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Easy Access to Health Services in Inclusive Government Governance

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Abstract: Access to health services is a fundamental right guaranteed by the 1945 Constitution. The Indonesian government has demonstrated its strong commitment through the Contribution Assistance Recipient (PBI) program, namely in Article 14 paragraph (2) of Law Number 40 of 2004 concerning the National Social Security System, which provides subsidies for National Health Insurance (JKN) premiums funded by the regional budget for the poor and underprivileged. However, there are serious challenges related to the accuracy of targeting recipients and the equitable distribution of health care facilities throughout Indonesia. The objective of this study is to analyze the mechanism for determining PBI recipient criteria, identify obstacles in program implementation, and offer strategic solutions to make health subsidies more effective and equitable. The method used is normative juridical, employing a legislative and analytical approach. Research shows that although PBI has succeeded in improving access to health services through Article 14 paragraph (2) of Law Number 40 of 2004 concerning the National Social Security System, the problem lies in the validation of recipient data, which is often inaccurate, so that the wealthy continue to enjoy subsidies while some of the poor are overlooked. Government efforts such as DTKS integration, supervision of aid distribution, and the construction of primary hospitals are significant steps toward improvement. effectiveness of the PBI program is highly dependent on the accuracy of beneficiary data and the equitable distribution of healthcare services. With strengthened databases, continuous verification, and improved healthcare infrastructure, this program can be more targeted and sustainable in achieving social justice in the field of health.

Keywords: Premium Assistance Recipients, National Health Insurance, Targeting, Equitable Services

INTRODUCTION

Health is the most fundamental human right and an integral part of social welfare. Every country recognizes that health is the greatest asset for achieving well-being (Ardinata, 2020). In the context of a state of law based on Pancasila, the right to health is not merely a biological necessity but a constitutional right inherent to every citizen that must be fulfilled by the state. This is explicitly regulated in Article 28H paragraph (1) of the 1945 Constitution

of the Republic of Indonesia, which states that "Everyone has the right to live in physical and spiritual welfare, to have a residence, to obtain a good and healthy environment, and to receive health services." This provision places health as a fundamental right that must be guaranteed, respected, and protected by the state as a form of its constitutional responsibility.

Furthermore, Article 34 paragraph (2) of the 1945 Constitution affirms that "The state develops a social security system for all citizens and empowers weak and incapable members of society in accordance with human dignity." This norm provides a legal basis for the state to ensure the implementation of a national social security system, including health insurance, to achieve welfare and social justice for all Indonesian people. In the Universal Declaration of Human Rights by the United Nations in 1984, it is stated that everyone has the right to a healthy and prosperous life both individually and as a family. This can be fulfilled by obtaining rights to food, clothing, housing, healthcare, social services, as well as security in times of unemployment, illness, disability, widowhood/widowerhood, old age, or other circumstances that result in financial hardship beyond their control (Oldistra & Machdum, 2020).

Within this framework, the state has a central role in guaranteeing the right to health by providing universal access to quality and affordable health services. This responsibility is not only normative but also practical, where the state must ensure that every individual, regardless of social, economic, or geographical status, has an equal opportunity to receive proper health care services. This principle aligns with the global commitment to the Sustainable Development Goals (SDGs), particularly the third goal (Good Health and Well-Being for All), which emphasizes the importance of universal health coverage as a form of equitable access to health services for everyone. Therefore, the government has created a program to guarantee health for all Indonesian citizens in the form of the National Health Insurance (JKN), which is one part of the National Social Security System (SJSN) (Alayda et al., 2024). This program has become the state's main instrument in expanding the reach of health services while also implementing the principle of social justice as mandated in the constitution.

The JKN program has been implemented since 2014 through a social insurance mechanism and a mandatory participation principle for all Indonesian citizens. Participation in the JKN program consists of two segments: Beneficiaries of Contribution Assistance (PBI) and non-PBI participants. The payment of JKN contributions for PBI participants is the responsibility of the central government, funded by the State Budget (APBN), and the local government, funded by the Regional Budget (APBD) (Darwati et al., 2023). The PBI scheme is intended for poor and underprivileged communities so that they can still receive health protection without bearing the cost of contributions. This scheme is regulated in Article 14 paragraph (2) of Law Number 40 of 2004 on the National Social Security System, whereby the central and regional governments are responsible for paying PBI participants' contributions through the APBN and APBD. Thus, the state is not only present as a provider of healthcare services but also as a social protector ensuring that groups vulnerable are not marginalized from the national health system. This program simultaneously becomes a tangible manifestation of the principles of equity and social justice in inclusive national development.

However, the implementation of PBI contribution assistance faces a number of complex challenges, particularly in terms of the equity of facilities and the accuracy of targeting aid recipients. The disparity in the quality and availability of health facilities between urban and rural areas, especially in underdeveloped, frontier, and outermost regions (3T), remains a fundamental issue. Many areas face limitations in medical personnel, minimal health infrastructure, and difficult transportation access, resulting in gaps in healthcare services. On the other hand, the issue of targeting accuracy in the implementation

of PBI also poses a serious obstacle to achieving social justice. Many poor people are still not registered as aid recipients, while some economically capable individuals are still recorded as PBI participants. Although JKN has increased access to health services, there are still several structural problems that hinder the achievement of the program's goals (Suafisa et al., 2025). This condition indicates weak data governance and coordination among government agencies, which ultimately impacts the effectiveness of policies and the fairness of benefit distribution.

The purpose of this study is to provide a deeper understanding of the effectiveness of health subsidy policies through the Contribution Assistance Recipient (PBI) program within the National Health Insurance (JKN) system. Specifically, this study aims to analyze the mechanism for determining PBI recipient criteria, so that it can be understood to what extent the selection process has reflected the principles of fairness and targeting accuracy for the poor and underprivileged. In addition, this study also seeks to identify various obstacles that arise in the implementation of the PBI program, whether from regulatory aspects, inter-agency coordination, data availability, or the effectiveness of its execution in the field. Based on these findings, this study is expected to offer strategic solutions and constructive policy recommendations to promote improvements in the governance of the health subsidy program to be more effective, transparent, and socially equitable. Thus, the results of this research are expected to make a tangible contribution in efforts to strengthen the implementation of the right to health as a constitutional right of citizens and to reinforce inclusive governance in the field of healthcare services.

Therefore, in the context of inclusive governance, the provision of healthcare services must be oriented towards equity, participation, and a focus on vulnerable groups. The government needs to build a responsive and sustainable health system by strengthening data integration, enhancing the capacity of healthcare workers, and expanding the reach of facilities even to remote areas. Inclusivity in health governance is not only about expanding physical access to services but also about ensuring that every policy is designed and implemented with principles of social justice and public participation. Thus, ease of access to healthcare services becomes a key indicator of a country's success in fulfilling its constitutional mandate, which is to protect all the people of Indonesia and the entire nation, as well as to realize public welfare as stated in the Preamble of the 1945 Constitution.

METHOD

This study uses a normative legal approach, which focuses on the analysis of laws, regulations, and legal principles related to financial obligations and the protection of healthcare professionals (Marzuki, 2019). The normative approach emphasizes the examination of statutory provisions, legal doctrines, and relevant jurisprudence to determine legal boundaries and responsibilities in managing financial risks within healthcare institutions (Mertokusumo, 2019). This study identifies access to healthcare services through the Contribution Assistance Recipient (PBI) program, as stipulated in Article 14 paragraph (2) of Law Number 40 of 2004 concerning the National Social Security System, providing subsidies for National Health Insurance (JKN) premiums funded by the Regional Revenue and Expenditure Budget (APBD) for the poor and underprivileged.

This study explores in depth the mechanisms for determining the eligibility criteria for PBI recipients, the effectiveness of data collection through the Integrated Social Welfare Data (DTKS), as well as the implementation challenges at both central and regional levels. The analysis focuses on the extent to which this contribution subsidy policy can ensure fair, equitable, and sustainable access to health services for poor and vulnerable populations. In addition, the study examines structural, administrative, and socio-economic constraints that affect the program's targeting accuracy, while offering improvement strategies based on data

integration, institutional capacity enhancement, and strengthened cross-sectoral coordination. With this approach, the study aims to provide both conceptual and practical contributions to the reformulation of a more inclusive and socially just national health policy.

RESULT AND DISCUSSION

As a welfare state, not only includes how to organize welfare or social services, but also emphasizes that everyone receives social services as their right (Putra, 2021). Indonesia has a constitutional obligation to guarantee the right to health for all its citizens without discrimination. Within the framework of inclusive governance, access to healthcare services becomes an important benchmark for the country's success in realizing social justice. Through the National Health Insurance (JKN) policy and the Contribution Assistance Recipient (PBI) program, the government strives to expand the reach of health services for the poor and vulnerable communities. However, its implementation still faces complex challenges, such as inaccurate targeting of beneficiaries, disparities in facilities across regions, as well as weak data validation and cross-sector coordination. Therefore, the following discussion will comprehensively outline government policies in ensuring access to health services, analyze the problems in their implementation, and offers strategic steps toward more effective, inclusive, and equitable health governance.

Analysis of the Mechanism for Determining PBI Recipient Criteria and Identification of Obstacles in Program Implementation

As a form of the state's responsibility to guarantee the constitutional right to health, the Indonesian government implements the Contribution Assistance Recipient (PBI) program within the National Health Insurance (JKN) system. This program aims to ensure that every resident in Indonesia has equitable and comprehensive access to healthcare services (Alayda et al., 2024). The legal basis for implementing the PBI is regulated in Article 14 paragraph (2) of Law Number 40 of 2004 concerning the National Social Security System, which states that "Contributions for the poor and underprivileged are paid by the Government as participants of the social security program." This provision is reinforced through Presidential Regulation Number 82 of 2018 concerning Health Insurance, which was later amended by Presidential Regulation Number 64 of 2020, providing more detailed regulations regarding participation mechanisms, funding, and determination of contribution assistance recipients.

The determination of PBI recipients is carried out through a unified data-based mechanism, managed by the Ministry of Social Affairs (Kemensos) in the Integrated Social Welfare Data (DTKS). DTKS is an electronic data system containing social, economic, and demographic information of approximately 99 million individuals with the lowest welfare status in Indonesia. The Minister of Social Affairs Regulation Number 5 of 2019 on the Management of DTKS changed the name from Integrated Database (BDT) to DTKS. DTKS includes: Social Welfare Service Recipients (PPKS), Recipients of Social Assistance and Empowerment, and Social Welfare Potentials and Sources (PSKS). DTKS contains 40% of the population with the lowest social welfare status. This DTKS needs to be updated periodically so that the available data is up-to-date and accurate. The role of local governments, as stated in the appendix of Law Number 23 of 2004, must conduct data collection and management of the poor and vulnerable people within the scope of regencies/cities. However, based on data from Pusdatin Kemensos RI, it turns out that not all regencies/cities throughout Indonesia are actively finalizing the DTKS (Dwiarto, 2023).

The process is carried out gradually through several main stages, namely: first, data collected from sub-districts or villages is submitted to the District/City Social Service; then, from the District/City Social Service, it continues with issuing recommendations for the removal or addition of PBI JKN participants to the Provincial Social Service. From the

Provincial Social Service, it is then forwarded to the Ministry of Social Affairs to issue decrees on the removal/addition of PBI participants. The Ministry of Social Affairs forwards it to the Ministry of Health to be registered with BPJS Kesehatan, which will then be printed and distributed to sub-districts or villages. Data collection is very important in determining which residents are eligible to receive BPJS Kesehatan contribution assistance (PBI). Proper data collection is conducted by paying attention to technical guidelines and the importance of field officers' knowledge regarding the data collection guidelines mechanism is necessary so that the data collected is accurate, ensuring that the subsidy recipients are genuinely poor and underprivileged. In addition, the validation and verification process carried out periodically is also a key factor to ensure that subsidy recipients can continue to be monitored and updated. Properly conducted data collection can certainly make this program implemented effectively and efficiently (Hepat & Rachman, 2018).

In the regulations, PBI JK is aimed at the poor and underprivileged communities. The category of BPJS health participants under PBI is participants who fall into the category of the poor, as stipulated in the Decree of the Minister of Social Affairs of the Republic of Indonesia No. 146/HUK/2013 concerning the Determination of Criteria and Data Collection of the Poor and Underprivileged (Amalia & Husada, 2021). However, identifying data on poor communities certainly requires accurate data collection criteria to ensure it is correctly targeted. This needs to be done so that poor communities registered as PBI do not lose their right to receive health insurance contribution assistance.

The criteria for PBI recipients are basically based on household welfare indicators that include income, housing conditions, ownership of assets, and the level of family economic dependency. This multidimensional approach aims to ensure that the health subsidy program truly targets the communities most in need. In its implementation, the updating of the DTKS is carried out periodically to adjust to changes in the socio-economic conditions of the community. However, in the context of field implementation, this mechanism faces a number of quite complex issues.

The use of DTKS as the basis for determining PBI participants indeed provides a strong systematic framework, but it still leaves issues in terms of accuracy and targeting. Many regions face difficulties in quickly and comprehensively updating data on poor communities, especially in remote areas with limited digital infrastructure. As a result, there is the phenomenon of inclusion error (well-off individuals who are included as aid recipients) and exclusion error (poor individuals who are not recorded in the DTKS).

Furthermore, the definition of "poor" is often narrowly defined based solely on income, without considering other factors such as dependents, family health, or the cost of living in each region. However, poverty is relative and contextual; what is considered poor in urban areas is not necessarily equivalent to poverty in rural areas. Therefore, the mechanism for determining the criteria for PBI recipients needs to be continuously refined to better reflect the socioeconomic realities of society and align with the principles of distributive justice. The primary criterion for PBI participants is socioeconomic status, which is categorized as poor or underprivileged.

The Establishment of Criteria and Data Collection for the Poor and Underprivileged was created to facilitate implementation efforts in the field. The Decree of the Minister of Social Affairs concerning the establishment of criteria and data collection for the poor and underprivileged includes the following categories: a. registered poor and underprivileged; and b. unregistered poor and underprivileged. Registered poor and underprivileged households are households that meet the following criteria (Vyandri & Handoko, 2014):

a. have no source of livelihood and/or have a source of livelihood but are unable to meet basic needs;
b. have expenses primarily used to meet basic food needs;

c. are unable or have difficulty accessing medical care, except for community health centers or government-subsidized services;
d. are unable to purchase clothing once a year for each household member;
e. are only able to send their children to junior high school;
f. having walls made of bamboo/wood/walls in poor condition/low quality, including worn/mossy walls or walls that are not plastered;
g. having floors made of earth or wood/cement/ceramic in poor condition/low quality;
h.having roofs made of palm fiber/sobriety palm or tiles/zinc/asbestos in poor ondition/low quality;
i. having lighting in the residential building that is not electric or has electricity without a meter;
j. having a small floor area of less than 8 m2 per person; and
k. havingdrinking having drinking water sources from wells or unprotectedsprings/rivers/rainwater/other sources.

Furthermore, the poor and underprivileged who have not been registered include:
a). homeless people;
b). beggars;
c). individuals from isolated indigenous communities;
d). socio-economically vulnerable women;
e). victims of violence;
f). migrant workers with social problems;
g). poor communities affected by natural and social disasters after emergency response up to one year after the disaster;
h). individuals receiving benefits from social welfare institutions;
i). inmates of detention centers/correctional institutions;
j). people with thalassemia major;
k). people with post-immunization adverse events (KIPI).

The process of determining PBI participants is based on the Integrated Social Welfare Data (DTKS) managed by the Ministry of Social Affairs (Kemensos). The DTKS contains individual and family data that has been verified and validated by local governments through Village Deliberations (Musdes) or Sub-district Deliberations (Muskel). Through these forums, the community, along with village/sub-district governments, assesses who is eligible to be included in the list of poor households based on actual conditions on the ground. The results of the deliberations are then sent to the district/city Social Services Office for verification, and then submitted to the Ministry of Social Affairs for inclusion in the national DTKS. Only individuals registered in the DTKS and meeting the criteria for being poor or disadvantaged are eligible to be nominated as PBI participants.

Regional governments play a crucial role in verifying and validating prospective PBI participants. Based on Article 8 paragraph (1) of Minister of Social Affairs Regulation Number 3 of 2021, verification is conducted to ensure the accuracy of the recipient's socioeconomic status, while validation ensures the accuracy of identity and eligibility based on population data (NIK). These verification and validation activities are conducted at least twice a year or at any time if there are reports of changes in the community's economic condition. For example, if someone was previously poor but now has a permanent job, the regional government is required to report this change in status to the Ministry of Social Affairs to be removed from the PBI participant list.

Another administrative criterion that prospective PBI participants must meet is having a Population Identification Number (NIK) registered with the Dukcapil (Population and Civil Registration Office). This is in accordance with Article 3 paragraph (3) of Presidential Regulation No. 82 of 2018, which states that "Health Insurance participation is mandatory

and is registered based on the Population Identification Number." Thus, integration between DTKS data and population data is a primary prerequisite to ensure that PBI participants are legitimate Indonesian citizens and entitled to receive subsidies.

After the verification and validation process is complete, the Ministry of Social Affairs determines PBI participants nationally through a Ministerial Decree (Kepmensos). This Decree serves as the basis for BPJS Kesehatan (Social Security Agency) to activate membership and cover monthly premiums using the state budget (APBN). Participants identified in the Decree will receive a Healthy Indonesia Card (KIS) as proof of active membership. Participants who no longer meet the criteria may be excluded during the next data update period. The main obstacles to the implementation of the PBI program can be categorized into three aspects: structural and institutional obstacles, technical-administrative obstacles, and socio-economic obstacles within the community.

First, structural and institutional obstacles relate to the suboptimal coordination between agencies involved in program management. Structural obstacles refer to all institutional/institutional/personal obstacles, including legal instruments used by the government in implementing various policies, particularly those related to public interests, in the areas of governance, services, and development (Zulfiqar, 2014). Responsibility for implementing PBI involves various institutions, such as the Ministry of Social Affairs, the Ministry of Health, the Ministry of Home Affairs, and BPJS Kesehatan. However, there is no truly effective policy integration mechanism between these agencies. For example, differences in data update times between the Ministry of Social Affairs and the BPJS Kesehatan often result in delays in validating active participants, which impacts the right to services for the poor. Furthermore, some local governments lack the institutional capacity to conduct comprehensive data collection and field verification, particularly in areas with limited human resources and information technology.

Second, technical-administrative constraints arise from the lack of synchronization of population data between the DTKS (Current Status of Citizens) and the BPJS Kesehatan (Healthcare and Social Security Agency) membership database. Many poor people lack complete population documents such as KTP (National Identity Card) or KK (Family Card) (Hanyfa & Rustianingsih, 2024), making them difficult to input into the system. This results in delays in registration or even rejection of PBI (Public Health Insurance) participants. Furthermore, manual data verification mechanisms in some regions slow down the data update process and are prone to input errors. The limited integrated information system also hinders the government from monitoring the social mobility of people entering and exiting the poverty category, ultimately impacting the effectiveness of subsidy distribution.

Third, socio-economic constraints include a lack of literacy and public awareness of their rights and obligations under the JKN-PBI program. Many poor people still do not understand the participation procedures, program benefits, or health care claims mechanisms. In some cases, negative perceptions of services at health facilities arise due to previous experiences perceived as discriminatory or unsatisfactory. Social factors such as geographical distance to health facilities, transportation costs, and long waiting times also act as barriers for poor people to utilize health services guaranteed by the state.

These various obstacles demonstrate that the governance of the PBI program still faces serious challenges in realizing the principles of inclusivity and social justice. The government needs to strengthen its information technology-based data collection system by integrating the DTKS (Current Status Data), population data (Dukcapil), and BPJS health data to ensure greater accuracy and real-time effectiveness. Furthermore, a participatory oversight mechanism involving the community, social institutions, and local governments in the recipient verification process is essential to minimize targeting errors. Furthermore, increasing the capacity of social verification personnel at the village and sub-district levels is

crucial to ensure that the data validation process is not merely administrative but also considers the local socio-economic context. The government must also strengthen public communication and public health literacy so that the PBI program is not merely a symbol of social assistance but is truly utilized as a means to sustainably improve the health of the poor.

Thus, an analysis of the mechanism for determining PBI recipient criteria and identifying implementation obstacles indicates that the program's success is determined not only by budget availability but also by the effectiveness of inclusive, integrated, and adaptive governance to the social dynamics of the community. Data collection system reform, institutional capacity building, and community participation are key to ensuring that health subsidies through the PBI program are more targeted, efficient, and socially just. These efforts also strengthen the implementation of the right to health as a constitutional right of citizens and realize national development goals oriented towards shared prosperity. Research shows that although PBI has succeeded in increasing access to health services through Article 14 paragraph (2) of Law Number 40 of 2004 concerning the National Social Security System, the problem lies in the validation of recipient data which is often inaccurate, so that the wealthy continue to enjoy subsidies while some of the poor are missed.

Strategic Solutions to Make Health Subsidies More Effective and Fair

The basis for realizing the implementation of JKN is constitutionally guaranteed in the 1945 Constitution of the Republic of Indonesia, ILO Convention number 102 of 1952 also states the implementation of social security which includes health interests plus the issuance of the International Covenant on Economic, Social, and Cultural Rights and the International Covenant on Civil and Political Rights with the approval of the UN General Assembly (Romansyah et al., 2017). Fulfillment of the right to health as a constitutional right of citizens requires public policies that not only guarantee the availability of services, but also ensure that access to health services can be felt fairly by all levels of society. Basically, it is very important to examine in depth the pattern of protection and fulfillment of human rights in Indonesia (Qalsum & Wibowo, 2023). The Contribution Assistance Recipient Program (PBI) within the framework of the National Health Insurance (JKN) is one concrete form of state responsibility to realize social justice through health subsidies for the poor and underprivileged. One of the main causes of PBI targeting errors is inaccurate data in the Integrated Social Welfare Data (DTKS) used by the Ministry of Social Affairs.

The DTKS (Direct Social Security Entity List) is often not updated regularly or does not reflect the community's current economic conditions. Changes in household economic status, such as increased income, new asset ownership, or job changes, are often not reported promptly. As a result, individuals who should no longer be eligible are still listed as aid recipients. Furthermore, the field verification process conducted by local governments is sometimes purely administrative in nature, lacking direct observation of the community's actual conditions. This makes the selection system less sensitive to household economic dynamics. Another contributing factor is data manipulation by individuals or families to remain registered as PBI recipients.

Some residents deliberately fail to update their population data or claim to be from low-income families, viewing the PBI program as a social right without considering their actual economic situation. Furthermore, some residents do not understand the categories and criteria for PBI participation, assuming participation in the program is a form of general government insurance without requiring verification of economic capacity. This lack of understanding creates the misperception that the PBI program is accessible to everyone. Another problem arises from data misalignment between agencies such as the Ministry of Social Affairs, BPJS Kesehatan, and the Population and Civil Registration Office. For example, when someone moves, their population data is not automatically integrated with their BPJS membership

data, so they remain registered as a PBI recipient in their home region. This lack of data interoperability leads to duplication and delays in updating their membership status.

Furthermore, coordination between the central and regional governments is often weak, particularly during the validation and evaluation stages of beneficiaries. Coordination between government agencies is a fundamental aspect of governance, particularly in efforts to realize effective and sustainable welfare policies (Widjaja & Dhanudibroto, 2025). In the global context because it reflects efforts to find a balance between the need for greater regional autonomy and the need for effective coordination and control from the central government (Arifin, 2024). Some regions still rely on manual reporting and lack effective digital-based monitoring systems to ensure the validity of recipient data. However, various structural, administrative, and social obstacles identified in the implementation of PBI indicate that there remains a gap between constitutional ideals and the reality of implementation on the ground. Therefore, comprehensive strategic steps are needed to improve the governance of health subsidies to make them more effective, targeted, and equitable.

The first solution that must be prioritized is strengthening the data collection system through cross-agency integration and continuous data updating. To date, the root of the problem of inaccurate targeting of PBI recipients often stems from a misalignment between the Integrated Social Welfare Data (DTKS) managed by the Ministry of Social Affairs, BPJS Kesehatan participant data, and population data from the Ministry of Home Affairs (Dukcapil). To address this, the government needs to develop a national integrated data system that integrates all social, economic, and health databases into a single digital platform that can be accessed and updated in real time by both central and regional governments. Furthermore, the verification and validation process for PBI recipient data needs to be carried out with a participatory approach.

Regional governments can involve village officials, neighborhood associations (RT/RW), community organizations, and community leaders in conducting ground-checks on data on the poor to ensure more accurate results and reflect the true socio-economic conditions. This participatory mechanism can also promote public transparency and prevent data manipulation by certain parties. With a robust, open, and integrated data system, health subsidies will be more targeted and able to reach those who truly need them. Evaluations indicate that data integration between the BPJS Kesehatan (Social Security Agency) and the population and socio-economic systems remains imperfect. The lack of a comprehensive information system results in participant data sometimes being out of date, leading to errors in determining the status of PBI participants (Santoso & Wardhana, 2025).

The effectiveness of health subsidies depends not only on the accuracy of recipient data but also on equitable and sustainable funding policies. The government needs to reform the JKN-PBI funding mechanism so that program funding is not simply based on annual quotas but also on the real needs of the poor in each region. The fund allocation system should use a needs-based approach, taking into account the number of poor people, the burden of disease, and the level of vulnerability in the region. In addition, the government can develop a tiered subsidy model where the amount of the subsidy is adjusted to the level of economic capacity of the community.

This scheme allows near-poor households not fully covered by the National Health Insurance (JKN) program (PBI) to still receive partial subsidies, thus preventing them from falling back into poverty due to healthcare costs. Furthermore, a progressive contribution mechanism from high-income groups or corporations through corporate social responsibility (CSR) programs and health taxes is needed, demonstrating social solidarity and the principle of mutual cooperation that underpins the national social security system. Effective health subsidies also depend on the extent to which local governments are able to optimally

implement health care services. Decentralization of authority in the health sector provides a significant role for regions in supporting the implementation of JKN-PBI.

However, many regions still face limitations in institutional capacity, medical personnel, and healthcare facilities. Systemic changes in healthcare services are needed to ensure excellence for all (Ikhtiari & Tarring, 2024). Remote areas in Indonesia generally have limitations in accessibility, both in terms of transportation, infrastructure and information technology. (Yatni et al., 2025). However, many regions still face limitations in institutional capacity, medical personnel, and health facilities. Therefore, strengthening local government capacity is the next strategic step. The central government needs to strengthen synergy with local governments through technical assistance, human resource capacity building, and joint oversight of health subsidy distribution. Furthermore, it is necessary to revitalize primary health care services such as community health centers (Puskesmas), primary clinics, and integrated health posts (Posyandu) to ensure their optimal function as the spearhead of health care for the poor.

Strengthening primary care services will not only increase the efficiency of health financing but also help reduce morbidity and reduce the financial burden at the hospital level. The government can also encourage the use of digital technology in the referral system and health monitoring for the poor, such as telemedicine, online queuing systems, and electronic medical records integrated with BPJS participant data. This step will improve the accessibility and effectiveness of health services, especially for people in remote areas. Equity in health subsidies can be achieved not only through sound policies but also through public awareness and active participation. Therefore, improving health literacy and social security literacy is a crucial part of the strategic solution.

The government, together with BPJS Kesehatan and community organizations, needs to conduct ongoing education regarding the rights and obligations of JKN participants, the procedures for PBI participation, and the benefits available. This literacy campaign should be conducted using a cultural and local approach, for example through health cadres, religious leaders, or community media, to ensure the message is more easily accepted by the community at the grassroots level. Public participation also needs to be strengthened in the planning and monitoring of health subsidy programs. Communities should be involved in village deliberation forums, regional health forums, or digital complaint channels to provide space to provide input, convey complaints, and monitor program effectiveness.

The final strategic solution is to strengthen inclusive, transparent, and accountable governance in the implementation of the health subsidy program. The government must establish a more effective oversight mechanism to prevent irregularities, both in data collection, budget allocation, and field implementation. Oversight can be carried out through a combination of internal audits, external oversight by the Supreme Audit Agency (BPK) and the Corruption Eradication Commission (KPK), and public accountability mechanisms through the involvement of civil society and independent institutions. Furthermore, a reward and punishment system is needed for local governments in implementing the PBI program.

Regions that successfully improve targeting accuracy, budget efficiency, and service quality can be awarded fiscal incentives, while regions that fail or are found to have irregularities should be subject to administrative sanctions. This performance-based approach will create stronger motivation for regions to continuously improve health subsidy governance. Overall, the success of health subsidies through the PBI program depends on three main foundations: accurate recipient data, funding efficiency, and inclusive governance. All three must be implemented simultaneously and sustainably, involving collaboration between the central and regional governments, social institutions, and the community. The principle of social justice as mandated in Article 34 paragraph (2) of the 1945 Constitution

must be the spirit of every health policy—that the state not only provides services, but also ensures that these services can be accessed fairly by all citizens without discrimination.

With these strategic steps, it is hoped that the health subsidy program can truly become an instrument for equitable welfare distribution, strengthening social solidarity, and accelerating the realization of inclusive governance in the health sector. On a macro scale, a population with a good level of health is an important input for reducing poverty, increasing economic growth rates, and playing a large role in long-term economic development (Murniati et al., 2021). Ultimately, the effectiveness of health subsidies is measured not only by the number of recipients, but by the extent to which every citizen, regardless of social and economic background, can enjoy their constitutional right to a healthy and dignified life. By considering various policy dynamics and the implementation challenges of the PBI program within the National Health Insurance system, this study confirms that efforts to fulfill the right to health cannot be achieved solely through fiscal interventions but rather require governance reforms based on data integration, cross-sector collaboration, and social participation that adapts to socio-economic changes in society.

A reconstructive approach to the PBI data collection and verification system emphasizes the concept of data justice in data management as an instrument to ensure that health subsidies truly reach the poor and vulnerable groups appropriately, accurately, and sustainably. This approach shifts the PBI policy paradigm from merely administrative assistance to an instrument for equitable welfare distribution based on distributive justice, transparency, and social accountability. Government efforts such as the integration of the Health Data Collection (DTKS), monitoring of aid distribution, and the construction of Primary Hospitals are significant improvements in strengthening an inclusive and equitable health system. These policies demonstrate the state's commitment to closing the gap in health services between regions and ensuring that every citizen, without exception, has access to adequate health facilities. Therefore, the results of this study are expected to provide conceptual and practical contributions to strengthening the direction of national health development that is inclusive, equitable, and in accordance with the constitutional mandate of the Indonesian welfare state.

CONCLUSION

The analysis concludes that the effectiveness of the Premium Assistance Recipient (PBI) program depends heavily on accurate recipient data collection and equitable distribution of healthcare services across Indonesia. Targeting accuracy not only reflects administrative success but also measures the extent to which the state is committed to guaranteeing the right to health for all citizens without discrimination. Therefore, strengthening an integrated database, continuous verification, and improving healthcare infrastructure and facilities are key prerequisites for the program's optimal operation. With these measures, the PBI program serves not only as a social protection instrument but also as a concrete manifestation of the state's commitment to realizing social justice and public welfare in the health sector.

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