BHINNEKA TUNGGAL IKA:
Pancasila Jurnal Internasional Berbahasa Indonesia

Volume 2 Issue 1, May 2025
P-ISSN: 3089-3178, E-ISSN: 3089-3224
DOI: https://doi.org/10.52738/bti.v2i1.41

Indonesian Unity for Equitable and Fair Health Policy

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Abstract: This article examines the contribution of Indonesia's value of unity to the development of inclusive health policies. Using a literature review approach, the study explores how the principle of unity, as articulated in Pancasila, particularly its third principle (*Persatuan Indonesia*), functions as both an ethical foundation and a practical guideline in shaping policies that respond to Indonesia's diverse society. The analysis highlights the role of Pancasila in influencing the formulation of inclusive health policies, especially in addressing disparities arising from geographical, cultural, and socioeconomic conditions. The findings suggest that the value of unity plays a crucial role in promoting equitable access to healthcare services and strengthening policy coherence in the pursuit of inclusive national development.

Keywords: Pancasila; Unity Values; Inclusive Health Policy; Health Equity; Social Cohesion.

1. Introduction

Indonesia, as a pluralistic nation characterized by diverse ethnic, cultural, and geographical conditions, continues to face persistent challenges in ensuring equitable access to healthcare. Disparities between urban and rural areas, unequal distribution of healthcare facilities, and variations in service quality continue to shape unequal health outcomes. These challenges reflect broader structural inequalities within the national health system, particularly in resource allocation and governance capacity (World Bank, 2023; World Health Organization, 2021). Studies in global health policy further highlight that unequal resource distribution and fragmented governance often exacerbate disparities in healthcare access and outcomes (Marmot et al., 2008; Gilson, 2012).

The principle of *Persatuan Indonesia* (The Unity of Indonesia), as articulated in the third principle of Pancasila, plays a central role as a normative foundation for public policy. Unity promotes solidarity, inclusivity, and collective responsibility in addressing social inequalities. However, despite its strong ideological presence, the translation of unity into effective health policy outcomes remains uneven. This reflects a broader challenge in policy implementation, where normative values often fail to be translated into effective institutional practices (Frenk, 2010; Reich et al., 2016).

From a theoretical perspective, unity in Pancasila aligns with the concept of social cohesion, which emphasizes shared values, trust, and collective identity as drivers of equitable public policy. Social cohesion is particularly important in diverse societies to prevent fragmentation and ensure inclusive development (Marmot et al., 2008). In parallel, the concept of health equity highlights fairness in access to health services and outcomes, requiring the reduction of avoidable disparities shaped by socioeconomic, geographic, and structural determinants (Braveman & Gruskin, 2003).

In Indonesia's health system, unity can be conceptualized not only as a moral value but also as a policy instrument that supports redistribution, coordination, and inclusion. This is reflected in national strategies aimed at achieving Universal Health Coverage (UHC), particularly through the implementation of the *Jaminan Kesehatan Nasional* (JKN). The program operationalizes solidarity through cross-subsidization mechanisms, which are widely recognized as essential for achieving equity in universal health systems (Savedoff et al., 2012; Cotlear et al., 2015). However, empirical evidence indicates that large-scale health insurance systems often face challenges related to sustainability, service quality, and regional disparities (Lagomarsino et al., 2012).

From a critical perspective, unity-based health policy must be understood not only as a moral commitment but also as a governance challenge. Issues such as fragmented institutional coordination, unequal resource allocation, and limited community participation indicate that inclusive health policy requires strong institutional capacity and policy coherence (Gilson, 2012; Reich et al., 2016). Without these elements, unity risks remaining symbolic rather than operational.

Despite Indonesia's strong ideological commitment to social justice and unity as enshrined in Pancasila, significant disparities in healthcare access, quality, and outcomes persist across regions and population groups. While policies such as the *Jaminan Kesehatan Nasional* (JKN) have substantially expanded coverage, they have not fully resolved structural inequalities in service distribution and quality. Existing studies on universal health coverage primarily emphasize institutional design, financing, and service delivery, with limited attention to how ideological values shape policy implementation and outcomes (Savedoff et al., 2012; Reich et al., 2016).

This gap is particularly critical in the Indonesian context, where *Persatuan Indonesia* is expected to function not only as a normative principle but also as a practical mechanism for fostering equity and integration in public policy. However, the persistence of regional disparities, governance fragmentation, and uneven resource allocation suggests that unity has not yet been effectively institutionalized within the health system. As a result, there remains a disconnect between ideological commitments and empirical realities. Addressing this gap requires a deeper examination of how unity can be

operationalized as a governance framework capable of reducing inequalities and strengthening inclusive health policy.

2. Method

This study employs a narrative literature review approach to examine the relationship between Pancasila values and inclusive health policies in Indonesia. The analysis focuses on policy documents, institutional reports, and peer-reviewed literature published between 2020 and 2025. Sources were selected based on their relevance, credibility, and alignment with the study's analytical framework on unity and health equity.

Drawing on a wide range of academic and institutional references, this study aims to provide a comprehensive understanding of how the principle of unity articulated in the third principle of Pancasila (*Persatuan Indonesia*) is integrated into the design and implementation of Indonesia's health system (World Bank, 2023; World Health Organization, 2020).

The study applies a thematic analytical approach, synthesizing evidence from policy documents and academic literature to identify key patterns related to equity, inclusivity, and social solidarity in health policymaking. Particular attention is given to major national initiatives, especially the *Jaminan Kesehatan Nasional* (JKN), as a case illustrating how Pancasila values are operationalized in expanding healthcare access across diverse population groups (Badan Penyelenggara Jaminan Sosial Kesehatan, 2023; World Bank, 2023).

This methodological approach enables the identification of critical challenges and opportunities in implementing inclusive health strategies within Indonesia's complex social, economic, and geographical context. By integrating perspectives from both national and global institutions, this study positions the principle of unity not only as a normative value but also as a practical governance framework for advancing Universal Health Coverage (UHC) in Indonesia (Badan Perencanaan Pembangunan Nasional & Badan Penyelenggara Jaminan Sosial Kesehatan, 2024; World Health Organization, 2021).

3. Analysis

The commemoration of Pancasila Day on June 1 should not be understood merely as a symbolic or ceremonial event, but rather as a critical moment to evaluate the extent to which Indonesia's foundational values are substantively implemented in public policy, particularly in the health sector. While Pancasila emphasizes principles such as unity, social justice, and humanity, their translation into concrete policy outcomes remains uneven. Empirical evidence suggests that structural inequalities in healthcare access persist, indicating a gap between normative ideals and actual implementation (World Bank, 2023; World Health Organization, 2021).

Recent data highlight continuing disparities in healthcare access between regions and population groups. For instance, unmet healthcare needs remain higher in rural areas compared to urban populations, reflecting unequal distribution of health services and infrastructure. Moreover, the concentration of healthcare facilities in more developed regions, particularly Java, contrasts sharply with limited access in eastern Indonesia. Such conditions demonstrate that the principle of unity has not yet been fully operationalized as an effective mechanism for equitable resource distribution (Marmot et al., 2008; Lagomarsino et al., 2012).

The principle of *Persatuan Indonesia* should function as an integrative force that ensures inclusivity and equal access across diverse communities. However, in practice, this principle is often reduced to a normative ideal rather than an operational framework. Studies in health policy indicate that disparities in Indonesia are not only driven by geographic constraints but also by governance fragmentation, unequal distribution of healthcare workers, and limited institutional capacity (Gilson, 2012; Reich et al., 2016).

In terms of healthcare utilization, empirical findings reveal that individuals in urban areas are significantly more likely to access health services compared to those in rural settings, further reinforcing structural inequalities. This situation contradicts the principle of social justice embedded in Pancasila, which mandates equitable access for all citizens regardless of socioeconomic status (Braveman & Gruskin, 2003).

The *Jaminan Kesehatan Nasional* (JKN) program is often presented as a concrete manifestation of unity through its cross-subsidization mechanism, which reflects the principle of mutual cooperation (*gotong royong*). The program has significantly expanded coverage, enrolling over 250 million participants and contributing to Indonesia's progress toward Universal Health Coverage (UHC). However, despite this achievement, JKN also reveals structural tensions between universality and service quality, particularly in underserved regions. Challenges such as financial sustainability, uneven service quality, and infrastructure limitations continue to hinder its effectiveness (Savedoff et al., 2012; Cotlear et al., 2015).

From a critical perspective, these findings suggest that unity in Indonesia's health policy remains more dominant as a source of normative legitimacy than as an effective governance mechanism. Without substantial institutional reform, improved policy coordination, and equitable resource allocation, the principle of unity risks remaining symbolic rather than transformative.

Strengthening inclusive health policy in Indonesia requires a shift from value-based rhetoric to evidence-based implementation. This includes improving health system governance, ensuring equitable distribution of healthcare resources, enhancing community participation, and strengthening cross-sectoral collaboration. In this way, unity can function not only as an

ideological foundation but also as a practical framework for achieving a more equitable and sustainable health system.

3.1 Challenges in Implementation

Despite the principle of unity being recognized as a fundamental value in Indonesia's health policy framework, significant challenges persist in ensuring equitable access to healthcare services. Disparities between urban and rural areas remain substantial, particularly in remote and underdeveloped regions where infrastructure, healthcare facilities, and human resources are limited. These inequalities reflect broader structural issues in health system governance and resource distribution, indicating that unity has not yet been fully operationalized as an effective mechanism for equity (World Bank, 2023; World Health Organization, 2021).

One of the most critical challenges is the unequal distribution of healthcare facilities and workforce. Healthcare infrastructure remains concentrated in urban centers, particularly in western Indonesia, while eastern regions continue to face shortages of hospitals, medical personnel, and essential services. Such imbalances are widely recognized in global health policy studies as key barriers to achieving universal health coverage (Lagomarsino et al., 2012; Reich et al., 2016). In addition, cultural diversity and socioeconomic disparities further complicate policy implementation, as health interventions must be adapted to local contexts while maintaining national policy coherence.

Governance fragmentation also poses a major obstacle. Coordination across different levels of government, as well as between public and private sectors, often remains weak, resulting in inefficiencies and policy inconsistencies. Financial constraints further exacerbate these challenges, particularly in the allocation and sustainability of health financing. Evidence suggests that large-scale health systems, including Indonesia's JKN program, frequently encounter fiscal pressures due to rising healthcare costs and uneven contribution compliance (Savedoff et al., 2012; Cotlear et al., 2015).

Community engagement represents another critical dimension. Limited health literacy, uneven public awareness, and varying levels of trust in health institutions reduce the effectiveness of policy implementation. Studies have shown that community participation is essential in strengthening health systems and improving service delivery outcomes, particularly in diverse and decentralized contexts (Gilson, 2012; Marmot et al., 2008). Without active public involvement, policies risk becoming top-down interventions that fail to address local needs.

Addressing these multidimensional challenges requires a more integrated and evidence-based approach. Strengthening multisectoral collaboration, improving governance capacity, and adopting tools such as

Health Technology Assessment (HTA) are essential to ensure efficient and equitable resource allocation. In this regard, unity should not be treated merely as a normative principle but as a functional governance framework that guides policy coordination, inclusivity, and sustainability. Ultimately, achieving equitable healthcare in Indonesia depends on the ability to translate the value of unity into concrete institutional practices that reduce disparities and strengthen the resilience of the national health system.

3.2 Unity as Normative Foundation

The principle of unity (*Persatuan Indonesia*), as articulated in the third principle of Pancasila, serves as a fundamental normative foundation in shaping Indonesia's public policy, including in the health sector. As a state ideology, Pancasila does not merely function as a symbolic value system but provides ethical and philosophical guidance that informs policy direction, governance practices, and the allocation of public resources. In the context of health policy, unity emphasizes solidarity, inclusiveness, and collective responsibility in ensuring equitable access to healthcare services for all citizens.

From a theoretical perspective, the concept of unity in Pancasila aligns closely with the notion of social cohesion, which highlights the importance of shared values, trust, and collective identity in achieving equitable social outcomes (Marmot et al., 2008). Social cohesion is widely recognized as a critical determinant of effective public policy, particularly in diverse societies, where inclusive governance is necessary to prevent social fragmentation and inequality (World Health Organization, 2020). In this regard, unity functions as a normative framework that promotes cooperation across different social groups and strengthens the legitimacy of state-led health interventions.

Unity as a normative principle is closely linked to the concept of health equity, which emphasizes fairness in access to health services and the reduction of avoidable disparities in health outcomes (Braveman & Gruskin, 2003). The integration of these principles into Indonesia's health system reflects the expectation that public policy should not only expand access but also address structural inequalities related to geography, socioeconomic status, and cultural diversity. This is particularly relevant in Indonesia, where disparities between regions and population groups remain a persistent challenge (World Bank, 2023).

Unity provides a strong normative foundation, its role in policymaking is not without limitations. From a critical standpoint, normative values alone are insufficient to ensure effective policy outcomes. Studies in health policy and systems research emphasize that the translation of values into practice depends heavily on institutional capacity, governance quality, and resource

distribution (Gilson, 2012; Reich et al., 2016). In Indonesia, the persistence of health inequalities suggests that unity, although deeply embedded in ideological discourse, has not been fully operationalized as a functional governance mechanism.

This gap between normative ideals and empirical realities highlights the need to reinterpret unity not only as a moral principle but also as a policy instrument. In this sense, unity should guide the development of integrated health policies that prioritize coordination across sectors, equitable allocation of resources, and inclusive participation in decision-making processes. Without such institutionalization, unity risks remaining rhetorical rather than transformative.

The context of Universal Health Coverage (UHC), unity plays a crucial role in legitimizing redistributive policies, such as cross-subsidization mechanisms in national health insurance systems. These mechanisms reflect the principle of collective responsibility, where healthier and wealthier populations contribute to supporting vulnerable groups (Savedoff et al., 2012; Cotlear et al., 2015). Thus, unity not only provides ethical justification but also underpins the political feasibility of inclusive health reforms.

Unity as a normative foundation offers a strong ideological basis for inclusive health policy in Indonesia. However, its effectiveness depends on the extent to which it is translated into concrete institutional practices. Strengthening governance structures, improving policy coherence, and ensuring equitable resource distribution are essential to transform unity from a symbolic value into a practical driver of health equity and social justice.

3.3 Unity in Policy Implementation: The National Health Insurance (JKN) Program

The *Jaminan Kesehatan Nasional* (JKN) program represents one of the most concrete manifestations of the principle of unity (*Persatuan Indonesia*) within Indonesia's health policy framework. Through its cross-subsidization mechanism, JKN operationalizes solidarity by redistributing financial risk across socioeconomic groups, reflecting the value of *gotong royong* in practice. By 2023, the program had enrolled more than 250 million participants, positioning Indonesia among the countries with the largest single-payer health insurance systems globally (Badan Penyelenggara Jaminan Sosial Kesehatan, 2023; World Bank, 2023).

JKN embodies unity as a normative principle, its implementation reveals significant structural and operational challenges that limit its effectiveness in achieving equitable healthcare. From a critical perspective, JKN illustrates a fundamental tension between universality and quality, a common issue identified in large-scale health insurance reforms (Lagomarsino et al., 2012;

Reich et al., 2016). Although coverage has expanded rapidly, disparities in service availability, quality of care, and access between regions persist, indicating that unity has not yet been fully translated into equitable outcomes.

One of the most pressing challenges lies in the financial sustainability of the program. Increasing membership and utilization rates have led to rising healthcare expenditures, often exceeding contribution revenues and creating fiscal pressures. Such conditions are consistent with global evidence showing that universal health coverage schemes frequently face sustainability challenges without adequate cost control and governance mechanisms (Savedoff et al., 2012; Cotlear et al., 2015).

Structural inequalities in healthcare infrastructure and workforce distribution continue to undermine the effectiveness of JKN. Healthcare facilities and medical personnel remain concentrated in urban and more developed regions, while rural and remote areas face shortages of essential services. This imbalance contributes to delays in treatment, overcrowding in referral hospitals, and unequal service quality across regions (World Health Organization, 2021; World Bank, 2023).

Variations in service quality further exacerbate inequality within the system. Limited availability of medical equipment, medicines, and skilled health workers in certain areas leads to inconsistent care and patient dissatisfaction. Moreover, administrative inefficiencies, including delays in claims processing and data management issues, reduce system performance and trust in public health services. These challenges reflect broader governance issues that hinder the effective institutionalization of unity in health policy implementation (Gilson, 2012).

Another critical issue concerns inequality between JKN participants and non-participants. While JKN improves affordability and access for many citizens, non-participants often relying on private healthcare tend to experience faster services and wider treatment options, albeit at higher costs. This duality creates a fragmented system in which access is expanded, but equality in quality remains uneven. Such disparities suggest that unity, as embodied in JKN, is still partially realized and has yet to achieve full integration across the health system.

Issues such as fraud, misuse of claims, and low compliance in premium payments continue to weaken the efficiency of the program. Without strong monitoring and accountability mechanisms, these problems risk undermining both financial sustainability and public trust. At the same time, limited public awareness and varying levels of health literacy reduce participation and hinder progress toward universal coverage.

From an analytical standpoint, these challenges indicate that unity in Indonesia's health policy operates more effectively as a normative

foundation than as a fully institutionalized governance mechanism. While JKN demonstrates the potential of unity to expand access, its limitations highlight the need for deeper structural reforms. Strengthening governance capacity, improving resource distribution, enhancing service quality, and ensuring financial sustainability are essential to transform unity from a symbolic value into an operational driver of health equity.

The success of JKN as a unity-based policy depends on its ability to reconcile the gap between inclusivity and quality. Without addressing systemic inequalities, the principle of unity risks remaining rhetorical rather than transformative. Therefore, continuous reform and evidence-based policy adjustments are necessary to ensure that JKN not only expands coverage but also delivers equitable, high-quality healthcare for all Indonesians.

3.4 The Role of Cultural Values in Health Policy

The role of cultural values emerges as a critical dimension in ensuring the effectiveness of inclusive health policies. While unity provides a macro-level ideological framework, cultural values operate at the micro and community levels, shaping how policies are received, interpreted, and implemented. In a diverse society such as Indonesia, the success of health policy is not determined solely by availability and coverage, but also by cultural acceptability and social trust.

From a theoretical perspective, this aligns with the concept of people-centered health systems, which emphasize responsiveness to cultural, social, and contextual factors in healthcare delivery (World Health Organization, 2020). Cultural values influence health-seeking behavior, trust in institutions, and community participation, all of which are essential for effective policy implementation. Without integrating these dimensions, health policies risk becoming technically sound but socially ineffective.

When connected to the empirical challenges outlined in Section 3.1, the integration of cultural values in Indonesia's health policy remains uneven. Structural inequalities, disparities in access, and governance fragmentation indicate that cultural sensitivity has not been fully institutionalized within the health system. In many cases, policies are designed at the national level without sufficient adaptation to local contexts, resulting in limited community engagement and suboptimal outcomes (Gilson, 2012; Marmot et al., 2008).

The importance of cultural values is particularly evident in public health interventions that rely heavily on community participation, such as vaccination campaigns and preventive health programs. Indonesia's response to the COVID-19 pandemic demonstrated that collaboration between government institutions, healthcare workers, and local

communities grounded in cultural norms of mutual cooperation (*gotong royong*) played a crucial role in policy effectiveness (World Health Organization, 2021). Nevertheless, variations in compliance and public trust across regions also revealed that cultural alignment is not uniform, highlighting the need for more localized and context-sensitive approaches.

Indonesia's rich cultural diversity, encompassing a wide range of ethnicities, religions, languages, and local traditions plays a decisive role in shaping health-seeking behavior, public trust, and community participation in health programs. Cultural beliefs influence how illness is perceived, how healthcare services are utilized, and how government interventions are received. Empirical studies in global health demonstrate that cultural alignment significantly affects the success of public health interventions, particularly in diverse and decentralized societies (Napier et al., 2014; Marmot et al., 2008). In the Indonesian context, this diversity creates both opportunities for inclusive policymaking and challenges in ensuring uniform policy effectiveness across regions.

From a critical standpoint, the integration of cultural values in health policy often remains normative rather than operational. While concepts such as *gotong royong* and humanitarian values are frequently emphasized in policy discourse, their translation into institutional practices is inconsistent. This reflects a broader issue identified in global health governance, where community participation is often promoted rhetorically but insufficiently supported by concrete mechanisms such as participatory governance, local accountability structures, and inclusive decision-making processes (Reich et al., 2016; Gilson, 2012).

In the author's view, this indicates a structural weakness in Indonesia's health policy framework: cultural values are used as legitimizing narratives rather than as operational tools embedded in policy design. As a result, policies may appear inclusive at the conceptual level but fail to deliver equitable outcomes in practice.

Cultural values also play a crucial role in addressing stigma and social exclusion, particularly among vulnerable groups such as persons with disabilities, women, and marginalized communities. A culturally responsive health system can reduce barriers to access by fostering inclusivity and respect for diversity. However, persistent inequalities in service quality and accessibility suggest that such inclusivity has not yet been fully realized. This reinforces the argument that cultural sensitivity must be institutionalized rather than treated as an auxiliary consideration (Braveman & Gruskin, 2003).

The increasing role of digital technology introduces both opportunities and risks in strengthening culturally responsive health policies. Digital platforms can enhance public awareness, expand access to health

information, and facilitate community engagement. However, unequal access to digital infrastructure may deepen existing disparities, particularly in rural and remote areas. Evidence indicates that without inclusive digital strategies, technological innovation can reinforce rather than reduce inequality (World Bank, 2023).

From a critical perspective, the main limitation lies in the absence of systematic integration between cultural values and governance mechanisms. Policies often adopt a top-down approach, with limited incorporation of local knowledge and community participation in decision-making processes. This weakens policy legitimacy and reduces effectiveness at the implementation level.

Therefore, integrating cultural values into health policy must go beyond symbolic recognition and be translated into institutional practices. This includes strengthening community-based health programs, promoting culturally competent healthcare delivery, enhancing health literacy, and ensuring meaningful participation of local communities in policy formulation and implementation.

Cultural values function as a critical intermediary between national policy frameworks and local implementation. While unity provides the ideological foundation, cultural values determine the effectiveness of policy execution at the community level. The author argues that without institutionalizing cultural responsiveness within governance structures, inclusive health policy will remain incomplete and fragmented, limiting its ability to achieve equitable and sustainable outcomes in Indonesia's health system.

3.5 Unity as Ideology, Inequality as Reality

A central finding of this study is the persistent gap between normative values and empirical realities in Indonesia's health policy. While the principle of Persatuan Indonesia is consistently emphasized in policy discourse as a foundation for equity, solidarity, and inclusiveness, its translation into concrete outcomes remains uneven. In other words, unity is strongly embedded at the ideological level but only weakly reflected in institutional practice.

This gap is clearly reflected in quantitative indicators of Indonesia's health system. The doctor-to-population ratio remains approximately 0.47–0.76 per 1,000 population, still below the World Health Organization's recommended threshold of 1 doctor per 1,000 population (Kementerian Kesehatan Republik Indonesia, 2023; World Bank, 2023). More critically, regional disparities are stark: provinces in Java and major urban centers have significantly higher concentrations of healthcare workers compared to eastern regions such as Papua and Maluku.

Similarly, disparities in access to healthcare services remain evident. Data from the Badan Pusat Statistik indicate that the proportion of unmet healthcare needs is 6.31% in rural areas compared to 4.65% in urban areas, reflecting persistent inequalities in access (Badan Pusat Statistik, 2023). In addition, healthcare infrastructure is unevenly distributed, with hospitals, specialists, and advanced medical facilities concentrated in urban regions, while remote areas continue to face limited availability of basic services.

These disparities demonstrate that despite the expansion of the *Jaminan Kesehatan Nasional* (JKN), which has covered more than 90% of Indonesia's population, equitable access and service quality have not yet been fully achieved (World Bank, 2023). This reinforces the argument that expanding coverage does not automatically ensure equity.

Indicator	Urban / Developed Regions	Rural / Less Developed Regions	Source
Doctor-to-population ratio	Up to ±2.0 per 1,000 (major cities)	Below 0.5 per 1,000 (eastern regions)	Kemenkes RI (2023)
Unmet healthcare needs	4.65%	6.31%	BPS (2023)
Health workforce distribution	Highly concentrated	Limited availability	World Bank (2023)
JKN coverage	>90% population	>90% population	World Bank (2023)
Service quality	Higher (urban hospitals)	Lower (limited facilities)	WHO / World Bank

Table 1. Key Indicators of Health Inequality in Indonesia

From an analytical perspective, this gap reflects deeper structural constraints. First, limited institutional capacity undermines policy implementation. Despite the existence of comprehensive national strategies, variations in administrative capacity across regions particularly in decentralized governance contexts result in uneven service delivery and policy execution. Health systems research shows that institutional strength is a key determinant of policy effectiveness, especially in achieving equity in complex and diverse settings (Gilson, 2012; Reich et al., 2016).

Second, the lack of policy coherence and coordination continues to weaken the integration of health policies. Fragmentation between central and local governments, as well as across sectors, often leads to overlapping programs, inefficiencies, and inconsistent service standards. This condition reflects a broader governance challenge in which normative commitments are not adequately supported by integrated institutional frameworks (Savedoff et al., 2012).

Third, inequitable resource allocation remains a critical barrier to achieving health equity. Empirical data confirm the persistence of structural disparities in Indonesia's health system. The national doctor-to-population ratio remains below optimal levels, and disparities across regions are significant, with higher concentrations of healthcare workers in urban areas compared to remote and eastern regions (Kementerian Kesehatan Republik Indonesia, 2023; World Bank, 2023). In addition, unmet healthcare needs are consistently higher in rural areas than in urban areas, indicating unequal access to essential health services (Badan Pusat Statistik, 2023). These inequalities are further exacerbated by the uneven distribution of health infrastructure and specialist services, which remain concentrated in more developed regions.

Empirical evidence therefore confirms that without deliberate redistributive mechanisms, universal health coverage policies risk reproducing existing inequalities rather than reducing them (Lagomarsino et al., 2012; Cotlear et al., 2015).

From a critical standpoint, these findings suggest that the core issue is not the absence of normative values, but the failure to institutionalize those values into operational policy mechanisms. The principle of unity, while normatively powerful, has not yet been fully embedded in governance structures that ensure equitable resource distribution, accountability, and policy integration. As a result, unity risks becoming a rhetorical tool that legitimizes policy discourse without substantially transforming outcomes.

The case of the *Jaminan Kesehatan Nasional* (JKN) illustrates this contradiction. While JKN embodies solidarity through cross-subsidization and has significantly expanded coverage, disparities in service quality, access, and system performance persist. This indicates a structural tension between universality and equity, where expanding coverage does not automatically translate into fair and equal healthcare outcomes (World Bank, 2023).

In the author's view, this reflects a fundamental imbalance: unity is strong ideologically but weak institutionally. The principle is widely accepted and promoted at the level of discourse, yet insufficiently translated into governance arrangements that ensure equal access and service quality across regions.

Addressing the normative–empirical gap therefore requires a shift from value-based rhetoric to institutional transformation. Strengthening governance capacity, ensuring policy coherence, and implementing equitable resource allocation mechanisms are essential to operationalize unity as a functional driver of health equity. Without such reforms, the principle of unity will remain aspirational rather than transformative within Indonesia's health system.

3.6 Recommendations

Building on the findings presented in previous sections particularly the persistence of regional disparities, governance fragmentation, and the gap between normative values and policy implementation, strengthening Indonesia's health system requires a shift from symbolic commitment to structural and evidence-based reform.

First, reducing geographic disparities must be prioritized through targeted investment in healthcare infrastructure and workforce distribution, particularly in remote and underserved regions. Despite progress under the *Jaminan Kesehatan Nasional* (JKN), significant inequalities remain in access to facilities and medical personnel, especially in eastern Indonesia. Evidence shows that strengthening primary healthcare systems is one of the most effective strategies to improve equity and overall health system performance (World Health Organization, 2020; World Bank, 2023). Without such intervention, disparities in access and outcomes will persist, undermining the principle of unity.

Second, the sustainability of the JKN program must be strengthened through financial and institutional reform. Although JKN has expanded coverage to more than 250 million participants, it continues to face fiscal pressures due to rising healthcare costs and utilization rates. Global studies on universal health coverage indicate that balancing coverage expansion with cost control and service quality is critical for long-term sustainability (Savedoff et al., 2012; Cotlear et al., 2015). Therefore, improving provider payment systems, enhancing efficiency, and strengthening accountability mechanisms are essential.

Third, governance reform is crucial to address fragmentation and improve policy coherence. Weak coordination across national and local governments, as well as between public and private sectors, continues to limit policy effectiveness. Strengthening governance capacity through integrated planning, data-driven decision-making, and robust monitoring systems can significantly enhance implementation outcomes (Gilson, 2012; Reich et al., 2016).

Fourth, improving service quality must be prioritized alongside expanding access. Evidence suggests that increasing coverage alone does not guarantee equitable health outcomes, particularly when disparities in service quality persist across regions (Lagomarsino et al., 2012). Investments in healthcare infrastructure must therefore be complemented by improvements in service standards, availability of medicines, and training of healthcare workers.

Fifth, community participation and health literacy should be strengthened through culturally sensitive, people-centered approaches.

Indonesia's diverse social and cultural context requires policies that are responsive to local values and practices. Studies show that community engagement is a key determinant of successful health interventions, particularly in decentralized and diverse settings (World Health Organization, 2021; Marmot et al., 2008). Strengthening health literacy and promoting *gotong royong* can enhance public trust and participation in health programs.

Sixth, inclusive policies must prioritize vulnerable and marginalized populations, including persons with disabilities, women, and low-income communities. Health equity requires targeted interventions to reduce avoidable disparities and ensure that no population group is left behind (Braveman & Gruskin, 2003). This includes improving accessibility, affordability, and quality of services for disadvantaged groups.

Finally, continuous innovation and evaluation are necessary to ensure the adaptability and resilience of the health system. The integration of digital health technologies, improved health information systems, and evidence-based policymaking can enhance efficiency and responsiveness. However, policymakers must also address the digital divide to prevent the reinforcement of existing inequalities (World Bank, 2023).

From a critical perspective, these recommendations highlight that the core challenge lies not in the absence of normative values such as unity, but in the limited institutionalization of those values. Without structural reform, unity risks remaining a symbolic principle rather than a transformative force in health policy. Therefore, future policy directions must focus on translating unity into a functional governance framework that ensures equitable resource distribution, policy coherence, and inclusive participation.

4. Conclusion

The principle of *Persatuan Indonesia* plays a fundamental role in shaping inclusive health policies by providing a normative foundation for equity, solidarity, and collective responsibility. However, the findings of this study indicate a persistent gap between these normative values and their practical implementation, as reflected in ongoing disparities in healthcare access, service quality, and system sustainability.

While initiatives such as the *Jaminan Kesehatan Nasional* (JKN) have significantly expanded coverage, structural challenges, including unequal resource distribution, governance fragmentation, and variations in service quality continue to limit the realization of equitable health outcomes. This suggests that unity has not yet been fully institutionalized as an effective governance mechanism. Embedding unity in health policymaking must go beyond symbolic commitment and be translated into concrete institutional

practices. Strengthening governance capacity, ensuring equitable resource allocation, and promoting inclusive participation are essential to transform unity into a functional driver of health equity. Achieving equitable and sustainable healthcare in Indonesia depends on the ability to operationalize the values of unity, social justice, and solidarity within the health system, ensuring that all citizens have equal access to quality healthcare services.

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