Legal Protection of Patients against Delayed Emergency Care Caused by Administrative Requirements in Hospitals

Viora Hertinda, Henry Aspan, Sutiarnoto

Abstract

Emergency care demands immediate help, yet hospitals also handle registration, verification of financing and payment. This study analyses how the hospital's duty to provide emergency care is regulated and what legal protection patients have when care is delayed by administrative requirements. It uses normative legal research that is descriptive and analytical, with statutory, conceptual and limited case approaches, based on library and document study. Article 174 of Law No. 17 of 2023 on Health and Article 836 of Government Regulation No. 28 of 2024 do not forbid administration, but forbid refusing a patient, asking for an advance payment and putting administrative matters first so that care is delayed. The third prohibition did not exist in the earlier law. Preventive protection comes from the financing guarantee in Presidential Regulation No. 82 of 2018 and from ministerial circulars, while repressive protection is spread over administrative sanctions, civil claims and criminal law. The gaps are that no criteria for choosing an administrative sanction were found, that Article 438 is worded as failing to give first aid so that a delay ending in help is not clearly covered, and that by the authors' calculation the fine in paragraph (1) falls by 75.00% if the fine categories of Law No. 1 of 2026 are applied. The study concludes that patients are protected at the level of the norm, but certainty of sanction and remedy is incomplete.

Keywords*: emergency care; administrative requirements; advance payment; legal protection of patients; hospital*

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Introduction

Article 28H(1) of the 1945 Constitution of the Republic of Indonesia guarantees everyone the right to health services, and Article 28I(4) makes the protection and fulfilment of human rights a responsibility of the state, above all the government [1]. In an emergency, that right means a right to help that does not wait. Minister of Health Regulation (MoH Reg.) No. 47 of 2018 on Emergency Services defines an emergency as a clinical condition that needs immediate medical action to save life and prevent disability [2]. Article 174(1) of Law No. 17 of 2023 on Health (the Health Law) obliges health facilities owned by the central government, regional governments and the community to serve patients in that condition by putting the saving of life and the prevention of disability first [3], [4].

A hospital does not only save lives. It also registers patients, checks identity and health-insurance membership, and bills for costs. The legal problem arises when those matters are put in front of help. Article 174(2) of the Health Law forbids a facility to refuse a patient, ask for an advance payment and put administrative matters first so that care is delayed [4], and Article 836(2) of Government Regulation (GR) No. 28 of 2024 contains a similar prohibition for hospitals [5]. The phrase "so that care is delayed" (*sehingga menyebabkan tertundanya*) shows that what is forbidden is an order of work that delays help, not administration itself. The line needs to be drawn carefully, because not every administrative process in an emergency department is unlawful.

Reported events show what is at stake. In September 2017 the death of baby Tiara Debora at a hospital in Kalideres, West Jakarta, was reported; she allegedly did not receive intensive care because the advance payment was not enough, while the hospital denied this and said it had given optimal medical action [6], [7]. The Jakarta Health Office then issued a written reprimand and signed a memorandum of understanding with 187 hospitals not to collect advance payments from emergency patients [6]. In November 2025 the Ministry of Health stated that the fourth hospital a pregnant woman was taken to in Jayapura required completion of administration and a payment of IDR 4 million before treating her, and stressed that emergency patients must not be subjected to administration first [8]. Both are allegations according to press reports and government statements, not facts tested in court.

Recent policy adds complexity. Ministry of Health Circular No. HK.02.02/D/539/2026 forbids hospitals to refuse patients whose National Health Insurance (*Jaminan Kesehatan Nasional*, JKN) membership has been temporarily deactivated, for up to three months from deactivation, but still requires hospitals to handle administration accountably, including verification of membership and submission of claims [9]. In other words, administration is not abolished. What is regulated is when administration is done, and that limit is not detailed in the articles the authors read.

Earlier studies approach the problem from criminal law and informed consent. Fahruddin et al. discuss the criminal liability of hospitals for refusing emergency patients [10], while Carlos et al. and Chairul, Risdawati and Aspan discuss informed consent in emergencies and the protection of patient rights [11], [12]. In the sources reviewed, the authors found no study that maps administrative acts by their position relative to help, that is, which are forbidden, which are allowed once the patient is under control and which may run alongside, and then assesses patient protection by preventive, repressive and remedial routes. That is the novelty of this article.

This article asks two questions. First, how is the hospital's duty to provide emergency care regulated? Second, what legal protection is available to patients whose emergency care is delayed by administrative requirements? The aim is to explain the limit of lawful administration, assess the protection available and identify the gaps and ways to close them.

Literature Review

2.1 Legal protection, legal certainty and hospital responsibility

Hadjon distinguishes preventive legal protection, which gives the people an opportunity to voice their views before a government decision becomes final so that disputes can be prevented, from repressive legal protection, which aims to settle disputes that have already arisen [13]. The formulation was made for the relationship between the people and the government. In this article the authors adapt it to the relationship between patient and hospital: preventive protection is the norms, financing guarantees and procedures that prevent delay, while repressive protection is the sanctions and remedies after a delay has occurred. This adaptation is the authors' choice.

The Health Law details patient rights, among them the right to services that fit medical needs, professional standards and quality (Article 276 letter c), and states that a hospital is legally responsible for all losses caused by the negligence of its human resources (Article 193) [4]. In this article legal certainty is understood operationally: hospitals, health workers and patients can know in advance which administrative acts are forbidden, when administration may be done and what follows a violation.

2.1 Earlier studies on emergency patients and patient rights

Fahruddin et al. (Universitas Sriwijaya, 2026) use statutory, conceptual and case approaches. They conclude that refusal caused by financial and administrative standard operating procedures (SOPs) can be qualified as a criminal omission and as conditional intent, that hospitals can bear corporate criminal liability under the Health Law, and propose the concept of *Corporate Administrative Malice* with a three-part test of triage objectivity, corporate capability and hypothetical causality. They also argue that criminal law should shift from *ultimum remedium* to *premium remedium* to protect the right to life [10]. This article uses the findings and concepts of that study but does not rely on its criminal-article references.

Carlos, Risdawati and Simarmata (2025), lecturers at Universitas Pembangunan Panca Budi, use empirical legal research with interviews, observation and a literature review. They find that the Health Law gives a legal basis to act without prior consent in an emergency, with obstacles in the form of limited medical documentation, low public understanding of emergency procedures and difficulty applying consent SOPs in emergencies [11]. Chairul, Risdawati and Aspan find that informed consent is now mandatory and legally well founded, but its application is hindered by administrative formalism, limited patient understanding, information imbalance, weak communication and weak institutional oversight. They argue that substantive rather than merely formal application better protects patients and health workers [12], [14]. Both studies concern informed consent. This article does not make it the main object and uses their findings for one point only, that a document that looks like a precondition can displace substantive protection.

Farhan, Sahlepi and Risdawati find that policies supporting the right of patients with mental disorders to health services in hospitals exist but are weakly applied [15]. Adrianto, Sumarno and Zarzani find a large gap between regulation and practice in the protection of health workers in remote areas, with weak coordination among institutions [16]. Sinaga, Zarzani and Sahlepi, in a study of medical disputes between midwives and patients, find that the shift from litigation to non-litigation has not been accompanied by norms on institutional roles and technical procedures [17].

2.2 Legal politics, criminal policy and oversight

The analytical framework draws on Tanjung's studies with co-authors. Tanjung and Arminsyah argue that a non-transparent omnibus process with minimal public participation weakens legitimacy, and that the breadth of the government's power to change regulations is a risk [18]. Tanjung, Syahnan and Syahputra judge that Government Regulation in Lieu of Law No. 2 of 2022 met the requirement of compelling urgency under Article 22(1) of the 1945 Constitution, but note concerns about subjectivity and potential abuse of power in its issuance,

and suggest House of Representatives approval that involves wider and more transparent stakeholders [19]. Tanjung examines the supervision of judges by the Judicial Commission and notes that other institutions also hold supervisory powers [20]. In studies of cybercrime (with Adriani) and narcotics trafficking, he analyses penal and non-penal efforts, and the narcotics study proposes an integrated approach of prevention, enforcement, therapy and rehabilitation [21], [22]. The latest study with Arminsyah and Syam proposes a model in which the National Sharia Arbitration Board settles sharia economic disputes through arbitration while the courts supervise, ratify and execute the awards, together with regulatory synchronisation [23].

Studies by other lecturers in the same institution complete the framework. Suwarto, Sutiarnoto and Magda judge that criminal law policy on digital crime in the era of artificial intelligence is still reactive, fragmented and based on classical thinking, which makes it hard to formulate offences, assign liability and prove cases; they suggest harmonising norms, strengthening accountability models and integrating penal and non-penal policy [24]. Mahruzar, Simarmata and Sahlepi find a conflict of norms between general criminal law and newer, more specific legislation in the legal protection of doctors, and see criminal law as a last resort [25]. Zarzani, Ismaidar and Sihombing study corporate criminal liability and note that Law No. 32 of 2009 raises the maximum fine by one third when an offence is committed by or on behalf of a legal entity [26].

Research Method

This is juridical-normative legal research that is descriptive and analytical, with statutory, conceptual and case approaches, the last limited to case documents. The primary legal materials are Articles 28H(1) and 28I(4) of the 1945 Constitution [1]; Articles 174, 189, 193, 275, 276, 296, 308, 310 and 438 of the Health Law [4]; Articles 836 and 853 of GR 28/2024 [5]; MoH Reg. 47/2018 [2]; Articles 63, 68 and 79 of Presidential Regulation (Perpres) No. 82 of 2018 on Health Insurance [27] and its third amendment [28]; Articles 32 and 190 of Law No. 36 of 2009 on Health (Law 36/2009) as a comparison [29]; Articles 36, 45, 46, 48 and 187 of the Criminal Code (KUHP) [30]; Article II(5) of Law No. 1 of 2026 on Criminal Penalty Adjustment [31]; and Article 1 of Law No. 37 of 2008 on the Ombudsman [32]. The secondary materials are journal articles, including the studies by Universitas Pembangunan Panca Budi lecturers cited above, legal commentary and press reports. The materials were collected through library and document study and analysed qualitatively with systematic legal reasoning: grammatical interpretation of the wording of the prohibitions, comparison of the wording of Law 36/2009 and the Health Law, and systematic interpretation across the law, government regulation, ministerial regulation and presidential regulation.

The authors found no court decision applying Article 174(2) of the Health Law, Article 836(2) of GR 28/2024 or Article 438. The case approach therefore uses two events (Jakarta 2017 and Jayapura 2025) and one policy (2026) as case documents, in the form of government statements as reported. The study did not conduct interviews, observation or surveys. The analysis uses one simple measure calculated by the authors: the change in the criminal fine equals the fine after adjustment minus the original fine, divided by the original fine.

The study has limitations. First, the official texts of the Health Law and GR 28/2024 on government sites could not be opened when read, so the articles were read from Pasal.id; the text there contains character errors, Article 189 shows only paragraph (2), and Article 438 shows only paragraph (1), so paragraph (2) was read from two other sources [33], [34]. Second, the definition of an emergency in Article 1 of the Health Law was not legible, so the definition was read from MoH Reg. 47/2018. The articles of the 1945 Constitution were read from a single-text compilation published by the Constitutional Court that states it is not an official text [1]. Third, the status of MoH Reg. 47/2018 against newer regulations was not checked in primary sources, and Articles 63, 68 and 79 of Perpres 82/2018 were read from a text downloaded from the Audit Board (BPK) database; Perpres 59/2024 does not amend them, but amendments by Perpres 75/2019 and Perpres 64/2020 were not checked. Fourth, the fine after

criminal-penalty adjustment was read from one legal commentary [34] and matched to the categories in Article II(5) of Law 1/2026; Annex I of that law was not legible, so the inclusion of Article 438 in it is not confirmed. Articles 36 and 187 of the KUHP were read from the original text, while Pasal.id notes that Law 1/2026 has amended the KUHP and no consolidated text is available. Fifth, Article 190(1) of Law 36/2009 was read from Pasal.id with the word "and" between imprisonment and fine, while the 2017 commentary paraphrases it as "and/or"; this article uses the Pasal.id text, and paragraph (2) was read from the 2017 commentary [7], [29]. Sixth, the events studied are allegations according to press reports; the final audit result of the Jakarta event and the later legal process were not read by the authors, while the final sanctions in the Jayapura event were not found. Seventh, the authors have no data on the number of complaints of delay caused by administration, so this article does not conclude how often delay occurs. Finally, the informed-consent studies cited are not the object of this research.

Results and Discussion

4.1 Legal regulation of the hospital's duty in emergency care

Table 1 maps the norms that determine the hospital's duty and the position of administration in emergency care. The regulation is layered, from the constitution, statute, government regulation and ministerial regulation to the presidential regulation on health insurance and the circular.

Table 1. Map of norms on duties and prohibitions in emergency care

Instrument and article	Content of the provision	Meaning for administrative matters
1945 Constitution, Articles 28H(1) and 28I(4)	Right to health services; protection, promotion, enforcement and fulfilment of human rights are the responsibility of the state, above all the government [1]	Constitutional basis for assessing administration that delays help
Health Law, Article 174(1)	Health facilities owned by the central government, regional governments and the community must serve emergency patients by putting the saving of life and the prevention of disability first [4]	Help is the first duty; administration is not named as a condition
Health Law, Article 174(2)	Forbidden to refuse patients, ask for advance payments and put administrative matters first so that care is delayed [4]	Three prohibitions; the third depends on the effect of delayed care
Health Law, Article 275	Paragraph (1): medical personnel and health workers in a facility must give first aid to emergency and/or disaster patients; paragraph (2): workers who save life or prevent disability are exempt from claims for compensation [4]	Workers who help first are protected; the article does not name hospitals
GR 28/2024, Article 836	Paragraph (1): hospitals give emergency care in accordance with their service capability in the emergency department as triage and life-saving or disability-preventing action; paragraph (2): forbidden to refuse patients, ask for advance payments and put administrative matters first so that care is delayed; paragraph (3): in accordance with statutory regulations [5]	Triage, not registration, is the first act named; the duty is limited by service capability
MoH Reg. 47/2018, Article 1(3), Article 3 and Article 12(2)	Definition of an emergency; criteria of threat to life, airway, breathing or circulation problems, decreased consciousness, haemodynamic disturbance or need for immediate action; the physician in charge determines whether the criteria are met [2]	Emergency status is determined by medical personnel, not administrative staff

Instrument and article	Content of the provision	Meaning for administrative matters
Perpres 82/2018, Articles 63, 68(2) and 79	Emergency participants can be served directly at any facility, contracted or not, without referral; facilities may not charge participants; non-contracted facilities bill BPJS Kesehatan through cost reimbursement; once the condition is controlled the patient is referred to a contracted facility [27]	Card, referral and contract are not conditions of help; the cost risk moves to the payer
Ministry of Health Circular HK.02.02/D/539/2026	Hospitals may not refuse patients with temporarily inactive JKN membership for up to three months; emergency care and life-saving action are prioritised; administration, coding, reporting and claims are still handled [9]	Administration remains mandatory but must not delay patients; no sanction stated

Note: the third column is the authors' reading. Articles 63, 68 and 79 of Perpres 82/2018 are not amended by Perpres 59/2024 [28]; amendments by other regulations were not checked.

The relationship between Article 174 of the Health Law and Article 836 of GR 28/2024 is that of a basic norm and an implementing norm. Article 174 applies to health facilities in general, while Article 836 is addressed to hospitals and adds two things: care "in accordance with its service capability" and the naming of triage and life-saving action as the forms of care in the emergency department [5]. The prohibitions in paragraph (2) of both articles are almost identical, so the government regulation does not change the content of the prohibition; it ties it to hospitals and to service capability. In the authors' reading, naming triage as the first act shifts the starting point of the duty: emergency care begins at triage, not at the registration desk.

Table 2 compares the wording of Law 36/2009, which the Health Law declared no longer valid [35], with the current wording. The most important difference is in the third prohibition. Article 32(2) of Law 36/2009 only forbade refusing patients and asking for advance payments [29], while Article 174(2) adds a prohibition on putting administrative matters first. In the authors' reading, the addition extends the prohibition from two easily recognised acts, refusing and taking money, to all administrative matters, including those that are not payments, such as verification of membership or filling in forms. The extension is also conditional: an administrative matter is forbidden only if it delays care.

Table 2. Comparison of the wording of Law 36/2009 and the Health Law on emergency care

Element	Law 36/2009	Health Law and GR 28/2024
Duty of care	Article 32(1): care to save life and prevent disability first [29]	Article 174(1): putting the saving of life and the prevention of disability first [4]; GR 28/2024 Article 836(1): triage and life-saving action [5]
Prohibitions	Refusing patients and asking for advance payments (Article 32(2)) [29]	Refusing patients, asking for advance payments and putting administrative matters first so that care is delayed (Article 174(2)) [4]
Element of criminal fault	Article 190(1): "intentionally" failing to give first aid [29]	Article 438: the word "intentionally" does not appear in the text read [4]
Criminal subject	Head of the health facility and/or health worker [29]	Head of the health facility, medical personnel and/or health workers; paragraph (2) for the head of the facility [4], [33]
Penalty, paragraph (1)	Imprisonment of up to 2 years and a fine of up to IDR 200 million [29]	Imprisonment of up to 2 years or a fine of up to IDR 200 million; IDR 50 million after criminal-penalty adjustment (−75.00%) [4], [34]

Element	Law 36/2009	Health Law and GR 28/2024
Penalty if disability or death	Imprisonment of up to 10 years and a fine of up to IDR 1 billion [7]	Imprisonment of up to 10 years or a fine of up to IDR 2 billion (+100.00% from IDR 1 billion); unchanged at IDR 2 billion after adjustment (0.00%) [33], [34]

Note: percentages are calculated by the authors; Law 36/2009 was declared no longer valid by the Health Law [35]. Article 190(1) was read from Pasal.id ("and"), while the 2017 commentary paraphrases it as "and/or"; paragraph (2) was read from the 2017 commentary, and the values after adjustment from one legal commentary that was not matched against Annex I of Law 1/2026.

The phrase "in accordance with its service capability" marks the limit of the duty. In the authors' reading, a hospital that is unable, for example because there is no anaesthetist or the operating room cannot be used, does not breach the prohibition in paragraph (2) merely because it cannot treat, but the duty of triage and life-saving action remains, and referral is reasonable only after the patient is stabilised [8], [10]. The distinction matters because delay caused by capacity and delay caused by administration have different legal consequences. The first tests capability and the accuracy of referral, the second tests breach of the prohibition. The Jayapura event contains both in one sequence: the first three hospitals could not help because of doctors, anaesthesia or operating rooms, while the fourth hospital directed the patient to a paid room because class 3 was full [8].

Financing reasons are also closed by the health-insurance regulation. Under Perpres 82/2018, a participant who needs emergency care can obtain care directly at any health facility, contracted or not, without a prior referral (Article 63(1)); a facility may not charge the participant for emergency care (Article 68(2)); and a non-contracted facility bills BPJS Kesehatan through cost reimbursement at a rate equivalent to the rate in force in that region (Article 79) [27]. Perpres 59/2024 is the third amendment of that regulation and, according to the text read, does not change those three articles [28]. As a result, the financial risk moves from the patient to the payer, and a hospital that asks a JKN participant for an advance payment breaches not only Article 174(2) but also Article 68(2) of that Perpres. For patients who are not participants, the articles read do not say who bears the cost.

From these norms, the position of administrative matters can be mapped by timing. Figure 1 arranges an order consistent with the texts read: triage and life-saving action first without administrative preconditions; administration, verification of membership and referral after the condition is controlled; billing and claims afterwards. That order is the authors' reading of Article 836(1) of GR 28/2024, Articles 63(5) and 79 of Perpres 82/2018 and the 2026 circular, not the wording of one article. The Ministry of Health's statement that emergency patients must not be subjected to administration first and must be helped first [8] is consistent with that order.

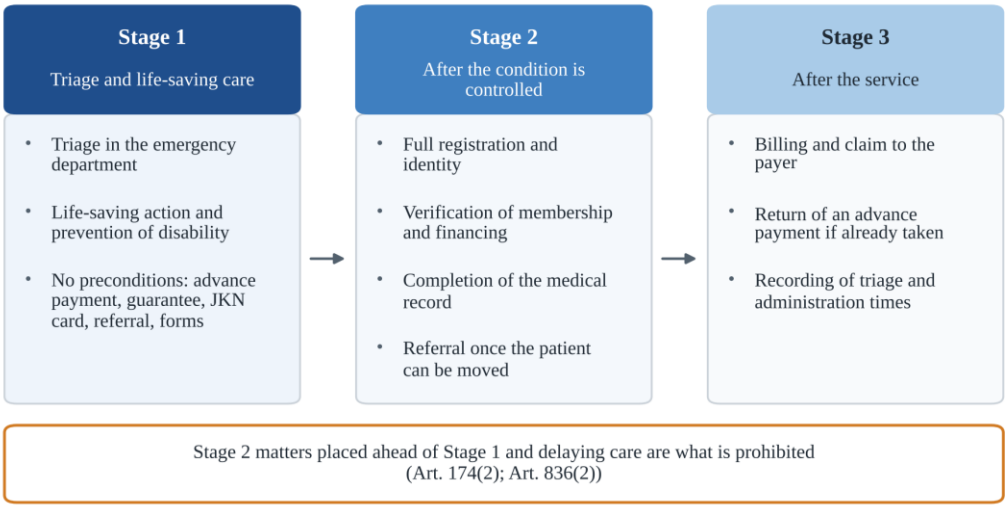


Figure 1. Order of emergency care and the place of administrative matters. Prepared by the authors based on [4], [5], [9], [27]; the order is the authors' reading.

Table 3 details the position of nine administrative acts. Three notes can be added. First, the measure of breach is order and effect, not the type of document. Article 174(2) speaks of "so that care is delayed" [4], so registration that runs together with triage or follows life-saving action does not breach that prohibition; in the authors' reading, that is where lawful administration has room. Second, an administrative breach does not require the patient to die. The element of effect is the delay of care, while death or disability is relevant for criminal law (Article 438(2)) and for compensation. Third, the person who determines emergency status is the physician in charge, using clinical criteria [2], [27]; in the authors' reading, administrative staff have no authority to judge that a condition is not yet an emergency in order to ask for requirements first.

Table 3. Administrative acts by their position relative to help

Act	Position	Basis and notes
Asking for an advance payment or payment guarantee before care	Forbidden	Health Law Article 174(2) and GR 28/2024 Article 836(2) [4], [5]
Refusing a patient for lack of a JKN card, referral, or because the facility is not contracted	Forbidden	Emergency participants can be served directly at any facility without referral (Perpres 82/2018 Article 63(1)) [27]; reasons such as lack of BPJS or identity do not remove the unlawful nature of refusal according to Fahruddin et al. [10]
Delaying triage or action until registration, forms or financing verification are done	Forbidden if it delays care	Article 174(2) and Article 836(2); triage is the first act in Article 836(1) [4], [5]
Directing a patient to a paid class or room as a condition of treatment	Forbidden if it delays help	Jayapura event: according to the Ministry of Health, no reason, including a full class 3 and administration, allows refusing an emergency patient [8]
Recording minimum identity and creating the medical record	Allowed, must not come first	A medical record must be created and promptly completed once the patient has finished receiving care (Health Law Article 296(1) and (3)) [4]
Verifying JKN membership and financing scheme	Allowed once help has begun	Hospitals still handle administration and coordinate with BPJS Kesehatan to verify membership and financing [9]
Referring to another facility	Allowed once the condition is controlled	A patient at a non-contracted facility is referred once the condition is controlled and the patient can be moved (Perpres 82/2018 Article 63(5)) [27]; referral without stabilisation is assessed as refusal by Fahruddin et al. [10]
Billing or submitting a claim	Allowed after the service	Claim to BPJS Kesehatan (Perpres 82/2018 Article 79) [27]; in the Jakarta 2017 event the advance payment already received was asked to be returned [36]; no rule was found for non-participants
Informed consent	Must not delay life-saving action	The Health Law gives a basis to act without prior consent in an emergency according to Carlos et al. [11]

Note: the classification of positions is the authors' reading of the texts read; the texts contain no list of administrative acts. Sources: as cited in the table.

Informed consent, often seen as a precondition, is given a way to act first in an emergency according to Carlos et al., who also note obstacles in documentation and SOPs [11]. Chairul et al. note administrative formalism as an obstacle to substantive protection in applying informed consent [12]. The same pattern can occur in emergency care: a document that should serve help turns into its obstacle. The distinctions in Table 3 are therefore not a technical matter but a question of which way a document serves.

4.2 Legal protection of patients against delayed care caused by administrative requirements

Table 4 maps legal protection by route. Preventive protection, which prevents delay before it happens, consists of prohibition norms in the law and government regulation, the financing guarantee in Perpres 82/2018 that moves the cost risk to the payer, and policies such as the Jakarta Health Office memorandum of understanding in 2017 and the 2026 circular [6], [9]. Repressive protection consists of administrative sanctions, civil claims and criminal law, together with remedies and complaints.

Table 4. Routes of legal protection for patients and their gaps

Route	Basis and content	Target	What remains unclear
Preventive: norms	Prohibitions in Article 174(2) and Article 836(2); emergency criteria and determination by the physician in charge [2], [4], [5]	Hospitals and staff	No list of forbidden administrative acts found; the line is drawn by interpretation
Preventive: financing and policy	Guarantee of emergency costs and cost reimbursement to non-contracted facilities [27]; 2026 circular for temporarily inactive JKN [9]; 2017 Jakarta memorandum of understanding with 187 hospitals, and a circular, mentioned in press reports, under which non-compliant hospitals could lose the recommendation for licence renewal [6]	JKN participants; hospitals	Financing of non-participant patients not found; the Jakarta policy applied in one province in 2017
Repressive: administrative	Article 189(2) of the Health Law; Article 853 of GR 28/2024: oral reprimand, written reprimand, administrative fine and/or revocation of the business licence, imposed by the central, provincial or regency/city government according to authority [4], [5]	Hospitals	Criteria for choosing a sanction and the amount of the administrative fine not found
Repressive: civil	Article 193: a hospital is responsible for losses caused by the negligence of its human resources; tort claim under Article 1365 of the Civil Code [4], [10]; Article 275(2): workers who save life are exempt from claims for compensation	Hospitals; workers	Proof of causation; unclear whether Article 275(2) protects hospitals
Repressive: criminal	Article 438(1) and (2) [4], [33]; Articles 36 and 187 of the KUHP: negligence punishable only when expressly provided; Articles 45, 46 and 48 of the KUHP: corporations as subjects [30]	Heads and workers; corporations under the KUHP	A delay that ends in help is not clearly “failing to give”; application to hospitals not found in decisions
Remedies and complaints	Return of the advance payment [36]; Article 308(2): council recommendation before a civil suit against a worker; Article 310: out-of-court settlement first for alleged worker fault [4]; health office and Ministry of Health receive reports [6], [9]; Ombudsman [32]	Patients and families	Articles 308 and 310 speak of workers, not hospitals; Ombudsman reach over private hospitals not determined; first complaint channel not stated

Note: the last column is the authors’ reading of the texts read. Sources: as cited in the table.

The weakness of the preventive route lies in detail. The articles read contain no list of forbidden administrative acts, so hospitals interpret the line themselves. Fahruddin et al. place financial and administrative SOPs as a source of refusal [10]; the content of SOPs, not only norms, is therefore the prevention point closest to the patient. The 2026 circular closes the reason of temporarily inactive membership but names no sanction [9], and the 2017 Jakarta circular applies in one province [6].

On the administrative route, Article 189(2) of the Health Law states that a breach of a hospital’s obligations is subject to administrative sanctions under statutory regulations, and

Article 853(1) of GR 28/2024 details oral reprimand, written reprimand, administrative fine and revocation of the business licence, the last two of which can be imposed alone or together, by the central, provincial or regency/city government according to authority [4], [5]. In the authors' reading, the prohibition in Article 836(2) lies within the range of articles that are the basis for those sanctions. Administrative sanctions fit delay caused by administration best, because what must be proved is order and effect of delay, not the cause of death. The articles read contain no criteria for choosing a sanction and no amount of administrative fine, so the choice between a reprimand and licence revocation depends on the competent official. In the Jakarta 2017 event, the sanctions reported were a written reprimand and the management restructuring that Commission IX of the House asked to be carried out [6], [37]; in the Jayapura event, the Ministry of Health referred to graduated sanctions from guidance to licence revocation determined by the health office as the licensing authority [8].

On the civil route, Article 193 makes a hospital legally responsible for all losses caused by the negligence of its human resources [4], and Fahruddin et al. name a tort claim under Article 1365 of the Civil Code as a route of recovery [10]. The plaintiff must prove an unlawful act, which can be a breach of the prohibition in Article 174(2), fault or negligence, loss and causation. Causation is the hardest, because the plaintiff must show that the administrative delay, and not the original clinical condition, caused or worsened the loss. Fahruddin et al. propose a hypothetical causality test [10], which in the authors' reading means assessing whether the patient would have survived had help been given on time. Two points remain unclear. Article 275(2) exempts workers who save a life from claims for compensation, but the article read does not say whether the exemption protects the hospital. Article 308(2) requires a recommendation from the council before a civil suit against a health worker, and Article 310 requires out-of-court settlement first for alleged fault of a health worker [4]; those articles speak of workers, so it is unclear whether a claim against a hospital that follows a delay SOP must pass through that route.

On the criminal route, Article 438(1) threatens the head of a health facility, medical personnel and/or health workers who fail to give first aid to an emergency patient with imprisonment of up to two years or a fine, and paragraph (2) threatens the head of the facility with imprisonment of up to ten years or a fine if the result is disability or death [4], [33]. Three problems of interpretation arise. First, the wording is "fail to give first aid", while Article 174(2) forbids "putting administrative matters first" so that care is "delayed". Article 438 refers to Article 174 without pointing to a paragraph [4], but a delay that ends in help does not automatically mean not giving help. In the authors' reading, a delay that ends in help is better met with administrative sanctions, while a delay that continues until help is never given is closer to the criminal wording; the line between them has not been tested in any decision the authors found.

Second, the element of fault. Article 190(1) of Law 36/2009 contains the word "intentionally" [29], while the text of Article 438 read does not [4]. Article 36 of the KUHP states that negligence is punishable only when expressly provided by law, and Article 187 applies the general provisions of Book One to offences in other laws unless otherwise provided [30]. In the authors' reading, without mention of negligence, intent remains a requirement. A head who sets an advance-payment SOP can be seen as acting with conditional intent, as Fahruddin et al. propose [10], while a worker who carelessly follows the order is harder to reach; in doctrine conditional intent is regarded as a form of intent, but the KUHP elucidation on this was not read. Third, the subject. Article 438 speaks of persons, while Articles 45, 46 and 48 of the KUHP make a corporation a subject of crime and allow its liability if the offence falls within its business, unlawfully benefits it, is accepted as policy, is allowed, or the corporation fails to prevent it [30]. A delay SOP is an example of corporate policy, but the application of those provisions to hospitals was not found in the decisions read, and the Article 438 read has no special corporate fine aggravation of the kind noted by Zarzani et al. for another law [26].

The fine threat has also changed. Article II(5) letters c and f of Law 1/2026 set fine category III for imprisonment of more than 1 to 3 years and category VI for more than 8 to 11 years [31], so, according to a legal commentary dated 10 June 2026, the fine in paragraph (1) is IDR 50 million and in paragraph (2) IDR 2 billion [34]. By the authors' calculation, the fine in paragraph (1) falls by 75.00% from IDR 200 million, while the fine in paragraph (2) stays at IDR 2 billion (0.00%). Compared with Article 190 of Law 36/2009, which according to the Pasal.id text uses the word "and" between imprisonment and fine [29], Article 438 uses "or" [4], so a judge can impose a fine alone. In the authors' reading, that combination weakens the deterrence of criminal law for delay that does not have a fatal result, so the burden of prevention rests on the administrative and financing routes.

On remedies and complaints, the concrete remedy found does not come from an article but from policy. In the Jakarta 2017 event, the Ministry of Health asked the hospital to return the advance payment it had received and to bill it to BPJS Kesehatan [36]. For complaints, the health office as licensing authority acted in both events [6], [8], the Ministry of Health said it would monitor and follow up reports of refusal [9], and the Ombudsman is authorised to supervise public services, including private bodies assigned public services and funded by the state or regional budget [32]; whether private hospitals that are JKN partners fall within that scope is not determined in the article read. The articles read do not say where a patient or family should complain first.

4.3 Comparative events

Table 5 summarises two events and one policy. The Jakarta 2017 and Jayapura 2025 events show two different forms of administrative element, namely an advance payment and a room payment offered after class 3 was full. In both, the responses reported were administrative and policy-based: reprimands, an audit, a memorandum of understanding and graduated sanctions. The Indonesian Advocates Council was reported to plan to report the Jakarta hospital to the police [7], but the follow-up was not read by the authors.

Table 5. Comparative events and policy

Event	Administrative element	Response reported	What is not known
Jakarta, Sep. 2017	Alleged delay of intensive care for a baby because the advance payment was not enough; the hospital had no cooperation with BPJS Kesehatan; the hospital denied this and said medical action was optimal [6], [7]	Written reprimand by the Jakarta Health Office on the Ministry of Health's recommendation; medical audit; memorandum of understanding with 187 hospitals; advance payment asked to be returned and billed to BPJS Kesehatan; management restructuring asked to be carried out by Commission IX of the House [6], [36], [37]	Final audit result and later legal process not read by the authors
Jayapura, Nov. 2025	Fourth hospital: class 3 full, patient directed to a VIP room of about IDR 3–4 million; according to the Ministry of Health the hospital required administration and a payment of IDR 4 million before treating her [8]	Ministry of Health: administration is not a reason to refuse an emergency patient; graduated sanctions from guidance to licence revocation, determined by the health office as licensing authority [8]	The three earlier hospitals failed for capacity, not administration; final sanctions not found
National, Feb. 2026	Temporarily inactive JKN membership; circular forbids refusal for up to three months and still requires administration and claims [9]	Ministry of Health will monitor and follow up reports of refusal [9]	No specific sanction stated

Note: all are allegations or statements as reported, not court decisions. Sources: as cited in the table.

Those responses fit the analysis above. Administrative sanctions can be imposed without proving the cause of death, while the criminal and civil routes demand proof of intent and causation that is difficult. The ban on advance payments has existed since Law 36/2009 [29], yet similar events were reported in 2017 and 2025. The number of events is unknown, so it cannot be concluded that the ban does not work; what can be said is that certainty of sanction in the events read was determined by officials outside the articles.

4.4 Legal-politics perspective

The findings above can be read through Tanjung's thinking. Tanjung and Arminsyah warn that the breadth of the government's power to change regulations is a risk to legitimacy [18]. Here, the law sets the prohibition, but its administrative sanctions are left to statutory regulations and their measure lies at the level of government regulation (Article 189(2) of the Health Law; Article 853 of GR 28/2024) [4], [5]. The criteria for choosing a sanction were not found in the articles read. In the authors' reading, those criteria need to be written so that sanctions can be predicted, which in the end is a matter of legal certainty for hospitals and patients alike.

Tanjung, Syahnan and Syahputra judge that compelling urgency can justify a departure from ordinary procedure, but flag the danger of subjectivity and abuse and therefore want more transparent ratification [19]. That study concerns government regulations in lieu of law, not hospitals, and the analogy that follows is the authors' proposal. An emergency justifies a departure from the ordinary administrative order, and the same danger can arise: emergency status can be judged subjectively by an interested party. Determination of an emergency by the physician in charge on clinical criteria [2] serves as an objective limit, and the departure is restored afterwards through a completed medical record (Article 296(3) of the Health Law) [4] and the claim.

Tanjung's study of the supervision of judges notes that oversight is divided among several institutions [20]. A similar pattern appears in patient protection: the central, provincial and regency/city governments under Article 853(2) of GR 28/2024, the health office as licensing authority, the Ministry of Health that receives reports of refusal, the Ombudsman, the police and the courts [5], [9], [32]. The findings of Adrianto et al. on weak coordination among institutions [16] and of Sinaga et al. on unclear institutional roles [17] are consistent with this.

Tanjung and Adriani analyse penal and non-penal efforts, and Tanjung's narcotics study proposes an integrated approach [21], [22]; Suwarto, Sutiarnoto and Magda suggest integrating penal and non-penal policy for digital crime [24]. For administrative delay, the non-penal route (prohibition, cost guarantee, administrative sanctions and remedies) carries the main burden, because the elements of Article 438 are narrow and its fine has fallen. Fahruddin et al. propose a shift to *premium remedium* [10], while Mahruzar, Simarmata and Sahlepi see criminal law as a last resort [25]. In the authors' reading, the two views can be reconciled in an integrated approach: administrative sanctions and remedies for delay without a fatal result, and criminal law for policies or acts that intentionally push help aside with a result of disability or death.

The model of Tanjung, Arminsyah and Syam, in which a body outside the court settles disputes while the courts supervise, ratify and execute the result, together with regulatory synchronisation [23], could be considered for Article 310, which requires out-of-court settlement first without naming the organiser or the execution of the result in the text read [4]. Applying that model to disputes between patients and hospitals is the authors' proposal, not a finding of that study. The finding of Farhan et al. that policies supporting patient rights exist but are weakly applied [15] is a reminder that a written norm does not necessarily become practice.

4.5 Recommendations

Five steps follow from this analysis. First, hospitals need emergency-department SOPs that place triage at the entrance, contain a list of administrative acts that must not come before help (Table 3), forbid advance payments and guarantees, train administrative staff, and record

the time of triage and the time administration is completed so that delay can be proved. Second, the Ministry of Health needs guidelines that detail the forbidden and permitted administrative acts, state who bears the cost of patients who are not JKN participants, and set criteria for choosing administrative sanctions and a duty to publish the outcome. Third, the norm needs to be clarified on whether a delay that ends in help falls within Article 438, whether the exemption in Article 275(2) protects hospitals, and whether a claim against a hospital requires a council recommendation and prior out-of-court settlement (Articles 308 and 310). Fourth, a clear patient complaint channel and a division of authority among the central, provincial and regency/city governments and the Ombudsman are needed, including a duty to publish the results of handling. Fifth, further research is needed that reads the official texts and Annex I of Law 1/2026, traces decisions and collects data on complaints of delay caused by administration.

Conclusion

First, the regulation of the hospital's duty in emergency care is layered: Article 174 of the Health Law requires care that puts the saving of life first and forbids refusing patients, asking for advance payments and putting administrative matters first so that care is delayed; Article 836 of GR 28/2024 ties that prohibition to hospitals, to service capability and to triage as the first act; and Perpres 82/2018 closes the reasons of membership, referral and contract. The third prohibition did not exist in Law 36/2009. Administration is not forbidden; what is forbidden is administration that comes before help and causes delay.

Second, legal protection of patients against delay caused by administrative requirements is available on the preventive route (prohibitions, financing guarantees, policy) and the repressive route (administrative sanctions, civil claims, criminal law), and as remedies such as the return of an advance payment. Administrative sanctions fit delay best because they do not require proof of the cause of death, but the criteria for choosing them were not found. The criminal provision in Article 438 is worded as failing to give first aid, so a delay that ends in help is not clearly covered, and by the authors' calculation the fine in paragraph (1) falls by 75.00% if the fine categories of Law 1/2026 are applied. A civil claim faces difficulty of causation and uncertainty about Articles 275(2), 308 and 310.

Third, patients are protected at the level of the norm, but certainty of sanction and remedy is incomplete. The authors recommend emergency SOPs that place triage first, guidelines on forbidden and permitted administrative acts, sanction criteria, clarity on Articles 438, 275, 308 and 310, and a clear complaint channel. Further research needs to read the official texts, trace decisions and collect complaint data.

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