Journal of International Islamic Law, Human Right and Public Policy
(JISHUP Journal) | ISSN (e): 3031-2280
Website https://jishup.org/index.php/ojs/index | Volume 4 No. 4 (2026)

LEGAL REVIEW OF LOCAL GOVERNMENT PRIMARY HEALTHCARE FACILITY SELECTION FOR JKN PBPU PEMDA PARTICIPANTS

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Received: 22/07/2026 | **Revised:** 10/08/2026 | **Accepted:** 24/08/2026 | **Published:** 30/10/2026

Abstract

Indonesia's National Health Insurance (JKN) program requires coordination between central and local governments, particularly in financing vulnerable residents through the locally funded PBPU Pemda scheme. This article examines tensions between regional head regulations directing participants to public community health centers (Puskesmas) as their first-level healthcare facilities (FKTP) and Article 6A of Presidential Regulation No. 59 of 2024, which protects participants' freedom of choice. Using normative legal research with statutory and conceptual approaches, the study assesses regulatory hierarchy, administrative discretion, fiscal sustainability, and principles of good governance. The findings indicate that conflicting local provisions arise partly from the absence of specific national operational guidance addressing regional financing responsibilities. Directing enrolment toward Puskesmas may support capitation-based funding, preventive programs, and service supervision, but compulsory placement risks violating superior regulations. Harmonized implementing rules are therefore needed to establish lawful, proportionate enrolment arrangements that safeguard public health financing without undermining participants' rights to choose accessible and appropriate healthcare facilities.

Keywords: Budget sustainability; JKN; Legal certainty; PBPU Pemda; Regulatory harmonization.

INTRODUCTION

Health is a fundamental human right and an essential element of public welfare under the 1945 Constitution of the Republic of Indonesia. To fulfill this commitment, the government established the National Health Insurance program (Jaminan Kesehatan Nasional, JKN) within the National Social Security System (Sistem Jaminan Sosial Nasional, SJSN) (Law No. 40 of 2004, Article 18). Implementing JKN is a shared responsibility that requires coordination between the central government and local governments (pemerintah daerah, Pemda). Local governments contribute by enrolling residents who lack health insurance and paying their contributions from regional budgets (Anggaran Pendapatan dan Belanja Daerah, APBD). This locally financed group, commonly referred to as PBPU Pemda, forms part of regional efforts to expand universal health coverage (UHC), consistent with Presidential Instruction No. 1 of 2022.

These commitments place substantial demands on local public finances. Seeking to maintain fiscal sustainability and make effective use of publicly owned healthcare facilities, some local governments have adopted regional head regulations (Peraturan Kepala Daerah, Perkada) governing JKN implementation. Such regulations may direct PBPU Pemda participants to select a public community health center (Pusat Kesehatan Masyarakat, Puskesmas) as their first-level healthcare facility (Fasilitas Kesehatan Tingkat Pertama, FKTP). From a regional budgeting perspective, this arrangement is intended to sustain the flow of JKN capitation payments to public primary care services and help Puskesmas maintain their operations (Hasyimzoem et al., 2023).

The rationale is not exclusively financial. Private first-level facilities generally emphasize individual clinical care (upaya kesehatan perorangan, UKP), whereas Puskesmas also have a public-health mandate (upaya kesehatan masyarakat, UKM) (Minister of Health Regulation No. 19 of 2024, Article 7). Concentrating locally financed JKN participants at Puskesmas may help district health offices assess community health conditions, organize preventive interventions, and connect vulnerable residents with territorial public-health programs. Administrative oversight is a further consideration. As local technical implementing units, Puskesmas operate under the district or municipal

health office (Minister of Health Regulation No. 19 of 2024, Article 49). This institutional relationship enables more direct monitoring, evaluation, coaching, and improvement of service quality. When participants are dispersed across private clinics, local governments must rely to a greater extent on indirect mechanisms to assess care quality and account for the effectiveness of expenditure. Government programs also require action on stunting, maternal and infant mortality, immunization, tuberculosis, and HIV/AIDS; Puskesmas play a central role in delivering these services (Minister of Health Regulation No. 6 of 2024). Nevertheless, this administrative and fiscal rationale raises a legal problem. Presidential Regulation No. 59 of 2024, the third amendment to Presidential Regulation No. 82 of 2018 on Health Insurance, introduced Article 6A on participants' rights to determine and change their first-level healthcare facility. Local provisions that make Puskesmas registration compulsory may therefore conflict with the national rule guaranteeing participant choice. Local governments must reconcile their obligations to finance and supervise services with the legally protected rights of JKN members.

This dispute should also be examined in light of the technical instruments available to regional administrators. The study identifies a lack of specific central operational guidance addressing how local governments should reconcile JKN participant choice with their responsibility to finance coverage for PBPU Pemda residents. The resulting uncertainty has encouraged regional policy initiatives that may be challenged for inconsistency with higher-ranking rules (Ridwan HR, 2024). This article consequently investigates two questions: (1) How does the absence of central technical guidance affect regional policies governing the selection of FKTP by PBPU Pemda participants? (2) Why is regulatory harmonization necessary to balance participants' freedom of choice and regional fiscal sustainability under the general principles of good governance?

LITERATURE REVIEW

Existing scholarship provides a foundation for assessing local JKN administration, although it does not fully address the particular regulatory conflict examined here. Wahyudi (2025) emphasizes the role of local governments in ensuring the sustainability, accountability, and quality of JKN services. Karim et al. (2018) show that the implementation of regional public-health policy depends on coordination between local regulation and enrolment governance. Sinaga et al. (2021) highlight disparities in access and service quality, while Hasibuan et al. (2024) examine the management and use of JKN capitation funds at Puskesmas. Taken together, these studies establish the importance of regional implementation capacity, financing, and institutional accountability.

The legal literature offers a complementary perspective. Busroh et al. (2023) argue that simplifying and synchronizing regulations can improve legal effectiveness and limit uncertainty. Surya and Wahab (2023) likewise associate regulatory harmonization with good governance. Indonesian administrative law provides two particularly relevant concepts: the hierarchy of legal norms, including the principle lex superior derogat legi inferiori, and administrative discretion (freies Ermessen) exercised within statutory limits (Law No. 12 of 2011; Law No. 30 of 2014; Ridwan HR, 2024). The general principles of good governance (Asas-Asas Umum Pemerintahan yang Baik, AUPB) further require attention to the public interest and quality of public services.

A remaining gap concerns the intersection of these issues. Previous studies have not specifically explained how a perceived absence of detailed central implementing rules may prompt local governments to steer PBPU Pemda participants toward Puskesmas, despite national rules protecting facility choice. The contribution of this study is a normative assessment of that interaction, rather than a claim that the administrative rationale can displace participant rights established by superior legislation.

METHOD

This study employs normative legal research, which examines positive-law norms and relevant legal scholarship (Kristiawanto, 2022). A statutory approach is used to assess consistency between central regulations and local rules, including the potential regulatory gap at the operational level. A conceptual approach is then applied to regional autonomy, administrative discretion, fiscal sustainability, and the general principles of good governance (Efendi & Ibrahim, 2018). Legal materials were collected through library research by identifying and classifying legislation, regional regulations, books, and scholarly articles relevant to JKN administration. The main legal materials include Presidential Regulation No. 59 of 2024, Laws Nos. 12 of 2011 and 30 of 2014, and selected regional head regulations. The materials were assessed through qualitative descriptive-prescriptive analysis. Conclusions were developed deductively by applying general legal principles to the issue of primary healthcare facility allocation for locally financed JKN participants. The regional regulations in Table 1 serve as illustrative documentary examples, not as a representative statistical sample of all Indonesian local governments.

RESULTS AND DISCUSSION

1. Implications of the Absence of Central Technical Regulations for Local FKTP Policies

JKN is a national program centrally regulated to promote consistent healthcare standards across Indonesia. Regional governments participate by enrolling eligible residents and paying their JKN contributions through the APBD under the PBPU Pemda mechanism. Regional heads use Perkada to establish operational arrangements for local insurance administration. In practice, however, the demand for fiscal efficiency and continued Puskesmas operations may be difficult to reconcile with the absence of explicit technical guidance for managing enrolment without restricting the right to select an FKTP. Several municipal and district regulations illustrate the resulting approaches. Some require locally registered participants to accept placement at publicly owned primary care facilities, while others provide for registration at a Puskesmas based on a participant's residential address. Table 1 presents four examples identified in the source manuscript through local legal documentation and information networks (Jaringan Dokumentasi dan Informasi Hukum, JDIH).

Table 1. Regional head regulations concerning FKTP selection for PBPU Pemda participants

No.	Local government	Regulation	Provision	Relevant requirement
1	Semarang City	Mayor Regulation No. 8 of 2025 on the Implementation of Health Insurance	Art. 5(2)(b)	Residents registered by the local government agree to registration at a local-government-owned FKTP.
2	Yogyakarta City	Mayor Regulation No. 27 of 2025 on the Implementation of Regional Health Insurance	Art. 5(3)	Residents enrolled by the local government agree to use a Puskesmas in the region as their registered FKTP.
3	Lebak Regency	Regent Regulation No. 110 of 2023 on Technical Guidelines for Locally Financed Non-Wage-Earner and Non-Worker JKN Participants	Art. 7	Participants whose contributions are financed by the local government are assigned to a Puskesmas according to the address recorded in their population documents.
4	Bangka Regency	Regent Regulation No. 51 of 2023 on Health Insurance for the Population of Bangka Regency	Art. 8(1)	Health insurance participants are entitled to receive first-level care at government-owned FKTP, namely Puskesmas throughout Bangka Regency.

Source: Compiled from regional legal documentation and information networks (JDIH), as cited in the original manuscript.

The documents reveal a recurring policy orientation toward publicly owned first-level facilities in the four jurisdictions reviewed. They illustrate a regulatory issue extending beyond a single local authority, although the selected cases do not establish its national prevalence. Local governments have an identifiable interest in ensuring that capitation payments support the operation of public health facilities and that healthcare programs remain administratively manageable.

From a formal legal perspective, compulsory Puskesmas selection is difficult to reconcile with Article 6A of Presidential Regulation No. 59 of 2024, which the study reads as protecting JKN participants' freedom to choose and change FKTP regardless of membership category. Under the principle lex superior derogat legi inferiori, regulations issued by regional heads may not contradict higher-level presidential regulations (Law No. 12 of 2011, Articles 7–8). Accordingly, regional financing arrangements cannot themselves supply authority to override rights protected by a superior legal norm.

However, attributing the entire conflict to an abuse of regional power would overlook the institutional context. According to the legal materials examined, neither a dedicated Ministry of Health regulation nor detailed BPJS Kesehatan operational guidance specifically resolves the tension between participant choice and the budgetary responsibilities of PBPU Pemda sponsors. In the absence of clear instruments, local authorities have sought administrative solutions to preserve the financial viability of Puskesmas while meeting UHC and minimum service standard commitments. The central government's policy objectives and regional implementation obligations thus remain insufficiently integrated.

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Indonesian administrative law recognizes discretion as a means of responding to concrete governance problems when legislation is incomplete or does not provide adequate direction (Law No. 30 of 2014, Articles 22–24; Ridwan HR, 2024). Regional officials may regard FKTP enrolment direction as an exercise of such discretion, intended to protect public funds and facilitate the achievement of minimum health service standards. Nevertheless, discretion is not unlimited: its exercise must remain consistent with statutory purposes, competence, applicable procedures, and higher-ranking norms. A general claim of fiscal necessity cannot automatically validate a Perkada provision that restricts an express right established by presidential regulation. The central consequence is legal uncertainty for local governments. A Perkada that attempts to impose mandatory FKTP placement could be subject to administrative supervision or judicial challenge, while local authorities remain responsible for health financing and service outcomes. The appropriate response therefore requires more than blaming local officials or removing isolated provisions. It calls for clear central guidance that reconciles regional administrative responsibilities with participant rights and establishes legally defensible implementation criteria.

2. Regulatory Harmonization, Regional Fiscal Sustainability, and Participants' Rights under Good Governance Principles

An assessment of regional FKTP policies should not end with an analysis of legal hierarchy. Their governance rationale must also be considered through the general principles of good governance (AUPB) established in Indonesian administrative law, particularly the public interest principle and the principle of good public service (Law No. 30 of 2014, Article 10). These principles help explain the objectives pursued by local governments, while also placing limits on the methods used to pursue them.

First, the public interest principle requires government decisions to prioritize collective welfare and social benefit. Directing capitation funding toward government-run Puskesmas may be intended to sustain their operational costs, remuneration of health personnel, and the delivery of community-oriented health programs. Puskesmas support preventive and promotive activities, including integrated community health services (posyandu), nutrition counseling, and disease prevention. The use of capitation funds is regulated, including under Presidential Regulation No. 32 of 2014, Article 12. The issue is therefore not merely whether a local government can maximize revenue, but whether publicly financed primary care remains capable of serving residents reliably.

A substantial loss of registered participants to private facilities could reduce Puskesmas capitation receipts and, depending on funding arrangements, undermine their operating capacity. Such an outcome may affect community-wide services that are not routinely provided under the same public-health mandate by private primary care clinics. From this perspective, regional enrolment policies may represent an attempt to protect public-health continuity rather than a purely commercial initiative. Yet the public interest must be considered alongside each participant's legal entitlement to select an appropriate provider; one objective does not categorically cancel the other.

Second, the principle of good public service emphasizes accessible, accountable, and effective administration. Concentrating some vulnerable PBPU Pemda residents at Puskesmas may facilitate the health office's monitoring of quality standards, coordination of medical staff, tracking of minimum health services, and implementation of priority programs addressing malnutrition, maternal and child health, and tuberculosis. These potential benefits provide a policy rationale for strengthening Puskesmas, but they do not eliminate the need for participants to have reasonable access to alternatives when a particular facility is distant, over capacity, or unable to provide necessary services.

The difficulty arises when reasonable administrative aims are implemented without sufficient legal safeguards. In the absence of national technical guidance defining permissible enrolment management, a Perkada may be criticized for restricting individual choice or concentrating service provision in public facilities. Accordingly, harmonization is needed to address the legal status of local enrolment arrangements, rather than relying only on their perceived budgetary advantages. A jointly developed instrument involving the Ministry of Health, the Ministry of Home Affairs, and BPJS Kesehatan could establish operational standards compatible with the presidential regulation. One proposal in the source study is a proportionate enrolment arrangement that takes Puskesmas capacity, local population needs, and regional financial obligations into account. For example, a planning model could assume that approximately 70–80% of initially registered PBPU Pemda participants would be allocated to public health centers, with the remaining places available for participants facing geographic, capacity-related, or medical access constraints. This percentage is an illustrative policy proposal, not an existing legal quota or a finding established by empirical testing. Any future model would require a lawful regulatory basis, objective and transparent criteria, and safeguards ensuring that it does not unlawfully constrain participants' right to select or change their FKTP.

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Under such an approach, exceptions and transfers would need to be available where the designated Puskesmas is geographically inaccessible, has exceeded its service capacity, or lacks a service required by the patient. More generally, meaningful participant choice should be preserved throughout enrolment and transfer procedures. Local authorities could simultaneously assess primary care capacity and improve Puskesmas quality rather than relying on mandatory assignment as the principal instrument of fiscal management. A carefully designed national framework could thereby improve legal certainty, regional budget accountability, and access to healthcare.

CONCLUSION

Regional head regulations directing PBPU Pemda participants to register with Puskesmas as their first-level healthcare facilities raise a hierarchical legal conflict with the participant-choice guarantee examined in Article 6A of Presidential Regulation No. 59 of 2024. Normative analysis indicates that this conflict is not adequately explained by regional overreach alone. It also reflects the absence of sufficiently specific central operational guidance for reconciling locally funded JKN obligations with participants' freedom to choose their FKTP. Fiscal constraints and the need to maintain public healthcare facilities help explain the regional response, but cannot by themselves displace requirements imposed by superior legislation.

Under the principles of public interest and good public service, local governments have legitimate reasons to maintain Puskesmas financing, strengthen direct service supervision, and deliver preventive and promotive programs. These responsibilities must nevertheless be performed within a clear and rights-respecting regulatory framework. Regulatory harmonization is essential to reduce legal uncertainty, sustain effective primary care, and protect JKN participants from unjustified limits on provider choice.

Recommendations

The Ministry of Health, the Ministry of Home Affairs, and BPJS Kesehatan should develop specific implementing guidance on PBPU Pemda enrolment, including transparent criteria for facility capacity, geographic accessibility, transfer procedures, and local financial accountability. Any proportionate allocation scheme should be adopted only if consistent with superior legislation and participants' choice rights. District and municipal governments should concurrently map and improve Puskesmas service capacity and revise relevant Perkada as national implementing rules are clarified.

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