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Health Security Policies: A Comparative Study Through Constitutional Frameworks and the Insights of Veronica Rodriguez-Blanco

Article

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Abstract

In Indonesia, the 1945 Constitution mandates the establishment of health social security. Similarly, Section 15 of Article II of the Philippines' 1987 Constitution asserts that the state has a duty to protect and promote the right to health for its citizens. Bangladesh's Constitution, while not explicit, recognizes healthcare as a fundamental human right under Articles 15 (which addresses the provision of basic necessities) and 18 (which pertains to public health). Through a classic socio-dogmatic research method—a type of normative legal research—this study interprets how these constitutional provisions are implemented in practice. While Indonesia's constitution clearloy requires the state to ensure health security, the government often falls short, lacking sufficient financial supports. In the Philippines, health security initiatives are gradually expanding but also suffer from inadequate funding. In contrast, Bangladesh has not prioritized health security, focusing instead on food security without emphasizing health as a state responsibility. Applying Rodriguez-Blanco's theory reveals that Indonesia's approach to social security leans towards an insurance model due to its reluctance to allocate adequate funds. In the Philippines, there is progress, albeit slow and underfund, while Bangladesh's lack of health security development stems from its prioritization of basic food needs over health provisions.

Keywords: *Law; constitution; health security; authority.*

INTRODUCTION

Indonesia's National Health Security program (*Jaminan Kesehatan Nasional*/JKN) is designed around the principles of social insurance and equity. Essentially, social insurance involves collecting mandatory contributions from participants, while equity ensures that everyone gets equal access to

health services in relation to what they pay.[1] However, challenges persist; the protection and health social security schemes are limited, leading to inadequate benefits in both quantity and quality.[2]

It is the state's responsibility to establish comprehensive social security for all Indonesian citizens, as mandated by the Constitution.[3] Specifically, Article 28H, clause (3) guarantees the right to social security, and Article 34, clause (2) states, "The state develops a social security system for all citizens and empowers the weak and incapable according to the honor and dignity of humanity."[4]

Participants in the *Badan Penyelenggara Jaminan Sosial* (BPJS, or Social Health Insurance Administration Body)[5] often encounter various service related issues. These include complex referral processes, rejection by hospitals, slow service delivery, and being turned away due to full treatment rooms.[6] Additionally, the claim system under the Indonesian Case Base Groups (INA CBGs) often fails to cover the actual costs associated with of healthcare services, leaving patients without adequate financial support for their recovery.[7]

Moreover, there seems to be a lack of clarity within the government regarding the distinction between the social insurance system and the broader social security framework. Although these concepts are fundamentally different, They are often treated as if they are the same. This confusion reflects an imperfect system:[8] national health security that is not truly secure, Despite being backed by public entities and a series of laws.

The implementation of the National Health Security system in Indonesia, which operates on an insurance model, reflects an effort by the government to shift the responsibility of social security onto the citizens. Unfortunately, this move also highlights the government's lack of commitment, as evidenced by a health budget that remains below 5%.[9]

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1 Yeni Riza et al., "Contribution Deposit Compliance: Income and Knowledge of BPJS Health Mandiri Participants," *Systematic Reviews in Pharmacy* 11, no. 10 (2020): 854 – 858, https://doi.org/10.31838/srp.2020.10.128.

2 Yohanes Kambaru Windi, Charles Livingstone, and Andrea Whittaker, "Does National Health Protection Cover the Vulnerable Groups in Indonesia? A Case Study of Waste Pickers in Surabaya," *Asia-Pacific Journal of Public Health* 35, no. 8 (2023): 479 – 485, https://doi.org/10.1177/10105395231199559.

3 Absori Absori, Harun Harun, and Moh Ikbal, "Kebijakan Pemerintah Dalam Pelayanan Kesehatan Bagi Penerima Bantuan Iuran Berbasis Keadilan Sosial Di Kota Yogyakarta (Government Policy in Health Services for Recipients of Social Justice-Based Contribution Assistance in the City of Yogyakarta)," *Jurnal Jurisprudence* 10, no. 2 (2020): 200–221, https://doi.org/10.23917/jurisprudence.v10i2.11696.

4 Haris Nurhayati et al., "Disaster Risk Index on Disaster Management Budgeting: Indonesia's National Data Set," *Jamba: Journal of Disaster Risk Studies* 15, no. 1 (2023), https://doi.org/10.4102/jamba.v15i1.1365.

5 Bambang P. S Brodjonegoro, Suhaisil Nazara, and Fauziah Zen, "Policy Challenges in Indonesian Social Security," in *Age Related Pension Expenditure and Fiscal Space: Modelling Techniques and Case Studies from East Asia* (London: Taylor and Francis, 2016), 137 – 151.

6 Barış Alpslan, King Yoong Lim, and Yan Song, "Growth and Welfare in Mixed Health System Financing with Physician Dual Practice in a Developing Economy: A Case of Indonesia," *International Journal of Health Economics and Management* 21, no. 1 (2021): 51 – 80, https://doi.org/10.1007/s10754-020-09289-9.

7 Arief Budiono et al., "Black Swan Theory: Legal Policy of the Indonesian National Healthcare," *LJIH* 30, no. 1 (2022): 42, https://doi.org/10.22219/ljih.v30i1.16867.

8 Anis Febri Nilansari, Nanang Munif Yasin, and Diah Ayu Puspandari, "Cost Analysis of Inpatient Hypertension Patients at Panembahan Senopati Hospital, Bantul, Yogyakarta, Indonesia: Comparison between INA-CBGs Rates and Hospitalized Actual Rate," *Journal of Public Health and Development* 21, no. 3 (2023): 153 – 167, https://doi.org/10.55131/jphd/2023/210312.

9 Diva Kurnianingtyas, Budi Santosa, and Nurhadi Siswanto, "A System Dynamics for Financial Strategy Model Assessment in National Health Insurance System," in *2nd International Conference on Management Science and Industrial Engineering, MSIE* (ACM International Conference Proceeding Series., 2020), 44–487.

This research dives into the legal aspects of Indonesia's National Health Security, focusing on Law No. 40 of 2004 regarding Social Security and Law No. 11 of 2004 regarding the *Badan Penyelenggara Jaminan Sosial* (BPJS, or Social Health Insurance Administration Body). The critical question is whether these laws align with the constitutional intent.[10] The constitution obligates the state to provide social security, yet the government fails to back commitment with adequate funding. This situation suggests that the laws and their implementation may simply mask the state's intention to transfer the financial burden from the government to the citizens.[11]

According to the theory of law and authority under the guise of good, the existence of the National Health Security can inadvertently relieve the government of its financial obligations.[12] By shifting the responsibility for funding the national health security from the state onto its citizens, the legal framework seems to contradict the constitutional promise.[13]

In contrast, the Philippines has established a Universal Health Coverage (UHC) system, which the government prioritizes to deliver quality healthcare services to all citizens. This system ensures financial protection and equity, achieving a universal coverage rate of approximately 92%.[14]This figure surpasses Indonesia's National Health Security program, which covers around 252.1 million people, or over 91% of the population.[15] While Indonesia has made significant strides towards universal coverage in a relatively short time, both countries face challenges in securing the necessary resources, particularly as low- and middle-income nations.[16]

All Filipino citizens are entitled to free healthcare through the Philippine Health Insurance Corporation, known as "PhilHealth." This insurance program is organized by the government and funded partly through local and national tax subsidies, along with payroll deductions from workers. PhilHealth covers emergency and urgent care, as well as inpatient healthcare and non-emergency surgeries.[17] However, despite covering a broad range of medical treatments, limited funding has restricted its universal coverage to 92%.[18]

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[10] Elizabeth Pisani, Maarten Olivier Kok, and Nugroho Kharisma, "Indonesia's Road to Universal Health Coverage: A Political Journey," *Health Policy and Planning* 32, no. 2 (2017): 267 – 276, https://doi.org/10.1093/heapol/czw120.

[11] Misbahul Munir et al., "Determinant Factors In Building Collaborative Sustainability Performance: Empiric Study In Health Social Insurance," *Quality - Access to Success* 23, no. 190 (2022): 211 – 225, https://doi.org/10.47750/QAS/23.190.23.

[12] Arief Budiono et al., "The Indonesian National Health Security's Deficits: Excises and the Handling of Non-Communicable Diseases," *IJIRSS* 8, no. 2 (2025): 375–84, https://doi.org/10.53894/ijirss.v8i2.5167.

[13] F. C. Permana et al., "Perception Analysis of the Indonesian Society on Twitter Social Media on the Increase in BPJS Kesehatan Contribution in the Covid 19 Pandemic Era," *Journal of Physics: Conference Series* 1722, no. 17 (2021), https://doi.org/10.1088/1742-6596/1722/1/012022.

[14] Dhian Kartikasari, Asfi Manzilati, and Tita Hariyanti, "What Are the Appropriate Leadership Styles for Class C Hospital in National Health Insurance (JKN) Era?," *Kemas* 17, no. 4 (2022): 630 – 645, https://doi.org/10.15294/kemas.v17i4.27111.

[15] Konrad Obermann et al., "Social Health Insurance in a Developing Country: The Case of the Philippines," *Social Science and Medicine* 62, no. 12 (2006): 3177 – 3185, https://doi.org/10.1016/j.socscimed.2005.11.047.

[16] Ali Gufron Mukti, Citra Jaya, and Rizki Lestari Suhardi, "Current Condition of Social Security Administrator for Health (BPJS Kesehatan) in Indonesia: Contextual Factors That Affected the National Health Insurance," *Medical Journal of Indonesia* 31, no. 2 (2022): 87 – 90, https://doi.org/10.13181/mji.com.226296.

[17] Caryn Bredenkamp et al., "Emerging Challenges in Implementing Universal Health Coverage in Asia," *Social Science and Medicine* 145 (2014): 243 – 248, https://doi.org/10.1016/j.socscimed.2015.07.025.

[18] Eltimar T. Castro and Nephi P. Romano, "Mining on Senior Citizens Data: Empirical Evidence in the Philippines Locale 'Basis for Social Services Improvement and Decision Making,'" in *IEEE International Conference on Automatic Control and Intelligent Systems, I2CACIS 2022 - Proceedings* (I2CACIS, 2022), 197 – 202, https://doi.org/10.1109/I2CACIS54679.2022.9815492.

In early 2019, the landscape of PhilHealth changed significantly with the enactment of the Universal Healthcare Bill, or "UHB," signed into law by President Rodrigo Duerte. This legislation aimed to include all citizens within the PhilHealth system to boost universal coverage.[19] When comparing the achievements of Indonesia, the Philippines, and Bangladesh in healthcare coverage, Indonesia's 91% coverage is notable, especially given its rapid progress. It adopts a mutual cooperation model, placing a greater financial load on citizens. On the other hand, the Philippines relies on substantial government subsidies to finance healthcare security.[20] In the Philippines, health insurance premiums are only required for workers and their families. In contrast, Indonesia's system mandates that all citizens contribute to the health insurance program.[21]

One unique feature of the Philippine healthcare system is the traditional funding derived from taxes on alcohol and cigarettes, which helps strengthen its national healthcare security. Additionally, pensioners and seniors are exempt from paying healthcare premium, distinguishing the Filipino system from those in Indonesia and Bangladesh.

In Bangladesh, the health security program is quite limited, as it does not yet provide universal coverage. The country's approach to health and social security in incorporated within the National Social Security Strategy (NSSS), which was launched in 2015 and has since been approved by the government.[22]

The NSSS aims to consolidate various support programs that address different life cycle risks, particularly focusing on food security. It includes initiatives for children, working-age individuals—especially youth and vulnerable women–seniors, and persons with disabilities. However, despite taking this life cycle approach, there are still significant gaps, particularly in addressing early childhood nutritional needs.[23] Almost a decade after the NSSS was approved, Bangladesh has yet to establish a comprehensive social security system. Additionally, the National Health Database (NHD) initiated in 2018, still lacks clarity on its future. Even if the NHD were implemented now, much of the data would be outdated due to demographic changes and rising incomes. Furthermore, the criteria for selecting beneficiaries, which were set in 2013, have not been updated.

Currently, about 40 million Bangladeshis live in extreme poverty, surviving on less than $1.90 per day, while another 30% are considered 'vulnerable,' with incomes just above that threshold. This stark reality has resulted in a nearly absent national health security system, as the government prioritizes security—viewed as more essential than health—over health coverage.

Constitutionally, the Bangladeshi government is not compelled to provide universal health security. The constitution emphasizes social security focused on basic needs, such as adequate food

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19 Roger Lee Mendoza, "The Insurance Role in Workplace Health Promotion: A Comparative Analysis of the United States and the Philippines," *Health Promotion International* 38, no. 21 (2023), https://doi.org/10.1093/heapro/daad001.

20 D. Hindle, L. Acuin, and M. Valera, "Health Insurance in the Philippines: Bold Policies and Socio-Economic Realities," *Australian Health Review : A Publication of the Australian Hospital Association* 24, no. 2 (2001): 96 – 111, https://doi.org/10.1071/AH010096.

21 Ihda Rasyada et al., "The Role of Autonomous and Intelligent Systems for Human Life and Comfort," in *International Electronics Symposium, IES 2020* (IES, 2020), 549 – 556, https://doi.org/10.1109/IES50839.2020.9231940.

22 Arief Budiono et al., "Lessons from Indonesian National Healthcare Security (BPJS Kesehatan): HIV/AIDS Patient Medical Data Protection Policies," *Malaysian Journal of Medicine and Health Sciences* 20, no. 9 (2024): 201–8, https://doi.org/10.47836/mjmhs/20.s9.33.

23 Nicole Lurie, "The Inextricable Relationship of Emergency Care, National Health Security/Preparedness, and Health Care Reform," *Annals of Emergency Medicine* 62, no. 5 (2013): 509–10, https://doi.org/10.1016/j.annemergmed.2013.05.017.

and income. Given the financial situation of many citizens, it would be unrealistic to impose health security premiums when most families are struggling to make ends meet. [24]

Previous research by Siu Ng and colleagues[25] examined health security and its implementation in Indonesia, the Philippines, and Vietnam. They analyzed the social health insurance administrative databases established in these countries in 2014, 2017, and 2012, respectively. Unfortunately, these databases have been underutilized for research purposes.[26]

This study assessed the feasibility and accessibility of using these databases for scientific research, illuminating the challenges and barriers researchers face. Improving patient privacy protection would enhance improve the usability of these databases. Access to data and the duration of extraction can vary significantly between countries. Common limitations across all databases include short data record spans and uncertainty regarding their internal validity. Additionally, both Indonesia's National Health Security and the Philippines' PhilHealth databases primarily capture bundled claims, which leaves out important details about prescriptions and out-of-pocket expenses.

Another insightful study was conducted by Gyanendra, focusing on health security services established by Southeast Asian countries. This research introduced the concept of 'One Health,' aimed at creating a health security framework that is cost-effective, sustainable, and practical. By taking a holistic, multidisciplinary approach, this model seeks to address the health challenges faced by resource-constrained countries.[27]

In a separate study, Pavitra and colleagues[28] examined the efficiency and equality of healthcare in low-income countries, including Bangladesh and Indonesia. They identified a tension between equality and efficiency in health security among these nations. Their findings revealed a complex, bidirectional relationship between the performance of national health systems and universal health coverage.[29] They argued rrom an empirical standpoint that, according to traditional economic perspectives, efficiency should take priority over equity in healthcare services. This means that ensuring quality and efficiency first can lead to a more equitable system later on.[30]

What sets this paper apart is that it addresses the health security systems in Indonesia, the Philippines, and Bangladesh through the lens of each country's constitution. This research analyzes data from these three nations and how their constitutions view health security, employing the theory of law and authority under the guise of good, as articulated by Veronica Rodriguez-Blanco. The academic contribution lies in deepening the understanding of intentional law, which relates to both constitutional issues and national health insurance implementation.

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24 The People's Republic of Bangladesh's Government, "1972 Constitution 18(1)" (1972).

25 Junice Yi Siu Ng et al., "National Health Insurance Databases in Indonesia, Vietnam and the Philippines," *PharmacoEconomics - Open* 3, no. 4 (2019): 517 – 526, https://doi.org/10.1007/s41669-019-0127-2.

26 Arief Budiono et al., "Strengthening National Health Insurance With Ideal Regulations on the Distribution of Foods Containing Sugar, Salt, and Fat to Prevent Obesity and Non-Communicable Diseases in Children," *Malaysian Journal of Medicine and Health Sciences* 20, no. SUPP9 (2024): 104–14, https://doi.org/10.47836/mjmhs.20.s9.17.

27 Gongal Gyanendra, "One Health Approach in the South East Asia Region: Opportunities and Challenges," *Current Topics in Microbiology and Immunology* 366 (2013): 113 – 122, https://doi.org/10.1007/82_2012_242.

28 Pavitra Paul et al., "Do Efficiency and Equity Move Together? Cross-Dynamics of Health System Performance and Universal Health Coverage," *Humanities and Social Sciences Communications* 9, no. 1 (2022), https://doi.org/10.1057/s41599-022-01271-9.

29 The Republic of the Philippines' Government, "1987 Constitution Article II, Section 15" (1987).

30 The Government of the Republic of Indonesia, "1945 Constitution Article 28H" (1945).

The authors chose Indonesia, the Philippines, and Bangladesh due to their contrasting health security systems And the varying constitutional regulations regarding health security in each country. By applying Rodriguez-Blanco's theoretical framework, the authors believe it is particularly compelling to explore how these constitutions relate to health security in practice.[31] The research poses two key questions: (1) What are the policies and challenges facing national health security in Indonesia, the Philippines, and Bangladesh? and (2) How do the constitutions of these countries address national health security, and what insights does the theory of law and authority under the guise of the good provide?

RESEARCH METHODS

This study utilizes the classical socio-dogmatic research method, a qualitative approach grounded in legal science.[32] The research combines a statutory approach with extensive library research. The statutory approach involves interpreting the meanings and implications of laws and constitutions, allowing for a depeer understanding of legal principles.[33] This process includes analyzing various laws and instilling essential meanings. In addition to the statutory approach, the authors conducted library research, gathering data from a wide array of sources. These included the constitutions and laws of Indonesia, the Philippines, and Bangladesh as well as previous studies from journals, books, reports, and other relevant literature. By systematically reviewing these legal texts, the authors aimed to extract information and discern the underlying purposes while also purposes, and differentiating between the various legal frameworks in light of the primary theory of law and authority under the guise of good. The authors analyzed the legal issues by examining the core aspects of laws, primarily focusing on the constitution and relevant legislation. This process involved assessing multiple laws to identify the relationships and any contradictions they may present.[34]

ANALYSIS AND DISCUSSION

The Policy and Challenges of National Health Security in Indonesia, the Philippines, and Bangladesh

The National Social Security System in Indonesia brings hope for improved social welfare for all citizens.[35] Law No. 40 of 2004 establishes a framework that aligns closely with the constitution, stating that social security—including National Health Security—is mandatory for all citizens. This means that when people face health issues, they have the right to access social security support.[36]

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31 Alifah Ratnawati, Widiyanto Mislan Cokrohadisumarto, and Noor Kholis, "Improving the Satisfaction and Loyalty of BPJS Healthcare in Indonesia: A Sharia Perspective," *Journal of Islamic Marketing* 12, no. 7 (2020): 1316 – 1338, https://doi.org/10.1108/JIMA-01-2020-0005.

32 M. Czuryk and J. Kostrubiec, "The Legal Status of Local Self-Government in the Field of Public Security," *Studia Nad Autorytaryzmem i Totalitaryzmem* 41, no. 1 (2019): 33–47, https://doi.org/10.19195/2300-7249.41.1.3.

33 Veronica Rodriguez Blanco, "The Why-Question Methodology, the Guise of the Good and Legal Normativity," *Jurisprudence* 8, no. 1 (2017): 127 – 142, https://doi.org/10.1080/20403313.2016.1237576.

34 Veronica Rodriguez Blanco, *The Authority of Law*, *Handbook of Legal Reasoning and Argumentation* (London: Springer, 2018), https://doi.org/10.1007/978-90-481-9452-0_9.

35 Aryo Dewanto and Nabiha A. K. Siti, "The Clinicians' Perspective on the National Health Insurance Implementation in Indonesia: A Study in a Government Hospital," *International Journal of Healthcare Management*, 2023, https://doi.org/10.1080/20479700.2023.2284468.

36 Evi Martha et al., "National Health Insurance Scheme: Internal and External Barriers in the Use of Reproductive Health Services among Women," *Kesmas* 16, no. 2 (2021): 91 – 99, https://doi.org/10.21109/KESMAS.V16I2.3712.

Indonesia's National Health Security is an integral part of this system and is managed by the *Badan Penyelenggara Jaminan Sosial* (BPJS), or the Social Health Insurance Administration Body, which was created under Law No. 24 of 2011.[37] This law is a formal representation of the constitutional commitment to guaranteeing social security for every Indonesian citizen.[38]

However, the approach taken so far has largely been demand-driven. For instance, a mission within the National Social Security System for Health aims to "increase services so that all citizens feel the need to become participants," yet lacks the proactive spirit needed to encourage citizens to register. This highlights a significant issue: the focus on responsiveness rather than proactive engagement.[39]

Furthermore, the protection scheme currently in place still has its limitation. The benefits offered under the existing Social Security for Health are inadequate in both quantity and quality. As it stands, the program has managed to reach only 91% of the population.[40]

According to Presidential Regulation No. 64 of 2020, which amends Presidential Regulation No. 82 of 2018 regarding Health Security, all citizens are required to pay premiums to access the National Health Security through BPJS. The monthly premiums vary based on membership class: Class I costs Rp 150,000, Class II costs Rp 100,000, and Class III costs Rp 35,000. These classes determine the type of facilities available to participants.[41]

In 2021, BPJS Kesehatan collected about Rp 143.2 trillion in premiums, which remains relatively consistent at Rp 143.1 trillion in 2022. These funds are essential for operating the national health security system. in terms of expenditures, health security costs were Rp 143.6 trillion in 2021 and Rp 113.7 trillion in 2022. While these figures reflect a positive trend, showing that the premiums collected generally cover operational costs, it is worth noting that premium fees increased by 37% at the end of 2020.

Despite these financial efforts, the health security policies through BPJS still face significant challenges. Although BPJS aims to provide health services to all citizens through Community Health Centers, Maternal and Child Health Centers, and affiliated hospitals, many people feel that the quality and availability of these services are lacking.[42] Researcher Stefi noted, "People often asks why certain treatments that were once covered by BPJS are no longer available."[43]

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37 Rotalena Napitupulu, Henry Eryanto, and Budi Santoso, "Employee Performance of the Social Security Agency of Health in Indonesia," *Quality - Access to Success* 24, no. 196 (2023): 119 – 123, https://doi.org/10.47750/QAS/24.196.16.

38 Rina Agustina et al., "Universal Health Coverage in Indonesia: Concept, Progress, and Challenges," *The Lancet* 393, no. 10166 (2019): 75 – 1025, https://doi.org/10.1016/S0140-6736(18)31647-7.

39 Xenia Scheil-Adlung and Florence Bennet, "Beyond Legal Coverage: Assessing the Performance of Social Health Protection," *International Social Security Review* 64, no. 3 (2011): 21 – 38, https://doi.org/10.1111/j.1468-246X.2011.01400.x.

40 Bappenas, *Satu Tahun Pelaksanaan JKN (A Year of the Implementation of the National Health Security)* (Jakarta: Bappenas, 2015).

41 Alifah Ratnawati, Widodo, and Wahyono, "Improving Partnership Performance of BPJS Healthcare in Indonesia," *Journal of Islamic Marketing* 14, no. 12 (2023): 3247 – 3265, https://doi.org/10.1108/JIMA-05-2022-0135.

42 Arih Diyaning Intiasari et al., "A Study of Ability to Pay and Willingness to Pay of National Health Insurance Voluntary Participant in Rural Area," *Annals of Tropical Medicine and Public Health* 22, no. 11 (2019), https://doi.org/10.36295/ASRO.2019.221124.

43 Ida Sugiarti, Imas Masturoh, and Fery Fadly, "Efforts to Prevent Fraud in Implementation of JKN (National Health Insurance)," in *AIP Conference Proceedings*, vol. 2510 (ICComSET, 2023), https://doi.org/10.1063/5.0128625.

The challenges facing Indonesia's National Health Security also include low rates of reimbursements under the INA CBGs (Indonesian Case Base Groups).[44] For many illnesses and treatments, the fees reimbursed are below the cost recovery rate (CRR). As a result, healthcare facilities may incur losses when treating BPJS patients, especially if their stay exceed three days.

Another pressing issue is that if the INA CBGs (Indonesian Case Base Groups) costs have not increased over the past three years, any attempt to raise those costs now could turn the surplus BPJS Kesehatan has into a deficit. This would mean the government would need to cover the shortfall, raising doubts about its commitment to doing so.[45] The central question in this discussion is how willing the government is to allocate a substantial budget to support health security as mandated by the constitution.

In the Philippines, the national health security system is managed by the Philippine Health Insurance Corporation (PhilHealth), which was established in 1995 to implement universal health coverage . PhilHealth is a tax-exempt government-owned corporation connected to the Department of Health. Its legal foundation dates back to August 4, 1969, when President Ferdinand E. Marcos signed Republic Act 6111, known as the Philippine Medical Care Act. However, there was little progress in implementing this health security system initially.[46]

The Philippine Medical Care Program officially began in 1971 following the earlier act, leading to the creation of the Philippine Medical Care Commission (PMCC). Significant advancements in public healthcare insurance occurred in 1990 with the passage of House Bill 14225 and Senate Bill 01738, which culminated in Republic Act 7875, also known as "The National Health Insurance Act of 1995." This act, approved by President Fidel Ramos on February 14, 1995, laid the groundwork for PhilHealth.[47]

PhilHealth's primary goal is to "ensure a sustainable national health insurance program for all.". By 2010, it claimed to have achieved "universal" coverage at 92% of the population. A significant milestone came in 2013 when Republic Act 10606 was enacted, mandating coverage for indigent patients and others sponsored by the Department of Social Welfare and Development (DSWD).[48]

This progress was bolstered by revenue gained from new excise taxes on alcohol and tobacco, allowing PhilHealth to provide coverage for around 93.5 million Filipinos. The goal now is to extend coverage to 100% of the population as quickly as possible. This social insurance program operates on the principle that those who are healthy help cover the costs for those who are sick, with support from both local and national governments.

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44 Siti Saharah Abdullah, Amelia Lorensia, and Suyanto, "Analysis of Real Costs and INA-CBG of Hyperthyroidism in Hasanuddin University Hospital," *Analysis of Real Costs and INA-CBG of Hyperthyroidism in Hasanuddin University Hospital* 16, no. 4 (2020): 421 – 429, https://doi.org/10.30597/mkmi.v16i4.10990.

45 Alpslan, Lim, and Song, "Growth and Welfare in Mixed Health System Financing with Physician Dual Practice in a Developing Economy: A Case of Indonesia."

46 Josephine R. Bundoc et al., "Function-Based Rehabilitation Model: An Initial Step towards Universal Health Coverage," *Acta Medica Philippina* 56, no. 4 (2022): 10 – 19, https://doi.org/10.47895/AMP.V56I4.4384.

47 Caryn Bredenkamp and Leander R. Buisman, "Financial Protection from Health Spending in the Philippines: Policies and Progress," *Health Policy and Planning* 31, no. 7 (2016): 919–27, https://doi.org/10.1093/heapol/czw011.

48 Andrea Hannah Kaiser et al., "Extending Universal Health Coverage to Informal Workers: A Systematic Review of Health Financing Schemes in Low- and Middle-Income Countries in Southeast Asia," *PLoS ONE* 18, no. 7 (2023), https://doi.org/10.1371/journal.pone.0288269.

In contrast, Indonesia's BPJS Kesehatan functions as a public agency that reports directly to the President. Its mission is to establish a comprehensive social health security program for all Indonesian citizens. BPJS Kesehatan manages participant registrations, data management, premium collection, funding health services, and the processing of claims.[49]

In 2021, Philhealth reported income of 32.2 billion pesos and utilized operational funds totaling 4.277 billion pesos. BPJS Kesehatan, based on Government Regulation No. 87 of 2013, derives its operational funds from premiums, capped at 10% of the total dues collected.[50] This means that the proportion of expenditures for wages and operations is higher for Philhealth compared to BPJS Kesehatan. It is important to note that the Philippines government subsidizes Philhealth using revenue from tobacco, alcohol, and wage taxes, while Indonesia's BPJS Kesehatan generates income solely from community contributions.

In the payment structure for PhilHealth, there are several categories: formal workers, iformal workers, indigents, foreign nationals working on land and sea, and senior citizens. each group pays different premiums, with seniors over 60 receiving free lifetime coverage and indigents receiving subsidies from the national government. Additionally, participants benefit from regional government subsidies.[51]

Table 1. ***Philhealth Program Summary***

No	Group	Premiums	Enrollment	Payment
1	Formal	Employer and employee each pay half, up to 2.5% (maximum 3%) of income, capped at 10,500 pesos	As of hire date	3 months
2	Indigent	2,400 pesos annually	National Government	None
3	Sponsored	2,400 pesos annually	Local Government fully subsidizes enrollment annually	None
4	Lifetime	Free lifetime coverage	Retirees and Pensioners	
5	Senior citizen	Free lifetime coverage for seniors (RA 10645)	Age 60 years and up	None
6	Informal	2,400 pesos annually for members earning P25,000 and lower; 3,600 pesos annually for those earning above P25,000	Enrollment date	
7	OFW (land-based)	2,400 pesos annually	Emigration date	No subsidy, paid at emigration date

[49] Monica Desai et al., "Critical Interactions between Global Fund-Supported Programmes and Health Systems: A Case Study in Indonesia," *Health Policy and Planning* 25, no. 1 (2010): 143–47, https://doi.org/10.1093/heapol/czq057.

[50] Haruddin, Dedi Purwana, and Choirul Anwar, "Phenomenon of Causal Fraud Health Insurance in Hospitals: Theory of Gear Fraud," *Asia Pacific Journal of Health Management Open Access* 16, no. 41 (2021), https://doi.org/10.24083/apjhm.v16i4.895.

[51] Joseph J. Capuno et al., "Health Conditions, Payments, Proximity, and Opportunity Costs: Examining Delays in Seeking Inpatient and Outpatient Care in the Philippines," *Social Science and Medicine* 238 (2019), https://doi.org/10.1016/j.socscimed.2019.112479.

No	Group	Premiums	Enrollment	Payment
8	OFW (sea-based)	Employer and employee each pay half, up to 2.5% (maximum 3%) of income, capped at 10,500 pesos	As of hire date	3 months

The table above summarizes the PhilHealth program, showing that on average, members pay about 2400 pesos per year. However, active informal workers earning below 25,000 pesos pay the same amount, while those earning above that threshold contribute 3600 pesos annually. Formal sector workers are charged 2.5% to 3% of their income, capped at 10,500 pesos—meaning they will not pay more than that, even if the percentage is higher. All foreign workers pay 2,400 pesos annually, while indigent individuals have their premiums fully covered, often receiving financial support from local government. Seniors and retirees enjoy free health insurance with no fees.

One significant issue regarding health security in the Philippines is the shortage of healthcare workers. Many doctors, nurses, and midwives are leaving for overseas jobs, particularly in the Middle East, where they can earn better salaries. The distribution of in the Philippines mirrors that of Indonesia, with plenty available in urban areas but a noticeable lack in rural regions and isolated islands.[52]

In Bangladesh, social and health security issues are defined by the Constitution under Chapter II, Article 15. It states, "It is the fundamental responsibility of the State to attain, through planned economic growth, the provision of basic necessities of life for its citizens, including: (a) food, clothing, shelter, education, and medical care; and (b) the right to work with guaranteed employment at reasonable wages.

From a legal standpoint, the right to health security is included in the Bangladeshi Constitution, but it exists more as a guiding principle than a legally enforceable right. Unfortunately, legislation regarding health security mainly focuses on the primary stakeholders without establishing specific programs. Bangladesh currently has the lowest government expenditure on health, education, and social security in South Asia, placing a heavy burden on households. In 2017, the country's tax revenue was below 15% of its gross domestic product (GDP), which is considered the minimum necessary to provide basic public services, including food security.

While social security plans for universal coverage have been proposed over the last decade, they have yet to materialize due to the government's lack of commitment to funding and service provision. The almost non-existent national health security in Bangladesh results in a staggering 70% of health expenses being out-of-pocket, with the government only providing support for 15% of health security costs for civil and military servants. This lack of structured support illustrates broader neglect of the health sector in the country.

One of the main challenges facing health security is funding. The government's reluctance to allocate sufficient resources, paired with poor socio-economic conditions, makes implementing health security premium programs nearly impossible. For many rural people, health security is virtually non-existent, compounded by a shortage of medical professionals like doctors and nurses.

[52] Joseph J. Capuno et al., "Effects of Price, Information, and Transactions Cost Interventions to Raise Voluntary Enrollment in a Social Health Insurance Scheme: A Randomized Experiment in the Philippines," *Health Economics (United Kingdom)* 25, no. 6 (2016): 650 – 662.

Patients often face misdiagnoses, negligence, and lack of proper care due to absenteeism and a general lack of professional ethics. Although most of the population lives in rural areas, most healthcare providers are concentrated in cities, as many doctors are hesitant to work in villages due to inadequate infrastructure, housing, transportation, and career opportunities.

When looking at out-of-pocket healthcare spending, Bangladesh shows a higher rate compared to Indonesia. In 2019, the average out-of-pocket expenditure for low- and middle-income countries was 35.25%. In the Philippines, out-of-pocket payments accounted for approximately 44.7% of total health expenditure. Thanks to BPJS Kesehatan and Philhealth, out-of-pocket costs in Indonesia and the Philippines have been significantly reduced. In contrast, Bangladesh lacks a similar support system.

Since 2014, the share of Filipino households' out-of-pocket health expenditures has shown a downward trend. Indonesia has experienced a similar decline since the introduction of BPJS Kesehatan in 2015, contributing to improvements in universal health coverage. Following the passage of the Universal Health Care Act in 2019, the Philippine government aims to further decrease the out-of-pocket expenses for its citizens.

The Constitution and National Security at Indonesia, the Philippines and Bangladesh: Understanding Legal Authority and the Pursuit of the Good

A robust national health security system is crucial for addressing the various challenges faced by society, particularly in the health sector. Indonesia's 1945 Constitution emphasizes the government's responsibility to provide social security and care for the underprivileged.[53] Article 27, clause (2) affirms that every citizen has the right to work and a decent work livelihood. Article 28H, clause (3) guarantees every individual the right to social security that supports their holistic development as dignified human beings.[54] Furthermore, Article 34, clause (1) mandates that the state care for the poor and neglected children, while clause (2) underscores the necessity of developing a social security system for all citizens and empowering the vulnerable in alignment with the human dignity.[55]

Ironically, the establishment of the national health security system has been transferred to a public agency, BPJS (Badan Penyelenggara Jaminan Sosial), which was specifically created to implement healthcare security and welfare programs for workers. This agency, mandated by the government, became operational on January 1, 2014, with the goal of ensuring health security for all Indonesian citizens.[56]

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[53] Diva Kurnianingtyas, Budi Santosa, and Nurhadi Siswanto, "Reforming Premium Amount in the Indonesian National Health Insurance System Program Using System Dynamics," *Cogent Engineering* 8, no. 1 (2021), https://doi.org/10.1080/23311916.2021.1938368.

[54] Virginia Wiseman et al., "An Evaluation of Health Systems Equity in Indonesia: Study Protocol," *International Journal for Equity in Health* 17, no. 112 (2018), https://doi.org/10.1186/s12939-018-0822-0."mendeley":{"formattedCitation":"Virginia Wiseman et al., "An Evaluation of Health Systems Equity in Indonesia: Study Protocol," International Journal for Equity in Health 17, no. 112 (2018

[55] Sukri Paluttri, "Comparative Approach in Public Health Social Security: A Legal Case Study of the Indonesian, France, and Singapore Health Systems," *International Journal of Human Rights in Healthcare*, 2023, https://doi.org/10.1108/IJHRH-03-2023-0020.

[56] Arief Budiono et al., "Pseudo National Security System of Health in Indonesia," *Indian Journal of Public Health Research & Development* 9, no. 10 (2018): 556–60, https://doi.org/10.5958/0976-5506.2018.01404.3.

Under this system, every person—regardless of their socio-economic status—has the right to health services,[57] including the poor.[58] Participation in the national health security program is mandatory for all individuals and companies, both private and public.[59] The similarities in rights and obligations ensure that all citizens have access to health services within a comparable financial framework.[60]

Participants in the Indonesian National Health Security program are required to pay monthly contributions. This means that once individuals enroll, they pay dues[61] that grant them a unique identity and access to health services from facilities that collaborate with BPJS Kesehatan.[62]

According to Veronica Rodriguez Blanco's theory of law and the authority under the guise of the good, the current state of health security in Indonesia highlights a concerning trend. The burden of funding has shifted from the state to the citizens. The BPJS Law and the National Social Security System Law effectively place much of the financial responsibility on participants. For instance, Law No. 24 of 2011 concerning BPJS allocated 2 trillion rupiah from the state budget (APBN) to set up BPJS Kesehatan. In 2018, allocated 14,464 trillion rupiah to cover BPJS Kesehatan deficits, followed by an increase to 28 trillion rupiah the following year. Additionally, in accordance with Presidential Regulation No. 75 of 2019, BPJS health premiums were raised by 90%. Projection indicate that regular contributions need to grow by 36% every two years to cover the JKN (Jaminan Kesehatan Nasional) deficit. Each premium hike is expected to raise participant contributions by around 13%, which should be enough to address this deficit.[63] From 2016 to 2019, the government provided subsidies totaling 25.7 trillion rupiah for PBI (*Penerima Bantuan Iuran* or premium paid by government).[64]

Interestingly, in 2020, BPJS Kesehatan recorded a notable surplus of 17 trillion rupiah, driven by several factors. First, the increase in contributions established in 2019 went into effect that year. Second, the budget allocation for COVID-19, which reached 405.1 trillion rupiah, reduced BPJS's health insurance costs. Many patients, particularly those with catastrophic and comorbid conditions, were treated with funds allocated for COVID-19.[65] This strategic approach was guided

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57 Seputra and Ariyanto, "Designing an Interoperable Social Assistance Health Insurance Validation System," *Journal of Physics: Conference Series* 1810, no. 117 (2021), https://doi.org/10.1088/1742-6596/1810/1/012027.

58 Gurendro Putro, Ristrini, and Tumaji, "Utilization of Deconcentration Health Funds in Planning, Budgeting, and Implementation in Indonesia," *Indian Journal of Forensic Medicine and Toxicology* 14, no. 2 (2020): 2294 – 2300.

59 Iyi Awofeso, "Vaccination, Public Health and National Security," *Australian and New Zealand Journal of Public Health* 36, no. 1 (2012): 90, https://doi.org/10.1111/j.1753-6405.2012.00831.x.

60 Teguh Dartanto et al., "Why Do Informal Sector Workers Not Pay the Premium Regularly? Evidence from the National Health Insurance System in Indonesia," *Applied Health Economics and Health Policy* 18, no. 1 (2020): 81 – 961, https://doi.org/10.1007/s40258-019-00518-y.

61 Irma Ardiana, Mario Ekoriano, and Siti Fathonah, "Universal Health Coverage 2019 in Indonesia: The Integration of Family Planning Services in Current Functioning Health System," *Journal of Population and Social Studies* 27, no. 3 (2019): 247 – 265, https://doi.org/10.25133/JPSSv27n3.0016.

62 Vera Yuliati and Helen Andriani, "Implementation of Lean Kaizen to Reduce Waiting Time for the Indonesian Health Social Security Agency Prescription Services in Hospital Pharmacy Installation," *Open Access Macedonian Journal of Medical Sciences* 9 (2021): 1495 – 1503, https://doi.org/10.3889/oamjms.2021.7610.

63 Eka Efarina Jambari, "*Defisit Jaminan Kesehatan Nasional (JKN): Mengapa dan Bagaimana Mengatasinya? (National Health Insurance (JKN) Deficit: Why and How to Solve It?),"* Jakarta (Indonesia): Prakarsa, 2020.

64 Kekeu Kirani Firdaus, Ludovicus Sensi Wondabio, "Analisis Iuran dan Beban Kesehatan dalam Rangka Evaluasi Program Jaminan Kesehatan (Analysis of Health Contributions and Burden in the Context of Program Evaluation Health insurance)." *Jurnal Aset (Akuntansi Riset),* 11 (1), 2019, 147-158 https://doi.org/10.17509/jaset.v11i1.16898

65 Afra Azizah, Dapot Pangihutan Silalahi, Mia Widiastuti and Nafikhatul Khikmah, *BPJS: Surplus Maker Pandemic*. Internal Research, Jakarta (Indonesia). Universitas Indonesia

by presidential regulations and health ministry directives.[66] Lastly, universal coverage under BPJS Kesehatan increased annually, reaching 91% of citizens by 2023.[67]

The theory of intention law posits that "if we understand how authorities exercise practical reason under legal directives, as well as how they engage practical reason following legal rules informed by reasons for actions,[68] we can comprehend the interplay between legal authority and legal normativity." This understanding must be holistic, taking into account both the conditions and structures within the law that reference distinct legal principles.[69] We can analyze this idea through the theory that understanding legal norms requires a grasp of how practical reasoning works within the legal context.[70] Essentially, to understand a law's intention, we need to look at how it functions in real-life situations and the context in which it operates.

We can understand the relationship between authority and legal regulations in terms of practicality. Essentially, the government has a valid reason for following these regulations because they help shape actions that are seen as beneficial.[71] However, there can be a significant disconnect between the intention behind these laws and their actual implementation. This understanding sheds light on the complexities of written laws and how their application often reveals contrasting realities.[72]

For instance, authorities often assert that the way social security is implemented aligns with legal regulations. While this is intended to give impression that everything is functioning properly, the truth can be different. People tend to believe that if the implementation adheres to regulations, it must have a positive character. However, this is not always the case.[73]

Take Indonesia, for example. Citizens are required to participate in the National Health Security system and pay dues, as outlined in Article 16, clause (1). Those who fail to comply face penalties. According to Article 17, clauses (1) to (3) of the Law on BPJS, anyone who does not meet these requirements can face administrative sanctions, which may include written warnings, fines or even being barred from accessing certain public services. The BPJS is responsible for enforcing some of these penalties, while others fall to the government.[74]

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66 Irma Dwi Fahriyani et al., "Implementasi Peraturan Menteri Kesehatan Nomor 9 Tahun 2020 Dalam Rangka Percepatan Penanganan Covid-19 Berdasarkan Perspektif Aliran Legal Positivism (Implementation of Minister of Health Regulation Number 9 of 2020 in the Context of Accelerating Handlin," *Jurnal Jurisprudence* 10, no. 2 (2020): 216–32, https://doi.org/10.23917/jurisprudence.v10i2.13037.

67 Zirma Julianda and Ecep Mochammad, "Supply Infrastructure Financing & Kualitas Mutu Layanan dalam Meningkatkan Kepuasan Peserta JKN (Supply Infrastructure Financing & Service Quality in Increasing JKN Participant Satisfaction)," *Jurnal Jaminan Kesehatan Nasional* 3, No. 1, (2023): 143-155 https://doi.org/10.53756/jjkn.v3i1.146

68 Anthony Reeves, "Practical Reason and Legality: Instrumental Political Authority Without Exclusion," *Law and Philosophy* 34, no. 3 (2015): 257 – 298, https://doi.org/10.1007/s10982-014-9221-x.

69 Christopher Essert, "Intentional Action and Law," *Jurisprudence* 8, no. 1 (2017): 110 – 1172, https://doi.org/10.1080/20403313.2016.1237569.

70 Veronica Rodriguez Blanco, *Law and the Authority under the Guise of the Good* (Oxfordshire: Hart Publishing, 2016).

71 Robert J. Preanger, "An Explanation for Why Final Political Authority Is Necessary," *American Political Science Review Journal* 60, no. 4 (1966): 994–997, https://doi.org/10.2307/1953772.

72 Joseph Raz, *Between Authority and Interpretation: On the Theory of Law and Practical Reason* (London: Oxford Academic, 2009), https://doi.org/10.1093/acprof:oso/9780199562688.001.0001.

73 Ming Yao Lim et al., "Health Financing Challenges in Southeast Asian Countries for Universal Health Coverage: A Systematic Review," *Archives of Public Health* 81, no. 1 (2023), https://doi.org/10.1186/s13690-023-01159-3.

74 Tika Indiraswari et al., "Health Insurance Literacy: Discussion and Reaction of Facebook Users' towards the National Health Insurance in Indonesia," *Journal of Public Health Research* 9, no. 2 (2020): 205 – 208, https://doi.org/10.4081/jphr.2020.184.

These threats of sanctions can be seen as a way fro the government to enforce compliance with the health security laws. The regulations aim to ensure that citizens are motivated to pay their contributions to BPJS, fulfilling a responsibility that ideally belongs to the state. In effect, the burden of providing health security has shifted to citizens, with the government imposing penalties on those who do not comply.

Tennenbaum, reflecting on his experiences as a legislator, shares his perspective on the nature of law and authority. He stated:

> "I can regard myself as the creator of the law, as a legislator. I can reasonably consider myself as a creator of the law and am now bound by my 'as if a legislator' own creations. I am satisfied and can be proud of my task because I have followed a rational procedure engaging my full capacities as a rational human being."[75]

Regarding penalties for not participating in the National Health Security system, the Law on BPJS explains that certain public services, like business permits and land ownership documentation, may be withheld from those who do not comply."[76] Additionally, participants who fall behind on payments incur fines of 2% for late payments; A recent regulation has increased that to 2.5%. It is crucial for participants to meet their obligations,[77] As failure to do so results in a temporary suspension of their benefits until all dues are paid.[78]

In the Philippines, health security is backed by the 1987 Constitution, which states that the state must protect and promote the people's right to health. The health security system in the Philippines was established in 2015, A year after Indonesia's BPJS was created in 2014. Interestingly, the universal coverage in the Philippines is slightly higher than in Indonesia, with 92% compared to Indonesia's 91%.This is notable given that Indonesia has a larger land area and a significantly larger population.

One of the key advantage of the Philippines' health security system is the strong financial backing it receives from the government. If there are any shortfalls, the government steps in to cover those gaps. This financial support is partly funded by on cigarettes and alcoholic beverages, which are allocated to regularly maintain the health security system.[79] As a result, Filipino citizens pay lower contributions compared to Indonesians for health coverage, and many groups are exempt from paying any health security dues at all.

In contrast, Indonesia has different registration approach. The Philippines uses a combination of active and passive registration for its health security program. For formal workers, civil servants, and business sowners, the government employs passive registration, which means they

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75 S. Tenenbaum, *On the Guise of the Good: Desire, Practical Reason and The Good* (Oxford: Oxford University Press, 2010); S. Tenenbaum, "Between Theory and Interpretation," *Minnesota Law and Review Journal* 10, no. 3 (2006): 321.

76 Agung Dwi Laksono et al., "Barriers to Expanding the National Health Insurance Membership in Indonesia: Who Should the Target?," *Journal of Primary Care and Community Health* 13 (2022), https://doi.org/10.1177/21501319221111112.

77 Gita Susanti et al., "Assessing The National Health Insurance System: A Study Of The Implementation Of Health Insurance Policy In Indonesia," *Public Policy and Administration* 21, no. 4 (2022): 511 – 525, https://doi.org/10.13165/VPA-22-21-4-13.

78 Ratna Dwi Wulandari et al., "Hospital Utilization among Urban Poor in Indonesia in 2018: Is Government-Run Insurance Effective?," *BMC Public Health* 23, no. 1 (2023), https://doi.org/10.1186/s12889-023-15017-y.

79 Anita K. Wagner et al., "Costs of Hospital Care for Hypertension in an Insured Population without an Outpatient Medicines Benefit: An Observational Study in the Philippines," *BMC Health Services Research* 8, no. 161 (2008), https://doi.org/10.1186/1472-6963-8-161.

are automatically registered based on their tax information. In this case, the government either sends bill invoices or deducts contributions directly from workers' wage. For individuals working in informal sector, like farmers or those not included in the tax database, active registration is necessary; these citizens have to take the initiative to sign up.[80]

When we compare the health security of Indonesia and the Philippines, there are also notable differences in their constitutional mandates. The Filipino Constitution primarily calls for the promotion and protection of citizens' health rights, which means the government is not strictly obligated to furnish large amount of funding for health security compared to the stronger mandates that exists in the Indonesian Constitution.

The allocation of funds is crucial in understanding the legal intent behind health security laws. It seems reasonable to expect that if the constitution obliges care for the poor and promotes social security that honors human dignity, the government would allocate more resources.[81] This is why it is logical the Indonesian government to invest more significantly in health security, similar to the efforts implemented by the Filipino government, even when the latter's constitution does not explicitly require it.

Both the BPJS Law and the National Social Security System Law in Indonesia emphasize a principle of togetherness—essentially, citizens supporting one another. Under this system, every citizen pays monthly for health security, which is mandated by the state. However, these laws also impose penalties for those who violate the regulations or fall behind in their payments. The intentions reflected in these laws indicate a reluctance on the part of the government to commit a more significant portion of the budget to health security programs.

This reluctance is evident in Indonesia's health budget allocation, which is only about 5% of the total budget—an amount Too small to effectively support a national health security system. In contrast, the Philippine government not only allocates sufficient funds but also adds revenue from cigarette and alcohol taxes to bolster social security. Overall, the Philippines dedicates around 4.3% of its annual budget to health security (excluding tax revenues) and 4% specifically for health expenditure. Comparatively, in 2023, Indonesia allocated 4.7% of its total budget to health, which is almost half of what the Philippines allocates.

These figures highlight that, despite both nations committing to universal health coverage, they face different challenges because of the disconnect between their constitutional obligations and the realities citizens experience. In Indonesia, the combination of mandatory enrollment, fixed contribution rates, and limited government funding has created a system that is not sustainable in the long run. High out-of-pocket expenses continue to hinder access to care, while low reimbursement rates weaken the quality of services. On the other hand, the Philippines benefits from higher government subsidies, enabling broader coverage, yet there are still gaps that persist, particularly for informal workers and the economically disadvantaged.[82]

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[80] Ardvin Kester S. Ong et al., "Economic Factors Affecting Member's Satisfaction towards National Health Insurance: An Evidence from the Philippines," *International Journal of Environmental Research and Public Health Open Access* 19, no. 22 (2022), https://doi.org/10.3390/ijerph192215395.

[81] Alfin Reza Syahputra, Adis Imam Munandar, and Adis Imam, "The Hike in BPJS Kesehatan's Premiums Based on The Principle of Justice in Service Regulation of Healthcare Insurance," *Law Reform: Jurnal Pembaharuan Hukum* 17, no. 1 (2021): 1 – 12, https://doi.org/10.14710/lr.v17i1.37548.

[82] Mecca E. Burris and Andrea S. Wiley, "Marginal Food Security Predicts Earlier Age at Menarche Among Girls From the 2009-2014 National Health and Nutrition Examination Surveys," *Journal of Pediatric and Adolescent Gynecology* 34, no. 4 (2021): 462–70, https://doi.org/10.1016/j.jpag.2021.03.010.

Both Indonesia and the Philippines have valuable lessons to share with one another. By adapting their financing and delivery models, they can better align with their constitutional values and socioeconomic realities they face. For instance, innovative technologies like blockchain for resource mobilization and AI for targeted subsidies could help address some of the existing challenges.[83] However, it is important to remember that technology alone cannot replace the essential political will needed to fulfill a government's obligations to its citizens.

The dues collected by BPJS are limited and structured according to specific treatment classes, which often leaves hospitals struggling. When these dues fall short of covering the actual costs of patient care, hospitals can face significant financial losses.[84] This situation has led some facilities to shorten treatment periods based on the funds they can claim from BPJS, which could adversely affect patients' health outcomes.

In Indonesia, BPJS Kesehatan operates on a class-based system that creates disparities among those who pay into it. This leads to questions of fairness. In contrast, the Philippines' national health security appears to be more equitable since it does not differentiate coverage based on treatment classes.[85]

In Indonesia, only the poorest citizens receive full coverage, with the government allocating funds specifically for Contribution Assistance Recipients. No other demographic benefits from complete coverage. Meanwhile, in the Philippines, many of the poor receive support from the central government, while others get help from local authorities, which means they do not have to worry about paying any dues.[86] Additionally, citizens over 60 years old are also fully covered, unlike in Indonesia, where everyone, regardless of ages, must contribute to BPJS.[87]

Patients in Indonesia frequently voice frustration over having to pay extra treatment costs, such as switching from National Health Security coverage to general patient status. This situation can lead to delays in receiving inpatient care. If a patient is classified as a higher treatment class, they have to cover the cost difference themselves, while those in lower class do not receive imbursement for the discrepancy in treatment costs.[88] A common issue arises for patients needing long-term are who often face rejection from hospitals because the funding they receive from BPJS is inadequate. For instance, the reimbursement for a four-day stay, which is problematic as it does not reflect the actual treatment needs of patient.[89]

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83 Anokye Acheampong Amponsah, Adebayo Felix Adekoya, and Benjamin Asubam Weyori, "Improving the Financial Security of National Health Insurance Using Cloud-Based Blockchain Technology Application," *International Journal of Information Management Data Insights* 2, no. 1 (2022), https://doi.org/10.1016/j.jjimei.2022.100081.

84 Putri Adian, Yesica Aprillia, and Wasis Budiarto, "Literature Review: The Implementation Of E-Health At Primary Healthcare Centers In Surabaya City," *Indonesian Journal of Health Administration (Jurnal Administrasi Kesehatan Indonesia)* 8, no. 1 (2020), https://doi.org/10.20473/jaki.v8i1.2020.40-55.

85 Reinhard Busse and Friedrich Wilhelm Schwartz, "The Philippines' National Health Insurance Act: A German Perspective," *International Journal of Health Planning and Management* 12, no. 2 (1997): 131 – 148, https://doi.org/10.1002/(sici)1099-1751(199704)12:213.

86 Capuno et al., "Health Conditions, Payments, Proximity, and Opportunity Costs: Examining Delays in Seeking Inpatient and Outpatient Care in the Philippines."

87 Novat Pugo Sambodo et al., "Effects of Performance-Based Capitation Payment on the Use of Public Primary Health Care Services in Indonesia," *Social Science and Medicine* 327 (2023), https://doi.org/10.1016/j.socscimed.2023.115921.

88 Purwanti Aminingsih, Ali Khatibi, and Ferdou Azam, "The Social Health Insurance (BPJS) Patient Satisfaction At Hermina Daan Mogot And Pasar Minggu Hospitals, Indonesia," *International Journal of Professional Business Review* 8, no. 3 (2023), https://doi.org/10.26668/businessreview/2023.v8i3.396.

89 Didit Darmawan et al., "BPJS Patients Satisfaction Analysis Towards Service Quality of Public Health Center in Surabaya," *Media Kesehatan Masyarakat Indonesia* 18, no. 4 (2022): 124 – 131, https://doi.org/10.30597/mkmi.v18i4.19773.

These rejections stem from insufficient funding, which leads to situations where claims from BPJS not cover the true costs of treatment.[90] The payment structure for health services defined by the Indonesian Case base Groups (INA CBGs) has sparked numerous complaints, as hospitals find themselves losing money because the claims do not adequate cover their costs.[91]

After discussing the constitutions and health security systems in Indonesia and the Philippines from an intentional law perspective, researchers have also explored similar issues in Bangladesh. According to Article 15 of the Constitution of Bangladesh, it is fundamental the state's responsibility to ensure basic necessities for its citizens, including food, clothing, shelter, education, and medical care, along with the right to social security through planned economic growth.

In analyzing the healthcare situation in Bangladeshi, it becomes clear that the government's primary focus is not health care itself, but rather on fulfilling basic needs such as food, clothing, housing, and education. Health comes afterwards, illustrating that it is not top priority for the government. According to the constitution, the health budget has remained quite low, with only around 2% allocated in recent years, increasing 2.9% in 2023, which reflects an average growth of just 0.05% to 0.1% since 2015.[92]

This gradual increase can be attributed to ongoing economic growth in Bangladesh, which has improved the purchasing power of the population. As income levels rise and education improve, people are beginning to seek higher-quality healthcare. However, even with this slight.[93] the 2.9% health budget allocation remains one of the lowest in the world. Compounding this issue, a staggering 70% of total health expenditure come from out-of-pocket expenses, which is among the highest rates globally. This heavy reliance on out-of-pocket costs can push many families into poverty.[94]

Despite having plans for health security that have been in place for over a decade, the Bangladeshi government has not made serious moves to provide adequate universal coverage. Their reluctance to allocate more than 3% of the budget to health highlights a troubling trend. Even though the economy has been improving continuously since the country's independence, health funding has not reflected that progress and remains woefuly low compared to international standards. The government has preferred to prioritize food security, even though Bangladesh has achieved food self-sufficiency and the food situation is no longer an emergency.

Establishing health security with universal coverage requires significant budget allocation and a sufficient number of medical professionals. Unfortunately, Bangladesh faces a severe shortage

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90 Juergen Schaefers et al., "Population-Based Study on Coverage and Healthcare Processes for Cancer during Implementation of National Healthcare Insurance in Indonesia," *The Lancet Regional Health - Southeast Asia* 6 (2022), https://doi.org/10.1016/j.lansea.2022.100045.

91 Syarifuddin Yusuf et al., "Revenue and Financing of Patients with National Health Insurance by the Social Security Organizing Agency to Improve Health Services," *Enfermería Clínica* 30, no. 6 (2020): 276–79, https://doi.org/10.1016/j.enfcli.2020.06.063.

92 Md. Ashadul Islam, Shamima Akhter, and Mursaleena Islam, "Health Financing in Bangladesh: Why Changes in Public Financial Management Rules Will Be Important," *Health Systems & Reform* 4, no. 2 (2018): 65–68, https://doi.org/10.1080/23288604.2018.1442650.

93 T. Koehlmoos et al., "Health Transcends Poverty: The Bangladesh Experience," in *"Good Health at Low Cost" 25 Years on. What Makes a Successful Health System?*, ed. D. Balabanova, M. McKee, and A. Mills (London: London School of Hygiene & Tropical Medicine, 2011), 47–81.

94 S. A. Hamid and S. M. Ahsan, *Disease-Specific Impoverishment Impact of out-of-Pocket Payments for Health Care: Evidence from Rural Bangladesh* (Dhaka (Bangladesh): Institute of Microfinance, 2014).

of healthcare workers, needing more than 800,000 human resources for in this field.[95] Developing adequate health facilities and providing education to healthcare workers demands considerable investment, yet the current budget is alarmingly low.

The Bangladeshi government could look to Indonesia and the Philippines for examples of how to effectively allocate health budget. While health funding in these countries is not perfect, if Bangladesh were to double its healthcare budget to 4%, it could lay the groundwork for a health security system with universal coverage similar to what Indonesia and the Philippines have achieved.

Realistically, the Bangladeshi government has been slow to establish health security and has not enacted laws to ensure universal coverage. The absence of such laws means that the government is not legally obligated to fund health security initiatives. According to Veronica Rodriguez Blanco's theory of law and authority, the government may intentionally avoid creating laws that could yield benefits for citizens, particularly if those laws are perceived as unfavorable to the government.

Comparing the three countries—Indonesia, the Philippines, and Bangladesh—highlights the critical interaction between constitutional frameworks, legal structures, and political economics in shaping health systems. Indonesia's constitution explicitly recognizes the right to health and mandates the development of a social security system; however, the implementation has been hampered by fragmentation and insufficient funding. Meanwhile, the Philippines has a more cohesive legal framework for universal health coverage but still struggles to extend coverage to informal sector workers and ensure quality care. In contrast, Bangladesh's constitution incorporates health as part of broader socioeconomic rights, yet the lack of specific legal guarantees and chronic underinvestment have stifled progress toward universal health coverage.

The aim of this research across all three countries illustrates how the theory of legal intentions serves as a valuable framework for understanding the gap between the stated goals of health policies and their real-world impact. It sheds light on how the design and implementation of laws can either support or hinder the realization of the right to health. In Indonesia, the reliance on a premium-based system with limited government funding indicates a shift of the financial burden onto individuals, rather than upholding the constitutional mandate for social security. In the Philippines, the government takes a more active role in subsidizing and regulating health insurance, reflecting a stronger commitment to social solidarity, though there have been challenges in execution. In Bangladesh, the lack of a dedicated legal framework for universal health coverage signals that health is not a top priority, even though the constitution acknowledges the right to medical care. Ultimately, achieving the right to health hinges on the political will to recognize health as a fundamental public good and allocate resources accordingly. The insights from Veronica Rodriguez Blanco reminds us that the true effectiveness of a health system is not just about its stated goals; it lies in its real impact on the lives and well-being of the people it serves.

CONCLUSION

National health security varies significantly across the three countries, both in constitutional provisions and in practical implementation. In Bangladesh, health care protection are implicitly

[95] T. Ensor et al., "Geographic Resource Allocation in Bangladesh," in *Health Policy Research in South Asia: Building Capacity for Reform*, ed. A. S. Yazbeck and D. H. Peters (Washington: The World Bank, 2003), 101–127.

guarantees under Article 18 as a component of human rights, but the implementation is lacking. Despite having plans in place for decades, the health security blueprint has never been realized. In the Philippines, national health security is mandated by Section 15 of Article II of the 1987 Constitution. The country allocates a large percentage of state funds to health than Indonesia and also generates additional revenue from taxes on cigarettes and alcohol to support its health system. Notably, pensioners and seniors over 60 do not pay premiums but still enjoy full access to national health security. Conversely, the Indonesian constitution mandates national health security, yet The government allocates only 5% of its budget for health, which includes funding for the National health security. Unlike the Philippines, Indonesia does not benefit from additional tobacco and alcohol tax revenue to support health funding. Seniors and pensioners in Indonesia still have to pay premiums, placing an additional burden on them. From the perspective of Veronica Rodriguez Blanco's Theory of Law and Authority, the lack of initiative by the Bangladeshi government to establish a national health security system becomes evident, as even the blueprint has yet to materialize after numerous decades. While the Philippines allocates more funds, including those from cigarette and alcohol taxes, Indonesia's reluctance To allocate more resources to support national health security reflects a significant budget constraint. The law governing BPJS and the National Social Security System can be seen as mere covers for their reluctance. Both Indonesia and Philippines need to construct a more efficient, equitable, and sustainable model for universal health coverage to truly meet the health needs of their citizens.

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