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MULTILEVEL GOVERNANCE IN IMPLEMENTING FREE HEALTH EXAMINATION PROGRAMS (PKG) IN NORTH MALUKU PROVINCE: A CONCEPTUAL FRAMEWORK

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A B S T R A CT

Drawing upon three complementary theoretical pillars Multilevel Governance (MLG) theory (Hooghe & Marks, 2003), the Consolidated Framework for Implementation Research (CFIR), and the Health Equity framework, this paper proposes a novel conceptual model termed the Archipelago Adapted Implementation and Health Equity Framework (AIHEF). The paper argues that conventional linear implementation models are insufficient to capture the multilevel, multiactor, and multicontext dynamics of PKG implementation in island territories. Situated within Indonesia's decentralized health governance system, PKG faces compounding implementation challenges rooted in geographic fragmentation (1,474 islands with 395 inhabited), critical workforce deficits (doctor to population ratio of 13.2 per 100,000 well below the national average of 24.4), limited digital connectivity (internet penetration of only 23% in outer islands), and vertical-horizontal coordination gaps across governance levels. The paper identifies a 'geographic tax' imposed on archipelagic health policy implementation and demonstrates how this tax systematically widens health equity gaps. The AIHEF framework integrates governance mechanisms, implementation determinants, and equity outcomes into a unified analytical lens, offering both theoretical contributions to implementation science and practical policy implications for health equity in remote island territories. The framework advances the understanding of how governance structures mediate implementation fidelity and health equity in decentralized, geographically complex settings.

PROCEEDING
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INTRODUCTION

The global health landscape is undergoing a fundamental paradigmatic transformation: from health consumption to health production (WHO, 2023). This shift is driven by the epidemiological transition from communicable to non-communicable diseases (NCDs), which now account for the majority of premature deaths even in low and middle-income countries. In Indonesia, cardiovascular disease, stroke, and diabetes collectively represent the leading causes of mortality and catastrophic health expenditure, consuming more than 30 percent of annual National Health Insurance (JKN) claims (BPJS Kesehatan, 2024).

In response to this systemic challenge, the Indonesian government launched the Free Health Examination Program (Program Pemeriksaan Kesehatan Gratis/PKG) on 10 February 2025 described by the Ministry of Health as the 'largest health operation' in the nation's history, surpassing even the COVID-19 vaccination campaign in scale. Targeting 100 million health screenings within the first year, PKG represents a strategic pivot toward preventive primary care and is positioned as a cost-containment mechanism for the JKN system (Kemenkes RI, 2025a; Reuters, 2025).

Yet the implementation of this ambitious national initiative unfolds within a profoundly complex governance landscape. Indonesia's decentralized health system instituted since the 2001 administrative reform distributes health management authority across central, provincial, and district/city levels. This multi-tiered architecture creates what Pressman and Wildavsky (1973) identified as 'implementation gaps': systematic divergences between policy design at the national level and actual delivery at the local level. These gaps are not randomly distributed; they are structurally determined by geographic, institutional, and socioeconomic inequalities.

North Maluku Province exemplifies this structural challenge in its most acute form. Scattered across 1,474 islands 395 of which are inhabited the province presents an extreme case of geographic fragmentation where 58 percent of villages are accessible only by sea, internet penetration in outer islands stands at a mere 23 percent, and the doctor-to-population ratio of 13.2 per 100,000 is nearly half the national average (BPS Maluku Utara, 2023; Kominfo, 2024). This configuration imposes what this paper conceptualizes as a 'geographic tax': a systematic additional burden of time, cost, and coordination that must be borne to implement national policies in archipelagic territories.

This paper makes three primary contributions. First, it provides a theoretically grounded critique of conventional implementation models when applied to multilevel, geographically complex health systems. Second, it develops an integrated conceptual framework, the Archipelago-Adapted Implementation and Health Equity Framework (AIHEF) that synthesizes Multilevel Governance (MLG) theory, the Consolidated Framework for Implementation Research (CFIR), and Health Equity theory. Third, it generates a research agenda and policy implications for health equity-oriented implementation in remote island territories. The paper is organized as

PROCEEDING
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follows: Section 2 reviews the theoretical foundations; Section 3 develops the AIHEF conceptual framework; Section 4 examines the contextual application to North Maluku; Section 5 presents propositions and implications; and Section 6 concludes with directions for future research.

METHODE

This paper integrates three interrelated theoretical bodies that, in combination, offer a comprehensive analytical lens for understanding the multilevel, implementation, and equity dimensions of PKG governance.

1. Multilevel Governance (MLG) Theory

Multilevel Governance (MLG), originally theorized by Marks (1992, 1993) and subsequently elaborated by Hooghe and Marks (2003), emerged from analyses of European Union policymaking to describe the dispersion of authoritative decision-making across multiple governmental and non-governmental actors at different territorial levels. The seminal typology distinguishes between Type I MLG characterized by general-purpose jurisdictions with non-intersecting memberships and limited levels and Type II MLG characterized by task-specific, overlapping, and intersecting jurisdictions.

In the context of Indonesian health governance, PKG implementation exhibits characteristics of both types. The national-provincial-district hierarchy reflects Type I dynamics with clear jurisdictional assignments, while the involvement of BPJS Kesehatan, community health centers (Puskesmas), local government agencies, and community organizations reflects Type II dynamics of overlapping authority and negotiated coordination. Piattoni (2010) extended MLG analysis to encompass the vertical (center-periphery) and horizontal (state-civil society) dimensions simultaneously, which is particularly relevant for archipelagic governance where horizontal coordination across islands must complement vertical authority chains.

The critical contribution of MLG theory for this paper is its conceptualization of governance as a negotiated process among interdependent actors at multiple levels, rather than a hierarchical command-and-control mechanism. This matters enormously for PKG implementation in North Maluku, where the capacity to implement national directives is fundamentally shaped by local institutional resources, geographic constraints, and inter-actor coordination dynamics.

2. Consolidated Framework for Implementation Research (CFIR)

The Consolidated Framework for Implementation Research (CFIR), originally developed by Damschroder et al. (2009) and updated to 48 constructs in subsequent iterations, constitutes the most comprehensive meta-framework for understanding the determinants of implementation success or failure. CFIR organizes implementation determinants across five domains: (1) Intervention Characteristics — the attributes of PKG as an intervention, including its relative advantage over existing practices, complexity, and adaptability; (2) Outer Setting — the external

PROCEEDING
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environment including socioeconomic conditions, geographic characteristics, and policy context; (3) Inner Setting — the organizational characteristics of implementing units (Puskesmas), including leadership, culture, and readiness for change; (4) Characteristics of Individuals — including implementers' knowledge, beliefs, and self-efficacy; and (5) Implementation Process — the active strategies employed to introduce and sustain the intervention.

Systematic reviews of CFIR applications in health programs (Kirk et al., 2016) identify consistent patterns of facilitators and barriers across diverse implementation contexts. For preventive programs specifically, implementation fidelity is strongly mediated by Inner Setting factors (organizational leadership and climate) and Characteristics of Individuals (health worker attitudes toward preventive care). In geographically isolated settings, Outer Setting factors particularly resource constraints and access barriers gain disproportionate explanatory weight.

CFIR's multi-domain structure is particularly suited to PKG implementation analysis because it can simultaneously capture macro-level governance conditions (Outer Setting), meso-level organizational dynamics (Inner Setting), and micro-level individual behaviors the exact multi-level structure that MLG theory identifies as central to governance analysis.

3. Health Equity Framework

The Health Equity framework, synthesized from foundational contributions by Whitehead (1992), Marmot et al. (2008), Braveman (2006), and Sen's (1999, 2002) Capability Approach, provides the normative-evaluative dimension of the analytical framework. Health equity is distinguished from health equality: whereas equality demands identical treatment, equity requires differential treatment to achieve comparable outcomes across groups with differing needs and circumstances. Braveman's (2006) operationalization defines health inequities as systematic, avoidable, and unjust differences in health status linked to social disadvantage.

In the archipelagic context of North Maluku, geographic isolation functions as a structural determinant of health inequity. The Dahlgren-Whitehead 'rainbow' model (1991) positions geographic isolation as a distal determinant that mediates access to healthcare, economic opportunities, and social capital all of which influence health outcomes. Tudor Hart's (1971) Inverse Care Law, the observation that healthcare availability tends to vary inversely with the need for it is a persistent empirical regularity in Indonesian remote island communities (Rahmawati & Sari, 2023).

The capability approach (Sen, 1999) extends health equity analysis beyond service access to encompass the actual capabilities individuals can achieve their real freedoms to lead healthy lives. This framing is critical for PKG evaluation: the provision of a free health examination is meaningless if geographic, financial, informational, or cultural barriers prevent its uptake. Equity analysis must therefore examine not only coverage rates but the distribution of real access across population subgroups.

PROCEEDING
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RESULT AND DISCUSSION

1. CONTEXTUAL ANALYSIS: PKG IMPLEMENTATION IN NORTH MALUKU

To ground the conceptual framework, this section analyzes the specific contextual conditions of PKG implementation in North Maluku Province, organized across the four levels of governance identified in MLG theory.

a. National Level: Policy Architecture and Design Challenges

At the national level, PKG was designed with an ambitious scope: universal birthday-based health examination coverage for all Indonesian citizens, targeting 100 million screenings in the first year at a budget of IDR 3 trillion. The program's components include blood pressure measurement, cardiovascular and stroke risk assessment, ophthalmological screening, and mental health screening for depression and anxiety (Kemenkes RI, 2025a).

However, the policy design exhibits a fundamental tension: while the program is nationally mandated with centrally defined standards, its implementation is fundamentally dependent on the capacity of local health facilities (Puskesmas) operating under decentralized authority. National standards assume uniform baseline capacity that does not exist across Indonesia's diverse regional contexts. In North Maluku, where 39.8 percent of Puskesmas are categorized as serving Remote, Border, and Island Areas (Daerah Terpencil, Perbatasan, dan Kepulauan/DTPK), this assumption is fundamentally challenged.

b. Provincial Level: Coordination Architecture and Resource Mediation

At the provincial level, the North Maluku Provincial Health Office (Dinas Kesehatan Provinsi) serves as the critical meso-level coordinator between national directives and district-level implementation. Provincial data from the PKG implementation dashboard (per 31 December 2025) reveals significant inter-district variation in achievement rates, reflecting differential local capacity rather than demand-side differences alone.

The provincial level faces a structural paradox: it possesses the formal authority to coordinate across districts but lacks direct operational control over Puskesmas that report to district-level governments. This authority-capacity mismatch is a classic manifestation of what Hooghe and Marks (2003) identify as the coordination challenge in Type II MLG: overlapping jurisdictions without clear hierarchical resolution mechanisms.

c. District/City Level: Operational Gaps and Local Adaptation

At the district level, implementation reality diverges most sharply from national design. Ten districts and cities in North Maluku exhibit markedly different implementation trajectories, shaped by combinations of factors including: local leadership commitment to preventive health priorities; budgetary allocation decisions within locally managed APBD (regional budgets); geographic distribution of health workforce; and island transportation logistics. Lipsky's (1980) street-level

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International Conference on Innovation of Science and Social Studies
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Volume : 1 | Issue: 2 | September 2026

bureaucracy framework illuminates the centrality of discretionary decision-making at this level: local health administrators and Puskesmas heads inevitably interpret, adapt, and modify PKG implementation to fit local resource constraints.

d. Community/Service Delivery Level: The Point of Implementation

At the community level, PKG implementation encounters its final and most critical test. Three sets of factors determine community-level implementation outcomes: supply-side factors (Puskesmas capacity, personnel, equipment, and outreach capability); demand-side factors (community awareness, health literacy, cultural acceptance, and geographic accessibility); and system-integration factors (referral pathways, follow-up mechanisms, and linkage to JKN services). In island communities of North Maluku, geographic isolation compounds demand-side barriers significantly: communities on outer islands may require multi-day sea journeys to access the nearest Puskesmas, effectively excluding them from birthday-based examination programs unless active outreach strategies are deployed.

Table 1. Multi-Level Governance Challenges in PKG Implementation, North Maluku Province

Governance Level	Key Actors	Primary Challenges	MLG Dynamics
National	Ministry of Health, BPJS Kesehatan	Uniform policy design; inadequate geographic differentiation; resource allocation rigidity	Type I hierarchy; center-to-periphery mandate without adaptive mechanisms
Provincial	Provincial Health Office, Regional Secretary	Coordination without operational control; data fragmentation; inter-district variation management	Type II coordination; meso-level mediation between national and local
District/City	District Health Office, Local Government	Budget constraints; workforce allocation; transportation logistics; leadership variation	Decentralized authority with implementation accountability gaps
Community/Puskesmas	Puskesmas heads, health workers, community leaders	Geographic isolation; low health literacy; demand-side barriers; outreach capacity gaps	Street-level bureaucracy; frontline discretion determines implementation fidelity

PROCEEDING
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2. THE AIHEF CONCEPTUAL FRAMEWORK

Building on the theoretical foundations and contextual analysis, this paper proposes the Archipelago Adapted Implementation and Health Equity Framework (AIHEF) as an integrated analytical tool for understanding PKG governance in island territories. AIHEF synthesizes the three theoretical pillars into a unified, multi-level model with four core components.

a. Component 1: Multi-Level Governance Architecture (MLG Pillar)

The first AIHEF component maps the governance architecture across four levels (national, provincial, district, community), identifying: the formal authority structures at each level; the resource flows and accountability mechanisms; the coordination modalities between levels; and the key actors and their roles. This component explicitly incorporates the 'geographic tax' concept the additional governance burden imposed by archipelagic geography into the analytical framework. The geographic tax operates across all governance levels but concentrates most intensely at the community and district levels, where physical logistics of health delivery are most directly confronted.

A critical insight from MLG theory applied to AIHEF is that governance effectiveness in archipelagic contexts requires not merely vertical coherence (alignment between levels) but also horizontal adaptability (flexibility to accommodate diverse local conditions). Effective implementation demands what this paper terms 'governance differentiation': the deliberate design of implementation pathways that diverge from national templates in proportion to the geographic and institutional distance from standard delivery conditions.

b. Component 2: Multi-Domain Implementation Determinants (CFIR Pillar)

The second AIHEF component applies the CFIR five-domain structure to systematically map implementation determinants specific to archipelagic health program delivery. Drawing on the CFIR literature and the North Maluku context, the framework identifies domain-specific facilitators and barriers with particular relevance to island settings.

In the Intervention Characteristics domain, PKG's relative advantage the value of preventive screening over existing reactive care is high in principle but attenuated in practice by the absence of robust follow-up mechanisms in remote settings. The program's complexity is compounded in island contexts where multi-component screening requires coordinated personnel and equipment that may be unavailable in DTPK Puskesmas. In the Outer Setting domain, geographic isolation, transportation infrastructure, digital connectivity, and socioeconomic conditions collectively determine the structural parameters of implementation possibility. In the Inner Setting domain, Puskesmas organizational capacity including leadership quality, staff competence, and implementation climate varies enormously across North Maluku's heterogeneous island landscape. CFIR's emphasis on 'implementation climate' the extent to which implementation is rewarded,

PROCEEDING
International Conference on Innovation of Science and Social Studies
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Volume : 1 | Issue: 2 | September 2026

supported, and expected within an organization suggests that provincial and district-level governance signals about PKG priority profoundly influence frontline implementation effort.

c. Component 3: Geographic Tax Mediation Mechanism

The third AIHEF component introduces a novel theoretical construct the geographic tax mediation mechanism that bridges governance architecture and implementation determinants. This mechanism posits that archipelagic geography does not merely add logistical costs to implementation; it systematically mediates the relationship between governance inputs and implementation outcomes through three channels.

The first channel is resource attrition: financial, human, and material resources allocated for health program delivery are partially consumed by the additional logistical demands of island transport, generating systematic under-resourcing relative to program requirements. The second channel is coordination friction: the physical and communicative barriers of island geography increase the time and cost of inter-actor coordination, slowing implementation cycles and increasing the probability of coordination failures. The third channel is information asymmetry: limited digital connectivity in outer islands restricts real-time monitoring, feedback, and adaptive management, creating systematic information gaps that hinder evidence-based implementation adjustment. These three channels collectively constitute the geographic tax, and AIHEF argues that effective governance of PKG in archipelagic territories must explicitly account for and compensate this tax through differentiated resource allocation, adaptive coordination mechanisms, and alternative monitoring strategies.

d. Component 4: Health Equity Outcomes and Equity-Governance Feedback Loop

The fourth AIHEF component positions health equity outcomes as both the ultimate evaluative criterion and a feedback mechanism that reshapes governance arrangements. Equity outcomes are assessed across four dimensions derived from the health equity framework: equity of access (geographic and financial accessibility of PKG to all population segments); equity of quality (consistency of examination quality across Puskesmas serving different population groups); equity of outcomes (distribution of health benefits from early detection across socioeconomic and geographic groups); and equity of financing (fairness of PKG cost distribution).

The feedback loop dimension of this component is theoretically significant: AIHEF posits that observed equity outcomes should systematically inform governance adaptations at all levels. If monitoring reveals that outer island communities have systematically lower PKG participation rates (an equity of access deficit), this should trigger governance responses such as mobile health outreach, budget reallocation to DTPK areas, or differentiated reporting requirements that address the structural cause of the equity gap. This feedback loop transforms AIHEF from a static analytical framework into a dynamic governance learning model.

PROCEEDING
International Conference on Innovation of Science and Social Studies
E-ISSN: 3164-5240
Volume : 1 | Issue: 2 | September 2026

Table 2. AIHEF Framework: Components, Constructs, and Indicators

AIHEF Component	Core Constructs	Key Indicators
1. MLG Architecture	Governance levels; authority distribution; coordination modalities; geographic tax	Authority clarity index; coordination meeting frequency; inter-level information flows; DTPK resource parity ratio
2. CFIR Implementation Determinants	Intervention characteristics; outer setting; inner setting; individual factors; implementation process	Puskesmas readiness score; health worker competency index; implementation fidelity rate; leadership support score
3. Geographic Tax Mediation	Resource attrition; coordination friction; information asymmetry	Per-capita PKG cost by island distance; transport time to Puskesmas; internet connectivity rate; reporting lag time
4. Health Equity Outcomes & Feedback	Access equity; quality equity; outcome equity; financing equity; governance feedback loop	Coverage rate by geographic zone; service quality score by Puskesmas type; detection rate by socioeconomic group; policy adaptation responsiveness

3. THEORETICAL PROPOSITIONS AND RESEARCH AGENDA

Based on the AIHEF framework, this paper advances five formal theoretical propositions that can guide future empirical investigation of PKG governance in North Maluku and analogous archipelagic health systems.

a. Proposition 1: Geographic Tax and Implementation Disparity

The magnitude of the geographic tax measured by transport costs, accessibility barriers, and connectivity limitations will positively predict the degree of implementation disparity between mainland and island Puskesmas, even after controlling for institutional capacity variables. This proposition challenges the conventional assumption in health policy analysis that implementation disparities primarily reflect institutional or organizational factors, asserting instead that geographic structural factors have independent and substantial explanatory power.

PROCEEDING
International Conference on Innovation of Science and Social Studies
E-ISSN: 3164-5240
Volume : 1 | Issue: 2 | September 2026

b. Proposition 2: Governance Coherence and Implementation Fidelity

The degree of vertical governance coherence alignment of policy priorities, resource allocation, and accountability mechanisms from national to Puskesmas levels will positively mediate the relationship between PKG design quality and implementation fidelity. This proposition operationalizes the MLG insight that multi-level governance effectiveness depends not merely on the strength of individual governance levels but on the quality of inter-level linkages. In North Maluku's archipelagic context, where communication and coordination face structural barriers, maintaining governance coherence requires deliberate design of inter-level coordination mechanisms.

c. Proposition 3: CFIR Outer Setting Dominance in Archipelagic Contexts

In archipelagic implementation contexts, the CFIR Outer Setting domain particularly structural characteristics of the external environment will exert a disproportionately large influence on implementation outcomes relative to Inner Setting and Individual Characteristics domains, compared to non-archipelagic contexts. This proposition advances implementation science by proposing context-specific weighting of CFIR domains, challenging the implicit assumption of domain equivalence in standard CFIR applications.

d. Proposition 4: Health Equity Gradient and Governance Differentiation

The steepness of the health equity gradient across geographic zones (mainland vs. near islands vs. outer islands) will be inversely related to the degree of governance differentiation the extent to which PKG implementation strategies explicitly adapt to geographic variation. Provinces that implement undifferentiated, uniform PKG strategies will exhibit steeper equity gradients than those that adopt adaptive, geography-sensitive implementation designs.

e. Proposition 5: Feedback Loop Activation and Governance Learning

The activation of the equity-governance feedback loop the systematic use of equity monitoring data to inform governance adaptations will moderate the negative impact of the geographic tax on health equity outcomes over time. Governance systems that institutionalize equity monitoring and feedback mechanisms will converge toward equity targets faster than those that rely on uniform implementation without adaptive feedback.

4. POLICY IMPLICATIONS

The AIHEF framework generates several concrete policy implications for PKG governance in North Maluku and analogous archipelagic territories.

PROCEEDING
International Conference on Innovation of Science and Social Studies
E-ISSN: 3164-5240
Volume : 1 | Issue: 2 | September 2026

a. Geographic Differentiation in Resource Allocation

National PKG resource allocation formulas must explicitly incorporate geographic tax coefficients that adjust per-capita resource allocations based on island distance, transport costs, and accessibility indices. The current DTPK categorization provides a partial foundation for this differentiation but requires expansion to include granular geographic weighting factors. Failure to institutionalize geographic differentiation will systematically disadvantage outer island communities and perpetuate health equity gaps.

b. Adaptive Coordination Mechanisms

Provincial and district health authorities must develop archipelago-specific coordination mechanisms that transcend conventional face-to-face coordination models. This includes: mobile health teams with island-circuit scheduling; asynchronous digital coordination platforms adapted to low-bandwidth environments; community health cadre networks in outer island communities; and inter-district resource-sharing arrangements for specialized equipment and personnel. The provincial level should function as an active coordinator and problem-solver rather than merely a passive data aggregator.

c. Equity Monitoring and Real-Time Feedback Systems

The PKG implementation dashboard must be redesigned to incorporate geographic equity indices as real-time governance indicators. Disaggregated data by island distance category, socioeconomic quintile, and gender should be routinely reported to enable evidence-based adaptive management. Where digital connectivity limits real-time reporting, offline data collection with periodic synchronization should be institutionalized with clear quality assurance protocols.

d. CFIR-Based Implementation Capacity Building

Implementation capacity building for PKG must be structured according to CFIR domain logic rather than generic training approaches. Inner Setting-focused interventions should build Puskesmas implementation climate and leadership capacity. Individual Characteristics-focused interventions should address health worker attitudes toward preventive care and self-efficacy for outreach in island conditions. Implementation Process-focused interventions should develop island-adapted outreach protocols, community engagement strategies, and referral pathway management.

CONCLUSSION

AIHEF opens pathways for governance compensation: geographic differentiation in resource allocation, adaptive coordination mechanisms, equity-oriented monitoring systems, and CFIR-grounded capacity building. North Maluku provides a powerful empirical grounding for AIHEF's propositions. With 1,474 islands, critical workforce deficits, minimal digital connectivity in outer

islands, and wide interdistrict implementation variation in PKG, North Maluku represents the archetypical archipelagic governance challenge in Indonesian health policy. Yet it is precisely this extremity that makes it analytically valuable: the governance challenges visible in North Maluku are present in attenuated form across all of Indonesia's 17,000 islands and beyond in archipelagic nations globally.

Future research should empirically test the five propositions advanced by AIHEF through mixed methods embedded case study designs that can capture the multilevel, multiactor, and multicontext dynamics of PKG implementation. Quantitative analyses of implementation performance data disaggregated by geographic zone can test propositions regarding the geographic tax. Qualitative studies of governance actors can illuminate the mechanisms of coordination friction and information asymmetry. Participatory research with remoted island communities can ground equity assessments in lived experience, generate the evidence base needed to transform AIHEF from a conceptual framework into an actionable governance tool for health equity in archipelagic territories.

The stakes are high: in territories like North Maluku, geographic isolation compounds systemic inequality, the governance of health programs like PKG is not merely an administrative problem but a social justice. The Universal Health Coverage not leaving one behind governance frameworks sophisticated enough to reach those whom geography has rendered most difficult to reach.

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