

The Role of Corporate University as a Strategic Enabler in the Transformation of Human Capital Management of Social Security Organizations: Qualitative Study on BPJS Health

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Abstract. *This study aims to analyze the role of the BPJS Health Corporate University as a strategic enabler in the transformation of Human Capital Management, and to describe how the learning function is integrated with talent management, performance management, and career development in strengthening organizational capability. The study employs a qualitative approach with a single case study design at BPJS Health. Data were collected through in-depth interviews with thirteen informants, consisting of four key informants and nine supporting informants, together with observation and a review of policy documents and secondary data covering the period 2021 to 2025. The analysis follows an empirical model of input, process, and output derived from the HR Strategic Architecture, while data validity was tested through source and method triangulation. The findings show that the strategic enabler role has only been partially realized. The Corporate University functions as a supplier of competency gap data, a provider of programs whose impact is measurable at the organizational level with a contribution of 13.92 per cent, and a translator of corporate values into learning habits, with the Mandatory Learning Program reaching almost 98 per cent. However, it has not yet become binding on decisions concerning position filling and the determination of development needs. Integration across systems occurs at different degrees: strongest and bidirectional between competency and learning, moderate with talent and performance management, and weakest with career management, since the Internal Job Posting process does not require the completion of tiered leadership programs. The study further finds that the four behaviors with the lowest implementation levels are all learning behaviours, so that weakness at the output stage in turn reduces the reliability of measurement at the input stage, making the empirical model operate as a loop rather than a one-directional chain. The principal barrier is institutional rather than a matter of program design. The study recommends unifying the learning data architecture, establishing the completion of tiered leadership programs as a formal prerequisite for position filling, and shifting the measure of success from participation volume towards movement in competency levels.*

Keywords: *Corporate University; Human Capital Management; Social Security Organization; Strategic Enabler; Talent Management.*

1. Introduction

The transformation of the social security system in Indonesia began with political awareness after the 1998 reforms. In 2000, or 55 years after Indonesia's independence, the People's Consultative Assembly of the Republic of Indonesia (MPR RI) for the 1999-2004 period amended the 1945 Constitution, including health as a basic right in Article 28H paragraph (1) and social security in paragraph (3). This mandate was reinforced by Article 34 paragraphs (2) and (4), which mandated the development of a social security system through legislation.

It was on this basis that Law No. 40 of 2004 concerning the National Social Security System was enacted, serving as the basis for the implementation of the National Health Insurance (JKN) and other social security programs. The idea that health is a human right is not new in global discourse. Long before the Indonesian reforms began, the 1946 WHO Constitution stated that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..."

Fundamental changes have also occurred in both the structure and governance of the social security organization. PT Askes (Persero), which was previously a State-Owned Enterprise (BUMN) under the Ministry of State-Owned Enterprises, changed its form to BPJS Kesehatan in 2014, a Public Legal Entity directly responsible to the President. This change is not just an adjustment to legal status, but rather a comprehensive transformation that includes updates to governance, operational mechanisms, service patterns, and human resource management. As a public legal entity mandated to administer the National Health Insurance (JKN) Program, BPJS Kesehatan manages membership on a massive scale, supported by a network of healthcare facilities spread across Indonesia. As of December 2025, 98.62% of Indonesia's 286.6 million population, or approximately 282.7 million people, were registered as JKN participants.

Over the past decade, the number of healthcare facilities collaborating with BPJS Kesehatan has also grown significantly. Primary Healthcare Facilities (FKTP) increased from approximately 18,437 in 2014 to 23,770 in 2025, while Advanced Referral Healthcare Facilities (FKRTL) increased from approximately 1,681 to 3,194 during the same period. This growth reflects both the expansion of service coverage and the diversification of healthcare providers. This scale and complexity require BPJS Kesehatan to continually adapt to demographic dynamics, digital technology developments, regulatory changes, and rising public expectations for service quality. At this point, organizational excellence is no longer solely driven by systems and procedures, but also by the quality and capabilities of the human resources who operate it.

2. Research Methods

This research uses a descriptive research design with a qualitative approach and is included in the type of case study research to analyze and describe the role of BPJS Kesehatan Corporate University as a strategic enabler in the Human Capital Management transformation process and identify and describe the process gone through by Corporate University in integrating learning functions with talent management, performance management, and career development in order to strengthen organizational capabilities.

Creswell (2016) states that qualitative research allows for in-depth exploration of complex social phenomena by emphasizing the meanings individuals construct within their environmental context. This research employs an inductive approach, starting with collected specific conclusions and then drawing general conclusions (Notoatmodjo, 2005).

This research places greater emphasis on the process, enabling it to uncover information that cannot be explained solely through statistical figures. Therefore, a qualitative approach is deemed most appropriate for gaining a comprehensive understanding of the dynamics of the BPJS Kesehatan Corporate University's role as a strategic enabler, including how the process works learning, competency development, and Human Capital Management practices are implemented, understood by stakeholders, and contribute to improving organizational capabilities in supporting the achievement of strategic goals.

3. Results and Discussion

3.1. Research Location Profile

This research was conducted at BPJS Kesehatan, a public legal entity established by Law Number 24 of 2011 concerning the Social Security Administration Agency. Its institutional position differs from that of corporations and government agencies in general. This organization is not under the auspices of a technical ministry, nor is it under the ministry overseeing State-Owned Enterprises (BUMN). Instead, it reports directly to the President of the Republic of Indonesia, as stipulated in Article 7 paragraph (1).

(2). The head office is located in the nation's capital according to the mandate of Article 8 paragraph (1), while Article 8 paragraph (2) opens up space for the existence of representative offices at the provincial level and branch offices at the district/city level.

Its primary mandate is to implement the National Health Insurance (JKN) Program. Because the law designates only one agency for this purpose, healthcare financing for all Indonesians is managed through a single payer system. By December 2025, 98.62% of Indonesia's 286.6 million population, or approximately 282.7 million people, will have registered as JKN

participants. This figure places Indonesia as an international benchmark for the implementation of Universal Health Coverage (UHC) globally.

a. BPJS Health Overview

The establishment of BPJS Kesehatan is the culmination of a long journey of implementing Health Insurance that spanned four eras of government, namely the Dutch East Indies, the Old Order, the New Order, and the Reformation, before finally culminating in the era of National Health Insurance.

1. The Journey of Health Insurance from Time to Time

- **Dutch East Indies Government Period**

The Dutch colonial government's investment in health was very limited. Neelakantan (2014) notes that the only notable large-scale intervention was the smallpox vaccination campaign, initiated in Java in 1804, which involved infant immunization and annual repeat vaccination of the population, resulting in the smallpox incidence dropping to almost zero by 1939–1940. Supporting facilities became the next priority, such as the health laboratory in Bandung in 1888 and the Pasteur Institute, which produced serum and vaccines (Simmons et al., 1944), the STOVIA medical school in Batavia in 1902 (Pribadi, 2017), and the first hospital in Batavia in 1926 (WHO, 2017).

The orientation of these facilities is not towards the welfare of the population in general, but rather to the officials, employees, and workers of the Dutch East India Company (VOC), while the indigenous population only received minimal services. This disparity is evident in the December 1938 statistics: there were 546 hospitals with 43,952 beds plus 79 specialized hospitals with 16,837 beds, but only 1,139 licensed doctors, so the doctor-to-do ratio was population was estimated at 1 in 60,000, the lowest in the world at that time (Simmons et al., 1944).

2. Old Order Period

Health gained a place as a key development agenda during the era of President Sukarno (Pribadi, 2017). The first Maternal and Child Health Center (BKIA) was established in Yogyakarta on January 1, 1952, with support from UNICEF and WHO, then grew from 748 units to 2,300 units in 1959 (Kasmiyati, 2017), although the availability of medical personnel remained unequal, with a ratio of one doctor for every 100,000 residents. The most important conceptual contribution came from Minister of Health Leimena through an idea known as the Bandung Plan in 1951, which combined prevention and treatment efforts as two complementary aspects, with the establishment of health centers at the sub-district

level and hospitals at the district level. This framework of thought would later become the foundation for the formulation of the National Health Insurance System (Pribadi, 2017).

In the same decade, Leimena pioneered health protection for civil servants through a cost reimbursement (indemnity) scheme known as Health Maintenance Restitution, namely employees bear the cost of treatment first, submit a claim to their agency, then the agency bills the Ministry of Health (Indonesian Ministry of Health, 1999).

3. New Order Period

The development direction after 1965 emphasized the growth of the market economy, with state attention to social welfare concentrated on civil servants, the military, and formal sector workers. (WHO, 2017). Ironically, it was during this period that the seeds of the National Health Insurance began to grow, and the trigger was fiscal. The indemnity scheme was deemed to be increasingly burdening the state budget, leading to the issuance of Presidential Decree Number 230 of 1968, which shifted healthcare financing to a pre-effort scheme for civil servants, retirees, their families, and veterans with a contribution of 2 percent of salary. Its management was entrusted to the Health Care Fund Management Agency (BPDPK) within the Ministry of Health (Ministry of Health of the Republic of Indonesia, 1999). The Minister of Health at that time, Prof. Dr. G.

A. Siwabessy, views the Health Insurance (Askes) program as the forerunner of National Health Insurance. The institutional form of the organizers continued to shift to meet efficiency demands. BPDPK was transformed into Perusahaan Umum Husada Bhakti through Government Regulation Number 23 of 1984, then into PT Askes (Persero) through Government Regulation Number 6 of 1992 because the previous operations were deemed too bureaucratic, and it also moved from the Ministry of Health to the Ministry of State-Owned Enterprises. Other community groups received separate schemes: Asabri for the Armed Forces since 1971 and Employment Insurance (Astek) for workers, which in 1992 was expanded to become the Workers' Social Security (Jamsostek) (WHO, 2017).

4. Reformation Period

The period from 1998 to 2013 was marked by the changing names and mechanisms of the insurance program for the poor: the Social Safety Net for Health (JPSBK) until 2003, then the Compensation Program for Reduction of Income. Fuel subsidies for the health sector, Askeskin in 2005, and Jamkesmas from 2008 until its end on December 31, 2013. Simultaneously, decentralization in 2001 gave birth to the Regional Health Insurance (Jamkesda). These diverse schemes have not been able to cover the entire population.

The amendment to the 1945 Constitution places Social Security as a constitutional mandate. Law Number 24 of 2011 confirms this basis, namely Article 28H paragraph (1), paragraph (2), and paragraph (3) as well as Article 34 paragraph

(1) and paragraph (2) of the 1945 Constitution, plus MPR Decree Number X/MPR/2001 which tasked the President to establish a National Social Security System. From this foundation was born Law Number 40 of 2004 concerning the National Social Security System, which was later supplemented by Law Number 24 of 2011 concerning the Social Security Administration Agency.

5. National Health Insurance Period

The new chapter in the implementation of Social Security was marked by the inauguration by President Susilo Bambang Yudhoyono on December 31, 2013 at the Bogor Palace, and BPJS Kesehatan began operating to manage the JKN Program on January 1, 2014 in accordance with the mandate of Article 60 paragraph (1) of Law Number 24 of 2011. According to Agustina et al. (2019), this step unites various health insurance and social assistance schemes that were previously scattered into one program under one manager, with the transfer of around 117 million participants in the initial stage, dominated by recipients of contribution assistance from the central and regional governments. As a mandatory program that relies on participant contributions, JKN opens access to benefits widespread in first-level and referral health facilities, both government and private, which have collaborated with BPJS Kesehatan.

a. Fundamental Changes Post-Institutional Transformation

The transition from PT Askes (Persero) to BPJS Kesehatan (Social Security Agency for Health) did not stop at changing the legal entity. The General Explanation of Law Number 24 of 2011 describes this event as an institutional transformation accompanied by the transfer of participants, programs, assets and liabilities, employees, and rights and obligations. What actually shifted was the nature of the organization, from a business entity to a public institution carrying out constitutional mandates. This phenomenon aligns with the institutional isomorphism thesis proposed by DiMaggio and Powell (1983), which states that public institutions are required to continuously align themselves with demands for efficiency and accountability. At least six fundamental shifts occurred after the law was enacted and before January 1, 2014.

- 1) **From many managers to one manager.** Article 57 orders four institutions to hand over health insurance matters to BPJS Kesehatan, namely PT Askes (Persero), the Ministry of Health which manages Jamkesmas, the Ministry of Defense together with the TNI and Polri for active members, and PT Jamsostek (Persero) for Health Maintenance Insurance participants. Article 60 paragraph (2) emphasizes that since BPJS Kesehatan began

operating, the last three institutions no longer organize health programs for their participants.

- 2) **From a limited liability company to a public legal entity.** Article 7 paragraph (1) confirms this status, so that its establishment does not require a notarial deed and does not require approval from a government agency. Its public nature is characterized by four things: it is formed through law, carries out matters of public interest, has the authority to impose administrative sanctions on negligent parties (Article 11 letter f), and cannot be declared bankrupt (Article 47).
- 3) **From responsibility to the Minister of State-Owned Enterprises to the President.** Article 7 paragraph (2) shifts the line of accountability. Reporting is carried out in layers, namely periodic reports every six months regarding program implementation and financial conditions to the President with a copy to the DJSN (Article 13 letter k), as well as program management reports and annual financial reports that have been audited by a public accountant no later than June 30 of the following year (Article 37 paragraph (1)), with an executive summary published no later than July 31 (Article 37 paragraph (5)).
- 4) **From corporate appointment to public selection determined by the President.** Articles 25 to 31 contain the requirements and procedures for selecting and appointing members of the Supervisory Board and Board of Directors, which begins with the formation of a selection committee by the President with a composition of two government elements and five community elements (Article 28).
- 5) **From contributions as corporate income to trust funds.** Article 40 requires the separation of BPJS assets and Social Security Fund assets, confirms that Social Security Fund assets are not BPJS assets, and requires them to be stored in a state-owned custodian bank. The agency's operational costs are sourced from Social Security Funds and/or other sources (Article 12 letter a) with a percentage determined by Government Regulation (Article 45 paragraph (2)). Initial capital is set at a maximum of IDR 2 trillion from the APBN (Article 42).
- 6) **From dissolution by the government to dissolution by law.** Article 46 states that BPJS can only be dissolved by law.

The changes also directly impact the personnel side. Article 60 paragraph (3) states that when BPJS Kesehatan begins operations, PT Askes (Persero) is declared dissolved without liquidation and all its employees are transferred to become BPJS Kesehatan employees. This means that the new agency inherits the composition of human resources formed within the company's culture, while the mandate it carries has changed to a public service mandate.

This gap between cultural heritage and the demands of the new role is the basis for the Human Capital Management transformation agenda within BPJS Kesehatan.

b. Functions, Duties, Authorities, Rights, Obligations and Supervision

Chapter IV of Law Number 24 of 2011 regulates the functions, duties, authorities, rights and obligations of the agency in a hierarchical manner.

1) Function

Article 9 paragraph (1) states that BPJS Kesehatan functions to organize a health insurance program. Referring to Article 19 paragraph (2) of Law Number 40 of 2004, the program is aimed at ensuring. Each participant receives health care benefits as well as protection in meeting their basic health needs.

2) Task

In order to carry out these functions, Article 10 details the following duties:

- a)** carry out and/or receive participant registration;
- b)** collecting and collecting contributions from participants and employers;
- c)** receive contribution assistance from the government;
- d)** manage Social Security Funds for the benefit of participants;
- e)** collect and manage social security program participant data;
- f)** pay benefits and/or cover the costs of health services in accordance with program provisions; and
- g)** convey information regarding program implementation to participants and the wider community.

3) Authority

Article 11 provides eight authorities, namely collecting contribution payments; placing Social Security Funds in short-term and long-term investments with due regard to liquidity, solvency, prudence, fund security, and adequate returns; supervising and checking participant and employer compliance; agreeing on payment amounts with health facilities in accordance with government tariff standards; creating or terminating employment

contracts with health facilities; imposing administrative sanctions; reporting negligent employers to authorized agencies; and establishing cooperation with other parties. The explanation of Article 11 letter a interprets the word "collect" as a request payments in the event of arrears, delays or shortfalls in payment of contributions.

4) Personnel Authority as the Basis for Human Capital Management

Law Number 24 of 2011 provides the Board of Directors with ample authority in managing the agency's human resources. Article 24 paragraph (3) letter b gives the Board of Directors the authority to determine the organizational structure along with the main duties and functions, organizational work procedures, and personnel systems. Letter c of the same paragraph adds the authority to organize BPJS personnel management, including the appointment, transfer, and dismissal of employees as well as determining their salaries.

This space is strengthened from a financing perspective. Article 41 paragraph (2) letter c states that BPJS assets can be used to finance service capacity improvements. Even more explicitly, Article 52 letter k essentially prohibits investment by the Supervisory Board and Directors, except in certain securities and/or investments to improve human resource quality and social welfare. In other words, the law explicitly exempts investment in human resource quality from the generally applicable prohibition. This provision provides a legal basis for developing organizational human capability, including through the institutionalization of corporate learning functions as defined by Meister (1998).

Competency standards are also set down to the management level. The explanation of Article 25 paragraph (1) letter e differentiates the qualification criteria, which are:

measured from the level of formal education, with competency criteria, which are measured based on experience, expertise, and knowledge according to the field of duty. The explanation of Article 27 further details the areas of competency required of prospective members of the Board of Directors, including economics, finance, banking, actuarial science, insurance, pension funds, information technology, risk management, health management, work accidents and occupational diseases, and law, which must be proven by a competency certificate.

5) Right

According to Article 12, the agency has the right to obtain operational funds for program implementation sourced from the Social Security Fund and/or other legitimate sources, as well as receive the results of monitoring and evaluation of program implementation from the DJSN every six months.

6) Obligation

Article 13 contains eleven obligations of the agency, including providing a single identity number to participants, developing Social Security Fund assets and BPJS assets for the greatest benefit of participants, conveying performance and financial condition information through mass media, forming technical reserves in accordance with actuarial practice standards, and maintaining bookkeeping in accordance with applicable accounting standards.

7) Supervision

Article 39 divides supervision into two channels. Internal supervision is carried out by the Supervisory Board and the internal supervisory unit, while external supervision is carried out by the DJSN and independent supervisory bodies.

The explanation of the article states that the independent supervisory agency in question is the Financial Services Authority, while the Audit Board of Indonesia can conduct audits in certain matters according to its authority.

c. Strategic Direction of the Organization

1) Vision

To become a dynamic, accountable, and trusted organizing body to realize quality, sustainable, equitable, and inclusive health insurance (BPJS Kesehatan, 2024).

2) Mission

- a) Improving the quality of services to participants through integrated information technology-based services.
- b) Maintaining the sustainability of the JKN Program by balancing social security funds and controlled benefit costs.
- c) Providing equitable and inclusive health insurance covering the entire population of Indonesia.
- d) Strengthening engagement by increasing synergy and collaboration between stakeholders in implementing the JKN Program.
- e) Improving the agency's capabilities in implementing the JKN Program efficiently and effectively, accountably, and prudently with the principles of good governance,

productive human resources, and encouraging digital transformation and sustainable innovation (BPJS Kesehatan, 2024).

d. Principles of Implementation

Article 4 of Law Number 24 of 2011 establishes nine principles that serve as the basis for the organization's implementation of the national social security system. The formulation is identical to Article 4 of Law Number 40 of 2004. The meaning of each principle is outlined in the Explanation to Article 4, as summarized in the following table.

Table Principles of JKN Implementation

No	Principle	Meaning according to the Explanation of Article 4
1	Mutual cooperation	The principle of togetherness among participants in bearing the burden of Social Security costs, which is realized by the obligation of each participant to pay contributions according to their salary, wage or income level.
2	Non-profit	The principle of business management that prioritizes the use of development funds to provide the greatest possible benefits for all participants.
3	Openness	The principle of facilitating access to complete, correct and clear information for each participant.
4	Caution	The principle of managing funds carefully, thoroughly, safely and orderly.
5	Accountability	The principle of accurate and accountable program implementation and financial management.
6	Portability	The principle of providing ongoing guarantees even if participants change jobs or residence within the territory of the Unitary State of the Republic of Indonesia.
7	Participation mandatory	The principle that requires all residents to become Social Security participants, which is implemented in stages.

8	Trust fund	Contributions and their development results are funds deposit from participant For used
No	Principle	Meaning according to the Explanation of Article 4
		as much as possible for interest participant Social Security.
9	Results management Social Security Fund	It is used entirely for program development and for the greatest benefit of the participants. The explanation of the article states this provision quite clearly.

e. Business Model and Organizational Structure

The BPJS Kesehatan business process is essentially built on three foundations for health insurance implementation: revenue collection, risk pooling, and strategic purchasing. All three refer to the Health Financing Framework formulated by the WHO (2010). This framework believes that the sustainability of a universal health financing system is determined by the extent to which the state is able to raise funds equitably, bear risks collectively through a spirit of mutual cooperation, and spend the collected funds to achieve optimal health outcomes.

BPJS Kesehatan translates these three foundations into five interconnected core processes. This process begins with participant registration, which forms a national participant database and serves as the starting point for equitable access to services. The next process is participant administration services, including issuing participant IDs, providing information on rights and obligations, and providing digital channels to facilitate access to services. The fundraising function is realized through the management of contributions and the Social Security Fund, which serves as the foundation for health liquidity national programs. Meanwhile, the strategic purchasing function is reflected in collaboration with healthcare facilities, which regulates tariff schemes, claims management,

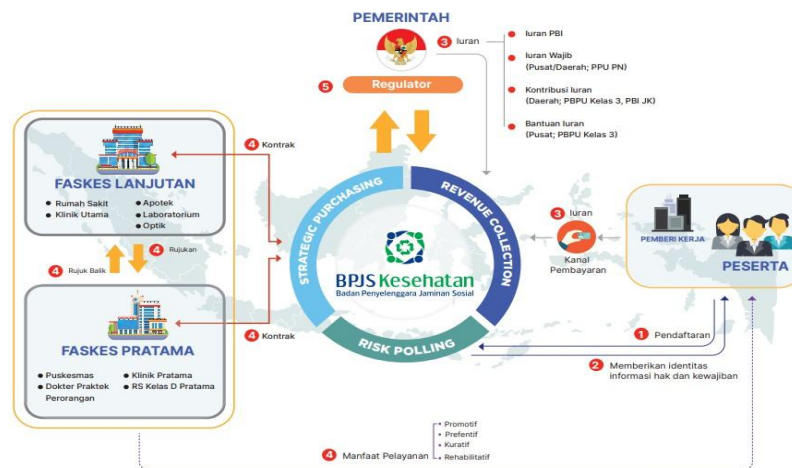


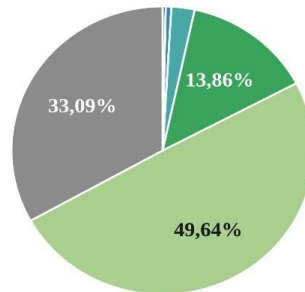
Figure BPJS Health Business Model

The following is the attached BPJS Health Organizational Structure which explains the command line, coordination line and indirect supervision line as shown in Figure.

3.2. BPJS Health Organizational Structure

a. Number of human resources

Until December 31, 2025, BPJS Kesehatan employs 10,214 people, consisting of 6,834 permanent employees and 3,380 non-permanent employees spread across the head office, regional deputies, and branch offices. The composition is presented in the following figure.



Jabatan	Jumlah	Persentase
Pegawai Tetap	6.834	66,91%
General Manager	34	0,33%
Senior Manager	61	0,60%
Manager	253	2,48%
Asisten Manager	1.416	13,86%
Pelaksana	5.070	49,64%
Pegawai Tidak Tetap	3.380	33,09%
Total	10.214	100,00%

Figure Composition of BPJS Kesehatan Employees Based on Position as of December 31, 2025

Source: BPJS Kesehatan personnel data, processed.

The figure shows two things. First, one-third of the BPJS Kesehatan workforce, or 3,380 people, or 33.09 percent, are non-permanent. Second, within the permanent employee group, the composition of Executive and Assistant levels

Managers comprise 6,486 people or 63.50 percent of the total workforce, while those at the Manager level and above only comprise 348 people or 3.41 percent.

b. Learning Objectives

The Corporate University's learning target is 10,214 employees spread across 12 Regional Deputies, 126 Branch Offices, and 514 Regency Offices. For human capital management, this work area configuration has several strategic implications. First, employee competency needs cannot be standardized, as role demands at Main Branch Offices in urban areas differ significantly from Type B Branch Offices in island regions. Second, centralized face-to-face learning is inefficient and unfair for employees in the most remote areas, necessitating digital and blended learning models that are accessible across regions. Third, the distribution of Main Branch Offices centralized on the island of Java has the potential to create gaps in career development opportunities, so a cadre development strategy and rotation of work unit leaders need to be consciously designed to ensure equal access for talent from the eastern region.

The human resource development function at BPJS Kesehatan requires a nationally standardized approach while remaining adaptive to regional characteristics. This situation provides the Corporate University with the opportunity to act as a strategic enabler, aligning the diverse competency needs of its 126 branch offices with the organization's overall strategic direction.

4. Conclusion

Based on the analysis of the research results and discussion above, the following conclusions can be drawn.

- 1) Corporate Universities have served as strategic enablers, providing competency gap data, providing programs with measurable impact at the organizational level, contributing 13.92 percent, and translating values into learning habits, achieving nearly 98 percent of compulsory education. However, they have not been optimal in binding decisions about filling positions and determining development needs.
- 2) In the input component, the competency set is complete but its quality is uneven. The functional-behavioral competency gap reached 87.93 percent, far exceeding basic competency at 64.63 percent and leadership at 65.31 percent. It actually reaches the decision-making level, with General Managers accounting for the highest proportion of gap positions at 76.9 percent.
- 3) In the process component, all four systems are mature, but their linkages vary in degree. The strongest, two-way linkage occurs between competency and learning, the intermediate and indirect linkage occurs between talent and performance, and the weakest linkage occurs with career because the Internal Job Posting flow does not require completion of a ladder. All linkages are based on one node, namely the immediate superior, so that its quality depends on the leadership of the unit and not on the system design.
- 4) In the output component, all three sub-variables are met, but distribution is uneven, and supply is shrinking. The competency index reached 86.00 in 2025, organizational performance was achieved, and the results of the value survey improved; however, learning participation decreased by 52.95 percent, and 84.80 percent of Compulsory Education hours were sourced from informal learning. Employee behavior is not yet fully strategically focused.
- 5) The empirical model operates as a circle, not a unidirectional chain. The four behaviors with the lowest implementation in 2025 are all learning behaviors, and providing honest feedback appears simultaneously as a competency in input, an assessment tool in

process, and the lowest behavior in output. Weaknesses in output reduce the reliability of input measurements.

- 6) The biggest obstacles are institutional, not program design. The five root causes of the problem stem from three interlocking nodes: intervention design, institutions, and measurement and data. Three board regulations have become a common reference, but they do not refer to each other at the point of filling positions, resulting in the appearance of complete learning tools while competency gaps persist.

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