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The Consistency of National Health Insurance Implementation in Achieving Health Equity

Jasran Asya[1], Arief Suryono[2], Ahmad Makbul[3]

[1] *Sekolah Tinggi Hukum Militer, DKI Jakarta, Indonesia. E-mail: jasranptc@gmail.com.*
[2] *Lecturer Fakultas Hukum Universitas Sebelas Maret, Surakarta, Indonesia. E-mail: arsur15@yahoo.co.id.*
[3] *Lecturer Sekolah Tinggi Hukum Militer, DKI Jakarta, Indonesia. E-mail: ahmadmakbul13@gmail.com.*

Abstract: The Constitution of the Republic of Indonesia mandates the state to fulfill health equity. The amendments to the Constitution reformed the health sector by decentralizing authority from the central government to regional governments. Both the regional and central governments share responsibility for health funding through public health efforts and individual health efforts. However, the National Social Security System Law and the Social Security Agency Law, which form the basis of the National Health Insurance program, were drafted and implemented without involving regional governments. This has widened the disparity in the availability of healthcare facilities and medical personnel between developed and underdeveloped regions. This research aims to assess the National Social Security System Law and the Social Security Agency Law in terms of their consistency with the Constitution and their synchronization with the Regional Government Law and the Health Law in achieving health equity. Additionally, it examines the role of regional governments in funding individual health efforts under the National Health Insurance program. This normative explanatory research, based on secondary data, investigates various legal norms related to the funding of individual health efforts by regional governments. The research concludes that the funding of individual health efforts under the National Health Insurance program by he Social Security Agency Law is inconsistent with the Constitution and is not synchronized with the Regional Government Law and the Health Law. Legislative corrections to the National Health Insurance program-related laws are necessary to involve regional governments.
Keywords: : Health Equity, National Health Insurance, Regional Governments, Individual Health Efforts

1. Introduction

The fourth paragraph of the 1945 Constitution of the Republic of Indonesia (hereinafter referred to as the "1945 Constitution") explicitly establishes the duty of the state to realize social justice for all Indonesian citizens. This obligation serves as a constitutional foundation underpinning the state's responsibility to ensure the welfare of its people. Furthermore, more detailed provisions regarding the state's responsibilities concerning social guarantees are enshrined in Article 28H, paragraph (3), and Article 34, paragraph (2) of the 1945 Constitution, which affirm that the state is obligated to provide social protection to all citizens. Through these provisions, the 1945 Constitution underscores the importance of the state's role in creating conditions that enable every individual to enjoy their rights fairly and equitably, thereby fostering a prosperous and just society. This underscores the constitutional commitment to the equitable and just provision of welfare.

Specifically, social justice in the health sector, known as health equity, is realized through various health efforts and interventions supported by diverse health resources. According to Article 20 of Law Number 17 of 2023 concerning Health (hereinafter referred to as the "Health Law"), these health resources encompass several essential elements. Among these are adequate health facilities, competent healthcare professionals, the availability of medical supplies, an integrated health information system, the utilization of advanced health technologies, and sufficient funding to support all aspects of health services. The combination of these resources serves as the main pillars in ensuring the realization of health equity for all layers of society, in accordance with the mandates stipulated in the Health Law.

In 1998, Indonesia underwent a significant transformation in governance with the implementation of decentralization. This change began with amendments to the 1945 Constitution, resulting in new articles concerning regional autonomy. These amendments subsequently led to the enactment of laws governing the implementation of regional autonomy, namely Law No. 32 of 2004, which was later refined by Law No. 23 of 2014 concerning Regional Government (hereinafter referred to as the “Regional Government Law”). This law stipulates that the health sector, along with its financing, is one of the sectors decentralized from the central government to regional governments. This indicates that regional governments possess greater authority in managing the health sector within their jurisdictions, as part of efforts to strengthen regional autonomy.

Funding in the health sector is generally divided into two main categories: a) Public Health Efforts; and b) Individual Health Efforts. Public Health Efforts are collective in nature and relate to public services, with their funding originating from the Regional Revenue and Expenditure Budget sourced from government allocations. This funding is intended to ensure equitable and fair access for the community to necessary health services, as well as to support preventive and promotional programs that can enhance the overall well-being of the population. Meanwhile, Individual Health Efforts focus on private health services, for which funding may come from various sources, such as personal finances, private health insurance, or social insurance. In some cases, funding may also be partially obtained from the National Revenue and Expenditure Budget. Individual Health Efforts emphasize the individual’s need for health services, wherein each person is responsible for their own health and may choose to utilize available resources according to their capabilities.

Ali Ghufron Mukti emphasizes that public health initiatives should receive direct funding support from the central government. This is crucial considering the strategic role of public health initiatives in promoting the growth and stability of the national economy. Conversely, individual health efforts should be managed in an integrated and decentralized manner, with funding sourced from local governments. This approach

enables local governments to be more responsive to the health needs of their communities while providing flexibility in resource management to achieve optimal health outcomes. Furthermore, it is anticipated that this approach will strengthen local autonomy in the management of Individual Health Efforts while promoting the development of more equitable Public Health Efforts through policy interventions at the central level. Strengthening local autonomy will not only enhance the effectiveness of healthcare services in each region but will also ensure that every individual has equal access to quality healthcare services. The integrated policies from the central government are expected to create synergy between health efforts at the local and national levels, thereby establishing a more holistic and responsive healthcare system that addresses the needs of the community. This will have a positive impact on the overall improvement of public health while simultaneously reducing disparities in healthcare service provision across various regions.

Funding sources for the health sector must be ensured to be adequately available, distributed equitably based on community needs, and managed with a high degree of prudence. Furthermore, the management of these funds should adhere to principles of effectiveness and efficiency, enabling the community to easily access and utilize available health services. However, the reality on the ground indicates that this situation has not yet been fully realized. There are limitations in the amount of available funds, accompanied by uneven distribution, resulting in insufficient fulfillment of public health service needs.

In the regions of Latin America, Africa, and Asia, many countries classified as upper-middle-income have successfully provided comprehensive health protection for a substantial portion of their populations. However, in many tropical countries classified as low and middle-income, the financing sector for healthcare services still faces significant challenges. Therefore, there is a need for the development and implementation of effective financing mechanisms that not only ensure accessibility to healthcare services for all segments of society but also provide financial protection for individuals. This is essential to prevent a financial crisis for individuals in need of healthcare, ensuring that they are not forced to choose between their health and personal economic stability.

In an effort to enhance public welfare, Indonesia has adopted a social insurance system as a funding method for Individual Health Efforts. The implementation of this system is detailed in Law Number 40 of 2004 concerning the National Social Security System (hereinafter referred to as “National Social Security System Law”) and Law Number 24 of 2011 regarding the Social Security Agency (hereinafter referred to as “Social Security Agency Law”). Through this legal framework, the government has established the National Health Insurance program aimed at providing health protection for all citizens. This National Health Insurance program is designed as a collective effort to ensure the

accessibility and sustainability of healthcare services, allowing every individual to receive adequate care without being burdened by high costs.

The funding for Individual Health Efforts since 2014, organized by the Health Social Security Agency through the National Health Insurance program, has undoubtedly achieved positive outcomes in terms of broader access for the public. According to a monitoring study on the implementation of the National Health Insurance from 2014 to 2019 conducted by Trisnantoro, as cited by Haerawati Idris, there is an increasing disparity between developed and underdeveloped regions regarding equitable access to health services, the availability of healthcare facilities, and the distribution of medical and healthcare personnel. Furthermore, in the conclusion of the research, it is stated that the findings align with the initial scenario forecast, indicating that given Indonesia's varied geographic and demographic conditions, a centralized National Health Insurance system, with relatively uniform funding regulations, will face challenges in achieving health equity.

Furthermore, when assessing the outcomes of the National Health Insurance program from the perspective of health equity as stipulated in the constitution, the results achieved to date remain significantly inadequate. Trisnantoro notes that during the first four years of National Health Insurance implementation, a striking phenomenon of fragmentation emerged within the healthcare system. Although both laws underlying the implementation of National Health Insurance focus on health funding, they are not integrated with the prevailing policies within the overall healthcare system. This indicates the necessity for synchronization between funding regulations and health policies to achieve better health equity goals and ensure more equitable access for the entire population.

The failure to achieve the desired objectives in individual health financing in Indonesia can be attributed to the lack of involvement from local governments, which are expected to play an active role in supporting such efforts, in accordance with the provisions set forth in the constitution and lower legislation. From the perspective of the Stufenbau Theory proposed by Hans Kelsen, there exists an inconsistency between the substance of laws related to the National Health Insurance program, namely the National Social Security System Law and the Social Security Agency Law, and the principles enshrined in the constitution. This indicates that the implementation of these laws does not fully reflect the directives of the constitution, thus necessitating a comprehensive evaluation and improvement to optimally achieve the objectives of health service delivery.

Considering the existing reality, there is a clear gap in the funding of Individual Health Efforts. The ideal concept of health development in Indonesia has been explicitly regulated in the 1945 Constitution, further clarified through its implementing regulations,

namely the Regional Government Law and the Health Law. Both laws emphasize that local governments bear significant responsibility for funding the health sector, which includes funding for Individual Health Efforts. However, in practice, funding for Individual Health Efforts under the National Health Insurance Program, based on the National Social Security System Law and the Social Security Agency Law, is implemented centrally. This results in a lack of local government involvement in the funding process, creating a disparity between existing policies and the reality on the ground.

Regional governments, both at the provincial and district/city levels, constitute an integral component of the governmental structure of the Republic of Indonesia. In the context of decentralization principles, regional governments are granted broad autonomy to manage and develop their territories, including in the aspect of health development. Therefore, to realize effective Individual Health Efforts, adequate funding support is essential. This provision is clearly stipulated in Regional Government Law and is also addressed in Article 401 paragraph (3) and Article 403 of the newly enacted Health Law. Both articles emphasize that regional governments have significant responsibilities regarding the funding of the health sector, which is a crucial part of efforts to enhance public health quality.

Since the launch of the National Health Insurance program in 2014, funding for Individual Health Efforts has been centrally managed by the Health Social Security Agency within a single framework. This approach clearly contradicts the principle of decentralization as stipulated in the Regional Government Law. The law emphasizes that the health sector is one of the fields that should be managed in a decentralized manner, including funding for Individual Health Efforts. Furthermore, this policy is also inconsistent with the provisions of the more recent Health Law, which underscores the importance of the role of Local Governments in being responsible for health funding. In other words, this centralized management has the potential to impede the optimization of health policy implementation at the local level, which should be more responsive to the needs of the community.

Based on the explanations provided previously, the primary focus of this research lies in two fundamental issues. First, it examines the consistency between the National Social Security System Law and the Social Security Agency Law in the context of fulfilling the principles enshrined in the 1945 Constitution of the Republic of Indonesia. This includes an analysis of how these two laws integrate with the Regional Government Law and the Health Law to achieve the comprehensive goal of Health Justice. Second, this study also aims to explore the role of local governments in the funding process for Individual Health Efforts related to the National Health Insurance program. In this regard, it is essential to understand the extent of local government contributions in ensuring the sustainability and effectiveness of the National Health Insurance program through optimal funding

mechanisms and supportive policies, so that the objective of providing equitable and fair health services can be achieved.

2. Method

In this study, the author employs a normative juridical approach based on secondary data obtained through library research. This approach is utilized to examine various legal norms relevant to health service funding by local governments through the National Health Insurance program. The method employed in this research is a literature study, where the author conducts an in-depth analysis of various legal sources related to the discussed topic.

The legal sources analyzed include both primary and secondary legal materials, such as statutes and relevant data. These sources encompass the National Social Security System Law, the Social Security Agency Law, the Regional Government Law, and the Health Law. Additionally, this research also refers to Constitutional Court Decision No. 007/PUU-III/2005, as well as data from various institutions such as the Directorate General of Financial Balance of the Ministry of Finance, the Central Statistics Agency, the National Social Security Council, and the Health Social Security Agency. All information obtained from these various sources is systematically processed to produce a comprehensive understanding of the legal issues being investigated.

This research adopts an explanatory nature by applying a legislative approach, commonly known as the statute approach. The primary objective of this study is to provide an in-depth analysis and offer alternative solutions to the identified issues. It is hoped that the solutions proposed in this study can serve as constructive recommendations for enhancing the implementation of the National Health Insurance Program in the future.

3. Discussion

3.1. National Health Insurance Arrangements from a Stufenbau Theory Perspective

Hans Kelsen argues that the validity of a legal norm cannot stand alone; it must be based on a higher legal norm, which ultimately leads to the concept of grundnorm. In the context of Indonesia, Pancasila and the 1945 Constitution serve as the grundnorm, or, in Hans Nawiasky's terminology,[1] are referred to as the statfundamentalnorm for our nation.[2] Both serve as the foundation for all prevailing legislation. Therefore, every legal product produced must adhere to the principles of Pancasila and the 1945 Constitution. In line with this, Notonagoro, as cited by Teguh Prasetyo and Abdul Halim Barkatullah,

[1] Jimly Asshiddiqie, *Teori Hierarki Norma Hukum*, Kedua (Jakarta: Konstitusi Press, 2021).
[2] Achmad Ali, *Menguak Teori Hukum Legal Theory Dan Teori Peradilan Judicialprudance* (Makassar: Kencana, 2007).

emphasizes that any law formulated must consider the fundamental values enshrined in the Preamble of the 1945 Constitution, which embody the essence of Pancasila itself.[3]

The universally recognized legal principle of lex superior derogate legi inferior mandates that the hierarchy of legal norms be strictly observed. According to this principle, a lower legal norm must not conflict with a higher legal norm within the hierarchy of laws and regulations. This emphasizes the necessity that every level of norm must align with the superior rules. For instance, as noted by Jimly Asshiddiqie, the relationship between legal norms must be structured hierarchically, so that a lower norm automatically becomes invalid if it conflicts with a higher norm.[4] More clearly, Teguh Prasetyo explains that no law in Indonesia can stand alone without recognizing that its entire structure, content, mechanisms, objectives, and functions are based on Pancasila as the foundational basis of the positive legal system in Indonesia.[5]

The legislation governing the implementation of the National Health Insurance by the Health Social Security Agency is not entirely in alignment with the legal principles that should serve as the primary reference. The National Social Security System Law and the Social Security Agency Law reveal inconsistencies with the provisions of the 1945 Constitution. These inconsistencies create issues in their application, as both laws are also not harmonized with other relevant regulations, such as the Regional Government Law and the Health Law. Consequently, there is a potential for overlapping implementation, which risks undermining the clarity of responsibilities among the various parties involved in administering health insurance in Indonesia.

There are several provisions deemed inconsistent with the 1945 Constitution concerning the regulation of Health Social Security Agency. First, Health Social Security Agency is regulated as the sole and centralized social security agency. Although the Social Security Agency Law does not explicitly state that Health Social Security Agency is the only social security agency, upon closer examination of the provisions within the law, such as Article 1 (1), Article 5 (1), Article 6 (1), Article 10, Article 11, and Article 14, it can be inferred that the law implicitly restricts the existence of other institutions besides Health Social Security Agency as social security administrators. This is also reflected in practice, where Health Social Security Agency acts as the sole body carrying out such functions.

Second, the 1945 Constitution explicitly mandates that regional governments are responsible for developing healthcare systems within their jurisdictions. This mandate is further elaborated in Regional Government Law, specifically in Article 22 H, which was subsequently updated by Law No. 23 of 2014. Moreover, the latest Health Law reinforces the notion that the health sector is one of the areas that must be funded by regional governments, thus making the responsibility for the provision of healthcare services in

[3] Teguh Prasetyo and Abdul Halim Barkatullah, *Filsafat, Teori, Dan Ilmu Hukum : Pemikiran Menuju Masyarakat Yang Berkeadilan Dan Bermartabat* (Depok: RajaGrafindo Persada, 2020).
[4] Asshiddiqie, *Teori Hierarki Norma Hukum*.
[5] Teguh Prasetyo, *Keadilan Bermartabat: Perspektif Teori Hukum* (Bandung: Nusa Media, 2019).

the regions part of the obligations that must be fulfilled by regional governments in accordance with the principle of decentralization in Indonesia's governance system

As a consequence, the impact of this condition significantly affects the achievement of development goals in the health sector, particularly in realizing Health Equity for all Indonesian citizens. This challenge is further reinforced by empirical findings from research conducted on the monitoring of the National Health Insurance implementation during the period from 2014 to 2019. The results of this study indicate a significant increase in the disparities between developing and underdeveloped regions. These disparities are particularly evident in terms of access to health services, the availability of health facilities, and the distribution of doctors and other healthcare professionals, which remains highly uneven to this day. Given this situation, efforts to achieve equitable access to health services become increasingly complex and require more strategic attention and intervention from all relevant parties.[6]

3.2. The Role of Local Government in the National Health Insurance Program

In the context of reform, a profound awareness emerged regarding the inadequacy of the New Order government system, which focused on central government dominance, in fostering active community participation and optimizing the uniqueness and potential of each region in the development process. During that time, the development approach employed was predominantly centralistic, wherein all aspects of development policy—from the planning stage, implementation, financing, to oversight—were entirely managed by the central government. This resulted in limited space for communities and regions to actively participate in development, which should be inclusive and empowering.

A centralistic system has several disadvantages, one of which is its inability to accommodate the particularities and uniqueness of each region. This includes local potential, cultural backgrounds, geographical conditions, as well as various issues and challenges faced by each area. Moreover, the differing needs and priority scales in each region are often overlooked. The diversity that characterizes Indonesia should be celebrated and taken into account; however, it is frequently homogenized from the perspective and interests of the central government. The expansion of the range of development control also contributes to processes that become less effective and efficient. In this context, the Second Amendment to the 1945 Constitution, which introduced regulations regarding regional autonomy, serves as a turning point for the implementation of decentralization that is more targeted and responsive to local community needs.

[6] Trisnantoro, *Kebijakan Pembiayaan Dan Fragmentasi Sistem Kesehatan*.

Decentralization fundamentally aims to enhance efficiency in both the production process and the distribution of public services. It is anticipated that this will improve the quality of decision-making by leveraging locally relevant information that aligns more closely with the needs of the local community. Additionally, decentralization is expected to increase governmental accountability and strengthen responsiveness to the circumstances and needs present in the regions. As articulated by Margherita Giannoni and Theodore Hitiris, the underlying principle of decentralization is to place power and responsibility closer to the populace.[7] According to Silverman, local governments tend to be more responsive than central authorities, and the policies adopted by local governments better reflect the aspirations and needs of the community.[8] Therefore, through the process of decentralization, the relationship between the government and the community can become more integrated, fostering active citizen participation in decision-making that affects their lives. This not only cultivates a sense of ownership among the populace but also ensures that the implemented policies are genuinely relevant and effective in addressing local needs.[9]

In 2014, the Indonesian government ratified a new Regional Governance Law, namely Law No. 23 of 2014. In the preamble of the law, it is stated that its establishment is not only an implementation of the mandate of Article 18, paragraph (7) of the 1945 Constitution, but also aims to enhance public participation, as well as efficiency and effectiveness in the administration of regional governance. This is expected to support the achievement of comprehensive public welfare. Furthermore, in Chapter VI, Articles 18, 18A, and 18B of the 1945 Constitution, it is emphasized that regional governments, both at the provincial and district/city levels, are an integral part of the governance structure of the Republic of Indonesia. Regional governments are granted the authority to formulate and enact regional regulations governing various local matters, provided that the limitations of such authority adhere to the provisions set forth in the law.[10]

Teguh Prasetyo argues that regional regulations, established by each local government in the context of implementing regional autonomy, constitute one of the sources of law in the formal sense within their respective jurisdictions.[11] As part of the hierarchy of legislation, regional regulations must adhere to the supervisory and control mechanisms provided by law, both through preventive and repressive approaches. In this context, preventive supervision aims to ensure that such regulations do not conflict with

[7] Margherita Giannoni and Theodore Hitiris, "The Regional Impact of Health Care Expenditure: The Case of Italy," *Applied Economics* 34, no. 14 (September 2002): 1829–36, https://doi.org/10.1080/00036840210126809.
[8] Anne Mills, "Decentralization and Accountability in the Health Sector from an International Perspective: What Are the Choices?," *Public Administration and Development* 14, no. 3 (January 2, 1994): 281–92, https://doi.org/10.1002/pad.4230140305.
[9] Mills.
[10] Teguh Prasetyo, *Pengantar Ilmu Hukum* (Depok: Rajawali Press, 2021).
[11] Prasetyo.

higher-level laws before their enactment, while repressive supervision is carried out post-enactment to assess their compliance with existing legal norms. Therefore, regional regulations are derivative legal products, subordinate to higher laws, but they must also take into account the specific characteristics of each respective region to address local needs and circumstances without violating broader legal provisions.

The division of authority between the central, provincial, and regency/municipal governments has been clearly regulated in various laws and regulations, taking into account the characteristics and diversity of each region in Indonesia. As stipulated in Article 18A paragraph (1) of the 1945 Constitution, this distribution of authority is not only formal but also adjusted to the unique features of each region. Furthermore, Regional Government Law, through Article 9 paragraph (1), confirms that governmental affairs are classified into three main categories: absolute government affairs, concurrent government affairs, and general government affairs. Absolute government affairs refer to full authority exercised by the central government without the involvement of regional governments. Meanwhile, concurrent government affairs serve as the basis for the implementation of regional autonomy, divided between the central government, provinces, and regencies/municipalities. Article 11 paragraphs (1) and (2) of the law further specifies that these concurrent affairs are divided into two types: mandatory and discretionary affairs. Mandatory affairs cover various sectors that are fundamental to the public, one of which is the health sector, as regulated in Article 11 paragraph (3) and Article 12 paragraph (1) letter b, which mandates that regional governments must provide healthcare services to the public.

The implementation of concurrent affairs between the central and regional governments results in the obligation of the central government to allocate a certain amount of funds to the regional governments.[12] In this regard, each year the Ministry of Finance transfers General Allocation Funds and Special Allocation Funds to the regional governments. These funds, together with locally generated revenue, form the primary sources of financing for the Regional Revenue and Expenditure Budget. Concerning the health sector, the previous Health Law mandated that a minimum of 10% of the Regional Revenue and Expenditure Budget be allocated for health sector financing.[13] In order to strengthen the legal basis for funding Individual Health Efforts through the National Health Insurance program, the government subsequently enacted the National Social Security System Law. However, in 2005, the Constitutional Court granted a judicial review request filed under case Number 007/PUU-III/2005 by an interested party. The Petitioners argued that Articles 5 paragraphs (2), (3), and (4) of the National Social

[12] Amelia Martira and Harsanto Nursandi, "Hubungan Keuangan Pemerintah Pusat Dan Daerah Dalam Penyelenggaraan Jaminan Kesehataan Nasional," *Jurnal Hukum & Pembangunan* 50, no. 1 (2020): 177–99.
[13] Marihot Nasution, "Studi Atas Belanja Kesehatan Pemerintah Daerah Di Indonesia," *Jurnal Budget: Isu Dan Masalah Keuangan Negara* 7, no. 1 (2022): 149–64.

Security System Law limited the authority of regional governments in the administration and development of social security programs in their respective regions.

The expert presented by the petitioner, Ali Ghufron Mukti, at that time stated that Indonesia, with its highly diverse demographic conditions, cultures, and levels of infrastructure development, cannot be managed through a monopolistic and centralistic approach as it would lead to injustice. A monopolistic centralization in the administration of the National Health Insurance is contrary to the reality of varying levels of infrastructure, community cultures, hospital rates, distribution of healthcare personnel, and so on, between different regions. Consequently, access to healthcare services for communities in underdeveloped areas becomes severely limited. The contributions paid by communities in underdeveloped areas are utilized by those in more advanced and developed regions. Moreover, the centralistic nature causes local resources to be absorbed by the central governing body, resulting in underdeveloped regions being further marginalized. What he conveyed during the Constitutional Court of the Republic of Indonesia session in 2005 now seems prophetic, as it has become a reality.

The Constitutional Court of the Republic of Indonesia ruled that Article 5 paragraphs (2), (3), and (4) were inconsistent with the 1945 Constitution and therefore have no binding legal force. In its consideration, based on Article 18 paragraph (5) of the 1945 Constitution, further regulated in Law No. 32 of 2004 on Regional Governance, particularly Article 22 letter h, the Constitutional Court of the Republic of Indonesia stated that the development of a social security system is a state duty, which falls under the authority of both the Central Government and Regional Governments. Therefore, the National Social Security System Law should not preclude Regional Governments from participating in the development of a social security system, and the implementation of such a system by the regions can be sufficiently based on local regulations alone.

It is evident that the Constitutional Court of the Republic of Indonesia's ruling further affirms the role of regional governments in the health sector and reminds all stakeholders that health and its funding are sectors that have been decentralized from the central government to the regions. This Constitutional Court decision must be regarded as an inseparable addendum to the National Social Security System Law in its entirety.[14] Regarding the ruling, Diah Arimbi argues that the state's social service function to its people requires authority to be effectively executed.[15] The authority of Regional Governments is guaranteed by the 1945 Constitution, the Regional Governance Law, the Constitutional Court of the Republic of Indonesia's ruling, and the latest Health Law. Therefore, in fact, Regional Governments already have the authority to carry out health funding functions, including the funding of Individual Health Efforts within the healthcare

[14] Jimly Asshiddiqie, *Konstitusi Keadilan Sosial: Serial Gagasan Konstitusi Sosial Negara Kesejahteraan Sosial Indonesia* (Jakarta: Kompas, 2018).
[15] Diah Arimbi, *Konsep Dasar Hukum Penyelenggaraan Jaminan Kesehatan Nasional Di Indonesia* (Banyumas: Wawasan Ilmu, 2022).

insurance program. This is a logical consequence of regional autonomy, as stipulated in Article 18 paragraph (2) of the 1945 Constitution, which states that "The provincial, regency, and municipal governments shall manage and regulate their own governmental affairs according to the principles of autonomy and co-administration," while paragraph (5) states that autonomy shall be exercised to the fullest extent, except for matters that have been determined as the affairs of the central government.

3.3. The Enactment of he Centralized Social Security Agency Law Disregards the 1945 Constitution of the Republic of Indonesia

Following the decision of the Constitutional Court of the Republic of Indonesia, the Law on the Social Security Agency was established as an implementing regulation of the National Social Security System Law. Although the academic text of the Social Security Agency Bill clearly states the importance of formulating the Social Security Agency Law to accommodate the Constitutional Court's decision, which allows local governments to develop health insurance, this aspect is not mentioned at all in the enacted Social Security Agency Law. There is no explicit statement regarding the authority of local governments in the administration of social security, whether permitted or not. Elizabeth Pisani, Maarten Olivier Kok, and Kharisma Nugroho note that the drafting and approval process of the two National Health Insurance laws was dominated more by political and economic tug-of-war than by technical aspects.[16] Furthermore, ideological discussions regarding the concept of equitable access to health insurance, which is a manifestation of the principles of social justice, and discussions about the fiscal burden on the government to finance the benefits included in the National Health Insurance did not occur during the approval process.[17]

In practice, the administration of the National Health Insurance by the Social Security Agency does not involve local governments at all, leading to a highly centralized system. It should be reiterated here that according to Article 18 paragraph (5) of the 1945 Constitution, as further elaborated in Article 22 letter h of the Regional Government Law, and confirmed by the decision of the Constitutional Court of the Republic of Indonesia, the development of the social security system, including health insurance, is a decentralized sector. Additionally, granting authority to local governments has a very logical basis, as most healthcare facilities, where health services are provided, are located in the regions and are owned by local governments. The regional government, where health service activities take place, is the state entity closest to the people, thus being more responsive to the needs of the communities in their respective areas.

[16] Elizabeth Pisani, Maarten Olivier Kok, and Kharisma Nugroho, "Indonesia's Road to Universal Health Coverage: A Political Journey," *Health Policy and Planning* 32, no. 2 (September 6, 2016): 267–276, https://doi.org/10.1093/heapol/czw120.
[17] Pisani, Olivier Kok, and Nugroho.

Consequently, the involvement of local governments is expected to encourage public participation in the administration of the National Health Insurance.[18]

3.4. Efforts to Eliminate Local Government Authority in the Development of Regional Health Insurance

The act of disregarding the provisions set forth in the Regional Government Law, as well as the decisions issued by the Constitutional Court of the Republic of Indonesia and the stipulations in the 1945 Constitution, strongly indicates that such measures were taken to create a legal basis that facilitates and simplifies the implementation of the monopolistic and centralized National Health Insurance Program. This practice suggests a tendency to prioritize specific interests, potentially undermining the principles of decentralization and regional autonomy, which should serve as the foundation for good governance. This raises concerns about the negative impact on public participation and equity in access to healthcare services, which should be regulated in a fair and transparent manner in accordance with applicable laws.

Alongside the commencement of the National Health Insurance program in 2014, Law No. 23 of 2014 was enacted as the new Regional Government Law. This was implemented to meet the needs of a monopolistic and centralized National Health Insurance system. In the previous law, Article 22 (h) stipulated that regions were also required to develop a social security system. However, in the new law, the substance of Article 22 (h) has been removed. It is noteworthy that Article 22(h), which is a derivation of Article 18 paragraphs (2) and (5) of the 1945 Constitution of the Republic of Indonesia, served as the basis for the Constitutional Court's consideration in ruling on Case No. 007/PUU-III/2005. The series of these facts makes it difficult to avoid the conclusion that the efforts to eliminate regional authority in developing regional health insurance are systematic!

The implementation of the National Health Insurance in a centralized manner (regulated by the Social Security Administration Agency Law) is not without justification. The primary argument presented is that a centralized approach is designed to achieve more efficient economies of scale and uniformity in the administration of the National Health Insurance across Indonesia. By adopting this centralized approach, it is hoped that the Health Social Security Administration Agency can collect contributions from all participants collectively, which will then be used to finance the healthcare services required by participants in various regions. However, this argument appears somewhat tenuous for two reasons. First, the argument is based on considerations of income and

[18] AS Ambariani, *Laporan Kajian Penentuan Besaran Unit Cost, Penyerapan Klaim INA-CBG's, Dan Kebijakan Pemanfaatan Dana Sisa Dalam Monitoring Penyelenggaraan Program JKN Di Provinsi NTT* (Yogyakarta: Pusat Kebijakan Manajemen Kesehatan Fakultas Kedokteran Universitas Gadjah Mada, 2015).

expenditure, culminating in a profit-and-loss calculation that lacks dignity when articulated in the context of social insurance such as the National Health Insurance.

Second, centralization and uniformity are characteristics of the New Order that disregard the diversity and potential of the regions. This uniformity has serious consequences, constituting a violation of the principles of justice as articulated by Aristotle, Aquinas, and others, which state that members of society or different groups should be treated differently and not homogenized, as is currently done by the Health Social Security Administration Agency. From the perspective of John Rawls' Theory of Justice as Fairness, the homogenization of the entire population in our society has placed lower strata community groups in an unfair position, who should receive special treatment or support from the state.

3.5. Health Resources: Unevenly Distributed and Managed Differently

In an effort to realize the expected health equity, all health resources regulated by the Health Law must be evenly available throughout all corners of Indonesia. Furthermore, each of these health resources must operate synergistically and harmoniously, in accordance with the established principles of regional autonomy. There are two crucial aspects of health resources that are closely related to health financing, namely Health Service Facilities and Human Health Resources. However, both of these aspects still face a number of challenges. First, the existence of Health Service Facilities in various regions, especially in remote areas, remains severely limited. Second, no less important is the issue of the distribution and availability of Human Health Resources, which includes medical personnel and healthcare workers from diverse educational backgrounds. This issue requires serious attention to ensure that all Indonesian citizens can enjoy adequate and quality access to health services.

The availability of a resource cannot be separated from the existence of other resources, as, without proper synergy, any achievements within the National Health Insurance system, even if obtained through effective social insurance, will be in vain. It is evident that without adequate and sufficient healthcare facilities, as well as trained and sufficient healthcare personnel, the provision of equitable and comprehensive healthcare services—which is the essence of Health Justice—will not be realized. On the other hand, even if healthcare facilities and personnel are available, this will be meaningless if not supported by adequate funding. In this context, both the central government, local governments, and private entities have made significant efforts to enhance the availability of healthcare facilities, at both primary and referral levels. Furthermore, efforts to provide and distribute medical personnel and healthcare workers have been implemented through various programs, such as the Presidential Instruction Doctor Program, the Non-Permanent Employee Doctor Program, and the Village Midwife Program. Although these measures have not yet been fully optimized and still leave many

challenges, particularly in underdeveloped regions and in Eastern Indonesia, the spirit of regional autonomy has encouraged local governments to actively participate in achieving better decentralization of healthcare services. Thus, collaboration among various parties becomes crucial in attaining this goal, aiming for a more inclusive and equitable healthcare system.

When other Health Resources have progressed in the right direction, in a decentralized manner in accordance with the Regional Autonomy Law, unfortunately, Health Funding within the National Health Insurance Program is managed by the Health Social Security Agency in the opposite direction, namely in a centralized manner. Health Social Security Agency has become the sole administrator, managing all Health Funding for Individual Health Efforts across all geographically diverse regions of Indonesia, each facing different issues and having distinct health needs in both the short and long term. As a result, there has been a standardization in addressing all health issues in the regions. If consistent with the 1945 Constitution, the Regional Government Law (version 2004), and the latest Health Law of 2023, Health Funding should also be managed in a decentralized manner by amending the Law on the Social Security Administration Agency. This would prevent the Health Social Security Agency from being the sole administrator managing all regions of Indonesia with their geographical diversity, demographic differences, varied issues, and distinct health needs in both the short and long term. Thus, standardization in addressing all health financing issues in the regions would be avoided.

3.6. Management of Health Insurance through an Integrated Decentralization Concept

At the onset of the reform era, prior to the establishment of the Health Social Security Organizing Agency, various regions had already implemented Regional Health Insurance schemes such as the Regional Health Insurance of Balikpapan City, Jembrana Regency, Sinjai Regency, Purbalingga Regency, Gowa Regency, the Social Health Insurance of the Special Region of Yogyakarta, and the Regional Health Insurance of the Special Capital Region of Jakarta, among others. These Regional Health Insurance schemes were established based on the Health Law of 1992. However, the existence of the National Social Security System Law, particularly Article 5, has obstructed regional opportunities to fulfill their obligations in developing regional health insurance.

The Constitutional Court's decision to annul paragraphs (2), (3), and (4) of Article 5 of the National Social Security System Law should have further solidified the legal foundation for the implementation of regional health insurance. Nevertheless, when the Law on the Organizing Agency for Social Security was enacted in 2011, it did not explicitly regulate this matter. In practice, the Health Social Security Organizing Agency has been implemented in a monopolistic centralist manner. The existing Regional Health Insurance programs, which were funded through the Regional Revenue and Expenditure Budget,

were even instructed to integrate into the Health Social Security Organizing Agency. The Ministry of Home Affairs issued Letter No. 440/3890/SJ to all regional heads, urging for immediate integration. The National Development Planning Agency of the Republic of Indonesia and the National Social Security Council drafted a roadmap for the integration of Regional Health Insurance, which was expected to be completed by 2016. However, this did not align with the desires of the constitution and the further regulatory provisions governing it. The Constitutional Court's ruling, which references letter h of Article 22 of the Regional Government Law and also refers to Article 18, paragraphs (2) and (5) of the 1945 Constitution, states that regions are authorized to develop their social security systems.

Ali Ghufron Mukti suggests managing health insurance through an Integrated Decentralization concept.[19] Public health efforts, which are publicly funded, are centrally financed by the central government, while Individual Health Efforts, which are private sector initiatives, should be financed by regional governments through an integrated decentralization concept, leading towards an insurance or social security system. The term "integrated" is intended to ensure that the management of health insurance in a region is not exclusive and addresses portability issues. As a foundational strategy for management, Ali Ghufron Mukti recommends that the institutional form of the Regional Health Insurance program be a non-profit-oriented Public Service Agency.[20]

Monitoring and oversight of Regional Health Insurance will be facilitated by advancements in information systems and technology. According to Article 402 of the new Health Law, the central government is tasked with monitoring all activities related to health financing by all stakeholders. The realization of expenditures and outcomes from such funding activities must be reported annually through the health financing information system. Nirvikar Singh shares his experience in the health decentralization process in India, stating that decentralization improves local responsiveness, but for optimal results, it must be preceded by capacity-building at the local (regional) level.[21] This implies that regional governments need to be prepared and their capacities enhanced if their roles in health insurance administration are to be expanded.

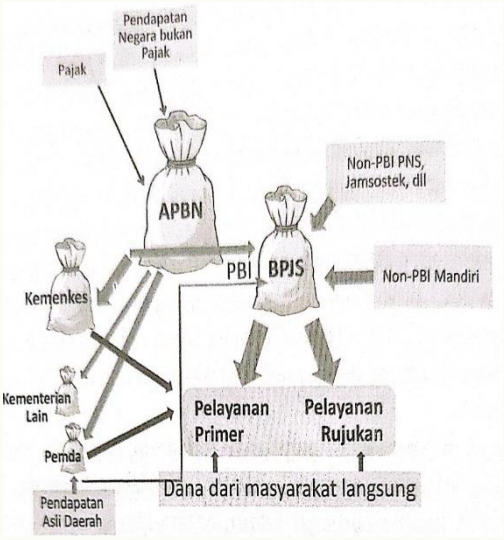
3.7. The Regional Financial Situation in Funding Individual Health Efforts

In principle, healthcare financing in Indonesia is sourced from various entities, with the primary contribution coming from the central government through the State Revenue and Expenditure Budget, derived from both tax and non-tax revenues. Additionally, regional governments also play a role through the allocation of the Regional Revenue and

[19] Mukti, *Sistem Jaminan Kesehatan: Konsep Desentralisasi Terintegrasi*.
[20] Mukti.
[21] Nirvikar Singh, "Decentralization and Public Delivery of Health Care Services in India," *Health Affairs* 27, no. 4 (July 2008): 991–1001, https://doi.org/10.1377/hlthaff.27.4.991.

Expenditure Budget. On the other hand, the public directly contributes through premium payments managed by the Social Security Agency for Health, which serves as a fund collection mechanism from the public to support the national health insurance program (see Figure 1).[22]

Figure 1. Concept of the Health Financing System



In the state financial management system, funds allocated to the health sector are primarily sourced from the State Revenue and Expenditure Budget, with the main distribution being carried out through the Ministry of Health. However, there are also several health sector programs whose funding is not solely reliant on the Ministry of Health, but also involves other relevant ministries or agencies. Meanwhile, at the regional level, the budget allocated to the health sector is regulated within the Regional Revenue and Expenditure Budget. The main source of the Regional Revenue and Expenditure Budget comes from Local Revenue, supplemented by Transfers from the Central Government, whether through the General Allocation Fund or the Special Allocation Fund. These two types of transfers are constitutionally mandated as a form of the central government's commitment to the implementation of Regional Autonomy. The combination of these funding sources aims to ensure continuity and stability in the financing of the health sector at the regional level.

The funding sources for the Regional Revenue and Expenditure Budget consist of Local Own Revenue and Transfers from the Central Government, which are distributed

[22] Trisnantoro, *Kebijakan Pembiayaan Dan Fragmentasi Sistem Kesehatan*.

through the General Allocation Fund and the Specific Allocation Fund. These funds are manifestations of the constitutional mandate that arises as part of the implementation of Regional Autonomy. For instance, the realization of Local Own Revenue in 2021 for each province, where the national total reached IDR 166.5 trillion.[23] During the same period, the amount of transfers from the central government, amounted to IDR 690.67 trillion.[24] When making a comparison, it is evident that the contribution of Local Own Revenue to the total regional funding remains very low, averaging only about 24% of the total transfer funds received from the central government, indicating a significant disparity in the regional financing structure.

Pursuant to the provisions of the latest Health Law, the health budget is allocated to support 23 Health Efforts, which encompass Public Health Efforts and Individual Health Efforts. Within each of these Health Efforts, there are interconnected elements of Public Health Efforts and Individual Health Efforts. Public Health Efforts, classified as public goods, are fully financed by the State Revenue and Expenditure Budget or the Regional Revenue and Expenditure Budget. This indicates that the financing of Public Health Efforts cannot be sourced from individual private funds or through insurance, including the National Health Insurance. Conversely, Individual Health Efforts, categorized as private goods, may be funded through sources such as personal funds, insurance, or social insurance systems, including the National Health Insurance. Nevertheless, there is an allocation of funds from the State Revenue and Expenditure Budget specifically designated for financing Individual Health Efforts for those classified as poor or underprivileged, such as the Premium Assistance Beneficiaries fund contributed by the government to the Social Security Organizing Agency. Furthermore, as illustrated in Figure 1, local governments also allocate certain funds to the Social Security Organizing Agency in the form of Premium Assistance Beneficiaries from the Regional Revenue and Expenditure Budget. In 2021, the total budget almost reached IDR 14.3 trillion, which is equivalent to approximately one-third of the total Premium Assistance Beneficiaries from the State Revenue and Expenditure Budget (IDR 46,997 trillion).[25]

3.7. The Allocation of the Regional Revenue and Expenditure Budget for Health

Within the framework of health regulations, the previous Health Law mandated a requirement for mandatory spending by provincial and district/city governments, set at 10% of the Regional Revenue and Expenditure Budget, excluding employee salary components. However, in the amendments provided by the new Health Law, the provisions concerning this mandatory spending requirement have not been continued. Instead, this law introduces the concept of mandatory services, which requires local governments to first develop and submit a

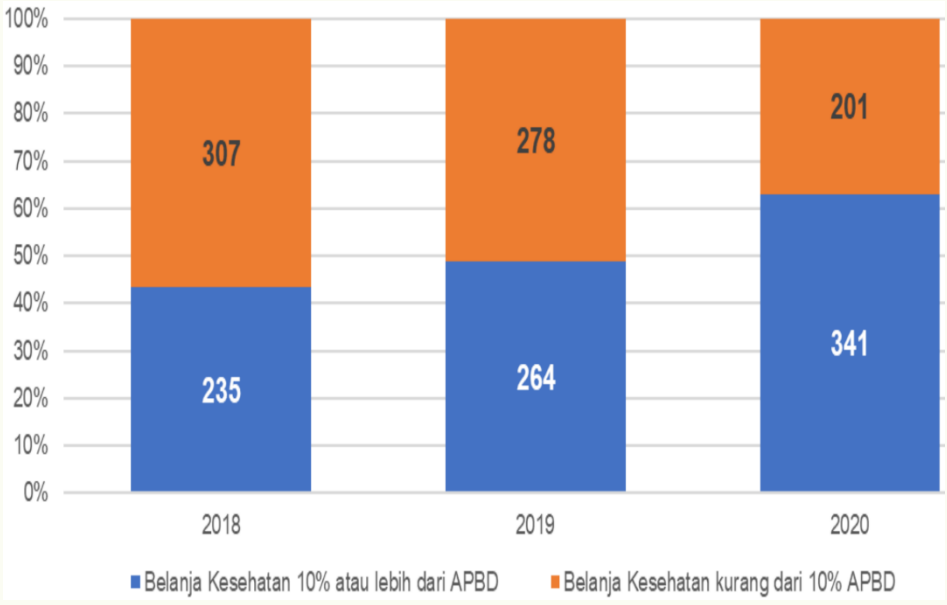
[23] Badan Pusat Statistik, *Statistik Keuangan Pemerintah Provinsi 2021 – 2022* (Jakarta: Badan Pusat Statistik, 2022).
[24] Direktorat Jenderal Perimbangan Keuangan Kementerian Keuangan, *Daftar Alokasi Dana Transfer Ke Daerah Dan Dana Desa Tahun Anggaran 2021* (Jakarta: Direktorat Jenderal Perimbangan Keuangan Kementerian Keuangan, 2021).
[25] Dewan Jaminan Sosial Nasional, *Statistik JKN 2016 – 2021* (Jakarta: Dewan Jaminan Sosial Nasional, 2023).

detailed list of activities eligible for funding allocation. This approach is expected to provide flexibility for local governments in managing their budgets and adapting health activities to meet local community needs.

In the context of budget preparation, both from the State Revenue and Expenditure Budget and the Regional Revenue and Expenditure Budget, Article 409 paragraph (1) of the Health Law emphasizes the importance of prioritizing programs and activities related to health. Conversely, Article 409 paragraph (4) asserts that budget allocations in the Regional Revenue and Expenditure Budget must be adjusted to the specific health needs of each region while also referring to the established national health programs. Therefore, this mandatory service should be optimally utilized to enrich the list of fundable activities, with a minimum target of 10% of the total available the Regional Revenue and Expenditure Budget funds. This approach not only reflects the government's commitment to enhancing the quality of health services but also demonstrates an effort to create coherence between regional and national health policies to establish a more effective and responsive health system that meets the needs of the community.

It should be noted that the provisions regarding mandatory expenditures, which mandate an allocation of 10% of the Regional Revenue and Expenditure Budget for the health sector, have not yet been fully implemented by the local government. This indicates challenges in fulfilling the legal mandate that is expected to strengthen the health system in the region, while also reflecting the expansion of the government's responsibilities in providing quality healthcare services to the community. Therefore, it is essential for the authorities to evaluate the implementation of this policy to ensure that the budget allocation is more effective and aligns with the goals of enhancing optimal healthcare services.

Figure 2. Realization of Health Expenditure at 10% of the Regional Revenue and Expenditure Budget.



Data Source: Nasution, M. (2022). Studi Atas Belanja Kesehatan Pemerintah Daerah di Indonesia. Jurnal Budget: Isu Dan Masalah Keuangan Negara, 7(1), 149-164.

Based on the data presented in Figure 2, it is evident that in 2019, only about half, or 50%, of local governments had complied with the mandatory spending provisions. In the following year, 2020, this proportion increased to approximately 60%. However, it is important to note that this figure was derived by including employee salaries as part of mandatory spending. This practice contradicts the applicable regulations, as expressed by Marihot Nasution.[26] The inclusion of employee salaries in the category of mandatory spending raises questions regarding local governments' compliance with established regulations and its implications for the overall effectiveness of regional budget management.

In 2021, the local government recorded a contribution of IDR 14.3 trillion to the Health Insurance Premium from the Regional Revenue and Expenditure Budget, which accounted for only 1.9% of the total regional budget. While there is a possibility that the remaining Regional Revenue and Expenditure Budget funds may be allocated for other Public Health Efforts, it should be noted that, aside from the funds deposited into the Social Security Agency as part of the Health Insurance Premium Regional Revenue and Expenditure Budget, there is no valid and comprehensive data regarding the budgetary expenditures made by the local government to fulfill its mandatory spending obligations. This indicates a gap in the transparency and accountability of regional budget usage, which is critical to evaluate to ensure the effective utilization of public funds in enhancing healthcare services for the community.

In 2021, the Ministry of Finance transferred funds for Regional Transfers and Village Funds to the regions, amounting to IDR 690.670 trillion. Additionally, each region recorded Original Regional Revenue of IDR 166.5 trillion. By summing these two sources of funding, the total Regional Revenue and Expenditure Budget for 2021 reflects a national figure of IDR 857 trillion. Referring to the provisions of the Health Law applicable prior to its amendment, mandatory expenditures established by law are set at 10% of the total Regional Revenue and Expenditure Budget, resulting in a total of IDR 85.7 trillion for all regions of Indonesia. These funds must be distributed and allocated proportionally to Public Health Efforts and Individual Health Efforts operating within 23 Health Initiatives. The balance of allocation in each region will vary, depending on the health priorities established by each locality. For example, if this fund allocation is assumed to be evenly divided between Public Health Efforts and Individual Health Efforts, each would receive a share of 50%, thus bringing the total allocation for Individual Health Efforts to IDR 43 trillion. However, compared to this figure, the contribution budgeted through the Contribution Assistance Program from the Regional Revenue and Expenditure Budget, amounting to IDR 14.3 trillion, only meets about one-third of the total funding allocation required. This indicates a discrepancy between the actual funding needs and the available

[26] Nasution, "Studi Atas Belanja Kesehatan Pemerintah Daerah Di Indonesia."

funds, necessitating further efforts to ensure that allocations can meet the demands for optimal healthcare services in the community.

4. Conclusion

After conducting a thorough analysis and discussion, two main issues have been identified that require attention. First, there is a discrepancy in the funding of Individual Health Efforts within the framework of the National Health Insurance Program managed by the Health Social Security Administration Agency. This indicates an inconsistency with the principles enshrined in the 1945 Constitution of the Republic of Indonesia and contradicts the provisions outlined Regional Government Law and Health Law. Second, the role of local government in funding Personal Health Efforts within the National Health Insurance Program appears to receive insufficient attention, leading to a lack of alignment in the implementation of the program. This situation has the potential to hinder the achievement of primary objectives in health development, which should focus on the principle of Health Equity. Therefore, it is imperative to implement the necessary improvements and adjustments to ensure the realization of inclusive and equitable health development goals.

There are some suggestions that researchers can convey through this research, including:

a. Corrections need to be made to the Social Security Agency Law so that the implementation of National Health Insurance Program by Health Social Security Administration Agency does not have a centralized character, by explicitly stating the authority of regional governments in terms of Health Funding.
b. Funding for individual health efforts as mandated by the constitution must involve regional governments. Regional governments with the assistance of the central government must develop their own health insurance in the regions.

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