHC.

This study is a descriptive study, focusing on qualitative methods complemented by quantitative data. The objective is to gain an in-depth understanding of private-foundation hospital governance in Indonesia and the feasibility of implementing the Value-Based Healthcare (VBHC) model. The initial phase of this study started with collecting and analyzing relevant secondary data, including literature, service policies, and relevant pricing policies. This data was used to identify the initial conditions of hospital management, particularly the financial and regulatory aspects directly related to the technical implementation of VBHC. The second phase collected primary data through Focus Group Discussions (FGDs), in-depth interviews with hospital directors, and observations at eight private-foundation hospitals

²¹ Dhiana Wijayanti and Christina Tri Setyorini, "Implementation of Good Corporate Governance in Public Hospitals in Indonesia," *Buletin Poltanesa* 2, no. 2 (2022): 110–115. <https://doi.org/10.51967/tanesa.v24i1.2567>

²² A foundation is a legal entity that has no members and whose assets are separated to achieve specific objectives in the social, humanitarian, or religious fields. Although it does not seek profit (non-profit), a foundation may have assets and even establish business entities whose profits are used to support the foundation's operations (Article 1 paragraph 1 of Law No. 16 of 2001 concerning Foundations).

classified as categories B, C, and D based on service level. The selection of these hospital types was intended to gain a thorough understanding of the differences in governance, resource constraints, and managerial strategies employed in addressing the challenges of service sustainability. In the third phase, the study analyzed the data using a thematic approach. Qualitative data from FGDs, interviews, and observations were coded, grouped, and then compared with quantitative data to build strong triangulation. This analysis aimed to answer the research questions regarding the existing mapping of hospital governance in Indonesia and the necessary preconditions for facilitating the implementation of VHBC governance.

Conversations About VBHC

Value-Based Healthcare focuses on value in healthcare as the outcome achieved per unit of cost incurred, emphasizing improvement in patient health outcomes relative to the cost of achieving those outcomes.²³ Porter introduced a model that requires restructuring healthcare delivery to focus on patient needs and minimize costs.²⁴ VBHC aligns mission, policy, and institutional service delivery systems with value-centered goals. It influences clinical decision-making, strategic oversight, performance measurement, and financial accountability across the healthcare system.²⁵ Hospitals implementing VBHC must coordinate interdisciplinary teams, increase transparency in performance reporting, and adopt patient-centered care models.²⁶

It relies on a series of interrelated pillars that ensure strategic coherence and operational feasibility. VBHC leverages core service elements, including patient-centered organization, clinical outcomes and cost metrics, pricing, and local and inter-geographic integration. A cultural transformation is necessary from a hierarchical and fragmented care system to an integrated,

²³ Judith F. Baumhauer and Kevin J. Bozic. "Value-based healthcare: patient-reported outcomes in clinical decision making." *Clinical Orthopaedics and Related Research* 474, no. 6 (2016): 1375-1378. <https://doi.org/10.1007/s11999-016-4813-4>

²⁴ Zanutto et al., "Value-Based Healthcare Initiatives in Practice."

²⁵ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston: Harvard Business School Press, 2006).

²⁶ Onilari Israel, "Assessing How Well Value-Based Care Models Improve Health Outcomes," ResearchGate (April 2024), <https://www.researchgate.net/publication/391279761>.

outcomes-focused system, wherein leaders and doctors share accountability for the patient's journey and its success.²⁷

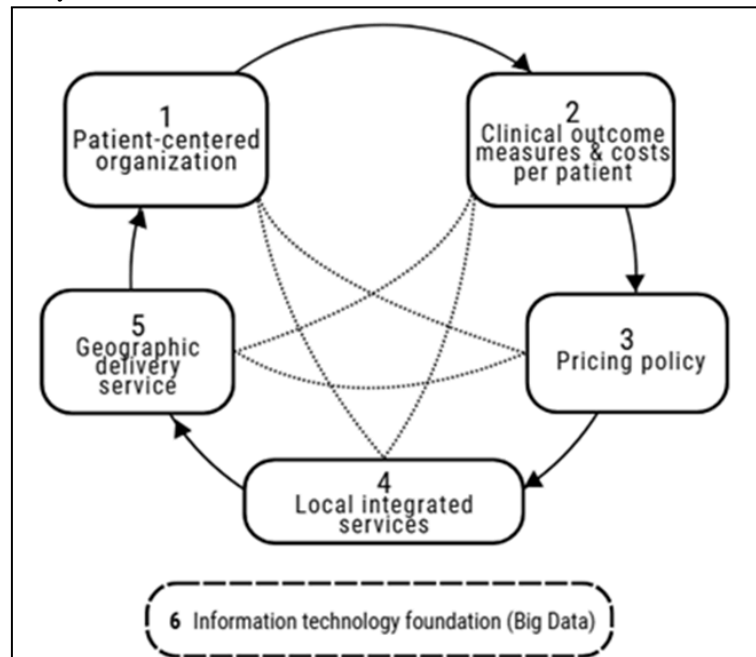


Figure 3

These pillars not only guide implementation but also facilitate strategic alignment at the governance level. These expanded principles acknowledge that the efficacy of VBHC depends not only on structural reform but also on cultural and professional transformation. In essence, the pillars of VBHC governance create a framework for institutions to provide personalized, efficient, and measurable care, ensuring patients receive the best outcomes at the lowest possible cost.

VBHC is a healthcare delivery model that measures success based on patient outcomes and resource efficiency, rather than simply the volume of services provided. The implementation of VBHC requires robust hospital governance, including effective leadership, the use of data and information technology, multidisciplinary collaboration, and the alignment of financial incentives to shift the focus from volume-based care to value-based and qualitative care.

Value-based healthcare is a healthcare service concept that focuses on providing high-quality healthcare services at a relatively lower cost. This concept

²⁷ Christian Colldén and Andreas Hellström, "Value-Based Healthcare Translated: A Complementary View of Implementation," *BMC Health Services Research* 18 (2018): 681, <https://doi.org/10.1186/s12913-018-3488-9>.

shifts the perspective of healthcare services from focusing on the quantity of care to the quality of care. Value-based healthcare has many benefits. From the patient's perspective, they will be able to experience better health improvements at a relatively lower cost, resulting in better healthcare services overall. For healthcare providers, value-based healthcare can provide benefits calculated based on quality of service, which has an impact on increasing patient health percentages, as well as efficiency and reduction of operational costs. One example of the application of the value-based healthcare concept in hospitals is the use of EMR (Electronic Medical Records). With this concept, all medical services are integrated into a coordinated system using EMR as patient health data information. Through this system, each service unit can access patient information such as test and examination results in real time, enabling faster and more accurate services, as well as reducing the potential for misdiagnosis and excessive treatment.

A. The Application of VBHC in Saudi Arabia and Egypt

The Kingdom of Saudi Arabia possesses an institution responsible for regulating and implementing VBHC, namely the Council of Health Insurance (CHI).²⁸ In mid-2025, the CHI launched its Strategy 2025–2027, which explicitly articulates its vision to become a regulatory body that facilitates a beneficiary-centered health ecosystem, with the implementation of VBHC principles as a fundamental strategic pillar.²⁹ This strategy encompasses five main pillars, including the use of data and smart technology, transparency, and innovation. It is supported by several initiatives aimed at enhancing the quality and efficiency of healthcare services. CHI envisions an enthusiastic and healthy society, with VBHC governance being implemented through the development of four essential enablers for best practices: informatics, benchmarking, payment systems, and reorganization of care delivery.³⁰ In the domain of informatics, CHI has launched a National Platform for Health Information

²⁸ Council of Health Insurance. "CHI Providers Classification Program." n.d. accessed July 22 2025. <https://www.chi.gov.sa/en/knowledge-center/Documents/CHI%20Providers%20Classification%20Program.pdf>.

²⁹ "The Council of Health Insurance Launches Its 2025–2027 Strategy." n.d. accessed July 22 2025. <https://www.chi.gov.sa/en/MediaCenter/News/pages/2025-7-20.aspx>.

³⁰ Alzahrani, Ahmed Ali, Milena Pavlova, Nizar Alsubahi, Ala'eddin Ahmad, and Wim Groot. 2025. "Impact of the Cooperative Health Insurance System in Saudi Arabia on Universal Health Coverage—A Systematic Literature Review." *Healthcare* 13 (1): 60. <https://doi.org/10.3390/healthcare13010060>.

Exchange and mandated the use of a standardized Minimum Data Set. These instruments enable consistent data collection and analysis, which constitute the foundation of outcomes-based care. On the financial front, CHI plans to implement case-based payment systems, performance-based payments, and blended payments by 2025.³¹ These models realign incentives by prioritizing outcomes over volume, addressing inefficiencies and overuse prevalent in the current system. Governance in this area includes developing a pricing framework, cost comparisons, and outcome-related reimbursement rules to ensure financial sustainability and value creation.

In terms of service delivery organization, CHI promotes integrated care models and team-based services such as disease-specific clinics (e.g., for diabetes) and home-based health services. These initiatives reflect global best practices and aim to reduce care fragmentation. Private hospitals are increasingly adopting VBHC practices, as evidenced by empirical studies on cost-effectiveness and clinical outcome measurement.³² A retrospective study conducted in a large private hospital group (Almoosa Health Group, Al-Ahsa) calculated incremental cost-effectiveness ratios (ICERs) for various surgical and therapeutic interventions, including ACL (anterior cruciate ligament) reconstruction, knee replacement, and treatment for low back pain.³³ The results indicated that certain procedures, such as ACL surgery and knee replacement, were cost-effective in improving mobility, reducing pain, and increasing daily activity capacity, relative to the additional costs incurred. This study reinforces the evidence that private hospitals in Saudi Arabia have significant potential to demonstrate both “clinical value” and economic value.

The implementation of VBHC in Saudi Arabia has been technically supported by regulatory oversight, inter-agency cooperation, and systematic alignment. Similar to several Arab countries undergoing reform, CHI's initiatives signify not merely a technocratic transition but also an institutional

³¹ AlJohani, Buthaynah Abdullah, and Bussma Ahmed Bugis. 2024. “Advantages and Challenges of Implementation and Strategies for Health Insurance in Saudi Arabia: A Systemic Review.” *INQUIRY the Journal of Health Care Organization Provision and Financing* 61 (January). <https://doi.org/10.1177/00469580241233447>.

³² Al Tamimi & Company. 2024. “Saudi Value Based Healthcare - Al Tamimi & Company.” Al Tamimi & Company. November 15. <https://www.tamimi.com/news/saudi-value-based-healthcare/>.

³³ Khamis, Mona, Zainab Almoosa, Marie Santos, Engineer Daa Kamal, Suhail Yaghmor, Muhammad Daniyal, and Abbas Al Mutair. 2025. “Analysis of Value-Based Healthcare (VBHC) Framework by Incremental Cost-Effectiveness of Surgical and Therapeutic Interventions: A Retrospective Study at Tertiary Private Health Group.” *BMC Health Services Research* 25 (1). <https://doi.org/10.1186/s12913-025-13272-w>.

commitment to increase public responsiveness and trust in the public system.³⁴ The transition to value-based healthcare in Saudi Arabia is a promising yet challenging journey.³⁵

Meanwhile, in Egypt, VBHC in private hospitals is being established on a framework of national health insurance reform that distinguishes the functions of service purchaser, service provider, and quality guarantor.³⁶ This new architecture emerged from the 2018 Universal Health Insurance Law, which established three authorities: the Universal Health Insurance Authority (UHIA) as the purchaser and fund manager, the Egypt Healthcare Authority (EHA) as the public service provider within the UHI network, and the General Authority for Healthcare Accreditation and Regulation (GAHAR) as the quality accreditation and regulatory body.³⁷ Private hospitals have access to the “value” scheme through GAHAR national accreditation and financing contracts with UHIA, which gradually shift incentives from volume to quality and efficiency.³⁸ This framework is essential as VBHC requires objective quality standards, payment mechanisms that align quality with costs, and data infrastructure to measure service outcomes beyond just clinical activities.³⁹ In practice, accreditation serves as a “gateway” for private hospitals to secure contracts with UHIA and functions as a governance mechanism that standardizes quality expectations between public and private facilities.⁴⁰

³⁴ Abdelkarim Amengay, “How Populist Are Arab Citizens? Assessing Populist Attitudes in the Arab World,” *Middle East Law and Governance* 17 (2025): 33–61. <https://doi.org/10.1163/18763375-20251489>

³⁵ Hariri, Bayan A., Faisal M. Albagmi, and Afnan A. Aljaffary. “Conceptualization and establishment of value-based healthcare in Saudi Arabia: A scoping review.” *Journal of Taibah University Medical Sciences* 19, no. 4 (2024): 835–846. <https://doi.org/10.1016/j.jtumed.2024.07.008>

³⁶ “About Egypt Healthcare Authority.” n.d. accessed July 26 2025. <https://eha.gov.eg/en/about-eha/>.

³⁷ Khalifa, Ahmed Yehia, Jean Yacoub Jabbour, Awad Mataria, Magdy Bakr, Mai Farid, and Inke Mathauer. 2021. “Purchasing Health Services under the Egypt’s New Universal Health Insurance Law: What Are the Implications for Universal Health Coverage?” *The International Journal of Health Planning and Management* 37 (2): 619–31. <https://doi.org/10.1002/hpm.3354>.

³⁸ El-Hini, Yasmine, Sudha Bala Krishnan, Andrew Myburgh, and International Finance Corporation. 2023. “COUNTRY PRIVATE SECTOR DIAGNOSTIC EGYPT HEALTH SECTOR DEEP DIVE.” International Finance Corporation. <https://www.ifc.org/en/insights-reports/2023/egypt-private-sector-diagnostic-health-sector-deep-dive>

³⁹ Al Tamimi & Company. 2020. “Egypt: Universal Health Insurance Law - Al Tamimi & Company.” Al Tamimi & Company. November 25. <https://www.tamimi.com/law-update-articles/egypt-universal-health-insurance-law/>.

⁴⁰ Dinana, Hesham, Basma M Saleh, Eman Mohamed Aly, Fatma MA Barakat, Hebatalla Ahmed Ismail, Marwa Hafiz, and Ranin Soliman. 2024. “Sustainability and Resilience in the Egyptian Health System.” *Partnership for Health System Sustainability and Resilience*. .” n.d. accessed July 26 2025. https://www3.weforum.org/docs/WEF_PHSSR_Egypt_2024.pdf.

Effective VBHC governance necessitates standardized clinical and economic data.⁴¹ Egypt initiated the foundation by adopting a standardized benefits package and an ICHI/WHO-based intervention classification as the basis for patient management, clinical audits, costing, tariff setting, claims management, and research. This step enables the comparison of quality and cost indicators across facilities, a prerequisite for fair value-based contracts for private hospitals.⁴² EHA presents a narrative and policy forum that clearly advocates leadership towards “value-based comprehensive health care” within the context of network governance and partnerships. Although EHA is a public facility operator, the policy language used and the forums in which it participates provide direction for the entire ecosystem, including private partners seeking to join the value-oriented service network. The international awards received by EHA and its accreditation achievements strengthen the legitimacy of national standards among private actors, as they indicate that GAHAR standards and local quality management practices are comparable to global benchmarks.⁴³

VBHC governance is inextricably linked to digital transformation. In Egypt, various initiatives demonstrate the enhancement of digital infrastructure for UHI, including the eHealth collaboration with UHIA to bolster policy processes and forums, as well as a memorandum of understanding for a national digital health platform. This platform functions as a “data highway” for e-claims, standardized coding, and the reporting of clinical outcome indicators and patient experiences in private hospitals. In the absence of a coherent data chain, the effective and accountable implementation of package-based payments, bundled payments, or performance bonuses is challenging. The governance of VBHC in private hospitals in Egypt is transitioning from the foundational phase to the operational phase. Success will hinge on the system's ability to swiftly and reliably convert accreditation and standards into payment incentives that evaluate outcomes, as well as the commitment of regulators, purchasers,

⁴¹ Rana, Tarek, Gillian Vesty, Miia Jansson, and Kerryn Butler-Henderson. “VBHC Control, Performance Measurement and Risk Management: Future Research Agenda.” In *Accounting for Healthcare*, pp. 103-126. Routledge, 2024.

⁴² Mathauer, Inke, Ahmed Yehia Khalifa, Awad Mataria, and World Health Organization. 2018. *Implementing the Universal Health Insurance Law of Egypt: What Are the Key Issues on Strategic Purchasing and Its Governance Arrangements?* Health Financing Case Study. Department of Health Systems Governance and Financing. <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>.

⁴³ General Authority for Healthcare Accreditation and Regulation. 2025. *GAHAR Handbook for Hospital Accreditation Standards*. 2025 Edition. General Authority for Healthcare Accreditation and Regulation.

and private providers to establishing data as irrefutable evidence of value.⁴⁴ The ongoing paradigm shift toward value-based care in the MENA region highlights the importance of healthcare reform that emphasizes patient outcomes, cost efficiency, and system sustainability.

B. Description of Hospital Governance in Indonesia

Hospital governance in Indonesia is currently shaped by a combination of accreditation standards, legal regulations, and public financing mechanisms through the National Health Insurance (Jaminan Kesehatan Nasional). In practice, this system has given rise to a governance model that prioritizes administrative compliance over achieving patient health outcomes.

Accreditation standards serve as the main instrument for measuring the quality of hospital services. The government, through the Hospital Accreditation Commission (KARS), stipulates standards for all hospitals, both in urban and remote areas. This accreditation emphasizes procedural compliance, documentation, and the achievement of standard indicators. Although designed to improve quality, many hospitals complain that accreditation is predominantly administrative rather than encouraging substantial improvements in clinical services.⁴⁵

Legal regulations govern hospitals with minimum service standards. Hospitals are subject to national regulations, including Law Number 17 of 2023 concerning Health, Implementing Regulation Number 28 of 2024 concerning the Implementation of Law Number 17 of 2023 concerning Health, Minister of Health Regulation Number 6 of 2024 concerning Technical Standards for Meeting Minimum Health Service Standards, and other technical regulations. The Health Law and its Implementing Regulations were established using the omnibus law method. Omnibus law grammatically denotes the rule of law that simultaneously pertains to multiple objects, encompassing numerous elements, each serving distinct objectives.⁴⁶ The omnibus law is also referred to as the law for all. This legal framework positions

⁴⁴ Ahmed El-Sobky and Mazen Aladdin. "From reform to excellence: the future of health care in Egypt." *The Lancet Global Health* 12, no. 10 (2024): e1584-e1585. [https://doi.org/10.1016/s2214-109x\(24\)00310-3](https://doi.org/10.1016/s2214-109x(24)00310-3).

⁴⁵ Komisi Akreditasi Rumah Sakit, *Standar Nasional Akreditasi Rumah Sakit* (Jakarta: KARS, 2022).

⁴⁶ Antari, Putu Eva Ditayani. "The Implementation of Omnibus Law in Indonesia Law Making Process on Philosophy Review." *De Jure: Jurnal Hukum dan Syar'iah* 14, no. 1 (2022): 179-194. <https://doi.org/10.18860/j-fsh.v14i1.15757>

hospitals under stringent regulations and numerous administrative obligations. This imposes a dual burden on hospital administration, particularly for private hospitals that are legal foundations or religious-based institutions, which also bear social and spiritual responsibilities.

Law is generally defined as the entire collection of rules or principles in a community: the entire set of rules governing behavior in a community, the enforcement of which can be enforced by sanctions.⁴⁷ According to O. Notohamidjojo, law is defined as the entirety of written and unwritten rules, usually of a coercive nature, governing human behavior in social interactions and within the community (as well as between communities). These rules are aimed at achieving justice, order, and peace with the goal of humanizing people within society.⁴⁸

BPJS Kesehatan has a significant influence on governance, not only functioning as a service payer and funding provider, but also as a system that dictates the operational direction of hospitals. Given that approximately 80–90 percent of hospital patients are covered by JKN, nearly all management aspects are significantly impacted by the hospital's effectiveness in submitting and processing claims.⁴⁹ Suboptimal INA-CBG rates frequently lead to delayed or rejected claims, and the presence of "mandatory diagnosis codes" necessitates hospitals to modify clinical decisions to align with the financing scheme rather than the medical needs of patients. As indicated in the FGD, "Occasionally, diagnoses are modified to facilitate claim payments, rather than being essential for the patient."⁵⁰

Health service tariff standards, including INA-CBG tariffs as a method of claim payment by BPJS Kesehatan to advanced referral health facilities. The INA-CBG system is a system of grouping healthcare service costs based on diagnosis, treatment, and patient condition, which forms the basis for claim payments by BPJS Kesehatan to hospitals.⁵¹ Normally, the purpose of setting these rates is to ensure objectivity in calculating service costs, improve quality,

⁴⁷ Sudikno Mertokusumo, 2010, *Mengenal Hukum*, Universitas Admajaya, Yogyakarta, 49.

⁴⁸ O. Notohamidjojo, 1975, *Demi Keadilan dan Kemanusiaan: Beberapa Bab dari Filsafat Hukum*, BPK Gunung Mulia, Jakarta, 68

⁴⁹ Rena Octora, Efrila Efrila, and Ani Maryani. "Peran BPJS Kesehatan Dalam Sistem Jaminan Sosial dari Perspektif Hukum Bisnis." *Jurnal Cahaya Mandalika* ISSN 2721-4796 (online) 3, no. 1 (2024): 652-657. <https://doi.org/10.36312/jcm.v3i1.3530>.

⁵⁰ Focus Group Discussion with participants of academics and practitioners, conducted by Dyah Hapsari, Endang Haryani, and Bagoes Widjanarko, Semarang, July 2025

⁵¹ Regulated in Minister of Health Regulation No. 3 of 2023 concerning Standard Rates for Health Services in the Implementation of Health Insurance.

and optimize the efficiency of healthcare services, but in practice this is often not the case.

This approach results in conflicts between the service mission of hospitals, particularly non-profit faith-based hospitals that are always foundations within the PELKESI network, and the financial requirements imposed by BPJS and government regulations. Hospitals must maintain spiritual values and community service; nonetheless, nonetheless constrained rates and inflexible claims significantly restrict opportunities for innovation. A tension emerges between the rationale of uniform certification and the specific circumstances of hospitals, particularly in remote areas that lack specialists yet are mandated to adhere to the same standards as urban referral hospitals.

Foundation hospitals with a majority of JKN patients tend to experience INA-CBG rates that are not commensurate with the actual cost of services. As a result, every medical procedure performed is always recalculated based on “how much can be claimed,” rather than “what should be given to the patient.” This pressure forces hospitals to limit long-term investments, such as in rehabilitation or prevention programs, which could actually provide greater value for public health. Instead of focusing on the quality of patient care, hospital management spends its energy ensuring that claims are administratively secure. Hospital cash flow becomes fragile, and the risk of declining service quality increases because clinical decisions are influenced by reimbursement certainty, not solely by medical considerations.

BPJS has become an actor that directs hospital behavior through claim regulations, diagnosis coding, and the implementation of the National Clinical Practice Guidelines (PNPK). Medical personnel complain that their clinical decisions often have to be “adjusted” to fit the codes recognized by BPJS. Otherwise, the actions they have taken risk not being paid for. This creates a direct conflict between clinical logic and administrative logic.

As a result of this misalignment of incentives, high-value service innovations such as post-stroke rehabilitation programs, family education, or community-based health programs are difficult to maintain. Many hospitals ultimately choose to play it safe by adjusting diagnoses or procedures so that claims can be paid. While this practice saves short-term cash flow, it undermines clinical ethics and obscures the hospital's orientation toward the actual needs of patients.

The issue of pricing or setting health service rates also emerges as a crucial issue in hospital management. Research shows that the INA-CBG rates set by

BPJS do not reflect the real costs of services in the field. For example, the normal delivery package rate paid by BPJS does not cover all costs incurred, especially if complications arise that require additional intervention. Hospital leaders revealed that the prices of medicines, medical equipment, and professional services continue to increase, but claim rates have not been adjusted proportionally. This has resulted in hospitals having to cross-subsidize from other services or seek additional sources of funding in order to continue carrying out their social mission. INA-CBGs rates are also considered non-adaptive to variations in patient conditions, with highly complex cases receiving the same rates as simple cases, resulting in hospitals bearing the cost difference. This pricing issue not only puts pressure on cash flow, but also creates a dilemma where hospitals must choose between providing the best service at the risk of deficit, or adjusting services to match claims even though they are not optimal for patients. Thus, pricing becomes a critical point that locks hospitals into a narrow logic of efficiency, rather than allowing them to focus on achieving broader health outcomes.

The implementation of VBHC governance in Indonesian hospitals reveals a landscape characterized by a profound commitment to patient-centered values, but is constantly hampered by systemic and financial constraints. Interviews with eight private hospital directors who responded about their experiences and daily hospital management practices reveal that while all hospitals excel in social and cultural service dimensions, they exhibit deficiencies in the technical aspects of VBHC (costing, pricing, and integrative digitization). The dominance of BPJS (Social Security Administration Agency) has evolved into a “burning platform” without revenue diversification and micro-costing, making VBHC initiatives less sustainable. An opportunity exists to establish VBHC networking as a digital hub, exemplifying a patient-centered culture, holistic care, patient safety, and community engagement, as well as a center of excellence for stroke and chemotherapy care.

At the conventional governance level, hospital leaders struggle to align this value-focused mission with the operational realities of Indonesia's healthcare financing system. With 90% or more of their patient base covered by BPJS (National Health Insurance), hospitals are heavily dependent on a single payer whose reimbursement scheme has been relatively stagnant since 2014, while hospital operating costs continue to rise. BPJS's strict standardization policies (particularly the enforcement of national clinical guidelines) create tension, especially for rural or small-scale hospitals with limited infrastructure and

availability of specialists. Governance responses to these constraints vary but share a common strategy: adaptive compliance with BPJS policies while maintaining core values through internal policy innovation.

Management faces challenges in maintaining pastoral care as a distinctive feature, while still having to maintain financial sustainability. This situation emphasizes that hospital leadership is often forced to deal with day-to-day problems arising from overlapping regulations and limited resources, rather than acting as agents of change capable of leading the organization towards value-based governance. The conflict between the social/religious mission and financial demands is particularly strong in Christian-based hospitals.

Pastoral care is an important part of the identity of some hospitals. However, this service is not recognized at all in the BPJS financing scheme, so it must be financed from internal funds. Hospitals like this continue to maintain their commitment to serving poor patients even though the INA-CBGs rates do not cover the costs. As a result, hospitals face an ethical dilemma: provide services in line with their mission but incur deficits, or adjust services to comply with BPJS claims even though they are not optimal. In the long term, reserve funds are depleted, and the hospital's ability to make strategic investments weakens.

The manifestation of this is a conflict between social/religious missions and financial demands. It is a difficult choice between providing ethically ideal services and maintaining operational sustainability.

The root cause is the lack of financial support for services that are part of the mission (e.g., pastoral services, social assistance). There is pressure to maintain claim numbers and profitability in a strict tariff environment.

The impact is ethical tension for management and medical staff; resource allocation decisions become dilemmatic. And the use of internal funds to cover gaps risks eroding reserves for strategic investment.

In terms of financial governance, hospitals are compelled to implement strict efficiency measures. Many expressed concerns about cash flow disruptions due to delayed or denied BPJS claims, with specific instances reaching delayed claim rates of 20–25%. These rejections frequently resulted from technical discrepancies between hospital records and the changing BPJS claim criteria. Consequently, hospital finance teams operated under immense pressure to meet administrative standards while maintaining service quality.

Meanwhile, the FGD focused on academics, with interdisciplinary scholars from public health, hospital administration, health economics, and social policy

convening to examine the governance dimension of VBHC in Indonesia critically. The discussion revealed VBHC was not initially limited to hospital management structures. Instead, governance encompassed the entire architecture of relationships between regulators, service providers, funders, and the public, which dictated decision-making processes, the distribution of accountability, and the interpretation of health values in practice and policy. However, in the Indonesian context, these relationships were often disconnected, resulting in systemic misalignment.

Academics have expressed significant concerns regarding the dominance of BPJS Kesehatan as the regulatory and financial gatekeeper in the national health system. While BPJS is crucial in financing care through the JKN (National Health Insurance) plan, its operational framework prioritizes efficiency, claim verification, and adherence to standards over long-term patient value or public health outcomes.

Some participants described BPJS as having a “hidden governance role,” functioning not only as a payer but also as a *de facto* controller of clinical decision-making and hospital behavior. This engenders a governance paradox because hospitals are expected to deliver value, yet their incentive frameworks are misaligned with value-based concepts. For example, BPJS frequently rejects claims that do not comply with coding rules or treatment algorithms, even when doctors have made patient-centered or context-sensitive decisions.

Participants also questioned the fragmented policy environment in which VBHC is expected to flourish. Ministries (Health, Home Affairs, PAN-RB), BPJS, local governments, and hospital accreditation agencies operate with overlapping mandates, frequently lacking coordinated objectives. For example, the Ministry of Health may promote patient-centered care, while BPJS imposes cost ceilings, and local governments dictate staffing policies. This institutional fragmentation results in a governance vacuum, where no single actor is responsible for delivering a value agenda. One participant described governance in Indonesia as a “mosaic of mandates without a frame,” indicating a tendency for each institution to act within its legal boundaries, but without a shared governance narrative that prioritizes health outcomes over bureaucratic metrics.

The discussion revealed that VBHC governance in Indonesia must evolve from a compliance-based, institution-centered model to a value-oriented systemic framework. This requires not only technical reforms, but also fundamental changes in governance culture, from control to trust, from fragmentation to integration, from short-term objectives to long-term health

impacts. This view posits that governance involves managing health values within a complex system, ensuring that every regulation, budget, and clinical decision contributes to a shared mission.

C. Conflict

The transition of hospital governance in Indonesia, as a developing country, remains currently oriented towards accreditation and requires deliberate structural and cultural reforms. Issues in hospitals originate from governance. In the existing hospital governance framework, hospital administrators allocate significant time to fulfilling accreditation criteria that have become less relevant. Conflict emerges when governance prioritizes cost management as the ultimate objective. One of the lecturers at the FGD remarked, “In the present system, efficiency is characterized by reduced expenditure rather than increased health output.” This approach leads to insufficient funding for optimal health service delivery, resulting in patients being referred to other hospitals or receiving inaccurate diagnoses from doctors. A hospital director remarked during FGD, “We modify the diagnosis not due to patient necessity, but because it is the sole means for the claim to be compensated.” Furthermore, beyond the service period, most hospitals discontinue patient care upon discharge, lacking initiatives to prevent the recurrence of similar diseases or facilitate long-term recovery. This practice contradicts the fundamental ideals that VBHC aims to promote. VBHC governance necessitates modifications in long-term services for patient health.

Values in VBHC are not rigid standards, such as uniform national accreditation standards. Values must be linked to the reality of hospitals in remote areas or those based on religion. The VBHC principle of contextual values illustrates this issue. Hospitals with value-based governance are encouraged to define their value indicators together with their communities. For example, faith-based hospitals in rural areas can measure their performance not only in terms of reduced mortality rates, but also in terms of patient trust, access to pastoral care, and family health literacy. These locally relevant outcomes need to be recognized in governance reporting frameworks, thereby influencing hospital funding and accountability.

VBHC is not merely a technical improvement to existing processes; it is an initiative to redefine the purposes of hospital governance. VBHC shifts the focus of leadership from simply maintaining institutional compliance to initiating value for patients. The implementation of this governance reform

requires deregulation, cross-sectoral commitment, and a shared measurement system. However, the FGD showed that without this reform, VBHC will remain an aspiration rather than an operational reality.

The adoption of VBHC in Indonesia is in its early and partial phases. Some hospitals have initiated experiments, such as appointing Patient Service Managers (PSMs) to coordinate services, or using local multi-stakeholder forums to resolve ethical dilemmas related to BPJS claims. However, VBHC has not yet been systematically integrated into Indonesian hospital management due to insufficient regulatory support and the lack of value-based payment systems.

D. Governance Ecosystem That Influences VBHC: MENA - Indonesia Institutional Lessons

The governance ecosystem comprises supporting organizations and regulations.⁵² The governance ecosystem is a framework that regulates the establishment, operation, and control of organizational networks to achieve shared values. This governance defines common priorities, ensures that each party complies with collective goals, clarifies decision-making authority, and guides acceptable behavior within the ecosystem. Brown asserts that “effective ecosystem governance is the key to creating trust among participants and growing value.”⁵³ Governance sets priorities, ensures that organizations act in the interest of all participants, clarifies decision rights, and guides acceptable behavior”. This ecosystem is essential as the foundation for the sustainability of VBHC implementation. Ecosystem support ensures that overlapping regulations, funding constraints, or organizational cultural resistance will not significantly hamper hospital-level innovation. Without such an ecosystem, VBHC will remain a normative concept and fail to bring about substantial transformation.

⁵² Kaisa Korhonen-Kurki et al. Transformative governance: Exploring theory of change and the role of the law." *Earth System Governance* 23 (2025): 100230. <https://doi.org/10.1016/j.esg.2024.100230>

⁵³ Tiara Fadila and Mursyid Hasan Basri. "Healthcare Ecosystem Mapping in Secondary Health Facility for Hypertension Case." In *Proceedings of International Conference on Management in Emerging Markets (ICMEM) SBM ITB*, vol. 3. 2021.

From an organizational perspective, VBHC requires integrated internal hospital governance.⁵⁴ The existence of a Patient Service Manager is a crucial instrument for integrating clinical, administrative, and community aspects into a unified objective. Nonetheless, such internal initiatives can only be sustainable with structural support, encompassing human resource training, an effective data system, and visionary leadership capable of transforming organizational culture from a volume orientation to a value orientation. Consequently, hospitals are now regarded not merely as providers of curative services but as organizations that oversee the overall health journey of patients.

From a legal and regulatory perspective, a robust ecosystem requires flexibility and alignment between national regulations and local needs.⁵⁵ Hospitals in Indonesia currently encounter complexity due to overlapping regulations between accreditation standards, legal obligations, and BPJS claim provisions. A more adaptive legal framework is required, one that not only regulates administrative compliance but also provides incentives for achieving better health outcomes. Regulations on bundled payments, recognition of patient outcome indicators (PROMs and PREMs), and provisions for contextual definitions of value at the community level exemplify rules that must be established to support VBHC.

The experience of Saudi Arabia and Egypt provides a useful comparative perspective for examining these institutional relationships. The comparison is not intended to suggest that the MENA models can be directly transferred to Indonesia, but rather to identify institutional similarities, differences, and mechanisms that may provide relevant lessons for Indonesian VBHC governance. Three dimensions are particularly relevant: the role of the purchaser, the function of accreditation institutions, and the readiness of digital health infrastructure.

First, the purchaser occupies a central position in both the MENA systems examined and Indonesia. In Egypt, the Universal Health Insurance Authority (UHIA) functions as the purchaser and fund manager within the Universal Health Insurance system. In Indonesia, BPJS Kesehatan performs a central purchasing and financing function within the Jaminan Kesehatan Nasional (JKN) system. In both contexts, the purchaser has significant influence over hospital financing and provider behaviour. The difference lies in the extent to

⁵⁴ "3 Approaches to Ecosystem Governance | MIT Sloan." 2024. MIT Sloan. March 5. <https://mitsloan.mit.edu/ideas-made-to-matter/3-approaches-to-ecosystem-governance>.

⁵⁵ La Ode Hidayat "Studi Sustainability Competitive Advantage Pada Rumah Sakit Swasta di Kota Makassar." PhD diss., Universitas Hasanuddin, 2023.

which purchasing arrangements are connected to value-oriented incentives. Egypt's health insurance reform links purchasing, accreditation, and financing arrangements, including the participation of private hospitals through accreditation and contracts with UHIA. In Indonesia, BPJS financing remains strongly associated with the INA-CBG payment mechanism, while the findings from private foundation hospitals indicate continuing challenges in costing, pricing, and the integration of outcome information into financing decisions. This comparison suggests that Indonesia already possesses an institutional entry point for value-based purchasing through BPJS, but further integration between purchasing, outcomes, costs, and patient experience remains an important consideration.

Second, accreditation represents a common governance instrument, although its institutional position differs between the two systems. Indonesia uses the Hospital Accreditation Commission (KARS), while Egypt has established the General Authority for Healthcare Accreditation and Regulation (GAHAR). In both systems, accreditation provides standardized expectations concerning hospital quality and safety. However, the Egyptian arrangement places accreditation more directly within the health insurance and purchasing architecture, with GAHAR accreditation functioning as a condition for private hospitals seeking participation in UHIA arrangements. In Indonesia, accreditation and BPJS purchasing operate through related but institutionally distinct mechanisms. This difference is relevant to VBHC because accreditation can provide a quality and compliance foundation, while value-based governance additionally requires mechanisms for connecting quality and outcome information with financing and provider incentives. The lesson for Indonesia is therefore not necessarily to replace the existing accreditation system, but to consider how accreditation information could be connected more effectively with outcome measurement and purchasing arrangements.

Third, digital infrastructure constitutes an important condition for operationalizing VBHC. Saudi Arabia has developed a National Platform for Health Information Exchange and a standardized Minimum Data Set as part of its VBHC strategy. Egypt has similarly developed digital initiatives supporting e-claims, standardized coding, and the reporting of clinical outcomes and patient experiences within the Universal Health Insurance system. These developments demonstrate the importance of integrated data for linking clinical activities, costs, claims, and outcomes. In Indonesia, the findings from the eight private foundation hospitals indicate continuing deficiencies in costing, pricing,

and integrative digitization. The difference therefore concerns not only the availability of digital technology but also the degree to which existing systems can connect clinical, financial, claims, and outcome data into a common information architecture.

The comparison between MENA and Indonesia indicates that several institutional components necessary for VBHC are already present in Indonesia. BPJS provides a centralized purchasing structure, KARS provides a standardized accreditation framework, and hospital information systems provide a basis for collecting service-related data. However, the MENA experience illustrates the importance of connecting these components within an integrated governance ecosystem. Purchasing arrangements need to be capable of incorporating value-related indicators; accreditation can provide a foundation for quality assurance while being connected to broader outcome measurement; and digital systems need to facilitate the integration and verification of clinical, financial, and patient-experience information.

Based on these similarities and differences, three practical lessons emerge for Indonesia. First, BPJS Kesehatan can provide an institutional entry point for the gradual development of value-based purchasing because of its central role in hospital financing. Second, KARS accreditation can serve as an existing quality infrastructure that may be complemented by outcome and patient-experience measures rather than treated as the sole indicator of value. Third, strengthening the integration of hospital information, costing, claims, and outcome data is an important precondition for the development of more sophisticated value-based payment arrangements. These lessons indicate that the implementation of VBHC in Indonesia does not necessarily require the creation of an entirely new governance architecture; rather, it requires greater coordination and integration among institutions and mechanisms that already form part of the healthcare system.

At the same time, the MENA experience cannot be replicated without contextual adaptation. Saudi Arabia and Egypt operate within different institutional, regulatory, financing, and technological environments. Indonesian private foundation hospitals also have particular legal, social, and organizational characteristics that distinguish them from both public and corporate hospitals. The relevance of the MENA experience therefore lies in identifying governance mechanisms that can be adapted to the Indonesian context, particularly the integration of purchasing, accreditation, digital infrastructure, outcome

measurement, and provider governance within a common value-oriented ecosystem.

E. Preconditions for VBHC

Value-based healthcare (VBHC) in this figure illustrates how hospitals need to integrate two main dimensions, namely clinical governance and corporate governance, with a meeting point in value domains. Clinical governance focuses on safe, high-quality, efficient, and patient-centered medical services. Key elements include the role of medical personnel, multidisciplinary communication, patient and family experience, and a transparent incident reporting system. The ultimate goal is to create customer intimacy in healthcare, which is a close relationship between hospitals and patients that goes beyond the mere aspect of healing.

Meanwhile, corporate governance focuses on the institutional and managerial aspects of hospitals, ranging from the formulation of business process propositions according to hospital type, continuous improvement management, infrastructure development, benchmarking and accreditation, to the achievement of healthcare sustainability.

The intersection of the two is manifested in value domains, which are core areas that unite clinical and corporate interests. The five main domains are: patient and family-centered care, measurement of outcomes and cost, innovative pricing policy, integrated service, and intra-regional service. These domains emphasize that value is not only generated from medical services, but also from how services are managed, measured, and linked between institutions.

The governance environment, both internal and external, is a supporting factor. Internal factors include organizational values, leadership, human resource management, change and risk management, and organizational culture. External factors include technological developments, legal regulations, the role of the government (Ministry of Health) and BPJS, the dynamics of the healthcare industry, and community involvement.

The adoption of VBHC in Indonesia cannot be implemented instantaneously; certain preconditions are necessary for this concept to operate effectively and not remain merely theoretical. The results of the FGD with hospital practitioners and academics revealed several aspects that must be fulfilled as prerequisites for implementing VBHC. The most crucial condition in implementing this value-based concept is visionary and consistent leadership.

FGD sources emphasized that value-based governance can only be effective if hospital administrators appreciate the VBHC concept not merely as a technical requirement, but as an ethical and strategic framework. Leadership must serve as the foundation that ensures managerial and clinical decisions remain focused on patient value. Furthermore, departmental fragmentation between clinical and administrative functions, as well as inadequate coordination across units, constitute major obstacles to the status quo. Integration between internal hospital systems is required. Preliminary observations following the appointment of Patient Service Managers in several hospitals suggest that the role of coordinators is crucial in ensuring service continuity and reducing overlap and bureaucratic barriers. Thus, value-based governance cannot be separated from the context of the organization and ecosystem in which the hospital operates. The role of top management, in this case the hospital director, is very important in translating policy to the operational level, so that the vision of value-based governance is truly realized in daily practice and leads to the ultimate goal: hospital sustainability.

In other words, before discussing national-level integration, hospitals must first establish an integrated internal governance system and a corresponding service culture. At the organizational level, cultural change can begin with small projects that accustom staff to think in terms of long-term outcomes, rather than just focusing on procedures. Regarding organizational cultural change and healthcare worker education, VBHC necessitates a mindset transformation from volume to value. Scholars advocate for VBHC to be integrated into the health education curriculum to ensure that future doctors, nurses, and hospital managers adopt a value-based orientation. VBHC is highly dependent on Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs). This must then be complemented by robust supporting data infrastructure and outcome assessment systems. Most hospitals in Indonesia lack adequate data systems to document patient outcomes consistently. Therefore, the development of an integrated health information system, training of health workers in data collection, and the integration of cross-unit and cross-facility data are fundamental prerequisites.

The subsequent precondition involves the government as the policy maker.⁵⁶ A robust legal ecosystem, regulatory support, and a clear and coherent financing system are crucial for implementing VBHC. Law is not merely a rigid set of rules, but an integral part that interacts with all elements within and

⁵⁶ Korhonen-Kurki et al., "Transformative Governance,"

around hospitals. Law here is defined as a highly specialized form of social control in a politically organized society, achieved through systematic and orderly application through the power of society. Law is defined as a social engineering task designed to eliminate differences of opinion and satisfy human interests. Roscoe Pound asserts that law cannot be assessed by referring to the law itself, as assessed by the analytical school, or in relation to an ideal picture of law, as done by formalists, but must be assessed functionally in relation to its purpose.⁵⁷

Hospitals face overlapping regulations from various institutions: the Ministry of Health, BPJS, KARS, and local governments. As a result, hospital management is bogged down by a heavy administrative burden. A case found in the field is how referral hospitals often have to follow the same accreditation standards as small hospitals. In fact, the complexity of cases and patient loads are very different, so these uniform standards are actually counterproductive. In addition, some hospital management complains about accreditation policies that often change without a clear transition period, so that strategic plans that have been prepared must be repeatedly adjusted. This situation makes hospitals more “compliance-driven,” busy preparing documents and meeting indicators, rather than directing their energy towards value-based services for patients. The result is that many regulations (Ministry of Health, KARS, BPJS, local regulations) run in parallel without harmonization. Uniform accreditation standards applied to hospitals with different capacities and contexts make it difficult for small type D or C foundation hospitals to meet these requirements. The root cause is top-down regulatory design that does not take into account the heterogeneity of facilities and regional capacities. Coordination mechanisms between regulatory agencies are weak or inconsistent. This situation results in a high administrative burden that diverts resources from direct services. Frequent policy changes make medium/long-term strategic planning difficult. Hospitals also become more “compliance-driven” than “value-driven.”

Currently, BPJS claims frequently pose challenges due to increased pressure on administrative requirements and short-term cost efficiency. It is imperative to discontinue regulations and financing mechanisms that create value, such as bundled payment trials or long-term, result-based financing schemes, to execute VBHC. In the absence of governmental support, VBHC risks becoming trapped in an anomalous and regressive system.

⁵⁷ McManaman, L. J. (1958). Social Engineering: The Legal Philosophy of Roscoe Pound. *St. John's Law Review*, 33(3), 33.

The aforementioned preconditions fundamentally pertain to the core principle of VBHC, which prioritizes patient welfare. Consequently, patients, the central emphasis of this management system, are pivotal to the successful execution of VBHC management. Patient and community engagement is essential in delineating value. The FGD indicated that value in Indonesian health services encompasses not only clinical components but also spiritual, social, and familial dimensions. Consequently, the prerequisites for executing VBHC encompass the involvement of patients and the community in defining locally pertinent value indicators, ensuring that VBHC does not transform into an externally imposed notion, but genuinely addresses the community's needs. Meeting these parameters renders the deployment of VBHC more feasible and contextually relevant. In the absence of these prerequisites, hospitals will only face the imposition of a novel notion without the capacity to incorporate it into their daily management operations.

The healthcare system in Indonesia faces many challenges, including limited resources, unequal access, and poor quality healthcare services in some areas. Through the concept of value-based healthcare, these challenges can be overcome through high-quality and efficient services that are accessible to everyone.

The implementation of value-based healthcare in Indonesia requires a diverse approach. First, there needs to be a systemic change in how healthcare facilities receive incentives, with calculations that emphasize service quality and patient health outcomes rather than the quantity or number of services provided. By providing incentives to healthcare providers to focus on service quality and patient outcomes, this can encourage improvements in healthcare quality and service efficiency. In addition, service quality improvement also needs to be encouraged through improving the quality of human resources and utilizing the Hospital Management Information System (SIMRS).

Finally, every service facility needs to focus on patient education and involvement (patient-centric), which can help encourage healthy lifestyles for improving the overall quality of public health.

Conclusion

The findings demonstrate that the implementation of Value-Based Healthcare (VBHC) in Indonesian hospitals depends on an integrated governance ecosystem involving regulation, purchasing, accreditation, digital infrastructure, leadership, and outcome measurement. The comparison with

Saudi Arabia and Egypt indicates that coordination among regulators, purchasers, and accreditation institutions is an important condition for value-oriented healthcare. In Indonesia, the Ministry of Health and BPJS Kesehatan are key institutional actors, while private foundation hospitals require a context-sensitive approach that considers financial sustainability, organizational capacity, data integration, and their specific non-profit characteristics.

The policy implication is that Indonesia should strengthen coordination among the Ministry of Health, BPJS Kesehatan, accreditation institutions, and hospitals to progressively integrate VBHC principles into existing governance and financing arrangements, particularly through outcome and patient-experience measures, integrated clinical and financial data, and value-oriented purchasing mechanisms. Further research should develop and empirically test a standardized but context-sensitive VBHC model for Indonesian hospitals, particularly private foundation hospitals, including validated outcome indicators, integrated data systems, value-based purchasing mechanisms, and the roles of leadership and interdisciplinary collaboration in sustaining implementation.

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