



Indonesian Health Law: Constitutional Mandates, Regulatory Architecture, and Contemporary Governance Challenges

Wiet Sidharta^{1*}, Hargianti Dini Iswandari²
Universitas Ngudi Waluyo

Corresponding Author: Wiet Sidharta wietsidharta5@gmail.com

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ABSTRACT

Indonesian health law must reconcile constitutional guarantees, welfare-state obligations, regulatory complexity, and contemporary governance pressures. This study aims to analyze the coherence between constitutional mandates, regulatory architecture, and health governance implementation in Indonesia. A normative juridical approach was employed through a review of constitutional provisions, statutes, regulations, and policy instruments; no respondents or informants were involved. The materials were examined using doctrinal and qualitative legal analysis. The findings show that legislative consolidation has strengthened the formal health-law framework, yet implementation remains constrained by decentralization, institutional fragmentation, weak accountability, legal uncertainty, digital-health risks, and unequal access to services. The study concludes that stronger regulatory coherence, interinstitutional coordination, and rights-based enforcement are essential to improve equitable and sustainable health governance.

INTRODUCTION

Health law has become a central field of contemporary legal development because it determines how states translate public welfare commitments, human rights, and scientific progress into enforceable standards of health protection. At the global level, the expansion of universal health coverage, population mobility, public health emergencies, and digitally mediated healthcare has broadened health law beyond professional licensing and medical ethics. In Indonesia, Articles 28H paragraph 1 and 34 paragraph 3 of the Constitution of the Republic of Indonesia of 1945 recognize access to healthcare and the provision of adequate health facilities as constitutional obligations of the state (Republic of Indonesia, 1945). The urgency of these obligations is reflected in the expansion of the National Health Insurance program, which covered more than 260 million people or over 95 percent of the population by December 2023, while direct household health expenditure declined to 27.5 percent of current health expenditure (World Health Organization, 2024). Nevertheless, broad insurance coverage continues to coexist with substantial regional disparities in health outcomes and an inadequate and unevenly distributed health workforce, indicating that formal coverage alone does not ensure substantive equality in access to health services (Muharram et al., 2024).

Indonesia's regulatory response reached a significant turning point through the enactment of Law Number 17 of 2023 on Health, which was designed to consolidate and restructure the previously fragmented legal framework. The law regulates patients' rights, governmental responsibilities, health personnel, healthcare facilities, pharmaceutical products, medical devices, health technologies, information systems, emergency management, financing, supervision, and criminal liability within a single legislative structure (Republic of Indonesia, 2023). Government Regulation Number 28 of 2024 subsequently operationalized many of these provisions, illustrating that constitutional health guarantees depend on detailed administrative rules, institutional authority, and effective enforcement mechanisms (Republic of Indonesia, 2024). From a governance perspective, the effectiveness of health regulation is determined not merely by the existence of legislation but also by the coherence between constitutional rules, institutional decision-making rules, and operational practices (Abimbola, 2020). The central legal problem is therefore whether legislative consolidation can convert constitutional health entitlements into accountable, participatory, equitable, and legally certain governance rather than merely reorganizing regulatory texts (Gamalliel & Fuady, 2024).

Existing scholarship has generated important evidence regarding the achievements and limitations of Indonesian health financing, but most studies have concentrated on particular service outcomes. Anindya et al. (2020) found that participation in the National Health Insurance program improved access to several maternal health services, although socioeconomic differences continued to influence the distribution of benefits. Lee et al. (2023) similarly demonstrated that insured women in wealthier households and more developed regions had a substantially greater probability of receiving specialist assistance and delivering in hospitals than women in poorer and geographically disadvantaged groups. Using national insurance claims, Nugroho et al. (2023) identified income-related differences in the use of secondary and tertiary healthcare, indicating that administrative membership does not eliminate unequal patterns of service utilization. The Global Burden of Disease 2019 Indonesia Subnational Collaborators (2022) further documented substantial variations in disease burdens and health outcomes among Indonesian provinces, confirming that nationally uniform legal guarantees operate within highly unequal territorial conditions.

Governance-oriented research also remains divided among emergency management, decentralization, democratic legislation, and digital transformation. Djalante et al. (2020) showed that Indonesia's early response to coronavirus disease 2019 was affected by coordination difficulties, fragmented authority, and inconsistencies between national and subnational institutions. Sapkota et al. (2023) found that decentralization may improve local responsiveness but can also weaken coordination, financing consistency, accountability, and the equitable distribution of health resources. In the field of digital health, Saheb and Saheb (2024) emphasized that national strategies must integrate regulatory structures, implementation processes, interoperability, privacy protection, security, and measurable health outcomes. Gamalliel and Fuady (2024) critically examined the democratic legitimacy and legislative process of Indonesia's new health law, but existing studies have not comprehensively connected constitutional obligations, regulatory hierarchy, decentralized authority, professional accountability, health financing, pharmaceutical governance, emergency powers, patients' rights, and digital health within one integrated legal analysis.

Against this research gap, this article aims to systematically examine the constitutional mandates, regulatory architecture, and contemporary governance challenges of Indonesian health law. First, it analyzes the philosophical and constitutional foundations that transform health from a discretionary public service into an enforceable legal entitlement. Second, it maps the relationship between Law Number 17 of 2023 on Health, its implementing regulations, sectoral standards, administrative institutions, and the distribution of authority between central and regional governments. Third, it evaluates the legal protection of patients, professional responsibility, healthcare delivery, pharmaceutical and medical device regulation, health financing, public health emergency authority, and the governance of digital health information. Finally, it identifies normative inconsistencies, institutional overlaps, enforcement

weaknesses, and structural inequalities that may prevent formal legal guarantees from producing accessible, safe, equitable, and accountable healthcare.

Theoretically, this study develops an integrated public-law framework that connects constitutional rights, welfare-state responsibility, administrative governance, institutional rule systems, and human rights-based health regulation. It advances Indonesian health-law scholarship by examining how constitutional norms are translated through legislation, implementing regulations, institutional decisions, professional standards, and service-delivery practices. Practically, the study provides evaluative criteria for lawmakers, government institutions, healthcare regulators, professional bodies, insurers, and healthcare facilities when assessing regulatory coherence and institutional accountability. Its recommendations emphasize clearer allocation of authority, stronger central and regional coordination, transparent supervision, effective remedies for patients, equitable resource distribution, and rights-based protection in digital health systems. Accordingly, the study contributes to the development of a more coherent and enforceable legal architecture capable of transforming the constitutional right to health into sustainable and equitable health governance.

THEORETICAL REVIEW

Constitutional Right to Health and Rules-Based Governance

The recognition of health as a constitutional right changes the legal status of healthcare from a discretionary governmental service into a public entitlement that requires active state protection. This transformation obliges the government to establish laws, institutions, financing arrangements, and enforcement mechanisms capable of ensuring accessible, acceptable, safe, and equitable healthcare. Abimbola (2020) explains health system governance through the interaction of constitutional rules, collective decision-making rules, and operational rules that influence the conduct of policymakers, healthcare providers, and communities. This theoretical framework is relevant to Indonesian health law because constitutional guarantees cannot be realized solely through general declarations of rights. Their implementation depends on consistency between constitutional mandates, national legislation, administrative regulations, institutional decisions, professional standards, and healthcare practices. Accordingly, the effectiveness of Indonesian health law must be assessed by examining whether these different levels of rules operate coherently and provide meaningful accountability when the right to health is violated.

Regulatory Consolidation and Democratic Health Legislation

The enactment of Law Number 17 of 2023 on Health represents a major restructuring of Indonesia's health regulatory architecture. The legislation consolidates numerous previously separate legal provisions concerning healthcare services, health personnel, hospitals, pharmaceutical products, medical devices, public health, health information, and governmental authority. Regulatory consolidation may improve coherence by reducing fragmented rules and establishing a more integrated national health system. Nevertheless, legal integration does not automatically guarantee democratic legitimacy, institutional accountability, or effective implementation. Gamalliel and Fuady (2024) argue that the formulation of Indonesia's new health law raised concerns regarding the limited duration and substantive quality of public participation during the legislative process. Their analysis demonstrates that health legislation should not be evaluated only through regulatory efficiency but also through evidence-based policymaking, transparency, stakeholder participation, and good governance. Therefore, the legitimacy of Indonesia's health regulatory architecture depends on both the substance of the law and the inclusiveness of the process through which it is formulated and implemented.

Health Financing and Substantive Equality

The implementation of the National Health Insurance program has significantly altered the legal and institutional structure of Indonesian healthcare financing. The program reflects the principles of social solidarity, risk pooling, and state responsibility for expanding access to essential health services. From a legal perspective, insurance membership represents an important mechanism for translating constitutional health guarantees into enforceable service entitlements. However, formal insurance coverage does not necessarily eliminate socioeconomic, geographic, and institutional barriers to healthcare. Anindya et al. (2020) found that participation in Indonesia's National Health Insurance program improved access to maternal healthcare services, particularly among disadvantaged groups, but significant socioeconomic and regional inequalities remained. These findings indicate that equal legal status as an insured participant may still produce unequal practical outcomes when healthcare facilities, transportation, specialist services, and financial resources are unevenly distributed. Consequently, Indonesian health law must address not only eligibility and insurance coverage but also the substantive availability and accessibility of healthcare services.

Decentralization and Institutional Coordination

Decentralization is a fundamental feature of Indonesian health governance because responsibility for healthcare is distributed among national, provincial, district, and municipal authorities. This arrangement can improve local responsiveness by allowing regional governments to develop programs suited to local disease patterns, geographic conditions, cultural characteristics, and community needs. At the same time, decentralization may generate differences in regulatory interpretation, fiscal capacity, administrative competence, service standards, and institutional accountability. Sapkota et al. (2023) demonstrate that decentralization has mixed effects on health systems because its outcomes depend heavily on leadership, governance, financing, workforce management, and coordination between levels of government. Decentralized authority may strengthen innovation and local participation, but it may also intensify territorial inequality when regional institutions possess substantially different resources and administrative capacities. In Indonesia, this tension requires a clear legal allocation of functions accompanied by national minimum standards, adequate fiscal transfers, transparent supervision, and effective coordination. Decentralization should therefore operate as a mechanism for responsive service delivery rather than as a justification for unequal protection of the right to health.

Digital Health and Data Governance

Digital transformation has expanded the scope of health law beyond conventional relationships among patients, healthcare professionals, hospitals, and governmental regulators. Electronic medical records, telemedicine, interconnected health information systems, algorithmic decision-making, and remote healthcare services create new opportunities to improve efficiency and extend access to underserved populations. However, these technologies also generate legal risks involving privacy, confidentiality, cybersecurity, data ownership, informed consent, professional responsibility, and discrimination arising from unequal digital access. Saheb (2024) found that effective national digital health policies require an integrated relationship between governance structures, implementation processes, and measurable health outcomes. Their analysis suggests that technological adoption must be accompanied by institutional capacity, interoperability standards, legal safeguards, and clear accountability mechanisms. For Indonesia, digital health governance must ensure that innovation remains consistent with patients' rights and does not widen existing inequalities between regions or social groups. A comprehensive legal framework is therefore required to regulate the collection, use, exchange, protection, and retention of personal health information.

METHODOLOGY

Research Design and Approaches

This study employs normative juridical research, also known as doctrinal legal research, to examine Indonesian health law as a system of binding norms, legal principles, doctrines, and institutional arrangements. Normative juridical research is appropriate because it enables the systematic identification, interpretation, synthesis, and evaluation of legal norms governing the constitutional right to health, state responsibility, professional accountability, and health governance without relying on empirical measurement of individual behaviour (Bhat, 2020). Doctrinal research also enables the researcher to identify inconsistencies, normative gaps, overlaps, and conflicts within an enacted legal framework and to formulate legally reasoned recommendations (Majeed et al., 2023). The study applies statutory, conceptual, case, comparative, and policy approaches. These approaches are integrated to evaluate the relationship between constitutional mandates, health legislation, implementing regulations, judicial interpretation, institutional authority, international standards, and contemporary governance challenges.

Legal Materials and Units of Analysis

The primary legal materials consist of the Constitution of the Republic of Indonesia of 1945, Law Number 17 of 2023 on Health, relevant implementing regulations, international human rights instruments, and selected decisions of the Constitutional Court of the Republic of Indonesia and the Supreme Court of the Republic of Indonesia concerning health rights, medical responsibility, public health measures, and governmental authority. Secondary legal materials include scholarly books and peer-reviewed journal articles on constitutional law, administrative law, health law, human rights, decentralization, digital health governance, and public policy, with priority given to publications issued between 2020 and 2024. The units of analysis are legal provisions, judicial reasoning, regulatory concepts, institutional mandates, and scholarly arguments rather than individual respondents or statistical observations. Because the study does not employ questionnaires, measurement scales, interviews, or experimental instruments, no research items are adopted or adapted from previous empirical studies. Legal documents are treated according to their authority, context, language, institutional origin, and normative function because legal texts possess distinct structures and performative characteristics that must be considered in qualitative legal interpretation (Mitchell, 2023).

Collection and Selection of Legal Materials

Legal materials are collected through structured document searches in official Indonesian legislative databases, official repositories of the Constitutional Court and Supreme Court, academic databases, university library catalogues, and journal publisher platforms. Searches of secondary literature use combinations of terms such as “Indonesian health law,” “constitutional right to health,” “health regulation,” “medical liability,” “decentralized health governance,” “digital health law,” and “public health emergency powers.” Materials are included when they are directly relevant to the research questions, possess identifiable legal or academic authority, provide sufficient bibliographic information, and contribute to the interpretation or evaluation of Indonesian health governance. Duplicate publications, non-authoritative summaries, unsupported opinion pieces, and sources without a clear connection to the legal issues under examination are excluded. Comparative materials are selected purposively according to functional and contextual relevance rather than solely on similarities between legal texts, thereby preventing comparisons that disregard differences in institutional structures, legal traditions, and social conditions (Siems, 2022).

Research Procedure

The research procedure begins with the formulation of legal issues concerning the relationship between constitutional health guarantees, regulatory consolidation, institutional governance, and the implementation of citizens’ health rights. The second stage involves mapping the hierarchy and substantive scope of the applicable constitutional provisions, statutes, implementing regulations, judicial decisions, and international instruments. The third stage classifies the materials into thematic categories covering constitutional obligations, regulatory architecture, patients’ rights, professional accountability, health service delivery, pharmaceutical and medical device regulation, health financing, emergency powers, decentralization, and digital health governance. The fourth stage compares the objectives of each legal rule with its institutional design, allocation of authority, accountability mechanisms, and potential implementation consequences. The policy-oriented assessment considers legal effectiveness, administrative feasibility, equity, institutional capacity, and rights protection because policy analysis requires the systematic examination of public problems, regulatory alternatives, institutional constraints, and expected consequences (Kraft & Furlong, 2024).

Validity, Reliability, and Research Trustworthiness

Psychometric validity and statistical reliability testing are not applicable because this research does not use respondents, questionnaires, scales, experiments, or numerical datasets. Instead, the trustworthiness of the analysis is maintained through source authentication, hierarchical verification, triangulation among different categories of legal materials, consistent application of interpretive criteria, and transparent documentation of the analytical process. Each legal proposition is checked against the original version of the relevant legislation or judgment, while interpretations are compared with scholarly commentaries and related legal provisions. A structured coding framework is used consistently across all documents, and the classification of legal materials is rechecked against the original texts to reduce selective interpretation and unsupported generalization. This procedure follows the principle that qualitative reliability should be assessed according to the coherence between the research paradigm, source selection, analytical procedure, and representation of findings rather than through the mechanical application of statistical measures (Rose & Johnson, 2020). Although no formal intercoder coefficient is calculated, systematic documentation and repeated verification are used to strengthen the transparency, communicability, and dependability of the interpretive process (O'Connor & Joffe, 2020).

Data Analysis and Supporting Tools

The legal materials are analyzed qualitatively through doctrinal synthesis and grammatical, systematic, and teleological interpretation. Grammatical interpretation is used to determine the ordinary and technical meaning of legal provisions, while systematic interpretation examines their relationship with the broader constitutional and regulatory framework. Teleological interpretation evaluates the objectives of health legislation, particularly the realization of the constitutional right to health, equitable access to services, patient protection, legal certainty, and accountable governance. Qualitative content analysis is additionally used to organize recurring legal themes, institutional responsibilities, normative conflicts, enforcement mechanisms, and governance risks through a deductive coding framework derived from the research questions and legal concepts (Kuckartz & Rädiker, 2023). Zotero is used to organize references and remove duplicate academic sources, while Microsoft Excel supports the construction of a legal-material matrix containing the source, year, legal hierarchy, thematic category, relevant provision, interpretive issue, and analytical finding. These tools perform organizational functions only, while the interpretation, evaluation, and synthesis of legal meaning remain the responsibility of the researcher.

RESEARCH RESULTS AND DISCUSSION

Overview of the Main Findings

The doctrinal analysis shows that Indonesian health law has developed into an integrated legal framework connecting constitutional rights, governmental obligations, professional accountability, health financing, public health protection, and digital governance. Law Number 17 of 2023 on Health has reduced formal fragmentation by consolidating previously separate regulatory fields. However, legislative consolidation has not fully resolved institutional overlap, unequal administrative capacity, implementation gaps, limited access to remedies, and legal uncertainty.

The findings reveal a persistent gap between formal legal recognition and substantive implementation. Constitutional guarantees, insurance membership, professional licensing, facility accreditation, and digital-health regulation provide essential formal protections, but they do not automatically guarantee equitable access, service quality, institutional accountability, or effective remedies. Therefore, Indonesian health law must be evaluated not only by the completeness of its rules but also by its capacity to produce accessible, safe, equitable, and accountable healthcare.

Table 1. Synthesis of the Main Doctrinal Findings

Analytical theme	Main finding	Governance consequence
Constitutional right to health	The Constitution creates an affirmative state obligation, but its implementation depends on legislation, budgeting, administration, and enforcement	Constitutional rights must be translated into clear institutional duties and accessible remedies
Regulatory architecture	Law Number 17 of 2023 improves formal integration but delegates extensive details to subordinate regulations	Excessive delegation may create uncertainty, broad administrative discretion, and inconsistent implementation
Decentralized governance	Local authority supports context-sensitive policies but produces differences in infrastructure, workforce, and institutional capacity	National standards must be supported by stronger coordination and differentiated regional assistance
Patients' rights and professional accountability	Patient autonomy and professional duties are formally recognized, but dispute-resolution mechanisms remain complex	Complaint and liability mechanisms must be accessible, impartial, and consistent
Healthcare services and workforce	Licensing and accreditation regulate quality but cannot independently overcome	Workforce planning and service capacity must form part of enforceable health governance

Analytical theme	Main finding	Governance consequence
	unequal facility and workforce distribution	
Health financing	National insurance has expanded protection, but benefits remain influenced by income, geography, and provider availability	Coverage indicators must be supplemented by effective-service and equity indicators
Public health emergencies	Emergency powers are necessary but may conflict with legality, proportionality, transparency, and human rights	Emergency measures require clear legal triggers, time limits, oversight, and review mechanisms
Digital health	Telemedicine and integrated health information systems expand access but create privacy, liability, and exclusion risks	Innovation must be accompanied by data protection, cybersecurity, accountability, and digital inclusion

The table 1 summarizes the qualitative findings derived from the statutory, conceptual, case-oriented, comparative, and policy analysis. It does not represent a new statistical dataset.

Constitutional Mandates and the Right to Health

The first finding is that the constitutional right to health imposes positive obligations on the state. Articles 28H and 34 of the Constitution of the Republic of Indonesia of 1945 require the government to establish healthcare services, social protection, and adequate public facilities. Within a welfare-state framework, these provisions support state intervention in health financing, healthcare regulation, public-health infrastructure, and the protection of vulnerable groups. Ferraz (2020) explains that constitutional recognition may strengthen legal and political claims but does not automatically ensure equal health outcomes. In Indonesia, the principal challenge lies in translating constitutional guarantees into specific service obligations, minimum entitlements, and accessible remedies. The right to health should therefore guide legislation, public budgeting, administrative action, professional regulation, and judicial interpretation.

This finding shows that the right to health functions both as a substantive entitlement and as a governance principle. It provides a standard for reviewing legislation, limits unreasonable administrative discretion, and requires public institutions to address inequality in healthcare availability, accessibility, and quality.

Regulatory Consolidation and Legal Certainty

The second finding concerns the integration introduced by Law Number 17 of 2023 on Health and Government Regulation Number 28 of 2024. These regulations consolidate health services, healthcare personnel, facilities, pharmaceutical products, medical devices, technology, financing, health information, emergency preparedness, supervision, and sanctions within a more unified framework. Although consolidation improves formal coherence, many operational matters remain delegated to government regulations, ministerial regulations, technical standards, and administrative decisions. Delegated regulation is necessary in a technically complex sector, but excessive delegation may create uncertainty regarding institutional authority, applicable standards, and available remedies.

Amiati et al. (2024) identify similar ambiguity in the regulation of medical malpractice, particularly concerning the relationship among professional discipline, civil liability, criminal responsibility, and legal remedies. This study finds that such uncertainty also affects facility licensing, emergency authority, health-data governance, pharmaceutical supervision, and central-regional coordination. Accordingly, regulatory integration should be followed by harmonized implementing rules, transparent subordinate legislation, and clear procedures for resolving regulatory conflict. Legal certainty depends not only on the existence of a consolidated statute but also on stable interpretation, accessible regulations, coordinated enforcement, and reasoned administrative decisions.

Decentralization and Structural Inequality

The third finding is that decentralization creates both responsiveness and inequality. Regional governments possess substantial authority over healthcare planning, budgeting, workforce deployment, facility management, and service implementation. This allows policies to reflect local health conditions but also creates variations in administrative capacity, infrastructure, and service quality. Pratiwi et al. (2021) found that Indonesia's progress toward universal health coverage remained constrained by structural underfunding and differences in service availability across districts. This indicates that legal entitlements and insurance membership cannot ensure equal access where healthcare facilities, professionals, medicines, and diagnostic services remain unavailable.

Sambodo et al. (2021) further found that healthcare expenditure disproportionately benefited wealthier groups, urban populations, and residents of Java and Bali. Although Java and Bali represented approximately 57 percent of Indonesia's population, these regions received approximately 67 percent of overall healthcare expenditure. The disparity was particularly visible in secondary healthcare services. These findings demonstrate that formally equal rules may produce unequal outcomes when regional capacities differ significantly. National minimum standards should therefore be supported by needs-based fiscal transfers, workforce redistribution, infrastructure development, interoperable information systems, and stronger assistance for disadvantaged regions.

Patients' Rights and Professional Accountability

The fourth finding is that Indonesian health law has moved toward a rights-based relationship between patients and healthcare professionals. Patients are formally entitled to information, informed consent, confidentiality, access to medical records, respectful treatment, non-discrimination, and complaint mechanisms. Healthcare professionals are correspondingly bound by competency, registration, licensing, ethical, and professional standards. However, uncertainty remains regarding the interaction among internal hospital review, professional discipline, administrative sanctions, mediation, civil litigation, and criminal proceedings. These mechanisms have different objectives and standards of proof, but their relationship is not always clearly understood by patients or healthcare professionals.

Amiati et al. (2024) argue that regulatory ambiguity may obstruct legal remedies for medical malpractice victims. At the same time, excessive reliance on criminal proceedings may encourage defensive medicine and fail to address institutional causes of harm. Medical injury may result not only from individual conduct but also from inadequate staffing, defective equipment, poor communication, unsafe procedures, or unavailable medicines. A balanced framework should distinguish professional error, ethical misconduct, administrative non-compliance, civil negligence, gross negligence, intentional conduct, and institutional failure. Effective protection requires access to medical documentation, impartial expert review, independent complaint procedures, proportionate sanctions, and fair compensation mechanisms.

Health Facilities, Workforce, and Pharmaceutical Governance

The fifth finding is that licensing and accreditation are necessary but insufficient to ensure healthcare availability and quality. Public and private facilities are required to comply with standards concerning personnel, equipment, infrastructure, medicines, referrals, patient safety, and service governance. Nevertheless, regulatory standards cannot operate effectively where facilities lack adequate professionals, financial resources, or supply-chain support. Meilianti et al. (2022) found significant challenges in Indonesia's pharmacy workforce, including disparities in education, workforce density, professional development, and geographical distribution. Unequal distribution affects medicine management, patient counselling, public-health programs, quality assurance, and pharmaceutical supervision.

Pharmaceutical and medical-device governance also involves multiple institutions, including the National Agency of Drug and Food Control, the Ministry of Health, regional governments, manufacturers, distributors, facilities, and professionals. Fragmented databases and unclear responsibilities may delay action against unsafe, falsified, unavailable, or improperly distributed products. The findings support a risk-based regulatory system integrating licensing, product traceability, safety reporting, procurement transparency, professional accountability, and public access to regulatory information. Workforce distribution and regulatory capacity should be treated as components of the state's legal obligations rather than merely administrative concerns.

National Health Insurance and Substantive Equality

The sixth finding is that the National Health Insurance program has significantly expanded formal financial protection. However, membership does not automatically constitute effective universal health coverage. Effective coverage requires available facilities, reasonable waiting times, geographic accessibility, adequate quality, medicine availability, and protection from additional financial burdens. Asante et al. (2023) found that public healthcare benefits were marginally concentrated among lower-income groups, whereas private healthcare benefits remained strongly concentrated among higher-income groups. The overall incidence of health financing also changed from moderately progressive in 2018 to mildly regressive in 2019. This finding appears different from Sambodo et al. (2021), who identified geographical and income-related inequality in the distribution of healthcare benefits. However, the difference results from the analytical methods employed.

Sambodo et al. focused on geographic variations in healthcare benefits and provider-payment costs, while Asante et al. distinguished financing sources and public and private services. Together, the studies show that equity varies according to geography, service level, payment mechanism, and healthcare sector. Mulyanto et al. (2023) also found geographical disparities in the use, quality, and outcomes of Indonesia's diabetes-management program. Urban participants were more likely to receive regular visits, standard medication, and favourable clinical outcomes than rural participants. The legal effectiveness of National Health Insurance should therefore be measured through effective-service and equity indicators, not membership alone. Provider payments, referral systems, benefit packages, facility capacity, medicine availability, and workforce distribution should be governed as an interconnected system.

Public Health Emergencies and State Authority

The seventh finding concerns the limits of state authority during public health emergencies. Restrictions on movement, assembly, commercial activities, or access to particular locations may be legally justified when they possess a clear legal basis, pursue legitimate health objectives, remain necessary and proportionate, and are subject to periodic review. Wiratraman (2020) found that Indonesia's response to coronavirus disease 2019 involved overlapping authority, unclear legal policy, delayed action, weak coordination, and insufficient integration of human-rights standards. The present analysis similarly identifies overlapping legal concepts concerning emergencies, disasters, quarantines, and financial crises.

Future emergency regulations should establish objective declaration criteria, institutional authority, geographical scope, permissible restrictions, review periods, oversight mechanisms, information duties, and termination procedures. Safeguards are also required for vulnerable populations, healthcare personnel, essential workers, and people whose livelihoods are affected. Public health emergencies should not be treated as exceptions to constitutional governance. Emergency authority must remain subject to legality, proportionality, accountability, scientific justification, transparency, and respect for human dignity.

Digital Health and Data Governance

The eighth finding is that digital transformation has changed the legal relationships among patients, professionals, healthcare facilities, technology providers, government institutions, and data processors. Telemedicine, electronic medical records, interconnected information systems, algorithmic decision-making, and artificial intelligence may improve access and continuity of care but also generate new risks. Alexandra et al. (2021) found that hospital telemedicine acceptance in Indonesia is influenced by perceived usefulness, ease of use, service quality, user behaviour, and technological conditions. Formal authorization is therefore insufficient when patients face weak connectivity, limited digital literacy, inaccessible systems, or concerns regarding data protection.

The legal analysis also identifies uncertainty concerning responsibility when remote treatment fails because of incomplete information, platform failure, poor data integration, or unreliable algorithmic recommendations. Additional concerns include electronic consent, cybersecurity, cross-institutional data sharing, data retention, automated profiling, and patient access to digital records. Kickbusch et al. (2021) argue that digital-health governance should protect public value, human rights, equitable access, and accountable data stewardship. Indonesian regulation should accordingly establish privacy-by-design requirements, cybersecurity standards, audit trails, breach-notification duties, human oversight, clear liability rules, and non-digital alternatives for people without adequate digital access.

Integrated Interpretation and Contribution

The findings show that Indonesian health law consists of three interacting layers. The constitutional layer establishes the right to health, equality, dignity, social security, and state responsibility. The institutional layer distributes authority among national and regional governments, courts, regulators, insurers, facilities, and professional bodies. The operational layer concerns how these rules are applied in healthcare delivery. Legal failure occurs when these layers are not aligned. Constitutional rights may lack remedies, national standards may exceed regional capacity, insurance membership may not correspond with available services, and digital innovation may develop faster than privacy and liability regulation.

The main theoretical contribution of this study is that regulatory coherence must be assessed both vertically and horizontally. Vertical coherence concerns the translation of constitutional principles into legislation, implementing regulations, institutional obligations, and service practices. Horizontal coherence concerns coordination among institutions, sectors, and legal regimes. The study also distinguishes regulatory comprehensiveness from regulatory effectiveness. Law Number 17 of 2023 provides a broader and more integrated framework, but its success depends on administrative capacity, fiscal policy, professional practices, regulatory coordination, and accessible enforcement mechanisms.

Policy and Regulatory Implications

Implementing regulations should clearly define institutional authority, service entitlements, procedural safeguards, and accountability mechanisms. Regional inequalities should be addressed through needs-based financing, workforce-distribution policies, infrastructure support, and enforceable minimum-service standards. Medical-dispute procedures should clearly distinguish professional discipline, administrative responsibility, civil liability, criminal conduct, and institutional failure. National Health Insurance should be evaluated using equity, quality, and effective-coverage indicators rather than membership alone.

Pharmaceutical governance should integrate product traceability, procurement transparency, safety monitoring, professional capacity, and coordinated enforcement. Emergency powers should be limited by objective triggers, time restrictions, review mechanisms, legislative oversight, and judicial remedies. Digital-health regulation should combine innovation with personal-data protection, cybersecurity, human oversight, clear liability, and digital inclusion. These reforms are necessary to translate constitutional guarantees into equitable, accountable, and sustainable health governance.

CONCLUSIONS AND RECOMMENDATIONS

This study concludes that Indonesian health law has developed into a more comprehensive regulatory framework through the constitutional recognition of the right to health, Law Number 17 of 2023 on Health, and Government Regulation Number 28 of 2024. These legal developments have strengthened the integration of healthcare services, professional regulation, health financing, pharmaceutical governance, emergency management, and digital-health administration. Nevertheless, regulatory comprehensiveness has not automatically resulted in regulatory effectiveness. Significant challenges remain in the form of institutional overlap, extensive delegation to subordinate regulations, unequal regional capacity, limited access to legal remedies, workforce and facility disparities, uneven National Health Insurance benefits, and emerging risks related to personal health data and digital technology. Effective health governance therefore requires vertical coherence between constitutional principles, legislation, implementing regulations, and healthcare practices, together with horizontal coordination among national and regional governments, regulators, professional bodies, insurers, and healthcare facilities.

The implementation of these findings requires clearer allocation of institutional authority, harmonization of implementing regulations, and enforceable minimum-service standards across regions. Government policy should prioritize needs-based financing, equitable workforce distribution, infrastructure development, transparent pharmaceutical supervision, and evaluation of National Health Insurance based on service quality, accessibility, and equity rather than membership alone. Medical-dispute mechanisms should clearly distinguish professional discipline, administrative responsibility, civil liability, criminal conduct, and institutional failure while ensuring accessible remedies for patients. Emergency health powers should remain subject to legality, necessity, proportionality, transparency, time limitations, legislative oversight, and judicial review. Digital-health regulation should also establish robust personal-data protection, cybersecurity standards, human oversight of automated systems, clear liability mechanisms, and non-digital alternatives for individuals facing technological barriers.

ADVANCED RESEARCH

This study is limited by its normative juridical design, which focuses on legislation, legal principles, institutional mandates, judicial reasoning, and published academic evidence without directly examining the experiences of patients, healthcare professionals, healthcare facilities, regulators, or regional governments. The relatively recent enactment of Law Number 17 of 2023 and Government Regulation Number 28 of 2024 also limits the availability of judicial decisions and long-term evidence concerning their implementation. Future studies should combine doctrinal analysis with empirical methods, including interviews, surveys, regional case studies, analysis of medical-dispute decisions, and comparative evaluations of healthcare institutions. Longitudinal research is particularly needed to assess whether the new legal framework improves patient remedies, regional service equality, workforce distribution, medicine

availability, emergency accountability, National Health Insurance outcomes, and personal health-data protection.

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