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Health Inequality and Structural Injustice in Indonesia's National Health Insurance System: A Rawlsian Analysis

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Abstract

This article analyzes structural inequalities in the implementation of the National Health Insurance Program (JKN) in Indonesia using John Rawls' Difference Principle as a normative framework. Although JKN has achieved near-universal coverage of approximately 98% of the population by 2025, disparities in access, quality, and distribution of healthcare services persist, particularly in remote, border, and archipelagic areas (DTPK). This study employs a normative legal method combined with policy analysis to evaluate whether the institutional structure of Indonesia's health system has provided optimal benefits for the least advantaged groups. The findings show that unequal distribution of medical personnel, the concentration of specialist doctors in urban areas, and limited primary healthcare infrastructure reflect structural failures that contradict the principle of distributive justice. The JKN system, which is formally universal, has not been able to ensure substantive justice as it continues to reproduce social and geographical inequalities. This article contributes theoretically by integrating Rawls' Difference Principle into health policy analysis, and practically by offering a justice-based reform framework through affirmative and redistributive interventions, including redistribution of health workers, inequality-based budget reallocation, and the use of health technology to overcome geographical barriers. These findings emphasize that achieving justice in the health system is not sufficient through expanding financial coverage alone, but requires structural transformation oriented towards the most vulnerable groups.

Keywords: *National Health Insurance; Distributive Justice; Health Inequality; Rawls's Difference Principle; Structural Injustice*

Introduction

Health is a fundamental determinant in human development and serves as a primary prerequisite for achieving sustainable social welfare. Within the global framework, access to quality healthcare services has been positioned as an integral part of the Universal Health Coverage (UHC) agenda in the Sustainable Development Goals (SDGs). However, various studies indicate that expanding financial coverage does not automatically guarantee equity in access to healthcare services.[1] This phenomenon also occurs in Indonesia, where the implementation of the National Health Insurance Program (JKN) has shown significant achievements in terms of participation, yet structural gaps in the distribution of healthcare services persist.

Inequality in access to healthcare services in Indonesia can be identified through various indicators. One of the most prominent is the geographic disparity in the distribution of specialist healthcare workers. Data from the Indonesian Medical Council (KKI) as of April 24, 2024, reveals that out of a total of 59,422 registered specialist doctors across Indonesia, 18.3% are concentrated in Jakarta.[2] This phenomenon creates an imbalance, where major urban areas, particularly the capital city, enjoy a high concentration of medical resources, while remote, border, and island regions face shortages of infrastructure, equipment, and especially competent healthcare human resources.[3] The same pattern is also observed in various low- and middle-income countries, where unequal distribution of human resources exacerbates differences in access to and quality of healthcare services.[4]

This inequality is not only limited to the availability of medical personnel but also extends to the quality and quantity of healthcare facilities. In rural and remote areas, communities often face substantial geographic and economic barriers to accessing adequate services.[5] A study published in The Lancet Global Health emphasizes that the quality of a health system is strongly

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[1] Margaret E. Kruk et al., "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution," *The Lancet Global Health* 6, no. 11 (2018): e1196–1252, https://doi.org/10.1016/S2214-109X(18)30386-3.

[2] Kruk et al.

[3] Maria T R I Diani, Rostika Flora, and Rizma Adlia Syakurah, "Optimalisasi Pemerataan SDM Kesehatan Di Indonesia" 11, no. 1 (2023): 234–45.

[4] Jasmin M. Ariff, Lokman H. Sulaiman, and Chandrashekhar T. Sreeramareddy, "Trends and Inequalities of Human Resources for Health across 15 States/Territories in Malaysia during 2010–2022," *Human Resources for Health* 23, no. 1 (2025), https://doi.org/10.1186/s12960-025-01029-9.

[5] Aprillia Dwi Astuti et al., "Aksesibilitas Layanan Kesehatan Modern Dan Tradisional Di Masyarakat Pantai Putra Serdang, Pantai Labu, Deli Serdang," *Jurnal Medika Nusantara* 3, no. 1 (2025): 78–85, https://doi.org/10.59680/medika.v3i1.1652.

influenced by the distribution of infrastructure and medical personnel as well as policy governance.[6] These findings are consistent with the situation in Indonesia, where access to healthcare services in non-urban areas still faces geographic and institutional barriers. Previous research has also highlighted several inequities within the health system, with supporting factors such as health insurance status proven to be associated with the utilization of healthcare services. This study has provided important evidence to inform policy design in order to achieve a more equitable pattern of healthcare utilization in Indonesia[7].

On the other hand, the success of JKN in expanding membership coverage shows progress in financial protection. However, various studies indicate that increased health insurance coverage is not always followed by an even increase in service utilization.[8] This suggests a gap between policy design and its implementation in the field. From a theoretical perspective, this issue can be analyzed through the theory of social justice developed by John Rawls. The Difference Principle asserts that inequality can only be justified if it provides the greatest benefit to the least advantaged groups (Rawls, 1971). In the context of healthcare, this principle demands a distribution of resources that favors vulnerable groups.

The concept of justice can be divided into two main streams, namely distributive justice and interpersonal justice. Distributive justice focuses on the fair distribution of resource allocation. This principle requires healthcare workers to treat all patients regardless of social, economic, or even political status. In situations where resources such as healthcare facilities and medicines are limited, medical decisions must be based on medical needs rather than non-medical factors. Distributive justice also emphasizes prioritizing the most vulnerable groups in society or those with complex medical conditions, with the aim of ensuring that these groups receive the necessary attention.[9]

From another perspective, interpersonal justice emphasizes the quality of interaction between healthcare workers and patients. This principle

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[6] Kruk et al., "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution."

[7] Qinglu Cheng et al., "Determinants of Healthcare Utilization under the Indonesian National Health Insurance System – a Cross-Sectional Study," *BMC Health Services Research* 25, no. 1 (2025), https://doi.org/10.1186/s12913-024-11951-8.

[8] Rina Agustina et al., "Universal Health Coverage in Indonesia: Concept, Progress, and Challenges," *The Lancet* 393, no. 10166 (2019).

[9] Ontran Sumantri Riyanto et al., "Pelayanan+Kesehatan+Yang+Berkeadilan+_+Peran+Tenaga+Kesehatan+Dalam+Menjamin+Hak+Setiap+Pasien (1)," *Jurnal Riset Dan Kajian Hukum Asasi Manusia*, 2023, 77–87.

demands that such relationships be based on clear communication, full attention, and respect for human dignity.[10] This includes conveying medical information in a way that is easy for patients to understand, listening to patients' complaints, and avoiding discriminatory actions in treatment based on gender, race, or social class. [11]The implementation of this principle supports the development of emotional relationships based on trust and respect, both of which are essential foundations for high-quality and humane healthcare services.

John Rawls' theory of justice, known as Justice as Fairness, provides a solid framework for correcting the basic structure of society and how social institutions should be regulated.[12] Rawls proposes two complementary principles of justice: 1) The Principle of Equal Liberty, which states that every person has an equal right to enjoy the most extensive total system of equal basic liberties compatible with a similar system of liberty for all; 2) The Difference Principle, which means that social and economic inequalities must be arranged in such a way that they provide the greatest benefit to those who are least advantaged, and positions or offices that give rise to such inequalities must be open to all under conditions of equal opportunity. [13]

Contemporary research shows that social determinants of health must be included as primary social public goods within a Rawlsian framework, so that inequalities in access to the social bases of health must be regulated to improve the health status of those who are least advantaged along the social health gradient.[14] Previous research results indicate that existing policies have not fully realized Rawls's principles of equal basic liberties, fair equality of opportunity, and the difference principle. The uneven distribution of health facilities and personnel, limited infrastructure in remote areas, and gaps in

[10] Riyanto et al.

[11] Arissy Jorgi Sutan and Ridho Al-Hamdi, "Keadilan Semi-Libertarianisme Pada Sistem Kesehatan Indonesia: Analisis Komparatif Pemikiran Bentham Kant Terhadap Implementasi Konsep Keadilan Pada Bpjs – Kesehatan," *Jurnal Kebijakan Kesehatan Indonesia : Jkki* 9, no. 3 (2020): 125–35, https://www.academia.edu/download/100066611/349555327.pdf.

[12] S. Christian, A., Nabilah, A., & Ajie, "Teori Keadilan Menurut Jhon Rawls," *Quantum Juris: Jurnal Hukum Modern* 7, no. 1 (2025).

[13] Christian, A., Nabilah, A., & Ajie.

[14] Jayna Fishman and Douglas MacKay, "Rawlsian Justice and the Social Determinants of Health," *Journal of Applied Philosophy* 36, no. 4 (2018): 608–25, https://doi.org/10.1111/japp.12339.

policy mechanisms suggest that Indonesia's health system still requires systematic improvement. [15]

In addition, research conducted in the United States shows that a full accounting of the social determinants of health requires a reworking of Rawlsian principles of justice. First, the social bases of health—a Rawlsian conception of the social determinants of health—should be regarded as primary social public goods. Second, incorporating the social bases of health as primary social public goods would lead parties in the original position to choose an additional principle of justice and give it lexical priority over Rawls's second principle. According to this principle, inequalities in the distribution of the social bases of health must be arranged in such a way as to improve the health status of those who are worst off along the social health gradient.[16]

A recent study developed the Rawlsian Grid—a structured evaluative framework that operationalizes Rawls's abstract principles within Indonesia's socio-political context. Through this framework, the study identified that disparities in health access in DTPK can be structurally addressed through three main policy pillars: equitable budget allocation, fair distribution of health personnel, and the expansion of infrastructure and telemedicine.[17] Another study focusing on North Sumatra also found significant disparities between urban and rural areas in access to public services, where the distribution of resources often favors urban areas—contrary to the difference principle, which requires that inequalities are only justified if they benefit the least advantaged.[18]

Furthermore, cross-country research shows that successful health policies require supportive political contexts, coherent law enforcement strategies, and alignment with evolving social values.[19] Without fundamental improvements in the physical provision of resources and centralized incentive structures, increasing financial coverage alone is not sufficient to comprehensively address unequal access. The Rawlsian approach is increasingly relevant in contemporary health policy studies, particularly in

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[15] Tony Richard Alexander Samosir and Mei Susanto, "Rawls's Justice as Fairness and Indonesian Health Policy: A Doctrinal Framework for Equity-Oriented Reform," *Justisi* 12, no. 1 (2025): 55–73, https://doi.org/10.33506/js.v12i1.4556.

[16] Fishman and MacKay, "Rawlsian Justice and the Social Determinants of Health."

[17] Alexander Samosir and Susanto, "Rawls's Justice as Fairness and Indonesian Health Policy: A Doctrinal Framework for Equity-Oriented Reform."

[18] Jopinus, "Bridging the Gap: Applying Rawls' Justice Principles in North Sumatra's Public Policies," *International Journal of Religion* 5, no. 10 (2024).

[19] Yuri Lee and Jiwon Park, "When Politics Meets Policy : A Realist Review of How Political Context Shapes the Impact of Public Health Legal Interventions," no. August (2025): 1–11, https://doi.org/10.3389/fpubh.2025.1601467.

integrating the social determinants of health as part of the "primary goods" that must be guaranteed.[20] Thus, access to health services cannot be separated from the state's obligation to correct structural inequalities arising from geographic and socio-economic conditions.

Based on these issues, this study positions the implementation of JKN not only as a public policy program but as an institutional structure that must be evaluated based on principles of distributive justice. This article aims to examine the extent to which Indonesia's health system, particularly through JKN, has fulfilled principles of justice for the least advantaged groups, and to formulate directions for more equitable and inclusive policy reform.

Methodology

This study employs a normative legal research approach combined with policy analysis to evaluate structural inequalities in the implementation of the National Health Insurance Program (JKN) in Indonesia. The normative legal approach is used to examine legal norms, principles, and doctrines related to the national health insurance system, including the principle of distributive justice in public policy. Meanwhile, policy analysis is used to assess the alignment between the design of the JKN policy and its implementation, particularly in aspects of the distribution of health resources, access to services, and quality of care in non-urban areas as well as disadvantaged, frontier, and outermost regions (DTPK).

The analytical framework of this study is based on the Difference Principle developed by John Rawls as a normative foundation for assessing justice in the distribution of health resources. This principle is used to examine whether inequalities in Indonesia's health system can be ethically justified, namely to what extent such inequalities provide the greatest benefit to the least advantaged groups. Thus, the analysis in this study is not only descriptive but also evaluative and prescriptive in formulating directions for policy reform.

The type and sources of data used in this study are secondary, obtained through library research. These include primary legal materials in the form of legislation related to the national health insurance system, secondary legal materials in the form of reputable national and international journal articles, reports from official institutions such as the World Health Organization (WHO), the World Bank, and the Ministry of Health, as well as scientific publications relevant to issues of health inequality. In addition, this study also

[20] Fishman and MacKay, "Rawlsian Justice and the Social Determinants of Health."

utilizes empirical data in the form of national health statistics and reports on the distribution of health workers to strengthen the policy analysis.

The data analysis technique is conducted qualitatively using content analysis and conceptual analysis approaches. Content analysis is used to identify patterns of inequality in the distribution of health services and the implementation of JKN policy, while conceptual analysis is used to examine the relevance and application of Rawls's theory of justice in the context of health policy in Indonesia. The results of the analysis are then interpreted systematically to produce normative arguments regarding structural failures in the health system and to formulate policy recommendations that are affirmative and redistributive in nature.

Discussion

Evaluation of the National Health Insurance Program and Disparities Outside Urban Areas

The evaluation of the implementation of the National Health Insurance Program (JKN) shows a policy paradox: significant success in financial coverage is not accompanied by substantial equity in access to healthcare services. The JKN program has achieved significant success in financial coverage, with total participation reaching 98% of the population as of July 2025—around 280 million people out of Indonesia's total population of 286.7 million.[21] This phenomenon aligns with global findings indicating that the expansion of Universal Health Coverage (UHC) often fails to address access inequality if it is not accompanied by fair resource distribution.[22]

Despite the massive funding, this increase does not mean that access to and quality healthcare services have become evenly distributed. Data show that the healthcare system is under considerable operational pressure. In December 2024, the claim ratio for JKN services, particularly for Advanced Outpatient Care (RJTL) and Advanced Inpatient Care (RITL), reached 105.9%, exceeding the growth of contribution revenues.[23] A claim ratio surpassing 100% indicates

[21] Ali Ghufron Mukti, "Lessons from Indonesia's 10-Year Journey towards Universal Health Coverage," *World Bank Group*, January 2026, https://www.worldbank.org/en/programs/multi-donor-trust-fund-for-integrating-externally-financed-health-programs/brief/lessons-from-indonesia-s-10-year-journey-towards-universal-health-coverage#:~:text=Pisero Photography,at the primary care level.

[22] Kruk et al., "High-Quality Health Systems in the Sustainable Development Goals Era: Time for a Revolution."

[23] Alexander Samosir and Susanto, "Rawls's Justice as Fairness and Indonesian Health Policy: A Doctrinal Framework for Equity-Oriented Reform."

a high system burden on referral services. This reflects a possible malfunction in primary healthcare services in the regions.

Access to healthcare services for lower-income populations through BPJS has not yet reached fair and equitable standards. The study identified that "access was provided to basic and referral healthcare services without achieving equitable and high-quality standards for citizens," as well as the existence of "differentiated services based on VIP, as well as Classes 1, 2, and 3," which reflects service segmentation based on financial capacity.[24] These findings indicate that success in financial coverage has instead given rise to new forms of discrimination within the healthcare system. Previous research shows clear access gaps in Southern Italy, particularly in Campania, where disparities exist both in supply and demand for healthcare services. Disparities in access are primarily driven by demand-side elements, especially variations in regional spending capacity. [25]

Recent studies show that although there has been a decline in national health complaint indicators, regional inequality remains high, even showing significant variation between regions (–13.16% to +4.66%), reflecting imbalances in regional healthcare system performance. This indicates that quantitative expansion of healthcare services does not automatically improve equity in service quality.[26]

Furthermore, the unequal distribution of healthcare workers is a major factor exacerbating access inequality. Data from the Indonesian Medical Council (KKI) as of April 2024 show an extreme concentration of specialists: of the total 59,422 registered specialist doctors, 18.3% are concentrated in Jakarta. This phenomenon creates an imbalance that violates the principle of distributive justice, where urban areas enjoy abundant medical resources while remote, underdeveloped, border, and island regions (DTPK) face shortages. Research findings identify that "shortage of medical personnel, particularly doctors, is a significant obstacle," and Indonesia's doctor-to-patient ratio is still far below WHO standards. This shortage is worsened by a "complex referral

[24] Syarief Makhya, R Pitojo Budiono, and Maulana Mukhlis, "Health Insurance and Access Policy for the Lower-Class Community in Obtaining Healthcare Services in Bandar Lampung City , Indonesia" 10 (2025): 24–35.

[25] Antonio Abatemarco et al., "Measuring Health Care Access and Its Inequality: A Decomposition Approach," *Economic Modelling* 132, no. 106659 (2024).

[26] Kadek Dwipa and Citra Lestari, "Ketimpangan Sistem Pelayanan Kesehatan Dan Dinamika Keluhan Penduduk : Bukti Spasial Dari Provinsi Kepulauan Di Indonesia Health System Inequality and the Dynamics of Population Health Complaints : Spatial Evidence from an Archipelagic" 2 (2025): 95–107, https://doi.org/10.63892/aletheia.2.2025.95-107.

system" that actually hinders patient access to specialists.[27] Studies show that healthcare workers tend to concentrate in urban areas due to economic incentives, facilities, and career opportunities, while remote areas experience significant shortages.[28] This condition reinforces that inequality in healthcare access in Indonesia is a structural issue, not merely a technical administrative one.

This shortage extends to the primary healthcare sector, data from the 2019 Health Facility Research show that community health centers (Puskesmas) in remote/very remote and rural areas have very limited numbers of doctors and dentists compared to urban areas.[29] This crisis is further worsened by the lack of specialists at the national level. For some important specialties such as Anesthesiology and Intensive Therapy, it is estimated that it would take more than 35 years to meet demand. Meanwhile, the field of Pediatrics requires more than 15 years.[30] This crisis requires a rapid increase in the number of specialists as well as appropriate placement policies. Accessing high-quality healthcare services remains a challenge in Indonesia due to population growth, geographic conditions, and the uneven distribution of healthcare services. Indonesia's geography, consisting of thousands of islands with limited transportation access, is a structural factor that exacerbates this inequality.[31]

From a political economy of health perspective, this inequality is also closely related to the distribution of economic resources and public policies that are not yet fully inclusive. Studies show that low-income groups face significant barriers in accessing healthcare services, even though they are

[27] Sadira Ferda Zahira and Reza Eka Lestari, "Enhancing Healthcare Consulting Services : Addressing Accessibility and Quality Challenges in Indonesia" 3, no. 1 (2025): 41–55.

[28] Kunnati et al., "Kesenjangan Digital Dalam Telemedicine Sebagai Faktor Penentu Ketimpangan Kesehatan Di Indonesia: Tinjauan Skoping," *Public Health Education* 04 (2025): 90–102, https://doi.org/10.53801/jphe.v4i3.422.

[29] Litbangkes, "Laporan Riset Fasilitas Kesehatan RIFASKES 2019 Puskesmas" (Jakarta, 2019).

[30] Djustiawan Widjaya, Hafiz Dwi Putra, and Cika Vanny, "Permasalahan Ketersediaan Dokter Di Indonesia" (Jakarta, 2023), https://repositori.dpr.go.id/id/eprint/628/1/BRIEF I TW I_KOMISI IX_PERMASALAHAN KETERSEDIAAN DOKTER_KEMENKES RI.pdf.

[31] Wahyu Pudji Nugraheni et al., "A Decade of Telehealth Implementation for Promotive and Preventive Care in Indonesia : A Scoping Review," *Asian Journal of Social Health and Behavior*, 2024, https://doi.org/10.4103/shb.shb.

covered under the national insurance scheme.[32] This indicates a gap between formal access (coverage) and actual access (utilization), which is one of the main criticisms of insurance-based healthcare financing models in developing countries.

Thus, it can be concluded that the failure of Indonesia's healthcare system does not lie solely in financing, but in the imbalance of resource distribution and weak integration between primary and referral service policies. Without structural improvements in these aspects, the expansion of JKN coverage risks producing only an "illusion of equality" without substantive justice.

John Rawls's Difference Principle as a Normative Analytical Framework and Structural Solution

The Difference Principle functions as a standard for assessing whether Indonesia's institutional systems—such as the National Health Insurance (JKN) and the distribution of human resources—have fulfilled their ethical obligation to prioritize the needs of the least advantaged. The application of the *maximin rule* inherent in the Difference Principle requires that systems be structured to generate the greatest benefit for society, particularly its most vulnerable members. The severe maldistribution of medical resources in Indonesia indicates that existing social institutions are not organized in accordance with societal needs. Instead, free-market incentive structures and centralization have produced inequalities that do not benefit the least advantaged but rather reinforce advantages for urban regions that are already relatively privileged.[33]

The application of Rawlsian analysis, as adapted in England, yields two general principles that may provide a normative foundation for guiding a just health care system. First, considering various instances where urgent individual needs conflict with future needs, there is a compelling necessity to develop institutions that are both fair and sustainable. Working conditions must encourage adequate recruitment, retention, and training of staff, while financial and structural infrastructures must incorporate long-term considerations. Second, greater transparency must be prioritized to safeguard the capacities

[32] Daniel Ginting and Nina Fentiana, "Analysis of Health Disparities Among Different Socioeconomic Groups in Indonesia : Implications for Health Policy," *Gema Lingkungan Kesehatan* 22, no. 2 (2024): 108–13.

[33] Alexander Samosir and Susanto, "Rawls's Justice as Fairness and Indonesian Health Policy: A Doctrinal Framework for Equity-Oriented Reform."

and opportunities of both health care providers and recipients.[34] Contemporary research demonstrates that structural inequalities in public policy, including health, often stem from imbalanced power relations and non-inclusive policy design.[35] In this context, the JKN system may be criticized as formally universal but substantively insufficient in ensuring distributive justice.

Furthermore, the Rawlsian approach emphasizes the importance of incorporating the social determinants of health as part of "primary goods." This implies that access to health care services cannot be separated from factors such as geographic conditions, infrastructure, and regional economic capacity. Without redistributive intervention, the health system tends to reproduce pre-existing inequalities. Accordingly, this analysis indicates that the failure of Indonesia's health system is not merely technocratic but constitutes a normative failure to uphold principles of social justice.

Based on empirical and normative analysis, reform of Indonesia's health system must be directed toward structural approaches that are both affirmative and redistributive. At least three key policy areas require attention. **Firstly**, **Inequality-Based Budget Reallocation**; the current single-pool financing system of BPJS is fundamentally inequitable as it overlooks fiscal disparities across regions.[36] Regions with stronger fiscal capacity, such as Java, derive greater benefits, while fiscally weaker regions such as Papua and Maluku are marginalized. This contradicts Rawls's Difference Principle, which permits inequalities only if they benefit the least advantaged. A necessary structural solution is significant budget reallocation prioritizing capital and operational expenditures in underdeveloped, frontier, and outermost regions (DTPK), including the development of health facilities exceeding minimum standards, particularly at primary health care facilities (FKTP).

Secondly, Unequal Distribution of Human Resources, the concentration of specialist medical personnel in urban areas represents one of the most evident manifestations of structural failure within Indonesia's health system. The limited number of medical professionals, particularly doctors and specialists, constitutes a significant barrier to accessing quality health

[34] Zoë Fritz and Caitríona Cox, "Conflicting Demands on a Modern Healthcare Service: Can Rawlsian Justice Provide a Guiding Philosophy for the NHS and Other Socialized Health Services?," *Bioethics* 33, no. 5 (2019): 609–16, https://doi.org/10.1111/bioe.12568.

[35] Dinar Sulistiya Ningrum and Devi Fitri Rizki Yanti, "Analisis Literatur Tentang Kemiskinan Struktural Di Indonesia: Perspektif Sosial, Ekonomi Dan Kebijakan," *Jurnal Ilmiah Detubuya*, 2024, 315–34.

[36] FK-KMK-UGM, "10 Years of JKN: UGM Experts Urge Systemic Healthcare Reform," Universitas Gajah Mada Faculty of medicine Public Health and medicine, 2024, https://fkkmk.ugm.ac.id/10-years-of-jkn-ugm-experts-urge-systemic-healthcare-reform/.

consultations. Additionally, complex referral systems further hinder patient access to specialist care. Structural solutions should include the large-scale acceleration of specialist training, affirmative policies such as mandatory placement for publicly funded specialists (as a philosophically justifiable redistributive intervention) and strengthened incentive systems to retain medical personnel in remote areas.[37]

Thirdly, Limited Infrastructure and Technological Access, in an archipelagic state facing geographical disadvantages (*natural lottery*), digital technology functions as a compensatory instrument of justice. The evolution of telehealth in Indonesia over the past decade (2015–2024) demonstrates significant potential to improve access to promotive and preventive health services, particularly in overcoming geographical barriers. However, its implementation faces substantial challenges: limited internet connectivity, especially in rural areas, and concerns regarding data privacy, security, and integration into existing health care systems.[38]

The Indonesian government has responded to these challenges through various initiatives. The Ministry of Health, in collaboration with PT Telkom Satelit Indonesia (Telkomsat), has launched the "AI Telehealth Gateway," integrating high-reliability satellite connectivity, telehealth services, and artificial intelligence technologies. This platform is designed to accelerate remote consultations and strengthen data-based referral systems, particularly in underserved regions lacking terrestrial internet infrastructure, with implementation targeted to begin in 2026. The Vice Minister of Health, Prof. Dante Saksono Harbuwono, emphasized that technology plays a critical role in transforming health services and must not be limited to major cities but accessible to all.[39]

Telehealth implementation has also progressed at the regional level. For instance, the East Kalimantan Provincial Health Office has optimized telemedicine services to reach remote areas with vast geographical conditions and transportation challenges. A concrete example is the Tabang Community Health Center in Kutai Kartanegara, which can now transmit patients' electrocardiogram results online to RSUD Aji Muhammad Parikesit

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[37] Zahira and Lestari, "Enhancing Healthcare Consulting Services : Addressing Accessibility and Quality Challenges in Indonesia."

[38] Septriyadi Nugraha, I Gusti Nyoman Guntur, and Sri Kistiyah, "Penolakan Masyarakat Adat Limau Manis Kota Padang Terhadap Pendaftaran Tanah," *Tunas Agraria* 3, no. 2 (2020), https://doi.org/10.31292/jta.v3i2.106.

[39] Ibnu Naufal, "Jangkau Wilayah 'Blank Spot', Kemenkes-Telkomsat Kerahkan AI Telehealth Berbasis Satelit," *Inilah,Com*, October 2025, https://www.inilah.com/jangkau-wilayah-blank-spot-kemenkes-telkomsat-kerahkan-ai-telehealth-berbasis-satelit.

Tenggarong for specialist analysis, eliminating the need for patients to undertake hours-long travel for initial diagnosis.[40]

The massive expansion of telemedicine and digital services constitutes a structural solution to address substantial geographical barriers. Telemedicine enables equitable access to specialist consultations, neutralizes unjust geographical disadvantages (*natural lottery*), and ensures that the most isolated populations receive the greatest benefits from technological advancement—consistent with Rawls's Difference Principle. Nevertheless, successful telehealth implementation requires a holistic approach encompassing patient acceptance, health worker readiness, policy support, reliable technology, efficient organizational structures, and adequate financing.[41]

Affirmative policies must also be applied within regulatory frameworks. Currently, disparities exist in the redistribution of participants between public health centers and private FKTPs, as regulated in BPJS Health Regulation No. 1 of 2017, Presidential Regulation No. 59 of 2024, and Presidential Instruction No. 1 of 2022. However, implementation remains suboptimal due to the absence of technical guidelines. Many public health centers serve populations far exceeding ideal capacity, while private FKTPs lack sufficient participants—often falling below the minimum threshold of 6,000 individuals required for operational sustainability. Consequently, private clinics struggle to pay medical staff, provide medicines, and maintain equipment. Djoko Sungkono, a former member of the National Social Security Council, emphasized that primary care facilities serve as the gatekeepers of JKN, and without strengthening them, the quality of primary health services will be compromised.[42]

From a policy perspective, this analysis demonstrates that reforms in the health system must prioritize structural improvements that are affirmative and redistributive in nature. The Difference Principle provides a normative justification for stronger state intervention in the distribution of health resources, including needs-based placement of medical personnel, budget reallocation prioritizing primary care in underdeveloped regions, and the utilization of health technologies to address geographical disadvantages. These

[40] Ahmad Rifandi, "Dinkes Kaltim Optimalkan Pengobatan Jarak Jauh Untuk Pelosok," *Antara Kaltim*, April 26, 2026, https://kaltim.antaranews.com/berita/260203/dinkes-kaltim-optimalkan-pengobatan-jarak-jauh-untuk-pelosok.

[41] Nugraheni et al., "A Decade of Telehealth Implementation for Promotive and Preventive Care in Indonesia : A Scoping Review."

[42] Rokimandakas, "Jaminan Kesehatan Nasional Penuh Problem Akibat 11 Juta Data PBI Dihapus," *Kemapalanews*, 2026, https://kempalan.com/2026/03/03/jaminan-kesehatan-nasional-penuh-problem-akibat-11-juta-data-pbi-dihapus/.

policies are both moral and technical, reflecting the state's commitment to social justice.

In conclusion, the current systemic failure violates the Difference Principle as it does not deliver optimal benefits to the most vulnerable groups. Solutions must focus on structural affirmative actions that compensate for disadvantages, reallocate resources, and leverage technology to ensure equitable access to health care across Indonesia. Through the health system transformation launched in 2022, comprising six strengthening pillars, the government must ensure that these affirmative policies are implemented consistently and sustainably.[43] The success of JKN should not be measured solely by enrolment figures but by the extent to which the most disadvantaged populations—those in remote, border, and archipelagic areas truly benefit from the national health insurance system.

Conclusion

This study shows that the success of the National Health Insurance Program (JKN) in achieving near-universal coverage has not been accompanied by the realization of equity in access, quality, and distribution of healthcare services. Structural inequalities remain clearly visible, particularly in the concentration of specialist medical personnel in urban areas, the limited availability of primary healthcare facilities in remote regions, and the imbalance in the allocation of health resources. These findings confirm that expanding financial coverage does not automatically result in equal access to healthcare services but instead requires more fundamental structural interventions.

From a normative perspective, analysis using the Difference Principle proposed by John Rawls indicates that Indonesia's healthcare system has not fully met the principles of distributive justice. The inequalities that occur do not provide the greatest benefit to the least advantaged groups but instead reproduce pre-existing social and geographic disparities. Thus, JKN as a formally universal public policy instrument has not yet been able to ensure substantive justice in practice.

Based on these findings, this study emphasizes that reform of Indonesia's healthcare system must be directed toward a structural approach that is both affirmative and redistributive. This includes restructuring the distribution of healthcare workers based on regional needs, reallocating budgets to prioritize areas with limited access, and utilizing health technology to overcome geographic barriers. This approach is not only normatively

[43] Mukti, "Lessons from Indonesia's 10-Year Journey towards Universal Health Coverage."

relevant but also practically important to ensure that the healthcare system truly supports the most vulnerable groups in society.

Theoretically, this study contributes by integrating Rawls' Difference Principle into the analysis of health policy in Indonesia, thereby expanding the use of justice frameworks in evaluating health insurance systems. Practically, this study offers directions for policy reform based on justice as an alternative to address long-standing structural inequalities. Thus, the achievement of justice in the healthcare system cannot be measured solely by participation rates, but by the extent to which the least advantaged groups truly benefit from the system.

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