# Legal Certainty of Nurses' Authority in the Conduct of Independent Nursing Practice

**Meydiana Putri Pratiwi, Sutiarnoto, Henry Aspan**

## Abstract

Independent nursing practice now operates under a new legal regime: Law No. 17 of 2023 on Health replaced the nursing law, and Minister of Health Regulation No. 13 of 2025 revoked the ministerial regulation that specifically governed nurses' independent practice. This study analyses how nurses' authority in independent practice is regulated and how certain the limits of that authority are in law. It uses normative legal research that is descriptive and analytical, with statutory, conceptual and limited case approaches, based on library and document study. The results show that a nurse's authority rests on competence, a registration certificate and a practice licence tied to the place of practice, with delegation by mandate or by delegation of authority. Practising without registration or a licence attracts administrative sanctions, while criminal penalties are aimed at people who are not health workers and at those who employ staff without a licence. Uncertainty lies in three matters: the list of procedures for each level of nurse, the requirements for an independent practice site, and the transitional norm, because, according to the summary the authors read, the transitional provision refers to earlier ministerial regulations although the nursing-specific regulation has been revoked. The study concludes that the basis of authority and sanctions is clear, but the limits of procedures and the transitional norm are not yet certain.

***Keywords****: legal certainty; nurse authority; independent nursing practice; practice licence; professional competence*

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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]. Nurses are among those who deliver those services. Law No. 17 of 2023 on Health (the Health Law) groups nursing personnel into vocational nurses, *ners* (professional nurses) and specialist *ners* (Article 199) [2], [3]. One form of nursing service is independent practice. According to a policy brief of the Directorate General of Advanced Health Services, independent nursing practice has been permitted since 2001 but is still little used, with licensing among the barriers [4].

The legal basis for that practice has changed. Law No. 38 of 2014 on Nursing is among the eleven laws declared no longer valid by the Health Law [5]. Minister of Health Regulation (MoH Reg.) No. 26 of 2019, which implemented that nursing law, regulated nurses' independent practice in Chapter V (Articles 37 to 51) [6]. According to the metadata in the database of the Legal Documentation and Information Network (JDIH) of the Ministry of Health, MoH Reg. 26/2019 is on the list of regulations revoked by MoH Reg. No. 13 of 2025 on Health Human Resources Management, promulgated on November 3, 2025 [7]; a commentary places that revocation in Article 309, with MoH Reg. 26/2019 as item 35 of 61 regulations [8]. Government Regulation (GR) No. 28 of 2024 contains the general provisions on the practice of medical personnel and health workers in Articles 739 to 746, and Article 746 leaves further provisions on the conduct of practice to a ministerial regulation [9].

The problem of legal certainty shows in the transitional provision. According to the secondary summary the authors read, Article 305(1) of MoH Reg. 13/2025 states that until the new professional standards, mandated by Article 174(3) of the same regulation, are set, the practice authority of medical personnel and health workers refers to the existing ministerial regulation for their profession [8]. At the same time, the ministerial regulation that most specifically governs nurses' authority and independent practice is revoked. In the authors' reading, the reference of Article 305 becomes unclear for nurses. The primary text of Articles 305 and 309 could not be opened when this study was made, so the conclusion on this point is conditional.

Earlier studies mostly discuss the delegation of medical acts to nurses. Putra et al. studied delegation in community health centres in Kerinci Regency [10]; Hertanto discusses legal responsibility in medical disputes arising from delegation after the Health Law [11]; Widyaningsih et al. and Praboandini and Jie discuss the responsibility and legal protection of nurses who carry out medical acts on delegation [12], [13]; and Kresnahadi discusses the legal uncertainty of delegating clinical mandate to nurse anaesthetists [14]. Lintang discusses the legal responsibility of independent-practice nurses for patient losses, but under the nursing law and MoH Reg. 26/2019, before the Health Law was issued [15]. In the sources reviewed, the authors found no study that assesses the legal certainty of the limits of nurses' authority in independent practice after the nursing law was replaced and the nursing-specific ministerial regulation revoked. That is the novelty of this article.

This article asks two questions. First, how is nurses' authority in conducting independent nursing practice regulated? Second, how certain in law are the limits of nurses' authority in providing health services through independent practice? The aim is to explain the limits of authority and the requirements of independent practice, to distinguish lawful practice from practice that breaks the law, and to identify points of uncertainty and ways to close them.

## Literature Review

### 2.1 Authority, competence and legal certainty

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 [16]. The formulation was made for the relationship between the people and the government. In this article the authors adapt it to nurses' practice: the preventive element is the norms that set who may practise and up to what limit, namely competence, registration, licensing and professional standards, while the repressive element is sanctions and dispute settlement after a violation. This adaptation is the authors' choice.

In this article authority means the lawful room for action of a nurse, which under Article 742 of GR 28/2024 must be based on the competence held [9]. Legal certainty is understood operationally: nurses, patients and licensing officials can know in advance (a) which acts fall within authority, (b) what must be met to practise, (c) what follows a violation, and (d) which norm applies during the transition. These four questions are used as the test in the discussion.

### 2.2 Earlier studies on nurses' authority and delegation

Putra, Afriwardi and Media (Universitas Bung Hatta, 2025) used a socio-legal approach in five community health centres in Kerinci Regency, with interviews and observation. They found that delegation of authority for medical acts to nurses had not been carried out in line with the health law and that most nurses and doctors did not delegate in writing [10]. Hertanto concludes, using statutory and case approaches, that under delegation by transfer of authority responsibility passes to the receiving nurse, while under mandate it stays with the doctor, and that instructions through messaging applications without integration into the electronic medical record risk being judged invalid; that study does not discuss independent practice [11]. Widyaningsih, Imbawani and Widodo discuss Article 290 of the Health Law and note that delegation often raises problems of disciplinary, civil and criminal responsibility for nurses, but do not discuss independent practice [12]. Praboandini and Jie name the conditions of delegation as written form, fit with competence, supervision, and exclusion of strategic medical decisions, and discuss Sidoarjo District Court Decision No. 1167/Pid.B/2010/PN.Sda [13].

Lintang studied independent-practice nurses under the nursing law and MoH Reg. 26/2019. She notes administrative, civil, criminal and moral sanctions, and discusses a nurse fined for practising without a permit, which in her view was an administrative violation, not malpractice [15]. Kresnahadi finds legal uncertainty in the delegation of clinical mandate in anaesthesiology because of disharmony among ministerial regulations and because the professional standard for nurses is general and lacks detail on competence [14]. The last two studies rest on the old regime or on a single field of service, so they do not answer the situation after MoH Reg. 26/2019 was revoked.

Studies by lecturers of Universitas Pembangunan Panca Budi complete the picture. 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 [17]. Sinaga, Zarzani and Sahlepi find that the shift in settling medical disputes between midwives and patients from litigation to non-litigation has not been accompanied by norms on institutional roles and technical procedures [18]. Chairul, Risdawati and Aspan find that informed consent is now mandatory and legally well founded but that its application is hindered by administrative formalism, limited patient understanding and weak oversight, and argue that substantive application protects patients and health workers better [19], [20]. Carlos, Risdawati and Simarmata find that the Health Law gives a basis to act without prior consent in an emergency, with obstacles of documentation and procedure [21].

### 2.3 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 [22]. 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, and suggest broader and more transparent approval by the House of Representatives [23]. Tanjung examines

the supervision of judges by the Judicial Commission and notes that other institutions also hold supervisory powers [24]. 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 [25], [26]. The latest study with Arminsyah and Syam proposes a model in which an arbitration body settles disputes while the courts supervise, ratify and execute its awards, together with regulatory synchronisation [27].

Suwarto, Sutiarnoto and Magda judge that criminal law policy on digital crime is still reactive and fragmented, and suggest harmonisation of norms, stronger accountability models and integration of penal and non-penal policy [28]. 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 [29].

## Research Method

This is normative legal research that is descriptive and analytical, with statutory, conceptual and case approaches, the latter limited to the decisions and case documents that could be read. The primary legal materials are Articles 28H(1) and 28I(4) of the 1945 Constitution [1]; Articles 199, 260, 263, 264, 290, 291, 308, 310, 312, 313, 439, 441, 442 and 449 of the Health Law [3]; Articles 735, 736, 739, 740, 742, 743, 745 and 746 of GR 28/2024 [9]; MoH Reg. 13/2025, read from metadata and a summary [7], [8]; Articles 3, 7, 8, 15 to 19, 26 to 28, 30 to 33, 37 to 51 and 54 of MoH Reg. 26/2019 [6]; and Minister of Health Decree No. HK.01.07/MENKES/425/2020 on Nursing Professional Standards [30]. The case documents are Constitutional Court (MK) Decision No. 12/PUU-VIII/2010 [31], [32], MK Decision No. 182/PUU-XXII/2024 [33], Purwokerto District Court Decision No. 229/Pid.Sus/2019/PN Pwt [34], and the service standard for practice licences in one regency [35]. The secondary materials are journal articles, including studies by lecturers of Universitas Pembangunan Panca Budi, and legal commentaries. The legal materials were gathered through library and document study and analysed qualitatively by grammatical interpretation of the wording of articles, systematic interpretation among statute, government regulation and ministerial regulation, and temporal interpretation to compare the old and new regimes.

This study did not conduct interviews, observation or surveys. The authors found no court decision that applies Article 312 letter c or Article 313 of the Health Law to a nurse, so the case approach uses two MK decisions, one district court decision on a person who is not a health worker, and one regional implementing document.

This study has limitations. First, the official text of MoH Reg. 13/2025 on the JDIH site of the Ministry of Health could be read only in part and the site of the Audit Board could not be opened, so Articles 305, 309, 149, 157, 158 and 176 to 178 were read from one secondary commentary that does not quote the full content of the articles [8]. The metadata say the regulation was enacted on October 8, 2025 and promulgated on November 3, 2025; one JDIH page shows a different enactment date, and one source calls number 902 a State Gazette while the JDIH page calls it an Official Gazette (*Berita Negara*), so this study uses *Berita Negara* [7]. The Pasal.id database lists only 28 revoked regulations, while the commentary says 61; both include MoH Reg. 26/2019. Second, the Health Law and GR 28/2024 were read from Pasal.id, with character errors in some text; Article 1, Article 454 and Article 744 of GR 28/2024 could not be read, and the revocation of the nursing law was read from a Hukumonline commentary [5]. Third, the copy of Ministerial Decree 425/2020 that was read is marked as a draft on its first page, and its status after the Health Law was not examined. Fourth, the full texts of the MK decisions were not read; Decision 12/PUU-VIII/2010 was read from an MK release, a Hukumonline report and a Pasal.id summary, and Decision 182/PUU-XXII/2024 from the official MK summary. Fifth, the Sidoarjo District Court decision and the case of the nurse who was fined were read only from the articles that discuss them, and the Purwokerto decision directory page does not give the basis of the charge. Sixth, the regional implementing document comes from one regency and cannot be generalised. Seventh, the authors have no data on the

number of independent nursing practices, so this article does not conclude how widespread the problem is.

## Results and Discussion

### 3.1 Regulation of nurses' authority in independent nursing practice

Table 1 maps the norms that determine the authority and requirements of nurses' independent practice. The regulation is layered: the constitution, statute, government regulation and ministerial regulation, down to the ministerial decree on professional standards.

**Table 1.** Map of the norms on authority and requirements of nurses' independent practice

| Instrument and article | Content of the provision | Meaning for independent practice |
|---|---|---|
| 1945 Constitution Articles 28H(1) and 28I(4) | The right to health services; protection and fulfilment of human rights are a responsibility of the state, above all the government [1] | Constitutional basis for access to services and certainty of rules |
| Health Law Article 199 | Nursing personnel consist of vocational nurses, *ners* and specialist *ners* [3] | Defines who is a nurse in law |
| Health Law Article 260 | An STR is mandatory; issued by the Council on behalf of the Minister; requires a diploma and a competence certificate; valid for life [3] | First basic requirement |
| Health Law Articles 263 and 264 | An SIP is issued by the district or city government; requires an STR and a place of practice; valid as long as the place of practice matches [3] | The SIP is tied to the place of practice |
| Health Law Articles 290 and 291 | Delegation by mandate or by delegation of authority; professional standards drawn up by the Council and the Colleges and set by the Minister, read conditionally by MK Decision 182/PUU-XXII/2024 [3], [33] | Source of limits of acts through delegation and standards |
| Health Law Articles 312, 313, 439, 441 and 442 | Prohibition of practice without an STR and/or SIP and of posing as licensed; administrative sanction for staff; criminal penalty for persons who are not health workers and for employers [3] | The line between lawful practice and practice that breaks the law |
| Health Law Articles 449 and 454 | STRs and SIPs already issued remain valid until they expire; the nursing law is declared no longer valid [3], [5] | Transition of the validity of licences |
| GR 28/2024 Articles 739, 740, 742 and 743 | Practice independently and/or in other facilities; disclosure of identity; practice according to competence-based authority, with the highest qualification and added training recorded in the STR; services according to clinical authority [9] | Core of authority and openness of practice |
| GR 28/2024 Articles 745 and 746 | Delegation by mandate or by delegation of authority; under mandate responsibility stays with the giver; the facility head determines the services that may be delegated; further provisions by ministerial regulation [9] | Basis of delegation; the follow-up ministerial regulation was not found |
| MoH Reg. 13/2025 (secondary summary) | Article 305(1): practice authority refers to the existing ministerial regulation until new professional standards are set; Article 309: revokes 61 regulations, including MoH Reg. 26/2019 [7], [8] | Point of uncertainty in the transition |
| Minister of Health Decree HK.01.07/MENKES/425/2020 | The nursing professional standard consists of a competence standard and a code of ethics [30] | Yardstick of competence; its status after the Health Law was not examined |

Note: the third column is the authors' reading. Articles of MoH Reg. 13/2025 were read from a secondary commentary because its primary text could not be read.

From those norms, a nurse's authority is built in three layers. The first layer is the basis of authority. A person becomes a nurse in law through education, competence and a lifetime registration certificate (*Surat Tanda Registrasi*, STR) (Articles 199 and 260 of the Health Law) [3], and the room for action is set by competence, with the highest qualification and any additional authority gained through training recorded in the STR (Article 742 of GR 28/2024) [9]. The second layer is the licence. The practice licence (*Surat Izin Praktik*, SIP) is issued by the district or city government, requires an STR and a place of practice, and is valid as long as the place of practice matches (Articles 263 and 264) [3]. The third layer is performance, including delegation by mandate or by delegation of authority (Article 290) and sanctions. Figure 1 summarises the three layers and their point of uncertainty.

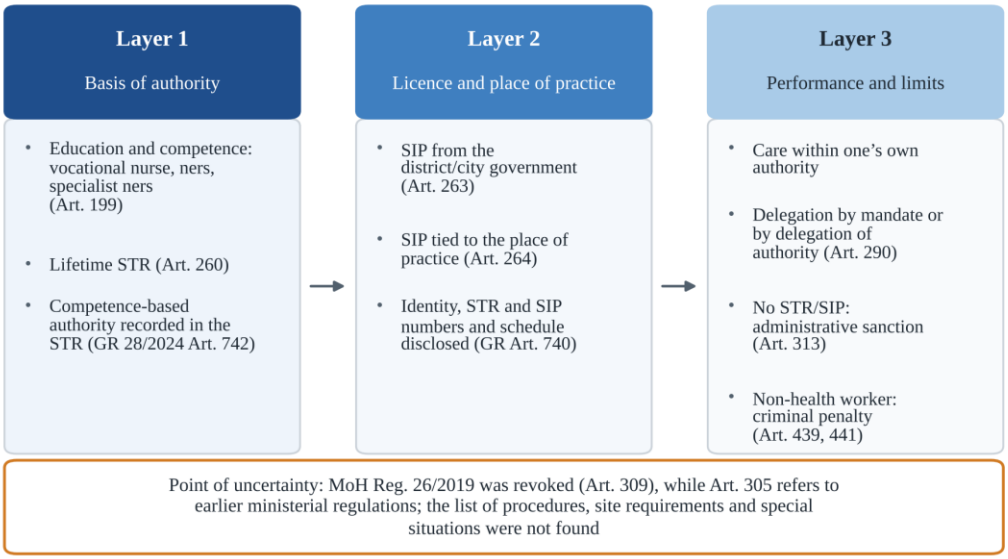



**Figure 1.** Layers of the basis of authority, the licence and the limits of independent nursing practice, and their point of uncertainty. Prepared by the authors based on [3], [8], [9], [36]; the division into layers and the marking of the point of uncertainty are the authors' reading.

Table 2 compares the old regime with the new. The most important difference is in how authority is worded. MoH Reg. 26/2019 detailed authority by level: a professional nurse has the authority listed in Article 17 letters a to j and may make a nursing diagnosis (Article 18), while a vocational nurse has part of that authority, with assessment limited to basic assessment (Article 19) [6]. The new regime words it generally as competence-based authority [9]. In the authors' reading, the detail of acts for each level has moved from regulation to professional standards, so the certainty of the limits of acts now depends on the content and status of those standards.

**Table 2.** Comparison of the old and new regimes

| Element | Old regime (Law 38/2014 and MoH Reg. 26/2019) | New regime (Health Law, GR 28/2024, MoH Reg. 13/2025) |
|---|---|---|
| Status | Law 38/2014 declared no longer valid [5]; MoH Reg. 26/2019 revoked [7], [8] | In force; MoH Reg. 13/2025 promulgated November 3, 2025 [7] |
| Types of nurse | Vocational nurses and professional nurses (*ners* and specialist *ners*) [6] | Vocational nurses, *ners* and specialist *ners* (Article 199) [3] |
| Registration and licence | A nurse practice licence from the district or city government, valid for one facility, at most two (Articles 7 and 8) [6] | A lifetime STR and an SIP per place of practice [3], [36]; according to the summary, at most three SIPs and a validity of five years [8]; no nurse-specific rule stated |

| Element | Old regime (Law 38/2014 and MoH Reg. 26/2019) | New regime (Health Law, GR 28/2024, MoH Reg. 13/2025) |
|---|---|---|
| Authority | Detailed by level (Articles 17 to 19) [6] | Competence-based; the highest qualification and training recorded in the STR (Article 742) [9]; no list of acts for each level was found |
| Requirements of independent practice | An independent nurse at least *ners* level (Article 15(9)); place, building, infrastructure, equipment, medicines, medical waste, health-office assessment, reporting to the community health centre (Articles 38 to 51) [6] | Practice independently and/or in other facilities with disclosure of identity (Articles 739 and 740) [9]; no standard for nurses' independent practice sites was found |
| Delegation | Mandate or delegation of authority; medical acts on a written request from a doctor (Articles 27, 28 and 37(6)) [6] | Mandate or delegation of authority (Articles 290 and 745); the facility head determines the services that may be delegated [3], [9] |
| Emergencies and areas without doctors | Acts and medicine within competence, then referral; limited authority in pharmacy (Articles 30 to 33) [6] | No replacement provision was found; MK Decision 12/PUU-VIII/2010 interprets the old law [5], [31] |
| Independent vocational nurses | Transition of at most seven years from promulgation (Article 54) [6] | No replacement provision was found |
| Sanctions | A nurse practising without a permit was treated as committing an administrative violation in one study [15] | Administrative fine (Article 313); administrative sanctions (GR 28/2024 Articles 735 and 736); criminal penalties for persons outside the profession and for employers (Articles 439, 441, 442) [3], [9] |

Note: the comparison is the authors' reading. Articles of MoH Reg. 13/2025 were read from a secondary commentary.

The nursing professional standard the authors found is Minister of Health Decree No. HK.01.07/MENKES/425/2020 of July 13, 2020. It states that the professional standard consists of a competence standard and a code of ethics, with the competence standard in five areas, including professional nursing practice [30]. That text does not regulate authority or independent practice explicitly. Its list of diagnoses and skills marks some to be done independently and completely, and others only under supervision or with referral, which is an indirect indication of the limits of independence [30]. Article 291 of the Health Law states that professional standards are drawn up by the Council (*Konsil*) and the Colleges (*Kolegium*) and set by the Minister [3]. MK Decision 182/PUU-XXII/2024, which according to the summary was pronounced on January 30, 2026, declared that phrase conditionally non-binding unless it is understood to involve professional organisations, with the Minister's role being administrative [33]. The standard awaited by Article 305(1) will therefore be drawn up differently from the 2020 ministerial decree. Whether the 2020 decree remains in force as a standard during the transition is not stated in the text that was read.

### 3.2 Delegation and special situations in independent practice

Delegation is the first weak point for an independent nurse. Article 290 of the Health Law regulates delegation by mandate or by delegation of authority, and Article 745 of GR 28/2024 states that a mandate is a delegation of duty with responsibility staying with the giver of authority, and that the head of a health facility determines which services may be delegated; paragraph (3) of that article could not be read [3], [9]. MoH Reg. 26/2019 contained two provisions close to independent practice: delegation of a medical act to an independent nurse requires a written request from a doctor (Article 37(6)), and delegation by transfer of authority is only for professional nurses or trained vocational nurses (Article 28(5)) [6]. In independent practice there is no facility head to determine a list of services, and the written-request requirement disappeared with the revocation of the ministerial regulation. In the authors' reading, Article 745(4) cannot operate as written in independent practice, so who sets the limits of delegation becomes unclear.

As a result the risk tends to shift to the nurse. Hertanto concludes that under delegation by transfer of authority responsibility passes to the receiving nurse [11], Praboandini and Jie require written form, fit with competence, supervision and exclusion of strategic medical decisions [13], and Putra et al. found that delegation in community health centres is generally not written [10]. If delegation is loose even in community health centres that have a head and doctors, in the authors' reading the looseness is greater in independent practice, which has neither. Kresnahadi notes that a general nursing professional standard makes delegation of clinical mandate uncertain [14], and that note is consistent with the reading above.

Special situations are the second weak point. MoH Reg. 26/2019 provided that in an emergency a nurse may carry out medical acts and give medicine within competence as first aid and must refer the patient afterwards (Article 33), and that in areas without medical personnel and/or pharmacy personnel a nurse may treat common illnesses with limited authority in pharmacy until such personnel are available (Articles 30 to 32) [6]. MK Decision 12/PUU-VIII/2010, pronounced on June 27, 2011, granted in part the petition of several nurses and heads of community health centres from remote areas of East Kalimantan. One of the petitioners, Misran, according to Hukumonline had been sentenced to three months in prison for giving medicine to a patient who needed help [31], [32]. The Court declared Article 108(1) of Law No. 36 of 2009 contrary to the 1945 Constitution unless it is understood that, where no pharmacy personnel exist, certain health workers, including nurses working in an emergency that threatens life, may carry out limited pharmacy practice. The Court also declared the elucidation of that article non-binding and considered that the norm should be in the article, not in the elucidation [31], [32].

That decision interprets a law that is no longer in force [5]. The authors did not find, in the text read, a replacement provision for emergencies and areas without doctors in the new regime, and Article 744 of GR 28/2024 could not be read. The force of the 2011 decision for the new regime is also not discussed in the sources read. Adrianto et al. found a gap between regulation and practice in remote areas [17]; that finding is a reminder that unclear norms on special situations are felt most where doctors are fewest.

### 3.3 Requirements of independent practice and the limits of lawful practice

The first requirement is the STR. Article 260 of the Health Law makes an STR mandatory, issued by the Council on behalf of the Minister on the basis of a diploma and a competence certificate, and valid for life [3]. The second requirement is an SIP tied to the place of practice (Article 264) [3]. According to the Ministry of Health, one SIP is valid for only one place of practice (Article 682(2) of GR 28/2024) [36]. According to the summary of a commentary on MoH Reg. 13/2025, the number of SIPs is capped at three (Article 149), with a validity of five years and a renewal that mainly requires sufficient professional credit units (Articles 157 and 158) [8]. Under the old regime a nurse could hold at most two nurse practice licences (Article 8(1) of MoH Reg. 26/2019) [6]. In 2024 the Ministry of Health mentioned the allowance of practice at three places only for doctors and dentists [36], so the two sources are not fully aligned and the limit for nurses is not stated explicitly in the sources read.

Article 740 of GR 28/2024 requires disclosure of identity, namely name and title, expertise, SIP and STR numbers, and practice schedule [9]. Under the old regime the signboard had to show at least the nurse's name, registration certificate number, practice licence number, and a statement that nursing care is provided (Article 15(8)) [6]. For nurses whose licences were issued before the Health Law, Article 449 states that STRs and SIPs already issued remain valid until their validity period ends [3], [37]. In the authors' reading, that article gives certainty about the validity period of the licence, not certainty about the limits of authority.

Requirements for the place of practice are harder to pin down. MoH Reg. 26/2019 required a location easy to reach for referral, a permanent building that is not physically joined to another building and has a separate entrance if it is in a dwelling, minimum rooms, basic infrastructure, equipment, medicines and consumables, medical waste management, a feasibility assessment by the district or city health office as the basis for a licence

recommendation, and recording and reporting to the community health centre of the practice area (Articles 38 to 47 and 51) [6]. The new regime says practice may be conducted independently and/or in other facilities (Article 739) and leaves further provisions to a ministerial regulation (Article 746) [9]; the authors did not find a ministerial regulation specific to nurses' independent practice sites. The service standard for SIPs in one regency, set in October 2024, requires an STR, a statement of the place of practice which for independent practice is acknowledged by the health office, a recommendation from the head of the community health centre of the practice area, and a health certificate, with a validity of five years, a processing time of at most five working days, no fee, and no recommendation from a professional organisation [35]. MK Decision 182/PUU-XXII/2024 rejected the petition concerning recommendations from professional organisations for SIPs [33]. In the authors' reading, requirements for the place of practice are now set by regional implementers, and a document from one regency cannot be generalised.

Vocational nurses face a separate question. MoH Reg. 26/2019 set the minimum education of an independent nurse at the professional (*ners*) level (Article 15(9)) and gave vocational nurses already in independent practice a transition of at most seven years from the promulgation of the regulation to continue practising (Article 54) [4], [6]. By the authors' calculation that deadline fell around August 2026, before this study was made, and no replacement provision for vocational nurses in the new regime was found.

Table 3 distinguishes acts and situations by their standing, namely permitted, permitted with conditions, prohibited, and unclear.

**Table 3.** Acts and situations by their standing

| Act or situation | Standing | Basis and notes |
|---|---|---|
| Nursing care within competence and level by a nurse with an STR and an SIP at the listed place of practice | Permitted | Articles 260 and 264 of the Health Law; Article 742 of GR 28/2024 [3], [9]; no list of acts for each level was found |
| Practice by a nurse without an STR and/or SIP | Prohibited; administrative sanction | Articles 312 letter c and 313; administrative fine, with the procedure in a government regulation [3] |
| Practice at a place that does not match the SIP | Prohibited in the authors' reading | The SIP is valid as long as the place of practice matches (Article 264) [3]; one SIP for one place of practice [36] |
| A person who is not a health worker practises as if holding an SIP, or uses a title or means that gives that impression | Prohibited; criminal penalty | Articles 439 and 441 [3]; example of a decision on a person outside the profession [34] |
| Employing a nurse without an SIP | Prohibited; criminal penalty | Article 442 [3] |
| A medical act on delegation by mandate | Permitted with conditions | Responsibility stays with the giver (Article 745(2)) [9]; written form and competence [13]; who sets the list in independent practice is unclear |
| A medical act on delegation by transfer of authority | Permitted with conditions | Responsibility passes to the nurse [11]; written form, competence and supervision [13]; under the old regime only for professional nurses or trained vocational nurses (Article 28(5)) [6] |
| An act outside competence without delegation | Prohibited in the authors' reading | Authority is based on competence (Article 742) [9] |
| First aid in an emergency that threatens life, including limited acts outside routine | Unclear in the new regime | Old regime: Article 33 [6]; MK Decision 12/PUU-VIII/2010 for limited pharmacy practice in an emergency [31]; no replacement provision was found |
| Treating common illnesses in an area without doctors | Unclear in the new regime | Old regime: Articles 30 to 32 [6]; no replacement provision was found |

| Act or situation | Standing | Basis and notes |
|---|---|---|
| A vocational nurse in independent practice | Unclear | Old regime: at least *ners* level and a seven-year transition (Articles 15(9) and 54) [6]; no new provision was found |

Note: the standing column is the authors' classification of the text that was read; the text contains no list of permitted and prohibited acts for independent nurses.

The line between lawful practice and practice that breaks the law is drawn by Article 312 of the Health Law. Everyone is prohibited from using, without right, an identity in the form of a title or other form that gives the impression of being a medical person or health worker who holds an STR and/or SIP (letter a), from using tools, methods or other means that give a similar impression (letter b), and from practising as a medical person or health worker without an STR and/or SIP (letter c) [3]. For staff who practise without an STR and/or SIP, Article 313(1) sets an administrative sanction in the form of an administrative fine, with the procedure to be set by government regulation, and GR 28/2024 contains administrative sanctions for medical personnel and health workers in Articles 735 and 736 [3], [9]. Criminal penalties are aimed at others, namely a person who is not a medical person or health worker but practises as if holding an SIP (Article 439), a person who uses an identity or means giving that impression (Article 441, with a maximum of five years' imprisonment or a fine of up to Rp500 million in paragraph (1)), and a person who employs staff without an SIP (Article 442, with the same penalty) [3]. The amounts of the fines may change because of the adjustment of criminal penalties, which was not examined for these articles.

In the authors' reading, that wording means a registered nurse who is not yet licensed faces an administrative sanction, while criminal law targets people outside the profession and employers. This direction is consistent with Lintang, who under the old regime judged that a nurse fined for practising without a permit committed an administrative violation [15]. Purwokerto District Court Decision No. 229/Pid.Sus/2019/PN Pwt of November 7, 2019 imposed five months' imprisonment on a defendant who, according to the verdict, was not a health worker but practised as if a licensed health worker. The directory page does not give the basis of the charge, and the decision is not about a nurse; it is used only to show that criminal law targets people outside the profession, and that similar conduct is now closer to Article 439 [3], [34].

### 3.4 Legal certainty of the limits of nurses' authority

Table 4 tests legal certainty with the four questions set in the literature review, with element (a) split into general acts and delegation. The assessments in that table are the authors' reading of the text that was read.

**Table 4.** Legal certainty test of the limits of nurses' authority

| Test question | Finding | Assessment |
|---|---|---|
| (a) Acts that fall within authority | Competence-based authority (Article 742); no replacement for the list by level in MoH Reg. 26/2019 was found; the 2020 professional standard does not regulate authority explicitly [6], [9], [30] | Partial |
| (a) Delegation in independent practice | Article 745(4) relies on the facility head; the requirement of a doctor's written request was revoked as well [6], [9] | Unclear |
| (a) Emergencies and areas without doctors | The old norm was revoked; the MK decision interprets the old law; no replacement was found [6], [31] | Unclear |
| (b) Requirements to practise | The STR and SIP are clear at statute level (Articles 260 and 264); requirements for the place of practice are set by the region [3], [35] | Partial |
| (c) Consequences of a violation | The form of sanction is clear (Articles 313, 439, 441, 442); criteria and amounts of the administrative fine were not found [3] | Partial |

| Test question | Finding | Assessment |
|---|---|---|
| (d) Transitional norm | Article 305 refers to earlier regulations although Article 309 revokes MoH Reg. 26/2019; the status of the 2020 professional standard is not stated; who drafts standards has changed [8], [33] | Unclear |
| (d) Validity of old licences | STRs and SIPs already issued remain valid until they expire (Article 449) [3], [37] | Sufficiently clear |

Note: the assessment is the authors' reading; Articles 305 and 309 were read from a secondary commentary.

The most critical point is the transitional norm. According to the secondary summary, Article 305(1) of MoH Reg. 13/2025 refers to the existing ministerial regulation for the profession until a new professional standard is set, while Article 309 revokes MoH Reg. 26/2019 [8]. In the authors' reading, at least three readings are possible. On the first reading, the content of MoH Reg. 26/2019 remains the reference during the transition; this is hard to reconcile with the revocation, because a revoked norm loses its binding force as a regulation. On the second reading, what is referred to is another ministerial regulation or ministerial decree that still exists for the nursing profession, such as the 2020 professional standard decree; this gives a competence reference but contains no rules of independent practice [30]. On the third reading, nurses no longer have a specific ministerial regulation, so their authority rests only on Article 742 of GR 28/2024 and professional standards. The practical results differ. For example, whether a nurse in an area without doctors may still treat common illnesses with limited pharmacy authority, or whether a vocational nurse already in independent practice may continue, depends on which reading is chosen. The primary text of Article 305 is needed to settle the correct reading.

Institutional uncertainty adds to the problem. MK Decision 182/PUU-XXII/2024 declared Article 311(1) conditionally non-binding unless it is understood that medical personnel and health workers form a single professional-organisation body as a "big house", to be coordinated by the coordinating minister within one year of the decision [33]. By the authors' calculation that deadline falls around the end of January 2027. As long as that body has not been formed and new professional standards have not been drawn up, who is authorised to draw up nurses' competence standards in the new system remains in transition.

Table 5 summarises the decisions and case documents that were read. Three things can be noted. First, the Court twice stressed where a norm belongs: in 2011, the norm on emergencies should be in the article, not the elucidation [31]; in 2026, drawing up professional standards must involve professional organisations and the Minister's role is administrative [33]. Second, no decision applying Article 312 letter c or Article 313 to a nurse was found. Third, implementing documents and field findings show variation: SIP requirements are set by the region [35] and delegation in community health centres is often not written [10].

**Table 5.** Decisions and case documents that were read

| Document | Content | Relevance | Not known |
|---|---|---|---|
| MK Decision 12/PUU-VIII/2010 (pronounced June 27, 2011) | Petitioners were nurses and heads of community health centres from remote areas of East Kalimantan; Article 108(1) of Law 36/2009 read conditionally and its elucidation non-binding; a nurse in an emergency that threatens life may carry out limited pharmacy practice [31], [32] | Limits of a nurse's authority in an emergency; the norm should be in the article | Full text not read; its force for the new regime is not discussed |
| MK Decision 182/PUU-XXII/2024 (January 30, 2026 according to the summary) | Article 291(2) read conditionally with the involvement of professional organisations and an administrative role for the Minister; Article 311(1) read as a single "big house" body; other petitions, including professional-organisation recommendations for SIPs, rejected [33] | Who drafts professional standards; institutions of the profession | Full text not read; nurses are not mentioned specifically |
| Purwokerto District Court Decision 229/Pid.Sus/2019/PN Pwt (November 7, 2019) | A defendant who was not a health worker practised as if licensed; five months' imprisonment [34] | Criminal law targets persons outside the profession | Not a nurse; the basis of the charge is not visible; before the Health Law |
| Sidoarjo District Court Decision 1167/Pid.B/2010/PN. Sda | Analysed as an example of the difficulty of nurses who act on a doctor's instruction [13] | Responsibility under delegation | Decision not read; known only from the article |
| A nurse fined for practising without a permit | Discussed by Lintang and judged an administrative violation [15] | Continuity of the administrative sanction | Decision not identified; known only from the article; old regime |
| Service standard for SIPs, Bantul Regency (October 14, 2024) | Requirements for health workers' SIPs; in independent practice the statement of the place of practice is acknowledged by the health office; includes a nurse SIP product [35] | Implementation of licensing in the region | One regency; other regions not examined |
| Findings of Putra et al. (Kerinci, 2025) | Five community health centres; delegation generally not written [10] | Practice of delegation | Another researcher's findings, from an abstract; not independent practice |

Note: the fourth column is the authors' reading. Sources: as cited in the table.

### 3.5 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 [22]. According to the commentary, MoH Reg. 13/2025 revoked 61 regulations in a single instrument [8]. Tanjung and Arminsyah's study concerns the omnibus law, not ministerial regulations, and the link below is the authors' reading. Such consolidation can simplify, but when a regulation specific to one profession is revoked without a replacement text that can be pointed to in the articles read, the government's power to change regulations turns into uncertainty for nurses. Whether the drafting of MoH Reg. 13/2025 involved public participation, including nurses' organisations, is not known to the authors.

Tanjung, Syahnan and Syahputra judge that compelling urgency may justify departing from the ordinary procedure, but flag the danger of subjectivity and abuse and therefore want

more transparent approval [23]. That study concerns a government regulation in lieu of law, not nurses, and the analogy below is the authors' proposal. An emergency justifies a nurse acting outside the routine of her acts, and the same danger of subjectivity can arise because the nurse herself judges that the situation is an emergency. Objective safeguards can be three elements visible in the old norm and the MK decision, namely a threat to life, action limited to competence and first aid, and a duty to refer afterwards [6], [31]. Placing that norm in the article, as the Court considered, is consistent with Tanjung et al.'s demand for transparency: the limits of departure should be written in a norm that nurses can read before an emergency occurs.

Tanjung notes that the supervision of judges is divided among several institutions [24]. A similar pattern appears in nurses' independent practice: district and city governments issue SIPs, the health office assessed the place of practice under the old regime, community health centres receive reports, the Council issues STRs, the Colleges and professional organisations take part in standards, and disputes involving health workers pass through a council recommendation and out-of-court settlement (Article 308(2) and Article 310) [3], [6], [33]. Adrianto et al.'s finding of weak coordination among institutions [17] and Sinaga et al.'s finding that institutional roles and technical procedures for non-litigation settlement are not yet regulated [18] are consistent with this. From the articles read, a patient harmed by an independent nurse gets no guidance on which institution to complain to first.

Tanjung and Adriani analyse penal and non-penal efforts, Tanjung's narcotics study proposes an integrated approach [25], [26], and Suwarto, Sutiarnoto and Magda suggest harmonisation of norms and integration of penal and non-penal policy [28]. For practice without a licence, the existing division appears consistent with that view: an administrative sanction for staff who are not yet licensed, and criminal law for people outside the profession and for employers. Mahruzar et al. see criminal law as a last resort [29]. In the authors' reading, an integrated approach to independent practice means guidance and licensing first, administrative sanctions for a nurse's violations, and criminal law for those who pose as licensed or employ staff without a licence. The criteria for choosing a sanction and the amount of the administrative fine were not found, so that integration cannot yet be tested.

The model of Tanjung, Arminsyah and Syam stresses regulatory synchronisation so that the division of authority between the settling body and the courts is clear [27]. Its application to nurses' authority is the authors' proposal, namely synchronisation among the Health Law, GR 28/2024, MoH Reg. 13/2025 and the professional standards drawn up by the Council and the Colleges through a transitional regulation that states which old provisions remain a reference. Chairul et al. stress substantive application of informed consent [19], [20], and Carlos et al. note the basis for acting in an emergency without prior consent [21]. In the authors' reading, a nurse's emergency authority needs to be read together with the duty to give information, because in independent practice the nurse is the only person who explains the act to the patient.

## Recommendations

Six steps follow from this analysis. First, the Minister of Health should issue an explanation or a transitional regulation that states which old provisions on nurses' authority and independent practice remain a reference until new professional standards are set, including for vocational nurses. Second, the Council, the Colleges and nurses' professional organisations should draw up professional standards that contain a list of acts for each level, with markers for acts done independently, acts under delegation, and acts that require referral. Third, a ministerial regulation as meant by Article 746 of GR 28/2024 is needed that sets requirements for nurses' independent practice sites and a delegation mechanism for practice with no facility head. Fourth, the norm on emergencies and areas without doctors should be placed in the article, following the reasoning of MK Decision 12/PUU-VIII/2010, with objective safeguards of a threat to life, the limit of competence and a duty to refer. Fifth, regional governments should align and publish SIP service standards and complaint channels. Sixth, further research should

read the official text of MoH Reg. 13/2025, trace decisions involving nurses, and collect data on independent practice.

## Conclusion

First, the regulation of nurses' authority in independent practice is layered. The Health Law sets nursing personnel, a lifetime STR, an SIP tied to the place of practice, and delegation by mandate or by delegation of authority; GR 28/2024 sets that practice is conducted according to competence-based authority. The detail of acts for each level and the requirements for independent practice sites, which were previously in MoH Reg. 26/2019, were not found replaced in the text that was read.

Second, legal certainty of the limits of authority is partial. The basis of authority and sanctions is clear: staff who practise without an STR or SIP face an administrative sanction, while criminal law targets people outside the profession and those who employ staff without an SIP. What is not yet certain is the limit of acts for each level, delegation in practice with no facility head, emergencies and areas without doctors, the requirements for the place of practice, the status of vocational nurses, and the transitional norm, because according to the summary the authors read the transitional provision refers to earlier ministerial regulations although the nursing-specific regulation has been revoked.

Third, the authors recommend a clear transitional regulation, professional standards that contain a list of acts for each level, a ministerial regulation on independent practice, an emergency norm placed in the article, and alignment of service standards in the regions. Further research should read the official text of MoH Reg. 13/2025, trace decisions involving nurses, and collect data on independent practice.

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