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Collaborative Governance in the Universal Health Coverage (UHC) Program in Mojokerto Regency

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ABSTRACT

This study aims to analyze the implementation of collaborative governance between the Mojokerto Regency Regional Government and BPJS Kesehatan in achieving Universal Health Coverage (UHC), as well as to identify its supporting and inhibiting factors. Utilizing a descriptive qualitative method, this research applies the Ansell & Gash (2008) model, encompassing starting conditions, facilitative leadership, institutional design, and the collaborative process. The results indicate that the collaboration operates highly effectively, evidenced by the National Health Insurance (JKN) coverage reaching 98.76% (1,141,807 individuals) and Mojokerto Regency securing the UHC Priority status. This success is driven by the regional budget commitment for the PBPU Pemda segment, the implementation of same-day activation, and the robust trust between institutions. The primary supporting factors include intensive dialogue, a shared vision, and strong institutional legitimacy. However, the study also identified several obstacles: uneven public literacy regarding JKN, demographic data validity dynamics, long-term regional fiscal constraints, and the suboptimal involvement of the Pentahelix scheme. The proposed recommendation emphasizes the inclusion of non-governmental actors (academics, media, and the private sector) to enhance public literacy and safeguard the sustainability of the UHC program.

INTRODUCTION

Poverty remains a paramount social issue in Indonesia, directly impacting the quality of life, particularly concerning the fulfillment of fundamental healthcare rights. According to Statistics Indonesia (BPS) data for 2025, the number of individuals living in poverty in Indonesia remains significantly high, with economic vulnerability severely restricting their access to medical facilities. This financial constraint frequently compels the impoverished population to delay seeking medical treatment, which consequently exacerbates health conditions and exponentially increases the economic burden on households (Agustina et al., 2019). Health, being a fundamental human right, mandates systematic and sustainable state intervention to ensure equitable access.

In response to these challenges, the Indonesian government adopted the Universal Health Coverage (UHC) concept through the National Health Insurance (JKN) instrument managed by BPJS Kesehatan. Nationally, JKN coverage achievements have demonstrated impressive figures, encompassing over 98% of the Indonesian population in 2025, with hundreds of regencies and cities successfully securing UHC status. This aggregate success reflects the governments steadfast commitment to implementing the mandate of Law Number 40 of 2004 concerning the National Social Security System, wherein the state is present to provide financial protection against health-related risks.

Beneath these high macro-achievement figures, a significant implementation gap persists. The Ministry of Social Affairs noted data anomalies revealing that approximately 54 million poor and vulnerable individuals remain unregistered as Contribution Assistance Recipients (PBI) of JKN, while conversely, around 15 million individuals from affluent demographics still benefit from these subsidies (Ministry of Health of the Republic of Indonesia, 2024). This phenomenon underscores that the quantity of enrollment is not always directly proportional to targeting accuracy. Administrative complexity, information asymmetry, and asynchronous demographic data constitute the root causes that frequently obstruct marginalized groups from accessing their constitutional rights.

Although numerous previous studies have extensively examined the implementation of collaborative governance in the public service sector, research specifically scrutinizing the collaboration between BPJS Kesehatan and Regional Governments within the framework of achieving Priority UHC status remains exceedingly limited. Prior studies, such as those conducted by Wijaya and Prasojo (2022) and Purwanti and Kurniawan (2023), predominantly focused on general enrollment dynamics or administrative constraints at primary healthcare facilities. These studies have not thoroughly explored affirmative and radical regional financing policy interventions, such as same-day activation or the conversion of delinquent independent members into regional dependents. Therefore, the research gap in this study lies in its locus and focus on local policy analysis that structurally resolves the bureaucratic gridlock of the national health insurance system. Filling this literature void is crucial to dissecting governance innovations at the regional level.

Mojokerto Regency serves as a prime example of an area that faced similar dynamics before ultimately establishing UHC as a regional priority program. As a strategic region in the Gerbangkertosusila area with a population exceeding 1.1 million, the Mojokerto Regency Government was confronted with a classic dilemma: impoverished citizens unable to access medical care due to inactive or delinquent BPJS memberships, compounded by lengthy registration bureaucracies. Recognizing that BPJS Kesehatan could not operate independently without the intervention of local authorities, the Mojokerto Regency Government initiated a strategic collaborative framework with BPJS Kesehatan, which ultimately birthed the UHC Priority status.

Table 1 Results of the UHC Priority in Mojokerto Regency (As of April 2025)

Aspect/Indicator	Achievement/Figure	Description/Implication	National Policy Foundation
JKN Enrollment Coverage	98.76% (1,141,807 out of 1,156,144)	Fulfills the absolute requirement for the regional UHC Priority status	Presidential Instruction No. 1/2022 (JKN Optimization)
Member Activity Rate	80.81% (922,689 active members)	Meets the minimum activity standard for UHC Priority in Regencies/Cities	Relevant as a UHC Quality benchmark in improving services
UHC Status & Service Consequences	Direct membership activation (same-day activation)	Requires only ID Card (KTP/NIK); Regional Govt guarantees coverage without the 14-day waiting period	Strengthening UHC performance for vulnerable/delinquent communities
Participant Segmentation (Proportion)	- PBI JK: 37.16% - PBPU Pemda: 16.56% - PBPU Mandiri: 19.26% - PPU BU: 18.95% - PPU PN: 5.02% - BP: 1.82%	The composition indicates a PBI JK base supported by PBPU Pemda in expanding social security.	A regional policy option to guarantee enrolled populations without dual coverage.
Regional Budget for UHC 2025	Total ± Rp 66 Billion (Rp 22B Initial APBD + Rp 44B Budget Shift)	Received the UHC Award from the Vice President of the Republic of Indonesia	Ensures the sustainability of public health financing
Policy for Delinquent Independent BPJS Members	Direct conversion to PBPU Pemda (Old arrears are suspended upon segment transfer)	Accommodates vulnerable communities and improves service quality	Highly relevant as a rapid response to prevent rejections at health facilities

Source: Ministry of Health, JKN Evaluation Report 2025

The data presented in Table 1 illustrates the urgency and success of this collaboration. Through the *same-day activation* policy, residents of Mojokerto who fall ill and do not yet possess BPJS coverage can have their membership activated on the exact same day, funded by the Regional Governments Non-Wage Earner (PBPU Pemda) budget, thereby eliminating the dreaded 14-day waiting period. Furthermore, the policy to transfer delinquent independent members to the PBPU Pemda segment without requiring upfront settlement of arrears represents a progressive policy breakthrough that resolves service deadlocks (Putri et al., 2023). The budget allocation of Rp 66 Billion signifies a robust political will from the regional head. Therefore, this study aims to answer two primary research questions: (1) How is collaborative governance implemented in the UHC Health Program in Mojokerto Regency? and (2) What are its supporting and inhibiting factors?.

THEORETICAL REVIEW

New Public Service (NPS)

The New Public Service paradigm introduced by Denhardt and Denhardt (2007) serves as the fundamental philosophical foundation of this research. NPS critiques the New Public Management (NPM) approach, which treats citizens merely as customers. Conversely, NPS asserts that the government must serve citizens by prioritizing democratic values, justice, and human rights (Nugroho, 2021). In the context of UHC, healthcare is not a market commodity but a civil right that the state is obligated to fulfill inclusively, regardless of socio-economic status.

Collaborative Governance

To dissect cross-sectoral cooperation mechanisms, this study utilizes the Collaborative Governance theory proposed by Ansell and Gash (2008). They define this collaboration as a governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective, formal, and consensus-oriented decision-making process. Ansell and Gash (2008) developed a model comprising four main variables determining collaborative success:

1. *Starting Conditions*: Encompassing initial trust levels, resource imbalances, and the history of conflict or cooperation.
2. *Facilitative Leadership*: The leaders role in mediating, empowering, and sustaining the collaborative process.
3. *Institutional Design*: Ground rules, transparency, forum exclusivity, and clarity of authority.
4. *Collaborative Process*: An iterative cycle encompassing face-to-face dialogue, trust building, commitment to the process, shared understanding, and intermediate outcomes.

Universal Health Coverage (UHC) Concept

Based on the World Health Organizations (WHO) mandate, UHC signifies that all individuals and communities receive the health services they require without suffering financial hardship (WHO, 2023). This concept is built upon three primary pillars: equity in access to health services, adequate service quality, and financial risk protection (Thabrany, 2018). UHC demands a sustainable financing system and an equitable supply of medical resources.

METHODOLOGY

This research employs a descriptive research design with a qualitative approach. Sugiyono (2023) elucidates that qualitative methods are utilized to examine the natural condition of objects, where the researcher acts as the key instrument to unearth the profound meaning of a phenomenon. The research location is focused on Mojokerto Regency, purposively selected due to its success in achieving the UHC Priority status featuring the *same-day activation* policy. Research informants were determined using purposive sampling, comprising the Regent of Mojokerto (IU-2) representing the top regional leadership, the Branch Manager of BPJS Kesehatan Mojokerto (IU-1) as the public agency executor, and the Head of the Health Services Division of the Mojokerto Regency Health Office (IU-3) as the medical service executor.

Data collection techniques were conducted through technical triangulation, specifically semi-structured in-depth interviews, direct observation at primary healthcare facilities and the Mojokerto BPJS branch office, and document study by reviewing BPJS performance reports and Regional Budget (APBD) documents (Moleong, 2021). The collected data were subsequently analyzed utilizing the interactive analysis model by Miles and Huberman (in Sugiyono, 2019), consisting of data reduction, data display (including compiling quantitative data matrices converted into qualitative narratives), and conclusion drawing. Data validity was tested using source and method triangulation to ensure the credibility and confirmability of the presented findings.

RESULTS AND DISCUSSION

Collaborative Governance in the UHC Health Program in Mojokerto Regency

Before dissecting the collaborative process, it is essential to understand the demographic landscape that serves as the policy target object, as presented in the table below.

Table 2 Demographic Overview of Mojokerto Regency

Description	Amount
Total Population	±1,130,000 Individuals
Male	±50%
Female	±50%
Districts (Kecamatan)	18
Villages/Sub-districts	304

Source: Statistics Indonesia (BPS) Mojokerto Regency, 2025

1. Starting Conditions

The starting conditions significantly determine the trajectory of collaboration. In Mojokerto Regency, a history of cooperation has been established since the initial launch of JKN in 2014. This historical precedent acted as a catalyst for a high initial trust level between the Regional Government and BPJS. Resource imbalances, which are commonplace in other regions, were managed elegantly. BPJS possessed superior system and data resources (primary

applications), while the Regional Government maintained control over fiscal space (budget) and regulatory authority at the grassroots level.

This established initial trust level minimized potential jurisdictional conflicts that frequently arise during the inception of new policies. Based on informant interviews, both the Regional Government and BPJS Kesehatan operated from a mutual recognition of interdependence (*mutual benefit*). The regional government required a nationally recognized social security instrument, whereas BPJS Kesehatan needed the backing of local political authorities to execute enrollment expansion at the grassroots level. This level of trust aligns with Emerson et al. (2012), who posit that trust is the primary foundation reducing transactional friction between public institutions.

The existing resource asymmetry was intentionally managed to create complementary strengths. BPJS Kesehatan, as a vertical agency, held absolute superiority in information technology infrastructure, enrollment management (P-Care and V-Claim applications), and national service quality standardization. Conversely, the Mojokerto Regency Government controlled formal legal instruments at the territorial level, the bureaucratic structure down to the village level, and fiscal capacity through the Regional Budget (APBD). This resource gap was bridged by merging strengths: the Regional Government injected funds to cover the blank spots of vulnerable populations excluded from national criteria, while BPJS executed systemic protection.

In addition to trust and resource asymmetry management, the extensive history of cooperation provided massive institutional advantages. Prior to attaining the UHC Priority status, both parties were accustomed to conducting periodic demographic data synchronization with the Population and Civil Registration Agency (Disdukcapil) and the Social Services Agency. This collaborative habituation ensured that the transition to UHC Priority was seamless. The exceptionally robust enrollment structure, as illustrated in Table 3, is the crystallization of a stable history of coordination spanning many years.

Table 3 JKN Enrollment Conditions in Mojokerto Regency 2025

Description	Amount
Total Population	±1,150,000 Individuals
JKN Enrollees	±1,127,000 Individuals
Enrollment Coverage	>98%
Regional Status	UHC Priority

Source: Mojokerto Regency Government and BPJS Kesehatan (2025)

The composition constituting this 98% figure did not materialize spontaneously but resulted from structured segmentation mapping. Table 4.2 below illustrates the strategic intervention of the Regional Government, particularly visible in the PBPU Pemda segment at 16.56% (191,414 individuals). This is a concrete manifestation of resolving the resource imbalance, wherein the Regional Government leverages its APBD to protect populations vulnerable to poverty.

Table 5. JKN Participant Composition in Mojokerto Regency 2025

No	Participant Segment	Number of Individuals	Percentage (%)
1	PBI JK (National Budget/APBN)	429,568	37.16
2	PBPU Pemda (Regional Budget/APBD)	191,414	16.56
3	PBPU Mandiri (Independent)	222,638	19.26
4	PPU Corporate Entities	219,054	18.95
5	PPU State Administrators	58,058	5.02
6	Non-Workers	21,043	1.82
Total		1,141,807	98.76

Source: BPJS Kesehatan Mojokerto Regency, 2025

2. Facilitative Leadership

According to Ansell & Gash (2008), a facilitative leader must be capable of empowering actors, mediating conflicts, and nurturing the collaborative process. The Regent of Mojokerto played this leadership role exceptionally well. UHC was designated as a priority within the Regents initial 100-day program. This leadership was demonstrated not merely through rhetoric but through the decisive execution of budget reallocation policies.

The leaders role as a mediator and guarantor of commitment was highly dominant. When tensions arose between regional budget availability and surging enrollment financing needs, the regional leadership acted responsively by executing fiscal maneuvers. A budget refocusing of Rp 44 Billion midway through the fiscal year proved that political will extended beyond vision statements and translated into concrete financial execution. This proactive step ensured that negotiations with BPJS and healthcare facilities were not hindered by bureaucratic disbursement excuses.

This facilitative leadership was actualized by empowering actors at the grassroots level. The Regent did not operate in isolation but instructionally mobilized the Health Office, Social Services, Disdukcapil, down to the Village Head structures. The formation of a cross-sectoral task force enabling parallel verification of impoverished citizens is a direct product of this facilitative leadership. The regional head ensured that no single Regional Apparatus Working Unit (SKPD) bore a disproportionate burden by distributing authority proportionally.

To maintain the credibility of the collaborative process, the regional leadership continuously monitored technical performance in the field. As explained by Ryan (in Ansell & Gash, 2008), a facilitative leader must safeguard technical credibility. The Regent of Mojokerto routinely conducted direct inspections of referral hospitals and community health centers (Puskesmas) to ensure that the *same-day activation* policy was genuinely respected by medical providers. This direct verification process proved to BPJS Kesehatan that the Regional Government was not merely paying premiums but actively maintaining governance quality on the supply side.

The leadership encouraged inclusive participation to mitigate sectoral egos. Coordination meetings were not exclusively attended by government elites but also involved technical representatives from BPJS Kesehatan and partnering private healthcare facilities. This inclusive involvement ensured that all decisions made such as the mechanism to transfer delinquent independent premiums to the regional government had undergone operational risk filtering across various sectors, rendering the policies both rational and executable in the field.

3. Institutional Design

The legitimacy of the collaboration in Mojokerto was secured through derivative regulations stemming from Presidential Instruction No. 1/2022 and Presidential Regulation No. 82/2018. This institutional design created a strict (rigid) yet inclusive division of roles, thereby successfully reducing overlapping authorities and sectoral egos, as detailed in Table 5.1 below.

Table 6. Stakeholder Role Division in UHC Mojokerto Regency

Stakeholder	Role
BPJS Kesehatan	Enrollment management and service guarantees
Regional Government	Funding PBID (Regional PBI) and local policies
Health Office	Fostering and monitoring healthcare facilities
Social Services	Validating data of impoverished communities
Regional Legislature (DPRD)	Oversight and budget support
Puskesmas and Hospitals	Providing health services to JKN participants

Source: Researchers Analysis, 2026

The ground rules supporting the role division table above were formalized through Regent Regulations and various Memoranda of Understanding (MoU) between the Regional Government and BPJS. These written regulations established a binding protocol for inter-institutional interaction. With a binding legal design, the administrative uncertainties that frequently derail regional public policies were minimized. For instance, if an obstacle occurred in National Identity Number (NIK) validation, the rules explicitly designated Disdukcapil as the sole authority required to provide troubleshooting within an agreed timeframe.

The institutional design in Mojokerto Regency also prioritized process transparency. Data regarding health insurance ownership, remaining PBPU Pemda quota, and recapitalizations of billing from the Regional Government to BPJS were communicated openly among the main stakeholders. This transparency prevented suspicions concerning billing mark-ups or accusations of budget politicization, considering UHC is often perceived as a populist program. Data transparency maintained the collaborative ecosystem to remain professional and performance-based.

Although the designed work mechanisms involved multiple parties, the institutional design successfully maintained forum exclusivity at the strategic decision-making level. This meant that for technical service issues, participation space was widely opened for Puskesmas, hospitals, and village representatives.

However, for decisions regarding budget shifts valued at tens of billions of rupiah, authority was exclusively returned to the executive leadership (Regent) and branch-level BPJS Kesehatan, ensuring speed and confidentiality in administrative negotiations prior to public announcement.

This governance system was fortified by institutional oversight involving the Regional House of Representatives (DPRD) of Mojokerto Regency. The DPRD acted as an instrument of checks and balances, not only smoothing budget approvals but also ensuring that the multi-billion funding was targeted accurately and free from political bias. Legislative involvement as an external supervisor strengthened institutional legitimacy, ensuring that the Pemda-BPJS collaboration did not deviate from the core essence of the New Public Service.

4. Collaborative Process

The collaborative process represents the operational heartbeat that activates all governance variables. The face-to-face dialogue phase was implemented through cross-sectoral meetings and periodic communication forums. These meetings were not merely ceremonial events but working forums specifically dissecting enrollment data constraints, hospital complaints, and monthly data reconciliation between BPJS and the Health Office. The existence of these technical forums broke through bureaucratic silos, allowing field obstacles to be resolved within days.

This dialogic process gradually fostered trust building. When data mismatches occurred between citizens proposed by villages and data rejected by the BPJS system (e.g., due to duplicate NIKs), the actors did not fall into a blame game. Instead, they responded by opening mutual data access for reverification. Small actions involving the willingness to exchange information rapidly are what cemented trust; BPJS trusted the integrity of the Regional Governments data, and the Regional Government trusted the strictness of the BPJS system.

This level of trust triggered an exceptionally high commitment to the process. This commitment was evidenced not only by success in registering residents but also by efforts to keep their premium payments active. This is clearly visible in Table 4.3 below, where cross-segment activity rates were maintained at highly robust levels.

Table 7. Active JKN Participants in Mojokerto Regency 2025

Active Participant Segment	Number of Individuals
PBI JK	387,470
PBPU Pemda	164,972
PBPU Mandiri	120,172
PPU Corporate Entities	186,709
PPU State Administrators	55,703
Non-Workers	19,230
Total Active Participants	922,689

Source: BPJS Kesehatan Mojokerto Regency, 2025

The commitment to maintaining active status generated a shared understanding that UHC was not merely a performance indicator for BPJS Kesehatan, but a political stake and developmental success for the Mojokerto Regency Government. The alignment of Key Performance Indicators (KPIs), where BPJSs success equals the Regents success and vice versa, meant that any bottleneck in healthcare facilities was perceived as a collective issue requiring immediate resolution, without delaying administrative responsibilities.

The results of this commitment and shared understanding were reflected in proud intermediate outcomes, one of which was receiving the UHC Award from the Vice President of the Republic of Indonesia. This national recognition functioned as a small win that recalibrated the stakeholders enthusiasm. This positive achievement validated that their time, budget, and lengthy debates had yielded tangible results, while simultaneously creating positive pressure to avoid degrading service quality in the future.

The success of this collaborative process crystallized in concrete achievements within the most determining segment: PBPU Pemda. The 86.18% activity rate in the regionally funded segment (as presented in Table 4.4) was a crucial intermediate outcome that qualified Mojokerto to implement *Same-Day Activation*.

Table 8. PBPU Pemda Achievements 2025

Description	Amount
Registered PBPU Pemda Participants	191,414
Active PBPU Pemda Participants	164,972
Activity Percentage	86.18%

Source: BPJS Kesehatan Mojokerto Regency, 2025

The audacity to absorb delinquent independent participants and fund them through the APBD represents the highest manifestation of the New Public Service. In this scenario, the logic of humanity and social protection successfully superseded the rigidity of actuarial insurance rules, proving that the collaborative process in Mojokerto operated with profound maturity and progressiveness (Putri et al., 2023).

Supporting and Inhibiting Factors in the UHC Program in Mojokerto Regency

Based on field analysis referring to the theoretical framework of Ansell and Gash (2008), the implementation of UHC collaborative governance in Mojokerto Regency is influenced by complex interaction dynamics. These dynamics give rise to various factors that significantly accelerate the program, as well as restrictive factors that inhibit service optimization at the grassroots level. Identifying the balance between these drivers and inhibitors is crucial for evaluating the sustainability of the UHC Priority status moving forward.

The most crucial supporting factor is the intensity of cross-sectoral dialogue supported by high social capital in the form of inter-institutional trust. Formal and informal communication established between BPJS Kesehatan, the Health Office, and the Social Services Agency was no longer hindered by bureaucratic rigidity but orchestrated in solution-oriented reconciliation meetings. This trust, cultivated over more than a decade, eliminated sectoral

egos; BPJS Kesehatan trusted the integrity of the Regional Governments data verification, while the Regional Government trusted BPJSs commitment to providing non-discriminatory access across various healthcare facilities.

In addition to relational aspects, another major supporting factor is the exceptionally bold regional fiscal commitment and a shared policy vision. The APBD allocation of Rp 66 Billion explicitly demonstrated that the Mojokerto Regency Governments political will aligned seamlessly with the national UHC vision. The shared understanding that healthcare is a fundamental right for the poor enabled the realization of radical innovations such as *same-day activation* and the suspension of blocked statuses due to independent participant arrears. This served as the primary driving engine ensuring vulnerable citizens were no longer rejected by hospitals merely due to temporary administrative issues.

Despite its impressive achievements, the program confronts a primary inhibiting factor: a literacy deficit among the public itself. While shared understanding at the government elite level is solid, communities at the grassroots level frequently hold misconceptions; many assume the UHC status entirely absolves them from prior premium obligations or ignore the tiered referral system. This lack of JKN literacy ultimately triggers operational friction and abnormal queuing surges at referral healthcare facilities (hospitals), which should ideally have been resolved at primary health centers (Sandirka et al., 2025).

A subsequent obstacle lies in the dynamics of demographic data validity and database synchronization issues. Demographic movements such as mortality rates, births, and population migration are daily occurrences, yet data updates between Disdukcapil servers, the Ministry of Social Affairs Integrated Social Welfare Data (DTKS), and BPJS Kesehatans master data (P-Care/V-Claim) often experience a time lag. This data desynchronization not only decelerates individual service activation processes in the field but also creates latent inefficiencies, as the APBD potentially pays premiums for individuals who are no longer eligible or have passed away (Mahendradhata et al., 2017).

The final and most threatening inhibiting factor to program sustainability is the long-term limitation of regional fiscal space amidst the absence of a Pentahelix collaborative scheme. The policy of accommodating delinquent independent BPJS participants into the PBPU Pemda segment is highly susceptible to triggering moral hazard (the free-rider phenomenon), where affluent individuals intentionally default to shift their burden to the state. On the other hand, the current collaborative design remains heavily state-centric. Non-governmental elements such as academics, mass media, NGOs, and the private sector (via corporate CSR funds) have not been structurally involved. Without the participation of Pentahelix actors to share the burden of education and financing, the Mojokerto Regency APBD risks collapse in the coming years (Emerson et al., 2012).

CONCLUSIONS AND RECOMMENDATIONS

Based on the analysis, it can be concluded that Collaborative Governance in the UHC program in Mojokerto Regency has been implemented exceptionally well and comprehensively when measured against the Ansell & Gash (2008) model. The success of reaching 98.76% coverage and securing the UHC Priority status is not merely an administrative byproduct, but the output of favorable starting conditions (trust and history), a facilitative Regent who supported budget allocations, an institutional design binding inter-agency roles, and a collaborative process that birthed affirmative policies such as *same-day activation*. The New Public Service paradigm genuinely materialized through bureaucratic relaxation for vulnerable groups.

Nevertheless, the sustainability of this UHC is characterized by an interplay of supporting and inhibiting factors. Robust fiscal support, intensive communication, and regulatory legitimacy serve as primary drivers. However, the program faces tangible threats from weak public literacy regarding JKN procedures, time lags in dynamic demographic data integration, the threat of PBID budget inflation due to independent defaulter conversions, and a collaborative design that remains centralized around the state bureaucracy without tapping into the broader power of civil society.

As a recommendation, the Mojokerto Regency Government and BPJS Kesehatan must broaden their governance spectrum toward a Pentahelix Collaboration model. Collaboration must not be exclusive to bureaucrats. Engaging mass media and academics is crucial to educating the public on health literacy to shift the mindset from curative to preventive care. Furthermore, optimizing CSR from the private sector within Mojokerto's industrial zones should be encouraged to co-finance local community health premiums, thereby alleviating the regional budget burden and ensuring the UHC Priority sustainability is maintained steadily in the long term.

FURTHER STUDY

For future research, it is highly recommended to conduct a comprehensive longitudinal study to evaluate the long-term fiscal resilience of the Regional Budget (APBD) in sustaining the conversion of delinquent independent members into regional dependents. Furthermore, upcoming studies should broaden the analytical scope by integrating the Pentahelix collaborative framework to empirically measure the impact of involving non-governmental actors—such as local universities, mass media, and the private sector—in accelerating public health literacy and mitigating the risks of data desynchronization. Comparative studies involving other regions with different fiscal capacities and socio-demographic profiles would also be invaluable for assessing the scalability and adaptability of the UHC Priority policy innovations currently applied in Mojokerto Regency.

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