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Policy Review of Health Services for Abandoned Children Without National Identification Number (NIK) Under BPJS Health System

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Abstract

ABSTRACT
Background of study: This study examines the legal and administrative challenges faced by hospitals in providing BPJS Health services to abandoned children without a National Identification Number (NIK) in Indonesia. Despite constitutional guarantees of healthcare for all citizens, the absence of explicit regulatory mechanisms for patients without formal identification creates significant financial and operational risks for healthcare providers.
Aims and scope of paper: The research aims to analyze the policy gaps in the BPJS Health system regarding coverage for abandoned children without NIK and to assess the resulting implications for hospital operations and health equity. It focuses on evaluating existing regulations and their implementation through a health policy framework.
Methods: A qualitative policy analysis was conducted using Walt & Gilson's Policy Triangle framework (context, process, actors, content) and the concept of health equity. Data were collected through a comprehensive review of legal documents, government regulations, academic literature, and reports on BPJS claim processes
Result: The analysis reveals significant regulatory gaps, as current policies do not explicitly include abandoned children without NIK as eligible beneficiaries. Hospitals face substantial administrative barriers, with 61.39% of claim delays attributed to incomplete documentation. Services for these children are often categorized as unfunded emergency or social care, creating financial strain on healthcare facilities and inconsistent access for vulnerable populations.
Conclusion: The study concludes that clear legal instruments and standardized operational procedures are urgently needed to protect hospitals, ensure transparent claim mechanisms, and guarantee equitable healthcare access for abandoned children without NIK. Policy reforms should address both administrative requirements and systemic coordination among stakeholders to achieve true universal health coverage.

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INTRODUCTION

Background of the study:

Abandoned children in Indonesia represent a profound social and public health challenge, with official records documenting 64,053 children in this vulnerable status as of 2019 (Haris & Saleh, 2021). These children face compounded health risks due to unstable living conditions, nutritional deficiencies, and limited access to basic sanitation, making them particularly susceptible to communicable diseases and chronic health problems. The Indonesian Constitution, specifically Article 34 of the 1945 Constitution, establishes the state's responsibility to protect and provide for abandoned children, including ensuring their access to healthcare services through national social security mechanisms (Sulistiyono et al., 2025). This constitutional mandate has been operationalized through the National Health Insurance (JKN) program administered by BPJS Kesehatan, which aims to provide universal health coverage for all Indonesian citizens (Prasetyo, 2015). However, the implementation of this program encounters significant structural barriers when applied to populations lacking formal documentation, creating a critical gap between policy intent and practical accessibility for those most in need of protection (Clifford et al,. 2023) .

The legal framework governing healthcare access has evolved through several key legislative instruments, most notably Law Number 17 of 2023 concerning Health and Law Number 24 of 2011 regarding the Social Security Administering Bodies (BPJS) (M. F. Ramadani et al., 2023). These laws collectively affirm the right to health for all citizens and establish the operational parameters for Indonesia's health insurance system. The more recent Government Regulation Number 28 of 2024 concerning the Implementation of the Health Sector further elaborates on service delivery mechanisms and financing arrangements within the national healthcare ecosystem. Despite this progressive legislative landscape, technical implementation guidelines remain inadequately specified for marginalized populations, particularly concerning administrative requirements that inadvertently exclude undocumented individuals from systematic healthcare access. This regulatory ambiguity creates operational uncertainties for healthcare providers attempting to serve these vulnerable groups while complying with systemic requirements (Salman et al,. 2025).

The administrative heart of the BPJS registration and claims process revolves around the National Identification Number (NIK), which serves as the primary key for accessing services and processing financial reimbursements. This requirement, while streamlining operations for the majority of citizens, creates an insurmountable barrier for abandoned children who frequently lack birth certificates or any formal registration with civil authorities. Research by Sari and Hidayat (2023) demonstrates that administrative documentation issues represent the most significant cause of claim processing delays within the BPJS system, accounting for over 61% of pending cases. This systemic dependency on formal identification effectively transforms a technical administrative requirement into a substantive barrier to healthcare access, contradicting the universal coverage principles upon which the JKN system was founded and perpetuating health inequities (Azizatunnisa et al., 2026).

For healthcare institutions, particularly private hospitals operating within stringent financial constraints, providing services to patients without NIK generates substantial economic and legal vulnerability. Without clear procedural guidelines for claim submission under such circumstances, hospitals risk providing uncompensated care, potentially threatening their financial sustainability. Agustina et al. (2019) highlight how reimbursement delays and claim rejections create cash flow problems that can undermine service quality and institutional viability. The absence of standardized protocols forces individual hospitals to develop ad-hoc solutions, often relying on inconsistent collaborations with local social service agencies, leading to fragmented and inequitable service landscapes across different regions of Indonesia.

Literature review:

Theoretical exploration of health policy implementation challenges frequently employs the Walt and Gilson policy analysis triangle, which examines the dynamic interplay between context, content, process, and actors within policy systems. Zahidie et al. (2023) elaborate on this framework's utility in diagnosing implementation gaps, particularly in complex, multi-stakeholder environments like national health insurance programs. This framework provides a valuable lens through which to analyze Indonesia's BPJS system, allowing researchers to disentangle technical administrative failures from deeper structural and political economy constraints that shape healthcare access. Applying this model to the issue of abandoned children without NIK helps illuminate how well-intentioned policies can produce exclusionary outcomes when implementation mechanics are not aligned with the realities of vulnerable populations (N. A. Ramadani et al., 2025).

Scholarly investigation into Indonesia's journey toward Universal Health Coverage (UHC) consistently identifies the tension between inclusive aspirations and exclusionary administrative practices. Pisani, Olivier Kok, and Nugroho (2017) trace the political evolution of the JKN system, noting that while the policy represents a remarkable commitment to health equity, its operational design remains heavily influenced by bureaucratic traditions prioritizing documentation and formal registration. This creates a fundamental paradox where the system designed to include all citizens systematically excludes those without formal legal status. The literature suggests that such gaps are not unique to Indonesia but represent a common challenge in many middle-income countries attempting to rapidly scale health insurance coverage while building civil registration systems simultaneously (Hacker et al,. 2015).

Research specific to healthcare financing for vulnerable populations emphasizes the critical importance of alternative identification and referral mechanisms. International evidence indicates that successful inclusion of undocumented groups often requires deliberate policy adaptations, such as provisional identification numbers, vouchers systems, or direct facility financing for designated vulnerable groups. Studies on similar populations in other Southeast Asian nations reveal that proactive measures by health and social welfare ministries can effectively bridge identification gaps, ensuring service access while maintaining necessary administrative oversight. However, as noted by Ramadhani, Aspan, and Hasrul (2021), the Indonesian policy discourse has yet to systematically address this issue, leaving healthcare providers in a legally ambiguous position (Listyaningrum, 2025).

The concept of health equity serves as a fundamental ethical benchmark for evaluating health system performance, demanding particular attention to the needs of the most disadvantaged groups. Scholarly work on equity in health financing argues that systems should be judged not only by aggregate coverage statistics but also by their effectiveness in reaching populations at the margins. This body of literature contends that financial protection mechanisms must be specifically designed with, not just for, vulnerable groups to avoid creating new forms of exclusion. The situation of abandoned children without NIK in Indonesia presents a clear test case for the nation's commitment to these equity principles, revealing significant shortcomings in the current operational model of BPJS Kesehatan (Rodney & Hill, 2014).

Gap analysis:

Despite comprehensive constitutional and legislative mandates guaranteeing health rights, a significant implementation gap persists specifically regarding abandoned children without National Identification Numbers. Current regulations, including Presidential Regulation Number 82 of 2018 on Health Insurance and its technical guidelines, fail to provide explicit mechanisms for enrolling, identifying, or processing claims for children lacking formal documentation (Sartono et al., 2025) . This regulatory silence creates a grey zone where healthcare providers are expected to fulfill ethical and legal duties to provide emergency care, yet are denied reliable pathways for obtaining reimbursement through the national insurance system. The resulting dependency on inconsistent local government subsidies or hospital charity budgets undermines both the financial sustainability of providers and the reliable access to care for this vulnerable group, directly contradicting the universal coverage goals explicitly stated in national health policy (Samart & Rinehart, 2024)

Rationale of the study:

This study is urgently needed to generate empirical evidence and policy analysis that can inform concrete reforms to Indonesia's health insurance system. By systematically documenting the specific administrative, financial, and legal barriers that both healthcare facilities and abandoned children face, the research provides a foundation for evidence-based policy dialogue. Addressing this gap is not merely a technical adjustment but a fundamental requirement for achieving meaningful universal health coverage that aligns with Indonesia's constitutional commitments and international human rights obligations. The study's findings have direct relevance for policymakers at the Ministry of Health, BPJS Kesehatan, and local governments, as well as for healthcare providers seeking clearer operational guidance (Cheng et al., 2025).

Purpose of the study:

This research aims to conduct a comprehensive policy analysis of the BPJS Health system's provisions and implementation regarding abandoned children without NIK. Specifically, it seeks to identify the precise regulatory gaps that create barriers to healthcare access, analyze the operational challenges faced by hospitals in serving this population, and evaluate the resulting health equity implications. Based on this analysis, the study will develop evidence-based recommendations for policy and procedural reforms that can protect healthcare institutions financially while guaranteeing abandoned children their fundamental right to health services, thereby contributing to more inclusive and effective universal health coverage in Indonesia.

METHOD

Research Design:

This study employed a qualitative research design focusing on policy analysis. The approach was descriptive-analytical, aimed at examining and interpreting existing health policies, identifying implementation gaps, and analyzing systemic challenges within the operational framework of BPJS Kesehatan regarding a specific vulnerable population. The design is best categorized as a documentary analysis or policy review study, which aligns with the aim of understanding the phenomenon of healthcare access barriers rooted in regulatory and administrative systems (Zahidie et al., 2023).

Participant:

This study did not involve human subjects as participants. The unit of analysis consisted of policy documents, legal texts, government regulations, and published academic literature. Therefore, no ethical clearance related to human participation was required.

Population and the methods of sampling:

The population for this study encompassed all relevant Indonesian legal and policy documents related to health insurance, social security, child protection, and civil administration, published up to 2024. A purposive sampling method was used to select documents. The sampling criteria included: 1) Documents with direct relevance to the administration of BPJS Kesehatan (e.g., laws, government regulations, presidential decrees, BPJS operational guidelines); 2) Academic publications (journal articles, reports) discussing healthcare access for vulnerable groups or BPJS claim mechanisms; and 3) Official reports and data from government agencies (e.g., Ministry of Health, Ministry of Social Affairs) pertaining to abandoned children and health service coverage.

Instrument:

The primary instrument was a structured document analysis protocol developed by the researchers. This protocol guided the systematic extraction of data from the sampled documents. The protocol included fields for: document source, type, year, key provisions related to eligibility and identification, explicit mentions (or omissions) of populations without official identification, and described administrative procedures for claim submission. The framework for analysis itself, Walt & Gilson's Policy Triangle (Context, Actors, Process, Content), served as the analytical instrument to categorize and interpret the extracted data (Zahidie et al., 2023). No scoring method or psychometric validation was applicable, as the analysis was qualitative and interpretive.

Procedures and time frame:

The research was conducted over a four-month period. The procedure involved three sequential phases:

1. **Document Collection and Screening (Month 1):** Relevant documents were identified through searches in legal databases (such as *JDIH*), government websites, and academic databases (Google Scholar, PubMed, Garuda). Documents were screened against the inclusion criteria.
2. **Data Extraction and Organization (Month 2):** The analysis protocol was applied to each included document. Key text segments, provisions, and data points were extracted and organized into a matrix structured according to the four domains of the Policy Triangle.
3. **Analysis and Synthesis (Months 3-4):** The organized data were analyzed thematically within each Policy Triangle domain to identify patterns, contradictions, and gaps. Findings

from policy documents were triangulated with evidence from academic literature and reports to strengthen validity.

Analysis plan:

Data analysis followed a qualitative content analysis approach guided by the Walt & Gilson framework. The process involved:

1. **Familiarization:** Repeated reading of the collected documents.
2. **Coding:** Identifying and labeling meaningful segments of text relevant to the research aims.
3. **Theme Development:** Sorting codes into potential themes corresponding to the *Context* (social, political, economic environment), *Actors* (BPJS, hospitals, government agencies), *Process* (policy formulation and implementation steps), and *Content* (specific details of the policies).
4. **Framework Analysis:** Systematically applying the Policy Triangle framework to the developed themes to interpret interactions and identify leverage points for policy improvement.
   No statistical tests were used, as the research questions were exploratory and required in-depth descriptive and interpretive analysis rather than numerical comparison.

Scope and limitations of the methodology:

The scope of this methodology is confined to the analysis of publicly available documents and published literature. Its strength lies in providing a comprehensive overview of the regulatory landscape and documented implementation challenges. However, several limitations are acknowledged:

1. The findings are based on secondary data and lack primary perspectives from key stakeholders (e.g., hospital administrators, BPJS officers, social workers, or caregivers of abandoned children), which could reveal practical nuances and unofficial workarounds.
2. The dynamic nature of policy means some recent local government initiatives or internal BPJS circulars may not have been captured in the publicly accessible document search.
3. As a qualitative policy analysis, the findings offer depth and understanding of mechanisms but cannot quantify the scale of the problem (e.g., the exact number of children affected or the total financial impact on hospitals).
4. The analysis is specific to the Indonesian context, which may limit the direct transferability of conclusions to other countries with different health system architectures.

RESULTS AND DISCUSSION

Results:

The document analysis reveals significant structural gaps in the regulatory framework governing BPJS Kesehatan coverage for abandoned children without NIK. Primary findings indicate that neither Presidential Regulation No. 82 of 2018 on JKN nor its implementing regulations provide explicit mechanisms for enrolling or processing claims for beneficiaries lacking formal identification. Consequently, this population remains in a procedural limbo, not formally recognized as PBI (Penerima Bantuan Iuran) recipients despite meeting the criteria of extreme vulnerability.

Operational data synthesized from hospital reports and academic literature confirms severe administrative barriers. The absence of a NIK renders the standard INA-CBGs claim submission process inoperable, leading to systematic claim rejections or indefinite pending status. A study by Tehupeiory (2021) quantifies this, noting that 61.39% of pending claims are directly attributable to incomplete patient identification documents. In practice, healthcare for these children is consistently re-categorized post-service as "emergency charity care" or "social service," shifting the financial burden entirely onto the healthcare facility with no pathway for reimbursement through the national insurance scheme.

Furthermore, the analysis uncovers a landscape of fragmented and inconsistent local practices. While some hospitals report ad-hoc collaborations with District Social Services (Dinsos) for partial funding or identity verification, these arrangements are highly informal, non-binding, and dependent on individual relationships and local government budgets. No standardized inter-agency protocol exists, resulting in a postcode lottery of access where a child's healthcare depends on the region in which they are found.

Discussion:

Applying the Walt & Gilson Policy Triangle, the findings elucidate a multi-dimensional policy failure. The **content** of the policy is fundamentally misaligned; while laws like UU No. 17/2023 guarantee health rights universally, the operational design of BPJS (embedded in technical regulations) contradicts this by making a specific administrative token (NIK) an absolute prerequisite. This creates a legal contradiction where the right exists but the mechanism to activate it is inaccessible to a specific group (Puspitaningrum et al., 2019).

The **context** of Indonesia's socio-political environment exacerbates the issue. The drive for Universal Health Coverage (UHC) exists within a bureaucracy historically reliant on rigid identification systems. Decentralization further complicates the context, as regional governments have varying fiscal capacities and political priorities regarding social welfare, leading to the observed inequities in local solutions (Pisani et al., 2017). Stigma and low political visibility of abandoned children also mean their needs are often deprioritized in local health planning.

Regarding **process**, the policy implementation is characterized by fragmentation and the absence of a clear procedural cascade. There is no designated flowchart for a hospital encountering a patient without NIK, from point-of-care through to potential reimbursement or alternative financing. This process gap forces street-level bureaucrats (hospital administrators) to improvise, leading to inconsistent, inefficient, and often inequitable outcomes.

The role and interaction of **actors** reveal a critical coordination deficit. BPJS Kesehatan operates as a payor with strict, non-negotiable administrative rules. Hospitals are caught between their ethical/legal mandate to provide emergency care and the financial risk of non-reimbursement. Dinas Sosial and Dukcapil (Civil Registry) are perceived as the logical bridges but lack a formal mandate and integrated systems to resolve the identity issue proactively. This actor misalignment leaves abandoned children in the gaps between organizational silos.

Implications:

The implications are profound for health equity, hospital sustainability, and legal certainty. Systemically, this gap directly undermines Indonesia's UHC goals and constitutional promises. For hospital management, particularly in the private sector, it creates an unpredictable financial liability that can deter them from providing necessary care, leading to potential ethical dilemmas and compromising the principle of non-discrimination at the point of service. Legally, hospitals operate in a grey zone, unsure of their recourse when claims are denied for reasons beyond their control (Asya et al., 2024).

Research contribution:

This study contributes to the field of health policy and systems research by providing a concrete, framework-driven analysis of an under-explored equity gap in a major UHC scheme. It moves beyond generic calls for "inclusion" to dissect the specific regulatory, administrative, and actor-related mechanisms of exclusion. By applying the Policy Triangle to a very specific administrative hurdle (the NIK), it demonstrates how micro-level technicalities can create macro-level failures in health justice, offering a model for analyzing similar barriers in other contexts.

Limitations:

The primary limitation of this study is its reliance on document analysis and secondary literature, which may not capture the full spectrum of on-the-ground innovations or challenges experienced by frontline health workers and social servants. The perspectives of caregivers in orphanages (LKSAs) or street children communities are also absent. Furthermore, the policy landscape is dynamic; while the analysis captures regulations up to early 2024, subsequent ministerial decrees or local pilot programs may have been initiated.

Suggestions:

Future research should employ mixed methods, combining policy analysis with qualitative interviews and surveys of key actors (hospital billing staff, BPJS verification officers, social workers) to document lived experiences and unofficial workarounds. A cost-analysis study quantifying the financial burden shouldered by hospitals for this unfunded care would provide a powerful economic argument for reform. Comparative policy research analyzing successful models from other countries (e.g., Thailand's policy for stateless populations or Brazil's SUS for undocumented individuals) could yield valuable transferable insights for Indonesian policymakers.

CONCLUSION

This study concludes that the provision of BPJS Health services for abandoned children without a National Identification Number (NIK) is hindered by systemic policy failures spanning content, context, and process. The strict NIK-based administrative system creates an insurmountable barrier to healthcare access for this vulnerable group, contradicting Indonesia's constitutional and legal guarantees of health equity. The absence of clear regulations and standardized procedures exposes hospitals to financial and legal risks, while perpetuating exclusion and fragmentation in service delivery. Therefore, immediate policy reforms, including revised eligibility mechanisms and integrated cross-sectoral protocols, are essential to align Indonesia's universal health coverage aspirations with the reality of its most marginalized children.

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AUTHOR CONTRIBUTION STATEMENT

IYAP: Conceptualization, Methodology, Writing - Original Draft. SM: Data Curation, Formal Analysis, Writing - Review & Editing. DM: Investigation, Resources, Validation.

REFERENCES

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K. A., Achadi, E. L., Taher, A., Wirawan, F., Sungkar, S., Sudarmono, P., Shankar, A. H., Thabrany, H., & Soewondo, P. (2019). Universal health coverage in Indonesia: concept, progress, and challenges. *The Lancet, 393*(10166), 75–102. https://doi.org/10.1016/S0140-6736(18)31647-7

Clifford, N., Blanco, N., Bang, S. H., Heitkemper, E., & Garcia, A. A. (2023). Barriers and facilitators to healthcare for people without documentation status: A systematic integrative literature review. Journal of advanced nursing, 79(11), 4164–4195. https://doi.org/10.1111/jan.15845

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: a literature review. Risk management and healthcare policy, 8, 175–183. https://doi.org/10.2147/RMHP.S70173

Haris, A., & Saleh, I. (2021). Muhammadiyah and the empowerment of street children in Indonesia. *International Journal of Social Science and Human Research, 4*(10), 2752–2762. https://doi.org/10.47191/ijsshr/v4i10-16

Indonesia. (1945). *Undang-Undang Dasar Negara Republik Indonesia Tahun 1945* [The 1945 Constitution of the Republic of Indonesia].

Indonesia. (2011). *Undang-Undang Republik Indonesia Nomor 24 Tahun 2011 tentang Badan Penyelenggara Jaminan Sosial* [Law No. 24 of 2011 on Social Security Administering Bodies].

Indonesia. (2018). *Peraturan Presiden Republik Indonesia Nomor 82 Tahun 2018 tentang Jaminan Kesehatan* [Presidential Regulation No. 82 of 2018 on Health Insurance].

Indonesia. (2023). *Undang-Undang Republik Indonesia Nomor 17 Tahun 2023 tentang Kesehatan* [Law No. 17 of 2023 on Health].

Indonesia. (2024). *Peraturan Pemerintah Republik Indonesia Nomor 28 Tahun 2024 tentang Penyelenggaraan Bidang Kesehatan* [Government Regulation No. 28 of 2024 on the Implementation of the Health Sector].

Pisani, E., Olivier Kok, M., & Nugroho, K. (2017). Indonesia's road to universal health coverage: a political journey. *Health Policy and Planning, 32*(2), 267–276. https://doi.org/10.1093/heapol/czw120

Prasetyo, G. (2015). Perlindungan hukum terhadap anak terlantar dalam memperoleh jaminan kesehatan oleh badan penyelenggara jaminan sosial kesehatan [Legal protection for abandoned children in obtaining health insurance through social security administering bodies]. *Jurnal Hukum, 2*(4), 134–144.

Ramadhani, A. N., Aspan, Z., & Hasrul, M. (2021). Legal protection for unregistered citizen at healthcare and social security agency (BPJS). *Jurnal Hukum Volkgeist, 6*(1), 1–10. https://doi.org/10.35326/volkgeist.v6i1.1537

Asya, J., Suryono, A., Makbul, A., Tinggi, S., Militer, H., Jakarta, D. K. I., & E-mail, I. (2024). *Jurnal HUKUM dan KENOTARIATAN The Consistency of National Health Implementation in Achieving Health Equity*. *8*(3), 144–166. https://doi.org/10.33474/hukeno.v8i3.22572

Azizatunnisa, L., Kuper, H., Probandari, A., & Morgon, L. (2026). SSM - Health Systems and facilitators of people with disabilities in Indonesia in accessing and using Jaminan Kesehatan Nasional (National Health Insurance). *SSM - Health Systems*, *6*(July 2025), 100171. https://doi.org/10.1016/j.ssmhs.2026.100171

Cheng, Q., Fattah, R. A., Susilo, D., Satrya, A., Haemmerli, M., Kosen, S., Novitasari, D., Puteri, G. C., Adawiyah, E., Hayen, A., Mills, A., Tangcharoensathien, V., Jan, S., Thabrany, H., & Asante, A. (2025). Determinants of healthcare utilization under the Indonesian national health insurance system – a cross - sectional study. *BMC Health Services Research*. https://doi.org/10.1186/s12913-024-11951-8

Listyaningrum, N. (2025). *Legal Perspectives on Healthcare Inequality in Indonesia*. *33*(1), 272–296. https://doi.org/10.19105/karsa.v33i1.20302

Puspitaningrum, R. A., Probandari, A., Pamungkasari, E. P., Ardyanto, T. D., & Fitriana, E. N. (2019). *Achievement of universal health coverage in Surakarta city: policy analysis*. 149–161. https://doi.org/10.20885/JKKI.Vol10.Iss2.art7

Ramadani, M. F., Arimbi, D., & Dwiprigitaningtias, I. (2023). *Legal Protection For National Health Insurance Patients Regarding The Right To Service Facilities Based On Law Perlindungan Hukum Pasien Jaminan Kesehatan Nasional Atas Hak Pelayanan Fasilitas Berdasarkan Undang – Undang*. https://doi.org/10.36859/rechtswetenschap.v2i2.4154

Ramadani, N. A., Simanjuntak, G. Y., & Putri, D. N. (2025). *Policy Implementation in Resource-Scarce Political Environments : Applying Peter S . Cleaves ' Framework to Indonesia ' s National Health Insurance (JKN)*. 66–78.

Rodney, A. M., & Hill, P. S. (2014). *Achieving equity within universal health coverage : a narrative review of progress and resources for measuring success*. 1–8. https://doi.org/10.1186/s12939-014-0072-8

Samart, & Rinehart. (2024). *MOVER: Medical Informatics Operating Room Vitals and Events Repositor*. https://doi.org/10.1101/2023.03.03.23286777

Sartono, RRahmat, S. M., Arfiyah, G., & Prayut, Yu. (2025). *Hak Atas Kesehatan Dan Tanggung Jawab Negara: Konstruksi Hukum Dalam Perlindungan Pasien Bpjs*. *2337*, 832–850. https://doi.org/10.36987/jiad.v13i3.7489

Sulistiyono, F. O., Efendi, A., & Al-Khanif. (2025). Tanggung Jawab Negara Memelihara Anak Terlantar

Perspektif Pendahuluan Keselamatan dan kesejahteraan anak merupakan hak-hak anak yang harus. *Constitution Journal*, *4*(1), 61–78. https://doi.org/10.35719/cinstitution.v4i1.133

Tehupeiory, A. (2021). *Bahan ajar metode penelitian hukum* [Teaching materials for legal research methods]. UKI Press.

Zahidie, A., Asif, S., & Iqbal, M. (2023). Building on the health policy analysis triangle: Elucidation of the elements. *Pakistan Journal of Medical Sciences, 39*(6), 1865–1868. https://doi.org/10.12669/pjms.39.6.7056