Jurnal Hukum UNISSULA

Volume 42 No. 1, March
P-ISSN: 1412-2723

# REGULATORY COHERENCE AND ACCOUNTABILITY IN INDONESIA'S NATIONAL HEALTH INSURANCE: A DOCTRINAL AND STAKEHOLDER ANALYSIS

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**ARTICLE INFO**

***Keywords:***
Administrative Accountability, Jkn; Legal Certainty; Regulatory Coherence; Proportionality.

***DOI :***
*10.30659/jh.v42i1.47037*

**ABSTRACT**

This article examines the regulatory coherence and accountability of Indonesia's National Health Insurance (JKN) within the framework of constitutional and administrative law. It addresses two principal legal questions: whether the JKN regulatory structure demonstrates hierarchical consistency within Indonesia's system of laws, and whether its governance design particularly in relation to the referral system and the arrears regime complies with principles of legal certainty, proportionality, and accountability. Using a doctrinal legal approach supported by stakeholder mapping through the MACTOR framework, the study evaluates both normative structure and institutional interaction. The findings indicate that the JKN framework is formally consistent with constitutional mandates and statutory delegation under the SJSN Law and the BPJS Law. However, horizontal regulatory harmonization remains incomplete, particularly regarding the interaction between hospital classification regulations and BPJS referral policies. The arrears enforcement system lacks clear criteria to distinguish inability to pay from non-compliance, requiring regulatory amendments and formal dispute mechanisms to improve fairness, consistency, and accountability within JKN.

## 1. Introduction

The National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) is one of the most important public law reforms in Indonesia after the reform era. JKN was established to achieve Universal Health Coverage (UHC) and to implement the constitutional mandate under Article 28H and Article 34 of the 1945 Constitution, which guarantee the right to health services and social security. Therefore, JKN is not only a social policy program but also a legal obligation of the state. The transformation from fragmented health insurance schemes into a single national system managed by BPJS Kesehatan reflects Indonesia's shift toward a rights-based welfare state model. However, although many studies discuss JKN from economic and public health perspectives, its legal and governance dimensions remain insufficiently analyzed.

A significant number of empirical studies have examined the progress and challenges of JKN. Agustina et al.[1] explain Indonesia's journey toward UHC, highlighting achievements and sustainability challenges. Mboi et al.[2] show improvements in health indicators across provinces after the expansion of health coverage. Erlangga et al.[3] and Nasution et al.[4] find that public health insurance increases healthcare utilization and improves equity, especially in maternal health services. More recent studies explore determinants of healthcare utilization, unmet healthcare needs, and coverage among persons with disabilities.[5] Financial

[1] Rina Agustina, Teguh Dartanto, Ratna Sitompul, Kun A. Susiloretni, Endang L. Achadi, Akmal Taher, Fadila Wirawan et al., Universal health coverage in Indonesia: concept, progress, and challenges, *The Lancet,* Vol.393, no.16, 2019, page.83.

[2] Nafsiah Mboi, Indra Murty Surbakti, Indang Trihandini, Iqbal Elyazar, Karen Houston Smith, Pungkas Bahjuri Ali, Soewarta Kosen et al., On the road to universal health care in Indonesia, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016, *The Lancet,* Vol.392, no.10147, 2018, page.585. See too, Nafsiah Mboi, Ruri Syailendrawati, Samuel M. Ostroff, Iqbal RF Elyazar, Scott D. Glenn, Tety Rachmawati, Wahyu Pudji Nugraheni et al., The state of health in Indonesia's provinces, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019, *The Lancet Global Health,* Vol.10, no.11, 2022, page.1635.

[3] Darius Erlangga, Shehzad Ali, and Karen Bloor., The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data, *international journal of public health,* Vol.64, no.4, 2019, page.609.

[4] Siti Khadijah Nasution, Yodi Mahendradhata, and Laksono Trisnantoro., Can a national health insurance policy increase equity in the utilization of skilled birth attendants in Indonesia? A secondary analysis of the 2012 to 2016 national socio-economic survey of Indonesia, *Asia Pacific Journal of Public Health,* Vol.32, no.1, 2020, page.12.

[5] Qinglu Cheng, Rifqi Abdul Fattah, Dwidjo Susilo, Aryana Satrya, Manon Haemmerli, Soewarta Kosen, Danty Novitasari et al., Determinants of healthcare utilization under the Indonesian national health insurance system–a cross-sectional study, *BMC Health Services Research,* Vol.25, no.1, 2025, page.48. See too, Farikh Alfa Firori, and I. Dewa Gede Karma Wisana., The effect of participation in JKN on unmet needs for healthcare services, *Editorial Board of Indonesian Journal of Health Administration,* Vol.11, no.2, 2023, page.32; Luthfi Azizatunnisa, Hannah Kuper, Ari Probandari, and Lena Morgon Banks., I was given the card, but no one told me how to use it: Challenges and Facilitators of People with Disabilities in Indonesia in Accessing and Using Jaminan Kesehatan Nasional (National Health Insurance), *SSM-Health Systems* Vol.22, no.3, 2026, page.10171.

sustainability and payment mechanisms are analyzed by Sambodo et al.[6] while Zahari et al.[7] examine tobacco excise policy as a financing source for UHC.

Previous scholarship on Indonesia's National Health Insurance (JKN) demonstrates strong methodological rigor and provides valuable empirical insights into economic sustainability, service utilization, health outcomes, and administrative efficiency.[8] However, these studies predominantly frame governance challenges in managerial or fiscal terms, rather than situating them within a structured legal and stakeholder-based analysis. Existing discussions on deficits, fraud, and inequitable access tend to reflect operational inefficiencies or policy failures, without sufficiently interrogating how regulatory design, authority fragmentation, and accountability mechanisms shape stakeholder interactions and outcomes.[9] Moreover, normative tensions, such as disparities in access or debates on compliance, are rarely examined as consequences of misaligned legal mandates or unclear stakeholder responsibilities.[10] Consequently, the research gap lies in the absence of a doctrinal and governance-oriented stakeholder analysis that maps

[6] Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, and Eddy van Doorslaer., Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, *Social science & medicine,* Vol.327, no.12, 2023, page.11592. See too, Novat Pugo Sambodo, Eddy Van Doorslaer, Menno Pradhan, and Robert Sparrow., Does geographic spending variation exacerbate healthcare benefit inequality? A benefit incidence analysis for Indonesia, *Health Policy and Planning,* Vol.36, no.7, 2021, page.1131.

[7] Teuku Naraski Zahari, and Akhmad Hidayatno., Sustainability Evaluation of Tobacco Excise Tax Policy to Finance Universal Health Coverage in Indonesia, In *2021 IEEE International Conference on Industrial Engineering and Engineering Management (IEEM)*, New York, IEEE, 2021, page.1639.

[8] Diah Arimbi., Legal Opportunities Solutions to Tackle the Deficit in Indonesia's National Health Insurance Program, *Padjadjaran Jurnal Ilmu Hukum*, Vol.11, no.3, 2024, page.321. See too, Arief Budiono, Absori Absori, Harun Harun, Heru Santoso Wahito Nugroho, Khudzaifah Dimyati, and Kelik Wardiono., The ideal management of health insurance for Indonesia according constitution, *Quality Access to Success*, Vol.21, no.176, 2020, page.49; Theta Murty, Sukarmi Sukarmi, Yenny Eta Widyanti, and Amelia Sri Kusuma Dewi., Philosophical Underpinnings of Social Insurance Mechanisms within the Framework of Health Insurance, *Sriwijaya Law Review,* Vol.8, no.2, 2024, page.307.

[9] Putri Galuh Inggi, and Anhari Achadi., Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review, *Media Publikasi Promosi Kesehatan Indonesia*, Vol.7, no.10, 2024, page.2451. See too, Ratna Juwita., Good governance and anti-corruption: Responsibility to protect universal health care in Indonesia, *Hasanuddin Law Review,* Vol.13, no.3, 2018, page.172; Irmawati Mathar, Oktia Woro Kasmini Handayani, Evi Widowati, and Intan Zainafree., Analysis of the need for the development of a misconduct prevention system on National Health Insurance (JKN) claims at Hospital X, *Procedia Environmental Science, Engineering and Management,* Vol.12, no.3, 2025, page.1017; Gita Susanti, Muhammad Irvan Nur Iva, Andi Ahmad Yani, and Andi Rahmat Hidayat., Assessing the national health insurance system: a study of the implementation of health insurance policy in Indonesia, *Public Policy and Administration,* Vol.21, no.4, 2022, page.23; Marif, Nurhaedah Nurhaedah, and Handar Subhandi Bakhtiar., The principles of good governance in health services, *Jambura Law Review,* Vol.3, no.2, 2021, page.298.

[10] Arief Budiono, Absori Absori, Ayesha Hendriana Ngestiningrum, and Heru Santoso Wahito Nugroho., Pseudo national security system of health in Indonesia, *Indian Journal of Public Health Research & Development,* Vol.9, no.10, 2018, page.558. See too, Sopa, Rini Fatma Kartika, Nurhadi Nurhadi, Dina Febriani Darmansyah, Taufiqurokhman Taufiqurokhman, and Ma'mun Murod., Social Security Programs in Islamic Law: A Comparative Study of Fatwa Institutions on Indonesia's Health Insurance, *Jurnal Hukum Unissula,* Vol.40, no.1, 2024, page.188.

regulatory hierarchy, clarifies institutional authority, and evaluates constitutional accountability.

In this context, one area where this legal gap is particularly visible concerns participant composition and contribution arrears. In 2023, government-subsidized participants accounted for 36.50% of total JKN membership, independent participants 26.25%, and employer-sponsored participants 20.10%. Independent participants, largely drawn from the informal sector, are responsible for paying their own monthly contributions. Empirical research identifies higher risks of arrears among this group and associates arrears with behavioral or economic constraints. However, from a legal standpoint, arrears involve broader normative issues. Temporary suspension of health service benefits due to unpaid contributions directly affects access to healthcare, which is constitutionally protected.

This raises several legal questions: Are sanctions for arrears proportionate and consistent with the constitutional guarantee of the right to health? Does the regulatory framework sufficiently differentiate between inability to pay and unwillingness to pay? How does the state reconcile contributory principles with its obligation to ensure non-discriminatory access to essential services? These questions are rarely addressed in existing literature, yet they are central to understanding JKN as a legal institution rather than solely as a financing mechanism.

The legal architecture governing JKN is complex and multilayered. Law Number 40 of 2004 on the National Social Security System (*Sistem Jaminan Sosial Nasional*/SJSN) establishes the general framework for social security administration. Law Number 24 of 2011 on BPJS defines institutional authority and organizational structure. Minister of Health Regulation Number 28 of 2014 provides technical guidelines for JKN implementation. At the same time, Indonesia's decentralization regime grants significant responsibilities in health service delivery to regional governments. This interaction between national insurance administration and regional service provision creates a hybrid governance model characterized by shared authority.

However, the distribution of authority is not always clearly defined. The regulatory framework does not comprehensively regulate inter-agency coordination, monitoring mechanisms, and dispute resolution processes among central institutions, BPJS, and local governments. Inggi and Achadi[11] note weaknesses in fraud prevention policy within the JKN system, indicating possible gaps in supervision and enforcement. Pharmaceutical pricing policies and financial performance of health-related industries also intersect with JKN sustainability, yet regulatory integration across these sectors remains limited.[12] These observations

[11] Putri Galuh Inggi, and Anhari Achadi., Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review, *Media Publikasi Promosi Kesehatan Indonesia,* Vol.7, no.10, 2024, page.2452.

[12] Yusi Anggriani, and Hesty Utami Ramadaniati., Pharmaceutical pricing policies in Indonesia.,

suggest that challenges in JKN are not merely economic but are closely linked to regulatory fragmentation and institutional coordination problems.

From the perspective of administrative law, public health insurance must comply with principles of legality, accountability, transparency, and proportionality. Every administrative decision affecting participant rights must have a clear legal basis and be subject to review. As a welfare state instrument, JKN also embodies distributive justice principles, requiring the state to prioritize vulnerable groups. Governance theory further emphasizes that policy outcomes are shaped by interactions among multiple actors with varying degrees of influence and resources.[13] In contrast to previous research that mainly focuses on health outcomes or financing sustainability, this article places JKN within a broader legal and governance framework.[14]

This article therefore combines doctrinal legal analysis with stakeholder mapping using the MACTOR (Matrix of Alliances and Conflicts: Tactics, Objectives, and Recommendations) method. The MACTOR approach is employed not to present empirical findings in the introduction, but to explain the analytical framework through which actor relationships and institutional configurations are examined in later sections. By identifying actors such as regulatory institutions, BPJS, hospitals, health centers, stakeholders and JKN participants, the study provides a structured basis for analyzing how authority, responsibility, and influence are distributed within the JKN system.

The use of MACTOR in a legal study serves a specific normative purpose. First, it helps clarify whether actor relationships reflect statutory mandates or reveal informal power structures that may lack legal justification. Second, it enables examination of whether rights holders, namely participants, are institutionally represented in governance processes. Third, it supports evaluation of vertical and horizontal accountability within a decentralized administrative framework. By integrating stakeholder mapping with doctrinal review, the study bridges empirical governance analysis and normative legal assessment.

Based on this background, this study formulates three legal research questions:

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In *Formulating and Implementing Pharmaceutical Pricing Policies*, Cambridge, Academic Press, 2025, page.85. See too, Candraditia Daryanto, and Wiwiek Mardawiyah Daryanto., Financial performance analysis and evaluation of pharmaceutical companies in Indonesia, *International Journal of Innovation, Creativity and Change,* Vol.6, no.3, 2019, page.212.

[13] Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.67.

[14] Rina Agustina, Teguh Dartanto, Ratna Sitompul, Kun A. Susiloretni, Endang L. Achadi, Akmal Taher, Fadila Wirawan et al., Universal health coverage in Indonesia: concept, progress, and challenges, *The Lancet,* Vol.393, no.16, 2019, page.84. See too, Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, and Eddy van Doorslaer., Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, *Social science & medicine,* Vol.327, no.12, 2023, page.11593; Novat Pugo Sambodo, Eddy Van Doorslaer, Menno Pradhan, and Robert Sparrow., Does geographic spending variation exacerbate healthcare benefit inequality? A benefit incidence analysis for Indonesia, *Health Policy and Planning,* Vol.36, no.7, 2021, page.1133.

1. How coherent and consistent is the regulatory framework governing JKN, particularly in relation to the hierarchy of norms and the distribution of authority between central and regional governments?
2. To what extent does the current legal regime protect the constitutional rights of JKN participants, especially independent contributors who are vulnerable to contribution arrears and service suspension?
3. How does the stakeholder convergence pattern identified through MACTOR analysis reveal strengths and weaknesses in JKN governance and accountability mechanisms?

This study contributes to health law and governance scholarship in three ways. First, it provides a doctrinal analysis of JKN regulations by examining their hierarchical consistency and potential normative gaps. Second, it reframes contribution arrears as a legal issue involving rights protection and state responsibility, rather than merely a financial problem. Third, it integrates stakeholder mapping with normative legal analysis, demonstrating how empirical patterns of actor influence relate to constitutional and administrative law principles. By combining doctrinal examination and MACTOR-based stakeholder analysis, this study aims to clarify regulatory weaknesses, strengthen accountability mechanisms, and ensure that the implementation of JKN remains consistent with Indonesia's constitutional commitment to equitable and universal health coverage.

## 2. Research Methods

This study adopts a normative juridical (doctrinal) legal approach combined with a structured stakeholder mapping technique. The primary paradigm is doctrinal legal research, aimed at examining the coherence of legal norms, hierarchy of regulations, and distribution of authority within the National Health Insurance (JKN) framework. The analysis focuses on statutory interpretation, principles of administrative law, and constitutional mandates concerning the right to health and social security. The empirical component (stakeholder mapping through MACTOR) is used as a complementary analytical tool to assess how legal norms operate within governance structures. Thus, the study remains grounded in legal doctrine while incorporating empirical mapping to strengthen normative evaluation.[15]

The research design utilized a sequential explanatory mixed-method within a legal research framework. First, qualitative doctrinal analysis is conducted on relevant legal documents. Second, the findings regarding authority distribution and regulatory mandates are integrated with stakeholder mapping results to evaluate

[15] Majid Heydari, Hesam Seyedin, Mehdi Jafari, and Reza Dehnavieh., Stakeholder analysis of Iran's health insurance system, *Journal of education and health promotion,* Vol.7, no.1, 2018, page.135. See too, Izza Mafruhah, Waridin Waridin, Deden Dinar Iskandar, and Mudjahirin Thohir., Social engineering strategy of entrepreneurship behavior of Indonesian migrant workers during the placement period, *International Journal of Economics and Business Administration,* Vol.7, no.2, 2019, page.56.

consistency between normative design and governance practice. The integration occurs analytically: doctrinal findings define legally mandated actors and objectives, while MACTOR mapping examines alignment, convergence, and potential structural tensions among those actors. Therefore, quantitative mapping does not replace legal reasoning but supports assessment of accountability and institutional coherence.

The legal materials analyzed include: (1) the 1945 Constitution of the Republic of Indonesia (Articles 28H and 34); (2) Law Number 40 of 2004 on the National Social Security System (SJSN); (3) Law Number 24 of 2011 on BPJS; (4) Minister of Health Regulation Number 28 of 2014 on Guidelines for JKN Implementation; and (5) related decentralization and health governance regulations. These instruments were selected based on hierarchical relevance and direct normative authority over JKN governance. Interpretation was conducted using statutory, systematic, and teleological approaches to ensure consistency within the hierarchy of norms.

Actor identification initially refers to Ministerial Regulation Number 28/2014, which explicitly regulates institutional roles in JKN implementation. However, from a legal authority perspective, the study expands the scope to include central government institutions, regional governments, and regulatory actors where relevant, to reflect statutory mandates under SJSN and BPJS Laws. This ensures that stakeholder mapping corresponds to legally recognized authority structures rather than solely administrative practice.

Qualitative data from regulatory texts and selected stakeholder interviews were coded using Atlas.ti to identify themes related to authority, accountability, sanctions, and rights protection. Where interviews were conducted, participants were selected purposively based on institutional relevance, informed consent was obtained, and data triangulation was applied through cross-verification with statutory documents and policy reports.

The MACTOR analysis proceeded through the Matrix of Direct Influence (MDI) and Actor-Objective (2MAO) matrices to identify patterns of convergence and divergence. These results are interpreted normatively to assess whether the governance configuration supports constitutional principles, regulatory coherence, and administrative accountability within the JKN system.

## 3. Results and Discussion

### 3.1. Regulatory Coherence and Hierarchical Consistency of the JKN Framework

The regulatory coherence of the Jaminan Kesehatan Nasional (JKN) framework must be examined within Indonesia's formal hierarchy of laws. At the constitutional level, Articles 28H(1) and 34(2) of the 1945 Constitution establish the state's obligation to guarantee access to health services and to develop a social security system for all citizens. These constitutional mandates are implemented through Law Number 40 of 2004 on the National Social Security System (SJSN) and Law Number 24 of 2011 on BPJS. The SJSN Law defines the principles of universality, solidarity, and mandatory participation, while the BPJS Law establishes BPJS Kesehatan as the public legal entity responsible for administering health insurance. Minister of Health Regulation Number 28 of 2014 further details the operational

guidelines for JKN implementation.

The governance framework of Indonesia's National Health Insurance (*Jaminan Kesehatan Nasional*/JKN) cannot be understood solely through its operational principles, but must first be situated within a coherent legal and institutional architecture. At the constitutional level, Articles 28H(1) and 34(2) of the 1945 Constitution mandate the state to guarantee access to healthcare and to establish a comprehensive social security system. These mandates are operationalized through Law Number 40 of 2004 on the National Social Security System and Law Number 24 of 2011 on BPJS, which institutionalize universality, solidarity, and mandatory participation as foundational legal norms. From a doctrinal perspective, this reflects vertical legal consistency, where lower regulations derive legitimacy from higher norms and must remain aligned with constitutional objectives.

Scholarly literature confirms that JKN represents Indonesia's most significant structural reform toward universal health coverage, consolidating fragmented schemes into a unified system to enhance equity and financial protection.[16] Moreover, the philosophical basis of social insurance emphasizes collective risk-sharing and state responsibility, reinforcing the welfare-state orientation embedded in the legal framework.[17] At the normative level, the JKN framework demonstrates strong alignment between constitutional commitments and statutory instruments.

However, governance analysis requires moving beyond formal legality toward institutional dynamics, where authority, coordination, and stakeholder interaction shape how these principles operate in practice.[18] The results of stakeholder mapping indicate that regulatory coherence cannot be assessed solely at the level of textual harmony. The Matrix of Direct Influence (MDI) shows that BPJS exercises strong direct influence over doctors, community health centers (puskesmas), clinics, and referral hospitals. The influence scores (3–4) illustrate BPJS's central role in contracting, reimbursement, and membership administration under the BPJS Law. This empirical pattern reflects the centralized authority embedded in the statutory design. In this sense, the legal architecture successfully translates hierarchical delegation into institutional dominance within the governance structure.

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[16] Rina Agustina, Teguh Dartanto, Ratna Sitompul, Kun A. Susiloretni, Endang L. Achadi, Akmal Taher, Fadila Wirawan et al., Universal health coverage in Indonesia: concept, progress, and challenges, *The Lancet,* Vol.393, no.16, 2019, page.85. See too, Nafsiah Mboi, Indra Murty Surbakti, Indang Trihandini, Iqbal Elyazar, Karen Houston Smith, Pungkas Bahjuri Ali, Soewarta Kosen et al., On the road to universal health care in Indonesia, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016, *The Lancet,* Vol.392, no.10147, 2018, page.586.

[17] Arief Budiono, Absori Absori, Harun Harun, Heru Santoso Wahito Nugroho, Khudzaifah Dimyati, and Kelik Wardiono., The ideal management of health insurance for Indonesia according constitution. *Quality Access to Success,* Vol.21, no.176, 2020, page.51.

[18] Rena Eichler, Susan Gigli, and Lisa LeRoy., Implementation research to strengthen health care financing reforms toward universal health coverage in Indonesia: a mixed-methods approach to real-world monitoring, *Global Health: Science and Practice,* Vol.6, no.4, 2018, page.749.

At the same time, the "Law" actor in the matrix demonstrates relatively limited direct operational influence. While law structures the system formally, its effectiveness depends on how institutional actors internalize and coordinate regulatory mandates. This does not indicate normative inconsistency; rather, it reveals a gap between formal authority and practical governance. Similar findings are observed in implementation research on health financing reforms, where statutory clarity alone does not guarantee effective coordination or compliance.[19]

The complexity of JKN governance is further shaped by Indonesia's decentralization framework. Under regional autonomy laws, local governments are responsible for managing public health facilities and ensuring service delivery. Meanwhile, BPJS centrally administers financing, reimbursement, and participant registration. This dual structure creates layered accountability. Empirical studies demonstrate that supply-side factors significantly affect healthcare utilization under JKN.[20] Variations in infrastructure, workforce distribution, and local governance capacity may lead to unequal outcomes despite uniform insurance coverage. From a legal standpoint, this means that vertical consistency in statutory design does not automatically ensure horizontal coherence among implementing institutions.

Stakeholder theory provides an analytical framework to interpret these findings. Freeman[21] defines stakeholders as individuals or groups who can affect or be affected by organizational objectives. In public policy analysis, stakeholder mapping identifies actors' influence, dependence, and strategic positions.[22] In the JKN system, stakeholders include BPJS, healthcare providers at different levels, participants, community leaders, regional governments, and academicians. Each actor operates within a legally defined mandate, yet their interactions shape how regulatory coherence functions in practice.

[19] Rena Eichler, Susan Gigli, and Lisa LeRoy., Implementation research to strengthen health care financing reforms toward universal health coverage in Indonesia: a mixed-methods approach to real-world monitoring, *Global Health: Science and Practice*, Vol.6, no.4, 2018, page.750.

[20] Darius Erlangga, Shehzad Ali, and Karen Bloor., The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data*, international journal of public health*, Vol.64, no.4, 2019, page.610. See too, Meliyanni Johar, Prastuti Soewondo, Retno Pujisubekti, Harsa Kunthara Satrio, and Ardi Adji., Inequality in access to health care, health insurance and the role of supply factors, *Social Science & Medicine,* Vol.213, no.11, 2018, page.137; Desdiani, Sri Mulatsih, and Diah Ayu Puspandari., Implementation of respect for autonomy in hospital services within the Indonesia national health insurance system, *National Journal of Community Medicine*, Vol.15, no.10, 2024, page.834.

[21] R. Edward Freeman., The stakeholder approach revisited, In *Wirtschafts-und unternehmensethik*, Wiesbaden, Springer Fachmedien Wiesbaden, 2020, page.664.

[22] John M. Bryson., What to do when stakeholders matter: stakeholder identification and analysis techniques. *Public management review,* Vol.6, no.1, 2004, page.24. See too, Kent Buse, Nicholas Mays, and Gill Walt., *Making Health Policy*, Yogyakarta, Kebijakan Kesehatan Indonesia, 2012, page.43.

**Table 1.** Matrix of Direct Influence (MDI)

| **Matrix of Direct Influence** | **BPJS** | **Doctors** | **Community health** | **Clinic** | **RS Type B** | **RS Type D** | **Health** | **Economy** | **Law** | **JKN Participants** | **Community Leaders** | **Family Physician** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BPJS | 0 | 4 | 3 | 3 | 4 | 4 | 2 | 2 | 2 | 3 | 1 | 1 |
| Doctors | 4 | 0 | 2 | 2 | 1 | 2 | 1 | 0 | 0 | 1 | 0 | 0 |
| Community health center | 4 | 3 | 0 | 3 | 2 | 3 | 1 | 0 | 0 | 2 | 2 | 1 |
| Clinic | 4 | 3 | 3 | 0 | 2 | 3 | 1 | 0 | 0 | 2 | 1 | 1 |
| Hospital - Type B | 4 | 1 | 1 | 1 | 0 | 3 | 0 | 0 | 0 | 2 | 0 | 0 |
| Hospital - Type D | 4 | 3 | 3 | 3 | 3 | 0 | 0 | 0 | 0 | 2 | 1 | 1 |
| Health | 2 | 1 | 1 | 1 | 2 | 2 | 0 | 1 | 1 | 1 | 1 | 1 |
| Economy | 2 | 1 | 1 | 0 | 0 | 0 | 2 | 0 | 1 | 1 | 1 | 1 |
| Law | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 1 | 1 | 1 |
| JKN Participants | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Community Leaders | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 0 | 0 | 2 | 0 | 0 |
| Religious Leaders | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 | 0 |

The Map of Influence and Dependence categorizes actors into four quadrants. Relay actors (BPJS, community health centers, primary clinics, and Type D hospitals) occupy central operational positions. Their high influence and moderate dependence reflect their statutory obligations under the SJSN and BPJS Laws. These actors serve as frontline implementers, translating financing rules into healthcare services. Empirical research shows that payment mechanisms, including performance-based capitation, influence primary healthcare utilization and provider behavior.[23] Thus, the centrality of these actors corresponds with the legal design of JKN.

Conversely, Type B hospitals and JKN participants appear as dominated actors, characterized by higher dependence and lower bargaining power. Divergence analysis reveals strong conflict intensity between Type B hospitals and BPJS, particularly concerning the tiered referral system. Although hospital classification

[23] Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, and Eddy van Doorslaer., Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, *Social science & medicine,* Vol.327, no.12, 2023, page.11595.

is regulated under Ministerial Regulation Number 340/MENKES/PER/III/2010, its interaction with BPJS referral and reimbursement policies may produce interpretive tension. Type D hospitals increasingly employ specialist doctors and expand facilities, reducing patient referrals to Type B hospitals. Representatives of Type B hospitals argue that inconsistent enforcement of classification standards disadvantages them within the referral hierarchy.

From a doctrinal perspective, this situation raises issues of regulatory harmonization. When sectoral regulations on hospital classification intersect with insurance reimbursement mechanisms, lack of integrative guidance can create institutional friction. Policy evaluations have identified similar governance challenges within JKN implementation, including disputes over claims, delayed payments, and referral inefficiencies.[24] These tensions do not necessarily reflect contradictions between laws, but they indicate insufficient coordination clauses and unclear supervisory mechanisms.

The convergence analysis provides additional insight into regulatory coherence. Strong alignment is observed between BPJS and community leaders, as well as between health academicians and community health centers. Convergent stakeholder theory suggests that shared objectives and moral commitments can strengthen governance sustainability.[25] Community leaders play an important role in encouraging premium compliance among self-paying participants, thereby supporting financial sustainability. Empirical studies demonstrate that insurance coverage under JKN has improved access to maternal health services and reduced unmet needs, particularly when supported by community engagement.[26]

Nevertheless, divergence among referral hospitals highlights structural pressure within the expanding UHC system. As coverage increases, demand for specialist services grows, intensifying competition among providers. Research on geographic spending variation indicates that unequal distribution of health resources may

[24] Diah Arimbi, Ahmad Fuady, Aryana Satrya, and Arika Dewi., Peluang dan tantangan dalam jaminan kesehatan nasional di Indonesia: Studi kebijakan, *Jurnal Kebijakan Kesehatan Indonesia,* Vol.11, no.1, 2022, page.18. See too, Aria Yuditia, Yusup Hidayat, and Suparji Achmad., Pelaksanaan Jaminan Kesehatan Nasional Oleh Bpjs Berdasarkan Undang-Undang No. 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, *Jurnal Magister Ilmu Hukum,* Vol.6, no.1, 2021, page.47.

[25] Thomas M. Jones., and Andrew C. Wicks., Convergent stakeholder theory, *Academy of management review,* Vol.24, no.2, 1999, page.212.

[26] Kanya Anindya, John Tayu Lee, Barbara McPake, Siswanto Agus Wilopo, Christopher Millett, and Natalie Carvalho., Impact of Indonesia's national health insurance scheme on inequality in access to maternal health services: A propensity scores matched analysis, *Journal of global health,* Vol.10, no.1, 2020; page.1429. See too, Siti Khadijah Nasution, Yodi Mahendradhata, and Laksono Trisnantoro., Can a national health insurance policy increase equity in the utilization of skilled birth attendants in Indonesia? A secondary analysis of the 2012 to 2016 national socio-economic survey of Indonesia, *Asia Pacific Journal of Public Health,* Vol.32, no.1, 2020, page.13; Sopa, Rini Fatma Kartika, Nurhadi Nurhadi, Dina Febriani Darmansyah, Taufiqurokhman Taufiqurokhman, and Ma'mun Murod., Social Security Programs in Islamic Law: A Comparative Study of Fatwa Institutions on Indonesia's Health Insurance, *Jurnal Hukum Unissula,* Vol.40, no.1, 2024, page.189.

exacerbate benefit inequality.[27] In legal terms, maintaining coherence requires ensuring that financing mechanisms and facility classification standards are systematically aligned.

Financial sustainability also affects regulatory coherence. Delays in claim payments and deficits within BPJS have been widely discussed in academic literature.[28] When financial pressures arise, institutional relationships may become strained, particularly between BPJS and healthcare providers. Such tensions can influence service quality and compliance with contractual obligations. Therefore, regulatory coherence must be understood as dynamic, requiring continuous adjustment to fiscal realities and healthcare demand.

Beyond normative design, the effectiveness of the JKN governance framework is shaped by the interaction among stakeholders operating within a multi-level institutional structure. Stakeholder mapping demonstrates that governance is not merely determined by formal legal authority, but also by patterns of influence, dependence, and coordination among actors. In this context, BPJS Kesehatan occupies a central position with strong influence over healthcare providers through contracting, reimbursement, and membership administration mechanisms, reflecting its statutory mandate. At the same time, decentralized responsibilities assigned to regional governments create layered accountability, where service delivery depends on local capacity and resource distribution.[29]

From a governance perspective, stakeholder theory provides a useful analytical lens to understand these dynamics. Actors such as healthcare providers, participants, community leaders, and government institutions operate within legally defined roles, yet their interactions determine the practical coherence of the system.[30] Some further highlights the importance of community engagement in supporting compliance and expanding access to healthcare services, particularly

[27] Novat Pugo Sambodo, Eddy Van Doorslaer, Menno Pradhan, and Robert Sparrow., Does geographic spending variation exacerbate healthcare benefit inequality? A benefit incidence analysis for Indonesia, *Health Policy and Planning,* Vol.36, no.7, 2021, page.1135.

[28] Immanuel Natanael Tarigan, and Feni Dwi Lestari., Penundaan Pembayaran Klaim Jaminan Kesehatan Nasional Oleh Bpjs Kesehatan Di Indonesia: Sebuah Scoping Review, *Jurnal Ekonomi Kesehatan Indonesia,* Vol.7, no.2, 2022, page.3.

[29] Darius Erlangga, Shehzad Ali, and Karen Bloor., The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data, *international journal of public health*, Vol.64, no.4, 2019, page.612. See too, Meliyanni Johar, Prastuti Soewondo, Retno Pujisubekti, Harsa Kunthara Satrio, and Ardi Adji., Inequality in access to health care, health insurance and the role of supply factors, *Social Science & Medicine,* Vol.213, no.11, 2018, page.138.

[30] John M. Bryson., What to do when stakeholders matter: stakeholder identification and analysis techniques. *Public management review,* Vol.6, no.1, 2004, page.26. See too, Kent Buse, Nicholas Mays, and Gill Walt., *Making Health Policy*, Yogyakarta, Kebijakan Kesehatan Indonesia, 2012, page.45; R. Edward Freeman., *Strategic management: A stakeholder approach*, Cambridge, Cambridge university press, 2010, page.23.

in maternal and primary care.[31] Thus, the governance framework of JKN is best understood as an interplay between legal structure and institutional practice, where regulatory coherence depends on both hierarchical alignment and effective stakeholder coordination.

### 3.2. Constitutional Protection of Participants and the Legal Regime on Arrears

The results of the stakeholder analysis demonstrate that constitutional protection of JKN participants, particularly independent contributors vulnerable to contribution arrears, cannot be assessed solely through statutory guarantees. Instead, protection must be examined through the distribution of influence, dependence, and actor positions toward key objectives such as premiums, fines, procedural flow, and access to facilities. The Matrix of Direct Influence (MDI) and the Valued Position Matrix (2MAO) reveal structural asymmetries that shape how rights are experienced in practice.

Within stakeholder theory, actors differ in their ability to influence policy outcomes depending on resource control, institutional authority, and access to information.[32] In the JKN system, JKN participants are positioned in quadrant III as dominated actors, characterized by low competitiveness and high dependence. The MDI scores indicate that participants exert minimal direct influence over institutional actors, while BPJS, community health centers, and referral hospitals possess significantly higher influence levels. This configuration reflects a typical pattern in social insurance governance, where beneficiaries depend structurally on administrative and provider institutions.[33]

[31] Kanya Anindya, John Tayu Lee, Barbara McPake, Siswanto Agus Wilopo, Christopher Millett, and Natalie Carvalho., Impact of Indonesia's national health insurance scheme on inequality in access to maternal health services: A propensity score matched analysis, *Journal of global health,* Vol.10, no.1, 2020; page.1430. See too, Siti Khadijah Nasution, Yodi Mahendradhata, and Laksono Trisnantoro., Can a national health insurance policy increase equity in the utilization of skilled birth attendants in Indonesia? A secondary analysis of the 2012 to 2016 national socio-economic survey of Indonesia, *Asia Pacific Journal of Public Health,* Vol.32, no.1, 2020, page.15; Sopa, Rini Fatma Kartika, Nurhadi Nurhadi, Dina Febriani Darmansyah, Taufiqurokhman Taufiqurokhman, and Ma'mun Murod., Social Security Programs in Islamic Law: A Comparative Study of Fatwa Institutions on Indonesia's Health Insurance, *Jurnal Hukum Unissula,* Vol.40, no.1, 2024, page.190.

[32] Bård Tronvoll., The actor: the key determinator in service ecosystems, *Systems,* Vol.5, no.2, 2017, page.38.

[33] Ruairí Brugha, and Zsuzsa Varvasovszky., Stakeholder analysis: a review, *Health policy and planning,* Vol.15, no.3, 2000, page.242. See too, Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.68.

**Table 2.** Matrix of Actor's Stance Toward Objectives (Valued Position Matrix / 2MAO)

| 2 Matrix of Actors and Objectives | BPJSK | Static media | Social media | Premiums Center | Imposition | Medicine | JKN Program | Facility | ProLanis* | Procedural Flow | Administration | Social Health Insurance | Family Physician |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BPJS | 4 | 0 | 0 | 4 | 4 | 4 | 4 | 4 | 4 | 0 | 4 | 4 | 4 |
| Doctors | 4 | 0 | 0 | 3 | 4 | 4 | 0 | 4 | 4 | 4 | 4 | 4 | 4 |
| Health Center | 4 | 1 | 4 | 4 | -2 | 2 | 3 | 3 | 4 | 4 | 4 | 4 | 2 |
| Clinic | 0 | 2 | 4 | 3 | -2 | 2 | 1 | 3 | 4 | 1 | 1 | 1 | 1 |
| RS Type B | 3 | 1 | 3 | 3 | -1 | 3 | 4 | 3 | 4 | 2 | -2 | 1 | -3 |
| RS Type D | 4 | 1 | 3 | -1 | 4 | 3 | 4 | 4 | 4 | 4 | 4 | 1 | 1 |
| Health | 3 | 1 | 4 | 3 | -2 | 3 | 3 | 2 | 3 | 4 | 3 | 2 | 3 |
| Economy | 3 | 1 | 3 | 2 | -1 | 2 | 1 | 2 | 3 | 3 | 3 | 2 | 2 |
| Law | 1 | 1 | 3 | 2 | -1 | 2 | 1 | 2 | 3 | 2 | 2 | 2 | 2 |
| JKN Participants | 2 | 1 | 3 | 3 | -2 | 2 | 2 | 3 | 4 | 2 | -1 | 3 | 1 |
| Community Leaders | 3 | 1 | 3 | 2 | -2 | 3 | -2 | 3 | 3 | 2 | 3 | 3 | 3 |
| Religious Leaders | 0 | 1 | 3 | 3 | -2 | 3 | 3 | 2 | 4 | 2 | -1 | 2 | 3 |
| * Prolanis: Chronic Disease Management Program | | | | | | | | | | | | | |

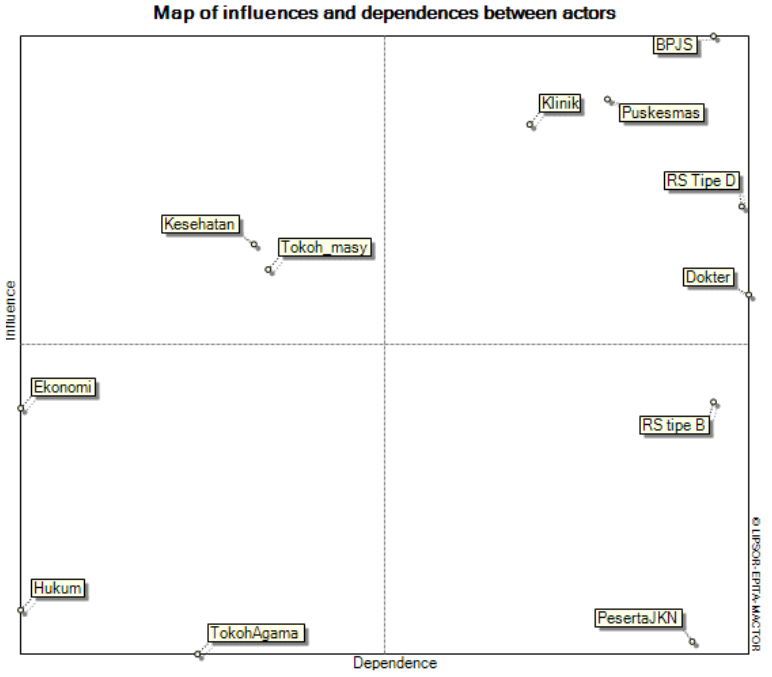


**Figure 1.** Map of Influences and Dependences between Actors

The 2MAO results further illustrate participants' normative stance toward premium obligations and sanctions. Participants show moderate positive alignment toward premiums (score 3), indicating acceptance of contributory obligations under the solidarity principle embedded in Law Number 40 of 2004. However, their stance toward fines (score -2) is clearly negative. This divergence suggests that while mandatory contributions are recognized as part of social insurance membership, punitive measures for arrears are perceived as burdensome. From a constitutional perspective, this pattern reflects tension between mandatory participation and proportional protection.

The solidarity principle requires that social insurance systems distribute risk collectively, but constitutional welfare doctrine also requires proportionality and non-discrimination in enforcement. Empirical evidence shows that ability to pay remains uneven across socioeconomic groups. Maulana et al.[34] measure the capacity to contribute (ability to pay) among Indonesian households and find that informal sector workers face higher vulnerability to irregular income flows. Similarly, Azizatunnisa et al.[35] demonstrate that financial protection under JKN remains uneven for persons with disabilities, indicating that coverage does not automatically eliminate structural vulnerability. In this context, sanction mechanisms for arrears must be evaluated not only as administrative tools but as potential barriers to equal access.

The MDI also reveals that participants' dependence is reinforced by procedural complexity. Access to services requires compliance with referral pathways and administrative requirements determined by BPJS and healthcare facilities. Erlangga et al.[36] show that insurance coverage increases healthcare utilization, but supply-side and procedural factors significantly affect effective access. Firori and Wisana[37] further indicate that participation in JKN reduces unmet healthcare needs, yet disparities persist when administrative procedures are difficult to navigate. These findings correspond with the 2MAO data, where participants demonstrate cautious positions toward procedural flow and administrative requirements.

Stakeholder analysis emphasizes that unequal access to information can intensify

[34] Andhika Nurwin Maulana, Yuli Fitrianti, and Farida Tri Hartini., Mengukur kemampuan mengiur untuk Jaminan Kesehatan Nasional (JKN) tahun 2021 di Indonesia, *Jurnal Jaminan Kesehatan Nasional,* Vol.2, no.1, 2022, page.32.

[35] Luthfi Azizatunnisa, Hannah Kuper, Ari Probandari, and Lena Morgon Banks., I was given the card, but no one told me how to use it: Challenges and Facilitators of People with Disabilities in Indonesia in Accessing and Using Jaminan Kesehatan Nasional (National Health Insurance), *SSM-Health Systems* Vol.22, no.3, 2026, page.10172. See too, Alia Istiqomah, Irene Putri Jayanti, Ratih Wijayanti, Fahmi Hidayatullah, and Fitri Diah Oktadewi., Telaah Artikel: Implementasi Sistem Pembayaran Kapitasi pada Jaminan Kesehatan Nasional sebagai Strategi dalam Mengatasi Kesenjangan Pelayanan Kesehatan, *STOMATOGNATIC-Jurnal Kedokteran Gigi,* Vol.20, no.1, 2023, page.234.

[36] Darius Erlangga, Shehzad Ali, and Karen Bloor., The impact of public health insurance on healthcare utilisation in Indonesia: evidence from panel data, *International journal of public health,* Vol.64, no.4, 2019, page.613.

[37] Farikh Alfa Firori, and I. Dewa Gede Karma Wisana., The effect of participation in JKN on unmet needs for healthcare services, *Editorial Board of Indonesian Journal of Health Administration,* Vol.11, no.2, 2023, page.36.

power asymmetry.[38] The relatively low influence score of participants in the MDI suggests limited capacity to shape policy adjustments or dispute sanction decisions. Although formal complaint mechanisms exist, their effectiveness depends on transparency, responsiveness, and digital accessibility. Handasari et al.[39] evaluate the JKN mobile application and find usability challenges that may reduce participant engagement. Information asymmetry, as described in stakeholder theory, often produces conflict and mistrust when actors lack clear communication channels.[40] In the context of arrears, misunderstanding of payment deadlines, grace periods, or reactivation procedures may transform temporary financial hardship into prolonged exclusion from benefits.

The mapping of influence also highlights the dominant role of BPJS as the central administrative authority. BPJS demonstrates the highest competitiveness, reflecting its statutory mandate to regulate membership, collect premiums, and impose sanctions. This centrality corresponds with implementation studies showing that institutional capacity strongly shapes reform outcomes.[41] However, when dominant actors impose sanctions without adequate differentiation between inability to pay and deliberate non-compliance, proportionality concerns arise. In social health insurance theory, enforcement mechanisms must balance financial sustainability with equitable protection.[42]

Convergence analysis provides additional insight into constitutional protection. Strong convergence is observed between BPJS and community leaders, particularly regarding premium compliance. Community leaders hold moderate influence and demonstrate positive alignment with premium objectives. Their involvement may strengthen social persuasion mechanisms that encourage timely payment. Nasution et al.[43] show that community engagement can enhance equitable utilization of maternal health services under JKN. This suggests that social mediation can complement formal enforcement in improving compliance without intensifying punitive pressure.

[38] Kent Buse, Nicholas Mays, and Gill Walt., *Making Health Policy*, Yogyakarta, Kebijakan Kesehatan Indonesia, 2012, page.47.

[39] Savira Putri Handasari, and Respati Wulandari., Evaluation of the usability and user experience of the Jaminan Kesehatan Nasional mobile application in Indonesia, *Healthcare Informatics Research,* Vol.30, no.4, 2024, page.327.

[40] Ritika Mahajan, Weng Marc Lim, Monica Sareen, Satish Kumar, and Rajat Panwar., Stakeholder theory, *Journal of Business Research,* Vol.166, no.2, 2023, page.1144.

[41] Rena Eichler, Susan Gigli, and Lisa LeRoy., Implementation research to strengthen health care financing reforms toward universal health coverage in Indonesia: a mixed-methods approach to real-world monitoring, *Global Health: Science and Practice*, Vol.6, no.4, 2018, page.751.

[42] Rina Agustina, Teguh Dartanto, Ratna Sitompul, Kun A. Susiloretni, Endang L. Achadi, Akmal Taher, Fadila Wirawan et al., Universal health coverage in Indonesia: concept, progress, and challenges, *The Lancet,* Vol.393, no.16, 2019, page.86.

[43] Siti Khadijah Nasution, Yodi Mahendradhata, and Laksono Trisnantoro., Can a national health insurance policy increase equity in the utilization of skilled birth attendants in Indonesia? A secondary analysis of the 2012 to 2016 national socio-economic survey of Indonesia, *Asia Pacific Journal of Public Health,* Vol.32, no.1, 2020, page.19.

However, convergence around premium objectives does not eliminate divergence concerning fines. Participants, community leaders, and several academic actors express negative or cautious positions toward sanction mechanisms. Divergence reflects average conflict intensity when actors disagree on objectives.[44] In this study, divergence between participants and institutional actors indicates disagreement about how arrears should be managed. Such disagreement is significant because constitutional protection requires that enforcement policies not disproportionately burden vulnerable groups.

The rights dimension becomes more complex when viewed alongside financial sustainability debates. Zahari et al.[45] analyze tobacco excise tax policy as an alternative financing source for universal coverage, illustrating ongoing concerns about fiscal balance. Arimbi[46] discusses legal opportunities to address JKN deficits, emphasizing that financial stability is necessary to maintain service guarantees. Within this fiscal context, strict arrears enforcement may be justified as a sustainability measure. Nevertheless, stakeholder mapping shows that participants lack symmetrical bargaining power in these debates, reinforcing the importance of procedural fairness.

The influence-dependence map also shows that relay actors (community health centers, clinics, and Type D hospitals) occupy central operational roles. Their relationship with participants directly affects access when arrears occur. If benefit suspension is triggered, service denial may occur at the facility level. Johar et al.[47] demonstrate that inequality in access to health care is shaped by both insurance coverage and supply distribution. Therefore, even temporary administrative suspension can translate into tangible health risks when participants require urgent services.

Furthermore, performance-based capitation reforms influence frontline provider incentives. Sambodo et al.[48] find that capitation adjustments affect primary care utilization patterns. When payment depends on active membership status, facilities may become stricter in verifying eligibility, indirectly reinforcing sanction effects. Thus, constitutional protection is mediated not only by BPJS decisions but also by provider-level implementation.

The stakeholder framework clarifies that participants are primary stakeholders

[44] Manel Elmsalmi, and Wafik Hachicha., Risk mitigation strategies according to the supply actors' objectives through MACTOR method, In *2014 International Conference on Advanced Logistics and Transport (ICALT)*, New York, IEEE, 2014, page.364.

[45] Teuku Naraski Zahari, and Akhmad Hidayatno., Sustainability Evaluation of Tobacco Excise Tax Policy to Finance Universal Health Coverage in Indonesia, In *2021 IEEE International Conference on Industrial Engineering and Engineering Management (IEEM)*, New York, IEEE, 2021, page.1640.

[46] Diah Arimbi., Legal Opportunities Solutions to Tackle the Deficit in Indonesia's National Health Insurance Program, *Padjadjaran Jurnal Ilmu Hukum*, Vol.11, no.3, 2024, page.323.

[47] Meliyanni Johar, Prastuti Soewondo, Retno Pujisubekti, Harsa Kunthara Satrio, and Ardi Adji., Inequality in access to health care, health insurance and the role of supply factors, *Social Science & Medicine,* Vol.213, no.11, 2018, page.139.

[48] Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, and Eddy van Doorslaer., Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, *Social science & medicine,* Vol.327, no.12, 2023, page.11596.

because the program's existence depends on their membership and contributions.[49] Yet, in practical governance terms, they remain structurally weaker actors. This imbalance illustrates the distinction between formal recognition and substantive empowerment. Gilson et al.[50] argue that stakeholder engagement is essential for achieving universal coverage objectives, particularly when reforms affect vulnerable populations. Without effective participation channels, dominated actors may experience policy outcomes without meaningful input.

Another relevant dimension is geographic inequality. Sambodo et al.[51] demonstrate that variation in regional health spending can exacerbate benefit inequality. If arrears enforcement interacts with regional disparities in facility capacity, the impact on participants may differ across provinces. Mboi et al.[52] document uneven health outcomes among Indonesian provinces, reinforcing that formal insurance membership does not guarantee uniform protection. Participants facing both economic hardship and regional service limitations may experience compounded vulnerability.

The 2MAO results also indicate that participants express moderate support for social health insurance as a concept (score 3). This suggests normative acceptance of the collective model, consistent with the solidarity principle. However, negative positions toward fines and certain administrative requirements reveal dissatisfaction with implementation details rather than rejection of the system itself. This distinction is important for constitutional analysis because it indicates that legitimacy concerns arise from enforcement design rather than from the social insurance model.

In sum, the stakeholder results show that constitutional protection of JKN participants is shaped by structural influence asymmetry, normative disagreement over sanctions, and procedural complexity. Participants accept contributory obligations but contest punitive measures perceived as disproportionate. Their low competitiveness in the governance structure underscores reliance on institutional accountability mechanisms. Empirical literature confirms that financial vulnerability, supply-side variation, and information barriers continue to affect effective access under JKN. The interaction between fiscal sustainability pressures and participant rights remains a central dynamic within the legal regime on arrears,

[49] R. Edward Freeman., The stakeholder approach revisited, In *Wirtschafts-und unternehmensethik*, Wiesbaden, Springer Fachmedien Wiesbaden, 2020, page.665.

[50] Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.69.

[51] Novat Pugo Sambodo, Eddy Van Doorslaer, Menno Pradhan, and Robert Sparrow., Does geographic spending variation exacerbate healthcare benefit inequality? A benefit incidence analysis for Indonesia, *Health Policy and Planning,* Vol.36, no.7, 2021, page.1138.

[52] Nafsiah Mboi, Ruri Syailendrawati, Samuel M. Ostroff, Iqbal RF Elyazar, Scott D. Glenn, Tety Rachmawati, Wahyu Pudji Nugraheni et al., The state of health in Indonesia's provinces, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019, *The Lancet Global Health,* Vol.10, no.11, 2022, page.1637.

as reflected in the patterns of convergence, divergence, and actor positioning identified through the MACTOR analysis.[53]

### 3.3. Institutional Configuration, Accountability, and Governance Design

The stakeholder mapping using MACTOR provides a structured explanation of how authority, influence, and dependence are distributed within JKN governance. Based on the Matrix of Direct Influence (MDI) and the Valued Position Matrix (2MAO), the institutional configuration of JKN reflects a semi-centralized governance model in which administrative authority is concentrated, while operational responsibilities are widely distributed across frontline actors. This section focuses specifically on how this configuration shapes accountability, authority distribution, and regulatory design.

Stakeholder theory explains that actors differ in their capacity to influence outcomes depending on resources, formal authority, and knowledge.[54] In public health systems, stakeholder mapping is often used to identify power structures and coordination gaps.[55] In the JKN context, the Map of Influence and Dependence categorizes actors into four quadrants: influential actors, relay actors, dominated actors, and autonomous actors.[56]

The mapping in Figure 1 shows that BPJS Kesehatan, community health centers, primary clinics, and Type D referral hospitals occupy central operational positions. These actors are classified mainly as relay actors in quadrant II. Relay actors are characterized by relatively high influence and high dependence. They act as connectors between regulatory authority and service recipients. In the JKN system, BPJS holds statutory authority over membership, premium collection, and reimbursement, while primary health facilities deliver services directly to participants. This configuration aligns with the BPJS Law and Law Number 40 of 2004 on the National Social Security System (SJSN), which assign BPJS both administrative and financial control.[57]

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[53] Tjondroargo Tandio, Cecep Kusmana, Akhmad Fauzi, and Endang Hilmi., Identification of key actors in mangroves plantation using the MACTOR Tool: Study in DKI Jakarta, *Jurnal Sylva Lestari*, Vol.11, no.1, 2023, page.168.

[54] R. Edward Freeman., The stakeholder approach revisited, In *Wirtschafts-und unternehmensethik*, Wiesbaden, Springer Fachmedien Wiesbaden, 2020, page.667. See too, Bård Tronvoll., The actor: the key determinator in service ecosystems, *Systems,* Vol.5, no.2, 2017, page.39.

[55] Ruairí Brugha, and Zsuzsa Varvasovszky., Stakeholder analysis: a review, *Health policy and planning,* Vol.15, no.3, 2000, page.243. See too, Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.70.

[56] Manel Elmsalmi, and Wafik Hachicha., Risk mitigation strategies according to the supply actors' objectives through MACTOR method, In *2014 International Conference on Advanced Logistics and Transport (ICALT)*, New York, IEEE, 2014, page.366.

[57] Ahmad Andrika, Ibrahim Ahmad, and Arifin Tumuhulawa., Badan Penyelenggara Jaminan Sosial Ketenagakerajaan Berdasarkan Undang-undang Nomor 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, *Journal Evidence of Law,* Vol.2, no.3, 2023, page.78. See too, Aria Yuditia, Yusup Hidayat, and Suparji Achmad., Pelaksanaan Jaminan Kesehatan Nasional Oleh Bpjs Berdasarkan

The Histogram of Competitiveness further confirms the dominance of BPJS and primary facilities in terms of influence.

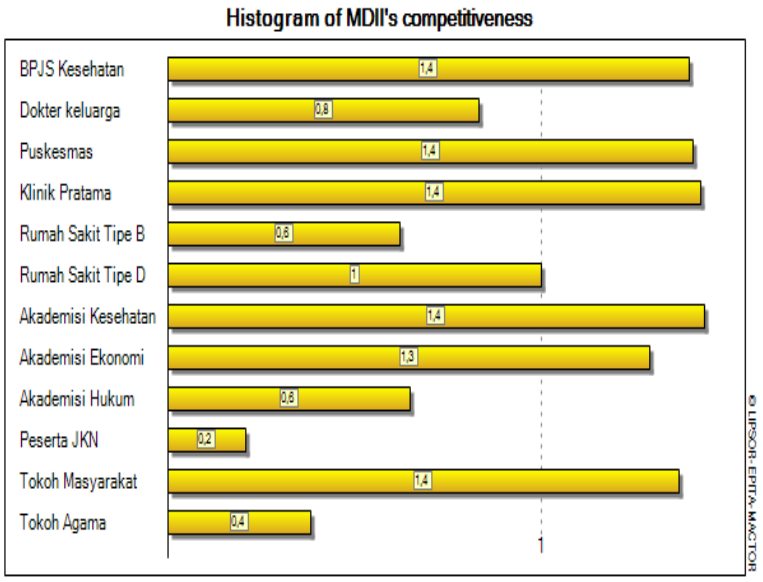


**Figure 2.** Histogram of Competitiveness

BPJS, community health centers, and clinics show the highest competitiveness scores. Competitiveness in MACTOR reflects the capacity to affect other actors' decisions and to shape policy direction. BPJS's central position is expected, given its role as a public legal entity responsible for managing JKN financing and contracts with providers. This institutional strength is consistent with findings from implementation research, which show that centralized purchasing bodies often exercise strong bargaining power over providers in social health insurance systems.[58]

However, high competitiveness also concentrates accountability. When administrative authority and financial control are centralized, vertical accountability mechanisms (reporting to central government and statutory oversight) become stronger than horizontal accountability among actors. This pattern reflects what governance literature describes as administrative centralization combined with

Undang-Undang No. 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, *Jurnal Magister Ilmu Hukum,* Vol.6, no.1, 2021, page.48.

[58] Rena Eichler, Susan Gigli, and Lisa LeRoy., Implementation research to strengthen health care financing reforms toward universal health coverage in Indonesia: a mixed-methods approach to real-world monitoring, *Global Health: Science and Practice,* Vol.6, no.4, 2018, page.752. See too, Mohamed Ben-Daoud, Badr El Mahrad, Gabriela Adina Moroșanu, Ismail Elhassnaoui, Aniss Moumen, Lhoussaine El Mezouary, Mohamed ELbouhaddioui, Ali Essahlaoui, and Samir Eljaafari., Stakeholders' interaction in water management system: insights from a MACTOR analysis in the R'Dom sub-basin, Morocco, *Environmental Management,* Vol.71, no.6, 2023, page.23.

operational decentralization.[59] Facilities deliver services locally, but key rules are determined centrally.

Community health centers and clinics are positioned as frontline institutions that translate central regulations into practice. Their influence is high because they interact directly with participants and determine access through referral decisions and service procedures. Research on capitation payment reform shows that primary care providers' behavior significantly affects utilization patterns.[60] This reinforces their practical authority within the governance structure. Nevertheless, these actors remain dependent on BPJS reimbursement systems and regulatory compliance frameworks. Delays in claim payments or changes in payment rules directly affect their operational stability.[61]

In quadrant I, health academicians and community figures appear as influential but less dependent actors. Health academicians contribute policy ideas and research-based recommendations. Empirical evidence suggests that academic engagement strengthens policy design and evaluation in universal coverage reforms.[62] Community figures, particularly members of local legislative bodies, also demonstrate significant influence at the local level. Their authority does not stem from direct administrative control but from political legitimacy and public trust. This position allows them to mediate between participants and implementing agencies, especially in matters related to premium compliance or service dissatisfaction. The Convergence Diagram highlights areas of shared objectives among actors (Figure 3).

[59] Tisno Leksani Tunjungwulan, and Alberto Daniel Hanani., Stakeholder Analysis Approach: Who Is Authorized to Regulate the National Health Insurance Benefits? *IPTEK Journal of Proceedings Series,* Vol.5, 2019, page.598. See too, Ari Probandari, Hannah Kuper, and Lena Morgon Banks., Health insurance coverage, healthcare use, and financial protection amongst people with disabilities in Indonesia: analysis of the 2021 National Socioeconomic Survey. *The Lancet Regional Health-Southeast Asia* Vol.39, no.4, 2025;

[60] Novat Pugo Sambodo, Igna Bonfrer, Robert Sparrow, Menno Pradhan, and Eddy van Doorslaer., Effects of performance-based capitation payment on the use of public primary health care services in Indonesia, *Social science & medicine,* Vol.327, no.12, 2023, page.11597.

[61] Immanuel Natanael Tarigan, and Feni Dwi Lestari., Penundaan Pembayaran Klaim Jaminan Kesehatan Nasional Oleh Bpjs Kesehatan Di Indonesia: Sebuah Scoping Review, *Jurnal Ekonomi Kesehatan Indonesia,* Vol.7, no.2, 2022, page.4.

[62] Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.71.

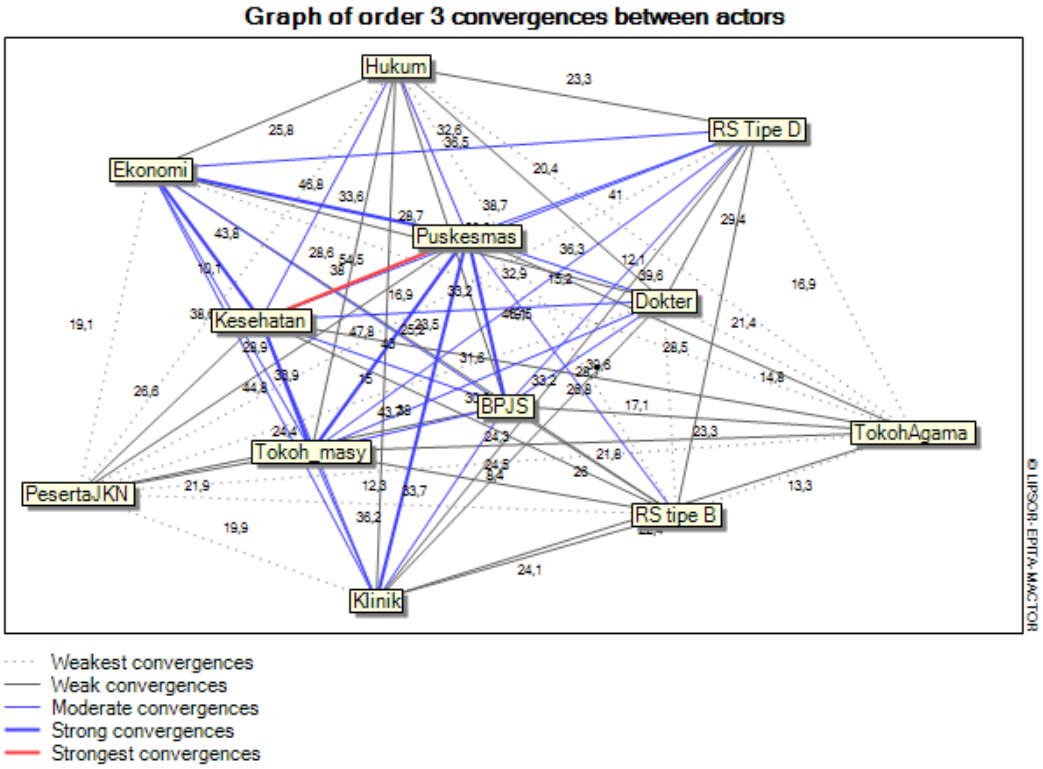


**Figure 3.** Convergence among Actors

Strong convergence appears between health academicians and community health centers, and between BPJS and community leaders. Convergence indicates alignment of interests and reduced conflict intensity. In governance terms, this suggests cooperative potential. When academic actors and frontline facilities share policy goals, evidence-based recommendations are more likely to influence operational practice. Similarly, convergence between BPJS and community leaders strengthens social compliance mechanisms, particularly in encouraging timely premium payment.

Convergence is important for program sustainability. Agustina et al.[63] emphasize that JKN's progress toward universal health coverage depends not only on financing but also on stakeholder coordination. Cooperative relationships can compensate for regulatory gaps by fostering informal mediation channels. However, convergence does not eliminate structural asymmetry. Even when objectives align, decision-making authority remains concentrated in central institutions. The Divergence Diagram provides insight into governance weaknesses (Figure 4).

[63] Rina Agustina, Teguh Dartanto, Ratna Sitompul, Kun A. Susiloretni, Endang L. Achadi, Akmal Taher, Fadila Wirawan et al., Universal health coverage in Indonesia: concept, progress, and challenges, *The Lancet,* Vol.393, no.16, 2019, page.87.

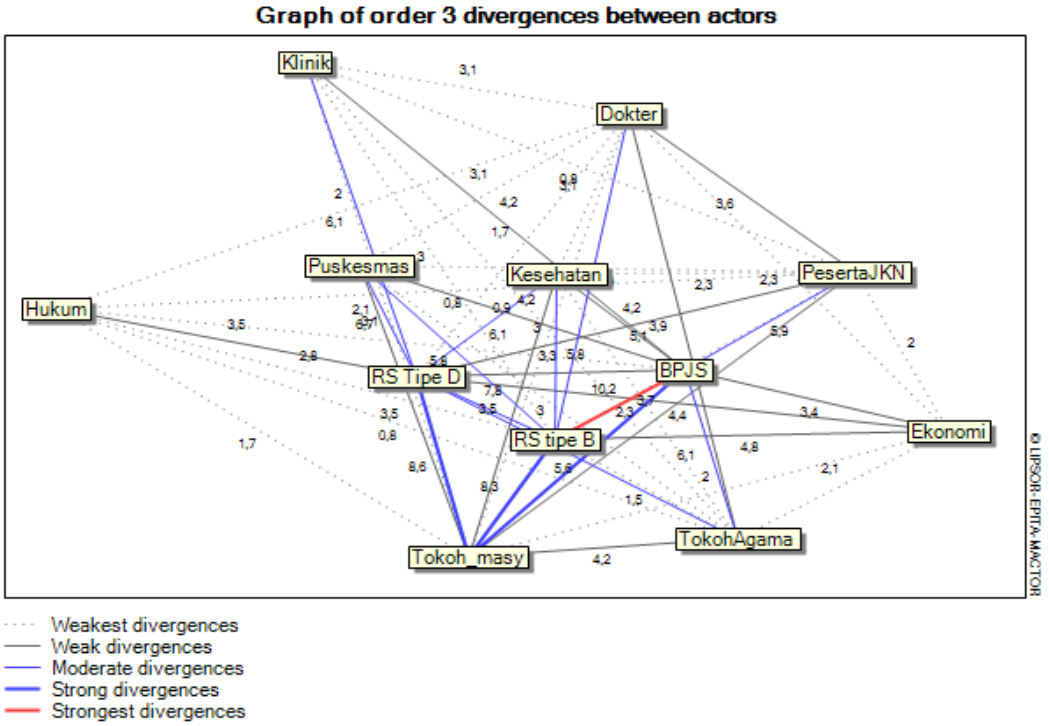


**Figure 4.** Divergence among Actors

The strongest divergence appears between Type B hospitals and BPJS regarding the tiered referral system. Type B hospitals are classified as dominated actors in quadrant III, with low competitiveness and high dependence. They rely heavily on referral flows determined by primary facilities and BPJS rules. The expansion of specialist services in Type D and Type C hospitals reduces patient inflow to Type B hospitals, creating dissatisfaction.

From a regulatory design perspective, this divergence signals incomplete coordination in hospital classification and referral policies. Although Ministry of Health Regulation Number 340/MENKES/PER/III/2010 provides formal classification standards, implementation under JKN has altered market incentives. When lower-tier hospitals increase specialist capacity, referral pathways become more flexible, potentially bypassing Type B facilities. This creates perceived inequity among providers and weakens horizontal coordination.

Such divergence reflects what stakeholder theory describes as conflict arising from differing interests and information asymmetry.[64] BPJS prioritizes cost efficiency and service accessibility, while Type B hospitals prioritize patient volume and financial sustainability. Without clear mediation mechanisms, conflict intensity increases. Similar patterns have been observed in other health insurance reforms where purchasing agencies gain strong negotiating power over hospitals.[65]

[64] Ritika Mahajan, Weng Marc Lim, Monica Sareen, Satish Kumar, and Rajat Panwar., Stakeholder theory, *Journal of Business Research,* Vol.166, no.2, 2023, page.1146.

[65] Majid Heydari, Hesam Seyedin, Mehdi Jafari, and Reza Dehnavieh., Stakeholder analysis of Iran's health insurance system, *Journal of education and health promotion,* Vol.7, no.1, 2018, page.136.

Accountability in this configuration is primarily vertical. BPJS is accountable to central government and statutory oversight bodies. Primary facilities are accountable to BPJS through contractual arrangements and performance indicators. However, horizontal accountability among providers, such as coordination between Type B and Type D hospitals, appears weaker. The divergence findings suggest insufficient regulatory integration between hospital classification policy and referral system implementation.

Autonomous actors in quadrant IV, such as economics and law academicians and religious leaders, have low influence and low dependence. Although they do not directly shape operational decisions, they provide normative oversight and ethical guidance. Governance literature recognizes the importance of such actors in maintaining legitimacy, especially in social insurance systems that rely on public trust.[66] Their limited influence in the mapping indicates that normative discourse is present but not structurally embedded in decision-making processes.

Institutional mapping also shows that JKN participants occupy a dominated position. Although this section does not focus on constitutional protection, their low competitiveness remains relevant to governance design. As primary stakeholders in Freeman's terminology, participants are essential for program sustainability.[67] Yet their structural influence over regulatory adjustments is minimal. This imbalance reflects limited participatory governance mechanisms within JKN.

Comparative health policy research demonstrates that inclusive stakeholder engagement improves reform durability.[68] When dominated actors lack effective channels to express concerns, dissatisfaction may manifest indirectly through reduced compliance or declining trust. In Indonesia, progress toward universal coverage has been significant, but regional inequality and benefit distribution disparities remain challenges.[69] Institutional design must therefore balance

[66] Ruairí Brugha, and Zsuzsa Varvasovszky., Stakeholder analysis: a review, *Health policy and planning,* Vol.15, no.3, 2000, page.244.

[67] R. Edward Freeman., The stakeholder approach revisited, In *Wirtschafts-und unternehmensethik*, Wiesbaden, Springer Fachmedien Wiesbaden, 2020, page.668.

[68] Lucy Gilson, Ermin Erasmus, Jo Borghi, Janet Macha, Peter Kamuzora, and Gemini Mtei., Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project, *Health policy and planning,* Vol.27, no.1, 2012, page.73. See too, Amit Makan, Abebaw Fekadu, Vaibhav Murhar, Nagendra Luitel, Tasneem Kathree, Joshua Ssebunya, and Crick Lund., Stakeholder analysis of the Programme for Improving Mental health carE (PRIME): baseline findings, *International Journal of Mental Health Systems,* Vol.9, no.1, 2015, page.27.

[69] Nafsiah Mboi, Indra Murty Surbakti, Indang Trihandini, Iqbal Elyazar, Karen Houston Smith, Pungkas Bahjuri Ali, Soewarta Kosen et al., On the road to universal health care in Indonesia, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016, *The Lancet,* Vol.392, no.10147, 2018, page.587. See too, Nafsiah Mboi, Ruri Syailendrawati, Samuel M. Ostroff, Iqbal RF Elyazar, Scott D. Glenn, Tety Rachmawati, Wahyu Pudji Nugraheni et al., The state of health in Indonesia's provinces, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019, *The Lancet Global Health,* Vol.10, no.11, 2022, page.1639; Novat Pugo Sambodo, Eddy Van Doorslaer, Menno Pradhan, and Robert Sparrow., Does geographic

efficiency with responsiveness.

Financial sustainability debates also influence authority distribution. Studies on JKN deficits highlight the need for stronger fiscal management.[70] In such contexts, centralization of authority may appear necessary to maintain cost control. However, excessive concentration of power can reduce transparency and participatory oversight. Governance law principles require clarity of authority, proportional enforcement, and accessible dispute resolution mechanisms.

Findings regarding the institutional configuration and distribution of actors' roles in the National Health Insurance (JKN) are strongly supported by the literature, which shows that the implementation of national-scale health policies is always supported by complex interactions between state actors, service providers, and the community. The government's role as provider of political commitment and financing is a key foundation in ensuring equitable access, while also demonstrating the importance of vertical coordination down to the regional level in addressing administrative and fiscal challenges.[71]

On the other hand, the dominance of operational actors such as healthcare facilities and BPJS Kesehatan reflects the nature of the social insurance system, which places service providers and purchasing institutions as key actors in determining the effectiveness of implementation. Studies show that clinical reform, cost control, and hospital managerial capacity are crucial for the success of policies at the service level.[72] However, these conditions are also accompanied by pressure on healthcare workers and a high dependence on financing mechanisms, which

spending variation exacerbate healthcare benefit inequality? A benefit incidence analysis for Indonesia, *Health Policy and Planning,* Vol.36, no.7, 2021, page.1139.

[70] Diah Arimbi., Legal Opportunities Solutions to Tackle the Deficit in Indonesia's National Health Insurance Program, *Padjadjaran Jurnal Ilmu Hukum,* Vol.11, no.3, 2024, page.325.

[71] Atikah Adyas., The Indonesian strategy to achieve universal health coverage through National Health Insurance System: challenges in human resources, Vol.2, no.3, 2021, page.32. See too, Yusi Anggriani, and Hesty Utami Ramadaniati., Pharmaceutical pricing policies in Indonesia., In *Formulating and Implementing Pharmaceutical Pricing Policies*, Cambridge, Academic Press, 2025, page.88; Adi Fahrudin., The construction model of the national health insurance policy for the poor people in Indonesia, *Brazilian Journal of Law & International Relations/Relações Internacionais no Mundo,* Vol.4, no.42, 2023, page.239; Abu Huraerah, Adi Fahrudin, and Husmiati Yusuf., Role of local government officers in the implementation of national health insurance for poor peoples, *Multidisciplinary Reviews* Vol.3, no.4, 2024, page.347; Arief Suryono., Healthcare BPJS Indonesia: Challenges and chances to provide right to health for all Indonesians, *International Journal of Advanced Science and Technology,* Vol.3, 2020, page.35.

[72] Aryo Dewanto, and A. K. Siti-Nabiha., The clinicians' perspective on the National Health Insurance implementation in Indonesia: A study in a government hospital, *International Journal of Healthcare Management,* Vol.18, no.2, 2025, page.225. See too, Alimin Maidin, Noer Bahry Noor, Fridawaty Rifai, and Anwar Mallongi., Cost Effective Analysis on the Implementation of Clinical Pathway in Anwar Makkatutu Hospital, Bantaeng District, South Sulawesi, Indonesia, *Indian Journal of Public Health Research & Development,* Vol.9, no.8, 2018, page.1425; Gita Susanti, Muhammad Irvan Nur Iva, Andi Ahmad Yani, and Andi Rahmat Hidayat., Assessing the national health insurance system: a study of the implementation of health insurance policy in Indonesia, *Public Policy and Administration,* Vol.21, no.4, 2022, page.26; Hardi Warsono, Retna Hanani, and Halim Dwi Putra., Collaborative Governance Framework in Health Care: A Qualitative Exploration of Hospital Pharmacy Management Reform at Hospital Setting in Indonesia, *Systematic Reviews in Pharmacy,* Vol.11, no.4, 2020, page.31.

impact workload and operational stability.[73]

Furthermore, successful implementation is inextricably linked to social factors, particularly community participation and public trust in the system. Participation motivation and compliance with premium payments have been shown to be significantly influenced by socioeconomic conditions and perceptions of service quality.[74] In this context, the role of normative actors such as religious leaders contributes to strengthening policy legitimacy.[75] Overall, the findings also confirms that the sustainability of the National Health Insurance (JKN) is highly dependent on collaboration, financing efficiency, and adaptation to change, including digitalization and strengthening governance to prevent fraud and improve system performance.[76]

## 4. Conclusion

This study has addressed two central legal questions: first, whether the regulatory framework of the JKN system demonstrates hierarchical coherence and legality within Indonesia's structure of laws; and second, whether the current governance design adequately safeguards constitutional principles of legal certainty, proportionality, and accountability, particularly in the regime on arrears and referral arrangements.

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[73] Anna Kurniati, Ellen Rosskam, and Ferry Efendi., Hospital nurses' perceptions of distributive justice under the national health insurance scheme in Indonesia, *Collegian,* Vol,28, no.5, 2021, page.509. See too, Arief Suryono., Healthcare BPJS Indonesia: Challenges and chances to provide right to health for all Indonesians, *International Journal of Advanced Science and Technology,* Vol.3, 2020, page.37.

[74] Agung Dwi Laksono, Ratna Dwi Wulandari, Diyan Ermawan Efendi, Tumaji Tumaji, and Zainul Khaqiqi Nantabah., Role of socioeconomic status in national health insurance ownership in Indonesia's rural areas, *Journal of Research in Health Sciences,* Vol.24, no.6, 2024, page.608. See too, S. Palutturi, M. Sahiddin, and H. Ishak Hamzah., Community Motivation and Learning to Pay the National Health Insurance Contribution*, Asian Journal of Scientific Research,* Vol.11, no.2, 2018, page. 278; Virginia Wiseman, Hasbullah Thabrany, Augustine Asante, Manon Haemmerli, Soewarta Kosen, Lucy Gilson, Anne Mills, Andrew Hayen, Viroj Tangcharoensathien, and Walaiporn Patcharanarumol., An evaluation of health systems equity in Indonesia: study protocol. *International journal for equity in health,* Vol.17, no.1, 2018, page.138.

[75] Sopa, Rini Fatma Kartika, Nurhadi Nurhadi, Dina Febriani Darmansyah, Taufiqurokhman Taufiqurokhman, and Ma'mun Murod., Social Security Programs in Islamic Law: A Comparative Study of Fatwa Institutions on Indonesia's Health Insurance, *Jurnal Hukum Unissula,* Vol.40, no.1, 2024, page.191.

[76] Putri Galuh Inggi, and Anhari Achadi., Evaluation of Fraud Prevention Policies in the National Health Insurance System in Indonesia: Narrative Literature Review, *Media Publikasi Promosi Kesehatan Indonesia,* Vol.7, no.10, 2024, page.2454. See too, Diva Kurnianingtyas, Budi Santosa, and Nurhadi Siswanto., A system dynamic to reforming of the healthcare sector in the Indonesian National Health Insurance System Program, *International Journal of Industrial and Systems Engineering,* Vol.42, no.4, 2022, page.456; Reyvaldo, Muh Ihsan Sakaruddin, Davin Fauzan Ma'Rifatullah, Erwin Halim, and Placide Poba-Nzao., The Influence of Features and Factor on Continuous Usage Intention in Indonesia's National Health Insurance Application, In *2023 IEEE 8th International Conference on Recent Advances and Innovations in Engineering (ICRAIE)*, New York, IEEE, 2023, page.4.

Doctrinally, the JKN framework satisfies formal vertical consistency. The constitutional mandates on the right to health and social security are operationalized through the SJSN Law and the BPJS Law, and further detailed in ministerial regulations. No direct normative contradiction is identified within this hierarchy. BPJS's dominant institutional position reflects lawful delegation of authority under statutory provisions. In this sense, the legality of centralized administrative control is not in question.

However, the analysis demonstrates that regulatory adequacy cannot be measured solely by formal conformity. The interaction between hospital classification regulations and BPJS referral policies reveals insufficient horizontal harmonization. Divergence between BPJS and Type B hospitals indicates that existing ministerial regulations lack integrative clauses clarifying referral authority, service boundaries, and financial consequences within the tiered system. This constitutes a problem of regulatory coherence rather than legality per se. Doctrinally, it calls for revision or consolidation of relevant ministerial regulations to ensure consistency between hospital classification rules and insurance reimbursement mechanisms.

Regarding the arrears regime, the imposition of fines and temporary suspension of benefits is legally grounded in the principle of mandatory participation. Nevertheless, the current regulatory design does not sufficiently differentiate between inability to pay and deliberate non-compliance. From the perspective of proportionality and legal certainty, clearer normative criteria are required. This reform should take the form of amendments to implementing regulations under the SJSN and BPJS Laws, explicitly defining hardship exemptions, structured grace periods, and procedural safeguards.

Finally, accountability mechanisms remain predominantly vertical. To comply with principles of good governance, the framework should formally institutionalize an independent administrative dispute-resolution mechanism within the JKN system. Such a mechanism would strengthen horizontal accountability without undermining statutory authority.

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