E-ISSN: 2776-9674
ISSN : 2776-9259
ILREJ, Vol 4, No 3, 2024

INDONESIA LAW REFORM JOURNAL

Optimal Design of Social Insurance Frameworks in National Health Insurance

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Abstract

The national health insurance program in Indonesia aims to ensure assurance, protection, and welfare for citizens in fulfilling their fundamental health requirements. The social insurance framework employed in the program's execution comprises four principles: the principle of cooperation, the principle of mandatory participation, the principle of income-based contribution determination, and the principle of non-profit orientation. After a decade of the program, numerous issues persist, including incomplete participation, prohibitively high contributions resulting in arrears, and suboptimal program benefits. This study establishes the optimal structure of social insurance systems inside national health insurance. The employed study method is normative, analyzing applicable laws and regulations, supplemented by a legislative and comparative approach to identify the optimal framework for social insurance regulation. By analyzing legal materials using descriptive-analysis, the study's main findings reveal that although JKN has enrolled over 91% of Indonesia's population, it still faces significant challenges, including delayed premium payments by participants and difficulties in achieving Universal Health Coverage (UHC). Compared to Thailand and Taiwan, JKN has yet to meet the UHC standards recognized by the WHO. The analysis concludes that the four foundational principles of social insurance within the national health insurance framework are insufficient; therefore, an additional four principles are required to ensure certainty, protection, and benefits for program participants, which is essential for the realization of the National Social Security System Law's objectives. The optimal design of a social insurance framework should include the principles of mutual cooperation, mandatory participation, proportional contributions, and non-profit operations.

Keywords: *National Health Insurance; Social Insurance; Mutual Cooperation Principle; Participation; Ideal Construction*

Abstrak

Program jaminan kesehatan nasional di Indonesia bertujuan untuk memastikan jaminan, perlindungan, dan kesejahteraan bagi warga negara dalam memenuhi kebutuhan dasar kesehatan mereka. Kerangka kerja asuransi sosial yang digunakan dalam pelaksanaan program ini terdiri dari empat prinsip: prinsip kerja sama, prinsip kepesertaan wajib, prinsip penentuan iuran berdasarkan pendapatan, dan prinsip orientasi nirlaba. Setelah satu dekade program ini berjalan, masih terdapat beberapa permasalahan yang dihadapi, termasuk kepesertaan yang tidak lengkap, iuran yang terlalu tinggi sehingga menimbulkan tunggakan, dan manfaat program yang tidak optimal. Penelitian ini bertujuan untuk menentukan struktur sistem asuransi sosial yang optimal di dalam jaminan kesehatan nasional. Metode penelitian yang digunakan adalah normatif, menganalisis peraturan perundang-undangan yang berlaku, dilengkapi dengan pendekatan legislatif dan komparatif untuk mengidentifikasi kerangka kerja yang optimal untuk

regulasi asuransi sosial. Dengan menganalisis bahan hukum menggunakan deskriptif-analisis, temuan utama studi ini mengungkapkan bahwa meskipun JKN telah mencakup lebih dari 91% penduduk Indonesia, JKN masih menghadapi tantangan yang signifikan, termasuk keterlambatan pembayaran premi oleh peserta dan kesulitan dalam mencapai Cakupan Kesehatan Semesta (Universal Health Coverage/UHC). Dibandingkan dengan Thailand dan Taiwan, JKN belum memenuhi standar UHC yang diakui oleh WHO. Analisis ini menyimpulkan bahwa empat prinsip dasar asuransi sosial dalam kerangka jaminan kesehatan nasional tidak cukup; oleh karena itu, diperlukan empat prinsip tambahan untuk memastikan kepastian, perlindungan, dan manfaat bagi peserta program, yang sangat penting untuk merealisasikan tujuan UU SJSN. Desain optimal dari kerangka kerja asuransi sosial harus mencakup prinsip-prinsip gotong royong, partisipasi wajib, iuran proporsional, dan operasi nirlaba.

Kata kunci: Asuransi Kesehatan Nasional; Asuransi Sosial; Prinsip Gotong Royong; Partisipasi; Konstruksi Ideal.

A. INTRODUCTION

The National Health Insurance is a healthcare insurance initiative in Indonesia. The national health insurance system, hereafter referred to as JKN is a governmental initiative that offers financial protection to the populace of Indonesia to address their fundamental health requirements.[1] JKN provides extensive health benefits, including preventive, curative, and rehabilitative services.[2] It is executed nationally according to social insurance and equality principles to guarantee that members have health maintenance benefits and protection to fulfill their fundamental health requirements.[3] The foundational legal principles guiding the formulation of norms in the SJSN Law are the principle of humanity, the principle of benefit, and the principle of social justice for all Indonesian citizens.[4,5] Legal principles are fundamental and overarching concepts that form the foundation of specific legal regulations within the legal system, as evidenced by statutes, judicial rulings, and various legal interactions in society.[6] Social insurance principles are 1) cooperation among affluent and impoverished, healthy and ill, elderly and youth, and high-risk and low-risk individuals; 2) compulsory and non-

[1] Abdu Nafan Aisul Muhlis, "Determinants Of The National Health Insurance Uptake In Indonesia," *Indonesian Journal of Health Administration* 10, no. 1 (2022), https://doi.org/10.20473/jaki.v10i1.2022.111-121.

[2] Lisda Amalia, "Does the Implementation of a National Health Insurance Program Result in Rationing Care for Ischemic Stroke Management? Analysis of the Indonesian National Health Insurance Program," *Risk Management and Healthcare Policy* 16 (2023), https://doi.org/10.2147/RMHP.S405986.

[3] https://www.badankebijakan.kemkes.go.id/program-jaminan-kesehatan-nasional-jkn/ (accessed July 21, 2024)

[4] Atikah Adyas, "The Indonesian Strategy to Achieve Universal Health Coveragethrough National Health Insurance System: Challenges in Human Resources," *Kesmas* 16, no. 4 (2021), https://doi.org/10.21109/kesmas.v16i4.5440.

[5] Putri Nur Hidayah, "Comparative Study of Legal Protection for Migrant Workers In Participation Of Social Security Programs In Indonesia And Singapore," *Legality : Jurnal Ilmiah Hukum* 28, no. 1 (2020): 47–59, https://doi.org/10.22219/ljih.v28i1.11786.

[6] Zainal Arifin Mochtar and Eddy Omaar Syarief Hiariej, *Fundamentals of Legal Science (Understanding Legal Methods, Theories, Principles, and Philosophy)* (Yogyakart: Rajwali Pers, 2021).

discriminatory participation; 3) contributions determined by a percentage of wages or income; and 4) non-profit status. The principle of equity asserts that all individuals have equal access to medical services tailored to their needs, irrespective of their contribution levels. The foundation for the execution of JKN is Law No. 40 of 2004 regarding the National Social Security System, hereafter referred to as SJSN, particularly Article 19, paragraph (1). The execution of JKN is conducted by the Social Security Administration Agency (BPJS) Kesehatan.

Despite a decade of JKN implementation, the Indonesian Government continues to encounter numerous challenges and impediments in realizing the objective of JKN, which is to guarantee that every Indonesian citizen possesses complete health insurance, enabling them to lead healthy, productive, and prosperous lives.[7] According to BPJS Kesehatan e-PPID data, as of 2022, JKN participants number 248,771,083, representing 91.69% of Indonesia's total population of 275.3 million. Consequently, Indonesia has not achieved the Universal Health Coverage (UHC) target, which guarantees access to quality preventive, curative, rehabilitative, and promotive health services for all individuals. A further issue that emerges is the substantial number of JKN participants subsidized by the Government, as delineated in Article 1, paragraph (5) of Presidential Regulation No. 82 of 2018 regarding Health Insurance, which identifies 151,798,726 individuals as participants receiving contribution assistance (PBI), while 15,623,749 individuals are in arrears.[8] Individuals with outstanding donations will be ineligible for JKN and thus unable to access health services and facilities. The significant number of members in arrears suggests that the Government's mandated contributions are perceived as excessive, rendering individuals unable to afford JKN payments.

This research aims to determine how the optimal design of adequate health insurance can achieve the objectives of JKN, specifically to foster a healthy, productive, and affluent society.

B. RESEARCH METHODS

This study employs normative research, a scientific methodology aimed at uncovering truth using legal, scientific reasoning from a normative perspective. The scientific rationale in normative research is founded on scientific disciplines and methods of normative laws.[9] The focus of normative law studies is on law conceived as a norm or rule. The standards under examination encompass statutes, governmental regulations, and additional frameworks. This paper examines Law No. 40 of 2004 on the National Social Security System (SJSN) and its associated regulations. This research employs a legislative and comparative methodology, specifically examining health insurance systems in Thailand and Taiwan, which are recognized for their successful implementation of social insurance mechanisms. In formulating a finding, the analysis of legal materials in this research uses descriptive-qualitative with evaluative and argumentative techniques.

C. RESULT AND DISCUSSION

The National Social Security System (SJSN) embodies the State's responsibility to guarantee protection and social security for all citizens. SJSN serves as the foundation for the

[7] https://berkas.dpr.go.id/pa3kn/kamus/file/kamus-43.pdf, (accessed August 02, 2024)
[8] https://e-ppid.bpjs-kesehatan.go.id/eppid (accessed August 02, 2024)
[9] Jhonny Ibrahim, *Normative Law Research Theory and Method* (Malang: Bayumedia Publishing, 2006).

creation of a national health insurance scheme for all citizens of Indonesia. SJSN is an initiative aimed at achieving welfare and ensuring security throughout an individual's life via a systematic, regular, and quantifiable methodology, which necessitates the involvement of the State and society, contingent upon the nation's foundational philosophy. Consequently, it is essential to understand the rationale underlying the establishment of the SJSN Law. SJSN exemplifies the State's initiative to enhance the national economy and social welfare through the establishment of a comprehensive social security system for all citizens while also empowering vulnerable and incapable individuals in alignment with human dignity, as articulated in Article 34, paragraph (2) of the 1945 Constitution of the Republic of Indonesia. Subsequently, the Government established a national health insurance scheme designed to guarantee the accessibility of comprehensive health facilities and services for all citizens of Indonesia. Social security is typically managed through a government-controlled system comprising two primary categories: public assistance and social insurance.[10] Public health is a fundamental component of a nation's progress.[11] Health constitutes a basic human necessity. Health is paramount; it is frequently asserted that life lacks significance without health. Consequently, all initiatives and endeavors to enhance public health follow the principles of non-discrimination, participation, protection, and sustainability. These are crucial for developing Indonesia's human resources, the augmentation of national resilience and competitiveness, and overall national development.[12]

The notion of the right to health differs from the notion of the right to health. The State guarantees the right to health. The State must ensure access to adequate and equal healthcare facilities for every individual. Health encompasses an individual's ability to sustain their well-being, which is also affected by several aspects beyond governmental control, such as biological and socio-economic situations.[13] The right to health encompasses more than merely the absence or presence of illness. The right to health encompasses two critical dimensions: the dimension of freedom and the dimension of entitlements. The freedom associated with the right to health entails granting individuals autonomy over their bodies and health conditions.

In contrast, the freedom inherent in the right to health encompasses the entitlement to equitable health services and the promotion of equality and equal opportunities, such as access to quality healthcare services.[14] To address the two elements above, the State, as the entity obligated to uphold the health rights of its residents, bears the responsibility to adhere to this duty. These responsibilities may be executed through the provision of health services, the establishment of quality health facilities, the delivery of non-discriminatory services, the

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[10] Hartini Retnaningsig, *Social Security in a Parliamentary Perspective* (Malang: Intelegensia Intrans Publishing, 2017).

[11] Martin Amogre Ayanore et al., "Health Insurance Coverage, Type of Payment for Health Insurance, and Reasons for Not Being Insured under the National Health Insurance Scheme in Ghana," *Health Economics Review* 9, no. 1 (2019), https://doi.org/10.1186/s13561-019-0255-5.

[12] Indra Perwira, "Heaalth as a Human Right," in *Dimensions of Human Rights Law* (Bandungng: PSKN FH UNPAD, 2009).

[13] Community Legal Aid Institute, *Pocket Book on the Right to Health* (Jakarta: Community Legal Aid Institute, 2019).

[14] Committee on Economic, Social and Cultural Rights, 2000, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, Paragraph 8.

formulation of pro-people policies, and the enactment of laws and regulations or other tangible measures to fulfill these health obligations.

The following elements influence an individual's health, as established by the World Health Organization:[15]

1. Social and economic status. High income and social status affect good access to health. This is what makes the gap between rich and poor in terms of health,
2. Education. Low levels of education are associated with poor health status, stress, and low levels of self-confidence,
3. Physical environment. Physical environments such as clean water, clean air, healthy workplaces, and others can contribute to creating a healthy environment, social support networks,
4. Support from family, friends, and community is very influential in health. Culture – customs and traditions, and family and community beliefs can all affect health,
5. Genetic. Genetic factors also play a role in determining age, health, and certain diseases. In addition, external factors such as personal behavior, smoking, drinking, and how to deal with stress can all affect health,
6. Healthcare services. Access to and use of health services can prevent and treat diseases that affect health.
7. Gender. Both genders, women and men, exhibit varying susceptibility to specific diseases at particular ages.

The four elements of the right to health are employed in assessing the adequacy of health insurance guarantees in a specific region, which are as follows:[16]

1. Availability. This principle states that health services must be available in sufficient quantities regarding human resources, medicines, and other facilities and infrastructure.
2. Accessibility. This affordability principle consists of the following:
   a) Non-discrimination health services must be accessible to everyone, especially to vulnerable and marginalized groups. There should be no discrimination based on gender, race, color, language, religion, political views, health status, and other social backgrounds that may limit or deprive people of their enjoyment of the right to health.
   b) Physical affordability, where health facilities and infrastructure must be accessible and safe for all groups.
   c) Economic affordability means health services must be economically affordable, especially for people experiencing poverty.
   d) Affordability of information, where information about health, health services, patient rights and obligations, and other matters related to the right to health must be affordable. The public has the right to seek, receive, and inform any information related to health.

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[15] Lembaga Bantuan Hukum Masyarakat, *Buku Saku Atas Hak Kesehatan* (Jakarta: Lembaga Bantuan Hukum Masyarakat, 2019).

[16] United Nations, *General Comment No. 14*, 2000, Paragraph 12, hlm. 4-5

1) Acceptability. The health services must follow medical ethics and be culturally acceptable, including respecting the confidentiality of health status and improving health status for those in need. The importance of this principle of acceptance is also closely related to indigenous groups.
2) Quality. The community must get the best quality health services, including medicines, health services (equipment), and competent health workers.

The Government safeguards the right to health through a social insurance mechanism founded on equality, as stipulated in Article 19, paragraph (1) of the SJSN Law. The concepts of social insurance encompass mutual collaboration among the affluent and the impoverished, the healthy and the ailing, the elderly and the youth, varying risk levels, mandatory participation, payments determined by a percentage of wages or income, and a non-profit framework.[17] Social insurance is a form of insurance that provides social security to community members at local, regional, and national levels. The Government mandates social insurance as compulsory, requiring the community or participants to contribute a specified sum, supplemented by government contributions to the administering entity.[18] The adoption of social insurance as a mechanism for implementing social security in Indonesia is predicated on its capacity to provide individuals with protection against socio-economic risks while simultaneously alleviating the financial burden on the State (APBN) regarding the provision of constrained social security funds.[19] Social insurance is an efficient vehicle for aggregating substantial community funds allocated to finance national development initiatives and enhance community welfare.

Furthermore, the amassed riches might serve as a source of investment capital for national economic development. The insurance mechanism highlighted involves compulsory contributions directed at social security participants, specifically health insurance.[20] Notably, the Government subsidizes contributions for the impoverished and those unable to pay. Article 1, number 8 of the SJSN Law stipulates that social security participants encompass all individuals, including foreigners, who have worked in Indonesia for at least six months and have made contributions. This health insurance is mandatory, and participants are required to make contributions. The contribution amount is a percentage of wages or a specific monetary sum.

This social security approach is called the corporate or the Bismarck model and originated in Germany.[21] Chancellor Otto von Bismarck instituted compulsory health insurance, workers' insurance, and old-age insurance at the close of the 19th century to safeguard individuals from

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[17] Tope Michael Ipinnimo et al., "The Nigeria National Health Insurance Authority Act and Its Implications towards Achieving Universal Health Coverage," *Nigerian Postgraduate Medical Journal*, 2022, https://doi.org/10.4103/npmj.npmj_216_22.

[18] Soeisno Djojosoedarso, *Principles of Risk Management and Insurance* (Jakarta: Salemba Empat, 1999).

[19] Nuzulul Kusuma Putri, Agung Dwi Laksono, and Nikmatur Rohmah, "Predictors of National Health Insurance Membership among the Poor with Different Education Levels in Indonesia," *BMC Public Health* 23, no. 1 (2023), https://doi.org/10.1186/s12889-023-15292-9.

[20] Eugenia Amporfu et al., "Strategic Health Purchasing Progress Mapping: A Spotlight on Ghana's National Health Insurance Scheme," *Health Systems and Reform* 8, no. 2 (2022), https://doi.org/10.1080/23288604.2022.2058337.

[21] Rok Hrzic et al., "Comparability in Cross-National Health Research Using Insurance Claims Data: The Cases of Germany and the Netherlands," *Gesundheitswesen, Supplement* 82 (2020), https://doi.org/10.1055/a-1005-6792.

financial difficulties, relying on obligatory contributions from participants, employers, and the Government to fund social security initiatives. Social insurance aims to shift the risk of public welfare to insurance providers.[22] In Indonesia, the SJSN Law employs a hybrid social insurance and social assistance model to execute social security. The attributes of the social security system utilizing the social insurance mechanism are:[23]

1. The social security program grows in line with the country's economic growth.
2. It involves the participation of the community in financing,
3. It is mandatory so that most people can follow it, and it can be imposed by imposing sanctions,

The social assistance mechanism serves to aid the impoverished. It offers guidance on enhancing the equity of the support provided, as social solidarity fosters societal interdependence in combating poverty, necessitating action at the national level.

The social insurance utilized in the national health insurance program assigns BPJS the duty to collect, administer, and enforce penalties on delinquent participants, as well as the ability to allocate contributions for investment purposes. The notion of social security illustrates the impact of neoliberalism on the development and execution of legislation in Indonesia. Social insurance constitutes a component of insurance. Social insurance encompasses four fundamental parts of insurance, as seen in the subsequent table:

Table 1. Implementation of the Four Elements of Insurance in Commercial Insurance and Social Insurance

Insurance Elements	Commercial Insurance	Social Insurance
Parties	Insurer and insured. The insurer's commercial insurance is usually a private company or state-owned enterprise, while the insured is an individual.	Insurer and Insured. The insurer is The Government, which forms the body, while the insured is all citizens or people of a country.
Legal Relationship	It occurs because of an engagement, that is, an agreement between the parties to an agreement, which is poured into a written contract in commercial insurance, referred to as a policy.	Legal relations occur because of the law, held by order of the law or stipulated by rules and regulations.

[22] Aaron Major, "Social Insurance and Social Justice: Social Security, Medicare, and the Campaign Against Entitlements," *Contemporary Sociology: A Journal of Reviews* 39, no. 6 (2010): 737–38, https://doi.org/10.1177/0094306110386886nn.

[23] Vladimir Rys, *Reiventing Social Security Worldwide: Back to Essentials* (Bristol: The Policy Press, n.d.).

Prize	Premium is a sum of money set by the Insurance Company and approved and agreed upon by the policyholder to be paid under the Insurance agreement.	Contributions, set by the Government and generally proportional to wages or income
Indemnity	Compensation is based on the risk that will be borne by the insured in the event of an uncertain event. This is in line with the insured object.	In the form of certainty, protection, and social welfare of the community.
Evenement	This indeterminate event follows the insurance object agreed upon in the insurance policy.	In social health insurance, eat an event that is not necessarily sick.

Table source: Created by the author

The distinction between social and commercial insurance lies solely in their intended function. Commercial or private insurance seeks profitability, indicating that the insurer and the insured pursue financial gain. The insured transfers the risk of potential loss to the insurer, increasing the profit derived from the premium paid for this risk transfer under the agreement. Conversely, suppose the objective of social insurance is to provide social security to fulfill the fundamental necessities of the community without pursuing profit in the endeavor to offer welfare. In that case, rules and regulations are the foundation for executing social insurance. To elucidate this remark, the subsequent description outlines the characteristics of business insurance:[24]

1. It is not held because laws and regulations stipulate it but is voluntary;
2. The agreement that occurs between the insured and the insurer based on the agreement;
3. It is voluntary for those who agree;
4. The insurer is usually the private sector or the Government, in this case SOEs;
5. Priority is given to protection against individual risks;
6. Intended for individual interests (in general) and intended for profit;
7. Comparison between premiums and proportional compensation;
8. The amount of the premium is determined based on the agreement that has been agreed;
9. The amount of compensation is determined based on the agreement, and
10. The insured has a choice regarding the interests and events to be insured.

Conversely, the attributes of social insurance previously outlined are contrary to the factors above, specifically:[25]

1. Held by order of law or stipulated by laws and regulations;

[24] Arief Suryono, "Asuransi Kesehatan Sosial: Sebagai Upaya Negara Dalam Mewujudkan Masyarakat Sejahtera," *YUSTISIA, Jurnal Ilmu Hukum* 9, no. 3 (2009): 213–21.

[25] Hasbullah Thabrani, *Asuransi Kesehatan Pilihan Kebijakan Nasional* (Jakarta: Fakultas Kesehatan Masyarakat Universitas Indonesia, 1998).

2. The alliance that occurs between the parties is born because the law requires;
3. It is mandatory for those who meet the statutory requirements as participants;
4. In general, the Government acts as an organizer or insurer;
5. Priority is given to the protection of matters related to social risks;
6. It is intended to provide social security to the community or community group and is not intended to make a profit;
7. The comparison between premiums and benefits is progressively regulated;
8. The amount of premiums is determined by the Government through laws and regulations and is determined more on social *adequacy* than on private equity;
9. There is no choice regarding matters of interest and events.

The notion of compulsory insurance transforms the Government's duty to provide public health care into an obligation for individuals to participate in health insurance, ensuring their rights to health services are met.[26] Government plans to develop a social protection system should adhere to the laws and rules governing that system. The SJSN Law has established a coordinated and integrated social security model framework. The SJSN Law mandates that all Indonesian citizens must participate, and it provides contribution support for every impoverished or disadvantaged individual. Individuals in poverty who cannot afford contributions will still receive social security, as the Government offers contribution subsidies for this demographic.[27] Article 17, paragraph (1) of the SJSN Law mandates that each participant remit contributions calculated as a percentage of their wages. This provision elucidates the mechanism for the monthly collection of obligatory contributions from all citizens, regardless of their financial status, including the affluent and the impoverished. This technique will pose an issue if individuals are neither classed as PBI nor PPU but cannot afford JKN donations. The cessation of obligatory contributions is regarded as a delegation of state obligation to its citizens to execute health insurance.[28] The retraction of the obligatory donation is deemed inappropriate.[29] The cessation of obligatory payments has alleviated the State's accountability in the healthcare sector.[30] The elimination of compulsory contributions has compelled individuals to engage in health insurance.[31] Third, for individuals in arrears, it will impose an additional strain on their lives. Consequently, the SJSN Law, as implemented, has challenges that create deficiencies, particularly with social insurance as a mechanism inside the

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[26] Silm Oktapani and Ardiansah, "Analysis Of The Arrangement Of Green Open Space In The City Of Pekanbaru," *JISPO* 9, no. 2 (2019), https://doi.org/https://doi.org/10.15575/jispo.v9i2.5408.

[27] Muh. Kadarisman, "Analysis On The Implementation Of The Health Social Security System After The Decision Of The Constitutional Court No. 07/Puu-Iii/2005," *Journal Of Law Ius Quia Iustum* 22, no. 3 (July 2015): 467–88, https://doi.org/10.20885/iustum.vol22.iss3.art7.

[28] Endang Sutiah Pane, "SJSN and BPJS, Bullying the People in the Name of Social Security," https://lintasgayo.co/2014/01/01/sjsn-dan-bpjs-memalak-rakyat-atas-nama-jaminan-sosial, January 2, 2014.

[29] Tika Indiraswari et al., "Health Insurance Literacy: Discussion and Reaction of Facebook Users' towards the National Health Insurance in Indonesia," *Journal of Public Health Research*, 2020, https://doi.org/10.4081/jphr.2020.1844.

[30] Gbadegesin O. Alawode and David A. Adewole, "Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers," *BMC Public Health* 21, no. 1 (2021), https://doi.org/10.1186/s12889-020-10133-5.

[31] Tanya Lee Pauw, "Catching up with the Constitution: An Analysis of National Health Insurance in South Africa Post-Apartheid," *Development Southern Africa* 39, no. 6 (2022), https://doi.org/10.1080/0376835X.2021.1945911.

JKN framework. The deployment of JKN, intended to benefit society, paradoxically complicates matters for the populace.

The social insurance mechanism employed in the execution of JKN is wholly administered by BPJS Kesehatan, which functions similarly to an insurance business, as delineated in Article 19, paragraphs (1), (2), (3), and (4) of the BPJS Law.[32] The SJSN, which relies on contributions or premiums, has been challenged in the Constitutional Court regarding its constitutionality, as these mandatory contributions are perceived to violate the constitution and the constitutional rights of the Indonesian populace. The presence of social security providers will merely exploit individuals due to the compulsion to remit social security premiums to these entities. The government-organized social security program has redefined social security as social insurance.[33] Social security and social security plus social insurance are two distinct concepts. Social security serves as state protection for inhabitants, ensuring welfare and achieving acceptable living standards. In contrast, social insurance is a government-created product utilized to accomplish social security for its populace.

The Explanation of Article 19, paragraph (1) of the SJSN Law articulates that the principle of social insurance encompasses cooperation among the affluent and impoverished, the healthy and ill, the elderly and youth, as well as individuals with varying risk levels; obligatory and inclusive participation; contributions determined by wage or income percentages; and a non-profit orientation. The definitions encompassed in the insurance above concepts shall be delineated sequentially:

1. **Gotong-royong,** a term signifying collaborative effort, shows the importance of mutual assistance and cooperation,[34] If it pertains to the execution of JKN, which employs the social insurance mechanism as delineated in Article 19 paragraph (1) of the SJSN Law, then the contributions established for JKN participants represent a collaborative effort aimed at mutual assistance among the affluent and the impoverished, the healthy and the ailing, the elderly and the youth, as well as those at varying levels of health risk, to ensure equitable access to health insurance for all individuals in Indonesia. Nonetheless, a deactivation system for participants who are delinquent in contribution payments, preventing them from accessing health insurance benefits until their debts are settled, diminishes the essence of social insurance based on cooperation. The JKN contributions, designated as mandate funds in the SJSN Law, are intended to assist participants who are genuinely unable to pay or are in arrears with their contributions, enabling them to receive the benefits of the JKN appropriately. Isn't the number of participants who pay significantly higher than those who are ill? Annually, BPJS Kesehatan consistently experiences a deficit, characterized by "bleeding" or

[32] Article 19 of the BPJS Law reads, paragraph (1) "Employers are obliged to collect Contributions that are a burden on Participants from their Workers and deposit them to BPJS", paragraph (2) "Employers are obliged to pay and deposit contributions that are their responsibility to BPJS", paragraph (3) Participants who are not Workers and not recipients of Contribution Assistance are obliged to pay and deposit Contributions that are their responsibility to BPJS" and paragraph (4) "The Government pays and deposits Contributions for Contribution Assistance recipients to BPJS".

[33] Thabrani, *Op.cit.*

[34] Language Development and Development Agency. 2023. Great Dictionary of Indonesian Language (KBBI): Online/Online Version of the Dictionary (Online). https://kbbi.web.id/gotongroyong/. (Accessed February 21, 2024)

"mismatch," as the contributions collected are insufficient to cover expenditures related to tariffs and service levels, resulting in a shortfall in payments for health services and facilities utilized by JKN participants. Deficient due to the contribution established by the Stated not aligning with the actuarial assessment of the DJSN,[35] The implemented remedy is to augment the contributions to BPJS Kesehatan. Increasing payments leads to a growing number of members unable to pay, resulting in arrears and exacerbating the economic strain. The community groups that engage extensively in singularity consist of individuals not categorized as PBI and PPU, specifically the PBPU and PB groupings. Participants in the PBI program have their contributions financed by the local Government of their residence, as stipulated in Article 29 of PP No. 82 of 2018 about Health Insurance, indicating that the regional Government's funds are derived from community taxation. In the PPU scheme, contributions are made by both the employer and the employee, amounting to 5% of the monthly wage, with 3% contributed by the employer and 2% deducted from the employee's salary, as stipulated in Article 30, paragraphs (1) and (2) of the regulation. PBPU and PB participants remit their monthly contributions as stipulated in Government Regulation No. 64 of 2021, Article 34. Contributions for health service benefits in class III treatment rooms amount to Rp. 35,000 per month (originally Rp. 42,000 per month, reduced by a government subsidy of Rp. 7,000). For health services in class II treatment rooms, the contribution is Rp. 100,000 per month, while for class I treatment rooms, it is Rp. 150,000 per month per individual. This contribution is particularly burdensome for individuals in the PBPU and PB groups, especially under the current challenging economic conditions.

2. **Mandatory participation** in JKN, as stipulated by Article 1, number (4) of the BPJS Law, is compulsory for all citizens to engage in this health insurance program. Specifically, participation in BPJS Kesehatan is mandatory for every Indonesian citizen and foreign nationals employed in Indonesia for a minimum duration of six months, who are required to contribute to BPJS Kesehatan. Conversely, to become a JKN participant, one must initially register with BPJS Kesehatan, as stipulated in Article 6, paragraphs (1) and (2) of Government Regulation No. 82 of 2018 about Health Insurance.[36] Participants of BPJS Kesehatan are categorized into two groups: Contribution Assistance Recipients (PBI) and Non-Contribution Assistance Recipients (Non-PBI), as delineated in Article 2 of Government Regulation No. 82 of 2018. The Ministry of Social Affairs decree determines the eligibility of PBI participants. The principle of compulsory participation is designed to ensure universal protection. While participation is obligatory for everybody, its execution remains contingent upon the economic capacities of the Government and the populace and the program's feasibility for implementation. The informal sector can voluntarily engage with the formal sector, allowing farmers, fishers, and independent laborers to integrate into the National Social Security System. Mandatory participation aligns with the goals of social security

[35] Muhamad Pazri, "Reconstruction of the Regulation of National Health Insurance Contributions Based on the Value of Justice" (Sultan Agung Islamic University, 2021).

[36] Government Regulation Number 82 of 2018 concerning Health Insurance, Article 6 paragraph (1) Every resident of Indonesia is required to participate in the health insurance program, and (2) Participate in the health insurance program referred to in paragraph (1) is carried out by registering or registering with BPJS Kesehatan

implementation as articulated in Article 4, subsection g. Examining the principle of social insurance through the registration model reveals a shift in interpretation, as the mandatory aspect outlined in the SJSN Law is legally enforced. In contrast, the social compulsory insurance mechanism operates through registration and adherence to specific conditions established by the JKN administrator, BPJS Kesehatan.

3. **Contributions based on the percentage of Wage and Income**, as stipulated in Article 1 number 6 of the SJSN Law, refer to a monetary amount consistently remitted by participants, employers, and/or the Government. The contribution is assessed based on the academic document of the SJSN Law, taking into account the following considerations:[37]
    1. For participants who receive wages, contributions are borne jointly by the employer and workers in equal portions (50:50). They will be considered by actuarial analysis every two years to ensure the adequacy of service financing.
    2. Contributions for formal workers are determined periodically by Government Regulations.
    3. Contributions for workers in the informal sector are determined by a formula that DJSN will develop by taking into account the income ability of the population and the level of cost of health services in an area.
    4. Contributions for retired participants are determined periodically by Government Regulations.
    5. Workers who experience Termination of Employment (PHK) are exempt from payment of contributions for 6 (six) months. After that, the participant becomes a particular participant, an incapable participant whose contributions are paid by the Government, until they get a new job.
    6. In the 11th year, at least 95% of the total contributions must be used for services and/or accumulating reserve funds. To accommodate regional autonomy, 95% of the fund is allocated for its use proportionally (after taking into account referral costs outside the region) for regions by considering regional contributions to stimulate the improvement of medical service facilities in the regions. At least 80% of the donations collected in an area can be negotiated to be allocated for the payment of health services in that area. The rest will be considered for referral costs to other regions, technical reserves, and operational costs for the JK program.
    7. Operational or management costs by BPJS are gradually limited to the 11th year and must not exceed 5% of the total contributions received for the JK program.
    8. During the transition period, the number of contributions that must be returned to participants in the form of services and reserve funds is at least 85% and gradually increased to 95% of the total contribution.

    The social security fund is a trust fund designated for participants' benefit and the operations of BPJS, necessitating cautious and trustworthy management. BPJS is empowered to allocate Social Security Funds for short-term and long-term investment endeavors. It seems that BPJS activities require participants' funding despite

[37] Academic Manuscript of the National Social Security System Bill, pp. 61-63

participants being taxpayers.[38] The current implementation of contributions is entirely governed by the Presidential Regulation, as outlined in the section titled "Considering." Government Regulation No. 64 of 2020, which pertains to the Second Amendment of Presidential Regulation Number 82 of 2018 regarding Health Insurance, establishes that to uphold the quality and sustainability of the Health Insurance Program, the funding policy for Health Insurance, including the contribution policy, must be harmonized with the State's financial policy proportionately and equitably. This explanation clarifies that the foundation for assessing contributions is not predicated on the percentage of wages or income.

4. **Non-profit:** The non-profit principle, as delineated in the Explanation of the SJSN Law, asserts that the management of trust funds by BPJS Kesahatan is not intended for profit generation but instead aims to serve the interests of participants to the fullest extent. Article 4 of the SJSN Law indicates that this non-profit principle embodies a business management approach that prioritizes the allocation of fund development proceeds to maximize benefits for all participants. According to Article 40 of the BPJS Law, paragraph (1) stipulates that BPJS manages both BPJS assets and Social Security Fund assets, indicating a distinction between BPJS assets and community contribution fund assets; paragraph (2) mandates BPJS to segregate these assets; paragraph (3) clarifies that social security fund assets do not constitute BPJS assets; and paragraph (4) requires BPJS to deposit and manage social security funds at custodian banks. Those are government-owned corporations. This division allows for the complete utilization of social security fund management for the advantage of participants. Fund management is conducted according to solvency, liquidity, transparency, prudence, accountability, efficiency, and effectiveness. Article 51 of the BPJS Law stipulates that designated authorities oversee BPJS financial management in line with applicable laws and regulations. The designated authority is the Ministry of Finance of the Republic of Indonesia, in conjunction with the Financial Services Authority (OJK).

I utilized health insurance in Thailand and Taiwan for comparative analysis. Thailand is a prominent Southeast Asian nation, achieving 100% health insurance coverage for participants in 2002. Thailand employs a system known as the Universal Health Coverage Scheme (UHC). Universal Health Coverage (UHC) has been established via the Universal Coverage Scheme (UCS), encompassing 76% of the population since its inception in 2001.[39] Taiwan possesses a national health insurance system known as National Health Insurance (NHI), which is regarded as one of the premier health insurance systems globally. The system has demonstrated its capacity to promote social justice by enhancing health coverage for Taiwanese citizens and foreigners residing in Taiwan. This achievement is seen in Taiwan's ability to manage and contain the spread of the COVID-19 virus despite its proximity to Wuhan and extensive

[38] Saut Parulian Panjaitan et al., "The Constitutional Perspective of Indonesian Social Security System," *Jurnal Hukum* 40, no. 1 (June 2024): 42, https://doi.org/10.26532/jh.v40i1.36933.

[39] Rizka Husnia Kanti, "Analysis of Management Strategies in the Universal Health Protection Program in Thailand," *Publisia: Journal of Public Administration* Science 5, no. 1 (April 30, 2020), https://doi.org/10.26905/pjiap.v5i1.3868.

connections with many Chinese provinces, mainly through aviation.[40] When comparing JKN with Thailand's Universal Health Coverage Scheme (UHC) and Taiwan's National Health Insurance (NHI), both of which utilize social insurance as a mechanism for health insurance implementation, several deficiencies emerge. Notably, Thailand and Taiwan have attained Universal Health Coverage (UHC), a health insurance standard recognized by the World Health Organization (WHO).

Universal Health Coverage (UHC) signifies that all individuals can access essential promotive, preventative, curative, rehabilitative, and palliative health treatments of high quality without financial hardship.[41] The World Health Organization defines Universal Health Coverage (UHC) as providing necessary health care to all individuals within a country, accessible at any time and place, without incurring financial hardship. Universal Health Coverage encompasses fundamental healthcare services, including prevention, treatment, rehabilitation, and palliative care. Over fifty percent of the global population lacks access to essential health services. Approximately 100 million individuals descend into extreme poverty annually as a result of personal expenditures on healthcare.[42] The comparison results indicate that JKN has not achieved Universal Health Coverage (UHC).

Moreover, Thailand and Taiwan possess specific legislation governing health insurance. Although Indonesia is not yet established, health insurance legislation in the country remains integrated within the SJSN Law and BPJS Law. In Thailand, all individuals enrolled in free health insurance incur no contributions. In contrast, in Indonesia and Taiwan, participants in paid health insurance, except those deemed impoverished and unable to secure public funding, must contribute. In Taiwan, there is no designation of inactivity, so participants may continue to utilize their health insurance cards throughout all regions, notwithstanding payment delays. However, late payments will incur a 5% interest charge. In Thailand and Taiwan, healthcare facilities and services are equitably spread, and access is economically accessible to the public. Health insurance regulation in Thailand and Taiwan is minimal, governed primarily by a singular basic rule. The health insurance legislation in Thailand and Taiwan meticulously delineates the rights and responsibilities of insurance participants, along with mechanisms for dispute resolution, facilitated by a specialized committee comprising public members and professionals. In contrast, Indonesia's national health insurance framework lacks detailed regulation of the rights and obligations of social insurance participants, and its dispute resolution mechanism remains general.

An optimal regulatory framework is required to encompass all legislation about health insurance, particularly the social insurance system employed in health insurance organizations in Indonesia. It is essential to incorporate social insurance principles as delineated in Article 19, paragraph (1) of the SJSN Law to enhance the current principles, which include mutual cooperation, required participation, proportional contributions, and non-profit contributions. A proportional principle must be incorporated into the formulation of social insurance policy to

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[40] Ardila Putri et al., "Taiwan National Health Insurance Policy and Learning for Developing Countries," *Journal of Indonesia Health Policy: JKKI* 9, no. 3 (September 2020): 167–77.

[41] Ari Wibowo et al., *BPJS Kesehatan National Health Insurance: Governance, Effectiveness and Comparison with Several ASEAN Countries* , 1st ed. (Jakarta: International NGO Forum on Indonesian Development, 2022).

[42] World Health Organization. 2020. Universal Health Coverage. https://www.who.int/health-topics/universal-health-coverage#tab=tab_3. (Diakses 11 April 2023)

counterbalance the unilateral determination of contributions by the Government. This principle should also govern the rights and obligations of the parties involved in health insurance implementation. Additionally, the principles of responsiveness and responsibility should be established, addressing the needs and development of health services and facilities required by JKN participants.

Furthermore, participants should be allowed to hold those responsible for unmet rights accountable by social insurance providers, thereby ensuring that the value of legal protection is realized as a foundational aspect of the SJSN Law's formation. It is essential to incorporate the principles of effectiveness and efficiency into controlled benefit management to eliminate negative funding in social insurance financing, ensuring prompt and comprehensive implementation. Furthermore, integrated protection is necessary, establishing a conflict resolution mechanism between participants and social insurance providers within a transparent and equitable framework. Disputes should be adjudicated by a committee formed by the Government, comprising impartial professionals independent of BPJS Kesehatan, thereby ensuring fair resolution and safeguarding the rights and certainty of JKN participants.

D. CONCLUSION

Optimal health insurance offers assurance, safeguarding, advantages, and well-being for each participant, enabling access to sufficient health services and facilities provided by the Government, thus enhancing their quality of life through a healthy and productive condition. Consequently, in light of this unmet requirement, an optimal framework is essential for regulating social insurance and executing national health insurance as a vehicle for program implementation. The optimal framework necessitates the incorporation of four additional principles alongside the four current principles outlined in the regulation of social insurance as stipulated by Article 19, paragraph (1) of the SJSN Law. The four new principles are the principle of proportionality, the principle of responsiveness and responsibility, the principle of effectiveness and efficiency, and the principle of integrated protection. Incorporating these four new principles is anticipated to enhance the quality of the national health insurance program by safeguarding participants' rights, augmenting the benefits received, and addressing participants' requirements by optimizing social insurance contributions.

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