Hospital Legal Liability for Violations of Patient Rights in Health Services under Law No. 17 of 2023 on Health

M. Fery Harison, Muhammad Arif Sahlepi, Rika Jamin Marbun

Abstract

The hospital is where patient rights are tested in practice, and Law No. 17 of 2023 on Health (the Health Law) changes the basis of its liability. This study analyses the responsibility of hospitals for fulfilling patient rights and the legal consequences when service standards are violated. It uses normative legal research with statutory, conceptual and case approaches, supported by secondary data from the Ministry of Health, press reports and legal literature. Article 276 lists patient rights and Article 189(1) lists hospital duties, but the two are not expressly linked; only emergency care has an explicit prohibition (Article 174(2)) and a criminal penalty (Article 438). Article 193 makes the hospital liable for losses caused by the negligence of its human resources, while the administrative sanctions of Article 189(2) are detailed only in Article 853 of Government Regulation No. 28 of 2024. By the authors' calculation, the maximum fine in Article 438(1) falls by 75.00%, from IDR 200 million to IDR 50 million (category III) after the criminal-penalty adjustment. In the Jayapura incident of November 2025, no sanction had been imposed when the last report was read, and a shortage of specialists (47,454 against a need of about 78,000) was a contributing cause. The study concludes that hospital liability needs clear sanction criteria, a clear civil route and state provision of capacity.

***Keywords**: legal liability; hospital; patient rights; service standards; Law No. 17 of 2023*

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Introduction

The hospital is where patient rights are tested most directly: information is given or withheld, consent is asked for or skipped, and help is given or delayed. The Ministry of Health put the number of hospitals in Indonesia at 3,176 in May 2024 [1]. At a working meeting with Commission IX of the House of Representatives on 2 July 2025, the Minister of Health reported 51 complaints of alleged malpractice and patient-safety incidents in 2023–2025, 21 received directly and 30 found through media monitoring. Twenty-four complaints concerned the death of the patient, 13 of them in 2025 [2], [3].

Two recent incidents show the problem. In November 2025, Irene Sokoy, a pregnant woman in Jayapura, died with her baby after being referred from one hospital to another. A Ministry of Health team named four causes: no obstetrician on site, only a midwife available, inadequate facilities, and a request for an administrative payment at one hospital [4]. In August 2026, a BPJS patient complained of waiting eight hours in the emergency department (ED) of a hospital, and the Indonesian Medical Association (IDI) urged an audit [5].

The legal basis has also changed. Law No. 17 of 2023 on Health (the Health Law) repealed eleven laws, among them Law No. 44 of 2009 on Hospitals [6], [7]. Article 46 of the old law, which made the hospital liable for the negligence of health workers, was revoked, and Article 193 of the Health Law replaces it with liability for the negligence of the hospital's health human resources, a wider group [8]. Earlier studies of hospital liability mostly discuss the old law [9], [10]. In the sources reviewed, the authors found no study that maps all the legal consequences for a hospital under the Health Law.

This paper asks three questions. First, what must a hospital do to fulfil patient rights under the Health Law? Second, what are the legal consequences when a hospital violates service standards, administratively, civilly and criminally? Third, where are the gaps between duty and consequence, and how can they be closed?

Literature Review

2.1 Patient rights and hospital duties

The Health Law lists patient rights in Article 276: to obtain information on their health, to receive an adequate explanation of the services received, to receive services in line with medical need, professional standards and good quality, to accept or refuse medical action, to access information in the medical record, to ask the opinion of another medical or health worker, and other rights under statutes and regulations [11]. In an emergency, a health facility may not refuse a patient or ask for a down payment (Article 174(2)), and medical and health personnel must give first aid (Article 275(1)) [11].

Hospital duties are set out in Article 189(1). According to a health-law academic, these include giving correct information about hospital services to the public (letter a), safe, good-quality, non-discriminatory and effective care (letter b), emergency care within the hospital's capacity (letter c), quality standards (letter g), medical records (letter h), a referral system (letter j), refusing patient requests that conflict with professional standards, ethics and law (letter k), giving correct information on patient rights and obligations (letter l), respecting and protecting patient rights (letter m), and drafting internal regulations (letter r) [12]. A violation of these duties incurs administrative sanctions under the applicable regulations (Article 189(2)) [11]. The same author names three areas of hospital responsibility: duty of care, facilities and infrastructure, and personnel. In his view, the hospital remains responsible for the doctors it engages whatever their status, because it selects them through credentialing and monitors their performance [12].

2.2 Civil liability of the hospital

Before the Health Law, civil liability of the hospital rested on Article 46 of Law No. 44 of 2009 and Article 1367 of the Civil Code. A case study concludes that a hospital was liable for the negligence of its doctor under both provisions, because the doctor worked for the

hospital [9]. A study of internship doctors concludes that the host institution bears institutional responsibility for their errors, including compensation to the patient [13]. Another study concludes that a hospital can be held liable, but that patients struggle to win compensation suits because not every act of negligence by a health worker is the hospital's responsibility, and it calls for clearer rules [10].

Andrianto's doctoral research on 73 court decisions found that judges are inconsistent about who is responsible for a wrongful act and whether the hospital is responsible when a doctor is alleged to have committed malpractice. The dissertation divides civil liability into the practice of medicine and the hospital's duty of care to the patient, describes the doctor as an independent contractor whose hospital liability derives from the agreement between patient and hospital, and proposes vicarious liability and central responsibility as the ideal model [14].

2.3 Legal politics, delegated regulation and dispute resolution

Five studies by Tanjung and co-authors frame the analysis. In a critique of the omnibus method, Tanjung and Arminsyah argue that opaque process and thin public participation weaken legitimacy, and that broad government power to change regulations is a risk [15]. In a study of judicial oversight, Tanjung examines the Judicial Commission's supervision of judges and notes that other bodies also hold oversight powers [16]. In studies of cybercrime (with Adriani) and narcotics trafficking, he analyses penal and non-penal measures, and the narcotics study proposes an integrated approach of prevention, enforcement, therapy and rehabilitation [17], [18]. In a recent study with Arminsyah and Syam on the authority dualism between the National Sharia Arbitration Board (Basyarnas) and the sharia courts, they propose a model in which Basyarnas resolves sharia economic disputes through arbitration and the court supervises, legalises and enforces the award, with synchronised regulation [19].

Research Method

This is normative legal research with statutory, conceptual and case approaches. The primary legal materials are the Health Law, especially Articles 174, 189, 193, 275, 276 and 438, and Article 853 of Government Regulation No. 28 of 2024. Other rules, namely Article 836(2) of that regulation, Minister of Health Regulation No. 3 of 2025 and the criminal-penalty adjustment in Law No. 1 of 2026, are read through legal commentary. Secondary materials are journal articles and legal commentary, including the studies by Tanjung and co-authors cited above. Secondary empirical data come from the Minister of Health's statement to the House (2025) as reported, the number of hospitals given by the Ministry of Health as reported (May 2024), and specialist-physician data from a Universitas Gadjah Mada news release (2024). The cases are two publicly reported incidents (Jayapura, 2025, and a BPJS patient in an emergency department, 2026) and one older incident (Sidikalang, 2018) for comparison.

The analysis is descriptive and qualitative with two simple measures, both calculated by the authors. A percentage is part divided by total. The change in a maximum fine is the fine after adjustment minus the fine before, divided by the fine before.

The study has limits. The text of Article 189(1) on Pasal.id is truncated, so the letters of the hospital's duties are read from a commentary [12], and the mapping of rights to duties in Table 1 is the authors' reading. The Health Law text on Pasal.id contains character errors and only the articles cited here were read, so a statement that the law does not regulate something refers to those articles. The maximum fines in Article 438 after the criminal-penalty adjustment (categories III and VI) are read from one legal commentary [20] and were not checked against the text of Law No. 1 of 2026; the figures before the adjustment are read from Pasal.id and press reports. Paragraph (1) of Article 308 did not appear on the page read. The authors could not access the Supreme Court Decision Directory and found no decision applying Article 193 or Article 438 to a hospital; this reflects the search, not proof that none exists. The incidents studied are allegations as reported, and the outcome of the sanctions in the Jayapura incident was not found after the last reports of late November 2025.

Results and Discussion

4.1 Patient rights and hospital duties

The Health Law details patient rights (Article 276) and hospital duties (Article 189(1)) in two separate articles, and no wording states that the violation of a given right is the violation of a given hospital duty. Table 1 maps the two as read by the authors.

Table 1. Patient rights under Article 276 and the related hospital duties

Patient right (Art. 276)	Related hospital duty	Violation that may be raised
Information on health condition and an adequate explanation (letters a–b)	Correct information on hospital services (Art. 189(1)(a)); correct, clear and honest information on patient rights and obligations (letter l) [12]	Information not given, incomplete or incorrect; patient not told of their rights
Services in line with medical need, professional standards and quality (letter c)	Safe, good-quality, non-discriminatory and effective care (letter b); quality standards (letter g); refusing requests that conflict with professional standards (letter k)	Substandard care; wrong diagnosis or procedure; negligence of hospital human resources (Art. 193)
Accept or refuse medical action (letter d)	Respect and protect patient rights (letter m)	Action without valid consent; patient's refusal not respected
Access to information in the medical record (letter e)	Medical records (letter h)	Access refused or record incomplete
Ask the opinion of another medical or health worker (letter f)	Referral system (letter j)	Referral or second opinion obstructed; referral with no certainty of destination
Emergency care (Art. 174)	Emergency care (letter c); no refusal of patients and no down payment (Art. 174(2))	Emergency patient refused or held up by administrative matters; first aid not given (Art. 275(1))

Note: the mapping is the authors' reading; the letters of the hospital duties are read from a commentary because the text of Article 189(1) on Pasal.id is truncated. Source: [11], [12].

Three points can be noted. First, the mapping is not one to one. The right to services in line with standards meets three duties at once, namely quality, standards, and refusing requests that conflict with professional standards, while the right to ask another opinion links only weakly to the referral system. Second, among the articles read, only emergency care has an explicit prohibition (Article 174(2)), a duty of first aid (Article 275(1)) and a criminal penalty (Article 438), while violations of the rights to information, consent or the medical record are reached only by general administrative sanctions and civil claims. Third, Article 189(2) says only "administrative sanctions in accordance with statutory regulations" [11]; the measure of those sanctions sits at the level of a government regulation, as discussed below.

4.2 Legal consequences for the hospital

Table 2 maps the legal consequences that can reach a hospital and the people in it. On the administrative route, violation of the duties in Articles 833 to 852 of Government Regulation No. 28 of 2024 incurs a verbal reprimand, a written reprimand, an administrative fine, or revocation of the hospital's business licence, imposed by the central, provincial or district/city government within its authority (Article 853(1)–(2)) [21]. Legal commentary notes that Article 836(2) of the regulation prohibits a hospital from refusing a patient or asking for a down payment [20]. The sanctions announced by the Ministry of Health for the Jayapura incident, namely guidance, temporary suspension of the licence and revocation of the operating licence [22], do not coincide exactly with the four types in Article 853(1); in the text read, suspension of the licence is not in that list.

Table 2. Legal consequences of a hospital's violation of service standards

Route	Basis and consequence	Target	What is unclear
Administrative	Art. 189(2); GR 28/2024 Art. 853(1): verbal reprimand, written reprimand, administrative fine, revocation of business licence [21]; ban on refusing patients (Art. 836(2)) [20]	Hospital	Criteria for choosing a sanction and the size of the fine were not found in the articles read
Civil	Art. 193: the hospital is liable for losses caused by negligence of its human resources; out-of-court resolution first (Art. 310) [11], [23]	Hospital	Violation of a right without negligence; effect of Art. 275(2); whether a council recommendation is needed [24]
Disciplinary	Arts. 304 and 306: the council assesses disciplinary violations; sanctions are a written warning, compulsory education or training, temporary deactivation of the registration certificate (STR) and/or a recommendation to revoke the practice permit (SIP) [11]; MoH Reg. 3/2025 Art. 28(1) [20]	Medical and health personnel	Does not reach the hospital as an institution
Criminal (person)	Art. 438(1): up to 2 years or a fine; (2): up to 10 years or a fine where disability or death results [11], [22]	Head of facility, medical personnel, health personnel	Fine in (1) falls from IDR 200 million to IDR 50 million (category III) after the adjustment [20]
Criminal (corporation)	New Criminal Code: prosecution of a corporation and/or the person who ordered or led the act [25], [26]	Hospital with legal-entity status	Application to hospitals was not found in the decisions read

Note: the last column is the authors' reading of the text read. Source: as cited in the table.

On the civil route, Article 193 provides that the hospital is legally liable for all losses caused by negligence of the hospital's human resources [11]. That group covers doctors, specialists and dentists, health workers such as nurses and midwives, and support staff such as administrative and catering staff [8]. This wording answers part of the concern in the older literature about the status of doctors, because liability attaches to the hospital for its human resources and not to employment status alone, in line with the view that the hospital remains responsible for the doctors it engages whatever their status [12]. In the authors' reading, however, there are three gaps. First, Article 193 speaks of losses caused by negligence; a violation of a right that is not negligence, for example a patient not told of their rights, is not expressly mentioned. Second, Article 275(2) exempts personnel who give help to save a life from compensation claims [11], and the article read does not say whether the exemption also protects the hospital. Third, Article 308 requires a recommendation of the council before an investigation or civil claim against medical and health personnel, and a dispute over their alleged professional error must first go through out-of-court dispute resolution (Article 310) [11], [23]. Those articles name personnel, not hospitals, so it is unclear whether a claim against the hospital alone needs a recommendation, and according to Andrianto there is as yet no regulation or study on the legal standing of the council's recommendation in civil proceedings [24]. The uncertainty matters because earlier court decisions were already inconsistent on hospital liability [14].

On the criminal route, Article 438(1) punishes the head of a health facility, medical personnel or health personnel who do not give first aid to an emergency patient with imprisonment of up to two years or a fine, and paragraph (2) raises it to up to ten years where the patient suffers disability or dies [11], [22]. The subject is a person, not the hospital as an entity. Liability of the entity is reported to be possible under the new Criminal Code, which allows prosecution of a corporation and/or the person who ordered or led the act [25], [26], but

its application to a hospital was not found in the decisions read. A legal commentary states that after the criminal-penalty adjustment in Law No. 1 of 2026, the fine in paragraph (1) is category III (IDR 50 million) and the fine in paragraph (2) is category VI (IDR 2 billion) [20]. Compared with the original values, IDR 200 million in paragraph (1) and IDR 2 billion in paragraph (2) [11], [22], the change by the authors' calculation is −75.00% and 0.00%. The fine for not giving first aid is therefore weaker, while the fine for refusal that results in disability or death is unchanged.

4.3 Incidents: when capacity fails

Table 3 summarises the incidents studied. In the Jayapura incident, the Ministry of Health stated that hospitals may not refuse emergency patients, that a full facility, no class 3 beds, incomplete staff and administrative matters are not valid reasons, and that the patient must be stabilised before referral [4], [22]. The sanctions named are graduated, from guidance for the director and the person responsible for medical services, through temporary suspension of the licence, to revocation of the operating licence, with the district health office as licensing authority examining further and deciding [22], [27]. On 27 November 2025 no sanction had been imposed because the examination was still under way [27], and the authors found no later report of the outcome. The reports read mention criminal sanctions as a possibility [28] but not a criminal investigation.

Table 3. Incidents of alleged violation of patient rights studied

Incident	Reported facts	Reported legal response
Jayapura, Papua (Nov. 2025)	Irene Sokoy, pregnant, died with her baby on Nov. 17, 2025 after referral between hospitals. At one hospital the obstetrician was at a seminar and a midwife attended; at another there was no anaesthesiologist and the NICU was full; at another all operating rooms were being renovated; at another class 3 was full and the family was asked to settle administration and pay about IDR 3–4 million for a VIP room [4], [28]	Ministry team named four causes; firm sanctions said to be coming [28]; graduated sanctions possible; on Nov. 27, 2025 no sanction yet and the health office to decide; evaluation within three months [22], [27], [29]
Emergency department, hospital not named (Aug. 2026)	BPJS patient complained of waiting eight hours in the ED [5]	IDI urged the Ministry of Health, regional IDI and local governments to audit the hospital to find the cause of the delay; no Ministry response in the article read [5]
Sidikalang, North Sumatra (Apr. 2018), under the old law	Pregnant woman and her unborn child died on Apr. 15, 2018; midwives and nurses reportedly slow to call the obstetrician [30]	A lawyer cited Articles 32 and 190 of Law 36/2009 and a penalty of up to 10 years for the director; final outcome not found [30]

Note: all are allegations as reported; no court decision was found. Source: as cited in the table.

The pattern is not new. In April 2018 a pregnant woman and her unborn child died at Sidikalang Regional Hospital, and a lawyer cited a criminal penalty of up to ten years for the director under Law No. 36 of 2009 [30]. In both incidents the criminal penalty mentioned was aimed at the head or at personnel, not at the hospital as an entity [22], [30]. In February 2026 the Ministry of Health, through Circular Letter No. HK.02.02/D/539/2026, barred hospitals from refusing patients whose JKN membership is temporarily inactive, for up to three months from the deactivation, and required emergency care, dialysis and cancer therapy to be prioritised [31]. The circular closes one real reason for refusal, but the report read names no particular sanction for breaching it.

4.4 Capacity as a limit on liability

The Jayapura incident shows that some causes lie within the hospital's control and some outside it. The Minister of Health named the shortage of obstetric and anaesthesia specialists,

especially outside Java, as one major cause, while in Papua all operating rooms were renovated at once so that none could be used, and incomplete referral data prevented emergency doctors from seeing which specialists and facilities were available [29]. Scheduling renovations and data discipline are hospital governance, whereas the number of specialists is a responsibility of the state. Table 4 gives the scale and capacity: 47,454 specialist physicians in December 2023, or 0.17 per 1,000 population, against a need of about 78,000, a gap of 30,546 (39.16%) [32].

Table 4. Scale and capacity indicators, and the change in the Article 438 fines

Indicator	Value	Source
Hospitals in Indonesia, May 2024	3,176	[1]
Complaints of alleged malpractice and incidents, 2023–2025	51	[2]
Of which death of the patient (13 in 2025)	24 (47.06%)	[3]
Specialist physicians, Dec. 2023	47,454	[32]
Specialist physicians per 1,000 population	0.17	[32]
Estimated need (280 million population)	about 78,000	[32]
Gap between need and supply	30,546 (39.16%)	Calculated
Maximum fine, Art. 438(1): IDR 200 million to IDR 50 million	−75.00%	Calculated; [20]
Maximum fine, Art. 438(2): IDR 2 billion to IDR 2 billion	0.00%	Calculated; [20]

Note: percentages calculated by the authors. The values after adjustment are read from one legal commentary and were not checked against the text of Law No. 1 of 2026.

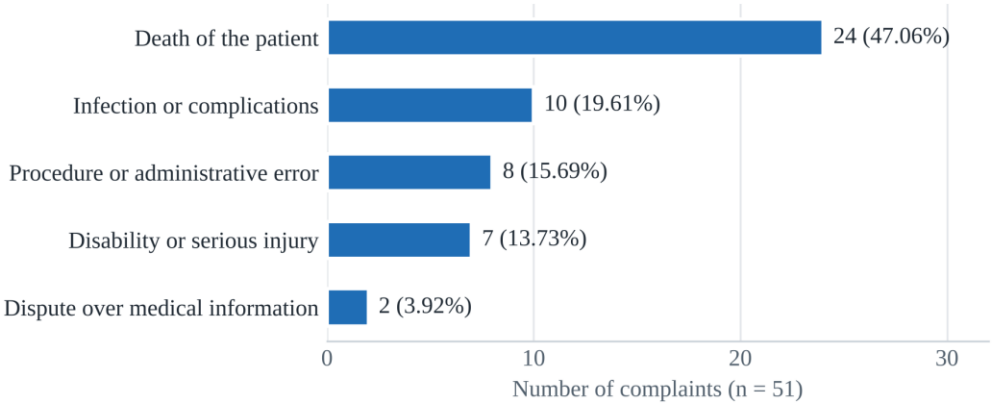


Figure 1. Complaints of alleged malpractice and patient-safety incidents by type of harm, 2023–2025 (n = 51). Source: [3]; percentages calculated by the authors.

Figure 1 shows the type of harm in the 51 complaints reported by the Minister. Death accounts for 24 complaints (47.06%) and procedure or administrative error for 8 (15.69%) [3]. The data do not say which hospital was complained about, which right was violated, or how the complaint ended, so they cannot be used to judge whether sanctions were imposed.

4.5 A legal-politics perspective

The findings can be read through Tanjung's thinking. The Health Law was made by the omnibus method, which the Constitutional Court accepted as formally valid [33]. Tanjung and Arminsyah warn that broad government power to change regulations is a legitimacy risk [15]. Here the law only says that violation of hospital duties incurs administrative sanctions under regulations, and the measure of the sanctions sits in Article 853 of a government regulation [11], [21]. No criteria for choosing among reprimand, fine and licence revocation were found in the article read, so the choice rests with the licensing official, which in the Jayapura incident is the district health office [27]. Tanjung's study of judicial oversight observes that supervision of judges is divided among several bodies [16]. Hospitals also have many overseers, namely

the central, provincial and district/city governments, the health office, the council and the courts, and in the authors' reading the division of authority among them needs to be clarified.

Tanjung's work on penal and non-penal measures and an integrated approach [17], [18] fits the incidents studied. The Ministry of Health's response to the Jayapura incident was largely non-penal: guidance, an evaluation within three months, hospital-based specialist education and BPJS payment of costs [29]. The criminal threat exists but was not used in the reports read. A hospital is therefore most likely to change through a combination of certain sanctions and available capacity, and not through either alone.

The recent study by Tanjung with Arminsyah and Syam offers a model for Article 310: an out-of-court body resolves the dispute, while the court supervises, legalises and enforces the result, with synchronised regulation [19]. In the Health Law, out-of-court resolution is required first, but the article read does not say who runs it, how an agreement is enforced, and how it relates to the council's recommendation. Applying that model to disputes between patients and hospitals is the authors' proposal, not a finding of that study.

4.6 Recommendations

Five steps follow from the analysis. First, hospitals need a written emergency protocol that requires stabilisation before referral, bars administrative matters and down payments from delaying help, and confirms that the receiving hospital accepts the patient before the patient is moved, together with live capacity and on-call specialist data in the referral system. Second, implementing regulations should clarify whether Article 193 covers violations of rights that are not negligence, and whether the exemption in Article 275(2) protects the hospital. Third, written criteria for choosing an administrative sanction and a duty to publish the outcome are needed, so that sanctions can be predicted and tested. Fourth, it should be made clear whether a claim against the hospital alone needs a council recommendation, who runs out-of-court resolution, and how its outcome is enforced. Fifth, the state should meet capacity needs, especially obstetric and anaesthesia specialists outside Java, and publish complaint data by hospital, right violated and final outcome.

Conclusion

First, the Health Law details patient rights (Article 276) and hospital duties (Article 189(1)) but does not link them expressly. Only emergency care has an explicit prohibition, a duty of first aid and a criminal penalty, so violations of the rights to information, consent or the medical record are reached only by general administrative sanctions and civil claims.

Second, the legal consequences for a hospital are layered: administrative sanctions from reprimand to licence revocation (Article 189(2), Government Regulation 28/2024 Article 853), civil liability for the negligence of its human resources (Article 193), and criminal penalties for heads and personnel (Article 438). The gaps are the sanction criteria that were not found, the clarity of the civil route and the role of the council's recommendation, a criminal subject that is a person, and a reduction of 75.00% in the fine in paragraph (1) by the authors' calculation. In the Jayapura incident no sanction had been imposed when the last report was read, and the specialist shortage (a gap of 30,546, or 39.16% of need) was a contributing cause.

Third, the authors recommend an emergency protocol and referral data in hospitals, clarification by implementing regulations of Articles 193 and 275, written sanction criteria, a clear dispute-resolution route, and state provision of capacity. Further research should read the official text of the Health Law and its implementing rules in full, obtain decisions applying Article 193 from the Supreme Court Decision Directory, and trace the final outcome of the sanctions in the Jayapura incident.

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