Analysis of Contractual Imbalance in the Cooperation Agreement Between *BPJS Kesehatan* and Community Health Centers

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Abstract

The National Health Insurance (JKN) program, administered by BPJS Kesehatan, is implemented through cooperation with Community Health Centers (Puskesmas) as Primary Healthcare Facilities. This cooperation is formalized through a Cooperation Agreement, which is normatively intended to ensure the equitable and comprehensive delivery of healthcare services. However, in practice, the PKS between BPJS Kesehatan and Puskesmas demonstrates contractual imbalance, primarily due to the use of standard form contracts unilaterally determined by BPJS Kesehatan. This study aims to analyze the structure and substance of the PKS and to assess its conformity with the principles of justice and proportionality under Indonesian contract law. The research employs an empirical juridical method with a sociological approach, utilizing primary data obtained through interviews and cooperation agreement documents, as well as secondary data derived from statutory regulations and legal literature. The findings reveal that although the PKS satisfies the legal requirements for a valid agreement under Article 1320 of the Indonesian Civil Code, its substantive provisions do not adequately reflect a balanced allocation of rights and obligations between the parties. The dominant position of BPJS Kesehatan in determining contractual clauses, financing mechanisms, and administrative sanctions places Puskesmas in a weaker bargaining position, thereby affecting the implementation of healthcare services. Therefore, a reformulation of the cooperation agreement model is necessary to establish a more equitable, participatory, and sustainable contractual framework that supports the achievement of the objectives of the National Health Insurance (JKN) program.

Keywords: National Health Insurance; Contractual Imbalance; Agreement; Community Health Centers.

Introduction

The National Health Insurance (JKN) program, administered by the Health Social Security Administering Agency (BPJS Kesehatan), represents one of the Indonesian government's commitments to achieving Universal Health Coverage (UHC) (Undang-Undang (UU) Nomor 40 Tahun 2004 Tentang Sistem Jaminan Sosial Nasional, 2004). In its implementation, BPJS Kesehatan does not directly provide healthcare services; instead, it collaborates with various healthcare providers, including Community Health Centers (Puskesmas), which function as Primary Healthcare Facilities (Fasilitas Kesehatan Tingkat Pertama/FKTP) responsible for delivering primary healthcare services (Wiasa, 2022). These services include emergency care, outpatient care, health promotion, preventive healthcare, and referral screening to Advanced Referral Healthcare Facilities (Fasilitas Kesehatan Rujukan Tingkat Lanjut/FKRTL), including hospitals.

According to the Indonesia Health Profile 2024, there are 10,268 Community Health Centers (Puskesmas) across Indonesia, of which 10,124—or approximately 98.59%—have established cooperation agreements with BPJS Kesehatan (Kementerian Kesehatan Republik Indonesia, 2025). This indicates that nearly all Community Health Centers in Indonesia participate in the National Health Insurance (JKN) program through contractual cooperation with BPJS Kesehatan. As the primary government healthcare institutions, Puskesmas play a pivotal role in fulfilling the State's constitutional obligation to ensure that every citizen has access to adequate healthcare services, as guaranteed under Article 28H paragraph (1) of the 1945 Constitution of the Republic of Indonesia (Yumame, 2025). Meanwhile, BPJS Kesehatan is the sole institution authorized to administer the National Health Insurance program in Indonesia pursuant to Law Number 24 of 2011 concerning the Social Security Administering Agency.

The Cooperation Agreement between BPJS Kesehatan and Community Health Centers is principally governed by Law Number 40 of 2004 concerning the National Social Security System and the Minister of Health Regulation

Number 71 of 2013 concerning Healthcare Services under the National Health Insurance Program. These legal instruments constitute the regulatory framework supporting the integration and coordination between BPJS Kesehatan and healthcare providers in promoting equitable and comprehensive healthcare services for the Indonesian population through the National Health Insurance program (Wiasa, 2022). Furthermore, these regulations provide the legal basis for BPJS Kesehatan to establish service delivery mechanisms, quality standards, and the obligations of healthcare providers in ensuring accessible and affordable healthcare services for all registered participants (Anita & Febriawati, 2019).

Despite the objectives of the National Health Insurance (JKN) program, several deficiencies have been identified in the delivery of healthcare services to BPJS Kesehatan participants at Community Health Centers (Puskesmas). The Indonesian Ombudsman (2023) reported various forms of maladministration, including restrictions on healthcare services, limitations on the duration, scope, and quality of services provided to participants (Ombudsman RI, 2023). One contributing factor is the delayed reimbursement of healthcare claims by BPJS Kesehatan beyond the payment deadlines stipulated in the Cooperation Agreement (PKS), as experienced by Dr. Moewardi Regional General Hospital in Surakarta (Zamharira & Suryono, 2020). Inadequate financing of healthcare services by BPJS Kesehatan has also resulted in shortages of essential medicines, insufficient medical equipment, and limited competency among healthcare personnel at Community Health Centers, as demonstrated in the study conducted by Putri Nurlailia Agustina (2024) in several Community Health Centers in Bogor Regency. Consequently, these conditions have adversely affected the quality of healthcare services provided to BPJS Kesehatan participants (Agustina et al., 2024). Another issue concerns the contractual provision authorizing BPJS Kesehatan to conduct post-payment claim audits, even though claims have already undergone a verification process by BPJS Kesehatan itself. This practice imposes an additional financial burden on healthcare providers, which may ultimately affect the sustainability of healthcare service delivery (Charisso, 2026).

From a normative legal perspective, a cooperation agreement between two parties should be founded upon the principle of consensualism, whereby mutual consent constitutes the basis for the formation of a legally binding contract (Kitab Undang-Undang Hukum Perdata (Burgerlijk Wetboek), 1847). Furthermore, contractual relationships should embody the principle of balance, ensuring that both parties enjoy equal legal standing and receive equitable treatment throughout both the formation and implementation of the agreement (Salim, 2021). In practice, however, the contractual clauses contained in the Cooperation Agreement (PKS) between BPJS Kesehatan and Community Health Centers are predominantly drafted unilaterally by BPJS Kesehatan. As a result, the agreement exhibits the characteristics of an adhesion contract, in which the contractual terms are prepared by one party without meaningful negotiation by the other (Salim, 2021). A notable example is the contractual obligation requiring healthcare providers to use BPJS Kesehatan's proprietary application as the sole platform for submitting reimbursement claims. Under this arrangement, any technical malfunction or system failure may prevent claims from being processed and paid, regardless of whether the healthcare provider has fulfilled its contractual obligations (Beleneti et al., 2026).

Such contractual arrangements give rise to concerns regarding fairness, particularly with respect to claim reimbursement, reporting obligations, and administrative sanctions that disproportionately burden Community Health Centers. Consequently, the implementation of the Cooperation Agreement between BPJS Kesehatan and Community Health Centers is frequently characterized by contractual imbalance, whereby the bargaining position of Community Health Centers is substantially weaker than that of BPJS Kesehatan. The excessive allocation of obligations and risks to one contracting party undermines the principle of proportionality, which requires a reasonable and equitable balance between the rights and obligations of the parties to a contract (Yesi, 2023). This imbalance may give rise to significant legal implications, particularly from the perspective of Indonesian civil law, which requires contractual obligations to be performed in good faith and prohibits either party from obtaining an unjustified advantage over the other (Subekti, 1979).

Consequently, the Cooperation Agreement has been criticized for reflecting the dominance of BPJS Kesehatan as the stronger contracting party, thereby creating the potential for contractual imbalance and undermining the principles of fairness and equality in contractual relations.

The practical implementation of the cooperation between BPJS Kesehatan and Community Health Centers demonstrates significant imbalances in terms of financing, administrative obligations, and workload distribution. In particular, many Community Health Centers reported delays in claim reimbursement and discrepancies between the actual costs of healthcare services and the reimbursement rates provided by BPJS Kesehatan. Similarly, Asnawi *et al.* (2022) found and concluded that the relationship between Community Health Centers and BPJS Kesehatan is inherently unequal, as BPJS Kesehatan occupies a dominant position in regulating technical procedures and controlling payment mechanisms (Asnawi & Fajarwati, 2022). The principal source of funding provided to Community Health Centers is the National Health Insurance (JKN) capitation fund, as regulated under the Minister of Health Regulation Number 6 of 2022. This regulation stipulates that JKN capitation funds are allocated to finance healthcare service remuneration and the operational expenses of Community Health Centers, including the procurement and maintenance of medical facilities and infrastructure. Nevertheless, numerous BPJS Kesehatan participants continue to express dissatisfaction with the quality of healthcare services delivered by Community Health Centers, particularly regarding the adequacy of healthcare facilities and the performance of healthcare personnel. Empirical evidence further indicates that service quality has a significant positive effect on patient satisfaction, as demonstrated in the study conducted by Anggraeni and Adriansyah at the Taman Community Health Center in Sidoarjo (Anggraeni & Adriansyah, 2022).

Although these previous studies have examined the implementation of cooperation between BPJS Kesehatan and Community Health Centers in delivering healthcare services to National Health Insurance participants, they have not comprehensively analyzed the contractual dimensions of the Cooperation Agreement (PKS), particularly from the perspectives of the

principles of proportionality and contractual balance. Ideally, the Cooperation Agreement between BPJS Kesehatan and Community Health Centers should be formulated in accordance with the fundamental principles of Indonesian contract law as stipulated in Article 1320 of the Indonesian Civil Code (*Kitab Undang-Undang Hukum Perdata*), namely mutual consent, legal capacity of the parties, a definite subject matter, and a lawful cause (Kitab Undang-Undang Hukum Perdata (Burgerlijk Wetboek), 1847). Beyond satisfying the formal and substantive requirements for contractual validity, the agreement should also embody the principle of contractual justice, which requires an equitable allocation of rights, obligations, and responsibilities between the contracting parties (Hernoko, 2010).

Therefore, a comprehensive analysis from the perspective of Indonesian civil law is required to examine both the form and the substantive provisions of this Cooperation Agreement (PKS), while also evaluating its practical implementation. Such an analysis is essential to provide recommendations for the development of a more equitable and balanced regulatory framework governing contractual cooperation within the National Health Insurance (JKN) system. This study was conducted at Community Health Centers (Puskesmas) in Batam City, Riau Islands Province, considering the Batam Municipal Government's strong commitment to ensuring universal access to healthcare by facilitating the enrollment of all Batam residents in the National Health Insurance program through Mayor of Batam Regulation Number 2 of 2026 concerning Regional Health Assistance Outside the National Health Insurance Scheme. At the same time, the fulfillment of JKN participants' right to receive high-quality healthcare services at Community Health Centers in Batam has not yet been considered optimal (Widyaningsih, 2020). This study is expected to contribute to the development of contract law within Indonesia's national healthcare sector by providing a legal framework for establishing contractual relationships that are more equitable, proportionate, and capable of ensuring legal certainty for all contracting parties.

Research Method

This study employs an empirical juridical research method, which examines the application of legal norms in actual social practice by viewing law not merely as a body of normative rules but also as a social phenomenon that can be empirically observed (Disemadi, 2022). This method is particularly appropriate for examining contractual imbalance, including the dominance of standard contractual clauses imposed by BPJS Kesehatan, the unequal bargaining positions of the contracting parties, and the disproportionate administrative and service obligations imposed upon Community Health Centers (Puskesmas). An empirical approach is necessary to evaluate the consistency between the contractual provisions and their implementation in practice, as well as to assess their implications for legal protection and the principle of proportionality within healthcare service cooperation (Yesi, 2023). Furthermore, this study adopts a sociological approach to assess the practical implementation of the Cooperation Agreement and its impact on the delivery of healthcare services to the community in Batam City.

The research utilizes both primary and secondary data (Efendi et al., 2016). Primary data were obtained from documents relating to the implementation of the Cooperation Agreement and through semi-structured interviews with relevant stakeholders, including the Heads of Community Health Centers and JKN coordinators responsible for managing the National Health Insurance program at the respective Community Health Centers. Secondary data consist of statutory regulations and other legal materials, including Law Number 40 of 2004 concerning the National Social Security System (SJSN), Law Number 24 of 2011 concerning the Social Security Administering Agency (BPJS), Law Number 17 of 2023 concerning Health, Presidential Regulation Number 82 of 2018 concerning National Health Insurance (JKN), Minister of Health Regulation Number 71 of 2013 concerning Healthcare Services under the National Health Insurance Program, Minister of Health Regulation Number 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program, Minister of Health Regulation Number 6 of 2022 concerning the Utilization of National Health Insurance Capitation Funds for Healthcare Service Remuneration and Operational Cost Support, Minister of

Health Regulation Number 3 of 2023 concerning Standards for Healthcare Service Tariffs, and Minister of Health Regulation Number 19 of 2024 concerning the Administration of Community Health Centers. In addition, this study examines the Cooperation Agreement between BPJS Kesehatan and Community Health Centers, specifically Agreement Number 138/KTR/II-03/1224 and Agreement Number 009/100.3.7/PKS/XII/2024. The collected data were analyzed using a qualitative juridical approach, whereby empirical findings were systematically described and interpreted in light of relevant legal theories, statutory provisions, and principles of contract law. This analytical approach aims to generate scientifically sound conclusions and formulate evidence-based recommendations. The research was conducted at Community Health Centers in Batam City that have entered into Cooperation Agreements with BPJS Kesehatan.

Results and Discussions

The Form and Substantive Provisions of the Cooperation Agreement Between BPJS Kesehatan and Community Health Centers (Puskesmas) Under the National Health Insurance (JKN) Framework

According to the World Health Organization (WHO), Universal Health Coverage (UHC) is a healthcare system that ensures all individuals have equitable access to quality promotive, preventive, curative, rehabilitative, and palliative health services without experiencing financial hardship. UHC constitutes one of the targets under Sustainable Development Goal (SDG) 3.8 of the United Nations (World Health Organization, 2025). In Indonesia, UHC has been implemented through the National Health Insurance (JKN) program since 2014 pursuant to Law Number 40 of 2004 concerning the National Social Security System (SJSN), with the objective of achieving health insurance coverage for approximately 98% of the national population (Widjaja et al., 2025). Achieving Universal Health Coverage through the JKN program requires an effective

cooperative relationship between BPJS Kesehatan and Primary Healthcare Facilities (Fasilitas Kesehatan Tingkat Pertama/FKTP) as providers of primary healthcare services. This legal relationship is formalized through a Cooperation Agreement (Perjanjian Kerja Sama/PKS), which is governed by Minister of Health Regulation Number 7 of 2021 concerning the Fourth Amendment to Minister of Health Regulation Number 71 of 2013 on Healthcare Services under the National Health Insurance Program.

The Health Social Security Administering Agency (BPJS Kesehatan) has served as the principal administrator of the National Health Insurance (JKN) program since 1 January 2014, pursuant to Law Number 24 of 2011 concerning the Social Security Administering Agency (BPJS). It is responsible for participant registration, premium collection, and the provision of comprehensive health insurance benefits (Octora et al., 2024). In delivering healthcare services to its participants, BPJS Kesehatan collaborates with Primary Healthcare Facilities (FKTP), including Community Health Centers (Puskesmas) and clinics, as well as Advanced Referral Healthcare Facilities (Fasilitas Kesehatan Rujukan Tingkat Lanjut/FKRTL), including hospitals (Octora et al., 2024). Healthcare services provided at Primary Healthcare Facilities are financed through a capitation payment system, whereas services delivered at hospitals are reimbursed under the Diagnosis-Related Groups (DRG) payment model, which is currently implemented in Indonesia as the Indonesia Case-Based Groups (INA-CBGs) system (Budiarto & Kristiana, 2015). Capitation funds constitute a prospective payment mechanism whereby BPJS Kesehatan provides monthly payments to Primary Healthcare Facilities based on the number of registered participants, irrespective of the type or volume of healthcare services actually delivered (Auharah & Yusuf, 2025).

Under Minister of Health Regulation Number 19 of 2024 concerning the Administration of Community Health Centers (Puskesmas), one of the principal functions of Community Health Centers is to support the implementation of the National Health Insurance (JKN) program by ensuring that healthcare services are accessible to all members of the community through simplified administrative procedures. This framework enables individuals to

obtain healthcare services without undue concern over the associated financial burden, including circumstances requiring referral to higher-level healthcare facilities (Peraturan Menteri Kesehatan Nomor 19 Tahun 2024 Tentang Penyelenggaraan Pusat Kesehatan Masyarakat, 2024). Accordingly, Community Health Centers serve as the government's primary instrument for fulfilling the State's constitutional obligation to provide healthcare services within the National Health Insurance system, while, at the same time, all citizens are legally obligated to participate in the JKN program (Betan et al., 2023).

To ensure that healthcare services delivered by Community Health Centers are consistent with the objectives and standards of the National Health Insurance program, Community Health Centers and BPJS Kesehatan enter into a formal Cooperation Agreement (*Perjanjian Kerja Sama* or PKS), which is executed by the Head of the Community Health Center and the Head of the respective BPJS Kesehatan Branch Office (Peraturan Menteri Kesehatan Republik Indonesia Nomor 28 Tahun 2014 Tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional, 2014). This study involved face-to-face semi-structured interviews with five Heads of Community Health Centers in Batam City to obtain primary data regarding the formulation and implementation of the Cooperation Agreement with BPJS Kesehatan, as well as the practical challenges encountered in the delivery of healthcare services. The interviews were conducted individually with each participant. The analysis presented in this section focuses primarily on findings that demonstrate consistent patterns and common perspectives across the interview responses.

Based on interviews conducted with the Heads of Community Health Centers (Puskesmas) in Batam City, the Cooperation Agreement (Perjanjian *Kerja Sama* or PKS) is renewed annually at the beginning of each year. The renewal process begins with the submission of a draft agreement by the Batam Branch of BPJS Kesehatan, followed by a socialization meeting to explain the contents of the agreement. However, no negotiation sessions are conducted to discuss or mutually determine the contractual provisions. Any amendments to the agreement compared with the previous year's PKS are incorporated directly into the draft prepared by BPJS Kesehatan before it is presented to the

Community Health Centers. Such an agreement is commonly characterized as a standard form contract or contract of adhesion. According to Mariam Darus Badrulzaman, a standard form contract is an agreement whose terms and conditions have been predetermined and standardized in advance (Harahap & Chrisanta, 2023). She further classifies standard form contracts into two categories: general standard agreements, in which the form and content are prepared unilaterally by one of the contracting parties, and special standard agreements, whose contents are prescribed by the government.

One example of a contractual provision that cannot be negotiated concerns the capitation rate paid by BPJS Kesehatan to Community Health Centers in Batam City. Article 4 of Minister of Health Regulation Number 3 of 2023 concerning Standards for Healthcare Service Tariffs in the Administration of the National Health Insurance Program stipulates that the capitation rate for Community Health Centers ranges from IDR 3,600 to IDR 9,000 per registered participant. In practice, however, the Batam Branch of BPJS Kesehatan unilaterally determines a capitation rate of IDR 7,000, without taking into account the additional assessment criteria prescribed under Article 5 of the same regulation, including the availability of human resources, the adequacy of healthcare facilities and infrastructure, the scope of healthcare services provided, and the healthcare provider's service performance commitments.

The interviews further revealed that another non-negotiable contractual provision is contained in Article 9, which grants BPJS Kesehatan exclusive authority to conduct administrative verification and claim audits, while Community Health Centers are afforded no equivalent opportunity to challenge or review the audit findings. Furthermore, the Cooperation Agreement does not provide Community Health Centers with an opportunity to correct or supplement incomplete claim documentation before a claim is declared ineligible for reimbursement. As a consequence, healthcare services that have already been provided to patients may remain unpaid solely because of administrative deficiencies in the supporting documentation.

The validity of any cooperation agreement or contract under Indonesian law is contingent upon the fulfillment of the legal requirements set forth in

Article 1320 of the Indonesian Civil Code (Kitab Undang-Undang Hukum Perdata), namely: mutual consent of the parties, legal capacity to enter into an agreement, a definite subject matter, and a lawful cause (Kartikawati, 2019). Nevertheless, standard form contracts generally fail to fully reflect the principle of freedom of contract, as recognized under Articles 1320 and 1338 of the Indonesian Civil Code, as well as Article 18 of Law Number 8 of 1999 concerning Consumer Protection (Atmoko, 2022). In contemporary contractual practice, the widespread use of standard form contracts illustrates the economic dominance of institutions or business entities possessing superior bargaining power. Consequently, the principal legal issue is no longer whether such agreements are formally valid, but rather whether the standardized contractual clauses satisfy the requirements of fairness, reasonableness, and substantive justice (Panggabean, 2010).

The Cooperation Agreement between the Batam Branch of BPJS Kesehatan and Community Health Centers (Puskesmas) constitutes a form of public contractual arrangement founded upon Law Number 24 of 2011 concerning the Social Security Administering Agency (BPJS) and Law Number 40 of 2004 concerning the National Social Security System (SJSN). Its primary purpose is to regulate the provision of healthcare services at the Primary Healthcare Facility level for participants of the National Health Insurance (JKN) program within the service areas of Community Health Centers (Wiasa, 2022). The Cooperation Agreement also specifies the categories of healthcare services covered under the National Health Insurance program in accordance with Minister of Health Regulation Number 71 of 2013 concerning Healthcare Services under the National Health Insurance Program, as subsequently amended by Minister of Health Regulations Number 99 of 2015, Number 23 of 2017, Number 5 of 2018, and Number 7 of 2021. Furthermore, the agreement regulates the operational implementation of the National Health Insurance program by referring to Minister of Health Regulation Number 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program.

Consistent with the structure of most cooperation agreements, the PKS comprises provisions relating to general terms, the scope of healthcare services, the rights and obligations of the contracting parties, claim reimbursement procedures, supervision and monitoring mechanisms, sanctions, and contract termination. The present study found that the Cooperation Agreement used by BPJS Kesehatan is identical across all Community Health Centers in Batam City. Its substantive provisions are highly detailed and formalistic and are predominantly drafted by BPJS Kesehatan. This characteristic is reflected in the extensive use of standard contractual clauses, which are nationally prescribed and mandatory for all Primary Healthcare Facilities, consistent with findings reported in previous research conducted at a healthcare clinic in Semarang (Jatmika et al., 2017). These standardized provisions provide Community Health Centers with little or no meaningful opportunity to negotiate the contractual terms, despite the principle of contract law that requires contracting parties to exercise their rights and perform their obligations with due regard to the legitimate interests of the other party (Kartikawati, 2019).

From a normative legal perspective, a cooperation agreement should be founded upon the principle of consensualism and should reflect the principles of contractual balance and equality between the contracting parties. However, both the empirical findings of this study and the existing literature indicate that, in practice, the PKS exhibits the characteristics of an adhesion contract, as its standardized contractual document has been prescribed at the national level and is uniformly applied to all Community Health Centers (Martono & Nugroho, 2016). The agreement therefore leaves the substantive contractual provisions to be determined almost exclusively by BPJS Kesehatan.

This contractual arrangement is attributable to the dominant institutional position of BPJS Kesehatan as the sole administrator of the National Health Insurance program under Law Number 24 of 2011, while Community Health Centers function as government healthcare institutions responsible for fulfilling the State's obligation to provide primary healthcare services pursuant to Law Number 40 of 2004. From the perspective of competition and contract law, this relationship reflects the characteristics of a monopsony, whereby BPJS

Kesehatan acts as the single dominant purchaser of healthcare services and possesses substantial market power to determine contractual terms, payment values, and the outcomes of contractual negotiations due to the absence of meaningful alternative contracting partners. Such circumstances have the potential to significantly weaken the bargaining position of Community Health Centers within the contractual relationship (Berger et al., 2024).

Article 2 of the Cooperation Agreement (PKS) expressly states that its objective is to "establish an equitable cooperation in the provision of primary healthcare services for participants of the National Health Insurance program." However, based on the interviews conducted with the Heads of Community Health Centers (Puskesmas) in Batam City, the substantive provisions of the agreement do not fully reflect this principle of equality in practice. Instead, BPJS Kesehatan retains considerably greater authority in determining capitation payment rates, administering claim audit mechanisms, and evaluating the performance of healthcare service providers.

With respect to the allocation of rights and obligations, the Cooperation Agreement provides that:

1. BPJS Kesehatan has the right to determine the capitation payment rate and to conduct administrative audits and supervisory activities.
2. BPJS Kesehatan is obligated to disburse capitation funds and reimburse eligible healthcare claims within the prescribed timeframe.
3. Community Health Centers (Puskesmas) are obligated to provide promotive and preventive healthcare services without discrimination, ensure the availability of qualified healthcare personnel, and maintain adequate supplies of medicines, medical equipment, and other healthcare facilities required for healthcare service delivery.

These provisions illustrate an asymmetrical contractual relationship, in which BPJS Kesehatan performs a dual function as both the regulatory authority and the contracting party, while Community Health Centers primarily serve as the entities responsible for fulfilling the contractual obligations. Consequently, the bargaining position of Community Health Centers is substantially weakened because they remain dependent upon BPJS Kesehatan for performance evaluation, administrative verification, and the disbursement of capitation funds

and claim reimbursements. This institutional arrangement reinforces BPJS Kesehatan's dominant position within the contractual relationship and limits the ability of Community Health Centers to participate on an equal footing in determining and implementing the contractual terms.

Furthermore, the substantive provisions of the Cooperation Agreement also encompass supervisory mechanisms and sanctions (Articles 8–11), which further reinforce the dominant position of BPJS Kesehatan within the contractual relationship. Under these provisions, BPJS Kesehatan is authorized to issue written warnings, suspend reimbursement payments, and even terminate the agreement unilaterally upon identifying contractual violations or indications of fraudulent conduct (*fraud*). By contrast, the agreement does not provide Community Health Centers (Puskesmas) with equivalent legal remedies in cases of delayed payments or policy inconsistencies attributable to BPJS Kesehatan, apart from administrative penalties that are largely symbolic in nature. The inclusion of clear and comprehensive provisions defining the rights and obligations of the contracting parties is essential to prevent misunderstandings and to ensure a balanced contractual relationship (Patrianegara, 2024).

The Cooperation Agreement between BPJS Kesehatan and Community Health Centers is required to satisfy the legal requirements for contractual validity set forth in Article 1320 of the Indonesian Civil Code (Kitab Undang-Undang Hukum Perdata), including the existence of mutual consent, legal capacity, a definite subject matter, and a lawful cause. From a formal legal perspective, the Cooperation Agreement may be regarded as satisfying these statutory requirements. However, when assessed in light of the principle of freedom of contract, which recognizes the autonomy of contracting parties to negotiate and determine the contents of their agreement, the dominant role of BPJS Kesehatan in unilaterally prescribing the standardized contractual clauses significantly constrains such contractual autonomy.

Accordingly, from the standpoint of Indonesian contract law, the Cooperation Agreement (PKS) between BPJS Kesehatan and Community Health Centers formally fulfills the legal requirements for a valid contract under Article 1320 of the Indonesian Civil Code. Nevertheless, its standardized and

centrally prescribed nature demonstrates a clear tendency toward institutional dominance by BPJS Kesehatan in determining the contractual provisions, overseeing the implementation of the agreement, and evaluating contractual performance. While these characteristics do not, in themselves, conclusively establish the existence of contractual imbalance, they give rise to a strong indication of potential contractual imbalance. Such a condition warrants further legal analysis in light of the principles of contractual balance, equality of the contracting parties, and proportionality, which constitute fundamental principles of Indonesian contract law.

Legal Analysis of the Cooperation Agreement Based on the Principles of Justice and Equality in Indonesian Contract Law

In contract formation, particularly in the context of commercial agreements, three principal stages are generally recognized prior to and during the implementation of a contract (Amalia et al., 2015):

1. The pre-contractual stage, which involves the processes of offer and acceptance.
2. The contractual stage, during which the parties reach a mutual agreement through the concurrence of their declarations of intent.
3. The post-contractual stage, which concerns the performance and implementation of the contractual obligations. Accordingly, contract drafting primarily takes place during the pre-contractual and contractual stages.

Formally, the Cooperation Agreement (PKS) between BPJS Kesehatan and Community Health Centers (Puskesmas) proceeds through the contractual stage, as evidenced by the execution of the agreement by both parties. However, during the pre-contractual stage, the participation of Community Health Centers in drafting and formulating the contractual provisions is highly limited. Based on the interview findings, the PKS is renewed annually using a draft agreement prepared in advance by BPJS Kesehatan, which is subsequently

presented to Community Health Centers through socialization sessions without any substantive negotiation. Several Community Health Centers in Batam have reportedly proposed amendments to specific contractual provisions; however, these proposals were not accommodated on the grounds that the format and substantive content of the Cooperation Agreement had already been standardized at the national level by the central office of BPJS Kesehatan. These findings demonstrate that Community Health Centers have only limited opportunities to participate in the negotiation process during the formation of the contract.

In implementing the Cooperation Agreement for the provision of healthcare services to National Health Insurance (JKN) participants, BPJS Kesehatan requires Community Health Centers to utilize the Primary Care (P-Care) application as the principal electronic system for recording and reporting healthcare services (Wahyuni & Sari, 2023). Through this platform, Community Health Centers are required to enter comprehensive patient service data, including medical diagnoses and prescribed treatments. The information recorded within the P-Care system enables BPJS Kesehatan to assess the compliance and performance of Community Health Centers. Furthermore, these data serve as the basis for BPJS Kesehatan's supervisory activities, performance evaluations, and assessments of healthcare providers' compliance with the requirements of the National Health Insurance program (Aryani, 2022).

Although the implementation of this digital platform enhances the efficiency, accountability, and transparency of healthcare service delivery, it also illustrates the extensive supervisory authority exercised by BPJS Kesehatan over Community Health Centers as its contractual partners. From the perspective of contractual relations, such an arrangement may create a significant degree of operational dependence on a system that is entirely designed, managed, and controlled by BPJS Kesehatan. Consequently, questions arise regarding the extent to which the parties occupy equal positions in the implementation of the Cooperation Agreement, particularly where system-generated performance

evaluations directly affect provider assessments and the reimbursement of healthcare service claims.

Nevertheless, the mandatory use of the P-Care application also reflects the application of the principle of good faith (*bona fide*) and the principle of *pacta sunt servanda*, as Community Health Centers, being legally bound by the Cooperation Agreement, are obligated to record and report healthcare services accurately, honestly, and consistently in accordance with the contractual commitments mutually agreed upon with BPJS Kesehatan (Salim, 2021).

BPJS Kesehatan is obligated to make advance monthly payments to Community Health Centers (Puskesmas) based on the capitation rate applicable to registered participants, as stipulated in Minister of Health Regulation Number 3 of 2023 concerning Standards for Healthcare Service Tariffs in the Administration of the National Health Insurance Program (Peraturan Menteri Kesehatan Nomor 59 Tahun 2014 Tentang Standar Tarif Pelayanan Kesehatan Dalam Penyelenggaraan Program Jaminan Kesehatan, 2014). However, this study identified inconsistencies in the implementation of the Regulation. Article 4(a) provides that the maximum capitation rate for Community Health Centers is IDR 9,000 per registered participant, whereas BPJS Kesehatan pays a maximum capitation rate of IDR 7,000 to Community Health Centers in Batam. This determination is based on Article 6(1), without taking into account the risk coefficient prescribed under Article 7 of the same Regulation.

This practice has the potential to create inequities in the distribution of healthcare financing, given that capitation payments should reflect differences in workload, service-related risks, and the availability of human and material resources among Community Health Centers. From the perspective of Indonesian administrative law, the application of a uniform monthly capitation payment without considering the prescribed risk coefficient may be inconsistent with the General Principles of Good Governance (Asas-Asas Umum Pemerintahan yang Baik/AAUPB), particularly the principles of legal certainty and fairness (Gunawan et al., 2024). From the standpoint of contract law, this practice may also undermine the principle of proportionality, which requires that the benefits and burdens arising from a contractual relationship be allocated

equitably in accordance with each party's respective contribution, responsibilities, risks, and contractual position (Bagaskara, 2025). Community Health Centers, as providers of primary healthcare services, assume varying levels of operational responsibility and service-related risk, while the capitation payments they receive do not adequately reflect those variations.

Pursuant to BPJS Kesehatan Regulation Number 3 of 2017 concerning the Administration of Healthcare Facility Claims under the National Health Insurance Program, Community Health Centers are entitled to submit reimbursement claims to BPJS Kesehatan for healthcare services provided to National Health Insurance participants, provided that the prescribed administrative requirements have been fulfilled. Once submitted, the claim documents undergo a verification process based on three principal components: participant eligibility documentation, patient healthcare service documentation, and individual patient reports (Muluk et al., 2023).

However, interviews with Community Health Centers (Puskesmas) in Batam revealed that not all reimbursement claims successfully pass the verification process. Claims are frequently rejected due to incomplete supporting documentation or administrative errors in the claim submission. Although the rejected claim files are returned to the respective Community Health Centers, they are not provided with an opportunity to correct or supplement the deficiencies, even when the six-month submission period prescribed under Article 7(1) of the Cooperation Agreement (PKS) has not yet expired. As a result, reimbursement claims remain unpaid despite the fact that the healthcare services were actually provided to patients in accordance with the applicable professional standards.

Furthermore, the practice of rejecting claims without providing an opportunity for correction may be regarded as inconsistent with the principle of good faith as embodied in Article 1338(3) of the Indonesian Civil Code (Kitab Undang-Undang Hukum Perdata). Under Indonesian contract law, the principle of good faith extends beyond the mere absence of bad faith; it constitutes a standard of fairness, honesty, and reasonableness that requires contracting parties to perform their contractual obligations in a manner that is

equitable, proportionate, and consistent with legitimate expectations (Priyono, 2025). Accordingly, denying reimbursement solely on the basis of rectifiable administrative deficiencies, without affording the healthcare provider an opportunity to remedy such deficiencies, raises concerns regarding the observance of good faith in the implementation of the Cooperation Agreement.

Following the disbursement of capitation payments and claim reimbursements, BPJS Kesehatan conducts random audits of Community Health Centers in Batam to assess whether the payments made correspond to the healthcare services actually delivered. During these audits, BPJS Kesehatan occasionally identifies instances in which healthcare services are considered inconsistent with the applicable regulatory requirements. One example concerns patient referrals to hospitals that, according to BPJS Kesehatan, do not satisfy the established referral criteria and therefore should not have been referred. Minister of Health Regulation Number 16 of 2019 concerning the Prevention and Handling of Fraud and the Imposition of Administrative Sanctions for Fraud in the Implementation of the National Health Insurance Program classifies referrals that do not comply with statutory referral requirements as a form of fraud committed by Primary Healthcare Facilities (Peraturan Menteri Kesehatan Nomor 16 Tahun 2019 Tentang Pencegahan Dan Penanganan Kecurangan (Fraud) Serta Pengenaan Sanksi Administrasi Terhadap Kecurangan (Fraud) Dalam Pelaksanaan Program Jaminan Kesehatan, 2019). On this basis, BPJS Kesehatan may characterize such referrals as fraudulent conduct intended to obtain improper financial benefits under the National Health Insurance scheme (Peraturan Menteri Kesehatan Nomor 16 Tahun 2019 Tentang Pencegahan Dan Penanganan Kecurangan (Fraud) Serta Pengenaan Sanksi Administrasi Terhadap Kecurangan (Fraud) Dalam Pelaksanaan Program Jaminan Kesehatan, 2019). In contrast, the Community Health Centers interviewed in this study maintained that these cases do not constitute fraud but rather reflect differences in clinical judgment between general practitioners at the Community Health Centers and specialist physicians at the referral hospitals.

Pursuant to Minister of Health Regulation Number 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program,

local governments, through their respective Health Offices (*Dinas Kesehatan*), are responsible for supporting the implementation of the National Health Insurance program by ensuring that Community Health Centers provide healthcare services in accordance with the applicable standards, maintain adequate healthcare resources, and facilitate the effective implementation of the program within their jurisdictions (Peraturan Menteri Kesehatan Nomor 28 Tahun 2014 Tentang Pedoman Pelaksanaan Program Jaminan Kesehatan Nasional, 2014). The Cooperation Agreement recognizes this supervisory function by requiring that copies of warning letters issued by BPJS Kesehatan to Community Health Centers for alleged non-compliance with the agreement be forwarded to the relevant Health Office. However, the empirical findings indicate that the Health Office does not have direct access to the P-Care application. Consequently, it is unable to independently monitor the implementation of the National Health Insurance program at Community Health Centers, including participant administration, claim processing, and referral management. This limitation significantly constrains the Health Office's capacity to exercise effective oversight and creates a supervisory structure that is heavily dependent upon information and assessments generated exclusively by BPJS Kesehatan.

As a public legal entity, BPJS Kesehatan bears the responsibility and possesses the statutory authority to ensure that National Health Insurance (JKN) participants receive healthcare services in accordance with their legal entitlements at healthcare facilities that have entered into cooperation agreements with BPJS Kesehatan. Where a healthcare facility fails to provide services in compliance with the applicable standards or contractual obligations, BPJS Kesehatan may exercise its public regulatory powers by taking legal or administrative measures in accordance with the prevailing regulatory framework. Such measures include the termination of the cooperation agreement or the adjustment of payments and reimbursement rates payable to the healthcare facility concerned (Yuditia et al., 2021).

Contract law constitutes a branch of civil law governing the legal relationships established between two or more parties who voluntarily undertake

reciprocal rights and obligations for the performance of a particular contractual undertaking (Subekti, 1979). One of the fundamental principles of contract law is the principle of freedom of contract, which recognizes the autonomy of contracting parties to enter into agreements and to determine their contents and form, provided that such agreements do not contravene statutory law, public order, or public morality (Salim, 2021; Sulastri et al., 2025).

In practice, however, particularly in contracts incorporating standardized terms and conditions, contractual imbalance may arise when one party possesses substantially greater bargaining power than the other. Under such circumstances, the resulting agreement may disproportionately favor the dominant party while disadvantaging the weaker contracting party (Sjahdeini, 1993). This phenomenon is also evident in the contractual relationship between BPJS Kesehatan and healthcare providers such as Community Health Centers (Puskesmas), where BPJS Kesehatan functions as the sole administrator of the National Health Insurance program, whereas Community Health Centers have only limited opportunities to influence or negotiate the substantive terms of the Cooperation Agreement.

The theory of justice in legal scholarship regards justice as the fundamental value that should be realized through the legal system (Rahardjo, 2000). From this perspective, law should not be understood merely as a rigid body of normative rules but rather as an instrument for achieving substantive justice within society (Soekanto, 1986). Accordingly, the principle of contractual balance plays a crucial role in preventing domination and the excessive exercise of power in legal relationships that are intended to be reciprocal and equitable (Salim, 2021).

From the perspective of John Rawls's theory of justice, disparities in the contractual positions of BPJS Kesehatan and Community Health Centers may only be justified if they ultimately provide greater benefits to the party occupying the less advantageous position. Consequently, where the institutional dominance of BPJS Kesehatan is not accompanied by a proportionate distribution of benefits and responsibilities, such an arrangement may be inconsistent with Rawls's concept of justice as fairness (Maulidina et al., 2025).

Likewise, when examined through the lens of the principle of equality of bargaining power, the Cooperation Agreement demonstrates a significant imbalance because Community Health Centers are afforded little meaningful opportunity to negotiate the contractual terms, thereby undermining the existence of an equal contractual relationship between the parties (Fuadi, 2003).

Within the context of a public healthcare program such as the National Health Insurance (JKN) scheme, contractual arrangements should embody substantive justice rather than merely satisfy the formal legal requirements for contractual validity (Sutedi, 2011). Accordingly, contractual imbalance in the Cooperation Agreement between BPJS Kesehatan and Community Health Centers has the potential to diminish the quality of healthcare services, weaken legal certainty, and adversely affect the effective implementation of the National Health Insurance program.

Policy Recommendations and Legal Solutions for Establishing a More Equitable, Transparent, and Sustainable Cooperation Agreement Between BPJS Kesehatan and Community Health Centers

Based on the findings of this study and the analysis of contractual imbalance in the Cooperation Agreement (PKS) between BPJS Kesehatan and Community Health Centers (Puskesmas), there is a need to reformulate the existing policy framework in a manner that not only promotes administrative certainty but also ensures substantive justice for all contracting parties. The contractual imbalance identified in this study primarily stems from the dominant position of BPJS Kesehatan as both a public legal entity and the sole administrator of the National Health Insurance (JKN) program, placing Community Health Centers in a comparatively weak bargaining position throughout both the formation and implementation of the contract. In practice, this imbalance is reflected in several concrete aspects of the Cooperation Agreement, including the unilateral determination of capitation payment rates by BPJS Kesehatan without meaningful opportunities for negotiation by Community Health Centers, the

mandatory use of the P-Care application as the principal platform for recording and evaluating healthcare services under the exclusive control of BPJS Kesehatan, and the verification and reimbursement mechanisms for healthcare claims, which are likewise governed by standards unilaterally established by BPJS Kesehatan. Accordingly, future policy reforms should be directed toward strengthening the principles of contractual balance, equality, and good faith, which constitute fundamental principles of Indonesian contract law as embodied in the Indonesian Civil Code (Irayadi, 2021).

First, the current model for drafting the Cooperation Agreement should be transformed from a unilaterally prescribed standard-form contract into a more participatory standard-form contract. In this context, *participatory* refers to the meaningful involvement of all relevant stakeholders in the formulation of contractual provisions, even though not every clause is subject to negotiation. This approach is consistent with the contractual classification proposed by Codrin Codrea (2021), who distinguishes contracts into three categories: negotiated contracts, mixed contracts, and standard-form contracts (Irayadi, 2021). Although the use of standard-form contracts is not prohibited under contract law, their legitimacy should be accompanied by mechanisms that facilitate consultation and participation by the parties who will be bound by the agreement, particularly Community Health Centers and the Regional Health Offices (*Dinas Kesehatan*) acting in their capacity as technical supervisory authorities. Accordingly, BPJS Kesehatan should provide opportunities for negotiation—albeit within reasonable limits—on strategic contractual provisions, including performance evaluation mechanisms, administrative sanctions, healthcare quality indicators, and the adjustment of capitation payment rates based on regional risk profiles. Such an approach would better reflect the principles of fairness, equality, and proportionality while preserving the administrative uniformity required for the implementation of the National Health Insurance program.

From this perspective, both BPJS Kesehatan and Community Health Centers (Puskesmas), as public legal entities, are required to exercise their respective authorities in accordance with the General Principles of Good

Governance (Asas-Asas Umum Pemerintahan yang Baik/AAUPB), including the principles of legality, proportionality, and fairness. Article 28H(1) of the 1945 Constitution of the Republic of Indonesia guarantees every person's right to obtain healthcare services, thereby affirming that the cooperative relationship between BPJS Kesehatan and Community Health Centers should not be driven solely by considerations of administrative efficiency. Rather, it must also ensure the sustainability and fairness of healthcare service delivery. Consequently, where policy dominance is not accompanied by adequate supervisory mechanisms and a proportionate distribution of responsibilities and benefits, such practices may be inconsistent with the State's constitutional obligation to provide equitable and accessible healthcare services for all citizens (Mardiansyah, 2018).

Second, the role of the Regional Health Office (*Dinas Kesehatan*) should be strengthened as both a contractual mediator and an oversight authority in the contractual relationship between BPJS Kesehatan and Community Health Centers. The empirical findings of this study reveal that although Community Health Centers operate as Technical Implementation Units (*Unit Pelaksana Teknis* or UPT) under the Regional Health Office, the latter possesses no substantive authority to supervise the implementation of the National Health Insurance program at the Primary Healthcare Facility (FKTP) level.

From a normative perspective, Law Number 24 of 2011 concerning BPJS authorizes BPJS Kesehatan, as a public legal entity, to administer the National Health Insurance program, including the establishment of contractual cooperation with healthcare providers. Conversely, Law Number 23 of 2014 concerning Regional Government and Law Number 17 of 2023 concerning Health designate regional governments, through their respective Regional Health Offices, as the authorities responsible for the development, supervision, and administration of healthcare services, including Community Health Centers operating as Technical Implementation Units. Furthermore, while Presidential Regulation Number 82 of 2018 concerning National Health Insurance and Minister of Health Regulation Number 28 of 2014 concerning Guidelines for the Implementation of the National Health Insurance Program regulate the cooperation between BPJS Kesehatan and healthcare facilities, as well as the

supervisory role of regional governments, neither regulation explicitly provides for the involvement of the Regional Health Office in the operational implementation and monitoring of the Cooperation Agreement (PKS), particularly with respect to the P-Care application system.

This regulatory framework gives rise to a regulatory gap, thereby increasing the potential for the excessive exercise or misuse of authority by BPJS Kesehatan. Accordingly, future policy reforms should explicitly integrate the Regional Health Office into the processes of contract formation, implementation, monitoring, and evaluation. Such an approach would ensure that the contractual relationship is not merely a vertical arrangement between BPJS Kesehatan and Community Health Centers but is also subject to effective oversight within the broader framework of regional public administration.

Consistent with this recommendation, Nasution et al. (2019) argue that, in the implementation of the National Health Insurance program, regional governments acting through the Regional Health Offices should exercise a strong supervisory role as the principal. In practice, however, this supervisory function remains relatively weak, thereby necessitating a stronger hierarchical role for the Regional Health Office in overseeing both BPJS Kesehatan and Community Health Centers. The authors further observe that the implementation of the National Health Insurance policy is characterized by an inherent principal–agent conflict, whereby the Government, as the principal, seeks to ensure the quality of healthcare services (quality control), whereas BPJS Kesehatan, as the agent, is primarily concerned with optimizing healthcare expenditures (cost containment) (Nasution et al., 2020). Strengthening the institutional role of the Regional Health Office would therefore contribute to balancing these competing objectives while promoting greater accountability, fairness, and legal certainty in the contractual implementation of the National Health Insurance program.

Third, the reformulation of the sanction clauses and audit mechanisms contained in the Cooperation Agreement (PKS) constitutes an urgent prerequisite for achieving contractual justice. At present, the sanction provisions primarily confer unilateral authority upon BPJS Kesehatan, including the power

to suspend payments and terminate the Cooperation Agreement, without providing Community Health Centers (Puskesmas) with effective mechanisms to challenge or appeal such decisions. A more equitable contractual model should incorporate the principle of fairness by guaranteeing Community Health Centers the right to receive adequate clarification, a reasonable opportunity to rectify identified deficiencies, and access to an independent appeal mechanism before administrative sanctions are imposed (Dale et al., 2023). Such procedural safeguards are essential to prevent maladministration and to avoid unfounded allegations of fraud against healthcare professionals who perform essential public service functions.

Fourth, to ensure the long-term sustainability of the contractual relationship, the capitation financing scheme should be restructured in accordance with the principle of distributive justice. The findings of this study indicate that although the performance-based capitation system was introduced to improve the efficiency and quality of healthcare services, the service performance achieved by Community Health Centers remains substantially below the expected targets. This suggests a mismatch between the level of financial compensation provided and the actual service burden borne by healthcare providers (Dale et al., 2023). Consequently, future capitation policies should incorporate a broader range of variables, including regional health risk profiles, referral burdens, and the availability of human and material resources, so that capitation payments more accurately reflect the differing operational realities of individual Community Health Centers. Such an approach would promote a more equitable allocation of healthcare financing and reduce the risk of funding disparities that may adversely affect the quality of healthcare services provided to National Health Insurance participants.

Fifth, an independent and effective contractual dispute resolution mechanism should be established outside the existing internal procedures of BPJS Kesehatan. Disputes concerning reimbursement claims, audit findings, and allegations of fraud should not be determined exclusively by BPJS Kesehatan, which simultaneously acts as both the contracting party and the supervisory authority. Instead, a sustainable contractual framework should provide for

alternative dispute resolution mechanisms, such as independent mediation or joint review panels comprising representatives of regional governments, healthcare professionals, and other relevant stakeholders (Triadi, 2025). Such mechanisms would enhance legal certainty, protect Community Health Centers from the potential misuse of regulatory authority, and strengthen mutual trust among the contracting parties over the long term.

Accordingly, the development of a more equitable, transparent, and sustainable model of cooperation between BPJS Kesehatan and Community Health Centers cannot be achieved merely through technical or administrative adjustments. Rather, it requires a fundamental transformation of the underlying contractual paradigm. Within the framework of the National Health Insurance (JKN) program, the Cooperation Agreement should be understood as an instrument of public law designed to advance the constitutional objective of social justice, rather than as an ordinary service contract governed solely by private contractual autonomy. From the perspective of administrative law, the concept of good governance, as articulated by the United Nations Development Programme (UNDP) (1997), requires that the delivery of public services be founded upon the principles of accountability, transparency, legal certainty, fairness, effectiveness, and public participation, rather than relying exclusively on the principle of freedom of contract (Suwanda & Tjenreng, 2025). If the principles of contractual balance, meaningful participation, and substantive justice can be effectively incorporated into the Cooperation Agreement, the objectives of the National Health Insurance (JKN) program and Universal Health Coverage (UHC) will not only be achieved from a normative legal perspective but will also be experienced in practice by healthcare providers and the communities they serve.

Conclusion

From the perspective of its form and substantive content, the Cooperation Agreement (PKS) between BPJS Kesehatan and Community Health Centers (Puskesmas) in Batam City constitutes a standard-form contract unilaterally drafted by BPJS Kesehatan. The Agreement contains highly detailed and

formalistic provisions governing the scope of healthcare services, the rights and obligations of the contracting parties, claim reimbursement procedures, and administrative sanctions. Although the PKS formally satisfies the legal requirements for contractual validity under Article 1320 of the Indonesian Civil Code, its drafting process does not involve meaningful participation by Community Health Centers. This is evident from the absence of any genuine opportunity to negotiate strategic contractual provisions, including the determination of capitation payment rates, which are established without fully incorporating the risk coefficients prescribed under Minister of Health Regulation Number 3 of 2023, as well as the claim verification mechanism, which fails to provide Community Health Centers with an opportunity to correct rejected claim documentation despite the contractual six-month submission period. Consequently, although the PKS is intended to function as an instrument of equal cooperation, its practical implementation reflects a predominantly vertical and asymmetrical contractual relationship between BPJS Kesehatan and Community Health Centers.

When examined through the principles of justice, equality, and Indonesian contract law, the Cooperation Agreement demonstrates a significant degree of contractual imbalance. This imbalance is manifested in several respects: (1) the dominant authority of BPJS Kesehatan in determining capitation payment rates without adequately considering variations in workload and regional health risks; (2) unilateral claim verification and audit mechanisms that provide Community Health Centers with neither meaningful opportunities for correction nor access to an independent appeal process; (3) the imposition of severe administrative sanctions, including the unilateral termination of the Cooperation Agreement, without effective procedural safeguards; and (4) the absence of substantive involvement by the Regional Health Office (*Dinas Kesehatan*), despite its statutory role as the technical supervisory authority for Community Health Centers. These circumstances may be regarded as inconsistent with the principles of proportionality and good faith embodied in Article 1338(3) of the Indonesian Civil Code, since Community Health Centers bear substantial service obligations without receiving commensurate legal protection or adequate

certainty regarding healthcare financing. Furthermore, when evaluated from the perspective of John Rawls's theory of justice, disparities in contractual bargaining power can only be justified where they ultimately benefit the less advantaged party. The empirical findings of this study, however, demonstrate that Community Health Centers instead bear a disproportionate share of the contractual burdens.

To establish a more equitable, transparent, and sustainable contractual relationship, the existing Cooperation Agreement should be comprehensively reformed through the adoption of a more participatory contractual model, providing Community Health Centers with meaningful opportunities for consultation and limited negotiation regarding strategic contractual provisions, including financing arrangements, performance indicators, and sanction mechanisms. In addition, the capitation financing policy should be revised in accordance with the principle of distributive justice by taking into account regional characteristics, service workloads, and public health risk profiles. The institutional role of the Regional Health Office should likewise be strengthened as both a contractual mediator and an oversight authority, given that it currently lacks substantive access to the implementation of the National Health Insurance program at Community Health Centers despite its statutory supervisory responsibilities. Finally, an independent and impartial dispute resolution mechanism, such as mediation or a joint review panel involving representatives of regional governments and healthcare professional organizations, should be established to ensure that disputes concerning reimbursement claims, audit findings, and allegations of fraud are not determined exclusively by BPJS Kesehatan as an interested party. Through these policy reforms and corresponding legal improvements, the contractual relationship between BPJS Kesehatan and Community Health Centers can better embody the principles of fairness, transparency, legal certainty, and sustainability, thereby contributing more effectively to the realization of the objectives of the National Health Insurance (JKN) program and Universal Health Coverage (UHC) in Indonesia.

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Declaration of Generative AI Use

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Competing Interest

The author declares that there is no conflict of interest